MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 15 Jul 03
Time In: 1010
Allergies: NKA
Pre-op V/S: 105/108/53, 99?, 2
Procedures: Graft

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid _____ Colloid _____
OR Output: UOP _____ EBL min.
Meds/Times: _____

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

Pre Op Meds History

Time	1010	1015	1020	1025	1030	1035	1040	1045
SaO2	92	97	92	95	96	96	97	98
FiO2								
Methods	RA	RA	RA	RA	RA	RA	RA	RA
240								
220								
200								
180								
160								
140								
120								
100								
80								
60								
40								
20								
HR	93	100	101	101	114	114	118	116
RR	22	31	28	24	25	24	20	20
T	97.3	97.4	97.4	97.4	97.9	97.6	97.6	97.8	97.8
Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE 15 Jul 03

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

[redacted] (b)(6) - 4

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

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date)
OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0630	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS		PERRLA 2-3mm BILAT		PERRL			
	SENSORIUM		A/OX3 PLEAS/COOP		A+O X3 responds to			
			FOLLOWS COMMANDS		verbal + pain stimuli			
			MAE X4					
RESPIRATORY	RESPIRATORY PATTERN		UNLABORED REG		= bilaterally			
	BREATH SOUNDS		CLEAR BILAT APEX		CTA			
	SECRETIONS		TO BASE. STRONG		Non productive cough			
			NON-PRODUCTIVE		S_pO_2 94%			
			COUGH					
SKIN	COLOR		PINK		UFR			
	INTEGRITY		SEE PN		skin graft			
I.V. SITE	LOCATION		(R) IJ TLC INFUSING		(R) IJ infusing			
	CONDITION		LR PATENT		LR @ 50cc/hr Ø			
			NO S/S INFILTRATION OR		erythema, swelling or heat			
			INFECTION					
GASTRO	ABDOMEN		SOFT ROUND TENDER		Soft round Tender			
	BOWEL SOUNDS		TO TOUCH BS (+) X4.		to touch skin graft			
					BS X4 quadrants			
GU	URINE:		FOLEY TO GRAVITY		Foley to gravity			
	COLOR/CLARITY		DRAINING CLEAR YELLOW		clear yellow urine			
			URINE > 60ML/HR					
CARDIOVASCULAR	CARDIAC RHYTHM		ST 100-110's NO		S_1S_2 Ø extra sounds			
			ECTOPY NOTED. (R)		+R radial and pedal pulse			
			RAD PULSE +3, CAP		<3sec capillary fill			
			REFILL <2SEC X4 EXT		Edema to scrotum +			
			S_1S_2 NOTED		(R) leg			

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

(b)(6)-2

PREPARED BY (Signature & Title) [redacted] 9/WM6

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 16 July 03

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

[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

DATE | 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	X																	
BP Cuff		108/54	107/54	101/54	109/49	100/50	107/50	116/66		113/66	116/64	105/67	108/58	106/53				
Temperature		100.6				100.4					100.0				100/54	104/52	103/49	
Pulse	117	110	112	114	114	108	110	112		110	122	120	124	114	115	113	117	
Respiratory Rate	96	16	16	20	20	16	16	12		14	16	14	16	14	18	18	20	
MODE	RA	NA	NA	NA	NA	NA	RA	4L NC		4L NC	2L NC	NA	NA	NA	RA	RA	RA	
SATS		96%	95%	94%	95%	96%	95%	98%		98%	96%	95%	94%	96%	95	95	95	
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	50	50	50	50	50	50	50	50	400	50	50	50	50	50	50	50	50	
IVPB																		
TF	128	0	0	0	Ø	Ø	Ø	Ø		100	110	120	128	128	128	129	128	
PO											240		240					
TOTALS									400									

OUTPUT

Foley URINE	HOUR	80	110	60	70	60	80	60	30	570	80	40		60	50	90	80	40	440
	TOTAL	80	190	250	320		480	540	570		80	120	120	180	230	320	400	440	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS/WOUND									100	100									
STOOL																			
DRAINS																			
TOTALS										670									

#[redacted]

(b)(6)-4

16 July 03

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
	102/50	107/59	114/55	102/61	109/50	96/49	97/49	100/48
	113	117	119	115	111	110	107	109
	18	18	21	20	21	19	20	15
	RA	3L	2L	2L	2L	RA	RA	RA
	94	95	96	96	96	95	95	96

INTAKE	21	22	23	00	01	02	03	04	8° T
	50	50	50	50	50	50	50	50	1200
	128	128	128	128	128	off	off	off	

OUTPUT	21	22	23	00	01	02	03	04	
	90/120	45/165	50/115	50/165	45/110	45/155	70/125	60/185	885 440 570
									1395

ACUITY LEVEL CLASSIFICATION

RESPIRATORY			
	TIME		0410
	MODE		
	F_IO_2		
	TV		
	RATE		
	PEEP		
ABG	pH		7.449
	PCO_2		41.6
	pO_2		
	HCO_3		29
	SAT		
	BASE		5

LABORATORY		
	TIME	0410
	GLUCOSE	178
	Na/K	138/4.1
	Cl/CO_2	98/30
	BUN/Cr	11
	WBC/PLATELET	8.3/829
	Hct/Hgb	29/10
	RBC	3.12
	%L Lymph	26.4

ACTIVITIES DAILY LIVING			
	TIME		1000
	MOUTH CARE	[redacted]	
	BATH		
	SKIN CARE	[redacted]	
	FOLEY CARE	[redacted]	
	TRACH CARE		
	ROM EXERCISES	[redacted]	

TURN	TIME
	0500 [redacted]
	1000 [redacted]

SUCTION	TIME

(b)(6)

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

(b)(6)-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

NURSING RECORD	TIME	0530.	INITIALS [redacted]	(b)(6)-2	INITIALS	1800	INITIALS
	PUPILS	Pt is awake and alert.				Alert, verbalizes	
	SENSORIUM	Pt is able to follow				needs, follows	
		simple verbal commands.				verbal commands	
RESPIRATORY PATTERN		Inspiratory wheezes noted				Even unlabored. BBS	
	BREATH SOUNDS	to (L) lung, otherwise				but diminished throughout	
	SECRETIONS	clear but diminished at				(bilateral) RA, sat 93-98%	
		the bases. SpO2 92-93%				c incentive spirometer	
		on RA. Incentive spirometry					
		used. SpO2 ↑ to 98% c use. RR 12-15.					
	COLOR	Skin grafts to abd, (B) thighs c				Skin grafts to abdomen,	
	INTEGRITY	dressing intact. Suction 125 mm				thigh, 30-35% burns	
		to abd. graft sites. W/All other				S/P debridement dressing to sites	
	LOCATION	burns c dressing intact.				(R) IJ TLC, patent. LR c soc	
	CONDITION	(R) IJ TLC CVC cath				hour, no signs of infection	
		inserted.					
		LR infusing @ 50 cc/hr via					
		medial port. Proximal &					
		distal ports capped.					
	ABDOMEN	BS x 4. last BM overnight				BBS all quadrants,	
	BOWEL SOUNDS	Ostomy to (R) nare clamped.				no reported stool	
		Pt NPO for sedation today.					
		Abd taut and round. Soft c					
		exploration. Foley to gravity					
	URINE:					Foley to gravity, sediments	
	COLOR/CLARITY	drng clear dark yellow				noted, yellow.	
		urine.					
	CARDIAC RHYTHM	S1-S2. Sinus tach. Rate				$S_1 S_2$, Sinus tach, rate	
		100's-110. Brisk cap refill				100-110. Bilateral pedal	
		to (B) LE. Will assess further				and radial pulses.	
		c dressing change. Scrotal and				generalized edema. Cap	
		generalized edema noted				refill < 3 seconds.	

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

PREPARED BY (Signature & Title)

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 17 Oct 93

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
BP Arterial Line																		
BP Cuff	97/52	99/45	105/55	107/48	139/78	107/78	117/6	117/63	107/56	102/50	117/60	102/52	104/52	117/61	93/53	114/61		122/60 114/60
Temperature	100.9		100.4	100.2	100.3			99.9	100.1		100.5							
Pulse	109	110	110	105	119	118	111	107	101	107	101	108	108	104	107	107	107	100.4 103
Respiratory Rate	15	12	18	16	21	21	11	20	12	20	22	17	11	11	20	18	20	17
Mode	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
SaO2	98%	93%	96%	93%	90%	92%	93%	93%	95%	93%	96%	92%	95%	93	94	93	94	93

INTAKE

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
LR	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	324
IVPB																			
PO																			
TF					98	98	98	98	98	98	98	98	98	98	98	98	98	98	1372
TOTALS																			1696

OUTPUT

			05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
Foley URINE	HOUR		80	80	65		80	45	70	90	120	100		150	95	70	120	85			150
	TOTAL		80	160	225		305	350	420	510	630	740		890	985	1055	1175				1325
	sp gr																				
	S/A																				
NG	OUTPUT																				
	pH																				
	GUIAC																				
~~EMESIS~~ bowel																					
STOOL																					
DRAINS																					
TOTALS																					

POST-OP DAY

VITAL SIGNS	23	24	01	02	03	04			
T				98.6					
BP	123/65	119/68	113/57	118/69	118/65	118/65			
R	14	10	12	10					
A	102	122	103	104	104	101			
L	RA	RA	RA	RA	RA	RA			
S	95	96		97	95	98			

INTAKE	23	24	01	02	03	04				
IV	50	50	50	50	50	50				300
TF	98	98	98	98	~~98~~	~~98~~				392
										692

I: 2388
O: 2025
363

OUTPUT										
	130/130	160/440	180/310	180/550	100/650	50/700				700
stool	T mucous									

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

TURN	TIME									
SUCTION										

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE: IV 2388, PO _____ TOTAL _____

OUTPUT: Urine: 2025 TOTAL _____

BALANCE +363

NURSE'S SIGNATURE / INITIALS

[redacted]

(b)(6)-2

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

Proponent agency is the Office of The Surgeon General.

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0000	INITIALS	1730	INITIALS [redacted] (b)(6)-2	INITIALS
NEURO	PUPILS	PERRL		PERRLA 3mm ++		
	SENSORIUM	Pt Alert + responsive to touch + voice follows simple commands		Alert, cooperative pleasant. Follows simple commands MAE & purpose.		
RESPIRATORY	RESPIRATORY PATTERN	Reg R+R equal bilat + fall		RA SATS 90's. BS		
	BREATH SOUNDS	CTA bilat		CTA Bilat & ↓ + Bases		
	SECRETIONS	Ø Ntd secretions Ø Ntd diff. breathing Pt on RA, & O2 sats From 94-96%		MDI Albuterol a incentive spirometry per Rx.		
SKIN	COLOR	NFR		Membranes pink		
	INTEGRITY	dressings in tact		See SF600 for wound assessment		
IV SITE	LOCATION	(R) FA 18G & LR		PIV 18g SF to (R) anterior FA & LR 100° via dial A-Flow & S/Sx infection/infiltration		
	CONDITION	@ 50cc/hr. Ø Ntd erythema/edema				
GASTRO	ABDOMEN			Soft, obese, tender		
	BOWEL SOUNDS			(+) BS in (4) Quads. Mod. amt large Brown Stool (continent)		
GU	URINE: COLOR/CLARITY	Clr yellow via Foley in adequate Amounts.		Foley 16F & clear yellow. U.O. > 100ml/hr.		
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2 present, Ø Ntd ectopy. Bilat Radial pulses +3 + (R) Pedal +3. & brisk cap refill X4 extremeties.		S S & ectopy noted. HR 80's. PP present x4. UE Palp. Pedal doppler.		

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SA1 - Saturation; TRACH - Tracheostomy

(b)(6)-2

PREPARED BY (Signature & Title) [redacted] 9/WMC

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 20 July 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent Dept of Nurs

MEDCOM - 13448

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

DX

HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
BP Arterial Line																	
BP Cuff		113/58	114/59							127/72	122/67	103/52	106/59	102/54	97/55	112/55	117/60
Temperature	99.4	96.8	97.6							97.4	98.8	100.8	100.5	99.1	98.6		
Pulse	93	92	91							109	109	112	114	102	102	98	98
Respiratory Rate	19	20	19							34	16	20	23	15	14	22	18
SAT	94	96	94							94%	100%	98%	96%	99%	98%	100	100
MODE	RA	RA	RA							RA	RA	RA	RA	RA	RA	RA	RA

PA to OR

pain

intervention

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20
LR	50	50	400	400	400	400	400	50	2150	100	100	100	100	100	100	100	100
NPB																	
Bolus																	
OR								300									
PO												240			50		

TOTALS

URINE HOUR	90	140	140	90	25	25	25	25		75	80	125	125	50	205	40	
URINE TOTAL	90	230	370	460				560		635	715	840	965	1015	1220		
10 gr								(1100 ml 24 hr)									
S/A																	
OUTPUT																	
NG pH																	
NG GUIAC																	
E[redacted] FBS								50									
STOOL																	
Wound															Bowel Lavage		
DRAINS																	
VAC																	

(b)(6) -2

21	22	23	00	01	02	03	04	
121/63	129/69	123/	X	120/63	112/56	115/67		
100	99	X	X	X	X	99	X	
103	105	106	111	107	61	100	101	
20	21	22	26	26	22	16	14	
100	100	100	95	98	98	95	96	
RA	RA	RA	RA	RA	RA	RA	RA	

	22	23	00	01	02	03	04	8° T
100	100	100	100	100	100	100	100	

50

315	75	200	200	150	160	200

Brown Liquid

100

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			
Peri Care	1830		

TURN / SUCTION TIME	
1800	0200
2000	0400
2200	
2400	

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	5700	Urine:	2460
po	340	EBL	50
	6040	VAC	100
			2610

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

(b)(6)-4

[redacted]

R 6 - 2450

MEDCOM - 13450

20 Sep 03

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS [redacted] (b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERRL			PERRL, 3mm	
	SENSORIUM	Pt alert & responsive to touch + voice stimuli.			Pt AFO,	
RESPIRATORY	RESPIRATORY PATTERN	Reg R+R			RR & Rhythm	
	BREATH SOUNDS	CTA bilat			CTA Bilat	
	SECRETIONS	Ø Ntd secretions or difficulty breathing.			Symmetrical rise & fall of chest	
SKIN	COLOR	NFR			NFR	
	INTEGRITY	dressings intact			Dressing intact	
I.V. SITE	LOCATION	(R) FA LR @ 100			(R) FA (P) flush	
	CONDITION	Ø Ntd erythema/edema			LR @ 100 c/hr Dob-hoff to (R) wrist No tube feeds at this time.	
GASTRO	ABDOMEN					
	BOWEL SOUNDS	BS + X 4 Quads NO BM			BS (+) X 4 quad No BM at this time	
GU	URINE COLOR/CLARITY	Clr Yellow to Foley			Foley to gravity clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2 Present Ø Ntd ectopy, HR - 100			S1 S2, HR 99 BP 125/74	

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

(b)(6)-2

PREPARED BY (Signature & Title) [redacted] 9/Wm6 — DEPARTMENT/SERVICE/CLINIC 1C43 (b)(6)-2 — DATE [redacted] 21 July 03

(Continue on reverse)

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

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

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

DA FORM 1 MAY 79 4700
Component: Dept of Nurs

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

21 July 03
386

DATE 21 July DX S/P grafting PAGE

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	114/89		112/58	114/58	106/56	114/92	110/59	111/62	106/65	106/65	107/56	113/63	108/60	113/65	121/68	125/74	119/69
	Temperature	X	100	99.1	99.2	99.2	X	99.4	99.4	99.1	99.1	99.6	99.6		99.8	99.6		98
	Pulse	101	100	100	100	94	102	104	104	105	105	104	102	100	99	100	99	98
	Respiratory Rate	20	15	18	17	17	22	18	22	20	20	17	15	21	23	21	20	23
	SAT	98	96	99%	99%	99%	99%	93%	100%	99%	99%	100%	94%	93%	97%	100%	100%	93
	MODE	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

PAIN

intensity

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20
	LR	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100
	IVPB																	
	Bolus																	
	PO											120						
	TOTALS																	

OUTPUT																			
Foley URINE	HOUR	60	50	40	40	40	55	45	55		75	120	120	125	140	50	50	150
	TOTAL	60	110	150	190	230	285	330	385	385	460	580	700	825	965	1015		
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
WOUND VAC																		

(b)(6)-4

July 03

[redacted]

116/62	129/67	123/74	124/72	99/67	106/68	120/72		
93	93	97	95	98	94	93		
13	11	18	15	28	13	21		
100	95	95	95	97	95	98		
22	23	00	01	02	03	04	8° T	
100	100	100	100	100	100	100	100	
75	128	140	72	100	100	100	100	

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

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

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

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
PUPILS		PERRL 3mm		PERRL 3mm #			
SENSORIUM		Busik		MAE ē purpose,			
				Pleasant, cooperative			
				Disoriented x to			
				person.			
RESPIRATORY PATTERN		RRR & Sounds		RR 20's, BS CTAB			
BREATH SOUNDS		CVA Bilat		ē ↓↓ Bases. Uses			
SECRETIONS		& secretions		incentive spirometer			
				& cough/secretions			
COLOR		Normal for Race		Membranes pink			
INTEGRITY		Dressings intact		Sec SF 600 yes			
				Skin assess —			
LOCATION		IV to (R) wrist site		PIV (R) lat wrist			
CONDITION		CDI & S/S erythema		18g LR 100 ml/hr			
				Dual-a-Flow.			
				Site ē S/Sx in-			
				fections/infiltration			
ABDOMEN		(+) BS x4 quads		Obese, soft,			
BOWEL SOUNDS		Soft & distention		tender to touch			
				2° wound. (+) BS			
				Loose Brown Stool			
URINE		Clear yellow		Foley ē cl. yellow			
COLOR/CLARITY		Foley to gravity		urine. H.O. ≥ 30			
				ml/hr.			
CARDIAC RHYTHM		S, S2 +2 pulses x		S/S HR 90-100's			
		4 extremities.		ē ice therapy noted			
				PDP ē (+) sensity			
				MAP > 60. CVP			
				Ref. 11 < 3 sec. —			

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)

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

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 22 July 03

IDENTIFICATION [redacted] typed or written entries give: Name—last, first, title; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

DX

HOSPITAL DAY 21

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff		114/67	120/69	120/67	114/68	114/64	115/66	119/71		130/63	130/73	119/64	120/67	110/62		117/50	100/68	117/63
Temperature						99.1		99.3					99.8		98	98.6	X	X
Pulse		98	100	101	98	99	100	113		132	118	107	105	120	112	110	113	100
Respiratory Rate		19	16	20	19	19	20	35		25	29	22	37	28	32	32	32	16
SaO2		94	96	97	97	97	100	98		96	96	96	96	97	96	96	96	96

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IV		100	100	100	100	100	100	780	760	100	100	180	100	100	100	102	100	
IVPB																		

TOTALS

URINE	HOUR / TOTAL		50/80	80/120	80/200	80/320	50/320	75/395	75/470	470	50/50	50/100	70/170	120/290	55/345	65/410	0	110	
	Sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			

Tmax 99.1

LG Bowel

PAGE

ACUITY LEVEL CLASSIFICATION

	22	23	00	04	02	03	04	
	109	121	108	129	119	131	126	
	83	69	65	68	64	76	79	
	X	X	X	X	X	X	X	
	102	104	106	101	94	96	99	
	32	21	17	27	31	32	35	
	96	95	95	97	98	97	99	

	22	23	00	04	02	03	04	8° T
	100	100	100	102	100	100	102	

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS	1800	INITIALS
NEURO		0044	[redacted]	(b)(6)-2			[redacted]
	PUPILS	PERL				PERRL	
	SENSORIUM	Pt alert & Oriented to place & name				pt A&O x2 purposefull movement x4 moves all extremities	
RESPIRATORY	RESPIRATORY PATTERN	45				21-RR	
	BREATH SOUNDS	normal				SpO2 - 97% on RA	
	SECRETIONS	∅ cough @ present time				∅ cough @ present	
SKIN	COLOR	normal for race				Normal for Race	
	INTEGRITY	warm dry intact				warm dry	
I.V. SITE	LOCATION	Rt Arm				Wounds, graft sites, donor sites Rt Arm	
	CONDITION	Patent to site 5 swelling/redness noted to area.				patent no S/S of infection/infiltration @100 infusing LR	
GASTRO	ABDOMEN	soft ∅ distention, tender				Soft flat no distention or tenderness noted	
	BOWEL SOUNDS	present to abd. Bowel sounds RQ quadrant				Bowel sound hyperactive x4	
GU	URINE: COLOR/CLARITY	dark yellow. Hx to RA				dark yellow clear drainage via catheter	
CARDIOVASCULAR	CARDIAC RHYTHM	ST				HR-91 pulse x4 capillary refill ≤3sec	

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] 91CMC

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 23 July 03

PATI[redacted] middle[redacted] hospital or medical facility) Name—last, first.

(b)(6)-2

[redacted]

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

DATE July 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	134																	
BP Cuff	77	115/69	125/71			115/69	123/70	122/69		120/80	111/64	112/74	119/61	123/63	105/61	120/100	116/60	
Temperature	99.3	98.6	98.5			99.3		100.4		98.2		99.2		99.2	99.3	99.2		
Pulse	97	97	105			112	98	104		139	101	99	90	94	99	91	95	
Respiratory Rate	30	45	46			28	20	33		35	27	24	20	36	25	17	15	
SAT	99	99	96			95	95	91		92	96	98	99	97	96	96	95	
MODE	RA	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	100	100	800	100	100	100	100	100	100	100		
IVPB																		
Bolus															IV			
													150					
													140					
													24					
									360									
									360									
									420									
									1740									
Dolthoff																		
PO				360				420	780		300							
TOTALS									3300									

OUTPUT

		HOUR / TOTAL	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
Foley	URINE		200	250 / 450	100 / 550	100 / 650	100 / 750	100 / 850		100 / 950	820	100 / 920	80 / 1000	80 / 1080	80 / 1160	80 / 1240	115	65		
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL				None																
DRAINS																				
TOTALS																				

Stool

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	21	22	23	00	01	02	03	04	
	113/61	110/59	112/65	101/63	99/54	114/65	109/58	114/61	
	99.7	99.8	99.3	99.5	99.3	99.8	99.7	99.5	
	105	99	98	102	97	94	93	94	
	93%	95%	94%	94%	96%	95%	96%	96%	
	RA	RA	RA	RA	RA	RA	RA	RA	
	20	24	24	24	25	19	24	19	

INTAKE	21	22	23	00	01	02	03	04	8° T
	100	100	100	100	100	100	100	100	

OUTPUT									
	100	100	100	150	100	100	0	0	

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

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

TURN	TIME				
	0100	0300	0500	0700	0900
	Lt Side	Back	Rt Side	Lt Side	Rt Side
SUCTION	Cont to BS				

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

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	✓																							
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5																								
		CONFUSED 4	✓																							
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 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																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS	✓																							
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	3																							
		REACTION	++																							
	LEFT	SIZE	3																							
		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
	R																								
	L																								
	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

(b)(6)-2

OTSG APPROVED (Date)
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEUROLOGIC	PUPILS	3mm PERRL PT.		PERRLA 2mm #			
	SENSORIUM	moves all extremities c̄ purposeful movement		Oriented to person only. Cooperative, pleasant. MAE c̄ purpose			
CARDIOPULMONARY	RESPIRATORY PATTERN	RRR equal rise & fall		RA SATS ↑90's.			
	BREATH SOUNDS	Q secretions		RR 20's. Q cough			
	SECRETIONS	LUA Bilat		NOTED. BS ↓/V Bilat Bases.			
SKIN INTEGRITY	COLOR	Normal for Race		Membranes pink			
	INTEGRITY			See SF600 for Skin Assess.			
VENOUS ACCESS	LOCATION	18 ga to (R) FA		PIV RESTART 20g			
	CONDITION	LR @ 100cc/hr Site CDI Q redness		to (L) upper arm. LR 100°			
GASTROINTESTINAL	ABDOMEN	+BS X 4 quads		OBese soft ABD tender 2° graft site to anterior ABD			
	BOWEL SOUNDS			(+) BS in (4) QUADS			
GENITOURINARY	URINE: COLOR/CLARITY	Clear yellow, foley to gravity		Foley 16F c̄ clear yellow 4.0 730ml/hr			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 +Pulses +2 X 4 extremities		S S c̄ HR 90's. Dectopy via monitor PPP c̄ (+) 3 density CAP REF: 1 < 3 sec.			

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)

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

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 24 July 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 1 Aug 03
Time In: 1020
Allergies: _____ OR Intake: Crystalloid _____ Colloid _____
Pre-op V/S: _____ OR Output: UOP _____ EBL _____
Procedures: Debridement Meds/Times: _____

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

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

Pre Op Meds History

Time	1035	1040	1045	1115	1145
SaO2	97	99	99	99	
FiO2					
Methods	RA	RA	RA	RA	
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	10	11	9	12	11
T					
Time					
Pain (0-10)					
LOS					

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 1 Aug 03

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

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

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		No Meds				

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'	See	SF	600				
60'							
90'							
D/C							

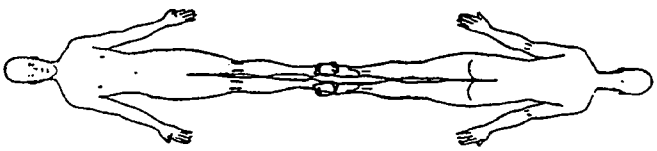
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Dressings Δ'd in OR		
30'	CDI		
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1035 - pt back from surgery fully awake and talking. VSS - for
1100 - pt VSS SpO2 96% on room air. Will continue to monitor - [redacted]
1130 - pt VSS, SpO2 98 on room air. pt being D/C'd (b)(6)-2 from PACU procedures - [redacted]

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

...agency is the Office of The Surgeon General.

OTSG APPROVED (Date
OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0141	INITIALS [redacted] (b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	Pt. alert & responsive.				
	SENSORIUM	PERL. Follows command well. Able to communicate needs well.				
RESPIRATORY	RESPIRATORY PATTERN	17 normal				
	BREATH SOUNDS	CTA				
	SECRETIONS	Ø. Ø cough noted @ this time				
SKIN	COLOR	normal for race				
	INTEGRITY	Warm + dry to touch				
I.V. SITE	LOCATION	(R) wrist.				
	CONDITION	LR @ 100cc/hr infusing. S complications. Ø S/SX of infiltration				
GASTRO	ABDOMEN	Soft + distended				
	BOWEL SOUNDS	Bowels Q 4°				
GU	URINE:	Fc to BS				
	COLOR/CLARITY	Clear yellow urine				
CARDIOVASCULAR	CARDIAC RHYTHM	HR 101 normal edema noted to (B) feet.				

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

PREPARED BY (Signature & Title) [redacted] 9 Wmb

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 03 Aug 03

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

(b)(6)-2

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

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 (b)(6)-2

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS [redacted]	(b)(6)-2	INITIALS	1845	INITIALS [redacted]
NEURO	PUPILS		3mm brisk				Pupils 3mm PERRL	
	SENSORIUM		Alert and oriented				A&Ox3	
			Able to follow commands					
			and express needs					
RESPIRATORY	RESPIRATORY PATTERN		RRR				equal rise/fall of	
	BREATH SOUNDS		Diminished bilat				chest, clear sounds	
	SECRETIONS		↓ bases.				clear in ade fields	
			Ø secretions @ this					
			time					
SKIN	COLOR		WNL for race				normal for race	
	INTEGRITY		Drsg Bilat vertand					
			BUE D+I					
IV SITE	LOCATION		(R) PA				(R) PA c̄ 2L @ 100cc/h	
	CONDITION		Ø S/S of infection c̄ LR				Ø S/S of infection/	
			infusing @ 100cc/°				infiltration	
GASTRO	ABDOMEN		soft, nontender				(→) TRD, (+) Bowel	
	BOWEL SOUNDS		(+) throughout all quad				sounds x 4 quads	
GU	URINE:		foley to gravity draining				foley to gravity	
	COLOR/CLARITY		clear yellow urine c̄ Ø				(QS), clear yellow	
			sediments					
CARDIOVASCULAR	CARDIAC RHYTHM		SR c̄ Ø ectopy, Edema				NSR, S, S, normal	
			+4 BLE, pulses palpable				S1 S2 w/ no murmurs	
			throughout, Cap refill				noted.	
			<3 sec.					

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)

IDENTIFIED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] 9 WM 6	ICU 2 West	5 Aug 03

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

(b)(6)-2

[redacted] — (b)(6)-4

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

DATE | DX | HOSPITAL DAY

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

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

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

5Aug # [redacted] - (b)(6) - 4

ICU Flowsheet Patient Name: Date: 08 / 05 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature								98.4												98.1			98	98.8		
Pulse	98				101			~~98.4~~ 91						97						90			94	94		
B/P A-Line																										
MAP																										
B/P Cuff								119/63												110/63				110/60		
Respirations	85				14			24						10						14				16		
Sa02	99				97			97						100						100				99		

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
LR	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	
[redacted] (b)(6)-2																										
PO								360					360													
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly					450/450	58/508	58/566	58/624	71/695	71/766	71/837	71/908	908	71/979	71/1050	72/1122				125/1247	100	100	70	30	50	
NG Tube																										
s #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R. OUT [redacted] (b)(6)-2																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13467

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA

For 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 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 2000 Initials: [redacted] (b)(6)-2	Time: Initials:
NEURO	Pupils	PERRL	
	Sensorium	Alert & Orientated x3	
	LOC / GCS	Follows all commands move all extremities	
CARDIAC	Cardiac Rhythm	NSR HR-85 BP-122/64	
	PRI: / QRS:	peripheral pulses (++) x 4	
	Pulse Strength	Cap Refill ≤3sec Ø edema	
	Cap Refil / JVD	noted @ present Ø chest	
	Edema	pain	
	Chest Pain		
RESP	Respiratory Pattern	RR- 12	
	Breath Sounds	Breath sound CTA (B)	
	Secretions	Ø secretions Ø cough	
	Cough		
SKIN	Color	Normal for Race	
	Integrity	Burns scattered small	
	Backside	breakdown noted Pt on side	
		or up ↑ of Bed when possible.	
IV	Access Devices	Ø	
	Location		
	Condition		
GI	Abdomen	Soft Round/Flat Nontender	
	Bowel Sounds	Non distended B.S. Normoactive	
	Stoma/Ostomy	x4 Ø Stoma/ostomy	
GU	Device	Pt voiding via urinal	
	Color / Clarity		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 12 Aug 03

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

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

'3 Patients Name: [redacted] (b)(6)-4 # [redacted] Date: 12 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP																										
TEMP														98.1				124/56				134/62				
HR														122/64				97.9				98.8				
RR														85				78				96				
SaO2														12				12				12				
FiO2														95%				95%				96%				
Source																										
M														RA				RA				RA				

See SF 511

NTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
: none														Ø				1								
PB																										
T																										
PO																		100		200						
Total																										

UTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	al
URINE																		350								
NGT																										
STOOL																										
DRAIN																										
Total																		350								

MEDCOM - 13469

JCAL RECORD-SUPPLEMENTAL MEDICAL DAT

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 0730 Initals: [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
NEURO	Pupils	PERL, Alert & Oriented.	PERRLA. Alert & oriented
	Sensorium	Able to communicate	follows all commands &
	LOC / GCS	all needs.	communicates w/ difficulty
CARDIAC	Cardiac Rhythm	Normal. HR 90	NSR
	PRI: / QRS:	+ pulses & good cap.	
	Pulse Strength	Refill. Edema noted	Strong UE pulses. LE's warm
	Cap Refil / JVD	to (LF) foot. ∅ chest pain	to touch. cap refill < 2 secs
	Edema		none noted
	Chest Pain		∅ complaints
RESP	Respiratory Pattern	Normal. RR 12	normal on RA
	Breath Sounds	Normal	CTA (B)
	Secretions		none
	Cough	non productive cough noted.	none
SKIN	Color	Normal for Race	NFR
	Integrity	warm + loose. Burns to	Dressings to UE's, abd, LE's
	Backside	buttocks, back, abd. (B) leg	feet
		also (B) hands.	
IV	Access Devices		∅ IV access
	Location	∅ IV access	
	Condition		
GI	Abdomen	Soft & nondistented	soft, nontender
	Bowel Sounds	Q4 quadrant	BS hypoactive
	Stoma/Ostomy	∅ Stoma/Ostomy	∅
GU	Device	cont. of B+B.	no void witnessed
	Color / Clarity		yet
		(b)(6)-2	

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 3, 28th Combat Support Hospital

DATE: 13 Aug 03

PA[redacted] *(For typed or written entr... first, middle, grade; date; hospital or medical facility)*

Name — last,

#[redacted]
13/Aug03 (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

Name: H[redacted] – (b)(6)-4 Date: 13Aug03

(b)(6)-2

	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	06
A																										
NB.	118/70				110/68				108/70						110/60		[redacted]	110/60								105/65
TEMP	98.1				97.2				97.2						97.6		[redacted]	98A								97.0
HR	90				94				85						77			89								80
RR	12				14				10						12			12								12
SaO2	95				95				95						97%			95%								98%
FiO2	RA				RA										RA			RA								RA
Source																										
M/																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
T																										
PO			360		120		360					120														
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE										400			400						350							350
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13471

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 16 AUG 07
Time In: 1145
Allergies:
Pre-op V/S: 106/[illegible] 97
Procedures:

Anesthesia Type (Circle)): General, Spinal, Epidural, IV Sedation, Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL MIN
Meds/Times: 3 Versed, 250 Fent

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

Pre Op Meds

History

Time	1145	1150	1155	1200	1215	1230
SaO2	98	96	95	97		98
FiO2						
Methods	RA	RA	RA	RA		RA
240						
220						
200						
180						
160						
140						
120						
(b)(6)-2						
100						
80						
60						
40						
20						
RR	12	14	12	12		14
T	98		97.6			

Time									
Pain (0-10)									
LOS									

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

(Continue on reverse)

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

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

[redacted] – (b)(6)-4

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

CAL RECORD-SUPPLEMENTAL MEDICAL DAT

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 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	3mm PERRL	PERRL
	Sensorium	Alert, speaks some english	A+O, able to follow
	LOC / GCS	Able to follow commands	simple commands
CARDIAC	Cardiac Rhythm	SR HR 80	
	PRI: / QRS:		
	Pulse Strength	+2 pulses throughout all 4 ext.	0 pulses x4 extremities
	Cap Refil / JVD	cap refill < 3sec all 4 ext.	< 3sec
	Edema	0 noted	
	Chest Pain	0 noted	
RESP	Respiratory Pattern	equal chest rise, RRR 12	CTA B/lat
	Breath Sounds	CTA throughout	
	Secretions	0 noted	
	Cough	0 noted	
SKIN	Color	WNL FOR RACE	WNL for Race
	Integrity	50% BSA BURNS, DRSGS ABD,	Drsgs to ABD, Thigh, B/LE
	Backside	THIGH, B/LE, BUE, BACK D+I	BUE + Back C/D/I
IV	Access Devices	0 ACCESS	No IV access
	Location		
	Condition		
GI	Abdomen	Soft, nontender	Soft nontender, nondistended
	Bowel Sounds	(+) normal all 4 quadrants	(+) BS x 4 quad
	Stoma/Ostomy	0	
GU	Device	urinals assist	Uses urinal w assist.
	Color / Clarity		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC [redacted] (b)(2)-2

DATE 14 AUG 03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: # [redacted] (b)(6)-4 Date: 14 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	105/65				112/70				116/76					116/76				107/74				115/78				
TEMP	97.9				96.7				96.9					97.2				98.5				98.4				
HR	80				75				82					82				82				80				
RR	12				12				13					13				16				12				
SaO2	96%				95%				96%					96%				96%				96%				
FiO2	RA																									
Source					RA				RA					RA				RA				RA				
M.																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
r																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																										
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13474

ICAL RECORD-SUPPLEMENTAL MEDICAL DAT

For u... s form, see AR 40-66; the proponent agency is the Office of The Surgeon...

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 0730 Initals: [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
NEURO	Pupils	PERL	
	Sensorium		A & O Verbalizes needs.
	LOC / GCS	Alert & Oriented	
CARDIAC	Cardiac Rhythm	Normal 91	NS @ 91
	PRI: / QRS:	+3 c Good Cap	
	Pulse Strength	refill	Radial/pedal pulses palpable
	Cap Refil / JVD		
	Edema	Edema to (LF) feet	edema to (D) LE +1
	Chest Pain	∅ chest pain	no chest pain
RESP	Respiratory Pattern	normal 11	RRR
	Breath Sounds	normal - CTA	CTA
	Secretions	N/A	NA
	Cough	∅ cough noted ∅ wheezing noted	∅ cough
SKIN	Color	normal for race	Normal for race
	Integrity	warm & dry to touch	Wound abdomen, thigh, back
	Backside	Burn area to Bactrels	+ bactrels applied
			redressed.
IV	Access Devices		
	Location	N/A	NA
	Condition		
GI	Abdomen	Soft non distended	Soft non-tender
	Bowel Sounds	Bowels ∅ 4 Quadrant	Positive BS
	Stoma/Ostomy		
GU	Device	Cath BTB	Voiding spontaneously
	Color / Clarity	dark yellow urine	amber/yellow urine

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC [redacted] (b)(2)-2

DATE 15AUG03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: EPW [redacted] (b)(6)-4 Date: 15AUG03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	102/58				112/72				110/68		106/68			104/60				106/64			104/66			106/68		
TEMP	97.7				97.8				97.8		97.8			97.4				97.6			97.7			97.6		
HR	93				91				87		87			86				84			86			87		
RR	12				12				11		11			12				14			12			12		
SaO2	96				95				97		98			97				96			96			96		
FiO2																										
Source	RA				RA				RA		RA			RA				RA			RA			RA		
M:																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
L																										
PO	358	188					466																			
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	550																									
NGT																										
STOOL																										
DRAIN																										
Total																										

Voided & BM
& large
hardstools

MEDCOM - 13476

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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
NEURO	Pupils	PERRL	PERRL
	Sensorium		A&O x3
	LOC / GCS		pt follows all commands, purposefull movement to All Extremities
CARDIAC	Cardiac Rhythm		HR- 79 BP- 116/69
	PRI: / QRS:		
	Pulse Strength		peripheal pulse strong x4
	Cap Refil / JVD		Cap Refill ≤3 sec Ø JVD
	Edema		Slight edema noted to ↓ Extremities
	Chest Pain		Ø chest pain
RESP	Respiratory Pattern		RR- SPO2
	Breath Sounds		Regular CTA (B)
	Secretions		Ø secretion
	Cough		Ø cough @ present
SKIN	Color		Normal for Race
	Integrity		Burns healing well (B) heel dressing A daily
	Backside		No backside issues
IV	Access Devices		I.V. @ TKO in (R) AC
	Location		patent ∃ S/S of infection or infiltration
	Condition		
GI	Abdomen		Soft Flat Non tender Non distended
	Bowel Sounds		BS Normo-active x4
	Stoma/Ostomy		Ø ostomy
			Ø stoma
GU	Device		urinal @ bedside
	Color / Clarity		clear yellow (MARK)

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 8-16-03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: # [redacted] (b)(6)-4 Date: 16 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	110/64				104/64		110/71																			
NBP														112/69				105/68				102/66				
TEMP	97.2				98.2		97.6							97.4				97.6				98.4				
HR	89				81		92							79				78				84				
RR	12				16		12							14				16				16				
SaO2	94				99%		97%							96%				94%				95%				
FiO2	RA				RA		RA																			
Source														RA				RA				RA				
M/														88				80				73				

ITAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B														TKO					~~250~~							
T																										
O	NPO																									
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																			250							
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13478

ME . RECORD-SUPPLEMENTAL MEDICA

For use of this fo... see AR 40-66; the proponent agency is the Office of T... Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] (b)(6)-2	Time: 0700 Initals:
NEURO	Pupils		PERRL
	Sensorium		A&O x3
	LOC / GCS		purposefull movement x4
			Follows commands
CARDIAC	Cardiac Rhythm		HR- 86 BP- 128/62
	PRI: / QRS:		
	Pulse Strength		(+)3 Peripheral pulses
	Cap Refil / JVD		≥3 sec Ø JVD
	Edema		Slight edema in lower extremities
	Chest Pain		Ø chest pain
RESP	Respiratory Pattern		RR- 12 SpO2 97% RA
	Breath Sounds		breath sounds CTA(B)
	Secretions		Ø sec
	Cough		Ø cough
SKIN	Color		NFR T- 98.4
	Integrity		healing burns (B) heel dressing Δ
	Backside		no breakdown
IV	Access Devices		IV in (L) forearm @ TKO
	Location		
	Condition		Patent
GI	Abdomen		Soft flat nontender
	Bowel Sounds		BS Normoactive x4
	Stoma/Ostomy		Ø ostoms
			Ø stoma
GU	Device		urinal @ bedside
	Color / Clarity		dark yellow / Amber clear

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC [redacted] (b)(2)-2

DATE 17 Aug 08

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: #[redacted] (b)(6)-4 Date: 17 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	116/74				102/60				102/62					128/62				112/62				122/66				
TEMP	98.4				97.9				96.6					98.4				98.6				97.6				
HR	94				72				64					86				77				73				
RR	11				12				10					12				12				14				
SaO2	91													97				97%				99%				
FiO2																										
Source	RA													RA				RA				RA				
M																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF																										
IVPB																										
NGT																										
F																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
LINE									X1-500cc																	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13480

ME . RECORD-SUPPLEMENTAL MEDICA . I.

For use of this fo. . see AR 40-66; the proponent agency is the Office of t.. Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0710 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRLA	
	Sensorium	A+O x 3	
	LOC / GCS	Responsive, Cooperative	
CARDIAC	Cardiac Rhythm	—	
	PRI: / QRS:	—	
	Pulse Strength	+3 in all Extremeties	
	Cap Refil / JVD	<3 secs, Ø JVD	
	Edema	BLE	
	Chest Pain	None	
RESP	Respiratory Pattern	Regular, Unlabored	
	Breath Sounds	Exp. Wheezing in upper + middle lobes, Bases CTA	
	Secretions		
	Cough	Ø cough or secretions	
SKIN	Color	Normal for race	
	Integrity	Burn to chest, Arms, BLE, back + Buttocks	
	Backside		
IV	Access Devices	IV (+) erythema, (+) pain	
	Location	IV DC'd	
	Condition		
GI	Abdomen	Soft + Nontender	
	Bowel Sounds	Active x 4	
	Stoma/Ostomy	None	
GU	Device	Not yet Voided	
	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] PSY/SW

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 18 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)* (b)(6)-2

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] (b)(6)-4 Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP					98/70										101/62											
TEMP															98.9											
HR					96										92											
RR																										
SaO2					96										98%											
FiO2					RA																					
Source																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
/F																										
/PB																										
IGT																										
		118					240			60			418													
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE			500										500													
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13482

MEI RECORD-SUPPLEMENTAL MEDICA A

For use of this fo.. ee AR 40-66; the proponent agency is the Office of Th. urgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] (b)(6)-2	Time: 1857 Initals: [redacted] (b)(6)-2
NEURO	Pupils	PERRL	3mm PERRL. Pt is responsive to verbal stimuli and is able to follow simple commands
	Sensorium	Pt responsive to touch	
	LOC / GCS	+ Voice stimuli	
CARDIAC	Cardiac Rhythm		Reg Rate + Rhythm.
	PRI: / QRS:	(b)(6)-2	(P)2 Radial and (B) pedal
	Pulse Strength	[redacted] ~~Ped~~ Radial + Pedal @ +2 c̄ brisk cap	pulses. <2sec cap refill
	Cap Refil / JVD	refill. Ø JVD	
	Edema	BLE	
	Chest Pain	Ø Ntd	
RESP	Respiratory Pattern	Reg R+R c̄ equal rise + fall	Even and unlabored. (L)
	Breath Sounds	inspiratory + expiratory wheezes	side Insp/Exp wheezes
	Secretions	in upper + middle lobes bilat.	noted.
	Cough	Bases CTA. Ø Ntd cough or	
		Secretions.	
SKIN	Color	NFR	Normal for race. Ors go to
	Integrity	dressings intact	burn areas D + I.
	Backside		
IV	Access Devices	Ø	None.
	Location		
	Condition		
GI	Abdomen	Soft + round	BS x 4. Abd soft and non
	Bowel Sounds	+ x 4 quads	tender. Pt states last
	Stoma/Ostomy	Ø	BM 3 days ago.
GU	Device	Pt voids to urinal @ bedside	voiding per urinal
	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: # [redacted] (b)(6)-4 Date: 19 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	~~103~~		103																							
NBP	~~69~~		69													104/65										
TEMP	~~98.6~~		98.6													96.6										
HR	~~87~~		87													79										
RR	~~14~~		14													14										
SaO2	~~97%~~		97%													95%										
FiO2																										
Source																RA										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF																										
IVPB																										
NGT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																					350					350
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13484

ME . RECORD-SUPPLEMENTAL MEDICA TA

For use of this f see AR 40-66; the proponent agency is the Office of . urgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT			
		Time: 0800 Initals: [redacted] (b)(6)-2	Time: 1845. Initals: [redacted] (b)(6)-2
NEURO	Pupils	PERRLA	2mm PERRL. Pt is A+O x3. Pt
	Sensorium	A+O x3	able to follow commands and
	LOC / GCS	~~Foll~~ Follows Commands [redacted] (b)(6)-2	is responsive to verbal stimuli.
CARDIAC	Cardiac Rhythm		+2 Reg rate. S1-S2. +2 (B)
	PRI: / QRS:		palpable radial + pedal pulses.
	Pulse Strength	+3 in all extremities	cap refill <3sec.
	Cap Refil / JVD	<3 secs, Ø JVP	
	Edema	None	
	Chest Pain	None	
RESP	Respiratory Pattern	Regular + Unlabored	Reg. + unlabored. Insp + Exp.
	Breath Sounds	Insp/Exp. Wheezing auscultated	wheezes noted to (B) upper & middle
	Secretions	in (B) Upper + Middles.	lobes. Diminished @ bases.
	Cough	Ø Cough or Secretions	Ø cough noted.
SKIN	Color	Normal for Race	Warm + dry. Disp intact to
	Integrity	Burn to Chest, (B) UE, (B) LE,	burn areas ∃ drng noted.
	Backside	Back, + [redacted] Buttocks (b)(6)-2	
IV	Access Devices	None	None.
	Location		
	Condition		
GI	Abdomen	Soft, Nontender	Soft and nontender. Hypo BS x4
	Bowel Sounds	Hypoactive	last BM ~4 days ago per
	Stoma/Ostomy	Ø N/V	patient.
GU	Device	Pt has not yet voided	Voids per urinal
	Color / Clarity		
		(b)(6)-2	(Continue on reverse)

PREPARED BY *(Sig[redacted] & Title)* [redacted] OH/AV

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 20Aug03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] (b)(6)-4 Date: 20 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			100/68													110/72		~~114/73~~								
TEMP			98													97.4										
HR			75													80		~~78~~								
RR			14													15		~~12~~								
SaO2			95													99%		~~100%~~								
FiO2			RA													RA		~~RA~~								
Source																										
M																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF																										
IVPB																										
NGT																										
PO			180						240	236			656													
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE															~~280~~								500			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13486

ME. RECORD-SUPPLEMENTAL MEDICAI

For use of this fo. e AR 40-66; the proponent agency is the Office of T. .geon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT			
		Time: Initals:	Time: Initals:
NEURO	Pupils		
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern		
	Breath Sounds		
	Secretions		
	Cough		
SKIN	Color		
	Integrity		
	Backside		
IV	Access Devices		
	Location		
	Condition		
GI	Abdomen		
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device		
	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 21Aug03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] (b)(6)-4 Date: 21 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP				108/70																						
TEMP				97.7																						
HR				103																						
RR				16																						
SaO2				96																						
FiO2				RA																						
Source																										
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
r																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																										
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13488

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 26 Aug 03
Time In: 1030
Allergies: NKDA
Pre-op V/S: 96 9 P-88
Procedures: full thickness skin graft to b/l heels, partial (R) thumb amp.

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP EBL min
Meds/Times: Ancef, Zofran, Fentanyl patch 50mcg MSO4

Drains: Hemovac, NG, (JP) b/l, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1030	1035	1040	1055	1110	1125	1130
SaO2	99	98	98	97	98	97	98
FiO2							
Methods							
240							
220							
200							
180							
160							
140							
120	✓	✓	✓	✓	✓	✓	✓
100	•	•	•	•	•	•	
80	^	^	^	^	^	^	^
60							
40							
20							
RR	16						
T	96.7	96.2			97.2		

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1030	LR	300	(D)AC	OR	100

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	N/A		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	8	9

Codes

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

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

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

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

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

(Continue on reverse)

PREP[redacted] (Signature & Title) [redacted], LPN / [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Aug 03

PATIENT'S IDENTIFICATION (For typed or written entries gi[redacted] Name – last, first, middle; grade; date; hospital or medical facility)

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

[redacted] (b)(6)-4

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

97%
ASA III
hx Asthma, DVT.

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1120		MSO4 2mg	IV		E	RL

NEUROVASCULAR

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

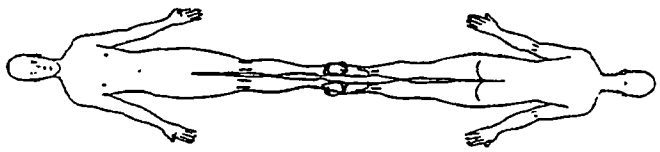
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1030	B/L heels	Tubrand	Ø
30'	B/L buttocks	4X4 gauze	Ø
60'	(R) hand	Kerlix	Ø
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1130	NSR	NO	NO

WAMC OP 173-E

NURSING NOTES

1030 pt rec'd via litter by OR. pt breathing on his own JP drains hooked up to cont pix. VSS. O2 given via face mask @6L will cont to monitor [redacted] (b)(6)-2
1040 O2 ↓ to 4L NC
1050 O2 ↓ to 2L. pt O2 Sat 98%
1100 O2 ↓ to 0.5L pt O2 Sat 97%
1110 O2 ↓ to 0, pt Sat 97%, pt c/o Pain in (R) hand, [redacted] (b)(6)-2 rotified [redacted] (b)(6)-2
1120 2mg MSO4 IV given by [redacted] (b)(6)-2 [redacted] (b)(6)-2

Discharge Criteria:
Date: 8/24/03 **Time:** 1130 **PARS:** 9
BP: 121/68 **T:** 97.2 **HR:** 87 **RR:** 16 **Sa02:** 97%
Pain Level at D/C (0-10):
Intake: 325 **Output:** Ø
Additional Data:
Transferred To: ICW2
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP: [redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 27 AUG 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block PRBC

Time In: 1120

Allergies: NKDA OR Intake: Crystalloid 600 Colloid 1 unit blood 500cc LR

Pre-op V/S: 100 60 120 OR Output: UOP 0 EBL 0

Procedures: Washout Meds/Times: Fentanyl 250mcg

Closure buttocks area

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

Pre Op Meds History

Time	1120	1125	1130	1135											
SaO2	96	100	95	95											
FiO2	NC 2L	NC 2L	RA	RA											
Methods															
240															
220															
200															
180															
160															
140															
120															
100															
80															
60															
40															
20															
RR	13	10	16	13	10										
T	95	96													
Time															
Pain (0-10)															
LOS															

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1120	LR	600	(L) AC	DK	400

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

Patient teaching done; Wound Care, Pain Management, T. C. & DB., Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED [redacted] & Title) (b)(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 27 AUG 03

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

[redacted] (b)(6)-2

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

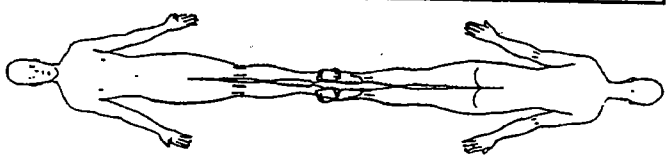
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Buttocks	2X2 C tape	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1170	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt to Recovery Room from OR s/p washout / closure. 2X2 C tape to buttocks Area. Foley to (R) hand Foley to bil. heels. IV of LR infusing into (L) AC. Ø s/s of redness OR edema to site. VS- BP 116/68 P-87 R-12 SpO2 95% RA. Ø C/O. (b)(6)-2 Will continue to monitor [redacted] To ICW#1 Report given to LPN [redacted] (b)(6)-2 [redacted] (b)(6)-2

Discharge Criteria:
Date: 27 Aug 03 **Time:** 1150 **PARS:** 9
BP: 115/66 **T:** 96.9 **HR:** 88 **RR:** 16 **Sa02:** 97%
Pain Level at D/C (0-10):
Intake: 50 **Output:** Ø
Additional Data:
Transferred To: ICW #1
Report Given To: 2LT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery R[redacted]
Charge Nurse Signature [redacted] (b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DAT

this form, see AR 40-66; the proponent agency is the Office of The Surg

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

OTSG APPROVED (Date)

Date: 7 OCT 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1705

Allergies: NKDA OR Intake: Crystalloid 700 Colloid

Pre-op V/S: 134/73 91 OR Output: UOP EBL NLM

Procedures: Closure Buttocks wounds Meds/Times: Fentanyl

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

Pre Op Meds History

Time	1705	1710	1715	1730
SaO2	100	100	100	
FiO2				
Methods	RA	RA	RA	
240				
220				
200				
180				
160				
140				
120	V	V		
100	•		V	V
80	^	^		
60		•	•	•
40			^	^
20				
RR	16	25	16	18
T	96			

Time	
Pain (0-10)	
LOS	

Patient teaching done: Wound Care, Pain Management, T, C, & DB., Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1705	LR	200	L Arm	LR	800

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

[redacted] LPN (b)(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 7 OCT 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

All (b)(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1720		DEMEROL 25mg	IM	shivering		[redacted]
1730		MSO4 3mg	IVP			[redacted]
					(b)(6)-2	

NEUROVASCULAR

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

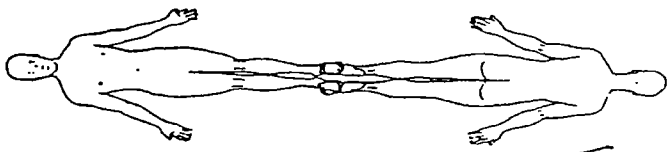
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	buttocks	bulky gauze & tape	mod
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1705	SR	∅	∅

NURSING NOTES

Pt to recovery room from OR via litter s/p closure buttocks wounds. Bulky gauze & tape to buttocks area c̄ mod amt drainage. IV of LR infusing into (L) arm. c̄ s/s of hematoma or swelling. c̄ c/o. VSS. Will continue to monitor [redacted]
1730 - Pt c/o pain. Medicated IC 3mg MSO4! [redacted] (b)(6)-2

Discharge Criteria:
Date: 7 OCT Time: 1730 PARS:
BP: 92/54 T: 96.2 HR: 69 RR: 22 Sa02: 100
Pain Level at D/C (0-10):
Intake: 50 Output: ∅
Additional Data:
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Rec Room SOP B-2
Charge Nurse Signature: [redacted]

WAMC OP 173-E

MEDCOM - 13494

ADMISSION AND CODING INFORMATION

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

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
NA	2	1000	NA

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
I 2				✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	IOW1	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
2 4		0 3 1 0 1 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B A A		0 3 0 9 0 6

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

FOR LOCAL USE

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
Dr [redacted]	(b)(6)-2 [redacted]

DA FORM 3985 MAR 89

ADMISSION AND C..DING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D) (b)(6)-4	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]	[redacted]	Z	Z	unk

10. LENGTH OF SERVICE	ETS	11. FMP (b)(6)-4	12. SOCIAL SECURITY NUMBER
		99 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
	Z	0929	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU3	unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b2-2	unk	unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
0 5		0 3 1 0 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B M A		0 3 0 7 0 3

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

FOR LOCAL USE

DX: 3TS6

DX: 0389
4538
94524
94523
94520
94522
94810
E9881

PX: 8609
863
8669 (X2)

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

Dr. [redacted]

[redacted]

F ADMITTING CLERK

(b)(6)-2

DA FORM 2085, MAR 90

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted] (b)(6)-4				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE [redacted] (b)(6)-4	6. RACE	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN (b)(6)-4 [redacted]		13. ORGANIZATION —			14. WARD ICW2
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct From ER			22. HOURS OF ADMISSION 1010	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION SO	26. DATE OF DISPOSITION 10 Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 3 July 03		ADMITTING OFFICER DR. [redacted] (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Unknown

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to (R) thigh, ex fix

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1 mth / 7 days	1 mth / 7 days

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	(b)(6)-2				

SIGNATURE OF ATTENDING MEDICAL OFFICER DR. [redacted]

SIGN[redacted]D OR MEDICAL RECORDS OFFICER [redacted] (b)(6)-2

MEDCOM - 1349[redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

(b)(6)-4 [redacted] YID GPW, SHOT IN (R) THIGH WHILE SUBDUING BY SOMEONE WHO GAVE THE APPEARANCE TO (R) PERSON OF IRAQI NATIONALITY

PROM - (D)

NOLOC

PHYSICAL EXAMINATION

HEENT - WT/NL

LUNGS - CLEAR

CHEST - WT/NL

~~LUNG~~ EXT - GAP FIX ON (R). SLOWS BLEEDING PULSES. LEFTHAN THIGH WOUND CLOSED WITH STERILE NO MOTION IN (R) FOOT. NO NEUROLOGY & SLIGHT (R) KNEE

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

X'RAYS - PENDING

(B) (R) THIGH GSW WITH FEMUR FX

(P). STABLE, SURGERY CONSULT, ETC

(b)(6)-2 [redacted]

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	30 NOV 03		

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

509-113

MEDICAL RECORD (b)(6)-4 PROGRESS NOTES

DATE

2215 EPW # [redacted] presented to Aid station with
2Jul03 (R) thigh external fixature. Upon arrival
IV was initiated. (b)(6)-2

T: 101 - 18 GA (L) AC. Bag #2 SGT [redacted]
P: 112 - Ancef 2 Gram @ 2145 91W
R: 18 - Tylenol 500mg x2 @ 2200
BP: 124/65 - Morphine 10mg IM @ 2210
SaO2: 98%

Patient was shooting at Americans and get shot in the thigh. He was taken to an Iraqi Hospital where an external fixation was placed. He cannot feel his (R) foot or move his (R) foot

PMHx: None

SHx: None

AHx: NKDA

Meds: None

O: (R) femur with anterolateral incision with 24 staples for closure x 20cm long. He has ex fix on (R) thigh. Weeping fluid from pin sites. There is swelling at the incision site that weeps serous fluid.

He cannot feel or move his (R) foot. while he has no problem with the (L). Mild (R) LE swelling

3:10 BP 110/54 P-104 SpO2-91 R-16 T-98.6. Pt. given 975mg Tylenol po. Pt. given 1gr. Ancef. IV. — [redacted]

(b)(6)-2

(Continue on reverse side)

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

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

PROGRESS NOTES

Medical Records

STANDARD FORM 509 (REV. ...)
Prescribed by OSA/ICMR

PS 1. admit to PT Hold (see orders.)
2. Ancef 1 gm IV Q6H
3. Morphine Sulfate 10 mg IM Q8H
4. Tylenol 1000 mg Q6H PRN.
5. Regular diet
6. Vitals Q4H
call MO for SBP ≥ 150 ≤ 90, DBP ≥ 100 ≤ 50
pulse ≥ 110 ≤ 60 temp ≥ 100.4
7. will hold in patient hold for observation.

(b)(6)-2

[redacted]

MD
MA 3, Me, USA

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

0600
3 July 03

Pt given 10mg IM [redacted] (b)(6)-2

S: Patient slept all night & comfort.

O: Gen WNL

Lungs: CTAB

Card: RRR

Abd: soft NT NABS

A: (R) Femur FX c̄ Tib-Fib

P: 1. Continues to weep large amounts of fluid from surgical wound

2. Continue to monitor

(b)(6)-2

[redacted]

MAJ, MC, USA

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

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

REGISTER NO.

WARD NO.

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3JUN03 8:30	BP 107/53 P-101 SpO_2-92 R-20 T-99 pt. given 975mg Tylenol po (b)(6)-2 [redacted]
: 8:14	Pt. evacted to (b)(2)-2 [redacted]. released from Patient hold (b)(6)-2 [redacted]

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

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

REGISTER NO.

WARD NO.

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

A11: (b)(6)-2

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
3 Jul 03	(1230) Pt received via litter from EMT. Ext. Fix (R) leg intact. Pt awake & alert. VSS. Lungs CTA &=. Pulses stronger. (R) foot edematous. BS(+)x4. IV SL. intact (L) arm.
1245 98.8 105 18 126/70 98%	3 July 03-1400: assumed pt care @ 1300. VSS. pt awake & alert. lung sounds CTA, abd soft nontender, nondistented BS(+)x4 quads. BUE c̄ full ROM (+) pulses, IV (R) FA HL'd flushes well (-) redness/swelling noted. (R) leg c̄ ext fix dressing CDI, knee ↓ to toes c̄ edema (+) pulse (L) ext c̄ full ROM (+) pulse. Foley cath to gravity intact, emptied 1600 cc cl yellow urine. (-) c/o pain voiced @ this time. Will cont to monitor — [redacted] 91WM6 SGT
2030	Emptied 400cc cl yellow urine from foley. [redacted] 91WM6 SGT
3 Jul 03 2150	Rec'd pt @ 21:00. Pt awake & alert in bed. VS WNL x 1 temp 101.0°. will monitor & retake. Skin W/D. PERRLA (+) WNL. LCM (+) BS(+)x4. (+) PPP (B). (R) Ext DSD removed small abrasion noted & open to air. to (2) of abrasion small blister noted. (R) LE ext fix in place c̄ ACE wrap dsg applied. CDI. PIV (R) FA patent. ~~Able to move and feel sensation in toes.~~ toes warm to touch. Pt. ~~c̄~~ able to move toes, but able to feel toes. Will cont. to mon [redacted]
0013	Temp retake 100.2 ii Tylenol given [redacted]
late entry @ 2205	Pt c/o pain to (R) LE. 5mg MSO4 given will monitor. [redacted]

All (b)(6)-2 except bottom one.

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:AL RECORD | PROGRESS NOTES

:E | NOTES

4 Jul 03 (0600) Pt awake and alert. VSS. resp. Ept. fix. intact.
Lungs CTA ↔. Pulses strong ↔. BS ⊕ x4. —
(R) foot edematous. IV as ordered saline
0500 98.6 locked, flushes easily, site ⊼ redness
95 or edema. Resting quietly ⊂ present [redacted]
18
120/54 (1000) Pinsite care done ⊂ ½ strx H2O2, dry sterile
96% DSG to pins as ordered. Wounds ⊂ small amt serous
drainage. Ace wrap ster (R) thigh. Procedure
tol. well. [redacted]

4 Jul 03 assumed care @ 1300 - VSS, T 100.0°F -
1510 ex fix in place in (R) femur, dsg CDI, staples
intact on outer (R) thigh, pt. can twiggle (R)
toes, <2 sec. cap. refill in (R) toes. - no c/o
pain @ this time - SL patient - [redacted]

4 Jul 03 pt. up to bedside commode, had large
1830 soft BM - pt. very unsteady when standing,
can't bear weight or move (R) leg independently,
(R) foot appears floppy, can't wiggle toes
[redacted]

4 Jul 03 @ 2300 Restarted IV to (L) FA. Antbx infusing ⊼
complications. Will cont to mon [redacted]

HIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST | MI | (SSN or Other)

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REGISTER NO | WARD NO

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

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
4Jul@2330	Pt A&Ox3, VSS, LCTA(B) ⊕BS x4qds. abd: soft, NO ⊖TTP. (R) foot slightly edematous. Ex fix in place drsg CDI, staples intact (R) foot has lux cap refill, pt can wiggle toes. Pincare done. Small amt. of serous drainage noted. ∅ c/o pain @ this time. Will cont to monitor + support. (b)(6)-2 [redacted] 91WM6-SPC
5JUL03	USS. NAD. EXT. FIX. INTACT. Pt awake, alert. S.L. intact, flexes easily. Lungs CTA &=. Pulses strong &=. BS⊕ x4. DSG to incision on thigh D&I. Resting quietly & present. (b)(6)-2 [redacted]
5 July03 1320	assumed pt care @ 1300. pt awake & alert. lungs CTA bilat, abd soft, nontender BS⊕x4quads. foley cath intact. (L) leg c̄ full ROM⊕ pulse. (R) thigh c̄ ext fix drsng CDI. (R) foot edematous⊕. pulse. BUE c̄ full ROM⊕ pulses. NL to (L) FA ⊖ s/sx of infection noted. pt voices ⊖ complaints @ this time. Will cont to monitor. [redacted] 91WM6, SGT

(b)(6)-2

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

All (b)(6)-2 except one at bottom.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
05 July 2324	Received pt resting in bed. Alert, easily awaken. LSCTAB, BS+x4, HRC, ABD SNT. RLE ↑ on folded blanket. Toes warm, pulse strong. Drsg Δ'd small amt sang. drainage noted around pins, pin care done. D/ns c/d/i. IV patent & intact @ fa. Will cont to monitor. [redacted]
6 July 03	0700 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS+. Pulses strong & equal bilat to ↑ & ↓ extremities. Dsg to R ext fix thigh. HL to L forearm infusing antibiotics. No complaints this am. Will cont. to monitor — [redacted] 2Lt
6 July 03 1030	Foley D/C @ 1030 — [redacted] 2Lt
6 July 03 1300	assumed pt care @ 1300. pt resting quietly. VSS. lungs CTA, abd soft BS+x4. L leg c̄ full ROM + pulse. R thigh c̄ ext fix drsing CDI. + pulse. BTE c̄ full ROM + pulses. HL to LFA ⊕ S/Sx of infection noted. C/O pain voiced @ this time. Will cont to monitor - [redacted] 9Lt
07 July 03 0130	Received pt resting in bed. Alert, VSS, LSCTAB, HRC, ABD SNT, BS+x4. SVGS. RLE ↑ on one folded blanket, Pin care + RLE drsg Δ'd. minimal sucsang. drainage noted. Will cont to monitor. R toes warm, capreflexed [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO. (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

7 July 03 (0800) VSS. NAD. EXT. Fix intact. DSG to pin sites D&I. S.L. blanches easily, site ⊖ redness or edema. BBS CTA ⊖ = Pulses strong ⊖ pulse distal to ex strong. Tolerated regdiet well. Resting quietly ⊖ present. [redacted] (b)(6)-2

0800 99.0
95
14
134/74
98%

1430 Assumed care of Pt @ 1300. VSS. A+O x 3. ⊘ dopain. DSG I&D x Fix (R) LE EDI. (F) sensation, cap refill < 3 sec, palpable pulse (P) foot. Pt unable to move foot/toes voluntarily ⊙/w assessment w/ NC will Monitor [redacted] (b)(6)-2

7 Jul 2347 Received pt resting in bed. Alert, VSS, S&I SI = SII. DSG to (R) LE c/d/i, Δ'd & pio care done this shift. toes warm, cap refill good, ⊕ pulse (R) LE, (R) LE q1. IV (L) fa patent. Will cont to monitor pt [redacted] (b)(6)-2

3 July 03 Assumed care of pt @ 0500. Pt is asleep. VSS. Lungs CTA. Bowel sounds x 4 quads.

0530 98.7
91
14
120/58
96%

Abd. soft and tender. Dsg Δ done @ 1015. Pin care done. Pin site mean skip looks injected. Site looks pale pink. ⊘ drainage - ⊘ odor. HL in (L) arm - patent. ⊘ c/o pain or discomfort. [redacted] LPN, SGT (b)(6)-2

NOTES

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

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DICAL RECORD

PROGRESS NOTES

DATE	NOTES
8 July 03 1340	Assumed pt care @ 1300. pt awake & alert. VSS. lungs CTA, abd soft nontender, BS(+). LLE c̄ full ROM (+) pulse. (R) thigh c̄ ext fix drsng CDI. (+) pulse. BUE c̄ full ROM (+) pulses. HL to (L) FA flushes & diff. (0) c/o pain or discomfort voiced. Will cont to monitor (b)(6)-2 [redacted] Nurse SGT
8 JUL 03 21:35	Assumed c/o pt @ 21:00. Awake + alert in bed. VS WL per flow sheet. PERRLA (+). LCA (B). BS (+) x4. HL (2) FA patent. (R) thigh ext. fix in place, dsg C/D/I (+) PPP (R) foot. (-) Babinski to (R) foot. Pt. states can feel light touch to (R) foot and pressure (L) foot (-) Babinski. (R) foot (+) <3sec cap refill. c/o pain will cont. to mon. [redacted] -2T/AN
0119 error (b)(6)-2	Pincare done. (b)(6)-2 Sm. amt yellow drainage @ pin sites on old dsg. Skin healing and healthy looking. Staples intact and skin well approximated. Sm. ~~aprasis~~ abrasion to (R) Buttocks covered c̄ DSD. ~~s~~ drainage noted on old dsg. DSD applied to all other wounds C/D/I. will mon [redacted] (b)(6)-2 -2T/AN
9 July 03 0648	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Reg, lungsands clear bilat, bowel sounds (+) x4 quads.

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(b)(6)-4

EPW # [redacted]

PROGRESS NOTES
Medical Record

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

.TE	NOTES
9 July 03 0645	HL in (L) FA flushed well c̄ 5cc NS s̄ s/s of infection or infiltration, Ext. fix on (R) LE ↑ c̄ rolled up blanket underneath. Popliteal pulse & pedal pulse on (R) extremity palpable, sensation (-), ROM absent, cap refill <3 sec. All other assessment findings WNL. Pt s̄ complaints @ this time. Will continue to monitor. [redacted] 24
1420	Assumed care of Pt @ 1300. VSS. A+O x 3. Ø dopamine. (R) femur Ex Fix/DRSG CDI. (+) palpable pulse, cap refill <3 sec (L) foot. minimal voluntary mvt (R) foot, sensation to pain (L) foot. IV AB X 1 (L) wrist IV HL. TOL REG DIET. O/W assessment WNL. Will Monitor. [redacted]
9 Jul 03 2100	Rec'd c/o pt. @ 21:00. Pt awake and alert in bed. Restraints x2 (R) wrist (L) ankle. Skin color WNL. LCAB. BS (+) x 4. C/O Generalized ABD pain. Dr. [redacted] notified. 1 dose Maalox given in substitution of my Lanta. will mon. for results. HL (L) FA in place. (R) thigh ex-fix intact. Staples intact skin approximated. Serosang. drainage to most distal pin site noted, mod. amt. 4x4 dsd to (R) Buttocks C/D/I. c̄ c/o of pain O/W. ~~[illegible]~~ [illegible] (R) foot has sensation. is warm to touch. <3sec capreffill (+) PP. Will cont. to mon. [redacted] 24 AN
10 July 03 0730	New IV placed in (R) FA. VSS. HR Reg. lung sands clear, bowel sands (+) x 4 quads. Dressing to (R) upper thigh & (R) LE ext. fix CDI. Pt has (+) sensation in (R) foot & digits, minimal ROM, <3 sec cap refill. pt. awake & alert in bed s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 24
0500 98.7 P 93 RR 16 BP 128/60 Sats 99%	

All (b)(6)-2 except bottom one.

NSN 7540-00-634-4178

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 July 03 1100	Dressing Δ'd to (R) ext. fix on LE & dressing on upper (R) thigh. Insertion sites are healing well ∃ s/s of infection. [redacted]
10 July 03 1323	Assumed pt care @ 1300. Pt awake & alert. VSS. lungs CTA, Abd soft BS(+) x4. (R) thigh c̄ ext fix staples intact OTA, drainage to ext fix. CDI. (+) pulse. (L) LE c̄ full ROM (+) pulse. ↑ ext c̄ full ROM (+) pulse. (R) KA c̄ HL flushes ∃ diff. (-) swelling/redness noted. (-) complaints voiced @ this time. Will cont to monitor — [redacted] 9lwme
10 July 03 2258	Rec'd c/o pt @ 21:00. Pt. awake and alert in bed. Restraint x2 (-) wrist and ankle. VS WNL per flowsheet. PERLA (+) Skin W/D. LCA (B). BS (+) x4. HL (R) wrist patent. (R) leg. ext. fix in place c̄ pin dsg. C/D/I. staples C/D/I. DSD to (R) buttocks C/D/I. Able to move and feel sensation in (R) foot. warm to touch c̄ <3 sec. cap refill. c/o pain to (R) leg. ∃ Tylenol given @ this time. Will cont. to mon — [redacted] /AW
0233	∅ further c/o pain @ this time. will mon. [redacted] AW
11 July 03 0530	Assumed pt. care @ 0500: Pt. awake. AOx3. lungs CTA. (+) pulses x4. Hypo active BS x4. Ext-fix c̄ dsing on (R) thigh CDI. (+) rom in extremities. HL (R) KA. c/o pain to (R) thigh. will continue to monitor — [redacted] 9lwneb

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

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 13510

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

All: (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 July 03 1315	pt awake et alert. VSS. lungs CTA, abd soft BS(+)x4. (R) thigh c̄ ext fix, drsing CDI (+) pulse. (R) leg c̄ full rom (+) pulse. (R) arm c̄ (+) pulse HL to (R) FA, (-) s/sx of infection noted. (L) arm c̄ (+) pulse. (-) c/o pain voiced @ this time. Will cont to monitor - [redacted] 91WMC
11 JUL 03 21:45	Rec'd c/o pt. @ 21:00. Awake and alert in bed. Restraints x2 (R) wrist (L) ankle. VS WNL per flowsheet. PERRLA (+) WNL Skin W/D. LCA (B). BS (+) x4. (+) PPP (B). HL (R) FA patent. DSD x2 to (R) buttocks C/D/I. Staples to (R) thigh intact. (R) ext. fix to thigh intact Dsg C/D/I. able to move and feel sensation in (R) foot and toes. Toes warm to touch and <3sec cap refill. c/o pain x1 ii Percocet given. will cont to mon [redacted] 21/[illegible]
12 July 03	0550 Assume pt care @ 0500. Awake and alert. c/o sm amt of pain to (R) femur. VSS. HL to (R) wrist no s/s redness / infiltration. HR reg. Lungs CTA. Abd flat soft BS x4. Ex-fix and dsg to (R) femur CD+I. Dsg's to (R) buttocks CD+I. Will continue to monitor — [redacted] 91WMC
12 July 03 1300	Assumed pt care @ 1300. pt awake et alert. VSS. assessment findings WNL, (R) thigh c̄ ext fix, staples OTA, drsing around pin CDI. HL to (R) FA (-) s/sx of infection. (-) complaints voiced. Will cont to monitor — [redacted] 91WMC
12 JUL 03	Assumed c/o Pt. @ 21:00. Pt. awake and alert in bed. Restraints x2 (L) ankle (R) wrist. VS WNL per flowsheet. PERRLA (+) WNL LCA (B). BS (+) x4. HL (R) FA patent. (R) thigh ext. fix intact c̄ old dsg yellow drainage c̄ foul odor noted, mod amt @ top pin site. Staples C/D/I. DSD x2 to (R) Buttocks C/D/I. Pin care done. open wounds @ pin insertion sites x8 well approx. New dsg applied C/D/I. DSD x2 applied to (R) Buttocks C/D/I (+) PPP (B). Able to move and feel toes. Toes

All (b)(6)-2 except bottom one.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Cont'd to (R) foot warm to touch c̄ <3sec cap refill. c/o pain x/ 4mg MSO4 given. & further complaints will cont to mon. [redacted] BLT/AN
13 July 03	0555 Assume pt care @ 0500. Pt asleep easy to awake. HL to (R) hand no s/s redness/infiltration c̄ flush. VSS. HR reg. Lungs CTA. Abd. soft No tenderness
0525 96.7 60 16 114/60 98%	or distension noted. Ex fix to (R) thigh Dsg CD&I. (R) knee swollen. (R) foot pulse palpable warm to touch. pt can move toes as one but unable to wiggle them. Dsgs to (R) buttock CD&I. No c/o pain @ this time Will continue to monitor. [redacted] 9lwmb
	1035 Dsg Δ and pin care done. Top pin site yellow drainage noted to old dsg. No drainage noted to other pins. [redacted] 9lwmb
13 July 03 1400	assumed pt care @ 1300. pt awake & alert. VSS. lungs CTA abd soft non-tender BS (+) x4 quads. L leg c̄ full ROM (+) pulse (R) thigh c̄ ext fix dressing CDI. Staples OTA. (+) pulse. ↑ ext c̄ full ROM (+) pulse. HL to (R) FA (-) S/Sx of infection. dressing to (R) buttock CDI. (-) c/o pain voiced @ this time. Will cont to monitor [redacted] 9lwme

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PROGRESS NOTES
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USAPA V1.00

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-13 2215	Pt. care assumed @ 2100. VSS, Pt. alert & compliant c̄ care. C/o mild pain to (R) LE. ⅐ percocet given. HRRR lungs CTA, ABD soft c̄ BS (+) XY. Ex-fix to (R) thigh intact. Pin-care done. Scant amt. serosanguinous drainage noted from pin sites. Dsng Δd, CDI. (R) ft. c̄ pulses 2+, (+) ROM, (+) sensation, brisk cap refill. HL to (R) Ae intact, flushes easily. Will cont. to monitor. — [redacted]
14 July 03	Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft and tender. Pin care done @ 1000 hrs.
0530 97.5 78 124/76 98%	Pins in place. Bandage applied - dry and intact. Pt given ⅐ percocet @ 0810 per (R) leg pain. Will continue to monitor. — [redacted]
1330	Assumed Care Pt @ 1300. VSS. A+O x3. Pt c/o pain (R) FA PIV HL c̄ IVABX patent. (R) LE EXFIX/DRSG CDI. Staples above EXFIX GTA CDI. (+) sensation, cap refill c̄ 3sec, palpable pulse, mvt of (R) foot. O/W assess. WNL. Will Monitor [redacted]
14 July 03 2030	Assume pt care @ 2100. Pt awake and alert. VSS. HR reg Lungs CTA abd soft BS x4 active Ex-fix dsg Δ done. drainage noted from top pin sm yellow amt. C/o pain @ site (R) thigh ⅐ percocet per order. (+) movement (+) sensation below dsg. HL to (R) FA flushes well no s/s redness/infiltration. Will continue to monitor — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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All (b)(6)-2 except bottom one.

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DICAL RECORD

PROGRESS NOTES

DATE	NOTES
15July03	0700 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕, Pulses ⊖ & strong bilat to ↑ & ↓ extremities. Dsg to ext fix on (R) thigh, staples intact. Voicing Ø complaints this AM. Will cont to monitor — [redacted]
15July03 1335	assumed pt care @ 1300. pt awake & alert. VSS. assessment findings WNL. (R) thigh drsng CDI, staples OTA, Ø S/Sx of infection noted. Ø complaints voiced @ this time. Will cont to monitor — [redacted] 91WMC
15July03 2135	Assume pt care @ 2100. pt awake and alert. HL to (R) wrist no s/s redness/infiltration c̄ flush. VSS. HR reg Lungs CTA. Abd soft BS x 4. Dsg to (R) thigh c̄ Ex Fix CD+I. staples intact. No s/s infection. no c/o pain @ this time. will continue to mon[redacted] 8/WMC
16July03	0910 - Pt alert sitting upright in bed. VSS, lungs CTA, HR reg, BS⊕. Dsg Δ'd & pincare done to (R) leg. Pulses ⊖ & strong bilat to ↑ & ↓ extremities. Voicing Ø complaints. Will cont to monitor — [redacted]

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T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

All (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 July 03 1325	assumed pt care @ 1300. VSS. lungs CTA, abd soft BS(+)x4. (R) thigh c̄ ext. fix dressing CDI, staples intact OTA (-) s/sx of infection, (+) pulse. (L) LE c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses. HL to (R) FA (-) s/sx of infection noted. (-) c/o pain voiced @ this time. Will cont to monitor — [redacted] 91WMC
16 July 03 1545	New HL started in (L) FA c̄ a 18g x̄ stick, good blood return & flushes well. old HL (R) FA dc'd. (-) complaints voiced @ this time. Will cont to monitor — [redacted] 91WMC
16 July 03	2225 Assume pt care @ 2100. pt awake and alert. HL to (L) FA no s/s redness/infiltration c̄ flush. VSS. Lungs CTA Abd soft non tender. urinates to urinal c̄ difficulty. Ex-fix c̄ dsg to (R) thigh CDI. Dsg Δ hip pin draining yellow drainage. Staples intact. (+) movement (+) pulse below Ex-fix. No c/o pain @ this time. — Will cont. to monitor — [redacted] 91WMC
17 Jul 03 0530	Assumed pt. care @ 0500: Pt. awake. A&O x 3. Lungs CTA. (+) Pulses x 4. (+) BS x 4. HL in (L) FA, no signs of redness or infection. Dsg c̄ Ex-fix on (R) thigh intact. staples on (R) thigh intact. Denies any discomfort @ this time. [redacted] 91WMC
17 July 03 1330	assumed pt care @ 1300. pt awake & alert. VSS. assessment findings WNL. (R) thigh c̄ ext fix dressing CDI. Staples intact OTA (-) s/sx of infection. HL to (L) FA (-) s/sx of infection noted. pt denies pain @ this time. Will cont to monitor — [redacted] 91WMC

MEDICAL RECORD

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DATE	NOTES
17 July 03 2315	Assume pt care @ 2100. pt awake and alert. HL to (L) hand. no S/S redness/infiltration c̄ flush. VSS. HR reg. Lungs CTA, Abd soft. BS x4 Ex-fix c̄ drsg to (L) thigh CDI. (+) movement & sensation below ex-fix. Tylenol 650 mg for pain. Will cont to monitor (b)(6)-2 [redacted] 91WM6
18 Jul 0500	Assumed pt care @ 0500: Pt sleeping. Awake easily. A&Ox3. Lungs CTA. (+) pulses x4. (+) BS x4. HL to (L) FA ō signs of infection. VSS. Drsg c̄ Ex-Fix on (R) thigh CDI. (+) sensation + movement below ~~right~~ site. (b)(6)-2 (b)(6)-2 [redacted] 91WM6
18 July 03 1325	Assumed pt care @ 1300. Pt awake & alert. VSS. Lungs CTA, abd soft nontender BS (+) x4. BUE c̄ full rom (+) pulses. HL to LFA (-) redness/swelling noted. (R) thigh c̄ ext. fix, dressing CDI. (L) wrist c̄ full ROM both + ext c̄ (+) pulses. (-) c/o pain voiced. Will cont to monitor (b)(6)-2 [redacted] 91WM6
18 July 03 2230	Pt. awake & alert in bed ō complaints @ this time. HL in (L) FA flushes well c̄ NS ō S/S of infection. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. (R) LE ↑ 30° c̄ folded blanket. Pin care done, new dressing applied, insertion sites ō S/S of infection. (R) pedal pulses (+) (+) sensation in digits, cap refill < 3 sec, minimal ROM. Pt. assessment ~~S/S~~

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

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PROGRESS NOTES
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Prescribed by GSA/ICMR FPMR (41CFR) 101-1

A11: (6)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 July 03 2230	findings WNL. Will continue to monitor. [redacted] 24/HN
18 July 03	Performed pin care on pt. small amt of drainage on bandage noted. Ø edema, Ø obvious drainage, Ø foul odor. Changed ≈ difficulty. Sgt [redacted]
0545 19 July	Pt care assumed @ 0500. VSS, sleeping awoken by verbal stimuli. Pt c̄ c/o pain in rle, no pain meds requested. Lung sounds CTA, pulses palpable x4, b/s (+) x4 quads. HL in (L) wrist flushes well, no s/s infection or infiltration. Rle Dsg c̄ ex-fix CDI, pt able to wiggle toes c̄ (+) pulse and sensation in rle. IV ABX, pin care to be performed @ 0600. Will continue to monitor. [redacted] 9/WMC
19 July 03 1310	assumed pt care @ 1300. pt awake & alert. VSS. assessment findings WNL x̄ (R) thigh c̄ ext fix drsing CDI, staples intact OTA (+) movement (+) sensation noted HL (R) OTA (-) s/s of infection. (-) c/o pain voiced @ this time. Will cont to monitor [redacted] 9/WMC

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Jul 03 21:47	Rec'd c/o pt @ 21:00. Pt. awake and alert in bed. Restraints x2 (D) wrist/ankle. Skin color WNL W/D. PERRLA (D) WNL. LCAB 8 (+) x4 (+) PPP (B). (R) thigh ex-fix intact CDSG CDI I.P pin care performed. Pin sites ~~s~~ sxs infection. Staples CDI. (+) sensation (+) ROM (+) <3 sec cap. refill. [redacted] (b)(6)-2 c/o pain ~~to~~ Tylenol given. Pt. requesting narcotics. able to read numbers on meds. and dictating what type of med. pt. receives. Will cont. to mon [redacted] (BOT/AW) (b)(6)-2
20 Jul 03	0520: Assumed pt. care @ 0500: Pt. A+O x3. lungs CTA (+) pulses x4 and strong. (+) BS x4. HL (R) FA ~~s~~ signs of infection. Drsg ~~c~~ ex-fix to (R) thigh CDI. c/o pain to (R) thigh. Will continue to monitor. (b)(6)-2 [redacted] 91WM6
20 July 03 1330	assumed pt care @ 1300. [redacted] Pt awake & alert. VSS assessment findings WNL. (R) thigh ~~c~~ ext fix drsing CDI, staples OTA (+) s/sx of infection noted HL to (L) FA (+) redness/swelling noted. pt denies pain @ this time. Will cont to monitor (b)(6)-2 [redacted] 91WM6
2 July 03 0210	Pt. having difficulty sleeping, 50mg Benadryl given po. HR Regular lung sounds clear bilat, bowel sounds (+) x4 quads. HL in (R) FA flushes well ~~s~~ s/s of infection. DSG A'd & pin care completed to (R) thigh, ext.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. CW2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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21 July 03 0210 fix. Pt. c̄ seemingly more c/o pain during procedure, insec sites appear to be s̄ infection, healing well. Pt. ō limited ROM in (R) LE, pedal pulse palpable, (+) sensation, cap refill <3sec Pt. s̄ other complaints @ this time. All other assessment findings WNL. Will continue to monitor. —— [redacted] 21 JA

21 July 03 0650 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕, HL to (L) arm infusing antibiotics. Ext fix intact to (R) leg c̄ dsg CDI. Voicing ∅ complaints at this time. Will cont. to monitor —— [redacted]

21 JUL 03 2000 assumed care @1300 - VSS - medicated c̄ 650mg tylenol for c/o pain p̄ dsg Δ, pins cleaned c̄ ½ strength H_2O_2 and wrapped c̄ kerlix to put pressure between skin & fixature - staples CDI & incision closed and dry - SL patent —— [redacted] cm

2200 Pt care assumed @ 2100. VSS, pt awake and alert c̄ c/o mild pain in RLE. Lungs CTA, pulses⊕ x4, bs⊕ x4 quads. Ex fix c̄ kerlix on RLE CDI. SL on (L) wrist patent, IV ABX running, will continue to monitor. —— [redacted] 9/WMC

22 July 03 0700 - Pt sleeping easily arousable in bed. VSS, lungs CTA, HR reg, BS⊕. Pulses ⊕ & strong bilat to ↑ & L extremities. Ext fix intact to (R) leg c̄ Dsg applied around pins. HL to (L) forearm for antibiotics. Voicing ∅ complaints at this time. Will cont to monitor. —— [redacted]

22 July 03 1335 assumed pt care @1300. Pt awake & alert eating lunch. VSS. assessment findings WNL. (R) thigh c̄ ext fix, dressing CDI ⊕ pulse. ∅ complaints voiced will cont to monitor. HL to (L) FA ∅ redness/swelling noted. —— [redacted] 9/WMC

All (b)(6)-2 except one at bottom

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 July 2100	Pt care assumed @ 2100. VSS, pt awake and alert c̄ c/o slight pain @ wound site. Lungs CTA, pulses palpable x4, bs⊕. HL @ L wrist flushes well. Ext fix c̄ Keeflix on rle CDI. Pin care to be done @ 23, will continue to monitor. [redacted] alum
22 July 2300	Pin care done @ 2300. Exudate more prevelant at lower pin insertion site, pt also c/o pain @ lower site. iī percocet were given 10 minutes prior to pin care. [redacted] alum
23 July 03	0920 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕. Pulses ⊖ c̄ stray bilat to ↑ + ↓ extremities. Ext fix intact to ⓡ leg. HL to ⓛ forearm → patent. Crew Tylenol for pain. Will cont to monitor. [redacted]
	1430 - Pt stable at this time. VSS. PERRLA. Mucous membranes pink moist & intact. Neck supple from. Lungs CTA bilat, ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. External fixator to ⓡ upper femur. Drsg CDI. Pin sites CDI. Strong pulses and brisk cap refill x4 extremities. Good movement to ⓡ LE. ø complaints [redacted]
23 July 0125	Pt care assumed @ 2100. VSS, alert and awake, ⅋ 650mg Tylenol given for pain @ 2230, 50mg Benadryl given @ 2300. Lung sounds CTA, pulses ⊕ x4, bs⊕ x4. Pin care done, c/o pain @ lower pin site. ⊕ pulse and sensation in rle. HL in l wrist flushes well, IV ABX treatment. Cont to monitor. [redacted] alum

STANDARD FORM 503 (REV. 5/1999) BACK

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

All (b)(6)-2 except ones at bottom labeled "(b)(6)-4"

DATE	NOTES
24 0600 July 03	Nursing Assessment: Pt awake, alert, x3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ≅ distention. BS(+)x4. Voids ≅ difficulty. PMS and neurovascularly intact to (R) UE and (L) LE. (P) LE neurovascularly intact ≅ exit to (R) lateral thigh. No significant bony to pin sites. Incision to (R) lateral thigh is steristrips, CDI — IV to (L) FA flushes well ≅ s/s infection/infiltration — [redacted]
24 July 03 1315	assumed pt care @ 1300. pt awake et alert. HL to (L) FA (-) s/sx of infection noted. lungs CTA, abd soft non-tender BS(+) x4 quads. (R) thigh ≅ ex-fix, dressing around pins CDI, steristripes CDI, (+) movement, (+) sensation (+) pulses. (L) Wrist ≅ full ROM (+) pulse. BUE ≅ full ROM (+) pulses. (-) complaints voiced @ this time. Will cont to monitor — [redacted] gilmore
24 July 03 0120	Pt care assumed @ 2100. VSS, awake and alert, 2 percocet given for pain @ 2300. Lung sounds CTA, pulses (+) x4, BS (+) x4. Dressing done on rle. Top 4 pin sites have minimal drainage and little pustulant, no pain noted. [redacted] Lower insertion site have moderate pain, and more pustulant then upper ones. Lower pin sites appear worse then yesterday. No c/o pain ↑ dsg Δ, will continue to monitor. [redacted] gilmore
25 0100 July 03	Nursing Assessment: Assumed care of pt. Airway intact. Breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ≅ distention. BS(+)x4. Voids ≅ difficulty. PMS and neurovascularly intact to (R) UE and (L) LE. (P) LE neurovascularly intact. Incision to RLE has steristrips and is CDI. Pin dressings are CDI at this time. IV to (L) FA flushes ≅ difficulty and is ≅ s/s infection or infiltration. — [redacted]
25 1000 July 03	Nursing Note: Dsg to pins CDI. Most proximal two pins have mod amount of purulent, serosang drng upon removal of dsg. Middle two pins bleeding slightly ↑ dsg removed. (continued over)

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

A11:(b)(6)-2

MEDICAL RECORD | PROGRESS NOTES

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DATE	NOTES
25 1000 July 03	(continued) Ø pain reported to those four pins. The most distal pins have no drng to removed drng, no bleeding, but significant pain. Sites are not overly reddened. Clean 4x4 & gauze applied to each pin site. [redacted] 1G AN
25 July 03 1300	Assumed pt care from previous shift. Pt resting quietly, easily aroused to verbal stimuli. VSS. Assessment findings WNL. (R) thigh c̄ ex-fix, dressing around 4 pins CDI, steri strips intact CDI. (+) movement (+) sensation. (-) c/o pain/discomfort. Will cont. to monitor [redacted] 9 WMC
25 July 03 2300	Pt care assumed at 2100. VSS, alert and awake, ⅔ percocet given for pain @ 2200. Lung sounds CTA, pulses + x4, BSO. HL @ RFA intact, IV ABX. ~~Dsg~~ [redacted] Pincare performed, more pain still noted at lower pin site. Some purulent discharge noted. Pt c̄ no complaints, will continue to monitor. [redacted] 9 WMC
26 0555 July 03	Morning Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields. Abd soft, nontender, c̄ distention. BS (+) x4. Units spontaneously. ROM and neurovascularly intact to (R) UE and (L) LE. (R) LE neurovascularly intact, ROM limited 2° pain. Ex fix c̄ 6 pin sites to (R) lateral thigh are CDI, but c̄ ↑ pain to two most distal pins. This pain radiates to toes per pt report. IV to (L) FA flushes well c̄ c̄/s distention or infiltration. [redacted] 1G AN

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

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
26 1200 July 03	Nursing Note: Completed PROM exercises c̄ pt. ROM to (R) knee very limited c̄ pain. Pt will not allow you to bend the knee greater than approx 15°. Pt unable to lift (R) leg off of bed when doing straight leg raises. Also, (R) leg tends to lay supinated to (R) when pt is lying in bed. Encouraged pt to ~~[illegible]~~ pronate leg throughout day. — (b)(6)-2 [redacted] LCT, AN
26 July 03 1330	Assumed pt care @ 1300. pt awake & alert, resting. Hard cuir. lungs CTA, abd soft non-tender BS(+) X4 quads. (R) thigh c̄ ex-fix OTA, steri strips intact (-) drainage noted (+) movement (+) sensation (+) pulses LLE c̄ full ROM (+) pulses. BUE c̄ full ROM (+) pulses. HL to CTA (-) signs of infection noted. Pt rec'd orders for PT consult, will notify PT. (-) complaints voiced @ this time. Will cont to monitor — (b)(6)-2 [redacted] 91WM6
1800	During knee bends pts leg started oozing blood around pin sites, site covered c̄ 4x4 gauzes, pt c/o pain given ∴ percocet per prn orders. Pt joking & laughing while complaining of pain. Will cont to monitor — (b)(6)-2 [redacted] 91WM6 —

SHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

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

PROGRESS NOTES
Medical Record

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DATE	NOTES
2236 26 July 4	Pt care assumed @2100. VSS, pt awake and alert ≥ c/o pain. Lung sound CTA, pulses ⊕x4, BS+. 2 percocet given at 2200 for c/o pain and to premedicate for dsg Δ. Ext fix on rle intact; CDI. Passive ROM done to rle, leg bent and raised x10 each. Pin care to be performed @2300. Pt c ⊕ sensation and able to wiggle toes, c/o slight pain in @foot. Continue to monitor. (b)(6)-2 [redacted] 9Lum6
2300	Pin care performed by PFC (b)(6)-2 [redacted]. Wound clean, ⊘ signs infection. Minimal pain during pin care, patient being taught so that he can perform it himself. (b)(6)-2 [redacted] 9Lum6
27 July 03	0710 - Pt alert sitting upright in bed. Tolerated breakfast. ROM completed c ⓡ leg. VSS, lungs CTA, HR reg, BS⊕. Ext fix intact to ⓡ leg. ⊕ sensation, ⊕ pulse, able to wiggle toes, warm to touch. Gave Percocet for pain. Will cont to monitor. (b)(6)-2 [redacted] 2Lum
	1430 Pt stable at this time. AAOx3. PERRLA. Mucous membranes pink, moist & intact. Neck supple. From. Lungs CTA bilat, ⊘ resp distress. NSR. Abd soft, non tender/distended, bowel sounds active x4 quads. Strong pulses & brisk cap refill x4 extremities. ⓡ leg ext fix CDI. ⊘ drainage ⊘ s/s infection at pin sites. ⊘ complaints. (b)(6)-2 [redacted] LCT/PN

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Jul 03 2206	Rec'd c/o pt @ 21:20. Restraints x2 (R) wrist (L) ankle. VS WNL per flowsheet. Pt. awake and alert in bed. LCA (B) BS (+) x4. (+) PPP (B). (R) ↑ thigh ex-fix intact. Steristrips intact @ incision site. Pinsites c̄ (+) dried blood @ sites. 10 straight leg lifts and 10 knee bends to (R) leg c̄ difficulty. c/o pain ī̄ Percocets given. Will cont. to mon [redacted] (b)(6)-2
28 Jul 03	0948 - VSS, lungs CTA, HR reg, BS (+). Pt alert OOB ambulating c̄ crutches x1. Gave percocet & MSO4 for pain. Pt did own pin care c̄ nurse watching. (+) sensation, (+) pulse, able to wiggle toes. Will cont to monitor [redacted] (b)(6)-2
28 Jul 03 1300	Received PT Alert sitting up in bed. VSS. (-) c/o pain or discomfort. Lung sounds are clear bilateral. PT has (+) ROM to (R) thigh ex-fix, toes. Cap Ref <3 sec. PT has + sensation to (R) foot. Physical Therapy will come in to assist in (+) Range of motion exercise. Will cont to monitor PT. Pins are clear Dry & intact. [redacted] (b)(6)-2 RN
28 Jul 03 2300	Pt care assumed @ 2100. VSS, a+ox3, no c/o pain. Lung sounds CTA, pulses (+) x4, bs+ x4. ROM performed on rle ī̄ c/o pain. Pin care performed by pt and PFC [redacted] little bloody drainage noted. Pt c̄ + sensation and cap refill in rle, slight pain in foot. 50mg benadryl

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. TCW2

EPW

[redacted] (b)(6)-4

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

A11 (b)(6) -2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	given @ 2300. No complaints at this time, continue to monitor. [redacted] 91WMC
29 July 03	1030 - Pt alert lying in bed with (R) knee elevated. ROM exercises done. Pin care completed by pt. (+) pulse, (+) sensation + warm to touch on (R) leg. VSS, lungs CTA, BS(+). Will cont to monitor [redacted]
29 July 03 1320	pt care assumed @ 1300. pt resting quietly. (-) complaints voiced. lungs CTA, abd soft BS(+). (R) thigh c̄ ex-fix (-) signs of infection noted (+) movement (+) sensation (+) pulse. LLE & BLE c̄ full ROM (+) pulse. will cont to monitor. [redacted] 91WMC
29 July 2145	Pt care assumed @ 2100. VSS, alert and awake, no c/o pain at this time. Lungs CTA, pulses x4, bs+ RLE c̄ ex-fix c̄ Pt performed pincare c̄ nurse at bedside, (-) signs infection. Passive ROM performed x10. No complaints at this time, will continue to monitor. [redacted] 91WMC
30 July 03	P.T. IV flushed @ 0000 5 good blood return [redacted] 0910 - Pt A&O x3. VSS, lungs CTA, BS(+), pulses (+) & strong bilat to ↑ & ↓ extremities. ROM performed on (R) leg. Ext fix intact. Pin care completed by pt. Voicing (-) complaints now. Will cont to monitor [redacted]
30 July 03 1300	pt care assumed from previous shift. VSS. pin care completed. lungs CTA, abd soft BS(+). (R) thigh c̄ ex-fix pins OTA steri strips intact (+) pulse, movement & sensation. LLE c̄ full ROM (+) pulse. BLE c̄ full ROM (+) pulse. HL to OTA flushes ŝ diff (-) s/s infection. (-) c/o pain. Will cont to monitor - [redacted] 91WMC

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Progress Notes

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MEDICAL RECORD ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30 July 03 1630	Pt given ii percocet @ the request of CPT [redacted] (b)(6)-2 for PT. (b)(6)-2 [redacted] (b)(6)-2 [redacted] 91WM6
1700	CPT [redacted] @ bs giving PT (b)(6)-2 [redacted] 91WM6.
1720	Pin site oozing bright red blood. Site cleaned & pins wrapped c̄ gauze, secured c̄ tape, pt tol well. will cont to monitor (b)(6)-2 [redacted] 91WM6
30 July 03 2145	Pt care assumed @ 2100, VSS, ato x3, c/o slight pain in rle, 10 sec̄ Tylenol given. Lung sounds CTA, pulses (+) x4, BS+. Pincare on rle done by pfc (b)(6)-2 [redacted]. Pt c̄ (+) sensation and rom in rle. States pain is sharp on (R) thigh, and absent on calf then continues on at the foot. During pincare more bloody drainage is noted then usual. Active and passive ROM x10 each. Will continue to monitor [redacted] (b)(6)-2 91WM6
31 July 03 0730	Pt. awake & alert in bed. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Ext fix to (R) leg, insertion sites draining bright red bld & yellowish fluid. Pincare done & DSG's applied to catch drainage. Pt. c/o pain @ 0530, II percocet given. Pedal pulse palpable in (R) foot, (+) sensation, cap refill < 3sec. ROM exercise completed, 10 leg raises, 10 small knee bends. Pt. in obvious pain, facial grimacing c̄ knee bends. All other assessment findings WNL. Pt s̄ complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] 91WM6

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) REGISTER NO. WARD NO. BCW 2

[redacted] (b)(6)-4

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

All: (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31July03 1335	assumed pt care @ 1300. VSS. pt c/o pain medicated c̄ ii Percocet per prn orders. BUE c̄ full ROM ⊕ pulse HL ⊖ RA flushes s̄ diff. ⊕ redness/swelling noted lungs CTA, and soft BS ⊕ x4 ⊕ high c̄ ex-fix draing c̄ scant amt of drainage noted ⊕ pulse LLE c̄ full ROM ⊕ pulse. Will cont to monitor — [redacted] 91Wm
31 July 2345	Pt care assumed @ 2100. VSS, alert and awake, pt OOB to wheelchair c̄ c/o slight pain in ⊕ foot. Lung sounds CTA, pulses palpable x4, bs+. Pincare done on rle, small amount of bleeding noted, ex fix insertion site s̄ s/s infection. Rle c̄ + sensation, passive ROM performed. No new complaints, will continue to monitor. — [redacted] 91Wm
1Aug03	1110 - Pt alert resting in bed. Completed ROM exercises s̄ difficulty. Pin care done to ex fix on ⊕ leg. VSS, lungs CTA, BS ⊕. Will cont to monitor — [redacted] 91Wm
1Aug03 1345	assumed pt care @ 1300. pt reading a magazine voices ⊖ complaints. assessment findings WNL. ⊕ high c̄ ex-fix pin care completed. Will cont to monitor — [redacted] 91Wm
2230	Pt care assumed @ 2100. VSS, no complaints. ROM performed, pincare done. Assessment WNL, will continue to monitor. — [redacted] 91Wm

All (b)(6)-2 except one at bottom

NSN 7540-00-634-4176 600-108

HEALTH RECORD Progress ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ Note

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03	0930 - Pt alert OOB x1 in wheelchair: VSS, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ x4. Pin care performed by patient. Ex-fix intact to ⓡ leg. Voicing ∅ complaints at this time. Will cont. to monitor — [redacted] Jtrer
2 Aug 03 1315	assumed pt care @ 1300. pt awake & alert, VSS assessment findings WNL. ⅓ ⓡ thigh c̄ ex-fix, drains to pin sites CDI. ⊖ complaints voiced @ this time. Will cont to monitor — [redacted] 91WMC
2 Aug 03 2130	Pt care assumed @ 2100. VSS, aware and alert c̄ c/o pain in ⓡ foot. Lung sounds CTA, pulses + x4, bs ⊕ x4. Pincare to be done @ 2200. Ex-fix site on rle intact, draining blood from pin sites to gauze p̄ rom. passive rom performed, c/o pain during rom. Will continue to monitor. — [redacted] 91WMC
3 Aug 03	0635 Assume pt care @ 0500. pt awake and alert no c/o pain @ this time. VSS. ex-fix to RLE intact dsg to pins CD+I. ROM performed. Tylenol ii for pain. ⊕ pulse ⊕ sensation ⊕ movement below ex-fix. Will Cont to monitor — [redacted] 91WMC
	1024 pt OOB to chair. pincare done by pt. Sm amt of red drainage from middle pins. pt encouraged to bend knee while OOB — [redacted] 91WMC

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

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

MEDCOM - 13529

STANDARD FORM 600 (REV. 5-84)
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FIRMR (41 CFR) 201-45.505

A11: (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3 Aug 03 1305	assumed pt care @ 1300. VSS. pt AAOX3. lungs CTA, abd soft BS(+). (R) thigh c̄ ex-fix, drainage c̄ sm amount of drainage noted. LLE c̄ FROM (+) pulses in both L ext. RLE c̄ FROM (+) pulses. (-) IV access noted. (-) complaints voiced. Will cont to monitor — [redacted] 91WM
3 Aug 03 1800	CPT [redacted] c̄ pt for PT. pt given ii Percocet @ the request of CPT [redacted] — [redacted] 91WM
3 Aug 03 2300	Pt care assumed @ 2100. VSS, alert and awake c̄ c/o pain; ii percocet given for pain @ 2200. Lung sounds CTA, pulses (+) x4, bs x4 quads. Pincare done @ 1933 by previous shift. ROM performed x10mins. Ex-fix intact, (-) draining, (+) sensation and capreft to rle. Continue to monitor. [redacted] 91WM
4 Aug 03	0825- Pt alert & oriented. VSS, lungs CTA, HR reg, BS(+) x4, pulse (+) x4. Ex-fix intact to (R) thigh. Pin Care completed by patient. Voicing (-) complaints at this time. ROM completed c̄ difficulty. Will cont. monitor — [redacted] 2Lt AN
4 Aug 03 1302	-Received PT Alert + oriented. VSS. HR R. Breath sounds clear Bilateral. BS x4. Skin is warm + Dry. Ex-fix to (R) leg is intact c̄ Dress CDI. PT has (+) ROM to all extremity c̄ good Pulse motor function + Cap Ref +2 sec to all extremity. PT Performed Active Range of motion exercise to (R) Leg, resulting in minor bleeding to pins site. PT given Percocet ii for pain + Dressing was changed. Will cont to monitor [redacted] Lpn

All (b)(6)-2 except bottom one

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Aug 03 22:35	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Awake and alert in bed. Restraints x 2 (R) wrist (R) ankle. Skin W/D. PERRLA (+) WNL. LCA (R). HRRS, S2. BS (+) x4 ABD soft and tender (+) PPP (R) thigh ex-fix in place. Pin care performed by pt and 91W PFC [redacted] c̄ guidance. Old dsgs c̄ bloody drainage noted. Pin sites well approximated. DSG's applied c/D/I. ā DSG Δ pt. performed AROM c̄ difficulty and pain expressed. Improvement noted. Pt premedicated c̄ II Percocet ā AROM/DSG Δ. (R) foot (+) PP (+) <3 sec capr refill (+) sensation (+) Plantarflexion/extension. ∅ c/o's @ this time will cont to mon. [redacted] 2LT/AD
5 Aug 03	1020: Pt alert & oriented lying in bed. VSS, lungs CTA, R leg, BS (+) x4, pulses (+) x4. Ex fix intact to (R) thigh. Pin care carried out by patient. ROM done ∃ difficulty. Voicing ∅ complaints at this time. Will cont. to monitor [redacted] 91WM
5 Aug 03 1300	pt awake & alert. VSS, lungs CTA, abd soft BS (+) x4. (R) thigh c̄ ex-fix - dressing c̄ sm amount of drainage noted (+) pulse. UE & BUE c̄ full ROM (+) pulses. (+) IV access noted. (+) c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted] 91WM
5 Aug 03 22:45	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (R) ankle. VS WNL per flow sheet. Awake and alert in bed. PERRLA (+) WNL. LCA (R) HRRS, S2. BS (+) x4. (R) thigh ex-fix intact. Pin

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

EPW

(b)(6)-4

[redacted]

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

all: (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	site dsgs C/D/I. Pt amb. length of ward c̄ crutches. 3 point gait unsteady. needs assistance when amb. AROM c̄ assist. exercises performed. Premedicated c̄ ii Percocet ā amb and exercising. Pin care performed. Old dsgs to pin sites c̄ bloody mod. amt drainage. pin sites w/o s/s infection, notable healed tissue. W→D dsgs wrapped around pins applied C/D/I. w/o further complaints [redacted] 2LT / [redacted]
Addendum	⊕ROM, ⊕sensation ⊕ <3sec cap refill RLE [redacted] 2LT AN
6Aug03	1140- Pt alert & oriented OOB to chair x1 today. VSS, HR reg, lungs CTA, BS⊕x4, pulse ⊕x4, Ext fx intact to ⊕ leg. Pin care done by pt. Given percocet for pain. Will cont to monitor [redacted] 2Lt
6Aug03 1310	pt resting c̄ eyes closed, easily aroused to verbal stimuli. VSS. assessment findings WNL ẋ ⊕4 thigh, ⊕ thigh c̄ ex-fix, dressing c̄ sm amount of pinkish color drainage, ⊕ pulse. ⊖ complaint of pain/discomfort voiced @ this time. Will cont to monitor [redacted] 9Wurke
5 6Aug03 21:09	Rec'd c/o pt @ 21:00. Restraints x1 ⊕ ankle. Awake and alert in bed. PERRLA ⊕ WNL. LCA ⊕. HRRS, S2. BS⊕x4. ⊕ thigh ex-fix intact. Pinsite dsgs c̄ scant amt. bloody drainage noted. ⊕ROM ⊕ sensation ⊕ PPP ⊕ to ⊕ foot digits. w/o c/o pain @ this time [redacted] 2LT / AN
6Aug03 2300	Pin care done p̄ pt amb on crutches and performed AROM c̄ assistance. Old dsgs to pinsites c̄ mod. amt bloody drainage noted. pin site wounds all well approx. c̄ healthy tissue noted w/o s/s infection present. New W→D dsgs applied C/D/I. c/o pain ẋ Percocet given for premedication ā AROM ẋ Percocet given for c/o pain p̄ dsg Δ. Will mon [redacted] 2Lt

All (b)(6)-2 except bottom one.

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
070945 Aug 03	NURSING ASSESSMENT: Awake, alert, Ox3, Airway intact, breathing easy and unlabored, LS clear to all fields (B). Abd soft, nontender, ± distention, BS(+)x4. Voids spontaneously. Pt and neurovascularly intact to (B)UE, (D)LE. (B)LE has ex-fix to lateral thigh, 6 pins, 4 distal pins have moderate amount of serosanguinous drng noted. ROM to (R) limited by pain and joint stiffness -- otherwise neurovascularly intact. —— (Ø) IV access. —— [redacted]
7 Aug 03 1330	assumed pt care @ 1300. pt AAOX3. VSS. assessment findings WNL. (R) thigh c̄ ex-fix, dressing CDI, (+) pulse. (Ø) IV access noted. (Ø) complaints voiced @ this time. Will cont to monitor —— [redacted] 9/WMC
1400	pt given ii percocet @ CDT [redacted] request - [redacted] 9/WMC
9 Aug 03 22:49	Rec'd c/o pt @ 21:00. Restraints x2 (L) wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. Skin W/D. PERRLA(+) WNL. LCA(+) HRRS, S2 BS(+)x4. (+)PP(B). (R) thigh ex-fix in place. ROM ~~excersized~~ Error exercises performed and pt amb length of ward x 1 1/2. Blood draining from Proximal pin site down leg upon return to bed. Pin care done & s/s infection noted. Bloody drainage on old dsgs. Pt c/o pain x 1 ii Percocet given. Will cont. to mon. [redacted] DLT
Addendum	(+) sensation (+) ROM (+) <3 sec cap refill will mon. [redacted] DLT
8 Aug 03 0610	Assumed pt. care @ 0500. Pt. asleep. Awaken easily VSS. AOx3. lungs CTA. (+) pulses x4. (+) BS x4. (R) thigh c̄ ex-fix c̄ slight drainage from pin site. Ø complaints @ this time —— [redacted] 9/WMC

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

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

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

All: (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Aug 03 1315	assumed pt care @ 1300. VSS. pt awake & alert. assessment findings WNL. (R) thigh c̄ ex-fix, CPT [redacted] @ BS for PT, pt given ⅓ percocet prior to PT @ CPT [redacted] request. Will cont to monitor [redacted] 9/WM4
8 Aug 03 21:56	Rec'd c/o pt. @21:00. Restraints x 2 (L) wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. PERRLA (+) WNL. LCA (B) HRRS, S2. BS (+) x4 ABD soft non-tender. Ex-fix in place DSGs c̄ to pin sites. c̄ scant amt. bloody drainage noted. (R) foot (+) sensation (+) <3sec cap refill (+) PP (+) ROM. c̄/o pain (D) bicept. Small hardened area noted. Will cont to mon [redacted] 2LT/AW
9 Aug 03	0530: Assumed pt. care @ 0500: VSS. A+O x3. lungs CTA. (+) Pulses x4. (+) BS x4. (R) thigh ex-fix c̄ dsing to pin CDI. Denies any complaints @ this time [redacted] 9 Aug
9 Aug 03 1450	pt care assumed @ 1300. pt AAO x3. VSS. assessment findings WNL. (R) thigh c̄ ex-fix. CPT [redacted] @ BS c̄ pt to do ROM exercise, pt given ⅓ percocet @ 1320 @ CPT [redacted] request. 1430 pain care completed. (0) complaints voiced, Will cont to monitor [redacted] 9/WM4
9 Aug 03 22:15	Rec'd ~~at~~ error c/o pt @21:00. VS WNL x̄ ↑ temp 100.2. Will retake temp in 1°. Skin w/D. PERRLA (+) WNL LCA (B) HRRS, S1, S2. BS (+) x4. ABD soft-non-tender. (+) PP (B). (R) thigh ex-fix in place. DSDs to pin sites c̄ scant amt visible bloody drainage. (+) ROM (+) sensation (+) warmth (+) Pedal pulse (+) <3sec capref/l to (R) foot. Amb c̄ crutches s̄ difficulty. AROM c̄ assistance performed s̄ difficulty. [redacted] 2LT/AW

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Progress [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03	1130 - Pt alert & oriented OOB x1 utilizing crutches while ambulating. VSS, lungs CTA, HR, BS⊕, pulses ⊕ x4. Ext fix intact to ⓡ leg. Pin care completed by pt. Minimal drainage noted on dd dsgs. Voicing ∅ complaints at this time. Will cont to monitor (b)(6)-2 [redacted]
10 Aug 03 1400	pt AAOX3. VSS. lungs CTA, abd soft non-tender BS⊕x4. ⓡ thigh c̄ ex-fix dressing CDI. LLE c̄ from ⊕ pulses to B.ext. BUE c̄ from ⊕ pulses. ∅% pain/discomfort voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 9 wm6
10 Aug 03 0830	Rec'd c/o pt @ 0830. ⊖ Restraints x2 ⓓ wrist/ankle. VS WNL per flow sheet. Pt. awake and alert in bed. PERRLA ⊕ WNL LCA ⊕ HRRS, SR. BS ⊕ x4 ⊕ PPB. ⓡ thigh ex-fix dsg's ⊠'d skin to pinsites well approx. ⊖ s/s infection. ⓛ foot digits ⊕ ROM ⊕ warm to ⊕ sensation ⊕ <3 sec cap refill. ⊖ c/o pain during ROM ⊖ assist or AMB on crutches. Will cont. to mon [redacted] (b)(6)-2
10 Aug 03 1530	[illegible] staff Pin site still clean. Engorged scrotum @ knee and hip. Jt ↑ some allow but still not limited.

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

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

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

[redacted]

Medical Record

STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13535

Progress Note

All: (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11Aug03	1211: Pt alert & oriented OOB x 1 ambulatory w/ crutches. VSS, lungs CTA, BS⊕, pulses ⊕x4. Ext fix intact ® thigh. Pin care done by pt. Voiding ∅ complaints. Will cont to monitor —— [redacted] JAM
11Aug03 1300	Pt stable. AAOx3. PERRLA. Resting in bed w/ ® knee bent. Lungs CTA bilat, ∅resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ext fix to ® thigh intact, dsg to pins CDI. ∅complaints. Strong pulses & brisk cap refill x4 extremities. —— [redacted] KA/JM
1545	ROM done w/ PT. Pt premedicated w/ Percocet. Leg raises done, Knee bent to 90° and stretched. Pin sites CDI. Pt tolerated procedure w/ some difficulty —— [redacted] KA/JM
1900	Pin care and dsg Δ's done by pt w/ supervision. Pin sites CDI. Dsg w/ minimal drainage from ROM exercises. ∅complaints —— [redacted] KA/JM
2330	Pt care assumed @2100. VSS, AAOx3 c̄ c/o pain p̄ ambulation and rom. Lung sounds clear, pulses ⊕x4, BS⊕. Pt ambulated x15 min and active and passive rom performed w/ difficulty. Pt performed pin care, sites are pink and free of s/s infection. On PO ABX, continue to monitor. —— [redacted] aumo
12Aug03	1040- Pt A&Ox3. VSS, lungs CTA, BS⊕, pulses ⊕x4. Ext fix intact to ® leg. Pin care done by pt. ∅ pain meds given. Voiding ∅ complaints, Will cont to monitor —— [redacted] JAM

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03 1320	assumed pt care @ 1300. VSS. pt awake et alert. assessment findings WNL. (R) thigh c̄ ext-fix, draing CDI. (+) pulse. (D) IV access noted. (D) complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 9/WM6
12 Aug 03 22:39	Rec'd c/o pt. @ 21:00. Restraints x 2 (D) wrist/Ankle. VS WNL per FS Awake and alert in bed. PERRLA (+) WNL. LCAB BS (+) x4. ABD soft - non-tender. (+) PP (B). (R) thigh ex-fix intact DSG's applied to pin sites. (+) ROM (+) sensation (+) <3sec cap refill to (B) foot digits. Pt amb. length of ward x 2. ROM Sassist. performed. c/o's @ this time. will cont to mon- (b)(6)-2 [redacted] DCT/AN
22:51	c/o pain to (B) LE while amb. only completed 1 length of ward ii Tylenol given for pain
13 Aug 03	1100 - Pt alert & oriented lying in bed c̄ (R) leg elevated. VSS, lungs CTA, BS (+), pulses (+) x4. Ext fix intact, pin care done by pt. AM care completed. Tolerated breakfast. Voicing Ø complaints at this time. Will cont to monitor (b)(6)-2 [redacted] 9/WM6
13 Aug 03 1330	pt awake et alert. VSS. assessment findings WNL x̄ (R) thigh c̄ ex-fix draing CDI (+) pulse (+) movement (+) sensation. (D) c/o pain/discomfort voiced Will cont to monitor [redacted] 9/WM6

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

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

RECORDS MAINTAINED AT: (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 21:05	Rec'd c/o pt @ 21:00. Restraints x 2 (L) wrist/Ankle. VS WNL per flowsheet. Awake and alert in bed. Skin w/D/I. PERRLA (+) WNL. LCA (+) HRR S1S2. BS (+) x4. ABD soft and ~~o~~ tender. (R) thigh ex-fix intact. 1st 2 prox. pins c̄ (+) exudate 2nd 2 medial pins c̄ ~~o~~ s/s infection (+) healing tissue @ pin sites 3rd set distal pins c̄ healing tissue/pink in color. Prox and distal pins DSD's applied. Medial pins OTA. (+) sensation (+) ROM (+) <3 sec cap refill to (R) foot digits. Pt. premedicated for PT. CPT [redacted] performed pt. PT. ~~o~~ c/o's will cont. to mon. [redacted] (b)(6)-2 DLT/ADJ
140530 Aug 03	NURSING ASSESSMENT: Assumed pt care AAOx3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender, ± distention. BS (+) x4. Voiding spontaneously. Motor and neurovascularly intact to (B) UE and LLE. (B) LE ROM limited by pain to knee & hip. Motor to (R) ankle. Neurovascularly intact to (L) LE. Ø IV access. Ex fix to (R) lateral thigh x 6 pins - drsgs CDI. [redacted] (b)(6)-2
140530 Aug 03	NURSING NOTE: Proximal two pins have small amount of purulent drng to pin sites. Cleansed c̄ H_2O_2 & NS. ~~Middle~~ Middle two pins and distal two pins have pink skin growing in around pins. Sites have beefy red tissue near as well. [redacted] (b)(6)-2
14 Aug 03 1415	pt care assumed @ 1300. pt awake & alert. VSS pt given ⅓ percocet prior to PT. SPC [redacted] @ (b)(6)-2 bedside performing ROM exercise. pt tol well. Drsing to pin sites (R) thigh ex-fix c̄ sm amt of red bloody drainage, site cleaned c̄ ½ NS & ½ H_2O_2. new drsings applied. lungs CTA, abd soft nontender BS (+) x4. BL Ext c̄ (+) pulses. BUE c̄ ROM (+) pulses. pt ambulated c̄ ~~crutches~~ [redacted] (b)(6)-2 crutches. (-) c/o pain/discomfort voiced. Will cont to monitor [redacted] (b)(6)-2 9/WMC

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Aug 03 22:11	Rec'd c/o pt @ 21:00. VS WNL per f.s. Alert and awake in bed. Restraints x2 (L) wrist/Ankle. Skin W/D. PERRLA (+) LCA (B). BS (+) x4. (+) PP (B) (-) thigh ex-fix in place. (+) ROM (+) sensation (+) Pedal pulse. (+) <3sec cap refill (+) (-) foot digits c/o pain. will cont. to mon. (b)(6)-2 [redacted] OIT /AN
14 Aug 03	Pt. temp 99.2 @ 2345. Sel (b)(6)-2 [redacted]
15 Aug 03 0041	II Tylenol given for ↑ temp and c/o pain to (L) thigh. Will mon. (b)(6)-2 [redacted] 2LT /AN
15 Aug 03	1215 - VSS, lungs CTA, HR reg, BS (+) x4, pulses (+) x4. Pt A+O x3. Ext fix intact to (R) leg. Pin care done by pt. PO antibiotics. (-) complaints at this time. Will cont to monitor (b)(6)-2 [redacted] 2Lt
15 Aug 03 1330	Pt care assumed @ 1300. Pt awake & alert, VSS lungs CTA, and sat BS (+) x4. (R) thigh c̄ ex-fix drainage CDI. (+) pulse. LLE c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulse. (-) complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 9/WMC
15 Aug 03 21:55	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Restraints x2 (L) wrist/ankle. Awake and alert in bed. PERRLA (+) WNL. Skin W/D/I. LCA (B). [redacted] (b)(6)-2 HRSSS2. BS (+) x4. (+) PP (B). (-) thigh ex-fix in place DEG's to pin sites [redacted] (b)(6)-2 CDI. (+) ROM (+) sensation (+) <3sec cap refill

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

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

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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All: (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
cont'd	to (R) foot digits. c/o pain @ this time. Will cont to mon — [redacted] DZT/AW
0116	c/o pain to knee and (R) thigh ~ Percocet given — [redacted] DZT/AW
16Aug03	1130 Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS(+), pulses (+)x4. Ext fix intact to (R) leg. Pin care done by pt. Voicing Ø complaints. Will cont to monitor — [redacted] 2Hu
16Aug03 1520	Pt care assumed @ 1300. pt awake & alert. VSS. assessment findings WNL ~ (R) thigh c̄ ex-fix, dressing CDI (+) movement, (+) sensation (+) pulse. 1500 PT c̄ pt doing ROM exercise. pt premedicated c̄ percocet p̄ exercise, dressing A'd & pin care done. (+) S/S of infection noted to pin sites. (+) complaint of pain/discomfort voiced @ this time. Will cont to monitor — [redacted] 9/WML6
16Aug03 21:35	Rec'd c/o pt @ 21:00. Restraints x 2 (L) wrist/Ankle. VS WNL per flow sheet. Awake and alert in bed. Skin w/D/I. PERRLA(+) WNL. LCA(+). HRRS. S.S. BS(+)x4. (+) PPB (R) thigh ex-fix in place c̄ pin site dsgs CDI. (+) ROM (+) sensation (+) <3 sec capref. ll (R) foot/ankle/digits. c/o pain. Will cont to mon [redacted] DZT/AW
17Aug03 0630	VSS. Pt. awake & alert in bed s̄ complaints @ this time. HR Regular. Lung sounds clear bilat, bowel sounds (+) x 4 quads. Ø IV access. Ext fix to (R) leg intact, dsg to pins CDI. (L) LE pedal pulses palpable, (+) sensation <3 sec capreffill, full ROM in digits & ankle, limited ROM in knee. All other assessment findings WNL. Will continue to monitor. [redacted] DZT/AW

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 1330	pt care assumed @ 1300. pt awake et alert. VSS. assessment findings WNL. (R) thigh c̄ ex-fix intact dressing to pin sites CDI, (+) movement (+) sensation (+) pulse. (D) IV access noted. pt denies pain @ this time. Will cont to monitor (b)(6)-2 [redacted] 9WMC
17 Aug 03 21:47	Rec'd c/o pt @ 21:00. Restraints x 2. VS WNL per flowsheet. Awake and alert in bed. Skin W/D/I. Perrla (+) WNL. LCA (B). HRR S1 S2. BS (+) x4. (R) thigh ex-fix in place. Pin site dsgs CDI. (-) apparent s/s infection. (R) LE FROM (+). sensation (+). (+) <3 sec cap refill (+) PP (B). (-) pain @ this time. Will cont. to (b)(6)-2 man. [redacted]
18 Aug 03	1215 - Pt A+O x 3 ODB x 1 using crutches VSS, lungs CTA, BS (+), pulses (+) x 4. Ext fix intact to (R) leg. Pin care done by pt. D/C orders written. Will be EVAC to camp today (b)(6)-2 [redacted]

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

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

REGISTER NO.

WARD NO. 1CW2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/18/03	D/C Summary

This Iraqi male had a gunshot wound to right femur which was stabilized with an external fixator late June 2003. He has a sub-trochanteric femur fracture. He is progressing well with ambulation and ranges of motion and strength. His fracture is still not healed. He is proficient in his own pin site care. He should remain non weight bearing on his right leg with crutches for assistance and continue to use prophylactic oral antibiotics as well as continue to perform his own pin site care daily

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

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

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

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

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACI[redacted]
		RECORDS MAINTAINED AT	(b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 30 July	TIME 0930
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY AIR	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE (b)(6)-4	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE [redacted]	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT Ex. Fix (R) Femur

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 0935	TIME 0930					
☐ URGENT		BP 108/60					
	INITIALS (b)(6)-2 [redacted]	PULSE 101					
		RESP 18					
☒ NON-URGENT		TEMP 99.8					
		WT 70/6					

LAB ORDERS				X-RAY ORDERS		
☒ CBC/DIFF [redacted]	ABG [redacted]	PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE	C-SPINE
URINE C&S	UA MSCC/CATH		[redacted]EM: N		ACUTE ABDOMEN	LS SPINE
BLOOD C&S X					SINUS	HEAD CT
					ANKLE R/L	
					(R) femur xray	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

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

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

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 7/26/93

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

Foley output

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0100	urine, med yellow	600	600
0400	urine	450	1050
1900			

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72

*U.S.GPO:1996-404-613/30343

MEDICAL REC

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

July 2003

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19 | DAY: 10, 11, 12, 13, 14, 15, 16 | HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

(b)(6)-2

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

REGISTER NO.

WARD NO. PCW2

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

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST-OPERATIVE DAY

MONTH-YEAR June 19 — DAY: 17, 18, 19, 20, 21, 22, 23

HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

	17	18	19	20	21	22	23
	128/70	112/58	114/68	126/80	116/96	112/58	
	118/70	114/62		124/62	110/76	105/70	116/60
HEIGHT: WEIGHT →	98%	98% 98%	96% 98%	98%	98%	99	

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW 2

STANDARD FORM 511 (REV. 7-95) BACK

EPW 11 [redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19 03

DAY: 24, 25, 26, 27, 28, 29, 30

HOUR

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

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: July 31 | August 1 | 2-3 | 3-4 | 4-5 | 5-6 | 6

19 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

SPO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU 7

EPW

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST-Ex-Fix placement DAY I/A

MONTH-YEAR Aug 2008 — DAY 7–8, 9, 10, 11, 12, 13, 14 — HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

EPW

[redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 67 | DAY 15 16 17 18 19 20 21

19 03 | HOUR

PULSE (O) | TEMP. F (•)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

Record special data only when so ordered

HEIGHT: | WEIGHT →

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

REGISTER NO.

WARD NO. KW2

EPW

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

Ward Section: ICW 2

REFERRING PHYSICIAN:

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

LAST FIRST MI: EPW# [redacted] -(b)(6)-4

DATE: 3 July 03 TIME: 1320

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	6.4	4.8-10.8 x 10³
RBC	2.34	4.7-6.1 x 10⁶
Hgb	6.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	20.9	42-52% (M) 37-47% (F)
MCV	89.5	80-94 fl (M) 81-99 fl (F)
Plt	242	140-500 x 10³ verified
Lymph %	27.8	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 3 Jul 03

LAB ID NO.:

Ward/Section: ICW2

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

...TRY RESULT FORM

(Su... to the Privacy Act of 1974)

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

DATE: 3/14/100

TIME:

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

(I-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	4	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	2977	39-380 u/l (M) 30-190 u/l (F)
NA^+	120	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	28	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

DATE: 3JUL03

LAB ID NO.:

Ward/Section: [redacted] | CU | REQUES[redacted]LAN: (b)(6)-2

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 3 July 2003 | TIME: | SSN: [redacted] SN: (b)(6)-4

ATORY RESULT FORM
to the Privacy Act of 1974)

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3
RBC	2.47	4.7-6.1 x 10^9
Hgb	7.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	22.1	42-52% (M) 37-47% (F)
MCV	89.4	80-94 fl (M) 81-99 fl (F)
Plt	239	130-500 x 10^3 verified
Lymph %	28.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] | **DATE:** 3 Jun 03 | **LAB ID NO.:**

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

SPW [redacted]

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

2 July 03 1037

Admit to Pt. Hold

Activity: Bedrest

Meds:

Ancef 1 gm IV Q6H

Morphine Sulfate 10mg/mL

10mg IM Q 8H

Tylenol 1000mg PO Q6H

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Diet: Regular

Vitals: Q 4H

Call H.O. for

SBP ≥ 150; ≤ 90

DBP ≥ 110 ≤ 50

Pulse ≥ 110 ≤ 60

Temp > 100.4

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Pin Care: Q 8H (b)(6)-2

Diagnosis: (1) Femur F x S/P [redacted]

Gunshot wound (2) thigh x

S/P Ex Fix

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] R

3 July 03 0800 HOURS (b)(2)-2

Routine Evacuation to [redacted]

Today for wound inspection

Dressing ~~Δs~~ and Position

assessment. Rpt injection

(b)(6)-2

[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

EPW

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 3 July 03 TIME OF ORDER: 1010 HOURS

LIST TIME ORDER NOTED AND SIGN

1. NPO
2. Rx - GSW (R) Thigh, Cast Fix
3. Clothing - Shoes
4. VS - Routine
5. UP to Leg, Crutches, Walk
6. Dressing Change Daily

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

7. Resume Diet HOURS
8. NGP 2000 N
9. Bhcos + Gram NPN Q 8 hrs
10. Percocet, 1-2 p.o. Q 4-6 hrs PRN
11. Tylenol 650 mg p.o. Q 4 hrs PRN
12. MSO4, 2-6 mg IVP Q 2 hrs PRN
13. (R) Bedside X-ray
14. Chest Physiotherapy [redacted]

NURSING UNIT	ROOM NO.	BED NO.
28/dme	[redacted]	

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

4 July 0830

Pin Leg BRD

Heat Hot

DOD Pomeroy

(b)(6)-2 [redacted] 1445

EPW

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		[redacted]

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

PATIENT IDENTIFICATION

TIME OF ORDER

6 July 03 0930

1. D/C Foley now

6 July 03 0930 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-2	9 Jul 03	21:31 HOURS	
	V.O.		noted 21:31 9 Jul 03 [redacted]
[redacted] (b)(6)-4	1 dose mylanta x 1 now for generalized abd. discomfort		
	Dr [redacted] / [redacted] (b)(6)-2		
G UNIT: ICW2 / ROOM NO. / BED NO. [redacted]	24hr/done [redacted] DCT/AN		DCT/AN

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
24° VS [redacted]	1/CT/AN	7-12-03 HOURS	2350
24° VS	1/CT/AN	7-15-03	0030.
[redacted] (b)(6)-4	(b)(6)-2		(b)(6)-2
G UNIT: ICW2 / ROOM NO. / BED NO. [redacted]			

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
~~ICW~~ [redacted] (b)(6)-4	21 July 03	0130 HOURS	
	V.O. from Dr. [redacted] (b)(6)-2 to LT [redacted] (b)(6)-2		
	(1) 50mg Benedryl po QHS PRN		
G UNIT: ICW2 / ROOM NO. / BED NO. [redacted]	(b)(6)-2 [redacted] DCT/AN		
24 chart V 24° V	[redacted] LT/AN	7-24-03	0030.

noted 21 July 0130

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
~~ICW~~ [redacted] (b)(6)-4	26 July 03	0900 HOURS	(b)(6)-2 [redacted]
	(1) DC Ancef		
	(2) Keflex 500 mg PO ~~TID~~ [redacted] (b)(6)-2 QID		
	(3) Δ Drsg changes to Peroxide & H_2O. No drsg to pelvis		LT/AN 20 July 03
	(4) Straight leg raises x10 QID (right leg)		2910
	(5) Ace bandage to (R) LE x10 QID		
G UNIT: ICW2 / ROOM NO. / BED NO. [redacted]	V.O. Dr. [redacted] LT/AN		
	(6) Consult PT for exercises		
24° VS 2200	26 July 03 [redacted] (b)(6)-2	(b)(6)-2	

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68, the proponent agency is OTSG

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

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

DATE OF ORDER: 26 July 03 TIME OF ORDER: 1605 HOURS

V.O. D/C M504

Dr. [redacted] / [redacted] 91Wm6

(b)(6)-2

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

(b)(6)-2 noted [redacted] 91Wm6 1605

NURSING UNIT: ICW 2 | ROOM NO.: 24 V/S | BED NO.: 26 Jul 03

PATIENT IDENTIFICATION

DATE OF ORDER: 7/28/03 TIME OF ORDER: 0630 HOURS

Start Lovenox 30mg SQ BID

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

28 July 03 0740 [redacted]

NURSING UNIT: 24 V/S | ROOM NO. | BED NO.: 28 Jul 03

(b)(6)-2

2300 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

DATE OF ORDER: 7/30/03 TIME OF ORDER: 1010 HOURS

(1) XR AP + LAteral of (R) HIP

(b)(6)-2 noted [redacted] 30 July 03 1010

NURSING UNIT: 24 V/S | ROOM NO. | BED NO.: 30 Jul 03

(b)(6)-2

2200 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

DATE OF ORDER: 8/10/03 TIME OF ORDER: 1550 HOURS

(1) XR AP & Lateral of (R) HIP

(b)(6)-2 [redacted]

noted [redacted] 91Wm6 10 Aug 1600

NURSING UNIT | ROOM NO. | BED NO.: 24 V done

(b)(6)-2 [redacted] 920/AN

IDENTIFICATION

DATE OF ORDER 13 Aug 03 TIME OF ORDER 0800 HOURS

V.O.
Clindamycin 150 mg PO
Dr [redacted] / [redacted] 2MAN

13 Aug 03 0000 [redacted] (b)(6)-2

(b)(6)-2

UNIT | ROOM | BED NO.

IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER 14 Aug TIME OF ORDER 23:16 HOURS

1 Imodium 2mg ii po now, then
i po p ea. BM; no more than 5/24hr
PRN diarrhea

noted 14 Aug 23:16 [redacted] (b)(6)-2

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

(b)(6)-2

UNIT | ROOM | BED NO.

24° V done [redacted] 2MAN

IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER 8/18/03 TIME OF ORDER 0900 HOURS

① D/C to EPW Camp
② Crutches for ambulation
③ RX on chart

[redacted] (b)(6)-2

UNIT | ROOM | BED NO.

IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

EPW (b)(6)-4

[redacted]

UNIT | ROOM | BED NO.

FORM 4259 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

U.S. GOVERNMENT PRINTING OFFICE: 2002-420-041

All (b)(6)-2 except one at bottom

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. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24	25
11 Aug	[redacted]	VS Routine	5	[redacted]													
			13														
			21														
11 Aug	[redacted]	Up ad-lib c̄ crutches	5														
		NWB (R) leg	13														
			21														
11 Aug	[redacted]	Reg Diet	8														
			12														
			17														
11 Aug	[redacted]	Pin care BID	10														
			22														
11 Aug	[redacted]	Straight leg raises	6														
		x10 to (R) leg QID	12														
			18														
			22														
11 Aug	[redacted]	RLE knee bends x10	6														
		QID	12														
			18														
			22														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P GSW (R) thigh c̄ ex-fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

All (b)(6)-2 (EXCEPT Bottom one)

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. 7 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 July	[redacted]	VS - routine	05	[redacted]													
			13														
			21														
3 July	[redacted]	Up ad lib, crutches	05														
		NWB	13														
			21														
3 July	[redacted]	Dressing Δs daily	10	[redacted]							03	[redacted]					
3 July	[redacted]	Regular diet	07	[redacted]													
			12														
			17														
4 July 03	[redacted]	PINCARE Bid 1/2 STR.	10	[redacted]													
		H_2O_2 / DRY STERILE	22														
		DSG TO WOUND															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) thigh, ext fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 July	[redacted]	Admit ICW-II ; Cond: stable	—	done		[redacted]
3 July	[redacted]	(R) femur X-Ray today				
	-----	CBC, Metabs 3	3 July		done	[redacted]
4 July	[redacted]	D'C Relay		done		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

All (b)(6)-2 (except bottom one)

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 July	[redacted]	Ancef 1 gm IVPB	06	[redacted]													
		Q8°	14														
			23														
3 July	[redacted]	HL IV	05														
			13														
			21														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ⓡ thigh, ext fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

A11 (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 7 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9JUL	[redacted]	1 dose Mylanta x1 now for generalized abd pain	9JUL	21:31	21:34	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
3 July	[redacted]	Percocet 1-11 PO Q4-6° PRN	4JUL 2200 11 [redacted]	11JUL 0840 11 [redacted]	11JUL 2241 11 [redacted]	12JUL 0740 11 PO [redacted]	13JUL 0101 11 PO [redacted]	13July 0640 11 PO [redacted]	7/13 11 1445 [redacted]	7/13 11 2015 [redacted]	7/15 11 PO July 2230 [redacted]	15 July 0730 11 [redacted]	18 Jul 0910 11 [redacted]	18 July 0315 11 PO [redacted]	19 July 0715 11 PO [redacted]	20 JUL 1100 11 PO [redacted]	20 July 2400 11 PO [redacted]
3 July	[redacted]	Tylenol 650mgs PO Q4° PRN	0830 4JUL 11 PO [redacted]	2300 10JUL 11 PO [redacted]	12 July 2015 11 PO	1 JUL 0230 11 PO [redacted]	1 JUL 2200 11 PO [redacted]	13JUL 2330 11 PO [redacted]	14JUL 2001 11 PO [redacted]	[redacted]							
3 July	[redacted]	MSO4 2-6 mg IVP Q2° PRN	0005 3JUL 3mg IVP [redacted]	1201 2015 4mg IVP [redacted]													
3 July	[redacted]	50mg Benadryl po QHS PRN	2JUL 0130 11 PO [redacted]														
3 July	[redacted]	Percocet 1-11 po q 4-6° PRN	30 July 11 1630 [redacted]														

USAPA V1.00

All (b)(6)-2 (EXCEPT Bottom one)

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 17	18	19	20	21	22	23	24	25	26	27	28	29	30
3 July	[redacted]	Ancef 1 gm IVPB Q8°	6	[redacted]													
			14												DC'd		
			22														
3 July	[redacted]	IV HL	5	[redacted]													
			13														
			21														
26 July	[redacted]	Keflex 500mg PO QID	06														
			12														
			18														
			24														
		Lovenox 30mg	08														
26 July	[redacted]	SQ BID	20														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) thigh ext. fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

Nurse		be Given	be Given		

All (b)(6)-2

Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
21 July [redacted]	Benedryl 50mg PO QHS PRN	2300 23 Jul 50mg	50 mg 2300 24 Jul	50mg 2300 25 July	25 Jul 0131 50mg PO	28 July 2300 PO	30 July 2300 50mg							
3 July [redacted]	Percocet 1-2 PO q4-6 prn pain	00 11 2300 24 Jul	25 Jul 0945 11 PO	00 11 0800 25 July	26 July 0745 11	26 July 1715 11 PO	26 July 2000	27 July 0700 11	27 July 01:47 11 PO	28 July 0730 11	28 July 1320 11	30 July 1430 11	1430 11	
3 July [redacted]	Tylenol 650 mg PO q4° prn	3 July 1430 11		2330 25 July 650mg	26 July 0615 650mg	30 July 11 1830	30 July 11	1/2 11 1615						
3 July [redacted]	Ketorolac 2-6mg IVP q2° prn	26 July 3mg W 0745	DC'd 26 July 03											

USAPA V1.

All : (b)(6)-2 EXCEPT bottom one.

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 31	1	2	3	4	5	6	7	8	9	10	11	12	13
3July	[redacted]	HL IV	5	[redacted]													
			13	[redacted]					Discontinued 2Aug								
			21	[redacted]													
26July	[redacted]	Keflex 500mg PO QID	6	[redacted]													
			12	[redacted]													
			18	[redacted]													
			24	[redacted]													
26July	[redacted]	Lovenox 30mg SQ BID	8	[redacted]													
			20	[redacted]													
13Aug	[redacted]	Clindamycin 150mg PO Q6	4														
			10														
			16														
			22														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P GSW to (R) thigh c̄ ext. fix

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -	All: (b)(6)-2				
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21 July	[redacted]	Benadryl 50mg	1 Aug 2000	3 Aug 2000												
- - - - -	- - - - -	QHS prn	[redacted]	[redacted]												
31 July	[redacted]	Percocet ½ - 1/2 PO	31 July 0520 1/2 PO [redacted]	31 July 1330 1/2 [redacted]	31 July 1945 1/2 [redacted]	1 Aug 1830 1/2 [redacted]	3 Aug 1755 1/2 [redacted]	3 Aug 2000 1/2 [redacted]	4 Aug 1430 1/2 [redacted]	4 Aug 2059 1/2 PO [redacted]	5 Aug 1500 1/2 [redacted]	6 Aug 2130 1/2 [redacted]	6 Aug 1330 1/2 [redacted]	6 Aug 2059 1/2 PO [redacted]	6 Aug 2148 1/2 PO [redacted]	7 Aug 1400 1/2 [redacted]
- - - - -	- - - - -	q4-6 prn pain														
31 July	[redacted]	Tylenol 650mg	2230 6 Aug 650mg PO [redacted]	0035 3 Aug PO 1/2 [redacted]	7 Aug 1240 1/2 PO [redacted]	10 Aug 2059 1/2 PO [redacted]										
- - - - -	- - - - -	Po q4° prn														
7 Aug	[redacted]	Percocet ½ - 1/2 PO	7 Aug 2059 1/2 PO [redacted]	8 Aug 1330 1/2 PO [redacted]	10 Aug 1445 1/2 [redacted]	16 Aug 1400 1/2 [redacted]										
- - - - -	- - - - -	q 4-6° pRN pain														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

All (b)(6)-2 Except bottom one

CORD

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.* ____

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18	19	20	21	22	23	24	25	26
26 July [redacted]	Lovenox 30mg	8	[redacted]													
	SQ BID	20														
	Clindamycin 150mg	4														
13 July [redacted]	PO QL	10														
		16														
		22														

OC

☒ NO

PRIMARY DIAGNOSIS: S/P GSW to (R) thigh c̄ ext. fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

DISPENSING TIMES

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

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

FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

All (b)(6) - 2 (except ones at bottom)

the proponent agency is the Office of The Surgeon General. MD. ___ Y.R 2003

RIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	1	2	3	4	5	6	7	8	9	10	11
3 July	[redacted]	VS Routine	5	[redacted]												
			13													
			21													
3 July	[redacted]	Upadlib Crutches NWB	5													
			13													
			21													
3 July	[redacted]	Regular Diet	6													
			11													
			17													
26 July	[redacted]	Pincare BID 1/2 H_2O_2	5													
		1/2 H_2O @ deg to pins	13													
			21													
26 July	[redacted]	Straight leg raises x10 to	6													
		@ leg QID	12													
			18													
			22													
26 July	[redacted]	RLE Knee bends x10	6													
		QID	12													
			18													
			22													

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW R thigh Ex fix

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: ___

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30	[redacted]	XR AP + LAT (R) hip	30	today	Done	
10Aug	[redacted]	XR AP + lat (R) hip	10 Aug	today	1645	[redacted]

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

All (b)(6)-2
Except bottom one.

MD. 7 YR 2003

the proponent agency is the Office of The Surgeon General.

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	29
3 July	[redacted]	VS - routine	5	[redacted]												
			13													
			21													
3 July	[redacted]	up ad lib, crutches, NWB	5	[redacted]												
			13													
			21													
3 July	[redacted]	Regular Diet	6	[redacted]												
			12	[redacted]												
			17	[redacted]												
3 July	[redacted]	pincare BID 1/2 str	10	[redacted]												
		H_2O_2 / Dry sterile Dsg	22													
		to wound														
26 July	[redacted]	Pincare BID ½ H_2O_2 / water	10													
		ø drsg to pins.	22													
26 July	[redacted]	Straight leg raises x10 to	06													
		(R) leg QID	12													
			18													
			22													
26 July	[redacted]	(R) LE knee bends x10 QID	06													
			12													
			18													
			22													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) thigh, ext fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USA

A11: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26	[redacted]	consult PT for exercises				

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
3 July	[redacted]	Percocet 5-325 PO Q4-6	2200 PO	See Medication Sheet												
		PRN pain	2200 [redacted]													
3 July	[redacted]	Tylenol 650mg PO	2200 OTJ	23 33 OHS												
		Q4° prn	[redacted]	650 [redacted]												
3 July	[redacted]	MSO4 2-6mg IVP														
		Q2° prn														
3 July	[redacted]	50mg Benadryl PO														
		QHS PRN														

All: (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	error [redacted]				
	~~Immodium~~				

Order Expir Date		PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21 July	[redacted]	Benedryl 50mg QHS PRN														
3 July	[redacted]	Percocet 1-11 PO Q4-6 PRN Pain	15Aug 2058 11PO [redacted]	14Aug 1305 11 [redacted]	15 Aug 1600 11 [redacted]	16Aug 0116 11PO [redacted]	16 Aug 1330 11 [redacted]									
3 July	[redacted]	Tylenol 650mg PO Q4° PRN	15Aug 20:38 11PO [redacted]													
14 Aug	[redacted]	Immodium 2mg 11 PO now then 1 PO p ea. BM; no more than 5/24° PRN diarrhea	15Aug 23:16 11PO [redacted]													

USAPA V1.00

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. 0070004 A
3. NAME [redacted]	4. DATE OF BIRTH (b)(6)-4
5. RANK	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT 1/2 ACR
9. LOCATION OF CAPTURE (*Grid coordinates*) [redacted] (b)(6)-4	
10. CIRCUMSTANCES OF CAPTURE Stole bus & Assault on US Forces	11. PHYSICAL CONDITION OF EPW Shot	12. WEAPONS, EQUIPMENT, DOCUMENTS

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. 0070004 B
3. NAME	4. DATE OF BIRTH
5. RANK	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT
9. LOCATION OF CAPTURE (*Grid coordinates*)	
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. 0070004 C
3. NAME	4. DATE OF BIRTH
5. RANK	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT
9. LOCATION OF CAPTURE (*Grid coordinates*)	
10. DESCRIPTION OF WEAPONS, SPECIAL EQUIPMENT, DOCUMENTS	

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
(b)(6)-4	[redacted]	Z	Z	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1010	(b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	A 7 8	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW 2	UNK

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 0		0 3 0 7 1 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		0 3 0 7 0 3

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

FOR LOCAL USE

Dx: C8w 40 (R) thigh ex fix

Dx: 82110
E9912
Px: 7965
7815

(b)(6)-2

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

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted] (b)(6)-4			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. [redacted]	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN (b)(6)-4 [redacted]		13. ORGANIZATION N/A		14. WARD ICU7
15. FLYING STATUS N/A	16. [redacted] DSG —	17. DEPT./BEN K79	18. BRANCH/CORPS N/A	19. UIC/ZIP —	20 TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22. HOURS OF ADMISSION 1810	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —		25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 11 July 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —		27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 04 July 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW's

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	7	7

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	7	7

SI[redacted] (b)(6)-2 SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] (b)(6)-2

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted] Civ # [redacted]			3. GRADE Civ	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN (b)(6)-4 [redacted]	13. ORGANIZATION —				14. WARD ICU 1
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT/BEN K76	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION: 0900	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK	25. TYPE DISPOSITION: 03	26. DATE OF DISPOSITION: 11 Jul 03	(b)(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK	27b. TELEPHONE NO.: UNK	28. DATE OF THIS ADMISSION: 4 Jul 03	ADMITTING OFFICER: Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: Osuo to abn, (D) femer, Bilateral arms

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	7	7

36. Total Days All Facilites (b)(6)-2

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: Dr. [redacted]

SIGNATURE OF MEDICAL RECORDS OFFICER: [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

(b)(6)-4

~ [redacted] YO MALE PAW SHOT BY RPG AFTER ATTACKING US TROOPS TO BOTH UE & LEFT LOWER EXTREMITY + ABDOMEN S/P EXLAP & RESECTION OF DESCENDING COLON & TRANSVERSE COLOSTOMY + HARTMANN'S. ALSO S/P RESECTION OF SMALL BOWEL ENTEROTOMIES & PRIMARY REPAIR, ALSO WASHOUT OF EXTREMITY WOUNDS

PMH: PSH: ALL: MEDS:

PHYSICAL EXAMINATION

VS: 98 127/87 24 98%

GEN: SEDATED MOVES EXTREMITIES TO PAINFUL STIMULI

H: NC
E: EOMI PERL
E: CLEAR
N: GPC
T: CLEAR

NECK: NT
LUNGS: CTA
CVS: RRR
ABD: SOFT. APPROPRIATE SURGICAL ITP

VOLUME: STABLE

EXT: GSW TO S/C UE & LLE

NEUR: SEDATED MOVES EXTREMITIES

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

Dx: MULTIPLE GSWs — SEE HPI

PLAN: TO ICU — SEE ORDERS
CONSULT ORTHO

(b)(6)-2

SIGNA[redacted]	DATE 4JL/03	IDENTIFICATION NO.	ORGANIZATION

[redacted]r typed or written entries give Name last, first, [redacted]ddle; grade; date; hospital or [redacted]

REGISTER NO.	WARD NO.

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD	PROGRESS NOTES
DATE 3 JUL 03	[redacted] (b)(2)-(2)
BP: 2100	(b)(6)-4 [redacted] go IM
P:	Was shooting at US soldiers.
R:	US ~~the~~ soldiers returned fire.
T:	Pt hit in both arms / (L) leg / abdomen
O2 SAT:	HD stable @ scene.
	Ground eval.
ALLERGIES ?	TOI = 2030 hrs.
PMH: ?	(RE) On arrival minimally responsive
	but conscious. Moving all 4.
PSH:	↓ respirations. Thready fem pulse.
	Taken directly to OR. Intubated.
	Resuscitated to BP 100/70 HR 85.
	NC/AT PERRLA o/p cl
	Neck supple
	Chest - CTA = BS (-) bullet wounds
	CV - RRR Back - 2 small entrance wound
	(R) lower back
	Abd - 2 exit (L) side. Lower one ∘ omentum
	Pelvis - stable Rectal - (-) heme
	Ext - GSW superficial thru-thru (L) thigh
	(-) fx. NVI distally. BUE - med entrance ∅
	exit. (-) fx. NVI distally.

(Continue on reverse side)

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

REGISTER NO.

WARD NO. (b)(2)-2 [redacted]

NAME: [redacted]

SSN:

UNIT:

(b)(6)-4

GSW x 2 to abd

GSW (R) UE (L) UE (L) thigh

To OR. Exp lap. HD.

PROGRESS NOTES

Medical Record

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

PPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 July 03	Assumed pt care from EMT nurse. Pt hemodynamically stable [redacted] (b)(6)-2 upon arrival, pt on RA 99-100% Spo2. NG placed to LIS, CR started @ 150cc/hr, fentanyl drip started @ 50mcg/hr. pt resting comfortably @ this time [redacted] (b)(6)-2
	1800 CHOW 03 - [N] Pt secluded on foot for [illegible]. ∅ FC; PERRL @ 2mm (cv/resp) S1S2, NSR, [illegible] on RA, CTA s/bil ⊖ s/s resp distr. [NM] b/l UEs have ⊕ pulses (+3), <3 sec cap refill, will ⊖ pulses / [illegible]. [PLAN] IAW on 5 JUL 03
	(b)(6)-2 [redacted] 1700
5 July/0600	Assumed pt care from ICT [redacted], pt resting comfortably, continuing infusing @ 50mcg/hr, CR @ 150cc/hr. NG/LIS ⊖ drainage small/moderate yellow drainage, dressings to GSW bilat arms c/d/I, colostomy, stoma, not as pink as yesterday, no output from colostomy noted. No other issues noted, (b)(6)-2 [redacted] pt scheduled for OR today [redacted] (b)(6)-2 RNBSN
5 July/[illegible]	Received pt from OR, pt arrived ⊖ LOS. No complications during surgery. Pt currently on RA Spo2 98-96%, follows all commands; appropriate ⊖ staff. CR infusing @ 125cc/hr. Nsg to raise [illegible] in 2/5, pt resting comfortably [illegible] (b)(6)-2 [redacted]

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

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

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

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

All: (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 June 03	Brief Op Note
	PreOp Dx MGSW (R arm (L) arm / (R) thigh)
	Post Op Dx Same
	Procedure washout / I+D GSW's (R) & (L) arms, (R) Leg
	Surgeon [redacted] / [redacted] / [redacted]
	Anesth GETA EBL min
	Findings - Clean, non-bleeding GSW's (R) + (L) arm.
	(R) thigh GSW c̄ min drainage.
	Pt tol procedure well, to ICU stable & extubated.
	[redacted] MDS.
05 Jun 03 1340	Report given. Pt. asleep-resting comfortably in NAD. NGT clamped. Drsgs to Bil. biceps & (R) thigh C,D,&I. Mid abd. drsg also C,D,&I. c̄ colostomy bag secured/empty. Stoma pink/moist. & complaints voiced when [redacted] aroused. LRQ 125 to RFA IV pat./benign. Sits in mid/high on RA. See flowsheet for further assessment.
06 Jun 03 0400	Pt. slept through entire shift. Po fluids encouraged. / Taking sips only. Temp 99.5 Med x1 w/Percs; effect. relief. & complaints voiced. Drsgs C,D,&I. HOB ↑. NGT clamped — [redacted] Eff/CPN.

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

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

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

All (b)(6)-2 (EXCEPT one at bottom)

AUTHORIZED FOR LOCAL REPRODUCTION

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

(0JUL) (1020) pt returned to bed c̄ mental assist; labs returned & reviewed by MD; new orders transcribed & copied for Rx; [redacted]
CTM

(1200) no change in assessment sts; no change in amt in colostomy bag; continues NPO [redacted]

(1600) IUF ↓ to 50cc/hr; no change in sts or assessment [redacted]

06 Jul 03 1730 Rec'd pt alert/coherent. HOB↑. See flowsheet for assessment. Care plan reinforced; act. level, diet, IV fluids, meds/pain control; needs reinforcement. ⊕ air/drainage in colostomy bag. IV ↓ 50cc/h [redacted] SgT/CPR

7/JUL/03 0500 ASSUMED CARE. REPORT GIVEN. SEE FLOWSHEET FOR INITIAL ASSESSMENT. [redacted] R
0630 DRSG D'ED TO MIDLINE ABDS & WOUND C̄ SCANT AMT OF OOZING & SERUSANGUIS NOTED. MIDLINE DRSG INTACT. COLOSTOMY AREA CLEANSED, NOTED C̄ BROWNISH STOOL. STOMA PINK 2¼ in in diameter. PLACED A NEW COLOSTOMY BAG. LEG DRSG CLEANSED, REMOVED, NEW DRSG [redacted] R
0730. UPDATED DR [redacted] ON PT'S STATUS [redacted] R

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

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

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
7/7/03	0815 cl. liquid diet given. Tolerated well w/ difficulty. Colostomy noted w/ liquid brown stool (b)(6)-2 [redacted] 1000 denies any pain @ this time (b)(6)-2 [redacted] 1215. Tolerated lunch meal w/ difficulty. Advance diet (b)(6)-2 [redacted] 1430 VSS. Ø distress noted @ (b)(6)-4 [redacted] time [redacted] 1600 colostomy bag emptied of loose liquid stool, brown color. Transfer @ bedside to Eyeline procedure (b)(6)-2 [redacted] 1630 Foley emptied. VSS. Ø distress noted (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

7/11/03

PROGRESS NOTES
Medical Record

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

All (b)(6)-2 (EXCEPT bottom one)

AUTHORIZED FOR LOCAL REPRODUCTION

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

8 Jul

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0500	Assumed care of pt. A/O x3, follows commands. LR infusing into (R) FA @ 100cc/hr, patent. Dressings to both UE & abdomen, midline. All CDI. + 2 radial pulses. Colostomy bag, intact & draining well. Foley to gravity draining yellow urine. Ø complaints to this time, resting well. Remains NPO due to scheduled to go to OR today. Will monitor [redacted] 9W
0700	Pt. resting quietly. Ate breakfast @ 0530, tolerated well. Ø complaints. Ø S/S of distress. Will continue to monitor [redacted]
0900	Ø change in pt. status, awaiting O.R. [redacted] 9W
1100	Pt. to O.R [redacted] 9W
1215	Pt. arrives from O.R., vasoactive drip. Dressing to abdomen (remains open) Dressings to
1400	Pt. rest quietly c Ø complaints. Ø distress noted [redacted] 9W
1700	Will brief oncoming shift. Ø change in assessment [redacted] 9W
1850	Pt Received, Physical assessment, Completed + Recorded on Flowsheet [redacted] CPT/AN
1-9-03 0224	Pt had large liquidy, Black Stool. Stool emptied + Noted to smell like Blood. [redacted] CPT/AN
0402	AM Labs drawn [redacted] CPT/AN

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

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9/11/03 0500 Assumed care. See Tour I Flow Sheet for initial assessment. 0640 pt awake. denies any pain/distress @ this time. 0830 pt eat breakfast meal. Ambulate well. 1040 ambulated to chair. Ambulated well. [redacted]

9/11/03 Surgery [redacted] (b)(6)-2

Pt stable post op

VSS

Abd soft, NT, ND + BS

Pt stable

Plan to ward [redacted] (b)(6)-2

(b)(6)-2

9/11/03 1230 remains sitting up. emptied colostomy bag. Area cleansed [redacted]

1400 pt back to bed.

1600 colostomy bag fed. Around site area cleansed [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			S[redacted]ER
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1O)
USAPA V1.00

All: (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Jul 03	Surgery USS [redacted] Wounds healing well NL in A.m. [redacted]
10 Jul 03	0500 Assumed care. Report given see TCU-2 flowsheet for initial assessment. [redacted] JR 0820 DC'ed Foley. Urinal given, voided [redacted] 0940 Void amber UOP in urinal 3 difficulty. [redacted] JR 1310 pt assisted ostomy emptying & care. bed bath given, assist c care. [redacted] JR 1700 Rpt received [redacted] [redacted]
11 July	0815: A/O; USS; colostomy draining; surgical sites CDI; tolerating diet; ambulating [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

558-103 (See Instructions on Back of [redacted] NSN [redacted]

(b)(6)-2

EMERGENCY CARE AND TREATMENT
(Medical Record)

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

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
4	Jul	03	0900

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

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED
- [ ] PATIENT
- [ ] C

ALLERGIES: NKDA

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

HOME TELE. NO. (In

(b)(6)-4

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

SEX: M

AGE: [redacted]

POSSIBLE THIRD PA
- [ ] YES

VITAL SIGNS			
TIME	0900	0930	
BP	137/87		
PULSE	97	94	
RESP.	24	20	
TEMP.	99.3		
WT. (Child)	55kg	98%	

96%

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

ORDERS	INITS.	TIME
IVF's	[redacted]	0905
CBC, UA, PT, PTT,	[redacted]	0905
Chem 12/Lytes, T&S		
X-ray thm & Elb	[redacted]	0925
Bilateral PA+LAT		
(L) US femur PA+LAT		

ASSESSMENT/DIAGNOSIS

(b)(6)-2

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

TIME SEEN BY PRO

(b)(6)-4 [redacted] 40 ♂ Iraqi S/p GSW's to abdomen, upper arms bilaterally & (L) femur. Nasal trumpet to (R) nare. A+O, sleepy + arousable. IV to (L) wrist. Foley to gravity c clear yellow urine, drained 700cc. Abd. wound Midline R/T GSW packed c̄ gauze & covered c̄ OPsite. NGT to (L) nare. Bilat. UE's GSW's, (L) upper & LE (femur) c̄ wound c̄ penrose drain

See abbreviated medical record

DISPOSITION (Check all that apply)			
HOME		FULL DUTY	
QUARTERS			
24 Hrs.		48 Hrs.	72 Hrs.
MODIFIED DUTY UNTIL:			
DAY	MONTH	YEAR	
REFERRED TO (Indicate clinic)			
EMERGENCY		TODAY	
72 HOURS		ROUTINE	
ADMIT. TO HOSP. UNIT/SERVICE			

CONDITION UPON RELEASE	
IMPROVED	UNCHANGED
DETERIORATED	

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitatio plans)

DATE: 4 July PATIENT ASSESSMENT [redacted] (b)(6)-2 PATIENT ASSESSMENT

TIME: 1030 SIGNATURE: [redacted] TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES	
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	
Skin: Temperature	warm
Color: Pale / Cyanotic / Jaundiced	appropriate for race
Mucous Membranes: Moist / Dry / Cracked	
Skin Breakdown: None Location:	Size:
NEUROLOGICAL	
Loc / Alert / Lethargic / Unresponsive	to voice GCS:
Orientated / Disoriented Pupils:	2mm sluggish
Extremity Movement: Full / Limited / None	
CARDIOVASCULAR	
Pulse (0 - 4): Radials	2+ Pedals 2+
Capillary Refill: <3 Seconds	Homan's Sign
Jugular Venous Distension	Edema
Heart Sounds	S1 S2 RUSB edema
Rhythm PRI:	QRS:
Vascular Catheter Central / Arterial / Peripheral 1 / Peripheral 2	
Waveforms	
Site	RFA
Solution	CR
Chest Pain	
RESPIRATORY	
Chest Expansion / Symmetrical / Asymmetrical	
Respiration / No Distress / SOB / Labored / Use of Access Muscles	
Breathing Patterns:	eu
Cough: Productive / Nonproductive / None	
Sputum: Color / Amount / Consistency / Odor	
Chest Drainage System Gravity:	Suction cm:
Air Leak No Yes	Crepitus
Character of Drainage:	
Trachea / Midline / Deviated (R) / Deviated (L)	
Artificial Airway Size: Type:	Position:
Breath Sounds / Anterior/Location / Posterior/Location	
Crackles	CTA Bilat
Wheezes	
Diminished	
Absent	
GASTROINTESTINAL	
Abdomen: Soft / Firm / Hard / Distended	cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	
Dressings:	
NG Tube: Clamped/Inter/Suction/Cont. Suction/Dependent Drainage	
NG Drainage: Color	Character
Tube Feeding: Day No: Strength:	Rate: Aspirate:
Stool: Character	
Drains:	colostomy pink strong
GENITOURINARY	
Urine Color:	amber Character: clear
Voiding: Continent / Incontinent /	Catheter PCA
EMOTIONAL/PSYCHOSOCIAL	
Sedated & intubated & sleeping	
Pain controlled	
OTHER:	

SKIN AND MUCOUS MEMBRANES	
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	
Skin: Temperature	warm
Color: Pale / Cyanotic / Jaundiced	NR
Mucous Membranes: Moist / Dry / Cracked	
Skin Breakdown: None Location:	Size:
NEUROLOGICAL	
Loc / Alert / Lethargic / Unresponsive	GCS:
Orientated / Disoriented Pupils:	2mm PERRL - sluggish
Extremity Movement: Full / Limited / None	
CARDIOVASCULAR	
Pulse (0 - 4): +3x4 Radials	Pedals
Capillary Refill: <3 Seconds	Homan's Sign
Jugular Venous Distension	Edema
Heart Sounds	S1 S2 NR
Rhythm PRI:	QRS:
Vascular Catheter Central / Arterial / Peripheral 1 / Peripheral 2	
Waveforms	
Site	RPA
Solution	LR
Chest Pain	
RESPIRATORY	
Chest Expansion / Symmetrical / Asymmetrical	
Respiration / No Distress / SOB / Labored / Use of Access Muscles	
Breathing Patterns:	CTA
Cough: Productive / Nonproductive / None	
Sputum: Color / Amount / Consistency / Odor	
Chest Drainage System Gravity:	Suction cm.
Air Leak No Yes	Crepitus
Character of Drainage:	
Trachea / Midline / Deviated (R) / Deviated (L)	
Artificial Airway Size: Type:	Position:
Breath Sounds / Anterior/Location / Posterior/Location	
Crackles	Coarse
Wheezes	
Diminished	
Absent	
GASTROINTESTINAL	
Abdomen: Soft / Firm / Hard / Distended	NDA cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	
Dressings:	Colostomy - Ø OR
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	
NG Drainage: Color	Character
Tube Feeding: Day No: Strength:	Rate: Aspirate
Stool: Character	
Drains:	
GENITOURINARY	
Urine Color:	Character:
Voiding: Continent / Incontinent /	Catheter
EMOTIONAL/PSYCHOSOCIAL	
OTHER:	

MIDLINE ADD INC - C/D/I

Date 4 Jul 03 Bed # 3

Patient's Name: EPW# [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP						158/67	154/64	148/70	121/45	147/88	147/64	148/78	158/78	135/67	137/64	140/70	147/72	145/71	140/50	151/54	153/62	143/46	157/67	136/67
TEMP						99.1	99.1				99.2													
HR						91	92	90	89	91	92	95	97	99	97	100	102	101	98	110	102	103	106	104
RR						17	18	16	16	15	15	15		17	18	15	15	15	16	12	16	18	19	19
SAO2						100	100	99	99	100	97	99		99	98	100	100	100	100	99	100	100	98	100
FIO2														RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO																								
IV LR						150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
NGT																								
Foley						10	10	10	10	10	8	8	8	8	7	7	7	7	7	7	7	7	7	7
TURN Q 2																								
Abx IV															100	100		100		100				100
TOTAL																								
OUTPUT																								
URINE						300	300	150	150	200	250	100	100	200	175	150	200	250	250	100	100	100	100	100
NGT											100										200		250	
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 13590

DATE 05JUL03

PATIENT ASSESSMENT

TIME: 0600 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

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

NEUROLOGICAL

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

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials --- Pedals 1
Capillary Refill: <3 Seconds Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1S2
Rhythm ST Sectopy PRI: QRS:

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

Chest Pain Ø

RESPIRATORY

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

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: Sterile - colostomy pouch
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: amber Character: clear
Voiding: Continent / Incontinent / Catheter FTG

EMOTIONAL/PSYCHOSOCIAL

OTHER: pt remains [illegible] drip 30mg/hr. tKO [illegible]

PATIENT ASSESSMENT

TIME: 1740 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

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

NEUROLOGICAL

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

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals Strong right only
Capillary Refill: <3 Seconds Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1S2 only
Rhythm ST Sect PRI: QRS:

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

Chest Pain Ø

RESPIRATORY

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

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: RUE / RLE Cyd, TI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage clamped
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: Cl
Voiding: Continent / Incontinent / Catheter FTG

EMOTIONAL/PSYCHOSOCIAL

OTHER: colostomy bag secured/clean + empty
dermal moist/pink. Ø I/S/S of inf. noted

[redacted] (b)(6)-4

100#1

Date 05JUL03 Bed #

Patient's Name (b)(6)-4 [redacted] 136

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	135/79	123/75	121/42	140/58	64/63	156/68		129/47	100/57		85/20	OR	137/99	146/65	165/66	165/93	153/70	125/59	131/57	146/80	135/74	138/66	134/64	136/72
TEMP		99.8		100.9		100.7					100.5		99	101.2		101.3		101.3		101.0		99.4		99.5
HR	105	110	111						111		111		112	110	110	114	86	83	119	110	108	102	99	96
RR	19	19	21	20	20	25		21	20		21		19	20	20	16	16	18	20	17	18	18	16	18
SAO2	98	100	98	97	98	95		96	96		99		96	96	96	96	96	97	96	96	96	97	96	96
FIO2	RA	RA	RA	RA	RA	RA		RA	RA		RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT	150																							
PO																								
IV (U2)	150	150	100	100	100	100	100	100	100	100	100		100	125	125	125	125	125	60 125	60 125	125	125	125	125
NGT																								
ABX		100	100																					
TURN Q 2																								
Sent	7	7	7	7	7	7	7	7	7	7	7		7											
TOTAL																								
OUTPUT																								
URINE	100	120	120	40	50	150	100	125	95									900 emptied						700 emptied
NGT																								
TOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 13592

Date 06/11/07 (b)(6)-4 ICU 1

EPW [redacted]

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES
Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:
NEUROLOGICAL
Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None
CARDIOVASCULAR
Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:
Vascular Catheter Central Arterial Peripheral 1 Peripheral 2
Waveforms
Site
Solution
Chest Pain
RESPIRATORY
Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL
Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:
GENITOURINARY
Urine Color: Character:
Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL
OTHER:

PATIENT ASSESSMENT (b)(6)-2

TIME: 1730 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES
Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature warm
Color: Pale / Cyanotic / Jaundiced NPR
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:
NEUROLOGICAL
Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None
CARDIOVASCULAR
Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø Ø
Heart Sounds
Rhythm NSR ST PRI: QRS:
Vascular Catheter Central Arterial Peripheral 1 Peripheral 2
Waveforms
Site RFA patent + benign
Solution
Chest Pain Ø
RESPIRATORY
Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: even
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Ø Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CB
Diminished		
Absent	Vat Bases	

GASTROINTESTINAL
Abdomen: Soft / Firm / Hard / Distended NT/ND cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: BUE, L thigh, Midline C, D & I
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:
GENITOURINARY
Urine Color: yel Character: cl
Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL
OTHER: colostomy bag removed + empty.

MS04 5

Date 06 Apr Bed [redacted]

Patient's Name [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		110/64				151/73	161/63	163/80	124/48	123/45	124/44	132/50	139/50	143/61	141/60	132/61	131/60	120/60	140/67	145/71	136/67	145/71	142/72	155/76
TEMP		98.6														99.5				99.9				99.9
HR		96				94	109	101	104	104	103	106	104	102	93	91	96	90	97	100	94	90	96	93
RR		20				20	23	12	12	14	12	16	16	17	16	18	18	18	18	18	16	19	18	17
SAO2		97%				97%	95%		95%		92%	98%	98	100	100	100	100	100	100	100	100	100	100	99
FIO2		RA				RA	RA	RA	RA	RA	RA	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	RA	RA	RA
											100.6													
INPUT UR	125	125	125	125	125	125	125	125	125	125	125	125	125 50	50	50	50	50	50	50	50	50	50	50	50
PO				50																				
IV																								
NGT			D/C																					
IVPB				50							100			100				100		100				
TURN Q 2																								
											IN (1700)													
TOTAL																								
OUTPUT		GAD				200	100	100	60	160	180	70	60	60	40	30	50	50	60	60	100	100	200	100
URINE												(1470) +LOST												
NGT																								
TOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 13594

DATE: 07 Jul 03 PATIENT ASSESSMENT [redacted] (b)(6) -2 PATIENT ASSESSMENT

TIME: SIGNATURE: [redacted] SIGNATURE:

SKIN AND MUCOUS MEMBRANES	SKIN AND MUCOUS MEMBRANES
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 97.3	Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced	Color: Pale / Cyanotic / Jaundiced MCR
Mucous Membranes: Moist / Dry / Cracked	Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:	Skin Breakdown: None Location: Size:
NEUROLOGICAL	**NEUROLOGICAL**
Loc: Alert / Lethargic / Unresponsive GCS:	Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:	Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None	Extremity Movement: Full / Limited / None
CARDIOVASCULAR	**CARDIOVASCULAR**
Pulse (0 - 4): +2 Radials +2 Pedals	Pulse (0 - 4): +3 x 2 Radials +3 Pedals +3
Capillary Refill: <2 Seconds Homan's Sign (-)	Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension: Edema	Jugular Venous Distension: Ø Edema
Heart Sounds: [illegible]	Heart Sounds: S1 S2 - NSR → ST
Rhythm: NSR 90 - 110 PRI: QRS:	Rhythm: regular PRI: QRS
Vascular Catheter: Central Arterial Peripheral 1 Peripheral 2	Vascular Catheter: Central Arterial Peripheral 1 Peripheral 2
Waveforms: [redacted]	Waveforms: [redacted]
Site: [illegible]	Site: (R) ACF LR
Solution: [illegible]	Solution: (L) PA M
Chest Pain	Chest Pain
RESPIRATORY	**RESPIRATORY**
Chest Expansion / Symmetrical / Asymmetrical	Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles	Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg.	Breathing Patterns: Reg.
Cough: Productive / Nonproductive / None	Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor	Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:	Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus	Air Leak No Yes Crepitus
Character of Drainage:	Character of Drainage: --
Trachea / Midline / Deviated (R) / Deviated (L)	Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:	Artificial Airway Size: Type: Position:
Breath Sounds / Anterior/Location / Posterior/Location	Breath Sounds / Anterior/Location / Posterior/Location
Crackles	Crackles
Wheezes: EES CTA	Wheezes: CTA S/L
Diminished	Diminished
Absent	Absent
GASTROINTESTINAL	**GASTROINTESTINAL**
Abdomen: Soft / Firm / Hard / Distended Rounded cm Girth 50 Incr	Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: mid line, abd desq c colostomy bag	Dressings: COLOSTOMY INTACT
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color: Character:	NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:	Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character: Brown liquid stool	Stool: Character: tel. yes dark
Drains:	Drains: Gr OU
GENITOURINARY	**GENITOURINARY**
Urine Color: dk yellow Character:	Urine Color: Lt Y Character: [illegible]
Voiding: Continent / Incontinent / Catheter	Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL	**EMOTIONAL/PSYCHOSOCIAL**
Appropriate	
OTHER:	OTHER:

07 Jul 03

[redacted] (b)(6) -4

Date 02 Jul 03 Bed # 3

Patient's Name: EPW [redacted] (b)(6)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		150/90	138/80	117/64	122/75	112/64	124/54	122/62	125/56	124/59	126/58	131/55	124/58	103/70	109/55	135/59	138/53	140/61	131/56	148/73	132/56	139/71	122/73	121/57
TEMP	97.5	98.6	98.8	98.7																				
HR		86	88	87	101	95	88	97	95	97	97	99	96	93	94	90	84	85	88	85	82	86	93	82
RR		20	14	13	19	16	14	15	13	17	17	16	22	22	18	12	12	19	15	14	14	18	20	14
SAO2		100	100	100	100	100	100	100	100	100	100	100	100	98	100	100	100	100	100	100	99	100	100	100
FIO2		44																						
INPUT										400				400	400	400	400	400	400	100	100	100	100	100
PO				340				340				340	340	400										
IV					100	50		100					350	100										
NGT																								
TURN Q 2																				97.9				
TOTAL													970											
OUTPUT																								
URINE		300	100	250	300	300	100	100	125	150	100	200	125	160	270	120	130	80	100	70	60	40	50	100
NGT																								
STOOL		colostomy								300			300		300									
OTAL																								
BALANCE																								
Initials																								

1220 / 2925

900

GOU IV-IN CARE

MEDCOM - 13596

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Jul 03	DC Summary (b)(6)-2
	[redacted] 20 mos PDD # [redacted] for GSW to Abdomen
	(b)(6)-2 small bowel + colon injury c̄ colostomy
	+ Delayed primary closure of all wounds including
	extremity wounds. Patient doing well s̄
	problems + normal vital signs
	DX: 1-GSW to Abdomen s/p colonic resection
	& diverting colostomy + treatment's
	2 - Repair of enterotomies
	3 - GSW to B/L UE + LLE s/p washout
	& bone injuries
	Treatment: 1 will need sutures & staples removed
	~ 20 Jul 03
	2 basic ostomy care - patient training
	3 - T3 1-2 po q4h prn pain (b)(6)-2 [redacted]
	4 Colace 100 g po BID
	(b)(6)-2
11 Jul 03	Ostomy care given; demonstrated by pt; pt ready to chow,
	ambulating; no s/s of distress — (b)(6)-2 [redacted]

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

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

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

[redacted] (b)(6)-2

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: [redacted] (b)(6)-4

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
See H&P

4. PROPOSED SURGICAL PROCEDURE:
I + D (L) Thigh (B) Arms

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

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

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

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

(b)(6)-2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since [redacted] ! Jewelry Removed
! LHCG/LMP [redacted] ! Body Pierce Removed
! Consent/Blood Transfusion
! Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon (L) Thigh (B) Arm
! Contact Precautions (Y) (N)
! Family/Friend: NONE

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

10. OR [redacted] /ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/AN 5 Jul 03 DATE

11. POS[redacted]ON:
LEVEL OF CONSCIOUS[redacted]S: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: [redacted] Moves All Extremities ☐ Moves Upper Extremities
[redacted] sferred to liter with roller due to spinal

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

12. PREOPER[redacted]ED BY
(Signature and [redacted] CPT/A BY (Signature and Title)

DATE: 5 Jul 03 TIME: [redacted] 0740 (b)(6)-2 DATE: TIME:

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECORD | **INTRA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY [redacted] (b)(6)-2

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

3. DATE 3 July 03 TIME PATIENT ARRIVED IN SUITE 2030

4. PATIENT IN ROOM TIME 2030 (b)(6)-2 NUMBER [redacted]

5. PREOPERATIVE EMOTIONAL STATUS (b)(6)-4

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

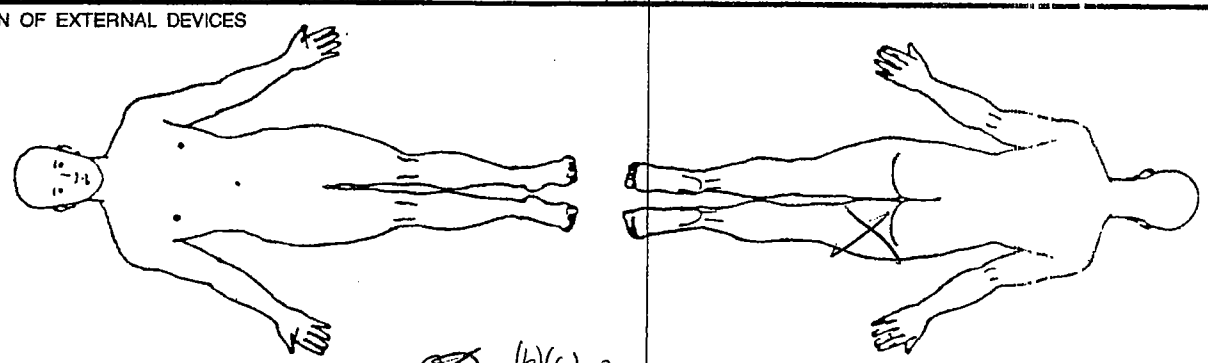
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: ABD + (L) thigh BY WHOM: Cpt [redacted]
SITE: (R) Arm (L) Arm BY WHOM: Cpt [redacted]

COMMENTS: (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Initial Count	Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No	[redacted]				[redacted] (b)(6)-2	[redacted] (b)(6)-2
Needle Sharp	☒ Yes	☐ No						
Instrument	☒ Yes	☐ No						
Other	☐ Yes	☐ No						

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

[redacted] (b)(6)-4

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

☒ ESU NO: F1043
GROUND PAD: BRAND Valleylab
LOT NO: [redacted] (b)(6)-4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☒ NO IF YES NAMI R; MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

6l NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

	1.	2.	3.
TYPE/SIZE	1 5/8 Penrose		
SITE	(L) thigh		

18. DRESSING/IMMOBILIZATION (Specify)

4X8 Iobaan
Xeroform Fluffs Kerlix
Colostomy

19. ADDITIONAL INFORMATION

DR [redacted] LTC
DR. [redacted] MAJ (b)(6)-2
Anes - [redacted] LTC - Gen

20. OPERATION(S) PERFORMED

Exploratory Lap, Small Bowel Resection x2

21. PATIENT TRANSFERRED TO ICU TIME METHOD

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

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 386-733/23952

MEDICAL RECORD

INTRAO[illegible]TIVE DOCUMENT

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

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

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

3. DATE: 5 Jul 03 TIME PATIENT ARRIVED IN SUITE: 1549

4. PATIENT IN ROOM TIME: 1549 NUMBER: 1-1 5th

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: uncomfortable-moaned

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

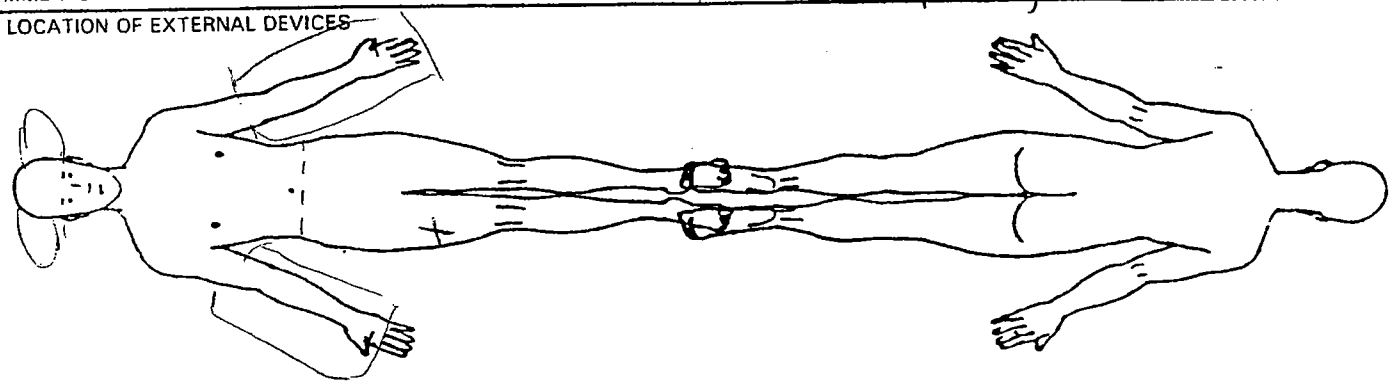
COMMENTS: Proper body alignment

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)*
SITE: (L) thigh BY WHOM: CPT [redacted]
SITE: BY WHOM: (b)(6)-2
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect in. tial -

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	[redacted]		[redacted]	PFC [redacted] / SGT [redacted]	CPT [redacted]
Needle Sharp	☐ Yes ☐ No		(b)(6)-2			
Instrument	☐ Yes ☐ No				(b)(6)-2	(b)(6)-2
Other	☒ Yes ☐ No	[redacted]		[redacted]	PFC [redacted] / Sgt [redacted]	CPT [redacted]

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

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

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

☒ ESU NO: #4 Cut
GROUND PAD: BRAND Valleylab
LOT NO: [redacted] - (b)(6)-4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
0.9% NS [redacted] (b)(6)-2					

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPER[redacted]ING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Wet-dry Kerlix (L) & (R) arm &
(L) Thigh

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Kerlix	Kerlix	Kerlix
SITE	(L) Arm Kerlix[redacted]	(R) Arm Kerlix[redacted]	(L) thigh

19. ADDITIONAL INFORMATION

F/C in place on arrival

Maj. [redacted]
CPT [redacted]
Col. [redacted]
(b)(6)-2 (b)(6)-2

(L) & (R) arm cleaned w/ H_2O

20. OPERATION(S) PERFORMED
I & D (R) & (L) Arm
I & D (L) thigh

21. PATIENT TRANSFERRED TO (b)(6)-2 ICU 1 TIME 1638 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CP-1 AN

REVERSE OF DA FORM [redacted] 1, O [redacted] USAPA V1.01

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

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

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

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] (b)(6)-2

3. DATE 8 Jul 03 TIME PATIENT ARRIVED IN SUITE 1105

4. PATIENT IN ROOM TIME 1105 NUMBER 1-1 #3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Supine on padded OR table BUE on padded armboards <90°

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

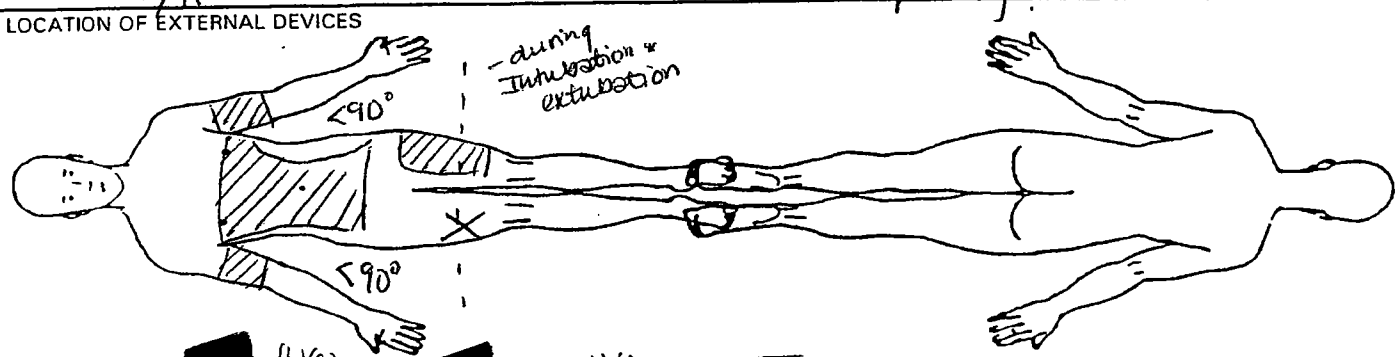
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Abdomen, BUE, BY WHOM:
SITE: ~~Rig~~ Left thigh BY WHOM:
(b)(6)-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



[redacted] (b)(6)-2 [redacted] N/A

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

Initial PFC [redacted] ILT

10. COUNTS (b)(6)-2

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	PFC [redacted] (b)(6)-2	1LT [redacted] (b)(6)-2
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted] (b)(6)-4

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

☒ ESU NO: #4 Cut: 30 Coag: 30
GROUND PAD: BRAND V2 Rem Poly Hesive II
LOT NO: [redacted] Exp 2004-11 (b)(6)-4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4X8 and Tape on all sites.
Ostomy bag Δ.

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

Patent Foley cath. & ostomy.

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Washout & DPC

21. PATIENT TRANSFERRED TO ICU 1 (b)(6)-2 TIME 1200 METHOD LITER O2

22. REGISTERED NURSE SIGNATURE [redacted]

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

(b)(6)-2

Ward/Section: 2MT | REQUESTING P[redacted] | LABORATORY RESULT FORM

S 21 10 1 rivacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 [redacted] | DATE: 4 JUL 05 | TIM: 0405 | SSN/PSEUDO SSN:

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	14.0	4.8-10.8 x 10^3
RBC	3.35	4.7-6.1 x 10^9
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.3	42-52% (M) 37-47% (F)
MCV	90.5	80-94 fl (M) 81-99 fl (F)
Plt	209	130-500 x 10^3 verified
Lymph %	7.2	20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis		
TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	trace	Negative
SG	1.020	N/A
Bld	trace	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

Coagulation Studies		
TEST	RESULT	REF. RANGE
PT	14.9	9.8-13.6 secs
APTT	25.1	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT

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

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 4 JUL 03 | TIME: 0905 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.8	3.5-5.5 g/dl
ALP	52	26-84 u/l
ALT	23	10-47 u/l
AMY	76	14-97 u/l
AST	63	11-38 u/l
TBIL	0.8	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	7.6	8.0-10.3mg/dl
CHOL	47	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	126	73-118 mg/dl
TP	5.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	135	128-145 mmol/l
K^+	4.5	3.3-4.7 mmol/l
CL^-	108	98-108 mmol/l
tCO_2	22	18-33 mmol/l

REMARKS:

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

DATE: 4-5 JUL 03

LAB ID NO.:

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

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 5 Jul 03 | TIME: 0400 | SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF
WBC	13.2	4.8-10.8 x 10^3	Color		N/A	RPR		Negati
RBC	3.48	4.7-6.1 x 10^9	App		N/A	Mono		Negati
Hgb	9.8	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	31.2	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	89.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	194	130-500 x 10^3 verified	SG		N/A	Occ Bld		Neg
Lymph %	14.6	20.5-51.1%	Bld		Negative	H. pylori		Neg
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinaly**		
RBC Morph			HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count			MUST SUBMIT SF 518 V EVERY UNIT REQUES	
Other			Directigen		Negative	ABO/Rh	

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

REMARKS:

REPORTED BY: (b)(6)-4 [redacted] | DATE: 5 July 03 | LAB ID NO.:

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

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

(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
GLU	104	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	2935	39-380 u/l (M) 30-190 u/l (F)
NA+	136	128-145 mmol/l
K+	4.2	3.3-4.7 mmol/l
CL-	99	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

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

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

REMARKS: [redacted] (b)(6)-4 lcv #2

REPORTED BY:

DATE: 5JUN03

LAB ID NO.:

[redacted] (b)(6)-2

Ward/Section: ICU #1	EQU[redacted]NG PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT R (Subject to the Privacy Act of
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 6 Jul 03 / TIME: 0835	SSN [redacted] SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.5	4.8-10.8 x 10^3
RBC	3.32	4.7-6.1 x 10^6
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.7	42-52% (M) 37-47% (F)
MCV	89.3	80-94 fl (M) 81-99 fl (F)
Plt	241	130-500 x 10^3 verified
Lymph %	20.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

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

Microscopic Urinalys

Blood Bank

MUST SUBMIT SF 518 W EVERY UNIT REQUEST

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMAT

REMARKS:

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

ICU #1

[redacted] (b)(6)-4

(i-STAT)		
TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	3.7	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BExcf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	10	8-26 mg/dl
GLU	106	70-105 mg/dl
Creat	0.7	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

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

(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

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

REMARKS:
Chem 7

REPORTED BY:	DATE: 6 Jul 03	LAB ID NO.: ICU #1

[redacted] (b)(6)-4

d/Section: Lab QUESTING PHYSICIAN: (b)(6)-4

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

ST, FIRST, MI: EPW [redacted] DATE: 07 Jul 03 TIME: 0400 SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.5	4.8-10.8 x 10^3
RBC	2.99	4.7-6.1 x 10^6
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.6	42-52% (M) 37-47% (F)
MCV	88.8	80-94 fl (M) 81-99 fl (F)
Plt	226.	130-500 x 10^3 verified
mph %	[redacted] 24.2	20.5-51.1%

Hematology) Manual Differential (b)(6)-2

gs		Mono	
nds		Eos	
mph		Baso	
yp		Imm	
BC orph			
m matocrit		42-52% (M) 37-47% (F)	
l Rate			
ner			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

EMARKS:

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

EPW [redacted] (b)(6)-4 04:00 Jul 03 ICU

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	85	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+	137	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	98	98-108 mmol/l
ICO_2	31	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
ICO_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
ICO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 7 Jan 03

LAB ID NO.:

(b)(6)-2

(COM) | REQUESTING PHYSICIAN: [redacted] (b)(6)-2 | LABORATORY RESULT F
(Subject to the Privacy Act of 1
(b)(6)-4 [redacted] | DATE 8 JUL 07 | TIME 0700 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3
RBC	3.13	4.7-6.1 x 10^9
Hgb	8.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	88.7	80-94 fl (M) 81-99 fl (F)
Plt	308	130-500 x 10^3 verified
Lymph %	31.0	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

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

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 V
EVERY UNIT REQUEST

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WHEN EVER UNIT OF BLO
REQUESTED

UNIT	TYPE	CROSSMA

REMARKS:

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

Ward/Section: ICU *

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

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 8 JUL

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		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	115	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	773	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

DATE: 8 Jul 03

LAB ID NO.:

/Section: ICU # 1 | UESTING PHYSICIAN: [redacted] (b)(6)-2

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

, FIRST, MI. [redacted] EPW # [redacted] (b)(6)-4

DATE	TIME	SSN/PSEUDO SSN
7/9/03	0400	[redacted] (b)(6)-4

[redacted] (b)(6)-2

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

Misc. Chemistry

F	RESULT	REF. RANGE
n-l		
of		

(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	94	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	716	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	4.0	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

RKS:

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

on: KU #1 | REQ | PHYSICIAN: [redacted] (b)(6)-2

ST. MI. EPW [redacted] (b)(6)-4 | DATE 7/9/03 | TIME 0400 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

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

(Hematology) CBC

RESULT	REF. RANGE
5.9	4.8-10.8 x 10^3
2.78	4.7-6.1 x 10^6
7.7	14-18 g/dl (M) 12-16 g/dl (F)
24.7	42-52% (M) 37-47% (F)
89.1	80-94 fl (M) 81-99 fl (F)
354	130-500 x 10^3 verified
28.7	20.5-51.1%

ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	

	42-52% (M) 37-47% (F)

Coagulation Studies

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

Urinalysis

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

CSF

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	

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

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

ICU#1 [redacted] (b)(6)-2

EPW# [redacted] (b)(6)-4 7/10/03 0345

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

SSN PSEUDO SSN:

(Hematology) CBC

RESULT	REF RANGE
	1.5-10.8 x 10³
	4.7-6.1 x 10⁶
	11-18 g/dl (M) 12-16 g/dl (F)
	42-52% (M) 37-47% (F)
	80-94 fl (M) 81-97 fl (F)
	1.6-5.8 x 10⁶ verified
	20.5-51.1%

(Hematology) Manual Differential

Mono	
Lym	
Baso	
Imm	

	12-52% (M) 37-47% (F)

Coagulation Studies

RESULT	REF RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ng/ml
	<10 ng/ml

Urinalysis

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

CSF

Cell Count		
Direct gen		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

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

NS:

ED BY: (b)(6)-2 DATE: LAB ID NO:

/Section: ICU #1

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

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

, FIRST, MI. EPW #[redacted] (b)(6)-4

DATE 7/10/03 TIME 0345 SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

T	RESULT	REF. RANGE
n-1		
of		

(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

(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

======= PICCOLO =======
10/07/03 04:45
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-4 [redacted]
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #(b)(6)-4 [redacted]

GLU	84	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	464*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

ARKS:

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

O.:

ID: [redacted] (b)(6)-4 10-07-03
WB 04:06

			Patient Limits	
WBC	6.6	x10^3/uL	4.5	10.5
RBC	2.87 L	x10^6/uL	4.00	6.00
Hgb	8.0 L	g/dL	11.0	18.0
Hct	25.7 L	%	35.0	60.0
MCV	89.4	fL	80.0	99.9
MCH	27.8	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	415.	x10^3/uL	150.	450.
LY%	37.0	%	20.5	51.1
LY#	2.5	x10^3/uL	1.2	3.4

2030 = Omnisyn - 3gm

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS											
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION											
DRUG	Dose										
Ti-S	( )	200									
SUX	( )	100									
Fent	( )		2	2	1		2			1	
Vec	( )		5		2	3			2		
	( )										
	( )										
VOLAT AGENT 200	% del	1	1.5	2.5	1.5	1.5	1.5		1.5	1.5	1.5
	% e.t.										
AIR	L/Min										
N2O	L/Min										
O2	L/Min	5	5	5	5	5	5		5	5	5
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		Omnisyn 3gm									
FLUIDS: LINE size 18	☐ Warmed	300		800	1000		1300		1400		
16	☐ Warmed	300		1000	1200		1400		1600		
	☐ Warmed										
	☐ Warmed										
LOSSES: EST BLOOD LOSS											
URINE			150				250				

TOTALS — TOTAL EBL — TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID– COLLOID– BLOOD–

REMARKS – Code drugs with numbers, events with letters

2030 pt brought directly to OR.
2100 - NGT placed
Drawn (+) yellow fluid returned.

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

BODY WEIGHT: 7 KG / LB

HEMATOCRIT:

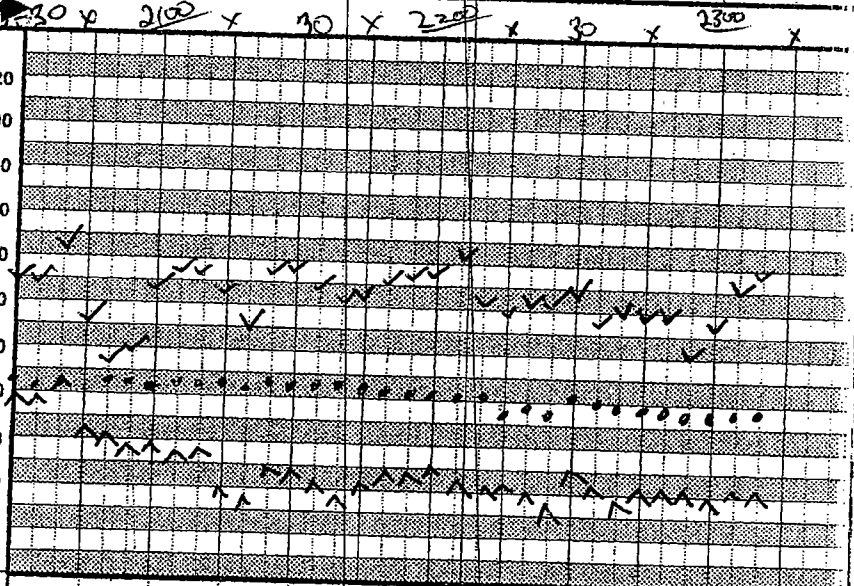
INITIAL DATA: BP – 130/80; HR – 78

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? yes; TIME – 2030

TIME → 1930 x 2100 x 30 x 2200 x 30 x 2300 x

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



VENTILATION											
VT – ml											
f – breaths/min		10	10	10	10	10	10	10	10	10	
Peak inf pres / PEEP											
MODE – S(pon), A(ssist), C(on)											
BP/Auto Cuff	ET CO2 (ton)	32	30	28	32	30	31	35	32	31	30
BP / oth	FIO2 (Frac or %)	.6	.6	.6	.6	.6	.6	.6	.6	.6	
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site										
	N-M Block (T/4)			4/4		2/4		4/4	4/4		2/4
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → D

RECOVERY AT PACU / ICU (Specify) 0034

CITIER

CONDITION: TEMP – 95 SpO2 – 100; BP – 161/78 HR – 91

PROCEDURE TIMES

	Start	Room	End
PREP	2030	2030	
	Ready	Begin	End
PROC	2045	2107	0014

PROCEDURES and CPT Codes: Exp Lap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x1, view Grade I, 8.0 ETT x1 BS=BL. ETCO2 ✓ BSL ETT taped @ 24 cm teeth eyes taped.

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

SURGEONS: [redacted] A1

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

PROCEDURE LOCATION: OR

DATE: 3/20/03

MEDICAL RECORD — ANESTHESIA

PAGE 1 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)					
	Fent	cc ( )	75				
		( )					
		( )					
	MS04	mg ( )	2	2	2		
		( )					
		( )					
	VOLAT AGENT: ISO	% del	1	1	1	X	
		% e.t.					
	AIR	L/Min					
	N2O	L/Min					
	O2	L/Min	5	5	5	5	5

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

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

FLUIDS			
LINE site (L)	☐ Warmed	170	2000
(R)	☐ Warmed	2000	2200
	☐ Warmed		
	☐ Warmed		

LOSSES		
EST BLOOD LOSS	100	
URINE –	250	350

TIME →	15	30	X	2400	X	30

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
- BP (transduced): ⊥ T
- TOURNIQUET: T – ✗
- ANES – X-X
- PROC – ⊙ – Ø

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

VENTIL						
	VT – ml					
	f – breaths/min	10	20	21	18	18
	Peak inf pres / PEEP					
	MODE – S(pon), A(ssist), C(on)	A	A	S	S	S
MONITORS / ACCESSORIES	BP/Auto Cuff	ET CO2 (torr)	35	39	45	44
	BP / oth	FIO2 (Frac or %)	.59	.6	.6	.6
	ART line	SpO2 (%)	100	100	100	100
	Steth- PC/ES	ECG	SR	SR	SR	SR
	Gas analyzer	TEMP- site				
		N-M Block (T/4)	4/4			4/4 sust tet.
	Warming blkt					
	Conv warmer					

TOTALS	
500	TOTAL FLUID
6	TOTAL URINE

FLUIDS SUMMARY
CRYSTALLOID –
COLLOID –
BLOOD –

REMARKS –
Code drugs with numbers, events with letters

0005 – mouth suctioned
0025 – extubated & awake, responds to verbal command.

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

PROCEDURES and CPT Codes: Exp Lap. Small Bowel Resec x2, colectomy transverse & Ⓓ colon resection, colostomy.

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: ITD GSW Ⓛ thigh & DVE & RVE Drain Ⓛ thigh

Frag: O → (b)(6)-4 [redacted]

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

All (b)(6)-2

SURGEONS: [redacted]

ANESTHETISTS: [redacted] LTC CRNA

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____

CONDITION:

RESP – SpO2 –

BP – HR –

ANES	Start	Room	End

PROC	Ready	Begin	End
			0014

PROCEDURE LOCATION: OR

DATE: 3 Jul 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

☆ U.S. GPO: 1999 – 528-336/10085

MEDCOM - 13622

MEDICAL RECORD — ANESTHESIA

DRUG	(Holder)	
INFRSED	(mg)	2
Fentanyl	(µg)	3
propofol	(mg)	150
Succ	(mg)	80
	( )	
	( )	
VOLAT AGENT Sevo	( )	
	% del	1.5 — X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 – 2 – 8

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

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

LINE site		
LL	☐ Warmed	300
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE – Foley

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: ~70 (KG) LB

HEMATOCRIT: 9.8/31.2

INITIAL DATA: BP – 120/57; HR – 111

CHIP CHECK: OK? – (✓) N

PATIENT REVIEWED: OK for PROCEDURE – yes; TIME – 1545

TIME → 1545 1600 X 30

SYMBOLS: BP by cuff (V); 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

VT – ml	200	300	400	
f – breaths/min	9	10	15	
Peak inf pres / PEEP				
MODE – S(pon), A(ssist), C(on)	S	S	S	S
ET CO2 (torr)	45	45	41	44
FIO2 (Frac or %)	.85	.85	.85	.85
SpO2 (%)	100	100	100	99
ECG	ST	ST	ST	ST
TEMP- site				
N-M Block (T/4)	Avent			

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 → [redacted] (b)(6)-2

TOTALS	
TOTAL FLUID	min
TOTAL URINE	200

FLUIDS – SUMMARY: CRYSTALLOID – 400; COLLOID – 0; BLOOD – 0

REMARKS – Code drugs with numbers, events with letters

Emergence ; delay (+) spont Resp, Extubated (suction prior)

RECOVERY AT 1645; PACU (ICU) (Specify); OTHER

CONDITION: 10/2 LLFM; RESP – 20; SpO2 – 95; BP – 134/71; HR – 117

ANES	Start	Room	End
	1545	1600	1650
PROC	Ready	Begin	End
	1610	1615	1625

PROCEDURES and CPT Codes: I&D (L) leg wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA; Eyes taped

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SIV1, DVOE x1, atraumatic, cuff, T, BS = BS

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: H [redacted] EPW (b)(6)-4 FCU1

SURGEONS:

ANES[redacted]ts: (b)(6)-2 [redacted] MAS, CRNA

PROCEDURE LOCATION: OR #1

5 Jul 03

(b)(6)-4 HESIA PLAN OF CARE P... ROCEDURAL ASSESSMENT (Sedation/Anesthesia)

[redacted] DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

ED PROCEDURE: I&D (R) knee / Drsg A both arm's

L SERVICE: ortho

CE: JMU

ASA Physical State 1 2 3 4 5 E

WT: ~70 KG/LB HT: ____ IN.

ALLERGIES: NKDA

CO: 7

OH: ____

GS: 1

T MEDICATIONS:

red as premed

Fent drop

Tugnut

Cefotetan

CATIONS:

(@ ____ Hrs) /CC

____ mg IV IM PO

____ mg IV IM PO

____ mg IV IM PO

TORY STUDIES:

9.8, 31.2

13.2 WBC

194 K

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

See previous pre-op on 3 Jul 03

GSW both Arms & (L) Leg

ASSESSMENT

PAST SURGICAL/ANESTHETIC

ex lap

Colostomy

I&D (GSW)

3 Jul 03

PHYSICAL EXAMINATION

BP 120/58 HR 111 R 20 T ____ 96% RA

Pain Scale 0-10 ____

HEENT - Teeth poor dentition

Trachea midline

TMJ/Neck 73 FP

Oropharnyx Grade II

Nares ____

CHEST: ____

CARDIAC: ____

EXTREMITIES: ____

IV Access: #16G (R) Arm

Ulnar Filling: ____

BACK: ____

OTHER: ____

NPO Since JMU

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

No interpreter present

D CONSENT/COUNSELING STATEMENT: Plans, alternative[redacted]s of anesthesia including death have been explained to a l with the patient/legal guardian.

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

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

Date: 5 Jul 03 Time: 1545 Hrs

ESTHESIA EVALUATION AND NOTE (NON ASU)

PARENT ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

entification: (Ward) ____

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

ICU, ICU,

SEDATION KEY:

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

ICU I
NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)
Midazolam	(MG)
Propofol	(MG)
Succ / Zemuron	(MG)
	( )
	( )
	( )
VOLAT AGENT	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

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

TOTALS	
TOTAL FLUID	Min
TOTAL URINE	600

FLUIDS – SUMMARY
CRYSTALLOID – OR – 700
COLLOID –
BLOOD –

FLUIDS: LINE site #17 (R) AR. — 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 – 155/71 HR – 93

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME – 0850

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

TIME → 1100 (induction) 1130 (DW)

	1100	1130	1145	1200	1215
VT – ml	1.0	790	710	1.80	
f – breaths/min	17	7	6	12	
Peak inf pres / PEEP	20	20			
MODE – S(pon), A(ssist), C(on)	SV	CV	CV	SV	
ET CO2 (torr)	30	31	33	34	
FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
SpO2 (%)	100	100	100	100	100
ECG	NS	NS	NS	NS	NS
TEMP- site Skin		97	97	97	97
N-M Block (T/4)					

Warming blkt: sheets / drapes
Conv warmer

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

aims <90 obstructed, padded

PROCEDURES and CPT Codes

Washout & DPC

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

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

REMARKS – Code drugs with numbers, events with letters

1100 1030 Pt ID'd → Procedure verified. (b)(6)-2
1145 HR. In room - monitors
on
1115 Induction initiated
1205 - spont resp. Sucktioned eyes opened Extubated - TO ICU I/VSS

(b)(6)-2 [redacted]

RECOVERY AT [redacted]
PACU ICU (Specify)
OTHER 5/7/06
CONDITION: 9.5
RESP – 30 SpO2 – 97%
BP – 144/89 HR – 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1145	1200
PROC	Ready	Begin	End
	1115	1125	1200

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
#3 MAC, taped 2 cm teeth. Eyes taped. GETA - A & O, Oral ETT GETA & return, soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Dx + P Airway. GL 1 view. ETT easily passed. Post ICU x3. Atraumatic. Teeth ok

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

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

PROCEDURE LOCATION #2

ICW - ICU

STHESIA PLAN OF CARE ... PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

[redacted] DAYS MOS YRS Sex (X) MALE ( ) FEMALE

(b)(6)-4

OSED PROCEDURE: Washout & DPC

ICAL SERVICE: Gen

INCE: Mid

ASA Physical State 1 2 3 4 5 E

WT: 70 KG/LB HT: ____ IN.

ALLERGIES: NKDA

S:

ACCO: Neg

ETOH:

RUGS:

ENT MEDICATIONS:

dered as premed

Ancef q8

Heparin 5000 sc q12

Tagamet q6

MS04 > gtt

Percocet > gtt

EDICATIONS:

Yes (@ ____ Hrs) /CC

.. ____ mg IV IM PO

.. ____ mg IV IM PO

.. ____ mg IV IM PO

RATORY STUDIES:

T: ____/____

R: ____

7 Jul 8.5 / 8.5 / 26.6 / 226

137 | 98 | - / 85

3.6 | 31 | -

8 Jul 8.6 / 7.1 / 27.8 / 308

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 (L) Colostomy
- Hiatal Hernia N Y
- PUD/GERD N Y

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

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

Gynecological :
- Pregnancy N Y NA

Other Significant Hx:
- N (Y) s/p GSW to abdomen, b/lat
- N Y Arm, (L) femur.

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

3 July Ex lap - Colon Resection

Ø comp

ISS PHYSICAL EXAMINATION

BP 71 HR 93 R 17 T 99

Pain Scale 0-10 ____

HEENT - Teeth intact Dentition

Trachea ____

TMJ/Neck ____

Oropharnyx MPI

Nares ____

CHEST: ____

CARDIAC: ____

EXTREMITIES:

IV Access: 18g (R) Arm

Ulnar Filling: ____

BACK: ____

OTHER: LRC 100cc/hr

NPO Since Mid

STHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) 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.

rtien[redacted]rdian seems to understand and agrees. Questions answered.

t: [redacted] CRNA CPT (b)(6)-2 Date: 8 Jul 03 Time: 0710 Hrs

ANES[redacted] NOTE (NON ASU)

APPARENT ANESTHETIC COMPLICATIONS { } OTHER

t: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) ____

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

SEDATION KEY:

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

DATE: 3 Jul 03

TIME: 2355

Name: [redacted]

SSN:

DOB: (b)(6)-4

Unit:

Nationality: Iraqi

HT:

WT: lb

WT: kg

Additional Orders w/ Date & Time/Charting:

1. **Admit:** Recovery transfer [illegible] Holding Company
2. **Diagnosis:** s/p exp lap / GB resection / colectomy / colostomy
3. **Condition:** VSI SI Critical Guarded (Stable)
4. **Allergies:** ?
5. **VS:** Q 1 hr; Q 2 hrs; Q 4 hrs; Q 8 hrs.
   Notify MD for SBP: >180 or <90; DBP: >100 <50;
   HR: >120 <60; RR: >20, <10; Temp: >102
6. **IVF: IVF:** LR @ 75 cc/hr; NS @ ____ cc/hr;
7. **Monitor:** Cardiac; Pulse Ox; Neuro Checks Q ___ m/hr; A-line;
8. **I & Os:** Q1 hr; Q ___ hrs
9. **Drains:** NG to Low/Cont suction; JP Drain; Foley to gravity
10. **Chest Tube:** 20 cm H2O suction, H2O seal; Heimlich
11. **LABS:** ABG now & Q1 hr; Q2 hrs; Q ___ hrs; PRN
    Hct now & Q ___ hrs; Chem now & Q ___ hrs; Urine Dip
12. **BLOOD:** T & S ___ units; T & C ___ units;
    Transfuse: ___ units PRBC or Whole Blood for Hct < ___%
13. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB; _____
    Keep Stats > 92%, > 95%, _____
14. **VENT:** SIMV; TV: ____; RR: ____; Fio2: ____%; PEEP: ____;
15. **Diet:** NPO, Sips of H2O, Clear liquids, Regular, MRE,
16. **Activity:** Bed Rest; BRP; HOB Up; Holding area/Unit; Other ____
17. **MEDS:** Morphine 2, 4, or 6 mg IVP Q 10 min/hr prn Pain
    Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/shivering
    Toradol 15/30 mg IVP/IM Q 6 hrs/prn Pain (up to 5 days)
    Percocet 1 –2 tabs or Tylenol III 1-2 tabs PO Q 6 hrs prn Pain
    Zofran 2-4 mg or Phenergan 12.5 – 25 mg IVP Q ___ hrs prn Nausea
    Zantac 50 mg IVPB Q 8 hrs
    Vent Sedation: Diprivan / Propafol: 5–50 mcg/kg/min on a pump
    Sedation: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg
    Abx: Ancef 1 gram in 100cc NS IVPB Q6-8 hrs
    Abx: Cefotan 2 grams in 100cc NS IVPB Q12 hrs starting now X 2
    Abx: Clindamycin 600 - 900mg 100cc NS IVPB over 30 minQ8 hrs [redacted]
    Abx: Gentamicin 5 or 7 mg/kg/day IVBP over 30 min Q day (b)(6)-2
    Abx: Pen G 2 mil units in 100cc NS IVPB Q4-6 hrs
    Abx: Unasyn 1.5 or 3 grams in 100cc NS IVPB Q 6 hrs
    Xrays: (B) humerus Dane Jca
18. **Ortho:** Wound Irrigation w/ NS; Batadine & Gauze Dsg
    Soiled Dsg = Reinforce & notify MD; Splint; Cast
    Neurovascular checks Q 1 hrs; Distal Pulse/Circulation
    Elevate extremity above heart on blankets
19. **Wound Care:** Wet to Dry Dsg Change NS Q ____ to _____
20. **BURNS:** IVF of LR: 4 cc/% BSA burn/kg = total 24 hr fluids;
    Give ½ over 1st 8 hrs from Time of Burn; Clean Sterile dsg
21. **Head Injury:** Neuro checks (GCS) Q ___ min/hrs;
    C-Spine: Clear/NOT Clear; Keep Head in midline position;
    Mannitol (20%): 0.25/0.50/1 gm/kg IVPB over 30-60 min
    Notify MD for Mental Status changes [redacted] (b)(6) – 2
20. **EVAC:** Priority w/in 4-6 hrs; R[redacted]
21. **Signature of Provider:** [redacted]

274th FST Post-OP Orders, By CP[redacted]un 2003

MEDICAL RECORD	PROGRESS NOTES
DATE	

3 Jul 03

~~23~~ 45

OPERATIVE NOTE

DIAGNOSIS: GSW to abd / (R) UE / (L) UE / (L) thigh

PROCEDURE: Expl lap / SB resxn x 2 / (L) colectomy c end transverse colostomy / I+D of other GSWs.

Anesth: GETA.

SURGEON: [redacted] / [redacted] both (b)(6)-2

FINDINGS: Inj to (R) gastroepiploic artery → ligated. Stomach / lesser sac ok. Liver / spleen ok. (L) colon c 2 holes (1 circumferential) stool in abd. 4 holes in SB — removed in 2 seg ≈ 8-10 cm long (1).

FLUIDS: Kidney / ureter ok.

EBL: (2) retroperitoneal hematoma

0 comps.

EBL: 200 cc

U/O: 350 cc

Fluids 4000 crystalloid

To PCU, stable, extubated (b)(6)-2

[redacted] WO

(Continued)

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

[redacted]

(b)(6)-4

NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

4 JUL 03 _____ HOURS

1- Admit to ICU
2- NPO
3- VS per ICU Routine
4- I/O q1° Foley to Gravity
5- Bed Rest
6- NG to low intermittent suction
7- Heparin 5000U SC q12°

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

~~8- Zantac 50mg IV q8°~~
9- Fentanyl 50 mcg/hr Titrate for pain control
10- Phenergan 25mg IVPB q4° prn
11- Cefotetan 2gm q8° IVPB
12- CBC + chem 7 q AM
13- Tigan 200mg q6° IVPB

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

7-4-03 1100 HOURS

per Dr. [redacted] Hr @ 150cc/hr

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

5 JUL 03 _____ HOURS

1- ↓ IVF to 100 cc/hr

(b)(6)-2 [redacted]

:DICAL RECORD

AUTHORIZED FOR LOCA

PROGRESS NOTES

DATE	NOTES
5 JUL 03	Surgery Progress
	22 yo male c̄ multiple GSW to abdomen & extremities c̄ colostomy stable. Pt to OR today for washout of wounds.
	CNS: appropriate
	Lungs: CTA 100% RA RR 20
	Card. HR 90-112 BP 123/45
	Abd: soft, appropriate TTP ØBS ostomy pink
	Renal: 136 / 4.2 / 25 / 1.0 / 9 / 104 I/O 997/2550
	Heme: 13.2 / 31.2 / 9.8 / 194
	Resp: stable RA #1
	Plan: JIFV
	to OR today
	DC NG later p OR
	Cont current orders
	[redacted] (b)(6)-2

ONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S I (SSN or Other)
	LAST	FIRST	MI	
/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NC

PROGRESS NOTES
Medical Record

STANDARD FORM 50

8 Jul 03

OP NOTE

Pre-op Dx: Multiple GSW to ABD and BUT
c open wounds

Proc: OPC + IOD + WASHOUT ABD WOUNDS + OBT.

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

Fluid: 700cc LR

UO: 600cc UO

OBL: min

Complications: Ø

(b)(6)-2

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 JUL 03 TIME OF ORDER: 1610 HOURS

LIST T ORDE NOTED SIGN

1. TO ICU / FROM TO ICW
2. S/P I+D OF NECROTIZING FASC
3. CONTINUE PEN (b)(6)-2 →
4. VS - ROUTINE
5. UP AD LIB PER PCW ROUTINE
6. REGULAR DIET

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

7. IV LR at 125 cc/hr KVO
   ADD TO LR: MVI, THIAMINE, FOLATE, MG
8. ZOFRAN 4 mg IVPB Q 8 hrs x 3 doses
9. TYLENOL 650 mg P.O. Q 4 hrs PRN
10. PERCOCET, 1-2 P.O. Q 4-6 hrs PRN
11. MSO4, 2-6 mg ~~PO~~ IVP Q 2 hrs PRN.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 JUL 03 TIME OF [redacted] (b)(6)-2 HOURS

1 - NPO
2 - TRAMADOL 300 mg IVPB q 6 ✓
3 - CBC & CMP 7 q AM ✓
4 - LR @ 125 cc/hr ✓
5 - UP @ ASSISTANCE ✓
6 - MORPHINE 5000 u SC q 12 ✓

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 JUL 03 TIME OF ORDER: 1610

1. ↓ IVF to 50 cc/hr.
   Run [redacted]
   (b)(6)-2

[redacted]

(b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7JUL03 SURGERY

(b)(6)-4 [redacted] 40 MALE S/P GSW TO EXTREMITIES & ABDOMEN STABLE.

CNS: AWAKE, ALERT

CVR: NRR HR 80s 113/47

ABD: SOFT, NT, NO BS ⊕ AIR + STOOL IN OSTomy - OSTomy PINK

RENAL: 137 (98) 7 (85) 3.6 31 I/O 2500/1920 424/2500

HEME: 8.5 8.9 226 26.6

RO: ABOS

RP: SNABLE

P/PW: TO OR TOMORROW FOR DPC & WASHOUT

NPO @ MIDNIGHT

[redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

388

PROGRESS NOTES
Medical Record

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST THE ORDER NOTED SIGN

7 Jul 03

1- Regular Diet
2- NPO p midnight
3- Hep-lock IV ~~until~~ until midnight & then start LRC 100 cc/hr (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

8 Jul 03

1- ~~Clear liquid~~ Diet Admit to ICU
2- Clear liquid diet advance as tolerated
3- Hep-lock IV
4- UA AD-lib
5- VS per Routine
6- Routine ostomy care

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

8 Jul 03
1230 HRS

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

7- Percocet 1-2 po q4-6° prn pain
8- Colace 100 mg po bid
9- Ancef 1gm q8° x 3 doses
10- Phenergan 25 mg IVPB q6° prn [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

9 Jul 03

1- Transfer to ICU
2- Regular Diet
3- Percocet 1-2 po q4° prn pain
4- UA AD-lib
5- Hep-lock IV (b)(6)-2
6- VS per Routine
7- Colace 100 mg po bid
8- [redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2001-478-200

"USE BALL POINT PEN, PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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 ORD NOTED SIG
[redacted] (b)(6)-4			10 Jul 03 1 - DC Foley 2 - DC LMBS 3 - Transfer to ward 4 - To Camp [illegible]	HOURS 0900/done	
NURSING UNIT	ROOM NO.	BED NO.	[redacted] (b)(6)-4		(b)(6)-2
PATIENT IDENTIFICATION			DATE OF ORDER (b)(6)-2	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.			

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

'ATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST ORD NOTED SIG
11/21/03	HOURS	
1-DC TO OPW CAMP		
(b)(6)-2 [redacted]		

IURSING UNIT	ROOM NO.	BED NO.

'ATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

IURSING UNIT	ROOM NO.	BED NO.

'ATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

IURSING UNIT	ROOM NO.	BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

IURSING UNIT	ROOM NO.	BED NO.

All (b)(6)-2 Except one on bottom.

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 4	5	6	7	8	9	10
7/4	[redacted]	NPO	05	[redacted]	[redacted]					
			17	[redacted]						
7/4	[redacted]	VS per ICU routine	05	[redacted]						
			17	[redacted]						
7/4	[redacted]	I/O q1° FTG	05	[redacted]						
			17	[redacted]						
7/4	[redacted]	Bedrest	05	[redacted]						
			17	[redacted]						
7/4	[redacted]	NG to LIS	05	[redacted]						
			17	[redacted]						
7/4	[redacted]	CBC & Chem 7 q AM	05	[redacted]	[redacted]					
7/5	[redacted]	Ambulate per EPW	05	[redacted]						
		routine	17	[redacted]						
7/5	[redacted]	Regular diet	05	[redacted]						
			17	[redacted]						
7/6	[redacted]	VS/ I+O q 1°	05	[redacted]						
			17	[redacted]						
	[redacted]	~~NPO until air in~~	05	[redacted]						
		~~bag, or drainage in~~	17	[redacted]						
		~~bag.~~								
	[redacted]	~~CBC, Chem 7 in AM~~	05	[redacted]						
	[redacted]	~~ODB c Assist~~	05	[redacted]						
			17	[redacted]						
7/6	[redacted]	~~Reg. Diet~~	05	[redacted]						
			17	[redacted]						
8 JUL	[redacted]	Clear Liquid Diet Advance	05	[redacted]						
		As Tolerated	17	[redacted]						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Gallbladder to ASD / GI HAL LE,

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nu[redacted]	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/4/03	[redacted]	NPO 5 MN	8/4/03	0000	OW	[redacted]
	[redacted]	(b)(6)-2			(b)(6)-2	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

All (b)(6)-2 Except Bottom One

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 8	9	10	11
8JUL	[redacted]	ACTIVITY: UP AD LIB	05	[redacted]			
			17				
8JUL	[redacted]	Vitals Per Routine	05	[redacted]			
			17				
8JUL	[redacted]	Routine ostomy care	05	[redacted]			
			17				
		[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/10/03	[redacted]	to WARD				
7/10/03	[redacted]	to EPW Camp in AM				
	[redacted]	(b)(6) -2				

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