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 28	29												
6/28	[redacted]	Stable	05	✓	[redacted]												
			17	[redacted]													
6/28	[redacted]	Vitals per protocol	05	✓													
			17	[redacted]		(b)(6)-2											
6/28	[redacted]	Bedrest	05	✓													
			17	[redacted]													
6/28	[redacted]	Dressing Δ's per	05	✓													
		protocol (bid)	17	[redacted]													
6/28	[redacted]	Foley cath	05	✓													
			17	[redacted]													
6/28	[redacted]	call MD if uo	05	✓													
		<50cc/°	17	[redacted]													

ALLERGIES: ☐ YES ☑ NO

NKA

PRIMARY DIAGNOSIS: 13% 2° burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6/28 [redacted]	[redacted]	Admit to ICU-3	6/28		1800	[redacted] (b)(6)-2
6/28	[redacted]	CBC, Chem 7 in am	6/29			

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.* ____ *Yr.* ____

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]	NS @ 150cc/°	05	/ [redacted]		(b)(6)-2											
			17	[redacted]		(b)(6)-2											

ALLERGIES: ☐ YES ☑ NO

NKA

PRIMARY DIAGNOSIS: Dx: 13% 2° burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ 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 ĪL NS then 150cc/o	6/28		[redacted]	
6/28	[redacted]	Morphine 4 mg IV upon arrival	6/28		[redacted]	

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
6/28	[redacted]	Morphine 2-10mg IV														
		q 1° prn wound														
		care & pain control														

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 (b)(6)(2)

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]		INITIALS	2100	INITIALS [redacted]
NEURO	PUPILS	29 June 03	PERRLA					
	SENSORIUM		A&O x3					
			purposeful movements x4					
			Follows commands					
RESPIRATORY	RESPIRATORY PATTERN		RR - 18 Spo2 - 97%					
	BREATH SOUNDS		on RA					
	SECRETIONS		Lungs Sounds CTA (B)					
SKIN	COLOR		Normal For Race					
	INTEGRITY		15% BSA Burns				15% BSA Burns	
I.V. SITE	LOCATION		18g to (L) wrist					
	CONDITION		infusing NS @ 150cc/hr					
			& NO S/S of infection					
			or infiltration					
GASTRO	ABDOMEN		Soft flat non distended					
	BOWEL SOUNDS		non tender					
			Normoactive bowel					
			Sounds x4					
GU	URINE:		Clear/yellow QS					
	COLOR/CLARITY		urine voiding via				Clear/yellow	
			Foley					
CARDIOVASCULAR	CARDIAC RHYTHM		HR - 80 BP - 130/80					
			NSR					
			Cap Refill ≤5 x4					
			Peripheral pulses x4					

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)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 29 June 2003

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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		139/50																
Temperature		100.7																
Pulse		80																
Respiratory Rate		18																
SPO2		91%																
~~RA~~ Method		RA																
open																		
intubation																		

INTAKE																		
TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																200	
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

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) OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2300	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERL					
	SENSORIUM	moving all extremities					
		[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	reg					
	BREATH SOUNDS	clear w/ crackles					
	SECRETIONS	⊘					
SKIN	COLOR	Burn to anterior left back					
	INTEGRITY	back, left lower leg + foot					
IV SITE	LOCATION	16G in L arm					
	CONDITION	patent + intact					
GASTRO	ABDOMEN	soft non tender					
	BOWEL SOUNDS	present x 4 quads					
		no bowel sounds					
GU	URINE: COLOR/CLARITY	clear yellow urine					
		foley cath to gravity drain					
CARDIOVASCULAR	CARDIAC RHYTHM	S/S regular					
		NSR					

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

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
28 Jun 2005

PATIENT'S IDENTIFICATION (For typed or [redacted]ast, 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																155		
	BP Cuff																64		
	Temperature																		
	Pulse																82		
	Respiratory Rate																17		
	O2 Sat																97		
	pain intervention																		

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	
	TOTALS																		

OUTPUT		HOUR / TOTAL																	
	URINE	sp gr																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

VITAL SIGNS	24	22	23	00	01	02	03	04	
		111/58			120/51			121/41	
					98.9			99°	
		65			73			80	
		12			21			15	
		100			98			98	

INTAKE	24	22	23	00	01	02	03	04	8° T
	150	150	150	150	150	150	150	150	

	100	120	100	110	90	100	150	170

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
ARTERIAL GAS	A: pH								
	A: PCO_2								
	A: pO_2								
	B: HCO_3								
	B: SAT								
	G: BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME								
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN	TIME							
SUCTION								

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

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. MOBILIZATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6: [redacted]	7 8: I Z	9 10 11 12 13 14 15: [redacted]	EPW # [redacted] (b)(6)-4	16 17:	18: M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26:	27 28 29: 5 0 4	30: Z	31: 9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34:		35 36: 9 9	37 38 39 40 41 42 43 44 45: [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46: U	1657	(b)(6)-2

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49:	50 51 52: K 7 9	53 54 55 56 57 58 59 60 61:

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63:	64 65 66 67 68 69 70:	71: 9	YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: 2 6 TRNSFR to CIV Acute Care Facility	75 76 77 78 79 80:	81 82 83 84 85 86: 0 3 0 6 2 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A B M A Burns	91 92 93 94 95 96:	97 98 99 100 101 102: 0 3 0 6 2 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104:	105 106 107 108 109 110:	111 112 113 114 115 116:

FOR LOCAL USE

DX-713 percent 2° Burns to Body [redacted]

Dx 94120
94325
94522
94810
Trauma 9
Inj 759

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
	[redacted] SPC

DA FORM 2085, MAR 80 — EDITION OF MAY 79 IS OBSOLETE

(b)(6)-2

b(a)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

[redacted] NAME (Last, First, MI) EPW # [redacted] (b)(6)-4 | 3 GRADE | ADMISSION REMARKS

M | IRAQI (b)(6)-4 | 9 CTS | 10 PREVIOUS ADMISSION NO

99 [redacted] | 13 ORGANIZATION | 14 WARD JE43

15 MILITARY STATUS | 16 DSG | 17 BEN K79 | 18 BRANCH CORPS | 19 ORG ZIP | 20 TYPE CASE VSI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER | 22 HOURS OF ADMISSION 1900 | 23 CLINIC SERVICE Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE | 25 TYPE DISPOSITION D/C to CW Care 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 | ADMITTING ORDER (b)(6)-2 [redacted]

29 NAME AND LOCATION OF ATTENDING PHYSICIAN [redacted] (b)(2)-2 | 30 DATE OF INITIAL ADMISSION | 32 UNITS OF WHOLE BLOOD, COMPONENT TRANSFUSED

Check if Continued on Reverse

33 FACTS OF INJURY

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

DX → 23% Burns to body ; 2°

35. Total Days This Facility

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

DA FOR [redacted] (b)(6)-2 EDITION OF 1 AUG 78 IS OBSOLETE DSAPPC V1.00

AUTHORIZED FOR LOCAL RI

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
28 Jun03 1918 (b)(6)-2	Nursing: Pt admitted to ICU 3 for burn to back, legs, upper arms + hands, back of neck, and tip of ears. Pt [redacted] 1922 ~~debrid~~ Debridement of burns completed per protocol. Posterior portion of legs white surrounded by pink/red tissues. Blisters noted on toes and legs. No pain felt while [redacted] 1927 ~~debrid~~ debreeding back of (R) leg (white area). Pt felt some pain during debridement of white tissue on ~~to~~ [redacted] 1930 (L) back of (L) leg. Silvadene cream applied. Blisters noted on posterior portion (B) upper extremeties from shoulder to elbow. Blisters also noted on ~~both~~ [redacted] 1933 ~~hand~~ on anterior portion of hands + fingers. Debridement completed, skin pink/red on arms + hands. Silvadene cream applied. Pink skin noted from neck to superior portion of buttocks. Minimal burn noted to neck. Silvadene cream applied and burn pad turned into vest to cover back. External meatus of (B) ears debreeded. Sulfamylon cream applied. Pt received 20 mg total Morphine during [redacted] 1940 ~~debreedement~~ debridement. Respirations regular + unlabored. Airway patent. VSS. SaO_2 95% on RA. Pt voided 200 cc clear urine per urinal. (Cont'd)

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NI (SSN [redacted]

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT (b)(6)-2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Jun03 1918	Nursing Cont'd: Strong pulses palpated in all extremeties. Cap refill <3 secs. Pt resting quietly in [redacted] Resort given to Maj [redacted] (b)(6) 12 CH/AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 JUN 03	Surgery Transfer Summary
0635	DATE OF BIRTH: 28 JUNE 03
	DATE OF TRANSFER: 29 JUNE 03
[illegible]	HOSPITAL COURSE & HPI: 30 [illegible] GA [illegible] THERAPY BORN
1511 [illegible]	[illegible] TO FATHER, MOTHER 46 yo G [illegible] PRENATAL TO
[illegible]	POSTERIOR [illegible], EARS, [illegible], [illegible]
[illegible]	& BIL [illegible] SEPARATION. [illegible] GA [illegible]
[illegible]	[illegible] BORN [illegible] TO [illegible] OR [illegible]
[illegible]	THERAPY GOALS. AT [illegible] OVERNIGHT
[illegible]	[illegible] / FEED [illegible], [illegible]
	[illegible] TO [illegible]. [illegible] TO [illegible]
	& [illegible] TO [illegible] [illegible]
	[illegible] (b)(6)-2
	[illegible]
	[illegible]
	[illegible]

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)

TREATMENT FACILITY (Stamp) [redacted] (b)(2)-2

LOG NUMBER

ARRIVAL — DATE: DAY 28 MONTH Jun YR. 03 TIME 1700

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

CURRENT MEDS. (tetanus immunization and other data): Seasonal allergy shots

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): Burns

SEX: M AGE: 31

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1700		
BP	136/64		
PULSE	99		
RESP.	14		
TEMP.			
WT. (Child)	85 kg		

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

ORDERS	INITS.	TIME
IV bolus, IC NS	[illegible]	1700
CBC / Lytes / BKG	[illegible]	
Td, 5 cc IM	[illegible]	1705

ASSESSMENT/DIAGNOSIS: 23% burns to body

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: ICU3

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)

Pt of 5yo burns for flash powder burns while getting wood @ 2 1200 today. Seen by

PMH: seasonal allergy

Dx: Acute pt in mod distress, VS as above

HEENT: OP/UR clear/pat mucosa, neck supple, eyes clear

Chest: CTA(b) tubes full bilaterally

CVS: nrm S1/S2

Abd: obese, soft, NT

Ext: great NC, 5/5 strength x4 (b)

Skin: (a) 2° burns entire back - 19%
(b) post arms 2° burns - 4% (b) hands circumferential 2° = 23%
(b) post calf burns 4%

A/P: Stable 23% burns to body/ext
→ Admit burn unit

(CONTINUE ON SF 507, IF NEEDED) [redacted]

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 [redacted] (b)(6)-2

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 June 03		2300	PT transfered to ICU #3 from EMT via litter. @1815
			Dx - 1° & 2° burns to 23% BSA. All burned areas
			cleaned and dressings applied. Foley cath
			placed 2215 hrs. PT vital signs stable, SaO2
			100% on RA — [redacted] (b)(6)-2 SPC 9/WMC
	0245		pt sleeping at this time. Adequate urine
			output. VSS. No s/s of pain or discomfort at
			this time. Will continue to monitor [redacted] (b)(6)
	0515		Report given to SPC [redacted] (b)(6)
	0520		Received report and care of pt. from previous shift
			pt. in bed resting awake & alert all vss well
			Cont to monitor. — [redacted] (b)(6)-2

STANDARD FORM 510 (REV. 7-91) BACK

rd/Section EMT [redacted] (b)(6)-2 **CHEMISTRY RESULT FORM**

(Subject to the Privacy Act of 1974)

ST FIRST MI [redacted] (b)(6)-4 [redacted] DATE 28 Jun 03 TIME 1710 SS [redacted]

(b)(6)-4

(i-S[redacted])		
EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
'O2		35-45 mmHg (art) 41-51 mmHg (ven)
)2		80-105 mmHg (art) N/A (ven)
'O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
'CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
)2		95-98%
Hect		(-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		
)rug of abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.9	3.5-5.5 g/dl
ALP	37	26-84 u/l
ALT	22	10-47 u/l
AMY	19	14-97 u/l
AST	29	11-38 u/l
TBIL	0.6	0.2-1.6 mg/dl
BUN	5	7-22 mg/dl
CA++	5.1	8.0-10.3mg/dl
CHOL	118	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	125	73-118 mg/dl
TP	3.8	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		
BUN		
CA		
CRE		
NA		
K		
CL		
tCO_2		

(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+	152	128-145 mmol/l
K+	2.7	3.3-4.7 mmol/l
CL-	114	98-108 mmol/l
tCO_2	17	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 | DATE: 28 Jun 03 | LAB ID NO.:

(b)(6)-2

Ward Section: ZMT	[redacted]	LA[illegible]TORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRS[redacted] (b)(6)-4	[redacted]	TIME 03 17[illegible] [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	24.4	4.8-10.8 x 10^3
RBC	5.91	4.7-6.1 x 10^6
Hgb	16.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	54.5	42-52% (M) 37-47% (F)
MCV	92.3	80-94 fl (M) 81-99 fl (F)
Plt	402	130-500 x 10^3 verified
Lymph %	10.6	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	Yell	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.010	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. 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 [redacted]	DATE: 28 Jun 03	LAB ID NO.:

(b)(6)-2

Seg-69 35.4

Band-20

Lymph-5

A Lymph-5

mono-1

lt Toxic granules

Normocytic/normochrom

Platelet increased

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 1700 HOURS	
			①	Adult ICU 3	
			②	Dx 3° burns	
			③	Confirm stable	
			④	NKDA	
			⑤	Vitals per protocol	
SING UNIT	ROOM NO.	BED NO.	⑥	Bed rest	
			⑦	Dressing Δs per burns	1755 Kpu
IENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
				HOURS	
			⑧	Regular diet	
			⑨	IV bolus T L NS then 150%	
			⑩	MSO4 4mg upon arrival to ICU then per surgery on call	
			⑪	Call Surgeon on call for [redacted]	
SING UNIT	ROOM NO.	BED NO.		Thank [redacted]	(b)(6)-2
IENT IDENTIFICATION				DATE OF ORDER	
				28 JUN 03 1805 HOURS	
			①	APPLY T WITH BURNS INCREASE IVF TO 200 cc/h x 8h THEN ↓ TO 150cc/h	
			②	MSO4 2-10mg IV q 1h PRN CHANGE Δs & PRN COMFORT	
SING UNIT	ROOM NO.	BED NO.	③	INCREASE TO ONE CONTACT X FLUORESCEIN TO EYES	
IENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
			④	MSO4 10mg IV x1 DOSE DURING FIRST DRESSING Δ	
				HOURS	
				Thank you [redacted]	(b)(6)-2
			⑤	FOLEY CATHETER	
			⑥	CBC NO FOR UO < 50cc/h [redacted]	(b)(6)-2
SING UNIT	ROOM NO.	BED NO.	⑦	CBC/CMP 7 in AM	

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 28	29											
28 Jun	[redacted]	Condition stable	05	[redacted]												
			17	[redacted]												
28 Jun	[redacted]	Vitals per protocol	05	[redacted]												
			17	[redacted]												
28 Jun	[redacted]	Bedrest	05	[redacted]												
			17	[redacted]												
28 Jun	[redacted]	Dressing Δ's per burn (bid)	05	[redacted]		(b)(6)-2										
			17	[redacted]												
28 Jun	[redacted]	Reg. diet	05	[redacted]												
			17	[redacted]												
28 Jun	[redacted]	Silvadene to all wounds	05	[redacted]												
		℞ sulfamycin to eacs	17	[redacted]												
		(bid)	/	[redacted]												
28 Jun	[redacted]	Foley cath	05	[redacted]												
			17	[redacted]												
28 Jun	[redacted]	Call MO for uo	05	[redacted]												
		< 50cc / 8	17	[redacted]												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	23% burn	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

Verbal Order 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
b)(6)-2 28 Jun	[redacted]	Admit to ICU 3	28 Jun		715 Done	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
b)(6)-2 28 Jun	[redacted]	Call Surgeon on														
		Call for further														
		orders.														
b)(6)-2 28 Jun	[redacted]	Call MD for														
		uo < 50cc/hr.														

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				28	29												
b)(6)-2 28 Jun	[redacted]	IV bolus 1 L 1 NS then 150cc/h	05	/	[redacted]	(b)(6)	-2										
			17														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: 23% burn

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

A11 (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
28 Jun	[redacted]	IV bolus ⅓ L NS	28 Jun			
28 Jun	[redacted]	MSO4 4mg upon arrival then per	28 Jun		Done	
	-----	Surgeon on Call				
28 Jun	[redacted]	After ⅓ liter bolus, ↑ IVF to	6/28			
	-----	200cc/h x 8h then ↓ to 150cc/h				
28 Jun	[redacted]	MSO4 10mg IV x 1 done during dressing	6/28			
	[redacted]	Δ'				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
6/28	[redacted]	MSO4 2-10mg IV	29 Jun 0451												
-----	-----	q 1h prn dressing	JM IV												
-----	-----	Δ's + pain contr	[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)
OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2100	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERL					
	SENSORIUM	moving all extremities x4					
		pulses palpable					
		appropriate response to pain					
RESPIRATORY	RESPIRATORY PATTERN	reg					
	BREATH SOUNDS	clear w all fields					
	SECRETIONS	∅ secretions					
SKIN	COLOR	burns to back, buttocks,					
	INTEGRITY	hands, upper arms, calves					
		of both legs 1, 2, 3° burns					
I.V. SITE	LOCATION	R jugular 18G PIV					
	CONDITION	patent & intact					
		∅ sign of infection					
GASTRO	ABDOMEN	soft non tender					
	BOWEL SOUNDS	present					
		tolerating po's diet					
GU	URINE:	clear yellow					
	COLOR/CLARITY	urine foley cath to					
		gravity drain					
CARDIOVASCULAR	CARDIAC RHYTHM	$S_1 S_2$ SR@ST					
		regular ∅ ectopy					
		∅ edema					

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
28 Jan 2003

PATIENT'S IDENTIFICATION (Use typed or printed name [redacted] 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															134/58			
BP Cuff																		
Temperature																		
Pulse															108			
Respiratory Rate															18			
O_2 Sat															97			
pain																		
intervention																		

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	
PO																		
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL															200			
	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	
						127/73			
		102				107			
		22				20			
		97				96			
						RA			

INTAKE	21	22	23	00	01	02	03	04	8° T
	150	150	150	150	150	150	150	150	
						200			

OUTPUT									
	900/1100		120/120			300/150		100	1620

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
	A: pH								
	A: PCO_2								
	B: pO_2								
	B: HCO_3								
	B: SAT								
	G: BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

DAILY ACTIVITIES DFG	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	1650	Urine:	
po	1400		
TOTAL	1650	TOTAL	1620

BALANCE _____

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) OA Appr 8 Mar 89

INI[redacted]IFT ASSESSMENT

	TIME	0600	INITIA[redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm PERRL Brisk					
	SENSORIUM	Awake & Alert Move all extremities & purposeful movements					
RESPIRATORY	RESPIRATORY PATTERN	Regular Pattern, Bilat & equal rise & fall CTA					
	BREATH SOUNDS						
	SECRETIONS	bilat ∅ secretions SaO2-95% RA					
SKIN	COLOR	1° & 2° Burns 23% TBSA					
	INTEGRITY						
I.V. SITE	LOCATION	20ga IV to (R) wrist					
	CONDITION	NS infusing @ 150cc/hr Site CDI ∅ S/S erythema					
GASTRO	ABDOMEN	+BS x 4 quads Soft Non tender ∅ distention					
	BOWEL SOUNDS						
GU	URINE: COLOR/CLARITY	Clear yellow foley to gravity					
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 Audible HR 106 Pulses +2 x 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
SA - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 29 Jun 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DK | 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	132/81	172/92																
Temperature		98.7																
Pulse	108	104																
Respiratory Rate	20	22																
SaO2	95	96																
Method O2	RA	RA																
pain intensity																		

INTAKE																			
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
NS	150	150																
TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL		10																
	SP GF																		
	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									
	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	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

[redacted]URE [redacted]

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE_____

(b)(6)-2

b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
[redacted]	I 2

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

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

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 (b)(6)-4
—	U	1900	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 9 Enemy POW	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D	ICU 3	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)
7 4 D/C to CIV Acute Care Facility 2 6		8 2 8 3 8 4 8 5 8 6 0 3 0 6 2 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		9 7 9 8 9 9 1 0 0 1 0 1 0 2 0 3 0 6 2 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116

FOR LOCAL USE

DX: 23 percent burns to body; 2°

DX: 94224
94323
94420
94524
94820
E892

Dx: 8622

Trauma
9

Injury
759

ADMITTING OFFICER (Signature, as required) [redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] SPC (b)(6)-2

DA FORM 3085, MAR 80

INPATIENT TREATMENT RECORD COV ET

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

[redacted]	2. NAME (Last, First, MI) [redacted] (b)(6)-4			3. GRADE N/A	ADMISSION REMARKS
4. M 28y	5. RACE Z	7. RELIGION N/A	8. SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No
11. FMP (b)(2)-2 99	12. SSN (b)(6)-4 [redacted]	13. ORGANIZATION N/A			14. WARD 1CU2
15. FLYING STATUS N/A	DSG	17. DEPT./BEN K91 K79	18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from E.R.			22. HOURS OF ADMISSION 1954	23. CLINIC SERVICE ABDA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —		25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 3 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —		27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 1 Jul 03	ADMITTING OFFICER (b)(6)-2 [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. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Head Laceration/ Trauma

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

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

SIGNATURE OF [redacted] RECORDS OFFICER [redacted] (b)(6)-2

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

MEDICAL RECORD — ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT AND CONDITION ON ADMISSION (Date / time of admission)

PHYSICAL EXAMINATION

PROGRESS (Include date of discharge and final diagnosis)

Head Laceration
&
trauma

SIGNATURE OF PHYSICIAN [redacted] DATE 1 Jul 03 IDENTIFICATION NO ORGANIZATION

PATIENT'S IDENTIFICATION [redacted] (When entries give Name, last, first, date, hospital or medical facility) (b)(6)-2 REGISTER NO. WARD NO.

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
STANDARD FORM 549
GENERAL SERVICES ADMINISTRATION
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1973

AUTHORIZED FOR LOCAL REPRODUC

CAL RECORD | PROGRESS NOTES

TE	NOTES
1 July 03 2300	Admitted from EMT to ICU #2 via litter. Alert, Verbal [redacted] applied wrist restraints. Eyes: PERRLA @ 2 mm. (R) eye scleral is slight redness noted. Lung sound clear bil. BS present in all 4 quads. (L) lateral head laceration c̄ staples. Top of head laceration c̄ staples noted. C/O (R) knee being sore. Scrapes noted to back. No drainage noted or active bleeding noted to back or head lacerations. (L) HL AC [redacted] or infection or infiltration noted. Will Monitor. [redacted]
2355	Applied bacitracin to lacerations on head. Pt [redacted] bed. Wrist restraints ~~still applied~~ [redacted] intact. Will Monitor [redacted]
2300	hate entry. Versed 2.5mg IVP given. Will Monitor [redacted]
2 July 03	#2 Facial bruising, head lac, Back contusions.
	pt c/o of pain. Transfer forward when possible 2 to SPW Cog.
	[redacted] (b)(6)-2
2 July 03 11:19	Nursing assessment - Pt A&O #3, VSS, Head c̄ 2 Lacerations closed c̄ staples to air. Minimal drainage noted, without S/S of infection. Eyes Perrla. Heart sounds S_1 S_2 present, Lung sounds clear bilaterally. + BS x 4 quadrants. Pt c̄ contusions to (L) side of neck, (L) Arm & Back. IV HL 18g in (L) AC patent & without S/S of infection. Pt now-combative at this time, wrist restraints in place. Will Continue to Monitor [redacted]

SHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other) [redacted] (b)(6)-2

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

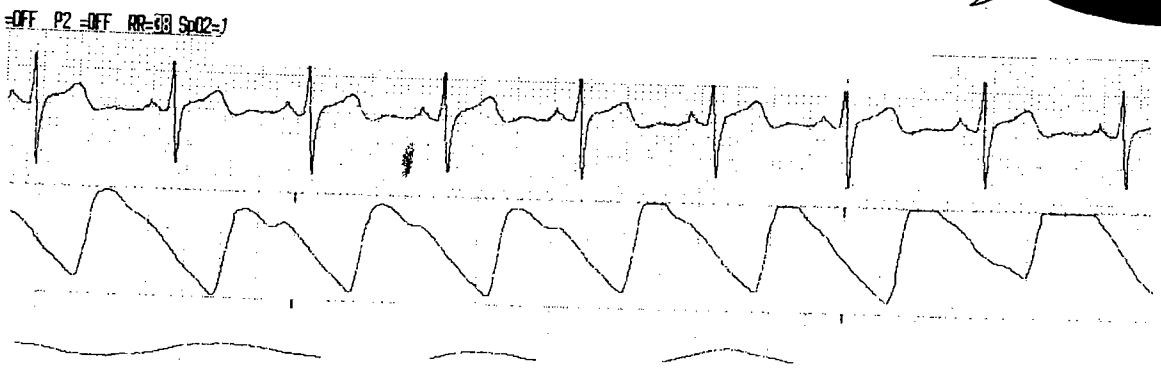
PROGRESS NOTES
Medical Record

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

A11 (b)(c)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 July 03 1700	Assumed care of pt @ day shift report given. Alert, [illegible] No c/o pain @ present time. (R) AC HL = S/S of infection or infiltration noted. Flushes = difficult, PIV RRL @ 3mL. Lung sounds clear bil, BS (+) in all 4 quads. Pedal pulses present bil. Radial pulse present bil. NSR = ectopy. Will monitor. Laceration on head open to air, + staples. No active bleeding noted. No drainage noted. — [redacted]
1900	Pt voided spont. approx 175cc clear yellow urine. — [redacted]



2321	Applied triple antibiotic ointment to laceration to head. Lacerations open to air c staples. No active bleeding or drainage noted. [redacted]
3 July 03 0013	DC'd HL 14G (R) AC. Cath intact. Applied 2 [illegible] pressure. Secured c tape. — [redacted]

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1

AUTHORIZED FOR LOCAL REPRODUC

CAL RECORD | PROGRESS NOTES

TE | D/c & Transfer Summary NOTES

2 July | 28 yo ~~[illegible]~~ Iraqi f/p physical attacks p̄ ~~[illegible]~~ [redacted] attacking US soldiers c̄ bayonet, by report. Brought in in restraints 2° Head Lac/trauma, reported LOC & Back trauma. CT & plain Films = Nl ∅ Fx.
Wounds - cleansed & closed c̄ staples.
No issues p̄ admission.
(A) Head trauma & Laceration. Back Trauma.
(P) - evac to SPW ward for processing removal of staples July 10th.
[redacted] / [redacted] (b)(6)-2
MAJ MC

SHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBE (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.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUC

CAL RECORD | PROGRESS NOTES

TE	NOTES
3 Jul 03 0830	Nursing Notes - Pt A&O x3, VSS, NO Δ's from previous shift. Pt c̄ staples to air (L) forehead, & (R) top of head. No S/S of infection. Pt c/o pain in his back & neck. 800mg Motrin given /Md orders. Pt tolerated diet w/o complaint. [redacted] 9lwm6 (b)(6)-2
3 Jul 03 11:00	Pt pending DC. No Δ's. Pt c/o pain & ☹ on shift. 800 Motrin given @ 0800, T3 given @ 1000.

ISHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBE (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.	WARD NO.
[redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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

558-103 (See Instructions on Back of this Sh NSN 7540-01-075-378

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) EMT

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
1	JULY	03	1954

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) MP's

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

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

ALLERGIES: Penicillin

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): Head injury

SEX: M AGE: 28

POSSIBLE THIRD PARTY PAYER? [ ] YES [X] NO

TIME SEEN BY PROVIDER:

VITAL SIGNS			
TIME	1905	2027	
BP	129/88	134/78	
PULSE	98	75	
RESP.	22	16	
TEMP.		99.9	
WT. (Child)	70 Kg		

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

ORDERS	INITS.	TIME
Metaclid	[redacted]	2013
X-Ray Skull Series	[redacted]	2013
T&S CBC	[redacted]	2013
V/S Ant		
TNS	[redacted]	2013
Ancef 1g IV	[redacted]	2013

ASSESSMENT/DIAGNOSIS: Head trauma c̄ ↓62 Laceration.

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)

28 yo Iraqi ♂ s/p physical restraints by MPs p̄ jesturing & attacking c̄ bayonet. Reported LOC by MP's & pt. c/o Face pain. Back pain.

(o) VSS; A&Ox3 Ambulates
Q - NAR
Ys = CTA (B)
ABD - NA NAOS
FAST US Neg.
Ext = Ø lac / edema / FRom

Head - EOMI
3 Head lac's.
Swelling pain over (R) eye.
Nose Not displaced
TTP
Blood c̄ nostrils.

Pupils
Ø
PERRL
Ø
Rx
Ø

Skull film
? No obvious Fr

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: ICU	

CONDITION UPON RELEASE
- [X] IMPROVED
- [ ] UNCHANGED
- [ ] DETERIORATED

TIME OF RELEASE:

ORDERS
Tetnus IM .5 2010
Morphine .5 2015
3mg Vercet 201[redacted]
MSO4 3mg 2040
2mg Versed 2040
2mg Morphine 2040

17 / 54 — 16 / 447

Procedure: wounds cleaned closed c̄ staples.

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

INSTRUCTIONS TO PATIENT [redacted] ordered, any limitations and follow-up plans)

[redacted] (b)(6)-2

EMERGENCY CARE AND TREATMENT
MEDCOM - 12478 Copy

STANDARD FORM 558 (Rev. 6-8
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

(b)(6)-4

EPW # [redacted] 1 July 03

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																			19/62					
TEMP																			98.4					
HR																			79					
RR																			19					
SAO2																			94					
FIO2																			RA					
INP[illegible]																								
PO[illegible]																								
[illegible]																								
NG[illegible]																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																								
NGT																								
S[illegible]OL																								
TO[illegible]																								
B[illegible]CE																								

MEDCOM - 12479

[redacted] (b)(6)-4

Patient Name: EMW [redacted] (b)(6)-4 2 July 08

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				114/66				130/86		/				132/82										
TEMP				98.4				98.5		/				99.1 A										
HR				80				75		/				81										
RR				20				18		/				28										
SAO2								97		/				100										
FIO2				RA				RA		/				RA										
UT				200				/		/														
P				/				/		/				100						60				
I								/		/														
NGT				/				/		/														
																								360
TURN Q 2	self turn			S				self		Self														
TOTAL				200				/		/														
OUTPUT																								
URINE			400	525				/		500					175									1600
NGT																								
STOOL	ϕ	ϕ	ϕ	ϕ	x1			/		/														
			400	525	—			/		/														
T			400	925				/		/														
B. CE					x1			/		/														
Stool					x1																			

MEDCOM - 12480

(b)(6) -4

[redacted] [redacted]

EPW 3 July 03

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	138/~~84~~ 182	138/82																						
TEMP		97.9																						
HR		72																						
RR		26																						
SAO2		97																						
FIO2		RA																						
[illegible]UT		/																						
P[illegible]		/																						
I[illegible]		/																						
NG[illegible]		/																						
TURN Q 2		self																						
TOTAL		/																						
OUTPUT		/																						
URINE		/	350																					
NGT		/																						
STOOL		/																						
TO[illegible]		/																						
B[illegible]CE		/																						

MEDCOM - 12481

Ward/Section: EMT

OUT[redacted]CIAN: (b)(6)-2

HE MISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

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

DATE: 1/30/03 TIME: 2015

SSN/D[redacted] (b)(6)-4

(I-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		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	138	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	284	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	3.9	3.3-4.7 mmol/l
CL^-	105	98-108 mmol/l
tCO_2	23	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]

(b)(6)-2

DATE: 01/30/03

LAB ID NO.:

d/Section: EMT

JES TING PHYSICIAN: [redacted] (b)(6)-2

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

ST, FIRST, M[redacted] (b)(6)-4 | DATE 14JUL03 | TIME 2015 | SS[redacted]N: [redacted] (b)(6)-4

(Hematology)			Urinalysis			Serology		
EST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	17.9	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	6.17	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	16.5	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	54.2	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	87.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
PLT	447	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
aph %	16.9	20.5-51.1%	Bld		Negative	H. pylori		Negative
Hematology Manual Differential			pH		N/A	Micro Parasites		
s		Mono	Prot		Negative	Malaria		
ds		Eos	Urob		0.2-1.0	O & P		
aph		Baso	Nit		Negative	Other		
p		Imm	Leuk		Negative	**Microscopic Urinalysis**		
C ph			HCG		Negative			
n natocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
er			Directigen		Negative	ABO/Rh		

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

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

PORTED BY [redacted] | DATE: | LAB ID 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.

DATE OF ORDER: 1 Jul 03 — TIME OF ORDER: ____ HOURS — LIST TIME ORDER NOTED & SIGN

- Adm: ICW
- Dx = Head Lac / Trauma
- 2 Cond: stable SPW Aggressive
- VS = q shift
- ALL = PCN
- Act = Restraints ÷ BRP
- Nursing = Wound care

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER

- Diet = NPO until 2 July AM Reg HOURS
- IV = HL / saline Lock
- Labs = Ø
- Specials = On call for Head CT [redacted]
- Meds = MSO4 2-5mg IVP q2° PRN pain
- Versed 2-4mg IVP q2° PRN agitation.
- Reflex 250mg ÷ po Q12
- Transfer to ICW when bed is available [redacted] / WYMC

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

Noted [redacted] 24°C [redacted] @ 1240 [redacted] noted [redacted]

July 2 1045

- Motrin 800mg ÷ po q8° PRN pain.
- Transfer to ICW, Same above orders
- D/c Versed ; D/c IV
- D/c MSO4
- T#3 ÷ po q4° PRN pain.
- D/c to SPW CAUP when ready [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] TIME OF ORDER [redacted]

Noted [redacted] 24°C @ 2340 2 July 03 orders noted [redacted] (b)(6)-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3										
1July03	[redacted]	VS q Shift	05	✓	[redacted]											
			1[redacted]													
1July03	[redacted]	Act: restraints c BRP	05[redacted]				(b)(6)-2									
			1[redacted]													
1July03	[redacted]	Nursing: wound care	05[redacted]													
			[redacted]													
1July03	[redacted]	NPO until 2July AM	05[redacted]													
		then Reg diet	1[redacted]													

(b)(6)-2

ALLERGIES: ☑ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: Head lac/trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: ~~Head lac/trauma~~ err

(b)(6)-4 [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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
[redacted]	[redacted]	Admit ICU #2	[redacted]	2300	2300	[redacted]
[redacted]	[redacted]	Cond is Stable EPN aggressive	[redacted]	2300	2300	[redacted]
[redacted]	[redacted]	Transfer to BCW when bed available	[redacted]			
[redacted]	[redacted]	DC to EPN Camp when ready				
[redacted]	[redacted]	DC IV				

(b)(6)-2

(b)(6)-

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. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3										
1 July 03	[redacted]	Keflex 250mg i po QID	06	[redacted]												
(b)(6)-2	- - - - - -		12	[redacted]												
	- - - - - -		18	[redacted]			(b)(6)-2									
	- - - - - -		24	[redacted]												
1 July 03	[redacted]	IV HL/Saline Lock	05	[redacted]			DCD									
	- - - - - -	(E) ~~Rt~~ JR ~~166~~ 14G.	12	[redacted]												
	- - - - - -															
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ALLERGIES: ☑ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: head lac/trauma

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

(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
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1 July 03	[redacted]	Versed 2-4mg IVP q 2°	1 July 03 2300 2.5mg [redacted]	pcd												
- - - - -	- - - - -	prn agitation														
1 July	[redacted]	MS04 2-5mg IVP		pcd												
- - - - -	- - - - -	q 2° prn pain														
2 July 03	[redacted]	Motrin 800mg i po q 8°	2 July 03 0800 [redacted]													
- - - - -	- - - - -	prn pain	[redacted]													
3 July 03	[redacted]	Tylenol #3 ii po q 4°	3 [redacted] 1000													
- - - - -	- - - - -	prn pain	[redacted]													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	28 y	Z	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	~~9 9~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	1954	N/A (b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	~~5 7 9~~ K91 K18	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU 2	
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND [redacted] MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

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

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B P A		Ø 3 Ø 7 Ø 1

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

FOR LOCAL USE

Dx: Head Laceration / Trauma

Trauma 9 Inj 979

Dx: 850.11 959.9 E995

ADMITTING OFFICER (Signature, as required) [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

PFC, 91G10

(b)(6)-2

DA FORM 2085, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, [redacted] EPW # [redacted] (b)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 27	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO					
11. EMP 99	12. SSN [redacted]	13. ORGANIZATION (b)(6)-4		14. WARD ICU/	
15. FLYING STATUS —	16. R[redacted] DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 2320	23. CLINIC SERVICE EAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION ~~50~~ 24	26. DATE OF DISPOSITION 6 Aug 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 1 July 03	ADMITTING OFF[redacted] DR [redacted] (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2				30. DATE OF INITIAL ADMISSION	32. UN[redacted] WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) Leg (foot), (R) Thumb

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1 mth 5 days	1 mth / 5 days

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDI[redacted]ICAL RECORDS OFFICER

Dr [redacted]

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

2ND INCIDENT GPW BLOWN TO RIGHT FOREARM
GSW TO (R) LEG 11 DAYS AGO. IN LLC.
C/O PAIN. ALSO (R) THUMB POSTAL TIP AMPUTATION.

NO HX AVAILABLE

Ø MEDS

NKDA 1 PPD

UPA/WPA
CR-97
135 | 101 | 9 | 8
3.7 | 25 | 0.7

PHYSICAL EXAMINATION

IN NAD
HEART - RR/RR
CHEST - SUTURE (L) CHEST WALL
ABD - BENIGN
EXT - (R) THUMB TIP AMPUTATION, WITH DRESSING
(R) LEG IN CAST

PROGRESS (Enter date of discharge and final diagnosis)

(10) I+D IN ADM

[redacted]

(b)(6)-2

SIG[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	1 JAN 03		

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

REGISTER NO.	WARD NO.

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 JUL 03	(S) PA c/o (R) ankle GSW, says has received no
2040	antibiotics or care in 10 days. GSW happened 14 days
BP: 122/80	ago. PA says he can feel bones moving under cast.
P: 96	
T: 99.4	(O) (R) leg cast, stab wound (L) hand.
Osat: 98%	
R: 24	

LOC I
EPW Camp

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

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

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
7-1-03	2330		Rpt recieved, Patient transferred & settled into bed, Pt A+O3, Respirations Unlabored, Skin CDI, except (R) hand GSW + (R) Leg GSW, Cast on (R) Leg, Abd Soft, Non-Tender, Cap Refill <3Sec, IV LR @ 125 cc/hr (L) AC PIV, IV Dressing CDI, No-Redness [redacted] Pt scheduled for Surgery in AM., NPO [redacted] 7PE/AN (b)(6)-2
	0030		pt A/O; VSS; wheezing to auscultation; c/ sls of respiratory distress; SaO2 >95%; nonproductive cough; pivot patient RLE to leg cast; thumb wrapped
		(1000)	CNA in to see pt; pt A/O; no Δ in status
		(1200)	Insert for pain to LE
7/2/03		1700	Received pt resting in bed. VSS. NPO going to OR today ate 75% of dinner. No c/o pain at this time. Right toes are black, day shift said they are aware. Right thumb still bandaged. No other issues at this time [redacted] (b)(6)-2
		0200	Pt VSS. No c/o pain. Sleeping [redacted]
7/3/03		0600	Assumed pt care from GG [redacted] sleeping @ change of shift & all VSS. CR infusing @ 125cc/hr Pt remains NPO d/t scheduled surgery for 7/3 per night shift [redacted] KTBV. (b)(6)-2

(Continue on reverse side)

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

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

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7.3.03/1600			Pt returned from OR approx 1800 after I&D of (R) thumb & (R) leg fx. No complications during surgery. Ali VSS 02 93-96% on RA pain mgmt well c̄ MSO4 IVP & percocet. Dressings C/D/I Tourniquet clears @ this time [redacted] ICTN
03 Jul 03 1830			Assessment done. ∅ significant Δ's from day shift. Pt. tol dinner well. RLE ↑ for comfort ⇒ cast C, D, + I. toes warm/discolored as noted earlier - Staff aware. (R) thumb dsgs C, D, I. HoBT. Care plan reinforced pain meds side effects, act. level, diet. D/C planning, P.T./rehab; needs reinforcement. VSS/Afeb [redacted]
03 Jul 03 2000			Pt. tol po well - drinking milkshake. IV HL & LRD/c'd. Medicated PRN c̄ effect relief [redacted] ICTN
04 July 03 0430			Pt. slept most of night. Medicated PRN - (+) results tol po well / VSS & Afeb. [redacted] ICTN

(b)(6)-2

[redacted]

N 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
300803	Orthos Op Note:
	Pre-Op Dx: R Grade III B open (R) tib-fib fracture - old. (L) traumatic amputation (R) thumb tip
	Post-Op Dx: Same
	Procedure: (R) I+D (R) leg
	(L) I+D DPL (R) thumb tip
	Surgeon: [redacted]
	Gen: MAC BLVIOS: SBP 42
	Findings: Grade III B open tib-fib fracture, unstable. Bits of bone, loose, in wound. Removed. Thumb tip with retained nail fragment, needed end of distal phalanx removed back.
	Plan: Report I+D in 48-72 hours, consider X-fixation vs casting

[redacted]

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

RECORDS MAINTAINED AT:	[redacted]	
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

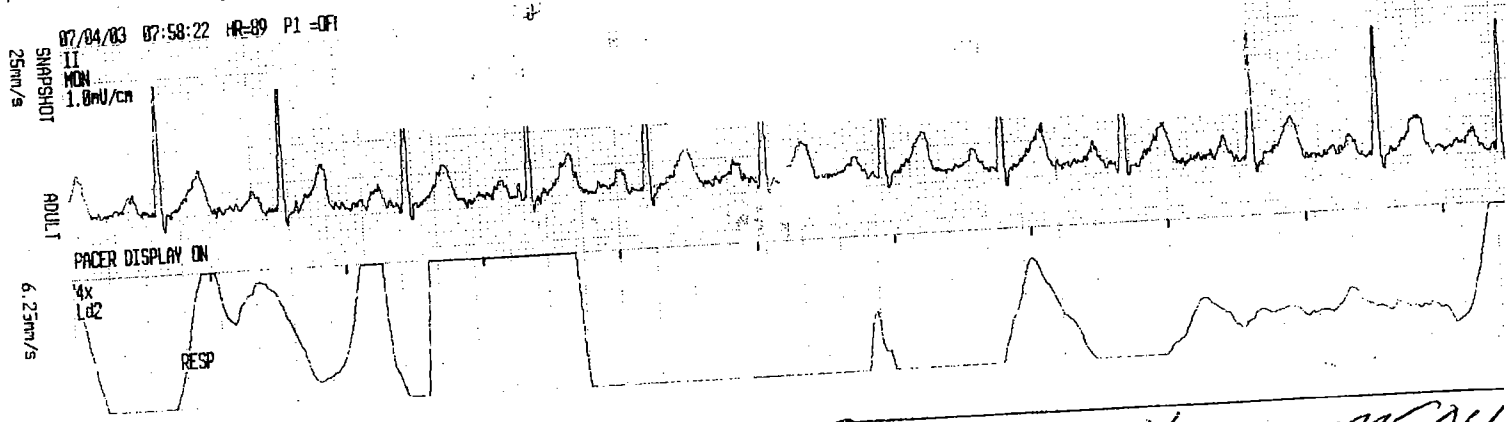
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible] 03	Ortho Op Note:
	Pre-Op Dx: GSW to III B open (R) tib-fib fracture s/p GSW
	Post Op Dx: same
	Procedure: I&D (R) knee
	I&D (R) knee
	Surgeon [redacted] (b)(6)-2
	GBL: none
	Blood: 700 cc
	Pt was taken to recovery room with stable from vascular with through external pin. Pulses acceptable, about 5° excessive valgus. Still some purulence from posterior wound.
	Plan: IV abx, repeat I&D for [redacted]
	(b)(6)-2 [redacted]
	[illegible]
	CDL [illegible]

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7/4/03	0500 assumed care. Report given. Pt [redacted] (b)(6)-2 orients. See ICU-1 flowsheet for initial assessment.



7/4/03	0730 c/o pain (R) leg. 4mg MSO4 IVP. 0800 pt breakfast & dressing [redacted] (b)(6)-2 0840 Dr Granger @ bedside. Orders received. 0900 sign placed over bed [redacted] MM. Noted on green sheet. 1000 5mg MSO4 IVP given c/o leg pain. 1230 pt use wet ones to wash body. Neurovascular signs intact. 1420 VSS. Pt rests noted @ this time.

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.

FPW [redacted] (b)(6)-4
11 Jul 03

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)-4 except where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 July 03	Received pt from Op [redacted] VSS. C/o pain 5mg MSO4 given. Pt assessment done. Pt c/o itching. Gave 50mg Benadryl IV per doctors orders. Pt resting now. Will continue to monitor. 0200 - Pt sleeping. C/o pain 5mg MSO4 given — [redacted] 0400 - Pt sleeping. Tried to have BM but couldn't. No other issues at this time — [redacted] (b)(6)-2
05 July 03	Rec'd pt from [redacted] (b)(6)-2. VSS Afebrile, pt sleeping. [redacted] 0630 Pt attempted to make bowel movement. [redacted] 0800 Prepare patient for OR — [redacted] — 0900 DC IV (L) HC, site red + infused, start (R) Hep 20G [redacted] 1600 Pt no c/o pain, still awaiting to go to OR [redacted]
4 July 03 1700	Assumed care @ 1700. VSS. pt sitting up in bed eating dinner. Assessment done. will continue to monitor. [redacted] CPT/AN
6 July 03	Recovery, Ex fix (R) ankle Gen BT, 700LR, UBC-M, Q UOP, 250m Fent 10mg MSO4
	0815 BP 134/67 P 102, RR 15, T 95.3 Sats 99%
	0820 146/87 105 13 97%
	0825 143/86 98 14 98%
	0840 149/83 93 12 98.1
	0855 144/77 96 14
	0920 136/81 98 10

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

MEDCOM - 12498

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 where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 July 03	0815 Pt back from OR, Brown/Black hardened digits in right foot, External fixator placed to (R) ankle. No c/o pain at this time, pt can move toes on command.
6 July 03 1720	Assumed care. VSS. Assessment done. see Assessment sheet. 5mg MSO4 given for pain. will continue to monitor [redacted] CPT/AN
0001 7 July 03	VSS pt remains stable. Assessment unchanged from earlier. pt c̄ mild complaints of pain x2 since shift Δ. wiggles toes and has ∂+ dorsalis pedis pulse bilat lower extremities. A-febrile will continue to monitor. [redacted] CPT/AN
7 July 0600	Assumed care, no changes from 6 July will [redacted] to monitor assessment in flow sheet USSA- [redacted]
1600	Pt remains stable nothing different from prior shift [redacted]
1600	Pt discharged to EPW Camp, escorted by MP. Discharge planning, x-rays, & medications in possession. [redacted]

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

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

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

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

(b)(6)-2 except where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 July	1700 · Received pt resting in bed. No c/o pain. Ate 100% of dinner. VSS. No other issues at this time — Sgt [redacted]
	1800 - Pt given basin & soap. Pt gave himself a bed bath. Pt now smells good — Sgt [redacted]
	2200 - Pt's IV's are infiltrated. Removed both & placed another 18G in Rt heel — Sgt [redacted]
	0400 - Pt VSS. No c/o pain. Resting in bed — Sgt [redacted]
	0420 - Pt vomiting up yellow fluid — Sgt [redacted]
8 July	0530 Received report from Sgt. [redacted], Pt resting quietly in bed. Sleeping. 3 S/S distress. Assessment performed see ICU-1 flowsheet. New IV started (P) forearm, (R) hand 22g IV removed, normal saline fluids would not run. — [redacted]
	0800 Pt up to Bedside commode - defecated a moderate amt of stool. Pt. now up in chair. Will continue to monitor — [redacted]
	0920 Pt received 1 Percoset & 3mg MSO4 for control of pain — [redacted]
	1100 - Pt's (R) [redacted] fix, old DRSG removed, site cleansed c 1/2 peroxide/1/2 sterile saline, Pedal pulse palpable, necrosis noted on toes of pt. Dr informed. medicated c 6mg MSO4 while DRSG Δ performed. Pt. tolerated well — [redacted]

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

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

[redacted] (b)(6)-4

(b)(6)-2 except where noted.

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

DATE	NOTES
8 July 03	1220 Pt. ate 75% of lunch tray. Pt back to bed, resting quietly [redacted]
	1540 Pt resting 3 co pain [redacted]
9 July 03 @ 0340	1866 Pt recieved physical assessment completed + recorded on flow sheet, [redacted] CPT/AN
~~0330~~ 9 July 03	Pt. had UOP of 570cc [redacted]
0449 9 July 03.	Pt had UOP of 300cc [redacted]
9 July 03 0843	Author Op Note:
	Pre-Op Dx - Open dislocation of tibia fracture
	Post-Op Dx - Same
	Procedure: I + D of wound
	Surgeon: [redacted] 66-2
	Anes - MN
	Anesthesia - General Endotracheal
	Findings: Wounds clean. Prior to reduction
	Plan: Daily wet to dry dressing change.

LATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] BER

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

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

[redacted] (b)(6)-4

REGISTER NO. | WARD NO. ICU

PROGRESS NOTES
Medical Record

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

(b)(6)-2 except where noted

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted] (b)(6)-4			

DATE	NOTES
9 July 03	RC'd Pt lying in bed sleeping. No c/o pain @ this time VS 97.4°, status unchanged, condition stable, will cont to monitor, prep for HP in OR this Am. [redacted]
	1600. Pt upOB this shift tolerated very well moved 80% by himself. Pt seems to be Hallucinating x 2 episodes since returning from OR this Am. MAO Greenly aware & will contact DR. NO other issues NO c/o pain at this time
1930 09 JUL 03	USS. Pt was Halucinating yelling for his mother stated that he saw his mother walk out of room. Haldol 5cg IV given. Resting quietly @ present time. Refused to eat dinner, Drank 100ml of H2O. Restraints to UE in place and secure. will continue to monitor. — SGT [redacted]
0200 09 JUL 03	Ø further hallucinations noted. Resting quietly c̄ eyes closed. IV of LR TKO. Is patent @ s/s of infiltration. USS. will continue to monitor. — SG [redacted]
0430 10 JUL 03	USS - Resting quietly c̄ eyes closed. Ø hallucinations noted. Restraints to UE in place and secure. — SG [redacted]
10 July 03	Pt USS, A febrile throughout shift. No c/o pain, Pt upOB @ 1430 to bedside commode [redacted] BM (n) solid stool. [redacted]
1530	Ad Dsg + did pin care to (R) ANKLE & TOE. NO c/o pain no issues @ this time
1700	Pt received from Sgt [redacted] VSS. Pt upOB to BSC changed dressings, did pin care, pt back is dred [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0C

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

All (b)(6)-2 except where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 July 1700	Received pt resting in bed. No c/o pain VSS. A+O x3. Assessment done. No issues at this time — [redacted]
	2015 - Pt OOB to chair. Tolerated fine. Dressings changed and pin care done. Pins look clean. Pt c/o dizziness and SOB, took vitals - VSS. Pt assured dizziness + SOB went away — [redacted] PN
	2050 - Pt liner changed. Pt put back in bed [redacted]
	0200 - No changes. No assessment. VSS. No c/o pain. Sleeping through night — [redacted] PN
	0400 - Pt still sleeping. No c/o pain — [redacted]
11 July	0500 Received report from [redacted] Pt. resting quietly in bed. No c/o pain. VSS. A+O x3. Assessment performed. Will continue to monitor — [redacted]
	0900 Pt. out of bed, sitting in chair. Tolerating well. no c/o pain — [redacted]
11 July 03 1700	Received pt from [redacted] No c/o pain. Assessment done. Got pt OOB to chair. Changed dressings, did pin care. All pins are clean. — [redacted] LPN
2000	Pt. OOB to BSC. One bowel movement — [redacted]
2400	Pt sleeping VSS. No c/o pain — [redacted]
0400	Pt slept through the night. No c/o pain — [redacted]
☆	Changed IV site at 2200 — [redacted]

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12/11/03	0500 Assumed care. Report given. See ICU-2 flow sheet for initial assessment. [redacted]
	0630 OOB to chair c̄ min assistance needed. [redacted]
	0850 Ran back to bed c̄ assistance.
	1130 Am care given. Linens changed.
	1355 Dsg chg'd. Area cleansed. Tolerated well. [redacted]
	1530 Foamed brown s/ooo/ in [redacted] chair [redacted]
13 July 03	0600 Received report. Pt resting quietly in bed, NO c/o pain, VSS. Spoke c̄ MD about IV antibiotic Gentamycin 400mg x 2 weeks. Will continue to monitor. [redacted]
	0810 Pt. c/o pain in (R) LL area, 1 Tylenol given, Pt. up to side of bed, eating. Will continue to monitor [redacted]
	0830 Pt. ate 100% of breakfast tray [redacted]
	1230 Pt ate 75% of dinner tray, Pin care provided. Cleansed c̄ 1/2 peroxide/1/2 sterile water. Left open to air. (R) thumb cleaned, redressed. [redacted]

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

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

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

REGISTER NO.	WARD NO.

12/11/03 [redacted] (b)(6)-4

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

(b)(6)(2)

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14July 03	pt remains stable. VSS. Resting well & complaint.
0100	tol dinner and performed own care himself.
	W/ instruction from Spc [redacted] pt demonstrated
	proper technique and tol procedure well. Ø
	c/o pain. will continue to monitor. [redacted] CPT/AW
0130	Assessment unchanged from earlier. (R) Lower
	extremity 2+ pulses DP + PT. can wiggle toes
	and has good sensation. will continue to
	monitor. [redacted] CPT/AW

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 JUL 03 0700	Rec'd pt lying in bed, Report given from CPT [redacted] Pt stable VSS/A see flow sheet for assessment. [redacted]
0800	Pt ate all of meal. No c/o pain. Pins show NO S/S infection. Will continue to monitor [redacted]
0900	Pt HOB ambulating w/crutches for approx 15 minutes, tolerated very well.
1300	Pin care/wound care [redacted] pt assist. NO S/S of infection [redacted]
1400	Pt HOB to chair [redacted]
1600	Pt Back to Bed [redacted]
~~0700~~ 1500 14 JUL 03	VSS - A&Ox3 - ø c/o pain or discomfort @ present. TOL reg diet. Ate 100% supper. sitting up in bed @ present. Sgt [redacted] 91C20
1745 14 JUL 03	Pin care dal to (R) Lower extremity. @ Redness or drainage. cleansed ō sterile H_2O_2. OA to back of (R) foot dress & wet to dry. small amt of bloody drainage noted. covered ō 2x2. Percocet 1 Po given @ 1900 for c/o (R) leg pain. sitting up in chair @ present time. Sgt [redacted] 91C20
0400 15 JUL 03	VSS - ø c/o pain or discomfort @ present time. Rested quietly all noc. Sgt [redacted] 91C20
15 JUL 03 0800	Assumed care of pt. coherent/cooperative. Ext. Fix. to (R) lower leg intact. (+) pedal pulses of both extremities. Dsg to (R) lower leg CDI.

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PATIENT'S IDENTIFICATION: *(For typed or written* [redacted]	*Name - last, first, middle; ID No or SSN; Sex;*	REGISTER NO.	WARD NO.

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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)*
	wet to dry. Ø% pn @ this time. Pt. sitting up in bed, Ø distress [redacted] noted.
JUL 0900	Pt. c/o (R) lower leg pn. Percocet po given. Will continue to moni- [redacted] tor
15 JUL 1130	Pt. tolerated lunch well. 30 min. later OOB to chair c̄ (R) [redacted] extremity elevated. Ø% pn.
15 JUL 1430	Pt. ambulated c̄ crutches for approx. 100 min. Currently resting [redacted] quietly in bed. Will continue to monitor.
15 JUL 1700	Pt. had x1 BM via bedside commode. Pt. eating dinner. [redacted] Ø% pn. Will brief oncoming shift.
15 JUL 03 2020	pt. transferred from ICU 1 to ICW2 @ ~ 1845 ambulatory c̄ crutches in stable condition – VSS – no c/o pain – (R) ankle ex fix intact, dsg CDI on inner as pect of (R) ankle, stitches intact on lower (R) shin – lungs CTA (B) – (+) BS – (+) 2 peripheral pulses x 4 extremeties – (R) toes 2nd 3rd & 5th c̄ healing burns – pt. did own pi-care c̄ ½ strength H_2O_2 – medicated for pain c̄ 650 mg tylenol PO – (+) IV access [redacted] R. AN

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. ICU 1 / ICW 2

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

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TE	NOTES
16Jul 03 22:25	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x2 (R) wrist (L) Ankle. Perrla (+) WNL. Skin color WNL. LCA (B) BS (+) x4. (+) PPP (B). (R) ↓ ext. ex fix in place. pin sites ⊖ sxs infection. (R) foot (+) ROM (+) sensation (+) PP (+) <3sec cap refill. Skin to (R) foot remains dry cracking. black in some areas on toes. C/O pain x1. ti Percocet given. will cont. to mon [redacted] AW
0640	Pt. care assumed @ 0500. Pt. febrile @ 100.4. Pt tach @ 110, diaphoretic. Tylenol 650mg given PO. HR ⊖ S1, S2. Lungs CTA, BS (+) x4. Ex-fix to (R) ankle intact. Pin sites CTA, ⊖ drainage noted. (R) leg 1. (R) ft skin dry, cracking in places, toenails black. Pulse 2+, toes warm. will cont. to monitor. [redacted] AW
17Jul03 1335	assumed care @ 1300 - VSS - no c/o pain @ this time - neuro V's WNL for (R) foot - pin sites for (R) ankle ex fix ⊖ S/S infection. dsg CDI on inner aspect of (R) ankle - [redacted]
17Jul 03 22:18	Rec'd c/o pt @ 21:00. VS WNL Per flow sheet. Awake and alert in bed. Perrla (+) WNL. Skin color WNL. LCA (B). BS (+) x4 (+) PPP (B). (R) ↓ ext. ex. fix in place. Pin sites and sutures ⊖ sxs infection. (+) sensation (+) ROM (+) <3sec cap refill to digits.

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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TE	NOTES
15JUL08	Recd c/o pt @ 21:00. VS WNL per flow sheet. Skin color WNL
2045	PERRLA (+) WNL. LCA (B). BS (+) x4. (+) PPP (B). (R) ext. fix to ankle intact.
	⊘ s/s infection @ pin site. Sutures intact. DSD C/D/I. c/o
	pain x1. ṗ Percocet given. Will cont to mon [redacted] AN
0530	Pt. care assumed @ 0500. Pt. c/o pain to (R) LE. ṗ Percocet
	given P.O. HR Reg, lungs CTA. BS (+) x4. (R) ex fix to ankle
	intact. Pinsites CTA, c̄ s/s infection. Drsng to (R) ft C/D,
	will Δ c̄ pin-care. (R) ft c̄ pedal pulse 2+, (+) ROM, (+) sensation
	metatarsals. Cap refill to (R) ft < 3sec. Toenails (R) ft
	thickened, black in color, c̄ skin peeling dorsal surface
	(R) ft. Will cont. to monitor. [redacted]
0640	Pt. assisted c̄ pin care using 50% H_2O_2 / 50% SW. ⊘ drainage
	noted @ pinsites. (R) ft soaked ṡ cleaned and lotion applied.
	Drsng to (R) ankle Δ'd ṡ is CDI. Will cont. to monitor [redacted]
1020	Pt. OOB → chair, restrained. [redacted]
1345	Assumed care of Pt @ 1300. VSS. A+Ox3. Pain controlled c̄
	po tylenol. (B) BS CTA (+) BS x4. (R) LE ex fix CDI. (+) sensation
	palpable pulse, cap refill < 3sec, mvt toes (R) foot. Drsg
	to (R) lower calf CDI. O/V Assessment WNL. Will
	Cont. to monitor [redacted]

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MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
cont'd.	c/o feeling cold and was shivering. Temp 99.0. c/o pain. ii Percocet given
0700	Pt. care assumed @ 0500. Pt. sleeping, arouses to verbal stimuli. Ft. febrile @ 100.9. 650mg Tylenol given PO. VS otherwise stable. HR Reg. lungs CTA, BS⊕x4. skin hot to touch. Ex-fix to (R) ankle intact. Pin sites CTA, ∅ drainage. (R) ft slightly edematous ∑ ⊕ KEM, ⊖ sensation toes ∑ pulse 2+. Skin to kt ft. peeling, dry. Will cont. to monitor. [redacted]
1400	Assumed care of Pt @ 1300. VSS. A+O x 3. ⊘ c/o pain. (L) LE EXFIX intact. lower (L) calf drsg CDI. ⊕ palpable pulse, mvt of toes, cap refill < 3 sec sensation. Pin care done kn st with H_2O_2. o/w Assessment [redacted] for [redacted]
1800	
23:00	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Restraints x2 (R) wrist (L) ankle. Skin color WNL. LCA (B). BS⊕x4 (+) PPPB (R) lower ext. ex fix to ankle intact. pins ∅ sxs infection. DSD applied to sutures CDI. Top of foot and toes remain pink and black to 2nd toe. Able to move digits. ⊕ sensation ⊕ < 3 sec blanching to skin on digits. c/o pain to top of foot. ii Tylenol given. Will cont to mon [redacted]

HIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST | MI

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(b)(6) -2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
7-19-03 0730	Pt care assumed @ 0500. VSS. HR Reg, lungs CTA, BS ⊕ X4. ∅ pain. Ex-fix to (R) ankle intact. Pin sites OTA ∓ s/s infection. (R) ft c̄ pulse 2+, (R) sensation, (R) ROM, cap refill <3sec. will cont. to moniter. [redacted] MAW
1330	Assumed care of Pt @ 1300. VSS. A+Ox3. ∅ c/o pain. (R) ankle Ex-Fix CDI. Drsg to lower (R) leg CDI. (+) sensation, cap refil <3sec, mvt toes (R) foot. Pt does complain ∅ s/s/sx of infection. O/W assessment cont. will cont. Monitor [redacted]
19 July 03 2155	Assume pt care @ 2100. pt awake and alert. OOB to chair c̄ (R) leg elevated. VSS. HR reg. Lungs CTA. Abd soft non tender non distended BSX4. (R) thumb stitches intact no signs of infection OTA. (R) LE ex-fix intact drsg CDI. pt c/o pain to top and bottom of foot. Will give pain meds as ordered. [redacted] MMP
20 July 03	0800 - Pt alert sitting in upright in bed eating breakfast. VSS, lungs CTA, BS⊕. Ext fix intact to (R) leg. (R) foot c̄ edema. Pulse ⊕, able to wiggle toes. Skin warm to touch. Will cont to monitor [redacted] DLMAW
1320	Assumed care of Pt @ 1300. VSS. A+Ox3. ∅ c/o pain. (L) LE ankle ex-fix CDI. ∅ s/s/sx infection @ pin site, (+) palapable pulse, cap refil <3sec, mvt toes, sensation. (R) foot (+) edema to foot O/W assessment WNL. Will Monitor [redacted]

(b)(6) -2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 JUL 03 0042	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Restraints x2 (L) ankle (R) wrist. PERRLA (+) WNL LCA (B). BS (+) x4. (+) RPP (B) c/o pain x2 to (R) ↓ ext. ii Tylenol given ∑ relief. ∴ percocet given for pain. (R) ↓ ext ex fix intact. (R) foot to mid-calf warm to touch and warmer than superior to ex-fix. (R) foot darker in color than (L) foot. Skin and toenails remain thick and black and pink. [redacted] (+) sensation (+) ROM (+) <3 sec. cap refill. Ex fix pins ∑ sxs infection. Will cont. to mon [redacted] OLT/AN
0900	Pt. care assumed @ 0500. VSS. HR Reg, lungs CTA, BS (+) xy. Ex-fix to (R) LE intact. Pin sites ∑ s/s infection. (R) foot edematous, warm to palpation. Pulse 2+. (+) sensation, (+) ROM. Will cont. to monitor. [redacted] TAN
1325	Assumed care @ 1300. VSS. A+O x3. Ø c/o pain. (R) LE Ex Fix CDI, pins OTA Ø s/s of infection. (+) palpable pulse, cap refill <3 sec, mot. tens, sensation (R) foot. [redacted] on crutches ∑ assistance. Ø IV Access. (+) IS & [redacted] Ø/C Assessment WNL. Will MONITOR [redacted]
21 July 2125	Pt care assumed @ 2100. Pt awake and alert ∑ c/o pain. Lung sounds CTA, pulses palpable xy, bs (+) xy quads. Ex fix on rle intact, insertion site is clean ∑ no drainage. Pt ∑ (+) pulse and sensation in (R) foot. RUE ∑ (+) pulse and sensation, wound ∑ sutures on (R) thumb CDI. Will continue to monitor. [redacted] gwm
22 July 03	0610 Assume pt care @ 0500. Pt Awake and Alert. c/o pain to (R) Foot. Will give meds as ordered. VSS. HR reg. Lungs CTA. Abd soft BS x4 (cont) [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22July03	0610 (cont) Ex-Fix to (R) LE intact. Sm dsg CDI+I (+) pulse (+) movement below ex-fix. Will continue to monitor [redacted]
22Jul03 2030	assumed care @ 1300 - VSS - medicated c Co50mg tylenol PO c good results @ 1700 - neuro checks WNL in (R) foot, pt. removed dsg on (R) ankle, wound dry and healing - pt. to do pin care [redacted]
22Jul03 23:00	Rec'd c/o pt @ 21:00. VS WNL - per flowsheet. Restraints x2 (R) wrist (L) ankle. PERRLA (+) WNL. Skin color WNL LCA (B). (+) BS x4. (R) thumb sutures intact. (R) + ext. ex. fix intact. Pin sites ⅗ sts infection. sutures OTA. (R) foot remains slightly darker in appearance than (L) foot. (+) PPP (R) do pain x1 650mg tylenol given. Will cont to mon [redacted]
23Jul	Assumed care of pt @ 0500. Pt was adeq. VSS. Lungs CTA. Bowel sounds x4 quads. Ext. fix on (R) leg. Pins intact. Pt did his own pin care. 0% pain/discomfort - [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 July 03 1400	Assumed pt care @ 1300. VSS. pt awake et alert. lungs CTA, and soft nontender. BS (+) x4 quads. (R) leg c̄ ext fix, OTA (-) S/Sx of infection noted, (+) pulse. (L) leg c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses. (-) IV access noted. (-) c/o pain/discomfort noted @ this time. Will cont to monitor — [redacted] SWM
23 Jul 03 23:00	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (L) ankle. VS WNL per flow sheet. Awake/alert in bed. Resp a (+) x02. Skin C/D/I LCA (-). BS (+) x4. (R) ex fix. intact. pins ↓ SXS infection @ insertion site. (R) foot +1 edema & pitting. digits remain black 1st and 2nd toes. Sutures to (R) thumb intact. c/o pain x1 ii tylenol given. will cont to mon [redacted] DLT/AW
24 Jul 03	0545 pt care assumed @ 0500. pt awake and alert. VSS. HR reg. lungs CTA. Abd soft BS x4 RLE ex-fix intact. (+) movement (+) sensation below pins. Suture to (R) thumb intact. No c/o pain @ this time. will continue to monitor [redacted] SWM
24 Jul 03 1510	Assumed care @ 1300 - VSS - medicated @ 1500 tylenol PO for pain - (+) radial pulse (+) movement & sensation in (R) toes - [redacted] CM

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24 Jul 03 2330	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Restraints x 2 (R) wrist (L) ankle. Skin W/D. LCA (R) BS (+) x 4. (+) PPP (R). (R) LE ex fix in place & s/s infection @ pin sites. c/o pain x 1 ~~i~~ Tylenol ~~i~~ Percocet given. Will cont. to mon [redacted]
25 July 03	1120 - Pt alert sitting upright in bed c (R) leg elevated. Ext fix intact to (R) leg. Tylenol given for pain. VSS, lungs CTA, HR reg, BS (+). ~~Will~~ very [redacted] Pulses (+) & strong bilat to ↑ & ↓ extremities. Able to wiggle (R) ft toes, (+) sensation, leg warm to touch. Will cont to monitor [redacted]
25 Jul 03 1830	assumed care @ 1330 - VSS - medicated c 650 mg tylenol PO @ 1800 c̄ good results - neuro V's WNL in (R) foot, foot becomes dark purple when pt. stands c̄ crutches (+) 2 pedal pulse @ all times - pt. did own [redacted] care, demonstrated correct technique ~~and~~ - [redacted] CR, AV
25 Jul 03 00:04	Rec'd c/o pt. @ 21:00. Restraints x 2 (R) wrist (L) ankle. VS WNL per flow sheet. Pt. awake and alert in bed. Skin W/D. PERRLA (+). LCA (R) BS (+) x 4. (+) PPP (R). (R) thumb sutures intact. ∅ s/s infection. (R) ↓ ext. ex-fix intact. Pin sites ∅ s/s infection. Digits (+) COM, (+) sensation, (+) < 3 sec cap refill. c/o pain x 1 to bottom of foot. ~~i~~ tylenol ~~i~~ Percocet given. Will cont. to mon [redacted] AV

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RECORD

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NOTES

26 July 03 0521- Pt alert this am sitting upright in bed. VSS, lungs CTA, HR reg, BS⊕. Ex1 fix intact to ® lower leg. Some edema noted to foot. Able to wiggle toes, ⊕ sensation, pulse ®, skin warm to touch. Voicing ∅ complaints at this time. Will cont. to monitor [redacted]

26 Jul 03 1500 assumed care @ 1300 - VSS - no c/o pain
1420 @ this time - pt. clipping toe nails - wound on ® leg healed, edges closed, ⊕ 2 pedal pulse in ® toes, pt. has ⊕ movement & ⊕ sensation in ® toes - [redacted]

26 Jul 03 Rec'd c/o pt @ 21:00. Restraints x 2 ® wrist/® ankle. VS
21:55 WNL per flowsheet. Pt. awake and alert in bed. Skin W/D PERRLA ⊕ WNL. LCA ®. BS ⊕ x 4 ⊕ PPP ®. Skin color to ® foot remains discolored compared to mid-calf skin color. ® ex-fix in place. pin sites ∅ DS sxs infection sutures intact to wounds on inner and outer aspect of ® ankle ⊕ ROM/limited ⊕ sensation ⊕ cap refill to ® foot digits ⊕ & pitting edema 1 ® foot/Ankle & c/o pain @ this time will cont. to mon. [redacted] PT/AVO — b(6)-2

Addendum Sutures to ® thumb c/D/I ∅ SS infection will mo[redacted] PT/AVO

SPONSOR'S NAME

LAST	FIRST	MI	SPONSOR'S ID NUMBER SSA or Other

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Patient's written address, give: Name - last, first, middle; Street & No., Sex, Date & Place of Birth, Rank, Grade

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TEW 2

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

PROGRESS NOTES
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27July03 0630 Pt. awake & alert sitting up in bed eating breakfast. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. (R) LE elevated on folded blanket, pedal pulse palpable, (+) sensation. Skin below (R) ankle reddened c̄ mild edema, cap refill unable to assess due to fungus on toenails, sutures on dorsal side of (R) foot intact s̄ s/s of infection. Pt. s̄ complaints @ this time. All other assessment findings WNL. Pt. s̄ IV access. Will continue to monitor. [redacted] /AN

27Jul03 1625 assumed care @ 1300 - VSS - neuro V's WNL in (R) foot, wounds healed - Tylenol #3 ordered for pain, percocet will no longer be used as pt. reports it is not effective for pain - no c/o pain @ this time [redacted] AN

27Jul03 2349 Rec'd c/o pt @ 21:20 Restraints x2 (R) wrist (L) ankle VS WNL per flow sheet. Awake and alert in bed. Skin W/D. ICAB BS (+) x4. (+) PPP (B) (R) LE c̄ ex fix intact. pin insertion sites s̄ s/s infection. Sutures to outer and inner aspect of ankle c/D/I OTA. Sutures to (R) thumb OTA s̄ s/s infection c/o pain x1 ṫ Percocet and ṫ Tylenol given. Will mar [redacted] 0520/AD

~~0517 c/o pain error~~ [redacted]

SPONSOR'S NAME
LAST | FIRST | MI | SPONSOR'S ID NUMBER
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PROGRESS NOTES
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 July 03 0900	Pt. asleep in bed easily aroused by verbal stimuli. No IV access. HR Regular, Lungsands clear bilat, bowel sands (+) x 4 quads. (R) LE ↑ on folded blanket, insertion sites from ext. fix ∓ s/s of infection. (R) foot c̄ small amt. of swelling & erythema, unable to assess cap refill due to nail fungus, foot warm to touch (+) sensation, limited ROM. Pt ∓ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] RN
28 Jul 03 1845	assumed care @ 1300 - VSS - medicated c̄ ⅋ T#3 PO @ 1430 for pain, no further c/o pain - pt. now stating T#3 does not help his pain as he is laughing and joking c̄ his brother - neuro V's WNL in (R) foot - pt. did own pin care c̄ H_2O_2 / saline mix [redacted] CRNA
2330 28 Jun 03	Pt care assumed @ 2100. VSS, c/o pain @ 2230, 325 tylenol, ⅋ percocet given. Lungs CTA, pulses (+) x4, BS (+). RLE c̄ ex fix (+) sensation and capillary refill, pins clean and intact. [redacted] foot c̄ swelling, and erythema, more so when ambulating. Pt ambulated x30 minutes. No complaints, continue to monitor. [redacted]
29 July 03	0610 Assume pt care @ 0500. pt awake and alert. No c/o pain or discomfort. VSS. RLE ex-fix intact. (+) sensation. limited movement, elevated @ this time (cont) [redacted]

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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. ICWO

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 July 03	0600 Sutures to thumb intact. Will cont to monitor [redacted] SMMP
	1400 Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non tender, bowel sounds active x4 quads. (R) LE ex-fix intact, pin sites CDI. Pt perform pin care by himself c̄ supervision. (R) foot c̄ strong pulse and brisk cap refill. (R) foot c̄ discoloration ∅ complaint of pain. [redacted] LE/HN
29 Jul 03 21:57	Rec'd c/o pt @ 21:00. Restraints x 2 (1) wrist (2) ankle. VS WNL per flowsheet. Awake and alert in bed. PERRLA (+) WNL. 2CAB. BS (+) x4. (+) PPP (R). (R) ex-fix in place. Pin insertion sites ∅ s/s infection. (+) ROM (+) <3 sec cap refill (+) sensation to digits. Foot up to ankle discolored. Sutures to entrance and exit wound C/D/I OTA. (R) thumb sutures C/D/I OTA. ∅ c/o pain @ this time. Will cont to mon [redacted] AN
30 July 03 0600	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular. Lung sounds clear bilat, bowel sounds (+) x4 quads. (R) LE ↑ on folded blanket. Ext fix insertion sites c̄ s/s of infection, (R) foot from ankle down c̄ erythema, ↑ temp, mild swelling, (+) sensation, (+) pedal pulse, unable to assess cap refill due to toe fungus. Pt. c/o pain, will give ↑ Percocet. All other assessment findings WNL. Pt c̄ other complaints @ this time. Will continue to monitor. [redacted] LJH
30:	

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

All (b)(6)-2 except where noted

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD PROGRESS NOTE ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30Jul03 1320	assumed care @1300 - VSS - no c/o pain @ this time - neuro v's WNL in (R) foot, foot remains discolored. Skin [redacted] Sites S&S/S infection — [redacted]
30Jul03 23:43	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (R) ankle. VS WNL per flowsheet. Awake and alert in bed. Skin W/D PERRLA (+) WNL. LCA (B). HR reg APEM WNL. BS (+) x4. (+) PP (B). Sutures to (R) thumb remain OTA & s/s infection. (R) ext ex-fix intact. Pin sites open to air as s/s infection. Sutures to entrance and exit wound on (R) ankle. OTA 5 s/s infection c/o pain x1 T Percocet given. Will cont to mon [redacted]
31 0510 July 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, b/s clear to all fields (B). Abd soft, nontender, ± distention, BS (+) x4. Voids spontaneously. FROM and neurovascularly intact to (B) UE and LLE. ROM to ankle of RLE limited 2° ex fix. Edematous, RLE has FROM and neurovascularly intact. Pin sites to (R) LE are CDE and open to air. (R) IV access. — [redacted]
31 July 03 1300	- Received pt Alert resting in bed. (-) c/o pain or discomfort. Lung sounds are clear Bilateral. BS x4. Pt has (+) ROM to (R) ex-fix leg. CAP Ref 2 secs. Skin is Dry & warm. Pin site is clear of infection and open to air. Sutures to entrance & exit wound on (R) Ankle remain clear of s/s of infection. 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: *(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

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

PROGRESS NOTE
~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~
Medical Record

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

(b)(6) -2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 Jul 03 23:25	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (L) ankle VS WNL per flow sheet. Awake and alert in bed. Skin W/D. LCA (B). BS (+) x4. (+) PP (B) (R) thumb sutures OTA & s/s infection (R) LE ex-fix intact. Pin sites & s/s infection. Wounds to ankle c̄ sutures OTA & s/s infection. (+) Com (+) <3sec cap refill (+) sensation to digits (R) foot. c/o pain @ this time will cont. to mon. [redacted] DLT/AN
1 Aug 03 0700	Assumed pt. care @ 0500. VSS. A+Ox3. Lungs CTA. (+) BS x4. (R) thumb sutures intact. Ex-fix to (R) leg intact, (+) sensation + movement below site. Ø Complaints @ this time [redacted] /AN
1400	Pt stable. AAOx3. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender. Bowel sounds active x4 quads. Brisk cap refill and strong pulses x4 extremities. Sutures to (R) thumb open to air, CDI. (R) LE ex-fix intact. pin sites CDI. Ø Complaints [redacted] /AN
01 Aug 03	Rec'd c/o patient @ 21:00. Pt c̄ restraints x2 (L) wrist (R) ankle VS WNL per flowsheet. pt. awake and alert. Voicing concerns about (R) leg amputation to interpretter. Concerns addressed. Skin W/D. PERRLA WNL. LCA (B). BS (+) x4 (+) PP (B). HR reg S1S2. Sutures to (R) thumb OTA & s/s infection. (R) LE ex-fix in place. Sutures to wounds @ inner and outter aspects of ankle OTA & s/s infection. Pin sites OTA & s/s infection. (+) Com (+) <3sec cap refill (+) sensation to (R) foot digits. & c/o pain @ this time will cont. to mon. [redacted] DLT/AN

All (b)(6)-2 except where noted.

NSN 7540-00-634-4178 600-108

HEALTH RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 August 03 0830	Pt. VSS. HR Regular, Lungsounds clear bilat, bowel sounds (+) x4 quad. Pt. ∅ IV access. Insertion sites of (R) LE ext fix ∅ s/s of infection, leg ↑ on folded blanket. Skin on (R) LE from ankle down to toes ∅ erythema ↑ temp, pedal pulse palpable, (+) sensation, limited ROM. Pt. ∅ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] /A
2 Aug 03 1800	Assumed care @ 1300, VSS no c/o pain @ this time - pt. did own pin care, sites ∅ s/s infection - 2 sutures removed from (R) thumb, site intact - 3 sutures removed from incision on (R) lower skin, wound healed, edges remain closed - pt. applied lotion to (R) leg 2° to dry skin [redacted] WNL to (R) foot, 1st & 2nd toenails black redness remains on 1, 2, 3 & 5th toes [redacted] R.A.
2 ~~Jul~~ Aug 03 02:22	Rec'd c/o pt. @ 21:00. VS WNL per flow sheet. Restraints x2 (R) wrist (L) ankle. Awake and alert in bed. PERRLA WNL. LCA (B) HRR S1 S2. BS (+) x4. (R) thumb ∅ s/s infection. (R) LE ex - site intact. Pin sites OTA ∅ s/s infection. Wounds to ankle ∅ s/s infection. (R) foot remains slightly darker in color than rest of leg. (+) sensation (+) ROM (+) <3 sec cap refill to (R) foot digits c/o pain x1 Tylenol given. will cont. to mon. [redacted] /AW

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

MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

ICW2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

(b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2Aug03 2235	Tylenol ī offered to pt. for pain management. Pt. refused tylenol stated "521". Pt. received nothing [redacted]
3Aug03 0226	Pt. c/o pain x 2 ii Tylenol given. Pt. accepted pain med. ō difficulty [redacted] 2LT/AN
3Aug03 0630	Pt. asleep in bed easily aroused by verbal stimuli. HR Regular, lungsands clear bilat, bowel sands (+) x4 quads. Ext fix to (R) LE intact ↑ on folded blanket, insertion sites ō s/s of infection. On (R) foot from ankle down skin is red, slightly swollen & very warm to the touch. Pt. ō complaints @ this time. No IV access. All other assessm findings WNL. Will continue to monitor. [redacted] /AN
1110	Pt. c/o pain, ii tylenol given — Cf
3 AUG-03 1300	Received pt Alert + sitting in bed ō (-) c/o pain or discomfort. VSS. Breath sounds clear bilateral. BS x 4 PT has (+) clam to (R) ex. fix. leg. CAP ref +2 seconds. (-) s/s of infection noted. skin is warm + Dry. PT has (-) IV access. Will cont to monitor PT. UAEWR Cpl —
2139	Pt. care assumed @ 2100. VSS HR Reg, lungs CTA, BS (+) x 4. Ex-fix (R) LE intact. Pin sites ō s/s infection. (R) ft ō (+) sensation, (+) ROM, pulse 2+. will cont. to monitor. — [redacted] /AN
4Aug03 0600	Pt. VSS. HR Regular, lungsands clear bilat, bowel sands (+) x4 quads. Ext fix to (R) LE intact, insertion sites ō s/s of infection. (R) foot from ankle down skin is red, slightly swollen & very warm to the touch, pedal pulse palpable, limited ROM in digits. Pt. ō complaints @ this time. All other assessment findings WNL. Will continue to monitor. — [redacted] 2LT/AN
4Aug03 2100	VSS. no c/o pain — neurovs WNL in (R) foot — [redacted] AN

All (b)(6)-2 except where noted

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
04Aug03 2357	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (L) ankle. VS WNL per flow sheet. Aware and alert in bed. Skin WD. PERRLA EOMI. LCA (R). HRRS, SR. BS (+) x4. (R) LE ex fix in place pin sites ≅ s/s infection. (+) com (+) sensation (+) PPP (R) (+) <3sec cap refill to (R) digits c/o pain x1 ii Tylenol given will cont. to mon. [redacted] /AO
5Aug03	0515 Assume pt care @ 0500. pt sleeping easy to awake. No c/o pain. VSS. HR reg Lungs CTA Abd soft non tender BS x4 RLE ex-fix intact. (+) movement (+) pulse (+) sensation below ex-fix. Elevated @ this time. Will continue to monitor [redacted]
5Aug03 2020	assumed care @ 1300 - VSS - pt. wants to return to EPW camp - X ray of (R) ankle done as requested, pt. to have ex fix removed and cast placed in next few days - pt. has cut on (L) foot due to trip on the way to X ray suite - medicated for pain c tylenol 200 @ ~1930, good relief [redacted]
5Aug03 2205	Pt care assumed @ 2100. VSS, c/o pain in R BKA. Lung sounds CTA, pulses + x4, BS (+). Dsg on R BKA c/d. Pt ambulated x 10 minutes this shift. Pt npo c surgery in am, to return to epw camp in 48 hrs. Will continue to monitor. [redacted]

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

SS [redacted] EPW [redacted]

(b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 12524

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 August 03 0600	Pt. awake & alert in bed. New IV placed in (R) FA for surgery this AM for removal & casting of ext fix. Pt's been NPO since MN. HR Regular, Lungsounds clear bilat, bowel sounds (+) x 4 quads. Insertion sites to (R) LE ext. fix ∅ s/s of infection, pedal pulse palpable, limited ROM in digits, erythema noted gromanhle down. Pt. ∅ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] LT/A
1130	Pt. back from OR via litter. VSS [redacted] b(6)-2 [redacted]
1200	IV D/c'd. [redacted]
6 Aug 03 1400	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quad. Strong pulses and brisk cap refill x 4 extremities. Cast from toes to groin on (R) leg. ∅ complaints. Ambulated on crutches to PT today. b(6)-2 [redacted] LT/A
6 Aug 03 2140	Pt care assumed @ 2100. VSS, alert and aware, ∅ c/o pain @ heel on rle. lung sounds CTA, pulses (+) x4, BS x4. Cast on rle CDI, (+) cap refill and able to wiggle toes. Pt to be discharged in AM, summary and orders written. b(6)-2 [redacted] Jumme
7 Aug 03 0525	Assume pt care @ 0500. Awake and alert. c/o pain mostly located @ (R) knee. ~~and p~~ Cast to RLE intact. (+) movement (+) sensation to toes. VSS. HR reg Lungs CTA Abd soft BSx4. Percocet for pain. Plan for discharge today. [redacted] b(6)-2

NSN 7540-00-634-4176 600-108

HEALTH RECORD progress ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ notes

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7Aug03 1340	assumed care @ 1300 - VSS - no c/o pain @ this time - <2 sec cap. refill in (R) toes, pt. can wiggle (R) toes, cast intact thigh to toes - pt. awaiting transport to EPW camp b(6)-2 [redacted] RAM
7AUG03 1600	Discharged to EPW Camp. Escorted by MT. Discharge summary x-rays & medications in possession. [redacted] b(6)-2

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

EPW

b(6)-4

[redacted]

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 12526

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

PATIENT ASSESSMENT [redacted] 7.3.0 PATIENT ASSESSMENT b(6)-2

TIME: 1700 SIGNA[redacted] TIME: 0500 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES	SKIN AND MUCOUS MEMBRANES
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature warm	Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced NPR	Color: Pale / Cyanotic / Jaundiced appropriate for race.
Mucous Membranes: Moist / Dry / Cracked	Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:	Skin Breakdown: None Location: Size:
NEUROLOGICAL	**NEUROLOGICAL**
Loc: Alert / Lethargic / Unresponsive GCS:	Loc: Alert / Lethargic / Unresponsive GCS: 15
Orientated / Disoriented Pupils:	Orientated / Disoriented Pupils: 3mm brisk
Extremity Movement: Full / Limited / None cast on right leg	Extremity Movement: Full / Limited / None RLE cast moves toes
CARDIOVASCULAR	**CARDIOVASCULAR**
Pulse (0 - 4): +2 Radials +2 Pedals unable to assess	Pulse (0 - 4): Radials +2 Pedals Ø pedal +2 UTA @ pedal
Capillary Refill: <2 Seconds Homan's Sign ✓ Ø	Capillary Refill: <3 Seconds Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø cast	Jugular Venous Distension Ø Edema Ø
Heart Sounds S1S2	Heart Sounds S1S2
Rhythm NSR PRI: QRS:	Rhythm NSR sinus PRI: QRS:
Vascular Catheter Central Arterial Peripheral 1 Peripheral 2	Vascular Catheter Central Arterial Peripheral 1 Peripheral 2
Waveforms	Waveforms
Site FA NS @125cc/hr	Site RFA CR
Solution	Solution
Chest Pain Ø	Chest Pain Ø
RESPIRATORY	**RESPIRATORY**
Chest Expansion / Symmetrical / Asymmetrical	Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles	Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: even	Breathing Patterns: even
Cough: Productive / Nonproductive / None	Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor	Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Suction cm:	Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus	Air Leak No Yes Crepitus
Character of Drainage:	Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)	Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:	Artificial Airway Size: Type: Position:
Breath Sounds / Anterior/Location / Posterior/Location	Breath Sounds / Anterior/Location / Posterior/Location
Crackles	Crackles
Wheezes CTA-B	Wheezes CTA Bilat
Diminished	Diminished
Absent	Absent
GASTROINTESTINAL	**GASTROINTESTINAL**
Abdomen: Soft / Firm / Hard / Distended cm Girth	Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: RLE cast C/D/I	Dressings: RLE C/D/I
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character	NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:	Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character	Stool: Character
Drains:	Drains: NPO denies N/V/D.
GENITOURINARY	**GENITOURINARY**
Urine Color: clear yellow Character:	Urine Color: amber Character: clear
Voiding: Continent / Incontinent / Catheter	Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL	**EMOTIONAL/PSYCHOSOCIAL**
OTHER: dsg to R thumb C,D,+I	OTHER: C/D/I dressing RLE

03 Jul 03

EPW # [redacted] b(6)-4

Date 4/[illegible]

b(6)-2

PATIENT ASSESSMENT

ME: 4/[illegible] SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

: Loose / Tight / Diaphoretic / Shiny / Dry

: Temperature 99.6

: Pale / Cyanotic / Jaundiced WNL

us Membranes: Moist / Dry / Cracked

Breakdown: None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS:

tated / Disoriented Pupils:

nity Movement: Full / Limited / None [illegible]

CARDIOVASCULAR

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

ary Refill: 2 Seconds Homan's Sign

r Venous Distension Edema

Sounds RSR

n PRI: QRS:

ar Catheter	Central	Arterial	Peripheral 1	Peripheral 2
orms			[redacted]	
			[illegible]	
n				

Pain

RESPIRATORY

xpansion Symmetrical / Asymmetrical

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

g Patterns: Reg

Productive / Nonproductive / None

: Color / Amount / Consistency / Odor

rainage System Gravity: Suction cm:

No Yes Crepitus

er of Drainage:

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

Airway Size: Type: Position:

th Sounds	Anterior/Location	Posterior/Location
	Ess. CTA	
ed		

GASTROINTESTINAL

: Soft / Firm / Hard / Distended cm Girth

unds: Normal / Hyperactive / Hypoactive / Absent

:

Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

age: Color Character

ding: Day No: Strength: Rate: Aspirate:

aracter

GENITOURINARY

Color: Character:

Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Appropriate

PATIENT ASSESSMENT

ME: 1750 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None Casts L Leg

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			LAC HL	
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	CTA	B
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: yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

EPW [redacted] b(6)-2

3 141 DATE 5-3-

PATIENT ASSESSMENT

E: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature 96.5

Pale / Cyanotic / Jaundiced

Membranes: Moist / Dry / Cracked

eakdown: None Location: Size:

NEUROLOGICAL

er / Lethargic / Unresponsive GCS:

ed / Disoriented Pupils:

y Movement: Full / Limited / None RFALLP CAST

CARDIOVASCULAR

) - 4): ✓ Radials Pedals

Refill: 73 Seconds Homan's Sign

Venous Distension Edema

unds 2-3-2

PRI: QRS:

Catheter	Central	Arterial	Peripheral 1	Peripheral 2
ns			[redacted]	
			R Hand	
			20 g HL	

ain

RESPIRATORY

pansion / Symmetrical / Asymmetrical

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

Patterns:

roductive / Nonproductive / None

Color / Amount / Consistency / Odor

nage System Gravity: Suction cm:

No Yes Crepitus

of Drainage:

Midline / Deviated (R) / Deviated (L)

rway Size: Type: Position:

Sounds	Anterior/Location	Posterior/Location
	CTA B	

GASTROINTESTINAL

Soft / Firm / Hard / Distended cm Girth

ds: Normal / Hyperactive / Hypoactive / Absent

lamped/Inter. Suction/Cont. Suction/Dependent Drainage

e: Color Yellow Character Clear

g: Day No: Strength: Rate: Aspirate:

acter

GENITOURINARY

lor: Character:

ntinent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

PATIENT ASSESSMENT b(6)-2

TIME: 1730 SIGNATURE: [redacted] /AW

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature 97.8

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: dsg to (R) leg and (R) thumb

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

upper and (R) lower CARDIOVASCULAR (R) Leg splint

Pulse (0 - 4): 2+ Radials (R) Not Pedals (L) 2+

Capillary Refill: < 3 Seconds Homan's Sign

Jugular Venous Distension Edema Ø edema

Heart Sounds S1 S2 present

Rhythm S Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms			[redacted]	
Site			(R) hand	
Solution			20g HL	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: even & unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor none

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage: none noted

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: (R) thumb & (R) Lower extremity

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

NG Drainage: Color Yellow Character clear Jiz and

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

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent /

ASK

EPW [redacted] b(6)-4

b(6)-2

DATE: 6 July PATIENT ASSESSMENT [redacted] PATIENT ASSESSMENT

TIME: 1720 SIGNATURE: [redacted] TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES	SKIN AND MUCOUS MEMBRANES
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 98°	Skin: Temperature 98.0
Color: Pale / Cyanotic / Jaundiced Normal for Race	Color: Pale / Cyanotic / Jaundiced N/R
Mucous Membranes: Moist / Dry / Cracked	Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: due to R blog & R thumb	Skin Breakdown: None Location: Size:
NEUROLOGICAL c X-fix	**NEUROLOGICAL**
Loc: Alert / Lethargic / Unresponsive GCS:	Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: 3mm Perrla	Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None Lower (R)	Extremity Movement: Full / Limited / None BKFN (R) Ankle
CARDIOVASCULAR	**CARDIOVASCULAR**
Pulse (0 - 4): 2+ Radials 2 Pedals (L) 2+	Pulse (0 - 4): 2 Radials 2 Pedals 2
Capillary Refill: Seconds Homan's Sign	Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema Ø edema	Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 S2 present	Heart Sounds S1 S2 RUSB
Rhythm SR 80 to ST 100s PRI: QRS:	Rhythm PRI: QRS:
Vascular Catheter Central Arterial Peripheral 1 Peripheral 2	Vascular Catheter Central Arterial Peripheral 1 Peripheral 2
Waveforms [redacted]	Waveforms [redacted]
Site (R) Hand	Site (R) HAND
Solution NS (R) 100cc/hr	Solution NS KL
Chest Pain	Chest Pain Ø
RESPIRATORY	**RESPIRATORY**
Chest Expansion / Symmetrical / Asymmetrical	Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles	Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: even and unlabored	Breathing Patterns: = + unlabored
Cough: Productive / Nonproductive / None	Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor none	Sputum: Color / Amount / Consistency / Odor None
Chest Drainage System Gravity: Suction cm: none	Chest Drainage System Gravity: Ø Suction cm:
Air Leak No Yes Crepitus	Air Leak No Yes Crepitus
Character of Drainage: none noted	Character of Drainage: None
Trachea / Midline / Deviated (R) / Deviated (L)	Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:	Artificial Airway Size: Type: Ø Position:
Breath Sounds / Anterior/Location / Posterior/Location	Breath Sounds / Anterior/Location / Posterior/Location
Crackles CTA bilat	Crackles
Wheezes	Wheezes
Diminished	Diminished CTA-B
Absent	Absent
GASTROINTESTINAL	**GASTROINTESTINAL**
Abdomen: Soft / Firm / Hard / Distended cm Girth	Abdomen: Soft / Firm / Hard / Distended ND cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: (R) thumb & (R) leg	Dressings: (R) thumb (R) leg
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color yellow Character clear viscous	NG Drainage: Color Ø Character
Tube Feeding: Day No: Strength: Rate: Aspirate:	Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character bedside urinal	Stool: Character Ø
Drains:	Drains:
GENITOURINARY	**GENITOURINARY**
Urine Color: Character: see above	Urine Color: yellow Character: clear
Voiding: Continent / Incontinent / Catheter	Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL	**EMOTIONAL/PSYCHOSOCIAL**
OTHER: VSS will continue to monitor	OTHER: VSS A&Ox3

[redacted]

EPW [redacted]

b(6)-4

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: 27

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: S/p GSW (R) leg x Chest wound.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ancef, MSO4, Percocet

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	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. o. 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. 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. ø Address pt. from either 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.	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] (SPT UN) b/w-2 3 July 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 Ti[redacted] Tub(w)-2
DATE: 2 Jul 03 TIME: 0955

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) Steff[redacted] CPT UN
DATE: 3 July 03 TIME: 1324 b/w-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12532 USAPA V1.0

MEDICAL RECORD

INTRAOP[illegible]IVE 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: Cart BY Anesthesia

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

3. DATE 3 July 03 TIME PATIENT ARRIVED IN SUITE 1205

4. PATIENT IN ROOM TIME 1205 NUMBER 1-1 | 7

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] 1240-1300 1LT [redacted] (1300)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: proper body alignment maintained, 2 armboards used for (R) arm positioning position approved by surgeon + anesthesia

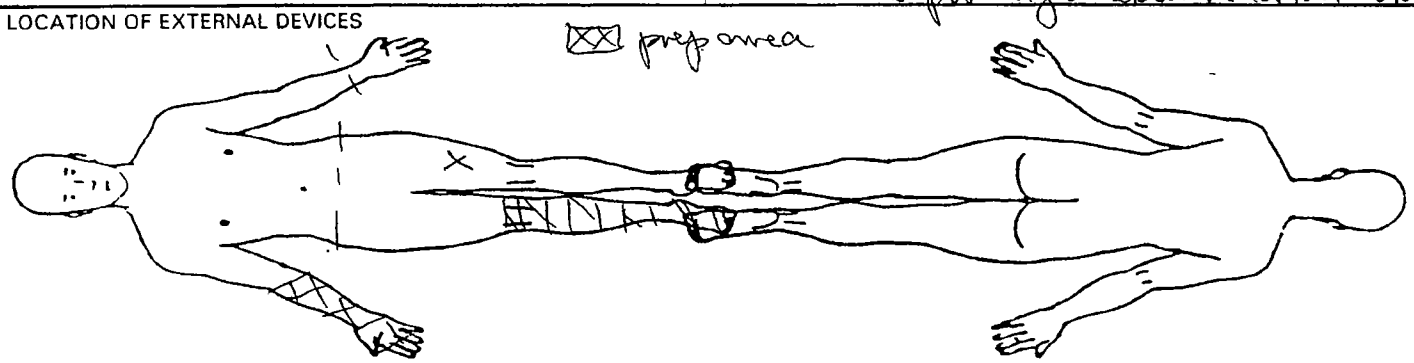
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta/Beta b(6)-2
SITE (R) arm to elbow BY WHOM: CPT [redacted]
SITE: (R) Leg to knee BY WHOM: CPT [redacted]

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB b(6)-2	CIRCULATOR
Sponge	☐ Yes	☐ No				PFC [redacted]	1LT [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]
ICU-1 b(6)-4

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

☐ ESU NO: Valleylab Force 2 # 4
GROUND PAD: BRAND Valleylab Rem Polyhesive II
LOT NO: 65706 2004-11

☐ 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 Normal

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Iodoform Gauze	2.	3.
SITE	1. Left ankle	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Acewrap
(R) thumb — Xeroform 2x2 tubegauze

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

I&D Right ankle & (R) thumb

21. PATIENT TRANSFERRED TO ICU-1 b(6)-2 | TIME Sep DA7389 | METHOD Litter c Saline

22. REGISTERED NURSE SIGNATURE Steff[redacted] RTAN

REVERSE OF D[redacted] USAPA V1.01

MEDICAL RECORD | **INTRAOP[illegible]IVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY OR staff

2. PATIENT IDEN[redacted]D AND PROCEDURE VERIFIED BY [redacted] b(6)-2

3. DATE 6 Jul 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM [redacted] TIME 0600 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO pMN

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Mg [redacted] 66E	RELIEF CIRCULATOR	ILT [redacted] 66E (0715)

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt placed — on bed. arms on arm boards <90° strapped. Strap across midline. Warm blanket used.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

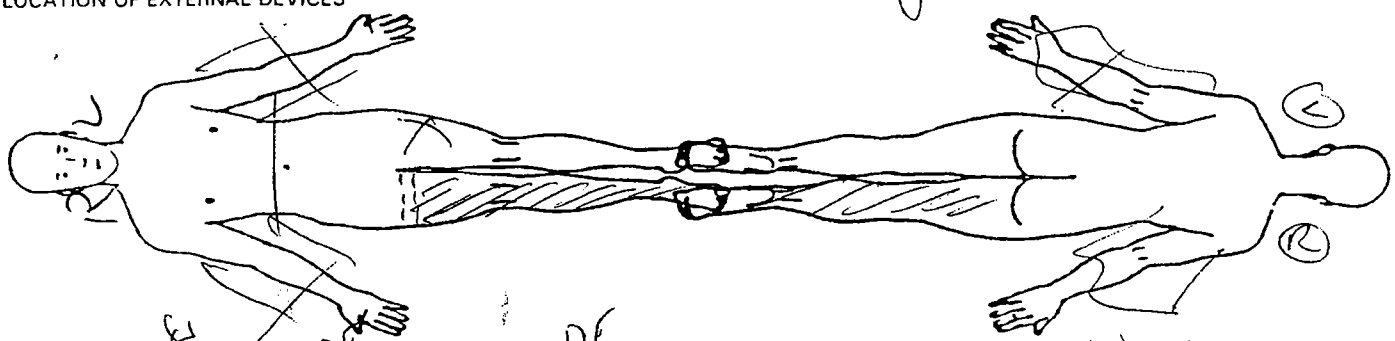
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: Right leg BY WHOM:

SITE: BY WHOM: DELAHZ AN

COMMENTS: Ø pooling of solution nb

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	ILT [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 30/30

☒ ESU NO: VL#

GROUND PAD: BRAND VL Rem Poly II

LOT NO: 65704

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12535

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

Stryker Howmedica
Hoffman II Load # 0618701

5018-6-180 x 2
5023-5-150 x 2

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPE[redacted]
YES ☒ NO ☐ IF YES, SITE
C-Arm of Rt ankle

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			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION

Cherry Albertson

geta

DA 5179 In Chart.

20. OPERATION(S) PERFORMED

External fixator application to Rt tibia

21. PATIENT TRANSFERRED TO ICU 1 b(6)-2 TIME 0809 METHOD litter 2 O2

22. REGISTERED NURSE SIGNAT[redacted]

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

MEDICAL RECORD | **INTRAOF ... E DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA BY litter

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/ANb (6)-2

3. DATE 6 AUG 03 TIME PATIENT ARRIVED IN SUITE 0908

4. PATIENT IN ROOM TIME 0908 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

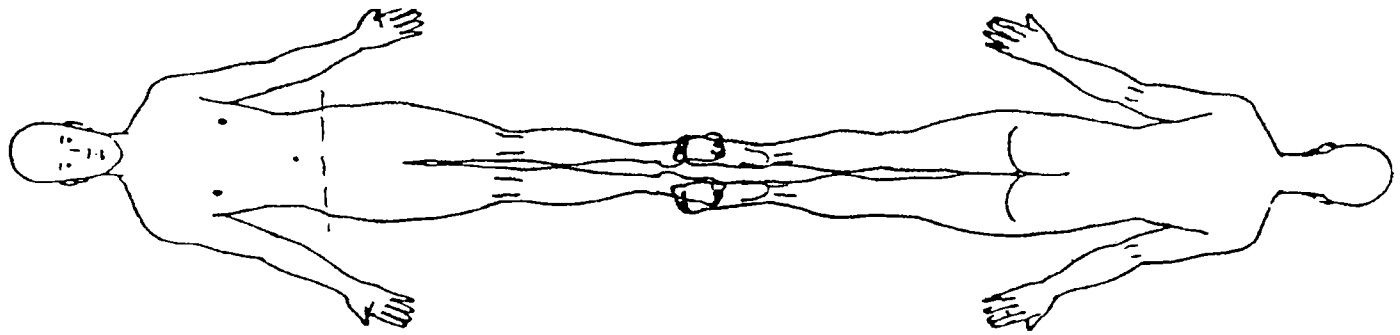
COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine prep sticks
SITE: (R) lower Leg BY WHOM: Meyer
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☑ No					
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: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ 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):

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE C-Arm – Rt. lower leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2
Kerlix
Webril
Fiberglass cast

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] bb-2 Anesthesia: Albritton Anesthesia Type: Sedation

Bovie Pad site intact pre-op —; post-op — Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op _____: post-op_____
Tourniquet Time: Up____ Down_____

20. OPERATION(S) PERFORMED

Removal of Ex-fix Rt. lower leg
Application of Rt. Long Leg Cast

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1110	Litter

22. REGISTERED NURSE SIGNATURE [redacted] PT/AN

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 CPT [redacted] b(6)-2

3. DATE 9 July 03 TIME PATIENT ARRIVED IN SUITE 0823

4. PATIENT IN ROOM TIME 0823 NUMBER 21 | 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: no changes from previous 5179 nkda s/p I+D (R) ankle + (R) thumb

6. NURSING PERSONNEL

ASSIGNED SCRUB	SP [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

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

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

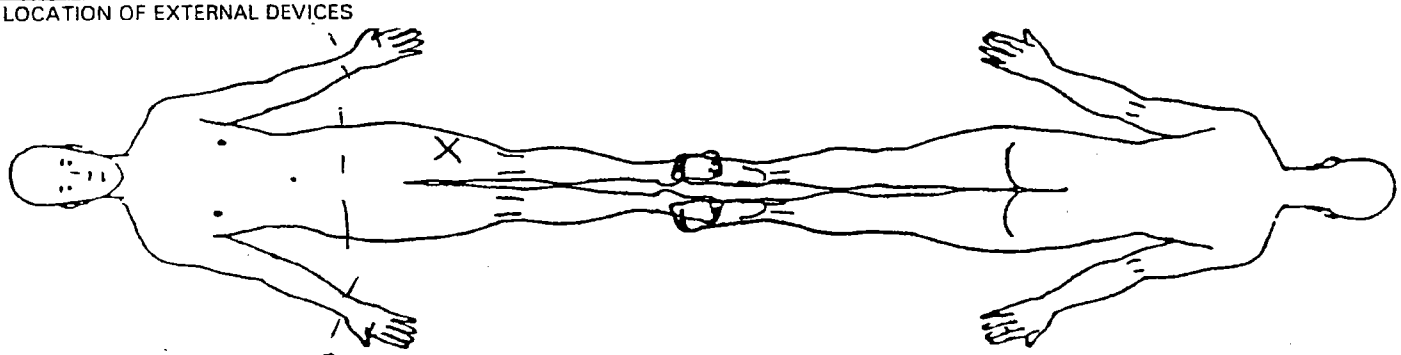
PREP SOLUTION *(Specify)* ~~Betadine~~

SITE: (R) BY WHOM [redacted]

SITE: N/A BY WHOM: b(6)-2

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

ICW-1

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

☐ ESU NO: Valleylab Force 2 #2

GROUND PAD: BRAND Valleylab Ram Polyhesive II

LOT NO: 65706 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Ace wrap

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

20. OPERATION(S) PERFORMED
I+D (R) ankle / foot, Dressing Δ

21. PATIENT TRANSFERRED TO
ICU-1 b(6)-2
TIME See DA7389
METHOD Litter

22. [redacted] NURSE SIGNATURE
[redacted] CPT 1 d N

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		7-2-03											
POST-	DAY												
MONTH-YEAR	DAY	01											
19	HOUR	0400	0800	1200		1600		2000		2400			

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

	16	16	16		16		16	16	16	16	16	16	16
		97.8			97.7		120/80	120/80	120/80	120/80	120/80	120/80	120/80
SaO2	97%	95% RA	95% RA		93% RA		98%	98%	97%		98%	99%	98%
IN		500	500		500								
out		800	700		500								

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

REGISTER NO.

WARD NO. ICW2

EPW [redacted] b(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: 10

POST-OPERATIVE DAY: 10

MONTH-YEAR: July 2003

DAY	15	16	17	18	19	20	21
HOUR	9	9	9	9	9	9	9

PULSE (0) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

	15	16	17	18	19	20	21
	120/70	118/78	124/82	132/86	128/80	128/78	118/70
	120/80	120/80		130/80	124/72	118/68	120/60

HEIGHT: WEIGHT →

	15	16	17	18	19	20	21
	99%	98%	98	98%	97%	98%	98%

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. 5CW 2

STANDARD FORM 511 (REV. 7–95) BACK

EPW [redacted] b(6)-4

Date [redacted] Bed # 2

Patient's Name: 3 July

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		104/51				107/62						99/56												
TEMP		96.5										98.7										97.3		
HR		102				108						60										96.3		
RR		13				12																16		
SAO2																						14		
FIO2																						98		
																						RA		
INPUT																								
PO																								
IV PB					100																			
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT		200			450	300																		
URINE																								
NGT																						400		
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 12543

500 NS
QUO
Long w PAGE 1 OF 12.5

DATE	DX													HOSPITAL DAY				
VITAL SIGNS TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	16
BP Arterial Line																		
BP Cuff			112/65				111/64			116/73	117/64	116/63	125/71		131/73	125/70	114/62	118/59
Temperature							98.7								97.5			
Pulse			65				57			58	57	57	65		97	99/70	71	88
Respiratory Rate			12				12			14	12	14	14		12	8	16	9
			96				96			96	96	96	97		95	94	93	93
			RA				RA			RA	RA	RA	RA		RA	RA	RA	RA
pain																		
intervention																		

INTAKE TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	16
LR	125/100	125/118	125/250	125/175	125	125	125	125		125	125	125	125		125	125	125	125
ABX							50											
TOTALS																		16

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	16
URINE					600			800 / 800				525			600					
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

AY

	17	18	19	20	21	22	23	
		125/60				110/68		
			99.1			98.5		
		72				68		
		19				14		
		96%				94%		
		RA				RA		
				162				
				[redacted]				
	17	18	19	20	[redacted]	22	23	8° T
	125	125/250	125/375	125/500	125/625	125/750	125/875	500
PO		300	300	240	240		240	1320
				milk	milk		milk	
50								
140								
180								
6								
1320								
			450		400			950

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME									
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME									
SUCTION										

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE

[redacted]

b(6)-2

POST-OP DAY

V	16	17	18	19	20	21	22	23	
BP	1	107/37							
T	97°	97°							
P	69	69							
R									
SPO2	98	98							
S									
I									
G									
N									
S									

I	16	17	18	19	20	21	22	23	8° T
N									
T									
A									
K									
E									
		200							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	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	NURSE'S SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____		
INTAKE: IV _____ po _____ _____ TOTAL _____	OUTPUT: Urine: _____ _____ _____ TOTAL _____	
BALANCE _____		

4/4/03

Date 04/4/03 Bed # 2

Patient's Name EDW[redacted]

b(6)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	125/64	106/64	124/62	117/71	120/64	102/61	123/66	125/75	113/69	120/71	116/69	120/73			112/69			100/76		112/59		109/65		108/63
TEMP	98.2	97.1	97.2	98.4	97.9	97.9	97.6	97.5	97.9	97.7	97.9	97.5								98.5				
HR	78	77	62	89	69	79	81	79	70	77	83	81			82			72		74		76		78
RR	14	12	15	21	16	15	17	18	12	14	21	20			20			18		16		16		18
SAO2	94	95	96	95	98	99	95	94	95	93	96	95			96			94		97		96		96
FIO2	RA														RA			RA		RA		RA		RA
INPUT																								
PO				240								450	720											
IV		50				100				50	~~150~~		300											
~~NGT~~																								
TURN Q 2																								
												970												
TOTAL																								
OUTPUT															400		400		400					
URINE	100				600				400			800	2300							700				
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 12547

Bed #2 EPW # [redacted] b(6)-4 DATE 04 April 72

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			[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 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

OTHER:

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			[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 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

OTHER:

EPW [redacted] b(6)-4

Date 7 July [redacted] Bed # 2

Patient's Name: [redacted]

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																123/66				118/64				110/60
TEMP	-																							
HR																75				81				68
RR																14				16				14
SAO2																96%				95%				96%
FIO2																RA				RA				RA
INPUT																								
PO													240											
IV																		100						
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT																~~400~~ 400						400		
URINE																								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 12549

b(6)-2

DATE: PATIENT ASSESSMENT [redacted]

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None Cast L/ Arm on right leg

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +1 Pedals 0

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			R Hand IV	
Solution			LAC IV	

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	CTA	B
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: none

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: yellow Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

b(6)-4

PATIENT ASSESSMENT [redacted]

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			[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 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

OTHER:

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY	7/8/03													
MONTH-YEAR	DAY		24	00	01	00									
19	HOUR	2000													

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 17 16

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

	7/9					7/10						7/11					
TIME	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16	20	24
BP Arterial Line	122/	127	129				129/		125/80	112/	119/	114/					
BP Cuff	90	69	66				/69		/80	71	66	65	119/65	125/70	115/75		
Temperature	99.0	98.9	99.0				98.9			98.0			98.2	98.4			
Pulse	68	77	82				87		72	91	67	72	90	90	85		
Respiratory Rate	20	20	22				18		20	18	14	16	16	20	20		
Spo2	97%	98%	99%				98%		98%	98	97	98	97	98	98		
Source	RA	RA	RA	RA			RA		RA	RA	RA	RA	RA	RA			
pain intensity	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16	20	24
INTAKE TIME																	
PO	250	150	200				100	200	200				100				
IV (XH)	125	125	HV				HL	HL	HL			I	HL				
IVPB	200	100					300	100					100				
													100				
TOTALS	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16	20	24
URINE HOUR	425	400	400				425	300	60				250				
URINE TOTAL																	
URINE sp gr																	
URINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL									X1								
DRAINS																	

70mg Ketamine
2.5 versed
150 mic fentanyl

400cc LR
MVBC

in OR 7/hr

		P	R	SpO2	
0845	128/70	70	18	97%	T 98.8
0855	119/59	67	19	97%	
0900	122/66	70	16	95%	
0905	121/61	70	9	98%	

[redacted]

[redacted]

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug/03 DAY 2-3 3-4 4-5 5 6 7 8

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

O_2 sats →

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. PW2

EPW

#[redacted]

b(6)-4

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

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 26, 27, 28, 29, 30, 31, August 1

19 | HOUR

PULSE (O) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW

EPW [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(6)-2

Ward/Section: BMT

REQUESTING PHYSICIAN: [redacted]

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 1 Jul 03 TIME: 2300

SSN/PATIENT ID NO. SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		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	81	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	97	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	25	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: 1/Jul/03

LAB ID NO.:

	5 July								6 July								7 July	
	DX													HOSPITAL DAY				
TIME	20	24	04	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16
Arterial Line	106/	94/	107	139	129		144/	132	119/	112	119	114						
Cuff	66	58	61	67	68	80/70	85	73	71	62	67	61						
Temperature	98.1	98.3	97.6	95.5	99.2		97.8	97.6	97.5	98.0	97.7	97.7						
Pulse	59	51	62	102	77	100	89	75	65	57	79	83						
Respiratory Rate	16	14	14	15	19	20	16	16	14	11	14	13						
Sat	97	96	96	99	98		96	96	97	95	98	98						
Infusion																		
TIME																		
TOTALS																		
URINE HOUR	500	500		1000	400		1300	350	1600	150	350	220						
URINE TOTAL	600	1000		1600	2200		3500	3850	5550									
URINE Sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

79
102
95.3

EP [redacted]

b(6)-2

b(6)-2

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

LAST, FI[redacted] | DATE: 1 July 2000 | TIME | SSN/PSEUDO SSN: [redacted]

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		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	81	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	97	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-2

d/Section: ZMT

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

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

ST, FIRST MI: [redacted] b(6)-4

DATE: 4 Jul 03 TIME: 2300

SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

EST	RESULT	REF. RANGE
C		4.8-10.8 x 10^3
C		4.7-6.1 x 10^9
)		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
V		80-94 fl (M) 81-99 fl (F)
		130-500 x 10^3 verified
ıph %		20.5-51.1%

Hematology) Manual Differential

s		Mono	
ds		Eos	
ıph		Baso	
p		Imm	
ph			

n ıatocrit		42-52% (M) 37-47% (F)
Rate		
er		

Coagulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
imer		<20 ug/ml
)		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	hazy	N/A
Glu	n	Negative
Bili	n	Negative
Ket	n	Negative
SG	1,020	N/A
Bld	n	Negative
pH	5.0	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

MARKS:

PORTED BY: [redacted] b(6)-2 DATE: LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS		
DRUG	(units)	
versed	(mg)	2.5
MSO4	(mg)	4 2/4
propofol	(mg)	150
phenergan	(mg)	12.5
	( )	
	( )	
VOLAT AGENT: Iso	% del	1.5 1.5 2.5-2.0-2.5 0.8 x
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6-2-2-2-2-2 2-6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS (1) (2) (3)

TOTALS	
2.5	
10	

TOTAL ANES: min

TOTAL URINE: NM

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– Ø

BLOOD– Ø

FLUIDS		
LINE site 20g LFA	☐ Warmed	60001 — 500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	
	URINE –	

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

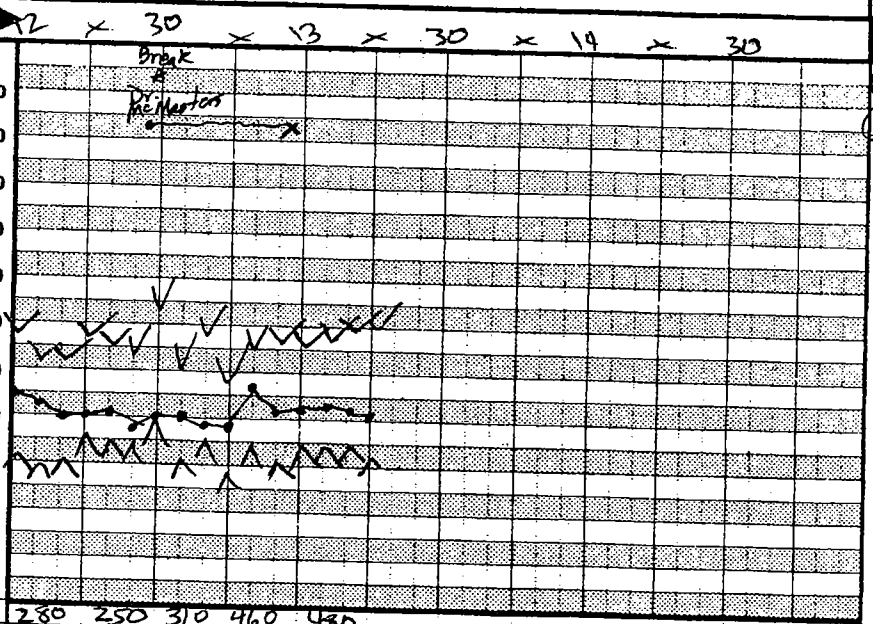
HEMATOCRIT: —

INITIAL DATA: BP – 117/63 HR– 90

EQUIP CHECK: OK? – (Y) N

PATIENT ID CHECK: OK for PROCEDURE? Y TIME– 1130

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



REMARKS – Code drugs with numbers, events with letters

Pt & chart ✓. OK to proceed.
(1) T. room, SOC monitors, pre O2.
(2) Smooth IV indx
(3) To recovery stable.

VENTIL						
	VT – ml		280	250	310	460	480
	f – breaths/min		26	20	10	15	16
	Peak inf pres / PEEP						
	MODE– S(pon), A(ssist), C(on)		S	S	S	S	S
MONITORS & ACCESSORIES	BP/Auto Cuff	ET CO2 (torr)	36	35	42	39	40
	BP / oth	FIO2 (Frac or %)	0.7	0.7	.7	.7	0.7
	ART line	SpO2 (%)	99	99	99	100	100
	Steth- PC/ES	ECG	SR	SR	SR	SR	SR
	Gas analyzer	TEMP- site available					
		N-M Block (T/4)					
	Warming blkt						
	Conv warmer						

RECOVERY AT 1325

PACU (ICU) (Specify)

OTHER 975

CONDITION:

RESP– 16 SpO2– 95

BP– 131/72 HR– 98

ANESTHESIA / PROCEDURE TIMES			
ANES	Start	Room	End
	1150	1200	1330
PROC	Ready	Begin	End
	1205	1230	1320

Mark with letters & symbols, explain under REMARKS

EVENTS Position →

PROCEDURES and CPT Codes

(1) I&D Rt thumb
(3) I&D Rt ankle

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GM

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Eyes taped, #90A placed, easy mask

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

b(6)-4

EPW #[redacted]

27yrs old

NKDA

SURGEON [redacted]

ANESTHETIST [redacted] MAS, CRNA

PROCEDURE LOCATION 1-1

7/3/03

GSW (R) ankle + stab T (L) n and several da gr >10

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	Route	
Fentanyl	(mg)	<200> 50
MSO4	(mg)	<5> 2 1 1/1
Lidocaine	(g)	50
Propofol	(g)	150
Sux	(g)	80
UCB	(g)	5 2
VOLAT AGENT: ISO	% ed / % e.t.	1.5 1.5 1.0 1.3 1.2 1.0 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 2 2 2 4

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (3) (4)

FLUIDS		
LINE site 16G (L) A	☒ Warmed	LR #1 — 100 — 200
20G (R) HO	☐ Warmed	NS (500) — 400-500 / saline locked
	☐ Warmed	
Ancef 1gm	☐ Warmed	IVPB →

LOSSES	
EST BLOOD LOSS	
URINE –	

TOTALS	
250	
10	
TOTAL EBL	min
TOTAL URINE	Ø
FLUIDS – SUMMARY	
CRYSTALLOID –	700
COLLOID –	Ø
BLOOD –	Ø

REMARKS: Code drugs with numbers, events with letters

(1) Review of system Agree c̄ 2 JUL 03 assessment lungs
(5) 2 tsp pre-op.
(2) Room, monitor O2, induced & cycled taped
(3) Relief [redacted]
(4) Soft 3cf NA placed. Pt extub deep 5 diff: - recovery stable

PHYS STATUS	
1 (2) 3 4 5 E	
BODY WEIGHT	70 (KG) LB
HEMATOCRIT	—
INITIAL DATA	BP – 107/61; HR – 62
COMP CHECK	OK? – (Y) N
PATIENT READY	OK for PROCEDURE? JC; TIME – 0550

TIME → 0600 . 30 . 0700 . 30 . 0800 x 30 x 09

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

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

DATE WRONG — SEE REMARKS SECTION "AGREE c̄ 2 JUL 03 ASSESSMENT X LUNGS" (SO DATE CAN'T BE 6 JUN)

VT – ml	+	660	700	690	690	420	380	420	450
f – breaths/min	—	10	7	7	7	8	10	10	10
Peak inf pres / PEEP	—	20	20	21	21	—	—	—	—
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	S	S	S	S
✓ BP/Auto Cuff / ET CO2 (torr)	45	33	35	33	33	46	42	45	
✓ BP / oth / FIO2 (Frac or %)	0.71	0.71	0.71	0.71	0.70	0.88	0.89	0.89	
ART line / SpO2 (%)	100	100	100	100	100	100	100	100	
Steth – PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer / TEMP – site Nasal	—	97.2	—	—	—	—	—	—	
✓ N-M Block (T/4)	0/4	4/4	3/4	4/4	4/4 (train of four)	4/4	4/4 c̄		
✓ DS	+	—							
✓ Warming blkt / Conv warmer	Wool Blanket → x1 → → →								

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) — Position — 0 1

RECOVERY AT	
PACU (ICU) ___ (Specify)	
OTHER	95-3 9X
CONDITION:	
RESP – 24	SpO2 – 97%
BP – 136/67	HR – 110

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	0550	0600	0815
PROC	Ready 0608	Begin 0639	End 0800

PROCEDURES and CPT Codes: I+D + Ex Fix (R) Ankle

ANESTHETIC TECHNIQUES: (Describe block technique under Remarks) G-ETA

AIRWAY MANAGEMENT: (Intubation route, blade, technique, comments) DL x1 MAC 3 Grade 1 view. 21 cm @ lip 8.0 ETT stylette 10 ml air to cuff. + BBS + Sux ETCO2

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

EPW # [redacted]

b(6)-4

SURGEONS: [redacted] b(6)-2

ANES [redacted] MAJ [redacted]

PROCEDURE LOCATION: 2

DATE: 6 Jun 03

PAGE 1 OF 1

[redacted] MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12561

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

Smoker
27/m

MEDICAL RECORD - ANESTH

...use of this form, see AR 40-66; the proponent ... y is the OTSG

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

DRUG	(Units)	
MIDAZ	(mg)	5
FENT	(mcg)	50 100/100
Propofol	(mg)	30 TTE →
	( )	
	( )	
	( )	
VOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
MASK O2	L/Min	8 →

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

FLUIDS

LINE site (L) A	☐ Warmed	NS →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	MIN
	TOTAL URINE
	NA

FLUIDS SUMMARY

CRYSTALLOID- NS 100

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

0955 Pre Op EVAL
REVIEW → NO Δ
IV → (R) A
1004 OR #2 MONITORS ↑
O2/MASK

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

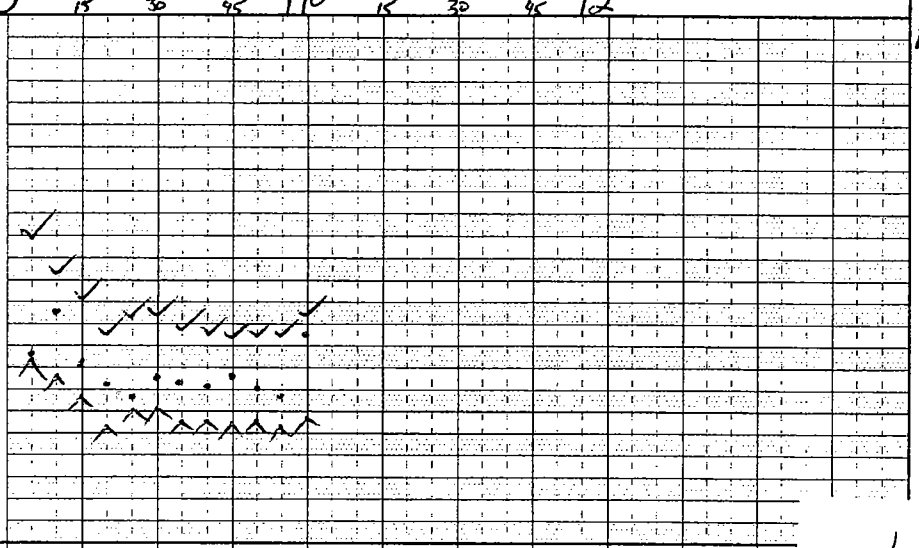
HEMATOCRIT:

INITIAL DATA: BP- 139, 84 HR- 86

EQUIP CHECK: (OK?) Y N

PATIENT RECHECK: (OK for PROCEDURE?) TIME-

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



6 AUG

VENTIL

	0900	15	30	45	1100
VT - ml					
f - breaths/min	16	8	8	10	12
Peak inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS/ACCESSORIES

		0900	15	30	45	1100
BP/Auto Cuff	ET CO2 (torr)					
BP/oth	FIO2 (Frac or %)	>.21	>.21	>.21	>.21	
ART line	SpO2 (%)	99	99	99	99	
Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP-site	AVAIL →				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS → *Position* 0 1

	Start	Room	End
ANES	0955	1004	1115
	Ready	Begin	End
PROC	1010	1015	1100

PROCEDURES and CPT Codes: Ex Fix Removal & Cast

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* LA & SED TTE = TITRATE TO EFFECT

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* NATURAL → O2 MASK

SURGEONS [redacted] b(6)-2

ANESTHETI[redacted]

PROCEDURE LOCATION: OR #2 28CSH

DATE: 06 AUG 03

PAGE 1 OF 1

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

MEDCOM - 12562

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG (Units)			
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML; "1"=CONSTANT INFUSION	Ketamine	10	<40> 10	10
	Midazolam	2	1.5	
	Fentanyl	100	<50> 50	50
		( )		
		( )		
		( )		
VOLAT AGENT		% del		
		% e.t.		
	AIR	L/Min		
	N2O	L/Min		
	O2 SFm	L/Min	10 10 10 X	
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶				

FLUIDS		
LINE site PIV(R)A	☒ Warmed	LR – #1
AnCEF Ign	☐ Warmed	FJPB →
	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	
	URINE –	

TOTALS	TOTAL FLUID
70	MIN
745	TOTAL URINE
150	Ø

FLUIDS – SUMMARY
CRYSTALLOID – 400
COLLOID – Ø
BLOOD – Ø

REMARKS –
Code drugs with numbers, events with letters
① Pre-op assess, mont & review of systems agree c Sylb pre-i
② Room, monitor. O2 Sedation TTE
③ Moved self to table + To ICU 1
④ Report to RA. Moved self to bed

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP – 130/70; HR – 68

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? JS; TIME – 0800

TIME → 0815 . . 0900 . 30 . 1000

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

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

VENTI				
	VT – ml	+	+	+
	f – breaths/min	20	20	20
	Peak inf pres / PEEP	—	—	
	MODE – S(pon), A(ssist), C(on)	S	S	S

MONITORS / ACCESSORIES				
BP/Auto Cuff	ET CO2 (torr)	+	+	
BP / oth	FIO2 (Frac or %)	.21	.21	.21
ART line	SpO2 (%)	100	100	
Steth- PC/ES	ECG	SR →		
Gas analyzer	TEMP- site	Available		
	N-M Block (T/4)			
Warming blkt	X\ wool blanket			
Conv warmer				

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

RECOVERY AT 0850
PAIN (100) 1 (Specify)
OTHER T – 98.8
CONDITION: stable, awake
RESP – 20 SpO2 – 96%
BP – 128/70 HR – 79

ANESTHETIC PROCEDURE TIMES

	Start	Room	End
ANES	0810	0815	0858
	Ready	Begin	End
PROC	0820	0825	0845

PROCEDURES and CPT Codes: I+D (R) tibia

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC c Sedation

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural + SFm

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

EPW # [redacted] b(6)-4

SURGEON/A [redacted] CRNA/ – ANESTHESIA

PROCEDURE LOCATION 1
DATE 9 July 03
PAGE 1 OF 1

[redacted] OP 376 REVISED 1 Jan 99

PATIENT RECO [redacted] b(6)-2

☆ U.S. GPO: 1999 – 528-336/10085

ANESTHESIA PLAN OF CAR... REPROCEDURAL ASSESSMENT (Sec...on/Anesthesia)

Age 27 DAYS MOS (YRS) Sex (X) MALE ( ) ~~FEMALE~~

PROPOSED PROCEDURE: I&D ANKLE & THUMB
SURGICAL SERVICE:
NPO SINCE:

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

HABITS:
TOBACCO: SMOKER
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

() MSO4
() PERCOCET
()
() ANCEF -06
() GENT - 1000

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	DENIED
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	BSW (L) THORAX
Bronchitis/URI	N	Y	OLD WD UNDETERMINED
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	DENIED
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	13 yr/o PELVIC Fx
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

9 July 03
PHYSICAL EXAMINATION
BP 130/70 HR 108 RR 16 T: JPC
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck 3+
Oropharnyx MP2 / TMD:
Nares
CHEST: CTA JPC
CARDIAC: S1 S2 JPC
EXTREMITIES:
IV Access: (L) AC 20G
Ulnar Filling:
BACK:
OTHER:

NPO Since MN 9 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 [redacted] al guardian. b(6)-2

The patient/leg[redacted]rstand and agrees. Questions answered.

Signed: [redacted] Date: 05 JUL 03 Time: 0800 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

9 July 03 0730
[redacted] MAJ CRNA

Patient Identification: (Ward)

#[redacted]
b(6)-4

ICU, → ICU,

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

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

PROPOSED PROCEDURE: Remove Ex Fix & Cast
SURGICAL SERVICE: ORTHO
NPO SINCE: ____

HABITS:
TOBACCO: Smoker
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) PRN/Pain
( ) Tylenol
( ) Percocet
( ) ____
( ) ____
( ) ____

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	GSW (L) Thorax
Bronchitis/URI	N	Y	Old WD Undetermined
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	Pelvic Fx X 13 yrs Ago
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Surgs Multiple
No Anes Probs

PHYSICAL EXAMINATION
BP ____ HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck 3+ TMJ
Oropharnyx MPZ
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

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

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

The patient/[redacted] and agrees. Questions answered. b(6)-2
Signed: [redacted] Date: 06 Aug 03 Time: 0940 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[redacted] ICW2/ICU2
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 CA[illegible] REPROCEDURAL ASSESSMENT (Se[illegible]on/Anesthesia)

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

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

PROPOSED PROCEDURE: I&D (R) thumb + (R) ankle
SURGICAL SERVICE: ORTHO
NPO SINCE: 7 24°

HABITS:
TOBACCO: yes
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) KS
( )
( ) Ancef 1gm IVPB q8°
( )
( )
( )

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	Denies
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	GSW (L) thorax
Bronchitis/URI	N	Y	old wound, unidetermined
COPD	N	Y	Denies cough
Other	N	Y	pulmo closed
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	(N)	Y	None

(R) ankle GSW or stab (L) hand 10 days ago

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Ø Denies

PHYSICAL EXAMINATION
BP 128/ HR 82 R 16 T: SaO2 95%
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MPZ: TMD 3
Nares
CHEST: Exp. wheezing
CARDIAC: RRR (S) (M)
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER: 6/6/03 Lung CTA (B)

NPO Since 7 24°

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

Interpreter present

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

b(6) The [redacted] CRNA/MAJ 6 July 03 107/61 97.6 62 14 96%
[redacted] understand and agrees. Questions answered.
[redacted] CRNA/MAJ Date: 7 July 03 Time: 0756 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU 1

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

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 YSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

ATIENT IDENTIFICATION

b(4)-4 [redacted]

HLOOD AUTO BOSH

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 JUL 03 TIME OF ORDER: 2320 HOURS

LIST TIME ORDER NOTED A SIGN

1. [illegible] TO ICU-1
2. DX - GSW TO (R) [illegible] (R) [redacted]
3. CONDITION [illegible]
4. VS - [illegible] b(6)-2 [redacted]
5. [illegible] NPO
6. RESUSCITATION STATUS, NPO [redacted] [illegible]

ATIENT IDENTIFICATION

b(4)-4 [redacted]

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

7. IV - LR AT 125 CC/HR HOURS
8. [illegible] + [illegible] IVPB Q 8 [illegible]
9. MSO4 2-6 mg IVP Q 2 [illegible] PRN
10. TYLENOL 650 mg P.O. Q 4 [illegible] PRN
11. PERCOCET, 1-2 TABS P.O. Q 4-6 [illegible] PRN
12. TO OR. IV [illegible] [redacted] b(6)-2 [redacted]

ATIENT IDENTIFICATION

DATE OF ORDER: 1 JUL 03 TIME OF ORDER: 1730 HOURS

1 Benadryl IV 50 mg XT Now.

V/O DR [redacted]

URSING UNIT | ROOM NO. | BED NO.

[redacted]

ATIENT IDENTIFICATION

b(6)-2 HOURS

URSING UNIT | 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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				3 JUL 03	1340 HOURS	1355
			(1)	S/P I+D (R) LEG, NORSION		
			(2)	FOLLOW TIP AMPUTATION		
			(3)	CONTINUE STERILE		
			(4)	VS: NORMAL b(6)-2		[redacted]
NURSING UNIT	ROOM NO.	BED NO.	(5)	BED REST, OOB TO CHAIR, TI		
			(6)	GLUCOSTAT (R) FOOT		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]			(6)	REGULAR DIET	HOURS	
			(7)	IV: D5 W AT 125 CC/HR. HEP LOCK WHEN FOR MEDICATION PRN WITH		
			(8)	PENICILLIN 1.2 MUS P.O. Q 4 HRS PRN		
NURSING UNIT	ROOM NO.	BED NO.	(9)	TYLENOL 650 MG P.O. Q 4 HRS PRN		
			(10)	MSO4 2-6 MG IVP Q 2 HRS PRN		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]			(11)	GLUCOSE + CHECK IVP Q 8 HRS	HOURS	
			(12)	GENTAMYCIN 400 MG ~~P.O.~~ IV Q 8 HRS		
				PE [redacted]		
				b(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				3 JUL 03	1705 HOURS	
			(1)	TRANSFER TO WARD WHEN BED AVAILABLE		
				4 JUL 03 / 0830	[redacted]	
NURSING UNIT	ROOM NO.	BED NO.	(1)	NPO P MN SCHEDULED FOR T&D U.O. DA [redacted]		

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

b(6)-2

WARD 5 @ 1650 R Howard

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
[redacted]				4 Jun 03	0545 HOURS	
				NPO p MN		
				for BD Sun 03		
NURSING UNIT	ROOM NO.	BED NO.		b(6)-2 [redacted]		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]				6 Jun 03	0805 HOURS	
			1	RESUME PREVIOUS ORDERS		
			2	S/P X-FIX TO LTD (R) BUCKO		
			3	COMMENCE STRICT		
			4	VS - ROUTINE		
NURSING UNIT	ROOM NO.	BED NO.	5	OOB TO CHAIR TID		
			6	ELEVATE (R) FOOT		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]			7	RESUME DIET	HOURS	
			8	N. LR at 125 cc/hr. HOP LOCK WOW FLUSH PRN WOW		
b(6)-4				b(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]				9 Jun 03	0845 HOURS	
			1	RESUME PREVIOUS ORDERS		
			2	TRANSFER TO ICW		
			3	RESUME DIET		
			4	N. LR at 125 cc/hr. HOP LOCK WOW FLUSH PRN WOW		
NURSING UNIT	ROOM NO.	BED NO.	5	DOCTOR WILL BE TO TODAY TO REVIEW ORDERS AND PLAN CARE		

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

b(6)-2

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9 Jul — TIME OF ORDER: 1720 HOURS — LIST ORD NOTED SIG

1) HalDol 5 mg IV PRN Q6° For Agitation b(6)-2

V.O. DR [redacted] MAJ/AN

9 July 1700

PATIENT IDENTIFICATION

DATE OF ORDER: 7/13/03 — TIME OF ORDER: 1500 HOURS

1) D.C. IV meds, Accef & Gentamycin
2) D.C. IV
3) Start Cipro 500 mg PO x BID

b(6)-2

V.O. Dr [redacted] MAJ/AN

NURSING UNIT	ROOM NO.	BED NO.
	24	

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

PATIENT IDENTIFICATION

FPW b(6)-4 [redacted]

DATE OF ORDER: 7/27/03 — TIME OF ORDER: 1620 HOURS

1) Fiorinal #3 1-2 PO Q 4-6 hrs PRN b(6)-2 [redacted] 1620

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24	2315

28 July 03 [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER: 29 July 03 — TIME OF ORDER: 2300 HOURS

1) Benadryl 50 mg T.I.D. q 6 hrs prn [redacted] b(6)-2

29 JUL 03 [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

b(6)-2

28 ✓ done [redacted] MAJ/AN

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24 V/S	2200

DATE OF ORDER: 5 Aug 03 TIME OF ORDER: 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) NPO pm m

(2) 0% to OR 6 Aug [redacted] noted

per Dr [redacted] 2100 b(6)-2

Take [redacted]

05 Aug 03 [redacted]

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24 V/S	2200

DATE OF ORDER: 6 Aug 03 TIME OF ORDER: 1100 HOURS

noted [redacted] 100 6

(1) Resume previous orders

(2) Regular diet

(3) N-2R 69 125 cc/hr, D/C IV when taking P.O. well

(4) Up all around with PT today

(5) [redacted] to grow [illegible] in A.M.

[redacted] b(6)-2

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 12571 MAY BE USED.

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	b(6)-2 RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
7-1-03	[redacted]	VS - routine	05	✓	[redacted]												
			17														
7-1-03																	
7-1-03			05														
7-3-03	[redacted]	Regular Diet	05	/	[redacted]												
			17	/													
7-3-03	[redacted]	Bedrest, OOB TC	05	/	[redacted]												
		TID	17	/													
6 Jul	[redacted]	Resume Previous Orders		/													
7/9	[redacted]	Daily wet to dry Dsg	05	/	/	/	/	/	/	/	[redacted]						
		Δ's PRN PIN care	17	/	/	/	/	/	/	/							

Dx 7 AUG03 1130 Am

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW - (R) Leg - (R) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

b(6)-4

EPW # [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 All

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	
7-1-03	[redacted]	Admit to ICU-4	7-1-03	2320	2320	[redacted]	
7-1-03	[redacted]	Dx - GSW to (R) Leg, (R) Hand	7-1-02	2320	2320	[redacted]	
7-1-03	[redacted]	Condition - Fair	7-1-02	2320	2320	[redacted]	
7/4	[redacted]	NPO F MN scheduled	7/5/03	AM			
	-----	Ser F ED in AM				done	
7/9	[redacted]	Transfer ICW	7/9	AM			

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

USAPA V1.00

b(4)-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
7-1-03	[redacted]	VS-routine	05	[redacted]													
			17														
7-1-03	[redacted]	Regular Diet	05														
			17														
7-3-03	[redacted]	Bedrest, OOBTC	05														
		TID	17														
7-8-03	[redacted]	Daily wet to dry Dsg A's prn	05														
		prn care BID	17														
7-6-03	[redacted]	Elevate (A) Foot	05														
			17														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW-(D) leg-(D) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: EPW# [redacted]

b(4)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b (6)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-1-03	[redacted]	Admit to ICU-1	7-1-03	2320	2320	[redacted]
7-1-03	[redacted]	DX-GSW to (R) leg, (R) hand	7-1-03	2320	2320	[redacted]
7-1-03	[redacted]	Condition-Fair	7-1-03	2320	2320	[redacted]
7-4-03	[redacted]	NPO p MN scheduled for I & D in AM	7-5-03	AM		
~~7-9-03~~	[redacted]	~~Transfer to ICU~~ CE			done	
7-9-03	[redacted]	Transfer to ICU	7-9-03	AM	done	[redacted]

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

USAPA V1.00

b(6)-2 A11

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
7-1-03	[redacted]	IV - LR @ 125 cc/hr	05	[redacted]													
			19	[redacted]													
			22	[redacted]													
7-1-03	[redacted]	Ancef 1 gram IVPB Q8°	06	[redacted]													
			14	[redacted]													
			22	[redacted]													
7.3.03	[redacted]	Gentamycin 40mg IV	10	[redacted]													
		Q8															
7.3.03	[redacted]	LR 125cc/hr, HL,	05	[redacted]													
		when tolerating, PO well	17	[redacted]													
		HL @ 2000 7.3.03															
		flush HL q shift.															
7/13/03	[redacted]	Cipro 500mg BID	10														[redacted]
			22														[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW [illegible] (R) Leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
7-1-03	[redacted]	To OR in AM ~~wrong order~~	7-1-03	2330	2330	[redacted]	
7/4	[redacted]	50mg Benadryl IV for itching	7/4	1800	1800	[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
7-1-03	[redacted]	MSO4 2-6mg IVP Q2hr	25Jul 4mg	25Jul 5mg	25Jul 5mg	25Jul 5mg	25Jul 5mg	25Jul 8mg	7-3 4mg 1100 TB	7-3 6mg 1630	7-3 4mg 1930	7-3 4mg 2030	7-3 4mg 2315	7-4 6mg 0100	7-4 6mg 0500	7-4 6mg 0800	[redacted]
7-1-03	[redacted]	Tylenol 650mg PO Q4hr PRN	[redacted]														
7-1-03	[redacted]	Percocet 1-2 tabs PO Q4-6 hrs PRN	7-3 TT 0830 TB	7-3 2 1920	7/4 [illegible]	7/4 TT 0142	7/6 TT 0001	7-5 TT 0605	7/7 TT 0630	7/8 TT 0900 CB	7-14 TT 1900	7-15 TT 0900					
7-1-03	[redacted]	T	[redacted]														
7/4/03	[redacted]	MSO4 2-6mg IVP Q2hr	7/4 5mg 1000	7/4 6mg 1500	7/4 4mg 1700 8Jul 3mg CB 0320	7/4 4mg 8Jul 6mg 1100	7-5 4mg 0030 8Jul 1mg WS 0	7-5 5mg 1215	7-5 6mg 1500	7/6 6mg 0830	7/6 4mg 0140	7/6 5mg 1030	7/6 5mg 1200	6Jul 5mg 1700	6Jul 5mg 2130	7Jul 5mg 0650 TB	
25Jul	[redacted]	Hal/Dol 5mg IV PRN Q6° for Agitation	1100 25Jul I Mee E(+)														

USAPA V1.00

b(6)-2

recopied

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 29	30	31	1	2	3	4	5	6	7	8	9	10
1	[redacted]	VS-routine	05	[redacted]												
			13													
			21													
			/													
1	[redacted]	regular diet	05	[redacted]												
			13													
			21													
			/													
3	[redacted]	bedrest - OOB to chair TID	05	[redacted]												
6	[redacted]	elevate (R) foot	13													
			21													
			/													
4	[redacted]	dir-care BID	05	[redacted]												
		daily w-D asgD - D'd	13													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (R) thumb (R) foot ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EP W/ [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 USED. USA

MEDCOM - 12578

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b (6) - 2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5 [redacted]		NPO PMN	6			
5 [redacted]		O/C FOOR in AM	6	O/C		
6Aug [redacted]		D/C to EPW camp in AM	7Aug	AM	1680	[redacted]
6Aug [redacted]		Up on crutches c̄ PT today	6Aug	AM	1650	[redacted]

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

b(6)-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
7-13-03	[redacted]	Cipro 500mg BID	10	[redacted]													
b(6)-2			22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) hand (R) leg

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. JUL Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7-4-03	[redacted]	50 mg Benadryl IV for itching	7-4-03	1800	1800	[redacted] Transcribed

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
7-1-03	[redacted]	Tylenol 650 mg PO	1330	17 July	17 Jul 1810	18 Jul 0800	19 Jul 1400	20 July 1000	20 Jul 0201	22 Jul 0930		22 Jul 1715	22 Jul 0230	23 July 1930	25 Jul 03 1810		
	[redacted]	Q4hr prn			[redacted]	[redacted]						[redacted]		[redacted]			
7-1-03	[redacted]	Percocet 1-2 tabs PO	15 Jul 1900	15 Jul 1 tab	16 Jul 0530	16 Jul 22:35	17 Jul 08:17		19 Jul 1030	19 Jul	19 Jul 1900		19 July 2300	20 Jul 0123			
		Q4-6 hrs prn	[redacted]						[redacted]					[redacted]			
7-1-03	[redacted]	Percocet 1-2 tabs	7/21 1151	21 July 0300	22 July 0930	22 July 1945	23 Jul 03:36	23 Jul 2210	23 Jul 0308	23 July 0930							
		PO Q4-6hrs PRN	[redacted]														
		Tylenol 650mg PO	23 Jul 0818	24 Jul 0705	24 Jul 0836	25 Jul 0077	25 Jul 650mg	25 Jul 03:18									
23 Jul	[redacted]	Q4° PRN	[redacted]														
27 Jul 30	[redacted]	Tylenol #3 1-2	27 Jul 1645	28 Jul 0830	28 July 1000	29 Jul 1430											
		tabs PO q4-6hrs	[redacted]														

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USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 8 Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
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	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION. TIME/DATE DISPENSED														
7/1/03	[redacted]	tylenol 650mg po	0	0	30 July	85	30 July	4 July	4 July	21 July							
		@4hr PRN	2300	0021	1340	0005	1110	1120	0526	1930							
		[redacted]															
7/1/03	[redacted]	Percocet 1-2 tabs po	0	0	0	30 July	30 July	30 July	31 July	31 July	3 Aug	3 Aug	3 Aug	5	6 Aug	7 Aug	
		q4-6° PRN	2300	1245	2300	0655	0351	0309	0330	1500	1515	2300	0730		1300	0520	
		[redacted]															
27 July	[redacted]	tylenol #3 1-2 tabs	27 July 0810														
		po q4-6° PRN	[redacted]														
30 Jul	[redacted]	Benadryl 50mg PO	30 Jul 0105														
		qHS	[redacted]														
		sleep															

DC 4 Aug 03

[redacted]

FPW #[redacted]

b(6)-4

MEDCOM - 12582

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	August DATE DISPENSED 29	30	31	1	2	3	4	5	6	7	8	9	10	11
28July03	[redacted]	Cipro 500mg BID po	10	[redacted]										D/C'd 7Aug 1600 hrs			
			22														
6Aug03	[redacted]	IV LR @125cc/hr : D/C IV when tolerating po well	06														
			14														
			22														

IV D/C'd 6Aug 1200 ok

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) hand (R) leg

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

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

Time In: 0845

Allergies: NKDA OR Intake: Crystalloid 400 cc/R Colloid _____

Pre-op V/S: _____ OR Output: UOP _____ EBL 5mm

Procedures: 1 KB DSAT (R) ANKLE Meds/Times: 70mg Ketamine 2.5 Versed 50 Fent

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

Pre Op Meds _____ History _____

Time	0845	0855	0900	0915	0930	0945									
SaO2	97	97	95	98	97	95									
FiO2															
Methods	RA	RA	RA	RA		RA									
240															
220															
200															
180															
160															
140															
120	✓	^	^	✓	✓	✓									
100															
80															
60	R	✓	✓	^	^	^									
40															
20															
RR	17	19	16	19	16	15									
T A	98.6				98.4										
Time															
Pain (0-10)															
LOS															

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0845	LR	500	(R) RA	OR	500
0945	LR	~~125~~	(R) RA	ICU	125

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	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	N/A	N/A	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	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 Blanket (el evation)
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(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,*

☐ 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	(R) Leg	Partial	+	P		W	
15'							
30'							
45'							
60'							
90'							
D/C							

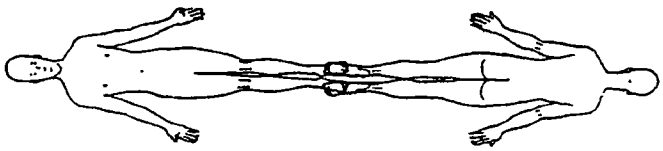
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Ankle	Ace wrap/Ice pk	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1000	Urine,	yellow, CLR	800

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

~~1891 (R) forearm, LR125 S/P IVD (R)~~
~~Ankle~~, PO
1000 S/P IVD (R) Ankle
Cond Stable
Neuro: Pt ~~com~~ cam move toes & bear min weight to (R) Ankle,
Card: PP x 2 R ankle, cap refill unable to assess.
IV Site (R) FA. LR infusing 125cc/hr via Dial a flow.
VOP through bedside comode & urinal.

Discharge Criteria:
Date: 7/9 **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:_____

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0615	0615	INITIALS [redacted]	b(6)-2	INITIALS	1835 / INITIALS
	PUPILS		PERRLA 3mm.				PERRLA 3mm
	SENSORIUM						A+Ox3, Cooperative
RESPIRATORY	RESPIRATORY PATTERN		no distress, (B) equal				Unlabored CTA (B)
	BREATH SOUNDS		chest rise/fall.				
	SECRETIONS		clear LS to aus.				
			BPM 12-18.				
SKIN	COLOR		normal for race				WD
	INTEGRITY		(R) LE, ex fixator in place,				(R) LE - Ex Fixator in place
			skin of toes - necrosis, hard & black				
IV SITE	LOCATION		(R) hand, site				(R) hand - ⊖ S/Sx inf
	CONDITION		S S/S infect/				
			infiltration -				
			0730 new IV started				
			(R) forearm				
GASTRO	ABDOMEN		+ BS x4 quads				+ BS x4
	BOWEL SOUNDS		NT, ND.				Non Tender, Soft
GU	URINE:						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM		S1, S2 SB -				$S_1 S_2$ SR-SB
			60-65 BPM				

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

b(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] 91WM6	ICU 2 unit	8 July 03

(Attach copy of written report or give: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted]

b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHAR
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Spe
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

PA

DX gubb HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15
P Arterial Line																	
P Cuff							130/85					120/80				118/90	
emperature							97.9					97.5				98.2	
ulse							65					72				68	
espiratory Rate							16					20				16	
~~ven~~																	
~~saturation~~																	

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
/ VPB							100					100				100	300
T																	

OTALS																	
	HOUR / TOTAL	/	/	/	/	/	/	/		200/500	/	/	/	/	275/475	/	400/875
JRINE	SP GR																
	S/A																
	OUTPUT																
NG	pH																
	GUIAC																
MESIS																	
TOOL										med. ord.							

PA

	17	18	19	20	21	22	23	
BP				126/64				
Temp				96				
Pulse				72				
Rt				16				
O2				98% RA				

	17	18	19	20	21	22	23	8°T
IV								
PO								
			275 / 275					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
	ABG	pH								
		PCO_2								
		pO_2								
		HCO_3								
		SAT								
		BASE								

LABORATORY DATA	TIME							
	GLUCOSE							
	Na/K							
	Cl/CO_2							
	BUN/Cr							
	WBC/PLATELET							
	Hct/Hgb							

ACTIVITIES OF DAILY LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE OUTPUT

IV ________ Urine: ________

NURSE'S SIGNATURE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
see AR 40-66; the proponent agency is the Office The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	1700 TIME	1	INITIALS	10 July AM	INITIALS [redacted]	July 1700	INITIALS [redacted]
	PUPILS	3 mm		PERRLA (R) 3mm		Perrla 3mm	
	SENSORIUM	Alert - when spoken		GAOX3		A+O x 3	
		TO Person & place?					
							b(6)-2
RESPIRATORY	RESPIRATORY PATTERN	Reg even		even unlabored		even, unlabored	
	BREATH SOUNDS	CTA Bil		CTA-(R)		CTA-R	
	SECRETIONS	0		0		none	
				SpO2 97-99%			
SKIN	COLOR	Normal for Race		NFR		NFR	
	INTEGRITY	(R) foot injury Toes		dry tape		dry/intact,	
		dark				cast on right leg	
IV SITE	LOCATION	(R) FA is patent		(R) FA patent		RFA 0 0	
	CONDITION	(R) SCS infiltration		HL ø ø		HLI	
GASTRO	ABDOMEN	Soft NON Tender		Soft NT ND		soft, nontender	
	BOWEL SOUNDS	BS(+) x4 Quads		(+) BS x4		+BS x 4 qds	
GU	URINE.	Clear yellow		Clear - dark		urinal	
	COLOR/CLARITY	uses urinal cont.		yellow		clear, yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR		S1S2 RISC		S1S2	
						NSR	
				B/P		+2 pulses radial/pedal	
				0		<3sec cap refill	

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

b(6)-2

(Continue on reverse)

[redacted] /ICU

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 09 JUL 03

(When entries give: Name—last, first, middle; grade; date; hospital or medical facility)

EPW [redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

m, see AR 40-66, the proponent agency is the Office

REPORT TITLE

INTENSIVE ... NURSING FLOW SHEET

TSG APPROVED (Date)
GA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1700	INITIALS [redacted]	0500	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Perrla 3mm		[illegible]			
	SENSORIUM	A+O×3		[illegible]			
		limited ROM		[illegible]			
RESPIRATORY	RESPIRATORY PATTERN	eupn, unilabored		[illegible]			
	BREATH SOUNDS	CTA-B		[illegible]			
	SECRETIONS	none		[illegible]			
SKIN	COLOR	NFR		[illegible]			
	INTEGRITY	dry, intact		[illegible]			
I.V. SITE	LOCATION	R hand		[illegible]			
	CONDITION	c/d/i patent		[illegible]			
GASTRO	ABDOMEN	~~NT~~, nondistended		[illegible]			
	BOWEL SOUNDS	+BS × 4qdr		[illegible]			
GU	URINE	clear yellow		[illegible]			
	COLOR/CLARITY	uses urinal		[illegible]			
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2		[illegible]			
		NSR		[illegible]			
		+2 pulses pedal/radial		[illegible]			
		<3sec capryfill		[illegible]			

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; SA - Fractional; Sat - Saturation; Trach - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 West

DATE

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

[redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE | DE | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	112/68				102/64					124/				124/66				
Temperature	98.2				98.1					98.3								
Pulse	79				74					84				76				
Respiratory Rate	14				14					12				16				
	98				96					96				99				
	RA				RA					RA				RA				

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
EDP										200					360			560
							50		50			100				100		250
TOTALS									50									950

OUTPUT

URINE	HOUR	400				400												
	TOTAL					120						600				300		900
	SP GR											600						
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL															1L			
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
BP					118/71				
Temp									
HR					85				
RR					14				
					98				
O2					RA				

INTAKE

	16	17	18	19	20	21	22	23	8° T

OUTPUT

					410				

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
ABG PCO_2									
ABG pO_2									
ABG HCO_3									
ABG SAT									
ABG BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME				TURN					
MOUTH CARE									
BATH									
SKIN CARE				SUCTION					
FOLEY CARE									
TRACH CARE									
ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE ________

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD–SUPPLEMENTAL MED[illegible]AT
form, see AR 40-66; the proponent agency is the Ge[illegible]neral

REPORT TITLE
INTENSI[illegible] [illegible]URSING FLOW SHEET b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS		3mm Perr[illegible]		3mm Perl			
	SENSORIUM		Pt. AOX3, no c/o pain.		A+Ox3 MAE x 4 RLE Toes only			
RESPIRATORY	RESPIRATORY PATTERN		unlabored, even		even + unlabored			
	BREATH SOUNDS		B, CTA		CTA bilat			
	SECRETIONS		Ø		Ø noted			
SKIN	COLOR		warm & dry		warm + dry			
	INTEGRITY		intact		Intact			
I.V. SITE	LOCATION		(R) FA, EDT,		D/C			
	CONDITION		no s/s of infiltrat		NO IV fluids			
GASTRO	ABDOMEN		Soft, NT, ND.		soft nontender			
	BOWEL SOUNDS		BS x 4 quads		BS x 4 quads			
					will start tube feeds			
GU	URINE: COLOR/CLARITY		warm yellow via urinal		yellow / clear			
CARDIOVASCULAR	CARDIAC RHYTHM		S1S2 70-80's		S1S2 70-80's			

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
SA1 - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted]

DEPARTMENT/SERVICE/CLINIC: ICU Quest

DATE: 13 July 03

[redacted]

b(6)-2

☐ 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	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line							120/84							118/79				
	BP Cuff																		
	Temperature							98											
	Pulse							76							80				
	Respiratory Rate							20							18				
	SpO2							98							99				
								RA											

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	TOTALS																		

OUTPUT																			
	URINE	HOUR				30			350						300				
		TOTAL																	
		10 gr																	
		SUR																	
	NG	OUTPUT																	
		BR																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

	16	17	18	19	20	21	22	23	
BP	119/75		120/78				115/75		
HR	99		83				73		
	16		16				20		
SpO2	99		100%				98		
							RA		

	16	17	18	19	20	21	22	23	8°T
PO									
			89/30					95/140	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	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 DAILY LIVING	TIME				TIME				
	MOUTH CARE				TURN				
	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

MEDICAL RECORD—SUPPLEMENTAL DATA
For use of this form, see AR 40-66; the proponent agency is The Surgeon General

REPORT TITLE
INTEN

CARE NURSING FLOW SHEET

b(6)-2

SG APPROVED (Date)
GA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS	1800	[redacted]	INITIALS
NEURO	PUPILS	0600 3mm PERRLA		Pearrla 3 mm		
	SENSORIUM	Can move all U extremities		Alert x 3		
RESPIRATORY	RESPIRATORY PATTERN	eupnea labored		Reg even		
	BREATH SOUNDS	CTA B		CTA B/L		
	SECRETIONS	Ø RR 14 SpO2 98%		Ø		
SKIN	COLOR	NPK		Normal for Race		
	INTEGRITY	Dry		warm dry		
IV SITE	LOCATION	Ø		Ø		
	CONDITION	Ø		Ø		
GASTRO	ABDOMEN	hypo x 4		BS(+) x 4 quads		
	BOWEL SOUNDS	Firm ND-T		soft NT		
GU	URINE	via urinal		clear yellow		
	COLOR/CLARITY	yellow clear		via urinal		
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 ausc PP x4/x4		S1 S2 WSR		

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; FiO2 - Fractional; SaO2 - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC: ICU 2 West | DATE

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

EPW [redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

15 Jul 03

For use of [illegible] MEDICAL RECORD—SUPPLEMENTAL N[illegible]
[illegible] see AR 40-66; the proponent agency is thi[illegible]

DATA
The Su[illegible]

REPORT TITLE
INTENS[illegible] CARE [illegible]ING FLOW SHEET

[illegible]SG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL [illegible] ASSESSMENT

	TIME	0500	INITIAL [redacted]		INITIALS		INITIALS
NEURO	PUPILS	PEARLE					
	SENSORIUM	A/O X3, follows all commands		b(6)-2			
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored					
	BREATH SOUNDS	CTA (B)					
	SECRETIONS	Ø					
SKIN	COLOR	NFR					
	INTEGRITY	warm & dry, intact					
IV SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN	SOM ND/NT					
	BOWEL SOUNDS	X4 hyperactive					
GU	URINE:	via urinal					
	COLOR/CLARITY	dark yellow & sediment					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR S1S2 auscultated					

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
SA - Fractional
SaO - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU Quest

DATE
15 Jul 03

[illegible] middle; grade; date; hospital or medical facility)

EPW-[redacted]
b(6)-9

☐ 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	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Asterial Line					128					121				118				
	BP Cuff					82					75				84				
	Temperature					98.2					98.6				97.8				
	Pulse					91					72				82				
	Respiratory Rate					12					14				14				
	O2					97					98				97				
	RA/O2					RA					RA				RA				

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
											200				200				
	TOTALS																		

OUTPUT																			
	URINE	HOUR / TOTAL										225				625			
		SP GR																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

	16	17	18	19	20	21	22	23	
B/P	109								
	60		120/52						
T	96.9		98						
P	96		93						
R	18		16						
SaO2	97		98						
	WX		RA						

	16	17	18	19	20	21	22	23	8° T
	400								
	0								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	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	INITIALS

DATE | DX | ...AL DAY

VITAL SIGNS																	
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line							94/0											
BP Cuff																		
Temperature																		
Pulse							79											
Respiratory Rate							14											
							99											
							84											

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL					100 / 100			1510							450 / 450		450
	10 gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									1510									450

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
		116							
		/65							
		80							
		13							
		91							
		[illegible]							

INTAKE

16	17	18	19	20	21	22	23	8° T

RESPIRATORY DATA

		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
A		pH									
		PCO_2									
B		pO_2									
		HCO_3									
G		SAT									
		BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE: IV ______ po ______

OUTPUT: Urine: ______

TOTAL ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

DICAL RECORD—SUPPLEMENTAL M CAL I
e AR 40-66; the proponent agency is t of on General

REPORT TITLE
INTENSIVE RE NU ING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1910	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm					
	SENSORIUM	A+O x 3					
RESPIRATORY	RESPIRATORY PATTERN	unlabored					
	BREATH SOUNDS	CTA B					
	SECRETIONS	Ø					
SKIN	COLOR	W.P					
	INTEGRITY	Intact					
IV SITE	LOCATION	(R) FA - Ø ~~s/s x Int~~					
	CONDITION	Dressing (R) Thumb - CDI					
		(L) Ankle - CDI					
GASTRO	ABDOMEN	Soft Non-Tender					
	BOWEL SOUNDS	BS x4					
GU	URINE:						
	COLOR/CLARITY	Yellow Clear					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR					

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
SA1 - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREP [redacted] Cpt/AN

DEPARTMENT/SERVICE/CLINIC ~~Med Surg~~ ICU I

DATE

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

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

DATE 0 2/1/03 | DX | HOSPITAL DAY

VITAL SIGNS																	
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line																	
BP Cuff																	
Temperature																	
Pulse																	
Respiratory Rate																	

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
Ancef iV																		
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL			700														
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS									
	16	17	18	19	20	21	22	23	
					134/67				
					96.2				
					98				
					16				
					97%				
					RA				
	16	17	18	19	20	21	22	23	8° T
					60			30	950

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

DAILY ACTIVITIES	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	_____	TOTAL	_____

BALANCE_____

NURSE'S SIGNATURE	INITIALS

b(6)-4

[redacted] NOM ET PRÉNOM | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ

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
- [X] AMPUTATION / AMPUTATION
- STRESS / TENSION
- [X] OTHER (Specify) / AUTRE (Spécifier)

(R) thumb amputation

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- [X] ALERT / ALERTE
- VERBAL RESPONSE / REPONSE VERBALE
- PAIN
- UNR

1 JUL 03
TO
28th CSH

5. PULSE / POULS | TIME / HEURE

6. TOURNIQUET / GARROT: NO / NON | YES /

7. MORPHINE / MORPHINE: NO / NON | [X] YES / OUI | DOSE / DOSE | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / AN

- Dressing (R) hand
- IV initiated (A) 0130
  2L (LR)
- Abx initiated @ 0135 1g.
- Morphine 2201

10. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE: b(6)-2

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ [redacted] | DATE/DATE (YYMMDD) 2003 06 01

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

MEDCOM - 12605

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD): 20030601 | TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	2230	0500			
BP / PS	[illegible]	T 98.6			
PULSE / POULS	82				
RESP / RESP	20				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

15. PROVIDER / OFFICIER MÉDICALE | DATE/DATE (YYMMDD)

16. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- BAPTISM / BAPTISÉ
- ANOINTING / ONCTION
- CONFESSION / CONFESSION
- PRAYER / PRIÈRE
- COMMUNION / COMMUNION
- OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MT. ATION (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 H [redacted] b(6)-4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
Z Z Z Z Z Z Z Z	2 7 Y	X	9	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
—	Z	2320	— b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU 1	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 (Y Y M M D D)
5 Ø		Ø 3 Ø 7 1 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		Ø 3 Ø 7 Ø 1

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

FOR LOCAL USE

GSW (R) hand (R) leg

Dx: 8241 [redacted] 882 E9112
Px: 8302 [redacted] 8021 8023

b(6)-2

ADMITTING OFFICER	SIGNATURE OF ADMITTING CLERK
[redacted]	[redacted]

DA FORM 2095, MAR [redacted]

b(6)-4

INPATIENT TREATMENT RECORD COVER SH

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]			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 32y	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP 99	12. SSN [redacted]			13. ORGANIZATION N/A		14. WARD ICW	
15. FLYING STATUS N/A	16. DSG	BEN K79		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE W1A	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22. HOURS OF ADMISSION: 2323

23. CLINIC SERVICE: AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25. TYPE DISPOSITION: 50

26. DATE OF DISPOSITION: 14 July 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b. TELEPHONE NO.: —

28. DATE OF THIS ADMISSION: 01 July 03

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

30. DATE OF INITIAL ADMISSION

31. [redacted]

32. UNITS COMPONENT TRANSFUSED: [redacted]

ADMITTING OFFICER: b(6)-2 [redacted]

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW (L) hand + (R) foot
S/P I + D (L) hand + (R) foot

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	15	15

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
Ø	Ø	Ø	Ø	15	15

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: For [redacted]

DA F[redacted] EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

b(6)-2

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

32 YO
~~Middle~~ age Iraqi male who is brought to the CSH from the EPW camp c̄ 6 day old GSW to leg | hand now c̄ evidence of infection. c/o pain c̄ hand movement

PMHx ∅ | PSHx ∅ | NKDA | meds ∅ | tob: ∅

PHYSICAL EXAMINATION

130/61 P56 R12 T98.1
WD/WN ♂ NAD
Cyc clear
LSF PERRLA
oral sym NAD
NL Ext gait
leg: straight good ROM, (R) foot c̄ puncture wound over metatarsal

Arms: left webby below pinkie and ring fingers c̄ puncture wound
NV intact

PROGRESS (Enter date of discharge and final diagnosis)

Dx: ① puncture wound (R) foot
② Infected wound (L) pinky finger

- to OR for washout w/ch
- Brief hospital

[redacted]

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	7 JUL 03		

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

REGISTER NO.	WARD NO.

b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOC

DATE	NOTES
02Jul 03 0000	Received report from outgoing shift. VSS NAD A+O x3 denies discomfort. LS - slight wheeze c̄ exhalation cleared c̄ cough. R-16 even unlabored BS active x 4 (-) DIN (-) Rigidity, NT. Skin - IV (R) FA NSS 100cc/hr patent (L) hand between 4th - 5th fingers in webbing (I) laceration c̄ dried blood (P) serous drg. Cleaned c̄ Benadine Soap, bacitracin, non stick gauze, Ace wrap tolerated well cap refill brisk pulses present x4 skin warm to touch NVI, (R) leg, [redacted] splint & ace wrap, NVI able to move toes cap refill +1, toes warm to touch. NPO since midnight pend surgery for (R) leg today. will cont to monitor SGT WAGNER 91WM
02Jul03 0015	late entry PT in soft restraints of both wrists as per protocol. - speaks English denies discomfort SGT [redacted] b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR (SSN or O

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. | WARI

EPW [redacted] b(6)-4

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

b(6)-4 b(6)-4

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

DATE	NOTES
2 FEB 03 1800	Received pt from offgoing nurse. Alert awake and oriented. MAE x 4. (+) sensation to all extremities. Ø c/o pain @ this time. Room air O2SAT 98%. Equal chest expansion. (B) CTA. Sinus brady Ø ectopy. PPP x 3 unable to assess (R) LE due dsg to the area. Afebrile. Admin BS x 4. Abd flat soft non-tender. Voiding without difficulty. Will keep monitoring. [redacted] b(6)-2
0532 2 FEB 03	Assumed care of pt, PT's V/S 120/80-97-18-16-SPO2 96% on RA, PT Alert, verbal can move all extremities, lungs CTA(B), equal rise and fall of chest, CV-S1S2 present, sinus brady, pulses x 4 extremities, LR @ 100/hr infusing in (R) forearm, [redacted] c/o/I, AND-NO, OT, BS x 4, voids clear yellow urine about 200cc. NV intact x 4 extremities. (R) Leg cast + dressing c/o/I. (L) hand wx dressing Δ'd - wx color is pink to white no drainage noted. Wet to dry dressing applied to wx, PT ambulating O.K. Ad (R) leg I+P to day. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999)
USAI

LAST NAME	FIRST NAME	M.I.	ID NUMBER

DATE	NOTES
3 JULY 03 1100	Author Op Note. [redacted] b(6)-2 Pre Op Dx [redacted] GSW (R) foot Old GSW (L) SP, brain Post Op Dx - same Procedure: I+D (R) foot I+D [redacted] hand Surgeon: [redacted] b(6)-2 Anesthesia: MAC Drains: ~~Lr~~ ~~JP~~ NS 800 cc Findings - No fresh pus. Some gross contamination - sand in (R) foot. No cotton batting already wound down to extensor tendon. Wounds packed with NV-GUEZ Plan: 1. Repeat I+D in 48 hours, then DPL of hand [redacted] b(6)-2
03 July 03 1900	Received pt. @ 1700. Neuro: AAO x 3. Pupils equal & reactive. Resp: equal rise & fall of chest. Lungs CTA throughout. SpO2 97% RA. CV: HR regular ∅ murmurs. 2+ pulses (R) hand, (L) foot. Cap refill brisk x4. GI: abd. soft, flat, non-tender. (+) BS x4. GU: able to void. void 400cc clear yellow urine. Skin: (L) hand bandage & wrapped c̄ ACE. (+) CSM - able to move fingers. Pinky finger on (L) hand very tender. Pt. withdrew hand c̄ light touch of that finger. (R) foot wrapped c̄ ACE. (+) CSM. Lines: PIV HL (R) FA [redacted] b(6)-2 ILT/AN

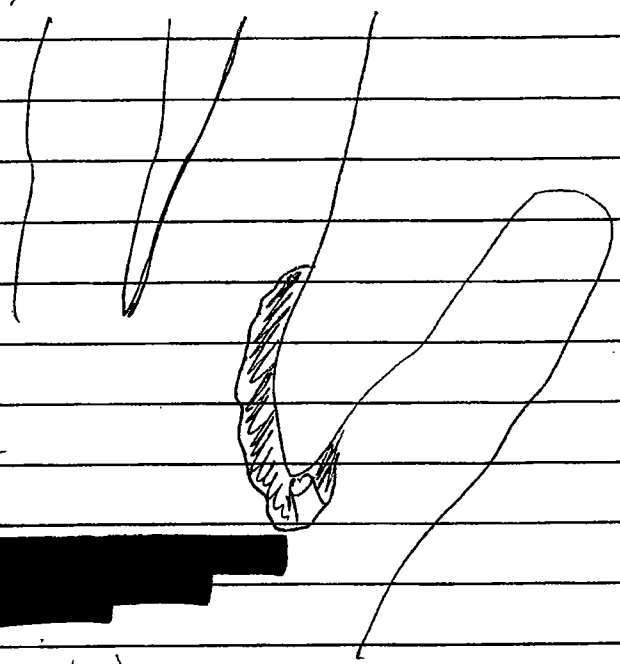
STANDARD FORM 509 (REV. 8/1999) BACK
USAPA V1.00

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES [redacted]
DATE	NOTES

1 July 03 Iraqi CI arrived tonight c/o (R) foot, (L) hand pain
Small Caliber GSW Entry dorsum (R) foot c̄ Exit Plantar
aspect (+) TTP Pulses 2/4 DP, PT foot warm
110/72 60 96% Sat RR 12
(L) hand c̄ Avulsion and ? joint space entry between
4th, 5th Phalange



A/ (1) GSW (R) foot
P (2) Avulsion ? GSW
grazing injury to
(L) MCP 4, 5
(1) SBI 1st
(2) Clean/Bandage
(3)

[redacted] b(4)-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 V1.0C

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b(6)-2 AW
05 July 03 0030	PIV to (R) FA reddened & leaking @ the site when flushed c̄ NS. IV d/c'd & new IV placed (R) FA c̄ Rog. Ancef 1gm IVPB infusing into site ↓ difficulty. — [redacted] KM/AN
05 July 03 0415	Pt. slept through the night c̄ minimal c/o. VSS. NV ✓ intact to (L) hand & (R) foot. Will cont. to monitor. — [redacted] KM/AN
05 July 03 1700	Pt. A&O x3. Lungs CTA. VSS. (L) hand & (R) foot wrapped c̄ kerlix & ACE wrap. NV ✓ intact to both. 2+ pulses x3 cap refill brisk x4. Pt. denies pain. — [redacted] KM/AN
05 July 03 1900	Pt. transfered to ICW 2. Able to walk to ICW 2 c̄ use of one crutch. NWB to (R) LE. — [redacted] KM/AN
1930	Assumed care of Pt upon transfer @ 1900. A&O x3. HL (R) UE patent. (R) ↑ drsg/ace CDI (+) cap refill <3sec mot, sensation (R) foot. (L) UE drsg CDI. (+) mot, cap refill <3sec. (L) hand ↓ c/o pain. (+) LS CTA. (+) BS ↓. Pt. Pain assessment done. Will monitor — [redacted]
5 Jul 03 2200	Rec'd pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. PERRLA (+). LCA (B). BS (+) x4. (+) PPP (B). PIV/HL (R) FA intact patent. ACE wrap DSG to (L) hand CDI. ACE wrap cast to (R) foot CDI. Pt able to move and feel (L) fingers and (R) toes. Each are warm to touch c̄ good <3sec. cap refill. No complaints @ this time. Will cont. to mon [redacted] AN
0200	C/o dizziness and nausea. 12.5 mg Phenergan given will cont. to mon. [redacted] AN
0300	Pt sleeping. No further c/o nausea. Will mon. b(6)-2 [redacted] AN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

EJW [redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
04 July 03 0350	Pt. able to sleep through the night until 0330. Woke up c/o pain in (L) hand. Medicated him c̄ Percocet ii PO. Cont. to have neurovascular ✓ intact in (L) hand & (R) foot. VSS through the night. Will cont. to monitor. b(6)-2 [redacted] KMm
04 Jul 03 0600	Received report from outgoing shift VSS NAD Pt. resting c̄ eyes closed easily aroused A+O x3 pleasant EOMI color good LS CTA equal bilat BS active x4 (-) DVI (-) Rigidity NT. Cap refill brisk skin warm, dry Drg (L) hand CDI, able to move fingers, color good pinky sore to move minimal edema. (R) leg drg CDI able to move toes, color good, good cap refill warm to touch minimal edema denies pain at this time. will cont to monitor SGT [redacted] /WM6 b(6)-2
04 July 03 1800	Pt. doing well today. Neuro: A+O x3, PERLA Resp: Lungs CTA throughout CV: HRR ⊘murmur 2+ pulses x3 cap refill brisk. GI: (+) BM earlier today. c/o abd. pain, pt. feels he needs another BM. (+) BS x4. GU: sport, void c̄ clear yellow urine. Skin: (L) hand wrapped c̄ kerlix & ACE - c/d/i. (+) CSM. (R) foot wrapped c̄ kerlix & ACE - c/d/i. (+) CSM. Able to wiggle fingers & toes. Lines: HL to (R) AC. [redacted] KMm

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

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

REGISTER NO. | WARD NO.

EPW # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1O)
USAPA V1.00

NOTES

6 Jul 03 0840 Pt. assessment Complete: VSS. Alert + oriented x3. (+) Perrla. Lungs CTA. (+) Pulses x4. (+) BS x4. Dsng to (R) hand + (R) foot. CDI. (+) movement + (+) sensation to (R) fingers + (R) toes. c/o pain when both extremities is touch. Cap refill < 3 sec. c/o dizziness. pt (R) ex patent to flush. Will continue to monitor [redacted]

1030 NPO p̄ lunch for washout today. [redacted]

1900. Assumed care of Pt @ 1300. VSS. A-O x 3. Ø c/o pain, PIV patent HLC IV ABX. NPO since 1200. (L) UE dsg bce CDI (+) sensation, mvt of fingers, cap refill < 3 sec (L) hand. (R) LE dsg bce CDI (+) sensation, cap refill < 3 sec. mvt toes (L) foot. Ø c/o [illegible] Will Monitor [redacted]

[illegible] Pt. returned from OR @ 2130. VS [illegible] per [illegible] flow sheet. PERRLA (+). LCTA (B). BS (+) x 4. (+) PPP (B). PIV HL (B) A patent. tolerating PO. (L) Hand ACE wrap Dsg CDI. able to move and feel fingers; warm to touch c̄ < 3 sec cap refill. Ø c/o pain or dizziness @ this time. Ø c/o n/v. Will cont. to mon. (R) foot ACE wrap dsg CDI. Able to move and feel toes. warm to touch c̄ < 3 sec cap refill. Will cont to mon. [redacted] /AN

22:35 c/o pain ⅲ Percocet given Will mon. [redacted] /AN

7 Jul 03 0900 - Pt alert tolerated breakfast this AM. VSS. Lungs CTA, BS (+). Dsg to (L) arm CDI. Ask to wiggle fingers, (+) sensation, warm to touch. Dsg to (R) LE extremities. (+) sensation, warm to touch. Voicing o complaints at this time will cont to monitor [redacted] /AN

1600 97.5 54 18 90/53 96%

blue - 2 AM

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

Ortho OP/EMC Note

72y o Fragile ESW

prop Dx: (P) Post GSW
(P) Hand GSW

Procedure Repeat Washout/I&D

Surgeon: [redacted] b(6)-2

EBL:

TOPAW Study

Findings: (P) Fat plantar Abscess
Improved pulse & Neurovascular
(P) SF pl Lac ⇒ DPR

Plan) Repeat Washout (P) Foot 48°

b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S ID NO. (Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS [redacted]

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

ESW [redacted] b(6)-4

DATE	NOTES
8 Jul 03 1615	assumed care @ 1300 - VSS - no c/o pain @ this time - SL patent - dsgs intact and clean on (D) hand and (R) foot - pt. can wiggle (L) fingers & (R) toes, <2 sec. cap. refill in the same - pt. hops to BR on (D) foot — [redacted] BrAN
2200.	Pt. care assumed @ 2100. VSS. Pt. c/o mild discomfort (L) little finger. HR reg, Lungs CTA, ABD soft BS (+) x4. Dsng to (L) LE CDI. UTA pulse 2° dsng. (+) sensation (+) ROM digits c̄ Brisk cap refill. Dsng to (R) LE CDI. UTA pulse 2° dsng. (+) sensation toes, (+) ROM, cap refill < 3 sec. Will cont. to monitor — [redacted]
9 July 03 0555	Assume pt care @ 0500. Pt asleep easy to awake. VSS. HL to (R) hand flushes well. HR reg Lungs CTA. Abd soft BS x4. Dsg c̄ ace wrap LUE to hand and wrist. CDI (+) movement (+) sensation to fingers. (R) LE dsg and ace wrap CDI (+) movement (+) sensation to toes cap refill <3 sec. No c/o pain. Will continue to monitor. — [redacted] WMP
1000	pt NPO for D&D @ 1400 [redacted] WMP
9 July 03 1330	assumed pt care @ 1300. VSS assessment findings WNL. pt off to OR in stable condition [redacted] WMP

blw - 2 AN

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
7 Jul 03 1710	assumed care @ 1300 - VSS - SL patient - no c/o pain @ this time - Keflex and Ace wrap dressings CDI on (L) hand & (R) foot - pt. can wiggle (L) fingers & (R) toes, <2 sec cap. refill in (L) fingers & (R) toes, tol. regular diet - ambulated to BR and had BM — b(6)-2 [redacted] CRNA
7 Jul 03 2700	Assumed pt. care @ 2000: Pt. A&O x3. (+) BS x4. lungs CTA - Prong & Ace wrap on (R) hand and (R) foot CDI - (+) sensation and movement in toes & fingers. HL (R) FA patent to flush. c/o dizziness. Will continue to monitor — b(6)-4 [redacted] 91 WMC
8 Jul 03 0700	0933 - Pt alert lying in bed. VSS, lungs CTA; (+) BS x4: Dsg to (L) hand & (R) ft CDI. HL to (R) arm patent. Voicing no complaints. Will cont to monitor — [redacted] b(6)-2 2600
	96.5 57 14 100/60 96%

IONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID # (SSN or Other)
	LAST	FIRST	MI	
:T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

T'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

EPW [redacted] b(6)-4

4 July 03 pt returned from ICU 2 in stable condition. VSS. drsng
1630 to ® foot & ©
2200 and CDI. will cont to monitor — [redacted] 9 lumc
Pt. care assumed @ 2100 - VSS. Pt. c/o dizziness,
⊘ N/V. HR Reg, Lungs CTA, BS⊕ x4. Drsng to © hand
CDI, brisk cap refill & ⊕ Sensation, ⊕ ROM. Drsng
to ® ft CDI, brisk cap refill & ⊕ Sensation, ⊕ ROM.
10 July 03 will cont. to monitor. b(6)-2 [redacted]
0620 Assume pt care @ 0500. pt asleep easy
to awake. VSS. LR @ 125cc/hr to © FA - no s/s
0500 96.7 redness / infiltration will HL ⊼ breakfast. HR reg. Lungs
56 CTA. BS x4 abd soft. no tenderness on palpation. ©
14
106/64 hand dsg and ace wrap CDI. ⊕ movement ⊕ sensation
96% to fingers. ® foot dsg and ace wrap CDI ⊕ movement
⊕ sensation to toes. No c/o pain. will continue to
monitor
10 July 03 assumed care @ 1300 - VSS - ® foot dsg Δ'd, b(6)-2 [redacted] 9 lumc
1645 4x4 gauze over wound packing, Kerlix, ace wrap
CDI - SL patent © FA - no c/o pain - c/o
nausea but no vomiting - tolerated
030 regular diet b(6)-2 [redacted]
July 03 Pt care assumed @ 2100 VSS, no c/o pain [redacted] AW
Sounds CTA, BS⊕ x4. Dsg on ® ft cdi, ⊕ sensation and
cap refill. HL @ LFA flushes well, will continue to monitor.
b(6)-2
0600 96.3 Assumed care of pt @ 0500. Pt asleep. VSS [redacted] lumc
62
16 Lungs CTA. Abd soft and tender. Bowel sounds
100/66 ✓ 4 quads. Dsg to ® ft. ⊕ sensation and cap
96% refill less than 3 sec. ⊘ c/o pain / discomfort.
b(6)-2
[redacted] LPN, SGT

AUTHORIZED FOR LOCAL RE

DICAL RECORD	PROGRESS NOTES
DATE	NOTES

9 Jan 03 Ortho Op Note

Pre-Op Dx - (1) ABSCESS (R) FOOT
(2) LEUKEMIA (L) SF

Post Op Dx - same

Procedure - (1) I+D (R) FOOT
(2) [illegible] (L) SFP

Surgeon [redacted]

Anesthesia - [redacted]

Anesthesia - MAC

Findings - (R) foot deep abscess yellowish material. Packed lower with 1/2" NW GAUZE. (L) SF had some light pus. Sutures opened irrigated NW-GAUZE

PLAN IV ABX. Dressing changes daily.

[redacted]

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID N (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.		WARD NO

PROGRESS NOTES
Medical Record
STANDARD FORM 509

EPW# [redacted] b(6)-4

	FIRST	LTW [redacted]	MIDDLE INITIAL

TE

NOTES

12 Jul Assumed care of pt @ 0500. Pt asleep. VSS. Pt went to OR @ 0730. Pt @ 0845. VSS. Lungs CTA. Abd soft and tender. Bowel sounds x 4 quadrs. Pt had I&D. Ø c/o pain/discomfort. Will continue to monitor. — [redacted], 91WM6, SGT

1630 Assumed care of Pt @ 1300. VSS. A+O x 3. (R) UE PIV HL CIVABX patent. (L) hand drsg CDI (+) sensation, mvt, cap refill < 3 sec, (R) LE Drsg CDI (+) sensation, mvt, cap refill < 3 sec (L) foot. Ø c/o pain. O/w assessment WNL. Will monitor — [redacted]

2130 Pt. care assumed @ 2100. Pt. c/o dizziness & nausea. 12.5mg phenergan given IV. IV site flushes easily (R) hand) and is ∫ s/s infections infiltration. HR Reg, Lungs CTA, BS (+) XY. Drsg to (R) ft CDI. Toes to (R) ft (+) sensation, (+) ROM, (+) pain to 2nd & third toes. Drsg to (L) UE CDI. (+) ROM, (+) sensation, Ø pain digits (L) hand. Brisk cap refill x 4 extremities. Will cont. to monitor. — [redacted]

13 Jul 03 0515: Assumed pt care @ 0500: Pt. resting, awakened easily. VSS. A+O x 3. HL in (R) FA. Denies any discomfort @ this time. Will continue to monitor — [redacted] 91WM6 —

1430 Assumed care of Pt @ 1300. [redacted] A+O x 3. Ø c/o pain. (+) BS x 4. (L) hand drsg CDI (+) sensation, cap refill < 3 sec, mvt of fingers. (R) LE drsg/ace CDI (+) sensation, cap refill < 3 sec mvt toes. patent (L) FA PIV HL & IV ABX. O/w assess. WNL. Will monitor — [redacted]

b(6)-2 A11

AUTHORIZED FOR LOCAL REPR

CAL RECORD | PROGRESS NOTES

TE | NOTES

11 JUN03 1355 - Assumed care of Pt @ 1300. VSS. A+O x3 C/O slight pain in (L) pinkey, ring finger, Drsg to (L) hand CDI, (+) sensation, cap refill <3 sec, mvt fingers. Drsg (+) foot CDI (+) sensation, cap refill <3 sec, mvt toes. Q4W b(6)-2 Assessment WNL. Will Monitor [redacted]

2300 Pt. care assumed @ 2100. VSS. HR Reg, [redacted] Lungs CTA BS (+) x4. Drsg to (L) UE CDI C brisk cap refill, (+) ROM, (+) sensation. Drsg to (R) UE CDI C (+) sensation, (+) ROM, brisk cap refill. Ø pain @ this time. Will cont. to monitor. [redacted]

b(6)-2

12 JUN 03 Orthopedic Op Note

0820 Pre-Op Dx - (1) (L) foot abscess
(2) (R) hand abscess

Post-Op Dx - same

Procedure: I + D (L) foot
I + D (R) hand

Surgeon: [redacted] b(6)-2

Findings: Foot abscess centrum to close
Lesse pus in hand [redacted] b(6)-2

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; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO

CPW # [redacted] b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Jul	Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. Bowel sounds x 4 quads. 0 % pain/discomfort. Pt has dc orders. Awaiting transportation. b(4)-2 [redacted] LPN-867
15 Jul 03 1500	assumed care @1500 - VSS - dsg CDI on (L) hand and (R) foot - ketlex @ bedside as pt. is awaiting dc to EPW camp - b(4)-2 pt. will leave c crutches [redacted]
15 Jul 03 1600	pt. had hands bound, meds in pocket c ID # tag attached, escorted to heli copter CMP escort for transport to EPW Camp [redacted] b(4)-2

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

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

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

REGISTER NO. | WARD NO. b(4)-2

#[redacted]
b(4)-2

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 JUL 03 21:32	Rec'd c/o pt. @ 21:00. Awake and alert in bed. Restraints x 2 wrist and ankle. Skin W/D. PERLA (+) WNL. LCA (B). BS (+) x4. (+) PPP (B). (L) Hand (+) ROM (+) sensation (+) <3 sec. cap refill. c/o 3/10 pain to [redacted] 3rd and 4th fingers. (R) foot (+) sensation (+) ROM (+) <3 sec. cap refill. [redacted] Kerlix dsg to (L) Hand C/D/I. ACE wrap dsg to (R) foot C/D/I. c/o 5/10 pain to (R) foot ∴ Percocet given. Will cont to mon [redacted] 2LT/AN
14 July 03 0830	New IV started in (R) hand. HR Regular. Lung sounds clear bilat, bowel sounds (+) x4 quads. Bandage to (L) hand CDI, (+) sensation in digits, full ROM, cap refill <3 sec. (R) foot dressing CDI, (+) sensation, limited ROM in digits, cap refill <3 sec. VSS. Pt. c/o complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT/AN
0630 96.6 P 54 RR 14 BP 116/74 Sats 96%	
14 JUL 03 1930	assumed care @ 1300 - VSS - SL removed - pt. started on PO Keflex 350mg QID - DC orders written, DC summary in chart, prescription to pharmacy - (R) foot dsg Δ'd, packing removed and dry dsg. placed on foot, 2 sutures in place around wound on foot - no c/o pain - (2) hand dsg intact - [redacted]
2120	Pt. care assumed @ 2100. Pt. resting quietly. HR Reg, Lungs CTA, BS (+) x4. Dsng to (L) hand, (R) ft CDI. Neuro checks (+) hand, (+) ft WNL. (+) IV access & pain @ this time. Will cont. to monitor. [redacted]
	b(6)-2 A11

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Transfer + D/C Note 28th CSH
14 Jan 03 1615	32 y.o. Iraqi male w/ hx sustained fragment wounds to (R) foot + (L) hand. Originally treated in Iraqi hospital, then sent to [redacted] b2-2 from GSW, camp. O/ on admission had abscess plantar surface of (R) foot w/ (L) RF-SF webspace. Multiple I+D's and wound packing w/ Chlorsol, with improvement.
	PLAN: D/C to GSW camp. Crutches, WBAT on (R). Daily dressing changes. Keflex 250 QID x 10 days
	[redacted]
	b(6)-2

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

[redacted]

b(6)-4

D [redacted]

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

1-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER

ARRIVAL — DATE: DAY 1, MONTH JULY, YR. 03 — TIME: 2300

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

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

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 (R) Foot

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2310

02.07.96

VITAL SIGNS			
TIME	2300		
BP	130/61		
PULSE	56		
RESP.	12		
TEMP.	98.1		
WT. (Child)			

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)

Prior to Admission Arrival,
PT CAS card stated 1Lm Amcf/SMSgt

Iraqi

32yo ♂ who came for EPW camp 2 days after a GSW to his foot and hand
Here for wound care

See HCP

Admit for wound care

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT 200

ORDERS	INITS.	TIME
1 cmpmcf IV	[redacted]	
5 mg MSO4 IV		2100
cefoxitin		2115
P7.077 TAS		2115
(R) Foot (L) Hand		2125
TENS Bilus.		2115

ASSESSMENT/DIAGNOSIS

(R) Foot (-)
(L) Hand (-)

7.2 / 12.3 / 27.4 / 39.7

CC 02/07.77

TAS

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: ICU2

Order 25 mg IV 2123
Tet. 5mg 2326

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(A)(a) [redacted] 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).

[redacted]

b(6)-4

SI [redacted] b(6)-2

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

EMERGENCY CARE AND TREATMENT

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

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: 32

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: Rt Foot I&D, Planning?

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco Ø ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Mscy, 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	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g.. warm blanket. touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

[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:_____

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 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] b(6)-2 PC/AN 3 July 03 DATE

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

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

BREATHING EASY: (Y) (N)

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

DATE: 3 JUL 03 TIME: 0840

13. POSTOPERATIVE EVA[redacted]PARED BY (Signature and Ti[redacted] PC/AN

DATE: 3 July 03 TIME: b(6)-2

REVERSE OF FORM 5179, JUN 91

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: 32

HEIGHT:

WEIGHT: 60 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
(R) foot (L) foot (R) foot I+D

4. PROPOSED SURGICAL PROCEDURE:
(R) (2) foot / (R) (L) hand washout

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

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

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
[redacted] b(6)-4
ICW-2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since noon ! 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

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

6. PATIENT PROBLEMS AND NEEDS	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	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. ✓ 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	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. Iraqi national	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 either 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 [redacted]ENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

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

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

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

BREATHING EASY: (Y)(N)

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

DATE: 6 July 03 TIME: 1545

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

DATE: 6 July 03 TIME: 2035 b(6)-2

MEDICAL RECORD — INTRAOPER... DOCUMENT b(6)-2

(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 I[redacted]WED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE: 9 July 2003 TIME PATIENT ARRIVED IN SUITE: ICW → OR

4. PATIENT IN ROOM TIME: 1305. NUMBER: 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA · NPO p MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT b(6)-2	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: (B) arm to padded arm board <90°.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

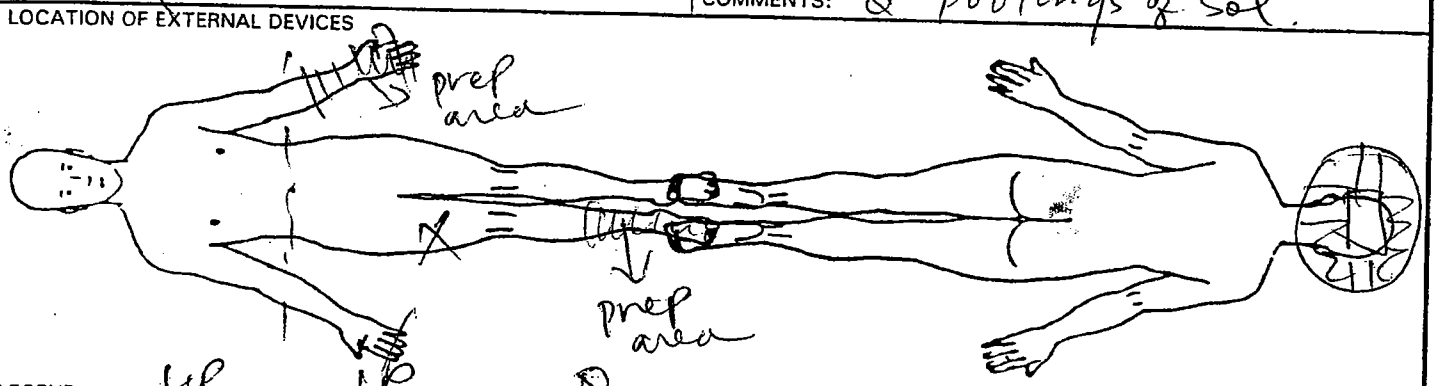
PREP SOLUTION (Specify) Betadine S/Sol

SITE: (R) foot BY WHOM: CPT. [redacted]

SITE: (L) hand > BY WHOM: >

COMMENTS: Pooltings of Sol. b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

b(6)-2

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

GPW [redacted]

b(6)-4

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

☑ ESU NO: Valley Lab

GROUND PAD: BRAND Polyhesive II

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag: 30, Cut: 30,

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ 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. 1/4" NU Gauze	2.	3.
SITE	1. Rt foot &	2. (Lt) hand	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Kerlix
Ace & Tape

19. ADDITIONAL INFORMATION

Surgeon: [redacted] b(6)-2
Anes: Maj [redacted] (CRNA)

20. OPERATION(S) PERFORMED

(Rt) foot I&D and (Lt) hand I&D

21. PATIENT TRANSFERRED TO b(6)-2 CCU TIME See Anes Record METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] LPT/Aide

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

MEDICAL RECORD | **INTRAOPERA[illegible] DOCUMENT**

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

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

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

3. DATE 6 July 03 TIME PATIENT ARRIVED IN SUITE 1940

4. PATIENT IN ROOM TIME 1940 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p 1200, NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Arms on armboards @ <90°. Left armboard doubled as an armtable.

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

COMMENTS:

8. SKIN PREPARATION

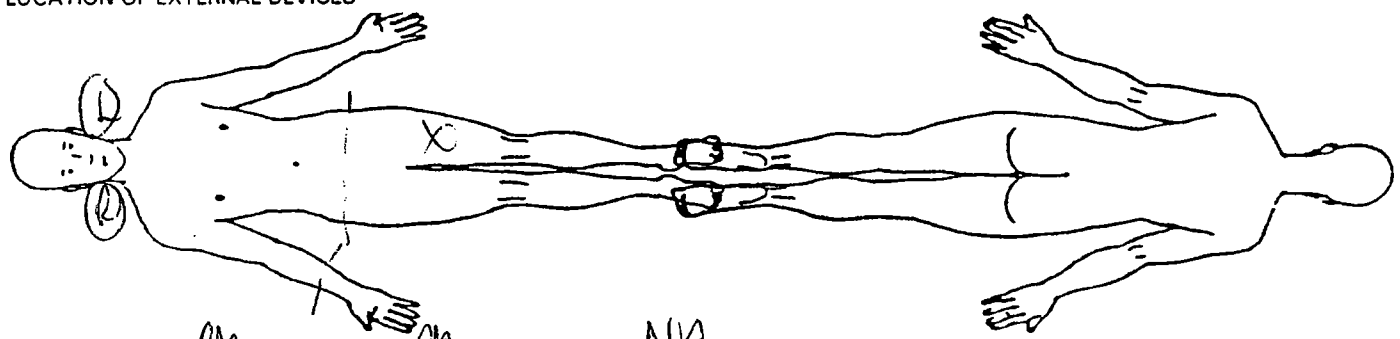
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betal Beta
SITE: Rt. leg knee → down BY WHOM [redacted]
SITE: Left Arm BY WHOM: [redacted]

COMMENTS: no pooling noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

Initial, C = Correct I = Incorrect b(6)-2

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
ICW-2

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

☒ ESU NO: # 000950
GROUND PAD: BRAND VL
LOT NO: 65706

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Iodoform Gauze	2.	3.
SITE	1. Right Foot	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, kerlex, Ace - (right foot & left hand)

19. ADDITIONAL INFORMATION

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

DA 5179 In Chart

20. OPERATION(S) PERFORMED
I&D Right Foot c packing / I&D left hand c delayed primary closure

21. PATIENT TRANSFERRED TO ICU-1 b(6)-2 TIME see DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

MEDICAL RECORD | **INTRAOPERAT[illegible]CUMENT**

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 Ames' Staff

2. PATIENT IDENT[redacted]ND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 29 July 03 TIME PATIENT ARRIVED IN SUITE 1CU2-20R

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

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. npop MN.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

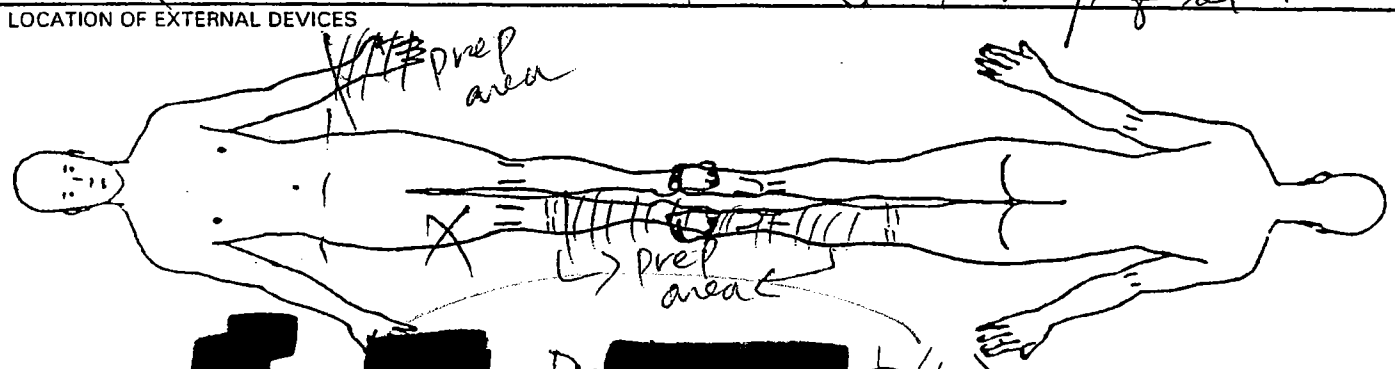
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine S/Sol.
SITE: (L) hand BY WHOM:
SITE: (Rt) Foot BY WHOM:
COMMENTS: 6 Pooling of Sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Sa[redacted]trap = = = Tourniquet Dr[redacted] b(6)-2

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] b(6)-4
Epon

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

☑ ESU NO: #1 Valleylab
GROUND PAD: BRAND Polyhesive II
LOT NO: 69652

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Coag: 30 Cut: 30

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): Orapo/oNacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	1/4" NU Gauze	1/2" NU Gauze	
SITE	(Rt) foot	(Lt) 5th finger hand	

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs.
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] b(6)-4
Anes: CPT [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Rt foot [redacted] I&D and Lt. hand I&D.

21. PATIENT TRANSFERRED TO b(6)-2 CU2 TIME See Anes. Record METHOD litter

22. REGISTER [redacted] CPT/AN

MEDICAL RECORD | **INTRAOPERA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Gurney BY Amo Staff

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

3. DATE 12 Jul 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0800 b(6)-2 NUMBER 1-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPOP MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] ORT b(6)-2	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:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

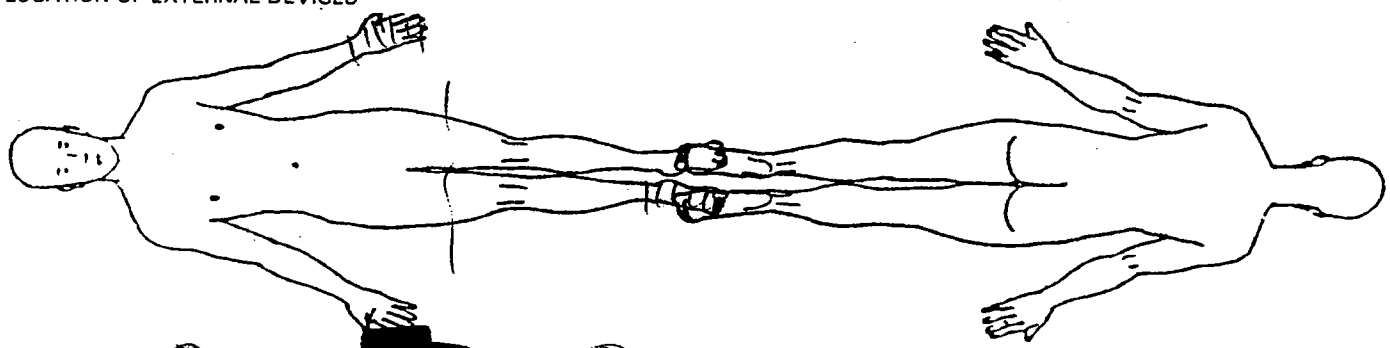
PREP SOLUTION *(Specify)* [redacted]

SITE: Rt foot BY WHOM: Dr [redacted]

SITE: Lt hand BY WHOM: b(6)-2

COMMENTS: ⊗ paeling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Su[illegible] = = = Tourniquet

C = Correct I = Incorrect

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

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

EPW #[redacted]

b(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ 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

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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Stuffs Ace
2x2
Kerlix Tape

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

Rt foot I&D & ⓛ hand washout

21. PATIENT TRANSFERRED TO b(6)-2 1 cu² TIME See Anes Record METHOD Litter

22. REGIST [redacted] Dr. (AN)

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

Date 04 July 03 Bed # 2

Patient's Name: EPW #[redacted]

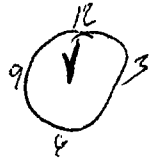
Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	110/76													110/74										110/73
TEMP	99.1													99.3										97.9
HR	104													107										101
RR	18													20										14
SAO2	94													96										97
FIO2	RA													RA										RA
INPUT																								
PO		250		180				250			250													
IV																								
NGT																				100				
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE		550		310			400				350				400			300						300
NGT																								
STOOL										X.1														
TOTAL		550		900			1300			1650					2050			2350						2650
BALANCE																								
Initials																								

MEDCOM - 12639

b(6)-1 [redacted]

3 Jun 03

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
					O																			
BP	120/50								120/68				122/82						115/80					
TEMP	97.4								98.3				99.1						98.0					
HR	48				R				68				64						61					
RR	16								14				18						20					
SAO2	96%								96				97						95					
FIO2	RA								RA				RA						RA					
	NPO	NPO	NPO						240															
Iv	100	100	100	100	520	100																		
NGT																								
IVPB																				50				
TURN Q 2																								
								1300																
								200																
TOTAL								1500	1340															
OUTPUT							750				650													
URINE	275	200												400					400					
NGT																								
STOOL																								
TOTAL	275	475				1225		1225			1875			2275					2075					
BALANCE																								



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