MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY / POST-DAY: DEC, 2 DEC, 3 DEC, 4 DEC, 5 DEC, 6 DEC, 7 DEC

MONTH-YEAR: Dec 1992 — DAY / HOUR

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

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		

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

b(6)-4

NSN 7540-00-634-4124

CAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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]

D(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY												
POST- DAY												
MONTH-YEAR	DAY	8 DEC 03		9		10		11		12	13 Dec	14 Dec
19	HOUR									0630	0445	0700

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE	116/64	106/56	107/62	117/63	99	108/57	112/58	110/60	110/59	110/47	120/62	
	96	103	91		108/61		99		H94		H 91	P100
	99.9	100.4	99.4	99.5	98.6		T98.9		T97.6		T	T99.1
HEIGHT: WEIGHT →	98.4	95% RA	97.1		98.2		98		98%		99%	98%
	RA		RA	95% RA	RA		96% RA		12A		12A	100%
			107/63	112/62								
			97% RA	98% RA								

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

b(6)-2

Error [redacted]

b(6)-4 [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 DEC DAY 15 Dec 16 17 18 19 20

19 2003 HOUR 0000 2400 0800 1600 2000

PULSE (O) — TEMP. F (°) — TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

#[redacted]

b(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC 2003 — DAY: 21 Tue, 22, 23/24, 24, 25, 25/26, 26, 27

HOUR: 0 4 8 12 0 4 8 12 0 4 8 12 0 4 8 12 0 4 8 12 0 4 8 12

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

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

[redacted]

b(4)-4

VITAL SIGNS RECORDS

Medical Record

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

VITAL SIGNS RECORD

	DAY	28		29		30		1 JAN	1 JAN/2 Jan		3		4	
18 2003	HOUR	0	6	0	2	09	12	0750	2		2		8	1

PULSE (O) — TEMP. F (•) — TEMP. C

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°

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

18	20	18	20		18	18	18	49/51		20		20	20

BLOOD PRESSURE

101/58	103/56		98/58	101/57	90/55	96/52	107/53	98/62	108/56	107/62	102/60	98/60	
			96	91			H 92	99				97	
			98.7	98.6			T 98.2	T 98.6			97.6		
HEIGHT: WEIGHT → 98%		98%		98%			98%	Sp 97				99%	
RA						99%	RA	98	98%		97%		
								RA	RA		RA		

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

b(4)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR | DAY: 5 Jan, 6 JAN, 7 JAN, 8 JAN, 9 JAN, 10 JAN, 11 Jan
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° 38.3°
140 100° 37.8°
130 99° 37.2°
98.6° 37.0°
120 98° 36.7°
110 97° 36.1°
100 96° 35.6°
90 95° 35.0°
80
70
60
50
40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

b(6)-4

[redacted]

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	DAY	12		12		13	13	14		15													
19	HOUR	0	1	2		0	12	0	12	0													
PULSE (O)	TEMP. F (•)	8	6	8		7	7	7	6	7													TEMP. C
	105°		0			3	2	0	3	3													40.6°
			0			0	8	0	0	0													
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		8	8	12/12		8	8	8	8														
Record special data only when so ordered	BLOOD PRESSURE					115/72		103/57		90/51													
				109																			
				T99.6		98.8		98.7															
	HEIGHT: WEIGHT →			97%																			
		25	99%			98	98% RA	99%	100% RA	97% RA													
						99% RA		99% RA															

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.

(Centigrade Equivalents, for Reference only)

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

[redacted]

b(6)-4

b(2)-2

b(6)-4

[redacted]

Name EPW [redacted] SSN _____ Unit _____ Location _____

PRE-OP/POST-OP

INTAKE

Time	Solution	Amount
0012	LR	1000 ML

OUTPUT

Time	Source	Amount
0038	FOLEY	400 cc

VITALS

Time	HR	B/P	RR	SaO_2	Temp	Notes
0031	90	146/82	27	100		
0042	86	148/78		100		
0052	80	142/80	25	100	6L FM	
0110	83	140/78	26	100%	2L NC	4mg MSO4 IMST
0115	80	156/84	27	100	2L NC	3mg MSO4 IMST
0130	78	143/78	26	100	2L NC	3mg MSO4 IMST
0145	86	156/83	28	100%	2L NC	3mg MSO4 IMST
0200						3mg MSO4 IMST
0215	86	140/76	22	100	2L NC	3mg MSO4 IMST - PT ALERT, EYES CLOSED
0250	89	147/81	22	100	1L NC	AWAITING OR
0315	96	145/79	22	98	1L NC	PT TO OR ON LITTER

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL _____

☐ DIA ☐ PIN ☐ UNI ☐ FIX ☐ SLOW

Time	Site	ROM	P	Cap Refill	T	Color
0045	RLG	+	+	<3	W	Pk
0315	RLG	+	+	<3	W	Pk

ROM
+ or -
Temp
C=cool
W=warm
Pulse
+ or –
Color
C = cyan
P = pale
Pk= pink

OUTPUT

URINE						~~NASOGASTRIC~~ JP drain			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
						0700	95cc	bloody	95cc
						1800	25cc	bloody	120cc
						28 Nov 03			
						1800	15cc		
								DCd	

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

JP output

~~26th 27th NOV~~
~~1800 = 1800~~

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

[redacted]

b(a)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

Ward/Section: CMT | [redacted] b(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

b(6)-4 [redacted] | DATE 12NOV03 | TIME 0407 | [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-13.8 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		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Hazy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	3+	Negative
pH	5.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	1+	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

WBC - 25-30
RBC - 40-50
Epi - 0-1

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: A POS

Crossmatch

(WITH EVERY UNIT OF BLOOD REQUESTED)

	CROSSMATCH

======= PICCOLO =======
12/11/03 07:32 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) 0000100684

GLU	221*	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	135	128-145	MMOL
K+	4.7	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	21	18-33	MMOL

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

REMARKS:

REPORTED BY: [redacted] | DATE: 12NOV03 | LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section: ICU #1 | REQUES[illegible] | PHYSICIAN: [redacted] | CHEM[illegible]Y RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 [redacted] | DATE 13NOV | TIME 0445 | SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
13/11/03 04:59
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA1
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 000010697

GLU	159*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	1341*	39-380	U/L
~~NA+~~	~~122*~~	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/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: 13Nov03 | LAB ID NO.:

b(6)-2

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

LAST, FIRST, MI: | DATE: 27 Nov | TIME: 0500 | 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		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		5.1-8.1 g/dl

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

(Piccolo) Metlyte 8

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

```
======= PICCOLO =======
27/11/03          05:11
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #:        3152AA4
OPER #: [redacted]  DR #: 000
SERIAL #: b(6)-2 0000100494
.........................
GLU   140*  73-118   MG/DL
BUN    31*   7-22    MG/DL
CRE    2.3*  0.6-1.2 MG/DL
CK    146   39-380   U/L
NA+   137   128-145  MMOL/L
K+    5.4*  3.3-4.7  MMOL/L
CL-   100   98-108   MMOL/L
tCO2   22   18-33    MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] b(2)-2

Microbiology Request Form

Last Name: [redacted] b(6)-4

First Name:

Patient # or SSN:

Collected by: [redacted] b(6)-2

Date: 12/26/03

Time: 1720

Ward: OR

Room:

Bed:

Physician: [redacted]

Source: (R) Knee

Site:

[redacted]

Received by: SPC [redacted] b(6)-2

Date: 26 Dec 03

Time: 1850

Specimen #: W201

Laboratory Results

Staphylococcus aureus

Reported

Date: 29 Dec 03

Time: 1154

Tech: [illegible]

Reviewer: [redacted]

b(6)-2

Number of attached sheets:

MEDCOM - 24254

Microbiology Report

[redacted] b(2)-2

Name: b(6)-4
Patient ID: [redacted]
Ward/Rm:

Specimen: W201
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected
Attd Phys

1 Staphylococcus aureus Status: Final

1 S. aureus

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	<=8/4	R			
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	>16	R			
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Ceftriaxone (c)	>32	R			
Cephalothin	<=8	R			
Chloramphenicol	>16	R			
Ciprofloxacin	>2	R			
Clindamycin	>2	R			
Erythromycin	>4	R			
Gatifloxacin	4	I			
Gentamicin	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	>4	R			
Linezolid	<=2	S			
Moxifloxacin	4	I			
Nitrofurantoin	64				
Norfloxacin	>8				
Ofloxacin	>4	R			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	>2/38	R			
Vancomycin	<=2	S			

Maxipen 1-2 gm q8°
Cefep
~~b.375~~ Zyvox 600mg QD

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

B = [illegible]
ESBL = Extended spectrum beta lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases. Potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs

For blood and CSF isolates a beta-lactamase test is recommended for Enterococcus species

a = Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections
b = Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (S=S, I=16, R=R. Footnote c applies to this drug
c = For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the [illegible]
d = For non beta-lactamase producing enterococci refer to the penicillin interpretation. Footnote a also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S. pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections use (S=S, I=[illegible], R=R

Name:
Patient ID: [redacted]
Ward/Rm: b(6)-4

Specimen: W201
Source: Wound/Sterile site
Ward of Iso:

Status: Final b(6)-2
Collected
Req Phys [redacted]

Tech: [redacted]

[redacted] b(2)-2

Microbiology Request Form

Last Name: [redacted] b(6)-4

First Name:

Patient # or SSN:

Collected by: [redacted] b(6)-2

Date: 12/26/03

Time: 1720

Ward: OR

Room:

Bed:

Physician: [redacted]

Source: (R) Knee

Site:

[redacted]

Received by: SPC [redacted]

Date: 26 DEC 03

Time: 1850

Specimen #: W201

Laboratory Results

Staphylococcus aureus (MRSA)

Reported

Date: 29Dec03

Time: 1154

Tech: rgc

Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 24256

b(2)-2

[redacted]

Name: [redacted] Specimen: W201 Status: Final
Patient ID: Source: Wound/Sterile site Collected:
Ward/Rm: / b(2)-4 Ward of Iso: Attd. Phys:

1 Staphylococcus aureus Status: Final MRSA

1 **S. aureus**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	<=8/4	R			
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	>16	R			
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Ceftriaxone (c)	>32	R			
Cephalothin	<=8	R			
Chloramphenicol	>16	R			
Ciprofloxacin	>2	R			
Clindamycin	>2	R			
Erythromycin	>4	R			
Gatifloxacin	4	I			
Gentamicin	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	>4	R			
Linezolid	<=2	S			
Moxifloxacin	4	I			
Nitrofurantoin	64				
Norfloxacin	>8				
Ofloxacin	>4	R			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	>2/38	R			
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R) Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R

Name: [redacted] Specimen: **W201** Status: **Final** b(2)-2
Patient ID: Source: Wound/Sterile site Collected:
Ward/Rm: / b(2)-4 Ward of Iso: Req. Phys: [redacted]

IBN-SINA HOSPITAL

[redacted] b(2)-2

Microbiology Request Form

Last Name #[redacted] b(6)-4 | Ward: OR

First Name: | Room:

Patient # or SSN: b(6)-2 | Bed: b(6)-2

Physician: [redacted]

Collected by: [redacted]

Date: 03 JAN 04 | Source: (R) Knee

Time: 0915 | Site:

[redacted]

Received by: Ommarath | Specimen #: W208

Date: 3 JAN 04

Time: 1000

Laboratory Results

Escherichia Coli

Reported

Date: 5 JAN 04

Time: 1000

Tech: Io

Reviewer: [redacted] b(6)-2 | Number of attached sheets:

MEDCOM - 24258

b(2)-2

[redacted]

Name:
Patient ID: [redacted]
Ward/Rm: OR/ b(6)-4

Specimen: W208
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected:
Attd. Phys:

1 Escherichia coli Status: Final

1 E. coli

Drug	MIC	Interps	Drug	MIC	Interps
Amikacin	<=16	S			
Amox/K Clav (c)	16/8	I			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	>16	R			
Cefazolin	>16	R			
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Cefotetan	<=16	S			
Cefoxitin	<=8	S			
Ceftazidime (a)	>16	R			
Ceftriaxone (c)	>32	R			
Cefuroxime (b)	>16	R			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	>2	R			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	>4	R			
Gentamicin	>8	R			
Imipenem (c)	<=4	S			
Levofloxacin	>4	R			
Meropenem (c)	<=4	S			
Moxifloxacin	>4	R			
Nitrofurantoin	<=32				
Norfloxacin	>8				
Pip/Tazo (d)	64	I			
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	64	I			
Tobramycin	>8	R			
Trimeth/Sulfa	<=2/38	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases, potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose For cefuroxime axetil (PO) use (8=S 8-16=I, >16=R) Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci refer to the penicillin interpretation Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections use <2=S 2=I >2=R

Name:
Patient ID: [redacted]
Ward/Rm: OR/ b(6)-4

Specimen: W208
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected:
b(6)-2
Req. Phy[redacted]

[redacted] b(2)-2

Microbiology Request Form

Last Name [redacted] b(6)-4
First Name:
Patient # or SSN:

Collected by: [redacted] b(6)-2
Date: 15 JAN 04
Time: 0080

Ward: ICW#1
Room: 2B
Bed: B
Physician: Oliverio

Site: Throat

[redacted]

Received by: [redacted] b(6)-2
Date: 15 JAN 04
Time: 1400

Specimen #: 7057

Gram Stain: Pick one

Same Day/ With Result

Specimen type: Pick one

- Wound
- Body Fluid/CSF
- Urine
- Urine foley
- Blood
- Throat
- Sputum
- Stool
- GC/Chlamydia
- Other:

Laboratory Results

Gram positive Cocci
Streptococcus Spp.

Reported
Date: ~~16~~ 20 JAN 04
Time: 1000
Tech: IU
Reviewer:

Number of attached sheets:

MEDCOM - 24260

b(6)-4

ID: [redacted]
MD

12-11-03
07:16

				Patient Limits	
WBC	12.1 H	x10^3/uL		4.5	10.5
RBC	3.87 L	x10^6/uL		4.00	6.00
Hgb	10.6 L	g/dL		11.0	18.0
Hct	33.8 L	%		35.0	60.0
MCV	87.3	fL		80.0	99.9
MCH	27.4	pg		27.0	31.0
MCHC	31.4 L	g/dL		33.0	37.0
Plt	335.	x10^3/uL		150.	450.
LY%	6.3	*L %		20.5	51.1
LY#	0.8	* x10^3/uL		1.2	3.4

ID: [redacted]
MD

26-11-03
17:06

				Patient Limits	
WBC	14.6 H	x10^3/uL		4.5	10.5
RBC	3.12 L	x10^6/uL		4.00	6.00
Hgb	8.5 L	g/dL		11.0	18.0
Hct	27.8 L	%		35.0	60.0
MCV	88.9	fL		80.0	99.9
MCH	27.3	pg		27.0	31.0
MCHC	30.7 L	g/dL		33.0	37.0
Plt	629.	H	x10^3/uL	150.	450.
LY%	16.5	*L %		20.5	51.1
LY#	2.4	* x10^3/uL		1.2	3.4

ID: [redacted]
MD

14-12-03
15:48

				Patient Limits	
WBC	17.8 H	x10^3/uL		4.5	10.5
RBC	3.34 L	x10^6/uL		4.00	6.00
Hgb	8.2 L	g/dL		11.0	18.0
Hct	28.9 L	%		35.0	60.0
MCV	86.7	fL		80.0	99.9
MCH	24.6 L	pg		27.0	31.0
MCHC	28.4 L	g/dL		33.0	37.0
Plt	777.	H	x10^3/uL	150.	450.
LY%	11.3	*L %		20.5	51.1
LY#	2.0	* x10^3/uL		1.2	3.4

ID: [redacted]
MD

15-11-03
04:58

				Patient Limits	
WBC	14.9 H	x10^3/uL		4.5	10.5
RBC	3.52 L	x10^6/uL		4.00	6.00
Hgb	9.7 L	g/dL		11.0	18.0
Hct	31.1 L	%		35.0	60.0
MCV	88.5	fL		80.0	99.9
MCH	27.7	pg		27.0	31.0
MCHC	31.3 L	g/dL		33.0	37.0
Plt	321.	x10^3/uL		150.	450.
LY%	....	%		20.5	51.1
LY#	------	x10^3/uL		1.2	3.4

b(6)-4

ID: [redacted]
MD

27-11-03
05:05

				Patient Limits	
WBC	9.3	x10^3/uL		4.5	10.5
RBC	2.24 L	x10^6/uL		4.00	6.00
Hgb	6.1 L	g/dL		11.0	18.0
Hct	19.7 L	%		35.0	60.0
MCV	87.9	fL		80.0	99.9
MCH	27.1	pg		27.0	31.0
MCHC	30.9 L	g/dL		33.0	37.0
Plt	553.	H	x10^3/uL	150.	450.
LY%	11.1	*L %		20.5	51.1
LY#	1.0	* x10^3/uL		1.2	3.4

ID: [redacted]
MD

01-15-04
09:34

				Patient Limits	
WBC	4.4 L	x10^3/uL		4.5	10.5
RBC	2.98 L	x10^6/uL		4.00	6.00
Hgb	7.5 L	g/dL		11.0	18.0
Hct	24.5 L	%		35.0	60.0
MCV	82.4	fL		80.0	99.9
MCH	25.4 L	pg		27.0	31.0
MCHC	30.8 L	g/dL		33.0	37.0
Plt	377.	x10^3/uL		150.	450.
LY%	33.3	%		20.5	51.1
LY#	1.5	x10^3/uL		1.2	3.4

b(6)-4

ID: [redacted]
MD

28-11-03
05:40

				Patient Limits	
WBC	12.5 H	x10^3/uL		4.5	10.5
RBC	2.87 L	x10^6/uL		4.00	6.00
Hgb	7.9 L	g/dL		11.0	18.0
Hct	25.4 L	%		35.0	60.0
MCV	88.6	fL		80.0	99.9
MCH	27.6	pg		27.0	31.0
MCHC	31.2 L	g/dL		33.0	37.0
Plt	469.	H	x10^3/uL	150.	450.
LY%	12.6	*L %		20.5	51.1
LY#	1.6	* x10^3/uL		1.2	3.4

---

i-STAT GS+

pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____25 mmol/L

Ai STO

pH_____7.101

pCO2_____52.5 mmHg

pO2_____108 mmHg

HCO3_____24 mmol/L

BEecf_____-5 mmol/L

sO2*_____97 %

*calculated

Hb 11
Hct 33
Sample Time

12NOV

b(1)-2

TEST(S)		
SPECIMEN TAKEN		
DATE 14Dec	TIME 1545 A.M. P.M.	
RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT: CONTROL	
	PT: PATIENT	
	PTT: CONTROL	
	PTT: PATIENT	
	PTT: % ACTIVITY	
	PTT: RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)

RBC

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

REF. AREA [redacted]

PROCESSING PHYSICIAN'S SIGNATURE

[redacted] b(6)-4

[redacted] b(6)-2

MD DATE

TECH 14Dec

HEMATOLOGY

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

PATIENT STATUS: ☐ BED ☐ AMI ☐ OUTPATIENT ☐ NP ☐ DON

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

FCW

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/12/03 07:40

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.1 sec.
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :11/12/03
Test Time :07:38
Card Lot :080201
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/12/03 07:44

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 36.5 sec.
Sample Type:citrated wh. blood
Test Date :11/12/03
Test Time :07:41
Card Lot :100212
Operator [redacted] b(6)-4

MEDICAL RECORD — ANESTHESIA

DRUG	(Route)	
Fentanyl	(mcg)	50 100
Ketamine	(mg)	75
SCh	(mg)	120
Vecuronium	( )	1 3 5
MSO4	( )	5 5 5 5
Phenylephrine	(mcg)	50 50
VOLAT. AGENT	% del	2.0 ~ 0.5 — 1.0 — 0.5 — 1.0 — 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
Concentrator O2 FM	L/Min	5 — 5 — 5 — 5 — 5 — 5

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

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

Reglan 10 mg IV @ 0340
Decadron 20 mg IV @ 0345

LINE site 14g (R) AC (L) Warmed — 300 — 0 — 300/600 — 400/1000 cc
Warmed — Hespan — 500 — 500 cc
Warmed
Warmed

LOSSES		
EST BLOOD LOSS	100	150 cc — 150 cc
URINE –	400	100/500 — 300/800 cc Clear yellow

TOTALS	
TOTAL EBL	150 cc
TOTAL URINE	800 cc

FLUIDS – SUMMARY
CRYSTALLOID – 1000 cc
COLLOID – Hespan 500 cc
BLOOD – —

REMARKS – Code drugs with numbers, events with letters

(A) Pt ID, Assessed IV Good
(B) To OR 2 – P-ELVIS monitors on
(C) RSI Induction Difficult Inf. Gaterin DL x 3 – Grade IV view I Miller 2 – Grade 2 view I Mac 3 2 DC. cuff visible past cords OV Taped LC SC
(D) Spontaneous Resp, Good reflexes, Head Cuff Extubate
(E) To PACU – Spontaneous Resp I Good Air Exchange – Somnolent Responsive – Report to SNCOD RN

VITAL SIGNS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: —

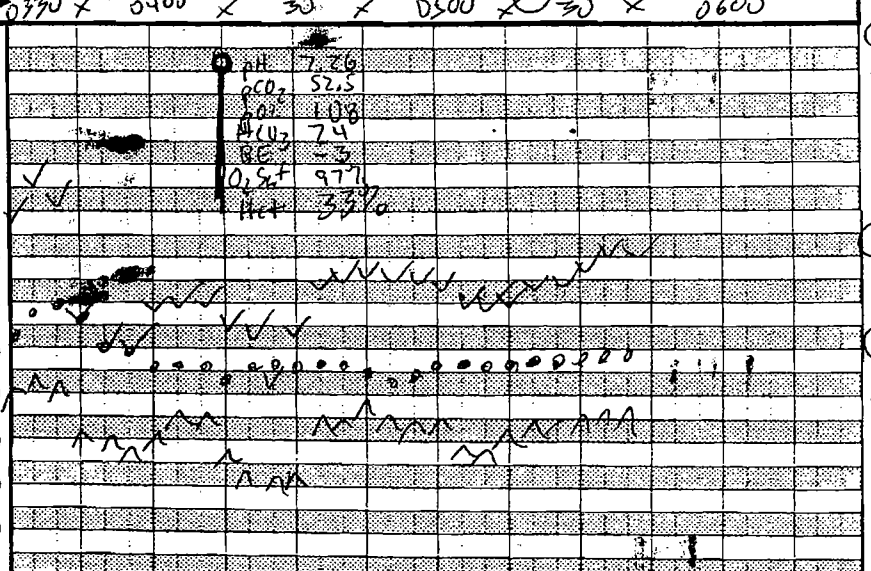
INITIAL DATA: BP – 155/81 HR – 98

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y

TIME: 0330 × 0400 × 30 × 0500 × 30 × 0600

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



VT – ml										
f – breaths/min	20	10	12	10	10	18	16	22	20	
Peak inf pres / PEEP										
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	A	S	S	S	
BP/Auto Cuff	ET CO2 (torr)	39	37	40	43	52	41	51	46	45
BP / oth	FIO2 (Frac or %)	.40	.59	.39	.58	.42	.61	.52	.56	.51
ART line	SpO2 (%)	100	100	100	100	102	100	100	100	100
Steth- PC/ES	ECG II	ST	ST	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site		36.4	36.5	36.5	36.4		36.4		
	N-M Block (T/4)									
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS

EVENTS (A) (B) (C) (D) (E)
Position — 0 — Arms < 90° Palms Up P.P.P.P.

RECOVERY AT 0545
(PACU) ICU ____ (Specify)
OTHER ____
CONDITION: STABLE
T 99.0
RESP – 20 SpO2 – 97%
BP – 136/73 HR – 108

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0325	0330	0550
PROC	Ready 0347	Begin 0359	End 0539

PROCEDURES and CPT Codes: Ex Fix (R) Femur / Reglan Hand (R) 5th Digit Amputation

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA RSI 8.5 oral ETT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Oral Mac 3, DL x 3 Bent but well. cuff 1 SC Air. Stylette out. EBS / ETCO2 (+). Bleeding noted in Hypopharynx

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

Iraqi Man

SURGEON [redacted]

[redacted] RNA

MEDICAL RECORD – ANESTHESIA

PROCEDURE 792 EST
LOCATION Fallujah, Iraq
DATE 12 Nov 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)														TOTALS	TOTAL EBL
Propofol	(mg)	200													200	
Fentanyl	(cc)	2/2	1		0.6										5 cc	
	( )															TOTAL URINE
	( )															
	( )															
	( )															
VOLAT AGENT	Forane % del	4	4	3	1.5	0.6	X								FLUIDS SUMMARY	
	% e.t.														CRYSTALLOID- 1800 cc	
AIR	L/Min														COLLOID-	
N2O	L/Min															
O2	L/Min	8	3	3	3	2	3								BLOOD-	

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

FLUIDS

LINE site LR														
☐ Warmed	600		#1				#2							
☐ Warmed														
☐ Warmed														
☐ Warmed														

LOSSES

EST BLOOD LOSS														
URINE -							1200							

REMARKS

Code drugs with numbers, events with letters

To OR #1. Monitors
Pre O2. Smooth IV
induction. Eyes
taped shut
Sx. LMA A/C
To recovery

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 100 KG LB

HEMATOCRIT:

INITIAL DATA:

BP- 147/78

HR- 104

EQUIP CHECK OK?- Y / N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 1200 1230 1300 1330 1400

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml					330	430
f - breaths/min	12	17	20	22	26	26
Peak inf pres / PEEP						
MODE - S(pon), A(ssist), C(on)	S/A	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	45	46	47	45	38	35
BP/oth	FIO2 (Frac or %)	.69	.70	.69	.69	0.7	0.7
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site Nasal		37.3	37.3	37.1	36.8	out
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

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

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP- 20 SpO2- 95% BP- 133/84 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1155	1153	1315
	Ready	Begin	End
PROC	1205	1225	1300

PROCEDURES and CPT Codes: I+D R Hand + RLE wounds w/debrid

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

b(6)-4

[redacted]

ICW #1

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* to R finger #4.0 LMA Tense (+) ETCO2 (+) B=BS

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR #1

DATE: 13 Nov 00

PAGE 1 OF 1

31y/o ♂ NKA Ancef Gent PMH ? Kidney Stones
S/P Ex Fix (R) Femur, 1x RA PIV ✓ MPCI Ex Fix

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													TOTALS	TOTAL EBL
Fentanyl	(cc)	1	2	2										5	mi
Propofol	(mg)		150				(50)								
Sux	(mg)		80												TOTAL URINE
	( )														
MSO4	(mg)				5/5									10	300
	( )														
VOLAT AGENT	Sevo % del	X2	2	2	2.5	1X	X1.5	X							
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	X6	2	3	3	3	3-8								
SINGLE DOSE DRUGS-MARK ON GRID → WITH NUMBERS & ENTER IN REMARKS															

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

FLUIDS

LINE site														
RA LR	☐ Warmed	X	200	300	600	800								
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES														
EST BLOOD LOSS														
URINE -				300										

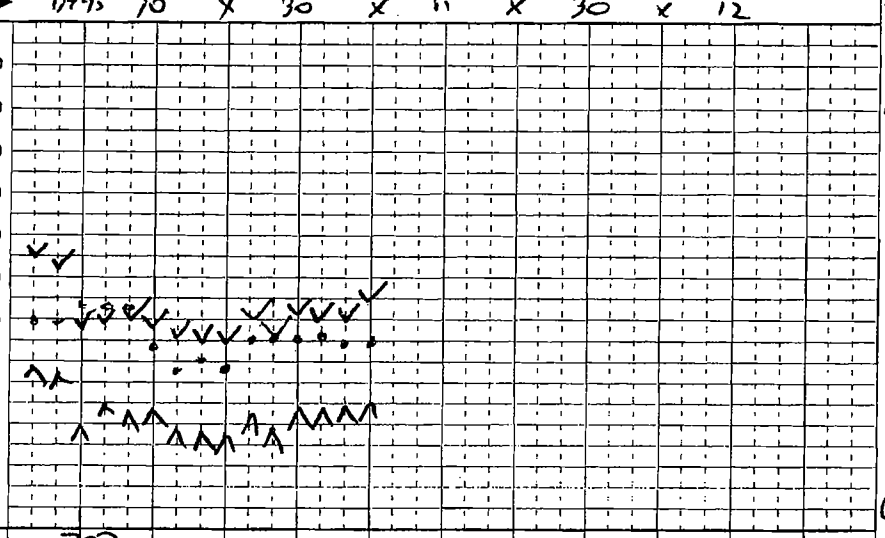
REMARKS
Code drugs with numbers, events with letters
prep, PIV ✓ to OR, monitors O2 stable IV Anbactic positive, prep drape
7P supine
SR extubated awake

Confusion
Cooperative

PHYS STATUS	TIME →	0945	10	X	30	X	11	X	30	X	12
1 (2) 3 4 5 E											

BODY WEIGHT: ~105 (KG) LB
HEMATOCRIT: 24.9
INITIAL DATA:
BP- 118/70
HR- 96
EQUIP CHECK
OK?- (Y) N
PATIENT RECHECK
OK for PROCEDURE? Yes
TIME- 0930

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



VENTIL

VT - ml		700				
f - breaths/min		10	26	29	24	23
Peak inf pres / PEEP		16				
MODE - S(pon), A(ssist), C(on)		S	C	S	S	S

MONITORS/ACCESSORIES

X	BP/Auto Cuff	X	ET CO2 (torr)	+	42	39	37	37
	BP/oth	X	FIO2 (Frac or %)	.8	.8	.8	.8	.8
	ART line	X	SpO2 (%)	100	100	100	100	100
	Steth- PC/ES	X	ECG	ST	ST	SR	SR	SR
	Gas analyzer		TEMP-site	AVAIL.				
		X	N-M Block (T/4)			4/4		
	Warming blkt							
	Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS / *Position* → Neck/Head Neutral Arms <90°

RECOVERY AT 1050
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- 16 SpO2- 98
BP- 142/77 HR- 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0930	0938	1055
	Ready	Begin	End
PROC	0945	1001	1048

PROCEDURES and CPT Codes:
(R) leg Washout

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

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA DLX1, 4mg, propofol II 1/min, 8.0 RTT @ 24 cm

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
BS=B, G.3.4., supraglottic.

SURGEONS: [redacted] b(6)-4

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: OR
DATE: 11-15-07
PAGE 1 OF 1

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 24265

MEDICAL RECORD - ANESTHESIA

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

Wasted

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

DRUG	(Units)												
Fent	(mcg)	150	200	50/00	150/50/50/50/50/50/50								
Prop	(mg)	200											
	( )												
MSO4	(mg)										4	2	
	( )												
	( )												
VOLAT AGENT	Sevo % del		2.0	2.5	2.5	2.5	2.7	(2) →	→	→	→	→	
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	8	2	2	2	2	2	(3) →	→	→	→	→	

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

FLUIDS

LINE site													
18ga @ H	☐ Warmed	Endotracheal											
18ga @ H	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS										200			
URINE -													

TOTALS	TOTAL EBL
	500
	TOTAL URINE
	N/M

FLUIDS - SUMMARY

CRYSTALLOID- 2000

COLLOID- 500

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

pt ID'd on ICW
Q In/Exit room
Tourniquet
Start/Stop
Ancef 1 gm IV per schedule
Gentamycin 400 mg IVPB PSR
(1) Dolan, CRNA.

see pg. 2

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 31

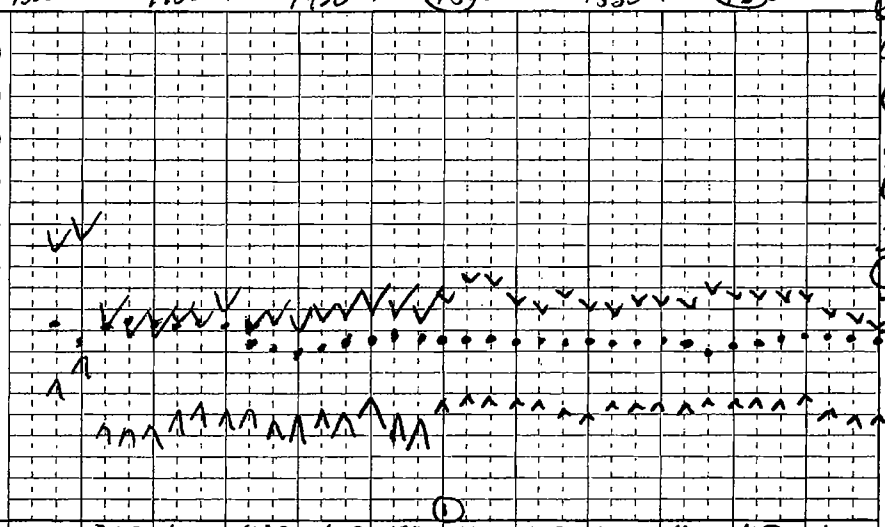
INITIAL DATA: BP- 122, 62 HR- 88

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1330

TIME → 1330 · 1400 · 1430 · (1500) · 1530 · (1600) ·

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



VENTIL

VT - ml		380	400	420	430	430	430	440	430	460	450	450
f - breaths/min		20	12	8	16	16	12	14	14	12	14	16
Peak inf pres / PEEP							-	-	-	-	-	-
MODE - S(pon), A(ssist), C(on)	SR	S	S	S	S	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		36	40	42	41.0	40	43	40	39	38	37	38
BP/oth	FIO2 (Frac or %)	.87	.88	.88	.89	.88	.88	90	90	90	90	89	88
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site			37.2	37.1	37.0	37	36.9	36.9	36.9	36.8	36.9	36.9
	N-M Block (T/4)												
Warming blkt													
Conv warmer													

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

RECOVERY AT 1925

PACU ICU _____ (Specify)

OTHER _____

CONDITION: Stable

RESP- 20 SpO2- 98%

BP- 139/70 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1325	1338	1930
	Ready	Begin	End
PROC	1350	1410	1915

PROCEDURES and CPT Codes:

ORIF @ Knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA

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

[redacted]

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

LMA #4 placed 3 difficulty, leak Vol @ ~ 18 cm H_2O pressure, eyes taped

[redacted] b(6) - 2

[redacted]

PROCEDURE LOCATION: 1

DATE: 26 NOV 03

PAGE 1 OF 2

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	1720	1730	1740	1750	1800	1810	1820	1830	1840	1850	1900
Fentanyl	(µg)	50					50/50/50/50/50					
	( )											
	( )											
MSO4	(mg)		2	2								
	( )											
	( )											
VOLAT AGENT	Sevo % del	2.5							1.5			X
	% e.t.											
AIR	L/Min											
N2O	L/Min											
O2	L/Min	3										10

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

FLUIDS

LINE site		1720	1730	1740	1750	1800	1810	1820	1830	1840	1850	1900
	☐ Warmed											
	☐ Warmed											
(R) hand 18g	☐ Warmed (2)					[Resp 500]		(3)				
	☐ Warmed											

LOSSES

	1720	1730	1740	1750	1800	1810	1820	1830	1840	1850	1900
EST BLOOD LOSS (200)	100/300		100/400			100/500					
URINE -											

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

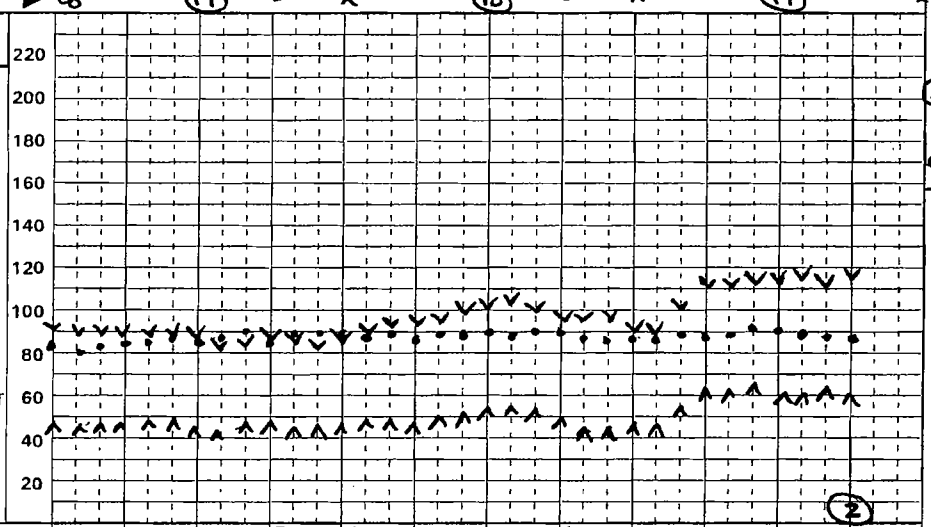
INITIAL DATA: BP- / HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 16 30 • (17) • x • (18) • x • (19) •

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



VENTIL

	1720	1730	1740	1750	1800	1810	1820	1830	1840	1850	1900
VT - ml	450	350	350	350	400	400	350	400	450	520	600
f - breaths/min	14	16	16	16	18	18	18	18	14	16	18
Peak inf pres / PEEP	-	-	-	-	-	-	-	-	-	-	-
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

		1720	1730	1740	1750	1800	1810	1820	1830	1840	1850	1900
BP/Auto Cuff	ET CO2 (torr)	38	39	38	37	35	35	37	36	36	34	38
BP/oth	FIO2 (Frac or %)	88	87	88	88	88	88	88	87	88	88	88
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	Sr	Sr	Sr	Sr	Sr	Sr	Sr	Sr	Sr	Sr	Sr
Gas analyzer	TEMP-site Hath	36.9	37.0	36.9	37.0	37.1	37.0	37.0	37.1	37.1	37.2	37.2
	N-M Block (T/4)											
Warming blkt												
Conv warmer												

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

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1720: H/H = 9/28 surgeon notified.

1900: anesthesiologist added to. LR (3) remarks.

(2) F/C placed per OR-RN. Pt opens eyes, extubated. To PACU, report.

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes: ORIF (R) knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* Gen LMA

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

#[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #4 LMA

SURGEONS: [redacted] b(6)-2

[redacted]

PROCEDURE LOCATION: 1

DATE: 26 NOV 03

PAGE 2 OF 2

31y0 ♂ fx RA HL(R)FA s/p Ex fix (R) femur

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)																	
Fentanyl (mcg)		50 -	50-100	<50>													
Lidocaine (mg)		100															
Propofol (g)		180				20											
MSO4 (g)			3	5	5	<5>											
(g)																	
( )																	
VOLAT AGENT	Hal % del	1.0	0.6	0.8	0.8	0.8	X										
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min	10	2	2	2	2	10										
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →																	

TOTALS	TOTAL EBL
250	<50
100	
300	TOTAL URINE
20	
	Ø

FLUIDS - SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site															
20G (R) FA	☒ Warmed	UR	#1	—	—										
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														

LOSSES

EST BLOOD LOSS			25												
URINE -															

REMARKS

Code drugs with numbers, events with lettters

(1) Lungs STA (6) HR (2) Room monitor O2 induced eyelid taped closed (3) LMA removed w/ complication (4) TO PACU - Report to nurse

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT: —

INITIAL DATA:

T- 99.4

BP- 99% 50 107 / 62

HR- 91

EQUIP CHECK

OK?- (Y) N

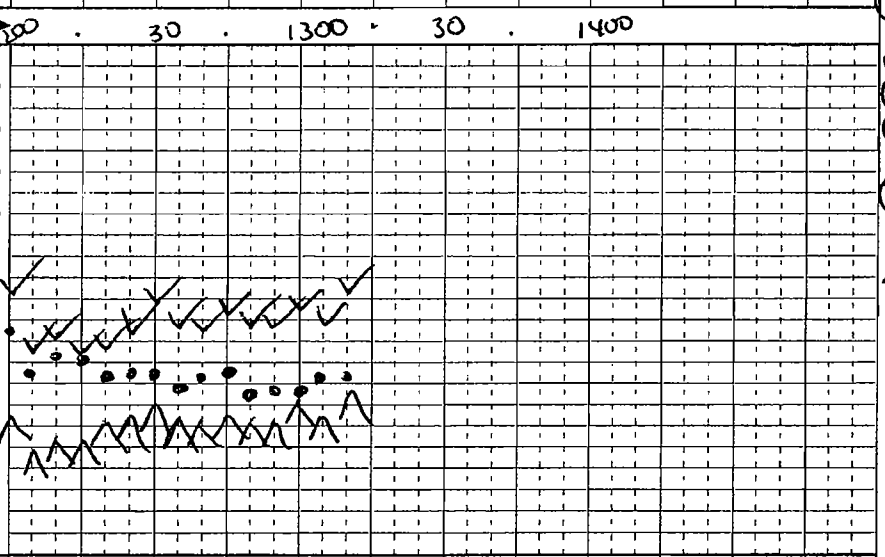
PATIENT RECHECK

OK for PROCEDURE? ✓

TIME- 1145

TIME 1200 . 30 . 1300 . 30 . 1400

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



VENTIL

VT - ml		+	260	300	360	340
f - breaths/min		+	22	18	15	17
Peak inf pres / PEEP		—	—	—	—	—
MODE - S(pon), A(ssist), C(on)		S G	S	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	+	41	40	37	37
BP/oth	✓FIO2 (Frac or %)	0.50	0.34	0.36	0.46	0.52
ART line	✓SpO2 (%)	99	100	100	100	100
Steth- PC/ES	✓ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site available					
	N-M Block (T/4)					
	BS	+				
✓Warming blkt	✓x1 Blanket	→	→	→	→	
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS (1) (2) (3) (4) *Position*

RECOVERY AT 1310

(PACU) CU ____ (Specify)

OTHER ____

CONDITION: Stable and awake

RESP- 20 SpO2- 97

BP- 134/80 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1150	1200	1320
	Ready	Begin	End
PROC	1210	1225	1310

PROCEDURES and CPT Codes:

I&D (R) knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GLMA

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

LMA #5 placed; seated GPU; BBS; sust ETCO2

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

[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: 2(2)

DATE: 9 Dec 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 COPY 2 ANESTHESIA DEPARTMENT USAPA V1.00

MED [redacted] 24268 CRNA/MA [redacted]

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
PROPOFOL	(mg)	150												
FENTANYL	(mcg)	X300	X200	X200										
MSO4	(mg)		4	6										
	( )													
	( )													
	( )													
VOLAT AGENT 1.50	% del	2.0	1.0	1.0	.8	.8	Ø							
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	1	1	1	1	8							

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

FLUIDS

LINE site													
LR 18 (R) HA	☐ Warmed			700			1300						
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS													
URINE -													

TOTALS	TOTAL EBL
	<100
	TOTAL URINE
	Ø

FLUIDS - SUMMARY

CRYSTALLOID- 1400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

INITIAL DATA:

BP- 114/66

HR- 94

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE? yes

TIME- 0812

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

TIME ▶ 0815 30 • 09⁰⁰ • 30 • 10⁰⁰ • 30 • 11⁰⁰

VENTIL

VT - ml	280	330	460	590	530	500
f - breaths/min	16	13	8	7	9	10
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)	39	40	39	38	35	39
BP/oth	FIO2 (Frac or %)	.91	.91	.91	.91	.91	.90
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAILABLE					
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → O-1

RECOVERY AT 0940

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0810	0910
PROC	Ready	Begin	End
	0815	0835	0957

PROCEDURES and CPT Codes:

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GENERAL CMA

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

Pre-ox 5 min 91% 1 FTO2 1 IV induction #4 2 mm Placed RT [illegible] 30cc Fully sedated

SURGEONS: [redacted] DISS DISTCO2

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: OR1

DATE: 12 DEC 03

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)														
droperidol	(mg)	2.5													
sufenta	(mcg)	10	10	10	10		5		5						
propofol	(mg)		200												
SUX	(mg)		140												
	( )														
	( )														
VOLAT AGENT Iso	% del		1.5	1.5	1.2	0.7	0.5	0.5							
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min		6	2	1	1	2	2	4						
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		1	2	3					4						

FLUIDS

LINE site														
18g LAC	☐ Warmed	RL		500		600		700						
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES — EST BLOOD LOSS / URINE -

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: N/A

INITIAL DATA:

BP- 110 / 63

HR- 92

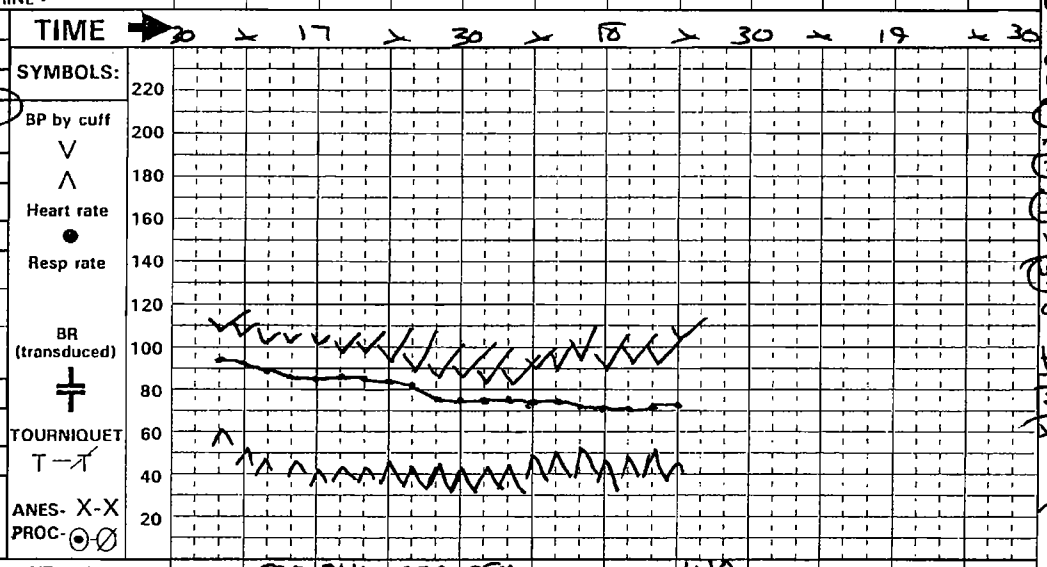
EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 1635



VENTIL

VT - ml		500	240	270	350	300	430	410
f - breaths/min		12	16	18	10	10	8	11
Peak inf pres / PEEP		30	~~16~~	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	C	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40	40	45	44	46	45	43	41
BP/oth	FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site avail								
	N-M Block (T/4)								
Warming blkt									
Conv warmer									

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

TOTALS	TOTAL EBL
50	min
	TOTAL URINE
	Ø

FLUIDS - SUMMARY

CRYSTALLOID- 700

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Chart & pt ✓. No change since prior surgery. S/P multiple anesthetics. Plan GA.
(1) To room, SOC monitors, pre-O2.
(2) I & I.
(3) Toradol 30mg IV.
(4) 32F nasal airway placed. Pt suctioned & extubated. S diff. to PACU stable.

RECOVERY AT 1820

PACU ICU ____ (Specify)

OTHER 958

CONDITION:

RESP- 12 SpO2- 98

BP- 114/70 HR- 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1635	1640	1825
	Ready	Begin	End
PROC	1650	1705	1815

PROCEDURES and CPT Codes:

I&D Rt knee; adjust antibx beads

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

*FastTrak LMA → 7.0 ETT

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

EPW # [redacted] b(6)-4
32 yo ♂, S/P GSW
Smoker

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

Eyes taped, ETT place via 4.0 FastTrak LMA. ⊕ ETCO2 & BEB.

SURGEON: [redacted] BMOC)

[redacted] MS, CRNA

PROCEDURE LOCATION: 1

DATE: 12/24/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MED[redacted] 2420 — [redacted] ANESTHESIA DEPARTMENT — USAPA V1.00

b(6)-1

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)																	
Midazolam (mg)	2.5																
Fentanyl (mcg)	75	25	<150>														
Lidocaine (mg)	80																
Propofol (mg)	180																
MSO4 (0)		<5>	<5>														
(0)																	
VOLAT AGENT: ISO % del		0.6	1.0	0.8	1.6												
% e.t.																	
AIR L/Min																	
N2O L/Min																	
O2 L/Min	10~2	2	2	2	2												

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

FLUIDS

LINE site																
18G-LRX Warmed	LR#1															
☐ Warmed																
☐ Warmed																
☐ Warmed																

LOSSES: EST BLOOD LOSS; URINE - Pre-op voided

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: —

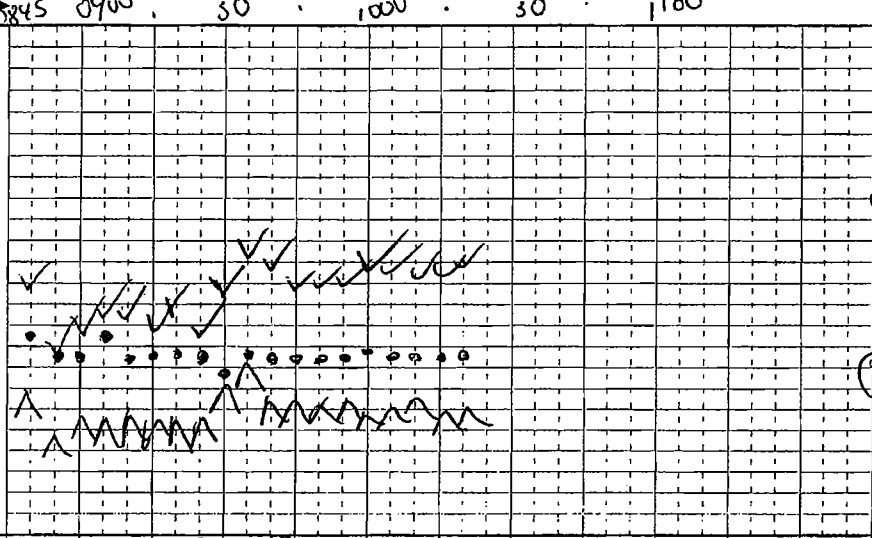
INITIAL DATA: BP- 99/55; HR- 97

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? JR; TIME- 0800

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

TIME → 0845 0900 . 30 . 1000 . 30 . 1100



VENTIL

VT - ml	—	670	230	240	330	300	300
f - breaths/min	—	7	23	18	28	24	24
Peak inf pres / PEEP	—	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S~	C	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	38	43	41	35	35	34
BP/oth	FIO2 (Frac or %)	0.62	0.62	0.65	0.68	0.78	0.7	0.7
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	x1 wool blanket →							
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS — *Position* (3)

TOTALS	TOTAL EBL
2.5	<50ml
250	
80	TOTAL URINE
180	
10	0

FLUIDS - SUMMARY: CRYSTALLOID- 400; COLLOID- 0; BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) Multiple surgeries for (R) Knee: No change in state. Plan G-LMA
(2) Room, 18G PI started, monitor O2; lids tape closed once induc
(2) Consulted c/n. Delivery + b/c of ATB's long term Central line place [redacted] with [redacted] BS.
(3) x2 [redacted]
x1 attempt (R) S

RECOVERY AT 1020

PACU ICU _____ (Specify)

OTHER _____

CONDITION: RESP- 16 SpO2- 99; BP- 123/75 HR- 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0815	0845	1030
	Ready	Begin	End
PROC	0855	0905	1015

PROCEDURES and CPT Codes: I+D (R) Knee / CUL UA

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

G-LMA

AIRWAY MANAGEMENT: *(intubation route, blade, technique, comments)*

LMA #4 seated; GPO; +BBS; Sust ETCO2

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: 7

DATE: 3 Jan 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — COPY 3 - ANESTHESIA [redacted] MENT — USAPA V1.00

MEDCOM - 24271 — [redacted] CRNA / MAJ (Che[redacted]

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG	(Units)	
Fentanyl	(µg)	150/100
propo	(mg)	100
MSO4	(mg)	5/5
	( )	
	( )	
	( )	
VOLAT AGENT: Sevo	% del	0.8 → ⊗
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 - (3) → →

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

FLUIDS

LINE site		
(R) SC TUL	☐ Warmed	
	☐ Warmed (1)	→ → →
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	Ø
	TOTAL URINE
	N/M

FLUIDS - SUMMARY

CRYSTALLOID- 950

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) room/O2/monitors SIVI, eyes taped, LMA placed A/T → (2) ETCO2 = 5°, BBS.

(3) LMA removed, O/A placed → PACU, report.

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 117 / 67

HR- 115

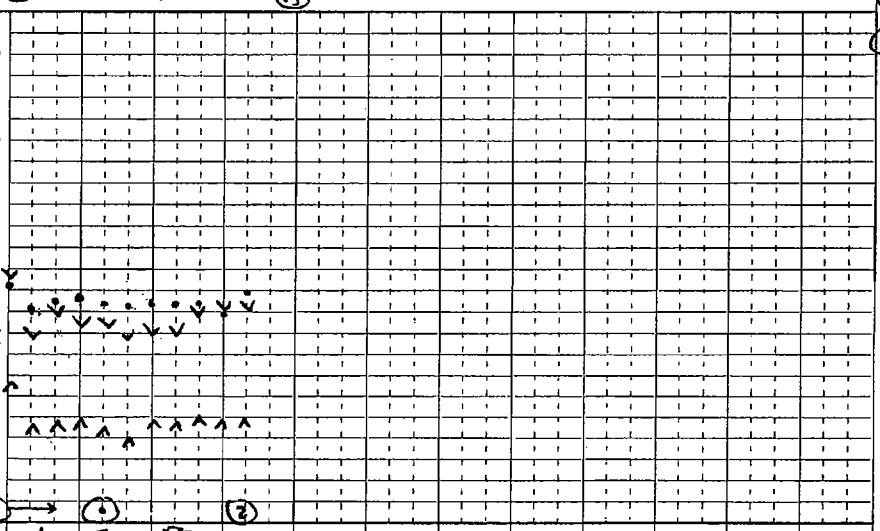
EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y)

TIME- 1450

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

TIME → (4) • x • (5)



VENTIL

VT - ml	+	500	500
f - breaths/min	18	20	24
Peak inf pres / PEEP	-	-	-
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	38	34	+
BP/oth	FIO2 (Frac or %)	62	56	53	53
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST
Gas analyzer	TEMP-site Skin	36	36	36	
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS / *Position* → (5) BUE on boards <90° @ shoulder, pulses ↑

RECOVERY AT 1452

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: Stable

RESP- 18 SpO2- 96%

BP- 104/55 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1345	1358	1455
	Ready	Begin	End
PROC	1408	1421	1450

PROCEDURES and CPT Codes: STSG (R) knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*: Gen LMA

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

Civ [redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: #4 LMA, A/T → see (1)

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: 2

DATE: 19 Jan 04

PAGE 1 OF 1

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 27 NOV 03

DATE AND HOUR REQUIRED: ASAP

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: /
HEMOLYTIC DISEASE OF NEWBORN? /

REQUESTING PHYSICIAN *(Print)* b(6)-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: ORF Femur

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED: 27 NOV 03

TIME VERIFIED: 1700

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. W0016 b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST b(6)-2 [redacted]

DONOR ABO: A Rh: POS

RECIPIENT ABO: A Rh: POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 27 Nov 03

REMARKS: Exp 27 Nov 03 at 23:59

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1715 ON *(Date)* 27 Nov 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] TC, RN b(6)-2

[redacted] LPN.

6.1 H prior to transfusion
19.7 H

PRE-TRANSFUSION TEMP. 100.9 PULSE 105 BP 110/61

DATE OF TRANSFUSION: 27 NOV 03

TIME STARTED: 1743

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME/DATE COMPLETED/INTERRUPTED: 27 Nov 03 2030

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.7	107	123/70

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO [redacted] [ ] YES *(Specify)*

[redacted] NOTING ABOVE b(6)-2 [redacted] 9 W m6

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first [redacted] rate; hospital or medical facility)

SEX: Male WARD: ICW #1

[redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* _____ ML

EMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 27 nov 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* b(6)-2 [redacted]

ORF Femur

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER b(6)-2 [redacted]

DATE VERIFIED 27 nov 03

TIME VERIFIED 1700

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO A

Rh POS

RECIPIENT

ABO A

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp b(6)-2

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 27 nov 03

REMARKS: b(6)-2

27 nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

(Hour) 2035 ON *(Date)* 27 nov 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

[redacted] b(6)-2

[redacted] Spc. 91Wmb

PRE-TRA[redacted]

TEMP. 100.1 PULSE 107 BP 123/70

DATE OF TRANSFUSION

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 2330 27 Nov 03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 101.0

PULSE 109

BLOOD PRESSURE 118/66

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHE[redacted]FICULTIES *(Equipment, clots, etc.)*

- [x] [redacted]
- [ ] YES *(Specify)*

[redacted]SON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—La[redacted] rate; hospital or medical facility)

[redacted]

male

WARD ICW#1

b(6)-4

[redacted]

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA, ICMR, FIRMR 41 CFR 201-5.202-1

Medical Record Copy

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 1-2 mg IV now and ~~15~~ 1 mg q 3-5 min prn pain for a		
	max dose of 15 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] b(6)-2		

PATIENT IDENTIFICATION b(6)-4

[redacted]

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD - DOCTOR'S ORDER

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	Jan 03, 2004 1030 POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN SaO_2 < 95%		
3	Morphine / Meperidine ~~mg IV now~~ and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
11	CXR in PACU		
12	Add LR MIVF @ TKO to distal		
	port of CVL		
	Flush Proximal + medial ports c NS		
	[redacted] CRNA / MAJ		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. prn SpO2 < 94%		
3	Morphine / ~~Meperidine~~ ~~10~~ mg ~~IV now~~ and 2 mg q 3-5 min prn pain for a		
	max dose of 15 mg. (+) 5 mg MSO4 IV now		
~~4~~	~~Zofran~~ ____ mg IV prn N/V q 15 min, may repeat x ____.		
~~5~~	~~Metoclopramide~~ ____ mg IV prn N/V x 1.		
~~6~~	~~Droperidol~~ ____ mg IV prn N/V x 1.		
7	Phenergan 12.5 mg IV prn N/V x 1.		
~~8~~	~~Benadryl 25-50mg IV~~P q1 hr prn, itching while in PACU.		
9	IVF: _____ @ _____ cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	CPT [redacted], CRNA		
	[redacted] b(6)-2		
	26 Nov 03 - 1930		

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 NOV 03 TIME OF ORDER: 0740 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICW-1
2. IV - OPEN (R) SALINE KL, (R) FOLEY IS, (R) SP ANESTHESIA
3. CONDITION - STABLE
4. VS - ROUTINE
5. BED REST

PATIENT IDENTIFICATION

b(6)-4

[redacted]

b(6)-2 Noted [redacted] 12NOV03 0845

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

6. NURSING DIAG, NPO after midnight HOURS on admission
7. IV - LR at 125 cc/HR.
8. TYLENOL 650 mg P.O. Q 4 HRS PRN
9. PERCOCET TABS 1-2 P.O. Q 4-6 HRS PRN
10. MSO4 2-6 mg IVP Q 2 HRS PRN
11. CBC, ~~[illegible]~~ 0600 TOMORROW
12. NPO after MIDNIGHT, FOR OR in AM
13. ANCEF 1 GRAM IVPB Q 8 HRS.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER | TIME OF ORDER

14. GENTAMICIN 400 mg IVPB (R) [redacted]
15. FOLEY TO GRAVITY [redacted]

b(6)-2

NURSING UNIT: 24 0/2100 | ROOM NO.: 12NOV03 | BED NO.: YSW

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER: 13 NOV 03 TIME OF ORDER: 1303 HOURS

1. Resume previous orders
2. Regular Diet
3. Begin ambulation P.O. [redacted]
4. AP pelvis X-RAY
5. CBC in AM.
6. NPO after midnight 13 NOV for OR tomorrow

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

2100 HANDS CLEAN

[redacted] (PAV) [redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDIT

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				15 Nov 03	1050 HOURS	
				(1) Resume previous orders		
				(2) Regular diet		
				(3) Flagyl 500 N when taking PO. see		
NURSING UNIT	[redacted]	BED NO.		b(6)-2 [redacted]		

Noted 15 Nov 03 1355

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
24 yr 7 Nov				0700		
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				19 NOV 03	1600 HOURS	
			(3)	DOB DOD DIAGNOSIS COLON (R) LOB BOD BUSTOLOL		
			(2)	b/c BOLOS b(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24° ✓ 19NOV03 0450	[redacted]					

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				19 NOV 03	1600 HOURS	
			(1)	UP 60 LOB WITH CANTOM		
				[redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				
24°	0220 20NOV	[redacted] b(6)-2				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				23 NOV 03	1545 HOURS	
			(1)	UP, FLT, OBLIGATED DIS (R) KUGE. b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				
24° ✓ 25NOV03 0450	[redacted]			[redacted]		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				25 NOV 03	1615 HOURS	
			(1)	NPO after midnight for OR tomorrow		
				b(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24° ✓ 25NOV03 0410		A-9-5				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

[redacted] b(6)-2

Noted 26 Nov 03 2005hrs

DATE OF ORDER: 26 NOV 03 TIME OF ORDER: 1915 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. IV D5 ½ NS @ 125 cc/hr, heparin lock when taking PO well
4. Foley to gravity
5. MSO4 2-8 mg IV Q 1 hr PRN.

DATE OF ORDER: TIME OF ORDER: HOURS

6. Glucose (R) Neg.
7. CBC at 0600
8. Morphine 8 at 0600

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 NOV 03 TIME OF ORDER: 1550 HOURS

noted [redacted] b(6) 27 Nov @ 1600.

1. FFP 2 units PRBC ✓
2. Platelets 2 units PRBCs ✓ over 2 hours each.
3. Benadryl 25 mg IV PRN ✓ to FFP and platelets
4. Repeat CBC in AM

PATIENT IDENTIFICATION

b(6)-2 [redacted] 27 Nov @ 1730

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER:

8. BP, LD, OF (R) K [redacted]

27 Nov 03 b(6)-2 [redacted]

US prior to transfusion Temp 100.9, 105, 110/[illegible]

Tylenol 650mg PO now prior to transfusion ✓

Transfuse each unit over 4hr ✓

Telephone order Dr [redacted]

LCAN

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				12-8-03	1830 HOURS	
				-NPO p MN		
				[redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				
[redacted]				0145 10DEC03		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
b(6)-4					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

Noted -WS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12-9-03 TIME OF ORDER: 1230 HOURS — LIST TIME ORDER NOTED AND SIGN

- New orders
- Routine vitals.
- Up c̄ crutches, NWB (R) LE
- Heplock IV
- Dress (R) thigh BID, dry
- Record output Drain q Shift
- Regular Diet

PATIENT IDENTIFICATION: [redacted] b(6)-2 noted

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

- Percocet 1 tab q 4° PRN T > 100.5 or pain
- Demerol 75 mg IV q 4° prn severe thigh
- Phenergan 25 mg IV q 6° prn nausea
- Ambien 10 mg po q HS prn insomnia
- Colace 100 mg po BID
- Levaquin 500 mg IV q D first dose tonight

PATIENT IDENTIFICATION: [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12-11-03 TIME OF ORDER: 0930 [redacted]

- Resume PreOp orders, meds, activity & diet

12/11/03 b(6)-2 [redacted]

[redacted] 12DEC03 0125 No IV [redacted] 12DEC03 0245

No new orders today 14DEC03 0100

PATIENT IDENTIFICATION: [redacted] b(6)-2 [redacted] 14Dec03 1501

NURSING UNIT	ROOM NO.	BED NO.
24°V		15 DEC

DATE OF ORDER: 12-14-03 TIME OF [redacted] 1500 HOURS

- Remove staples (R) small finger
- CBC
- Add salt to diet [redacted]

b(6)-2

(0330) [redacted] 20 AM

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				12-10-03	1530 HOURS	
				-S/C Gentamycin	b(6)-2 [redacted]	
				-NPO p MN		[redacted]
						27/10/03 1600
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				12 Dec 03	HOURS	
NOTED 15 DEC 03 @ 1225				— Δ Ambien to 10 mg po Q HS		
b(6)-2 [redacted] ILT, AN						
NURSING UNIT	ROOM NO.	BED NO.				
24° ✓ [redacted] 16DEC03				0130 / No new orders [redacted] b(6)-2 18DEC03 0225		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] orders 19Dec 03 3308 [redacted]					HOURS	
No new orders [redacted] 19DEC03 2045						
No new orders [redacted] 21DEC03 0125						
No new orders [redacted] 22DEC03 0010				25DEC03	1230	
24° ✓ 25DEC03 [redacted] ILT, AN						
b(6)-4 [redacted] b(6)-2 [redacted] 25 Dec 1230				① NPO p MN → OR		
				26 DEC 03		
				V-O Dr [redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.		24° ✓ 26DEC03 @ 0400 [redacted] ILT, AN		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION b(4)-4 [redacted]

b(6)-2 Noted [redacted]

26DEC03 1955

NURSING UNIT	ROOM NO.	BED NO.
b(4)-2 [redacted]	26DEC03	2200

24°✓

DATE OF ORDER: 12/26/03 TIME OF ORDER: 1830 HOURS

- Resume pre op orders, meds, activity, diet -
- Record output JP q 8 hrs
- Dressing D, day, 48°
- Nystatin Oral susp. swish & swallow 2 tsp qid TID [redacted]

No new orders 28DEC03 0045 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 28 DEC03 TIME OF ORDER: 1130 b(4)-2 HOURS

b(4)-2

(1) Daily dry dsg AS to RLE.

V.O. DR [redacted]

Noted [redacted]

NURSING UNIT	ROOM NO.	BED NO.
b(4)-2 [redacted]	29DEC03 0115	

24°

PATIENT IDENTIFICATION

DATE OF ORDER: 12/30/03 TIME OF ORDER: 1200 HOURS

- D/C Levaquin
- Start Zyvox 600 mg IV q D

1-1-04 1530 [redacted]

- NPO p MN b(4)-2 [redacted]

b(6)-2 [redacted] Noted 1530

NURSING UNIT	ROOM NO.	BED NO.
ICW1 24°✓	31DEC03 0410	[redacted]

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER: 1-5-04 TIME OF ORDER: 1700 HOURS

- D/C Zyvox
- D/C Nystatin
- 1.2 gm Amikacin IV q D -

b(6)-2

b(6)-2 noted [redacted]

[redacted]

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

b(6)-2 AR unless noted differently

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

b(6)-4 [redacted]

NOTED [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	249	3

DATE OF ORDER: 1-3-03 TIME OF ORDER: 1000 HOURS

- Resume preop orders, meds, diet
- Keep leg in knee immobilizer
- Dressing Δ begin 1-5-03
- Add Vancomycin 1.0gm IVPB q12°
- Central line care & sterile dressing Δ's q3D.

[redacted]

PATIENT IDENTIFICATION

24*V07JAN04R0230 [redacted]

[redacted]

NOTED [redacted] 10 JAN 0900

NURSING UNIT	ROOM NO.	BED NO.
249/ [redacted]		

DATE OF ORDER: 1-10-04 TIME OF [redacted] 0900 HOURS

- D/C Vancomycin
- Restart Synthroid 600mcg IV qD

[redacted]

PATIENT [redacted]

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted] noted 12 Jan 04 0230 [redacted] b(6)-2			1-12-04	1845 HOURS	
			- Return pt to general ward		
			- D/C MRSA precautions		
			- Continue general universal precautions		
			[redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted] noted b(6)-2 13 Jan 04 1000			1-15-04	0500 HOURS	
			- CBC - diff		
			- throat culture prior to transfer		
			[redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

1-15-04 | 0900

- Transfer ICW-2 - Dr [redacted] (Dr O
- Stable b(6)-2
- Routine V, tals
- OOB & ambulate c crutches as tol.
- Central line care c sterile dressing Δ q 3 days
- Regular diet

PATIENT IDENTIFICATION

b(6)-4 [redacted] NOTED 15 Jan 04 [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- Percocet 1 tab q 4° PRN pain or T > 100.5
- Demerol 50-75 mg IV q 4° PRN breakthrough
- Phenergan 25 mg IV q 6° PRN nausea
- Colace 100 mg po BID
- Ambien 10 mg po q HS PRN
- Ancef 1.2 gm IV q 8
- Zyvox 600 mg IV q 8

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- Wet to dry dressing Δ daily to (R) leg

b(6)-2 [redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

19 Jan '04 | 0920

(1) NPO Now

(2) Sup today

Noted 19 Jan 04 0920 [redacted]

b(6)-2 [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

b(6)-2 A-1 except where noted

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

b(6)-4 [redacted]

DATE OF ORDER: 1/29/04 TIME OF ORDER: 1500 HOURS

LIST TIME ORDER NOTED AND SIGN

- Resume PreOp orders, meds, activities & diet.
- No Dressing Δ's until 1/24/04 ✓

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

30 Jan 04 [redacted] W/ AN 24° chart ✓

PATIENT IDENTIFICATION

DATE OF ORDER: 1/23/2004 TIME OF ORDER: 2200 HOURS

Give 1L NS bolus taken by 21 [redacted] from D[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ 23 Jan 04 2300 [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Jan 04 TIME OF ORDER: 0800 HOURS

(1) DISCHARGE HOME TODAY
(2) BLOOD SUGAR #3 TIMES TO AM & HS
(3) PROLOXIN - 1-2 P.O. Q 4-6 HRS PRN #20
(4) LEVOFLOXACIN 250mg P.O. Q DAY x 10 DAYS #14
(5) F/U 5 DAYS FOL SUTURE/STAPLE REMOVAL
(6) PLACE GAUZE & KERLIX [redacted] 4x4s.

NURSING UNIT | ROOM NO. | BED NO.

noted 24 Jan [redacted]

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

CL[illegible]AL RECORD - [illegible]TOR'S ORDERS

For use of this form, see AR 40-66, [illegible] proponent agency is OTSG

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

PATIENT IDENTIFICATION				DATE OF ORD[illegible]	TIME OF ORDER _____ HOURS	LIST TIME ORDER NOTED AND SIGN
				T.O. DR [illegible]NG LABETALOL 40mg X1		
				IVP FOR BP 169/100 HR 81		
				noted [redacted] RN		
				blas[illegible] [redacted]		
NURSING UNIT	ROOM NO.	BED NO.		done [redacted]		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

b(6)-2 A11

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. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24
12 NOV 03	[redacted]	VS-routine	[redacted]													
12	[redacted]	Bedrest	[redacted]										DC'D			
12/15	[redacted]	Regular diet	[redacted]													
12	[redacted]	Foley to gravity	[redacted]													
18 NOV	[redacted]	Daily dry dsg Δ @ leg and buttock	[redacted]													
19 NOV	[redacted]	up ad lib c crutches	6													
			18													

Rewritten

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN @ FEMUR FX, @ TIBIA FX @ ⅓ AMPUTATION

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

b(6)-2 A 11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 11 Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12 NOV	[redacted]	Admit to ICW, Cond.-Stable	12 NOV	—	—	[redacted]
12	[redacted]	NPO p MN for OR in am	13 NOV	0001	?	
12	[redacted]	CBC, metlyte 8 0000 tom.	13	0000	done	
11/13	[redacted]	Resume previous orders	13 nov	noted		[redacted]
11/13	[redacted]	AP Pelvis (X-Ray)	13 nov	1500		X-ray
11/13	[redacted]	CBC in A.M.	14 nov	0400	0400	[redacted]
11/13	[redacted]	NPO p MN 14 nov for OR	14 nov	2400	—	[redacted]
	[redacted]	15 Nov	/	/	/	/
15 NOV	[redacted]	Resume previous orders	15	—	—	[redacted]
18 NOV	[redacted]	D/C foley	18	—	1710	[redacted]
23 NOV	[redacted]	AP/LAT/OBLIQUES of (R) KNEE	23	—	1635 JBS	[redacted]
11/25	[redacted]	NPO p MN for OR tomorrow	11/26	0001	—	[redacted]

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

USAPA V1.00

b(4)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 01 Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24				
15	[redacted]	Vital Signs (q 8) / q 6 / q 4	D	[redacted]													
		ROUTINE	E														
			N														
15	[redacted]	Activity: OOB & AMBULATE E	D	[redacted]													
		CRUTCHES AD LIB	E														
			N														
15	[redacted]	Diet: (Regular) Clear Liquids / Advance	B	[redacted]													
		as tolerated / Other _____	L	[redacted]													
			D	[redacted]													
15	[redacted]	NIO: Time/date IV site and change q 72 hours and prn	10	[redacted]	X	X	[redacted]	X	[redacted]	[redacted]	[redacted]	X					
15	[redacted]	NIO: Time/date IV tubing and change q 72 hours	10	[redacted]	X	X	[redacted]	X	[redacted]	[redacted]	[redacted]	X					
15	[redacted]	NIO: Complete skin assessment on admission/transfer, q 7 days and prn	10	[redacted]	X	X	X	X	X	X		X	X	X	X	X	X
15	[redacted]	CENTRAL LINE CARE & STERILE	10	FCL 1	[redacted]	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X		X
		DRESSING Δ q 3 DAYS															
15	[redacted]	WET TODAY DRSG Δ DAILY TO	10	[redacted]					//		//		[redacted]				
		(R) LEG (NO DRSG Δs															
		until 24JAN)															

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: ICW 2 S/P (R) FEMUR FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15	[redacted]	Admit to ICW 2. Dr. [redacted]				done
15	[redacted]	Condition: STABLE				[redacted]
19	[redacted]	NPO now, Surgery today	19 Jan	1300	1300	[redacted]
19	[redacted]	No Drug charges until 24 Jan	19-24 JAN			b(6)-2
23	[redacted]	RETURN TO DUTY	23 Jan			
24	[redacted]	DC home today, Bilothacol oitment #31 bes. 24 Jan				
	-----	Knee Q Day, Percocet 1-2 PO Q4-6 hrs				
	-----	PRN #120, Levofloxacin 250mg P.O Q Day				
	-----	#14, FU 5 days For suture/staple removal				
	-----	Please give 5 kerlex rolls and 4x4.				

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

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 06	07	8	9	10	11	R	13	14	15
25 NOV03	[redacted]	VS routine	06 14	[redacted]									
			14 22										
			22 06										
25	[redacted]	Reg. diet - add salt	06 14										
			14 22										
			22 06										
25	[redacted]	Up ad lib c̄ crutches	06 14										
		NWB RLE	14 22										
			22 06										
26	[redacted]	Elevate (R) leg	06 14										
			14 22										
			22 06										
04 DEC	[redacted]	Braden scale QTD	10	—	—	—	—	—	—	—	—	—	—
03 JAN	[redacted]	Keep leg in knee	06 14	[redacted]									
		immobilizer	14 22										
			22 06										
03	[redacted]	dsg Δ (begin 1-5-03)	10	[redacted]									
		WTD c̄ Kerlix *BID*	22										
03	[redacted]	CL care and sterile	10	—	—	—	—	—	—	—	—	—	—
		dsg Δs Q3D											
04	[redacted]	NU: fall risk assess.	10	—	—	—	—	—	W	—	—	—	—
		ment QTD & prn											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) FEMUR FX (R) TIBIA FX / SF AMP

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

b(6) - 2 A-1

Verity 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
12 Jan	[redacted]	Return pt to general ward	12 Jan			[redacted]
12 Jan	[redacted]	DIC MRSA precautions	12 Jan			[redacted]
12 Jan	[redacted]	Continue general universal precautions	12 Jan			[redacted]
15 Jan	[redacted]	CBC c̄ diff	15 Jan			[redacted]
15 Jan	[redacted]	Throat culture prior to transfer	15 Jan			[redacted]

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

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	1	2	3	4	5	6	7
25Nov03	[redacted]	VS - Routine	06-18	/	[redacted]											
			18-06	[redacted]												
25Nov03	[redacted]	Regular Diet	06-18	/	[redacted]											
			18-06	[redacted]												
25Nov03	[redacted]	Daily dry dsg Δ (R) leg	10	/	[redacted]											
		and buttock		/												
25Nov03	[redacted]	UP ad lib c̄ crutches	06-18	/		[redacted]										
			18-06	[redacted]												
26Nov	[redacted]	Foley to drainage	06	/	/	[redacted]										
			18	/	[redacted]											
26	[redacted]	Elevate R leg	06	/	/	[redacted]										
			18	/	[redacted]											
4Dec03	[redacted]	Braden Scale Q7 days	06	/							/		X			
			18	/							/		[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) femur fx / (R) tibia fx / (R) 5th Fin. Amp

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Nov Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/26	[redacted]	NPO F MN for OR tomorrow	11/26	0001		[redacted]
26	[redacted]	CBC at 0600	~~26~~ 27	0600		[redacted]
26	[redacted]	Metalyte 8 @ 0600	27	0600		[redacted]
26	[redacted]	Resume Previous Orders	26	2000		[redacted]
27	[redacted]	~~T*C 2 U PRBC~~	~~27~~	~~1600~~	~~1600~~	[redacted]
~~27~~	[redacted]	~~Transfuse 2u PRBC OVER 2 hrs~~		Rewritten on		
		each. BR		White Sheet		
27	[redacted]	~~Benadryl 25mg IV PRIOR TO~~	27 Nov			
		~~Transfusion.~~ BR		rewritten on	White Sheet.	
27	[redacted]	repeat CBC in AM	28	0500		[redacted]
27	[redacted]	AP/LAT (R) Knee	27th		done	[redacted]
27 NOV	[redacted]	VS prior to transfusion 100.9 | 105/20 | 110/61	27 NOV	noted	1725	[redacted]

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

USAPA V1.00

blw-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15	16	17	18	19	20
25NOV	[redacted]	VS-Routine	06	[redacted]												
9DEC			18													
			06													
25NOV	[redacted]	Regular Diet	06													
9DEC		(ADD SALT TO DIET)	18													
25NOV	[redacted]	Daily Dry dsg Δ (R) leg	10													
		+ buttocks														
25NOV	[redacted]	Upad Lib & crutches	06	[redacted]												
9DEC		NWB RLE	18													
26NOV	[redacted]	Elevate (R) leg	06													
			18													
			06													
4DEC		Braden Scale Q7 days	06													
			18													
12/9	[redacted]	Document I&O output	6													
9DEC		~~NPO~~ QS	18													
9DEC		Drsg Δ (R) thigh, BID, dry	18													
			22													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) Femur Fx (R) tibia Fx / 5th finger Amp.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted]

Rewritten blw-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

MEDCOM - 24300

b(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
09 DEC	[redacted]	NPO p MN	09 DEC	0001	—	[redacted]
12/10	[redacted]	NPO p MN	10 DEC	0001	—	
12/11	[redacted]	Resume Pre-Op Orders, Meds, Activity & Diet	11 DEC	1200	—	[redacted]
14D[redacted]	[redacted]	Remove staples @ small Engr	14 Dec	—	—	[redacted]
14Dec	[redacted]	CBC Now	14 Dec	Now	—	[redacted]
14Dec	[redacted]	Add salt to diet	14 Dec	noted	—	[redacted]

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

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	31	1	2
25 NOV	[redacted]	VS Routine	06 18	[redacted]												
			18 06													
25	[redacted]	Reg diet. add salt	06 18													
			18 06													
25	[redacted]	UP ad lib C	06 18													
		crutches NWB RLE	18 06													
26 NOV	[redacted]	Elevate (R) leg	06 18													
			18 06													
09 DEC	[redacted]	Dsg Δ (R) thigh, BID,	06 18													
		dry	18 06													
04 DEC	[redacted]	Braden scale q 7 days	06 18				/	JR	/					/	DH	/
			18 06				/	/	/					/		/
26 DEC	[redacted]	Record output JP q	06 18						[redacted]							
		shift	18 06					/								
28	[redacted]	Daily dry dsg Δ to	10										[redacted]			
		RLE	/													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) Femur Fx (R) TIBIA Fx / 5TH FINGER Amp.

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

b(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25DEC	[redacted]	NPO p MN → OR 26 DEC	26DEC	0001	0001	[redacted]
26 DEC	[redacted]	Resume pre op orders, meds, act. & diet	26			[redacted]
26	[redacted]	Dressing Δ, day, 48°	28 DEC			
NTW	[redacted]	NPO p MN	2Dec	0001		

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

USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6									
25 Nov	[redacted]	VS Routine	06 18	[redacted]												
			18 06													
25	[redacted]	Reg diet - add salt	06 18													
			18 06													
25 Nov	[redacted]	Up ad lib c crutches	06 18													
~~26 Nov~~ 27th		NWB RLE	18 06													
26 Nov	[redacted]	Elevate (R) Leg	06 18													
			18 06													
04 Dec	[redacted]	Braden Scale Q7 days	06 18	/				/		/					/	
			18 06	/				/		/					/	
28	[redacted]	Daily dsg Δ to RLE	10	DICD												
3 JAN	[redacted]	Keep leg in knee	6	[redacted]												
		immobilizer	18													
3 JAN	[redacted]	Dsg Δ begin 1-5-03	10	/	/	[redacted]										
		WTD c Kerlix,	~~22~~	/	/											
			/													
3 JAN	[redacted]	CL care & sterile drsg	10	/	[redacted]	/	/		/	/		/	/		/	/
		Δ's Q3D°														
4 JAN	[redacted]	NIO: Falls risk assessmt	10	[redacted]		/					/		/			
		QTD or PRN	/													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) Femur Fx
(R) tibia Fx / 5th finger amp.

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

Verity 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
3	[redacted]	Resume prevog orders				
	----	b(6)-2				

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

USAPA V1.00

b16)-2 A1

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 23	24
23 Jan 04	[redacted]	Foley	06	✓	[redacted]
			18		[redacted]
23 Jan 03	[redacted]	US Routine	06	✓	[redacted]
			18		[redacted]
23 Jan 03	[redacted]	Chest tube x2 to 20	06	✓	[redacted]
		Suction continuous	18		[redacted]
23 Jan 04	[redacted]	NG to LIS irrigate	06	✓	[redacted]
		30ml h2o q 4°	18		[redacted]
23 Jan 04	[redacted]	CXR q AM	06	✓	[redacted]
			18		[redacted]
23 Jan 04	[redacted]	ABG P vent ∆'s	06	✓	[redacted]
			18		[redacted]
23 Jan 04	[redacted]	CBC, Chem8 - Chem12	06	✓	[redacted]
		PT/PTT, ABG	18		[redacted]
23 Jan 04	[redacted]	vent 800 TV - Peep 5 - FIO2/100	06	✓	[redacted]
		RR-18	18		[redacted]
23 Jan 04	[redacted]	TRACH CARE	06	✓	[redacted]
			18		[redacted]
23 Jan 04	[redacted]				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW Respiratory Arrest, CPR

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Jan Yr ~~2003~~ 2004
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23Jan	[redacted]	CXR NOW	23Jan04	2200	2200	[redacted]
23Jan	[redacted]	ABG NOW F T Pvent ds	23Jan	2200	200	[redacted]

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

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12 Nov 03	[redacted]	IV: LR @ 125cc/hr	06	[redacted]													
	-----		18														
			06														
12	[redacted]	Ancef 1 gram IVPB q	06	[redacted]													
	-----	8°	14														
	-----		22														
12	[redacted]	Gentamycin 400mg	14	[redacted]													
	-----	IVPB q day															
11/13/6	[redacted]	Heplock IV when	06	[redacted]													
	[redacted]	taking po. well	18														
			06														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN @ FEMUR FX, @ TIBIA FX @ 5F AMPUTATION

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 11 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
		b(a)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
12NOV	[redacted]	Nerd 65mg po q 4° prn	D/T	13NOV 1730												
			D/I	[redacted]												
12	[redacted]	Percocet tabs 1-2 po q 4-6° prn	D/T	17NOV 1700	13NOV 1600	17NOV 1200	18NOV 1100	19NOV 1705	19NOV 1100	19NOV 1907	20NOV 1030	20NOV 1945	21NOV 0815	21NOV 1910	22NOV 0735	22NOV 1645
			D/I	[redacted]												
12	[redacted]	MSO4 2.6mg IVP q 2° prn	D/T													
			D/I													
12	[redacted]	Percocet tabs 1-2 po q 4-6° prn	D/T	22NOV 2246	23NOV 0530	23NOV 1700	23NOV 0400									
			D/I	[redacted]												

*U.S. GPO: 1998-454-110/95216

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 01 Yr. 00

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	00	21	22	23	24				
15	[redacted]	COLACE 100mg PO BID	08	[redacted]													
			20														
15	[redacted]	AMIKACIN 1.2gm IV QD	10	[redacted]													
15	[redacted]	ZYVOX 600mg IV QD	10	[redacted]													

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P (B) FEMUR FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*					Mo. Jan Yr. 04
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**	

	-----	b(6)-2 A71					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15	[redacted]	Percocet 1/1 PO q 4° PRN	16 Jan 0400 1/1 PO	16 Jan 0115 1/1 PO	17 Jan 2030 1/1 PO	18 Jan 2000 2 tab	[redacted]	19 Jan 0200 1/1 PO	20 Jan 1204 1/1 PO	20 Jan 1800 1/1	21 Jan 2000 2 tab	21 Jan 1330 2 tab	[redacted]	21 Jan 2000 1/1 PO	22 Jan 0830 1/1 PO	22 Jan 0400 1/1 PO
-----	-----	Pain or Temp > 100.5	[redacted]													
15	[redacted]	Demerol 50-75 mg IV q 4°														
-----	-----	PRN BREAKTHROUGH														
15	[redacted]	Phenergan 25 mg IV	22 Jan 0450													
-----	[redacted]	q 6° PRN NAUSEA	[redacted] 25 mg													
15	[redacted]	Ambien 10 mg PO q HS														
-----	[redacted]	PRN														
15	[redacted]	Percocet 1/1 PO q 4 PRN		23 Jan 1200	24 [redacted] 0815											
-----	-----	Pain or Temp > 100.5	23 Jan 0400 1/1 PO	[redacted]												
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	1	2	3	4	5	6	7	8
25Nov03	[redacted]	Ancef 1 gram IVPB Q	06	/	[redacted]												
	-----	8°	14	/	[redacted]												
	-----		22	[redacted]													
25Nov03	[redacted]	Gentamycin 400mg IVPB	10	/	[redacted]												
	-----	Q Day															
25Nov03	[redacted]	Heplock IV when taking PO	06-19	/	[redacted]												
	-----	well	18-06	[redacted]	DC SEE PSUM												
26	[redacted]	IV LR @ 150 cc/hr	06	/	/	[redacted]											
	-----	hep lock when taking PO	18	/	[redacted]												
	-----	Well	/														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) femur fx / (R) Tibia fx / (R) 5th finger Amp.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4070 — MEDCOM-24312

bled-2 A11

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. ____ Yr. ____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
27	[redacted]	T+C 2u PRBC	27th	—	[redacted]	
27	[redacted]	Transfuse 2u PRBC over 4	27th	not 17 43	[illegible]	[illegible] 03 003835P
		hrs each.				
27th	[redacted]	Benadryl 25mg IV prior to	27th		1635	[redacted]
		Transfusion				
27th	[redacted]	Tylenol 650mg PO now prior	27th	now	1630	[redacted]
		to transfusion				
27 NOV 03	[redacted]	VSP A				

Order/ Expir Date	Clerk/ N	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
26 Nov 03	[redacted]	Tylenol 650mg PO Q	D/T	27 22	30 NOV 2000	3 DEC 2015	7 DEC 1900										
		4° PRN	D/I	[redacted]													
26 Nov 03	[redacted]	Percocet tabs 1-2 PO	D/T	27 NOV 1400	27 1930	28 NOV 0550	29 NOV 2246	30 NOV 0330	1 DEC 1000	1 DEC 1640	1 DEC 1970	2 DEC 1100	3 DEC 1200	4 DEC 1340	4 DEC 2030	7 DEC 1400	7 DEC 2100
		Q4-6° prn	D/I	[redacted]													
26 Nov 03	[redacted]	MSO4 2-6mg IVP Q2°	D/T	ORDER													
		prn	D/I														
26	[redacted]	MSO4 2-8mg	D/T														
		IVP Q1hr PRN	D/I														
1		Percocet tabs 1-2 PO	D/T	3 DEC 0550													
		Q4-6 PRN	D/I	[redacted]													
26 NOV	[redacted]	Percoset Tabs 1-2 PO q4-6° prn	D/T	3 DEC 1320													
			D/I	[redacted]													

*U.S. GPO: 1998-454-110/95216

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13	14	15	16	17	18	19	20	21	22
25NOV	[redacted]	Ancef 1gram IV PB	06	[redacted]													
	-----	@8°	14														
	-		22														
25NOV	[redacted] -	Gentamycin 400mg IVPB	10	[redacted]													
	-	QD															
26NOV	[redacted] -	IV LR @ 150cc/hr	06	[redacted]													
	-----	heplock when taking	1[redacted]														
	--	PO well															
9DEC	[redacted]	HLIV:	6	/	[redacted]												
	-		18	/													
9DEC	[redacted]	Colace 100mg PO BID	08	/													
			20	/													
9DEC	[redacted]	Levoquin 500mg IV	08	/													
	[redacted] -	QD	/	/													
15DEC	- [redacted]	AMBIEN 10mg PO QHS	22						/	[redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) femur fx (R) finger 5th finger Amp. (R) tibia Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

b(6)-4 [redacted] Rewritten

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. 12 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5 Dec	[redacted]	Ambien to 10mg po qHS	15	—		[redacted]
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
26Nov	[redacted]	Tylenol 650mg PO	D/T														
		Q4 PRN	D/I														
26Nov	[redacted]	Percocet tabs 1-2 PO	D/T	9Dec 0830	9Dec 0300	11Dec 1100	11Dec 2200	12Dec 2100	13Dec 1125	16Dec 1130	19Dec 0900	21Dec 2000					
		Q4-6 PRN pain or T>100.5	D/I	2	HPO	TT	TT	TT	TT	2	HPO	TT					
			D/T	[redacted]													
			D/I														
26Nov	[redacted]	MSO4 2-8mg IVP	D/T		D/C'd 9Dec												
		Q 1hr PRN	D/I														
9Dec	[redacted]	Demerol 75mg IV q4° prn breakthrough	D/T														
			D/I														
9Dec	[redacted]	Phenergan 25mg IV q6° prn nausea	D/T	D[redacted] 1100													
			D/I	2553 D													
9Dec	[redacted]	Ambien 10mg PO QHS prn insomnia	D/T/I														

*U.S. GPO: 1998-454-110/95216

b(6)-2

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

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	12	13	14	15
23	[redacted]	HLIV	6	[redacted]									
	-----		14	[redacted]									
	-----		22	[redacted]									
23	[redacted]	Colace 100mg po BID	08	[redacted]									
	-----		20	[redacted]									
23	[redacted]	Ambien 10mg po QHS	22	[redacted]									
23	[redacted]	Vancomycin 1.0 gm	10	[redacted] DC 10 JAN									
	[redacted]	IVPB Q12	22	[redacted]									
23	[redacted]	Amikacin 1.2 gm	08	[redacted]									
	[redacted]	IV QD	/										
10 JAN	[redacted]	Zyrox 600mg IV QD	10	[redacted]									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) femur fx (R) TIBfx (R) finger (5th) Amp

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

Rewritten

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	

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

MEDCOM - 24316

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 01 Yr. 04
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 JAN	[redacted]	D/C Vancomycin Restart zyvox 600mg IV QD	10 JAN	1000	—	[redacted]
		b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
23	[redacted]	Tylenol 650mg po q4° prn	D/T/1	13 Jan 650mg 0830 [redacted]												
23	[redacted]	Percocet tabs 1-2 po q4-6° prn pain or T>100.5	D/T/1	9 JAN 2030 ++ [redacted]	10 JAN 1645 ++ [redacted]	9 JAN 1030 T	12 Jan 1630 ++	(3) Jan 0000 ++ [redacted]								
23	[redacted]	Demerol 75mg IV q4° prn breakthrough	D/T													
			D/1													
23	[redacted]	Phenergan 25mg IV q6° prn n/v	D/T													
			D/1													

*U.S. GPO: 1998-454-110/95216

b/w-2th

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 23	24	25	26	27	28	29	30	31	1	2	3	4	5
23	[redacted]	HL IV	06	[redacted]													
			18														
23.	[redacted]	Colace 100mg PO	08														
		BID	20														
23	[redacted]	Levaquin 500mg IV	08														
		QD															
23	[redacted]	Ambien 10mg PO	22	[redacted]													
		QHS															
26 Dec 03	[redacted]	Nystatin oral susp.	08														
		swish and swallow 2	16														
		tsp PO TID	24														
23	[redacted]	Zyvox 600mg IVQD	08														
		(NTO: Give over 1-2 hrs.	/														
		must pick up from Pharmacy	/														
		Incompatible c̄ most drugs)	/														
3/PM	[redacted]	Vancomycin 1.0 gm	10														
		IVPB q12	22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) femur Fx (R) tib fx (R) finger 5th. Amp.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: Rewritten

[redacted]

b/w-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 — ITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED

MEDCOM - 24318

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 12 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
30Dec	[redacted]	D/C Levaquin	12-30	—		[redacted]
		b(4)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23	[redacted]	Tylenol 650mg PO	29Dec 1500													
		Q4 PRN	[redacted]													
23	[redacted]	Percocet tab s 1-2	30Dec 1700	24Dec 1300	24Dec 1850	25Dec 2345	26Dec 2000	28Dec 2030	28Dec 1325	29 Dec 0815	31 Dec 0840	31Dec 2160	1Jan 1575	2Jan 2300	3Jan 2100	4Jan 1000
		po Q4-6 PRN pain	[redacted]													
		or temp >100.5														
23	[redacted]	Demerol 75mg IV														
		Q4° PRN breakthrough														
23	[redacted]	Phenergan 25mg IV														
		Q6° PRN nausea.														

*U.S. GPO: 1998-454-110/95216

b(6)-2 A11

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25
23 Jan 04	[redacted]	IV LR @ 150 ml/hr 125/hr	06	/	[redacted]	
	-----		18	[redacted]		
23 Jan 04	[redacted]	IV Fentanyl gtt	06	/	[redacted]	
	-----	Titrate	18	[redacted]		
23 Jan 04	[redacted]	Hold sedation for now	06	/	[redacted]	
	-----		18	[redacted]		
23 Jan 04	[redacted]	Zosyn 3.375g IVPq 8°	06	/	[redacted]	
	-----		14	/	[redacted]	Δd 24 Jan 04
	-----		22	[redacted]		
23 Jan 04	[redacted]	Zantac 50mg IVPq 8°	06	/	[redacted]	
	-----		14	/	[redacted]	
	-----		22	[redacted]		
24 Jan 04	[redacted]	Zosyn 3.375g IVPq6°	06	/	/	
	-----		12	/	[redacted]	
	-----		18	/	[redacted]	
	-----	[redacted]	24	/		
1/24/04	[redacted]	VALPROIC ACID	06	X	[redacted]	
	[redacted]	400MG NGT bid	14	X	[redacted]	
	-----		22	X		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW Respiratory Arrest, CPR

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-2

20/[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

HERNANDEZ RN

MEDCOM - 24320

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Jan Yr. 04
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
1/24/04	[redacted]	LABETALOL 40 mg IVP			1500	[redacted]
		b(6)-2				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1/23	[redacted]	Labetalol 20mg IVP	1/24 1440													
		for systolic BP > 180														

*U.S. GPO: 1998-454-110/95216

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: **POST-ANESTHESIA CARE UNIT (PACU) FLOW SHEET**

OTSG APPROVED (Date)

DATE: 12 Nov 03

TIME IN: 0545

PROCEDURE: Ex Fix (R) Femur 5th digit Amputation

PRE-OP VS: 155/81 98

TYPE ANESTHESIA: GEN SAB EPIDURI NERVE BLOCK IV SED.

OR INTAKE: Crystalloid: 1000 Colloid 500

OR OUTPUT: Urine Output 800 EBL 150

30 mPop Pre-Op
3 cefazolin
10 Reglan
20 decadron

INTAKE						OUTPUT			
TIME	SOLUTION	Amt. Hung	SITE	BY	Amt. Infused	TIME	SOURCE	COLOR	AMT
ADM.	LR	400	(R) EA	MS					
X-RAYS DONE:					LABS DRAWN:				

TIME	0545	0550	0555	0600	0605
FO_2	40	40	40	40	40
O_2 SAT	97	98	99	97	100
TEMP			96.0		
BP by Cuff					
Heart Rate					
RESP	20	18	24	24	18
LOS					

BP by Cuff ✓ Heart Rate ^

REACT SCORE	IN	30 Min	OUT
ACTIVITY SCORE			
(R)espirations: 0 Ventilator essential; 1 Spont. resp. <10/min: airway essential; 2 Spont. resp.: no support >10/min	2	2	2
(E)nergy 0 Does not move legs; 1 Moves legs, cannot sustain head lift; 2 Sustains head lift, moves legs	0	1	1
(A)lertness 0 Awakens only with vigorous stimulation; 1 Awakens only with stimulation gently; 2 Awake, seldom dozes	1	2	2
(C)irculation Adults 0 BP 20% pre-anesthesia level; 1 BP 20–50% pre-anesthesia level; 2 BP 50% pre-anesthesia level	2	2	2
Infants 0 Carotid only reliable pulse palpable; 1 Axillary pulse felt feet but not wrist; 2 Pulse can be felt easily at wrist			
(T)emperature 0 Axillary temp. <95 F; 1 Temp. 95–96 F; 2 Temp. >96 F	2	2	2
	7	9	9

* LOS Level of Sensation

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: WARD 2-D

DATE

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

Adult Iraqi #2 surgical pt.

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 76 4700

MEDDAC FBg OP 173 (Revised) 1 Nov 89 (HSXC-NU)

INITIAL ASSESSMENT:

LEVEL OF CONSCIOUSNESS:
- Alert
- Responsive
- Unresponsive

AIRWAY: Open
- Nasal
- Oral
- Endotracheal
- Tracheostomy

OXYGEN
- Hudson Mask 40%
- Oxygen Mist
- Nasal Cannula
- Room Air

DRAINS Ø
- Hemovac
- Jackson-Pratt
- N/G
- Foley

SIGNATURE:

MEDICATIONS

ALLERGIES:

Time	Medication/AMT	Route/Site	BY

NURSES NOTES: At on monitor - ST 100's POx 97-98%. FM 40% FiO2. lethargic. Irritable & Stimulable (+) Cap refill <2 to affected extremity (+) DP BBS & Rhonchi Ø % pn. Report given to Ambulance Crew. On Mark on POx 100%. Ø S/S bleeding to extremity. [redacted] AN

b(6) - 2

DRESSINGS

SITE	TYPE	DRAINAGE

CBI INFORMATION

TIME	CBI IN	URINE OUT	COLOR	URINE BAL

PACU FLUID TOTALS

CRYSTALLOID IN		URINE OUTPUT	
COLLOID IN		EMESIS	
P.C		NG TUBE	
		JP DRAIN/HEMOVAC	
TOTAL INTAKE		TOTAL OUTPUT	

DISCHARGE CRITERIA Time: Date:

REACT Score:

VS: BP / R HR T

Cleared according to WARD 2-D SOP C-2

Charge Nurse 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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 13 NOV 03
Time In: 1317
Allergies: —
Pre-op V/S: 147/78 104
Procedures: I+D R Hand R LE
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1800 Colloid —
OR Output: UOP — EBL —
Meds/Times: Propofol, Fent

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

Pre Op Meds History

Time	1307	1322	1327	1332	1337	1350
SaO2	93	96	96	95	95	94
FiO2	4L	4L	4L	4L		
Methods	NC	NC	RA	NC	NC	NC
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	24	20	33	27	24	23
T	98.3					97.3

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1317	RL	1000	R HAND	D	950

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	1	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	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

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

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

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

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

[redacted] ture & Title) b(6)-2 [redacted]

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/13/03

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

[redacted] b(6)-4

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

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	RLE	limited	+	+	B	W	PK
15'	RLE	Limited	Ø	Ø	B	W	PK
30'	RLE	Limited	Ø	Ø	B	W	PK.
45'	RLE	Limited	Ø	Ø	B	W	PK
60'							
90'							
D/C							

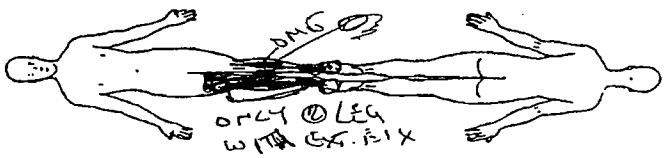
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1317	RLE	ex fix/ace	Ø
30' 1335	RLE	Ext Fix	Ø
60' 1350	RLE	Ext Fix	Ø
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1312	ASPY	yellow.	—
1350	ASPY	yellow	150cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1317	NSR	O	O

NURSING NOTES

Pt received from OR s/p I+D R LE + R Hand. PTSpO2 88%, NC put on 4L/min. SpO2 ↑ 96%, no c/o pain

1325. Pt easily arousable to light touch and verbal stimuli - foley patent. NC @ 4L O2. SpO2 at 95%. Pt has bilateral chest movement, breath sounds clear, bowel sounds present. Encouraged deep breathe & incispirometer. Ⓡ Ext Fix & lower leg and thighs intact. Ⓡ foot

1350 Pt transferred to TCU2, report given to SPC Jackson [redacted]

b/w-2 A/1

Discharge Criteria:
Date: 11/13/03 **Time:** 1350 **PARS:** 10
BP: 125/81 **T:** 97.3 **HR:** 99 **RR:** 24 **Sa02:** 94%
Pain Level at D/C (0-10):
Intake: 50cc NL **Output:** 150cc urine
Additional Data: —
Transferred To: TCU I [redacted]
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatu [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

DTSG APPROVED (Date)

Date: 15 Nov 03
Time In: 1030
Allergies: NKA
Pre-op V/S: 118/70 96
Procedures: R) DB wrist

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 300 EBL
Meds/Times: Fentanyl, MSO4

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1030	1035	1040	1045	1050											
SaO2	98	96	97	96	97											
FiO2																
Methods	RA	RA	RA	RA	RA											
240																
220																
200																
180																
160																
140	✓	✓	✓	✓	✓											
120																
100																
80	•	•	•	•	•											
60	✓	✓	✓	✓	✓											
40																
20																
RR	16	14	16													
T	98.2															

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1030	LR	700	R) Arm	DC	800

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREP [redacted] LAC b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Nov 03

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

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	LROM	+	+	B	W	PC
15'							
30'							
45'							
60'							
90'							
D/C							

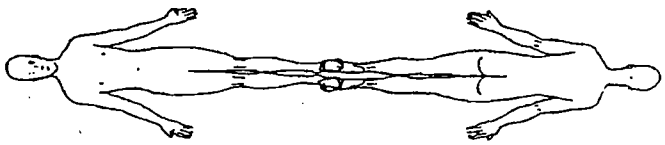
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Ext-fix c	Mod
30'		Kerlix	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
10:50	SR	-	-

NURSING NOTES

A to recovery room from OR s/p HD (R) leg. Kerlix c ext fix to (R) leg intact. Mod drainage noted to (R) leg. NVS intact. IV of LR infusing into (R) Arm. VS [redacted] will continue to monitor [redacted]

b(6)-2 All

Discharge Criteria:
Date: 15 Nov **Time:** 1180 **PARS:** 9
BP: 150/82 **T:** 96 **HR:** 93 **RR:** 162 **Sa02:** 94
Pain Level at D/C (0-10):
Intake: 100 **Output:** -0-
Additional Data:
Transferred To: ICW1
Report Given To: [redacted]
Transferred Vi [redacted] **mbulance**
Transferred By: [redacted]
Cleared IAW Recovery Ro [redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 26 Nov
Time In: 1930
Allergies: NKDA
Pre-op V/S: 122/62 88
Procedures: ORI of (R) distal femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2300 Colloid 500
OR Output: UOP Ø EBL 500
Meds/Times: Fent 100mcg; MS04 10

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1930	1935	1940	1945	2000	2005
SaO2	97	96	97	99	93	99
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140		✓				
120	✓		✓	✓		
100				✓		
80			^		^	
60	^			^		^
40		^				
20						
RR	23	21	25	22	27	29
T				98		99

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1930	LR	150	(R) hand	[illegible]	100
1950	H2O	150	PO	[illegible]	150

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b(6)-2 [redacted] (Typed or written entries give: Name — last, first, middle; grade; date; hospital or medical facility)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Nov 03

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1935		5mg MSO4	IVP		I	[redacted]
1950		3mg MSO4	IVP		I	
2035		2mg MSO4	IVP			

NEUROVASCULAR

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

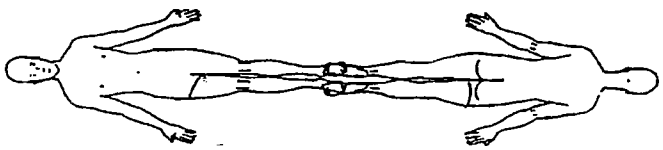
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	RLE	acewrap	Ø
30'	" "	"	Ø
60'			
D/C	" "	"	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2020	Foley	yellow clear	160

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1930	ST	Ø	Ø

WAMC OP 173-E

NURSING NOTES

1930: Pt arrived to PACU via gurney from OR in stable condition. C/o pain & given 5mg MSO4. will cont. to monitor. [redacted] AM

2020: Report called to floor & pt transfered via gurney in stable condition. [redacted] PN

Discharge Criteria:
Date: 24 Nov **Time:** 2020 **PARS:** 10
BP: 115/64 **T:** 97.4 **HR:** 116 **RR:** 23 **Sa02:** 95%
Pain Level at D/C (0-10):
Intake: 2300 **Output:** 160
Additional Data:
Transferred To: ICW 1 [redacted]
Report Given To: SPC [redacted]
Transferred Via: W/C ~~Litter~~ ~~Gurney~~ Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted] IAW

b(6)-2 A11

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: 9 Dec 03
Time In: 1315
Allergies: 107/42 91 ↘
Pre-op V/S: NKDA
Procedures: I+D R Knee, JP drain

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP 0 EBL <50
Meds/Times: 250mcg Fent 20mg MSO4

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1315	1320	1325	1330	1335
SaO2	95	95	95	95	95
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	18	19	13	19	19
T	96.5				

Time									
Pain (0-10)									
LOS									

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	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	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes

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

V/S: X = A-line BP, * = Cuff BP, = Pulse

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

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 09 Dec 03

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

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	R Knee	limited	+	+	B	W	PK
15'	R Knee	limited	+	+	B	W	PK
30'	R Knee	limited	+	+	B	W	PK
45'							
60'							
90'							
D/C	R Knee	limited	+	+	B	W	PK

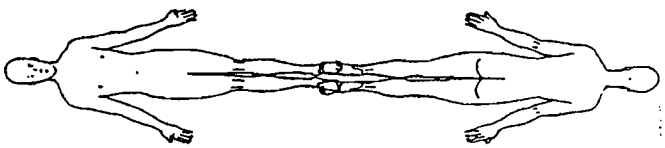
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1315	R Knee	Iodoform	O
30' 1345	R Knee	"	O
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1315	NSR	O	O

NURSING NOTES

PT RECEIVED FROM OR S/P I+D R KNEE. PT VSS, NO C/O PAIN, SPO2 95% RA, PT AWAKE UPON ARRIVAL. Report given to Sgt [redacted], VSS, NO C/O PAIN [redacted] SPO2 96% RA. Sgt [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 9 Dec 03 **Time:** 1345 **PARS:** 10
BP: 124/82 **T:** 96.5 **HR:** 96 **RR:** 16 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: — **Output:** —
Additional Data: —
Transferred To: ICW1
Report Given To: Sgt [redacted]
Transferred Via: W/C [redacted] ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse 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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 11Dec03
Time In: 0946
Allergies: NKDA
Pre-op V/S: 114/66 94
Procedures: I+D ⊕ Le

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

OR Intake: Crystalloid 1360 Colloid
OR Output: UOP — EBL min
Meds/Times: Propofol, Fent, MSO4

700 Fent
20 MSO4

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

Pre Op Meds

History

Time	0946	0951	0956	1001	1006
SaO2	98	99	95	94	95
FiO2	RA	RA	RA	2L	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	14	12	14	15	12
T	96.2				

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11Dec03

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

[redacted]

b(6)-4

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

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	RLE	limited	+	+	B	W	PK
15'	RLE	limited	+	+	B	W	PK
30'	RLE	limited	+	+	B	W	PK
45'							
60'							
90'							
D/C	RLE	limited	+	+	B	W	PK

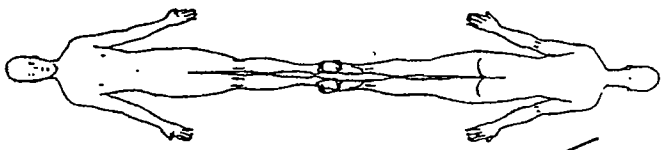
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, PK = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 0946	RLE	ace	G
30' 1016	RLE	ace	O
60'			
D/C 1026	RLE	ace	G



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0946	NSR	O	O

NURSING NOTES

Pt received from OR s/p I+D RLE. SpO_2 97% RA, no c/o pain, pt awake and talking. Report given to Lt [redacted] + [redacted] No c/o pain. VSS SpO_2 97% RA. Sgt [redacted] LPN

b(6)-2 A11

Discharge Criteria:
Date: 11Dec05 **Time:** **PARS:** 9
BP: 124/60 **T:** 96 **HR:** 95 **RR:** 12 **Sa02:** 96%
Pain Level at D/C (0-10):
Intake: — **Output:** —
Additional Data: —
Transferred To: TCW
Report Given To: Lt [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room S[redacted]
Charge Nurse 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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 26 Dec 03 Anesthesia Type (Circle)): General Spinal Epidural endot
Time In: 1825 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 700 Colloid
Pre-op V/S: 119/103 92 OR Output: UOP 0 EBL min
Procedures: Meds/Times: 50mcg Sul. 30 tramadol
1% D (R) knee reconst. lat tib plateau

Drains: Hemovac, ~~NG~~, JP, ~~Tube~~, Foley, TLS — Knee

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1820	1830	1835	1840	1845	1910
SaO2	95%	97%	97%	98%	98%	97%
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120	V	V	V	V	V	V
100						
80	•	•	•	•	•	•
60	∧	∧	∧	∧	∧	∧
40						
20						
RR						
T	96.1		96.8		97.3	

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	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	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

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

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

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

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

PREPARED BY (Signature & Title): [redacted] LTC

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Dec 03

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

32yom Smoker

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1900	6	MsO4 2mg	IVP	3	E	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	+	+	P	B	W	Pk
15'	(R) leg	+	+	P	B	W	Pk
30'	(R) leg	+	+	P	B	W	Pk
45'	(R) leg	+	+	P	B	W	Pk
60'							
90'							
D/C	(R) leg	+	+	P	B	W	Pk

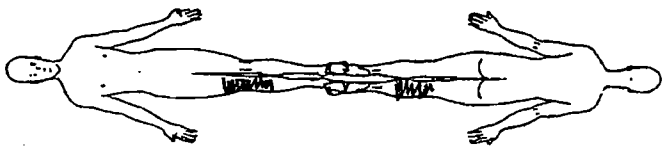
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) knee	ace	JP min
30'	(R) knee	ace	JP min
60'			
D/C	(R) knee	ace	JP min



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1835	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

1825- pt arrived via gurney arousable but sleepy. denies pain. moves all extr ~ difficulty. JP to (R) knee sang. drainage Ø foley. Sats 96-100% on RA. [redacted]
1835- pt awoke. removed own nasal trumpet. maintaining own airway ~ difficulty sats 96-100% RA [redacted]
1900 pt c/o (R) knee pain ~6/10 given 2mg MsO4 IVP - c August
1915- report called pt stable — [redacted]

Ø (Ce) - 2 A11

Discharge Criteria:
Date: 26 Dec 08 **Time:** 1915 **PARS:** 10
BP: 114/73 **T:** 97.2 **HR:** 86 **RR:** 14 **Sa02:** 97%
Pain Level at D/C (0-10):
Intake: 20cc H2O **Output:** Ø
Additional Data:
Transferred To: ICW1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 03 Jan 04
Time In: 1078
Allergies: NKDA
Pre-op V/S: 99/SS 97
Procedures: I&D @ Knee
C.L. placement

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP — EBL 250
Meds/Times: 2.5 Versed 250mcg Fent 10mg MSO4

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

Pre Op Meds History

Time	1028	1033	1038	1043	1048
SaO2	99	97	96	97	97
FiO2					
Methods	RA	RA	RA	RA	RA
RR	12	17	17	9	16
T	98				
Time					
Pain (0-10)					

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1030	LR	50			

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	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
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	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ~~03 Jan 04~~ PACU

DATE: 03 Jan 04

Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1044		2mg MSO4	IV			[redacted]
1057		2mg MSO4	IV			

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Rleg	limited	+	+	B	W	PK
15'	Rleg	"	+	+	B	W	PK
30'	Rleg	"	+	+	B	W	PK
45'							
60'							
90'							
D/C	Rleg	"	+	+	B	W	PK

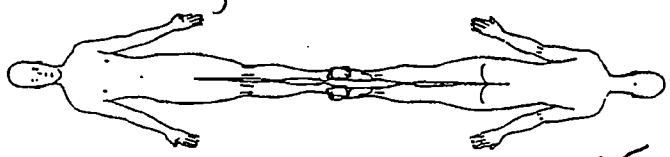
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1028	R leg	Kerlex	—
30' 1058	R leg	Kerlex	—
60'			
D/C 1102	R leg	Kerlex	—



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1028	NSR	—	—

WAMC OP 173-E

NURSING NOTES

Received pt from OR s/p I+D R leg + central line placement. SpO2 99% RA, pt arousable to verbal, states he has pain. Maj Cherry at bedside to give more MSO4. CXR ordered for CL placement. CXR done, read by Maj Cherry, ~~ta~~ CL is in the correct placement, ports flushed c̄ NS and LR hung through brown port. Report given to Cpt [redacted] SPC

b(6) 2 A11

Discharge Criteria:
Date: 03Jan04 **Time:** 1100 **PARS:** 9
BP: 114/72 **T:** 96.8 **HR:** 89 **RR:** 19 **Sa02:** 97
Pain Level at D/C (0-10):
Intake: 50 **Output:** —
Additional Data: —
Transferred To: ICU
Report Given To: Cpt [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse 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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 18 Jan 04
Time In: 1455
Allergies: —
Pre-op V/S: 117/67 113
Procedures: 5 SCG LD (R) Knee
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 LR Colloid —
OR Output: UOP — EBL Ø
Meds/Times: SCC Fent 100 mg MSO4 1

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

Pre Op Meds / History

Time	1455	1500	1505	1510	1520											
SaO2	94	94	95	95	95											
FiO2	RA	FT	RA	RA	RA											
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	20	15	21	20	15											
T	151															

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1520	LR	100	(R) AR	EV	

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 18 Jan 04

[redacted] ...itten entries give: Name – last, ...e; date; hospital or medical facility)

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) foot	+	+	P	B	W	PK
15'	(R) foot	(+)	(+)	P	B	W	PK
30'	(R) foot	(+)	(+)	D	B	W	PK
45'							
60'							
90'							
D/C							

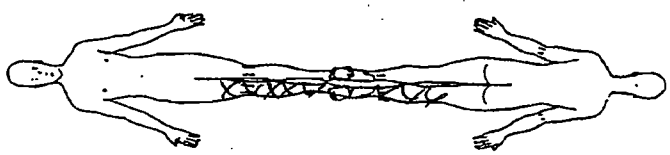
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm (R) LE	(R) LE	bulky	Ø
30' (R) LE	(R) LE	bulky	Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1500	ST	Ø	Ø

WAMC OP 173-E

NURSING NOTES

pt recieved from OR @ 1455 pt c̄ STSG to (R) knee c̄ (R) thigh as donor site pt doing well @ this time will monitor for Δs — [redacted]

b(6)-2

Discharge Criteria:
Date: 16 Jan **Time:** 1525 **PARS:** 10
BP: 126/40 **T:** 101.0 **HR:** 120 **RR:** 13 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: 100 **Output:** Ø
Additional Data: None
Transferred To: ICW 2
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW: [redacted]
Charge Nurse: [redacted]

b(6)-2

b(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Loca. IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-2		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1971-01-01	7. Age at Admission 32Y	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number 000-00-1290	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 06:35	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma Inj	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2004-01-24		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-12		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-12		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: R LEG EX FIX, 5TH DIGIT AMP

Procedure Narrative(s):

T: 9
Inj: 569

Dx: 82130
99832
82310
8860
8911
8770
6869
4580
34690
E9912

PR: 8674
7815
7845
8016
7935
8628
8604
8401
9357
7965
8309
8604
8669

9788
3893
9904x2

Blood: y

Cause of Injury Narrative: MVA

b(6)-2

Admitting Officer (Signature, as required) [redacted]

[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 24340

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

ise of this form, see AR 40-400, the proponent a is OTSG

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted] b(4)-2	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		X				NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]	b(4)-4	ICW1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
NO	K78-PRISONER OF WAR/INTER			BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	22:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-24

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-12	DOWNEY

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-12	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P I&D MULTI SHRAPNEL WNDS

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	12	12

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0 b(6)-2	0	12	12

Signature of Attending Medical C[redacted] [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

19 year old ♂ who sustained multiple injuries from GSW(?) under unclear situation

PMHx Ø
PSHx Ø
meds Ø
NKDA
Ø tob
Last meal @ 2030

PHYSICAL EXAMINATION

P 88 BP 108/55 RR
NCAT
PERLA
Neck sutures ML
abd soft non tender
Distal pulses +2 symmetric
(L) post chest / m
(+) (L) scrotal laceration / medial (L) buttock
multiple (R) posterior thigh puncture
(R) medial distal thigh
(R) post medial calf
(L) heel (R) plantar

PROGRESS (Enter date of discharge and final diagnosis)

Dx: Multiple shrapnel wounds
to CT pelvis
to OR f scalp Exploration

CXR (–) PTX
abd multiple lacs
pelvic fracture
testicular US – intratesticular echo of trauma

[redacted] b(6)-2

DATE	IDENTIFICATION NO.	ORGANIZATION

PAT[redacted] (Patient entries give Name, last, first, middle, grade, rate; hospital or medical facility)

REGISTER NO.	WARD NO.

[redacted] b(6)-4

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

ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE *(YYYYMMDD)*

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

18yo Iraqi male with multiple GSW were for eval,
pmH ⊖
PSH ⊖

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

VSS
Lungs clear
Heart - RR
Abd nontender

Ext → all pulses

(L) arm & forearm large defects
(L) hip x3 L anterior 4th 8 rib
(L) midthigh R lower leg R upper thigh
L ankle R med thigh

4. IMPRESSION *(Enter admission note with plan on progress notes)*

Imp - multiple GSW c̄ large arm lac
plan - OR

5. ADMITTING O[redacted] b(6)-2

a. SIGNA[redacted]

b. DATE SIGNED *(YYYYMMDD)*
11/12/3

6. D[redacted] *procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0415 13NOV03	RT note: Pt came in from OR, Nurse + Anesthesiologist at bedside. SpO_2 on monitor 77%. Pt was placed on 15L NRB c̄ oral airway. Pt unresponsive but breathing on his own. NT suction via nasal trumpet + suction oral airway c̄ bloody sputum. Narcan given + interpreter called, Pt is in + out of consciousness. ABG drawn @ 0445 7.33/42.1/139/-3/23/99%. Pt followed command to cough. BBS @0450 coarse ⊕ wheezing ⊕ upper airway (coarse snoring) ↓ FiO_2 from 15L → 12L. Pt HR 114, RR 20, breath even + unlabored. BP 129/60. HOB 30°. Will continue to monitor — [redacted] b(4)-2
13Nov03 0705	Neurosurgery (S/O) Exam this AM finds no evidence of L5 or S1 radiculopathy. (A/P) Incidental L5 spondylolysis. Consider Flex/Ext L-spine x-rays when patient is able to stand.

[redacted] b(4)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] EPW-51

b(4)-4

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 b(6)-2 A11
13Nov03 0710	Pt received resting comfortably in bed c̄ NRB c̄ IOL. O2 sats 99-100% c̄ audible wheezing noted. V/S stable, See AA 4700 for initial assessment [redacted]
0800	Aml care performed. Pt deep suctioned via nasal trumpet and [redacted] Pt vomited moderate amount. Dsgs changed to sacral area & buttocks. Will continue to monitor [redacted]
1200	Pt continues to rest comfortably in bed s̄ difficulty [redacted]
1345	MSO4 10mg given for c/o pain [redacted]
1400	Dsgs changed to sacral area, buttocks, & back area. Pt [redacted] s̄ difficulty, will continue to monitor [redacted]
1620	Pt given NRO, 4mg for c/o pain [redacted]
1830	Pt given 10mg MSO4 for c/o pain c̄ good effect. VSS. [redacted]
2300	Pt given 4mg MSO4 for c/o pain c̄ good effect. VSS. [redacted]
14Nov03 0030	Pt bathed linen Δ'd, wound dsg's Δ'd except for (B) feet and (L) hip. See wound & skin assessment form. VSS. [redacted]
0230	Pt given 4mg MSO4 for c/o pain c̄ good effect. VSS. [redacted]
14Nov03 0630	Pt received resting comfortably in bed. V/S stable c̄ O2 sats 95-99% on room air. See AA 4700 for initial assessment [redacted]
0800	Dsgs Δ'd by Dr. [redacted] MSO4 5mg given IVP. Aml care performed, report to be given to ICW1 [redacted]

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14NOV03@1100	Assumed care of pt. @ 0850, transfer from ICU. Temp 100, tachy-115. Other V.S.S. Pt. received 2mg MSO4 prior to transfer. Pt. given ii T3's for pain & fever. Pt. has multiple GSW's to soft tissue in LE bilat. Large dressing to (L) buttocks & thigh. DRY dressing Δ's done this AM in ICU, large amount of sero-sang drainage to wounds. Pt. unable to move (L) LE, (+) pulses to all extremeties, (+) sensation to all extremeties. Foley intact, draining clear yellow urine. D5 1/2 NS c 20 KCl to (R) AC 20G @ 100cc/h. 18G to (L) AC was occluded & D/C'd. Pt. reported urgency to defecate, pt. placed on bedpan, (-) BM ~ 30 min. Pt. is NPO, sign placed above bed. Pt. given ii T3's for pain @ this time. Will cont. to monitor. Pt. in 2-point restraints, (-) signs of skin breakdown. All other assessments WNL — b(6)-2 [redacted]
14 Nov03	Assumed care of Pt @ 1800 hrs. Pt in pain Tylenol 3 for pain. Drsgs to Bilat legs feet Butteck and on Back. All puncture wound c̄ minimal Drainage. Drsg Δ'd D5 1/2 NS c̄ 20 KCL to (R) AC 20 G @ 100 cc/hr. Will Cont to monitor. — [redacted] b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15NOV03@1800	Assumed care of pt. @0600. V.S.S., A&O, ⅐ T3's for pain in AM. Pt. NPO, LR @100cc/h ⅊ ® AC. FTG → CKU. All dressings Δ'd, MD into assess wounds during DRSNG Δ. Some necrotic tissue to ⅐ puncture wounds to ⓛ buttocks; all other wounds show ∅ signs of infection. Penrose drain intact to ® lower buttocks. Pt. unable to move ⓛLE, ⊕ sensation & ~~pedifoal~~ ~~palpated~~ pulses. Pt. in 2-point restraints, ∅ signs of breakdown to skin. All other assessments WNL. [redacted] ZET. 4N
0015 -	assumed care of pt. @ 1800. VSS - A+O b(6)-2 ⅐ Tylenol #3 given @ 2323. attempted to ambulate pt. to shower. Pt. ~~[illegible]~~ walked about 5ft. + Refused to go any further. Returned pt. to bed. D/C'd foley @ 2300. ∅ urine output @ this time. Conducted drsng Δ's. penrose intact to Buttocks, cleaned all wounds c̄ 1/2 peroxide + 1/2 NS. Pt. tolerated well. Pt. NPO. D5 1/2 NS c̄ 20mEQ @100cc/h infusing ® FA. ⊖ S/S infection. Will cont. to monitor pt. + [redacted] FV I Concur with above assessment [redacted] 2ZN
16NOV03 0650	Pt voided in urinal 400cc of clear, yellow urine ⅐ difficulty. b(6)-2 [redacted] TAL
16Nov	Surgery abeh, NPO body, diet 11/17 cont abx
	[redacted]

STANDARD FORM 509 (REV. 5/1989) BACK

USAPA V1.00

b(6)-4 [redacted] [redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16NOV03	(1650) Pt requested to get on Bedpan. Pt on bedpan. Pt had large, soft, light brown bowel movement. Informed Dr [redacted] b(6)-2 [redacted]
17NOV03	0100 Assumed care of pt @ 0100. LSS-AO 15 CTAB Resp. even unlabored, BS x4, abd. soft non-tender, voiding cyu via urinal. (+) Pedal + Radial pulse. two pt restraints in place. IV (R) FA infusing 100cc/h of D5 1/2 NS c 20meq KCL. IV cdi (-) s/sx infections. conducted dsng Δ's to (L) heel, (R) foot, Back of (L) knee c staples intact, (L) calf wound (+) s/sx inf. c circle of redness on outside of wound, (R) inner thigh, (L) inner thigh, 12in. incision to (L) hip c staples intact c (-) s/sx inf. two shrapnel wound to (L) Buttock Packed c w→D gauze, Incision to lower back c staples intact, two shrapnel wounds to upper back, penrose intact to buttocks draining min drainage. All cleaned c 1/2 NS + 1/2 peroxide. Pt. has [redacted] no complaints @ this time. will cont. to monitor. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME (LAST)	(FIRST)	(Other)	SPONSOR'S ID NUMBER
	Fireman Calvin	[redacted]	b(6)-2	5 2 7

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0605	- Pt. had BM. Light Brown. [redacted] b(6)-2
17Nov	Surgery wounds clean cont wound care + abx prob here 4-7 days
	[redacted] b(6)-2
17NOV03	(1300) NSG-VSS. Completed DSG Δ. Pt tolerated well. C/o pain. Med c̄ ⅓ Ty #3. Dr. [redacted] viewed pt's staples on buttocks. D/c'ed penrose drain. MD wrote new orders. Pt may ~~tet~~ consume po food. Will monitor po intake. b(6)-2 [redacted]
2100-	VSS - A+O completed drsng Δs pt. tol. well. staples intact to (L) hip, (L) bottom, knee, (+) s/sx inf. and redness around wound to (R) calf. all other wounds (-) s/sx infection. voiding per urinal cyl. Pt. resting well @ this time. Two pt. restraints in place c̄ (-) skin break-down (+) circulation. will cont. to monitor pt. [redacted]
	STA[redacted]

b(6)-4 [redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2
18NOV03	0300 - Pm had large light brown BM. b(6)-2 [redacted]
18NOV03	(1540) NSG - VSS. c/o not able to sleep. Will speak c̄ MD ~ pt's complaint. Completed DSG Δ. WTD. Sutures to on buttocks loosely approximated. Staples along outer (L) thigh well-approximated, ⊖s/sx of infection. Pt OOB to chair ~ 1hr. Tol well. Refused food 2° pt does not like hospital food. Will get MRE from DFAC for pt on b(6)-2 [redacted]
18NOV03 2000	VSS Multi wounds to Bilateral LE & buttocks clean + redressed as ordered. Tissue to open wounds red + moist. Staples to (L) hip/lateral thigh intact without drainage or crusting and incision well approximated. Voiding clear amber urine. [redacted] Tylenol #3 effective for pain. Pt Restraint applied without compromising circulation or skin integrity. Will continue care as planned [redacted]
19NOV03@1400	Assumed care of pt. @ 0600. VSS. A&O. ⅊ T3's given for pain + pre-med for DRESS Δ. Pt. OOB to shower this AM, pt. ambulated c̄ walker to BR. H_2O_2 used to clean wounds, dry dressings reapplied. Mod serous drainage to old dressings, Ø signs of

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19NOV03 (cont)	infestation. Ancef ~~TI~~ grams IVPB hanging at this time. Urinal c̄ bedside → CYC, sufficient output. Pt. ~~into~~ (m) in 2-point restraints, Ø signs of skin breakdown. Will cont. to monitor [redacted] b(6)-2 [redacted]
20NOV03 0020	– USS – A+O speaking arabic. Completed dsng's to multiple wounds to (B) LE + hip + buttocks. Staples well approximated + intact to hip. All wounds cleaned c̄ H2O2 as ordered per MD. Ø S/S/S inf. New IV Bd started to (L) Bicep. Pt. voiding c̄ yu per urinal. Two pt. restraints in place. (–) skin breakdown (+) circulation. Will cont. to monitor pt. b(6)-2 [redacted] I concur with above assessment [redacted]
20NOV03 @ 1500	Assumed care of pt @ 0600. USS, A&O, ~~TI~~ T 3.5 for C/O pain to (D) LE. All wounds cleaned c̄ H_2O_2. Sero-sang drainage to (L) buttocks wounds, moderate, thick yellow drainage to other wounds. W → D Dsng Δ to (L) buttocks wounds, Dry Dsng Δ to all other wounds. Pt. ambulated in hallway for 5 min. @ 1330 c̄ walker, drags feet. Pt. cries frequently, worried about family as reported by interpreter. Pt. in 2-point restraints, Ø signs of skin breakdown. Will cont. to monitor. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] b(6)-4

AUTHORIZED FOR L(

RD | **PROGRESS NOTES**

NOTES

2/-/-/ 2300. assumed care of pt. @ 180c
VSS-A+O 15 CTA (B), Resp. even unl
abd. soft nontender BSx4. completed
all dsng Δ's. applied hrcr to all
& SSxinf. sutures to lower b
loosely in place. One not intact. w
is not well approximated. Pt. void
cyn per urinal. Pt. OOB → chair
13 mins. ambulated to BR c̄ walk
conducted personal hygiene. ii Tylo
given for pain. Two pt. Restra
in place c̄ compromise to skin
circulation. Will monitor pt. [redacted]
I can c̄ with alone assistant
Assumed care 0600 pt awake & oriented x3
pt hx ∅ c/o of pain at this time, Pedal pulse (B) c
to lower extremities, Pt dsg Δd. H2O applied, bilat
by WOD, 3½" wound on buttock is loosely held toge
one staple, some yellow/greenish drainage preser
most of wounds, pt tolerated dsg change with
medication, pt ambulated x2 with minimal diff

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

b(6)-4 [redacted]

MEDCOM - 24352

PROGRESS NOTES
Medical Record
STANDARD FORM 509

b(6)-2 A11

DATE	NOTES
Nov '03	pt in restraints x2 [redacted] circulation, IV intact patent (L) wrist [redacted]
1 Nov 03 1700	I concur c̄ above assessment [redacted]
Nov 03 @ 0405	Assumed care @ 1800; VSS, pt A&O speaking arabic; pain controlled c̄ T3's; (+) CMS, TBP, brisk cap Ref throughout, NV intact; all drsgs to LEs (B) Δd W→D p̄ they were cleaned c̄ H2O2; pt OOB to amb to BR; S/L patent; cont c̄ IV abx; Restraints in place, (+) circ, (-) skin break↓, cont to monitor [redacted]
22 Nov '03 @ 930	Pt awake + oriented x3 complaining in arabic, pt c/o of pain, tiredness, boredom. IV intact and patent. 1400 pt premedicated with T#3's prior to [redacted] drsg Δ's. Pt completed personal hygiene prior to drsg change. Some greenish brown drainage from wound, the iodoform gauze soaked with sero-sang drainage. Pt complains of pain in his (R) foot, but doesn't complain during dressing change. Restraints x2 in place [redacted] (1655) I concur c̄ above assessment. [redacted]
23 Nov 03 @ 0430	Assumed care @ 1800; VSS, pt A&O speaking arabic, pain controlled c̄ T3s; all drsgs to LEs Δd W→D, (-) S/Sx infection; NV intact; pt OOB to amb c̄ walker assistance; S/L patent, cont c̄ IV abx; Restraints in place [redacted] (+) circ, (-) skin break↓, cont to monitor [redacted]
23 nov 03 @ 1300	Pt a/o, VSS, drsgs Δ'd to (B) extr & buttocks, sero-sang drainage noted to buttocks, iodoform gauze saturated c̄ mod. amt sero-sang, NV intact, pt ambulated to Bathroom x2 c̄ walker. c/o pain but fell asleep. Pt tosses & turns alot requiring frequent drsg Δ's. Will monitor [redacted] 9/wmte

STANDARD FORM 509 (REV. 5/1999) BA
USAPA V

[redacted]

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 NOV @1600	Pt pulled IV out - catheter intact, new 20ga IV started to (L) FA x 1 attempt. Cont. to monitor [redacted] LPN
24 NOV @ 1530	Pt c/o, VSS, medicated c̄ Tylenol #3 for pain today @ 1440. drsgs A&D [redacted] major Ponder @ BS during drsg Δ, removed staples. Pt c/o pain upon moving (R) leg, (+) pulses, brisk cap refill. IV Ancef now d/c'd, Ø oozing or s/s/x infection noted to wounds. Will monitor [redacted] 91WM6.
	blue-2 All

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. ICW #1

[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 LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Nov03	Neurosurgery Consult
2359	HPI 19 y/o male suffered multiple shrapnel injuries when struck by presumed gunfire earlier today. Pt underwent workup which included CT abd + pelvis. This showed L5 abnormalities.
	PmH Unknown.
	Exam Pt under anesthesia for scrotal exploration. No abnormalities noted by 1° team.
	CT Scan Chronic L5 spondylolysis with early (≤ Grade I) listhesis, no canal compromise.
	Impression: Suspect this is an unrelated abnormality, likely more than several months old, and doubtful unstable condition.
	Recs: (1) OK to proceed with treatments as scheduled.
	(2) Will need F/U with spine surgeon after 1° injuries are resolved.
	(3) I will examine postop + follow.
	[redacted] b(6)-2
	[redacted]4797

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

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

#[redacted]
b(6)-4

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

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 14 Nov 0115 Wound number 13
Stage I-IV _____ Surgical or Non-Surgical _____
Location (R) foot
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) _____
Dressing Type Gauze + ACE wrap
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____
DSG from OR left on 1st 24°

Date and Time 14 Nov 0115 Wound number 14
Stage I-IV _____ Surgical or Non-Surgical _____
Location (L) foot
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) Smamt. sanguinous drng through ACE
Dressing Type Gauze + ACE wrap
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____
DSG from OR left on 1st 24°

Date and Time _____ Wound number _____
Stage I-IV _____ Surgical or Non-Surgical _____
Location _____
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) _____
Dressing Type _____
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____

Patient ID: b(6)-4 [redacted]

Unit No. ICU2
Standard Form 509

EPW-51

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 14 Nov 03 0115 Wound number 10
Stage I-IV II Surgical or Non-Surgical Shrapnel wound
Location (R) upper inner thigh
Shape circular Measurements 2cm
Tissue Color pink granular edges
Drains and Type none
Drainage (amt and color) Sm amt sanguinous
Dressing Type 4x4 DSD
Dressing Change Frequency BID+prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 14 Nov 03 0115 Wound number 11
Stage I-IV II Surgical or Non-Surgical Shrapnel wound
Location (R) upper inner thigh
Shape circular Measurements 2cm
Tissue Color pink granular edges
Drains and Type none
Drainage (amt and color) Sm amt sanguinous
Dressing Type 4x4 DSD
Dressing Change Frequency BID+prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 14 Nov 03 0115 Wound number 12
Stage I-IV Surgical or Non-Surgical Surgical
Location (R) calf
Shape Measurements
Tissue Color
Drains and Type
Drainage (amt and color)
Dressing Type Gauze covered c̄ ACE wrap
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)
original DSG from OR left on 24°

Patient ID: Unit No. ICU2
Standard Form 509

[redacted] - EPWS-51

b(6)-4

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 14Nov03 0115 Wound number 7
Stage I-IV III Surgical or Non-Surgical Surgical
Location (L) hip, upper outer thigh
Shape unknown Measurements Dsg from OR 33cm
Tissue Color
Drains and Type
Drainage (amt and color) Sanguinous noted to upper back + lower portions
Dressing Type Sterile Gauze & loban
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)
Dsg remains from OR for 1st 24°

Date and Time 14Nov03 0115 Wound number 8
Stage I-IV III Surgical or Non-Surgical Surgical
Location bottom of scrotum
Shape linear Measurements 1cm
Tissue Color pink granular edges
Drains and Type penrose x1
Drainage (amt and color) mod amts serosanguinous
Dressing Type Kerlix fluff
Dressing Change Frequency BID + prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 14Nov03 0115 Wound number 9
Stage I-IV III Surgical or Non-Surgical Surgical
Location (L) outer lower hamstring
Shape linear Measurements
Tissue Color pink granular edges
Drains and Type none
Drainage (amt and color) sm amt sanguinous drng
Dressing Type 4x4 DSD & staples
Dressing Change Frequency BID + prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: b(6)-4 Unit No. ICU2
Standard Form 509

#[redacted] - EPW-S1

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 14 Nov 03 0115 Wound number 4
Stage I-IV III Surgical or Non-Surgical Surgical
Location (L) Flank
Shape linear Measurements 6 1/4 cm
Tissue Color pink granular edges & red center
Drains and Type none
Drainage (amt and color) mod amt serous drng
Dressing Type Staples + 4x4 DSD
Dressing Change Frequency BID + prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.) turned to (R) side

Date and Time 14 Nov 03 0115 Wound number 5
Stage I-IV III Surgical or Non-Surgical Surgical
Location (R) sacral
Shape linear Measurements 10cm
Tissue Color pink granular edges
Drains and Type penrose x1
Drainage (amt and color) lg amt serous drng
Dressing Type staples & ABD pad DSD
Dressing Change Frequency BID + prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 14 Nov 03 0115 Wound number 6
Stage I-IV III Surgical or Non-Surgical Shrapnel wound
Location (R) lower buttock
Shape circular Measurements 2cm
Tissue Color pink granular edges
Drains and Type penrose x1
Drainage (amt and color) mod amt serous
Dressing Type 4x4 DSD
Dressing Change Frequency BID + prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: b(6)-4 Unit No. ICU2
Standard Form 509

#[redacted] - EPW-51

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 14 Nov 03 0115 Wound number 1
Stage I-IV II Surgical or Non-Surgical Shrapnel wound
Location (L) inner FA
Shape Circular Measurements 1cm x 1cm x ½cm
Tissue Color pink granular edges & red center
Drains and Type none
Drainage (amt and color) Sm. amt. serosanguinous
Dressing Type Comfeel
Dressing Change Frequency prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 14 Nov 03 0115 Wound number 2
Stage I-IV II Surgical or Non-Surgical Shrapnel wound
Location (R) posterior FA
Shape Circular Measurements 2cm x 1cm x ½cm
Tissue Color pink granular edges & red center
Drains and Type none
Drainage (amt and color) Sm amt serosanguinous
Dressing Type Comfeel
Dressing Change Frequency prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 14 Nov 03 0115 Wound number 3
Stage I-IV III Surgical or Non-Surgical Surgical
Location (L) Shoulder
Shape linear Measurements 3½ cm
Tissue Color pink granular tissue edges & red center
Drains and Type none
Drainage (amt and color) mod amt serous – serosanguinous
Dressing Type Staples + 4x4 DSD
Dressing Change Frequency BID + prn Wound Cleansing water
Additional Info (turning, elevation of extremeties, etc.) turned to (R) side

Patient ID: Unit No. ICU2
Standard Form 509

b(6)-4
#[redacted] EPW-51

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS ES
DATE	NOTES
11/17	DC SUMM
	admit 11/12/3
	d/c -
	d/c dx - multiple GSW; ext, back, legs, foot, pelvis
	hx - I male involved in ambush + sustained multiple wounds
	OR - 11/12 Ortho - Deb foot
	Gen Surg - flex sig ⊖, Deb wounds (No rectal injury seen)
	hosp course - Admit for eval + tx of wounds. Placed NPO x 4 days, Diet started + wounds healing
	DC Meds - Motrin 600mg po tid prn
	b(4)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S N[redacted]		NSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECOR[redacted]NTAINED 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.

PROGRESS NOTES
Medical Record

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

[redacted]

b(4)-4

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23NOV.03			Pt AtOx3, VSS, LS CTA(B), (+) BS
1900			x4, pain controlled c̄ percs, multi-
			ple dsg's throughout body + LE x2,
			Δ'd, wound on buttock packed c̄
			WTD dsg, beefy red, ø s/sx of infex,
			staples ODT, iodiform Δ'd, satura-
			ted c̄ serosang drainage [redacted] → BR
			x2, voiding s̄ diff. [redacted]
			I&O c̄ alone [redacted]
			b(6)-2

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 24Nov03 2015 Wound number 1
Stage I-IV — Surgical or Non-Surgical
Location ~~SR~~ (D) hip
Shape linear Measurements 7 inches
Tissue Color well approximated
Drains and Type Ø
Drainage (amt and color) Ø
Dressing Type steristrips
Dressing Change Frequency Ø Wound Cleansing Ø
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 24Nov03 2015 Wound number 2
Stage I-IV Surgical or Non-Surgical
Location sacral
Shape undefined Measurements 1 inch x 1 inch
Tissue Color pink
Drains and Type Ø
Drainage (amt and color) yellow
Dressing Type 2x2 dry sterile dressing ~~Exosm~~ ~~W-S~~ D→D
Dressing Change Frequency BID Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Date and Time Wound number
Stage I-IV Surgical or Non-Surgical
Location
Shape Measurements
Tissue Color
Drains and Type
Drainage (amt and color)
Dressing Type
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

EPW b(6)-4
[redacted]

Medical Rec ... gress Notes

Braden Scale Evaluation

Date: 24 NOV 03

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: 21

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Date: _____

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: _____

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Patient ID:

Unit No. TCW2

Standard Form 509

EPW

[redacted] b(6) -4

MEDICAL RECORD

PREOPERATIVE/POSTOPER^ ~'VE NURSING DOCUMENT

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

1. AGE: 19

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication):

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

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X 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 X 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 X Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted]

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ 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] 12 NOV 2003 DATE

11. POSTOPERATIVE EVALUATION:

Bowie site clear
Dressings dry & intact
Betty sponges.

blue 2 A11

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 12 NOV 2003 TIME: [illegible]

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

DATE: 13 NOV TIME: 0406

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY [redacted]

3. DATE 12 NOV 03 TIME PATIENT ARRIVED IN SUITE 2345

4. PATIENT IN ROOM TIME 2345 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: blue - 2 Ant

6. NURSING PERSONNEL

ASSIGNED SCRUB	SP2 [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CP [redacted]	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in Supine body alignment. Arms on armboards <90°. Post sacral elevation + flex sigmoidoscopy pt placed to left side up.

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

COMMENTS: Axillary roll under R axilla. Pillow between arms. Blanket under dependent leg. Pillow between legs.

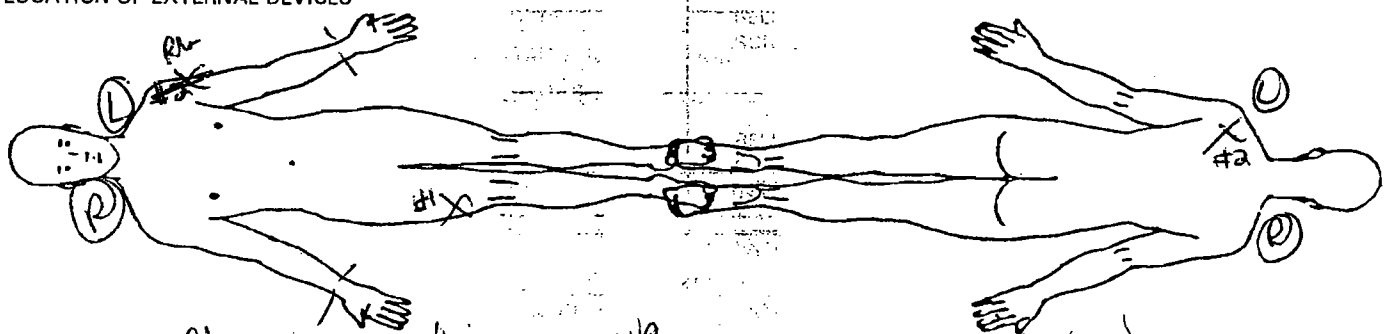
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/paint
SITE: Scrotum, penis & surrounding area BY WHOM: CP [redacted]
SITE: left leg & hip BY WHOM: CP [redacted]
Left flank & back CP [redacted]
COMMENTS: Prepping noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (Rt) -- Safety Strap (Anesthesia) = = = Tourniquet (UP)

blue - 2

10. COUNTS

C = Correct I = Incorrect

Initial count - see reverse / CP / [illegible]

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

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

[redacted]

blue - 4

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

☒ ESU NO: R8B 103795
GROUND PAD: BRAND Valleylab
LOT NO: (1) 70337 (2) 70337

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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

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. 3/8" Penrose	2. 3/8" Penrose	3.
SITE	1. Scrotum/(D) heel	2. (R) B-Hack x2	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs & tape scrotum / 4x8 & Iodoform gauze left hip

Fluffs, ABD, kelly, Ace (D) heel

4x8 & Tape

19. ADDITIONAL INFORMATION

Surgeons - Dr [redacted] Dr [redacted] Dr [redacted] Dr [redacted]

Anesthesia - CRT Stas, CRNA

b(6)-2 All

20. OPERATION(S) PERFORMED

(1) Scrotal Exploration (2) Flex sigmoid biopsy (3) left hip Exploration c washout / JAD multiple wounds (L) shoulder, (R) B-Hack, (L) leg, (L) heel (R) heel (R) calf

21. PATIENT TRANSFERRED TO ICU #2 TIME 0240 METHOD Litt.

22. REGISTERED NURSE SIGNA[redacted] RN

REVERSE OF DA FORM 5179-1, OCT[redacted] USAPA V1.00

MEDCOM - 24368

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 20 22 22 23/24

19 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] b(6)-4

11-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER 2003 — DAY: 14, 15, 15, 16, 16, 17, 18, 19, 20, 20

HOUR

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE

Temp

HEIGHT: WEIGHT

O_2 Sat

Source

O_2 Sat

Source

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]

VITAL SIGNS RECORDS

Medical Record

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY		25															
MONTH-YEAR	DAY																
19	HOUR																
PULSE (O)	TEMP. F (°)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO.

EPW-[redacted]

b(1)-1

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular

SECTION I - PATIENT ASSESSMENT

DATE: 24 Nov 05 | PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1640 To 1W2 From 1W2 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician [redacted] Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast 2 deep wounds - dry dsg changed Tubes _____

Intake (IV, po) Ø IV fluids Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication T#3 for pain

Other D/C to camp tomorrow - Cleaning all wounds T#202

Report From SPC [redacted] b(6)-2 Received By LT [redacted] b(6)-2

VITAL SIGNS

TIME:	1730	2400														
BP ARTERIAL LINE	—															
BP CUFF	140/69	137/63														
TEMPERATURE	98.3	99.2														
PULSE	84	81														
RESPIRATORY RATE	16	16														
OXYGEN (L/%)	—															
PULSE OXIMETER	98%	98%														
O_2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1730	2030						
PAIN INTENSITY (10 / 5 / 0)	x	X						
MED ADMINISTERED (Y/N)	N	Y						
RELIEF ACCEPTABLE (Y/N)	NA	Y						
Motrin		1						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1730		
*Skin breakdown prevention	NA		
*Falls prevention protocol			
*Restraint protocol	NA		
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

DIAGNOSIS: Multi soft tissue GSW

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SEC - PATIENT ASSESSMENT - REVIEW OF SYS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6) 2

	TIME: 1730 INIT[redacted]	TIME: INITIALS:	TIME: 2215 INITIA[redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM to (L) LE 2° to GSW to (D) hip	☐	☐ GSW (L) hip and multiple wounds to sacral area and (B) (L) (B) LE [illegible]
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Tinasuture line to left hip; Drg to (D) hip CDI	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b(6)-2	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1730 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2215 INITIALS [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr: PRN
IV site care provided:	IV site care provided:	IV site care provided: (L) AC Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1:	IV Site #1: (L) AC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments: Flushed 5cc NS

SECTION III - PATIENT INTERVENTIONS & TEACHING

b(6)-2

NEUROVASCULAR

SITE: (L) LE	TIME: 17[illegible]	1[illegible]5				
COLOR	P	P				
CAPILLARY REFILL	2	2				
TEMPERATURE	W	W				
EDEMA	1	1				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	DP	—				
PERIPHERAL PULSE	2	2P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 1730	[redacted]
SAFETY: ID band visible/legible	AW	
SAFETY: Orient to environment prn	AW	
SAFETY: Side rails (2/4) up	NA	
SAFETY: Bed position low		
SAFETY: Call light within reach		
OTHER: Review & post lab results		
OTHER: Notify MD abnormal labs		
OTHER: Incontinent urine/stool		
OTHER: Linen change prn		
OTHER: Turn/reposition q2h		
OTHER: ROM q2h if immobile		
OTHER: Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT b(6)-2	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT b(6)-2

TEACHING

TIME: 1730 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2215 INITIALS: [redacted]
CONTENT: Call for assist EPW restraint protocol	CONTENT:	CONTENT: Call for assist
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW [redacted] b(6)-4	[redacted] b(6)-2	[redacted]	D

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - INTERVENTIONS & TEACHING (Con

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

24 Nov 03 1730 Pt transferred from ICU1 in stable condition. ambulatory at time of transfer.

[redacted] DC/AP

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular

SECTION I - PATIENT ASSESSMENT

DATE: 23 Nov 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:																
BP ARTERIAL LINE																
BP CUFF																
TEMPERATURE																
PULSE																
RESPIRATORY RATE																
OXYGEN (L/%)																
PULSE OXIMETER																
O_2 METHOD																

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:									
PAIN INTENSITY 10									
PAIN INTENSITY 5									
PAIN INTENSITY 0									
MED ADMINISTERED (Y/N)									
RELIEF ACCEPTABLE (Y/N)									

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ

[redacted]

b7(c) 4

DIAGNOSIS: Mult. Soft tissue GSW

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ Bles 2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
				b(6)-2

SECTION IV - NOTES

1300: PT D/c'd to camp in stable and [redacted]

b(6)-2

b(6)-2

Ward Section: EMT	NUCLEI [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW	DATE: 12NOV	TIME: 2205

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.3-10.8 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		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
[illegible]		9.3-13.5 secs
APTT		21-34 secs
D-Dimer		<[illegible] ug/ml
FDP		<[illegible] ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
Appr	clear	N/A
Glu	1g	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	trace	Negative
pH	5.0	N/A
Prot	1+	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA - 1+
Glucose - 1%
1-3 RBC
mod mucous
3-4 granular casts

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW	DATE: 12NOV TIME: 2209	SSN/PSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		135-146 mmol/L
K		3.5-4.9 mmol/L
Cl		99-109 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) 23-25 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry

```
======= PICCOLO =======
12/11/03            22:17
REFERENCE RANGE:        MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #:          3154AA7
OPER # [redacted]  DR #: 000
SERIAL #: b(6)-2 0000100697
.....
```

ALB	3.1*	3.3-5.5	G/DL
ALP	79	26-84	U/L
ALT	34	10-47	U/L
AMY	29	14-97	U/L
AST	44*	11-38	U/L
TBIL	0.4	0.2-1.6	MG/DL
GGT	15	5-65	U/L
TP	6.0*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		
Cl		
tCO2		

```
======= PICCOLO =======
12/11/03            22:31
REFERENCE RANGE:        MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #:          3325AA4
OPER #: [redacted]  DR #: 000
SERIAL #: b(6)-2 0000100494
.....
```

GLU	369*	73-118	MG/DL
BUN	10	7-22	MG/DL
CA++	8.5	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	131	128-145	MMOL
K+	4.0	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	20	18-33	MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ID: 001305 12-11-03
NP 22:15

			Patient Limits	
WBC	20.9 H	x10^3/uL	4.5	10.5
RBC	4.12	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	39.7	%	35.0	60.0
MCV	96.8	fL	80.0	99.9
MCH	30.9	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	167.	x10^3/uL	150.	450.
Lym%	16.4	%	20.5	51.1
Lym#	3.4 H	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/12/03 22:22

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.8 sec.
Ratio = 1.2
Calculated INR = 1.37
Sample Type:citrated wh. blood
Test Date :11/12/03
Test Time :22:20
Card Lot :080201
Operator : CAIN REBECCA

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/12/03 22:31

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.9 sec.
Sample Type:citrated wh. blood
Test Date :11/12/03
Test Time :22:22
Card Lot :100202
Operator : CAIN REBECCA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)														TOTALS	TOTAL EBL
Fentanyl (mcg)		100	150	100	50	100	100	50	50	50		50		800	100
Propofol (mg)		150													TOTAL URINE
SUX (mg)		100													
Neostigmine (mcg)			100												
MSO4 ( )								2,2,4						10	440
( )															
VOLAT AGENT	1.5 % del	2.5	1.5	2.0	1.5	1.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	FLUIDS - SUMMARY	
	% e.t.													CRYSTALLOID: 8550	
AIR	L/Min														
N2O	L/Min													COLLOID: ∅	
O2	L/Min	8/2	2	2	3	3	3	2	2	2	2	2	2	BLOOD: ∅	

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

FLUIDS

LINE site													
18G (R) IAC	☐ Warmed		800		1000			1700			2000		
18G (R) AC	☐ Warmed		500			1000		1700			2000		
	☐ Warmed												

LOSSES

EST BLOOD LOSS								100					
URINE -			100		100/200		40/240						90/330

REMARKS

Code drugs with numbers, events with letters

(2355) NON FUGUS. SPEAKING IRAQI TRAUMA. 2400 PT TO OR MONITORS ON SMOOTH RSI INDUCTION ⊘ PROBLEM

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

BODY WEIGHT: 80 (KG) LB

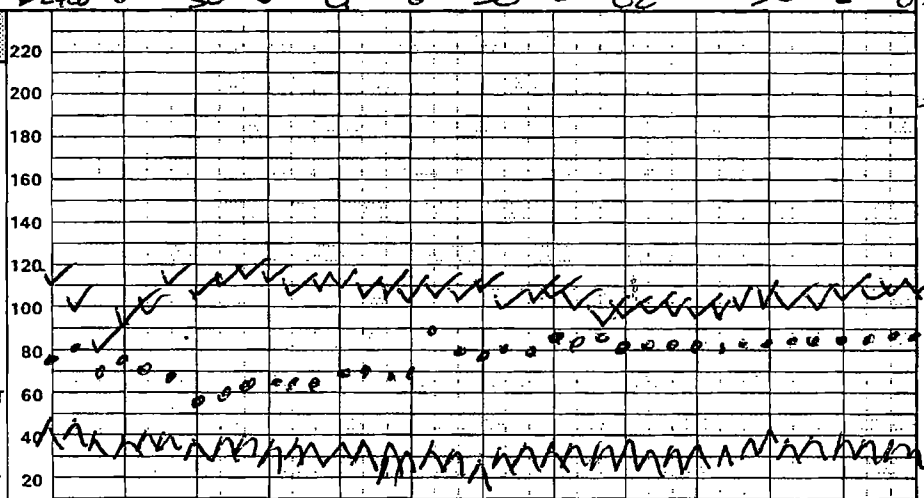
HEMATOCRIT: 13/40

INITIAL DATA: BP- 113/55 HR- 78

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? yes TIME- 2355

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



VENTIL

VT - ml	840	130	660	480	480	490	540	630	700	640	620	810
f - breaths/min	10	9	4	6	10	9	11	10	9	6	8	4
Peak inf pres / PEEP	31											
MODE - S(pon), A(ssist), C(on)	C	S	S	S	S	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	39	54	60	57	56	52	56	56	59	61	59	59
BP/oth	FIO2 (Frac or %)	.46	.46	.53	.58	.58	.58	.57	.58	.59	.59	.59	.59
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVERAGE											
	N-M Block (T/4)	4/4	4/4										
Warming blkt													
Conv warmer													

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

RECOVERY AT 0402

PACU ICU 2 (Specify)

OTHER

CONDITION PT in NAD

T 97.7 RESP. SpO2 99

BP 122/67 HR 127

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2345	2350	0417
PROC	Ready	Begin	End
	2400	0010	0340

PROCEDURES and CPT Codes: Scrotal washout (L) MYP WASHOUT. Colonoscopy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETTT

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: PRA-00. Sux 50% FIO2, RSI & CRICOID, DL XI MIL 3 Grade I View, 8.0 ETT PLACED 23cm @ lip (+) BBS

SURGEONS: [redacted]

ANESTH: [redacted]

PROCEDURE LOCATION: OR 2

DATE: 13 NOV 03

PAGE 1 OF 2

b(6)-4

b(6)-2

DA FORM 7389, FEB 1998 [redacted] PATIENT'S MEDICAL RECORD USAPA V1.00

MEDICAL RECORD - ANESTHESIA

Fr of this form, see AR 40-66; the proponent agen e OTSG

used/wasted

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

DRUG	(Units)													
FENTANYL	(mg)	50,00	50	50										
	( )													
	( )													
	( )													
MSO4	( )													
	( )													
VOLAT AGENT	150 % del	1.0	1.0	1.0										
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	2	2	2										

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

FLUIDS

LINE site														
(L)	☐ Warmed													
(R)	☐ Warmed	2300	—	2450										
	☐ Warmed	2500	—	2900										
	☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE - 110/440

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

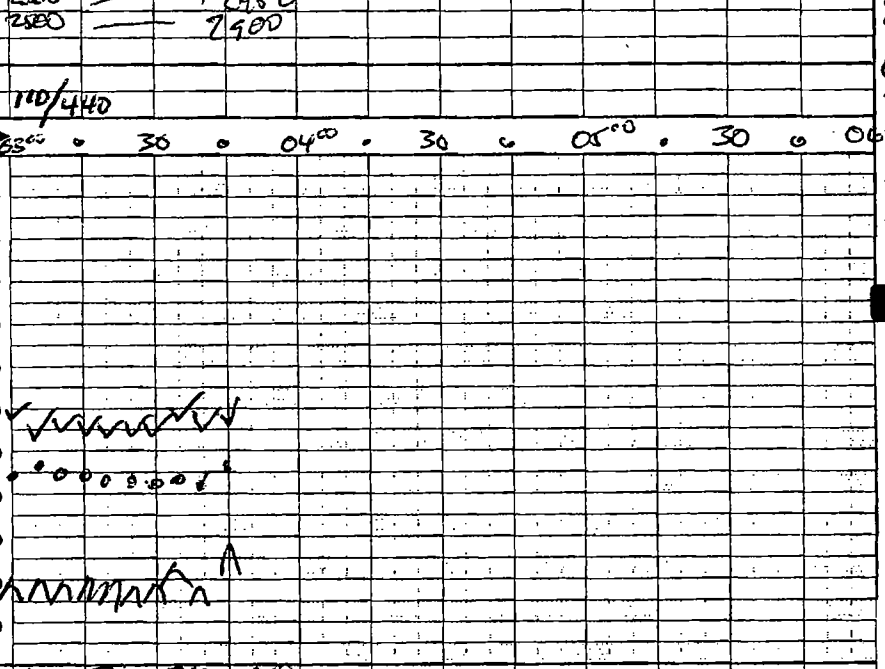
INITIAL DATA: BP- 113/55; HR- 78

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? yes; TIME- 2355

TIME → 23:00 • 30 • 04:00 • 30 • 05:00 • 30 • 06:00

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



VENTIL

VT - ml	690	810	760	1080
f - breaths/min	7	8	4	18
Peak inf pres / PEEP				
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	64	68	68	56
BP/oth	FIO2 (Frac or %)	.59	.59	.59	.60
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAILABLE	—		
	N-M Block (T/4)	4/4	—		
Warming blkt					
Conv warmer					

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

TOTALS: ~~200~~ 1000/100

TOTAL EBL

TOTAL URINE: 110/440

FLUIDS - SUMMARY: CRYSTALLOID- ~~1000~~ 5350; COLLOID- Ø; BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(E) tubated @ SV + O2 Sat: SV cont to ICU on O2 + Fm Report to ICU RN

[redacted]

RECOVERY AT: PACU ICU _____ (Specify); OTHER _____

CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2345	2355	0410
	Ready	Begin	End
PROC	2400	0010	0340

PROCEDURES and CPT Codes:

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

#[redacted]

b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

Pt #1

SURGEONS:

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 13 NOV 03

PAGE 2 OF 2

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

b(6)-2 ATI unless marked otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11/12/03 TIME OF ORDER 1015 HOURS

LIST TIME ORDER NOTED AND SIGN

- Transfer to ~~ward~~ ICU
- Dx: multiple shrapnel wounds
- Condition stable
- VS q2°
- Diet NPO
- LRQ 150 cc/h
- ~~to CT room for films of pelvis~~

noted [redacted] 13 Nov 03 0600

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Ancef IV gm q 8
- MSO4 2-6 g IVP q 2° PRN
- Phenergan 12.5 g IVP q 6° PRN nausea
- MCDR

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Levaquin 500 mg PO q day ~~c~~ sip H2O

noted c orders 13 Nov 03

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

[redacted]

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
4-13-03	OR40 Summary
	Fragi nule & Shrapnel wounds to (D) hip.
	Intratubular fragments removed via posterior
	approach. Intratubular shrapnel removed.
13 Nov	Op Note
	Debridement of multiple wounds
	buttock, Back, leg
	Flex Sig (-) [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.

PROGRESS NOTES
Medical Record

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

UTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/14	Surg
	wounds look good
	to floor
	[redacted] b(6)-7

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6) -4

PROGRESS NOTES
Medical Record

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

b(6)-2 M1
unless noted otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]			11/14 _____ HOURS	
			1) ICU → ICW	
			2) S/P GSW	
			3) VS 94°	
			* 4) NPO	
			- sign over bed	
NURSING UNIT	ROOM NO.	BED NO.	5) Tylenol #3 1-2 po 94° min	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER _____ HOURS	
			6) Ancef 2gm IVP 8°	
			7) dry dressings on wounds change b.i.d	
NURSING UNIT	ROOM NO.	BED NO.	8) D5W NS ; 2gm Ancef 100 cc/hr	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER [redacted]	
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER 15NOV03 @ 1600 _____ HOURS	
b(6)-4 [redacted] NOTED 15NOV03 [redacted]			① D/C FOLEY,	
			V.O. DR, [redacted] 2LT, AN	
			[redacted]	
NURSING UNIT	ROOM NO.	BED NO.		
240	17	NOV	@ 0200 [illegible]	

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

U.S. GOVERNMENT PRINTING OFFICE: 1994-[illegible]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11/17 TIME OF ORDER _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1) Reg Diet

2) hep lock

3) Motrin 600mg + PO t.d prn

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

4) clean all wounds c̄ H_2O_2 + pack with 4x4 bid

[redacted]

PATIENT IDENTIFICATION 24° ✓ 19 NOV @ 0200

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 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 SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24NOV03 TIME OF ORDER: 0700

(1) D/C ABX

(2) D/C to comp

(3) Gen the left [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24 V done		[redacted]

DATE OF ORDER: 24Nov TIME OF ORDER: 1730

V. O. from Dr [redacted]

Transfer to ICW 2

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

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 Nov Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15
13Nov	[redacted]	Diet: NPO	06	[redacted]		
			18	[redacted]		
13Nov	[redacted]	VS Q1°	06	[redacted]		
		b(6)-2	18	[redacted]		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P I+D multiple shrapnel wounds

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

PATIENT IDENTIFICATION:
[redacted] EPW-51
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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

13Nov JA Transfer ICU2 condition Stable - 13Nov 0400 JA

[redacted]

b(w)-4

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407 the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22	23	24
11/14	[redacted]	Ancef 2gm IV q8°	06	[redacted]										
	[redacted]		14	[redacted]										
			22	[redacted]										
11/14	[redacted]	D5 1/2 NSC 20mEq	06											
	[redacted]	KCl/L 100cc/hr	18	[redacted]										
			18											
			06											
11/17	[redacted]	Heplock	06											
			18											
			18											
			06											

D/C'ed d/m

D/C'd 24hrs

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: S/P GSW	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO.

PATIENT IDENTIFICATION: [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Nov Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11/24	[redacted]	D/C Abx	11/24	~~0900~~		[redacted]
		b(a)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14NOV	[redacted]	TYLENOL #3 1-2 PO	14NOV 1050	14NOV 1600	15NOV 0930	15NOV 1347	15NOV 1747	15NO 2323	16NO 0620	16NOV 1400	17NOV 1100	18NO 0900	18NOV 1640	18NOV 2100	19NOV 0845	19NOV 1400
		Q4° PRN	[redacted]													
11/17	[redacted]	~~Motrin 600mg~~	Unwritten													
	[redacted]	~~1 po tid prn~~	D/T	2010 2800	22/NOV 1650	22NOV 2120		1	28NOV 1835	2340 2275	24NOV 0600	24 1440				
11/20 03	[redacted]	Rewritten: Tylenol #3 1-2 PO	D/L	1	1	1	22NOV	22NOV	2 PO	2	2	2				
	[redacted]	Q4° PRN														
11/17	[redacted]	motrin 600mg	D/T													
	[redacted]	1 PO TID PRN	D/I													

CLINICAL RECORD

THF[illegible]UTIC DOCUMENTATION CARE PLA[illegible]EDICATIONS)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeo[illegible]al.

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COL[illegible]N FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED / 13	14	15
13Nov	[redacted]	IVF: LR @ 150cc/hr	06	[redacted]		
	[redacted]		18	[redacted]		
13Nov	[redacted]	Ancef 1/11 gm Q8°	08	[redacted]		
	------		16	[redacted]		
	------		24	[redacted]		
13Nov	[redacted]	Levaquin 500mg PO Qday	10	[redacted]		

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

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P I&D multiple shrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: b/6 1-4

[redacted] EPW-S1

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATION)*				Mo._____ Yr. _____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -	b(6)-2 A11				
	- - - - -					

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* **TIME/DATE DISPENSED**													
13Nov	[redacted]	MSO4 2-6mg IVP Q2° prn pain	11/14 1345	11/14 1620	13Nov 1530	13Nov 2300	14Nov 0230	14Nov 0400	14Nov 0550	14Nov 0800						
- - - - -	- - - - -		[redacted]													
13Nov	[redacted]	Phenergan 12.5mg IVP Q6° prn nausea														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED												
				24	25											
24Nov	[redacted]	Ancef 2gm IVq8°	06	/	[redacted]								24Nov			
	-----		14	/									0700			
	-----		22	[redacted]												

24Nov	[redacted]	Heplock	D	[redacted]												
	[redacted]		N	[redacted]												

	-----	b(6)-2														

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	Mult soft tissue GSW	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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. _____ 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													
14NOV	[redacted]	Tylenol #3 1-2PO	11/25													
		q4° PRN	1155													
			11													
			405													
17NOV	[redacted]	Motrin 600mg	24 Nov	25NOV												
		1 PO TID PRN	0800	1200												
			1130	1												
			[redacted]													
		bLW-2 A11														

*U.S. GPO: 1998-454-110/95216

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 24	25
24 Nov	[redacted]	VS q4°	00	/	[redacted]
			04	/	[redacted]
			08	/	[redacted]
		b(2)-3	12	/	
			16	/	
		A1	20	[redacted]	
24 Nov	[redacted]	Dry dsg on wounds	08	/	
		Δ BID	20	☐	
		Reg diet	B	/	
			L	/	
			D	[redacted]	
24 Nov	[redacted]	Clean all wounds	08	/	
		c̄ H2O2 & pack c̄	20	☐	
		4x4 BID			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Mult Soft tissue GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:
EPW [redacted] b(2)-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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo Nov Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/4	[redacted]	ICU → ICW	11/4	—	0850	[redacted]
11/15	[redacted]	D/C FOLEY.	11/15			
11/24	[redacted]	D/C TO camp.				

	----	bled-2				

	----	AM				

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

USAPA V1.00

Verity 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
24N[redacted]	[redacted]	D/C to camp	25Nov			
24N[redacted]	[redacted]	Transfer to 1LW2	24Nov		1730	[redacted]

	----	b(6)-2 A1				

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

USAPA V1.00

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME	06/15	INTILAS [redacted]	INTILAS		INTILAS
NEURO	PUPLIS	Pupils 2-3mm and				
	SENSORIUM	reactive. Alert +				
		Oriented x3. Moves				
		all extremities.				
RESPIRATORY	RESPIRATION PATTERN	Lungs CTA bilaterally				
	BREATH SOUNDS	c̄ expiratory wheezing				
	SECRETIONS	noted bilaterally c̄				
		O2 sat 96-99% on				
		room air.				
SKIN	COLOR	Color normal for				
	INTEGRITY	race. Multiple shrapnel				
		wounds noted				
IV SITE	LOCATION	18ga in @ AC an				
	CONDITION	@ forearm. Both				
		patent c̄ edema +				
		erythema.				
GASTRO	ABDOMEN	Abdomen round +				
	BOWEL SOUNDS	soft c̄ @ bowel sounds				
		noted x 4 quads.				
GU	URINE	Foley to gravity draining				
	COLOR/CLARITY	clear yellow urine				
CARDIOVASCULAR	CARDIACRHYTHM	Currently sinus tach				
		c̄ HR in 120's. Receiving				
		@ 125cc/hr via @ 18ga				
		@ palpable pulses c̄ cap refill < 3 seconds				

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

b(6)-2

(Continue on reverse)

[redacted] DEPARTMENT/SERVICE/CINC ICU2 DATE 14Nov03

PATI[redacted] *middle; grade; date; hospital or medical [redacted]e: Name --Last, First,*

[redacted] EPW-S1

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DATE 14 Nov 03 | DX S/P 1+D Shrapnel wounds | HOSPITAL DAY 2

VITAL SIGNS																			
TIME	24	07	08	09	00	01	02	03		04	05	06	07	08	09	10	11	
BP Arterial line																		
BP Cuff	137/65																	
Temperature		100.7																
Pulse	117	116																
Respiratory Rate	20	13																
SatS	94	95																
map	90																	
Source	RA	RA																

INTAKE																			
TIME	24	07	08	09	00	01	02	03	8°T	04	05	06	07	08	09	10	11	8°T
maint	125	125	125															
IVPB			50															
bolus																		
TOTALS																		

OUTPUT																			
URINE	HOUR	110	200	200															
	TOTAL	110	310	510															
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY 2 1

ACUITY LEVEL CLASSIFICATION II

VITAL SIGNS	22	23	24	01	02	03	04	05	

INTAKE	22	23	24	01	02	03	04	05	8°T

OUTPUT									

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

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

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

24°180 TOTALS [redacted] LS

WT Yesterday _____ wt Today _____

INTAKE OUTPUT

IV _____ Urine: _____

Po _____ _____

TOTAL _____ TOTAL _____

BALANCE _____

MEDCOM - 24402

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET b(6)-2

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0710	INTILAS [redacted]	2030	INTILAS [redacted]	INTILAS
	PUPLIS	Pupils 5mm+reactive		2mm b(6)-2 reaction		
	SENSORIUM	Follows simple		Alert + O x 3 Follows		
		commands, A+Ox3		commands, weak		
				LE MAE		
				MSO4 for pain		
RESPIRATORY	RESPIRATION PATTERN	Lungs ~~eff~~ & expiratory		RR 20's unlabored		
	BREATH SOUNDS	Wheezing noted		Sats 97% on RA		
	SECRETIONS	bilaterally, O2 sat		LS CTA		
		100% on 10L via NRB				
SKIN	COLOR	Skin normal for race		See wound		
	INTEGRITY	& multiple shrapnel		assessment		
		wounds noted		sheet		
IV SITE	LOCATION	Right 2in antecubital		18G (L) AC		
	CONDITION	sites patent & edema		18G (R) AC Ø		
		or erythema		S/Sx infection		
				noted, LR @		
				125cc/hr		
GASTRO	ABDOMEN	Abdomen round +		abd soft non-tender		
	BOWEL SOUNDS	soft & hyperactive		↓ BS x(4) quad		
		bowel sounds		NPO		
GU	URINE	Foley to gravity		Foley to gravity		
	COLOR/CLARITY	draining, clear		drained yellow		
		yellow urine		sufficient amts		
CARDIOVASCULAR	CARDIACRHYTHM	Sinus tach ~~eff~~ in		ST 110's ectopy		
		100's. ⊕ palpable		S1 S2 ⊖ murmurs		
		pulses in all ext.		2+ pulses all extrem		
				1+ edema (B) LE		

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED [redacted] TAN

DEPARTMENT/SERVICE/CINC ICU2

DATE 18 Nov 03

PATIENT'S IN[redacted]ve: Name—Last, First, middle; grade; date; hospital or medical facility)

[redacted] EPW-51

b(6)-1

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 13 Feb 03 | DX Multiple Thoracic Wounds | HOSPITAL DAY 1

VITAL SIGNS																		
TIME	06	07	08	09	00	01	02	03		04	05	16	17	18	19	20	21	
BP Arterial line																		
BP Cuff	128/61		128/57	117/60	118/54	115/62	121/61	124/58		132/59	125/52	122/55	109/57	110/52	139/60	134/61	124/65	
Temperature			99.6											101.1				
Pulse	118	118	114	115	114	118	119	120		122	128	139	131	140	131	133	138	
Respiratory Rate	22	21	20	17	20	20	20	18		21	20	13	16	11	18	16	13	
Sats	100	98	97	98	99	98	98	99		98	98	98	96	98	97	96	98	
Source	~~NRB~~	~~NRB~~	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
FiO_2	10L	10L	RA															

INTAKE																		
TIME	06	07	08	09	00	01	02	03	8°T	04	05	16	17	18	19	20	21	8°T
Maint	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125	125	
IVPB			50									50						
subtotal																		
TOTALS									1000									2100

OUTPUT																			
URINE	HOUR / TOTAL	150/150	150/300	200/500	110/610	110/720	120/840	140/980	140/1120	120/1240	130/130	130/260	120/380	140/520	100/620	100/720	100/820	100/920	
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY 10 S

ACUITY LEVEL CLASSIFICATION U

VITAL SIGNS	22	23	24	01	02	03	04	05
BP	125/63	119/59	118/106	119/57	119/63	125/62	128/65	120/106
T	101.5						100.4	
P	129	133	128	135	133	124	125	119
RR	20	11	17	20	12	20	20	20
Sat	96	98	95	97	95	93	93	97
Source	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE	22	23	24	01	02	03	04	05	8°T
	125	125	125	125	125	125	125	125	
			50						
								1050	3150

OUTPUT									
	200 1720	200 1920	200 2120	200 2320	200 2520	200 2720	200 2920	110 3030	3030

RESPIRATORY	TIME	1130
	MODE	SIMV
	F_IO_2	60%
	TV	250
	RATE	8
	PEEP	10
ABG A	pH	7.44
ABG B	PCO_2	41.9
ABG B	pO_2	113
ABG B	HCO_3	4
ABG G	SAT	65
ABG G	BASE	+15

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

DAILY ACTIVITY	TIME			
	MOUTH CARE	0830		
	BATH	0830		
	SKIN CARE	0830		
	FOLEY CARE	0830		
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME					
SUCTION						

24-HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE [redacted] INITIALS

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 2155 ETA: _____ UNIT: _____
MED COM: [Y] [N]

ARRIVAL STATUS

TIME 2155 ☐ IV x 0 ☐ O_2 0 1/min ☐ C-Spine Immob
Meds: ☐ UKN ☒ None ☐ Yes: _____
Allergies: ☐ UKN ☒ None ☐ Yes: _____
Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake _____ hrs
LMP: _____ ☐ _____

PRIMARY SURVEY

AIRWAY
☒ Natural Patient [Y] [N]
☐ ETT ____ ☐ _____
☐ Secretions _____

BRETHING
☐ Labored ☒ Unlabored ☐ Absent
TRACHEA: ☐ Midline ☐ Deviated [L] [R]
CHEST SYMMETRY: [L] > = < [R]

CIRCULATION
PULSE: ☐ Present ☐ Absent
BLEEDING: ☒ [N]
HEART TONES: ☒ Clear ☐ Muffled
SKIN: ☒ Warm ☐ Cool ☐ Hot
☒ Pink ☐ Pale ☐ Cyanotic ☐ _____
☒ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY
GCS: E 4
V 5
M 6
SPHINCTER TONE: ☐ WNL ☐ None

HEAD
PUPILS: ☐ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]
TM: ☐ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: [Y] [N]
Pain @ _____
JVD: [Y] [N]

HEART
RHYTHM: ☐ Regular ☐ _____
PULSES: ☐ Central ☐ Peripheral

LUNGS
BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

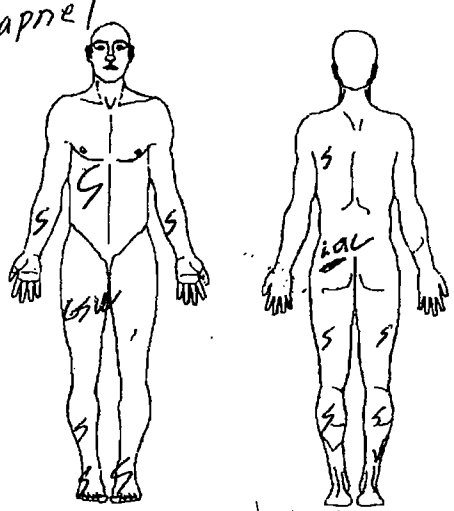
ABDOMEN
☐ Soft ☐ Rigid ☐ Non-Tender
☐ Tender:

PELVIS
☐ Stable ☐ Unstable ☐ _____
Blood at meatus/vagina: [Y] [N]
Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

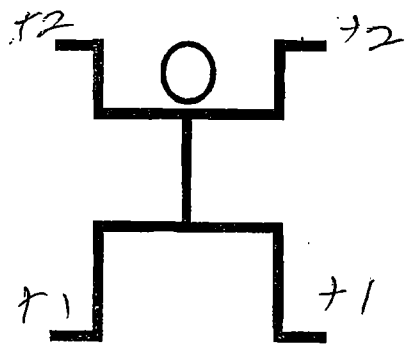
(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound

(4) shrapnel



b(6)-2

VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN: CPT [redacted] RN
PHYSICIAN: [redacted] (Continue on reverse)
PREPARED: 2Lt [redacted] RN
DEPARTMENT/SERVICE/CLINIC: EMT
DATE:

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

EPW
[redacted]
born 1984 b(6)-4

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

DA FORM 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth	[redacted]	☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
2220	Urinary	16Fr	☒ Meatus ☐ Supra-Public [redacted]		☒ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:	Comments		

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
~~2220~~	~~☐ D-stick_____ ☐ SHct_____~~
	☐ D-stick_____ ☐ SHct_____
	☑ CBC ☑ Chem ☑ PT/PTT
2215	☐ ETOH ☑ T&S ☐ T&C x_____
	☐ Tox Screen
✓	☑ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
2205	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
2205	☒ Pelvis
2206	☐ abd
	☐ Rib frac
2215	☒ (R) femur

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Con[redacted]		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
2205	1	18	Y	N	(L) AC	LR		
2215	1	18	Y	N	(R) AC	LR		
			Y	N				
			Y	N				

MEDICATIONS

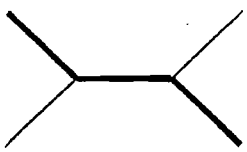
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Td	2210	.5cc	IM						
Anlet	2210	1gm	IV						
Fent.	2210	100mcg	IV						
Reflan	2225	10mg	IV						
Fent.	2232	50mcg	IV						

BLOOD PRODUCTS

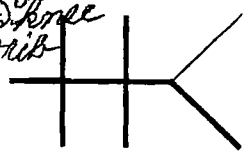
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC:



Chem: (L) foot
2215 (L) knee
2215 (R) rib



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]			
Surgeon	[redacted]			
Anesth	b(6)-2			
X-Ray	[redacted]			
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

Accompanied By _____

Via: ☐ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp:

TIME	BP	HR	RHY	RR	[redacted]	FIO2	MODE	GCS: E	V	M	T
2205	98/44	96	NSR	24	110						
2215	140/92	70	NSR	20	100						
2225	120/54	94	NSR	20	110						
2235	123/49	87	NSR	16	96						

GLASGOW COMA SCALE

EYE OPE[redacted]	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spont[redacted]	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

2205 pt arrived wounds exposed cy
2210 X rays started
IV placed + labs sent, meds given cy
2220 foley placed + VA sent. cy
2225 medium emesis + starting I.V. contracting antiemetic given. [redacted]
2230 wounds irrigated + irrigation gun.
2232 more pain meds given. [redacted]
2245 Pt to CT c BV.
[redacted] BY

b6(u)-2

(page 3)

☆U.S.GOVERNMENT PRINTING OFFICE 1997-571-7000

1. Reporting MTF	2. MTF Locati	Admission a... Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG
[redacted]	IZ	

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]		FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	000-00-1305	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		22:00	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
NO	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee
[redacted] and Location of Medical Treatment Facility: b(2)-2		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-24

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-11-12

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-11-12

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P I&D MULTI SHRAPNEL WNDS

Procedure Narrative(s):

Cause of Injury Narrative:

878.2
890.0
891.0
892.0
881.00
877.0
756.12
E991.9

86.28
45.24

b(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	[redacted]

ADMISSION . CODING INFORMATION

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

1. REPORTING MTF						2. OCATION (State or Country Code.)	
1	2	3	4	5	6	7	8
A							

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		

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

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

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

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

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

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 8783 8921
88010 89919
8771
8911
8739

Pr. 4823
8345
8801

Jmg Trauma
4/43

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Automated Facsimile

NPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted] b(4)-4		FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		X				NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted] b(4)-4		ICW2

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	22:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-18

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-12	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-12	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P DEBRIM L ARM (MULT (PENETRATING WNDS)

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	7	7

Signature of Attending Medi[redacted]	Signat[redacted]

Automated Facsimile - DA[redacted] May 79 b(6)-2

b(u)-2 AIL

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 Nov 03 0100	Pt arrived from EMT via litter. VSS pt has shrapnel wounds to LUE. Wound covered c̄ Kerlex roll. Pt has numerous shrapnel wounds to Bilat LE. Wounds open to air. Pt is NPO for surgery this AM. ~~t SPB~~ LS CTA (B). HRRR. (+) BS x4 quads. Pt voiding spontaneously c̄ difficulty. Pt denies pain. Will continue to monitor [redacted] pc 9/WM6
(1220)	Pt back from OR. S/P debriment of (R) arm. Pt alo VSS, Ø c/o pain, drsg c̄ Kerlix wrap to (R) arm, small amt. bloody show, TOC. PO well. ace wrap to (L) LE CDI Ø drainage noted. HRRR, LCTAB, (+) BS x4, (+) peripheral pulses. 2 pt restraints on c̄ compromise to skin or circulation, Plan: pain ctrl, monitor drsgs, neurov's. IV ancef, Cont to monitor [redacted] 9/WM6.
(1530)	Pt upset about brother being discharged to camp. Neurov's WNL. Ø c/o pain or other issues. Cont to monitor [redacted] PN
13 NOV03 2000	VSS Alert & Oriented. Answers questions asked by interpreter but doesn't initiate any conversation. (L) arm dry dyst intact. (L) Lower leg drsg dyst intact covered c̄ ace wrap. (R) AC Saline lock patent

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	[redacted] NUMBER

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT (Over)

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. CW/#1

b(u)-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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 NOV 2000	Consumed only 10% of dinner. Drinking P.O fluids. Peripheral pulses palpable +2. Capillary refill to fingers & toes brisk. Voiding clear amber urine. 2+ Restraints applied. Circulation & skin integrity intact. Will continue as planned. [redacted] b(6)-2
11/14	Surg [illegible] wounds clean [redacted] b(6)-2
14 NOV 03 1100	Pt alo, VSS (C slight temp-99). Ø c/o pain expressed. HRRR, LCTAB, ⊕BS x4, (R) arm drsg s'd by Dr [redacted] Penrose drains removed. (L) LE drsg removed by MD. dry drsg applied ⊽ cleaning area c̄ Peroxide. ⊕ peripheral pulses swelling noted around incisions to (R) arm. sutures intact. IV Ancef cont per orders. Pt eating less than 50% of breakfast, only eats fruit / bread & juices. Extra fruit & juice given. voiding cyn via urinal. IV (R) AC Hr'd. 2pt restraints on 5 compromise to skin or circulation. Will monitor [redacted] neurovs WNL. [redacted] 91WM b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 NOV 03 2215	assumed care of pt @ 1800. VSS, no c/o. Alert, speaks some English; LSCTA, NKA, ⊖ x 4 quads, voids per urinal clear urine. Tol approx. 25% of dinner. (R) FA drsg CDI, ⊕ CMS to LUE, +2 radial pulse, +1 edema to (L) hand. LUE elevated on blankets. (L) LE drsg CDI, ⊕ CMS to (L) foot, +2 DP pulse. (R) ac IV flushed well, IV Abx cont. T#3 given for pain c̄ good relief noted. Plan: cont Abx, monitor neuros, pain control. Will monitor [redacted] Addendum: Pt restrained, ONS S/Sx of skin & circulation compromise. Will monitor [redacted]
15 Nov	Survey wounds ok b(4)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(4)-4

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	IRST NAME	DLE INITIAL	ID NUMBER

DATE	NOTES
15 NOV 03 0800	Assumed care of pt. VSS c/o of small amt of pain to (L) hand neurovascular check intact AEB pt being able to wiggle finger, strong radial pulse, capillary refill and skin coloration WNL. Surgical incision x2 to (L) upper extremity closed wound secured c sutures. small amts of serous drainage to dsg dry 4x4 kerlix wrapped CDI. (L) LE wound 2x2 circular wound minimal active bleed and ~~serous~~ drainage 2x2 dsg kerlix wrap CDI. Lungs clear HRRR active BS. Voiding QS. Ambulates [redacted] Will cont to monitor b(6) 2 [redacted]
15 NOV 03 0100	Assumed care of pt @ 1800. VSS, no c/o pain. pt speaks some English. (L) arm dsg CDI, (+) CMS to UE. (L) foot dsg CDI, (+) CMS. Tol sm amt of reg diet, only 20% of dinner. (R) AC IV flushes well, IV Abx continue. 2pt restraints on S S/S of skin/circulation compromise. Plan: encpo intake, monitor dsgs, pain control. [redacted] b(6)2
16 Nov	Super wound clean switch to kerlex [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16 NOV 03 0800	Assumed care of pt. AOx3. VSS Denies having pain or discomfort @ this time. AM care given. IV ABX changed to PO. Lungs CTA HRRR Active BS. x4 quads urinating spontaneously BS. Nuerovascular check intact. (L) ARM surgical incision x2 intact c̄ sutures. Small amts of serous drainage. Dry dsg 4x4 kerlix wrap. CDI Will cont to monitor [redacted]
2200 -	assumed care of pt. @1800. VSS-AO pt. tolerated 30% of dinner. encouraged b(4) pt. PO but denied. LS CTA (B) NSR, Resp. even unlabored, BS x4, and soft non tender. voiding dark yellow urine via urinal. dsng to left foot CDI. Dsng to (L) arm CDI. IV HL (R) AC Flushes well patent. b(4) nuero vascular intact. NO C/O pain @ this time. Will cont. to monitor pt [redacted] I concur c̄ nurse assessment [redacted]
0530 -	Pt. resting well @ this time. (+) neuro. insult intact. will cont. to monitor pt. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted]
b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17nov03 1100	Rt a10, VSS, ø c10 pain, pt able to move (L) arm in all directions (c̄ pain). (+) sensation, brisk cap refill, (+) pulses. (L) arm drsg S'd, small amt serosang drainage on drsg. Sutures intact. (L) foot drsg S'd; small 1 cm wound noted, ø drainage. Rt refuses to eat, drinks fluids occasionally, voiding mod. yellow urine, ambulates s̄ difficulty. PO Reflex cont. Discharge meds @ pharmacy. Awaiting D/C to camp. 2 pt restraints on s̄ compromise to skin & circulation. Will monitor [redacted] LPN. b(6)-2
17nov03 @2315	Assumed care of pt @1800. VSS, no c/o pain. Pt speaking some English. Sleeping most of shift but awakens to verbal stimuli. Drsgs to RUE CDI, LLE drsg CDI. (+) CMS to LUE/LLE. Poor appetite noted, voiding s̄ difficulty, ↑ AMB to BR s̄ assistance. (R) AC IV flushes well. 2 pt restraints on s̄ s/sx skin/circulation compromise. Plan: cont po Abx as ordered, monitor drsg, monitor pain control. D/C possible tomorrow. 2 [redacted] CPT b(6)-2
18NOV03 0805	Rt a10, VSS, ø c10 pain, drsgs to (L) U+L extr. S'd, scant sero-sang drainage noted. Sutures intact to upper extr. pt voiding mod. yellow urine, amb. s̄ difficulty. Cont PO Reflex. (+) pulses to extr + brisk cap refill (+) CMS. 2 pt restraints on

STANDARD FORM 509 (REV. 5/1999) BACI

USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

18 NOV 08 (con't) 5 compromise to skin/circulation
(0805) Will monitor [redacted] LPN.
(1235) Pt d/c'd to camp. d/c meds given to escorts. [redacted] LPN.
b(6)-2 A11

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)-2
[redacted]
b(6)-4

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

anc up
fetanes

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: 16 HEIGHT: WEIGHT: 50Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: I+D (B) LE I+D

5. ADDITIONAL INFORMATION: PMHx (-) NPO PM Hx (-)

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to surgery	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. Via interpreter 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 X Potential for respiratory dysfunction due to anes	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 X Potential impairment of skin integuity due to ESU, Bovie	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted] BLW-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anes/positioning	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to anes E.2. X Potential discomfort due to surgery	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 ____ F.2. ____ Potential for decreased communictaion due to ____ F.3. Potential injury due to dentures. ____	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ____ 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. 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. [redacted] ERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT [illegible] 13 NOV 03 DATE

11. POSTOPERATIVE EVALUATION:

Drowsy

Bovie pad site C+I

Dressings b(6)-2 D+I

b(6)-2

[redacted] EVALUATION PREPARED BY	13. PREOPERATIVE EVALUATION PREPARED BY [redacted]
[redacted] CPT [illegible]	CPT [illegible]
DATE: 13 NOV 03 TIME: 0500	DATE: 13 NOV 03 TIME: [illegible]

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT** b(6)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Ward staff
2. PATIENT [redacted] AND PROCEDURE VERIFIED BY [redacted] CPT
3. DATE 13 NOV 03 TIME PATIENT ARRIVED IN SUITE —
4. PATIENT ROOM [redacted] TIME 0520 [redacted] NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA ∅ PMHx ∅ PSHx thru interpreter

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] ID 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: Pt placed on padded OR table w arms on padded turnboard ∅ < 90°

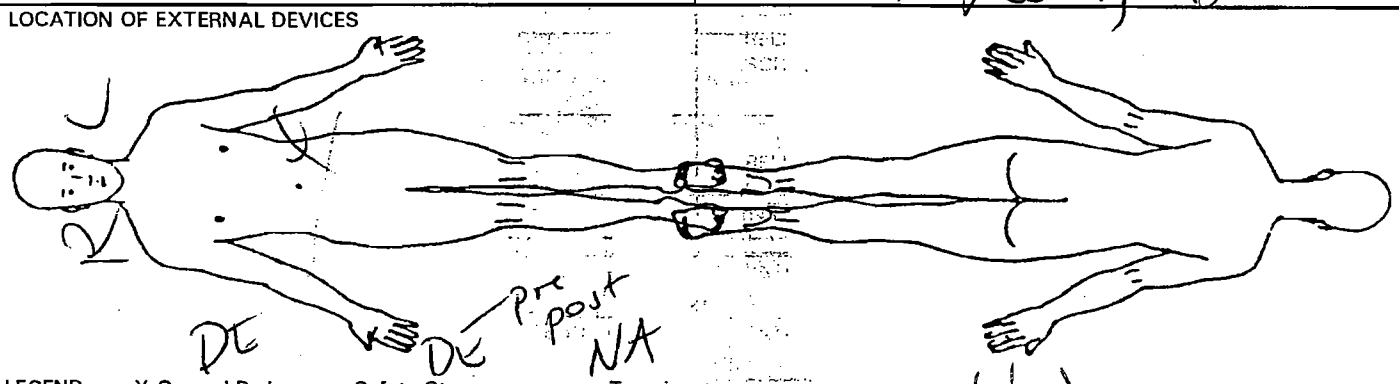
8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: (L) UE BY WHOM: [redacted]
SITE: (L) LE BY WHOM: [redacted]

COMMENTS: ∅ pooling b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS C = Correct I = Incorrect

	Yes	No	Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒	☐				[redacted]	[redacted]
Needle Sharp	☒	☐					
Instrument	☐	☒					
Other	☐	☒					

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 Form 40 R8B 10 2 3 5
GROUND PAD: BRAND VL Rem Poly II
LOT NO: 70337

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ YE ☒ NO IF YES NAME: ID NU : JUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Penrose 3/8"	2.	3.
SITE	1. (L) UE	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs Kerlix ace wrap (L) foot
fluffs - Kerlix (L) UE

19. ADDITIONAL INFORMATION
[redacted] / [redacted]
[redacted] CRNA
(R) inner thigh scrubbed c̄ Betadine per surgeon
geta

20. OPERATION(S) PERFORMED
(L) UE I+D
(L) LE I+D

21. PATIENT TRANSFERRED TO PACU TIME 655 METHOD litter

22. REGIS[redacted]

REVERSE OF D[redacted]

USAPA V1.00

b(6)-2

MEDCOM - 24422

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1																	
POST-OP DAY		0																	
MONTH-YEAR Nov 03	DAY	13			13/14			15/16		17		17/18		18					
19	HOUR	9	11	12	01			0800		00		1		0					
PULSE (O)	TEMP. F (•)	4	98	79	99					98		99		97					TEMP. C
		5	99	00	99							0							
			00	00	00							5							
180	104°																		40.6°
170	103°																		40.0°
160	102°																		39.4°
150	101°																		38.9°
140	100°																		38.3°
130	99°																		37.8°
	98.6°																		37.2°
120	98°																		37.0°
110	97°																		36.7°
100	96°																		36.1°
90	95°																		35.6°
80																			35.0°
70																			
60																			
50																			
40																			
RESPIRATION RECORD			18	21	18	16		115/66		16		18							
BLOOD PRESSURE		140/72	128/80	114/78	117/76	116/72		P89		114/69		118/76		118/69					
		89	122/74		120/82			T98.6											
		99.8		99.1				SA 99		97.9									
HEIGHT:	WEIGHT →	98%																	
						98%			98%	99%									
			98% (RA)	97% RA	98% (RA)	RA			RA	RA									
					98% RA				118/72			99% (RA)							
			pulse	92					98% (RA)										

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

C [redacted]

b(4) -4

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 [redacted]	DATE: 12 Nov 03 TIME: 2110	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		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl

======= PICCOLO =======
12/11/03 22:11
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: 0000100494

GLU	169*	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CRE	0.6	0.6-1.2	MG/DL
NA+	133	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

======= PICCOLO =======
12/11/03 16:23 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: 0000100684

ALB	3.9	3.3-5.5	G/DL
ALP	430*	26-84	U/L
ALT	18	10-47	U/L
AMY	41	14-97	U/L
AST	31	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	7.5	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PH: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI:	DATE: 11 Nov	TIME: 2210	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology b(6)		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10⁶	Asp		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		150-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	Microscopic Urinalysis		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	CSF			Blood Bank		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS: T&S

REPORTED BY:	DATE:	LAB ID NO.:

ID [redacted] 12-11-03
22:11

				Patient Limits	
WBC	16.7	H	x10^3/uL	4.5	10.5
RBC	4.01		x10^6/uL	4.00	6.00
Hgb	11.0		g/dL	11.0	18.0
HCT	32.1		%	35.0	60.0
MCV	95.4		fL	80.0	99.9
MCH	29.7		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plts	471.	H	x10^3/uL	150.	450.
LYM	15.2	*L	%	20.5	51.1
LYM	2.5	*	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/12/03 22:14

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.5 sec.
Ratio = 1.2
Calculated INR = 1.32
Sample Type:citrated wh. blood
Test Date :11/12/03
Test Time :22:13
Card Lot [redacted]
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/12/03 22:17

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 22.1 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/12/03
Test Time :22:15
Card Lot :100212[redacted]
Operator [redacted]
b(6)-2

MEDICAL RECORD - ANESTHESIA

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

60cc wasted

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

DRUG	(Units)												
Sufenta	(mcg)	24	20		10								
Propofol	(mg)	120											
Succ	(mg)	75											
	( )												
	( )												
	( )												
VOLAT AGENT Iso	% del		1.4	1.4	1.0	1.2 X							
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	8-2	2	2	2	2	8						
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		1											

FLUIDS

LINE site													
18Gn R AC	☐ Warmed	FI 2156009		Pocuroni									
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 50 (KG/LB)

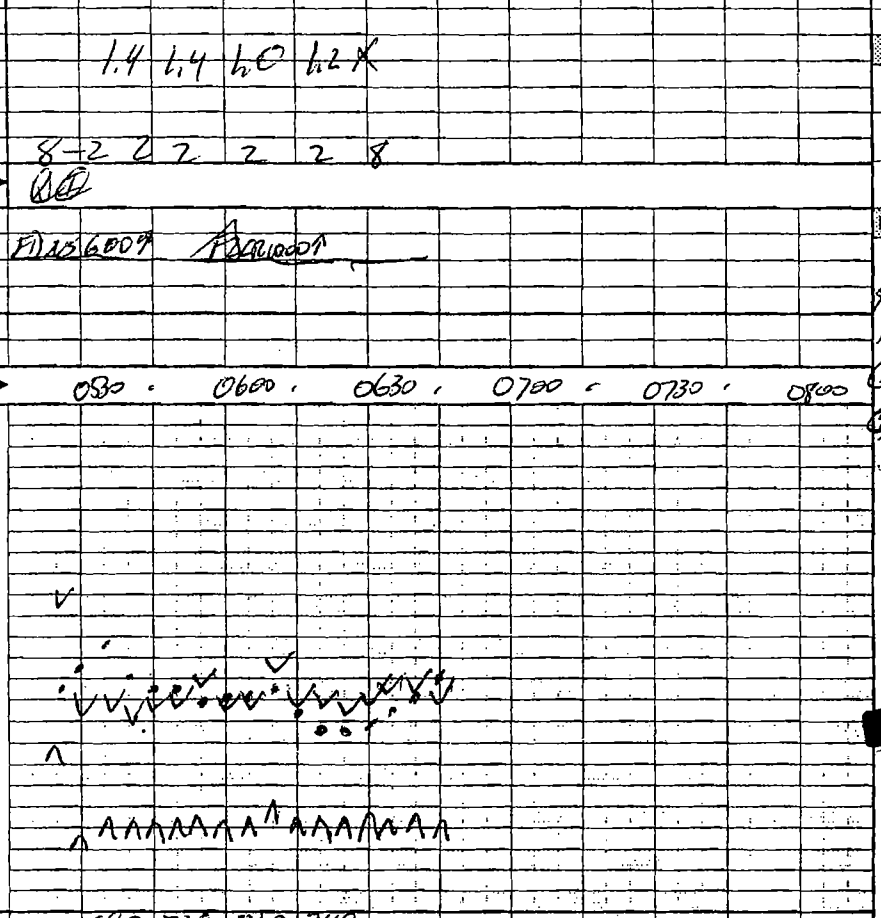
HEMATOCRIT: 38.2

INITIAL DATA: BP- / HR-

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0516

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



VENTIL

VT - ml		640	730	860	740		
f - breaths/min		10	10	10	8		
Peak inf pres / PEEP		23	22	26	21		
MODE - S(pon), A(ssist), C(on)	S A	C	C	C	C	A S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40	37	37	32	37	42
BP/oth	FIO2 (Frac or %)	.69	.69	.62	.57	.66	.55
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site		37.1	37.4	37.0	36.7	
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

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

TOTALS 50 | **TOTAL EBL** 50 min

TOTAL URINE Ø measured

FLUIDS - SUMMARY
CRYSTALLOID- 850
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
pt ID'd, in IV, POC discussed, Induction, Intubation, Induction, Stop, Rocuron 0.16 mg IVP, Extubated pt SV + PP Stand SV, Cont to PACU [redacted]

RECOVERY AT 0655
PACU ICU ____ (Specify)
OTHER ____
CONDITION: pt in NAD
T 95.5 T RESP- 12 SpO2- 99
BP- 144/44 HR- 114

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0505	0520	0620
PROC	Ready	Begin	End
	0530	0545	0635

PROCEDURES and CPT Codes: Ⓓ F I&D Ⓓ Elbow Ⓑ LE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL + 7 Emil 2 Grade I view, GETCO2 & BBS, Taped @ 21cm @ lip

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: 2
DATE: 13 NOV 03
PAGE 1 OF 1

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

133 | 104 | 9
4.1 | 22 | 0.6 | 169
Ca 8.6
16.7 | 11.9 | 38.2 | 471
INR 1.32
Multiple GSW
NPO ?
NKDA

MEDCOM - 24427

CLINICAL RECORD - DOCTOR'S OR[illegible]

se of this form, see AR 40-66, the proponent [illegible] s 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

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

Noted [redacted] 00[illegible] b(6)-2

DATE OF ORDER 12 Nov 03 | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) Admit 2cw 2
2) Dxsv multiple pathology
3) Cardiac stat
4) Vital q4° with neurovascular check
5) Activity Bedrest
6) Diet NPO

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

7) IV NS at 125cc/L
8) Meds
Ancef 1gm IV q8°
9) Ready OR tomorrow/

NURSING UNIT | ROOM NO. | BED NO.

[redacted] b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

note BRich 13Nov 0930

DATE OF ORDER 13 Nov | TIME OF ORDER _____ HOURS

1) adm. L ICW
2) s/p deb arm
3) VS q4° neurovas
4) Re, Diet
5) hep lock
6) Ancef 1gm IV q8°
7) Mag 2-6mg IV q2° prn

8/16/24

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

8) Tylenol #3 1-2 po q4° prn

b(6)-2 [redacted]

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

MEDCOM - 24428

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13 Nov	Op Note
	Debride & close arm & foot wound
	finding contused / punctured ulnar nerve at arm & forearm
	[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.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD - DOCTOR'S O[illegible]RS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	(Morphine) / Meperidine 1 mg IV now and 1 mg q 3-5 min prn pain for a	11/13/03	0745
	max dose of 10 mg.		
4	Zofran____ mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____ mg IV prn N/V x 1.		
6	Droperidol 0.625 mg IV prn N/V x 1. (or)	11/13/03	
7	Phenergan 12.5 mg IV prn N/V x 1.	11/13/03	
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ KVO cc/hr.	11/13/03	
10	Discharge from recovery status when PACU discharge criteria met.	11/13/03	
	[redacted] CRNA		
11	Meperidine 12.5 mg IVP for shivers up to 25 mg	11/13/03	0705
	Rodyn S Ehrlich CRNA		

PATIENT IDENTIFICATION

[redacted]

D(a)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: ____ Weight: 50 Kg Diet: ____

Allergies: NKDA

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

b(6)-2 A1
unless noted otherwise

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: b(6)-4 [redacted]

DATE OF ORDER: 11/14 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) D dressings q day + prn

noted [redacted]

NURSING UNIT: 240/0835 | ROOM NO. | BED NO.: 15 Nov 03 0600 [redacted]

PATIENT IDENTIFICATION: 15 Nov 03

DATE OF ORDER: 11/16

1) d/c MSO4
2) Tylenol #3 1-2 po q 4° prn
3) d/c Ariet
4) Keflex 500 mg po qid

Noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.: 16 Nov 03 1400

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER | TIME: [redacted]

24° v 17 Nov @ 0200 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 11/17 | TIME OF ORDER: _____ HOURS

1) d/c T#3 ✓
2) Motrin 400 mg po ✓ tid prn
3) Scripts in chart
4) Cump 11/1[redacted]

noted [redacted] 17 Nov 03 0835

NURSING UNIT: 240/15 Nov 03 0200 ugh | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHIC[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] b(6)-4				18NOV03	0815 HOURS	
			1	D/C to Camp		[redacted]
				[redacted] b(6)-2		18NOV03 0817
NURSING UNIT	ROOM NO.	BED NO.				
ICW#1						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

b(6)-7 A11

CLINICAL RECORD	TH EUTIC DOCUMENTATION CARE PLA ON-MEDICATION) For use of this form, see AR 40-4 the proponent agency is the Office of The Surg neral.	Mo. Nov Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18
13 Nov	[redacted]	V/S q 4° & neurovascular	D	/	[redacted]					
		checks	N	[redacted]						
13 Nov	[redacted]	Activity - bedrest (?)	D	/	[redacted]					
			N	[redacted]						
13 Nov	[redacted]	Diet: NPO	D	/						
			N	[redacted]						
13 Nov	[redacted]	Reg diet	D	[redacted]						
			N	[redacted]						
14 Nov	[redacted]	dressings Q day	10	/	[redacted]					

DIC'd

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p delgr. Arm. s/p multiple penetrating inj.

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13NOV	[redacted]	Admit ICW2 - stable	13NOV	Done		[redacted]
13NOV	[redacted]	Ready OR tonight	13NOV			
13NOV	[redacted]	admit ICW	13NOV	1135	1135	[redacted]
17NOV	[redacted]	Scrips in chart (@ pharmacy)				[redacted]
17NOV	[redacted]	camp 11/18	18NOV			
18 NOV	[redacted]	D/C to Camp	18 NOV	Noted		[redacted]

	----	b(6) - 2 A1				

Order/ Explr Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION / TIME/DATE COMPLETED													
14NOV	[redacted]	Δ dressings ~~Q eod~~	P/T													
----	----	PRN	Initial													
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

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. NOV Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17
13 NOV	[redacted]	Heplock IV	D	[redacted]				
	-----		N	[redacted]				
[redacted]								
16 Nov 03	[redacted]	Keflex 500mg po	06				[redacted]	
	-----	qid	12					
	-----		18					
	-----		24					

	-----	b(6)-2 A1						

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/p debrim. (L) arm. (mult. penetrat. injury).

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(EPW)

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
16 NOV 03	[redacted]	D/C MSO4	16	—	—	[redacted]
16	[redacted]	D/C Ancef	16	—	—	[redacted]
17	[redacted]	D/C T#3	17	—	—	[redacted]
		b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
13NOV 03	[redacted]	MSO4 2-6mg IV	D/T	D/C 16 NOV 03											
		Q2° PRN	D/I												
		Tylenol #3 1-2	D/T	13NOV 1730	15NOV 0010	15NOV 1400	16NOV 0600	16NOV 1730	D/C			17 NOV 03 @ 0830			
13NOV 16	[redacted]	PO Q4° PRN	D/I	2	[redacted]										
17NOV	[redacted]	motrin 400mg	D/T												
		TID PRN PO	D/I												

*U.S. GPO: 1998-454-110/95216

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: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 2208 ETA: 2205 UNIT: 1306
MED COM: [Y] [N]

ARRIVAL STATUS

TIME 2200 ☒ IV x Ø ☐ O_2 Ø 1/min ☐ C-Spine Immob
Meds: ☐ UKN ☒ None ☐ Yes:
Allergies: ☐ UKN ☒ None ☐ Yes:
Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake ____ hrs
LMP: ____ ☐

PRIMARY SURVEY

AIRWAY
☒ Natural Patient [Y] [N]
☐ ETT ____ ☐ ____
☐ Secretions ____

BRETHING
☐ Labored ☒ Unlabored ☐ Absent
TRACHEA: ☒ Midline ☐ Deviated [L] [R]
CHEST SYMMETRY: [L] [=] [R]

CIRCULATION
PULSE: ☒ Present ☐ Absent
BLEEDING: [Y] [N]
HEART TONES: ☒ Clear ☐ Muffled
SKIN: ☒ Warm ☐ Cool ☐ Hot
☒ Pink ☐ Pale ☐ Cyanotic ☐ ____
☒ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY
GCS: E ____ V ____ M ____ 15
SPHINCTER TONE: ☐ WNL ☐ None

HEAD
PUPILS: ☒ Equal ☐ Fixed ☒ React ☐ Dilated [L] [R]
TM: ☐ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: [Y] [N]
Pain @ ____
JVD: [Y] [N]

HEART
RHYTHM: ☒ Regular ☐ ____
PULSES: ☐ Central ☒ Peripheral

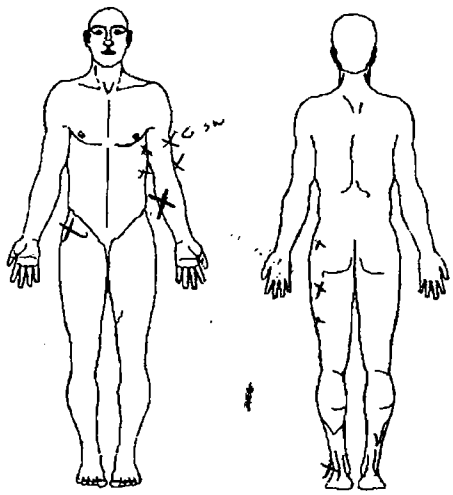
LUNGS
BREATH SOUNDS: ☒ Bilat ☒ Equal ☒ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☒ Soft ☐ Rigid ☒ Non-Tender
☐ Tender: ____

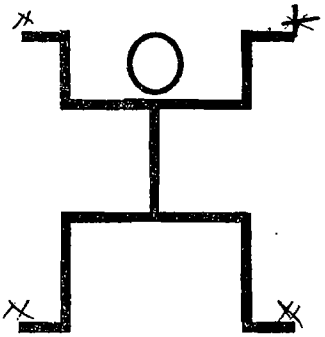
PELVIS
☒ Stable ☐ Unstable ☐ ____
Blood at meatus/vagina: [Y] [N]
Heme+/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN: [redacted]

PHYSICIAN: [redacted]

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: 28th EMT

DATE: 12 NOV 03

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

[redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		[redacted] TCO_2 Change [redacted]BS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☐ Chem ☒ PT/PTT
2205	☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☒ Pelvis
	☐ (A) Femur Groin
	☐ (B) Femur Foot
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast [redacted]		
	☐ Head ☐ Abd ☐ [redacted]		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
2205	1	18	Y	N	RAC	NS	1L	
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

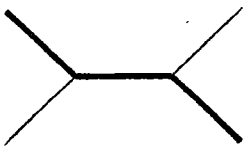
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Ancef	2205	1Gm	IV						
tetanus	2205	.5cc	IM						
MSO4	2220	1.5mg	IV						

BLOOD PRODUCTS

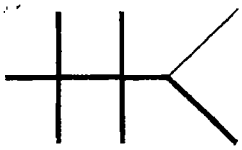
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]	✓	✓	✓
Surgeon	[redacted]	✓	✓	✓
Anesth				
	blue-2			
X-Ray	[redacted]	✓	✓	✓
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to_____

Report Called to_____

Time Transferred_____

Accompanied By_____

Via: ☐ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp: Tympanic 97.[illegible] GCS: 15

TIME	BP	HR	RHY	[illegible]	SAO$_2$	FIO$_2$	MODE	E	V	M	T
2206	145/72	105	SR	23	98%		RA	4	5	6	15
2200	134/71	100	SR	20	98		RA	4	5	6	15
2240	152/81	101	SR	20	99		RA	4	5	6	15
2310	129/83	95	SR	20	99		RA	4	5	6	15
2325	138/77	93	SR	20	98		RA	4	5	6	15

GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - [illegible]aneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

2200 - 15y/o IRAQI CIV c̄ GSW to (D) humerus. Airway intact, Lungs CTA bilat. Heart RRR. Open wound to (D) humerus, (L) forearm. Shrapnel to (D) chest, bilat femur, (D) heel. X-RAY & LABS pending. 18g to RAC started c̄ NS. Ancef and Tetanus given. MSO4 1.5mg IV for pain. Wounds to (D) arm covered c̄ Kerlix.
2230 - Ortho & Surgery consult. Pt has Ø c/o pain at this time. pt sleeping c̄ brother at bedside.

2400 Report given to ICW2 Lt [redacted] transport to ICW2 via stretcher c̄ staff and IP [redacted] ILt/AN
2430 Report given to ICW1 Cpt [redacted] ILt/AN

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDI

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

TA

on General.

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

OTSG APPROVED (Date)

Date: 13 NOV 03

Time In: 0705

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

Allergies: _____ OR Intake: Crystalloid 800 Colloid _____

Pre-op V/S: _____ OR Output: UOP _____ EBL M.A.

Procedures: _____ Meds/Times: _____

I&D elbow BIL LF

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

Pre Op Meds _____ History _____

Time	0700	0710	0715	0720	0730	0740	0750
SaO2	100	100	95	100	98	95	95
FiO2	2L	2L	2L	2L	2L		
Methods	NC	NC	NC	NC	NC	RA	RA
240							
220							
200							
180							
160							
140						134/76	145
						132/86	
120							
100							
80						85	85
60							
40							
20							
HR					12	125	132
RR	20	16	20	20	22	20	20
T	99						99

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0705	PL	500	RA	TNG	250

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	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

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

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

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

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

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 13 NOV 03

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

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

USAPPC V2.00