STHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

3 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 100 KG/LB HT: ____ IN.
ALLERGIES: ~~NKDA~~ PCN

OSED PROCEDURE: (L) Thigh I&D / PPC
ICAL SERVICE: GS
INCE: P MN

S:
ACCO: ____
ETOH: ____
RUGS: ____

ENT MEDICATIONS:
dered as premed
~~Zofran~~ Zantac
Cefotan 2 Gms
MSO4

EDICATIONS:
Yes (@ ____ Hrs) /CC
.. ____ mg IV IM PO
.. ____ mg IV IM PO
.. ____ mg IV IM PO

RATORY STUDIES:
T: ____/____
R: ____

9.6 / 12.2 / 39.7 / 24.6

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Wound Exp (FST) 27 June
I&D wounds 23 June

PHYSICAL EXAMINATION

BP 130/8 HR 88 R 16 T 99
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck 3FB
Oropharnyx grade 2
Nares ____
CHEST: distant sounds / CTA
CARDIAC: S1 S2 ± (NV)
EXTREMITIES:
IV Access: 18GAC (L) hand
Ulnar Filling: ____
BACK: ____
OTHER: grade 1 view on previous intubation

NPO Since P MN

STHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): b(6)-2 { } ~~General~~: Mask Intubation
EPW (No interpreter / [redacted] MAT, CRNA

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

tient/legal guardian seems to understand and agrees. Questions answered.
: ____ Date: 29 Jun Time: 1030 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER
: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) ____
[redacted] (ICW2 - FCU1)
b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	(mg)	3
Fent	(µg)	150 50
Lido	(mg)	50
Succs	(100)	100
STP	(mg)	300
MSO4	(mg)	5
VOLAT AGENT Sevo	% del	2.0 2.0 2.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 10

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

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

FLUIDS		
LINE site 18ga (R) LR	☐ Warmed	500 1200
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		15 min
URINE –		1800

TOTALS	
TOTAL FLUID	Min
TOTAL URINE	1800

FLUIDS – SUMMARY

CRYSTALLOID– 1200

COLLOID– Ø

BLOOD– Ø

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

BODY WEIGHT: 100 (KG) LB

HEMATOCRIT: 39.7

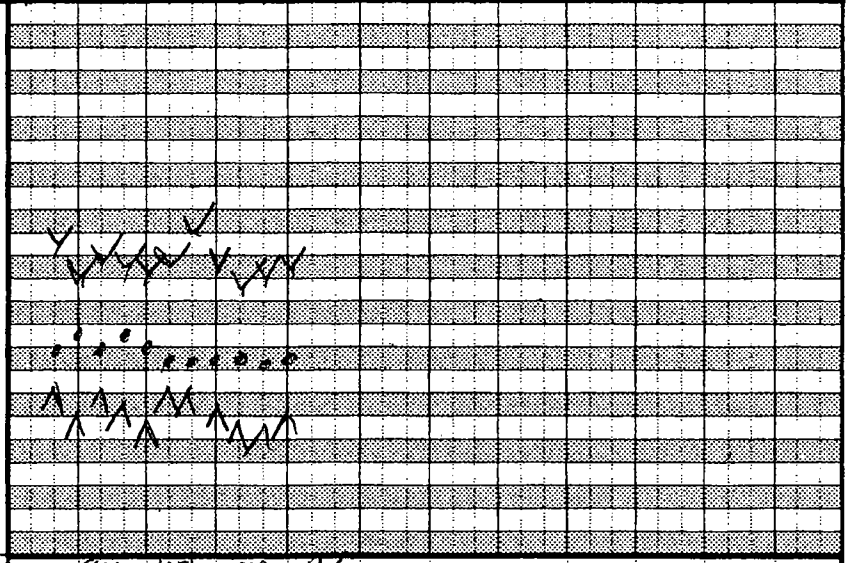
INITIAL DATA: BP – 133 / 72 HR– 90

TEMP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME– 1630

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

TIME → 17 X 30 X 18 X 30 X 19



VT – ml		900	1000	1000	SV
f – breaths/min		10	10	10	10
Peak inf pres / PEEP			27	27	27
MODE– S(pon), A(ssist), C(on)		S→	CV	CV	CV S
BP/Auto Cuff	ET CO2 (torr)	38	39	38	33 42
BP / oth	FIO2 (Frac or %)		.55%	.55%	.55
ART line	SpO2 (%)		100	100	100
Steth- PC/ES	ECG		SR	SR	SR
Gas analyzer	TEMP- site		Avail site		
	N-M Block (T/4)		0/4		
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS

EVENTS Position → 900 on prone pillows

REMARKS– Code drugs with numbers, events with letters

1705 Pt interviewed in ER intervewer explained plan. To OR Monitors applied. 1715 I@I 1720 turned to prone pillows at ankles, Up chest, Face on pillow nose, eyes ETT checked (+) Bilat BS. Shoulders supported.

1859 Returned to supine (+) bilat BS

1800 Reversal 5 mg Neostig, 1.8 mg Robinul

1805 Spont Resp. Oral suction. Purposful movement extubation

transfered to ICU

Report given

RECOVERY AT 1820 1815

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP– 18 SpO2– 99.9

BP– 147/59 HR– 98

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES	1625	1705	1820
	Ready	Begin	End
PROC	1715	1735	1755

PROCEDURES and CPT Codes: Washout GSW to (R) Butt & Bilat thighs

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #3 MAC, 8.0 ETT one attempt grade I view, secured at 24 cm teeth. (+) ETCO2 (+) Bilat A

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

EPW [redacted] b(6)-4

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

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

PROCEDURE LOCATION [redacted]

DATE 6/27/03 b(2)-2

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12242

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D leg wounds.
SURGICAL SERVICE: Gen. S.
NPO SINCE: 12hr

ASA Physical State 1 2 3 4 5 E
WT: 100 KG/LB HT: ____ IN. 18cm
ALLERGIES: PCN

HABITS:
TOBACCO: Ø
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

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

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea mid line
TMJ/Neck ____
Oropharnyx cl 3
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: gd
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patien[redacted] b(6)-2 ms to understand and agrees. Questions answered.
Signed: [redacted] Date: 7/12/03 Time: 0730 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

Sa [redacted] b(6)-4

SEDATION KEY:

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D leg wounds.
SURGICAL SERVICE: G.S.
NPO SINCE: 12hr

ASA Physical State 1 2 3 4 5 E
WT: 100 KG/LB HT: ____ IN. 18 mon
ALLERGIES: PCN

HABITS:
TOBACCO: Ø
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

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

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y Ø

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth unremarkable
Trachea midline
TMJ/Neck ____
Oropharnyx Cl 3
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: gd
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient [redacted] seems to understand and agrees. Questions answered. b(6)-2
Signed: [redacted] Date: 2/12/03 Time: 0730 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

Sd [redacted]
b(6)-4

SEDATION KEY:

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

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
EPW # [redacted] b(6)-4			15 Mar	1932 HOURS	
			OK to Bone Scan		Hospital [redacted]
				b(6)-2	1330
NURSING UNIT	ROOM NO.	BED NO.			
ICW 2		7			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b(6)-4				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
ICW 2		7			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b(6)-4				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
ICW 2		7			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b(6)-4				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
ICW		7			

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AN SIGN
EPW [redacted] b(6)-4	27 Jun 03	1710 HOURS	
ISING UNIT: 1CW2 / ROOM NO. / BED NO.	1- Admit to ICW		
	2- NPO		
	3- IVP LR @ 100 cc/hr		
	4- VS per Routine		
	5- I/O q shift		
	6- UP AD-lib		
	7- MSO4 1-2 mg q 1° prn pain		
IENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b(6)-4		HOURS	
	8- Phenergan 25 mg IVPB q 8° prn nausea		
	9- Heparin 5000 U SQ q 12°		
	10- Foley to Gravity		
SING UNIT: 1CW2 / ROOM NO.: 24Vs 28 Jun 03 (1400) / BED NO.	[redacted]		b(6)-2
IENT IDENTIFICATION	DATE OF OR[redacted]	IME OF ORDER	
EPW [redacted] b(6)-4	28 Jun 03	0815 HOURS	
	1- Regular Diet		
	2- Hep-lock IV		
	3. MSO4 1-4 mg q 0		
	4 - Bed Dressing Δs [redacted]		28 Jun 0900 b(6)-2 [redacted]
SING UNIT: 1CW2 / ROOM NO. / BED NO.	[redacted]		b(6)-2
ENT IDENTIFICATION	DATE OF ORDER	T[redacted]	
EPW [redacted] b(6)-4	28 Jun 03	1700 HOURS	
	1- Demerol 1/2 mg q 4° prn pain		[redacted] b(6)-2
	2. Ac nursery		28 Jun 03 1733
SING [redacted] 1CW2 / ROOM NO. / BED NO.			

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.: [redacted]

DATE OF ORDER: 28 JUN 03 TIME OF ORDER: 1900 HOURS

NPO - MN
for wsnot / DPC
28 JUN 03

LIST TIME ORDER NOTED AND SIGN: [redacted] b(6)-2 9/Jun 03 28 June 03 1900

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: t

DATE OF ORDER: 29 JUN 03 TIME OF ORDER: [redacted] HOURS

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

[redacted] 29 June 03 0640 b(6)-2

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: t

DATE OF ORDER: 29 JUN 03 TIME OF ORDER: _____ HOURS

1. Admit to ICW
2. Clear liquid diet - may advance
3. IVP URC w/a/m - Hep-lock when tolerating PO
4. VS per routine
5. up c̄ assistance b(6)-2
6. D/C q shift

[redacted]

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: t

DATE OF ORDER: TIME OF ORDER: _____ HOURS

7. Percocet 1-2 PO q3-4° prn pain
8. MSO4 1-2 mg q2° prn Breakthrough pain
9. Phenergan 25 mg IVPB q8° prn nausea
10. Ativan 1 gm q8° IVPB
11. Heparin 5000 u SubCut q12°
12. Bid dressing changes for anterior wounds only cut to [redacted]

6/11/22

[redacted] b(6)-2

[redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES [redacted] CH 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
EPW [redacted] b(6)-4				30 Jun 03	1600 HOURS	
			(1)	DC I/O's		[redacted] b(6)-2
			(2)	Continue to record JP output		[redacted] 1800
NURSING UNIT	ROOM NO.	BED NO.		[redacted] b(6)-2		
ICW2	24	7				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
				[redacted] b(6)-2	HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW# [redacted] b(6)-4					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
ICW2		7				

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29
27	[redacted]	NPO	6	/	[redacted]	/
			11	/		/ DC 28 Jun
			17	/		/
27	[redacted]	VS PER Routine	5	/	[redacted]	
			13	[redacted]		
			21	[redacted]		
27	[redacted]	I + O's	5	/	[redacted]	
			13	[redacted]		
			21	[redacted]		
27	[redacted]	ACT: UP AD LIB	5	/	[redacted]	
			13	[redacted]		
			21	[redacted]		
27	[redacted]	Foley to Gravity	5	/	[redacted]	/
			13	[redacted]		/ DC 28 Jun
			21	[redacted]		/
28 Jun	[redacted]	Regular diet	09	/	/	[redacted]
			13	/	[redacted]	
			17	/	[redacted]	
28 Jun	[redacted]	Dsg Δ's BID	08	/	/	[redacted]
		Wet → Dry	20	/	[redacted]	

ALLERGIES: ☒ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: GSW buttocks & thighs

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27	[redacted]	ADMIT TO ICW	27		1930	[redacted]
28	[redacted]	NPO PMN for IP washout	28	2400		[redacted]
29	[redacted]	NPO	29	now		

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

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD

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

Mo. 10 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2	3	4	5
29	[redacted]	CL diet-advastol.	07	/	[redacted]					
			11	/						
			17	[redacted]						
			/							
29	[redacted]	VS per routine	06	/	[redacted]					
			14	[redacted]						
			22							
			/							
29	[redacted]	up c assistance	06	/	[redacted]					
			14	[redacted]						
			22							
			/							
29	[redacted]	dressing changes BID	08	/	[redacted]					
		for anterior wounds	20	[redacted]						
		only - wet to dry	/							
			/							
29	[redacted]	record JP output	06	/	[redacted]					
		QS	14	[redacted]						
			22							
30	[redacted]	I/O q shift	05	/	[redacted]					
			13	/						
			21	[redacted]						

DCd 30 Jun 03

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
SIP IBD thigh GSW

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

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

"EPW"

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

All b(6)-2

Verify Initials		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29	[redacted]	admit to ECW2	29	—		[redacted]
1	[redacted]	evac to Iraqi hospital				

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

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 27	28	29	30	1	2	3	4	5
27	[redacted]	IVP: LR@100cc/hr	5	/	[redacted]		/					
			13	[redacted]				D/C			28	
			21	[redacted]		/						
27	[redacted]	Heparin 5000U	10	/	[redacted]							
		subcut Q12°	21	[redacted]								
27	[redacted]	HL: flush QS	05	/	[redacted]							
			13	/	[redacted]							
			21	/	[redacted]							

ALLERGIES: ☐ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: GSW buttocks & thighs

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27	[redacted]	MSO4 1-2mg	2mg 28 Jun 0000 IVP	28 Jun 0530 2mg	28 Jun 0900 2mg		DC 28 Jun									
- - - - -	- - - - -	Q1° prn pain	[redacted]	[redacted]	[redacted]											
- - - - -	- - - - -															
27	[redacted]	Phenergan 25mg IVPB														
- - - - -	- - - - -	Q8° prn nausea														
- - - - -	- - - - -															
28 prn	[redacted]	MSO4 1-4 mg	28 Jun 1020 4mg	28 Jun 1345 4mg			DC'd 28 June									
- - - - -	- - - - -	Q1° PRN	[redacted]	[redacted]												
- - - - -	- - - - -															
28	[redacted]	Percocet 1-1 po	28 June 1735 1	28 June 0415	28 June 1000 2											
- - - - -	- - - - -	q4° prn pain	[redacted]	[redacted]	[redacted]											
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1	2	3	4	5
29	[redacted]	LR @100 cc/hr - HL	06	[redacted]						
		When TOL PO	14							
		(HL 20 Sm 0630)	22							
			1							
29	[redacted]	ancef 1 gm 980	06	[redacted]						
		IVPB	14							
			22							
			1							
29	[redacted]	Heparin 5000u	10	[redacted]						
		SQ 912	22							

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: S/P I&D GSW (R) thigh

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

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 6 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
29 2	[redacted]	Percocet 1-2 po q3-4° prn-pain	29 Jun [redacted] 1930	30 Jun 00:57 [redacted]	30 Jun 0900 [redacted]		30 Jun 1800 [redacted]	30 Jun 2000 [redacted]	30 Jun 2315 [redacted]	1 Jul 1630 [redacted]	1 Jul 2130 [redacted]					
29 2	[redacted]	MSO4 1-2 mg q2° prn-breakthrough pain	29 Jun 2mg [redacted] 1930	30 Jun 2mg 1030 [redacted]												
29 13	[redacted]	Phenergan 25 mg IVPB q8° prn nausea														

USAPA V1.00

100Kg

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 27 JUN
Time In: 1815
Allergies: PCN
Pre-op V/S: 133/72 HR 90
Procedures: Wash out EPW buttock & thighs

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

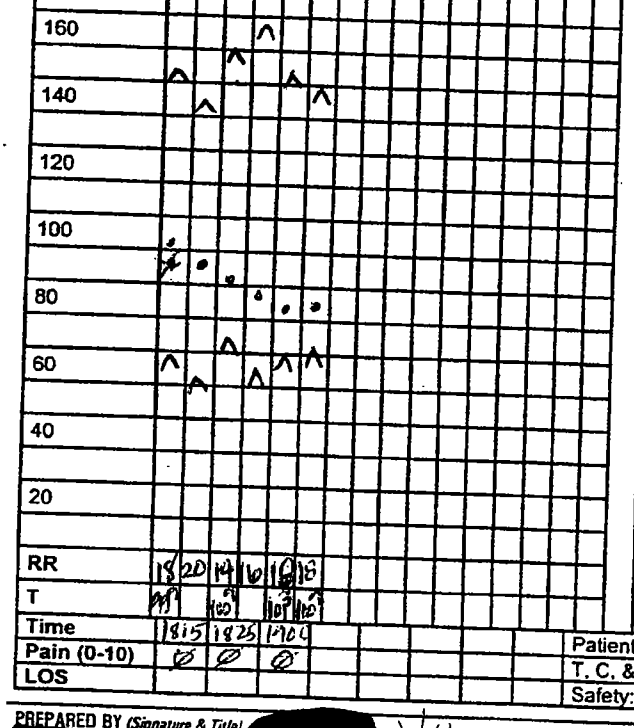
OR Intake: Crystalloid 1200 LR Colloid
OR Output: UOP 1800 EBL minimal
Meds/Times:

3 versed 200mcg fentanyl 50mg MS04

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

Pre Op Meds History

Time	1815	1820	1825	1830	1835	1900	1930	
SaO2	97	96	96	100	96	98		
FiO2	RA	RA	RA	100	RA	RA		
Methods				NRB				



RR	18	20	14	16	18	18		
T	99		100		101	100		
Time	1815		1825		1900			
Pain (0-10)	0		0		0			
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b(6)-2 SPC 91WML6

DEPARTMENT/SERVICE/CLINIC: ICU2/PACU

DATE: 27 JUN 03

[redacted] entries give: Name – last, EPW # [redacted] b(6)-4 35 y/o ♂

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

All b(6)-2

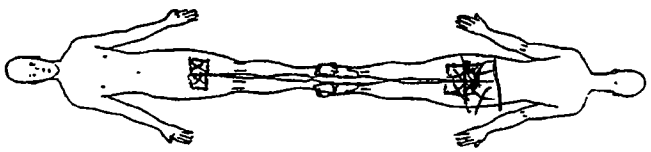
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS							
	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	RFL inner thigh buttocks	16x8" gauze	minimal
30'	"	"	minimal
60'	"	"	
D/C	"	"	



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1920	foley	Clear/Yellow	625

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1815 Pt arrived from OR via litter. Lung Sounds clear bilaterally apex to base. RR equal + unlabored. O_2 Sat 96-99% RA. BS active x4 Quadrants. Radial + pedal pulses strong + equal to palpation. Cap Refill <3sec to all extremities. LR @ 100cc/hr to (L) forearm. No c/o pain. Alert to verbal stimuli. SPC [redacted] WMC

1825 Pt placed on 10L Non-Rebreather for O_2 Sat of 88% RA. Will wean as tolerated SPC [redacted]

1842 Dressings to Pt buttocks + bilateral inner thighs. 16"x8" gauze + tape. Drainage noted, minimal > (R) thigh.

1846 Pt removed from 10L Non-Rebreather, placed on RA. Maintained O_2 Sat @ 100% RA, RR 20. Will continue to monitor. SPC [redacted]

1919 Pt temp 101.3°. MD informed. SPC [redacted]

1925 Report given to ICW #2. SPC [redacted]

1928 Pt able to wiggle toes on (L) extremity, able to move/bend (R) knee, pt not able to wiggle toes on (R) foot. - SPC [redacted]

Discharge Criteria:
Date: 27 Jun 03 Time: 1930 PARS: 9
BP: 139/62 T: 100.9 HR: 74 RR: 18 Sa02: 98% RA
Pain Level at D/C (0-10):
Intake: 200cc LR Output: 625cc
Additional Data: ~~[illegible]~~ temp 101.3 MD aware
Transferred To: ICW #2
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SPC [redacted]
Cleared IAW Recovery Room SOP [redacted]
Charge Nurse Signature: [redacted]

Name:
SSN:
DOB:
Unit:
Nationality:

HT:
WT: lb
WT: kg

DATE:
TIME:

Additional Orders/Charting:

1st Flight Doc

1. Admit: OR; ICU; Holding:
2. **Diagnosis:**
3. Condition: VSI SI Critical Guarded Stable
4. **Allergies:**
5. **VS:** Q5-15 min; Q1 hr; Q2 hrs; Q4 hrs; Q ___ hrs; Notify MD for SBP: > ____ or < ___; DBP: > ___ or < ___; HR: > ____, < ____; RR: > ____, < ____; Temp: > _____
6. **IVF:** LR @ _____ cc/hr; NS @ _____ cc/hr; Albumin @ ____ cc/hr; Hespan @ _____ cc/hr
7. Monitor: Cardiac; Pulse Ox; Neuro Q ____ m/hr; A-line;
8. I&O: Q1 hr; Q ____ hrs
9. Drains: NG to Low or Cont suction; Foley to gravity
10. CT #1: 20 cm H2O suction, H2O seal; Heimlich
11. CT #2: 20 cm H2O suction, H2O seal; Heimlich
12. **LABS:** ABG now & Q1 hr; Q2 hrs; Q ___ hrs; PRN Hct now & Q ___ hrs; Chem now & Q ___ hrs; UA
13. **BLOOD:** T&S ____ units; T&C ____ units; Transfuse: ___ units PRBC or Whole Blood for Hct < ___%
14. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB _____; Keep Stats > 92%, > 95%
15. Diet: NPO, Sips of H2O, Clear liq, Regular, Other ____
16. Activity: Bed rest; BRP; Ward/Unit; Other _____
17. **MEDS:**
    - Morphine 2, 4, or 6 mg IVP Q ____ min/hr prn Pain
    - Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
    - Zofran 2-4 mg IVP Q ___ hrs prn Nausea
    - Zantac 50 mg IVPB Q 8 hrs
    - Abx: Ancef 1 gram in 100cc NS IVPB Q6-8 hrs
    - Abx: Cefotan 2 grams in 100cc NS IVPB Q12 hrs
    - Abx: Clindamycin 600 or 900mg in 100cc NS IVPB
    - Abx: Pen G 2 mil units in 100cc NS IVPB Q4-6 hrs
    - Abx: Gentamicin 5 or 7 mg/kg/day IVBP over 30 min
18. **VENT:** SIMV; TV: ____; RR: ___; Fio2: ___%; PEEP ABG Q ___ hrs;
19. **Ortho:** Wound Irrigation w/ NS; Batadine & Gauze Dsg
    - Soiled Dsg = Reinforce & notify MD; Splint; Cast
    - Neurovascular checks Q ___ hrs; Distal Pulse/Circulation
    - Elevate extremity above heart on blankets
20. X-Ray:
21. **EVAC:** Priority w/in 4-6 hrs; Routine w/in 24 hrs;

274th FST Doctors Orders +, by CPT [redacted] as of 29 Nov 2001

b(6)-2

DATE: 27 Jan 03

TIME: 1000 b(6)-4

Name: [redacted]

SSN: 33 yo IM

DOB:

Unit:

Nationality: Iraqi

HT:

WT: lb

WT: 100 kg

Additional Orders w/ Date & Time/Charting:

1. **Admit:** Recovery transfer to ICU ... Holding Company
2. **Diagnosis:** S/P GSW (3) Thigh / (1) Buttock.
3. **Condition:** VSI SI Critical Guarded Stable
4. **Allergies:** PCN 2 Ceph ok.
5. **VS:** Q 1 hr; Q 2 hrs; Q 4 hrs; Q 8 hrs.
   Notify MD for SBP: > 180 or < 90; DBP: > 100 < 50;
   HR: > 120 < 60; RR: > 30, < 10; Temp: > 101
6. **IVF:** IVF: LR @ 100 cc/hr; NS @ ____ cc/hr;
7. **Monitor:** Cardiac; Pulse Ox; Neuro Checks Q ____ m/hr; A-line:
8. **I & Os:** Q1 hr; Q ____ hrs
9. **Drains:** NG to Low/Cont suction; JP Drain; Foley to gravity
10. **Chest Tube:** 20 cm H2O suction, H2O seal; Heimlich
11. **LABS:** ABG now & Q1 hr; Q2 hrs; Q ___ hrs; PRN
    Hct now & Q ___ hrs; Chem now & Q ___ hrs; Urine Dip
12. **BLOOD:** T & S ____ units; T & C ____ units;
    Transfuse: ___ units PRBC or Whole Blood for Hct < ___%
13. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB; _____
    Keep Stats > 92%, > 95%, _____
14. **VENT:** SIMV; TV: ____; RR: ____; Fio2: ____%; PEEP: ____;
15. **Diet:** NPO; Sips of H2O, Clear liquids, Regular, MRE,
16. **Activity:** Bed Rest; BRP; HOB Up; Holding area/Unit; Other ____
17. **MEDS:** Morphine 2, 4, or 6 mg IVP Q 10 min/hr prn Pain
    Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/shivering
    Toradol 15/30 mg IVP/IM Q 6 hrs/prn Pain (up to 5 days)
    Percocet 1 –2 tabs or Tylenol III 1-2 tabs PO Q 6 hrs prn Pain
    Zofran 2-4 mg or Phenergan 12.5 – 25 mg IVP Q ___ hrs prn Nausea
    Zantac 50 mg IVPB Q 8 hrs
    Vent Sedation: Diprivan / Propafol: 5–50 mcg/kg/min on a pump
    Sedation: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg
    Abx: Ancef 1 gram in 100cc NS IVPB Q6-8 hrs
    Abx: Cefotan 2 grams in 100cc NS IVPB Q12 hrs (1st done at 0730 [redacted]) b6-2
    Abx: Clindamycin 600 - 900mg 100cc NS IVPB over 30 minQ8 hrs
    Abx: Gentamicin 5 or 7 mg/kg/day IVBP over 30 min Q day
    Abx: Pen G 2 mil units in 100cc NS IVPB Q4-6 hrs
    Abx: Unasyn 1.5 or 3 grams in 100cc NS IVPB Q 6 hrs
18. **Ortho:** Wound Irrigation w/ NS; Batadine & Gauze Dsg
    Soiled Dsg = Reinforce & notify MD; Splint; Cast
    Neurovascular checks Q 1 hrs; Distal Pulse/Circulation
    Elevate extremity above heart on blankets
19. **Wound Care:** Wet to Dry Dsg Change NS Q ____ to _____
20. **BURNS:** IVF of LR: 4 cc/% BSA burn/kg = total 24 hr fluids;
    Give ½ over 1st 8 hrs from Time of Burn; Clean Sterile dsg
21. **Head Injury:** Neuro checks (GCS) Q ___ min/hrs;
    C-Spine: Clear/NOT Clear; Keep Head in midli[redacted]ion;
    Mannitol (20%): 0.25/0.50/1 gm/kg IV[redacted]
    Notify MD for Mental Status c[redacted]
20. **EVAC:** Priority w/in 4-6 hrs: [redacted]
21. **Signature of Provider:** [redacted] MD

274th FST Post-OP Orders, By CP[redacted]

b(6)-2

Initial Assessment
Date 27 June 03 Time 0452

TH FORWARD SURGICAL TE

ICU____
OR____

NEUROLOGICAL ASSESSMENT

2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level on Consciousness
X Awake __Alert __Drowsy
__Restlessness __Lethargic
__Unconscious

Orientation:
__Time __Place __Person

Eyes Open:
__Spontaneous
__To Speech
__To Pain
__No Response

Best Verbal:
X Oriented & Converses
__Disoriented & Converses
__Inappropriate Words
__Incomprehensible Sounds
__No Response

Best Motor:
X Obeys Commands
__Localizes Pain
__Extension
__No Response

Motor Ability & Strength:

	Strong	Weak	Absent
RA	5/5		
LA	5/5		
RL		4/5	
LL	5/5		

PSYCHOLOGICAL
__Calm __Combative
__Cooperative X Anxious

INTEGUMENTARY

Color:	Skin:
X Normal	X Warm
__Pale	X Dry
__Flushed	__Diaphoretic
__Cyanotic	__Cool
__Jaundiced	__Clammy

RESPIRATORY
X Unlabored __Labored

Breath Sounds:
X Clear Bilaterally
__Absent R L
__Rales R L
__Wheezes R L

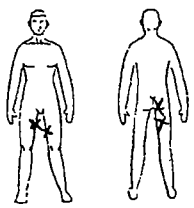
ABDOMINAL
X Soft __Tender
__Rigid __Non-Tender
__Distended __Rebound

Bowel Sounds:
__Active __Hypoactive
__Hyperactive __Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial		
Femoral		
Pedal		
Edema		

0-Absent + 2-Normal
- 1-Weak + 3-Bounding



Time	Temp	P	R	B/P	NURSING OBSERVATIONS/INTERVENTIONS
0510		93	18	136/68	Irrig: of approx 36 y/o c GSW
0545		80	18	116/64	to upper (R) thigh, (R) buttocks cheek,
					& upper (L) thigh. Pt recieved
					16gu IV in (R) arm & 18gu
					IV in (L) arm. of LR.

Allergies

Time	IV	MEDICATIONS (dose/route site)
0502	4mg	Morphine [redacted] b(6)-2
~~05~~	~~1g~~	~~Ancef~~ Not given 2° possible allergies
0540	3mg	Morphine

INTAKE/OUTPUT	Time	IV	Urine	Chest	Gastric	Pertinent Lab Values
	Total:					

b(6)-4
[redacted]
33 yo JM

ATLS WORKUP SHEET

DA FORM 4700 274th FST OP 1

Remove Drain (L) thigh packed w/ gauze (R) thigh

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 27 JUN 03
Time In: 1015
Allergies: Penicillin
Pre-op V/S:
Procedures: GSW (L) thigh (R) buttock

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

OR Intake: Crystalloid 3700 Colloid
OR Output: UOP 900 EBL 100
Meds/Times: 10mg MSO4

[redacted]

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1015	1020	1025	1030	1045	1100	1115	1145	1215
SaO2	98	99	97	97	96	95	96	96	95
FiO2	SL	SL							
Methods	FM	FM	RA	RA	RA	RA	RA	RA	RA
240									
220									
200									
180									
160									
140	V	V	V	V	V	V	V	V	V
120									
100	•	•	•	•	•	•	•	•	•
80									
60	^	^	^	^	^	^	^	^	^
40									
20									
RR	12	10	13	16	17	14	13	15	11
T									

Time									
Pain (0-10)									
LOS									

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1115	LR	150 cc	(L) (R)		
1215	LR/NNL	200 cc	(L) FA		

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
" = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

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

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

[redacted] b(6)-4

37 y/o ♂

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

[redacted]

All b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1146		MSO4 4mg	IVP			[redacted]
1219		MSO4 4mg	IVP			[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Foot		+	P	B	W	
15'	Foot		+	P	B	W	
30'	Foot		+	P	B	W	
45'	Foot		+	P	B	W	
60'	Foot		+	P	B	W	
90'							
D/C							

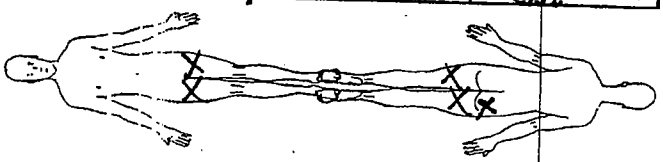
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Bilat Thigh	Gauze	CDI
30'	Bilat thigh	Gauze	CDI
60'	(R) thigh	Abd pad	red drainage
D/C	Bilat thigh	Gauze	CDI



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1115	Foley	clear yellow	350 mL
1215	Foley	clear yellow	250 mL

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1015	NSR	N/A	
1045	NSR	N/A	

WAMC OP 173-E

NURSING NOTES

1015 - Pt arrived from OR via Litter. Responsive to voice, LCTA all fields, respiratory effort even unlabored. Skin warm, dry, color weak. IV running LR (L) FA & (R) AC. S_1 S_2 present cap refill < 2 sec. Bandages to bilateral thigh & (L) shoulder. Penrose drains bilateral thigh. Foley to gravity. Strong, active, movements all extremities. [redacted]

1016 - Strong palpable radial & pedal pulses bilat.

1115 - PMS present bilateral lower extremities skin warm dry [redacted]

1146 - Dressing reinforced (R) thigh due to seepage. [redacted]

1156 - IV (R) Ac D/c'd, sluggish flow poor draw back. IV (L) FA ↑ 1000 cc NaCl 0.9% [redacted]

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 29 June 03
Time In: 1900
Allergies: NKA
Pre-op V/S:
Procedures:

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

OR Intake: Crystalloid ____ Colloid ____
OR Output: UOP ____ EBL ____
Meds/Times: ____

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

Pre Op Meds

History

Time	1900	1905	1910	1920	1930
SaO2	100	100	100	97	97
FiO2	4L	6L	6L	RA	RA
Methods	FM	FM	FM	/	

240
220
200
180
160
140
120
100
80
60
40
20

RR	12				
T	100.8		100.9		100.7

Time																		
Pain (0-10)																		
LOS																		

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:
Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	11	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
* = Cuff BP
@ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREPARED BY (Signature & Tit[redacted] b(6)-2

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: TCU 1

DATE: 29 JUN 03

PATIENT'S [redacted]
first, middle, grade; date; hospital or medical facility)

Name – last,

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

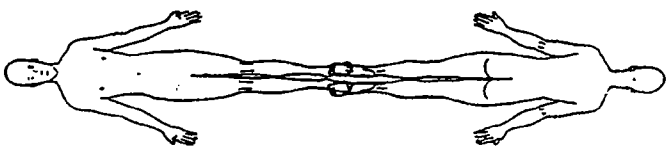
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'	R thigh, buttock	gauze, tape	Ø
60'	L thigh, buttock	gauze, tape	Ø
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1925	ST-117		

WAMC OP 173-E

NURSING NOTES

Pt Brought To ICU Via Litter For Recovery. Anesthesia OB Bs. O2 sat 100% upon Arrival c O2 @ 6L Non Rebreather [redacted] Mg/AN

b(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A 1 1 D 1	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	EPW # [redacted] b(6)-4	EPW	M

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1710	b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW #2	UNK
[redacted] b(2)-2		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
21		030701

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030627

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

FOR LOCAL USE

Dx: GSW to buttocks & Thighs

Dx 8770 Proc 8604
8900 8659
9560 9635
E9912 Trauma 9
194 Inj 569

b(6)-2 [redacted]

ADMITTING OFFICER (Signa[redacted]

DR. [redacted]

SIGNATU[redacted]TTING CLERK

[redacted] b(6)-2

DA FORM 2085, MAR 80

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 1 D 1	I Z	[redacted]	EPW # b(6)-4 [redacted] b(6)-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	Ø 3 7	2	2	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1373	b(6)-4

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

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
Ø	ICW #2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
3 0		0 3 0 6 2 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		0 3 0 6 2 7

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

FOR LOCAL USE

DX: 6500 Bilateral Thighs & Buttocks

DX 8901 Trauma
8771 Inj 56

Proc 8605 X 3
4823

b(6)-2

b(6)-2

ADMITTING OFFICER	SIGNATURE OF ADMITTING CLERK
DR. [redacted]	[redacted] b(6)-2

DA FORM [illegible] EDITION OF MAY [illegible]

[redacted]

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW# [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 23y	6. RACE —	7. RELIGION —	LENGTH OF SVC —	8. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION —			14. WARD 1011
15. FLYING STATUS —	16. FLYING DSG —	17. DEPT/BRN b(6)-4 K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 1534	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 26 July 03		b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 28 June 03		ADMITTING OFFICER Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: S/P Colostomy / I&D (L) FA

863.54
821.10
813.32
879.4
E922.9
958.8

78.53
79.62
86.28
86.59

35. Total Days This Facility 54.62

a. ABSENT SICK DAYS	b. OTHER DAYS	c. [redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø		Ø	22	22

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL O[redacted]DICAL RECORDS OFFICER

DR [redacted]

DA FORM [redacted] USAPPC V1.10

b(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23 yo Iraqi male states he was in taxi with a friend. His friend fired a weapon in the air. US Army Returned fire. No friend @ scene

AH	PMH	PSH	TOB	Meds
Ø	Ø	Ø	Ø	Ø

PHYSICAL EXAMINATION

NC AT HR 88 117/57 99% on RA

Neck c̄ Clear

Chest CBTA

Car RRR 2+PP. @ Ulnar Ø @ Ø

Abd (L) flank wound @ iliac crest

Appears soft.

Pelvis stable

Ext thru & thru (L) Arm GSW c̄ soft tissue loss

Ulnar nerve out medically compromised

(R) knee ext entrance wound NVI

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

A/P GSW to (L) Forearm, (L) flank (R) knee.

(1) CT Abd/pelvis

(2) to OR for (L) Forearm I/D

b(6)-2

SIGN [redacted]	E 28 Jan 03	IDENTIFICATION NO.	ORGANIZATION
PATI [redacted]	e Name last, first, ...grade, date, hospital or medical facility)	REGISTER NO.	WARD NO.

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28JUN03	Surgery Brief op note
1830	indication GSW to Abd
	Procedure - Ex LAP, (L) colon Resection
	Descending colostomy with Hand pouch.
	Surgeon: b(6)-2 [redacted] / [redacted] b(6)-2
	Anesth - GEA
	Fluids 1400 CR UO 450
	EBL 50
	Findings Through & Through GSW to (L) colon
	@ Junction i Sigmoid, Area Resected
	and Descending colostomy 'Hartman
	pouch.
	No ureteral / vascular injury.
	Comp None
	to ICU in good cond.
	[redacted] b(6)-2

AUTHORIZED FOR LOC

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
1 July 03 0245	Pt transferred from ICU1 @ 2330, Pt had heart rate @125, c/o pain. 4mg MSO4 IVP given @0040. At 0200 pt had no c/o pain hr=95. Lung sounds CTA, BS(+)X4. Pt on 1-2L O2 via nasal cannula, sats>95%. Foley output cyu, insertion site CDI. Colostomy bag c̄ minimal output, site CDI. Pt with NG tube clamped, green residue in tube. Dsg on RLE, inner thigh CDI. Dsg's on Abd CDI; LUE dsg CDI, pt c̄ (+) sensation and rom. c/o slight irritation in throat. Will continue to monitor. SPC [redacted] 91WM26 b(6)-2
1 July 03 0715	MD Progress POD # 3 Had I+D (L) arm yesterday + t'fered to ICW S/ No complaints. No nausea. Some pain in (L) arm O/ Afebrile HR 120's BP 126/78 Abd soft ND (+)BS Ostomy pink ØGas Incision CDI JP pulled yesterday 6.9 / 28 A/ Doing well. Bowel function returning P/ 1) PO pain meds 4) D/C Ceftetan. Ancef for Fx 2) NGT pulled 5) Clear diet 3) Clear diet 6) Transfer to Iraqi hospital if Civilian status. If not will keep until tol res diet + t'fer to [redacted] EPW Camp. b(6)-2

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S SSN or Other

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED [redacted]

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

→ OK this per Dr [redacted]

[redacted] b(6)-4

EPW

PROGRESS NOTES
Medical Record
STANDARD FORM 50

AUTHORIZED FOR LOC

EDICAL RECORD

PROGRESS NOTES

DATE	NOTES
1 July 03	0740 D/C Pt foley cath withdrew 9cc of normal saline — Spec [redacted] b(6)-2
1000	Assumed care of pt @ 0500. VSS. Pt is on 1L O_2 NC - Sat's are 98%. Lowered O_2 to 1/2L - pt still sats @ 98%. Pt was given ~~to~~ percocet II tabs @ 0710. Pt has 2 R. IV in (2) arm. (2) lower arm in cast. Elevated on pillow. Pt is now resting comfortably. — b(6)-2 [redacted] 91WM6, S87
1 Jul 03 1845	assumed care @ 1300 - VSS - staples intact on abdomen, small amount of sero-sang. drainage near navel, colostomy (2) output, bag in place, stoma pink moist - bandage CDI on (2) FA - pt. urinated 700cc @ 1600 - through interpreter pt. made aware that colostomy would remain for life, pt. stated understanding and disappointment - IV SL patent, abx continue - medicated for (2) arm pain I II Percocet PO - pt. tolerated tang, jello & H_2O for dinner [redacted] b(6)-2

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

/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

[redacted] b(6)-4

EPW

PROGRESS NOTES
Medical Record

STANDARD FORM 50

AUTHORIZED FOR LOCAL RE

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
1 July @ 0030	Pt resting, easily aroused. BP 144/68, P: 92 R 20 O2 sat 97% RA. HOB ↑ to facilitate breathing. Stoma: pink & moist, ∅ output to colostomy. Urinated 450cc yellow urine ∅ complication. hypoactive Bs x 4 qds abd: ND, soft. incision site CDI. I will con't to monitor & support — [redacted] 7 IWPM b(6)-2
2 Jul 03	Surgery No events had to scheduled for OR washout of ⓓ Arm today. VSS AFeb. wound + purulent drainage @ umbilicus staples removed and wound Dressed w/D Abd soft ND strong visible Bowel Rep. A/P Day will D/C plan pending [redacted] b(6)-2

NSHIP TO SPONSOR | SPONSOR [redacted] | SPONSOR'S ID NO (SSN or Other)

LAST | FIRST | MI

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

All b(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE 2 Jul	Assumed care of pt @ 0500. Pt resting quietly. O2 sats were in the lower 80's. Pt was put on O2 @ 1/pm. Sats came up to 97%. Pt was up OOB ambulating and BR. Dr. [redacted] removed staples in the middle. Pt now has wet to dry dsg change twice a day. Pt is going to OR today. [redacted] 91WM6, SGT
1500-	Assumed care of PE @ 1300. VSS, AOx3. (-) clo pain. (B) LS clear. (+) BS (+) ostomy c̄ ∅ drainage NPO since MN, mid ABD incision staples CDI, w/ → Dobhoff CDI. (L) UE dsg/ace CDI. (R) wrist PIV HL, patent c̄ IV ABX. O/C to OR. O/W assess WNL. Will [redacted]
	O/M PPNA Prep Rec: (D) GSW abd P2 Procedure: Wound / DPC [redacted] Tube Drains TOPN Sr Wound clean & closed IP DM

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] NOTES

Medical Record

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

PROGRESS NOTES

DATE	
1930	Pt returned from OR, ambulated ⅗ assistance. JP suction bulb draining bldy drainage. S/W No Δ [redacted] b(6)-2
3Jul03	Surgery. No events Ast. in Bag (P) Stool USS AFeb Abd ND Soft NT stoma visible wound - open middle clean
	Ap Doing well (O) ext per ortho [redacted] b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

:E | NOTES

2JUL03 Rec'd pt @ 21:00. Awake and alert. PERRLA ⊕. Skin W/D. LCAB ⊕
22:00 BS ⊕ x4 ⊕ PPP ⊕. ⓛ arm ACE wrap dsg + cast in place CDI
able to move and feel fingers ↓ ROM to [redacted] b6-2 fingers + thumb c/o
pain ñ Percocet given. <3 sec. cap refill WNL to ⓛ fingers.

3 July 03 Assumed pt. care @ 0500. Pt. asleep. Awake easily
0630 on verbal command. A+O x3. ⊕ PERRLA. Lungs CTA
⊕ Pulses x4. HL in ⓡ AC patent. Colostomy bag intact
0600 98 2 staples to mid abd. ñ s/s of infection. Ace wrap dsg +
95 cast to ⓛ arm CDI. ⊕ sensation in fingers c̄ decrease
16 ROM. JP drainage in ⓛ arm c̄ small amount of
132/80 95% Reddish fluids. Ø complaints @ this time. will
continue to monitor [redacted] b(6)-2 9LW MB
0820 Dsg A Complete. Ø s[redacted] or foul odor
noted. b6-2 [redacted] 9LW MB

3 July 03 assumed pt care @ [redacted] 0500. pt resting quietly. VSS. lungs
0500 CTA, abd drsng CDI, staples intact CTA, colostomy bag
intact Ø drainage noted. HL ⓡ AC flushes well Ø s/s x
of redness/swelling. ⓛ arm c̄ cast & ace wrap, drsng
CDI, fingers c̄ swelling ⊕ sensation ↓ ROM. JP tube intact
draining sm amt of reddish color drainage. B↓ Ext ⊕ pulses
Ø c/o pain voiced. Will cont to monitor — [redacted] 9LW MB SG 7

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

LAST | FIRST | MI b(6)-2

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

DENTIFICATION (For typed or written entries give Name - last, first, middle, ID No or SSN Sex Date of Birth Rank Grade) | REGISTER NO | WARD NO

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

All b(6)-2

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3rd 2325	Received pt resting in bed. VSS, HOB↑ 30°. LSCTAB, Abd SNT, BS⊕, Colostomy to RUQ, midline abd incision OTA, upper half w/ wet > dry dsg c/d/i. IV patent, n⊕ ac, dsg ⊕ UE c/d/i. medicated x1 for pain. Will cont to monitor [redacted]
4 July 03	1000 - Pt Alert lying in bed. VSS, HR regular, BS⊕ x3. Colostomy intact → stoma pink. DSG Δ'd to incision on ABD. Opened 5 ½ of infx. New HL to ⓡ forearm. Ace wrap [redacted] CDI to ⓛ arm. Able to wiggle fingers, cap refill <3, ⊕ sensation. Continuing c̄ antibiotics. Medicated x1 c̄ percocet. Will cont to monitor [redacted]
4 July 03 1325	Assumed pt care @ 1300. Pt awake & alert. VS: BP 130/74, P: 95, R: 18, Temp: 98.5, O2 sats 95% on RA. lungs CTA abd BS⊕, colostomy intact, small amt of [redacted] brown stool noted, drsng CDI. ↓ ext full ROM ⊕ pulses ⓛ arm c̄ ace wrap drsng CDI. JP drain intact. ⓡ FA c̄ HL ⊖ S/Sx of infection. ⊖ complaints voiced. Will cont to monitor. [redacted] 91WM6 SGT
4 July 03 21:53	Rec'd pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. Skin W/D. PERRLA⊕. PIV ⓡ FA & patent new IV initiated to ⓡ FA. ⓛ arm c̄ ACE wrap dsg CDI. Able to move and feel fingers. fingers warm to touch c̄ <3 sec cap refill. ML Abd incision c̄ staples intact and well approx. Colostomy draining liquid watery brown fluid. ⊖ c/o pain @ this time will cont to mon [redacted]

All b(6)-2

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
2330	pt c/o pain ii percocet given will mon [redacted] AN
5 Jul 03	Assumed pt. care @ 0800: Pt. awake. A+Ox3. Lung CTA
0630: T 98.6	(+) pulses, movement + good sensation in (R) fingers. (+) BSx4.
P 86	Colostomy bag intact. JP drain c̄ red serous. HL (R) FA
R 16	patent. Dsing c̄ ace wrap (L) arm CDI. Denies
BP 130/80	any c/o @ this time. [redacted]
SATS: 93%	
1530	Assumed care of pt @ 1300. VSS. A+Dx3. Ø c/o pain. (R) FA PW
	c̄ IV ABX patent. Abd incision dsg CDI. Ostomy bag intact putting out
	brown sticky feces. (L) UE dsg CDI, JP draining sero sanguinous
	fluid. (+) sensation, cap refill < 3sec, mvt of fingers (L) hand. (B) LS
	CTA (B) BS. O/W assessment WNL [redacted]
05 Jun 03	
2149	Pt. awake and alert in bed. PERRLA. Skin W/D. LCA (B)
	BS (+) x4. (+) PPP (B). HL to (R) FA intact and patent. Colostomy
	in place draining dk brown stool. Stoma beefy red in
	color. ML ABD incision c̄ staples intact well approx.
	DSG to incision C/D/I. (L) arm ACE wrap dsg C/D/I.
	(L) arm c̄ ice. Able to move and feel fingers. Fingers
	warm to touch c̄ (+) <3sec. Cap refill. Ø c/o pain
	will cont. to mon [redacted] AN
0800	pt. awake & alert in bed. JP drain D/C'd by MD, cast applied
	to (L) UE. Colostomy draining dark brown liquid stool, stoma pink
	& moist. VSS. Dressing to ABD d'd, noted ō s/s of infection.
	IV in (R) FA flushed well c̄ 3cc NS ō s/s of infection or infiltration.
	HR Reg, lung sounds clear bilat. Pt ō complaints @ this time.
	All other assessment findings WNL. Will continue to monitor [redacted]

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:AL RECORD | PROGRESS NOTES

:E | NOTES

5 M(0) Surgery

No events Stoma functional

VS, ABGs

Abd Benign

Wound healing

Ap Doing well plan per ortho fu ©

Arm wound

[redacted] b(6)-2

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EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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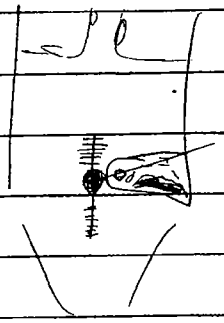
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(2)-2

6 July 03 EPW c̄ ① Colostomy returned from [redacted] today.
He has fever of 101° and open (dehisced) wound midline to ⊕ of Colostomy
Colostomy bag c̄ gas + stool. Stoma pink.

101.2 oral 122/90

P 120 regular



① Cast

A/P ① Colostomy / functioning ② SIRS
② Fever ? Etiology Tachycardia 120 Likely Fever + Dehydration. R/o Early Sepsis
① Open Abd wound. We are concerned that Pt. will not be able to keep this wound clean. He will live in the dirt and sleep on the ground. If feel there is a risk of fecal contamination.

② Consult 581st ? Pt hold
③ c/w Percocet, Keflex

Note: Pt had (2) Percocet @ 2023 hrs b(6)-2

[redacted] CPL 38

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PROGRESS NOTES
Medical Record

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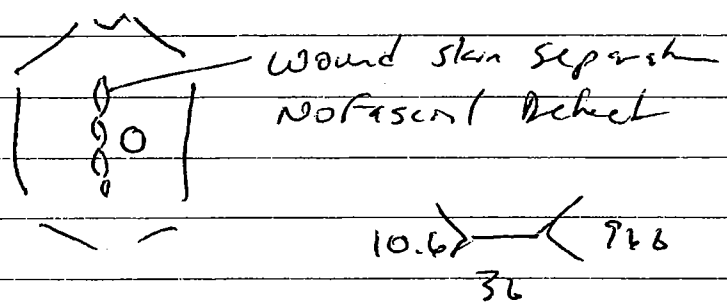
[redacted] b(6)-4

All b(6)-2

DATE	NOTES
6/5/03 1430	Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain. (L) UE cast CDI (+) sensation, cap refill <3sec. MVI (L) hand. Ostomy Bag draining dark brown liquid stool. MID ABD incision approximately well. half of staples removed steri strips applied. W/D due to abd wound D'D, Ø s/s of infection. (D) US CVA. (+) BS. TOL PO Regular DIET. O/W assessment WNL. Will cont to monitor [redacted]
1530	Removed rest of staples. D/C IV (R) FA d/t leaking + pain, Ø s/s of infection. New IV started (R) FA [redacted] well.
6/5/03	Surgery Pt returns from [redacted] with wound separation as "concern for cleanliness". VS: 97 123/63 98.6 ex —



A/P wound separation
Readmit for wound c[redacted]

All b(6)-2

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DICAL RECORD | PROGRESS NOTES

DATE	NOTES
6 Jul 03	Pt readmitted for dx of wound separation via EMT
22:30	stretcher. Awake and alert. able to amb from stretcher
	to bed $\bar{5}$ difficulty. Skin W/D. PERRLA (+). LCA (B).
	BS (+) x4. Colostomy bag Δ'd. M/L ABD incision $\bar{c}$
	WSD dsg C/D/I. Cast to (L) arm C/D/I. able to
	move and feel fingers. (+) <3sec cap refill. Warm
	to touch. C/o pain @ this time will cont to mon.
0103	C/o pain ii Percocet given will mon [redacted]
7 July 03	1100 - Pt alert out of bed x1. VSS, lungs CTA,
	BS (+). Cast to (L) arm, able to wiggle fingers,
	(+) sensation, warm to touch. Dsg Δ'd to
0600 97.6	abd. incision, site $\bar{5}$ s/s of infx. Colostomy
72	intact. 2 dsg applied to $\downarrow$ extremities for
12	minor wounds. Medicated x1 $\bar{c}$ Percocet
120/80	for pain. Tolerated breakfast & lunch.
95%	Will cont. to monitor — [redacted]
1900	Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain. (2) U/E cast CDI (+)
	sensation, mot cap refill <3sec (L) hand - M/L ABD incision w/ WSD Δ done
	Ø s/sx infection. Ostomy bag intact Ø drainage in bag. Ob
	assessment WNL. Will cont to mon Pt — [redacted]

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PROGRESS NOTES
Medical Record

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All b(6)-2

.TE	NOTES
7 Jul 03	Assumed pt. care @ 2100 - Pt. OOB & sitting up in chair. A+O x3. Lungs CTA. Hypo active BS x4. Colostomy bag intact and empty. dsng to Mid abd. CDI. Dsng c̄ ace wrap on (R) arm CDI. (+) sensation and movement in (R) fingers. Denies any discomfort @ this time — [redacted] 9lwmb
8 Jul 03	0910 - Pt alert lying in bed. Dsg Δ'd to abd. Incision opened c̄ ∅ s/s of infx noted. Colostomy bag Δ'd. Cast to (L) arm. (+) Sensation in fingers. Pain to small finger. Give percocet for pain. VSS, lungs CTA,
0640 97.4 64 12 112/74 99%90	BS(+) x3. Pulses (+). Will cont. to monitor — [redacted] 2 L+dcc
8 July 03 1400	Assumed pt care @ 1300. pt resting quietly. VSS. lungs CTA, abd colostomy bag intact BS present. ↓ ext (+) pulses. (L) arm c̄ cast (+) movement. ↓ IV (R) AC infusing s̄ diff. (-) s/sx of infiltration. (-) complaints voiced @ this time. Will cont to monitor [redacted] 9lwmb
2145	Pt. care assumed @ 2100. VSS. HR Reg, Lungs CTA, BS(+) x4. Colostomy bag intact draining soft brown stool. Midline ABD dsng CDI. (L) UE ^ on blanket. cast CDI. (L) hand has brisk cap refill c̄ (+) ROM digits, (+) sensation. Will cont. to monitor. Pt ↑ to BR to void s ambulated length of ward x6. — [redacted] CTAN

.TE NOTES

Ortho EMAC Note

6/24/03

23 yo Dragl o

GSW (R) forearm

Preop Dx: (R) GSW Ulna Fx

Ulnar Neuropathy

Loss muscle Belly Overlyr Carp

Carp Syndrome

Loss Ulnar Arty

procedure: Multiple I&D

IM Stenting fm Ulna

c̄ Segmental Defect

Delayed 1° Closure wounds

Hospital Course Benign

D/C Meds: Keflex 250 QID

percocet fm pm

Motrin 800 TID

b(6)-1

Plan) Suture Removal 2wks

LAE x 6wks

then consider for

Bone Graft w/

Defect

b(6)-2

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CAL RECORD | PROGRESS NOTES

TE	NOTES
11 July 03	0800 Pt alert lying in bed. VSS, lungs CTA, HR regular, BS ⊕ x 3. Colostomy intact. Dsg to incision midline abd CDI. HL ⓡ forearm patent. Did not eat breakfast this AM. Cast to ⓛ arm, able to wiggle fingers, ⊕ sensation, warm to touch. Voicing ∅ complaints at this time. Will cont to monitor — b(6)-2 [redacted] 2Lt AN
0600 96.4 55 14 120/78 96%	
1730	Assumed care of pt @ 1300. VSS. A+O x 3. ∅ c/o pain. ⓑ CTA, Abd wound to suction/dsg CDI. Ostomy bag producing formed brown stool. ⓛ UE cast CDI, ⊕ sensation, mvt fingers, cap refill < 3 sec. Elevated ⓛ UE. HL ⓡ AC HL & IV ABX. Other assessment WNL. Will Monitor [redacted] 1Lt AN
2200	Pt. care assumed @ 2100. Pt. c/o ABD pain. b(6)-2 Percocet given. HR Reg, lungs CTA, BS ⊕ x 4. ABD wound dsng CDI, JP to suction draining rust brown fluid. colostomy intact, passing soft formed stool. cast to ⓛ UE CDI. CSMTS ⓛ hand WNL - UTA pulse 2° cast - will cont to monitor. — [redacted] 1Lt AN. b(6)-2

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EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record
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All b(6)-2

TE	NOTES
7-12-03 0100	colostomy bag leaking @ edges ~~p~~ being emptied. colostomy bag Δ'd. sm. open area to skin approx. 1cm in length noted under old colostomy bag. Tissue pink ~~5~~ drainage. Sterile 2x2 applied to open area. [redacted] CTAN
0345	< 20cc out per ABD drain, brown mucous-like fluid [redacted]
12 July 03 1100	- Pt alert lying in bed. VSS, lungs CTA, [redacted] HR reg, BS⊕ x 3. Cast to ⊖ arm, able to wiggle fingers, ⊕ sensation, warm to touch. Colostomy intact. Dsg to suction intact to medial abd. Gave percocet for pain. Will cont to monitor [redacted] 2Lt
1700	Assumed care of patient @ 1300. VSS. A+O x3. ∅c/o pain. ABD dsng CDI. Ostomy bag ~~intact & stable~~ [redacted]. Cast (L) arm CDI, (+) sensation mvt, cap refill <3 sec (L) hand. TOL REGIMEN (L) AC PIV HLC IV ABX patent. O/W assessment WNL. Will [redacted]
2145	Pt. care assumed @ 2100. HR reg, lungs CTA, patient using IS while awake c̄ good results. BS ⊕ x4. Ostomy pink ~~5~~ drainage today. Colostomy bag intact. ML ABD dsng CDI, will cont. to monitor. [redacted]
2230	ML ABD dsng Δ'd. wound is beefy red in color c̄ ∅ purulent drainage. W→D dsng done [redacted]
0130	- Pt c/o nausea → phenergan given IVP [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13 July 03	1200 - Pt alert lying in bed. VSS throughout shift. Lungs CTA, BS ⊕ x 3. Began having loose stool in colostomy around noon today. Pt has been c/o stomach cramping most of shift. Had forceful vomiting x1 around 1100. MD was informed. New IV started in ® wrist for antibiotics. DSG D/C to abd, CDI. Will cont to monitor b(6)-2 [redacted]
0720 97.5 79 108/72 99%	
1420	Assumed care of Pt @ 1300. VSS. A+O x3. ⊕ BS CTA, ⊕ BS ostomy bag draining [redacted] brown stool. Abd dsg CDI ⊕ UE cast CDI. ⊕ sensation/cap refill < 3sec/mvt ⊕ fingers. Ø c/o pain b(6)-2 [redacted] O/W assessment WNL. Will continue [redacted]
13 Jul 03 21:57	Rec'd c/o pt @ 21:00. Pt awake and alert in bed. Restraints x 2 ® wrist ® ankle. PERRLA ⊕ Skin W/D. LCA ® ⊕ BS x 4. C/O epigastric pain ii maalox tab given. c/o pain to old PIV site ® AC. Heat pack applied for 15 min. New PIV @ ® FA patent. cast to ® Arm C/D/I ⊕ sensation to fingers. ⊕ ROM. ⊕ <3 sec capreffill to fingers. ⊕ PPP ®. Colostomy intact c ⊕ brown stool draining to bag. ML ABD dsg C/D/I. Wound to ® outer aspect of thigh healing and scabbing over. DSD to

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EPW # [redacted] b(6)-4

PROGRESS NOTES
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All b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	to (L) side of lower back. c/o pain in abd [redacted] from gas. will cont to mon [redacted] 2LT/AN
13 Jul 03	ABD Dressing change done. Wound appears wet, red. No foul odor a color noted. W→D dressing c̄ 4x4 covering wound. Changed ∑ difficulty. S [redacted]
14 July 03	0800 - Pt alert lying in bed. VSS, lungs [redacted], HR reg, BS⊕, Colostomy intact emptying loose stool into bag. LR @ 75 "/" into (R) wrist. DSG to abd incision. Voicing Ø complaints at this time. Will cont to monitor [redacted]
1500.	Assumed care of pt @ 1300. VSS. A+O x3. Ø c/o pain. ABD DRSG CDI. Ostomy Bag draining loose brown stools, Cast (L) UE CDI ⊕sensation/cap refill 3 sec/mot fingers (L) hand. LR @ 75cc/hr c̄ IV ABX via (R) wrist IV. O/A Assessment WNL. Will Monitor [redacted]
2300.	Pt. care assumed @ 2100. HR Reg, Lungs CTA, BS ⊕ x4 MCABD dsng Δ'd & CDI. ostomy pink, draining soft brown semi-liquid stool. colostomy bag CDI. cast to (L) UE intact & neuro checks WNL. Pt given ⅡⅡ accorcet for pain. Will cont. to monitor — [redacted]
15 Jul	Assumed care of pt @ 0200. Pt asleep. VSS Lungs CTA. Dsg on abd. dry and intact. Ostomy bag on (L) side of abd. - intact. Pt awaiting OR. Will continue to monitor. — [redacted], LPN, SGT
1200	Pt R/T from OR. VSS. Pt awake — [redacted] LPN, SGT
15 Jul	[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 Jul 03	Brief op note
	indication open clean Laparotomy wound
	Procedure DPC
	Surgeon [redacted] b(6)-2
	Anest GEA
	wound closed : interrupted Mattress
	sutures
	to ward in good cond.
	[redacted] b(6)-2
16 Jul 03	Surgery
	No event
	USS AFeb
	wound - 10 distum Gauze pulled
	Drsd
	A/P Dony well
	cont wound care b(6)-2
	[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] b(6)-4

PROGRESS NOTES
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DICAL RECORD

PROGRESS NOTES

DATE	NOTES
15 July 1300	- Assumed care of PT. PT is alert lying in bed. PT response to verbal stimuli. PT c/o pain to Abdomen. PT received 2 tabs Percocet P.O. for pain. Abdominal dressing is CDI. No S/S of infection c̄ Brown, stool, loose draining. PT crusted 800cc of urine and now feels much better. Lung sounds are clear bilateral. Abdomen is soft + Tender. PT has Good Pulse noted function on All extremity. Skin is warm + Dry. PT has 75 c/hr LR on (R) hand. Site is Dry + INTACT. PT is now resting comfortably in bed. Will continue to monitor. SGT [redacted] CPN b(6)-2
15 July	- PT is sleeping in bed no c/o pain for Abdomen. Will continue to monitor [redacted]. CPN b(6)-2
15 July 03	2325 Assume pt care @ 2100. pt awake and Alert. VSS. Cast to LUE CD+I (+) movement (+) sensation to fingers. Abd dsg. D+I Red drainage to gauze. Colostomy bag intact c̄ Urinary Soft Stool. LR @ 75 cc/hr to (R) wrist no s/s redness/infiltration. No c/o pain @ this time Will Continue to monitor [redacted] BLUMO b(6)-2

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[redacted] b(6)-4

All b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Jul	Assumed care of pt @ 0500. Pt asleep, ambs → BR. VSS. Lungs CTA. Bowel sounds x 4 quads. Cast on (R) arm. Bandage down middle of abdomen. Dry and intact. Colostomy bag on (R) side of abd. Pt was given 650 mg of Tylenol @ 0900 for pain — [redacted] LPN, SGT
1700	Assumed care of Pt @ 1800. VSS. A+O x3. ∅ c/o pain. ABD incision CDI. Ostomy Bag patent/intact (R) wrist PIV 18G Tech hep c IV ABX patent. (L) UE cast CDI (+) sensation, cap refill <3 sec, mvt fingers (L) hand. (+) BS (B) S CTA HR. C/W Cardiac [redacted] + WNL. Will monitor — [redacted]
16 JUL 03 21:34	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x2 (R) + (L) ankles. Resp [redacted] WNL. Skin color WNL. LOA (B) [redacted] x4. ML ABD [redacted] DSG C/D/I. Colostomy c scant amt stool draining. (+) PPP (B) BS hyperactive x4. c/o pain x1 650mg Tylenol given. PIV (R) hand patent new IV initiated. Cast to (R) arm C/D/I. (+) sensation (+) <3 sec cap refill. Will cont to mon [redacted] DT/AW
0428	c/o nausea. 12.5mg Phenergan given DT/AW
17 Jul	Assumed care of pt @ 0500. Pt awake and alert. VSS. Lungs CTA. Bowel sounds x 4 quads. Abd. soft and tender. Pt ~~awaiting~~ [redacted] ~~may leave tomorrow tomorrow. c/o pain~~ ~~doctor first~~ — [redacted] LPN-SGT

All b(6)-2 except last

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
17 July 03 1430	Assumed pt care @ 1300. VSS. lungs CTA, abd soft BS(+). colostomy bag intact. ↓ est c̄ full ROM (+) pulse. (L) arm c̄ cast (+) movement (+) sensation. <3 sec cap refill. (R) arm c̄ full ROM (+) pulse. IV (L) AC infusing LR @ 75cc/hr. 3 diff. (D) c/o pain voiced @ this time. Will cont to monitor — [redacted] 91WMC -
18 Jul 03 00:08	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Restraints x2 (R) and (L) ankles. Awake and alert in bed. Skin color WNL PERLA (+) WNL. 2CA (+) (B) AC PIV patent c̄ 75cc/hr LR infusing (L) arm cast C/D/I. Digits c̄ (+) ROM x̄ thumb and for finger. (+) sensation (+) <3 sec. cap refill. BS (+) x4. M2 DSG C/D/I. Colostomy intact. Stoma beefy red in color (+) flatus (+) brown loose stool. c/o pain x1 to M2 ABD. ii Percocet given. & c/o NV @ this time. Will cont to mon. [redacted] /AW
~~and 0256~~ [redacted]	~~c/o pain @ M2 ABD inc. ii Percocet given will mon~~ [redacted] /AW
18 Jul [redacted]	Assumed care of pt @ 0530. Pt asleep. Bandage intact and dry. Ostomy bag intact. VSS. Lungs CTA. Bowel sounds ↓ 4 quads. Ø c/o pain / discomfort. Will continue to monitor. — [redacted]

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#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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All b(6)-2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18Jul03 1650	assumed care @ 1300 - VSS - no c/o pain @ this time - SL patent in (R) AC - neuro ✓'s WNL in (L) fingers - abd dsg intact - colostomy putting out liquid reddish-brown stool and gas, bag intact - pt. not willing to get out of bed to ambulate - tol. regular diet for lunch - IAW QS — [redacted] CH, AN
18Jul03 23:17	Rec'd c/o pt @ 21:00 VS WNL per flow sheet. Restraints x2. (R) wrist (L) ankle. LCA (5) BS (+) x4. M/L DSG to ABD C/D/I. Colostomy LUQ ☐ sm. amt. formed stool draining. Cast to (L) arm C/D/I. (+) sensation to digits (+) Comp (+) <3 sec. cap refill. PIVHL to (R) AC patent. c/o pain x1 ii Tylenol given will cont to mon [redacted] AN
19Jul	Assumed care of pt @ 0020. VSS. Lungs CTA. Incision down mid-abdomen. Bandage dry and intact. Colostomy bag changed. Ø c/o pain/discomfort ✓ [redacted] LPN, SET
19Jul03 1630	assumed care of pt. @ 1300 - VSS - no c/o pain @ this time - LPE 75cc/hr infusing into (R) AC IV site patent - (L) arm cast intact, (L) finger cap refill <2 sec, pt can wiggle fingers (+) sensation x5 fingers - (+) BS in (R) upper quad, stoma pink, liquid green stool output — [redacted]

All b(6)-2 except last

AUTHORIZED FOR LOCAL REPR

CAL RECORD | PROGRESS NOTES

NOTES

19Jul03 2045 Pt. ambulated on board x 15 minutes SS assistance - medicated c 650mg tylenol PO for abd pain - pt. encouraged to exercise (D) fingers to improve mobility

[redacted]

19July03 2150 Assume pt care @ 2100. pt awake and alert. No c/o pain @ this time. VSS - HR reg. lungs CTA. Abd ~~[illegible]~~ midline dsg CD+I. Colostomy bag intact to (D)UQ draining brown watery stool. BS x 3. Cast to LUE CD+I (+) movement (+) sensation to fingers. LR @ 75cc/hr to (R) AC infusing 5 s/s infiltration/redness. Will continue to monitor [redacted] 1100 - Pt vomited x1. Given Phenergan - [redacted]

20July03 1000 - Pt alert ambulatory x1 this AM. VSS, lungs CTA, BS(+). Colostomy intact. Dsg Δd to closed incision midline abd. Cast to (D) arm, (+) sensation, able to wiggle fingers, skin warm to touch. IV to (R) AC. Well [redacted] Cast to remain

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; (1) No. or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO | PAGE NO

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR 41 CFR 101

All b(6)-2

TE	NOTES
20Jul03 1330	assumed care @1300 - VSS - pt. sleeping @ present, easy to awaken - stoma pink - LR ETS cath - infusing into (2) AC IV - neuro V's WNL in (D) fingers - abd incision & sutures intact, open to air, no drng - noted - no c/o pain or nausea @ this time. [redacted]
20Jul03 23:23	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Restraints x2 to (C)/(D) ankles. Awake and alert in bed. PERRLA (+) WNL Skin w/D/LCA (B). BS (+) x4. NL inc. OTA C/D/I. Ostomy draining brown stool, scant amt. Stoma beefy red in color. Cast to (D) arm C/D/I. (+) sensation (+) ROM (D) <3sec cap refill to digits. Encouraged and instructed pt. to perform ~~passing~~ passive and active ROM to (D) fingers c/o pain @ this time. Will cont. to mon [redacted]
21 July	Assumed care of pt @ 0500. Pt awake and alert. VSS. Lungs CTA. Sticks down abd. intact and dry. Colostomy bag changed @ 0600. Ø c/o pain / discomfort — [redacted] LPN SG.

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD

PROGRESS NOTES

ATE	NOTES
27 July 03 1430	Pt stable. AAOx3. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Ostomy emptied and cleaned. Formed brown stool. Ø complaints [redacted] b6-2
28 July 03 1700	pt. d'c'd to EPW camp, hands restrained - pt. had colostomy supplies and x rays & d/c summary - escorted to helicopter by MP [redacted] b(6)-2

O SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
C	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.

WARD NO. ICU 2

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.20

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

30 Jan 03 Ortho op note
Preop Dx: D6 SW fracture
procedure Repair TAD 9 balance
IM 1/8" Steinmann pin
Fixation Ulna
Partial Closure wound

Surg: [redacted] b(6)-2
EBL: [redacted]
Tio
PO PACU stable
Imp = still continued weak
Dehydrated unable to fully
cover Bone — elected for
IM Steinmann Pin Fixation

Plan Repair TAD full Clean
48°

[redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

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

29 JUN 03 (0600) pt A/O; VSS; distal pulses palpable; no s/s of hemorrhage; assessment completed; [redacted]

0730 pt OOB to ⅟S difficulty; tolerating movement well; no change in VS [redacted] b(6)-2

29 JUN 03 MD Note

0831 POD #1 s/p Ex lap, (L) partial colectomy + Hartman's procedure + I+D (L) forearm by OAHO.

S/ No complaints this am.

O/ T 98.2 HR low 100s BP 104/64 RR 19 97% 2L nc

UO 50-200 cc/hr JP 40 cc since surgery

A+O x3

Lungs CTA-B

RR nl S_1+S_2

11.4	11.4	342	131	102	10	13
	36.6		4.6	26	0.9	

Abd soft, ND, mildly TTP no BS

Ostomy pink Ø gas in bag

Dressing CDI

(R) LE GSW wound Ø erythema

A/ Doing well POD #1. No issues

P/ 1) OOB today, ambulate

2) Keep NPO for now

3) Ortho plan to I+D (L) arm tomorrow.

4) Continue abx

5) Transfer to ward late today or tomorrow.

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

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

[redacted] b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Jun 03	(1750) JP pulled intact; pt premedicated c̄ morphine 4mg IV; nn dressing intact c̄ staples; pt ambs some doors; will ambulate + return to bed @ 1000; pt told by interpreter POC + reasons for OOB/amb + IS/MPO — pt verbalized understanding of instructions — [redacted] b(6)-2
30 JUN 03	MD Progress
0842	POD #2 s/p Ex lap, partial colectomy, colostomy + Hartman's S/ No complaints. No nausea/emesis No flatus. O/ Afebrile VS normal O_2 sat 99% 2L NC UO 50-150 cc/hr JP 14 cc/24° Abd soft ND (+) BS Incision CDI Lungs CTA A/ Doing well, Return of bowel function P/ Clamp NOT To OR today for I+D (L) arm b(6)-2 Ambulate Adv diet after OR today. [redacted] NAF MC USA
1450	pt ambulated x 15m c̄ assist; returned to bed; ostomy bag changed c̄ difficulty no drainage noted; 2mg MSO4 for pain before procedure; pt resting; VSS — [redacted]

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

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

EPW [redacted] b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 JUN 1400	pt may go to OR today; was OOB today x 4°, ambulated 15m; using IS qi°; no change in assessment status; [redacted]
	(1600) pt reports pain to LUE; ann T, MS04 4mg for pain; wasted 10mg Demerol accidentally opened for 353 but not used — b(6)-2
	witnessed by my ATN [redacted]
1 July 03	Assumed care of pt @ 0500. Pt is awake. Dr. [redacted] came in. - Removed pt's bandage from his abdomen. She said there was no need to bandage wound again. Pt has staples going down his midsection. Colostomy bag was changed due to pt wound weeping blood. It looked as though feces might get into the wound. Two 2x2's were placed on incision to absorb discharge. Pt was medicated twice with percocet @ 0710 and 1220. Pt is now sleeping. [redacted], 91WM6, 87
	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. ICW2

[redacted] b(6)-4

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

AUTHORIZED FOR LOCAL RE

:DICAL RECORD

PROGRESS NOTES

DATE

NOTES

Ortho Op Note

Preop Dx: (L) Forearm GSW Rx

Postop Dx: Same, Multiple ulna Defect
Ulnar A/N Laceration/Defect
Volar Forearm muscle Defect
Med N. / Rad Art (8)
c̄ contus

Procedure: I&D/Lavage/Debrid
Fasciotome

Surgeon: [redacted] b(6)-2

EBL: 300cc

FTC

PO PAW stable

Plan: Repeat lavage 30 sec
ORIF c̄ plate/screws if
wound clean

b(6)-2

[redacted]

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

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F
Prescribed by GSA/ICMR FPMR (41 CFR) 101-1

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Jul03	Surgery
	No events
	VRS AFeb
	wound good ~~tr~~ granulation ~~tx~~
	in deepest part of wound
	~~Ap~~ wound separation.
	Plan W-D for 2 more days then
	to OR for closure.
	[redacted]
	b(6)-2

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

All b(6)-2 except last

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 July 03	0735 Assume pt care @ 0500. Pt asleep easy to awake. VSS. HR regular Lungs CTA throughout. Abd soft. Colostomy bag intact BS active x3. ∅ BS under colostomy. Dsg Δ'd area pink no s/s infection Dsg Δ'd to (L) side and behind (R) knee. No drainage no signs of infection noted. (L) arm cast CD+I. (+) sensation (+) movement to fingers. Pt amb ∅ difficulty. LR @ 150cc/hr to (R) FA no s/s redness or infiltration 60 ti percocet for pain. Will continue to monitor [redacted] 1235 New colostomy bag placed. Drainage soft formed brown stool. [redacted]
1430	Assumed care of Pt @ 1300. LOC. A+O x3. ∅ c/o pain. LR @ 150 via (R) FA PIV. (L) UE cast CDI (+) sensation, mvt, cap refill <3sec (L) fingers. (B) LS CTA, (+) BS, Ostomy bag drainage ~~from formed stool~~ ~~stool~~ ostomy. MW ABD incision dry CDI. O/W Assessment WNL. Will Monitor [redacted]
2130	Pt. care assumed @ 2100. Pt. alert & compliant c̄ care. HR Reg, lungs CTA, ABD c̄ BS (+) x4. ABD dsng CDI. Colostomy bag intact. Ostomy pink, passing soft formed stool. Cast to (L) arm CDI. (L) Arm ↑. ∅ pain, brisk cap refill c̄ (+) sensation, (+) ROM. Pt. c/o pain to IV site. ∅ swelling, ∅ erythema, ∅ leaking, flushes well. Will cont. to monitor [redacted]

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

PATIENT'S IDENTIFICATION: ([redacted] written entries, give: Name (last, first, middle; ID No or SSN; Sex; D[redacted] Rank/Grade.)

REGISTER NO. | WARD NO.

[redacted] b(6)-4

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

A11 b(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 July 03	0600 Assume care @ 0500. Pt awake and alert. VSS. HL to (R) FA no s/s redness/inflammation c̄ flush. No c/o pain @ this time. HR reg. Lungs CTA. Abd soft. Midline dsg CD+I. Colostomy bag intact. Site pink draining soft brown stool. LUE cast CD+I. (+) movement (+) sensation cap refill < 3sec to fingers. pt amb ī difficulty. Will continue to monitor [redacted] 1WM6
	0915 Abd wound dsg to suction, continuous 125mmHg X3 days [redacted] 9WM6
10 July 03 1410	assumed pt care @ 1300. pt awake & alert. VSS lungs CTA, abd drain CDI c̄ intermittent suction, colostomy bag intact. BLE c̄ full ROM (+) pulses. LUE c̄ cast (+) movement of fingers, < 3 sec cap refill. (-) c/o pain voiced @ this time. Will cont to monitor [redacted] 9WM6
2015	5cc reddish thin drainage emptied from suction. (-) complaints voiced [redacted] 9WM6
10 Jul 03 21:26	Rec'd c/o pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. Restraints x2 (R) + (L) ankles. PERRLA (+) WNL. Skin color WNL. LCA (B). BS (+) x4. M/L ABD drg CDI to suction. Colostomy intact c̄ scant amt. stool draining. (L) arm cast C/D/I. Pt able to move and feel fingers. fingers warm to touch c̄ < 3sec cap refill. (+) PPP (B). c/o pain x1 ī̄ Percocet given. (-) further complaints @ this time. Will cont. to mon: [redacted] 6LD/AW
0140	Pt sitting in bedpan for most of shift. @ this time vomitted x1. ī̄ tabs maalox and 25 mg Phenergan given IVP. Pt sleeping @ 0207. Will cont. to mon [redacted] KT/AW

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) [redacted] b(2)-2

LOG NUMBER

ARRIVAL — DATE: DAY 6, MONTH 28, YR. 03 — TIME 0520

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify) Medevac

CURRENT MEDS. (Tetanus immunization and other data): MSO4

HISTORY OBTAINED FROM: ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

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

SEX: ♂ AGE: 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0520

VITAL SIGNS			
TIME	1200	1215	1230
BP	117/57	123/63	124/66
PULSE	80	91	94
RESP.	20	20	18
TEMP.	—		
WT. (Child)	73kg		

CATEGORY (See reverse)
- EMERGENT
- ☑ URGENT
- NON-URGENT

662

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)

ABC intact
buttock surgery last year

S: GSW abd/flank approx 1° PTA.
Pt states he was radially stable while in Thai.

NPO

ORDERS	INITS.	TIME
abs CBC Chem 7 & type	[redacted]	1200
UA PT/PTT UA		1200
2 LNS Boluses		1200
XR O FA (R) knee		1200
Ig Tetanus		1205
[illegible]		1215

1° A: AP/AP clear/patent, no JVD, speech clear/articulate
B: CPA (B) = ⅤJ, no [illegible]
C: (P) 2 pulses (B) x4/ext =
D: GCS 15
E: Abd (P) GSW (L) flank x2 externally
Foley placed clear 200cc yellow urine

2° trauma: AP/AP clear/neck: supple, NT
PERRL, conj [illegible] head abrasion
chest pr (L)
CV: no [illegible]
Abd: no [illegible] (P) tenderness, ↓ BS
bacteria we [illegible] bowel
Ext: (P) neck. (L) open fracture fx
(P) red pulses/[illegible]/motor [illegible] +5
[illegible] n. deficit

CXR: CXR [illegible]

ASSESSMENT/DIAGNOSIS: Stable 1230
(L) arm GSW
(P) Abd GSW stable

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

A/P: stable, [redacted] b(6)-2

b(6)-2

CONDITION UPON RELEASE
- ☑ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(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).

[redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ord[illegible] follow-up plans)

[redacted]

EMERGENCY CARE AND TREATMENT

MEDCOM - 12305

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

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 6 July 03	TIME 2215
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Medevac	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO.	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
19	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES NKDA	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
	HOW					

CHIEF COMPLAINT Multiple GSW, exceeds Cap acute Abd. Colostomy bag Caston L arm

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME 2215					
		BP 123/63					
☐ URGENT		PULSE 157					
	INITIALS	RESP 20					
☐ NON-URGENT		TEMP 98.6					
		WT SPO² 97					

LAB ORDERS						X-RAY ORDERS		
CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE		C-SPINE
URINE C&S	UA MSCC/CATH		CHEM:		ACUTE ABDOMEN		LS SPINE
BLOOD C&S X					SINUS		HEAD CT
					ANKLE R/L		

ORDERS

☒ PULSE OX 95 ☒ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

[redacted] b(6)-4 Date: MON - TY 30 JUNE

PATIENT ASSESSMENT

TIME: 0600 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature WD
Color: Pale / Cyanotic / Jaundiced NPR
Mucous Membranes: Moisty Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive X3 GCS: 15
Orientated / Disoriented Pupils: 3+2
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials 2+ Pedals 2+
Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension NA Edema
Heart Sounds S1 S2
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: None
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor White
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	NN	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character None in bag
Drains: JP DIC

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: 30 JUN 03

PATIENT ASSESSMENT b(6)-2

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature 98.6
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: 3mm
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 4 Radials 2+ Pedals 2+
Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension NA Edema
Heart Sounds S1, S2
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended tender cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character none in bag
Drains:

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

30 June 03

b(6)-2

2/4/07 3.6 Jan 03 - Pt received from OR.

VSS → [redacted] 110, 146/88, 98 on 4/2 Fm, 17, Temp:

[N] reactive to stimuli; eyes - pupils 2mm; groggy from anesthesia, human voices purposeful movements; [CV] S1/S2;

(+) pulses (3+) x4; <3 sec cap refill; [R] CTA upper apex, diffusely (-) wheezes bilat lobes scattered bilat rales; wheezes occasional; (+) productive cough of dark sputum.

[GI/GU] tolerate NPO (see/7-0); hyperactive bowel sounds. NGT clamp.

[MSK] (-) c/o soreness (-) change noted

[PLAN] admission transfer to ICU #2.

ICU PLAN

[redacted]

b(6)-2

Date 28 June

28 June

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature – warm to touch

Color: Pale / Cyanotic / Jaundiced normal for race (–) cyanosis

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS: 15

Orientated / Disoriented Pupils: 1mm sluggish

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): +3 x 4 Radials positive Pedals positive

Capillary Refill: brisk Seconds <3 Homan's Sign

Jugular Venous Distension (–) Edema (–)

Heart Sounds S1 / S2 S3

Rhythm sinus tach PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) hand #18	(L) foot #18
Solution			LR	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor (–)

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA b/l	
Diminished		bases small
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Midline – clean, intact

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

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

Stool: Character NOD

Drains: JP to midline upper-sternum

GENITOURINARY

Urine Color: clear yellow Character: – fully to gravity

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: echymb b/l

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

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

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Skin: (1) two fragment wounds,
size 1/2 dime to (L) lip
draining serosang-med. amount;
pressure dsg applied
(2) 1/2 dime size frag wound
draining small amount of
serosang from (R) distal
thigh - lateral aspect.
- bulky dsg to (L) PA - c/d/i
[N] groggy from anesthesia; responsive
to painful stimuli; moves
purposeful movements (attempts to
take off oxygen mask) with
JEs

b(6)-4 #[redacted] Date: 29 Jun 03

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature WNL

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive FC GCS: 15

Orientated / Disoriented Pupils: 3 R

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: regular

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped / Inter. Suction / Cont. Suction / Dependent Drainage

NG Drainage: Color Character

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

Stool: Character

Drains: JP

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / [redacted]

EMOTIONAL [redacted]

THER [redacted]

b(6)-2 24 [illegible]

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry / Purge

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced NFR b(6)-2

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: ~~None~~ ~~Location:~~ ~~Size:~~ see back

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS: 15

Orientated / Disoriented Pupils: 2 R

Extremity Movement: Full / Limited / None — see back

CARDIOVASCULAR

Pulse (0 - 4): 3+ Radials 3+ Pedals 3+

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 + S2 ST

Rhythm ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns:

Cough: Productive / Nonproductive / None small amt brn/yel

Sputum: Color / Amount / Consistency / Odor Sum small, spec

Chest Drainage System Gravity: DJ wc Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA s bbt	
Diminished		
Absent		SAS 9bt

GASTROINTESTINAL

Abdomen Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: minimal

NG Tube: Clamped / Inter. Suction / Cont. Suction / Dependent Drainage R nare

NG Drainage: Color Green Character

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

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

see back

SC MCPS

[redacted]

b(6)-4

29 JUN 2 03 1750:

[SKIN] (4) FLANK DSG - SMALL AMOUNT
SERO SANG ; SIZE = PAPER WADS x 2 ;
(10) HP DSG - SMALL AMOUNT
SERO SAN , 1/2 DIME SIZE = [redacted] b6-2
PAPER WADS

[MSK] ULE to sling ; (7) ice ;
OOD to chair x 1

[PAIN] MSOY / tracheal jam as ordered.

Cefotetan

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 24

HEIGHT:

WEIGHT: 80 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Exp Lap c̄ colostomy, I&D Lt forearm

4. PROPOSED SURGICAL PROCEDURE:
I&D Lt forearm

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco ✓ ppd X___ yrs. Body Piercing____ Diabetes (Y) (N) ROM____ ASA/Motrin w/72 hrs (Y) (N)
ETOH ✓ Implants____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Cefotetan, Tramadol, Ancef

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

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

#[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility 2) Positioning 3) Existing Disease 4) Safety Devices ✓ 5) Hypothermia	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis 4) Positioning 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. NA Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. o Address pt. from Rt side. ø Validate pt.'s understanding of verbal communication. ø Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. b(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. O[redacted]S COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] 117 RN 2Jul03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MNAN
DATE: 2Jul03 TIME: 1515

13. POSTOPERATIV[redacted]RED BY (Signature and Title) [redacted] RN
DATE: 2Jul03 TIME: b(6)-2

REVERSE OF FORM 5179, JUN 91 b(6)-2

MEDCOM - 12314

USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: ?

HEIGHT: ?

WEIGHT: \

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

3. PREVIOUS SURGERY [ ] NO [ ] YES (type): EPW

4. PROPOSED SURGICAL PROCEDURE:
Ex-Lap / (L) Forearm I&D

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

UNABLE to access due to Emergency

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

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

EPW H[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning ___ 3) Existing Disease X 4) Safety Devices X 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: X 1) Pain X 2) Intraoperative Hazards ___ 3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery X 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ___ Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ___ Potential for decreased communication due to: ___ 1) Diminished Hearing ___ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted] b(6)-2 28 JUN 03 DATE

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

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

LEVEL OF ACTIVITY: X Moves All Extremities ☐ Moves Upper Extremities

☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 28 JUN 03 TIME: 1285

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Ti[redacted] b(6)-2

DATE: 28 JUN 03 TIME: 1715

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 23

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
I&D Left arm & ex lap

4. PROPOSED SURGICAL PROCEDURE:
ORIF ulna

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition intact w/ wound sitting
Tobacco Ø ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM ✓ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (X) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (X) MEDS: Toradol, cefotan Mscy pm

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

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

[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (X)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ✓ Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from Either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted] ILT/AU b(6)-2 30 JUN 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities
☐ Transferred to litter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] ILT/AU
DATE: 30 JUN 03 TIME: 0914

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
DATE: TIME:

All b(6)-2 except last

MEDICAL RECORD — INTRAOPER OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATIN I
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Anesthesia

3. DATE 08 June 03 TIME PATIENT ARRIVED IN SUITE 1255

4. PATIENT IN ROOM TIME 1255 NUMBER 2 case #4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ~~Allergies~~ Pt sedated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	MAJ [redacted] 1145-1230

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Arms on arm boards @ <90°. Tourniquet placed on left upper arm by Dr [redacted] Tourniquet isolated

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

COMMENTS: From prep @ 1015 w-drape.

8. SKIN PREPARATION

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

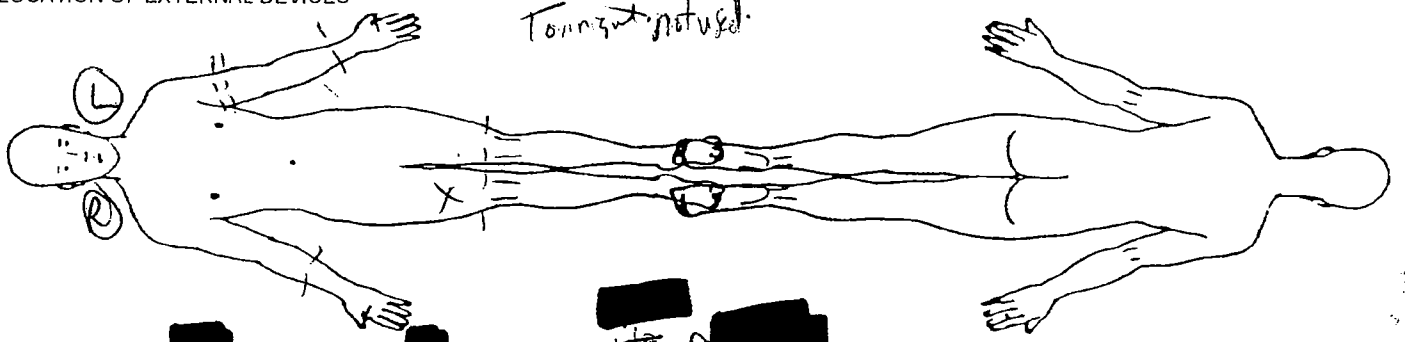
COMMENTS: No nicks noted - shaved ABO - MAJ [redacted]

PREP SOLUTION *(Specify)* Betadine Scrub / Paint
SITE: ABO BY WHOM: MAJ [redacted]
SITE: left Arm BY WHOM: CPT [redacted]

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES

Tourniquet not used.



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] === Tourniquet [redacted]

C = Correct I = Incorrect Initial count - SPC [redacted] / CPT [redacted]

10. COUNTS		First Closing Count Other**	First Closing Count Gen	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C		SPC	MAJ
Other	☐ Yes ☒ No					

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

EPW # [redacted] b(6)-4

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

☒ ESU NO: 000450
GROUND PAD: BRAND Kellyclb
LOT NO: 69652

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP		
SITE	ABD		

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8-ABD

Fluff, webril, splint, webril, ace - left forearm

19. ADDITIONAL INFORMATION

WC IV

Surgeons: Bergman/Poindo/Bergman Anesthesia: CRT [redacted] CND Anesthesia Type: General

b(6)-2

Bovie Pad site intact pre-op CDI ; post-op CDI Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED

#1 Exploratory Laparotomy, c small bowel resection & colectomy / #2 I&D left forearm

21. PATIENT TRANSFERRED TO ICU #1 TIME 1710 METHOD Litter

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

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

All, b(6)-2 except last

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Amb. Staff

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

3. DATE: 30 June 2003 TIME PATIENT ARRIVED IN SUITE: ICU → 0012

4. PATIENT [redacted] TIME: 1909 NUMBER: 24

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: MCDA, NPOPMN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] bbE)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Two armboard used to Lt arm

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: Q

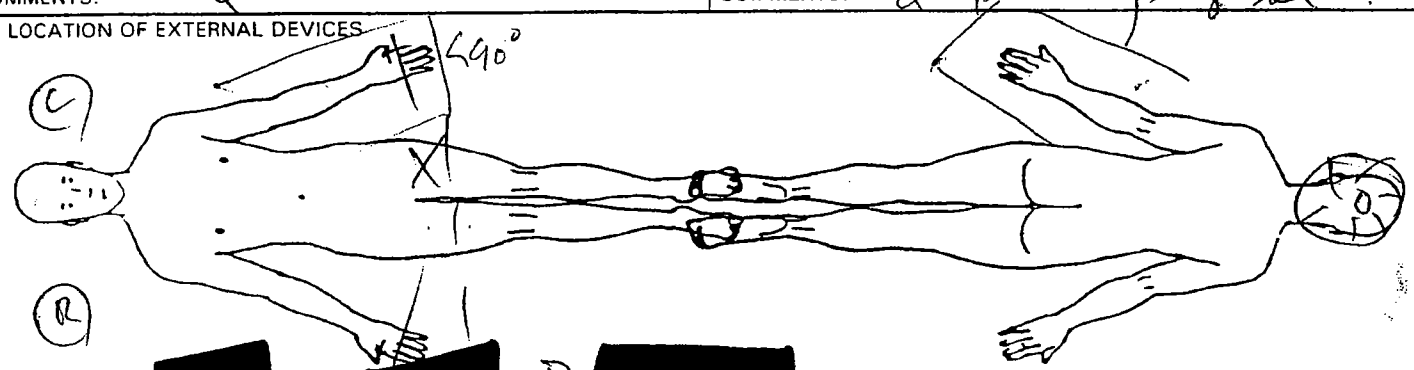
PREP SOLUTION (Specify) Betadine s/sol

SITE: Lt. arm BY WHOM: NA [redacted]

SITE: BY WHOM:

COMMENTS: 2 Doulings of Sol

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- [redacted] ap [redacted]

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes ☐ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

[redacted] b(6)-4

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

☑ ESU NO: Valley Lab 4

GROUND PAD: BRAND Polyhesive

LOT NO: 68936

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag: 30 Cut: 30

MEDCOM - 12321

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

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

K-wire 1/8" X 1 Lot # 0617102.

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl Pulse Lavage

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☑

	1.	2.	3.
TYPE/SIZE	Penrose Pantex		
SITE	@ Ulna		

18. DRESSING/IMMOBILIZATION *(Specify)*

Huffs
Kerlex
Ace & splint

19. ADDITIONAL INFORMATION

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

Anes: Mr [redacted]

20. OPERATION(S) PERFORMED

Ot. Arm. Washout, @ R I F.

21. PATIENT TRANSFERRED TO ICU TIME Ace Anes Record METHOD Litter

22. REGIS[redacted] LPT/AN

b(6)-2

REVERSE O[redacted] 5179-1, OCT 87 [redacted] USAPA V1.01

MEDCOM - 12322

All b(6)-2 except last

MEDICAL RECORD | **INTRAOPERA. DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY MAJ [redacted] / MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted]

3. DATE 2 Jul 03 TIME PATIENT ARRIVED IN SUITE 1525

4. PATIENT IN ROOM TIME 1525 NUMBER 12-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN. NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] ILT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

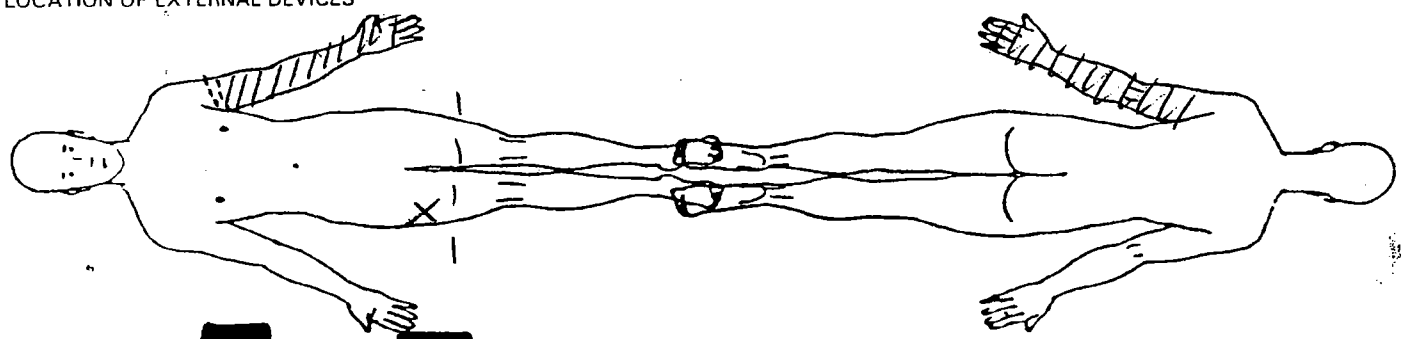
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Povidine scrub & solution
SITE: Left arm BY WHOM:
SITE: BY WHOM: ILT
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet ☒ prep

Initial: SPC [redacted] ILT

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No				[redacted]	[redacted]
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

#[redacted] b(6)-4

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

☑ ESU NO: Valleylab # 3 cut 30 coag 30
GROUND PAD: BRAND Vallaylab
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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. 10mm J-P drain	2.	3.
SITE	1. LFA	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, webril splint, ACE

19. ADDITIONAL INFORMATION

Surgeon Dr. [redacted] b(6)-2

Anes: MAC [redacted]

DA 5179 In Chart

20. OPERATION(S) PERFORMED

I&D Lt forearm

21. PATIENT TRANSFERRED TO ICU 2 TIME See DA 3389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] RN AN

b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

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

3. DATE 15 JUL 03 TIME PATIENT ARRIVED IN SUITE 1036

4. PATIENT IN [redacted] b(6)-4 TIME 1036 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-4	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment

8. SKIN PREPARATION

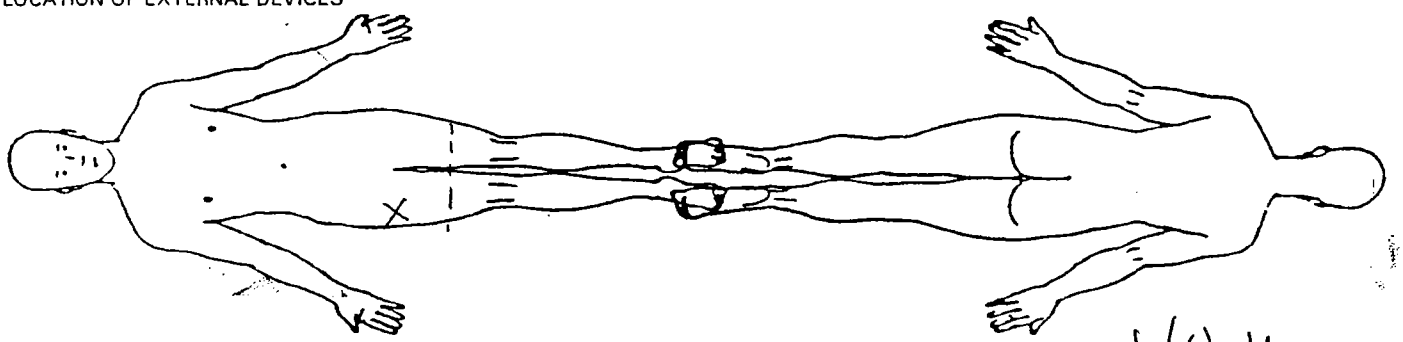
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens / NS
SITE: Abd. BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-4

C = Correct I = Incorrect Initial C [redacted]

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

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

[redacted] b(6)-4

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

☐ ESU NO: FOE000450
GROUND PAD: BRAND Valleylab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12325

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
NONE		

PHYS[redacted] b(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1/2" Iodoform		
SITE	abdomen		

18. DRESSING/IMMOBILIZATION *(Specify)*

4X8 Dpsite

Tape b(6)-2

19. ADDITIONAL INFORMATION

Surgeon: [redacted]

Anesthesia: [redacted] b(6)-2

20. OPERATION(S) PERFORMED

DPC Open Abd. Wound

21. PATIENT TRANSFERRED TO ICW 2 Recover in ICU 2 | TIME 1130 | METHOD Litter w/anesthesia

22. REGISTERE[redacted] CPT/AN

REVERSE OF DA[redacted] USAPA V1.01

b(6)-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19

DAY / HOUR

PULSE (O) / TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

SPO2 R

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] b(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 8 | 9 | 10 | 11 | 12 | 13 | 14

19 | HOUR

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

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR JULY 2003 | DAY | HOUR

DAY	11	12	13	14	15	16	17

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

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99° / 98.6°	37.2° / 37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19 2007 DAY

HOUR

DAY	18	19	20	21	22	23	24

PULSE (0) — TEMP. F (°) — TEMP. C (Centigrade Equivalents, for Reference only)

TEMP. F (°)	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. FCW 2

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

[redacted] b(6)-4

Date 28 JUNE 03 Bed # 5

Patient's Name: EDW [redacted] B(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP														153/87	137/85	129/90	137/92	138/89	133/82					
TEMP															99.1									
HR														110	114	110	111	112	109					
RR														16	16	15	14	13	14					
SAO2														98	99	98	97	96	97					
FIO2														10LPM	10LPM	2LNC	2LNC	2LNC	2LNC					
INPUT																								
PO																								
IV																								
NGT														100	125	125	125	125	125					
Running Total														CLAM	LINS									
TURN Q 2															225	350	375	500	625					
TOTAL																								
OUTPUT																								
URINE																								
NGT														200	125	140	135	150	75					
STOOL																								
JP																								
TOTAL														30										
BALANCE														230	355	495	625	775	850					
Initials																								
													[redacted]											

b(6)-2

EMT
#[redacted] b(6)-4

28 Jun

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		[illegible]
PCO2		[illegible] mmHg (arterial) [illegible] mmHg (venous)
PO2		[illegible] mmHg (arterial) [illegible] mmHg (venous)
TCO2		[illegible] mmol/L (arterial) [illegible] mmol/L (venous)
HCO3		[illegible] mmol/L (arterial) [illegible] mmol/L (venous)
sO2		95-98%
BEecf		[illegible] mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Dipstick		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.3	3.5-5.5 g/dl
ALP	57	26-84 u/l
ALT	34	10-47 u/l
AMY	33	14-97 u/l
AST	32	11-38 u/l
TBIL	0.6	0.2-1.6 mg/dl
BUN	11	7-22 mg/dl
CA	8.0	8.0-10.3 mg/dl
CHOL	98	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	125	73-118 mg/dl
TP	5.6	6.4-8.1 g/dl

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		8-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Metabolite 8

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA	130	128-145 mmol/l
K	4.3	3.3-4.7 mmol/l
CL	108	98-108 mmol/l
tCO_2	23	18-33 mmol/l

REMARKS:

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

DATE: 28 Jun

LAB ID NO.:

Ward/Section: ZMT | REQUI | G PH [redacted] B(6)-2 | L ORATORY RESULT FORM (Subject to the Privacy Act of ...)

LAST, FIRST [redacted] B(6)-4 | [redacted] 26 SUN 08 | TIME 1200 | SSN [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	17.2	4.8-10.8 x 10^3
RBC	4.13	4.7-6.1 x 10^9
Hgb	12.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.0	42-52% (M) 37-47% (F)
MCV	91.9	80-94 fl (M) 81-99 fl (F)
Plt	405	130-500 x 10^3 verified
Lymph %	10.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF.
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH
[redacted] b(6)-4		

PT = 12.1
PTT = 22.9

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

Ward/Section: ICU #1	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT F (Subject to the Privacy Act of 1

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW # [redacted] b(6)-4	4/29/03	0400	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.4	4.8-10.8 x 10^3
RBC	3.95	4.7-6.1 x 10^9
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.6	42-52% (M) 37-47% (F)
MCV	92.6	80-94 fl (M) 81-99 fl (F)
Plt	342	130-500 x 10^3 verified
Lymph %	12.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

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

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 V
EVERY UNIT REQUEST

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatches
MUST SUBMIT SF 518 WITH EVERY UNIT OF BLO
REQUESTED

UNIT	TYPE	CROSSMA

REMARKS: CBC

REPORTED BY:	DATE:	LAB ID NO:
b(6)-2 [redacted]	29 Mar 03	

ection: 1CU#1 | REQ | NG PHYSICIAN: [redacted] b(6)-2 | RATORY RESULT FORM (Subject to the Privacy A

FIRST, MI. | EPW [redacted] b(6)-4 | DATE 6/30/03 | TIME 0400 | SSN/PSEUDO SSN

(Hematology) CBC			Urinalysis			Misc. Serology		
T	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF.
	8.8	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
	3.06	4.7-6.1 x 10^9	App		N/A	Mono		
	9.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
	28.1	42-52% (M) 37-47% (F)	Bili		Negative	Source		
	91.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
	311	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
%	16.4	20.5-51.1%	Bld		Negative	H. pylori		Negative
matology) Manual Differential			pH		N/A	Micro Parasites		
		Mono	Prot		Negative	Malaria		
		Eos	Urob		0.2-1.0	O & P		
		Baso	Nit		Negative	Other		
		Imm	Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
crit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
e			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
			Directigen		Negative	ABO/Rh		

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

RKS:

RTED BY: [redacted] | DATE: 30 Jun 03 | LAB ID NO.:

b(6)-2

Ward Section: ICW#1 | REQUEST: | PHYSICIAN: [redacted] b(6)-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW [redacted] b(6)-4 | DATE: 9/30 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	118	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	1369	39-380 u/l (M) 30-190 u/l (F)
NA	116	128-145 mmol/l
K	4.4	3.3-4.7 mmol/l
CL	101	98-108 mmol/l
tCO_2	30	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | **DATE:** 30Jun03 | **LAB ID NO.:**

Ward Section	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
ICW 2	[redacted] b(6)-2	
LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE: 060 / TIME: 1 July	SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	6.8	4.8-10.8 x 10^3
RBC	3.07	4.7-6.1 x 10^6
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.3	42-52% (M) 37-47% (F)
MCV	92.1	80-94 fl (M) 81-99 fl (F)
Plt	404	130-500 x 10^3 verified
Lymph %	20.3	20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: [illegible]

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

Ward/Section: EMT	JESTING PHYSICIAN: Dr [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 05JUL03 / TIME 0215	[redacted]DO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.6	4.8-10.8 x 10^3
RBC	3.91	4.7-6.1 x 10^9
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.2	42-52% (M) 37-47% (F)
MCV	92.4	80-94 fl (M) 81-99 fl (F)
Plt	966	130-500 x 10^3 verified
Lymph %	18.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
		<20 ug/ml
		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2 | **DATE:** 6 Jul 03 | **LAB ID NO.:**

MEDICAL RECORD - ANESTHESI

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

NYDA

Procedure verified

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

DRUG	(Units)	
Lidocaine	(MG)	50
Fentanyl	(UG)	250
Propofol	(MG)	200
Succ	(MG)	100
	( )	
	( )	
VOLAT AGENT 1.5	% del	3.0-2.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6-2-2

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

FLUIDS

LINE site		
#20	☑ Warmed	LH
(R) PA	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 105/55; HR- 85

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (+); TIME- 1030

TIME → 0815 (11cw) X 30 X (12cw) X 30 X (13cw)

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	600	350	330
f - breaths/min	8	17	20
Peak inf pres / PEEP	23		
MODE - S(pon), A(ssist), C(on)	SV	CV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		37	37	36
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	
ART line	SpO2 (%)	100	100	100	
Steth- PC/ES	ECG	NS	NS	NS	
Gas analyzer CO2	TEMP-site	available			
	N-M Block (T/4)				
Warming blkt		Blanket on b/s/head array			
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → arms <90° abducted & padded

TOTALS: TOTAL EBL - mci; TOTAL URINE -

FLUIDS - SUMMARY: CRYSTALLOID- 2L-700; COLLOID-; BLOOD-

REMARKS

Code drugs with numbers, events with letters

1030 - Meta 10 - Resp done - Chest fed IV in place

1045 On 100% monitors on Induction & intubation

1130 - Opened eyes - extubated to ICU 2 for recovery

66-2 [redacted] ICU 2

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

CONDITION: 70-2

RESP 23 SpO2- 96% BP- 117/67 HR- 99

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1045	1140
	Ready	Begin	End
PROC	1055	1100	1125

PROCEDURES and CPT Codes: DPC Abx induction

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

[redacted] ICU 2 b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA - Gal ETT, Mod 22 cm teeth ≥ 7 3 RAC. Eyes taped. Soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DL x 1 P. Grade 1. CL view & A. cricoid pressure ETT easily passed. Atraumatic. Teeth OK

SURGEONS: [redacted] b(6)-2

ANESTHETI[redacted]

PROCEDURE LOCATION: 2

DATE: 15 Apr 03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)	
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION	Fentanyl	(cc)	(5) 3
	Lidocaine	(mg)	100
	Propofol	(mg)	150 50
	Bleb	(mg)	80
	Vec	(mg)	6
		( )	
VOLAT AGENT	Forane	% del	2.0 2.5 X
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	8 – 2 – 2 – 2 – 8
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS			VERSED 3mg IV

FLUIDS		
LINE site LH1	☐ Warmed	500 LH2
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	50
	URINE –	200

TOTALS	
	50
	200

FLUIDS – SUMMARY
CRYSTALLOID– 1500
COLLOID– 0
BLOOD– 0

REMARKS–
Code drugs with numbers, events with letters

Suction ↓ VIE
GTT

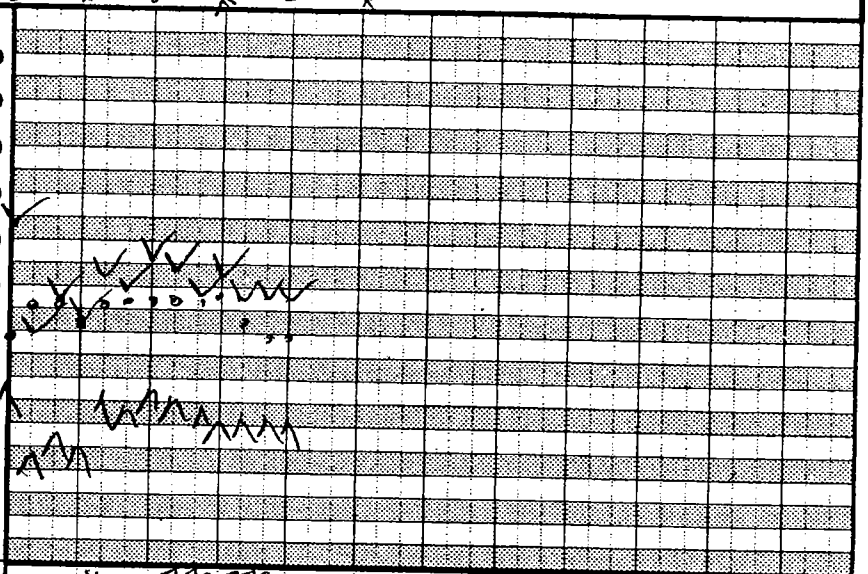
Reversed = 5mg Neostigmine
1mg Robinul
T4 = Antiemetic

Tovadal 30g
2100

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 80 KG LB
HEMATOCRIT: 9/28
INITIAL DATA: BP – 118/67 HR – 99
COMP CHECK: OK? – Y N
PATIENT RECHECK: OK for PROCEDURE – TIME – 1940

TIME → 2000 30 2100

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



VT – ml			700	780	770
f – breaths/min			10	10	8
Peak inf pres / PEEP			23	25	25
MODE– S(pon), A(ssist), C(on)			S	C	C
BP/Auto Cuff	ET CO2 (torr)		54	46	32
BP / oth	FIO2 (Frac or %)		.91	.91	.91
ART line	SpO2 (%)		100	100	100
Steth- PC/ES	ECG		ST	ST	ST
Gas analyzer	TEMP- site PO			98'	
	N-M Block (T/4)			4/4	3/4
Warming blkt					
Conv warmer					

RECOVERY AT PACU #1
PACU ICU (Specify)
OTHER
CONDITION: 98
RESP– 10 SpO2–
BP– 134/85 HR– 121

ANESTHESIA / PROCEDURE TIME	Start	Room	End
ANES	1940	1950	2130
PROC	Ready	Begin	End
	2005	2020	2115

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

PROCEDURES and CPT Codes
I & D (R) Forearm

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Tube taped 23 cm
Eyes taped
SIVI, DVOI VI, atraumatic, cuff ↑, BS = BS

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

SURGEONS: Dr [redacted] b(6)-2
ANESTHETIST [redacted] NAT, CRNA

PROCEDURE LOCATION # 2
DATE 30 Jun 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 12340
*U.S. GPO: 2002-729-180/40137

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Nuromax	(ml)	2 1.5
Fentanyl	( )	50
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT Forane	% del	1.5 — 1.5 — 1.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 — 2 — 2 — 2 — 8

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION

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

FLUIDS		
LINE site 18G (R) hand	☐ Warmed	~~400~~ 400 — 500
18G (R) Arm	☐ Warmed	1000 — 1200 — 1300
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	50/100 50/150 50/200
URINE – Foley	50/500

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 KG LB

HEMATOCRIT: 12/38

INITIAL DATA: BP – HR –

TIME-OUT CHECK: OK? Y N

PATIENT READINESS: OK for PROCEDURE? TIME –

TIME → 1600 2 x 30 x 1700 x 30

SYMBOLS: BP by cuff; Heart rate; Resp rate; BP (transduced); TOURNIQUET T – ✓; ANES – X-X; PROC – ⊙ – Ø

VITALS					
VT – ml	830	830	810	830	320
f – breaths/min	10	10	10	10	11
Peak inf pres / PEEP	23	23	23	23	
MODE– S(pon), A(ssist), C(on)	C	C	C	C	S
BP/Auto Cuff / ET CO2 (torr)	34	33	34	33	31
BP / oth / FIO2 (Frac or %)	.77	.77	.77	.77	.77
ART line / SpO2 (%)	100	100	100	100	901
Steth- PC/ES / ECG	ST	ST	ST	ST	ST
Gas analyzer / TEMP- site NO	99.3				
N-M Block (T/4)	4/4			4/4 i Sustained	
Warming blkt					
Conv warmer					

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

TOTALS	
	TOTAL EBL
	TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID – COLLOID – BLOOD –

REMARKS – Code drugs with numbers, events with letters

1550: Dr [redacted] starts op-procedure on (R) Forearm

1640: b(6)-2 Reversed i Sug Neostigmine + 1.0, Robinul T4 i Sustained

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: RESP – SpO2 – BP – HR –

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: I&D (R) Forearm – Fasciotomy; Ex. Lap – Partial Colon Resection

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SEE PG #1 b(6)-2

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

EPW # [redacted] b(6)-4

SURGEONS: [redacted]

ANESTH [redacted] b(6)-2

PROCEDURE LOCATION: OR #2

DATE: 28 Jun 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12341

*U.S. GPO: 2002-729-180/40137

EMT → ICU2 for [redacted]* (If ICU admit → ICU 1 for RR) → to ICU 1

(4 liters crystalloid in EMT)

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DOSAGE (CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION)	DRUG	(Units)	1	2	3	4	5	6	7	8	9	10	11
	Fentanyl	(mcg)	100	100	50						100		
	Propofol	( )	100										
	Lidocaine	( )	50										
	SCH	(mg)	140										
	Vecuronium	(mg)	8		2	3		4	3		1		
	MSO4	( )		5		(5)	(5)	2					
	VOLAT AGENT ISO	% del	1.6	1.6	1.8	1.5	1.5	1.6	1.8	1.6	1.8		
		% e.t.											
	AIR	L/Min											
	N2O	L/Min											
	O2	L/Min	10	2	2	2	2	2	2	2	2		

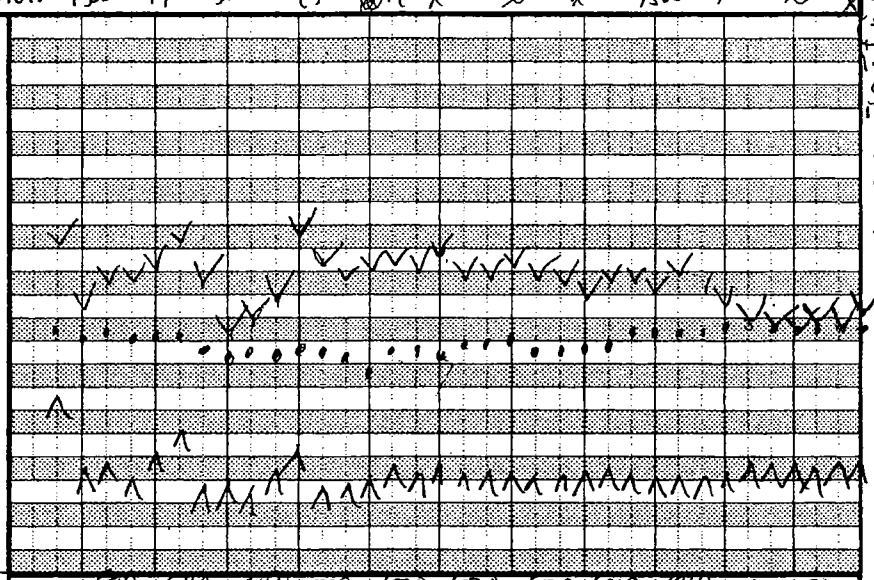
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ 1525 4mg Zofran IV; 1530 – 30mg Toradol IV

FLUIDS	LINE site			
	18g (R) Hand	☐ Warmed	LR 300+ → 1100	KVO → 1400
	18g (R) Arm	☐ Warmed	LR 900+ → X1000	
		☐ Warmed		
		☐ Warmed		

LOSSES											
	EST BLOOD LOSS	(Accepted)									
	URINE – Foley			400			50/450			50	

TIME →	1215	1300	15	30	45	1400	X	30	X	1500	X	30	X
VT – ml	–	810	840	840	830	820	830	830	840	840	830	830	
f – breaths/min	20	10	10	10	10	9	9	10	10	10	10	10	
Peak inf pres / PEEP	–	24	24	24	23	23	23	23	22	23	23	23	
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C	
ET CO2 (torr)	(+)	36	35	32	33	31	34	35	34	35	34	35	
FIO2 (Frac or %)	.76	.76	.76	.76	.76	.78	.78	.78	.78	.81	.77	.77	
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100	
ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	ST	ST	
TEMP- site	Available												
N-M Block (T/4)		4/4	0/4		4/4	0/4	4/4	1/4		3/4			

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



PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 KG LB

HEMATOCRIT: 12/38

INITIAL DATA: BP – 141/75; HR– 101

COMP CHECK: OK?– ✓ N

PATIENT RECHECK: OK for PROCEDURE? Okay; TIME– 1230

Warming blkt

Conv warmer

PP padded, Eyes taped, Soft white block placed, Arms < 90°

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

PROCEDURES and CPT Codes: I + D (L) Forearm; Ex. lap, partial colon resection

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

EPW # [redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: RSI (+) Cricoid pressure. IN x 1 attempt c # 6 ETT, MAE 3. (+) BBS (+) ETCO2. Secured @ 21 cm teeth. Atraumatic.

SURGEONS: [redacted] CRT / CRNA [redacted] MAJ CRNA

MEDICAL RECORD

TOTALS	
	200
	500

FLUIDS – SUMMARY: CRYSTALLOID– 1800; COLLOID– 0; BLOOD–

REMARKS– Code drugs with numbers, events with letters

1245 Pt. id in EMT. To OR via litter.
1255 In room, (+) O2, (+) monitors. Smooth IV induction. OG placed, Stomach SKW. 1317 Incision. Ex Lap. 1325 Bank sent in for Bnk. Report Received. 1335 OGT Δ to NGT (R) nare. 1420 Tsn Ancef IVPB. 1515: [redacted] relieves b(6)-2

RECOVERY AT: FCG #1; PACU ICU ____ (Specify); OTHER Surg 99; CONDITION: 10L/F; RESP– 16; SpO2– 99; BP– 134/79; HR– 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1245	1255	1720
	Ready	Begin	End
PROC	1303	1317	1652

PROCEDURE LOCATION: OR #2; DATE: 28 Jun 03; PAGE 1 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12342

b(6)-2

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PR[illegible]OCEDURAL ASSESSMENT (Sedatio[illegible]esthesia) Smoker

Age 24 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: DPC Abdom wound
SURGICAL SERVICE: [redacted] General Surg b(6)-2
NPO SINCE: Midnight [redacted] 03

HABITS:
TOBACCO: (✓)
ETOH: (✓)
DRUGS: (✓)

CURRENT MEDICATIONS:
( ) = ordered as premed
() Ancef QC
()
()
()
()
()

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

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

6 July 03
10.6 / 11.4 / 96.6 / 36.2

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	GSW b(6)
	N	Y	abdomen
Familial HX	N	Y	GSW (L) arm

ASSESSMENT
PAST SURGICAL/ANESTHETIC
mult GYO ?
D&C
c̄ anesth compl
ok hx

PHYSICAL EXAMINATION
BP 170/70 HR 70R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth Intact
Trachea midline
TMJ/Neck FROM
Oropharnyx Cl 2, 3 pb tm
Nares OK
CHEST: BBS/CTA
CARDIAC: S/S ©
EXTREMITIES:
IV Access: #20 Right
Ulnar Filling: ✓
BACK: OK
OTHER: ____

NPO Since MD 14 July 03

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

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

The patient/legal g[redacted]ees. Questions answered.
Signed: [redacted] Date: 15 July 03 Time: 0800 Hrs
b(6)-2

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

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ____

[redacted] b(6)-4 Q-DAY
1CW2

ESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

24 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

POSED PROCEDURE: I&D Clam + Ex lap
GICAL SERVICE: Ortho + General
SINCE: last night; water lady

ITS:
BACCO: yes
ETOH: yes
DRUGS: Ø

RENT MEDICATIONS:
ordered as premed

Ø

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
__ . ____ mg IV IM PO
__ . ____ mg IV IM PO
__ . ____ mg IV IM PO

ORATORY STUDIES:

HCT: ____/____
IER:

17.2 | 12.1 / 38.0 | 405

130 | 108
4.3 | 23

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y

Renal System:
Acute/Chronic RF N Y

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

Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological :
Pregnancy N Y N/A

Other Significant Hx:
N Y G-SW To (L)
N Y Lateral abdomen
Familial HX N Y + G-SW (L) FA

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MPZ
Nares
CHEST: CTA (B)
CARDIAC: RRR (-) M
EXTREMITIES:
IV Access: 18G (R) A
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

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

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

pat[redacted] and agrees. Questions answered.
b(6)-2 [redacted] LVN/CPT Date: 28 Jun 03 Time: 1246 Hrs

[redacted] EVALUATION AND NOTE (PON ASU)
N APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: ____ Date: ____ Time: ____ Hrs

ent Identification: (Ward) ____

EPW# [redacted] b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.

(7)

ANESTHESIA PLAN O E PREPROCEDURAL ASSESSMENT (Sec. Anesthesia)

Age 24 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D Barm
SURGICAL SERVICE: Ortho
NPO SINCE: MN

HABITS:
TOBACCO: yes
ETOH: yes
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) cefotetan 2wg
( ) MSO4
( ) ____
( ) ____
( ) ____
( ) ____

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

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

8.8 > 9.1 / 28.1 < 311

116 | 101 | 10 / 118
4.4 | 30 | .8

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	____
Angina	N	Y	____
MI	N	Y	____
CVA	N	Y	____
Other	N	Y	____
Pulmonary System:			
Asthma	N	Y	____
Bronchitis/URI	N	Y	____
COPD	N	Y	____
Other	N	Y	____
Renal System:			
Acute/Chronic RF	N	Y	____
Gastrointestinal:			
Hepatitis	N	Y	____
Hiatal Hernia	N	Y	____
PUD/GERD	N	Y	____
Endocrine System:			
Diabetes	N	Y	____
Steriods	N	Y	____
Thyroid	N	Y	____
Neurological:			
Seizures	N	Y	____
Neuropathy	N	Y	____
Other	N	Y	____
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	Y	GSW to (L)
	N	Y	abdomen and
Familial HX	N	Y	GSW to L arm

ASSESSMENT
PAST SURGICAL/ANESTHETIC
____
____
____
____
____
____

PHYSICAL EXAMINATION
BP 110/67 HR 99 R 18 T 98.7
Pain Scale 0-10 ____
HEENT - Teeth ____
Tracnea Intact
MP2 TMJ/Neck Midline
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

Chart Reviewed -

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

The patien[redacted]ees. Questions answered.

b(6)-2

Signed: [redacted] Date: 6/30/03 Time: 1110 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU Rec ICU

EPW [redacted]

b(6)-4

SEDATION KEY:

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS Previous edition is obsolete
PATIENT RECORD COPY ☆ U.S. GPO. 2002-729-265

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

EPW
[redacted] b(6)-4
ICU #1

ISING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 28 June 03 TIME OF ORDER: 1534 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit ICU 1
(2) Dx s/p Ex lap, colectomy, end colostomy + I&D (L) forearm
(3) Condition good
(4) VS q 1hr including SaO_2 + UO
(5) Call MD for HR <50 >120 SBP >160 <90 DBP >90 <60 RR >30 <10 UO <30cc/hr T >100.4

IENT IDENTIFICATION

ISING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(6) All NKDA
(7) Azt ~~adf~~ [redacted] b(6)-2
(8) Diet NPO
(9) NF LRC 125 cc/hr
(10) MSO4 1-4 mg IV q 1 hr prn pain
(11) Toradol 30 mg IV q 6 hrs x 6 doses then D/C
(12) Cefotetan 2 mg IV q 8 hrs. First dose when new.

b(6)-2 [redacted]

b(6)-2 [redacted]

IENT IDENTIFI

SING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(13) NGT to LIWS
(14) Foley to gravity
(15) CBC Chemistry 8 q AM
(16) Ortho Dr [redacted] Surg Dr [redacted] or [redacted] MC USA

b(6)-2

28 JUN 03
2230 hrs

ENT IDENTIFICATION

SING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 29 June TIME OF ORDER: 1700 HOURS

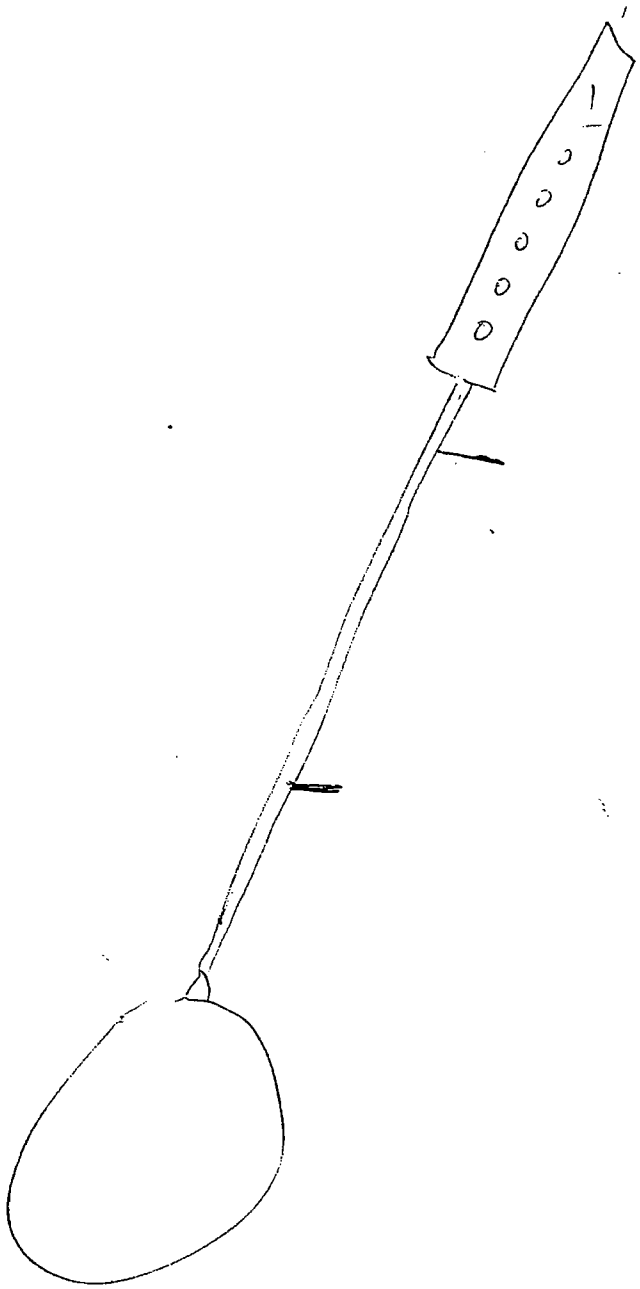
Pentamycin 500 in W of TNW
Ice/Elev (L) UE
29 June 03 [redacted]

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. WHERE EXPANDED ORDER FORM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW ABOVE.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	ORDERS
EPW # [redacted] b(6)-4	29 Jun 03	0717	(1) Activity OOB to chair today + walk c assistance (2) IS 10 x q 1hr while awake (3) Wean O_2 to keep sats > 96% [redacted] b(6)-2
ASSIGNED UNIT: ICU#1 / ROOM NO: / BED NO: 5			[redacted] 9230 b(6)-2
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	ORDERS
	30 Jun 03	0708	(1) NGT clamped (2) NPO for surgery. After surgery may have 2 sips of clears [redacted] 30 Jun 03 0710 MAJ MC USA b(6)-2
ASSIGNED UNIT / ROOM NO / BED NO			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	ORDERS
ASSIGNED UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	ORDERS
ASSIGNED UNIT / ROOM NO. / BED NO.			



CLINICAL RECORD - DOCTOR'S ORDER

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: [redacted]

DATE OF ORDER: 30 Jun 03 | TIME OF ORDER: 2115 | HOURS | LIST TIME ORDER NOTED AND SIGN

Transfer SICU → ICW 2 ✓
SP washout / IM pain U/m R
Stable ✓
US per routine ✓
Diet: Adv Ad lib ✓
Continue Surg prep order and meds ✓

Noted 08:03

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

DATE OF ORDER: [redacted] b(6)-2 | TIME OF ORDER | HOURS

Adv Diet Clears ✓
Clamp NGT ✓
IV: LR @ TKO ✓
Foley (Elect) DVR ✓
Dry: AP/Left Forearm in Splint ✓
24° V Cbne [redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

DATE OF ORDER: 30 Jun 03 | 23:38 | [redacted] HOURS

V.O.
I+O's q shift /
CBC in AM only / JUL 03
D/C q AM CBC ✓

noted 23:40 30 Jun 03

NURSING UNIT: ICW 2 | ROOM NO.: 24°/s | BED NO.: 1200

1 July 03 [redacted] b(6)-2

PATIENT IDENTIFICATION

ICW
[redacted] b(6)-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER [redacted] OF ORDER

1 JULY 03 | HOURS

1) D/C cefotetan ✓
2) Ancef 1gm IV q 8 hrs ✓ b(6)-2 [redacted]
3) D/C'd NGT ✓
4) Diet Clears / Liquids
5) D/C Foley. Void q 6 hrs. ✓
6) Percocet 1-2 tab po q 4-6 hrs pm pain
7) OOB to chair & Ambulate Q shift

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED. [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: [redacted] b(6)-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: [redacted] | TIME OF ORDER: 2230 HOURS | LIST TIME ORDER NOTED AND ACTION TAKEN: [redacted]

NPO p MN
for [illegible] 2 20h

b(6)-2

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

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 2 Jul 03 | TIME OF ORDER: 1000 HOURS

1. D middle dressing w-7D BID
2. Pt may Ambulate TID

[redacted] b(6)-2

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

NURSING UNIT: ICW 2 | ROOM NO.: [redacted] | BED NO.: 10

DATE OF ORDER: 2 Jul 03 | TIME OF ORDER: 1530 HOURS

NPO Clear liquid
Cont all prev orders
by DNA
JP to Bulk [illegible]

[redacted]

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

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 15 Jul 03 | TIME OF ORDER: [redacted]

Resume previous orders

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION

EPN

[redacted] b(6)-4

DATE OF ORDER: 6 May 03 TIME OF ORDER: 1000 HOURS

LAST TIME ORDER NOTED AND SIGN

√D/C to TPW Camp if OK c̄ Gen Surgery

[redacted] b(6)-2

UNIT: ICW2 ROOM NO. BED NO.

IDENTIFICATION

DATE OF ORDER TIME [redacted] HOURS

1. Admit to ICW √
2. DX wound separation √
3. Cond stable √
4. Vitals Routine (Q4° with I&O) √
5. All NKDA √
6. Act OOB Ad lib √

Nurse colostomy care √

UNIT ROOM NO. BED NO.

IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

Noted [illegible]

b6-2 [redacted]

Wet to Dry Dressing to Mid line wound BID √

Regular Diet √

IVF LRC @ 150 √

meds

Percocet 1-2 tabs PO Q4°-6° PRN Pain √

Tylenol 650 mg PO Q6° PRN Pain √

UNIT ROOM NO. BED NO.

IDENTIFICATION

DATE OF ORDER TIME OF ORDER

Noted [illegible]

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

0-3-00 7 July 03

04, 10, 16, 22 → [redacted] gm Ancef IV Q6° [redacted] √ dme

UNIT ROOM NO. BED NO.

[redacted] b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	FIRST TIME ORDER NOTED AND SIGN
EPW # [redacted] b(6)-4	7 Jul 03	0700 HOURS	
	(1) D/C IV		
	(2) QC° vital signs		
	[redacted] b(6)-2		
UNIT: 1CW; ROOM NO. b(6)-2 BED NO. [redacted]			
IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
27 US G [redacted]	10/AN 7-8-03	2300 HOURS	
EPW # [redacted] b(6)-4	9 Jul 03	1630	
	(1) D/C IVF		
	V.O. [redacted] b(6)-2		
UNIT: 1CW; ROOM NO. BED NO.	b(6)-2	b(6)-2	
IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b(6)-4	10 Jul 03	0940 HOURS	
	(1) IP to continuous 125mm Hg suction.		
	b(6)-2 [redacted]		
UNIT: 1CW; ROOM NO. BED NO.	noted 10 July 1000 CT		
IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	11 Jun 03	0141 HOURS	
	V.O. Maalox 2-4 tabs PO TID PRN Phenergan 25mg IVP q6° PRN Nausea/vomiting [redacted] b(6)-2		noted 0141 11 Jun 03 [redacted] b(6)-2
UNIT: ROOM NO. BED NO.	240 [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

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12 Jul 03 TIME OF ORDER: 1600 HOURS

(1) D/C suction

(2) wet to Dry Dressing BID to Abd

[redacted] b(6)-2

b(6)-2 [redacted]

LIST THE ORDERS NOTED BY SIGN

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24 V's	[redacted]	

DATE OF ORDER: 13 JUL 03 TIME OF ORDER: 1645 HOURS

(1) NPO ~~7~~ MN

CRC Trach @ 2400

b(6)-2 [redacted]

b(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
		24°

DATE OF ORDER: 13 JUL 03 TIME OF ORDER: 1030 HOURS

(1) Reg Diet

NPO ~~7~~ MN for OR on 15 [redacted]

b(6)-2 [redacted]

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24° V's	[redacted]	

7-14-03 2350

b(6)-2

DATE OF ORDER: 15 JUL 03 TIME OF ORDER: 1100 HOURS

(1) Resume previous order ~~7~~

No dressing Δ's

b(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24V°	10

[redacted]

~~20 July 03~~ 0105

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

RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED ... WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW

PATIENT IDENTIFICATION

[redacted] b(6)-4

WARD OR UNIT	ROOM NO.	BED NO.
ICW 2		6

DATE OF ORDER | TIME OF ORDER

20a 21JU03

① Dlc to EPW camp. wife - Available

b6-2

[redacted] 0721

PATIENT IDENTIFICATION

WARD OR UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

PATIENT IDENTIFICATION

WARD OR UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

PATIENT IDENTIFICATION

WARD OR UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 26 Jul 03 | TIME OF ORDER: 1900 HOURS | LIST TIME ORDER NOTED AND SIGN

Admit: ICW#2
dx: ulnar fx s/p suture removal
condition - stable
VS - none
diet Regular
Activity - ad lib [redacted] b(6)-2

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] b(6)-2

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 26 JUL | TIME OF ORDER: 21:05 HOURS

b(6)-2

V.O. from Dr. [redacted] to LT [redacted] b(6)-2
D/C Pt to EPW camp when available escort.
Dr [redacted] b(6)-2 [redacted]

noted 21:05 [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

All b(6)-2 except last

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30		
28 JUN	[redacted]	VS q1hr Including SaO2 + UO	05 / 17	[redacted]	[redacted]		D/C'd	See next sheet
28 JUN	[redacted]	I+O's (UO) q1hr	05 / 17	[redacted]	[redacted]		Rewritten	See next sheet
28 JUN	[redacted]	Call MD for HR<50 >120, SBP>160<90, DBP>90<60, RR>30 <10, UO <30cc/HR, T>100.4	05 / 17	[redacted]	[redacted]		see rewritten	Green sheet
28 JUN	[redacted]	Activity: ~~Bed Rest~~ OOB to chair / Amb c Assist.	05 / 17	[redacted]	[redacted]		see rewritten	Green sheet
28 JUN	[redacted]	Diet: NPO	05 / 17	[redacted]	[redacted]		D/C'd	
28 JUN	[redacted]	NGT to ~~LIWS~~ clamped	05 / 17	[redacted]	[redacted]		See rewritten	Green sheet
28 JUN	[redacted]	Foley to Gravity	05 / 17	[redacted]	[redacted]		see rewritten	Green sheet
28 JUN	[redacted]	CBC + MetLyte 8 q AM	05 / 17	[redacted]	[redacted]		D/C'd EM	
28 JUN	[redacted]	Ice/Elevate (L) UE	05 / 17	[redacted]	[redacted]		Rewritten	See next sheet

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Dx S/P Exp lap colectomy, end colostomy, I+D (L) Forearm

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28Jun	[redacted]	ADMIT ICU 1	28Jun	Done		[redacted]
28Jun	[redacted]	CONDITION Good	28Jun	Done		[redacted]
30Jun	[redacted]	Transfer from ICU → ICW 2	30Jun	Done		[redacted]
30Jun	[redacted]	S/P washout / Impending ulnar repair	30Jun	Done		[redacted]
30Jun	[redacted]	Stable condition	30Jun	Done		[redacted]
30Jun	[redacted]	Continue same preop orders and meds	30Jun	Done		[redacted]
30Jun	[redacted]	X-Ray ~~AB~~ AP/Lat forearm in AM	01Jul	AM ⇒	See run sheet Green	

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

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30
29JUN	[redacted]	IS: 10 q1° w/A.	05	[redacted]	
			7		
29 Jun	[redacted]	Wean O2 Keep	05		
		Sats >94%	7		
30Jun	[redacted]	VS Per routine	05	/	/
			13	/	/
			21	/	/
30Jun	[redacted]	Advance diet to clears	05	/	/
			13	/	/
			21	/	/
30Jun	[redacted]	Clamp NGT	05	/	/
			13	/	/
			21	/	/
30Jun	[redacted]	TCQ/elevate LUE	05	/	/
			13	/	/
			21	/	/
30Jun	[redacted]	I+O's UOQ ~~thr~~ shift	05		
			13		
			21		
30Jun	[redacted]				

See rewritten Green Sheet

ALLERGIES: ☐ YES ☐ NO
MKDA

PRIMARY DIAGNOSIS:
S/p Colectomy / I+D (L) FA.

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*					Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
30JUN	[redacted]	CBC in AM 1JUL03	01JUL	0400			
	-----	b(6)-2					

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

All b(6)-2 except last

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	01	02	03	4	5	6	7	8	9	10	11	12	13
30Jun	[redacted]	VS: Per Routine	05	/	[redacted]												
			13	/													
			21	[redacted]													
30Jun	[redacted]	Diet: ~~Adv to clears~~ REG (25Jun03) [redacted]	07	/	[redacted]												
			12	/													
			17	/													
30Jun	[redacted]	IS: 10 q1° while awake	05	/	[redacted]												
			13	/													
			21	[redacted]													
30Jun	[redacted]	Clamp NG tube	05	/				DC'd @ 0700 1 July									
			13	/													
			21	[redacted]													
30Jun	[redacted]	Ice/Elevate (R) UE	05	/	[redacted]												
			13	/													
			21	[redacted]													
30Jun	[redacted]	Wear O2 keep Sats >96%	05	/	[redacted]												
			13	/													
			21	[redacted]													
30Jun	[redacted]	I+O's q Shift	05	/	[redacted]												
			13	/													
			21	[redacted]													
30Jun	[redacted]	NGT clamped	05	/													
			13	/													
			21														
30Jun	[redacted]	Foley to Gravity	05	/				DC'd @ 0700 1 July									
			13	/													
			21	[redacted]													

ALLERGIES: ☒ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Colectomy/I+D (R) ft

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 31

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30Jun	[redacted]	X-ray LAT/AP	1Jul	AM		
30Jun	[redacted]	CBC In AM	1Jul	~~AM~~ 0400	0400	[redacted]
1Jul	[redacted]	NPO p mn / OR in am	2Jul	mn	0800	
2	[redacted]	s/p Closure Wound	2		1600	
2	[redacted]	Cont Previous Orders	2		1600	
Daily	[redacted]	D/C to EPW Camp if OK c̄ Gen Surgery	Daily	ASAP		

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

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. JUN Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	1	2	3	4	5	6	7	8	9	10	11
28JUN	[redacted]	IVF: LRB 125 cc/HR	05	[redacted]				D/d			See						
			17	[redacted]							below						
28JUN	[redacted]	Toradol 30 mg IV	06	[redacted]													
		Q6 hrs x 6 doses	12	[redacted]													
		Then D/C	18	[redacted]													
			24	[redacted]													
28JUN	[redacted]	Cefotetan 2 mg	06	[redacted]							DC'd			[redacted]			
		IV Q8 hrs	14	[redacted]							14 July						
			22	[redacted]													
30Jun	[redacted]	IVF TVO	05	[redacted]													
			13	[redacted]							1 Jul 03						
			21	[redacted]													
1 July	[redacted]	Ancef 1 gm IV	06	[redacted]													
		q 8 hrs	14	[redacted]							See						
			22	[redacted]							A 15 and PAGE						

ALLERGIES: ☐ YES ☒ NO
~~AF~~ NKDA

PRIMARY DIAGNOSIS: Dx S/P Exp Lap, Colectomy, End Colostomy + I+D (L) Forearm

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28JUN	[redacted]	Cefotetan 2mg (First Dose Now)	28JUN	1910	1950	[redacted]
28JUN	[redacted]	Gentamycin 500 mg IV x 1 Now	28JUN	1845	1910	[redacted]

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED													
28JUN	[redacted]	MS04 1-4 Mg IV q1hr PRN Pain	28 Jun 0120 4mg IV	29 Jun 0800 4mg	29 Jun 0911	29 Jun 1100 2mg	3mg 6/29 1V	2mg 0900 6/30 [redacted]	30 Jun 4mg 0630	30 Jun 4mg 0730	30 Jun 4mg 1600	4mg 0040 1JUY	4mg 0918 2JUL	4mg IV 5JUL 0043	4mg IV 0001 1537	4mg IV 1JULY 0730 [redacted]
		~~Toradol 30mg IV q6hrs x 6~~														
1JUL	[redacted]	Percocet 1-2 tabs q 4-6 hr PRN	1JUL 0210 AS 1-2 11	1JUL AS 1-2 12	1JUL 1845 AS 1-2 18:45	3JUL 0855 1-2 11	3 JUL 1805 1-2 11	3 JUL 2337 1-2 11	1JUL 0900 1-2 11	1 JUL 0730 1-2 11	1 JUL 2330 1-2 11	3JUL 2000 1-2 11	[redacted]	[redacted]	[redacted]	[redacted]

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. JUL Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	28	29	30	1	2	3	4	5	6	7	8	9	10	11
28JUN	[redacted]	IVF: LRB 125cc/HR	05	[redacted]				D/d			see			1			
			17	[redacted]							below						
28JUN	[redacted]	Toradol 30 mg IV	06	[redacted]													
		Q6 hrs x 6 doses	12	[redacted]													
		Then D/C	18	[redacted]													
			24	[redacted]													
28JUN	[redacted]	Cefotetan 2 mg	06	[redacted]							DC'd			[redacted]			
		IV Q8 hrs	14	[redacted]							1 July						
			22	[redacted]							0400						
30Jun	[redacted]	IVF TVO	05	[redacted]													
			13	[redacted]							1 Jul 03						
			21	[redacted]							[redacted]						
1July	[redacted]	Ancef 1 gm IV	06	[redacted]													
		q 8 hrs	14	[redacted]													
			22	[redacted]													

SEE ABOVE PAGE

ALLERGIES: ☐ YES ☒ NO
~~AF~~ NKDA

PRIMARY DIAGNOSIS: Dx S/P Exp Lap, Colectomy, Ent Colostomy + I+D (L) ForeArm

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	30	01	02	03	4	5	6	7	8	9	10
30Jun	[redacted]	Activity: BR OOB>	05	/	[redacted]									
		Chair, Amb c̄ assist	13	/										
			21	[redacted]										
30Jun	[redacted]	Call MD for HR<50	05	/	[redacted]									
		>120, SBP <90 >150	13	/										
		DBP <60 >90, RR >30	21	[redacted]										
		<10, UO <30cc												
		T- >100.4												
2Jul	[redacted]	A middle dsg, wet	08	/	[redacted]									
		to dry BID	20	/	/	[redacted]								
2 Jul	[redacted]	Pt may ambulate TID	05	/	[redacted]									
			13	/	/	[redacted]								
			21	/	/	[redacted]								
2Jul	[redacted]	JP to Bulb Suction	5	/	/	/	[redacted]							
			13	/	/	[redacted]								
			21	/	/	[redacted]								

DICD

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Colectomy/T+D @ FA

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2 except last

the proponent agency is the Office of The Surgeon General. MO. YR 2003

RIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION	
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21
6 Jul	[redacted]	OOB ad lib	05	[redacted]
			13	
			21	
6 Jul	[redacted]	Ostomy care	05	[redacted]
			13	
			21	
6 Jul	[redacted]	Regular diet	05	[redacted]
			13	
			21	
6 Jul	[redacted]	VS q 6	06	
			12	
			18	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Wound Separation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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

All b(6)-2 except last

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 07	8	9	10	11	12	13	14	15	16	17	18	19	20
6 Jul	[redacted]	VS Q4°	02	[redacted]													
			06	[redacted]													
			10	[redacted]				D'C 7 July									
			14														
			18														
			22														
6 Jul	[redacted]	I + O's	05	[redacted]			D'C 7 July										
			13														
			21														
6 Jul	[redacted]	OOB → ~~chair~~ Ex or chair qd	05	[redacted]													
		lip	13														
			21														
6 Jul	[redacted]	Colostomy Care	05														
			13														
			21														
6 Jul	[redacted]	W → D dsg midline	08	[redacted]													
		wound BID	20														
6 Jul	[redacted]	Reg diet	07														
			12														
			17														
6 Jul	[redacted]	VS Q6	06														
			12														
			18														
			24														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Wound Separation

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13	[redacted]	NPO p MN	13	2355		[redacted]
15	[redacted]	NPO p MN (15 July)	15	000/	000/	[redacted]

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

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD

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

Mo. July Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12	13	14	15
10 July	[redacted]	SP to continuous	06	[redacted]					
		125 mmHg suction.	14	[redacted]					
			22	[redacted]					
12	[redacted]	W → D dsg BID	10	[redacted]					
		to ABD	22	[redacted]					

D/C 12 July

D/C 15 July 2003

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Wound Separation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

All b(6)-2 except last

the proponent agency is the Office of The Surgeon General.

MO 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 24 27 28
26	[redacted]	activity-ad lib	05	✓
			13	[redacted]
			21	
			✓	
26	[redacted]	diet: regular	07	✓
			12	✓ [redacted]
			17	✓ [redacted]
			✓	
26	[redacted]	VS-none	05	✓
			13	[redacted]
			21	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Boarder - urinary s/p suture removal

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26	[redacted]	Condition: stable				
	-----	admit ICW #2				
26	[redacted]	D/C pt. to EPW Camp when	ASAP			
	-----	available escort				

	-----					

b(6)-2

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

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. July Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22
6 July	[redacted]	HR @ 25cc/hr @	06	[redacted]								
			14									
			22									
8 July	[redacted]	Ancef 1gm IV @6	04	[redacted]								
			10									
			16									
			22									

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Wound separation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*					Mo. 7 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
16 July	[redacted]	Percocet 1-11 tabs PO	15 July TT	15 July TT 1320	15 July TT 2045	16 July 0945 TT	19 July 0010 TT PO	17 Jul 2242 TT PO	18 Jul 0555 TT PO	19 July 2250 TT						
		q4-6 PRN pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
16 July	[redacted]	Tylenol 650mg po	16 Jul 0900	16 Jul 0154 650 mg PO	18 Jul 975mg 1900 (4)	18 Jul 2045 TT PO	18 Jul 2040									
		Q6° PRN pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]									
11 July	[redacted]	Maalox 2-4 tabs														
		po TID PRN														
11 July	[redacted]	Phenergan 25mg	17 Jul 0907 12.5mg 1300	20 July 1112												
		IVP q6° PRN for nausea	[redacted]	[redacted]												
		& vomitting														

USAPA V1.00

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	6	8	9	10	11	12	13	14	15	16	17	18	19
~~10 03~~	[redacted]	~~IVF LR@ 150cc/hr~~ D/C	05	/	[redacted]											
6 Jul	------	HL	13	/												
	------		21	8m												
7 Jul	[redacted]	1gm Ancef IV	01	/												
	------	Q6°	10	/												
	------		16	/												
	------		22	/												

13	[redacted]	Start LR@ 75cc/hr	5	/	—	—	—	—	—	/	[redacted]					
	------	@ 2400 13JUL03	13	/	—	—	—	—	—	/						
	------		21	/	—	—	—	—	—	[redacted]						
	------	Ancef 1gm IV	08	/	/	/	/	/	/	/	[redacted]					
	------	Q6	14	/	/	/	/	/	/	/						
	------		20	/	/	/	/	/	/	/						
	------		02	/	/	/	/	/	/	/						

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Wound Separation

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo._____ Yr._____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
16Jul	[redacted]	Percocet ½-1½ tabs	16Jul 0105 ½ PO	16Jul 0500 ½	16Jul 1230 ½	16Jul 0140 ½	16Jul 0730 1½ PO	16Jul 0400 ½ PO	16Jul 1030 1½ PO	16Jul 1130	16Jul 21:35 ½ PO	16Jul 1245 ½ PO	16Jul 2200 ½ PO	16Jul 0630 ½	16Jul 2200 ½ PO	16Jul 2330 ½ PO
		PO Q4°-Q6° PRN	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]								
		Pain														
16Jul	[redacted]	Tylenol 650mg														
		PO Q6° PRN Pain														
17Jul	[redacted]	Maalox 2-4 tabs	0141 17Jul ½ PO	0230 ½ PO												
		PO TID PRN	[redacted]	[redacted] 15Jul												
16Jul	[redacted]	Phenergan 25mg IVP	0141 17Jul 25mg IVP	0115 25mg IVP	13Jul 1130											
		Q6° PRN for Nausea	[redacted]	[redacted]												
		and Vomitting														

USAPA V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HRS TO ____ HOURS | TOTAL HOURS COVERED | DATE [illegible]

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	Juice	120cc	120cc
0800	Water	60cc	180cc
1600	Jello	120	300
	tang	200	500
	H_2O	100	600

INTRAVENOUS

Lactated Lig.

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0450	500cc	LR TKO	500	9.00	500
0900	500cc	LR	500	~~1400~~ 1200	1000
14	50	amcef	50		1050

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1600	urine	700	700

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

CPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

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

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

b(6)-4

[redacted] 29 Jun Fcu #7

PAGE

DATE | DX | HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	124/51	137/88	141/77	125/80	124/99	133/86	124/82	132/74		104/64	110/81	129/85	132/70	124/70	131/72	125/73	126/69
BP Cuff																	
Temperature	98.8				99.4		98.2								99.2		
Pulse	105	115	99	97	96	106	103	105		104	101	78	97	94	97	113	99
Respiratory Rate	13	19	14	14	16	16	17	17		19	19	19	15	16	18	16	16
SAO2	100	98	99	99	99	100	95%	97%		97%	97%	97%	97%	97%	97%	99	99
O2 Source	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L		2L	2L	2L	2L	2L	2L	2L	2L
pain intervention																	

TIME	24	01	02	03	04	05	06	07	8T	08	09	10	11	12	13	14	15	
IVP	125	125	125	125	125	125	100	200	950	100	100	100	100	100	100	100	100	500
										50						50		100
									66.2 [redacted]									
TOTALS		250		500	625	750			950									900
URINE HOUR / TOTAL	125/125	100/225	75/300	100/400	75/475	50/525	100/625	200/825	8LT	100/100	100/200	50/250	200/450	100/550	100/650	100/750	100/850	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS JP					10			0	10			4						
DRAINS									0									
TOTALS									835									804

[redacted] b(6)-4

29 Jun 03

PAGE

OF DAY

16	17	18	19	20	21	22	23
117	124	132	135	133	126	125	132
74	70	66	72	80	73	60	71
103	102	105	97	85	92	90	89
23	17	25	19	24	18	18	17
98%	98%	96	96	96	98	98	99
2L	2L	2L	2L	2L	2L	2L	2L
						98.6	
						NY	

COB 40 Chest

16	17	18	19	20	21	22	23	8° T
125	125	125	125	125	125	125	125	
					50			

CR
ABX

100/100	100/200	100/300	50/350	100/400	200/600	250/900	250/150	

UOP

ACUITY LEVEL CLASSIFICATION

RESPIRATORY

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

LABORATORY

TIME	04							
GLUCOSE	130							
Na/K	131/4.6							
Cl/CO_2	102/23							
BUN/Cr	10/0.4							
WBC/PLATELET	16.4/312							
Hct/Hgb	30/11							

ACTIVITIES OF DAILY LIVING

TIME				TURN	TIME			
MOUTH CARE								
BATH								
SKIN CARE								
FOLEY CARE				SUCTION				
TRACH CARE								
ROM EXERCISES								

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

NURSE'S SIGNATURE

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS
TO [illegible] HOURS
TOTAL HOURS COVERED 24

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	Milk	250	250
1800	milk	250	500
1800	H2O	50	550

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0610	50	Ancef	50	0630	50
1415	50	Ancef	50	1445	100
2200	50	Ancef	50		150

JP ~~MEDICATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0845	Red serosanguinous fluid	20	20
0800	Red serous fluid	20	40
2025	Red serosanguinous fluid	20	60cc
0300	Bloody	20	80cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

MEDCOM - 12379

*U.S.GPO:1996-404-613/3034

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ___ HOURS TO ___ HOURS	TOTAL HOURS COVERED	DATE
			2JUL03

INTAKE

~~ORAL~~ JP Drain

TIME	TYPE	AMOUNT	ACCUM TOTAL
1930	Bldy	30	30

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

gPW [redacted] b(6)-4

INTAKE EQUIVALENTS (*Serving levels cc*)

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

DD FORM 1 JAN 74 792 EDITION OF 1 FEB 74 IS OBSOLETE REPLACES DA FORM 3630(TEMP) 1 JUL 7

MEDCOM - 12380

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

TWENTY-FOUR HOUR PATIENT INTA... AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 2359 HOURS | TOTAL HOURS COVERED 24 | DATE 5 Jul 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0610	500cc	Ancef	500cc	0650	500cc
1400	100	Ancef	100		150
2300	100	Ancef	100		250

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0200	Red fluid	100cc	100cc
2100	Red fluid	10	[illegible]

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 EDITION OF 1 JUL 72 WHICH MAY BE USED. REPLACES DA FORM 3830(TEMP)

MEDCOM - 12381

*U.S.GPO:1998-404-612/20343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 4 Jul

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
08	milk + 2	480	
1000	H_2O	100	580
1700	milk	240	820

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	100	Ancef	100	0630	100
14	100	Ancef	100	1430	200
22	100	Ancef	100	2330	300

JP ~~(INTRAVENOUS (N/G,~~ Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
09	red	15 cc	15
2000	red	10cc	25cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO 05 HOURS | TOTAL HOURS COVERED 24 | DATE 6 July

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0400	Red bloody fluid	7cc	7cc
	JP Removed 6 July 03 0930		

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW #[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	1445	INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
NEURO	PUPILS		unequal, (R) eye reactive		OS 2mm sluggish			
	SENSORIUM		to light sluggish. Pt		OD irregular 4mm &			
			open eyes to voice and		Reaction. Opens OU to			
			moves all ext. Will be		voices follows sound &			
			sedated & paralyzed & fentanyl		move head; MAE's purposefully			
RESPIRATORY	RESPIRATORY PATTERN		RRR, equal chest rise		Vent: FIO 50%, rate			
	BREATH SOUNDS		Clear throughout		12, PEEP 5, TV 750.			
	SECRETIONS		Ø noted @ this time.		BS CTAB & ↓↓ (L) lobes.			
					Bilat symmetrical			
					Chest expansion.			
					SaTS 100%.			
SKIN	COLOR		WNL for race		Membranes pink. Neck			
	INTEGRITY		drsg on mouth and head		& mandible & face/			
			Oil & sanguinous fluid on (R)		cheek. Press. Band wpp			
I.V. SITE	LOCATION		(R) AC, + (L) AC & LR inhaling		P IV 18g (R) AC...			
	CONDITION		(L) radial A-line		Saline lock & PIV (L) AC			
			Ø S/S of infection noted		18g infuse LR 150, Propofol			
					14mcg, fent 25mcg, (R)			
					RADIAL A line. Lines patent			
					& S/S inf. Hx action			
GASTRO	ABDOMEN		soft and nondistended		Obese, Round, Soft.			
	BOWEL SOUNDS		BS(+) in all quadrants		hypoactive BS in (4)			
					Quads. NPO maintained			
GU	URINE:		Foley to gravity draining		#16 F Foley CATH intact			
	COLOR/CLARITY		clear yellow urine		Secure to (L) thigh.			
					Cl. yellow urine (>30/hr)			
CARDIOVASCULAR	CARDIAC RHYTHM		SR & Ectopy, HR 80-90		S S & ectopy. HR			
			pulses palpable +2		80's & +100's. HTN A-			
			wrists, +1 dorsalis pedis,		Line B/P 170's/60-70's.			
			tibialis pulses dobbler. Pt		PPP +2 density & post			
			above. Edema to face		Tib doppler +2 density			

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 28 Jan 03

PATIENT'S IDE[redacted]ive: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 28 Jun03 | DX | HOSPITAL DAY

VITAL SIGNS	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line											137/64	137/65	144/71	165/75	172/74	112/65		
BP Cuff															140/63	146/63		
Temperature											98.3		98.9	98.9	X	X		
Pulse											83	81	93	85	102	86		
Respiratory Rate											14	14	27	16	16	25		
MAP											90	91	112	107	94	86		
SaO2											100	100	100	100	100	99		
O2 Source											Vent	Vent	vent	vent	SIMV	Simv		
open extubation																		

INTAKE	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR											3000 OR	125	125	125	125	125	125	3750
Propofol												5.0	5.4	7.6	7.6	8.0	8.0	41.6
Fentanyl												5.0	5.0	5.0	5.0	5.0	7.0	42
TOTALS																		3833.6

OUTPUT		HOUR / TOTAL	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	
URINE												OR 300/300	60/360	35/395	35/430	105/535	55/590	40/630	630
		sp gr																	
		S/A																	
NG		OUTPUT																	
		pH																	
		GUIAC																	
EMESIS																			
STOOL																			
DRAINS		JP										EBL 150		35				70	255
TOTALS																			

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
	159/98	116/60	124/61	116/57	93/50	100/56	114/58	
	144/79	116/56	X	119/62	X	X	X	
	X	101b	X	X	100	99	X	X
	105	94	91	93	93	87	82	86
	25	11	10	12	12	12	12	21
	121	81	84	79	69	76	78	
	100	100	100	100	100	100	100	100
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV

INTAKE	21	22	23	00	01	02	03	04	8° T
	125	125	125	125	125	125	125	125	1000
	10	15	15	15	15	15	15	15	115
	7°	7°	7°	7°	7°	7°	7°	7°	56
									1171

OUTPUT	21	22	23	00	01	02	03	04	
	45/45	30/75	30/105	30/135	30/165	26/191	30/221	26/247	247

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	1445	1513	1832
	MODE	SIMV		
	F_IO_2	50		
	TV	750		
	RATE	14		
	PEEP	5		
ABG	pH		7.443	7.461
	PCO_2		30	31
	pO_2		91	126
	HCO_3		21	22
	SAT		98	99
	BASE		-3	-2

LABORATORY	TIME	1500
	GLUCOSE	127
	Na/K	134/4.4
	Cl/CO_2	112/20
	BUN/Cr	14/0.6
	WBC/PLATELET	16.4/384
	Hct/Hgb	34.1/10.7
	CK	352

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

TURN	TIME
	1730
	180
	2100
	2330
SUCTION	2100
	0100

24 I&O TOTALS

wt Yesterday

wt Today b(6)-2

INTAKE		OUTPUT	
IV	5004.6	Urine:	577
PO	0		
TOTAL	5004.6	TOTAL	
		BALANCE	4427.6

NURSE'S SIGNATURE	INITIALS
[redacted]	AIR

NEUROLOGICAL ASSESSMENT

HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
SPONTANEOUSLY 4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
TO SPEECH 3																								
TO PAIN 2																								
NO EYE OPENING 1																								
ORIENTED 5																								
CONFUSED 4																								
VERBALIZES 3																								
VOCALIZES 2																								
NO VOCALIZATION 1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
OBEYS COMMANDS 6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
LOCALIZES PAIN 5																								
FLEXION WITHDRAWAL 4																								
ABNORMAL FLEXION 3																								
EXTENSION TO PAIN 2																								
NO MOTOR RESPONSE 1																								
NORMAL POWER	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R
MILD WEAKNESS																								
SEVERE WEAKNESS																								
ABNORMAL FLEXION																								
ABNORMAL EXTENSION																								
NO RESPONSE																								
NORMAL POWER	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R		
MILD WEAKNESS																								
SEVERE WEAKNESS																								
ABNORMAL FLEXION																								
ABNORMAL EXTENSION																								
NO RESPONSE																								
RIGHT SIZE	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
RIGHT REACTION	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
LEFT SIZE	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
LEFT REACTION	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
SCALE	● 2		● 3		● 4		● 5		● 6		● 7 mm													
CEREBRAL PERFUSION PRESSURE																								

LEG

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by sw

T Trac
S Slur
D Dys
R Rec
E Expr

R R
L L

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- I
Res

+ Inta
- Abn

VASCULAR ASSESSMENT

HOURS		05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Radial	R	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
	L	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
Pedal	R	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
	L	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
Post tibial	R	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
	L	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+

LEGE

+ + Nc
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CIV [redacted] b(6)-4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0500	INITIALS [redacted]	2 Dec	INITIALS [redacted]		INITIALS
NEURO	PUPILS			R pupil elongated due to surgery segment L pupil reactive to light			
	SENSORIUM	Alert, open eyes spontaneously to voice. Sedated c̄ propofol and fentanyl		move all extremities purposefully sedated c̄ propofol pain control c̄ fentanyl			
RESPIRATORY	RESPIRATORY PATTERN	RRR, equal chest rise		reg. + clear FT tube 26cm at nare			
	BREATH SOUNDS	ETT @ 26cm @ nare SIMV,		SIMV 40% peep 5 TV 730			
	SECRETIONS	peep 5, TV 750, FiO2 50%, RR 12. Ø secretions noted @ this time		rate 4 breaths breath on own on ventilator			
SKIN	COLOR	WNL for race		shaving to face s/p GSW			
	INTEGRITY	GSW (R) mandible/jaw. Drsg DH		to L mandible drsg c̄ hemorrhage gauze on L ear			
I.V. SITE	LOCATION	(R) radial a-line (R) AC,		L + R AC PMB Stings			
	CONDITION	(R) XC c̄ Ø s/s of infection. (L) AC - propofol, UR, fentanyl infusing (R) AC - S.L.		L radial A line c̄ positive waveform			
GASTRO	ABDOMEN	soft nondistended		soft nondistended			
	BOWEL SOUNDS	BS(+) in all quads. hypoactive		BS(+)			
GU	URINE: COLOR/CLARITY	foley to gravity draining dark yellow urine		yellow urine clear in color amounts over foley to gravity			
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ Ø ectopy noted. Edema h(D) side face. pulses +2 throughout c̄ tibialis +1		NSR c̄ ectopy noted facial edema pulses palpable & 4 extremities			

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 29 Jun 03

(When signature or initials are used, typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	125/62	119/60	123/61	104/55	146/65	140/57	139/66	138/61		131/65	106/60	112/55	112/54	123/59	137/65	143/73	122/67	
BP Cuff																		
Temperature	99°	98.7	98.4	98.1	97.9	97.9	97.4	98.7		98.8	99.2	99.6	99.1	99.7	99.6	99.2	99.7	
Pulse	89	81	81	80	82	80	80	80		90	92	90	90	92	94	91	88	
Respiratory Rate	12	25	12	12	36	12	31	25		17	24	20	20	24	19	19	17	
MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
SAT	100	100	100	100	100	100	100	100		99	98	96	98	97	96	94	95	
MAP (Aline)	87	82	85	74	100	80	95	91		89	90	77	76	84	92	103	86	
pain																		
sedation																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	125	125	125	125	125	125	125	125	900	125	125	125	125	125	125	125	129	
Propofol	15	15	15	15	15	15	15	15	120	18.9	16.2	16.2	16.2	16.2	19	13	12	
Fentanyl	7	7	7.0	7.0	7.0	7.0	7.0	7.0	56	7.0	8.0	8.0	8.0	8.0	10	10	10	
Bolus					500				500									
TOTALS																		

OUTPUT

		HOUR / TOTAL																
Foley URINE		30/30	45/75	27/102	26/128	42/170	32/202	32/234	44/278	278	42/320	46/366	65/431	38/469	52/521	70/591	70	85
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	JP		20					15	35				15					
TOTALS																		

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
		110/61	105/66	72/69				
					142/50		126/55	135/57
		99.7				99.5		
		92	88	84	90		84	93
		16	15	14	14		13	13
		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
		99	98	100	100		100	100
			82	70	95		83	98

INTAKE	21	22	23	00	01	02	03	04	8° T
	125	125	125	125	125	125	125	125	
	12	12	12						
	10	10	10	10	10	10	10	6	

OUTPUT								
	40	50	110	60	100	104		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0500	1200
	MODE	SIMV	SIMV
	F_IO_2	50	40
	TV	750	750
	RATE	12	14
	PEEP	5	5
ARTERIAL BLOOD GAS	pH		7.354
	PCO_2		40.3
	pO_2		76
	HCO_3		24
	SAT		94
	BASE		-2

LABORATORY	TIME	0500
	GLUCOSE	135
	Na/K	132/4.3
	Cl/CO_2	107/22
	BUN/Cr	12/0.5
	WBC/PLATELET	10.2/331
	Hct/Hgb	31.2/9.5
	RBC	3.7
	MCV	84.2
	lymph	21.6

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

TURN	TIME

SUCTION	TIME

24 I&O TOTALS

wt Yesterday _____ wt Today b(6)-2

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	

DATE MON 30JUN03 | DX S/P COLECTOMY J BOW | HOSPITAL DAY 3

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	124	129	117	131	135	134	126	101		122	131	118	135	128	135	138	130
BP Cuff	49	63	67	71	76	68	69	42		73	75	67	75	72	74	74	74
Temperature					98.9							98.7					
Pulse	92	89	97	85	105	92	111	99		99	101	99	98	89	85	99	100
Respiratory Rate	18	16	20	17	14	15	17	20		21	16	18	14	15	16	18	17
SAO2	98	98	99	99	96	97	94	100		100	100	96	96	99	99	98	100
Source	2LNC	2LNC	2LNC	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L

pain
sedation

TIME	24	01	02	03	04	05	06	07	8T	08	09	10	11	12	13	14	15	
UR	125	125	125	125	125	125	125	125	100	125	125	125	125	125	125	125	125	100
ABX							100		100							100		300
TOTALS	125	250	375	500	625	775			1100									1300
URINE HOUR	125	125	75	150	150	150	100	100	175	50	100	100	100	200	150	100	200
URINE TOTAL	125	250	325	475	625	775	875	975	1150		150	250	350	550	700	800	1000
URINE sp gr																	
URINE S/A																	
NG OUTPUT																300	300
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL JP									10	DL							
DRAINS																	
TOTALS									985								1350

OF DAY

	16	17	18	19	20	21	22	23	
	131	130	121/73						
Cuff	74	73	121/73	139/73					
Temp		97	98.6						
Pulse	99	100	91	90					
Resp	97%	100%	100%	98					
	2L	2L	2L	2L					
	NC	NC	NC	NC					
			20	18					

	16	17	18	19	20	21	22	23	8° T
CK	125	125	125	125					
	150/150	100/150	275/525						
NGT		200							

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S SIGNATURE

All b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 30 Jun 03
Time In: 2145
Allergies: NKDA
Pre-op V/S:
Procedures: IOD Jonesfule

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1500 ~~Colloid~~ LR
OR Output: UOP 200 EBL 50
Meds/Times:

Drains		Airway
Hemovac	1	Nasal
(NG)		Oral
JP		ETT
T-tube		Trach
(Foley)		Other
TLS		

Pre Op Meds

History

Time	2145	2155	2220	2310	2220
SaO2	99	100	100	97	98
FiO2					
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	21	16	19	13	17
T		98.8			

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2145	LR	KVO			

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11		

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREPARED BY (Signature & Title): [redacted] ILTA

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 30 JUN 03

PATIENT'S IDENTIFICATION (Print or typed or written entries [redacted] Name — last, first, middle; grade; date; hospital or medical facility)

[redacted]

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

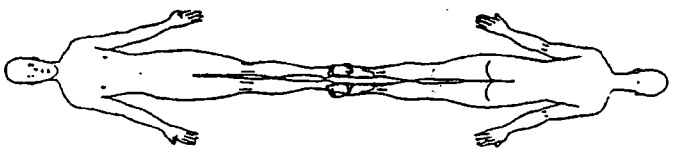
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm			x4		<3	W	NRL
15'			x4		<3	W	NRL
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS							
	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	ULE	[illegible]	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

-see backside/ daily assessment for initial nsg assmt.

2200: [illegible] NOA; [illegible] sensitive; Pt has purposeful movements, still groggy from anesthesia; [illegible] 4 RR; excessive clear secretions. Sats 98% on 2 LNC; [illegible] NSR-ST; [illegible] cg right; GI - total I/O of 300cc in LCU [illegible] for recovery.

b(6)-2 [redacted]

Transferred to ICW-2 at 2235

300cc [redacted]

b(6)-2

Discharge Criteria:
Date: Time: PARS:
BP: T: HR: RR: SaO2:
Pain Level at D/C (0-10):
Intake: _____ Output: _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 2 Jul 02
Time In: 1615
Allergies: WKDA
Pre-op V/S: 127/56 / 85
Procedures: I+D LUE

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL minimal
Meds/Times:

Versed 2mg
Fent 250mcg

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

Pre Op Meds

History

Time	1610	1625	1630	1635	1640	1645	1700	1715	1730
SaO2	99	99	99	99	99	99	99	99	
FiO2	2L	2L	2L	2L	2L	2L	2L	2L	
Methods									
240									
220									
200									
180									
160		V							
140			V	V	V		V		
120	V					V		V	
100									
80									
60									
40									
20									
RR	19	19	20	18	18	17	18	17	
T	98.3							98.1	
Time									
Pain (0-10)	2/10	-	-						
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREPARED BY: [redacted] LPN b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: x 25 July 03

[redacted] for typed entries give: Name – last, grade; date; hospital or medical facility)

EPW # [redacted] b(6)-4

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

All b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) Arm	+	+	P	B	W	PK
15'	(L) ARM	+	+	P	B	W	PK
30'	(L) Arm	+	+	P	B	W	PK
45'	(L) ARM	+	+	P	B	W	PK
60'	(L) ARM	+	+	P	B	W	PK
90'	(L) ARM						
D/C	(L) ARM	"	"	"	"	"	"

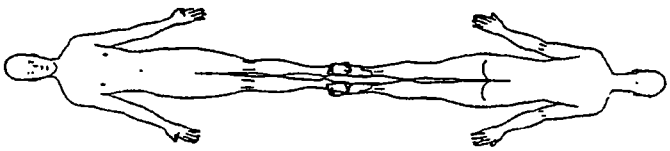
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Left Arm	Ace	Ø
30'	Left Arm	Ace	Ø
60'	Left Arm	Ace	Ø
D/C	" "	"	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

PT admitted @ 1645. USS, Alert, responsive, follows commands. Pt placed on 2L O_2 NC Sats - 98-99%. Pt c̄ Acewrap + splint to (R) forearm. Drsg C/D/I. JP Drain in place, draining red fluid. Neurochecks to extremity WNL. Pt can wiggle extremities. Extremity warm to touch. Cap refill < 2 sec. Pt c/o ~~pain~~ minimal pain.

[redacted] LPN

Discharge Criteria:
Date: 3 July 03 **Time:** 1720 **PARS:** 10
BP: 137/85 **T:** 98.9 **HR:** 62 **RR:** 18 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: JCW
Report Given To: Sgt [redacted]
Transferred Via: [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Re [redacted] SOP B-3 [redacted]
Charge Nurse S [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 15Jun03
Time In: 1130
Allergies: NKDA
Pre-op V/S:
Procedures: Abdominal closure

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

OR Intake: Crystalloid 700 Colloid
OR Output: UOP Ø EBL minimal
Meds/Times:

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

Pre Op Meds History

Time	1130	1140	1145	1200	1215	1220
SaO2	97%	98%	97%	97%	96%	
FiO2	RA	RA	RA	RA	RA	
Methods						
240						
220						
200						
180						
160						
140						
120	V		V			
		V		V	V	
100	•					
80		•	•	•		
					•	
60	^		^			
		^		^	^	
40						
20						
RR	22	14	17	12	13	
T	97				97	

Pacu Intake					
Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable; not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 15Jun03

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

[redacted]

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

All b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Dorm	+	+	P	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

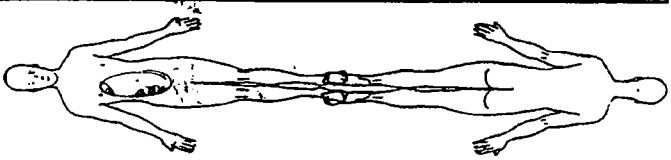
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia			N/A				
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Abdomen	gauze	small amt
30'	Abdomen	gauze	small amt serous
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
			5.1M

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt received on unit s/p abdominal closure. A+O x3 c̄ sats 96-100% on room air. lungs CTA bilaterally Abdominal dsg c̄ small amt of serous drainage noted. ⊕BS x4 quads. Will continue to monitor [redacted] PM

Discharge Criteria:
Date: 5-4-03 **Time:** [illegible] **PARS:** [illegible]
BP: 117/5[illegible] **T:** [illegible] **HR:** [illegible] **RR:** 20 **SaO2:** 96%
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: [illegible]
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [illegible]
Cleared IAW Recovery Room SOP B-3 [redacted]
Charge Nurse Signature [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 28 June 03
Time In: 1730
Allergies: NKDA
Pre-op V/S:
Procedures: Ex Lap

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1400 Colloid
OR Output: UOP EBL
Meds/Times: Ancef 1gm 1420

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1730	1733	1740	1748	1750	1800
SaO2	100	100	100	100	100	100
FiO2	10L	10L	10L	10L	10L	10L
Methods	FM	FM	FM	FM	FM	FM

240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, RR, T

Time								
Pain (0-10)	0	0	0					
LOS	Full	Full	Full					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1750	LR				
	LR				

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	7	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 28 June 03

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

EPW [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

See green Intake sheet & PK Admitted

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'	(L) h	unable to assess		+	<3sec WP	Normal	
30'	(L) hand	unable to assess		+	<3sec WP	Nor	
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

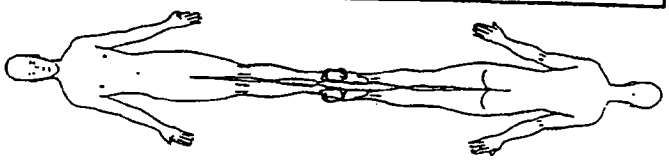
C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

N/A

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) ARM	splint Ace wrap	
30'	(L) ARM	splint Ace wrap	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1500	JP	Bloody	30
1800	Foley	Clear yellow	200

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1730	ST 100's		NO

NURSING NOTES

pt Arrived @ 1230 - VSS. O2 Applied. transported to unit bed. Assessment done see ICU Assessment sheet. nasal trumpet in place. pt very sedated at this time. does not follow instructions. will continue to monitor [redacted] CPT/AN

b(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

WAMC OP 173-E

b(6)-4

1. LAST NAME [redacted]	RANK / GRADE EPW	MALE / HOMME X FEMALE / FEMME
SS[redacted]	SPECIALTY CODE / GPM	RELIGION / RELIGION

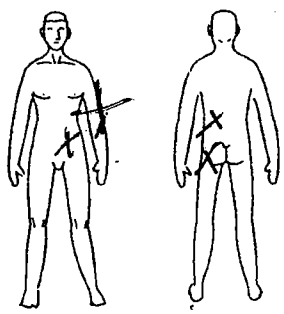
2. UNIT / UNITÉ

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

	BC / BC		NBI / BNC		DISEASE / MALADIE		PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE



	AIRWAY / TRACHÉE
	HEAD / TÊTE
X	WOUND / BLESSURE
	NECK/BACK INJURY / BLESSURE AU COU/AU DOS
	BURN / BRÛLURE
	AMPUTATION / AMPUTATION
	STRESS / TENSION
	OTHER (Specify) / AUTRE (Spécifier)

2030 HRS
Recieved 2 Tablets
Percocet PO.

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

	ALERT / ALERTE		PAIN RESPONSE / RÉPONSE À LA DOULEUR
	VERBAL RESPONSE / RÉPONSE VERBALE		UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI	TIME / HEURE

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

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

6 Jul 03
mutiple GSW, exceeds care,
also needs Surg. Eval, for
Acute Abd.
T 101.4 Rectal
BP 122/78
P102

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

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ	DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 *This form replaces previous editions of DD Form 1380 and DD Form* U.S. FI FICHE MÉDICALE DE L'

49

1. [redacted] RANK / GRADE

MALE / HOMME
FEMALE / FEMME
RELIGION / RELIGION

2. UNIT / UNITÉ 115th

FORCE / ÉLÉMENT

A/T | AF/A | N/M | MC/M | BC / BC | NBI / BNC

Shot At US Troops

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIERE

DISEASE / MALADIE

PSYCH / PSYCH

AIRWAY / TRACHÉE
HEAD / TÊTE
WOUND / BLESSURE
NECK/BACK INJURY / BLESSURE AU COU/AU DOS
BURN / BRÛLURE
AMPUTATION / AMPUTATION
STRESS / TENSION
OTHER (Specify) / AUTRE (Spécifier)

GSW (R) Forearm (L) Arm (R) Leg

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

ALERT / ALERTE
VERBAL RESPONSE / RÉPONSE VERBALE
PAIN RESPONSE / RÉPONSE À LA DOULEUR
UNRESPONSIVE / SANS RÉPONSE

5. PULSE/POULS 127 TIME / HEURE 0459

6. TOURNIQUET / GARROT NO / NON YES / OUI TIME / HEURE

7. MORPHINE / MORPHINE NO / NON YES / OUI DOSE / DOSE TIME / HEURE

8. IV / IV TIME / HEURE

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

Pulse/72 99 Pulse Impact Radial Ulnar
Field dressings tourniquets
0.9% Saline
Morphine 10mg/ml 10ml

10. DISPOSITION / DISPOSITION

RETURNED TO DUTY / RETOUR À L'UNITÉ
EVACUATED / EVACUÉ
DECEASED / DÉCÉDÉ

11. PROVIDER / OFFICER / DOCTEUR / OFFICIER

TIME / HEURE

DATE/DATE

DD Form 1380 DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

J 10

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.	4. DATE OF BIRTH
08-25 28 June 03	0432878	
3. NAME [redacted]		
5. RANK [redacted]	8. CAPTURING UNIT [redacted]	
7. UNIT OF EPW 62-2 [redacted]		
9. LOCATION OF CAPTURE (Grid coordinates) MB 359-380 3959 7755		12. WEAPONS, EQUIPMENT, DOCUMENTS 2x AK47 9mm
10. CIRCUMSTANCES OF CAPTURE Wapiro	11. PHYSICAL CONDITION OF EPW Shot in Arm	

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

6(b)-4

ADMISSIO 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.)
A 1 1 D 1	I 2

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	EPW# [redacted] b(6)-4	EPW	M

b6-4

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 1 3	0 2 3	2	2	UNK

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

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	ICU1	UNK
NAME A [redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
6 0		0 3 0 7 2 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		0 3 0 6 2 8

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

FOR LOCAL USE

DR. S/P Colectomy / IED (2) FA

T: 1 Jw: 81290 PR: 5421 4610
Inj: 450 [illegible] [illegible]
E910
E9912

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

OF ADMITTING CLERK: b(6)-2

DA FO

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NUMBER: 0013676

2 NAME (Last, First, MI): EPW # [redacted] b(6)-4

3 GRADE:

ADMISSION REMARKS

4 SEX: M

5 AGE: 33Y

6 RACE: Iraqi

7 RELIGION: b(6)-4

8 [illegible] SVC:

9 ETS:

10 PREVIOUS ADMISSION: NO

11 FMP: 99 20

12 SSN: [redacted]

13 ORGANIZATION:

14 WARD: ICU3

15 FLYING STATUS:

16 [illegible] DSG:

17 DEPT BUN: K78

18 BRANCH/CORPS:

19. UIC/ZIP:

20 TYPE CASE: VSI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22 HOURS OF ADMISSION: 1455

23. CLINIC SERVICE: Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

25. TYPE DISPOSITION: Pt to CIV Facility

26. DATE OF DISPOSITION: 2003 June 29

22a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

26b. TELEPHONE NO:

28 DATE OF THIS ADMISSION: 2003 June 28

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

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

30 DATE OF INITIAL ADMISSION:

31 UNITS WITH COMPONENT TRANSFERRED:

Check if Continued on Reverse

33 CAUSE OF INJURY:

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Dx → 2° Burns ≈ 14% of Body

943.25
943.29
945.29
948.10
E923.8

86.22

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

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

SIGNATURE: [redacted] SIGNATURE OF PAID MEDICAL RECORDS SERVICE: [redacted] SPC

DA FOR [redacted] EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.00

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

33yo male admitted 2wks 2° mechanical explosion

transferred to [redacted] for further treatment

b(2)-2

patient

Pulse	BP	Resp	Weight
?	?	?	

PHYSICAL EXAMINATION

BG/GR - 104 - 18 - 99.?

Neurologically

Alert - ⓐ CN ⓐ minor facial fractures bilat

Cerebellar CFT BL — Cover Ext - minor fractures, gross

CN Rad — Move all Ext full strength but below knees B/L

Babinski not — Babinski present once

Ext B/L upper arms chest tubes minor fractures bilat

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

Cont: 20L TBSA minor fractures & 4-5L full thick burns

Pain: Demerol ē IVP

Jolly

Dressings - Dressings

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

b(6)-4

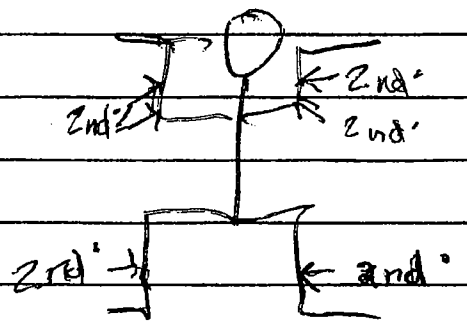
ABBREVIATED MEDICAL RECORD
Standard Form 539

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 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03	30 to 40 y/o male c 2nd° Burns to elbows and forarms and to both calves.
1218	1222 IV changed to NS 1000cc 14Ga.
BP: 113/88	Burn dressings changed out on lower legs and arms
P: 112	
SPO: 94	
A: WRNA	Tylenol given at 14:06 hrs 975 mg. PO.
Meds: Motrin 975 mg	



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

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

[redacted] b(6)-4

[redacted]

b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28JUN03	~35-40 y/o Iraqi, was in bunker c̄ ammunition. Cigarette triggered explosion. Awake, alert, Ø signs of smoke inhalation.

(L) (R)

BURNS, 2°
< 5%

(A)/(P) Press wounds
LR @ 150ml/0
Evac to [redacted] b(2)-2
Security
[redacted] b(6)-2
[redacted] MAJ, MC, USA

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

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

[redacted]

b(6)-4

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATM[redacted] b(2)-2

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME			
DAY	MONTH	YR.				
28	June	03	1455	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) Bird	None	☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

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): BURNS

SEX: 33 AGE: M

POSSIBLE THIRD PARTY PAYER? ☒ YES ☐ NO

VITAL SIGNS			
TIME	1654	1710	
BP	105/60	110/70	
PULSE	105	104	
RESP.	18	18	
TEMP.	99.7		
WT. (Child)	80 kg		

CATEGORY (See reverse)

- EMERGENT
- URGENT
- ☒ NON-URGENT b6-2

ORDERS	INITS.	TIME
~~Chem 10~~ CBC	[redacted]	1700
Methanol		1700
Sulfamethoxazole		1700
Td. Tox Pn		1700
~~[illegible]~~		~~1750~~
4 mg MSO4 IV		1750

ASSESSMENT/DIAGNO[redacted]

1406 burns

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)

33 y/o ♂ c/o Burns to the feet, arms, face etc. Bilateral 3rd° burns to ~~[illegible]~~ Back of calf, Back of upper arm and (R) side of manubrium.

Shelf: Flash burns to arms/legs Thus on a ≥ 1000 Hrs.
(-) SOB/cough/Fever unknown ~~x~~ (L) ear.

O: A&Ox[illegible] in no distress. VSS
Heart: S1/S2 clear/rit ausp (-) neck: supple w/o
(L) ear (+) 2° burns
Lungs: CTA (B)
CV: NSR no S/G
Abd: soft NT
Skin (+) 2° burns back of legs/arms (B) (10%) ear, feet 4% = 14%

A/P (1) 2° burns 14% stable
→ Burn unit

b(6)-2

(CONTINUE ON SF 507, IF NEEDED)

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: IRU3

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

TIME SEEN BY PROVIDER

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

[redacted]

b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medi[redacted]ns and follow-up plans)

[redacted]

b(6)-2

b(6)-2

EMERGENCY CARE AND TREATMENT

MEDCOM - 12409 [illegible]py

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 Jun 03		2300	PT Transfered to ICU#3 from EMT @ 1800
			via litter. Dx 2° burns to 14% BSA. All
			burned areas were cleaned and dressed.
			Foley catheter inserted @ 2200hrs.
			PT vital signs stable, SaO_2 98 % on b(6)-2
		b(6)-2	room air [redacted] SPC
	0230	[redacted]	PT sleeping comfortably in bed. Ø c/o pain
			or discomfort. will continue to monitor [redacted]
29 Jun 03	0627		Nursing: See ICU Flow Sheet for nursing assessment
			Pt prepared for Evac to Baghdad Hospital.
			All dressings reinforced. Pt given 3mg MSO4 IV
			for % pain. IV Heplocked. [redacted]
			b(6)-2

STANDARD FORM 510 (REV. 7-91) BACK

rd/Section | Emt | E | TING PHYSICIAN: | CHEMISTRY RESULT FORM
Subject to the Privacy Act of 1974

ST FIRST MI	DATE	TIME	SSN/PSEUDO SSN
[redacted] b(6)-4	[redacted]	1655	

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
CO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
Eecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0.7-1.5 mg/dl
ct		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-I		
Drug of abuse		

(P[redacted])

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

Void

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	100	
BUN	7	
CA++	~~0.8~~	
CRE		
NA+		
K+		
CL-		
tCO_2		

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	677	39-380 u/l (M) 30-190 u/l (F)
NA+	139	128-145 mmol/l
K+	4.3	3.3-4.7 mmol/l
CL-	108	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	28 Jun03	

b(6)-4

Ward/Section: FMT	E ING PHYSICIAN:	AT TORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted]	DATE: 28 June	TIME: 1655	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	19.6	4.8-10.8 x 10^3
RBC	5.94	4.7-6.1 x 10^9
Hgb	16.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	53.6	42-52% (M) 37-47% (F)
MCV	90.3	80-94 fl (M) 81-99 fl (F)
Plt	354	130-500 x 10^3 verified
Lymph %	15.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 28 Jun 03	LAB ID NO.:

b(6)-2

Ward Section: TCU 3

PHYSICIAN: [redacted] b(6)-2

CH... RESULT FORM
(Subject to the Privacy Act of 1974)

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

DATE: 29 June 03

TIME: 0330

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	91	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	913	39-380 u/l (M) 30-190 u/l (F)
NA^+	134	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 29 Jun 03

LAB ID NO.:

ICU [redacted] b(6)-2

CIV [redacted] b(6)-4 29 June 03 0330 [redacted] b(6)-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	13.4	4.8-10.8 x 10^3
RBC	5.61	4.7-6.1 x 10^9
Hgb	15.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	50.7	42-52% (M) 37-47% (F)
MCV	90.3	80-94 fl (M) 81-99 fl (F)
Plt	291.	130-500 x 10^3 verified
Lymph %	23.6	20.5-51.1%

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

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

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

CSF		
Cell Count		
Directigen		Negative

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

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

REMARKS:

REPORTED BY: DATE: LAB ID NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				28 Jun 03	1730 HOURS	
			(1)	Admit ICU		
			(2)	Ax 2° burns 2 14%		
			(3)	Stable		
			(4)	NKDA		
			(5)	Vitals per protocol		1845
SING UNIT	ROOM NO.	BED NO.	(6)	Bedrest		[redacted] b(6)-2
			(7)	Nursing dressing Ds per burn protocol		
IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4					HOURS	
			(8)	Regular diet		
			(9)	IV bolus TL NS then 150 cc/h		
			(10)	MSO4 4mg IV upon arrival then per Surgeon on call		Done in ICU [redacted]
SING UNIT	ROOM NO.	BED NO.	(11)	~~Call Surgeon on call~~ Thanks! [redacted]	0730	b(6)-2
IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				29 JUN 03	1810 HOURS	
			(1)	MSO4 1-15 mg IV for initial dressing & debridement		
			(2)	MSO4 1-15 mg IV q 10 PRN		
			(3)	~~[illegible]~~		
			(3)	Foley cath [redacted]		b(6)-2
SING UNIT	ROOM NO.	BED NO.		CBC NS		
				U/O < 50 cc/h		
IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				U.O.	HOURS	
			(4)	CBC, Chem 7 in AM		
				b(6)-2		
SING UNIT	ROOM NO.	BED NO.		24° [redacted]	29 Jun 03 4/AN 0552	

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				28 JAN 03	0630		
				① PATIENT TO CONUS HOSP.			
				[redacted] b(6)-2			Noted b(6)-2 [redacted] 28 Jan 03 0637

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

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 JUNE 03	Surgery Transfer Note
0630	DATE OF INJURY 28 JUNE 03
	DATE OF TRANSFER 29 JUNE 03
[illegible]	DX: 20% TBSA partial thickness flame burns
[illegible]	HOSPITAL COURSE: 33 yo [illegible] sustained burns to hands, [illegible] upper arms, posterior [illegible] & posterior lower legs. [illegible] total body surface area burned 20%. Pt resuscitated c IV fluid overnight. Foley catheter placed & 20 cc/hr urine resulted & started c diuresis. No complications
NESS	
[illegible]	
[illegible]	
[illegible]	
	[redacted] b(6)-2
	[redacted] NS
	NOF NE

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

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

[redacted] b(6)-4

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

All b(6)-2 except last

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29
6/28	[redacted]	Stable	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Vitals per protocol	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Bedrest	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Nursing dressing Δ's	05	/	[redacted]
		per burn protocol (bid)	17	[redacted]	
6/28	[redacted]	Reg. diet	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Foley cath	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	call MD if uo	05	/	[redacted]
		< 50 cc/°	17	[redacted]	

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS: 2° burn ≈ 14%

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Jun Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6/28	[redacted]	Admit to ICU 3	6/28		Done 1730	[redacted]
6/29	[redacted]	CBC Chem 7 in am	6/29	0'4	0330	[redacted]

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29												
6/28	[redacted]	IVF NS @ 150 cc/hr	05	/ [redacted]	b(6)-2												
		b(6)-2	17 [redacted]	b(6)-2													

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS: 2° burn ≈ 14%

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/28	[redacted]	IV bolus ĪLNS then 150cc/°	6/28	done		[redacted]
6/28	[redacted]	MSoy 4mg IV upon arrival then	6/28	Done in ER		[redacted]
		per surgeon on call.				
~~6/28~~	~~[redacted]~~	~~MSoy 1-15mg IV q 1° pra~~				
6/28	[redacted]	MSoy 1-15mg IV for initial	6/28	done		[redacted]
		dressing + debridement				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
6/28	[redacted]	MSoy 1-10mg IV	B Jun 03												
		q 1° prn	BMaf 0622												
			[redacted]												

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
NEURO		2200	[redacted]	b(6)-2			
	PUPILS	PERL bilat					
	SENSORIUM	moves all extremities					
		x 4					
RESPIRATORY	RESPIRATORY PATTERN	regular					
	BREATH SOUNDS	clear all fields					
	SECRETIONS	Ø					
SKIN	COLOR	brown to bronze bilat					
	INTEGRITY	upper arms R hand					
		bilat calf + foot					
I.V. SITE	LOCATION	hepblock 18G L hand					
	CONDITION	18G PIV R wrist					
		patent + intact					
GASTRO	ABDOMEN	soft non tender					
	BOWEL SOUNDS	present x 4 quads					
		hyperactive x 5 diffusely					
GU	URINE:						
	COLOR/CLARITY	clear yellow urine					
		foley to gravity drg					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2					

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 28 Jan 2003

PATIENT'S IDENT[redacted]ve: Name—last, first, middle; grade, [redacted]

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE	DX	HOSPITAL DAY

VITAL SIGNS																		
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line															113			
BP Cuff															58			
Temperature																		
Pulse															112			
Respiratory Rate															20			
[illegible]																		

INTAKE																		
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IVF															150	150	150	
TOTALS																		

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

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
		120/51							
						110/62			
		81				84			
		18				16			
		98				100			
						RA			

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

OUTPUT									
		700	150/850			400/1250		350	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

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

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

24 I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV		Urine:
po		
TOTAL	1650	TOTAL 1600

BALANCE _____

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

All b(6)-2 except last

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0523	INITIALS [redacted]		INITIALS		INITIALS
	PUPILS	PERRLA				
	SENSORIUM	A+O x 3				
RESPIRATORY	RESPIRATORY PATTERN	Regular + Unlabored				
	BREATH SOUNDS	CTA				
	SECRETIONS	None				
		Airway Patent				
SKIN	COLOR	Normal for Race				
	INTEGRITY	14% TBSA burn,				
		dressings c/d/I				
IV SITE	LOCATION	ⓓ Hand + ⓔ Hand				
	CONDITION	Ø S/S of infection				
GASTRO	ABDOMEN	Soft + Nontender				
	BOWEL SOUNDS	Active Hyperactive BS				
		Ø N/V				
GU	URINE:					
	COLOR/CLARITY	Clear, Yellow				
		Foley to Gravity				
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, Ø ectopy				
		CV = S1 S2				
		strong pulses palpated				
		in all extremeties				
		Cap Refill < 3 secs				

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

(Continue on reverse)

PREPARED BY (Signature [redacted] ct/sw

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 29 Jun 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff	112/61	159/62																
	Temperature		97.4																
	Pulse	96	96																
	Respiratory Rate	12	16																
	SaO2	95	99																
	O2 Meth	RA	RA																
	pain intervention																		

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	NS	160	150																
	PO																		
	TOTALS																		

OUTPUT		HOUR / TOTAL	50	60	80														
	URINE	sp gr																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	

INTAKE	21	22	23	00	01	02	03	04	8° T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0330								
	GLUCOSE	91								
	Na/K	134/4.3								
	Cl/CO_2	106/24								
	BUN/Cr	7/1.0								
	WBC/PLATELET	13.4/281								
	Hct/Hgb	50.7/15.8								

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION
A A A D A	I Z (State or Country Code.)

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	APW # [redacted] b(6)-4	—	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—	35	Z	9	—

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1455	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 9	—

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
12 D/C to civ Acute care facility		03 06 29

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B MA Burns		03 06 28

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

FOR LOCAL USE

DX → 14 percent body burns (2°)

b(6)-2

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

DA FORM 2095, MAR 80

INPATIENT TREATMENT RECORD CO[illegible] SHEET

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

1 REGISTER NUMBER [redacted]

12 NAME (Last, First, MI) EPW # [redacted] b(6)-4

3 GRADE —

ADMISSION REMARKS

4 SEX M | 5 AGE 50Y | 6 RACE Iraqi | 7 RELIGION b(6)-4

8 LENGTH OF SVC —

9. ETS —

10 PREVIOUS ADMISSION NO

11 EMP 9/20

13 SSN [redacted]

14 WARD ICU3

15 FURLOUGH STATUS —

16 RATING USG —

17 DEPT RLN K78

18 BRANCH/CORPS

19 UIC/ZIP —

20 TYPE CASE VSI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER

22. HOURS OF ADMISSION 1700

23. CLINIC SERVICE Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —

25 TYPE DISPOSITION TRNFR to CIV FACILITY

26. DATE OF DISPOSITION 2003 June 29

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —

27b TELEPHONE NO —

28 DATE OF THIS ADMISSION 2003 June 28

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY b(2)-2 [redacted]

30 DATE OF INITIAL ADMISSION

ADMITTING OFFICER b(6)-2 [redacted]

32 COMPONENT TRANSFERRED

Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Dx → 13 percent 2° Burns to Body

946.2
948.10
E993

86.28

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

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
[redacted]		[redacted]			

37a. [redacted] 37b. [redacted] 37c. SIGNATURE OF [redacted] for [redacted] SPC

DA FO[redacted] EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

b(6)-2

INPATIENT TREATMENT RECORD CO[illegible] SHEET

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

1 REGISTER NUMBER [redacted]	2 NAME (Last, First, MI) EPW # [redacted] b(6)-4			3 GRADE —	ADMISSION REMARKS
M 50Y Iraqi	7 RELIGION — b(6)-4	8 LENGTH OF SVC —	9 ETS —	10 PREVIOUS ADMISSION NO	
11 FMP 9920	12 SSN [redacted]	13 ORGANIZATION —		14 WARD ICU3	
15 DUTY STATUS —	16 RATING DSG —	17 DEPT BEN K78	18 ORGANIZATIONS —	19 DIC/ZIP —	20 TYPE CASE VSI
21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22 HOURS OF ADMISSION 1700	23 CLINIC SERVICE Burns	
24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25 TYPE DISPOSITION TRNFR to CIV FACILITY	26 DATE OF DISPOSITION 2003 June 29	
24a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b TELEPHONE NO —	28 DATE OF THIS ADMISSION 2003 June 28	ADMITTING OFFICER b(6)-2 [redacted]
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY b(2)-2 [redacted]				30 DATE OF INITIAL ADMISSION	32 COMPONENT TRANSFERRED

Check if Continued on Reverse

33 CAUSE OF DEATH

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Dx → 13 percent 2° Burns to Body

946.2
948.10
E993

86.28

35. Total Days This Facility

a. AIRENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities

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

[redacted] for [redacted] SPC

DA FOR [redacted] EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.00

b(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible] 50yo image was injured [illegible] 2° to ammunition explosion in [illegible]. Burns to B/C [illegible] LE / feet, arms & shoulders posteriorly / upper back

Power [illegible] ASH [illegible] Resp [illegible]

posterior

[redacted] b(6)-2

PHYSICAL EXAMINATION

HR/BP - 110 - 24 upon presentation now 114/68 - 88 - 20 - 98

84 kg / [illegible] wt, [illegible] & [illegible] [illegible]

CERT CPT BL — Ext - upper arms & forearms partial thickness

CCR RR — lower Ext & buttocks / ankles partial thickness

NSL Foley wt

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

INP / pain: Bilateral thickness burns - B/C

- Resp - IVF resuscitation
- [illegible] & deep cleanse
- pain control.

[redacted] b(6)-2

SIGN[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	[illegible]		

PAT[redacted] *(Typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible] 40 yo male [illegible] pain radiates down to back, posterior [illegible] & upper [illegible] 2° to OXO encountered while [illegible]

Presented hemodynamically stable

Pulse ±
Resp ±
Resus ±
Neuro

PHYSICAL EXAMINATION

[illegible] BP 145/80 HR 105 [illegible] 100% on EA [illegible]
Heart regular [illegible]
Lungs clear bilat bilateral
Neck: [illegible] pain posteriorly - superficial bruise to neck [illegible]
Back: [illegible] tenderness bruises - extreme [illegible] to palpation
Extremities [illegible] tenderness, LE ↓ strength (R) deep [illegible] [illegible] bruising [illegible] one thigh
Chest clear bilat
Neuro [illegible] (L) [illegible] left

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

Dx: 30-35% [illegible] thickness - [illegible] full thickness (3rd)
[illegible] burst [illegible] OXO

Plan: [illegible]
[illegible] care
[illegible] Debridement

[redacted] b(6)-2

SIG[redacted]AN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted] MS	28 Mar 03		

PA[redacted]CATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
[redacted] b(6)-4		

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AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03	ER Note
14:40	Iraqi male sustained burn ⊽ explosion in ammunition bunker
	Ø PMH & C/o pain at burn sites
PE:	BP 141/61 p-110 r-24 sat 95%
	HEENT - large blister c̄ fluid on top of head
	Lungs - clear
	CVR - Reg
	Abd - soft
	Ext - ~15% 2° burns bilat shoulder area + post. upper arms, bilat ankles + bottom of feet
A/P	15% TBSA 2° burns
	- wounds cleansed c̄ NS & debrided
	- Silvadene + bandages applied
	- MS 6mg IV given for pain
	[redacted] b(6)-2
	PT MC

Back

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

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

[redacted] b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28Jan03	ARRIVES 1437 IV R HAND
	BURNS FROM BLAST IN BUNKER
1439	BP: 141/61 P: 110 R: 24 SPO2 95%
	2° BURNS ON TO TOP OF HEAD AND BACK, BOTH FEET
1442	IV (L) HAND
1444	BURNS DÉBRIDED
	15% 2° BURNS
1450	6 mg MS JP
1450	SILVADINE APPLIED TO BURNS
1455	P: 109 BP: R: 20 SPO2 95%

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.

[redacted] b(6)-4

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)*
29 JUNE 03	Transfer summary - Surgery
0640	DATE OF ADMISSION: 28 JUNE 03
	DATE OF TRANSFER: 29 JUNE 03
PMH:	DX: 1st Tibial Plateau fracture
Pt	Approx 50 yo ♂ presenting post MVA from
HPI:	immediate explosion to top of head posterior
Multiple	laceration & bilat leg. Pt has bony
MSK	fractures of R lateral tibial plateau
	Pt's certain place & motor deficits at
	neurologically intact. Pt's wounds dressed
	& splinted prior to evacuation.
	Transfer for ortho consult.
	[redacted] b(6)-2
	NAME

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

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

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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ICU3

558-103 (See Instructions on Back ... is Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): [redacted] b(2)-2

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSP[redacted] (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE		☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.		☒ OTHER (Specify) Medivac	∅	ALLERGIES
28	June	03	1657			NKDA

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): Sp 02 BURNS back, hands, feet, calves

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1655

VITAL SIGNS			
TIME	1657		
BP	114/68		
PULSE	88		
RESP.	20		
TEMP.	98.8		
WT. (Child)	84 kg		

96

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
.5 Tetanus	[redacted]	1713
involved wounds		
~~Other~~		

b(6)-2

ASSESSMENT/DIAGNOSIS: 2° burns

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)

M.d 40s ♂ s/p flash powder burns this am ≈ 1000 hrs this am. denies F/C/SOB/CP/eye involvement.

Seen by American provider

Pending

OS A&O x4 on arrival

Head no l/w clear/mt unremarkable neck supple no

eyes clear

Chest CTA(B)

CV: rr no m/r/g

Abd soft NT

S/S 2° to the U/E(B) gait NL

Skin: (P)(B) shoulder 2° burns 5%
top of head 2° burn – 1%
(B) lower extremity/feet – 5%
(B) hands – 2%
} 12%

A/P 13% burns 2°

→ Admit

b(6)-2

(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).

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medi[redacted]tations and follow-up plans)

[redacted] b(6)-4 →

All b(6)-2

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 June 03		2143	PT admitted to ICU 3 @ 1800hrs Dx 2° burns 15% BSA. — SPC [redacted]
28 June 03		2300	Dressing change done to burns. Tolerated procedure & difficulty. Care continued as ordered — [redacted]
29 June 03	0530	~~0530~~	pt VSS. pt report received from Spc [redacted] No problems @ present will continue to monitor — [redacted]
	0655		pt transferred to Baghdad see Dr's progress notes for details — [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

1C43 [redacted] b(6)-4 [redacted] b(6)-2 29 Jun 0330 [redacted] b(6)-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	10.2	4.8-10.8 x 10^3
RBC	5.99	4.7-6.1 x 10^6
Hgb	17.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	55.0	42-52% (M) 37-47% (F)
MCV	91.7	80-98 fl (M) 81-99 fl (F)
Plt	245.	130-500 x 10^3 verified
Lymph %	14.9	20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Atypical		Baso	
Blasts		Imm	
Other Atypical			
Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

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

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank
MUST SUBMIT SF 518 WI EVERY UNIT REQUESTE
ABO/Rh

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

REMARKS:

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

b(6)-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: Dr [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b(6)-4	DATE 29 June 03 / TIME 0330	SSN/PSEUDO SSN: [redacted] b(6)-4

ECBT

(i-STAT)

TEST	RESULT	REF. RANGE
Na	129	138-146 mmol/L
K	>9.0	3.5-4.9 mmol/L
Cl	114	98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN	26	8-26 mg/dl
GLU	98	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	51	38-51% PCV
Hgb	17	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				28 Jan 03	1900 HOURS	
			(1)	Admit ICU 3		
			(2)	Dx 13°C 2° burns		
			(3)	Stable		
			(4)	NPO		
			(5)	Vitals per protocol		
SING UNIT	ROOM NO.	BED NO.	(6)	Bedrest		1820 [redacted] b(6)-2
			(7)	Dressing BS per protocol		
IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4					HOURS	
			(8)	IV bolus T LNS then 150 cc/h		
			(9)	MSO4 4mg IV upon arrival		
				Thanks [redacted]		
SING UNIT	ROOM NO.	BED NO.				b(6)-2
IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				28 DEC 03	1825 HOURS	
			(1)	MSO4 2-10mg IV q1° PRN		
				[illegible]		
			(2)	Foley [illegible] - [illegible] q < 50 cc/h		185° [redacted] b(6)-2
			(3)	CBC, [illegible]		
SING UNIT	ROOM NO.	BED NO.		[redacted] MD b(6)-2		
IENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				29 DEC 03	0645 HOURS	
			(1)	NC to [illegible]		
				[redacted]		
SING UNIT	ROOM NO.	BED NO.		b(6)-2		