i-STAT EC8+

Pt: [redacted] b6-4

Pt Name:_____

Glu_____141 mg/dL

BUN_____13 mg/dL

Na_____133 mmol/L

K_____4.2 mmol/L

Cl_____102 mmol/L

TCO2_____26 mmol/L

AnGap_____11 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.402

PCO2_____39.2 mm

HCO3_____24 mmol/L

BEecf_____0 mmol/L

Sample Type_:

18JUL03 03:49

Oper: [redacted] b6-2

Physician:_____

Ser# 42011

Ver: JAMS046A
CLEW A93

RE [redacted] NG PHYSICIAN b6-2

LAB [illegible] Y RESULT FORM
(Subj[illegible] to the Privacy Act of 1974)

DATE 7/18/03 TIME 0330 SSN/PSEUDO SSN:

C						
F. RANGE						
10.8 x 10³						
6.1 x 10⁶						
8 g/dl (M) 6 g/dl (F)						
2% (M) 7% (F)						
4 0 (M) 9 0 (F)						
500 x 10³ fied						
-51.1%						
ifferential						
2% (M) 47% (F)						
lies						
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

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	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

rgl 18Jul03

Ward/Section: ICU 3	RE[redacted]TING PHYS b6-2
LAST, FIRST, MI. EPW [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		
Drug of Abuse		

i-STAT EC8+

Pt: [redacted] b6-4

Pt Name:_____

Glu_____119 mg/dL
BUN_____14 mg/dL
Na_____132 mmol/L
K_____4.2 mmol/L
Cl_____101 mmol/L
TCO2_____25 mmol/L
AnGap_____11 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct
PH_____7.403
PCO2_____38.5 mmHg
HCO3_____24 mmol/L
BEecf_____-1 mmol/L

Sample Type_:

19JUL03 04:31

Oper: [redacted] b6-2

Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

i-STAT CREA

Pt: 386
Pt Name:_____
Crea_____0.9 mg/dL
Sample Type_:
19JUL03 4:32
Oper: 13
Physician:_____
Ser# 40788
Ver: JAMS046A
CLEW A93

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		5-65 u/l
CRE		6.4-8.1 g/dl
GLU		
TP		
TES		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b6-2	DATE: 19Jul03	LAB ID NO.:

Ward/Section: ICU 3	REQ	NG PHYSICIAN: [redacted] b6-2	LAB (Sec	C 7 RESULT FORM 5 the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted] b6-4	DATE 7/15/03	TIME 0400	SSN/PSEUDO SSN:	

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted] b6-4		
[illegible]		17-07-03 04:06
WB		Patient Limits
WBC	8.1	x10^3/uL 4.5 10.5
RBC	3.25 L	x10^6/uL 4.00 6.00
HGB	9.5 L	g/dL 11.0 18.0
HCT	32.5 L	% 35.0 60.0
MCV	93.9	fL 80.0 99.9
MCH	29.2	pg 27.0 31.0
MCHC	31.0 L	g/dL 33.0 37.0
PLT	257. H	x10^3/uL 150. 450.
LYM	28.0	% 20.5 51.1
LYM	2.3	x10^3/uL 1.2 3.4
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

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:

REPORTED BY: [redacted] b6-2	DATE: 19 July 03	LAB ID NO.:

Ward/Section: 1143 | RE[illegible]TING PHYSICIAN: [redacted] b6-2 | [illegible]EMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: # [redacted] b6-4 | DATE: 20 Jul 03 | TIME: 0330 | SSN/PSEUDO-SS[illegible]

(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		

(I[illegible]

TEST
ALB
ALP
ALT
AMY
AST
TBIL
BUN
CA^{++}
CHOL
CRE
GLU
TP

i-STAT CREA

Pt: [redacted] b6-4

Pt Name:_____

Crea_____0.9 mg/dL

Sample Type_:

20JUL03 04:10

Oper: [redacted] b6-2

Physician:_____

Ser# 42011

Ver: JAMS046A CLEW A93

(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

(P[illegible]

TEST		
ALT		
AMY		
AST		
TBIL		
GGT		
TP		
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

i-STAT EC8+

Pt: [redacted] b6-4

Pt Name:_____

Glu_____117 mg/dL

BUN_____14 mg/dL

Na_____132 mmol/L

K_____4.3 mmol/L

Cl_____[illegible] mmol/L

TCO2____[illegible] mmol/L

AnGap_____9 mmol/L

Hct_____29 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.459

PCO2_____34.5 mmHg

HCO3_____24 mmol/L

BEecf_____1 mmol/L

Sample Type_:

20JUL03 04:10

Oper: [redacted]

Physician:_____

Ser# 40763

Ver: JAMS046A CLEW A93

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 20 Jul 03

LAB ID NO.:

Ward/Section	REC	PHYSICIAN: [redacted] b6-2	LAB RESULT FORM (Subj... the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]		DATE: 20 July	TIME: 0330	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
[redacted] b6-4		
Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
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

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	[redacted]

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: 20 July 03

LAB ID NO.:

b6-2

Ward/Section: 1CW3	REQUESTING PHYSICIAN: [redacted] b6-2	LAB ONLY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b6-4	DATE: 21 July	TIME: 0330	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.1	4.8-10.8 x 10^3
RBC	2.98	4.7-6.1 x 10^6
Hgb	8.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.0	42-52% (M) 37-47% (F)
MCV	93.9	80-94 fl (M) 81-99 fl (F)
Plt	887	130-500 x 10^3 verified
Lymph %	33.7	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			

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]	DATE: 21 July 03	LAB ID NO.:

b6-2

Ward/Section: ICU3	R	STING PHYSICIAN: [redacted] b6-2	HEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] b6-4	DATE 21 July	TIME 0330	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
AL T		10-47 u/l
A		
A		
T		
B		
C		
C		
C		
G		
Tl		
G		
Bl		
Cl		
Cl		
N		
K		
Cl		
tC		

```
======= PICCOLO =======
21/07/03          05:19
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:       3152AA4
OPER #: 013     DR #: 000
SERIAL #:     0000100684
.......................
GLU   94   73-118   MG/DL
BUN   10   7-22     MG/DL
CRE   1.0  0.6-1.2  MG/DL
CK    88   39-380   U/L
NA+   ♦♦♦  128-145  MMOL/L
K+    4.5  3.3-4.7  MMOL/L
CL-   100  98-108   MMOL/L
tCO2  23   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 2+, LIP 0, ICT 0
```

Na 134

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	21 July 03	

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] 66-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] 66-4	DATE 225.0	TIME	SSN/PSEUDO SSN: [redacted] 66-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.0	4.8-10.8 x 10^3
RBC	3.19	4.7-6.1 x 10^9
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.8	42-52% (M) 37-47% (F)
MCV	93.4	80-94 fl (M) 81-99 fl (F)
Plt	917	130-500 x 10^3 verified
Lymph %	36.8	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		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] 66-2	DATE: 225a/03	LAB ID NO.:

b6-2

Ward/Section:	QUESTING PHYSICIAN:	MISTRY RESULT FORM (Subject to the Privacy Act of 1974)
Ec43	[redacted]	

LAST, FIRST, MI	DATE	TIME	SSN/PS SSN:
[redacted] b6-4	22 Jul		[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 (a 41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (ve
HCO3		22-26 mmol/L (a 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol.
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		

======= PICCOLO =======
22/07/03 05:18
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METHYIE 8
DISC LOT #: 3152AA4
OPER #: DR #: 000
SERIAL # 000100684

GLU	96	[illegible]	MG/DL
BUN	10	7-22	MG/DL
CRE	0.9	0.5-1.2	MG/DL
[illegible]	74	39-380	U/
[illegible]	[illegible]	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL	101	98-108	MMOL
tCO2	21	18-33	MMOL

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

Na 135 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
CO_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
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A^+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	22 Jul 03	

b6-2

Ward/Section: 1C43 | QUESTING PHYSICIAN: [redacted] b6-2 | MISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4 | DATE 25Jul4 | TIME 0430 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
25/07/03 04:32
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100676

GLU	102	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	141	39-380	U/L
NA+	♦♦♦	128-145	MMOl/L
K+	4.5	3.3-4.7	MMOl/L
CL-	99	98-108	MMOl/L
tCO2	22	18-33	MMOl/L

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

Na-134

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
MY		14-97 u/l
GT		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2 | **DATE:** 25Jul03 | **LAB ID NO.:**

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
# [redacted] b6-4	25 July	0400	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.1	4.8-10.8 x 10^3
RBC	3.53	4.7-6.1 x 10^9
Hgb	10.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.1	42-52% (M) 37-47% (F)
MCV	93.7	80-94 fl (M) 81-99 fl (F)
Plt	1016	130-500 x 10^3 verified
Lymph %	32.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	25 July 03	

Ward/Section: 1C43	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. #[redacted] b6-4	DATE 27 Jul	TIME 0355	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
Lymph		Baso
Atyp		Imm
RBC Morph		

ID: 000[redacted] b6-4 27-07-03 04:56
MD

			Patient Limits	
WBC	9.5	x10^3/uL	4.5	10.5
RBC	3.34 L	x10^6/uL	4.00	6.00
Hgb	9.7 L	g/dL	11.0	18.0
Hct	31.7 L	%	35.0	60.0
MCV	94.9	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	990. H	x10^3/uL	150.	450.
LY%	36.8 *	%	20.5	51.1
LY#	3.5 *H	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

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] b6-2	DATE: 27 Jul 03	LAB ID NO.:

Ward/Section: IC43

QUESTING PHYSICIAN: [redacted] b6-2 [redacted]

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

LAST, FIRST, MI. # [redacted] b6-4

DATE 27Jul

TIME 0345

SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

PICCOLO
27/07/03 04:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100684

GLU	98	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	124	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

Na-136

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
U		73-118 mg/dl
N		7-22 mg/dl
++		8.0-10.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
IY		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 27Jul03

LAB ID NO.:

Ward/Section: 1CU3	REQUESTING PHYSICIAN: Dr [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 29 July	TIME 21:30	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		4.8-10.8 x 10³	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		
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		

ID: 0[redacted] b6-4
WR

29-07-03
07:16

			Patient Limits	
WBC	7.9	x10^3/uL	4.5	10.5
RBC	3.42 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	32.5 L	%	35.0	60.0
MCV	95.0	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	1014. *H	x10^3/uL	150.	450.
LY%	48.5 *	%	20.5	51.1
LY#	3.8 *H	x10^3/uL	1.2	3.4

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:** 29 July 03	**LAB ID NO.:**

b6-2

Ward/Section: CL3	QUESTING PHYSICIAN: [redacted] b6-2		MISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 29Jul	TIME 06:32	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
29/07/03 06:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100676

GLU	92	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	58	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

EST	RESULT	REF. RANGE
LU		73-118 mg/dl
IN		7-22 mg/dl
++		8.0-10.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

EST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
IY		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

EST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
O_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	DATE: 29/07/03	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. H [redacted] b6-4		DATE 2Aug	TIME 0550	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 (ar 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
02/08/03 06:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 269 DR #: 000
SERIAL #: 0000100494

GLU	92	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	30*	39-380	U/L
NA+	134	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(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: 2Aug03	LAB ID NO.:

b6-2

Ward/Section: 1C43	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 2Aug	TIME 0550	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
		.8-10.8 x 10^3
		.7-6.1 x 10^9
		4-18 g/dl (M) 2-16 g/dl (F)
		2-52% (M) 7-47% (F)
		0-94 fl (M) 1-99 fl (F)
		.30-500 x 10^3 verified
		20.5-51.1%
Differential		
no		
o		
n		
Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: 000[redacted] b6-4
AB 02-08-03 07:59

			Patient Limits	
WBC	8.9 *	x10^3/uL	4.5	10.5
RBC	3.70 L	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	35.1	%	35.0	60.0
MCV	94.9	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	764. H	x10^3/uL	150.	450.
LY%	44.5 *	%	20.5	51.1
LY#	4.0 *H	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

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:

REPORTED BY: [redacted]	DATE: 2Aug03	LAB ID NO.:

b6-2

Ward/Section: 1CU3	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 8/5/03 TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MC		
Pl		
L		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: 00[redacted] b6-4
WB
05-08-03
04:04
Patient Limits

WBC	7.0	x10^3/uL	4.5	10.5
RBC	3.66 L	x10^6/uL	4.00	6.00
Hgb	10.5 L	g/dL	11.0	18.0
Hct	34.4 L	%	35.0	60.0
MCV	94.1	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	30.5 L	g/dL	33.0	37.0
Plt	585. H	x10^3/uL	150.	450.
LYM	56.0 HH	%	20.5	51.1
LYM	3.9 HH	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
Sp		N/A
[illegible]		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

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:	DATE: 5 Aug 03	LAB ID NO.:

[redacted] b6-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 8/5/03 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%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 1/2

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
tCO_2		18-33 mmol/l

======= PICCOLO =======
05/08/03 04:04
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100884

GLU	92	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	39	39-380	U/L
NA+	130	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	21	18-33	MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	5Aug03	

Ward/Section: 1C43	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. # [redacted] b6-4	DATE 9 Aug	TIME 0520 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		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		

======= PICCOLO =======
09/08/03 05:28
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100676

GLU	92	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	44	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 0

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**
[redacted] b6-2	9Aug03	

Ward/Section: ICU-3	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] b6-4	9 Aug	[illegible]	

(Hematology) CBC

TEST	RESULT	REF. RANGE

ID: [redacted] b6-4 09-AUG-03 05:58
AB

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	4.10	x10^6/uL	4.00	6.00
Hgb	11.7	g/dL	11.0	18.0
Hct	36.2	%	35.0	60.0
MCV	87.8	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	481 H	x10^3/uL	130.	450.
Lym	64.7	%	24.5	51.1
Lym#	5.0	x10^3/uL	1.0	3.4

Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	9 Aug 03	

b6-2

b6-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] b6-4	DATE 12 AUG	TIME 0430	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	1.0	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyre 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

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____85 mg/dL

BUN_____8 mg/dL

Na_____138 mmol/L

K_____4.0 mmol/L

Cl_____105 mmol/L

TCO2_____29 mmol/L

AnGap_____9 mmol/L

Hct_____38 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.414

PCO2_____42.9 mmHg

HCO3_____27 mmol/L

BEecf_____3 mmol/L

Sample Type_: Cr cal. 0

12AUG03 04:37

Oper: [redacted] b6-2

Physician:_____

Ser# 42011

Ver: JAMS046A
CLEW A93

REMARKS: Chem 7

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	12AUG03	

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 12AUG	TIME 0430	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
RI		
H		
H		
M		
Pl		
L		
S		
B		
L		
A		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted] b6-4
AB
12-08-03
04:35
Patient Units

WBC	7.0	x10^3/uL	4.5	10.5
RBC	3.87 L	x10^6/uL	4.00	5.00
Hgb	11.4	g/dL	11.0	18.0
Hct	36.1	%	35.0	60.0
MCV	93.4	fL	80.0	99.0
MCH	29.5	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
PLT	414.	x10^3/uL	150.	450.
LYM%	50.6 HH	%	21.5	51.1
LYM#	3.8 HH	x10^3/uL	.2	5.4

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

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:

REPORTED BY: [redacted]	DATE: 12AUG03	LAB ID NO.:

b6-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] b6-4	DATE: (8/16)	TIME: 0400	SSN/PSEUDO SSN: 386

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALE					73-118 mg/dl
K		3.5-4.9 mmol/L	ALP					7-22 mg/dl
Cl		98-109 mmol/L	ALT					8.0-10.3 mg/dl
pH		7.31-7.45	AM					0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST					128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBI					3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN					98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA+					18-33 mmol/l
sO2		95-98%	CHC					
BEecf		(-2) – (+3) mmol/L	CRE					
AnGap		10-20 mmol/L	GLU					
Ca		1.12-1.32 mmol/L	TP					
BUN		8-26 mg/dl						
GLU		70-105 mg/dl	TE					
Creat		0.7-1.5 mg/dl	GLU					
Hct		38-51% PCV	BUN					
Hgb		12-17 g/dl	CRE					
			CK					
			NA+					
			K+					
			CL-					
			tCO_2					

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

```
======= PICCOLO =======
16/08/03          04:43
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:       3151AA4
OPER #: 678       DR #: 000
SERIAL #:     0000100676
.......................
GLU    86   73-118   MG/DL
BUN    6*   7-22     MG/DL
CRE    0.9  0.6-1.2  MG/DL
CK     49   39-380   U/L
NA+    127* 128-145  MMOL/L
K+     5.4* 3.3-4.7  MMOL/L
CL-    99   98-108   MMOL/L
tCO2   19   18-33    MMOL/L

INST QC: OK     CHEM QC: OK
HEM 3+,  LIP 1+,  ICT 0
```

lo) Liver Panel Plus	
RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

ccolo) Electrolyte	
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	16 Aug 03	

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 16 Aug	TIME 0825	SSN/PSEUDO SSN: #386

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.9	Color		N/A	RPR		Negative
RBC			App		N/A	Mono		Negative
H	[redacted] b6-4		Glu		Negative	**Microbiology**		
H			Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
Ph			SG		N/A	Occ Bld		Negative
Ly			Bld		Negative	H. pylori		Negative
(			pH		N/A	Micro Parasites		
Seg			Prot		Negative	Malaria		
Ban			Urob		0.2-1.0	O & P		
Lym			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:

REPORTED BY: [redacted]	**DATE:** 16 Aug 03	**LAB ID NO.:**

b6-2

Ward/Section: KW#1	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: #[redacted] b6-4	DATE: 22AUG03 TIME: 1530	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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	Amber	N/A
App	cloudy	N/A
Glu	NeG	Negative
Bili	NeG	Negative
Ket	small	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	30	Negative
Urob	0.2	0.2-1.0
Nit	POS	Negative
Leuk	NeG	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA - Trace
bac - many
rbc - 25-50
Epi - 1-5

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

REMARKS:

REPORTED BY: [redacted]	DATE: 22Aug03	LAB ID NO.:

b6-2

Ward/Section: ICW#1	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] b6-4	DATE 23AUG03	TIME 0730	SSN/PSEUDO SSN:

CBC

ID: 00[redacted] b6-4
WB

08-22-03
23:46

			Patient Limits	
WBC	9.9	x10^3/uL	4.5	10.5
RBC	4.35	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	39.9	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	447.	x10^3/uL	150.	450.
LY%	25.9 *	%	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

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: 8-23-03	LAB ID NO.:

b6-2

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
		98-106 mmol/L

i-STAT CREA

Pt: [redacted] b6-4

Pt Name:

Crea 1.1 mg/dL

Cl [illegible] mmol/L

TCO2 28 mmol/L

AnGap 7 mmol/L

Hct 42 %PCV

Hb* 14 g/dL

*via Hct

PH 7.484

PCO2 36.1 mmHg

HCO3 27 mmol/L

BEecf 4 mmol/L

Sample Type:

23AUG03 08:14

Oper: [redacted] b6-2

Physician:

Ser# 42015

Ser: JAMS046A
CLEW A93

Re

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======

23/08/03 07:43

REFERENCE RANGE: MALE

PATIENT #: [redacted] b6-4

METLYTE 8

DISC LOT #: 3152AA4

OPER #: 034 DR #: 000

SERIAL #: 0000100684

GLU	102	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	34*	39-380	U/L
~~NA+~~	~~125~~	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 2+, LIP 0 , ICT 0

(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
CO_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

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW 1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
# [redacted] b6-4	26 Aug	@ 0600	# [redacted] b6-4

26 Aug 03 @ 0600

ID: 00[redacted] b6-4

WB

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	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**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

WBC 7.0 x10^3/uL
RBC 4.04 x10^6/uL
Hgb 11.5 g/dL
Hct 37.0 %
MCV 91.6
MCH 28.5
MCHC 31.1 L
Plt 498.
LY% 64.4
LYM 4.5

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.:

Ward/Section: ICU 1	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW #[redacted] b6-4	DATE: 26Aug03	TIME: 0600	SSN/PSEUDO SSN: EPW #[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		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

(Piccolo) Methyte 8

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

======= PICCOLO =======
26/08/03 06:38
REFERENCE RANGE: MALE
PATIENT #: 0[redacted] b6-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 034 DR #: 000
SERIAL #: 0000100494

GLU	87	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	22*	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	23	[illegible]	MMOL/L

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

REMARKS:

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

Chem 8

Ward/Section: ICW 1	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. # [redacted] b6-4	DATE 27 Aug	TIME 0240	SSN/PSEUDO SSN # [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
R		
H		
H		
M		
P		
I		

27 Aug 03 @ 0245

ID: 000[redacted] 08-28-03
WB b6-4 18:30

			Patient Limits	
WBC	11.4 H	x10^3/uL	4.5	10.5
RBC	4.14	x10^6/uL	4.00	6.00
Hgb	11.7	g/dL	11.0	16.0
Hct	38.3	%	35.0	60.0
MCV	92.6	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	201.	x10^3/uL	150.	450.
LY%	51.7 *H	%	20.5	51.1
LY#	5.9 *H	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

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:	DATE:	LAB ID NO.:

CBC = C&T x2 units

27Aug03

@ 0510

[redacted] b6-4

WBC	16.4	x10^3/uL	4.5	10.5
RBC	3.37 L	x10^6/uL	4.00	5.00
HGB	9.5 L	g/dl	11.0	18.0
HCT	31.1 L	%	35.0	60.0
MCV	92.4	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	30.5 L	g/dL	33.0	37.0
Plt	530. H	x10^3/uL	150.	450.
LY%	46.8 *	%	20.5	51.1
LYM	4.9 *	x10^3/uL	1.2	3.4

Patient Limits

REQUESTING PHYSICIAN: [redacted] b6-2

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

[redacted] DATE: 27Aug03 TIME: 0600 SSN/PSEUDO SSN: # [redacted] EPW

b6-4

	F. RANGE	.8 x 10^3	
		1 x 10^9	
		g/dl (M)	
		g/dl (F)	
		% (M)	
		% (F)	
		fl (M)	
		fl (F)	
		0 x 10^3	
		ed	
		51.1%	

ferential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
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 b6-4

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.:

CBC only!

Ward/Section: KW#1	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. #[redacted] b6-4	DATE 27AUG03	TIME 1715	SSN/PSEUDO SSN:

27aug @1715

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	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			

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: [redacted]	DATE: 8-27-03	LAB ID NO.:

b6-2

#1

27SEP03 21:45

ID: [redacted] b6-4

WB

09-28-03
20:14

			Patient Limits	
WBC	9.4	x10^3/uL	4.5	10.5
RBC	2.98 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	27.2 L	%	35.0	60.0
MCV	91.1	fL	80.0	99.9
MCH	28.8	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	417.	x10^3/uL	150.	450.
LY%	52.8 *H	%	20.5	51.1
LY#	5.0 *H	x10^3/uL	1.2	3.4

#2

mg/dL

mmol/L

4.5 mmol/L

16 mmol/L

iCa 1.26 mmol/L

Hct %PCV

g/dL

Hct

37C

pH 7.328

PCO2 29.2 mmHg

PO2 47 mmHg

HCO3 15 mmol/L

BEecf -11 mmol/L

sO2* 80 %

*calculated

Sample Type_:

27SEP03 22:14

#[redacted] 66-4 CPW

ICW#1

29Aug03 @ 0500.

PATIENT'S MED. RECORD

SPECIMEN/LAB RPT. NO.

ATOLOGY

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

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

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

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

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY | MD | DATE | TECH | LAB. ID. NO.

REMARKS CBC

549-107

HEMATOLOGY

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

TEST(S) | SPECIMEN TAKEN DATE | TIME | A.M. P.M. | (X) | REQUESTED | RESULTS

RBC COUNT | HEMOGLOBIN | HEMATOCRIT | MCV | MCH | MCHC | WBC COUNT

WBC DIFF AND BLOOD CELL MORPH: IMMATURE | NEUTRO-BANDS | NEUTROSEGS | LYMPHS | EOSINOPHILS | BASOPHILS | MONOCYTES | PLATELETS | RBC

SED. RATE | PLATELET COUNT | RETICULOCYTE COUNT | CLOTTING TIME | BLEEDING TIME | PT CONTROL | PT PATIENT | PTT CONTROL | PTT PATIENT | % ACTIVITY | RATIO | SICKLING TEST | LE PREP

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

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY | MD | DATE | TECH | LAB. ID. NO.

REMARKS

546-107

CHEMISTRY I

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

TEST(S) | SPECIMEN TAKEN DATE | TIME | A.M. P.M.

PROFILE (Specify)

```
====== PICCOLO ======
29/08/03      04:16
REFERENCE RANGE:  [redacted]  66-4   MALE
PATIENT #:  0                3151AA4
METLYTE 8                    DR #: 000
DISC LOT #:                  0000100676
OPER #: 034
SERIAL #:
GLU   99
BUN   0
CRE
CK
NA+   3.5
K+    103
CL-   98-10
tCO2  23
```

☐ PRE-OP ☐ STAT ☐ SPECIMEN SOURCE (Specify)

REQUESTING PHYSICIAN'S SIGNATURE | MD | DATE | LAB ID NO.

557-107

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

66-4

08-29-03 21:50

			Patient Limits
WBC	12.0 H	x10^3/uL	4.5 10.5
RBC	2.73 L	x10^6/uL	4.00 6.00
Hgb	7.8 L	g/dL	11.0 18.0
Hct	24.8 L	%	35.0 60.0
MCV	91.0	fL	80.0 99.0
MCH	28.6	pg	27.0 31.0
MCHC	31.4 L	g/dL	33.0 37.0
Plt	441.	x10^3/uL	150. 450.
LYM	50.4 *	%	20.5 51.1
LYM	6.0 #H	x10^3/uL	1.2 3.4

ID: [redacted]
NB

DATE

b6-2

Ward/Section: ICW#1	REQUESTING PHYSICAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] b6-4	DATE 07OCT03	TIME 0735	SSN/PEEUDO SSN:

(Hematology) CBC

TE	REF RANGE
WI	
RE	
Hi	
He	
M	
P	
I	

[redacted] b6-4

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

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		

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Set Rate		
Other		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b6-2

Ward/Section: ICW#1	REQUESTING PHYSICAN: [redacted] b6-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] b6-4	DATE 07/07/03 TIME 0735	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

```
======= PICCOLO =======
10/07/03          08:17
REFERENCE RANGE:      MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #:        3204AA4
OPER #: 678      DR #: 000
SERIAL #:      0000100684
.......................
ALB   3.3   3.3-5.5   G/DL
ALP   65    26-84     U/L
ALT   112*  10-47     U/L
AMY   51    14-97     U/L
AST   61*   11-38     U/L
TBIL  0.7   0.2-1.6   MG/DL
BUN   7     7-22      MG/DL
CA++  9.0   8.0-10.3 MG/DL
CHOL  216*  100-200   MG/DL
CRE   0.7   0.6-1.2   MG/DL
GLU   92    73-118    MG/DL
TP    6.9   6.4-8.1   G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	DATE: 7/8/03	LAB ID NO.:

b6-2

START

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)				
Fentanyl	25 mcg/cc	3.2	2	1	2
Versed	(mg/cc)	4	2	1	1
Ketamine	(10 mg/cc)	4.1	2	2	1

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

VOLAT. AGENT	% det	
	% e.t.	T
AIR	L/Min	15L
N2O	L/Min	
O2	L/Min	

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

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES — EST BLOOD LOSS — URINE –

TOTALS	TOTAL EBL
250	
8	
100	TOTAL URINE
	2

FLUIDS – SUMMARY
CRYSTALLOID – 75 LR
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers, enter with letters

Robinul, 2 mg prior to procedure
1000 pt lethargic, ~~[illegible]~~ intracts ≈ eff & follows commands
99% on RA, 12-14

[redacted] LT [illegible]
b6-2

ASA STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 KG / LB

HEMATOCRIT:

INITIAL DATA: 160/55

HR – 107

EQUIP CHECK: K/– (Y) N

PATIENT RIGHTS CHECK: for PROCEDURE? Y

TIME: 1 15 30 45 0900 15 30 45 1000

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

220 / 200 / 180 / 160 / 140 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 40 / 20

VT, = ml
f, = breaths/min: 15 12 12 10 20 12 27 15 30 20 25 25 20 19 18 14 12
Peak inl pres / PEEP: 22 13
MODE – S(pon), A(ssist), C(on)

BP/Auto Cuff	ET CO2 (torr)
BP / oth	FIO2 (Frac or %)
ART line	SpO2 (%): 99 100 100 100 100 100 100 100 100 95 99 99 97
Stethi PC/ES	ECG: ST ST ST ST ST RA
Gas analyzer	TEMP- site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

Mark with letters & symbols, explain under REMARKS

EVENTS: Urg: 9 mg ABD Roll
Position —

RECOVERY AT: PACU ICU (CVS) (Specify) OTHER
CONDITION:
TEMP – 16 SpO2 – 96 RA
BP – 112 HR – 119/64

ANES	Start	Room	End
	0806	0806	
PROC	Ready	Begin	End
	0800	0810	0920

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Versed, fentanyl, ketamine

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted] b6-4

SURGEONS: b6-2

ANESTHETISTS: LT [redacted] RN,

PROCEDURE LOCATION: (CVS)
DATE

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99

PAGE 1 OF 1

U.S. GPO: 1999 529-336/10

PATIENT RECORD

ITHESIA PLAN OF CARE PRE CEDURAL ASSESSMENT (Sedation/ sthesia)

__ DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

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

)SED PROCEDURE: Conscious Sedation
CAL SERVICE: ____
INCE: ____

S:
CCO: 2pk/day
ETOH: ____
RUGS: ____

NT MEDICATIONS:
lered as premed

Fentanyl patch
Albuterol
Lovenox

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 8.7, 28.

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 106/77 HR 77 R 20 T ____ 96%
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea Midline
TMJ/Neck ____
Oropharnyx ____
Nares patent
CHEST: Equal
CARDIAC: S1-S2
EXTREMITIES:
IV Access: (R) hand patent
Ulnar Filling: ____
BACK: LBP
OTHER: ____

NPO Since ____

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

Conscious sedation

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

ient/legal guardian seems to understand and agrees. Questions answered.

____ Date: ____ Time: ____ Hrs

NESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

____ Date: ____ Time: ____ Hrs

Identification: (Ward) ICU 3.

SEDATION KEY:

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

#[redacted] b6-4

STHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

OSED PROCEDURE: Conscious Sedation
ICAL SERVICE: _____
INCE: _____

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

S: 2/day.
ACCO: _____
ETOH: _____
RUGS: _____

ENT MEDICATIONS:
dered as premed
Levaquin
LRP
MSO4

EDICATIONS:
/es (@ _____ Hrs) /CC
_____ mg IV IM PO
_____ mg IV IM PO
_____ mg IV IM PO

RATORY STUDIES:
T: 9, 31
R: _____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

_____

PHYSICAL EXAMINATION

BP 146/64 HR 110 R 10 T 101 2
Pain Scale 0-10 _____
HEENT - Teeth intact
Trachea midline.
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: S1-S2-Ø ectopy.
EXTREMITIES: _____
IV Access: (R) IJ CVC
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

STHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ { } General: Mask Intubation

Conscious Sedation

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

tient/legal guardian seems to understand and agrees. Questions answered.
: _____ Date: 05 Jul 03 Time: 0900 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

: _____ Date: _____ Time: _____ Hrs

t Identification: (Ward) _____

#[redacted] - 06-4

SEDATION KEY:

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

Le: .vin 500mg IVPB : Tus g from ICU.

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
versed	(mg)	3
fentanyl	(µg)	100 50 50
propofol	(mg)	120
sux/Roc	(mg)	100/ 30 10 10
Morphine	(mg)	4 2 2 2-4
	( )	
VOLAT AGENT: Iso	% del	1.5 1.5 1.5 1.5 1.5 1.2 1.2X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 — 2 — 2 — 2 — 2 — 2 — 2 — 2

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

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

FLUIDS — LINE site 18g LxEJ ☐ Warmed: NS — 500 — 600 — 800

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES — EST BLOOD LOSS: 100

URINE – Foley: 200

TOTALS	
3	TOTAL FLUID: 100
250	
	TOTAL URINE: 200
10	

FLUIDS – SUMMARY: CRYSTALLOID – 800; COLLOID – Ø; BLOOD – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 85 (KG) LB

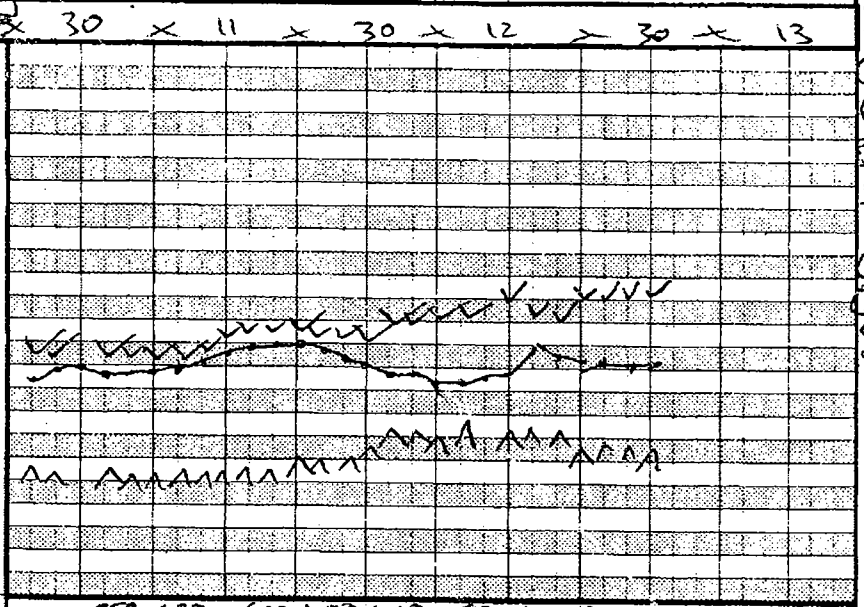
HEMATOCRIT: 37.2

INITIAL DATA: BP – 103/54; HR – 102

BOHP CHECK: OK? (Y) N

PATIENT BRONCH: OK for PROCEDURE? TIME – 1010

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



VT – ml		550	600	600	600	600	180	300	340	350
f – breaths/min		10	10	10	10	10	24	16	14	14
Peak inf pres / PEEP		28	30	28	27	29	—			
MODE – S(pon), A(ssist), C(on)		S	C	C	C	C	C	S	S	S
✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	38	38	34	32	31	40	48	35
BP / oth	✓ FIO2 (Frac or %)	0.86	0.86	0.87	0.87	0.87	0.87	0.87	.87	.87
ART line	✓ SpO2 (%)	99	99	99	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site									
	N-M Block (T/4)	2/4	2/4	3/4	3/4	4/4	4/4			
Warming blkt										
Conv warmer										

LTC [redacted] 66-2 YES

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

REMARKS – Code drugs with numbers, events with letters

Pt & chart ✓. OK to proceed.
① To room, SOC monitors, preO2.
② Smooth IV ⅛.
③ 7F triple lumen placed via Seldinger technique to rt IJ. Unused ports flushed c heparinized saline. EJ removed.
④ Lasix 10mg IV PSR.
⑤ Responds to commands, suck & extub, to recovery stable.

RECOVERY AT: PACU (ICU) 3 (Specify) OTHER

CONDITION: RESP – 21 SpO2 – 94; BP – 133/72 HR – 104

ANES / PROC TIMES

	Start	Room	End
ANES	1010	1020	1250
	Ready	Begin	End
PROC	1025	1100	1230

PROCEDURES and CPT Codes: ① Excision/debridement 10% BSA burns ② Burn Dsg Δ ③ Central line

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA 8.0 ETT 4 mac 2 3um @ teeth

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped DLX1 5 trauma, ⊕ ETCO2, BJEB, Secured c tape.

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

[redacted] – 66-4

[redacted]

47yo ASA 2 (asthma

SURGEON [redacted]

ANESTHE[redacted] MAJ, CRNA 7/6/03

66-2

PROCEDURE LOCATION: 1-1

STHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

ASA Physical State 1 (2) 3 4 5 E
WT: 85 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

OSED PROCEDURE: Debride/STSG burn
ICAL SERVICE: GS
INCE: 2400

S:
ACCO: (+)
ETOH: Ø
RUGS: Ø

ENT MEDICATIONS:
dered as premed

Lovenox
Prevantil
Levaavin

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

RATORY STUDIES:
T: 11.9 , 37.2
R:

4.1 | 0.9 | 27 | 100/102

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension (N) Y
- Angina (N) Y
- MI (N) Y
- CVA (N) Y
- Other N (Y) LLE DVT

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

Renal System:
- Acute/Chronic RF N (Y) Foley

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

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

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

Gynecological :
- Pregnancy (N) Y

Other Significant Hx:
- N (Y) 10% BSA burns
- N (Y) Signif generalized edema

Familial HX (N) Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Ø PSHx

PHYSICAL EXAMINATION

BP 114/62 HR 93 R 12 T ____
Pain Scale 0-10 2
HEENT - Teeth Solid
Trachea ML
TMJ/Neck MPI
Oropharynx FROM
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: 2T RFA 20g
Ulnar Filling:
BACK: N/A
OTHER: N/A

NPO Since 2400

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

Some english, counselled for GA

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

ntien[redacted]ms to understand and agrees. Questions answered.
1: [redacted] MAS, CRNA Date: 7/6/03 Time: 0845 Hrs

ANESTHESIA EVALUA[redacted]NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER
b6-2

1: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) SW3

[redacted] — b6-4

[redacted]

SEDATION KEY:

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

STHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

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

OSED PROCEDURE: Dressing D
ICAL SERVICE: ____
INCE: MN

S: 2/day
ACCO: ____
ETOH: ____
RUGS: Ø

ENT MEDICATIONS:
dered as premed

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

RATORY STUDIES:
T: 10 , 32
R: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 106/68 HR 112 R 19 T ____
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: S1 S2 ST Ø ectopy
EXTREMITIES:
IV Access: (PO) IJ
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

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

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

[redacted] 06-2 n seems to understand and agrees. Questions answered.

t: [redacted] LV/RN Date: 7/1/03 Time: 1030 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

t: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) ____

[redacted] 06-4

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS / FLUIDS — CONTINUOUS / REPEATED DRUGS; SPECIFY UNITS – MG / MCG / ML; (* = CONSTANT INFUSION)

DRUG	(Units)				TOTALS
Versed	(1mg/a)	3	1		7
Ketamine	(10mg/a)	3	1 2		80
fent	(25mg/a)	4	2		200
	( )				
	( )				
	( )				

VOLAT AGENT — % del / % e.t.
AIR L/Min
N2O L/Min
O2 L/Min

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

LINE site — ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE –

TOTAL EBL / TOTAL URINE

FLUIDS SUMMARY
CRYSTALLOID– LR 200
COLLOID– Ø
BLOOD– Ø

REMARKS — Code drugs with numbers, events with letters

.2 mg robinul given

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 80 KG / LB

HEMATOCRIT:

INITIAL DATA: BP – 122, 62; HR – 98

EQUIP CHECK: OK?– Y (N)

PATIENT READINESS: OK for PROCEDURE? Y; TIME – 0650

TIME → 45 0700 15 30 45 0800 15 30 45 0900 15 30

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

Scale: 220 200 180 160 140 120 100 80 60 40 20

VT – ml											
f – breaths/min	12	10	10	12	14	10 15	10	18	12 15	16	
Peak inf pres / PEEP		NRB									
MODE – S(pon), A(ssist), C(on)	RA	RA	NRB →						RA		
ET CO2 (torr)											
FIO2 (Frac or %)											
SpO2 (%)	97	96	99 100	100	100	100	100	100 100	100		
ECG	ST	ST									
TEMP – site											
N-M Block (T/4)											

MONITORS: BP/Auto Cuff; BP / oth; ART line; Steth: PC/ES; Gas analyzer; Warming blkt; Conv. warmer

Mark with letters & symbols; explain under REMARKS — EVENTS: pre, legs, arms, buttocks back; Position →

RECOVERY AT: PACU / ICU → (Specify); OTHER
CONDITION – RESP 14; SpO2 – 97 RA; BP 131/78; HR 105

ANESTHESIA AND PROCEDURE TIMES

	Start	Room	End
ANES	0702	0702	0850

	Ready	Begin	End
PROC	0705	0705	0815

PROCEDURES and CPT Codes: dressing changed

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — versed, fent, Ketamine

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted] 86-4

SURGEONS:

ANESTHETISTS:

PROCEDURE LOCATION: ICU3

DATE: 8 Jul 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED Jan 99
MEDCOM - 13284

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

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 47 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: dressing Δ
SURGICAL SERVICE:
NPO SINCE: MN

ASA Physical State 1 2 (3) 4 5 E
WT: 8 KG/LB HT: ____ IN.
ALLERGIES: Ø

HABITS:
TOBACCO: 2 ppd
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) percocet
( ) MSO4 prn
( ) versed prn
( ) lasix
( ) lovenox
( ) prevacid

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

LABORATORY STUDIES:
HB/HCT: 9.3 , 30.1
U/A: Ø
OTHER: K=3.3

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 122/62 HR 97 R 12 T 97.8
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA bil
CARDIAC: S1 S2 NSR ø rub/gallop
EXTREMITIES:
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

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

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

The p[redacted] seems to understand and agrees. Questions answered.
Signed: [redacted] LCT/RN Date: 8 JUL 03 Time: 0655 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU 3

[redacted]

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)
Fent	25 mcg/cc
Ketamine	10 mg/cc
Versed	1 mg/cc
	( )
	( )
	( )
VOLAT AGENT	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

FLUIDS

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES — EST BLOOD LOSS — URINE –

TOTALS	TOTAL FLUID
350	
100	
5	TOTAL URINE
1	

FLUIDS – SUMMARY

CRYSTALLOID–

COLLOID–

BLOOD–

REMARKS–

Code drugs with numbers, events with letters

.2 mg ~~Phg~~ Robinul

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 85 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP 106/58 HR– 112

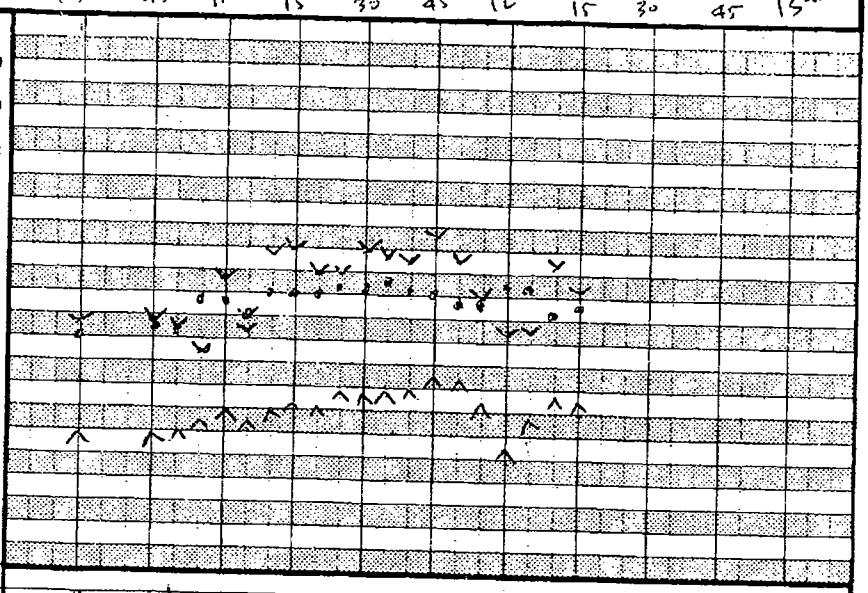
BOHP CHECK: OK?– (Y) N

PATIENT IDENTITY: OK for PROCEDURE? ✓ TIME– 1030

TIME → 1030 · 45 11:00 15 30 45 12:00 15 30 45 13:00

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

220 200 180 160 140 120 100 80 60 40 20



VENTILATION: VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE– S(pon), A(ssist), C(on)

f: 18 12 16 10 21 20 12 10 13 12 20 12 16 17 24

MODE: RA NRB → 12A NRB

MONITORS & ACCESSORIES

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

SpO2: 93 99 99 97 97 97 99 98 99 99 99 99 99 95 100

ECG: ST

RECOVERY AT

PACU ICU III (Specify)

OTHER

CONDITION:

RESP– 20 SpO2– 96 RA

BP– 123/73 HR– 119

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → Start hands feet legs ob on side

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Versed, fent, Ketamine

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SURGEONS:

ANESTHETISTS:

PROCEDURE LOCATION

[redacted] b6-4

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)
Robinul ( )	6
Versed 1mg/cc ( )	2 2 1 1 1
Fentanyl 75mcg/cc ( )	2 1 1 1 1 2 2
Ketamine 10mg/cc ( )	1 2 1 1 1 1
O ( )	
( )	

VOLAT AGENT: % del / % e.t.

AIR L/Min

N2O L/Min

O2 L/Min

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

FLUIDS

LINE site ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE –

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 85 (KG) LB

HEMATOCRIT 31

INITIAL DATA BP – 116/64 HR – 110

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME – 0700

TIME →

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

Resp rate

BP (transduced)

TOURNIQUET T – ✗

ANES – X-X

PROC – ⊙ – Ø

220 200 180 160 140 120 100 80 60 40 20

VENTS

VT – ml

f – breaths/min

Peak inf pres / PEEP

MODE – S(pon), A(ssist), C(on)

MONITORS / ACCESSORIES

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

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

TOTALS — TOTAL EIN: 7mg; 250mcg; 80mg — TOTAL URINE

FLUIDS – SUMMARY

CRYSTALLOID – 200

COLLOID –

BLOOD –

REMARKS – Code drugs with numbers, events with letters

- Anesthesia Start 0905
- Procedure 0910
- End 1015

RECOVERY AT

PACU ICU_____ (Specify)

OTHER_____

CONDITION:

RESP – SpO2 –

BP – HR –

TIMES – THERAPY / PROCEDURE TIMES

	Start	Room	End
ANES	0905		0940
	Ready	Begin	End
PROC	0910		1015

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

SURGEONS:

ANESTHETISTS: [redacted] certified [redacted] conscious sedation

PROCEDURE LOCATION ICU3

DATE 09Jul03

PAGE OF

[redacted] 66-4

66-2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10085

S/P Skin graft to heels ASA II ? HX RAD NKA

b6 (BSTA, HRRRCOM @ PIV 18g

Fent Patch / Incoctt [redacted] pm 107/64-66-.. SO2 98% T. 98?

10/7/03 GETA [redacted]

b6-2

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
Fentanyl	(mg)	50	100				50						
Propofol	(mg)		200										
SUX	(mg)		100										
ROC	(mg)			20									
	( )												
	( )												
VOLAT AGENT ISO	% del	1.5	2.0	1.5	1.2	1.0							
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	6	2	2	2	2	10						

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

FLUIDS

LINE site												
20g RFA	☐ Warmed	RL	500	700								
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
200	min
	TOTAL URINE
	None

FLUIDS - SUMMARY

CRYSTALLOID- 700

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

1. Robinul 0.2 & phenergan 12.5 mg IV.
2. To room via litter, SOR moms, preO2
3. I&S on litter.
4. Pt turned prone to bed.
5. Suctioned & extubated pt turning supine to litter. To PACU stable.

RAD

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 36.2

INITIAL DATA: BP- 134/73 HR- 91

EQUIP CHECK OK? - Y N

PATIENT RECHECK OK for PROCEDURE Y TIME- 1545

TIME → 16 30 17 30

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

VENTIL

VT - ml		700	700	710	500
f - breaths/min		10	10	10	10
Peak inf pres / PEEP		14	17	16	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40	42	36	36	
BP/oth	FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.6
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	SR	ST	ST	SR	SR
Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Arms tucked all pressure points padded, pillow under face, foam pillow under face

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

RECOVERY AT 1700

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2- 99

BP- 122/77 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1545	1550	1710
	Ready	Begin	End
PROC	1600	1610	1655

PROCEDURES and CPT Codes: Close Buttocks Wounds

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Esophageal, DL x1 3 trauma, ⊕ETCO2, BVEB. Secured benzoin & tape, 23 cm @ teeth 3 Miller 8.0 ETT

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

[redacted] - Wd / 2A

-b6-4

[redacted]

SURGEONS: [redacted]

[redacted] ETIST: [redacted] -b6-2

MAJ, CRNA

PROCEDURE LOCATION: 2-2

DATE: 10/7/03

PAGE 1 OF

ITHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

__ DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 (3) 4 5 E
WT: 55 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

)SED PROCEDURE: conscious sedation for drsg Δ.
CAL SERVICE: -
INCE: ____

S:
CCO: 2 pack/day
ETOH: ____
RUGS: ____

NT MEDICATIONS:
lered as premed

Vancomycin
Levaquin
Levefloxacin
Albuterol
LR

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 9.7 / 30.5

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
conscious sedation & wound debridement

PHYSICAL EXAMINATION
BP 106/68 HR 111 R 14 T 100.3 94%
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea Midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: Equal expansion.
CARDIAC: ____
EXTREMITIES: ____
IV Access: (R) IJ CVC
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

'HETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): conscious sedation. { } General: Mask Intubation

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

ient/legal guardian seems to understand and agrees. Questions answered.

____ Date: ____ Time: ____ Hrs

NESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

Identification: (Ward) ICU 3

#[redacted] b6-4

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I" = CONSTANT INFUSION			
DRUG	(Units)		TOTALS
MSO4	(mg)	5 5	10mg
Versed	(mg)	2.5 2.5	10mg
Ketamine	(mg)	50 50	100mg
Propofol	( )	210 210 70 50 50 40 20	180mg
Fent	( )	25 25 25 25 25 25	
	( )		
VOLAT AGENT	% del		
	% e.t.		
AIR RA	L/Min		
N2O	L/Min		
O2 MASK	L/Min		

TOTAL FLUID

TOTAL URINE

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

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

FLUIDS – SUMMARY
CRYSTALLOID– 300 LR
COLLOID– Ø
BLOOD– Ø

REMARKS – Code drugs with numbers, even with letters

IV Sed for dressing Δ. Chart reviewed ST, KKK see Pre-op 105 ulcy –

@ 2230 Dressing Δ complete. Pt responding to voice commands, USS. ICU nurse @ bedside

Fentanyl 100mg

PATIENT STATUS: (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BLOOD CHECK

TOURNIQUET CHECK

TIME → 21 X 30 X 22 X 30 X 23

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

	21	30	22	30	23	
VT – ml	SV	SV	SV	SV	SV	SV
f – breaths/min	16	16	13	12	12	13
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)						
BP/Auto Cuff / ET CO2 (torr)						
BP / oth / FIO2 (Frac or %)	.21	.21	.21	.21	.21	.21
ART line / SpO2 (%)	94	98	97	96	98	96
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP- site						
N-M Block (T/4)						
Warming blkt						
Conv warmer						

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

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

	TIMES		
ANES	Start	Room	End
	2055		2230
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Dressing Δ

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: IV Sedation Spont Resp

AIRWAY MANAGEMENT: Intubation route, blade, technique, complications

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

SURGEONS: [redacted]

ANESTHET[redacted] CRNA

PROCEDURE LOCATION: ICU 3

DATE: 7/10/03

PAGE 1 OF 1

[redacted] b6-4

[redacted]

b6-2

PATIENT RECORD

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99

U.S. GPO: 1999 – 528-336/10

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. ↑ = CONSTANT INFUSION

DRUG	(Units)
Fentanyl	(ml) (5)
propofol	( ) 100 50
Rapacuron	( ) 30 30
Lidocaine	(%) 80
	( )
	( )

ISOLAT AGENT: Forane — % del / % e.t.
AIR L/Min
N2O L/Min
O2 L/Min

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: propofol 150 mg IV x 1

LINE site: LR, UK, PRA — Warmed

EST BLOOD LOSS: 400
URINE –

TIME: 0550 x 50 x 0600 x 10 x 30 x 45 0800 15 30 45

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

TOTALS: TOTAL EBL 450; TOTAL URINE 175

FLUIDS – SUMMARY: CRYSTALLOID– 1100 (LR 500 NS); COLLOID–; BLOOD– 2 units PRBCs

REMARKS – Code drugs with numbers, event with letters: 0.6 cc; 2 mg versed

0715 Albritton Relief
0720 Replaced ETT 2° BP cuff
0725 Unit #2 PRBCs ↑ 119/40 109
0745 10 mg Morphine / IM
0755 20 mg Lasix / SURG REQ
0813 Suction Agreed to Extub

VT – ml	750	940	850	600	420	320	840			
f – breaths/min	10	8	7	7	7	6	6	24	20	
Peak inf pres / PEEP	25	27	22	20	20	21	20			
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S	S	
BP/Auto Cuff / ET CO2 (torr)	35	30	30	30	28	32	33	39	46	
BP / oth / FIO2 (Frac or %)	.87	.87	.87	.86	.86	.85	.85	.85	.88	
ART line / SpO2 (%)	100	100	96	100	100	100	100	100	100	
Steth. PC/ES / ECG	ST	ST	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer / TEMP- site			36.5					36.1		
H-M Block (T/4)										
Warming blkt										
Conv warmer										

Report to [redacted] b6-2

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

RECOVERY AT: PACU ICU 3 (Specif) OTHER
CONDITION: STABLE Room Air
RESP– 16 SpO2– 93%
BP– 129/72 HR– 118

ANES	Start	Room	End
	0550	0610	0830
PROC	Ready	Begin	End
	0625	0648	0807

PROCEDURES and CPT Codes: Debridement burns

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA (+ wheezing Exp Bilat)

AIRWAY MANAGEMENT: Intubation route, blade, technique, confirmation: SIVI, DVOI x1 atraumatic, cuff T, BS = BS

SURGEONS: [redacted]

ANESTHETIST: [redacted] CRNA

PROCEDURE LOCATION: OR #1

DATE: 16 Jul 03

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

[redacted] b6-4 ICU-3 / ICU-3

b6-2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PAGE 1 OF 1

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10

ANESTHESIA PLAN OF CARE PR[illegible] [illegible]OCEDURAL ASSESSMENT (Sedation, [illegible]esthesia)

Age 4 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: wound debridement
SURGICAL SERVICE: GS
NPO SINCE:

HABITS:
TOBACCO: (+)
ETOH: (+)
DRUGS: ∅

CURRENT MEDICATIONS:
( ) = ordered as premed

() Vancomycin 1Gm Q12
() prometril MDP
() Levenox 90mg SQ BID
() Levaquin 500mg IV QD
() Lasix 10mg IV ∅
() KCL 40mEq IVX1

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

LABORATORY STUDIES:
HB/HCT: ∅ , 28
U/A:
OTHER:

T&C - 2uPRBC 9ful

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
Acute/Chronic RF N Y Foley

Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y Robaoff tube feeding off @ 2200

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

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological :
Pregnancy N Y N/A

Other Significant Hx:
N Y
N Y

Familial HX N Y DVT, Burn

ASSESSMENT
PAST SURGICAL/ANESTHETIC
None known
pt. dentist
? understands

PHYSICAL EXAMINATION
BP 119/6 HR 105 R 16 T 99 SpO2 97% RA
Pain Scale 0-10
HEENT - Teeth Chipped central Incis
Trachea poor dentition
TMJ/Neck 3FB
Oropharynx grade III-IV
Nares
CHEST: scattered ronchi
bases bilat
CARDIAC: S1S2 ; (M) ⅋ Mr
EXTREMITIES:
IV Access: (R) EJ
Ulnar Filling:
BACK:
OTHER:

NPO Since 2200

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): [redacted] { } General: Mask Intubation
Premedicate Chart Patient [redacted] MA 5 CRNA

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

The patient/legal guardian seems to understand and agrees. Questions answered. b6-2
Signed: ____ Date: 10 Jul 03 Time: 0030 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward)

[redacted] (ICU3) b6-4
[redacted]

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS & DRUGS — CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS – MG / MCG / ML. "|" = CONSTANT INFUSION

DRUG	Units	Doses	TOTALS
Fentanyl 25mcg/cc	( )	2 1 1 1 2 1 3	250mcg
Ketamine 10mg/ml	( )	1 1 2 1 1 1 1 1 1	100mg
Versed 1mg/ml	( )	3 2 1 1	7mg
	( )		
	( )		
Robinul .2mg	( )		.2mg
VOLAT AGENT	% del		
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min		

TOTAL EBL — TOTAL URINE

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

FLUIDS — LINE site — ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES — EST BLOOD LOSS — URINE —

FLUIDS – SUMMARY
CRYSTALLOID– 150
COLLOID–
BLOOD–

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 85 (KG) LB

HEMATOCRIT 30.

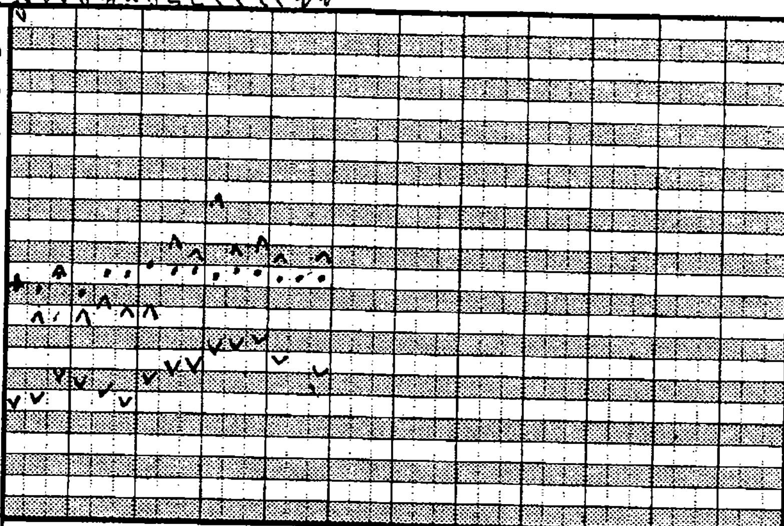
INITIAL DATA:
BP – 117 / 57
HR – 111

EQUIP CHECK OK?– (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME– 0750

TIME → 0915, 20, 25, 0930, 35, 40, 0945, 50, 55, 1000, 1005, 10, 1015, 20, 25

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



REMARKS– Code drugs with numbers, events with letters

- Anesthesia Start 0910
- Procedure start 0915
- Procedure stop 1010

No complications

VT – ml	
f – breaths/min	31 17 12 25 20 23 20 25 14 20 18 15 16 16
SpO2 ~~Peak insp pres / PEEP~~	99 99 100 100 100 100 100 100 100 100 99 98 98 92
MODE– S(pon), A(ssist), C(on)	RA RA NRB NRB NRB NRB NR NRB

MONITORS & EQUIPMENT
(BP/Auto Cuff) — ET CO2 (torr)
BP / oth — FIO2 (Frac or %)
ART line — SpO2 (%)
Steth– PC/ES — ECG
Gas analyzer — TEMP– site
N-M Block (T/4)
Warming blkt
Conv warmer

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

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

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0910		0955
	Ready	**Begin**	**End**
PROC	0915		1010

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted] 66-4

SURGEONS:

ANESTHETISTS: conscious sedation certified
[redacted]

PROCEDURE LOCATION ICU 3
DATE 11July03
PAGE OF

MEDICAL RECORD – ANESTHESIA

66-2 WAMC OP 376 REVISED 1 ?-n 99

MEDCOM - 13293

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

IESTHESIA PLAN OF CARE P. OCEDURAL ASSESSMENT (Sedation, thesia)

ie ___ DAYS MOS YRS Sex (X) MALE ( ) FEMALE

OPOSED PROCEDURE: Dressing Δ
RGICAL SERVICE: ___
D SINCE: mn

ASA Physical State 1 2 (3) 4 5 E
WT: 80 KG/LB HT: ___ IN.
ALLERGIES: NKA

BITS:
OBACCO: ___
ETOH: ___
DRUGS: ___

RRENT MEDICATIONS:
: ordered as premed
Vancomycin 1g BID
Fentanyl patch
Levenox
Albuterol
Cipro

MEDICATIONS:
es (@ ___ Hrs) /CC
___ mg IV IM PO
Fentanyl patch ___ mg IV IM PO 50mcg/hr
___ . ___ mg IV IM PO

BORATORY STUDIES:
HCT: 9 / 28.4
: ___
HER: ___

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
wound dehiscence

PHYSICAL EXAMINATION
BP 115/59 HR 104 R 15 T 98.7
Pain Scale 0-10 8
HEENT - Teeth intact
Trachea midline
TMJ/Neck ___
Oropharnyx ___
Nares ___
CHEST: C
CARDIAC: ST ∅ ectopy
EXTREMITIES: ___
IV Access: (R) IJ CVC
Ulnar Filling: ___
BACK: ___
OTHER: ___

NPO Since ___

IESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ___ ( ) General: Mask Intubation
Conscious sedation

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

pati[redacted] seems to understand and agrees. Questions answered.
ned: [redacted] Date: ___ Time: 0700 Hrs

ST-ANE[redacted]VALUATION AND NOTE (NON ASU)
NO APP[redacted]ESTHETIC COMPLICATIONS ( ) OTHER

ned: ___ Date: ___ Time: ___ Hrs

ient Identification: (Ward) 1cw3

[redacted]

SEDATION KEY:

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

MEDICAL RECORD - ANESTHESIA

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

Pre Op Robinul 0.2mg

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

DRUG	(Units)	0800	30	45	0900	15	30	45	1000
MIDAZ	(mg)	5							
FENT	(mcg)	50 50	50	25					
KETAMINE	(mg)	50/50/50/20/20/100							
	( )								
	( )								
	( )								
VOLAT AGENT	% del								
	% e.t.								
AIR	L/Min								
N2O	L/Min								
MASK O2	L/Min								

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

TOTALS	TOTAL EBL
5mg	MIN
175mcg	
300mg	
	TOTAL URINE
	NA

FLUIDS - SUMMARY

CRYSTALLOID- 400 LR

COLLOID-

BLOOD-

FLUIDS

LINE site			0800	30	45	0900	15	30	45	1000
(R) IJ/3	☐ Warmed		LR, →							
	☐ Warmed									
	☐ Warmed									
	☐ Warmed									

LOSSES

EST BLOOD LOSS										
URINE -										

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

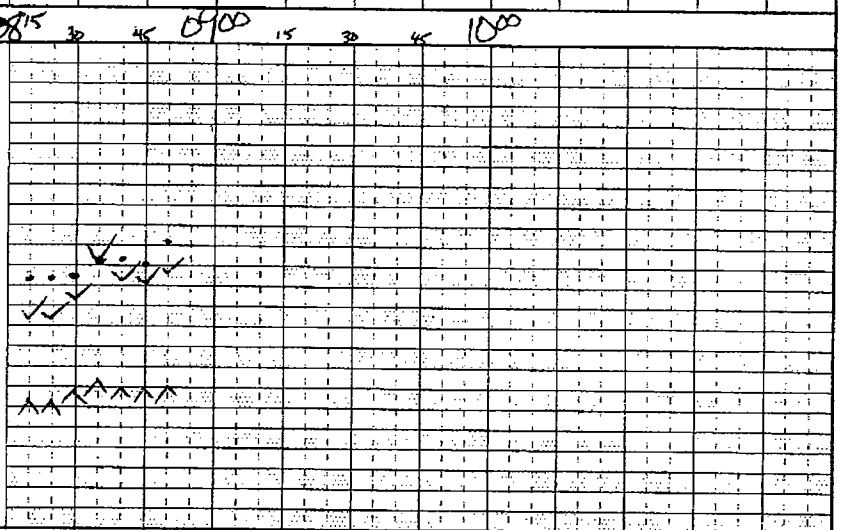
INITIAL DATA: BP- 102/63 HR- 123

EQUIP CHECK (OK?) Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME 0815 30 45 0900 15 30 45 1000

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



VENTIL

	0800	30	45	0900
VT - ml				
f - breaths/min	16	20	12	12
Peak inf pres / PEEP				
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)				
BP/oth	FIO2 (Frac or %)	>.21			
ART line	SpO2 (%)	98	98	100	
Steth- PC/ES	ECG	ST			
Gas analyzer	TEMP-site	AVRIL →			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

REMARKS

Code drugs with numbers, events with letters

0800 Pre Op Eval Review, NPO.

0815 OR #2 monitors ↑ Mask O_2

Report to [redacted] b6-2 LT

RECOVERY AT

PACU (CU 3) (Specify)

OTHER

CONDITION: STABLE

RESP- 16 O_2/mask SpO2- 99

BP- 119/59 HR- 131

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0815	0910
	Ready	Begin	End
PROC	0820	0825	0855

PROCEDURES and CPT Codes: Burn WD Debridement & Dsg Δ.

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

[redacted] b6-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

SED

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

MASK O_2

SURGEONS: [redacted] b6-2

ANESTHETIS[redacted]

PROCEDURE LOCATION: OR #2

DATE: 13 JULY 03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PRE EDURAL ASSESSMENT (Sedation/ Anesthesia)

Age 47 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: WD DEBRIDEMENT / DSG Δ
SURGICAL SERVICE:
NPO SINCE:

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

HABITS:
TOBACCO: Smoker
ETOH: yes
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ket
( ) Fent
( ) Versed
( ) Lovenox
( ) Albuterol
( ) Ciprofloxin

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

LABORATORY STUDIES:

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
DEBRIDEMENT &
DSG Δ

PHYSICAL EXAMINATION
BP 107/55 HR 107 R 16 T ____
Pain Scale 0-10 ____
HEENT - Teeth Chipped & Poor Dent
Trachea
TMJ/Neck 3+
Oropharnyx MP 2+
Nares
CHEST:
CARDIAC:
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

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

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

The patie[redacted] 66-2 [redacted]nderstand and agrees. Questions answered.
Signed: [redacted] Date: 13 July 03 Time: 0800 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] 66-4
[redacted]

ICU3 / ICU3

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)					
Ketamine	(10 mg/cc)	5	2 1	1	2	
Fentanyl	(mcg)	41		2	2	
Versed	(mg)	42		2		

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML; ** = CONSTANT INFUSION

INHALAT AGENT: % del / % e.t.

AIR L/Min
N2O L/Min
O2 L/Min

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

LINE site — Warmed / Warmed / Warmed / Warmed

DOSES — EST BLOOD LOSS / URINE –

TIME → 45 8:00 15 30 45 9:00 15 30 45

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

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

VT – ml																							
f – breaths/min	18	18	18	20	18	15	14	12	12	16	18	20	22										
Peak inf pres / PEEP																							
MODE– S(pont), A(ssist), C(on)	S	S	S	S	S	S	S	S	S	S	S	S	S										
BP/Auto Cuff																							
BP / otb																							
ART line																							
Stethe PC/ES																							
Gas analyzer																							
Warming blkt																							
Conv warmer																							

ET CO2 (torr)
FIO2 (Frac or %) NRB
SpO2 (%) 96 100 100 100 100 100 100 100 100 100
ECG ST ST
TEMP- site
N-M Block (T/4)

Mark with letters & symbols, explain under REMARKS. EVENTS / Position — legs arms tm

TOTALS: 120 / 100 / 8 — TOTAL FLUID: Ø — TOTAL URINE

FLUIDS SUMMARY: CRYSTALLOID– 100 / COLLOID– / BLOOD–

REMARKS – Code drugs with numbers, even with letters

Robinul .2 mg
Pt recovered e ICU 3
Ø complications

RECOVERY AT: PACU ICU 3 (Specify) / OTHER / CONDITION:
RESP– 18 SpO2– 99 on NRB
BP– 128/68 HR– 124

	Start	Room	End
ANES	0750	0750	0900
PROC	Ready 0755	Begin 0755	End 0900

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES – Describe block technique under Remarks: Versed, fentanyl, ketamine

AIRWAY MANAGEMENT: Intubation / tube, blade, technique, comm...

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

SURGEONS: bb-2

ANESTHESIOLOGIST: LT [redacted] RN

PROCEDURE LOCATION: ICU 3
DATE: 14 Jul
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99

U.S. GPO 1999 – 528 336/10

[redacted] bb-4

PATIENT RECORD

MEDCOM - 13297

IESTHESIA PLAN OF CARE PR OCEDURAL ASSESSMENT (Sedation/A thesia)

? ie 4 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

OPOSED PROCEDURE: drsy D
RGICAL SERVICE:
O SINCE: 0700

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

BITS:
OBACCO: Ø 2ppd
ETOH: Ø
DRUGS:

RRENT MEDICATIONS:
= ordered as premed

Vanc
CIPRO
Percocet pm
Tylenol
Albuterol

EMEDICATIONS: none
ne Yes (@ ____ Hrs) /CC
___ . ____ mg IV IM PO
___ . ____ mg IV IM PO
___ . ____ mg IV IM PO

BORATORY STUDIES:
HCT: 87 , 27.8
:
HER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
- Acute/Chronic RF (N) (Y)

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

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

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

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR 105 R 18 T 99 S
Pain Scale 0-10 0
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA bil
CARDIAC: ST S1S2
EXTREMITIES:
IV Access: (P) SC
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

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

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

: patie[redacted]eems to understand and agrees. Questions answered.
ned: [redacted] ICU/pm Date: 14 Jul 03 Time: 0700 Hrs

ST-ANE[redacted]UATION AND NOTE (NON ASU)
NO APPA[redacted]NT ANESTHETIC COMPLICATIONS { } OTHER

ned: ____ Date: ____ Time: ____ Hrs

ient Identification: (Ward) ICU

SEDATION KEY:

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

[redacted]

45/MALE - NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
MIDAZ	(mg)	5											
FENT	(mcg)	100	50										
PROPOFOL	(mg)	150											
	( )												
MS04	( )			5		5					5	5	
SUCC	(mg)	100											
VOLAT AGENT — FORANE	% del	2	4	2					1.5		1	X	
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	4	2	4									

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

FLUIDS

LINE site												
(R) IJ 3L	☐ Warmed	LR										
	☒ Warmed			1000				4N				
	☐ Warmed				PRBC				XXXXXXXX			
	☐ Warmed											

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 kg

HEMATOCRIT:

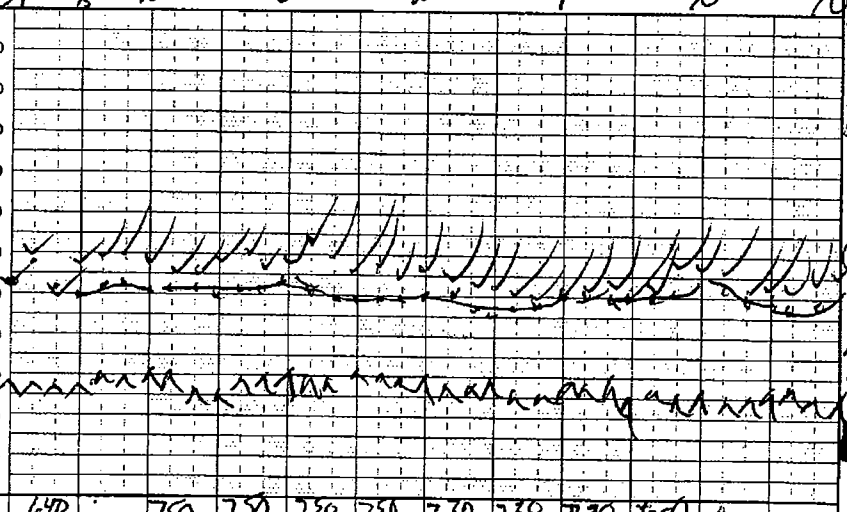
INITIAL DATA: BP- 104/67; HR- 104

EQUIP CHECK: (OK?) Y N

PATIENT RECHECK: OK for PROCEDURE? TIME- 0658

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

TIME → 7:00, 15, 30, 8, 30, 9, 30, 10



VENTIL

VT - ml	640		750	750	750	750	730	730	730	700		
f - breaths/min	12 8	12	8	8	8	8	8	8	8	8		
Peak inf pres / PEEP	23		26	27	27	27	27	27	27	30		
MODE - S(pon), A(assist), C(on)	S C	A	C	C	C	C	C	C	C	A	S/	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40	46	40	38	40	29	34	29	23	38	38	
BP/oth	FIO2 (Frac or %)	.82	.18	.83	.87	.87	.87	.8	.8	.8	.8	.8	.9
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site other AVAIL		34	34	34	34	34	34	34	34	34	34	33
	N-M Block (T/4)	4/4	4/4	4/4									
Warming blkt													
Conv warmer													

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

TOTALS: TOTAL EBL 50cc; 250cc; 150cc; TOTAL URINE 300cc

FLUIDS SUMMARY: CRYSTALLOID 2/R 1350; COLLOID-; BLOOD- PRBC 2 u

REMARKS

Code drugs with numbers, events with letters

0645 PreOp EVAL REVIEW. (R) IJ 3L → LR

0657 OR #2 MONITORS ↑ PreO2 IND/INT Robinul 1.0 [redacted] @ 0735

0855 - PRBC (B+)

1860465

0805 - PRBC (O+) [redacted]

4824472

HCT - 30.2 @ 9

Lasix 20 x 1 @ 0935 [redacted]

0948 To ICU 3 @ 10cc obe

RECOVERY AT: PACU ICU (3) (Specify); OTHER; CONDITION: RESP 18, SpO2 90, BP 133/82, HR 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0645	0659	:
PROC	Ready 0705	Begin 0735	End 0945

PROCEDURES and CPT Codes: SKIN GRAFT DEBRIDEMENT

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

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

[redacted] b6-4 ICU-3/ICU-3

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DLX1/MAC3, 8.0 ETT → VC ≈ BBSE, ETCO2 (+), EYES TAPED, SECURED 22cm/TEETH

SURGEONS [redacted] — b6-2

PROCEDURE 28 CSA

LOCATION: OR#2

DATE: 15 July 03

PAGE 1 OF

ANESTHESIA PLAN OF CARE PRE. EDURAL ASSESSMENT (Sedation/ thesia)

Age 45 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: Debridement + Graft Burns
SURGICAL SERVICE: _____
NPO SINCE: 24 a

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: _____ IN.
ALLERGIES: 0

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Vanco
( ) Cipro
( ) Lodenoh
( ) Albuterol
( ) _____
( ) _____

PREMEDICATIONS: 0
None Yes (@ _____ Hrs) /CC
_____ . _____ mg IV IM PO
_____ . _____ mg IV IM PO
_____ . _____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 8.7 / 27.8
U/A: _____
OTHER: _____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
_____

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

NPO Since _____

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

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

The patient/legal guardian [redacted] to understand [redacted] agrees. Questions answered.
Signed: [redacted] Date: 18 July 03 Time: 0700 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted] 66-4 ICU-3/ICU-3

SEDATION KEY:

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

Used Dressing Δ

MEDICAL RECORD - ANESTHESIA

For this form, see AR 40-66; the proponent agenc

Chart Reviewed
~~HR 50~~ 100/50 T 100.4
BR 16 HR 108 Sat 98%

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

DRUG (Units)												
Versed (mg)	5	5										
Ketamine (mg)	50	25/25										
MSO4 (mg)	5	5										
Fentanyl (mcg)	25	25 50	50 50	50								
Propofol (mcg)	10<	30>	<70 >	<50>								
( )												
VOLAT AGENT % del												
VOLAT AGENT % e.t.												
AIR L/Min												
N2O L/Min												
O2 NC L/Min	4	4	4	4	4							

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

FLUIDS

LINE site												
LR 1000 ☐ Warmed		100		200								
☐ Warmed												
☐ Warmed												
☐ Warmed												

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT:

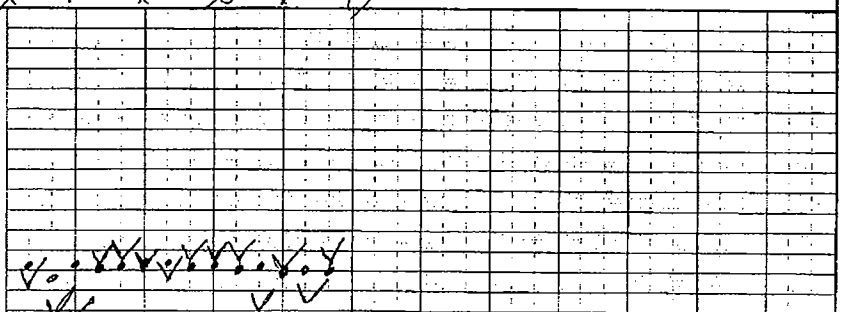
INITIAL DATA: BP- 102/51; HR- 111

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → X 12 X 30 X 13

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



VENTIL

VT - ml	SV	SV	SV	SV	SV
f - breaths/min	24	28	20	21	18
Peak inf pres / PEEP					
MODE - S(pon), A(assist), C(on)					

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)					
BP/oth	FIO2 (Frac or %)	1.21	1.21	1.21	1.21	1.21
ART line	SpO2 (%) NC	98	100	92	96	98
Steth- PC/ES	ECG	SR ~~98~~	~~100~~	SR	SR	SR
Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

TOTALS	TOTAL EBL
10 mg	Ø
100 mg	
10 mg	TOTAL URINE
250 mg	
1100 mg	Ø

FLUIDS SUMMARY
CRYSTALLOID- LR 200
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
TO ICU 3 for Dressing Δ. PH NPO since 0500. monitors on

1245 Dressing Δ complete spont resp & responsive throughout

1255 USS Report given.

RECOVERY AT: ICU3
PACU ICU ____ (Specify)
OTHER ____
CONDITION:
RESP- 16 SpO2- 98
BP- 110/74 HR- 110

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1150		1245
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Burn Dressing Δ

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

ETW [redacted] b6-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SURGEONS: [redacted] b6-2 [redacted] CRNA

PROCEDURE LOCATION: ICU 3
DATE: 7/16/03
PAGE / OF /

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

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)	Doses	TOTALS
KETAmine (10mg/cc)	50 30 20	100
fentanyl 25mcg/cc	125 50 75 25	275
Versed 1mg/cc	5 2 1	8
MSO4	2	2
VOLAT AGENT % del / % e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min		

TOTAL FLUIDS: 6

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 50
COLLOID–
BLOOD–

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

FLUIDS: LINE site ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES: EST BLOOD LOSS / URINE –

REMARKS–
Code drugs with numbers, events with letters
.2 mg Robinul
– monitors on
– ∅ complications

PHYS STATUS: 1 2 (3) 4 5 E

TIME ➡ 45 | 8⁰⁰ | 15 | 30 | 45 | 9⁰⁰ | 15 | 30 | 45 | 10⁰⁰

BODY WEIGHT: 80 (KG) LB

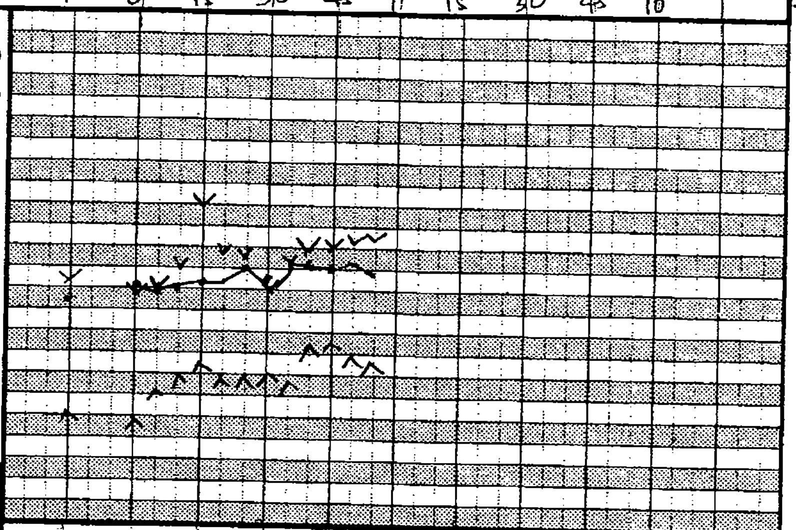
HEMATOCRIT: 35

INITIAL DATA: BP – 105/55, HR – 107

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y, TIME– 0746

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



VENTILATION:

VT – ml				
f – breaths/min	16	12 19	20 30 10 / 12 20	18 19
Peak inf pres / PEEP				
MODE– S(pon), A(ssist), C(on)	S	S S	S	

MONITORS AND EQUIPMENT: BP/Auto Cuff, BP / oth, ART line, Steth- PC/ES, Gas analyzer, Warming blkt, Conv warmer

ET CO2 (torr)			
FIO2 (Frac or %)	RA	NPB ———→	RA
SpO2 (%)	RA	95 97 99 98 96 96 94	94
ECG	ST	ST	ST
TEMP- site			
N-M Block (T/4)			

Mark with letters & symbols, explain under REMARKS
EVENTS: start | drs | turn
Position ⟶ legs

RECOVERY AT: PACU ICU 3 (Specify)
OTHER
CONDITION: stable, awake
RESP– 14 SpO2– 94 RA
BP– 121/69 HR– 117

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0800	0900

	Ready	Begin	End
PROC	0745	0805	0850

PROCEDURES and CPT Codes
dressing change

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
Versed, fentanyl, Ketamine

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

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

[redacted] b6-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] – b6-2

PROCEDURE LOCATION: ICU 3

DATE: 17 Jul 03

PAGE | OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99
PATIENT RECORD
MEDCOM - 13302

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

ANESTHESIA PLAN OF CARE PRE[illegible]CEDURAL ASSESSMENT (Sedation/[illegible]sthesia)

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

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

PROPOSED PROCEDURE: dressing change
SURGICAL SERVICE:
NPO SINCE: 0200

HABITS:
TOBACCO: Y
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) lovenox
( ) 50 mg Demerol patch
( )
( )
( )
( )

PREMEDICATIONS: (0)
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 11 / 35
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 10[illegible] HR 109 R 18 T 100.4
Pain Scale 0-10 4/10
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA dim bases
CARDIAC: S1S2 ST ectopy
EXTREMITIES:
IV Access: (R) SC
Ulnar Filling:
BACK:
OTHER:

NPO Since 0200

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

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

The pa[redacted] b6-2 seems to understand and agrees. Questions answered.
Signed: [redacted] Date: 17 Jul 03 Time: 0745 Hrs

POST-ANES[illegible]ESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] b6-4

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (Continuous / repeated drugs — specify units — MG / MCG / ML, "I" = constant infusion)

DRUG (Units)								TOTALS
Ketamine 10mg/cc	50	20		20 10	30	20	30	180
Fent 25mcg/cc	180		50	30				250
Versed 1mg/cc	5 2			1				8
MSO4 1mg/cc	(5) 3			3	2	2		13
( )								
( )								

VOLAT AGENT % del	
% e.t.	
AIR L/Min	
N2O L/Min	
O2 L/Min	
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	

TOTAL ETI / **TOTAL URINE**

FLUIDS — SUMMARY
- CRYSTALLOID– 100
- COLLOID– Ø
- BLOOD– Ø

FLUIDS: LINE site — ☐ Warmed / ☐ Warmed / ☐ Warmed / ☐ Warmed

LOSSES: EST BLOOD LOSS / URINE –

REMARKS– *Code drugs with numbers, events with letters*

12 mg robinul

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT:

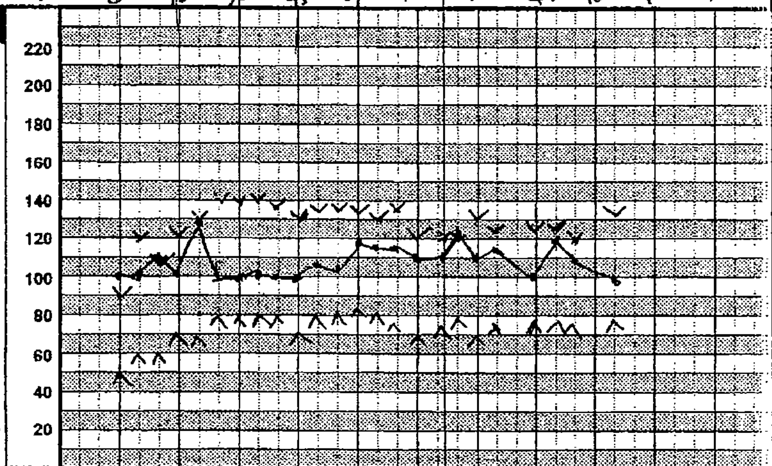
INITIAL DATA: BP– 107, 54 HR– 94

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 0800

TIME → 8^00 15 30 45 9^00 15 30 45 10^00 15 30 45

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



VT – ml	
f – breaths/min	16 14 12 14 14 14 14 14 14 12 12 14 10 12 14 14
Peak inf pres / PEEP	
MODE– S(pon), A(ssist), C(on)	S S S S S S S S S ——

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	
BP / oth	FIO2 (Frac or %)	NRB NC
ART line	SpO2 (%)	99 98 99 99 99 100 100 100 100 100 98 99 100 100 99 100
Steth- PC/ES	ECG	
Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → belly graft, legs graft, hands, legs, roll

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

ANES / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0800	
	Ready	**Begin**	**End**
PROC	0800	0805	

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
Versed, Ketamine, Fent, MSO4

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

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

[redacted] 66-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] RN 66-2

PROCEDURE LOCATION: ICU3

DATE: 18 Jul

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

PAGE 1 OF 1

☆ U.S. GPO: 1999 – 528-336/10085

PATIENT RECORD

MEDICAL RECORD — ANESTHESIA

DRUG	Dose	1	2	3	4	5	6	7	8	9	10	TOTALS
Versed	1mg/cc	8										8
Ketamine	10mg/cc	50	30									50
Fentanyl	25mcg/cc	25	100/50	75								325
MSO4	1mg/cc	4										4
	( )											
	( )											

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

VOLAT AGENT: % del / % e.t.

AIR L/Min
N2O L/Min
O2 L/Min

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

LINE site — Warmed / Warmed / Warmed / Warmed

LOSSES: EST BLOOD LOSS / URINE –

TOTAL EST. / TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 50
COLLOID–
BLOOD–

REMARKS – Code drugs with numbers, events with letters

.2 mg robinul

Ø Complications on PA awake returning in ICU3

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 30.5

INITIAL DATA: BP 114/64 HR– 101

SCRUB CHECK: OK?– Y N

PATIENT MONITOR: OK for PROCEDURE? Y TIME– 0820

TIME → 30 45 9 15 30 45 10

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml												
f – breaths/min	20	16	22	23	25	22	17	14				
Peak inf pres / PEEP												
MODE– S(pon), A(ssist), C(on)	S		S			S	S					
ET CO2 (torr)												
FIO2 (Frac or %)	NB		NB			RA						
SpO2 (%)	99		100		99	100	99	100				
ECG												
TEMP- site												
N-M Block (T/4)												

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS — Position: arms legs trunk abdomen

RECOVERY AT: PACU ICU 103 (Specify) OTHER

CONDITION: RESP– 14 SpO2– 98 RA BP– 130/70 HR– 103

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0825	0825	0930
	Ready	Begin	End
PROC	0825	0830	0915

PROCEDURES and CPT Codes: dressing Δ

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: versed, fentanyl, MSO4, Ketamine

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: b6-2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility: [redacted] b6-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted], RN

PROCEDURE LOCATION: ICU3

DATE: 19 JUL 03

PAGE | OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED n 99

MEDCOM - 13305

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

24
20
00
480
480

480
700
1180
938
2118
50
2168
50
2218

1
480
700
50
1230

938
50

- 2
2329

THESIA PLAN OF CARE PRE. ___ CEDURAL ASSESSMENT (Sedation/A...esthesia)

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

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

)SED PROCEDURE: dressing Δ
CAL SERVICE: ____
INCE: May 0700

:
CCO: 2ppd
ETOH: Ø
IUGS: Ø

INT MEDICATIONS:
lered as premed
feat patch 50 mcg/hr
albuterol
lovenox
7mg MSO4 @ 0700

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 9.5 / 30.5

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
- Acute/Chronic RF (N) Y

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

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

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

Gynecological :
- Pregnancy NA N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
dressing change
debridement
grafting

PHYSICAL EXAMINATION

BP 116/64 HR 111 R 20 T 101.8
Pain Scale 0-10 5
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharynx
Nares
CHEST: CTA c̄ diminished bases
CARDIAC: S1 S2 ST
EXTREMITIES:
IV Access: (2) SC
Ulnar Filling:
BACK:
OTHER:

NPO Since 0700

'HETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

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

[redacted] 66-2
[redacted] n seems to understand and agrees. Questions answered.
[redacted] 17/AN Date: 19 Jul 03 Time: 0748 Hrs

[redacted] A EVALUATION AND NOTE (NON ASU)
AP[redacted] ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

Identification: (Ward) ICU3

[redacted] 66-4

SEDATION KEY:

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

Smoker
57/M NKDA

MEDICAL RECORD - ANESTHESIA

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

Page 1 of 2

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

DRUG	(Units)													
MIDAZ	(mg)	2 3	/											
FENT	(mcg)	100 50	/		150		50 50	/	100	100	50	/		
PROPOFOL	(mg)	200												
LIDO	(mg)	50												
	( )													
	( )													
VOLAT AGENT: ISOFLURANE	% del	3	1.5	1.5	1.5	1.5	1.5	1.5	1.5	0.8	0.5	1.0	1.5	1.5
	% e.t.										1.5			
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8 4	2	2	2	2	2	2	2	2	2	2	2	2

b6-2 [redacted]

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

FLUIDS

LINE site (R) A													
☐ Warmed	LR1				500 LR2							1500 LR3	
☐ Warmed													
☐ Warmed													
☐ Warmed													

LOSSES

EST BLOOD LOSS						50/50							
URINE -									50/50				

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 70 (KG) LB

HEMATOCRIT

INITIAL DATA
BP- 116/70
HR- 98

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 0749

TIME 0745 0800 15 30 45 0900 15 30 45 1000 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		900	890	870	720	690							740	760
f - breaths/min	12	10	10	8	8	8	20	24	20	12	16	16	12 8	8
Peak inf pres / PEEP		30	28	28	27	27							22	22
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	S	S	S	S	S	S	S C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	36	31	30	31	33	33	31	26	38	30	740	800
BP/oth	FIO2 (Frac or %)	.75	.75	.75	.75	.75	.73	.73	.73	.73	.72	.73	.72	.72
ART line	SpO2 (%)	100	99	99	99	100	100	100	94/100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAILABLE →												
	N-M Block (T/4)													
Warming blkt														
Conv warmer														

Report TO [redacted] SPC b6-2

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

TOTALS 5mg / 1000mcg

TOTAL EBL 50

TOTAL URINE 100

FLUIDS SUMMARY
CRYSTALLOID- 2000 LR
COLLOID-
BLOOD-

REMARKS
Code drugs with numbers, events with letters
0735 PreOp EVAL
IV → (R) A
0748 OR#2 MONITORS ↑
Pre O2 IND/INT
LOG ROLL → PRONE ONTO OR TABLE
✓ BBS (=) ✓ PRESSURE POINTS
0845 0.2mg ROBINUL
0920 LOG ROLL → STRETCHER
LIFT → OR TABLE, SUPINE

RECOVERY AT
PACU (ICU 3) (Specify)
OTHER
CONDITION: STABLE
RESP- 20 O2/Room Air SpO2- 97
BP- 106/62 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0735	0748	1215
	Ready	Begin	End
PROC	0800	0829	1155

PROCEDURES and CPT Codes: SKIN GRAFT FROM BACK TO FRONT
D56 Δ 1

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DLX1/MAC 4 8.0 ETT → VC = BBS (=), ETCO2 (+) SECURED 22cm LIPS

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b6-4 ICU3 - ICU3

SURGEONS: [redacted] b6-2

ANES [redacted]

PROCEDURE [redacted]
LOCATION: OR#2
DATE: 20 July 03
PAGE 1 OF 2

b2-2

Smoker
57/m NKDA

MEDICAL RECORD - ANESTHESIA

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

Page 2 of 2

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "1" = CONSTANT INFUSION)																		
DRUG	(Units)																	
	( )																	
FENT	(mcg)	100	100	50														
	( )																	
	( )																	
	( )																	
	( )																	
VOLAT AGENT	FORANE % del	1.5	1.5/0.6	0.6/2.0	2.0/1.0													
	% e.t.																	
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	2	2 8	2 8/2	8													
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →																		
FLUIDS: LINE site (R) A	☐ Warmed	LR3 →																
	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	
LOSSES: EST BLOOD LOSS																		
URINE -		50/100																

TOTALS	TOTAL EBL
1000mcg	TOTAL URINE

FLUIDS SUMMARY
CRYSTALLOID-
COLLOID-
BLOOD-

REMARKS
Code drugs with numbers, events with letters

11:18 Suction
Strong Spont
Vent. Deep
Extub
Oral airway ↑

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

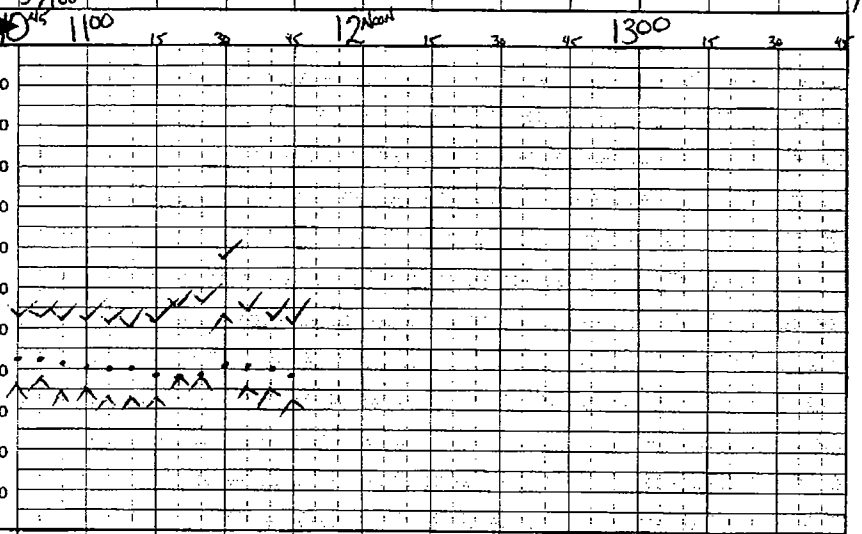
HEMATOCRIT:

INITIAL DATA: BP- / HR-

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

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



See Pg One

VENTIL							
VT - ml		740	720				
f - breaths/min		6	6 12	8	12	20	
Peak inf pres / PEEP		20	20				
MODE - S(pon), A(ssist), C(on)		C	C S	S	S	S	
MONITORS/ACCESSORIES: BP/Auto Cuff	ET CO2 (torr)	30	30	41	41	30	
BP/oth	FIO2 (Frac or %)	.73	.74	.75	.73	.73	
ART line	SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site AVAILABLE →						
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

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

See Pg ONE

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

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End
			1155

PROCEDURES and CPT Codes: See Page ONE

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

[redacted]

b6-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

SURGEONS:

ANESTHETIS[redacted] b6-2

PROCEDURE LOCATION: 28 CSH OR#2

DATE: 20 July 03

PAGE 2 OF 2

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

ANESTHESIA PLAN OF CARE PRE[illegible] EDURAL ASSESSMENT (Sedation/A[illegible]esia)

Age 57 DAYS MOS YRS Sex ~~(X)~~ MALE ( ) ~~FEMALE~~

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

PROPOSED PROCEDURE: DBSG Δ SKIN GRAFT/PRONE OFF BACK
SURGICAL SERVICE: ____
NPO SINCE: MN

HABITS:
TOBACCO: SMOKER
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) LOVENOX
( ) FENT PATCH
( ) ALBUTEROL
( ) MSO4
( ) ____
( ) ____

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

LABORATORY STUDIES: 20 July
HB/HCT: 10 / 29
U/A: ____
OTHER: ____

19 July
★ PLT=959

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
MULTIPLE DBG Δs & DEBRIDEMENT

PHYSICAL EXAMINATION
BP ____ HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea (WNL)
TMJ/Neck 3+
Oropharnyx MP-3
Nares ____
CHEST: CTA
CARDIAC: S1, S2
EXTREMITIES:
IV Access: 18G / (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

b6-2

The patient/legal [redacted] understand and agrees. Questions answered.
Signed: [redacted] Date: 20 July 03 Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU-3, ICU-3

[redacted] b6-4

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

DRUGS	Dosage
Fentanyl, 25mg/cc	225 21
Versed 1mg/cc	2
( )	
( )	
( )	
( )	

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

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

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

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT:

INITIAL DATA: BP – 106/56; HR – 97

COMP CHECK: OK? Y N

PATIENT READINESS: OK for PROCEDURE? TIME –

TIME → 0930 0935 0945 1000 1015 1030

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

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

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

BP/Auto Cuff	ET CO2 (torr)
BP / oth	FIO2 (Frac or %)
ART line	SpO2 (%)
Steth- PC/ES	ECG
Gas analyzer	TEMP- site
	M-M Block (T/4)
Warming blkt	
Conv warmer	

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

TOTALS: 225mg; 2mg

TOTAL BLD; TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID – LR; COLLOID –; BLOOD –

REMARKS – Code drugs with numbers, events with letters

0930 - Conscious sedation start
0935 - Procedure start
1030 - Procedure end.

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

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted] 66-4

SURGEONS:

ANESTH[redacted] certified

66-2 [redacted]ICAL RECORD – ANESTHESIA

PROCEDURE LOCATION: ICU3

DATE: 21Jul03

PAGE OF

WAM[redacted] OP 376 REVISED n 99

MEDCOM - 13311

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

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML – I.V. CONSTANT INFUSION

DRUG	(Units)
Propofol 1%	4
Versed 1mg/4	2 3

VOLAT. AGENT: % del / % e.t.

AIR L/Min

N_2O L/Min

O_2 L/Min

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

LINE site — Warmed / Warmed / Warmed / Warmed

EST BLOOD LOSS

URINE –

TIME → 1100 15 30 45 1200 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml

f – breaths/min 22 23 24

Peak inf pres / PEEP

MODE – S(pont), A(ssist), C(on) S S S

BP/Auto Cuff	ET CO_2 (torr)
BP / oth	FIO2 (Frac or %) NRB RA
ART line	SpO2 (%) 100 100 100
Steth. PC/ES	ECG
Gas analyzer	TEMP- site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

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

PROCEDURES and CPT Codes

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

[redacted] b6-2

TOTALS — TOTAL EBL — TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID – COLLOID – BLOOD –

REMARKS – Code drugs with numbers, events with letters

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: BP – SpO2 – HR –

ANES. THERAPY PROCEDURE TIMES

	Start	Room	End
ANES.	1055		
PROC.	Ready	Begin	End

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, complications b6-2

SURGEONS: [redacted], LPN

ANESTHETISTS: [redacted] RN

PROCEDURE LOCATION: ICU3

DATE: 22 Jul 07

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

U.S. GPO 1999 – 528-336/10

PATIENT RECORD

ITHESIA PLAN OF CARE PRE ACEDURAL ASSESSMENT (Sedation/ esthesia)

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

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

OSED PROCEDURE: dressing change
CAL SERVICE: ____
INCE: 0200

S:
CCO: 2ppd
ETOH: ____
RUGS: ____

NT MEDICATIONS:
lered as premed
fent versed
albuterol
Xanax

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 9.2, 29.8
: 21 Jul

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
- Acute/Chronic RF (N) Y

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

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

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

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 114/60 HR 101 R 18 T 99.1
Pain Scale 0-10 0
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: equal CTA bil
CARDIAC: S1S2 ST ectopy
EXTREMITIES:
IV Access: (R) wrist
Ulnar Filling:
BACK:
OTHER:

NPO Since 0200

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

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

ien [redacted] ems to understand and agrees. Questions answered.
[redacted] b6-2 Date: 22 July 07 Time: 1025 Hrs

NESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

Identification: (Ward) ____

[redacted] b6-4

SEDATION KEY:

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

MEDICAL RECORD - ANESTHESIA

For . this form, see AR 40-66; the proponent agenc . ie OTSG

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

DRUG	(Units)																		
Versed	(mg)	1	1															TOTALS	TOTAL EBL
Fentanyl	(mcg)	50	50	50	50	50	50	100	100	50	50							500	
Propofol	(mg)	150								30									TOTAL URINE
Rocuronium	(mg)	40																	
MSO4	(mg)									4		4							
	( )																		
VOLAT AGENT 1.5	% del	1.0	1.4	1.5	1.0	1.0	0.6	2.0	1.5	1.7								FLUIDS SUMMARY	
	% e.t.																	CRYSTALLOID-	
AIR	L/Min																		
N2O	L/Min																	COLLOID-	
O2	L/Min	8/1	1	1	1	1	1	3	2	10								BLOOD-	

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

FLUIDS

LINE site												
18 (L) AC	☐ Warmed		1000				2000	2500				
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES

EST BLOOD LOSS								Minimal				
URINE -								No Foley				

REMARKS

Code drugs with numbers, events with letters

0746 IV PIV
Alert remain
0900 To room
Standard monitors placed.
0945 LMA
Smooth out.

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 70 KG LB

HEMATOCRIT

INITIAL DATA

BP- 113/67

HR- 113

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME 0800 0850 0900 0950 1000

SYMBOLS

BP by cuff V ∧

Heart rate ●

Resp rate

BR (transduced)

TOURNIQUET T—T

ANES. X-X

PROC. ⊙-⊙

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

Dr. [redacted] gives break

VENTIL

VT - ml	640	670	600	410	530	240	330	410	510
f - breaths/min	8	8	7	18	11	12	11	12	12
Peak inf pres / PEEP	15	14	14						
MODE - S(pon), A(ssist), C(on)	S/A	C	C	SV	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)	29	30	41	43	41	44	45	46
BP/oth	FIO2 (Frac or %)	.86	.86	.86	.85	.87	.87	.86	.86	.86
ART line	SpO2 (%)	96	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Esw	96	96	96	96	96	96	96	—	96
	N-M Block (T/4)	4/4	4/4	4/4	4/4	4/4	4/4	C Substance	Stimulator	
Warming blkt										
Conv warmer										

See previous pre-op

Mark with letters & symbols, explain under REMARKS — EVENTS → Position 10-1

RECOVERY AT PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 16 SpO2- 97%

BP- HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0800	1030
PROC	Ready	Begin	End
	0810	0820	1015

PROCEDURES and CPT Codes: Burn debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

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

[redacted] b6-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Pre-ox 5 min 100% FiO2, IV induction, easy mask ventilation, IV x1 nubain 2 opened 7 mini 7.0 ETT blood 23cm @ lip (+) BBS (+) ETCO2

SURGEONS: [redacted] SN. b6-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR1

DATE: 1 AUG 05

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	1100	x 30	x 1200	x 30
Versed	(mg)	3			
Fent	(cc)	2	2 1		
Lidocaine/Propofol	(mg)	20/150			
	( )				
Epinephrine	(mg)		5		
	( )				
VOLAT AGENT: Forane	% del	X1.5	—2 X		
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	X6	+2 —6		

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

FLUIDS

LINE site		1100	x 30	x 1200	x 30
20g LR	☐ Warmed	700	400		
	☐ Warmed				
	☐ Warmed				
	☐ Warmed				

LOSSES

EST BLOOD LOSS					
URINE -					

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

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 38

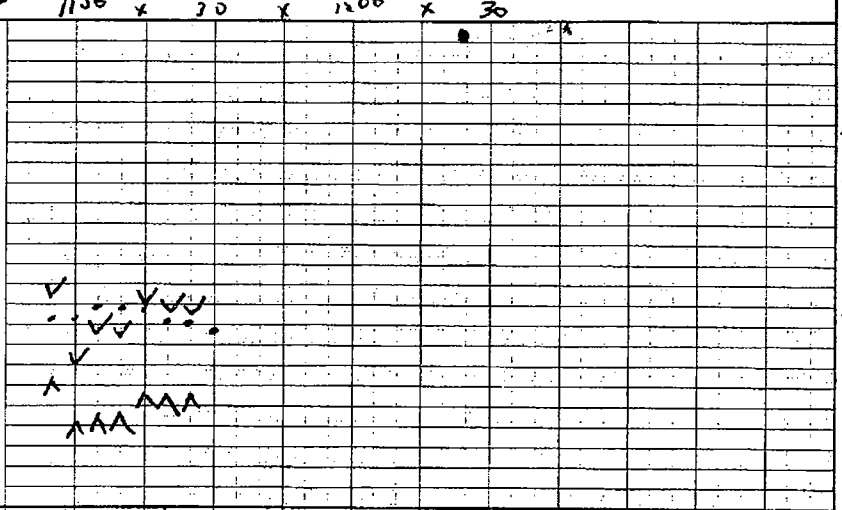
INITIAL DATA: BP- 106/62 HR- 93

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE Yes TIME- 1030

TIME → 1100 x 30 x 1200 x 30

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



VENTIL

	1100	x 30	x 1200
VT - ml	680		400
f - breaths/min	9		9
Peak inf pres / PEEP	16		16
MODE - S(pon), A(ssist), C(on)	C		C S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)		34		35
BP/oth	X FIO2 (Frac or %)		.86		.90
ART line	X SpO2 (%)	100	100		100
Steth- PC/ES	X ECG		SR		SR
Gas analyzer	TEMP-site	ARMIC.			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

TOTALS 3 / 5 — **TOTAL EBL** mi — **TOTAL URINE** Ø

FLUIDS SUMMARY
CRYSTALLOID- LR 800
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters

Preop, PIV, NPO agree to GA for (B) Heel Surgery OR O2 monitors stable N tolerates post/preop/dose drug on SV LMA out to gurney

RECOVERY AT:
PACU ICU #3 (Specify)
OTHER
CONDITION: Sedated
RESP- 14 SpO2- 98 RA
BP- 115/78 HR- 101

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1050	1055	1145
	Ready	Begin	End
PROC	1100	1108	1123

PROCEDURES and CPT Codes: (B) Heel Debridement

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

#[redacted] ICU #3 66-44

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA LMA #4

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

SURGEONS: [redacted] — 66-2

ANESTHETISTS: [redacted] AC

PROCEDURE LOCATION: OR1

DATE: 16 Aug 03

PAGE 1 OF 1

PRE-ANESTHETIC ASSESSM .ND PLAN OF CARE

AGE: 47 Days Mos (Yrs) GENDER: (X) Male ( ) Female ALLERGIES: NKDA PS: 1 2 (3) 4 5 E WT: 85 (Kg)/Lb HT: ____ In.

PROPOSED PROCEDURE: (B) Heel Debridement
SURGICAL SERVICE: Gen
NPO SINCE: 7 PM
PREOP DX / MECHANISM OF INJURY: 10% Burn BSA 2° to Hot Humvee
ASA III Pt case reviewed c̄ Cpt McMasters MDA properly

HABITS:
Tobacco: Hx 2 ppd
EtOH: ____
Drugs: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Fent Patch 8/15
( ) ____
( ) ATIVAN 2400
( ) ____
( ) PAXIL 2200
( ) LOVENOX 2200
ALBUTEROL 8/15

PREMEDICATIONS:
None / Yes @ ____ Hrs

LABORATORY STUDIES:
8/14
127 | 99 | 6 | 86
5.4 | 19 | .9
8/22
38 | 13 | 38 | 13

Other: ____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	Hx DVT
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	RAD
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	Ø
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	Ø
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	Ø
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	Ø
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	Y	S/P Burns Hands/Knees
Familial Hx	N	Y	

SURGICAL HISTORY
8/1 Debridement
7/15 STSG
7/20 Dressing Δ
7/6 Debridement

PHYSICAL EXAMINATION
BP: 114/71 HR: 75 RR: 12 T: 97.6
Pain (0/10 Scale): Ø SaO2 96%
Airway Exam:
Dentition: NL
Trachea: MID
TMJ/C-spine: ~~MPCI~~
Oropharynx: 3FB IN → H
Chest:
Lungs: Rhonchi
Heart: Rr - B + Wheeze
IV Access: Ø
Ulnar Filling: Arterial MDI
Back: X-111
Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: Intubation / Mask-LMA Notes: ____

NFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and cussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

Speaks English
b6-2 [redacted] w/ consent
d: ____ Date: 16 Aug 03 Time: 0850

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

NT IDENTIFICATION:
4 [redacted] ICU #3
b6-4

[redacted]
b6-2

POST-ANESTHESIA EVALUATION AND NOTE:
( ) No apparent anesthetic complications.
( ) Other (see progress notes)
Signed: ____ Date: ____ Time: ____

Never Hospitalized Fentanyl patch 50mcg/hr placed 8-24-03

RAD; Hx DVT; S/P

MEDICAL RECORD - ANESTHESIA

66-2

This form, see AR 40-66; the proponent agency is [redacted]

Discussed case c [redacted] anesthesiologist

NKDA

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

DRUG	(Units)	(Glycopyrrolate/0.2mg IV pre-op)								
Midazolam	(1 mg)	1								
Fentanyl	(mcg)		100	<150>						
Ketorolac	(mg)	50								
Propofol	(mg)	200								
VCR	(mg)	5-2								
MSO4	(mg)			3-3		3 4	32			
VOLAT AGENT Fso	% del	2.0	1.5	1.5	2	1.7	1.7	1.7	0.4	X
	% e.t.									
AIR	L/Min									
N2O	L/Min									
O2	L/Min	10	10	2	2	2	2	2	1.5	10

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

FLUIDS — LINE site (L) 18G AC ☐ Warmed LR#1 — 400

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES — EST BLOOD LOSS Ø

URINE - 25

TOTALS	TOTAL EBL
2	<50
250	
50	TOTAL URINE
200	Voided pre-op
10	Ø
15	

FLUIDS - SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

PHYS STATUS 1 2 (3) 4 5 E

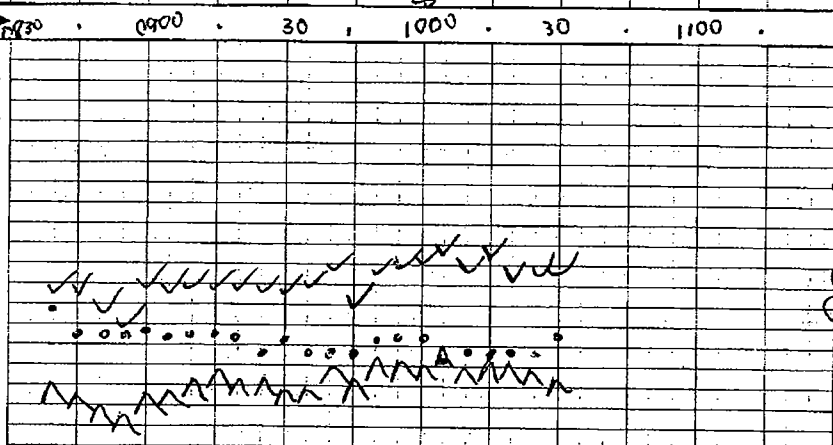
BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 39.9

INITIAL DATA: BP- SaO2 97% 96/59 HR- 88

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? JT TIME- 0800



VENTIL

VT - ml	+	750	750	750	690	690	700	700	450
f - breaths/min	+	10	7	7	6	6	6	6	15
Peak inf pres / PEEP	—	24	24	24	24	24	23	23	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	+	32	27	27	28	28	29	30	
BP/oth / FIO2 (Frac or %)	0.89	0.89	0.89	0.89	0.88	0.88	0.87	0.88	0.88
ART line / SpO2 (%)	100	100	100	100	100	100	100	100	
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer / TEMP-site	available		SK-35.2		35.1	35.1	34.8	34.6	
N-M Block (T/4)		0/4	1/4	1/4	4/4	0/4		1/4	Stand Off
BS		+	+	+					
Warming blkt / x1 Blanket									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position (1) (2) (3) (4) (5)

REMARKS — Code drugs with numbers, events with letters

(1) Esperato, alcohol RUE, LLE GTA. HRP ⊖ ⊖. Allowed inhaler Tolay. Speaks english & discussed anesthesia c pt. Resolution c clear lungs equal (B)
(2) RSOW, monitors O2 Induced, eyelids tape, soft Bite block
(3) Ancef 1gm IVPB Fentanyl, eyelids, arms neck & nose checked post prone position
(4) Zofran 4mg IV
(5) Turned supine Suctioned OA, SV To >4ml/kg; Reversal Neostigmine 5mg IV + Glycopyrrolate 0.3g Responsive; Extubated S Complication To PACU. Report to nurse pt left attended

RECOVERY AT 1030

PACU ICU _____ (Specify) OTHER T-95.1 Ax

CONDITION: Stable

RESP- 24 SpO2- 99 BP- 136/78 HR- 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0815	0835	1040
	Ready	Begin	End
PROC	0845	0910	1025

PROCEDURES and CPT Codes: Harvested from contralat Full thickness Skin Graft Bilateral heels

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

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

(R) Partial thickness burns

[redacted] ICW #1 b/6 ctl

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#4 LMA Fast track; 7.5 OETT placed verified + BBS; Sust ETCO2 8cc air cuff; LMA removed

SURGEONS: [redacted]

ANESTHETIST: [redacted] CRNA/MA

PROCEDURE LOCATION: 2#(L)

DATE: 20 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 13317 PATIENT'S MEDICAL RECORD USAPA V1.00

66-2 [redacted]

Procedure verified

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
fentanyl	(µg)	150	50	50									
propofol	(mg)	150											
versed	(mg)	40											
ketamine	(mg)	50											
	( )												
	( )												
VOLAT AGENT 150	% del		1.5	1.0	1.0	1.0							
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	6	2	2	2	2-6							

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

FLUIDS

LINE site												
#18 LUE	☐ Warmed	LRT										
#20 LAC	☐ Warmed		PBC/IV									
	☐ Warmed											
	☐ Warmed											

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 30

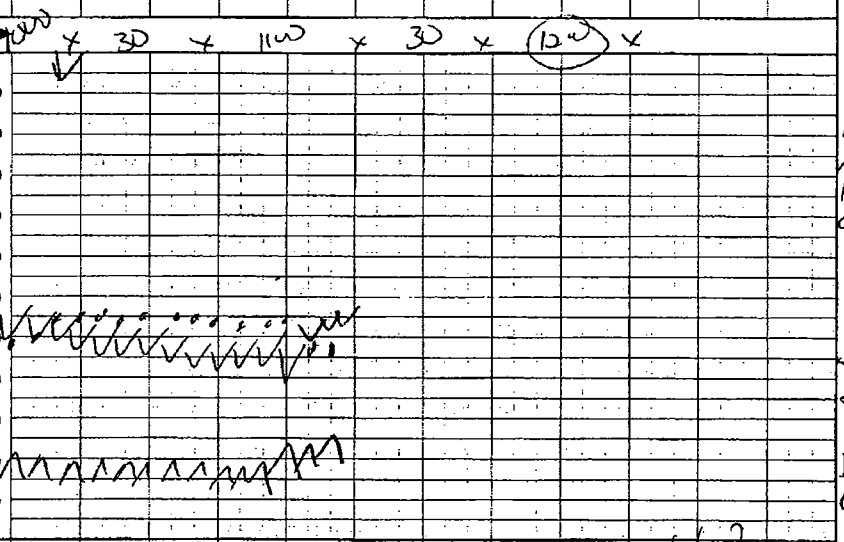
INITIAL DATA: BP- 100/60; HR- 120

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? ✓; TIME- 0945

TIME → 1100 x 30 x 1100 x 30 x 1200 x

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



VENTIL

VT - ml		430	750	750	750	510	
f - breaths/min		10	10	6	6	10	
Peak inf pres / PEEP		21	22	22	6		
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	SV	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		33	33	33	33	39
BP/oth	FIO2 (Frac or %)	.7L	.7L	.7L	.7L	.7L	.7L
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	ID	ST	ST	ST	ST	ID
Gas analyzer	TEMP-site	skin		35		35	
	N M Block (T/4)		0/4	2/4		4/4	
Warming blkt	sheets/head wrap						
Conv warmer							

Mark with letters & symbols, explain under REMARKS. EVENTS / Position → o-o alms <90° abducted/padded 8 yes/Eyes Vsd

TOTALS: 2500 cc; **TOTAL EBL**: min; **TOTAL URINE**: —

FLUIDS - SUMMARY: CRYSTALLOID- LR - 500; COLLOID-; BLOOD- PRBC - left

REMARKS — Code drugs with numbers, events with letters

0945: pat ID - IV in place - Prep done. Chart rev'd 1000 - Dr Tank punctas OK. Induction albut puffs for (B) wheezing p intubation 1115 - Neostig 2g / Robinul 2c IV 1130 - supine. Opened eyes sustained / stable TO PACU VS

RECOVERY AT: PACU ICU ____ (Specify); OTHER Stable; CONDITION: 95; RESP- 14; SpO2- 95; BP- 120/60; HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0945	1000	1130
	Ready	Begin	End
PROC	1000	1040	1110

W0013 03 011374

PROCEDURES and CPT Codes: Wound closure

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

[redacted] b6-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA #8 ETT #3 Miller, taped 2 ways, eyes taped. OST LC + Foley soft & clear. DLXT Tracheal GEI views. ETT easily passed. OST-LCOT. Atraumatic.

SURGEON: [redacted] b6-2

ANESTHETIST: [redacted]

PROCEDURE LOCATION: 1

DATE: 27 AUG 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 13318 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

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

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 9 ~~10~~ Jul 03

DATE AND HOUR REQUIRED: 10 Jul 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: unknown

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Burn Debridement

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

SIGNATURE OF VERIFIER: [redacted] b6-2

DATE VERIFIED: 9 Jul 03

TIME VERIFIED: 1350

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 1642392

TRANSFUSION NO.:

PATIENT NO.: 1642392

DONOR ABO: B Rh: positive

RECIPIENT ABO: B Rh: positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 9 Jul 03

REMARKS: EXP 15 JUL 03

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b6-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED BY *(Signature)*: [redacted] b6-2

AT *(Hour)*: 1646 ON *(Date)*: 10 Jul 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted] MAJ Clark

2nd VERIFIER *(Signature)*: [redacted] b6-2 Cooper

PRE-TRANSFUSION VITALS: TEMP. 36.4 PULSE 104 BP 122/76

DATE OF TRANSFUSION: 10 Jul 03 TIME STARTED: 0630

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME DATE COMPLETED: 10 Jul 03 INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: [redacted] MAJ Clark b6-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

WARD: OR

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

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

DATE REQUESTED: 9Jul03

DATE AND HOUR REQUIRED: 10Jul03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: unknown

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Burn debridement

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

SIGNATURE OF VERIFIER: [redacted] b6-2 AW

DATE: 9Jul0[redacted]

TIME VERIFIED: 1350

SECTION II – PRE-TRANSFUSION TESTING

5304891

5304891

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B, Rh positive

RECIPIENT: ABO B, Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatable

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b6-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE [redacted]

REMARKS: EXP DATE 15 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: [redacted] b6-2

AT *(Hour)*: 0646 ON *(Date)*: 10Jul03

IDENTIFICATION

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

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*: [redacted] b6-2

PRE-TR[redacted]

TEMP. [redacted]4 PULSE 122 BP 120/82

DATE OF [redacted]USION: 10 Jul 02 TIME STARTED: 0725

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME DATE COMPLETED INTERRUPTED: 0742 09 July 03

REACTION
- [x] NONE
- [ ] SUSPECTED

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

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

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

SIGNATURE OF PE[redacted]ING ABOVE: [redacted] b6-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

SEX: M

WARD:

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

DATE REQUESTED: 10 Jul 03

DATE AND HOUR REQUIRED: 10 Jul 03 0900

REQUESTING PHYSICIAN *(Print)*: Dr. [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Burn Debridement

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

VOLUME REQUESTED *(If applicable)*: 10 ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: previous clot

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 5304904 5304904

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B; Rh positive

RECIPIENT: ABO B; Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b6-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 10 JUL 03

REMARKS: EXP 15 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b6-2

AT *(Hour)* 0900 ON *(Date)* 10 JUL 03

IDENTIFICATION

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

[redacted] *(Signature)* RN/BN

2nd Verifier: [redacted] b6-2 LPN

PRE-TRANSFUSION VITALS

TEMP. 98.3 PULSE 123 BP 129/72

DATE OF TRANSFUSION: 10 Jul 03

TIME STARTED: 0908

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME: 1111 DATE: 10 Jul 03 COMPLETED INTERRUPTED

REACTION
- [x] NONE
- [ ] SUSPECTED

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

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

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

SIGNATURE OF PERSON NOTING ABOVE: [redacted] RN/BN b6-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b6-4

SEX: M

WARD: 1C03

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* 10 ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 10 Jul 03

DATE AND HOUR REQUIRED 10 Jul 03 0900

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* Dr [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE Burn Debridement

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

SIGNATURE OF VERIFIER Previous clot

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1199964 1199964

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh positive

RECIPIENT

ABO B

Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b6-2 [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 10 JUL 03

REMARKS:

EXP DATE 11 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 1123 [redacted] ON *(Date)* 10 JUL 03

IDENTIFICATION

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

[redacted] *(Signature)*

[redacted] b6-2

[redacted]

PRE-TRANSFUSION

TEMP. PULSE 119 BP 128/78

DATE OF TRANSFUSION 10 JUL 03

TIME STARTED 1135

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME DATE COMPLETED 1250 10 JUL

INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE [redacted] b6-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b6-4

SEX M

WARD ICU3

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 15 July 03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE SKIN GRAFT + DEBRIDEMENT

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct. b6-2

SIG[redacted]

DA[redacted] 15 July 03

TIME VERIFIED 0758

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 4824472

TRANSFUSION NO.

PATIENT NO. 020-00-0386

DONOR

ABO O

Rh pos

RECIPIENT

ABO B

Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

b6-2

SIGNAT[redacted]

DATE 15 Jul 03

REMARKS:

Exp. Date: 17Jul03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted] b6-2

AT *(Hour)* 0845 [redacted]ON *(Date)* 15 JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] b6-2

2nd VERI[redacted]

PRE-TRANSFUS[redacted] 89 100/65

TEMP. 37 PULSE BP

DATE OF TRANSFUSION 15 July 03

TIME STARTED 0855

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 0920 15 July 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 37

PULSE 90

BLOOD PRESSURE 100/64

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [ ] NO
- [ ] YES *(Speci[redacted]*

SIGNATU[redacted] b6-2

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

SEX M

WARD OR

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 15 July 03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* b6-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE SKIN GRAFT & DEBRIDEMENT

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

S[redacted] b6-2

15 July 03

TIME VERIFIED 0750

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1860465

TRANSFUSION NO. b6-4

PATIENT NO. [redacted]

DONOR

ABO

Rh B Pos

RECIPIENT

ABO

Rh B Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted] 15 Jul 03

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

[redacted] PERSON PERFORMING TEST [redacted] b6-2

REMARKS:

Exp. Date: 26 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY [redacted] b6-2

AT *(Hour)* 0832 ON *(Date)* 15 Jul 03

IDENTIFICATION

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

1st VERIFI[redacted]ure) [redacted] b6-2

2nd VE[redacted]

PRE-TRANSFUSION

TEMP. 37 PULSE 100 BP 110/60

DATE OF TRANSFUSION 15 July TIME STARTED 0830

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 15 Jul 03 0835

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 37 PULSE 99 BLOOD PRESSURE 120/60

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [ ] NO
- [ ] YES *(Specify)* [redacted]

SIGNATURE OF PER[redacted] b6-2

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

SEX M

WARD OK

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS: 1 of 2

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

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 27 AUG 03

DATE AND HOUR REQUIRED 1350

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE S/P SKULL [illegible]

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

SIGNATURE OF VERIFIER [redacted] b6-2

DATE VERIFIED 27 AUG 03

TIME VERIFIED [illegible]

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 550 45666

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B

Rh Pos

RECIPIENT

ABO B

Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD b6-2

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: EXP 02 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 1235 ON *(Date)* 27 Aug 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] b6-2 2LT ANC

2nd VERIFIER *(Signature)* [redacted] b6-2

PRE-TRANSFUSION TEMP. 97.4 PULSE 91 BP 98/58

DATE OF TRANSFUSION 27 AUG 03 TIME STARTED 1250

POST-TRANSFUSION DATA

AMOUNT GIVEN 500 ML

TIME/DATE COMPLETED/INTERRUPTED [illegible]

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE [illegible] PULSE [illegible] BLOOD PRESSURE [illegible]

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] b6-2

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

1305

SEX

WARD

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 13325

Return to Transfusion Service

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 27AUG03

DATE AND HOUR REQUIRED ASAP

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE S/P skingraft

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER [redacted] b6-2

REMARKS: 2 of 2

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN N/A

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 27AUG03

TIME VERIFIED 0845

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 011374

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b6-2

DONOR

ABO B

Rh Pos

RECIPIENT

ABO B

Rh Pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: EXP 02 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 1035 ON *(Date)* 27 Aug 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] b6-2

2nd VERIFIER *(Signature)* [redacted] b6-2

PRE-TRANSFUSION

TEMP. 36 PULSE 104 BP 80/56

DATE OF TRANSFUSION 27 AUG03 TIME STARTED 1030

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1055 / 27 AUG 03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 36 PULSE 103 BLOOD PRESSURE 80/53

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] b6-2

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

SEX

WARD

SECTION I—REQ...

INSTRUCTI...

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*: 1 unit / 250 ML

REMARKS: HCT 24.8

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 30AUG03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: s/p (B) skin grafts to heels

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

SIGNATURE OF VERIFIER: [redacted] b6-2

DATE VERIFIED: 30AUG03

TIME VERIFIED: 0915

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 1262548

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B; Rh POS

RECIPIENT: ABO B; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	COMP

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

SIGNATURE OF PERSON PERFORMING TEST: C—

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 30 Aug 03

REMARKS: Exp: 9 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

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

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted] b6-2

2nd VERIFIER *(Signature)*: [redacted]

[redacted] TION

TEMP. 99.8 | PULSE 99 | BP 96/50

DATE OF TRANSFUSION: 30AUG03

TIME STARTED: 1310

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME/DATE COMPLETED/INTERRUPTED: 1515 30AUG03

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 100.0°

PULSE: 97

BLOOD PRESSURE: 92/52

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: [redacted]

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

#[redacted] b6-4

b6-2

SEX: MALE

WARD: ICW#1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 13327

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* 1 unit/250 ML

REMARKS: HCT 24.8

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

DATE REQUESTED 30AUG03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (B) skin graft to heels

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

SIGNATURE OF VERIFIER [redacted] b6-2

DATE VERIFIED 30AUG03

TIME VERIFIED 0915

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1644311

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B; Rh POS

RECIPIENT: ABO B; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH: Comp

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 30Aug03

REMARKS: EXP: 9Sep03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* 1017 ON *(Date)* 30Aug03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] ZLTAW

2nd VERIFIER *(Signature)* [redacted] b6-2

PRE-TRANSFUSION TEMP. 99.3 PULSE 94 BP 89/47

DATE OF TRANSFUSION 30AUG03 TIME STARTED 1020

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 30AUG03 1245

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 99.9 PULSE 103 BLOOD PRESSURE 99/53

If reaction is suspected—IMMEDIATELY: [redacted] b6-2

1. Discontinue transfusion, treat shock if present, [redacted] avenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

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

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

SIGN[redacted]NOTING ABOVE [redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility) b6-2

SEX MALE WARD KW#1

#[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 13328

Medical Record Copy

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 2-3 mg IV now and 2 mg q 3-5 min prn pain for a		1730 [redacted]
	~~max~~ dose of 10 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x 1.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr. per surgeon		
10	Discharge from recovery status when PACU discharge criteria met.		
11	Demerol 25 mg IV x 1 PRN shivering		1730 [redacted]
	[redacted] CRNA		
	b6-2		

PATIENT IDENTIFICATION

[redacted] b6-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

[redacted]

Copy to Pharm: Y/N

NURSING UNIT | ROOM NO. | BED NO.

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

① Admit to ICU 3 X
Stp Burn X
DVT X
Cond stable
Wbls Qi°, I/O, SAT ✓
All Ø X
Act Bed rest X

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER | TIME OF ORDER | HOURS

Nurse ① Bleg to Grant X
② Burn Dressing D's Pr protocol X
Diet Regular X
WF LR @ 150 c/hr X
meds
McOq 1-10 mg IV Qi° PRN pain for X

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER | TIME OF ORDER | HOURS

Dressing D
Versed 2-5 mg IV Qi° PRN sedation X
for Dressing D
Percocet I-II (1-2) PO Q4° PRN pain X
Proventil MDI II Q4° X
Lovenox 90 mg SQ BID X
UA, CXR, CBC, medical LB Qam X

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER | TIME OF ORDER | HOURS

Levaquin 500 mg IV QD X
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] Maj (AW) USA b6-2

b6-2 [redacted] 1711 3 Jul 07

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

HVD #[redacted] — b6-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 02 July 03 TIME OF ORDER 0609 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to patient hold for ~10% BSA Burns
NKDA
Meds [redacted] Albuterol MDI 2 p q 4° — 0830
~~ASA 325 po q d~~ — 0600
Unasyn 3g IV q 6° x 3 doses
MSO4 2mg IV every 2 hours as needed for severe pain or Dressing changes

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Apply Silvadine cream to wound BID & cover with sterile dressing
Tylenol 650 po q 6° — [redacted] 0830
Aciphex 20mg po q d — 0830
IVF - LR @ 200cc/hr
Foley to gravity
Record Strict I&O's

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

notify MD if UOP is <40 cc/hr
ISTAT 6 & creatine now & q AM — 0830
Diet Regular, give more food than normal as burns require ↑ energy to heal
Vitals q 4° x 2 then q 8° notify MD for SBP >160 <100, DBP >110 <50 HR >110 <50 Sats <90% on RA; Temp >101 <96 RR >24 <12

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

wound care BID to include scrubbing wound with sterile water & sponge then dry w/ sterile bandages & apply Silvadine cream & then dressing w/ sterile dressing
Range of Motion Exercises ~~To maintain~~ 3x a day
[redacted]
b6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Jul 03 — TIME OF ORDER: 1458 HOURS

Albuterol 0.5cc in 2.5cc NS Q4° x48hrs

[redacted] b6-2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Jul 03 — TIME OF ORDER: 1609 HOURS

1. ABG Now ✓
2. EKG Now ✓
3. NS 500cc Bolus IV x 1 ✓
4. Narcan 0.2 mg IV Now ✓

v.o. per Dr. [redacted] b6-2

[redacted] 3 Jul 03

PATIENT IDENTIFICATION

0[redacted] b6-4 ✓

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Jul 03 — TIME OF ORDER: 1656 HOURS

1. Give another 500cc NS Bolus Now

v.o. per Dr. [redacted] b6-2

[redacted] 3 Jul 03

PATIENT IDENTIFICATION

0[redacted] b6-4 ✓

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Jul — TIME OF ORDER: 1800 HOURS

1. LR 500cc Bolus KT Now ✓
2. Albuterol Neb 0.5/2.5 Now ✓

b6-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

26 [redacted] b6-2

Maj MC 2103

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 13332 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 03 July 03 TIME OF ORDER: 0700 HOURS

1) Add WBC count to AM labs
2) have patient out of bed into chair QID
3) Rupture any cloudy blisters [redacted]

b6-2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 03 July 03 TIME OF ORDER: 0800 HOURS

1) vitals q 2° x 10 then q 4°
2) WBC count q 8° x 4 then q AM

[redacted]

b6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER / TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
# [redacted] b6-4 [redacted]				3JUL03 0920	
			(1)	↑ IVF @ 200 cc/hr	done
					noted
				[redacted]	b6-2
NURSING UNIT	ROOM NO.	BED NO.			
24° [redacted]				[redacted] MAJ/AN 2100	

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER / HOURS	
# [redacted] b6-4				4 July 02 0255	
				V.O. Dr [redacted]	
				Give Lasix 20 mg IV/PX I now	done
				[redacted] MAJ/AN	
				b6-2 [redacted]	
NURSING UNIT	ROOM NO.	BED NO.			
24° [redacted]				MAJ/AN 0200	

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER / HOURS
# [redacted] b6-4				5 July 03 0700
			(1)	Pt may Ambulate
			(2)	No labs today
				b6-2 [redacted]
NURSING UNIT	ROOM NO.	BED NO		

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER / HOURS	
# [redacted] b6-4				5JUL03 2035	
			(1)	Type & Cross & 2 units of Blood	noted 2100 5JUL [redacted]
			(2)	NPO p MN	ILT/AN
				[redacted]	b6-2
NURSING UNIT	ROOM NO.	BED NO.			
24° Chart Check		0030		06JUL03 [redacted]	ILT/AN

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b6-4				6 Jul 03	____ HOURS	
			✓ ①	Resume Previous Orders		
				except		
			✓ ②	↓ IVF to LL @ 100 cc/hr		noted 6 Jul 03 1450.
			✓ ③	W-D drainage QD @ each site [redacted]		
				sites.		
NURSING UNIT	ROOM NO.	BED NO.	4	Regular Diet [redacted]		b6-2
24' [redacted] Maj/AW				2300		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4				7 Jul 03	0700 ____ HOURS	
			①	D/C Daily C&R		noted
						b6-2
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4				____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4				____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] b6-4

NURSING UNIT | ROOM NO. 24 | BED NO. [redacted]

DATE OF ORDER: 8 Jul 03 | TIME OF ORDER: 0740 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) KCl 40 meq in 100 ccNS over 2hrs.

[redacted] b6-2

Noted 8 Jul 03 0750 [redacted] 19/14

May PMW 2110

PATIENT IDENTIFICATION: # [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 Jul 03 | TIME OF ORDER: 0735 HOURS

Type and cross 2u PRBC for OR tomorrow

NPO p MN.

Incentive spirometry

Vancomycin Fqn IV Q12

Lasix 10mg IV Q[redacted]

IVF to 20 cc/hr. [redacted] b6-2

Noted b6-2 [redacted] 1440 09 Jul 03

PATIENT IDENTIFICATION: # [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 Jul 03 | TIME OF ORDER: 2300 HOURS

(1) ↑ IVF to 100cc/h p Tube feeding off

[redacted] b6-2

[redacted] b6-2

PATIENT IDENTIFICATION: # [redacted] - b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Jul 03 | TIME OF ORDER: 1000 HOURS

~~(1) Lasix~~

(1) Lasix 20mg IV x1 Now

[redacted] b6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 Jul 03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Start TF: 2000 Kcal/day, start @ 40 cc/hr & advance to goal rate as tolerated.
2. 20mg Lasix IVP x1 now — [redacted]
3. [redacted] 90mg SQ BID b6-2
4. Albuterol 2puff Q4° [redacted]

PATIENT IDENTIFICATION

24° [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: [redacted] TIME OF ORDER: [redacted] HOURS

[redacted] Mg/AN ~~[illegible]~~ [redacted] June 03 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11 Jul 03 TIME OF ORDER: 1130 HOURS

1. Lasix 20mg IV x1 now (1:25)
2. Cipro 400mg IV BID.
   D/c levoquin
3. Thorazine 10mg IM BID [redacted] b6-2

noted 11 Jul 03 1130 [redacted] MAN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24° Chart Check		12 JUL

DATE OF ORDER: 1940 TIME OF ORDER: 11 July 03 HOURS

V.O. Dr [redacted] b6-2

DC IM Thorazine give 25 mg P.O. BID

MOM now + 2 hours later if no result. [redacted] /AN

0100 [redacted] ILT/AN b6-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF [illegible] MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] b6-4

DATE OF ORDER: 13JUL03 TIME OF ORDER: 1630 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Tylenol 650 mg PO Q4-6 PRN fever — Noted 13Jul03 1630 [redacted]

[redacted] b6-2

NURSING UNIT: 24 | ROOM NO.: | BED NO.:

14 JUL 0030 24 Chart Check [redacted] /AN

PATIENT IDENTIFICATION

DATE OF ORDER: 15 Jul 03 TIME OF ORDER: 1130 HOURS

V.O. Suction to Abdominal drains. Bedrest until taken back to OR then re-evaluate. Cont.

From Dr. [redacted] / [redacted] LTC/a

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted] b6-4

DATE OF ORDER: 15Jul03 TIME OF ORDER: 1200 HOURS

(1) Resume previous order x̄ 125 mg ~~IV~~ A Suction to Abdominal JP's continuous

(2) Keep thigh STSG dressings Moist x̄ 5% Sulfamylon solution

Noted [redacted] b6-2 15 Jul 03 @1600

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 16JUL03 TIME OF ORDER: 0700 HOURS

(1) D/C cipro

(2) D/C Vancomycin

NOTED 16JUL03 0700 [redacted] b6-2

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] 0130

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

ICU-3

[redacted] b2-2

NOT ΣΔ 16JUL03 1410 [redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] May 1 AM

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

16JUL03 | 1400 HOURS

① D/C THORAZINE

V.O. DR [redacted] b6-2

0130

PATIENT IDENTIFICATION b6-2

NOT ΣΔ 19JUL03 0945 [redacted]

NURSING UNIT | ROOM NO. | BED NO. b6-2

DATE OF ORDER | TIME OF ORDER

19JUL03 | 0845 HOURS

① NPO PMN

② T & Cross 2u PRBC

③ Hold Lovenox bowl and in AM. b6-2

[redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

ICU-3

[redacted] b2-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

19JUL03 | 1715 HOURS

① Sitz bath to Ant Abd wound QD

② D/C central line when PIV placed

[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

CLINICAL RECORD DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER

20 Jul 03 | 1200 HOURS

A Admit to ICW

S/P STSG

cond stable

vitals Q1° & SAT

All ∅

Act - Bed rest

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER

HOURS

Nurse - JPs to 125 mm Hg continuous suction (4 JP's) 1415

Moisten (R) calf STSG site & 5% Sulfamylon [redacted] b6-2

Foley to gravity

NO TF for the next 3 days

Diet - Clears

IVF LR @ 100 cc/hr

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER

HOURS

Med't

(1) [redacted] drun on tab when Awake [redacted] & tab with each Dressing [redacted] as needed.

(2) MSO4 2-10 mg Q1° as need

(3) continue previous sedation orders

(4) QD silvadene Dressing Δ's to

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER

remaining Burns, older STSG sites and open Donor sites

Position Pt on sides most of Day.

Albuterol TI puffs Q6°

LAB: CBC, Chem 8 QOD.

Ace wrap to (R) leg & [redacted]

Lovenox 90 mg SQ BID [redacted] b6-2

b6-2 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] Day (PM) 7/24 21 [redacted]

DATE OF ORDER: 24 Jul 03 | TIME OF ORDER: 1610 HOURS | LIST TIME ORDER NOTED AND SIGN

Ambien 5mg PO QHS PRN

V.O. per Dr. [redacted] b6-2

24 Jul 03 [redacted] 1729

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 25 JUL 03 | TIME OF ORDER: 0811 HOURS

- ↑ Ambien to 10g q HS PRN
- Add Dietary Supplements (Ensure / Carnation instant breakfast) to [redacted] of 3 cans / day.

[redacted] b6-2

noted 25 July 03 0855 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.: 3

DATE OF ORDER: 25 JULY 03 | TIME: 1545 HOURS

① 1 L NS bolus x 1 now.

V.O. Dr. [redacted] b6-2 [redacted]

noted 25 July 03 1550 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.: 3

DATE OF ORDER: 27 JUL 03 | TIME OF ORDER: 0712 HOURS

DC labs QOD

Δ to labs [redacted] TUESDAY and Saturday [redacted] b6-2

Δ ~~HS~~ to 9 [redacted]

Transcribed 27 July 03 @ 0712 via [redacted]

DA FORM 1 APR 79 4256 2 [redacted] b6-2

MEDCOM - 13341 MAY BE [redacted] b6-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted]

DATE OF ORDER: 28 JUL 03 TIME OF ORDER: 0718 HOURS

Percocet 1-2 tablets PO q 4° PRN chronic D's and/or pain

[redacted] b6-2

LIST TIME ORDER NOTED AND SIGN

[redacted] AW 0300 7/29/03 24° Chart VAC

PATIENT IDENTIFICATION b6-2

[redacted] b6-4

NURSING UNIT | ROOM NO. b6-2 | BED NO.

24° [redacted]

DATE OF ORDER: 31 JUL 03 TIME OF ORDER: 0819 HOURS

NPO after midnight
Start IV @ 1800 today
Fluid NS @ 100 cc/hr.
Consult Ign on call to OR

[redacted] b6-2

[redacted] AW 0830

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 04AUG03 TIME OF ORDER: HOURS

Albuterol 2 puff q6° PRN wheeze

noted 04AUG03 @ 0915 VTA Sgt. [redacted] b6-2

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

NURSING UNIT | ROOM NO. | BED NO.

24° Chart [redacted] AW 4 Aug 03 0939

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

b6-2

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 May 03 TIME OF ORDER: 1030 HOURS

LIST TIME ORDER NOTED AND SIGN

Resume previous orders
D heel dressings BID
Paxil 20 g PO qd
MSO4 2-6 g IVP q 2-4 PRN pain
Phenergan 12.5 g IVP q 6-8 PRN nausea

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: IVF LR @ 100 cc/hr TIME OF ORDER: HOURS

[redacted] b6-2

[redacted] 1125 1 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 May 03 TIME OF ORDER: 1828 HOURS

(1) ↑ Ensure + 1 to 6 cans/day + regular meal (Target Calories 4000 cal/day if unable to eat/drink 6 kg) replace Dobhoff

(2) Plain X-rays of both feet to r/o osteomyelitis plus calcaneus

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

[redacted] b6-2

[redacted] May 1 AM 0300

[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	FIRST TIME ORDER NOTED AND SIGN
[redacted] b6-4			4 Aug 03	0724 HOURS	
			Δ Albuterol to 2 puff q 6° PRN		noted 04AUG03 @ 0915 VIA SGT [redacted]
			Colace 100g PO BID		
24° Chart ✓ [redacted] b6-2			0937 4 Aug 03 [redacted]		b6-2
NURSING UNIT: ICU3	ROOM NO.	BED NO. 4			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4			6 Aug 03	1634 HOURS	
			D/C Foley		
			V.O. per Dr [redacted] b6-2		[redacted]
NURSING UNIT: ICU3	ROOM NO.	BED NO. 24° Chart	[redacted] 07AUG03 0400		6 Aug 03
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4			8/8/03	0728 HOURS	
			Cipro 500g PO BID X 3 days		Hd by [redacted] 08 Aug @ 1115 b6-2
NURSING UNIT: ICU3	ROOM NO. 24°	BED NO. [redacted]	b6-2 [redacted]	8 Aug 03 1249	
PATIENT IDENTIFICATION			ORDER	TIME OF ORDER	
[redacted] b6-4			8/9/03	0830 HOURS	
			(1) D/C PIV		
			(2) Benadryl 25mg PO Q6° PRN itch		
			(3) Atarax 10mg PO Q8°.		
			Δ Atrax 10mg PO Q8° To Atran 25mg PO Q8°		Noted 1000 on 09 Aug 03 [redacted]
NURSING UNIT: ICU3	ROOM NO.	BED NO. 4	b6-2 [redacted]		b6-2

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

24° Chart ✓ [redacted] 1726 11 Aug 03

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"USE BALL POINT PEN—PRESS FIRMLY! NO CARBON PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.
24° Chart		[redacted]

DATE OF ORDER: 16 Aug 03 TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Resume pre op orders

(2) Add (B) heel wet to dry

Dressing D's BID

[redacted] b6-2

1715 17 Aug 03

PATIENT IDENTIFICATION

[redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.
24° Chart		[redacted]

DATE OF ORDER: 18 Aug 03 TIME OF ORDER: 0713 HOURS

Δ VS to Q shift

V.O. per Dr. [redacted] b6-2 [redacted] b6-2

b6-2 [redacted] 0716 18 Aug 03

[redacted] 2200 19 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 31 Aug 03 TIME OF ORDER: 1016 HOURS

Please give patient MSO4 5 mg IVP now

[redacted] b6-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
		[redacted]

DATE OF ORDER: 31 Aug 03 TIME OF ORDER: 1034 HOURS

Dressing Δ's to both heels T vaseline gauze QD

[redacted] b6-2

b6-2

1 SEP 03

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER: 22 AUG 03 TIME OF ORDER: 1430 HOURS

(1) Please Apply Silvadene to (L) heel wound. BID

(2) QA Every wound

[redacted] b6-2

LIST TIME ORDER NOTED AND SIGN

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

PATIENT IDENTIFICATION

#0 [redacted] b6-4

DATE OF ORDER: 23 AUG 03 TIME OF ORDER: 0945 HOURS

(1) NPO PMN

(2) Cipro 500 mg po BID x 3 days

(3) on call to OR in AM

[redacted] b6-2

[redacted] 23 Aug 03 0955

NURSING UNIT: ICW | ROOM NO. 2PR | BED NO. 2345 2320

[redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Aug 03 TIME OF ORDER: 1450 HOURS

(1) LR @ KVO for surgery in AM

(2) Regular Diet

(3) NPO PMN

(4) Please cover PIV site q 4°

[redacted] MAJ/CWA [redacted]

[redacted] b6-2

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 25 AUG 03 TIME OF ORDER: 1830 HOURS

(1) NPO PMN

Regular Diet Now

b6-2

[redacted] b6-4

NURSING UNIT | ROOM NO. 2PR | BED NO. 2330 [redacted]

b6-2

[redacted]

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

Dave

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b6-4

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

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

26 AUG 03 — 1030 HOURS

(1) Admit to PACU → ward
S/p skin graft to heels
Cond stable
Vitals @ Bedside Q shift
All Ø
Act Bed rest
Nurse (1) Apply Eucerin Cream to

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER — HOURS

all Healed Graft sites
Silvadene with kerlix to STSG sites
(2) with openings
(3) IP to 125 cm H_2O wall suction
continuous.

NURSING UNIT | ROOM NO. | BED NO.

(4) Do not change Dressings on Heels
or Buttock creases or (12) thumb.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER — HOURS

Regular Diet
IUF - HL
weds
Ancef 1 gm IV Q 8° x 24 hrs
Klonopin 80mg SQ BID start tonite

NURSING UNIT | ROOM NO. | BED NO.

[redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER — HOURS

26 Aug 03 — 1115

(10) MSO4 2mg q 5 min to max 10mg IV
Keep RR > 10 @ sat > 95 [redacted]

b6-2

(11) MSO4 2-10 mg IV Q1° PRN Pain

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

DA FORM 1 APR 79 4256 REPLAI MEDCOM - 13347 ICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b6-4

[redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.
1WW#1		

DATE OF ORDER: 27AUG03 TIME OF ORDER: 0030 HOURS

LIST TIME ORDER NOTED AND SIGN

1. LR bolus 1L rt now
2. CBC, T+C x2 units p̄ bolus
3. Notify MD if Hct < 28, cont'd saturated drsgs, HR > 100
4. O2 2LNC PRN to keep sats > 95%

V.O. DR [redacted] / [redacted]

PATIENT IDENTIFICATION: 24/0115 27AUG03 [redacted]

DATE OF ORDER: 27AUG03 TIME OF ORDER: 0300 HOURS

1. LR @ 125cc/hr
2. CBC in AM
3. NPO for OR in AM.

V.O. DR [redacted] / [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted] b6-4 Noted 27 Aug 03 1200 27 Aug [redacted] b6-2

DATE OF ORDER: 27AUG03 HOURS

1. ✓ Give long act K Surgery 4d for 3 days
2. Transfuse to PRBC
3. ✓ CBC + PT/PTT p̄ transfusion
4. ✓ Regular Diet
5. ✓ VS q4°
6. Continue previous orders [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted] b6-2

DATE OF ORDER: 27AUG03 TIME OF ORDER: 2130 HOURS

1. DC IVFs
2. Percocet 1-2 po q4-6° prn pain

V.O. DR [redacted] / [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.
2W/	28AUG03 [redacted]	

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

Noted 28 Aug 03 0900 [redacted] b6-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
28 AUG 03	HOURS	
1. Start IV @ 100 cc/hr		
2. Phenobarbital 30 mg IM q 8 hr PRN		
3. CBC + chem 7 in A.M.		b6-2
		[redacted]

NURSING UNIT	ROOM NO.	BED NO.
FCU	28 Aug 03	24 Chart [redacted]

b6-2

PATIENT IDENTIFICATION

Noted [redacted] b6-2

DATE OF ORDER	TIME OF ORDER	
29 AUG 03	1550 HOURS	
1 CBC in AM		b6-2
		[redacted]

NURSING UNIT	ROOM NO.	BED NO.
2/2	2345	30 Aug 03 [redacted]

b6-2

PATIENT IDENTIFICATION

Noted [redacted] b6-2

DATE OF ORDER	TIME OF ORDER	
30 AUG 03	HOURS	
1. Transfuse two (2) units PRBC		
2. Fosamax 35 mg tab PO		[redacted]
		b6-2

NURSING UNIT	ROOM NO.	BED NO.
2/2	[redacted]	30 Aug 03

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
31 Aug 03	1000 HOURS	
VO Dr. [redacted]		b6-2
Drs dis to bilat heel		
w/ vaseline gauze +		
Kerlix wrap		[redacted]

NURSING UNIT	ROOM NO.	BED NO.
2/2	201	1 Sep 03

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b6-4 Noted 28 Aug 03 0900 [redacted] b6-2	28 Aug 03	HOURS	
	1/ Start IV @ 100 cc/hr		
	2/ Phenergan 25 mg IVPB q 8° prn nausea		
	3/ CBC + chem 7 in A.M.		
			[redacted] b6-2
NURSING UNIT / ROOM NO. / BED NO.			
JCWA / 20 Aug 2002 24 Chart / [redacted]			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Next Shift [redacted] b6-2	24 Aug 03	1550 HOURS	
	1 CBC in AM		
			[redacted] b6-2
NURSING UNIT / ROOM / BED NO.			
240 / 2345 / 20 Aug 03 [redacted] b6-2			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	30 Aug 03	HOURS	
	1. Transfuse 2 (2) units PRBC		
	2. Fosamax 35 mg tab PO		
			[redacted] b6-2
NURSING UNIT / ROOM / BED NO.			
240 / 0200 / 30 Aug 03 [redacted] b6-2 Noted with [redacted] 30 Aug 03 0800			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	31 Aug 03	1000 HOURS	
	VO Dr. [redacted] b6-2		
	Drs. D's to bilat heels		
	w/ vaseline gauze +		
	Kerlix wrap		[redacted]
NURSING UNIT / ROOM NO. / BED NO.			
240/2 / 20 / 1 SEP 03 [redacted]			

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

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is [illegible]

THE DOCTOR SHALL RECORD DATE, TI[illegible] SIGN EACH SET OF ORDERS. IF PROB[illegible] RIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMB[illegible] IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

#0[redacted] b6-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
06SEP03	1000 HOURS	

OOB to chair X3 days, then pt may ambulate ad lib
VO. DR [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	2	A

24th/2115 06SEP03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
08 Sept	1500 HOURS

(1) D/C Lovenox
(2) D/C IV

Per Dr [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.
24th	2015	[illegible]

PATIENT IDENTIFICATION

[redacted] b6-4

Noted 9 Sept [illegible]

DATE OF ORDER	TIME OF ORDER
9Sep 03	0820 HOURS

(1) Pt may Ambulate with Assist.
(2) D/C ATARAX
(3) Ace wrap to heels for Ambulation.

NURSING UNIT	ROOM NO.	BED NO.
24th	2015	9SEP[redacted]

b6-2 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

Noted 10 Sept

[redacted] b6-2

DATE OF ORDER	TIME OF ORDER
10Sep03	900 HOURS

(1) Wet to Dry Dressing to Buttock wounds BID
(2) Warm compress to foot with Q6 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24th	2100	10SEP03

b6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

#[redacted] b6-4

b6-2 Noted [redacted] 13SEP03 0710

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13sep03 | TIME OF ORDER: 0710 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) warm compresses to tender areas on (R) Leg Q6° As needed

[redacted] b6-2

PATIENT IDENTIFICATION

b6-2 [redacted] Noted 13SEP03 1630

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] b6-2

DATE OF ORDER: 13sep03 | TIME OF ORDER: 1630 HOURS

(1) Mom 800 mg PO TID

b6-2 [redacted]

b6-2 [redacted] 9/14/03 0500

PATIENT IDENTIFICATION

DATE OF ORDER: 26Sept03 | TIME OF ORDER: 1630 HOURS

b6-2

VO DR [redacted]

Begin dress OS to (B)/buttock w/ NSS and Dakins Solution. BID.

NURSING UNIT | ROOM NO. | BED NO.

tcw 24 | 27sep03@0445 | 110

PATIENT IDENTIFICATION

Noted

[redacted] b6-4 noted

DATE OF ORDER: 27 Sep 03 | TIME OF ORDER: 1402 HOURS

Ventolin inhaler 2 puff Q6° PRN

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256 REPLACES MEDCOM - 13352 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] k6-41				6 OCT 03	0913 HOURS	
				NPO after midnight		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.		24 2405 [redacted]	k6-2	
ICW#1	2	A				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 OCT 03 TIME OF ORDER: 1700 HOURS | LIST TIME ORDER NOTED AND SIGN

Transfer to ward
Dx. S/P closure buttock wound
condition stable
IV LR @ 100 cc/hr heparin lock
Ancef 1 gm q 8° x 48°
first dose on return to ward
Ventolin 2 puffs q 6° PRN

PATIENT IDENTIFICATION: Noted [redacted] 07OCT03 1750 b6-2

DATE OF ORDER | TIME OF ORDER

Percocet 1-2 PO q 4° PRN pain
MSO4 2-4 mg IVP q 3° PRN pain
Deny changes OD to buttock wound
MOA
Dr [redacted] b6-2
ON [redacted]

NURSING UNIT | ROOM NO. | BED NO.

10/8/03 0135 24°K [redacted] b6-2

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

DATE OF ORDER: 12 OCT 03 HOURS

Eucerin cream to wound (healed) have patient apply herself
May have Tylenol #3 1-2 tabs PO q 4° PRN pain if pain more mild
[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

ICW | 24°V | 12OCT03 2045

PATIENT IDENTIFICATION: 12OCT03 [redacted] 2045 b6-2

DATE OF ORDER: 12 OCT 03 TIME OF ORDER: 2045 HOURS

(1) Loperamide 1 qflm each stool max 4 per day
[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

24°V | 13 OCT 03 | 1910 RDI

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

Noted

b6-2 [redacted] 07OCT03

NURSING UNIT | ROOM NO. 0750 | BED NO.

DATE OF ORDER 7 OCT 03 | TIME OF ORDER 0723 HOURS | LIST TIME ORDER NOTED AND SIGN

Please send CBC, chem 7 and start IV

IVF LR @ 100 cc/h

[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10/10/03 TIME OF ORDER: 0800 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU 3
Full Thickness Burn
cond stable
Vitals Q1° c̄ I/O ; SAT
All Ø
Act. OOB -> Chair

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b6-2 [redacted]

Foley to gravity
Foley care
Ace wrap to (L) leg at All times
Central Line care.
Silvadene Dressing Δ's
per protocol

PATIENT IDENTIFICATION: [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Diet Regular NPO P 0200 for Conc sedation
INF LR @ 50cc/hr
Meds
Levaquin 500mg IV QD
Vancomycin 1g IV BID
Ketamine } for sedation titrate to Effect
Fentanyl

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Versed > for sedation
Fentanyl Patch 50µg/hr to CW Q3 days
MSQ 1-5mg Q1° for Breakthrough

NURSING UNIT | ROOM NO. | BED NO.

CBC Medlyte 3 QAm

11 Jun 03 [redacted]

DA FORM 1 APR 79 4256 [redacted] WHICH MAY BE U [redacted]

b6-2

10/10/03 1000

CLINICAL RECORD - DOCTOR'S ORDERS

F e of this form, see AR 40-66, the proponent ager OTSG

THE DOCTOR SHALL RECORD DA ME AND SIGN EACH SET OF ORDERS. IF EM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM MBER IN COLUMN INDICATED BY ARROW BE

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] b6-4 noted				16 OCT 0	1456 HOURS	[redacted]
				D/C to Camp in Am		
				Convoy / Guard if orders need		
				Please give adequate		
				Supply of 10 days chemo S'		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
ICW1				[redacted] b6-2		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME [redacted] HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Jul Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3Jul	[redacted]	Admit to ICU 3	3 Jul		Done	[redacted]
3Jul03	[redacted]	ABG Now	3Jul03		1530	[redacted]
3Jul03	[redacted]	EKG Now	3Jul03		1545	[redacted]
5Jul	[redacted]	No Labs on 6/Jul/03	6Jul	0400	0400	[redacted]
5Jul	[redacted]	T&C 2 units blood	6Jul	—	0245	[redacted]
5Jul	[redacted]	NPO p̄ MN	6Jul	0000	0000	[redacted]
9Jul	[redacted]	Abbiff Placement ✓	9Jul	stat		[redacted]
9Jul03	[redacted]	Type + Cross 2units PRBCS for OR tomorrow	9Jul03			[redacted]
9Jul03	[redacted]	NPO p̄ MN	9Jul03			[redacted]
	-----	66-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 Jul	[redacted]	Condition Stable	05	[redacted]													
			17	[redacted]													
3 Jul	[redacted]	Vitals q 1°, I+O, Sat	05	[redacted]													
			17	[redacted]													
3 Jul	[redacted]	Activity: bedrest	05	[redacted]							5 Jul 0700						
			17	[redacted]													
3 Jul	[redacted]	Foley to gravity	05	[redacted]													
			17	[redacted]													
3 Jul	[redacted]	Burn dressing Δ's	05	[redacted]													
		per protocol (bid)	17	[redacted]					> Δ'd 6 Jul 05								
3 Jul	[redacted]	Reg diet	05	[redacted]													
			17	[redacted]													
3 Jul	[redacted]	Labs: ~~CXR~~ DC, CBC,	04	[redacted]													
		Chem 8 q am															
5 JUL	[redacted]	Patient may ambulate	05	X	X	X	[redacted]										
			17	X	X	[redacted]											
6 JUL	[redacted]	Wet to Dry drsg QD@	10 05	[redacted]	/	/	[redacted]										
		excision sites (bilat legs															
		and stomach)															
6 JUL	[redacted]	Regular diet	05	/	/	/	[redacted]										
			17				[redacted]										
9 Jul 03	[redacted]	Incentive Spirometry	05	/	—	—	—	—	/	[redacted]							
			17	/	—	—	—	/	/	[redacted]							

all 66-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: DVT, Burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted]

[redacted] 66-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12	13	14	15	16	17	18	19	20	21	22	23
10 Jul	[redacted]	Vitals q1° c̄ I&O & Sat	05	[redacted]													
			17	[redacted]													
10 Jul	[redacted]	~~Activity OOB~~ → chair	05	[redacted]													
17 Jul		Bedrest	17	[redacted]										7/17/03			
10 Jul	[redacted]	foley to gravity	05	[redacted]													
			17	[redacted]													
10 Jul	[redacted]	foley care q shift	05	[redacted]													
			17	[redacted]													
10 Jul	[redacted]	Ice wrap to (L) leg	05	[redacted]													
		at all times	17	[redacted]													
10 Jul	[redacted]	Central line care	05	[redacted]			[redacted]		[redacted]				[redacted]		[redacted]		[redacted]
			17	[redacted]							[redacted]			July 03			
10 Jul	[redacted]	Silvadene dressing Δ's	05	[redacted]													
		per protocol (takes	17	[redacted]													
10 Jul	[redacted]	Diet regular	05	[redacted]										c			
			17	[redacted]													
10 Jul	[redacted]	NPO p̄ 0200 for conscious	05	[redacted]										c			
		sedation	17	[redacted]													

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P Burn Debridement

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b6-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12	13	14	15	16	17	18	19	20	21
10 Jul	[redacted]	CBC, mellyte 8	[redacted]												
		q AM													
10 Jul	[redacted]	TF @ 2000 Kcal/day	05	[redacted]											
		start @ 40 a/hr and	17	[redacted]											
		advance to goal rate													
		as tolerated													
15 Jul	[redacted]	Continous suction to JPS	05	/	/	/	/	/	[redacted]						
		abdominal dressing.	17	/	/	/	/	/	[redacted]						
		Keep suction @ 125 mm Hg	/												
15 Jul	[redacted]	Bedrest until taken	05	/	/	/	/	/	[redacted]						
		back to OR then	17	/	/	/	/		[redacted]						
		re-evaluate	/												
15 Jul	[redacted]	Keep graft sites	05	/	/	/	/	/	[redacted]						
		(bilateral upper	17	/	/	/	/	/	[redacted]						
		thighs) moist	/												
15 Jul	[redacted]														

911 b6-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS: S/P Burn Debridement	ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO: 2

PATIENT IDENTIFICATION: [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo JUL Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----	Admit to BCU 3, Full Thickness				
	-----	Burn, Condition Stable.				
19 JUL03	[redacted]	DIET: NPO P MN 19JUL03 FOR SURGERY	19 JUL03	2400		
19 JUL03	[redacted]	LAB: T/C FOR 2 UNITS PRBC	19 JUL03		1530	[redacted]
	-----	b6-2				b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23
20 Jul	[redacted]	Condition stable	05	[redacted]		[redacted]	[redacted]
			17	[redacted]			[redacted]
20 Jul	[redacted]	V.S. q 1° c̄ sat	05	[redacted]			[redacted]
			17	[redacted]			[redacted]
20 Jul	[redacted]	Bedrest	05	[redacted]			[redacted]
			17	[redacted]			[redacted]
20 Jul	[redacted]	JPs to 125 mmHg	05	[redacted]			[redacted]
		Continuous suction	17	[redacted]			[redacted]
		(4 JPs)					
20 Jul	[redacted]	Moisten ® calf STSG	05		[redacted]		[redacted]
		site c̄ 5% Sulfamylon	17		[redacted]		
20 Jul	[redacted]	Foley to gravity	05		[redacted]		[redacted]
			17		[redacted]		
20 Jul	[redacted]	No TF for the next	05		[redacted]		[redacted]
		3 days.	17		[redacted]		
20 Jul	[redacted]	Diet – clears	05		[redacted]		[redacted]
			17		[redacted]		
20 Jul	[redacted]	QD silvadene Dressing	05		[redacted]		[redacted]
		Δ's to remaining					
		burns, older STSG					
		sites and open donor					
		sites.					
20 Jul	[redacted]	Position pt on sides	05		[redacted]		[redacted]
N.O.	[redacted]	most of day. (N.O. document	17		[redacted]		
		on nursing flowsheet)					
20 Jul	[redacted]	CBC, Chem 8 QOD	04		[redacted]		

Δ [redacted]

all b6-2

ALLERGIES: ☐ YES ☑ NO — Ø

PRIMARY DIAGNOSIS: S/p STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

#[redacted] b6-4

Duplicate

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20Jul	[redacted]	Admit to ICU 3	20Jul		Done	[redacted]
	-----	b6-2				b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24
20 Jul	[redacted]	Ace wraps to (B) legs	05	[redacted]			[redacted]	
		w/ splints.	17	[redacted]				
10 Jul	[redacted]	NPO p 0200 for	05	[redacted]			[redacted]	
		Conscious Sedation	17	[redacted]				

all bb-2

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/p STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted] bb-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30	31	1	2	3	4
7 Jul	[redacted]	Ace wraps to (B) Legs	06	[redacted]													
		c̄ splints	18														
10 Jul	[redacted]	NPO p̄ 0200 for	06	[redacted]													
		conscious sedation	18														
25 Jul 03	[redacted]	Add Dietary supplement	06	/	/	[redacted]											
		(Ensure/Carnation)	18	/	/												
		breakfast to equate of															
		3 cans/day															
27 July 03	[redacted]	Labs Q Tuesday and	04							→	[redacted]			→	[redacted]		
		Saturday CBC + Chem 8															
27 July 03	[redacted]	Vital Signs Q 4°	06					→	[redacted]								
			18					→	[redacted]								
1 Aug 03	[redacted]	Δ Heel Dressings	08	/									/	[redacted]			
		BID (Use Silvadene Cream)	20	/									/	[redacted]			
1 Aug 03	[redacted]	↑ Ensure +1 to 6 cans/	6											[redacted]			
		day + Regular meal	18											[redacted]			
		(Target Calories 4000															
		cal/day. If unable															
		to eat/drink 6 cans															
		replace dayhoff.															

ASC 66-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30	31	1	2	3	4
22Jul	[redacted]	Condition stable	06	[redacted]													
			18	[redacted]													
22Jul	[redacted]	VS q1° c̄ SATS	06	[redacted]													
			18	[redacted]													
22Jul	[redacted]	Bedrest	06	[redacted]													
			18	[redacted]													
22Jul	[redacted]	JP's to 125 mmHg	06	[redacted]													
		continuous suction	18	[redacted]													
		(4 JP.)															
22Jul	[redacted]	Moisten ⓒ calf STSG	06	[redacted]													
		site c̄ Sq Sufamylon	18	[redacted]													
22Jul	[redacted]	Foley to gravity	06	[redacted]													
			18	[redacted]													
22Jul	[redacted]	NO TF for the next	06	[redacted]													
		3 days	18	[redacted]													
22Jul	[redacted]	Diet ~~clear~~ regular	06	[redacted]													
			18	[redacted]													
22Jul	[redacted]	QD silvadene Dressing	06	[redacted]													
		D's to remaining															
		burns, older STSG															
		sites and open donor															
		sites															
22Jul	[redacted]	Position pt on sides	06	[redacted]													
		most of day (document	18	[redacted]													
		on nursing flow sheet															
22Jul	[redacted]	CBC, Chem 8 QOD	04	[redacted]								X		X		X	
												[redacted]	D'ed 27 July 03				

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P STSG

ADDITIONAL PAGES IN USE: [redacted] ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b6-4

b6-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1Aug	[redacted]	Plan X-rays of both feet to R/O	2Aug	0400		
	[illegible]	osteomyelitis				

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

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 2003
Order Date	Clerk Nurse	b6-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Aug 03	[redacted]	Resume previous orders	1 Aug 03		1042	[redacted] b6-2

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 07 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Recopy SAug	[redacted]	Labs Q Tuesday	04	[redacted]	/	/	/	[redacted]	/	/	[redacted]	/	/	/		/	/
		and Saturday		Recopied													
		CBC + chem8															
Recopy SAug	[redacted]	Vital Signs Q4°	06	[redacted]													
			18	[redacted]													
Recopy SAug	[redacted]	Attend Dressings BID	06	[redacted]													
		(Use Silvadene Cream)	18	[redacted]													
Recopy SAug	[redacted]	↑Ensure Plus to 6	06	[redacted]													
		cans/day + Reg meals	18	[redacted]													
		Target calories 4000															
		Cons															
5Aug03	[redacted]	Diet Reg	06	[redacted]													
			18	[redacted]													
Recopy SAug	[redacted]	QD Silvadene Dressing	06	[redacted]													
		A to remaining burns	18	[redacted]													
		STSG sites + open															
		donor sites															
Recopy SAug	[redacted]	Position pt on	06	[redacted]													
		Sides most of day	18	[redacted]													
		(document on Nursing															
		Flow sheet)															
14Aug03	[redacted]	Add (B) heel wet to dry dressing	06	/	/	/	/	/	/	/	/	/	/	/	[redacted]		
		BID	18	/	/	/	/	/	/	/	/	/	/	/	[redacted]		

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: # [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Aug03	[redacted]	b6-2 DIC Foley	6Aug03			[redacted]
2		NPDP M.D.				b6-2

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

USAPA V1.00

CLINICAL RECORD

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

Mo. Aug Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20	21	22	23	24	25	26	27	28
17Aug03	[redacted]	Add (B) heel wet to	06	[redacted]											
		dry dressing Δ's	18	[redacted]											
		BID													
18 Aug03	[redacted]	Δ VS to Q shift	06	[redacted]											
			18	[redacted]											
Recd PV 05 Aug	[redacted]	Labs Q Tuesday + Saturday	04							[redacted]					
		CBC + Chem 8													
Recd PV 05 Aug	[redacted]	↑ Ensure Plus to 6 cans/day	06	[redacted]											
		~~Free~~ NC + Reg meals, Target Calorie	18	[redacted]											
		4000													
		~~Diet Reg~~ NC	06												
Recd PV 05 Aug	[redacted]	QD dressing Δ's to remaining	06	[redacted]											
		burns, STSG sites, + open	18	[redacted]											
		donor sites c̄ silvidine													
Recd PV 05 Aug	[redacted]	Diet Reg (NPO 24 hrs pm)	06	[redacted]											
			18	[redacted]											
Recd PV 05 Aug	[redacted]	Position Pt on sides most	06	[redacted]											
		of day (document on	18	[redacted]											
		Nursing Flowsheet)													
24 Aug	[redacted]	Please address PIN	06							[redacted]					
		Site q 4°	18							[redacted]					

all b6-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P STSG

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

PATIENT IDENTIFICATION:
[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22 Aug 03	[redacted]	UA c next void	22 Aug 03	—	1530	[redacted]
23 Aug	[redacted]	NPO p MN	23 Aug	2400	cancelled	
23 Aug	[redacted]	O/C to OR in AM	[redacted] 24 Aug	—	cancelled	
25	[redacted]	O/C to OR in AM, NPO p MN	25 Aug	AM		
	.....		25 Aug	0001		
	.....	all bb-2				
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26Aug	[redacted]	Admit to PACU → ward	26Aug	2nd	1140	[redacted]
26Aug	[redacted]	Condition stable	26	—	1140	[redacted]
27	[redacted]	CBC, T+C x2 units PRBCs bolus	27Aug	prior	—	[redacted]
27	[redacted]	Notify MD tonight if HCT<28, control	27Aug	0600	noted	[redacted]
	-----	saturated drsg, HR>100				
27	[redacted]	CBC in AM	27Aug	0600	—	[redacted]
27	[redacted]	NPO for OR in AM.	27Aug	AM	noted	[redacted]
27	[redacted]	✓ CBC + PT PTT ⊕ trans-	27Aug	1630	+	[redacted]
	-----	fusion.				
28	[redacted]	CBC & Chem 7 in AM	28Aug	0400	—	[redacted]

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all 66-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28	29	30
26 Aug	[redacted]	VS @ BS @ Shift	06	[redacted]				
			18	[redacted]				
26 Aug	[redacted]	Activity Bedrest	06	[redacted]				
			18	[redacted]				
26 Aug	[redacted]	Apply Sucerm	06	[redacted]				
		Cream to all	18	[redacted]				
		healed Graft	X					
		sites	X					
26 Aug	[redacted]	Silvadene with	06	[redacted]				
		Kerlex to STSG	18	[redacted]				
		sites with openings	X					
26 Aug	[redacted]	JP to 125 cc H2O	06	[redacted]				
		Wall suction	18	[redacted]				
		continuous	X					
26 Aug	[redacted]	Do NOT change	06	[redacted]				
		dressings on	18	[redacted]				
		heels, or Buttocks	X					
		creases or (R) thumb	X					
26 Aug	[redacted]	Regular Diet	06	[redacted]				
			18	[redacted]				
27 Aug	[redacted]	Vitals Q4°	06	[redacted]				
			18	[redacted]				

ed 27 Aug 03

recopied

All b6-2

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKA	S/P Skin Graft to heels	PAGE NO:

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

~ REWRITTEN ~

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
27 aug	[redacted]	Regular diet	6	[redacted]													
			14														
			22														
27 aug	[redacted]	VS Q4°	6														
			14														
			22														
27 aug	[redacted]	Apply Eucerin	10														
		Cream to all healed	22														
		graft sites	X														
27 aug	[redacted]	Silvadene c̄ Kerlex	10														
		to STSG sites c̄	22														
		openings	X														
28 sun	[redacted]	Incentive Spirometry	6	[redacted]													
			14	[redacted]													
			22	[redacted]													
29 aug	[redacted]	Dressg Δ QD to BILAT	10	[redacted]													
		heels c̄ vaseline	X														
		gauze & Kerlex wrap	X														
			X														
9 sep	[redacted]	May ambulate c̄	6	[redacted]													
		assist, Ace wrap	14	[redacted]													
		to heels for MMB	22	[redacted]													
		~~Warm compress to ms~~															
		~~tender areas on (R) ...~~															
20 sept	[redacted]	Wet → Dry Dressg to	10	[redacted]													
		(L) knee open area BID	22	[redacted]													

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted] b6-4

All b6-2

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — USED. — USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General	Mo. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER C[illegible] IN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	1	2	3	4	5	6	7
27 AUG 03	[redacted]	Regular diet	06	[redacted]												
			18													
27	[redacted]	VS ~~q4~~ KAS q shift	06	[redacted]												
			18													
27	[redacted]	Apply Eucerin cream	06	[redacted]												
		to all healed graft sites	18	[redacted]												
27	[redacted]	incentive spirometry	06	[redacted]												
			18	[redacted]												
31 AUG 03	[redacted]	drsg Δ QD to (B) heels c̄	10	[redacted]												
		vaseline gauze/kerlex	/													
		wrap	/													
09 SEP 03	[redacted]	may amb c̄ assist, ace	06	[redacted]												
		wrap to heels for amb	18	[redacted]												
26 SEP 03	[redacted]	wet-dry drsg to (C)	10	[redacted]												
		knee open area BID	22	[redacted]												
26 SEP 03	[redacted]	Begin (B) buttock drsg	10	/	/	[redacted]										
		w/ Dakin's solution	22	/		[redacted]										
		W→D BID	/													

All 66-2

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#0[redacted] 66-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 08 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28 Aug03	[redacted]	CBC, Chem 7 in am	29aug03	—	—	[redacted]
29 AUG03	[redacted]	CBC in AM	30 AUG03	0500	0500	[redacted]
30 AUG03	[redacted]	Transfuse two (2) units PRBC	30 AUG03	—	1020	[redacted]
	-----	\ bb-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
27 Aug	[redacted]	Notify MO if HCT < 28, cont'd Saturated dsg's, HR > 100	2046 0700 LAS													
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 06	07	08	09	10
06 Sep03	[redacted]	OOB to chair X3	06	[redacted]				
		days, then ambad	18	[redacted]				
		lib (09Sep03)						
9Sept	[redacted]	May Ambulate E	X					
9Sept	[redacted]	asst Ace wraps	06				[redacted]	
		to Heels for	18				[redacted]	
		ambulation	X					
10Sep	[redacted]	Wet to Dry Drsg	10				[redacted]	
		to Buttocks wound	22				[redacted]	
		BID						
10Sep	[redacted]	Warm Compress to	06 TS				[redacted]	
		R foot IV site Q6°	18 06				[redacted]	

Discontinued

All b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P SKIN GRAFTS TO HEELS

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: #0[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
13SEP03	[redacted]	Warm compress to tender areas on @ leg 96° as needed.														

USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6	[redacted]	NPO p MN	6 OCT 03	2359	—	[redacted]
07 OCT 03	[redacted]	Please send CBC, chem 7	07 OCT 03	—	0735	[redacted]
10/16	[redacted]	DC to camp in Am	10/17	Am		
10/16	[redacted]	Please give adequate supplies of 10 day dressings	10/17			
		b6-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
13SEP03	[redacted]	warm compress to tender areas on R leg q 6° as needed	D/T
	b6-2		

CLINICAL RECORD	THERA[illegible]TIC DOCUMENTATION CARE PLAN (N[illegible]-MEDICATION) For use of this form, see AR 40-407; [illegible]he proponent agency is the Office of The Surgeon	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER CO[illegible] FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 07	08	9	10	11	12	13	14	15	16	17	18	19
07 Oct 03	[redacted]	Dressing changed QD	10	/	[redacted]											
b6-2		to buttocks wound						b6-2								
		(@buttock only 10/10)														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P CLOSURE BUTTOCK WOUND

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

PATIENT IDENTIFICATION:

#C[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
07 OCT03	[redacted]	Transfer to ward, Cond. - Stable	07 OCT03	—	—	[redacted]
	----	bb-2				bb-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
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Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. July Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
3d-4	[redacted]	Recopied 10 July 03 m SO4 1-10mg IV q1° prn														
- - - - -	hb-2	pain for dressing Δ's														
- - - - -	- - - - -															
3d-4	[redacted]	Recopied 10 July 03 Versed 1-5mg IV q1° prn														
- - - - -	hb-2	sedative for dsg Δ														
- - - - -	- - - - -															
3d-4	[redacted]	percocet 1-2 q4°ps														
- - - - -	hb-2	prn pain														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. JUL Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3Jul03	[redacted]	NS 500cc Bolus x1 IV	3Jul03		1545	[redacted]
3Jul03	[redacted]	Narcan 0.2mg IV Now	3Jul03		1550	[redacted]
3Jul03	[redacted]	Give another 500cc NS Bolus Now	3Jul03		1656	[redacted]
4Jul	[redacted]	Lasix 20mg IVP	4Jul03		0255	[redacted]
6Jul	[redacted]	Resume previous orders except	6Jul03	done	1255	[redacted]
	-----	⊙↓IVF to LR@100cc/hr				[redacted]
8Jul	[redacted]	KCl 40mEq in 100cc NS over 2 hrs	8Jul03	Now	0900	[redacted]
9Jul03	[redacted]	Lasix 10mg IV Now	09Jul03		1100	[redacted]

	-----					

all 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
3Jul	KP	MSO4 1-10mg IV	D 3Jul03	3Jul03	3Jul	3Jul	3Jul	3Jul03	3Jul	3Jul	3Jul	3Jul	5Jul	5Jul	5Jul	6Jul
			T 1200	1213	1235	1243	1250	1308	1316	1320	1342	1355	0000	2045	2200	1400
-----	-----	g 1° prn pain for	D 2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	10mg	10mg	10mg	2mg
			I [redacted]													
-----	-----	dressing Δ's														
3Jul	KP	Versed 1-5mg IV	D 3Jul03	3Jul03	3Jul	3Jul03	3Jul03	3Jul	3Jul	3Jul	5Jul	5Jul	5Jul	6Jul	8Jul	8Jul 10Jul
			T 1204	1213	1235	1243	1308	1316	1325	1342	0000	2045	2200	2107	2215	2330 0010
-----	-----	g 1' prn sedation	D 2mg	1mg	1mg	1mg	2mg	1mg	1mg	1mg	5mg	5mg	5mg	4mg	3mg	4mg 5mg IV
			I [redacted]													
-----	-----	for dressing Δ'														
3Jul	KP	Percocet I-II	po g 4°	3Jul 2300	8Jul 2300	8Jul 1332	8Jul 2301	9Jul03 1345								
				II	II	2100	2200	2300								
-----	-----	prn pain	[redacted]													
-----	-----	Recycled 7/8/03	SN	SN												
			+	+												
3Jul 03	[redacted]	MSO4 1-10mg IV	7Jul 2130	7Jul 2200	8Jul 2100	0200	8Jul 0400	2215	8Jul 2300	9Jul 0030	9Jul 1300	9Jul 1830	10Jul 0010			
			6mg	4mg	2	4	4	5mg	3mg	3mg	2mg					
-----	-----	g1 prn/pain +	−	+	+	+	+	−	+	[redacted]						
-----	-----	dressing Δ														
-----	-----															

result 10July03 [redacted]

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 Jul	[redacted]	IVF LR @ ~~150cc/hr~~	05	[redacted]													
0920	[redacted]	↑ rate to 200cc/hr	17	[redacted]													
3 Jul	[redacted]	Proventil MDI II	04	/	[redacted]												
		puffs q 4°	08	/	[redacted]												
			12	/	[redacted]												
			16	[redacted]													
			20	[redacted]													
			24	[redacted]													
3 Jul	[redacted]	Lovenox 90mg SQ	10	[redacted]													
		bid°	22	[redacted]													
3 Jul	[redacted]	Levaquin 500mg IV q day	10	[redacted]													
6 Jul	[redacted]	↓ IVF to LR @ 100cc/hr	05	/	/	/	[redacted]			/							
			17	/	/	/	[redacted]			/							
9 Jul 03	[redacted]	vancomycin 1gm IV	12	/	—	—	/	/	/	[redacted]							
		q 12°	24	/	—	—	—	—	/	[redacted]							
9 Jul 03	[redacted]	↓ IVF (LR) to 20cc/hr	05	/	—	—	—	—	/	[redacted]							
			17	/	—	—	—	—	/	[redacted]							
9 Jul 03	[redacted]	↑ IVF to 100cc/hr	05	/	/	/	/	/	/	/							
		Tube feeding stopped	17	/	/	/	/	/	/	[redacted]							

all b6-2

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Burn, DVT

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: # [redacted]

b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

CLINICAL RECORD

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
			11	11	12	13	14	15	16	17	18							
11 Jul	[redacted]	Thorazine 10mg IM	10	[redacted]	DC	Δ	to	po	11 July 03	2000								
		BID	22															
11 Jul	[redacted]	Therazine 25mg p.o.	06		NPO	[redacted]	Held	Hold NPO	[redacted]									
		TID	14		[redacted]					D/c'd	16 JUL 03							
			22	m	[redacted]					[redacted]	[redacted]							
			X															
15 July	[redacted]	Keep thighs ST SG dressings	05	/	/	/	/	[redacted]										
		moist c 5% Sulfamylon Soln	10	/	/	/	[redacted]											
19 July 03	[redacted]	Silvadene to ANT	10	X	X	X	X	X	X	X	X							
		ABD QD																

b1 b6-2

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P Burn debridement

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. JUL Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10/7	[redacted]	20 mg lasix IVP x1 now	10 Jul	1600	1600	[redacted]
11 Jul	[redacted]	Lasix 20mg IV x 1 now	11 Jul	NOW	1125	[redacted]
11 Jul	[redacted]	MOM now + 2 hours after if no	11 Jul	1940	1940	[redacted]
	-----	result (BM)	11 July	2240	NA	[redacted]
19 JUL 03	[redacted]	HOLD LOVENOX TONIGHT AND IN AM 19JUL03 20JUL03	19JUL03			

	-----					

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
10 Jul	[redacted]	MSO4 1-5 mg q1°	D	11 July 03	12 JUL	12 JUL	13 Jul 1040	13 JUL 2100	13 JUL 0100	14 Jul 1500	14 Jul 2000	15 Jul 1130	15 Jul 1330	15 July 1730	16 JUL 0615	17 July 2028
-----	-----	for breakthrough pain	T	2230 4mg	2345 4mg	0300 4mg	4mg	4mg	4mg	4mg	4mg	[redacted]			4mg	10mg
-----	-----		I	[redacted]												
13 Jul	[redacted]	Tylenol 650mg PO	D	13 Jul 1630	14 JUL 0200	14 Jul 1230	15 July 0130	15 July 610	19 JUL 0615	19 JUL 17	20 July 0315					
-----	-----	Q4-6° prn fever	T		1015	101.0	101.2	101.5	101.8	102	[redacted]					
-----	-----		I	[redacted]			[redacted]									
-----	-----															
10 JUL 03	[redacted]	MSO4 1-5 mg IV	18 JUL 03 1000	18 JUL 1400	18 JUL 1645	19 July 0045	19 Jul 1200	19 Jul 2030								
-----	-----	Q1° FOR PAIN	5mg	5mg	5mg	7mg	4mg	5mg								
-----	-----		[redacted]													
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

CLINICAL RECORD

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

Mo. JUL Y. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12	13	14	15	16	17	18	19	20	21	22
10 Jul	[redacted]	IVF: LR @ 50 cc/hr	05	[redacted]												
			17	[redacted]												
10 Jul	[redacted]	Levaquin 500 mg IV qD	10	[redacted] — D/C'd 11 Jul 03												
10 Jul	[redacted]	Vancomycin 1g IV BID	10	[redacted]							D/C'd 16 Jul 03					
			22	[redacted]												
10 Jul	[redacted]	Ketamine } for conscious	05	[redacted]												
		Fentanyl } sedation, tit-	17	[redacted]												
		Versed } rate to effect														
10 Jul	[redacted]	Fentanyl patch 50 µg/hr	05	[redacted]												
		to q 3 days	17	[redacted]												
10 Jul	[redacted]	Lovenox 40 mg SQ BID	10	/ [redacted] HOLD												
			22	[redacted] HOLD HOLD												
10 Jul	[redacted]	Albuterol 2 puffs q4°	04	/ [redacted]												
			08	/ [redacted]												
			12	/ [redacted]												
			16	[redacted]												
			20	[redacted]												
			24	[redacted]												
11 Jul	~~[redacted]~~	Cipro 400 mg IV BID	12	/ [redacted]							D/C'd 16 Jul 03					
			24	/ [redacted]												

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P Burn Debridement

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

PATIENT IDENTIFICATION:
[redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
20Jul	[redacted]	Immodium one tab when awake	20Jul	ASAP	1400	[redacted]	
	-----	then ⅈ tab with each Diarrheal					
	-----	Stool as needed.					
25Jul03	[redacted]	1L NS bolus x ⅈ now	25Jul03		1550	[redacted]	

	-----						

911 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20Jul	[redacted]	Immodium tab ⅈ	20 Jul 1845	20 Jul 2400	23 July 03 [redacted]											
-----	-----	with each diarrheal														
-----	-----	Stool														
20Jul	[redacted]	Moy 2-10mg q 1°	20 July 0500 5mg	21Jul 0340 6mg	21Jul 1140 3mg	21Jul 2150 4mg	22 July 0100 4mg	23Jul@1900 5mg	23Jul@2130 5mg	23Jul@2330 5mg	25Jul 1145 4mg	25Jul 1600 2mg	DC'd			
-----	-----	as needed	[redacted]													
20Jul	[redacted]	Continue previous	23July03 0800 250mcg Fentanyl		24July03 [redacted]	24July03 1434 [redacted]	DC'd									
-----	-----	Sedation orders		[redacted]		25July Fentanyl IV [redacted]										
13Jul	[redacted]	Tylenol 650mg po	20Jul 1515 100.8	23 July 03 1205 100.4	23 July 03 1250 [redacted]	23July 2000 2										
-----	-----	q 4-6° prn fever														
24July03	[redacted]	Ambien 5mg PO	24 July [redacted]	DC'd 25 July 03												
-----	-----	QHS PRN	[redacted]													
25Jul03	[redacted]	Ambien 10mg qHS	25 July 2000	2 Aug 0050	1 Aug 0100											
-----	-----	PRN	2 (+)	[redacted]												

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25	26	27	28	29	30	31	Aug 1	2
20 Jul	[redacted]	IVF: LR @ 100cc/hr	05	[redacted]													
			17														
20 Jul	[redacted]	Albuterol Ti puffs	06	/	[redacted]												
		q 6°	12	/													
			18	[redacted]													
			24	[redacted]													
20 Jul	[redacted]	Lovenox 90mg SQ	10	/	[redacted]												
		bid (start tonight)	22	[redacted]													
20 Jul	[redacted]	Continue previous	05	[redacted]													
		sedation orders	17														
10 20 Jul	[redacted]	Ketamine } for continuous	05	[redacted]													
		Fentanyl } sedation -	17	[redacted]													
		Versed / track to effect	/														
10 Jul	[redacted]	Fentanyl patch 50mg/hr	05	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	
		q 3 day															

all bb-2

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
∅	S/p STSG	PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] bb-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

THERA U. UMENTATION CARE PLAN
_DICATIONS)

Mo. _____ Yr. _____

SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

all b6-2

PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
28 July [redacted] Percocet 1-2 tablet	0800 28 July 03	0740 30 July 03	0730 1 July 03	1500 1 Aug	1225 1 Aug	2249 0050	2 Aug 0113	03 Aug 0737	04 Aug 0715	4 Aug 2200	06 Aug 0745	07 Aug 0644	8 Aug 1345	9 Aug 0820
p.o. q4° PRN	TPO	TPO	TPO	TPO	TPO	TT	TT	TT	T	TT	T	T	T	T
dressing Δ's and/or	[redacted]													
pain														
1 Aug 03 [redacted] MSO4 2-6 mg IVP Q2° PRN Pain	D 2 Aug 0912 T 6 mg	D 2 Aug 4 mg 2115	D 2 Aug 2 mg 2125	2 Aug 2110 6 mg	4 Aug 2310 4 mg	6 Aug 2145 6 mg	7 Aug 0733 4 mg	9 Aug 0045 6 mg						
1 Aug 03 Phenergan 12.5 mg IVP Q6° PRN Nausea	23 Aug 1930 12.5 mg													
06 AUG 03 [redacted] Albuterol 2 puffs Q6° prn wheeze	5 Aug 0930 puffs	5 Aug 0856												
09 AUG 03 [redacted] Benadry 25mg PO Q6° prn itch	9 Aug 0830 TPO													

Rewriten

EPW [redacted] b6-4

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
01Aug03 RECEPT	[redacted]	Paxil 20mg po QD	22	[redacted]													
20Jul RECEPT	[redacted]	Lovenox 90mg SQ BID	10	[redacted]													
			22	[redacted]													
10Jul	[redacted]	Fentanyl Patch 50µg/hr	05	[redacted]													
		Q3day															
04Aug	[redacted]	Colace 100mg po	10	[redacted]													
		BID	22	[redacted]													
05Aug	[redacted]	Atarax 25 mg po	08	[redacted]													
		Q8°	16	[redacted]													
			24	[redacted]													
22Aug03	[redacted]	Please apply Silvadene	10	[redacted]													
		to heel wound BID	22	[redacted]													
23Aug	[redacted]	Cipro 500mg po	10	[redacted]													
		BID x 3 days	22	[redacted]													
24Aug	[redacted]	LR KVO	06	[redacted]													
			18	[redacted]													

all b6-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPN [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

CLINICAL RECORD

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

Mo. 07 Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 Aug 03	[redacted]	Paxil 20 mg PO QD	[redacted]														
1 Aug 03	[redacted]	NF LR @ 100 cc/hr	[redacted]														
			[redacted]											09 AUG 03			
20 Jul	[redacted]	Lovenox 90 mg SQ Bid	10	[redacted]													
Recopy			22	[redacted]													
10 Jul	[redacted]	Fentanyl Patch 50 mg/hr q 3 day	05	/	/	[redacted]	/	[redacted]	/	[redacted]	/	[redacted]	/	[redacted]	/		
~~11 AUG~~	[redacted]	~~Albuterol~~															
11 AUG 03	[redacted]	Colace 100 mg PO BID	06	/	/	/	[redacted]										
			18	/	/	10	[redacted]										
~~4 Aug 03~~	[redacted]	~~Δ Albuterol (SP 4 Aug 03 0936~~															
04 Aug 03	[redacted]	Colace 100 mg PO BID	10	/			/	/	/	[redacted]							
			22	/			/	/	[redacted]								
08 Aug 03	[redacted]	Cipro 500 mg PO Bid X 3 days	/														
			10	/	/	/	/	/	/	/	[redacted]	/	/	/	/		
			22	/	/	/	/	/	/	/	[redacted]	/	/	/	/		
08 Aug 03	[redacted]	Atarax 25 mg PO Q 8°	08	/							/	[redacted]					
			16	/							/	[redacted]					
			24	/							/	[redacted]					

all bb-2

ALLERGIES: ☐ YES ☐ NO
NKOA

PRIMARY DIAGNOSIS:
S/P STSG

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

PATIENT IDENTIFICATION:
EPW [redacted] bb-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo 09 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
9 Aug	[redacted]	FENTANYL PATCH 50mcg/	00	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X
	------	hr to CW Q3days	X														
30 aug	[redacted]	FeSO4 325mg po TID	60	[redacted]													
	------		120														
	------		180														
13 sep	[redacted]	Motrin 800mg PO	08	—	—	/	[redacted]										
	------	TID	16	—	—	/	[redacted]										
	------		24	—	—	/	[redacted]										

	------																

all 66-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: ST567

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

PATIENT IDENTIFICATION:
EPW# [redacted] 66-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
rewrite 10Aug03	[redacted]	Percocet ½-1½ tabs	10Aug 03 0733	11Aug 03 1206	11Aug 2230	12Aug 0730	13Aug 0749	13Aug 2300	14Aug 1115	14Aug 2139	15Aug 0633	16Aug 1200	16 Aug 1600	16Aug [illegible]	17Aug 0151	17Aug [illegible]	Rewrite
-----	-----	P.O. Q4° pen	[redacted]				[redacted]		[redacted]	[redacted]							
10Aug03	[redacted]	Percocet 1½ tabs	18Aug 1001	18Aug 1345	19Aug 1515	19Aug 2003	20Aug 03 1346	21Aug 03 0740									
-----	-----	PO Q4° PRN	[redacted]														
-----	-----																
-----	-----																
-----	-----																
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all b6-2

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 24	27	28	29									
25 Aug	[redacted]	IV HL	06	[redacted]												
		LR@125cc/hr	18	[redacted]												
26 Aug	[redacted]	Amicacin IV	08	[redacted]	X											
		Q8° x 24°	16	[redacted]	X											
			24	[redacted]	X											
26 Aug	[redacted]	Lovenox 80 mg	10	[redacted]												
		SQ BID start	22	[redacted]												
		tonight	X													
27	[redacted]	O2 2L NC PRN	6	X	[redacted]											
		to keep sats >95%	18	[redacted]												
27	[redacted]	Give 10mg Vit K	13	X	[redacted]											
		SubQ qd for	X													
		3 day.														
28 Aug	[redacted]	Start LR @ 100cc/hr	06	→ [redacted]												
			18	→ [redacted]												

All b6-2

ALLERGIES: ☐ YES ☑ NO
NKA

PRIMARY DIAGNOSIS:
S/P R/L skin graft to heels

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

PATIENT IDENTIFICATION:
[redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	31	1	2	3	4	5	6	7	8	9	10
28 Aug 03	[redacted]	Start LR @ 100 cc/	06	[redacted]													
		(recopied)	18														
			06														
27 Aug 03	[redacted]	Give 10mg Vit K															
		Subcutaneous QD x	13	X	[redacted]	X	X	X	X	X	X	X	X	X	X	X	X
		3 days (recopied)															
26 Aug	[redacted]	~~Levaquin 500mg PO~~	10	X	[redacted]												
		~~BID (recopied)~~	22	X													
9 Aug 03	[redacted]	Atarax ~~10mg PO Q8~~	06	X	[redacted]												
		25mg PO Q8	14	X													
		(recopied)	22	X													
9 Aug 03	[redacted]	FENTANYL PATCH	06	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]
		50 mcg/hr to CW															
		Q 3 days (recopied)															
30 Aug 03	[redacted]	FeSO4 325mg TID	06					[redacted]									
		PO	12														
			18														

911 b6-2

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: S/p skin graft to heels

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

PATIENT IDENTIFICATION:
EPW # [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 09 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27AUG 03	[redacted]	Percocet 1/1 - 00/11	D/T	8Sep 1930	9Sep 0835	9Sep 1246	10Sep 0415	10Sep 2235	11Sep 0545	11Sep 2145	12Sep 23:00	13Sep 0045	14Sep 0630	14Sep 2345	15Sep 1135	15Sep 1915
-----	-----	PO, PRN pain	D/I	[redacted]												
-----	-----	Q 4-6 (rewritten)	E/I	E											E	E
28AUG	[redacted]	Phenergan 25mg IVPB q8° PRN nausea	D/T													
-----	-----		D/I													
27..	[redacted]	O2 2LNC prn to keep Sats >95%	D/T/I													
27..	[redacted]	MSO4 2-10mg IV q1°	D/T													
-----	-----		D/I													
27..	[redacted]	Benadryl 25mg N/PO q6 PRN ITCH	D/T													
-----	-----		D/I													
27..	[redacted]	ALBUTEROL # puffs q6° PRN	D/T/I													
27AUG03	[redacted]	Percocet 1/1 - 11/11	D/T	15Sep 2145	16Sep 0800	17Sep 0215	18Sep 2316	19Sep 0710	20Sep 2326	22Sep 2355	23Sep 0080					
-----	-----	PO, PRN pain	D/I	[redacted]												

all b6-2

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 08-09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8/31	[redacted]	Please give patient 5mg $MgSO_4$ IVP now	8/31	—		[redacted]

all 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	D/T/I	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
28 Aug 03	[redacted]	PHENERgan 25mg IVPB Q8 PRN nausea	D/T/I	27Aug 0700 KRS	1Sep 2000	2Sep 0530	3Sep 0270	3Sep 1105										
					12.5mg	12.5mg	25mg	12.5mg										
				[redacted]														
27 Aug 03	[redacted]	O2 2L NC PRN to keep sats >95%	D/T/I															
27 Aug 03	[redacted]	Percocet ÷ - ÷÷ PO PRN pain Q4-6	D/T/I	28 0030	28Aug 0615	28Aug 0204	2Sep 0550	2Sep 1820	2Sep 2305	3Sep 2035	4Sep 0000	4Sep 2226	5Sep 2245	5Sep 0700	6Sep 1535	6Sep 2245	Obs pt O2 sat 0800	Obs pt O2 sat 1340
				÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷	÷÷
				[redacted]														[redacted]
26 Aug	[redacted]	MSO4 ~~2mg Q5min to max 10mg IV - keep RR ↑ to sat ↑95%~~ 2-10mg IV Q1	D/T/I	26Aug 1050	26Aug 525	26Aug 1000	26Aug 2000											
				6mg	6mg	5mg	12.5mg											
				[redacted]														
9 Aug	[redacted]	Benadryl 25mg IV/PO Q6 PRN itch	D/T/I															
6 Aug	[redacted]	albuterol ÷÷ puffs Q6 PRN	D/T/I	10Sep 0915														
				[redacted]														

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26	[redacted]	LR bolus 1L x 1 now	0045	26 Aug		[redacted]
27	[redacted]	Transfuse 1u PRBC	27 Aug	1252	[redacted]	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
26 Aug	[redacted]	MSO4 2-10 mg	26 Aug 1200	26 Aug 1438	26 Aug 1650	26th 1535	26th 1880	26th 2200	26 2300	27th 0220					
.....	.....	IV Q 1°	5mg	5mg	5mg	5mg	5mg	10mg	10mg	10mg					
.....	.....	Keep RR ↑ 10 @	[redacted]												
.....	.....	SAT ↑ 95%													
27	[redacted]	Percocet + 11 po QA- 10° prn pain	D/T	[redacted]											
.....	.....		D/1	11											
28 Aug	[redacted]	Phenergan 25mg IVPB Q8° prn nausea	D/T/I												
.....	.....														
.....	.....														
.....	.....														
.....	.....	1													
.....	.....														
.....	.....														

USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
07AUG03	[redacted]	Percocet 1-II po pm pain q4-6	D/T	2450 2330	26Sep 2230	27Sep 0300	28Sep 0210	29Sep 0930	30Sep 2345	01Oct 0910	10Oct 0000	2Oct 2245	3Oct 2235	4Oct 2235	5Oct 2245
- - - - -	- - - - -		D/I	2	II	II	II	II	2	II	II	II	II	II	II
08AUG03	[redacted]	Phenergan 25mg IVP q8° prn nausea	D/T												
- - - - -	- - - - -		D/I												
07AUG03	[redacted]	O2 2LNC prn to keep SaO2 >95%	D/T/I												
07AUG03	[redacted]	MSO4 2-10mg IV q1°	D/T												
- - - - -	- - - - -		D/I												
07AUG03	[redacted]	Benadryl 25mg IV/PO q6° prn itch	D/T												
- - - - -	- - - - -		D/I												
07AUG03	[redacted]	Albuterol II puffs q6° pm	D/T												
- - - - -	- - - - -		D/I												
06OCT03	[redacted]	Percocet 1-II po pm pain q4-6	D/T	06Oct 1750		06Oct 2210									
- - - - -	- - - - -		D/I	II		II									

[redacted]

911 b6-2

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 07	08	09	10	11	12	13	14	15	16	17	18	19	20
07 OCT 03	[redacted]	IV: LR @ 100cc/hr, HL	06	[redacted]													
	-----	when to po	18	[redacted]													
07	[redacted]	Amoxil 1gm 98°X48°	08	[redacted]													
	-----	(1st dose on return to ward)	16	[redacted]													
	-----		24	[redacted]													
10/12	----- [redacted]	Eucerum Cream	06 18					/	[redacted]								
	[redacted]	to wound (healed).	18 06					/	[redacted]								
	-----	have patient apply	/														
	-----	himself	/														

	-----																

all b6-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P CLOSURE BUTTOCK WOUND

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

PATIENT IDENTIFICATION:
#[redacted] b6-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 10 Yr. 03				
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

all 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
07OCT03	[redacted]	Ventolin 2puffs q6° prn	D/T														
			D/I														
07OCT03	[redacted]	MSO4 2.6mg IVP q3° prn pain	D/T	07OCT 1750	8OCT 0845	9OCT 1330											
			D/I	6mg	4mg	4mg											
07OCT03	[redacted]	Percocet 1-2 po q4° prn pain	D/T	7OCT 2250	8OCT 0250	8OCT 0600	8OCT 1745	8OCT 2215	9OCT 0730	9OCT 0930	9OCT 0900	9OCT 1745	11 OCT 0800	11OCT 2130	12OCT 1030	15 OCT 1030	
			D/I	[redacted]													
10/12 10/15	[redacted]	May have T#3 1-2 tabs po q 4° pen pain if pain more mild	Date Time	12 OCT 1000	12OCT03 2115	13OCT03 2330	14 OCT 0730	14 OCT 2230									
			Dose	[redacted]													
			T/E														
12OCT03	PD	Loperamide ¼ after each stool, max 4/day	D/T/I	12OCT03 2115 [redacted]													

Exp

CLINICAL RECORD	Th. .PEUTIC DOCUMENTATION CARE PLA .MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Ø9 Yr. Ø3

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	01	2	3	4	5	6	7	8
Ø9 AUGØ3	[redacted]	Fentanyl patch 50mcg/hr to CW q 3 days	Q6	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	
3Ø AUGØ3	[redacted]	FeSO4 325mg po TID	Q6	[redacted]													
			12	[redacted]													
			18	[redacted]													
13 SEPØ3	[redacted]	morphin 800mg po TID	08	[redacted]													
			16	[redacted]													
			24	[redacted]													
Ø7 OCTØ3	[redacted]	IVF: LR @ 100cc/hr (start IV)	Q6	/	/	/	/	/	/	/	/	/	/	/	/	AS	
			18	/	/	/	/	/	/	/	/	/	/	/	/	/	
		PRN meds															
27 AUGØ3	[redacted]	Percocet 1-tt po q4° pm pain	D/I	01OCT 11Ø5													
			D/I	[redacted]													
		PRN meds (cont)															
5OCT	[redacted]	Ventalin inh 2 puffs Q6° prn	D/I														

all b6-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	STSG	PAGE NO.

PATIENT IDENTIFICATION:

#Ø[redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1230	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS	PERRLA		b6-2			
	SENSORIUM	Alert, Follows Commands, Understands some English.				Drowsy but responsive to verbal stimuli. Appears to understand English	
RESPIRATORY	RESPIRATORY PATTERN	Regular & Unlabored				Regular, unlabored	
	BREATH SOUNDS	Exp Wheezes Bilaterally Lobes & Diminished Middle & Lower Lobes				& BS throughout c̄ mild exp wheezing. history of asthma	
	SECRETIONS	Pt denies any difficulty breathing				Sat 90% on face mask, received MSO4 20mg c̄ Versed 5mg earlier today.	
SKIN	COLOR	Normal for Race				NL for race	
	INTEGRITY	≈10% TBSA Burn Debridement in progress				10% BSA, both arms, bilat feet dressing intact	
INTUBATIONS	LOCATION	IVin (R) + (L) FA				IV (R) + (L) FA started	
	CONDITION	Dressing Changed, ∅ s/s of infection noted				7/3/03 on admission (L) arm LR 150 c/hr.	
GASTROINTESTINAL	ABDOMEN	Soft, Nondistended				soft non-tender	
	BOWEL SOUNDS	Normal ∅ N/V, ∅ BM				BBS all quadrants	
URINARY	URINE:	Foley to gravity				Foley to gravity	
	COLOR/CLARITY	Clear, Yellow				clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	ST, ∅ ectopy Pulses weak but palpable. Cap refill <3 secs Edema noted in BUE + BLE				ST 110, ∅ ectopy radial pulses palpable (R) pedal pulse faint palpable (L) pedal pulse palpable c̄ doppler edema (L) [redacted]	b6-2

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

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b6-2 CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 3 Jul 03

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

EPW [redacted] b6-4

	DX													HOSPITAL DAY			
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line								130/79		132/83	131/81		105/72	114/77	116/76	115/79	
Cuff																	
mperature										99.5		99.3		98.9			99.3
lse								103		106	118	134	121	121	92	92	100
spiratory Rate								26		26	27	26	13	14	20	26	22
SaO2								97%		96	91	91	93	91	90	92	96
O2								2L		2L	4L	6L	50%	50%	50%	50%	50%
O2 Mode								NC		NC	NC	NC	VM	VM	VM	VM	VM
MAP								96		98	98		86	93	92	92	90
TIME									8° T								
LR								150	150	150	150	150	150	150	150	150	150 (1200)
IVPB																	
NS													500	500	500		1500
PO														240			150
TALS									150								
HOUR / TOTAL											350	25	10	30		200	50 (685)
INE 10 gr																	
S/A																	
OUTPUT																	
IG pH																	
GUIAC																	
ESIS																	
OL																	

350
25
40
615
776
1385
1200
1500
390
1550
4140

ACUITY LEVEL CLASSIFICATION

	21	22	23	24	01	02	03	04
BP	122/90	120/73	120/73	124/74	118/94	124/74		
T	98.7							
P	103	100	96	103		104	97	
R	11	16	16	16	14	13		
O2 Sat	99	100	100	100	94	92	97	
O2	50%	2L	2L	RA	RA	RA	RA	
mode	FM	NC	—					
MAP	89	90	89	89	88	88	90	
								8° T
L&D	150	200	200	200	200	200	200	200 (150)
	35	50	50	20	20	200	200	200 (110)

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

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

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

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE

IV 4640

OUTPUT

Urine: ~~1385~~ 1475 + 200 = 1675

~~1385~~ 1675

Balance: +2965

NURSE'S SIGNATURE

[redacted]

66-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	blank	INITIALS	1700	INITIALS [redacted]
NEURO	PUPILS	4 X 0 X3				A + O X3	
	SENSORIUM	expresses needs appropriately				PERRLA	
		cooperative & care				Verbalizes needs	
		interacts & staff				Interactive & staff	
RESPIRATORY	RESPIRATORY PATTERN						
	BREATH SOUNDS	regular unlabored				Unlabored, even	
	SECRETIONS	CTA bil				decreased BS throughout	
		RR 90's on RA				CTA & mild wheezing	
						upper lobe. On	
						RA, sat 94%	
SKIN	COLOR	normal to race				Normal to race	
	INTEGRITY	1°, 2° & 3° burns				10% BSA on back	
						hands & feet	
IV SITE	LOCATION						
	CONDITION	(L) & (R) AC PIV				(D) & (R) AC PIV	
GASTRO	ABDOMEN	rounds, soft NT ND				Soft non-tender	
	BOWEL SOUNDS	BS x 4 quads				BBS x 4 quadrant	
		Ø BM				Ø BM	
GU	URINE:	good response to				Urine borderline	
	COLOR/CLARITY	lasix,				output 40 cc/hr	
		light yellow, clear				clear yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2				ST 110's S1S2	
		RRR Ø ectopy				edema hands + feet	
		ST				(L) > (R)	

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

(Continue on reverse)

PREPARED [redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 4 July 03

PATIENT'S IDENT[redacted] d or written entries give: Name—last, first, middle; grade [redacted] or medical facility)

EPW [redacted] — b6-4

[redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line	115	118	117	117		104		98		97	91	91	90	95	97	105	110	
	BP Cuff	68	60	71	70		81		60		59	58	58	59	55	55	62	59	
	Temperature	98.9							100.4							100.6			
	Pulse	102	104	110	120	115	120	131	128		134	131	129	129	128	118	116	122	
	Respiratory Rate	13	14	15	15	15	15	15	18		19	21	18	18	21	21	22	26	
		100	97	98	97	97	96	97	98		98	100	100	100	100	93	94	90	
		RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
	pain intervention																		

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	LR	200	200	200	100	100	100	100	200		200	200	200	200	200	200	200	200	
	PO				120				100					100		150		150	300
	TOTALS																		

OUTPUT		HOUR / TOTAL	200	170	210	100	65	50	50	50	895	50	40	40	40	40	35 / 35	30 / 65	30 / 95	95
	URINE	sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

Pacu left out 1105
in 1840
1735

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	21	22	23	00	01	02	03	04	
	off	off		104/60	102/58	101/51	104/44	92/56	
				101	102	97	102	103	
				18	16	17	20	16	
				94	92	90	92	93	
				RA	RA	RA	RA	15	
								98.6	

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

INTAKE	21	22	23	00	01	02	03	04	8° T
I	200	200	200	200	200	200	200	200	2200
N		150		NPO	p	MN			150

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

OUTPUT	21	22	23	00	01	02	03	04	8° T
	35/35	40/35	40/15	40/155	200/355	260/615	100/715	70/785	785

stool + large rept

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

TURN / SUCTION	TIME			

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2650	Urine:	~~1815~~ 785
PO			
TOTAL		TOTAL	

BALANCE ~~1835~~ +1865

SIGNATURE	INITIALS
[redacted]	[redacted]
606-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0600	INITIALS [redacted]	INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	Ord 0 x 3			A:0 x 3 PERRLA 3mm	
	SENSORIUM	interacts appropriately			Able to follow simple commands. Moves extremities.	
RESPIRATORY	RESPIRATORY PATTERN	unlabored			RRR	
	BREATH SOUNDS	CTA bilaterally			(B) Clear	
	SECRETIONS	Hi-90s on RA			∅ secretions	
					SaO_2 > 94% RA	
SKIN	COLOR	normal for race			Normal for Race	
	INTEGRITY	1° 2° 3° burns			10% BSA Burns	
I.V. SITE	LOCATION					
	CONDITION	(R) FA (L) PIV			(R) FA 20g PIV	
					LR @ 200cc/h	
GASTRO	ABDOMEN	round, soft, NT			soft, round, nontender	
	BOWEL SOUNDS	NP BSX + good			BS(+)	
GU	URINE:	marginally adequate			Foley to gravity	
	COLOR/CLARITY	clear yellow			clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2, RRR			SR, S1/S2	
		ST ∅ ectopy			Pulses +2 x 4 extremities	
		Generalized edema			Cap refill < 3 sec x 4 extremities	
		+2 pulses x 4 ext			Generalized edema, +3 pitting to extremities	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; FI - Fractional; SAT - Saturation; TRACH - Tracheostomy

PREPARED BY (Signature & Title)

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 05JUL03

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

[redacted] 606-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

[redacted] 106-4

DATE 05Jul03 | DX | HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line	107	98	112			107	82	91		88	93	95	84	94	75/53			
	BP Cuff	51	51	53			48	45	49		47	51	55	53	53		94/60	106/52	
	Temperature	99.9							100.4								98.8		
	Pulse	106	105	109	110	108	111	111	119	119	114	122	121	115	114	111	103	103	
	Respiratory Rate	16	12	20	20	20	23	23	20		21	24	20	18	25	27	22	16	
		93%	93	96	95	96	95	92	95		95	93	94	93	93	90	92	94	
		RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
	pain																		
	intervention																		

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	LR	200	200	200	200	200	200	200	200	1600	200	200	200	200	200	200	200	200	1600
	PO						120			120	120			360					480
	TOTALS	200/200	200/400	200/600	200/800	200/1000	320/1320	200/1520	200/1720	1720	320/320	200/520	200/720	560/1280	200/1480	200/1680	200/1880	200/2080	2080

OUTPUT		HOUR / TOTAL	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	URINE		40/40	60/100	60/160	60/220	50/270	40/310	40/350	50/400	400	60/60	60/120	40/160	40/200	50/250	60/310	60/370	60/430	430
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS										400									430

830

Dress Δ
20 mg Mscl4
10 mg Versed

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
	103/52	99/54	130/69	110/59	113/60	97/56	102/69	103/55	
				99					
	89	96	100	96	92	91	92	91	
	16	14	22	13	12	14	20	11	
	95	87	97	94	96	96	96	98	
	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	21	22	23	00	01	02	03	04	8° T
I	200	200	200	200	200	200	200	200	1600
	200/200	200/400	200/600	200/800	200/1000	200/1200	200/1400	200/1600	1600

OUTPUT									
O	80/40	80/160	70/230	80/310	90/400	100/500	85/585	70/655	655
									635

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES DAILY LIVING	TIME	2200			TURN	TIME			
	MOUTH CARE					self			
	BATH								
	SKIN CARE	[redacted]							
	FOLEY CARE				SUCTION				
	TRACH CARE		b6-2						
	ROM EXERCISES	[redacted]							

24 I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	1720	Urine:	830
po	2080		655
	1600		
TOTAL	5400	TOTAL	1485

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted] RT/AN	[redacted]
b6-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0520	INITIALS [redacted]	1600	INITIALS	1800	INITIALS
NEURO	PUPILS						
	SENSORIUM	Alert, able to follow simple commands and express needs, speaks some english.				Alert, verbalizes needs, PERRLA	
RESPIRATORY	RESPIRATORY PATTERN	RRR, equal chest rise				BBS, CTA c̄ intermittent mild wheezing, on RAD sat >95%	
	BREATH SOUNDS	clear throughout					
	SECRETIONS	0 noted @ this time					
SKIN	COLOR	WNL for race				WNL for race	
	INTEGRITY	40-50% BSA burn				40-50% BSA, part dehiscence	
IV SITE	LOCATION	(R) FA c̄ 0 S/S of infection				(R) SC triple lumen	
	CONDITION	LR infusing @ 200cc/h				intact LR @ 100cc/hr	
GASTRO	ABDOMEN	soft, nondistended				soft non tender	
	BOWEL SOUNDS	c̄ throughout hyperactive (pt NPO pMN 5 Jul 03)				BS x 4 quadrants tolerating p.o. appetite poor	
GU	URINE: COLOR/CLARITY	Foley to gravity drainage clear yellow urine c̄ 0 sediment				Foley to gravity drainage clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	SR HR 90's c̄ 0 ectopy, pulses palpable throughout, +3-+4 pitting edema throughout				ST 100's palpable pulses radial (+) pedal pulses (+) edema LE + UE.	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 06JUL03

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

[redacted] 66-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

EBL 100 cc

PAG

06 SUL | DX DVT, 10% BSA BURNS | HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff	105/62	93/54	104/61	114/62	109/57					134/76	126/69	120/60		124/65		106/51	107/56
mperature	98.7	99.1	99.4	99.1	99.1					97.2	98.3	98.7		99.4	100		
lse	92	88	91	94	97					106	103	101	105	111	103	104	106
spiratory Rate	9	16	11	13	8					20	12	9	13	20	8	12	14
SAO2	95	96	100	94	96					91	91	94	95	96	96	95	97
Source	RA	RA	RA	RA	RA					5L NC	RA	RA	RA	RA	RA	RA	RA

OR

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20
LR	200	200	200	200	200				1000	100	100	100	100	100	100	100	100
PO											300					240	
OR(NS)						200 cc			200				300				

800
240
300
1340
1150
2530

TALS

HOUR / TOTAL	50/50	60/110	65/175	160/335	100/435	200cc OR			635	140/775	110/885	70/955	75/1030		100/1130	60/1190	90/1280
INE sp gr																	
S/A																	
OUTPUT																	
IG pH																	
GUIAC																	
ESIS																	
OL																	

1280
440
1720

O[redacted] 66-4

ACUITY LEVEL CLASSIFICATION

	21	22	23	00	01	02	03	04	
	112/56	120/57	120/57		120/56	122/56		113/16	
			98.8					100.2	
	100	101	102	101	104	111	106	105	
	13	13	16	14	16	14	14	17	
	97	97	98	96	97	96	96	95	
	RA	RA	RA	RA	RA	RA	RA	RA	

	21	22	23	00	01	02	03	04	8° T
	100	100	100	100	100	100	100	100	800
PO			240			150			390
									1190

	50	60	50	50	50	60	70	60	
		110	150	200	235	310	380	440	440
							loose		
							T large		
								BM	

BESPIRATORY DATA	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
ABG	pH								
	PCO_2								
	pO_2								
	HCO_3								
	SAT								
	BASE								

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

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

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE IV 2530 PO 1720 — OUTPUT Urine: 1720

(+810) balance

NURSE'S SIGNATURE

[redacted] 10/XX/XX

[redacted] XXX/XX

b6-2

[redacted] b6-4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89 b6-2

INITIAL SHIFT ASSESSMENT

	TIME	0530.	INITIALS [redacted]	b6-2	INITIALS	2330	INITIALS [redacted]
NEURO	PUPILS	Pt is unresponsive to				pt appropriately responsive	
	SENSORIUM	verbal and voice stimuli.				able to move all extremities	
		Pt able to follow simple				PERL bilat	
		commands. Pt c/o pain					
		w mvmt.					
RESPIRATORY	RESPIRATORY PATTERN	Clear breath sounds				clear breath sounds in all	
	BREATH SOUNDS	bilat. Diminished bases.				lung fields. Dry cough	
	SECRETIONS	Sp02 97-98% on RA. RR				very infrequent. Quietly	
		12/min. Pt has snoring					
		naps while sleeping					
SKIN	COLOR	≈10% BSA Burns to abd.				≈10% BSA Burns to abd	
	INTEGRITY	Blisp Blanchg. Drsgs moist				Bilat leg + arms dressing	
		bilat intact.				taken on on intact	
I.V. SITE	LOCATION	R IJ TLCVC. LRA				Central line R	
	CONDITION	Hepsalin infusing via				Intermittent peripheral 3 lumen	
		white port. Drsg D+I				catheter	
		S redness or drng noted.					
GASTRO	ABDOMEN	Hypo BS. Distension to				hyperactive bowel sounds	
	BOWEL SOUNDS	R. Large in stomach as				feeding tube in (R) nare	
		per KUB this AM. Gently					
		distended. Last BM 07/04/03.					
GU	URINE:	Foley to gravity drng				foley to gravity drain	
	COLOR/CLARITY	clear yellow urine.				clear yellow urine in adequate	
						amounts	
CARDIOVASCULAR	CARDIAC RHYTHM	Rate 100's. ~~AFSF~~ SINUS				S.S. sinus rhythm ~~Ex~~ sinus	
		tach. S1-S2 (+2 (B)				tachycardia. Edema to lower	
		radial pulses and				extremities. Positive pulses	
		(+2 (B) pedal pulses (+4				palpable x 4 extremities	
		pitting edema to (B) feet and scrotal edema.					

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b6-2

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 09JUL03.

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

[redacted] b6-4

[redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff		113/65	115/68	121/65	116/64		127/68	101/56		126/66	122/68	117/63	117/65		120/59	122/61	117/67	
Temperature (axil)		99.9			101.2			101.3		101.4	100.4							
Pulse		107	106	100	110		120	128		129	136	123	115		99	104	105	
Respiratory Rate		15	11	9	10		16	21		13	13	21	22		18	16	30	
SpO2		99%	96%	95%	95%		93%	90%		97%	95%	97%	95%		91	91	97	
Mode		RA	RA	RA	RA		RA	RA		RA	RA	RA	RA		RA	RA	RA	

pain
sedation

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR	100	100	100	100	100	100	20	20		20	20	20	20	20	20	20	20	
IVPB						100		250						(1160)				
TF							125	125		125	125	125	125	125 (870)	80	80	80	
TF flush														240				
PO							100			140		60	150 (400)		100		100	
TOTALS																		

OUTPUT

			05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
URINE	HOUR	TOTAL		70 / 70	60 / 130	60 / 190	70 / 260	30 / 290	30 / 320	360 / 680		240 / 920	80 / 1000	30 / 1030	60 / 1090				200 / 1268	
	sp gr																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
	124/68	114/62	119/61	121/61	114/53	116/57	120/56	116/60
							100.5	
	107	108	105	111	105	105	106	106
	20	19	16	22	12	17	17	12
	100	97	97	96	94	97	95	97
	RA	RA	RA	RA	RA	RA	RA	RA

INPUT	21	22	23	00	01	02	03	04	8° T
LR	20	20	20	20	100	100	100	100	1280
				250					600
									1115
TF									
									650
PO									
									3645

OUTPUT									
			200/1468				550/2018		

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN	TIME				
SUCTION					

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3645	Urine:	2018
po			
TOTAL	3645	TOTAL	2018

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
h6-2	

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	b6-2	INITIALS		INITIALS
NEURO	PUPILS	PERRLA				PERRLA	
	SENSORIUM	A lethargic but Oriented X3				drowsy easily aroused.	
RESPIRATORY	RESPIRATORY PATTERN	CTA bil diminished				BBS, CTA ↓ diminished	
	BREATH SOUNDS	on baser				air exchange (volume	
	SECRETIONS	regular unlabored				throughout ↓ baseline)	
		B X 10 q1° when				I + S	
		awake (2-3 bolus)					
SKIN	COLOR	dressing to burn				NL, 30% burn to	
	INTEGRITY	areas				arms, hands, legs, abd	
						+ bilateral back.	
LINES	LOCATION	(D) IJ 3cc				(R) SC, I/F LR @ 50	
	CONDITION	Ø S/S of infexn				flushed 2 lumen	
						patent.	
GASTROINTESTINAL	ABDOMEN	Ø BS				Hyposactive BS	
	BOWEL SOUNDS					TF, c/o bloating	
						& BM	
URINE	URINE.	clear yellow					
	COLOR/CLARITY						
CARDIAC	CARDIAC RHYTHM	S1S2 ST Dectgy				ST 110-113, & retapy	
		generalized edma				edema arms + LE	
		↑				(R) side > (L) side	
						radial / pedal pulses	
						palpable.	

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 West

DATE: 10 July 03

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

~~424~~ [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

	DX			0830										HOSPITAL DAY			
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line	120	OR	OR	129		122	121	123		119	118	115		124	114	109	
Cuff	72			72		70	74	70		70	70	60		71	65		
mperature				96	98.3			100.9									
lse	113			121	123	118	113	112	11	112	118	119	115	117	112	115	
spiratory Rate	16			14	16	16	16	15		20	14	15	16	16	13	22	
O2 Sat	94			98	98	98	97	97		97	94	95	95	95	96	94	
O2 Source	RA			RA	NRB	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	
UR	100	~~100~~	~~100~~ 1100	50	50	50	50	50	1450	50	50	50	50	50	50	50	50	400
IVPB						350												
TF		OR						50		50	50	50	50	Ø	Ø	Ø		250
PRBC		TT		350		350												700
																		1350

TALS

	HOUR / TOTAL	40	OR	OR	510	150	100	70	70	930	70	70	70	30	200	260	200	120	1020
RINE	SP.GR																		
	S/A																		
	OUTPUT																		
IG	pH																		
	GUIAC																		
ESIS																			
OL																			

	21	22	23	24	01	02	03	04
BP	109/64	115/62	117/62	112/62		112/54		
T		99.0		99.2		99.7		
P	110	110	112	112		114		114
R	27	12	8	16		15		19
O2 sat	92	99	100	94		98		95
Mode	RA	RA	FM	RA		RA		RA
		sedation	sedation					
~~foley~~	~~60~~	50						
~~Output~~								(300)
LR		.50	.50	.50	50	50	50	8° T (400)
TF		0	50	50	50	50	X	X
IVPB		250						
	60	50	/	80	/	80	50	40 (360)

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES DAILY LIVING

TIME	2200		
MOUTH CARE			
BATH			
SKIN CARE	✓		
FOLEY CARE	✓		
TRACH CARE	✓		
ROM EXERCISES	✓		

TURN / SUCTION — TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE: IV/PO 2050

OUTPUT: Urine: 1380

NURSE'S SIGNATURE

[redacted] [redacted]

bb-d

Bal: +670
+500 blood OR

MEDCOM - 13423

1: ('' 10)

PAGE

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	b6-2	INITIALS	1800-0500	INITIALS
NEURO	PUPILS	PERRLA, 2mm				PERRLA, drowsy	
	SENSORIUM	Alert and able to follow simple commands and express needs				most of the time but alertable. Verbalizes need, cooperative	
RESPIRATORY	RESPIRATORY PATTERN	RRR				RRR, BBS	
	BREATH SOUNDS	clear, diminished bilat ↓ bases.				deminiished throughout	
	SECRETIONS	Ø secretions noted @ this time.				RA, Sat 96-100%	
SKIN	COLOR	WNL for race.				WNL, burn up	
	INTEGRITY	burn wound debridement throughout body surface.				to 35% post debridement X 2 days, drsg	
IV SITE	LOCATION	(R) LJ 3-lumen c̄ Ø S/S				(R) SC, triple lumen	
	CONDITION	of infection infusing LR @ 50cc/hr				clean D+I, LR @ 50cc/hr Antibiotic as ordered	
GASTRO	ABDOMEN						
	BOWEL SOUNDS	dophoff (R) nare clamped @ this time BS(+) x 4 quad hypoactive				BBS, hyperactive. Had BM + moderate amt. soft stool	
GU	URINE: COLOR/CLARITY	Foley to gravity draining dark yellow urine.				Foley draining clear, tea yellow urine, varies by hour but > 35cc/hr	
CARDIOVASCULAR	CARDIAC RHYTHM	ST c̄ Ø ectopy. all ext pulses palpable. 3+ pitting edema on bilat ↓ ext, + edema bilat fem scrotal edema				ST 110, Ø ectopy Radial & pedal pulses (+) Edema hands & legs, UE resolving, (L) LE > (R) LE	

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

(Continue on reverse)

REPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 11 July 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specif

☐ DIAGNOSTIC STUDIES

	DX													HOSPITAL DAY				
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	21
Arterial Line																		
Cuff	106/60	103/58	117/57	104/62	112/52	152/79	123/70	123/70		113/57	107/58	104/54	104/61	114/59	125/64	116/57	114/53	105/53
mperature	101.0	100.5	101.1	100.8	100.5		100.2	100.1		99.5		101.4	100.7	100.5		100.2		
lse	112	112	111	111	109	112	112	105		117	119	118	121	111	106	109	107	116
spiratory Rate	22	14	14	14	11	11	27	15		20	21	20	21	14	14	10	21	
O2sats	96	94	96	94	97	99	97	97		97	96	94	90	96	95	95	95	96
Source	RA	RA	RA	RA	RA	[illegible]	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA
						Continuous Sedation 8:20 - 10:20												
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	21
LR	50	50	50	50	50	50	50	50	400	50	50	50	40	50	50	50	50	50 (800)
TF	0	0	0	0	0	0	50	50	100	50	50	hold	hold	hold	50	50	50	50 (400)
IVPB								100	100	250								(350)
PO		60			60			60	180			100			150			(430)
Residual																	T:	(1980)
TALS																		
HOUR / TOTAL	50/50	24/74	30/104	40/144	36/180	30/210	30/240	246/486	486	280/766	50/816	50/866	30/896	30/926	32/958	200	70	90/1318
INE 10 gr																		
S/A																		
OUTPUT																		
IG pH																		
GUIAC																		
ESIS																		moderate
OL																		large stool

ACUITY LEVEL CLASSIFICATION

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

REQUESTING PHYSICIAN:

LAST FIRST MI.

SSN/PSEUDO SSN: [redacted] 66-4

DATE 19 Sep 03 TIME 2150

	22	23	24	01	02	03	04
	103	119	108	190/55	108/52	85	
	110	116	110	110	105	103	103
	9	14	10				
	95	95	96	99	97	98	
	RA	RA	RA	RA	RA	RA	RA

(Hematology) CBC

TEST	RESULT	REF RANGE

ID: [redacted] 66-4 19-09-03 21:50

Patient Limits

	22	23	24	01	02	03	04	8° T
IV	50	50	50	50	50	50	50	400
TF	75	100	100	50	off	off	off	325
IVPB	250		260					510
PO	150	100						350

MCV	86.0	fL	80.0	99.0
MCH	28.7	pg	27.0	31.0
MCHC	33.0 L	g/dL	33.0	37.0
PLT	356.	x10^3/ul	150.	450.
LY%	27.4	%	20.5	51.1
LY#	1.2	x10^3/ul	1.2	3.4

T 1575

NPO drsg

RAPIDPOINT COAG ANALYZER V4.54
SERIAL

Patient ID: [redacted] 66-4
Test Name :PT
Test Result : 14. sec
RESULT NOT RANGE CHECKED
Ratio :
Calculated INR :

45	45	90	90	70	70	490 / 560

Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :09:58 PM
Card Lot :010308
Operator : [redacted] 66-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/19/03 10:02 PM

Patient ID: [redacted] 66-4
Test Name :APTT
Test Result:= 32.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :09:59 PM

Urinalysis

TEST	RESULT	REF RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld	mod	Negative
PH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
		Negative

RESPIRATORY: MODE, FiO2, RATE, PEEP, TIME; ABG: pH, PCO2, PO2, HCO3, SAT, BASE; GLUCOSE; Na/K; Cl/CO2; BUN/Cr; WBC/PLATELET; Hct/Hgb

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

Rbc 1-5
Epi 1-5

CSF TIME

Blood Bank TIME

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

ACTIVITIES OF DAILY LIVING: MOUTH CARE; BATH; SKIN CARE; FOLEY CARE; ROM EXERCISES

24° I&O TOTALS

NURSE'S SIGNATURE [redacted] 66-4

wt Yesterday wt Today

INTAKE IV 3555 OUTPUT Urine: 1808

Balance +1747

LAB ID NO.:

MEDCOM - 13426

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	1630	INITIALS	1830	INITIALS [redacted]
NEURO	PUPILS		alert but confused		bb-2		PERRL 3mm	bb-2
	SENSORIUM		Ø oriented to time or place				Follows simple commands	
			follows commands				Confused at times	
RESPIRATORY	RESPIRATORY PATTERN		unlabored, shallow				RRR	
	BREATH SOUNDS		96% on RA				wheezes (B) on inspiration	
	SECRETIONS		bilateral inspiratory wheeze, albuterol neb given → CTA bil				Ø secretions	
							RA SaO2 96	
SKIN	COLOR		dressing on burn area				Normal for Race	
	INTEGRITY						Multiple burn sites c̄ drsg	
IV SITE	LOCATION		(R) IJ 3LC all ports				(R) IJ TLC	
	CONDITION		patent, flushed				LR 50cc/h	
							~~Fentanyl 50 mcg/hr~~ [redacted]	bb-2
							Tube feeding 100cc/° currently on hold 1 hours	
GASTRO	ABDOMEN		+ BS x 4 quad				BS↓	
	BOWEL SOUNDS						Jevity @ 100cc/° on hold for one hour, hiccups @ 1810	
GU	URINE: COLOR/CLARITY		clear yellow, foley positional				Foley to gravity Clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM		ST Ø ectopy				ST 51/52	
			dependent edema on LE / flank area				Pulses +2 x 4 quads	
			penile, scrotal edema				Cap Refill < 3 sec x 4 quads	
			↓ pulses x 4 ext				generalized edema.	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SA1 - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPA[redacted] bb-2 (Title) UN/pr

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 12 July 03

PATIEN[redacted] (For typed or written entries give: Name—last, first, middle; g[redacted] hospital or medical facility)

EPW O[redacted] bb-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	105	118	115	101	121	127	110	105		102			110	92	109/53	104/53		
BP Cuff	53	53	58	50	69	67	55	55		98			65	58				
Temperature	100			98.7			100						98.7				98.8	
Pulse	103	102	103	110	116	111	109	112		109	116	115	107	112	109	113	119	
Respiratory Rate	10	12	9	12	18	22	11	14		17	14	22	20	10	14	19	19	
SAO2	99	98	98	98	99	97	96	96		98	97	98	99	97	96	95	94	
Source O2	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	

pain
intervention

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
IV	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
TF	0					50	50	75		75	75	90	90	100		100	0	
IVPB	0					200		200										
PO	0	0	0	0		120		120		120		240						
TOTALS	50/50	50/100	50/150	50/200	50/250	470/520	100/620	445/1065	1065	245/245	125/370	380/750	140/890	150/1040	50/1090	150/1240	50/1290	1290

OUTPUT

		TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
URINE		HOUR	90	140	100	100	50	50	200	260	990	200	200	130	100	70	100	180	250	1230
		TOTAL	90	230	330	430	480	530	730	990		200	400	530	630	700	800	980	1230	
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
			107/57		102/54	102/51	106/53	101/51	
		98.6			99.8				
	119	115	111	111	109	107	109	110	
	26	20	22	15	15	16	13	10	
			96	96	95	96	96	97	
					RA	RA	RA	RA	

INTAKE	21	22	23	00	01	02	03	04	8° T
	50	50	50	50	50	50	50	50	
	0	100	0	100	0				
		250		200					
				240					
	50 / 50	400 / 450	50 / 500	590 / 1090	50 / 1140	50 / 1190	50 / 1240	50 / 1290	1290

OUTPUT									
	240 / 240	250 / 490	200 / 690	200 / 890	200 / 1090	180 / 1170	200 / 1370	200 / 1570	1570

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES DAILY LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE	2330 [redacted]	1606-2	
	FOLEY CARE	0030 [redacted]		
	TRACH CARE	—		
	ROM EXERCISES			

TURN	TIME			

SUCTION				

24 I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	1065	Urine:	990
po	1290		1230
	1290		1570
TOTAL	3645	TOTAL	3790

BALANCE _____

NURSE'S SIGNATURE

[redacted] 14/pm [redacted]

1606-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0550	INITIAL [redacted]	b6-2	INITIALS	1730	INI [redacted] b6-2
	PUPILS	PERRLA, 2mm				PERRLA 2mm brisk	
	SENSORIUM	Alert and oriented x2. Able to follow simple commands				Alert, follows simple commands. Able to move extremities	
RESPIRATORY	RESPIRATORY PATTERN	RRR				RRR	
	BREATH SOUNDS	unproductive wheezes (L) lobe and (R) upper and middle lobe. (Ø) secretions noted @ this time.				CTA	
	SECRETIONS					Ø secretions	
						RA SaO2 > 94%	
SKIN	COLOR	WNL for skin				Normal for Race	
	INTEGRITY	40% BSA burn, drsg D+I				BSA burns covered c̄ drsg, CDI	
I.V. SITE	LOCATION	(R) IJ 3-lumen catheter				(R) IJ TLC	
	CONDITION	c̄ Ø S/S of infection c̄ LR @ 50cc/h				LR @ 50cc/h	
						Ports flushed c̄ 10cc N/S.	
GASTRO	ABDOMEN	slightly distended				Rounded, tender, c̄	
	BOWEL SOUNDS	hyperactive throughout abdomen (R) nare clamped @ this time				BS ↓ Dobhoff (R) nare, Jevity @ 100cc/h	
GU	URINE:	foley to gravity draining				Foley to gravity	
	COLOR/CLARITY	clear yellow urine, 100cc/hr				Clear, light yellow urine s̄ sediment	
CARDIOVASCULAR	CARDIAC RHYTHM	ST c̄ Ø ectopy, pulses palpable in all ext. pitting edema BLE and BUE. S1S2 present				ST, S1/S2 Pulses +2 x4 quads/extremities Cap Refill < 3 sec. x4 extremities Generalized edema, pitting on extremities.	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SA1 - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 13 JUL

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 13JUL | DX | HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff	103/55	102/51	107/50	107/55	119/59	136/70	118/64	125/69		114/58	102/57	105/64	112/56	107/55	105/53	104/48		
	Temperature		98.7	98.7			98.7	99.5	100.0		101.4	100.2	100.4	101.3	101.7		100.3		
	Pulse	106	108	107	107	125	121	125	128		121	121	119	114	117	97	115	115	
	Respiratory Rate	8	9	14	16	20	20	25	20		18	22	13	19	11	21	19		
	SaO_2	97	97	97	97	99	95	99	97		97	96	95	94	95	95	95	95	
	O_2 Source	RA	RA	RA	RA	FM	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
														Gave Lasix @ 1630					
	pain																		
	intervention																		

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	IVF	50	50	50	400	0	50	50	50	700	50	50	50	50	50	50	50	50	400
	TF						75	75	100	250	100	100	100	100	100	100	100	100	800
	PO		60			60			60	180		200						220	~~1200~~
	IVPB						250		200	450		300							420 360
											150 150	710 860	150 1010	150 1160	150 1310	150 1460	150 1610	370 1980	1980
	TOTALS	50 50	110 160	50 210	400 610	60 670	375 1045	125 1170	410 1580	1580	150 150	350 500	150 650	150 800	150 950	150 1100	150 1250	370 1620	1620

OUTPUT		HOUR / TOTAL	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	URINE		180 / 180	310 / 490	300 / 790	360 / 1150	360 / 1510	375 / 1885	465 / 1350	245 / 1595	1481	130 / 1729	130 / 1859	140 / 1999	100 / 2099	75 / 2174	75 / 2249	80 / 2329	75 / 2404	2294
		30 gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS										1489									2294

standing @ bedside

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
		105/58	93/45	120/52	101/55	96/49	85/45	102/52
		100.4				101.5		98.8
	107		116	112	111	114	111	106
			21	17	19	19	10	10
	97		94	97	96	90	92	93
	RA		RA	RA	RA	RA	RA	RA

INTAKE	21	22	23	00	01	02	03	04	8° T
IVF	50	50	50	50	50	50	50	50	
TF	200	200	~~200~~	150	50	OFF	OFF	OFF	
PO	220	220	150	200		200			
NEB		250		200					
FLUSH			10		10	30			
	450 / 450								
	~~470~~ / 2350	~~320~~ / ~~2970~~	~~240~~ / 3280	~~600~~ / 3880	~~100~~ / 3990	~~280~~ / 4270	~~50~~ / 4320	~~50~~ / 4370	

OUTPUT									
	70 / 1364	70 / 2434	70 / 2504	65 / 2569	65 / 2634	70 / 2704	100 / 2804	90 / 2894	

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES OF DAILY LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE	2000 [redacted]		
	TRACH CARE	—		
	ROM EXERCISES	—		

TURN	TIME						
	2100 (C)	2200 (B)					
	[redacted]	[redacted]					
	b/o						

SUCTION							

24 hr I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1580	Urine:	
po	~~1980~~ 4370		
TOTAL	6950	TOTAL	2894

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
b/o-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	1700	INITIALS [redacted]		INITIALS
NEURO	PUPILS	PERRL	b6-4	2mm PERRL (+)			
	SENSORIUM	Pt alert & Responsive to touch & voice stimuli		Alert, Oriented, Cooperative, Appropriate, ↑ Crying out ē MAE ē transparency.			
RESPIRATORY	RESPIRATORY PATTERN	Reg R&R		RR 20's ē S/Sx dyspnea			
	BREATH SOUNDS	CTA bilat		RA SATS 96-100%.			
	SECRETIONS	Ø Ntd secretions equal rise & fall		Ø cough nurse. Ut Bases, uses IS exercise correctly.			
SKIN	COLOR	NER		Membrane pink.			
	INTEGRITY	See Dressings intact See Burn Note.		See DEP SF 509 for Assessment.			
IV SITE	LOCATION	(R) IJ TLC		(R) IJ TLC			
	CONDITION	All Ports Flush well Ø Ntd erythema/Edema LR @ 50cc/hr		Proximal - clamped Medial LR 50° Distal - clamped. Ports flush easily ē (+) Flash Back.			
GASTRO	ABDOMEN	Soft, Non distended		Site ē S/Sx infec./infil.			
	BOWEL SOUNDS	Active X 4 Quads		(+) BS in ∆Bex, Soft, Tender ABD.			
GU	URINE: COLOR/CLARITY	CIR Yellow Urine in adequate Amounts to Foley		H/L F Foley ē U.O. ≥ 30ml/hr clear yellow urine.			
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2 Present Ø Ntd ectopy, +3 pitting edema. Radial + Pedal Pulses @ +2 ē brisk cap refill.		S1 S2 ē noted ectopy S1 ē HR ↓ 100's. Edema per pt. + to scrotum ~ glans penis PPP ē + 2 density.			

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 91WM6 b6-4

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 14 JUL 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE 14 JUL | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	104/51	95/49	109/70		126/64	116/65	112/57	105/48		103/49	99/49	98/61	115/65	105/66	112/68	108/57		
Temperature		99.2	99.5		99.1		100.1	101.0	~~101.0~~	101.0	101.9	100.8	X	100	X	X		
Pulse	105	101	110		114	117	114	115	~~110~~	110	115	120	115	112	107	109		
Respiratory Rate	18	16	14		15	14	15	18	~~18~~	18	18	24	22	20	18	12		
SaO_2	93	95	96		100	99	97	93	~~96~~	96	93	92	95	95	97	100		
O_2 Source	RA	RA	RA		NRB	NRB	RA	RA	~~RA~~	RA	RA	RA	RA	RA	RA	RA		
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IVF	50	50	50	50	50	50	50	50	400	50	50	50	50	50	50	50	50	400
TF					25	101	101	101	~~328~~	101	101	101	101	101	101	101	101	808
PO												480			240			720
IVPB						250		250	500									
Flush			20						20									
TOTALS																		

OUTPUT

		HOUR / TOTAL	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
URINE			140/140	80/220	110/330	110/440	40/480	45/525	45/570	60/630		110/740	90/830	50/880	45/925	X	70/995	X	70/1065	1065
		30 gr																		
		S/A																		
~~Dob~~ ~~No F~~ NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
BP	103/62			117/57	108/52	117/57	109/56	114/49	
T	100.1	X	X	X	101.2	X	100.1	X	
P	115	105	106	116	109	125	110	108	
RR	16	16	15	15	16	19	11	12	
SAT	99	100	95	100	95	95	93	94	
MODE	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	21	22	23	00	01	02	03	04	8° T
I	50	50	50	50	50	50	50	50	450
	101	101	101	101	—	—	—	—	404
		250		250					500
									1304

OUTPUT									
	100/100	50/150	50/200	60/260	85/345	200/545	250/795	70/865	865
			5M Bowel Voided						

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES OF DAILY LIVING	TIME				TIME
	MOUTH CARE	2100		TURN	C ASSIST
	BATH				
	SKIN CARE	2100			
	FOLEY CARE	2100		SUCTION	
	TRACH CARE				
	ROM EXERCISES	PASSIVE			

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	[redacted]
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		
BALANCE			

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
	EYES OPEN	SPONTANEOUSLY 4													4				4				4		1	
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5													5				5				5			
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6													6				6				6			
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO MOTOR RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS													X				X				X			
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS													X				X				X			
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE													2				2				2			
		REACTION													+				+				+			
	LEFT	SIZE													2				2				2			
		REACTION													+				+				+			
PUPIL SCALE			2			3			4			5			6				7 mm							
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

	HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
Pedal	R													+				+				+			
	L													+				+				+			
Radial	R													+				+				+			
	L													+				+				+			
	R																								
	L																								
	R																								
	L																								
	R																								
	L																								

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	1700	INITIALS [redacted]	b6-2	INITIALS
NEURO	PUPILS	2+ PERRL b6-2		PERRLA 2mm (+)			
	SENSORIUM	A&O x3		Alert, oriented, appropriate, cooperative			
		purpose Full movement x4		MAE c purpose			
		at Follows commands					
RESPIRATORY	RESPIRATORY PATTERN	RR-14 SpO2-97%		RA SATS 90's x93.			
	BREATH SOUNDS	on RA		MDI Albuterol Q4°			
	SECRETIONS	Lung sounds CTA (B) Ø		Occ. Exp. Wheeze			
		in RLL no secretions		Rhonchi			
		@ present		Vt Bases exp. (R)			
				Bone			
SKIN	COLOR	Normal For Race		Membranous Arch.			
	INTEGRITY	partial thickness burns		SEE SF600			
		to head, stomach, legs CDI					
IV SITE	LOCATION	Triple lumen cath to		(R) I.J. TL			
	CONDITION	(R) jugular Flushes well		Proximal LR50			
		x3 (+) blood return		Medial Clamped			
		dressing CDI		distal Clamped			
				Site c S/Sx infection			
				Infiltration in dressing			
GASTRO	ABDOMEN	Firm Round Non-distended		Firm Obese,			
	BOWEL SOUNDS	sensitive due to burns		tender c (+) BS in			
		Bowel sound Normoactive		(4) Quads. Dobhoff c			
		x4 dobhoff @ NPO @ Present		Lenity (+) @ 125ml/hr			
GU	URINE:	Clear Yellow QS		RN/K SEE SF600 —			
	COLOR/CLARITY	voiding via Catheter		Foley #16 F c concentrated yellow urine 775 ml/hr			
CARDIOVASCULAR	CARDIAC RHYTHM	HR - 106 BP-108/53		S1 S2 ST ↓100's S			
		peripheral pulses x4		Dets c extrasys. PP			
		capillary Refill ≤ 3sec		LE (+) 2+ Dipplex			
		NST		Bilat Rales Palp. +2			
				Generalized dependent Edema			

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

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 15 July 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE 15 July 03 | DX | HOSPITAL DAY

VITAL SIGNS	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	104/51	100/55																
BP Cuff		108/53						106/60		104/52	104/54	104/55	91/50	116/55		109/55	114/60	
Temperature	103	99.7						99.2		99.7	99.8	101.5	101.1	99.9	99.4	X	X	
Pulse	107	105						114		113	122	120	115	99		106	109	
Respiratory Rate	11	20						16		12	20	16	12	12		20	19	
MODE	RA	RA						RA		RA	RA	RA	RA	RA		RA	RA	
SaT	95	97						98		100	97	98	96	95		95	98	
			To OR															
			Received in OR															
						See PACU Flowsheet												
						See PACU Flowsheet												
pain intervention						Return												

INTAKE	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	50	50	-in OR-			50	50	50	250	50	50	50	50	50	50	50	50	400
IVPB						250		200	450									
OR (LR)						1350			1350									
TF	0	0	-OR-				0	128	128	128	128	128	128	128	128	128	128	1024
FLUSH	20	0	-OR-				20	0	40									
PRBC (OR) x2 HCT 30 P 2 units					600				600									
PO	NPO	NPO						0		0		200		0			100	300
TOTALS																		

OUTPUT		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
Foley URINE	HOUR / TOTAL	90	80			0		1150	550		50	0	0	370	0	300	140	300	
	sp gr																		
	S/A																		
~~DOB Hess~~ NG wound	OUTPUT																		
	pH																		
	~~SHRE~~																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	21	22	23	00	04	02	03	04
BP	107/62	116/51	107/51	123/56	112/62	106/57		
HR	103	105	105	109	107	101	111	
RR	22	14	16	24	27	27	13	
	RA	RA	RA	RA	RA	RA	RA	
SpO2	96	96	96	98	97	95	97	
Temp						97.7	X	

INTAKE	21	22	23	00	04	02	03	04	8° T
I.V.	50	50	50	50	50	50	50	50	400
		200		200					400
PO	128	128	128	128	128	128	128		1024
	20	200		200					
									1824

OUTPUT	21	22	23	00	04	02	03	04	
Urine	150	90	250	200	100	150	160	135	1235
									175

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A pH	7.414								
	A PCO_2	40.4								
	A pO_2	80								
	B HCO_3	30								
	B SAT	3								
	G BASE	5								

LABORATORY	TIME	0330								
	GLUCOSE	118								
	Na/K	131/4.1								
	Cl/CO_2	97/31								
	BUN/Cr	11								
	WBC/PLATELET									
	Hct/Hgb	25/9								

ACTIVITIES OF DAILY LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE	1800		
	FOLEY CARE	1800		
	TRACH CARE			
	ROM EXERCISES	1800	2100	2330

TURN	TIME
	1800
	2100
	2330

SUCTION	TIME

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3450	Urine	3965
PO	2476	Wound	175
			4140
TOTAL	5926	TOTAL	
		BALANCE	1786

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4														4				4				4	4	
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5														5				5				5		
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6														6				6				6		
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO MOTOR RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION														X				X				X		
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION														X				X				X		
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE														2				2				2		
		REACTION														+				+				+		
	LEFT	SIZE														2				2				2		
		REACTION														+				+				+		
PUPIL SCALE			2		3		4		5		6		7 mm													
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
Radial	R															+				+				+		
	L															+				+				+		
Pedal	R															D				D				D		
	L															D				D				D		
	R																									
	L																									
	R																									
	L																									

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left