PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 15 SEP 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		1						1								1									
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		Intubated						1 T								1 ETT									
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		Withdraw						4								4									
GLASGOW COMA SCALE (A+B+C)								6T								6T									
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2r						2+																	
	L	2r						2+																	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4						4								4									
	LUE	4						4								4									
	RLE	0						0								0									
	LLE	0						0								0									
GRIP (S) Strong (W) Weak (-) absent	R	S						S								S									
	L	S						S								S									
RESPIRATIONS	REGULAR	✓						✓																	
	IRREGULAR	✓						✓																	
	UNLABORED	✓						✓								VENT									
	LABORED	✗																							
	SHALLOW							T																	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5						3								5									
	LUL	5						3								5									
	RLL	1						3								3									
	LLL	1						3								3									
	BOTH BASES							1								1									
COUGH	NONE	✓						✓								✓									
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		3																							
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt	700						700								700									
	FiO2	40%						40								40									
	RATE (SIMV/CMV)	12						12								12									
	PEEP / CPAP	5						5								5									
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE ETT # 8.0	NC (l/min)																								
	FM (l/min)																								
	NRBM (l/min)																								
	ETT 23 cm gums	✓						✓								✓									
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED								✓	✓	✓		✓	✓	✓											
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2						(b)(6)-2				(b)(6)-2				(b)(6)-2									

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.9 AX	107	22	128/88	98%												
0200		111	21	123/55	99%												
0300	102 AX	120	20	119/54	97%												
0400		128	22	134/52	100%												Tylenol Sup 650mg
	102.5																
0500		128	23	107/54	99%												
	102.2																
0600	101.9	123	21	121/54	100%												
0700	101.4 (A)	117	21	120/59	100%												
0800	101.8 (A)	119	20	123/56	100%												
0900	101.0 (A)	112	20	122/59	100%												
1000	101.0 (A)	113	19	121/56	100%												
1100	101.7 (A)	121	23	109/53	100%												
1200	100.7 (A)	125	20	120/56	100												
1300	101.0 (A)	129	22	121/53	100%												
1400	101.0 (A)	125	21	96/49	98												
1500	101.9	123	20	115/52	97												
1600																	
1700	103.8	134	21	99/37	100												
1800	102.6	136	24	112/47	100												
1900		134	22	121/51	98												
2000	101.6	134	12	119/52	100												
2100	100.6	125	20	111/57	98												
2200	100.2	114	20	112/54	100%												
2300		115	20	108/58	99%												
2400	100.4	119	21	104/49	100%												

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15SEP03	0030		Pt agitated and sats ↓ to 85%, Dr (b)(6)-2 @ bedside. Fentanyl turned on and 100mcg bolus given @ 2230. Rate set @ 100mcg/hr. Continued agitation but sats ↑ing resolved @ 2300. ABG drawn and sent to lab. No vent Ds p̄ ABG. Generalized edema especially to face. JP drainage serosanguinous, J tube drainage green. OG tube drainage. (b)(6)-2 KAN
	0400		Pt HR ↑ to 120s, temp ↑ to 102°, noted Dr (b)(6)-2 pt given 650mg hydrol PR (b)(6)-2 KAN
	0430		IV in RAC d/c'd signs of infiltration but patent. 22 hour 18G placed in R wrist and blood drawn (b)(6)-2 KAN
15Sep03	0630		Supine c̄ soft restraints. Generalized edema. JP & G Tubes to drainage patent c̄ greenish liquid drainage. JP drain patent c̄ serous drainage. D5½NS c̄ 20meq KCl @ 125cc/hr. Versed 2mg/hr & Fentanyl 100mcg/hr. See flowsheet for further assessment. (b)(6)-2 LT, AN
15Sep03	0745		Desaturation to 88 RR 23 ST 120's. Pt suctioned. Given Bolus of Versed 2mg, Fentanyl 100mcg & MSO4 2mg IV. Sats ↑ 97-98%. RR 22 ST 120's. Will continue to monitor. Will notify Physician when in (b)(6)-2 LT, AN
15Sep03	1100		No Δ's from previous assessment. Dr (b)(6)-2 informed of previous desaturations. No new orders. (b)(6)-2
15Sep03		1320	Episodes of desaturation to 86's. RR ↑ 20's. ETT & oral suctioned c̄ ns. frequently. Thick brown/yellow secretions. Continues to desat. Dr (b)(6)-2 informed. Instructed to ↑ rate from 8 back to 12. Will continue to monitor. (b)(6)-2 LT, AN
15Sep03		1415	Pt's BP ↓ 96/49 HR 125 RR 21 O_2 SAT 98%. Dr (b)(6)-2 informed. Saw pt. RAN 2 consecutive BP checks 98/41 & 99/39 respectively. INSTRUCTED TO watch pt. EVENING SHIFT Nursing Staff informed. (b)(6)-2 LT, AN

(b)(6)-2

	INTAKE									OUTPUT						
	IVF	Versed	Fentanyl	LMPB	Tube feeding	Flush			Total	Urine	J tube	G tube	JP		Total	COMMENTS
0100	125 / 125	2 / 2	2 / 2													
0200	125 / 250	2 / 4	2 / 4							450 / 450			10 / 10			
0300	125 / 375	2 / 6	2 / 6													
0400	125 / 500	2 / 8	2 / 8							350 / 800			10 / 20			
0500	125 / 625	2 / 10	2 / 10													
0600	125 / 750	2 / 12	2 / 12							250 / 1050	100 / 100	350 / 350	5 / 25			
0700	125 / 875	2 / 14	2 / 14	100 / 100						325 / 1375						
0800	125 / 1000	2 / 16	2 / 16							175 / 1550		225 / 575				
8 HR	1000	16	16	100					8 HR. 1132	1550	100	575	25		8 HR 2250	⊖ 1118
0900	125 / 125	2 / 18	2 / 18							175 / 175		175 / 175				
1000	125 / 250	2 / 20	2 / 20							175 / 350						
1100	125 / 375	2 / 22	2 / 22							800 / 1150						20 LASIX IV @ 1025 h
1200	125 / 500	2 / 24	2 / 24	100 / 100						425 / 1575	20 / 20	125 / 300				
1300	125 / 625	2 / 26	2 / 26		10 / 10											
1400	125 / 750	2 / 28	2 / 28	50 / 150	20 / 30					450 / 2025		125 / 425	10 / 10			
1500	125 / 875	2 / 30	2 / 30		20 / 50					200 / 2225						
1600	125 / 1000	2 / 32	2 / 32		20 / 70	30				175 / 2400					2855	
8 HR	1000	16	16	150	70	30			16 HR. 1282	2400	20	425	10		16 HR. 5105	
1700	125 / 125	2 / 2	2 / 2		20 / 20					100 / 2500						
1800	125 / 250	2 / 4	2 / 4		20 / 40					200 / 300		200 / 200				
1900	125 / 375	2 / 6	2 / 6	100 / 100	20 / 60					150 / 450						
2000	125 / 500	2 / 8	2 / 8		20 / 80					150 / 600		75 / 275				
2100	125 / 625	2 / 10	2 / 10		20 / 100					250 / 850			5 / 5			
2200	125 / 750	2 / 12	2 / 12	50 / 150	20 / 120					150 / 1000						
2300	125 / 875	2 / 14	2 / 14		20 / 140					150 / 1150		300 / 575				
2400	125 / 1000	2 / 16	2 / 16	100 / 250	20 / 160	30 / 30			1472	175 / 1325					1905	
8 HR	1000	16	16	250	160	30			24 HR. 2764	1325		575	5		24 HR 1905	7010

MEDCOM - 2020

7010
1764

(- 4246)

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES

DATE	
1930 18 Sep 03	Assumed care of pt, assessment per flowsheet pt c̄ fever 101.2 Dr (b)(6)-2 aware, no orders given. (b)(6)-2
1715	Pt c̄ fever Tmax 103.8 A. kepalis applied to groin and armpits. will monitor. (b)(6)-2
1800	Pt s̄ change in status Temp 102.6. Ø change in VS or physical status. (b)(6)-2
1930	Pt SII ~~[illegible]~~ suctioned x 2 passes. small amt of ~~small~~ white mucus c̄ blood tinging. Pt tolerated well. continue to be febrile. (b)(6)-2
2100	Ø change in status. assessment unchanged cont c̄ fever. will continue to monitor (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.	WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11SEP03
DOS	11SEP/13SEP
POD	2 5/3

24 HOUR DATA	
24 Hour Balance	-1034
24 Hour Intake	3126
24 Hour Output	4160
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach		N/A	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 ICU AN	ICU#1	16SEP03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2			2			2				2			2					2				–	
	RADIAL L	2			2			2				2			2					2					
	DORSALIS PEDIS R	2			2			2				2			2					2					
	DORSALIS PEDIS L	2			2			2				2			2					2					
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale		1			1			1				1			1					1					
		3			3			3				3			3					3					
		8			8			8				8			8					8					
EDEMA		*			–			Generalized				–			±1/2					±1/2					
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S1S2			S1S2			✓				✓			✓					✓					
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST			ST			ST				ST			ST					ST					
SWAN GANZ CATHETER (Zeroed & calibrated)		Ø			Ø										/					/					
ARTERIAL LINE (zeroed & calibrated)		Ø			Ø										/					/					
HYGIENE	BED BATH											✓													
	FOLEY CARE											✓													
	ORAL CARE											✓													
MOBILITY	BEDREST	✓			✓			✓				✓			✓					✓					
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓			✓			✓				✓			✓					✓					
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	Fentanyl			Fent			Fent				Fent			Fent					Fent					
	PAIN SCALE (1-10)	gtt			gtt			gtt				gtt			gtt					gtt					
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended		2			2			2				2			2					2					
BOWEL SOUNDS (active all quads)		x4			x4			x4				x4			x4					x4					
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓			✓			✓				✓			✓					✓					
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown							✓				✓			✓					✓					
	Surgical Wounds	✓			✓			✓				✓			✓					✓					
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 hubedressings		✓			✓			✓				✓			✓					✓					
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) bicep	14SEP03	Patent Ø S/Sx infection/infiltration /0700 1400
PIV 18G	(R) wrist	15SEP03	Patent Ø S/Sx infection/infiltration/0700 1400
18G IV(P)	(L) Bicep	14SEP03	Ø S/S Inf/Infiltration patent 1400/1900
18G IV(P)	(R) wrist	15SEP03	Ø S/S Inf/Infiltration patent 1400/1900

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 16SEP03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4			4			2				2			2					2					
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		ETT			AT			1 T				1 T			1 ETT					1					
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		4			4			4				4			4					4					
GLASCOW COMA SCALE (A+B+C)		8			8			7T				7T			7					7					
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	3+			3+			2+				2+			2+					2+					
	L	3+			3+			2+				2+			2+					2+					
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4			4			4				4			1/2					1/2					
	LUE	4			4			4				4			1/2					1/2					
	RLE	0			0			0				0			0					0					
	LLE	0			0			0				0			0					0					
GRIP (S) Strong (W) Weak (-) absent	R	S			S			4				S			/					\					
	L	S			S			4				S			/					\					
RESPIRATIONS	REGULAR	V			V			V				V			V					V					
	IRREGULAR	E			E			E				E			E					E					
	UNLABORED	N			N			n				L			n					n					
	LABORED	T			T			T				n			T					T					
	SHALLOW											T													
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5			5			3				3			5					5					
	LUL	5			5			3				3			5					3					
	RLL	1			1			1/3				1/3			1/3					1/3					
	LLL	1			1			1/3				1/3			1/3					1/3					
	BOTH BASES							1/3				1/3			1/3					1/3					
COUGH	NONE	✓			✓			USELESS				--			✓					✓					
	SPONTANEOUS																								
	PRODUCTIVE				✓																				
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear								5				--								/					
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin								3				--								/					
VENTILATOR	Vt	700			700			700			700	700	700		700					700					
	FiO2	40%			40%			40%			40%	40%	40%		40%					40%					
	RATE (SIMV/CMV)	12			12			12			11	10	10		8					12					
	PEEP / CPAP	5			5			5			5	5	5		5					5					
	PRESS. SUPPORT							0			0	0	0		0					0					
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8.0	NRBM (l/min)																								
	ETT 23 cm gums	✓			✓			✓							✓					✓					
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED			✓		✓		✓	✓		✓		✓	✓		✓					✓					
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2																		(b)(6)-2					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		117	20	112/56	100%												
0200	101'	130	21	120/56	97%												
0300	102.4	120	22	107/55	100%												
0400	103'	126	23	118/56	100%												
0500	103.2	128	19	102/49	99%												
0600	103'	144	25	110/56	95%												
0700	101.0(A)	131	18	115/56	100												
0800	101.5(A)	129	22	116/58	100												
0900	101.7(A)	134	29	118/60	100												
1000	102.3(A)	125	19	111/56	100	RATE OF 11 on Vent											
1100	102.2(A)	139	22	121/42	97%	VENT RR 10											
1200	103.6(A)	144	22	102/40	100%												
1300	103.2(A)	135	22	113/51	100%	Vent RR 9											
1400	102.3(A)	123	18	104/56	100%	VENT RR 8											
1500	101.7(A)	120	18	115/55	98%	VENT RR 6											
1600	101.3(A)	125	21	108/55	97%												
1700	100.4(A)	114	18	102/51	99%	VENT to 12											
1800	99.4(A)	100	16	113/59	100%												
1900	99.7(A)	102	15	116/56	100%												
2000	99.0(A)	120	26	115/54	100%												
2100	100.1(A)	120	24	112/55	100%												
2130	101(A)																
2200	101.5A	125	20	124/61	86%	97 to 100%											
2300	102.3A	131	23		100%												
2400	100.4(A)	119	18	109/56	100%												

	INTAKE									OUTPUT						
	IVF	IVPB	Tube Feed	Food	Fent	Versed			Total	Urine	G tube	JP			Total	COMMENTS
0100	125 / 125		20 / 20	75 / 75	2 / 2	2 / 2										
0200	125 / 250		20 / 40	25 / 50	2 / 4	2 / 4				325 / 325	175 / 175					
0300	125 / 375		20 / 60	75 / 75	2 / 6	2 / 6										
0400	125 / 500		20 / 80		2 / 8	2 / 8				200 / 575						
0500	125 / 625		20 / 100		2 / 10	2 / 10										
0600	125 / 750		20 / 120		2 / 12	2 / 12				225 / 800	350 / 525					
0700	125 / 875	20	175 / 295	140	2 / 14	2 / 14				150 / 950	175 / 700					
0800	125 / 1000	100 / 100	20 / 160		2 / 16	2 / 16				125 / 1075						
8 HR	1000	100	160		16	16			8 HR 1292	1075	700	0			8 HR 1775	-483
0900	125 / 125		20 / 20		2 / 2	2 / 2			1292	125 / 125						
1000	75 / 200		20 / 40		2 / 4	2 / 4				175 / 300						
1100	75 / 275		20 / 60		2 / 6	2 / 6				100 / 400						
1200	75 / 350	100 / 100	20 / 80		2 / 8	2 / 8				150 / 550						
1300	75 / 425		20 / 100		2 / 10	2 / 10				175 / 725	275 / 325					
1400	75 / 500	50 / 150	20 / 120		2 / 12	2 / 12				150 / 875	50 / 325	15 / 15				
1500	75 / 575	9	20 / 140		2 / 14	2 / 14				100 / 975	200 / 525					
1600	75 / 650		20 / 160		2 / 16	2 / 16				75 / 1050	75 / 600					
8 HR	650	150	160		16	16			16 HR. 2584	1050	60	15			16 HR. 2900	-616
1700	75 / 75		20 / 20		2 / 2	2 / 2				50 / 50	25 / 25					
1800	75 / 150		20 / 40		2 / 4	2 / 4				200 / 250	125 / 150					
1900	75 / 225		20 / 60		2 / 6	2 / 6				50 / 300	50 / 200					
2000	75 / 300		20 / 80		2 / 8	2 / 8				100 / 400	50 / 250	10 / 10				
2100	75 / 375		20 / 100		2 / 10	2 / 10										
2200	75 / 450	50 / 50	20 / 120		2 / 12	2 / 12										
2300	75 / 525		20 / 140		2 / 14	2 / 14			310							5 4160 3126 1034
2400	75 / 600		20 / 160		2 / 16	2 / 16			842	375 / 775	275 / 475				1260	
8 HR	600	50	160		16	16			24 HR. 3126	775	475	10			24 HR 4160	-1034

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16SEP03	0010		Pt remains sedated c̄ 2mg/hr versed and 100mcg Fentanyl for pain. Scleral edema ⊕. Incision midline open to air staples present & drainage. Heparin given SQ to ⊕ upper arm. Pt remains restrained (b)(6)-2 LT AN
	0220		~~Tylenol 650mg given per NOT, ensure tolerated followed by 60cc H2O. IS completed c̄ pt IS~~ (b)(6)-2 (b)(6)-2 LT AN
	0400		Temp continues to ↑, suctioned @ 0200 and @ 0350 brownish mucus and bloody tinge suctioned also wet washcloth placed in axilla, pt turned and foley placed in pt (b)(6)-2 LT AN
9/16/03	0700		Pt c̄ periodic episodes of desats into 80's, suctioned 4X's. SAT fluctuating between 90-100% (b)(6)-2 LT, AN
9/16/03	0900		Dr (b)(6)-2 informed of temp spikes desaturations, ⊖ Urasyn in pharmacy (b)(6)-2 LT, AN
9/16/03	1100		T 103.2 (A). Tepid bath given. Linen removed from patient. Temp 102.1 (A) W/C cont to monitor. (b)(6)-2 LT, AN
9/16/03		1245	Medicated c̄ Tylenol 650mg PR supp (b)(6)-2 LT, AN
16SEP03		1600	Pt ABG drawn. Pt has desated for 3rd time requiring manuel vent. c̄ bag. MD informed (b)(6)-2
		1700	Pt vent setting returned to 12 bpm (b)(6)-2
		2000	Pt drsg Δ'd as it has soaked through (b)(6)-2
		2130	Pt desated to mid 70's requiring several minutes of manuel ventilation c̄ bag value ~~bag~~. Pt temp 101.1 @ this time O2 sat back to 100%. (b)(6)-2 LT AN

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11
DOS	11SEP03 / 13SEP03
POD	6/4

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LITAN	ICU #1	17SEP03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2			2			2																	
	RADIAL L	2			2			2																	
	DORSALIS PEDIS R	2			2			2																	
	DORSALIS PEDIS L	2			2			2																	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale		1 3 8			1 3 8			1 3 8																	
EDEMA								✓																	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S1S2			S1S2																				
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST			ST			ST																	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE	✓			✓			✓																	
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓			✓			✓																	
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	Fent			Fent			Fent																	
	PAIN SCALE (1-10)	9/10			9/10			9/10																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended	2			2			2																	
BOWEL SOUNDS (active all quads)		X4			X4			✓																	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓			✓			✓																	
VOIDING CLEAR, YELLOW URINE q.s.		\																							
SKIN INTEGRITY	No Breakdown							✓																	
	Surgical Wounds	✓			✓			✓																	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 J tube G tube J drain 4x4		✓			✓			✓																	
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) bicep	16SEP03/2300	Patent ~~S~~/Sx infection/infiltration/0700
PIV 18G #L	(L) forearm	16SEP03/2300	Patent ~~S~~/Sx infection/infiltration/0700

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 17SEP03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4			4			2																	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		ETT			ETT			1 T																	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		4			4			4																	
GLASGOW COMA SCALE (A+B+C)								7T																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+			2+			2+																	
	L	2+			2+			2+																	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4			4			4																	
	LUE	4			4			4																	
	RLE	0			0			0																	
	LLE	0			0			0																	
GRIP (S) Strong (W) Weak (-) absent	R	S			S			S																	
	L	S			S			S																	
RESPIRATIONS	REGULAR																								
	IRREGULAR	V			V			V																	
	UNLABORED	E			E			E																	
	LABORED	N			N			N																	
	SHALLOW	T			T			T																	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5			5			5																	
	LUL	5			5			5																	
	RLL	1			1			5/1																	
	LLL	1			1			5/1																	
	BOTH BASES							6/1																	
COUGH	NONE																								
	SPONTANEOUS	✓			✓																				
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt	700			700			700																	
	FiO2	40%			40%			40%																	
	RATE (SIMV/CMV)	12			12			12																	
	PEEP / CPAP	5			5			5																	
	PRESS. SUPPORT							0																	
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8.0	NRBM (l/min)																								
	ETT 23 cm gums							✓																	
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED			✓		✓			✓																	
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2			(b)(6)-2			(b)(6)-2																	

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	101.5 (a)	116	18	109/53	100%												
0200	101.9	128	19	117/52	98%												
0300	102.2	127	19	109/62	99%												
0400	101.9	119	18	103/53	100%												
0500	102.5	122	18	113/42	100%												
0600	102.6	123	18	107/54	100%												
0700	102.4 (A)	133	19	113/51	100%												
0800	102.1 (A)	122	18	116/55	100%												
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 SEP 03	0015		Temp ↑, ice pack to groin and axillae also wet washcloth to neck. IV's d/c'd in ⓓ bicep and ⓓ wrist: 18g placed in ~~ⓓbicep and~~ ⓓbicep and ⓓforearm. Betadine placed to midline incision staples because redness around staples. (b)(6)-2
	0200		Pt suctioned; yellow thick sputum pt spontaneously coughs (b)(6)-2
	0400		Pt suctioned, lungs CTA ⓑ ↑ suctioning remain diminished in bases oral care complete (b)(6)-2
17 SEP 03		0620	NAD noted. D5NS c̄ 20 meq KCl @ 75cc/hr. VERSED 2mg/h & Fentanyl @ 100mcg/hr. J-Tube Patent infusing VIVONEX @ 20cc/hr. G Tube c̄ Moderate amt of green liquid drainage. JP Patent c̄ minimal amt. of serous fluid. See flowsheet for further assessment Will continue to monitor & prepare for 1000 hrs transfer to civilian facility — (b)(6)-2

	INTAKE									OUTPUT						
	IVF	IVPB	J tube Feed	Feed	Versed	Flush			Total	Urine	G tube	JP			Total	COMMENTS
0100	75 / 75		20 / 20	2 / 2	2 / 2											
0200	75 / 150		20 / 40	2 / 4	2 / 4	30 / 30				250 / 250	100 / 100					
0300	75 / 225		20 / 60	2 / 6	2 / 6											
0400	75 / 300		20 / 80	2 / 8	2 / 8					175 / 475	100 / 200					
0500	75 / 375		20 / 100	2 / 10	2 / 10											
0600	75 / 450		20 / 120	2 / 12	2 / 12					175 / 650	50 / 250	3 / 3				
0700	75 / 525	50 / 50	20 / 140	2 / 14	2 / 14					100 / 750						
0800	75 / 600		20 / 160	2 / 16	2 / 16					100 / 850	175 / 175					
8 HR	600	50	160	16	16	30			8 HR. 872 (b)(6)-2 842	850	175	3			8 HR 1028	(b)(6)-2 ~~86~~ 15
0900						30 / 30										
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD - PATIENT RELEASE / DISCHARGE INSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 11 Sept 01
2. ADMITTING/DIAGNOSIS: Gunshot wound Left Flank
3. PERTINENT LAB, X-RAY, FINDINGS:
   ~~Dx~~ Lumbar Spine fracture.
   ~~Dx~~ Lumbar Fracture, Left Renal laceration
   Repair of duodenum & IVC
   Appendectomy
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   Exploratory laparotomy - repair of IVC, Duodenum. Found to have left renal laceration w/ left ureter. Through & Through injury to liver. Bogota bag placed. Pt. taken back to OR 2 days later for re-exploration. G-tube, J-tube, JP drain placed. Abdomen closed. Pt. on tube feed - Vivonex 20cc/hr. Pt. on logroll procedure for spine fracture.
5. ~~FINAL DIAGNOSIS AND CONDITION AT DISCHARGE~~:
6. ACTIVITY: Bedrest / Logroll
7. DIET: NPO / Tube Feeds
8. MEDICATIONS:
   ☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
   Versed 5mg in syringe
   Fentanyl 50ug in syringe
   MS04 5mg in syringe
   Levaquin 500mg IV QD
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:
   Pt. intubated - on versed + fentanyl drip. Vivonex tube feeds. G-tube to drainage. JP to S-15 suction
   logroll only - spine fracture
10. DISCHARGING PROVIDER: (b)(6)(2)
    (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER _____
   ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☐ OTHER _____
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. ☐ YES ☐ NO
   If no, explain: _____
   Patient ☐ states ☐ demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   ☐ YES ☐ NO If no, explain: _____
5. If transferred to another health care facility, report called to nurse.
   ☐ YES ☐ NO If no, explain: _____
6. NUTRITION CARE - Comments:
7. MEDICATIONS:
   Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
   Printed medication literature provided. ☐ YES ☐ NO
   Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY:
    (Signature and Title) *(Date and Time)*

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

(Patient/Responsible Adult's Signature) *(Date and Time)*

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Cart BY CPT (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAT (b)(6)-2

3. DATE 11 SEPT 07 TIME PATIENT ARRIVED IN SUITE 0100

4. PATIENT IN ROOM TIME 0100 NUMBER B #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: EMERGENT PROCEDURE

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: all bony areas padded

8. SKIN PREPARATION

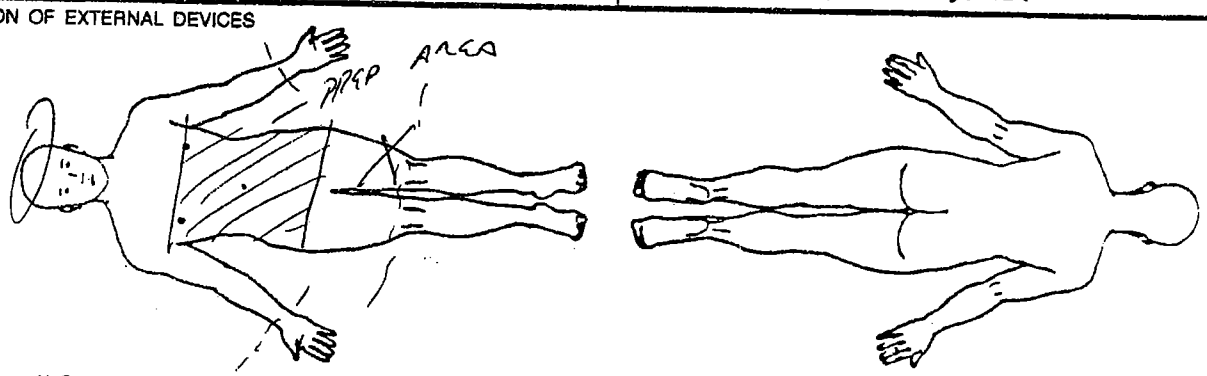
HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: No Blood or Nicks

PREP SOLUTION *(Specify)* BETA / BETA
SITE: NIPPLES TO PUBIS BY WHOM: MAT (b)(6)-2
SITE: BY WHOM:

COMMENTS: No Pooling or Reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ▬▬ Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C		
Needle Sharp	☑ Yes ☐ No		C	C	(b)(6)-2	
Instrument	☑ Yes ☐ No		C	C		(b)(6)-2
Other	☐ Yes ☐ No					

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

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO 35/35

☑ ESU NO: ROC 000434
GROUND PAD: BRAND Valleylab
LOT NO: 07K11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

BIPOLAR NO

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): N.S.

OTHER ORDERS None

	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE Yes

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. 16 Fr Foley	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
BOLTA BAC & WET LAPS
COVERED BY ZOBAN DRESSING
SIDE WOUND GAUZE DRESSING

19. ADDITIONAL INFORMATION
SURGEONS = MAJ (b)(6)-2, LTC (b)(6)-2
WC = 4
ESU PAD SITE clean & dry Pre & Post-op

20. OPERATION(S) PERFORMED
EXP LAP

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	0950	LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA letter BY Cpt (b)(6)-2

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY (b)(6)-2 RN

3. DATE 13 Sept 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER B

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ #1 SUPINE #2 ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Arms on bil armboards < 90°. Safety strap over thighs

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

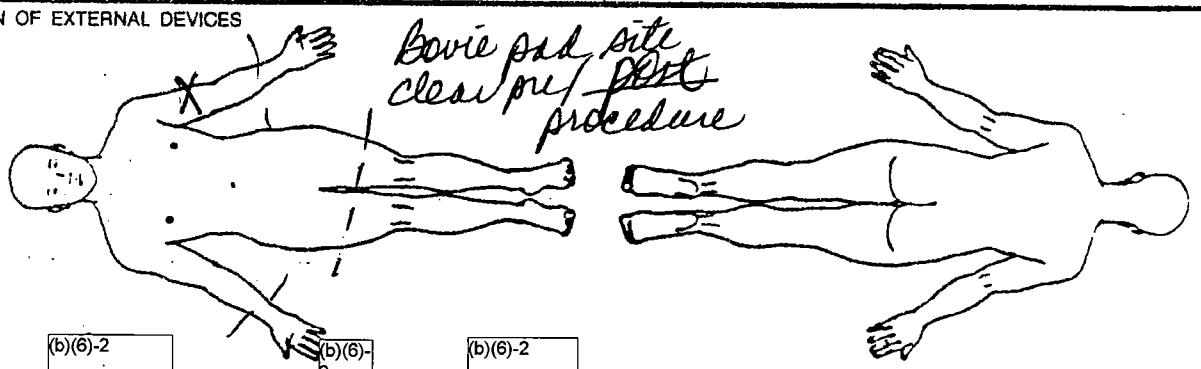
PREP SOLUTION *(Specify)* Betadine scrub/sol

SITE: abd BY WHOM: Maj

SITE: Scrotum BY WHOM: (b)(6)-2

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 === Tourniquet (b)(6)-2

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No				(b)(6)-2	(b)(6)-2
Needle Sharp	☐ Yes ☐ No		C	C		
Instrument	☐ Yes ☐ No				Spc	Maj
Other	☐ Yes ☐ No					

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

(b)(6)-4

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

☐ ESU NO: Valleylab 00438

GROUND PAD: BRAND Valleylab

LOT NO: 70011, exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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 9N S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIG (b)(6)-2 [redacted] not a

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☑ NO ☐	NAME appendix (5) discarded	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	NAME

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE JP drains x 2	1.	2. abd	3.
SITE RR #16F x 1	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8s
silk tape

19. ADDITIONAL INFORMATION
18F x 1

Surgeons - (b)(6)-2 / (b)(6)-2 / (b)(6)-2 / (b)(6)-2

20. OPERATION(S) PERFORMED
~~Exp Lap~~ Laparotomy, Remove Bogata Bag, Wash out Abd, Gastrostomy Tube Closure Wd, ~~Cy~~ Cysto, Placement of Tube

21. PATIENT TRANSFERRED TO SICU #1 TIME 1525 METHOD litter

22. REGISTERED NURSE S (b)(6)-2 [redacted] Mg RN

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
9/11	0600	SIMV	700	12	70	5	24	10	100	65	127/87	1:2.3	(b)(6)-2
9/11	0800	SIMV	700	12	70	5	23	11	100	77	120/68	1:2.3	
9/11	1000	SIMV	700	12	70	5	23	10	100	75	109/61	1:2.3	
9/11	1200	SIMV	700	12	50	5	23	10	100	91	114/65	1:2.3	
9/11	1400	SIMV	700	12	50	5	22	10	100	108	117/66	1:2.3	
9/11	1600	SIMV	700	12	40	5	23	11	100	96	120/61	1:2.3	
9/11	1800	SIMV	700	12	40	5	25	11	100	111	110/61	1:2.3	
9/11	2000	SIMV	700	12	40	5	22	11	100	114	119/68	1:2.3	
9/11	2200	SIMV	700	12	35	5	23	9	100	103	114/68	1:2.3	
9/12	2400	SIMV	700	12	35	5	24	10	99	105	128/74	1:2.5	
9/12	0200	SIMV	700	12	35	5	23	9	100	89	132/78	1:2.3	
9/12	0400	SIMV	700	12	35	5	25	11	100	82	144/73	1:2.3	
9/12	0600	SIMV	700	12	35	5	30	12	100	98	157/73	1:2.3	
9/12	0800	SIMV	700	12	40	5	26	12	100%	85	128/61	1:2.3	
9/12	1000	SIMV	700	12	40	5	26	12	100%	94	150/73	1:2.3	
9/12	1200	SIMV	700	12	40	5	26	11	100%	96	124/65	1:2.3	
9/12	1400	SIMV	700	12	40	5	26	11	100%	101	138/66	1:2.3	
9/12	1600	SIMV	700	12	40	5	26	12	100%	102	137/70	1:2.3	
9/12	1800	SIMV	700	12	40	5	26	11	100%	95	131/51	1:2.3	
9/12	2000	SIMV	700	12	40	5	26	10	100	106	142/68	1:2.3	
9/12	2200	SIMV	700	12	40	5	25	11	100%	89	134/65	1:2.3	
9/12	2400	SIMV	700	12	40	5	27	10	100%	91	142/66	1:2.3	
9/13	0200	SIMV	700	12	40	5	30	12	100%	88	151/65	1:2.3	
9/13	0400	SIMV	700	12	40	5	27	12	100	96	143/66	1:2.3	
9/13	0600	SIMV	700	12	40	5	28	10	100	106	148/67	1:2.3	
9/13	0800	SIMV	700	12	40	5	26	11	100	99	170/66	1:2.3	
9/13	1000	SIMV	700	12	40	5	27	12	100	101	132/54	1:2.3	
9/13	1200	SIMV	700	12	40	5	25	11	100	140	124/78	1:2.3	
9/13	1800	SIMV	700	12	40	5	27	11	100	92	141/67	1:2.3	

(b)(6)-4

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
9/13	2000	SIMV	700	12	40	5	27	12	100	94	151/74	1:2.3	(b)(6)-2
9/13	2200	SIMV	700	12	40	5	27	12	100	107	143/65	1:2.3	
9/14	2400	SIMV	700	12	40	5	26	11	100	110	147/53	1:2.3	
9/14	0200	SIMV	700	12	40	5	25	10	100	135	117/66	1:2.3	
9/14	0400	SIMV	700	12	40	5	27	12	100	121	115/81	1:2.3	
9/14	0600	SIMV	700	12	40	5	25	12	100	132	128/71	1:2.3	
9/14	0800	SIMV	700	12	40	5	26	12	100	131	130/61	1:2.3	
9/14	0836	SIMV		16									
9/14	1003	SIMV	700	16	40	5	16	8	100	129	125/64	1:2.3	
9/14	1102			16									
9/14	1200	SIMV	700	6	40	5	26	12	100	140	116/62	1:2.3	
9/14	1400	SIMV	700	6	40	5	28	12	100	135			
9/14	1600	SIMV	700	12	40	5	27	14	100	143	135/55	1:2.3	
9/14	1620	SIMV	700	12	40	5	12	9	100	120	134/60	1:2.3	
9/14	1700	SIMV	700	12	40	5	21	12	100	115	126/60	1:2.3	
9/14	2000	SIMV	700	12	40	5	21	12	100	110	127/63	1:2.3	
9/14	2200	SIMV	700	12	40	5	22	12	100	111	122/68	1:2.3	
9/14	2400	SIMV	700	12	40	5	26	9	100	101	129/69	1:2.3	
9/15	0200	SIMV	700	12	40	5	24	6	99	100	123/70	1:2	
9/15	0400	SIMV	700	12	40	5	25	11	93	159	112/51	1:2	
9/15	0600	SIMV	700	12	40	5	23	13	100	115	121/54	1:2.1	
9/15	0800	SIMV	700	12	40	5	24	11	99	121	139/69	1:2.1	
9/15	1000	SIMV	700	12	40	5	18	10	100	115	121/52	1:2.1	
9/15	1030	SIMV	700	11	40	5							
9/15	1115	SIMV	700	10	40	5							
9/15	1215	SIMV	700	9	40	5							
9/15	1230	SIMV	700	9	40	5	23	12	100	123	112/53	1:2.3	
9/15	1315	SIMV	700	8	40	5							
9/15	1345	SIMV	700	12	40	5							

Suction

Time	Int
1700	(b)(6)-2
1900	
2100	
0315	

(b)(6)-4

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO_2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
9/15	1400	SIMV	700	12	40	5	21	13	99	125	96/49	1:2.1	(b)(6)-2
9/15	1600	SIMV	700	12	40	5	22	12	97	131	113/48	1:2.1	
9/15	1800	SIMV	700	12	40	5	22	13	100	135	107/40	1:2.1	
9/15	2000	SIMV	700	12	40	5	23	12	100	126	119/[illegible]	1:2.1	
9/15	2200	SIMV	700	12	40	5	20	11	100	114	114/59	1:2.1	
9/16	2400	SIMV	700	12	40	5	17	9	98	119	106/44	1:2.1	
9/16	0200	SIMV	700	12	40	5	22	7	100	126	120/52	1:2.1	
9/16	0400	SIMV	700	12	40	5	18	11	100	129	118/57	1:2.1	
9/16	0600	SIMV	700	12	40	5	43	15	95	146	104/49	1:2.1	
9/16	0800	SIMV	700	12	40	5	22	12	100	121	124/61	1:2.1	
9/16	0425	SIMV	700	11	40	5							(b)(6)-2
9/16	1010	SIMV	700	10	40	5							
9/16	1020	SIMV	700	10	40	5	21	10	100	133	114/58	1:2.1	(b)(6)-2
9/16	1235	SIMV	700	9	40	5							
9/16	1315	SIMV	700	8	40	5							
9/16	1350	SIMV	700	8	40	5	11	4	100	125	112/56	1:2.1	
9/16	1600	SIMV	700		40	5	18	5	100	118	108/53	1:2.1	
9/16	1830	SIMV	700	12	40	5	19	6	100	101	111/58	1:1.9	
9/16	2000	SIMV	700	12	40	5	24	12	100	110		1:1.9	
9/16	2200	SIMV	700	12	40	5	28	14	100	125		1:1.9	
9/17	0000	SIMV	700	12	40	5	19	10	100	117	117/61	1:1.9	
9/17	0200	SIMV	700	12	40	5	18	11	98	123	110/52	1:1.9	
9/17	0425	SIMV	700	12	40	5	22	7	100	123	104/53	1:1.9	

(b)(6)-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	RANK	SSN
(b)(6)-4		CIV	(b)(6)-4 (b)(6)-4

Physician:	Ward:	X STAT / Routine	Date and Time:	Reported by:	Date and Time:
Maj (b)(6)-2	EMT		10Sep 2340	(b)(6)-2	10Sep 2350

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	2.9	3.3-4.7 mmol/L
	Cl	104	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	14	7-22 mg/dL
	Glu	213 *	73-118 mg/dL
	Creat	1.7 +	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:		

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	B	Pos
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	18.5 *	4.8-10.8 x10(3)/uL
	RBC	4.76	4.2-6.1 x10(6)/uL
	Hgb	15.2	12.0-18.0 g/dL
	Hct	45.5	35.0-60.0%
	MCV	95.6	80.0-99.0 fl
	MCH	31.9	27.0-31.0 pg
	MCHC	33.4	33.0-37.0 g/dL
	Plt	323	130-400 x10(3)/uL
	LY%	26.5	15.0-55.0%
	LY#	4.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

RBC Morph:

Plt verify:

Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Type: ~~Cross~~, I-Stat 6, Crit, CBC, UA

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Fio2 80% imp: 94.0

ABG & CBC

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI: (b)(6)-4

UNIT:

RANK:

SSN: -

Physician: (b)(6)-2

Ward: ICU

X STAT / Routine

Date and Time: 0510 11 Sep 03

Reported by: (b)(6)-2

Date and Time: 11 Sept 03

X Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.326	7.35-7.45
	PCO2	37.0	35-45 mmHg
	PO2	298	80-90 mmHg
	TCO2	20	18-33 mmol/L
	HCO3	19	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	-7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other:

X Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	5.6	4.8-10.8 x10(3)/uL
	RBC	4.00	4.2-6.1 x10(6)/uL
	Hgb	12.4	12.0-18.0 g/dL
	Hct	37.7	35.0-60.0%
	MCV	94.2	80.0-99.0 fl
	MCH	30.9	27.0-31.0 pg
	MCHC	32.9	33.0-37.0 g/dL
	Plt	89	130-400 x10(3)/uL
	LY%	7.3	15.0-55.0%
	LY#	1.1	0.7-4.3 x10(3)/uL

Differential

	Segs		Mono
	Bands		Eos
	Lymph		Baso
	Atyp Ly		Imm
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

, FIRST MI (b)(6)-4

UNIT | DOB | RANK | SSN

sician: OR | Ward: | STAT / Routine | Specimen Date and Time: | Reported by: (b)(6)-2 | Date and Time: 11 Sep 0315

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.309	7.35-7.45
	PCO2	30.3	35-45 mmHg
	PO2	335	80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3	15	22-28 mmol/L
	sO2	100	95-99%
	BEecf	-11	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			
Other:			

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
S		ve

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	14.3	4.8-10.8 x10(3)/uL
	RBC	2.71	4.2-6.1 x10(6)/uL
	Hgb	8.9	12.0-18.0 g/dL
	Hct	25.5	35.0-60.0%
	MCV	94.0	80.0-99.0 fl
	MCH	32.8	27.0-31.0 pg
	MCHC	34.9	33.0-37.0 g/dL
	Plt	115	130-400 x10(3)/uL
	LY%	10.9	15.0-55.0%
	LY#	1.6	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

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21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
(b)(6)-2	ICU #1		(b)(6)-2

Physician	Ward:	STAT / Routine	Date and Time:	Reported to:	Date and Time:
(b)(6)-2			11 Sep 03 1200	(b)(6)-2 (b)(6)-2	11 Sept 1220 HR

Chemistry (i-STAT) 0400 1230 HR

X	TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	4.9	3.3-4.7 mmol/L
	Cl	113	98-108 mmol/L
	pH	7.306	7.35-7.45
	PCO2	41.9	35-45 mmHg
	PO2	232	80-90 mmHg
	TCO2	23	18-33 mmol/L
	HCO3	21	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	17	7-22 mg/dL
	Glu	157	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	3.4	3.3-5.5 g/dL
	ALP	78	26-84 U/L
	ALT	27	10-47 U/L
	AMY	40	14-97 U/L
	AST	45 ↑	11-38 U/L
	Tbil	0.6	0.2-1.6 mg/dL
	BUN	7 14	7-22 mg/dL
	Ca	9.1 7.2	8.0-10.3 mg/dL
	Chol	135	100-200 mg/dL
	CK		30-170 U/L
	CL	106	98-108 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	PP 1.0 0.8	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	88 157	73-118 mg/dL
	K	5.0	3.3-4.7 mmol/L
	TProtein	6.9	6.4-8.1 g/dL
	Na	138	128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	12.7	4.8-10.8 x10(3)/uL
	RBC	4.32	4.2-6.1 x10(6)/uL
	Hgb	13.4	12.0-18.0 g/dL
	Hct	40.7	35.0-60.0%
	MCV	94.0	80.0-99.0 fl
	MCH	31.0	27.0-31.0 pg
	MCHC	33.0	33.0-37.0 g/dL
	Plt	145	130-400 x10(3)/uL
	LY%	7.6	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp Ly		Imm	
RBC Morph:			
Plt verify:			
Spun Crit		35-60%	

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

RBC, ABG, [illegible] Dent- Fio2 50% TV 700 Rate [illegible]

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST (b)(6)-4	UNIT ICU 1	RANK	SSN -
Physician: Ward:	STAT / Routine — Date and Time: 11 Sep 1240	Reported by: (b)(6)-2	Date and Time: 11 Sept 1306

X	Chemistry (i-STAT) TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	5.0	3.3-4.7 mmol/L
	Cl	112	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	17	7-22 mg/dL
	Glu	163	73-118 mg/dL
	Creat	1.1	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

X	Chemistry (Piccolo Analyzer) 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
	BUN	15	7-22 mg/dL
	Ca	7.1	8.0-10.3 mg/dL
	Chol	160	100-200 mg/dL
	CK		30-170 U/L
	CL	106	98-108 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	1.1	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	159	73-118 mg/dL
	K	5.0	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	138	128-145 mmol/L

X	Hematology TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL
	Differential		
	Segs		Mono
	Bands		Eos
	Lymph		Baso
	Atyp Ly		Imm
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Urinalysis		
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative
Urine Microscopic		
WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:		

Microbiology		
Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank		
ABO/Rh		
T&C		
T&S		

HCG		
Urine		Negative
Serum		Negative

Malaria Smear		
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate		
Sed Rate		1hr = 0-20 mm

Coagulation		
PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry		
Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Dr Dnt Istu

ABG, CBC, PA-7 TEMP 98.4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	RANK	SSN
(b)(6)-2	ICU I		

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 1		12Sep03 0500	(b)(6)-2	12Sep 0515

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.462	7.35-7.45
	PCO2	34.1	35-45 mmHg
	PO2	186	80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3	26	22-28 mmol/L
	sO2	100	95-99%
	BEecf	2	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mmol/L
	Glu		73-118 mmol/L
	Creat		0.6-1.2 mmol/L
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Other:

Chemistry (Piccolo Analyzer)

X	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
	BUN	18	7-22 mg/dL
	Ca	7.6	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	105	98-108 mmol/L
	TCO2	23	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	128	73-118 mg/dL
	K	4.2	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	136	128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	11.3	4.8-10.8 x10(3)/uL
	RBC	3.16	4.2-6.1 x10(6)/uL
	Hgb	10.5	12.0-18.0 g/dL
	Hct	29.8	35.0-60.0%
	MCV	94.2	80.0-99.0 fl
	MCH	33.2	27.0-31.0 pg
	MCHC	35.3	33.0-37.0 g/dL
	Plt	126	130-400 x10(3)/uL
	LY%	14.2	15.0-55.0%
	LY#	1.6	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

98.4 on 40% CBC, ABG, + STAT 6, Creat

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4			-

Physician	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU		13 Sep 03 0515	(b)(6)-2	13 Sep 03 0530

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	140	128-145 mmol/L
	K	3.4	3.3-4.7 mmol/L
	Cl	105	98-108 mmol/L
	pH	7.455	7.35-7.45
	PCO2	40.7	35-45 mmHg
	PO2	218	80-90 mmHg
	TCO2	30	18-33 mmol/L
	HCO3	29	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	19	7-22 mg/dL
	Glu	101	73-118 mg/dL
	Creat	1.0	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Other

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	9.5	4.8-10.8 x10(3)/uL
	RBC	2.68	4.2-6.1 x10(6)/uL
	Hgb	8.4	12.0-18.0 g/dL
	Hct	25.0	35.0-60.0%
	MCV	93.2	80.0-99.0 fl
	MCH	31.4	27.0-31.0 pg
	MCHC	33.7	33.0-37.0 g/dL
	Plt	135	130-400 x10(3)/uL
	LY%	12.0	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	RANK	SSN
(b)(6)-2	ICU 1		-

Physician:	Ward:	STAT / X Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2			1400 / 13 Sept 10	(b)(6)-2	13 Sept 2010

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate X 2 Days (b)(6)-2

	Sed Rate	>140 mm. 1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative

Other: CSR

ABG bo4 60% FiO2

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIR(b)(6)-4 | UNIT | RANK | SSN

Physician: ICU | X STAT / Routine | Date and Time: 14Sep03 | Reported by: (b)(6)-2 | Date and Time: 14Sep 03

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	136	128-145 mmol/L
	K	3.4	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.699	7.35-7.45
	PCO2	21.8	35-45 mmHg
	PO2	87	80-90 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	27	22-28 mmol/L
	sO2	99	95-99%
	BEecf	7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.85	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct	20	35.0-60.0%
	Hgb	7	12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative

MEDCOM - 2050

Venous ABC Fio2 @ 40%, Temp - 100.8 (A)

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST (b)(6)-4	UNIT	RANK	SSN

Physician: (b)(6)-2	Ward:	STAT / Routine	Date and Time: 14 Sep 03 1200	Reported by: (b)(6)-2	Date and Time: 14 Sep 03

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	138	128-145 mmol/L
	K	3.5	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.366	7.35-7.45
	PCO2	51.5	35-45 mmHg
	PO2	37	80-90 mmHg
	TCO2	31	18-33 mmol/L
	HCO3	29	22-28 mmol/L
	sO2	63	95-99%
	BEecf	4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct	19	35.0-60.0%
	Hgb	6	12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Other:

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4	ICU 1		-

Physician:	Ward:			Requested by:	Date and Time:
(b)(6)-2		X STAT / Routine	Date and Time: 14Sep 1945	(b)(6)-2	14Sep03 0250

Chemistry (i-STAT)				Chemistry (Piccolo Analyzer)				Hematology			
X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L		ALB		3.3-5.5 g/dL		WBC	7.0	4.8-10.8 x10(3)/uL
	K		3.3-4.7 mmol/L		ALP		26-84 U/L		RBC	2.44	4.2-6.1 x10(6)/uL
	Cl		98-108 mmol/L		ALT		10-47 U/L		Hgb	7.8	12.0-18.0 g/dL
	pH		7.35-7.45		AMY		14-97 U/L		Hct	22.8	35.0-60.0%
	PCO2		35-45 mmHg		AST		11-38 U/L		MCV	93.7	80.0-99.0 fl
	PO2		80-90 mmHg		Tbil		0.2-1.6 mg/dL		MCH	32.0	27.0-31.0 pg
	TCO2		18-33 mmol/L		BUN		7-22 mg/dL		MCHC	34.2	33.0-37.0 g/dL
	HCO3		22-28 mmol/L		Ca		8.0-10.3 mg/dL		Plt	161	130-400 x10(3)/uL
	sO2		95-99%		Chol		100-200 mg/dL		LY%	12.9	15.0-55.0%
	BEecf		(-2) - (+3)		CK		30-170 U/L		LY#	0.9	0.7-4.3 x10(3)/uL
	AGap		8-16 mmol/L		CL		98-108 mmol/L		Differential		
	iCa		0.11-1.23 mmol/L		TCO2		18-33 mmol/L		Segs		Mono
	BUN		7-22 mg/dL		Creat		0.6-1.2 mg/dL		Bands		Eos
	Glu		73-118 mg/dL		GGT		5-65 U/L		Lymph		Baso
	Creat		0.6-1.2 mg/dL		Glu		73-118 mg/dL		Atyp Ly		Imm
	Hct		35.0-60.0%		K		3.3-4.7 mmol/L		RBC Morph:		
	Hgb		12.0-18.0 g/dL		TProtein		6.4-8.1 g/dL				
					Na		128-145 mmol/L		Plt verify:		
	Urinalysis								Spun Crit		35-60%
	Color		Straw/Yellow		Microbiology				Malaria Smear		
	Clarity		Clear		Source:				Thin		No Plasmodium Seen
	Glucose		Negative		FecLeuk		Negative				
	Bilirubin		Negative		Gram St				Thick		No Plasmodium Seen
	Ketone		Negative		WetPrep		Negative				
	SG		1.010-1.025		KOH		No Fungal Elements		Sed Rate		
	Blood		Negative		OccBld		Negative		Sed Rate		1hr = 0-20 mm
	pH		5.0-8.0		O&P		No Ova/Parasite		Coagulation		
	Protein		Negative-Trace						PT		10-13 seconds
	Urobili		Negative						APTT		22.1-33.7 seconds
	Nitrite		Negative		Blood Bank				FDP		Negative
	Leuko		Negative		ABO/Rh						
	Urine Microscopic				T&C				Misc. Chemistry		
	WBC		Epi		T&S				Mono		Negative
	RBC		Mucus						RPR		Negative
	Bacteria		Yeast		HCG				HIV		Negative
	Casts:				Urine		Negative		Meningitis		Negative
	Crystals:				Serum		Negative				
	Other:										
	Other:										

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, M	UNIT	RANK	SSN
(b)(6)-4			-

(b)(6)-2	Ward: ICU 1	STAT / Routine	Date and Time: 14 Sep / 0515	Reported by: (b)(6)-2	Date and Time: 14Sep13 0539

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	3.5	3.3-4.7 mmol/L
	Cl	105	98-108 mmol/L
	pH	7.373	7.35-7.45
	PCO2	45.2	35-45 mmHg
	PO2	170	80-90 mmHg
	TCO2	28	18-33 mmol/L
	HCO3	26	22-28 mmol/L
	sO2	100	95-99%
	BEecf	1	(-2) - (+3)
	AGap	11	8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	16	7-22 mg/dL
	Glu	124	73-118 mg/dL
	Creat	1.0	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	7.4	4.8-10.8 x10(3)/uL
	RBC	2.38	4.2-6.1 x10(6)/uL
	Hgb	7.8	12.0-18.0 g/dL
	Hct	22.5	35.0-60.0%
	MCV	94.5	80.0-99.0 fl
	MCH	32.8	27.0-31.0 pg
	MCHC	34.8	33.0-37.0 g/dL
	Plt	164	130-400 x10(3)/uL
	LY%	12.2	15.0-55.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: ABG, PA-Tube T- [illegible] 40%

FiO2 40% Temp 100.1

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	DOB	RANK	SSN
(b)(6)-4				

Physici (b)(6)-2	Ward: ICU1	STAT / Routine	Specimen Date and Time: 14 Sep03 2302	Reported by: (b)(6)-	Date and Time: 14Sep03 2317

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	136	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl	101	98-108 mmol/L
	pH	7.407	7.35-7.45
	PCO2	49.9	35-45 mmHg
	PO2	222	80-90 mmHg
	TCO2	33	18-33 mmol/L
	HCO3	31	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN	9	7-22 mg/dL
	Glu	112	73-118 mg/dL
	Creat	1.1	0.6-1.2 mg/dL
	Hct	21	35.0-60.0%
	Hgb	7	12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		Spermatozoa
Crystals:		Amorph Sed
Other:		
Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
		legative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4				-

Physician:	Ward:	X	STAT	Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 1		Routine	15 Sep 03	(b)(6)-2	15 Sep 0845

Chemistry (I-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	135	128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.327	7.35-7.45
	PCO2	60.7	35-45 mmHg
	PO2	97	80-90 mmHg
	TCO2	33	18-33 mmol/L
	HCO3	31	22-28 mmol/L
	sO2	96	95-99%
	BEecf	6	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative
	Urine Microscopic		
	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	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
	BUN	9	7-22 mg/dL
	Ca	7.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	98	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat	1.0	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	112	73-118 mg/dL
	K	4.1	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	6.8	4.8-10.8 x10(3)/uL
	RBC	2.34	4.2-6.1 x10(6)/uL
	Hgb	7.6	12.0-18.0 g/dL
	Hct	22.2	35.0-60.0%
	MCV	95.0	80.0-99.0 fl
	MCH	32.4	27.0-31.0 pg
	MCHC	34.1	33.0-37.0 g/dL
	Plt	207	130-400 x10(3)/uL
	LY%	14.6	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs			Mono
Bands			Eos
Lymph			Baso
Atyp Ly			Immature cells
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4		[redacted]		-

Physician:	Ward:		STAT	Specimen Date and Time:	Date and Time:
(b)(6)-2	ICU		Routine	16SEP03 0582 0530	16SEP03

(b)(6)-2

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	6+ 7+ 8+ Glu Crea		
	Na	134	128-145 mmol/L
	K	4.1	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.419	7.35-7.45
	PCO2	53.2	35-45 mmHg
	PO2	141	80-90 mmHg
	TCO2	35	18-33 mmol/L
	HCO3	34	22-28 mmol/L
	sO2	99	95-99%
	BEecf	10	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.08	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative
	Urine Microscopic		
	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	Chem 12 MetLyte8 BMP Liver		
	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
	BUN	9	7-22 mg/dL
	Ca	7.9	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	97	98-108 mmol/L
	TCO2	26	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	125	73-118 mg/dL
	K	4.5	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	128	128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	CBC Malaria H/H		
	WBC	8.8	4.8-10.8 x10(3)/uL
	RBC	2.36 *	4.2-6.1 x10(6)/uL
	Hgb	7.8 *	12.0-18.0 g/dL
	Hct	22.4 *	35.0-60.0%
	MCV	94.7	80.0-99.0 fl
	MCH	33.0 *	27.0-31.0 pg
	MCHC	34.9	33.0-37.0 g/dL
	Plt	272	130-400 x10(3)/uL
	LY%	11.7 *	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL
	Differential		
	Segs		Mono
	Bands		Eos
	Lymph		Baso
	Atyp Ly		Immature cells
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium See
	Thick		No Plasmodium See

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

QNS Request repeat Draw.

21st COMBAT SUPPORT HOSPITAL

[redacted] (b)(6)(2) BORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	DOB	RANK	SSN
(b)(6)-4	ICU #1			-

Physician:	Ward:		Specimen Date and Time:	Re	Date and Time:
(b)(6)-2		STAT / Routine		(b)(6)-2	1635 Hr 1664

Chemistry (I-STAT)				Chemistry (Piccolo Analyzer)				Hematology			
6+ 7+ 8+ Glu Crea				Chem 12 MetLyte8 BMP Liver				CBC Malaria H/H			
X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L		ALB		3.3-5.5 g/dL		WBC		4.8-10.8 x10(3)/uL
	K		3.3-4.7 mmol/L		ALP		26-84 U/L		RBC		4.2-6.1 x10(6)/uL
	Cl		98-108 mmol/L		ALT		10-47 U/L		Hgb		12.0-18.0 g/dL
	pH	7.440	7.35-7.45		AMY		14-97 U/L		Hct		35.0-60.0%
	PCO2	46.2	35-45 mmHg		AST		11-38 U/L		MCV		80.0-99.0 fl
	PO2	72	80-90 mmHg		Tbil		0.2-1.6 mg/dL		MCH		27.0-31.0 pg
	TCO2	32	18-33 mmol/L		BUN		7-22 mg/dL		MCHC		33.0-37.0 g/dL
	HCO3	31	22-28 mmol/L		Ca		8.0-10.3 mg/dL		Plt		130-400 x10(3)/uL
	sO2	93	95-99%		Chol		100-200 mg/dL		LY%		15.0-55.0%
	BEecf	7	(-2) - (+3)		CK		30-170 U/L		LY#		0.7-4.3 x10(3)/uL
	AGap		8-16 mmol/L		CL		98-108 mmol/L		Differential		
	iCa		0.11-1.23 mmol/L		TCO2		18-33 mmol/L		Segs		Mono
	BUN		7-22 mg/dL		Creat		0.6-1.2 mg/dL		Bands		Eos
	Glu		73-118 mg/dL		GGT		5-65 U/L		Lymph		Baso
	Creat		0.6-1.2 mg/dL		Glu		73-118 mg/dL		Atyp Ly		Immature cells
	Hct		35.0-60.0%		K		3.3-4.7 mmol/L		RBC Morph:		
	Hgb		12.0-18.0 g/dL		TProtein		6.4-8.1 g/dL				
	Lactate		0.90-1.70 mmol/L		Na		128-145 mmol/L		Plt verify:		
	Urinalysis				Misc. Chemistry				Spun Crit		35-60%
	Color		Straw/Yellow		Mono		Negative		Malaria Smear		
	Clarity		Clear		RPR		Negative		Thin		No Plasmodium See
	Glucose		Negative		HIV		Negative				
	Bilirubin		Negative		Meningitis		Negative		Thick		No Plasmodium See
	Ketone		Negative		DOA		Negative				
	SG		1.010-1.025		CK-MB		< 4.3 ng/mL		Sed Rate		
	Blood		Negative		Troponin I		< 0.19 ng/mL		Sed Rate		1hr = 0-20 mm
	pH		5.0-8.0		Myoglobin		< 107 ng/mL		Coagulation		
	Protein		Negative-Trace		Microbiology				PT		10-13 seconds
	Urobili		Negative		Source:				APTT		22.1-33.7 seconds
	Nitrite		Negative		FecLeuk		Negative		FDP		Negative
	Leuko		Negative		Gram Stain				D-Dimer		Negative
	Urine Microscopic				WetPrep		Negative		Fibrinogen		200-400 mg/dL
	WBC		Epi		KOH		No Fungal Elements				
	RBC		Mucus		OccBld		Negative		Blood Bank		
	Bacteria		Yeast		O&P		No Ova/Parasite		ABO/Rh		
	Casts:		Spermatozoa		HCG				T&C		
	Crystals:		Amorph Sed		Urine		Negative		T&S		
	Other:				Serum		Negative				
	Other:										

4.01

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	DOB	RANK	SSN
(b)(6)-4				

Physician:	Ward:	X STAT / Routine	Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU#1	X STAT	17SEP03 0520	(b)(6)-2	17SEP03 0558

Chemistry (i-STAT)

6+ (7+) 8+ Glu (Crea)

X	TEST	RESULT	REF. RANGE
	Na	134	128-145 mmol/L
	K	4.1	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.419	7.35-7.45
	PCO2	50.9	35-45 mmHg
	PO2	191	80-90 mmHg
	TCO2	34	18-33 mmol/L
	HCO3	32	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	8	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.11	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat	1.2	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		Spermatozoa
Crystals:		Amorph Sed
Other:		

Other:

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	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
	BUN	13	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	97	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	118	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	13.0	4.8-10.8 x10(3)/uL
	RBC	2.38	4.2-6.1 x10(6)/uL
	Hgb	7.7	12.0-18.0 g/dL
	Hct	22.8	35.0-60.0%
	MCV	95.5	80.0-99.0 fl
	MCH	32.2	27.0-31.0 pg
	MCHC	33.7	33.0-37.0 g/dL
	Plt	266	130-400 x10(3)/uL
	LY%	21.3	15.0-55.0%
	LY#	2.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

03 001926 Q

PRBC's 2456472 -#3 -#1 4825749 -#4

1262955 -#2

MEDICAL RECORD - ANESTHESIA

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

DRUG (Units)													
Propofol (mg)		80											
Ketamine (mg)		100											
Fentanyl (µg)													
Succ / Ilec (mg)		100	5		5						25	25	50
Phenylephrine (µg)			100	100	100					5			
Ephedrine (mg)			10						100 100 100				5
VOLAT AGENT	% del												
	Iso % e.t.	1.5	1.0	.8	1.2	.6	.6	.6	.20	.6	.4	1.0	1.6
AIR	L/Min												
N2O	L/Min			.6	.6								
O2	L/Min	8	1	.6	.6	1	1	1	1	1	1	1	1

CONTINUOUS/REPEATED SPECIFY UNITS - MG/MCG "T" = CONSTANT INFUSION

ANESTHETIC

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: 1 2 3 4 6 5

FLUIDS

LINE site LR 14g ☐ Warmed	#4												
Hetastarch 6% ☐ Warmed		#1			400								
PRBC ☐ Warmed				500cc		#2		(1000)					
LR 3L 16 ☐ Warmed	#1/Unit		#2 Unit										
	#5												

LOSSES: EST BLOOD LOSS / URINE

EST BLOOD LOSS		100			600								
URINE				100/250		250/500							
			(red urine)	400									

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 10/32

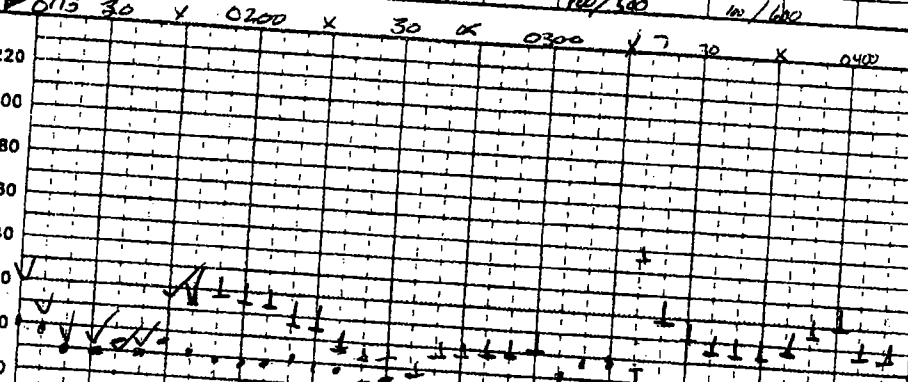
INITIAL DATA: BP 145/85 HR 92

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? Y/N TIME 0045

TIME → 0115 30 X 0200 X 30 X 0300 X 30 X 0400

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



VT - ml		710	720	680	690	690	690	690	690	690	710	690	670
f - breaths/min		10	10	8	8	8	8	8	8	8	8	10	10
Peak Inf pres / PEEP		7	26	24	23	24	26	25	24	25	25	24	24
MODE - S(pon), A(assist), C(on)		S	C	C	C	C	C	C	C	C	C	C	C
BP/Auto Cuff	ET CO2 (torr)		39	36	30	29	30	28	29	28	29	26	27
BP/oth	FIO2 (Frac or %)	1.0	1.0	.57	.59	.60	.6	.80	.80	.80	.80	.80	.80
ART line	SpO2 (%)	100		100	100	100	100	100	100	100	100	100	100
Stath- PC/ES	ECG	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR
Gas analyzer	TEMP-site	—	—	—	—	—	—	—	—	—	—	—	—
	N-M Block (T/4)		4/4	0/4	2/4	0/4	0/4	0/4	0/4	2/4	0/4	0/4	0/4
Pressure points checked and padded		✓											
Warming blkt	Warm sheets applied	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Conv warmer	Room warmed												

with letters & symbols, under REMARKS

EVENTS / Position → 0 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

TOTALS	TOTAL EBL
80mg	850
100mg	
100mg	TOTAL URINE
100/20mg	
600mg	600
10mg	

FLUIDS - SUMMARY

CRYSTALLOID: 4,000

COLLOID: 1,000

BLOOD: 4 Units PRBC's

REMARKS

Code drugs with numbers, events with letters

① Pt identified, chart reviewed, all pt questions answered via interpreter.
② Pt to OR, ASA monitors applied. Pt induced & intubated w difficulty
③ Pt tolerated procedure & extubated well
④ Urecyn 3gm IV infused.
⑤ ALINE STARTED @ 0150
⑥ Entry out of sequence: NGT placed, moderate amount of yellowish drainage returned by suction.
⑦ CBC sent - results on way
⑧ H/H 8.9/25.5 Two units PRBC's sent for
⑨ Surgeon stated bleeding is under control at present.
⑩ 2nd two units PRBC's infusing.
⑪ PT/PTT sent - results on way

RECOVERY AT

PACU (CU) ____ (Specify)

OTHER ____

CONDITION:

RESP. SpO2.

BP. HR.

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0030	0105	0145
	Ready	Begin	End
PROC	0110	0125	0500

EDURES and CPT Codes:

Ex - lap

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA - RSI & CP - eyes taped prior to DL

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DLx1 (Miller2) grade 1 view ETT 8.0 placed, @ 6cm, secured @ 22cm @ teeth

(b)(6)-4

MEDCOM - 2059

PROCEDURE

0409 PT-16.0 INR-1.77

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
X-lap	19	70Kg	-

PHYSICAL STATUS: 1 2 3 4 5 6 7

MPT, teeth bloody, intact, NGK-FLOW

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	-

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Ø	BP ..... PULSE ..... ECG (IF PERTINENT) Pt T:S in ER PT T:C for 2 Units	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) Ø	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
None	

PREOPERATIVE DIAGNOSIS	PREMEDICATION
Unable to move bilateral LE GSW to @ flank	Ø

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 CPT, CRNA	11 Sept 03

V/S - 90 RR-20 145/85

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

O2 sat 100% on NRB

*U.S. Government Printing Office: 1994 — 300-892/10029

(b)(6)-4 EPW

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)
	( )
	( )
	( )
	( )
	( )
	( )
VOLAT AGENT	% del
Iso	% e.t. .6 X
AIR	L/Min
N2O	L/Min
O2	L/Min 1

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (12) (12) (13)

FLUIDS

LINE site		
	☐ Warmed	
	☐ Warmed	
LR	☐ Warmed	#9
LR	☐ Warmed	#8

LOSSES

EST BLOOD LOSS	
URINE -	600

PHYS STATUS 1 2 3 4 5 6

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- see page #1 / HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME 0415 30 X 0600 X 30 X 0600 X 30 X 0700

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

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

VENTIL

VT - ml	640	640
f - breaths/min	8	8
Peak Inf pres / PEEP	26	26
MODE - S(pon), A(assist), C(on)	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	26	26
BP/oth	FIO2 (Frac or %)	.83	.83
ART line	SpO2 (%)	100	100
Steth- PC/ES	ECG	NSR	NSR
Gas analyzer	TEMP-site	—	—
	N-M Block (T/4)	0/4	0/4
Pressure Points checked and padded		✓	✓
Warming blkt		—	—
Conv warmer		—	—

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

TOTALS	TOTAL EBL
	—
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID- see page #1

BLOOD-

REMARKS

Code drugs with numbers, events with letters

(12) Pt transported to ICU via Ambu ventilated FiO2. Report given CPT (b)(6)-2 V/S stable

(13) Vent setting - 12, 700, Peep 5, FiO2 .8

RECOVERY AT 0455

PACU ICU ____ (Specify)

OTHER

CONDITION: stable

RESP. 12 SpO2. 100

BP. 132/86 HR. 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

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

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

See page #1

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

SURGEONS:

(b)(6)-2 (b)(6)-2

PROCEDURE LOCATION:

DATE:

13/75
ASA 2
NKDA

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)																		
Versed (mg)	2mg	From	Tor	10														
Fentanyl (mcg)	25	125	100	100	50													
Ver (mg)	5				5													
MSO4 (mg)		3	2	3	2													
Ephedrine (mg)			5	5	5	5	5	5										
( )																		
VOLAT AGENT 1.50 % del / % e.t.	/	1.2	1.0	1.0	1.0	1.0	1.0	1.0										
AIR L/Min																		
N2O L/Min																		
O2 L/Min	10	2	2	2	2	2	2	2										

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

FLUIDS

LINE site																	
(L) ☐ Warmed		200	300	400	500	600	700										
(R) ☐ Warmed		100	250	400	500	600	700										
☐ Warmed																	
☐ Warmed																	

LOSSES

EST BLOOD LOSS																	
URINE					75					100							

TOTALS	TOTAL EBL
2/0	NIL
500/0	TOTAL URINE
10/0	100

FLUIDS - SUMMARY

CRYSTALLOID LR 1400
COLLOID Ø
BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) To OR intubated BNRAL Zaw
(2) A ZANTAC 50mg IVPB
(3) ABD closure
(4) To ICU VSS. Report given

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 75 ~~25~~ KG LB

HEMATOCRIT: 35

INITIAL DATA: BP- 118/56 HR- 120

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1430

TIME 1200 X 30 X 1400 X 30 X 1500 X 30 X

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL.

VT - ml	690	690	740	690	670	680	670	650
f - breaths/min	10	8	8	8	8	8	7	8
Peak inf pres / PEEP	26	28	24	23	23	25	26	25
MODE - S(pon), A(assist), C(on)	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	30	30	29	31	30	30	31	31
BP/oth	FIO2 (Frac or %)	.89	.89	.89	.88	.88	.89	.88	.89
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	SR	ST	ST	SR
Gas analyzer	TEMP-site	AXILLARY							
	N-M Block (T/4)	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position (1) (2) (3) (4)

RECOVERY AT 1515

PACU (ICU) (Specify)
OTHER T= 95.2
CONDITION: STABLE
RESP. 12 SpO2: 100
BP- 132/70 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1300	1300	1520
PROC	Ready 1305	Begin 1310	End 1505

PROCEDURES and CPT Codes: ABD WASHOUT & CLOSURE, G-TUBE placed, APPY, J-TUBE PLACED cystoscopy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks From ICU INTUBATED BSE (B) ETCO2 X4 Tube secure Eyes TAPED

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

(b)(6)-4

(b)(6)-4

HEAQI

SURGEONS:

PROCEDURE LOCATION:

DATE: 1-10-05

See P Hx

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
ABD WASHOUT & Closure		75	

PHYSICAL STATUS

1 2 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS
	Dyne [illegible] @ 1800 ZANTAC @ 1400

PREOPERATIVE DIAGNOSIS	PREMEDICATION

(b)(6)-2

[illegible] DATE 13 Sep

POSTAN

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

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)* _____

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

DATE REQUESTED 9/10/03

DATE AND HOUR REQUIRED 2358 9/10/03

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE ABD 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.

VOLUME REQUESTED *(If applicable)* 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 9/11/03

TIME VERIFIED 0046

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: comp

PREVIOUS RECORD CHECK:
- [ ] RECORD [redacted] [x] NO RECORD (b)(6)

SIGNATURE (b)(6)-2

DONOR
ABO O
Rh POS

RECIPIENT
ABO B
Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPO[redacted]T REC (b)(6)-2 DATE 11 Sept 2003

REMARKS: Due to the critical condition of below named patient, the requesting physician named above request the immediate release of this product for the transfusion without complete testing and is accepting full responsibility for the administration of the transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

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)*

2nd VERIFIER *(Signature)* (b)(6)-2

PRE-TRANSFUSION

TEMP. PULSE 106 BP 93/60

DATE OF TRANSFUSION 9/11/03

TIME STARTED 0120

POST-TRANSFUSION DATA

AMOUNT GIVEN 367 ML

TIME/DATE COMPLETED/INTERRUPTED 9/11/03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE

PULSE 105

BLOOD PRESSURE 91/51

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 NOTING ABOVE (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; (b)(6)-4 edical facility)

SEX M

WARD EMT

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 - 2064

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

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

- [X] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 9/10/03

DATE AND HOUR REQUIRED: 2358 9/10/03

REQUESTING PHYSICIAN *(Print)*: Maj (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: ABD 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.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 9/10/03

TIME VERIFIED: 0046

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: Comp

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

(b)(6)-2

DONOR: ABO O; Rh POS

RECIPIENT: ABO B; Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE

REMARKS: due to the critical condition of below named patient, the requesting physician named above request the immediate release of the product for the transfusion without complete testing and is accepting full responsibility for the administration of the transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

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)*: (b)(6)-2 CIT, CLNA

2nd VERIFIER *(Signature)*: (b)(6)-2 CRNA

PRE-TRANSFUSION

TEMP. 98 PULSE 104 BP 72/52

DATE OF TRANSFUSION: 9/10/03

TIME STARTED: 0030

POST-TRANSFUSION DATA

AMOUNT GIVEN: 200 ML

TIME/DATE COMPLETED/INTERRUPTED: 0140 9/11/03

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 98 PULSE: 105 BLOOD PRESSURE: 93/56

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: (b)(6)-2 CRNA

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

SEX: M

WARD: EMT

Name/Rank
FMP/SS #
DOB
unit

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 - 2065

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

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

DATE REQUESTED 9/11/03

DATE AND HOUR REQUIRED 0300

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW FLANK

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 9/10/03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: Comp

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

(b)(6)-2

DONOR
ABO O
Rh POS

RECIPIENT
ABO AB
Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT (b)(6)-2 10 Sept 03

REMARKS: Due to the critical condition of the below-named patient, the requesting physician named above requests the immediate release of this blood product for transfusion without complete testing and is accepting full responsibility for the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 0300 ON *(Date)* 11 Sept 2003

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient 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)* (b)(6)-2 CPT, CLNC

2nd VERIFIER *(Signature)* (b)(6)-2 SPC

PRE-TRANSFUSION
TEMP. 98 PULSE 77 BP 104/69

DATE OF TRANSFUSION 9/11/03 TIME STARTED 0330

POST-TRANSFUSION DATA

AMOUNT GIVEN 459 ML

TIME/DATE COMPLETED/INTERRUPTED 9/11/03 0345

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98	76	107/87

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 (b)(6)-2 SPC

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

Name/Rank (b)(6)-4

FMSSN

DOB

Unit

SEX MALE WARD O.R.

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 - 2066

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 9/11/03

DATE AND HOUR REQUIRED 0300

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

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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

SIGNATURE OF VERIFIER (b)(6)-2

DATE VERIFIED 9/10/03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
not performed	compatible

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD [redacted] (b)(6)(2)

(b)(6)-2 [redacted]

DONOR

ABO O

Rh POS

RECIPIENT

ABO B

Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUES[redacted] DATE 11 Sept 03

REMARKS: Due to the critical condition of the below named patient the requesting physician named above requests the immediate release of this blood product without complete testing and is taking full responsibility for the transfusion with administration of this transf

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2 A

AT *(Hour)* 0320 ON *(Date)* 11 Sept 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)* (b)(6)-2 CPT/CNA

2 ature) (b)(6)-2 CPT/CNA

PRE-TRANSFUSION

TEMP. _____ PULSE 76 BP 107/86

DATE OF TRANSFUSION 9/11/03

TIME STARTED 0345

POST-TRANSFUSION DATA

AMOUNT GIVEN 270 ML

TIME/DATE ~~COMPLETED~~/INTERRUPTED 0400

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE

PULSE 79

BLOOD PRESSURE 161/58

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 (b)(6)-2 CPT/CNA

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

MALE

WARD OR

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 2067

Medical Record Copy

NSN 7540-01-185-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
PORTABLE CXR				ICU #1	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)* Dr (b)(6)-2				TELEPHONE/PAGE NO. (b)(3)-1
	(b)(6)-2		F REQUESTOR 1LT, AN		DATE REQUESTED 9/16/03

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

INTUBATED
FEBRILE ↑ 104
J-TUBE
G-TUBE
LUMBAR SPINE FX

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

RADIOLOGIC REPORT

- ET tip 3cm above carina
- mottern ashfrd but no evidence of pneumonia
  RLL streaky atelectasis

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2068

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11 Sep 03	0430 HOURS	
1 Admit to ICU		
2 Dx - GSW ABD w/ Ex lap / Duodenal Repair / IVC repair, Lumbar spine Fx		
3 Condition - stable		
4 vitals Q1°		
5 Activity - bedrest		
6 Allergies - NKDA		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
7 IVF LR at 150 cc/hr	HOURS	
8 Diet - NPO		
9 Foley to gravity		
10 NGT to suction ~~(Esp)~~ - low intermittent suction		
11 I&O		
12 Lab - CBC, PA-> ABG on arrival		

NURSING UNIT | (b)(6)-2 | BED NO.

11 Sep 03

PATIENT IDENTIFICATION 0445

DATE OF ORDER	TIME OF ORDER	
13 Vent settings - SIMV [redacted]	HOURS	(b)(6)(2)
R = 12 TV = 700 [redacted]		(b)(6)(2)
FiO2 - 100% PEEP = [redacted]		
14 Meds		
versed 1-2mg IV q 15 minutes PRN agitation		
Vecuronium 1-4mg IV Q1° for train of 4		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
MSO4 1-2mg IV Q15 min PRN pain	HOURS	
Unasyn 3.0gm IV Q6°		
Zantac 50mg IV Q8°		
15 Call MD for UOP < 30cc/hr		
16 Bed Flat - strict log roll only		

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

MAJ MC

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 11 Sep 03 TIME OF ORDER: 0630 HOURS

Δ versed prn to versed gtt 1-4 mg/hr

V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

LIST TIME ORDER NOTED AND SIGN: Noted (b)(6)-2 0930 11 Sep 03

PATIENT IDENTIFICATION

DATE OF ORDER: 11 Sep 03 TIME OF ORDER: 0920 HOURS

1) Bolus 2 mg Vec IV now. Recheck Train of Four (TOF) in 5 min. Give additional 1 mg Bolus Vec IV until barely 1/4 twitches

(b)(6)-2 CRNA

NURSING UNIT | ROOM NO. | BED NO.

LIST TIME ORDER NOTED AND SIGN: (b)(6)-2 Noted 1000 11 Sept 03

PATIENT IDENTIFICATION

DATE OF ORDER: 11 Sept 03 TIME OF ORDER: 0945 HOURS

1) CAC, ABG, PA-2 at 1300 hrs

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

LIST TIME ORDER NOTED AND SIGN: (b)(6)-2 Noted 1500 11 Sep 03

PATIENT IDENTIFICATION

DATE OF ORDER: 11 Sep 03 TIME OF ORDER: 1420 HOURS

Vecuronium bolus 2 mg now - then ↑ gtt to 6-8 mg/hr

V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2

24° Chart dr (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

LIST TIME ORDER NOTED AND SIGN: (b)(6)-2 2220 11 Sep 03

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

(5)(6)2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sep. 03 TIME OF ORDER: 1441 HOURS

(1) D/c Morphine

(2) Fentanyl ~~gtt~~ gtt @ 50 mcg/hr.

X10

(b)(6)-2 ND

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN: Noted 1560 1545

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sep 03 TIME OF ORDER: 1530 HOURS

(1) 10 mg Ephedrine IVP now

(2) LR Bolus 400 cc now

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

(b)(6)-2

(b)(6)-2 LT [redacted] MD 12 Sep 03 1200

(b)(6)-2 FAMILY PRACTICE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sept 03 TIME OF ORDER: 1811 HOURS

(1) ABG, CBC, PA-7 in AM

(b)(6)-2

(b)(6)-2

Noted 11 Sep 03 0612

(b)(6)-2

24° Chest tube

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 Sep 03 TIME OF ORDER: 0145 HOURS

10 mg Ephedrine IVP Now

LR Bolus 400 cc Now

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

(b)(6)-2

(b)(6)-2

MD 12 Sep 03 1200

Noted

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH ' 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

DATE OF ORDER 12 Sept 03 TIME OF ORDER 0815 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) FER to 40 %

(b)(6)-2

Noted 9/12/03 0830 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAJ MC

PATIENT IDENTIFICATION

DATE OF ORDER 12 Sept 03 TIME OF ORDER 0925 HOURS

(1) CAC, ABG, PA-7 in AM

(b)(6)-2

Noted 9/12/03 1000 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAJ MC

PATIENT IDENTIFICATION

DATE OF ORDER 9/12/03 TIME OF ORDER 1405 HOURS

~~Lacrilube~~ ARTIFICIAL TEARS ii drops OU QID V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2

Noted 9/12/03 1435 (b)(6)-2

MAJ MC

12 Sep 03

FAMILY PRACTICE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 Sept 03 TIME OF ORDER 1514 HOURS

(1) Aspirin 325 mg Supp PR QD - 1st dose now

(2) Heparin 5000 u SQ BID 1st dose now

Noted 12 SEP 03 1515 (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° Chart Check 2330, 12 Sep 03 MAJ MC

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 13 Sept 03 TIME OF ORDER: 1475 HOURS

LIST TIME ORDER NOTED AND SIGN

1. To ICU-1
2. Dx - S/p Re-exploration / w/ colon / G-tube / J-tube / JP drain / Abd closure
3. Condition - stable
4. Vitals Q 1°
5. Activity - bed rest - log roll only

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

6. Allergies - NKDA
7. IVF D5½NS c 20meq KCl at 125cc/h
8. Diet - NPO
9. Foley to gravity
10. I & O
11. J-tube to gravity drain
12. G-tube to gravity drain
13. JP to suis suction
14. Lab - CBC ABG, PA-> in AM
15. Vent Setting SIMV RR=12 TV=700 PEEP=5 FIO2=40%
16. Meds
Versed 6mg/hr drip
Fentanyl 25mg/hr drip 50cc/hr
Artificial tears (Tears) 2 drops QID OU
Aspirin 325mg supp PR QD
Heparin 5000u SQ BID
Impo 1-3mg IV Q15min PRN
Vancyn 3.0gm IV Q6°
Zantac 50mg IV Q8°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

13 Sep 03 | 1655 | USMC

(b)(6)-2

Note 13 Sep 1600

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

MAJ MC

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				13 Sep 03	0615 HOURS	(b)(6)-2
			1	Versed 1-2 mg 915		
				VO: MAJ (b)(6)-2	(b)(6)-2	13 Sep 03 0615
NURSING UNIT	ROOM NO.	BED NO.				

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

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

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 14 Sep — TIME OF ORDER: 0300 HOURS — LIST TIME ORDER NOTED AND SIGN

Tylenol 650 mg PR now
U.O. MAT (b)(6)-2 Cpt Dr (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2

NURSING UNIT: Chart ✓ — ROOM NO.: 9/14/03 0815

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 14 Sept 03 — TIME OF ORDER: 0911 HOURS

(1) bolus 20 mg ET X 1 now
(2) ↓ R-te to 10 now
+ slowly wean to rate of 6-0.11 HO if HR > 30
(3) ABG 1 hr after rate of 6 is reached (b)(6)-2

NURSING UNIT: — ROOM NO.: — BED NO.:

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: — TIME OF ORDER: — HOURS

(4) when Fentanyl to off
(5) ↓ versed (b)(6)-2

NURSING UNIT: — ROOM NO.: — BED NO.:

PATIENT IDENTIFICATION:

DATE OF ORDER: — TIME OF ORDER: — HOURS

NURSING UNIT: — ROOM NO.: 14 Sep 03 0130 — BED NO.: (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 14 Sep 03 TIME OF ORDER: 1514 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Keep vent rate at 12
2. Portable CXR
3. Versed gtt @ 2mg/hr

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 14 Sep 03 TIME OF ORDER: 1625 HOURS

1. Suction ETT / pulmonary toilet q 2°
2. Tylenol 650 mg supp PR now
3. CBC, DA-7, ABG - AM.

V.O. Dr (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 15 Sep 03 0130 (b)(6)-2 UTAN

PATIENT IDENTIFICATION

DATE OF ORDER: 14 Sep 03 TIME OF ORDER: 2230 HOURS

1. ABG now and Pa-7
2. Fentanyl 100mcg bolus now then run gtt @ 100mcg/hr.
3. Repeat Fentanyl bolus of 100mcg in 30 minutes if pt remains agitated

V.O.Dr (b)(6)-2 (b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 15 Sep 03 TIME OF ORDER: 0350

1. Tylenol 650mg PR x1 now

V.O.Dr (b)(6)-2 (b)(6)-2 UTAN MD

(b)(6)-2

NURSING UNIT | ROOM NO. | BED

√ 9/16/03 0930 (b)(6)-2 ICU/A

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

DATE OF ORDER 15 Sept 03 TIME OF ORDER 1020 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Vivonex TF 20 cc/hr through J-tube
2. Flush J-tube q 30 cc water q shift
3. Mix 20 g Δ X 1 now slowly upon rate to goal of 6 over next 4 hrs

noted in error 9/16/03 1645

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 Sept 03 TIME OF ORDER 2001 HOURS

1. RR to 12
2. CBC, ABG, PA-7 in AM

(b)(6)-2 15 Sep 03 2000

(b)(6)-2

NURSING UNIT Chart | ROOM NO. 9/16/03 | BED NO. 0930

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 16 Sept 03 TIME OF ORDER 0910 HOURS

1. RR to 10
2. CBC, ABG, PA-7 in AM
3. Switch J-tube to NS q 2 hrs
4. KCl at 75 cc/hr

noted in error 9/16/03 0930

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
16 Sept 03	1020 HOURS	
1) D/C Vancyn		
2) Levaquin 500mg		
IV QD - PT dose		
now		
(b)(6)-2		

NURSING UNIT | ROOM NO. (b)(6)-2

noted 9/16/03 1105

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
16 Sept 03	1231 HOURS	
1) Tylenol 650mg supp		
PR X1 now		
2) ↓ r.r. to 8		
(b)(6)-2		

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

noted 9/16/03 1230

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
16 Sept 03	1505 HOURS	
1) ↓ r.r. to 6		
2) ABG 1 hour after		
rate of 6		
(b)(6)-2		

NURSING UNIT | ROOM NO. | BED NO.

Noted 1505 16 SEP 03 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
16 SEP 03	1700 HOURS	
1) ↑ rate to 12		
VO Dr (b)(6)-2	(b)(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

Noted 16 SEP 03 1722 (b)(6)-2

chart 17 SEP 03 (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
				17 Sept 03	0920 HOURS	
			(1)	Versed 5 mg IV at		
				1000 cc		
			(2)	Fentanyl 50 mg IV at		
				1000 cc		
			(3)	Ulc drips		
NURSING UNIT	ROOM NO.	BED NO.				

(b)(6)-2

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

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

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

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

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
11Sep 03	(b)(6)-2	Admit to ICU #1		(b)(6)-2
		Dx: GS- ASA 3/p EX LAP, DUODENAL REPAIR/IVC REPAIR LUMBAR FX		(b)(6)-2
11Sep 03		Condition Stable		(b)(6)-2
11Sep 03		CBC, PA-7 ABG ON ARRIVAL	11Sep 0500	0500 (b)(6)-2
11Sept03		Bolus 2mg vec IV NOW	NOW	0820 (b)(6)-2
11Sept03		Begbock Train of four (TOF) in five	5min	0825 (b)(6)-2
11Sept03		CBC, ABG, PA-7 @ 1200hrs	1200 11Sept	(b)(6)-2 1200 11Sept
11Sept		Vecuronium bolus 2mg now	NOW	(b)(6)-2 1425 11Sept
11SEPT		D/C morphine		(b)(6)-2
11SEPT		10mg Ephedrine IVP NOW	NOW	(b)(6)-2
11SEP		LR Bolus 400cc	NOW	(b)(6)-2
11SEP		ABG, CBC, PA-7 IN AM	12SEP03 0500	12Sep03 0445
12Sep		EPHEDRINE 10mg IVP/NOW	9/12 NOW	12Sep03 0145
12Sep		LR Bolus 400cc NOW	9/12 NOW	12Sep03 0145
12Sep		CBC, ABG, PA-7 IN AM	9/13 0500	13Sep03 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: 3/p EXLAP/ LUMBAR FX

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED													
				11	12	13	14	15									
1 Sep	(b)(6)-2	Versed prn to	D														
		versed gtt 1-4 mg/hr	E														
			N														

MEDCOM FORM 690-R (TEST) (WCHO) MAR 99

(b)(6)-4

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 10	11	12	13	14
11 Sep 03	(b)(6)-2	Vent Settings: SIMV	D	/	(b)(6)-2			
		Rate = 12 TV = 700 FiO2 = 100%	E	/				
		PEEP = 5	N	/				
		~~FiO2 @ 60~~ (b)(6)-2						
12 Sep 03	(b)(6)-2	Vent Settings: SIMV	D	/	/	(b)(6)-2		
		Rate - 12 TV = 700 FiO2 = 40%	E	/	/			
		PEEP = 5 PS = 0	N	/	/	(b)(6)-2		

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P EXLAP/ LUMBAR FX

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 10	11	12	13	14	15	16	17	18	19	20	21	22
11Sep07	(b)(6)-2	VS q1°	D	/	(b)(6)-2		(b)(6)-2									
			E	/												
			N	@												
11Sep07	(b)(6)-	ACTIVITY BR	D	/												
			E	/												
			N	@												
11Sep07	(b)(6)-2	IV: LR @ 150 cc/HR	D	/												
			E	/												
			N	@												
11Sep07	(b)(6)-2	DIET: NPO	D	/												
			E	/	(b)(6)-2											
			N	@												
11Sep07	(b)(6)-2	FOLEY TO GRAVITY	D	/												
			E	/												
			N	@												
11Sep07	(b)(6)-2	NGT TO LIS	D	/												
			E	/												
			N	@												
11Sep07	(b)(6)-2	F/O	D	/												
			E	/												
			N	@												
11Sep07	(b)(6)-2	UNASYN 3.0gm iV q6°	06	/												
			12	/												
			18	/												
			24	/												
11Sep07	(b)(6)-2	ZANTAC 50mg iV q8°	10	/												
			14	/												
			22	/												
		See Next Page														

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P EXPLAP - LUMBAR FX / DUODENAL REPAIR.

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER EXPIRATION DATE	TRANSCRIBER REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE											
11sept03	(b)(6)-2	MSO4 1-2 mg IV q 15 min	11 Sep 2mg 0815	11 Sept 2mg 0830	11 Sep 2mg 0915	11 Sep 2mg 0900	11 Sept 2 mg 0918 (b)(6)-2	11 Sep 2mg 1045	1326 11 sept 2mg	1430 11 Sept (b)(6)-2				
		PRN PAIN I/E	(b)(6)-2 I	I	I			I						
11sept03	(b)(6)-2	Versed 1-2mg IV Q15min, prn adjitation	Return Her 11 Sep 03 0630 (b)(6)-2											
11sept	(b)(6)-2	Give additional 1mg bolus sec IV until Barely 1/4 Twitches	1035 1mg (b)(6)-2	1130 1mg	(b)(6)-2 1mg 1322									

CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MED L RECORD - MEDICATION ADMINIST ION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PR COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 10	11	12	13	14	15	16	17	18	19	20	21	22	23
11Sep03	(b)(6)-2	CALL MD for UOP < 30 cc/HR	D	/	(b)(6)-2												
			E	/													
			N	@													
11Sep03		BED FLAT - STRICT LOG ROLL	D	/													
		ONLY	E	/													
			N	@													
11Sep03		VECURONIUM 1-4 mg IV q1°	D	/													
		FOR TRAIN OF 1	E	/													
			N	/													
11Sep03		Versed gtt 1-4 mg/hr	D	/													
			E	/													
			N	/													
11Sep03		Vecuronium gtt to 6-8 mg	D	/													
		hr	E	/													
			N	/													
11SEP03		Fentanyl gtt @ 50 mcg/hr	D	/													
			E	/													
			N	/													
12Sep03		ARTIFICIAL TEARS ou	06	/													
		drops OU QID	12	/													
			18	/													
			24	/													
12SEP03		Aspirin 325 mg suppo	15	/													
		PR - QD 1st dose now															
12SEP03		Heparin 5000 U SQ	18	/													
		BID 1st dose now	29	/													
13Sep03		Versed 1-2 mg q 15"	D	/													
			E	/	/	/	/										
			N	/	/	/	/										

D/C'd @ 1420

MEDCOM FORM 690-R (TEST) (INCHO) MAR 99

(b)(6)-4

Page 2 of 4 pages

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

DATE	TRANSCRIBER/REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 13	14	15	16	17
13SEP03	(b)(6)-2	Vitals Q1°	D	(b)(6)-2		(b)(6)-2		
			E					
			N					
13SEP03	(b)(6)-2	Activity - Bedrest - log roll only	D					
			E					
			N					
13SEP03		IVF - D5½NS + 20meq KCL @ 125 cc/hr	D					
			E					
			N					
13SEP03	(b)(6)-2	Diet - NPO	D					
			E	(b)(6)-2				
			N					
13SEP03		Foley to gravity	D					
			E					
			N					
13SEP03		I & O	D					
			E					
			N					
13SEP03		J-tube to gravity drain	D					
			E					
			N					
13SEP03		G-tube to gravity drain	D					
			E					
			N					
13SEP03		JP to bulb suction	D	(b)(6)-2				
			E					
			N					
13SEP03	(b)(6)-2	Vent setting SIMV R=12, TV=700, Peep=5 FiO2=40%	D					
			E					
			N					
13SEP03		Versed 6mg/hr drip	D					
			E					
			N					
13SEP03		Aspirin (b)(6)-2 5325mg SUPP PR QD	15					

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
13SEP03	(b)(6)-2	To ICU - 1	13SEP03	(b)(6)-2
13SEP03		Condition - stable	13SEP03	
13SEP03		Labs - CBC, ABG, PA-7 in AM	13SEP03	
14sep		~~Tylenol 650 mg PR now~~ see below	14SEP03 AM	(b)(6)-2 0300 (b)(6)-
14sep		Tylenol 650 mg PR now	14 Sep	0300 (b)(6)-2
14Sep03		Lasix 20mg IV x 1 now	14 Sep now	14 Sep 0935
14Sep03		↓ rate to 10 now & slowly wean to rate of 6 - Call Ho if RR > 30	14 Sep	(b)(6)-2 14 Sep 1003 ↓ 8 14 Sep 1102 ↓ 6
14Sep03		ABG of 1 hr after rate of 6 is reached		
14Sep03		Wean Fentanyl to off	9/14/03	9/14/03 0945 (b)(6)
14Sep03		↓ versed	9/14/03	9/14 0919 ↓ 1013 ↓
14Sep03		Pmt CXR	9/14/03	9/14 (b)(6)-2 (b)(6)-2
14Sep03		Keep vent rate @ 12	9/14/03	9/14/03 1450
14Sep03		Tylenol 650 mg supp PR Now	—	14Sep03 1630 (b)(6)-
14Sep03		CBC, PA-7, ABG in AM	15Sep03 @0500	(b)(6)-2 0430
14SEP03	(b)(6)-2	ABG now + PA7	2300 14SEP03	(b)(6)-2
14SEP03		Fentanyl bolus 100 mcg now	2230	(b)(6)-2
14SEP03		Repeat Fentanyl bolus in 30 min 100 mcg/hr NTF if remains agitated	2300	(b)(6)-2 14SEP03
14SEP03		Tylenol 650 mg PR x1 now	0900	15SEP03 (b)(6)-2
15SEP03		Lasix 20mg IV x1 Now	9/15/03	9/15/03
15Sep03		Slowly WEAN RATE TO GOAL of 6 OVER NEXT 4 hrs	(b)(6)-2 9/15 R11	1025 (b)(6)-2 9/15 1030
			R10	9/15 1115
			R9	9/15 1215
			R8	1310
			R7	
			R6	
15Sep	(b)(6)-2	CBC, ABG and PA7 in AM	16Sep03 @0500	(b)(6)-2 0530
16Sep03		↓ RR to 10	9/16/03	10 0945 (b)(6) 10 1015 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

S/P re-exploratory washout / G tube

DIAGNOSIS: J-tube / JP drain / ABD closure

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBED/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 13	14	15	16	17
13Sep03	(b)(6)-2	Fentanyl 50mcg/hr	D	(b)(6)-2				
		drip	E					
			N					
13Sep03		Artificial drops	06					
		(tears) 2 drops QID	12					
		OU	18					
			24					
13Sep03		Heparin 5000 u SQ	12					
		BID	24					
13Sep03		Unasyn 3.0gm IV	06					
		Q6°	12					
			18					
			24					
13Sep03		Zantac 50mg IV Q8°	06					
			14					
			22					
14Sep03		Versed gtt @ 2mg/hr	D					
			E					
			N					
14Sep03		Suction ETT/Pulmonary	D					
		Toilet q 2° (RT)	E					
		odd hours c̄ NS	N					
14Sep03		Fentanyl 100mcg/hr	D					
		gtt	E					
			N					
15Sep03		Vivonex TF 20cc/hr	D					
		through J TUBE	E					
			N					

D/C'd 9/14/03 (b)(6)-2

D/C'd 9/14 (b)(6)-2

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: s/p re-exploratory washout/4 tube
ALLERGIES: NKDA J-tube/JP drain/ABD closure

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE												
13 16	(b)(6)-2	MSO4 1-2mg IV q15 min prn	Date	13 Sep	13 Sep	14 Sep	14 Sep	14 Sep	14 Sep	14 Sep	14 Sep	14 Sep	14 Sep	14 Sep	14 Sep
			Time	2030	2300	0200	0200	0500	1028	1109	1225	1530	1930		2040
			Amt	2mg	2mg	2mg	2mg	2mg	2mg IV	2mg IV	2mg IV	2mg IV	2mg IV	2mg IV	2mg IV
			(b)(6)-2												
			I/E	I	E	I	E	I	E	E	E	E	E		
9/13 9/16	(b)(6)-2	(b)(6)-2 MSO4 1-2mg IV Q 15 min PRN	9/15 0747	9/15 1130	9/15 1320	9/16 1520	9/17 0645								
			2mg IV	2mg IV	2mg IV	2mg IV	2mg IV								
			(b)(6)-2												
			E	E	E	E	E								

CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

MED[illegible] RECORD - MEDICATION ADMINIST[illegible]ON RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PR[illegible] COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 15	16	17	18
15SEP03	(b)(6)-2	FLUSH J-TUBE c̄ 30cc	08	(b)(6)-2			
		WATER Q SHIFT	16				
			24				
16Sep03	(b)(6)-2	D5NS c̄ 20meq KCl @	D				
		75cc/hr p̄ peripheral bag	E				
			N				
16Sep03	(b)(6)-2	LEVAQUIN 500mg IV	11				
		QID					
16Sep03	(b)(6)-2	VENT SETTINGS: SIMV	D				
		TV 700 RR10 FiO2 40%	E				
		PEEP 5	N				
16Sep03	(b)(6)-2	VENT: SIMV TV 700	D				
		RR 8 FiO2 40% PEEP 5	E				
			N				
16Sep03	(b)(6)-2	VENT: SIMV TV 700	D				
		RR12 FiO2 40% PEEP5	E				
			N				

Dc'd 9/16/03 (b)(6)-2

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
9/16	(b)(6)-2	CBC, ABG, PA-7 in AM	9/17 0500	0520 (b)(6)-2
9/16		Tylenol 650mg Supp PR X 1 Now	9/16	9/16 1245 (b)(6)-2
9/16		↓ rate to 8	9/16	9/16 9-1233 8 1310 (b)(6)-2
16SEP		↓ rate to 6	9/16	1505 (b)(6)-2
16SEP		ABG 1hour after rate of 6	9/16	1600 (b)(6)-2
16SEP		↑ rate to 12	16SEP	(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS:

ALLERGIES:

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: S/P exploration Wound Drube Tube Jpdrain and closure

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary

Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: _____ Time DC'D _____

(ETT) Nasal Oral Trach

OXYGEN: 8.0 @ 23 l/p/min

Mask Nasal Face Blow-By

Prongs Tent

Liter/min. _____ %

ASA ___ History _____

Cardiac Rhythm _____

IV#1 _____ (Patent) Infiltrated

Site (DAC) Rate 125 Gauge 16

IV#2 _____ (Patent) Infiltrated

Site (DAC) Rate 125 Gauge 14

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper: Lower: Pulse DP PT RAC
PRE-OP	/												Blanche Warm Pulse Moves Y N
1525	119/63	86	31	100%	95.2								Blanche Warm Pulse Moves Y N
1530	125/67	87	17	100%									Blanche Warm Pulse Moves Y N
1535	126/64	86	18	100%									Blanche Warm Pulse Moves Y N
1540	109/58	85	13	100%									Blanche Warm Pulse Moves Y N
1600	131/66	84	12	100%									Blanche Warm Pulse Moves Y N
1615	119/64	86	14	100%	96.3								Blanche Warm Pulse Moves Y N
1630	125/69	85	12	100%									Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

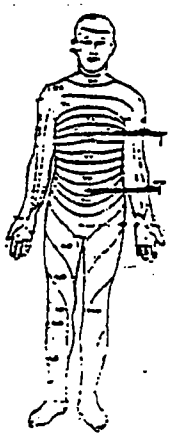
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 ...UTAN

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 13 Sep 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1400	OR	EBL	100
			OR	Urine	75
TOTAL		1400	TOTAL		175

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

See assessment in ICU flowsheet. (b)(6)-2 WRKW

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

Original given to LT Chewoni.

609496

RECEIPT FOR PRISONER OR DETAINED PERSON

RECEIVED FROM (Unit or A[illegible] and Station) 101ST CASC [illegible] MOSUL IRAQ		TIME	DATE 16 SEP 03
LAST NAME — FIRST N[illegible] — MIDDLE INITIAL [redacted]		SERVICE NUMBER/SSN	GRADE
ORGANIZATION (b)(6)(4)		STATION	
OFFENSE AHA[illegible] [illegible]n COALITION FORCES			
PERSONAL PR[illegible] [illegible]e			
REMARKS Gunshot wound to Lower BACK			
NAME AND TITLE OF PERSON RECEIVING ABOVE INDIVIDUAL (Typed or Printed) Kareem Saleem		SERVICE NUMBER/SS[illegible]	GRADE
RECEIVING UNIT OR AGENCY AND STATION Al-Zahrawi Hos[illegible]al		SIGNATURE [redacted]	

DD FORM 1 MAR 58 629 [illegible]N OF 1 MAR 52, IS OBSELETE. (b)(6)(4) U.S[illegible]ment Printing Office: 1992 — 311-830/65132

(b)(6)-4

(b)(6)-2

(b)(3)-1

(b)(6)-4

(b)(6)-4

MEDCOM - 2094

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
A 1 4 A 1	I Z	(b)(6)-4	Iraqi (b)(6)-4	C i V	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
(b)(6)-4		X	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
			(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW Iraqi		2337	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K76 K78	

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
0	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
B CO, 21st Combat Support Hospital, Mosul, Iraq

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
01		20030917

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A6AA		20030910

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
	A14A1	20030910

FOR LOCAL USE

Dx: 86414, 86612, 86331, 8065, 86812, 8708, 5997, 86814, 89912

Px: 8622(x4), 5061, 5581, 4671, 0820, 0881, 5122, 4719, 9904(x4), 4311, 4639, 5732, 5412, 9659, 5794

Trauma 9

Injury

(b)(6)-2

(b)(6)-2

(b)(6)-2 MD

(b)(6)-2

FAMILY PRACTICE

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS V1.00

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Iraq (b)(6)-4

(b)(6)-4

Reg # (b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-2

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 16 Oct 03

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

- GSW to ABDOMEN and Evisceration
- GSW to (L) thigh } E985.3 ICD9FY02
- S/P Exploratory Laparotomy – 54.11 ICD9FY02
- S/P Small bowel resection – 45.51 ICD9FY02
- S/P Large Bowel repair – 45.52
- S/P appendectomy – 47.09 ICD9FY02
- (B) Chest Tubes – 40 Oct 03 } 20 Oct 03
- Hypoxia – (Acute) S/O Acute Pulmonary Embolism – 40 Oct 03 } 780.6 ICD9FY02 – Fever – 40 Oct 03 – Tachycardia – 40 Oct 03
- 799.0 ICD9FY02 38.87 ICD9FY02 – Anticoagulation

☐ CHECK IF CONTINUED ON REVERSE

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

36. TOTAL DAYS ALL FACILITIES

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

(b)(6)-2

FICER

(b)(6)-2

MEDICAL RECORDS OFFICER

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG 76 IS OBSOLETE.

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See H&P by Dr. SF 558

(b)(6)-2

PHYSICAL EXAMINATION

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

(b)(6)-2

MD	DATE 02/20/03	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

(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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2 Oct 03 2050	Pt cont. to c/o severe abd pain. HR remains 140's, RR 22-32. Dr. (b)(6)-2 aware of VS, ordered demerol 25mg + phenergan 12.5mg IV Q4° prn breakthrough pain. 4mg MSO4 IV given @ 2040. Will continue to monitor pt. — (b)(6)-2 MA3 AN
2Oct03 2230	Recvd supine. Performing IS c difficulty. HR 140's. RR 22-25. Assessment completed. IV's to AC's patent. Pulses palpable. AOX3 per interpreter. Dressings CDI. Continue to monitor. — (b)(6)-2 Cpt AN
3 Oct 03 0030	Resting quietly. VSS. HR ↓ to 140's p 160's. Demerol & Phenergan given at 2230 for c/o's pain. HR 160's. Post demerol Rest to teens from high 20's & 30's UOP adq. Ø intervention by phys. Cont. to monitor. — (b)(6)-2 Cpt AN

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.
(b)(6)-4		

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 Oct 03	Surg Note
0920	S: Pt. stable, ⊘ sig events overnight
	pain controlled
	O: 100.2 141/66 127-140 19-31 Sats 100% RA
	Heart - tachy ⊘ murmurs
	Lungs - CTA (B)
	Abd - soft, ND, approp TTP
	minimal BS
	NGT = 205 cc
	I/O = 1155 / 1651
	over past 8 hrs - 1300/750
	9.8 11.5 (10 — 122/104 / 2.7/23 (117 / 34.9 / 0.9
	Ap: Pt. POD 1 Ex Lap/SB resection c anastomosis / Sigmoid repair x 2
	doing well
	(1) Cont NPO / NGT
	(2) IVF
	(3) Cont dressing change (L) lower abd & (L) thigh
	(4) will D/C NGT when bowel fxn returns
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

4 Oct 03 Surg note

0855 S: Overnight, pt. placed on NRB for ↓ sats
Currently, pt. comfortably, no new complaints

O: 100 132/75 117-134 28-42 RA 94-95%
100% NRB
Heart - tachy
Lungs - rhonchi R > L
Abd - soft, NO, approp TTP
hyperactive BS, Incision CDI c staples
LLQ wound - healing slowly
NGT = nina
I/O - 3625/2625 CXR - pulm edema, atelectasis
9.7 18/23.5 160 136/3.5 109/26 8/0.7 96

A/P: Pt. POD 2 Ex lap / SB resection c anastomosis / sigmoid repair X 2
stable but ↓ sats probably due to atelectasis / pulm edema. Pt. not compliant c IS.

1. Cont NGT until return of bowel fxn - advance tube
2. Lasix for diuresis
3. OOB to chair / aggressive IS
4. Cont dressing QD
5. [redacted] (b)(6)(2)

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(18)

509-114

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5Oct03	2115: Pt turned to (R) side. Sub Q emphysema continues to upper sternal area. Lung Sounds to (R) lobes & (L) lobes have inspiratory and exp wheezes and rhonchi. Oral care complete. Chest tube drainage counted and marked [redacted]
5 Oct 03 2200	Recvd on (R) side. VSS. Assessment completed. Crepitus to (R) sub clavicular area. Vecuronium, Fentanyl, & versed infusing to (R) AC. See assess flowsheet for vent settings & drip rates. VSS. Cont. [redacted]
	to monitor.
5 Oct 03 2300	Pt placed supine from (R) side. No apparent distress. VSS. Cont [redacted] monitor.
~~5 Oct 03~~	
~~0100~~	

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7 Oct 03 1845 (cont) to command. Pt followed no commands to move extremities. ABG @ 1800: pH 7.53, pCO_2 - 37, pO_2 - 134, HCO_3 - 30, BE-8, SO_2-99%. Dr. (b)(6)-2 notified → FiO_2 ↓ to 0.50, Rate ↓ to 23. ABG due @ 1915. Cont to suction ETT for Ø secretions. Ins + Ex wheezing noted in (B) bases and LUL. (b)(6)-2 MAJ AN

7 Oct 03 1930 ABG @ 1915: pH 7.52, PCO_2 - 37.4, PO_2 - 138, HCO_3 - 30. Dr (b)(6)-2 aware → ↓ FiO_2 to 0.45, ↓ rate to 23. (b)(6)-2 MAJ AN

7 Oct 03 2200 At 2000, pt became very agitated, bucking vent, thrashing about in bed. HR ↑, SpO_2 ↓ to 88, RR ↑ to 30-40. Dr. (b)(6)-2 notified and came to bedside. Pt seemed to calm down ~~while~~ when disconnected from vent and bagged c̄ ambu. Multiple med boluses were given to calm pt down: total of 25mg versed and 6mg ativan in addition to maintenance doses/drips. Fentanyl drip maintained @ 200μ/hr, versed ↑ to 8mg/hr, FiO_2 ↑ to 0.60. Unable to given IV med thru (R) wrist saline lock → discontinued. Another saline lock, 18G, was started in (R) wrist above previous site. IV inserted c̄ good flashback, flushed p̄ insertion. (b)(6)-2 MAJ AN

2210 – continues to be agitated c̄ RT @ bedside bagging & physician @ bedside, Ativan ↑ to 3cc/hr (b)(6)-2

2220 – continues to show S/S of agitation, Ativan ↑ to 4cc/hr

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

DATE	NOTES
	will cont to monitor pt (b)(6)-2
2245	Diplivan started for agitation, Ativan 5/E1d (b)(6)-2 (b)(6)-2 cpw
	& chest x ray done

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 Oct 03 2130	1st unit PRBCs finished @ 2000. No s/sx transfusion rxn noted. Second of 2 units started @ 2020, no adverse effects noted c̄ unit #2 thus far. Pt easily arousable, responds appropriately to yes/no questions per interpreter. Denies pain, appears uncomfortable c̄ ETT + bite block. ETT suctioned for small amount of frothy, white secretions, (+) gag reflex. Vivonex tube feedings cont. c̄ 10cc residual x 2 this ~~shift~~ shift; no s/sx aspiration noted. Unable to hear bowel sounds on auscultation; abd soft, non-distended. LLQ abd dsg Δ'd - small amt blood noted in wound, no purulent discharge noted. Chest tubes x2 (R + L) remain on -20cm H_2O suction each c̄ small amt drainage, mainly serous. Course ronchi throughout all lung fields. Pt re-assured thru interpreter. [redacted] MAJ AP
09 Oct 03 2200	report recieved from evening shift nurse, pt resting but slightly agitated, moving arms & hands, IV fluids continue to infuse as ordered, Blood (2 unit) infusing c̄ s/s of side effects, cont. suction to Bil chest tubes, will cont to monitor pt [redacted]
2300	pt now extremely agitated, unable to calm pt down c̄ assistance of interpreter & 2 other nurses; doctor informed new orders recieved, prn given (see MAR) to sedate pt [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]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

DATE	NOTES
2300 cont	Infusion of Blood transfusing complete ~ S/S of non sole effects will continue to monitor pt (b)(6)-2
10Oct03 0200	Assumed at from previous nurse pt sedated lying supine, continuous suction, NG to ® nare, CT x2 bilateral monitors on 2MA pain, NAD (b)(6)-2
0230	Assessment complete consult DA for 4700 for more infusion. D5NS @125 cc/hr to triple lumen central line, Propofol 60ml/hr, Vec, Fentanyl, versed & ninonex running into pt. NG to ® nare c̄ ICU to continuous suction, monitors on, ID bracelet to (L) wrist b/p cuff to (L) UE, soft restraints x2 to UE's L/R bilateral CT's, patent, PSO2 monitor (L) hand, A-line ® wrist, midline incision CDI staples CDI, (L) lower abd bandage CDI ~ saturation, foley intact patent attached, tubing, to ® thigh non-pitting generalized edema 2MA ® radial d/t taping around wrist & A-line positioning, pulses present normal x3 est. conducted foley care, will continue to monitor per ICU SOP (b)(6)-2
0430	NG residual assessed 8cc residual fluid (b)(6)-2
0520	CXR performed by radiology (b)(6)-2

STANDARD FORM 509 (REV. 5-99) BACK

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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11/20/03 (850)	Surgery Pt has been extubated 24hrs, reports chest mechanically improved Uses Aqb L-CTX 8/8 886 exp this am - a fractured PTX, chest tube removed, Pleurevac's d'd repeat xray and on NSR HR 70-80 BP stable Abd-NABS, soft mildly tender TBL clear liquid B/o UOP adequate labs - per flow sheet A/P 5/F GSW Abd - marked improvement last 36hrs. (1) Pt extubated (2) Advance diet as tol (3) Continue CD (4) pain control (4) D/c Aline

RELATIONSHIP TO SPONSOR	SPONSOR'S ID NUMBER (or Other)
LAST	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
~~13OCT03~~ 2045	Pt awake, IS complete able to take in inspiration to raise 1 ball and 2nd ball halfway. Productive cough when using IS. (b)(6)-2 RAW
13OCT03	2200- Awake in bed, requesting pill for insomnia, (see MAR) will continue to monitor (b)(6)-2 (b)(6)-2
30CT03	2230- resting @ this time (b)(6)-2
13OCT03	0001- c/o pain to RBD via hand motions pain med. given (see MAR) will continue to monitor pt (b)(6)-2
14OCT03 0145	Assumed pt, pt resting supine c̄ NOS ↑, Breathing regular unlabored, DSNS c̄ ZOKCL to TLC patent intact, O2 via NC @ 3L feet slightly elevated, MPC BS, interpreter @ BS (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1400	G Surgery
	Pt c̄ abd distension (-) flatus/BM
	Ass Abdo
	L-CTA Sat 99% 2L
	CXR - ⌀ PTX CT - ⌀ air leak
	CV - NSR, HR 60-70
	BP stable
	D/U adequate WOP CR 0.8
	WBC 8/K
	P/C S/P (6hrs) to dtl/PRIDS
	(1) CT to water seal
	(2) D/C foley
	(3) Diuretics prn

(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 OCT 03 1930	Pt c/o chest/abd pain → 5mg MSO4 IVP given @ this time. This dose appears to keep pain tolerable x ~1.5 hrs. (R) radial A-line d/c'd per MD order. Pressure held to site x 5 minutes p̄ d/c and pressure dsg applied. No s/sx infection, infiltration, bleeding, or hematoma noted. — [redacted] MAJ AN
11 Oct 03 2120	Uses incentive spirometry q 1-2 hrs, able to raise the ball ~10 times, well not C+DB p̄ IS. Does cough mod amt c̄ light yellow/tan, thick secretions on own. Poor po intake, only ~300cc over last 8 hrs. — [redacted] MAJ AN
11 Oct 03 2200	Assumed pt. pt sleeping supine c̄ HOB @ 30°, NAD, Bilateral CT to suction per order, D5NS bo TLC @125cc/hr NC@3L on pt PSO2 99%, monitors on, BVM @ BS — [redacted]
12 Oct 03 0001	pt has high pitched wheezes x2 LL's, RT reassessed this UOP ↓ to 40cc/hr from 95cc/hr @ 2200, full assessment on DA from 4700, generalized edema non-pitting pulses easily palpated x4 extremities, breathing regular, unlabored will continue to monitor, — [redacted]
12 Oct 03 0500	dsg Δ, pt tolerated c̄ minimal complaint, dressing packed tightly previously, minimal drainage, bright red blood c̄ smell amount q yellow drainage, pulled skin around edges q bandage — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
120703	0540 Radiology came to do CXR — (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.0

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2 Oct 03	Brief op note
0535	1) Pre-op Dx - GSW Abd / Evisceration of Small Bowel in exit wound @ lower abd
	2) Post-op Dx - GSW Abd / multiple SB enterotomies & 2 areas of transection of Small bowel, Sigmoid Injury X 2
	3) Procedure - Ex Lap / Small bowel resection c primary anastomosis / Sigmoid Repair X 2, Incidental Appendectomy
	4) Surgeon - (b)(6)-2 / (b)(6)-2
	5) Anesthesia - GETA
	6) Findings - 30 cm small bowel resected - 2 enterotomies & 2 transections contained in the 30 cm, two small injuries to the sigmoid colon - minimal contamination.
	7) EBL - 300 cc UOP = 500
	8) Fluids - 5800 cc crys 250 5% Alb
	9) Complication - Ø
	10) Condition - Stable to ICU
	(b)(6)-2
	MAJ MC

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.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
10/2/03	Prehospital - Received Incis. of s/p GSW to ABD (L)
0220	Thigh. IV 16g (R) AC Patent. 18 in Tolly L Place.
	ABD Dressing L Place. O2 via NRB @ 15 Lpm
0221	Arrival - A&Ox3. GCS-15. Lungs CTAB. ABD GSW to
	(R) RUQ / LLQ. (+) Bowel eviscerat. - . ∅ Exit. (+)
	GSW to (L) Thigh. ∅ Exit. Bleeding Controlled. —
0222	Monitors placed. V.S.S. O2 via NRB @ 15 Lpm. PN
	16g placed @ AC. Labs Sent. Type / X-match x IV.
0226	X-ray @ Bedside. NS 1 Bolus x 2 Liters. Tolly Patient
	Prepping Anther UA. (+) Pulse Pulse L (L) Foot.
0235	Urinary III Cath 1 IVB. Tetanus .5 IM.
0250	X-ray Complete. V.S.S. Pt Prepped for OR. —

Vitals

0220	124/52 - 84 - 28 - 97.6(R) 100%
0230	128/60 - 90 - 30 - 100%
0240	120/64 - 86 - 30 - 100%
0250	128/70 - 90 - 30 - 100%

Meds

0230 Urinary III Cath IVB

0230 Tetanus .5 cc IM

I&O

IVF's 2000 cc —

UA - 520 cc

(b)(6)-2

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

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Civ of Iraqi

Trauma

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	— Transfer Note —
10/2/03 0135	Encounter) 1/187 (apparent attack) → 1 fatality + 3 Iraqi WIAs. This pt has:
	(A) LLQ GSW) small bowel evisceration/open area of small bowel
	*(packed) sterile 4x4/saline/Betadine)
	(B) RUQ GSW, no hemodynamic instability (140-150 BP) SaO2 90-92%, but CXR) fragments in RUQ
	(C) (b) left thigh entrance wound, round in left thigh muscle (Xray copies sent)
	Rx (1) Zosyn 3.0/Phen 12.5 IV
	(2) Rocephin 1gm IV (no Flagyl here)
	(3) O2 1 L NC x 2 l
	(4) 21 CSH by SOMA AA

HOSPITAL OR MEDICAL FACILITY	STATUS
SPONSOR'S NAME	SSN/ID NO.

(b)(6)-2

(b)(3)-1

ONSOR MJO LTC, MC, FS

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, mi Date of Birth; Rank/Grade.)*

STER NO. | WARD NO. 6 2 6 RDB

(b)(6)-4

Iraqi Combatant (b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4 Oct 03	
1000	Pt intubated c̄ size 7.5 ET tube placed 22cm @ the teeth. Placed on Impact Uni-Vent mode: SIMV V_T: 700 RR: 12 PEEP: 10 FiO_2: 100% — SGT [redacted] 9IV20
04 Oct 03 1420	Notify about CXRay showing (R) pneumothorax after noting desaturation. Chest tet tube placed in a sterile fashion (Brizuela/choi) and placement verify by another CXR, pt currently intubated and saturation in 89's %. Concerned for possible PE. pt will be started on Heparin load 10,000 u and then on heparin drip to keep INR ≥ 2.5 [redacted] MD
4 Oct. 03 2044	Chest tube insertion, left:
	- Sterile prep of left chest, sterile drape. Local anesthesia c̄ 1% lidocaine @ 5th IC space, mid-ax. line. Incision at this site, 3cm in length to SQ fat. Pleura penetrated c̄ Kelly clamp, chest tube advanced into pleural space causing egress of bloody fluid and air. Tube secured c̄ suture. CXR pending. [redacted] [redacted]

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

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

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Medical Record
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4 Oct 03 2100	pt given 10 puffs Alb via inline MDI pt SpO2 91
	BP 164/70 HR 116 IV given NC No adverse Rx — (b)(6)-2 9/1120
4 Oct. 03	CXR reviewed - chest tube in good position, lung well-expanded.
2203	(b)(6)-2
0100 5 Oct 03	pt given 10 puffs alb 10 puffs via inline (b)(6)-2
	MDI HR 112 BP 18/61 SpO2 92 — pro (b)(6)-2
5 Oct 03	
0900	pt given 10 puff albuterol via aerovent spacer
	HR: 93 SpO2: 100% BP: 53/49 — SCT (b)(6)-2 2100

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4 Oct 03 2130 (con't)	(L) chest tube = 95cc serosang drainage initially. Vent rate ↑ from 15-17 @ 2000. Lasix 80mg IVP given @ 2100. Post CXR done following CT insertion. O_2 sat @ this time are 90-93%, pH-7.25, PCO_2-77.7 and PO_2-96, HCO_3-34, BE 7. HR ↓ to 115-120. BP stable, A-line ~ 20mmHg above cuff BP(sys). Solu-medrol 500mg IVPB given @ 2030. — [redacted] MJ AN
4Oct03 2200	Report received assumed care of pt. See flowsheet for complete assessment. Dres [redacted] in to see pt. (+) SQ emphysema noted (R) lateral neck, ∅ other appreciated. NGT drainage appears coffee ground. Dr [redacted] notified. ∅ air leaks noted on Chest tube (R) ∅ drainage noted, (L) small serosang. drainage. [redacted] HAM

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	Surgery ICU note
10/05/03 1030	Events of last 24 hrs significant for
	(1) Acute respiratory failure
	(2) Pneumothorax on (R)
	(3) Bilateral CT for PTX/effusions
	(4) Pt started on Imipenem
	(5) Steroid pulse for acute lung injury
	Marked Improvement in Resp status overnight
	UOS Trop 102
	Resp - L-vec rhonchi
	Sat 100% → FIO2 80% 10 PEEP
	PAP - 30's
	Cont ABG 7.35/226/73.6/[illegible]
	CXR - bilateral aeration
	L lobe atelectasis
	still bilateral (R) pleural effusion
	CV - RRR/ST 90-100's BP 100/56
	sedated & Versed/Fentanyl

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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.
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	Abd - (b)BS, soft, nondistended
	NG ≈ 200cc/24hr
	I/O - (-) 5000 24hr
	WBC 9.1 Hct stable
	K - 3.5 CR 0.9
	A/P S/P GSW Abd, resolving, Gastro-mild injury
	(1) Wean Vasopressors tolerated
	(2) Continue diuresis
	(b)(6)-2
	LTC mcw S/N

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
6 oct. 03 0818	ICU note
	pt stable overnight, ∅ sig. events. ICU D# 4 POD # 3
	VSS: 111 141/73 15 95% (50% FiO2)
	Neuro: sedated, paralyzed
	Pulm: SIMV R 17 TV 600 FiO2 50% PEEP 10 PIP 20s
(B) chest tubes on suc. ∅ air leak, min. drainage	exam - good (B) air exchange. Diffuse rhonchi
	CVS: stable. mild tachycardia / HTN. nl S1, S2, III/VI SEM @ RUSB.
meds: - Fentanyl gtt - versed gtt - Zantac - Levemir 80 SQ bid - Impenem 500 q6° - Albuterol MDI q4°	GI / Hepatic: Abd soft, min. distension. Wound healthy. (+) Bowel sounds. LFTs nml.
	Renal: excellent ongoing diuresis.
	Acid/base: PCO2 45. Met. alkalosis c̄ pH app. 7.5. Most likely cause is diuretic and NG suction. on D5 NS @ 75cc/hr - look for it to correct.
	CXR: Effusions clearing, (B) hemidiaphragms visible. ETT position good. NG position - distal esophagus? Stomach well-decompressed. ↑ radiodensity on (L). ↓ radiodensity on (R).
	Imp/plan: s/p ex. lap for GSW. Improving pulmonary status c̄ PCO2 in nl range and PaO2 in low 100s on 50% FiO2. Iatrogenic ~~compensatory~~ met. alkalosis being treated c̄ NS.
	over →

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
	– ↓ vent. rate to 15
	– ↓ FiO2 to 40%
	– D/C vecuronium
	– once alkalosis corrects, work toward extubation.
	(b)(6)-2 MD (b)(6)-2
4 Jan 03	Icu Note
0740	– The patient doing well this am, ∅ sig. changes
	overnight. ~~Continues to have~~
By systems:	Neuro: sedated, paralyzed
	CV: Hypotensive – hypertensive, mildly tachycardic.
	Heart sounds difficult to hear 2° to rhonchorous breath
	sounds.
	Resp: oxygenation more than adequate. PaO2 179 on FiO2 40%
Chest tubes on	diffuse rhonchi / exp. wheezes on exam. Resp. acidosis. c̄ PCO2 57
Sux. ∅ air	Abd: soft, (+) BS, minimal distension. NG c̄ ↑ op – appears
leak. Minimal	to be in duodenum. Will pull back.
O.P.	Renal: Nl renal fct. electrolytes Wnl. met. alkalosis continues.
CXR: improved	Expect to correct.
over yesterday.	Nutrition – none
(B) lungs well-	Plan: – ↑ vent. rate to 16.
expanded.	– ↑ withdraw ~~tube~~ NG into stomach.
ETT - good posn.	– D/C vec.
NGT – in	– Consider spont. vent. trial today once vec.
duodenum	wears off. Will D/W Dr. (b)(6)-2
	(b)(6)-2 MD (b)(6)-2

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT (Sign each entry)	TREATING ORGANIZATION
06 OCT 03 1845	D/C'd 14g IV to (R) AC D/T leaking @ site. No evidence infection noted. Restarted 18g in (L) H.	(b)(6)-2
1900	Rolled pt to (L) side, ensured proper body alignment. Cleaned eyes & administered eye gtts on. Will continue to monitor	(b)(6)-2
2035	Repositioned to supine c HOB @ 30°. Body in proper alignment. Will continue to monitor	(b)(6)-2
2125	IV to (R) Hand inadvertantly D/C'd. Attempted to restart x 6. Gave report to next shift	(b)(6)-2
2200	Received report from Eve shift nurse, pt paralyzed via medication (see MAR); IV, 20 guage to (R) AC started c difficulty on first try, vent rates continue (see Dr. Orders) Ø Resp distress noted; all dressings CDI, Ø leakage noted to chest tubes #1 or #2, NG tube LIS c dark green secretions, ET tube in place, A-line & IV sites to C & (R) AC CDI, IV fluids infusing as ordered will continue to monitor pt	(b)(6)-2
1 Oct 03 0100	Assumed pt, pt sedated receiving IV medications to bilateral AC's, pt on respirator, has bilateral CT's, foley to gravity, (R) arm wrist A-line, lying supine, turned to (R) side c assist, pt also has NG tube, will continue to monitor	(b)(6)-2
0250	Assessment complete, consult D4 form 4700 for full assess	(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.)

(b)(6)-4

6 Oct 03

REGISTER NO. | WARD NO. ICU

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
0103	ment, (R) LE pedial pulse faint, pt has generalized non-
0250	pitting edema skin cool dry pale, L/R AC PIV
(tinued)	patent CDI flushed (R) AC, (L) fluids running per
	order by physician, (R) wrist A-line patent CDI, zeroed
	L/R CT's c̄ little to Ø fluid expelled operating properly
	pt has NG c̄ int suctioning to (R) none, foley to gravity
	putting out 100-200 cc/hr yellow w/ urine c̄ sediment
	conducted foley care. pt heavily sedated does not actively
	move extremities [redacted]
0250	increased pt dosage Vec drip from 5ml/hr to 2ml/hr
	d/t pt tremors & ↑ R. to 32bpm [redacted]
0310	pt stopped tremors, NAD [redacted]
0435	increased pt dosage Vec d/t increased tremors during
	dressing Δ [redacted]
0520	Portable CXR taken [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
8 Oct 03 1430	Surgery ICU Note Pt had desaturation last pm requiring ↑'d FIO2 and paralysis to improve oxygenation VSS 101.6 L- diaphragm blunted b/l BS (R) lung coarse - RLL atelectasis Current Vent - FIO2 90 PEEP 10 TV 600 IMV 16 Sat 99% Pt sedated x2 c̄ normal large amt secretions CV - ST, RRR 100's ABD - soft, ⊕ BS, mildly distended, well healed incisions NG ≈ 200 last shift S/O WNP - adequate - 997 last 24hrs WBC 10.8 Hct 29 Hgb 10.1 K 3.3 Amy 208 T Bili 0.3 A/P S/P GSW - Abdomen (1) Diaphragmatic Respiratory failure (2) Central line placed (3) Hct Replacement (4) Start trophic feed.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
		(3) blood x to 30 mg SQ Q12	
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; Sa Date of Birth; Rank/Grade.)* (b)(6)-2 WARD NO.

(b)(6)-4

(b)(6)-2 LTC McCrory

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
90 d03	ICU Note
1500	Pt relatively stable overnight, paralytics weaned, sedation d/c
	Vss Afeb (Tmax 100)
	L-coma slowly
	exp unremarkable (R) lung
	ABG 60% → 7.5/175/33.8/-6 Sat 100
	CT-minimal output
	CV-ST 100's
	BP-stable
	ABD-NABS, soft nontender
	tube feed @ 10cc/hr tolerated
	Wound Bio ex
	Lab-see chart
	A/P 8/F GSW ABD
	(1) Wean vent as tol
	(2) Transfuse 2 units PRBC
	(3) ↑ tube feed to 20cc/hr

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
10 Oct 03	(Continued) breathing rapid / shallow, midline incision OTA intact
2150	Rhonchi to lungs, ® pedal faint (L) radial & pedal ~~ant~~ pulses
	normal present, 2+TA ® radial d/t bandaging cap refill <2 sec, more
	fingers ∃ difficulty, skin warm & dry ∃ generalized non-pitting edema
	A&O x3 ∃ interpreter C BS, MPC BS — [redacted]
10 Oct 03	(2255) MSO4 administered by RN on duty PRN pain — [redacted]
10 Oct 03	(2345) changed CT x2 to water seal per orders — [redacted]
10 Oct 03	pt had a respiration rate of 30bpm normally, physician was
0100	notified by RT, pt's breathing continues to be rapid & shallow
	physician orders on ABG — [redacted]
11 Oct 03	(0130) placed mask on pt per pt comfort Ø O2 administered at this
	time PSO2 set 95% RA — [redacted]
11 Oct 03	(0135) physician visit, looked C ABG results decides not to
	intubate, will continue monitoring per physician orders [redacted]
11 Oct 03	(0149) MSO4 administered by RN on duty per pt pain [redacted]
11 Oct 03	pt A&O, generalized edema noticably lessened in LE's, HOB
0315	elevated 30 degrees, BS hyperactive x4 quads LS LDL & LLL
	Rales audible from front & back, rhonchi to ® ~~side~~ lung
	skin warm & dry, pt talks to himself often, HOB exceeds
	DSNS input, color yellow ∃ nodular, MPC BS — [redacted]
11 OCT 03	(0500) X-ray came, pt tolerated — [redacted]
11 OCT 03	(0515) pt resting ∃ HOB elevated O2 C 2L via NC PSO2 set 94%

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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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 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
11 OCT 03 0515	(continued) 0430 dressing Δ, (R) lower abd purulent drainage blood staining to removed dressing. (R) CT dressing Δ, activated normal chest tube drainage, reinforced tape on (L) chest tube. pt continues to talk to self — [redacted]
11 OCT 03	0540 D/C NC O_2, pt ambulated C 94% RA — [redacted]
11 OCT 03 0615	Pt continuously moaning. Requesting O_2 MASK. O_2 SAT 93-95%. Pt c̄ shallow respirations 40-50's. Placed O_2 NC 3l/min Medicated c̄ MSO4 4mg IVP. CT #2 c̄ AIR LEAK. CT #1 ∅ air leak. TLC Patent c̄ s/sx of infection. D5NS c̄ 20KCl @ 125cc/hr. O_2 SATS 96-97. See flowsheet for assessment. — [redacted] LT, A
11 OCT 0900	CT DRSGS Δ (B). New Pleurovacs placed on suction. Portable CXR done. Toradol 30mg IV given for pain. [redacted] LT, A
11 Oct 03 1430	Pt c/o generalized abd pain and (R) chest pain around CT insertion site. Received 5mg MSO4 IV @ 1330; due for toradol 30mg IV @ 1500. Pt has spontaneous cough for mod amt of thick, tan secretions. Appears alert & oriented, answering questions appropriately per interpreter. (R) + (L) CT → -20cm H_2O suction. (L) triple lumen - subclavian - patent, s/sx infection or infiltration. (R) radial A-line → transducer/monitor c̄ good waveform. [redacted] MAJ, AN
11 Oct 1510	Toradol 30mg IV given @ 1450. c/o pain → 5mg MSO4 IV given @ 1505. Will continue to monitor. — [redacted] MAJ AN
11 Oct 1630	Up in chair, only supported ~50% of weight. c/o hunger, asking for bread. Hair washed. — [redacted] MAJ AN
11 Oct 1830	Pt went back to bed p̄ attempting BM - no results. Ate ~25% of ī jello and drank small amt 7-up + water (total ~120cc). [redacted] MAJ A
11 Oct 1900	UOP steadily ↓ throughout day, 21cc last hr; Dr. [redacted] aware → 500cc LR IV bolus hung per order. — [redacted] MAJ, AN

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
130203	Surgery
	Pt tol dent
	Uss Agents
	LMTA
	cw RVR
	Old not [illegible]
	wound healing
	P/p s/p GSW to abd
	(1) Dx Transfusion / [illegible]
	(2) Pulmonary [illegible]
	(3) Po Pain med
	(4) Ambulate q shift
	(5) Dx labs / CXR
	(6) Plan D/c [illegible] 24-48°

(b)(6)-2

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

NSN 7540-00-634-4176

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
140ct03	2300 - C10 PAIN to ABD 7/10 via interpreter, PAIN medication given (see MAR) will continue to monitor pt - (b)(6)-2 R

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
14 Oct 03	Surgery
0900	Pt tolerating regular diet, Ambulating
	UBs Aft
	LBM
	Abd - soft, nondistended
	Wound healing
	A/P S/P GSW to Abd
	D/C to VMP's
	Wound care LLQ BID
	F/u Q week for wound ✓
	(b)(6)-2
	LTC [illegible]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 02, MONTH Oct, YR. 03 — TIME 0220

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

CURRENT MEDS. (tetanus immunization and other data): denies

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

ALLERGIES: denies

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW abdomen

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

VITAL SIGNS

TIME	0228
BP	124/52
PULSE	84
RESP.	31
TEMP.	97.6
WT. (Child)	100 70

(b)(6)-2

CATEGORY (See reverse)
- EMERGENT
- [x] URGENT
- NON-URGENT

ORDERS	INITS.	TIME
CXR (P)		
(R) (L) femur		
CBC, 1 stat 6,3		
2L NS bolus		
UA		

(b)(6)-2

ASSESSMENT/DIAGNOSIS: GSW (B)

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

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

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic)

EMERGENCY [ ] TODAY [ ]
72 HOURS [ ] ROUTINE [ ]

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: IMPROVED [ ] UNCHANGED [ ] DETERIORATED [ ]

TIME OF RELEASE:

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

TIME SEEN BY PROVIDER: 0220

S/p GSW abdomen, XZ, small bowell evisceration. Seen in @ Tallyn + transfer here for further care. Stable enroute, wl. vitals. Also noted small FW to (L) thigh / lat aspect. Bowel dressed c̄ saline / gauze.

C - WDWN. Mild distress. Alert.
A - speaking
B - BBS =
C - strong fem pulses
HEENT - atraumatic, NC
neck - ¢ HP.
CV - Reg ¢ m
lungs - B = BS
chest - atraumatic
neuro - MAE, GCS 15
back - ¢ injury seen.

D - GCS 15
MAE to command
(L) leg - thigh - lat aspect small FW
abd - GSW to RUQ + LLQ. LLQ c̄ evisceration of bowel, pink, swollen. penetrating (+) stool @ bowel injury to ileum

P - ¢
S - ¢

109 / 41.2
141 / 105 / 15 / 16
3.2 / 1.2

CXR
elevated (R) hemidiaph ¢ ptx

(L) thigh
Frag
Lat. thigh

EDC - To CR c̄ Gen Surgery - Eastman for ex-lap.

(CONTINUE ON SF 507, IF NEEDED)

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

Ivagene

#

(b)(6)-4

(b)(6)-2

MAJ MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

— To CR —

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 2130

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Maj (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Maj (b)(6)-2

3. DATE 02 Oct 03 TIME PATIENT ARRIVED IN SUITE 0305

4. PATIENT IN ROOM TIME 0305 NUMBER OR #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 RID	RELIEF SCRUB	
	SPC (b)(6)-2 RID 66F (b)(3)-1		
ASSIGNED CIRCULATOR	Maj (b)(6)-2 66E	RELIEF CIRCULATOR	
	Maj (b)(6)-2 66E (b)(3)-1		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

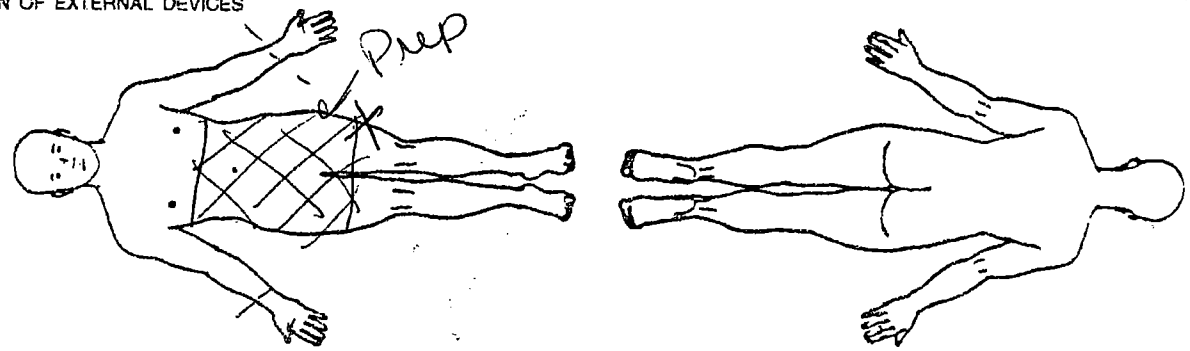
COMMENTS: Body alignment

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Abd BY WHOM: Maj (b)(6)-2
SITE: (see Below) BY WHOM:
COMMENTS: No irritation noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC (b)(6)-2	Maj (b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C	SPC	Maj
Instrument	☒ Yes ☐ No		C			
Other	☒ Yes ☐ No					

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

(b)(6)-4

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

☐ ESU NO: 000434
GROUND PAD: BRAND Vital Tab Polyhesive II
LOT NO: 696 #1 04/05

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 2131

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM (b)(6)-2 IF YES, SITE

YES ☐ NO

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. Kerlex → moist	2.	3.
SITE	1. (L) side	2.	3.

4x4's
tape

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED

Ex lap

21. PATIENT TRANSFERRED TO TCU TIME See DA73 89 METHOD litter c safety straps

22. REGISTERED NURSE (b)(6)-2 Mg/n

REVERSE OF DA FO

*U.S. GPO: 1996-404-613/40449

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	20ct Ø3
DOS	20ct Ø3
POD	D08

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	MAJ AN
	MAJ AN

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach		N/A	
Side Rails Up		N/A	
Bed in Low Position		N/A	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAJ AN	ICU	20ct Ø3

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2						2								2		
	RADIAL L								2						A-Line								2		
	DORSALIS PEDIS R								1						1								1		
	DORSALIS PEDIS L								1						1								1		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale									1 4 8						2 3								1 3 8		
EDEMA									Ø						(b)(6)-2 bedal non pitting								(b)(6)-2		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						ST								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)									✓						✓								✓		
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST								✓						✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE								✓						✓								✓		
	HOB 30 DEGREES														✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																						8/16		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended								2						2								2		
BOWEL SOUNDS (active all quads)									Ø						Ø								Ø		
NG / DOBHOFF PLACEMENT VERIFIED									✓						✓								✓		
RESIDUAL ASSESSED									suction						suction								suction		
Ph																									
FOLEY CATHETER PATENT									✓						✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.									✓						✓										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds								✓						✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Ex Lap - Midline ABD															✓								✓		
#2 (L) thigh															✓								✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) radial A-line	(L) radial	2 Oct 03	
16ga	(R) AC	2 Oct 03	
14ga	(R) AC	2 Oct 03	

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 2 Oct 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open									2						3								3		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response									5						5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response									6						6								6		
GLASCOW COMA SCALE (A+B+C)									13						14								14		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R								2S						4+								3+		
	L								2S						4+								3+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE								4						3								3		
	LUE								4						3								3		
	RLE								4						3								3		
	LLE								4						3								3		
GRIP (S) Strong (W) Weak (-) absent	R														W								W		
	L														W								W		
RESPIRATIONS	REGULAR								✓						✓								✓		
	IRREGULAR																								
	UNLABORED								✓						✓								✓		
	LABORED																								
	SHALLOW														✓								✓		
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL								3						5								5		
	LUL								3						5								5		
	RLL								1						1								1		
	LLL								1						1								1		
	BOTH BASES								1						1								1		
COUGH	NONE								✓						✓								✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear															Ø										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							5L						5L											
	FM (l/min)																						5L/M		
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓	✓	✓		✓	✓			✓		
COUGH / DEEP BREATH																				✓			✓		
INITIALS								(b)(6)-2						(b)(6)-2				(b)(6)-2				(b)(6)-2			

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700				(b)(6)-2													
0800	97.2	125	25	146/77	100	5LNC											
0900	98.7	136	27	145/79	100	5LNC											
1000		142	28	143/77	100	5LNC											
1100	100.5	137	30	142/78	100	5LNC											
1200																	
1300	100.7	148	32	117/75	100%	117/74											
1400	100 (b)(6)-2	156	32	114/72	99%	117/70	83										
1500	101.[illegible]	150	28	111/72	99%	120/67	84	(b)(6)-2									
					~~99~~	~~117/61~~	~~78~~										
1600	99.[illegible]	153	32	111/68	99	117/64	78										
1700	99.8	152	32	110/72	99	124/68											
1800	100.3 (D)	144	26	114/66	100	137/71	~~137/69~~ ~~86~~	(b)(6)-2									
1900	100.1 (D)	146	28	112/65	100	137/69	86										
2000	100.0 (D)	145	28	111/65	100	132/64											
2100		146	26	116/66	99	133/62											
2200	100.4 (D)	144	24	114/66	100	140/65											
2300		160	18	118/54	98	122/56	86										
2400	~~100.7~~ 99.7 A	139	22	114/65	100	123/64	84										

	INTAKE									OUTPUT						
	LR	IVPB	BOWL					OR	Total	URINE	NGT			OR	Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600														300 / 300		
0700	150 / 150									100 / 100						
0800	150 / 300	100								80 / 180						
8 HR	300	100						6050	8 HR. 6450	180				300	8 HR 480	
0900	150									55 / 55						
1000	150 / 300															
1100	150 / 450		500 / 500							140 / 195						
1200	150 / 600									70 / 265						
1300	150 / 750	100 / 100	1000 / 1500							60 / 325						
1400	150 / 900									50 / 375	100 / 100					
1500	150 / 1050									65 / 440	75 / 175					
1600	150 / 1200									34 / 474						
8 HR	1200	100	1500						~~16 HR.~~ 9250	474	175				~~16 HR.~~ 1129	
1700	150 / 150									32 / 32						
1800	150 / 300	100 / 100	1000 / 1000							65 / 97						
1900	150 / 450									100 / 197						
2000	150 / 600									70 / 167						
2100	150 / 750									65 / 232						
2200	150 / 900									100 / 332	30 / 30					
2300	150 / 1050									60 / 392						
2400	150 / 1200									80 / 472						
8 HR	1200 / ~~2700~~	100 / ~~300~~	1000 / ~~2500~~						24 HR. 11,550	472	30				24 HR 1681	

MEDICAL RECORD

NSN 7540-00-634-4123

NURSIN JTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20ct03	0730		Pt discharged from recovery, see flowsheet for assessment details. MP guard bedside. [redacted] MAJ/AN
	1030		May [redacted] (anes) in to see pt, informed of non-pulsatile HR 140's. Fluid bolus ordered, hung.
	1130		(D) thigh dsgs Δ'd. Lg amt sang drg. 1cm area x 2 (D) lateral thigh. Anterior thigh packing left in place, dsd applied over. Moderate/lg. amt sanguinous drainage noted. [redacted] MAJ AN
	1150		Dr [redacted] in to see pt, aware of tachycardia, labs sent. [redacted] MAJ AN
	1230		Labs back, 1L NS bolus hung [redacted] MAJ AN
20ct03		1430	Midline abd dsg and (L) hip/thigh dsg dry and intact. NG → LIS c̄ small amt light brown drainage. Pt easily arousable and appears oriented per interpreter. Abd soft, ~~none dist~~ non-distended. Ø bowel sounds heard. A-line zeroed, correlates well c̄ cuff BP. (B) AC IV's appear intact s̄ S/Sx infiltration, infection, bleeding from site. [redacted] MAJ AN
		1545	Per interpreter, pt states good relief of pain (abd) c̄ 4mg MSO4 given @ 1515. [redacted] MAJ AN
		1600	Attempting to use incentive spirometer q hour. Pt refuses/unable to lift first ball. Will continue to encourage IS and C+DB. [redacted] MAJ AN
		1720	↓UOP to 30-35cc/hr x 2 hrs. HR remains in 150's, Sys BP 115-120. Dr. [redacted] notified of ↓UOP → ordered 1L fluid bolus NS, hung @ that time. [redacted] MAJ AN
		1735	Continues to refuse incentive spirometer stating hurt abd hurts. 4mg MSO4 IVP given @ this time. [redacted] MAJ AN
		2000	LLQ abd and (L) lateral thigh dsgs Δ's, W → D dsg covered c̄ sterile 4x4 and ABD dressings. Mod to lg. amt sang. drainage noted from both wounds. Pt medicated c̄ 4mg MSO4 IVP prior to dsg Δ. [redacted] MAJ AN

Cont. notes on attached sheet.

[redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	20 Oct 03
DOS	20 Oct 03
POD	~~DOS~~ 1

24 HOUR DATA	
24 Hour Balance	+950
24 Hour Intake	~~4,550~~ 3625
24 Hour Output	~~1600~~ 2675
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	30 Oct 03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2		2			2				2					2				2			2	
	RADIAL L		2		2			2				2					2				2			2	
	DORSALIS PEDIS R		1		1			1				1					1				1			1	
	DORSALIS PEDIS L		2		2			2				2					2				2			2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8		2 3 5			2 3 8				1 3 8					1 3 8				1 3 5			1 3 5	
EDEMA			B/L LE		B LE			Gen				Gen					Gen				Gen			Gen	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓		✓			✓				✓					S1S2				✓			✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST		ST			ST				ST					ST				ST			ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)								✓									✓				✓			✓	
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE										✓	✓													
MOBILITY	BEDREST		✓		✓			✓				✓					✓				✓			✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓		✓			✓				✓					✓				✓			✓	
	HOB 30 DEGREES		✓		✓			✓				✓					✓				✓			✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		X		✓			✓																	
	PAIN SCALE (1-10)		5/10									4/10									4/10			5/10	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2		2			2				2					2				2			2	
BOWEL SOUNDS (active all quads)			Ø		Ø			Hypo				Hypo					Hypo				Hypo			Hypo	
NG / DOBHOFF PLACEMENT VERIFIED			✓		✓																				
RESIDUAL ASSESSED L15			✓		✓																				
Ph																									
FOLEY CATHETER PATENT			✓		✓			✓				✓					✓				✓			✓	
VOIDING CLEAR, YELLOW URINE q.s.								✓				✓					✓				✓				
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓		✓			✓				✓					✓				✓			✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Ex lap-Midline Abd			✓		✓			✓				✓					✓				✓			✓	
#2 (R) thigh			✓		✓			✓				✓					✓				✓			*	
#3																									

(b)(6)-2 (b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) Radial Alive	(L) Radial	2 Oct 03	Patent & S/Sx of infection or infiltration 0700
16 ga	(L) AC	2 Oct 03	Patent & S/Sx of infection or infiltration 0700
18 ga	(R) AC	2 Oct 03	Patent & S/Sx of infection or infiltration 0700

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 30+03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			3		3			4 (b)(6)-2				4					4				4			4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5		5			5				5					5				5			5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6		6			6				6					6				6			6	
GLASCOW COMA SCALE (A+B+C)			14		14			15				15					15				15			15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		3+		3+																				
	L		3+		3+																				
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4		4			4				4					4				4			4	
	LUE		4		4			4				4					4				4			4	
	RLE		4		4			4				4					4				4			4	
	LLE		4		4			4				4					4				4			4	
GRIP (S) Strong (W) Weak (-) absent	R		W		W			W				W					W				W			W	
	L		W		W			W				W					W				W			W	
RESPIRATIONS	REGULAR		✓		✓			✓				✓					✓				✓			✓	
	IRREGULAR																								
	UNLABORED		✓		✓			✓				✓												✓	
	LABORED																								
	SHALLOW		✓		✓												✓				✓			✓	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5		5			5				5					3,2				3,2			3	
	LUL		5		5			5				5					3,2				3,2			3	
	RLL		1		1			5				5					2				2			1	
	LLL		1		1			5				5					2				2			1	
	BOTH BASES		1		1			1				1					1				1			1	
COUGH	NONE		✓		✓			✓				✓													
	SPONTANEOUS																✓				✓			✓	
	PRODUCTIVE																								
	NONPRODUCTIVE																✓				✓			✓	
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)		5L		5L			5L				3L					3L				3L			3L	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE			✓		✓			✓				✓					✓				✓			✓	
COUGH / DEEP BREATH			✓		✓			✓													✓			✓	
INITIALS			(b)(6)-2		(b)(6)-2			(b)(6)-2				(b)(6)-2					(b)(6)-2				(b)(6)-2			(b)(6)-2	

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		136	19	127/65	99	138/70	89										5L
0200	99.8 A	138	23	123/68	98	149/73	89										
0300		139	27	122/64	98	147/70	87										
0400	99.9	137	23	129/67	99	154/73	90										
0500		136	26	—	96	160/72	92										
0600		140	29	~~160/72~~ (b)(6)-2	92%	160/72	92										
0700	100.3 (A)	135	21	~~160/72~~ 129/66 (b)(6)-2	99%	152/76	94										
0800		127	22	132/74	99%	156/75	92										
0900	100.2 (A)	132	31	121/66	100	158/75	94										
1000		123	23	131/73	98%	165/73	97										
1100	99.8 (A)	122	25	125/70	98%	169/74	98										
1200		125	23	129/71	99%	174/76	100										
1300	100.3 (A)	127	22	132/69	98%	177/77	101										
1400		127	19	133/67	99%	162/76	97										
1500	99.7 (A)	118	22	127/72	99%	170/76											
1600		123	22	120/75	98%	178/75											
1700		125	25	133/69	97%	187/72											
1800	100.9 M	135	30	129/65	93%	194/71											
1900	100.8	135	31	116/68	92%	186/73											
2000	101.3	140	29	121/67	98%	167/74											Tylenol
2100	102.3	143	32	109/67	92%	97/67											15/Cough
2200	100.9	141	32	116/64	90	163/73	87										
2300	100.7	133	26	120/62	93	146/72	83										
2400		134	37	120/62	91	150/75	96										

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30 Oct 03	0200		MS04 given for 5/10 abd pain. Pulse has improved in (L) LE. Lungs remain clear. VSS. HR in 140's. RR 20's. O_2 Sat 98-100%. IsOP adq. Cont to monitor — [redacted] GPTAN
30 Oct 03	0245		Cont c/o pain. Demerol/Phenergan given. Appears to have some relief. VS remain stable. Cont. to monitor — [redacted] GPTAN
30 Oct 03	0445		Resting quietly c̄ distress. VSS. Ø further c/o pain. Dressings remain CDI. — [redacted] GPTAN
30 OCT 03	0625		Pt morning. Medicated c̄ MS04 4mg. IVP See flowsheet for assessment. — [redacted] LCT, RN
30 OCT 03		1300	PT c̄ NAD throughout shift. VSS. A-Line not correlating c̄ NIBP. Drsg's remain CD&I. Voiding, Ø S via foley. Medicated c̄ MS04 for pain control. [redacted] LCT, RN
		1600	attempted IS c̄ pt. explained importance of recovery. Pt unable to lift one ball of IS when inhaling. Also tried to encourage cough — [redacted] LCT RN
		1730	4mg MS04 given for pain to abd. — [redacted] LCT RN
		1810	IS complete @ bedside c̄ help of interpreter, completely understands pr interpreter. Able to pull 900 c/sec. Art. BP not correlating c̄ NIBP. — [redacted] LCT RN
		1820	Dressing change for evening not complete per day shift nurse speaking c̄ physician. — [redacted] LCT RN
		2000	Pt medicated c̄ 4mg MS04 for abd pain. [redacted]
		2140	25mg Demerol/12.5mg Phenergan admin. for breakthrough pain — [redacted]
30 Oct 03		2215	c/o pain. 2mg MS04 given. A-line zeroed. Cont to monitor. — [redacted] GPTAN
30 Oct 03		2330	Dressings reinforced. CHUX + Dressing saturated from exit wound on back. VSS. Assessment complete. Performing IS c̄ encouragement. Cont. to monitor. — [redacted] GPTAN
30 Oct 03		2400	O_2 Sats decreasing. O_2 to 5L/NC. Resp at 36 bpm. IS + CS performed. Continue to monitor. — [redacted] GPTAN

	INTAKE									OUTPUT						
	IV	Urinary Hacen	DSNSC 20 Kcal						Total	Urine	NGT				Total	COMMENTS
0100	150 / 150									85 / 85						
0200	150 / 300									100 / 185						
0300	150 / 450									85 / 270						
0400	150 / 600									120 / 390						
0500	150 / 750									60 / 450						
0600	150 / 900	100 / 100								↓						
0700	150 / 1050									175 / 625						
0800	150 / 1200									125 / 750						
8 HR	1200	100							8 HR. 1300	750					8 HR 750	(+) 450
0900	150 / 150									35 / 35 / 785						
1000			125 / 125							135 / 170						
1100			125 / 250							125 / 295						
1200		100 / 100	125 / 375							135 / 430						
1300			125 / 500							100 / 530						
1400			125 / 625							130 / 660						
1500			125 / 750						925	90 / 750						
1600			125 / 875						1125	160 / 910					910	
8 HR	150	100	875						16 HR. 2425	910					16 HR. 1760	
1700			125 / 125							140						
1800		100 / 100	125 / 250							115 / 155						
1900			125 / 375													
2000			125 / 500							350 / 635						
2100			125 / 625													
2200			125 / 750							80 / 715						
2300			125 / 875							90 / 805						
2400		100 / 200	125 / 1000						1200	110 / 915					915	
8 HR		200	1000						24 HR. 3625	~~915~~					24 HR 2675	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 Oct 03
DOS	3 Oct 03
POD	1

24 HOUR DATA	
24 Hour Balance	-4719
24 Hour Intake	~~3825~~ 2996
24 Hour Output	~~2075~~ 7715
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE		Initials
(b)(6)-2	Cpt AN	
(b)(6)-2	1LT AN	(b)(6)-2
(b)(6)-2	1LT/MC	
(b)(6)-2	MAJ AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N		
Call Light Within Reach			
Side Rails Up	A		
Bed in Low Position			

PREPARED BY (Signature)	Department/Service/Clinic	DATE
(b)(6)-2 Cpt AN	ICU	4 Oct 03

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

(b)(6)-4

(EPW)

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2			2					2			2 A line				A line				2		
	RADIAL L			2			2					2			~~A line~~	(b)(6)			2				2		
	DORSALIS PEDIS R			1			1					1			1				1				1 2		
	DORSALIS PEDIS L			2			2					2			2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 8			1 3 8					1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA				Gen			Gen					Gen			gen				Gen				+		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓					✓			✓				✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				ST			ST					ST			ST				ST				ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)															✓				✓				✓		
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓					✓			✓				✓				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT														✓								✓		
	SUPINE			✓			✓					✓													
	HOB 30 DEGREES			✓			✓					✓			✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			✓			✓								Fentanyl drip				Morphine				Sedated		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2			2					2			1				1				1		
BOWEL SOUNDS (active all quads)				hypo			Hypo					✓			Ø				Ø				Ø		
NG / DOBHOFF PLACEMENT VERIFIED				✓						✓					✓								✓		
RESIDUAL ASSESSED	HS			✓																					
Ph																									
FOLEY CATHETER PATENT				✓			✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.							✓					✓			✓				✓				✓		
SKIN INTEGRITY	No Breakdown											✓													
	Surgical Wounds			✓			✓					✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Ex Lab - Midline abd.				✓			✓					✓			✓				✓				✓		
#2 (R) thigh				✓			✓					✓			✓				✓				✓		
#3 CT (R)																							✓		
CT (L)																							✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
16 ga PIV	(L) AC	2 Oct 03	Patent & S/Sx of infection or infiltration /0700
18 ga PIV	(R) AC	2 Oct 03	A/L'd. Ø S/Sx of infiction /0700

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 4 OCT 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open				4			4					1			1				1				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response				5			5					1/T			1				1				T		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response				6			6					4			1				1				1		
GLASCOW COMA SCALE (A+B+C)				15			15					9T			3 (Meds)				3 (Meds)				2T		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R			3+																			2+		
	L			3+																			2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE			4			4					0			0				0				0 paralyzed		
	LUE			4			4					0			0				0						
	RLE			4			4					0			0				0						
	LLE			4			4					0			0				0						
GRIP (S) Strong (W) Weak (-) absent	R			W			W					0			0				0				1		
	L			W			W					0			0				0				1		
RESPIRATIONS	REGULAR			✓			✓					✓			✓				✓				✓		
	IRREGULAR											e							E				E		
	UNLABORED																								
	LABORED											n			Eff				N				N		
	SHALLOW			✓			✓					T			well				T				✓		
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL			3			3								3				3				3		
	LUL			3			3								3				3				3		
	RLL			3			3								3				3				3		
	LLL			1			3								3				3				3		
	BOTH BASES			1			1					✓			3				1				1		
COUGH	NONE			✓			✓					✓			✓				✓				✓		
	SPONTANEOUS			✓																					
	PRODUCTIVE																								
	NONPRODUCTIVE			✓																					
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt											700			550			580	550				560		
	FIO2											100			100			100	100				1.0		
	RATE (SIMV/CMV)											12			16			15	17				17		
	PEEP / CPAP											10			10			5	10				10		
	PRESS. SUPPORT											Ø													
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 7.5	NRBM (l/min)			10L			10L					✓													
	ETT 22 cm gums																		✓				✓		
ETT CARE / POSITION CHANGE												✓	✓		✓										
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE				✓																					
COUGH / DEEP BREATH				✓																					
INITIALS				(b)(6)-2			(b)(6)-2								(b)(6)-2				(b)(6)-2				(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	100.7	134	42	117/61	88	150/71	93										
0200		138	30	117/66	85	D/C											
0300	101.0	122	28	116/68	93	—	85										
0400	99.8 A	120	31	120/72	94	—	97										
0500		122	30	121/70	93	—	98										
0600	100.8 (A)	124	35	121/72	95%		90	100%		NRB	13L/Min						
0700		121	29	123/73	94%		91										
0800	100.3 (A)	117	35	132/75	95%		96										
0900		122	34	126/62	91		86										
1000	100.8 (A)	144	47	127/77	75%		97										
1100		144	13	131/76	96%	171/82	105										
1200	100.3 (A)	143	12		100%	186/75	110										
1300	101.5 (A)	146	16		79%	146/73	102										
1400																	
1500		144		150/78	91%	190/74	105										
1600	101.2 (ex)	149	16	142/77	92	189/67	104										
1700	101.8 (A)	145	15	135/77	86	163/71	101										
1800	102.3 (A)	139	10/15	148/72	95	145/70	96										
1900	101.8 (A)	126	17	132/75	88	171/80	110										
2000		129	21		82	159/69	97										
2100	101.6 (A)	119	24/17		89	165/75	100										
2200	102.1	115	30/17	141/69	87%	130/64											
2300		112	24/17		94%	125/65	1HF										
2400	101	111	22/17		97%	125/64	88										

MEDICAL RECORD			NURSING .ES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Oct 03	0100 → 0200		O_2 Sat to 75%. Placed on NRM. Sat to 85%. Had pt use IS + cough DB. Ø change to O_2 sats. ABG drawn. Pt's breaths very shallow + labored. ABG drawn. Sent to lab. Phys. notified. ~~MS 50~~ Demerol/Phenergan given for pain. O_2 Sat to 90% Resp to 27 bpm. Continue to monitor. [redacted] CPT AN
4 Oct 03	0300		O_2 Sats + Resp improved c̄ pain control. HR 120's. Resp 28. O_2 Sat 95%. Cont to monitor. [redacted] CPT AN
4 Oct 03	0500		Resting quietly. Eyes closed. Resp deep + even. VSS. Ø apparent distress. [redacted] CPT AN
4 Oct 03	0840		Dr [redacted] informed of Pt's Respiratory status. New orders initiated. CBC, PA-7/Inelytes sent to lab. PICC ordered. D5NS c̄ 20 KCL ↓ 75 cc/hr. VSS. Will cont to monitor [redacted] LCT, AN
4 OCT 03	1100		PT c̄ Continued desaturation on 100% NRB. O_2 SATS ↓ 70's when pt OOB in Chair. Pt returned to bed c̄ intubated. IV D5 1/2 NS c̄ 20 KCL @ 75 cc/hr. Versed gtt @ 2 mg/hr. Fentanyl gtt @ 100 mcg/hr c̄ Vecuronium @ 4 mg/hr. See flowsheet for assessment [redacted] LCT, AN
4 OCT 03		1300	DESATS 70-80's despite suctioning c̄ BVM. Dr [redacted] @ BS. ABG's sent. ↑ RR to 16. X-ray ordered. [redacted] LL, AN
4 Oct 03		1500	CXR showed RUL pneumo → CT inserted per (D). [redacted] (+) rush of air on insertion and ~100 cc serosang drainage. CT → pleur Evac @ -20 cc H_2O suction. Pt on vec, fentanyl, and versed drips. ETT → SIMV 16, F_iO_2 100%, P-10 V_T-550 cc. ETT suctioned for min secretions. Coarse rhonchi throughout all lung fields. SpO_2 remains mid-upper 80's. Pt rolled to (L) side. Lasix 20 mg IV given. Midline incision c̄ staples intact; Ø S/Sx infection or evisceration. LLQ and (L) hip drg c̄ mod amt serous drainage. [redacted] AN
4 Oct 03		2130	Pt cont c̄ ↓ SpO_2 → lower 80's @ 2000. Fentanyl 150 µg, Vec 5 mg + Versed 5 mg IVP given. ETT suctioned for min white secretions. Dr. Choi notified. CXR done → (L) pleural effusion → (L) CT inserted → -20 cm H_2O suction.

See progress note for continuation (attached) [redacted]

	INTAKE									OUTPUT						
	DS/NS/D5W/RL	Infusion/NPB	Versed	Vecuronium	Fentanyl	Heparin			Total	Urine #1	chest tube #1	NG tube	Chest tube #2		Total	COMMENTS
0100	125 / 125									100 / 100						
0200	125 / 250									110 / 120						
0300	125 / 375															
0400	125 / 500									170 / 290						
0500	125 / 625									110 / 400						
0600	125 / 750	100 / 100								120 / 520						
0700	125 / 875									135 / 655						
0800	125 / 1000									160 / 815						
8 HR	1000	100							8 HR. 1100	815					8 HR 815	(+) 285
0900	75 / 75									145 / 145						
1000	75 / 150														LASIX	
1100	75 / 225															
1200	75 / 300		2 / 2	4 / 4	2 / 2					1190 / 1335						
1300	75 / 375	100 / 100	2 / 4	4 / 8	2 / 4					180 / 1515						
1400	75 / 450		2 / 6	4 / 12	2 / 6							100 / 100				
1500	75 / 525	100 / 200	3 / 9	4 / 16	2 / 8	10 / 10				300 / 1815	105 / 105					
1600	75 / 600		3 / 12	5 / 21	3 / 11	25 / 35				750 / 2565	0 / 105					
8 HR	600	200	12	21	11	35		879	16 HR. 1979	2565	105	100		2670	16 HR. 3485	-691 (5)(6)(2) [redacted] ~~-1506~~
1700	75 / 75		3 / 3	5 / 5	3 / 3	25 / 25				425 / 425	15 / 15					
1800	75 / 150		5 / 8	5 / 10	3 / 6	25 / 50				120 / 545	20 / 35	100 / 100				
1900	75 / 225		5 / 13	5 / 15	3 / 9	25 / 75				120 / 665	20 / 55					
2000	75 / 300		5 / 18	5 / 20	3 / 12	20 / 95				160 / 825	10 / 65		45 / 95			
2100	75 / 375		5 / 23	5 / 25	3 / 15	30 / 125				160 / 985	10 / 65		45 / 140			
2200	75 / 450		5 / 28	5 / 30	3 / 18	30 / 155				180 / 1165						
2300	75 / 525	50 / 50	5 / 33	5 / 35	3 / 21	30 / 185				900 / 2065						
2400	75 / 600	50 / 100	5 / 38	5 / 40	3 / 24	30 / 215				350 / 3925						-1234 (5)(6)(2) [redacted] ~~-1234~~
8 HR	600	100	38	40	24	215		107	24 HR. 2996	3925	65	100	140	4230	24 HR 7715	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 oct 03
DOS	3 oct 03
POD	2

(b)(6)(2) (b)(6)(2)

24 HOUR DATA	
24 Hour Balance	~~(-4719)~~ 217
24 Hour Intake	~~2996~~ 2988
24 Hour Output	~~7715~~ 2771
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	MAT IAN
(b)(6)-2	LCT, AN
(b)(6)-2	MAN
(b)(6)-2	CPT AN

(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	N/A	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAT IAN	ICU	5 oct 03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2				2		
	RADIAL L		2				2					2			2				2				2		
	DORSALIS PEDIS R		1				1					1			1				1				1		
	DORSALIS PEDIS L		2				2					1			1				1				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA			gen.				gen					gen			gen				gen				gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓				✓					✓			S1S2				S1S2				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST				✓					✓			NSR				NSR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓								✓				✓				✓		
HYGIENE	BED BATH				✓							✓													
	FOLEY CARE				✓							✓							✓						
	ORAL CARE											✓							✓						
MOBILITY	BEDREST				✓		✓					✓											✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																					✓	✓		
	LEFT		✓														✓								
	SUPINE				✓		✓					✓			✓				✓				✓	✓	
	HOB 30 DEGREES		✓		✓		✓					✓			✓		✓		✓				✓	✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		UTA				UTA					UTA			Pent				Pent				Pent		
	PAIN SCALE (1-10)														gtt				gtt						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		1				2					2			2				2				2		
													✓												
BOWEL SOUNDS (active all quads)			Ø				–	✓				✓			Hypo				Hypo				Hypo		
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓								✓										
RESIDUAL ASSESSED	L15																						✓		
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓					✓													
SKIN INTEGRITY	No Breakdown																								
(R) hip	Surgical Wounds		✓				✓					✓			✓				✓				✓		
ABD	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD (STAPLES)			✓		OPA		✓					✓			✓				✓				✓		
#2 (L) thigh			✓		✓		✓					✓			✓				✓				✓		
#3 CT #1					✓		✓					✓			✓				✓				✓		
CT #2					✓		✓					✓			✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
14 ga	(R) AC	3 oct 03	A'd 5 oct Patent ∅ s/sx of infection or infiltration
16 ga	(L) AC	3 oct 03	A'd 5 oct Patent ∅ s/sx of infection or infiltration
chest tube	(R)	4 oct 03	A'd 5 oct Patent ∅ AIR LEAK
chest tube	(L)	4 oct 03	✓ CDI Patent ∅ AIR LEAK

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 5 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		1				1					1			1				1				2		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		T				1 T					1 T			ETT				ETT				T		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		1				1					1			1				1				1		
GLASCOW COMA SCALE (A+B+C)		2T				3T					3T			2T				2T				3T		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+				2+					2+			2+				2+				2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+				2+					2+			2+				2+				2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		Paralyzed				IMMOBILIZED SEDATED					Paralyzed Pelvic			Paralyzed				Paralyzed				Chronic Paralyzed		
MOVEMENT — LUE																								
MOVEMENT — RLE																								
MOVEMENT — LLE																								
GRIP (S) Strong (W) Weak (-) absent — R																								
GRIP — L																								
RESPIRATIONS — REGULAR																								
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		VENT				VENT					VENT			VENT				VENT				VENT		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		3/2				3/2					3			3/2				3/2				3		
BREATH SOUNDS — LUL		3/2				3/2					3			3/2				3/2				3		
BREATH SOUNDS — RLL		3/2				3/2					3			3				3/2				3		
BREATH SOUNDS — LLL		3/2				3/2					3			3/2				3/2				3		
BREATH SOUNDS — BOTH BASES		3/2				1					1			1				1				1		
COUGH — NONE		✓				✓					✓			✓				✓				✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt		550				550					600			600	600		600	600				600		
VENTILATOR — FiO2		1.0				100					80			60	50		40	50				50		
VENTILATOR — RATE (SIMV/CMV)		17				17					17			17	17		17	17				17		
VENTILATOR — ~~PEEP/ CPAP~~		+10				10					10			10	10		10	10				10		
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # 7.5 — NRBM (l/min)																								
ETT 22 cm gums						✓					✓			✓			✓					✓		
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED						✓					✓							✓		✓				
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS		(b)(6)-2				(b)(6)-2					(b)(6)-2			(b)(6)-2			(b)(6)-2			(b)(6)-2				

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.2	109	21/17		98%	125/62	88										
0200		105	20/17		100%	117/63	81										
0300		101	18/17		100%	119/62	80										
0400	98.8	97	17/17		100%	107/56	73										
0500		93	17/17		100%	105/55	72										
0600	100.5 (A)	94	17/17		100%	103/54	68										
0700	99.4 (A)	89	17/17		100%	102/53	68										
0800	99.7 (A)	90	17/17		100%	115/60	77										
0900	99.4 (A)	88	17/17		100%	97/53	67										
1000	98.9 (A)	90	17/17		100%	96/51	65										
1100	97.5 (A)	89	17/17		100%	104/54	70										
						~~114/60~~	~~7~~										
1200	99.5 (A)	97	17/17		99%	114/60	77										
1300	98.5 (A)	100	17/17		98%	128/63	83										
1400	98.6 (A)	94	17/17	105/50	100%	101/52	67										
1500	99.3 (A)	94	17/17		98%	99/52	65										↓Fentanyl to 100mg/hr
															↓FiO2 50%		↓Versed to 2mg/hr
1600	99.4 (A)	95	17/17		99%	96/51	65										
1700	99.9 (A)	116	17/17		96%	131/71	92										40% FiO2
1800	100.1 (A)	103	17/17		94%	114/60	77										
1900	100.1 (A)	96	17/17		97%	112/59	76										
2000	99.5	92	17/17		96%	106/56	72										
2100	99.7 (A)	107	21/17		100%	123/71	88										
2200	99.5 A	105	17/17		96	136/74	92										↑Versed 3mg
2300	99.9	96	17/17		97	114/72											
2400		92	17/17		98	122/70	85										

	INTAKE									OUTPUT						
	D5NS c 20K	IVPB	Vecuronium	Fentanyl	Versed	A-line flush	Kcl		Total	Urine	NGT	CT #1	CT #2		Total	COMMENTS
0100	75 / 75	50 / 50	5 / 5	3 / 3	5 / 5	3 / 3				190 / 190						
0200	75 / 150		5 / 10	3 / 6	5 / 10	3 / 6				100 / 290						
0300	75 / 225		5 / 15	3 / 9	5 / 15	3 / 9				80 / 370						
0400	75 / 300		5 / 20	3 / 12	5 / 20	3 / 12				40 / 410						
0500	75 / 375		5 / 25	3 / 15	5 / 25	3 / 15				100 / 510	ø	20	45			
0600	75 / 450	50 / 100	5 / 30	3 / 18	5 / 30	3 / 18				100 / 610						
0700	75 / 525	100 / 200	5 / 35	3 / 21	5 / 35	3 / 21				85 / 695						
0800	75 / 600		5 / 40	3 / 24	5 / 40	3 / 24				215 / 910						
8 HR	600	200	40	24	40	24			8 HR 928	910		20	45		8 HR 975	-47
0900	75 / 75		5 / 5	3 / 3	5 / 5	3 / 3				500 / 500						
1000	75 / 150		5 / 10	3 / 6	5 / 10	3 / 6				80 / 580						
1100	75 / 225		4 / 14	3 / 9	4 / 14	3 / 9				65 / 645						
1200	75 / 300	100 / 100	4 / 18	3 / 12	4 / 18	3 / 12				60 / 705						
1300	75 / 375		4 / 22	3 / 15	4 / 22	3 / 12				70 / 775		40 / 40	160 / 160			
1400	75 / 450		4 / 26	3 / 18	4 / 26	3 / 15				55 / 830						
1500	75 / 525	100 / 200	4 / 30	2 / 20	4 / 30	3 / 18				55 / 885						
1600	75 / 600		4 / 34	2 / 22	4 / 34	3 / 21			909	50 / 935					1135	
8 HR	600	200	34	22	34	21			16 HR 1837	935		40	160		16 HR 2110	-273
1700	75 / 75		4 / 4	1 / 1	2 / 2	3 / 3				55 / 55						
1800	75 / 150	100 / 100	5 / 9	2 / 3	3 / 5	3 / 6				60 / 115						
1900	75		5 / 14	2 / 5	3 / 8	3 / 9	100 / 100			50 / 165						
2000			5 / 19	2 / 7	3 / 11	3 / 12	100 / 200			45 / 210						
2100			5 / 24	2 / 9	3 / 14	3 / 15	100 / 300			70 / 280		6 / 6	30 / 190			
2200			5 / 29	2 / 11	3 / 17	3 / 18	100 / 400						30			
2300		100 / 200	5 / 34	2 / 13	3 / 20	3 / 21	100 / 500			100 / 400						
2400		100 / 300	5 / 39	2 / 15	3 / 23	3 / 24	100 / 600			65 / 465						
8 HR	150	300	39	15	23	24	600	1151	24 HR 2988	465		6	190		24 HR 2771	+217

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Oct 03	2400		Pt stable, ∅Δ in subq emphysema, CT ∅ air leak noted, O2 sats continue to improve. [redacted] LAT, AN
	0200		No Δ, O2 sats good, see flowsheet for assessment [redacted]
	0400		AM completed. Ⓑ CT dsg Δ'd - old dsg non adherent. Ⓛ hip dsg Δ'd, old packing ī sero sang drainage noted. Pt now awake, resting stable. [redacted] LAT, AN
5 OCT 03	0600		NAD. VERSED 5mg/hr, VECURONIUM 5mg/hr & Fentanyl @ 150mcg/hr. D5NS ī 20meq KCl @ 75cc/hr. Pt ī SQ Emphysema to Clavicular & cervical area. VSS. Pt not breathing over Vent Set Rate. Will con't to monitor. [redacted] LCT, AN
5 OCT 03	0734		F_iO_2 ↓ 90% O_2 SAT 100% — [redacted] LCT, AN
5 OCT 03	0930		F_iO_2 ↓ 80% O_2 SAT 100%. VSS. [redacted] MINIMAL Sero-Sanguinous drainage From Ⓑ CT [redacted] LCT, AN
5 OCT 03	1025		↓ Versed to 4mg/hr & VECURONIUM to 4mg/hr to ↑ BP. NAD NOTED VSS — [redacted] LCT, AN
5 OCT 03	1130		↓ F_iO_2 70%. SATS 100%. VSS [redacted] LCT, AN
5 OCT 03		1230	↓ F_iO_2 60%. SATS 97-99%. PT CONTINUES TO NOT Breath over set rate. CT Ⓑ ī SMALL amount of Serous Sanguinous drainage. VSS [redacted] LCT, AN
5 OCT 03		1430	Assessment complete. Subq emphysema present and inspiratory wheeze to Ⓑ lung fields & air leak present in CT Ⓑ. Pt paralyzed sufficiently - not overbreathing vent. Ø drainage on dressings to Ⓑ lg or chest tube sights. Sats 98-100% on 60% F_iO_2. Eye drops to eyes Ⓑ for lubrication [redacted] LCT, AN
		1500	↓ F_iO_2 to 50% SaO_2 99% ↓ Versed to 2mg/hr for [redacted] ↓ BP Fentanyl ↓ @ 1430 to 100 mcg/hr — [redacted] AN
		1700	↓ F_iO_2 to 40% pt positioned on Ⓑ side. Sats 96% [redacted] MO
		1800	↑ F_iO_2 to 50% Sats 93-95% on 40% F_iO_2. Pt rolled to back and suctioned. Ø Sputum suctioned. [redacted] MO
		1815	Pt lung sounds more diminished than previous assessment. Sats not improving much on 50% F_iO_2 94-95%. Dressing to LLQ and Ⓑ thigh changed @ 1600. Drainage drsg on LLQ and drsg. Minimal drng. on Ⓑ thigh drsg. Pt temp ↑ [redacted] AN

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2				2			2				2				2		
	RADIAL L		2					2				2			2				2				2		
	DORSALIS PEDIS R		1					2				2			2				2				2		
	DORSALIS PEDIS L		2					2				2			2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8				1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA			Gen					Gen				Gen			Gen				Gen				→		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓				✓			✓				✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					✓				ST			ST				ST				→		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)															✓								✓		
HYGIENE	BED BATH										✓														
	FOLEY CARE		✓								✓														
	ORAL CARE										✓								✓				✓		
MOBILITY	BEDREST		✓					✓				✓			✓				✓				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT														✓										
	LEFT		✓															✓							
	SUPINE							✓				✓				✓		✓			✓				
	HOB 30 DEGREES		✓					✓				✓			✓			✓			✓		✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		LOA					UA				UA			gtt				GTT				✗		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2				2			2				2				2		
BOWEL SOUNDS (active all quads)			Hypo					Hypo				Hypo			Hypo				hypo				→		
NG / DOBHOFF PLACEMENT VERIFIED			✓					✓						✓	✓				✓				✓		
RESIDUAL ASSESSED	L15		✓												✓				✓						
Ph																									
FOLEY CATHETER PATENT			✓					✓				✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
(R) Hip	Surgical Wounds		✓					✓				✓			✓				✓				✓		
Abd	Rashes, Lac's, etc														✓				✓						
DRESSING (Dry & Intact: specify site below)																									
#1 Abd staples			✓					✓				✓			✓				✓				✓		
#2 CT #1			✓					✓				✓			✓				✓				✓		
#3 CT #2			✓					✓				✓			✓				✓				✓		
(R) Thigh			✓					✓				✓			✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
14 ga	(R) AC	30 Oct 03	Patent ∅ S/Sx of infection/infiltration/0700
16 ga	(L) AC	30 Oct 03	Patent ∅ S/Sx of infection/infiltration/0700
Chest tube	(R)	4 Oct 03	Patent ∅ air leak 0700
Chest tube	(L)	4 Oct 03	Patent ∅ air leak 0700
NGT	(R) NARE	2 Oct 03	Patent to suction
18g	(L) hand	6 Oct 03	

D/C'd 1900 6 Oct

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 Oct 03
DOS	3 Oct 03
POD	3

24 HOUR DATA	
24 Hour Balance	(b)(6)-2 ~~+277~~ -1261
24 Hour Intake	(b)(6)-2 ~~2985~~ 2596
24 Hour Output	(b)(6)-2 ~~2777~~ 3857
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 LCT, AN	
(b)(6)-2 LCT/AN	
(b)(6)-2 Hwm2, SPC	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N	N	N
Call Light Within Reach	A	A	A
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CPT AN	ICU	6 Oct 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 6 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		1					1				1			1				1				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		E T T					1 T				1 T			1 (T)				1 (T)				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		Posturing					1				1			1				1				1		
GLASCOW COMA SCALE (A+B+C)		2T					3T				3T			3T				3T				3		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+					2+				2+			2+				2+				2		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+					2+				2+			2+				2+				2		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		P					P				S			P S				B				✱		
MOVEMENT — LUE		P					P				S			P S				E						
MOVEMENT — RLE		P					P				S			P S				D						
MOVEMENT — LLE		P					P				S			P S				A						
GRIP (S) Strong (W) Weak (-) absent — R																		E						
GRIP — L														NA				NA				✱		
RESPIRATIONS — REGULAR		V					V				V			V				V				V		
RESPIRATIONS — IRREGULAR		V					V				V			V				V				V		
RESPIRATIONS — UNLABORED		V					V				V			V				V				V		
RESPIRATIONS — LABORED		T					T				T			E				E				E		
RESPIRATIONS — SHALLOW							T							N				N				N		
RESPIRATIONS — RETRACTIONS														T				T				T		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		3					3				3			3				3				2		
BREATH SOUNDS — LUL		3					3/2				3/2			3/2 EX				3/2				2		
BREATH SOUNDS — RLL		3					3				3			3/2 EX				3/2				2		
BREATH SOUNDS — LLL		3					3/2				3/2			3/2 EX				3/2				2		
BREATH SOUNDS — BOTH BASES		1					1				1			3/2 EX				1				2		
COUGH — NONE		✓					✓				✓			✓				✓				✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt		600					600				600			600				600				600		
VENTILATOR — FIO2		50%					50				40			45%				45%				45		
VENTILATOR — RATE (SIMV/CMV)		17					12				15			15				15				15		
VENTILATOR — PEEP / CPAP		10					10				0			8				8				0		
VENTILATOR — PRESS. SUPPORT		—																						
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # 7.5 — NRBM (l/min)																								
ETT 22 cm gums		✓					✓				✓			✓				✓				✓		
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH		✓																						
INITIALS		(b)(6)-2					(b)(6)-2				(b)(6)-2			(b)(6)-2				(b)(6)-2				(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	97.8 A	119	17/17	154/83	99	151/83	89										
0200		97	17/17		99	127/60	79										
0300	97.9 A	102	17/17		100	142/75	96										
0400		106	17/17		100	134/71	82										
0500	98.9	98	17/17		97	115/61	78										
0600	98.5 (A)	91	17/17		98	97/49	61										
0700		99	17/17		98%	126/63	85										
0800	98.7 (A)	112	17/17	129/71	96%	141/76	100										
0900	98.7 (A)	113	31	141/70	96%	140/71	95										
1000		115	37	126/59	92%	126/65	84										
1100	99 (A)	118	53*	141/69	83*	139/71	96										
1200	100.0 (A)	109	15	136/68	92	122/72	91	FiO_2 60%									
1300	99.3 (A)	117	15		91*	143/81	104										
1400	99.7 (A)	110	16/15	137/66	94	132/75	97	FiO_2 45%									
1500	100.1 (A)	110	15/15		94	134/76	98										ABG
1600	99.4 (A)	94	16/15		96	119/67	82										
1700	99.3 (A)	107	15/15		96	141/80	109										
1800	99.4 (A)	97	15/15	137/73	95	138/74	96										
1900	99.3 (A)	86	15/15		98	125/61	81										
2000	99.6 (A)	103	15/15		98	154/78	98										
2100		102	15/15		98	152/81	102										
2200	97.8	97	15/15		99%	155/82	110										
2300	99%	102	15/15		99%	149/80	104										
2400	99%	82	15/15		99%	147/71	90										

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
6 Oct 03	0200		Placed on (R) side. VS remain stable. Ø signs of distress. F_iO_2 remains at 50%. O_2 Sat 99%. Cont. to monitor [(b)(6)-2] cpt.bw
6 Oct 03	0430		Placed supine. Dressings changed. VSS. O_2 Sat 99%. Ø apparent distress. CT's x2 min drainage. Ø drainage from NGT. [(b)(6)-2] cpt.bw
6 OCT 03	0630		Pt c̄ systolics in 90's; Diastolic in 40's. ↓ Versed to 2mg hr. NIBP 100's/40's. CT (B) c̄ minimal Serous Sanguinous drainage. See flowsheet for assessment. [(b)(6)-2] ILT, [illegible]
6 OCT 03	0700		BP 120-130's/50-60's ↑ Versed 3mg/hr. [(b)(6)-2] ILT, [illegible]
6 OCT 03	1130 ~~0930~~		INFORMED BY RT PEEP is @ Ø. Informed Dr [(b)(6)-2]. PEEP placed on 8. Pt bucking vent c̄ ↑ RR 40-50's. DESAT into 70's-80's. Bolused c̄ approximately 20mg Versed in 5mg increments over 30 mins. Pt Sectional & F_iO_2 ↑ 100%. SATS ↑ 95-97% RR ↓ 20's. Attempted to wean down F_iO_2 c̄ resultant ↓ O_2 Sats ↑ 80's. F_iO_2 placed on 60%. O_2 SATS 90-93%. Dr [(b)(6)-2] informed. Placed on Vecuronium gtt @ 5mg/hr p̄ 5mg bolus. Will con't to monitor & ↓ F_iO_2 [(b)(6)-2], ILT, [illegible]
6 OCT 03		1300	VS: HR 45%. Sats ↓ 88-89% @ 40% F_iO_2. Unable to start I.V. p̄ 6 attempts. Dr [(b)(6)-2] aware. Fentanyl @ 100mcg hr Versed @ 3mg/hr & Vecuronium @ 5mg/hr. VSS. [(b)(6)-2], ILT, [illegible]
6 OCT 03		1400	Assumed care. See flowsheet for details. Pt on (R) side. Ø skin breakdown noted. Pt paralyzed & sedated, c̄ no evidence of pain/discomfort. VSS. Low grade fever. adequate UOP - clear yellow. Minimal NGT output on LIS from (R) nare. No air leaks noted in chest tube #1 or #2. Drsg to LLQ L thigh CDI. Staples on midline incision c̄ S/S of infection - No drainage noted. Will continue to monitor [(b)(6)-2] [illegible]
		1530	Drsg Δ to LLQ (L) thigh completed. Moderate drainage (serous) noted to LLQ drsg. No evidence of infection. Minimal Serous drainage noted to L thigh [(b)(6)-2] [illegible]

	INTAKE									OUTPUT						
	D5½NS 2 boles	IVPB	Vecuronium	Fentanyl	Versed	A-line flush	KCl	NS Flush	Total	Urine	NGT	CT #1	CT #2		Total	COMMENTS
0100			5 / 5	2 / 2	3 / 3	3 / 3	100 / 160			70 / 70						
0200			5 / 10	2 / 4	3 / 6	3 / 6	100 / 260			75 / 145						
0300			5 / 15	2 / 6	3 / 9	3 / 9	100 / 360			90 / 235						
0400			5 / 20	2 / 8	3 / 12	3 / 12	100 / 460			80 / 315						
0500			5 / 25	2 / 10	3 / 15	3 / 15	100 / 560			70 / 385	Ø / Ø	Ø / Ø	15 / 15			
0600	75 / 75	100 / 100	5 / 30	2 / 12	3 / 18	3 / 18	Ø			60 / 445						
0700	75 / 150		5 / 35	2 / 14	2 / 20	3 / 21				120 / 565						
0800	75 / 225	100 / 200	5 / 40	2 / 16	3 / 23	3 / 24	t	10 / 10		200 / 765						
8 HR	225	200	40	16	23	24	500	10	8 HR 1038	765					8 HR 765	+ 273
0900	75 / 75		5 / 5	2 / 2	3 / 3	3 / 3				200 / 200						
1000	75 / 150		5 / 10	2 / 6	8 / 11	3 / 6				175 / 375						
1100	75 / 225			2 / 8	7 / 18	3 / 9				110 / 485						
1200	75 / 300	100 / 100	10 / 10	4 / 12	20 / 38	3 / 12		10 / 10		90 / 575		32 / 32	40 / 40			
1300	75 / 375		5 / 15	2 / 14	3 / 41	3 / 15				85 / 660	25 / 25	↓	↓			
1400	75 / 450		5 / 20	2 / 16	3 / 44	3 / 18				140 / 800						
1500	75 / 525		5 / 25	2 / 18	3 / 47	3 / 21				80 / 880						
1600	75 / 600	50 / 150	5 / 30	2 / 20	3 / 50	3 / 24				100 / 980						
8 HR	600	150	30	20	50	24			16 HR 874	980	25	32	40		16 HR 1077	− 203
1700	75 / 75		5 / 5	2 / 2	3 / 3	3 / 3		10 / 10		80 / 80						
1800	75 / 150	100 / 100	5 / 10	2 / 4	3 / 6	3 / 6		20 / 30		110 / 190						
1900	75 / 225		5 / 15	2 / 6	3 / 9	3 / 9		10 / 40		100 / 290						
2000	75 / 300		5 / 20	2 / 8	3 / 12	3 / 12				100 / 390	450 / 450	35 / 35	20 / 20			
2100	75 / 375		5 / 25	2 / 10	3 / 15	3 / 15				160 / 550	↓	↓	↓			
2200	75 / 450		5 / 30	2 / 12	3 / 18	3 / 18				60 / 610	300 / 750	Ø / 35	Ø / 20			
2300	75 / 525	100 / 200	5 / 35	2 / 14	3 / 21	3 / 21				100 / 710	100 / 850	Ø / 35	Ø / 20			
2400	75 / 600	100 / 300	5 / 40	2 / 16	3 / 24	3 / 24		40		200 / 910	200 / 1050	Ø / 35	Ø / 20			
8 HR	600	300	40	16	24	24		40	24 HR (b)(6)-2 ~~100~~ 1044	910	1050	35	20		24 HR 2015	~~+ 101~~ − 971

(b)(6)-2

(b)(6)-2

24 − 971

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2				2			2				2				—		
	RADIAL L		2					2				2			2				2				—		
	DORSALIS PEDIS R		1					1				1			1				1				—		
	DORSALIS PEDIS L		2					2				2			2				2				—		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1					1				1			1				1				—		
			3					3				3			3				3				—		
			8					8				8			8				8				—		
EDEMA			*					gen				gen			Gen non pitting				gen				—		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓				✓													
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR					SR ST				SR			ST				SR ST				—		
SWAN GANZ CATHETER (Zeroed & calibrated)								✓																	
ARTERIAL LINE (zeroed & calibrated)			✓					✓							✓				✓				—		
HYGIENE	BED BATH																								
	FOLEY CARE		✓																						
	ORAL CARE																								
MOBILITY	BEDREST		✓					✓				✓			✓				✓				—		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		✓																	✓					
	LEFT																	✓	✓						
	SUPINE							✓				✓			✓								✓		
	HOB 30 DEGREES							✓				✓			✓			✓	✓	✓			✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		UTA					UTA				UTA			UTA				UTA				—		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2				2			2				2				2		
BOWEL SOUNDS (active all quads)			(+)					(−)				(−)			(−)				(−)				—		
NG / DOBHOFF PLACEMENT VERIFIED															✓				✓				—		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓					✓				✓			✓				✓				—		
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓				✓			✓				✓				—		
SKIN INTEGRITY	No Breakdown		✓					✓				✓													
midline incision	Surgical Wounds		✓					✓				✓			✓				✓				—		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) lower abd			✓					✓				✓			✓				✓				—		
#2 (L) upper thigh detered			✓					✓				✓			✓				✓				—		
#3 CT1 (R) chest								✓				✓			✓				✓				—		
#4 CT2 (L) chest								✓				✓			✓				✓				—		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
~~arterial~~ A-line	(R) radial		CDI 10700
20 gauge	(R) AC		Patent S/Sx of infection or infiltration 10700
18 gauge	(L) AC		Patent S/Sx of infection or infiltration 0700
NGT	(R) NARE		
PIV 18g	(R) wrist	10/7/03	Patent S/Sx of infection or infiltration
PIV 18g	(R) wrist	10/7/03	Patent S/Sx of infection or infiltration
PIV 18g	(R) wrist	7 Oct 03	Saline lock appears patent.

CRITICAL CARE FLOW SHEET

(b)(6)-4

LOS DATA	
DOA	03 OCT 03
DOS	03 OCT 03
POD	3

24 HOUR DATA	
24 Hour Balance	-997.5
24 Hour Intake	3737.5
24 Hour Output	4735
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 CPN	(b)(6)-2
(b)(6)-2 LCT AN	
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	N/A	
Side Rails Up			
Bed in Low Position		(b)(6)-2	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CDR	ICU2	07 OCT 03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		81	15/15	114/83	98%		88										
0200	99.5° (A) 100A	97	24/15	128/[illegible]	100%	128/72	93										VENT
0300	99° (A) 99A	90	23/15	/	98%	112/60	75										VENT
0400	99.2° (A) 100A	94	18/15	/	99%	155/74	94										VENT
0500	99.7° (A) 99A	94	19/15	/	97%	121/62	78										VENT
0600	100° (A)	101	23/15	137/69	98%	137/74	95										
0700		104	15/15	140/74	97%	165/87	112										
0800	99.3° (A)	94	22/15	137/65	96%	154/75	98										
0900		94	20/15	118/54	96%	123/63	82										
1000	99.4° (A)	82	16/16	122/61	97%	122/67	83										
1100		90	18/16	116/61	97%	119/65	81										
1200	100° (A)	111	23/16	122/57	98%	127/68	86										
1300	101°	114	33/16	122/58	89%	126/67	85										
1400	101° (A)	119	25/25	105/54	92	108/58	73										
1500	101.6° (A)	111	25/25	102/54	94	111/62	76										
1600	101° (A)	103	25/25	107/57	94	102/56	70										
1700	100.3° (A)	99	25/25	119/63	99	119/68	84										
1800	100° (A)	100	25/25	110/62	97	110/64	78										
1900	100.5° (A)	100	23/23	118/66	97	111/68	82										
2000	100° (A)	107	36/20	122/82	88	124/81	95										
2100	98.2° (A)	106	38/20	123/76	92	131/83	98										
2200	97.8	111	42/20	125/82	98		102										
2300		95	19	/	95%	85/44											
2330						134/72											
2400	98.5	104	20		97%	163/92	113										

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 7 OCT 03

TIME	03	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		1					1				1			1			2	2				–		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		1					1 / T				1			1			T	T				–		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		1					1 / 2				1 / T			4			4	4				–		
GLASCOW COMA SCALE (A+B+C)		7*					3T				3T			6			T	T				–		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R							2+				2+			2+										
L							2+				2+			2+										
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		P					1				1			1			1	2				–		
LUE		3					1				1			1			2	2				–		
RLE		6					1				1			1			1	2				–		
LLE		M					1				1			1			2	2						
GRIP (S) Strong (W) Weak (-) absent — R		AP												UTA				UTA				–		
L														UTA				UTA				–		
RESPIRATIONS — REGULAR																								
IRREGULAR																								
UNLABORED		*					X				X			V				X						
LABORED														E										
SHALLOW							on				on			N				on				on		
RETRACTIONS														T										
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		3					3/2				3		3	3				3				–		
LUL		3					3/2				3		3	3				2				–		
RLL		3					3				3		3	2				3				–		
LLL		3					3				3		3	2				2				–		
BOTH BASES		✓					1				1		✓	2				3				–		
COUGH — NONE		✓					✓				✓		✓	✓				✓				✓		
SPONTANEOUS																								
PRODUCTIVE																								
NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear														Ø										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt		600					600				600			600			600	600	600	600	600			
FiO2		45%					40				40			0.60			0.60	.60	.5	.45	.60			
RATE (SIMV/CMV)		15					15				16			25			25	25	23	20	20			
PEEP / CPAP		8					8				6			6			6	6	6	6	6			
PRESS. SUPPORT		–												Ø →										
OXYGEN DELIVERY DEVICE — NC (l/min)																								
FM (l/min)																								
ETT # 7.5 — NRBM (l/min)																								
ETT 22 cm gums							✓				✓			✓			✓	✓						
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED							✓						✓	✓			✓	✓						
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS		(b)(6)-2					(b)(6)-2				(b)(6)-2		(b)(6)-2				(b)(6)-2				(b)(6)-2			

	INTAKE									OUTPUT						
	D5NS20KCL	versed	Fentanyl	VCC	IVPB	A-Line	ATIVAN	CR	Total	Urine	NG	Chest #1	Chest #2		Total	COMMENTS
0100	75/75	3/3	2/2	5/5	100/100	3/3				45/45	Ø/Ø	Ø/Ø	Ø/Ø			
0200	75/150	3/6	2/4	5/10	Ø/100	3/6				100/145	Ø/Ø	Ø/Ø	Ø/Ø			
0300	75/225	3/9	3/7	6/16	—/100	3/9				90/235	—/Ø	—/Ø	—/Ø			
0400	75/300	3/12	3/10	6/22	—/100	3/12				90/325	—/Ø	—/Ø	—/Ø			
0500	75/375	4/16	3/13	7/29	—/100	3/15				135/440	—/Ø	—/Ø	10/10			
0600	75/450	4/20	3/16	7/26		3/18				125/565						
0700	75/525	7/27	3/19	7/33	100/200	3/21				180/745						
0800	75/600	7/34	3/22	3.5/36.5	100/300	3/24				135/880						
8 HR	600	34	22	36.5	300	24			8 HR 1016.5	880					8 HR 880	136.5
0900	75/75	7/7	4/4	0/0		3/3				140/140						
1000	75/150	7/14	4/8			3/6				125/265						
1100	75/225	7/21	4/12			3/9				200/465						
1200	75/300	7/28	6/18		100/100	3/12				255/720						
1300	75/375	17/45	6/24			3/15				200/920	400/400	15/15	20/20			
1400	15/450	22/67	8/26			3/18				250/1170						
1500	50/500	13/80	5/31		100/200	3/21	1/1			140/1310						
1600	50/550	8/88	5/36			3/24	2/3			140/1450		15/30	15/35			
8 HR	550	88	36		200	24	3 901		16 HR 1917.5	1450	400	30	35	1915	16 HR 2795	-877.5
1700	50/50	8/8	5/5			3/3	2/2			160/160		15/15	5/5			
1800	50/100	8/16	5/10		100/100	3/6	2/4			140/300						
1900	50/150	8/24	5/15			3/9	2/6			170/470						
2000	50/200	6/30	4/19			3/12	2/8			180/650						
2100	50/250	6/36	4/23		21/121	3/15	2/10			170/820						
2200	50/300	8/44	4/27			3/18	2/12			160/980	450/450	30/45	25/30			
2300	50/350	8/52	4/31	4/0	100/221	3/21		1000/1000		150/1130	75/525	25/70	Ø/Ø			
2400	50/400	8/60	4/35	0/4	100/321	3/24				160/1290	25/550	Ø/Ø	Ø/Ø			
8 HR	400	60	35	4	321			1000	24 HR 1820	1290	550	70	30		24 HR 1940	

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10/7/03	0745		NAD. VSS. ↑ VENT RR to 16. D/c'd Vecuronium gtt. Albuterol MDI given by RT d/t Expiratory wheezing. Fentanyl 150 mcg bolus IV & ↑ Fentanyl gtt to 200 mcg/hr. ↓ IVF to 75cc/hr. See flowsheet for assessment. [redacted] LVT, RN
10/7/03	0930		PEEP ↓ 6. VSS O_2 SATS > 95% [redacted] LVT, RN
10/7/03		1230	Pt agitated. Turning head side to side & pulling against restraints. Unable to verbally calm down. O_2 SATS ↓ Lows 80's. Bolused c̄ 10mg Versed & notified Dr [redacted] Pt bagged c̄ BV. SATS ↑ 100%. Placed back on vent & suctioned q̄ minimal secretions. Pt calm q̄ 10-15 mins [redacted] LVT RN
10/7/03		1200 ~~1230~~	(LATE ENTRY) IV's 18g started in (R) wrists. Patent & ∅ SX of infection or infiltration. (R) AC IV's D/c'd c̄ caths intact & ∅ S/SX of infection or infiltration [redacted] LVT, RN
10/7/03		1315	Pt once again agitated. Thrashing in bed. Bolused c̄ approximately 20mg Versed & 200mcg Fentanyl. BV d/t power outage. O_2 SATS >95%. PTD TO Ventilator 100% FiO_2. MDI given. Will continue to monitor [redacted] LVT, RN
7 Oct 03		1445	Ax temp 101. MD notified → Tylenol prn ordered. Tylenol supp 650mg ī PR given. [redacted] MAP RN
7 Oct 03		1530	ETT suctioned c̄ in-line catheter → ∅ secretions. [redacted] MAP RN
7 Oct 03		1630	LLQ and (L) hip drgs Δ'd. Small area of necrosis noted of inferior-medial subcutaneous tissue on LLQ wound. (L) hip/upper leg wound appears closed, ∅ drainage, left open to air. Pt opened eyes and withdrew to pain while packing abd wound. ETT suctioned for ∅ secretions. [redacted] MAP RN
7 Oct 03		1700	Physician ordered for maintenance IV D5 ½ NS c̄ 20 mEq KCl per liter @ 50cc/hr. Pharmacy is out of D5 ½ NS, pt. has D5NS + 20 KCl @ 50cc/hr hanging. MD is aware. [redacted] MAP RN
7 Oct 03		1845	Attempted to communicate c̄ pt using interpreter. Pt turned head towards voice and attempted to open eyes (con't on attached sheet) [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 OCT03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+10
24 Hour Intake	3669
24 Hour Output	-3659
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 ICU, Ar	
(b)(6)-2 MAW	
10/a	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N		
Call Light Within Reach		X	
Side Rails Up	A		
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	08OCT03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2				2		
	L		2				2					2			2				2				2		
	DORSALIS PEDIS R		2				1					2			2				1				2		
	L		Δ				2					2			2				2				Δ		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA			gen				gen					gen			gen				gen				gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				✓					✓			S.S2				S.S2				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR					ST			ST				SR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓			✓					✓				✓				✓		
HYGIENE	BED BATH									✓															
	FOLEY CARE		✓							✓									✓				✓		
	ORAL CARE									✓									✓						
MOBILITY	BEDREST		✓				✓					✓			✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT											✓			✓										
	LEFT																								
	SUPINE		✓				✓												✓				✓		
	HOB 30 DEGREES		✓				✓					✓			✓				✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		Δ				VSA					STA			Pent				Pent				Δ		
	PAIN SCALE (1-10)														gtt				gtt						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2					2			2				2				2		
BOWEL SOUNDS (active all quads)			low				Hyp					Hyp			Hyp				abs				Δ		
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓								✓				✓						
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓					✓											✓		
SKIN INTEGRITY	No Breakdown						✓					* ✓													
	Surgical Wounds		✓				✓								✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) thigh OTA			✓				✓					✓			✓				✓				✓		
#2 ABD Incision + staples OTA			✓				✓					✓			✓				✓				✓		
#3 Chest tubes #1 & #2 CDI			✓				✓					✓			✓				✓				✓		
(L) ABD CDI			✓				✓								✓				✓						

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
A-Line	(R) wrist		CDI /0600 / 1100 / 1800
18G vacc	(R) hand	7 OCT	CDI /0600 / 1100
18G vacc	(L) AC	7 OCT	CDI /0600 / 1100
NGT	(R) NARE	3 OCT	Patent /0600 / 1100 / 1800
Central TLC	(L) subclavian	8 OCT 03	Patent all 3 lumen CDI VSS infusing
18G PIV	(L) wrist	7 OCT 03	CDI 1800

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		102	20	159/86			114										
0200	98.3	104	18	162/90	97%		115										
0300		104	23	165/93	98%		119										
0400	98.2	102	19	158/88	97%		111										
0500		95	16	133/76	96%		95										
0600	100.3(A)	100	16/16		98%	152/85	106										
0700		89	16/20		95%	125/72	88										
0800	100.4(A)	90	10/16		96	127/73	90										
0900		86	16/16		95	129/72	91										
1000	99.9(A)	101	16/19		98%	149/78	101										
1100		109	16/16		97%	125/73	89										
1200		108	16/16		95%	120/74	89										
1300	99.3(A)	108	16/18		100%	100/65	78										
1400		110	35/18		96%	97/57	69										
1500	99.0(A)	105	16/16		94%	105/63	77										
1600		94	16/16	103/57	96%	102/56	75										
1700	99.8(A)	96	16/16		97%	107/63	78										
1800		101	16/16		98%	112/65	81										
1900	99.7(A)	99	14/14		98	110/66	81										
2000	100.8(A)	101	14/14		97	108/64	79										
2100	99.9(A)	113	21/14		98	115/67	80										RT TX
2200	101.5(A)	113	10/12		96	124/70	79										
2300	101.6	109	19/12	110/52	96	121/69	86										
2400	101.8	109	14/12	117/58	97	118/68	109										

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable./Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	6= Paralyzed & Sedated	No Change from Previous Assessment --

DATE: 8OCT03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			1				1					1			1				1				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			1				1 T					1 T			1 T				1 T				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			1				1					1			1				1				1		
GLASCOW COMA SCALE (A+B+C)			3T				3T					3T			3T				3T				*		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2				2+					2+			2+				2+				2+		
	L		2				2+					2+			2+				2+				2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		P				P S					6			6				6				6		
	LUE		A									6			6				6				6		
	RLE		5									6			6				6				6		
	LLE		4									6			6				6				6		
GRIP (S) Strong (W) Weak (-) absent	R		2				P S					6			6				6				6		
	L											6			6				6				6		
RESPIRATIONS	REGULAR		✓				V					X			V				V				V		
	IRREGULAR						e					e			e				E				e		
	UNLABORED		/				n					n			n				N				n		
	LABORED						T					T			T				T				T		
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		2				3/1					3			3/1				3/1				2/1		
	LUL		2				3					3/2			3/2				3/2				2/1		
	RLL		2				5					3			1				1				2/1		
	LLL		2				3					3			3				3				2/1		
	BOTH BASES		2				1					1			1				1				1		
COUGH	NONE		/				✓					✓			✓								✓		
	SPONTANEOUS																		✓						
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt		600				600					600			600		750		800			850			
	FIO2		100				50					100			90		60		60			50			
	RATE (SIMV/CMV)		12				16					16			16		16		14			12			
	PEEP / CPAP		8				8					8			10		10		10			10			
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 7.5	NRBM (l/min)																								
	ETT 22 cm gums											22			✓		✓		✓				✓		
ETT CARE / POSITION CHANGE												✓													
ETT / NT SUCTIONED										✓	✓														
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2				(b)(6)-2			(b)(6)-2					(b)(6)-2		(b)(6)-2		(b)(6)-2			(b)(6)-2			

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0200		Cont no movement as result of medication for paralysis (see MAR), vitals within normal limits IV sites to (L) AC, (R) hand; Art line to (R) wrist CDI, Incisions to ABD CDI, cont. suction to chest tubes, NG to LTS, vent continued c̄ resp therapie to assist (see MAR for settings) Foley draining clear yellow urine — [redacted]
10/8/03	0730		Temp 100.3 (A) Medicated c̄ Tylenol 650mg supp PR. D5NS @ 50 cc/hr. Fentanyl @ 200mcg/hr, Versed @ 6mg/hr & Vecuronium @ 7mg/hr. FiO_2 ↓ 40%. O_2 SATS ≥ 95%. (R) CT's c̄ minimal serosanguinous drainage @ site, no air leak. See flowsheet for assessment. — [redacted] ICT RN
10/8/03	1030		Bronchoscopy performed by Dr's [redacted] ~~Fentanyl~~ Thick brown secretions aspirated c̄ suction & copious amounts of NS lavages. Pt tolerated procedure well. FiO_2 kept @ 100% to allow pt to recover well. Cont to monitor & titrate ↓ FiO_2 appropriately. VSS. — [redacted], ICT, RN
10/8/03		1130	Pt c̄ break in skin in sacral area [redacted] (size). Area cleaned. Turned to (R) side. VSS. Will cont to monitor [redacted] CTRN
		1600	Current Adition Fent 200mcg/hr Versed 6mg/hr Vecuronium 7mg/hr. Vivonex fed @ 10cc/hr residual Vol was zero. KCl infusion @ 25cc/hr to TLC. Chest tube #2 secured dry. Chest tube #1 drains as well. — [redacted] RTAW
		1630	Pt turned to (L) side dressing ▷ complete [redacted] RTAW
		1800	Assumed care. Pt turned to supine @ 1855. Proper body alignment maintained. Will continue to monitor [redacted] RN
		1015	↓ FiO_2 to 50%, ↓ RR to 12 per Dr [redacted]
		2120	↑ Tvol to 850 per Dr [redacted]
		2200	~~No change from previous shift assessment~~, Tube feedings via NG cont. as ordered via NG tube, ventilation cont. as ordered, lung sounds diminished all lobes c̄ wheezing, IV fluids infusing via central line to (L) subclavian as ordered, HL to (L) wrist CDI, Art line zeroed to (R) wrist, Incision c̄ staples ARN DTA, Dressings to chest tube sites CDI. [illegible] lower ABD, CNT. Incision [illegible]

[redacted]

	INTAKE									OUTPUT						
	D5W 5:20 KCL	Fentanyl	Versed	Vecuronium	IVPB	Vionexe KCL			Total	Urine	NG	chest #1	chest #2	residual NGT	Total	COMMENTS
0100	50 / 50	4 / 4	4 / 4	4 / 4						100 / 100	200 / 200	Ø	Ø			
0200	50 / 100	4 / 8	4 / 8	4 / 8						100 / 200	Ø	Ø	Ø			
0300	50 / 150	4 / 12	4 / 12	4 / 12						140 / 340	Ø	Ø	Ø			
0400	50 / 200	4 / 16	4 / 16	4 / 16						100 / 440	100 / 300	Ø	Ø			
0500	50 / 250	4 / 20	4 / 20	4 / 20						160 / 600	100 / 400	5	Ø			
0600	50 / 300	4 / 24	4 / 24	4 / 24						125 / 725	~~400~~ / 400	0 / 5	0 / 0			
0700	50 / 350	6 / 30	4 / 28	9 / 31	100 / 100					105 / 830						
0800	50 / 400	8 / 38	6 / 34	7 / 38	100 / 200					120 / 950						
8 HR	400	38	34	38	200				8 HR 710	954	400	5	0		8 HR 1359	~~-649~~
0900	50 / 450	8 / 8	6 / 6	7 / 7						80 / 80						
1000	50 / 500	8 / 16	6 / 12	7 / 14						85 / 165						
1100	50 / 550	16 / 32	6 / 18	7 / 21						130 / 295						
1200	50 / 600	8 / 40	6 / 24	7 / 28						75 / 370						
1300	50 / 650	8 / 48	6 / 30	7 / 35						65 / 435	400 / 400	95 / 95	40 / 40			
1400	50 / 700	8 / 56	6 / 36	7 / 42						80 / 515						
1500	125 / 825	8 / 64	6 / 42	7 / 49						65 / 580						
1600	125 / 950	8 / 72	6 / 48	7 / 56	100 /	10 /	25 /		1261	65 / 645					1180	
8 HR	950	72	48	56	100	10	25		16 HR 1971	645	400	95	40		16 HR 2539	-568
1700	125 / 125	8 / 8	6 / 6	7 / 7		10 / 10	25 / 25			80 / 80						
1800	125 / 250	8 / 16	6 / 12	7 / 14	100 / 100	10 / 20	25 / 50			120 / 200						
1900	125 / 375	8 / 24	6 / 18	7 / 21		10 / 30	25 / 75			160 / 360						
2000	125 / 500	8 / 32	6 / 24	7 / 28		10 / 40	25 / 100			90 / 450				Ø / 25		
2100	125 / 625	8 / 40	6 / 30	7 / 35		10 / 50	25 / 125			100 / 550		80 / 80	15 / 15	- / 25		
2200	125 / 750	8 / 48	6 / 36	7 / 42		10 / 60	25 / 150			110 / 660	Ø	Ø	Ø	Ø		
2300	125 / 875	8 / 56	6 / 42	7 / 49		10 / 70	50 / 200			120 / 780		Ø	Ø	Ø		
2400	125 / 1000	8 / 64	6 / 48	7 / 56		10 / 80	50 / 250		1698	120 / 1000		Ø	Ø	10	1120	
8 HR	1100	64	48	56	100	80	250		24 HR 3669	1000		80	15	25	24 HR 3659	

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2				2		
	RADIAL L		2				2					2			2				2				2		
	DORSALIS PEDIS R		2				2					2			2				2				2		
	DORSALIS PEDIS L		1				2					2			2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 5 8 face				1 3 8		
EDEMA			Gen				Gen					Gen			Gen				gen				Gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				R					R			ST/R				R				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR					NSR			ST				ST				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓					✓			✓				✓				✓		
HYGIENE	BED BATH											✓													
	FOLEY CARE		✓									✓											✓		
	ORAL CARE																								
MOBILITY	BEDREST		✓				✓					✓			✓		✓		✓				✓		
	BSC																								
	DANGLE																								
	CHAIR											✓													
POSITIONED	RIGHT																✓								
	LEFT						✓												✓						
	SUPINE		✓												✓								✓		
	HOB 30 DEGREES		✓				✓					✓			✓		✓		✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																			✓ per interpreter →						
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2				2					2			2				2				2		
BOWEL SOUNDS (active all quads)			Low				hypo active					hypo active			Ø								Low		
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓					✓			✓				✓						
RESIDUAL ASSESSED															10cc				5cc						10
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓					✓			✓				✓				✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓				✓					✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																			✓						
#1 Chest tube Ⓛ Chest / Ⓡ chest			✓				✓					✓			✓				✓				✓		
#2 ABD - Incision staples O+A			✓				✓					✓			✓				✓				✓		
#3 Ⓛ ↓ AB - CDF			✓				✓					✓			✓				✓				✓		
Ⓛ thigh O+A																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
NG tube	Ⓡ nasal		
TLC	Ⓡ subclavian	DC'd	
18 gage	Ⓛ wrist		
A-Line	Ⓡ radial		

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	030ct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+3820
24 Hour Intake	6180
24 Hour Output	-2360
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN	(b)(6)-2
(b)(6)-2 SPC 91WMC	
(b)(6)-2 MAN	
(b)(6)-2 MAJ AN	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach		N/A	N
Side Rails Up		N/A	
Bed in Low Position		N/A	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	09oct03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		106	17/12	105/58	97	114/58	81										
0200	101.1	110	17/12	111/56	96	113/69	82										
0300		110	17/12	110/46	97	113/68	82										
0400	101.8	104	17/12	109/56	99	118/66	84										
0500		107	17/12	115/71	100%	117/68	82										
0600																	
		103	12/12	117/58	100%	117/66	81										
0700	100.8	105	14/12	113/59	100%	112/70	81										
0800		100	12/12	114/60	100%	117/60	81										
0900		106	12/12	108/59	100%	108/52	78										
1000		109	17/10	138/77	97%												
1100	101	107	10/10	136/76	97%	140/70	100										
1200		115	11/10	135/76	98%	138/74	106										
1300		120	10/10	124/70	100%	114/51	89										
1400	100.6 (A)	123	15/15	116/63	95	116/62	78										
1500	100.5 (A)	116	13/15	113/60	99	114/58	77										
1600	101.3 (A)	102	16/12	120/64	100	105/70	84										
1700	100.3 (A)	114	12/12	110/65	100	116/64	81										
1800	100.2 (A)	106	14/12	112/65	99	117/65	80										
1900	100.5 (A)	102	20/12	133/71	99	125/67	85										
2000	99.7 (A)	95	12/12	121/64	99	124/60	77										
2100	100.6 (A)	101	16/10	132/61	100	130/66	85										
2200	100.2	98		124/54	100												
2300	100.2	102		126/58	100												
2400		105	24/12	109/54	98%	104/96											

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance
to paralyzed (medication)

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			1				1					1			1				4				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			1				1					1			1				ETT 1				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			1				1					1			3				4				1		
GLASCOW COMA SCALE (A+B+C)			~~8~~				~~8~~					~~8~~			5				9				~~8~~		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+				2+					2+			2-3 +								2+		
	L		2+				2+					2+			2-3 +								2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		6				6					6			2				2				6		
	LUE		6				6					6			2				2				6		
	RLE		6				6					6			2				2				6		
	LLE		6				6					6			2				2				6		
GRIP (S) Strong (W) Weak (-) absent	R		6				6					6			6				~~0~~				6		
	L		6				6					6			6				~~0~~				6		
RESPIRATIONS	REGULAR		✓				✓					✓			✓				✓				✓		
	IRREGULAR																								
	UNLABORED		✓				✓					✓			✓				✓				✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		1/2				3					3			3				3				3		
	LUL		1/2				3					3			3				3				3		
	RLL		1/2				3/1					3/1			3				3				3		
	LLL		1/2				3					3			3				3				3		
	BOTH BASES						1					1			1				1				1		
COUGH	NONE		✓				✓					✓			✓				✓				✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																			2			1			
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																			2			2			
VENTILATOR	Vt		850				850					800			1000	100	1000		1000		1000				
	FiO2		50				50					40			60	40	40		40		40				
	RATE (SIMV/CMV)		12				12					10			15	12	12		12		10				
	PEEP / CPAP		10				10					10			10	10	10		10		8				
	PRESS. SUPPORT														~~0~~	~~0~~	~~0~~		~~0~~		~~0~~				
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums		✓				✓					✓			✓				✓				✓		
ETT CARE / POSITION CHANGE			✓				✓					✓			✓								✓		
ETT / NT SUCTIONED																						✓			
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2				(b)(6)-2					(b)(6)-2			(b)(6)-2				(b)(6)-2						

propofol

	INTAKE									OUTPUT						
	D5NS 20KCL	versed	vivonex	vecuronium	fentanyl	~~[illegible]~~	IVPB	BLOOD	Total	urine	chest 1	chest 2	residual NG Wbol		Total	COMMENTS
0100	125 / 125	6 / 6	10 / 10	7 / 7	8 / 8					140 / 140	0 / 0	0 / 0	0 / 0			
0200	125 / 250	6 / 12	10 / 20	7 / 14	8 / 16					120 / 260	0 / 0	0 / 0	0 / 0			
0300	125 / 375	6 / 18	10 / 30	7 / 21	8 / 24					100 / 360	0 / 0	0 / 0	0 / 0			
0400	125 / 500	6 / 24	10 / 40	7 / 28	8 / 32					100 / 460	0 / 0	0 / 0	20 / 20			
0500	125 / 625	6 / 30	10 / 50	7 / 35	8 / 40					100 / 560	0 / 0	0 / 0	20 / 20			
0600	125 / 750	6 / 30	10 / 60	7 / 42	8 / 48					100 / 660	0 / 0	0 / 0	0 / 20			
0700	125 / 875	6 / 36	10 / 70	7 / 49	8 / 56		100 / 100			110 / 770	0 / 0	0 / 0	0 / 20			
0800	125 / 1000	6 / 42	10 / 80	7 / 56	8 / 64		50 / 150			160 / 930	25 / 25	0 / 0	40 / 60			
8 HR	1000	42	80	56	64		150		8 HR. 1392	930	25	0	60		8 HR 1015	+377
0900	125 / 125	6 / 6	20 / 20	7 / 7	8 / 8					170 / 170	0 / 0	5 / 5	0 / 0			
1000	125 / 250	8 / 14	20 / 40	7 / 14	8 / 16					100 / 270	0 / 0	0 / 5	0 / 0			
1100	125 / 375	8 / 22	20 / 60	7 / 21	8 / 24					110 / 380	15 / 15	0 / 5	0 / 0			
1200	125 / 500	8 / 30	20 / 80	7 / 28	8 / 32					140 / 520	35 / 50	0 / 5	10 / 10			
1300	125 / 625	8 / 38	20 / 100	0 / 28	8 / 40					140 / 560	0 / 50	0 / 5	0 / 10			
1400	125 / 750	4 / 42	0 / 100	0 / 28	4 / 44					100 / 660						
1500	125 / 875	2 / 44	20 / 120	0 / 28	1 / 45		1000 ml / 1000			100 / 760						
1600	125 / 1000	2 / 46	20 / 140	0 / 28	1 / 46		50 / 1050		2310	250 / 1010						
8 HR	1000	46	140	28	46		1050		16 HR. 3700	1010	50	5	10		16 HR 2090	
1700	125 / 125	2 / 2	20 / 20	0 / 0	1 / 1					100 / 100						
1800	125 / 250	2 / 4	20 / 40	0 / 0	1 / 2		100 / 100			300 / 400						
1900	125 / 375	2 / 6	20 / 60	0 / 0	1 / 3		150 / 250	400 / 400		180 / 580						
2000	125 / 500	2 / 8	20 / 80	0 / 0	1 / 4					350 / 930						
2100	125 / 625	2 / 10	20 / 100	0 / 0	1 / 5					200 / 1130	60 / 60	15 / 15				
2200	125 / 750	2	20	3	1 / 6					200						
2300	125 / 875	2	20	3	1 / 7	25	50 / 300	400		200	25	0				
2400	125 / 1000	2	20	3	1 / 8	60	100		2478	160	0	0	10		220	
8 HR	1000	16	160	9	8	85	400	800	24 HR. 6180	160	85	15	10		24 HR 2360	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
09Oct03	0200		Non movement of pt, paralysis (see MAR), fen edema noted, Ø Bowel sounds heard to ABD, NG tube & tube feedings as ordered, TLC to Ⓒ subclavian & IV fluids as ordered, A-line to Ⓡ wrist zeroed, HL 18g to Ⓒ wrist CDI, cont suctioning to chest tubes #1 & 2, Incision to ABD OTA & staples CDI, Dressing to Ⓒ ↓ ABD CDI, Incision to Ⓒ thigh OTA, will cont to monitor pt while on vent as ordered [redacted]
	0600		received pt this AM; NAD; assessment completed; Ⓒ subclavian flushed w/o difficulty; will cont to monitor
	0745		A-line tubing + NS Δ'd; break down to Ⓡ hand from moisture; Coban used to hold A-line in place so that hand will get more air [redacted]
	0815		vent settings Δ'd to TV 950 mL, FiO_2 40%, PEEP @ 10, rate 12; tube feeding increased to 20 cc/hr, [redacted]
	1030		Vecuronium decreased to 3 mg/hr; will cont to monitor [redacted]
	1300		Vecuronium turned off; will cont to monitor [redacted]
9Oct03		1420	Versed ↓ to 2 mg/hr; Fentanyl ↓ to 50 μ/hr. [redacted] MAJ AN
		1430	500 cc LR bolus IV given, 1000 cc. [redacted] MAJ AN
		1630	Vent settings Δ'd per Dr. [redacted] - A/C - 12, V_T 1000 cc, FiO_2 - 40%, PEEP - 10. O_2 sats > 95%, RR 18, A-line positional. NG tube position √'d, 10 cc residual - replaced. Tube feedings (Vivonex) cont @ 20 cc/hr. ETT cuff inflated, HOB elevated. Temp @ 1600 was 101.3 (A) → Tylenol Supp 650 mg PR given @ 1615. Versed @ 2 mg/hr; Fentanyl @ 25 μ/hr, Vec ↓ & d/c'd. Pt moving all extremities spontaneously and opening eyes. Follows no commands. [redacted] MAJ AN
		1830	Pt appears more awake, opening eyes spontaneously. Shaking head "yes" and "no" appropriately per interpreter. Moves all extremities but followed no commands. Turns head to voice. 1 unit PRBCs hung @ 1730 in (L) SCV triple lumen. No transfusion reactions noted this pm. See flowsheet (M 4700 BP 132-116) for vitals. [redacted] MAJ AN

CRITICAL CARE FLOW SHEET

(b)(6)-4

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-115
24 Hour Intake	4493
24 Hour Output	4608
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN 9/10/02	(b)(6)-2
(b)(6)-2 LCT, AN	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N		N
Side Rails Up	A		A
Bed in Low Position			

(b)(6)-2	Department/Service/Clinic	DATE
	ICU	10 Oct 03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		UTA				2				2				2				—				UTA		
	L		2				2				2				2				—				2		
	DORSALIS PEDIS (first two) R		2				2				2				2				—				2		
	L		2				2				2				2				—				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8				1 3 8				1 3 8				—				1 3 8 9		
EDEMA			*				Gen				Gen				GEN				—				*		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓				✓				✓				✓				—				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR				SR-ST				SR				SR				—				SR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓				✓				✓				—				✓		
HYGIENE	BED BATH										✓														
	FOLEY CARE		✓								✓				✓				—				✓		
	ORAL CARE										✓														
MOBILITY	BEDREST		✓				✓				✓				✓				—				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT										✓														
	SUPINE						✓																		
	HOB 30 DEGREES		✓				✓				✓				✓				—				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			*				UTA																*		
PAIN	PAIN FREE		UTA								UTA				✓				—				UTA		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2				2				2				—				2		
BOWEL SOUNDS (active all quads)			x4				Hypo				Hypo				Hypo				—				x4		
NG / DOBHOFF PLACEMENT VERIFIED							✓				✓														
RESIDUAL ASSESSED					✓		14cc				12cc														
Ph																									
FOLEY CATHETER PATENT			✓				✓				✓				✓				—				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				Amber				Amber												✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)											✓														
#1 Incision ABD OTA Staples			✓				✓				✓				✓				—				✓		
#2 Chest tube #1 ⓡ CDI			✓				✓				✓				✓				—				✓		
#3 ⓛ ↓ABD CDI			✓				✓				✓				✓				—				✓		
ⓛ thigh OTA Incision			✓				✓				✓				✓				—				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
NG tube	ⓡ nostril		CDI 1600/1000
A-line	ⓡ radial		CDI 1600/1000
TLC	ⓛ subclavian		CDI 1600/1000

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance
6 = SEDATED

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 10 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		1				1				1				4				—				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		1				1 T				1 T				5				—				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		1				1				1				6				—				6		
GLASGOW COMA SCALE (A+B+C)		3				3T				3T				15				—				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R						5+				3+				+3				—				13		
PUPIL RESPONSE — L						5+				3+				+3				—				13		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		6				6				6				5				—				5		
MOVEMENT — LUE		6				6				6				5				—				5		
MOVEMENT — RLE		6				6				6				5				—				5		
MOVEMENT — LLE		6				6				4				5				—				5		
GRIP (S) Strong (W) Weak (-) absent — R		—				6				4				—				—				3		
GRIP — L		—				6				4				—				—				3		
RESPIRATIONS — REGULAR		✓																—						
RESPIRATIONS — IRREGULAR																						✓		
RESPIRATIONS — UNLABORED		✓				vent				vent				✓				—				✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW														✓				—				✓		
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		3				3				3				3				—				3		
BREATH SOUNDS — LUL		3				3				3				3				—				3		
BREATH SOUNDS — RLL		3				3				3/1				3				—				3		
BREATH SOUNDS — LLL		3				3				3/1				3				—				3		
BREATH SOUNDS — BOTH BASES		1				1				1				1				—				✓		
COUGH — NONE		✓				✓				✓				✓										
COUGH — SPONTANEOUS																		✓				✓		
COUGH — PRODUCTIVE																		✓				✓		
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		1																1				1		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		1																				3		
VENTILATOR SIMV — Vt		1000				1000				1000														
VENTILATOR — FIO2		40				40				40														
VENTILATOR — RATE (SIMV/CMV)		10				10				10														
VENTILATOR — PEEP / CPAP		6				6				5														
VENTILATOR — PRESS. SUPPORT		—																						
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — VM (l/min) VM 40%														✓				—						
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
OXYGEN DELIVERY DEVICE — ETT 22 cm gums (ETT # 7.5)										✓														
ETT CARE / POSITION CHANGE										✓														
ETT / NT SUCTIONED		✓							✓															
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																						✓		
INITIALS		(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		99	20	108/48	99%	111/47	71										
0200	99¹	102	29	~~119/60~~ error	99	119/60	74										Vent
0300	99²	95	15	/	100	109/53	70										Vent
0400	99¹	92	10	/	100	108/52	62										Vent
0500	98.8	90	12	/	100	105/49	66										Vent
0600	98.5 (A)	97	10/15		99%	112/56	73										
0700		97	10/10		99%	138/66	85										
0800	98.8 (A)	94	10/21		100	136/66	85										
0900		94	10/17		100%	135/64	82										
1000		101	10/28		99%	149/75	95										
1100	99.5 (A)	103	10/28		99%	141/70	88										
1200		105	10/48		100%	135/65	88										
1300	100.7 (A)	100	40		99	141/71	92	T-Piece									
1400	99²	100	32		100	150/64	87				↓						
1500		92	28		[illegible]	124-68	88			VM	40%						
1600		96	30		100	140-66											
1700		93	16		100	126-71	86										
1800	98³	86	33		100%	137-65	85										
1900		80	28		100	140-65	87										
2000	99³	87	36		100	133-68	86										
		~~81~~	~~28~~			~~122-54~~	~~72~~										
2100		81	28		100	122-54	72			VM	40%						
2200																	
2245	99.5	91	28	/	95%	141/63	84										(b)(6)-2
2300		85	33	/	96%	123/54	73										
2400	99.6	89	34	/	94%	134/67	86										

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10/10/03	0630		Well sedated. D5NS c̄ 20KCl @ 125cc/hr, Fentanyl 25mcg/hr, VERSED 2mg/hr. Vecuronex NGT Feeding @ 20cc/hr. VSS See flow sheet for assessment. (b)(6)-2 LCT, RN.
10/10/03		1325	Placed on T-PIECE blow by c̄ 40% O2. Maintained sats 98%. HR & BP stable. RR 20-40's. Pt restless. Propofol turned off. Fentanyl ↓ 25mcg/hr & Versed ↓ 1mg/hr. Vecuronex turned off & NGT placed on ILWS. Temp 100.7 (A) Medicated c̄ Tylenol 650mg Supp PR. (b)(6)-2 LCT, RN.
10/10/03		1330	Pt extubated & placed on 40% VM. O2 SATS >97%. NGT D/c'd. Fentanyl & Versed turned off. VSS (b)(6)-2 LCT, RN.
		1430	Extubated c̄ vm @ 40% sat's 99% Responds to intiqa ter question. ABG done. MD notified of results. CT Dressing Changed by MD tolerated well. See DA Form 4700 for assessment. Will cont to monitor pen condition. (b)(6)-2
		1620	OOB to w/c tolerated needed lots assistance with move. Translator at the bedside explained what was going on. (b)(6)-2
		1800	Back to bed tolerated well. ABG done results shown to MD (b)(6)-2 (b)(6)-2
		1815	MSO4 given for pain (b)(6)-2
		1825	Resting well NAD. Dressing D/S done at this time. Tolerated well. (b)(6)-2
		2000	Nursing chart in bed. HOB 30° VM in place. Comfortable to C.B. Will cont to monitor. (b)(6)-2
10/10/03		2200	Assumed pt., pt supine c̄ HOB elevated NAD — (b)(6)-2
		2250	Assessment complete, monitors on ID bracelet @ wrist PSOR probe @ hand, A-line to @ wrist, D5NS to triple lumen central line cath, ventilator mode CBS, moves ext x4, c/o pain to chest c̄ moaning. L/R bilateral CT notes, gauze bandaging c̄ tape CDT. @ hand padding around A-line

	INTAKE									OUTPUT						
	D5NS c 20KCL	Versed	Fentanyl	VEC	Vivonex	propofol	IVPB	Flush A-line	Total	Urine	Chest 1	Chest 2	NGT		Total	COMMENTS
0100	125 / 125	2 / 2	1 / 1	3 / 3	20 / 20	60 / 60			3 / 3	180 / 180	Ø / Ø	Ø / Ø				
0200	125 / 250	2 / 4	1 / 2	3 / 6	20 / 40	60 / 120			6 / 6	170 / 350	Ø / Ø	Ø / Ø				
0300	125 / 375	2 / 6	1 / 3	3 / 9	20 / 60	60 / 180			3 / 9	120 / 470	Ø / Ø	Ø / Ø				
0400	125 / 500	2 / 8	1 / 4	3 / 12	20 / 80	60 / 240		20 / 20	3 / 12	180 / 650	— / Ø	— / Ø				
0500	125 / 625	2 / 10	1 / 5	3 / 15	20 / 100	60 / 300		— / 20	3 / 15	170 / 820	— / Ø	— / Ø				
0600	125 / 750	2 / 12	1 / 6		20 / 120	60 / 360			3 / 18	175 / 995						
0700	125 / 875	2 / 14	1 / 7		20 / 140	60 / 420	100 / 100		3 / 21	115 / 1110						
0800	125 / 1000	2 / 16	2 / 9		20 / 160	60 / 480	50		3 / 24	220 / 1330						
8 HR	1000	16	9		160	480			8 HR. 1665	1330					8 HR 1330	+ 335
0900	125 / 125	2 / 2	2 / 2		20 / 20	60 / 60	150 / 150	20 / 20	3 / 27	240 / 240						
1000	125 / 250	2 / 4	2 / 4		20 / 40	40 / 100			3 / 30	120 / 420						
1100	125 / 375	2 / 6	2 / 6		20 / 60	40 / 140			3 / 33	160 / 580						
1200	125 / 500	2 / 8	2 / 8		20 / 80	40 / 180	100 / 250	10 / 30	3 / 36	190 / 770						
1300	125 / 625	1 / 9	1 / 9		0 / 80	0 / 180			3 / 39	190 / 960	20 / 20	20 / 20	150 / 150			
1400	125 / 750	0	0		0	0				310 / 1270						
1500	125 / 875									210 / 1480						
1600	125 / 1000						50 / 300			200 / 1680						
8 HR	1000	9	9		80	180	300		16 HR. 1578	1680	20	20	150		16 HR. 1870	+ 292
1700	125									300						
1800	125 / 250						100 / 100			200 / 500						
1900	125 / 375									100 / 600						
2000	125 / 500									120 / 720						
2100	125 / 625									278 / 998						
2200	125 / 750									100 / 1098						
2300	125 / 875						50 / 150			100 / 1198						
2400	125 / 1000						100 / 250			210 / 1408						
8 HR	1000						250		24 HR. 1250	1408					24 HR 1408	− 158

−115

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	02 Oct 03
DOS	02 Oct 03
POD	7 9

24 HOUR DATA	
24 Hour Balance	+2224
24 Hour Intake	4809
24 Hour Output	2585
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 9/Wells	(b)(6)-2
(b)(6)-2 LCT	
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	N/A	N/A
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SPC, 9/Wells	ICU	11 Oct 03

...TION (*For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility*)

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(*Specify*) Nursing notes
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL (b)(6)- PT2 TIB/ R			2				2				2			2				2						2
	RADIAL L			2				2				2			2				2						2
	DORSALIS PEDIS POST TIB/ R			2				2				2			2				2						2
	DORSALIS PEDIS L			2				2				2			2				2						2
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 8				1 3 8				1 3 8			1 3 8				1 3 8						1 3 8
EDEMA				—				Gen				Gen			gen				gen						—
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓				✓				✓			✓				✓						✓
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				SR				SR				SR			SR				SR						SR
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)				✓				✓				✓			✓				✓						
HYGIENE	BED BATH																	* HALF BATH							
	FOLEY CARE			✓																					✓
	ORAL CARE							✓																	
MOBILITY	BEDREST			✓				✓				✓			✓										✓
	BSC																								
	DANGLE																								
	CHAIR																	✓	✓						
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓				✓			✓					✓					✓
	HOB 30 DEGREES			✓				✓				✓			✓			✓	✓	✓					✓
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				—																					
PAIN	PAIN FREE											✓				+			+	+					✓
	PAIN SCALE (1-10)			VTA												VTA			VTA						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended				2				2				2			2				2						2
BOWEL SOUNDS (active all quads)				x4				HYPO				✓			✓				✓						x4
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓				✓			✓				✓	✓					✓
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓				✓			✓ amber										✓
SKIN INTEGRITY	No Breakdown																								
MID LINE AND 2 STAPLES	Surgical Wounds							✓				✓			✓				✓						✓
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) lower abd				✓				✓				✓			✓				✓						✓
#2 Midline incision OTA				✓				✓				✓			✓				✓						✓
#3 L/R CT #1 & #2				✓				✓				✓			✓				✓						✓
(L) thigh OTA				✓				✓				✓			✓				✓						✓

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
TLC	(R) subclavian		Intact, patent 1070D/1100/2400
A-line	(R) radial		CDI 1070D/1100
Foley	GROIN		Intact, patent 1070D/1100/2200

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 11 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			4				4				4			4				4						4
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			5				5				5			5				5						5
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			6				6				6			6				6						6
GLASGOW COMA SCALE (A+B+C)			15				15				15			15				15						15
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R			x3				3+							3+				3+						3+
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L			x3				3+							3+				3+						3+
MOVEMENT (See Motor Function Scale at Top of Page) — RUE			4				4				4			4				4						4
MOVEMENT — LUE			5				4				4			4				4						4
MOVEMENT — RLE			5				4				4			4				4						4
MOVEMENT — LLE			5				4				4			4				4						4
GRIP (5) Strong (W) Weak (-) absent — R			5				UTA				UTA			UTA				4						5
GRIP — L			UTA				5				5			4				4						5
RESPIRATIONS — REGULAR			✓				✓				✓			✓				✓						✓
RESPIRATIONS — IRREGULAR			✓				✓				✓			✓				✓						✓
RESPIRATIONS — UNLABORED			✓				✓																	
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW			✓				✓							✓				✓						
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL			3				3				5			5				5						5
BREATH SOUNDS — LUL			*				3				5			2				5						5
BREATH SOUNDS — RLL			3				3				5			5				2						2
BREATH SOUNDS — LLL			*				3				5			5				2						2
BREATH SOUNDS — BOTH BASES			✓				✓				1			1				2						*
COUGH — NONE			✓				✓				✓			✓				✓						✓
COUGH — SPONTANEOUS			✓								✓			✓				✓						✓
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear			1								5			5				5						1
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin			3								3			3				3						3
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)			RA				3L				3L			3L	3L			3L			3L			3L
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE						✓	✓				✓			✓	✓			✓	✓		✓			✓
COUGH / DEEP BREATH			✓											✓	✓			✓	✓		✓			✓
INITIALS			(b)(6)-2				(b)(6)-2				(b)(6)-2			(b)(6)-2				(b)(6)-2			(b)(6)-2			

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		86	50	124/62	96	/	85										(b)(6)-2
0200	99.2	87	46	12 /	94	133/59	81										
0300		85	34	/	95	130/60	79										
0400	99.2	80	35	121/62	95	125/58	85 NIBP										
0500		88	36	/	98	134/63	84										
0600	98.7 (A)	87	41		95	131/58	83										
0700		85	49		97	132/62	83										
0800		83	33		94%	130/60	83										
0900		87			96%	142/74	96										
1000	99.7 (A)	80	29		98%	120/56	75										
1100		76	26		98%	122/57	76										
1200		77	31		96%	124/58	77										
1300	99.8 (A)	78	28		98%	122/56	75										
1400	99.7 (O)	78	28		97	121/55	72										
1500		74	25		98	122/55	74										
1600		69	21		99	117/55	74										
1700	99.3 (A)	80	22	108/55	100												
1800		84	19	117/60	98												
1900																	
2000																	
2100																	
2200	/	71	20	/	99	/	/										(b)(6)-2
2300																	
2300	/	69	19	/	99	/	/										(b)(6)-2
2400	98.6	68	24	107/52	99	/	74										

	INTAKE									OUTPUT					
	D5W5 200cc	IVPB/Bolus	A-line	PO					Total	Urine	BM	CT #1	CT #2		Total
0100	125 / 125		3 / 3							810 / 810					
0200	125 / 250		3 / 6							195 / 405					
0300	125 / 375		3 / 9							180 / 585					
0400	125 / 500		3 / 12							150 / 735					
0500	125 / 625		3 / 15							150 / 885					
0600	125 / 650		3 / 18							150 / 1050					
0700	125 / 775	100 / 100	3 / 21							190 / 1240					
0800	125 / 900	100 / 200	3 / 24							155 / 1395					
8 HR	900	200	24						8 HR. 1124	1395				8 HR 1395	# 271
0900	125 / 125		5 / 5							180 / 180					
1000	125 / 250		3 / 6							80 / 260					
1100	125 / 375		3 / 9							140 / 400					
1200	125 / 500	100 / 100	3 / 12							75 / 475					
1300	125 / 625		3 / 15	400 / 400						60 / 535		25 / 25	23 / 23		
1400	125 / 750		3 / 18	120 / 520						65 / 600					
1500	125 / 875	100 / 200	3 / 21							40 / 640					
1600	125 / 1000	80 / 280	3 / 24	30 / 550						60 / 700		15 / 40	10 / 33		
8 HR	1000	280	24	550					1174 / 16 HR. 2898	700		40	33	73 / 16 HR. 2168	+ 730
1700	125 / 125		3 / 3							40 / 40					
1800	125 / 250	100 / 100	3 / 6	120 / 120						45 / 85		20 / 20	6 / 6		
1900	125 / 375	500 / 600	3 / 9							21 / 106					
2000	125 / 500		2 / 11	30 / 150						34 / 140					
2100	125 / 625	0 / 600	0 / 11	0 / 150						80 / 220		0 / 20	4 / 10		
2200	125 / 750	— / 600	— / 11	— / 150						95 / 315		— / 20	— / 10		
2300	125 / 875	50 / 650	— / 11	— / 150						32 / 347					
2400	125 / 1000	100 / 750	— / 11	— / 150						40 / 387					
8 HR	1000	750	11	150					24 HR.	+		20	10	24 HR. 117	+ 1493

COMA

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2					2					2				2				2		
	L				2					2					2				2				2		
	DORSALIS PEDIS (POST TIBI) R				2					2					2				1				2		
	L				2					2					2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1 3 8					1 3 8					1 3 8				1 3 8				1 3 8		
EDEMA					–					Gen					Gen				Gen				0		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓					✓					S1S2 ✓				S1S2 ✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					SR					SR					SR				NSR				SR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST				✓					✓													✓		
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓					✓					✓				✓				✓		
	HOB 30 DEGREES				✓					✓					✓				✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)					—																				
PAIN	PAIN FREE									✓					PR								✓		
	PAIN SCALE (1-10)				✓														✓				✓		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				2					2					2				2				2		
BOWEL SOUNDS (active all quads)					x4					✓					x4				✓ x4				x4 hyp		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT										✓															
VOIDING CLEAR, YELLOW URINE q.s.					Amber					Tea Amber					✓				✓				✓		
SKIN INTEGRITY	No Breakdown				✓																				
Midline incision	Surgical Wounds				✓					✓					✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) Lower Abd					✓					✓					✓				✓				✓		
#2 (L) + (R) CT					✓					✓					✓				✓				✓		
#3 Midline OTA incision					✓					✓					✓				✓				✓		
(L) lateral thigh OTA					✓					✓					✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Foley to Gravity	Groin		Intact, patent / 0500 / 0900 > DCd 0930
TLC	(L) Subclavian		Intact, patent / 0500 / 0900 / 1800

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 OCT 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-92
24 Hour Intake	4170
24 Hour Output	4262
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 9/wk6	(b)(6)-2
(b)(6)-2 1ST.AN	
(b)(6)-2 MAN	
(b)(6)-2 1ST/AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N		N
Side Rails Up	A		A
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9/wk6	ICU	12

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 12Oct03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4					4					4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5					5					5				5				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6					6					6				6				6		
GLASGOW COMA SCALE (A+B+C)					15					15					15				15				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R				3+										3+				3+				3+		
	L				3+										3+				3+				3+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				4					4					5				5				5		
	LUE				4					4					5				5				5		
	RLE				4					4					5				5				5		
	LLE				4					4					5				5				5		
GRIP (S) Strong (W) Weak (-) absent	R				S					S					S				S				S		
	L				S					S					S				S				S		
RESPIRATIONS	REGULAR				✓					✓					✓				✓				✓		
	IRREGULAR																								
	UNLABORED				✓					✓					✓				✓				✓		
	LABORED																								
	SHALLOW																		✓						
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5					3/2					3/2	3			3/2				5		
	LUL				3					3/2					3/2	3			3/2				5		
	RLL				2					1					2	3/2			3/2				5		
	LLL				2					1					2	3/2			3/2				5		
	BOTH BASES				✓					1					1	1			1				✓		
COUGH	NONE																								
	SPONTANEOUS				✓					✓									✓				✓		
	PRODUCTIVE									✓									✓				✓		
	NONPRODUCTIVE				✓																				
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear										1/5									1/5				1		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin										3									3				3		
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)				RA					3L									3L				3L		
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓	✓		✓	✓	✓	✓				
COUGH / DEEP BREATH					✓					✓					✓	✓	✓	✓	✓	✓	✓	✓	✓		
INITIALS				(b)(6)-2						✓												(b)(6)-2			

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	99.6 (D)	69	20	104/80	95	—	70										(b)(6)-2
0500																	
0600																	
0700																	
0800																	
0900	98° (A)	69	22	114/57	98%		79										
1000																	
1100																	
1200																	
1300	98° (A)	63	25	113/58	100%		79										
1400																	
1500																	
1600																	
1700	99.7 (A)	79	25	121/57	99%		81										
1800																	
1830	99.3 (A)	80	31	124/62	95	3/NC	85										
1900																	
2000																	
2100																	
2200	99.8	68	23	114/57	97	—	79										(b)(6)-2
2300																	
2400																	

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
10/12/03		0930	(B) CT Placed on H_2O Seal. Ø leaks. Dulcolax 10mg Supp. PR X1 Foley D'c'd. U/A Sent to lab VSS. NAD. See flowsheet for assessments. — [redacted] ICT, A
10/12/03	1130	1	OOB TO BSC. BM MOD amt, Brown, soft + formed. IN CHAIR FOR 1 hr. Tolerated well. RTO TO BED [redacted] ICT, A
10/12/03		1330	Pt refused breakfast & Lunch. ↓ Appetite [redacted] ICT, A.
		1430	Assessment complete. pt refused jello wants "Drajin food" per interpreter. Pt sat up at bedside c̄ assistance and ambulated to wheelchair c̄ assist. — [redacted] CAW
		1630	Pt up in chair for 1.5 hours. Pain medicine MSO4 5mg given p̄ patient got back in bed and voided into urinal. HOB 30° pt requested to be lower but told he cannot. CT to water seal Serous straw colored fluid draining (B). — [redacted] CAW
		1800	Assumed care. Pt A&Ox3, cheerful. Denies pain, but c/o "being cold" via interpretor. Blankets x2. VSS. low grade fever @ 99.3(o). Pt voiding / urinal Q's - yellow urine. Encouraged frequent IS use. Pt c/o being hungry, but denies clear liquid diet. CT x2 to water seal. No air leaks noted. Connections secured. LLQ drsg CDI. ML incision c̄ staples - noted redness around staples. O2 @ 3L/NC. SpO2 97-99%. Will continue to monitor — [redacted]
		1900.	Pt c/o pain @ CT insertion sites. Administered 5mg MSO4 IVP. — [redacted]
12OCT03		2000	Assumed pt, pt supine c̄ NOB T DSWS @125cc/hr to TLC patent, intact, A&Ox3 via interpreter @ BS, mec BS, O2 @ 3L via NC, Breathing regular unlabored, spontaneous cough productive thin, clear void 1.2 urinal clear of sediment, yellow, Ø s/s of infiltration, infection to TLC, full assessment DA Form 4700 TLC flushes c̄ difficulty — [redacted]

	INTAKE									OUTPUT						
	D5W	IVPB	PO						Total	Urine	BM	CT #1	CT #2		Total	COMMENTS
0100	125 / 125									32 / 32						
0200	125 / 250									60 / 92						
0300	125 / 375	1 / 1								55 / 147						
0400	125 / 500									55 / 202						
0500	125 / 625									65 / 267	10 / 10	15 / 15				
0600	125 / 750									60 / 327						
0700	125 / 875									65 / 392						
0800	125 / 1000	200 / 200								65 / 457						
8 HR	1000	200							8 HR. 1200	457		10	15		8 HR 482	+ 718
0900	125 / 125		100 / 100							140 / 140						Foley DC'd 0930
1000	125 / 250									100 / 240						
1100	125 / 375									300 / 540	X' / X'				←	Post Foley VOID
1200	125 / 500	100 / 100														
1300	125 / 625											53 / 53	19 / 19			
1400	125 / 750									625 / 1165						
1500	125 / 875															
1600	125 / 1000	50 / 150	100							475 / 1640						
8 HR	1000	150	200						16 HR. 2570	1640	X1	53	19		16 HR 2194	+376
1700	125 / 125															
1800	125 / 250		250 / 250							460 / 460						
1900	125 / 375	100 / 100								400 / 800						
2000	125 / 500															
2100	125 / 625		200 / 400							425 / 1225		28 / 28	15 / 15			
2200	125 / 750									375 / 1600						
2300	125 / 875	50 / 150								0 / 1600						
2400	125 / 1000									425 / 2025						
8 HR	1000	150	450						24 HR. 4170	2025		28	15		24 HR 4262	- 92

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 OCT 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-85
24 Hour Intake	3290
24 Hour Output	3375
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	13 Oct 03

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

(b)(6)-4

- ☐ HISTORY PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2							2				2				2		
	RADIAL L		2					2							2				2				2		
	DORSALIS PEDIS POST TIB R		2					2							2				2				2		
	DORSALIS PEDIS POST TIB L		2					2							2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8							1 3 8				1 3 8				1 3 8		
EDEMA			Gen					Gen							Min				b				Gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					✓							SS2 ✓				SS2				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					NSR							NSR				NSR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST		✓					✓							✓										
	BSC																								
	DANGLE																								
	CHAIR																		✓						
POSITIONED	RIGHT		S																S				S		
	LEFT		E																E				E		
	SUPINE		F					✓							✓				L				I		
	HOB 30 DEGREES		S					✓							✓				F				S		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✱												✓				PF	*			✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2							2				2				2		
								✓																	
BOWEL SOUNDS (active all quads)															x4				x4				x4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓							✓				✓				✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																		✓						
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 2 chest tube ℄ R CDI ACCT/Nurse/CDI								✓							✓				P/G						
#2 ℄ left ABD CDI								✓							✓				✓				✓		
#3 ABD Incision OTA								✓							✓				✓				✓		
℄ thigh OTA Incision															✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
TLC	℄ subclavian		CDI / 0700 / 1400

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 13 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4							4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		4					5							5				5				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6							6				6				6		
GLASCOW COMA SCALE (A+B+C)		14					15							15				15				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+												3+								2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+												3+								2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		5					4							4				5				5		
MOVEMENT — LUE		5					4							4				5				5		
MOVEMENT — RLE		5					4							4				5				5		
MOVEMENT — LLE		5					4							4				5				5		
GRIP (S) Strong (W) Weak (-) absent — R		3					5							5				5				5		
GRIP — L		3					5							5				5				5		
RESPIRATIONS — REGULAR							✓							✓				✓				✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		—					✓							✓				✓				✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																		✓						
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		2					5							3				5				2		
BREATH SOUNDS — LUL		2					5							5				5				2		
BREATH SOUNDS — RLL		1					5/1							5/1				3				1		
BREATH SOUNDS — LLL		1					5/1							5/1				5				1		
BREATH SOUNDS — BOTH BASES							1							1				1						
COUGH — NONE		—																				✓		
COUGH — SPONTANEOUS							✓							✓				✓						
COUGH — PRODUCTIVE							✓							✓				✓						
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear							1							1				1						
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin							3							3				3						
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)							3L							3L				3L						
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓	✓					✓				
COUGH / DEEP BREATH		✓																✓		✓				
INITIALS		(b)(6)-2					(b)(6)-2							(b)(6)-2				(b)(6)-2						

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	99.3	70	28	117/62	97%		83										
0300																	
0400																	
0500																	
0600																	
0700	99°(A)	66	30	107/56	97%		75										
0800																	
0900																	
1000																	
1100																	
1200	99°(A)	69	29	115/52	96%		76										
1300																	
1400																	
1500																	
1600	100.4	74	18	93/47	97%	34/AC	(b)(6)-2										IS
1700																	
1800																	
1900																	
2000	100.1°(A)	71	24	108/48	95%		71										
2100																	
2200																	
2300																	
2400	100.2	68	20	117/56	97%												

	INTAKE									OUTPUT						
	D5W5	IVPB	PO						Total	URINE		BM	CT #1	CT #2	Total	COMMENTS
0100	125 / 125	100 / 100								200 / 200						
0200	125 / 250	0 / 0								150 / 400						
0300	125 / 375	0 / 0								0 / 400						
0400	125 / 500	0 / 100								400 / 800						
0500	125 / 625															
0600	125 / 750															
0700	125 / 875	100 / 200														
0800	125 / 1000	50 / 250								425 / 1225						
8 HR	1250	250							8 HR 1500	1225					8 HR 1225	+275
0900	125 / 125									350 / 350						
1000	125 / 250															
1100	125 / 375															
1200	125 / 500	100 / 100	250 / 250							475 / 825						
1300	125 / 625		250 / 500							75 / 900						
1400	125 / 750															
1500	125 / 875	100 / 200														
1600	125 / 1000									375 / 1275						
8 HR	1000	200	500						16 HR 1700	1275		—	—		16 HR 1275	+425
1700	125 / 125	100 / 100	250 / 250													
1800	125 / 250									350 / 350						
1900	125 / 375		120 / 370							125 / 475						
2000	125 / 500									400 / 875						
2100	125 / 625									150 / 1025						
2200	125 / 750		120 / 490							250 / 1275						
2300	125 / 875															
2400	~~100~~ 125 / 1000								1590	100						1700 / 1675
8 HR	~~150~~ 1000	100	490						24 HR 3290	1675					24 HR	~~3171 + 50~~ 3375

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12 Oct 03		2200	(continued) (B) CT to H_2O seal w/d Pur leaks (Ø) leaks found (B) CT bandaging CDI, LLQ bandaging CDI OTA (4) thigh abrasions closing well to touch, midline OTA incision CDI, pt c/o discomfort when touched but no actual pain to touch, RN on duty admin 3mg MSO4 + Benadryl 25mg to help pt sleep. Will continue to monitor — (b)(6)-2 [redacted]
13 Oct 03	0200		resting @ this time will continue to monitor pt — (b)(6)-2 [redacted]
13 Oct 03	0230		c/o pain through hand motions to ABD; prn (medication given) see MAR; will cont. to monitor pt — (b)(6)-2 [redacted]
13 Oct 03	0300		sleeping @ this time will continue to monitor pt — (b)(6)-2 [redacted]
13 OCT 03	0930		(B) LT Dcid c̄ Petroleum impregnated gauze + 4x4's securely placed c̄ tape. Pt tolerated well. Medicated c̄ MSO4 5mg IVP. VSS. — (b)(6)-2 [redacted]
13 Oct 03		1315	Pt ambulated approximately 4 ft c̄ ↓ sat in chair for > 1hr. Tolerated well — (b)(6)-2 [redacted]
13 Oct 03	LATE ENTRY	1245	Tolerated approximately 15% of Reg diet — (b)(6)-2 [redacted]
13 Oct 03		1400	Assumed care. Per report, pt just got back in bed from chair. Pt denies pain/discomfort. Will continue to monitor — (b)(6)-2 [redacted]
		1530	Drsg Δ to LLQ completed. Wound red beefy c̄ small amt serous drainage on drsg. Pt tolerated well. Low grade fever @ 100.4°. Encouraged IS. Will continue to monitor — (b)(6)-2 [redacted]
		1800	Pt ate ~10% of dinner meal. Stated that "he did not like it" but was hungry. Offered other food but pt refused. Will continue to monitor. — (b)(6)-2 [redacted]
		1900	ambulated pt from bed up and down ward. Steady on feet but slow. Sats ↓ to 92% on room air. MSO4 5mg given @ 1850 for pain to LLQ (exit wound) and pain in Olecr. Resting in bed currently — (b)(6)-2 [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 OCT 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position		(b)(6)-2	

PREPARED BY (Signature and Title)

(b)(6)-2

CPN

Department/Service/Clinic: ICU

DA (b)(6)-2 14 (b)(6)-2 OCT 3

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

(b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R					2		2							3								2		
	RADIAL L					2		2							2								2		
	DORSALIS PEDIS R					2		2							2								2		
	DORSALIS PEDIS L					2		2							2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale						1		1							1								1		
						3		3							3								3		
						0		8							8								8		
EDEMA						—		—							Ø										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)						✓		✓							✓								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)						SR		NR															NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST					✓		✓															✓		
	BSC																								
	DANGLE																								
	CHAIR															✓					✓				
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓		✓		✓			✓			
	HOB 30 DEGREES					✓		✓							✓		✓		✓			✓	—		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE					✓		✓							✓										
	PAIN SCALE (1-10)																							4	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended						2		2							2								2		
BOWEL SOUNDS (active all quads)						x4		x4							x4 hyper								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.						✓ *		✓									✓						✓		
SKIN INTEGRITY	No Breakdown																								
midline incision	Surgical Wounds					✓	-	✓							✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) + (R) CT site						✓		✓							✓				✓				✓		
#2 (L) LQ						✓		✓							✓				✓				✓		
#3 OTA midline incision						✓		✓							✓				✓				✓		
(L) OTA lateral thigh						✓		✓							✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
TLC	(L) subclavian		CDT /0500 D/C'd 14 Oct 03

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 14 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4		4							4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5		5							5				5				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6		6							6				6				6		
GLASCOW COMA SCALE (A+B+C)					15		15							15				15				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R					3+		3+							4+								2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L					3+		3+							4+								2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE					5		5							4				4				5		
LUE					5		5							4				4				5		
RLE					5		5							4				4				5		
LLE					5		5							4				4				5		
GRIP (S) Strong (W) Weak (-) absent — R					5		5							4				4				5		
GRIP — L					5		5							4				4				5		
RESPIRATIONS — REGULAR					✓		✓							✓				✓				✓		
IRREGULAR																								
UNLABORED					✓		✓							✓				✓				✓		
LABORED																								
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL					5		5							5								5		
LUL					5		5							5								5		
RLL					5		5							4								1		
LLL					5		5							4								1		
BOTH BASES					✓		1							1								1		
COUGH — NONE														✓	✓	✓	✓	✓	✓	✓				
SPONTANEOUS							✓									✓	✓	✓	✓	✓				
PRODUCTIVE																								
NONPRODUCTIVE														✓										
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear							1							1		1	1	1	1	1				
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin							2									2 →								
VENTILATOR — Vt																								
FiO2																								
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)					3L		3L							2L	3L →			2L	1L	0				
FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓					✓					
COUGH / DEEP BREATH														✓				✓	✓					
INITIALS				(b)(6)-2		(b)(6)-2								(b)(6)-2				(b)(6)-2	(b)(6)-2			(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	98.7	70	20	113/53	98		75										3LNC
0600	98.6	75	16	115/70	96%												3LNC
0700																	
0800																	
0900																	
1000	98.2	82	16	113/60	99%												3LNC
1100																	
1200																	
1300																	
1400	98.2 oral	69	24	107/56	93%												3LNC
1500																	
1600																	
1700																	
1800	99.1 oral	67	24	121/54	96%												3LNC
1830																	↓ O_2 → 2LNC
1900		70			97%												
1920																	↓ O_2 → 1LNC
2000		67			96%												O_2 d/c'd
2030		84			92%												up in chair - Ø O_2
2100		78			94%												
2145		~~85~~ 86			95%												
2200	99.0	68	20	138/56	97%												
2300																	
2400																	

	INTAKE									OUTPUT						
	D5NS 20KCl	PO	Zantac	Tylenol					Total	Urine	Blk				Total	COMMENTS
0100	125 / 125															
0200	125 / 250															
0300	125 / 375															
0400	125 / 600															
0500	125 / 725									575 / 575						
0600	125 / 850	50 / 50														
0700	125 / 975		100 / 100													
0800	125 / 1100									400 / 975						
8 HR	1100		50	100					8 HR. 1250						8 HR 975	
0900	125 / 125	120 / 120														
1000	125 / 250															
1100																
1200																
1300																
1400																
1500																
1600										375						
8 HR									16 HR.						16 HR.	
1700																
1800																
1900										200						
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR. 1620						24 HR 1900	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14oct03	0600		pt resting quietly s s/s of distress V/SS. ① abdominal dressing CDI, midline abdominal incision OTA, dressing CDI, ② thigh OTA Dressing CDI, ③ Subclavian TLC patent. SSC [redacted] gl work
	0800		Pt tolerated 40% of breakfast s s/s of distress Ø c/o pain will continue to monitor SSC [redacted] gl work
	1000		pt c/o pain 7mg MSO4 Given [redacted] Ordered will continue to monitor SSC [redacted] gl work
14 Oct 03		1430	Pt ambulated c̄ minimal assistance to main hallway, to OR door → ICU entrance → ICU and up + down ICU x2. Cough x 2-3 times, loose, did not cough up secretions. Ambulated on RA. SpO_2 on RA p̄ walk is 89-90%, HR 80. Placed on 3L O_2 via NC in chair c̄ SpO_2 92-93%. [redacted] MAJ AN
14 Oct 03		1630	LLQ dsg Δ'd w → Δ. Wound bed is beefy red c̄ minimal blood upon removal of old dsg. No S/Sx infection or discharge noted. Pt sat in chair x 1 hr, tolerated well. [redacted] MAJ AN
14 Oct 03		1815	Pt ate ~ 25% of dinner, drinking fluids well. Appears to ~~relate~~ receive adequate pain relief with ~~percet~~ percocet for ~ 4 hrs. Pt is pleasant and cooperative, will continue to monitor. [redacted] MAJ AN
14 Oct 03		2015	Attempted to ambulate, more unsteady @ this time, only walked to ICU entrance and back → chair @ this time on RA c̄ O_2 sat 91-93%. Resp shallow and rapid d/t ↑ pain c̄ deep respirations (per interpreter). [redacted] MAJ AN
14 Oct 03		2145	Neb tx completed @ 2130, lungs CTA in all lobes, diminished in bases. Ø wheezing noted @ this time. Pt used IS and C+DB p̄ neb tx → loose cough, productive for mod. → lg amt white, frothy secretions. SpO_2 95-96% on RA @ this time. [redacted] MAJ AN

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 CPN	(b)(6)-2
(b)(6)-2 CLT, AN	
(b)(6)-2 1st/AN	
(b)(6)-2 MAN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A		
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	15 Oct 03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2							2						2							2		
	RADIAL L		2							2						2							2		
	DORSALIS PEDIS (Post Tib) R		2							2						2							2		
	DORSALIS PEDIS (Post Tib) L		2							2						2							2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8							1 3 8						1 3 8							1 3 8		
EDEMA			0							0						0							0		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R							✓						✓							R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR							✓						✓							NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST		✓							✓						✓									
	BSC																								
	DANGLE																								
	CHAIR										✓														
POSITIONED	RIGHT		S							S						S							S		
	LEFT		E							E						E							E		
	SUPINE		L							L						L							L		
	HOB 30 DEGREES		F							F						F							F		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓													✓							✓		☆
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2							1 2						2							2		
BOWEL SOUNDS (active all quads)			✓							✓						✓							✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓							✓						✓							✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓							✓						✓							✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Incision ABD ~~[illegible]~~			—							✓						✓							✓		
#2 C VABD w/o dressing CDI			—							✓						✓							✓		
#3 C thigh Incision DTA			—							✓						✓							✓		
Chest tube sites #1 & #2 CDI			—													✓							✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)

PUPIL SIZE **PUPILS**

1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 15 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4							4						4							4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		5							5						5							5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6							6						6							6		
GLASCOW COMA SCALE (A+B+C)		15							15						15							15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+																						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+																						
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		5							4						4							5		
LUE		5							4						4							5		
RLE		5							4						4							5		
LLE		5							4						4							5		
GRIP (S) Strong (W) Weak (-) absent — R		5							5						5							5		
GRIP — L		✓							✓						✓							✓		
RESPIRATIONS — REGULAR																								
IRREGULAR																								
UNLABORED		✓							✓						✓							✓		
LABORED																								
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		1							5						5							5		
LUL		1							5						5							5		
RLL		1							5/1						5/1							1		
LLL		1							5/1						5/1							1		
BOTH BASES									1						1							1		
COUGH — NONE																								
SPONTANEOUS			✓												✓									
PRODUCTIVE		✓							✓						✓							✓		
NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		White							1						1									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		3							3						3									
VENTILATOR — Vt																								
FIO2																								
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE		✓																				✓		
COUGH / DEEP BREATH		✓																						
INITIALS		(b)(6)-2							(b)(6)-2						(b)(6)-2							(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.7	56	16	126/52	100%												
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900	98.2(a)	79	22	97/53	95%		69										
1000																	
1100																	
1200																	
1300																	
1400																	
1500	99.5(a)	75	19	104/52	96%		72										
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	99.2	68	16	113/56	99%												
2300																	
2400																	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15OCT03	0001		resting comfortably will continue to monitor pt [illegible]
15OCT03	0830		Tolerated 10-15% regular diet. VSS. NAD. [redacted] ICT, [illegible]
15OCT03	0930		c/o abd pain. Ambulated. Pt belching [redacted] [redacted] To see pt. ordered acute abd series [redacted] ICT, [illegible]
15OCT03		1245	Pt OOB in Chair X2 hrs. Ambulated X2. Pt c̄ unsteady gait. Tolerated well. Consumed approx 10% of regular diet. [redacted] ICT, [illegible]
		1500.	Pt resting comfortably in bed. Got up OOB X1 to use urinal. Moved well, tolerated c̄ minimal discomfort. Will continue to monitor [redacted] [illegible]
		1730	Pt tolerated ~ 10% dinner. Pt stated that he was "not hungry" per interpreter. [redacted] [illegible]
		1735	Drsg Δ completed in sterile fashion. Wound red & beefy c̄ small pocket of mucous like drainage. Sm. amt. Serous drainage noted on drsg. Pt tolerated well. DR [redacted] removed drsgs. to (B) CT sites. No s/s of infection noted [redacted] [illegible]
		1810	Pt c/o pain to abd area. Medicated c̄ 2 percocet per pt request. [redacted] [illegible]
		1830	Pt ambulated around ward and in hall pst. ICW and lack of difficulty or complaint. [redacted] [illegible]
16OCT03		2200	~~ste~~ resting comfortably Ø s/s of resp. distress will cont. to monitor pt [redacted] [illegible]

	INTAKE									OUTPUT						
	PO								Total	Urine	BM				Total	COMMENTS
0100																
0200										300/300						
0300																
0400																
0500																
0600																
0700																
0800	200/200															
8 HR	200								8 HR. 200	200					8 HR 200	
0900										300/300						
1000																
1100																
1200	120/120															
1300																
1400																
1500										375/675						tea-colored
1600	240/360															
8 HR	360								16 HR.	675					16 HR.	–
1700																
1800	60/60									250/250						
1900																
2000																
2100																
2200																
2300										200	x1					
2400																
8 HR									24 HR.						24 HR	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CPL	ICU	16 Oct 03

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

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78