MEDICAL RECORD - ANESTHESIA

For u[illegible] his form, see AR 40-66; the proponent agency [illegible] OTSG

NKDA

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML; "I" = CONSTANT INFUSION)													
DRUG (Units)													
Fentanyl (500) mcg													
MSO4 (10)			3			2							
UCB (30)				5							5		
Midazolam													
Decadron (mg)		10											
VOLAT AGENT % del / % e.t.	1.8 2.0	1.8	1.8	1.3	1.8	2.0	1.5	1.8	1.5	1.3	1.3		
AIR L/Min													
N2O L/Min													
O2 L/Min	2 1	1	1	1	1	1	2	2	2	2	2		
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS													

TOTALS	TOTAL EBL
20	See
TOTAL URINE	
PG	

FLUIDS SUMMARY
CRYSTALLOID- 1
COLLOID- 500mL Hespa
BLOOD-

FLUIDS
LINE site 18g (R) AC Warmed — 5000 (R#7, L#6) — 600 — 6500 — 7000
18g (L) AC Warmed
Warmed
Warmed

LOSSES
EST BLOOD LOSS 200 — 300 — 400 — 100
URINE - 2200 — 3200 — 3550 — 3800 — 3900

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA: BP PG HR 1

EQUIP CHECK OK? Y N

PATIENT ID CHECK

OK TO PROCEDURE? TIME

TIME 130 x 1200 x 30 1300 x 30 1400 x 30

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

	1200	1300	1400
pH	7.34		7.34
pCO2	41.1		42.7
pO2	419		522
HCO3	23		23
BE	-2		-3
Na	142		139
K	5.6		4.9
Cl	115		111
Ca	1.28		1.40

VENTIL

	130	200	230	300	330	400	430	500	530	600	630	700
VT - ml	640	800	700	760	780	670	680	750	680	870	920	820
f - breaths/min	8	9	10	9	10	10	10	10	10	10	10	10
Peak inf pres / PEEP	28	30	30	30	27	29	35	38	29	28	28	38
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C
MONITORS/ACCESSORIES: BP/Auto Cuff — ET CO2 (torr)	30	32	33	35	33	35	35	35	35	33	33	33
BP/oth — FIO2 (Frac or %)	0.76	0.76	0.76	0.75	0.76	.76	76	.76	0.76	0.76	0.76	0.76
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG=PAC's	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP-site	[illegible]											
N-M Block (T/4)	0/4	X	—	—	1/4	0/4	—	0/4	0/4	0/4	1/4	0/4
Warming blkt	✓ x1 Blanket											
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (4) (5) (6)

REMARKS
Code drugs with numbers, events with letters
- Threatpack in [illegible]
- TP out 1453
- Dr. [redacted] [illegible] the [illegible]
- (4) Zofran IV
- (5) Banks count incorr
- Ark report given —
- (6) LR fluid

66-2

RECOVERY AT
PACU CU (Specify) See
OTHER
CONDITION PG #
RESP. SpO2
BP- HR-

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: PG (1)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

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

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical [illegible]

[redacted]

CIV

SURGEONS: [illegible]

[redacted] CRNA/MAJ

PROCEDURE LOCATION: Trauma

DATE: 2 Sept 03

PAGE 2 OF 3

MEDICAL RECORD - ANESTHESIA

For u[illegible] his form, see AR 40-66; the proponent agency OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG (Units)							
Fentanyl 500 (mg)							
MSO4 [15] (mg)		2			3		
URO [40] (mg)				5			
Midazolam 2 (mg)			1	1	1.27	1	
( )							
( )							
VOLAT AGENT: ISO % del / % e.t.	1.4	1.4	1.4	1.4	1.4	1.4	
AIR L/Min							
N2O L/Min							
O2 L/Min	2	2	2	2	2	2	

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

FLUIDS

LINE site							
18G (R) AC ☒ Warmed	800		800				
☒ Warmed							
☐ Warmed							
☐ Warmed							

LOSSES

EST BLOOD LOSS	400	500					
URINE -	300						

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT See KG LB

HEMATOCRIT: PG

INITIAL DATA

BP- #1

HR- 1

EQUIP CHECK OK? Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

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

TIME → 1430 x 1500 x 30 x 1600

	1430	1500	30	1600
pH	7.34	7.34	7.40	
PO2	334	334	4.0	
PCO2	431	431	4.3	
HCO3	23	23	20	
BD	-2	-2		

VENTIL

VT - ml	900	790	750	920	930	700
f - breaths/min	10	10	10	10	10	10
Peak inf pres / PEEP	28	28	29	28	28	
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	34	33	35	35	35	
BP/oth	FIO2 (Frac or %)	0.76	0.76	0.76	0.76	0.76	0.76
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site available	→	→	→			
	N-M Block (T/4)	0/4	0/4	0/4	1/4		0/4
Warming blkt	x1 Blanket	→					
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS → *Position* (7)

TOTALS — TOTAL EBL: See

TOTAL URINE: PG

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID- #

BLOOD- 1

REMARKS

Code drugs with numbers, events with letters

(1) 2455658 PRBC

(5) Xeroform gauze packed to rectum by the surgeon

(8) TO ICU-2 via Litter, RPO SaO2 monitor Report to RN Suctioned Cricothyroidotomy for moderate blood, secretions FiO2 70% SIMV +5 PEEP, 1:2 TV 800mL

RECOVERY AT

PACU ICU (Specify) OTHER See

CONDITION: RESP- PG SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
		1	
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

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

Iraqi CIV

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* See Pg 1

SURGEONS: b(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: Trauma

DATE: 2 Sept 03

PAGE 3 OF 3

DA FORM 7389, FEB 1998 MEDCOM - 1844 [redacted] COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDICAL RECORD - ANESTHESIA

Fr f this form, see AR 40-66; the proponent agen OTSG

ANESTHETIC AGENTS AND DRUGS																
CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION	DRUG	(Units)														
	Fentanyl	(mcg)	100	100												
	Versed	(mg)		2	3											
		( )														
		( )														
		( )														
		( )														
	VOLAT AGENT	150 % del	1.5	1.5	2.0	(6)										
		% e.t.														
	AIR	L/Min														
	N2O	L/Min														
	O2	L/Min	1	2	2											
	SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →															

FLUIDS																
	LINE site	☐ Warmed														
	LR Rs (L) AC	☐ Warmed														
		☐ Warmed														
		☐ Warmed														
LOSSES	EST BLOOD LOSS															
	URINE -															

TOTALS	TOTAL EBL
250	
5	min
	TOTAL URIN
	130

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 130/78 HR- 87

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Yes TIME- 0820

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

TIME → 0815 30 0900 30 1000 30 1100

VENTIL						
	VT - ml	560	440	600	610	
	f - breaths/min	12	12	12	12	
	Peak inf pres / PEEP	30	29	16	16	
	MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	

MONITORS/ACCESSORIES						
BP/Auto Cuff	ET CO2 (torr)	36			32	
BP/oth	FIO2 (Frac or %)	.68	.68	.68	.68	
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	SR			SR	
Gas analyzer	TEMP-site	Axilla				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT	0915
PACU ICU ____ (Specify)	
OTHER ____	
CONDITION:	
RESP- 10	SpO2- 100
BP- 135/49	HR- 73

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1800	0815	0925
	Ready	Begin	End
PROC	0825	0835	0905

PROCEDURES and CPT Codes: TRACH

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GEN

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* b(6)-2

[redacted]

PROCEDURE LOCATION: OR 1

DATE: 4 SEP 05

PAGE 1 OF

DA FORM 7389, FEB 1998 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 2 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Cricothyroidotomy
SURGICAL SERVICE: General, ortho, OF Surgeon
NPO SINCE:

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

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ?
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

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

133 | 20 | 7 (197
3.0 | 104 | 1.1
23.7 > 12.8 / 39.6 (332

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW Emergency

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
- kidney stone removed

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth open/chipped
Trachea
TMJ/Neck unable to
Oropharnyx
Nares
CHEST: Lungs CTA (B)
CARDIAC:
EXTREMITIES:
IV Access: 18G (R) + (L) Ar
Ulnar Filling:
BACK:
OTHER:

(-SW) - (L) lip (-SW) mandible laceration (R) thumb

NPO Since ____

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
Interpreter present in OR; Propofol + Fenta TTE, supior cricothyroidotomy
The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] b6-2 Date: 2 Sept 03 Time: 0803 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) b(4)-4
[redacted]
Iraqi CIV

SEDATION KEY:

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS (YRS) Sex (X) MALE ~~( ) FEMALE~~

PROPOSED PROCEDURE: TRACHEOSTOMY & MOUTH I&D
SURGICAL SERVICE: GEN & OMF
NPO SINCE: _____

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

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ? ZANTAC
( ) FENT
( ) VERSED
( ) DECADRON
( ) COPRESSOR PRN
( ) PHENERGAN PRN
TYLENOL PRN

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

LABORATORY STUDIES:

HB/HCT: _____ / _____
U/A: _____
OTHER: _____

10.6 / 7.3 / 22.8 / 174
H/O BLOOD INF'N 2SEP03
↑ GLU 139
↑ CREAT 1.3
↑ CK 622

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	(N)	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	CRICOTHYROTOMY
Bronchitis/URI	N	Y	
COPD	(N)	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	H/O RENAL STONES & (B) SURG
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
FACE REPAIR F GSW
(2) HIP REPAIR GSW } 2SEP03
EXP LAPAROTOMY

PHYSICAL EXAMINATION
BP 61 / HR 73 R 14 T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____ } SURG SITE
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ CRIC → TRACH
(X) General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b6-2

The patient/legal gua[redacted]derstand and agrees. Questions answered.
Signed: [redacted] Date: 04SEP 03 Time: 0655 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICU-2
CIV [redacted] [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.

Returned 14 Stat

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED (If applicable) _____ ML

REMARKS: [redacted] b(6)-2

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

b(6)-2

DATE REQUESTED 2 Sept 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE

G-SW

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

SIGNATURE [redacted] b(6)-2

DATE VERIFIED 2 Sept 03 807

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO 2455658

TRANSFUSION NO.

PATIENT NO bb-4

[redacted]

DONOR ABO B Rh POS

RECIPIENT ABO B Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: comp

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

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 2 Sep 03

REMARKS: b(6)-2

Exp - 4 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Hour) ~~1400~~ 1504 ON (Date) 2 Sep 03

IDENTIFICATION

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

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

2nd VERIFIER (Signature) [redacted]

TEMP 35 PULSE 86 BP 118/58

DATE OF TRANSFUSION 2 Sept 03 TIME STARTED 1503

POST-TRANSFUSION DATA

AMOUNT GIVEN all ML

TIME/DATE COMPLETED/INTERRUPTED 1515 9/02/03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
35	88	125/61

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

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

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

SIGNATURE OF OPERATOR [redacted] CRNA/MA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, First, Middle Initial; Date of birth; Sex; Hospital or medical facility)

SEX Male

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

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 18446

Medical Record Copy

NSN 7540-01-165-7294

591-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography)

EXAMINATIONS (S) REQUESTED

Portable CXR in A.M.

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
			ICU	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED Dr [redacted] b(6)-2

TELEPHONE/PAGE NO.

[redacted] rpt

DATE REQUESTED 1 SEP

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

Intubated

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

RADIOLOGIC REPORT

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

CIV

[redacted]

b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1—MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 Sep 03	Surgery of Note
	Pre-op Dx: Severe facial trauma & Respiratory Distress
	Left flank wound + right 2nd digit wound
	Proc: Emergent Cricothyroidotomy & placement of #4 Shiley trach
	ex-lap + G-tube / washout of flank & I+D
	Findings: NBO ex-lap
	EBL:
	Fluids: 8500 crystalloids, 500 colloid
	UO: 3900
	Complications: Ø
	Patient stable at end of case. Dr [redacted]
	operates on facial trauma
	Surgeons: [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.

#[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 USAPA V2.00

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 1CM2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 2 SEP 03 TIME OF ORDER: 1545 HOURS

LIST TIME ORDER NOTED AND SIGN

1 - ADMIT TO ICU
2 - NPO
3 - VS q1°
4 - I/O q1°
5 - G-TUBE TO GRAVITY DRAINAGE
6 - CHART G-TUBE DRAINAGE
7 - ABG ROUTINE TRACH CARE

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

8 - BED-REST HOB 0-45°
9 - MSO4 1-5 mg q1° PRN PAIN
10 - Ativan 2.5 mg IV q6° PRN NAUSEA
11 - ZANTAC 50 mg IVPB q8°
12 - ANCEF 1gm q8° IVPB
13 - CXR ADMIT q AM + ON ADMIT
14 - CBC, PT/PTT q AM + ON ADMIT

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4 1CM2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: & q AM TIME OF ORDER: HOURS

15 - ~~fentanyl~~ & versed drip titrate to effect
16 Tv 750 SIMV 16 peep 5 FIO2 70%
17 Lopressor 2.5mg IV PRN to maintain Doctor's Order
18 ~~Vecuronium~~ (KA)

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 2 Sept 03 TIME OF ORDER: 1950 HOURS

1 Decadron 10mg IV x 1 dose now then decadron 8mg IV x 2 doses then decadron 4mg IV x 2 doses then D/C [decadron q8°]

[redacted] b(6)

Note 2 Sep 2003

Ø38

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

b(6)-2 A11

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE AND SIGN EACH SET OF ORDERS. IF PI[illegible] W ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM N[illegible]ER IN COLUMN INDICATED BY ARROW BE[illegible]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
2 Sept 03	2300 HOURS	
① Tylenol Tgm PRN q4° PRN		
② D5 @ 125cc/hr maintainence		
[redacted]		

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

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
3 Sept 03	0015 HOURS	
① Δ vent Setting SIMV 14		
TV 750 FiO2 40% peep 5 [redacted]		
repeat ABG in AM		
V.O. Dr [redacted]		
[redacted]		

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

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
3 Sept 03	0815 HOURS	
1- TV to 700 ✓		
2- [illegible] vent		
3- [illegible]		
4- clean [illegible] wounds		
c̄ H2O2 + Saline +		
replace Lactracin		BID

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

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDE[illegible]	
3 Sep 03	[illegible]RS	
1- ABG	[redacted]	

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

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
3 Sep 03 @ 0909	Brief OP NOTE
	Pre OP dx: GSW to face c̄ cricothyroidotomy
	Post OP dx: Same
	Procedure: tracheostomy + EUA
	Surg: [redacted] b(6)-2
	Anesth: General
	U/O: 130cc
	fluids 500cc LR
	EBL: min
	comp: Ø
	Condition: stable remained sedated + transferred to alcu on proper monitors, ⅋ esmt. 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

PROGRESS NOTES

Medical Record

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

USAPPC V1.00

b(6)-2 unless noted differently

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] b(6)-4	4 Sep 03 0909 HOURS (1) Resume previous orders (2) 100cc q 4° hold for residual >100 - Jevity (3) Oral care BID (there is xeroform gauze in palate) [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
[redacted]	4 Sept 03 1040 HOURS (1) Wean pt to trach mask/collar ↓RR to 2 c̄ simv p̄ wean pt ~~off~~ off sedation. Keep SpO2 >93%. V.O. Dr. [redacted] CPT [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
	4 Sept 03 1040 HOURS (1) ABG p̄ wean to trach collar V.O. Dr. [redacted] CPT [redacted] CPT [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
	5 Sep 03 0900 HOURS (1) Okay for sips of water + clears CPT [redacted] [illegible] note	
NURSING UNIT / ROOM NO. / BED NO.		

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
530203	Surgery
	Pt [illegible] well - Awake + Alert
	CNS: Follows commands
	Lungs: ETT 30% Trach mask O2 SAT = 100%
	7.47/40/213/30/6/100%
	CVS: HR 103 132/76
	Abd: Soft, NT, ND (+) BS
	Renal: 129/107/13/4.0/21/1.1 <156 I/O IV 125cc/hr 236 OUT
	Heme: 10.7/23.5 (8) 214
	Inpt: STABLE
	Plan: TP Tev.t 400cc 94°
	IVF TO 50cc/hr
	cont labs

b(w)-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.

PROGRESS NOTES

Medical Record

[redacted]

b(w)-4

MEDCOM - 18453

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE AND SIGN EACH SET OF ORDERS. IF P... M ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM N... ER IN COLUMN INDICATED BY ARROW BE...

PATIENT IDENTIFICATION

[redacted] b(6)-4

DONE/noted

NURSING UNIT | ROOM-NO. | BED NO.

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

5 Sep 03 — 1500

1 - IVR TO 50cc/hr

2 - Jeanty 400cc q 4 hours

b(6)-2

5/9/03 1500

[redacted]

PATIENT IDENTIFICATION

CIV # [redacted] b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 1

DATE OF ORDER | TIME OF ORDER | HOURS

4 Sep 03

1 - Tylenol ~~Tylenol~~ OCF

2. T3 [illegible] q 4 prn 2 tablespoons [illegible]

6 - TUB3

3. 1-5 mg MSO4 q 1° IVP PRN Breakthrough pain

4 - Hep-lock IV when [illegible]

[redacted]

PATIENT IDENTIFICATION

CIV # [redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 1

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] b(6)-2

PATIENT IDENTIFICATION

CIV # [redacted] b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 1

DATE OF ORDER | TIME OF ORDER | HOURS

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 Sep 03	Surgery Progress Note
	PT stable, Awake & Alert
	WL HR 90-120 129/85
	Lungs: CTA 31% Trache mask 7.42/47/142/31/6/89%
	Abd: soft, NT, ND (+) BS Tolerating Tube Feeds
	Renal: 132/104/12 / 4.0/24/1.5 154 I/O ~150cc/hr UO
	Heme: 8.0 / 30 9.7 / 243
	ID Tc 99' T- 99'
	Exp: stable s/p facial & abdominal ISO injury
	Plan: monitor Lab
	cont current management
	[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.

Civ # [redacted] b(4)-4

PROGRESS NOTES
Medical Record

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

b(4)-2 All unless noted otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE 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

H[redacted]

b(4)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Sep 03 TIME OF ORDER: 1202 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Δ pain meds to Roxicet elixir ~~percocet 1-2 tabs~~ [redacted] 5-10 ml per g tube q 6° prn pain

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Sept 03 TIME OF ORDER: 1322 HOURS

(1) D/C Roxicet Elixer

(2) Percocet ½-1½ tabs q 4-6° prn pN - CRUSH then give per G Tube

V.O. Dr [redacted]

CPT [redacted]

Verbal Order

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Sep 03 TIME OF ORDER: 1600 HOURS

(1) Benadryl 25-50mg IV q 4° prn insomnia

(2) Ambien 5mg per g tube crushed @ HS for insomnia if benadryl ineffective

CPT [redacted] (RN) 7/9/03 [redacted]

Verbal order noted

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] TIME OF ORDER: HOURS

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

b(6)-2 A11

CLINICAL RECORD

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	RE F. NG ACTIONS, ENCY, TIME	HR	DATE COMPLETED 2	3	4	5	7	8	9
2Sept	[redacted]	NPO	07	/	[redacted]					
			12	/						
			16							
2Sept	[redacted]	4/5 Q1°	06							
			18							
2Sept	[redacted]	HO Q1°	06							
			18							
2Sept	[redacted]	G-tube to gravity drainage	06							
			18							
2Sept	[redacted]	routine trach care	06							
			18							
2Sept	[redacted]	Bedrest, HOB 1 45°	06							
			18							
2 Sept	[redacted]	CXR QAM + on arrival	05							
2Sept	[redacted]	CBC, AT/PTT, + chem 7 on	05							
		arrival + QAM								
2Sept	[redacted]	vent settings: TV 750,	06							
		SIMV 16, TV 750, Peep 5,	18							
		FiO2 70%								
2Sept	[redacted]	NIO: Δ IV Tubing	06							
		Q72°	18							
2Sept	[redacted]	NIO: Δ IV site	06							
		Q72°	18							
2Sept	[redacted]	NIO: Foley care Q5	06							
			18							
3Sept	[redacted]	Vent settings: SIMV 14	06							
		TV 750 Peep 5 FiO2 40%	18							

Δ at 3Sept 03 JK

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Cricothyroidotomy / Chip I+D / closure of mouth wounds / open gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A11

Verify by initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo SEP Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 Sept	[redacted]	Admit to icu	2 Sept	—	1630	[redacted]
3 Sept	[redacted]	↓ TV 700	3 Sept	[illegible]	1100	[redacted]
3 Sept	[redacted]	Amio	3 Sept	1/2h	1110	[redacted]
3/9	[redacted]	wean sedation	3/9	cont	cont	[redacted]
3/9	[redacted]	wean vent	3/9	cont	cont	[redacted]
4/9	[redacted]	Resume all previous orders	4/9	0909	0900	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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b(6)-2 7/1

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10
3/9	[redacted]	Clean face wounds c̄	[redacted]								
		H2O & saline + Replace	18								
		Bacitracin BID									
			/	/							
4/9	[redacted]	ORAL CARE BID	06	[redacted]							
		(Onnes & eroform gauz	18								
		on palate)	/	/	/	/	/	/			
4/9	[redacted]	Wean pt to trach collar-	06	/	[redacted]						
		mask. ↓RR to 2 c̄ simv.	18	/							
		F̄ weaning pt from sedation.	/	/	/	/	/	/	/		
		Keep SPO2 >93%.	/								
5/9	[redacted]	OKAY FOR SIPS OF	06	/	/	[redacted]					
		water & clears	18	/							

D/C. 9 Sept 03

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
CNDA	S/P Chicothyradectomy / Ⓛ hip F/D / Closure of mouth wounds / open gastrostomy /	PAGE NO:

PATIENT IDENTIFICATION:

I/C # [redacted]
254.0.0 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 _____ Yr 2003
Order Date	Clerk Nurse	b(e)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4/9	[redacted]	ABG p pt on trach collar	4/Sept			
	- - - - -					
	- - - - -					
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

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. 8 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9
7Sep	[redacted]	Nursing order:	08	[redacted]		
	b(6)-2	clean trach. tube	16		b(6)-2	
b(6)		q 8°	24			

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

CTV [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 A1

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. SEP Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	1
2Sept	[redacted]	Zantac 50mg IVPB Q8°	08	[redacted]								
			16									
			[redacted]									00
2Sept	[redacted]	Ancef 1gm q8° IVPB	08									
			16									
			[redacted]									
2Sept	[redacted]	Fentanyl gtt, titrate to effect	06									
			18									
2Sept	[redacted]	Versed gtt, titrate to effect	06									
			18									
2Sept	[redacted]	Decadron 8mg IV x2 doses Q8°	04			X						
			12			X						
2Sept	[redacted]	Decadron 6mg IV x2 doses Q8°	20			X	X					
			04				X					
2Sept	[redacted]	LR @125 cc/hr	06									
			18									
4Sept	[redacted]	JEVITY 100cc Q4° hold for residuals >100	08									
			12									
			16									
			20									
			24									
			04									
5Sept	[redacted]	JEVITY 400cc Q4hr.	08									
			12									
			16									
			20									

D/C 6Sep03

D/C 5Sep03

D/C

Permanent

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Cricothyroidotomy / Chest tube / closure of mouth wounds / Open gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. _____

PATIENT IDENTIFICATION:
#[redacted]
b(6)

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. SEP Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25Sept	[redacted]	Decadron 10mg IV x1 now	25Sept	2000	2000	[redacted]
6SEP03	[redacted]	TITRATE FENTANYL OFF	6SEP	7SEP		[redacted]
6SEP	[redacted]	HEPLOCK IV WHEN ABLE	6SEP	7SEP 05		[redacted]
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25Sept	[redacted]	Lopressor 2.5mg IV prn maint. Diastolic <90 Q1°	25Sept 1810													
25Sept	[redacted]	MSO4 1-5 mg IV Q1° prn pain	[redacted]	Reviewed, See below												
25Sept	[redacted]	Phenergan 25mg IV Q6° prn-nausea														
25Sept	[redacted]	Tylenol 1gm PR Q4° prn	25Sept 2050	[redacted]												
6Sep	[redacted]	MSO4 1-5mg IV q1° PRN PAIN	6Sep 1430 4mg	[redacted] NEW ORDER See Below												
6SEP 03	[redacted]	T3 ELIXIR q4hrs PRN 2 teaspoons	7Sept 0600 10cc	7Sept 1200 10cc	7Sept 2115 10cc	8Sept 0430 10cc										
		THROUGH NG-TUBE	[redacted]													
6SEP	[redacted]	MSO4 1-5mg IVP q1° PRN	25Sept 1830 4mg	25Sept 2330 4mg	6Sep 0130 8mg	7Sept 03 3mg	7Sept 0610 3mg	7Sept 0740 2mg	7Sept 0810 4mg	7Sept 1200 4mg	7Sept 1450 5mg	7Sept 1850 5mg	7Sept 2030 5mg	8Sept 00 5mg	8Sept 03 3mg	
		BREAKTHROUGH PAIN	[redacted]													
		Percocet 1-2 tabs Q4-6°														
		prn pn-crush-give	7Sept 1600													
		per GT	[redacted]													

USAPA V1.00

b(6)-2 +11

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. SEP Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8
5Sept	[redacted]	Jevity 400cc Q4°	08	/	[redacted]		
			12	/			
			16	[redacted]			
			20				
			24				
			04				
			/				
5Sept	[redacted]	LR @ 50cc	06	[redacted]			
			18				
			/				

ALLERGIES: ☐ YES ☐ NO

KNDA

PRIMARY DIAGNOSIS: cricothyrodotomy (L) hip, H/o closure of mouth wounds, ~~[illegible]~~ open gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. SEP Yr. 03

Verify by Initialing: 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													
7Sep	[redacted]	Benedryl 25-50mg IV	7Sep 1600	7Sep 2300												
		Q4' PRN insomnia	50mg	[redacted]												
		Ambien 5mg per G tube	7SEP 5mg													
7Sep	[redacted]	Crush @ HS for insomnia	[redacted]													
		if Benedryl ineffective														
		b(6)-2 All														

USAPA V1.00

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 1/6 Initals: [redacted]
NEURO	Pupils	OD 2-3 unreactive / OS - 3mm - sluggish reactive	Ø react on to OD, sluggish reactive to LD
	Sensorium	Responds to opn stimuli	Responds to stimulation
	LOC / GCS	Sedated - Versed 5mg Fent 20mcg	Sedated versed 4mg - Fent 125mcg
CARDIAC	Cardiac Rhythm	ST c HR 107's - 110	ST, HR = low 100's
	PRI: / QRS:	- Ø ectopy noted -	Ø ectopy
	Pulse Strength	2-3+ @ UE/LE	2+-3+ x4 extremities
	Cap Refil / JVD	<3sec Ø JVD	<3sec x4 extremities / Ø JVD
	Edema	FACIAL - mandible R>L	Face - bilat mandible
	Chest Pain	NONE TO REPORT DIT sedation	Ø
		Ø EKG Δ's noted.	
RESP	Respiratory Pattern	Thyroid/cricoidotomy c #4 shiley -	cricoidotomy / equal rise & fall of chest
	Breath Sounds	cuffed = BBS - CTA Pao2 193% on ac vent	CTA
	Secretions	oral secretions @ trachinline	
	Cough	Ø cough. SIMV RR 14, TV 750	None. SIMV=14; P=5; TV=700
		FIO2 35%, PS SPO2 = 100%.	FIO2 - 35%
SKIN	Color	Brown - intact except for surgical clean	Normal
	Integrity	Facial incisions c sutures on (R)	Sutures to face, wound to abd, (R)
	Backside	mandibles c lip involvement: Nasal	thumb, and (L) Hip area
		packing + midline unc c CDI.	
IV	Access Devices	(R) AC c (L) AC (sq. (D) port line.	(L) IV AC, (R) IV AC, (A) line (L) Radial
	Location	DAC c fluid unf - using. (R) ac	
	Condition	WL - NPB / Patent	Ø Signs of infection
GI	Abdomen (D) hip	Flat, tenderness assumed d/t surgical	Dsg to Abd c reinforced dsg
	Bowel Sounds c CB, PA	unc. BS RLQ - hypoactive (-) to all	hypoactive x 4 quad.
	Stoma/Ostomy CDI	other quads. midline unc., CDI	GT to gravity, (L) upper quad
		Reinforced on pm shift: GT to Gravity	
GU	Device	Foley to Gravity.	Foley to gravity
	Color / Clarity	clear - yellow - urine - 100cc	clear and yellow urine
		MIVF @ 125cc	

PREPARED BY (Signature & Title): CPT [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 3 Sept 03

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

NAME: [redacted] b(6)-4

RANK: AGE:

UNIT: Police Officer

GENDER: male

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

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

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 1C Initals: [redacted]	Time: Initals: [redacted]
NEURO	Pupils	OD 2mm unreactive OS 23mm sluggish	Alert, responds to voice
	Sensorium	(+) sensation Sedated versed 4mg/	Sedated Versed @ 4mg/hr
	LOC / GCS	Fent 125mcg/ GCS:	Fent @ 75 mcg/hr
			Agitated + restless
CARDIAC	Cardiac Rhythm	NSR c RBB - cuffed HR 60's.	ST 110-120's ectopy SS,
	PRI: / QRS:	2-3+ pulses (B) ue/le. CR < 3sec.	Ø murmur 2+ pulses all extremities
	Pulse Strength	trace edema to body extremities	1+ edema, generalized, B/P
	Cap Refil / JVD	mostly. 2-3+ no (L) jaw - mandible	MAP 100-110's when agitated
	Edema	area c 2+ swelling (R) mandible area	
	Chest Pain	None to reports or s/s of.	
RESP	Respiratory Pattern	TRACH #8 Shiley cuffed, SIMV RR14	Trach #8 Shiley cuffed SIMV
	Breath Sounds	TV 700 FiO2 35%. PS. SPO2 100%.	14 TV 700 FiO2 35% peep 5
	Secretions	BLOODY - THICK secretions post OR.	sats 100%. HOB 75° per pt
	Cough	(+) cough - needs prn suctioning	request, sanguinous drng noted
			to trach + oral cavity
SKIN	Color	Brown. - warm	W+D norm for race
	Integrity	intact except (L) hip c sutures &	(R) thumb (L) hip dsgs CDI,
	Backside	penrose drng, abd midline - staples	midline abd staples intact,
		dra CDI, multi facial sut. + mouth sut	dsg to G-tube site CDI
IV	Access Devices	18g (L) AC 18g (R) AC (L) ART RADIAL	18G (L) + (R) AC patent Ø S/S infection LR @ 125 cc/hr
	Location		
	Condition	Patent. (R) AC HL - IVABX +	(L) Rad A-line circulated
		Q4° NS flushes	well c cuff pressure
GI	Abdomen	SOFT, Tenderness assumed,	Soft, tender BS (+) x 4 quads
	Bowel Sounds	BS to RLQ + RUQ. Ø BM.	G tube to gravity, Jevity
	Stoma/Ostomy	G Tube LUQ to gravity.	100 cc @ 4°
		DARK GRN LIQUID DRNG.	
GU	Device	Foley placed 2 Sept 03	Foley drng clyellow
	Color / Clarity	~100-200cc cyu.	
		HL F/O mouth wounds / Trach.	

PREPARED BY (Sign): [redacted] CPT

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 4 Sept 03

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

NAME: F/C H[redacted] RANK: b(6)-2 AGE: 25

UNIT: Police Officer b(6)-4 GENDER: male

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 1400 Initals: [redacted]
NEURO	Pupils	Alert - MAE, makes appropriate	Alert
	Sensorium	hand gestures (+) purposeful	Purposeful movements
	LOC / GCS	mvmt, (+) sensation - Agitation	versed 2mg/hr Fent @ 50mcg
		fent @ 50mcg° / versed 2mg°	
CARDIAC	Cardiac Rhythm	NSR HR 80's - 100's (when agitated)	NSR = HR upper 90's
	PRI: / QRS:	S1S2 ∅ ECTOPY noted / RRR	∅ ectopy
	Pulse Strength	2+ UE/LE	palpable x4 extremities, 2+
	Cap Refil / JVD	<3sec	<3sec x4 extremities
	Edema	Generalized to neck/face	to neck & face
	Chest Pain	∅	∅
RESP	Respiratory Pattern	RR 14-26, TRACH (HUMIDIFIED) collar, Shiley 8 cuffed	unlabored, trach collar
	Breath Sounds	BBS, CTA - suction PRN	Clear bilat.
	Secretions	NONE AS OF NOW - often, old	None at this time.
	Cough	BLOODY - THICK secretions	occasional minimal production
		(+) cough c̄ productivity	at this time.
SKIN	Color	Bloom	Normal
	Integrity	(L) hip/midline ABD, (R) thumb	Edema to face, (L) hip, staples to mid. ABD
	Backside	+ facial wounds @ mouth +	tongue c̄ sutures.
		inner mouth/tongue	
IV	Access Devices	(L) AC 18g	(L) B.cep, (R) forearm 18gu IV
	Location	(R) AC 18g	A line (L) gd. u/
	Condition	(L) ART - RADIAL placed 2Sept03	∅ signs of infection
		All patent	
GI	Abdomen	SNT ND	Tender to touch, staples mid line
	Bowel Sounds	+BS x 4 quads	+BS x 4 quad.
	Stoma/Ostomy	∅ stoma/ostomy	∅
GU	Device	Foley, #16 placed 2/9/03	Foley
	Color / Clarity	CYU ~ 100-200cc	Clear + yellow

b(6)-2

PREPARED BY (Signature & Title): CP [redacted] | DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital | DATE: 5 Sept 03

PATIENT'S IDENTIFICATION (Type or print last, first, middle; grade; date; hospital or medical facility)

NAME: #700 RANK: AGE: 25

UNIT: police officer GENDER: male

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 LSAFPC V2.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

		INITIAL SHI[redacted]SSESSMENT	
		Time: 0800 Initals: [redacted]	Time: 1900 Initals: [redacted]
NEURO	Pupils	OU reactive 3-4mm	Pettig
	Sensorium	Orientation to AE c pins/needle	(+) sensation
	LOC / GCS	intubated; Alert, Orient, MPE, EC, spont mvmt	Alert
CARDIAC	Cardiac Rhythm	NSR to ST HR 80's - low 100's	Pt. presently in Sinus tach
	PRI: / QRS:	RRR	
	Pulse Strength	2-3+ c/r c 3sec throughout	2+-3 c/r refill < 3sec
	Cap Refill / JVD	ØJVD	ØJVD
	Edema	1+ facial/neck edema c̄ some	to face and neck
	Chest Pain	generalized throughout	none
RESP	Respiratory Pattern	RR 18-12 BPM c̄ SpO2 - 99% RA	equal rise and fall of chest, unlabored
	Breath Sounds	suction via trach x 2 for	clear bilat
	Secretions	Dry, mucus plug c̄ saline flush.	Thick secretions from trach
	Cough	thick - bloody - yellow secretions	opening.
		Doughy c̄ productivity: Humidification	
SKIN	Color	Brown: intact except for	Normal
	Integrity	(R) hip sutures c̄ drng - Δ strong	sutures to face, staples to abd, and
	Backside	QD-QS midline ABD inc staples	(L) side of hip.
		Ntx/COTE PRN/al mouth sutures. Bacitracin/cleans	
IV	Access Devices	(R) bicept 18g IVL FLUSH Q4-6' / patent	IV to (R) forearm
	Location	(R) FA 18g IVL FLUSH Q4-6' / patent	
	Condition	patent / intact Ø s/s infection	Ø s/s of infection
GI	Abdomen	FSNTND	c̄ staples, minimal swelling noted on abd
	Bowel Sounds	X4 quads Ø BM	Active Ø BM
	Stoma/Ostomy	GT Δ Jevity feeds Q4' 400cc.	
GU	Device	Foley ave 200cc Q 1-2'	Foley
	Color / Clarity	Ø MIVF - gdt amber	amber urine
		UA order -	

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE

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

NAME: [redacted] b(6)-4

RANK:

AGE: 25

UNIT:

GENDER: M

STATUS: US: AD / CIV IRAQI: CIV EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V2.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initials: [redacted]	Time: 1850 Initials: [redacted]
NEURO	Pupils	Alert intermittently. ↑ actions from time to	Alert at times
	Sensorium	time. Communicates c̄ hand gestures & brother	Sedated @ 2mg of versed, agitated and
	LOC / GCS	@ bedside. (+) movement all extremities.	restless
		Versed @ 2mg/h, FENT @ 50mcg/h	Fent @ 10mcg/hr
CARDIAC	Cardiac Rhythm	ST → 100-110 bpm	
	PRI / QRS:	$S_1 S_2$ c̄ @ current rate 100.	S_1 & S_2 present
	Pulse Strength	2+-3+ x 4	2+-3+ x 4 extremities.
	Cap Refil / JVD	brisk, < 3sec throughout	less than 3sec x4
	Edema	decreased from yesterday, but generalized to face/neck	to face and neck area
	Chest Pain	Ø	
RESP	Respiratory Pattern	RPR c̄ use of accessory muscles (#8 Shelly, trach)	[redacted] Equal rise & fall of chest
	Breath Sounds	upper lobes CTA, bases diminished	clear bilat, diminished at Bases
	Secretions	Intermittent, thick white c̄ spontaneous cough & suction	around trach site thick blood tinged
	Cough	(+) when instructed to do so	Ø
		FiO2 Ø humidified trach collar @ ~ 31%	
SKIN	Color	normal for multiracial	Normal
	Integrity	intact c̄ for multi focal lac's (sutured) (L) hip pressure	Sutures to face [redacted] lip, (L) hip.
	Backside	dressing, bilat medial incision c̄ staples.	ABD c̄ staples
IV	Access Devices	(A) AC PIV #18ga patent / intact	IV (L) Bicep area 18ga patent
	Location	(R) AC PIV #18ga patent / intact	IV (R) forearm area 18ga patent
	Condition	(L) arterial line (radial site) patent	Ø sign of infection.
GI	Abdomen	semi-round, soft & nondistended	soft & tender to touch
	Bowel Sounds	hyperactive bowel sounds x 4	Active x 4 quad
	Stoma/Ostomy	PEG tube patent / intact c̄ signs/sx infection	GT - patent
GU	Device	#16 Foley Cath to gravity drain.	Foley
	Color / Clarity	yellow, clear urine c̄ U/O ~ 200cc/h	clear & yellow urine

[redacted] b(6)-3

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 6 SEP 03

PAT[redacted] (For written entries give: Name – last, first, middle; grade; date; 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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A110 1	12	[redacted]	EPW [redacted] b(6)-4	1	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19801 01	25 Y	X	9	

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

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)

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

FOR LOCAL USE

DX 802.5, 802.31, 873.61, 873.63, 873.43, E9128, 883.0, 87364, 87343, 8900, V550, V551, E9112

PROC 5412, 4319, 8628, 2551, 7676, 7673, 2752, 311

I T
1 450

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

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	25 Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	—	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1545	b(4)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 8	Z Z Z Z Z

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
8	ICU	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] 622	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 0		0 3 0 9 0 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
		0 3 0 9 0 2

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

FOR LOCAL USE

GSW L mp, jaw

PROC.
8628

b(4)-2

ADM[redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FO[redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) UNK - EPW [redacted] b(6)-4		3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 31	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 9920		12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICW1
15. FLYING STATUS NO	16. OSG —	17. DEPT./BEN K78	18. BRANCH/CORPS b(6)-4	19. DIC/ZIP —		20. TYPE CASE UBI, ICW1
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER.				22. HOURS OF ADMISSION 1800	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION D/C TO CAMP	26. DATE OF DISPOSITION 3 Sept 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 2 Sept 03	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. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Motorcycle Accident.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: MULTI CONTUSIONS & ABRASIONS

780.09
910.0
723.1
913.0
922.1
E819.2

35. Total Days This Facility

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

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	[redacted]	b(6)-2	[redacted]		

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

DR. [redacted]

DA FORM 3047, MAY 73 USAPPC V1.10

b(6)-2

[redacted]

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

DATE OF DISCHARGE	TIME OF DISCHARGE
03SEP03	1625

SIGNATURE [redacted] FICER

[redacted] b(6)-2

PATIENT'S IDENTIFICATION

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	[redacted]
7. Other *(Specify)*	[redacted]	11.	
8.		12.	b(6)-2
9.	b(6)-2	13.	

REMARKS

b(6)-2

DATE

3 Sep 2003

[redacted]

* INITIALS OF PERSON AUTHORIZING CLEARANCE

DA FORM 4029, MAR 73 [redacted] USAPPC V1.00

MEDCOM - 18474

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See ER sheet

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2 Sep 03 @ 1900	26 y/o ♂ Iraqi admitted via EMT. Pt alert + follows commands. Pt has multiple abrasions to extr, contusion to chest, abrasions to face. VSS. Ø IV access upon arrival to ward. labs, xrays & tetanus done in ER. HRRR, lungs CTA⊕, hypo active BS x4 quads. extr. (upper) bandaged c̄ Kerlix. 800mg motrin given for pain. Tol. PO fluids well. Pt resting @ this time. awaiting next convoy to EPW camp. Ø other remarkable assessment findings noted. Will cont to monito [redacted] b(6)-2 [redacted]
03 Sep 03	(0920) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. lungs CTA. ⊕ bs x4 quads. multiple abrasions noted on ⊕ UE and face. Contusion to chest. Drsg to ⊕/⊖ forearms. Ad this am - Ø s/sx infection. Pt tol clear liquids. Will adv. to reg diet for lunch. Awaiting tx to EPW camp. Will cont. to monitor. [redacted] b(6)-2 (1025) Pt amb to ER s̄ difficulty. P[redacted] for D/C to EPW camp. Ambulatory - escorted by MPs. Records to PAD [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED [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.

WARD NO. TCW 1

EPW

#[redacted] b(6)-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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
SEP 0 2 2003	S - 206 pr old drugs rob -
Ozset 97	in Mosul brought 2-3 days ago
pulse 81	No history avail -
BP - 100/76	brought to prison today
Resp. 18	pt with pt arm pain
	Chest / Abd pain -
	PMH. No history available
	Held for vehicular homicide - prison
	hit & robbed died [redacted]
	[redacted] (Orig Dt) 13:50
	Mental status: A awake
	disoriented - b(6)-2
	roaming in pain
	Exam - penile
	Abd acute - tender tender
	Neck - tender to palp.
	Abd old blood [redacted]
	lips bruised
	Resp - cl out w/ chest tender
	tender w/ chest
	Abd - BS present [redacted]

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

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

D16067

CPW

b(6)-4 [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	~~[illegible]~~ pelvis orally [illegible] [illegible]
	Leg - no obvious [illegible] pain
	Skin - large abrasion [illegible] both arms
	S - Second day old with cycle accident -
	apparent LOC / amnesia -
	- tender neck -
	- chest
	- lower abd
	large abrasions of both arms
	apparent deformity [illegible] elbow area
	P - to CSH for evaluation
	Comm - 13:30
	morphine sulfate 10 mg [redacted] c/ [illegible]
	b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 2 Sept 03 | TIME: 1500

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP			✓	ADDITIONAL INSURANCE		✓
AGE	HOME PHONE		FLYING STATUS			✓	DD 2568 IN CHART		✓
31	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM: interpreter, (2) forearm surgery				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: "sedatives"

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

HOW: MVC

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☑ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: neck

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1500

INITIALS: CHF

VITAL SIGNS

TIME	1500	1700				
BP	117/93	125/63				
PULSE	76	80				
RESP	20	18				
TEMP	97.9					
WT	80 kg					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 96 % ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1520	Td 0.5cc IM	Duis	Lt [redacted]	1520	
1520	Toradol 30mg IV	Duis	Lt [redacted]	1520	
			b(6)-2		

DISPOSITION
☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[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		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP 02	PH	PO2	RESULTS: C-Spine - Normal Skull - NO Bilateral Forearm - normal Pelvis - Normal	
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A	DIP		EKG INTERPRETATION CXR - normal	
APTT		BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

36 yr old Iraqi male "EPW" in motorcycle accident 3 days ago.
He is being held for vehicular homicide. ~~Person he hold~~

PMH: Surgery (L) Forea
MEDS: sedative
Allergies: 0
O/ awake alert, follows commands
HEAD - multiple abrasion
Mouth - not injured
Eye: PERRLA EOM - + Ear - TM - clear Nose - clear
Heart - RR NO (M)
Lungs - clear
Abd - soft, B.S. - Normal NO masses
TTP+ - lower sternum
Back - clear Nontender
Rectal
G.U. - 0
Large - abrasion - bilateral lower arm

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] b(6)-2

DIAGNOSIS
1) Multiple contusion & abrasions
Abrasion - bilateral Forearm
Contussion - sternum

CODES

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 Bed 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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1	2												
POST- DAY															
MONTH-YEAR	DAY	25 Sep 03	26 Sep 03												
19	HOUR	8													

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: 129/76 | 125/57

HEIGHT: WEIGHT →

99% | 98% (CPA)

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.

EPW # [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

b(6)-4

ID: [redacted]
WB

09-02-03
07:51

			Patient Limits	
WBC	11.3 H	x10^3/uL	4.5	10.5
RBC	5.33	x10^6/uL	4.00	6.00
Hgb	15.1	g/dL	11.0	18.0
Hct	47.4	%	35.0	60.0
MCV	88.8	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	263.	x10^3/uL	150.	450.
LYM%	27.2 *	%	20.5	51.1
LYM#	3.1 *	x10^3/uL	1.2	3.4

Ward/Section: EMT | QUESTING PHYSICAN: [redacted] b(6)-2 | ORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW | DATE | TIME | SSN/DEBUD [redacted]

b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

```
======= PICCOLO =======
02/09/03          15:15
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #:        3204AA4
OPER # [redacted]  DR #: 000
SERIAL #: b(6)-2 0000100676
.......................
ALB   3.6   3.3-5.5   G/DL
ALP   72    26-84     U/L
ALT   28    10-47     U/L
AMY   43    14-97     U/L
AST   28    11-38     U/L
TBIL  0.8   0.2-1.6   MG/DL
BUN   22    7-22      MG/DL
CA++  9.4   8.0-10.3 MG/DL
CHOL  154   100-200   MG/DL
CRE   1.0   0.6-1.2   MG/DL
GLU   107   73-118    MG/DL
TP    8.5*  6.4-8.1   G/DL

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

Misc. Serology

EST	RESULT	REF. RANGE
R		Negative
no		Negative

Microbiology

rce		
am in		
Bld		Negative
ylori		Negative
ro sites		
aria		
P		
er		

Macroscopic Urinalysis

Blood Bank

ST SUBMIT SF 518 WITH
ERY UNIT REQUESTED

/Rh

ssmatch
ERY UNIT OF BLOOD

			CROSSMATCH

REMARKS:

REPORTED BY: Gyc | DATE: 9-2-03 | LAB ID NO.:

[redacted] b(6)-4

Color - Yellow
App - Hazy
Glucose - Neg
Bili - Neg
Ketone - trace

specific gravity - 1.030
Blood - Neg
pH - 6.0
protein - 30 +
urobili - 0.2

nitrite - Neg
SSA - Trace
mucus - Heavy
Epi - 0-1

Ward/Section:	R. .STING PHYSICAN:	CHE..ISTRY RESULT FORM (Subject to the Privacy Act of 1974)

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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 (art)
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
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry P2

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		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/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		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
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

---

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu_____101 mg/dL

BUN_____27 mg/dL

Na_____139 mmol/L

K_____3.4 mmol/L

Cl_____105 mmol/L

TCO2_____26 mmol/L

AnGap_____11 mmol/L

Hct_____48 %PCV

Hb*_____16 g/dL

*via Hct

PH_____7.501

PCO2_____32.3 mmHg

HCO3_____25 mmol/L

BEecf_____2 mmol/L

Sample Type_:

02SEP03 15:18

Oper: [redacted] b(6)-2

Physician:_____

** PRINT CANCELLED **

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

DATE OF ORDER: 2 Sept TIME OF ORDER: 1800 HOURS

1) Admit to ICW.
Dx: Multiple contusion & abrasions
Abrasions - both arms, head
Contusion - sternum (Boards)

NURSING UNIT | ROOM NO. | BED NO.

2) Condition: stable

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

3) V.S. per ~~routine~~ HOURS
4) I.V. at TKO rate.
5) Diet: ~~Advance~~ Clear liquids
Advance as tolerated
6) Activity: Bedrest
7) Notify Dr. [redacted] if wind #
8) Return to EPW camp when next convoy available

b(6)-2 [redacted]

NURSING UNIT | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

9) Tet toxoid
X-ray skull
CXR
arm
} done in ER.

NURSING UNIT | ROOM NO. | BED NO.

9) Lotrin 800 mg P.O. q 8h prn pain

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

2000 / 2 SEP 03 HOURS

13) DC NFS / DC IV. b(6)-2
VO. Dr [redacted]

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

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

b(6)-2

CLINICAL RECORD

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

Mo. 09 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3
2	[redacted]	VS: Routine	6	X	[redacted]
			18		[redacted]
2	[redacted]	Clear liquids,	6	X	[redacted]
		adv as tol	18		[redacted]
2	[redacted]	BR	6	X	[redacted]
			18		[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Mult contusions & abrasions
Hemum contusion

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:

EPW# [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(a)-2 A11

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	
2	[redacted]	admit ICU, stable	02 SEP 03			[redacted]	
2	[redacted]	Notify Dr [redacted] of ward #	02				
2	[redacted]	Return to EPW camp when next convoy available	03 SEP 03			[redacted]	
2	[redacted]	labs, Xray, tetanus given in ER				[redacted]	

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 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				23	4												
[redacted]				[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Mult contussions & abrasions
sternum contussion

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													
- - - - -	[redacted]	Motrin 600mg po q8° prn pain	D/T	2300 1900	0300 0905	0300										
- - - - -	- - - - -	b(6)-2	D/T	[redacted]												
- - - - -	- - - - -															
- - - - -	- - - - -															
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USAPA V1.00

Ø38

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A 1 1 D 1 [redacted] I Z

LOCATION (State or Country Code.)

3. REGISTER NUMBER: [redacted]

NAME (Last, First, Middle Initial): [redacted] K EPW

4. PAY GRADE: EPW

5. SEX: M

6. DATE OF BIRTH (YYYYMMDD): 19 7 0 1 0 1

7. AGE AT ADMISSION: 3 1 Y

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE: —

ETS: —

11. FMP: 9 9 00

12. SOCIAL SECURITY NUMBER: b(6)-4 [redacted]

ORGANIZATION (Active Duty Only): —

13. MARITAL STATUS: 4

HOUR OF ADMISSION: 1800

BRANCH/CORPS: —

14. FLYING STATUS: N O

15. BENEFICIARY CATEGORY: K 7 8

16. ZIP CODE OF RESIDENCE: —

17. UNIT LOCATION (State or Country Code): —

18. MOS: —

19. TRAUMA: 9

PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Ø b(2)-2

WARD: ICW1

NAME AND LOCATION OF [redacted] FACILITY

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

21. TYPE OF DISPOSITION: Ø 5

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (YYYYMMDD): 2 0 0 3 0 9 0 3

24. CLINIC SVC - ADMITTING:

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYYYMMDD): 2 0 0 3 0 9 0 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYYYMMDD):

FOR LOCAL USE

DX: MULTI CONTUSIONS & ABRASIONS

DX	T	INJ
9248	9	989
9221		
P 9100		
E8193		

b(6)-2

ADMITTING OFFICER (Signature, as required): [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

DR. [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER [redacted]			2. [redacted] EPW			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 23	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 98	12. SSN [redacted]			ORGANIZATION N/A		14. WARD ICW	
15. FLYING STATUS N/A	16. RATING/DSG	17. DEPENDENT BEN ~~N/A~~ KZ8		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 0600	23. CLINIC SERVICE 80+03	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNKNOWN					25. TYPE DISPOSITION DT 05	26. DATE OF DISPOSITION ~~30 SEP 03~~	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK					27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 08 SEP 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2						30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: SHRAPNEL, GSW TO (L) ARM (L) LEG

DX: 81230 Trauma
9031
9552
8901
E9912 Injury
E9919 449

Px: 8622
3883
8605
7812
7842

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	29	

36. Total Days All Facilites

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

SIGNATURE OF ATTE[redacted] b(6)-2 SIGNATURE OF PA OR MEDICAL RECORDS OFFICER [redacted]

MEDCOM - 18492

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OB[redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

23 yo Iraqi male TP from 2ACR FST – wounds from M203. Incident occurred at around 5 pm 9/7. At FST, failure to OR noted – (L) BA transection. (L) Ulnar transection. Pt sp Ex Fix. small amt. Pulse initial spontaneous. Pt also had (R) thigh wound I+D. Arrival to FST A+O. 28 Fr intubated. Pupils unk. Motor unk. Pulses unk.

PHYSICAL EXAMINATION

Intubated, paralyzed 15/73 P 88 R 13 100%
Neck: OP clear. Scalp LAC.
Chest: CTA (B). CV. RRR
Abd soft. (+)BS
Ext: (L) UE s/p blast wound visible mass. 1+ radial pulse. 1 bar 1 pin Ex Fix
(R) LE thigh wound 2 x 2 cm. clean. 2+ (B) DP.

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

A/ Shrapnel / blast (L) Arm. (R) LEG
FST Ex Fix; shock

P/ OR. Revision Ex Fix, BA bypass

[redacted] b(6)-2

[redacted]	DATE 9/8	IDENTIFICATION NO.	ORGANIZATION
IDENTIFICATION *(For typed or written entries give name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
# [redacted]			# 723

DATE	NOTES
2400	85 - 158/88 - 16
	CBC/Chem 12 Lytes T&S, UA, PT, PTT
0015	156/73 - 79 100% O2 sat
0025	ABG done in Right radial — [redacted] b(6)-2
8 Sept 03	Brief Note
	Pt's Dx - MGSW (R) thigh / (L) arm s/p ex fix & brachial art shunt
	sev PST.
	Procedure (1) (L) brachial artery interposition graft c (L) GSV
	(2) Placement additional ex-fix pins (L) humerus, re-adjust ex-fix
	(3) Washout (R) thigh
	(4) (L) forearm fasciotomies
	Surgeon Mortsamob / Sauer / Gwinn Anesth CRNA
	IOF (1) (L) Ulna nerve nearly severed in upper arm, (2) Severe comminuted
	(L) humerus fx (3) Palpable (L) radial pulse @ end of case (4) Forearm
	compartments as well as biceps right - fasciotomies yielded good
	release and softening of compartments.
	EBL
	Intra op fluids Per anesth
	Pt tolerated procedure well, to ICU stable b(6)-2 [redacted]

[redacted] b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
9 Sep 2003 0600	received report from night shift. Patient condition stable. IV infusing via E/J & difficulty. Serosanguinous drainage noted on occlusive dressing around fixator on L arm. Foley draining clear yellow urine. Patient awake + alert appropriately responsive [redacted] A
0645	Heparin drip placed on hold, for OR today. b(6)-2 [redacted] A
0800	pt pickup for OR. Transferred on litter condition stable [redacted] A
0950	return from OR sleepy. FiO2 @ 31% & adequate sats (100%). VS stable. occlusive dressing + fixator in place on L arm. b(6)-2 [redacted]
1000	pt sleepy but arousable, free movement in all extremities x L arm. FiO2 @ 31% O2 & sats 100%, breathing reg + non labored; NSR ⇒ ST, heart sounds S.S. heard, cap refill < 3sec, pulses palpable x 4 extremities; abd soft non tender, bowel sounds present x 4; foley catheter to gravity drain & clear yellow urine in adequate amounts, external fixator to humerus L arm. occlusive dressing from below shoulder to hand on L arm. Occlusive dressings to L thigh from groin to above the knee. Occlusive dressing on anterior R thigh & small amount of serosanguinous drainage observed; 18G peripheral IV in R AC replaced & extension tubing. 18 gauge (R) external jugular IV infusing LR @ 125 cc/hr [redacted] b(6)-2
9/10/03	Surgery Arm well perfused 2+ Radial pulse. Still no motion in hand. Continue wound packing. Wound clean. Plan to go to OR in 2-3 days to close wound. Not stable @ 23% b(6)-2 [redacted]

(Continue on reverse [redacted])

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

REGISTER NO.

WARD NO. ICU-1

PROGRESS NOTES
Medical Record

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

#[redacted]

b(6)-4

b(6)-2 A11

PROGRESS NOTES

DATE	
10 Sep 03 0600	report received from night shift condition stable resting c̄ difficulty
10 Sep 03 0800	day Δ done by Dr [redacted] 5g in 50cc given pre dressing Δ pt tolerated procedure well V/S remain stable [redacted]
10 Sep 03 1200	pt not resting much but drinking plenty of fluid, milk & some water [redacted]
1515 10 Sep 03	pt gotten up OOB to chair c̄ assistance condition remains stable
1700	pt returned to bed tolerated setting up c̄ difficulty given 2 percocet for pain upon return to bed [redacted]
1830	pt still complain of pain requiring given IV [redacted]
11 Sep 03	Pt remained afebrile throughout this shift T max 100.5, cont. to have pt use his incentive spirometer. Pt medicated x2 for pain & Q 2° NV V/S performed c̄ +2 pulses, warm dry skin & capillary refill < 3 secs. Will cont. to monitor. [redacted]
11 Sep 03 0610	Received report & care of pt from previous Shift. Pt sleeping in bed. Q S/S of pain or discomfort. Will cont to monitor [redacted]
0730	Pt C/O pain to (L) arm. Given 2 percocet for pain. T↑ 101.5 Pt given 650mg Tylenol PO for temp. VSS will cont to monitor [redacted]
0930	Pt to X-Ray for Follow up on (L) Humerus. Pt received 5mg MSO4 for pain in (L) Arm before going to X-Ray T-↓ 100.3 VSS will cont to monitor [redacted]
1000	Pt to chair up after returning from X-Ray T-100.0 VSS will cont to monitor [redacted]
1230	Pt back into bed. Pt consumed 1/3 lunch. C/O pain to (L) arm. Received 2 percocet for pain VSS will cont to monitor [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES b(6)-2 A11
11Sep03 1630	Pt IV to (R) at DC'd. IV restarted to (R) hand 20ga placed. Saline locked VSS will cont to monitor [redacted]
1800	Report + care of pt given to oncoming sh [redacted]
11SEP03 2315	Assessment completed @ 2100, patient resting c̄ eyes closed prior to this time, VSS. Patient complaining of pain to (L) arm @ 2100, given MSO4 5mg IVP. Patient complaining of pain @ 2315 to (L) arm, given Percocet 2 tabs. Patient told about NPO status p̄ MN. Sensation to (L) hand intact, cap refill < 3sec, (R) pulse +2. [redacted] /AN
12SEP03 0345	Patient complaining of pain to (L) arm, given MSO4 5mg, will continue to monitor. [redacted] /AN
12Sep03 0810	Nursing: See ICU flowsheet for nursing assessment. T-100.4, HR-98, BP 142/62, SaO2 100% on RA. Pt escorted to O.R. by anesthesia. [redacted] /AN
12Sep03 ~~0820~~ 1311 1311	Nursing: 0800 dose of Ancef not given due to pt being in O.R. Next dose scheduled for 1600. [redacted] /AN
12Sep03 1339	Nursing: Pt escorted back from PACU. T-100.3, BP 150/62, HR-114, R-11, Sats 98% on RA. Respirations regular and unlabored. Airway patent. LUE elevated on blankets. Skin warm to touch (cont'd)

(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]

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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USAPPC V1.00

PROGRESS NOTES

DATE	
12Sep03 1359	Nursing: Cap refill <3secs. Unable to assess pulse due to splint. External fixator intact. Pt c/o pain. Given 5mg Morphine IVP @1320 and 2tabs Percocet @1325. Pt tolerating PO fluids & N/V. Pt sleeping quietly @this time. b(6)-2 [redacted] /an
12Sep03 1522	Nursing: Pt c/o (L) arm pain. Given 5mg Morphine T-102.4, given Tylenol 650mg PO and encouraged to use incentive spirometer. Pt averages 2400ml TV on I.S. Fingers on (L) arm warm to touch, cap refill <3secs, ↓ movement, (+) sensation [redacted] /an
12Sep03 1610	Nursing: Dr. [redacted] notified of temperature, pain control requirements, and Aline. ~~Morphine~~ Order given to D H5O4 to @30mins, D/C Aline, and encourage ambulation. Will continue to monitor. b(4)-2 [redacted] /an
12Sep03 1721	Nursing: T-102.3, pt using I.S. & difficulty. Pt tolerating PO fluids & N/V. Aline D/C'd. Direct pressure applied for 5mins ∅ bleeding noted, ~~4x4 Dressing~~ 1734 [redacted] 2x2 dressing applied. Pt given PRN Morphine for c/o pain. [redacted] /an b(6)-2

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES** b(6)-2, A1

DATE	NOTES
15 Sept 03 0730	Pt received 3mg Morphine for c/o pain to (L) arm will cont to monitor [redacted]
0930	Pt c/o pain to (L) arm. Pt received 2 percocet for pain. N/V checks to (L) extremity done c no changes. Pt has +2 pulses in (L) Radial <3 sec cap refill. ↓ sensation in pinky ring, middle, or index finger. Sensation felt in thumb. Unable to move arm, hand, or fingers. VSS. will cont. to monitor [redacted]
1140	N/V check done to (L) upper extremities & changes noted will cont to monitor [redacted]
1215	IV to [redacted] (R) bicep DC'd. IV restarted to (R) forearm 20ga patent to NS flush [redacted]
1240	Pt received 7mg Morphine and 2mg Versed for Dsg Δ to (R) arm. Dsg Δ's complete pt tolerated well. VSS T-98.5 will cont to monitor [redacted]
1440	Pt received 3mg Morphine for c/o pain in (L) arm. Dsg Δ's to bilat. upper legs completed. will cont to monitor [redacted]
1445	N/V checks to LUE done & changes noted. will cont to monitor [redacted]

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. ICU I

[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
1540	Pt c/o pain to LUE. Pt received 5mg Morphine for pain. Will cont to monitor [redacted]
1730	Pt c/o pain to LUE & received 2 tabs percocet for pain. VSS. T-99.1 will cont to monitor [redacted]
1800	Report & care of pt given to oncoming [redacted]
1820	Pt report received from SPC [redacted]. Pt denies any pain @ time. Pt is in bed eating. VSS. Dressings are C/D/I. Assessment complete. Will continue to monitor Pt. [redacted]
2110	Pt given II Percocet for pain. Neuro checks have been the same. Pt in bed resting. will continue to monitor. [redacted]
2220	Pt received 3mg MSO4 for Pain, given by charge nurse [redacted]
16~~2300~~	(0000) Pt VSS, neuro check the same fairly in pt foot & leg, & movements will continue to monitor. [redacted]
	(0120) 5mg MSO4 given for pain. will continue to monitor Pain and Pt. VSS. [redacted]
	(0320) VSS, Pt resting in bed. Neuro check is as a [redacted]
	(0500) Pt has received 2mg of MSO4 for pain & good effect. Pt now sleeping in bed. VSS. Temp is ↓ to 99.1. Pt has urine to foley Q8. will continue to monitor [redacted]
0600	Received report & care of pt from previous shift. Pt sleeping in bed will cont to monitor [redacted]
0730	Pt received 2 tabs percocet for c/o pain to LUE. Consumed 90% of breakfast. will cont to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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b/(6)-2

A11

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2A11
18Sept03 1750	Returned to ICU 1 s dishes noted. Tolerate p.o. s difficulty. (L) arm elevated per order. Will continue to monitor. [redacted]
1830	Report recieved from SGT [redacted]. pt vss afebrile. pt denies pain @ this time. Neuro ✓ (L) Hand- full sensation to thumb and index finger. Ø sensation to remaining fingers. radial pulse +4. Will continue to monitor — [redacted] 9/WM6
2000	Neuro ✓: same as previous check — [redacted]
2200	pt temp 101.5. Tylenol 650 mg given. will recheck temp in 1 hour. Neuro ✓: same as previous ✓ no change in sensation to (L) hand — [redacted] 9/WM6
2300	Temp recheck 98.9 — [redacted] 9/WM6
2400	Neuro ✓: No Δ from previous check [redacted]
0200	Neuro ✓: No Δ from previous check — [redacted] 9/WM6
0400	pt resting in bed, VSS afebrile. Neuro ✓: No Δ from previous ✓ — [redacted] 9/WM6
19 Sept 03 0600	Received report from previous shift. Pt resting c̄ eyes closed. VSS. Pt c/o pain (L) upper arm + thumb + pointer finger. Gave MSO4 mg IVP. Pt also c/o no sleep during night. All IV lines intact. (L) arm elevated. [illegible]

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

DEPARTJSERVICE	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
19 Sept 03 0800	Ø Δ in NOV ✓ of LUE. Prep pt for transfer to ICW. Gave brief report to Lt Gross. Will cont care & complete drsg Δ in ICW. b(6)-2 [redacted]
Ø925	Gave versed 2mg IVP + MSO4 4mg IVP in prep for drsg Δ. Transferred pt to ICW. Will cont care. b(6)-2 [redacted]
1020	Completed drsg Δ. Incision well approximated + intact c̄ suture ⓛUE. Applied bacitracin + completed pin care using betadine. Cleaned ⓡarm c̄ NS. Wrapped ⓛUE c̄ kerlex. Replaced half splint + wrapped c̄ ace bandage. Pt assisted. Small amt blood noted on lower aspect of bicep. Δ'd drsg ⓑ upper thigh. Sutures ⓡthigh intact, wound well approximated c̄ Ø s/s of infection. ⓛthigh staples intact. Wound well approximated c̄ Ø s/s of infection. Applied bacitracin to ⓑ upper thigh wounds. Covered c̄ 4x4 + secured c̄ cloth tape. Pt c/o pain. Gave 4mg MSO4 IVP. Pt resting c̄ eyes closed @ this time. Lt Gross @ bedside assisting c̄ drsg Δ. b(6)-2 [redacted]
2/Ø/1559	Received pt in stable condition, A+OX3, VSS, awake speaking. Drsg Δ'd on arrival w/ LT [redacted] SWB, and w/ steady gait. Drs [illegible] to po. IV ⓡ fc patent + intact. Ø c/o pain for this part of shift. [illegible]

STANDARD FORM 509 (REV. 5/1999) BACK

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b(6)-2A

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

DATE	NOTES
20Sep03 @ 1539	Care pt unable to feel two fingers only @ this time, pinky & ring. Pt unable to wiggle fingers. ⊕ pulse and normal fingers warm to touch. Limited mobility noted w/ ⊖ arm. ⊘ other remarkable assessments at this time. Will cont to monitor pt [redacted]
20Sep03 @ 0100	Assumed care @ 1800; All VSS; A&Ox3, ⊕ [redacted], intact, brisk cap ref ⊕ pulses x 4; pt amb to BR ÷ difficulty; ⊖ c/o pain; ⊕ sensation in thumb & pointer finger, ⊖ sensation in remaining fingers; ⊕ movement in all fingers; otherwise, NV intact; S, S2, LSCTA ⊖; ⊕ BS x 4; ⊕ BM this shift, pt voiding QS, clear, yellow urine; HL patent, cont ÷ IV abx, enc. IS use, ⊕ arm elevated; restraints in place; ⊕ circulation, ⊖ skin breakdown; [redacted]
20Sep03 @ 0230	VSS alert down OOB to BR for AM care. Neuro vasc check to RUE WNL, splint in place to RUE. Pen care done to external fix. ⊕ EA IV patent & intact ÷ heline lock, hemp clean. BS ⊕ x4 quad. Peripheral pulses palpable. Will continue plan of care [redacted]

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)-1

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 A11
20Sep03@2050	Assumed care @ 1800; USS; A&Ox3, (+) sensation to thumb & pointer finger, (-) sensation to other digits; (-) movement in ~~affected~~ [redacted] (L) hand & digits; (+) circulation; (+) pulses x4, brisk cap ref throughout; otherwise pt NV intact; Ex-fix in place, dsg CDI+ (-) drainage; HL in (R) FA patent ē s/sx infection/infiltration; cont ē IV abx; pt OOB to amb to BR ē in hall w/, pt tol well ē complications; (L) arm ↑; IS use encouraged; cont ē Q2° NVV; restraints in place, (+) circulation, (-) skin breakdown, cont to monitor [redacted]
21 Sept 03 0800	Alert & Oriented. (L) UE diag. Dsd. (L) UE lateral incision from (L) axilla to left wrist. Sutures intact ē 2cm open area to incision 1cm above elbow. Has sensation to (L) UE. Capillary refill < 3sec (L) fingertips. (L) radial & brachial pulse palpable +2. Pain care done to (L) upper arm. Extra fix. Sutures to (L) & (R) thigh intact with edges to wounds well approximated. OOB to BR & tolerated well. Sling / ~~shoulder~~ splint implaced to (L) UE. (R) FA IV patent & infused Saline locked. Resp clear. BS (+) x4 quad. Abd soft non-distended. Percocet ii tabs given for pain. Will continue with plan of care. [redacted] 208 AN
21 Sept 03 1915	External fixator to upper [redacted] (L) arm dressing intact. (+) distal pulse. Sutures to (B) thighs intact. No sign of infection. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
23 sep 03 0200	- Assumed care of pt. A+O x3 VSS. c/o pain to (R) shoulder that radiates to (R) flank throbing pain. Medicated c̄ MSO4 5mg for relief. a2 Neuro check to (L) UE vein graft from (L) thigh surgical incision c̄ sutures open to air clean dry and intact. (L) UE warm good cap refill strong radial pulse. External fixator pin care complete dressing to bicep changed. States having SOB pain upon inhalation O2 sat 98% on RA lungs clear bilat. IS @ bedside. Will cont to monitor
	(1500) I concur c̄ above assessment. [redacted]
	b(6)-2 A11
24 SEP 03 2013	VSS. AO. Provided 2 Tylenol for T @ 101.6. Pin care performed as ordered and tolerated well. Denies c/o SOB and states feeling "fine." Vital signs checked. All other systems WNL. (+) Radial pulse to (L) arm, reduced CVS to all fingers on (L) arm. Sutures to entitled arm and upper arm intact. [redacted]
	pt received pt resting in bed [redacted] VSS w/ ↑ T of 103, safe ⅡP percocet for pain w/ additional ½ tylenol T ↓101.9. Drsg Δ done w/ bacitracin on suture line gauze dry on upper arm and pin care. Bilateral wounds on thighs covered w/ bacitracin (R) sutures intact, (L) staples intact. edges well approximated. pt c/o to have ↓ motor & sensation in UE. HL @ fc. patent, flushed daily. COM + amb indep. restraints in place per POC

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MEDICAL RECORD | **PROGRESS NOTES**

NOTES b(6)-2 All

DATE	NOTES
23 sep 03 0700	- Assumed care of pt. A+OX3. VSS. Lungs CTA HRRR Active BS x4 quad's to elevating PO well. GSW to (R) anterior thigh open to air healing well Ø bleeding noted. (R) LE vein graft incision line open to air sutures in place Ø drainage. (L) UE ī external fixator surgical incision from hand to axillary sutures in place dressing 4x4 dry the inner bicep drainage noted. Remains afebrile Ø s/s of infection will cont to monitor. [redacted] [redacted]
23sep03@1930	Assumed care @1900; VSS, pt A&OX3 speaking both arabic & english; Ø A in NVV, cont ī Q2° NUV; pain controlled ī perc & MSO4; pt ambX1 in hall ī difficulty; Ex-fix in place, dsg to (L) bicep CDI ī drainage; GSW to (R) anterior Quad OTA sutures intact, Ø drainage, well approximated; sutures to (L) LE OTA ī drainage, well approximated; sutures to (L) UE intact, ī drainage, well approximated Ø s/sx infection; pt voiding ī difficulty, Ø BM this tour; restraints in place; (+) circulation [redacted] cont to monitor [redacted]

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

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[redacted]

b(6)-4

b(6)-2 A11

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE | NOTES

Pt. verbalized understanding. LSCLAB. S, S. PERRLA. BS (+) x(2). Urine light yellow QS. [redacted] RN

24 Sep 03 - Assumed care of pt. A+O x 3. USS & c/o pain or
0700 discomfort @ this time. Dressing Δ to (R) posterior thigh
GSW 4x4 secured c̄ tape CDI. External fixator to (R) LE
pin care complete incision to leg c̄ suture 4x4 dressing for
minimal drainage secured c̄ kerlix. Lungs CTA HRRR Active
BS. Tolerating PO. Urinating per urinal c̄ difficulty GSW to
(L) ankle suture intact wound open to air & drainage noted
will cont to monitor

(1240) I concur c̄ above assessment. [redacted] RN

24 SEP 03 USS. Pin care performed to LLE. DSG intact (R) thigh.
2000 (+) pulse to LLE. Tolerated OOB c̄ minimal assistance.
1 staple & cuff sutures to (L) leg OTA. WNL. [redacted]

September 1054 Received pt resting in bed, USS, A+O x 3, Arabic
speaking. Dress to (L) thigh/ex fix d/d, pin care
done. Dry w→D done on (R) thigh wound, serosang
drainage noted. IV started (R) fa, patent, flushes
easily. Sugs, ∅ on this shift. Pt able to flex
(R) LE w/o assist. ∅ other remarkable assessments @
this time will cont to monitor. Restraints on per
CPN Ordered ∅ skin breakdown or circulation issues
noted [redacted]

SEP 03 USS. AO. DSG changed to (R) inner thigh c̄ complaint. BS (+) x 4.
1304 (+) pulses to LLE. Pin care performed. Tolerated LLE. [redacted]

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PROGRESS NOTES

MEDICAL RECORD

DATE	NOTES
	CDI c̄ (-) S/S inf. (+) Pedal pulses. cap refil < 3 seconds. Pt. Resting [redacted] @ this time will cont to monitor pt. [redacted]
23 Sep 03 @ 1900	Assumed care @ 1800; VSS, pt A&O x 3, (+) CMS, brisk cap ref, (+) pulses x4, ∅ c/o pain or discomfort @ this time; Ex-fix in place, dsg CDI ∅ drainage; (-) s/sx infection; SL in (R) wrist patent ∅ s/sx infection/infiltration; S1S2, CSCTA(B); (+) BS x4, pt voiding QS, clear yellow urine; all dsgs CDI; pt OOBTC c̄ assistance; [redacted] restraints in place, (+) circulation, (-) skin break ↓ cont to monitor [redacted]
23 Sep 03 0700	- Assumed care pt. awake A+O x 3 VSS. ∅ c/o pain or discomfort @ this time lungs clear bilat HRRR. Active BS x4 quads. Voiding QS per usual. External fixator to (L) LE intact pin care complete incision to leg dressing with 4x4 and wrapped c̄ kerlix. GSW to (L) ankle ace wrap taken off stitches CDI 2x2 dressing applied to open area of wound to ankle. GSW to (R) posterior thigh ace wrap taken off. Wet → Dry dressing applied c̄ 4x4 secured c̄ tape. Will cont to monitor [redacted] cont c̄ IV ABX therapy
24 SEP 03 0125	VSS. AO. Activity like a baby. (R) thigh DSG Δ'd for 0430 AM. (+) pulses BLE. Pins intact & clean. Reinforced understanding of restraint policy to patient.

SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	MI
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	WARD NO.
		REGISTER NO.	

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

b(6)-2 A11

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1994)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

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PROGRESS NOTES

MEDICAL RECORD

DATE	NOTES
September	cont protocol, ø skin breakdown or circulation issues noted. ø other remarkable assessments @ this time. Will cont to monitor [redacted] b(6)-2
25 SEP 03 2317	135. A0. ø pain. Ambulated x1 for 10 min on ward. Placed [illegible] gauze to lower pin site @ large. ⊕ radial pulse to to ⊖ arm. c/o intact to ⊕ radial pulse to to ⊖ arm. c/o intact to pressed pain. Unable to move fingers. Sister pulse throbbing in ⊖ wrist and ⊖ hand. b(6)-2 [redacted]
Sept 26 1100	Received pt resting in bed, USS, [redacted], speaks Arabic and some English. OOBTC and amb in hallways today. Drsg to ⊖ arm Δd and pin care done. Bacitracin applied to suture line, ROM performed w/ pt assist and pt taught to perform ROM of ⊖ arm on own. Pt has ↓ minimal and sensation to ⊖ arm, up ⊖ hand. ⊕ pain this shift, pt indicated good relief. ø other remarkable assessments at this time. Pt applied bacitracin to bilateral ⊖ wounds, ⊖ LE staples intact and ⊖ sutures intact. Restraints per CDM protocol, ø skin breakdown or circulation issues noted. Will cont to monitor p[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST		SPONSOR'S ID NUMBER (SSN or other) b(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT	
		REGISTER NO.		WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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C# [redacted]
b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03 2010	Rt c/o, VSS, ∅ c/o pain @ this time. LCTAB, ~~HRR~~, ⊕BS x4 qds. Drug Ad. to Ⓡ thigh. 4x4 applied. Pin care done to Ⓛ ex-fix. Ⓛ leg incision OTA c̄ 2x2 to open area. ⊕ pedal pulses, Restraints on, ⊕ circulation. Gentamycin + ancef cont. voiding c̄ u via urinal. Will monitor [redacted] 91WM6 SPC b(6)-2 [redacted]
27 Sep 0240	c/o pain to Ⓛ leg. II Percocet given per MD orders. Relief noted. Will monitor [redacted] 91WM6
27 Sept 03 0900	VSS. Alert & oriented. OOB → chair for Breakfast & AM care. Tolerated Well. Ambulated c̄ assist to BR. Had BM x1 medium formed Brown. Peripheral pulses +2. Pin care done to Ⓛ ex fix. Ⓛ leg incision with sutures intact. Percocet 2 tabs given P.O [redacted] for pain. Restraints 2 points applied. Skin intact under restraints. Will continue plan of care. b(6)-2 [redacted] 27 A

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. 6/1991)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

#[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27sep03 0315	Assumed care @ 1800; All VSS; pt A&OX3, Ø Δ's, Venous vascularity, cont c̄ Neuro ✓; (R) arm ↑, pt ambX1 for 20 min; pain controlled c̄ percs; pin care complete; dsg to (L) UE CDI c̄ drainage; sutures to thighs (R) intact c̄ ↓s infection, (+) dung; well approximated - self-application of bacitracin; pt assisted ROM performed (R) BM this shift; pt voiding QS c̄ difficulty; restraints in place, (+) circulation, (+) skin break ↓, cont to monitor [redacted] b(6)-2 A 11
27Sept 03 0900	VSS Alert / oriented (L) arm slung in place after elbow removed. excision edges well approximated. Pen care done to (L) upper arm exp. Peripheral pulses palpable. (L) arm ↑ on folded blankets. IDB ↑ 30°. (R) FH Salin lock patent & intact. Flushed without difficulty. (R) & (L) incision clean and dressed as ordered. OOB → BR and back. Remain c̄ 2 point restraints which are bed. Will continue plan of care [redacted]
27sep03 2245	Assumed care @ 1800; [redacted] T: 101.8 c̄ pt c/o pain, II percs given c̄ good relief, Temp taken T: 98.0°; All other VSS; pt A&O, No Δ Venous vascularity; pt ↑ ambin wheelX1 for 15 min c̄ difficulty; dsg to (L) arm Δd, wrapped c̄ Kerlix - CDI, scant amt of drainage on old dsg; pin care complete c̄ 1/2 sterile H2O & 1/2 NS; min. drainage noted; SL patent, cont c̄ IV alert; Restraints in place, (+) circ. (+) skin break ↓, cont to monitor [redacted]
Sept 03 0900	VSS Alert & oriented OOB → BR with (L) arm in sling. (R) FA Salin lock patent and intact. IDB ↑ 30°. (L) arm elevated on folded blankets. Peripheral pulses palpable. Incision done to (L) UE extend from [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2 + 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sep 03 2100	Pt a10, VSS, (B) thigh drg Δ'd. ⊕ pulses to (B) ext. pin care done. (L) thigh sutures OTA. open area covered. minimal drainage @ pin sites. OOB to chair ⊖ minimal assistance. ⊘ c/o pain @ this time. Restraints on. ⊕ circulation. in full monitor [redacted] 91WM6 SPC [redacted]
28 Sept 0900	VSS; A&O; OOB → chair for breakfast & AM Care. Ambulated ⊖ assist to BR. Void well. Had BM. Peripheral pulses palpable. (R) FA IV patent & intact. Flushes without difficulty. Pin care done with minimal ambulation. Will continue plan of care.
28 Sep 03	2100: VSS, c/o pain, gave II [redacted] as ordered, Dsg to (R) back thigh Δ'd CDI - reinforcing PRN. Ex-fix to (L) LE intact, sutures to (L) LE approximated & CDI. (L) LE elevated, edema noted. IV HL to (R) FA flushed & patent, continuing IV antibiotic around the clock. Tolerate PO, OOB PRN ⊖ difficulty. Pain Management & Palliative care. 2+ pedal pulse (L) foot. Will continue to monitor for acute A/S [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
28 Sep 03	2330: IV to (R) FA infiltrated, D/C'd intact. IV 18G restarted to (L) AC running Ancef 1gm IV @ present time. b(6)-2 [redacted]
4 Sep 03	Received pt resting in bed, VSS, A+O x3, speaks arabic. Pt amb to BR w/ walker, no untoward BBM, am care. amb to chair w/ walker. (L) LE T. PMS care done, Dicetracin applied to suture line. IV to (L) AC patent & intact flushes easily. Medicated w/ percocet x1 tab. Will cont to monitor pt. Restraints in place per EPW protocol & breakdown noted [redacted] b(6)-2
29 Sep 03	2045: VSS, c/o pain, gave 2 percocet tabs PO as ordered, leg dix to (L) LE in place, Dsg's CDI, sutures approximated, Dsg to back of (R) thigh S'd W→D. IV HL to (L) AC 18G flushed & patent, running Gent IV. Continuing antibx IV around the clock. x2 restraints when in bed (L) skin breakdown. Pain Control, palliative care. Continue to monitor. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
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USAPA V1.00

[redacted]
b(6)-4

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	(continue)
28 Sep 03	Rt(L) thigh dry. Bed [redacted]
28 Sep 03	Will continue plan of care [redacted]
1845	Pt resting in bed, A+O x3, VSS, LS CTA (B), (+) BS x4, SL (R) FA patent, Ex Fix (L) arm, arm elevated, pin dsg's CDI, voiding w/o complications, denies pain at this time, proper circulation + ø skin break down on [redacted] pts of restraint. [redacted] b(6)-2
28 Sep 03	(1455) Assumed care of pt w/ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/Neurontin. Ex fix in place on LE. Pin care done. Incision on LE covered c̄ Kerlex drsg p̄ Bacitracin applied. ↓ ROM noted c̄ @ hand/wrist. PT notified of consult. Pt amb well. Tol. reg diet well. voiding s̄ difficulty. Pt OOB to shower this am for personal hygiene. SL in (R) forearm flushes well s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will [redacted] continue to monitor. 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. 5/1990)
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USAPA V1.0

b(4)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sep 03 1845	Pt resting in bed, A+O x3, VSS, Ex Fix to LUE, incision covered c̄ kerlix CDI, pt able to move LUE, movement limited because of injury, peripheral pulses equal bilat, LS CTA (B), (+) BS x4, abd soft flat non tender, pt voiding well, HL IV (R) FA intact, ø s/sx of infex, pt ambulates w/o complications, ø s/sx of poor circulation or skin break down on pts of restraints. [redacted]
29 Sep 03	2ND: I concur c̄ above assessment. [redacted]
30 SEP 03	(1450) Assumed care of pt @ ~~0800~~ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/Neurontin. Ex fix in place on LUE. ↓ ROM in LUE. Skin warm to touch. cap refill <3 secs. Pin care done. Drsg to LUE ∆d. Incision CDI s̄ s/sx infection. Bacitracin applied to incision. SL in (R) forearm flushes well s̄ s/sx infection/infiltration. Pt amb in hallway s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted]
1900	Pt c/o, VSS, ø c/o pain @ this time. Ex. fix intact to DLE. pin care done. ↓ ROM LUE. Irrit cap refill, skin: warm + dry. drsg DLE CDI. HL (R) arm patent ambulating s̄ difficulty. neurontin cont as sched-uled. dosage 1 to 100mg TID. NV/IS DLE @ 2°. Restraints on (B) LE (+) circulation, will monitor [redacted]
200	last dose ancef given, Keflex started PO per order. [redacted]

[redacted]

b(4)-4

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
30 SEP 03	(1105) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4. Pt OOB to shower for personal hygiene this am. Amb c̄ assist of walker. ↑ to chair for 2°. Ex fix in place on LE. Pt able to move LE. ⊕ pedal pulse equal bilat. Cap refill <3 secs. Sutures to LE CDI. Drsg to back of ⊕ thigh ⊘d, wet → dry. ⊘ s/sx infection @ wound site. SL in ⊕ ac flushes well s̄ s/sx complications. Pt remains NPO for sx today. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted] (b)(6)
	(1300) SL in ⊕ ac d/c'd d/t infiltration. 18g IV started in ⊕ forearm. LR infusing @ TKO d/t NPO status for surgery. Monitoring. [redacted] (b)(6)
	(1515) Pt to OR via gurney in stable condition. [redacted] (b)(6)
	(1715) Pt tx back to ward p̄ surgery via gurney in stable cond. Drsg to LE CDI. MSO4 given for pain monitoring [redacted] (b)(6)
30 SEP 03	VSS. AO. BS's to ⊕ stump and pins intact. ⊕ pulses to BLE.
2000	BS's to ⊕ inner stump and wrapped. CR < 3 seconds. Put up dressing to ⊕ stump left in place. ⊘ s/s of wound infection to either extremity. [redacted]
01 OCT 03	(1650) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to BR c̄ assist of walker. Personal hygiene done. Drsgs to LE d/c'd. Steri strips to incisions intact c̄ small amount sero-sang

STANDARD FORM 509 (REV. 5/1999) BACK

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b(6)-2

A11

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

DATE	NOTES
01 OCT 03	(1700) Assumed care of pt w/ report from night shift. Pt alert, speaking Arabic. VSS. Drsg to LUE ΔΔ. Incision CDI. Pin care done to ex fix. Pt tol. well. Pain controlled c̄ Percs. Pt tol. reg diet well. Voiding s̄ difficulty. 4-point restraints in place s̄ sex complications. Will cont. to monitor. [redacted] b(6)-2
1 OCT. 03 1845	Pt A+O×3, VSS, OOB to BR + ambulate, Ex Fix on LUE, dsg on LUE CDI, denies pain, voiding well, LS CTA (B), (+) BS x4, ∅ s/sx of poor circulation or skin breakdown on pts of restraint. [redacted]
1 Oct 03 2000-0700	2100: I concur c̄ above assessment [redacted] Received pt resting on bed, VSS, A+O x 3; arabic speaking. Medicated x1 5mg MSO4 for pain prior to dressing Δ. Wound cleaned w/ NS, bacitracin applied to suture lines, + pin care done. Pt assist w/ ax Δ, and is suf sufficient in range exercises. Sups, tol to, OOB + amb in hallway. Restraints off c̄ pt's permission, ∅ skin breakdown noted. Numbness [redacted] w/ sensation (+) sim in bilateral arm. Will cont to monitor [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] ER (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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2oct03@2115	Assumed care @ 1800; All VSS; pt A&OX3, ØØ Neurovascularly; cont ε NVU; dsg to (L) UE ad, minimal drainage; pin care complete; (-) drainage; SL in (R) FA patent; pt ↑ to amb in hall X1 for 15 min ε diff, pt voiding Ø S, clear, yellow urine ε diff; Restraints in place, (+) circulation, (-) skin breakdown; cont to monitor [redacted] b (6).2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
03[illegible]1H7	Received pt resting in bed, VSS, tol po, A+O x3, arabic speaking. Drsg to (R) arm removed and left OTA per MD instruction, ~~bar~~ wound cleaned w/ NS and bacitracin applied to suture lines. Pin care done w/ 1/2 strength H_2O_2. Pt able to self perform ROM exercises to (R) arm and pt states cont ↓ feeling and movement to (R) arm. Ex fix in place w/ sling for support during amb and when up ad lib. Pt amb in hallways indep. BOM, and arm care provided. Will [redacted] Restraints in place per CPG protocol, ∅ breakdown noted. ∅ other remarkable [redacted] C this time. Will cont to monitor pt [redacted]
	Assumed care @ 1800; All VSS, pt A+O x3, (R) Δ's Neurovas[redacted] ↑ to amb in hall X1 for 30 min. Tol well; Ex-fix in place; pin care complete c̄ 1/2 strength H_2O_2; (R) S/Sx infection; (L) arm OTA, bacitracin applied; (L) arm ↑ on pillow; pt [redacted] performs ROM; (R) significant Δ's in assessment Restraints in place; (R) circulation, (R) skin break ↓; cont to monitor [redacted]
	b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

b(6)-4

E # [redacted]

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4Oct03 0900	VSS. Alert Oriented. OOB → BR for AM Care. Pin Care done to Ex Fix to (R) upper arm. ∅ drainage noted. Pt c/o pain at site. (L) arm ↑ on folded blankets. NSV WNL's. (L) UE. Denies pain or discomfort @ this time. Will continue care as planned. [redacted] 7A
4Oct03 2100	Assumed care @ 1800; All VSS, pt A&O, ∅ Δ NV; pt medicated c̄ perc & MS04 for pain; ↑ ambs in hall, pt in NAD; Ex-fix in place, pin care done ⊖ drainage, ⊖ s/sx infection, (D) arm ↑; ∅ Δ's. Restraints in place, ⊕ circ, ⊖ skin break ↓, cont to monitor. [redacted]
5Oct03 0900	VSS. Alert & Oriented. OOB ambulated to BR. (L) arm in sling. (R) fingers capillary refill <3sec (L) radial / brachial pulse palpable. Pain site to ext fix (L) humerus without drainage and crustation. (L) arm ↑ on folded blankets. Denies pain or discomfort @ this time. Will continue plan of care. [redacted]
5OCT.04	Pt A+O×3, VSS, LS CTA (B), (+) BS×4, Ex Fix LUE in place, incision on LUE open to air, ∅ drainage noted, c/o moderate pain to LUE, voiding c̄ difficulty, pt able to move fingers, radial pulse equal (B), LUE elevated c̄ blanket, ∅ s/sx of poor circulation or skin integrity, on pts of restraint. — [redacted] 9W

/ b(6)-2A11

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
06OCT03	(1625) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Neurontin. Ex fix in place on LUE. Pin care done. Incision on LUE CDI - open to air. LUE elevated on pillow. Skin warm to touch. Cap refill <3 secs. Pt OOB to BR this am for personal hygiene. Amb well. SL in @ forearm dlcd d/t infiltration - catheter intact. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. b(6)-2 [redacted] WJAD
6OCT03 1945	Pt A+Ox3, VSS, Ex Fix @ LUE, dsgs on pins intact, incision LUE healed, abd soft flat non tender, OOB to BR + ambulate, voiding well, pain controlled c̄ percs, pt had X RAYS taken, XRAYS @ bedside, Elavil 20mg PO QHS, Ø s/sx of poor circulation or skin breakdown on pts of restraint. b(6)-2 [redacted] aiw
07OCT03	(1610) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/Neurontin. Ex fix in place on LUE. Pin care

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

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

REGISTER NO.

WARD NO. ICW#1

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

DATE	NOTES
10-8-03	

Summary

This is a Iraqi male who sustained a gunshot wound to his left arm. He sustained a comminuted humerus fracture and lacerated his brachial artery, median nerve, ulnar nerve, and musculocutaneous nerve. The radial nerve was found to be intact but contused.

The brachial artery was repaired with a vein graft, the nerves were tagged with suture, and the humerus was fixed with an external fixator.

His wounds are closed and pin sites are clean. There is no callous at the fracture site and there is some sensory radial nerve function. The patient wishes to keep his arm even if not fully functional. In three months consideration for nerve repair or grafting should be made at a facility equipped to do that. This facility does not have that capability.

Currently he is treated with Neurontin 600mg po TID, Elavil 25 mg po qHS for nerve pain. Twice a day pin site care should be done and external fixator removed when fracture is healed. 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		

orthopedic surgery

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

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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07OCT03 (1600)	(cont) done. ↓ ROM on LUE. Cap refill <3 secs. incision on LUE CDI - open to air. Tol. reg diet well. voiding ~~s~~ difficulty. 2 point restraints in place ~~s~~ s/sx complications. Will cont. to monitor. [redacted]
7OCT.03 1930	Pt A+O x3, VSS, OOB to ambulate, Ex Fix LUE in place, pin care done, radial pulses equal (B), pt unable to move fingers on (L) hand, pain controlled c̄ percs + neurotin, voiding well, abd soft flat nontender, incision on LUE appears healed, 2 pt restraint, ∅ s/sx of poor circulation or skin breakdown. [redacted]
08OCT03	(1255) Assumed care of pt at 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/Neurontin. Pt amb well. OOB to BR for personal hygiene. Ex fix in place on LUE. ↓ROM noted c̄ LUE. Pin care done. Skin warm to touch. Incision to LUE CDI - open to air. Tol reg diet well. Voiding ~~s~~ difficulty. 2 point restraints in place ~~s~~ S/Sx complications. Awaiting tx to Iraqi hospital. Will continue to monitor. [redacted]
	(1330) Pt tx to Iraqi hosp in stable condition - ambulatory c̄ meds for d/c. [redacted]
	b(6)-2 All

STANDARD FORM 509 (REV. 5/1999) BACK

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ICAL RECORD

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CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 Sept 03	Brief Op Note + H&P
1107 pm	Reportedly struck in LUE & noted unable to move (L) fingers or (L) UE. Other noted injuries: (R) thigh shrapnel wound c̄ = radiation at thigh wound. (-) FB. (R) parietal/occipital c̄ = 3 cm + 4 cm lacs.
	Pre op Dx: 1) (L) humerus fx
	2) Large soft tissue defect to (L) medial biceps
	3) neuro sx intact - (+) sensory, (-) motor
	Post op Dx: Same
	4) Transected (L) brachial artery
	5) Transected (L) ulnar nerve
	Surgeon: [redacted] b(6)-2
	Anes: [illegible] IV's: see anesthesia
	Procedure: 1) Explore (L) UE c̄ shunt of (L) brachial art. Dopplerable pulse, <3 sec cap refill
	2) Ligation of basilic + cephalic veins
	3) Gross approx + marking of ulnar nerve c̄ 4-0 prolene
	4) Exp/Fix for stabilization of (L) humerus
	5) Debridement + marking of (R) thigh [redacted]

ITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR | REGISTER NO.

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

CHRON [redacted]

[redacted] USAPA V2.00

b(6)-2

(P) 7mm x 5mm possible GSW (P) (R) ant thigh
(R) exit wound, minimal bleeding
(A) GSW (L) arm, 2 lacs/avul to (R) posterior parietal,
possible GSW to (R) ant thigh

(P) 1000 mL LR IV (L) Antecub @ 1823
1000 mL LR IV (L) Antecub @ 1840
10mg Morphine Inj (L) Glutea l @ 1828
15 L/min O2 @ 1840 - d/c @ 1900
1000 mL LR IV (L) Antecub @ 1903
Pt stable for transport to 125th FSB. b(6)-2
Bag #4 1000mL LR hung in [redacted]
FLA @ 1925

DLT. SP. PA-C

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
07 Sep 03	(S) 23 y/o Iraqi male c̄ GSW to (L) arm. Pt presents to 1/2 ACR FAS one to one-half hour s/p incident. Ø LOC (+) on (C) 9 (1-10)

Vitals

BP	P	R	O2	Time
18/62	150	29	97	18:20
20/60	130	28	96	18:33
18/70	113	24	100	18:42
~~[illegible]~~ MB				
118/50	118	28	100	18:57
30/70	127	25	99	19:12
24/60	113	24	99	19:22

PMH - Ø PSH - Ø

Allergies - Ø Meds - Ø

(O) WWD Iraqi male Mod distress
A&O x 4
PERLA
Lungs - CTA (B) Heart - Tachy
3 WCR Ø MRG

Abd - BS (+) x 6 Ø TTP Ø splenomegaly (B)
Ø blood @ opening of meatus Cap refill 3 sec (B)
Rectal - Ø bleeding WNL N/V intact x
c̄ (L) extremity

(+) GSW - entrance - (L) Deltoid 7mm x 8mm
exit - medial arm

(+) 2 lacerations on (R) post parietal region
- minimal bleeding
Ø 2 in (2) 1 in

over

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPARTMENT/SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (If not typed or written entire name, middle, ID No or SSN, Sex, Date of Birth, Rank/Grade)

[redacted]

REGISTER NO. | WARD NO.

b(6)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-67)
Prescribed by GSA/ICMR
FIRMS (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Sept 03	(Op Note - ortho)
0400	Dx (L) III c Humerus fx
	Rx Revision Ex. Fix
	Surgeon [redacted] b(6)-2
	(GEA
	Plan re-check c Fluoro [redacted]
	~ 48.
8/9	Op Note b(6)-2
	Procedure: Wound Ⓐ Arm
	Revision & Fix
	Surgeon: [redacted]
	Fluid (saline) 2 u PRBC b(6)-2
	Purdy - Bleeding - Hematoma
	To 2Lt, Atlk
	[redacted] b(6)-2
	[redacted]
	# [redacted] b(6)-4

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0600 8 Sep 03	Received Pt from OR accompanied by anesthesia & surgeon around 0440. Ø spontaneous movement. Versed & fent gtt started. Heparin gtt started @ 800 u/hr. DSUR not available at pharm UR @ 125 going as substitution for now until order clarified. NGT inserted by anesthesia, 600 cc of clear, gastric drainage suctioned initially. ~~Placement~~ Placed on LIS. Currently, NGT clamped 2° to aspirin administration per NGT (325 mg). UE pulse +2, cap refill <3sec, warm & dry fingers, pulse ox secured from (L) middle finger c̄ good waveform. Pt's temp initially @ 93.6 blankets on & warming lamp on now @ 94.7, will continue to warm pt. Pt hypertensive initially in the 170's/90's, Relored c̄ 8 mg Versed & 100 mcg fent, currently BP in the 140's/70's, fent 100 mcg/hr, versed 10 mg/hr. Report given to CPT Rogski b(6)-2 [redacted] CPT/AN
8 Sep 03 0833	Nursing: T-94.9, HR 107, R 14, Sats 100% on [redacted] following vent settings: SIMV, TV 800, FiO2 50%, R 14, Peep 5. See ICU flow sheet for complete nursing assessment. ETT intact, airway patent. Heating lamp on, more blankets applied to pt. Strong pulses palpated in (R) radial. Skin warm to touch, cap refill <3 secs, (+) edema. Skin on (R) arm and BLE cool to touch. Pulses weak on palpation. (R) hand and feet wrapped in chux to ↑ warmth. (L) arm dressing (posterior portion) soaked in blood. Dr. Matsumoto notified. (L) arm (Cont'd)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE b(6)-2 [redacted]

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR [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. | 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 USAPA V2.00

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Sep 03 0833	Nursing Cont'd: Dressing reinforced. Dressings to Ⓡ thigh and Ⓛ thigh c/o/I. Receiving LR @ 125 cc/hr, Fentanyl @ 100 mcg/hr, Versed ↓ 5 mg/hr, and Heparin @ 800 u/hr. Foley to gravity. Voiding >200 cc/hr. CBC, PTT, Chem 8, + ABG sent to lab. Results pending. Will continue to monitor. — [redacted]
8 Sep 03 1004	Nursing: HR 140s, ABP 91/43, NBP 106/51. Dr. [redacted] notified of HR, BP, and lab results. Pt 1LR bolus @ 0940. FiO2 ↓ 40% and RR ↓ 12. Heparin ↓ 700 u/hr. Pt assessed by Dr. [redacted] — [redacted]
8 Sep 03 1040	Nursing: Ⓛ arm dressing soaked in blood, blood pouring down chest. Dressing reinforced. Dr. [redacted] notified. Ø new orders written. — [redacted]
8 Sep 03 1115	Nursing: ABG drawn. pH - 7.376, pO2 - 207, HCO3 - 22, Sat - 100%, BE (-3). Pt waking up. Opens eyes spontaneously, lifts head from bed. Pt lifting Ⓡ arm towards ETT. Pt notified [redacted] 1124 of his location, condition, and purpose of ETT through interpreter. Pt continues to attempt to raise hand [redacted] 25 towards his ETT. Soft-restraint applied to Ⓡ wrist. — [redacted]
8 Sep 03 1323	Nursing: HR 130-140s, UOP 20-28 cc/hr. Attempted to radio Dr. [redacted] Ø response @ this time. Pt awake, writing simple words on paper for translator. Ø respiratory distress noted. Versed concentration Δ'd to 100 mg/50 ml = 2.5 cc for 5 mg Versed. [redacted]
8 Sep 03 1415	Nursing: UOP - 16 cc this hour. HR 156. Versed ↑ 7.5 mg/hr. BP 97/51. — [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry) b(6)-2
8 Sep 03 1435	Nursing: H/H - 8.9/26.9, PT/PTT - 14.5/46.3. Dr. [redacted] called on radio x 2. Pt awake, writing on paper that he wants ETT out. Restraint remains on (R) wrist. HR-140s, Sats 100%. b(6)-2 [redacted]
8 Sep 03 1520	Nursing: b(6)-2 Dr. [redacted] notified of VS, ↓ UOP, [redacted] pt gesturing to have ETT pulled out. (L) UE dressing Δ'd by Dr. [redacted] (L) arm elevated on blanket. Pulse strong, skin warm to touch, Ø movement. Pt tolerated procedure well. Versed and Fentanyl gtts weaned off in preparation for extubation. [redacted]
8 Sep 03	PRBC VS [redacted] b(6)-2

Time	HR	BP	T	R	Comments
1546	130	125/53	101.3	20	PRBC transfusion started
1550	149	143/39	—	17	—
1555	142	122/37	—	18	—
1600	144	138/50	101.6	21	Øs/s of reaction
1615	158	129/36	—	19	—
1630	143	105/45		18	NG DC'd, Instructed
transfusion completed 1725	131	114/51	101.8	18	on I.S. use, Tolerating PO fluids

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

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPO [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. | 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 USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Sep 03 1610	Nursing: RT notified that pt ready for extubation. ETT D/C'd, mouth suctioned, airway clear and patent. Placed on 40% Venti Mask. HOB ↑ 45°. [redacted] SG/RN
8 Sep 03 1650	Nursing: Sats 99% on Venti Mask. Pt placed on 2L NC. Sats 99%. No distress noted. Dr. [redacted] notified of fever. Incentive spirometer encouraged. [redacted]
8 Sep 03 1733	Nursing: 1st unit PRBC transfusion completed @ 1725 5 S/S of transfusion reaction. 2nd unit PRBC transfusion started @ 1733. Lasix 20 mg IV given @ 1730. Pt had emesis x 1. Will continue to monitor. [redacted] SG/RN
8 Sep 03	PRBC Transfusion b(6)-2 A11

Time	HR	BP	R	T	COMMENTS
1733	135	133/70	18	101.8	PRBC transfusion started
1737	131	126/43	21	—	—
1741	136	111/39	19	101.9	Ø S/S of transfusion Reaction
1745	134	114/51	18	—	—
1800	143	116/43	23	101.9	[redacted] SG/RN
1815	141	116/43	20	—	
1830	137	122/68	21		
1845	131	110/53	19	100	
1900	138	119/63	21	100	completed [redacted] 8 SEP 03

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

MEDICAL RECORD

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CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/12/03	OP Note
	Procedure: Adjust Ex Fix
	Neck exploration
	wound-hand
	Surgeon [redacted] b(6)-2
	Anes: LMA
	Fluids: UR 1600 urine 800
	Findings: ① Problem: injury on pin
	② medial; lifeless neck complete transection
	To Inc. Ward
	[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.!!

[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

USAPA V2.00

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13 Sep 03 1555	Pt Medicated c̄ 2 tabs Percocet for (L) Arm pain per PRN order. Will monitor. [redacted] 9/WMC
1600	N/V check c̄ ø changes to status. [redacted] 9/WMC
1615-1700	Pt ↑ OOB Ambulated to BR for BM. Pt was not able to have BM. While on toilet, bathed Pt + changed his pants. Pt then Ambulated back to bed + layed down c̄ arm elevated. Pt Now sleeping + appears to be resting comfortably @ this time. VSS, temp ↓ to 99.9, will continue to monitor. [redacted] 9/WMC
13 Sep 1830	Received report from SPC clinic @ 1800, pt resting comfortably in bed (L) UE elevated, no sensation on (L) small finger, ring finger, & middle finger, unable to move all 5 (L) fingers. Pt's baseline per SPC clinic, +2 pulse (L) UE. warm & dry, cap refill <3secs on (L) UE. Pt ate 80% of dinner, [redacted] CPT/[redacted]
2030	Medicated pt c̄ 5mg MSO4 for (L) UE pa[redacted]
2130	Pt C/O (L) UE pain, no relief from MSO4, medicated c̄ 2 tabs percocet. VSS will reassess for effectiveness [redacted] CPT
2200	Pt states relief from pain, falling in & out of sleep. Pulses +2 (L) UE since 1800 will continue to monitor pulse [redacted] CPT/[redacted]
2300	ø c/o pain, no significant change on neuro-[redacted] (L) UE since last assessment. [redacted] CPT/[redacted]
0400	Labs drawn, Medicated pt c̄ 5mg MS[redacted] (L) UE pain ø significant change on neuro-vascular ✓ since last assessment VSS will monitor [redacted] CPT/[redacted]
Sep 13 0600	Received report + assumed care of Pt. ø Report [redacted] change in N/V status + ø other Reported significant changes. Pt appears to be resting comfortably @ this time. Will assess + Monitor. [redacted] 9/WMC

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13SEP03 0600	Received report & assumed care of Pt. VSS, Pt lying in bed looking around room & appears to be resting comfortable @ this time c̄ Ø Ntd complaints or concerns Will assess & continue to monitor. [redacted] 9/6/MG
0800	Assessment Complete, IV Ancef Started. Pt lying in bed eating breakfast @ this time. VSS, Ø Ntd complaints. Will monitor. [redacted] 9/6/MG
0801	N/V assessment done, Pulses Palpable to Radial + Pedal Pulses bilat @ +4 c̄ brisk cap refill. Unable to lift (L) arm or move any fingers on (L) hand. Loss of feeling to middle, ring, + pinky fingers, ~~sensation to~~ to (L) hand, sensation to pointer finger + thumb present. ~~Ut~~ NC All extremeties warm + dry to touch. [redacted] 9/6/MG
0910	Pt medicated c̄ 5mg MSO4 for (L) arm pain per PRN orders. [redacted] 9/6/MG
1000	N/V check done c̄ Ø changes to status. [redacted] 9/6/MG
1115	Pt medicated c̄ 2tabs Percocet for (L) Arm Pain per PRN order. Will monitor. [redacted] 9/6/MG
1200	N/V check done c̄ Ø changes to status. [redacted] 9/6/MG
1315	Pt sitting up in bed eating lunch. Ø complaints or concerns ntd @ this time. [redacted] 9/6/MG
1400	N/V check done c̄ Ø Ntd changes to status. [redacted] 9/6/MG

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.
		ICU3

[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

USAPA V2.00

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14Sep03 0645	Pt Medicated c̄ 2 tabs Percocet per PRN order for (L) arm pain. Will re-assess in 1°. [redacted] /WMG
0700	Assessment complete to include detailed N/V check. Radial Pulse to LUE baseline @ +3 + [redacted] bilat LE baseline @ +3. Pt has sensation to Thumb + Pointer Finger of LUE c̄ Ø sensation to Pinky, ring, + middle fingers of LUE. Pt Not able to move any LUE fingers. Brisk cap refill to all extremeties. Will continue to monitor N/V status. [redacted] 9/WMG
0730	Pt finished c̄ breakfast, ate about 60% of meal. Pt lying in bed + appears to be resting comfortably @ this time. Will continue to monitor. [redacted] 9/WMG
0800	N/V check done c̄ Ø changes to status @ this time. VSS, temp ↓ to 98.4°. Pt sitting in bed c̄ ØNtd complaints or concerns + appears to be resting comfortably. [redacted] 9/WMG
1000	Pt Medicated c̄ 5mg MSO4 for (L) arm pain per PRN order. N/V check done c̄ Ø changes Ntd. Will monitor. [redacted] 9/WMG
1030-1100	Pt Pre Medicated c̄ 5mg MSO4 + 2mg Versed for LUE dressing Δ. Dressing change performed by DR's [redacted] + [redacted]. Old dressing removed, Kerlex fluffs applied + wrapped c̄ Kerlex rolls. Splint then applied to arm. Pt tollerated well. [redacted] 9/WMG
1210	Pt complaining of LUE pain, medicated c̄ 2mg MSO4 + 2 tabs Percocet per PRN orders. Will monitor. [redacted] 9/WMG

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. ICU3

[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 USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14SEP03 1220	Re-elevated LLE following new splint placement for dressing change. [redacted] 9/WMG
Late Entry	1200 - N/V check done c̄ Ø changes to status. Will continue to monitor. [redacted] 9/WMG
1400	N/V check done c̄ Ø changes to status ntd. Pt was sleeping before assessment + appeared to be resting comfortably. Will continue to monitor. [redacted] 9/WMG
1600	N/V check done c̄ Ø ntd changes to status. Bilateral inner thigh dressings changed. Old dressings removed, sites wiped clean c̄ Normal saline, ~~but~~ 4x4's applied + secured c̄ cloth tape. ~~Pt medicated~~ [redacted] 9/WMG
1645	Pt medicated c̄ 2 tabs Percocet for LLE [redacted] PRN orders. VSS, will continue to monitor. [redacted] 9/WMG
1800	N/V check done c̄ Ø ntd changes to status. [redacted] 9/WMG
1805	Report given to nightshift. [redacted] 9/WMG
1806	Pt complaining of pain, medicated c̄ 3mg MSO4 per PRN order. [redacted] 9/WMG
1815	Received report from SPC clinic - Pt sleeping in bed. VSS. Will continue to monitor. [redacted] 9/WMG
2000	Pt sleeping in bed; Pt received II Percocet prior c̄ good effect. VSS. Will continue to monitor. [redacted] 9/WMG
2200	Pt resting in bed. 3mg MSO4 [redacted] continue to monitor. [redacted] 9/WMG
15SEP03	0200 Pt resting in bed VSS, Ø BM this shift. Urine Q5 to foley. Remove clamp c̄ no [redacted] 9/WMG
0600	Received report + care of pt. from previous N. Pt awake in bed. [redacted]

b(c)-2 A11

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)*
22SEP03	1317 Assumed care of Pt. @ 0600. Assessment completed. VSS, AO PERRLA lungs CTA(B) Resp. even-unlabored, NSR, IV (R) wrist C redness. IV DC'd, new IV C heplock started to (L) FA. CDI 18G. Pt. Ambulated to latrine. Performed am care C no c/o pain. Abd soft, non-tender BS x4. (L) UE dressing D/d. Pin care performed. Incision to (L) wrist to (L) armpit. Sutures intact (-) s/s of infection. Cap refill < 3secs (+) radial + pedal pulses. Dressing Δ to (L) + (R) thigh's C (-) s/s inf. staples intact. Voiding per urinal. Tolerating PO well. no complaints of pain @ this time. Will cont. to monitor pt. b(6)-2 [redacted]
22sep03@1930	Assumed care @ 1800; All VSS, pt A&OX3, NVV done. (+) sensation in thumb & pointer finger; (-) sensation in remaining digits; (-) movement in (L) arm & hand pt states he has sensation from his (L) wrist up through his arm; pt OOB to amb in hall X1 for 30 min; cont E NVV Q2°, ∅ c/o pain/discomfort @ this time; IS was encouraged; (L) arm ↑; pin care completed; dsg to (L) arm & bilat. thighs CDI E drainage; all sutures intact, (-) drainage, well approximated; restraints in place, (+) circulation, (-) skin breakdown, cont to monitor b(6)-2 [redacted]

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

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

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 8-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

510-112

NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 Sep 03		2300	Pt taken to X-Ray for Q LE, drsg reinforced, Dr [redacted] made aware of pt Temp 102.3 & ordered Tylenol 650mg pm fever >101, given. Temp 100.7. Will cont to monitor. [redacted] 9MC/MC/M3
9 Sep 03	0030		Pt NPO p midnight, Temp 100.1. Cont c̄ 2hr neuro check to Q LE, pt c̄ ⊕ pulse & warm extremity c̄ cap refill <3 sec. Will cont to monitor. [redacted] 9MC/MC/M3

b(6)-2 A11

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

(Continue on reverse side)

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)

[redacted] b(6)-4

Ahmed

DTG IN: 2010 *

TO OR:

NAME: Iraqi National - IWD

SSN: UNIT: 5th

WT LBS: 175 WT KG:

ALLERGIES: NKDA

PATIENT RECORD

TIME OF INJURY:

DETAILS OF INJURY EVENT: Shot when firing @ troops

GCS PRIOR TO ARRIVAL=

(#1) W0018 03 002934 N (VOORS) H/H 23/8 @ 2030

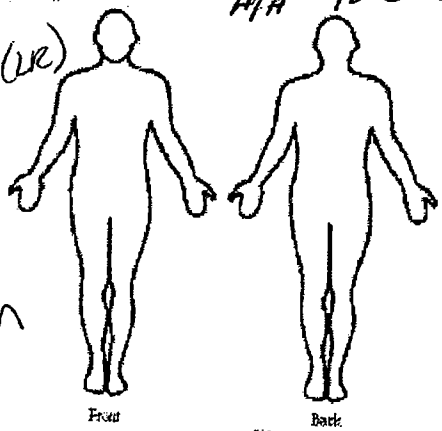
TIME	IV	SZ	SITE
	1	14 Gold	(L) arm
2015	2	18	(L) hand
	3		
	4		

LITERS OF FLUID IN: 2nd Bag ↑ 2015 (Jul) - Bags 5 total (LR)
bag 6 @ 2030, 7 2040

UNITS OF BLOOD IN: #1 ↑ 2010

TIME	MED & DOSE	INIT.
2010	Ancef 1gm	
2025	Fentanyl 50	

TIME	INTERVENTION
2015	OXYGEN ON & RATE: (L via FM
	ETT SIZE:
	SURG. AIRWAY
	CT #1 & SITE:
	CT #2 & SITE:
2055	FOLEY 16F
	GASTRIC



4633858 (#2)

AIRWAY: Patent PATENT (ETT) ORAL NASAL FM @ 6 fr → INTUB. IN EMT

CHEST: clear

RIGHT BS= LEFT BS=

NEURO: Alert GCS=

HEAD, FACE, & NECK: laceration (2) down to skull 2" long

ABDOMEN: clear

PELVIS: clear

UPPER LEGS: GSW RT thigh - no exit wound

LOWER LEGS: clear

ARMS: (L) arm - Drsg ↑ (L) arm / Sam Padded Splint
(L) Deltoid ½ inch exit - medial - R/O fx humerus

POSTERIOR: clear

ANESTHESIA / OR

TIMES	
IN:	2100
INCISION:	2115
PROC. END:	2345
TO ACW:	2355
ANESTESIA TECH.	
MAC:	
REGIONAL:	
GENERAL	RSI ETOMID

MEDICATIONS	
MIDAZOAM	ANTIBIOTIC: SEE PROF
PENTOTHAL	
ETOMIDATE 20mg	
FENTANYL 250mcg	REVERSAL:
MSO4	
SUCCINYL.	
ROCURONIUM 150mg	OTHER: ALBUMIN 5%
VECURONIUM	SCOPOLAMINE 0.4
AGENTS FORane	

FLUID TOTALS	
CRYSTAL:	7000
COLLOID:	PRBC 600 FFP 50
EBV:	
EBL:	
U.O.:	400
DRAINS:	1½ LR
	#6, #7, 8

VITAL SIGNS	PACU		
TIME:	2110	2345	
BP:	82/40	116/57	
HR:	86	94	
RR:	10	10	
SpO2:	100	101	
TEMP:	97		

PROCED: SHUNT TO (L) ARM
EX FIX (L) ARM

RECOVERY

TIME IN: O2 VIA & RATE:

SURGEON(S):

PROCEURE:

DRESSINGS:

TUBES:

DRAINS:

IV SITE RE-EVALUATION				
IV	SZ	SITE	RATE	AMT IN BAG

POST-OP MEDICATIONS		
TIME	MED & DOSE	ROUTE

CUMULATIVE I & O			
INTAKE		OUTPUT	
SOURCE	AMT	SOURCE	AMT
TOTAL=		TOTAL=	

POST-ANESTHESIA RECOVERY SCORE	
ADMIT=	
30 MIN=	
D/C=	

VITAL SIGNS	ADMIT	D/C
BP:		
HR:		
RR:		
SpO2		
TEMP:		

Doppel radial Pulse ↑ OR.

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 23

HEIGHT:

WEIGHT: 175 lbs.

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type): Ex Fix

4. PROPOSED SURGICAL PROCEDURE: Revision of Ex Fix Brachial artery Repair S/P GSW Emergency Case
Intubated
Foley Cath

5. ADDITIONAL INFORMATION: (Previous surgical and medical history)
Tobacco ? ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ? Skin Condition ?
ETOH ? Implants Ø ROM ?
Glasses/Contact (Y) (N) Dentures Ø Respiratory Disease (Asthma/COPD) (Y) (N) ? ASA/Motrin w/72 hrs (Y) (N)
Hypertension (Y) (N) ? Herbal Medicines (Y) (N) Anticoagulants (Y) (N)
MEDS: Ancef, Percocet

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

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

EPW [redacted]
blw-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since ? ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: NO

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

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

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

[redacted] 8 Sept 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTAC (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☑ Intubated BREATHING EASY (Y) (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liner with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] IT/AN

DATE: 8 Sep 03 TIME: 0030

13. POSTOPERATIVE EVALUATION PREPARED BY [redacted]

DATE: 8 Sept TIME: 0430

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, P[redacted]OCEDURE VERIFIED BY CPT [redacted]

3. DATE 12 Sept 03 TIME PATIENT ARRIVED IN SUITE ____

4. PATIENT IN ROOM TIME 0815 b(6)-2 NUMBER 2-2 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	LTC [redacted] 040-1110 [redacted] b(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) armboard used

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

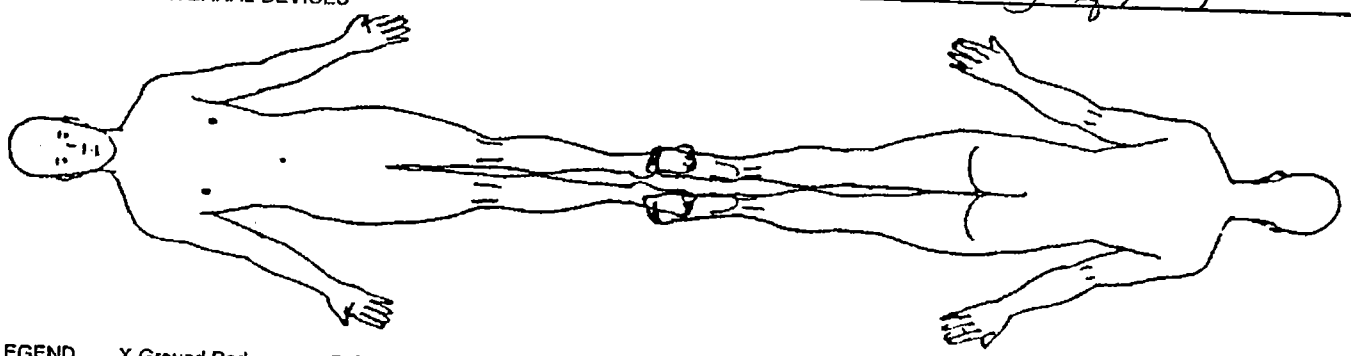
PREP SOLUTION (Specify) Betad/Betad

SITE: (L) arm BY WHOM: CPT [redacted]

SITE: ____ BY WHOM: ____

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

b(6)-2

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	/	C	Spc [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C	/	C	Spc [redacted]	CPT [redacted]
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 Sep 03

[redacted] b(2)-2

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

CUT 20 COAG 30

☒ ESU NO: Valleylab

GROUND PAD: BRAND Valleylab E7507

LOT NO: 696701

☐ ESU NO: ____

GROUND PAD: BRAND ____

LOT NO: ____

☐ BIPOLAR NO: ____

DA FORM 5179-1, OCT 87 REPLACES DA FO[illegible] BSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):
0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-ARM IF YES, SITE (L) ARM

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- ace wraps.

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type:
CRNA

Bovie Pad site intact pre-op_____; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____; post-op_____
Tourniquet Time: Up____ Down____ YA b(6)-2 All
DA5179 In Chart

20. OPERATION(S) PERFORMED
I&D (L) arm, wound exploration, adjust ex-fix (L) arm.

21. PATIENT TRANSFERRED TO PCU3 TIME 1230 METHOD [redacted]

22. REGIST[redacted] CPT/AN [redacted] LTC, AN

REVER[redacted] USAPA V1.01

MEDCOM - 18543

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Wheeled litter BY Anesthesia

2. PATIENT IDENTIFIED [redacted] ED AND PROCEDURE
VERIFIED BY CPT [redacted] b(6)-2

3. DATE 09SEP03
TIME PATIENT ARRIVED IN SUITE 0810

4. PATIENT IN ROOM
TIME 0810 NUMBER 2/1/1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed, head on foam doughnut, Bilateral Arms extended out to sides 90°. RUE secured to padded arm board & Safety Strap. LUE prepped into Sterile field + placed on padded double arm boards. folded towels under heels. Correct Body Alignment maintained

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

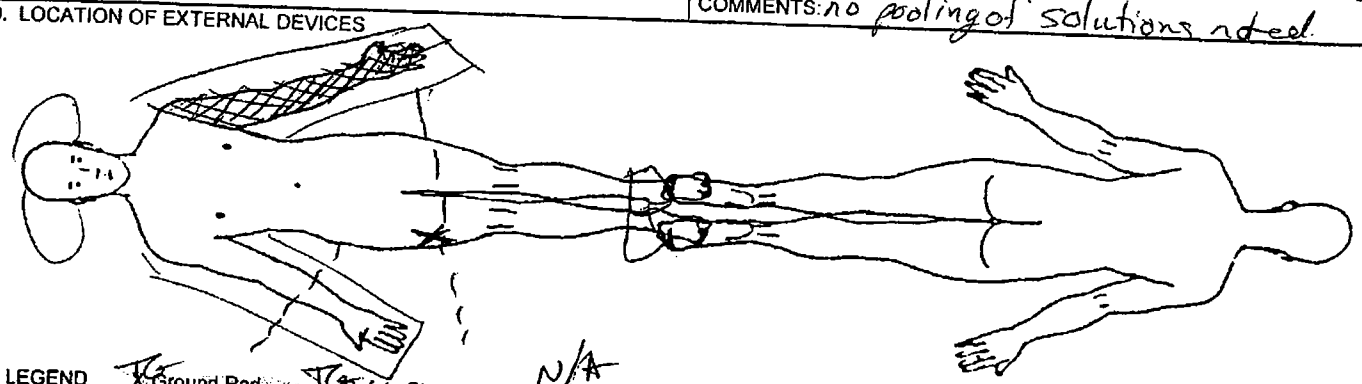
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: LUE BY WHOM: CPT [redacted]
SITE: BY WHOM: Mrs [redacted]
COMMENTS: no pooling of solutions noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND Ground Pad Safety Strap N/A Tourniquet

10. COUNTS

C = Correct I = Incorrect

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

b(6)-2

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

[redacted]

b(6)-4

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

☒ ESU NO: RSE 105305
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 68936/2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST) DEC 83 WHICH IS OBSOLETE. USAPA V1.01

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

just previous ex fix remains.

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

QS. 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ fluoro via C-Arm IF YES SITE LUE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*

KERLEX Fluffs
KERLEX Rolls
Xeroform Gauze

19. ADDITIONAL INFORMATION

WC III

Surgeons: Dr [redacted] Anesthesia: MAJ [redacted] CRNA Anesthesia Type: GEN LMA

Dr [redacted] bb-2

Dr [redacted]

Bovie Pad site intact pre-op CDI; post-op CDI Bovie Settings: Coag/Cut 40/40 Blend 1

Tourniquet Site intact pre-op N/A post-op _____

Tourniquet Time: Up N/A Down _____

20. OPERATION(S) PERFORMED

wash out LUE + Ex Fix adjustment

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	0940	wheeled litter

22. REG[redacted] PT/AN

REVERS[redacted]

b(6)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 8 SEP 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0114 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA
S/P GSW Emergency Case
EPW intubated
Patent Foley cath 16 Fr.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

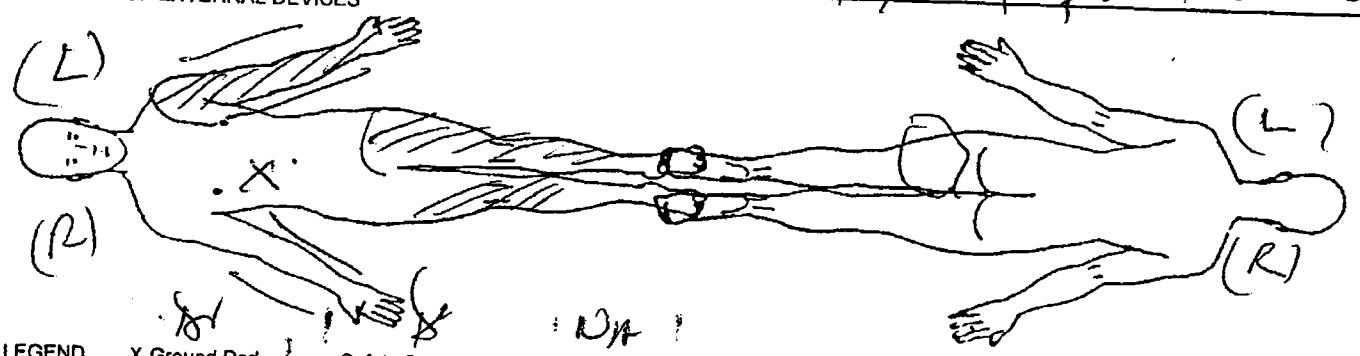
7. POSITION AND POSITIONAL AIDS (Specify)
Pt placed on OR bed. Arms on arm board, <90°
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP
COMMENTS: Sandbags. Spray across chest. All IV's. Bump under (L) hip. Intubated.

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: ∅ cuts or wounds noted

PREP SOLUTION (Specify) Betadine b(6)-2
SITE: (L) leg (Foley) BY WHOM: [redacted]
SITE: (L) arm BY WHOM:
COMMENTS: ∅ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad | – Safety Strap === Tourniquet

Initial:

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C		
Needle Sharp	☒ Yes ☐ No				SPC [redacted] b(6)-2	MAJ [redacted]
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;)

EPW # [redacted] b(6)-4

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

☒ ESU NO: Valleylab 40 RS6 102395
GROUND PAD: BRAND Valleylab
LOT NO: 68245 2005/02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

b(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Heparin in Normal 1/1 (1000u/1000ml)	QS	intra-op	irrigation	[redacted]	Dr [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSI[redacted] b(6)2

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE (L-arm) (L) arm

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. Foley 16Fr	2. Penrose	3.
SITE	1. (Bladder)	2. (R) leg	3.

18. DRESSING/IMMOBILIZATION (Specify)
ARM (L) (L) Leg
fluff TEFA
Kerlix 4x8
ACE TAPE

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted]
Dr [redacted]
Anesthesia: [redacted]
Anesthesia Type: general
b(6)-2

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 40/40
Tourniquet Site intact pre-op N/A post-op N/A
Tourniquet Time: Up N/A Down N/A

DA5179 Initiated

20. OPERATION(S) PERFORMED
External fix adjustment (L) arm / Brachial artery repair vein graft
L→D (R) leg

21. PATIENT TRANSFERRED TO ICU | TIME 0425 | METHOD Litter c O2

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

REVERSE OF DA FORM 5179-4, OCT 87 USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

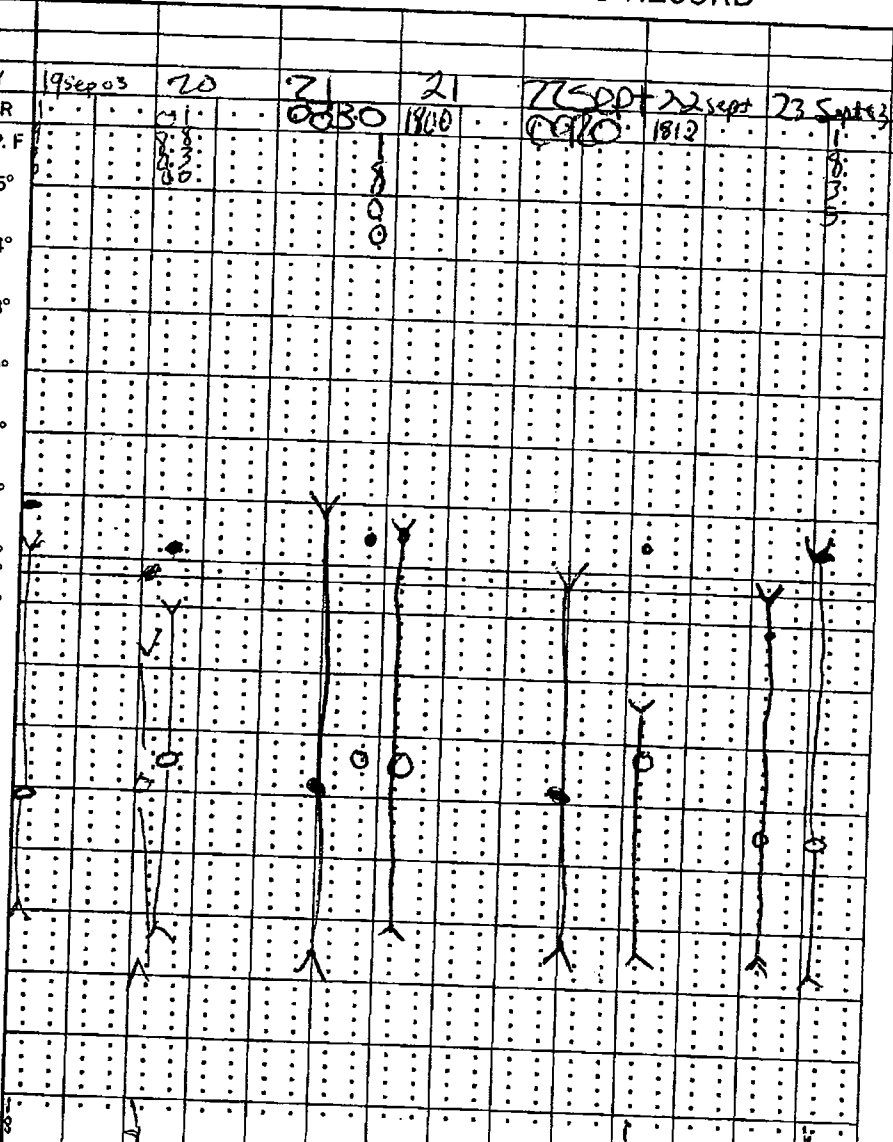
POST- DAY

MONTH-YEAR | DAY | 19sep03 | 20 | 21 | 21 | 22sept | 23 Sept03

19 | HOUR | 0830 | 1800 | 0930 | 1812

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE | 132/71 | 113/64 | 119/69 | 138/64 | 134/69 | 116/71 | 106/64 | 125/66 | 134/64

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

104

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

7540-01-075-371

LOG NUMBER [redacted]

RECORDS MAINTAINED AT

b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE | ZIP CODE

SEX: ♂

AGE: 23

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

ARRIVAL

DATE (Day, Month, Year): 7 Sept 03

TIME: 2345

TRANSPORTATION TO FACILITY: Air evac

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: unknown

ALLERGIES: unknown

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN: ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INITIAL SERIES: ☐ YES ☐ NO

CHIEF COMPLAINT: GSW rt upper leg / GSW Lt upper arm

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	0050	2355	0001		
BP	152/88		158/80		
PULSE	151	100	85		
RESP	28 12	12	12		
TEMP					
WT					

LAB ORDERS

CBC/DIFF | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT

URINE C&S | UA MSCC/CATH | CHEM: R lytes

BLOOD C&S X

Type Screen

X-RAY ORDERS

L CXR PA & LAT/PORTABLE | C-SPINE

ACUTE ABDOMEN | LS SPINE

SINUS | HEAD CT

ANKLE R/L | Pelvis

Skull | Thoracic/Lumbar

☒ PULSE OX 100%

ORDERS

TIME	ORDERS	BY	COMPLETED BY	TIME
00	10 mg vec			
05	5mg morphine		Vecuronium	2350
55	Ampicillin		MSO4 Sept	0005
	Ampicillin IV			0005

☐ MONITOR

☐ ECG

PATIENT'S RESPONSE

POSITION: HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: IMPROVED ☐ UNCHANGED DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO WHEN

I have received and understand these instructions.

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

PATIENT'S SIGNATURE

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP O2	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT							
PT			U/A	DIP		EKG INTERPRETATION	
PTT	BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL
Upon arrival pt intubated, foley catheter in place. soft tissue Rt thigh, GSW Lt upper arm. Ring given to PAD

? Age reported 23 y/o ♂ s/p GSW to arm @ 2100 last night, seen by OST team, ORDER ext fix (L) humerus. (Drape CIV w/ Cerv stabs) (+)(L) brachial plexus? / vascular repair done (see note)

O: Intubated Head (+) 2cm lac (R) post occ. / parietal to galea, ∅ actual bleed / staples
Chest: CTA (B) = air vent CVS NSR ∅ murmur / gallop 100 a marker Abd: ∅ soft ∅ masses
Ext: ex fix w/ splint (L) humerus ∅ active bleed / (+) pulses = (B)
Back:
Pelvis stable

A/P (1) s/p GSW / post op pt stable, begin to wake from RSI, purposeful grasp MUSC / VEC. Eval by Ortho → OR

CONSULT WITH	TIME	ACTION
Surg		
Ortho		

DIAGNOSIS

RESIDENT/MEDICAL STUDENT SIGNATURE [redacted] STAMP

PROVIDER SIGNA [redacted]

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)*

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 553 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD — VITAL SIGNS RECORD

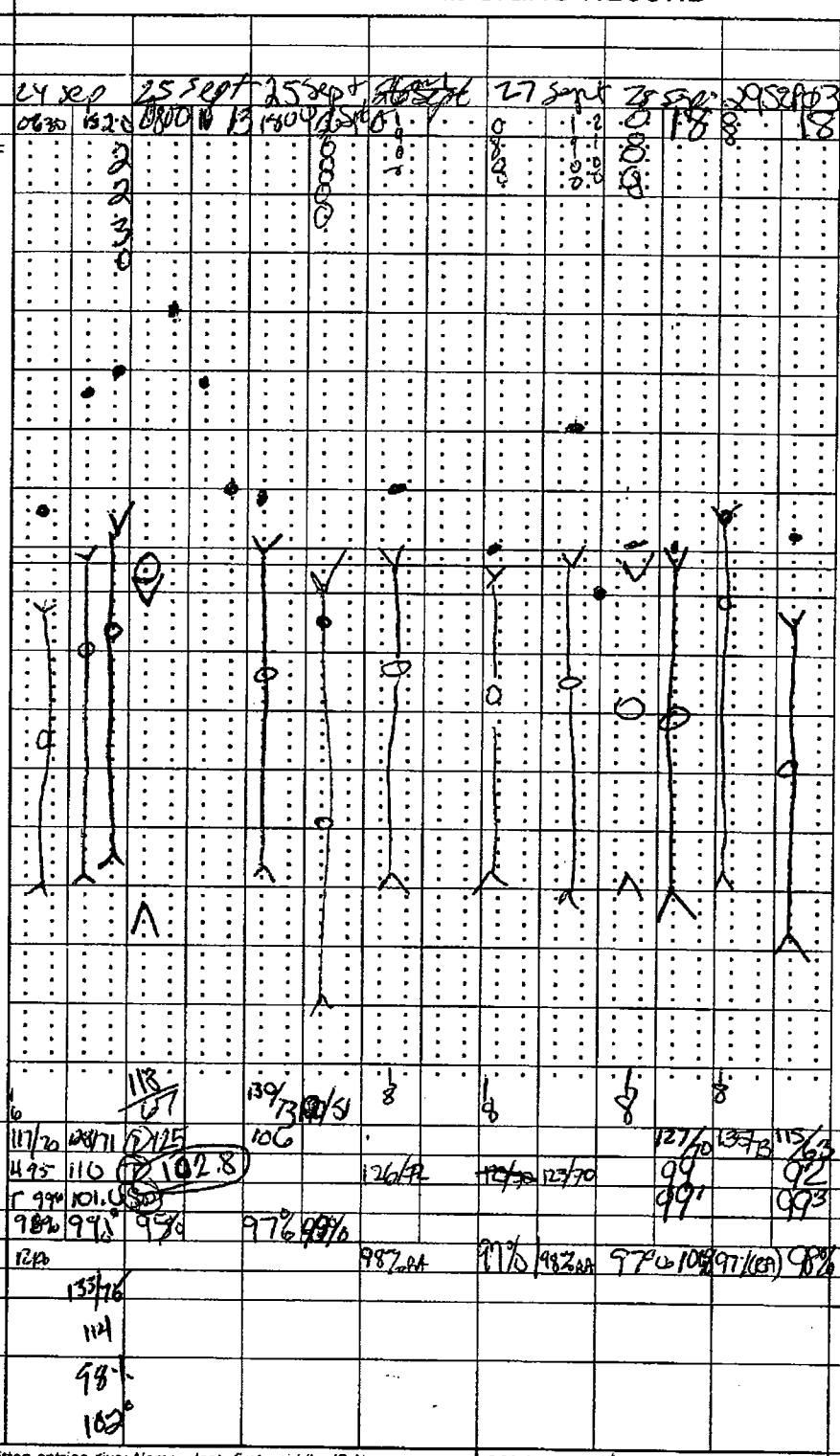
HOSPITAL DAY

POST- DAY

MONTH-YEAR Sept 2003 | DAY | HOUR

PULSE (0) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted]

b(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

511-119

MEDICAL RECORD

NSN 7540-00-634-4124

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Oct 2003

DAY 07 08 09 10 11 12 13

HOUR 8 20 8 8

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 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		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE 125/67 120/68 119/49

97 8

HEIGHT: WEIGHT →

95.4 kg 98.8 kg 98.8 kg

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

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

19 HOUR

PULSE (O) TEMP. F (•)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

TEMP. C

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

#[redacted]

b(6)-4

Icu #1

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

Pt [redacted] b(3)-1
Size 7.5cm
24cm @ lip

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
8Sep03	0433	Simv	14	750	50	5	23	14	80	100%	61/89								[redacted]
	554	Simv	14	750	50	5	22	14	89	100	140/90								
	08K	Simv	14	750	50	5	24	14	95	100									
	1020	Simv	↓12	750	↓40	5	24	12	136	100	69/26								
	1200	Simv	12	800	40	5	26	24	118	100	97/51								
	1400	Simv		800	40	5	30	28	162	100									
			EXT,			1600													

b6-2

MEDCOM - 18554

ICU #1 [redacted] b(6), 2

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

(L) lower ext. 8.0 ETT 22@ lip

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
8 Oct 03	0545	SIMV	10	900	40%	5	28	0	93	100	139/71							
	0800	SIMV	10	900	40	5	24	10	99	100	141/80							ROK
	1000	SIMV	10	900	40	5	25	10	101	100	157/83							RRR
	1200	SIMV	10	900	40	5	24	10	105	100	141/87							RRR
	1400	SIMV	10	900	40	5	25	10	103	100	166/85							RRR
	1559	SIMV	10	900	40	5	25	10	114	100	144/71							RRR
	1841	SIMV	10	900	40	5	23	10	109	100	160/81							OHA
	2010	SIMV	10	900	40	5	32	10	125	100	156/88							BPS CTA bilat
	2200	SIMV	14	900	40	5	29	14	130	100	156/83							
9 Oct	0002	SIMV	14	900	40	5	29	14	117	100	158/80							
	0200	evacued to Germany																ROK
																		ROK

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

LAST, FIRST, MI: [redacted] b(6)-4	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/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) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	9Sep03	

b(6)-2

Ward/Section: ICU-1	REQUESTING PHYSICIAN: [redacted] (u)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted]	DATE 9 Sep 03	TIME 0920	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	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. b(6)-4 # [redacted]	DATE 15 Sep 03 / TIME 0032	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	HZY	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	1.020	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	1RG	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	TR	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	NEG	Negative	Other		
Atyp		Imm	Leuk	NEG	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.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 # [redacted]	DATE 8 Sept 03 / TIME 0010	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 e.g.

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____23 mmol/L

At 37C

PH_____7.422

PCO2_____33.5 mmHg

PO2_____284 mmHg

HCO3_____22 mmol/L

BEecf_____-3 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.456

PCO2_____30.3 mmHg

PO2_____273 mmHg

Patient Temp: 94.5F

FIO2_____: 50

Sample Type_: ART

08SEP03 07:17

Oper: [redacted]

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.483

PCO2_____23.4 mmHg

PO2_____136 mmHg

HCO3_____18 mmol/L

BEecf_____-6 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.481

PCO2_____23.6 mmHg

PO2_____137 mmHg

Patient Temp: 98.9F

FIO2_____: 80

Sample Type_:

05SEP03 04:32

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAM5046A

---

i-STAT EG7+

Pt: 0 [redacted]

Pt Name:_____

Na_____142 mmol/L

K_____3.7 mmol/L

TCO2_____21 mmol/L

iCa_____1.28 mmol/L

Hct_____23 %PCV

Hb*_____8 g/dL

*via Hct

At 37C

PH_____7.089

PCO2_____63.8 mmHg

PO2_____25 mmHg

HCO3_____19 mmol/L

BEecf_____-11 mmol/L

sO2*_____27 %

*calculated

Sample Type_:

10MAR03

Oper: [redacted]

Physician:_____

---

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.300

PCO2_____41.8 mmHg

PO2_____310 mmHg

HCO3_____21 mmol/L

BEecf_____-6 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

08SEP03 03:01

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAM5046A
CLEW A93

---

i-STAT G3+ b(6)-4 RR 12

Pt: [redacted] FIO 100%

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.293

PCO2_____46.0 mmHg

PO2_____463 mmHg

HCO3_____22 mmol/L

BEecf_____-4 mmol/L

sO2*_____100 %

*calculated

FIO2_____: 100

Sample Type_: ART

08SEP03 00:24

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAM5046A
CLEW A93

Pt: [redacted] b(6)-4

Pt Name:_____

Na_____137 mmol/L

K_____3.8 mmol/L

TCO2_____28 mmol/L

iCa_____1.15 mmol/L

Hct_____21 %PCV

Hb*_____7 g/dL

*via Hct

At 37C

PH_____7.312

PCO2_____53.2 mmHg

PO2_____545 mmHg

HCO3_____27 mmol/L

BEecf_____1 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

09SEP03 09:09

Oper: [redacted]

Physician:_____

Ser# 42011

Ver: JAM5046A
CLEW A93

STANDARD FORM 545 (rev. 10-75)
545-108

LABORATORY REPORT DISPLAY

======= PICCOLO =======
08/09/03 00:34
REFERENCE RANGE: MALE
PATIENT #: 0723
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100676 b(6)-2

GLU	119*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	2817*	39-380	U/L
NA+	136	128-145	MMOL
K+	5.9*	3.3-4.7	MMOL
CL-	105	98-108	MMOL
tCO2	20	18-33	MMOL

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

======= PICCOLO =======
08/09/03 00:34
REFERENCE RANGE: MALE
PATIENT #: 0723
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100684

ALB	3.4	3.3-5.5	G/DL
ALP	41	26-84	U/L
ALT	36	10-47	U/L
AMY	463*	14-97	U/L
AST	57*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CHOL	59*	100-200	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
GLU	125*	73-118	MG/DL
TP	5.4*	6.4-8.1	G/DL

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

REMOVE PROTECTIVE STRIP—PLACE TOP OF 3D REPORT HERE AND SUCCEEDING ONES ON LINES TO THE RIGHT

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

① ② ③ ④ ⑤ ⑥ ⑦

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted]

b(6)-4

FORMS DISPLAYED ON THIS SHEET ARE *(Check one)*

MOUNTED ON STRIPS 1 THROUGH 7
- [x] CHEMISTRY I (SF 546)
- [ ] CHEMISTRY II (SF 547)
- [ ] CHEMISTRY III (SF 548)
- [x] HEMATOLOGY (SF 549)
- [ ] URINALYSIS (SF 550)
- [ ] SEROLOGY (SF 551)
- [ ] SPINAL FLUID (SF 555)

MOUNTED ON STRIPS 1, 3, 5, AND 7
- [ ] PARASITOLOGY (SF 552)
- [ ] IMMUNOHEMATOLOGY (SF 556)
- [ ] ASSORTED FORMS
- [ ] OTHER *(Specify)*

MOUNTED ON STRIPS 1, 4, AND 7
- [ ] MICROBIOLOGY I (SF 553)
- [ ] MICROBIOLOGY II (SF 554)
- [ ] MISCELLANEOUS (SF 557)
- [ ] ASSORTED FORMS

PRESCRIBE BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

LABORATORY REPORT DISPLAY

★ U.S. GOVERNMENT PRINTING OFFICE 2001–660-043

TEST(S)

SPECIMEN TAKEN

DATE: 9 Sep 03 TIME: 0145 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	
less than adequate	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: [redacted] CBC

b(6)-2

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

TECH MD DATE 9 Sep 03

LAB. ID. NO.

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

PATIENT: ☐ BED ☐ OUTPATIENT ☐ NP ☐ DOM

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

SPECIMEN

HEMATOLOGY 549-107

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

[redacted] b(6)-4

ICU#1

TEST(S)

SPECIMEN TAKEN

DATE: 9 Sep 2003 TIME: 1800 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	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: [redacted] CBC

b(6)-2

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

REPORTED BY

TECH MD DATE

LAB. ID. NO.

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

PATIENT: ☐ BED ☐ OUTPATIENT ☐ NP ☐ DOM

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

SPECIMEN

HEMATOLOGY 549-107

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

PATIENT'S MED. RECORD

[redacted] b(6)-4

[redacted] b(6)-4

ICU#1

CHEM 1

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

PATIENT STATUS: ☐ BED ☐ AM.. ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN

LABORATORY FILE

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

```
PICCOLO
09/09/03          04:44
RULING RANGE:     MALE
PATIENT #:  [redacted] b(6)-4
MEDICAL
DISC LOT #:       3141A4
OPER #:  [redacted] DR # 000
SERIAL #: b(6)-2 0000100694
C   126*   73-118   MG/DL
E    16    7-22    MG/DL
C   1.6*   0.6-1.2 MG/DL
C   488C*  339-380 U/L
N   128    128-145 MMOL
K   3.8    3.3-4.7 MMOL
C   105    98-108  MMOL
t2  21     18-33   MMOL
I...J QC: OK   CHEM QC: OK
HEM 0 , LIP 0 , ICT 0
```

MEDCOM - 18562

#[redacted] b(a)-4

ICU#1

HEMATOLOGY

SPEC NO.

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

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

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

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

REQUESTING PHYSICIAN'S SIGNATURE: [redacted] b(a)-2

REPORTED BY MD TECH

DATE 18 Sep 03

LAB. ID. NO.

LABORATORY FILE

CBC / 17/177

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RESULTS	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
												WBC DIFF AND BLOOD CELL MORPH																					
	18 Sep 03																					less than	adequate										

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev 7-78) PRESCRIBED BY GSA/ICMR FPMR (41 CFR) 201-45.505

#[redacted] b(a)-4

ICU#1

CHEM 1

SPECIMEN

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

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

PATIENT'S MED. RECORD

PICCOLO
10/09/03 04:35
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
METLYTE 8 31524A4
DISC LOT #:
OPER #: [redacted] DR #: 000
SERIAL #: 00001000684

GLU	123*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.7*	0.6-1.2	MG/DL
CK	3069*	39-380	U/L
NA+	123*	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

b(a)-2

11/09/03 04:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) 0000100676

GLU	106	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	1709*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	27	18-33	MMOL/L

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

FIRMR (41 CFR) 201-45.505

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted] b(6)-4

ICU #1

CHEM 1
URGENCY: ROUTINE, TODAY, STAT, PRE-OP
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.

LABORATORY FILE

TEST(S)
SPECIMEN TAKEN
DATE 11 Sep 03 TIME 0420 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	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	PT: % ACTIVITY	
	PT: RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS [redacted]
HCT/HGB/RBC

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

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH 11 Sep 03
MD DATE
HEMATOLOGY
URGENCY: ROUTINE, TODAY, STAT, PRE-OP
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.

PHYSICIAN COPY

[redacted] b(6)-4

ICU #1

b(6)-2

TEST(S)

SPECIMEN TAKEN

DATE 12SEP TIME 0355 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	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	PT: % ACTIVITY	
	PT: RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: CBC

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE: [redacted]

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted] b(6)-4

REPORTED BY

TECH

MD

DATE 12SEP

HEMATOLOGY

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

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

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

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

b(6)-2

TEST(S)

SPECIMEN TAKEN

DATE 12SEP TIME 0355 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 8, PT/PTT

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE: [redacted]

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted] b(6)-4

REPORTED BY

TECH

MD

DATE 12SEP

CHEM I

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)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

PHYSICIAN'S COPY

SPE

DATE 13SEP

RESULTS

===== PICCOLO =====

13/09/03 04:56

REFERENCE RANGE: MALE

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

BASIC METABOLIC

DISC LOT #: 3145AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-2 0000100494

GLU	120*	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	+++130	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

ICU 1

[redacted] b(6)-4

CHEM 1

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

SPEC AKEN

DATE 13SEP TIME 0410 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	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	PT: % ACTIVITY	
	PT: RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS CBC PT/PTT

HEMATOLOGY 549-107

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

b(6)-2

Enter in above space

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted]

REPORTED BY

[redacted] b(6)-4

ICU1

TECH MD DATE 13SEP 0410

HEMATOLOGY

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PHYSICIAN COPY

b(6)-2

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)	

REMARKS

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 8-4-23 1458P03

b(6)-4

CHEM 1

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

546-107

LABORATORY FILE

b(6)-2

TEST(S)

SPECIMEN TAKEN

DATE | TIME A.M. P.M.

REQUESTED

RESULTS

REMARKS

PT/PTT

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 8-4-23 1458P03

b(6)-4

MISC

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

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

SPECIMEN SOURCE (Specify): VEIN

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

LABORATORY FILE

#[redacted]

b(6)-4

HEMATOLOGY

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

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

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

SPECIMEN/LAB RPT. NO.

LABORATORY FILE

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

REPORTED BY MD TECH

DATE 8-4-23 1458P03

LAB. ID. NO.

REMARKS CBC

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

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

549-107

b(6)-2

b(6)-2

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)	

REMARKS

[redacted]

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD

TECH

DATE 0355 155EP03

LAB. ID. NO.

CHEMISTRY I

STANDARD FORM 548 (Rev. 3-77)

PRESCRIBED BY GSA ICMR

FIRMR (41 CFR) 201-45.505

548-107

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PHYSICIAN'S COPY

[redacted] b(6)-4

b(6)-4

TEST(S)

SPECIMEN TAKEN

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

REQUESTED

RESULTS

PT/PTT

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-45.505

557-107

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD

TECH

DATE 0355 155EP03

LAB ID NO.

MISC

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

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PHYSICIAN'S COPY

[redacted] b(6)-4

HEMATOLOGY

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

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

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

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE

[redacted] b(6)-2

REPORTED BY

MD

TECH

DATE 0355 155EP03

LAB. ID. NO.

CBC

TEST(S)

SPECIMEN TAKEN

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

RESULTS	REQUESTED	(X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	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
										WBC DIFF AND BLOOD CELL MORPH																					

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)

PRESCRIBED BY GSA/ICMR

FIRMR (41-CFR) 201-45.505

b(6)-2

ICU

b(6)-4

[redacted]

======= PICCOLO =======
08/09/03 07:53
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100676

GLU	133*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	108	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY MD TECH DATE 8 Sep 03

REMARKS CBC, PT/PTT

LAB. ID. NO. Artery

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

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

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

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

PATIENT'S MED. RECORD

549-107

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

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	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	PT: % ACTIVITY	
	PT: RATIO	
	SICKLING TEST	
	LE PREP	

PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

CHEM 1

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

ICU

b(6)-4

[redacted]

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

REPORTED BY MD TECH DATE 8 Sep 03

REMARKS CBC, PT/PTT

LAB. ID. NO. Artery

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

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

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

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

PATIENT'S MED. RECORD

549-107

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

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	
	PTT: PATIENT	
	PT: CONTROL	
	PT: PATIENT	
	PT: % ACTIVITY	
	PT: RATIO	
	SICKLING TEST	
	LE PREP	

#[redacted] ICU#1

HEMATOLOGY

SPECIMEN/LAB RPT NO.

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

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

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

LABORATORY FILE

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

b(6)-2

REPORTED BY | MD | DATE 2115 | TECH 8 Sep 03 | LAB. ID. NO.

TEST(S) CBC / PT/PTT

SPECIMEN TAKEN: TIME 2115 A.M. (P.M.) | DATE 8 Sep 03

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

WBC DIFF AND BLOOD CELL MORPH

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

549-107

#[redacted] b(6)-4

ICU#1

HEMATOLOGY

SPECIMEN

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

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

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

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY | MD | DATE | TECH 8 Sep 03 | LAB. ID. NO.

TEST(S) CBC

SPECIMEN TAKEN: TIME 2225 A.M. (P.M.) | DATE 8 Sep 03

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

WBC DIFF AND BLOOD CELL MORPH

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

549-107

==== PICCOLO : ====

15/09/03 04:24

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: 0000100494

b(6)-2

GLU	110	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	149	39-380	U/L
NA+	121*	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	26	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 1+, ICT 0

4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 08:16 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.3
Calculated INR = 1.46
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :08:16 AM
Card Lot :010301
Operator [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 08:22 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 67.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :08:19 AM
Card Lot :100212
Operator [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 02:05 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.5 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.32
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :02:04 PM
Card Lot :010301
Operator [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 02:06 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 46.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :02:06 PM
Card Lot :100212
Operator [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4
SERIAL #005485 09/08/03 12:36 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :12:36 AM
Card Lot :010301
Operator [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 12:40 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :12:39 AM
Card Lot :100212
Operator [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 09:56 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 53.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :09:54 PM
Card Lot :100212
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 09:58 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :09:57 PM
Card Lot :010301
Operator [redacted]

b(6)-2

RAPID[illegible] ANALYZER [illegible]
SERIAL [illegible]

b(6)-4

Patient ID [redacted]
Test Name :PT
Test Result:- 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :09/09/03
Test Time :04:56 AM
Card Lot :010301
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/09/03 05:02 AM

Patient ID [redacted]
Test Name :APTT
Test Result:- 48.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/09/03
Test Time :04:59 AM
Card Lot :100212
Operator [redacted]

b(6)-2

ID: [redacted]
WB

09-09-03
17:49

			Patient Limits	
WBC	6.4	x10^3/uL	4.5	10.5
RBC	2.53 L	x10^6/uL	4.00	6.00
Hgb	7.5 L	g/dL	11.0	18.0
Hct	23.4 L	%	35.0	60.0
MCV	92.4	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	111. L	x10^3/uL	150.	450.
LY%	21.7	%	20.5	51.1
LY#	1.4	x10^3/uL	1.2	3.4

ID: [redacted]
WB

09-09-03
12:28

			Patient Limits	
WBC	9.3	x10^3/uL	4.5	10.5
RBC	2.54 L	x10^6/uL	4.00	6.00
Hgb	7.5 L	g/dL	11.0	18.0
Hct	22.3 L	%	35.0	60.0
MCV	91.5	fL	80.0	99.9
MCH	29.5	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	106. L	x10^3/uL	150.	450.
LY%	16.8 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

09-09-03
[illegible]

			Patient Limits	
WBC	7.0	x10^3/uL	4.5	10.5
RBC	2.41 L	x10^6/uL	4.00	6.00
Hgb	7.3 L	g/dL	11.0	18.0
Hct	22.1 L	%	35.0	60.0
MCV	91.5	fL	80.0	99.9
MCH	30.1	pg	27.0	31.0
MCHC	32.9 L	g/dL	33.0	37.0
Plt	114. L	x10^3/uL	150.	450.
LY%	22.5	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

ID: 000723 09-09-03
WB 03:02

			Patient Limits	
WBC	12.6 H	x10^3/uL	4.5	10.5
RBC	3.21 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	29.5 L	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	130. L	x10^3/uL	150.	450.
LYM	14.6 *L	%	20.5	51.1
LYM	2.0 *	x10^3/uL	1.2	3.4

ID: 000723 10-09-03
WB 04:33

			Patient Limits	
WBC	5.0	x10^3/uL	4.5	10.5
RBC	2.49 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	22.4 L	%	35.0	60.0
MCV	89.9	fL	80.0	99.9
MCH	30.6	pg	27.0	31.0
MCHC	34.0	g/dL	33.0	37.0
Plt	117. L	x10^3/uL	150.	450.
LYM	27.0	%	20.5	51.1
LYM	1.3	x10^3/uL	1.2	3.4

ID: 00[illegible] 11-09-03
WB [illegible]

			Patient Limits	
WBC	5.0	x10^3/uL	4.5	10.5
RBC	2.67 L	x10^6/uL	4.00	6.00
Hgb	8.2 L	g/dL	11.0	18.0
Hct	24.1 L	%	35.0	60.0
MCV	90.3	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	33.7	g/dL	33.0	37.0
Plt	172.	x10^3/uL	150.	450.
LYM	30.6	%	20.5	51.1
LYM	1.5	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/10/03 04:35 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :09/10/03
Test Time :04:34 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/10/03 04:38 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 35.7 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/10/03
Test Time :04:35 AM
Card Lot :100212
Operator [redacted]

b(a)-4

b(a)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/11/03 04:53 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.00
Sample Type:citrated wh. blood
Test Date :09/11/03
Test Time :04:51 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/11/03 05:01 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 26.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/11/03
Test Time :04:59 AM
Card Lot 100212
Operator [redacted]

[redacted]

WBC	5.3	x10^3/uL	4.5	10.5
RBC	1.56 L	x10^6/uL	4.50	5.90
Hgb	7.9 L	g/dL	11.0	16.0
Hct	22.5 L	%	35.0	50.0
MCV	90.9	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	33.6	g/dL	33.0	37.0
Plt	205.	x10^3/uL	150.	450.
LYM%	31.1	%	20.5	51.1
LYM#	1.6	x10^3/uL	1.2	3.4

[redacted]

WBC	[illegible]	[illegible]	[illegible]	[illegible]
RBC	[illegible]	[illegible]	[illegible]	[illegible]
Hgb	[illegible]	[illegible]	[illegible]	[illegible]
Hct	[illegible] L	%	[illegible]	[illegible]
MCV	[illegible]	fL	[illegible]	[illegible]
MCH	[illegible]	pg	[illegible]	[illegible]
MCHC	[illegible]	g/dL	[illegible]	[illegible]
Plt	[illegible]	x10^3/uL	150.	450.
LYM%	[illegible]	%	[illegible]	[illegible]
LYM#	[illegible]	x10^3/uL	[illegible]	[illegible]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/12/03 04:19 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.00
Sample Type:citrated wh. blood
Test Date :09/12/03
Test Time :04:18 AM
Card Lot :010301
Operator : [redacted] b(e)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/12/03 04:23 AM

Patient ID: [redacted] b(e)-4
Test Name :APTT
Test Result:= 26.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/12/03
Test Time :04:19 AM
Card Lot :100212
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/13/03 04:34 AM

Patient ID: [redacted] b(e)-4
Test Name :PT
Test Result:= 13.0 sec.
***RESULT NOT RANGE CHECKED ***
Ratio = 1.1
Calculated INR = 1.11
Sample Type:citrated wh. blood
Test Date :09/13/03
Test Time :04:32 AM
Card Lot :010301
Operator : [redacted] b(e)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/13/03 04:40 AM

Patient ID: [redacted] b(e)-4
Test Name :APTT
Test Result:= 31.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/13/03
Test Time :04:37 AM
Card Lot :100212
Operator : [redacted] b(e)-2

=====PICCOLO=====
12/09/03 04:11
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 034 DR #: 000
SERIAL #: 0000100676

GLU	108	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	712*	39-380	U/L
NA+	133	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	22	18-33	MMOL

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

ID: [redacted] 14-09-03
MB 04:49

			Patient Limits	
WBC	8.8	x10^3/uL	4.5	10.5
RBC	2.65 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	24.5 L	%	35.0	60.0
MCV	92.4	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	443.	x10^3/uL	150.	450.
LY%	19.5 *	%	20.5	51.1
LY#	1.7 *	x10^3/uL	1.2	3.4

ID: [redacted] 15-09-03
MB 04:10

			Patient Limits	
WBC	7.6	x10^3/uL	4.5	10.5
RBC	2.50 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	22.7 L	%	35.0	60.0
MCV	90.7	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	33.6	g/dL	33.0	37.0
Plt	560. H	x10^3/uL	150.	450.
LY%	21.5	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/14/03 04:52 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :09/14/03
Test Time :04:50 AM
Card Lot :010301
Operator [redacted]
b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/14/03 04:55 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 35.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/14/03
Test Time :04:52 AM
Card [illegible]
Oper[illegible]

RAPID
SERIA[illegible]

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= [illegible] sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.11
Sample Type:citrated wh. blood
Test Date :09/15/03
Test Time :04:16 AM
Card Lot :010301
Operator [redacted]
b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/15/03 04:20 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/15/03
Test Time :04:17 AM
Card Lot :100212
Operator [redacted]
b(6)-2

==== PICCOLO =======
14/09/03 05:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

GLU	111	73-118	MG/DL
BUN	3*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	~~116*~~ 131	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

25YO

GSW to (L) shoulder

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)														TOTALS	TOTAL ERL
fentanyl (mcg)	100	100	50											250	100
vecu (mg)	10		10												
heparin units/hr ( )								10		800			10		TOTAL URINE
MSO4 (mg) ( )												5	5	100 ml	1200
VOLAT AGENT 1.50 % del	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		
% e.t.															
AIR L/Min															
N2O L/Min															
O2 L/Min	2	2	2	2	2	2	2	2	2	2	2	2	2		

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

FLUIDS — LINE site: A (R) 2 ☐ Warmed; (L) (P) A ☐ Warmed; ☐ Warmed; ☐ Warmed

NS; LR #21 800; 1000; PLASM #21

LOSSES — EST BLOOD LOSS; URINE - 900

FLUIDS SUMMARY
CRYSTALLOID- LR 1300 NS 1000
COLLOID-
BLOOD- PRBC 2 unit

REMARKS
Code drugs with numbers, events with letters

0101 - Sensis
ER - intubated
0114 - Dr OR - monitors on
0230 - #1 PRBC
1262676
0235 - 500 cc hepari 1M
0302 9.5/130 13.4/29.5
7.30/41.8/310/21-6 100%
0410 - PRBC #2

4825461

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 29.9

INITIAL DATA: BP- 110/70 HR- 105

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? + TIME- 0100

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

TIME → 0115 30 X (22w) X 30 X (33w) X 30 X 0410

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

VENTIL

	0115	30	22w	30	33w	30	0410
VT - ml	810	810	810	810	810	820	810	830	730	850	830	830
f - breaths/min	9	9	9	9	9	9	9	9	9	9	9	9
Peak Inf pres / PEEP	23	23	23	23	23	23	23	23	22	24	24	24
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	32	32	32	33	34	31	32	33	30	30	30
BP/oth	FIO2 (Frac or %)	.44	.44	.44	.44	.51	.51	.51	.51	.51	.49	.49	.49
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth-PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Gas analyzer	TEMP-site												
O2	N-M Block (T/4)	0/4	4/4	4/4	0/4		0/4	0/4	4/4	0/4			
Warming blkt	blankets												
Conv warmer													

Mark with letters & symbols, explain under REMARKS. EVENTS Position → (L) Gens < 90 abducted / padded

RECOVERY AT PACU ICU (Specify) OTHER stable

CONDITION: 10 GAW

RESP- BP- 144/78 SpO2- HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0100	0101	0415
PROC	Ready	Begin	End
	0115	0122	0415

PR[redacted] (L) brachial artery

PA[redacted] entries: Name, Grade/Rate, Medical facility repair

[redacted] b(6)-4

[redacted]

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
8 intubated orally - BSS + Ca2+

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
b(6)-2

S[redacted] Sewn

PROCEDURE LOCATION: 2-2
DATE: 15 Sep 03
PAGE 1 OF 2

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DOSE (Units)

( )
( )
( )
( )
( )
( )

VOLAT AGENT 150 % del 10 %
% e.t.
AIR L/Min
N2O L/Min
O2 L/Min 2

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

DRUGS

LINE site #1 R AC ☑ Warmed
#1 R ☐ Warmed
☐ Warmed
☐ Warmed

LOSSES

EST BLOOD LOSS
URINE –

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

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – HR –

COMP CHECK: OK? – Y N

PATIENT RECORDS: OK for PROCEDURE? TIME –

TIME → 1530

SYMBOLS:

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml 850
f – breaths/min 8
Peak inf pres / PEEP 23
MODE – S(pon), A(ssist), C(on) C

BP/Auto Cuff	ET CO2 (torr) 30
BP / oth	FIO2 (Frac or %) .49
ART line	SpO2 (%) 100
Steth- PC/ES	ECG ✓
Gas analyzer	TEMP- site 33
	N-M Block (T/4) 0/4
Warming blkt	Blankets
Conv warmer	

Mark with letters & symbols, explain under REMARKS

EVENTS
Position

TOTALS

TOTAL INS

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID –
COLLOID –
BLOOD –

REMARKS –
Code drugs with numbers, events with letters

O120 –
TO ICU 1
VS
monitors on

See p1

RECOVERY AT
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP – SpO2 –
BP – HR –

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES			
	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes
Revise (L) Ex fix (L) brachial artery repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
See p1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted] b(6)-4

SURGEONS: b(6)-2

ANESTH[redacted]THESIA

PROCEDURE LOCATION #22

DATE 8 Jul 03

PAGE 2 OF 2

Hosp gtt d/c @ 0715 7.3/22.1 < 114K @ 0500 K 1.1 RA SaO2 97% ANCEF — @ 0300 23 y/o
to have 2u PRBC now for 12.8/3.8 < 126 K A1 in E HR 101 GENT @ 06 NKA
Foley ABP 158/ Percocet @ 0300 90 kg
TMAX 102.3 @ 23 ASA II

MEDICAL RECORD — ANESTHESIA

DRUG	Units					TOTALS	
Fent	(mcg)	50	50	50	50	200 mcg	
Versed	(mg)	2/3				5 mg	50
Lido	(mg)	100					
Propofol	(mg)	150	50				
MSO4	( )		3			3 mg	325
Forane	% del	1.5	1.8	1.5	1.5	1.0	
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	8	2	2	2	2	2

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

FLUIDS
LINE site LR ☐ Warmed 2001
NS ☐ Warmed 1000
Bld ☐ Warmed #1 #2

LOSSES
EST BLOOD LOSS 50
URINE — 200 325

CRYSTALLOID— 1300
COLLOID— Ø
BLOOD— 2u PRBCs

PHYS STATUS 1 (2) 3 4 5 E
BODY WEIGHT 90 KG
HEMATOCRIT 22.1
INITIAL DATA BP— 120/ HR— 86
EQUIP CHECK OK?— (Y) N
PATIENT PREPARED OK for PROCEDURE? TIME— 0730

TIME → 08 X 20 X 09 X 30 X 10

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

Grid annotations: pH 7.31? PaCO2 53.2? PaO2 545 HCO3 27 BE +1 SaO2 100 Hct 21 Hb 7; Na 137 K 3.8

VT — ml		550	410	480	440	460	580
f — breaths/min	12	16	17	9	12	13	14
Peak inf pres / PEEP							
MODE— S(pon), A(ssist), C(on)	S·C	A	S	S	S	S	S
ET CO2 (torr)	36	45	47	50	49	48	46
FIO2 (Frac or %)	.60	.60	.60	.65	.67	.68	.68
SpO2 (%)	100	100	100	100	100	100	100
ECG		SR	SR	SR	SR	SR	SR
TEMP- site	skin	35			36	36	
N-M Block (T/4)							X

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

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

REMARKS—
Code drugs with numbers, events with letters
0810 in OR monitors applied.
4361681
1863590
0915 Induction proseal placed two attempts as below —
0935 Proseal out, spont resp c̄ oral airway —
0940 transferred to litter, Oral airway out, spont resp, responsive
to ICU c̄ mask O2 report given

RECOVERY AT ICU
PACU ICU 0950 (Specify)
OTHER
CONDITION: Responsive 99.1 Ax
RESP— 17 SpO2— 100
BP— 134/66 HR— 83

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0730	0810	1000
	Ready	Begin	End
PROC	0820	0850	0930

PROCEDURES and CPT Codes
9/8
S/P L Humerus Ex Fix, (L) Ahyll Vein Graft to L Brachial A

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
proseal — #4 unsuccessful x1 Δ to #5 x1 attempt

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #5 Proseal placed
⊕ ETCO2 ⊕ BBS b(6)-2

PATIENT IDENTIFICATION— Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] civ s/p GSW
b(6)-4

SURGEON [redacted]
ANESTH [redacted]
b2-2

PROCEDURE LOCATION [redacted]
DATE 9/9/03

MEDCOM - 18579
MEDICAL RECORD — ANESTHESIA
SF 517 / OP 376 REVISED
PAGE 1 OF 1

Ancef 0.8
Gent 0.6
petocef MSO4, Tylenol

Oral Alline - Rev. -V(HL)

CTA
MPI
Foley

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Fentanyl	(Mg)	200	300				100	100		50				
Midazolam	(Mg)	40												
Propofol	(Mg)	200												
Pavulon	(Mg)	10												
MSO4	(Mg)					5	5							
	( )													
VOLAT AGENT 150	% del		1.7	1.7	1.7	1.7	1.7	2.5	1.7	1.7	1.7	1.7	1.5	
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	6	2	2	2	2	2	2	2	2	2	2	2	

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

FLUIDS

LINE site													
20 Rt hand	☐ Warmed	18A											
	☐ Warmed									#21			1400
	☐ Warmed												
	☐ Warmed												

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
750	Min
	TOTAL URINE
10	350

FLUIDS - SUMMARY: CRYSTALLOID- 1600; COLLOID-; BLOOD-

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

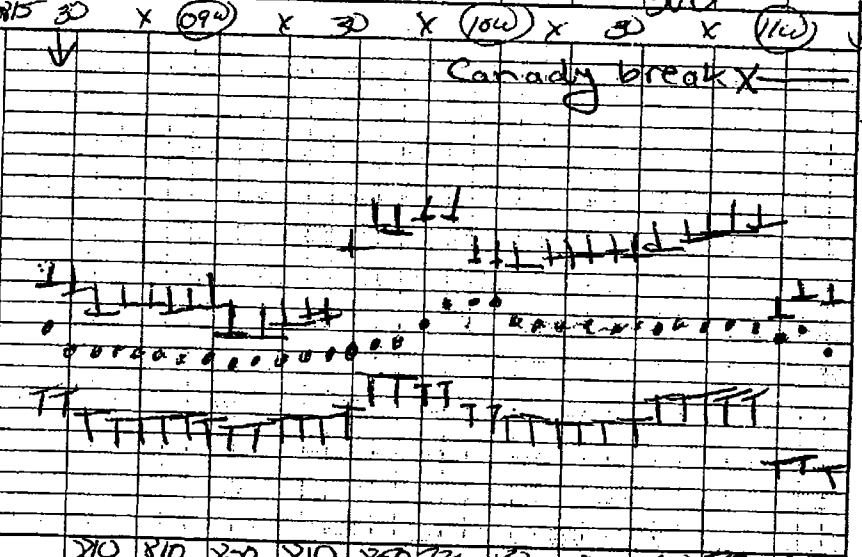
HEMATOCRIT:

INITIAL DATA: BP- 112/80; HR- 105

EQUIP CHECK: OK? - Y N

PATIENT RECHECK: OK for PROCEDURE? TIME- 0700

TIME 0715 0730 X 0900 X 30 X 1000 X 30 X 1100



VENTIL

VT - ml			810	810	800	810	850	820	820	820	330	950
f - breaths/min		15	10	10	10	10	10	10	10	10	7	14
Peak inf pres / PEEP			18	18	18	18	18	19	19	19	—	—
MODE - S(pon), A(ssist), C(on)		S	CV	CV	CV	CV	CV	CV	CV	CV	SV	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		32	34	34	35	35	35	34	34		35
BP/oth	FIO2 (Frac or %)		.76	.76	.76	.76	.76	.76	.76	.76	.76	.76
ART line	SpO2 (%)	98	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG		ND	ND	ND	ND	ND	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site		Skin		35							
CO2	N-M Block (T/4)			4/4 ST								
Warming blkt	Sheets/blankets											
Conv warmer												

REMARKS: Code drugs with numbers, events with letters

0700 - Met ID - IV A-line in place. Chart reviewed. Pt seen by CRNA. Monitors on. Induction

1230 - Sponges opened up. Suction → extubated to PACU LES

49 6

RECOVERY AT: PACU ICU ____ (Specify) OTHER Stable

CONDITION: RESP- 15 SpO2- 97% BP- 105/80 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0700	0720	1245
PROC	Ready 0730	Begin 0918	End 1200

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Left arm ~90 abducted and dec

PROCEDURES and CPT Codes: (L) arm/x repair/excision of ulna fix

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

[redacted] b(6)-4

[redacted] CW-1

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA #3 ad

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: ET #3 Miller taped over teeth - Eyes taped. Dx: ET placement, CR view. ET easily passed. Atraumatic

SURGE[redacted] Teeth ok

[redacted] b(6)-2

PROCEDURE LOCATION: 22

DATE: 12 apr 15

PAGE 1 OF

DA FOR [redacted] S MEDICAL RECORD USAPA V1.00

NKDD

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG	(Units)																		
MSO4	(mg)																		
	( )																		
	( )																		
	( )																		
	( )																		
	( )																		
VOLAT AGENT	150 % del	1.5	1.5	1.5	X														
	% e.t.																		
AIR	L/Min																		
~~N2O~~	L/Min																		
✓ O2	L/Min	2	2	2-6-6															

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

FLUIDS

LINE site																		
L20	☐ Warmed	1st 1400																
(R) hand	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	

LOSSES: EST BLOOD LOSS; URINE - 300 — 350

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 112/80; HR- 70's

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 0800

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

TIME	1130	45	(Dw)	1	30
220	X	X			
200	Canada Break				
180					
160					
140					
120					
100					
80					
60					
40					
20					

VENTIL

VT - ml	960	770	770	540	480	530
f - breaths/min	10	7	7	7	10	16
Peak inf pres / PEEP	21	19	19	—	—	—
MODE - S(pon), A(ssist), C(on)	C	C	C	S	S	S

MONITORS/ACCESSORIES

~~BP/Auto Cuff~~	~~ET CO2 (torr)~~	35	47	47	50	37	48
~~BP/oth~~	~~FIO2 (Frac or %)~~	0.76	.76	.76	.75	.75	.75
~~ART line~~	~~SpO2 (%)~~	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ND	ND	ND	ND
~~Gas analyzer~~	TEMP-site		35				
CO	N-M Block (T/4)						
~~Warming blkt~~	Sheet/blanket						
Conv warmer							

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

TOTALS	TOTAL EBL
1gl	
	TOTAL URINE

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

REMARKS: Code drugs with numbers, events with letters

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

CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Revise ex fix LUE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — See US 1

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

[redacted] b(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SURGEONS: b(6)-2

ANE[redacted]

PROCEDURE LOCATION: 2-2

DATE: 12 Sep 03

PAGE 2 OF

DA FORM 7389, F[redacted]

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

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

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

PROPOSED PROCEDURE: Leg wire (L) ex fix / (L) brachial artery repair

SURGICAL SERVICE: Ortho

NPO SINCE: _____

ASA Physical State 1 2 3 4 5 E

WT: 90 (KG/LB) HT: ____ IN.

ALLERGIES: NKDA

HABITS:

TOBACCO: _____

ETOH: _____

DRUGS: _____

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) _____

( ) _____

( ) _____

( ) _____

( ) _____

( ) _____

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: _____ / _____

U/A: _____

OTHER: _____

13.6 / 29.9 / 153 / 9.7

13.4 / 32.3 / 5.9 / 201.4 / 12/19

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

avoid intubation per EK

ASSESSMENT

PAST SURGICAL/ANESTHETIC

_____

_____

_____

_____

_____

_____

PHYSICAL EXAMINATION

BP 110/70 HR 70 R ___ T ___

Pain Scale 0-10 ____

HEENT - Teeth _____

Trachea _____

TMJ/Neck _____

Oropharynx intubated

Nares _____

CHEST: BBS+ CTA

CARDIAC: S1 S2 RR

EXTREMITIES:

IV Access: OK

Ulnar Filling: OK

BACK: OK

OTHER: _____

NPO Since _____

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b(6)-2

The patient [redacted] s. Questions answered. Unable to consent

Signed: [redacted] Date: 0220 Time: 8:50 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

information taken from PST notes

Patient Identification: [redacted]

[redacted] b(6)-4

* GSW to (L) shoulder

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.

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

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

VOLUME REQUESTED (If applicable) 1 U ML

REMARKS: b(6)-2

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

- [X] TYPE AND SCREEN ~~2 units~~
- [X] CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW ntles / Lt arm

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

SIGNATURE [redacted] b(6)-2

DATE VE[redacted] 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

UNIT [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR		RECIPIENT	
ABO	O	ABO	O
Rh	Pos	Rh	Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQ[redacted]

REMARKS: EXP 09 SEP 2003 b(6)-2

PREVIOUS RECORD CHECK:

[ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Hour) 1131 ON (Date) 8 Sep 03

IDENTIFICATION

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

1st VERIF[redacted] CH/AW

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

PR[redacted]

TEMP. 101.8 PULSE 135 BP 133/70

DATE OF TRANSFUSION 8 Sep 03

TIME STARTED 1733

POST-TRANSFUSION DATA

AMOUNT GIVEN 425 ML

TIME/DATE COMPLETED/INTERRUPTED 1918 8 Sep 03

REACTION

[X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
104	138	119/63

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

[ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

[X] NO [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE [redacted] b(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name-[redacted] rate: hospital or medical facility)

#[redacted] b(6)-4

SEX M

WARD ICU#1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

PRINTED ON RECYCLED PAPER

Medical Record Copy

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 U ML

REMARKS:

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

- [ ] TYPE AND SCREEN ~~x 2 units~~
- [X] CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE GSW Rt leg / Lt arm

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

SIGNA[redacted] blue-2

DATE VERIFIED 8 Sept 03

TIME VERIFIED 0032

b(6)-4

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR		RECIPIENT	
ABO	O	ABO	O
Rh	Pos	Rh	Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 09 SEP 2003

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

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

DATE

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1555 ON *(Date)* 9-8-03

IDENTIFICATION

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

1st VERIFIER *(Si[redacted]* 49/AW

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

PRE-TR[redacted]

TEMP. 101.3 PULSE 130 BP 125/53

DATE OF TRANSFUSION 8 Sep 03

TIME STARTED 1546

POST-TRANSFUSION DATA

AMOUNT GIVEN 425 ML

TIME/DATE COMPLETED/INTERRUPTED 8 Sep 03 1725

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.8	131	114/51

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

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

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

M

WARD ICU1

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 U ML

REMARKS:

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

- [X] TYPE AND SCREEN ~~2 units~~
- [X] CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

Rh/G TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE GSW Rt leg

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

SIGNAT[redacted] b(6)-2

DATE VER[redacted] 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR		RECIPIENT	
ABO	O	ABO	O
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQU[redacted]

REMARKS:

EXP 09 SEP 2003

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [✓] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE

b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AN[redacted]

AT *(Hour)* 0220 ON *(Date)* 8 SEP 03

IDENTIFICATION

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

1st [redacted] b(6)-2

2nd [redacted]

PRE-TRANSFUSION

TEMP.

PULSE 96

BP 110/43

DATE OF TRANSFUSION 9 SEP 03

TIME STARTED 0230

POST-TR[redacted]

AMOUNT GIVEN 1 unit ML

TIME/DA[redacted] 03[redacted] Sept 03

REACTION

- [✓] NONE
- [ ] SUSPECTED

TEMPERATURE 35

PULSE 86

BLOOD PRESSURE 123/61

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

- [✓] NO
- [ ] YES *(Specify)*

SI[redacted] b(6)-2

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

WARD

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- ☒ TYPE AND SCREEN ~~1 unit~~
- ☒ CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW Rt leg Rt arm

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

SIGNAT[redacted] b(6)-2

DATE VERIFIED 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:

☐ RECORD ☒ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR	RECIPIENT
ABO O	ABO O
Rh Pos	Rh Pos

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQ[redacted]

REMARKS:

EXP 09 SEP 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT [redacted] 0400 ON *(Date)* 8 SEP 03

IDENTIFICATION

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

1st VERIF[redacted]

2nd V[redacted]

PRE-TRANSFUSION

TEMP. 35 PULSE 88 BP 117/64

DATE OF TRANSFUSION 8 SEP 2003

TIME STARTED 0404

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 0415 / 8 Sept 03

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE 35 PULSE 105 BLOOD PRESSURE 123/67

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)*

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

☒ NO ☐ YES *(Specify)*

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

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

WARD

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS: 1 unit

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 09 Sept 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE s/p GSW

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

SIGNATURE [redacted] b(6)-2

DATE VERIFIED 08 Sept 03

TIME VERIFIED [redacted]

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(4)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O; Rh pos

RECIPIENT: ABO O; Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Comp

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

SIGNATURE OF PERSON PERFORMING TEST C. [illegible]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 9-5-03

REMARKS: EXP: 12 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0757 ON *(Date)* 9-Sep 03

IDENTIFICATION

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

1 [redacted] MD

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

PRE-T [redacted]

TEMP. 37 PULSE 100 BP 75/40

DATE OF TRANSFUSION 9/9/03 TIME STARTED 0725

POST-TRANSFUSION DATA

AMOUNT GIVEN 7U ML

TIME/DATE COMPLETED/INTERRUPTED 9/9/03 0850

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 95.5 PULSE 96 BLOOD PRESSURE 100/55

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIF[redacted]ment, clots, etc.)

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

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

[redacted] m

WARD ICU-1

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS: 1 unit

b(6)-4

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 09 Sept 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE s/p GSW

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

SIGNATURE [redacted] b(6)-2

DATE VERIFIED [redacted]

TIME VERIFIED [redacted]

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

[redacted]TIENT NO.

DONOR		RECIPIENT	
ABO	O	ABO	O
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 9-9-03

REMARKS: EXP: 12 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] bb2

AT *(Hour)* 0757 ON *(Date)* 9 Sep 03

IDENTIFICATION

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

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

[redacted] CPT/[illegible]

[redacted] LTC CCMA

TEMP. 37 PULSE 110 BP 114/60

DATE OF TRANSFUSION 9/9/03

TIME STARTED 0810

POST-TRANSFUSION DATA

AMOUNT GIVEN 320 ML

TIME/DATE COMPLETED/INTERRUPTED 9/9 0820

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 37

PULSE 100

BLOOD PRESSURE 90/50

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] LTC Comp b(6)-2

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

SEX M

WARD ICU-1

#[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 Sep | TIME OF ORDER: 0600 | HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Δ DS LR → DS @ 125 cc/hr
VO Dr [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 Sep 03 | TIME OF ORDER: 0746 | HOURS | 0820 8 Sep 03 [redacted]

Δ IVF to LR @ 125 cc/hr
V.O. per Dr. [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° chart [redacted]

DATE OF ORDER: 9/8 | TIME OF ORDER: 930 | HOURS

(1) Vent RR 12 FiO2 40%
(2) ABG 1 hour
(3) IV KVO now
(4) U Hepam 7000 u/hr
(5) CBC, PT/PTT @ 1400

b(6)-2 [redacted] 8 Sep 03 0949

8 Sep 03 1236

PATIENT IDENTIFICATION

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° chart | check [redacted]

b(6)-2

DATE OF ORDER: 8 Sep 03 | TIME OF ORDER: 1505 | HOURS

(1) Transfuse 2 units PRBCs
(2) Give 500 cc NS Bolus
(3) Wean pt off Versed and Fentanyl. Notify RT when ready to extubate [redacted]
V.O. per Dr. [redacted]

b(6)-2 [redacted] 1509 8 Sep 03

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

b(6)-2

b(a)-2 unless noted otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER: 9/7 TIME OF ORDER: 1600 HOURS

1. D/C NG
2. Clears
3. Lasix 20 mg in between units blood
4. elevate arm
5. IS.

[redacted]

LIST TIME ORDER NOTED AND SIGN: MD

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/8 TIME OF ORDER: 2100 HOURS

1. Left humerus AP + Lat X ray
2. NPO @ MN

[redacted]

LIST TIME ORDER NOTED AND SIGN: 8580 03 1611

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/8 TIME OF ORDER: 2100 HOURS

1. Tylenol 650 mg p.o. q 4 hr prn

[redacted]

LIST TIME ORDER NOTED AND SIGN: Noted 2100

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/9 TIME OF ORDER: 0700 HOURS

1. Transfer to PRBC now

[redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

NURSING UNIT	ROOM NO.	BED
2d floor check		[redacted]

CPT/pm 11 Sep 03 0700

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

1

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/9/03 TIME OF ORDER: 0630 HOURS

(1) Hold heparin drip

VO Dr [redacted]

b(6)-2

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/9 TIME OF ORDER: HOURS

(1) Resume previous orders

(2) D/C Heparin drip

(3) Regular diet

[redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/9/03 TIME OF ORDER: 1600 HOURS

(1) CBC @ 1800

(2) Replace IV

b(6)-2

VO Dr [redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/10 TIME OF ORDER: 0800 HOURS

(1) OOB to chair

b(6)-2

b(6)-2

[redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24 chart check done		

[redacted]

11 Sep 03 10

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
Post-op	Admit ICU	
	STP Revision Rt Fx ① humerus,	
	① thigh NV Graft	to
	② Brachial Ac	
	vital - routine	
	- NV checks LUE q 1° x 6°	
	then q 2°	
	Activity strict BR	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	
~~W → D pt's ~~	~~BID ~~	~~thigh~~
MCB	Ancef ↑ q IV q 8°	
	Gent 100 mg IV q 6°	
	MSO4 2-5 mg IV q 2° PRN	
	Percocet 1-2 po q 4° PRN	
Lab	~~CBC in AM~~ chem	
Rad	~~Pt~~ ~~NPO~~	
IV	D5LR @ 125 cc/h	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	
Heparin	800 u/h IV	
~~PT/PTT~~	~~2° - ordered~~	~~q 6 hrs~~
ASA 325 mg ~~PR~~ QD, 1st dose on		
arrival to ICU.		b(4)-2
~~ASA 2-6~~		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	
9/4	0930	
① Vent IV820 RR14 FIO2 50%		
PEEP 5.		
② NG to CIS		
③ ~~Morphine 2-4 mg IV q 15 min prn pain~~		
③ Versed in drip titrate to effect		
④ Fentanyl in drip titrate to effect		
⑤ AM labs CBC, PT/PTT, Chem 8		

[redacted] 0810 8/4/03

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

24° Chart ✓ [redacted] b(6)-2

[redacted] 354903

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
9-11-03	0900 HOURS	
XR - (E) humerus AP + LAT Re: F/A F[redacted]		[redacted]
b(6)-2		
24° Chart Check 11Sep03 2330 [redacted]		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11 Sep03	1850 HOURS	
V.O. Dr [redacted] b(6)-2		
NPO p Midnight for OR		
[redacted] b(6)-2		
24° Chart Check 11Sep03 2330 [redacted]		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

038

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/12 TIME OF ORDER: 1230 HOURS

1. Resume orders
2. Reg diet
3. ODS / Ambulate

LIST TIME ORDER NOTED AND SIGN: b(6)-2 [redacted] 12 Sep 03 1255

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12 Sep 03 TIME OF ORDER: 1600 HOURS

V.O. Δ Morphine to 2-5 mg IV Q 30 mins PRN per Dr. [redacted] b(6)-2

[redacted] 1601 12 Sep 03

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

NURSING UNIT	ROOM NO.	BED NO.
24° ✓ dum	[redacted]	CPT/AW

DATE OF ORDER: 12 Sep 03 TIME OF ORDER: 1627 HOURS

D/C A line b(6)-2

V.O. per Dr [redacted] CPT/AW

b(6)-2 [redacted] CPT/AW 12 Sep 03 1649

PATIENT IDENT [redacted] 14 Sep 0030

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

NURSING UNIT	ROOM NO.
24° Chart	[redacted]

DATE OF ORDER: 9/14 TIME OF ORDER: 0930 HOURS

1. Cdra 10 bid po
2. Δ L tr thigh drsng qd. [redacted] Ntd by [redacted] 9/14/03 1000
3. Ambien 10 mg qhs PO [redacted] 14 Sep 03

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

CPT/AW 14 Sep 03 1109

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

DATE OF ORDER: 9/14 TIME OF ORDER: 1000 HOURS

① Daily Dressing change - AM
Med: Morphine 7-10 mg IVP PRN Dressing Δ
Versed 2-4 mg IVP PRN Dressing Δ

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

DATE/TIME ORDER NOTED AND SIGN: [redacted] 14 Sep 03 /AN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER: 9/15 TIME OF ORDER: HOURS

① D/C AM Cath

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

[redacted] 15 Sep 03

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER: 16 Sep 03 TIME OF ORDER: 1605 HOURS

D/C Foley

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

[redacted] 16 Sep 03 /AN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER: 17 Sept 03 TIME OF ORDER: 1600 HOURS

① NPO 8 MN
V.O. Dr. [redacted] b(6)-4

Noted 17 Sept 03 1600 /AN

NURSING UNIT: 24° Chart | ROOM: [redacted] /AN 0926 18 Sep 03

DA FORM 4256, 1 APR 79 PREVIOUS EDITIONS OBSOLETE. ITEM 71, WHICH MAY BE USED.

U.S. GOVERNMENT PRINTING OFFICE: 1989—409-924

"USE BALL POINT PEN. PRESS FIRMLY. NO CARBON PAPER REQUIRED."

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT: b(6)-2 [redacted] BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
17 SEPT 03	1630 HOURS	
① RESUME PREVIOUS ORDERS		
② IV: LR @ 150 cc/hr, D5W LR w/ 40 KCL PO w/		
③ RESUME BILLS		
[redacted]		
9/18/03 0230 [redacted]		
30 SEPT 03	0030 HOURS	b(6)-2
① NPO		
② SD OR FOS PO		
b(6)-2 [redacted]		9/30/03 0740

DATE OF ORDER | TIME OF ORDER ____ HOURS

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: ICU1 | ROOM NO. | BED NO. 4

DATE OF ORDER: 9/18/03 | TIME OF ORDER: 1700 HOURS | DATE TIME ORDER NOTED AND SIGN

- Resume Preop orders, meds & activity
- D/C Gentamycin

b(6)-2 [redacted]

Transcribed 1757 on 18 Sept 03 [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT: ICU1 | ROOM NO. | BED NO. 4

DATE OF ORDER: 19 Sept 03 | TIME OF ORDER: 0705 HOURS

1. Transfer to ICU/Dx s/p ex-fix (L) thigh vein graft to (L) [illegible] numerous [illegible]
2. Resume orders from ICU1
   - Ancef 1 gm IV Q8°
   - ASA 325mg po QDAY
   - Colace 100mg po BID
   - Ambien 10mg po QHS
   - Morphine 7-10mg IVP prn drsg Δ
   - Versed 2-4mg IVP prn drsg Δ
   - Morphine 2-5mg IV Q30min prn
   - Percocet 1-2 tabs po Q4° prn
   - Vitals: routine
   - NV check (L) UE Q2°
   - Elevate arm
   - Incentive spirometer
   - Reg: Diet

[redacted]

b(6)-2

NURSING UNIT: ICU1 | ROOM NO. | BED NO. 4

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT: ICU1 | ROOM NO. | BED NO. 4

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER | TIME OF ORDER

- Versed 2-4mg IVP prn drsg Δ
- Morphine 2-5mg IV Q30min prn
- Percocet 1-2 tabs po Q4° prn
- Vitals: routine
- NV check (L) UE Q2°
- Elevate arm
- Incentive spirometer
- Reg: Diet

DATE OF ORDER | TIME OF ORDER

- OOB/ambulate HOURS
- Δ (L)-(R) thigh drsg QD
- Daily drsg Δ in arm (L) Arm

[redacted]

b(6)-2

NURSING UNIT: ICU1 | ROOM NO. | BED NO. 4

21/0700 Sep 03 [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE 1986—[illegible]

"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

b(6)-2 ATL unless noted otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

C# [redacted]

DATE OF ORDER	TIME OF ORDER	HOURS	LAST TIME ORDER NOTED AND SIGN
19 Sep 03	1755		
(1) 30cc Milk of Magnesia			
XL now			[redacted]

NURSING UNIT: 24/21 Sep 03 @ 0015 | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
9-22-03	1530	
- Begin Pin site care BID		
instruct patient in care		
- Physical therapy for ROM at elbow + wrist		

Noted [redacted]

NURSING UNIT: [redacted] | ROOM NO. | BED NO.

1600

24/0200 23 Sep 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
10 1/24/03	1835	
Tylenol PO 625mg q6°		
prn for T>101.5		

[redacted]

9/24/03 1840

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW# [redacted]

b(6)-4

DATE OF ORDER	TIME OF ORDER	HOURS
9/25/03	1640	
Neurontin 300mg po TID		

[redacted]

9/25/03 1645

NURSING UNIT: ICW/24 | ROOM NO. | BED NO.

27 Sep 03 0325 [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE: 1985—NO[illegible]

"USE BALL POINT PEN—PRESS FIRMLY—NO CARBON PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

Noted 30 Sep 03 0945 [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 9/30 TIME OF ORDER 0800 HOURS

(1) ↑ Neurontin to 600 ~~qid~~ tid

[redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

b(6)-4 # [redacted]

noted [redacted] 2230 9-30-03

NURSING UNIT	ROOM NO.	BED NO.
292	0215	[redacted]

DATE OF ORDER 9/30/03 TIME OF ORDER 2230 HOURS

✓ (1) D/C Ancef

✓ (2) Start Keflex 500 mg QID po

✓ (3) start elavil 10 mg po q HS

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

Noted [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW#1		[redacted]

DATE OF ORDER 10-6-03 TIME OF ORDER 2045 HOURS

- ↑ elavil to 25 mg po q HS

XR - AP + LAT (L) humerus

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted]

NURSING UNIT	
[redacted]	

DATE OF ORDER 10-8-03 TIME OF ORDER 1000 HOURS

D/C pt to Iraqi hospital

[redacted]

b(6)-2

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

CLINICAL RECORD

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

Mo. Sept. 2003

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

ORDER DATE	CLERK/ NURSE	b(6)-2 RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12	13	14	15	16	17	18	19	20
8Sep03.	[redacted]	Vitals: routine	06	[redacted]													
			18														
8Sep03	[redacted]	IV check (L)UE q1° x6°	06														
		then q 2°	18														
8Sep03.	[redacted]	Activity - Strict Bedrest	06														
			18														
8Sep03	[redacted]	Diet NPO	06														
			18														
08Sep03	[redacted]	Vent. TV 800, RR 14,	06														
		FiO2 50%, Peep 5	18														
08Sep03	[redacted]	NG to LIS.	06														
			18														
08Sep03	[redacted]	AM labs CBC, PT/PTT,	04	[redacted]													
		Chem 8															
8Sep03	[redacted]	Clears	06	[redacted]													
			18														
8Sep03	[redacted]	Elevate Arm	06	[redacted]													
			18														
8Sep03	[redacted]	Incentive Spirometer	06														
			18														
9Sep03	[redacted]	reg. diet	07														
renewed 12Sep03			12														
			17														
10Sep03	[redacted]	OOB to chair	06														
			18														
12Sep03	[redacted]	OOB / Ambulate	06														
			18														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Ex Fix (L) humerus, (L) thigh vein graft to (L) Brachial A/C

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo SEP Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8Sep03	[redacted]	ABG 1 hour	8Sep03	0940	1053	[redacted]
8Sep03	[redacted]	CBC, PT/PTT @ 1400	8Sep03	1400	1340	[redacted]
8Sep	[redacted]	Left Humerus AP + Lat X ray	8Sep03		2300	[redacted]
8Sep03	[redacted]	NPO p MN	9Sep03	0001	0001	[redacted]
9Sep	[redacted]	Resume previous orders	9Sep	noted		[redacted]
9Sep	[redacted]	CBC @ 1800	9Sep	1800		[redacted]
11Sep03	[redacted]	X Ray (L) Humerus AP + Lat F/U FX	11Sep03	Now	1000	[redacted]
11Sep03	[redacted]	NPO p Midnight to OR in AM	11Sep03	2400	2400	[redacted]
12Sep03	[redacted]	Resume Orders	12Sep03		1233	[redacted]
12Sep03	[redacted]	D/C Aline	12Sep03		1655	[redacted]
16Sep03	[redacted]	D/C Foley	16Sep03		1630	[redacted]
17Sep03	[redacted]	NPO p MN	17Sept	2400	Cont	[redacted]
		b(6)-2 A1				

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

USAPA V1.00

b(6)-2 AV

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 14	15	16	17	18	19	20	21
14SEP03	[redacted]	Δ (L) + (R) Thigh dressings	08	NC	[redacted]						
		QD	X								
14Sep03	[redacted]	Daily Dressing Δ	10	[redacted]							
		in AM (L arm)	X								

Reviewed

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p Ex Fix (L) humerus, (L) thigh vein Graft to (L) Brachial a

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-7 A1

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo 09 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	1	2	3	4
8Sep	[redacted]	Lasix 40mg IV q8°	[redacted]														
remove																	
8Sep	[redacted]	ASA 325mg po QD	[redacted]														
remove																	
8Sep	[redacted]	Celace 100mg po BID	[redacted]														
remove																	
8Sep	[redacted]	Tylenol 10mg po QHS	[redacted]														
remove																	
25Sep	[redacted]	Neurontin 300mg	06														
30Sep03		po BID (q to 600mg) 30Sep03	14														
30Sep	[redacted]	Reflex 500mg po q6	18														
			12														
			18														
			24														
30Sep03	[redacted]	Elavil 10mg po QHS	22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 9R EXFIX (R) numerus, (L) thigh van graft to (L) brachial a/c

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

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

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
		PRN meds		
9/19/-9/22	[redacted]	Percoset 1-2 tabs po q 4°	D/K	[illegible]
			D/I	[redacted]
9/24	[redacted]	Percoset 1-2 tabs po q4° pm	D/K	[illegible]
			D/I	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Fix (L) humerus, (L) thigh graft to (L) brachial AC

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO. 3

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. Sep Yr. 23
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
		b(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
9/19 9/22	[redacted]	Morphine 7-10mg	Date	21Sep	22Sep	22Sep	1Oct										
		IVP prn desg Δ	Time	0100	2120		2400										
			Dose	5mg	7mg		7mg										
			[redacted]														
			E	E													
9/19 9/22	[redacted]	Versed 2-4mg IVP	Date														
		prn desg Δ	Time														
			Dose														
			Init														
9/19 9/22	[redacted]	Morphine 2-5mg IV	Date	23Sep	23Sep	24Sep	24Sep	25Sep	26Sep	26Sep	27Sep	27Sep					
		q 30 min prn	Time	0535	1445	0920	0745	1030	0230	1000	2230	1410					
			Dose	5mg	5mg	5mg	5mg	5mg	5mg	4mg	5mg	5mg					
			[redacted]														
			E														
9/19 9/22	[redacted]	Percocet 1-2 tabs	Date	20Sep	21Sep	21Sep	22Sep	22Sep	22Sep	23Sep	23Sep	23Sep	24Sep	24Sep	24Sep	25Sep	25Sep
		PO q 4° prn	Time	1940	0030	0810	2034	0715	2150	0555	1520	2120	[redacted]				0500
			Dose	2	2		2	2	2	2	2	2					2
			[redacted]														
			E	E			E	E									
24Sep	[redacted]	Tylenol 650mg PO q6°	9/24 1811	9/24 2218	25 0026												
		Gs T>101.5	2	2	1												
			[redacted]														

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 10 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	07	08
8 Sept	[redacted]	ASA 325 mg PO QD	10	[redacted]				
8 Sept	[redacted]	Colace 100 mg PO BID	10	[redacted]				
		~~AB~~	20	[redacted]				
8 Sept	[redacted]	Ambien 10 mg PO QSH	22	[redacted]				
30 Sept	[redacted]	Neurontin 600 mg	06	[redacted]				
		PO TID	14	[redacted]				
			20	[redacted]				
30 Sept	[redacted]	Keflex 500 mg PO	06	[redacted]				
		QID	12	[redacted]				
			18	[redacted]				
			24	[redacted]				
30 Sept	[redacted]	Elavil 10 mg PO QHS	2[illegible]	[redacted]				
6 Oct	[redacted]	Elavil 25 mg po QHS	22	[redacted]				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SP Ex fix (R) humerus / (L) ~~humerus~~ (L) ~~tibia~~ (L) thigh vein graft to (R) brachial

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

Verify by Initialing	THERA[illegible]IC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo._____ Yr._____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION													
			TIME/DATE DISPENSED													
19 Sept	[redacted]	Percocet 5-325	D/T	4 Oct 2030	5 Oct 0700	5 Oct 2045	6 OCT 0500	6 OCT 1945	7 OCT 0430	7 OCT 1100	7 OCT 1730	7 OCT 2330	7 OCT 0500			
		tabs PO Q4-6 PRN	D/I	[redacted]												
			E/I													
		blurr AM														

USAPA V1.00

b(6)-2

CLINICAL RECORD	TH[illegible]EUTIC DOCUMENTATION CARE PL[illegible]ON-MEDICATION) For use of this form, see AR 40-4 the proponent agency is the Office of The Surg[illegible]general.	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 04	5	06	07	08
8 Sept	[redacted]	VS Routine	06	[redacted]				
			18					
8 Sept	[redacted]	NV Check LUE ~~92°~~	06 18					
		(L) Arm to be left OTA	18 06					
8 Sept	[redacted]	↑ (L) Arm	06 18					
			18 06					
8 Sept	[redacted]	Regular diet	06 18					
			18 06					
8 Sept	[redacted]	OOB / Ambulate	06 18					
			18 06					
8 Sept	[redacted]	Pin site care BID	06 18					
			18 06					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex-fix (L) humerus / (L) thigh vein graft to (L) Brachial

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

5(cd) - 2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10	[redacted]	XR - AP/LAT (L) humerus	10/07			[redacted]
08 10/03	[redacted]	P/C pt to Iraqi hosp				

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

b(6)-2 A11

CLINICAL RECORD | THE [redacted]UTIC DOCUMENTATION CARE PLA[redacted]N-MEDICATION)

For use of this form, see AR 40-40; the proponent agency is the Office of The Surgeo[redacted]neral.

Mo. 09 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	[redacted]	30	01	02	03
08 Sep	[redacted]	VS: routine	6	[redacted]								
reunten			18									
8 Sep	[redacted]	NV check LUE Q2°	6									
			18									
8 Sep	[redacted]	Elevate arm	6									
			18									
8 Sep	[redacted]	Incentive Spirometer	6									
			18									
8 Sep	[redacted]	Regular diet	6									
			18									
8 Sep	[redacted]	OOB/ambulate	6									
			18									
14 Sep	[redacted]	Δ (L) + (R) thigh	08									
		drsgs QD	X									
14 Sep	[redacted]	Daily drsg Δs to (L)	08									
		arm in AM	X									
22 Sep 03	[redacted]	Pin site care BID and	10									
		instruct pt in care	22									
13 Oct	[redacted]	(L) arm to be left	06									
		OTA	18									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX-FIX (L) humerus, (L) thigh vein graft to (L) Brachial a/c

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity 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
22 SEP03	[redacted]	Physical therapy for ROM @ elbow/wrist				
	----	b(6)-2				

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

b(4)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General	Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12	13	14	15	16	17	18	19	20
08Sep03	[redacted]	Ancef 1 gm IV q8°	08	/	[redacted]												
			16	/													
			24	/													
08Sep03	[redacted]	Gent 100mg IV q16°	06	/													
			12	/													
			18	/													
			24	/													
08Sep03	[redacted]	IV-D5LR @ 125cc/hr	06														
			18	[redacted]													
08Sep03	[redacted]	Heparin 800 u/hr IV	06	[redacted]													
			18	[redacted]													
08Sep03	[redacted]	ASA 325 mg ~~PO~~ Q day	10	[redacted]													
08Sep03	[redacted]	Versed drip. Titrate to	06	[redacted]													
		effect	18	[redacted]													
08Sep03	[redacted]	Fentanyl gtt Titrate to	06	[redacted]													
		effect	18	[redacted]													
8Sep03	[redacted]	Δ IVF to LR @ 125cc/hr	06	[redacted]													
			18	/													
8Sep03	[redacted]	↓ Heparin to 700u/hr	06	[redacted]													
			18	/													
8Sep03	[redacted]	Vent: SIMV, TV 800,	06	/													
		R14, FiO2 — 50%, Peep 5	18	/													
8Sep03	[redacted]	Vent: SIMV, TV 800,	06	/													
		R12, FiO2 40%, Peep 5	18	/													
14Sep03	[redacted]	Colace 100mg PO Bid	10	/	/	/	/	/	/	/	[redacted]						
			22	/	/	/	/	/	/	/							
14Sep03	[redacted]	Ambien 10mg PO QHS	22	/	/	/	/	/	/	/							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Ex Fix, (L) humerus, (L) thigh vein graft, to (L) Brachial AC.

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION: [redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
08Sep03	[redacted]	ASA 325mg per NG - 1st dose now	8Sep	0600	0600	[redacted]
8Sep03	[redacted]	Vent RR-12, FiO2 40%	8Sep03		0938	[redacted]
8Sep03	[redacted]	1L LR Now	8Sep03		0940	[redacted]
8Sep03	[redacted]	Transfuse 2units PRBCs	8Sep03	#1	1546	[redacted]
	-----		8Sep03	#2	1733	[redacted]
8Sep03	[redacted]	Give 500cc NS Bolus	8Sep03		1540	[redacted]
8Sep03	[redacted]	Wean pt off Versed + Fentanyl	8Sep03		1558	[redacted]
	-----	Notify RT when ready to extubate				
	-----	pt.				
8Sep03	[redacted]	Lasix 20mg IV in between units	8Sep03		1730	[redacted]
	-----	blood				
8Sep	[redacted]	Transfuse units PRBC	9Sep03	done in CR		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
08Sep03	[redacted]	MSO4 2-5mg IV	D	MSO4 5 IV	MSO4 5 IV	MSO4 5 IV	11SEP 2100	12SEP 0330	12SEP 0555	12Sep03 5mg	12Sep03 1515					
		q 2° prn	T	10Sep 0960	10Sep 1830	0930 11Sep03	1500	5mg	5mg	5mg	1320	5mg				
			D													
			I													
08Sep03	[redacted]	Percocet 1-2 PO q		9Sep 1925	9Sep 0715	9Sep 1525	9Sep 2315	10Sep 0615	10Sep 1900	10Sep 2310	11Sep 0730	11Sep 1230	11Sep 1800	11SEP 2370	12Sep03 1325	12Sep 1410	13Sep 1115
		4° PRN														
8Sep	[redacted]	Tylenol 650mg po prn		8Sep 2115	9Sep 1830	11Sep 0730	12Sep03 1521	2105	650mg							
		temp >101														
12Sep03	[redacted]	Δ Morphine to		12Sep 03 1620	12Sep 03 1725	12Sep 2155	13Sep 0005	13Sep 0445	13Sep 0930	14Sep 0400	14Sep 1000	14Sep 1210	14SEP 2125	15Sep 0320	15Sep 0780	15Sep 1430
		2-5mg IV Q 30mins		5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	2mg	3mg	3mg	3mg	3mg
		PRN														
08Sep03	[redacted]	Percocet 1-2 PO		13Sep 03 1555	13Sep 2430	14Sep 0645	14Sep 1215	14Sep 1645	14Sep 1940	15Sep 0782	15Sep 2100	16Sep 0739	16Sep 1800	16Sep 2327	17Sep 2160	18Sep
		94° PRN		2tab	2tab	2tab	2tab	2tab								

Rewritten

Rewritten

Δ dose 1600 12Sep03

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. Sept *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/P Ex Fix, (L) humerus, (L) thigh vein graft to (L) Brachial AC

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 7

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14Sep 03	[redacted]	Morphine 7-10mg	14Sep 03 5mg	15Sep 03 7mg	16Sep 03 7mg	17Sep 5mg	18Sep 7mg	19Sep 03 5mg								
-----	-----	IVP PRN Dressing	1030	1240	1515	1350	1110	0925	[redacted]							
-----	-----	△														
14Sep03	[redacted]	Versed 2-4mg	14Sep 03	15Sep 03	16Sep 03	17Sep 03		19Sep 03								
-----	-----	IVP PRN Dressing	1038	1295	1520	5mg	[redacted]	0925 2mg	[redacted]							
-----	-----	△														
12Sep03	[redacted]	△ Morphine to 2-5mg	15Sep03 @ 2220	16Sep03 @ 2125	16Sep03 @ 0410	16Sep 1830	16Sep 2140	17Sep 2140	17Sep 0520	17Sep 0715	17Sep 1000	17Sep 139[redacted]	17Sep 1620	18Sep 0110	18Sep 0319	18Sep 0741
-----	-----	IV Q 30 mins AR[redacted]	3mg	5mg	2mg	3mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg
-----	-----		18Sep 0430	18Sep 0514	18Sep 0904	18Sep 1052	18Sep 1230	18Sep 1550	18Sep 1955	18Sep 2210	18Sep 0245	18Sep 0445	18Sep 0610	1090		
-----	-----		5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	4mg		
rewritten 18Sep 03	[redacted]	Percocet 1-2 po Q4°	18Sep 1404	19Sep 1850	18Sep 2314											
-----	-----	prn	TI	TIA	TIA	[redacted]										
-----	-----															

USAPA V1.00

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted] DATA

For use of [redacted]orm, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89 b(6)-2

SHIFT ASSESSMENT 08 Sep [redacted]

		TIME: INITIALS:	TIME: 0500 INITIA[redacted]
NEURO	PUPILS		Perrla Sluggish 3mm [redacted]
	SENSORIUM		Ø Spont movement
	EXTREMITY MOVEMENT		post-op sedation } muscle relaxation
	SEDATION		fent 100 mcg/hr versed 10mg/hr
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN		Vent SIMV-14, P-5, 50%, 100%
	BREATH SOUNDS		PIP-mid-20's, 28cm @ hub
	SECRETIONS		CTA bilaterally c̄ dim. bases
	O2 SOURCE/FLOW/SAO2		
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM		S1S2 NSR, Ø ectopy +2 pulses
	CAPILLARY REFILL		x4 ext. - LUE edema
	PULSES		cap refill <3 sec x4 ext
	EDEMA		LUE, warm } dry, LLE, RUE, RLE:
			cool } dry
GI	ABDOMEN		flat ND, NT, Ø BS x 4 quad
	BOWEL SOUNDS		NGT → LIS
	BOWEL MOVEMENT		
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING		foley clear yellow adequate out
	COLOR/CLARITY		
SKIN	COLOR		- LUE dressing saturated c̄ sanguinous
	INTEGRITY		drainage
			- LLE dressing CDI
			- RLE dressing sat c̄ serosanguinous drainage
			- LUE ex-fix
ACCESS	#1 TYPE/LOCATION/SIZE		(R) ⊡ PIV } dressing CDI
	DRESSING CONDITION		(R) Ac PIV } Ø S/S of infxn
	IV FLUID/RATE		(R) radial A-line }
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

~~(Continue on reverse)~~

PR[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 9 Sep 03

PA[redacted]CATION (For typed or written entries give: Name – last, first, middle; grade; date; 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

ICU1

Patients Name: [redacted] 8/E/2

Date: 8 Sep

0440

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																								171/89	166/86	
NBP																										
TEMP																								93.6	94.3	
HR																								81	77	
RR																								14	14	
SaO2																								100	100	
FiO2																								50	50	
Source																								Vent	Vent	
MAP																								115	110	

ITAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
T																								60		
rt																								10	10	
rsed																								10	10	
parin																								16	16	
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																								50		
NGT																								600		
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18618

773

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	06 30	INTILAS [redacted]	INTILAS	1815	INTILAS [redacted]
NEURO	PUPLIS		PERRLA, Reaction sluggish			PERRL (R)	
	SENSORIUM		Pt on Versed + Fentanyl			Pt A&O speaking Arabic	
			Does not respond to				
			stimuli				
RESPIRATORY	RESPIRATION PATTERN		Regular, Unlabored			RRR	
	BREATH SOUNDS		CTA			CTA (R)	
	SECRETIONS		None			Ø	
			Vent: SIMV, TV 800, FiO2 50%				
			Peep 5, ETT 27cm @ Hub				
SKIN	COLOR		Normal for Race			WNL	
	INTEGRITY		Dressings to LUE, (L)			Drsg to (R) UE, bloody, drsg to	
			thigh, (R) thigh			(R) Foley, RDF	
IV SITE	LOCATION		(R) EJ, (R) AC			(R) EJ infusing LR @ 125cc	
	CONDITION		Patent, ∃ S/S of infection			& Hep @ 1ml/hr = PRN/hr, (R) AC	
			@ IV sites			infusing PRBC's, (R) radial	
			(R) Radial A line			A-line	
			Leveled + Zeroed, waveform				
			sharp, Ø S/S of infection				
GASTRO	ABDOMEN		Soft Nontender			Flat, soft, nontender	
	BOWEL SOUNDS		Absent			(+) bowel sounds	
			NG to (L) Nare to LIS				
			Placement verified				
GU	URINE		Foley to gravity			Foley to gravity	
	COLOR/CLARITY		Dark Yellow			Clear yellow	
CARDIOVASCULAR	CARDIACRHYTHM		ST			ST ∃ (R) pulses & cap refill	
			Edema (L) arm, Ø JVD			< 3 sec	
			Cap Refill < 3 secs				

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & [redacted] b(6)-2 DEPARTMENT/SERVICE/CINC ICU DATE Sep 03

PATIENT'S INDICATIONS (For typ[redacted]give: Name—Last, First, middle; grade; date; hospital or me[redacted]

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DATE 8 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial line	136/80	136/77	121/61	91/43	105/49	71/39	81/44	81/41		83/50	153/70	105/64	135/67	115/43	119/63	115/59	114/74	
BP Cuff *	142/81	127/78	119/75	106/51	111/54	101/54	109/44	124/53		97/51	143/39	138/50	120/65	116/43		112/59	110/55	
Temperature	94.7	94.5	94.9	96.6	98.1	99.5	98.9				101.3	101.6	99.8	101.8	100.0	102.3	101.4	
Pulse	87	94	107	142	137	143	136	136		156	148	144	138	140	138	134	128	
Respiratory Rate	14	14	22	15	13	12	14	14		12	20	20	21	18	18	21	19	
MAP	99	93	89	67	68	72	70	78		72	101	83	92	87	93	79	77	
O2 Sats	100	100	100	100	100	100	100	100		100	99	99	99	97%	97%	98%	98%	
O2	50%	50%	50%	50%	40%	40%	40%	40%		40%	40%	40%	2L	RA		RA	RA	
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	VM	VM	PC					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
LR	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	2000
Fentanyl	10	10	10	10	10	10	10	10	80	10	/							90
Versed	5	5	5	5	5	5	5	5	40	2.8	/							42.8
Heparin	16	16	16	16	14	14	14	14	120	14	14	14	14	14	14	14	14	232
IVPB	100		50				100		250			50		100				400
Bolus					1000				1000		NS 500							1500
PRBC												425	425					850
PO												240	460		260	100		860
TOTALS									2490									5974.8

OUTPUT

URINE	HOUR	250	170	225	170	100	30	20	28	993	16	40	45	70	45	200	200	210	
	TOTAL																	1827
	SP gr																	
	S/A																	
NG	OUTPUT								650	650								
	PH																	
	GUIAC																	
EMESIS															400			400
STOOL																		
DRAINS																		

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05	
	124/57		124/61	127/62	128/66	159/68	131/68	126/63	
	124/42	110/63	114/58	121/60	124/65	147/73	126/69	122/61	
	100.7		100		99.3		99.4		
	122	121	121	109	105	110	107	100	
	19	19	20	17	14	18	16	15	
	84	80	79	82	86	98	90	82	
	98%	97%	98%	98%	99%	98%	98%	98%	
	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	22	23	24	01	02	03	04	05	8°T
	125	125	125	125	125	125	125	125	3000
									90
									42.8
	14	14	14	14	14	14	14	14	344
			150						550
									1500
									850
		100	240						1200

OUTPUT	22	23	24	01	02	03	04	05	
	75/1922	75/1997	40/1057	55/1097	80/1177	70/1247	90/1337	60/1397	2392
									650
									400

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA											
	TIME		0714	1053							
	MODE		SIMV	SIMV							
	F_IO_2		50%	40%							
	TV		800	800							
	RATE		14	12							
	PEEP		5	5							
	A	pH	7.422	7.376							
	B	PCO_2	33.5	37.6							
		pO_2	284	207							
		HCO_3	22	22							
	G	SAT	100%	100%							
		BASE	-3	-3							

LABORATORY DATA											
	TIME		0710								
	GLUCOSE		133								
	Na/K		132/3.5								
	Cl/CO_2		108/19								
	BUN/Cr		12/0.8								
	WBC/PLATELET		9.3/118								
	Hct/Hgb		31.7/10.5								
	CK		75000								
	PT/PTT		15.4/37.1								
	INR		1.46								

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

24 180 TOTALS | NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV 6376.8

OUTPUT

Urine: 2392

1050

[redacted]

10/6)-2

NEUROLOGICAL ASSESSMENT

		HOURS	06	07	08	09	10	11
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4						
		TO SPEECH 3						
		TO PAIN 2						
		NO EYE OPENING 1						
	BEST VERAL RESPONSE	ORIENTED 5						
		CONFUSED 4						
		VERBALIZES 3						
		VOCALIZES 2						
		NO VOCALIZATION 1						
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6						
		LOCALIZESPAIN 5						
		FLEXION WITHDRAWAL 4						
		ABNORMAL FLEXION 3						
		EXTENSION TO PAIN 2						
		NO RESPONSE 1						
LIMB MOVEMENT	ARMS	NORMAL POWER						
		MILD WEAKNESS						
		SEVERE WEAKNESS						
		ABNORMAL FLEXION						
		ABNORMAL EXTENSION						
		NO RESPONSE	X	X	X	X	X	X
	LEGS	NORMAL POWER						
		MILD WEAKNESS						
		SEVEREWEAKNESS						
		ABNORMAL FLEXION						
		ABNORMAL EXTENSION						
		NO RESPONSE	X	X	X	X	X	X
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
$ Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record Separately if there is a Difference between the tow sides

+ + Brisk
+ Slow
No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		06	07	08	09	10	11	12	13	14
Radial	R	+					+			+
	L	++	++	++	++	+	+		+	++
Pedal	R	+					+		+	+
	L	+					+		+	+
	R									
	L									
	R									
	L									

+ + Normal
+ Weak
– Absent
D Doppler
R Right

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted]DATA

For use of [redacted]orm, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0630 INITIALS: [redacted]	TIME: 1830 INITIALS [redacted]
NEURO	PUPILS	WNL PERL	PERRL (B)
	SENSORIUM	[illegible]	AEO x3 speaking Arabic
	EXTREMITY MOVEMENT	[illegible]	Moves all extremities, (R) UE [illegible]
	SEDATION		(0)
	PAIN CONTROL		C/O pain in (R) LE
RESP	RESPIRATORY PATTERN	reg non labored	Reg, nonlabored
	BREATH SOUNDS	CTA	CTA
	SECRETIONS	(0)	(0)
	O2 SOURCE/FLOW/SAO2	Room air	Room air
	VENTILATOR SETTINGS	NA	NA
CV	CARDIAC RHYTHM	NSR [illegible]	ST [illegible]
	CAPILLARY REFILL	<3sec	<3 sec
	PULSES	palpable x4 extremities	(P) all extremities
	EDEMA	(0)	(0) hand
GI	ABDOMEN	soft non tender	flat soft nontender
	BOWEL SOUNDS	present x 4	(P) x 4 quads
	BOWEL MOVEMENT	UTA	(0)
	NGT/OGT	(0)	(0)
	TUBE FEDDINGS	(0)	(0)
	DRAINS	(0)	(0)
GU	VOIDING	via foley clear yellow urine	Foley to gravity
	COLOR/CLARITY	in urine [illegible]	Clear yellow
SKIN	COLOR	[illegible]	WNL
	INTEGRITY	dressing from below shoulder to L hand	Dry (R) UE [illegible] drainage, drsg to
		dressing to bilat thighs occlusive	(B) [illegible] thigh CDI
		dry intact	
ACCESS	#1 TYPE/LOCATION/SIZE	18G (R) E.J IV infusing fluid [illegible]	18ga (R) EJ
	DRESSING CONDITION	18G (R) AC IV replaced	
	IV FLUID/RATE	LR@125cc/h	heplocked
	#2 TYPE/LOCATION/SIZE		18ga (R) AC
	DRESSING CONDITION		
	IV FLUIDS/RATE		heplocked

(Continue on reverse)

PREPARED BY (Signature & Title)
b(6)-2 [redacted] 9/Sep/03

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE
9 Sep 03

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

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

RANK: CI

AGE:

UNIT: ICU #1

GENDER: M

STATUS: US: AD / CIV

IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL

☒ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION

☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 18623

USAPPC V2.00

ICU1

Patients Name: [redacted] Date: 9 Sep 2009

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line	131/62	148/65	137/66			164/70			125/80		113/87				157/56	137/71	136/65	146/64	127/61	125/62	127/62	126/59	120/60	127/62
NBP	128/64	138/66		137/69	138/65	141/64	129/63	141/63		128/70		133/72	117/49	131/64	150/66	129/69	134/67	134/62	129/56	127/53	130/56	124/54	126/58	120/62
TEMP	98.3	99.8	99.1					100.5		101.5		101.3	101.8		101.3		100.8		100.2		99.7		99.2	
HR	104	101	83	98	97	101	107	118	111	119	114	114	125	109	113	121	109	117	106	99	100	94	96	92
RR	16	16	17	21	14	16	15	14	13	18	20	21	17	17	20	17	11	23	16	15	14	15	13	14
SaO2	97%	97	100	98	97	100	100	100	100	98	100	100	95%	99%	98%	98%	97%	100%	96%	97%	97%	97%	98%	98%
FiO2			31%	31	31	21	~~100~~																	
Source	RA	RA	31% FM	FM	FM	FM	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
MAP	88	89																						
neuropulse																								

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
LR	125	125			125	125	125	125	125	125	125	125	1250	125												1375
B	100		50				100				50		300	100					150							550
[illegible]																										
D	14	14	—										28													28
RC				250	250								500													500
[illegible]						60	240						300	240				200	100							540
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	75/95	70/140		325/180		300/220	160/230	200/180	200/230	200/530	180/210	250/100	1910	210/980	170/210	200/370	100/470	120/390	115/270	130/390	140/305	200/325	300/345	130/305	170/325	3825
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18624

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted] DATA

For use of [redacted]rm, see AR 40-66; the proponent agency is the Office [redacted]e Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: INITIALS: [redacted]	TIME: 1830 INITIAL[redacted]
NEURO	PUPILS	pupils PERL	PERRL (R)
	SENSORIUM	↓ sensation or movement in L arm	A&O x3 speaking Arabic
	EXTREMITY MOVEMENT	↓ hand all other extremities moving	Moves all extremities QUE & assistant
	SEDATION	∅ disorientation	∅
	PAIN CONTROL	pain controlled c̄ IV morphine + po percocet	Pt given 5mg MSO4 IV for pain
RESP	RESPIRATORY PATTERN	reg + unlabored	Reg & unlabored
	BREATH SOUNDS	CTA all lobes	CTA (B)
	SECRETIONS	∅	∅
	O2 SOURCE/FLOW/SAO2	Room air	Room air
	VENTILATOR SETTINGS	∅	∅
CV	CARDIAC RHYTHM	NSR ⇌ ST c̄ ectopy ran	SR to ST c̄ ectopy noted
	CAPILLARY REFILL	<3 sec	<3 sec
	PULSES	palpable x 4 extremities	(+) x4 extremities
	EDEMA	∅	∅
			(R) radial A-line, flushed & zeroed
GI	ABDOMEN	soft non tender	Flat soft nontender
	BOWEL SOUNDS	present x 4 quads	(+) x4 quads
	BOWEL MOVEMENT	∅	∅
	NGT/OGT	∅	∅
	TUBE FEDDINGS	∅	∅
	DRAINS	∅	∅
GU	VOIDING	pt foley clear yellow in adequate amounts	Foley to gravity
	COLOR/CLARITY		Clear light yellow
SKIN	COLOR	WNL	WNL
	INTEGRITY	redness during left arm rotational fracture & bruises dress to L + R thigh ecchymosis c̄ drainage	Dry QUE mod amount serous fluid Dry (R) thigh CDI
ACCESS	#1 TYPE/LOCATION/SIZE	R radial A-line c̄ good waveform	(R) A-line IV heparinized
	DRESSING CONDITION	R AC peripheral IV heparinized	
	IV FLUID/RATE	R EJ IV heparinized	
	#2 TYPE/LOCATION/SIZE		(R) AC peripheral IV heparinized
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY: [redacted] b(6)-2 [redacted] 91WM6M3

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 10 Sep 03

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

NAME: #[redacted]

RANK: CI

AGE:

UNIT: b(6)-4

GENDER: M

STATUS: US: AD / CIV

IRAQI: CIV / EPW / CI

☐ HISTORY/PHYSICAL

☒ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION

☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

ICU1

Patients Name: # [redacted]

Date: 10 Sep 2003

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	134/61	133/61	142/73	135/64							155/73					134/63	131/62	135/65			132/61	132/64	129/65	124/62	134/65	
NBP	134/66				136/61	136/69	135/68								124/70	131/64	132/67	132/64	155/66	124/65	132/65	144/63	132/65	135/69	134/65	
TEMP	99.1			100.6	99.8					100.3					100.5		99.9		99.6			100.5		99.7		
HR	94	104	99	104	100	100	98	93		102	103			97	94	97	116	97	96	92	94	101	94	100	94	
RR	17	23	13	17	13	15	14	14		14				21	18	14	25	18	12	14	13	19	13	20	16	
SaO2	98	96	99	97	97	97	95	98		97				98	98%	97%	100%	99%	98%	98%	97%	96%	96%	95%	100%	
FiO2																										
Source	RA	RA	RA	RA	RA	RA	RA	RA		RA				RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100		50				100				50		300	100		~~240~~				~~250~~						550
T																										
O		480		240			480	240			240					240				200				100	100	2320

PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	150/150	200/350	200/550	260/810				200/1010	200/1210	200/1410		600/2010	2010	300/2310	300/2610	120/2730	200/2930	240/3170	250/3420	300/3720	280/4000	250/4250	50/4300	340/4640	150	4840
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18626

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted]L D[redacted]A

For use of [redacted]orm, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0645 INITIALS [redacted]	TIME: 2100 INITIAL [redacted]
NEURO	PUPILS	3mm PERRL	PERRLA 3mm
	SENSORIUM	Awake + Alert Unable to	Alert, Follows commands
	EXTREMITY MOVEMENT	move LUE All other extremities	LUE ≅ ex-fib humerous unable to
	SEDATION	Pt move without difficulty	move fingers. Moves other extre-
	PAIN CONTROL	Percocet / Morphine	mities unaided. Sensation to LUE ⊕
			Percocet / MSO4 upon request
RESP	RESPIRATORY PATTERN	RRR Symmetrical chest expansion	RRR RA SaO2 100%
	BREATH SOUNDS	CTA bilat	CTA (B)
	SECRETIONS	∅ Secretions	∅
	O2 SOURCE/FLOW/SAO2	RA	RA / 100%
	VENTILATOR SETTINGS		—
CV	CARDIAC RHYTHM	S1S2 +2 pulses x4 extremities	SR/ST S1/S2
	CAPILLARY REFILL	<3 cap refill	<3 sec
	PULSES		+2 x 4 extremites
	EDEMA		∅
GI	ABDOMEN	+BS x4 quads Soft Non	Soft, Flat, Nontender
	BOWEL SOUNDS	tender & distentions	(+)
	BOWEL MOVEMENT		∅
	NGT/OGT		—
	TUBE FEDDINGS		—
	DRAINS		—
GU	VOIDING	Voids to foley	Foley to gravity
	COLOR/CLARITY	clear yellow	Light yellow, clear
SKIN	COLOR	NFR, external fixator to	NFR, Warm, Dry
	INTEGRITY	(L) Humerus	Drsg to LUE CDI ≅ Ex Fix
			to humerous. Sensation in
			fingers, unable to move fingers
			skin to (L) fingers warm & dry
ACCESS	#1 TYPE/LOCATION/SIZE	18ga (R) A/C Site CDI	18G PIV (R) AC
	DRESSING CONDITION	& S/S of erythema	CDI
	IV FLUID/RATE	A-line to (R) Radial	HL
	#2 TYPE/LOCATION/SIZE		A-Line 20G (L) Radial
	DRESSING CONDITION		CDI
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY *(Signature & Title)* b(6)-2 [redacted] 9/11/06/03

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 11 Sep 03

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

NAME: # [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW / (CI)

☐ HISTORY/PHYSICAL ☒ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU

Patients Name: [redacted] b(6)

Date: 11 Sep 03

NPO 24

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																	159/55				136/65	100/62	134/66	169/71		
NBP	144/81	137/81	137/69	137/72		137/69			114/68	128/62	127/73	121/65		125/70	115/62	124/62	122/61	120/63	120/60	122/66	136/68	131/73	124/69	134/68		
TEMP		101.5	100.5	100.3	100.0	99.8		99.1	98.6		98.7						99.5				100.5		99.6			
HR	106	99	102	107		101		100	101	89	94	93		98	93	95	100	92	91	95	99	95	87	91		
RR	16	15	14	14		13		15	13	11	14	18		13	14	12	12	9	12	13	13	16	12	10		
SaO2	99%	98%	98	98%		99%		98%	100	100	100	99		100	100	99	100	99	100	100	99	100	100	99		
FiO2																										
Source	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		
MAP																										

ITAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100		50				100				50		300							150						150
T																										
PO		120	120	150			250						640				240		240	NPO						480
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	200/110	150/350	150/500	140/610	100/710	160/870	120/990	100/1090	120/1210	250/1460	260/1720	200/1920	1936	80/80	110/190	100/290	150/440	150/590	140/730	160/890	120/1110	160/1270	140/1410			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18628

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 12 Sept 03
Time In: 1230
Allergies: NKDA
Pre-op V/S: 112/80 70
Procedures: I+D (L) Arm, Lt fix Adjustment

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1600 Colloid
OR Output: UOP 350 EBL
Meds/Times: Fentanyl, MSO4

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

Pre Op Meds History

Time	1230	1235	1240	1250
SaO2	97	96	98	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	14	14	14	14
T	97			

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1230	NS	400	R hand	CR	1600

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY: [redacted] LPN b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 12 Sept 03

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

[redacted] b(6)-4
PCU #1

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

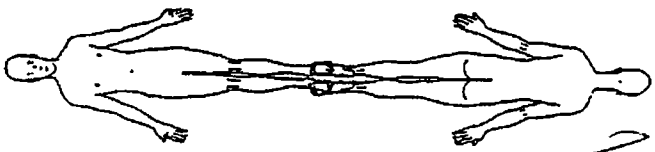
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Arm	Splint + cast	~~0~~
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1230	ST	~~0~~	~~0~~

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p (L) arm fx. repair. Pt asleep easily arousable. Ext. fix and bulky splint to (L) arm intact. ~~0~~ drainage noted. IV of NS infusing into (R) hand ~~A~~ ~~0~~ s/s of redness or swelling. A-line intact to (R) radial area. ~~0~~ c/o pain @ this time. NV intact. VSS. Will continue to monitor & assess [redacted] Pt to ICU #1. Report given to SPC [redacted]

b(6)-2 A11

Discharge Criteria:
Date: **Time:** **PARS:**
BP: 141/70 **T:** 99.2 **HR:** 111 **RR:** 14 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 50 **Output:** ~~0~~
Additional Data:
Transferred To: ICU #1
Report Given To: ICU #1 SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SS [redacted]
Cleared IAW Recovery R [redacted]
Charge Nurse Signature: [redacted]

[redacted] RECORD-SUPPLEMENTAL ME[redacted] DATA

For use of [redacted]orm, 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

SHIFT ASSES[redacted]T b(6)-2

		TIME: 0635 INITIAL[redacted]	TIME: INITIALS:
NEURO	PUPILS	PERRLA	PERRL (B)
	SENSORIUM	A+O X 3	A+O X 3 speaking broken English & Arabic
	EXTREMITY MOVEMENT	Active in RUE + RLE. Ø movement LUE	movement (B) LE's, (Ø) UE
	SEDATION	N/A	Ø
	PAIN CONTROL	Morphine	Ø c/o pain taking MSO4 & Percocet
RESP	RESPIRATORY PATTERN	Regular + Unlabored	Reg unlabored
	BREATH SOUNDS	CTA	CTA
	SECRETIONS	None	Ø
	O2 SOURCE/FLOW/SAO2	RA	Room Air
	VENTILATOR SETTINGS	N/A	N/A
CV	CARDIAC RHYTHM	ST, Ø ectopy	ST & 1, 2, 3 noted
	CAPILLARY REFILL	<3 secs	<3 sec X 4 extremities
	PULSES	+3 in all extremeties	(+) in all extremities
	EDEMA	LUE + BLE	(Ø) UE
		~~[illegible]~~ 0635	
GI	ABDOMEN	Soft, Nontender	Flat, soft nontender
	BOWEL SOUNDS	Active	(P) all quads
	BOWEL MOVEMENT	None	Ø
	NGT/OGT	—	N/A
	TUBE FEDDINGS	—	N/A
	DRAINS	—	N/A
		Ø N/V	
GU	VOIDING	Foley to Gravity	Foley to gravity
	COLOR/CLARITY	Straw, Clear	Clear yellow
SKIN	COLOR	Normal for race	WNL
	INTEGRITY	Serous drainage noted on	Drsg to (Ø) UE CDI
		LUE dressing	
ACCESS	#1 TYPE/LOCATION/SIZE	18G IV (R) Hand	18ga PIV (R) hand
	DRESSING CONDITION	CDI, Ø S/S of infection, Patent	
	IV FLUID/RATE	Saline Lock	
	#2 TYPE/LOCATION/SIZE	(R) Radial A-line	
	DRESSING CONDITION	CDI, Ø S/S of infection	
	IV FLUIDS/RATE	NS to Pressure Bag	

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 12SEP03

PATIENT [redacted]ped or written entries give: Name – last, first, middle; grade; date; [redacted]

NA[redacted]NK: AGE:

UNIT: [redacted] b(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: #[redacted] 3(E)-d

Date: 12 Sept 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line									145/82	138/63	136/84	137/67	133/73											
NBP	151/65	142/62						156/69	164/75	174/68	138/63	144/82	↓	148/81	144/79	139/76	132/74	132/74	126/78	139/69	132/73	127/74	136/76	138/94
TEMP	100.4							100.3		102.4		102.3	102.3	102		101.9		102		101.3	101		100.3	
HR	97	98	0					114	119	119	113	115	110	111	117	109	105	105	110	114	114	105	103	101
RR	10	14	2					11	19	21	15	23	13	11	14	16	19	17	18	22	19	17	17	16
SaO2	99	100	0					98	98	98	98	98	98	99%	99%	99%	99%	99%	98%	99%	99%	100%	100%	100%
FiO2								RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Source	RA	RA	RA						98/140															
MAP									101	69	86	87	94	104	101	92	97	95	91	95	94	94	98	98

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[illegible]						OR	1600	600 -	PACU				2200													2200
PB	100						100				50		250	100												350
IT																										
PO								160	380	480	500	480	2000		240		100				200					
Total													2450													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	140	180	125				OR	350	100	100	100	100	1175	120 / 1295	55 / 1350	60 / 1410	180 / 1590	180 / 1770	100 / 1870	100 / 1970	80 / 2050	120 / 2170	180 / 2350	250 / 2600	160 / 2760	2760
NGT																										
STOOL																										
DRAIN																										
Total													1175													

MEDCOM - 18632

ICU1

Patients Name: #[redacted] Date: 13 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	136/25		138/25				127/69				137/25			135/69		148/68				145/56				140/60		
TEMP	100.4		98.5						100.2		101.0			100.2		99.7				99.8				100.4		
HR	102		101				100				110			106		109				102				109		
RR	16		18				16				14			19		12				15				21		
SaO2	100%		100%				100%				99%			99%		99%				100				100		
FiO2							—				—															
Source	RA		RA				RA				RA			RA		RA				RA				RA		
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100		50				100				50	100	400							150						
r																										
PO																										
tal																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	120/120						310/330					500/500	1500			500				100				600		
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18633

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

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0730 INITIALS: [redacted]	TIME: 1840 INITIALS: [redacted]
NEURO	PUPILS	PERRL	Equal, A&O x 3, intact c slight appropriate, ex fix (L) UE elevated! Ø sensation small, ring middle finger on (L) UE, Ø movement all 5 (L) fingers, moves all 3 other ext.
	SENSORIUM	Pt Alert + Oriented X 3	
	EXTREMITY MOVEMENT	Limited ROM To LUE	
	SEDATION	Ø	
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	Reg R+R	even and unlabored, 98% RA
	BREATH SOUNDS	CTA bilat	CTA bilaterally
	SECRETIONS	Ø Ntd	
	O2 SOURCE/FLOW/SAO2	RA	
	VENTILATOR SETTINGS	N/A	
CV	CARDIAC RHYTHM		S1S2, ST Ø ectopy
	CAPILLARY REFILL	brisk	+2 pulses x dept, all ext warm
	PULSES	Radial + Pedal Pulses @ +4 bilat	dry Ø edema noted
	EDEMA	Ø Ntd	
GI	ABDOMEN		soft nt, nd, BS x 4 quad
	BOWEL SOUNDS	BS + X 4 Quads	ate 90% of dinner, tolerated well.
	BOWEL MOVEMENT	Ø to this Point in shift	
	NGT/OGT	Ø	
	TUBE FEDDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	Pt Voiding Clr Yellow urine ~~to~~	fdy clear yellow
	COLOR/CLARITY	via Foley to gravity in adequate	adequate amt
		Ammounts	
SKIN	COLOR	NER	ace wrap (L) UE ABD,
	INTEGRITY	Dressings to (L) arm + bilat	Bilateral (L) (R) inner thigh
		inner thighs intact.	dressing CDI
ACCESS	#1 TYPE/LOCATION/SIZE	(R) bicep PIV Dressing C/D/I	(R) bicep PIV, patent Ø S/S
	DRESSING CONDITION	Flushes well. Heplocked	of infiltration
	IV FLUID/RATE		
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 13 Sep 03

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

NAME: [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☒ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 18634

USAPPC V2.00

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted] DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0700 INITIALS: [redacted]	TIME: 1830 INITIA[redacted]
NEURO	PUPILS	PERRL	3mm PERRL. Pt responds to verbal stimuli. Follows simple commands
	SENSORIUM	Pt Alert to touch + voice. Able to follow Commands	
	EXTREMITY MOVEMENT	Limited LUE movement	
	SEDATION	Ø	
	PAIN CONTROL	Pt receiving Percocet + MSO4 PRN	MSO4 & Percocet
		c̄ Moderate Pain Control	
RESP	RESPIRATORY PATTERN	Reg R+R	Even, equal rise/fall of chest. Lungs sounds clear in all fields.
	BREATH SOUNDS	CTA bilat	
	SECRETIONS	Ø Ntd	
	O2 SOURCE/FLOW/SAO2	Pt on RA, O2 sats @ 100%	
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM		S1 S2 normal. no ectopy or murmurs noted. Pulses palpable in radial & pedal
	CAPILLARY REFILL	brisk	
	PULSES	+3 bilat radials + Pedals	
	EDEMA	Ø Ntd	
GI	ABDOMEN	Soft, Non tender Non-distended	(+) TRO (+) BS x 4 quads
	BOWEL SOUNDS	+ x 4 Quads	
	BOWEL MOVEMENT	Ø to this Point in Shift	
	NGT/OGT	Ø	
	TUBE FEDDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	Pt voiding. Clr Yellow via Foley	pt has foley D/S & clear / yellow
	COLOR/CLARITY	to gravity in adequate Amounts.	
SKIN	COLOR	NFR	NFR, thigh wounds (B) healing
	INTEGRITY	Bilat inner thigh + LUE	Enterococcal fistula to (2) ann
		dressings intact.	
ACCESS	#1 TYPE/LOCATION/SIZE	PIV to (L) bicep heplocked.	(R) Brief HL
	DRESSING CONDITION	Dressing C/D/I c̄ Ø Ntd	
	IV FLUID/RATE	erythema / Edema.	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

~~(Continue on reverse)~~

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 14 Sep 03

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

NAME: [redacted] RANK: AGE:

UNIT: [redacted] b(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: [redacted]

Date: ~~14 Oct~~ 14 SeP 07

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			101/72				143/60				137/46					132/43				132/56				148/69		
TEMP		99.8	98.4				99.1				99.9					99°								98.7		
HR			109				94				98					103				95				105		
RR			20				17				12					18				15				20		
SaO2		100%	99%				100%				100%					99				100				99		
FiO2																										
Source		RA	RA				RA				RA					RA				RA				RA		
MAP																										

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

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	280/280		175/455						850/1305			450/1755	1755			75	100	200	100	350	120	150	100	300		2200
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18636

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

b(6)-2

INITIAL [redacted] ASSESSMENT			
		Time: Initals: [redacted]	Time: 1815 Initals: [redacted]
NEURO	Pupils	3mm PERRL Brisk	Pupils 3mm & PERRL
	Sensorium	Follows commands appropriately	Pt follows simple commands
	LOC / GCS	LUE & movement all other	Pt is awake/alert
		extremities have purposeful movement	
CARDIAC	Cardiac Rhythm	S1S2 +2 pulses x4 extremities	S1S2 normal & no ectopy
	PRI: / QRS:	<3 sec cap refill	S1 murmur noted. Pulses
	Pulse Strength		are palpable x 4 extremities.
	Cap Refil / JVD		Cap refill < 3 sec.
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	RRR symmetrical rise & fall	RRR, non labored & equal
	Breath Sounds	of chest CTA bilat	rise & fall of chest. Lung
	Secretions	& secretions	sounds are clear in
	Cough		all fields.
SKIN	Color	NFR External fixators	NFR
	Integrity	(L) humerus	
	Backside		
IV	Access Devices	18 ga IV to (R) bicep	20g (R) wrist flushing
	Location	Site CDI & erythema	with no difficulties. & S/S
	Condition		of infection/infiltration. HL
GI	Abdomen	+BS x 4 quads Soft non-	(-) TRD (+) BS x 4 quads
	Bowel Sounds	tender & distention	tolerating reg diet
	Stoma/Ostomy		
GU	Device	Foley to gravity Clear	Pt has foley to gravity
	Color / Clarity	yellow urine	QS, clear yellow.

(Continue on reverse)

[redacted] Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
b(6)-2 [redacted]	ICU #1, 28TH Combat Support Hospital	15 Sep 03

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

NAME: [redacted] RANK: AGE:

UNIT: ICU 1 b(6)-4 GENDER: M

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

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

ICU3

Patients Name: [redacted]

Date: 15 Sept 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			96/65				133/65				138/67					116/62				112/55				122/60		
TEMP			100.1				98.5				99.1					98.6				100.2				99.1		
HR			105				89				99					110				97				98		
RR			20				17				14					23				16				21		
SaO2			99%				99				99					100				98				98		
FiO2																										
Source			RA				RA				RA					RA										
[redacted]																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF																										
IVPB	100		50				100				50		200	100						150						
NGT																										
[redacted]																										
Total																										

[redacted]UTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	150	160	210	190	180	300	150	110	110	120	110	150	1940	200	200	200	250	120	100	150	100	100	100	150	80	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18638

[redacted] RECORD-SUPPLEMENTAL MED[redacted] DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 1700 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]
NEURO	PUPILS	PERL	Perrla
	SENSORIUM	Follow all command	Follows commands, understands
	EXTREMITY MOVEMENT	Limited usage to (R) extremities	& speaks some english
	SEDATION		
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	12	RRR
	BREATH SOUNDS	CLEAR	Clear bilat
	SECRETIONS	Ø	—
	O2 SOURCE/FLOW/SAO2	Ø	—
	VENTILATOR SETTINGS	Ø	—
CV	CARDIAC RHYTHM	HR 90	SR 90's
	CAPILLARY REFILL		< 3sec
	PULSES	+4 to (+)	+2 pulses & LUE +4
	EDEMA		
GI	ABDOMEN	LGH, soft & nondistended	Soft, nondistended
	BOWEL SOUNDS	4 quadrant	BS active x4 quads
	BOWEL MOVEMENT		
	NGT/OGT	Ø	—
	TUBE FEDDINGS	Ø	—
	DRAINS		
GU	VOIDING	pen self	Voids to urinal
	COLOR/CLARITY		
SKIN	COLOR	normal for race	Normal to Race
	INTEGRITY	Skin warm + dry to touch.	Skin warm & dry to touch
ACCESS	#1 TYPE/LOCATION/SIZE	(R) wrist Heparin @ site of infection.	(R) wrist (HL)
	DRESSING CONDITION		
	IV FLUID/RATE		
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 18 Sept 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade [redacted] 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

ICU1

Patients Name: [redacted]

Date: 18Sep03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	134/73	117/60	114/60				115/64							134/75				114/66				120/68				
TEMP	98.7						98.7							98.7				101.5								
HR	89	90	90				91							105				105				100				
RR	18	12	12				14							18				18				16				
SaO2	100%	100%	100%				100%							100%				100%				100%				
FiO2	—	—	—				—							—				—				—				
Source	RA	RA	RA				RA							RA				RA				RA				
MAP	—	—					—							—				—				—				

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100	50																								
T																										
PO																										
Total																			500		683/125					

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE			X1																							
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18640