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 4	5	6	7	8									
7-4	[redacted]	Heparin 5000U SC q12°	10	[redacted]													
			[redacted]														
7-4	[redacted]	~~Zantac 50mg IVPB q8°~~						D/C									
~~7-4~~	[redacted]	~~Phenergan 25mg IVPB~~															
7-4	[redacted]	Cefotetan 2gm q8° IVPB	06	/	[redacted]												
			[redacted]														
			22														
7-4	[redacted]	fentanyl 50mcg/hr	05	[redacted]													
		titrate for pain control	17	[redacted]													
7-4	[redacted]	LR @ 150cc/hr	05	[redacted]													
			17	[redacted]													
7-4-01		Tagamet 300mg IVPB	06	/	[redacted]												
		Q6	12	[redacted]													
			18	[redacted]													
			00	[redacted]													
7-4	[redacted]	LR @ 150cc/hr	05	[redacted]													
			17	[redacted]													
7-5	[redacted]	LR @ 100cc/hr	05	/	[redacted]												
			17	/													
7-5	[redacted]	LR @ 125cc/hr HL	05	/		[redacted]		[redacted]									
		when tolerating to well	17	/	[redacted]												
7-5	[redacted]	Amoxicillin 1g IVPB	06	/	/	[redacted]											
		Q8hrs x 3 doses	14	/	/												
			22	/	[redacted]												

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: Gsw to b.l. upper ext / +Sd.	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted]

(5)(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
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
7/5	TB	Tylenol 650mg PO	
- - - - -	- - - - -	Q4hrs prn	
7/5	TB	Percocet 1-2 po Q4hrs	Oct 2 2001
- - - - -	- - - - -	PRN	[redacted]
7/5	TB	morphine 2-5mg IVP	
- - - - -	- - - - -	q 2-4hrs PRN.	
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		

hmmmmbt [redacted] (b)(6)(7

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10	11
6 JUL	[redacted]	LR ~~@125 ↓50~~ KVO	05	[redacted]					
			17	[redacted]					
	[redacted]	Tagamet 300mg	6	/	[redacted]				
		IVPB q6	12	/	[redacted]				
			18	[redacted]					
			24	[redacted]					
	[redacted]	Heparin 5000 SC	06	[redacted]					
		q 12°	18	[redacted]					
	[redacted]	Ancef 1gm IVPB	06	[redacted]					
		q 8° x 3 days	14	[redacted]					
			22	[redacted]					
7 Jul 03	[redacted]	Hep Lock IV	15	/	[redacted]				
		until midnight +	17	/	[redacted]	/	DC	[redacted]	
		then start LR @							
		100cc/hr							
8 JUL	[redacted]	Hep-Lock IV	05	/	/	[redacted]			
			17	/	/	[redacted]			
				/					
8 JUL	[redacted]	ANCEF 1gm Q8°	06	/	/	[redacted]	/	/	/
		x 3 Doses	14	/	/	[redacted]	/	/	/
			22	/	/	[redacted]	/	/	/
				/					
8 JUL	[redacted]	Colace 100 mg PO BID	10	/	/	[redacted]			
			22	/	/	[redacted]			

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: SIP GSW's	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO.

PATIENT IDENTIFICATION: [redacted] (5)(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**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
[redacted]	[redacted]	Tylenol 650 po														
- - - - -	- - - - -	q4° prn														
[redacted]	7/8	Percocet 1-2 po	7-9-09 0230 [redacted]	7-10-09 1740 [redacted]	7-10 [redacted]	7-11 0230 [redacted]	7-11 0200 [redacted]									
7/8	[redacted]	q4-6 pm pain														
- - - - -	[redacted]	MSO4 2-4 mg	8 Jul 1220 5mg	8 Jul 2035 5mg	8 Jul 0400 5mg	[redacted]	2200 5mg	0400 [redacted]								
- - - - -	- - - - -	IVP q2-4 hrs	[redacted]													
- - - - -	- - - - -	PRN														
8 Jul	[redacted]	Phenergan 25 mg														
- - - - -	- - - - -	IVPB q6° PRN														
- - - - -	- - - - -	Nausea														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

(5)(1-2)

USAPA V1.00

exp. Lap. Small Bowel resection
transverse " resection
colostomy
I+D. GSW to L thigh
CVS+(R) VS

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: 4 JUL 03
Time In: 0035
Allergies: ?
Pre-op V/S: 130/80 - 84
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 4200 Colloid Ø
OR Output: UOP 350 EBL 100
Meds/Times: Unisyn 3 gms @ 2030

Drains: Hemovac, NG, JP, T-tube, Foley, TLS, Penrose (Thigh)

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

Time	2030	2130	2230	2330	0000	0015	0130	0230	0330	0430	0530	0630	0730	0830	0930	1030	1130
SaO2	96	100	100	100	100	97	100	100	100	100	100	100	100	100	100	100	100
FiO2	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL
Methods	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm
RR	16	14	18	22	18	14	16	17	17	18	22	16	17	18	18	19	
T																	
Time																	
Pain (0-10)																	
LOS																	

History

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

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
0130	0.9% NaCl	100 mL	(L) Arm		100
0230	0.9% NaCl	100 mL	(R) Arm		100
0330	0.9% NaCl	100 cc	(R) Arm		100
0430	0.9% NaCl	100 mL	(R) Arm		100
0530	0.9% NaCl	100 cc	(R) Arm		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	Ø	Ø	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	1	
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.	6	6	

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 LPN
DEPARTMENT/SERVICE/CLINIC: [redacted] (b)(2)-2 ICU
DATE: 04 JUL 03

PATIENT'S IDENTIFICATION (For typed or written entries give: first, middle; grade; date; hospital or medical facility)
Name – last,
Iraqi 07 ~20040.
[redacted]
(b)(6)-4

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

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0058		Cefotax 2 gm	IVPB		(b)(6)	[redacted]
0200		Zantac 50mg	IVPB			
0620		Lorazepam 0.2 mg	IVPB			

NEUROVASCULAR

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

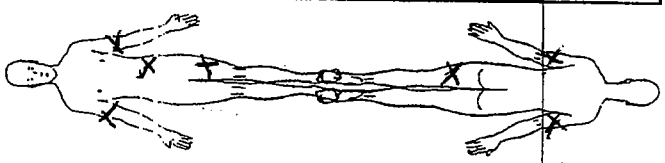
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Arm	Kerlix	mod drainage
30'	(L) Arm	Kerlix	CDI
60'	(L) Arm	Kerlix	CDI
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0130	Foley	clear yellow	700 mL
0230	Foley	clear yellow	500 mL
0330	Foley	clear yellow	200 mL
0430	Foley	clear yellow	300 mL

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0030	NSR	N/A	

WAMC OP 173-E

NURSING NOTES

0030- Pt arrives from OR on litter, responsive to verbal stimuli, NPA airway placed, even, deep, regular respirations LCTA all fields, O2 via Venturi mask @ 5LPM SaO2 100%. Radial pulses weak but palpable bilateral, Pedal pulses strong bilateral. Skin cool, dry, cap refill ≤ 3 sec. IV (L) Ac. & (R) Arm running 0.9% NaCl, (L) & (R) biceps bandages, colostomy LLQ, Bleg to gravity, bandage to (L) thigh. Gastric tube in place. [redacted]

0130- Strong pedal pulses, cap refill < 3 sec, weak but palpable radial bilat, cap refill 3 sec [redacted]

0145- IV (L) Arm D/C'd, not flowing, pnc flush & drawback [redacted]

0230- Radial pulses weak, palpable bilateral, pedal pulses strong bilat. cap refill < 3 sec skin cool moist.

0330- Radial pulses present weak bilat, pedal pulses strong bilat [redacted]

0430- Pedal pulses strong, radials weak but palpable, bilat skin cool, dry, cap refill < 3 sec [redacted]

0530- pt with movement of all extremities, distal pulses present [redacted]

0620- Pt starting to wake up, interpreter @ bed side VSS [redacted]

(b)(6)-2

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

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			90/78								120							
	BP Cuff											72							
	Temperature																		
	Pulse			78								76							
	Respiratory Rate			14								16							
	SpO2			99								99%							
	PA/O2											[redacted]	(b)(6)-2						
	pain intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
												50							
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE						300													
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

[redacted] (b)(6)-4

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8° T

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

24° I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday ________ wt Today ________		
INTAKE: IV ________ po ________ TOTAL ________		
OUTPUT: Urine: ________ TOTAL ________		
BALANCE ________		

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0526	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
	PUPILS	PERRLA, 3mm					
	SENSORIUM	A/O x3					
RESPIRATORY	RESPIRATORY PATTERN	eupnea unlabored					
	BREATH SOUNDS	CTA (B)					
	SECRETIONS						
SKIN	COLOR	NFR					
	INTEGRITY	warm & dry					
IV SITE	LOCATION	(R) FA					
	CONDITION	Ø s/s edema or redness, patent					
GASTRO	ABDOMEN	soft ND (+) tender-					
	BOWEL SOUNDS	ness					
		midline abd. drsg. &					
		colostomy bag, intact					
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	yellow & clear					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR					
		S1S2					

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

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] (b)(6)-2	ICU 2 west	

PATIENT IDENTIFICATION *(For typed or written entries give: Name—last, first, middle [redacted]de; date; hospital or medical facility)*

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

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

PA

	DX													HOSPITAL DAY			
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
P Arterial Line						120/				121/	125/				141/		
P Cuff						/52				/55	/69				/89		
Temperature															96.8		
Pulse						89				81	78				120		
Respiratory Rate						18				12	13				16		
SpO2						100				100	100				100		
						[redacted]				[redacted]					[redacted]		
Pain																	
Intervention																	

(b)(6)-2

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15
LR						100	100/	100/300		100	100	100		100	100	100	100 (700)

TOTALS																		(700)
URINE	HOUR / TOTAL						100/	200/300	200/500	(500)	100/800	150/550			100/	100/	30/(850)
	sp gr																
	S/A																
NG	OUTPUT																
	pH																
	GUAC																
MESIS																	
TOOL																	

PA

ACUITY LEVEL CLASSIFICATION

	17	18	19	20	21	22	23	
	140/85	140/85	124/64	140/64	140/64	102/54	130/66	
			99.1				100.2	
	96	96	98	95	88	91	93	
	17	23	10	27	18	26	10	
	100	100	100	100	100	100	99	
	RA	RA	RA	RA	RA	RA	RA	

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

	16	17	18	19	20	21	22	23	8° T
	125	125/80	125/80	125/80	125	125	125	125	100
PO			34	25					

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

16 20% 200	50/550	120/80	130/50	200/50	200/80	150/80	90/75	100/75	100

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

TURN	TIME								
SUCTION									

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE

IV _____

OUTPUT

Urine: _____

NURSE'S SIGNATURE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (1

QA Appr 8 Mar 8

INITIAL SHIFT ASSESSMENT

	TIME	2500	INITIALS [redacted]	2000	INITIALS		INIT
NEURO	PUPILS	PUPILS [redacted]		4mm PERRLA			
	SENSORIUM	[redacted]		A+O x3 Cooperative			
		[redacted]					
		[redacted]					
		[redacted]					
RESPIRATORY	RESPIRATORY PATTERN	[redacted]		Unlabored, even			
	BREATH SOUNDS	[redacted]		CTA (B)			
	SECRETIONS	[redacted]		⊖			
		[redacted]					
		[redacted]					
		[redacted]					
SKIN	COLOR	[redacted]		W.O.			
	INTEGRITY	[redacted]		Intact			
		[redacted]					
IV SITE	LOCATION	[redacted]		(R) PIV			
	CONDITION	[redacted]		Abd medline CDI			
		[redacted]		Bil-UE CDI			
		[redacted]					
		[redacted]					
		[redacted]					
GASTRO	ABDOMEN	[redacted]		Soft, non-tender			
	BOWEL SOUNDS	[redacted]		BS X4			
		[redacted]					
		[redacted]					
GU	URINE:	[redacted]		Foley			
	COLOR/CLARITY	[redacted]		Clear Yellow			
		[redacted]					
CARDIOVASCULAR	CARDIAC RHYTHM	[redacted]		NSR			
		[redacted]		S_1 S_2			
		[redacted]		+2 Pulses UE/LE (B)			
		[redacted]					
		[redacted]					
		[redacted]					

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: 9/10/03

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

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

ICU# 1

☐ HISTORY/PHYSICAL

☐ OTHER EXAMINATION OR EVALUATION

☐ DIAGNOSTIC STUDIES

☐ FLOW CHA

☐ OTHER (S)

E	DX													HOSPITAL DAY			
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	130	143	139	137	115	110	116	114		130	116	120	130	116	104		
BP Cuff	60	68	63	55	45	45	65	64		65	53	60	61	71	61		
Temperature	100.2		98.6		97.5							99.1					
Pulse	85	79	94	78	75	69	76	69		86	80	91	92	90	76	71	
Respiratory Rate	18	18	18	14	10	9	11	12		18	17	16	15	21	22	22	
O2	100	99	100	100	99	100	100	100		99	97	96	99	97	98	99	
	[redacted]									[redacted]							
(b)(6)-2																	
pain																	
intervention																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
IV	125	125	125	125	125	125	125	125		125	125	125					
PO	125	125	125	30	30	30	30	30	950	540	200	200		460			700
TOTALS									950								700
URINE HOUR	20	160	250	180	75	95	200	100		200	100	200	130	200	100	200	150
URINE TOTAL	20	180	530	710	785	940	1140	1240	1860		100	300	430	630	730	930	1350
URINE sp gr																	
URINE S/A																	
NG OUTPUT												300					
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS																	

DAY

	16	17	18	19	20	21	22	23	
BP			125/62				119/76		
T									
P			93				86		
R			16				18		
O2			98				99		
RA/O2			RA				RA		

	16	17	18	19	20	21	22	23	8° T
IV									
PO									
URINE			165						

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	04/0						
	GLUCOSE							
	Na/K							
	Cl/CO_2							
	BUN/Cr							
	WBC/PLATELET	59/154						
	Hct/Hgb	29.1/7.7						

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE: IV _____ po _____

OUTPUT: Urine: _____

NURSE'S SIGNATURE

[redacted] (b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDI... DATA

For form, see AR 40-66; the proponent agency is the O... Surgeon General

REPORT TITLE

INTENSIVE CA... NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530 INITIALS [redacted]	(b)(6)-2 INITIALS		INITIALS
NEURO	PUPILS	pupils [redacted]	PERRLA		
	SENSORIUM	[redacted]	A+OX3		
		commands s			
		disability			
RESPIRATORY	RESPIRATORY PATTERN	[redacted] even at un-	even-unlabored		
	BREATH SOUNDS	diminished LS	CTA		
	SECRETIONS	ess cha [redacted]	Ø secretions.		
		on RA good			
		SPO2 @ good			
		Ø SOB/distress			
SKIN	COLOR	[redacted] skin	normal for race		
	INTEGRITY	[redacted]	intact		
IV SITE	LOCATION	[redacted]	(R) FA replaced		
	CONDITION	well	CDI		
GASTRO	ABDOMEN	[redacted] soft NT/ND	soft - complain of		
	BOWEL SOUNDS	c Ø BS x 4	upset stomach		
		nutritive [redacted]	bs x 4		
		drg [redacted]			
GU	URINE:	[redacted] yellow urine	clear foley		
	COLOR/CLARITY	FC [redacted]	yellow		
		patent			
CARDIOVASCULAR	CARDIAC RHYTHM	[redacted] noted	NSR		
		BP 80-90 s Ø	S1 S2		
		edema [redacted]	+2 pulses x4 extremities		
		noted			

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 [redacted] DEPARTMENT/SERVICE/CLINIC ICU 2nd DATE [illegible]

PATIENT [redacted] (For type of ... name—last, first, middle ... date; hospital or medical ...

(b)(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

[redacted]

EPW

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			113				120											
	BP Cuff			61				60											
	Temperature						97.6												
	Pulse			73				73											
	Respiratory Rate			14				13											
	SpO2			100				100											
				RA				RA											
	pain intensity																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	PO								360	360					240	120			360
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	URINE					350				250	600						500			500
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS										600									500

[redacted]

(b)(6)-4

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
BP			96/60			115/60			
T			99.3						
P			88			77			
R			12			16			
O2			100			98			
RA/O2			RA			RA			

PO	16	17	18	19	20	21	22	23	8° T

URIN									
						1600			

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSES SIGNATURE	INITIALS
[redacted]	
(b)(6)-2	

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						MTF LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	(5)(6)-2 EPW [redacted]	16	17	18
[redacted]									EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
Z	Z	Z	Z	Z	Z	Z	Z	2	2	Y	Z	9	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (5)(6)-2
N/A	46: U	1800	N/A

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

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	☒ NO
									1		

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICU1	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted]		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (5)(2)-2		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
5	Ø							Ø	3	Ø	7	1	1

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	A	A							Ø	3	Ø	7	Ø	5

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

FOR LOCAL USE

Dx: s/p GSW

Dx: 86330
86350
89912
82116

Px: 8622
8364
8659
4579
1905
916

[redacted] (5)(6)-2

ADMITTING OFFICER (Signature required)	SIGNATURE OF ADMITTING CLERK
[redacted]	(5)(6)-2 [redacted] SPC, 916-118

DD FORM 2095, MAR 90

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	Ø 2 Ø	Z	Z	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0900	(b)(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
6		9		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU-1	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
Ø 5		0 3 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 4

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: 6 SW's to abn, (L) thigh, Bilateral arms

Dx: 86330
86350
82110
E9912

Px: 8622
8364
8659
4519
4905
79[illegible]

(b)(6)-2

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

DA FORM 3985 MAR 89

INPATIENT TREATMENT RECORD COVER S

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]					3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP [redacted]	12. SSN [redacted]			13. ORGANIZATION N/A		14. WARD 1CW2	
15. FLYING STATUS N/A	16. RATING/DSG	17. DEPT/BEN ~~K79~~ KMO		18. BRANCH/CORPS ~~K40~~ N/A	19. DIC/ZIP	20. TYPE CASE W1A	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION: 0930	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —	26. TYPE DISPOSITION: 50	28. DATE OF DISPOSITION: 12 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —	27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 4 Jul 03	ADMITTING OFFICER: Dr. [redacted] (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) ankle fx

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	9	9

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	9	9

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted] Dr. [redacted]

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

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

S 28 yo c hx of GSW to (L) Ankle w/o attempt to steal car.
Shot by another iraq. in incident.
pain (L) ankle

O - VSS Afebrile
PMH ø
Allergy ø
No meds

PHYSICAL EXAMINATION

VSS Afebrile
HEENT clear
NMT clear
neck supple
Chest lungs clear
heart RRR
Abd benign
Guard at ankle

PROGRESS (Enter date of discharge and final diagnosis)

Exam: tender over (L) lateral Ankle. c̄ ecchymosis and
ROM limited
bullet frag in Ankle
fibular hole.
Orthopedics

(b)(6)-2

SIGNATURE OF PHYSICIAN

[redacted]

DATE 7/7/03

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

IDENTIFICATION NO.

ORGANIZATION

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

539-106

[redacted]

DICAL RECORD

AUTHORIZED FOR LOCAL RE

PROGRESS NOTES

DATE

NOTES

[illegible] comes c [illegible]
[illegible] 2 [illegible] Drayi Felon Car [illegible]
GSW [illegible] Arrive Handgun by
car [illegible]
[illegible] PMHx [illegible] PSHx [illegible]

Exam [illegible] CLE
Total Ext / Bowing
= Return easily to Baseline
Ant / Lateral
A/ [illegible] Hidden fibula
[illegible] GSW Fibula
PM) washout (DA)
splint
consult IM Stevens Pm

NSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID N
(SSN or Other)

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F

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)
4 July 03	1225 - Pt alert lying in bed c Ⓡ foot elevated
	VSS, HR regular, BS⊕. Cast applied to Ⓡ
	½ leg below knee. Able to wiggle toes, ⊕
	Sensation. Pulses equal & strong bilat to ↑ &
1200 96.8	extremities. LR @ 100 into Ⓛ AC. Voicing ∅
68	Complaints. Will cont. to monitor (b)(6)-2 [redacted]
16	1400 → Assumed care of Pt @ 1300. VSS. A+O×3
126/74	c/o pain. Ⓛ AC PIV c LR @ 100cc/hr. Ⓛ LE
98%	splint/ace CDI. ⊕ sensation, cap refill <3sec, mvt Ⓛ
	foot. NPO for OR. O/W assess. WNL. Will
	cont. to monitor (b)(6)-2 [redacted]
5 July	Assumed @ ~~early~~ 2100. Pt has been sleeping.
	Lungs CTA. Bowel sounds x4 quads. Pt has
	∅ % pain/discomfort @ this time. Will con-
	tinue to monitor. (b)(6)-2 [redacted], RN/LPN
5 July 03	0540 Assume pt care @ 0500. pt awake and
	alert. c/o an amt of pain. LR @ 100cc/hr to Ⓛ
	AC no s/s redness/infiltration. VSS. HR regular. Lungs
	CTA. BS×4 abd soft no c/o pain/tenderness on
	palpation. LLE dsg CD+I. ⊕ movement ⊕ sensation
	to toes. NPO for OR today. Will continue to monitor.
	(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. ICW2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5Jul03 1900	assumed care @ 1300 - VSS - SL patent CLR @ 100cc/hr into (L) FA - pt. o/c to OR, NPO - dsg intact on (L) ankle, L2 sec. cap refill in (L) toes - no c/o pain @ this time (b)(6)-2 [redacted]
5Jul03 1900	pt. surgery cancelled for today - pt. ate regular diet for dinner - IV patent c LR @ 100cc/hr - no c/o pain @ this time (b)(6)-2 [redacted] CPT A
5Jul03	Pt A/O x3, VSA, LCTA(B), (+) BS all quads. c/o pain @ this time. LE dsg CDI (+) movement (+) sensation to toes. brisk cap refill. will cont to monitor (b)(6)-2 [redacted] SPC Grumle
6Jul03 0540	Assumed pt. care @ 0500. Pt. A+O x3. lungs CTA. (+) BS x4. LLE dsg CDI (+) movement c/o no feeling in toes. IV LR infusing @
0530 96.4 55 22 118/76 98%	100cc/hr in (L) FA. Will continue to monitor. (b)(6)-2 [redacted] Grumle
6Jul03 1230	Pt. returned from Recovery room. Pt. A+O x3. lungs
T 97.1	CTA. (+) PERRLA. (+) movement in (L) toes c̄ decrease sensation
P 56	Ace wrap on (L) leg CDI. IV LR TKO. SAT @ 97%
R 16	on room air. Will continue to monitor
B/P 120/70	(b)(6)-2 [redacted]
SATS: 97	[redacted]
6Jul03 1520	assumed care @ 1300 - VSS - pt. tolerating water - IV HL'd - pt. due to void by 1800 - dsg cdi on (L) LE, no c/o pain [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

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

DATE | NOTES

[illegible] OP/[illegible] Note

6 July 03 28yo Iraqi OIF carjacker

Prop Dx: (R) GSW Fibula R

procedure I&D / Frgmnt Rem

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

ESL: [illegible]

TT: 25 m

To PACU stable

Findings: Shattered Distal Fibula

Frgmnt c defect

(R) Mortise level

disruption of Syndesmosis

on Fluoro Exam

Plan: SR 7 Days Pain Scale Nurse

6 wks

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINT[redacted]

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. ICW2

[redacted] (b)(6)-4

EPW

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
[illegible]	[illegible]
	[illegible]
	[illegible]
	[illegible]
	D/C to [illegible] Camp [redacted] (b)(6)-2

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

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD

PROGRESS NOTES

DATE	NOTES
6Jul03 1925	SL restarted in (L) AC, center - outer AL (L) site ddd s/s infection - no c/o pain - pt. voided 300cc urine @1730 - pt can wiggle (L) toes & has good sensation (5)(6)-2 <2sec cap. refill in (L) toes - [redacted] CRN
6Jul03 @ 2200	Pt. sleeping, easily aroused. VSS. CTA (B), (+) BS x fades & c/o pain. HL flushing easily. abd: soft, ND (-) TTP. (L) LE dsg CDI (+) movement & sensation to toes. taking PO well. Will cont to monitor — (5)(6)-2 [redacted] SPC 91WM6
7July03 0700	Pt. asleep in bed easily aroused by verbal stimuli. VSS, slightly bradycardic P 47. lung sounds clear bilat. HL in (L) AC s/s of infection. Pt. has cast to (L) LE, full ROM in (L) LE digits, cap refill <3sec, (+) sensation. All other assessment findings WNL. Pt. c̄ complaints @ this time. Will continue to monitor. (5)(6)-2 [redacted] 2LT/AN
7Jul03 1335	assumed care @1300 - VSS - split cast, ace wrap CDI on (L) LE - given scheduled motrin - SL patent in (L) AC - pt. can wiggle (L) toes, <2 sec. cap. refill in (L) toes - no c/o pain @ this time — [redacted] CRNA (5)(6)-2

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

UNIT./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. ICW2

EPW

[redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

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

.TE	NOTES
l 03 @	2345: Pt resting, easily aroused, VSS, CTA B, ⊕ BS x4 ad. ⊘ clo pain or discomfort @ this time. abd: soft, NT. (L) LE drsg CDI ⊕ movement & sensation to toes. Brisk cap refill. Will cont to monitor — [redacted] 9llwmb (b)(6)-2
July 03	0600. Assume pt care @ 0500. Pt asleep easy to awake. No c/o pain. (D) LE Splint/ace wrap CD+I. ⊕ sensation ⊕ movement to toes. VSS. HR reg LUNGS CTA BS x4 HL to (R) AC flushes well. Will continue to monitor [redacted] 9llwmb (b)(6)-2
5/1/03	assumed care @ 1300 - VSS - SL patent
1400	in (D) AC - pt. ambulated to bathroom c one crutch c some difficulty - no c/o pain @ this time - splint/ace wrap intact on (D) foot, <2 sec. cap. refill and good movement in (D) toes — [redacted] CPN (b)(6)-2
2230	Pt care assumed @ 2100. VSS, alert and awake, no c/o pain. Lung sounds CTA, pulses palpable x4, BS ⊕ x4, Dsg on lle CDI, ⊕ pulse and sensation, pt able to wiggle toes. Pt resting, will continue to monitor. — [redacted] 9llwmb (b)(6)-2
ly 03	Assumed pt. care @ 0500: pt. A+O x3. lungs CTA
530	⊕ pulses x4. ⊕ BS x4. HL in (R) AC patent! Dsing c ace wrap on (R) leg CDI. ⊕ Sensation + Movement in (L) toes. ⊘ Complaints — [redacted] 9lwmb. (b)(6)-2
96.7	
54	
16	
117/66	
98%	

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
9 July 03 1400	assumed pt care @ 1300. pt awake & alert. VSS. lungs CTA, abd soft, nondender. BS(+)x4. RLE c̄ full ROM (+) pulse. LE c̄ drsing CDI, pt able to wiggle toes. HL to LFA flushes well. (-) redness/swelling noted. (-)c/o pain/discomfort noted @ this time. Will cont to monitor — (b)(6)-2 [redacted] 91WM6
2230 9 July	Pt care assumed @2100. VSS, lungs CTA, pulses palpable x4, bs(+)x4. Dsg to lle CDI, pt c̄ + sensation and capillary refill to lle. No complaints at this time. HL to lfa intact flushes well. [redacted] (b)(6)-2 91WM6
10 July 03	Assumed care of pt @ 0500. Pt asleep. Lungs CTA. Bowel sounds x 4 quads. Pulses palpable. HL to (R) arm - patent. Pt has (-) c/o pain / discomfort @ this. Will continue to monitor — [redacted], LPN, SGT (b)(6)-2
0500 96.5 61 18 110/72 98%	
10 Jul 03 2030	assumed care @1300 - VSS - SL patent - pt. can ambulate c̄ crutches per Dr. [redacted] neurov's intact for (R) LE — [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SSN or Other (b)(6)-2

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No. or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | CARD NO. ICW 2

PROGRESS NOTES
Medical Record
STANDARD FORM 509

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

MIDDLE INITIAL | ID NUMBER

NOTES

2130 10 July — Pt care assumed @ 2100. VSS, pt resting. ∅ c/o pain. Lung sounds CTA, ∅ bs ⊕ x 4 quads. HL @ L wrist patent. Dsg on lle CDI, ⊕ sensation, ⊕ cap refill. Pt ∅ complaints at this time, will continue to monitor. (b)(6)-2 [redacted] 91WM6

11 July 03 0840 — Pt. awake & alert sitting up in bed bathing. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt HL in ⓛ FA flushed well c̄ 5cc NS ∅ s/s of infection or infiltration. Splint dressing to ⓛ LE CDI, sensation in digits (+), full ROM, <3 sec cap refill. Pt. has white splotches over upper trunk & neck, looks like a fungus of some sort. Pt. VSS, ∅ complaints @ this time. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted] 2CT/AN

0525 96.7 53 18 100/69 98%

1 July 03 1745 — Assumed care @ 1300 - VSS - ⓛ FA SL patent - splint intact on ⓛ LE, neuro V's intact - pt. to have sutures removed 13 July 03 - [redacted] CR, AN

(b)(6)-2

AUTHORIZED FOR LOCAL REPR

CAL RECORD | PROGRESS NOTES

TE	NOTES
12 July 0145	Pt care assumed @ 2100. VSS, alert and awake, no c/o pain. Lung sounds CTA, DS (+) x4 quads. Dsg on LLE CDI, pt able to wiggle toes, (+) sensation, (+) cap refill. HL flushes well, IV ABX tx continues. No complaints at this time, will continue to monitor. (b)(6)-2 [redacted] 9LWMC
12 July 0600	Pt. VSS, asleep in bed easily aroused by verbal stimuli. HR reg, Lung sounds clear bilat, bowel sounds (+) x 4 quads (L) LE c̄ cast, digits c̄ (+) sensation, full ROM, cap refill <3sec. Pt. c̄ fungus-like white splotches on neck & upper back, pt. c/o the site being itchy. HL (R) FA c̄ s/s of infection. All other assessment findings WNL. Pt. c̄ other complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] 2LYK
12 Jul 03 1530	assumed care @ 1300 - VSS - SL patent - splint removed by MD - SPC [redacted] (b)(6)-2 removed sutures and placed steri strips on (L) LE wound, all edges approximated except small area in middle of wound, no suture was on that spot, MD aware of that area - SL WC placed by orthotech, (L) LE elevated @ present - pt. awaiting transport to EPW camp [redacted] CR
12 Jul 03 1600	neuro's intact in (L) toes [redacted] CR, AV

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

I CW 2

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

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

TE	NOTES
2300 12JUL	Pt care assumed @2100. VSS, no c/o pain. Lung sounds CTA, pulses palpable x4. Deg on lle SLC, col. Pt c̄ (-) sensation, able to wiggle toes. Pt c̄ no IV access, taking PO meds. Possible D/C in am, continue to monitor. [redacted] (5)(6)-2 assumed
13JULY 0548	Pt. asleep in bed easily aroused by verbal stimuli. HR Regular, Lung sounds clear bilat, bowel sounds (+) x4 quads. (L) LE c̄ cast, digits c̄ full ROM, (+) sensation, cap refill <3 sec. Pt. c̄ complaints @ this time. Pt ready to D/C to EPW camp. All other assessment findings WNL. [redacted] (5)(6)-2 24/AA
0605 96.8 64 18 110/72 97%	
13JUL03 1600	assumed care @ 1300 - VSS - no c/o pain @ this time - neuro V's intact in (D) toes, pt. can walk slowly c̄ difficulty - had BM today - awaiting transport to camp - [redacted] (5)(6)-2 CH, AA
13JUL03 1900	pt's wrists restrained c̄ flex tix, escorted to x rays, dc summary & meds by MP to helicopter for transport back to EPW camp - [redacted] (5)(6)-2

558-103 Sec. [redacted] (b)(6)-2

EMERGENCY CARE AND TREATMENT
(Medical Record)

(Instructions on Back of Sheet)

NSN

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR	
4	July	03	0925

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

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

HISTORY OBTAINED: [ ] PATIENT [ ] O

ALLERGIES: NKDA

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

CHIEF COMPLAINT(S) (Include symptom(s), duration) (b)(6)-2 [redacted]

SEX: M AGE: 28

HOME TELE. NO. (In

POSSIBLE THIRD PA
[ ] YES [ ]

TIME SEEN BY PRO

Epid 97

VITAL SIGNS

TIME	0919		
BP	124/64		
PULSE	92		
RESP.	16		
TEMP.	96.5		
WT. (Child)	75 kg		

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

ORDERS	INITS.	TIME
X-Ray (L) Ankle.		

ASSESSMENT/DIAGNOSIS
GSW to (L) fibula ankle.

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

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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

28 y/o ♂ hx of attempting to steal car and driver of car fired shot him in self defense in the (L) ankle.

O. VSS Afebrile
HEENT clear
PMT clear
Neck supple
Chest lungs clear
heart RRR
Abd benign.
Bone ML ankle 1+
Ext pulses reflexes ok.
Entrance wound lateral (L) ankle.
Dorsal plantar flexion ok.
minimal bleeding
Exit: (L) ankle.
bullet through fibula.

(b)(6)-2 (CONTINUE ON SF 507, IF NEEDED)

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

SIGNATURE OF PROVIDER AND ID STAMP
[redacted] LTC MC 735

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations, plans)
Orthe Admit

[redacted] (b)(6)-4

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 28

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
I&D (L) ankle

4. PROPOSED SURGICAL PROCEDURE:
(L) Ankle I & D.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco ___ ppd X ___ yrs. Body Piercing ___ Diabetes (Y) (N) ROM ___ ASA/Motrin w/72 hrs (Y) (N)
ETOH ___ Implants ___ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ___ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

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

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

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: 1) Intraoperative Mobility 2) Positioning 3) Existing Disease 4) Safety Devices 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: 1) Pain 2) Intraoperative Hazards 3) Prosthesis 4) Positioning 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: 1) Length of Surgery 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ 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 2) Lower 3) Bridges 4) Caps 5) Crowns	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted] CPT/AN 5 July 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT (✓) (N)
BREATHING EASY: (✓) (N)
(b)(6)-2

12. PREOPERATIVE [redacted] PREPARED BY (Signature and Title) CPT/AN (b)(6)-2
DATE: 5 July 03 TIME: 07

13. POSTOPERATIVE [redacted] PREPARED BY (Signature and Title) [redacted] RN
DATE: 5 July 03 TIME:

REVERSE OF FORM 3179 JUN 91 USAPA V1.0

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Body Litter BY CPT [redacted] (b)(6)-2

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

3. DATE: 6 Jul 03 TIME PATIENT ARRIVED IN SUITE: 1030

4. PATIENT IN ROOM TIME: 1030 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO P MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPEC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	2LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt-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 1LT Malachi

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

Bullie Pad Site

COMMENTS: No nicks

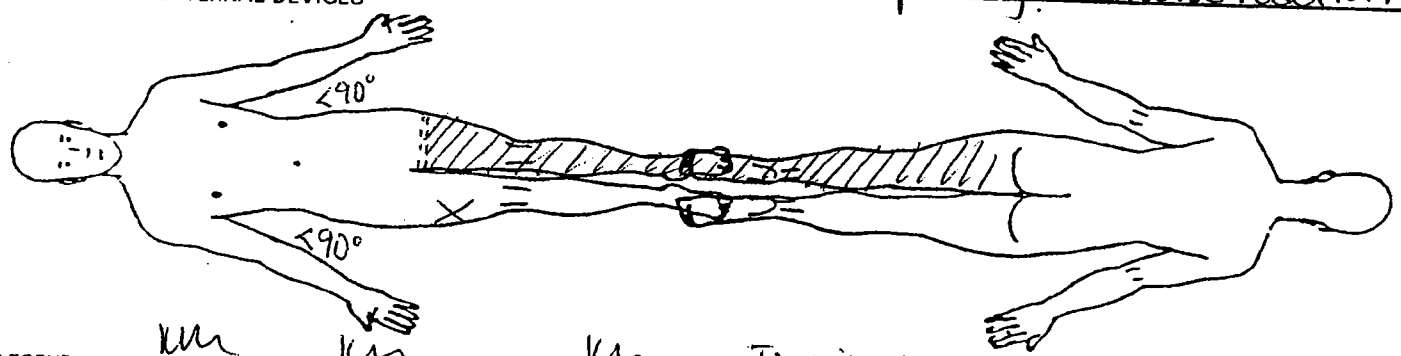
PREP SOLUTION (Specify): Betadine / Betadine

SITE: Left leg BY WHOM: 1LT [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND: X Ground Pad (Km) -- Safety Strap (Km) = = = Tourniquet (Km) Tourniquet @ 250mmHg X

Initial: PFC Gesellchen, 1LT Malachi

C = Correct I = Incorrect

10. COUNTS

		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No					
Needle Sharp	☒ Yes ☐ No		C	C	PFC [redacted]	1LT [redacted]
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted] (b)(6)-4

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

☑ ESU NO: Valleylab #3 Cut 30 Coag 30

GROUND PAD: BRAND Valleylab

LOT NO: 65706 Exp 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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 ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
webril
splint ACE

19. ADDITIONAL INFORMATION

GETA

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

DA 5179 in Chart

20. OPERATION(S) PERFORMED

Left ankle I&D

21. PATIENT TRANSFERRED TO 1CU2 (b)(6)-2 TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] 17 AM

USAPA V1.01

REVERSE OF DA FORM 5179-1, O

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. CW2

EPW # [redacted] (5)(6)-4

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

511-119

NSN 7540-00-6

MEDICAL RECORD

VITAL SI

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19

DAY: 4, 5, 6, 7, 8, 9, 10

HOUR

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW 2

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 — ANESTHESIA

DRUG	(Units)	
Versed	(mg)	2.5
Fent	(µg)	200 50
Lido/succs	(mg)	75/80
Propofol	(mg)	200
Nimbex	(mg)	6
	( )	
VOLAT AGENT	% del	1.5/2.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Mn	
O2	L/Min	8 2 2 8

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 LR	☐ Warmed	800
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		min
URINE –		Ø

TOTALS	
TOTAL BIL	min
TOTAL URINE	Ø

FLUIDS – SUMMARY

CRYSTALLOID– 800

COLLOID– Ø

BLOOD– Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 KG LB

HEMATOCRIT: NI

INITIAL DATA: BP – 117/60 HR– 59

CONSP CHECK: OK?– (Y) N

PATIENT SIGNOFF: OK for PROCEDURE? TIME– 1000

TIME → 10 X 11 X 30 X 12 X 30 X 13 X

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

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

VT – ml	S	870	660	AV	SV	
f – breaths/min	12	8	8	5	12	
Peak inf pres / PEEP		20	20			
MODE– S(pon), A(ssist), C(on)	S-C	C	C			
BP/Auto Cuff / ET CO2 (torr)	38	32	31		42	
BP / oth / FIO2 (Frac or %)	.87	.87	.87			
ART line / SpO2 (%)	99	99	100			
Steth- PC/ES / ECG	SR	SR	SR			
Gas analyzer / TEMP- site	Available					
N-M Block (T/4)	(+) twitch					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS Position → 0—1

REMARKS– Code drugs with numbers, events with letters

1030 in OR pt IV – monitors applied.
1035 I@I 5 diff. (+) Bilat BS (+) ETCO2
Tourniquet set 250 mmHg
1055 T/19 V-25 TTT
1118 Reversal 5mg neostigmine, 8mg Robinul
1125 Spont Resp oral suction extubated pt purposful movement
1128 transferred to ICU 2 Report given

RECOVERY AT 1130

PACU ICU ICU2 (Specify)

OTHER 96.5

CONDITION: awake cooperative

RESP– 18 SpO2– 96%

BP– 117/59 HR– 87

ANESTHESIA & PROCEDURE TIME

	Start	Room	End
ANES	1000	1030	1140
PROC	Ready	Begin	End
	1040	1055	1120

PROCEDURES and CPT Codes: I&D (L) foot GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: attempt grade 2 view, 8.0 ETT placed orally (+) ETCO2 (+) Bilat BS, 3 MAC Blade.

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

EPW [redacted] ICW2 / ICU2

(b)(6)-4

SURGEONS [redacted]

ANESTHETISTS: MA CRNA [redacted]

(b)(6)-2

PROCEDURE LOCATION [redacted]

DATE 7/6/03 (b)(2)-2

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 13680

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

HESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

28 DAYS MOS YRS

Sex (✓) MALE ( ) FEMALE

ED PROCEDURE: I&D (L) foot GSW
L SERVICE: Ortho
CE: NPO pm

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

CO: (+)
OH: (+)
GS:

T MEDICATIONS:
red as premed

Ancef
motrin

CATIONS:
(@ ____ Hrs) /CC
LR ____ mg IV IM PO
____ mg IV IM PO
____ mg IV IM PO

TORY STUDIES:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	[redacted] (b)(6)-2
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	Nk
Other Significant Hx:			
	N	Y	GSW (L) foot, shot
	N	Y	while trying to steal
Familial HX	N	Y	car —

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION

BP 118/76 HR 56 R 22 T 96.4
Pain Scale 0-10 ____
HEENT - Teeth Intact Poor condition -
Trachea midline
TMJ/Neck Oral 3FB TM 3FB
Oropharnyx ____
Nares ____
CHEST: RRR
CARDIAC: CTA
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

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

Questions asked & assistance of intubation prove

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

t/legal [redacted] (b)(6)-2 to understand and agrees. Questions answered.

[redacted] Date: 7/6/03 Time: 1000 Hrs

ESTHESIA EVALUATION AND NOTE (NON ASU)
PARENT ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

entification: (Ward) ICW2 - ICU2

[redacted] (b)(6)-7

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

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)-7

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

DATE OF ORDER | TIME OF ORDER 0930 HOURS | LIST TIME ORDER NOTED AND SIGN

✓ Admit: ICW 2
✓ (D) Anle GSW Fe
✓ Stable
✓ VS per Rsn
✓ Acth Bedrest
Fig (Elevate (D) LE
~~Rec Diet~~

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

NPO
✓ IV - LR @ 100cc/hr
✓ Meds: Ancef 1 gm IV Q8°
✓ MSO4 2 mg IV Q2 prn
Reglan 1 IV Q 4h prn
✓ Mon gud PCTED
✓ For OR Study on Lateral

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

✓ IV we doame Bags

(b)(6)-2 [redacted]

4JUL03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

DATE OF ORDER: 6 Jun 03 | TIME OF ORDER: 1130 HOURS | LIST TIME ORDER NOTED AND SIGN

Transfer PACU → ICW2
s/p R & D (b) Ankle GSW Rt
spine (b)(6)-2 [redacted] MD
Resume preop meds
Pt Diet 1500

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO.: 24°C/S | BED NO.: 19

DATE OF ORDER: Plan: Transfer to DMA | TIME OF ORDER: HOURS | 7 Day

Pt SR [redacted] noted

(b)(6)-2 [redacted]

09 JUN 03

(b)(6)-5

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

DATE OF ORDER: 12 Jul 03 | TIME OF ORDER: 0750 HOURS

Clotrimazole cream - apply to affected area TID

noted 12 July 0740

[redacted]

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

DATE OF ORDER: 12 Jul 03 | TIME OF ORDER: 1300 HOURS

SR/SS (b)(6)-2 [redacted]
SLWC
DC to DMA

12 Jul 03 1540

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.
ICW2	24/522	19

DATE OF ORDER: 12 Jul 03 TIME OF ORDER: 2115 HOURS

LIST T ORDE NOTED SIGN

① DC ancef

② Keflex 250mg PO Q 1D pro Dc [redacted] 2100

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

13 July 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

CLINICAL RECORD

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

Mo July Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10	11	12	13
4 July	[redacted]	vitals: per routine	06	[redacted]									
			14										
			22										
4 July	[redacted]	Activity: Bedrest c̄ ice/ elevate (L) LE	06	[redacted]									
			22										
4 July (OTW)	[redacted]	Diet: NPO-Δ'd B Regular diet	07	[redacted]									
			11										
			17										
~~to~~	[redacted]	~~Activity: ma/SS ambulate~~											
to	[redacted]	pt. may ambulate c̄ crutches	05										
			13										
			21										

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) ankle GSW fx

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 July Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4July	[redacted]	Admit to ICW2 :	—	—	—	[redacted]
4July	[redacted]	condition stable	—	—	—	[redacted]
4July	[redacted]	For OR 5July or later today if we do	4or5July			[redacted]
	-----	any cases			6Jul	[redacted]
6	[redacted]	transfer PACU→ICW2	6	1230	/	[redacted]
6	[redacted]	resume preop orders	6	1230	/	[redacted]
6	[redacted]	Plan: transfer to dist 7d p suture	/	—	—	/
	-----	removal and casting	noted			[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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. July Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION !

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10	11	12	13				
4July	[redacted]	~~IV: LR @ 100 cc/hr~~	06	[redacted]													
6July	[redacted]	HL	14														
			22														
4July	[redacted]	Ancef 1 gram IV q 8°	8	[redacted]													
			16														
			24														
4July	[redacted]	Motrin 800mg PO TID	06	[redacted]													
			14														
			22														
12July	[redacted]	Clotrimazole cream: apply to affected area TID	06									[redacted]					
			14														
			22														
12	[redacted]	Keflex 250mg PO QID - see outpt. meds	06														
			12														
			18														
			24														

DCd 12Jul03

DCd 12Jul03

DCd 12Jul03

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) ankle GSW fx.

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

USAPA V1.00

FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. July Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
4 July	[redacted]	MSO4 2mg IV q2° PRN	
4 JUL 03	[redacted]	PERCOCET II PO Q 4 hr prn	DC'd [redacted] 13 JUL 03 (b)(6)-2

(b)(6)-2

USAPA V1.00

28y/o

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: 6 Jul 03
Time In: 1130
Allergies: NKDA
Pre-op V/S: 117/60, 59
Procedures: GSW (L) Ankle

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid —
OR Output: UOP Ø EBL MINIMAL
Meds/Times: .5 2mg Versed 250 fent

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

Pre Op Meds History

Time	1130	1135	1140	1145	1150	1155	1200	1205
SaO2	96	96	96	95	94	94	95	94
FiO2	/	/	/	/	/	/	/	/
Methods	RA	RA	RA	RA	RA	RA	RA	RA
240								
220								
200								
180								
160								
140								
120	1	1	1	1	1	1	✓	✓
100								
80								
60		✓		✓				
40								
20								
RR	10	10	12	12	12	12		
T	97.5					97		

Time	1150
Pain (0-10)	2
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

(b)(6)-7

PREPARED BY (Signature & Title): [redacted] SGT. 9 Lumb

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 6 JUL 03

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

EPW # [redacted] (b)(6)-7

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

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

USAPPC V2.00

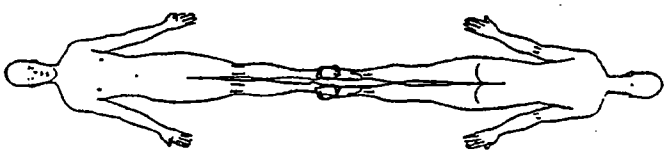
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LUE	+	+	+	B	C	PK
15'	LUE	+	+	+	B	C	PK
30'	LUE	+	+	+	B	C	PK
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	(L) LE	Soft Splint	Ø
30'	(L) LE	Soft Splint	Ø
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1130 Recieved from OR A+OX3. VSS O2 SAT 96, Able to move LUE (+) Pulse. Lungs CTA bilaterally. (+) BS X4 Quads. Able to cough + Deep breath. Will Continue to monitor - [redacted] 91 [illegible] SGT (b)(6)-2

1155 Cardiac Rhythm is Sinus brady @ 58 bpm. Non-Symptomatic. No Complaints of pain or discomfort. DRSG (L) LE CDI. Will Continue to monitor. - [redacted] (b)(6)-2 SGT 91 [illegible]

1210 Report Given to ICW 2. Condition Stable for transport. Recovery time 40 minutes VSS O2 SAT 95%. Will Continue to monitor - [redacted] - SGT 91 [illegible] (b)(6)-2

Discharge Criteria:
Date: 6 Jul 03 Time: 1210 hrs PARS: 12
BP: 119/60 T: 97' HR: 59 RR: 12 SaO2: 95%
Pain Level at D/C (0-10): 0
Intake: 100 Output: Ø
Additional Data: —
Transferred To: ICW 2
Report Given To: SFC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room OP B-3 [redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. [redacted] A
3. NAME [redacted]	4. DATE OF BIRTH
5. RANK	6. [redacted] (b)(6)-4
7. UNIT OF EPW	8. CAPTURING UNIT 1/1 CAV
9. LOCATION OF CAPTURE (*Grid coordinates*)	
10. CIRCUMSTANCES OF CAPTURE Car Traffic	11. PHYSICAL CONDITION OF EPW Stay in L fwd	12. WEAPONS, EQUIPMENT, DOCUMENTS

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. [redacted] 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

(b)(6)-4

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. [redacted] 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	

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE
030703	2[redacted]

TIME / HEURE	2215			
BP / PS	119/59	SpO2 96		
PULSE / POULS	57			
RESP / RESP	20			

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

2nd Bag @ 2235 100mL
LR ⊼ 1gm Ancef in Bag

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

Has "punch out" fx. (L) distal fibula w/ entry / exit wounds

A: Distal fibula fx. 2° GSW
P: Evac. to CSH for cast vs. possible debridement

(b)(6)-2

551 A.S.M.C

[redacted] MD — DATE/DATE (YYMMDD) 030703

DISPOSITION		TIME / HEURE
	RETURNED TO DUTY / RETOUR À L'UNITÉ	2300
	X EVACUATED / EVACUÉ	
	DECEASED / DÉCÉDÉ	

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

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

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

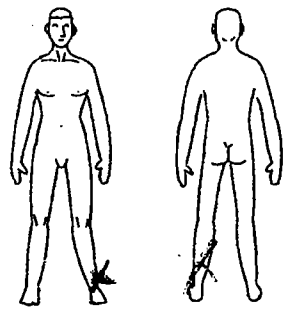
2. [redacted] (b)(2)-2

FORCE / ÉLÉMENT | NATIONALITY / NATIONALITÉ: IRAQ

A/T	AF/A	N/M	MC/M	BC / BC	NBI / BNC	DISEASE / MALADIE	PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- ✓ WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

GSW
(L) ANKLE

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ✓ ALERT / ALERTE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- VERBAL RESPONSE / RÉPONSE VERBALE
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
120	1932	✓ NO / NON; YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
✓ NO / NON; YES / OUI			500 mL	2152

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

DRESS AND SPLINT WITH BACITRACIN
(+) DISTAL PULSE AND CAP REFILL
100/52 R: 22
* entrance: Achil. tend.
exit: lat ankle near top of foot

10. DISPOSITION / DISPOSITION		TIME / HEURE
	RETURNED TO DUTY / RETOUR À L'UNITÉ	2150
	✓ EVACUATED / EVACUÉ	
	DECEASED / DÉCÉDÉ	

[redacted] (b)(6)-2 — DATE/DATE (YYMMDD) 030703

DD Form 1380, DEC 91 — Previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	2 8 y	Z	9	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	u	0930	N/A (5)(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (5)(2)-2	

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

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		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: (L) ankle GSW fx

Dx: 8911
E9912
Px: 7966

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] (5)(6)-2	[redacted]

DA FORM 2098, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER	2 NAME (Last, First, MI)	3 GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted]	N/A	

SEX	AGE	RACE	RELIGION	LENGTH OF SVC	ETS	PREVIOUS ADMISSION
m	284	Z	(b)(6)-4	N/A	N/A	No

PAY GRADE	SSN	ORGANIZATION	WARD
20	[redacted]	N/A	ICW2

FLYING STATUS	DSG	BEN	BRANCH/CORPS	UIC/ZIP	TYPE CASE
N/A	K79	N/A			W1A

SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	HOURS OF ADMISSION	CLINIC SERVICE
Direct from ER	1915	AEAA

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	TYPE DISPOSITION	DATE OF DISPOSITION
—	50	5 Jul 03

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NO.	DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	4 Jul 03	(b)(6)-2 Dr [redacted]

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	DATE OF INTIAL ADMISSION	UNIT OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] (b)(2)-2		

ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

CAUSE OF INJURY

DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(R) humerous fx

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	2	2

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	2	2

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted] Dr [redacted]

SIGNATURE OF [redacted] RECORDS OFFICER: For [redacted]

DA FORM [redacted] MAY 79 EDITION OF 1 JUL 70 IS OBSOLETE

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
	admit note: Pt. admitted as boarder only. Pt a/ox3, VSS, ∅ complaints. Cast on (R) Arm. good cap refill. (+) sensation & movement of digits. Pt up to be DIC'd @ 0700 to epw camp. Will cont to monitor — (b)(6)-2 [redacted] 91WM6.
5 JUL 03 0800 122/70 HR 76 RR 16 T 98.0	Pt awake & alert. VSS. NAD. Cast intact to (R) arm, DSG to (R) hand D & I. Lungs CTA & =. Pulses strong & =. BS (+) x4. Resting quietly @ present [redacted] MAS/IAS (b)(6)-2
5 July 03 1315	assumed pt care @ 1300. pt is a boarder. Pt awake & alert, VSS. cast to (R) arm (+) sensation, (+) movement < 3 sec cap refill. assessment finds WNL. (∅) complaints voiced. will cont to monitor — [redacted] 91WM6 SGT (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO (SSN or Other)
	LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (F

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 4 July 03	TIME 1830
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Aero	

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

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

CHIEF COMPLAINT GSW to Right Homerous

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME 1830					
		BP 105/66					
☐ URGENT		PULSE 81					
	INITIALS	RESP 14					
		TEMP 99.4					
☒ NON-URGENT		WT 5'10" 97#					

LAB ORDERS						X-RAY ORDERS		
X	CBC/DIFF	ABG	PT/PTT		BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S	UA MSCC/CATH		X	CHEM: not ?		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X						SINUS	HEAD CT
							ANKLE R/L	X (L) Homerous

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1830	1G LR		[redacted]	(b)(6)-2	
↓	1g Ancef				
	12.5mg				
2030	10mg MSO4		[redacted] in ER		

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC				SUP O2	PH	PO2	RESULTS	
H/H				PCO2	SAT	OTHER	(R) Fractured Humerus	
PLT								
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

25 y/o EPW ♂ c̄ c/o GSW to (Right) humerous. X 10 DAYS ago Pt was shot for Burgerly. Pt has FRM in digits and wrist, ⊕ Bounding pulse distal to injury. PT came in Alert X3, no past surgery. Pt states that he is Anemic. GSW was stitched up and Pt came with a SAM splint on. 9/10

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

GE: WD, WN, NAD AAOX3
Ext. well Healed wounds (R), NVI, Fair ROM wrist/Fingers.
NO compartment tenderness.

(b)(6)-2

Pt seen + Exam by ortho Dr [redacted] - Hanging Arm CAST +

(R) Hanging Arm cast. Return to ER w collapse c̄

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

(R) Arm Humerus Fx, 10 Days old

CODES (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)*

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1		2											
POST- DAY															
MONTH-YEAR 003	DAY	4 July		5											
19 2003	HOUR	23													
PULSE (0)	TEMP. F (°)	18													TEMP. C
	105°	30													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°	3													35.0°
80		A													
70															
60		A													
50															
40															
RESPIRATION RECORD		11													
		66													
BLOOD PRESSURE		120/80													
		120/80													
HEIGHT:	WEIGHT →														
		99%													
		RA													

(Centigrade Equivalents, for Reference only)

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. FCW2

EPW [redacted] (5)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2

Ward/Section: Emr

REQUESTING PHYSICIAN: [redacted]

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted]

DATE: 7/4/03

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		6.4-8.1 g/dl

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
GLU	145	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	234	39-380 u/l (M) 30-190 u/l (F)
NA^+	130	128-145 mmol/l
K^+	4.0	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	23	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: [redacted]

DATE: 4 Jul 03

LAB ID NO.:

(b)(6)-2

Ward/Section: Emst

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

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

LAST, FIRST, MI: [redacted] (b)(6)-2

DATE: 7/4/03

TIME:

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.8	4.8-10.8 x 10^3
RBC	5.54	4.7-6.1 x 10^9
Hgb	13.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	46.7	42-52% (M) 37-47% (F)
MCV	84.3	80-94 fl (M) 81-99 fl (F)
Plt	516	130-500 x 10^3 verified
Lymph %	25.3	20.5-51.1%

(Hematology) Manual Differential

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

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:

LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

EPW

NURSING UNIT	ROOM NO.	BED NO.
ICW2		2

DATE OF ORDER: 04 July 03 TIME OF ORDER: 1915 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ICW #2
Dx: @ Humerus Fracture
Condition: Stable
Vitals Per Protocol
ALL: NKDA
Meds: ~~250 mg po @~~
650 mg Tylenol po q6° prn

[redacted] (b)(6)-2 2030

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		2

DATE OF ORDER: TIME OF ORDER: HOURS

Diet: Regular
Activity: As tolerated
Nursg: F.U prescriptions for nausea + Reflux
Discharge patient @ 0700 and
Return him to EPW camp
- Pt is a Boarder only (b)(6)-2 [redacted] D

(b)(6)-5

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF [redacted] HOURS

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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 4	5	6	7
4	[redacted]	vitals per routine	06	/	[redacted]		
			14	/			
			22	[redacted]			
			/				
4	[redacted]	diet-regular	07	/	[redacted]		
			11	/			
			17	/			
			/				
4	[redacted]	activity: as tol	06	/	[redacted]		
			14	/			
			22	[redacted]			

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) numerus Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (5)(6)-4

EPW [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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	
4	[redacted]	admit to ICWZ	4th	2100	[redacted]		
4	[redacted]	condition stable	4				
4	[redacted]	DC pt. @0700 and return him					
	-----	to EPW camp	5				
4	[redacted]	Pt is a boarder	4	noted	[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

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														
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ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (P) numerous Ex

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. 7 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
4	[redacted]	motrin & Keflex prescriptions				
(4)(6)-2		in pharmacy				
	- - - - -					
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	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
4	[redacted]	Tylenol 650mg PO														
(4)(6)-2		Q6H - prn														
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USAPA V1.00

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

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A) (P)

TIME			
AGE		SEX	
LUNGS			
PULSE			
RESP.			
B.P.			
A	V	P	U

Patient Name (if known) [redacted] (b)(6)-4

Notes/Treatment G.S.W TO (R) side Distal to Scapula thrue the (R) ARM possible fracture to (R) humerus with deformity with no range of motion to ARM. It has good pulses and capillary refill

To be given to:
TRANSPORTATION OFFICER

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

Priority # [redacted] 2 [redacted]

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	[redacted] 4	Z	9	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A.	U	1915	N/A (b)(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 7 Ø 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 7 Ø 4

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

FOR LOCAL USE

Dx: (R) humerous fx

Dx: 812.30
E9912
Px: 7961

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] (b)(6)-2	[redacted] 91610, PFC

DA FORM 2085, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER [redacted]			2. NAME (La. ...) EPW [redacted]			GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE unk	6. RACE Z	7. RELIGION (b)(6)-7	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION N/A		14. WARD 10W	
15. FLYING STATUS N/A	16. RATING/ CSG	17. DEPT./ BEN K78		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 1430	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —				25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 26 Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —				27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 5 Jul 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (R) Femur fx

821.11
E991.2

7/5 79.25
78.15
7/13 79.65
93.59
7/21 79.65
8/4 79.65
93.59

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	51	51

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	51	51

SIGNATURE [redacted] MEDICAL OFFICER (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

DA FORM [redacted] MAY 70

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible]

PHYSICAL EXAMINATION

[illegible]

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

[illegible]

SIGNATURE OF [redacted]	(b)(6)-2	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICA[redacted]	*(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

EPW [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

(b)(6)-2

8-25-03 Pt. refs. d cleocin. [redacted] CTAN
1640

1942 Discussed pt's refusal of care c̄ MD. If pt. is compliant c̄ care, MD will D/C to camp tomorrow. Pt. is [redacted] CTAN
aware of plan

(b)(6)-2

2200	98.0
	88
	20
	100%
	118/74

26Aug03 assumed care @ 2200 - VSS - took 2400 abt as
0015 ordered - dsgs intact on pin sites, sutures in thigh wound intact, neuro V's WNL in (R) foot - pt. expressed desire to be discharged since he feels his surgeries have been unsuccessful (b)(6)-2 [redacted] CTAN
0400 Pt vitals BP 108/61 P 78 T 99.6 R 14 Spo2 99 SPC [redacted] 911
0315 - Pt alert & oriented lying in bed. C/o pain, gave percocet PO. VSS, lungs CTA, BS⊕, pulses ⊕ x 4. Ext fix intact to (R) leg. Pt wishing to get D/C to camp today. Will cont to monitor (b)(6)-2 [redacted] 2600
0826 pt. care assumed @ 1400. HR Reg, lungs CTA, BS ⊕ x4. Pt performed self pin-care and self dsng Δ. Ex-fix to (R) leg intact, dsng to pin sites CDI. (R) leg ext. NV checks WNL. pt. awaiting D/C to camp. Will cont. to monitor (b)(6)-2 [redacted] CTAN

~~26Aug03~~ 2200	98.3
	83
	24
	100%
	122/71
	∅

27Aug03 assumed care @ 2200 - VSS - no c/o pain @
0015 this time - dsg intact on (R) ex fix pin sites - neuro V's WNL in (R) foot - pt. to be d/c'd to BPW camp today - DC summary in chart [redacted] CTAN
27AUG0300400 P 79, BR 99, BP 103/65, T 96 [redacted] SPC FUQUA 911
(b)(6)-2

27 Aug03 Pt. awake & alert & complaints @ this time. VSS. AM care completed
1215 HR Regular, lung sounds clear bilat, bowel sounds (+) X4 quads. Pt. ⊼
IV access. Pt. c/o pain x 1 @ 0800, ⊼ percocet given. Pt. ⊼ D/C summary
& order in place, meds @ bedside, awaiting evac to EPW camp. WILL
continue to monitor. (b)(6)-2 [redacted] CPT/AN

1620 Pt. care assumed @ 1400. Pt. stable ⊼ ∅ complaints. HR Reg,
lungs CTA, BS (P) X4. Ex-fix to (R) ↓ ext intact, drsng
to pin sites C.D.I. Neuro vasc. checks. (R) ↓ ext WWL. will
cont. to monitor. (b)(6)-2 [redacted] CPT/AN

28Aug03 assumed care @ 2200 - VSS - pt. refused
~~1450~~ 2000 dsg Δ and 2400 dose of cleocin - medicated
0250 for pain @ 0215 ⊼ 800 mg motrin PO - pt. to be d'c'd
to EPW camp @ 1800 28Aug03 [redacted] CPT/AN
(b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
7/4/03	0500 assume care. Report given, see Initial Assessment for [redacted] (b)(6)-2
	0630 5mg MSO4 +UP. for leg pain [redacted]
	0700 pt asleep. VSS. Ø distress noted [redacted]
	0800 pt. s difficulty. [redacted]
	1030 VSS. Ø distress. Leg (R) warm, able to wiggle toes s difficulty. pain from knee decreased. +2 pulse noted [redacted]
	1250 DASG remains intact. Area cleansed, bound, ext. Ex. [redacted] (b)(6)-2
	1510 assist partial bath. new linen. Alert & cleans, chat on [redacted]
1600	denies any pain @ this time [redacted]
	1730 07Jul03 - Received call of pt. vss [illegible] @ pain 03 rec [illegible] Ctrl to truck, @ pt's + (R) LE. [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

EPW [redacted] (b)(6)-4 7/4/03

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8JUL03	pt A/O. VSS. assessment complete; distal pulses palpable;
0600	VS: 135/71, 83, 16, 96%, RA, 98.3 [redacted]
0830	pt tolerated breakfast; MSO4 for pain. (b)(6)-2 [redacted]
0945	WP BID; no change in status
1100	no change in status; ~~IV~~ MSO4 5mg IVP for pain; WP 1000 cc tolerated lunch well [redacted]
1100:	126/68, 89, 12, 96%; 99.3 (b)(6)-2 [redacted] CPT
1835-8July03	Pt Received, physical assessment Completed + Recorded on physical assessment form, (R) PIV Flushed, IV D/C'd, (L) PIV Flushed, pt consumed 90% evening meal, 250cc po Fluid [redacted] CPT/AN
2000-8July03	Pt ↑ Chair ō 2x Assists, (b)(6)-2 Some Bleeding Noted from Lower Pin site, Oriented to crutches, c/o pain 2Mg MSO4 IV Given [redacted]
2200-8July03	Pin Care Completed with ½ strength Hydrogen peroxide [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.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCA

:DICAL RECORD | PROGRESS NOTES

DATE	NOTES
15JUL08	Rec'd c/o pt. @ 21:00. Awake and alert in bed. Restraints x2
21:42	(R) wrist (L) ankle. PERRLA (+). Skin color WNL. LCA (B). BS (+) x4.
	(+) PPP (B). (R) ↑ ext. fix in place (+) SXS infection @ pin sited.
	(+) redness (+) swelling (+) drainage. (+) ROM to toes. (+) <3 sec
	cap refill. sutures to (R) thigh intact. C/o pain x1. ii Percocet
	given. Will cont. to mon (b)(6)-2 [redacted] /AN (b)(6)-2
0320	c/o pain in (R) leg x1. ~~tx~~ ii Percocet given will mon [redacted] /AN
0540	Pt. care assumed @ 0500. Pt. awake, resting quietly.
	HR Reg, Lungs CTA throughout. BS (+) X4, ABD soft,
	flat. (R) ex-fix to femur intact. 1+ edema noted
	to (R) femur. Pedal pulses (R) ft 2+ c̄ brisk cap refill,
	(+) ROM, (+) Sensation (R) LE. (R) leg ↑ on blankets.
	Pin sites (R) femur OTA ∅ new drainage. Crusted
	drainage noted at pin sites. Will assist pt. c̄ pin
	care. Pt. c/o min pain @ this time. (medicated
	@ 0330). Will cont. to monitor. — [redacted] LCP/AN
0710	Pt. given ii Percocet for pain (R) LE. — (b)(6)-2 [redacted] LCP/AN
1000	Pt. assisted c̄ pin care. Skin to pinsites 3 & 4 [redacted]
	adhered to pins, erythema & purulent drainage noted. P̄ pin
	care, pin sites covered c̄ w → D. — [redacted] LCP/AN
	(b)(6)-2

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S I (SSN or Other)
	LAST	FIRST	MI	
/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

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

PROGRESS NOTES
Medical Record
STANDARD FORM 50

AUTHORIZED FOR LOCAL REPR

CAL RECORD | PROGRESS NOTES

16/July/03 - Assumed PT care @ 1300 hrs. Received PT resting comfortably in bed. c̄ N/O c/o PAIN. VSS. BS in all 4 QUADS present, c̄ no abdominal distention. Breath sounds are equal on both sides. PT has good Pulse notch function on (R) foot. Minimal amount of swelling noted on (R) foot. Good Pedal pulse present (+2). (R) leg elevated 15°. No drainage noted in pin care. No S/S of infection is visible, but will continue to monitor for drainage.

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

17 July 03 0020 Pt awake & alert in bed c̄ complaints @ this time. HR Reg. Lung sounds clear bilat, bowel sounds slightly hypoactive x 4 quads, ABD hard, pt. c̄ c/o pain c̄ palpation. DSG to (R) ext. fix on leg CDI. (R) pedal pulses palpable, sensation (+), capr refill < 3 sec, full ROM. (L) LE ↑ @ 30°. Pin care done via pt. All other assessment findings WNL. Pt. c̄ IV access. Will continue to monitor. (b)(6)-2 [redacted] LPN

0620 Pt. care assumed @ 0500. VSS. Pt. c/o min pain @ this time. HR Reg. Lungs CTA, BS (+) x 4. Ex-fix to (R) femur intact, dsng CDI. 1+ edema to (R) thigh. (R) ft c̄ (+) sensation, (+) ROM, brisk capr refill, pulse 2+. (R) leg ↑ on blanket. Will cont. to monitor (b)(6)-2 [redacted] LPN

0730 ~~Pt. care~~ AS Pt. assisted c̄ pin care. Pin sites 1, 2 ∅ drainage. #3 c̄ purulent drainage. #4 ∅ drainage. Pin sites covered c̄ Kerlix. See diagram over

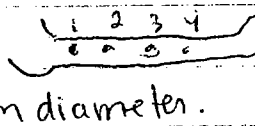
SPONSOR'S NAME			SPONSOR'S ID (SSN or Other)
LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

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

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

TE | NOTES

7-17 cont.  Pinsite #3 c̄ skin breakdown approx. 1cm diameter. (b)(6)-2 [redacted] /LT/AN.

17Jul03 assumed care @ 1300 - VSS - dsg intact on
1410 (R) leg ex fix, pinsites covered, stitches above lower pins have small open area c̄ small amt of drainage - c/o small amount of pain will continue to monitor, given 800 mg motrin PC (b)(6)-2 [redacted] CRA/AN

17Jul03 Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Awake and
2236 alert in bed. Restraints x2 (L) wrist and ankle. Skin color WNL. PERRLA (+) WNL. ICA (B). BS (+) x4. (+) PPP (B). (R) ↓ ext ex. Fix intact. Kerlix dsg CDI. Pinsites (+) Redness (+) drainage (+) swelling (R) leg. c/o pain x1 ⅓ Percocet given. Will cont to mon
(b)(6)-2 [redacted] 2nd/AW

17Jul03 Pin care done. 3rd and 2/4th distal pins debrided c̄
23:31 Dr. [redacted] guidance. Copious amt pus ~~dep~~ debrided c̄ sterile scissors. Eschar debrided from sutures to outer aspect of thigh. Dr. (b)(6)-2 [redacted] to discuss possible washout for 18 Jul c̄ surgeons. (R) thigh cool to touch @ cont'l la hot to touch and tender. Will cont to mon.
(b)(6)-2 [redacted] 2LT/AW

06 40 Pt. care assumed @ 0500. VSS. HR Reg, lungs CTA, BS (+) x4. Pt. denies pain @ this time. (R) LE ex fix intact, dsng CDI. (R) LE edematous, hot to touch, appears shorter than (L) leg. (R) LE has pedal pulse 2+ c̄ (+) sensation, (+) ROM, brisk cap refill. Will cont. to monitor. [redacted] /LT/AW
(b)(6)-2

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
7-19 0620	Pt. care assumed @ 0500. VSS. Pt. awake and alert. LR running KVO to (R) AC. IV site CDI ∃ s/s infection. HR Reg, lungs CTA, BS (+) X4. (R) LE ex-fix intact, dsng D/I. (R) LE (+) ROM, (+) sensation, pulse 2+, brisk cap refill, 1+ edema, warm to touch. Will cont. to monitor. (5)(6)-2 [redacted] CT/AN
1900	Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain. SL (R) AC c IV ABX patent. (R) Femur Ex Fix intact. Dsg c Dry Bld, intact (+) sensation, palpable pulse, cap refill <3 sec, mvt toes (R) foot. O/A G3 seen and cwn. Will Monitor. (5)(6)-2 [redacted]
20 July 0030	Pt. asleep in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. HL in (R) AC flushed well with 3cc NS. DSG to (R) femur CDI, pedal pulses palpable, Full ROM in (R) LE digits, (+) sensation. Dr [redacted] (5)(6)-2 or Dr [redacted] wants to Δ the DSG to (R) LE ext. fix ō Iodoform packing. Pt. ∃ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] (5)(6)-2

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

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

REGISTER NO.

WARD NO. ICWA

EPW

[redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

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

FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-18-03	0800. MD consulted about drainage from pin sites. CBC drawn; Sent, x-Ray order sent. IV started (R) AC. Pin care done c̄ Dakins solution. Mod. purulent drainage noted pin sites #3, #4 (two most distal pins). W/ D dsng applied two distal pins dry dsng to two proximal pins. (b)(6)-2 [redacted]
0930	Pt. to x-Ray on crutches c̄ assist; seat belt. Pt returned @ 1000 (b)(6)-2 [redacted]
1630	Assumed care, Pt @ 1300. VSS. A+O x3. (R) claudication (R) LE Ex Fix (Dsg CDI. (+) sensation, palpable pulses, mit/toes, cap refill <3 sec (R) foot O/C to OR NPO. IV AB'X (R) AC SL O/N assess w/ VS Will Monitor (b)(6)-2 [redacted]
15 Jul 03 22:53	Rec'd c/o pt @ 22:00. Returned from OR @ 2200 via stretcher. Awake and alert. VS WNL per flowsheet. PEPPLA (+) WNL Skin color WNL. LCA (B). BS (+) x2. (+) PPP (B). (R) thigh ex. fix in place and adjusted. Dsgs to pins intact c̄ bloody drainage 3rd and 4th distal pins. Dsg to underside of Ex. fix. c̄ moderate amt. Red orange tinged drainage. (R) foot cool to touch (+) <3 sec. cap refill. (R) claudication @ ~~first~~ prior to this time. Will cont to mon.
(b)(6)-2	[redacted] DLT/AN
0330	Reinforced DSG to (R) ex-fix x1 c̄ 4 4x4's and 1 Kerlix wrap d/t copious amt. drainage. Will mon
(b)(6)-2	[redacted] DLT/AN

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RECORD

PROGRESS NOTES

23JULY 2310 Pt. care assumed @ 2100. VSS. Pt. has ∅ complaints. HR Reg, lungs CTA, ABD soft ~~c~~ BS(+) x4. Ex-fix to (R) thigh intact, dressings CDI, Ioban intact. (R) thigh edematous, warm to palpation. (R) foot ~~c~~ pulse 2+, (R) sensation, (R) toes brisk cap refill. Will cont. to monitor. (b)(6)-2 [redacted]

24July03 Pt. awake & alert sitting up in bed. VSS. ttl in (L) FA flushed well ~~c~~ 3cc NS ~~c~~ s/s of infection. HR Regular, bowel sounds (+) x4 quads, lung sounds clear bilat. (R) leg ↑ on folded blanket, full ROM in digits & feet pedal pulse palpable, (+) sensation, <3sec cap refill. Pt. ~~c~~ complaints @ this time. All other assessment findings WNL. (b)(6)-2 [redacted]

0600

24JUL03 assumed care @ 1300 - VSS - medicated for pain ~~c~~ nothing ~~c~~ good results and premedicated ~~c~~ Percocet PO for (R) ex fix pincare - SL patent - ioban intact but leaking serosang, 4x4 placed at leak site, MD aware and 4x4's will be replaced as necessary - neuro's WNL in (R) foot (b)(6)-2 [redacted]

2100

24JUL03 Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (R) ankle. VS WNL per flowsheet. Skin w/D. LCA (R). BS(+) x4. (+) PPP (R) (+) O2 (R) thigh ex fix intact ~~c~~ DSD to pinsites and ioban to 4th and

21:49

SPONSOR'S NAME

LAST FIRST MI SPONSOR'S SS# NUMBER

HOSPITAL OR MEDICAL FACILITY RECORDS MAINTAINED AT

REGISTER NO WARD

ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509

[redacted] (b)(6)-4

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
25 JULY 2214	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ x4. ⓡ↓E ex-fix intact, dsngs to pin sites CDI. Bloody drainage noted from pin c̄ Ioban. Dsng reinforced w/ ABD. ⓛ↓E edematous c̄ pedal pulse 2+, ⊕ ROM toes, ⊕ sensation, brisk cap refill. Will cont. to monitor. (b)(6)-2 [redacted] CTAN
26 July 03	0540 Assume pt care @ 0500. Pt Awake and alert. C/o pain to ⓡ LE @ Distal pin sites. Dsgs CDI ex-fix intact. ⊕ pulse ⊕ movement ⊕ sensation below site. HL to ⓛ FA no s/s redness/infiltration c̄ flush. VSS. HR reg Lungs CTA Abd soft BS x4 Will cont. to monitor (b)(6)-2 [redacted] Alumbo
	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, bowel sounds active x4 quads. ⓡ leg dsg reinforced to Ioban due to drainage. Pin care done. Sites swollen red, dsgs wrapped tightly. Wet to dry dsg done to pin on ⓛ side. Strong pulses and brisk cap refill x4 extremities [redacted] CTA/AN

HIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

ENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. 14 W2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R

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

DATE	NOTES
cont'd.	5th distal pins. Ioban c̄ ~~dt~~ bloody drainage in pocket. ⊕ ROM ⊕ sensation ⊕ PPP (B). c/o pain @ this time will cont. to mon (b)(6)-2 [redacted] /AN
25 July 0515	Pt. awake & alert in bed. HR Regular, Lungs sands clear bilat, bowel sands (+) x 4 quads. HL in (L) FA ~~5~~ s/s of infection. (R) LE ↑ on folded blanket. Kerlex around pins & DSG to ex fix CDI, pedal pulse palpable, (+) sensation, limited ROM in digits, cap refill < 3 sec. Pt ~~5~~ complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] 2L/4hr
1115	DSG's to pins Δ'd on ext fixator (R) femur. Insertion sites ~~5~~ s/s of infection, Kerlex to pins removed, cleaned c̄ ½ sterile water ½ peroxide. Q-tips, rewrapped c̄ Kerlex. Pt. c/o pain, 2 percocets given. (b)(6)-2 [redacted]
1130	Dr. [redacted] notified about status of ext fix. insertion sites, requested to please come by & visualize them. MD agreed to come by this afternoon. (b)(6)-2 [redacted]
25 Jul 03 1945	assumed care @ 1330 - VSS - medicated for pain @ 1800 c̄ ~~it~~ Percocet PO, (R) ex fix pin care done. W→D as applied on pin above knee per Dr. [redacted] instructions - medicated @ 1945 for pain @ pin sites c̄ motrin 800 mg PO - SL patent - ioban remains on sutures, 4x4's replaced, serosang drng. still present - abx beads to be removed from (R) thigh wound in one wk from 21 Jul per Dr. [redacted] CR/AN [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] (b)(6)-4

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
28July03 0620	pedal pulse palpable, cap refill <3sec, pt. states that 3,4,5th digits are painful c̄ palpation. Insertion sites from ext. fixator ō DSG's that are CDI. Pt. c̄ full ROM in (R) foot & digits. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted] JUTH
28Jul03 2030	Pt assumed care @ 1300 - VSS - medicated c̄ IV Percocet 10 mg 2000 for dsg Δ - dsg Δ and w → D packing loosely placed in wound, Dr. [redacted] saw wound and wants loose packing in wound - pin care done - jaban continues to drain serosang fluid, ~~reinf~~ 4x4's replaced near leak in jaban - SL patent - pt. ambulated to BR c̄ crutches - had BM today - stitches removed from wound on thigh, wound healed, skin open site of removed suture 2° to skin growth on sutures - [redacted] (b)(6)-2
2117	Pt. care assumed @ 2100. HR Reg, lungs CTA, BS (+) x4. (R) LE ex-fix intact. Drsngs to pins c̄ I. scant drainage from jaban. (R) leg edematous but ↓ from yesterday. Pedal pulse 2+ c̄ (+) sensation, (+) ROM toes brisk cap refill. will cont. to monitor. (b)(6)-2 [redacted] JTAN
7 28 03 0040	IV D'd to (L) FA. (R) FA IV D'c'd 2° c/o pain @ site. Hot pack applied [redacted]

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

RVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO. BCW2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R

Prescribed by: GSA/ISMD FPMR (41 CFR) 101-11

DATE	NOTES
7-26-03 2100	Pt. care assumed @ 2100. VSS. Pt c/o pain @ distal pins sites on ex-fix. HR Reg, lungs CTA, BS (+) x4. (R) LE ex-fix intact. Drsngs to pins CDI. Bright red bloody drainage from pin site c̄ Ioban. Site reinforced c̄ ABD drsng. (R) LE c̄ pedal pulse 2+, (+) Sensation, (+) RUN toes, brisk cap refill. (R) LE is warm, edematous. Will cont. to monitor. (b)(6)-2 [redacted]
27 July 03 0635	Assume pt care @ 0500. Pt awake and alert. No c/o pain or discomfort @ this time. HL to (L) FA no s/s redness/infiltration c̄ fluid. VSS. HR reg Lungs CTA Abd soft BS x 4. (R) LE ex-fix intact. Dsg ~~[illegible]~~ intact @ red drainage noted. Red drainage noted under Ioban. (+) movement @ sensation @ pulse below ex-fix. Will continue to monitor (b)(6)-2 [redacted]
1200	DSG Δ and pin care done @ 0900. Red drainage from Ioban and serosang drainage from pin sites percocet given for pain @ 0730, no other complaints since (b)(6)-2 [redacted]
2245	Pt. care assumed @ 2100. VSS. HR Reg. Lungs CTA, BS x4. Ex-fix to (R) femur intact. Drsng to pin sites CDI. Some scant amt. bloody drainage from pin-sites c̄ Ioban. Site reinforced c̄ ABD. Neuro vs (R) LE unc. (R) leg edematous, warm to touch. Will cont. to monitor. (b)(6)-2 [redacted]
28 July 03 0630	Pt. awake & alert sitting up in bed. Pt. c/o pain, morphine 2000 mg given. HR Regular, lung sounds clear bilat, bowel sounds ~~[illegible]~~ (+) x4 quads. HL in (R) AC flushed well c̄ 3cc NS c̄ s/s of infection. (R) LE ↑ on folded blanket,

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23Aug03	1400 - Pt alert + oriented OOB x 1 utilizing crutches. Physical therapy worked c Pt this AM. VSS, lungs CTA, BS⊕, pulses ⊕ x4. Ext fix intact to (R) leg. Pin care done by pt. Voiding ∅ complaints. Will cont to monitor (b)(6)-2 [redacted]
23Aug 03	2100: Assumed care @ 1500. A+Ox3. T-98.1°F P-83 R-16 BP-108/61 SpO2-100%, HR-regular. Lung sounds clear bilat. BS x4. No c/o pain or discomfort @ this time. Ex fix to (R) Femur. Pin care done. Foldform packing to pins 1,2+9, sm amt. serosanguinous drainage noted. (+) sensation to (R) LE. Will continue to monitor. [redacted] (b)(6)-2
23Aug03 2330	Pt awake and alert. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non tender, bowel sounds active x4 quads. Ex fix to (R) femur intact, dsg to pin sites CDI. Pt encouraged to do active ROM to (R) knee. Assisted c ROM to increase amt of flexion to knee. ∅ complaints [redacted] (b)(6)-2
24Aug03 1332	Pt A-O x 3 OOB x1 ambulating c physical therapy. VSS; lungs CTA, BS⊕ x4, pulses ⊕ x4. Ext fix

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. IICW2

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

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Jul (1600)	pt arrived from OR EMT on litter, transferred to bed; distal pulses palpable; traction splint in place; pt A/O x 3; See assment flowsheet — [redacted] (b)(6)-2
1713	Pt received from Dayshift Assessment Completed (See Assessment Form) VSS. Pt. Denies pain. Request Blanket. — (b)(6)-2 [redacted] RTN
05Jul03 0150	Pt. c/o pain @ (R) L6 - 2mg IVP SMSO4 given. Pt asleep — (b)(6)-2 [redacted] RTN
0300	Pt c/o pain @ (R) L6 ~~8mg~~ 5mg IVP MSO4 given [redacted] RTN
0545	report received from night shift; pt resting @ this time — [redacted]
0700	medicated for pain; MSO4 5mg IVP [redacted]
0900	tolerated Regular diet this AM (50%). — (b)(6)-2 [redacted]
0933	medicated for pain; MSO4 5mg IVP — [redacted]
1400	no change in status; pain controlled; incision, dry, small drainage, & hemorrhage; distal pulses palpable; pt using IS; MSO4 for during A — (b)(6)-2 [redacted]
06 July 03 1700	Rec'd alert/calm/cooperative. Positioned T for dinner. PIV to RFA patent/benign. (R) ext. fix. intact ~~at~~ ice dry intact c̄ scant-mod. serosanang. drainage. Sl po well c̄ complaints noted. See flowsheet ~~distal pedal pulses/drainage~~ for further assessment. — (b)(6)-2 [redacted] Sgt/LPN
07 Jul 03 0420	Pt assessment unchanged. Medicated ORW c̄ effect. relief. — [redacted] Sgt/LPN (b)(6)-2

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

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Jul 03	0500 Received report. See report sheet for initial assessment — (b)(6)-2 [redacted]
	1000 OOB to chair s difficulty — [redacted]
	1400 Ambulated back to bed st difficulty.
	VSS. 0 distress noted — (b)(6)-2 [redacted]
	1610 VSS. 0 distress noted — [redacted]
9 Jul 03 1914	Rpt recieved, physical assessment completed + recorded on flowsheet, PIV care completed [redacted] RPT/AA
	(b)(6)-2
10 Jul 03	0500 Report given. See ICU-7 flowsheet for initial assessment. — (b)(6)-2 [redacted]
	0630 5mg MSO4 IVP c/o leg pain.
	(b)(6)-2 [redacted]
	0800 VSS. 0 distress noted [redacted]
	1260 OOB to chair, ambulated pulling up s difficulty — [redacted] (b)(6)-2
	1450 Amb back. Up bed c assist [redacted]
10 Jul 03 1700	Rpt Received [redacted] (b)(6)-2 RPT/AA (b)(6)-2 [redacted]
11 Jul 03 0900	Received report, Pt tolerated A ne to meal well. Pt OOB for crutch training. I/M care performed. Pt c/o pain after crutch training. Medicated c 5mg MSO4. Will continue to monitor — [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] D 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 NO. | WARD NO.

EPW [redacted] (b)(6)-7

ICU-7

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Jul 03 1400	Tolerated lunch meal. OOB to chair. Pt c/o slight pain. Medicated c̄ 800 mg Motrin. Cold pain & inflammation. Pt continues using incentive spirometer QI while awake. ⊘ other c/o @ this time. Will continue to assess. — [redacted] (b)(6)-2
1800 11 JUL 03	VSS - Ate local & supper drank 300cc h2o. Ambulated x 3. Amb length of ward x 2. Percocet IĪ for c/o ® leg pain. SAL lock to ® FA is patent ⊖ sis of infiltration. (b)(6)-2 [redacted]
2200 11 JUL 03	VSS - Amb ward back and forth x1 c̄ IĪ Assist and crutches. Pin care done to ® L Long. mod. amt of serosanguous drainage from pins. 3RD Pin from top is reddened c̄ some inflamatory. Restraints to LE in place and secure. — SAT (b)(6)-2 [redacted]
0400 12 JUL 03	VSS - ⊘ further c/o ® leg pain. Resting quietly c̄ eyes closed. Restraints in place and secure. — SAT [redacted]
0730	Percs for pain; comfort explore; [redacted] (b)(6)-2
0840	pt tolerated breakfast; ambulated c̄ crutches x 10m; steady gait; OOB playing cards — [redacted]
	pin care done, bedside applied to single site [redacted] (b)(6)-2
1200	no change in status; percs for pain —
12 JUL 1700	Received pt VSS. c/o pain 2 percs given. OOB & walked around. Pin care done — (b)(6)-2 [redacted]
0800	Pt slept through most of night. 2 percs given for pain [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.)*

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

ICU - 1

REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03	0440 - Pt c/o pain. Can't get percocet until 0630. Will notify day shift to talk to docs about pain control. [redacted] (b)(6)-2 LPN
13 July 03 0030	Rec'd report from previous shift, Pt sleeping at this time. VSS, A&O. Flowsheet for pt assessment. [redacted] (b)(6)-2
0530	Pt VOB to chair w/ minimal help, precaution taken for moving (R) thigh, ex fix pins no S/S infection [redacted] (b)(6)-2 (b)(6)-2
0800	Pt ate 100% of breakfast, c/o pain ~~at~~ it percocet PO, [redacted]
1000	Pt back into bed, sleeping. NAD. Will cont. to monitor [redacted]
1330	Pt VOB to chair w/ minimal difficulty. Walked down to [redacted]
1415	Pin care done, (+) S/S of inf noted, notified Dr [redacted] (b)(6)-2 started on Keflex 250 QID x10D. [redacted]
7/14/0600	Assumed pt care from ICU manually, pt resting comfortably in no apparent distress, pt denied any pain. Plan [redacted] (b)(6)-2 [redacted]

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. 2CW2

[redacted] EPW

(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15July03	0630 Received report, Pt. sleeping in bed, no distress. Will continue to monitor — [redacted]
	0845 Pt. OOB, self pin care performed using 1/2 hydrogen peroxide 1/2 sterile saline. Pt. ate 100% of breakfast tray. [redacted] (b)(6)-2 LPN
15Jul03 1815 BJS	pt. transferred to ICW2 from ICU1 ambulatory in stable condition - VSS - medicated for pain @ 1800 prior to transfer - pt. received @ ~1830 - (R) Femur ex fix in place, lower pin sites red and serosang drainage noted, upper pin sites also red & drainage, sutures on outer aspect of thigh intact, sutures on inner thigh also intact, small healing wound noted on posterior thigh - DIV access - neuro's WNL on (R) foot - (+) 2 peripheral pulses in extremeties - lungs CTA (B) - BS (+) x4 quads - pt. understands and speaks small amount of english - [redacted] (b)(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. ICW2

[redacted]

ICU1

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Medical Record
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 JUL 03	@ 1340. Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain (B) LS CTA. (+) BS x4 HRR. (R) Femur Ex Fix/Deg & drainage on backside of leg. (+) sensation, palpable pulse, cap refill <3sec, [redacted] of toes (R) foot. (R) FA PIV patent. Amb c crutches assistance. O/W Assessment WNL. Will Monitor — [redacted] (b)(6)-2
21 Jul 03	Admit Ap Move prep Dx: (R) Femur Fx Infection Procedure: I&D / Intramedullary Rod pending Surgeon [redacted] (b)(6)-2 EBL: [redacted] TO PACU stable Pass Pocket T to Chart @ Fosd Debridement Ph) Bed x 2 days then consider for ORIF w/ wound improved [redacted] (b)(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO. ICW2

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7-20-03 0(0500):	Pt. care assumed @ 0500. VSS. afebrile. HR Reg, lungs CTA Bilat, ABD soft c̄ BS(+)x4. HL to (R) AC intact, flushes ⊼ diff. Ex-fix to (R) thigh intact, dsng CDI. (R) LE c̄ edema +1, pulses 2+, warm to touch, (+) sensation, brisk cap refill. Pt c/o ↓ROM toes to (R) ft x great toe. Will cont. to monitor. (b)(6)-2 [redacted]
1000	MD in to do dsng Δ. Pt. premedicated c̄ 4mg MSO4 (b)(6)-2 [redacted]
1340	Assumed care of Pt @ 1300. VSS. A+Ox3. ∅ c/o pain. (R) Femur Ex-fix/Drsg CDI. MD to do Dsng Δ. (+) sensation, palpable pulse, cap refill <3sec, mvty toes (R) foot. (+) 1+ Edema Below Knee (R) LE. PIV (R) FA HL c̄ IV ABX patent. O/W assess WNL. Will monitor (b)(6)-2 [redacted]
1900	MD stated no dsng Δ, pt c/c to OR in AM [redacted]
20JUL03 23:33	Rec'd pt @ 21:00. VS WNL per flowsheet. Restraints x2 (L) wrist/Ankle. Awake and alert in bed. PE PERLA (+) EOM LCA (B). BS (+) x4. (+) PPP (B). (R) ↓ ext. ex-fix intact c̄ DSG intact mod amt. drainage noted from evening shift. Scant amt. exceeded border drawn. c/o pain 8/10. Percocet given. (R) FA IV patent. Will cont. to mon (b)(6)-2 [redacted]
0538	Pt. care assumed @ 0500. Pt. resting quietly. Pt. NPO for surgery. HL to (R) FA flushed ⊼ diff, ∅ s/s infection or infiltration. HR Reg, lungs CTA, ABD soft c̄ BS (+) x4. Ex-fix to (R) femur intact. Dsng c̄ serosanguinous drainage back of leg. (R) leg edematous warm to touch c̄ pulses 2+, brisk cap refill, (+) sensation, ↓ ROM toes. Will cont. to monitor [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

(b)(6)-2

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July 03 0125	Pt. back from OR via litter. Pt. asleep in bed s̄ complaints @ this time. HR Regular, Lungs sounds clear bilat, bowel sounds (+) x4 quads. (R) leg ↑ on folded blanket, insertion sites on ext. fix appear clean s̄ s/s of infection, DSG CDI, pedal pulse palpable, digits c̄ limited ROM, (+) sensation. HL in (R) FA flushes well c̄ 3cc NS s̄ s/s of infection. ~~Pt~~ All other assessments WNL. Will continue to monitor. [redacted] RN (b)(6)-2
0535	Assume pt care @ 0500. Pt awake and alert. VSS. HR reg. Lungs CTA. Abd soft. BS x4. (R) thigh c̄ ex-fix intact. Dsg c̄ red drainage Ioban intact. Stitches to inner thigh intact. HL to (R) FA no s/s redness/infiltration c̄ flush. (R) pedal pulse palpable (+) movement (+) sensation below ex-fix. no c/o pain or discomfort @ this time [redacted] Allum
1330	HL DC'd from (R) FA. New HL placed to (L) FA (b)(6)-2 no s/s redness/infiltration c̄ flush [redacted] Allum
22 Jul 03 2025	Assumed care @ 1300 - VSS - SL patent - medicated c̄ motrin @ 1700 for pain c̄ good results - pin care done c̄ H_2O_2, Ioban removed and replaced, Ioban should not be removed again, it is holding beads in wound, serosang. drng small this shift - neuro V's WNL in (R) foot - [redacted] (b)(6)-2

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

[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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7.22.03	2130 Pt. care assumed @ 2100. VSS. Pt. resting quietly. Ex-fix to (R) femur intact. Drsng to pin sites CDI & drainage @ this time. (R) leg edematous, warm to palpation c̄ pedal pulse 2+, (+) sensation, (+) but ↓ ROM toes. Will cont. to monitor. [redacted] /CPSR
23July03	0520 Assume pt care @ 0500. Pt Awake and (b)(6)-2 Alert. VSS. HR reg. Lungs CTA Abd soft no tenderness or distension on palpation. BS x 4. RLE Ex-Fix @ thigh intact. Dsg's to pins CD+I. Ioban intact sm. amt of red drainage pooling. (+) pulse (+) movement (+) sensation ↓ ex-fix. HL to (L) FA no s/s redness/infiltration c̄ flush. No c/o pain or discomfort @ this time. Will cont. to monitor [redacted] (b)(6)-2 91WM6
1210	pin care done @ 1000. no signs of infection noted. no drainage from pins. pt c/o pain 800mg Motrin given. [redacted] (b)(6)-2 WM6
23July03 1430	assumed pt care @ 1300. VSS. pt sleeping easily aroused to verbal stimuli. Lungs CTA, abd soft BS(+) x4 quads. (R)LE c̄ ext fix @ thigh, drsng around pins CDI. (+) pulse. LLE c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses. HL to CFA (-) redness/swelling noted. (-) c/o pain/discomfort voiced @ this time. Will cont to monitor - LDavis 91WM6
2015	pin care done, (-) s/sx of infection noted. mod amt of red drainage pooling under Ioban. (-) c/o of pain voiced @ this time [redacted] 91WM6 (b)(6)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
290600 JUL 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 spontaneously. ROM and neurovascularly intact to (B) UE and (D) LE. (R) LE has ex fix and drsg to thigh. but is neurovascularly intact. ROM to (B) LE limited by pain. Drsg to ass CDI. IV to (L) FA is ↑ s/s infection/infiltration. Flushes well. (b)(6)-2 [redacted]
29 July 03 1500	At rest at this time. AAOx3. PERRLA. Resp CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Strong pulses and brisk cap refill x 4 extremities. Drsg to (R) ~~leg~~ arm, leg ex fix changed. Pins clean. Middle pin site packed W→D. Pins wrapped tightly, minimal drainage noted. Given Percocet for pain (b)(6)-2 [redacted]
29 JUL 03 2211:8	Rec'd c/o pt @ 21:00. Restraints x 2 (R) wrist (L) ankle VS WNL per flowsheet. Awake and alert in bed. Skin W/D. PERRLA (+) WNL. LCA (B). BS (+) x4. (+) PPP (B). HR Reg S1S2. (R) thigh ex-fix intact. 1st and 2nd proximal pins ¯ DSD's C/D/I. 3rd/4th distal pins ¯ (+) s/s infection. I-clean ~~C/D~~ I intact ¯ (+) pus and serous drainage noted. DSD on anterior aspect of thigh C/D/I. (+) sensation (+) ROM (+) strength to foot. c/o sm. amt. pain ↑ Motrin 800 given will mon [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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 NO. | WARD NO. (b)(6)-2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30 July 03	0630 Assume pt care @ 0500. Pt awake and alert. No c/o pain @ this time. VSS. HL to (R) PA no s/s redness/infiltration c̄ flush. Ex-fix to (R) LE intact. Toban dsg draining used fluid. Dsgs to pins CD+I. HR reg Lungs CTA Abd BSx4 no EBO noted. (+) movement (+) pulse cap refill <3sec below ex-fix. Will continue to monitor (b)(6)-2 [redacted] SIGNAL
	1045 pin care and dsg Δ done. proximal pin c̄ green drainage. distal c̄ red drainage. Dsgs CD+I (b)(6)-2 [redacted] SIGNAL
30 Jul 03 22:12	Recd pt @ 21:00. Restraints x2 (R) wrist (L) ankle. Pt. awake and alert in bed. Skin W/D, PERRLAEOMWNL LCA(6). BS(+)x4. HR APTM WNL Resp. (L) AC HR patent. (R) thigh ex. fix intact. ~~1st and 2nd distal Proximal pin sites c̄ DSD CDI~~ 5th distal pin site c̄ ioban dsg present c̄ (+) drainage. All other pin sites c̄ DSD's CDI. (+) PPP (B) equal @ 2+. (+) sensation (+) ROM (+) <3sec cap refill (R) foot. c/o pain @ this time. Will cont. to mon [redacted] (b)(6)-2
31 0520 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 spontaneously. ROM and neurovascularly intact to (B) UE and LLE. RLE has ex fix to lateral thigh c̄ Toband dsg to distal posterior portion of pins. Moderate amt of serosang drng to Toban dsg. Pin sites have minimal serosang drng. IV to (L) AC flushes well & is c̄ s/s infection or infiltration. [redacted]
31 July 03 1300	Received PT resting in bed c̄ (-) c/o pain or discomfort. VSS (b)(6)-2 Breath sounds clear bilateral. (+) ROM on all extremity c̄ ex fix to (R) leg COI. +2 second cap ref. +BSx4. HL to (L) Arm Flushes well c̄ 3cc. (-) s/s of infection to HL. will cont to monitor. [redacted] CPN

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(b)(6)-2

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)*
31 Jul 03 2253	Rec'd c/o pt. @ 21:00. Restraints x2 (R) wrist (L) ankle. VS WNL per flowsheet. Sleeping in bed. Easily awakened. Alert. PERRLA (+) WNL. LCA (B). BS (+) x4. (+) PPP (B). (R) thigh ex-fix intact. 5th pin c̄ Ioban in place. all other pin sites c̄ DSD's C/D/I. Drainage, pus and serous noted @ 5th pin site. c/o pain @ this time. (+) sensation (+) ROM (+) <3 sec cap refill to (R) foot. will cont. to mon [redacted]
010530 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Arrived intact, breathing comfortably, [redacted] CS (b)(6)-2 clear to all fields (B). Abd soft, nontender, [redacted] distention. BS (+) x4. IV to (L) FA flushes well and is c̄ s/s infection or infiltration. Voids spontaneously. ROM and neurovascularly intact to (B) UE and (L) LE. (R) LE has Ex-fix x 6 pins c̄ Ioban to (R) lateral posterior portion of thigh. Pins are tightly wrapped to act as packing for wounds around pins. Drains correctly show little drainage, serosang, to pins. (b)(6)-2 [redacted]
1 Aug 03 2030	ASSUMED CARE @ 1300 - VSS - no c/o pain throughout shift - SL patent - wound @ pin above knee packed c̄ iodoform soaked in saline, 2x2 placed on top, pin care done on other pins c̄ H_2O_2, no dsg applied on other pins, ioban in place, no drainage noted - (b)(6)-2 [redacted] CRP
01 Aug 03 2212	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (L) ankle. VS WNL per flow sheet. Pt awake and alert in bed. Skin W/D. Perrla (+) WNL. LCA (B) HRRR S1S2. BS (+) x4. (+) PPP (B) (R) thigh ex-fix in place

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

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[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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont'd.	5th distal pin c̄ ioban intact. All other pinsites OTA approximated c̄ pins. ⊕sxs infection. ⊕ foot digits ⊕ROM ⊕ plantar flexion/extension ⊕<3 sec. cap refill. ⊕PPP⊕. ⊖c/o pain @ this time. Will cont. to mon [redacted] OT/AN (5)(6)-2
020730 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, pt's breathing is even and unlabored, LS clear to all fields (B). Abd soft, nontender, ≠ distention. BS⊕x4. Voids spontaneously. FROM and neurovascularly intact to (B) UE and (B) LE. (B) LE exit to (B) lateral thigh, pins are open to air. Minimal serosang drng noted to 1st-3rd distal pins. 4th distal pin has packing of iodoform gauze (serosang drng noted). 5th distal pin continues to have ioban + beads in place. Ø drng seeping from posterior portion of ioban. 6th distal pin open to air. IV to (B) FA flushes well & ∑ s/s infection/infiltration. (5)(6)-2 [redacted]
2 Aug 03 1945	assumed care of pt @ 1300 - VSS - no c/o pain throughout shift - pincare done, incind packed c̄ iodoform/saline, scant amount of serosang drainage noted from 3 pinsites - SL patent - pt. ambulated on ward during shift - ioban remains in place on incision, no drainage noted (5)(6)-2 [redacted]
2 Aug 03 21:12	Rec'd c/o pt @ 21:00. Restraints x 2 (B) wrist (B) ankle. VS WNL per flow sheet. Pt. sleeping, easily awakened. Skin W/D. PERLA⊕. LCA⊕. HRRS, S1S2WNL. BS⊕x4 hypoactive. (B) thigh ex-fix in place 5th distal pin site c̄ Ioban intact. dried bloody drainage noted. All other pins OTA c̄ serous drainage noted ⊕ redness noted. ⊕ PPP⊕. ⊕<3 sec. cap refill ⊕ ROM to ankle and digits ⊕ sensation ⊖ pain x1 ∴ Motrin 800 given will cont. to mon [redacted] OT/AN
0323	Pt c/o pain x 2 ∴ Percocet given. Will mon [redacted] OT/AN (5)(6)-2 (5)(6)-2

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03 0530 July 03	NURSING Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields, (B). Abd soft, nontender, ~ distended, BS(+)x4. Voids spontaneously. ROM and neurovascularly intact to (B) UE and ULEs. (B) LE limited ROM related 2° pain. Ams to (B) LE ex-fix (thigh) are open to air. 5th pin site continues to be packed c iodoform gauze. Minimal serosang drng to all pins. [redacted]
3 AUG 03 1300	- Received PT sleeping in bed. VSS, HR R. Breathsounds clear bilateral. BS x4. PT has (B) RAM to (R) Lg ex-fix. (B) DMS ~ capillary refill, (HL) to (L) Arm flushes well c 3cc NS. Drsg to (R) ex-fix CDI. Will cont to monitor PT. [redacted] (b)(6)-2
3 AUG 03 1700	PT is to be NPO after midnight. [redacted]
2121	Pt care assumed @ 2100. VSS. HR Reg. lungs CTA, BS(+) x4. Ex-fix to (R) UE intact. Neuro checks (R) UE WNL ~ edema to (R) Leg. Drsng to (R) UE intact. HL to (R) FA flushed ~ diff. Pt. to be NPO p MN for surgery. Will cont. to monitor. [redacted] (b)(6)-2
4 Aug 03	0625 Assume pt care @ 0500. Pt awake and alert. percocet for pain. VSS. HR reg lungs CTA. Abd soft BS x4. Ex-fix RLE intact. Dsg CDI. New HL placed to (R) FA (+) flush. NPO for surgery @ this time. Will monitor [redacted] Plump (b)(6)-2

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[redacted] (b)(6)-2

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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)*
4 Aug 03	O/Pw
1330	Dx (R) Femur Fx s/p Ex Fix - Abx Bead placement
	Rx (1) Abx Removed
	(2) T - D
	(3) Ex Fix Adjustment
	(4) Knee Manipulation
	Surgeon Gurun
	GTGA
	(b)(6)-2 [redacted]
4 Aug 03 1500	pt. returned from Surgery ~ 1445 - VSS - medicated c̄ IV Percocet tabs - ace wrap intact around ex-fix, no drainage noted on dressing, neuro V's WNL in (R) foot - pt. alert and oriented - SL in (R) FA patent, IVF d/c'd, pt. tol. juice & crackers - SA c̄ ex fix readjustment and abx bead removal under general anesthesia - lungs CTA (B) - (+) BS - Urine output since surgery, DTV by 2130 — [redacted] CR, A2 (b)(6)-2

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/4/03 2200	Pt. care assumed @ 2100. VSS. HR reg, lungs CTA, BS (+) x4. Ex-fix c̄ Ace wrap to (R) LE intact, C.D. (R) LE c̄ (+) sensation, pulse 2+, brisk cap refill. PROM performed (R) knee to approx. 20-30°. will cont. to monitor. (b)(6)-2 [redacted] CTAN
5Aug03 0600	Assume pt care @ 0500. Pt awake and alert. temp. 99.8 HR reg Lungs CTA Abd soft non tender BS x4 (R) thigh ex fix intact c̄ ace wrap CD+I. (+) movement (+) pulse (+) sensation. Passive ROM performed encouraged pt to do active ROM. HL to (R) FA (+) flush c̄ redness/infiltration. Will continue to monitor (b)(6)-2 [redacted] RWMC
5Aug03 1430	assumed care @1300-VSS-dsg Δ'd on (R) ex fix, pin care done, w/D dsg. placed on 4 pins, 4x4's placed on stitches - medicated c̄ 800 mg motrin PO ~~given~~ PRN for pain @ 1400 - neuro V's WNL in (R) foot, ROM done c̄ (R) knee (b)(6)-2 [redacted] CR, AF
5 Aug03 2115	Pt care assumed @ 2100 VSS, alert and awake c̄ c/o small amount of pain in le. Lung sounds CTA, pulses (+) x4, BS (+) x4 Ex fix on rle draining small amounts of bloody fluid. Pt c/o pain @ middle pin site and small toe on (R) foot. HL on rle flushes well. will continue to monitor. [redacted] RWMC (b)(6)-2

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

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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)*
6Aug03	0555 Assume pt care at 0500. Pt awake and alert. No c/o pain or discomfort at this time. VSS. HR reg Lungs CTA (B) Abd soft non-tender BS×4. Ex-Fix to RLE intact. Dsgs to pins ī sm amt of red drainage. (+) pulse (+) movement (+) sensation. HL to (R) FA (+) flush ī redness or infiltration. Will continue to monitor — (b)(6)-2 [redacted] SIUM6
6Aug03 1400	Pt stable. AAO×3. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender bowel sounds active × 4 quads. Strong pulses and brisk cap refill × 4 extremities (R) leg/knee exercised by PT today ī good results. Ø complaints. Ex fix ī packing, Dsg CDI. — (b)(6)-2 [redacted] WT/10
6Aug03 1900	Dsgs to pins D'd. Pins not wrapped. Pins packed and wounds at pin sites covered. Ø complaints minimal bleeding at sites ī ROM exercises ī PT. — (b)(6)-2 [redacted] LA/MT
2215	Pt care assumed @ 2100. VSS, alert and awake ī c/o slight pain in mid thigh and toes. Lung sounds CTA, pulses ×4, bst. HL in rfa flushes well, IV abx. Pins on rle CDI, (+) sensation and rom. Aggressive rom done at 2200 3c/o increased pain. Pt ī no complaints, will continue to monitor. — (b)(6)-2 [redacted] SIUM6
7Aug03	0605 Assume pt care @ 0500. Alert. VSS. No c/o pain @ this time. HR reg Lungs CTA Abd. soft BS×4. Ex-fix intact. dsgs ī sm amt of red drainage. HL to (R) FA (+) flush ī redness/infiltration. Will continue to monitor — [redacted] (b)(6)-2 MG

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7AUG03 2040	A+O x3. % pain in (R) leg. Motrin 800mg PO given. Dressing Δ to (R) leg done - wet to dry dressings x5. Iodoform to 1 pin. Wounds oozing out sm. amt. serosanguinous drainage. Stitches to (R) leg clean & intact. Capillary refill to (R) foot good. Pedal [redacted] pulses palpable. (b)(6)-2 [redacted]
8Aug03 0100	Pt care assumed @2100. VSS, 650mg Tylenol given for pain @2200. Lung sounds CTA, pulses +x4, BS+x4 quads. Ex fix on rle. ODI. Active rom done @2200. (+) sensation, (+) rom in rle. IV ABX, will continue to monitor. (b)(6)-2 [redacted] alumne
080515 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breath, even and unlabored, LS clear to all fields (B). Abd soft, nontender, ∅ distention. BS(+)x4. Voids spontaneously. ROM and neurovascularly intact to (B)UE, (D)LE. (R)LE ex fix ∅ 6 pins, site dsgs are CDI. Neurovascularly intact and ROM limited by pain to knee of RLE. IV to [redacted] ∅ s/s of infection or infiltration. (b)(6)-2 [redacted]
8AUG03 2015	Assumed care @ 1300. VSS. Alert & oriented. Denies pain or discomfort @ this time. Lung sounds clear. BS x4. SL (R) forearm patent. (R) leg fixed ∅ pins. Dressings Δ'd wet to dry ∅ Iodoform packed in 4th pin. Draining small amt. serosanguinous drainage. (b)(6)-2 Good capillary refill in (R)LE, sensation present. PPP. [redacted]
2100	Pt. care assumed @ 2100. HR Reg, lungs CTA, BS(+)x4. (R)LE ex-fix intact. (R)LE ∅ (+)ROM, (+)sensation, pulse 2+, brisk cap refill. will cont. to monitor. [redacted]

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

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[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)*
9Aug03	0745 Assume pt care @ 0500. Pt awake and alert. C/o pain to (L) thigh @ distal pin sites and to third thru fifth toe. HL to (R) FA (+) flush $\bar{s}$ redness/infiltration. VSS. HR reg Lungs CTA. Abd. soft BS x 4. Ex fix to LLE intact dsg to distal pin $\bar{c}$ sed drainage. percocet for pain. Will continue to monitor — (b)(6)-2 [redacted] SIUWMC
9AUG03 2030	Assumed care @ 1300. VSS. Lung sounds clear bilat, SL (R) FA patent. C/o pain in (R) leg @ 1330 + 1730. Percocet ii PO given. Ex fix to (R) leg. Dressing Δ done - wet to dry $\bar{c}$ Iodoform to 4th pin. Sm amt. sanguinous drainage noted. — [redacted]
2215	Pt. care assumed @ 2100. VSS HR Reg, lungs CTA, (b)(6)-2 BS (+) x4. (R) LE ex-fix intact. Drsngs to pin sites CDI, $\bar{s}$ drainage. (R) ft. $\bar{c}$ pulse 2+, (+) sensation, (+) rcan brisk cap refill. Will cont. to monitor. — [redacted] CTA
10Aug03	0625 Assume pt care @ 0500. pt awake (b)(6)-2 and alert. VSS. HR reg lungs CTA Abd soft BS x 4. HL to (R) FA (+) flush $\bar{s}$ redness/infiltration. Ex-fix to RLE intact. Dsgs $\bar{c}$ sm amt of sed drainage. Pt c/o pain to inner thigh and 3-5 toes. (+) pulse (+) movement (+) sensation. Will continue to monitor SIUWMC
10Aug03	1120 pin care done. sm amt of drainage noted from 1st and 4th pin. W→D dsg. — [redacted] SIUWMC
2126	PA caught stashing percocet and cigarettes (b)(6)-2 under pillow and mattress. — [redacted] CTA

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03 5p--12m	Pt alert & oriented x3. Ate breakfast, Pt medicated PO, bed pans cleaned and area dressed. Pt performed own BM care. still & rest comfortably during shift. Medicated IV PB with NB therapy and PO with meds. No S/S of distress — VSS Stable [redacted] (b)(6)-2
12Aug03 2000	Patient care assumed @ 1300. VSS. Lung sounds clear bilat. BS x4. C/o pain in (R) leg. Motrin 800mg given PO @ 1505. Ex-fix to (R) leg. Pin care done — Pt today dressings c Iodoform to 4 x 2 pin. Sm amt. serous sanguinous drainage noted. Will continue to monitor. — [redacted]
12Aug03 2020	No PT done today. Therapist has not come [redacted]
12Aug03 2300	Pt care assumed @ 2100. VSS, a+ox3, no complaints. (b)(6)-2 Lung sounds CTA, pulses ⊕x4, DSG. Ex-fix on r/e c01, sutures CTA. Pt able to wiggle toes and good cap refill. Will continue to monitor. — (b)(6)-2 [redacted]
13Aug03	0559 Assume pt care @ 0500. pt awake and alert. No c/o pain @ this time. VSS. HR reg lungs (b)(6)-2 CTA Abd soft BS x4 last BM yesterday. Ex-fix to RLE O.M [redacted] ; drsg to pins CDI. pt performed active ROM [redacted] (R) leg. ⊕ROM ⊕Sensation below ex-fix. HL to (D) FA ⊕ flush ⊖ redness/infiltration — [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	REC[redacted] 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 NO. | WARD NO.

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Aug 2313	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ X4. (R)↓ ext. ex-fix intact, pinsite dsngs CDI & drainage. (R) ft. ⊕ sensation, ⊕ ROM, brisk cap refill, pulse 2+. will cont. to moniter. (b)(6)-2 [redacted] USAN.
11 Aug 03 0600	Pt alert and oriented x3. Pt ambulated with crutches at least 20 yds. Pt able to climb back into bed. Pt ate breakfast and after dressing changed (R) leg with referred Jeff Nurses done. Pins clean and no exudate noted around leg. Pt medicated PO for pain. Pt went to bed at 9 pm [redacted]
11 Aug 03 2030	Assumed care @ 1300. VSS. Lung sounds clear bilat. [redacted] BS x 4. Percocet ii prepared for PT. Pin care done. Wet-to-dry dsngs (b)(6)-2 & iodoform packing to 4th pin. Ex-fix to (R) LE + Good capillary refill, sensation present. [redacted]
2215	Pt. care assumed @ 2100. VSS. Pt. c/o ⊘ pain @ this time. HR Reg, lungs CTA, BS ⊕ X4. Ex-fix to (R) LE intact. Dsngs to pin sites CDI. NV checks (R) LE CDI - will cont. to moniter. [redacted] USAN. (b)(6)-2

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MEDICAL RECORD PROGRESS **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG03	2000: Assumed care @ 1300. VSS. Lung sounds clear, BS x4, c/o pain @ 2000. Percocet II PO given. SL (L) FA patent. Ex-fix to (R) leg. Pin care done, wet-to-dry c̄ iodoform to 4th pin. Sm, amt. serosanguinous drainage noted. Will continue to monitor. (b)(6)-2 [redacted]
2300	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. Ex-fix (R) NVE intact, dsings to pin sites CDI. (R) ft. c̄ pulse 2+, (+) sensation (+) ROM, brisk cap refill. Will cont. to monitor. (b)(6)-2 [redacted] /LT/AN
14Aug03 0555	Pt. asleep in bed easily aroused by verbal stimuli. HR Reg, lungs and clear bilat, bowel sounds (+) x 4 quads. Ext fix to (R) femur intact, DSG around pin insertion site c̄ [redacted] (b)(6)-2 redish, yellow drainage, (+) sensation pedal pulse palpable, <3sec cap refill, full ROM in digits & ankle. Pt. c̄ complaints @ this time. VSS. HL in (L) FA s̄ s/s of infection, fished well c̄ 3cc NS. All other assessment findings WNL. Will continue to monitor. C. Jones
0955	Pt. c/o pain II tylenol given (b)(6)-2 [redacted]
1330	Pt alert and oriented. PERRLA. Lungs CTA bilat, Ø resp distress. NSR and soft, non-tender, bowel sounds active x4 quads. External fix to (R) femur intact. DSG to pin sites every CDI. Packing to 4th pin. Aggressive ROM to (R)

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

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	leg done by PT. Pt able to bend knee to >90° ⊼ assist. Given Percocet for pain. Ambulating to BR on crutches ⊼ assist. Strong pulses and brisk cap refill to bilat LE. (b)(6)-2 [redacted] LT/BN
1930 14Aug03	Pin care and dsg Δ's done to ex fix in (R) femur. H202/H20 soln used to clean pins and sites. Pins 5 and 6 sites packed c̄ vaseline gauze, all other pins wrapped loosely. Ø complaints (b)(6)-2 [redacted] LT/BN
2300	Care assumed @2100. VSS, AOX3, 650 mg tylenol given for pain @2300. Lung sounds CTA, pulses ⊕ x4, BSE. ROM done on RLE, slight pain during rom. Pt ambulate to BR x1. Ex fix site CDI, ⊕ pulse and sensation on rt. Will continue to monitor. [redacted] Alumia
15Aug03 0525	Pt. c/o pain in (R) femur, ⊼ tylenol given. (b)(6)-2 [redacted] LT/BN
0630	Pt. awake & alert sitting up in bed performing ROM exercises on (L) leg. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Ex. fix to (R) femur intact, pin 3&4 sites c̄ small amt. of yellowish fluid drain (+) sensation in digits, <3 sec cap refill, full rom in digits & ankle, limited ROM in knee. Pt. ⊼ other complaints @ this time. All other assessment findings WNL. Will continue to monitor (b)(6)-2 [redacted] LT/BN
1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex-fix to (R) femur intact. Dsgs to pin sites CDI. Pt doing ROM exercises to (R) knee. Strong pedal pulses and brisk cap refill to bilat LE. New started to (R) PA. Ø complaints [redacted] LT/BN

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MEDICAL RECORD Progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1830 15 Aug 03	DSG Δ to ex-fix pin sites done. 1, 2 and 4 pins packed c iodoform gauze. Site @ 4th pin deep 3-4 cm. Other pins wrapped c dry gauze. Ø complaints (b)(6)-2 [redacted] LCW
2215	Care assumed @ 2100. VSS, AOX3, 650mg tylenol for pain. Lungs CTA, pulses (+) x4, bsf. RLE ROM performed. Sutures CTA and ex-fix sites CDI. PTC (+) pulse and sensation on rle. HL on LFA. No complaints at this time. (b)(6)-2 [redacted]
16 Aug 03	0515 650mg tylenol for pain to RLE - [redacted] 0542 Assume pt care @ 0500. pt awake and alert. No c/o pain @ this time. VSS. HR reg. Lungs CTA. Abd soft BS x 4. HL to (L) FA (+) flush ~~5~~ redness/ infiltration. Ex-fix (R) thigh intact. pin site dsgs intact c yellow drainage. (+) ROM below ex-fix (b)(6)-2 (+) pulse (+) sensation. Will continue to monitor [redacted]
16 Aug 03 1330	Sleeping, easily arousable c verbal stimuli. PERRLA. Lungs CTA bilat, Ø resp distress NSR. Abd soft, none-tender, bowel sounds active x4 quads. Ex-fix to (R) femur intact aggressive ROM done by PT. Pin sites CDI. Strong pulses and brisk cap refill to bilat LE. (b)(6)-2 [redacted] LCW

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. LCW2

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

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 1730	Pin care done to (R) femur ex-fix. Pins cleaned c̄ H_2O_2/H_2O soln. 1, 2, 4 pins packed c̄ iodoform gauze. All other pins wrapped c̄ plain dry gauze. Ø complaints (b)(6)-2 [redacted] CT/DV
2230	Care assumed @2100. VSS, a+o x3, 800 mg motrin given for pain @2100. Lung sounds CTA, pulses (+) x4 extremities, bs (+) x4. Pins on lle intact, sites clean, good rom on lle. HL on LFA intact, Ø s/s infection. Will continue to monitor. (b)(6)-2 [redacted] gilumco
17 Aug 03 0700	Pt. awake & alert in bed c̄ c/o pain to (R) femur, c̄ motrin given. HR Regular, Lung sands clear bilat, bowel sounds (+) x 4 quads. New IV started in (R) FA. VSS. Ext fix to (R) femur intact, DSG's clean pin sites clr. (R) pedal pulse palpable, (+) sensation, cap refill <3sec. Full ROM in digits & ankle, limited ROM in knee. Pt c̄ other complaints @ this time. All other assessment findings WNL. (b)(6)-2 [redacted] DV/AN
17 Aug 03 1500	Awake and alert in bed. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex-fix to (R) femur intact, dsgs to pins clr. Strong pedal pulse and brisk cap refill to bilat LE. Pt doing active ROM to (R) knee. Ø complaints at this time. (b)(6)-2 [redacted] CT/DV
1900	Pin care done. Pins and pin sites cleaned c̄ H_2O_2/H_2O soln. 1, 2, 4th pins packed c̄ iodoform gauze, then all pins wrapped c̄ plain gauze. Ø complaints (b)(6)-2 [redacted] CT/DV

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)*
8-17-03 2100.	Pt. care assumed @2100. HR Reg, lungs CTA, BS⊕ x4. ⓡ↓ ext. ex-fix intact, pin sites CDI. ⓡ ft. ⊖ pulse 2+, brisk cap refill, ⊕ROM ⊕ sensation. will cont. to monitor. (b)(6)-2 [redacted] 1CW/AN
18 Aug 03 0520	Pt. awake & alert c/o pain in ⓡ femur, ⊖percocet given. HR regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Ext. fix to ⓡ femur intact, pin site dsgs CDI, pedal pulse palpable, (+) sensation, <3sec cap refill, Full ROM in digits & ankle, pain ⊖ ROM to knee. HL in ⓡFA ⊖ s/s of infection. VSS. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted] 2CT/AN
18 Aug 03	2045: Assumed care @1300: VSS, Lung sounds clear bilat. Abd. Soft, non-distended, BS x4. ⊖ pain @ 1330. Motrin 600mg PO given. Relief acceptable. Pin care done. Iodoform packing to pins 1, 2, & 4. ROM exercises done. Will monitor. [redacted] 2CT/AN
19 Aug 0500	Care assumed @2100. VSS, ÷ motrin given for pain. (b)(6)-2 Lung sounds CTA, pulses ⊕ x4, bs ⊕. Pins intact ⊖ drainage, ⊕ pulse and sensation in le, Pt ambulated x2 and rom performed. Will continue to monitor. [redacted] 91WM6 (b)(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. 1CW2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Aug03	0645 Assume pt care @ 0500. pt awake and Alert. c/o pain to RLE requesting Motrin. VSS. HR reg Lungs CTA. Abd soft BSx4. (R) Ex-fix intact Dsgs to pins CD+I. (+) pulse (+) movement (+) sensation below ex-fix. pt being active ROM exercise to Knee, HL to (R) FA (+) flush ~~5~~ redness/infiltration will cont. to monitor (b)(6)-2 [redacted] SIUMS
19Aug03 2030	Assumed care @ 1300. A+Ox3, VSS. No c/o pain @ this time. c/o pain @ 1645. Motrin 800 mg given PO. Abd. soft, non-distended. Lung sounds clear bilat. Pin care done to ex-fix c̄ packing to pins 1, 2 + 4. 5/L to (R) FA patent. Will continue to monitor. [redacted]
2220	PA. care assumed @ 2100. HR reg, lungs CTA, (b)(6)-2 BS(+) x4. Ex-fix (R) ext. intact. dsrgs to pinsites CDI ~~5~~ drainage. (R) ft. c̄ pulse ~~2+~~, (+) ROM, (+) sensation. Ø c/o pain @ this time. Will cont. to monitor. (b)(6)-2 [redacted] CTAN
20Aug03	0639 Assume pt care @ 0500. Awake and Alert. c/o large amt of pain to (R) thigh and (R) foot. percocet given. Ex-fix (R) thigh intact Dsgs to pins CD+I. (+) pulse (+) movement (+) sensation. VSS. Will continue to monitor (b)(6)-2 [redacted] SIUMS
	0640 (R) FA HL (+) flush ~~5~~ redness/infiltration [redacted] SIUMS (b)(6)-2
20Aug03	2010: Assumed care @ 1300. VSS. Lung sounds clear bilat. BSx4. Ex-fix to (R) Leg. Pin care done c̄ Iodoform packing to pins 1, 2 & 4. No c/o pain @ this time. Will continue to monitor. [redacted], ZLT, AN (b)(6)-2

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)*
21Aug03	2105= VSS, A+O x3, IV HL to (R) FA patent, continuing IV+PO antibiotics routinely. Pin care & W→D dsg Δ's done tonight, aggressive ROM exercises done to (R) LE/(R) knee. Neuro-Vascular checks done (+) sensation (+) movement to (R) LE. 2+ pedal 2+ popliteal pulse to (R) LE. No other remarkable assessment findings. Ø c/o pain. Will continue to monitor — [redacted]
22Aug 0715	PTVS BP 118/68, HR84, RR16, T98.3, SpO2 99% — [redacted]
22Aug 1600	Pt. c/o pain. Tylenol given po — (b)(6)-2 [redacted]
1610	Pt. awake & alert & complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Ext fix to (R) femur intact, pin care completed & all insertion sites ~ s/s of infection. BM x 2. All other assessments WNL HL in (R) FA ~ s/s of infection. VSS. Will continue to monitor. — [redacted]
22Aug 03	2120: Assumed care @ 1700. A+O x3. No c/o pain or discomfort (b)(6)-2 @ this time. c/o diarrhea x5. Immodium 2mg PO given. HR-regular. Lung sounds clear bilat. Abd. soft, non-distended. BS x4. Ext fix to (R) Femur. Pin care done, no s/s of infection. Will continue to monitor. — [redacted]
23Aug03	0415. Late entry for 22Aug03 1700. T-98.6°F P-82 R-16 BP-126/74 SpO2-98% — (b)(6)-2 [redacted]
23Aug 0720	PTVS BP 119/69, HR84, T98.2, RR16, SpO2 99% — [redacted]

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO. ICW2

[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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8:20	Pt. care assumed @ 2100. VSS. (R) ↓ ext. ex-fix
2134	intact. (R) ft. ⊂ pulse 2+, (R) ROM (R) sensation, brisk
	capr refill. Pt c/o ∅ pain @ this time. will cont to
	monitor. (b)(6)-2 [redacted]
21Aug03	Pt awake and alert. Lungs CTA bilat, ∅ resp
0630	distress. VSR. Abd soft, non-tender, bowel
	sounds active x4 quads. IV to (R) arm flushing
	easily. Ex fix to (R) femur intact, pin sites
	and drsg CDI. Strong pulses and brisk cap
	refill to bilat LE. Pt doing ROM to (R) knee.
	∅ complaints (b)(6)-2 [redacted]
0930	ROM done to (R) knee. Pt premed ⊂ Percocet
	for pain. Pin care done ⊂ H2O2/H2O soln
	1st, 2nd & 4th pins packed ⊂ Iodoform
	gauze. All pins dressed with plain
	dry gauze. Minimal serosanguinous
	drainage noted to 1, 2, 4 pins. ∅ noted
	to 3, 5, 6. ∅ complaints (b)(6)-2 [redacted]
	Received pt ~~resting~~ in stable condition from
	Dogwood facility. No S/S noted in above assessment.
	Dsg cont intact, minimal drainage noted on (R)
	pin site, dsg Δ due @ 2000. Leg warm, ~~and~~ pulse
	intact. Amb on crutches down hallway to bedroom
	room. IV flushes easily, ∅ redness or swelling
	noted. Pt placed in restraints per protocol.
	Will cont to mon. [redacted]
	(b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

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

LOG NUMBER

ARRIVAL			TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE		TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE	Ø	☒ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.	☐ OTHER (Specify) AIR		ALLERGIES MRSA
5	01	03	1800		

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) Fever Fx

SEX M AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	1700		
BP	123/69		
PULSE	105		
RESP.	16		
TEMP.			
WT. (Child)	80 kg		

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 PROVIDER

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
CBC	[redacted]	1700
FES		1700
IV c NS		1700
	(b)(6)-2	

ASSESSMENT/DIAGNOSIS

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

SIGNATURE OF PROVIDER AND ID STAMP

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

PATIENT ASSESS ENT

TIME: 1600 SIGNATUR [redacted]

SKIN AND MUCOUS MEMBRANES

in : Loose / Tight / Diaphoretic / Shiny / Dry

in : Temperature WD

lor: Pale / Cyanotic / Jaundiced NPR

cous Membranes: Moist / Dry / Cracked

in Breakdown: None Location: Size:

NEUROLOGICAL

c / Alert / Lethargic / Unresponsive GCS: 15

ientated / Disoriented Pupils: 3 R

tremity Movement: Full / Limited / None RLE

CARDIOVASCULAR

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

pillary Refill: <3 Seconds Homan's Sign

gular Venous Distension Ø Edema Ø

art Sounds WNL

rthm SR PRI: QRS:

scular Catheter Central Arterial Peripheral 1 Peripheral 2

veforms

ution

est Pain

RESPIRATORY

est Expansion / Symmetrical / Asymmetrical

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

athing Patterns: Normal

ugh: Productive / Nonproductive / None NA

tum: Color / Amount / Consistency / Odor

est Drainage System Gravity: Suction cm:

Leak No Yes Crepitus

racter of Drainage:

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

ficial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA B	
eezes		
inished		
ent		

GASTROINTESTINAL

lomen: Soft / Firm / Hard / Distended cm Girth

vel Sounds: Normal / Hyperactive / Hypoactive / Absent

ssings: Ø

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

Drainage: Color Character

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

ol: Character

ns:

GENITOURINARY

e Color: UNK Character:

ding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

UNK

HER: [redacted]

(5)(6)-2

TIME: SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature WD

Color: Pale / Cyanotic / Jaundiced WNL Ex Pack

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm (B) Round

Extremity Movement: Full / Limited / None (R) LG XFix

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm SR PRI: QRS:

Vascular Catheter Central Arterial Peripheral 1 Peripheral

Waveforms

Site

Solution

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 Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: (R) LG

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

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:

(5)(6)-4

5 Jul 03

CIV - [redacted]

Date 5 July Bed # 5

Patient's Name EPW [redacted] (5)(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																	149/67			130/70				136/76
TEMP																	99.4							
HR																	99			89				80
RR																	20			14				16
SAO2																	99			100				98
~~FIO2~~																	4L							
																	NC			RA				RA
INPUT																								
PO																								
IV																	10	10	10	10	10	10	10	10
~~NGT~~ VPB																	100			100				
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																						550		
NGT																								
STOOL																								
OTAL																								
BALANCE																								
Initials																								

(5)(6)-4 [redacted]

MEDCOM - 13756

Date 06 Apl

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

(5)(6)-2

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

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

NEUROLOGICAL

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

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals strong & pulsy
Capillary Refill: 2 Seconds 3 Homan's Sign 0
Jugular Venous Distension 0 Edema generalized RIE
Heart Sounds S1 S2 Bowel
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: 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 (B)	
Wheezes		VC Bases
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: RIE & Mast - Mod. sang drainage
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

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

EMOTIONAL/PSYCHOSOCIAL

OTHER:

Date 06JUL03 Bed # 3

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

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		125/76														126/73				129/73				129/79
TEMP																98.0				98.6				100.5
HR		92														80				80				76
RR		20														18				18				16
SAO2		90														96				98				96
FIO2		RA														RA				RA				RA
																								[redacted]
INPUT																								
PO													250											
IV																								
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT															[redacted]									
URINE															700								500	
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

(b)(6)-2

(b)(6)-2

MEDCOM - 13758

DATE 07 JUL 03 PATIENT ASS[redacted] F. [redacted] ASSESSMENT

TIME: SIGNATURE: [redacted] SIGNATURE:

(b)(6)-2

SKIN AND MUCOUS MEMBRANES	SKIN AND MUCOUS MEMBRANES
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin Temperature: Wm	Skin: Temperature: Wm
Color: Pale / Cyanotic / Jaundiced: WNL	Color: Pale / Cyanotic / Jaundiced: NSR
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 [illegible]	Extremity Movement: Full / Limited / None see [illegible]
CARDIOVASCULAR	**CARDIOVASCULAR**
Pulse (0 - 4): +2 Radials +2 Pedals	Pulse (0 - 4): +3 Radials +3 Pedals
Capillary Refill: <3 Seconds Homan's Sign	Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension: 0 Edema: 0	Jugular Venous Distension: (-) Edema
Heart Sounds: RRR	Heart Sounds: S1 S2
Rhythm: NSR PRI: QRS:	Rhythm: NSR PRI: QRS:
Vascular Catheter: Central / Arterial / Peripheral 1 / Peripheral 2	Vascular Catheter: Central / Arterial / Peripheral 1 / Peripheral 2
Waveforms	Waveforms
Site: Bilateral AVG	Site: (L) RA (R) LA / RA / LA
Solution: NS	Solution
Chest Pain	Chest Pain
RESPIRATORY	**RESPIRATORY** FIS use
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: NEG	Breathing Patterns:
Cough: Productive / Nonproductive / None	Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor: NONE	Sputum: Color / Amount / Consistency / Odor: None
Chest Drainage System Gravity: 0 Suction cm: 0	Chest Drainage System Gravity: Suction cm.
Air Leak: 0 No 0 Yes 0 Crepitus 0	Air Leak: No Yes Crepitus
Character of Drainage: 0	Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L): 0	Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:	Artificial Airway Size: Type: Position:
Breath Sounds / Anterior/Location / Posterior/Location	Breath Sounds / Anterior/Location / Posterior/Location
Crackles	Crackles
Wheezes: CTA	Wheezes: CTA Sx
Diminished	Diminished
Absent	Absent
GASTROINTESTINAL	**GASTROINTESTINAL**
Abdomen: Soft / Firm / Hard / Distended cm Girth	Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: COMING FROM SITE	Dressings: [illegible]
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color 0 Character 0	NG Drainage: Color Character
Tube Feeding: Day No: 0 Strength: 0 Rate: 0 Aspirate: 0	Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character: 0	Stool: Character
Drains: EXTERNAL SUTURES	Drains:
GENITOURINARY	**GENITOURINARY**
Urine Color: WNL Character:	Urine Color: Character:
Voiding: Continent / Incontinent / Catheter	Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL	**EMOTIONAL/PSYCHOSOCIAL**
OTHER: APPROPRIATE	OTHER: See [illegible]

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

Date 07 Jul 03 Bed # [redacted] (5)(6)-2

Patient's Name EPW [redacted] (5)(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		127/70				124/74				140/72				137/76						130/68				120/59
TEMP		97.2				97.1				97.1				96						94				90
HR		26				25				26				20						20				20
RR		99				99				99				97						98				97
SAO2		RA				RA				RA				RA						RA				RA
FIO2																								
INPUT																								
PO														400										
IV																								
NGT																								
TURN Q 2																				N				
																				98				
TOTAL																								
OUTPUT			900																					
URINE																								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

[redacted] (5)(6)-2

750

1450

(5)(6)-2 [redacted] Family Physician

MEDCOM - 13760

Date 08JUL [redacted] (b)(6)-7

PATIENT ASSESSMENT (b)(6)-2

TIME: 1600 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

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

NEUROLOGICAL

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

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension 0 Edema
Heart Sounds S1S2
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				
Chest Pain				

RESPIRATORY

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

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA (B)	
Diminished		
Absent		

GASTROINTESTINAL

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

GENITOURINARY

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

EMOTIONAL/PSYCHOSOCIAL

NA

OTHER:

PATIENT ASSESSMENT (b)(6)-2

TIME: 1835 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

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

NEUROLOGICAL

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

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials +2 Pedals +2
Capillary Refill: < 3 sec Seconds Homan's Sign
Jugular Venous Distension 0 Edema 0
Heart Sounds S1S2
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			RPIV	
Solution			LPIV	
Chest Pain				

RESPIRATORY

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

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA (B)	CTA (B)
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: Yellow Character: Clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

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

4. PROPOSED SURGICAL PROCEDURE:

I+D (R) thigh, adjust ex-fix.

5. ADDITIONAL INFORMATION: Last PO: since MIDNIGHT Medical Hx: Ø Implants: Ø Medications: Cleocin Unasyn
Jewelry removed: yes/no Family waiting: yes/no

Smokes, Drinks Ø Drug use

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

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

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

ICW2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion [redacted] (b)(6)-2 o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. N/A	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 Rt side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT, ON 4 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Bowie site:

Drsg:

Breathing:

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title [redacted] NAT N	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 4 Apr TIME: 0919	DATE: 4 Aug 03 TIME: 1340

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 40

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
ORIF Right Femur.

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

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

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

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	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. N/A o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning N/A 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: N/A 1) Diminished Hearing ✓ 2) Language Barrier F.3. ✓ Potential injury due to dentures: N/A ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. (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 NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/AN 5 July 03 DATE

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

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

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

BREATHING EASY: (Y)(N)

(b)(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 5 July 03 TIME: 1610

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 05 Jul 03 TIME: 0803 (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: 40

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
ORIF Rt femur

4. PROPOSED SURGICAL PROCEDURE:
I + D Rt femur, adjust Ex fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition intact
Tobacco yes ppd X ___ yrs. Body Piercing ___ Diabetes (Y) (N) ROM limited (R) Motrin w/72 hrs (Y) (N)
ETOH yes Implants Rt femur Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ___ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: ∅

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	✓ 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	o 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	o 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] (5)(6)-4

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

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

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

[redacted] RD 18 JUL 03 DATE

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

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

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

☐ Transferred to litter with roller due to spinal

(b)(6)-2

12. PREOPERATIVE EVALUATION (Signature and Title) PREPARED BY [redacted] MAJ AN

DATE: 18 Jul 03 TIME: 1055

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 18 Jul 03 TIME: 2045

(b)(6)-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 13767 USAPA V1.0

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Cart BY [redacted] Staff

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

3. DATE 5 July 03 TIME PATIENT ARRIVED IN SUITE 1 Cu → OR

4. PATIENT IN ROOM TIME 1809 (b)(6)-7 NUMBER 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO since Yesterday.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (91D) (b)(6)-2	RELIEF SCRUB	SPC [redacted] (1945-EOC) (b)(6)-7
ASSIGNED CIRCULATOR	CPT. [redacted] (66E)	RELIEF CIRCULATOR	CPT [redacted] (1940-EOC)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Bil arm to padded armboard <90°, Roll under (R) Hip.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine S/Sol
SITE: Rt. leg BY WHOM: CPT. [redacted]
SITE: ~ BY WHOM: ~
COMMENTS: Ø pooling of Sol

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-7	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes ☐ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION (F[redacted]ntries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

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

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

☑ ESU NO: Valley Lab #1
GROUND PAD: BRAND 3M
LOT NO: 2005-10 OT

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO: Coag: 30 Cut: 30

MEDCOM - 13768

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATING R[redacted] ARM. IF YES, SITE (Rt) [redacted]

YES ☑ NO ☐

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME [redacted] (b)(6)-2
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform, Fluffs, Kerlix, Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] (b)(6)-2
Anes: Maj [redacted] (CRNA)
CPT [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Ex-Fix to Right Femur

21. PATIENT TRANSFERRED TO (CSU) TIME See Anes Record METHOD Litter [redacted]

22. R[redacted]STERE[redacted]NATURE [redacted] UPT/SN

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

(b)(6)-2

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

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

3. DATE 18 Jul 03 TIME PATIENT ARRIVED IN SUITE 1845

4. PATIENT IN ROOM [redacted] TIME 1845 (b)(6)-2 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] (b)(6)-2	RELIEF SCRUB	Spc. [redacted] (b)(6)-2 p 1900
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	LTC [redacted] p 1900

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table. BUE on padded armboards < 90°

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

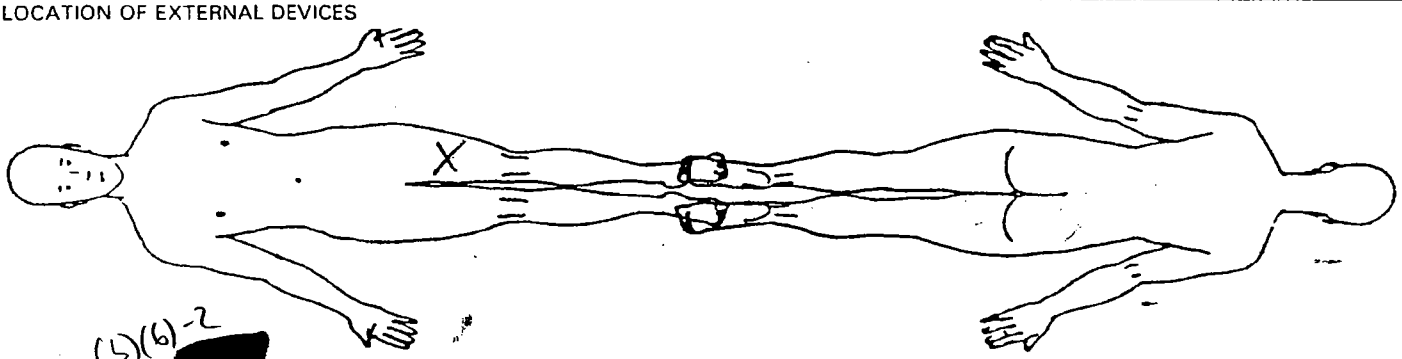
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify)
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 [redacted]

LEGEND X G[redacted]ad -- Safety Strap = = = Tourniquet

Initial: SSG [redacted] 1LT

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR
Sponge	[X] Yes [ ] No	/	C	C	Spc [redacted]	Lt [redacted]
Needle Sharp	[X] Yes [ ] No	/	C	C	Spc [redacted]	LTC [redacted]
Instrument	[ ] Yes [X] No	/	/	/	/	/
Other	[ ] Yes [X] No	/	/	/	/	/

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

[redacted] (b)(6)-4

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

[X] ESU NO: 000450
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 EXP 2005-03

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

[ ] BIPOLAR NO:

MEDCOM - 13770 cut: 30 coag: 30

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE C-Arm (R) femur

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)*
Iodoform Gauze
kerlix fluffs
kerlix roll

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

DA 5179 initiated

20. OPERATION(S) PERFORMED
I&D Ext. fix. pins; revision of pins

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	2030	LITER CO_2

22. REGISTERED NURSE SIGNATURE [redacted]

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY ones

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

3. DATE 21 July 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 2125 (b)(6)-7 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Bump placed under (R) hip by [redacted] (b)(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

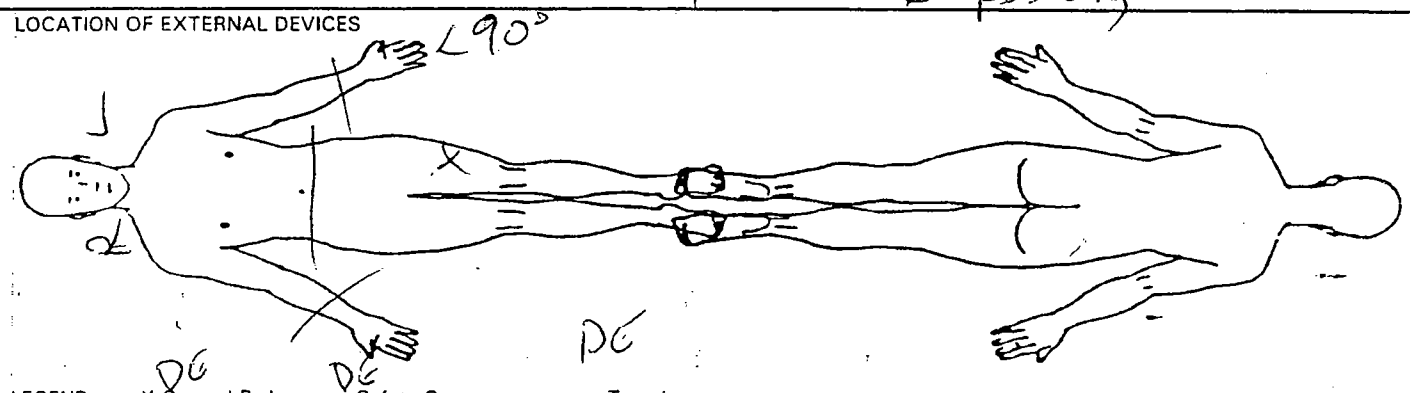
PREP SOLUTION *(Specify)* Betadine / Betadine

SITE: (R) thigh BY WHOM: [redacted]

SITE: Ex fix frame BY WHOM:

COMMENTS: ∅ pooling

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

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

☐ ESU NO: VL # 3 25/25

GROUND PAD: BRAND VL Rem Poly-H

LOT NO: 68936

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13

MEDCOM - 13772

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

PROSTHESIS, IMPLANTS ☑ YES ☐ NO IF YES NAME:

Surgical Simplex® P
Howmedica Int. S. de R.L.
Raheen Business Park
Limerick, Ireland.
Full Dose
REF 6191 0 001
LOT CLJ157

Surgical Simplex® P
RADIOPAQUE BONE CEMENT
Distributed by:
Stryker®
Howmedica
Osteonics Mahwah, New Jersey
Full Dose
Cat. No. 6191 1 001
Control No. RAJ019

14. [redacted] MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANES

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	
Tobramycin 1.2gm	1.2gm	Intraop	Mixed E cement	[redacted]	
				(b)(6)-2	

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.7 N.C1

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. [redacted] ORY 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. antibotic beads	2.	3.
SITE	1. (R) thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix
Ioban

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

Gete

20. OPERATION(S) PERFORMED
I+D (R) LE Ex Fix

21. PATIENT TRANSFERRED TO ICU 2 TIME 2242 METHOD litter w/anesth

22. REGIS[redacted] SIGNATURE [redacted] OT/AN

REVERSE OF DA FORM 5179-[redacted]7 USAPA V1.01

(b)(6)-2

MEDCOM - 13773

MEDICAL RECORD — **INTRAOPER : DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia / OR nurse

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

3. DATE 4 Aug 03 TIME PATIENT ARRIVED IN SUITE 1220

4. PATIENT [redacted] (b)(6)-2 TIME 1220 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine

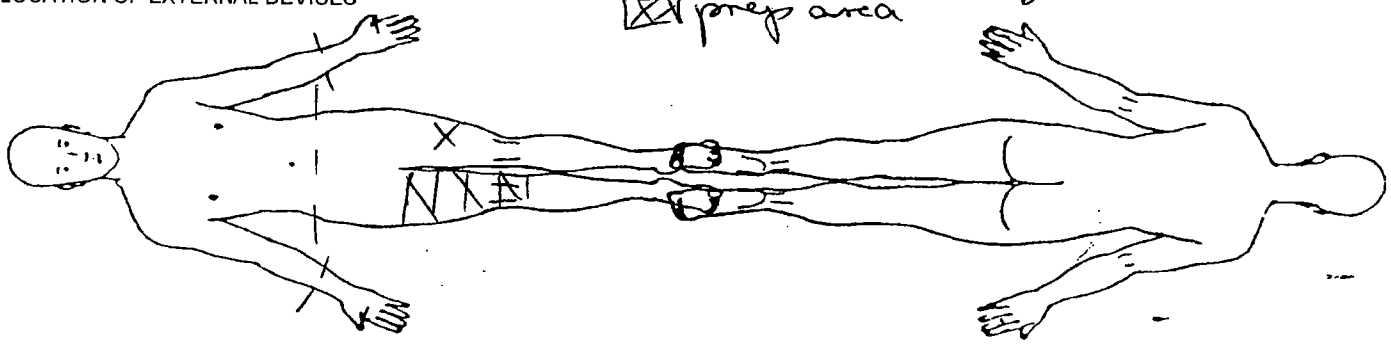
SITE: Thigh to zipper BY WHOM: Humphrey

SITE: Knee (R) BY WHOM:

COMMENTS: no piercing or skin d's noted

9. LOCATION OF EXTERNAL DEVICES

☒ prep area



LEGEND X Ground Pad – Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No					
Needle Sharp	☒ Yes	☐ No		C	C	[redacted] (b)(6)-2	[redacted]
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] (b)(6)-4

ICW2

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

☒ ESU NO: VL Force 2 # 3

GROUND PAD: BRAND VL Perm Polyhesive II

LOT NO: 68936 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

[redacted]

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE (R) Femur C-arm

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix
Tempfs
Acewrap

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: GETA (LMA)
(5)(6)-2

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

20. OPERATION(S) PERFORMED
I+D (R) thigh + Ex Fix Adjustment

21. PATIENT TRANSFERRED TO ICU 2 TIME See DA 73 89 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] PTAN

(5)(6)-2

MEDCOM - 13775

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY					31 Aug 83											
MONTH-YEAR Aug	DAY	20		21												
19 83	HOUR			0600	16	2000	0715									
PULSE (O)	TEMP. F (•)	0571					0715									
	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		148/74		6/16		88										
		98/60		108/58		87										
				20/76		16										
		97				92										
HEIGHT:	WEIGHT →	98%		98%			99%									
				99%		98%										
						RA										

(Centigrade Equivalents, for Reference only)

data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 13776

MEDICAL RECORD — VITAL SIGNS REC

(REV. 7–95)
FIRMR (41 CFR) 201–9.202–1

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug DAY 13 14 15 16 17 18 19

19 2003 HOUR

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE

	13	14	15	16	17	18	19
	122/76	122/78	116/72	126/82	130/74	112/76	122/84
	114/70	118/60	112/70	120/70		110/76	110/68
	97	97 98	97	97/70	97/70	99	97 98	97
HEIGHT: WEIGHT →	95%	98				99	98	97%	97%

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. ICU2

STANDARD FORM 511 (REV. 7–95) BACK

[redacted] (5)(6)-4

[redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

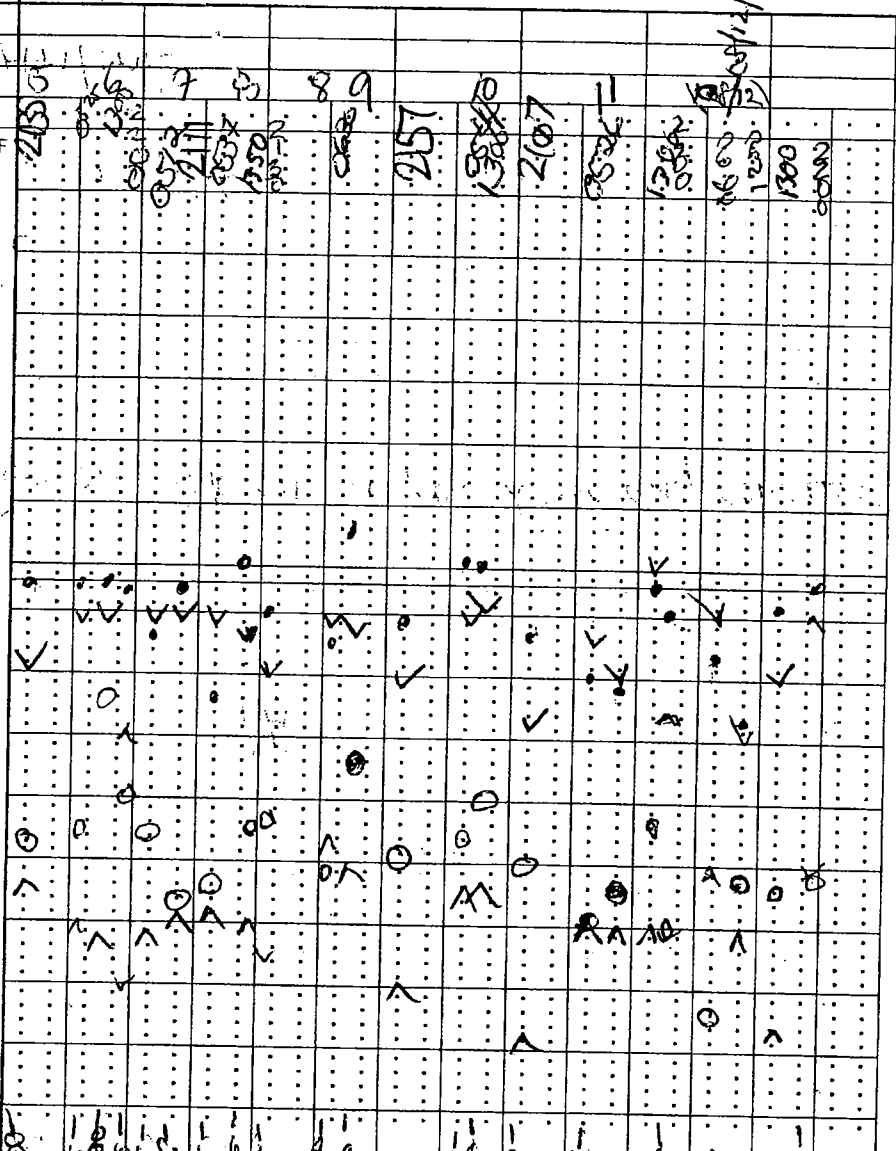
HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (0) | TEMP. F (°) | TEMP. C



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.

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

VITAL SIGNS RECORDS

Medical Record

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		1														
POST- DAY																
MONTH-YEAR	DAY	5 JUL														
19	HOUR	1600														

PULSE (0)	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)

V

O

Λ

RESPIRATION RECORD	RR	16														
BLOOD PRESSURE		115/67														
HEIGHT:	WEIGHT →															
	SPO2	96%														
	~~RR~~	RA														

Record special data only when so ordered

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

GPW ~~GTV~~ - [redacted] (b)(6)-2

5 JUL 03

REGISTER NO.

WARD NO. CU #1

VITAL SIGNS RECORDS

Medical Record

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

-- -19

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	08	12	16	20												
19	HOUR																

PULSE (0)	TEMP. F (°)	TEMP. C (Centigrade Equivalents, for Reference only)
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101° 101.4	38.3°
140	100° 99.9	37.8°
130	99° 98.6°	37.2° 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE		128/81	129/75												
HEIGHT:	WEIGHT →														
PR		20	20												
				See flowsheet											
SPO2		100%													
		PA													

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

6 Jul 03

VITAL SIGNS RECORDS

Medical Record

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

MEDICA

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

(b)(6)-2

TIENT'S IDENTIFICATION (Typed or written entries give: Name—last, first, middle; ID No. (Hospital or other); hospital or medical facility)

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

EPW

(b)(6)-4

1-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY 7/8/03

MONTH-YEAR | DAY | 0800 2400 0400

19 | HOUR

PULSE (O)	TEMP. F (•)	TEMP. C (Centigrade Equivalents, for Reference only)
	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: 16 16 18

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

NSN 7540-00-634-4124

AL RECORD — VITAL SIGNS RECORD

		HOSPITAL DAY																	
		DAY																	
MONTH-YEAR		DAY	22		23		24		25		26		27		28				
19		HOUR	3	12	3	12	3	12	3	12	3	12	3	12	3	12			
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 →																		

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 | DAY | HOUR

19

August

PULSE (0) | TEMP. F (°)

TEMP. C (Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT

Record special data only when so ordered

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

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

REGISTER NO.

WARD NO.

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

Ward/Section: ICU (b)(6)-2 QUESTING PHYSICIAN: [redacted] (b)(6)-2

LABORATORY RESULT F
(Subject to the Privacy Act of 1

LAST FIRST MI: [redacted] EPW [redacted] (b)(6) DATE: 05JUL03 TIME: 0330 SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	16.3	4.8-10.8 x 10^3
RBC	3.80	4.7-6.1 x 10^9
Hgb	11.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.7	42-52% (M) 37-47% (F)
MCV	96.5	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10^3 verified
Lymph %	17.0	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 WITH EVERY UNIT OF BLO REQUESTED)

UNIT	TYPE	CROSSMA

REMARKS:

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

Ward/Section:	RE[illegible]ING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	[redacted] (b)(6)-2	DATE: 5 Jul · TIME: 1520 · SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	16.0	4.8-10.8 x 10^3
RBC	3.86	4.7-6.1 x 10^9
Hgb	11.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.9	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	326	130-500 x 10^3 verified
Lymph %	16.4	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		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

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

DATE: 5 JUL 03

LAB ID NO.:

[redacted] (b)(6)-4 ICW#2 7-18-03 0730

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC		1.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-398 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Seg		Mono	
Bands		Eos	
Lymph		Baso	
Myelo		Imm	
RBC Morph			
Stim Hemoglobin		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		
Direct Gen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Culture	

	Negative
	Negative

lysis

WITH STED

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.0 secs
APTT		21-34 secs
D-dimer		20 ng/ml
FDP		10 ng/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:

[redacted] (b)(6)-2

EPW [redacted] (b)(6)-4 19 July 0422

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
MCH		26-32 pg/dl Verified
Platelets		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		
SG		
Bld		
pH		
Prot		
Urob		
Nit		
Leuk		
Hcas		
Cell Count		
Direcrigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
		Negative
		Negative

Microscopic Urinalysis

Blood Bank

SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 DATE: TAR ID NO:

[redacted] 09 Jul 03

O/M NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION	DOSING	(Units)	
	MIDAZ	(mg)	2
	FENT	(mcg)	50 150 / MSO4 – 10 —— 10
	PROPOFOL	(mg)	150 50
	LIDO	(mg)	50 (MAC) 50 5 — 1-1
	VEC	( )	
	SUCC	(mg)	100
	VOLAT AGENT FORANE	% det	4 1.5 / 1.6 / 1.0 / 0.8 / 1 / 1.4 / 1 / 1
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	8 2 2 / 2 / 2 / 2 / 2 / 2 / 4 / 5
	SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

TOTALS	TOTAL INS
	<100
	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID – 1600
COLLOID – Ø
BLOOD – Ø

ACCESS		
LINE site (R) FA 16 G	☐ Warmed	LR → 500 – 200 – LR2 ↑ – 300 ↓
(L) FA 18 G	☐ Warmed	1000 LR3 ↑ – 300 ↓ / 1600
	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	
	URINE –	

REMARKS –
Code drugs with numbers, events with letters

1800 Pre Op Eval Revie
IV's x 2 (B) FA's
TRANS → OR
1809 OR #2 monitors ↑
Pre O2 IND/INT
1845 CASE ASSUMED by CPT [redacted] CRNA
RPT [redacted] MAS
1855 2g Ancef (b)(6)-7 SIR.
1945 5mg Neost / 8 Rob
1/4 TOF
1950 TOF 4/4
1955 ST
1959 PT EVT > 4ml/kg
cpt – SXA
2000 OOR TO ICU
2005 RPT TO CPT
[redacted]

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 70 KG LB
HEMATOCRIT:
INITIAL DATA: BP – 122, 71 HR – 93
BLOOD CHECK: OK? Y N
PATIENT REQUEST: OK for PROCEDURE? TIME – 1810

TIME → 1815 30 45 1900 15 30 45 2000 15 30 45 2100

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

220 200 180 160 140 120 100 80 60 40 20

VITALS								
VT – ml		920	920	740	740	740	750	750
f – breaths/min		6	~~26~~ 6	6	6	8	7	
Peak inf pres / PEEP		26	26	25	26	26	26	15
MODE – S(pon), A(ssist), C(on)		SC	C	C	C	C	C	S
BP/Auto Cuff	ET CO2 (torr)	35	36	33	35	34	34	43
BP / oth	FIO2 (Frac or %)	.81	.81	.82	.81	.81	.81	.81
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	AVAIL →						
	N-M Block (T/4)			0/4	0/4 PTC	1/4	1/4	4/4 TF
Warming blkt								
Conv warmer								

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

RECOVERY AT 2002
PACU ICU ____ (Specify)
OTHER ____
CONDITION: Stable
RESP – SpO2 – 95
BP – HR – 117

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1800	1809	2015
	Ready	Begin	End
PROC	1815	1830	1958

PROCEDURES and CPT Codes
Ex Fix (R) Femur

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 / mac 5 & ETT → VC = BBS (=), ETCO2 (+) Secured 20cm LIPS

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

SURGEONS: [redacted] CPT CRNA
(b)(6)-7 MEDICAL [redacted] ESTHESIA

PROCEDURE LOCATION OR 2
DATE 05 JUL 03
PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 13789
*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PL PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS Sex (X) MALE ~~( ) FEMALE~~

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

PROPOSED PROCEDURE: Ex Fix (R) Femur
SURGICAL SERVICE: ____
NPO SINCE: ____

HABITS:
TOBACCO: Smoker
ETOH: yes
DRUGS: No

CURRENT MEDICATIONS:
( ) = ordered as premed

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

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

LABORATORY STUDIES:
HB/HCT: 11.2 / 36.9
U/A: ____
OTHER: PLT 326

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC
X 1 ABD '83
No Anes Prob

PHYSICAL EXAMINATION
BP 115/67 HR 98 R 16 T ____
Pain Scale 0-10 ____
HEENT - Teeth WNL
Trachea ____
TMJ/Neck 3
Oropharnyx MP 2
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: ____
IV Access: (B) FA's
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since yesterday

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

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

The patient/legal guard[redacted] derstand and agrees. Questions answered.
Signed: [redacted] (b)(6)-7 Date: 05 July 03 Time: 1630 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[redacted] (b)(6)-7 ICU1 / ICU1

SEDATION KEY:

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	(mg)	2.5
MSO4	(mg)	5/5 5/5/5/5/10
Diprivan	( )	
Propofol	(cc)	50
Propofol	(mg)	200
	( )	
VOLAT AGENT: Halo	% del	X1-2-1.5-1.5-1.5-1 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	4-4-4-4-4-6-10

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

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

LINE site		
LR 20g	☐ Warmed	100
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE –

TOTALS: 2.5 L / 40 mg — TOTAL FLUID: MN — TOTAL URINE: 500 / 0

FLUIDS – SUMMARY: CRYSTALLOID – LR-600; COLLOID –; BLOOD –

REMARKS – Code drugs with numbers, event with letters

1840 - Met c ID & IV in place - hep/chart rev'd
1845 - On room monitors on induction
2022 - Awake LMA OK & TO ICU2 for recovery

ASA STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (G) LB

HEMATOCRIT:

INITIAL DATA: BP 120/60; HR 105

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: for PROCEDURE (+); TIME 1840

TIME → 1845 MAC x 30 x 2000 x 30

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

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

VT – ml							
f – breaths/min	34	26	29	16	20	18	
Peak inf pres / PEEP							
MODE – S(pon), A(ssist), C(on)	S	S	S	S	S	S	S
BP/Auto Cuff ✓ / ET CO2 (torr)	4	40	36	41	32	33	38
BP / oth / FIO2 (Frac or %)	7.21	7.21	7.21	7.21	7.21	7.21	7.21
ART line / SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES ✓ / ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP- site	available						
N-M Block (T/4)							
Warming blkt	WW Blanket						
Conv warmer							

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

PROCEDURES and CPT Codes: I&D Rt Femur Fx Fix/Adjustment

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Masked down using drawover, LMA #4 inserted x 1 attempt

AIRWAY MANAGEMENT: Intubation route, blade, technique, confirmation: 20cc cuff - Eyes taped, retraumatic soft bite block

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

[redacted] (b)(6)-4 ICU 2

SURGEON [redacted]

ANESTHET[redacted]

(b)(6)-2

PROCEDURE LOCATION: OR 2

DATE: 13 Jul 03

PAGE 1 OF 1

RECOVERY AT: PACU ICU (Specif) OTHER stable

CONDITION: 97.1

RESP – 16 SpO2 – 93%

BP – 184/76 HR – 125

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1840	1845	2040
	Ready	Begin	End
PROC	1857	1910	2010

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical Status (1) 2 3 4 5
WT: 70 (KG)/LB HT: ____
ALLERGIES: NKA

PROPOSED PROCEDURE: I+D (R) femur, adjust ex fix.
SURGICAL SERVICE: ORTHO
NPO SINCE: ____

HABITS:
TOBACCO: Smoker
ETOH: Yes
DRUGS: no

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ofendanyen
( ) Urasy
( ) ____
( ) ____
( ) ____
( ) ____

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

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

9.0 / 10.2 / 32.3 / 916

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTH
X (AB) '83
no anes. prob

PHYSICAL EXAMINATION
BP 116/76 HR 98 R 16 T 98
Pain Scale 0-10 ____
HEENT - Teeth: WNL
Trachea ____
Thro/Neck: 3
Oropharynx: MP2
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: ____
IV Access: ____
Urine Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: LMA mask intubation

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

The patient/legal (b)(6)-2 [redacted] to understand and agrees. Questions answered.
Signed: [redacted] RVR Date: 18 July 03 Time: 1210 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ____

(b)(6)-4
[redacted]

CH_2-CH_2

MEDICAL RECORD - ANESTHESI

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

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

DRUG	(Units)	1	2	3	4	5	6
Versed	(mg)	1.5					
Fentanyl	(ml)	2	1	1			
Propofol	(mg)	100					
	( )						
	( )						
	( )						
VOLAT AGENT 1.50	% del	2	1.4	1.4	1.5	0.5	X
	% e.t.	—	—	—	—	—	—
AIR	L/Min	—	—	—	—	—	—
N2O	L/Min	—	—	—	—	—	—
O2	L/Min	RA 4	2	2	2	2	8 RA

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

FLUIDS

LINE site		1	2	3	4	5	6
# 18 (R) RA	☐ Warmed						
	☒ Warmed	100/20	100/100			150/350	
	☐ Warmed						
	☐ Warmed						

LOSSES

EST BLOOD LOSS	0/0						
URINE -	N/M						

TOTALS: 25 mg, 5 ml, 100 mg

TOTAL EBL: Ø

TOTAL URINE: N-M

FLUIDS SUMMARY
CRYSTALLOID- LR 350
COLLOID- Ø
BLOOD- Ø

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

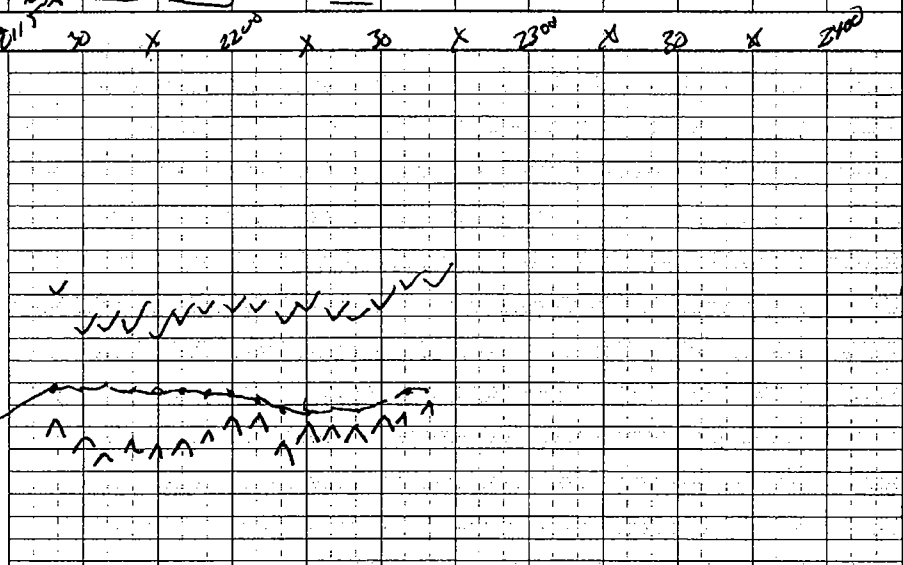
INITIAL DATA:
BP- 130/74
HR- 87

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE? Yes
TIME- 2120

TIME → 21 30 X 22 00 X 30 X 23 00 X 30 X 24 00

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



VENTIL

VT - ml	X-440	360	410	380	440	600	
f - breaths/min	18-12	16	30	20	18	19	15
Peak inf pres / PEEP	X-6	6	6	6	6	—	
MODE - S(pon), A(ssist), C(on)	S	A	A	A	A	A	S

MONITORS/ACCESSORIES

BP/Auto Cuff	X ET CO2 (torr)	34	36	39	37	40	36	38
BP/oth	FIO2 (Frac or %)	10	10	10	10	10	10	10
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	—	—	—	—	—	—	—
	N-M Block (T/4)	—	—	—	—	—	—	—
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1)(3) (4)(5)

REMARKS
Code drugs with numbers, events with letters
(1) in room, mask applied
(2) induction + placement of LMA
(3) Eyes taped and bore block
(4) pt awake + LMA removed + reflexes intact
(5) 20 PM

RECOVERY AT 2240
PACU ICU (Specify)
OTHER Rm 0/10
CONDITION: Sleepy Talk
RESP- 19 SpO2- 98
BP- HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2115	2125	2250
	Ready	Begin	End
PROC	2132	2140	2235

PROCEDURES and CPT Codes:
I&D (R) femur

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] (5)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GEN/LMA SCIA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
#4 LMA EASY PLACEMENT

SURGEONS: [redacted] (5)(6)2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: 3
DATE: 21 July 03
PAGE 1 OF 1

KW-2 - KW-2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D (2) Tem
SURGICAL SERVICE: OPAC
NPO SINCE:

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

HABITS:
TOBACCO: yes
ETOH: yes
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) clindamycin
( )
( )
( )
( )
( )

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
5 Anes problem

PHYSICAL EXAMINATION
BP 114/59 HR 80 R ____ T ____
Pain Scale 0-10 Ø
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharynx ____
Nares ____
CHEST: CTA
CARDIAC: RRR S1 S2
EXTREMITIES:
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since X 24

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. (5)(6)-2

The patient/le[redacted] and agrees. Questions answered.
Signed: [redacted] Date: 21 July 03 Time: 2000 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ____

[redacted] (5)(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

PATIENT RECORD COPY

① ~~477~~ U_3 Burn Deb Soon

0930 ① ~~376~~ W_2/U_2 R BKA dry A pro AKA Gen Mal/Alk

② ~~366~~ U_1 Cholangiogram Bruy MAC

② ~~478~~ W_2/U_1 I & D per pin ① Thumb Gen Gen

? ~~Int U_3 pt ?~~

~~Ex TUB~~

texasbyrnes@yahoo.com

7 groupes@MSN.com

Tobacco S/P USW → (R) thigh

MEDICAL RECORD - ANESTHESI/

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

NKDA

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

DRUG (Units)																		
Lidocaine (mg)	100																	
Propofol (mg)	200																	
Fentanyl (mg)	<150>	<100>			50	50	25											
Midazolam (mg)	2																	
( )																		
Reglan (mg)	10																	
VOLAT AGENT Sevo % del	2.0	~2.0	~2.0	2.0	1.8X													
% e.t.																		
AIR L/Min																		
N2O L/Min																		
O2 L/Min	10	~2	~2	~2	2	2	10											

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

FLUIDS

LINE site																	
18G (R) FA ☐ Warmed	LR #1	—			500												
☐ Warmed																	
☐ Warmed																	
☐ Warmed																	

LOSSES

EST BLOOD LOSS				25													
URINE -																	

TOTALS	TOTAL EBL
100	30
200	
375	TOTAL URINE
2	Ø
10	

FLUIDS SUMMARY
CRYSTALLOID- 600
COLLOID- Ø
BLOOD- Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: —

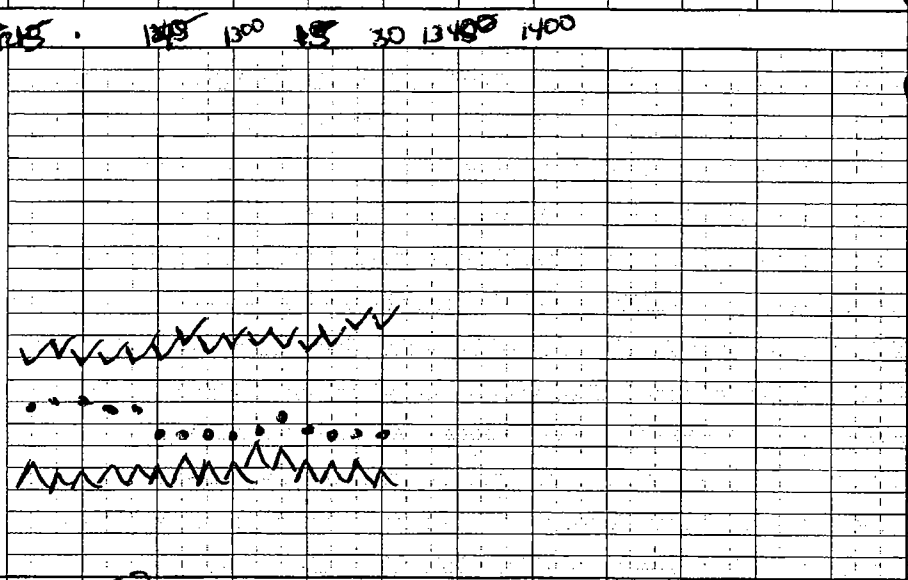
INITIAL DATA: BP- 142/88 HR- 78

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? JR TIME- 1200

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

TIME → 1215 · 1245 1300 1315 30 1340 1400



VENTIL

VT - ml	—	300	410	570	450	570
f - breaths/min	—	8	7	12	6	12
Peak inf pres / PEEP	—	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	48	52	49	42	51	50
BP/oth / FiO2 (Frac or %)	0.66	0.66	0.66	0.65	0.65	0.65
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	
Gas analyzer / TEMP-site Skin	—		34	—	34	
N-M Block (T/4) BS	+	+				
Warming blkt / x1 Blanket	→	→	→			
Conv warmer						

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

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op assessment NPO verified
(2) Room, monitors 100% O2, induced eyelids taped
(3) awake, alert LMA removed w/ complication
(4) To PACU-2 Report to RN.

RECOVERY AT 1335

PACU (ICU) 2 (Specify)

OTHER T 95.9 Ax

CONDITION: stable, awake

RESP- SpO2- 99

BP- 138/82 HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1210	1220	1345
	Ready	Begin	End
PROC	1230	1250	1327

PROCEDURES and CPT Codes:
I+D (R) LE external fixator adjustment

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
G-LMA

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
LMA #4; Easy placement; seated, PPV; sust ETCO2 + BBS

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

ANESTHE[redacted] CRNA/MAJ

PROCEDURE LOCATION: 2

DATE: 4 Aug 03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) thigh I+D and Ex Fix Adjustment
SURGICAL SERVICE: Orthopedics
NPO SINCE: MN

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

HABITS:
TOBACCO: yes
ETOH: yes
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Percocet
( ) Cleocin 300mg po tid
( ) Unasyn 3g IV q 6°
( ) _____
( ) _____
( ) _____

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
No problems

PHYSICAL EXAMINATION
BP 142/86 HR 78 R 12 T 37°C
Pain Scale 0-10 _____
HEENT - Teeth OK
Trachea Midline
TMJ/Neck WNL / Full ROM
Oropharnyx MPI TMD 3
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: PIV - 18 ga (R)
Ulnar Filling: forearm
BACK: _____
OTHER: _____

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ {X} General: Mask Intubation vs LM

LMA size 4 used & last anesthetic - no problems

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

The patien[redacted] guardian [redacted] understand and agrees. Questions answered.
Signed: [redacted] MD Date: 04 AUG 03 Time: 0920 Hrs

(b)(6)-2

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICW #2

[redacted] (b)(6)-4

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 Jul 03	1430 HOURS	
Admit to BCU		
- Dor ① Flow GSW		
- Splint		
- NPO		
- Keep Trach Splint on		
Pm ORDER		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
- MSO4 2mg	NPO2	[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER	TIME OF ORDER
8 Jul 03	1733 HOURS

① Admit to ICW when bed Available
② Saline Lock IV
③ Pin Care Bid ō half strength hydrogen Peroxide

Noted 8 July 03 @ [redacted] 1834 [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.
ICW2 | | 4

PATIENT IDENTIFICATION

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

DATE OF ORDER	TIME OF ORDER
8 Jul 03	1930 HOURS

① OOB x 3 /day

Noted 8 July 03 @ 1942 [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-1

NURSING UNIT | ROOM NO. | BED NO.

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

5 July 1940

Trach care PCU ~~[illegible]~~ PCW

Gp (R) GSW Femur Rt Bone

Fx

Stable

VS Pr rash

Ac + Adv Ad lib NPO

By Diet

PATIENT IDENTIFICATION

5 Jul 2050 Doris

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

NZ LRCTVO

Meds: Ancef 1 gm IV Q8 x 72

Gentamycin 80mg IV x 1

MSO4 2-5mg IVP Q2 PRN

Percocet ~~II~~ PO Q4 PRN

Multivitamin PO QD

Pin care BID H2O2

PATIENT IDENTIFICATION

Murphy

2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

H2O2

~~Xrays~~ AP lat (R) Femur in PACU

CBC in AM

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME [redacted] HOURS

6 Jul 03 0930

(1) Transfer to ICW #2 with same orders.

VO [redacted]

10 Jul 03 / 1300

OOB and walk around unit [illegible]

V.O. DA [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

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]				13 Jul 03	1430 HOURS	
				Vesly 250 PRN x10 hrs		
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2 24° [redacted]		
PATIENT IDENTIFICATION				DATE OF [redacted]	TIME OF [redacted]	
(b)(6)-2 EPW [redacted]				18 Jul 03	0720 HOURS	
				CBC		
				AP Lat (R) Femur		
				Pain Care Infusion Solution x 3 days		
				Chloramphenicol 3000 PO TID		
NURSING UNIT	ROOM NO.	BED		Unasyn 1.5 gm IV Q6H		
ICW2						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	[redacted]
				7-18-03 0730 V.O. Dr. [redacted] / LT [redacted]		
				(1) D/C Reflex [redacted]		CHAN
				(b)(6)-2		
				7-18-03 1000		
NURSING UNIT	ROOM NO.	BED NO.		V.O. Dr. [redacted] (b)(6)-2 LT [redacted]		
				(1) NPO on call OR		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER [redacted] HOURS	CHAN
NURSING UNIT	ROOM NO.	BED NO.				

Not delivered

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
#[redacted]			18 Jul 03	2000
			Push PAW → ICW2 ✓	
			SD down to the	
			packing / I&D prior ✓	
			Strike ✓	
			Up prn ✓	
			Acth Dau Ad lib NWB at	
			by Dr ✓	
			IV: Heplock	
			meds: Ulcsyn 3 gm IV Q6° ✓	
			Clindamycin 300 mg PO TID ✓	
			Msy 2 wks IV Q12° ✓	
			moffenow PO TID ✓	
			percocet 1 PO Q4 PRN ✓	
			CBC in AM ✓	
			Pen Cre c Gum or Grayck	
			tomorrow PM	
			Δ Iodo fom packing ✓	
			(b)(6)-2	
			24° Vone [redacted]	
			21 Jul 03 2223	
			Push PAW → ICW2	
			SD westwtt / Bed rest	
			Resume all prior orders / meds	
			Pen Cure Hzor BID ✓	
			pen cureel c Iodo	
			(b)(6)-2 [redacted]	

PATIENT IDENTIFICATION	ROOM NO.	BED NO.
ICW2		14

PATIENT IDENTIFICATION	ROOM NO.	BED NO.
EPW [redacted]		
ICW2		14

PATIENT IDENTIFICATION	ROOM NO.	BED NO.
EPW [redacted]		
ICW2		14

PATIENT IDENTIFICATION	ROOM NO.	BED NO.
[redacted] EPW		
ICW2		14

(b)(6)-2

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

NOTED

NURSING UNIT: ICU 2 | ROOM NO.: PACU | BED NO.:

DATE OF ORDER: 21 [illegible] | TIME OF ORDER: 2300 HOURS | LIST TIME ORDER NOTED AND SIGN

[redacted]

[redacted] (b)(6)-2

24° VS [illegible] ICTAN [redacted] 0320 03 2 03

(b)(6)-7

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 12

DATE OF ORDER: 3/4/03 | TIME OF ORDER: 1230 HOURS

Do NOT wrap pins.

Pack wound ~~to~~ 4/5 pin ~~from~~ c̄ iodoform gauze as previously ordered.

V.O. Dr [redacted] AN

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

(b)(6)-2

24° VS done [redacted] 0320 AN

PATIENT IDENTIFICATION: 24° VS [illegible] ICTAN | DATE OF ORDER: 3/3/04 | TIME OF ORDER: 3/3/04 HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

PHYSICIAN SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM OBSERVED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW

4 Aug 03 1530

PATIENT IDENTIFICATION: [redacted] EPW

DATE OF ORDER / TIME OF ORDER

Post-op s/p I&D (R) thigh
& Ex Fix Adjustment
resume all p/w
in Recovery
MSO4 2.5 mg IV [redacted] (5)(6)-2 [redacted]

WARD: ICW2 | ROOM NO | BED NO. 4

PATIENT IDENTIFICATION: EPW [redacted]

DATE OF ORDER: 4Aug03 TIME OF ORDER: 2015

(1) resume dsg Δ in AM
(2) WB-7D dsg Δ pin site deep tracts
(3) aggressive ROM (R) leg/knee

Dear Dr [redacted] (5)(6)-2 [redacted] 2020

WARD: ICW2 | ROOM NO | BED NO. 4

24°V [redacted] 8/4/03 2200

PATIENT IDENTIFICATION: [redacted]

S/A
054 V.O. Dr. [redacted] (T [redacted]
(1) 2mg Immodium P.O. x1 now
(5)(6)-2 [redacted] 2145

noted

WARD: ICW2 | ROOM NO. | BED NO. 24V | 2 Aug 2200 [redacted]

PATIENT IDENTIFICATION: EPW [redacted]

DATE OF ORDER: 8/22/03 TIME OF ORDER: 1420

S/ - D/C Unasyn
- start keflex 500mg po QID
- XR (R) femur ~~PA~~ AP + LAT

noted 8/22/03 1420

[redacted] (5)(6)-2 [redacted]

WARD: ICW2 | ROOM NO | BED NO. | 22 Aug 03
Immodium 2mg PO x1 Now
V.O.
noted 8/23/03 0130 [redacted] (5)(6)-2 [redacted]

24°V 23 Aug 03 0400 [redacted]

(5)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted]			25Aug	0930 HOURS	
			V.O. from Dr. [redacted] to LT [redacted]: ① TT tabs Pepto-bismal X1 NOW (b)(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
ICW2	5	F	24P/26Aug030100 [redacted]		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW [redacted]			8/26/03 D/C to EPW Camp (b)(6)-2	HOURS	Noted 8/26/03 1130 [redacted]
NURSING UNIT	ROOM NO.	BED NO.			
ICW2	5	F	24P/0015 27Aug03 [redacted]		
PATIENT IDENTIFICATION			DATE OF ORDER		
EPW [redacted]				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
ICW2	5	F			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

(b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

5 July 03

OVMO OP / EVAC NOTE

40 yo Iraqi GT Felony Army Rifle
prop Do: (R) GSW Femur / Fe
procedure: I&D, Open Reduction
External Fixation
Surgeon: [redacted] (b)(6)-2

EBL: 300cc
TPN
TO PACU stable

Findings: Severely Comminuted Distal Femur
fx 2° Low Velocity GSW
Anatomic Reduction
Stable Hoffman II Ex fix placed

Plan: BED pm care
DBS wounds q 72°
D/C to EPW Camp 3-7 Days

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	[redacted] (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)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18SEP03	OPNOT OP NOTE
	PROP DX: (P) FEMUR FRACTURE LOCK REDUCE
	IN FOR
	PROCEDURE: IM NAIL/WASH
	REVISION FOR
	SURGEON: [redacted]
	OBL: [redacted] (b)(6)-2 PACKED FOLLOW
	TO: ONCE PATS
	TO PACU SR + SINUS TRACT
	PROD: SINUS TRACT IN FOR SITE
	EASILY REDUCED
	PLACED IN 2 NAME PAD
	AND ANCHOR BAR
	PR: PLANE PADDED 4 8"
	TOOL FOR VARCO BANDS FNB
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11	12	13	14	15	16	17	18
5JUL03	[redacted]	VS PER ROUTINE (~~QH~~) QS	05	/	[redacted]												
			17	KS													
5JUL03	[redacted]	ACTIVITY ADVANCE ADLIB	05	/													
			17	KS													
5JUL03	[redacted]	REG DIET	05	/													
			17	KS													
8JUL03	[redacted]	PIN CARE BID	10	/													
		c ½ strength Hydrogen Peroxide	22	[redacted]													
6JUL	[redacted]	IS q 1° wk	05														
			17														
8Jul	[redacted]	OOB 3x daily	05	/	/	/	/										
			17	/	/	/	/										
[illegible]	[redacted]	OOB and walk around unit c assist	05	/	/	/	/	/									
			17	/	/	/	/	/									
7-18	[redacted]	Pin care c Dakins Solution BID x3days	10	X	X	X	X	X	X	X	X	X	X	X	X	X	[redacted]
			22	X	X	X	X	X	X	X	X	X	X	X	X	X	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: DX GSW Femur Fx/15/D readjustment (B) ex-fix/I+D

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO PAGE NO: 1

PATIENT IDENTIFICATION: EPW [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2

(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
5Jul	[redacted]	CBC in AM	6Jul	0400	0400	[redacted]
8Jul	[redacted]	Admit to ICW when bed available	8Jul03	1750	1750	[redacted]
8Jul	[redacted]	CBC x1 now	8Jul	0730	0730	[redacted]
18Jul	[redacted]	AP & LAT (R) femur x1 now	18Jul	0800	0930	[redacted]
7-18	[redacted]	NPO; on-call OK	18Jul	1000	1000	[redacted]
18Jul	[redacted]	Transfer pt to ICW 2: Stable	18Jul	2210	—	[redacted]
	(5)(6)-2					(5)(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

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. ___

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINIST.*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11	12	13	14	15	16	17	18
5JUL03	[redacted]	LR @ TKO	05	/	[redacted]				D/Ced 8 Jul 03								
	[redacted]		17	[redacted]													
5JUL03	[redacted]	ANCEF 1 Gm IV q8h x 72°	08	/	[redacted]				(5)(6)-2								
			16	/	[redacted]												
			24	[redacted]													
5JUL03	[redacted]	GENTAMYCIN 500mg x 1 now	22	[redacted]				(6)	[redacted]								
8JUL03	[redacted]	Saline Lock IV	05	/	/	/	/	[redacted]									
			17	/	/	/	[redacted]										
7/13	[redacted]	Keflex 500mg QID X 10 D	08	/	/	/	/	/	/	/	/	/	[redacted]				
			12	/	/	/	/	/	/	/	/	/					
			18	/	/	/	/	/	/	/	/						
			24	/	/	/	/	/	/	/	/						
7/18	[redacted]	Clindamycin 300mg PO TID	08														[redacted]
			16														
			24														
7/18	[redacted]	Unasyn 1.5gm IV Q4°	00														
			04														
			08														[redacted]
			12														
			16														
			20														

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx (R) FEMUR GSW FX S/P Readjustment @ ex-fix I+D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: EPW-[redacted]

(5)(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	

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 13809

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 7 Yr. 13
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5JUL	[redacted]	MSO4 2mg IVP Q2°	[redacted]													
			(b)(6)-2													
5JUL	[redacted]	MSO4 2-5mg IVP Q2° PRN	2mg 0800	5mg 0300		6JUL 0700 5mg	6JUL 0930 5mg	6 JUL 5mg	7JUL 0400	[redacted]			1120 4mg 5JUL	5mg 2200	4mg 0120	reunition
5JUL	[redacted]	Percocet ½ PO Q4° PRN	6JUL 2035	7JUL 1230	8JUL 1130			0000	[redacted]				2 7/2 1500	0200 7/11	[redacted]	11JUL 1230 2000 1
5JUL	[redacted]	MOTRIN 800mg PO TID PRN	6JUL	6JUL	11JUL 800mg 1230	13JUL 800mg	7/13 0120	7/15 0245	17JUL 1410	[redacted]						
			7 0700	5mg 1370	[redacted]	800			[redacted]							
5JUL	[redacted]	MSO4 2-5mg IVP	8JUL 0330	8JUL	8JUL 0830	8JUL 11	8JUL 2000	10/11	11JUL 0835	13JUL 0230						
	[redacted]	Q2° PRN	5mg	5mg	5mg	5mg	[redacted]		5mg	[redacted]						
15JUL	[redacted]	Percocet ½ PO														
	[redacted]	Q4° PRN	7/12 0130	7/12 0730	7/12 1200	7/12 1850	7/12 2250	7/13 0230	7/13	7/13	7/13	7/14	7/14 0100	7/14 0330	7/15 0830	7/15 1500 2100
15JUL	[redacted]	PR							0830	1230	[redacted]					
15JUL	[redacted]	Percocet ½ PO Q4°	15JUL 2200	16JUL 0315	16JUL 0710	16JUL 1105	16JUL 2230	17JUL 0230	17JUL 0810	17JUL 1359	18JUL 0300	18JUL 0720	18JUL 1630	18JUL		
		PRN	[redacted]													

(b)(6)-2

(b)(6)-2

reunition

reunition

USAPA V1.00

the proponent agency is the Office of The Surgeon General.

Mo. 7 YR 2003

RIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30	31	1	2	3
21 July	[redacted]	pin care H_2O_2 BID	10	[redacted]												
		pin covered c̄ Ioban	20	[redacted]												
		- do not remove Ioban														
		from pin!														
25 Jul	[redacted]	W→D dsg. in	10	[redacted]												
		wound around pin	20	[redacted]												
		above Knee - do														
		not touch ioban														
		- all other pin care														
		remains the same														
1 Aug	[redacted]	Do not wrap pins. Cover	10	[redacted]												
		~~place~~ puckering wound to	20	[redacted]												
		4th pin c̄ iodoform gauze														
		as previously ordered.														

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p washout (R) LE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

EPW

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

Recopied

the proponent agency is the Office of The Surgeon General. M.D. YR 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
01 Aug 03	[redacted]	VS per Routine	05	[redacted]													
			13														
			21														
01 Aug 03	[redacted]	Activity: Advance to	05														
		ad lib	13														
			21														
01 Aug 03	[redacted]	Reg Diet	07														
			12														
			17														
01 Aug 03	[redacted]	OOB 3x daily	05														
		walk around unit	13														
		c̄ assist WBB (R) leg	21														
										(5)(6)-2							
01 Aug	[redacted]	W→D drsg in wound around	10	/	/	[redacted]											
		pin above knee - do not touch	20	/	/												
		ribbons.															
01 Aug	[redacted]	Do not wrap pins. Continue	10	/	/	[redacted]											
		packing wound to 4th pin c̄	20	/	/												
		iodoform gauze as previously															
		ordered.								(5)(6)-2							
				/													
4	[redacted]	aggressive ROM c̄	05	/	/	/	[redacted]										
		(R) leg/knee	13	/	/												
			21	/	/												

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: GSW (R) femur ex-fix

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

PATIENT IDENTIFICATION:
EPW# [redacted] (5)(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 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4	[redacted]	SLP IBD (R) tight ex Ex adjustment	4	1530		[redacted]
4	[redacted]	resume dsg Δ in Am		noted		[redacted]
	(b)(6)-2					(b)(6)-2

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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Recopied 1 Aug 03

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
1800 01 Aug 03	[redacted]	SL IV	05	[redacted]													
4 Aug			13														
			21														
1800 01 Aug 03	[redacted]	Cleocin 300mg PO TID	08														
4 Aug			16														
			24														
1800 01 Aug 03	[redacted]	Unasyn 3.0gm IV q 6°	06														
4 Aug			12														
			18														
			24														
									(5)(6)-2								

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: (R) femur GSW (R) thigh ex-fix

SIP I&D (R) thigh / ex fix readjustment

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW (5)(6)-4

SSN [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 9 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4	[redacted]	resume all previous orders	4	—	1530	[redacted]
	(5)(6)-2					(5)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED			
copied 17 JUL	[redacted]	Motrin 800mg PO TID PRN	11 Aug 2015 1505 800mg PO	12 Aug 1505 800mg PO	13 Aug 0935 800mg PO	
	(5)(6)-2		[redacted]			
8/14	[redacted]	Percocet 1 PO Q 4° PRN pain	8/14 8/14 [redacted]			(5)(6)-2

USAPA V1.00

CLIN RECORD

[redacted] For use of this form, the proponent agency is the Office of The Surgeon General.

Mo. 8 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
4Aug	[redacted]	SL IV	5	[redacted]													
			13														
			21														
4Aug	[redacted]	Cleocin 300 mg PO TID	8														
			16														
			24														
4Aug	[redacted]	Unasyn 3.0 gm IV q6°	6														
			12														
			18														
			24														
22Aug03	[redacted]	Keflex 500mg po QID	06														
			12														
			18														
			24														

D/C

D/C'd 22Aug03 1600 [redacted]

(5)(6)-2

D/C'd 22 Aug

(5)(6)-2

(5)(6)-2

ALLER YES ☐ NO

nKDA

PRIMARY DIAGNOSIS: (R) thigh ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PAT EI TION:

eDW

[redacted] (5)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FOR , 1 OCT 78 MEDCOM - 13816 ED.

USAPA V1.00

er	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/18 0154	2mg Immodium P.O. X1 now	8/18	0154	0154	[redacted]
22Aug03	2mg Immodium PO x1 Now	8/22	2120	2120	
25Aug	ii tabs Pepto bismol x 1 Now	25Aug	0930	0930	
					(b)(6)-2

PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
27 Jul [redacted] Motrin 800mg PO TID PRN	16Aug 1010 ÷PO	17Aug 0630 ÷PO	17Aug 1015 ÷PO	18Aug 1330 ÷PO	19Aug 0047 ÷PO	19Aug 1645 ÷PO	20Aug 0730 ÷	20Aug 2015 ÷PO	22Aug 0030 800mg ÷PO	22Aug 1050 ÷PO	22Aug 2015 ÷	27Aug ÷	27Aug 1415 ÷PO	
	[redacted]													
							(b)(6)-2							
4Aug [redacted] Percocet ii PO Q4 PRN pain	16Aug 1430 ÷PO	20Aug 0030 ÷PO	21Aug 0915 ÷PO	23 Aug 1000 ÷PO	26 Aug 0030 ÷PO	27Aug 0800 ÷PO								
	[redacted]						(b)(6)-2							
27 Jul [redacted] Motrin 800mg PO TID prn pain [redacted]	28 0200													
	(b)(6)-2													

USAPA V1.00

the proponent agency is the Office of The Surgeon General.

MO. APR 2003

VERIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION	
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED (19 20 21 22 23 24 25 26 27 28 29 30 31 1)
7-5	[redacted]	VS per routine	05	[redacted]
			13	
			21	
7-5	[redacted]	Act. Advance APLIB	05	[redacted]
			3	
			21	
7-5	[redacted]	Reg Diet	7	[redacted]
			11	
			17	
7-8	[redacted]	PIN care BID c̄ Dong Δ	10	Pin care c̄ Dr [redacted] on [redacted]
			22	c̄ Δ Jodoform packing 19 Jul
7-6	[redacted]	IS Q1° WA	5	[redacted]
			13	Dc'd
			21	
7-8	[redacted]	COB 3x daily	5	[redacted]
			13	
			21	
7-8	[redacted]	COB's walk around unit c̄ assist NWB (R) leg	5	[redacted]
			13	
			21	

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) femur fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18	[redacted]	CBC in AM	18	0400	0400	Done [redacted]
	(b)(6)-2					(b)(6)-2

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

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. 8 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
1Aug	[redacted]	VS Routine	5	[redacted]													
			13														
			21														
1Aug	[redacted]	Activity: Advance Ad Lib	5														
			13														
			21														
1Aug	[redacted]	Diet: Regular	7														
			12														
			17														
1Aug	[redacted]	OOB 3x daily Walk around Unit c̄ assistance NWB ® le	5														
			13														
			21														
1Aug	[redacted]	W→D Dsg in wound around pin above knee - don't turn loosen	10	[redacted]													
			20														
1Aug	[redacted]	Don't wrap pins Continue packing wound to 4th pin c̄ iodoform gauze as prev ordered	10	[redacted]													
			20														
4Aug	[redacted]	Aggressive ROM c̄ @ leg/ knee	5	[redacted]													
			13														
			21														

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ® le ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

CPW [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
22Aug	[redacted] (5)(6)-2	XRay ® femur, AP & LAT	22Aug	today	1500	[redacted] (6)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
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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. [illegible]

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27	28	29	30	31	1
7-18	[redacted]	SL IV	05	[redacted]													
			13														
			21														
7-18	[redacted]	Clindamycin 300mg	08	[redacted]													
		PO TID	16														
			24														
7-18	[redacted]	Unasyn 3.0mg IV	00	[redacted]													
		Q6°	06														
			12														
			18														
			~~24~~														
			~~30~~														
		Dakins sol. ⊂̄	16	XD/C													
		pin care BID x	22														
		3 days															

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) Femur GSW FX.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: SP Bedjustment (R) ex-fix/I+D

#[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		THERAPEU[illegible]CUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20July	[redacted]	Benedryl 50mg				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15July	[redacted]	Motrin 800mg PO TID PRN	7-19 800mg 1239 [redacted]	7-20 800mg 1300	21Jul 0425 PO	23Jul 1700 BS	23Jul 2210	24Jul 0705 PO	24Jul 1500 PO	24Jul 0338 PO	25Jul 1940 PO	26Jul 0545 PO	26Jul 1400 PO	[redacted]		
18Jul	[redacted]	MSO4 2-10mg IVP Q2° PRN for Pain	7-20 1000 0918 2mg IV 2mg IV [redacted]	7-21 4mg IV 1500 [redacted]												
19July	[redacted]	Percocet ii PO Q 4° PRN	7-19 09:00 ii [redacted]	19July 2250 ii po	20July 0430 ii po	20July 1030 ii	20July 1035 ii	22July 0940 ii po	22July 0820 ii po	7-23 0210 ii	7-23 0041 ii	23July 1115 ii po	23July 2000 ii po	[redacted]		
7-22	[redacted]	Benadryl 50mg IV Q4° PRN	22July 0900 50mg IV [redacted]													

(5)(6)-2

(5)(6)-2

(5)(6)-2

(5)(6)-2

Copied

USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 7 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
28 Jul	[redacted]	Percocet ½ PO q 4° PRN	0108 28JUL ½ PO	0320 25JUL ½ PO	25JUL 1140 ½ PO	25JUL 1810 ½ PO	21 JUL 0000	26 JUL 1900	26 JUL 7-28	27 JUL 0400	27 JUL 0000	27 JUL 2030	28 JUL 0130	28 JUL 1200	
			[redacted]												
27 Jul copied	[redacted]	MOTRIN 800mg PO TID PRN	27JUL 0730 ½ PO	27JUL 1545 ½	27JUL 2020 ½ PO	27JUL 2225 ½ PO	28JUL 1400 ½ PO	01AUG 0100 ½ PO	2AUG 1430 ½ PO	2AUG 0030 ½ PO	3AUG 1215 ½ PO	3AUG 1615	4AUG 1400 ½ PO	6AUG 0705 ½ PO	7AUG 2040 ½ PO	8AUG 0415
			[redacted]												
2C	[redacted]	Percocet ½ PO q 4° PRN pain	28JUL 2000 ½	29JUL ½ 420	29JUL	29JUL 2215 ½ PO 0415	29JUL ½ 1600	29JUL ½ 2000	30JUL 0440 ½ PO	30JUL 0446 ½ PO	31JUL 0415 ½ PO	31JUL 1245 ½ PO	2AUG 0440 ½ PO	3AUG 0830 ½ PO	3AUG 0445 ½ PO
			[redacted]												
2C	[redacted]	Percocet ½ PO q 4° PRN pain.	3AUG 2600 ½		4AUG 0620 ½ PO	4AUG 0530 ½ PO	4AUG 2115 ½ PO	5AUG 0445 ½ PO	5AUG 0525 ½ PO	6AUG 0000 ½ PO	6AUG 1345 ½	7AUG 0705 ½ PO	7AUG 1410 ½ PO	8AUG 0415 ½ PO	8AUG 1315 ½ PO	8AUG 2030 ½ PO
			[redacted]												
2030	[redacted]	Percocet ½ 10 q 4° PRN pain.	7AUG 1740 ½ PO	9AUG 1330 ½ PO	9AUG 1730 ½ PO	9AUG 0630 ½ PO	10AUG 2100 ½	11AUG 0045 ½		11AUG 0600 ½ PO	11AUG 1415 ½ PO	11AUG 2227 ½ PO	12AUG 730 ½	13AUG 1030 ½ PO	13AUG 2008 ½ PO
			[redacted]												

USAPA V1.00

(b)(6)-2

(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTS PROVED (Date) Q: Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS	1700	INITIALS		INITIALS
NEURO	PUPILS	2 R		Perrla. 3mm			
	SENSORIUM	A/O		A+O×3			
RESPIRATORY	RESPIRATORY PATTERN	eqn		even, unlabored			
	BREATH SOUNDS	LCTA-B		CTA-B			
	SECRETIONS	∅		∅			
SKIN	COLOR	NIR		NIR			
	INTEGRITY	∅		dry, intact			
				ex fix on right forearm			
IV SITE	LOCATION	∅		∅			
	CONDITION						
GASTRO	ABDOMEN	(+)		soft, nontender			
	BOWEL SOUNDS	(+)		+BS x4 qds			
GU	URINE			urinal			
	COLOR/CLARITY	yellow/clear		clear, yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	SR		S1S2			
				NSR			
				+2 pulses radial/			
				pedal			
				<3sec cap refill			

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

PREPA[redacted] (Continue on reverse)

PATIENT IDENTIFICATION (For typed or written [redacted] middle; grade; date, hospital or medical facility)

(b)(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent Dept of Nurs

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

12/6/03

DATE | DE | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line										124								
	BP Cuff			118/68							72								
	Temperature			99							98.0								
	Pulse			88							84								
	Respiratory Rate			16							16								
	SPO2			98							98								

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

OUTPUT		HOUR / TOTAL	24																
	URINE	10 gr																	
		Sa																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

	16	17	18	19	20	21	22	23	
		19/16							
		98							
		18							
		97%							
		RA							

	16	17	18	19	20	21	22	23	8° T
PO							240		

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN	TIME				
SUCTION					

24 H&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today		
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		
BALANCE			

NEUROLOGICAL ASSESSMENT

		HOURS	0
COMA SCALE	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 (L)	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
	LEGS	NORMAL POWER	✓
		MILD WEAKNESS (R)	
		SEVERE WEAKNESS	✓
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
PUPILS	RIGHT	SIZE	2
		REACTION	+
	LEFT	SIZE	2
		REACTION	+
PUPIL SCALE			2 3 4 5 6 7 mm
ICP			
CEREBRAL PERFUSION PRESSURE			

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- + + Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

	HOURS	
RLE	R	21
	L	21
	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 (1
QA Appr 8 Mar 8

INITIAL SHIFT ASSESSMENT

	TIME	0500	INITIALS [redacted]	1914	INITIALS		INI
NEURO	PUPILS	[illegible]		3mm	PERRLA		
	SENSORIUM	[illegible]		Ox3, Cooperative			
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		Unlabored			
	BREATH SOUNDS	[illegible]		CTA (B)			
	SECRETIONS	[illegible]		0			
SKIN	COLOR	[illegible]		W, D, I			
	INTEGRITY	[illegible]		Intact			
IV SITE	LOCATION	(R) [illegible]		(R) FA - 0			
	CONDITION	[illegible]					
GASTRO	ABDOMEN	[illegible]		Soft, Non-tender			
	BOWEL SOUNDS	[illegible]		BS x4			
GU	URINE: COLOR/CLARITY	[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		RSR			
				S1 S2			
				+2 LE/UE (Bilat)			
				Pulses			

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

(Continue on reverse

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 9/4/03

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

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

ICU #1

☐ HISTORY/PHYSICAL ☐ FLOW CHA

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (S)

☐ DIAGNOSTIC STUDIES

E | DX | HOSPITAL DAY | P

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line						126	118	118		138				120			
BP Cuff						66/76	67	49		68				70			
Temperature						92	83	85		99				91			
Pulse						4	4	4		4							
Respiratory Rate						18	10	14		16				18			
14:02						80								80			
														100			
pain intensity																	

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
PO																	
										240				120		240	600

TOTALS

URINE	HOUR / TOTAL											900 / 900				500 / 140	180
	sp gr																
	S/A																
NG	OUTPUT																
	pH																
	GUIAC																
EMESIS																	
STOOL																	
DRAINS																	

[redacted] 9/21/03

(b)(6)-4

DAY

ACUITY LEVEL CLASSIFICATION

	16	17	18	19	20	21	22	23	
BP			135/70		[illegible]		130/80		
TEMP									
Pulse			95		[illegible]		92		
RR			16		[illegible]		14		
O2			98		[illegible]		99		
			RA		[illegible]		RA		

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

	16	17	18	19	20	21	22	23	8°T
IV									
PO					100				
Urine				600	[illegible]				

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE

IV _____

po

OUTPUT

Urine: _____

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

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

CLINICAL RECORD—SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS	1800	INITIALS		INITIALS
NEURO	PUPILS	[illegible]	[illegible]	3mm PERRLA			
	SENSORIUM	[illegible]		A+OX3 very cooperative			
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		even-unlabored			
	BREATH SOUNDS	[illegible]		CTA bilat			
	SECRETIONS	[illegible]		⊘secretions			
SKIN	COLOR	[illegible]		normal for race			
	INTEGRITY	[illegible]		intact			
IV SITE	LOCATION	[illegible]		(R) FA [redacted]			
	CONDITION	[illegible]		CDI			
GASTRO	ABDOMEN	[illegible]		soft nontender			
	BOWEL SOUNDS	[illegible]		⊕BS X4			
GU	URINE: COLOR/CLARITY	[illegible]		clear yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		NSR S1S2 pulses 2+ X4 distal extremities			

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

(Continue on reverse)

PREPARED BY [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: [illegible]

PATIENT'S ID [redacted] (Entries give: Name—last, first, middle; [redacted] facility)

(b)(6)-2

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line			128				120				120					126		
BP Cuff			71				62				67					81		
Temperature																		
Pulse			92				90				76					88		
Respiratory Rate			12				14				15					14		
SpO2			98				98				99					99		
			RA				RA				RA					RA		
pain intervention																		

INTAKE	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
PO								360	360					360				360
TOTALS																		

OUTPUT			24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
URINE	HOUR / TOTAL					300							300					600		900
	sp gr																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

[redacted] (b)(6)-4

10/11/03

POST-OP DAY

V	16	17	18	19	20	21	22	23	
BP			140/72				162/102		
T			99						
P			96				87		
R			12				16		
O2			RA				98 RA		

	16	17	18	19	20	21	22	23	8° T
PO									
urine			400		200			100	

ACUITY LEVEL CLASSIFICATION

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

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

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

24*I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE [redacted]

(b)(6)-7

NAME is [redacted]

[redacted] (b)(6)-4

bed 5

For us

DICAL RECORD—SUPPLEMENTAL MEDICAL DATA
see AR 40-66; the proponent agency is the Offic

Su . General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0840	INITIALS [redacted]	(b)(6)1800	INITIALS		INITIALS
NEURO	PUPILS	PERRLA @ 3mm		PERRLA			
	SENSORIUM	Alert & Oriented		Alert x 3			
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored		even, unlabored			
	BREATH SOUNDS	BBS CTA		BTA B/L			
	SECRETIONS						
SKIN	COLOR	Normal for race		Normal for Race			
	INTEGRITY	intact		intact			
IV SITE	LOCATION	(R) FA		(R) FA			
	CONDITION	Patent & intact		Patent & intact			
GASTRO	ABDOMEN	BS (+) soft		BS (+) soft			
	BOWEL SOUNDS	non tender		Non-Tend			
		BS x 4					
GU	URINE	voids per urinal		voids urinal			
	COLOR/CLARITY	clear yellow		clear yel			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 & S2		S1 S2			
		RRR, ⊖ edema		RSR			

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

(b)(6)-2

(Continue on reverse)

PREPARED BY [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 1 Jul 03

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

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

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
TIME																		
BP Arterial Line																		
BP Cuff			67/87							126/99						125/89		
Temperature										99.1								
Pulse			84							97						88		
Respiratory Rate			17							22						20		
SpO2			97							98						98		
RA/O2										RA						RA		
pain																		
intuvation																		

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

OUTPUT																			
URINE	HOUR / TOTAL							400									500		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

PO

[redacted] (b)(6)-4

POST-OP DAY

V	16	17	18	19	20	21	22	23	
BP			170/60				133/74		
P			90				96		
T			97				98		
R			16				18		
SpO2							97		

	16	17	18	19	20	21	22	23	8° T
UR								250	

ACUITY LEVEL CLASSIFICATION

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

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

DAILY ACTIVITIES DEFINING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME				
SUCTION					

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

NEUROLOGICAL ASSESSMENT

HOURS	16	17
ONTANEOUSLY 4	✓	✓
SPEECH 3		
PAIN 2		
EYE OPENING 1		
ENTED 5	✓	✓
NFUSED 4		
BALIZES 3		
CALIZES 2		
VOCALIZATION 1		
YS AMANDS 6	✓	✓
ALIZES PAIN 5		
TION HDRAWAL 4		
NORMAL TION 3		
ENSION PAIN 2		
MOTOR PONSE 1		
RLE: MAL POWER	✗	
D WEAKNESS	✓	
ERE WEAKNESS	a	✓
NORMAL FLEXION	C	
NORMAL EXTENSION	I	
RESPONSE	hm	
LLE: MAL POWER	✓	
D WEAKNESS		
ERE WEAKNESS		
NORMAL FLEXION		
NORMAL EXTENSION		
RESPONSE		
SIZE	3	
REACTION	R	
SIZE	3	
REACTION	R	
	2 3 4 5 6 7 mm	
ERFUSION E		

LEGEND

C Clos by swell

T Trach/E

S Slurring

D Dyspha

R Recepti

E Express

R Right

L Left

Record separately there is a difference between t two sides.

+ + Bris

+ Slow

- No Respor

+ Intact

- Abnorm

VASCULAR ASSESSMENT

HOURS		17
Ant Tib	R	2+
	L	2+
Radial	R	2+
	L	2+
Pedal	R	
	L	

LEGEND

+ + Norm

+ Weak

- Absen

D Doppl

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DA
For m. see AR 40-66; the proponent agency is the Office of Th

REPORT TITLE
INTENSIVE C NURSING FLOW SHEET

JTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	INITIALS	INITIALS	[redacted]
NEUROLOGICAL	PUPILS	2mm BEARRA		CBSO
	SENSORIUM			Alert) Follows
				A+O x3
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		even, unlab
	BREATH SOUNDS	CTA(B)		Sats 100% on CPAP
	SECRETIONS	Ø		
		RR 12		RR 18-15
SKIN	COLOR	NFR		NFR
	INTEGRITY	Dry		Dry
IV SITE	LOCATION	Ø		Ø
	CONDITION	NA		Ø
GASTRO	ABDOMEN	NFR NT-D		SE NT/ND
	BOWEL SOUNDS	(+) all (quad)		(+)
GU	URINE	via URINAL		voiding via urinal
	COLOR/CLARITY	Yellow clear		with sx
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 auscl		S1/S2
		P-R NL		pulsus paradoxus

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU Quest

DATE

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

[redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

(b)(6)-2

incer thrombus

13 Jul 03

(b)(6)-4

L.903 FP/C[redacted]

DATE

PAGE 2 OF 4

HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line										119								
BP Cuff										114								
Temperature										97.6								
Pulse										89								
Respiratory Rate										18								

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			00						25				05				
	TOTAL																	
	Void																	
	S/A																	
NG	OUTPUT																	
	DH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		