NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Jul 03 1245	Nursing: Pt admitted from ER for DVT (L) LE and Burns. ~~A+O x 4 meter~~ [redacted] 1245 A+O x 3, understands some english. Airway patent, respirations regular & unlabored. Sats 97% on 2L NC. Nursing staff starting debridement will administer pain medication as ordered. Infusing LR @ 150cc/hr via IV in (L) FA. Pulses in all extremeties weak but palpable. DVT to LLE. Leg swollen c̄ palpable pulse. Foley to gravity. Draining clear, yellow urine. Will continue to monitor. [redacted] /Au b6-2
3 Jul 03 1430	Nursing: Debridement completed. ~~Burn noted on~~ [redacted] 1433 Patches of 2nd degree burn noted on (R) palm up to armpit. Skin pink, (+) pain. 2° burn noted on (L) palm up to wrist. Skin pink and bleeding. White/yellow ~~areas of tissue~~ [redacted] 1443 no tissue noted on abdomen and (R)+(L) thigh. Skin red c̄ black areas noted on (B) heel. Skin red on buttocks. Silvadene cream applied to burn areas and wrapped c̄ Kerlex. Pt did not tolerate procedure. Pt very agitated and fighting staff during debridement. Total of 20mg MSO4 IV and 10mg Versed IV used for pain and sedation. Pt resting quietly. Easily arousable. Respirations unlabored.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED BY [redacted] /Au b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

#[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3 Jul 03 1545	Nursing: ~~General Surgeons n~~ 1545 Pt diaphoretic, T-99.5, pt lethargic but arousable. Respirations tachypneic and labored. Sats 89-90% on 6L NC. Pt switched to 50% Ventimask. Sats 92%. Expiratory wheezing c̄ Rhonchi noted in Ⓑ upper lobes. HR ↑ 130-140s. General Surgeons notified. ABG + EKG done. Nasal trumpet inserted in Ⓡ nare. 0.2 mg of Narcan IV administered. Neb treatment given by RT. Pt more comfortable p̄ treatments. Sats 90-92% on Venti Mask (50%), RR 16, HR 122. Respirations regular + unlabored. UOP < 20cc/hr. Pt given 500 cc NS bolus. Will continue to monitor. [redacted] b6-2
3 Jul 03 1656	Nursing: UOP - 10cc, pt given another 500cc NS bolus per Dr. [redacted] b6-2 b6-2 [redacted]
3 Jul 03 1800	Received report from ongoing shift. Pt on FM 50%, Sat 89-90% drowsy but arousable. Speak + understand English, gave albuterol neppz x2. Burn dressing to arms + legs intact. Edema to UE + LE. Ⓛ LE > Ⓡ LE. Pt is monitored for possible DVT. See flow sheets for pertinent info [redacted] b6-2
1830	UO still decreased, given another bolus of LR 500 C 1500 today. Monitor urine output, notify MD if still on urine [redacted] b6-2
2130	Increased IVF rate from 150cc-200cc, urine output from 35-50c. O_2 sat up to 100% c̄ VM@50%. Titrated O_2 ↓ to NC 2L/min sat remained in the upper 90s, lungs c̄ crackles upper lobe c̄ mild wheezing, ↓ BS lower lobe. Pt observed to be asleep but arousable. In no apparent distress. Ⓛ LE elevated. [redacted] b6-2
2300	Dressing changed to hands/arms, LE + back c̄ debridement. Burn surfaces on the arms + legs appear ~~[illegible]~~ whitish.

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J-00-534-4178

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
31 Mar	Progress Note
	Ø complaints
	VSS afebrile
	wounds Eschar on heel (fr) loosing
	(+) necrotic tissue (B) knees
	loss of soft tissue (C) right
	Hand graft looks good
	Dx: needs further debridement
	to OR in Mx [redacted] b6-2

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

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1

[redacted] b6-4

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)*
2300	Pt is observed to be asleep @ this time UO increasing. Will monitor closely. Afebile, sat 91-99% (nasal) Pain well managed by MSO4 6mg during dressing changes. b6-2 [redacted] Maj/AN
0400	Pt slept throughout the night. Received nebs treatment @ this time c̄ albuterol puffs x4, breathing unlabored maintaining sat >90% in RA, probe nasal. T99.9 @ this hour. Pain and comfort well controlled c̄ p.o. + IV management. b6-2 [redacted] Maj/AN
5JUL03	Surgery
0700	No events overnight Foley patent
	VSS AFCS.
	Chest CBTA
	CVS RRR 2HP
	Abd NABS soft ND
	wound to be dressed
	A/P 10 2° BSA Burn and (L) DVT
	Doing well much improved Mental status Needs to eat or will Repume DHT. Pt may Ambulate [redacted] b6-2

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1/4/0 [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Jul 03	Pt doing well after dressing change, medicated c̄
1030	MSO4 16 mg & Versed 5 mg but pt still in great pain
	may require conscious sedation next time, Pt up out of
	bed & stood for 15 min for dressing change on back &
	bottom. (L) AC PIV infiltrated → Blood, catheter intact,
	will continue to monitor ~~ [redacted] b6-2 ILT/AN
1700	Received report from RN. ~~ [redacted] b6-2 ILT/AN
1800	Assessment completed. ~~ [redacted] b6-2 ILT/AN
2100	Drsg changed started. Premedicated c̄ MSO4 5mg,
	Versed 3mg. Given total MSO4 of 20mg, Versed
	10mg. Patient did not tolerate any scrubbing; would
	withdrawn. Recommend conscious sedation for
	debridement of multiple burn sites. VS remained b6-2
	stable throughout drsg Δ. Drsg Δ compled 2240. [redacted]
6 JULY 03 0100	Patient sleeping VSS ~~ [redacted] b6-2 ILT/AN
0300	Patient sleeping. VSS. Awakened for T&C blood drawn.
	Arterial blood drawn from (R) radial stick. [redacted] b6-2 ILT/A
0500	Report given to RN. ~~ [redacted] b6-2 ILT/AN
6 July 03 0500	Received report from previous shift. Pt resting
	quietly c̄ eyes closed. Peripheral IV intact. O2
	sats 96% on RA. Bilat. ↓ ext. elevated on half
	donuts. Noted scrotal edema. Scrotum elevated.
	Pt is edematous. Will ambulate. CXray complete
	Ø labs drawn this a.m. Type and cross 2 units
	PRBC prepared by previous shift. Concern about
	pain control during drsg Δ. Suggest conscious
	sedation. Will discuss with MD. Will cont.
	care. ~~ b6-2 [redacted] ILT/AN

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6Jul03	Surgery Op Note
1205	indication Burn wound
	procedure excision of Burn
	Surgeons [redacted] b6-2
	Anesth GETA
	Finding Large Burns on Abd/Thighs/Ant Knee
	excised to viable tissue WND Dressing.
	Cerving None
	DBps to ICU 3 in good cond.
	[redacted] b6-2
6 Jul 03	Pt resting c̄ any complaints, has not requested any need
2200	for pain. Foley draining gs yellow urine. No new issues.
	Dressing to the abdomen draining slowly drain. Will change
	dressing & continue to monitor — b6-2 [redacted] Mary Ann
2330	Medicated c̄ MSO4 4 mg IVP for c/o wound pain. b6-2 [redacted] Mary Ann
0200	Pt is observed to be asleep. VSS. UE/LE elevated. b6-2
	Aerotal elevated elevated on a trivel — [redacted] Mary Ann
0400	Pt up to the BSC c̄ assistance, put out large amt of
	soft/loose stool. Received total of 7 mg MSO4 prior to OOB
	& upon return to bed. Max T 100.2 @ thirteen. Foley ↓

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[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Jul 03	Continuation:
0400	UO from 50 to 30 cc per. Pts. continue to monitor UO report if continue to decrease. b6-2 [redacted] Key/N
0500	Rcvd report & care of pt. from previous Shift. pt sleeping in bed A&S of pain/discomfort VSS will cont to monitor b6-2 [redacted] LPN
0800	Pt awake resting in bed VSS will cont to monitor b6-2 [redacted] LPN
1200	Dsg Δ's complete tol well. Conscious sedation tol well. Wounds appear beefy red to pink c̄ some eschar remaining. Wet to dry Δ's on Abd. and bilat. thighs. Silvadene applied to feet bilat., buttocks, arms & hands bilat, and back. VSS throughout will cont to monitor b6-2 [redacted] LPN
1500	Pt consumed 2 cans of Ensure Plus and told he needs to eat and drink his ensure or the other option will be to place a dobhoff tube. Pt understands options that were explained to him VSS will cont to monitor b6-2 [redacted]
1700	Report and care of pt given to oncoming shift. b6-2 [redacted] LPN
1730	Received report from ongoing shift. patient appear drowsy but easily aroused. IV LR @100 thru the SC triple lumen cath Foley intact draining tea colored urine. dressing intact, instructed to change grafted area c̄ W-D dressing. Pt to have Ensure as tolerated & encourage p.o. food intake b6-2 [redacted] Key/N

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 JUL 03 0630	Pt resting quietly. Discussed POC c̄ pt. Gave RT tx. Pt remains NPO status. Will do daily hygiene care — b6-2 [redacted]
1015	Prep pt. for OR. Pt left for OR via litter. [redacted]
1200	Completed drsg Δ in OR. Cleaned bilat ↑ext c̄ hibiclens and rinsed c̄ NS. Covered burns c̄ silvadene and gauze. Wrapped wounds c̄ kerlex. — b6-2 [redacted]
1200	Cleaned buttocks and back wounds c̄ hibiclens and rinsed c̄ NS. Applied silvadene and covered c̄ gauze. — b6-2 [redacted]
1240	Received pt from OR. Pt has bilat ↓ ext wrapped c̄ ace wraps. Bilat ↓ ext and stomach are wet → dry drsgs. Montgomery straps present on stomach/abd region. Pt awaken easily by verbal response. Pt able to swallow water. Gave RT tx. O_2 sats low 90s. Will cont. care. [redacted]
1240	Pt on 5L O_2 via NC due to anesthesia from OR. — b6-2 [redacted]
1255	Noted ® jugular central line placed by anesthesia in OR. ∅ S/S of infection. Will secure c̄ tape b6-2 [redacted]
1350	Pt ↑ pain in arms and legs. Gave MSO4 ii mg IVP. Will cont. care.

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[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 JUL 02 1350	to assess pain level. — b6-2 [redacted] 17/X
1420	Reinforced dsg on bilat ↑ ext due to weeping wounds will cont. care. — b6-2 [redacted] 17/XX
1600	Pt resting quietly c̄ eyes closed. Appears to be in Ø pain. LR @ 100cc/hr infusing. Will cont. care. [redacted]
1700	Gave report to night shift. — b6-2 [redacted] 17/XX
1800	Received report from ongoing shift. Pt alert, able to verbalize needs. IV LR @ 100 thru (R) SC triple lumen. VSS, T 100.0 dressing intact. Brief pt regarding plan of care. — b6-2 [redacted]

per pt
per pulg
7/7/03

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
08July03 0000	Premedicated c̄ MSO4 6 mg c̄ Versed 2.5mg for dressing change to the abdomen and upper legs (thighs) Wound S/P dehiscence 6 July. Wound clean applied W-D dressing. Given additional MSO4 4mg and Versed 2.5mg during the procedure at approx 2300. Pt continue to c/o pain, gave Percocet ii p.o. and MSO4 2mg. Pt is observed to be asleep, RR 11-12 [redacted] SAO2 98% RA. [redacted] Maj/AN
0400	CBC, Met 8, T + C ii sent. Pt slept c̄ intermittent wakefulness for c/o generalized wound pain received a total of MSO4 10 mg from 0000 - 0400 given three increments. Pt. is observed to be asleep. Just received 4mg MSO4 @ 0350. Afebile, VSS [redacted] Maj/AN
0500 8Jul03	Rcvd report & care of pt from previous shift VSS [redacted] (P) Surgery HD # 5 POD #2 No events Not taking PO well VSS AFeb HO increasing Chest CBTA cor RRR 2ABD Wounds - Granulation beginning on exogenous sites. 6 30 474 134/98 7 104 SB 20 0.7 over →

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8JUL03	Surgery (cont)
	A/P 10% Burn mostly full thickness, plan grafting in the next couple of days.
	DVT - Resolving edema swelling.
	[redacted] b6-2
0730	Pt resting comfortably in bed. VSS pt shows no s/s of pain/discomfort will cont. to monitor b6-2 [redacted]
0930	Dsg. Δ's complete tol well c̄ conscious sedation wounds appear beefy red to pink, some eschar remains. Wet to dry dsg. to Abdomen + upper legs. Silvadene applied to lower legs, hands, arms, buttocks + back. VSS throughout will cont to monitor b6-2 [redacted] LPN
1015	Dobhoff tube placed and placement verified by X-RAY. b6-2 [redacted] LPN
1215	Pt sleeping in bed & s/s of pain or discomfort. VSS will cont to monitor b6-2 [redacted] LPN
1330	Pt given Percocet 2 tabs for pain will ambulate in 30 minutes VSS will cont to monitor b6-2 [redacted] LPN
1630	Pt OOBTC for 2½ hrs. Pt now back in bed. Pt VSS throughout will cont to monitor b6-2 [redacted] LPN
1700	Care of pt and report given to oncoming shift VSS. b6-2 [redacted] LPN
2000	~~pt complaining of abdominal pain. Pt [illegible] pain with [illegible] & moaning & tossing & turning~~ b6-2 [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1050	7.7 / 28 < 6.74 129 / 3.7 | 96 / 28 < 10 / 0.9
	A/P s/p Burn excision Aga to viable tissue
	Necrotic Areas remaind.
	on Abx for possible cellulitis Vanc / Levaquin
	DVT on Lovenox
	[redacted] b6-2
10/30/03	Brief op Note
	indication Full thickness Burns
	~~surge~~ Procedure Repeat Burn excision
	Surgeon [redacted]
	Anest [redacted] b6-2
	LR - 1100 40-175
	PRBC - 2u EBL 450
	Findings Previous Burns excised to SUBQ
	tissue. Necrotic tissue Debrided
	(R) Arm Debrided.
	Comp None.
	[redacted] b6-2

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9 JUL 03	Surgery
	No events overnight
	Tm 101.6 99. now HR 100's
	Eom Chest CBTA Lung Nodules
	Abd ND NT
	Wounds (R) Knee & (L) Hip Region
	more Debridement.
	? cellulitis, around (L) Groin by wound
	A/P ? burn cellulitis
	Add Vancomycin
	↓ IVF due to Goal @ TF
	Plan Op Debridement on Aug
	[redacted] b6-2
10 JUL 03	Surgery
	Tm HR BP
	Chest CBTA
	CO RRR 2+PD
	Abd Quite BS
	Wounds - Debrided to Viable tissue today.
	Over →

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
20 Jul 03 0745	OR staff here to pick up pt for Procedure. VSS. [redacted] 9/WMC b6-2
20Jul03	Surgery op Note
	Indication Burn
	Procedure STSG from BACK to (L) Forearm/HAND, (R) Ant knees, (R) Lateral Lower Leg, SACRAL AREA
	Surgeons - [redacted] b6-2
	Anesth [redacted] b6-2
	Fluids -
	Procedure as Above. VAC to most sites
	Comp None.
	to ICW U 3 stable
	[redacted] b6-2
	[redacted] 28CSH MD RACS
1215	Pt returned from OR. Pt awake + alert to voice + Pain stimuli. Pt had EBL of 50cc, UOP of 100cc, Received 2000ml LR, 1000 mcg Fentanyl, +5mg Versed. Will Monitor. [redacted] 9/WMC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted] b6-2
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[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
20 Jul 03	Recovery VS below — [redacted] 9/6/M6 b6-2

Time	1220	1225	1230	1245	1300	1315	1330
BP	126/77	120/76	125/75	147/79	127/72	134/72	131/69
HR	92	94	98	103	109	108	107
RR	24	26	26	36	34	26	22
Temp	94.2	94.2	94.3	94.6	96.4	97.4	98.2
SAO2	95%	95%	95%	94%	94%	94%	93%
Method	RA	RA	RA	RA	RA	RA	RA

1330 Pt currently stable, VSS, Lying in bed looking around ward. Will continue c̄ Plan of care. b6-2 [redacted] 9/6/M

1515 Pt temp ↑ to 100.8, Medicated c̄ 650 mg tylenol. Will continue to Monitor. b6-2 [redacted] 9/6/M6

1620 Pt Lying in bed on (R) side. VSS, No issues @ this time. Temp ↓ to 100.8, Will continue to Monitor. b6-2 [redacted] 9/6/M6

20 July 03 (1800) PT CARE Report Recieved from SPC [redacted] Pt b6-2 Resting awake in Bed c̄ acute Episode Reported or noted. Wound VAC to (L) leg, ABD & (L) arm on a continuous 125 mmHg suction. PIV 18g to (R) FA c̄ S/Sr infiltration. c̄ LR 100° via Gravity flow. Dressing to graft sites (L) arm, ABD, BLE) intact, clean, dry. Back drsg intact, clean + dry. Sacrum drsg intact clean + dry. b6-2 [redacted] 9/6/M6

20 July (1840 + 2400) Tmax lim tAC ÷ Po for loose Brown Stool. Resting c̄ core. Refused Cl. liq diet. [redacted] 9/6/M6 b6-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
21 July 03 1130	Dsg Δs complete Pt tol well. Dsgs to Skingrafts on buttocks, (L) arm + hand + Bilat. Lower extremities intact. Dsgs to Donor sites on back + leg intact VSS throughout conscious sedation. Will cont to monitor b6-2 [redacted] 2D
1330	Pt resting in bed & c/o pain or discomfort VSS, will cont to monitor b6-2 [redacted] LPN
1600	Pt awake in bed. & c/o pain or discomfort VSS
22 July (1800)	will cont. to monitor b6-2 [redacted] 2D
	Pt CARE Report Received from SPC [redacted] b6-2
	Pt awake, alert, oriented to person only.
	NO Acute Episode noted / Reported. b6-2 [redacted] 91WMB
22 July 03 (1900)	Immodium tab i Given po for loose Stool by brown. Pt's adverse effects. b6-2 [redacted] 91WMB
22 July 03 (2200/2400)	Albuterol inhaler + IS exercise administered per Rx. Pt remains awake for this shift. b6-2 [redacted] 91WMB
23 July (0300)	Remain awake i acute Episodes. b6-2 [redacted] 91WMB
23 July (0600)	Blood Specimen for CBC, [redacted] Sent to lab. Pt's adverse effect noted from procedure. [redacted] 91WMB
23 July (0600)	Pt care Report given to SGT [redacted] b6-2 Pt Still awake i acute episode noted. b6-2 [redacted] 91WMB

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22July03	Rcvd report + care of patient VSS pt. sleeping. b/s
0600	of pain or discomfort. will cont to monitor b6-2 [redacted] LP
0830	Pt DC'd own dobhoff tube. Pt scheduled to restart
	tube feeds tomorrow 23July03, VSS pt resting
	comfortably in bed will cont to monitor b6-2 [redacted] LP
22Jul03	Surgery
Lovenox	No complaints POD#2 from STSG to (C) Arm
Albuterol	(B) knees and Buttocks
Sedation	Tm 99.8 90-100HR BP 110's/60's 40 50-80 cc/hr
	AxO
	Chest CBTA
	wounds Dressed
	ABG. 135/101/4.4 21 10/96/0.9 7.0/29.8 91.7
	A/P Doing well. will Remove VAC on STSG tomorrow.
	[redacted] b6-2

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[redacted] b6-4

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(41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23 July 03 1545	Unable to flush pt's IV. New IV started. 20g needle catheter inserted in (R) AC. Site flushes well. Ø infiltration noted to area. Will continue to monitor pt. b6-2 [redacted]
1708	Pt. resting in bed quietly & distress. Ø complaints noted @ present time. Will continue to monitor. b6-2 [redacted]
1630	pt report received @ 1800 by SGT [redacted] b6-2 pt lying calmly in bed no problems @ present will continue to monitor b6-2 [redacted] SPC
2300	pt remains awake pt medicated due to BM Pad Δ. pt VSS No sign of acute distress noted @ present will continue to monitor throughout night b6-2 [redacted] PFC
@0300	pt resting calmly in bed no problems @ present VSS pt shows no signs of acute distress @ present will continue to monitor b6-2 [redacted] PFC
@0555	pt resting calmly in bed condition & vital signs stable pt has Ø complaints of pain @ this time graft site maintained throughout night no problems noted No S/S of acute distress noted @ this time will continue to monitor b6-2 [redacted] PFC
@0610	pt report given to Spc [redacted] VSS no problems @ present b6-2 [redacted] PFC
0630	Received report and care of pt from previous shift. Pt awake in bed & c/o pain or discomfort. VSS will cont to monitor b6-2 [redacted] LPN
0830	Pt sleeping in bed & s/s of pain or discomfort. Dressing intact will cont to monitor b6-2 [redacted] LPN
1130	Pt awake in bed, VSS & c/o pain or discomfort will ~~comfort~~ continue to monitor b6-2 [redacted] LPN
1330	Pt sleeping in bed VSS & s/s of pain or discomfort will cont to monitor b6-2 [redacted] LPN
1630	Pt Dsg Δ's complete Pt received 250 mcg Fentanyl Pt tol well. Graft sites healing well wounds appear pink to beefy red VSS. will cont to monitor [redacted] LPN

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23 July 03 0715	Received report from Sgt [redacted] b6-2 @ 0700. Pt. sitting up in bed c̄ eyes opened. Ø complaints voiced. Ø distress noted @ present time. HR @ 100 bpm/hr. Incontinent to (B) area c̄ redness/swelling noted to area. Drsg. noted to (B) leg c̄ vacuum band, also noted to abd. region. Pt has TIC to gravity @ 88. Will continue to monitor. Sgt. [redacted] b6-2
0819	Pt. resting in bed c̄ eyes open c̄ discomfort noted @ present time. Will continue to monitor for S/SX. Ø distress. Sgt. [redacted] b6-2
0953	Sutures removed from graft site in front. Pt. tolerated procedure well. VSS. BP 105/69 RR 19 SpO2 95% HR 101. Drsg. Δed done as Ø ma. D.O. Pt. resting comfortable in bed after Drsg Δed completed. Ø distress noted. Will continue to monitor. Sgt [redacted] b6-2
1225	Temp 100.4 Tylenol tab ii po given for fever. Sgt [redacted]
1306	Temp. 98.2. Rest in ⓟ bed c̄ eyes opened. Ø distress noted. Will continue to monitor. Sgt [redacted] b6-2
1348	Pt. restless, appears confused @ present time. Removing bandages as soon as staff walks away from bed. Rambling on and on in Arabic when translated Pt. would like to have all staff. Will continue to monitor. Sgt [redacted] b6-2

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

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
(41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 July	(0600) Pt care Report given to LT [redacted] b6-2. Pt awake c̄ noted distress. b6-2 [redacted] 9 lumo
25 July 0600-1100	Received report from previous shift. Pt resting comfortably c̄ eyes closed. Intermittent sleep. LR infusing @ 100 cc/h via dial-a-flow. Drsgs intact. Viewed labs. Will report abnormal results to Dr [redacted] b6-2. Will con't care [redacted] b6-2
0800	Completed drsg Δ. Covered donor site on back c̄ burn pad. Washed burn sites c̄ hibiclens x̄ back (R) thigh and rinsed c̄ NS. Placed silvadene on (R) heel and (L) heel, (R) upper thigh, bilat hands, upper back, (L) thigh. Placed xeroform gauze on bilat knees, buttocks and covered c̄ sulfamylon soln. Wrapped (L) leg c̄ splint and ace bandage. Need to get splint made for (L) leg. Will contact PT. Gave total 225mcg fentanyl throughout drsg Δ. Wasted 25mcg fentanyl witnessed by Sgt b6-2 [redacted]. Completed foley care and bed bath. Pt tolerated drsg Δ well. Pt lifted own leg and turned self. Δ'd linen and placed two burn pads. Turned pt on (R) side. Pt resting quietly c̄ eyes closed @ this time. Will cont. care. b6-2 [redacted] 1000
1100	Pt resting in bed at this time. Pt has ∅ complaints of pain or discomfort VSS will cont. to monitor [redacted] b6-2 [redacted] JPA
1200	IV in (R) FA infiltrated. D/C'd IV. Will restart IV. b6-2 [redacted] 1000
1300	Pt UO <30cc. Attempting to restart IV. [redacted] 1000

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b6-2

NSN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
24 July (1800)	Pt CARE Report Recieved from SPC [redacted]. b6-2 Pt Awake, Alert & NOTED/Reported Acute episodes [redacted] b6-2 9 Ulmo
24 July 03 (2000)	Ambien 5mg PO given for rest. Pt go being tired but noted ↑ agitation: pulling at lines, dressing & Blankets. PO intake of ↑↑ glasses of juice, 1 jello cup & 1/2 glass H2O Readily taken & noted dysphagia, N/V. Resting awake & care. [redacted] b6-2 9 Ulmo
24 July 03 (2200)	Pt dangling @ Bedside, @ Own self Repositioning. Placed in Chair @ Bedside. Resting awake & distress noted. [redacted] b6-2 9 Ulmo
24 July 03 (2300)	Assisted Back to Bed. Ambs c̄ slow maneuvers. Needs Reminding to Rotate feet. Assisted by (2) Staff members. Sideboards is ↑ to HOB (antifalters). PIV (L) upper arm patent/intact & S/Sx infiltration. Dressing intact to UE/LE, ABD + [redacted] Buttocks [redacted] b6-2 9 Ulmo
25 July (0300)	Incontinent of large Soft Brown Stool. Buttock wound cleaned / Red Resolved c̄ Vaseline Gauze + Sulfamylon Solution. (L) leg immobilizer Removed & ↑ soiling. Pt resting Quiet & care.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS [redacted] 9 Ulmo
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	b6-2

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
# [redacted] b6-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
9 (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 July 03	(2100) Assisted back to Bed c̄ (2) Staff members Transfers c̄ partial weight bearing & poor Rotation of feet. HOB ↑ low fowlers. Ambien 10mg Po given per Rx. Resting Awake s̄ distress noted. PIV 20g to (L) wrist s̄ s/sx inf. Heation. Foley draining b6-2 cloudy yellow urine (U.O. ≥ 30cc/hr.) — [redacted] 91WM6
25 July 03	(2300) Pt Remains Awake. Noted yawning. Frequently. — b6-2 [redacted] 91WM6
26 July 03	(0100) Pt c̄ snoring Respiration. Asleep s̄ noted distress. — b6-2 [redacted] 91WM6
26 July 03	(0300) Pt Remains Asleep s̄ acute episode noted. — b6-2 [redacted] 91WM6
26 July 03	Pt care report given to LT [redacted] b6-2 P & awake s̄ acute episode. — [redacted] 97WM6 b6-2

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NSN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
25 JUL 03 1450	Restarted IV 20 gauge (R) wrist. LR infusing @ 100cc/h. Will cont to monitor UO. Will cont. care. b6-2 [redacted] ICTAN
1500	Pt UO <200cc/°. Informed Dr. [redacted]. 1L NS bolus verbal order. Will cont to monitor U.O. b6-2 [redacted]
1600	Pt walked from bed to chair ō minimal assistance. Pt wincing in pain. Gave 4mg MSO4 @ 1645. NS bolus infusing. Sing linen. Bneeds from pt. Will cont. care b6-2 [redacted]
1700	Pt sitting in chair & tolerating well. Pt ate 6 bites of dinner and refused the rest. Explained to pt if not eat will give dophaff tube. Will cont care. b6-2 [redacted] ICTAN
1800	Gave report to night shift. ∅ BM throughout day. UO ≈ 38 p bolus. ≈ 300cc bolus still to infuse. b6-2 [redacted] ICTAN
25 July (1800)	Pt CARE Report Recieved from LT [redacted]. b6-2 Pt Awake & NOTED Acute Episode. Oriented only TO Person. Co-Operative. Sitting in Chair At Beside. [redacted] 9ICW b6-2

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#[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
27JUL03	Progress Note
	Patient 5 specific complaints today
	HR 91 RR 14 97%SAO2 RA 136/4.6 | 103/22 | 7/1.0 <98
meds	VOP 7855
Albuterol 2 puff	Tmax 100' 9.5 > 9.7/31.7 < 990
90°	wounds newly dressed
Lovenox 90g SQ	Ø central line
BID	Pg: Progressing well
Fentanyl patch	Plan DVS to q 3°
	Δ labs to thrice weekly [redacted] b6-2

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1 [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
29 July 03 0711	Recieved report from Sg [redacted] b6-2. Pt. resting in bed c̄ eyes closed. Ø distress noted. Ø complaints voiced. VSS. LR@ 100cc/hr. IV site patent. Will continue to monitor — b6-2 Sgt [redacted]
0800	Percocet Tab ii po for disq Δ. Tolerated procedure well. Ø distress noted @ time. Pt. up to chair for breakfast p̄ disq Δ. Consumed 50% of morning meal. Drank 360cc of fluids c̄ meal. Up to chair-bedside toilet for BM p̄ breakfast. Will continue to monitor. — b6-2 Sgt [redacted]
1044	Pt. remain sitting in chair s̄ discomfort. Will continue to monitor. — b6-2 Sgt [redacted]
1147	Pt. back to bed s̄ difficulty. Will continue to monitor. — b6-2 Sgt [redacted]
1226	Pt. consumed 50% of meal. — b6-2 Sgt [redacted]
1418	Resting in bed c̄ eyes closed. Ø distress noted. Will cont. to monitor. — Sgt [redacted]
1753.	Up to BS toilet. Ø distress noted. Will continue to monitor. — b6-2 Sgt [redacted] b6-2
1830	Received report from day shift, pt resting comfortably in bed. [redacted] b6-2 SPC, 91WM6
1900	Pt IV DC'd due to leaking. Spoke to MD, Dr [redacted] b6-2 would like pt but put monitored through night. [redacted] SPC 91WM6
2300	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] b6-2 SPC, 91WM6
30 Jul 03 2400	pt ↑ OOB to Bedside commode, small BM (formed). Will continue to monitor. [redacted] b6-2 SPC, 91WM6
0400	Pt resting comfortably in bed. Will continue to monitor [redacted] SPC, 91WM6

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b6-2

NSN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 July	1000 received report from previous nurse @ 0600; Pt resting comfortably in bed. IS x 10 (3hrs), Dressing changed c̄ 2 percent, Silvadene to burn and donor sites, petrolatum gauze c̄ sulmylon soaked gauze on graft areas, Ace wrap c̄ splint in (D) leg. Pt stood up for dressing change on back and butt, Sat on chair for breakfast ate 20% c̄ 1 can ensure, foley care done, Arm care done, VSS afebrile, will monitor [illegible]
1700	Pt walked the length of ward x2 mostly on his own c̄ minimal assist, Sitting up on chair, Ate 25% of dinner, 1 can ensure, VSS. tolerated well, Ø c/o will monitor [redacted] b6-2 b7/A
28 July 03 (1800)	Pt can Report Received from U [redacted] b6-2 Pt up in chair ~~3~~ Acute Episode noted / Reported. b6-2 [redacted] 91WM6
28 July (2120)	Back to bed c̄ assist of (2) Sp4s. Slow, unsteady gait c̄ posture leaning forward. Positioned on (L) side. b6-2 [redacted] 91WM6
29 July (0100)	Continue sleeping @ 1.5-2.0 hr intervals ~~3~~ Acute Episode, b6-2 [redacted] 91WM6
29 July (0600)	Pt care report given to [redacted]. Pt Resting Asleep ~~3~~ acute episode noted. — [redacted] 91WM6 b6-2

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[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIP' '41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
31 July 03 0630	Report recieved from night shift nurse. pt VSS, Ø IV access, foley cath in place draining clear yellow urine. Will continue to monitor. [redacted] 91WM6
0730	pt pre medicated for drsg Δ c̄ percocet II tabs PO [redacted] b6-2 b6-2
0930	Pt's dressings Δ'd. Xeroform on back trimmed. Dr. [redacted] b6-2 present during drsg Δ to evaluate wounds. pt for OR tomorrow in AM [redacted] 91WM6
1200	pt VSS, asleep in bed @ this time. Consumed 50% of lunch. [redacted] 91WM6
1400	pt out of bed, sitting in chair. [redacted] 91WM6
1756	pt currently sleeping. VSS. Consumed 40% of dinner. [redacted] 91WM6
~~1800 3D~~	(31 July 1800) Pt CARE Report Recieved from day [redacted] b6-2 / SPC [redacted] b6-2. Pt resting in Bed aware's acute episode noted / Reported. [redacted] 91WM6
31 July 03	(1900) Skin Assessment unremarkable pt wounds to Bilat Heels, ABD, Back, Buttock & BLE (thighs, LE). Pt Request & Analgesia. Denies discomfort. All wounds dressed per Rx. [redacted] b6-2 91WM6
31 July 03	(2030) PIV 20g CATH STARTED TO (L) upper Anterior Arm by LT [redacted] b6-2. Previous attempts to Bilat FA unsuccessful by SSG [redacted] b6-2 / SPC [redacted] b6-2 NS @ 100° per dial-A-flow. Site intact w̄ opaque dressing. [redacted] b6-2 91WM6
01 July 03	(0315) To BSC per Request "my stomach". No acute distress noted @ present. [redacted] 91WM6

FPI. LEX. Printed or 17:57:48 HR=97 P1 =OFF P2 =OFF RR=18 SpO2=83% NIBP=OFF T1=OFF T2=OFF ΔT=OFF b6-2 BACK

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
30 July 03 0630	Recieved report from SPC [redacted] b6-2. pt VSS Ø IV access, foley cath in place. Will continue to monitor. — SPC [redacted] b6-2 91WM6
0830	Drsg changes done. pre medicated c̄ Percocet II tabs. — [redacted] b6-2 91WM6
1200	Foley cath D/C'D — [redacted] b6-2 91WM6
Correction	Last note, wrong pt — [redacted] 91WM6
1200	pt sleeping @ this time. VSS, afebrile. UOP adequate. Will continue to monitor — [redacted] b6-2
1600	VSS, no Δ in condition — [redacted] b6-2
[redacted] 30 Jul 03 1800	~~Received report from of going shift. Pt appears to be resting comfortably in bed. VSS. PICC to ⓪ E4 ⊕ Flush to both ports~~ [redacted] b6-2
30 Jul 03 -	
1910.	Pt up sitting in chair. Pt transferred c̄ minimal assist — [redacted] b6-2
2010.	Pt had small soft brown BM. Pt back to bed — [redacted] b6-2
31 Jul 03.	
0130.	Pt continues to appear restless in bed. Ambien 5mg PO given to help pt sleep — [redacted] b6-2
0545	Pt resting quietly in bed c̄ complaint. VSS — [redacted] b6-2

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Pt EPW [redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
01 Aug 03	(0600) Pt Remains hemodynamically stable. NPO Status intact for pending surgical procedure. Eve dose of Lovenox held. Pt Care Report given to SPC [redacted] b6-2. Pt asleep's Acute Episode. — [redacted] 91WM6
0630	Report recieved from night shift nurse. pt VSS, No significant changes in pt condition over night. IV 18g L AC LR @ 100 cc/hr. — [redacted] b6-2 91WM6
0730	pt leaving for OR at this time — [redacted] 91WM6
1030	pt back from OR. VSS will initiate recovery procedures — [redacted] b6-2
1200	pt sleeping at this time. VSS, afebrile Ø c/o pain at this time — [redacted] 91WM6 b6-2
1230	pt medicated c̄ Percocet II Tabs for c/o pain — [redacted] b6-2
1500	pt asleep @ this time. VSS — [redacted] b6-2
1 Aug 03 (1800)	Pt care report from SPC [redacted]. Pt's acute Episode noted/Reported. — [redacted] b6-2 b6-2 91WM6
2 Aug 03 (0600)	Pt care report given to SPC [redacted]. Pt night uneventful. BSC c̄ ī Small Bowel movements BM Ø CDS. 0055 Ambien + Percocet given. — [redacted] b6-2 91WM6

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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.

H [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2 Aug 03 0630	Recieved report from SSG [redacted] b6-2 pt VSS, no significant Δ in condition over night. [redacted] b6-2 9MarM6
0800	pt to Xray [redacted]
0900	IV in pt's (L) ac infiltrated during trip to X-ray new IV started in (L) wrist [redacted] b6-2
0930	Orsg Δs done at this time. [redacted] b6-2
1200	VSS, pt asleep at this time. Ø new c/o pain [redacted] b6-2
02 Aug 03	(1800) Pt CARE Report Recieved from SPC [redacted] b6-2 Pt awake, alert, oriented to person, c̄ easy Re-orientation to place/event. No acute episodes noted / Reported. [redacted] b6-2 9MarM6
02 Aug 03	(2100) Bilat heel dressing Δ per Rx in progress. Medicated c̄ total (8mg IVP MSO4 for procedure. Tolerated Care c̄ ↑↑ crying out / withdrawing esp. c̄ (L) foot ((R) lateral edge + heel). Wound edges erythemic @ (R) edge. Quiet ⊖ care. [redacted] b6-2 9MarM6
02 Aug 03	(2200) c/o "Stomach not good", "gas". Pt denies need to defecate. No flatulence noted. BS active, ABD Soft, non tender c̄ wounds. [redacted] b6-2 9MarM6
03 Aug 03	(0050) Ambien 10mg PO for noted wakefulness c̄ Restlessness. Pt quiet p̄ care. [redacted] b6-2 9MarM6
03 Aug	(0600) PT CARE report given to Cpt [redacted] SSG. Pt Resting ⊖ Acute Episode [redacted] 9MarM6 b6-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	Brief op note
	Procedure: ① Debridement (B) fingers
	② Debrident of heel Eschar
	Dr Jay
	GETA
	EBL min.
	⊘ complications
	Finding purulent drainage (R) heel.
	[redacted] b6-2

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
04AUG03	Pregnen note
	Patient comfortable
med	Ofelule
Loveox	WP 1500
Nosil	wonds dressed
Tenkylpr	Dr: Dry OK
MSO4 OM	Cont c current plan [redacted] b6-2
04AUG03 0919	Dressg Δ completed. Pt was premedicated c Percocet Tab II po. Tolerated procedure well. Will continue to monitor. b6-2 [redacted]
1048	Pt. resting in bed c eyes closed. RR 10 HR 86. Ø distress noted. Will continue to monitor. b6-2 [redacted]
1202	Resting c eyes closed. Easy to arouse. Ø distress noted. RR 10 HR 82. Will continue to monitor. b6-2 [redacted]
1403	Resting in bed c eyes opened. Ø distress noted. Will monitor. b6-2 [redacted]
1712	Pt. lying in bed c eyes opened. Will cont. to monitor. b6-2 [redacted]
1800	Pt care report Received from [redacted] b6-2 b6-2 Pt awake, alert, Oriented & acute Epi sode. [redacted] b6-2 [illegible]
2100	Dressing Δ to B/L T heels completed per Rx. Pt c ↑↑ % discomfort throughout procedure. Premed c. 1cc IVP MSO4 By LT [redacted] b6-2 II percocet given @ 2200 & Ambien 10mg @ 2230. Pt continue c % discomfort.

FPI. LEX. Printed on Recycled Paper STANDARD FORM 60 [redacted] [illegible]

b6-2

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
02 AUG 03 0741	Pt. resting in bed ⅰ complaints. Consumed ½ cans of ensure c̄ coca added for flavoring. Consumed 30% of breakfast @ that time. Will continue to encourage fluid intake for calories. b6-2 [redacted]
0757	Percocet Tab ii po for pre-medication for disc Δ. b6-2 Sgt. [redacted]
1042	Dsg change completed. Ø distress noted. Will continue to monitor. b6-2 Sgt [redacted]
1244	Resting in bed ⅰ distress. Will continue to monitor. b6-2 Sgt. [redacted]
1346	Resting in bed c̄ eyes opened. Ø distress noted. Will continue to monitor. Sgt. [redacted]
1554	Up to ICW I due to AC problems. Ø distress noted. b6-2 b6-2 Sgt [redacted]
1738	IV pulled out. New one placed to (Rt) inner arm. Ø redness/swelling noted to area. Will continue to monitor. b6-2 Sgt [redacted]
[redacted] 0600	Gave report to SGT [redacted] b6-2 [redacted]
04 AUG 03 0600	Received report from Spc [redacted]. Pt. resting in bed ⅰ complaints. Ø distress noted. Condition remain stable @ present time. Will continue to monitor. Sgt [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

#[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
FP 41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
5 Aug 03 1800	Gave report to night shift. — [redacted] b6-2
1820	Received report from day shift. Pt resting in bed c̄ no c/o pain. VSS. — [redacted] b6-2
(2100)	Pt's VSS, ∅ c/o pain, resting in bed. [redacted] b6-2
(2300)	Pt's VSS, ∅ c/o pain. Pt sleeping in bed. will continue to monitor. — [redacted] b6-2
06 Aug 03	(0100) Pt sleeping in bed VSS, urine to foley ds clear yellow w/o c/o pain. — [redacted] b6-2
	(0300) Pt had formed BM, VSS, ∅ c/o pain. will continue to monitor — [redacted] b6-2
	(0500) VSS, Pt sleeping in bed, w/o c/o pain. will continue to monitor. — [redacted]
	(0600) Gave report to day shift. [redacted] b6-2
06 Aug 03 0600	Received report from Sgt. [redacted] b6-2. Pt. resting in bed c̄ eyes opened s̄ complaints. ∅ distress noted @ present time. Vital Signs stable; B/P 109/68 HR 81 RR 18. Will continue to monitor. Sgt. [redacted]
0700	Pt. consumed 50% of breakfast. Drank leisure. — Sgt. [redacted] b6-2
0745	Percocet tab ii given po for pre-medication for disg Δ. Sgt. [redacted] b6-2
0800	Disg Δ start. Dr. [redacted] b6-2 @ bs. Pt tolerated procedure well. 0840 Disg Δ completed. Pt up to bs toilet. Will continue to monitor. — Sgt. [redacted] b6-2
1025	Pt. back to bed @ present time. Up talking c̄ PAD personnel. ∅ distress noted. Will continue to monitor — Sgt. [redacted] b6-2
1225	Consumed 60% of lunch s̄ difficulty. Will ~~continue~~ continue to monitor. — Sgt. [redacted] b6-2

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STANDARD FORM 600 (REV. 8-97) BACK

b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2400	Pt asleep ∃ acute Episode noted. ! —
4 Aug 03	— b6-2 [redacted] 91WM
5 Aug 03 (0600)	Pt core report Aglin to LT [redacted]. Pt awake, calm, pleasant. Bilat heels / BLE ↑ on pillow supports. — b6-2 [redacted] 91WM6
5 Aug 03 0600	Received report from previous shift. Pt awake c̄ Ø % pain / discomfort. LR infusing. Ø needs expressed. Will cont. care. — b6-2 [redacted] LT/SN
0700	Pt ate 45% of breakfast c̄ minimal assistance. Encourage pt to eat more food and drink more ensure. Will cont. care. — b6-2 [redacted] LT/SN
1200	Completed drsg Δ's. Washed burn wounds & graft sites c̄ hibiclens. Rinsed c̄ NS. Applied silvadene wrapped c̄ kerlex & burn drsgs. Wrapped (L) leg c̄ ace bandage. Gave total MSO4 4 mg IVP. Pt tol. well. Δ'd linens. Pt to BSC. Bilat heels appear necrotic. Will inform Dr. for possible OR to debride/clean wound. Will cont. care. — b6-2 [redacted] LT/SN
1400	Pt resting quietly c̄ eyes closed. Ø % pain, discomfort. Will cont. care. — b6-2 [redacted] LT/SN
1600	Pt awake in bed. Ø needs expressed. Will cont. care. — [redacted] LT/SN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03 @2250	pt report received from Sgt [redacted] b6-2 pt VSS Assessment Complete pt resting quietly @ this time no problems @ present dressings remain CDI will continue to monitor throughout night for acute Δs [redacted] b6-2
11 Aug 03 @0500	pt slept comfortably throughout night no problems noted @ present and pt has Ø complaint at this time VSS will continue to monitor [redacted] b6-2
11 Aug 03 0844	Nursing: VSS. Ø distress noted. Pt ate 60% of breakfast. Dressings C/D/I. Resting quietly @ this time. Ø complaints voiced @ this time. [redacted] b6-2
11 Aug 03 1349	Nursing: Dressing Δ completed. Pt received 2 tabs Percocet prior to ~~begin~~ 1345 dressing Δ. Pt tolerated procedure well and able to assist staff during dressing Δ. Graft and donor sites healing well except for graft site on (L) knee. Pus noted on (L) knee. Silvadene cream applied to (L) knee, (R) heels and small segments of grafts that are not healing as well. Eucerin [redacted] 1352 cream applied healed graft + donor sites. Pt resting quietly @ this time & complaint. [redacted] b6-2

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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[redacted] b6-4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12Aug03 @2335	pt Assessment Complete VSS pt condition S A's pt is resting quietly in bed with Ø complaints @ this time pt shows no signs of acute distress @ present will continue to monitor throughout night [redacted] SFC [redacted]
13Aug03 0628	Received report from night shift nurse. Pt. resting in bed c̄ eyes opened. Ø distress noted. Ø complaints voiced @ present time. Will continue to monitor. — Sgt. [redacted] b6-2
0740	Percocet Tab ii p.o. for pre-med before dressg Δ. — Sgt [redacted] b6-2
0943	Dressg Δ complete @ this time. Pt. tolerated procedure well. Resting in bed @ present time c̄ eyes opened. Ø complaints. Will continue to monitor. — Sgt [redacted] b6-2
	Surgeon No complaints VSS Afeb Wounds healing No Loss M/P cont Dressing D's [redacted] b6-2
1137	Pt. resting in bed c̄ eyes closed. Ø distress noted. RR 11. Will continue to monitor. — Sgt [redacted] b6-2
1317	Lying in bed c̄ eyes closed. Ø distress noted. Will monitor. — Sgt [redacted] b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Aug 03	Nursing: Pt resting quietly ~~c~~ complaints.
1726	Dressings c/d/I. VSS. [redacted] b6-2
1800	Received report. Patient resting in bed. [redacted] LCT/AN
1850	Assessment completed. VSS. ∅ Complaints. [redacted] LCT/AN
2100	Patient sleeping. [redacted] b6-2 LCT/AN
2300	Drsg change to feed. Premedicated c̄ Percocet II tabs. Small amount of yellowish drainage on heels (B) [redacted] LCT/AN
12 AUG 03 0100	Patient sleeping. [redacted] b6-2 LCT/AN
0430	Labs drawn / sent to lab. [redacted] LCT/AN
0500	Fentanyl patch changed. [redacted] b6-2 LCT/AN
0600	Received report from Lt [redacted] ∅ distress noted. Will monitor. [redacted] b6-2
0730	Percocet Tab II p.o. given for pre-med. Drsg Δ. [redacted] b6-2
0930	Drsg Δ completed @ present time. ∅ distress noted. Will monitor. [redacted] b6-2
1105	Resting in bed, c̄ eyes closed. ∅ distress noted @ present time. Resp 16 + even. Will monitor. [redacted] b6-2
1402	Resting c̄ eyes closed. ∅ distress noted @ present time. Will continue to monitor. [redacted] b6-2
1617	Resting quietly in bed ~~c~~ distress. Will continue to monitor. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted] b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2230	Dressing Δ complete. Pt tolerated procedure well. Will continue to monitor. [redacted] b6-2 Spc, 91WM6
13Aug03 0300	Pt resting comfortably in bed. Will continue to monitor. [redacted] b6-2 Spc, 91WM6
15Aug03 0609	Received report from Spc. [redacted] Pt sitting up in bed eating breakfast ⅁ distur. ∅ complaints voiced @ present time. Will continue to monitor. [redacted] b6-2
0615	MD in this morning to make rounds. New orders noted @ present time. [redacted] b6-2
0633	Premedicated c̄ percocet for dsg Δ. Will monitor. [redacted] b6-2
0800	Dsg Δ completed @ present time. Pt. tolerated procedure well. Will continue to monitor. [redacted] b6-2
1000	Resting in bed ⅁ distur. Will continue to monitor. [redacted] b6-2
1213	Sitting up in bed talking c̄ staff. ∅ complaints voiced @ present time. Will continue to monitor. [redacted] b6-2
1415	Resting in bed c̄ eyes closed. ∅ distur noted. Will monitor. [redacted] b6-2
1617	Resting in bed on Rt side. ∅ complaints voiced. Will continue to monitor. [redacted] b6-2
1830	Received report from ongoing shift. Pt resting in bed. Plan: Continue c̄ POC and dressing change to the heel tonight. [redacted] Maj/AN b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 1528	Resting c̄ eyes closed. Ø distress noted. b6-2 Will continue to monitor. — Sgt [redacted]
1745	Sitting up in bed eating dinner c̄ distress. Will monitor. — Sgt [redacted] b6-2
14 Aug 03 0600	Received report from night shift. Pt awake in bed c̄ Ø complaints @ this time. VSS. Will cont. care. — [redacted] b6-2
1015	Gave percocet II tabs for drsg Δ. Δ'd drsgs by washing wounds c̄ hibiclens and rinsing c̄ NS. Applied silvadene and wrapped wounds in burn drsgs. Ace wrapped (L) LE. Pt tol. drsg Δ well. Will cont care. — b6-2 [redacted] ILT [redacted]
1230	Pt resting quietly c̄ eyes closed. Ø needs expressed. Will cont care. — [redacted] ILT [redacted] b6-2
1700	Ø needs expressed @ this time. Pt resting quietly. Ate 60% dinner. Will cont care. — b6-2 [redacted] TSgt [redacted]
1800	Gave report to next shift. b6-2 [redacted] ILT [redacted]
1800	Received report from ILT [redacted] Pt resting comfortably in bed, VSS, Dressings C/D/I. Will continue to monitor. [redacted] b6-2 SPC, 91 WMG
2130	Pre medicated c̄ II tabs percocet for dressing Δ. [redacted] b6-2 SPC, 91 WMG

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EPM [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Aug 03 0600	Received report from Nightshift & assumed care of Pt. VSS, Ø Ntd distress @ this time. Will monitor. — [redacted] b6-2 9/WMG
0800	Pt lying in bed sleeping & appears to be resting comfortably @ this time. Will monitor. — [redacted] b6-2 9/WMG
1050	Pt to OR for heel debridement. — [redacted] b6-2 9/WMG
1145	Pt back from OR, see recovery sheet — [redacted] 9/WMG
1215	Pt medicated c̄ 2 tabs percocet for dressing Δ. Will monitor. — [redacted] b6-2 9/WMG
NC 1250-1330	DRSNG Δ's performed @ this time. Old dressings removed & sites cleaned c̄ hibiclens & rinsed thourough/y. Silvidine applied to sites & bulky dressings. Pt tolerated well, Will monitor. — [redacted] b6-2 9/WMG
1600	Pt complaining of heel pain, medicated c̄ 2 tabs percocet. Will continue to monitor. — [redacted] b6-2 9/WMG
16 Aug 03 1800	pt report recieved from Spc [redacted] b6-2 No problems noted @ this time will continue to monitor — [redacted] b6-2 PFC [redacted]
@2100	pt c/o pain medicated as per doctors orders no problems @ present will continue to monitor — [redacted] b6-2 PFC [redacted]
@2305	pt VSS no problems @ present pt remains calm resting in bed @ this time will continue to monitor — [redacted] b6-2 PFC [redacted]
@0005	pt dressing Δ'd s̄ complication medicated as per doctors orders pt resting quietly @ this time will continue to monitor — [redacted] PFC [redacted] b6-2
17 Aug 03 0700	Received report from PFC [redacted] b6-2 Pt in bed c̄ eyes opened. Ø distress noted. Bandage to (B) feet, leg & hands IV site to (R) AC s̄ infiltration Ø complaints voiced. VSS. Will monitor. — [redacted] b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Aug 03 2300	Dressing changed earlier, applied Silvadene c̄ 4x4 gauze. Wound base white/cheesy like appearance. Needed debridement. Spoke to MD. about debriding it. MD will debride in AM. Pt placed on NPO status after MN. Pt made aware — [redacted] b6-2 Maj/AN
0300	Up the bedside commode, c/o abdominal cramps. Had one hard stool in large amt. Voiding spontaneously 5 problems. VSS, afebrile. Remained NPO for heel debridement Friday — [redacted] b6-2 Maj/AN
0430	Draw blood, able to draw enough amount for chem 8, CBC deferred @ this time, previous H + H 11.9/36.1 from Wednesday, no active bleeding noted to necessitate reading CBC. Will notify physician. Pt [redacted] b6-2 remain NPO
16 Aug ~~0600~~ 1100	OP Note Indication heel wound Surgeon [redacted] b6-2 Anesth GCA Findings heel necrotic tissue debrided & Dressed. to ICU c-pod cond. [redacted] b6-2

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#[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03	Surgery No complaints heel debridement yesterday VSS AFEB. cont dressing D's. will Plan full thickness skin graft to heels when good Granulation.
	[redacted] b6-2
17 Aug 03 1032	Drsg Δ completed @ present time. Pt med. c Percocet Tab II p.o. @ 0820. Ø complaints voiced. Ø distress noted. Tolerated drsg Δ well. Sgt [redacted] b6-2
1324	Up to BS toilet s complication. C/o pain ~~tried~~ restraint to bed. Ø complaints of pain voiced. Will continue to monitor. Sgt [redacted] b6-2
1623	Lying in bed, on back. Ø complaints voiced. Will continue to monitor. [redacted]
1758	Percocet Tab II p.o. for pain. [redacted] b6-2
17 Aug 03 @ 1818	pt report recieved @ 1800 from Sgt [redacted] b6-2 pt resting quietly @ this time Ø complaint No signs of acute distress noted @ present will continue to monitor throughout night [redacted] b6-2 AFC 9/10 [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.

EPW [redacted]

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Aug 03 @ 1730	pt VSS Assessment complete pt doing well No complaints @ this time will continue to monitor — [redacted] b6-2
17 Aug 03 0715	Nursing: VSS, see ICU flow sheet for nursing assessment. Exp. wheezing auscultated in upper + middle lobes. Pt denies any respiratory distress. Pt using Albuterol inhaler w/ difficulty. Sats 96% on RA. [redacted]
17 Aug 03 1510	Nursing: Dressing Δ completed. Pt received Percocet 2 tabs prior to dressing Δ. ~~Both~~ 1511. Grafts healing well except for (L) knee. Purulent yellow drainage noted on (L) knee extending to ~~tendons~~ 1517 possible bone. Wet to dry dressing done on (R) heels. Heels red to pink. Pt tolerated procedure well. — [redacted] b6-2
18 Aug 03 1800	Received report from off going shift, Pt has dressings to (R) UE, BLE, ABD, Back. C/D/I. Will continue to monitor. [redacted] b6-2 SPC, 91WM6
2200	Pt resting comfortably in bed VSS. Will continue to monitor. [redacted] SPC 91WM6
19 Aug 03 0100	Pt resting comfortably in bed VSS. Will continue to monitor. [redacted] b6-2 SPC 91WM6
0600	Reported off to on coming shift. [redacted] b6-2
0600	Received report + assumed care of pt. VSS, Pt stable. Pt lying in bed sleeping + appears to be resting comfortably @ this time. Will monitor. — [redacted] 91WM6
0820	Pt awake, sitting ↑ in bed eating breakfast c̄ Ø Ntd complaints @ this time. Will continue to monitor. — [redacted] 91WM6 b6-2
1300	Pt up in chair @ side of bed to eat lunch. Ø Ntd complaints. Ø signs of distress. Will continue to monitor. — [redacted] 91WM6

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 Aug 03 1518	Nursing: Dressing Δ completed. Pt tolerated procedure [redacted] well. Pt assisted to clean and rinse hands. Purulent drainage noted on (R) knee. Silvadene cream applied to graft + donor sites on arms legs, abdomen, and back. Wet to dry dressing Δ ~~done to~~ [redacted] 1520 done to (B) heels. Pt premedicated c̄ Percocet 2 tabs P.O. Pt ambulated up and down unit. Pt sitting up in chair eating lunch. b6-2 [redacted]
20 Aug 03 0100	Drsg Δ complete to (B) heels. Heels are pink c̄ some yellow exudate. Saline soaked gauze placed and wound redressed b6-2 [redacted]
23 AUG 03 2032	NSS. AO. PSG's CDI on all extremities. (+) pulses to all extremities and warm to touch. CR ≤ 2 seconds. Patient more flesh toned in face. Rotating in bed per routine turning. Denies pain @ this time. NPO P MN. b6-2 [redacted]
25 Aug 03 @ 2100	Drsg Δ's completed to burn sites. IVF infusing to (R) AC 5 complication. VSS, +2 pulses, Drsg Δ to heels, no c/o pain or discomfort. Will cont to mon b6-2 [redacted] 91WM6 [redacted]
25 Aug @ 2130	Pt repositioned, meds given. Will cont to monitor [redacted] 91WM6 SPC b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03 1515	Pt Pre-Medicated c̄ 2 tabs Percocet for dressing Δ. Will monitor. Plan to start dressing Δ in 30 mins. b6-2 [redacted] 9W/MC
1610-1715	Dressing Changes Performed. Old dressings removed, sites cleaned c̄ hibiclens + rinsed thourroughly. W/T/D to heels, other sites covered c̄ silvidine + bulky drsngs. Tolerated Drsng Δ well. Will continue to monitor. b6-2 [redacted] 9W/M
1840	Nightshift Nurse finaly ready for report, Reported O.F.F. b6-2 [redacted] 9W/M
1840	~~Dayshift finally ready to give report~~ Error Report received from day shift [redacted] b6-2
2005	Percocet 2 tabs PO given in preparation for drsg Δ to heels. [redacted] b6-2
2040	Drsg Δ'd to (B) heels. Heels appear beefy red c̄ some areas of yellow exudate noted. W to D drsg as ordered b6-2 [redacted]
0050	Pt up @ BS voiding. Pt voided clear dark yellow urine. Pt c/o difficulty urinating @ times, but denies burning. Will notify MD in am. b6-2 [redacted]
20 Aug 03 0911	Nursing: VSS, sats 95% on RA. Pt denies any difficulty breathing. Inspiratory / Expiratory wheezing auscultated in (B) upper + middle lobes. Pressings c̄/D/I. No complaints voiced. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO. | WARD NO. ICU-3

#[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21AUG03	(1605) Pt admitted to unit via litter in stable condition. Pt A/O speaking some English. ∅ C/O pain. VSS. Lungs CTA(B). ⊕BS X4 quads. Drsgs CDI. Ace wraps to feet intact. Pt positioned on ⓡ side ⓐ this time. Pt restrained to bed c̄ mast restraints. Pt resting quietly ⓐ this time. Will continue to monitor. [redacted] b6-2 (4)(A)
21 AUG03 2300	VSS. AO. DSG's to Abdomen & arms CDI as well as to back. Denies pain @ this time. IS performed x10 c̄ difficulty. ⊕ pulses. Flushed color to skin. Resting comfortably. [redacted] b6-2
22AUG03	(1345) Assumed care of pt ⓐ 0100 c̄ report from night shift. Pt alert speaking some English. Drsg on abdomen Δd this am - silvadene cream applied to wound site. Drsgs on arms and back CDI. Ace wraps on feet CDI. Feet elevated on blankets. Temp ⓐ 1300 - 100.7 Pt C/O chills. Pt medicated c̄ ii Tylenol. Will recheck temp in 1°. ∅ C/O pain. 2 point restraints in place. Pt resting quietly ⓐ this time. Will cont. to monitor. [redacted] b6-2 (4)(A) (1440) Drsgs to heels Δd. Silvadene applied to ⓛ heel. Heels elevated off of bed. Pt denies need for pain meds. Dr. [redacted] aware of pt's fever. Will send UA c̄ next void. Monitoring [redacted] b6-2 (4)(A)
22AUG03 2005	Elevated T @ 101.9 and provided 2 tylenol. AO. Denies pain @ this time. DSG's CDI. LSCAB. S_1, S_2. ⊕ pulses. Refused IS use q1-2° to reduce fever. Resting comfortably in bed. Somewhat pale color / flushed. [redacted]

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b6-2 USAPA V2.00

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 AUG 03	Surgery VSS afeb No significant changes Lungs: CTA CV: RRR Rp: SMB/B Plan: to Baghdad tomorrow [redacted] b6-2
21 Aug 03 0904	Nursing: VSS. Sats 96% on RA. Denies any SOB. Respirations regular & unlabored. Dressing Δ completed. Pt given Percocet ii tabs prior to dressing Δ. Pt tolerated procedure well. Pt assisted in cleaning arms and thigh. Purulent drainage noted on (L) knee. Silvadene cream applied to graft and donor sites. Wet to dry dressings done on (R) heel. Fentanyl patch Δd. Pt given scheduled dose of Atarax and Colace. Pt prepared for transport to Baghdad hospital. Pt to be transferred via litter. [redacted] b6-2

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

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

[redacted] b6-6

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
26Aug03 1145hr	VSS Alert & Oriented. Medicated c [redacted] MSO4 5mg IVP upon arrival to floor from PACU via litter. O2 SAT 96% on [redacted] 18 Bpm. Resp 18/min even and unlabored. Lower extremities elevated to keep heels clear of bed. Continuous suction on as ordered. Lungs clear. BS(+) x4 quadrants. Pedal pulses palpable bilateral. Capillary refill < 3.5 sec to toes bilaterally. Will continue to monitor comfort level. Restraints reapplied with check restraints frequently. Will keplock IV to (L) AC which is patent & intact. [redacted] 2274
26Aug03 1830	Pt. resting, easily aroused. Uresp (18) even & unlabored. O2 Sat 96%. VSS, c/o pain 5mg MSO4 given c obvious relief. Suite to heels c continuous suction as ordered. Legs elevated slightly c heels off bed in air. Drsg c xeroform to lower extr. Drsn site to abdomen c no drsg noted. IV suite to (L) AC patent c s/s of infection/infiltration. Pt voiding dyu adequately. Encourage po fluids. Will cont to mon [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	DATE
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[redacted] b6-b7

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27Aug03 @ 0015	Site of skin graft removal (buttocks) began bleeding. Hematoma present. sutures intact c̄ active bleeding noted. Pressure applied. MD notified. (Dr [redacted] MD came to BS. Pt saturated 2 dressings & linen. MD cut one suture & packed site c̄ iodiform, then applied pressure dressing. VS were taken BP 120/75 P: 120 R 22 O2 Sat 83. LR [redacted] started into ② FA S̄ complication. CBC c̄ C&T x2 units to be done after bolus. O2 by NC applied. 2L. New orders given: O2 by NC 2L PRN, notify MD if HCT<28, HR>100, or if pt continues to saturate dressing. Will monitor drsg frequently, cont to mon — [redacted] 91Um6
27Aug @ 0130	Pt VS taken: 118/68 R:20 P:89 O2 Sat 95 resp. even & unlabored. ∅ distress noted. Pt may go back to OR in AM? Will cont to mon — [redacted] 91Um6
27Aug03 @ 0215	Pt suture site to buttocks began bleeding. Saturated dressings again c̄ small amt of pooling. O2 by NC 2L on. BP 108/73 R:20 P: 101 O2 Sat 94%. resp. even & unlabored. MD notified. Dressings re-reinforced. MD came to bedside. soaked gauze in lidocaine c̄ epi & packed the site. LR @ 125cc/hr infusing per orders

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27 AUG 03 0800	VSS. NPO O/C for OR. A&O oriented. Lungs clear (A) O2SAT 98% on 2L NC. Peripheral pulses palpable. Reinforce bottock dsg and change linen soiled c blood @ 0600. Ø soiling of blood on sheet @ this time. Foley @ 125 continuous c bilateral heels. Lower extremities elevated c keep heels clear of bed. (L) FA IV patent & intact infusing LR @ 125cc/hr. Will continue to monitor [redacted] 27 AUG AM b6-2
27 AUG 03	OR NOTE PRE-OP DX: LEFT BUTTOCK HEMATOMA / BLEEDING POST-OP DX: SAME PROCEDURE: CONTROL OF BLEEDING & WASH-OUT/CLOSURE SURG: [redacted] / [redacted] b6-2 EBL: 500cc FLUID: 1 UNIT PRBC 500cc LR COMPLICATIONS: Ø STABLE TO RR [redacted] b6-2
27 AUG 03 1200	Received Pt from PACU Alert & Oriented VSS ~~Dsg~~ Dsg to (L) buttocks dry & intact Lungs clear. Abd soft non distended. BS(+) x4 quadrant. (L) upper arm IV patent & intact infusing LR @ 125cc/hr. O2SAT 98% on Room air. Bilateral heel drains connected to suction 125 mmHg continuous. ~~Heels elev~~

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(continued) [redacted] 27 AU b6-2

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27Aug03 cont'd (0215)	given. CBC done @0230 HCT: 38.3, another CBC due @0600. now NPO for OR in AM. for washout & resuture of site. Will monitor graft sites closely [redacted] b6-2 9Lumb
27Aug03 @0320	VS: 112/70 R:18 P:89 O2sat 95%. O2@2L by NC. Will monitor closely [redacted] 9Lumb b6-2
27Aug03 @0445	Reinforced drsg to buttocks. Drsg's sat wrated. SpO2 95% HR 104. labs drawn (CBC). O2 by NC@2L. Pt voided 300cc yel. 800cc total output this shift. R:16 lwn & unlabored. circulation assessed. brisk cap refill, ++2 pulses to extr. 2pt restraints on. LR@125 & complication/unfiltr Will cont to monitor [redacted] b6-2 9Lumb, SPC
27Aug@ 0600	HCT now 31.1 (dropped 4 pts) 38.3 this am @0215. Will notify MD & oncoming shift [redacted] 9Lumb b6-2

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EPW # [redacted] b6-4

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28AUG03	Surgery
	Pt stable / AFeb
	Lungs: CTB
	CVS: RRR
	Abd: soft, NT → 2 BBS
	Wounds: Healing well
	Exp: stable
	Cont current management
	[redacted] b6-2

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REGISTER NO.	WARD NO.

[redacted] b6-4

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(cont) place ∅ Sx complications ∈ circulation/skin break ↓. Will continue to monitor. [redacted]
	b6-2
29 AUG 03	Surgery
	POD 4/3 Doing well ∅ complaints
	VSS/AFOB
	Lungs: CTA
	CVS: RRR
	Wounds: Dressings clean Dry & Intact
	Burns healing well
	Rp: stable
	Plan: cont current management [redacted] b6-2
29 AUG 03 2000	Pt resting in bed, AtOx3, VSS, LS CTA (B), (D) BS x4, SAT 96% w/o O2, S1 S2 present, ∅% pain @ this time, ∅ c/o nausea, Dsg to LE x2 CDI, wound appear to be healing properly ∈ ∅ s/sx of infex, Dsg to hands (B) CDI, IV (R) wrist patent infusing LR @ 100cc/hr, wall suction in place ∅ drainage noted, Dsg to heel (B) intact, able to ambulate, able to move toes, peripheral pulses

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[redacted] b6-4

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DATE	[redacted]MPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Cont.	[redacted]tact. palpable, proper circulation + skin integrity on pts. of restraint. [redacted] 91WM6
	[redacted]
:0200	Dsg's Δ'd. b6-2 [redacted] 91WM6
30AU603	(1025) Assumed care of pt @ 0000 p̄ report from night shift. Pt sleeping, but easily aroused. VSS. Tol small amount of breakfast. Hct 24.8 this am. Dr. [redacted] b6-2 notified. 1st unit PRBC started @ 1020 into IV in ⓡ forearm. ∅ S/Sx adverse rxn @ this time. See SF511 for VS. Will cont. to monitor. b6-2 [redacted] WM/AW
	(1245) 1st unit PRBC completed. ∅ adv. rxn noted. VSS. New 18g IV started in ⓡ ankle d/t IV in ⓡ forearm infiltrating during infusion. NS infusing s̄ S/Sx infiltration. monitoring. b6-2 [redacted] WM/AW
	(1320) 2nd unit PRBCs started @ 1310. ∅ S/Sx adverse rxn @ this time. See SF511 for VS monitoring. b6-2 [redacted] WM/AW
	(1640) 2nd unit PRBCs finished @ 1515. ∅ adverse rxn noted. IV restarted @ 100cc/hr via dial a flow p̄ completion of PRBCs. ∅ S/Sx infiltration of IV site. Dsgs to ⓑLE Δd. Silvadene cream applied to ⓑ knees and ⓡ shin. moisturin cream applied to healing skin graft sites. Dsgs to ⓑ buttocks removed this pm. Sutures intact - open to air. Small amount of sero-sang drainage noted on dr. Dsgs to heels intact. SP to heels to well suction - cont. @ 125. Pt started on FeSO4. T reg diet well. Voiding s̄ difficulty. 2 poir

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Aug 03	Surgery
	PT STABLE / AFEB TOLERATING PO
	LUNGS: CTA
	CVS: RRR HCT = 24.8
	ABD: SOFT, NT, NO ⊕ GS
	Rp: STABLE
	PLAN: WILL NARSFUSE 2u PRBCS [redacted] b6-2
2 Sep 03	~~September~~ Surgery
	No complaints
	VSS AFeb.
	Heel grafts - ⓡ ~80% take
	ⓛ ~60% take & some ? Dehisce
	A/P Doing well cont Redressing.
	[redacted] b6-2

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30AUG03	(cont) restraints in place. - ∅ S/Sx complications c̄ circulation/skin break. Will continue to monitor. b6-2 [redacted]
30AUG 03 1950	Pt resting in bed, HOB 45°, LS CTA (B), (+) BS x4, S1 S2 present, VSS, IV (R) foot patent infusing LR @ 100cc/hr, ∅ c/o pain @ this time, drsgs LE x2 CDI, drsgs to UE x2 CDI, proper circulation + skin integrity on pts of restraint. [redacted] b6-2 [redacted] b6-2
31AUG03 0200 MD	Received pt resting in bed. VSS, A+OX3. Dressing Δ'd by MD on heels bilaterally. MD states that dressing Δ's are BID on heels w/ vaseline gauze and heelex wrap + to cont heel protection. Pt. other drgs Δ'd + c/D/I. pt bottock incisions OTA, ∅ drainage noted and small 2x2 dsg noted on sacral area. IV patent & intact on (R) foot. HOB↑ and heels off bed. No (R) thumb w/ sutures c/d/i with ∅ drainage noted. Will cont to monitor pt. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
[redacted]	b6-2		
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

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b6-4

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31Aug @ 2300	Assumed care @ 1800; VSS, pt A&OX3 speaking some english; Ø c/o pain or discomfort @ this time; S1, S2; LS CTA (B); (+) BS x4, pt voiding QS clear, yellow urine, Ø BM this shift. all dsgs Δd, Eucerin, Silvadene, & petroleum gauze applied to those ordered areas; dsgs CDI; sutures to (R) thumb CDI, well approximated; incisions to buttocks OTA, Ø drng noted; HOB ↑, heels off bed on pads; restraints in place, circulation & skin integrity intact, cont to monitor. [redacted]
01Sept 1530	Assumed pt resting in bed. VSS, A&OX3, Drsg Δ'd done per orders; (L) knee appears to have yellow substance in the middle of wound, Ø odor noted. BS hyperactive. Loose stools x2 on this shift. Sutures (R) thumb c/d/i. SWGS, HOB ↑ heels on relief pads/doughnuts. Restraint in place per CPW protocol, good skin circulation + integrity noted. [redacted]
1 Sep 03 1830	Pt awake in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, Dsg's Hand (B) CDI, Dsg's on LE (B) CDI, IV (R) foot patent infusing LR @ 100cc/hr c/o stomache ache + cramping ∇ pt ate meal, HOB 45°, proper circulation + skin integrity on pts of restraint. [redacted]
2030	Stomache ache controlled c̄ 12.5mg Phenergan, will cont. to monitor. [redacted]
	Lancuc c̄ [illegible] [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3 Sep 03 0700	integrity and extremity circulation frequently [redacted] b6-2
3 Sep. 03 1815	Pt A+O x3, resting in bed, VSS, wheezing noted (B), SAT 95%, encouraged use of IS, hyperactive BS x4, dsgs LE x2 CDI, sutures on (R) thumb intact, Ø c/o pain @ this time, IV (R) foot patent infusing LR 100 cc/hr, voiding c/y urine, peripheral pulses ±2. [redacted] b6-2 91WM6
1900	Assessed for proper circulation + skin integrity on pts of restraint. [redacted] 91WM6 [redacted] b6-2
4 Sept 03 0900	VSS A+O. Lungs clear Bilateral. Properly use Incentive spirometer @ 900-1200 cc/sec. Non productive cough. O2 SAT 95% RA. BSA x4 quad. Consumed regular diet for breakfast Ø c/o N/V. (R) chest c sutures intact. Ø drainage or swelling noted to (R) thumb suture line. (R) lower leg IV patent + intact without redness, swelling or pain. Infusing LR @ 100 cc/hr. Heels Graft sites with staples intact. Eucerin cream applied to all STSG sites except to (L) knee which Aloadene cream was applied. Sutures intact to buttock incision c drainage or swelling noted. Voiding clear yellow urine. ~~Asst~~ Restraints: removed + recomplied. Skin intact under restraints. Will check restraints, skin integrity c circulation to extremities frequently [redacted] b6-2 ZCB
4 sep 03 @ 1945	Assumed care @ 1800; VSS, pt A&O x3 speaking both English & arabic;

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Sep 03 0900	VSS Alert & Oriented. IV LR @ 100cc/hr to (R) lower leg patent & intact. Lungs clear. BS (+) x4 quad. Peripheral pulses palpable +2. Dsg dry and intact. Voiding clear yellow urine. Continued Regular diet. Repositioned in bed q2hrs & prn for comfort. [redacted] b6-2
2 Sep 03 1730	Pt A+Ox3, VSS, LS CTA (B), (+) BS x4, c/o pain on stomach, medicated ≈ 2 percocets, dsg's on LE x2 CDI, dsg's on hands x2 CDI, IV (R) Foot intact infusing LR @ 100cc/hr, LE x2 resting on round blue pillows, HOB 30°, encouraged use of TS, voiding c/y urine, proper circulation + skin integrity on pts. of restraint. [redacted] b6-2
2200	Dsg's Δ'd and vaseline gauze applied to heals. [redacted] b6-2
3 Sept 03 0730	VSS Alert & Oriented. (R) lower leg IV intact and patent infusing LR @ 100cc/hr. Dsg to STSG dry & intact. Voiding clear yellow urine. Lungs clear. BS (+) 4 quad. Peripheral Pulses palpable +2. Resting comfort & regular diet. Pt. [illegible] under [illegible] restraints [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE (Continue)	RECORD [illegible] ED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	[redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
05SEP03	(cont) breath/circulation. Will continue to monitor.
5 Sep. 03	b6-2 [redacted] WD/AN
1830	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, S_1 S_2 present, peripheral pulses equal (B), (Ø) c/o pain @ this time, c/o diahrea x2, dsgs to heels CDT, sutures on (R) thumb intact (Ø) s/sx of infex, IV (R) foot patent infusing LR@100cc/hr, dsg (L) Knee CDI, voiding c/y urine, proper circulation + skin integrity on pts of restraint b6-2 [redacted] 9/UM16 [redacted]
06SEP03	(1400) Assumed care of pt w/ Ø600 ~~p~~ report from night shift. Pt alert, speaking some Arabic, some English. VSS. Pain controlled c̄ Percs. *Drsgs to heels Δd this am. Bactracin applied to heels prior to vaseline gauze and Kerlex. Drsg to (L) knee Δd - silvadene applied to wound. Moistorin cream applied to healing graft sites. Staples on heels intact. Sutures to (R) thumb CDI. Sutures to bilat. buttock c̄ small amount serosang drainage. Intact. IVFs infusing into IV in (R) ankle s̄ s/sx infection, infiltration. Pt tol reg diet well. Voiding s̄ difficulty. Pt ↑ to chair w/ this time - tol. well. AM care done by pt. Pt able to move toes. (+) sensation. Restraint on when in bed - Ø s/sx complications c̄ b6-2 skin breath/circulation. Will cont to monitor [redacted] WD/AN

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(Cont) S1 S2 (+) pulses x4, LS CTA (R); (+) BS x 4, pt voiding QS, clear, yellow urine; BM x1 this shift; dsg to (R) thumb Δd c̄ sutures intact & well approximated (-) drng or edema; dsg to (L) knee Δd c̄ minimal amt sanguinous drng noted; dsg to heels CDI, (-) drainage; PIV to (R) LE patent & infusing LR @ 100 cc/hr s̄ s/sx infection/infiltration; Eucerin cream applied to all applicable areas, silvadene to (L) knee; Sutures to buttocks incision b/l intact, sutures well approximated (-) drng or edema noted; restraints in place, circulation & skin integrity intact; Cont to monitor — b6-2 [redacted]
05SEP03	(1315) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking some English. VSS. ¢c/o pain @ this time. Pt tol. reg. diet well. Voiding s̄ difficulty. Drsg to (R) knee Δd this am. Silvadene cream applied to wound. Drsgs to b/l pt heels Δd, c̄ vaseline gauze covered c̄ Kerlex. Silvadene cream applied to (R) heel. Staples to skin grafts on heels intact. moistorin cream applied to healing skin graft sites. Drsg to (R) thumb Δd - sutures intact - (-) s/sx infection. Sutures to b/l pt buttock CDI - open to air. Pt able to move toes s̄ difficulty. (+) sensation in heels. cap refill <3secs. IVF infusing into IV in (R) ankle s̄ s/sx infection/infiltration. Restraint in place s̄ s/sx complications of skin

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep. 03 1845	Pt lying in bed, AtOX3, VSS, LS CTA (B), (+) BS x4, S1 S2 present, skin warm + dry, cap. ref. <3sec, peripheral pulses +2, c/o some pain on buttocks, dsgs on heels c̄ some bloody drainage noted, dsg on (L) Knee CDI, IV (R) foot intact infusing LR @ 100 cc/hr, assessed for proper circulation + skin integrity on pts of restraint. — b6-2 [redacted] 91WM6
2000	Pt had a BM this PM, Dsgs on heels Δ'd c̄ vaseline gauze + kerlix wrapped around heels. — b6-2 [redacted] 91WM6
0630	Pt had BM, formed. — b6-2 [redacted] 91WM6
7 Sept 03 0700	Received pt in stable condition, VSS, AtOX3, sleeping intermittently. LS CTA B, BS(+)4, ABD SNT, HR, pulses strong + equal bilat. Dsgs Δ's done, currently c/d/i, old dsgs w/ dry bloody drainage on heels. Silvadene cream applied to (L) knee. IV to (R) foot patent, infusing IVF w/o apparent complications. Restraint to RLE w/ kerlix underneath, skin integrity + circulation intact. Q 2hr this shift. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	[redacted] RVICE b6-2	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELA[redacted]SHIP TO SPONSOR	

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

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7sep03@1845	Assumed care @1800; USS, pt A&OX3 speaking both arabic & english; S1S2, ⊕ pulses x4; LS CTA(B); (A) BSX4, pt voiding QS, clear yellow urine; BMX1, soft semiformed brown stool; All dsg CDI; dsg to (L) knee Δ'd & silvadene applied; eucerin cream applied to all open burns; PN to (R) foot patent & infusing LR @ 100 cc/hr ∓ s/sx infection/infiltration; 2-point restraints in place circulation; skin integrity intact; Cont to monitor [redacted] b6-2
8sep03 0130	Pt c/o upset stomach and provided 30cc of Maalox Instead. [redacted] b6-2
	Surgery
8sept	No complt
	USS AFES
	wnds - (L) FTSG Donor site & SQ hematoma & some oozing. Pressure bandage Applied.
	A/O Day well
	Plan walking tomorrow [redacted] b6-2
8sept 03	Received pt this am in stable condition, USS, AXOX3 speaks minor english. Drsgs Δ'd, lucerin applied to all wounds, vaseline gauze + kerlex to heels bilaterally. Wet to dry Drsg to (L) knee w/ kerlex. IV d/c'ed, foley d/c'ed. Sutures removed this afternoon by MD on buttock (L). (R) buttocks suture line oozing from hematoma, pressure applied to buttocks by MD. OOBTC ordered MD [redacted] b6-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9Sep03 1200	VSS. Alert & Oriented. OOB ambulate around in room. Tolerated well. STSG sites to (L) buttocks c bleeding upon ambulation. Pressure dsg applied bleeding stops. Lungs clear BS (+) x4 quad. abd, non distended. Voiding clear yellow urine in urinal. ACE wraps in place to heels upon ambulation. ~~ATB~~ Mupirocin applied to STSG sites. Restraints removed and reapplied. Skin intact under restraints. Will continue to monitor. [redacted] b6-2 SCT RN
9Sept03 1420	(R) Buttock graft area opened c ooze blood. pressure dsg applied for [redacted] b6-2 infm & neuro checks. Will continue to monitor. [redacted] b6-2 SCT RN
9Sep.03 1845	Pt A+Ox3, VSS, resting in bed, LS CTA (B), (+) BS x4, abd soft flat nontender, pressure dsg to buttocks CDI, dsg's on heels x2 CDI, (-) c/o pain @ this time, voiding clear yellow urine to urinal, HOB 30°, dsg (L) Knee CDI, assessed for proper circulation + skin breakdown on pts of restraint. [redacted] b6-2 91WM6 [redacted] CPS
2045	Pt OOB to ambulate, (R) foot sensitive in area where pt had IV, ambulated 10 steps and sat on chair, medicated for pain prior to ambulation. [redacted] b6-2 91WM6 [redacted]

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
08Sep03 1613 (cont)	pt c/o stomach trouble, pt feels he has diarrhea, BM's are soft but formed, ø stools this shift. Comfeel placed on (R) ankle area and pt educated to keep moving extremity to different positions + keep pressure off ankle area -> Stage II decub. Restraint x1 on (R) wrist ø skin breakdown or impaired circulation noted. ø other remarkable assessments noted. Will cont to monitor. [redacted] b6-2
8sep03@1930	Assumed care @ 1800; A&Ox3, ↓ pain, perc ~~IV~~ given ~~w~~ good relief; S, S2, LS CT4 (B); (+) BSx4, (-) BM this shift; all dsgs ~~##~~ CDI, dsg to (L) knee ad; No remarkable assessment findings; 1-point restraint in place, (-) skin breakdown, circulation intact; cont to monitor — b6-2 [redacted]
9sep03	Surgery
0820	No complaints
	VSS Afeb.
	Heels - Good overall take. Now 2wks post op
	(L) FTSG Donor ↓ Hematoma.
	A/D Doing well Allow Ambulation
	b6-2 [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.)* [redacted] | REGISTER NO. | WARD NO.

EPW # [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Sept 03 0845	A+O VSS. OOB ambulating to toilet w/ CC. Dsg changed to heels, (R) knee & buttocks as ordered. Lungs clear RS (D) x4 quadrant. Peripheral pulses palpable +2. Knee compression applied to (R) foot. IV d/c via ordered. Dsg removed. Pt c/o pain in (R) foot when DW & restraints removed & repositioned. Ø [redacted] Skin intact under restraints [redacted] b6-2
10 Sep 03 1845	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, peripheral pulses +2, voiding c/y urine, dsg's on heels x2 CDI, pressure dsg on buttocks CDI, Ø c/o pain @ this time, Ø skin breakdown + proper circulation on pts of restraint. [redacted] b6-2 GIWMC [redacted]
11 Sept 03 0900	Assume care of Pt. VSS, A+Ox3. Changed dressing on arm, no sign of infection. Little drainage around IV stocks. Can walk c̄ help. Dsg's on heels x2. Ø c/o pain. Cont. to monitor Pt. [redacted] b6-2
11 Sept 03 0950	Concur c above. Lungs CTA (B) WAB. Will assist c̄ ambulation. Circulation & skin integrity checked throughout shift w/o 2pt restraint extremities. Intact.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	b6-2

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

[redacted] b6-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Sept 03	Surgery No events USS Afeb Wounds Healing No new issues Ap Pt must Ambulate and be out of Bed!
	[redacted] b6-2
11 Sept 03 1100	Asst MD c̄ assessing wounds & changing dsgs. Pt up to chair. Will ambulate p̄ lunch — [redacted] b6-2 [redacted]
11 Sep 03 @ 2230	Assumed care @ 1800; USS; pt A&O x3, (+) movement & sensation, NV intact, (+) pulses x4; LS CTA (B); (+) BS x4, pt voiding QS, c/o urine, (-) BM this shift; dsg to (L) knee ΔΔ; all other ΔΔ CDI ∃ drainage; Eucerin cream applied to all open burn sites; pt ↑ to amb in hall x1 c̄ minimal assistance from walker; medicated x1 c̄ percs c̄ good relief; restraints in place; (+) circ. & skin integrity; cont to monitor — [redacted]
12 Sep 03 0700	Assumed care of pt. A+O x 3 sitting up in bed eating Breakfast. c/o pain to feet. bilat skin graft. wound care this AM. Lungs CTA HRRR S1 S2 present Active BS x4 quads. Encourge ambulation this AM c̄ walker. Will cont to monitor — b6-2 [redacted] 9/WMC
12 Sep 03 1300	- c/o pain medicated c̄ percocet ii tabs for relief. Will cont to monitor — b6-2 [redacted]

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 sep @ 0130	Assumed care @ 1800; USS, A&Ox3, ⊖ C/o pain, NV intact - ⊕ CMS; ⊕ pulses x4 LS CTA (B); ⊕ BSX4, pt voiding QS, c/y urine; ⊖ BM thus far; pt ↑ amb in hall X1 for 15 min ⅋ min assistance from walker & ⅁ complications, pt was in NAD ⊖ SOB, ⊖ C/o dizziness during amb; dsg to (L) knee Δ'd, all other dsgs CDI ⅋ min amt drainage noted; Eucerin cream applied to healing burn sites; 2-point restraints in place; ⊕ circulation & skin integrity; cont to mon. tos — b6-2 [redacted]
13 sep 03 @ 0700	— Pt resting in bed @ this time c/o pain to (R) calf skin graft. VSS. Warm compress ordered per MD to apply. Dressings Δ to bilat heels and buttock. Sylvedene creme applied to wounds. Ambulation encouraged. Lungs CTA HRRR Active BS. Will cont to monitor — b6-2 [redacted] 1 x m (1600) I concur ⅋ above assessment — [redacted]
13 SEP 03 2025	VSS, AO. Speaking fair english and arabic @ times. DSC's to (R) heels, (L) & (R) buttocks clear, (L) knee intact and dry. ⊕ pulses to all extremities. Voiding light amber urine, quantity sufficient. Able to ambulate ⅋ minimal assistance. (L) and (R) buttock contain blue/purple in color and @ sitting I vacuum for skin breakdown. Tolerated PO meals & fluids well. Foley & 3 Day patch placed to (L) shoulder — [redacted] b6-2

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

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

6
12
18
29

[redacted] b6-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Sep 03 0700	- Assumed care of pt. A+O x3. VSS c/o pain to skin graft bilat feet medicated c̄ percocet II tab's for relief. Dressing Δ's to feet and buttock complete silvadene cream and moisturin applied to skin graft. Pt instructed to ambulate more apply pressure to heels. and exercise ROM Will cont to monitor [redacted] 9/wana b6-2
14Sep03@2330	Assumed care @ 1800 p̄ receiving report from day shift; VSS, A&O X3; c/o pain, medicated c̄ II perc c̄ good relief; dsg to buttocks Δd; all other dsgs CDI; lucerin cream applied to open sites; pt amb in hall x1 for 20 min c̄ min. assistance from walker; ø complications during amb; IS encouraged q1°; ROM completed; restraints x2 applied; ø skin break ↓; ⊕ circulation; cont to monitor b6-2 [redacted]
15SEPØ3	(1630) Assumed care of pt @ Ø600 p̄ report from night shift. Pt alert, speaking Arabic and some English. VSS. Pain controlled c̄ Percs. Dsgs to heels, ⊖ knee, and buttocks Δd this am. Ø sisx infection @ wound sites. Pt applied moisturin to healing graft sites. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ sisx complications. Will cont. to monitor. b6-4 [redacted] WAN
	(1640) Pt OOB to amb in hallway. Gait steady. Pt tol. well. monitoring. b6-2 [redacted] WAN
15Sep.Ø3 1830	Pt resting in bed, VSS, AtOx3, Ø c/o pain @ this time, Dsg's to heels, ⊖ Knee + buttocks CDI, LS CTA(B), ⊕ BS x4, voiding w/o complications, 2 pt restraint c̄ proper circulation * Ø skin break down. b6-2 [redacted] 9/Wa [redacted] MD

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

62-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 3 Jul 03	TIME 929
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Aircraft	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE 47	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT burns Smoke +

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 0930	TIME	930	1625			
		BP	113/71	123/79			
☐ URGENT		PULSE	120	121			
	INITIALS RD	RESP	16	16			
☑ NON-URGENT		TEMP	104.2	103.0			
		WT	95 kg				

LAB ORDERS					X-RAY ORDERS		
☑ CBC/DIFF	ABG ☑	PT/PTT ☑	BHCG/URINE/BLOOD/QUANT		☑ CXR PA & LAT/PORTABLE		C-SPINE
☑ URINE C&S ☑	UA MSCC/CATH		☑ CHEM: 12 SMA		ACUTE ABDOMEN		LS SPINE
BLOOD C&S X					SINUS		HEAD CT
					ANKLE R/L		

ORDERS

☑ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1005	Lovenox 90mg SQ	[redacted]	[redacted]	1005	
1020	Levaquin 500mg IV			1020	
1023	Lymigen 1 PO			1023	

66-2

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

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

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

EPN 000-00-[redacted] 66-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC					SUP 02	PH	PO2	RESULTS	
	H/H					PCO2	SAT	OTHER		
	PLT									
PT					U/A	DIP			EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

(S)

PMhx
ashma
Pshx ⊖

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

EPW 000-00-0[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
09Jul03. cont.		1015	sedation for pain management. Versed 6mg IV, fentanyl 250mcg, & Ketamine 90mg and 0.2mg Robinul given. VSS. Pt on NRB for ~~sed~~ during sedation. SaO2 100%. WTD dressing for abdomen. Silvadene applied to all other areas. Will continue to monitor. [redacted]
		1110.	Lasix 10mg IVP given as ordered - [redacted]
		1115.	Pt refused to eat lunch. Will try again later [redacted]
		1300.	SpO2 ↓ to 89-90%. Continue working IS and gave MDI as ordered. SpO2 remains decreased. Pt up to chair c̄ 4 assist. Pt medicated c̄ 2mg MSO4. [redacted]
		1310	SpO2 ↑ to 96% - 97% Will continue to monitor [redacted]
		1345.	Percocet 2 tabs PO given for c/o pain to Burns [redacted]
		1350	Type and cross drawn from distal port of CVC and sent to lab [redacted]
		1600.	Pt back to bed c̄ ~~minimal assist~~ 2 person assist. Pt is unsteady on feet, however used more of own body strength for mvmt. Pt turned to (R) side. Will continue to monitor. — [redacted]
9Jul 03		2100	pt complains of biceps + abd pain given med and H2O/juice c̄ some relief
		2200	continued

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 July 03		2000	Received report from ongoing shift, pt just got back
2000			to bed, alert, verbalized wanting to rest. Slabhoff in
			place TF Jevity @ 125cc/hr. IVF LR @ 125 to
			SCCL. T 99.3, VSS on monitor, foley draining >30cc/hr
			Tea colored urine. Continue plan of care - [redacted] b6-2
2230-			Premedicated c̄ MSO4 8mg c̄ Versed 5mg 30' prior to dressing
2300			change. Then gave additional MSO4 2mg c̄ 2.5mg Versed
			plus Percocet 1 p.o. pr continued c/o pain during dressing
			change. Pt groaning + screaming during the procedure but
			started to calm down once dressing completed. VSS.
2330			Pt is observed to be asleep. TF resumed @ 125cc/hr
			residual ✓ <30cc. Monitor abdominal distention.
			Gave Nexium 30cc p.o. pr c/o indigestion. [redacted] b6-2 Xray/Pm
0100			Pt awaken slowly but went back to sleep. Appears
			comfortable. Foley draining minute amt. <50cc/hr. Continue
			to monitor. Notify MD @ this time [redacted] b6-2 Xray/Pm
0400			Slabhoff halfway out. Removed and pushed
			back in place. Tube feeding on hold for
			now until placement is confirmed by X-ray.
			Request seat. No significant incident
			this shift. VSS [redacted] b6-2, Xray/ACU
1015 -			Orsg Δ complete to burn areas. Almost burns 3°. Dr
			[redacted] @ BS to assess wounds. Conscious

b6-2

(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 0[redacted] b6-4

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 JUL 1003		0500	cont'd... TF on hold due to conscious sedation for drsg Δ. Will cont. care. — b6-2 [redacted] 10/40
		0600	Pt UO < 30cc. Will cont to monitor and inform MD. — b6-2 [redacted] 10/40
		0700	Pt completed IS x 10 breaths while awake. Pt did IS well. Plan to complete Drsg Δ and ambulate pt. Pt temp 101°. Will cont to monitor temp. Pt also has hiccups. Will discuss pt care c̄ Dr. [redacted]. [redacted] b6-2 10/40
		0930	Completed drsg Δ. Washed all burn wounds c̄ hibiclens and rinsed c̄ sterile water. Applied silvadene and covered c̄ burn drsgs. Wrapped ext. wounds in kerlex. Wrapped abd burn wound c̄ abd binder. Ace wrapped bilat ↓ ext. Pulses present. Cap. refill < 3 sec. Gave pt bed bath simultaneously. Pt put under conscious sedation. Fentanyl 250mcg, ketamine 100mcg, versed 7mg, and robinol 0.2mg given. Pt on nonrebreather c̄ 10L O2 @ time of sedation. O2 sats 100%. Δ'd pt bed sheets and elevated (L) ↓ ext and scrotum. Completed foley care. Noted erythemia around border of most burn wounds. Dr. [redacted] aware. Will cont. care. — b6-2 — [redacted] 10/40
		1040	Dr. [redacted] in to see pt. Aware of condition b6-2

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

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 June 03		1815	Received report from ongoing shift. Pt awake; had debridement of the wound today. TF on hold for now for dressing change under conscious sedation. Received total of PRBC 4 units today (2 u OR, 2 u ICU 3). Afebrile.
		0820	H + Hct 12.9 / 37.5 (10.6) 537. Continue c̄ POC — [redacted] Maj, AN
		0820	Pt remain NPO for conscious sedation. Anesthesia notified. Pt informed of the upcoming procedure. Anticipatory anxiety noted but otherwise understand necessity of dressing change tonight — b6-2 [redacted] Maj, AN
		2230	Complete dressing change done c̄ the pt conscious sedation: Versed 10 mg, MSO4 10 mg, Fentanyl 150 mcg + Ketamine 100 mg throughout the procedure. Pt. ~~Hard~~ very tolerated procedure well, drowsy but easily aroused. Wound fully debrided today, had area of heavy bleeding, pressure applied.
		0330	Slept throughout the night c̄ intermittent weakfullness due to hiccups. VSS T max 99.7. No significant events @ night. NPO @ 0300 (TF) on hold for dressing change conscious sedation b6-2 [redacted] Maj, AN
		0400	Lab results: 9.2 / 30.5 (9.7) 5.39, 12.9 / 3.9 (.95), BUN 13 Creat .7
11 July 03		0800	Received report from previous shift. Pt awake and in bed in chair mode. LR infusing in (R) IJ central line. Pt hiccuping. Wounds unpeeased cont

(Continue on reverse side)

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

[redacted] b6-6

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 July 03	1040		UO, temp, and hiccups. ~~[illegible]~~ New orders given and completed. Started TF @ 50cc/hr. Pt resting quietly @ this time. Plan to ambulate @ ≈ 1400. — b6-2 [redacted] 1040
	1200		Pt resting quietly. Unneds expressed @ this time. — b6-2 [redacted] 1200
	1310		Gave pt thorazine for hiccups IM (L) deltoid. Attempted to place NGT x III. Will assess affects of thorazine c̄ attempting to place NGT to assess if NGT is necessary. Will cont. care. — b6-2 [redacted] 1310
	1515		Pt walked around bed to chair c̄ assist. Pt dragged feet and stood tall. Pt currently in chair. Stopped TF. Will restart when place pt in bed. Pt tol. walk well c̄ lots of encouragement. Will cont. care. — b6-2 [redacted] 1515
	1650		PT assisted self into getting into bed. PT lifted both lower ext c̄ minimal assist into bed. PT O2 sat remained in 90s. Elevated DLE and scrotum. Pt appears to be free of pain @ this time. Gave pt encouragement for doing a great job. Gave report to night shift. b6-2 [redacted] 1650
	1650		Pt sat in chair ≈ 2 hours and tol. somewhat well. O2 sats 94%-97%. — b6-2 [redacted] 1650

NURSING NOTES
(Sign all notes)

DATE 2003	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 July 03		1700 1800	Received report from ongoing shift. Pt observed up on the chair. Returned to bed @ the beginning of the shift c̄ 4 people assisting. pt able to move LE slowly & upper arms. Alert, able to verbalize needs. Wanting to rest, refuse to eat dinner. TF off, reconnected @ 1800. Denies need for pain medicine @ this time. VSS, T 100.5 - 107 - 12 - 94% RA, BP 125/64. In no apparent distress. IVF @ 50cc/hr (LR) Foley @ 30cc amber colored urine. Monitor + continue c̄ POC. b6-2 [redacted] Nuj/An
11 July 03		2100	Pt OOB to BSC c̄ assistance (2 people), able to assist c̄ difficulty but trying. Had ↑ moderate amt of stool, received MOM half an hour ago. Returned to bed maneuvering self c̄ assist. Pt asked to rest, request to remove abd binder. I explored c̄ ass/Kerlex to hold dressing. Pt feel more comfortable, dressing c̄ some drainage, reinforced + recovered. Denies need for pain medicine when asked. T. 100.5, already on broad antibiotic b6-2 [redacted] Nuj/An
11 July 03		2360	Pt awaken c/o generalized pain specifically back pain, pt repositioned in bed. gave MSO4 5 mg IV at this time. Continue to monitor pain level. b6-2 [redacted] Nuj/An
11 July 03		2400	Pt awaken, asked to sit up in bed. Checked dressing, drainage noted, & foul smell. applied silvadene to expand area on the thigh + buttocks, reapplied dressing. T 100.3 Verbalized pain relief from MSO4. b6-2 [redacted] Nuj/An
12 July 03	1	0030	Hold TF for conscious sedation in AM b6-2 [redacted] Nuj

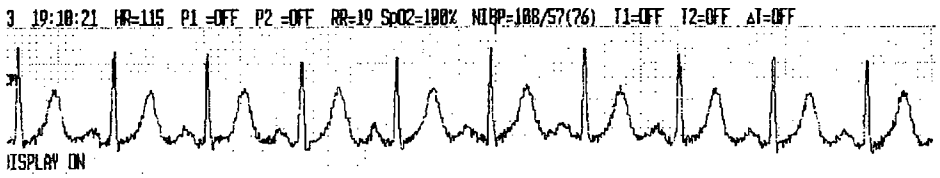
EPW [redacted] b6-4

NSN 7540-00-63

DICAL RECORD

NURSING
(Sign all n

TE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 July	(1700)		Pt CARE Report Recieved from SPC [redacted] b6-2. Pt Sitting in Chair: Awake, Alert, Co-operative. Occassional moaning. Responds appropriately to verbal commands / Requests. No Acute episodes noted / Reported. [redacted] Pl wm b6-2



14 July 03	(1745)		Pt Refused solids for meal. Readily drank 100% milk, & Retained. Continuous Dobhoff feed of Jevity @ via pump @ 101ml/hr on ~~s~~ adverse effects noted. (+) hyperactive BS in (4) Quads. b6-2 [redacted] 91WM6
14 July 03	(1830)		Assisted back to Bed c̄ (2) Staff @ Bedside. Noted ↑ Attempt to do transfer c̄ ↓ passive assist. Supports partial weight c̄ stooped posture. ↑ crying out c̄ movement. Quiet when resting. Crying out sporatically & when asked to Raise hand or call Staff by name. Able to ↓ ? incident of Acute distress. States "Sister" when need assist. b6-2 [redacted] 91WM6

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b6-4

NURSING NOTES
Medical Record

14 June (1900) Inquiring about plan of care. "How long to stay here". Pt resting quietly w/ Review of Pending surgical procedure & recovery w/ him.
b6-2 [redacted] 9 LWMP

14 June 03 (2000) MDI Albuterol given per Rx. BS w/ Occ Ext Exp wheeze/rhonchi in Base exp. (L) w/ ↓↓ move in (R) Base. [redacted] 9 LWMP
b6-2

14 June (2300) To BSC for loose low bowel stool. No adverse effects noted [redacted] 9 LWMP

15 June (0130) Tylenol tab 650mg PO for fever 101.2
b6-2 [redacted] 9 LWMP

15 June (0500) Pt care report given to PFC [redacted]
b6-2
Pt awake, alert, oriented & acute episode noted. NPO for conscious sedation procedure.
[redacted] 9 LWMP
b6-2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 Jul 03 0130			winged pt off NC to RA. SaO2 @ 95%.
			pt sleeping in bed. will cont to monitor. [redacted]
0200			stopped tube feeding. pt is NPO for conscious sedation this A.M. will cont to monitor. [redacted]
17 Jul 03 0500			Received report from SPC [redacted] b6 pt resting in bed on back. Drsgs intact to all wounds. SPO2 92-93%. Incentive spirometry used. SPO2 ↑ to 98% with use. Will monitor [redacted]
0840			Drsg Δ complete to burn areas. LT [redacted] @ BS for conscious sedation. Fentanyl 275 mcg, Ketamine 100 mg, versed 8 mg and 2 mg MSO4 IVP along with .2 mg Robinul. (L) heel appears black, wound to (R) knee beefy red c̄ active bleeding and some white areas. (L) knee also beefy red c̄ active bleeding and white patchy areas. Wounds all appear beefy red c̄ some areas containing white full thickness areas. Ace wrap to (L) leg. Large drsg intact to abd to suction. (R) thigh donor site appears weepy, heat lamp applied. Graft site drsgs on (R) upper thigh intact and moist. [redacted]
0900			Pt refused to use IS. [redacted]
1015			Pt shaved and mouth care complete. [redacted]
1800			Received report from ongoing shift. Pt awake no c/o of pain @ this time. Graft site in the abdomen hook up to suction. Dressing intact c̄ some drainage noted left hand. Top of flow sheet for other pertinent info [redacted]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16JUL03			NN CONT'D: BILAT LOWER EXT DRESSING C&I E KERLEX AND
0630			ACE WRAP ON (L) LEG. CAP REFILL < 2 SECS X 4 EXT. ABD DRESSING
			INTACT E GAUZE AND PLASTIC WRAP TO CONT SXN VIA JP
			DRAINS X 2. BILAT ANTERIOR THIGH DRESSING INTACT E GAUZE
			WHICH ARE MOIST. DOBHOFF TF NASAL STOPPED FOR CONSCIOUS
			SEDATION ~~BURING~~ DRESSING D's FLUSHED E STERILE H_2O. PT
			RESTING QUIETLY IN BED PAIN CONTROLLED E MSO4. WILL CONT
			TO MONITOR [redacted] CAPN
16JUL03			b6-2
1230			NN: DRESSING Δ DONE PT TOLERATED WELL E
			CONSCIOUS SEDATION GIVEN BY ANESTHESIA SERVICES.
			PULSE: BILAT RAD +3 BILAT DP +2. EDEMA NOTED ON
			(L) LE AND TRUNK. RESTARTED TF @ 100 mL/HR
			VSS. WILL CONT TO MONITOR [redacted] b6-2 CAPN
1730			received pt's report from day shift. pt resting in
			bed 5 any complaints will cont to monitor b6 [redacted]
2000			pt oob to bedside comode. pt had light brown
			loose stool. pt tolerated ambulating E assistance
			pt now sitting up in bed on (R) side. will
			cont to monitor [redacted] b6
2100			Dressing Δ started. Changed (L) arm + (R) arm + heel
			(L) foot ~~and thigh~~. [redacted] (R) foot and knee. moistened
			graft (R)+(L) thigh. pt tolerated dressing change
			E 200mg of Fentanyl + 8mg Versed. pt S_aO_2 to
			87-88% put on 3L NC. pt now resting in bed.
			will cont to monitor [redacted] CA
[redacted] b6-4			b6-2
ICU-3 [redacted] b2-2			

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 July	(0330)		PIV 18g to (R) FA c̄ S/Sx Infiltration, No Flow / Flash. Edema @ Site. Restart 18g PIV to (R) lateral wrist c̄ incident. b6-2 [redacted] 91WM6
21 July	(0500)		5mg IVP MSO4 given by MAJ. Neumein 2° c/o "Alarm" to (L) Hand. Continues c/o discomfort p̄ analgesia. Hand c̄ ↑ swelling noted. Hand ↑ on Blanket Roll. b6-2 [redacted] 91WM6
21 July	(0600)		Pt care Report to SPC [redacted] b6-2 Awake c̄ noted distress. b6-2 [redacted] 91WM6
21 Jul 03	0600		Received report + Assumed care of Pt. VSS, Pt Appears to be resting well @ this time. Will Monitor. [redacted] b6-2 [redacted] 91WM6
	0745		Pt Lying in bed sleeping c̄ Ø Ntd distress + Appears to be resting comfortably @ this time. Will continue to Monitor. b6-2 [redacted] 91WM6
	0840		Pt Complaining of Pain, Medicated c̄ 6mg MSO4. Will continue to Monitor. b6-2 [redacted] 91WM6
	0945-1045		Dressing Changes Performed. Ace wrap + splints removed from Legs, dressings removed from old graft sites + old donersite. Areas Cleaned c̄ hibiclens + rinsed thoroughly. Silvidine + bulky dressings Applied + Ace wrap re-applied. Old dressings removed from (R) arm + Abd. Areas Cleaned c̄ Hibiclens + rinsed thoroughly c̄ Silvidine + bulky dressings Applied.

Continued →

DATE	TIME A.M.	TIME P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Jul 03	0945-	1045	Pt tolerated well c̄ minimal sedation. Will continue to monitor. [redacted] 91WM6
	1245		Pt lying in bed + appears to be in cheery mood. VSS, Ø N/d distress @ this time, Will continue to monitor. [redacted] 91WM6
	1415		Pt lying in bed + appears to be resting comfortably @ this time. VSS; UOP good. Will continue to monitor. [redacted] 91WM6
	1620		Pt lying in bed sleeping + appears to be resting comfortably @ this time. Will continue to monitor. [redacted] 91WM6
21 Jul	~~1800~~ 1800		Pt appearse to be resting comfortably in bed. VSS. Dobhoff to R nare, no TF. JP drain to R arm ABD, JP LE, draining serous sanguinous fluid. IV to R FA c̄ LR @ 125 cc/hr. Will continue to monitor [redacted], SPC, 91WM6
21 Jul		2080	Pt resting comfortably in bed. Repositioned onto R side. Dressings C/D/I VSS, will continue to monitor. [redacted], SPC, 91WM6
21 Jul		2200	Pt resting in bed, turned on L side VSS. Will continue to monitor. [redacted]
22 Jul		0001	Pt resting comfortably in bed, VSS. Will continue to monitor [redacted]
22 Jul		0200	Turned pt on R side. VSS. Will continue to monitor. [redacted]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July	(0600)		Pt care Report given to LT [redacted] b6-2 Pt c̄ No acute episode noted. Awake, alert, orientated only to person [redacted]
	0600		Report received from SSG [redacted] Pt laying in bed on (R) side c̄ complaints. [redacted] b6-2
	0700		Pt turned to (L) side [redacted]
	0850		Pt ate couple of bites of [redacted] and drank 1 can ensure plus [redacted] b6-2
	1115		Dsg change complete. 150 mcg of fentanyl IVP given for Δ. Pt tolerated well. Wounds redressed as ordered. Pt up to chair following procedure. Pt drank 1 can Ensure Plus and water. Pt refusing lunch tray.
27 Jul 03		1800	Pt resting comfortably in bed. Dressings CNT. IV to (L) Ft c̄ NS @ 100cc/hr. VSS. will continue to monitor. [redacted], SPC, 9/W/M6 b6-2
27 Jul 03		2200	Pt appears to be resting comfortably in bed. Moistened dressing to (R) calf. VSS. will continue to monitor. [redacted] 9/W/M6 b6-2
28 Jul 03		0200	Pt appears to be resting comfortably in bed. VSS. Will continue to monitor. [redacted] b6-2
28 Jul 03		0500	Replaced pt fent. patch. Patch located in (R) upper back. VSS. will continue to monitor. [redacted], SPC, 9/W/M6 b6-2
28 Jul 03		0600	Gave report to day shift. [redacted] b6-2

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Jul 03	0600		Received report from previous nurse. Pt sleeping comfortably VSS no c/o @ time, will continue to monitor [redacted] b6-2
26 Jul	0900		Dressing changed. Silvadene to axilla, legs & abdomen, back and sacrum, sulfamylon solution to graft site, petroleum dressing to graft site. Pt laying down on his side p̄ dressing change. Medicated c̄ 225 mcg of fentanyl, Tolerated procedure well, VSS, will continue to monitor. [redacted]
1630	26 Jul	03	AM care done, Pt shaved, teeth brushed, Pt had BM using BSC. Walked to dirty utility sink to wash hair & tolerated well, 2 cans of ensure given since 0600, Pt taking adequate # water intake, VSS. will continue to monitor [redacted]
1700	26 Jul	03	Pt ate 50% of dinner. tolerated well [redacted] b6-2
26 July 03	(1800)		Pt Care. Report Received from LT [redacted] Pt asleep & acute episodes noted. [redacted] b6-2 [redacted] RN/LPN
26 July	(2200)		Continue to sleep @ intervals of 1.5 hr @ a time. No acute episodes noted. Ben x1 on commode. Passing formed Brown stool. [redacted] b6-2 [redacted] RN/LPN
27 July	(0200)		No acute episode. [redacted] RN/LPN

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) [redacted] b6-4

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

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

[redacted] blond 8 Jul 03

PATIENT ASSESSMENT

TIME 1000 SIGNATURE: [redacted] blond

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature warm

Pale / Cyanotic / Jaundiced normal for pace

Mucous Membranes: Moist / Dry / Cracked dressing to burn area

Breakdown: None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS: 15

Oriented / Disoriented Pupils: confused

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: Seconds <3 sec Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1S2

Rhythm reg PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) FA p/s +	
Solution			reflex	

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

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	OTA bilaterally	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended NTND cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

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

Drainage: Color Character

Tube Feeding Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: light yellow Character: clear

Voiding: Continent / Incontinent / Catheter foley

PATIENT ASSESSMENT blond

TIME: 1800 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm to touch

Color: Pale / Cyanotic / Jaundiced membranes pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: See SF 600 Size

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS

Orientated / Disoriented Pupils: person, place, only

Extremity Movement: Full / Limited / None 2° dressings

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S1S2

Rhythm Regular ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms				
Site			20g L)	
Solution			lactated	

Chest Pain Ø

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Mus

Breathing Patterns: Regular RA SpO2 90's

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm

Air Leak Ø No Yes Crepitus

Character of Drainage: Ø

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

Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/L
Crackles		
Wheezes		
Diminished	Bilat in Base	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: See SF 600

NG Tube: Clamped/Inter. Suction/Cont Suction/Dependent D Ø

NG Drainage: Color Ø Character

Tube Feeding: Day No: Ø Strength: Rate: Asp.

Stool: Character Ø

Drains: Foley 16 Fr

GENITOURINARY

Urine Color: yellow Character: concentrated

Voiding: Continent / Incontinent / Catheter

PATIENT ASSESSMENT 29 July 03 66-2

ME: 0600 SIGNATURE: Sgt [redacted]

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature 98.4

Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERL

Extremity Movement: Full / Limited / None DRSG to hands + legs

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension N/A Edema 0

Heart Sounds normal

Rhythm 96 PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			IV to Rt	
Solution	LRO 100cc/hr		Rt Arm	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: 24

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		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: DRSG to hands + legs/feet

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 FIC

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None Splints to LEG

CARDIOVASCULAR

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

Capillary Refill: < 3 Seconds 0 Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm RR+R PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RR+R

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/L
Crackles	CTA bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: C DI to hand + leg

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

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Asp

Stool: Character None @ this time

Drains:

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent

foley draining to gravity. 29 July

[redacted] 66-4

~~26~~ 27 July 03 H: [redacted]

PATIENT ASSESSMENT

ME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature warm.

Pale / Cyanotic / Jaundiced

ous Membranes: Moist / Dry / Cracked

Breakdown None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS:

ntated / Disoriented UTA Pupils: Splint to (L) leg.

emity Movement: Full / Limited / None

CARDIOVASCULAR

e (0 - 4) +3 Radials +2 Pedals

illary Refill <2 Seconds Homan's Sign

ular Venous Distension Edema Ø

t Sounds S1-S2. Rate 90's.

thm NSR PRI: QRS:

cular Catheter Central Arterial Peripheral 1 Peripheral 2

vforms

tion (R) FA 20G IV LR @ 100 inserted 26 July 03

st Pain

RESPIRATORY

st Expansion / Symmetrical / Asymmetrical

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

thing Patterns: SpO2 98% on RA

gh: Productive / Nonproductive / None

um: Color / Amount / Consistency / Odor

st Drainage System Gravity: Suction cm:

ak: No Yes Crepitus

acter of Drainage:

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

icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles		
ezes	clear bilat	
nished		
ent		

GASTROINTESTINAL

omen Soft / Firm / Hard / Distended cm Girth

el Sounds Normal / Hyperactive / Hypoactive / Absent

ssings to burn areas on body.

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

Drainage: Color Character

e Feeding: Day No: Strength: Rate: Aspirate:

l: Character

ins:

GENITOURINARY

e: Color: Foley to gravity dnc clear yellow urine

ing Continent / Incontinent /

EPW

PATIENT ASSESSMENT

TIME: SIGNATURE:

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: UTA

Extremity Movement: Full / Limited / None Splint to (L) leg

CARDIOVASCULAR

Pulse (0 - 4): +3 Radials +2 Pedals

Capillary Refill: <3 Seconds (-) Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter Central Arterial Peripheral 1 Pe

Waveforms

Site (R) FA

Solution @ 100 cc/hr

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: NRR

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/L
Crackles	CTA Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: C/D/I

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

NG Drainage: Color dark Character yellow

Tube Feeding: Day No: Strength: Rate: Asp

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Foley to gravity

66-4

PATIENT ASSESSMENT

ME [redacted] SIGNATURE: [redacted] 66-2

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature warm

Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS: 15

Orientated / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: 3 sec Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R wrist	
Solution				

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

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 bilaterally	
Wheezes		
Diminished	BS X10 q1°	
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: clear yellow Character:

Voiding: Continent / Incontinent / Catheter

PATIENT ASSESSMENT 66-2

TIME: 1800 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm to Touch

Color: Pale / Cyanotic / Jaundiced membranes pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: See SF Size 600

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 2mm

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: < 3 Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm ST HR 100's PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms				
Site			20g (R)	
Solution			wrist	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Regular c ↓↓ Bases

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/L
Crackles		
Wheezes		
Diminished	Bilat	Bilat
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: See SF 600

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

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Asp

Stool: Character Loose Brown

Drains: Foley 16 F.

GENITOURINARY

Urine Color: yellow Character: cloudy

Voiding: Continent / Incontinent / Catheter

H [redacted] 66-4

26 July 03

b6-2 ASSESSMENT b6-2

TIME: 0600 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 97.7 normal
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: PERL
Extremity Movement: Full / Limited / None Burns to ↑+↓ extremities

CARDIOVASCULAR

Pulse (0 - 4): + Radials --- + Pedals
Capillary Refill: Good Seconds Homan's Sign
Jugular Venous Distension N/A Edema to (L) feet
Heart Sounds normal
Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			Rhinnialam	
Solution			RL 100cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: normal
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor N/A
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	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: To abdomen, back, U&L extremities
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character -0-
Drains: -0-

GENITOURINARY

Urine Color: pale yellow Character:
Voiding: Continent / Incontinent / Catheter HC

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1800 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature warm to touch
Color: Pale / Cyanotic / Jaundiced membranes pink
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: SEE SF 600 Size:
SEE SF 600

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None 2° BLE/UE wounds

CARDIOVASCULAR

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

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			PIV 20g	
Solution	LR 100°		Right	

Chest Pain Denies

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: Regular RA SATS MID 90's
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm:
Air Leak Ø No Yes Crepitus
Character of Drainage: Ø
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Ø Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: SEE SF 600 for wound assessment
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage Ø
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate
Stool: Character Ø
Drains: Ø

GENITOURINARY

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

EMOTIONAL/PSYCHOSOCIAL

Oriented person, place, event
Cooperative / Pleasant

OTHER:

[redacted] 04Aug03
b6-4

b6-2

TIME: 0645 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to Pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Burn Area Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: Seconds <3sec Homan's Sign

Jugular Venous Distension Ø Edema Ø Foot

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			Dac	
Solution			LR @ 100	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Ø 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	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Dressings to be A'd in OR

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

NG Drainage: Color Character

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

Stool: Character Ø

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 18 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm to Touch

Color: Pale / Cyanotic / Jaundiced Membranes Pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None 2° BLE wounds

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign neg

Jugular Venous Distension Ø Edema

Heart Sounds SS

Rhythm Regular PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			20g PIV (L) AC	
Solution	LR 100			

Chest Pain Denies

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Reg

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm:

Air Leak No Yes Crepitus

Character of Drainage: Ø

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

Artificial Airway Size: Type: Ø Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	B. lat	B. lat
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: See DF 600 for Skin Assess

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

NG Drainage: Color Ø Character

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

Stool: Character Ø

Drains: Ø

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

01 Aug 03

b6-4

#[redacted]

ACUITY LEVEL CLASSIFICATION

22	23	00	04	02	03	04	
22	23	00	04	02	03	04	8° T

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								
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN	TIME		
SUCTION			

24 HR I&O TOTALS	NURSE'S SIGNATURE
wt Yesterday _____ wt Today _____	
INTAKE / OUTPUT	
IV _____ Urine: _____	
po _____ _____	

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP			109/63				120/69				119/68					109				105/60				X
TEMP	X		98.2				98.5				98.7				97.6	97.9								
HR	85	86	98				97				97					108				96				87
RR	14	11	14				11				16					10				12				11
SA02	93	96	96				97				100					98				97				98
				IN OR																				
INPUT																								
PO																								
NS IV	100	100	100		~~200~~		100	100	100	100	100	100	100		240			200		100				
NGT																								
LR														100	100	100	100	100	100	100	100	100	100	100
TOTAL																								
OUTPUT																								
URINE					200		200				300		100											
NGT																								500
STOOL																								
TOTAL																								
BALANCE																								

OR

IV 2100 urine

PO

Balance

01Aug03

#[redacted] blank

MEDCOM - 13134

TIME: 0607 SIGNATU. [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm Perrla

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: Seconds <3 Homan's Sign Ø

Jugular Venous Distension Ø Edema

Heart Sounds S1 S2 No ectopy

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Ø 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	CTA
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: Clear

Voiding: Continent / Incontinent / Catheter Foley

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1800 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm.

Color: Pale / Cyanotic / Jaundiced Normal for Race.

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: <2 Seconds Homan's Sign

Jugular Venous Distension Edema Ø

Heart Sounds S1-S2

Rhythm Sinus tach. Rate 100's PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site	Ø			
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Regular

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Burn areas, D'd in AM.

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: Clear dark yellow urine Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: Ø

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30 Jul 03 pt: EPW [redacted] b6-4

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm to touch

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None 0% Burns

CARDIOVASCULAR

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

Capillary Refill: Seconds <3 Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S1S2

Rhythm RRR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site	TLC Neck			
Solution	LR @ 100cc/hr			

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm:

Air Leak No Yes Crepitus

Character of Drainage: NA

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Abd, Bilat hands, Bilat legs, buttocks, Back

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

NG Drainage: Color N/A Character

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

Stool Character

Drains Ø

GENITOURINARY

Urine Color Clear Character: yellow

Voiding: Continent / Incontinent / Catheter Urostomy

EMOTIONAL/PSYCHOSOCIAL

Presenting comfortably X 5D & pain/distress

OTHER

TIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry 30-40% burn

Skin: Temperature warm & dry

Color: Pale / Cyanotic / Jaundiced WNL for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: arms/LE Size: buttocks back

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS: —

Orientated / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None due to pain

CARDIOVASCULAR

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

Capillary Refill: <3 sec Seconds — Homan's Sign —

Jugular Venous Distension Ø Edema hands/LE

Heart Sounds S1S2, ST 100's

Rhythm NSR (R) PRI: — QRS: —

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: unlabored even, NAD

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor —

Chest Drainage System Gravity: Ø Suction cm

Air Leak Ø No Yes Crepitus

Character of Drainage: —

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

Artificial Airway Size: Ø Type: Ø Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	X occasional exp wheeze	
Diminished	X 2 pack/day smoker	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: hands, LE, buttocks, back

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

NG Drainage: Color — Character —

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character soft large last BM 7/6/03

Drains: —

GENITOURINARY

Urine Color: tea Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Cooperative, awake, verbalize needs

OTHER:

TIME: 0900 SIGNATU. [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal to Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Burn Sites Size:

NEUROLOGICAL

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

CARDIOVASCULAR

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

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			B wrist	
Solution			LR@100	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: RR
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Ø 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	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: Dcsgs A&C CAT
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character Ø
Drains: Ø

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / Catheter Foley

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1800 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature WARM TO TOUCH
Color: Pale / Cyanotic / Jaundiced Membranes pink
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None 2° BLE WOUNDS

CARDIOVASCULAR

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

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			20g PIV	
Solution	LR		(R) wrist	

Chest Pain Denies

RESPIRATORY

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

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: See SF600 for Skin assess
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage Ø
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate
Stool: Character Ø
Drains: Ø

GENITOURINARY

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

EMOTIONAL/PSYCHOSOCIAL

Cooperative, pleasant. Oriented person, place. Remembers time + event easily.

OTHER:

02 Aug 03

[redacted] b6-4

TIME: 0840 SIGNA [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Burns arms, legs, Back

NEUROLOGICAL Abdomen, Back

Loc: Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None Active

CARDIOVASCULAR

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

Capillary Refill Seconds <3 Homan's Sign

Jugular Venous Distension Ø Edema BLE

Heart Sounds CV=S1S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Dilution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Regular, Unlabored

Cough: Productive / Nonproductive / None 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	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: C/D/I

NG Tube: Clamped/Intac. Suction/Cont. Gravity/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Not yet voided Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Calm, Cooperative

OTHER:

TIME: 0 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Burns Dressing CDI

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: PERRLA 3mm brisk

Extremity Movement: Full / Limited / None Weak

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds — Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Dilution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RRR

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: ARMS, LEGS, ABD, BACK BURN DRSG

NG Tube: Clamped/Intac. Suction/Cont. Gravity/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Spontaneously Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Cooperative, Follows Simple Commands

OTHER:

66-4

ICU Flowsheet **Patient Name:** [redacted] **Date:** 11 / Aug / 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	98.4	→	98.4						97.2					97.7				97.7			98.0					
Pulse	83		83						81					80				82			84					
B/P → A-Line																										
MAAP		→																								
B/P → Cuff	122/64		122/64						100/78					112/74				122/68			120/60					
Resspirations	14		14						16					17				16			16					
SaO02	98%		98%						95					96				97			96					
	RA	→	RA						RA					RA				RA			RA					
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF :																										
PO Intake											240	60		60					237							
O.RR. IN																										
Totals																										
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly																		250								
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

#[redacted] 66-4

11 Aug 03

MEDCOM - 13139

PATIENT ASSESSMENT

TIME: SIGNATURE

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm to touch

Color: Pale / Cyanotic / Jaundiced Normal for Race

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 +2 Pedals +2

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Ø Edema Scrotal, Bilat legs

Heart Sounds S1 S2

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site	Bracd			
Solution	LR @ 100 cc/hr			

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: NA Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Legs, Arms, Hands, Abd, buttock, back

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

NG Drainage: Color Ø Character

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

Stool: Character

Drains Ø

GENITOURINARY

Urine Color: Yellow Character: Clear

Voiding Continent / Incontinent / Catheter Foley

EMOTIONAL/PSYCHOSOCIAL

Pt resting comfortably in bed Ø c/o pain, discomfort

OTHER

POST ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm dry to touch

Color: Pale / Cyanotic / Jaundiced WNL for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: 10-20% burn Size: hands arms legs

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None due to pain

CARDIOVASCULAR

Pulse (0 - 4): Radials + Pedals +

Capillary Refill: <3 sec Seconds Homan's Sign –

Jugular Venous Distension – Edema hands + legs, feet

Heart Sounds S1 S2

Rhythm ST 110 PRI: – QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain –

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: BBS regular unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor —

Chest Drainage System Gravity: NA Suction cm NA

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	✓ throughout	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: hands, LE, buttocks, abd, back

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

NG Drainage: Color Character

Tube Feeding: Day No: 1 Strength: Rate: 125 Aspirate

Stool: Character –

Drains:

GENITOURINARY

Urine Foley Color: amber Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Low tolerance for pain, requiring maximum MSO4 10 mg during dressing Δ. alert, cooperative

OTHER: Comfort returns after procedure.

25 July 03

[redacted]

b6-4

0635 PATIENT ASSESSMENT b6-2

VE: [redacted] b6-4 SIGNATURE: [redacted] LT/SN

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature WARM

Pale / Cyanotic / Jaundiced WNL for RACE

Mucous Membranes: Moist / Dry / Cracked

Breakdown: None Location: — Size: —

NEUROLOGICAL

Alert / Lethargic / Unresponsive confused GCS: —

Orientated / Disoriented Pupils: 3+ brisk

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals

Capillary Refill: <3 Seconds Homan's Sign (—)

Jugular Venous Distension — Edema pitting @ LE +3

Heart Sounds S1 S2

Rhythm ST PRI: — QRS: —

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	—	—		
Site	—	—	(L) upper arm	
Soln			LR @ 100cc/h	

Chest Pain Ø

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 N/A

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 bilat & bases	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended — cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: BLE, BUE, buttocks, back, stomach intact + dry

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

Drainage: Color — Character —

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

Stool: Character Ø @ this time

Drains: —

GENITOURINARY

Urine Color: DARK YELLOW Character: Ø sediment

Voiding: Continent / Incontinent / Catheter

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WARM TO TOUCH

Color: Pale / Cyanotic / Jaundiced membranes pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: SEE SF 600

NEUROLOGICAL

Loc Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S1 S2 ST ↑ HR ↓ 100's

Rhythm Regular PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			20g (R)	
Solution			WRIST	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Regular ↑ ↓ ↓ Bases

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/L
Crackles		
Wheezes		
Diminished	Bilat Bases	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / ~~Hyperactive / Hypoactive / Absent~~

Dressings: SEE DR SF 600 b6-2

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

NG Drainage: Color Ø Character

Tube Feeding: Day No: Ø Strength: Rate: Asp

Stool: Character Loose Brown

Drains: Foley 16 F

GENITOURINARY

Urine Color: yellow Character: Cloudy

Voiding: Continent / Incontinent / Catheter

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: See H+P WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): See H+P

4. PROPOSED SURGICAL PROCEDURE:

Full Thickness Skin Graft

5. ADDITIONAL INFORMATION:

See H+P for additional information

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to Traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury; previous medical condition	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; poistion; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

EPW # [redacted] b6-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury ; sedation F.2. ✓ Potential for decreased communictaion due to languag e barrier; sedation; pain; injury F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Either side. o Validate pt.'s understanding of verbal communications. ~~o Verify removal of dentures.~~
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURS[redacted]D/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AR 26 Aug 03 DATE

11. PO[redacted]OPERATIVE EVALU[redacted]ION: b6-2

12. PREOPERTIVE [redacted] b6-2
(Signature and Title) [redacted] CPT/AR

DATE: 26 Aug 03 TIME: 0925

13. PREOPERTIVE EVALUATION [redacted] b6-2
BY (Signature and Ti[redacted] CPT/AR

DATE: 26 Aug 03 TIME: 1030

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: unknown WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): SEE H+P

4. PROPOSED SURGICAL PROCEDURE:

Burn Debridement of Both Hands/Feet Dsg Change

5. ADDITIONAL INFORMATION: Last PO: ~~p MN~~ Medical Hx: see H+P Implants: Q Medications: Ancef
Jewelry removed: yes/no Family waiting: yes/no

NPO p MN

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o PT. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted] - EPW
ICU-13 b6-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ____ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. ~~o Place and take down legs from stirrups with slow bilateral motion.~~ o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ____ Potential impairment of mobility due to sedation; pain; injury E.2. ____ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ____ Disminished visual perception due to being injury; sedation; F.2. ____ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR[redacted]NS COMP[redacted]ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 1 Aug 03 DATE

11. POSTOP[redacted]TIVE EVALUATION: [redacted] b6-2

12. PREOP[redacted]ON[redacted]RED BY (Signature and T[redacted]	13. PREO[redacted]TIVE [redacted]ATION [redacted]RED BY (Sign[redacted]
[redacted] CPT/AN b6-2	[redacted] CPT/AN b6-2
DATE: 1 Aug 03 TIME: 0835	DATE: 1 Aug 03 TIME: 1015

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Dressing A See H+P

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

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

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

[redacted] b6-4

b6-2

VERIFICATIONS AT HOLDING AREA:
[redacted]/Allergy Band [redacted]ntures Removed
[redacted] & P [redacted]ntacts Removed
! NPO Since 0 AM [redacted]ewelry Removed
! ~~UHCG/LM~~ [redacted] Body Pierce Removed
[redacted]onsent/Blood Transfusion
[redacted]ed/Witnessed/Dated
[redacted]rgical Site/Consent verified by
[redacted]/Anesthesia/Surgeon
[redacted] Contact Precautions (Y) (N)
! Family/Friend: None

6. PATIENT PROBLEMS AND NEEDS	ATIENT 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	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.	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 Cpt 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 NUR[redacted]ERVENTIONS CO[redacted]PLETE [redacted]/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/hr 13 Jul 03 DATE

11. PO[redacted]OPERATIVE EV[redacted]UATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☒ N/A DRESSING DRY & INTACT: (Y) (N)

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

LEVEL OF ACTIVITY: [redacted] Moves All Ex[redacted]ities ☐ Moves Upper Extremities

[redacted]nsferred to litter with roller due to spinal

12. PREOPER[redacted] [redacted]ON [redacted]ARED BY (Signature and [redacted] CPT/hr

DATE: 13 Jul 03 TIME: 0910

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 13 Jul 03 TIME: 0910

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: 4M

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Wound Excision + grafting

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

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] b6-4

ICM; 3

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since Midnight ! 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	ATIENT 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. 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] b6-2 CRTIAN 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 BREATHING EASY (Y)(N)

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CRTIAN b6-2

DATE: 6 July 03 TIME: 0740

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CRTIAN b6-2

DATE: 6 July 03 TIME: 1240

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD

INTRAOPER. E 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 ILT [redacted] b6-2

3. DATE 20 JUL 03 TIME PATIENT ARRIVED IN SUITE 0750

4. PATIENT IN ROOM TIME 0750 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Multiple burns
NPO p MN, NKDA Foley cath

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b6-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] b6-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) #1 Pt prone on padded OR table. Pillows under chest and legs. Genitals free from impingement.

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

#2 Pt. supine - BUE <90°

COMMENTS: Normal anatomic body alignment maintained.

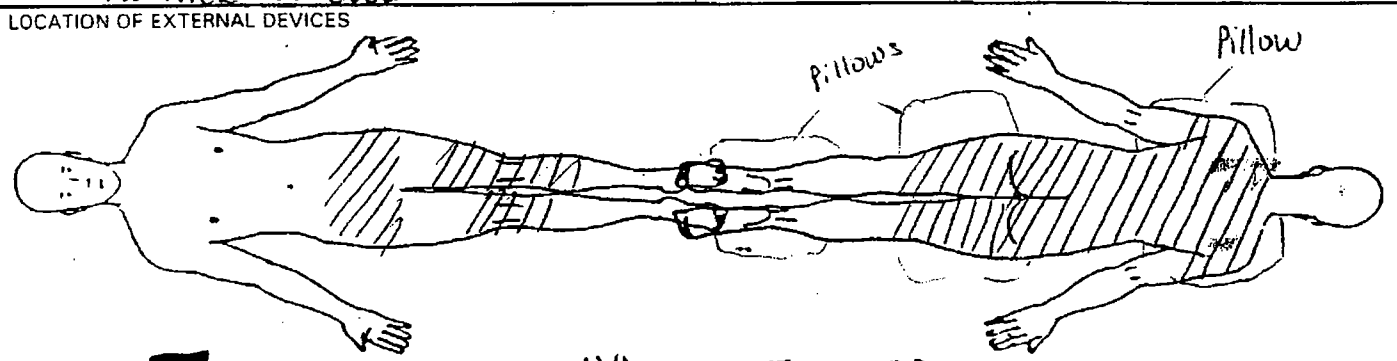
8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Buttocks
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR By Dr. [redacted] ☐ CLIP

COMMENTS: No nicks or cuts noted.

PREP SOLUTION (Specify) HiDiciens b6-2
SITE: Back of thighs - to neck BY WHOM: ILT [redacted]
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Ground Pad -- [redacted] Strap N/A = = = Tourniquet ▨ - prep

Initial: SSG ILT [redacted] b6-2

10. COUNTS

C = Correct I = Incorrect

			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] b6-4

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

☒ ESU NO: 000450 CUT 30 COAG 30
GROUND PAD: BRAND VL 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
NaCl & Epi 1:100,000 Lot 3047 Exp Jul-04 American Regent	Q.S.	intra-op	local application	CPT [redacted]	Dr. [redacted]
Mineral Oil Lot ~~5704~~ 857101 Nov 03	Q.S	intra-op	local application	[redacted]	Dr. [redacted]
					b6-2

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. 10mm J-P drain	2. 10mm J-P drain	3. 10mm J-P drain
SITE	1. Buttocks wound	2. Left Arm wound	3.

18. DRESSING/IMMOBILIZATION (Specify)
STSG site: Xeroform fluffs, ABD
Buttocks/sacrum: Xeroform, Ioban
BLE - Xeroform, Kerlix, splint ACE
LUE - Xeroform, Kerlix, splint ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted], Dr [redacted]
Anesthesia: MAJ [redacted] b6-2

DA 5179 in Chart

20. OPERATION(S) PERFORMED
Debridement of burns
STSG
Dressing Δ

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	1200	LITTER & U2

22. REGISTERED NURSE SIGNATURE [redacted] RN

MEDICAL RECORD

INTRAOPER[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 OR Sta 86

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

3. DATE 15 Jul 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 06:57 NUMBER 2-1 b6-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: dass 4066 026 @ 0200

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] (1st FIST) b6-2	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

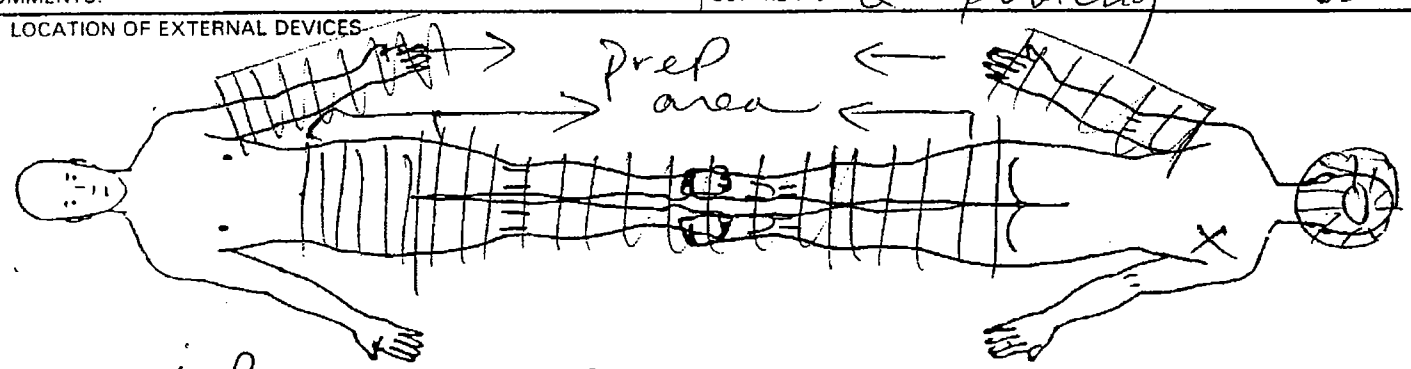
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens Sol
SITE: (B) leg BY WHOM: Dr [redacted]
SITE: (L) arm BY WHOM: CPT. [redacted] b6-2

COMMENTS: ⊘ pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (cup) -- Safety Strap = = Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☑ Yes ☐ No				SGT [redacted]	CPT. [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] b6-4

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

☑ ESU NO: Valley Lab
GROUND PAD: BRAND polyhesive II
LOT NO: 68-9136

☐ 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
1:1000 epi with 1L NS	Q.S	intraop	topical use	[redacted]	Dr. [redacted]
Mineral oil	Q.S	"	"	[redacted]	[redacted]
1:1 Wadell's	Q.S	"	"	[redacted]	"

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

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)*

Xeroform
Fluffs
Kerlix
Ace & Spandage.
Loban

19. ADDITIONAL INFORMATION

Dr. [redacted] ([redacted]
may [redacted] (CRNA)
b6-2

20. OPERATION(S) PERFORMED

(B) leg & (L) arm Burn wd Excision & Debridement, Abd. Skin graft to Burn wd.

21. PATIENT TRANSFERRED TO ICU TIME 5:00 Arrival Record METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

b6-2 b6-2

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia (Cherry)

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

3. DATE 26 Aug 03 TIME PATIENT ARRIVED IN SUITE 0835

4. PATIENT IN ROOM TIME 0835 b6-2 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table anatomically aligned for surgical procedure c̄ pillow under chest, legs, H+N pillow under head (B) arms c̄ padded arm boards less 90°

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

COMMENTS:

8. SKIN PREPARATION

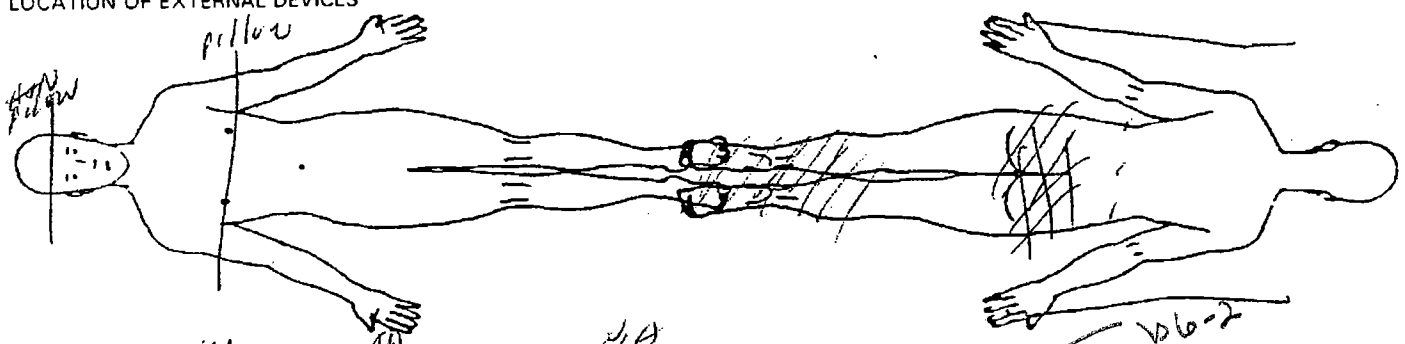
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine / Betadine
SITE: (B) leg calf to feet BY WHOM: CPT [redacted]
SITE: Buttocks BY WHOM: MAJ [redacted] b6-2

COMMENTS: ☒ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect initial CPT [redacted] / SPC [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					b6-2

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

EPW # [redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: 405 R&B 102395
GROUND PAD: BRAND Valley lab
LOT NO: 68936

☐ 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): 1:1000 Epi c̄ 300 cc NACl (30 cc) 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. JP x2 10mm	2.	3.
SITE	1. Both ankles	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
4x8
Xeroform

19. ADDITIONAL INFORMATION

Surgeons [redacted]

Anesthesia [redacted]

b6-2

20. OPERATION(S) PERFORMED

Split Thickness Skin Graft to (B) heels
(L) Thumb partial Amputation

21. PATIENT TRANSFERRED TO RACU TIME 1030 METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

b6-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13155 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: Gurney BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] - b6-2

3. DATE 6 July 03 TIME PATIENT ARRIVED IN SUITE 1015

4. PATIENT IN ROOM TIME 1015 NUMBER H 1 6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] - b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] b6-2	RELIEF CIRCULATOR	MAJ [redacted] b6-2 (1125 - 1150)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

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

8. SKIN PREPARATION

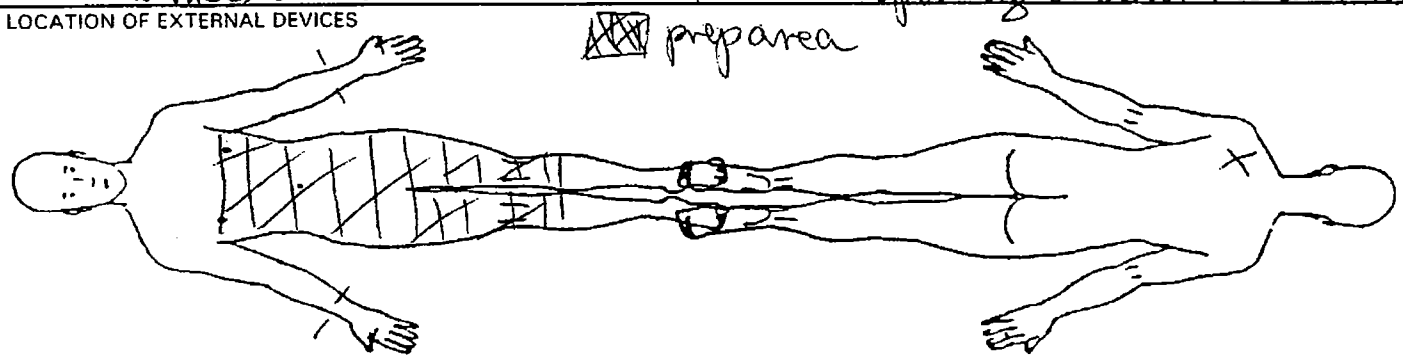
HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
b6-2

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine
SITE: Abdomen to nipples BY WHOM [redacted]
SITE: Bilt thighs to 2 in below knees BY WHOM [redacted]

COMMENTS: no pooling or skin reaction noted

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] - b6-4
ICU-3

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% NaCl
0.9% NaCl c̄ Epi 1:100,000

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 ☐

	1.	2.	3.
TYPE/SIZE	16 F FIC		
SITE	Bladder		

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs ABD
Kurlix
Acewrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b6-2
- FIC in place prior to arrival to OR

20. OPERATION(S) PERFORMED
Burn Debridement (thighs, knees bil, abdomen)
Dressing Δ feet + hands

21. PATIENT TRANSFERRED TO ICU-3 TIME see DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] PT b6-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13157 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: Litter BY OR staff

2. PATIENT IDENTI[redacted] RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CAPT

3. DATE 10 Jul 03 TIME PATIENT ARRIVED IN SUITE 0610

4. PATIENT IN ROOM TIME 0610 [redacted] b6-2 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted] 91D b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E CPT [redacted] b6-2	RELIEF CIRCULATOR	MAJ [redacted] b6-2 (CTIS-

7. POSITION AND POSITIONAL AIDS (Specify) Pt in proper body alignment. Arms on armboards @ <90°. Bumpers left hip.

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

COMMENTS:

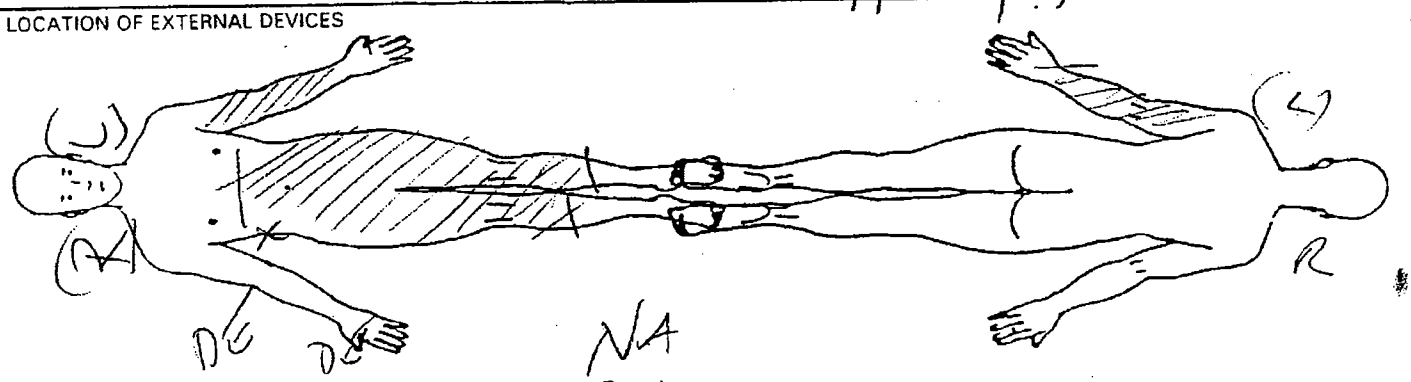
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) H biclens
SITE: left Arm, ABD, Left leg BY WHOM: CPT [redacted] / CPT [redacted]
SITE: Right leg BY WHOM:

COMMENTS: Pooling of Solution noted.

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	✓				
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] - b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☐ ESU NO: VL #1
GROUND PAD: BRAND VL Rem Poly II
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):
Warm 0.9% NaCl c̄ Epinephrine 1:100,000

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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)*

19. ADDITIONAL INFORMATION

[redacted] b6-2

20. OPERATION(S) PERFORMED
Wound Debridement (L)(R) LE Abdomen
(L) Arm

21. PATIENT TRANSFERRED TO ICU 3 TIME [illegible] METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

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

b6-2 MEDCOM - 13159

MEDICAL RECORD | **INTRAOPER[redacted] DOCUMENT**

For use of this form, see AR 40-66, the propon[redacted]ency is the offi[redacted]he Surgeon General.

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

2. PATIENT IDENT[redacted], RECORD R[redacted]ED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 13 Jul 03 b6-2 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM [redacted] TIME b6-2 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] b6-2 AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure c̄ pad under head

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

COMMENTS:

8. SKIN PREPARATION

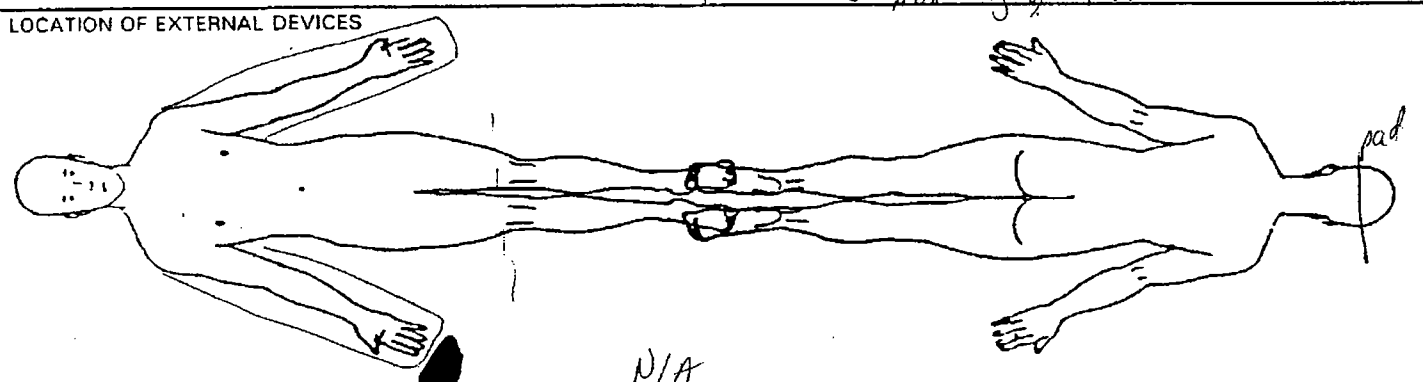
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: Entire Body BY WHOM: [redacted] b6-2
SITE: BY WHOM: [redacted] PFC

COMMENTS: ☒ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

			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] b6-4

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% NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b6-2

15. X-RAY IN[redacted] 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)*
Burn Blanket
Silver Cream
Fluff

19. ADDITIONAL INFORMATION
Surgeon [redacted] Anesthesia [redacted]
b6-2

20. OPERATION(S) PERFORMED
Dressing Change

21. PATIENT TRANSFERRED TO ICU-3 b6-2 TIME 0910 METHOD Litter [redacted]

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN [redacted]

MEDICAL RECORD — **INTRAOPER[illegible]D[illegible]JMENT**

For use of this form, see AR 40-66, the pro[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

2. PATIENT IDE[illegible]IED, RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] CPT/Ar b6-2

3. DATE 1 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	~~SSG~~ SPC [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] Ar b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure c̄ (B) arms on padded arm board less 90°

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

COMMENTS:

8. SKIN PREPARATION

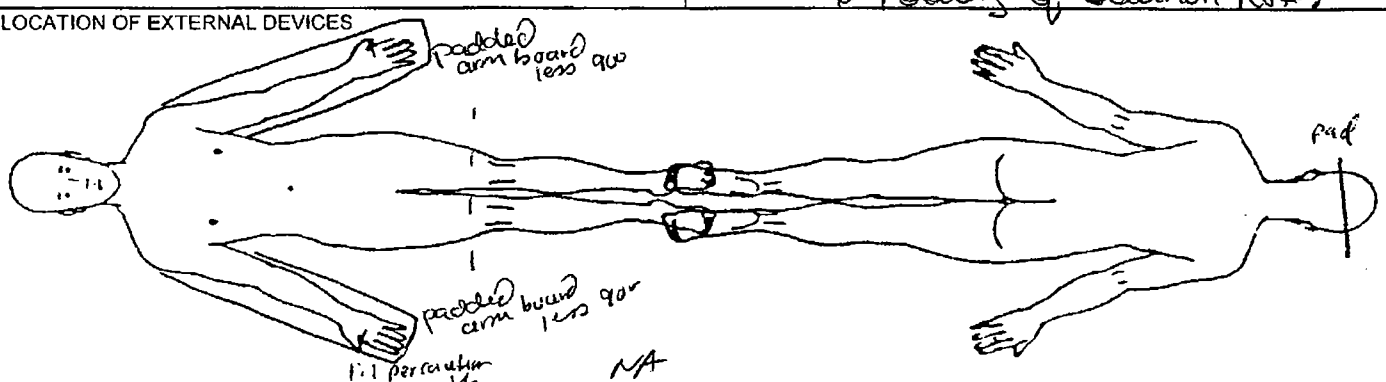
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclen
SITE: (B) Hands BY WHOM: CPT [redacted] Ar
SITE: (B) Feet BY WHOM: b6-2

COMMENTS: ☒ Pooling of solution NOTED

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
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] - EPW
b6-4

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):

0.9-1 NACL

OTHER ORDERS	TIME	CARRIED OUT BY
Foley / b/r changed in OR.		

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
ABD pad

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] b6-2 Anesthesia: STAS-CRNA General Anesthesia Type: General

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

20. OPERATION(S) PERFORMED

Burn Debridement (B) Hands ~~arms~~ / Feet

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1015	Litter EOR

22. REGISTERED NURSE SIGNATURE [redacted] b6-2 CPT/AN

MEDICAL RECORD — **INTRAOPER/ D JMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY LTC [redacted] b6-2

3. DATE 16 Aug 83 TIME PATIENT ARRIVED IN SUITE 1055

4. PATIENT IN ROOM TIME 1055 NUMB[redacted] 1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
	Sgt [redacted] b6-2		
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS:

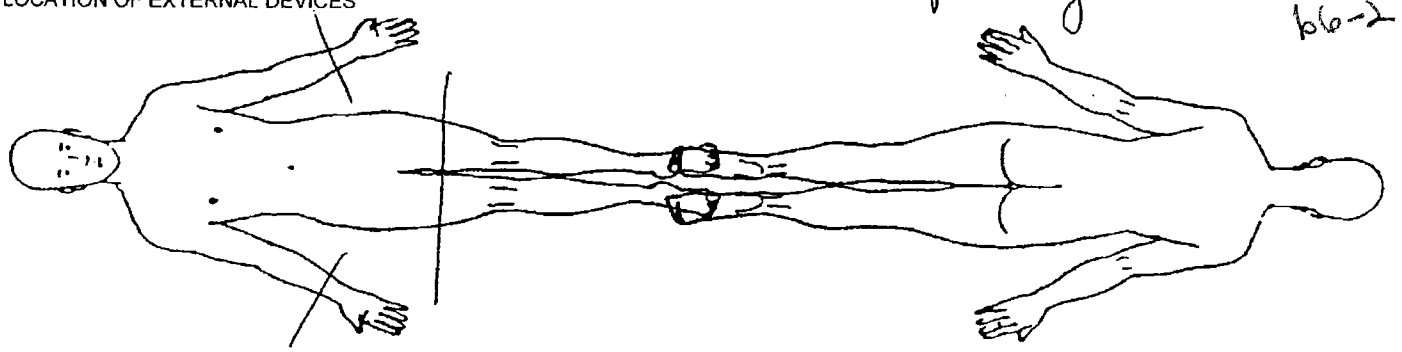
8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine soap/sol.
SITE: (R) ↓ leg BY WHOM: LTC [redacted]
SITE (Lt) ↓ leg BY WHOM: MAJ [redacted]
COMMENTS: No pooling noted b6-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No	✓	C	C	PFC [redacted] b6-2	LTC [redacted]
Needle Sharp	[X] Yes [ ] No	✓			Sgt. [redacted]	
Instrument	[ ] Yes [X] No					
Other	[ ] Yes [X] No					

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

#[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) [ ] YES [X] NO

[X] ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM Polyhesive II
LOT NO: 68936

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

cut: 30 coag: 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 [redacted] b6-2

15. X-RAY IN OPERATING ROOM [redacted] 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

19. ADDITIONAL INFORMATION

WC

Surgeons: Dr. [redacted] b6-2 Anesthesia: LTC [redacted] b6-2 Anesthesia Type: ~~GETA~~ [redacted] b6-2

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

20. OPERATION(S) PERFORMED

Bil. heel debriedment

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	1140	via Gurney

22. REGISTERED NURSE [redacted] b6-2, LTC, AN

MEDICAL RECORD — **INTRAOPER D IMENT**

For use of this form, see AR 40-66, the prop gens; ie office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM (MAS [redacted]) VIA Wheeled litter BY Anesthesia [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b6-2

3. DATE 27AUG03 TIME PATIENT ARRIVED IN SUITE 1000 b6-2

4. PATIENT IN ROOM TIME 1000 NUMBER Rm 2 bed / case 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] RN b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt intubated on Stretcher - Pt log-rolled onto padded OR bed maintaining correct body alignment, Arms in superman position on padded armboards. pillow under chest + hips, pillow under shins, toes hanging freely. face on foam doughnut.

☐ 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:

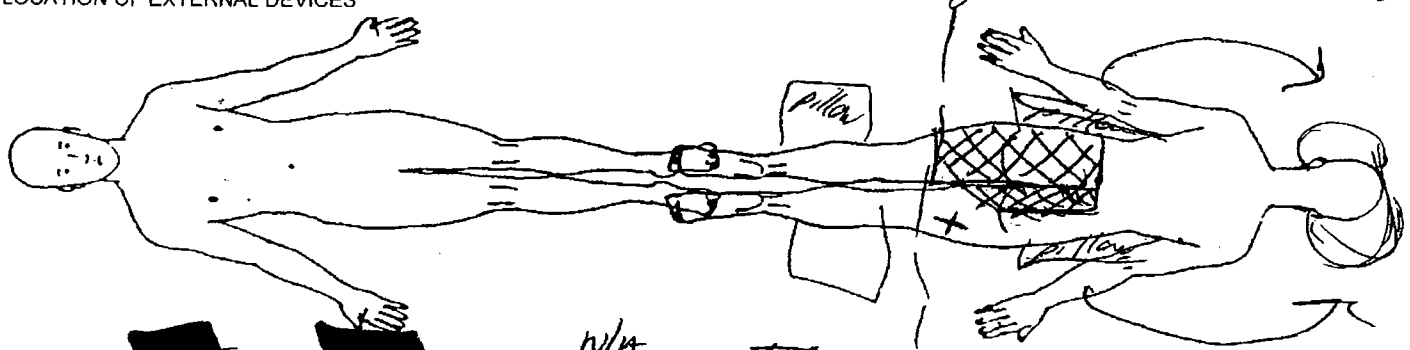
PREP SOLUTION (Specify) Betadine/Betadine

SITE (L) Buttock BY WHOM:

SITE: (as below) BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Ground Pad — [redacted] Safety Strap N/A === Tourniquet [redacted] - prep

10. COUNTS

C = Correct I = Incorrect

			Initial ~~Other~~	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C		C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes	☐ No	C		C		
Instrument	☐ Yes	☒ No					b6-2
Other	☐ Yes	☒ No					

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

[redacted] b6-4

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

☒ ESU NO: R8E 105305

GROUND PAD: BRAND Valleylab PolyHesive II REF

LOT NO: 68936 / 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

QS 0.9% Nacl.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b6-2

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 plain sponges + Silk Tape

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

WC //

Surgeons: Dr [redacted] Anesthesia: MAJ [redacted] CRNA b6-2 Anesthesia Type: GEN/ENDO

Dr [redacted] b6-2

Bovie Pad site intact pre-op CI ; post-op CI Bovie Settings: Coag/Cut 30/30 Blend 1 -

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

Tourniquet Time: Up N/A Down ____ - correct body alignment maintained throughout roll back to wheeled litter.

DA 5179 completed previously

20. OPERATION(S) PERFORMED

wash out + closure (L) Buttock -

21. PATIENT TRANSFERRED TO ICU3/PACU TIME 1115 METHOD wheeled litte -

22. REGISTERED NURSE SIGNATURE [redacted]

b6-2

MEDICAL RECORD — **INTRAOPERATIVE D UMENT**

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

1. PATIENT TRANSPORTED TO OPERATIN OM VIA Litter BY anesthesia

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

3. DATE 7 Oct 03 TIME PATIENT ARRIVED IN SUITE 1554

4. PATIENT IN ROOM TIME 1554 [redacted] NUMBER b6-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b6-2	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. Pillow under chest, lower legs. Padding under knees. Arms at sides

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

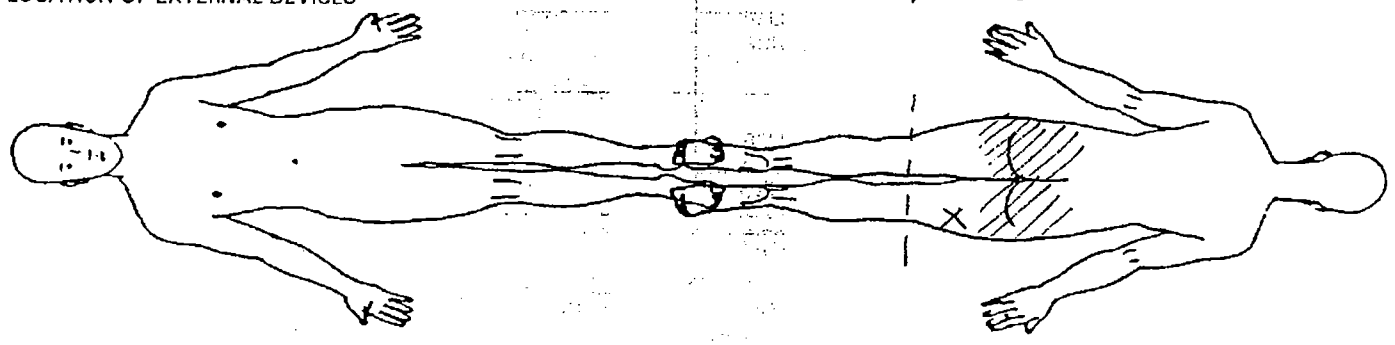
PREP SOLUTION *(Specify)* Betadine scrub/sol'n

SITE: Bilat buttocks BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No			C	[redacted] b6-2	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

H [redacted] b6-4

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

☒ ESU NO: R88 102393 30/30

GROUND PAD: BRAND Valleylab REM

LOT NO: 70011

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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

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

b6-2

PH[redacted]

15. [redacted] ROOM IF YES, SITE

YES ☐ NO ☒

16. [redacted] LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

4 X 8

Tape

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surg: [redacted] – b6-2

Anesth: [redacted] CRNA

Anesth: General

20. OPERATION(S) PERFORMED

Closure of buttocks wounds

21. PATIENT TRANSFERRED TO PACU TIME 1702 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] b6-2 CPT/AN

REVERSE OF DA FORM 5179-1, OCT 2

USAPA V1.00

EPW #0 [redacted] b6-4

7 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	
BP	113/61	129/69	117/62	117/59	1	114/60	138/73	102/65	93/70	112/63	108/60	109/59	100/58			100/51				98/51					
TEMP																									
HR	101	102	102	103	102	104	120	124	109	109	117	114	107	109	111	105	104			99	100	99	96	94	
RR	12	11	14	14	14	14	20	24	20	22	18	22	18	13	18	15	16			10	10	10	12	7	
SA02	97	96	96	97	96	96	97	96	96	94	93	95	96	94	94	94	95			95	96	96	97	96	
	RA	RA	RA	RA		RA	4LNC	4L	RA	RA	RA	RA	RA	RA	RA	RA	RA			RA	RA	RA	RA	RA	
IN IT																									987
PO								237			326					300			150						2400
LR IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
NGT																									3387
TOTAL																									
OUTPUT																									
URINE	35	35	35	35	100	50	50	50	50	50	80	60	80	60	70	60	90	50	60	60	125	120	270	90	1885
NGT																									
STOOL																									
TOTAL																									
B E																							+	1502	

MEDCOM - 13170

PTS NAME #0[redacted] 66-4 8 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	102/66		115/65	136/78	126/66	126/88	110/61	115/61	99/52	104/54					105/61	101/61	113/63	120/63	123/68	120/64	125/64	113/61	113/63	117/60
TEMP	97.8		98.9			99.2			101.3	101.6	101.3	99.9		99.3						99.5			98.9	
HR	94	95	100	109	113	111	116	115	119	118	128	111		99	105	109	111	112	108	110	107	105	107	
RR	11	11	16	16	18	18	18	18	16	21	15	14		18	17	21	18	17	20	14	14	19	17	13
SA02	97	96	97	100	96	99	95	96	98	95	90	97		96	96	93	96	94	92	91	92	93	off	97
	RA	RA	RA	NRB	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								2400
PO	NPO																							
LR IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
IVPB				50	52	100																		2050
Dobhoff						100	100	100	125	125	125	125	125	125	125	125	125	off	125	125	125	125	125	off
Furosemide																	750	430						
TOTAL																								1605
OUTPUT																								
URINE	170	90	200	35	35	100	60	75	75	100	50	60		60	40	50	70	100	35	25	30	25	40	80
NGT				50																				
STOOL																								
TOTAL																								
BALANCE																								

Balance +2845 −200 +2645

[redacted] EPW O[redacted] 9 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02
BP	121/64																					
Temp																						
HR	105																					
RR	16																					
SAO2	99																					
	RA																					
INPUT																						
PO																						
LR IV	100																					
TPN																						
TOTAL																						
OUTPUT																						
Urine																						
NGT																						
Stool																						
TOTAL																						
BALANCE																						

MEDCOM - 13172

MEDCOM - 13173

PATIENT ASSESSMENT

TIME: 0800 SIGNATURE: [redacted] b6-2 CAPT

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry CDI
Skin: Temperature WARM
Color: Pale / Cyanotic / Jaundiced PINK
Mucous Membranes: (Moist) / Dry / Cracked
Skin Breakdown: (None) Location: Size:

NEUROLOGICAL

Loc / (Alert) / Lethargic / Unresponsive ORIENTX3 GCS: 15
(Orientated) / Disoriented Pupils: 3-4mm BILAT
Extremity Movement: Full / (Limited) / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 BILAT Pedals +3 BILAT
Capillary Refill: < 2SEC Seconds Homan's Sign NEG
Jugular Venous Distension NONE Edema +3 (L) UE/LE/Trunk
Heart Sounds S1 S2 NORES
Rhythm NSR/ST 90-110's PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	—	—		
Site	(R) IJ			
Solution	LR			

Chest Pain NONE

RESPIRATORY

Chest Expansion / (Symmetrical) / Asymmetrical REG
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	~~BILAT BASES~~	BILAT BASES
Wheezes		
Diminished	BILAT BASE	
Absent		

GASTROINTESTINAL

Abdomen: (Soft) / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / (Hypoactive) / Absent
Dressings: CLEAN/INTACT MOIST & SILVANYLON SOL
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color — Character —
Tube Feeding: Day No: — Strength: ~~IS~~ Rate: Aspirate:
Stool: Character
Drains NONE

GENITOURINARY

Urine Color: YELLOW Character: CLEAR
Voiding: Continent / Incontinent / (Catheter)

EMOTIONAL/PSYCHOSOCIAL

OTHER: SEE NOTE

PATIENT ASSESSMENT

TIME: 1800 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / (Dry) 30-35% burns
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced Normal
Mucous Membranes: (Moist) / Dry / Cracked
Skin Breakdown: None Location: ~~Donor~~ abd, LE Size: graft site abd + thigh

NEUROLOGICAL

Loc / (Alert) / Lethargic / Unresponsive GCS:
(Orientated) / Disoriented Pupils:
Extremity Movement: (Full) / (Limited) / None due to pain LE arms ↓

CARDIOVASCULAR

Pulse (0 - 4): Radials (4) Pedals
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension Edema feet, LE L > R
Heart Sounds ST 104s, ectopy, S1 S2
Rhythm ST PRI: ~~QRS:~~

~~Vascular Catheter~~	~~Central~~	~~Arterial~~	~~Peripheral 1~~	~~Peripheral 2~~
Waveforms				
Site				
Solution				

~~Chest Pain~~ ↓

RESPIRATORY

Chest Expansion / (Symmetrical) / Asymmetrical
Respiration / (No Distress) / SOB / Labored / Use of Access Muscles
Breathing Patterns: unlabored, even
Cough: Productive / Nonproductive / (None)
Sputum: Color / Amount / Consistency / Odor none
~~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	expiratory	
Diminished	throughout	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / (Distended) cm Girth
Bowel Sounds: (Normal) / Hyperactive / Hypoactive / Absent
Dressings: arms, abd, thigh, feet
~~NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage~~
~~NG Drainage: Color Character~~
Tube Feeding: Day No: Strength: FS Rate: 128 Aspirate ↓
Stool: Character mucoisy, light color
~~Drains:~~

GENITOURINARY

Urine Color: foley, Character: yellow
~~Voiding: Continent / Incontinent / Catheter~~

EMOTIONAL/PSYCHOSOCIAL

intermittent confusion due to narcotics + anesthetics (sedation) otherwise cooperative
OTHER: Low tolerance for pain during dressing changes

MEDCOM 13173

PT'S NAME

18 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	109/59	105/54	107/54	104/61	135/84	124/76	129/70	125/77	125	124/69	111/64	114/59	116/62	114/62	114/60	115/59		117/63	116/58	114/58				
TEMP	100.2					100.0			71	99.8				101.1							100.2			99.9
HR	101	98	94	106	114	110	88	88	104	108	102	104	104	103	102	105	103	102	105	107	102		98	100
RR	10	14	16	20	20	16	16	16	14	16	18	16	20	20	20	18	18	19	20	18	~~102~~		20	20
SA02	92	94	95%	99%	96%	96%	97%	98%	97	97	96	94	98%	94	97	93	94	95	96	94	95		94	95
O_2 MODE	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA
INPUT																								
PO																								
IV	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
NGT	0					100	100	110	110	120	128	128	128	128	128	128	128	128	128	128	128	128	0	0
TOTAL												1396												
OUTPUT																								
URINE	80	170	0	250		120		80	80	110		120	100	100	100	100	125	125	125	125	170	120	120	
NGT																								
STOOL																								
TOTAL	80	250		500		620		700	780	890		1010												
BALANCE																								

MEDCOM - 13174

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

PH # [redacted]
8.0 ETT b6-4
24 @ teeth

total

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
19 July	1400	SIMV	13	800	40	8	37	13	115	100	121/65								[redacted]
19 JUL	1830	SIMV	13	800	60	8	35	13	131	99	124/70								
19 JUL	20006	SIMV	13	800	60	8	37	13	119	99	109/55							Alb/Atro + lavage + SP	
19 JUL	2158	SIMV	13	800	60	8	39	13	112	100	125/61								
20 JUL	0144	SIMV	13	800	60	8	38	0	106	99	101/44								
20 JUL	0315	SIMV	13	800	60	8	36	0	106	100	104/45	7.516	42	69	11	34	95%	Alb/Atro lavage Sx	
20 JUL	0601	SIMV	13	800	60	8	39	0	111	98	113/57								
20 JUL	0818	SIMV	13	800	60	8	40	0	108	97	100/57							Alb/Atro lavage	
20 JUL	1200	SIMV	13	800	60	8	39	0	112	99	131/71							~~Alb/Atro/lavage~~	
20 July	1400	SIMV	13	800	60	8	37	8	125	99	143/87								
20 July	1600	SIMV	13	800	60	8	33	30	125	99	135/85							Alb/Atro/lavage	
20 JUL	1800	SIMV	13	800	60	8	33	13	103	99	109/49								
20 JUL	2000	SIMV	13	800	60	8	36	13	108	98	111/60							Alb/muco/Sx/lavage	
20 JUL	2200	SIMV	13	800	60	8	36	13	104	100	94/57								
20 JUL	2345	SIMV	13	800	60	8	38	13	93	100	86/45								
21 JUL	0235	SIMV	13	800	60	8	38	13	95	100	104/35								
21 JUL	0427	SIMV	13	800	60	8	43	0	99	99	104/55								
21 JUL	0554	SIMV	13	800	60	8	40	0	97	99	103/52							~~Alb/muco/lavage~~	
21 JUL	0750	SIMV	13	800	60	8	40	0	117	99	1							Alb/muco/ss/lavage	
21 July	1200	SIMV	13	800	40	8	34	13	99	100	123/65							Suction by Doc	
21 July	1400	SIMV	13	800	40	8	35	15	103	100	110/54							Alb/muco/ss/lavage	
21 July	1630	SIMV	13	800	40	8	37	28	112	100	119/63								
21 JUL	1725	SIMV	13	800	50	8	38	28	123	99	134/71								
21 JUL	1945	SIMV	13	800	50	8	38	13	105	100	110/60							Alb/muco/CPT/Sx	
21 JUL	2155	SIMV	13	800	50	8	36	13	104	100	110/58								
22 JUL	0012	SIMV	13	800	50	8	37	13	97	100	109/60								
22 JUL	0157	SIMV	13	800	50	8	37	13	99	100	102/52								
22 JUL	0420	SIMV	13	800	50	8	36	13	101	100	—								
22 JUL	0557	SIMV	13	800	50	8	40	13	104	100	116/61							Alb/muc/S.Atro	
22	0803	SIMV	13	800	50	8	40	13	114	100	90/4							133 coarse	
22 July	1000	SIMV	13	800	45%	5	37	28	109	100	112/86								
22 July	1215	SIMV	13	800	35	5	40	13	104	100	134/108								
22 July	1600	SIMV	11	800	50	5	29	13	121	100	115/60								
22 JUL	1710	SIMV	11	800	45	5	27	15	121	100	109/57								
22 JUL	1820	SIMV	11	800	45	5	30	28	114	100	123/62							Alb/mu/SP/ABS	

all b6-2

[redacted] 19 July 03 — 19 June 03

66-4

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	111/59	104/56	114/64	114/66	135/84	127/73	139/70	125/64	118/70	111/63	111/77	112/61	137/72	94/52	X	X		104/50	99/49	104/53	111/62	105/57	118/57	111/53
TEMP	99.9	101.8		98.6				98.8					102.0	102.2	X	X	99.4	X	99		100.4	101.7	X	X
HR	111	106	102	98	100	108	104	106	100	98	102	104	114	112	103	99	98	101	101	100	102	101	105	98
RR	25	16	18	16	20	20	20	16	16	14	14	16	29	23	20	29	21	18	19	20	19	19	15	14
SaO2	94	95	96	99%	97%	96%	97%	98%	97%	96%	95%	98%	97%	98	98	94	100	100	99	93	95	96	96	94
[illegible]	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	4LNC	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
PUT																								
PO	0														100									
IV	50	50	50	50	50	50	50	250	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
NGT	0					100	110	110	120	120	128	128	128	128	128	128	128	128	128	0	0	0	0	0
TOTAL																				Tuesday AM				
OUTPUT																								
URINE	90	120	100	170	240	70		230	150	160	120	80	100	100	100	100	200	100	160	100	150	200	200	
NGT																								
STOOL			X T																				3060	
TOTAL																								
BALANCE																								

IV 1200 URINE
PO 1812
3012
BALANCE

MEDCOM - 13176

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

[redacted] b6-4

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE (total)	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
23JUL	0020	SIMV	12	850	50%	5	28	12	98	100	134/72								
23JUL	0021	SIMV	11	800	45%	5	29	11	105	98	96/51								
0220	23JUL	SIMV	11	800	45	5	31	11	102	100	108/54								
23JUL	0430	SIMV	11	800	45	5	38	24	123	100	122/62	7.602	34.8	59	13	34	94%	Nurse gave tx	
23JUL	0636	SIMV	11	800	55	5	28	22	110	100	98/52								
23JUL	0803	SIMV	11	800	55	5	27	11	107	100	104/56								
23JUL	1000	SIMV	12	800	55	5	09	80	109	100	112/59								
23JUL	1430	SIMV	12	900	55	5	09	12	122	99	97/52								
23JUL	1605	SIMV	14	800	55	5	34	14	114	100	96/57								
23JUL	1755	SIMV	14	800	55	5	34	22	106	100	108/64								
23JUL	2000	SIMV	14	800	55	5	35	14	104	100	105/53								
23JUL	2115	SIMV	14	800	50	5	36	14	103	100	115/60								
24JUL	0000	SIMV	14	8720	50	5	40	14	103	100	137/71							Sx mucous plug	
24JUL	0300	SIMV	14	800	50	5	36	14	104	99	94/49								
24JUL	0417	SIMV	14	800	50	5	40	18	104	98	88/47								
24JUL	0637	SIMV	14	800	50	5	38	14	96	99	87/45								
24JUL	1000	SIMV	14	800	100	5	36	14	112	100	97/48								
24JUL	1200	SIMV	14	800	50	5	39	15	102	96	—								
24JUL	1400	SIMV	14	800	50	5	38	14	115	98	—								
24JUL	1630	SIMV	14	800	50	5	37	14	102	98	127/58								
24JUL	1735	SIMV	15	800	50	5	36	15	114	98	129/58								
24JUL	1950	SIMV	14	800	50	5	35	14	106	98	164/53							Sx, mob. CPT	
24JUL	2125	SIMV	14	800	50	5	33	14	119	96	108/55								
25JUL	0000	SIMV	14	800	45	5	34	14	104	100	132/64								
25JUL	0337	SIMV	14	800	45	5	34	14	106	98	106/62								
25JUL	0407	SIMV	14	800	45	5	34	15	106	98	105/59							Sx, CPT	
25JUL	0559	SIMV	14	800	45	5	36	14	103	99	123/60							BS coarse	
25JUL	0746	SIMV	14	800	45	5	34	14	103	98	122/63								
25JUL	1000	SIMV	14	800	50	5	33	15	106	100	124/63								
25JUL	1200	SIMV	14	800	50	5	32	14	102	100	119/56								
25JUL	1814	SIMV	14	800	50	5	39	24	112	97	103/52								
25JUL	1915	SIMV	14	800	50	5	36	14	107	97	97/48								
25JUL	2150	SIMV	14	800	50	5	40	24	102	98	100/48								
25JUL	2344	SIMV	14	800	50	5	37	24	112	96	101/44								
26JUL	0155	SIMV	14	800	50	5	40	14	120	98	94/46								
26JUL	0407	SIMV	14	800	50	5	42	14	89	98	89/45								
26JUL	0547	SIMV	14	800	50	5	38	14	88	100	107/46								

9M b6-2

MEDCOM - 13177

#386

24 July 03

	06	00	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	113/61	112/61	117/64	118/62	120/61	118/67	120/62	124/81	111/65	117/63	110/60	127/70	111/65		124/63	120/65	117/69	117/61	115/68		117/63	103/62		114/74
TEMP	99.7	99.2						98.6				99.8			99.3	X	X	X	X	X	X	X	X	99.3
HR	106	111	102	101	95	89	91	93	94	94	96	96	92	94	100	108	104		103	112	97	108	163	102
RR	21	26	13	17	19	20		38	18	20	21	22	21	18	20	33	16		21	21	20	31	28	24
SA02	96%	94%	96%	96	97	98	97	96	97	97	95	96	97	97	97	93	96		93	95	95	94	93	93
	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO																725	120		50					
IV	100	100	100	100	100	100	100	100	100	100	100	100	—	—	↑	100	100	100	100	100	100	100	100	100
NGT																								
																Ambien	Aunica	Aunica	Aunica	Sleep				
TOTAL																								
OUTPUT																								
URINE	35	70	100	75	90	70	100	120	60	50	50	90	90	100	85	50	60	140	65	60	80	—	140	—
NGT																								
STOOL																							49 Loose Brown	
TOTAL																								
BALANCE																								

IV 2100
PO 695
2795

URINE 1830

Balance 965

MEDCOM - 13178

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP			114/60	97/70	107/78	97/65	118/64	116/72	118/70	110/82	103/64	108/65		117/65	X	X	101/63	106/68	114/73	X	115/65	114/72	115/54	116/61
TEMP			99.5	98.5	98.5	98.7				99°	99.3	99°	97.7	97.7	X	X				X	X	X	X	X
HR	109	97	98		116	97	96	110	107	130	94	100	100	101	99	96	91	118	105	104	99	104	101	93
RR	23	29	24	29	29	25	27	23	15	30	18	16	20	20	29	19	22	41	30	28	19	31	21	20
SA02	94	98	94	96	96	95	94	92	76	95	96	97	97	97	97	96	99	96	98	96	95	94	98	93
MODE	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO			100									360	1200		495									
LR IV	100	100	100	100	100	100	100	100	—	—	100	100	~~100~~ 200		100	100	100	100	102	100	100	100	100	100
NGT																								
BOLUS												1000		↑										
TOTAL	100	200	400	500	600	700	800	900	900	900	1000	2360	2480											
OUTPUT																								
Foley URINE	40	28	60	30	30	45	140	75	20	20	28	36	38	—	—	65	60	—	140	65	100	115	160	100
NGT																								
STOOL																								
TOTAL	40	68	128	158	188	233	373	448	468	488	516	552	590											
BALANCE																								

Iv Urine

PO

~~Balance~~

#[redacted] b6-4

25 July 03

MEDCOM - 13179

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	123/64	12/66		105	116/64	108/73	129/78	117/70		104/67		115/67		113/58	95/58	105/69	111/55	119/55				105/67		
TEMP	99.3	X				97				98					100	X	X	98						
HR	95	96			106	95	91	94		107		107		102	110	93	98	84				100		
RR	23	21			18	23	19	17				18		20	20	28	30	26				24		
SA02	93	97			95	95	97	96		97%		96		97	98	98	97	97				97		
MODE	RA	RA			RA	RA	RA	RA		RA		RA		RA	RA	RA	RA	RA				RA		
INPUT																								
PO																								
IV	100	100			100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
TOTAL																								
OUTPUT																								
URINE	—	200				300	40	60				350		40				65		200		200	500	200
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

IV 2200
PO 240
2440

Urine
1555
(SRC Balance)

26 July 03
H [redacted]

MEDCOM - 13180

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	X	X	97/57					101/69				111/63				115/68			111/64				118/69	
TEMP								97				98.4				98.7			98.7				98.4	
HR	91	97	91					105				101				110			101				110	
RR	10	12	14					20				20				18			22				22	
SA02	98	97	97%					97%				94%				96%			96%				96%	
MODE	RA	RA	RA					RA				RA				RA			RA				RA	
INPUT																								
PO				140				300																
I/R IV	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100
NGT																								
TOTAL																								
OUTPUT																								
URINE			130					200				250				250			275				275	
NGT																								
STOOL									1 Bowel Soft															
TOTAL																								
BALANCE																								

MEDCOM - 13181

b6-4

27 Sept #[redacted]

BP				120/73					107/63				103/71	983						X					
TEMP				97					98																
HR				100					97				107							100					
RR				18					20				18							20					
SA02				95					97				98							97					
				RA					RA				RA							RA					
INPUT																									
PO				360																					
IV																									
NGT																									
AL																									
OUTPUT																									
URINE	200		200		200				480				280								250				
NGT																									
STOOL																									
TAL																									
LANCE																									

MEDCOM - 13182

EPW [redacted] 28 Jul 03

b6-4

IV Q

PO 360

urine

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
	108/57	110/63				115/73				102/66					110/68				108/57				110/63	
TEMP	98.6	98.4				96.8				98.4					98.5				98.3				99.4	
HR	80	96				106				93					101				94				103	
RR	13	24				17				13					20				14				14	
SA02	98	99				95				97					98%				97%				98%	
INPUT																								
PO				360	120			120		120		357												
LR IV	100	100	100	100	100	100	100	100	100	100	100	100	100		250									
NGT																			~~60~~	~~60~~	~~60~~	~~60~~	~~60~~	~~60~~
												1300												
												~~157~~												
TAL													2857											
UTPUT																								
URINE	145	140			140			80		200		140				200		275		275		150		200
NGT																								
STOOL				Ø																				
TAL													845											
LANCE																								

CBC
Chem 8

29 July 03
[redacted] b6-4

MEDCOM - 13183

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
TEMP																				99°				98.4
HR			107				83				85				88					95				94
RR			17				18				11				19					16				16
SA.02			99				99				98				100%					96%				97%
BP			104/62				112/50				104/54				104/75					109/62				112/66
															RA					RA				RA
INPUT																								
PO			300				600																	
IV																								
NGT																								
TAL																								
OUTPUT																								
URINE			200				50				300					200				150				
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

pt: EPW [redacted] b6-4

30 Jul 03

MEDCOM - 13184

	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	115/60		102/71				104/73			131/63	[illegible]			X	114/57					
TEMP	98.6						97.5				98.2									97.6
HR	105		96				98				102			88	[illegible]					
RR	20		10				14				36			13	17					
SA.02	98		97				95				96			97	94					
O2 source	RA		RA				RA				RA			RA	RA					
															[redacted] b6-2					
INPUT																				
PO																				
NS IV																			240	
NGT												↑	50	100	100	100	100	100	100	100
TOTAL																				
OUTPUT																				
URINE	200		200				220					120								
NGT																				
STOOL																				
TOTAL																				
BALANCE																				

[redacted] b6-4

31 Jul 03

MEDCOM - 13185

MEDCOM - 13186

b6-2

TIME: 10 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal to Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Burn Sites Size:

NEUROLOGICAL

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

CARDIOVASCULAR

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

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
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	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: Drsgs C/D CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains: Ø

GENITOURINARY

Urine Color: Yellow Character: Clear
Voiding: Continent / Incontinent / Catheter Foley

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1900 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm to touch
Color: Pale / Cyanotic / Jaundiced Membranes pink
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: See SF600 for Skin Assess Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None 2° BLE wounds

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: <3 Seconds Homan's Sign Neg
Jugular Venous Distension Ø Edema
Heart Sounds S1 S2
Rhythm SR HR 80-90's PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			Ø	Ø
Solution			Ø	Ø

Chest Pain Denies

RESPIRATORY

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

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: See SF600 for Wound Assess
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage Ø
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate
Stool: Character Ø
Drains: Foley

GENITOURINARY

Urine Color: Yellow Character: Clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Pleasant, calm

OTHER:

#319403 # [redacted] b6-4

13186

TIME: 0045 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Lesions / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Cool + moist to touch

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: (None) Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulses (0 - 4): + Radials + Pedals

Capillary Refill Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds normal

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral
Waveforms				
Site				
Saline			Ø	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Dyspnea / SOB / Labored / Use of Access. Muscles

Breathing Patterns: normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor N/A

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	
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:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Lesions / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature 97.9 warm

Color: Pale / Cyanotic / Jaundiced Normal for race

Mucous Membranes: Moist / Dry / Cracked moist

Skin Breakdown: (None) Location: Burn to Hands & feet Size: healing CDC

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRL

Extremity Movement: Full / Limited / None slightly weak

CARDIOVASCULAR

Pulses (0 - 4): 92 - HR Radials (+)(+) Pedals (+)(+)

Capillary Refill: ≤ 3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema to Ø Foot

Heart Sounds

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral
Waveforms				
Site				
Saline			Ø	

Chest Pain None

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Dyspnea / SOB / Labored / Use of Access. Muscles

Breathing Patterns: Normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

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: Ø

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

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character N/A @ present

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Calm Helpful

OTHER:

13187

#[redacted] 66-2 0394903

ICU Flowsheet Patient Name: # 386 Date: 03/AUG/ 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temmperature								98.7			97.2					97.6				97.9				98.3		
Pulsse	85	87	101	95	95	86	92	101			95					97				96				92		
B/P - A-Line	–																									
MAAP																										
B/P - Cuff						115/63	113/62	105/65			100/61					109/63				109/60				110/62		
Resspirations	12	12	13	12	11	8	15	9			15					13				11	14			18		
S-O2	97	97	97	95	96	95	96	97%			98					99				100	100			100%		

ntake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF - LR	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
O intake																										
.RR. IN																										
Totals																										

(Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urinne Hourly				350	550/900	100/1000		125/1125			250/1175					850/1250		400/1750	100/1750	75/1650	150	125	85	200	175	
NG Tube																										
is #1																										
#2																										
#3																										
Emnesis																										
Stoool										1																
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13188

Carrigan
[redacted] 66-4

VSQ4°

ICU Flowsheet **Patient Name:** **Date: / / 2003**

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temmperature										98.6										98.6						
Pulsse						88				102					100				94				94			
B/P > A-Line																										
MARP															108/59				116/67							
B/P > Cuff										114/65																
Resspirations						12				18					11				12				15			
Sa002						98				98					96				99%				98			

ntake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF: LR						150	100	100	100		100	100	600	100	100	100	100	100	100	100	100	100	100	100	100	1200
O intake																				240		100				340
.RR. IN																										
Totals																										1540

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urinne Hourly										460			460		200				400	150				300		1050
NG Tube																										
ns #1																										
#2																										
#3																										
Emnesis																										
Stoool																										
O.RR. OUT																										
Totals																										

24 hour input	2540
24 hour output	1510
24 hour balance	630

MEDCOM - 13189

ICU Flowsheet — Patient Name: 3816 — Date: 04 / AUG / 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temmperature			97.7				97				96.8					97										
Pulse			84				88				87					84								98		
B/P ᵓ A-Line	–		108/51				113/63				102/62					111/64										
MAAP																										
B/P ᵓ Cuff																										
Resspirations			14				10				10					17								30		
S 2			99				100				96					98								99		
itake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF							100	100	100	100	100	100	600	100	100	100	100	100	102	100	110	100	100	100	100	
																			1200							
) intake								712	120	120			952	237			120				340					
RR. IN									82	952				114 9			1309		1309							
Totals																										
(Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urinne Hourly	62	100	50	50	68		75 / 75	100 / 175	100 / 275				275	75 / 500	115 / 575	150 / 725	100 / 825		825							
NG Tube																										
s #1																										
#2																										
#3																										
Emnesis																										
Stoool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13190

[redacted] b6-4

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	109/88	124/71				113/72				109/63				107/62				120/71				104/75		
TEMP	98.1	98.8				97.9				97.9				98.2				98.1				97.5		
HR	81	95				85				89				84				80				71		
RR	18	15				12				17				16				15						
SA02	98	95								94				95				95				96%		
	–																							
INPUT																								
PO			357					240		120														
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT													1200											
													1917									IN		2117
TOTAL																								
OUTPUT																								
URINE	150		175		100		75			200			150					275 1 wd						
NGT																								
STOOL													850									OUT		1125
TOTAL																								
BALANCE																								

06 AUG 03

[redacted] b6-4

MEDCOM - 13191

[redacted] 66-4 06AUG

TIME: 1700 SIGNATU. [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature 98.6

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

LOC: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None Burn to hands, legs feet, abd, back

CARDIOVASCULAR

Pulse (0 - 4): >4 Radials >4 Pedals

Capillary Refill: good Seconds Homan's Sign

Jugular Venous Distension + Edema +2 (R) foot

Heart Sounds normal 95

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			R Dorsum	
Solution			NS @ 100 cc/hr	

Chest Pain NA

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: 15 normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor NA

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	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Dry-to abd, feet, back, legs + hands

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

NG Drainage: Color Character

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

Stool: Character

Drains: NA

GENITOURINARY

Urine Color: yellow Character:

Voiding: Continent / Incontinent / Catheter: NO

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 13192

66-2 ASSESSMENT 66-2

TIME: 1800 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

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): +2 Radials Pedals

Capillary Refill: <2 Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 - S2

Rhythm Reg. PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site	(R) FA	LR	100 cc/h	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Regular

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Burn areas, grafts

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: Due to voiding Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

13192

b6-4

ICU Flowsheet Patient Name: EPW [redacted] Date: 07 AUG / 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temmperature						97.5	97.1				97.6					97.5				98.5				98.3		
Pulsse						83	81				90					90				92				88		
B/P > A-Line																										
MARP																										
B/P > Cuff						114/67	114/70				128/79					117/69				116/68				109/64		
Resspirations						10	12				12					12				12				12		
Sa002						94	94				96					95				96%				94%		
																				RA				RA		

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Iv. - Uk						100	100	100	100	100	100	100		100	100	100				100	100	100	100	100	100	
PO intake							357		120/97							477/954										
O.RR. IN																										
Totals																										

(Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urinne Hourly						50/350			125/375									x1		x1				350		
NG Tube																										
ns #1																										
#2																										
#3																										
Emnesis																										
Stoool																		1								
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13193

b6-2

FLIGHT ASSESSMENT

TIME: 0600 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 97.5
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None Burns to feet, legs, back + hands

CARDIOVASCULAR

Pulse (0 - 4): 74 Radials 4 Pedals
Capillary Refill: good Seconds Homan's Sign
Jugular Venous Distension Ø Edema (+) feet
Heart Sounds S3 normal
Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			RF inner arm	
Solution			LR @ 100cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: Normal
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor N/A
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	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: feet, legs, abd, back + hands
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 dark yellow Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature - 98.5
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Burns Size: Approx. less Sect. Stomach

NEUROLOGICAL

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

CARDIOVASCULAR

Pulse (0 - 4): 92 Radials +4 Pedals +4
Capillary Refill: ≤3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema Ø minimal
Heart Sounds NSR Reg
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) inner Arm	
Solution			LR @ 100cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: 12 BPM 96% SPO2 RA
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor N/A
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: Feet legs Arm Abd, back CDI
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: Dark Yellow Character: Clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

helpfull cooperative
Scared

OTHER:

EPW [redacted] b6-4
07 AUG 03
13194

ICU Flowsheet Patient Name: [redacted] 66-41 Date: 8/Aug/2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature			X				97.5				97.7					98.2				97.9				98.3		
Pulses			89				85				97					91				92				88		94
B/P a A-Line			X																							
MAP			X																							
B/P a Cuff			X				117/68				112/65					112/66				117/63				113/70		
Respirations			26				12				18					18				16				16		16
Sa002			X								99									96%				96%		98
			X																	RA				RA		RA

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF: LR	100	100	100						D/Ced																	
PO I Intake																										
O.RR. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly			400 480													350 350								375		
NG I Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13195

1-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														1		2		
POST-OP DAY																		
MONTH-YEAR AUG	DAY	12			0600						1800			21AUG03		22AUG03		
19 2003	HOUR	4			0600	1000		1400						5 1 9 4 0		8 3 1 2	1 3 4 0	

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

Record special data only when so ordered

BLOOD PRESSURE					118/70	116/68		116/68				107/68	108/70	98/57		121/69		
	HR				91	76		85					81			105		
	RR				12	10		10					17			10		
HEIGHT:	WEIGHT →												97			95		
SAO2		99			96	96		95				97/(RA)	96	96/(RA)				
Source		RA			RA	RA		RA										
OUT Put		250				300												

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. ICU3

[redacted] 66-4

VITAL SIGNS RECORDS

Medical Record

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

13196

MEDCOM - 13197

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 23 AUG 03 | 24 AUG 03

POST- DAY

MONTH-YEAR: 23 AUG 03 | 24 AUG 03 | 25 AUG 03 | 26 | 27th | 28th

19 — DAY / HOUR

PULSE (O) — TEMP. F (•) — TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

[redacted] 66-4

13197

MEDCOM - 13198

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

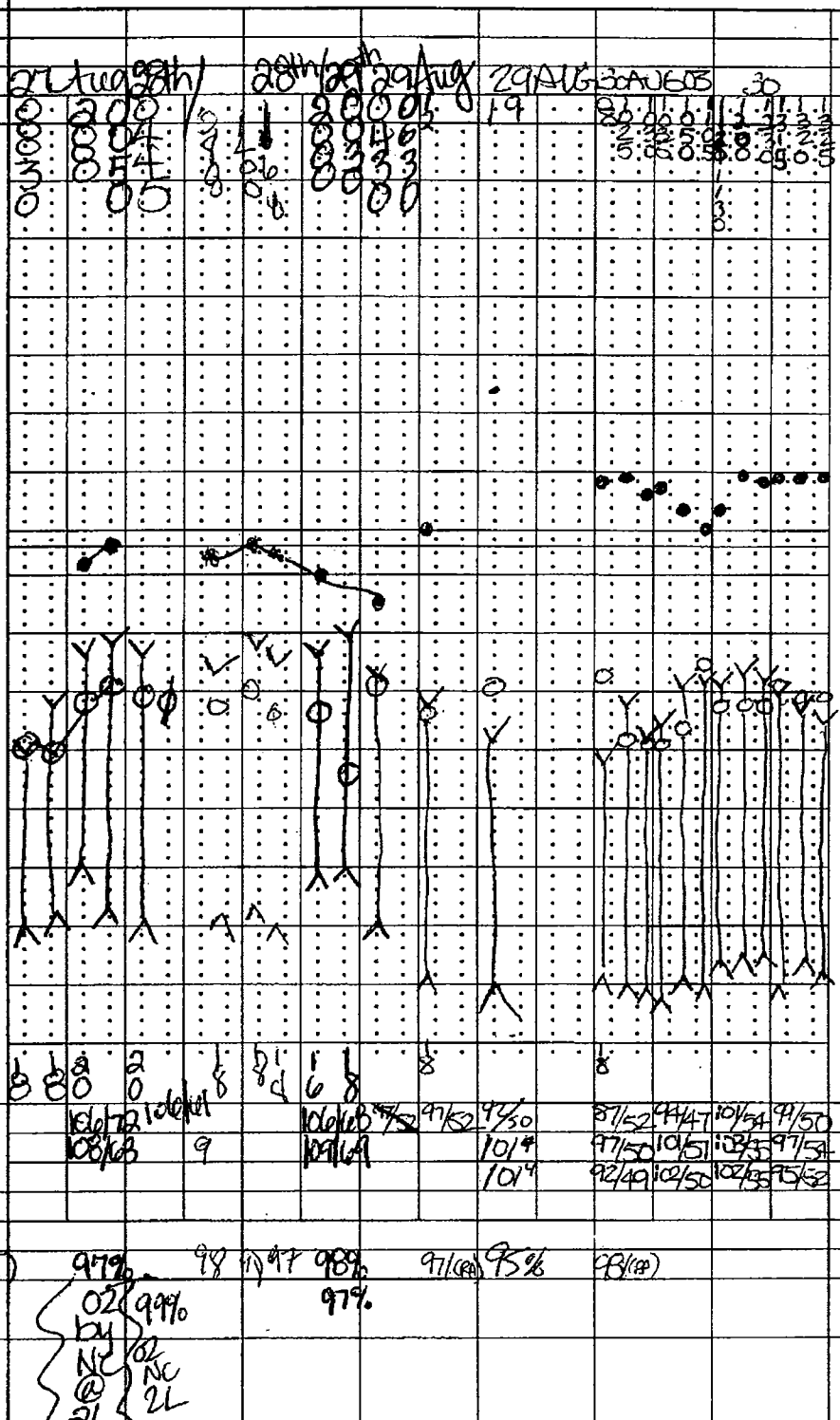
HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

(O2 Sat) 97% 98 97 98% 97% 91(RA) 95% 98(RA)

O2 99% by NC @ 2L

O2 NC 2L

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

(99% @ 0050)

REGISTER NO.

WARD NO.

[redacted]

66-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511
Prescribed by

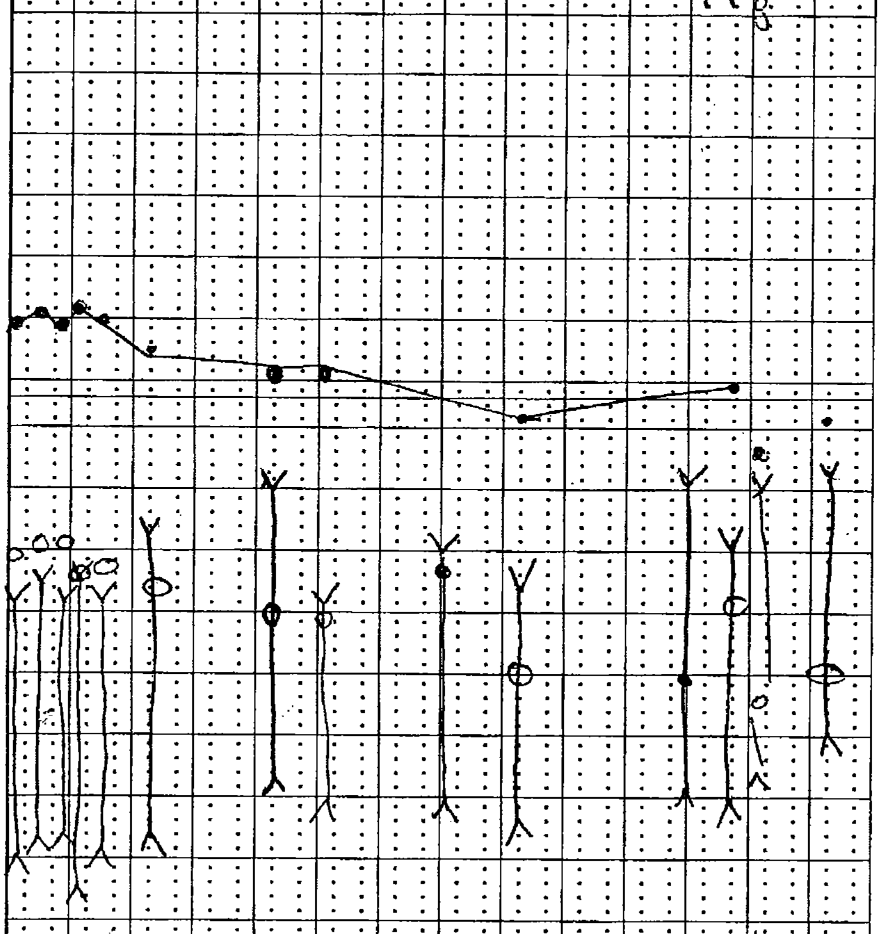
13198

MEDICAL RECORD

VITAL SIGNS RECORD

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

HOSPITAL DAY						
POST- DAY						
MONTH-YEAR / DAY	30AUG03	30	31AUG	1Sept	1 Sep.	2Sept
19 / HOUR	1345, 1415, 1450, 1500, 1510	19	0800	0800	19	0700, 19, 0800



RESPIRATION RECORD 16 18

Record special data only when so ordered									
BLOOD PRESSURE	92/50, 94/53, 92/51	95/45, 92/52	103/54, 94, 99.5	111/60, 90, 99.1	92/59, 103/59, 97, 96.5	94/56, 81, 98.2	119/61, 79, 97.3	101/59, 92, 98.9, 96%	110/64	113/70, 81, 98.2
HEIGHT: / WEIGHT →									
			95%	96%, 96%	93%	98%		93%, R-14	97%	95%

16

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.

#0[redacted] 66-4

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

13199

MEDCOM - 13200

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b6-4

VITAL SIGNS RECORDS

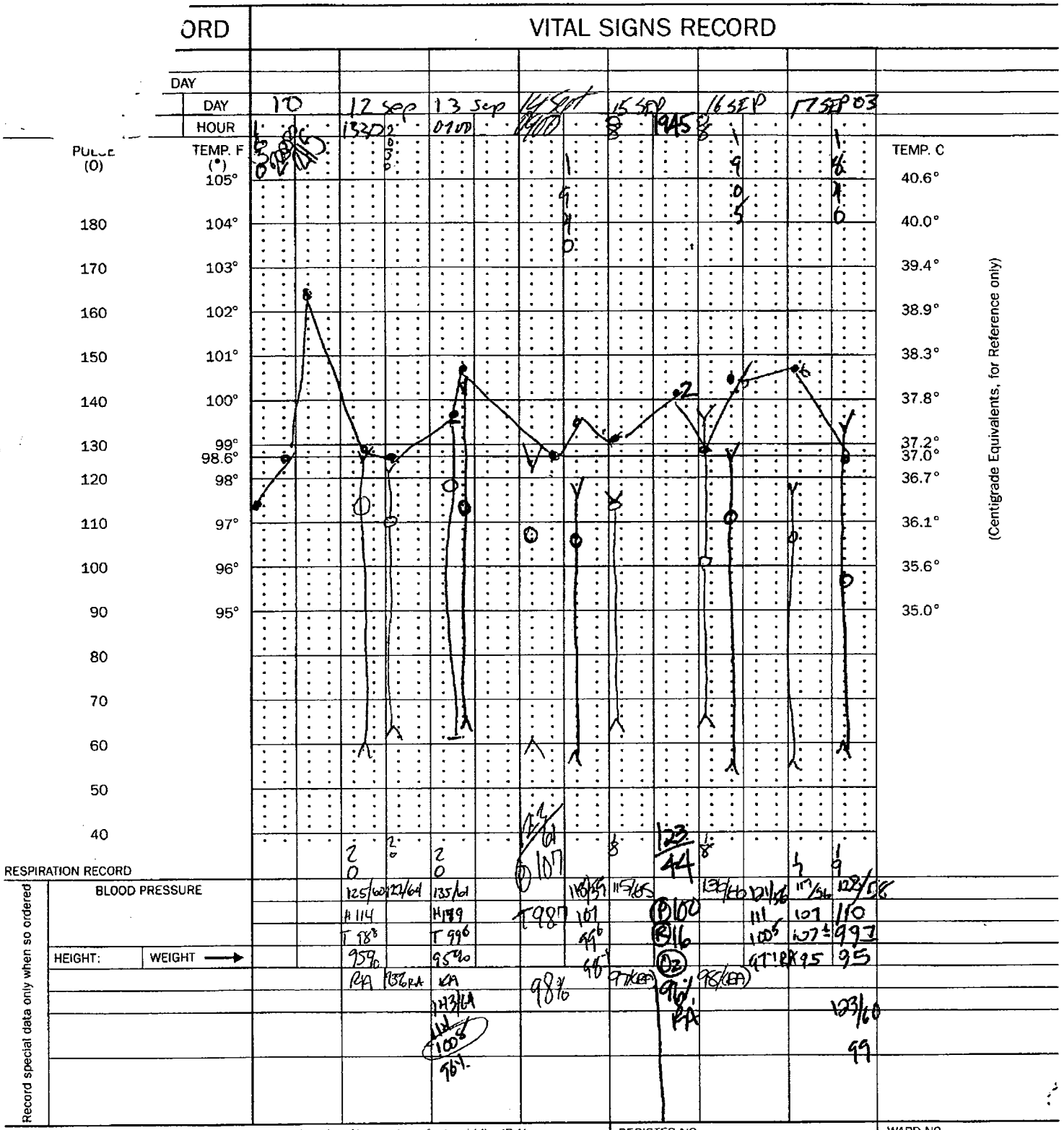
Medical Record

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

13200

NSN 7540-00-634-4124

ORD — VITAL SIGNS RECORD



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.

C724

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 13202

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	11 Sept 03		12 Sep		13 Sep		14 Sept		15 Sep 03		16 Sep 03		17 Sep		
19	HOUR		1800	0700	1800	0700	1800		1800	8	18	8	18		18	

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: 98% 18 | 18 | 18 | 18 | 100/56 | 18 | 18 | 18 | 16

BLOOD PRESSURE: 110/60 | 108/56 | 98/55 | 101/59 | 116/69 | 106/66 | 100/88 | 104/58 | 107/59 | 117/60 | 109/50 | 109/52 | 99/47 | 107/60

T 97.6 | H 88 | H 89 | 26 | 97.2 | 87 | 80 | 35 | 84

R 18 | T 97.4 | T 98° | 98 | 97.4 | 98 | 97.8 | 98.4

HEIGHT: | WEIGHT → R 18 | 97.6 | 98% | 96 | 95

O2 Sat: 98% RA | 97% RA | RA | 93% | 96% RA | 97% (RA) | 98% | 97% (RA) | 98% | 96%

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] b6-4

13202

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP 1 DAY

MONTH-YEAR Sep 03 DAY 18 19 20 21 22 23 24

19 HOUR 2 07 9 1 0830 1130 1 0700 1800

PULSE (O) / TEMP. F (°)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

EPW

Ø [redacted] 606-41

13203

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Sep 03 DAY 18 19 20 Sept 21 Sept 22 Sept 23 Sept 03

19 HOUR 2 18 07 1 8 1 0845 0916 1809 1

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 12 18 18 18 18 18

BLOOD PRESSURE 102/14 98/54 105/60 113/65 100/51 109/68 100/53 55/55 105/62

71 83 103/56 102/5 RD 87 87 74 97.4 97.4

97.2 98 79 (R) 18 R-18 HR88 HR88

HEIGHT: WEIGHT: 93% 95% 96% RA 96% 94% GN 97% 95% 97% 96% 96% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

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

13204

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST-DAY		24 Sep	25 Sept	26 SEP	27 SEP	28 SEP		29 SEP 03		30 SEP 04				
MONTH-YEAR	DAY													
19	HOUR	0700	1920	1800	1700	0800								

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

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

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD: 16 | 16 | 101/52 16 | 16 | 18 | 18 | 18 | 16

BLOOD PRESSURE: 101/55 | 108/57 | 90 | 99/56 | 99/50 | | | 108/57 | 108/51 | 113/66 | 110/55

H 70 | 80 | 91 | 80 | 100/60 | | 105/55 | 80 | | 78 |

T 97.5 | 98.5 | 97.6 | | | | | 96 | 98.5 | | 98.6 | 110/60

HEIGHT: | WEIGHT → 97% | 97 | 97% | 96% RA

0752 | RA | 100% | 94 | 96 | 95% 96% RA | 95% | 96% RA | 96% | 96% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] 66-4

STANDARD FORM 511 (REV. 7-95) BACK

13205

MEDCOM - 13206

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

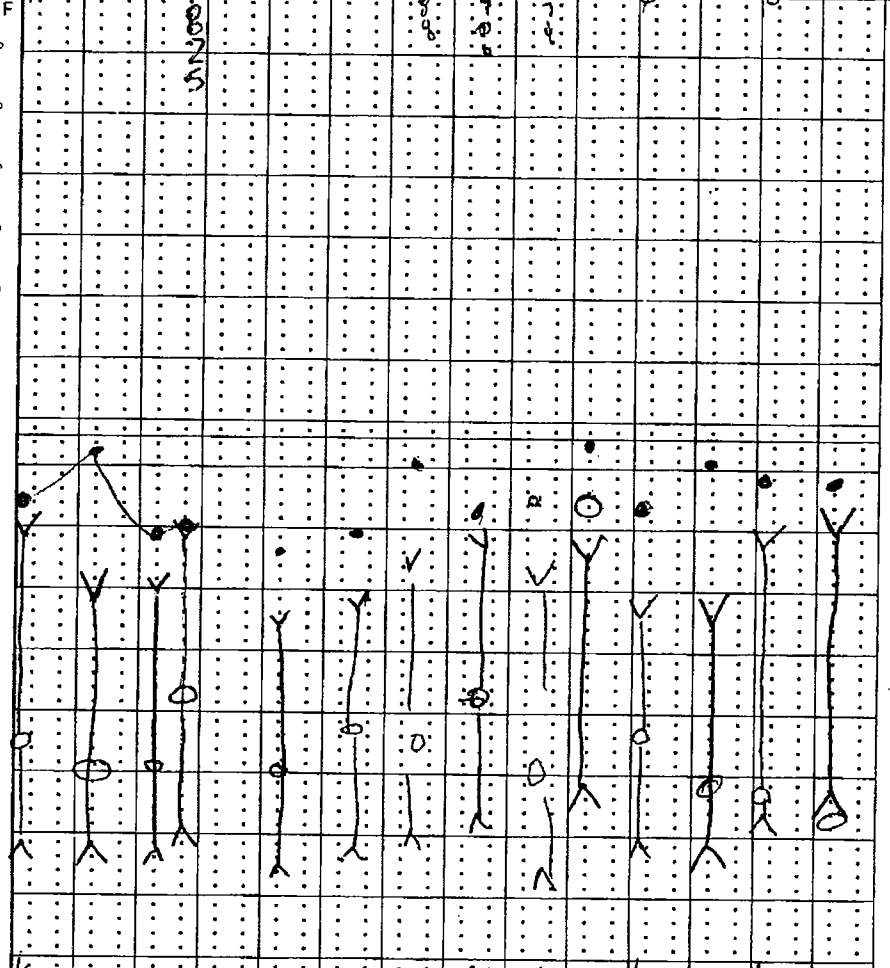
POST- DAY

MONTH-YEAR OCT 2003

DAY: 01 | 02 Oct | 3 Oct | 4 Oct | 5 Oct | 6 Oct | 7 Oct

HOUR: 8 | 18 | 01 | 8 | 2 | 5 | 8 | 18 | 8 | 20 | 8 | 20

PULSE (O) / TEMP. F (°)



RESPIRATION RECORD

BLOOD PRESSURE

	01	02	03	4 Oct	5 Oct	6 Oct	7 Oct
	108/58	98/58	99/67	95/55	105/68	94/60	105/59	107/64	110/67
		70	108/64	96/79	97/57	109/64	118		68	63
		98		H70			98		98	97

HEIGHT: WEIGHT →

O2 Sat 95(RA) 98% 99% 96% 97% 97% 97% 98 98 95(RA) 98% 95(RA) 95%

96% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] 66-4

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

13206

MEDCOM - 13207

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

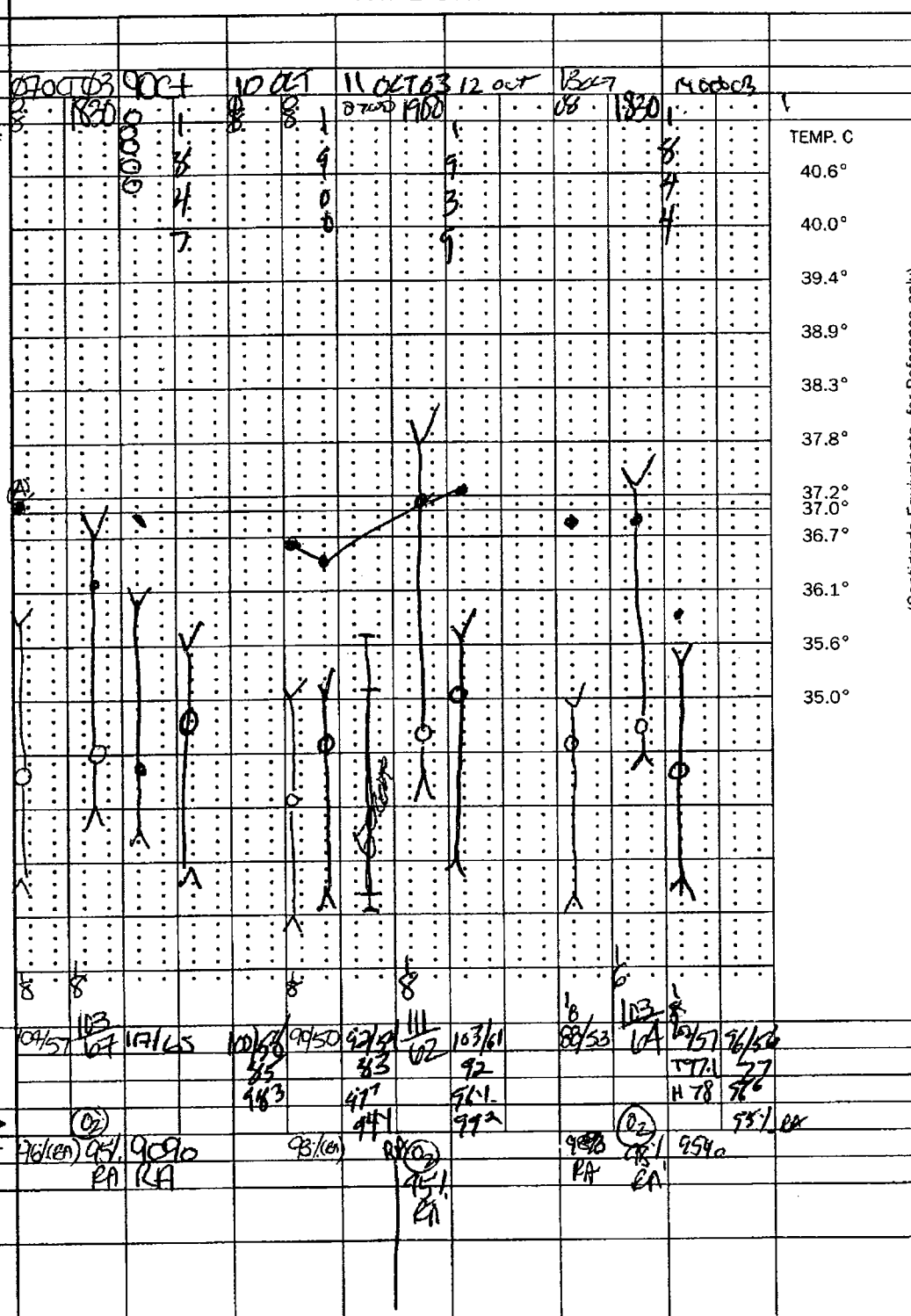
POST- DAY

MONTH-YEAR | DAY | 19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C

(Centigrade Equivalents, for Reference only)



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.

#C[redacted] 66-4

VITAL SIGNS RECORDS

Medical Record

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

13207

MEDCOM - 13208

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST-	DAY													
MONTH-YEAR	DAY	15 oct		16 oct		17 oct								
19	HOUR	0700		0800		0700								

PULSE (O) / 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°

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

		102/53	58/60	94/53	96/55	109/68								
		H 80	80	96.8	80	74								
		T 98	97.4	H 72	97.5	97.9								
HEIGHT:	WEIGHT →	98%	98%		96%	97%								
		RA	RA	96%	96%	RA								

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] 66-4

VITAL SIGNS RECORDS

Medical Record

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

13208

Ward/Section: Emy	REQUESTING PHYSICIAN:	LA[illegible]RA[illegible]RY RESULT FORM (t to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] 66-4	DATE: 3Jul03 TIME: 5320	SSN/PSEUDO SSN:

Hematology: CBC

TEST	RESULT	REF. RANGE
WBC	8.7	4.8-10.8 x 10^3
RBC	4.03	4.7-6.1 x 10^9
Hgb	12.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.5	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	290	130-500 x 10^3 verified
Lymph %	24.2	20.5-51.1%

Hematology: Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	80	Negative
SG	1.030	N/A
Bld	LRG	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	N/T	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

TNTC RBC
occ WBC
mod EPI-CELL
2+ mucous

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.1	9.8-13.6 secs
APTT	30.1	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] 66-2	DATE: 3JUL03	LAB ID NO.:

Ward/Section: EMT

TESTING PHYSICIAN:

CH[illegible]RY RESULT FORM
(Su[illegible] the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] 66-2

DATE: 3 JUN 03 TIME: 938

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BFecf		(-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	1.5	3.5-5.5 g/dl
ALP	53	26-84 u/l
ALT	39	10-47 u/l
AMY	19	14-97 u/l
AST	36	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	7.2	8.0-10.3mg/dl
CHOL	115	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	87	73-118 mg/dl
TP	4.6	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	138	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	110	98-108 mmol/l
tCO_2	13	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 3 JUN 03

LAB ID NO.:

66-2

Ward Section: ICU 3 | REQ: | PHYSICIAN:

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

PAT. FIRST, MI: # [redacted] b6-4 | DATE: 4 Jul 03 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
SO2		95-98%
BExcf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CHOL		100-300 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	94	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
[illegible]		39-580 u/l (M) 30-190 u/l (F)
NA+	110	128-145 mmol/l
K+	5.2	3.3-4.7 mmol/l
CL-	101	98-108 mmol/l
HCO_3	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
HCO_3		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
HCO_3		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 4 Jul 03

LAB ID NO.:

Ward/Section: ICU 3	R[redacted]	[redacted] b6-2	L[redacted]ATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] b6-4	DATE 4 Jul 03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10^3
RBC	4.61	4.7-6.1 x 10^9
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.5	42-52% (M) 37-47% (F)
MCV	96.7	80-94 fl (M) 81-99 fl (F)
Plt	327	130-500 x 10^3 verified
Lymph %	20.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 4 Jul 03	**LAB ID NO.:**

b6-2

ICU3

[redacted] b6-4

5JUN08 0640

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.0	4.8-10.8 x 10^3
RBC	3.88	4.7-6.1 x 10^6
[illegible]	11.9	14-18 g/dl (M) 12-16 g/dl (F)
[illegible]	37.2	42-52% (M) 37-47% (F)
[illegible]	95.8	80-94 fl (M) 81-99 fl (F)
[illegible]	324	130-500 x 10^3 verified
Lymph %	33.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
[illegible]		Imm	
[illegible] Lymph			
[illegible] Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI
EVERY UNIT REQUESTE

ABO/Rh	

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

UNIT	TYPE	CROSSMATC

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	5JUN08	

Chemistry Only

Section: ICU3 | REQUESTING PHYSICIAN:

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

FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] 66-4	5JUL03	0640	

(ESTAT) Arterial Blood Gas

T	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

T	RESULT	REF. RANGE

(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) Activity 8

TEST	RESULT	REF. RANGE
GLU	102	73-118 mg/dl
BUN		7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	410	39-380 u/l (M) 30-190 u/l (F)
NA^+	<110	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	27	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

ARKS:

RTED BY: [redacted] 66-2 | DATE: 5JUL03 | LAB ID NO.:

Chemistry Only

1CH3	REQUESTING PHYSICIAN: [redacted] b6-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
FIRST, MI: #0[redacted] b6-4	DATE 5/7/03	TIME 0400	SSN/PSEUDO SSN:

RESULT	REF. RANGE
	138-146 mmol/L
	3.5-4.9 mmol/L
	98-109 mmol/L
	7.31-7.45
	35-45 mmHg (art) 41-51 mmHg (ven)
	30-105 mmHg (art) N/A (ven)
	23-27 mmol/L (art) 24-29 mmol/L (ven)
	22-26 mmol/L (art) 23-28 mmol/L (ven)
	95-98%
	(1-2) [illegible] mmol/L
	10-20 mmol/L
	1.12-1.32 mmol/L
	8-26 mg/dl
	70-105 mg/dl
	0.7-1.5 mg/dl
	38-51% PCV
	12-17 g/dl

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		25-84 u/l
ALT		13-47 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

TEST	RESULT	REF. RANGE
GLU	99	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	114	39-380 u/l (M) 30-190 u/l (F)
NA	115	128-145 mmol/l
K	3.6	3.3-4.7 mmol/l
CL	93	95-108 mmol/l
HCO_3	27	18-33 mmol/l

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		95-108 mmol/l
HCO_3		18-33 mmol/l

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		25-84 u/l
ALT		13-47 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

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		95-108 mmol/l
HCO_3		18-33 mmol/l

RELEASED BY: [redacted]	DATE: 7 May 03	LAB ID NO.: b6-4

MEDCOM - 13215

Ward/Section: ICU 3	TESTING PHYSICIAN: [redacted] 66-2			LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. #EPW O[redacted] 66-4	DATE 7/7/03	TIME 0400		SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.0	4.8-10.8 x 10^3
RBC	3.45	4.7-6.1 x 10^9
Hgb	10.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.8	42-52% (M) 37-47% (F)
MCV	94.8	80-94 fl (M) 81-99 fl (F)
Plt	424	130-500 x 10^3 verified
Lymph %	41.6	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		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: 66-2

REPORTED BY: [redacted]	DATE: 07-7-03	LAB ID NO.:

Ward/Section: ICU 3	REQ	NG PHYSICIAN: [redacted] b6-2	LAB ORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b6-4	DATE: 08 Jul 03	TIME: 0330	SSN/PSEUDO SSN: 0 [redacted] EPW b6-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	6.1	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.14	4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	30.1	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	95.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	474	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	40.8	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS: Misc. rACT (activated clotting time)

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

b6-2

Ward/Section: ICU 3 | RUC | NG PHYSICIAN: [redacted] b6-2

CHE[illegible]RY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW #0[redacted] b6-4 | DATE: 8 Jul 03 | TIME: 0330 | SSN/PSEUDO[illegible]: EPW 0[redacted] b6-4

(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) 38-47 (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
Tuponin-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) 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
HCO_3		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
HCO_3		18-33 mmol/l

(Piccolo) Metabolic 8

TEST	RESULT	REF. RANGE
GLU	104	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	95	39-380 u/l (M) 30-190 u/l (F)
NA+	134	128-145 mmol/l
K+	3.8	3.3-4.7 mmol/l
CL-	98	98-108 mmol/l
HCO_2	26	18-33 mmol/l

REMARKS:

b6-2

REPORTED BY: [redacted] | DATE: | LAB ID NO.:

1CH#3 #0 86

#0 [redacted] b6-4

12/9/03 0402

(Hematology) CBC

TEST	RESULT	REF. RANGE
(WBC)	7.4	4.8-10.8 x 10³
(RBC)	3.21	4.2-6.1 x 10⁶
(Hgb)	9.5	14-18 g/dl (M) 12-16 g/dl (F)
(Hct)	31.0	42-52% (M) 37-47% (F)
(MCV)	96.6	80-98 fl (M) 81-99 fl (F)
(Plt)	603	130-500 x 10³ verified
(Neut%)	39.2	20.5-51.1%

(Hematology) Manual Differential

TEST	RESULT	REF. RANGE
Mono		
Eos		
Baso		
Imm		
		42-52% (M) 37-47% (F)

Coagulation Studies

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

Urinalysis

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

CSF

TEST	RESULT	REF. RANGE
Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

TEST	RESULT	REF. RANGE
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

TEST	RESULT
ABO/Rh	

REMARKS:

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

b6-2

1P 3 #0[redacted] b6-4

Chemistry Only

rd/Section: Ward ICU3 | REQUESTING PHYSICIAN: [redacted] b6-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

ST, FIRST, MI: #0[redacted] b6-4 | DATE 7/9/03 | TIME 0400 | SSN/PSEUDO SSN:

(ISTAT)

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)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
U		70-105 mg/dl
ar		0.7-1.5 mg/dl
t		38-51% PCV
b		12-17 g/dl

Misc Chemistry

EST	RESULT	REF. RANGE
ponin-I		
ug of use		

Chronic Chemistry

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

[redacted]

TEST	RESULT	REF. RANGE
GLU (104)	137	73-118 mg/dl
BUN (7)	11	7-22 mg/dl
CRE (0.1)	0.5	0.6-1.2 mg/dl
CK (95)	74	39-380 u/l (M) 30-190 u/l (F)
NA+ (134)	~~11~~ 132	128-145 mmol/l
K+ (3.8)	4.0	3.3-4.7 mmol/l
CL- (98)	97	98-108 mmol/l
tCO2 (26)	27	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
tCO2		18-33 mmol/l

Piccolo Lipid 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

Bicarb Electrolyte

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

MARKS: [redacted] b6-2

post xfusion CBC
2 UPRBC OR, 2 UPRBC – ICU3

Ward/Section: ICU3	REQUESTING PHYS: Dr [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b6-4	[redacted]	TIME	SSN/PSEUDO SSN:

ID: 000[redacted] b6-4 10-07-03 14:42
MS Patient Limits

WBC	12.9 H	x10^3/uL	4.5	10.5
RBC	3.71 L	x10^6/uL	4.00	6.00
Hgb	10.5 L	g/dL	11.0	18.0
Hct	34.5 L	%	35.0	60.0
MCV	93.2	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	30.7 L	g/dL	33.0	37.0
Plt	557. H	x10^3/uL	150.	450.
Neut	16.6	%	20.5	51.1
Lym	2.1	x10^3/uL	1.2	3.4

Urinalysis

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

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

CSF

Cell Count		
Directigen		Negative

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:

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] b6-4	DATE 10 July 2003	TIME 0350	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	
Se		
Ba		
Lyr		
Atyp		
RBC Morp		
Spun Hemat		
Sed Rat		
Other		

b6-4

ID: [redacted] 10-07-03 03:51 WB

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	2.92 L	x10^6/uL	4.00	6.00
Hgb	8.7 L	g/dL	11.0	18.0
Hct	28.2 L	%	35.0	60.0
MCV	96.6	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	30.7 L	g/dL	33.0	37.0
Plt	642. H	x10^3/uL	150.	450.
LY%	33.3	%	20.5	51.1
LYM	2.6	x10^3/uL	1.2	3.4

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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: [redacted] 10 July 03

b6-2

Ward Section: ICU 3	REQ. [redacted] G PHYSICIAN: [redacted] b6-2	CHE[illegible]RY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b6-4	DATE: 10 Jul 03 / TIME: 0350	SSN/PSEUDO SSN:

(i-ST[illegible])

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%
BFecf		(-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	122	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	88	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	129	128-145 mmol/l
K^{+}	3.9	3.3-4.7 mmol/l
CL^{-}	96	98-108 mmol/l
tCO_2	28	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]	DATE: 10 Jul 03	LAB ID NO.:

b6-2

Ward/Section: 1113	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b6-4 [redacted]	DATE 11 July / TIME 0445	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.2	4.8-10.8 x 10^3
RBC	3.29	4.7-6.1 x 10^9
Hgb	9.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.5	42-52% (M) 37-47% (F)
MCV	92.7	80-94 fl (M) 81-99 fl (F)
Plt	539	130-500 x 10^3 verified
Lymph %	26.8	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

Chemistry Only

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b6-4		DATE 11 Jun 4	TIME 0445	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Biochem Panel)

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

(Biochem Panel)

TEST	RESULT	REF. RANGE
GLU	148	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	115	39-380 u/l (M) 30-190 u/l (F)
NA+	129	128-145 mmol/l
K+	3.9	3.3-4.7 mmol/l
CL-	95	98-108 mmol/l
tCO2	28	18-33 mmol/l

(Biochem 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
tCO2		18-33 mmol/l

(Biochem 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

(Biochem Electrolyte)

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

REMARKS:

Chemistry Only

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] b6-4		DATE 11 Jun 4	TIME 0445	SSN/PSEUDO SSN:

ISTAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Clinical Chemistry

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

[illegible]

TEST	RESULT	REF. RANGE
GLU	148	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	115	39-380 u/l (M) 30-190 u/l (F)
NA+	129	128-145 mmol/l
K+	3.9	3.3-4.7 mmol/l
CL-	95	98-108 mmol/l
tCO2	28	18-33 mmol/l

Basic(a) 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
tCO2		18-33 mmol/l

Chemistry 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

Normal Electrolyte

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

REMARKS:

ICU 3 EPW [redacted] b6-4 12 July 03 0400

(Hematology) CBC		
TEST	RESULT	REF. RANGE
		4.8-10.8 x 10
		4.7-6.1 x 10
		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
		80-94 fl (M) 81-99 fl (F)
		130-500 x 10 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Mon

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

Misc. Serology		
TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

[redacted] b6-4

ID: 000[redacted] b6-4 12-07-03
WB 03:33

			Patient Limits	
WBC	7.[illegible]	x10^3/uL	4.5	10.5
RBC	3.06 L	x10^6/uL	4.00	6.00
Hgb	9.0 L	g/dL	11.0	18.0
Hct	28.4 L	%	35.0	60.0
MCV	93.0	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	583. H	x10^3/uL	150.	450.
LY%	32.4	%	20.5	51.1
LY#	2.3	x10^3/uL	1.2	3.4

CSF

tigen | | Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Co

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

UNIT	TYPE	CROSSMATCH

TEST	R	
		21-34 secs
D-dimer		<250 ng/ml
		<10 ug/ml

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

Chemistry Only

/Section: ICU 3

REQUESTING PHYSICIAN:

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

T, FIRST, MI. 0[redacted] b6-4

DATE	TIME	SSN/PSEUDO SSN:
12/24/03	0400	0[redacted] b6-4

STAT

ST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
G		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
f		(-2) – (+3) mmol/L
ap		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

ST	RESULT	REF. RANGE
in-I		
of e		

Pathology Chemistry

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

Pathology 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

Pathology 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

Pathology Electrolytes

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

Pathology Chemistry

TEST	RESULT	REF. RANGE
GLU	125	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	137	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	3.5	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	29	18-33 mmol/l

ARKS:

[redacted] b6-2 12/24/03

0200-0800 off
0800-1000 drsg △ } 8° off

$$\begin{array}{r} 112 \\ 16\overline{)2000} \\ \underline{16} \\ 20 \\ \underline{16} \\ 40 \\ 48 \end{array}$$

$$\begin{array}{r} 1000 \\ 800 \\ \underline{550} \\ 250 \end{array}$$

Ward/Section: 1C03	R[redacted]TING PHYSICIAN: [redacted] b6-2	L[redacted]ORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 13 JUL	TIME 0335	SSN/PSEUDO SSN:

b6-4

ID: 630[redacted] 13-07-03
WB 04:00

			Patient Limits	
WBC	6.7	x10^3/uL	4.5	10.5
RBC	2.99 L	x10^6/uL	4.00	6.00
Hgb	6.7 L	g/dL	11.0	18.0
Hct	28.2 L	%	35.0	60.0
MCV	94.3	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	674. H	x10^3/uL	150.	450.
LY%	29.3	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

CBC

REF. RANGE
1.8-10.8 x 10^3
4.7-6.1 x 10^6
14-18 g/dl (M) 12-16 g/dl (F)
42-52% (M) 37-47% (F)
80-94 fl (M) 81-99 fl (F)
130-500 x 10^3 Verified
40.5-51.1%

Differential

o		

Urinalysis

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

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

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 13 JUL 03	LAB ID NO.:

b6-2

Ward/Section: ICU3 | REQUESTING PHYSICIAN: [redacted] b6-2

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

LAST, FIRST, MI: [redacted] b6-4 | DATE: 13JUL | TIME: 0335 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

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

```
======= PICCOLO =======
13/07/03          04:12
REFERENCE RANGE:      MALE
PATIENT #: [redacted] b6-4
GENERAL CHEMISTRY 12
DISC LOT #:       3082AA4
OPER #: 678     DR #: 000
SERIAL #:     0000100697
.......................
ALB   1.5*  3.3-5.5   G/DL
ALP   109*  26-84     U/L
ALT   137*  10-47     U/L
AMY   91    14-97     U/L
AST   141*  11-38     U/L
TBIL  0.6   0.2-1.6   MG/DL
BUN   ***   7-22      MG/DL
CA++  7.4*  8.0-10.3  MG/DL
CHOL  136   100-200   MG/DL
CRE   1.0   0.6-1.2   MG/DL
GLU   126*  73-118    MG/DL
TP    4.8*  6.4-8.1   G/DL

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

CL⁻		98-108 mmol/l
tCO_2		18-33 mmol/l
BUN	7	

(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^+	132	128-145 mmol/l
K^+	3.2	3.3-4.7 mmol/l
CL^-	97	98-108 mmol/l
tCO_2	31	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2		

555 70 1481

555 1341 7750 909
1484
1481

Chemistry Only

Ward/Section: ICU3

REQUESTING PHYSICIAN: [redacted] b6-2

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

LAST, FIRST, MI. [redacted] b6-4

DATE 14JUL | TIME 0300 | SSN/PSEUDO SSN:

Stat Chem

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

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

[redacted] 1/5/03

b6-2

Chemo Chemistry

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
14/07/03 03:08
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100676

GLU	102	73-113	MG/DL
BUN	7	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	84	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

Na 133mmol/L

Chemo 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
CO_2		18-33 mmol/l

Chemo 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

Chemo Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO_2		18-33 mmol/l

Ward/Section: ICU3	TESTING PHYSICIAN: [redacted] 66-2			ORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] 66-4		DATE 14JUL	TIME 0300	SSN/PSEUDO SSN:

(Hematology) CBC

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

ual Differential

Mono		
Eos		
Baso		
Imm		
		42-52% (M) 37-47% (F)
Other		

ID: 00[redacted] 66-4
DB 14-07-03 03:13

			Patient Limits	
WBC	6.0	x10^3/uL	4.5	10.5
RBC	2.95 L	x10^6/uL	4.00	6.00
Hgb	8.7 L	g/dL	11.0	18.0
Hct	27.8 L	%	35.0	60.0
MCV	94.4	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	752. H	x10^3/uL	150.	450.
LY%	32.1	%	20.5	51.1
LY#	2.6	x10^3/uL	1.2	3.4

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b6-4

ID: 00[redacted] 15-07-03
WB 03:44

				Patient Limits	
WBC	7.3		x10^3/uL	4.5	10.5
RBC	2.97	L	x10^6/uL	4.00	6.00
Hgb	8.6	L	g/dL	11.0	18.0
Hct	28.5	L	%	35.0	60.0
MCV	96.1		fL	80.0	99.9
MCH	29.1		pg	27.0	31.0
MCHC	30.3	L	g/dL	33.0	37.0
Plt	999.	H	x10^3/uL	150.	450.
LY%	26.0		%	20.5	51.1
LYN	1.9		x10^3/uL	1.2	3.4

---

i-STAT EC8+

Pt. [redacted]

Pt Name:_____

Glu_____110 mg/dL

BUN_____11 mg/dL

Na_____141 mmol/L

K_____4.1 mmol/L

Cl_____97 mmol/L

TCO2_____31 mmol/L

An Gap_____9 mmol/L

Hct%_____25 %PCV

Hb*_____9 g/dL

Hct

pH_____7.414

PCO2_____46.4 mmHg

HCO3_____30 mmol/L

BEecf_____5 mmol/L

Sample Type:

Operl 1678

Physician:_____

Serr# 48763

Verf: [illegible]

Ward/Section: / 3 | .STING [redacted] b6-2 | L. ATORY RESULT FORM (Subject to the Privacy Act of 1974)

DATE	TIME	SSN/PSEUDO SSN:
15 JUL 03	0915	

[redacted] b6-4

CBC			Urinalysis			Misc. Serology		
	REF. RANGE		TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	4.8-10.8 x 10^3		Color		N/A	RPR		Negative
	4.7-6.1 x 10^6		App		N/A	Mono		Negative
	14-18 g/dl (M) 12-16 g/dl (F)		Glu		Negative	**Microbiology**		
	42-52% (M) 37-47% (F)		Bili		Negative	Source		
	80-94 fl (M) 81-99 fl (F)		Ket		Negative	Gram Stain		
	130-500 x 10^3 verified		SG		N/A	Occ Bld		Negative
	20.5-51.1%		Bld		Negative	H. pylori		Negative
	al Differential		pH		N/A	Micro Parasites		
	ono		Prot		Negative	Malaria		
	s		Urob		0.2-1.0	O & P		
	iso		Nit		Negative	Other		
	im		Leuk		Negative	**Microscopic Urinalysis**		
Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	15 JUL 03	

b6-2

[redacted] b6-4

Ward/Section: 1C43	REQ	NG PHYSICIAN: [redacted] b6-4	LAB (Sub)	RESULT FORM the Privacy Act of 1974)
LAST, FIRST, MI.	H [redacted]	DATE 16 July	TIME 0410	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		

ID: 00[redacted] b6-4 16-07-03
WE 04:24

			Patient Limits	
WBC	8.3	x10^3/uL	4.5	10.5
RBC	3.12 L	x10^6/uL	4.00	6.00
Hgb	9.1 L	g/dL	11.0	18.0
Hct	29.3 L	%	35.0	60.0
MCV	93.7	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.2 L	g/dL	32.0	37.0
Plt	829. H	x10^3/uL	150.	450.
L%	26.4	%	20.5	51.1
L#	2.2	x10^3/uL	1.2	3.4

Other

Urinalysis b6-4

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

1-STAT EC8+

Pt: [redacted] b6-4

Pt Name: _____

Glu_____178 mg/dL
BUN_____11 mg/dL
Na_____132 mmol/L
K_____4.1 mmol/L
Cl_____96 mmol/L
TCO2_____30 mmol/L
AnGap_____6 mmol/L
Hct_____29 %PCV
Hb*_____10 g/dL
*Calc. Hct
pH_____7.449
PCO2_____41.6 mmHg
HCO3_____28 mmol/L
BEecf_____5 mmol/L

Sample Type_

16JUL03 04:20

Oper: [redacted] b6-2

Physician: _____

Ser# 40763
Ver: JAMS046A
CLEW R93

1643

REQU [redacted] b6-7 CHEM [redacted] RESULT FORM
(Subject to the Privacy Act of 1974)

[redacted] b6-4 | DATE 16 Jul | TIME 0410 | SSN/PSEUDO SSN:

RANGE	(Piccolo) Chemistry 12 TEST	RESULT	REF. RANGE	(Piccolo) Metabolic Panel TEST	RESULT	REF. RANGE
6 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
0 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
0 mmol/L	ALT		10-47 u/l	CA++		8.0-10.3 mg/dl
45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
mmHg (art) mmHg (ven)	AST		11-38 u/l	NA+		128-145 mmol/l
5 mmHg (art) (ven)	TBIL		0.2-1.6 mg/dl	K+		3.6-4.7 mmol/l
mmol/L (art) mmol/L (ven)	BUN		7-22 mg/dl	CL-		98-108 mmol/l
mmol/L (art) mmol/L (ven)	CA++		8.0-10.3mg/dl	HCO_3		18-33 mmol/l
8%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
(+3)	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
0 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
5-132 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
5 mg/dl	**(Piccolo) Metlyte 8**			ALT		10-47 u/l
105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
-12 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
ry	CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
EF. RANGE	NA+		128-145 mmol/l	**(Piccolo) Electrolyte**		
egative	K+		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
egative	CL-		98-108 mmol/l	NA		128-145 mmol/l
egative	HCO_3		18-33 mmol/l	K+		3.3-4.7 mmol/l
Negative				CL-		98-108 mmol/l
Negative				HCO_3		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2		

Ward/Section: 1C43 | REQ | IG PHYSICIAN: [redacted] b6-2 | CHE[illegible]RY RESULT FORM (Subje[illegible] the Privacy Act of 1974)

LAST, FIRS[redacted] b6-4 | DATE [illegible] | TIME 45 | SSN/PSEUDO SSN: [redacted] b6-4

(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

i-STAT EC8+

Pt: [redacted] b6-4

Pt Name:_____

Glu_(176)_____112 mg/dL

BUN__(11)_____15 mg/dL

Na__(132)_____130 mmol/L

K___(4.1)_____4.1 mmol/L

Cl__(98)_____100 mmol/L

TCO2_____30 mmol/L

AnGap(_10)_____[illegible] mmol/L

Hct_____24 %PCV

Hb*_____8 g/dL

*via Hct

pH_____7.423

PCO2_____43.2 mmHg

HCO3_____28 mmol/L

BEecf_____4 mmol/L

Sample Type_:

17JUL03 03:53

Oper: [redacted] b6-2

Physician:_____

Ser# 40763

Ver: JAN5046A CLEW A93

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA[illegible]		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA[illegible]		128-145 mmol/l
K[illegible]		3.3-4.7 mmol/l
CL[illegible]		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
TY		14-97 u/l
[illegible]		11-38 u/l
[illegible]		0.2-1.6 mg/dl
[illegible]		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

T	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	17Jul03	

Ward/Section: ICU3	REQ[illegible]NG PHYSICIAN: Dr [redacted] b6-2	LABO[illegible]RY RESULT FORM (Subj[illegible] the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 17 Jan 03 / TIME 0345	SSN/PSEUDO SSN: [redacted] b6-4

ID: [redacted] b6-4
DOB

17-07-03
03:55

			Patient Limits
WBC	5.0	x10^3/uL	4.5 10.5
RBC	3.10 L	x10^6/uL 8.3	4.00 6.00
Hgb	9.1 L	g/dL 9.2	11.0 16.0
Hct	29.5 L	% 9.1	35.0 60.0
MCV	94.9	fL 29.3	80.0 99.0
MCH	29.3	pg 93.1	27.0 31.0
MCHC	30.9 L	g/dL 29.3	33.0 37.0
Plt	900. H	x10^3/uL 32.2	150. 450.
RDW	37.7	% 889	36.5 51.1
MPV	3.0	fL 20.4	1.2 3.4
		x10^3/uL 2.2	

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	**Microbiology**		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
Leuk		Negative	**Microscopic Urinalysis**		
HCG		Negative			

			CSF			Blood Bank	
Spun Hematocrit		42-[illegible] (M) 37-47% (F)	Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Sed Rate			Directigen		Negative	ABO/Rh	
Other							

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

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b6-4