AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/30/07	Surgery POD #2
	No F/C. Face contused. Hungry
	APPI wet more wound
	d (L) PDL paresis, hypoglossal paresis, facial droop
	(L) 4/5 strength 4/5
	wounds healing, scans dry.
	d/c to neck exploring LSW neck. stable
	d TC wound
	[redacted] (b)(6)-2
	WAS

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.

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

MEDICAL RECORD	PROGRESS NOTES

DATE

20 Aug 03 1526 Received pt ~~restime~~ from ICU in stable condition. VSS, sats @ 95%, no resp distress noted. LS w/ minor wheezes, clear w/ cough. encs'd CPB and IS. Pt able to raise dark blue bars halfway w/ enc. Tol PO, H_2O. IV to ⓛ ac patent & intact IV= infusing w/o apparent complication. ⓡ fa HL patent & intact, flushes easily. HOB ↑, Pt able to cough up own secretions, needs enc. suction @ BS as precaution for resp management. Staples to ⓛ neck OTA w/ bacitracin. Ins to ⓛ neck ear and back of head w/ drug c/i, drug Δ done in ICU prior to arrival. Per report pt foley d/c'ed @ 1130, pt has not yet voided c this time. Restraints in place per CPW protocol. Circulation and skin integrity checked and intact. Medicated x1 w/ ⅓ percocet. Will cont to monitor. HR, pulse equal & bilaterally strong.

[redacted] (b)(6)-2

1616 Pt had not voided, c/o cramp, bladder distended abd tent. Stood pt to urinate & voided 100 cc w/ difficulty. Pt cont to have pain and distention and unable to urinate. Foley placed and pt

(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] (b)(6)-2

#[redacted] CPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
30aug 1616	cont had relief. 1100 cc urine return upon placement distention resolved. Foley left in place, will notify md. [redacted] (b)(6)-2 /LAN
30aug 2000	Pt lying in bed. HOB ↑. suction @BS VSS: O2 Sat 95%. Pt A&O, speaking in Arabic. HRRR, resp. even & unlabored. productive cough c̄ expectorant. COB & IS encouraged. Staples to (L) neck open to air c̄ bacitracin applied. Drsg to (R) ear & back of neck DII. Foley to gravity: cloudy yellow urine. 2 pt restraints on, circulation assessed. +2 pulses, brisk cap refill. Abx given. will cont to monitor [redacted] (b)(6)-2 911 WMB, RC [redacted] (b)(6)-2
31aug @0515	Drsg to neck changed. small amt of drainage noted. Bacitracin applied to (R) ear. Foley draining dark yellow cloudy urine. 2 pt restraints on. circulation assessed. Will cont to mon [redacted] (b)(6)-2 911 WMB
31AUG03 @0800	VSS. Alert & cooperative. Answered questions. diet ~~B~~ fed self. HOB ↑30°. Had productive cough. Lungs clear. O2 SAT 96% RA. Use IS properly @ 900cc/sec. Foley to gravity drainage clear yellow urine. (L) AC IV patent & intact. infusing LR @ 75cc/hr. Restraints removed and reapplied, ~~cont~~ skin intact. Will check restraints, skin integrity, and capillary refill frequently [redacted] RN (b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	(cont) open to air. Pt has productive cough. Enc. use of IS. Lungs CTA⊕ ⊕BS X4 quads. IVF infusing into IV in ⊙ac ⊼ S/Sx infection/ infiltration. Cont. IV anbx. Foley draining quantity sufficient clear yellow urine. Pt tol reg diet well. 2 point restraints in place - ∅ S/Sx complications ⊼ circulation/skin breakdown. Will cont. to monitor. (b)(6)-2 [redacted]
1Sep03 1930	: VSS, ∅/10 pain @ this time, A+O X3, minimal ROM to neck area R/T injury. Staples to (L) side of neck - open to air. Pt. has some edema to face. Sats 97% RA, ∅ signs of distress. Pt now getting OOB and ambulating during the day. Foley to gravity draining clear yellow urine. Tolerates PO. IV Hl to (L) AC flushed & patent - continuing IV Ancef. Restraints x2 when in bed. S_1S_2, LCTAB, ⊕BS x4. ∅ other remarkable assessment findings. Continue to monitor. (b)(6)-2 [redacted]
1Sep03 @ 1950	- Addendum Note: Power back on now, so can assess ⊼ better light. Pt.'s left eye more swollen than (R) eye. Visual acuity WNL. DSG's to back of neck CDI. (L) ear swollen, applying bacitracin to it. Sutures to (L) ear & back of neck (under DSG's). Pt is

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
31 Aug @ 1930	Pt sitting up in bed consuming dinner c̄ some assistance. VSS, lungs CTA(B) HRRR productive cough. IS used often. O^2 Sat 96%. Drsg to (R) side of neck & back of neck CDI. (L) ear staples open to air. Bacitracin applied to (R) ear. Foley to gravity draining dark yellow urine c̄ some sediment. IVF to (R) AC infusing ∃ complication. Pt pulled out HL to (R) arm - catheter intact. Will cont to monitor (b)(6)-2 [redacted] 91WM6.
31 Aug @ 2030	Pt was sleeping c̄ head toward (L) side, & woke up c̄ swollen (L) eye. HOB ↑ & warm compress applied. Will mon. for ↓ in swelling. (b)(6)-2 [redacted] 91WM6, SC
1 Sep 03 @ 0200	Drsg A'd to back of neck, small amt of drainage. Bacitracin applied to (L) ear. Swelling to (L) side of face ↓. Pt ambulated c̄ assistance down hallway x2. Restraints put back on. Circulation assessed frequently. HOB ↑. IVF cont to (L) AC ∃ complication. Foley draining dark cloudy urine. ∅ Bm. Will cont to mon - (b)(6)-2 [redacted] 91WM6
1 Sep 03 @ 0430	HCT: 23.5 RBC & HGB ↓ L per this AM blood draw. Circulation assessed - (b)(6)-2 [redacted] 91WM6.
01 SEP 03	(1025) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ ⅡPerc this am for pain c̄ good relief. Drsg to back of neck CDI. staples to (L) ear/neck CDI -

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

[redacted]
(b)(6)-4

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Continued	from 18Sep03 1950: ambulating in hall c up escort. (L) side of face obviously > swollen than (R). [redacted] (b)(6)-2
8/3/03	Surgery 1006
	NV Δ. Ambulatory w/ walker
	MEWS.
	(L) Pleural poly. (D) WX motor 3/5
	Stable s/p neck exploration.
	TAntm. Nl [illegible]
	[redacted] (b)(6)-2
02SEP03	(1240) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking/mumbling Arabic. VSS. Pain controlled c̄ Percs. Staples to (D) ear/neck CDI. Drsgs to back of neck Δd this am. Pen rose drain to back of neck draining sm. amount sero-sang drainage. (D) side of face swollen. Pt able to open (D) eye. PERRLA. Tol reg diet. Foley dlcd this am. Pt voiding clear yellow urine s̄ difficulty. SL in (D) arm flushes s̄ difficulty - ϕ S/Sx infection/infiltration. 2 point restraints in place - ϕ S/Sx complications c̄ circulation/skin breakdown. Will cont. to monitor. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT (b)(6)-2
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) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02SEP03	(1415) Pt OOB to amb in hallway c̄ c/o dizziness when pt first started to amb. Pt cont. to void clear yellow urine s̄ difficulty. monitoring. (b)(6)-2 [redacted]
2 Sep03 @ 1935	Pt resting un bed. VSS, HOB ↑ 30°. HRRR, lungs CTA (B) prod. cough. ⊕BS x4qd, +2 pulses. brisk cap refill to digits. 2 pt. restraints on, circulation assessed. HL to (D) AC flushing easily. Drsg to back of neck CDI. Bactracin applied to (L) ear. Pt voiding using urinal s̄ difficulty. Cyn. Suction @ BS for precautions. Will cont to monitor (b)(6)-2 [redacted]
2100	Pt ambulated c̄ unsteady gait. movement c̄ (L) side of body increasing. Will cont to monitor — (b)(6)-2 [redacted]
03SEP03	(1025) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Staples to (D) ear/neck CDI - open to air. Drsg to penrose drain ∆d this am by MD. Small amount sero-sang drainage noted. Pt tol reg diet well. Voiding s̄ difficulty. SL in (D) forearm flushes well s̄ S/Sx infection/infiltration. 2 point restraints in place - ∅ S/Sx complications from skin breakd/circulation. Will cont. to monitor. (b)(6)-2 [redacted]
	(1505) Pt OOB to amb in hallway s̄ difficulty. ∅ c/o dizziness, gait steady. ROM improving on (D) side. Pt sitting ↑ in chair @ this time. Will continue to monitor. (b)(6)-2 [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Sep Ø3 @ 1855	Pt a10x3, sitting ↑ un bed. VSS, HRRR, lungs: CTA(B), (+) BS x4 qd. drsg to pen nose drain CDI. staples to (L) side of neck + ear OTA. Ø drainage noted. Ø c/o pain @ this time. + pulses to extr, brisk cap refill. circulation assessed often. 2 pt restraints on. Bactracin applied to ear (L). Will cont to monitor (b)(6)-2 [redacted] 9Nwmle, [redacted] (b)(6)-2 (PT)
3 Sep @ 2215	Pt amb. down hallway, needs minimal assistance if any. ROM c̄ left side increasing. Heparin 5000 sq given. Will cont to monitor (b)(6)-2 [redacted] 9NWMC SPC
4 Sep 03 0900	Ms O appropriately. VSS. WNL. Staples to (L) neck & ear CDI. Penrose to back of neck d/c'd by MD this a.m. minimal sero-sang. drainage. Drsgs to back of neck d/c'd. Facial swelling ↓. No c/o pain. 2 pt restraints. Skin integrity & circulation intact. Tolerated breakfast. Will get OOB to ambulate & shower (b)(6)-2 [redacted] MWS
4 Sept 03 1430	OOB to shower. Neck drsgs d/c'd. medicated c two percocet p.o. for c/o pain. Will continue monitoring (b)(6)-2 [redacted] MWS
4 Sep Ø3 @ 1945	Pt a10, sitting ↑ un bed. New IV 18G. started to (R) arm. (SL). VSS, HRRR, lungs CTA(B), (+) BS x4 qdn

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RE [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(b)(2)-2

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. 1CW 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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1945 CONT (4Sep03)	Sutures removed from (R) ear by MD this AM. Bacitracin applied to wound. (R) neck staples OTA: Ø s/sx infection. Drsg to back of neck (2x2). Encouraging PO fluids, H2O @ BS within reach. IS encouraged. 2 pt restraints on. circulation (b)(6)-2 [redacted] ~~applied~~. intact. ambulated down hallway C minimal assistance. Will cont. to monitor [redacted] 9WM6 (b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

(b)(6)-4 [redacted]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5Sep03 0700			Pt complains of pain along the whole neck region. Vitals are good. Left side of neck has staples, no visual sign of drainage or infection. Left ear had staples removed, healing nicely. Given pain medication for discomfort. Will continue to access Pt. (b)(6)-2
			I concur c̄ above assessment (b)(6)-2 [redacted] RN/AN
5Sep03		1310	– Pt. c/o pain to (R) side and back of neck medicated c̄ ii tabs of percocets (b)(6)-2 [redacted] RN
5Sep03	@1915		= VSS, Φ10 pain, A+O x3, staples to (L) side of neck, (L) facial edema, can open mouth but less movement on (L) side of mouth. ↓ facial movement in (L) side in general. Applying bacitracin to (L) ear wounds. Dsg's to back of neck CDI, sutures approximated. IV HL to (L) FA infiltrated ∅ blood return D/C'd intact. Restarted new IV HL'd to (L) upper FA patent when flushed c̄ good blood return. Tolerates PO well. OOB & ambulating in hallway this evening ∅ difficulty. Steady gait, guarded of face. Will continue to monitor. [redacted] RN/AN (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
6 Sep 03	0700		Assumed care pt. awake A+O x3. VSS c/o pain to neck and chest. medicated c̄ percocet II tabs. (L) side neck exploration staples CDI ∅ drainage or bleeding - Two GSW to back of neck c̄ serosanguous drainage minimal 2x2 dressing applied. Lungs clear HRRR S1S2 present Active BS x4 quad Tolerating P.O. Encourage to ambulate. stretch and rotate head and neck. AM care complete Will cont to monitor. [redacted] 91WM6
			(1445) I concur c̄ above assessment. [redacted]
6 Sep 03 @ 2000			Recieved pt p̄ report @ 1800. Rt c/o, VSS, speaking un arabic. ∅ c/o pain @ this time. (L) neck staples CTA. ∅ drainage noted. 2x2 drsg to prev. penrose drains CDI. lungs: CTA(B), HRRR (+) BS x4 qdb. IS use encouraged. H2O within reach @ BS. 2 pt restraints on, circulation intact. Will ambulate tonight. Ancef cont. Will monitor [redacted] 91WM

(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

(b)(6)-4
[redacted]

STANDARD FORM 510 (REV. 7-91)
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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep 03 @ 2300	: Pt sitting ↑ in bed. Just finished ambulating. BM x 1 formed, brown. Restraints put back on. Circulation intact. Pain relieved temporarily c̄ percocet. HL (R) AC flushing easily. ancef cont. Will monitor [redacted] (b)(6)-2 91WM6.
7 Sep @ 0515	: ii Perc given for pain [redacted] (b)(6)-2. 91WM6
7 Sep 03 0700	Assumed care A+O x 3. medicated on prior shift Ø c/o pain or discomfort @ this time. Lungs CTA. HRRR Active BS x 4 quads. Wounds accessed. GSW to back of neck x 2. Dressing A CDI minimal drainage. Surgical repair incision to (L) side of neck staples CDI Ø drainage s/s of infection. Instructed to walk and shower regaining strength and mobility to neck and upper body. Will cont to monitor [redacted] (b)(6)-2 91WM6
7 Sep 03 1920	Pt sitting ↑ in bed. VSS, Ø c/o pain @ this time lungs CTA(B), HRRR, (+) BS x 4. Staples to neck OTA, Ø new drainage noted. 2x2 to prev. penrose drain sites. c̄ minimal sero-sang. drainage. new dsg applied. Strength to (L) side of body increasing. Ambulated in hallway c̄ steady gait. c̄ c/o occasional dizziness. Will monitor [redacted] 91WM6.

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

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. TCW 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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7Sep@ 2230	Pt OOB, had BM. Pt told translator that she felt constipated. Will monitor [redacted] (b)(6)-2
08SEP03	(1330) Assumed care of pt @ 0600 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. SL in (R) arm flushes well s̄ S/Sx infection/infiltration. cont. IV abx. Pt tol. reg. diet well. Voiding s̄ difficulty. Wet → dry drsgs Δd on back of neck. ∅ S/Sx infection @ wound sites. Staples to neck - open to air - CDI. Bacitracin applied to (L) ear. 2 point restraints in place s̄ S/Sx ~~infection/~~ [redacted] (b)(6)-2 complications from skin breakdown/circulation. Will cont. to monitor. [redacted] (b)(6)-2
	(1630) 20g IV started in (L) forearm - flushes well s̄ S/Sx infiltration. SL in (R) forearm d/c'd d/t infiltration. Rom in (L) arm improving. Will cont. to monitor. [redacted] (b)(6)-2
8 Sep. 03 1945	Pt resting in bed, AtOx3, VSS, LS CTA(B), (+) BS x4, S_1 S_2 present, HOB 45°, staples on neck open to air, ∅ S/Sx of infex, applied bacitracin to (L) ear, SL in (R) arm patent, voiding c/y urine, ∅ skin breakdown + proper skin integrity on pts of restraint. [redacted] (b)(6)-2 (b)(6)-2
09SEP03	(1115) Assumed care of pt @ 0600 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to shower this am - amb s̄ difficulty. Staples to neck/ear CDI - open to air. Wet → dry drsgs Δd

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09SEP03	(cont) this am. Ø S/Sx infection @ wound sites. SL in Ⓡ arm flushes well ī S/Sx infiltration/infection. Pt tol. reg diet well. Voiding ī difficulty. ROM ī Ⓛ UE improving. 2 point restraints in place ī S/Sx complication from skin breakdown/circulation. Will cont. to monitor. (b)(6)-2 [redacted]
09Sep03 @ 1930	Assumed care @ 1800; AU VSS; pt A&O X3 speaking arabic; (+) sensation & movement in all extremities, (L) UE ↓ movement, grasp & strength; Ø c/o pain or discomfort @ this time; pt OOB to ambin hall X1 ī assistance or complications, Ø c/o dizziness during amb; staples to neck, CDI, OTA, well approximated ī S/Sx infection, Ⓝ drainage; dsgs Δd, W→D; (+) BM this shift; pt voiding QS, c/y, urine ī difficulty; 2 point restraints in place; skin integrity & circulation intact; cont to monitor (b)(6)-2 [redacted]
10 Sep 03 0630	Pt A+o x 3 VSS Ø c/o pain or discomfort @ this time. Lungs CTA HRRR S1 S2 present. Active BS tolerated PO 75% breakfast consumed. Wound care completed laceration to (L) side of neck ī staples CDI no s/s of infection noted. (L) ear bacitracin ī zinc applied. GSW x 2 to back of neck dressing Δ CDI minimal drainage on gauze. IV ABX therapy cont. will cont to monitor (b)(6)-2 [redacted]
	1135) I concur ī above assessment. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	REC[redacted] MAINTAINED AT (b)(6)-2
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) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Sep 03	1915= VSS, ¢ c/o pain, A+OX3, Staples to (L) side of neck, x2 Dsg's c̄ Opsite to back of neck CDI. Pt. seems to have a stiff neck & is guarded of upper neck & facial area. Applying Bacitracin to (L) ear as needed. IV Hr to (L) FA 20G flushed & patent. Swelling ↓ to (L) side of face. Pt. gets OOB & ambulates c̄ difficulty. Continuing IV antibiotics around the clock. ¢ other remarkable assessment findings. Will continue to monitor. [redacted] LT/AN (b)(6)-2
10 Sep 03	1915= restraints x2 while in bed. Skin integrity intact to extremities restrained. — [redacted] LT/AN (b)(6)-2

Use other sheet?

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Sept 03 0900	Pt A+O x 3. VSS Ø c/o pain. Pt guarded on left side of face. Pt self applies bacitracin. tolerates food; voided clear yellow urine. pt reluctant to ambulate. no other remarkable findings. [redacted] (b)(6)-2
11 Sep 03 1910	Pt sleeping, easily aroused. HL (L) Arm flushing easily, VSS, Ø c/o pain @ this time. (L) neck sutures (staples) intact Ø s/s/x infection noted. (L) ear incision site Ø s/s/x infection. clear drsg to back of neck (prev. penrose drain site) minimal sero-sang drainage noted. 2 pt restraints on. +2 pulses, circulation intact. Will monitor [redacted] (b)(6)-2 911 MC.
2030	IT Percocet given for pain [redacted] (b)(6)-2 911 MC
12 Sept 0830	Pt. A+O x 3, VSS Ø c/o pain, neck skin intact with Ø signs of infection; sutures & staples intact Ø infection. Dressing to back of neck (prev. penrose draining a sero-sang little) (b)(6)-2 pt restrained. 2 pulses and circulation intact. Will monitor [redacted]
12 Sep 03	195 = VSS, Ø c/o pain @ this time, ambulating in hallway w/ difficulty. Staples to (L) side of neck CDI, DSG's to back of neck CDI - reinforcing prn. Applies bacitracin to (L) ear by himself prn. ↓ swelling to (L)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(b)(2)-2

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. ICU #1

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(continued 12Sep03@1915): side of face but still guarded of that area. IV Hr to (L) FA. Continuing IV antibiotics. Ø other remarkable findings. Will continue to monitor. [redacted] (b)(6)-2
13Sept03	VSS. Alert & oriented. COB to Br for AM care.
0500	Consumed regular diet for [redacted] (b)(6)-2 breakfast. Lungs clear bilateral. BS(+) x4 quad. Abd. soft-non distended. Peripheral pulses palpable. Left ear sutures intact and without drainage. Left neck staples intact and without drainage. Back of neck drsg dry & intact. Restraints removed & replaced. Skin under restraints intact. Will continue plan of care. [redacted] (b)(6)-2
1945	Rt c/o, sitting ↑ in bed, VSS, c/o neck pain. ⅡⅡ Percocet given. Staples intact to (L) neck, bacitracin applied to (L) ear. Drsg to back of neck, dry & intact. 2 pt restraints on. circulation intact. Clindamycin & Ancef cont. Will monitor [redacted] (b)(6)-2 91WM6. [redacted] (b)(6)-2
2100	ambulated in hallway for 30 min. c̄ steady gait. Ø c/o dizziness. [redacted] (b)(6)-2 91WM6.
2140	Drsg to back of neck d̄'d. small amt of sero-sang. drainage noted. [redacted] (b)(6)-2 91WM6.

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

[redacted]
(b)(6)-4

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Sep 03 0500	VSS. Alert & Oriented. Lungs clear Bilateral. BS(+) x4 quad. Abd soft - non-distended. Urine clear yellow urine. Consumed regular diet for breakfast. OOB to BR this AM for AM care. (L) [redacted] (b)(6)-2 neck incision with staples intact. (L) ear incision with sutures intact - dry intact & dry to back of neck. Bacitracin applied to (L) ear wound. (L) FA Saline lock patent & intact. [redacted] (b)(6)-2 Peripheral pulses. palpable +2. Ambulate - steady gait. Restraints removed & repositioned skin intact under restraints. Will continue plan of care. [redacted] (b)(6)-2 27 N
14 Sep 03 1900	Pt a&o x3, VSS, ∅ c/o pain @ this time. Lungs: CTA(B), HRRR, (+) BS x4 qds, +2 pulses. 2 pt restraints on, circulation intact. Bacitracin applied to (L) ear. Staples to (L) neck: ∅ c/s/s infection/[redacted] (b)(6)-2 Drsg to back of neck dry & intact. Pt does not want to ambulate @ this time due to dizziness. Will monitor [redacted] (b)(6)-2 911 WM6 SPC
2200	ambulated in hallway x2 (30 min). ∅ c/o dizziness. Restraints put back on [redacted] (b)(6)-2 911 WM6

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) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sept 0900	Pt. Awake + alert x 3, pupils equal and reactive to light VSS, pulse regular and in range for age, warm beds and skin pink, drg to back of the neck intact pt hds ∅ of pain except from right IV site, new IV on left started, sutures skin intact healing well pt voiding dark yellow urine - [redacted] (b)(6)-2
16sep03@0300	Assumed care @ 1800; All VSS, pt A&Ox3, ⊕CMS x4, ↓strength & movement in ⊕UE; otherwise N/V intact; pt OOB to amb x1 to BR & then in hall for 20 min, pt tol well, ⊖ c/o dizziness or SOB, slow, steady gait; dsg to back of neck Δd ⊖ drainage noted; Bacitracin applied to ⊕ ear; sutures intact ⊖ s/sx infection, well approximated; HL in ⊕ FA patent & intact, freely flushes Cont c̄ plan of tx; ⊖ Δs in assessment; cont to monitor [redacted] (b)(6)-2
16sep03 0315	2 point restraints in place; ⊕ circulation, ⊖ skin breakdown [redacted] (b)(6)-2
16Sept03 0800	VSS. Alert & oriented. Lungs clear bilaterally. BS(+) x 4 quad. Abd soft-non distended. Consume regular diet for Breakfast. ⊕ [redacted] (b)(6)-2 neck incis intact/dry c̄ staples in place. ⊕ ear incision intact & dry c̄ sutures in place. Bacitracin applied as ordered. OOB to BR. Ambulates c̄ steady gait. Saline lock to ⊕ FA patent & intact —

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER
	LAST	FIRST	MI	[redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
		(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)*

REGISTER NO.	WARD NO.

[redacted]

(b)(6)-2

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Sep Ø3 1900	Pt A&O, VSS, Ø c/o pain. HRRR, lungs CTAB, EBS x4. staples to neck intact. Ø drainage noted. Ø s/s infection. Bacitracin to (L) ear. drsg to back of neck d/d. scant amt of sero-sang drainage noted. Ambulated x1 (15 min). Ø c/o dizziness, steady gait. 2 pt restraints put on, circulation intact. Pt refused mattress to prevent skin breakdown. Will monitor. (b)(6)-2 [redacted] 91WM6. (b)(6)-2 [redacted] CMT
17 Sep 0100	18ga IV restarted to (L) wrist. prev. IV c̄ pain & redness. (cath intact). Will monitor. (b)(6)-2 [redacted] 91WM6
17 Sep 03 0700	- Assumed care of pt. A+O x3 VSS Ø c/o pain or discomfort at this time Dressing change BSW to back of neck 2x2 c̄ small amount of bleeding. surgical incision to (L) side of neck closed c̄ staples [redacted] (b)(6)-2 open to air CDI Ø s/s of infection healing well. Will cont to monitor (b)(6)-2 [redacted] 91WM6.
17 Sep 03 0900	- staples to (L) side of neck removed per MD Ø drainage noted No bleeding Will cont to monitor (b)(6)-2 [redacted]
	(17HØ) I concur c̄ above assessment. (b)(6)-2 [redacted]
1905	Pt resting in bed. prev. staple incision to (L) neck - Ø drainage noted. Bacitracin to (L) ear Ø c/o pain. ambulated x1. Ø c/o dizziness. 2 pt restraints on, circulation intact. Back of neck drsg d/d. scant amt. blood noted. Will monitor (b)(6)-2 [redacted] 91WM6. (b)(6)-2 [redacted]

BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19Sep03 1900	Pt lying on bed, a/o, VSS, LCTAB, ⊕ BS, HRRR, ∅ c/o pain @ this time. Prev incisions to neck ō ∅ s/sx infection. ∅ drainage noted. Pt ambulated x1, voiding cyo via urinal. 2 pt restraints on circulation intact. Will monitor. (b)(6)-2 [redacted] gluemic
20Sep03 @0100	I concur c̄ above assessment. [redacted] (b)(6)-2
20Sep03	(1515) Assumed care of pt @ ∅700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb s̄ difficulty. Incision/wounds to back of neck CDI s̄ s/sx infection. SL in @ forearm flushes well s̄ s/sx infiltration/infection. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. (b)(6)-2 [redacted]
(1910)	Pt a/o, VSS, HRRR, lungs: clear, ⊕ BS x4, ∅ c/o pain @ this time. Wounds to back of neck clean + dry c̄ ∅ s/sx infection, ∅ dizziness when ambulating noted. ⊕ FA HL flushing easily. voiding adeq. cyo. 2 pt restraints on. ⊕ circulation. Will mon (b)(6)-2 [redacted] gluemic. (b)(6)-2 [redacted]
21Sep03 0530	Received pt report this am. LBS, A+O x3, speaks arabic. ∅ drainage to wounds on back of head/neck ∅ s/s infection noted. Amb in halls unsp w/ steady gait, ann care provided. Sings, IV access ⊕ ∅ c/d/i, flushes easily @ this time. ∅ other remarkable assessments, restraints in place per

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
18Sep03@0	Received pt this am in stable condition, A&OX3, VSS, speaks minimal English. Cont ambto restroom, shower provided ⊕BM, SWS, IV ⊕ fa patent + intact. Bacitracin to ⊖ear. pt has cont stuff mvmt to neck and three small wounds to back of head. Ø other remarkable assessments. Tol po. Will cont to monitor. [redacted] (b)(6)-2
18sep03@2330	Assumed care @ 1800; VSS; A&OX3 speaking Arabic & minimal english; medicated c̄ percs ē good relief; pt ↑ ad lib amb to BR & up & down hallway ē supervision; S1, S2, LSCTA(B); ⊕BS x4, ⊖BM thus far, pt voiding QS, c/y urine; wounds to back of neck OTA ē minimal drainage - serosang; HL intact & patent, freely flushes; No Δs in assessment; 2 point restraints in place; ⊕circulation, ⊖skin breakdn; Cont to monitor (b)(6)-2 [redacted]
19SEP03	(1125) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb in hallway s̄ difficulty. Incision/wounds to back of neck CDI s̄ S/Sx infection. SL in ⊖ forearm flushes well s̄ S/Sx infiltration/infection. Pt voiding s̄ difficulty. Tol. reg diet well. 2-point restraints in place s̄ S/Sx complications. Will monitor [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR S/D NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
		ICW #1

PROGRESS NOTES
Medical Record

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Before 1800	CAW protocol. Ø S/S of skin breakdown or vascular issues. Will cont to monitor pt. [redacted] (b)(6)-2
1905	Pt a/o, VSS, Ø c/o pain @ this time. ambulated x 1 c̄ steady gait, Ø c/o dizziness. back of neck wounds OTA Ø drainage noted, Ø s/sx infection. ~~or [redacted]~~ (b)(6)-2 HL Ø FA flushing easily. voiding adequate cyu. 2 pt restraints on + circulation. will monitor [redacted] (b)(6)-2 9 Hours
2210	Pt refused scheduled ambien 10mg. [redacted] (b)(6)-2
22Sep03 0900	Awakens to his name. VSS. NAD. Wounds to (L) side of neck, ear & back of neck open to air & healing well. Ø drainage. Void per Bathroom. Skin integrity & circulation to restrained extremities without compromise. Will assess throughout shift. Will ambulate & complete Am Care [redacted] (b)(6)-2
22Sep03 1300	Medicated c̄ 2 (two) percocet p.o. for c/o (2°) neck & facial pain. Will monitor for effect [redacted] (b)(6)-2
22Sep03 1300	Sleeping: NAD. [redacted] (b)(6)-2
22Sep03	2015 = VSS, IV to (L) arm flushed & patent HL'd, wounds to back of neck healing, edema to (L) side of face, (L) ear wound - applying →

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.

C# [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	bacitracin (pt. does on his own), DOB and ambulates s difficulty, pain management issues. Will continue to monitor. (b)(6)-2 [redacted] MT/AN
9-23-03 0940	Sleeping. Tolerated breakfast well. VSS. Lungs CTAB VAS. Neck & ear wounds healing well. Open to air. ∅ drainage. Great improvement on moving head. Ambulates in hall for exercise. Denies pain @ this time. Will continue monitoring. (b)(6)-2 [redacted] MAS/CON
9-23-03 1440	D/C to EPW Camp escorted by MPs. Hospital d/c'd s complications. Pt A & P. Wounds open to air s drainage. (b)(6)-2 [redacted] MAS/CON

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9/23/03	D/C Summary
	Date Admit 8/28
	Date D/C 9/22/03
	Diagnosis: GSW neck
	Rescue: Pt alerted via EOC - taken to OR for neck exploration - Pending, no vascular injury, mandible guze used. no evidence of neurologic injury, airway or esophageal injury. Post-op pt stable. Chronic pain & abscess, pt on iv Abx. Slowly regained other vitals stable. Pt D/C Ambulatory fine. vitals intact. tolerate po well. Wound stable.
	Disposition: custody
	Cond: Stable
	Med: none
	[redacted] (b)(6)-2
	MA[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY [redacted]
		RECORDS MAINTAINED AT	(b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW [redacted] (b)(6)-4

CITY: [redacted]

STATE:

ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 28 AUG 03

TIME: 0430

TRANSPORTATION TO FACILITY: AIR

SEX: M

AGE: 27

DUTY/LOCAL PHONE	
AREA CODE	NUMBER

HOME PHONE	
AREA CODE	NUMBER

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

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

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAIN: GSW to Posterior Neck

CATEGORY OF TREATMENT

☒ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0430

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

VITAL SIGNS

TIME	0430	~~0500~~ 0500	0515		
BP	103/46	100/44	101/46		
PULSE	90	91	93		
RESP	20	20	18		
TEMP	97.1				
WT	150	97% RA	97% RA		

LAB ORDERS

X CBC/DIFF	X ABG	X PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		X CHEM: Met B
BLOOD C&S X			
X Td X2			

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 97% RA ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0430	1 Gm Ancef IV	[redacted]	[redacted]	0440	(b)(6)-2 all
0430	.5 Tetanus IM			0440	
0435	2 mg MSO4 IV			0445	
0500	3 mg MSO4 IV			0500	

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)*

EPW ♂

[redacted] (b)(6)-4

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				VBG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			141	107	9	SUP 02 50	PH 7.30	PO2	RESULTS CXR – no pneumo C-spine – [illegible] shrapnel C7-T1, [illegible] multiple	
H/H 11/33			4.0	28		PCO2 57	SAT	OTHER		
PLT									EKG INTERPRETATION See	
PT						U/A DIP				
APTT		BHCG	ETOH	GLU		MICRO		7+c		

PROVIDER HISTORY/PHYSICAL

27 y/o ♂ EPW GSW to BACK of neck tonight "By Helicopter" pt AAOx3 arrived via Medevac. last meal @ 2100.
Pt c/o (L) + (R) side (Rm?) neck pain. Pt follows all command. though interpretes. Pt 50 chem complaints

(L) wd, wn, (+) pain, AAOx3
H: (+) multiple wounds to BACK of head and thigh
N: (L) ear. (R) 7th (L) Ant neck, (R) Edema
O/P(R), PERRLA, face (R) Bog 7th, (R) strabs
L: (L) 7th (3) (R) s/s/sh
BMRA (R) s/s/sh
Fx: (R) c/c/E
ABN: soft, NT NO (R)S

(A/P)
to OR for Exploration.
IV F 3300 prior to leaving For OR.

pmd – (R)
psit – (R)
Iv – ~~[illegible]~~?
See (R) 703

News: Noted Exam
i ? (L) Lip Droop
Old vs new.
pt not sure

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
[redacted]	Arrival 1gm		
(b)(6)-2	d70.5 1m	IV	
	5mg	prsdy	PROVIDER SIGNATURE AND STAMP (b)(6)-2

DIAGNOSIS (1) GSW to Neck and (2) Ear

[redacted] 2 2 Lag

CODES (b)(6)-2

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

EPW ♂
[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)
USAPA V1.00

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
8.28/0900			Assumed pt care from anesthesia @ approx 0820. Pt arrived hemodynamically stable. Pt arrived on CRO KVO. Pt placed on vent: SIMV 16, VT 650, FiO2 100%, PEEP 5. Pt placed on versed, fentanyl & vecuronium drip. NG placed to LIS, foley placed to gravity. Pt in no apparent distress. [redacted] (b)(6)-2 ICTRU
8.28/1030			(R) Femoral-A line placed, zeroed, & correlating c̄ NIBP. CXRay done for ETT placement [redacted] (b)(6)-2 ICTR
8.28/1900			Pt remains paralyzed on vec & sedated c̄ versed & pain medd c̄ fentanyl. Remains hemodynamically stable & afebrile. Vent settings d'd to FiO2 ↓ to 35% & RR ↓ 14 will redraw ABG c/hn 30-45mins. U/O remains high ≥ 200cc/hr. [redacted] (b)(6)-2 ICTRU
8.28/1645			Dr. [redacted] (b)(6)-2 notified of ↑ U/O. Per Dr. [redacted] (b)(6)-2, UX & chem sent [redacted] (b)(6)-2 ICTRU.
8.28/1800.			Report given to CT [redacted] (b)(6)-2 for change of shift pt stable [redacted] (b)(6)-2 ICTRU

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

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

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)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/28/03		1900	NSG ASSESSMENT AS FOLLOWS: Received right from off gwn staff. Pt resting comfortably in bed ↑ HOB 15°. (N) paralyzed on vecuronium @ 100 mcg/kg/hr; sedated on versed @ 4 mg/hr & fent @ 100 mcg/hr; PEEP 7 cm; Ø movement noted; (R) stable on vent; 35% FiO2, PEEP 5, TV 650; 4.0 ETT 22 @ the teeth; CTA (B) ⊖ S/S cyanosis noted (CVS) S1, S2 NR (BOS); Pt BP currently 120/60. Peripheral edema noted; cool distal extremities, pulses in LE > UE (3+ > 2+); cap refill < 3 sec. (GI) NPO to LWS; physiology NPT as ordered; hyperactive BS ⊖ on auscultation (GU) ⊕ U/O (see I/O); clear yellow urine, foley to gravity (Skin) neck wounds with (S) perforated drains - scant/moderate amount of serosanguinous drainage noted. (Lines) foley, ETT, PIV x2; (P) femoral art line. (Pain) morphine through NG tube; positive for extubation & wakeup; [redacted] / [redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted]
8/28/03		2200	Pt remains resting with no S/S of alert setting. ⊕ sedation; ⊕ paralytic; Positive ⊕ interacting with staff via PHR PBP when stimulated with sterile chest rub/movement of socks. [redacted] (b)(6)-2 ICT/Ar [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
8.29.03	0630		Assumed pt care from LT [redacted] (b)(6)-2 At change of shift pt in no apparent distress. All VSS & afebrile. @ change of shift pt on 1.4mcg/kg/min vec, 2mg/hr versed, 70mcg/hr fentanyl, 125cc/hr LR, NG (Cuare to LIS, FTG, on vent settings SIMV 14, peep 5, fio2 35%, vt 650 spo2 100%, no overbreathing vent. Pt non responsive to painful stimuli either known ↑ HR & ↑ BP c painful stimuli [redacted] (b)(6)-2 ICTAN
8.29.03	0900		At approx 0900 per V/O Dr [redacted] (b)(6)-2 vecuronium turned off for possible extubation. versed & fentanyl remain @ 2mg/hr & 70mcg/hr respectively. Will cont to monitor closely [redacted] (b)(6)-2 ICTAN
8.29	1430		At approx 1430 pt extubated c̄ complications. Dr. [redacted] (b)(6)-2 & RT present @ time of extubation. Pt currently on 2L NC & SpO2 98-100%. RR 14-18 all other VSS. ABG sent 40 mins postextubation. ABG grossly WNL. Dr. [redacted] (b)(6)-2 assessed pt during rounds & no further actions rqd. Pt in no apparent distress @ this time. Pt currently resting quietly in bed.
8.29	1600		LUE remains weak as so does (L) sided facial drooping. Dr [redacted] (b)(6)-2 aware [redacted] ICTAN
29Aug03	2050		Received report from LT [redacted] (b)(6)-2 and assumed care of pt. See DA Form 4700 for assessment data. @ 1900 added more pressure tubing to arline so transducer could be placed for proper

(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.

GPW [redacted]

(b)(6)-4

NURSING NOTES

Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
cont.			zeroing. New tubing added, zeroed & BP's correlating. SL to (R) AC flushed. Assisted pt to turn on (L) side. Foley still draining well. Fentanyl was increased d/t pt c/o pain in neck/throat. Interpreter came to tell pt plan of care. Gave pt small sips of H_2O. Tolerated well. (b)(6)-2 [redacted] TAN
	0420		Pt has been up all night asking to be suctioned but there is nothing to suction. Occasionally Pt will have strong cough able to clear secretions on own. VSS. (b)(6)-2 [redacted] TAN
	0615		Drew labs through A line @ 0430. Taken to lab. Washed up patient. Δ'd some linen. Δ'd bandages on head & Penrose drain to (R) side of upper neck. Moderate serosanguineous drainage. & Penrose drain by drainage (RN) to (L) side of neck & Penrose drain behind (L) ear minimal drainage. pt (b)(6)-2 Staples intact from behind (L) ear and down (L) side of neck from head. Slightly painful for patient. Still unable to lift (L) arm but can move hand. Pt put on RA and sats >95%. Report given to LT (b)(6)-2 [redacted]. Pt stable @ this time. [redacted] LT/RN
0.35	0730		Assumed pt care from (b)(6)-2 [redacted] Pt in no apparent distress @ change of shift. Pt currently on U @ 75cc/hr d/ut @ 5cc/hr. Dr. (b)(6)-2 [redacted] changed dressing & pulled penrose out slightly approx 2cm each (R). Wounds draining serosanguinous moderate amounts of purulent drainage noted. Pt tolerated dressing well. Report given to (b)(6)-2 [redacted]
0.35			

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
30 Aug 03	0930		Assumed care, agree c̄ the initial assessment. Pt. to chair ambulated well. Transfer @ bedside, update, given to pt for coughing & deep breathing exercises, given Rx. ISOP x10. pt verbalized agreement to intake drinking H2O's discuss (b)(6)-2 [redacted]
	1000		
	1130		Rm back to bed, pt complains very hesitate to move. [redacted] (b)(6)-2 assistance @ bedside. (b)(6)-2 [redacted]
	1230		Tolerate cl. liquid diet IS [redacted] (b)(6)-2 adequately.
	1235		DC'ed Foley, orders received to RN to ward. (b)(6)-2 [redacted]
	1300		Report given to TCW (LT [redacted] (b)(6)-2 DC'ed 4-hrs x5 min pressure applied dry. (b)(6)-2 [redacted]
	1300		Updated RN, when Foley cath was DC'ed @ 1235. [redacted] (b)(6)-2

(Continue on reverse side)

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

[redacted]

(b)(6)-4

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

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
30 Aug 03	0930	Assumed care, agree c the initial assessment. Oob to chair, ambulated well. Ambulated @ bedside, update given to pt for coughing c deep breathing exercises, given Dr. TS of X10. Pt verbalized agreement to intake drinking H2O. (b)(6)-2 [redacted]
	1000	
	1130	Pt back to bed, pt remains very lethargic to move. (b)(6)-2 [redacted] @ bedside. (b)(6)-2 [redacted]
	1530	Tolerate cl. liquid diet. (b)(6)-2 [redacted]
	1235	DC'ed Foley, orders received to NS to ward. (b)(6)-2 [redacted]
	1300	Report given to TCW (LT) (b)(6)-2 [redacted] DC'ed 4-hr x5 min pressure applied dsg. (b)(6)-2 [redacted]
	1300	Updated NS when Foley cath was DC'ed @ 1235. (b)(6)-2 [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)(6)-4

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

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: 70	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: Neck Exploration
C-spine - cleared NPO p 2100

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: (-) Implants: ? Medications: ?
Jewelry removed: yes no Family waiting: yes no
(+) TUB

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 and 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)(6)-4

Needles 8 L-5+5
4x8 10

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. ____	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.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. [redacted] COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.
(b)(6)-2 [redacted] CPT N 28 aug 03 DATE

11. POSTOPERATIVE EVALUATION:

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
(b)(6)-2 (S [redacted] CPT N DATE: 8/28/03 TIME: 0535	[redacted] CPT, AN DATE: 28 Aug 03 TIME: 0830

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: Litter BY: OR staff

2. PATIENT ID[illegible]ED AND PROCEDURE VERIFIED BY: [redacted] CPT

3. DATE: 28 aug 03 TIME PATIENT ARRIVED IN SUITE: —

4. PATIENT IN ROOM [redacted] (b)(6)-2 TIME: 0547 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: speaks no english; info through translator

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D (b)(6)-2 [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (b)(6)-2 66E; MAJ [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] 66E (0705-end) (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) (b)(6)-2

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

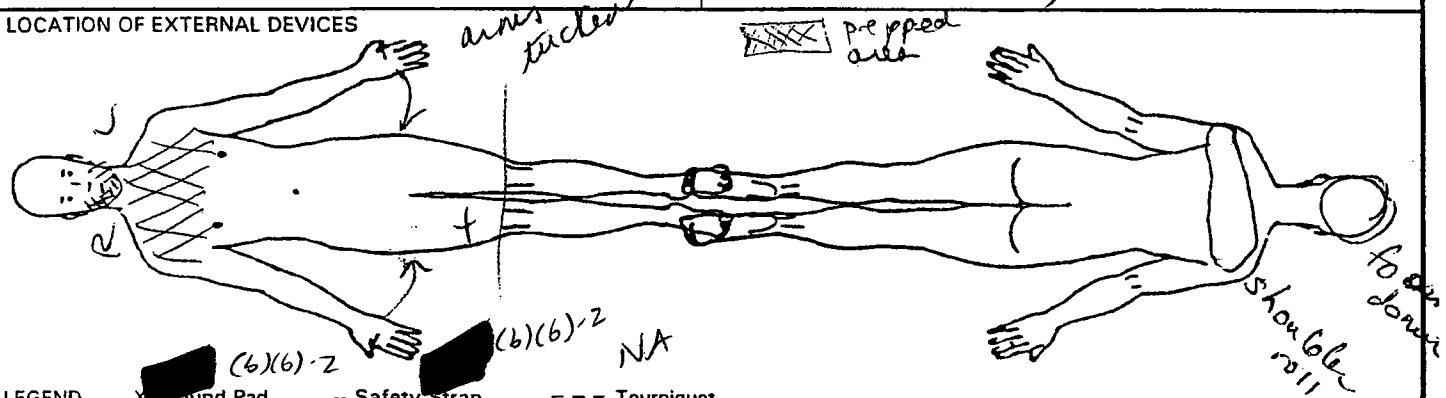
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: no nicks

PREP SOLUTION (Specify) Betadine / Betadine [redacted] BY WHOM:
SITE: face see 4-9
SITE: BY WHOM: (b)(6)-2
COMMENTS: no pooling

9. LOCATION OF EXTERNAL DEVICES



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

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	/	ε	ε	(b)(6)-2 [redacted]	(b)(6)-2 [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 40/40

☑ ESU NO: 105305 VL
GROUND PAD: BRAND VL Rem Poly II
LOT NO: [redacted]

☐ 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) (b)(6)-2 YES ☑ NO ☐ (b)(6)-2

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin ointment	QS	intraop	topical	[redacted]	Dr [redacted]
Surgicel	QS	intraop	topical	[redacted]	Dr. [redacted]
				(b)(6)-2	(b)(6)-2

WOUND IRRIGATION 0.9% NaCl ☑ YES ☐ NO, TYPE(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. 16 FR (EMT) Foley	2. Penrose	3.
SITE	1. Bladder	2. (L) ear.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- 4x8
- medipore

19. ADDITIONAL INFORMATION
[redacted] (b)(6)-2
[redacted] (b)(6)-2
[redacted] (b)(6)-2

Foley draining clear yellow urine

Geta

20. OPERATION(S) PERFORMED
Neck Exploration, NG tube placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3/RR	0830	litter

22. REGISTERED NURSE SIGNATURE
[redacted] (b)(6)-2

ICU #3

(b)(6)-4 [redacted]

8. ETT 24@lip

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
28 Aug	1015	SIMV	16	650	50	5	22	Ø	60	100	124/83								[redacted]
28 Aug	1225	SIMV	16	650	35	5	23	Ø	66	100	128/83							↓FIO2 40%	
28 Aug	1400	SIMV	16	650	35	5	23	Ø	78	100	131/70								
28 Aug	1600	SIMV	14	650	35	5	22	Ø	81	100	129/72								
28 Aug	1800	SIMV	14	650	35	5	23	Ø	88	100	129/74								
28 Aug	2005	SIMV	14	650	35	5	23	Ø	84	100	132/71								
28 Aug	2321	SIMV	14	650	35	5	22	0	79	100	133/70								
29 Aug	0133	SIMV	14	650	35	5	17	Ø	93	100	118/66								
29 Aug	0602	SIMV	14	650	35	6	24	Ø	97	100	128/72								
29 Aug	0800	SIMV	12	650	35	5	24	12	85	100	120/64								
29 Aug	1000	SIMV	12	650	35	5	19	12	85	100	121/62								
29 Aug	1200	SIMV	12	650	35	5	26	12	95	100	117/65		(b)(6)-2						
29 Aug	1500	Pt extubated by CPT [redacted] / LT [redacted]																	

(b)(6)-2

(b)(6)-2

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		5 Sep03		5 Sep03		6 Sep		7 Sep								
POST- DAY																
MONTH-YEAR	DAY									08Sep03		09Sep03		10 Sep		
19	HOUR	07	39	1100		0900	1	0700	1	8		8	4	0630	1900	

PULSE (O) — TEMP. F (°) — TEMP. C

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 (O): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD				115/61		18	18	16	16	18		18		16	13/59	
BLOOD PRESSURE		107/65		P84		93/52		116/63	119/60	117/61	111/56	105/61		105/56	P92	
		H88		P16		H74		H79			74/87	104/64		H68	P16	
		T98.2		O2		T100.4		T98.4						T97	O2	
HEIGHT:	WEIGHT →	R16		96% RA		98% RA	95% RA	98% RA	96% RA	98% (RA)	97%	98% (RA) 97% RA		98% RA	98% RA	

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95)

NSN 7540-00-634-41

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY						1 Sep				
POST-OP DAY										
MONTH-YEAR	DAY	30 AUG 03	31 AUG	01 Sep			02 SEP 03	03 SEP 03	4 Sept	
19	HOUR	0800			1430				0730	
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° / 98.6°									37.2° / 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		18	16	16	16	10/55	16	16		
BLOOD PRESSURE		111/67	100/59		103/60	(P) 78	101/56	101/53	112/59	
		113/74	91			(P) 18	109/66	106/57	81	
			97.6						98.0	
HEIGHT:	WEIGHT →					(O2)			95% on RA	
		95%	95%	96%	96%	97% (RA)	98% (RA)	97% (RA)	R-16	
						91	97%		98%	
			1000			PA				
Urine Out			1600 cc							

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY										
POST-OPERATIVE DAY										
MONTH-YEAR	DAY	16 Sep 03	17th	18 Sep	19 Sep 03	20 Sep 03	9/21	9/22		
19	HOUR	0 1	1	0 1	8 1	8 2	0 1	0 1		
PULSE (0)	TEMP. F (°)	78	99		99	99	79	88	TEMP. C	
	105°	30	30		30	30	30	10	40.6°	
180	104°	00	00		00	00	00	00	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		18	18	18	18 18	18	16	16 18		
BLOOD PRESSURE		113/68	123/57	104/57	105/50	108/53	96/51	101/55	110/59	
			185	97/46	111/59		68	73	75	
HEIGHT: WEIGHT →			99.9				97.0	97.4	97.8	
		97 98	98 (RA)	98 (RA)	97 (RA)	98 (RA)	98%	97%		
			118/72	98% (RA)	97 (RA)		114/68			

Record special data only when so ordered

(Centigrade Equivalents, for Reference only)

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

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)-4

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)

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. 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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	23 Sept															
19	HOUR																
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

Record special data only when so ordered

BLOOD PRESSURE		112/64															
		79															
		97.0															
HEIGHT:	WEIGHT →	118															
		069	069														

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

EPW

[redacted]

(b)(6)-4

REGISTER NO.

WARD NO.

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

(b)(6)-2 [redacted]

(b)(6)-4

EPW [redacted]

CBC

Chem 7

Abg

ICU 3

[redacted]

(b)(6)-2

(b)(6)-2

ID: [redacted]			08-28-03	
WB			01:55	
			Reference Limits	
WBC	17.6 H	x10^3/uL	4.5	10.5
RBC	3.68 L	x10^6/uL	4.00	6.00
Hgb	9.0 L	g/dL	11.1	18.0
Hct	28.6 L	%	33.0	60.0
MCV	92.9	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.5 L	g/dL	31.0	37.0
Plt	152.	x10^3/uL	150.	450.
LYM%	9.3	%	30.5	51.1
LYM#	1.8	x10^3/uL	1.2	3.4

---

i-STAT G3+

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

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.477

PCO2_____28.8 mmHg

PO2_____178 mmHg

HCO3_____21 mmol/L

BEecf_____-2 mmol/L

SO2*_____100 %

*calculated

Sample Type_:

28AUG03 10:09

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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

28/08/03 09:57

REFERENCE RANGE: MALE

PATIENT #: [redacted] (b)(6)-2

BASIC METABOLIC

DISC LOT #: 3203AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	137*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CRE	0.4*	0.6-1.2	MG/DL
NA+	132	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

Ward/Section: EMT	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW	DATE 28 AUG03 / TIME 0440	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. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: ABG (0440) 664 Ph= 7.294 PCO2=57.8
PO2=15 HCO2=28 TCO2=30 BC=2 SO2 Hb=11 Hct 32
Na=141 K=4.0 Cl=107 TO2 28 BUN 9 Creat

REPORTED BY:	DATE:	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. EDW	DATE 28AUG09 / TIME 0440	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	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.010	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	7.0	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	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:	DATE:	LAB ID NO.:

TEST(S)
SPECIMEN TAKEN
DATE | TIME | A.M. P.M.
REQUESTED
RESULTS
REMARKS

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH | MD | DATE
LAB ID NO.

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

TEST(S)
SPECIMEN
DATE | A.M. P.M.

RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
(41 CFR) 201-45.505
546-107

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH | MD | DATE
LAB. ID. NO.

URGENCY: ROUTINE | TODAY | PRE-OP | STAT
PATIENT STATUS: BED | AMB | OUTPATIENT | NP | DOM
SPECIMEN SOURCE: BLOOD | OTHER (Specify)
SPECIMEN/LAB. RPT. NO.
LABORATORY FILE

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____26 mmol/l

At 37C

pH_____7.544

PCO2_____29.3 mmHg

PO2_____141 mmHg

HCO3_____25 mmol/L

BEecf_____3 mmol/L

SO2*_____99 %

*calculated

Sample Type_:

29AUG03 04:32

Oper:

Physician:_____

Ser#

Ver: JAM5046A
CLE

======= PICCOLO =======
28/08/03 16:53
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: DR #: 000
SERIAL #:

GLU	101	73-118	MG/DL
BUN	4*	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
[illegible]	910*	39-380	U/L
Na+	128	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

(b)(6)-4 08-29-03 20:42

			Patient Limits	
WBC	11.7 H	x10^3/uL	4.5	10.5
RBC	2.96 L	x10^6/uL	4.00	6.00
Hgb	8.8 L	g/dL	11.0	18.0
Hct	27.2 L	%	35.0	60.0
MCV	91.9	fL	80.0	99.9
MCH	29.9	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	230.	x10^3/uL	150.	450.
Neut	21.3 *	%	20.5	51.1
Lymph	2.5 *	x10^3/uL	1.2	3.4

SPECIMEN TAKEN
DATE 8-28 TIME 1630 A.M. P.M.
REQUESTED

RESULTS
yellow
Hazy
GLU - Neg
BIL - Neg
KET - Neg
SG - 1.010
BLD - Neg
pH - 6.0
PROT - Neg
URO - Neg 0.2
WBC - Neg

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

REMARKS
Gen. Analysis.

n above space
ESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY (b)(6)-2
TECH
MD
DA 8-28-03

MISC
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT (b)(b)-2
PATIENT STATUS ☐ BED ☐ OUTPATIENT ☐ NP
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT

Gen. Analysis
(b)(6)-4
ICC 2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 08/28/03 05:05 AM

Patient I (b)(6)-4
Test Name :APTT
Test Result:= 30.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :08/28/03
Test Time :05:03 AM
Card Lot :010301
Operator :

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 08/28/03 05:

Patient ID (b)(6)-4
Test Name :PT
Test Result:= 19.3 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.6
Calculated INR = 2.10
Sample Type:citrated wh. blood
Test Date :08/28/03
Test Time :05:06 AM
Card Lot :080201
Operator :

PICCOLO
28/08/03 05:01
REFERENCE RANGE: MALE
PATIENT # (b)(6)-4
METLYTE 8
DISC LOT #: 31 4A4
OPER #: DR #. 000
SERIAL #:

	126*	73-118	MG/DL
	8	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	419*	39-380	U/L
NA+	129	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	109*	98-108	MMOL
tCO2	20	18-33	MMOL

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

(b)(6)-4

ID: [redacted] 08-27-[illegible]

DB [illegible]

				Patient Limits	
WBC	14.1 H	x10^3/uL		4.5	10.5
RBC	5.27 L	x10^6/uL		4.00	6.00
Hgb	9.6 L	g/dL		11.0	18.0
Hct	36.3 L	%		35.0	60.0
MCV	92.8	fL		80.0	99.9
MCH	29.3	pg		27.0	31.0
MCHC	[illegible].6 L	g/dL		33.0	37.0
PLT		x10^3/uL		150.	450.
Lym	[illegible] #L	%		20.5	51.1
LYM#	1.5 *	x10^3/uL		1.2	3.4

---

i-STAT G3+

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

Pt Name:_____

TCO2_____23 mmol/L

At 37C

pH_____7.485

PCO2_____29.3 mmHg

PO2_____142 mmHg

HCO3_____22 mmol/L

BEecf_____-1 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.485

PCO2_____29.3 mmHg

PO2_____142 mmHg

Patient Temp: 98.6F

FIO2_____: 30

Sample Type_: ART

28AUG03 14:58

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

AT G3+

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

Pt Name:_____

TCO2_____24 mmol/L

At 37C

pH_____7.467

PCO2_____32.1 mmHg

PO2_____110 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.468

PCO2_____32.0 mmHg

PO2_____110 mmHg

Patient Temp: 98.4F

FIO2_____: 35

Sample Type_: ART

28AUG03 15:56

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

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

Pt Name:_____

TCO2_____26 mmol/L

At 37C

PH_____7.469

PCO2_____34.6 mmHg

PO2_____125 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.460

PCO2_____35.5 mmHg

PO2_____129 mmHg

Patient Temp: 99.7F

FIO2_____: .35

Sample Type_: ART

29AUG03 09:22

Oper: 0

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

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

Pt Name:_____

TCO2_____29 mmol/L

At 37C

PH_____7.358

PCO2_____49.0 mmHg

PO2_____109 mmHg

HCO3_____28 mmol/L

BEecf_____2 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

PH_____7.345

PCO2_____51.1 mmHg

PO2_____115 mmHg

Patient Temp: 100.3F

Sample Type_: ART

29AUG03 15:33

Oper: 0

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

TEST(S)		
SPECIMEN TAKEN		
DATE	TIME	A.M. / P.M.
RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
546-107

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
REMARKS [redacted]
(b)(6)-2
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MD
DATE
URGENCY: ROUTINE / TODAY / PRE-OP / STAT
PATIENT STATUS: BED / AMB / OUTPATIENT / NP / DOM
SPECIMEN SOURCE: BLOOD / OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
TCU3
PHYSICIAN'S COPY

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

======= PICCOLO =======
29/08/03 04:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	12	10-47	U/L
CK	104*	14-97	U/L
AST	32	11-38	U/L
TBIL	2.3*	0.2-1.6	MG/DL
BUN	3*	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CHOL	66*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	112	73-118	MG/DL
TP	4.9*	6.4-8.1	G/DL

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

======= PICCOLO =======
29/08/03 04:38
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	107	73-118	MG/DL
BUN	3*	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	1155*	39-380	U/L
NA+	127*	128-145	MMOL
K+	3.3	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	21	18-33	MMOL

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

TEST(S)
SPECIMEN 1
DATE 30Aug03 TIME 0430 A.M. P.M.
REQUESTED
Chem12, CBC
RESULTS

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

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY ICU 3
TECH
MD
DATE 30Aug03

[redacted]

(b)(6)-4

DISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP STAT ☒
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify) Blood
LAB ID NO.
SPECIMEN/LAB RPT. NO.

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

PATIENT'S MED. RECORD

======= PICCOLO =======
30/08/03 04:34
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	55	26-84	U/L
ALT	27	10-47	U/L
AMY	105*	14-97	U/L
AST	41*	11-38	U/L
TBIL	2.5*	0.2-1.6	MG/DL
BUN	4*	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CHOL	53*	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	112	73-118	MG/DL
TP	5.0*	6.4-8.1	G/DL

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

EPW# [redacted] (b)(6)-4
ICW 1
31 Aug @ 0400

DATE	TIME A.M. P.M.	
RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT CONTROL	
	PT PATIENT	
	PTT CONTROL	
	PTT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS CBC

[redacted] (b)(6)-2

IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

TECH MD DATE

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

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

SPECIMEN SOURCE: BLOOD ☐ VEIN ☐ CAP ☐ OTHER (Specify) ☐

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

PATIENT'S MED. RECORD

EPW# [redacted] (b)(6)-4
ICW #1
31 Aug 03 @ 0400

DATE	A.M. P.M.	
RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS Chem 12

[redacted] (b)(6)-2

IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

TECH MD DATE

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

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

SPECIMEN SOURCE: BLOOD ☐ OTHER (Specify) ☐

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

CHEMISTRY I 546-107
STANDARD FORM 546 (Rev. 8-77)

PATIENT'S MED. RECORD

(b)(6)-4

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

31/08/03 04:10

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3082AA4

OPER # [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	57	26-84	U/L
ALT	30	10-47	U/L
AMY	112*	14-97	U/L
AST	43*	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
BUN	<2*	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	107	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	117	73-118	MG/DL
TP	5.4*	6.4-8.1	G/DL

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

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

01/09/03 04:00

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.8*	3.3-5.5	G/DL
ALP	71	26-84	U/L
ALT	20	10-47	U/L
AMY	90	14-97	U/L
AST	37	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	<2*	7-22	MG/DL
CA++	8.7	8.0-10.3	MG/DL
CHOL	143	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	108	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

[redacted] (b)(6)-4

1CW1

911103 @ 0415

TEST(s)

SPECIMEN TAKEN

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

RESULTS | REQUESTED (X)

RBC COUNT

HEMOGLOBIN

HEMATOCRIT

MCV

MCH

MCHC

WBC COUNT

WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC

SED. RATE

PLATELET COUNT

RETICULOCYTE COUNT

CLOTTING TIME

BLEEDING TIME

PTT: CONTROL, PATIENT

PT: CONTROL, PATIENT, % ACTIVITY, RATIO

SICKLING TEST

LE PREP

REMARKS CBC

(b)(6)-2

REPORTED BY

TECH

MD DATE

LAB. ID. NO.

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

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

SPECIMEN SOURCE: BLOOD

SPECIMEN/LAB. RPT. NO.

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)

PRESCRIBED BY GSA/ICMR

FIRMR (41-CFR) 201-45.505

PATIENT'S MED. RECORD

[redacted] (b)(6)-4

1CW1

911103 @ 0415

ENTER IN ABOVE REQUESTING FACILITY—WARD NO.—DATE

[redacted]

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

PATIENT STATUS: BED, OUTPATIENT, NP

SPECIMEN: VEIN, OTHER (Spe

SPECIMEN/LAB RPT. NO.

1Sep 0400

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20 DAYS MOS YRS (27) Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: _____
NPO SINCE: 2100 / 0330 (OSW)

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

HABITS:
TOBACCO: yes
ETOH: 0
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

(✓) Ø
( ) _____
( ) _____
( ) Ign Ancef
( ) Tetanus
( ) Ms04 5mg

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

LABORATORY STUDIES:
HB/HCT: 11 / 33
U/A: _____
OTHER: _____

3400mc NS
T+C 2ii

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	Denies
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	N/A
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 104/80 HR 98 R 32 T ____
Pain Scale 0-10 8
HEENT - Teeth intact
Trachea midline
TMJ/Neck limited ROM
Oropharnyx MP4; MO-1 FB
Nares patent 2° to foreign body
CHEST: Coarse equal (B)
CARDIAC: RRR S1 S2
EXTREMITIES:
IV Access: 18G / 18G (R) (L) AC
Ulnar Filling: _____
BACK: _____
OTHER: C-Spine cleared

NPO Since 2100 / 0330 OSW

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. Discussed c̄ interpreter + pt plan.

The patient/legal guardian seems to understand and agrees. Questions answered.
(b)(6)-2
Signed: [redacted] CRNA/MAJ Date: 28 Aug 03 Time: 0538 Hrs

POST[redacted]HESIA EVALUATION AND NOTE (NON ASU)
{ } NO[redacted]ARENT 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.

Jolracco GSW → face

MEDICAL RECORD - ANESTHESIA

...is form, see AR 40-66; the proponent agency ... OTSG

NKDA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)											TOTALS
Midazolam (1) (mg)									4		5 mg
Fentanyl (mcg)	50	50							50		
Lidocaine (mg)	80										
Propofol (mg)	160										
Sux (mg)	80										
VCB (mg)		8									
VOLAT AGENT Iso % del			2								
% e.t.	0.8	1.0	1.0	1.008		1.0	0.8	0.8	0.8X		
AIR L/Min									10		
N2O L/Min											
O2 L/Min	10 ~ 2 ~ 2		2	2	2	2	2	2	2	2	

TOTAL EBL: 600

TOTAL URINE: 500

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

3400 ER

FLUIDS

LINE site 18G (R) AC; 18G (L) AC

- ☐ Warmed — (600mL NS ER) LR #1 →
- ☐ Warmed — LR #2 → 1000 LR3 → → NS5 →
- ☐ Warmed — → LR4 →
- ☐ Warmed

LOSSES

EST BLOOD LOSS: + Urine

URINE: 200 — 25 — 500 — 575/600

FLUIDS SUMMARY
CRYSTALLOID- LR 3000
COLLOID-
BLOOD-

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 33

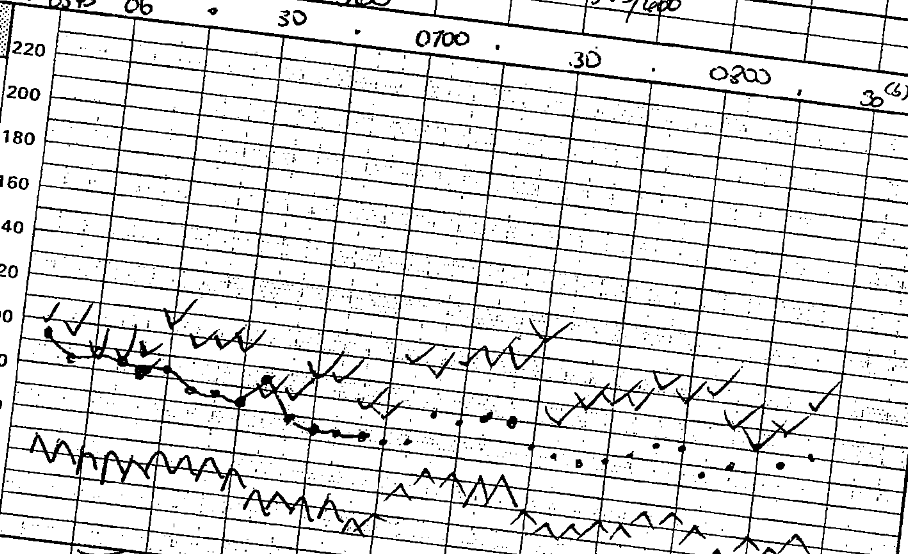
INITIAL DATA:
BP- 104/80
HR- 98

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE [redacted]
TIME- 0530

TIME → 0545 06 · 30 · 0700 · 30 · 0800 · 30 (b)(6)-2

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T—T; (b)(6)-2; ANES- X-X; PROC- ⊙-Ø



VT - ml	=	750	740	770	810	720	700	710	700	680	700
f - breaths/min	=	13	10	10	8	8	8	8	8	8	8
Peak inf pres / PEEP	—	16	16	17	19-17	18	18 10	17	18	21	18
MODE - S(pon), A(ssist), C(on)	S ~	C ~	C ~	C	C	C	CV	C	C	C	C
✓ ET CO2 (torr)	35	35	34	31	32	34	34	33	34	35	34
✓ FIO2 (Frac or %)	0.76	0.76	0.76	0.76	0.76	.75	.75	.75	.74	.75	.76
✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
✓ TEMP-site Ax				35.4	35.3	35.4	35.4	35.4	35.4	35.4	35.2
✓ N-M Block (T/4)	0/4	4/4		4/4, 1/4							
✓ BS	H=										

✓ BP/Auto Cuff; BP/oth; ART line; Steth- PC/ES; Gas analyzer

Warming blkt — x1 Blanket →
Fluid warmer

Use letters & symbols, enter REMARKS: EVENTS (1) (2) (3); Position 0 ~ Turned 90°; (3) (3)

PROCEDURES and CPT Codes: Neck exploration

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

(b)(6)-2

REMARKS
Code drugs with numbers, events with letters
(1) Pre-op assessment. Counseled c interpreter. C-Spine cleared. Pt never supported c C-collar. Dr. [redacted]
(2) Room, monitors, (b)(6)- 100% O2, Induced, intubated see Airway management.
(3) Phenylephrine 100mcg IV
0700 Neo Syn 200mcg IV
0830 TRANS → INTE ICU - BED 1

RECOVERY AT: PACU (ICU BED 1) (Specify)
OTHER
CONDITION: STABLE MECH VENT
RESP- 16 SpO2- 100
BP- 120/60 HR- 86

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0530	0545	0840
	Ready	Begin	End
PROC	0555	0620	0815

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
RSI c Cricoid
DL c MAC 4 Grade I view, no visible blood in OP, 8.0 styletted OETT 24 @ teeth + BBS, sust ETCO2

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

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

PROCEDURE LOCATION: 2

DATE: 28 Apr 03

PAGE

...M 7389, FEB 1998

MEDCOM - 17896

[redacted] COPY 1 [redacted] MAJ CRNA

NSN 7540-01-165-7294

591-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATIONS (S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINC	REGISTER NO.
CT scan neck, jaw	26	m		ICW1	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)* (b)(6)-2				TELEPHONE/PAGE NO. (b)(6)-2
	SIGNATURE OF REQUESTOR [redacted]				DATE REQUESTED /

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

26yo s/p GSW neck s/p exploration 10d ago.
Pt with ↑ pain, swelling at operative site, (L) neck

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

RADIOLOGIC REPORT

1) Large (L) perimandibular ~~and~~ soft tissue metallic debris w/ signif metallic artifact. w/o drainable fluid collection/abscess.

2) Soft tissue swelling/inflammation and some air.

3) (L) vert artery intact but ~~[illegible]~~ caliber throughout (from C2 ↑) – cannot exclude dissection.

4) Carotid appears intact. (b)(6)-2 [redacted]

(b)(2)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS [redacted]

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 17897

RADIOLOGIC CONSULTATION STANDARD FORM 513

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

ICU 3

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8/28 | TIME OF ORDER 1 wk | HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Admit ICU
(2) Cond: critical
(3) Sp C&W neck, ear
(4) VS routine q1°
(5) NL to LIS
(6) Irrigate NL ĩ 30cc water q4°
(7) Foley

0900

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

(8) IVF NR a 125cc/hr
(9) Ancef 1g ivp q8°
(10) Zantac 50mg ivp q8°
(11) Labs now: CBC, Chem 12, ABG
(12) AM labs CBC, Chem 12
(13) CXR upon arrival to ICU
(14) Versed ivd titrate to effect

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

(15) Fentanyl ivd titrate to effect
(16) Bacitrain to (6) ear wound

[redacted] (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

DATE OF ORDER 8-28 | TIME OF ORDER 0900 | HOURS

(1) Vent: SIMV: 16, 50%, PEEP 5, vt 650 per V/O Dr. [redacted] (b)(6)-2
(2) Neuromuscular drip titrate to effect per V/O Dr. [redacted] (b)(6)-2

0900

[redacted] (b)(6)-2

[redacted] ILTRN

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] GPW

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-2	0900 HOURS	
(1) Per V/O Dr. [redacted], Vecuronium off until further notice		[redacted] 0900 ILTRN
(2) Per V/O Dr. [redacted] rate for LR ↓ to 75cc/hr (b)(6)-2		[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
29Aug03	1900 HOURS	
1) DC Vecuronium	DONE	
2) DC Versed	DONE	
3) DC NGT	DONE	
4) Diet: NPO		
V.O. Dr [redacted] ILTMN (b)(6)-2 (b)(6)-2		noted [redacted] ILTMN 08/29/03 2250 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
29Aug03	2050 HOURS	
1) Diet: Sips of water		
Dr. [redacted] ILTMN (b)(6)-2 (b)(6)-2		
24° V [redacted] ILTMN 08/29/03 2310 (b)(6)-2		

PATIENT IDENTIFICATION

GPW

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24° / [redacted]		

DATE OF ORDER	TIME OF ORDER	
8/30	0730 HOURS	0730
(1) per V/O Dr. [redacted] (b)(6)-2 Diet: Adv as tolerated		[redacted] (b)(6)-2
(2) per V/O Dr. [redacted] (b)(6)-2 1-2 percocet 4-6° p.r.n		
(3) DC fentanyl per V/O Dr [redacted] (b)(6)-2		
(4) DC foley per V/O Dr. [redacted] (b)(6)-2		
(5) DC Zantac per V/O Dr [redacted] (b)(6)-2		
(6) Transfer out		[redacted] (b)(6)-2

DA FORM 1 APR 79 4256 [redacted] (b)(6)-2 PREVIOUS EDITIONS 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 | ROOM NO.: 24 | BED NO.: [redacted]

DATE OF ORDER: 9/1 | TIME OF ORDER: 1430 HOURS | LIST TIME ORDER NOTED AND SIGN: [redacted] 9/1/03 1440 (b)(6)-2

(1) D/C All Labs
(2) D/C IV Fluid
(3) Out of bed, ambulate daily
(4) Heparin 5000 u sq bid

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

PATIENT IDENTIFICATION: (b)(6)-2 [redacted] (b)(6)-2

NURSING UNIT: 24 | ROOM NO.: 2015 | BED NO.: 15

DATE OF ORDER: 9/2 | TIME OF ORDER: 0200 HOURS

(1) D/C Fluids
(2) On bed rest

[redacted] (b)(6)-2

PATIENT IDENTIFICATION: [redacted] (b)(6)-2

NURSING UNIT: | ROOM NO.: | BED NO.: 1545

DATE OF ORDER: 9/10 | TIME OF ORDER: 1530 HOURS

(1) Clindamycin 600 mg iv q 8

[redacted] (b)(6)-2

24 Chart [redacted] RN 11 Sep 03 2130 (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4 [redacted] (b)(6)-2

Noted 17 Sept 1040 2CTV

NURSING UNIT: 24 | ROOM NO.: 2015 | BED NO.: 17 SEP 03 [redacted] (b)(6)-2

DATE OF ORDER: 9/17 | TIME OF ORDER: (b)(6)-2 HOURS

D/C IV abx

(b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

(b)(6)-2 [redacted] Noted 20SEP03

NURSING UNIT: ICW#1 | ROOM NO.: 1215 | BED NO.: 24 V 2100 20SEP

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
9/20	1000	
① Ambien 10mg PO qHS		
[redacted] (b)(6)-2		
MATTHEW		

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

DATE OF ORDER	TIME OF ORDER / HOURS	
9/22		
① Olanzapine		
[redacted] (b)(6)-2		
[redacted] (b)(6)-2		
23 Sep 03	1430	

NURSING UNIT: CW 1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER / HOURS	

UNIT | ROOM NO. | BED NO.

IDENTIFICATION

DATE OF ORDER	TIME OF ORDER / HOURS	

ROOM NO. | BED NO.

256

REPLACES EDITION OF 1 JUL 77, WHICH MAY

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. Aug Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	31	01	02	03	4	5	6	7	8	9	10
8-28	(b)(6)-2 [redacted]	~~VS routine q1°~~	06	[redacted]													
			18	[redacted]													
8-28	(b)(6)-2 [redacted]	NG to LIS	06	[redacted]													
	(b)(6)-2		18	[redacted]													
8-28	[redacted]	Irrigate NGT 30cc	06	[redacted]													
	(b)(6)-2	water q 4°	18	[redacted]													
8-28	[redacted]	Patient to ground	06	[redacted]													
			18	[redacted]													
8-28	[redacted]	F/O's q1°	06	[redacted]													
	(b)(6)-2		18	[redacted]													
8-28	[redacted]	CBC check 12 q am	06	[redacted]													
	(b)(6)-2		18														
8-28	[redacted]	Lactic Critical	06	[redacted]													
	(b)(6)-2		18	[redacted]													
29Aug03	(b)(6)-2 [redacted]	Dict: NPO															
29Aug	[redacted]	Dict: sips of water	06														
	(b)(6)-2		18														
8-30	[redacted]	Diet: Adv antelor	06														
	(b)(6)-2		18														
30 AUG03	[redacted]	VS routine - q shift	06														
	(b)(6)-2		18														
1 Sept	[redacted]	OOB ~~to~~ Ambulate	06														
	(b)(6)-2	daily	18														
			06														

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW neck/ear
S/P Exploration w/ GSW

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo Aug Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
8.28	(b)(6)-2 [redacted]	Admit to ICU	8.28	0030	0030	[redacted]	(b)(6)-2
8.28	(b)(6)-2 [redacted]	CBC, chem 12, ABG now	8.28	ASAP 0030	0030	[redacted]	(b)(6)-2
28 Aug	(b)(6)-2 [redacted]	CXR upon arrival to ICU	28 Aug				
28 Aug	(b)(6)-2 [redacted]	Vent: SIMV 16, 50%, peep 5 TV 650	28 Aug				
8.30	(b)(6)-2 [redacted]	D/c foley	8.30 ASAP	—		[redacted]	(b)(6)-2
30 AUG03	(b)(6)-2 [redacted]	Transfer to ward	30 AUG03	—	—	[redacted]	(b)(6)-2
1 Sept	(b)(6)-2 [redacted]	D/C all labs	1 Sept	—	—	[redacted]	(b)(6)-2
02 Sep03	[redacted]	DC foley - DTV in 8°	02 SEP03	—	0735	[redacted]	(b)(6)-2
	(b)(6)-2						

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

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	19	20	21	22	23	24
30 days	[redacted]	DIET: as tolerated	6	[redacted]													
	(b)(6)-2		14	[redacted]													
	(b)(6)-2		22	[redacted]													
30 days	[redacted]	VS-routine - QS	6	[redacted]													
			14						[redacted]								
	(b)(6)-2		22	[redacted]													
30 days	[redacted]	OOB to AMB Daily	6	[redacted]													
			14	[redacted]													
			22	[redacted]													

all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to neck/ear

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo #09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/23	[redacted]	D/C today	9/23		1435	[redacted]
	-----	(b)(6)-2				(b)(6)-2

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (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 28	29	30	31	01	02	03	4	5	6	7	08	9	10
8.28	[redacted] (b)(6)-2	Ancef 1g IVPq8°	08	[redacted]													
			16	[redacted]													
	(b)(6)-2		24	[redacted]													
8.28	[redacted]	Zantac 50mg IVPq8°	08	[redacted]							D/C						
			16	[redacted]									830 [redacted]		0730		
	(b)(6)-2		24	[redacted]													
8.28	[redacted]	IVF LR@125cc/hr	08	[redacted]													
	(b)(6)-2		18	[redacted]							D/C		8.29/0900				
8.28	[redacted]	versed IVD titrate to	08	[redacted]													
		effect	18	[redacted]													
8.28	(b)(6)-2 [redacted]	Fentanyl IVD titrate	08	[redacted]							D/C		8.30		0730		
		to effect	18	[redacted]													
8.28	(b)(6)-2 [redacted]	Vecuronium IVD titrate	08	[redacted]													
		to effect	18	[redacted]													
8.28	(b)(6)-2 [redacted]	Bacitracin to O car	08	[redacted]													
	(b)(6)-2	wound	18	[redacted]													
8.29	[redacted]	LRe 75cc/hr	08	[redacted]													
	(b)(6)-2		18	[redacted]													
8.30	[redacted]																
1 Sept	[redacted]	Heparin 5000u sq	10	[redacted]													
	(b)(6)-2	bid	22	[redacted]													
10 Sept 03	[redacted]	Clindamycin 600mg	08														
	(b)(6)-2	IV q8°	16														[redacted]
			24														[redacted]

all (b)(b)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW neck/ear R/T GSW

S/P Neck Exploration

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. 08-09 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8/30	[redacted]	Percocet 1-2 tabs	30 Aug MP	30 2000	31 2000	01 Sep 03 0800	1 Sep 03 2210	03 Sep 0715	03 Sep 1755	2 Sep 2345	03 Sep 0715	03 Sep 1650	4 Sep 0019	4 Sep 1410	5 Sep 0030	
	(b)(6)-2	4-6° prn	11													(b)(6)-2 all
8/30	[redacted]	Percocet 1-2 tabs	5 Sep 0416	5 Sep 1315	5 Sep 03 2200		6 Sep 1600	6 Sep 2116	7 Sep 0515	7 Sep 1145	7 Sep 1930	8 Sep 03 0120	08 Sep 0924	08 Sep 1525	8 Sep 2045	
	(b)(6)-2	4-6° PRN														
8/30	[redacted]	Percocet 1-2 tabs po q4-6° PRN	D/T	9 Sep 0230	09 Sep 0934	9 Sep 2350	10 Sep 0545	10 Sep 03 2330								
	(b)(6)-2		D/1													

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	11	12	13	14	15	16	17	18	19	20	21	22	23	24
8/28	[redacted]	Ancef 1gm IVP q8°	8	[redacted]									D/Ced				
	(b)(6)-2		16	[redacted]									12 Sept 03				
			24	[redacted]													
8/28	[redacted]	Bactracin to L ear	10	[redacted]									DC'd				
	(b)(6)-2	wound	22	[redacted]									SEP 03				
9/1	[redacted]	Heparin 5000 SQ BID	10	[redacted]													
	(b)(6)-2		22	[redacted]													
10 Sept 03	[redacted]	Clindamycin 600mg	02	[redacted]									D/Ced				
	(b)(6)-2	IV q8°	16	[redacted]									12 Sept 03				
			24	[redacted]													
20 SEP 03	[redacted]	Ambien 10mg po qhs	22	/	/	/	/	/	/	/	/	/	[redacted]				
	(b)(6)-2																

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to neck / ear

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 09 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8/30	[redacted]	Percocet 1-2 tab. Q4-6 PRN	D/I	11Sep 2030	12 0445	12Sep 2215	13	13th 2000	2350	16th 2140	17 2300	18 2300	19Sep 0940	19 2200	20Sep 1115	22 0200
- - - - -	(b)(6)-2		D/I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
8/30	[redacted]	Percocet 1-2 tabs	Date Time	9/22 1050	9/22		23Sep 1210									
- - - - -	(b)(6)-2	Q4-6 prn	Dose Initial	(2) [redacted]	2030		[redacted]									
- - - - -	- - - - -	(rewritten)	I/E	E	[redacted]		E									
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

(b)(6)-2 all

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0830	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm sluggish PERL					
	SENSORIUM	paralyzed & sed					
		c̄ versed & fent drip.					
		Ø movement x4 extremity					
		Ø response to painful stimuli					
RESPIRATORY	RESPIRATORY PATTERN	eventual unbinded vent					
	BREATH SOUNDS	SIMV 16 FiO2 60 peep 5					
	SECRETIONS	VT 650 ETT #7 24 cm @					
		lip, CTA (B) Ø secretions					
		not overbreathing					
		vent.					
SKIN	COLOR	appropriate for race					
	INTEGRITY	see progress notes					
IV SITE	LOCATION	(L) AC PIV (R) AC PIV					
	CONDITION	(R) femoral A-line. zero'd					
		all patent					
GASTRO	ABDOMEN	Soft non distended					
	BOWEL SOUNDS	hypo BS x4 Ø N/V/O					
		NG (R) nare to CZ8.					
		Clear yellow fluid drained					
GU	URINE:	Straw colored & clear					
	COLOR/CLARITY	QS.					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR & ectopy, SinBP					
		stable, Ø JVD, +2					
		radial & pedal pulses					
		cap refill <3secs					
		trace periorbital edema.					

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

(Continue on reverse)

PREPARED BY (Signature & Title) 1800-0600

DEPARTMENT/SERVICE/CLINIC FW 3

DATE 8-28

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

@ 0900 - on vec, versed fentanyl
@ 1500 - remains on vec, versed, fentanyl

NEUROLOGICAL ASSESSMENT

		HOURS	R 0900	F 1500
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4		
		TO SPEECH 3		
		TO PAIN 2		
		NO EYE OPENING 1	1	1
	BEST VERBAL RESPONSE	ORIENTED 5		
		CONFUSED 4		
		VERBALIZES 3		
		VOCALIZES 2		
		NO VOCALIZATION 1	1	1
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6		
		LOCALIZES PAIN 5		
		FLEXION WITHDRAWAL 4		
		ABNORMAL FLEXION 3		
		EXTENSION TO PAIN 2		
		NO MOTOR RESPONSE 1	1	1
LIMB MOVEMENT	ARMS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE	1	1
	LEGS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE	1	1
PUPILS	RIGHT	SIZE	3	
		REACTION	+	
	LEFT	SIZE	3	
		REACTION	+	
PUPIL SCALE			2 3 4 5 6 7 mm	
ICP				
CEREBRAL PERFUSION PRESSURE				

LEGEND

C Closed by swelling

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

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

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS																																
	R																															
	L																															
	R																															
	L																															
	R																															
	L																															
	R																															
	L																															
	R																															
	L																															

LEGEND

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

M AL RECORD-SUPPLEMENTAL MEDIC. .TA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0640 Inital: [redacted] (b)(6)-2	Time: 1830 Inital: [redacted] (b)(6)-2
NEURO	Pupils Sensorium LOC / GCS	3mm sluggish Perrl, paralyzed ε vec, Sedated ε vecuronium paralyzed ε fent drip. Moves ⊘ extrem, ⊘ observable response to painful stimuli all extremities ↑HR & BP.	Perrl 3mm, Sluggish. Slight (D) sided facial droop ↑ weakness (D) arm. Good strength in grips R>L. Moves all other extremities. Eyes follow. Moderate cough.
CARDIAC	Cardiac Rhythm PRI: / QRS: Pulse Strength Cap Refil / JVD Edema Chest Pain	NSR ε ectopy, S1S2, +2 radial & pedal pulses bilat, Cap refill <3sec & ⊘ JVD. periorbital edema, +1 bilat hand edema non pitting. WA chest pain. pt ventilator	ST 110's-120's ε ectopy. S1S2. Radial / Pedal pulses 3+. Cap refill all extremities <3sec. ⊘ JVD on (R) side 2+ edema BUE. ⊘ CP per interpreter.
RESP	Respiratory Pattern Breath Sounds Secretions Cough	ventilator assisted vent: SIMV 14, peep 5, fio2 35% VT 650 ETT # 8 24cm @ lip. Rales bilat & throughout. ⊘ secretions ⊘ cough. Not over breathing vent spontaneously.	Regular, even, unlabored. Coarse crackles over anterior upper lobes. ↑ secretions. Moderate cough. Occasionally able to clear secretions. Thick, clear-yellow secretions. Voice slightly hoarse
SKIN	Color Integrity Backside	appropriate for race. see progress note intact ⊘ indications of breakdown	WNL, Warm, dry. Dressings to (D) jugular area and back of neck. Sanguineous drainage. minimal. Dressing over (D) neck.
IV	Access Devices Location Condition	PIV & ~~Radial~~ femoral-A line (D) AC, (R) Femoral-art line all patent. A-line zeroed & correlating ε NIBP	(D) AC IV infusing LR @ 75cc/hr ε fentanyl to titrate. (R) AC SL flushed ε resistance A-line to (R) groin. ~~Pressure tubing~~ Dressings CDI. ⊘ S/S of infection.
GI	Abdomen Bowel Sounds Stoma/Ostomy	Soft nondistended ~~hypo BS x4~~ hypo x4 ⊘ NG (D) nare to CTS. Scant-small clear brown drainage.	Soft, nondistended. Hypoactive BS x4. Nontender. ⊘ BM. NPO.
GU	Device Color / Clarity	FTG amber clear QS.	Foley to DD. Clear yellow urine. tube secured to leg.

(Continue on reverse)

600 - 1800 PREPARED BY (Signature & Title): 1800 - 0600

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

DATE: 8.29.03

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

NAME: #[redacted] EPW

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

GPW # [redacted] 29 AUG 03

(b)(6)-4

ICU Flowsheet **Patient Name:** [redacted] (b)(6)-4 **Date:** 8 / 29 / 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						100.1	99.6					100.8										99.8				
Pulse	96	90	89	91	94	91	86	90	91	83	85	103		97	99	125	123	134	121	115	125	111	95	103	104	
B/P A-Line	114/65	116/66	119/65	113/65	123/67	120/65	119/63	123/67	127/71	123/62	122/63	128/71		120/65	123/66	129/68	129/68	110/62	123/69	125/70	115/63	112/63	111/62	126/72	133/71	
MAP	88	84		81																	89	87	80	91	93	
B/P Cuff	127/67		120/67		113/66		125/67																		124/73	
Respirations	14	14	14	14	14	14	14	12	12	12	12	12		12	12	15	17	19	19	14	21	14	14	16	14	
SaO2	100	100	100	100	100	100	100	100	100	100	100	100		100	100	99	100	100	98	100	100	100	100	100	100	
F.O2	35%					35%		35	35	35	35	35		35	35	(b)(6)-2	2A	2A	2L	2L	2L	2L	2L	2L	2L	
MODE	SIMV					SIMV		SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	[redacted]	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
IVF - LR	125	125	125	125	125	125	125/85	125	125	75	75	75	1350	75	75	75	75	75	75	75	75	75	75	75	75	900
VERSED	3	3	3	2	2	2	2/1.5	2	2	2	2	1	26	1	off	off	off	off	off	off	Dc'd	—	—	—	—	1
FENT	14	14	14	14	14	14	14/98	14	14	14	14	12	166	12	12	6	6	6	6	6	6	6.6	6.6	6.6	6.6	76.4
VAC	6.3	6.3	6.3	5.9	5.9	5.9	5.9/41.0	5.9	5.9	off	off	off	54.3	off	off	off	off	off	off	off	Dc'd	—	—	—	—	
IVPB									100				100					100					(b)(6)-2			100
~~PO intake~~ NGT	30				30				30				90	30				30			Dc'd		[redacted] 30	3	(b)(6)-2	60
~~O.R. IN~~ PO													[redacted]	(b)(6)-2									30	30	30	90
Totals													1786.3													1227.4

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	215	200	150/625	200	200/1025	200/1225	175	200	250	200	200	150	2500	100	75/175	100/275	100/375	75/450	150/600	75/675	150/825	125/950	125/1075	100/1175	100/1275	1275
NG Tube						200						100	300							200	Dc'd					200
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													2800													1475

12 / 24 hour input	1786.3	3013.7
12 / 24 hour output	2800	4275
12 / 24 hour balance	714	-1261.3

MEDCOM - 17913

:AL RECORD-SUPPLEMENTAL MEDI(ATA

For use of t n, 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: 0700 Initals:	Time: Initals:
NEURO			
	Pupils	3mm sluggish Bilat	
	Sensorium	alert & appropriate follows commands.	
	LOC / GCS	(L) lower extremity weak but weight bearing (R) UE weak non weight bearing	
CARDIAC	Cardiac Rhythm	ST s ectopy S1S2	
	PRI: / QRS:		
	Pulse Strength	+2 radial & +2 pedal pulses	
	Cap Refil / JVD	<3sec & JVD.	
	Edema	+2 non pitting UE. bilat.	
	Chest Pain	∅ denied.	
RESP	Respiratory Pattern	even unlabored	
	Breath Sounds	coarse upper lobes bilat.	
	Secretions	thick white or yellow c̄ strong cough	
	Cough	strong.	
SKIN	Color	appropriate for race	
	Integrity	see progress note.	
	Backside	intact ∅ breakdown	
IV	Access Devices	(L) AC & (R) AC PIV KVO.	
	Location	(R) femoral - d. line zeroed &	
	Condition	correlating c̄ MABP.	
GI	Abdomen	soft nontender distended.	
	Bowel Sounds	hypo BS x 4.	
	Stoma/Ostomy	∅	
		Barotrauma well ∅ H/V/D.	
GU	Device	FTG	
	Color / Clarity	clear/yellow.	

(Continue on reverse)

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

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

DATE 8-30-03

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

NAME: [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

6.6 8/30

[redacted] (b)(6)-4

ICU Flowsheet Patient Name: EPW # [redacted] (b)(6)-4 Date: 8 / 30 / 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		99.7			99.1			99.7																		
Pulse	116	114	112	103	92	100	112	109	106																	
B/P A-Line	120/64	113/62	123/65	115/64	124/65	118/61	117/61	119/63	116/65	118/71	120/70	109/61		116/63												
MAP	87	88	86	83	89	81	84																			
B/P Cuff	118/68		114/65		116/64		109/65																			
Respirations	15	15	19	13	17	20	18	18	17	18	17	18		19												
Sa02	100	98	99	100	100	100	96	97	CR	92	110	102		103												
FiO_2	2L	2L	2L	2L	2L	2L	✓			RA	RA	RA		RA												
mode	NC	NC	NC	NC	NC	NC	RA	RA	RA			CM		CM												
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												
Fentanyl	6.6	6.6	6.6	8	10	10	10	10	10	8			698													
IVPB	50	50							100				200													
														840												
PO intake	30										120		150													
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	75	75/50	50/200	100/300	100/400	100/500	75/575	75/650	50	100/800	75/875	90/965	965													
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													965													

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 17915

Trauma Resuscitation Form

Name:

SSN:

Date and time of injury: 28 AUG 03 2[illegible] 30 z/hr

Date and time of arrival: 28 AUG 03 2[illegible] 45 z/hr

Chief complaint: GSW → POLS WEEK

Pre-hospital information

Mechanism of injury:
- [x] Gunshot wound
- [ ] Stabbing
- [ ] Burn
- [ ] Chemical casualty
- [ ] Other:

Procedures before arrival

- [x] Airway: type NASAL TRUMPET size #
- [ ] O_2 @ L/min via
- [ ] IV's: location and #
- [ ] Chest tube: location size #
- [ ] Splints: Type
- [ ] Medications:
- [ ] Chemical casualty:
  - [ ] Decontamination date/time:

	Dosage	Date/time
[ ] Atropine:		
[ ] 2-PAM:		
[ ] Other:		

- [ ] Other procedures:

P = 76

BP = 94/52

AMPLE history

Allergies:

Medications:

Past illnesses:

Last meal: Last Tetanus:

Events:

Unknown

shot @ oil line, initially unconscious now GCS15

Initial assessment

Airway
- [x] Patent
- [ ] Obstructed

Breathing
- [x] Normal
- [ ] Labored
- [ ] Symmetrical
- [ ] Asymmetrical

Trachea midline? [x] Yes [ ] No

Breath sounds:	Right	Left
Present	[x]	[x]
Clear	[ ]	[ ]
Decreased	[ ]	[ ]
Absent	[ ]	[ ]
Rales/Rhonchi	[ ]	[ ]

Crepitus: [ ] Yes [x] No

Initial assessment

Circulation

Skin/mucous membrane color:
- [x] Pink
- [ ] Flushed
- [ ] Pale
- [ ] Jaundiced
- [ ] Ashen
- [ ] Cyanotic

Skin temperature:
- [x] Warm
- [ ] Hot
- [ ] Cool

Skin moisture:
- [x] Normal
- [ ] Dry
- [ ] Moist

Pulses:

	Carotid		Radial		Femoral	
	R	L	R	L	R	L
Normal	[x]	[x]	[x]	[x]	[x]	[x]
Bounding	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Weak	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Absent	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Disability

Glasgow Coma Scale (circle appropriate scores):

	Score:
1. Eye opening:	
Spontaneous	4
To voice	3
To pain	2
None	1
2. Verbal:	
Oriented	5
Confused	4
Inappropriate words	3
Incomprehensible words	2
None	1
3. Motor:	
Obeys commands	6
Localizes to pain	5
Withdrawls to pain	4
Flexion	3
Extension	2
None	1
Total GCS	15

Pupillary response

Pupil reaction:	Right	Left
Brisk	[x]	[x]
Constricted	[ ]	[ ]
Sluggish	[ ]	[ ]
Dilated	[ ]	[ ]
Nonreactive	[ ]	[ ]
Size	5 mm	5 mm

1 2 3 4 5 6 7 8

Trauma Resuscitation Form

Physical examination:

Age (years): ? Height (inches): _____ Weight (kg's): _____

Head, eyes, ears, nose, throat: see diagram TM's clear, ⊖ obvious hematoma, face atraumatic

Neck:

Chest: CTA (B), heart sounds nl

Back: atraumatic

Cervical/Thoracic/Lumbar spine:

Abdomen: soft NT, ND

Perineum and rectum:

Extremity: ⊖ trauma, strength appears intact x 4.

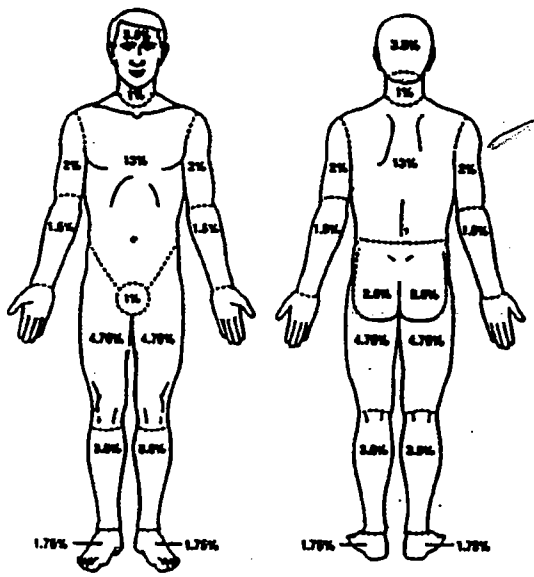
Skin: warm, pink

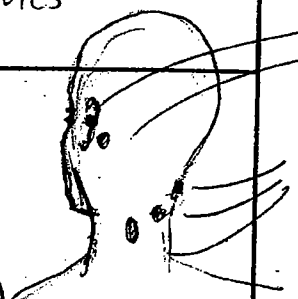
Neurologic:

Other: GCS = 15, pt. moves all 4 extremities

Diagram for documenting injuries
(Identify injury site by number)

1. Laceration
2. Abrasion
3. Hematoma
4. Contusion
5. Deformity
6. Fracture
7. GSW(s)
8. Stab wound(s)
9. Pain
10. Cold injury
11. Edema
12. Amputation
13. Avulsion
14. Burn
15. Other (Describe)





5 entrance exit wounds in post. neck

(With permission from JB Lippincott Company. After Deming RH. Burns. In: Greenfield LJ, Mulholland MW, Oldham KT, and Zelenock GB, eds. Surgery: Scientific Principles and Practice. Philadelphia, JB Lippincott Company, 1993.)

Trauma Resuscitation Form

Burn data (fill in appropriate boxes)

Area	Adult BSA	2°	3°	Total
Head	7			
Neck	2			
Ant. Trunk	13			
Post. Trunk	13			
R. Buttock	$2^{1/2}$			
L. Buttock	$2^{1/2}$			
Genitalia	1			
R.U. Arm	4			
L.U. Arm	4			
R.L. Arm	3			
L.L. Arm	3			
R. Hand	$2^{1/2}$			
L. Hand	$2^{1/2}$			
R. Thigh	$9^{1/2}$			
L. Thigh	$9^{1/2}$			
R. Leg	7			
L. Leg	7			
R. Foot	$3^{1/2}$			
L. Foot	$3^{1/2}$			
	Total			

(With permission from McGraw-Hill Inc. Alby Gaudete CW, Finkelstein JL, and Madden MR. Burns. In: Schwartz SI, Shires GT, and Spencer FC, eds. Principles of Surgery. Sixth edition. New York, McGraw-Hill Inc., 1994.)

Laboratory data

CBC:	Lytes, BUN, Cr, Glu:	UA:

ABG:

Time	FIO_2	pH	PO_2	PCO_2	BD

Other labs:

X-Ray

C-spine: collared: shrapnel frags @ (L) cspine (C_1 & C_2)

CXR:

Pelvis:

Other:

Trauma Resuscitation Form

Procedures performed by trauma team		Medications			
Time:	Procedure:	Time:	Drug:	Dosage:	Route:
2200 zulu	(L) AC → + L NS				
"	4MG MSO4 IV				
2240	1 GM ANCEF (N)				
2300 z	+ L NS running				
2300	1 L LR running				
	(L)				

Trauma fluid resuscitation data

Estimated initial postburn IV fluid requirement

1. IV fluid of choice: Lactated Ringer's solution.
   (Use the following equations)
2. Total fluid requirement (TFR):
   TFR = 4 ml x wt (kg's) x % burn (2° and 3°)
   TFR = (4 x _____ x _____) = _____cc
3. Estimated fluid requirement 1st 8 hours post burn:
   (TFR/2) = _____cc
4. Estimated fluid requirement next 16 hours post burn:
   (TFR/2) = _____cc

Resuscitation area fluid intake and output

Intake:		Output:	
LR	_____ml	Blood	_____ml
PRBC	_____ml	Urine	_____ml
FFP	_____ml	NG tube	_____ml
Platelets	_____ml	Chest tube	_____ml
Other	_____ml	Other	_____ml
Total	_____ml	Total	_____ml

Vital signs

Time:	23 zulu							
BP:	90/47							
Pulse:	78							
Temp:								
Resp:	40							
GCS:	15							

Notes: PT WAS combated on arrival, GCS 15

Impression: GSW x 5 to neck, neurovascularly intact. GCS 15

Plan: Med-evac → III echelon

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

Signature: [redacted] MD

(With permission from the American College of Surgeons Committee on Trauma, *Advanced Trauma Life Support Student Manual*, 1993 edition.)

(b)(6)-2

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 I I D I	I Z	[redacted]	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	27 y	2	9	

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	0900	NA

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
I Z			YEAR ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	Icu 3	Unk

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
Unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 0		0 3 0 9 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		0 3 0 8 2 8

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

FOR LOCAL USE

GSW TO POSTERIOR NECK
T: 9
Inj: 569
Dx: 874.8 [illegible] PR: 0609
80220 E9912 966
[illegible]

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

DA FORM 2085, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted] (b)(6)-4			2. NAME (LAST, FIRST, MI) UNK			GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE 28	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted] (b)(6)-4		13. ORGANIZATION NA		14. WARD ICU3	
15. FLYING STATUS NA	16. RATING/ DSG	17. DEPT/ BEN NA		18. BRANCH/CORPS NA	19. UIC/ZIP	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from Emt				22. HOURS OF ADMISSION 1800	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 24	26. DATE OF DISPOSITION ~~10/5/03~~ 11/3/03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 8/29/03	ADMITTING OFFICER (b)(6)-2 Dr. [redacted]	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2					30. DATE OF INTIAL ADMISSION 8/29/03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED (b)(6)-2	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW TO CHEST
Paraplegia
Sacral decubitus

875.1
862.1
864.14
952.15
707.0
E991.2

34.84
50.22
43.19
31.1
86.22
86.69
86.25
46.10
86.22

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	[redacted] 0	0	0	38	38

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	38	38

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

SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER [redacted] Four [redacted] (b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted] (b)(6)-4			2. NAME (L ... M) UNK			GRADE N/A	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted] (b)(6)-4		13. ORGANIZATION N/A		14. WARD ICU	
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT/ BEN N/A		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM EMT					22. HOURS OF ADMISSION 1300	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 01		26. DATE OF DISPOSITION 31 01	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 20SEP03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2						30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

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		

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. [redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0		

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

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

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

(b)(6)-4
[redacted]

ICU #3

1) Head w/o
2) A/P w/IV and oral (max 500 cc spread over 1 ½ hr)
3) T10 - T12.
7) Med free until in pelvis
8) (a) T11 vert body shattered, (b) L lamina fx (c) small fragm
9) Brain ~~[illegible]~~ Mild gray/white loss c/w anoxic in
10) (R) ant chest exit wound
MD [redacted] (b)(6)-2 (b)(2)-2

1) Local (R) ant PTX small
2) Small (R) local oblig. fissure PTX
3) (R) C Tube
4) (B) Bilat. opacity/atlx/consolid.
5) (R) ant hepat laceration
6) (B) stretched kid — pyelonephritis slightly edematous (b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2 ÷ 40 IRAQI GUN SHOT IN CHEST 2 APPARENT
POSTERIOR ENTRANCE WOUND 2 EXIT THROUGH RIGHT ANTERIOR
CHEST. PT TREATED 2 TUBE THORACOSTOMY & EX-LAP. PT
REQUIRED TO HAVE STELLATE LACERATION OF CHEST LIVER TREATED
2 PACKS. PT ARRIVES ENTUBATED & PARALYZED.

PMH: PSH: MEDS: ALL:

PHYSICAL EXAMINATION

VS HR 56 140/70 RR 16 SAT 100%

H: NC
E: PERRL, EOM
B: DULL PERCUSSION
N: CLOSTRAVIS
T:
NECK: ↓ CRACKLING
BACK: ↓ CRACKLING
LUNGS: CTA
CVS: RRR

ABD: DRESSINGS CLEAN DRY INTACT
DISTENDED SOFT

WOUNDS: ENTRANCE (R) POSTERIOR
NEAR MIDLINE
EXIT (R) CHEST

VASC

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

ICU: STABLE S/P TUBE THORACOSTOMY & LIVER LAC
PLAN TO ICU
SEE ORDERS

[redacted] (b)(6)-2

[redacted]	DATE 29 NOV 03	IDENTIFICATION NO.	ORGANIZATION
[redacted]TION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 Aug 03	(S) 28 y/o Iraqi male s/p GSW. (+) wheezing (+) pain ~~LLQ~~ (+) SOB
Vitals	(O)
BP HR Spo2	WNWD. Male Mod distress A&Ox3
80/60 114 95 @ 1300	CN I-~~XII~~ grossly intact
82/58 97 97 @ 1307	Card - RRR & MOR
	Distal pulses (+) (B)
96/62 74 98 @ 1315	Cap refill <3sec (B)
119/68 76 98 @ 1524	Lungs - (+) wheezing & sucking chest wound on (R) lower lobe vs middle lobe
	~~Entrance wound~~ - 7mm x 6mm puncture on (R) post chest
	Exit - (+) 1in x ~~3in~~ exit wound
	(+) wheezing c minimal bleeding between (R) 7-9th ribs
	(A) GSW - Sucking Chest wound - (R) sided
	(P) O2 via NRB mask @ 12L/min
	1000mL LR IV @ (L) Dorsal wrist
	Asherman chest seal applied to (R) chest & 4x4 over entrance to (R) post chest
	Pt stable & ready for transport

(b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPT/SERVICE [redacted]

SPONSOR'S NAME | SSN/ID NO | RELATIONSHIP TO (b)(6)-2 [redacted]

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. JC T. SP. | RA-C

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 8)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

1330 P- 80
R-40

1335 P-
R-40

1340 P- 78
R. 40

1345 P
R changed O2

1350 P- 80
R-34

1355 P-80
R-34

1400 P-78
R-40

1405 P-76
R-40

1410 P -78
R-

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/29/03 1530	Surg (b)(6)-2 [redacted] Surg - CPT [redacted] First Asst. Cal [redacted] (b)(6)-2
	op note
	(R) clear track c 950 cc blood output Exploratory c repair of diaphragm c O'Brien. (approx 4 cm location) drug stellate gave wound to (R) ant lobe of liver c contained ooze of blood c packing + surgicel + adrenaline. 6 laparotomy sponges used to pack liver + abdomen closed c #1 loxpel PDS
	(R) lower chest exit wound deep tissue closed c single 2'0 vicryl & pursestr. sterile dry applied [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.)* | REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 AUG 03	OP NOTES
	PRE-OP DX: GSW TO CHEST & LIVER S/P EX-LAP
	& PACKING OF LIVER & REPAIR OF DIAPHRAGM &
	TUBE THORACOSTOMY
	PROC: EX-LAP & LIVER RESECTION (NON-ANATOMICAL),
	REMOVAL OF SPONGES & WASH-OUT
	SURG: [redacted] / [redacted]
	(b)(6)-2 (b)(6)-2
	EBL: 440 cc
	UO: 165 cc
	FLUIDS: 1700 LR 2u PRBC
	DRAINS: 2 JPs PLACED
	NO COMPLICATIONS (b)(6)-2 [redacted]
	STABLE TO ICU

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

Nursing Note

AUTHORIZED FOR LOCAL REPRODUCTION

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

28/Aug03 1610 EPW ↑ arrived via MEDEVAC. Pt c̄ [redacted] (b)(6)-2 ET in place @ 24 teeth. VSS 138/62, 77, 24, 16 100% on vent. Chest to to (R) side of chest to continuous suction. Foley to gravity. ADD & CDI & to (R) Lower back CDI. 18G IV to (R) Bicep c̄ NS, 18 to (L) FA c̄ Albumin and NS infusing. # of infused fluid unknown. Total of 1400cc of blood from CT. Plenovac &. WSI continue to monitor

1700 DR [redacted] (b)(6)-2 completed exam. CXR and KUB complete. Labs drawn and sent c̄ ABG's from (R) femoral Artery. 142/65 48 16 100% on Vent. Report given to ICU3 by [redacted] (b)(6)-2, RN. Pt Rt in to place ET Tube to 26 @ teeth. Pt ready for Transport. off vent to BVM. [redacted] (b)(6)-2 WTBD.

1709 Pt WAKING up reacting from ET NDL (2mg of Vec., 5mg versed, 100 mcg of Fentanyl) IV given. Pt to ICU3 [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.)*

EPW [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

MEDICAL RECORD	PROGRESS TES
DATE	
1700	pt removed from ~~OR~~ ER via litter; transferred to bed c̄ blanket; VSS; temp 95° axilly; pt covered c̄ space blanket, blanket, A/C turned off; Vent pen MD V.O.; ETT @ 23 cm; NGT to LWS; CT to SX; foley to gravity; pt GCS 3 c̄ vec on board; pt log rolled for T-spine xrays; MD (b)(6)-2 [redacted] in to see pt; Xrays ordered; [redacted] (b)(6)-2
1800	SBP >120; HR 49-65; pt covered c̄ additional blankets for warming; temp @ 95° axilly; [redacted] (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

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

1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29AUG03	Neurosurgery Consult
2032	History 28 y/o EPW GSW posterior chest @ ~1200 today. [redacted] packed abdomen / (R) Chest tube p̄ hypotension 82/60 and 850 cc output (R). Op note documents liver injury - packed and sent here, arrival ~1600. Initial exam @ FST documents awake patient but does not mention lower extremity function
	Exam Intubated, sedated c̄ propofol and Fentanyl.
	HR 67. BP 126/84.
	Eyes open to noxious.
	Localizes uppers to noxious.
	Lowers plegic.
	Perineum (+) Foley. (+) Priapism. Rectum good tone.
	(+) Stool (-) blood. (-) bulbocavernosus (-) Cremasteric
	LE Reflexes Flaccid.
	AP T/L Spine x-rays show no malalignment. There is a foreign body in the midline at T-11. Lateral not completed.
	Back exam: Midline wound dressed @ Low thorax.
	Impression: Flaccid plegia, appears complete.
	Plan: (1.) CT Scan when stable.
	(2.) Log Roll Precautions for now. [redacted]
	(3.) Would not offer steroids in this case.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RE[redacted]NTAINED AT (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)*

REGISTER N[redacted] WARD NO.

EPW [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Aug 03 0300	Pt's HR increased from 80's; 90's to 120's between 2300 hrs & now. WOP continues dark & concentrated c̄ average of 40-60 cc per hr. CBC Chem 7 & coags sent to lab. MD notified of HR change, who in turn evaluated the pt for bleeding. No evidence of continued bleeding per MD - H/H WNL. 1/2 L of LR given as bolus. CXR neg. MD also notified of temporary vent disconnection. After returning from lab RN noted ET disconnected from vent. O_2 sats ↓ 30's% HR ↑ 170's & sys BP ↑ 150's. Pt immediately bagged & brought up to 100% O_2 sat c̄ immediate stabilization of vital signs to pre event levels. LPN watching over pt @ the time stated pt could not have been disconnected for more than 30 secs since he had checked on pt right before RN's arrival. [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15Sep03	SURGERY
	CNS: PT SEDATED / PARALYZED
	LUNGS: CTA CVR: ϕ EFFUSION ϕ PNEUMOTHORAX VENT FIO2 50% RR22
	SIMV PEEP 7 TV 500 7.37/45/136/26/1/99%
	CVS: RRR HR 91-115 134/54
	ABD: SOFT, NT, ND ⊕BS TOLL JP c/w BILE LAST SHIFT
	NG: 250 LAST SHIFT
	RENAL: 140/10.4/4.2/25/1.0 (81 UO 2 40cc/hr
	HEME: 9.7/30.2 (131 ID Tm 99.2 Tc 99.1
	ENDO: STABLE
	IMPROVED OXYGENATION
	PLAN: FIO2 TO 40%
	PEEP TO 5
	DC VEC
	HOLD VASSOD
	[redacted]
	(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

EPW [redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
1400:	CL placed per NS surg; CX taken for placement; X-ray read by NS surg - OK to use CL; pt [redacted] (b)(6)-2
	currently stable; VS noted @ 1400;
(1500)	continues hemodynamically stable; no change in status;
	vent ↑ slowly to effect; temp ↓ 99.3 - pt comfort - ↓ breath;
(b)(6)-2	[redacted] (b)(6)-2
31 Aug 03	Assumed pt's care @ 0600. USS [redacted] assessment done
0850	see flow sheet ↓ F_IO_2 @ 0800 (50%) ABG's sent @ 0900 Ph 7.36
	P_aCO_2 40.9 P_aO_2 84 HCO_3 24 SO_2 96%. Suctioning pt. pon.
	thick mucous in small amounts. Will continue to monitor
	[redacted] KT/AW
	[redacted] (b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	

30 Aug 3 report received; pt sedated adequately; moves upper extremities to painful stimuli & 5x; T-11 GSW; Propofol ↓ 30mg; Lab's obtained by Night nurse. [redacted] (b)(6)-2

(0845) PRBC #1 started; 103, 103/42, 20, 98.2 (0850) 105/43, 101 98.5, 25, (0855) 106/45, 99, 26, 99. (0923) unit complete; no s/s of reaction; 111/48, 97, 26, 98.7 [redacted] (b)(6)-2

0900 ↓ UOP discussed c̄ anesthesiology; will CTM [redacted] (b)(6)-2

(0945) PRBC #2: 121/51, 98, 93, 24, (0950) 123/52, 91, 24, 98.7 (0955) 115/50, 93, 30, 98.5 – no s/s of reaction; (1030) 121/51, 93, 26, 98.2

(1000) Propofol ↑ to 19cc/hr to ↓ BP – vent PAWP (45-50) [redacted] (b)(6)-2

(1045) PRBC's complete; UA bolus 500cc p̄ blood completed for ↓ UOP as discussed c̄ MD [redacted] (b)(6)-2; no other orders given; will trigger FFP p̄ UA bolus

(1100) foley d/c to ensure ¢ blockage – no blockage noted [redacted] (b)(6)-2

(1130) FFP started; 114/54, 86, 16, 97.4 (1135) 115/53, 87, 16, 97.4 (1140) unit complete; ¢ s/s of reaction noted; 117/55, 97.4, 85 [redacted] (b)(6)-2

(1145) FFP #2: 97.4, 88, 120/57, 16 (1150) 114/56, 87, 96.3a, 22 (1155) 114/57, 84, 96.3 16 – unit complete; [redacted] (b)(6)-2

(1230) SBP ↓ 80's; SaO2 ↓ 88-90s; ↑ PAWP – 60's; no [redacted] (b)(6)-2 noted; Multiple UA/NS bolus given (x3) FFP complete (2 units rapidly transfused); Dopamine started; Vec started p̄ load drip 10mg IVP; Versed started @ 2mg; [redacted] (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

31Aug03 (2345) Received report from 1LT [redacted] (b)(6)-2 and assumed care of pt @ 1815. See DA form 4700. OP 375 for assessment data. Pt's lungs c̄ Rhonchi all fields. Lavaged pt c̄ NS and suctioned lungs @ 1830. Secretions very thick. Don't get secretions up ī lavaging. Peak pressures 35 q̄ p̄ suctioning. Some way c̄ every suction. Around 2000 pt started to get blood colored drainage from NGT. Dr [redacted] (b)(6)-2 & Dr [redacted] (b)(6)-2 aware. Drainage turned back to a dull green color around 2200. Cleaned pt's mouth c̄ cepacol mouth wash around 1845 and suctioned mouth. Pt's temp was 94.5 (R) @ 2100 rechecked 96.° (R). Dr's aware. A/C in room turned off and warming blanket c̄ ompt. heat lamps over pt. Pt's temp rechecked an hr. later and was 95.° (R). Heat lamps moved closer. Dr [redacted] (b)(6)-2 aware of pt's HOB being on the lower end. Pt flat on back [redacted] (b)(6)-2 1LT/AN

01Sept.03 (0030) Pt reassessed. Lungs still c̄ Rhonchi all fields. RT come and suctioned moderate amts of yellowish-white secretions. Temp ↑ to 96.0°F (R). Heat lamps still over pt. No further O's from previous assessment. [redacted] (b)(6)-2 1LT/AN

(0115) Suctioned pt. Lavaged and got moderate amt thick yellow-white secretions. Pt tolerates well. Peak pressure p̄ 32. [redacted] 1LT/AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Aug 03	SURGERY IMAGE EPW CURRENTLY ... SEDATED & PARALYZED c̄ GSW TO SPINE RIGHT CHEST & LUNG & LIVER S/P TUBE THORACOSTOMY X2, DIAPHRAGM REPAIR & NON-ANATOMICAL LIVER RESECTION. CURRENTLY STABLE PT HAD HYPOXIC EVENT THIS A.M. WHEN HE WAS DISCONNECTED FROM VENTILATOR FOR UNKNOWN PERIOD. NEUROLOGICAL STATUS CURRENTLY UNKNOWN. CNS: SEDATED & PARALYZED CVS: HR 114 132/53 LUNGS: COARSE B/L BS FIO2 50% PEEP 8 RR 22 TV 500 SIMV 7.34/42/88/23/-3/96% ABD: SOFT, NT, ND BS Renal: 140/109/14 / 4.5/25/1.2 <86 UO 490 cc last 10 hours Heme: 5.7 > 12/37 < 157 ID Tm 99.8 Tc 97.9 Imp: STABLE: LIVER LAC, DIAPHRAGMATIC injury, LUNG injury + SPINE injury. (b)(6)-2 Plan: CONT CURRENT MANAGEMENT [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted] ONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	[redacted] RECORDS MAINTAINED AT	

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
01Sep03(0615)	Suctioned pt approx Q°. Still having to lavage pt to get anything. RT came in before 0600 for Tx. Labs drawn @ 0400. CXR done @0500. Brushed pt's teeth and rinsed c̄ cepacol mouthwash @0525. Heating blanket taken off of pt but on lamp still over pt. JP's and foley emptied. NGT still to LIS and draining dull green liquid. CT×2 to continuous suction. RT dropped FiO2 to 45% p̄ tx and upon results of ABG. Report given to CPT [redacted] (b)(6)-2 [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1Sept03/1330	Pt placed on [illegible] 5mg/hr. Pt [illegible] c [illegible] Pt NAS 30° per Dr. orders (b)(6)-2 [redacted] 1620 Update given to Dr. & [illegible] orders received (b)(6)-2 [redacted] MD to assess pt done - see 1700; ms in to assess pt; no new orders (b)(6)-2 [redacted]
9/1/03 2130	dressing Δ's to CT x2 & JP drains x2 and M/L incision Q s/s infection, & drainage noted. Tape @ ET tube Δ'd. T.L.C. IJ flushed c NS. Distal port occluded. (b)(6)-2 [redacted] LPN
9/1/03 2131	ET tube Δ'd to (R) side of lip (b)(6)-2 [redacted] LPN
9/2/03 0430	A-Line d/c'd due to it infiltrating (b)(6)-2 [redacted] LPN
9/2/03 0500	Bed bath given, oral care done. Backside skin CDI. & breakdown noted. pt SV'd in ET tube and nose c scant, thick, tan-colored secretions observed. [redacted] LPN (b)(6)-2
9/2/0700	Assumed pt care from [redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted] (b)(6)-2 approx 0600. At change of shift pt ~~[illegible]~~ resting quietly keeping in bed & no apparent distress intubated (ETT 8.5 w/ VE 500 peeps fio2 50% RR ≤ 2) VSS, NG to CIS CT x2 water seal. Lbc 100cc/hr fentanyl drip @ 50mcg/hr, versed @ 5mg/hr. No issues noted (b)(6)-2 [redacted] RCT RN
9/2/0730	Rec. Dr. [redacted] (b)(6)-2 LB Δ'd to D5½NS c 20 KCl @ 125cc/hr, Zantac 100cc given VIC NG, NG clamped (b)(6)-2 [redacted] RCT RN

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 Sept 03 / 0605	Assumed care. Report given see TIU-3 Flowsheet for initial assessment. 0700 Sx'd as before off with generalized rapheis on using Lopressor. Tech (b)(6)-2 [redacted]
0809	Dr [redacted] (b)(6)-2 @ bedside. Orders received. Labs & CXR reviewed. Vent A/S made by Dr. FiO2 of 40% PEEP of 5, VCV & VCRSD. Turned off pt in 30 minutes (b)(6)-2 [redacted]
0840	Pt's daughter per P-line sent to lab. Sx'd scant amt of secretions per ET. & response from pt. (b)(6)-2 [redacted]
0910	Abg results reviewed by Dr [redacted] (b)(6)-2 orders received to call once pt is awake/sedation needed. (b)(6)-2
1215	Dr [redacted] (b)(6)-2 @ bedside. Orders received to reduce sedation. VCRSD @ 3mg/hr. (b)(6)-2 [redacted]
1330	Update given to Dr [redacted] Dr [redacted] (b)(6)-2 FiO2 50%. Deep Sx'd scant amt of secretions noted (b)(6)-2 [redacted]

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

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
9.2.03	0930		Dr. (b)(6)-2 [redacted] placed R-Radial A-line. Lun cerd & c̄ in lo pts w/ SBP NIBP maps are correlating. Pt tolerated procedure well. No changes in VS noted — [redacted] KTRN-
9.2.03	1700		Per Dr. (b)(6)-2 [redacted] fentanyl turned off until further notice (b)(6)-2
9.2.03	1755		Resp ↑ 7. Dr. (b)(6)-2 [redacted] called in ABG 7.0/63 & SPR 9/1 — (b)(6)-2 [redacted] KTRN —
		1900	report received; pt hypertensive; Am nurse informed; no orders written; currently S.O2 79% on 6 peep, 80% FiO2; sedation has been off by Am nurse per MD order; pt unresponsive; ⊕ gag c̄ SX; [redacted] (b)(6)-2
		1930	MD (b)(6)-2 [redacted] to see pt; limited neuro exam done; ↓ response for pt; ventilator ↑ to 550; no other orders given — [redacted] (b)(6)-2
		1945	pt SX per RT; small amt of tan secretions noted; VSS returned to baseline — [redacted] (b)(6)-2
		2400	pt noted to be moving head/arms. MD Dixon @ BS; propofol ordered for sedation to control HR; arms restrained; episodic event of ↓ sat to 85%; pt SX'd, bagged; FiO2 ↑, peep ↑ to 8 then 10; VT remained the same; Pmax 40-50; vent ↑'s made; changes slowly to previous settings slowly — [redacted] (b)(6)-2
		0400	labs sent; CXR ordered; MSO4 dose; both given; propofol ↓titrated for ↓ BP; S.O2 ≥90%, HR 26-30 — [redacted] (b)(6)-2

— over —

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

MEDCOM - 17941

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Sep	0430		no pixon code for ↓ sat 83% on 100% FiO2; pt bagged ↑ to 94%; POG failure noted ∴ 100% O2 demand; vent ↑'d to H-glandi; RT notified; 500 cc NS gm. per MD. Dixon; ↓ UOP, q 1HR noted; [redacted] (b)(6)-2 [redacted] (b)(6)-2
03SEP03	0628		Neurosurgery
			(4/6) Nonsedated Neuro exam:
			No Eye Opening Intubated No response in Extremities } GCS 3-T.
			Pupils 5/R.
			Corneals Present
			Oculocephalics Present
			Gag Present
			Cough Brisk
			(4/6) Low comatose state consistent with global encephalopathy. Will look at CT head when completed. Understand that patient's respiratory status is guarded. [redacted] (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0800	Pt started to de sat post IL bolus UR.
0358803	Sat > 86-87; ↑'d F.O2 to 100%; ∅ ↑ in saturation from pulse ox; suctioned attempted. Difficult to pass suction catheter x 3 attempts. Pt [redacted] (b)(b)-2 put site block in. RR 23. Repositioned @ 2mg/kg/min, Dr Langer x3 attempts successful pass of suction catheter. Suctioning revealed moderate amount of thick white secretions. Sat, ↑ to 97. ↓ F.O2 to 90%. ~~[redacted]~~ (b)(b)-2 Dr [redacted] (b)(b)-2 in room when staff started to bag patient. ~~[redacted]~~ Pt made DNR/DNI (b)(b)-2 [redacted] (b)(b)-2 [redacted] LCR
0815	VSS. 128, 98 on 90% F.O2; RR 23, Dopa @ 10mg/kg/min.
0358803	98/41. Vasopressin given as ordered [redacted] (b)(b)-2 [redacted] (b)(b)-2 [redacted] LCR
0900	Urine output ↓ to 10cc/hr. Dr [redacted] (b)(b)-2 notified. Will monitor
0358803	this hour and follow up w/ the staff [redacted] (b)(b)-2 LCR
1015	Notified MD of ∅ u/o this hour + ↓'s in sats (current
0358803	at 86%). ↑ PEEP to 14; 100% F.O2. 1 Liter LR Bolus to be given. Will follow [redacted] (b)(b)-2 LCR

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

[redacted] (b)(b)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0554 8 02	Assumed care for patient. Pt. resting comfortably
0630	in bed. HOB ↑; (B) restraints on. [A] Ø responds to (b)(6)-2
	nipple twist; PERRL @ 2mm - sluggish; Ø mouth ~~out~~ [redacted] noted
	outside oversheating vent. Ø sedation on; Possible CT
	today; (R) coarse (S) breath sounds; min. exp. wheeze
	noted in upper (R) quad. of (R) lobe; vent setting of
	SMV 22; TV 550; 60% FiO2; PEEP 8; # 7 ETT 20
	cm @ teeth; Heavy work load of breathing noted (CV) stable,
	ST; S1, S2, +2 edema to (5) LEs/UEs; pulses palpable +2 (LE & UE)
	SpO2s 93-95% on above settings; cool UEs, CT x2 to water seal
	(R) sides); (GI) midline abd. inc. - open x in with
	staples - C/D/I; JP x2. NGT from (R) nare clamped;
	starting TF; Foley (b)(6)-2 [redacted] (GU) minimal, dark concentrated
	urine from Foley. 1L LR x1 given; [SKIN] heel/head ducts
	Mepilex; patient turned q2 hours; [LINES] CTT, Foley, JP x2;
	~~(R) IJ x3~~ (b)(6)-2 [redacted] (R) IJ lumen x3; (L) femoral cath.; (L) radial
	A-line. [PLAN] ↑ TF; Atelectasis (CXR); ? CT. will follow
	(b)(6)-2 [redacted] LCT
	(b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Sept 03 08[illegible]	Pulmonary / Critical Care EPW s/p GSW to abdomen / chest. Diaphragm injury with liver involvement. ↑ O_2 requirements overnight with desaturation. Neuroexam by Dr. [redacted] (b)(6)-2 T11 paraplegia with GCS-3 off versed 24 hrs. On propofol 135/55 Tmax-101.5 126 93% [80% - Fio2] General: sedated, ventilated EPW Lungs: [redacted] (b)(6)-2 rhonchi → scattered throughout CV: regular tachy CT×2 right side → water seal Abdomen: midline incision Ext: paraplegia voids down Labs: 11.8 / 30 / 112 7.36/41/66 -2 / 15 / 1.2 135 CXR: diffuse peribronchial fullness (R) lung infiltrate Question early ARDS (1) Neuro → criminal neurologic function only. Need to stop propofol as oxygenation will tolerate and cross. Would not withdraw care until after CT and 72 hours off sedation. Will discuss with team (2) Pulm → early ARDS. Recommend broader spectrum coverage such as Zosyn / Cipro. Much of infiltrate due to capillary leak. ↑ PEEP when FiO2 [illegible]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

(3) Hemodynamically stable. → continue volume support
(4) Renal → ↑Cr → volume support but at expense of lungs
(5) ID → infiltrates and ARDS use double gm ⊖ coverage
73 days hospitalization. World broad spectrum coverage and
fungal Bld Cx sent
(6) Heme → no current issues
(7) Continue to follow renal status

[redacted]

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
350903	Surgery
	Trauma patient s/p ex-lap x2 for severe blunt injury + diaphragmatic injury c̄ right lung injury now c̄ only brainstem function on neuro-exam by Dr [redacted] (b)(6)-2 /Neurosurgery
	Pt. also c̄ developing RLL pneumonia
	CNS: No response to pain
	Lungs: coarse b/l ↓s PEEP 60% RR 8 SIMV RR 22
	TV 530 7.36/41/66/23/-2/92% CT #1 325 cc CT #2 166
	CVR HR 126 114/38
	Abd: soft, nt, no [redacted] (b)(6)-2 of BS wound healing well
	JP drain drains less bilious JD #1 = 105 cc JD #2 32 cc
	Renal: 1.5/1.2/135 In 1726 UO = 1800 cc
	Heme: H.8 9.7/30.2 PD Tm 105
	Dx: GSW to (R) chest, spine, lung, diaphragm & liver
	c̄ subsequent iatrogenic anoxic brain injury + new pneumonia
	Plan: unasyn 3gm IV q8°
	Inf to support urine output
	DNR - no vasoactives drugs + No CPR
	Renal panel
	(b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 Sep 03	SURGERY Pt s/p OSW to spine (R) chest, diaphragm & liver. Pt c̄ high WBC on Zosyn, Vanc & Cipro. Now grimaces & painful stimuli CNS: sedated CVS: HR 101 BP 121/65 CT = 240cc Lungs: FIO2 50% TV 550 RR 22 SIMV PEEP 10 ABG: CXR: B/L infiltrates ABD: soft, NT, ND (+) BS JP 1 = 48 JP 2 = 227 Renal: 125/112/29 / 4.3 / 25 / 1.9 / 108 I/O 2.3 L/4L Heme: 34.5 / 10 / 32 / 254 ID Tm 100.3 T2 96.6 Imp: stable - critical Plan: continue current management DC JP 2 DC CT 2 ↓ DVT

(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4Sep03 0000	UOP continues @ 5cc average since 2100hrs. One liter LR bolus plus Hespan 500cc given per Dr [redacted] (b)(6)-2 orders @ 2230hrs. IVF's ↑ 150cc/hr also. Foley irrigated c̄ 40cc NS c̄ a return of 40cc. Pt continues to sat 98-100% on SIMV 22 TV 500, Peep 15 & FIO2 50%. Pr [redacted] (b)(6)-2 aware of UOP. Will continue to monitor — [redacted] (b)(6)-2 CPT/NA
4Sep03 0800.	
9.4.03/0630	Assumed pt care from Cpt [redacted] (b)(6)-2 @ approx 0630. Pt is no apparent distress @ change of shift all VSS. At change of shift pt rcvg D5½NS c̄ 20KCl @ 150cc/hr, dopa @ 3mcg/kg/min, CT x2 RCW to water seal, NG (R) nare clamped. Pt on vent AC 22, FIO2 50%, peep 15 @ VT 500. At change of shift Cpt [redacted] (b)(6)-2 gave sbar Cassy ZVP. Propofol on standby. No issues noted — [redacted] (b)(6)-2 1LT RN
9.4.03/0825	Peep ↓ 10 per 15 by Dr. [redacted] (b)(6)-2. SpO2 95% prior to change, pt currently 93% SpO2
9.4.03/1105	PRBC [redacted] started (b)(6)-2 Pre [redacted] VS: 100.4 (axx), HR 128, BP 123/67 (A-line)
1110	100.3 (axx) 126, 133/72 (A-line)
1115	100.4 (axx) 124 119/66 (A-line)

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)*

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0256-03 1200	VSS: 119, 24, 114/5, 96%. SaO2s 100% on FiO2 100%. PEEP 14; SIMV22; TV 550; will ↓ FiO2 to keep SaO2s 90% or more. (b)(6)-2 [redacted] 1LT A (b)(6)-2 [redacted]
1230 0256-03	~~VSS ↑ ↓ in saturation. Pt. [redacted] (75-79)~~
1230 0256-03	Past 2.5 min report: Pt ↓ in SaO2s. PFiO2 to 100%. SaO2s continue to ↓. (+) P to 80 with Sig [redacted] (b)(6)-2 pattern. SaO2s 74-76% on 100% FiO2 otherwise. SBP ↓ to 80/30. Sedation off. Unable to correct HDS; after several attempts Dr. [redacted] cann. Pt Chest Tube broke at water seal & inserted CT to 3 cm. Noss obtained X-ray & ABG. Currently (1275) VSS. 98% on 100% FiO2, PEEP 14, 120s/60s, 118. [illegible] fallen (b)(6)-2 [redacted] 2LT A (b)(6)-2 [redacted]
0256-03	1450: Pupils fixed @ 1mm. Pressure on @ 15 mcg/kg/min. (b)(6)-2 [redacted] 1LT/A

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

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
Hospital VS Cont..			
9.4.03	1130		100.3, 124, 116/67
	1145		100.3, 124, 125/70
	1215		99.9, 126, 122/67
Post xfsn VS	1245		100.3 124 133/76 [redacted] complete, ∅ adverse reaction
	1248		PRBC# [redacted] hung pre xfsn VS 100.3, 128, 158/6
	1249		" " Stewart
	1255		100.3, 138/69, 134
	1300		100.3, 146/73, 133
	1305		100.1, 139, 71, 132
	1335		99.9, 129/69, 133
post xfsn VS	1355		99.9, 132/67 130 [redacted] complete ∅ adverse reaction. CBC, ABC & Chem 7 sent. Pt 2U PRBC. (b)(6)-2
4 Sept 03		1830	Rec'd pt from LT [redacted]. D5½NS +20KCL infusing @150cc/hr into (R) IJ TLC. pt has NG tube to (R) nare @ LIS, CT X2 to H2O seal draining serosanguinous fluid, JP drains X2 draining serosanguinous fluid. Pt has (R) femoral Alinosite CDI. pt has 2 small blisters to (R) hip. Will cont to monitor — (b)(6)-2 [redacted]
4 Sept 03		2000	ETT tape Δ'd and ETT moved to (L) side of mouth. ETT 26 cm @ teeth. Oral care also completed — (b)(6)-2 [redacted] LPN
5 Sept 03	0400		(R) sided JVD noted. Unable to assess (R) side d/t bandages. Will cont to monitor — [redacted] LPN

(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] ARD NO. (b)(6)-2

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

NURSING NOTES

Medical Record

MEDCOM - 17951

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8Sep03	0400		½ cm circular bed sore observed m/L r pt's back. Duoderm applied — [redacted] LPN [redacted] (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	(b)(6)-2 NOTES
0730	NSG: ~~while suctioning~~ [redacted] Staff unavailable & Peak pressures in
5 SEP 03	65-72; Attempted to place S.A. Stack in patient. Patient sat down on staff's fingers; Multiple attempts to place S.A.
	Stack (b)(6)-2 [redacted] unsuccessful due to P in resistance from patient
	(+) eye opening by patient, PMR to 40s-50s; PBP to 160/80
	During placement of S.A. Stack peak pressures 60+; Suctioning revealed large amounts of thick, white with blood tinged
	secretions. Sensal (4-6) suctions revealed same
	amount of secretions. Sats dt to 83-85%; After 1st
	suction placed patient on previous vent settings.
	Currently @ SIMV 22 50% to 560; PEEP 10; VS: 117, 167/82, 44,
	sats 93%; will place patient on 100% F.O2. Dr. [redacted] /
	127 [redacted] (b)(6)-2 with eye opening. Ø response to painful (b)(6)-2
	stimuli noted. Received order to place patient on
	propofol drip. w/ [redacted] (b)(6)-2 109 m
	[redacted]
	(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

+) [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0630	Pt recieved from surgery staff. ↑ HOB / resting comfortably
SSUP US	Assessment as follows: (N) Ø response to painful stimuli; PERRL @ 3mm; Ø sedation; patient does have (P) gag reflex; (P) not breathe the vent setting [R] vent setting of SIMV 22 TV650 PEEP 10 FiO2; #7 ETT 22 @ teeth; Peak Airway Pressures 40s → 50s; (B) coarse breath sounds; SpO2 95% with RR 30's. Θ S/S cardiac [CV] RSR - ST (90s - 110s); BP 115 - 130s systolic; CVP 9 - 14; ↓ pulses x4 (2+ (LE < UE)); +3 edema x4 (LE > UE); S1/S2; warm throughout to touch [GI] midline abdomen incision - C/D/I; JP x2 to bulb suction - serosanguinous drainage noted - NGT from (P) nare to LWS - green drainage noted; (-) BS x4 [GU] foley to gravity with dark amber urine. [Skin] multiple skin breakdown noted - not noted on stick (none size) a (B) 2Cs; Prevention = tying q hour + heel pads; [LINES] (R) femoral art; (R) IJ; (L) femoral. (R) IJ is a triple lumen; D5½ w/ 20 KCL running @ 150/hr. [PAIN] possible extubation; Ativan / Morphine as ordered. Will monitor — (b)(6)-2 [redacted] LCT + [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Sep 03	1900		report received; pt sedated; [redacted] (b)(6)-2
	2200		DNR removed; no chest compression, no vasoactive drips; NSG sign off. [redacted] (b)(6)-2
	0200		no change in status; SX per RT large secretions for in order E type & blood [redacted] (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

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
06 SEP 03	0420		Recieved report from off going staff. Pt resting in bed with HOB P30°. Assessment as follows. (A) sedated on propofol 40mcg/kg/min; Responds to head shake & sucking with facial grimace & bite down on ETT. Fent PCA @ 2mcg/hr. (B) Voluntary movement noted. PERRL @ 2mm; [R] 26 @ the vent; HFETT vent setting: SIMV 22; 650 TV; FiO2 50%; PEEP 6; Coarse breath sounds although improved from previous days (L > R side); Sats 97% L; RR 22-35; PRN with suctioning which revealed large amounts of blood tinged thick clear secretions. [C] NSR-ST 90s-110s; BPS 120-140 (A-L); +2 pulses all extremities; +4 edema noted throughout body; most noticeable in (B) LE & scrotum; CVP 15; S1 & S2 noted; (GI) (B) bowel NTT distended; recieving jevity 100cc/hr; (-) BS; Abd NT/ND; (GU) foley to gravity; dark-clear amber urine; Sec Foley for cont; (Skin) multiple skin breakdown from edema - most noticeable on upper back, (B) LE; pitted heel boots + thigh wraps; (Lines) (R) IJ x3 lumen; (R) femoral art line; Foley; ETT; [Plan] continue to wean ventilator; Pt is a DNR with continue Rx management. (b)(6)-2 [redacted] RN, A

(Continue on reverse side [redacted])

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

REGISTER NO. (b)(6)-2

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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
06Sept03(2000)	Received report from LT [redacted] (b)(6)-2 and assumed care of pt @ 1815. See DA Form 4700 OP 375 for assessment data. Suctioned pt. Pt started moving head back and forth, bucking the vent, opened eyes a bit, and moved shoulders and a bit of arms. Rate of Fentanyl Δ'd d/t concentration in bag. Propofol increased d/t pt getting a bit aggitated c̄ moving head back and forth, biting the ETT. CTxT to H2O seal. Secured. No drainage on dressing, Ø air leak. Will monitor. [redacted] (b)(6)-2 /LT/AN
(2015)	Propofol increased d/t increased aggitation. (b)(6)-2 [redacted] /LT/AN
(2230)	Around 2100 gave pt bed bath and Δ'd sheets and chux. Pt has serous drainage from old blisters. Suctioned pt around 2130 c̄ assistance from RT. Got lg amts of red thick secretions. Pt would bite on tube when trying to insert suction catheter. Peak pressures went from 51 to 37 p̄ suctioning. Hands proped up on blankets, leg elevated, and heel pads on. Neck supported c̄ towel. Inserted more air into cuff of ETT. It was flattened slightly. Pt tolerated all ok. VSS back to stable. (b)(6)-2 [redacted] /LT/AN
07Sep03 (0045)	No Δ in assessment. Δ'd out all IV tubing x̄ Fentanyl. TF's given p̄ 55cc residual checked. H2O bolus p̄. Central line dressing Δ to (R) IJ. Propofol needing to be increased d/t aggitation. (b)(6)-2 [redacted] /LT/AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EPW # [redacted]

(b)(6)-2

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
07Sep03 (0600)	Pt had periods of aggitation throughout night. Kept having to go up on propofol. Suctioned pt @ 0330. Needed some lavaging. Got lg amts of red-pink secretions. S'd linen under pt. S'd bite block. CXR done. Labs drawn and taken to lab. Results back. Report given to next shift. — [redacted]RTIAN (b)(6)-2
7Sep (2100)	pt status unchanged; assessment chotel; no new issues noted; pt turned frequently to prevent skin breakdn no [redacted] (b)(6)-2 in to see pt, no new orders given (b)(6)-2 [redacted]
(2400)	no chnge in assessment status; no new issues — [redacted]
(0600)	report given to nn shift — [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

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
07 SEP 03	0620:		Pt recieved from surgery staff. Patient resting comfortably in bed ↑ HOB 30°; [IV] sedated with 50 mcg/kg/hr of propofol; 2 mcg/kg/hr; Pupils reactive @ 2mm; Grimaces to painful stimuli although more upright than yesterday; ↑ sedation to 40 mcg/kg/hr (prop.); [R] SIMV 22; TV 650; PEEP 6 FiO2 50%; #7 ETT 26 @ the teeth; cough (3) bilateral sounds although improving from yesterday; (b)(6)-2 [redacted] LLL > RLL in regards to crackles/rhonchi; sats 95% ↓ on setting ⊖ s/s of cyanosis; suctioning revealed large amounts of bloody tinged, clear-milky white sputum; [CV] NSR (80s) with SBP in 110s-120s (↑ to 160 when suctioning); +2 pulses x4; +4 edema noted throughout body; most notably (R) LE > sacral CVPs 4-7; Temp: 95.7; S1, S2 noted. [GI] ↓ BS x4 NGT from (R) nare clamped; Anticipate TF @ 60; [GU] Foley to gravity; marked (dec 740) of dark concentrated urine (output 30-70/h); [Skin] multiple skin issues; most noted (R) LE (LSK); upper back - middle of contact applied; turning Q2; [Lines] (R) x3 IJ; (R) femoral line; Foley, ETT; [Pain] analgesics as ordered.
			(b)(6)-2 [redacted] LCT/AN
			(b)(6)-2 [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.

[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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9.8/0700	Assumed pt care from (pt [redacted] (b)(6)-2 pt in no apparent distress @ change of shift. Pt on 55mcg/kg/min of propofol, 30mcg/hr of fentanyl, D5½NS ē 20kcl @ 125cc/hr, NG clamped, pt on vent SIMV 50%, peep 6, VT 550, RR 22, CT to ⊕ CW to H2 seal, Foley to gravity. No issues or discrepancies noted [redacted] (b)(6)-2
1100	Pt rest rested; assessment complete & charted [redacted] (b)(6)-2
2100	pt SX ē RT; HR ↓ 40's; SX terminated [redacted] (b)(6)-2
0200	no change in status; continue ē vagal bradycardia ē SX 40-50 HR SaO2 79-80 on 60% FiO2; no changes made to pt's pm meds; NPO for possible OR in AM; drains ⊕ serosal ē serous fluid; 4⊕ pitting edema throughout pt trunk. [redacted] (b)(6)-2
9.9/0700	Assumed pt care from (pt [redacted] (b)(6)-2 pt in no apparent distress @ change of shift, propofol @ 60mcg/kg/min, fentanyl @ 30mcg/hr, D5½NS ē 20 KCl @ 125cc/hr, FTG, NG clamped, CT (RCW) to cont. suction, [redacted] (b)(6)-2 all chambers functioning well. No air leaks noted, pt ventilated ē SIMV FiO2 60%, peep 8 VT 550 RR 22. No issues noted, will cont to monitor [redacted] (b)(6)-2 ICTRN
9.9/1700	Take foley hold d/t residual 150cc [redacted] (b)(6)-2 ICTRN
1900	Pt rest rested; MAP; VSS; neuro status unchanged; pO2 no change [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EPW [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
10 Sep 02	0200: no chge in status; VSS; vsp QS; (b)(6)-2 [redacted] 0400: ABG done c̄ l/s; CO2=49 pH=7.30; Pamp 45-50, Pmp 8, VT 550; RR↑24; CTM, report gas. (b)(6)-2 [redacted] Amr cmx due; no new skin breakdown; drsgs to cold SAME, mil-brk Stg I dmbs; pt tmc gryty. (b)(6)-2 [redacted]
0700	Assumed pt's care @ 0600 VSS. Continue to monitor. Suction pm thick secretions. Sat 98%. No changes from last night pt sedated, responded to pain stimuli, open eyes while suctioning (+) cough. ✓ residual @ 0800 270cc. held feed ~~till~~ (b)(6)-2 [redacted] Will ✓ residual @ 1200. [redacted] (b)(6)-2 ILT AW
1200	Residual 160cc Will hold tube feed. Will check residual @ 1600
(b)(6)-2	[redacted] ILT AW
1630	Pt c̄ no changes in condition. Suction pm medium amount of thick clear secretions. Residual @ 1600 150cc. Will continue to moni
(b)(6)-2	[redacted] ILT/AW.
9.11/0730	Assumed pt care from (b)(6)-2 [redacted] @ approx 0630, pt in no apparent distress @ change of shift. At change of shift pt on 150mcg fentanyl, 05mcg/kg/min propofol, 0.5mg/kg c̄ dobut @ 125cc/hr. NG changed CT to cont. suction, FiO2 pt on 50%, pm, peep 8. RR24. VSS. No issues noted [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

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

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
9.11 / 1230	Pt returned from OR hemodynamically stable. All VSS at pt arrival & at time of sign. Pt placed on 100cc/hr D5½ NS c̄ KCl, 80mg/hr propofol, 100mg/hr fentanyl. Foley & PEG placed to gravity drainage, CT x3 (b) (b) to cont. suction, no air leaks. Detubated Pt trached 8 and placed on 100% FiO2 VE 550 prop 8 mg 24, Spo2 100%. No issues noted (b)(6)-2 [redacted] /LTR.
9.11 / 1700	Pt remains hemodynamically stable. Pt localizes pain, opens eyes spont & able to move arms spont. LIJ TLC c̄ cords placed and confirmed c̄ CXR. No issues noted (b)(6)-2 [redacted] KTRU.
1900	Report received; pt sedated c̄ propofol/fentanyl; opens eyes spont; trach c̄ min drainage; peg to gravity (b)(6)-2 [redacted]
2100	No change in status; SX frequently for large, thick secretions; pt tolerated well; sedated & d/t in agitation; frequent drainage & d/t large amount of drainage from abdominal wound; (b)(6)-2 [redacted]

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

EPCN [redacted]

(b)(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
12 Sep 03	pt moving LUE; responds to commands; propofol/fentanyl for sedation; SX frequently; abdomen draining serosanguinous fluid [redacted] (b)(6)-2
0200	drainage ↓'d frequently; NL WTD drainage; area clean; ∅ purulent drainage; ∅ foul odor; area around T drainage drainage; (L) hand restraint for grabbing @ medical devices; no change in status [redacted] (b)(6)-2
0500	frequent SX; DIC needs ↑'d; no supply of DICs; no change in status; non one done. [redacted] (b)(6)-2
0800	DIC ↑'d - 7.6 FiO [redacted] (b)(6)-2
9/13/0700	assumed pt care from pt [redacted] (b)(6)-2. Pt in no apparent distress @ change of shift. 05½ NS c̄ 20 KCl infusing @ 100cc/hr, propofol @ 20mcg/kg/min, fentanyl @ 50mcg/hr. CT to cont suction, foley to gravity. No issues noted. [redacted] (b)(6)-2
14 Nov 03	SURG
	PT STABLE AFEBRILE MORE ALERT MOVING UE MORE
	LUNGS: CTA FIO2 40% on 20 PEEP 5 SIMV TV 550 7.45/39/149/28/4/99
	CVS: HR 90s 109/59 EXT: LEFT OPPOSION - SWELL
	ABD: SOFT, NT, ND (+) BS TOLERATING TF
	Renal: 136/4.2/29 UO ~200cc/hr
	ID: AFEBRILE CSF 4/23/624
	Tx: STABLE
	Plan: MINIMIZE DVF
	TRACH MASK CONT ABX (Continue on reverse) [redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility) | WARD NO.

[redacted] (b)(6)-2

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

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
11 Sep 03	OP NOTE PRE-OP DX: GSW TO SPINE, (R) LUNG & LIVER/DIAPHRAGM PROC: G-TUBE / TRACHEOSTOMY COMPLICATIONS: Ø SURG: [redacted] / [redacted] (b)(6)-2 (b)(6)-2 ANES: MAC FLUIDS: 1L LR UO = 200 cc DRAINS: 16F MALINCOTT II SILICONE STABLE TO ICU (b)(6)-2 [redacted]
13 Sep 03	PROGRESS NOTES PT NOUND EXTUB, IMPROVING MAIN & SPONTANEOUS MOVEMENTS OF ARMS. VSS: HR 90s 130/63 LUNGS: CTA ABX ↓ SIGNIFICANT OPACITY ON CXR FIO2 50% RR 20 TV 550 ABGS 7.36/47/148/27/2/95% LT OUT ABD: SOFT, NTND BS TOLERATING TF Renal ~~[illegible]~~ 14/97 UO = 200cc/hr CASTS 2+ Hemo: 13 / 23 \ 7 / 513 ⊕ Tmax 2 Inf: Improving Plan: CONT CURRENT TX & ABX WITHES PONDING LT OUT CONT bid DRESSING CHANGES (b)(6)-2 [redacted]

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9-12-03	0800		BI Cx x2 (ALINE, SC); UA/C Urin Cx Chem as ordered; Cefotaxim / ice pk / zantac sim as ordered; Stretch TT 200cc thigh & tube. rolled future on side. call MD. — (b)(b)-2 [redacted] LCT/A
			(b)(b)-2 [redacted]
9-12-03	1100		Medline sent cls 4'd; Placed Montgomery strips on patient; CT cls 4; Placed cath in femur (L) sec SC site. Attempt sim as ordered — (b)(b)-2 [redacted] LCT A
			(b)(b)-2 [redacted]
13 Sept 03	1700		Anes — ~~G~~ postop anesthesia complications [redacted]
12 Sept 03	1700	-	PM noting confusing. Propofol x2 Solns (5mg) post cls 4. USS. ~~Ah~~ [redacted] (b)(b)-2
			[redacted] (b)(b)-2 LCT A
			[redacted] (b)(b)-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
	12 SEP 03		0720: Pt recieved from outgoing shift. Pt resting comfortably in bed with HOB @ 30°. Assessment as follows: [N] Generalized upper extem/head spontaneous movements. Eyes open, localizing to painful stimuli. ~~Follows~~ (b)(6)-2 [redacted] Attempts to show stuff 2 fingers when asked. (L) UE > (R) UE movement. Pain (b)(6)-2 [redacted] controlled with titration of fentanyl & propofol. [R] #8 trach with setting of SIMV 23 PEEP 8 50% TV 550; course breath sounds throughout (R)>(L); SpO2s 95% & above settings. [CV] NSR-ST, 110-130s/50-60; S1, S2. +3 edema throughout UE/LE; generalized weeping of serosanguinous fluid from old invasive sites - most notably (L) Fem.; CS capping; T 100.6 (GT) midline ABD drg clot; BBS; CT to (R) side to wall suction; G tube draining dark green fluid. [GU] foley to gravity draining dark, concentrated urine; grossly edematous scrotum. (Skin) multiple skin tears; most notable UR E; (B) LE (Cross) (R) dorsum artifact; (L) SC cuts with xs L; trach; foley; G tube; chest tube; (Plan) attempt wean off trach; continue skin care (q2° turning); will monitor; Ativan as ordered — (b)(6)-2 [redacted] 117/m
		(b)(6)-2 [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.

#[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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sep2003	(0200) Received report and assumed care of pt @ 1815. Δ'd ML dressing W+D c̄ assistance from previous nurse. Around 1915 did trach care. Cleaned inner cannula Δ'd ties and cleaned area c̄ ½ H2O2 & [redacted] (b)(6)-2 NS. Pt has lg amts of thick clear secretions from around trach. Red/pink to clear secretions from trach. Pts sats remained >96%. Tolerated well. Δ'd pts linen d/t BM. Gave pt bed bath. Pt was very aggitated. RR ↑ >than 32 BPM. up to 40 BPM. Pt was diaphoretic. Room was warm @ the time. Temp was 101.0 F. Informed Dr [redacted] (b)(6)-2 about pt's RR. Placed pt back on vent @ 2120 for the night. SIMV 20, TV 600, FIO2 40%, peep 5. Pt. placed on some propofol for aggitation and sedation. ABG drawn and CXR done. Dr [redacted] (b)(6)-2 saw results. Pt calmed down p̄ a while. Pt didn't cough as much p̄ hooked up to vent. Pt tried to communicate but couldn't write. and mouthing wasn't working. Pt been having adequate UOP. Old chest tube site Δ'd c̄ ptholeum gauze. Continuing to monitor. [redacted] (b)(6)-2 RN/RN
15Sep03 (0500)	Pt's labs drawn and sent to lab. Pt suctioned per RT. Dressing Δ to ML incision. W+D. Foley care. Suctioned around the

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont.	trach. Cleaned skin around trach. Pt keep trying to get out of restraints. Monitoring. (b)(6)-2 [redacted] UTAN
(0600)	Δ'd pt's linen. Pt had small BM. Cleaned pt's back. Stopped pt's propofol @ 0540 and put pt back on T.C. 50%. Pt coughed for a bit then calmed down. Pt's RR in the 30's. Monitoring. [redacted] UTAN (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Sep03	1345 transfusion infusing PRBC's 2nd unit, ⊘ RLN noted @ this time. [redacted] (b)(6)-2 1340 Fentanyl on back. Blood completed & RLN noted pt able to cough up secretions, much clear secretion noted. [redacted] (b)(6)-2 1400 CBC drawn, sent to lab. [redacted] (b)(6)-2 1430 Update given to Dr [redacted] (b)(6)-2 orders received to give ⊖ ips of Hal-[redacted] 1445 Dr [redacted] @ bedside [redacted] (b)(6)-2 [redacted] (b)(6)-2 speaks c̄ pt about continual improvement. [redacted] (b)(6)-2 1500 Deep sx'd copious amt of thick, tan color secretion, partial with green, linen d'ed, midline and dry d'ed, wound pink c̄ odor / draining noted. Turn & pillow support. [redacted] (b)(6)-2 1600 Dr [redacted] (b)(6)-2 @ bedside. Labs reviewed, orders received. [redacted] (b)(6)-2 1610 Lasix IV given, dressing applied to ⊘ lower leg. [redacted] (b)(6)-2 1700 Dr's round. Orders received. [redacted] (b)(6)-2
1830	UD Alb/Atr tx given to pt pre Tx hr 97 RR 32 SpO2 100%
15Sep03	BS clear post Tx HR 97 RR 30 SpO2 100% BBS coarse
	(b)(6)-2 SGT [redacted] 91U20
15Sep03 (1945)	Received report on pt and assumed care of pt @ 1915. See DA Form 4700 OP 375 for assessment data. Sutured, yellowish-clear copious

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

15Sep03/ 0600 Pain given. pt awake. see IV's flowsheet for initial assessment. — [redacted] (b)(6)-2
0650 pt resting c oral care. appears to be in good spirits, trying to locate translator — [redacted] (b)(6)-2 JR
0800 translator @ bedside. update given to pt [redacted] (b)(6)-2 clinical condition & future outcome, pt nods & agreement — [redacted] (b)(6)-2
0850 DR [redacted] (b)(6)-2 @ bedside. orders received. 40mg lasix IVP given per pt [redacted] (b)(6)-2 — [redacted] (b)(6)-2 JR
0930 Blood drawn per A-line for ABG, T&C for 2uPRBCs — [redacted] (b)(6)-2
1000 pt consult completed, at bedside c ROM exercises. — [redacted] (b)(6)-2
1045 1st unit PRBC's given [redacted] (b)(6)-4. see flowsheet for continuous monitoring — [redacted] (b)(6)-2
1130 1st unit PRBC's given, pt rxn noted. continue to reposition & pillow support use. — [redacted] (b)(6)-2 JR
1230 2nd unit [redacted] (b)(6)-4 started. see flowsheet for continuous vs. — [redacted] (b)(6)-2 JR

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
		[redacted] (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)*

REGISTER NO. | WARD NO.

(b)(6)-4

EPW [redacted] ICU-B

[redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

15Sept2003(1945) cont - Secretions from around trach. Cleared skin around and applied 4x4 for secretions. PT came to see pt and (b)(6)-2 [redacted] put pt. on humidified O2. Flushed all ports to TLC c̄ NS. Flushed well. Dressing to site was Δ'd yesterday @0500. Pt calm, HR down to 80's c̄ regular even breaths. (b)(6)-2 [redacted] AN

(2015) Pt assisted c̄ TF by holding syringe for fewly. Pt resisted a little but assisted. MSO4 5mg given. Pt c/o lower abdominal pain. Appeared to be affective (b)(6)-2 [redacted] LT/AN

(2230) Pt doing well. Calm & cooperative. c/o pain in stomach. MSO4 given. Pt turned to (P) side & scooted up in bed. Tolerating TC's problems (b)(6)-2 [redacted] LT/A

0004 16 Sept UD Alb/Atro tx given HR 78 RR 24 SpO2 100% on 40% trach collar BBS coarse Post tx HR 76 RR 21 SpO2 100% BBS clear Pt resting comfortably (b)(6)-2 Sgt [redacted] 91W2

16Sep03(0525) Pt. has slept well throughout the night. Sat remained in the high 90's, HR down to 70's. When pt awoke c/o pain in abdomen, mainly lower. When tried to give TF pt would push tube away then put hand over abdomen. Kept pushing it away and grimacing. Held off on TF till talk to Dr. Pt had a period of desating down to 88%. Bumped

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	cont.- wp FiO2 from 40% to 50%. Cleaned trach and cannula. Gave pt a little extra O2 for a bit. Pt did sound a bit wheezy in Anterior lobes. P about 10 min pt went back up to >96%. Has maintained >96% on 50% FiO2. This was around 0300. @ 0400 dressing Δ to abdomen was done w→D. Tissue pink and healthy. W→D dressings Δ on DLE. White-black in color. Blood drawn and taken to lab. Pt's linen was Δ'd @ 0500 and bed bath done. PCXR was completed. (b)(6)-2 [redacted] RUTAN
16 Sep 03 0530	WD Alb/Atro T4 given to pt Pre Tx BBS coarse HR 78 RR 28 SPO2 96% on Trach collar Post Tx HR 77 RR 22 SPO2 100% BBS clear (b)(6)-2 Sgt [redacted] 7102Ø
16Sep03	0600 - Received pt from Lt (b)(6)-2 [redacted] VSS. A+O. Trach 50% O2 Sats 100%. D5 ½ NS c 20K running through central line. Triple lumen cordis at 25cc/hr. Pt c/o pain in stomach. 5mg MSO4 given. Will continue to monitor. (b)(6)-2 Sgt [redacted] LPN
	0800 - Central line dressing changed. Dressing to abdomen and R leg changed. Abd wound looks purulent. Pt refuses fecity c/o squeezing feeling. Pt c/o pain in stomach, asked for MSO4. 5mg given. (b)(6)-2 Sgt [redacted] LPN
	0800 - Dr (b)(6)-2 [redacted] notified of stomach issues and of pts ABG. Pt instructed to get another ABG later. (b)(6)-2 Sgt [redacted] LPN
17 Sep 03 Ø100	Pre Tx HR 88, RR 26, SPO2 97. WD Alb & Atro given. BBS coarse. Post Tx HR 92, RR 24, SPO2 97. Pt tol well (b)(6)-2 Sgt [redacted] 9116Ø
17 Sep Ø3 Ø532	Pre Tx HR 94, RR 26, SPO2 99. WD Alb + Atro given. BBS slight coarse otherwise CTA. Post Tx HR 85, RR 28, SPO2 100% on 40% T-collar - Will continue to monitor (b)(6)-2 Sgt [redacted] 9116Ø8

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17 Sep03	0600 Received pt from Cpt [redacted] (b)(6)-2 Pt awake and A+O. VSS. Assessment done. Pt lungs sound coarse throughout. Pt dressings c/d/i. Pt on 40% via TC. sats at 99%. Pt has no c/o pain at this time. Will attempt to eat breakfast this AM. Will notify Dr. of no BM in 2 days (b)(6)-2 Sgt [redacted] LPN
	0800 - Suctioned pt, thick secretions, O2 sats 98%. Jevity given. Pt rolled to R side (b)(6)-2 SGT [redacted] LPN
	1080 - Have had to suction pt quite often this AM. Secretions very thick (b)(6)-2 Sgt [redacted]
17SepT03	1830 Rec'd pt from SGT [redacted] (b)(6)-2. Pt resting in bed, awake and A+O. attempted to feed pt dinner, pt took 1 bite of Cookie and refused anything else. Assessment Completed. VSS. Sx'd pt's TC & thick mucous tinged w/ blood obtained. Pt's O2 Sats remain 99%-100%. Skin breakdown noticed on top and (L) side of pt's penis. (b)(6)-2 [redacted] LPN
17SepT03	1930 pt position Δ'd to back. Trach care completed. pt Sx'd via TC & thick, clear mucous obtained. pt resting at this time (b)(6)-2 [redacted]
17SepT03	2300 pt turned to (L) side @ 2200. pt c/o pain to abd; 5mg MSO4 given. pt coughing ↓; resting comfortably (b)(6)-2 [redacted] LPN
18SepT03	0130 Edema to (R) hand ↓ Significantly. pt turned to (R) side. pt moved pulse ox from (L) to (R) ear on (con

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted]
(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont'd)	his own. Pt tries to hand signal what he wants. pt doing well @ this time (b)(6)-2 [redacted] LPN
18SepT03	W→D dressing Δ's to M/L and wound & (L) LE done. Tissue looks pink. Rom Exercises done x4 times this shift. pt coughing up thick clear to yellowish mucous. (b)(6)-2 [redacted] LPN
18Sept03 0436	Pre tx HR 92, RR 24, SPO2 100% on 40% T-collar. UO Alb + Afro Neb given. Post tx HR 99, RR 27, SPO2 100% on 40%. [redacted] CTA. ↓ FO2 35% pm ABG. 7.47/44/114/9/32/99% — Sgt (b)(6)-2 [redacted] SPO2
18SepT03	0500 Bed bath given, linen Δ'd. pt Sx'd via TC copious clear to yellow mucous obtained. [redacted] LPN (b)(6)-2
18Sep03	0600 Rymart given. Assumed care. see Ltr-C Shoemaker for initial assessment. (b)(6)-2 [redacted]
(b)(6)-2	0700 med time and dress Δ'd by RN [redacted]. labs reviewed. 0 new orders received (b)(6)-2 [redacted]
	0820 Sx'd black m'n and of secretion, foul appearance (b)(6)-2 [redacted]
	0900 encouraged use of I.S. unable to make balls go up & down (b)(6)-2 [redacted]
	1050 Repositioned once again. c shoulder support. (b)(6)-2 [redacted]
	1300 pt will not eat. Tried several times. pt refused (b)(6)-2 [redacted]

[redacted] (b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19 Sep 03	pt alert response; NAD; assessment complete [redacted] (b)(6)-2
(2100)	pt SX'd for large blood tinged sputum; S.O2 94% on 35% t-c; pt coughing effortlessly; pt tired [redacted] (b)(6)-2
(2400)	no change in assessment; NAD; nsg fu pain to delay [redacted] (b)(6)-2
(0300)	no change in status; tired for comfort & pt's rest; NAD [redacted] (b)(6)-2
(0400)	labs done; sputum done; pt tired easily [redacted] (b)(6)-2
9.19/0700	Assumed pt care from CPT [redacted] (b)(6)-2 pt sleeping at change of shift and VSS. Status 2L O2 @ 2 cc/hr, FTG, Trach intact. No issues noted. Will cont to monitor [redacted] (b)(6)-2 LCT RN
9/20/03	0600 Assumed care. Report given. See TCU-3 Shuffler for initial assessment. 0730 [redacted] (b)(6)-2 @ bedside, update given. Orders received. [redacted] (b)(6)-2 0900. VSS. Counselor @ bedside. Patient tried to convince of the importance of eating. pt refused to listen. [redacted] (b)(6)-2 1000 Respiratory assistance [redacted] (b)(6)-2 1040 Resp SX again response [redacted] white secretion [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR NUMBER (SSN) [redacted] (b)(6)-2
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EPW [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sep03	1240 Dose given by Dr [redacted] (b)(6)-2 (b)(6)-2 Orders received, s/d, & explained [redacted] 1350 Dietary @ bedside, nutritional status access [redacted] (b)(6)-2 1615 Update given to Dr [redacted] (b)(6)-2 about pt's status [redacted] (b)(6)-2 1720 lower leg dose given [redacted] (b)(6)-2
21Sep03	0000 assumed care, report given, initial assessment on ICU-35 flowsheet [redacted]
21Sep03	0024 20mg MSO4, 25 phenergan, EBL [redacted] (b)(6)-2 min, RPR from OR, report given, pt medicated to comfort, sedation, placed on monitor [redacted] (b)(6)-2 0030 VS, resp curve analyzed, SpO2 99%-98%, currently on 3L. [redacted] (b)(6)-2 1200 dressing s/d, bleeding [redacted] min amt of blood, secretions [redacted] (b)(6)-2 1350 VSS, febrile, ⊘ discomfort noted [redacted] (b)(6)-2 1615 Update given to Dr [redacted] (b)(6)-2 orders received [redacted] (b)(6)-2 1720 s/d c/ps of H2O given [redacted] (b)(6)-2

[redacted] (b)(6)-4

STANDARD FORM 589 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20Sep03 1330	Nutrition Note: Pt not eating, refuses food. Is receiving 500cc Jevity Plus q 4° providing 3900 kcals/day. This exceeds his est. needs of 1750-2100 kcals/day (25-30 kcal/kg) and may explain Ø po intake. Recommend ↓TF to 65cc/hr to provide 2028 kcals/day to meet pts need; then ↓TF to 30cc/hr to meet 50% of needs + encourage pt's appetite. (b)(6)-2 [redacted] CPT, SP RD/LD
21Sep03 Ø455	Rt note: Pt resting. HR-95, RR 20, SpO2 99% on 35% T colla. BBS CTA. Pt needs re-eval from Dr. for Resp tx due to improvement up to date. Last order on 18 Sept 03. Will notify nurse. (b)(6)-2 Sgt [redacted] 9/22Ø
22 Sep Ø3 Ø726	Rt note: spoke to nurse about Δ's in RT tx. Pt is able to bring up secretions and was CTA BBS @ Ø4Ø0 so tx was not given. Tx needs to be reevaluated by doctor every 72 hours. Humidification is needed to prevent mucous plugs in pt due to bypass of nasal cavity. Please reorder treatments or Δ it to PRN. Sgt [redacted] 9/22Ø (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Sep03 0830	Assumed Pt care @ 0600. VSS. Dsr/A. Pt interacts w/ nurse. Can make Needs Known. Lungs coarse along lower Fields. Pt breathing is unlabored and does bring up Lg amounts of thick white secretions. RT making suggestion to Dr to make Neb TI Prn. Skin is warm & Dry color is WNR. Pt has healing wound to chest @ RT nipple. Large Abdominal Dressing which is CDI 2 Dressing to LLL CDI also. Edema noted in (R) hand and Lower extremities +1. Pt has (L) Subclavian Triple lumen c/o t/s. running D5½ w/ Kcal @ 25 ml/hr. Pt also has (R) Femoral a Line all Lines Flushed and are Patent and free from S/S of infection/Inf. Bowel sound present x4 bowel sounds hypo active. Pt refusing to eat will continue to push PO but if Pt still does not eat will give Jevity via Feeding Tube. abdomen is non tender non distended pt had Large (very Large) Bm of loose dark brown stool this Am. Pt has FTG draining light yellow urine free from sediment. Urinating adequate amount. Foley care done. Pt is S.S. NSR. w/ adequate Perfusion and cap refill. Pt currently resting will continue to monitor ——— pte [redacted] cpn (b)(6)-2
22Sep03 0940	Dressings D/C. Abdominal Incision no bleeding or redness noted D/C using W-D NaCl solution, upper wound on LLL has brownish exudate medium amount no redness noted. bottom wound had minimal amount of blood tinged drainage no redness or swelling noted. LLL dressing D/C using Saline (b)(6)-2 [redacted] (b)(6)-2 ——— pte [redacted]
22Sep03 1240	Tube feeding done 500cc. Peripheral IV started in (L) AC Running D5½NS w/ Kcal @ 25 ml/hr. ——— pte [redacted] cpn. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 Sep 05	Surgery Note
	Pre-op Dx: LLE Eschar
	Proc: I & D
	Surg: Nassau
	EBL ~ 100cc
	Fluid: 200cc LR
	UO: 100cc
	Complications: None
	Stable to ICU
	will start B & Dressing changes
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22SEP03 1400	TRACH care done. Pt coughing up large amounts of ~~Pink~~ (b)(6)-2 blood tinged sputum. Vaseline up Peri-ostomy also applied. PFC [redacted] (b)(6)-2
22SEP03 1640	External ~~sutures~~ sutures removed down trach incisions, LT [redacted] (b)(6)-2 Internal sutures left in place. collar tightened. PFC [redacted] (b)(6)-2
22Sep03 (1900)	Received report from ~~LT~~ [redacted] (b)(6)-2 PFC [redacted] (b)(6)-2. Pt c/o some abd. pain. MS04 given as ordered. Pain Relief. Dr [redacted] (b)(6)-2 came in to see pt. Foot board removed to prevent sores on feet. Pt. appears comfortable. [redacted] (b)(6)-2 UTAN
22Sep03 (1945)	See PA Form 4700 OP 375 for assessment data. Pt c/o pain in lower abd. Tried to put vaseline on lips but refused. Adequate uop. ⊕BM. Coughing up secretions well. [redacted] (b)(6)-2 UTAN
(2230)	Around 2000 did pt's trach care. Stimulated pt to ~~go~~ cough a lot of yellow thick secretions and small dkrd mucous plug. Cleaned around site well c̄ ½ H_2O_2 & NS. Put gauze under. Pt tolerated well. Gave pt TF + 50 cc H_2O. Pre-medicated c̄ MS04 prior to abd. dressing Δ. Δ'd ML abd c̄ dakins solution w→D & 4x4's. Δ'd dressing on ⓛ leg. Upper wound has black spots throughout lower wound beefy red. Gave pt bed bath around 2145. Δ'd linen. ⊕ flg. BM brown friendly. Tolerated well. [redacted] (b)(6)-2 UTAN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23Sep 0600	- Received pt from Lt. [redacted] (b)(6)-2 VSS. Sats 97%. No c/o pain, but has cramping in stomach. Pt had large BM, very runny. Coughing up thick secretions — Sgt [redacted] (b)(6)-2
	0930 - gave pt 650mg Tylenol for temp 101.5 Will continue to monitor — Sgt [redacted] LPN (b)(6)-2
	1000 - Dressings changed. Abdominal wound is still purulent in spots. Upper wound on leg purulent, lower wound is (b)(6)-2 briefly red. Pt is having a lot of stomach cramping. Sgt [redacted] LPN
	1440 - pt fever up again. 650mg Tylenol given. Will continue to monitor — Sgt [redacted] LPN (b)(6)-2
	1530 - Dr. [redacted] (b)(6)-2 notified of pt temps. Ordered blood culture, urine culture, and sputum culture. Gave new orders for Vanc and Ceftaz. Pt had another large BM. Pt IV site infiltrated, new IV started on L FA, site c/d/i. — Sgt [redacted] LPN (b)(6)-2
23Sep03(2145)	Received report from SGT [redacted] (b)(6)-2. Pt had a lg. brown soft BM. Pt's bath given and cleaned. Linen Δ'd. W→D dressing Δ to ML abdomen and (c) lateral lower leg c̄ Dakin's solution and 4x4. Trach care done. Pt coughed lg amts of secretions. Pt c/o pain in lower abdomen. MSO4 given as ordered. Pt given TF. Pt started fighting me when giving him more fluid. C/O a lot of pain to abdomen. Only gave pt 420cc + 30cc of H_2O. Pt turned on (c) side. Pt asleep (c) this time. — [redacted] (b)(6)-2
24Sep03(0600)	Pt did well throughout night. Did have ↑ watery BM when coughing. Refused TF. Kept forcefully pushing away. C/O nausea & cramping. Rotated q2°. — [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24Sept03 2040	pt c/o hunger. Pt ate sm portion of cracker and drank H_2O — (b)(6)-2 SGT [redacted]
24SepT03	2200 pt turned onto (R) side @ 2130. pt resting comfortably @ this time — (b)(6)-2 SGT [redacted]
25SepT03	0120 pt c/o abd pain. 5mg MSO4 given — SGT [redacted]
25SepT03	0550 pt rested comfortably through the night. pt didn't require any deep suctioning this shift. Pt given bed bath, linen Δ'd. ~~Pt~~ pt had large runny brown BM. Dressing Δ's done to mfl abd and (L) LE. Both sites have beefy red looking tissue. — (b)(6)-2 SGT [redacted]
25SepT03	0555 RT Δ'd FiO2 to 28% and O_2 to 4L. pt sats remain 98-100%. — (b)(6)-2 SGT [redacted]
25Sep03	0600 ~~the~~ assume care. Report given see ICU-3 flowsheet for initial assessment. 0750 pt ate 50% of breakfast feed to by hospital WKER, pt required to take BGM pc. — (b)(6)-2 [redacted]
	0900 deep Sx'd min amt of secretions noted. — [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] NUMBER
	LAST	FIRST	MI	(b)(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sep 03	(b)(6)-2 1210 Tolerated lunch well ate 50% - [redacted] 1530 All VASS Ed. & drainage OR odor noted. (b)(6)-2 [redacted] 1650 Emp MSG given c/o back pain [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24Sep03	0600 assumed care. Report given. See TCU SBAR for initial assessment.
	0630 large, loose paste stool. (b)(6)-2 [redacted]
	0750 DR [redacted] (b)(6)-2 @ pt bedside. update given. orders received (b)(6)-2 [redacted]
	0830 pt attempted to eat but was unable to swallow.
	1215 XR attempts to place ovg, success by (b)(6)-2 [redacted]. ovg shifted to #4, inflat balloon, (b)(6)-2
	SpO2 99%, RR 20's. ∅ distress noted. (b)(6)-2 [redacted]
	1230 reposition, ∅ assistance. VSS (b)(6)-2 [redacted]
	1345 PRN taken. (b)(6)-2 [redacted]
	1420 Hygiene given. pt remains able to clear own secretions w/ difficulty. (b)(6)-2
	1615 ovg placed by Dr [redacted] @ 30cm. Opt'd care given. (b)(6)-2 [redacted]
24SEP03 1815	Rec'd pt from CPT [redacted] (b)(6)-2 pt resting in bed. pt has (L) femoral line CTLC infusing D5½NS C2K @25cc/hr. VSS. Dressings to M/L abd and (L) LE CDI. pt c/o "cramping" to abd. pt turned to (L) side @ 1810. H/L to (L) wrist d/c'd. (b)(6)-2 [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02 Sep 03	Surgery
	Pt single AFOB
	Lungs: CTA
	Card: RRR ST
	Abd: soft, int, NT BS+
	Labs: noted
	UO: ~120 ml/hr
	Tp: 00.46 well
	Plan: DC central lines + PICC lines
	DC ~~Pt~~ daily labs + CXR
	cont wound care [redacted] (b)(6)-2
24 Sep	(1900) pt alert, responsive; assessment unchanged — [redacted] (b)(6)-2
	~~[illegible]~~ no change in assessment; VSS — [redacted] (b)(6)-2
	(0400) am care done; drsg A's - wounds pink, ⊘ fmt abs; [redacted]
	⊘ pleural drainage; FiO2 ↓ 28% by RT; pt tolerating well [redacted] (b)(6)-2
26 Sept 03 0700	Performed Assessment. Midline Abd dressing C, DTI dressing to (L) leg intact. Blood culture drawn, nasal culture sent to lab. Triple lumen cath to (b)(6)-2 (L) femoral Area intact ⊘ c/o @ this time [redacted]
26 Sept 03 0930	Pt c/o pain. Medicated c 3mg MSO4 Pt helped @ this time — [redacted] (b)(6)-2
26 Sep 03 1030	Dressing change done to mid abd Area + to (L) leg. ⊘ drainage or odor noted. Will continue to monitor + assess. — [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03 1345	Pt c/o pain. Medicated c 3mg. MSO4 Pt c/o pain. (b)(6)-2 [redacted]
26 Sep 03 1700	Pt resting comfortably. c/o c/o @ this time. Will continue to monitor. [redacted]
27 Sep 03	0600 Assumed care. Report given. SEE TCU-3 flowsheet for initial assessment. At 0730 pt [redacted] to eat breakfast. (b)(6)-2 1010 Dr [redacted] (b)(6)-2 @ bedside. Staples remove. Wound cleaned, over site dressing 4x4 gauze & secure. midline abd dressing d/c'd, wound uncovered by Dr [redacted] (b)(6)-2 (b)(6)-2 [redacted] leg wound [redacted] 1130 Leg foot brown uncovered from [redacted] (b)(6)-2 [redacted] 1245 pt made attempts to eat, snack given [redacted] (b)(6)-2 1540 Partial bath given. Linen changed
28 Sep 03	Nursing: Pt stable during shift afebrile. Turned q 2hrs pain well managed c̄ MSO4 3-5mg IVP prn. Ate <50% of food + cough medium amount of thick clear secretions. Abd wound dressing changed. Will continue to monitor. [redacted] 1LT AN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] (b)(6)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
28Sep03(1920)	Received report from [redacted] and assumed care of pt @ 1815. See DA Form 4700 OP 375 for assessment data. Pt able to talk by placing hand over old trach site. Verbalizes pain in bilateral legs, abdomen and (R) arm when trying to move. MSO4 given as ordered. Pt resting @ this time. [redacted]
(2155)	Dressing Δ to Abdomen ML. W→DC Dakin's Solution. Beefy red c̄ some white patches. Improvement from last time seeing pt. Dressing Δ to (R) LE c̄ Dakin's solution. Improvement. Beefy red. MSO4 given a Δ'ing dressing. Pt tolerated it well. [redacted]
(2155)	Also Δ'd old trach site dressing. Healthy red. Dabbed c̄ Dakins solution. [redacted]
29Sep03 0100	Resting quietly c̄ HOB↑ UOP 100-120/hr Ø c/o pain or discomfort. Regular IV pump. [redacted]
0300	Bed bath given c̄ linen Δ. dress to (L) leg clean and intact. IV of D5½NS c̄ 20 Kcl @ 25 ml/hr to (L) femoral centrveline all ports flush easily. offers Ø c/o pain or discomfort @ present. [redacted]
29Sep03 0530	Pt is resting quietly c̄ HOB↑. IV of D5½NS c̄ 20 KCL. offers Ø c/o Pain or Discomfort. Foley to Gravity UOP 100-110/hr clear yellow. MSO4 5mg given 2350 for pain control and c/o pain. [redacted]
29 Sep 03 0745	Received report from previous shift. Assessment completed. Pt refused breakfast. Tube feeding started. VSS. Pt resting in bed. NAD. Will continue to monitor. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Sep 03	Surgery
	Patient c GSW to Right Chest, Lungs
	2 Diaphragm & T-11 c Resulting complete
	Paralysis Below T-11. Stable, Awake & Alert
	VS: HR 90s 139/74 RR 20 100% RA
	Lungs: CTA
	Cor: RRR
	Abd: Soft, NT, ND (BS) - Wound Healing
	LLE: Wound Healing
	Plan: To ICW
	Will plan skin graft to LE in 1-2 weeks
	See orders
	[redacted] (b)(6)-2
27 Sep 03	Progress
	Stable Afeb
	No acute changes
	Cont current management
	[redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29Sept03 1245	Rec'd pt from ICU3. Pt transfer to bed c staff assistant. (L) ↓ leg Dsg D&I. Foley to gravity amber urine. Dsg to throat D&I lungs CTA diminished (L) base BS(+) triple lumen (L) femur (-) skin breakdown under restraint x1 Will continue to monitor [redacted] 91WM6 (b)(6)-2
29Sep03 @2115	Assumed care of pt @1800. VSS. AAO, speaking Arabic. LS CTA, ↓ bases on (L) LL, (+) BS, Foley c clr urine. MI abd dsg & LLE dsg CDI. Dsg to old trach site CDI, sats 94-98% on RA. (L) femoral TL c dsg CDI, flushes well. 1 pt restraint on S S/Sx of skin/circulation compromise. Plan: turn Q2° while in bed, dsg Δs as ordered. [redacted] CPH (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

30Sep03 Sunday

PT STABLE VFDS

Lungs: CTA

Card: RRR

Abd: SOC/NT, ND (+) BS

Wounds: Healing

Rpi: STABLE

PLAN: CONT CURRENT TX [redacted] (b)(6)-2

30Sept@1010/ Pt awake in bed all drsgs Δ (−) drainage wounds on legs pink (−) foul odor. Pt has legged BM AM care complete (L) triple lumen. GT tube clamp. lungs CTA decreased in (R) base. BS (+) (−) skin breakdown under restraint. Will continue to monitor— [redacted] (b)(6)-2

30Sept@2245 — assumed care of pt @ 1800. VSS. 4/10 pain to abd, medicated c̄ percocet. c̄ some relief noted. RLE drsg CDI, W→D c̄ Dakins soln. wound healing, healthy red granulating tissue noted c̄ patches of white & green noted. inner stitches intact. [redacted] (b)(6)-2 drsg Δ'd, granulating tissue noted. (L) femoral TL central line drsg Δ'd using sterile technique. Throat drsg CDI. LS CTA, ↓ bases RLL, enc. CDB. (+) BS x 4 quads. Plan: monitor pain issues, turn Q2° to prevent skin breakdown, encourage CDB. [redacted] (b)(6)-2 CPT

Addendum: 1 pt restraint on S S/Sx of skin or circulation compromise. [redacted] (b)(6)-2 CPT

[redacted] (b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10CT03 (1850) ←(cont)	prevent skin breakdown. (+) equal pedal pulses. brisk cap refill. 1 pt restraint on @ this time s compromise to circulation or skin. Will monitor (b)(6)-2 [redacted] 91WMC
1900	NG Tube clamped, tol PO well, sutures to (b)(6)-2 (R) chest wall intact, ø sx infection [redacted] 91WMC
2230	Percocet II given for abd. pain c̄ relief noted [redacted] 91WMC (b)(6)-2
20CT03 0800	Pt Awake. A&O (b)(6)-2 [redacted] LS CTA (B). S1, S2 Present. (+) BS x 4 quads. Abd Drsg CDI. LLE Drsg CDI. Anterior neck drsg CDI. Pt wants to walk. Will have interpreter in to explain paraparesis. Pt sb "small" pain. FTG Draining sl/urine. Will continue to monitor. (b)(6)-2 [redacted] 91WMC
20CT03 (1900)	Pt c/o, VSS, c/o abd pain, II Percocet given. LCTAB, HRRR, (+) BS x 4, abd drsg s/d. c̄ Dakins solution red granulated tissue c̄ patches of white & green sen. LLE drsg s/d. - red granulated tissue sen. minimal drainage to both drsgs. Drsg s/d to prev. trach site. (L) femoral cath drsg intact (CDI). gastric tube intact c̄ syringe attached. (cont)
(CONT)	

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10Oct03	1227 - assumed care of pt. @ 0000. Assessment completed. Pt. c/o pain. medicate c̄ 2mg MSO4 + 800mg motrin per lt. [redacted] (b)(6)-2 Relief noted. Drsng Δ's performed. w → D c̄ Dakin's solution to abd. ⊖ s/sx of infection. w → D drsng to ⓛ LE c̄ Dakins solution. ⊖ s/sx infect. foley to gravity draining dark yellow urine. strict I/Os. Encouraging pt. to drink H2O. Drsng Δ to trachea c̄ min. drainage. central line to ⓛ femoral artery CDI c̄ ⊖ s/sx infection. Turning Q2° to prevent skin breakdown. One restraint to ⓛ LE. ⊕ circulation. ⊖ skin breakdown. ⊕ pedal pulse. <3 seconds cap refill. [redacted] (b)(6)-2 cont. to monitor pt.
(1740)	I concur c̄ above assessment. [redacted] (b)(6)-2
(1850)	assumed care @ 1800 p̄ report, pt alert & speaking arabic, VSS (temp 99.1), ∅ complaints @ this time. drsg Δ's to ⓛ LE & abd (c̄ dakins solution). ∅ drainage noted, healthy granulated tissue seen. foley to gravity draining c̄ yellow urine / strict I/O's. H2O @ BS. ⓛ femoral CL intact, drsg CDI, ⊖ edema or redness @ site. throat drsg CDI, Q2° turning to

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20CT (1900) (CONT) ->	(R) chest wall sutures intact, Ø S/Sx infection noted. foley to gravity draining mod. yellow urine. H2O @ BS, will encourage intake. (+) & equal pedal pulses, brisk cap refill. (1) 2° turns to prevent skin breakdown. strict I/O. 2 pt restraints on, (+) circulation. will monitor [redacted] (b)(6)-2 9MM6 SPC
(2215)	Pt had BM x2, brown-semi-liquid, CL dressing Δ'd using sterile technique. (due to stool ruining the dressing). will monitor [redacted] (b)(6)-2 9MM6.
3 OCT 03	pt Awake & Alert VSS / AFVSS wounds: Healing Plan to OR tomorrow for 2° closure of abdominal wound & STSG to LOC wounds [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30CT03	PT A&O LS CTA(B). $S_1 S_2$ present. (+) BS X4 quads. Ø c/o @ this time. drsg Δd to (D)LE & Abd [redacted] (b)(6)-2 (D) [redacted] (b)(6)-2 Femoral CL Drsg Δd. Pt x2 BM. (b)(6)-2 [redacted] Abdomen noted pink healthy granulated tissue c̄ sporatic spots of pus. (D)LE wound ⊖ pink healthy tissue. CL was contaminated c̄ Pt Feces. Water and IS @ Bedside. Will continue to monitor. (b)(6)-2 [redacted] 9WMb
30CT03 2000	Pt resting in bed, A+OX3, VSS, foley to gravity draining amber urine, LS CTA(B), (+)BS x4, medicated for pain c̄ 2 percs, dsg's on abd + LLE CDI, ROM → LEx2, ⊖ S/Sx of poor circulation or skin break d̄ on pts of restraint, dsg on trachea CDI, turn q2°. (b)(6)-2 [redacted] 9WW [redacted] (b)(6)-2
4OCT03	OP NOTE Pre-op Dx: open LBG wound / open abdominal wound Proc: STSG to prethigal left LBG. closure of abdominal wound. G-TWBS Removed Surg: (b)(6)-2 [redacted] (b)(6)-2 EBL: minimal Fluid: 1L NS UO: 600cc complications: Ø STABLE TO RR [redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
04OCT03	Pt A&O S_1 S_2 Present LS CTA (B). (+) BS x4 quads. Pt continues Loose bowel movements. Pt Appears to be incontinent. Pt c/o pain controled c̄ MSO4. CL in (b) Femoral area CDI NO S/S of infection. (b)(6)-2 [redacted] NS infusing at TKO in (b) hand via 20G IV. FTG Draining cyu. continue to Roll Pt [redacted] q 2°. (b)(6)-2 will continue to monitor. (b)(6)-2 [redacted] Spc 91WM6
	(1600) I concur c̄ above assessment! (b)(6)-2 [redacted] (MA)
4OCT.03 1930	Pt A+Ox3, VSS, LS CTA (B), (+) BSx4, pain controlled c̄ percs, pt has sporadic episodes of loose BM, abd soft flat non tender, dsg's to abd + LLE CDI, foley to gravity draining c/y urine c̄ Ø s/sx of infex, IV HL (D) Hand intact, flushes well, Ø s/sx of infex or infiltration, Ø s/sx of poor circulation or skin break down on pts of restraint, ROM to LE x2. (b)(6)-2 [redacted] 91W
	(b)(6)-2 [redacted]
	Received pt resting in bed, VSS, Tol PO, turn q2°, Alert + oriented. Dsg Δ's done, intact, Pt had large loose liquid stool. Dsg to medial and suture

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05OCT03 cont	Δ'd, serosang drainage noted on old dsg. (L) LE graft site intact w/ occlusive dsg covering. Gauze dsg intact to LLE below knee and with serous drainage note ∴ percocet for pain. Will cont to monitor. [redacted] (b)(6)-2
5OCT03	2130= VSS, A+O, follows commands, ∅ c/o pain @ present time, X1 restraint, ⊕ skin breakdown to (R) wrist – dry dsg applied CDI, ∅ CL @ femoral site, D/C'd NIO for CL Dsg Δ's, (L) thigh graft site has op-site CDI, midline abdomen Dsg CDI, (L) shin dsg CDI, IV to (L) hand flushed & patent, turning Q2, 2+ pitting edema to (B) LE's → ↑ (B) LE's. FTG draining clear yellow urine. Tolerates PO well, drinks plenty of H_2O. Continuing to monitor for acute Δ's. [redacted] (b)(6)-2 WT/AN
6OCT03	0530= pt. had x BM large & loose light brown colored, cleaned up, provided new linens & gown. [redacted] (b)(6)-2 WT/AN
[illegible]	Moved pt. lying on bed. VSS, tol PO, A+O x3, [illegible] speaking. Trach stoma to ant neck covered w/ 2x2, pt plugs to speak. ⊙ for IV patent. BM large x2. Duoderm placed on skin tear (L) buttock/sacral area. @ nc H_2O_2. (L) shin + (L) thigh dsgs intact ∅ changes in drainage noted. Midline sutures clean, OTA w/ minimal serosang drainage. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 OCT 03 @ 2215	- assumed care of pt @ 1800. VSS, 9/10 pain to general abdominal area. alert, speaking Arabic. LS CTA, ⊕ BS x 4 quads, voiding amber urine per foley. Enc po intake & ↑ po fluids. (L) thigh graft site & opsite intact, serous drainage noted. LLE calf dsg CDI. Throat dsg CDI. PRN complete. 1 pt restraint on while in bed. S/S of skin or circulation compromise. Plan: cont TCR, monitor skin integrity, enc po intake. Will monitor — [redacted] (b)(6)-2
8 OCT 03 @ 0000	Shift totals 1-7: Ins = Po fluids ≈ 3000cc Out = urine = 9000cc. Pt encouraged to ↑ po intake. — [redacted] (b)(6)-2
8 oct 03 0700	- Assumed care pt. A+O x 3. Lungs clear bilat. HRRR. Active BS x 4 quads. Foley to gravity dark yellow urine QS. Midline abdominal incision open to air healing minimal drainage. (L) thigh skin graft site moist pink opsite dressing intact. LL calf dressing kerlix wrapped CDI. Trach site & dressing CDI Q2 hr position change. Prevent skin breakdown. Will cont to monitor — (b)(6)-2 [redacted] Glowacki
	(1725) I concur & above assessment. (b)(6)-2 [redacted]
8 OCT 03 @ 2145	- Assumed care of pt @ 1800. VSS. alert, speaking Arabic. LS CTA, ⊕ BS, tol reg diet, encouraged po fluid intake. Foley to gravity draining clear amber urine. (L) thigh skin graft site OTA, healing well, drainage noted. LLE calf dsg CDI. Throat — (CONTD) (b)(6)-2

STANDARD FORM 509 [redacted]

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

6 OCT 03 @2045 – nursing assumed care of pt @1800. VSS. Alert, speaking arabic. No c/o @ this time. Medicated c̄ Percocet approx 1900 c̄ good pain relief noted. ML incision OTA, healing well. (L) thigh graft site c̄ opsite dsg leaking scant amt of sero sanguinous drng, o/w healthy looking. LE heels dsg CDI. Throat dsg for drg/trach site CDI. PROM completed to BLE. Plan: Encourage IS, enc PO intake, Turn Q2°, cont Abx as ordered. Addendum: foley to gravity c̄ clear/yellow urine noted. [redacted] (b)(6)-2 pt restraint on while in bed S/Sx of skin or circulation compromise. Will monitor. [redacted] (b)(6)-2

7 Oct 03 0700 – Assumed care pt A+O x3. VSS AM care given Ø c/o pain or discomfort @ this time. Skin graft (L) thigh ~~site~~ [redacted] (b)(6)-2 vascular pink Ø s/s of infection. Lungs clear bilat. HRRR. Foley to gravity dark yellow urine. Midline surgical incision from chest to abdomen c̄ sutures intact healing minimal drainage. Q2° position change ROM exercise comp. Will cont to monitor. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

UTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

8OCT03 2145 (CONT) dsg c̄ Vaseline gauze, CDI. PROM completed. Plan: cont decubitus preventi on care Turn q2°, PROM, encourage po intake. [redacted] MAJ
Addendum: 1 pt restraint on c̄ s/sx of skin or circulation compromise. (b)(6)-2 [redacted] MAJ

9Oct03 1440 VSS. Assumed care @ 1600. A&O able to make needs known. HRRR, resp even & unlabored. Trach site has not closed. Drsg applied over site. Abd soft nontender c̄ ⊕BS. Voiding clear yellow urine quantity sufficient via foley. Pt turned q 2°. Skin warm & dry. (L) thigh skin graft site healing c̄ signs of infection. (R) calf wound healing well. Vaseline gauze drsg applied by MD. Pt tolerating regular diet well. HL patent. Medicated @ 1000 c̄ percocet two tabs po for c/o pain. ∅ complaints @ this time. Will continue to monitor. Restraint x one c̄ s̄ skin or circulation compromise - [redacted] MAJ (b)(6)-2

9oct@2015 Assumed care @ 1800; All VSS, pt Alert, verbalizes needs; S, O_2, LS CTA (B); ⊕BSX4, FTG draining QS, clear dark yellow urine; dsg to (L) LE CDI ⊖drainage; graft site healing well; [redacted] (b)(6)-2 pain controlled c̄ percc. HL patent c̄ s̄ s/sx infection/infiltration; dsg to track site CDI c̄ drng; ⊖BM; cont to monitor [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 OCT 03	Pt Awake c/o pain controlled c̄ percocet LS CTA (B), S1,S2 present ⊕BS x4 quads. Pt roll curvy 2°. Drsg to (L)LE CDI. Will continue to monitor.
10 oct 03	Assumed care @ 1800; All VSS, pt Alert, pain managed c̄ percocet x1; dsg to (L) LE CDI ⊖drainage, FTG patent draining QS, clear, dark yellow urine HL patent, dsg to trach site CDI, ⊖drainage; (b)(6)-2 [redacted] Cont to monitor (b)(6)-2 [redacted]
11 OCT 03	Assumed care 0600 Pt A&O. BM x1 this Am. Am care completed. VSS. LS CTA (B), ⊕BM x4 quads. S1,S2 present. Pain controlled c̄ percocet. Will continue to monitor. (b)(6)-2 [redacted] Spc 9/ NMB
11 OCT 03 1000	Colace Held. BM x1 Loose (b)(6)-2 [redacted] Spc 9/WMB (1445) I concur c̄ above assessment. (b)(6)-2 [redacted] 4/A
(1930)	Pt alo, VSS, ⊖ complaints @ this time, drsg to (L)LE CDI, drsg to trach site CDI, voiding clear mod. yellow urine via foley. LCTAB, ⊕BS, HRRR Q2 turns. 1 pt restraint on ⅋ compromise to skin or circulation Will monitor (b)(6)-2 [redacted] 9/WMB.
12 OCT 03 0900	Pt Awake Pain controlled c̄ percocet LS CTA (B). S1,S2 Present. ⊕ BS x4 quads. DRSG TO LLE CDI Q 2° turns. ON call For transfer to Iraqi hospital. (b)(6)-2 [redacted] Spc 9/WMB.
(1855)	Pt awake, VSS, speaking Arabic, ⊖ alo pain @ this time. (R)LE bractracin applied (OTA) Q2 turns, being done. trach site drsg CDI. LCTAB, ⊕BS, 1 pt restraint on ⅋ compromise to skin or

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(cont)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9 OCT 03 DC Summary

PATIENT INITIALLY SHOT THROUGH SPINE, RIGHT CHEST & LIVER. INITIAL TREATMENT INCLUDED TUBE THORACOSTOMY & EXPLORATORY LAPAROTOMY & PACKING OF GRADE IV LIVER LACERATIONS. PACKS REMOVED 24 HOURS LATER. POST-OP COURSE SUGGESTIVE OF ANOXIC BRAIN INJURY DUE TO PLACEMENT OF G-TUBE & TRACHEOSTOMY. PATIENT'S NEUROLOGICAL FUNCTION IMPROVED & PATIENT IS NOW AWAKE & ALERT. ABDOMINAL MIDLINE WOUND CLOSED 14 OCT. ALSO, STSG TO LLE X2. G-TUBE REMOVED & TRACHEOSTOMY OUT. TRACHEOSTOMY WOUND CONTINUES TO HEAL & WILL REQUIRE OCCLUSIVE DRESSING. PATIENT WILL NEED ABDOMINAL SUTURES OUT IN 7 DAYS. APPLY BACITRACIN TO SKIN GRAFTS PRN. PATIENT IS TOTAL PARAPLEGIC. CURRENTLY, PATIENT IS DOING WELL. WILL GO TO PRISON HOSPITAL CONT: FLAGYL FOR DIARRHEA FOR 7 DAYS

[redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] Hospital

(b)(6) -4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12OCT@ (1855)	circulation. sutures intact to midline (b)(6)-2 abd. (OTA). Will monitor [redacted] 91WM6.
13OCT03 1500	Pt Awak Roll q 2°. VSS. FTG draining L/U. Sacrum Drsg Δ. ~~[illegible]~~ Pt Teaching IS. Pt Demonstrate proper use of IS. Will continue to monitor (b)(6)-2 [redacted] Spec 91WM
13OCT03 @2000	- assumed care of pt @ 1800. [redacted] no ↓. (L) thigh graft site ? (R) Calf donor sites healing well, all OTA, sacitracin applied. ML incision healing well. Throat drsg ε smant of drainage, d/w intact. Pt c/o abd & back pain, Percocet given ε good relief noted. PROM to BLE done. Plan: Turn q2°, monitor skin breakdown, pain control. (b)(6)-2 [redacted]
14OCT03 1100	VSS Alert & Oriented. Lungs clear. BS(+)x4 grad. Abd soft non distended. Midline Abd incision ε sutures intact. Edges to midline incision well approximated. (R) Calf & (L) thigh graft sites varied S/S of infecte. Had large soft BM: Reposition q2h for comfort. [redacted] care as planned. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted]
(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14OCT03 @2000.	assumed care of pt @1800. no C/O. Tol reg diet well. (L) thigh & calf wounds OTA, draining serous drainage; bacitracin applied. LS CTA, (+) BS, Foley ¯ clear, yellow urine. Encpo intake & IS. Throat disc CDI. Plan: cont Turn Q2°, PROM to BLE, pain control. Will monitor. 1pt restraint on ¯ S/S of skin/circulation compromise. (b)(6)-2 [redacted]
15Oct03 @ 0800	Pt no c/o pain. Incision mid-line abdomen. Open to air. (-) S/S of infection. (-) drainage + well approximated. Lung sounds clear through all fields. (+) bowel sounds (+) foley draining clear, yellow urine. (+) BIL pedal pulses. (L) lower leg abrasions open to air. Bacitracin application. (-) S/S of infections. (-) arm restraint. (-) skin breakdown. (b)(6)-2 [redacted]
0850	Med ¯ 1/2 percocet. Pt incontinent of stool. D'ed pads x 1. [redacted] (b)(6)-2
15Oct03 @ 1930:	VSS, (+) 101.0, gave 800mg Motrin PO, will reevaluate later. DSG to old graft site CDI, sutures to midline abd wound approximated, (-) drainage noted, graft sites to (L) leg open to air ¯ (-) drainage, healing, foley to gravity draining adequate clear yellow urine. Applying bacitracin to leg PRN. Tolerates PO well. Q2 logroll turns to prevent skin breakdown, X1 restraint ¯ skin breakdown noted, POC: palliative care, pain mgt, drainage monitoring. Continue to monitor for acute Δ's. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16Oct03 0900	Temp 97.8. Percocet given for pain upon request and effective. Both sites clean & sterile [redacted] Normal saline. Each site without crustation/drainage. (b)(6)-2 [redacted] Redressed with sterile dry gauze. Lungs clear Bilat. Abd soft nondistend. Midline ABD incision & edges well approximated. (L) thigh donor site & (L) [redacted] (b)(6)-2 calf graft sites cleaned with sterile saline & bacitracin oint applied. Ø drainage noted from either sites @ this time. Foley to gravity draining amber clear urine. Repositioned Q2 for comfort. Will continue care as planned. (b)(6)-2 [redacted] 24 hr
16OCT03 1945	Pt awake, speaking arabic, LS CTA(B), (+) BS x4, skin break down precautions, roll q 2°, sutures on midline abd incision intact, foley to gravity draining c/y urine, graft sites on L LE appear clean dry intact and healing properly, 2 pt restraint & complications. (b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
				(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Oct 03	VSS. pt A+OX3 pt c/o pain all over esp around shoulder. pt given nothing for pain but pt slept. pt had BM and has been rotated as per schedule. restraints x2 in place. pt voiding dark amber urine. (b)(6)-2 SPC [redacted]
	(1735) I concur c above assessment. (b)(6)-2 [redacted]
17OCT03 1900	Pt A+O x3, LS CTA (B), (+) BS x4, medicated for pain c percs + motrin, dsg on old trach site CDI, skin graft sites on LLE open to air, applied bacitricin to sites, ROM on LE x2 given, logroll q 2° for skin breakdown prevention sutures to midline abd incision intact, foley → gravity draining amber urine, 2 pt restraint in place c complications. [redacted] qiw (b)(6)-2
18Oct03 1646	Assume care of PT @ 0800. VSS, A+OX3. Stitches are ready to come out. c/o pain in stomach. His problem with bikes. Need buttocks dsg, area needs to be seen by Dr. Don't sitting better. No sign of infection or bleeding at [redacted] (b)(6)-2 skin graph site. Will cont. to monitor. (b)(6)-2 qiw SPC [redacted]
	(1740) I concur c above assessment. [redacted] (b)(6)-2
18OCT03 2206	1155. AO. Performed small BM c soft formed brown stool. Cleaned patients head/hair and BLE and performed foley care. Placed large Duoderm to stage 2 sacral ulcer and notified MD. Tried @ other point voiding light amber urine. F76 [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/18	Operation Note
	Procedure: Scalp Dermoid dissection
	Surgeon: [redacted] (b)(6)-2
	Anesthesia
	Propofol 300 IV
	100 [illegible]
	Findings: Large vascular deep dermal cyst with purulent
	collection and green foul smelling pus
	Estimated
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19Oct03 1654	Assume care of Pt @ 0600. VSS, A+OX3 In ~~ex~~ restraints, Ø skin irritation. C/O Ø pain. ~~Used~~ Bile is runny light brown color. Past 6 liles three times today. Replaced decaderm on buttocks, area looks better than yesterday. Let air dry for an hour. Will continue to monitor. 9/W SPC [redacted] (b)(6)-2 (b)(6)-2
	(1745) I concur c above assessment [redacted]
19OCT03 2100	Pt Awake and resting on (R) side. Several Decub c op site Drsg. Pt denies pain @ this time. Will continue to log roll. [redacted] (b)(6)-2 Spc 9/WM6
20OCT @0915	Pt awake, VSS, Ø c/o pain. Q2° turns to prevent further skin breakdown. Drsg Δ'd to incrum. Pt NPO today for OR. LCTAB, HRRR, ⊕BS x4 qds. foley to gravity draining, mod yellow urine. 1 pt restraint on ⊖ compromise to skin or circulation. Will monitor [redacted] (b)(6)-2 9/WM6
20OCT 1600	Pt left for OR via litter. 18ga IV started to (R) AC. [redacted] 9/WM6 (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

[redacted]E (b)(6)-2	NOTES
20Oct03 1730	(L) PIV T. antibiotical. NS infusing TKO @ this time. pt Braden Scale 13. pt high risk for further skin breakdown. pt will need PT and Nutrition consult as soon as possible. pt condition stable @ this time. pt on regular diet pt able to feed himself. Report given to on coming shift.
20Oct03 1830	Pt resting bed alert communication limited due to language barrier. Turned to (L) side c present VSS. No distress noted Respirations even and unlabored BBS CTA pt c̄ productive cough. Palpable pulses (B) paraplegic but Moves UE well asst c̄ care. Abd soft c̄ hypoactive bowel sounds Midline incision with skin well approximated open to air. Scarring to old surgical sites to chest walls Foley to gravity c̄ amber urine IV LR infusing via PIV in (R) FA. Tolerated meal c̄ complications Will cont. to monitor status. Dsg to coccyx changed by previous shift CPI [redacted] (b)(6)-2
21Oct03 2330	Pt asleep c̄ intervals VSS. C/o pain to (L) shoulder Rec'd Dorado1 30mg IVP per Dr [redacted] (b)(6)-2 IVF cont to infuse Will cont. to monitor and reevaluate [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted]ONSOR'S ID NUMBER (SSN or Other) (b)(6)-2
	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.
X [redacted] (b)(6)-2		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 Oct 03 0300	Pt resting comfortably. No changes in status. Assisting c̄ repositioning. Foley remains ⊕ BSP. No distress noted. pain relieved — (b)(6)-2 [redacted]
0600	assumed care of pt. Pt turned to (L) side. Drsng intact. VSS. CPT [redacted] (b)(6)-2
0800	Pt has been turned + pressure kept off of sacrum area. (Neuro) AOx3, FA, moves UE only d/t paraplegic to BLE. UE weak. (RESP) 20 BPM c̄ SpO2 > 98%. RA. CTA, BBS, even, unlabored. (CV) HR 80's, RRR, Ø ectopy noted. (+) pulses throughout. (GI/GU) Soft, tender to LQ's + midline incison c̄ sutures. BS (+) hypoactive. (+) flatulence (foul smelling). Ø BM. Foley to gravity c̄ are 50cc/hr. golden yellow urine. Pt tolerating PO c̄ intake ~35%. Interpreter explained to pt about nutritional intake must ↑ in order for proper healing. Will ask
(b)(6)-2	Dr [redacted] abt Nutrition consult. Pt already getting Ensure drinks. TID. (Integ) Braden score done c̄ w/s care sheet. Pt @ HIGH RISK for developing ulcer. Dry skin, feet skin is dry + flaky. But warm. Pressure ulcer to sacral area Stage IV - wet dry drsng ▷ BID. LLE, lateral calf, graft site - ota - Ø orders for wound care to be followed. Donor site - ota - d/t no orders for drsng / site care. PIV @ FA patent intact c̄ LR 75 cc. POC: PN mgmt, turn, monitor. — CPT [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

(b)(6)-2

DATE	NOTES
[redacted] 20OCT03 1700	Pt received from OR. S/P coccix pressure ulcer debridement. Age unknown. This pt is an EPW transferred to us from ICW 1 prior to debridement. Upon arrival to unit, pt fully awake and alert. Unable to communicate due to language barrier. V/S. HR 86, NSR, Ø ectopy. BP 124/65, RR 20. O Sat 98%. No respiratory distress noted. Lung. CTA bilaterally. Ø cough Ø sputum. Heart S1 S2 Ø murmers. Skin cool to touch. pt emaciated. Radial pulses - weak. Dorsalis pedal pulses. strong @ 2+. Ø peripheral edema. Capillary refill < 3 sec. pt is a paraplegic, unable to turn side to side ~~&~~ staff assistance. pt has strong hand grip. able to sit up and able to support upper torso using upper arm. Pupils 3mm bilateral, PERL. Occipital region has 3cm pressure ulcer - unable to stage due to covered c̄ hard scab. Abd flat non-tender. active bowel sounds x4 quads. Foley intact - draining clear - cout

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

REGISTER NO. | WARD NO.

#[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted] (b)(6)-2			

NOTES

[redacted] (b)(6)-2
1930 [redacted] (b)(6)-2 amber color urine. Drained approximately 1000 cc's urine in bag. abd. has long incision from below the nipple line to symphysis pubic region. Incision line well approximated and closed [redacted] (b)(6)-2 Closed & sutures still in place. Suture line covered & dry drainage particles. (R) chest area has healed S/P CT incision sites x2. (L) leg healed graft site that is 6cm long 3cm wide. wound bed pink. (L) lower leg and [redacted] (b)(6)-2 below the knee - healed wound. Temp 97.8 (F) Foot drop noted bilaterally. Removed cavity dressing to assess S/P wound debridement. packing removed. Bloody drainage noted. Stage IV pressure ulcer that is approximately 8cm in diameter - wound edges - irregular. wound depth approximately 2cm deep. Tunneling noted from 7° clock to 11° clock position & 8cm deep towards left cheek. Undermining 2-3cm deep from 11° clock to 1° clock position wound bed red. packed wound & wet to dry kirlex sponge. Reinforced it & 4x4s and tape. Placed pt on (L) lateral position & [redacted] (b)(6)-2 Knees supported and back. pt needs to be turned q 1-2° side to side. Keep pressure totally off the back

STANDARD FORM 509 (REV. 5/1999) BACK

[redacted]

MEDCOM - 18011

(b)(6)-2 MAJ, MC

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Oct03 1200	positioned pt on (R) lateral position, between the legs supported c̄ rolled blanket. Heels off the mattress. Pt able to assist some using side rails. — No signs and/or symptoms noted. (b)(6)-2 [redacted]
1545	Pt has turned Q1hr from (D)→(R). Pt was able 35% of b.fast + 80% of lunch. He has had a total of 3 ensures up to this time since 0100 this am. Pt asked for a snack. Ate it all c̄ success + drank 1 glass of H2O. Appetite has ↑ today w/o any N/V. Pain mgmt c̄ Percocet tabs Q4-6hr/prn. Pt's demeanor seems more enlightened today - smiling + participating in care. VS Q4hr VSS. U/O ~100-100cc/hr. Yellow physical therapy bands applied to each side rail - pt taught/encouraged how to utilize them. Cont to monitor. (b)(6)-2 CPT [redacted]
22Oct03 1800	Assumed care of pt. Pt in bed c̄ eyes open resting comfortably. VSS. Will continue to monitor. SPC (b)(6)-2 [redacted]
1845	Pupils Perrla @ 3mm brisk, responds to external stimuli, moves upper extremities, paralyzed in lower extremities, HR in 60's, NSR, Ø ectopy noted, Ø S's 2HS, Ø murmurs noted, Ø peripheral pulses X4 extremities +2, +1 edema in lower extremities, 18G (R) AC running LR @ 75 cc/hr C/D/I Ø S+S of infection, RXR unlabored, Sats High 90's, Lungs CTA Bilat c̄ equal rise + fall, pt on reg diet + ensure

continued one next page

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22OCT 03 continued	Sacral decub c̄ w/o drsng BID. Turn Q1hr keep pressure off @ all times. LLE, thigh, anterior, donor graft site. OTA, CDI. LLE, calf, lateral anterior, graft site/OTA/PRACtraun BID/PRN. — POC: Turn Q1hr c̄ pn mgmnt, hygiene + nutritional encouragement, ensure PT visits pt. VSS (b)(6)-2 CPT [redacted]
1100 22OCT 03	Pt has been turned Q1hr from D → R. Pt now helping turn himself by using side rails. Drsng Δ to sacral area using W=Dry drsng. Wound irrigated, measured, and repacked under tunneling. WOUND DIMENSIONS: 10cmL x 8cmW x tunneling from 7 o'clock to 12 o'clock c̄ 2cm-3cm from 3 o'clock to 6 o'clock. Wound clean c̄ Ø drainage. [redacted] (b)(6)-2 Heel ulcer - 4cmL x 3cm W, staging unable to be done. B/C it is covered c̄ dry tissue. Area around [redacted] (b)(6)-2 wound shaved - comfeel put over. Pt shaved, brushed teeth, + put deodorant on this AM. New gown placed. Braden scale (N/S assessment) has been done upon entering unit. VSS. D'ed to Q4° VS record. Spoke c̄ MD [redacted] about multivitamin + appetite enhancer. — [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Continued 21Oct03
	bilat equal rise + fall, pt on Reg diet + Ensure, ABD incision midline closed c̄ sutures open to air C/D/I Ø sts of infection, ABD soft ND. tender around incision, Ø BS x4 Quadrants, Foley to gravity [redacted] (b)(6)-2 draining clear yellow urine >30cc/hr free of sediment, Stage IV Decubitus Ulcer to coccix c̄ wet to dry drsg Ø sts of infection, 3 wounds from old chest tubes to (R) Flank covered c̄ duoderm Ø sts of infection, old trach site Ø sts of infection covered c̄ gauze C/D/I. Will continue to monitor + turn Q1°. SPC [redacted] 9W/MG
1030	Performed DRSG Δ to Decubitus on coccix. (b)(6)-2 Continueing to turn Q1°. SPC [redacted] 9W/MG (b)(6)-2
22Oct03 0600	Assumed care of pt @ 0600 from SPC
(b)(6)-2	[redacted] Pt on (R) side. CPT [redacted] (b)(6)-2
0700	Neuro AOX3 PERRLA, EOMI, communicates via gestures + interpretor. PC, move UE but LE is weak. Pt consult submitted 21Oct03. Resp 14-16 BPM, CTA, SpO2 ≥96% RA. No cough noted @ this time. CV SIS2 c̄ HR 70's RRR. Ectopy noted @ this time. 2+ pulses to extremities. (+) edema to (B) LE. (B) LE warm, dry. GI/GU Foley to gravity c̄ ave ~40-60cc/hr U/O, cyu. Midline line, sutures, Ota. Scabbing noted. BS x 4 quads. Reg diet c̄ poor appetite but LH will drink Ensure drinks. Nutrition consult 21Oct03. Pt usually eats <35% meal times. Sq (R) AC c̄ LR 15cc/hr. Wound Abd, midline, sutures/Ota/scabbed. ¢ S/S infection; Decubitus occipital head. (b)(6)-2 comfeel placed or W-D Drsng Δ. Keep pressure off. continued CPT [redacted]

STANDARD FORM 503 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
210403 1500	Addition to RN assessment. Ĉ turning Q1h. Pt's head (occipital pressure ulcer) also inspected as well as sacral decubs. Begun VS Q1 @ 1400. Afebrile. Will talk ĉ Dr. [redacted] About PO pain medicine. VSS. (b)(6)-2 CPT [redacted] (b)(6)-2
1730	Pt turned Q1° OVSQ1 VSS. Pt drank 2 ensures + ate <35% each meal. PT + nutrition consults turned in. HR75cc° MIVFĈ PO intake fluids encouraged. Percocet ii tabs PO for PN. 40 ~30. 50cc/hr. PIV (R) AC intact. Report to be given to SPC [redacted] (b)(6)-2 VSS CPT [redacted] (b)(6)-2
1800	Assumed care of pt. Pt resting in bed ĉ eyes open. VSS. Pt ate 75% of dinner meal. Will continue to monitor. SPC [redacted] (b)(6)-2 91WML
1920	Pupils perrla @ 3mm, responds to external stimuli, Ø sedation, moves upper extremities, paralyzed in lower extremities, HR in 70's, NSR, Ø ectopy noted, Ø S'S² HS, Ø murmurs noted, Ø peripheral pulses X4 extremities +2, +1 edema in lower extremities, 18G (R) AC running LR @ 75 cc/hr C/D/I Ø S+S of infection, RER unlabored, Sats High 90's, Lungs CTA

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Continued **PROGRESS NOTES**

DATE	NOTES
Continue 1845	Midline ABD incision closed c̄ sutures open to air C/D/I ØSYS of infection, ABD soft ND but tender around incision site, ⊕BS X4 Quad., Foley to gravity draining clear yellow urine >30ccHr free of sedement, Pressure ulcer to back of head covered c̄ duoderm, Stage IV ulcer to coccix c̄ wet to dry drsg C/D/I Ø SYS of infection, skin graft site to (L) LE ØSYS of infection, will continue to monitor throughout shift. SPC (b)(6)-2 [redacted] 9/WMG
2200	Performed DRSG Δ to coccix + TRACH site /Neck. /—/ Continued to turn throughout shift. SPC (b)(6)-2 [redacted] 9/WMG
23 Oct 03 1115	Nutrition F/U: PO intake improving (per nsg.). Pt consumed 80% of lunch tray yesterday + 4 Ensure. Continue to encourage PO intake. No labs noted. Will provide pt c̄ crackers as snacks. (b)(6)-2 [redacted] RD/LD
23OCT03 1120	Late entry: assumed care of pt @ 0700 this am from SPC Smalley. VSS. Neuro sleeping but easily arousable. PERRLA, nods conversation well, PC, move LUE well, RUE c̄ pain + weakness. Resp 14-20 BPM c̄ SPO2 ~ 100% c̄ RA. CTA. nonlabored - even. BBS. CV S1 S2 HR 70-90's. RRR, Ø ectopy noted @ this time. UE 2+ pulse, (B) LE 1-2+ Pitting edema

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	to RLE / fed. GIGU soft / tender. / BS x4 Hypoactive. Pom x 2 - small, runny. Foul - greenish in color. Foley ĉ QS urine output. Wounds sacral decub - drsng intact - wet to dry ĉ soft packing of area and tunneling. Occipital lobe decube - old comfeel - will replace + clean. Intact ĉ drainage. Midline Abd inc. sutures - scabbed / ota / CDI. LLE - thigh - donor graft site / ota / CDI. LLE - calf - lateral graft site ĉ Bacitracin + nonadherent drsng. VSS. CT n ——— CPT [redacted] (b)(6)-2
1200	WOUND CARE: Removed sacral drsng - foul odorous ĉ much drainage & overwet drsng. Wound clean, no drainage, no foul odor noted. Wound irrigated ĉ NS + toomey syringe. then patted dry ĉ 4x4. Afterwards a wet to dry drsng was placed, packed the tunneling + area lightly but to the edges. Two 4x4's - dry - placed over drsng then covered / secured ĉ Tegaderm opsite. Skin barrier applied. Wound #2 Trach - old drsng removed area cleansed ĉ NS + 4x4 - then patted dry. Four 2x2's ~~on~~ then covered with a tegaderm was applied. Wound #3: Occipital decube: Old comfeel removed. Area cleansed ĉ NS / dried / then new comfeel placed. Scabbing is sloughing off slightly. Expect scab removal w/in 2-3 days ĉ removal of comfeel. Then will apply wet - Dry drsng BID or per MD orders. VSS ——— CPT [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23Oct03 1710	Summary of day: Uneventful day Pt turned Q1 hr. Dressing A to sacral decube, occipital decube, trach, LLE x2. See w/s note for details of dressing A. U/O qs today. VSS. Slight temp @ 1600. Percocet tabs x2 given x2 today for pn. Physical therapy conducted ROM exercises this afr. Pt used BIPADS thus a.m/p.m. x2. Breakfast 35%, lunch 80% eaten. Pt has drank ensure drinks x2 & snacks x2 (one in am/one in pm) of peanut butter + crackers. Pt c/o pain to (R) shoulder. ROM exercises done & encouraged. VSS. Cont to monitor (b)(6)-2 CPT [redacted]
1710	addition: nutrition to reassess pt today. Pt c ↑ appetite + intake x 48hrs - must insist on drinking the ensure's. Pt helping more c upper body in turning. (b)(6)-2 CPT [redacted]
23Oct03 1800	Assumed care of pt. Pt in bed on (L) side, VSS. Performed wound care/DRSG A to coccix c̄ MAT (b)(6)-2 [redacted] stage IV pressure ulcer 8cm W x 10cm L x 4cm D c̄ tunneling to the 12 o'clock posistion 2cm deep, wound has slight whitish exodate to outer region, coccix bone presentable in center of

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. 1 CCU2

[redacted]

(b)(6)-4

EPW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Continued	wound, ~~debrided~~ (b)(6)-2 2300 flushed + cleaned wound, repacked wound c̄ damp 4x4's, covered c̄ dry 4x4's + covered c̄ tega derm. SPC (b)(6)-2 [redacted] 9WM6
1930	Pupils perrla @ 3mm, responds to external stimuli, moves upper extremities q̄ paralyzed in lower extremities, HR in 90's NSR ∅ ectopy noted, ∅ S's S² HS, ∅ murmurs noted, ∅ peripheral pulses x4 extremities +2, +1 edema noted in lower extremities 18G (R) AC c̄ LR @ 75cc/hr C/D/I ∅ S+S of infection, RRR unlabored c̄ equal ~~rise~~ [redacted] (b)(6)-2 rise + fall of chest, Sats in high 90's, Lungs CTA Bilat, Reg diet + ensure, ABD soft ND, ∅ BS x4 Quad, Foley to gravity draining clear yellow urine 780cc/hr free of sediment, Stage I pressure ulcer to back of head covered c̄ duoderm, Midline ABD incision closed c̄ sutures open to air ∅ S+S of infection, stage IV pressure ulcer to coccix described earlier in notes, skin graft sites to (L) LE ∅ S+S of infection, skin color normal for race, will continue to monitor. SPC (b)(6)-2 [redacted] 9WM6
2130	Pt drank 1 can of ensure. SPC (b)(6)-2 [redacted] 9WM6
2200	Offered pt second can of ensure but pt refused and said ensure was making him nauseated. SPC (b)(6)-2 [redacted] 9WM6
0400	Performed 2nd ORSG4 + afterwards pt had a bath. Summary of night. Night was uneventful after assessment roled pt to other side, between sides had pt do arm exercises c̄ bands. Pt complained of pain to (R) side hip + (R) shoulder pain while awake during the night. Gave pt perscribed percocet then reassessed 45 min later and the

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24/OCT/03 1130	- Performed wound care to sacric Area. STAGE IV ulcer. 8cm w x 10cm L c̄ tunneling to 12 oclock. Moderate amount of debrisment done around edges. Small amount of granulation noted. wound was packed c̄ sterile 4x4's wet → Dry dressing. In process of wound care PT had passed watery stool followed by several hard granular stools. Edge of dressing was redressed and skin prep applied to perirectal area. PT given 1 TAB percocet @ 1220 for comfort. As per MD order and turned to (R) side. Call cont to monitor. USBER [redacted] (b)(6)-2
1300	- PT tolerated lunch very well eating 75% of lunch. PT check of dressing remain WNL + Dry c̄ ⊖ c/o pain or discomfort @ present time. call cont to monitor. USBER [redacted] (b)(6)-2
1600	- PT passed watery stool followed by a large BM. PT has passed several of these BM. PT Temp has risen to 101.3. encouraged cough + Deep breathing c̄ ⊖ Resp Ts. (b)(6)-2
1745	As per MD [redacted] Give PT 2 Tylenol 325mg per tab and call send Blood culture. Call cont to monitor. USBER [redacted] (b)(6)-2
24 Oct 03 1800	Assumed care of pt. Pt in bed c̄ eyes closed resting comfortably. VSS. Will continue to monitor throughout shift. SPC [redacted] (b)(6)-2
1930	Pupils perrla @ 3mm, pt responds to external stimuli, moves upper extremities c̄ paralyzation to lower extremities, HR in 90's, NSR, ⊖ ectopy, ⊖ S's & HS's murmurs noted, ⊖ peripheral pulses X4 extremities +2, +2 edema to LE, IBG to @ AC c̄ LR

STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00
Next page

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES (b)(6)-2
Continued	pt was not complaining of pain. SPC [redacted] 9 IWMG
10/24/03	- Received PT Asleep in bed c̄ ⊖ c/o pain or discomfort.
0615	Bilateral rise & fall of chest. ⊖ Respiratory distress noted. [redacted] (b)(6)-2
	sounds are clear throughout. PT SpO2 96% on RA. BS x 4
	c̄ Abdomen Non-Distended or rebound tenderness noted. ⊕ Radial
	& medial pulses present, bilaterally. PT has ⊕ Pulse motor sensation
	to upper extremities. ⊖ sensation or movement to lower extremity.
	cap refill <3sec throughout. Foley to gravity drainage clear
	colored urine. T&G w̄ ⊕ AC c̄ LN @ Tricilla c̄ ⊖ S/S
	of infection or infiltration. STAGE I pressure ulcer to back of
	head c̄ Duoderm in place CDI. Abd scrotal M.D/in CDI
	open to Air c̄ ⊖ S/S of infection. STAGE IV pressure
	ulcer to coccyx 5cm W x 10cm L c̄ tunneling is CDI c̄
	dressing in place correctly not draining anything. S/Co graft to
	⊕ LE c̄ ⊖ S/S of infection. ↓ Extremities has +2 edema noted.
	Will cont to monitor PT [redacted] [redacted] (b)(6)-2
0635	- PT returned to ER Backfast. Encouraged PT to drink
	water. PT then ATE 25% of Breakfast. Will cont to monitor.
	Vasover [redacted] (b)(6)-2
0815	- PT c/o pain to ⊕ side of hip. PT was given Percocet
	5̄ As per MD order + moved to ⊕ side. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	clear colored urine. Drg to track site CDI ō ⊖ S/S of infection. MID line abdominal incision is crusty ō dry yellow drainage on edge. ⊖ redness or swelling noted to surrounding sites. Drg to (L) thigh CDI. (R) old IV site has some mild tenderness to touch + slight redness noted on IV insertion site. IV on (L) AC LR @ 75cc/hr infusing well ō ⊖ S/S of infection or infiltration. Will continue to monitor VS for fever + level of comfort. VASQUEZ [redacted] (b)(6)-2
1600	- PT has had several BM, some of which has managed to seep into the ostomy drainage. Dr [redacted] (b)(6)-2 notified & PT will be NPO after MIDNIGHT under to put a colostomy bag. Will notify next shift. [redacted] [redacted] (b)(6)-2
25OCT03 1750	Braden Scale done 21OCT03. Pt @ 13 - High Risk. Plan of Care + wound drsng management worksheet done also. Next Braden scale to be done 28 OCT03. CPT [redacted] W/S (b)(6)-2
2000	Pt received lying in bed on (R) side. Alert, follows commands [redacted] (b)(6)-2 moves UE (B) spont. paraplegia, LE positioned ō pillows. SR 80's 2+ UE pulses 1+ LE pulses 2+ edema LE noted LR @ 75cc/hr infusing to (L) FA 18G, VSS - Q4°. Sats 95% on RA RR 20's LS CTA. Ø cough or secretions. Abd soft, midline sutures intact, (+) BS x 4, BM x 2 upon turning to (R) side. Sacral stage IV decub packed W→D dsg Δ'd as ordered turning Q1° keeping off sacrum. Reg diet tol well, NPO p MN for OR tomorrow. Foley intact drng

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Oct 03 Continued	@ 75 cc/hr C/O/I Ø S+S of infection, RRR unlabored equal rise + fall of chest, Lungs CTA Bilat, Reg Diet + Ensure, ABD soft ND, ⊕ BS x4 Quadrants, ⊕ BM x1 since 18ØØ, Foley to gravity ~ clear yellow urine >3Ø cc/hr, Pressure ulcer stage I to back of head covered ~ duoderm, Pressure ulcer to coccix Stag IV 8cm W x 1Ø cm L x 4cm D ~ tunneling 2cm D Ø S+S of infection, Will continue to monitor. SBC [redacted]
Ø53Ø	Summary of shift, uneventful night, ⊕ BM x4 mainly solid large amounts of feces, Δ'D IV site to 18G @ FA, temp stayed @ 1ØØ to 1ØØ.8 hit 1Ø1 @ Ø55Ø informed H. [redacted] and was told to inform oncoming shift. SBC [redacted] (b)(6)-2
25/Oct/03 Ø6ØØ	- Received PT in bed c/o pain to (R) shoulder. Pertrb ~
0600	PT is Alert + Oriented x3. Gave PT 1 Percocet PO IAW per MD order for pain + Repositioned to (R) side. Upon turn PT had a large watery BM. PT was Afebrile ~ temp 100.3 low grade. PT's Duoderm site to back of head was coming loose. Refaced and found a large Black scab covered on Duoderm patch. Refaced patch and cleaned site. Breath sounds are clear Bilaterally ~ ⊖ Respiratory distress. BS x4 Active. ⊖ Abdominal distension noted. ⊕ Pedal + Brachial pulses throughout ⊖ PMS to ↓ Extremities. Cap Ref + 3 sec throughout. ↓ extremity ~ +2 edema noted. Foley drains

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	A febrile. Will cat to monitor PT [redacted] (b)(6)-2
1335	- PT is to return to regular diet until probably Wednesday when PT will go to O.R. for surgery. Will cat to monitor PT. [redacted] (b)(6)-2
26Oct03 2300	Pt placed on abdomen to sleep, medicated c̄ ~~1~~ Percocet and 4mg MSO4 IVP prior to turning. VSS. Will monitor. [redacted] (b)(6)-2 /LTAN
2330	Pt lying on abdomen Alert, follows commands pupils brisk reaction. ST 100's 2+ pulses UE 1+ pulses LE, 2+ edema LE. B/P stable. LR@ 75cc/hr infusing to 18G (L) FA. RR 20 sats 100% on RA LS CTA bases ⊖ secretions. Reg diet tol well, abd sft + tender to midline incision c̄ sutures intact. (R) BS x4 quads BM x2 this shift. Foley drng cl yellow sufficient amts. (R) thigh graft site LS TA pink granular tissue present. Duoderm to decub Stage II to occiput intact, Δ'd this pm. Stage IV decub c̄ sacral W→D ¼ Dakins sol dsg intact, Δ'd as ordered. Plan to monitor until Wed to OR for colostomy. [redacted] (b)(6)-2 /LTA
27Oct03 0500	Pt placed back to (R) side. VSS will monitor. [redacted] (b)(6)-2 /LTAN
27Oct03 1000	Nutrition Note: Pt c̄ liquid stools, per nsg. Recommend adding 1 scoop Metamucil to Ensure Plus to create Bulk. Give pt 1 scoop today + increase by 1 scoop/day to max of 3 scoops/day. Will continue to monitor + follow. [redacted] RD/LD

CPT, SP (b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25Oct03 2000 (Cont)	cl yellow sufficient amts. Plan to Δ dsg again @ 0400. will monitor. [redacted] /LTAN (b)(6)-2
2300	Pt turned and placed on stomach. C/o pain given 4mg MSO4 IVP and 1 Percocet PO. will monitor. (b)(6)-2 [redacted] /LTAN
0250	Pt repositioned d/t tilting to (R) side. given 2mg MSO4 for pain. Will monitor. VSS (b)(6)-2 [redacted] /LTAN
0400	Dsg Δ'd to sacral area 8cm circumference c̄ sacral bone visible. packed w/ D c̄ Dakin's sol. as ordered. mod amt white drng noted to old dsg. Pt sleeping on abd. repositioned to assist c̄ comfort. VSS. will monitor. [redacted] /LTAN (b)(6)-2
0530	Pt turned back to side position (L) side. VSS. Will monitor. (b)(6)-2 [redacted] /LTAN
0630-	Received Pt Awake in bed c̄ ⊖ c/o pain or distress. Pt is still awaiting transfer to the O.R. for colostomy placement. VSS. Hrn ⊖ resp. by distress noted. Dsg to sacral area remains c̄ 8cm circumference. Packed c̄ w-d dressing. CDI. Pt is currently on (R) side

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. ICU2

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)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Oct 05 1200	necrotic tissue gone. Washed area c̄ saline. gently patted dry. Wound bed pink and soft, no bleeding or lesion open. Wound size 4.5 cm long x 4 cm wide. Wound fragile - need to prevent from ~~pt~~ abrasion or rupture - Compeel drsg applied. Cleaned abd. suture line. Sutures need to be removed. Yo ↑ pain while doing wound care. Washed ~~the~~ incision site c̄ soap & water. Rinsed & patted dry. No exudate or signs of infection noted. Need to keep sacral region off the mattress by turn head side to side - continue turn q 1° Monitor for non-blanchable erythema
1215	pt appear comfortable @ this time. pt Yo abd. discomfort. ——— Offered lunch. pt refuses to eat. Making faces of total disgust! pt not happy with menu selection (b)(6)-2 [redacted] MAJ
1855	Received report from SGT [redacted] (b)(6)-2 Pt awake and on (L) Side. Pt eating dinner @ this time VS. 98.3 89 125/64 18 100% RA. Will continue to monitor pt [redacted] (b)(6)-2
1930	Pt ate ½ chicken & slices bread. Poor appetite. Does not like food. Will continue to mon [redacted] (b)(6)-2

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
270403 1130	pt awake: requesting something to drink offered water. pt is a total care. unable to move LLE 2° to paralysis. Repositioned every 1hr. side to side. pt continues to stool. Changed linen x 3 within 30 minutes due to liquid brown stool. Sacral dsg is done. Removed old dsg. Stage IV pressure ulcer that is approximately 10cm long x 8cm wide x 4cm deep & 2cm deep tunneling noted to 9° clock position. Cavity bone visible. Wound bed moist & foul odor or exudate. Wound bed pink & healthy granulation tissue present. Wound irrigated & sterile saline (b)(b)-2 [redacted] wound packed loosely & wet to dry dakin's ½% solution. dry 4x4 applied over dsg. and secured it & clear op-site dsg. to keep dsg moist and keep stool from leaking into wound bed. Coccyx region. Stage II pressure ulcer noted. Removed old dsg. 80% of dry crust - cont

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
	LAST	FIRST	[redacted]
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	[redacted] RECORDS MAINTAINED AT MHATA (b)(b)-2	

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)(b)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 OCT 03	REO Duoderm (+) occipital area prulent fluid noted to scalp: old dsg. Round wound ≈ necrotic area to middle. Cleaned. New duoderm applied. New duoderm applied x3 areas to (R) chest wall - pt had x2 Ensure ≈ meals. Other complications (b)(b)-2 [redacted]
28 OCT 03 1530	Received care of pt. @ this time. Pt. lying on (R) (L) side. Pt. has drainage to (R) hip - DRSG covered with bandage to sacral area. Pt. had a BM which was cleaned up. Pt. turned to (R) side + DRSG d'd with a loose packing, wet with 1/4 strength Dakins solution. (b)(b)-2 SPC [redacted]
2215	Pt. rolled over onto ABD @ this time (b)(b)-2 SPC [redacted]
29 OCT 03 0615	- Received Pt asleep in ⊂⊃ c/o pain or discomfort. PT is npo for surgery. Pertb 2mm Brisk. PT A+O x3. Breathing on clear Bilateral ⊂⊃ Respiratory distress. equal rise + fall of chest. BS x4 ⊂ loose stools. ⊂⊃ Abdominal distension noted. Scrotal size in N.D Abdomen is tender to touch. PT has foley cath to gravity drain clear colored urine - foley intact. Capillary NSR +2 Pedal edema on ↓ Extremities. (+) Pedal (+) Radial pulse. Slightly cap ref +3 sec throughout. Will cont to monitor PT for comfort. (b)(b)-2 [redacted]
1600	- Excoriated areas noted (R) lower calf. Will cont to monitor. PT spills up small amts of clear colored sputum. Will cont to monitor. PT is still npo for surgery. (b)(b)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0400	DRESSING CHANGE TO COCCYX DECUB STAGE III ULCER. IRREGULAR WOUND MARGINS C̄ TUNNELING TO UPPER PORTION OF WOUND. DEBRIDEMENT C̄ DAKINS SOLUTION EFFECTIVE AS A RESULT GRANULATION TISSUE IS PRESENT THROUGHOUT AND SLOUGH IS REMOVED C̄ EACH APPLICATION OF DAKINS. COCCYX SEEN AND AREA AROUND COCCYX C̄ (+) GRANULATION TISSUE. Ø NECROTIC TISSUE NOTED IN WOUND BED. PT TOLERATED WELL AND C̄ DIFFICULTY. PT TURNED Q 2° HOURS TO AVOID PRESSURE TO DECUB. PLAN CONTINUE C̄ DRESSING CHANGES AND NOTE WOUND BED. [redacted] (b)(6)-2
0800	[redacted] Dsg Δ to Coccyx X 2 daily - irregular wound Borders - granulation tissue present undermining to (R) side of wound - wound packed c̄ 1/4 Iodoform baseline c̄ Dry 4X4 dressing placed to same area - pt had three loose Bowel movements during 1° hr - New IV started to (R) arm - 20G old IV removed. to (L) OC - Medicated PRN c̄ MSW: percocet for pain - Bed Bath given: Foley Care and ROM exercises to (B) LE - pt instructed to use Bands for strengthening cont [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Pt dressing to coccyx changed. Packing c̄ slough melodonus and blood @ periphery of wound. Pt continues to have irregular wound margins (+) granulation tissue to area. Dakins Solution 4x4 applied and tegaderm placed over top of wound. Will continue to monitor pt [redacted] (b)(6)-2
30Oct03 0400	Wound care note: Dsg Δ'd to coccyx packed W→D c̄ ¼ Dakins sol. Pink granular tissue to edges, old dsg noted to have mod amt. yellow slough on dsg. Dsg covered c̄ tegaderm. Medicated for pain prior to Δ'ing dsg. Placed on (R) side. VSS will monitor. (b)(6)-2 [redacted] /LPN
0400	Assumed care of pt @ 0400 from LPN [redacted] (b)(6)-2 Pt turned to side per WOCN. VSS. (b)(6)-2 CPT [redacted]
0400	Neuro alert, oriented, easily arousable when asleep. PERRLA, EOMI, tracks people around the room. More UE (R) weaker than (L). Physical therapy stretch bands to siderails. Uses TID/PRN. Resp clear to auscultation, slight rhonchi to ul lat. Clears c̄ cough. Old trach wound healing c̄ dry dressing placed c̄ tegaderm BID. Greenish-yellow sputum noted @ drsng Δ. RR even/unlabored. CV SR/SZ HR 90's, [redacted] 100 100/50's UE pulses 2+, LE pulses 1-2+. All extremities warm. (b)(6)-2
	GI/GU BS to LUQ/LLQ. Ulta (R) quadrants d/t drsng. Colostomy to LLQ c̄ pink-red liquid drainage. Reg diet to resume today per MD post surgical orders. Tolerating Reg diet w/o N/V @ this time. QS U/O via FTG. Midline incision/covered/serosanguinous drainage noted + reinforced.
	This AM (Interp) Stg IV sacral decubs, Stg 1-2 occipital decubs c̄ comfort. cont. CPT [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) [redacted]

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29Oct03	Brief OR note Pre Op Dx - Double Ulcer Post Op Dx - Same Procedure - Exp Laparotomy Simple Repair 15mm Surgeon - [redacted] (b)(6)-2 Anes GET Findings - Small Bowel Adhesions. Enlarged Sigmoid Colon Complications ∅ EBL 200 ml [redacted] (b)(6)-2
2000	Pt returned from OR. Pt sleepy but easily arousable. Pt 2L NC SaO2 100%. VS. 101 129/64 19. Pt S/P colostomy. Pt tolerated procedure well per anesthesia. Pt Tmax 97.9. Will continue to monitor closely. [redacted] (b)(6)-2
2200	Pt turned to (L) side c̄ (resistance ~~complaints of pain~~) pt became aggressive and then medicated c̄ 4mg MSO4 for ↑ HR and pain verbalized by pt. Pt stoma colostomy beefy red c̄ (+) blanching c̄ quick return. Small amount of bloody drainage in ostomy bag. No stool noted or flatus.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 OCT 03 2105	Pt c/o pain to sacral area. Received II tabs Percocet PO for pain. Will monitor for effectiveness. — SPC [redacted] (b)(6)-2 /1WM
LE 30 OCT 03 1800	Assumed care of pt @ 1800. VSS, afebrile. A+OX3. PERRL, 3mm. Pt has decub. to back of head c̄ duoderm dressing applied. Mucous membranes moist. Pt tolerated 25% of Reg diet c̄ Ensure. Pt refused Ensure @ this time, will encourage @ a later time. Pt has 2x2 dressing c̄ opsite to neck, CDI. Pt has lung sounds [redacted] (b)(6)-2 CTA bilaterally, apex to base. PR equal + unlabored. O_2 Sat 100% RA. BS active x 4 Quadrants. Ø tender, Ø distended. Pt has healing midline incision, Ø drainage noted, open to air. Pt has colostomy to UQ c̄ moderate red/brown drainage. Pt has foley to gravity draining clear, yellow urine >30 cc/hr. Pt has stage 4 decub to sacral area + coccyx c̄ Kerlix wet-to-dry, Dakins 1/4, dressing c̄ opsite. Δ ing TID. Pt has DuoDerm dressing to (R) hip. Pt has Opsite to (L) thigh on a 2x4 area from graft site. Pt has 2 wounds to (L) shin 2x4 horizontal, open to air. Pt has small wound to (L) ankle, open to air. Pt has complete ROM to BUE. Pt has No feeling or movement to BLE. Turning Q1°. ~~Will~~ [redacted] (b)(6)-2 Pt has IV to (R) ac, 20G c̄ LR @ 75cc/hr. Will continue to monitor for Δ's. — SPC [redacted] (b)(6)-2 /1WM
30 OCT 03 2100	Dressing Δ done c̄ 1/4 Dakins solution, wet-to-dry. Loosely packed c̄ Kerlix pads + covered c̄ opsite. Stage IV c̄ tunneling to (R). Will continue to monitor for Δ's. Next dressing Δ due @ 0400. — SPC [redacted] (b)(6)-2 /1WM6
31 OCT 03 0015	Pt VSS, temp 100.2°. Turning Q1°. Med x1 c̄ II Percocet PO this shift. Dressing Δ'd. Will continue to monitor for Δ's. — SPC [redacted] (b)(6)-2 /1WM6
0300	Pt IV to (R) ac D/c'd by pt movement. New site started to (R) hand, 20G c̄ LR @ 75cc/hr, will continue to monitor. — SPC [redacted] /1WM (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30Oct03	cont. midline abd incision dta c̄ sutures removed. multiple
0900	(R) chest drg ll decubes c̄ comfeel over site. LLE-thigh
	graft donor site c̄ tegaderm over - CDI, LLE Shin, lateral
	dta, graft site. Some scabbing noted. drnes (R) AC PIV, 18g
	intact. placed 28-29 Oct.03. MIVF @ 75cc/hr. POC: IVMG
	turn Qhr, Adv diet as tolerated, hygiene, drsng ll
	pain mngmt. VSS ——— CPT [redacted] (b)(6)-2
0930	Trach site cleansed c̄ NS p̄ ventral lg ald drsng.
	New 2x2's placed c̄ Tegaderm covering site.
	Dated + labeled. ——— (b)(6)-2 CPT [redacted]
1200	Wound care: Sacral drsng Δed @ 1030 this
	am. Granulated tissue developing. No foul odors.
	No new tunneling noted. Wound margins definable.
	Cleansed c̄ 1/4 Dakins solution, wet to dry drsng placed
	into wound, then tegaderm placed to seal the wound.
	No drainage noted from site. VSS. Percocet, two
	tabs + 5mg MSO4 IVP given for pain. (b)(6)-2 CPT [redacted]
1600	Pt has had uneventful day - Turned per protocol.
	Ate very little Bfast, but had a snack + ensure drink
	abt 0900/1000. Ate 50% lunch c̄ snack @ 1600 of crackers
	and water. Drsng's Δed: 40 QS. VSS. Afebrile. (b)(6)-2 CPT [redacted]

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. ICU 2

[redacted]
(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont.) Restraint x1's skin integrity or circulation issues. Will monitor pt's status & provide emotional support. Will provide pain control meds. [redacted] (b)(6)-2 MOS
10/31/03 2135	Duoderm placed to (R) inner knee for Stage I (1) pressure areas. Old (R) leg wounds healed. [redacted] (b)(6)-2 MOS
10/31/03 2148	Back of head pressure wound drsg Δ'd. Wet to dry drsg & 4x4 on top then fluffs & loose stockinette. [redacted] (b)(6)-2 MOS
1NOV03 @0515	Pt (+) BM (through anus), liquid & brown, similar to colostomy output. Pt turned Q2° throughout night. Foley & good urine output. Will monitor [redacted] (b)(6)-2
1NOV03 @1630	Assumed care of pt. @ 0600. V.S.S., A&O, W → D DRSNG Δ to stage IV decub. to sacrum, 7-8 cm wide, 4cm deep, tunneling to (L) side of decub. 25% DAKINS solution, 75% NS to Kerlix Super Sponge, topped c̄ Combine DRSNG. DRSNG Δ'd @ 0800 & 1600. Colostomy bag Δ'd & DRY DRESSING to midline abdominal incision Δ'd. Stoma approx. 2cm to (L) of midline incision. Stool was leaking into wound due to its close proximity to stoma & Q2° turning. MD informed. Staples & penrose drain to midline incision intact. Betadine swabs applied to incision site during DRSNG Δ @ 0800. Vaseline gauze & DRY Gauze to old trach site intact. IVSL to (R) arm, flushes well. (+) BM per rectum this AM. Duoderm to hips & knees intact. Pt. in 2-point restraints, Ø signs of skin breakdown, ~~other assessments WNL~~ [redacted] 2-3+ edema to LE, bilat. Foot of

(b)(6)-2

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2030	PT TO BE TRANSFERED TO ICW 2. AWAITING M.D. ORDERS
31 OCT 03	@ THIS TIME. PT C VSS. NAD. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
2145	PT TO TRANSFER TO ICW 1. REPORT GIVEN TO MAJ RAIGE. PT VSS.
31 OCT 03	NAD. @ THIS TIME. PT WILL BE MOVED IN HOSPITAL BED PER MD
	ORDER [redacted] (b)(6)-2
31 Oct 03	Pt to ICW #1 from ICU #2 via hospital bed.
(b)(6)-2 0900 [redacted]	VS T 99.2 (A), P 92 R 20 B/P 124/61, RA Sat 97%.
2100	A&O. Able to make needs known. HRRR. Resp
	equal & regular. GI - Abd soft. (2) flank colostomy
	c loose light brown stool. Same also anal. Diaper
	placed. GU Foley c large amount of dark tea colored
	urine. Skin warm. Moist stage III wound x 2 c
	duoderm to upper (R) chest wall. Stage III (3) pressure
	ulcer c eschar and yellow drainage to back of head.
	Duoderm in place. Stage I (1) pressure area to (B)
	lips. Duoderm intact. Stage IV (4) pressure ulcer
	to coccyx c moderate yellow drainage. 4x4 dsg c opsite
	intact. Old healed midline abd wound. IV to (R)
	hand HL & patent. (B) feet +1 pitting edema.
	Trach site dsg D&I & vaseline gauze applied. Hygiene
	care done & pt placed on (L) side. Side rails ↑ x 4.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31OCT03	- Received PT in bed c̄ ⊖ c/o pain or discomfort. PT AAO
0630	x3 thru translator. Perrla 2+ Brisk. PT has ⊖ ROM or sensation to ↓ Extremities. PT does have full ROM c̄ ⊕ Pulse motor function to (R) hand. (R) hand PT has ROM c̄ Asst from (L) hand. PT is able to grasp objects bilaterally. Bilateral rise + fall of chest c̄ slight coarse breath on Inspiration on (R) lower lobe. ⊖ Respiratory distress noted. PT SpO^2 is 92% on RA. BS x4 ⊖ Abdominal distension noted ⊖ Rebound tenderness. NSR 80's. Bilateral Pedal + Radial pulses present. Thready. CAP ref +3 sec Throughout. Skin is warm to touch. Lower extremities have +2 pedis Edema noted. Back of occipital head has stage 2 ulcer c̄ DUODERM in place. 2x2 inches of tissue size CDI. MIDline abdominal incision dress size CDI c̄ ⊖ S/S of infection. Stage 4 in Coccyx area is CDI. Will reevaluate later in Shift. PT has a small wound to left ankle open to Air. 20G IV in (R) hand c̄ LR @ 75 cc/hr infusing, site is not infiltrated c̄ ⊖ S/S of infection noted. PT is currently resting in bed. Will cont to monitor [redacted] (b)(6)-2
0632	-late entry PT also has Foley to gravity drain clear colored urine. Colostomy bag [redacted] (b)(6)-2 to ⊕ Flank draining red/Brown drainage. Ø drainage @ This time. Cont to monitor. [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS**

DATE	NOTES (b)(2)-2
1 NOV 03	Transfer during [redacted] 23yo GSW to (L) Back Exiting Right Lower chest, xfly [redacted] right chest tube placed, left femoral grade IV liver laceration Packed and transferred to [redacted] Pack removed 24° later. Patient (b)(2)-2 comes remarkable for coma suggestive Anoxic Brain injury which cleared. Treated with G-tube and Trach which partial exclude the diaphragm. Developed large Decubitus regions with debridement and to saw. Brevity Colostomy performed 29 October to help with prevent wound care.
	Dx- S/P GSW Abd with good IV liver laceration T12 paraplegia Respiratory Failure - treated with G-tube and trach which resolved Sacral Decubitus ulcer requiring debridement to sacrum and Brevity Colostomy Plan transfer Care to [redacted] (b)(2)-2

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	[redacted]
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		

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

REGISTER NO. [redacted] | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	ME	MIDDLE	ID NUMBER

DATE	NOTES
	Medication 1) Flagyl 500mg IV Q8° for 7 day for colitis
	2) Prenatal Vitamin QD
	3) Heparin 5000 U SQ BID
	4) Percocet PRN.
	Nursing - Rollpatrol Q2°
	Wet to dry dressing to Decubitus w/
	1/4% dakin's solution three times a
	day.
	Rectal osbyg care.
	(b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	ST NAME	INI	ID NUMBER

DATE	NOTES
2 NOV. 03 0915	Pt. A&O x 3, V.S.S. Assessment complete. W-2 D to Stage IV decub Δ'd @ 0830. Pt. given ii Percocet for pain @ 0820. No Δ's from previous assessment. Pt. to be transfe to ICW 2. [redacted] 2CT, AN (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
CONT. FROM 1 NOV @ 1630	bed elevated. Foley draining clear amber urine c̄ foul odor. Pt. turned Q2°. DRY DRSNG to stop ⅓ decub to occipital aspect of head. Pt. to be transferred to [redacted] (b)(2)-1 All other assessments WNL. (b)(6)-2 [redacted] 2LT, AN
2NOV03 @0300	assumed care of pt @ 1800. VSS - c/o pain to abd & back continuously, though relief noted c̄ percocet. LS CTA, old trach stoma covered c̄ vaseline gauze dsg, CDI; productive cough noted, IS encouraged. NL drsg c̄ penrose drain, CDI. (L) LQ colostomy intact, brown liquid stool noted. Tol reg diet, but does ∅ like food, encouraged treat. (BIL) LE edema +2 noted, legs elevated c̄ bed, ⊕ PP (BIL) equal. Foley draining amber, foul smelling urine; Sacral Stage IV decub c̄ Dakins soaked dsg Δ beefy red granulating tissue noted. Stage I [redacted] decub to (BIL) hips, (bil) inner knees. Occipital lobe Stage III decub c̄ WTD dsg noted, stretch cap on to secure dsg. Duoderm placed on hips & knees. Blanket roll b/w knees for support. Pt turned Q2° & positioned anatomically correct. Restraints removed. Pt EPW status Δ to CIV status. Plan: enc po, turn Q2°, monitor skin integrity, cont dsg Δs as ordered. will monitor [redacted] RN (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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