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 R VIA ~~to~~ ICU bed BY Anesthesia	2. PATIENT IDENTIFI[redacted]ORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 10OCT03 TIME PATIENT ARRIVED IN SUITE 0835	4. PATIENT IN ROOM TIME 0835 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER (Specify) intubated

COMMENTS: NKA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt initially supine on padded OR Bed, Head on foam doughnut Arms out to sides <90°, in CAP secured to padded Armboards c safety straps. Then pt moved

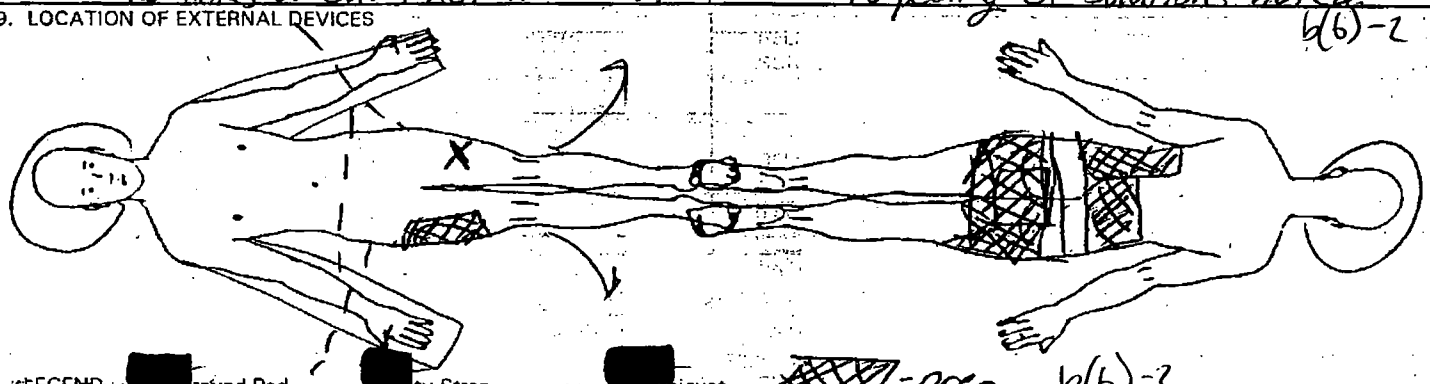
☒ SUPINE ☒ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☒ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: to low lith - legs supported in padded Black Leg holders, - no pressure points noted. Pt rolled to (R) side for access to back injury. Pt secured via nursing staff. Correct Body Alignment maintained throughout

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☒ RAZOR by Dr [redacted] ☐ CLIP	PREP SOLUTION (Specify) Beta / Beta SITE: anal area BY WHOM: CPT [redacted] SITE: (R) thigh + lower back BY WHOM: Beta paint [redacted]
COMMENTS: no nicks or cuts noted b(6)-2	COMMENTS: no pooling of solutions noted.

9. LOCATION OF EXTERNAL DEVICES b(6)-2



LEGEND: [redacted] round Pad [redacted] ty Strap = = = [redacted] ourniquet -prep b(6)-2

10. COUNTS C = Correct I = Incorrect

			Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	SGT [redacted]	CPT [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] b(6)-4

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

☒ ESU NO: RSE 105305
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 70011 / 2005-04

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM A E .URER

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 - QS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1" penrose	2.	3.
SITE	1. wound to R of anus.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Moist Kerlex, Kerlex Fluffs, Kerlex Roll Silk tape to ~~Dressing~~ I+D sites to (R) thigh + lower back

19. ADDITIONAL INFORMATION
WC IV b(6)-2
Surgeon: Dr [redacted] Anesthesia: Gen/Endo CPT [redacted]
Bovie pad site preop COI postop COI Bovie set 30/30 Blend 1

DA Form 5179 initiated

20. OPERATION(S) PERFORMED
Rectal wash out, Presacral drainage, arteriogram, I+D (R) thigh
I+D lower back

21. PATIENT TRANSFERRED TO ICU 3 b(6)-2 TIME 1030 METHOD ICU Bed

22. REGIS [redacted] CPT/AN

REVER [redacted] MEDCOM - 21442 USAPA V1.00

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the propon[illegible] s the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING F. VIA ICU bed BY Anesthesia	2. PATIENT IDENTIFI[illegible] CORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 11OCT03 TIME PATIENT ARRIVED IN SUITE 1020	4. PATIENT IN ROOM TIME 1020 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) pt on padded OR bed head on foam doughnut, B/L arms out to sides 290 on CAP, secured to padded armboards c safety straps, p (R) thigh pt rolled to (R) lateral position

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

COMMENTS: bag Axillary roll in place (L) arm across chest + on pillow (R) arm out on padded armboard both secured pillow between knees + ankles. Bean bag used throughout case for proper positioning + securing (also as bump under (R) hip during supine) Correct Body Alignment maintained through

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR (R) thigh by CPT [redacted]
☐ CLIP

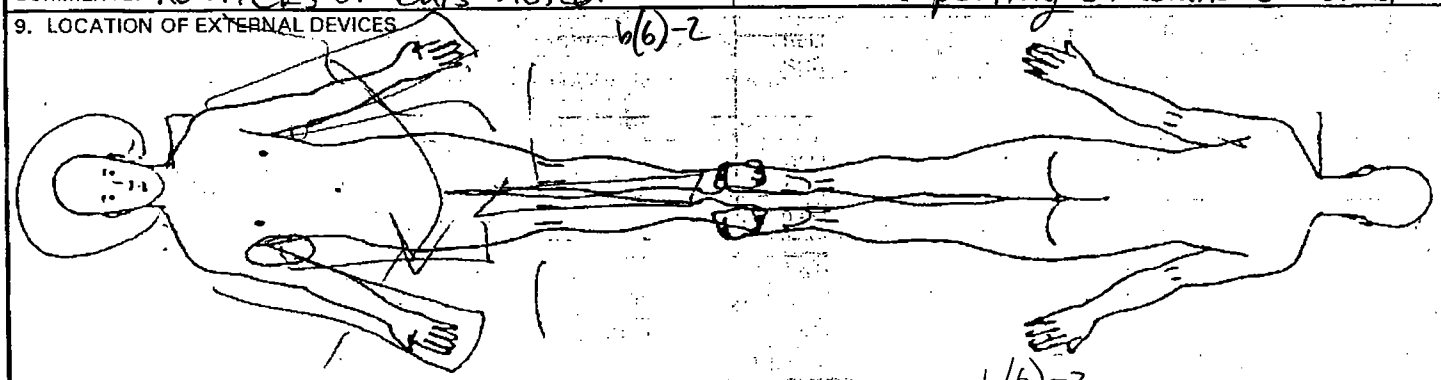
PREP SOLUTION (Specify) Beta/Beta
SITE: BY WHOM: CPT [redacted]
SITE: (as below) BY WHOM:

COMMENTS: no nicks or cuts noted

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES

b(6)-2



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

b(6)-2

C = Correct I = Incorrect

10. COUNTS			Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	SSG [redacted]	CPT [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] b(6)-4

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

☒ ESU NO: R8E 105305
GROUND PAD: BRAND Valleylab Blyhesive II REM
LOT NO: 20011/2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUMB N TURER

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 - QS.

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 (R) thigh wound tissue CX	NAME (L) Buttock tissue CX
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)
(R) Thigh - Kerlex Fluffs, ABD, Pad Kerlex Roll, Silk tape.
(L) Buttock - NS moist Kerlex Roll, ABD pad - Silk tape

19. ADDITIONAL INFORMATION
WC - IV
Surgeon - Dr [redacted] b(6)-2 Anesthesia - Gen/Endo - CPT [redacted] b(6)-2 CRNA.
Bovie setting: 30/30 + 45/45 Blend 2 - Bovie pad Site pre-op - CDI / Post-op - CDI

DA 5179 previously initiated Ø O's noted

20. OPERATION(S) PERFORMED
I+D of (R) thigh wound
I+D of (L) Buttock wound

21. PATIENT TRANSFERRED TO ICU b(6)-2 | TIME 1150 | METHOD ICU Bed

22. [redacted] CPT/AN

[redacted]

USAPA V1.00

b(6)-2

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 ROOM VIA Wheeled ICU bed BY CPT [redacted]

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

3. DATE 12OCT03 TIME PATIENT ARRIVED IN ROOM 1600

4. PATIENT IN ROOM TIME 1600 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 910 b(6)-2	RELIEF SCRUB	b(6)2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	MAJ [redacted] (1255-End)

7. POSITION AND POSITIONAL AIDS (Specify) Pt began in supine B/L at arms extended out to sides <90° in CAP secured to padded arm boards c safety straps. ⊕ Laparotomy pt rolled to (R) side secured

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

COMMENTS: in place c bean bag. IV bag Axillary roll in place, folded Blankets between arms (R) arm on padded armboard. (L) across to front of body, Pillow between knees + ankles Correct Body Alignment maintained throughout.

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

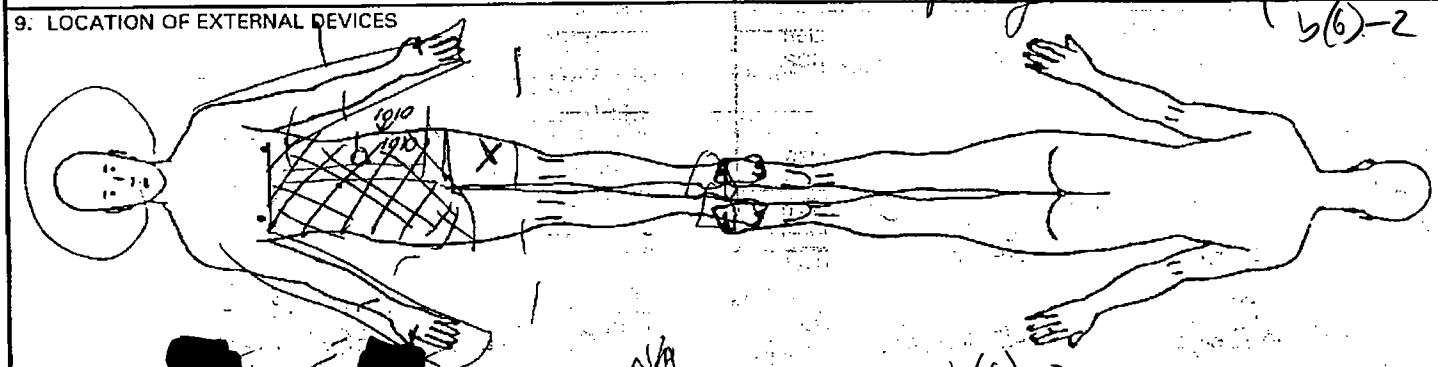
PREP SOLUTION (Specify) Betadine/Betadine

SITE: ABD (Q) below BY WHOM: CPT [redacted]

SITE (L) Flank + Buttock BY WHOM: CPT [redacted]

COMMENTS: no pooling of solutions (noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No	C	C	C	PFC [redacted]	CPT [redacted]
Needle Sharp	[X] Yes	[ ] No	C	C	C		
Instrument	[X] Yes	[ ] No	C	C	C		
Other	[ ] Yes	[ ] No					

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

[redacted]

b(6)-4

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

[X] ESU NO: R8E 105305

GROUND PAD: BRAND Valleylab Polyhesive II REM

LOT NO: 79011/2005-04

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ Y ☒ NO IF YES NAME: ID NUME AC RER

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 - QS

OTHER ORDERS	TIME	CARRIED OUT BY

b(6)-2

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING R[redacted] F YES, SITE

YES ☐ NO ☒ [redacted]

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME (L) Buttock wound CX	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlix	2. Kerlix	3.
SITE	1. LT ~~Rt~~ hip	2. Rt thigh	3.

18. DRESSING/IMMOBILIZATION (Specify)

ABD - Kerlex Roll c 0.9% NaCl, Kerlex Fluffs, ABD pads, silk tape - new colostomy wafer + bag.

(L) Buttock - ABD tape

Rt Thigh - ABD tape

19. ADDITIONAL INFORMATION

WC-IV

Surgeons Dr [redacted] b(6)-2

Dr [redacted]

Anesthesia - Gen/Endo - CPT [redacted] CRNA

Bovie settings 30/30 Blend 1 - Pad site pre-op CDI post-op C

20. OPERATION(S) PERFORMED

Reclosure of Abdominal wound dehiscence.

b(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	See SF577	ICU Bed.

22. [redacted] CPT/RN

[redacted] 5179-1, OCT 87 MEDCOM - 21446 USAPA V1.00

MEDICAL RECORD

INTRAOPERATI" E DCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING R
VIA Litter BY Anesthesia

2. PATIENT IDENTIFI CORD REVIEWED AND PROCEDURE
VERIFIED BY CPT [redacted] b(6)-2

3. DATE 13 Oct 05
TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1045 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained, beam bag used, axillary roll in place, (R) arm on pillow, (L) arm on pillow, pillow between legs, position approved by surgeon + anesthesia

8. SKIN PREPARATION

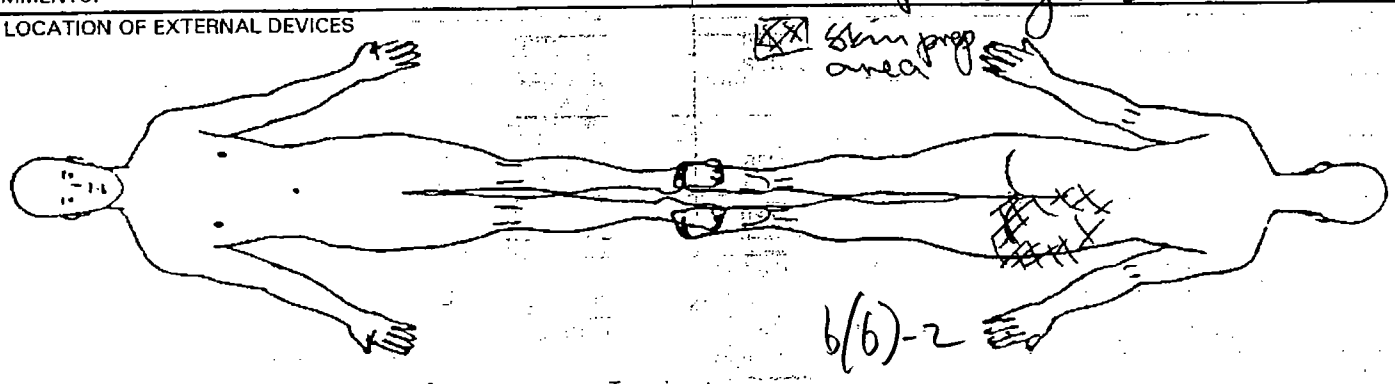
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (L) Buttock (except wound) BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial: [redacted]

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	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] b(6)-4

13 Oct 05

28th CSH

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
Coag 45, cut 45

☒ ESU NO: Valleylab Force 40
GROUND PAD: BRAND VL Dual Polyhesive II
LOT NO: 70011 2005-40

☐ 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 NUMBI NUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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. 16F FIC	2. Kerlix +2	3.
SITE	1. Bladder	2. (L) Buttock	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix
ABD
Tape

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

-DA 5179 on chart, ∅ 4's noted
-FIC already in place prior to arrival in OR

20. OPERATION(S) PERFORMED
Washout + Debridement (L) Buttock Wound

21. PATIENT TRANSFERRED TO		TIME	METHOD
ICU 3	b(6)-2	see DA 5179	Bed

22. [redacted] CPT HN

REV[redacted]

USAPA V1.00

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the prop[illegible]y is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATI[illegible] VIA ICU Bed BY Anesthesia
2. PATIENT IDENTIF[illegible] VERIFIED BY ILT [redacted] ORD REVIEWED AND PROCEDURE b(6)-2
3. DATE 15 OCT 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 1500 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] AN	RELIEF CIRCULATOR	

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

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

(R) arm across chest c̄ pillow between arm. (R) leg bent c̄ pillow between legs.

COMMENTS:

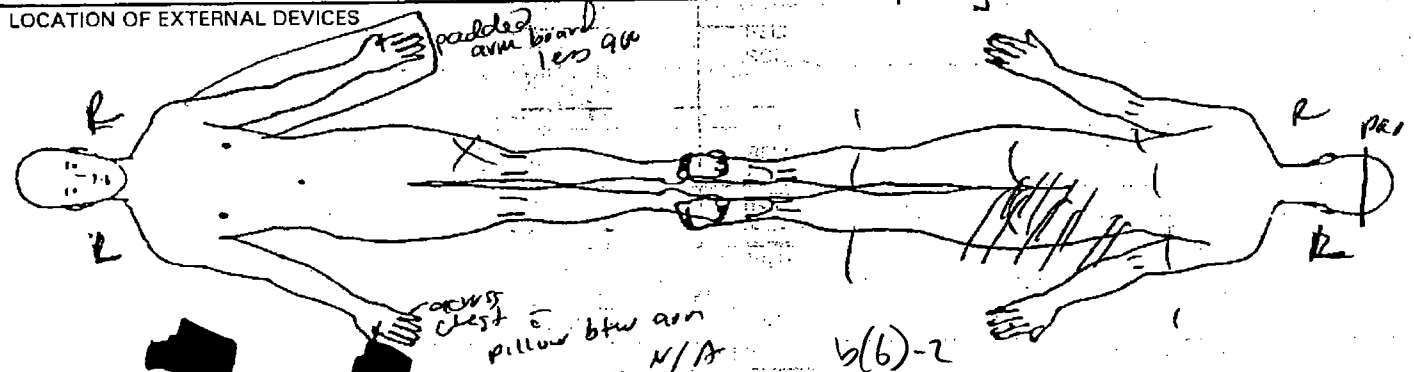
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine
SITE: (R) hip/Bethesda BY WHOM: MAJ [redacted] AN
SITE: ~~XX~~ see #9 BY WHOM: b(6)-2
COMMENTS: ∅ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X Ground Pad [redacted] Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect Initial SPC [redacted] / MAJ [redacted] AN

			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	SPC [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] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 35/35

☒ ESU NO: R&B 102395
GROUND PAD: BRAND Valleylab
LOT NO: 68245 Exp 2005-02

☐ 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 NUMBE N C ER

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 total 6 l

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 FR Fob [redacted]	2. Kerlix 6ply x2	3.
SITE	1. (R) buttock	2. (R) Buttock	3.

19. ADDITIONAL INFORMATION
Surgeon:
Anesthesia: MAJ [redacted]

b(6)-2

20. OPERATION(S) PERFORMED
I+D Rectal injury / (L) Flank

21. PATIENT TRANSFERRED TO ICU 3 TIME 1635 METHOD Litter c O2

22. REGISTERED [redacted] IGNATURE [redacted] MAJ/AN

REVERSE OF DA F[redacted] [redacted] MEDCOM - 21450

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the [redacted]cy is the [redacted] of The Surgeon General.

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

2. PATIENT [redacted] AND PROCEDURE
VERIFIED BY [redacted] MAJ/AC

3. DATE 17 OCT 03 TIME PATIENT ARRIVED IN SUITE 1610

4. PATIENT [redacted] TIME 1610 [redacted] NUMBER 2-8

5. PREOPERATIVE EMOTIONAL STATUS b(6)-2

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

COMMENTS: Pt awake c/o pain

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], ORT b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table anatomically aligned for surgical procedure c̄ pillow + towel under head, R arm on padded arm board less 90°

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

COMMENTS: R arm across chest. pillow between legs

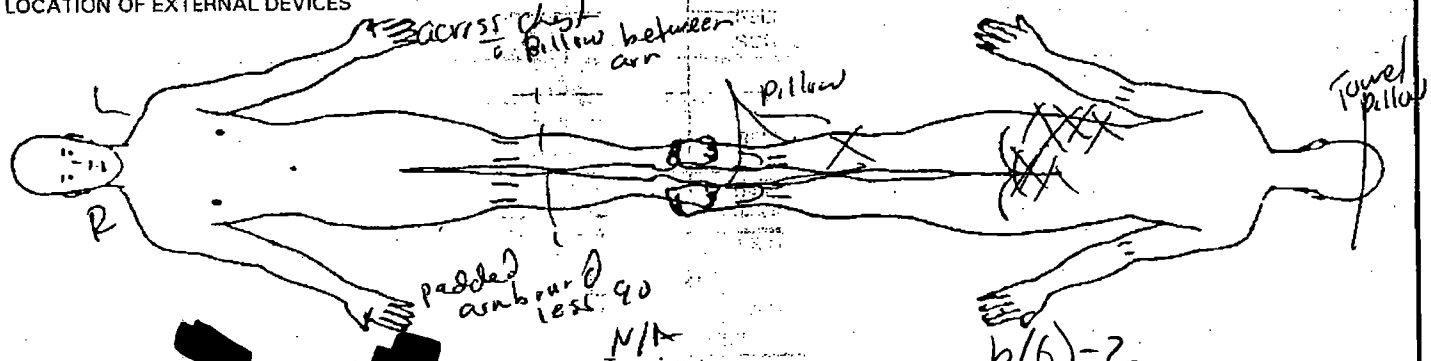
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine / Betadine
SITE: L Buttock BY WHOM: MAJ [redacted] AC
SITE: BY WHOM: b(6)-2
COMMENTS: ☆ prolong of solution note)

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Groun[redacted]ad -- S[redacted]trap = = = Tourniquet

b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	PFC [redacted]	MAJ [redacted]
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] b(6)-4

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

☒ ESU NO: SN: BRB 102395
GROUND PAD: BRAND Valley lab Rem Polyhesive
LOT NO: 70011 Exp 2005-04

☐ 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

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 Aerobic culture (L)	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlix roll x2	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix packing
Ioband

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

20. OPERATION(S) PERFORMED
I+D (L) flank wound / Buttock

21. PATIENT TRANSFERRED TO ICU TIME 1700 METHOD Litter c O2

22. REGISTERED NU[redacted] MAJ/AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 21452

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 ROOM VIA Litter BY MAJ [redacted]

2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 20 Oct 03 TIME PATIENT ARRIVED IN SUITE 1225 b(6)-2

4. PATIENT IN ROOM TIME 1225 b(6)-2 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB b(6)-2	
ASSIGNED CIRCULATOR	MAJ [redacted] (SOC-1240)	RELIEF CIRCULATOR	CPT [redacted] (1235-ECC)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Pt positioned on beanbag, pillow between legs, arm on padded armboard

8. SKIN PREPARATION

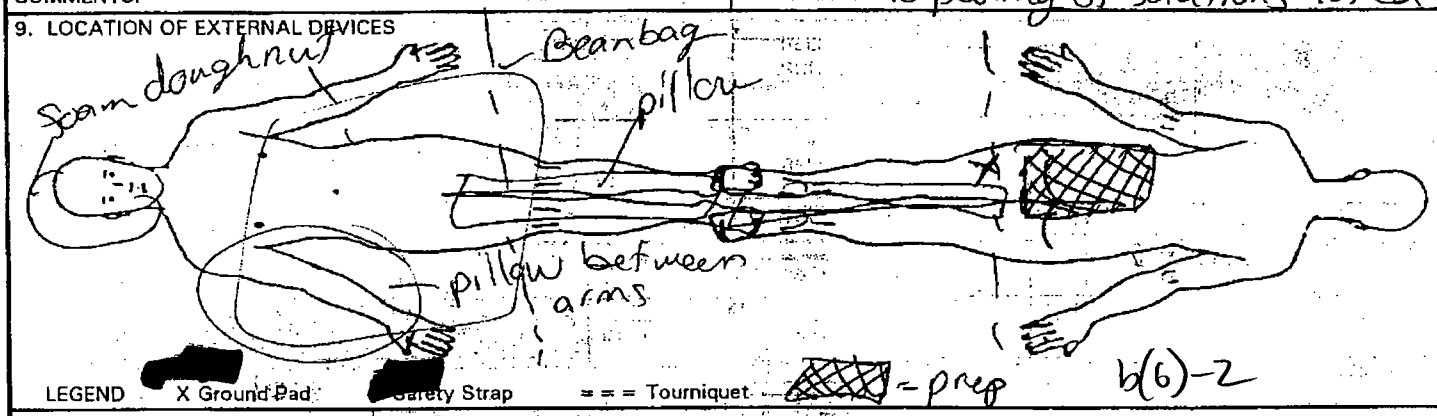
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine scrub & solution
SITE: (L) Buttock BY WHOM: CPT Gibbon;
SITE: (as below) BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Safety Strap = = = Tourniquet [redacted] = prep

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	C		C	[redacted]	[redacted]
Needle Sharp	☐ Yes	☐ No	C		C		
Instrument	☐ Yes	☑ No					CPT
Other	☐ Yes	☐ No					

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

[redacted] b(6)-2

b(2)-2

[redacted] 20 Oct 03

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

☑ ESU NO: R&B 10239S
GROUND PAD: BRAND Valleylab
LOT NO: 70011 Exp 2005-04

☐ 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 NUMB[illegible] [illegible]TURER

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): N.S.
0.9% NaCl - QS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. ~~J.P. x 2~~ TG 10mm Flat Drain	2.	3.
SITE	1. in (L) Buttock wound - to wall suction	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
0.9% NaCl moist Kerlex Rolls, (packed) Kerlex Fluffs. Ioban.

19. ADDITIONAL INFORMATION WC-IV
Surgeon: Dr [redacted] b(6)-2
Anes: MAJ [redacted] CRNA
Bovie settings 30/30 Blend 1-F - Pad site pre-op CDI - post-op CDI

DA 5179 previously initiated ØΔ's noted.

20. OPERATION(S) PERFORMED
I&D (L) Buttock wound. Δ colostomy wafer + bag.

b(6)-2

21. PATIENT TRANSFERRED TO ICU 3 TIME 1340 METHOD wheeled litter

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

REVERSE OF DA FORM 5179, [illegible] MEDCOM - 21434 USAPA V1.00

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 VIA Wheeled litter BY Anesthesia

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

3. DATE 24OCT03 TIME PATIENT ARRIVED IN SUITE 0905

4. PATIENT IN ROOM TIME 0905 b(6)-2 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR Bed. + Bean bag used to secure position. Head on foam doughnut (R) Arm extended out + (L) arm across to front of body, pillow between arms, pillow between knees + ankles, folded towel under (R) Ankle

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

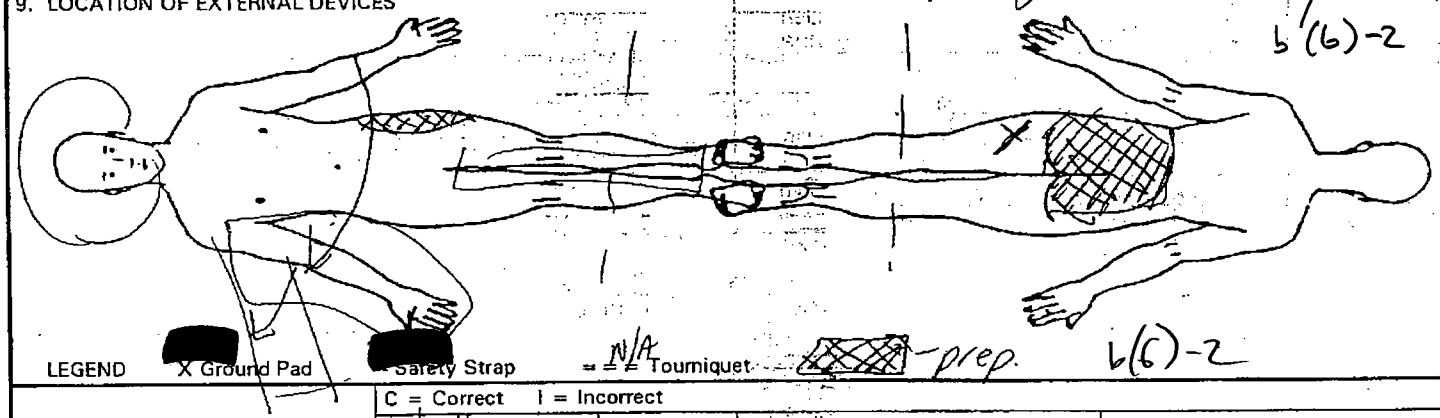
COMMENTS: Correct Body Alignment maintained throughout.

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR to Buttocks ☐ CLIP
By Dr. [redacted] b(6)-2
COMMENTS: no nicks or cuts noted.

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Buttocks + (L) hip BY WHOM: CPT [redacted]
SITE (R) thigh + Abdominal wound + colostomy BY WHOM: Chlorhexidine by [redacted]
COMMENTS: no pooling of solutions noted.

9. LOCATION OF EXTERNAL DEVICES



10. COUNTS

C = Correct I = Incorrect

			Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No	C		C	PFC [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No	C		C		
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] b(6)-2

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

☒ ESU NO: R8E 105305
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 70011 / 2605-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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 NUMBE UF URER

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	

18. DRESSING/IMMOBILIZATION (Specify)
(R) Thigh (A) bdomen - NS soaked Kerlex Fluffs, ABD, Silk tape.
(L) Buttocks - NS soaked Kerlex Roll, Ioban.

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10 Fr Bobbhoff	2.	3.
SITE	1. NG	2.	3.

19. ADDITIONAL INFORMATION
WC-IV b(6)-2
Surgeon: Dr [redacted]
Anesthesia: MAJ [redacted] CRNA
Bovie: Setting 30/30 Blend 1-Ful. / Pad site: pre-op CDI post-op CDI

DA 5179 previously initiated ∅ ∆'s noted

20. OPERATION(S) PERFORMED
wash out (L) Buttocks wound + ~~re~~ - Vac dressing, replace dobhoff.
∆ Colostomy Bag, Abdominal wound, + (R) Thigh wound Dressings c̄ washing

21. PATIENT TRANSFERRED TO ICU3/PACU TIME 1040 METHOD wheeled litter

22. [redacted] CPT/AN
[redacted] b(6)-2

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the prop[illegible] ency [illegible] he office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING
VIA Litter BY CPT [redacted] / CPT [redacted]

2. PATIENT IDEN[redacted]IEWED AND PROCEDURE
VERIFIED BY [redacted] b(6)-2

3. DATE 27OCT03 TIME PATIENT ARRIVED IN SUITE b(6)-2

4. PATIENT IN ROOM
TIME NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Irrigi made for repeat rectal workup

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Pillow between arms. Axillary roll under down axilla. Pillow between legs.

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

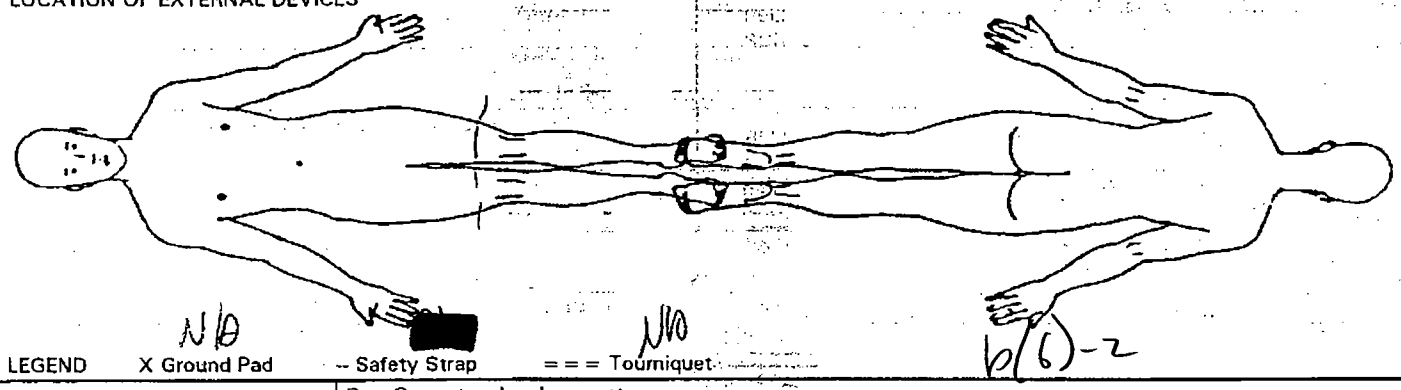
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/paint
SITE: Left Buttock BY WHOM: CPT [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS: no poultry noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (N/A) -- Safety Strap [redacted] b(6)-2 = = = Tourniquet (N/A)

10. COUNTS

C = Correct I = Incorrect

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

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

#[redacted] b(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBE JU TURER

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME (1) Gram Stain Left Buttock Fluid	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME (2) Aerobic Left Buttock Fluid	NAME
CULTURE (C) YES ☒ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*

DBDx2 Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerley Bulb	2.	3.
SITE	1. Left Buttock	2.	3.

19. ADDITIONAL INFORMATION

Surgeon – Dr [redacted] b(6)-2
Anesthesia – CRNA [redacted]

20. OPERATION(S) PERFORMED

I&D Left Buttock wound b(6)-2

21. PATIENT TRANSFERRED TO [redacted] TIME 2020 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CRL

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

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 ROOM VIA Wheeled stretcher BY Anesthesia

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

3. DATE 02NOV03 TIME PATIENT ARRIVED IN SUITE 0750

4. PATIENT IN ROOM TIME 0750 b(6)-2 NUMBER 1-2 Day

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed Head on foam doughnut R Ears pressure, Bean Bag used to maintain position, Arms out to front of body (R) Arm on padded armboard, pillow on top of (R) Arm, (L) Arm on top of pillow, Arms secured c safety strap, Axillary Roll in Place, Pillow between legs (knees + ankles)

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

COMMENTS: Correct Body Alignment Maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

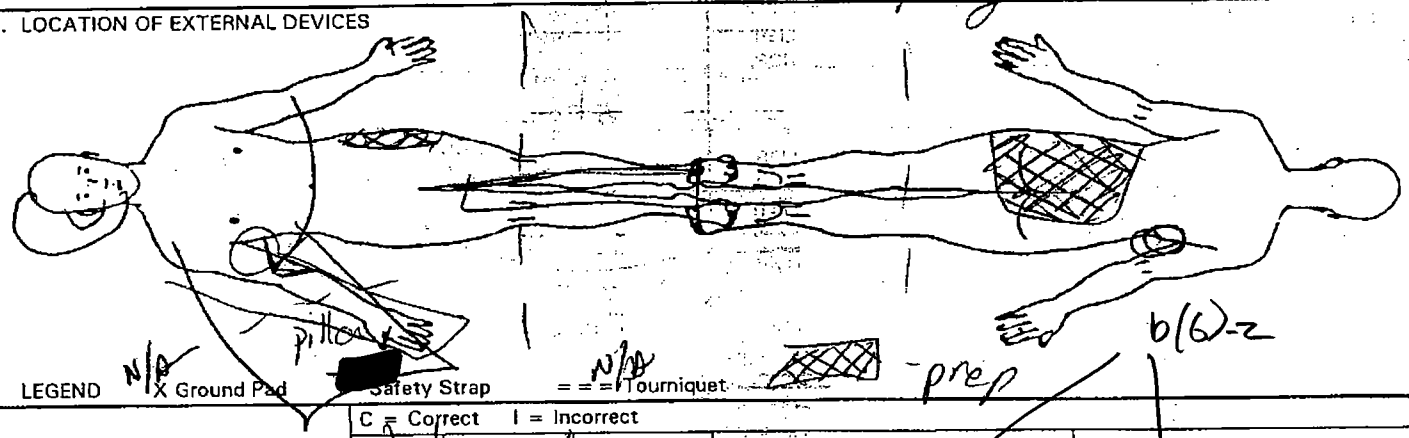
COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine BY WHOM: CPT [redacted]

SITE: (L) Buttocks + Back (as below) BY WHOM: b(6)-2

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Initial Count Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	C		C	PFC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No	C		C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

b(6)-4

[redacted]

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

13. PROSTHESIS, IMPLANTS ☐ Y ☒ NO IF YES NAME: ID NUMB N...ACTURER

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 - 3000 + cc

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. 16F Foley Replaced	2.	3.
SITE	1. urinary Bladder	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
0.9% NaCl moistened Kerlex Roll, ABD pad, silk tape.

19. ADDITIONAL INFORMATION
WC - IV
Surgeon - Dr [redacted]
Anesthesia - MAJ [redacted] CRNA - Gen/Mask
b(6)-2

DN 5179 previously initiated

20. OPERATION(S) PERFORMED
I&D/washout (L) hip wound b(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	0835	wheeled stretcher

22. REGISTER [redacted] CPT/MW

REVERSE OF [redacted]

MEDCOM - 21460

USAPA V1.00

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	29 OCT										
POST- DAY											
MONTH-YEAR / DAY			31/31			1 Nov	2/3				
19 / HOUR	0	8	12	16	20	24	0	8	12	16	20

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 109/56, 104/53, 89/41, 108/65, 108/81, 84, 89, 98, 111/56, 9/108, 110/60, 109/61, 108/60

HEIGHT: WEIGHT →

97, 99.2, 99%, RA, 98% (RA), 98% (RA), 99%, 98%, 99% (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)-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 OCT 2003 | DAY: 23, 24 OCT, 27/28th, 26, 26, 27, 28 OCT | HOUR

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

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

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

b(6)-2

RESPIRATION RECORD

BLOOD PRESSURE

113/52 117/57 110/60 110/50 107/55 110/58 108/60 106/58
119/58 113/56 114/58 110 104/57 91 10/49 116/62
102
99 8
94

HEIGHT: WEIGHT →

99% (RA) 99% (RA) 99% (RA) 99% (RA) 99% (RA) 98% (RA) 98% (RA) 98% (RA) 98%

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] b(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

(b)(2)-2 ICU 3 PACU [redacted] b(6)-4 8.0 ETT 25@ teeth

[redacted]

VENTILATOR FLOW SHEET

GSW thru butt

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
10 Oct	0600	SIMV	14	650	40	15	18	20	98	98	107/67	7.28	42	272	-7	20	100	ok - [redacted] 12-7/4
	0800	SIMV	14	650	40	5	19	21	123	100	93/40							[redacted]
	1010		OK															[redacted]
	1220	SIMV	16	650	40	5	18	20	128	100	78/52							[redacted]
	1420	SIMV	16	650	40	5	20	16	119	100	89/55							[redacted]
	1559	SIMV	16	650	40	5	20	18	123	100	85/47	7.39	37	179	-2	23	100	[redacted]
	1812	SIMV	14	650	40	5	22	14	121	100	93/45							[redacted] BBS CTA 5+
	1951	SIMV	16	650	40	5	21	17	123	100	94/44							[redacted]
	2237	SIMV	16	650	40	5	21	16	130	100	81/40							[redacted] BBS CTA 2+
11 Oct	0020	SIMV	16	650	40	5	23	16	117	100	83/48							[redacted]
	0240	SIMV	16	650	40	5	22	16	116	100	88/50							[redacted]
	0430	SIMV	16	650	40	5	24	16	117	100	93/45							[redacted]
	0530	SIMV	16	650	40	5	22	16	114	100	94/48							[redacted] nurse doing during [redacted]
	0800	SIMV	16	650	40	5	23	16	114	100	N2							[redacted]
	1000	SIMV	14	650	40	5	23	16	110	99	109/59							[redacted]
	1200	SIMV	16	650	50	5	23	16	99	98	117/58							[redacted]
	1400	SIMV	16	650	50	5	24	16	106	99	119/49							[redacted]
	1600	SIMV	16	650	40	5	25	16	111	99	122/52							[redacted]
	1743	SIMV	PE	extubated		Placed		on	8L	Aerosol	1	mask						[redacted]
12 Oct	0430	[redacted]			3L	NC		23	123	98	130/62							[redacted]

b(6)-2

MEDCOM - 21463

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 06 HOURS TO 06 HOURS	TOTAL HOURS COVERED 24	DATE 24-25OCT

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

buttock vac ~~IRRIGATIONS (NG, Bladder, etc.)~~ (suction)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

b(6)-4

#[redacted]

24OCT - 25OCT
0600 - 0600

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
06-18	H2O	600	600cc
↓	Ensure X 4		
↓	Juice X 2	480	
31OCT06	H2O	400	400
18	juice X 3	680	1080cc
1400	H2O	240	1320cc
2NOV03	06-1800	———	↓
→ 1200	200cc (H2O)		200cc
→			

INTRAVENOUS

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

(FOLEY) ~~IRRIGATIONS (NG, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
(31OCT) 1400	(CYU)	1000	1000cc
2NOV.03	06-1800	↓	↓ ↓
1230	(CYU)		400cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

TEST(S)
SPECIMEN TAKEN
DATE 10/10/03 TIME 1531
REQUESTED
RESULTS

ABG:
pH - 7.392
PCO_2 - 37.2
PO_2 - 179
Na - 143
K - 3.8
iCa - 1.17
Hct 23 Hb-8
HCO_3 - 23
TCO_2 - 24
BE - -2
SO_2 - 100

REMARKS [redacted]

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD TECH
DATE
LAB ID NO.

MISC
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ OUTPATIENT ☐ NP
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.

MISCELLANEOUS 557-107
STANDAI Prescri FIRMR

[redacted] b(6)-4

TEST(S)
SPECIMEN TAKEN
DATE 10 OCT 03 TIME 1800 A.M. P.M.
REQUESTED
CBC with DIFF
RESULTS
ABG (1-shot)
4 Pm
99.0
pH - 7.419
PCO_2 - 38.4
PO_2 - 172
HCO_3 - 25
TCO_2 - 26
SO_2 - 100
BE - 0
Na - 143
K - 4.1
iCa - 0.98
Hct - 18
Hb - 6

REMARKS [redacted] b(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD TECH
DATE
LAB ID NO.

MISC
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO. 1C043

MISCELLANEOUS 557-107
JARD Prescribi MR (4

[redacted] b(6)-2

[redacted] b(6)-4

SPECIMEN/LAB RPT. NO. 1603
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
MED. RECORD
PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S [redacted]URE
REPORTED BY
MD TECH
DATE 10 OCT 03
LAB ID NO. 1550
REMARKS
[redacted] b(6)-2

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

557-107
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

Baso - 2
EOS - 4
Band - 36
Seg - 12
Lymph - 30
Mono - 16

2+ Hypochromic
Platelet decreased

b(6)-2

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

10/10/03 16:14

REFERENCE RANGE: MALE

PATIENT #: [redacted]

GENERAL CHEMISTRY 12

DISC LOT #: [redacted]

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

b(6)-4

ALB	2.2*	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	33	14-97	U/L
AST	52*	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	72*	100-200	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
GLU	106	73-118	MG/DL
TP	4.4*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

[redacted] (b)(2)-2

Microbiology Request Form

Last Name: EPW

First Name:

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

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

Date: 28 SEP 03

Time: 1115

Ward: EMT ICU

Room:

Bed: b(6)-2

Physician: [redacted]

Source: BLOOD

Site:

[redacted]

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

Date: 28 SEP 03

Time: 1230

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

Laboratory Results

NO GROWTH

Reported

Date: 3 OCT 03

Time: 0900

Tech: [redacted]

Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 21468

b(6)-4 b(6)-2

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 10/10/03 TIME 0505	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
[redacted]		
Bands		Eos

Urinalysis

TEST	RESULT	REF. RANGE
Color	straw	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	trg	Negative
pH	6.5	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
	neg	Negative
		Negative
		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

Nothing Seen

CSF

gen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH
	F+C x2	

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/10/03 05:31

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 :10/10/03
Test Time :05:29
Card Lot [redacted]
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/10/03 05:33

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 :10/10/03
Test Time :05:31
Card Lot [redacted]
Operator : [redacted]

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section:	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. # [redacted]	[redacted] DATE 10/10/03	TIME 0505	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANG
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.285	7.31-7.45
PCO2	42.0	35-45 mmHg (a 41-51 mmHg (ve
PO2	224	80-105 mmHg (a N/A (ven)
TCO2	21	23-27 mmol/L (a 24-29 mmol/L (ve
HCO3	20	22-26 mmol/L (a 23-28 mmol/L (ve
sO2	100	95-98%
BEecf	-7	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
10/10/03 05:20
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(6)-2

ALB	2.9*	3.3-5.5	G/DL
ALP	58	26-84	U/L
ALT	24	10-47	U/L
AMY	43	14-97	U/L
AST	56*	11-38	U/L
TBIL	1.1	0.2-1.6	MG/DL
BUN	10	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CHOL	26*	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	159*	73-118	MG/DL
TP	4.6*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl

======= PICCOLO =======
10/10/03 05:16
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6)-2 [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	153*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	2390*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4

Ward/Section: 1603	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted]	DATE 10 00 20	TIME 1230	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
[redacted]		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

TEST			
Mono			
Eos			
Baso			
Imm			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4

Ward/Section: 1C03	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted]	1230	1007B	

(i-STAT)

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/L
K	4.1	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.373	7.31-7.45
PCO2	38.2	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	155	80-105 mmHg (art) N/A (ven)
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99	95-98%
BEecf	-3	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.07	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	25	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section: 1 E 03	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 100003 / TIME 083	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI	[redacted]	
RB		
Hg		
Hct		
MC		
Plt		
Lyr		
(		

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.
PT		9.8-13.
APTT		21-34
D dimer		<20 u
FDP		<10 u

REMARKS:

REPORTED BY:

Urinalysis

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

RAPIDPOINT COAG ANALYZER V4.54
SERIA[redacted] 10/10/03 09:25
Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 49.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :10/10/03
Test Time :09:22
Card Lot [redacted] b(6)-4
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL[redacted] 10/10/03 08:54
Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 16.1 sec.
Ratio = 1.3
Calculated INR = 1.57
Sample Type:citrated wh. blood
Test Date :10/10/03
Test Time :08:52
Card Lot [redacted] b(6)-4
Operator [redacted] b(6)-2

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

k Unit Crossmatch
WITH EVERY UNIT OF BLOOD
QUESTED)

CROSSMATCH

b(6)-4 b(6)-2

Ward/Section: 1603	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. W[redacted]	DATE 100903	TIME 0830	SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na					3.5-5.5 g/dl	GLU		73-118 mg/dl
K					26-84 u/l	BUN		7-22 mg/dl
Cl					10-47 u/l			
pH					14-97 u/l			
PCO2					11-38 u/l			
PO2					0.2-1.6 mg/c			
TCO2					7-22 mg/dl			
HCO3					8.0-10.3mg/			
sO2					100-200 mg/c			
BEecf					0.6-1.2 mg/			
AnGap					73-118 mg/			
Ca					6.4-8.1 g/dl			
BUN					) Metlyte 8			
GLU					RESULT	REF. RANGE		
Creat						73-118 mg		
Hct						7-22 mg/dl		
Hgb						0.6-1.2 mg		
Mis						39-380 u/l		
						30-190 u/l		
TEST	RE					128-145 m		
Troponin-I						3.3-4.7 mm		
Drug of Abuse						98-108 mr		
						18-33 mm		

```
====== PICCOLO ======
10/10/03          08:55
REFERENCE RANGE:      MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: b(6)-2 [redacted]
OPER #: [redacted]      DR #: 000
SERIAL #: [redacted]
.......................
ALB   2.2*  3.3-5.5   G/DL
ALP   40    26-84     U/L
ALT   22    10-47     U/L
AMY   43    14-97     U/L
AST   58*   11-38     U/L
TBIL  0.9   0.2-1.6   MG/DL
BUN   9     7-22      MG/DL
CA++  7.3*  8.0-10.3  MG/DL
CHOL  <20*  100-200   MG/DL
CRE   0.7   0.6-1.2   MG/DL
GLU   176*  73-118    MG/DL
TP    3.4*  6.4-8.1   G/DL

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

```
====== PICCOLO ======
10/10/03          08:56
REFERENCE RANGE:      MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6)-4 [redacted]
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: b(6)-4 [redacted]
.......................
GLU   172*  73-118    MG/DL
BUN   9     7-22      MG/DL
CRE   0.8   0.6-1.2   MG/DL
CK    2844* 39-380    U/L
NA+   128   128-145   MMOL/L
K+    4.2   3.3-4.7   MMOL/L
CL-   107   98-108    MMOL/L
tCO2  19    18-33     MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2 b(6)-4

Ward/Section:	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 100ct03 TIME: 0915	SSN/PEEUDC: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/dL
K	3.8	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.360	7.31-7.45
PCO2	~~70.360~~ 38.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	382	80-105 mmHg (art) N/A (ven)
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-4	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.20	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	8	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
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		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(Hematology) CBC

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

(Hematology) Manual Differentia

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

[redacted] b(6)-4

Plts - decreased

Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section: ICU 3	[redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted]	DATE 100903 / TIME 2320	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	143	136-146 mmol/L
K	3.5	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.412	7.31-7.45
PCO2	38.8	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	190	80-105 mmHg (art) N/A (ven)
TCO2	26	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	100	95-98%
BEecf	0	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.10	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	~~20~~ 33	38-51% PCV
Hgb	7.11	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MISC

ABG

b(6)-4 b(6)-2

Ward/Section: ICU # 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted]	DATE 11 Oct 03	TIME	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

[redacted]

W	
E	
H	
H	
M	
Pl	
Ly	

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit			
Sed Rate			
Other			

Coagulation S

TEST	RESULT	RI
PT		9.8
APTT		21
D dimer		<2
FDP		<1

REMARKS:

REPORTED BY:

Urinalysis

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/11/03 04:31

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 17.9 sec.
Ratio = 1.5
Calculated INR = 1.86
Sample Type:citrated wh. blood
Test Date :10/11/03
Test Time :04:30
Card Lot [redacted] b(6)-2
Operator :

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/11/03 04:36 b(6)-4

Patient ID: 983
Test Name :APTT
Test Result:= 63.9 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/11/03
Test Time :04:32
Card Lot [redacted] b(6)-2
Operator

Misc. Serology

TEST	RESULT	REF RANGE

======= PICCOLO =======
11/10/03 05:54
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.6*	3.3-5.5	G/DL
ALP	31	26-84	U/L
ALT	17	10-47	U/L
AMY	57	14-97	U/L
AST	64*	11-38	U/L
TBIL	0.4	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	6.4*	8.0-10.3	MG/DL
CHOL	♦♦♦	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	70*	73-118	MG/DL
TP	2.4*	6.4-8.1	G/DL

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

b(6)-4 b(6)-2 b(6)-4

Ward/Section: ICU #3	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted]	DATE: 11/02/03	TIME	SSN/PSEUDO SSN: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.430	7.31-7.45
PCO2	38.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	167	80-105 mmHg (art) N/A (ven)
TCO2	26	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	100	95-98%
BEecf	1	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.08	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	26	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

```
======= PICCOLO =======
11/10/03                 04:23
REFERENCE RANGE:         MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted]       DR #: 000
SERIAL #: b(6)-2 [redacted]
.......................
GLU   89    73-118   MG/DL
BUN   6*    7-22     MG/DL
CRE   0.8   0.6-1.2  MG/DL
CK    4279* 39-380   U/L
NA+   128   128-145  MMOL
K+    3.8   3.3-4.7  MMOL
CL-   102   98-108   MMOL
tCO2  21    18-33    MMOL
```

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^{+}		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: ABG

REPORTED BY:	DATE:	LAB ID NO.:

500 1505

b(6)-2

Ward/Section: [redacted]	REQUESTING P[redacted]		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 11/04/03	TIME 1500	SSN/PSEUDO SSN:

b(6)-4

(Hematology) CBC				Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE		TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
W[redacted]		4.8-10.8 x 10³		Color		N/A	RPR		Negative
RE				App		N/A	Mono		Negative
Hg				Glu		Negative	**Microbiology**		
Hc				Bili		Negative	Source		
M				Ket		Negative	Gram Stain		
Pl				SG		N/A	Occ Bld		Negative
Ly				Bld		Negative	H. pylori		Negative
				pH		N/A	Micro Parasites		
S				Prot		Negative	Malaria		
B				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:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-7 b(6)-2

Ward/Section:	REQUESTING [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 11 Oct 03 TIME 1450	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	2.9	3.5-4.9 mmol/L
Cl	103	98-109 mmol/L
pH	7.477	7.31-7.45
PCO2	36.8	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	28	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	27	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	4	(-2) – (+3) mmol/L
AnGap	13	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	10	8-26 mg/dl
GLU	77	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	27	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: SR	DATE: 11 Oct 03	LAB ID NO.:

b(6)-4

b(6)-2

Ward/Section: ICU	REQ[redacted]CIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
[redacted], MI.	DATE 1/02/03 / TIME 0100	SSN/PSEUDO SSN:

(Hematology) CBC				Urinalysis			Misc. Serology		
TEST	[redacted]			T	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC				r		N/A	RPR		Negative
RBC						N/A	Mono		Negative
Hgb						Negative	Microbiology		
Hct						Negative	Source		
MCV						Negative	Gram Stain		
Plt						N/A	Occ Bld		Negative
Lymph %						Negative	H. pylori		Negative
(Hematology) Manual Differential				pH		N/A	Micro Parasites		
Segs	15	Mono	21	Prot		Negative	Malaria		
Bands	33	Eos	3	Urob		0.2-1.0	O & P		
Lymph	25	Baso	3	Nit		Negative	Other		
Atyp		Imm		Leuk		Negative	Microscopic Urinalysis		
RBC Morph	Plts decreased			HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	CSF				Blood Bank
Sed Rate			Cell Count				MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen		Negative		ABO/Rh

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2 b(6)-4

Ward/Section: OR	REQUESTING PH [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted]	DATE 11 Oct 03 TIME 1035	SSN/PEEUDO SSN [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	139	138-146 mmol/dL
K	3.1	3.5-4.9 mmol/L
Cl	103	98-109 mmol/L
pH	7.418	7.31-7.45
PCO2	45.2	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	301	80-105 mmHg (art) N/A (ven)
TCO2	31	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	29	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	5	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.15	1.12-1.32 mmol/L
BUN	10	8-26 mg/dl
GLU	83	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	8	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-1		
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		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-4

Ward/Section: 1C03	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE 12 oct	TIME 0400	SSN [redacted] SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WE [redacted]		
RB b(6)-4		
Hgl		
Hct		
MC		
Plt		
Lyn		
Q		

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

Coagulation Studies

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

Urinalysis

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

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

Bank

SF 518 WITH
QUESTED

F BLOOD

OSSMATCH

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/12/03 04:37

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.9 sec.
Ratio = 1.2
Calculated INR = 1.38
Sample Type:citrated wh. blood
Test Date :10/12/03
Test Time :04:36
Card Lot [redacted] b(6)-4
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/12/03 04:40

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 59.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/12/03
Test Time :04:37
Card Lot [redacted] b(6)-2
Operator

REMARKS:

REPORTED BY:	DATE

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

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

(i-STAT) Chem 7

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	3.0	3.5-4.9 mmol/L
Cl	102	98-109 mmol/L
pH	7.438	7.31-7.45
PCO2	43.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	80	80-105 mmHg (art) N/A (ven)
TCO2	30	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	29	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	95	95-98%
BEecf	5	(-2) – (+3) mmol/L
AnGap	9	10-20 mmol/L
Ca	1.24	1.12-1.32 mmol/L
BUN	10	8-26 mg/dl
GLU	62	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	38	38-51% PCV
Hgb	13	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] b(6)-2

Microbiology Request Form

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

First Name:

Patient # or SSN:

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

Date: 10 oct 03 [redacted]

Time: 1130

Ward: ICU3

Room:

Bed:

Physician: [redacted] b(6)-4

Source: (R) Femoral

Site:

[redacted]

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

Date: 10 oct 03

Time: 1252

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

Laboratory Results

Escherichia coli

Reported

Date: 13 oct 03

Time: 1030

Tech: [redacted]

Reviewer:

Number of attached sheets:

MEDCOM - 21486

Microbiology Report

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

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted]	Source:	Blood	Collected:	
Ward/Rm:	/	Ward of Iso:		Attd. Phys:	

1 Escherichia coli Status: Final

1 **E. coli**

Drug	MIC	Interps	Drug	MIC	Interps
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	>16	R			
Ciprofloxacin	>2	R			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	>4	R			
Gentamicin	<=4	S			
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	R			
Tobramycin	<=4	S			
Trimeth/Sulfa	>2/38	R			

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.

b(6)-2

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:		Specimen:	[redacted] b(6)-4	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Blood	Collected:	
Ward/Rm:	/	Ward of Iso:		Req. Phys:	[redacted]

Printed 10/13/2003 10:38:54 AM

Tech: [redacted]

b(6)-4 b(6)-2 b(6)-4

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, [redacted]	DATE 14 OCT 03 / TIME 0400	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC				Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE		TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
W [redacted]				Color		N/A	RPR		Negative
R				App		N/A	Mono		Negative
H				Glu		Negative	**Microbiology**		
H				Bili		Negative	Source		
M				Ket		Negative	Gram Stain		
Pl				SG		N/A	Occ Bld		Negative
L				Bld		Negative	H. pylori		Negative
				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:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2 b(6)-4

Ward/Section: ICU B	REQUE[redacted]IAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, [redacted]	DATE 14OCT03 / TIME 0400	SSN/PS[redacted]: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	2.8	3.5-4.9 mmol/L
Cl	101	98-109 mmol/L
pH	7.453	7.31-7.45
PCO2	47.1	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	34	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	33	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	9	(-2) – (+3) mmol/L
AnGap	9	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	13	8-26 mg/dl
GLU	84	70-105 mg/dl
Creat	0.9	0.7-1.5 mg/dl
Hct	27	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4

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

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

(Hematology) CBC

ID [redacted]
15-10-03
04:40

				Patient Limits	
WBC	7.2		x10^3/uL	4.5	10.5
RBC	3.39	L	x10^6/uL	4.00	6.00
Hgb	9.5	L	g/dL	11.0	18.0
Hct	30.3	L	%	35.0	60.0
MCV	89.1		fL	80.0	99.9
MCH	28.1		pg	27.0	31.0
MCHC	31.6	L	g/dL	33.0	37.0
Plt	66.	*L	x10^3/uL	150.	450.
LYM%	12.1	*L	%	20.5	51.1
LYM#	0.9	*L	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2 b(6)-4

Ward/Section: ICU 3	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LA[redacted]	DATE 16OCT03 / TIME 0900	SS[redacted] SSN: [redacted]

(Piccolo) (STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	134	138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K	3.4	3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH	7.517	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	39.8	35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^{+}		128-145 mmol/l
PO2	58	80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^{+}		3.3-4.7 mmol/l
TCO2	33	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^{-}		98-108 mmol/l
HCO3	32	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2	92	95-98%	CHOL		100-200 mg/dl	(Piccolo) Liver Panel Plus		
BEecf	9	(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca	1.17	1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	(Piccolo) Metlyte 8			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct	30	38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb	10	12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^{+}		128-145 mmol/l	(Piccolo) Electrolyte		
Troponin-I			K^{+}		3.3-4.7 mmol/l			
Drug of Abuse			CL^{-}		98-108 mmol/l			
			tCO_2		18-33 mmol/l			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

======= PICCOLO =======
15/10/03 04:42
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
b(6)-2

GLU	112	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	342	39-380	U/L
NA+	↔134	128-145	MMOL
K+	4.0	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	29	18-33	MMOL

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

b(6)-4 b(6)-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 6OCT03 / TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT			REF. RANGE	
ID: [redacted]				16-10-03	
WB				04:11	
				Patient Limits	
WBC	14.8 H		x10^3/uL	4.5	10.5
RBC	3.14 L		x10^6/uL	4.00	6.00
Hgb	8.8 L		g/dL	11.0	18.0
Hct	28.2 L		%	35.0	60.0
MCV	89.9		fL	80.0	99.9
MCH	28.1		pg	27.0	31.0
MCHC	31.3 L		g/dL	33.0	37.0
Plt	81. L		x10^3/uL	150.	450.
LYZ	7.9 *L		%	20.5	51.1
LY#	1.2 *L		x10^3/uL	1.2	3.4

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, [redacted]	DATE 16 OCT 03 / TIME 0490	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======
16/10/03 04:13
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	110	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	452*	39-380	U/L
~~NA+~~	~~123*~~	~~128-145~~	~~MMOL~~
K+	4.4	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	22	18-33	MMOL

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

I-Stat
Na - 134
Bun - 11

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] (b)(2)-2

Microbiology Request Form

b(6)-4

Last Name: #[redacted]
First Name:
Patient # or SSN:

Collected by: Dr [redacted] b(6)-2
Date: 15 Oct 03
Time: 1030

Ward: ICW 1
Room:
Bed:
Physician:

Source: [redacted]
Site: Lt [redacted] error
thigh wound

[redacted]

Received by: [redacted] b(6)-2
Date: 15 Oct 03
Time: 1100

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

Laboratory Results

Escherichia coli

Reported
Date: 18 Oct 03
Time: 1207
Tech: [redacted] b(6)-2
Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 21494

b(6)-4

Microbiology Report

[redacted] (b)(2)-2

Name:		Specimen:	[redacted] b(6)-4	Status:	**Final**
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	EMT/	Ward of Iso:		Attd. Phys:	

2 Escherichia coli Status: Final

2 E. coli

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	<=8	S			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	<=8	S			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	<=8	S			
Cefuroxime (b)	<=4	S			
Cephalothin	<=8	S			
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	64				
Norfloxacin	>8				
Pip/Tazo (d)	<=16	S			
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

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:		Specimen:	[redacted] b(6)-4	Status:	**Final**
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	b(6)-2
Ward/Rm:	EMT/	Ward of Iso:		Req. Phys:	[redacted]

b(6)-4 b(6)-2

Ward/Section: HUB	REQUESTING PH [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	TIME 1020	SSN/PSEUDO SSN:

(Hematology) [redacted]

TEST	RESULT	REF. RANGE
ID [redacted]		19-10-03 10:39
WB		Patient Limits
WBC	18.0 H x10^3/uL	4.5 10.5
RBC	2.76 L x10^6/uL	4.00 6.00
Hgb	7.6 L g/dL	11.0 18.0
Hct	24.8 L %	35.0 60.0
MCV	89.8 fL	80.0 99.9
MCH	27.6 pg	27.0 31.0
MCHC	30.7 L g/dL	33.0 37.0
Plt	582. H x10^3/uL	150. 450.
LY%	12.4 *L %	20.5 51.1
LYM	2.2 * x10^3/uL	1.2 3.4

b(6)-4

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

REMARKS:

REPORTED BY:

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/19/03 10:46

Patient ID [redacted] b(6)-4
Test Name :PT
Test Result:= 12.2 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.00
Sample Type:citrated wh. blood
Test Date :10/19/03
Test Time :10:44
Card Lot [redacted] b(6)-4
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/19/03 10:49

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 26.6 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/19/03
Test Time :10:46
Card Lot [redacted] b(6)-2
Operator

od Bank

IT SF 518 WITH
REQUESTED

T OF BLOOD

CROSSMATCH

LAST, FIRST, MI.	DATE 190403	TIME 1020	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	131	138-146 mmol/L
K	3.9	3.5-4.9 mmol/L
Cl	98	98-109 mmol/L
pH	7.435	7.31-7.45
PCO2	43.2	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	40	80-105 mmHg (art) N/A (ven)
TCO2	30	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	29	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	76	95-98%
BEecf	5	(-2) – (+3) mmol/L
AnGap	8	10-20 mmol/L
Ca	1.04	1.12-1.32 mmol/L
BUN	11	8-26 mg/dl
GLU	119	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-2

b(6)-4 b(6)-2

Ward/Section:	REQUESTING P[redacted]		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, [redacted]	DATE:	TIME: 1400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
A		
A		
A		
A		
T		
E		
C		
(C		
(C		
(C		
(C		
(C		
(C		
(C		
(C		
(C		
(C		

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

```
======= PICCOLO =======
20/10/03                14:18
REFERENCE RANGE:        MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted]      DR #: 000
SERIAL #: [redacted]
.......................
GLU   224*  73-118   MG/DL
BUN   10    7-22     MG/DL
CRE   0.6   0.6-1.2  MG/DL
CK    205   39-380   U/L
NA+   [redacted]  128-145  MMOL
K+    4.9*  3.3-4.7  MMOL
CL-   91*   98-108   MMOL
tCO2  18    18-33    MMOL

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

b(6)-4 [redacted]

b(6)-2

Na-129

b(6)-2 [redacted]

Dr [redacted] Reviewed

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 20040	LAB ID NO.:

b(2)-2 [redacted]

Microbiology Request Form

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

First Name:

Patient # or SSN:

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

Date: 15 OCT 03

Time: 1545

Ward: ~~# ICW~~ ICU3

Room:

Bed:

Physician: [redacted] b(6)-2

Source: (R) Buttock

Site: (R) Buttock

[redacted]

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

Date: 15 OCT 03

Time: 2000

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

Laboratory Results

Klebsiella pneumoniae
Morganella morganii
Proteus mirabilis

Reported

Date: 20 OCT 03

Time: 1647

Tech: [redacted] b(6)-2

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 21499

Microbiology Report [redacted] (b)(2)-2

Name:		Specimen: [redacted] b(6)-4		Status:	Final
Patient ID: [redacted] b(6)-4		Source:	Wound/Sterile site	Collected:	
Ward/Rm:		Ward of Iso:		Attd. Phys:	

1	Klebsiella pneumoniae	Status: Final
3	Morganella morganii	Status: Final
4	Proteus mirabilis	Status: Final

1 K. pneumoniae

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

3 M. morganii

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

b(6)-2

Name:		Specimen: [redacted] b(6)-4		Status:	Final
Patient ID: [redacted] b(6)-4		Source:	Wound/Sterile site	Collected:	
Ward/Rm:		Ward of Iso:		Req. Phys:	[redacted]

Tech: [redacted]

b(6)-4 b(6)-4 (b)(2)-2

Microbiology Report

[redacted]

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Attd. Phys:	

1 K. pneumoniae

Drug	MIC	Interps
Trimeth/Sulfa	<=2/38	S

3 M. morganii

Drug	MIC	Interps
Trimeth/Sulfa	<=2/38	S

4 P. mirabilis

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

b(6)-2

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 patie[redacted] meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:		Specimen:	[redacted] b(6)-4	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Req. Phys:	[redacted]

b(6)-4 **Microbiology Report** [redacted] (b)(2)-2

Name:		Specimen:	[redacted]	Status:	**Final**
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Attd. Phys:	

4 **P. mirabilis**

Drug	MIC	Interps	Drug	MIC	Interps
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)
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 (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
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Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative Isolates) and moxifloxacin are based on FDA approved breakpoints.
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b(6)-2

Name:		Specimen:	[redacted] b(6)-4	Status:	**Final**
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Req. Phys:	[redacted]

b(2)-2 [redacted]

Microbiology Request Form

Last Name [redacted] b(6)-4

First Name:

Patient # or SSN: [redacted]

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

Date: 17 Oct 03

Time: 1645

Ward: ICU3

Room:

Bed: b(6)-2

Physician: [redacted]

Source: ① Buttock

Site: ② Buttock

[redacted]

Received by:

Date:

Time:

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

Laboratory Results

Escherichia coli
Proteus mirabilis
Enterobacter aerogenes

Reported

Date: 20 Oct 03

Time: 1417

Tech: [redacted] b(6)-2

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 21503

b(6)-4 **Microbiology Report** [redacted] (b)(2)2

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Attd. Phys:	

1	Escherichia coli	Status:	Final
2	Proteus mirabilis	Status:	Final
3	Enterobacter aerogenes	Status:	Final

1 E. coli

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S
Amp/Sulbactam (c)	16/8	I
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	>16	R
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)	<=16	S
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	<=16	S
Tobramycin	>8	R

2 P. mirabilis

Drug	MIC	Interps
Amox/K Clav (c)	16/8	I
Amp/Sulbactam (c)	<=8/4	S
Ampicillin	<=8	S
Aztreonam	<=8	S
Cefazolin	<=8	S
Cefepime	<=8	S
Cefotaxime (c)	<=8	S
Cefotetan	<=16	S
Cefoxitin	<=8	S
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	<=8	S
Cefuroxime (b)	<=4	S
Cephalothin	<=8	S
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
ESBL-a Scrn	<=4	
ESBL-b Scrn	<=1	
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	>8	R
Ticar/K Clav (a)	<=16	S
Tobramycin	<=4	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)
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(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.
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(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. b(6)-2
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:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Req. Phys:	[redacted]

b(6)-4

Microbiology Report

[redacted]

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Attd. Phys:	

1 E. coli

Drug	MIC	Interps
Trimeth/Sulfa	>2/38	R

2 P. mirabilis

Drug	MIC	Interps
Trimeth/Sulfa	<=2/38	S

3 E. aerogenes

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

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

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

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b(6)-2

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Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Req. Phys:	[redacted]

Tech: [redacted]

b(6)-4

Microbiology Report

[redacted]

Name:
Patient ID: [redacted]
Ward/Rm:

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

3 **E. aerogenes**

Drug	MIC	Interps	Drug	MIC	Interps
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

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b(6)-2

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Req. Phys: [redacted]

Tech: [redacted]

b(6)-4 b(6)-2

Ward/Section: ICU 3

REFERRING PHYSICIAN: [redacted]

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

LAST, FIRST, MI.: EPW [redacted]

DATE: 22 Oct TIME: 0500

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted]		4.8-10.8 x 10³
		22-10-03 05:10
		Patient Limits
WBC	10.2 H	x10^3/uL 6.5 10.5
RBC	3.56 L	x10^6/uL 4.00 6.00
Hgb	7.1 L	g/dL 11.0 16.0
Hct	23.3 L	% 35.0 50.0
MCV	90.8	fL 80.0 99.9
MCH	27.7	pg 27.0 31.0
MCHC	30.5 L	g/dL 33.0 37.0
Plt	1127.	x10^3/uL 150. 450.
Lym	11.7 L	% 20.5 51.1
Lym	2.1	x10^3/uL 1.2 3.4

b(6)-4

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Neg
pH		N/A
Prot		Nega
Urob		0.2-1.
Nit		Negat
Leuk		Negati
HCG		Negativ

CSF

Cell Count		
Directigen		Neg

Blood (MUST SUBMIT SF

UNIT	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram	

======= PICCOLO =======
22/10/03 , 06:08
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: b(6)-2 [redacted]
OPER # [redacted] DR #: 000
SERIAL #: [redacted]

b(6)-4

GLU	123*	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
NA+	129	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

REMARKS:

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

misc. Chem 7

[redacted]

Microbiology Request Form

Preliminary Report

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

First Name:

Patient # or SSN: [redacted]

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

Date: 19 OCT 03

Time: 1024

Ward: ICW 1

Room:

Bed: b(6)-2

Physician: DR[redacted]

Source: WOUND

Site: (L) FEMUR

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

Date: 19 OCT 03

Time:

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

Preliminary Laboratory Results

Enterococcus faecium

Reported

Date: 22 OCT 03

Time: 1419

Tech: [redacted] b(6)-2

Reviewer:

Number of attached sheets: 1

Preliminary Report

MEDCOM - 21508

Microbiology Report

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

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	EMT/	Ward of Iso:		Attd. Phys:	

2 Enterococcus faecium Status: Final

2 E. faecium

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2				
Amp/Sulbactam (c)	>16/8				
Ampicillin	>8	R			
Cefazolin	>16				
Cefepime	>16				
Cefotaxime (c)	>32				
Ceftriaxone (c)	>32				
Cephalothin	>16				
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
Clindamycin	<=0.5				
Erythromycin	<=0.5	S			
Gatifloxacin	>4				
Gent. Synergy	<=500	S			
Gentamicin	<=4				
Levofloxacin	4	I			
Linezolid	<=2	S			
Moxifloxacin	>4				
Nitrofurantoin	<=32				
Norfloxacin	>8				
Ofloxacin	<=2				
Oxacillin	>2				
Penicillin	>8	R			
Pip/Tazo (d)	>8				
Rifampin	2	I			
Strep. Synergy	<=1000	S			
Synercid	<=1	S			
Tetracycline	8	I			
Trimeth/Sulfa	<=2/38				
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)
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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:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	b(6)-2
Ward/Rm:	EMT/	Ward of Iso:		Req. Phys:	[redacted]

b(6)-4 b(6)-2 b(6)-4

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 23Oct / TIME 0818	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC						Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE				TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WE	[redacted]					Color		N/A	RPR		Negative
RB						App		N/A	Mono		Negative
Hgt						Glu		Negative	**Microbiology**		
Hct						Bili		Negative	Source		
MC						Ket		Negative	Gram Stain		
Plt						SG		N/A	Occ Bld		Negative
Lym						Bld		Negative	H. pylori		Negative
(I						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	PLT's Increased					HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)				**CSF**			**Blood Bank**		
Sed Rate						Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other						Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] b(2)-2

Microbiology Request Form

Last Name [redacted] b(6)-4

First Name:

Patient # or SSN:

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

Date: 27 Oct

Time: 2000

Ward: ICW 1

Room:

Bed:

Physician:

Source: (2) hip wound

Site:

[redacted]

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

Date: 27OCT03

Time: 2150

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

Laboratory Results

Proteus Mirabilis

Reported

Date: 30 OCT 03

Time: 1000

Tech: [redacted] b(6)-2

Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 21511

b(6)-4

Microbiology Report [redacted] (b)(2)-2

Name:		Specimen:	[redacted] b(6)-4	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/	Ward of Iso:		Attd. Phys:	

1 Proteus mirabilis Status: Final

1 P. mirabilis

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

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

N/R = Not Reported
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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.

b(6)-2

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:		Specimen:	[redacted] b(6)-4	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/	Ward of Iso:		Req. Phys:	[redacted]

Tech: JU [redacted]

[redacted] (b)(2)-2

31

Microbiology Request Form

Last Name [redacted] b(6)-4

First Name:

Patient # or SSN:

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

Date: 21 Oct

Time: 2000

Ward: ICW I

Room:

Bed:

Physician:

Source: (2) hip wound

Site:

[redacted]

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

Date: 22OCT03

Time: 2150

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

Laboratory Results

Proteus Mirabilis

Reported

Date: 30 OCT 03

Time: 1000

Tech: [redacted] b(6)-2

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 21513

Microbiology Report

[redacted] b(2)-2

Name:		Specimen:	[redacted] b(6)-4	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W17	Ward of Iso:		Attd. Phys:	

1 Proteus mirabilis Status: Final

1 P. mirabilis

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

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

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(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
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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. b(6)-2

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W17	Ward of Iso:		Req. Phys:	[redacted]

Printed 10/30/2003 10:48:35 AM

Tech: JU [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: 29 Oct 03

Time:

Ward: ICW

Room:

Bed:

~~Physician:~~ [redacted]

Source: Wound

Site: (R) Tibia / Thigh

[redacted]

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

Date: 29 OCT 03

Time: 1100

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

Laboratory Results

Escherichia coli

Reported

Date: 31 OCT 03 b(6)-2

Time: 0000

Tech: [redacted]

Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 21515

b(6)-4 b(6)-4 (b)(2)-2

Microbiology Report [redacted]

Name:		Specimen:	[redacted]	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/	Ward of I:		Attd. Phys:	

1 Escherichia coli Status: Final

1 E. coli

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S			
Amp/Sulbactam (c)	16/8	I			
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	>16	R			
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)	<=16	S			
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

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

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Blank = Data not available, or drug not advisable or tested
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R* = Resistant due to extended spectrum beta-lactamases (ESBL)
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For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

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For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

b(6)-2

Name:		Specimen: [redacted]		Status:	Final
Patient ID:	[redacted] b(6)-4	MEDCOM - 21516	ite	Collected:	
Ward/Rm:	W1/	Ward of I:		Req. Phys:	[redacted]

b(6)-4 b(6)-2 b(6)-4

Ward/Section: CW 1	REQUESTING PHYSICIAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 2nov03 TIME 1015	SSN/PSEUDO SSN: # [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.025	N/A
Bld	~~Large~~	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	moderate ~~Trace~~	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

TNTC RBC
20-25 WBC

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: UA C electrolytes = no urine lytes capability

REPORTED BY: [redacted]	DATE: 02nov03	LAB ID NO.:

b(6)-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)												
Vecuronium (mg)		5		5								
Neosynephrine (mcg)		100										
Versed (mg)				1								
( )												
( )												
( )												
VOLAT AGENT Iso	% del		0.4	0.4X		0.8X						
	% e.t.											
AIR	L/Min											
N2O	L/Min											
O2	L/Min	2	2	2	2	2	2	2	2			

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

FLUIDS

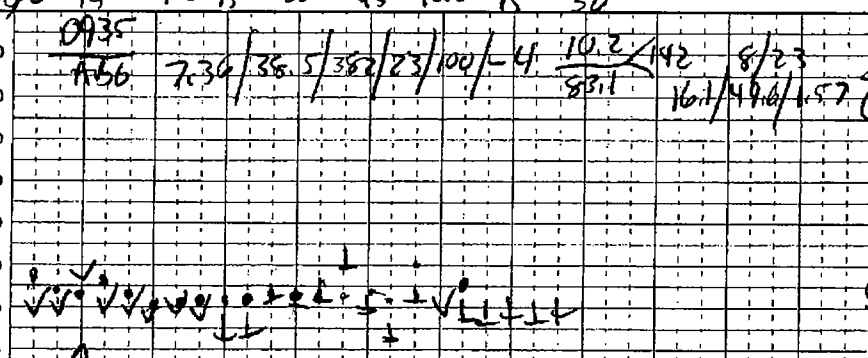
LINE site												
(L) SCL	☐ Warmed	LR (500)	X	LR				1200		1100		
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE - Foley					110							

PHYS STATUS	TIME	0800	45	0900	15	30	45	1000	15	30
1 2 3 4 5 E										
BODY WEIGHT: 70 KG LB										
HEMATOCRIT: 12/41										
INITIAL DATA:										
BP- /										
HR-										
EQUIP CHECK										
OK? - (Y) N										
PATIENT RECHECK										
OK for PROCEDURE Okay										
TIME- 0800										

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



VENTIL

VT - ml	750	750	740	680	780	800	700	700
f - breaths/min	10	11	11	11	10	10	10	10
Peak inf pres / PEEP	26	27	27	20	23	23	22	22
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	36	33	32	34	33	34	35	31
BP/oth	X EIO2 (Frac or %)	.57	.57	.57	.57	.57	.57	.54	.55
ART line	X SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	X ECG	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	X TEMP-site	37.1	37.1	37.1	37.1	37.3	37.3	37.5	37.6
	X N-M Block (T/4)	4/4							
Warming blkt									
Conv warmer									

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

TOTALS	TOTAL EBL
	100
	TOTAL URINE
	150

FLUIDS - SUMMARY
CRYSTALLOID 1400
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
0810 Pt ID'd in ICU. To OR via bed c̄ (+) manitors / (+) Ambu O2.
0835 In OR (+) O2 (+) monitors, PA jelly eyes taped. Arms ⊥ Arterial line A-line
0845 Induction start to Angiogram (R) knee completed @ 0905
0915 (A) Rad A-line placed, ABG sent. Placed in Low lithotomy
1030 To PACU c̄ Ambu O2 / (+) monitors stable. Report to [redacted]

RECOVERY AT 1030
PACU (ICU) 3 (Specify)
OTHER ---
CONDITION: Stable - transferred to Vent c̄ pt care setting
RESP- SpO2- 100
BP- 102/63 HR- 130

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0835	1035
	Ready	Begin	End
PROC	0840	0848	1025

[redacted] CPT Codes: Prosacral drainage c̄ Placement

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rank, Medical facility
Watkins
[redacted] b(6)-2 — b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Pt intubated already in ICU #3 #8 ETT secured to wide @ 27.5 cm

SURGEONS [redacted] b(6)-2

A [redacted] b(6)-2 CRNA

PROCEDURE LOCATION: OR 1
DATE: 10 Oct 03
PAGE 1 OF 1

MEDICAL RECORD ANESTHESIA

DRUG (Units)								TOTALS
FENTANYL (mcg)	150		50	50				250
KETAMINE (mg)	100							100
SUX (mg)	100							100
VEC (mg)		5		2				7
( )								
( )								
VOLAT AGENT (150) % del								
% e.t.	.5	.5	.5	.5				
AIR L/Min								
N2O L/Min								
O2 L/Min	5	2	2	2	2			

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

ANESTHETIC AGENTS AND DRUGS

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ 0 0

TOTAL FBL: 200

TOTAL URINE: 400

FLUIDS – SUMMARY

CRYSTALLOID– 3L

COLLOID– 500

BLOOD– 1 PRBC

FLUIDS

LINE site			
18G	☐ Warmed	1L	2	3
	☐ Warmed			
	☐ Warmed	HESPAN		
	☐ Warmed	500 cc		

LOSSES: EST BLOOD LOSS 200; URINE – 400

REMARKS– Code drugs with numbers, events with letters

to OR / Sp Lap
PRBC given per surgeon.
ABG Hct 18.2

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 13

INITIAL DATA: BP – 110 50; HR– 95

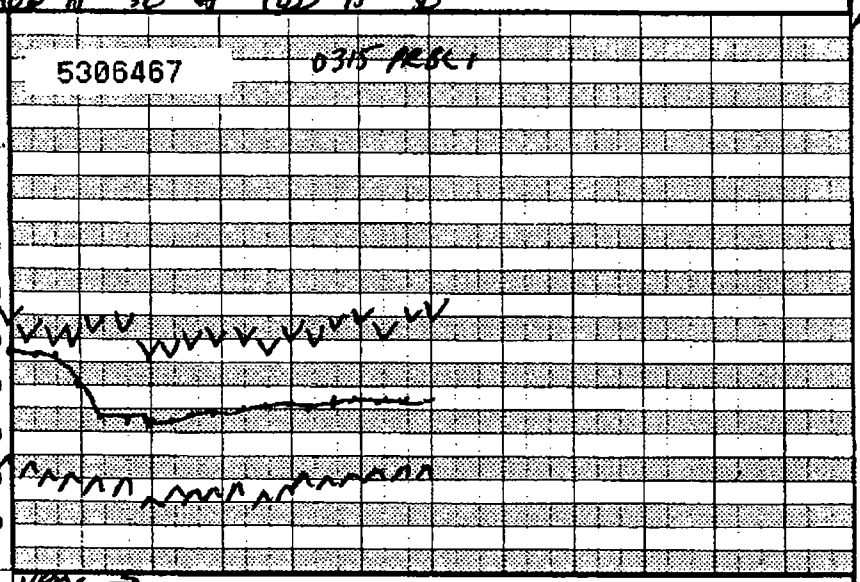
EQUIP CHECK: OK?– 0 N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME → 02 00 30 00 (03) 15 30

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

5306467 0315 ARRST



VENTIL

VT – ml		VPAC →					
f – breaths/min		10	10	10	10	10	10
Peak inf pres / PEEP		VPAC →					
MODE– S(pon), A(assist), C(on)		S	C	C	C →		

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	48	36	34	36	34
BP / oth	FIO2 (Frac or %)	.72	.74	.74	.72	.71	.72
ART line	SpO2 (%)	100	99	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site						
	N-M Block (T/4)	4/4	4/4	4/4	—	3/4	— 1/4
Warming blkt							
Conv warmer							

036 VANCOMYCIN
0 500mg FLAGYL

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: CSH

RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0140	0150	
	Ready	Begin	End
PROC	0200	0230	0330

Mark with letters & symbols, explain under REMARKS. EVENTS Position (A) 0 →

PROCEDURES and CPT Codes: EX LAP

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA / RSI C CRICOID / IVx2 22 Gauge

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x1 3 diff. 8 OET tube cuff. (+) Eth Co (+) BBS. SpO2 100%

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

IRAQI
10 OCT 03

SURGEONS: [redacted]

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: FST

DATE: 10 OCT 03

PAGE 1 OF 1

[redacted] MEDICAL RECORD – ANESTHESIA

b(6)-2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 21519

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

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

Age 24 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: ex lap, Place drains, etc
SURGICAL SERVICE: general
NPO SINCE: N/A

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) ?
( )
( )
( )
( ) 0
( )

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

LABORATORY STUDIES: PHs 130
HB/HCT: 12.7, 41.2
U/A: ____
OTHER: ____
PT/PTT 14.5/22.1
130 | 104 | 10 / 153
4.4 | 20 | 0.8
T&C x2

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ex lap/colostomy @ FST this AM
b(6)-2

PHYSICAL EXAMINATION
BP 130/75 HR 100 R 16 T [redacted]
Pain Scale 0-10 8.0
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharyx ____
Nares ____
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES: LE TLSCL
IV Access: RAC/LFA
Ulnar Filling: ____
BACK: N/A
OTHER: None

NPO Since N/A

ABG 7.29/42/224/20/-7

b(6)-2

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ (X) General: Mask Intubation
existing ETT

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

The pati[redacted] to understand and agrees. Questions answered. N/A
Signed [redacted] CRNA Date: 10/10/03 Time: 0600 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER
b(6)-2
Signed: ____ Date: ____ Time: ____ Hrs

Arrived from FST @ 0500 w/ no records

Patient Identification: (Ward) ICW

EPW #[redacted] b(6)-4

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

* Currently in coma [redacted]

Last Anesthesia 10 Oct 03
Current drips: Levophed D/C @ 0530, 100 mcg Fentanyl, 3 mcg Dopamine, 250 cc/hr LR
24 yo ♂ NKDA

7.8 / 25.2 < 94 | 128/102 | 6/59 | 3.8/21/0.8
PT 17.4, INR 1.86, PTT 63.9

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION)		
DRUG	(Units)	
Scopolamine	(mg)	.4
Vecuronium	(mg)	10
Fentanyl	(mcg)	50 50 5 25
	( )	
	( )	
	( )	
VOLAT AGENT: Iso	% del	1.3 – 1.0 0.8 – 0.8 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3 – 2 2 – 2 – 2 – 2

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

FLUIDS		
LINE site		
(L) SCL	☐ Warmed	
(R) Cordis	☐ Warmed	
	☐ Warmed	LR 500 — 300 — 400
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE – Foley	80 50/160

TOTALS	
TOTAL EBL	75
TOTAL URINE	160

FLUIDS - SUMMARY
CRYSTALLOID – 400
COLLOID – Ø
BLOOD – 1 Unit PRBC

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 70 KG LB
HEMATOCRIT: 7.8/25.2
INITIAL DATA: BP – 106/56, HR – 115
CONSENT CHECK: OK? – Y N
PATIENT RECHECK: OK for PROCEDURE? Okay, TIME – 0730

TIME: 0945 30 45 1000 15 30 45 1200

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

ABG: 7.41 / 45.2 / 29 / 301 / 100 / 139/3.1 / 103 / 1115
Hct 5 Hct 8/23

	0945	1000	1015	1030	1045	1200
VT – ml	630	630	600	600	600	610
f – breaths/min	12	14	14	14	14	14
Peak Inf pres / PEEP	23	23	23	22	22	23
MODE – S(pon), A(ssist), C(on)	C	C	C	C	C	C
☒ BP/Auto Cuff	42	38	37	37	37	37
☒ BR / oth	.56	.56	.58	.61	.62	.62
☒ ART line	100	100	100	100	100	100
☒ Steth- PC/ES	ST	ST	ST	ST	ST	ST
☒ Gas analyzer	38.5	38.6	38.7	38.8	38.8	38.7
☒ N-M Block (T/4)		4/4				
Warming blkt						
Conv warmer						

REMARKS – Code drugs with numbers, events with letters
1010 Pt rec'd in ICU 3, Chart reviewed. Tp OR in bed ⊙ monitors, Ambu O2.
1020 In room. Pt sedated, placed on Anes vent, Eyes taped, Pt padded.
1043 Procedure started, ABG sent.
1055 Pt placed RLD – Ax roll placed ⊙BBS⊙ETCO2. Eyes/ears/nose free of pressure.
1115 Lab results reported to surgeon, 2 units PRBCs requested.
1130 1 unit PRBC +
1145 To ICU 3 – Stable, Transported ⊙ Ambu O2, ⊙ monitors

RECOVERY AT: 1150
PACU / ICU 3 (Specify)
OTHER
CONDITION: Stable / Intubated – placed on vent @ usual settings
RESP – 16, SpO2 – 100
BP – 120/82, HR – 98

ANESTHESIA / PROCEDURE TIME	Start	Room	End
ANES	1010	1020	1200
PROC	Ready	Begin	End
	1025	1043	1145

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

PROCEDURES and CPT Codes: I&D (R) thigh / (L) Buttock Wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: (Intubation route, blade, technique, comments): Pt already intubated – #5 ETT – Secured @ 27cm on ETT holder ⊙BBS⊙ETCO2

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

EPW
[redacted] b(6)-4

SURGEONS: [redacted]
ANES: [redacted] CRNA b(6)-2

PROCEDURE LOCATION: OR 1
DATE: 11 Oct 03
PAGE 1 OF 1

No Δ from previous anesthesia 11 Oct 03 x̄ 10.1 9.4 66

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)	80																	
Fentanyl	(mcg)	150		100															
SCH	(mg)	100																	
Zemron	(mg)			20	20	10				10		5							
MSO4	(mg)						(3)	2	(3)	2									
	( )																		
VOLAT AGENT	I-50 % del		0.8	1.5	1.5	1.0	0.6	0.6	0.8	1.0									
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	10	2	2	2	2	2	2	2	10									

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

TOTALS	TOTAL EBL
250	min
	TOTAL URINE
10	100

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site																		
(R) Cardis	☐ Warmed	KVO																
(L) SCL	☐ Warmed	(LR 400 ml)	—	XLR	—			600	—	—	—	800	—					
	☐ Warmed																	
	☐ Warmed																	

LOSSES

EST BLOOD LOSS																		
URINE - Foley	50							50/100										

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 8.9/29

INITIAL DATA:

BP-

HR-

EQUIP CHECK

OK? - (Y) N

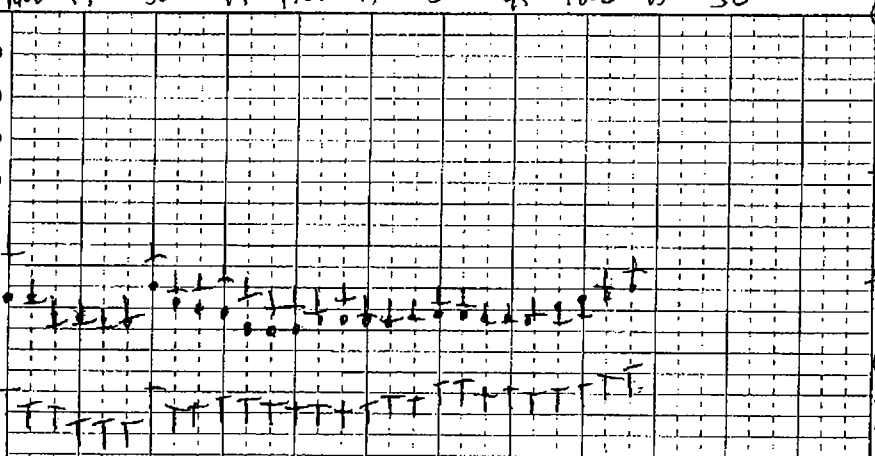
PATIENT RECHECK

OK for PROCEDURE Okay

TIME- 1545

TIME → 1600 15 30 45 1700 15 30 45 1800 15 30

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



VENTIL

VT - ml	—	650	700	600	630	650	620	600	500	
f - breaths/min	20	12	10	12	12	12	12	12	14	
Peak inf pres / PEEP	—	26	28	24	25	25	26	26	—	
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	CS	

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	(+)	37	34	35	35	35	36	37	48
BP/oth	X FIO2 (Frac or %)	.71	.71	.70	.70	.70	.70	.71	.71	.71
ART line	X SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	X ECG	ST	SR	ST	SR	SR	SR	SR	SR	ST
Gas analyzer	X TEMP-site Nasal		37.2	37.7	37.7	37.7	37.7	37.7	X	
	X N-M Block (T/4)		0/4	3/4	1/4		0/4	3/4	1/4	4/4 0 ST 050
Warming blkt										
Conv warmer										

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

REMARKS

Code drugs with numbers, events with letters

1550 Pt rec'd in ICU 3. Chart/labs reviewed. 1600 In OR. ⊕ monitors ⊕ O2, S mask IV induction, Eyes taped, easy ventilation, Pt paddled, airway LR 1622 Procedure started 1640 NG tube repositioned, checked by surgeon. 1710 Pt placed RLD — Ax roll, ≡ eyes/Ears/nose free, passive, moderable ⊕ BBS ⊕ ETCO2, 1805 Reversed c̄ Sug, Neostigmine ⊕ 0.8, Residual. Extubated 5 diff ē, to Pos'n. To ICU 3 stable.

RECOVERY AT 1875

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable/awake

RESP- 16 SpO2- 100

BP- 126/65 HR- 121

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1550	1600	1820
	Ready	Begin	End
PROC	1610	1622	1810

PROCEDURES and CPT Codes:

I&D Rectal Wound Pilonidal Abdominal Pelvic

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

[redacted] b(6)-4 ICU 3

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

DL x 1 att ē #7, MPC 4, Grade I view, ⊕ BBS ⊕ ETCO2 secured @ 22 c̄ teeth, soft bite block placed

SURGEONS: [redacted] b(6)-2

ANEST [redacted] CRNA CPT b(6)-2

PROCEDURE LOCATION: OR 1

DATE: 12 Oct 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)	1	2	3	4	5	6	7	8	9	10	11	12
Fentanyl	50 µg/cc	150		50									
Norcuron	2 mg/cc	2											
	( )												
	( )												
	( )												
VOLAT AGENT	Forane % del	2.5-2-1.5-1											
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	3 L/Min												

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

FLUIDS

LINE site		1	2	3	4	5	6	7	8	9	10	11	12
RL-1000	☐ Warmed	1000		RL									
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES — EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	MIN
	TOTAL URINE
	44cc

FLUIDS - SUMMARY

CRYSTALLOID- 1150

COLLOID-

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters.

(1) VS taken
(2) Induced c Lidocaine 20mg Diprivan 120mg Anectine 100mg intubated
(3) Procedure begun
(4) Procedure ended
(5) suctioned O2 breathing, cuff extubated, to recovery

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

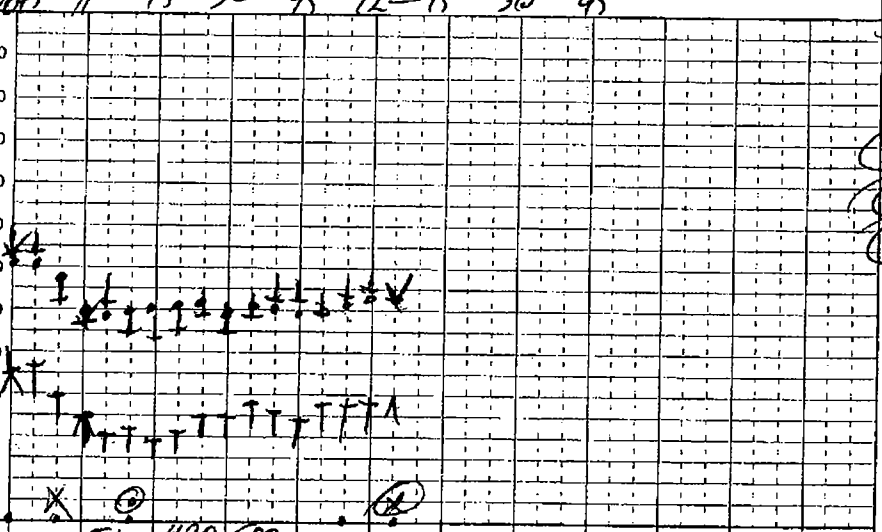
INITIAL DATA: BP- 124 / 71; HR- 122 / 88

EQUIP CHECK: OK? - Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 1045 1100 15 30 45 1200 15 30 45

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



VENTIL

	1	2	3	4	5	6	7	8	9	10	11	12
VT - ml			510	490	500							
f - breaths/min			10	12	12	13						
Peak Inf pres / PEEP			20	20	20							
MODE - S(pon), A(ssist), C(on)			CV	CV	CV	S						

MONITORS/ACCESSORIES

		1	2	3	4	5	6	7	8	9	10	11	12
✓ BP/Auto Cuff	✓ ET CO2 (torr)			42	41	41	48						
BP/oth	✓ FIO2 (Frac or %)			82%	82%	81%	81						
ART line	✓ SpO2 (%)			100	100	100	100						
Steth- PC/ES	✓ ECG			ST	ST	ST	ST						
✓ Gas analyzer	TEMP-site												
	N-M Block (T/4)												
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position (1) (2) (3) (4) (5)

RECOVERY AT

PACU ICU _____ (Specify)

OTHER

CONDITION:

RESP- SpO2- 90

BP- 140/68 HR- 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1029	1046	1204
	Ready	Begin	End
PROC	1100	1111	1154

PROCEDURES and CPT Codes: Wash-out (L) hip

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen Endo

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #7.0 ET tube c #3 Mac

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

[redacted] b(6)-4

[redacted] b(6)-2

[redacted] CRNA

PROCEDURE LOCATION:

DATE: 13 / Oct / 03

PAGE 1 OF

Hep SQ
Cefoxitin
KCl P.O.
2 4 4/0 BSCTA Hyperan 8 m
L SC Triple - 'mod
Foley
T. 1[illegible] - 110 - 22 108/56 RAS 74% before BSCT
10/1-103 [illegible]
[redacted]
b(6)-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)	1500	30	1600	30	1700							
Propofol	(mg)	150											
Versed	(mg)	25											
Lido	(mg)	100											
Fentanyl	(mcg)	100		25	25								
NDS	(mcg)		100	200	200								
Succ	(mg)	100											
VOLAT AGENT: Forane	% del	2	1.5	1	.8	1.5	1						
	% e.t.												
AIR	L/Min	8											
N2O	L/Min	0											
O2	L/Min	4	3										

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

FLUIDS

LINE site (L) SC												
☐ Warmed	1L											
☐ Warmed												
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS												
URINE -												

TOTALS	TOTAL EBL
	[redacted]
	TOTAL URINE
	80

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 15 Oct 9.5/30.3

INITIAL DATA: BP- 104 152 HR- 110

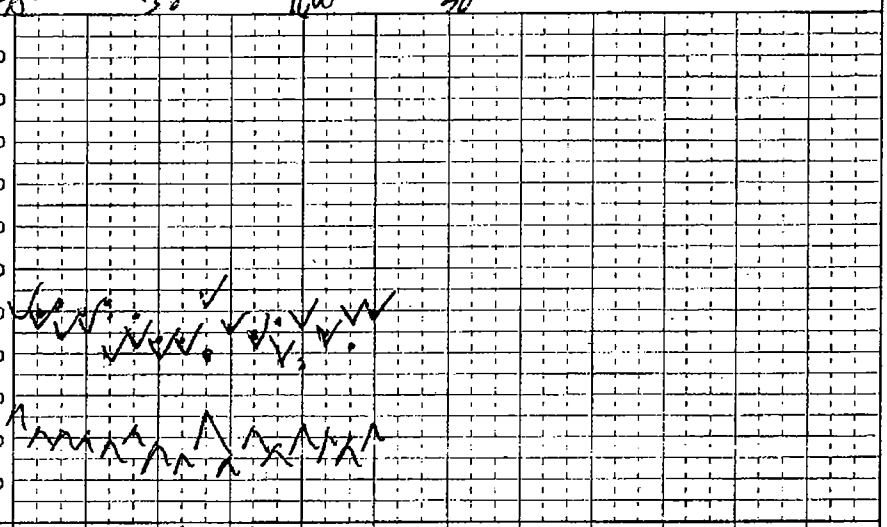
EQUIP CHECK OK? - Y N

PATIENT RECHECK

OK for PROCEDURE? TIME-

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

TIME → 1500 30 1600 30



VENTIL

	1500	1500	1500	1600	1500
VT - ml	570	570	540	620	510
f - breaths/min	10	10	12	14	14
Peak inf pres / PEEP	20	20	25	25	25
MODE - S(pon), A(ssist), C(on)	C	C	C	S/C	C

MONITORS/ACCESSORIES

		1500	1500	1500	1600	1500
✓ BP/Auto Cuff	ET CO2 (torr)	48	46	49	50	48
BP/oth	FIO2 (Frac or %)	100	100	100	100	100
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	34				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT 1421

PACU ICU _____ (Specify)

OTHER _____

CONDITION: RA

RESP. 16 SpO2- 95

BP- 105/60 HR- 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1500	1500	1622
	Ready	Begin	End
PROC	1515	1521	1615

PROCEDURES and CPT Codes:

Rectal wound I & D

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

[redacted]

ICU #3

b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

GETA 80 mac 4

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR 2

DATE: 15 OCT 05

PAGE 1 OF 1

No Δ since last Anesthetic X 14.6 8.8/28.2 81

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)																
Fentanyl	(mcg)	200			50												
Zofran	(mg)	35	15														
Lidocaine	(mg)	100															
Propofol	(mg)	130															
	( )				X Neostigmine 3cc @ 2cc Rectal												
	( )																
VOLAT AGENT Iso	% del		0.4	0.8X	1.0X												
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min	10	2	2	2	10											

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

FLUIDS

LINE site																	
(L) Triple lumen	☐ Warmed	D5 2NS		150		300											
	☐ Warmed																
	☐ Warmed																
	☐ Warmed																

LOSSES — EST BLOOD LOSS: — URINE - Foley (emptied on IC3)

TIME	1600	15	30	45	1700	15

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 8.8/28.2

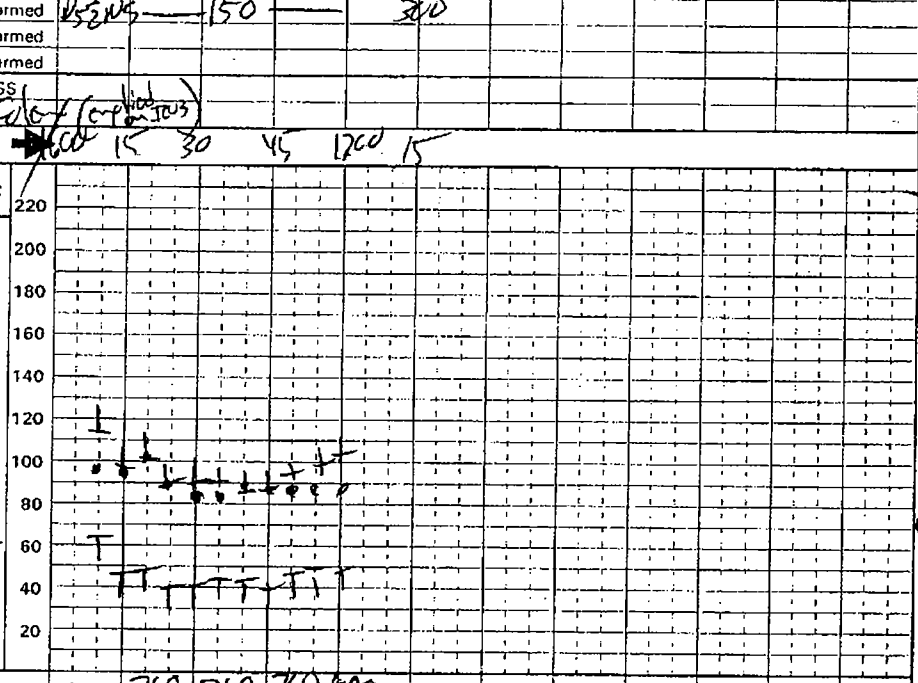
INITIAL DATA: BP- 117/62 HR- 98

EQUIP CHECK: OK? - Y N

PATIENT RECHECK

OK for PROCEDURE: Okay TIME- 1600

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



VENTIL

VT - ml	—	760	760	760	800
f - breaths/min	16	10	10	10	10
Peak inf pres / PEEP	—	27	26	26	
MODE - S(pon), A(ssist), C(on)	S	C	C	C/S	

MONITORS/ACCESSORIES

X BP/Auto Cuff	ET CO2 (torr)	(P)	36	35	36
X BP/oth	X FIO2 (Frac or %)	.57	.57	.57	.57
X ART line	X SpO2 (%)	100	100	100	100
X Steth- PC/ES	X ECG	SR	SR	SR	SR
X Gas analyzer	X TEMP-site	Available			
	X N-M Block (T/4)		4/4		
Warming blkt					
Conv warmer	Position	OR → RLD			OR

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

TOTALS	TOTAL EBL
250	40
	TOTAL URINE
	90

FLUIDS - SUMMARY: CRYSTALLOID- 300; COLLOID- Ø; BLOOD- Ø

REMARKS — Code drugs with numbers, events with letters

A id @ 1600 ICU 3 Chart reviewed. Ok via letter. 1610 In room, ⊕ monitor, ⊕ O_2, smooth IV induction, PP padded - turned to RLD - Ax roll placed head neck midline (PP padded) 1700 A awake, PO sxw. Extubated & diff. To PACU stable.

RECOVERY AT 1700

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable

RESP- 120 SpO2- 100 BP- 99/66 HR- 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1600	1610	1710
	Ready	Begin	End
PROC	1615	1630	1655

PROCEDURES and CPT Codes: Tod Rectal Wound

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL X Tube ETT c MAC 3 #7 ETT, Grade I view, ⊕ BBS ⊕ ETCO2 secured @ 23 cm teeth, soft bite placed

SURGEON: [redacted] b(6)-2

ANESTHESIA: [redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 17 Oct 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)	100	100	50
Fentanyl/50cc				
( )				
( )				
( )				
( )				
VOLAT AGENT	Forane % del	1½		
	% e.t.			
AIR	L/Min			
N2O	L/Min			
O2	3 L/Min			

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

FLUIDS

LINE site		
LRS ~ 40 KCl	☐ Warmed	
700	☐ Warmed	
	☐ Warmed	250
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
	<20
	TOTAL URINE
	30

FLUIDS - SUMMARY

CRYSTALLOID- IV 250

COLLOID-

BLOOD- 1 (b(6)-2)

REMARKS

Code drugs with numbers, events with letters

~~(a) Induced~~ [redacted]

(1) VS Taken

(2) Induced c Diprivan 170mg Fentanyl/2cc O2 Forane Leg mask

(3) Procedure begun

(4) D50 25cc 12.5 Gm IVP

(5) Procedure ended

(6) O2, breathing well, PO recovery

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- 119 / 61

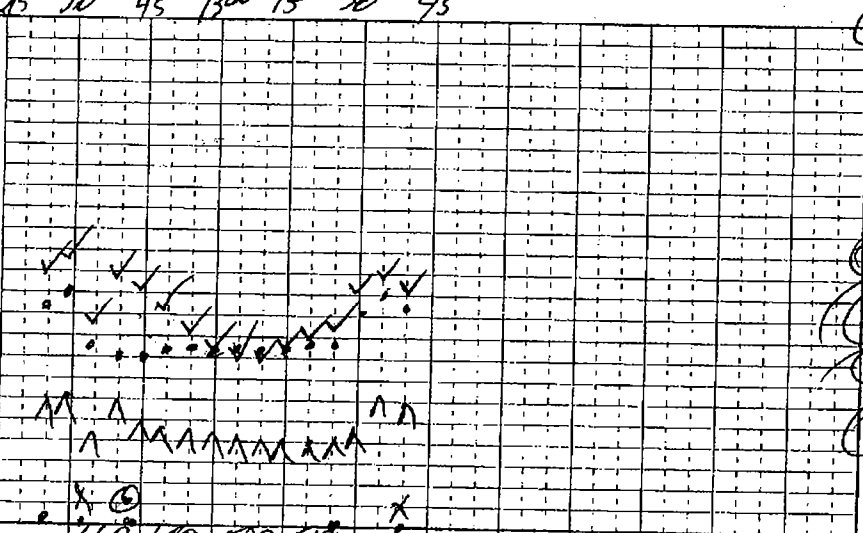
HR- 104 98%

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME 1205 30 45 1300 15 30 45

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



VENTIL

	1	2	3	4
VT - ml	660	640	590	510
f - breaths/min	10	16	12	13
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	AS	AS	AS	AS

MONITORS/ACCESSORIES

		1	2	3	4
✓ BP/Auto Cuff	✓ ET-CO2 (torr)	44	46	42	45
BP/oth	✓ FIO2 (Frac or %)	24%	74%	70%	70%
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (6)

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION: 99°

RESP- 11 SpO2- 98

BP- 132/60 HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1159	1226	1339
	Ready	Begin	End
PROC	1235	1243	1326

PROCEDURES and CPT Codes: I&D c Washout (2) hip

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* 90mm Berman c Mask

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

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

SURGEONS: [redacted]

A[redacted] CRNA

PROCEDURE LOCATION: OR

DATE: 20 Oct 03

PAGE 1 OF

110/50, 82, 20
99%
cefoxitin - Heparin p.ooc

10/23/03
18.2 > 7.3 < 24 1196

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)													
Versed (mg)	2/3												
Fent (mg)	150					50							
Lido propofol (mg)	40/150												
Vec ( )	1 7												
MSO4 ( )					5	5							
( )													
VOLAT AGENT: Forane % del		1	1.5	1.2	1.2	X							
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	8	2	2	2	2	10							
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →													

FLUIDS

LINE site LR													
☐ Warmed			200		400	6000							
☐ Warmed													
☐ Warmed													
☐ Warmed													

LOSSES

EST BLOOD LOSS													
URINE - (1200)						200							

TOTALS	TOTAL EBL
5mg 200mg	Min
	TOTAL URINE
10mg	200

FLUIDS - SUMMARY

CRYSTALLOID- 6000

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

0905 in OR
mon. to IS applied
0915 I & I ⊕ BBS
⊕ ETCO2

0915 - 0940
ostomy Bag Δ -
abd wound ⊕ Δ
⊕ leg dressing Δ

0940 Δ to RLD
AX roll placed -
⊕ arm supported
ex ⊕ ear checked
⊕ BBS

1035 - Spont
Resp. ⊕ Sensible
purposeful movement
oral suction &
extubated
to PACU
Report given

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

INITIAL DATA:

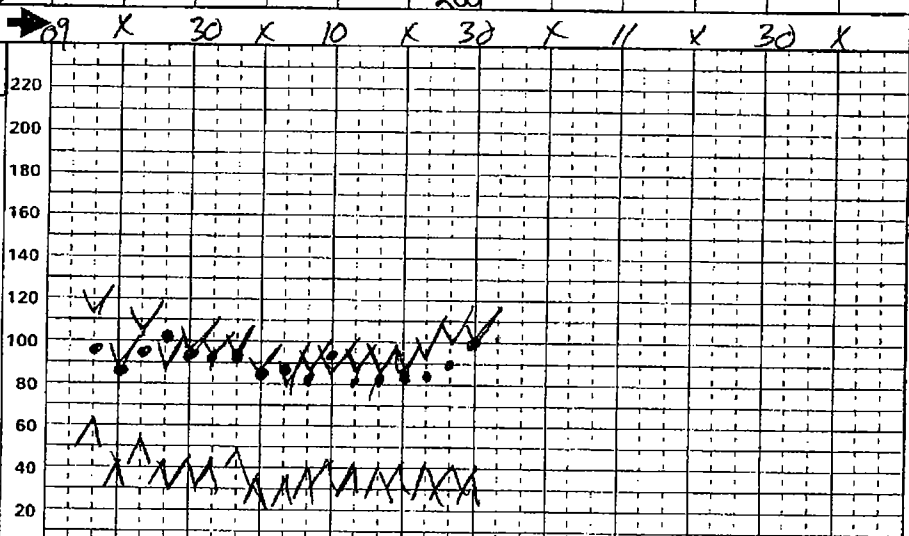
BP- 113/61

HR- 96

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 0700

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



VENTIL

VT - ml		10	780	710	760	760	SV
f - breaths/min			10	10	10	8	24
Peak inf pres / PEEP			23	21	24	25	
MODE - S(pon), A(ssist), C(on)			C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		34	33	32	32	50
BP/oth	FIO2 (Frac or %)	.73	.73	.74	.73	.73	.73
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	SR, M					
	N-M Block (T/4)		3/4		4/4		5 succ. extra
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS → *Position* o—1 OPRD

RECOVERY AT 1040

PACU ICU _____ (Specify)

OTHER T:98.4

CONDITION:

RESP- 12 SpO2- 100

BP- 102/60 HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0905	1100
	Ready	Begin	End
PROC	0920	0940	1037

PROCEDURES and CPT Codes:

Wound / Dressing Δ

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

3D

[redacted] ~~ICW~~ ICW, b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation-route, blade, technique, comments* 7.5 ETT placed 7 cm @ rt. side of mouth, 3 miller blade glide view secured 22 cm ⊕ ETCO2 ⊕ BBS

SURGEONS: [redacted] b(6)-2

AN[redacted] CRNA

PROCEDURE LOCATION: OR 1

DATE: 10/24/03

PAGE 1 OF 1

no Δ from last Anesthesia 1-/2-/03
NKDA

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	(mcg)	200
Propofol	(mg)	100
Rocuronium	(mg)	30
Zofran	(mg)	4
	( )	
	( )	
VOLAT AGENT: Iso	% del	1.5-1.2X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10-2-2-10

*2 mg Neostigmine @ 1.2 hr

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

FLUIDS

LINE site		
(L) SCL	☐ Warmed	LR (900)
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE - Foley

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: N/A

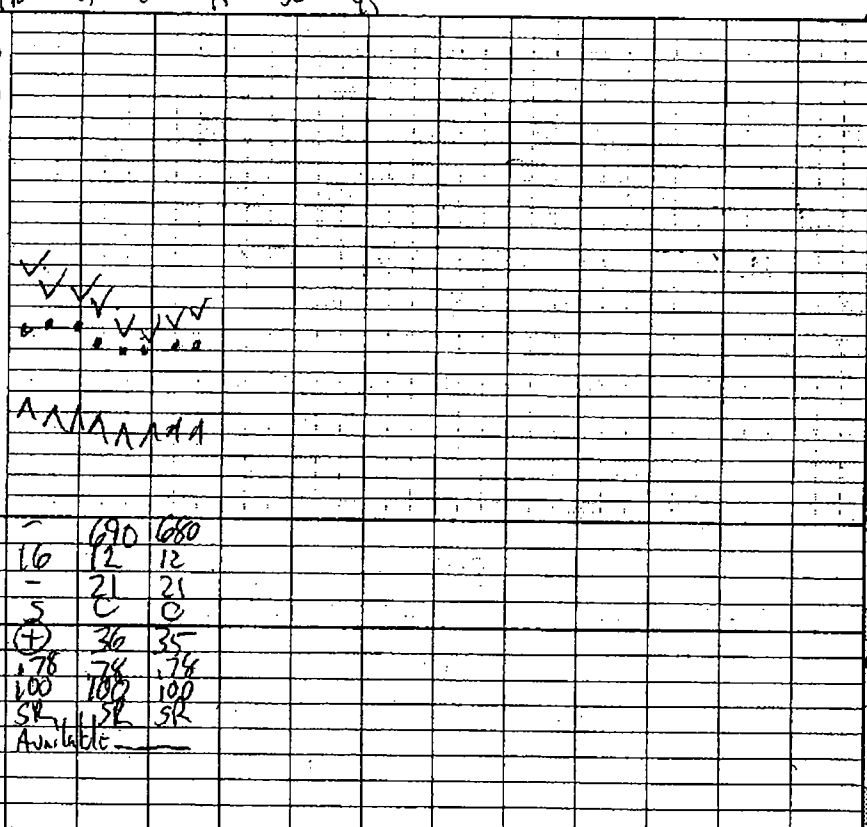
INITIAL DATA: BP- 119/56; HR- 49

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE Okay; TIME- 1920

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

TIME → 1930 45 2000 15 30 45



VENTIL

VT - ml	–	690	680
f - breaths/min	16	12	12
Peak inf pres / PEEP	–	21	21
MODE - S(pon), A(ssist), C(lon)	S	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)	36	35
BP/oth	FIO2 (Frac or %)	.78	.78	.78
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	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 → ol → RLD

TOTALS	TOTAL EBL
200	nil
100	
30	TOTAL URINE
4	
2/12	50

FLUIDS - SUMMARY: CRYSTALLOID- 200 cc; COLLOID- Ø; BLOOD- Ø

REMARKS — Code drugs with numbers, events with letters

1920 Pt in OR to dark litter, 1930 In room, ⊕ monitors, ⊕ O2, Smooth IV induction, Gas taped, easy mask vent'l'ation, 1930 Pt placed, RLD - Ax coll, ⊕ BBS ⊕ ETCO2, PP padded, neck midline, 2000 Washout started, 2015 Placed supine, Nasal oxidated, 5 diff, To PACU awake - Report to [redacted]

RECOVERY AT: 2020; (PACU) ICU ____ (Specify); OTHER ____; CONDITION: Stable; RESP- 20; SpO2- 100; BP- 112/54; HR- 71

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1920	1930	2020
	Ready	Begin	End
PROC	1940	1941	2015

PROCEDURES and CPT Codes: Washout Rectal Wound; Dx Δ

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*: GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: OR X, Tat'ed c MAC, #7.5 ETT, ⊕ BBS ⊕ ETCO2, ⊕ BBS ⊕ ETCO2, Secured c Zilco tech.

SURGEONS: [redacted] b(6)-2

ANESTH [redacted] b(6)-2 [redacted] CRNA CPT

PROCEDURE LOCATION: OR 2

DATE: 27 Oct 03

PAGE 1 OF 1

MEDCOM - 21528

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Fentanyl	50µ/cc	100 50 50 50
Reconvan	10mg/cc	20mg
	( )	
	( )	
	( )	
VOLAT AGENT	Forane % del	3-2.5
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	3 L/Min	

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

FLUIDS

LINE site		
RL-200	☐ Warmed	150
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	
URINE -	850

TOTALS

TOTAL EBL	TOTAL URINE
<3cc	850

FLUIDS SUMMARY

CRYSTALLOID- 1500

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

(1) VS Taken

(2) Induced c Lidocaine 20mg Diprivan 160mg Fentanyl 100µg O2, Forane & mask

(3) Procedure Began

(4) Procedure ended

(5) Breathing well, O2, To recovery

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 109 155 HR- 96 96%

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME 745 800 15 30 45

SYMBOLS: BP by cuff ∨ ∧; 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

	745	800	15	30	45
VT - ml		440	390		
f - breaths/min		12	15		
Peak inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)		AC	AC		

MONITORS/ACCESSORIES

		745	800	15	30	45
✓ BP/Auto Cuff	✓ ET CO2 (torr)		31	29		
BP/oth	FIO2 (Frac or %)		60%	63%		
ART line	✓ SpO2 (%)	96%	98%	97%	99	
Steth- PC/ES	✓ ECG		SR	SR		
✓ Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (5)

RECOVERY AT

PACU ICU _____ (Specify)

OTHER

CONDITION:

RESP- SpO2- 99

BP 93/42 HR- 83

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0732	0750	0839
	Ready	Begin	End
PROC	0805	0809	0827

PROCEDURES and CPT Codes: Washout + (R) Hip Wound

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen Mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

90mm Berman

SURGE[redacted] b(6)-2

A[redacted] CRNA

PROCEDURE LOCATION: OR

DATE: 2 Nov 03

PAGE 1 OF

MEDCOM - 21529

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

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

REMARKS:

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

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

DATE REQUESTED: 10 OCT 03

DATE AND HOUR REQUIRED: 10 OCT 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW to buttock

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. b(6)-2

SIGNATURE OF VERIFIER: [redacted] CPT/AN [redacted]

DATE VERIFIED: 10 Oct 03

TIME VERIFIED: 2045

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A; Rh pos

RECIPIENT: ABO A; Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

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

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

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 10 Oct 03

REMARKS: Exp 12 Oct 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: [redacted] b(6)-2

AT *(Hour)* 2130 ON *(Date)* 10 Oct 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 [redacted] b(6)-2

[redacted] AN

PRE-T[redacted]

TEMP. 100.9 PULSE 127 BP 109/52

DATE OF TRANSFUSION: 10 Oct 03 TIME STARTED: 2135

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 10 Oct 03 2250

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99.8	131	86/44

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] N[redacted] [ ] YES *(Specify)*

SIG[redacted]ERSON NOTING ABOVE

[redacted] AN b(6)-2

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

EPW

[redacted] b(6)-4

M

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

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

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 10 OCT 03

DATE AND HOUR REQUIRED: 10 OCT 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW buttock

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] b(6)-2

DATE VERIFIED: 10 OCT 03

TIME VERIFIED: 2045

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A; Rh POS

RECIPIENT: ABO A; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 10 OCT 03

REMARKS:

Exp 12 OCT 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature): [redacted] b(6)-2

AT (Hour): 2330 ON (Date): 10 OCT 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] b(6)-2

2nd VERIFIER (Signature): [redacted]

PRE-TRANSFUSION

TEMP. 99.8 PULSE 125 BP 75/42

DATE OF TRANSFUSION: 10 OCT 03

TIME STARTED: 2300

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 0035 11 OCT

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99.0	118	92/53

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [x] NO
- [ ] YES (Specify)

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

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle initial; rank; rate; hospital or medical facility)

[redacted] b(6)-4

M

WARD: ICU3

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 21531

Medical Record Copy

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION 1 - REQUISTION

COMPONENET REQUITED *(Check One)*

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

VOLUME REQUESTED *(If applicable)* 1 Unit ML

REMARKS: OR

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

- [ ] TYPE AND SCREEN
- [x] CROSSHATCH

DATE REQUESTED 11 Oct 03

DATE AND HOUR REQUIRED 11 Oct 03

KNOWN ANTIBODY FORMATION / TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: I&D Trauma

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: See previous 518

DATE VERIFIER

TIME VERIFIER

SECTION 11 - PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUION NO.

PATIENT NO.

DONOR: ABO A; Rh pos

RECIPENT: ABO A; Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

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

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

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 11 Oct 03

REMARKS: Exp 12 Oct 03

SECTION 111- RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 11 30 ON *(Date)* 11 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form 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 *(Si* [redacted]

2nd VERIFI [redacted] ICT RN b(6)-2

PR [redacted]

Temp 97.5 PULSE 99 BP 105/66

DATE OF TRANSFUSION 11 Oct 03 TIME STARTED 1155

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 ML

TIME/DATE COMPLETED / INTERRUPTED 11 Oct 03 / 1300

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 97.0 PULSE 99 BLOOD PRESSURE 113/60

If reaction is suspected-immdately

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

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

OTHER DIFFICULTIES *(Equipment, clots, ets.)*

[x] NO [ ] YES *(Specify)*

SIG[redacted] PERSON NOTING ABOVE [redacted]

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

SEX M WARD FCU3

[redacted] b(6)-4

MEDCOM - 21532

BLOOD OR COMPONENT TRANSFUSION

MEDICAL RECORD

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

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION 1 - REQUISTION

COMPONENET REQUITED *(Check One)*

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

VOLUME REQUESTED *(If applicable)* 1 Unit ML

REMARKS: CR

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

- [ ] TYPE AND SCREEN
- [x] CROSSHATCH

DATE REQUESTED 11 Oct 03

DATE AND HOUR REQUIRED 11 Oct 03 1115

KNOWN ANTIBODY FORMATION / TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE I & D

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

DATE VERIFIER

TIME VERIFIER

SECTION 11 - PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH	PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD / SIGNATURE OF PERSON PERFORMING TEST
DONOR	RECIPENT	[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED		DATE
ABO	ABO	REMARKS:		
Rh	Rh			

SECTION 111- RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form I find all information identifying the container with the intended recipient matches item by item. The [redacted] on named on this Blood Component Transfusion Form and on th[redacted] b(6)-2

1st V[redacted] SPT Chuck

2nd VERIFIER ([redacted]

PRE-TRANFUSION [redacted]

Temp 38.7 PULSE 108 BP 109/60

DATE OF TRANSFUSION 11 Oct 03 TIME STARTED 1130

POST-TRANSFUSION DATA

AMOUNT GIVEN All ML

TIME/DATE COMPLETED / INTERRUPTED 11 Oct 03 1140

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 38.7 PULSE 103 BLOOD PRESSURE 108/65

If reaction is suspected-immdately

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]

b(6)-2

SIGNATU[redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name-Last, first middle; grade; rank, rate; hospital or medical facility)

SEX M

WARD ICU 3

BLOOD OR COMPONENT TRANSFUSION

MEDICAL RECORD

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

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

Admit ICU
Cond stable
Diet NPO #14 NG to low cont suction
water
Act DR b(6)-2
VS q1h
Dx GSW neck
IV LR at 125/h
[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER ____ HOURS

Poly to gram [redacted]
Ceftazidime 2 gm IV q8h
Versed drip 1-3 mg/h
Fentanyl 50-100 µg/h
Versed 10 mg IV now
warm pt - chills
CXR for line placement
[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER ____ HOURS

T.O 10 OCT 03 1400
① LR x1 now - chills
② Heparin 5000 u x1 now - chills
③ ↑ UR @ 20 ml/hr
DR [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER ____ HOURS

10 Oct 2003 — 16 30

① Fentanyl 25-50 mcg q 60 prn
② Versed 1-2 mg q 40 IVP prn
[redacted]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

ICU3

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 1130 10 Oct HOURS | LIST TIME ORDER NOTED AND SIGN

1. blood cult
2. LR 500 bolus
3. imipenem 500 mg IVPB q 6h
4. CBC 1800 today
5. CBC lyte 8400 11 Oct b(6)-2 [redacted]
6. fx washout 11 Oct
7. DC Urange [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

8. LR 1 liter bolus over 1/2 h [redacted]
9. ↑ fluid to 150/h
10. call MD if UO < 60 cc/h x 2 consecutive h
11. pack wound q 8h c̄ NS soaked 2x2 [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

1200 10 Oct HOURS

d/c ET < 28 Fx II w/ PDCs

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

10OCT03 @ 1935 HOURS

1) Titrate Dopamine to keep MAPs > then 50. b(6)-2
2) Call M.D. If Dopamine > then 15 mcg/kg/min or CVP consistently below 8.

V.O. Dr [redacted] TIAN

T.O.

[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 2000 TIME OF ORDER 10 Oct HOURS — LIST TIME ORDER NOTED AND SIGN

(1) 25% albumin 100 cc over 1-2 hr — X2
(2) LR at 250 cc/hr
(3) ideal wedge ~ 12-14
(4) wean dopamine to 5 µg/min
(5) ⅡⅡ ut PRBC's over ~ 2 hr
(6) call MD if sat ↓ < 90%
" " UO < 60 cc/2 hr

[redacted] Noted

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(7) call MD if SBP consistently ~~HOURS~~ less than [illegible] or MAP < 55
(8) portable CXR + PT PIV at [redacted] 04 11 Oct
(9) OR 11 Oct
(10) Call MD if P > 135 [redacted] 75
(11) X-ray typing per NA [redacted] Helpy 10 if T > 101°

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(12) Dobhoff
Oct 2300 b(6)-2
XR for feed tube placement in [redacted]

b(6)-2 [redacted]

24° [redacted] 130/03 0415

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Oct 2003 TIME OF ORDER: 2300 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ① ↓ dopamine to 3 mcg/kg/min
2. ② Norepinephrine 2 mcg/min
3. ③ complete 2nd unit of transfusion
4. ④ LR at 250cc/hr
5. ⑤ ABG now ∞ wellcos CBC/diff
6. ⑥ titrate levophed to keep MAP 75-85

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Oct TIME OF ORDER: 1530 HOURS

1. 15 MEQ KCl to each liter LR at 150 cc/h
2. CBC lyts ABG CXR 04 120 ct

[redacted] b(6)-2

1640 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Oct TIME OF ORDER: 1805 HOURS

Give 500cc LR Bolus now

ABG now

V.O. Dr. [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Oct 03 TIME OF ORDER: 2100 HOURS

1. Tylenol 650 mg PO for temp > 101.5

VO: [redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES ... 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-OCT03 TIME OF ORDER: 1811 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICU #3
2. S/P EX LAP, WOUND DEBRIDEMENT
3. COND: STABLE
4. ORDERS AS WRITTEN & FOLLOWING ADDITIONS
   a.) HEPARIN 5000u SQ BID
   b.) WET-DRY DRESSING Δ'S BID TO ABDOMINAL WOUND

PATIENT IDENTIFICATION

#[redacted] b(6)-2

#[redacted] b(6)-4

[redacted] 12OCT03 1955

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [redacted] TIME OF ORDER: 13OCT03 0418 HOURS

[redacted] b(6)-2

1) DC NG + Dobhoff
2) sign of write
3) CBC [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

[redacted] 14OCT03

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES ... 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(6)-4 [redacted] b(6)-2 14 Oct [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

14 Oct 1090 _____ HOURS

1. Clear liq advance to reg
2. DC fentanyl
3. MS 2-6 mg IV q 1-2 h prn pain
4. DC Imipenem
5. cefotaxim 1 gm IVPB q 6h b(6)-2
6. Δ IV to D5 ½ NS 1000 cc @ 40 mg/h [redacted] at 100 cc/h

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

1. KCl 40 meq po TID _____ HOURS

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

DA FORM 1 APR 79 4256 REPLACES [illegible] MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

14 Oct 1900

NPO p MN for OR 15 Oct [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

15 Oct 1630

Admit ICU

Cont fluid

Diet - sips water only

Oct - BR

VS - q4h

O2 - nasal 4 LW

IV D5 NS 1000 cc c̄ 40 meq KCl at 100/h

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

cefotaxim 1 gm IVPB q6h

PC imipenem

heparin 5000 u SQ q12h

Mg - 2-6 mg IV q1-2h prn pain

change Hemovac drain q12h

change abd drain q12h - use NS normal Ringer + ADD lactic do NOT life colostomy works

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

foley gravity drain

PAC drain to continuous high suction

CBC/diff 16 Oct am

KUB for feed tube placement

b(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

16 Oct 03 OM

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 16 Oct 03 TIME OF ORDER: 0900 HOURS. LIST TIME ORDER NOTED AND SIGN

(1) Change abd wound dressing qid c̄ NS soaked gauze - do NOT lift ostomy wafer

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(2) Start Pentolive at 20 HOURS per hr; if no floating, nausea, or emesis for 4 hr ↑ to 40 cc/hr; if ō nausea x 4 hr ↑ to 60 cc/hr

(3) OOB chair if possible

[redacted]

24 [redacted] N 10/16/03 2130

PATIENT IDENTIFICATION

17 Oct 03 Done OM

DATE OF ORDER b(6)-2 TIME OF ORDER

17 Oct 0230 HOURS b(6)-2

NPO for OR

↑ IV to 125/hr

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

PATIENT IDENTIFICATION

b(6)-2 Noted 17 Oct 03 SAT 1845

DATE OF ORDER: 17 Oct 03 TIME OF ORDER: 1710 HOURS

(1) Resume previous orders

(2) Resume TF @ 80 cc/hr

(3) IVF @ 400 [redacted]

V.O. [redacted]

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] SaT [redacted] LLC/AN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL [redacted] USED.

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Oct 03 TIME OF ORDER: 1800 HOURS

DNR A 94° NBD

NPO

V.O. Dr [redacted]

[redacted] @ 1810 [redacted]

LIST TIME ORDER NOTED AND SIGN: b(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 Oct 1000 TIME OF ORDER: b(6)-2 HOURS

1. CBC 'lyte today done 1020
2. Hold IV at 0400 20 Oct for OR washout
3. ↑ IV to 100/h at 0400

[redacted] 1800 [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 Oct 03 TIME OF [redacted] HOURS

1. V.O.: Maalox 30cc x 1 p.o. [redacted] MD

b(6)-2

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 Oct 03 TIME OF ORDER: 1200 HOURS

Resume IV @ 80cc/hr

Check glucose & chem 7 done

V.O. Dr [redacted]

b(6)-2

[redacted] @ 1200 [redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE US[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

(1) ↓ IVF to 40/h b(6)-2 [redacted]
(2) Percocet 1-2 po q4 [redacted]
(3) Hydrocodone [redacted]

24 hr ce Done 22 Oct 03 @ 0100 hrs [redacted]

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 21 Oct 03 | TIME OF ORDER 2230 HOURS

(1) Tylenol 650 mg PO/per stomach q 4 h PRN fever
V.O. Dr [redacted] CPT [redacted] b(6)-2 [redacted]

24 hr ce Done 22 Oct 03 @ 0100 hrs [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 22 Oct 1930 | TIME OF OR[redacted] HOURS

(1) ~~IM Morphine~~ Mepto X 30 cc po q4 prn [redacted]
(2) ~~DOB~~ chair q [redacted]
(3) ↑ Pressure to 100 cc/h
(4) $FeSO_4$ 300 mg po BID

24° [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER

23 Oct 0800 HOURS

(1) NPO p 0400 24/Oct for OR
(2) CBC ~~[illegible]~~ today
(3) Transfer to ward to see next page b(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 MAR 72 WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

[redacted] b(6)-4

Osmolite HN

NURSING UNIT | ROOM NO. | BED NO.

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

23 Oct 0800

Transfer to ward

Cond stable - sacral-rectal GSW c̄ vac drain and colostomy, + open mid line incision

D/C - ~~Jevity Plus~~ at 100 cc/h

~~Feed 8 feed at~~ ewn

Act - OOB chair BID

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. 1025 | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

begin ambulation

VS - q4

Dx - see above

IV $D_5\frac{1}{2}NS$ 1000 cc c̄ 20 mg KCl at 40 cc/h

cefoxitin 1 gm IVPB q 8h

Heparin 5000 ut SQ q 12h

$FeSO_4$ 300 mg po BID

(8-16-24)

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Percocet 2 po q 4 prn

change midline abd dressing q 4h c̄ NS soaked gauze

change colostomy if leaks - watch rear wound

vac drain on high continuous suction

NPO p̄ 0400 24 Oct for OR

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

IV to 100/h at that time

(flush feed tube c̄ water + cap)

change cut foley today

[redacted] b(6)-2

b(6)-2

NURSI[redacted]

[redacted] 24 Oct @ 0100

[redacted] USED.

MEDCOM - 21544

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: ICW #1 | ROOM NO. | BED NO.

DATE OF ORDER: 24 Oct 0930 | TIME OF ORDER: ____ HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Chest/KUB to check feeding tube placement

(2) Flow IV D ½ NS/1000 cc c̄ 20 meq KCl to 40 cc/h

(3) Resume Osmolite HN at 100 cc/h AFTER tube placement confirmed

[redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | ____ HOURS

(4) Resume all prev. orders

(5) (R) High wound change q d c̄ NS moist gauze

(6) MS 2-5 mg IV q 2-4 h prn breakthrough pain

[redacted] b(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 OCT 0700 | TIME OF ORDER: 1400 ____ HOURS

(1) D/C DOPHOFF / OSMOLITE

(2) DIET: REGULAR c̄ 3-4 cans ENSURE QD

V.O. DR. [redacted] 2LT [redacted] LT, AN

[redacted] b(6)-2

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 OCT 03 | TIME OF ORDER: 1910 ____ HOURS

(1) Δ Mefoxin to Cefotetan 2 gms IVPB Q8°

V.O. DR [redacted]

25 Oct 0900

OOB chair 1-2X daily, ambulate - ab

NOT, discontinue Mefoxin

[redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 21545 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

b(6)-2 [redacted] Noted 28 OCT 03 1610

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 Oct TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) NPO p MN

(2) IVLR at 150 cc/h at MN for OR [redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

29 / 29 Oct 03 0300 [redacted]

DATE OF ORDER | TIME OF ORDER HOURS | b(6)-2

(1) Ambien 10mg PO QHS x 1 tonight. V.O. Dr. [redacted] b(6)-2

PATIENT IDENTIFICATION

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 OCT 03 TIME OF ORDER: 0820 HOURS

(1) Cefoxitin IVPB q 8° V.O. Dr. [redacted] b(6)-2 [redacted]

0800 29 OCT 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 OCT 03 TIME OF ORDER: 0900 HOURS

(1) Percocet 1-2 q 4° PO for pain V.O. Dr. [redacted] b(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES [illegible] MAY BE USED.

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
2	2 Oct 03 2030 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 3 mg IV now and 2 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	Di[redacted]overy status when PACU discharge criteria met.		
	[redacted]CKWA CRT		
	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

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 27 Oct 2000 TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ICW1
Cardiostable
Diet - reg c̄ 6 cans Ensure poly
11 cans TID & record intake
Act - ambulate q d
PT consult
VS - q 4h

PATIENT IDENTIFICATION

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

Dx - rectal GSW
IV $D_5\frac{1}{2}NS$ 1000 cc c̄ 20 mg KCl at 40 cc/h
ibuprofen 400 mg po q 4 prn pain
5-10 mg MS IV prn to q d
→ dressing change at bedside - loosely

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

pack (L) hip wound c̄ NS soaked Kerlex
→ change ostomy wafer prn leak
→ change midline wound dressing q 8h c̄ NS soaked gauze
Jackson Pratt to gravity drain
FRSO4 300 mg po BID [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

heparin 5000 ut SQ q 8 hours [redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 21548 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: 24 ward | ROOM NO.: 30OCT03 | BED NO.: [redacted]

DATE OF ORDER: 29OCT03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

V.O. Dr. [redacted] b(6)-2

1. Colace PO BID
2. Maalox 30cc PO q6° prn for gastric pain [redacted]

1600 29OCT03

[redacted] b(6)-2

PATIENT IDENTIFICATION

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

DATE OF ORDER: 30 Oct | TIME OF ORDER: HOURS

1. DC foley
2. MS 10mg IV for dressing change tody-dress
3. ambulate q d
4. OOB chair BID [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30OCT03 | TIME OF ORDER: 0920 HOURS

MSO4 5mg IV p dressing Δ

V.O. Dr. [redacted] b(6)-2

PATIENT IDENTIFICATION

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

0905 30OCT03

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

DATE OF ORDER: 31 Oct 0830 | TIME OF ORDER: HOURS

1. Benadryl 50 mg po hs 2200
2. NPO p MN for dressing Δ 1 Nov
3. IV LR at 125/h at 2400
4. MS 10mg IV before dressing Δ b(6)-2

1 NOV @ 0400 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

Noted [redacted] 01NOV03 0945

NURSING UNIT | R[redacted] | BED NO.

DATE OF ORDER: 1 NOV | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Reg. diet as was given prior this am

(2) NPO p MN for OR 2NOV [redacted] (2400)

b(6)-2

[redacted]

PATIENT IDENTIFICATION

b(6)-2

DATE OF ORDER: 2 NOV 0045 | TIME OF ORDER: _____ HOURS

NPO now for OR [redacted] (Clots today)

Noted

b(6)-2

[redacted]

b(6)-2

NURSING UNIT: NP/0500 | ROOM NO.: 2NOV03 | BED NO.: [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.

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
b(6)-4 [redacted]				2 Nov	0730 HOURS.	[redacted]
				Resume pre-op		
NURSING UNIT	ROOM NO.	BED NO.				
	3 Rene	03C		0030		[redacted]

2 NOV @ 0925

b(6)-2

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

b(6)-2

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

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. Oct Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 10 11 13 14 15 22 23 24 25 26 27 28
10 Oct 03		DIET: NPO	06	[redacted]
			18	
10 Oct 03		NGT to LWS	06	[redacted]
			18	
10 Oct 03		ACT: ~~BID~~ QD	06	[redacted]
		to Chem q	18	
10 Oct 03		VS: ~~Q4h~~ Q4h	06	
			18	
10 Oct 03	[redacted]	Foley to gravity	06	
			11	
10 Oct 03	[redacted]	PACK wound Q 8 hrs with	02	[redacted]
		~~for~~ NS moist 2x2	10	
			18	
10 Oct 03	[redacted]	Total weight at 1244	06	3 Clar.
			18	
10 Oct 03	[redacted]	Call MD if sat ↓ < 90%, UOP < 60	06	[redacted]
		cc/hr, SBP consistently < 85	18	
		or MAP < 55, P > 135 or < 75		
11 Oct 03	[redacted]	CBC, Lytes, ABG	04	
		CXR 0400		
12 Oct 03	[redacted]	Pack wound (Q8)	06	
		HRSE NS soaked	18	
		2X2		
12 Oct 03	[redacted]	Condition: Stable	06	
			18	
12 Oct 03	[redacted]	Wet to Dry dressing Δ's	08	
		BID to abdominal wound	20	
14 Oct 03	[redacted]	sips of H2O	06	
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ex Lap, wound debridement

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

EDITION OF 1 DEC 77 MAY BE USED USAPA V1.00

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

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
10 Oct 03	[redacted]	ADMIT TO ICU 3	10 Oct 03	0610	0610	[redacted]
10 Oct 03	[redacted]	CVRD STABLE	10 Oct 03	0610	0610	[redacted]
10 Oct 03	[redacted]	CXR for line placement	10 Oct 03	0610	0610	[redacted]
10 Oct 03	[redacted]	CBC 1800 TODAY	10 Oct 03	1800	1800	[redacted]
10 Oct 03	[redacted]	CBC, LYTES	11 Oct 03	0400	0415	[redacted]
10 Oct 03	[redacted]	TO OR ON 11 Oct	11 Oct			
10 Oct	[redacted]	Portable CXR & PT/PTT @ 0400 11 Oct	11 Oct	0400	0415	[redacted]
10 Oct	[redacted]	Dobhoff	10 Oct	now	Done	[redacted]
10 Oct	[redacted]	ABG now as well as CBC & diff	10 Oct	now	2340	[redacted]
11 Oct	[redacted]	ABG/500LR bolus	11 Oct	done		[redacted]
12 OCT	[redacted]	XR for feeding tube placement in AM	13 OCT	0400		[redacted]
10 OCT	[redacted]	Blood culture now	10 OCT	1130		[redacted]
14 Oct	[redacted]	CBC, Lytes AM	14 Oct	0400	0400	[redacted]
14 Oct	[redacted]	NPO P MW for OR 15 Oct	15 Oct	12 MW	12 MW	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
10 Oct 03	2	CALL MD FOR: UO <60 for any 2 hrs														

USAPA V1.00

b(6)-2 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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27
15Oct	[redacted]	DIET: SIPS WATER	06	[redacted]												
		ONLY	18													
15Oct	[redacted]	ACTIVITY: BEDREST	06													
			18													
15Oct	[redacted]	Vital Sigs Q4°	06													
			18													
15Oct	[redacted]	Change thigh dressing	06													
		Q12°	18													
15Oct	[redacted]	Change abd. dressing	06													
		Q12° USE NS soaked	18													
		Kerlex & ABD pads														
		DO NOT LIFT														
		LOL OSTOMY WAFER														
15Oct	[redacted]	Foley to gravity	06													
			18													
15Oct	[redacted]	Vacuum drain to	06													
		continuous high suction	18													
16Oct	[redacted]	Change abd wound	02													
		dressing q12° & PS	08													
		soaked gauze-do not lift	14													
		ostomy bag	20													
16Oct	[redacted]	Start peristole @ 20 per hr	06													
		if no vomiting, nausea or	18													
		emesis q 4h ↑ to 40cc/hr														
		if ō prob. x 1hr ↑ to 60cc/hr														
16Oct	[redacted]	OOB chair if possible	06													
			18													
17Oct	[redacted]	resume TF @ 80cc/hr	06													
			18													

[redacted]

DC'd Δ'd to QID

Δ'd 18Oct03

Δ'd 17 Oct 03

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: RECTAL GSW

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: EPW

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

MEDCOM - 21554
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
15Oct	[redacted]	Admit to ICU, condition FAIR, Dx: RECTAL [illegible]	15Oct			[redacted]
15Oct		CBC, LYTES	16Oct	AM	0900	
15Oct		KUB for Feed Tube Placement	15Oct			
19Oct	[redacted]	Hold H2O @ 0400 20Oct for wound washout	[redacted]	0400		
		b(6)-2		b(6)-2		

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

USAPA V1.00

b(6)-2 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. 10 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
14Oct03	[redacted]	Clear liquid advance	06	BW	[redacted]		
		as tolerated - Regular	18	KN			
22nd	[redacted]	↑ Perature TF to	06				
		100 cc/hr	18				
22nd	[redacted]	Dressing Δ q40° to	06	/			
		abdomen open	18	/			
22nd	[redacted]	NS q40°	06	/			
			18	/			
22nd	[redacted]	thigh dsrg Δ q12°	06	/			
			18	/			
22nd	[redacted]	Foley to gravity	06	/			
			18	/			
22nd	[redacted]	Vacuum drain to	06	/			
		continue Sx.	18	/			
22nd	[redacted]	OOB to chair qD	06	/			
			18	/			
24Oct	[redacted]	R thigh wound	06 18	/	/		
	[redacted]	change q d c̄ NS	/				
		soaked gauze.	/				
10/24	[redacted]	Resume Osmolite	06 18	—	/		
		HN @ 100cc/hr AFTER	18 06	—	/		
		tube placement	/				
		confirmed.	/				

See sheet started on 23 Oct 03 [redacted]

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Sacral Rectal GSW c̄ Vac Drain and colostomy & open midline incision.

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 Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/24	[redacted]	Resume all previous orders	10/24	noted		[redacted]
10/24	[redacted]	Check KUB to check feeding tube placement	10/24			
		b(6)-2				

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 ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22
16Oct03	[redacted]	Dressing Q40 ABD Area	04	/	[redacted]			
			08	/				
			12	[redacted]				
			16					
			20					
			24					
2002	[redacted]	Reg Diet	06	/	/	[redacted]		
			18	/	/	/		
~~21oct~~	[redacted]	~~D/W/F (a 40/0~~	~~06~~	~~/~~	~~/~~	~~/~~	[redacted]	
			~~18~~	~~/~~	~~/~~	~~/~~		

Wet to Dry Gauze

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Rectal GSW

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 Green Sh + 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. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27
23 0003	[redacted]	Osmolite HN @ 100cc/	06 18	[redacted]				
		hr	18 06					
23	[redacted]	Act - OOB to chair 1-2x/D	06 18					
		BID - begin ambulation	18 06					
23	[redacted]	NS q4°	06 18					
			18 06					
23	[redacted]	change midline abd	06					
		drsg q4° c̄ NS soaked	08					
		gauze	12					
			16					
			20					
			24					
23	[redacted]	Wound vac on high	06 18					
		continuous suction	18 06					
2300	[redacted]	N10: CL drsg Δ Q3d	22	X	X	X	X	X
2400	[redacted]	(R) thigh wound	06	/	/	[redacted]		
		Δ q d c̄ NS soaked						
		gauze						
24 Oct	[redacted]	Resume Osmolite	06	/				
		HN @ 100cc AFTER	18 06	/		D/C'D		
		tube placement	/					
		confirmed	/					
24	[redacted]	DIET: Regular c̄	6	/	/	[redacted]		
		3-4 cans ENSURE	18	/		[redacted]		
25	[redacted]	DO NOT DISCONNECT	6	/	/	/	[redacted]	
		SXN when OOB!	18	/	/	/	[redacted]	

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SACRAL-RECTAL GSW c̄ VAC DRAIN AND COLOSTOMY & OPEN MIDLINE INC

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

Green Sheet

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 OCT03	[redacted]	Tx to ward - Cond. stable	23 OCT03	—		[redacted]
23	[redacted]	NPO p 0400 24 OCT for OR	24 OCT03	0400	—	[redacted]
23	[redacted]	Flush feed tube c water & cap	24	0400	—	[redacted]
23	[redacted]	Change out foley today	23 OCT03	—	in ICU	[redacted]
23	[redacted]	CBC today	23	—		[redacted]
26 OCT03	[redacted]	NPO p MN	27 OCT03	0001	0001	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
23 OCT03	[redacted]	Change colostomy if leaks - watch rearward	D/T/I	26 OCT 0730 KAG												

b(6)-2

USAPK V1.00

b(6)-2 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. OCT Yr. 2003

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

ORDER DATE	CLERK/NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29	30	31	1	2	3
27	[redacted]	DIET: regular c̄ 6	6	/	[redacted]						
		cans Ensure/day	18								
		# cans TID	X								
27	[redacted]	RECORD INTAKE	6								
			18								
27/30	[redacted]	ACT: amb QD	6	/							
			18								
27	[redacted]	VS: Q4°	6	/							
			18								
27	[redacted]	QD dressing Δ @ PS:	10	/							
		Loosely pack Ⓓ hip	/								
		c̄ NS soaked Kerlix	/								
27	[redacted]	Δ mL wound drsg Q6°	6	/							
		c̄ NS soaked gauze	12	/							
			18	/							
			24								
27	[redacted]	Foley to gravity drainage	6	/							
			18								
30 OCT 03	[redacted]	OOB to chair BID	10	/	/	/					
			22	/	/	/					
31 OCT	[redacted]	foley to gravity	6	—	—	—					
			18	—	—	—					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Sacral-rectal GSW c̄ vacdrain open ML incision (EX-LAP

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

MEDCOM - 21561

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27	[redacted]	P.T. consult				
30 OCT03	[redacted]	Dic foley	30 OCT03	—	0930	[redacted]
31OCT	[redacted]	NPO p MN for drsg Δ 1 November	31OCT	0001	0001	[redacted]
01 NOV03	[redacted]	NPO p MN for OR 02NOV03	02 NOV03	0001	0001	[redacted]
2	[redacted]	NPO now for OR later today	2NOV	0005	0001	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
[redacted] 29OCT	----	Δ Ostomy wafer prn leak	D/T	30OCT 1330												
----	----		D/1	1720												
----	----	b(6)-2		[redacted]												
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

b(6)-2 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 10	11	12	13	14
10 Oct 03	-----	IVP: LRC 200	06	[redacted]				
	-----		18					
10 Oct 03	-----	UNASYN 3 GM IVPB Q6	06	[redacted]				
	-----		12					
	-----		18					
	-----		24					
10 Oct 03	-----	Versed gtt (1-3mg/hr)	06	[redacted]				
	-----		18					
10 Oct 03	-----	Fent gtt (50-150mcg/hr)	06	[redacted]				
	-----		18					
10 Oct 03	-----	Imipenem 500 mg	06	[redacted]				
	-----	IVPB Q6	12					
	-----		18					
	-----		24					
	-----	LRC 125						
10 Oct 03	[redacted]	LRC 250cc/hr	06	[redacted]				
	-----		18					
18 Oct 03	[redacted]	Titrate Dopamine to keep MAPS	06	[redacted]				
	-----	> then 50.	18					
18 Oct 03	[redacted]	Call MD if Dopamine > then 15mcg/	06					
	-----	kg/min or CVP consistently > 8	18					
18 Oct 03	[redacted]	Wean Dopamine to 5mcg/min	06					
	-----		18					
18 Oct 03	[redacted]	Dopamine to 3mcg/kg/min	06	[redacted]				
	-----		18					
18 Oct 03	[redacted]	Norepinephrine 2mcg/min	06					
	-----		18					

D/C'd

D/C'd 18 Oct 03 [redacted]

b(6)-2

D/C'd 18 Oct

D/C'd 14 Oct

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW s/p Ex lap, Wound debridement

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

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 1 FEB 79 4678 EDITION [illegible] IL EXHAUSTED.

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
10 Oct		Vecuronium 10mg IVP x 1 now	10 Oct	now	0710	[redacted]	
10 Oct	[redacted]	LR 1000 cc	10 Oct	1600	1600	[redacted]	
10 Oct	[redacted]	500 cc Hes plan	10 Oct	1600	1600	[redacted]	
10 Oct	[redacted]	25% Albumin 100cc over 1-2 hrs x 2	10 Oct	now	2030 2200	[redacted]	
10 Oct	[redacted]	4 units PRBCs over 2 hrs	10 Oct		2135 2200	[redacted]	
10 Oct	[redacted]	LR 500 bolus	10 Oct	1130	[redacted]		
		LR bolus 1 Liter over 1/2 hr					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Oct	[redacted]	Fentanyl 25-50 mcg														
		Q6° PRN ~~pain~~ sedation IVP														
10 Oct	[redacted]	Versed 1-2 mg														
		Q4° PRN pain IVP														
10 Oct	[redacted]	If Hct < 28 transfuse 4 units PRBCs														
10 Oct	[redacted]	5 gr Tylenol per NG & clamp	D T	1200 [illegible]	1800 [illegible]	1400 [illegible]	1400 1900 [illegible]	1500 0500 [illegible]	1500 0900 [illegible]							
		1 hr if T > 101.5	D T	101.4	[redacted]											
10 Oct	[redacted]	MSO4 2-10 mg IV q1° prn	10.14 [illegible]	[redacted]	[redacted]	1400 1000	1900 2200	1600 0500	1500 1130	[redacted]						
		pain		[redacted]												

b(6)-2

*U.S. GPO: 1998-454-110/95218

b(6)-2 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. Oct Yr. 05

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24
10Oct05	[redacted]	Titrate Levophed to Keep	06	[redacted]						
		MAP 55	18	[redacted]						
11Oct05	[redacted]	15 meq KCL 40	06	/	[redacted]					
		each liter LR	18	/	[redacted]					
		@ 150cc/hr								
12Oct	[redacted]	Heparin 5,000 SQ BID	08	/	/	[redacted]				
~~12Oct~~			20	/	/	[redacted]				
14Oct	[redacted]	Cefoxitin 1gm IVPB	06	/	/	/	/	/	[redacted]	
		q 6°	12	/	/	/	/		[redacted]	
			18	/	/	/	/		[redacted]	
			24	/	/	/	/		[redacted]	
14Oct	[redacted]	D 5½NS 1000cc i 40	06	/	/	/	/		[redacted]	
		meq KCl at ~~100cc~~/hr	18	/	/	/	/		[redacted]	
		↓40/hr								
14Oct	[redacted]	KCl 40meq po TID	06	/	/	/	/		[redacted]	
			14	/	/	/	/		[redacted]	
			22	/	/	/	/		[redacted]	
m	[redacted]	Tesol 300mg po BID	10						[redacted]	
			22							

Δ'd 14Oct05

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW s/p ex lap, wound debridement

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

7 of 15 pgs.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
22OCT	[redacted]	~~Mylanta 30~~ (Maalox)	22OCT93 [redacted]															
		30cc po q4° pRN	[redacted]															
		epigastric pain	[redacted]															
22NA (rewritten)	[redacted]	MS04 2-6mg IV	[redacted]															
		q 1-2° pm pm	[redacted]															
22NA (rewritten)	[redacted]	Percocet 1-2 po																
		q4° pm pain																
22NA	[redacted]	Tylenol 650mg po/																
		PAT q4 pm fever																

*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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23
15 Oct	[redacted]	D5½NS c 40 KCL	06	[redacted]								
	----	@ 100cc/hr	18									
15 Oct	[redacted]	CEFOXITIN 1gm	06									
	----	IVPB Q6°	12									
	----		18									
	----		24									
15 Oct	[redacted]	HEPARIN 5000u	10									
	----	SQ Q12°	22									
17 Oct	----	D5½NS c 40KCL	06									
	----	@ 40 cc/hr	18									
19 Oct	[redacted]	[redacted]	06									
	----	@ 0900										
21 Oct	[redacted]	@ 40 cc/hr	06									
	----	D5½NS c 40 KCL	18									

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
RECTAL ESD

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO. 3

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.

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
19 Oct	a	Macks x 30 cc po	19 Oct	2100	due	[redacted]

See Rev A

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
15 Oct	[redacted]	MSO4 2-4mg IV q 1-2hr PRN pain	1500 1945 4mg	1500 1945	1900	1230	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2050 5mg	0045 5mg	10-17 0215 5mg	
		MSO4 continues	0345 10/17 5mg	0500 10/17 5mg	0700 10/17 5mg	1215 10/17 5mg	1420 10/17 5mg	1830	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
			1930 4mg	1000 4mg	10-18 1815 4mg	10-18 2014 2mg	10-18 2130 3mg	10-19 0010 5mg	10-19 0130 5mg	[redacted]	10-19 1830 5mg	10-19 2110 5mg	10/19 0100 5mg	[redacted]	
			[redacted]												
21 Oct	[redacted]	Percocet 1-2 po q4° prn; pain	D/T	0815	2100 1245	[redacted]		10/22	[redacted]						
21 Oct 03	[redacted]	Tylenol 650 mg po per doctor order q4h PRN fever	[redacted]												

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

*U.S. GPO: 1998-454-110/95218

b(6)-2 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. 10 Yr. 03

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
23 OCT03	[redacted]	IV D5½NS 1000cc c̄	06 18	[redacted]				
	-----	20mEq KCl @ 40cc/hr	18 06	[redacted]	re ordered			
23	[redacted]	Cefoxitin 1gm IVPB	06	[redacted]				
	-----	q8°	12	[redacted]				
	-----		18	[redacted]	order NO			
	-----		24	[redacted]				
23	[redacted]	Heparin 5000U SQ	10	[redacted]				
	-----	q12°	22	[redacted]				
23	[redacted]	FeSO4 300mg po BID	10	[redacted]				
	-----		22	[redacted]				
	-----	N		[redacted]				
24	[redacted]	0S/0N IV D5½NS	06 18	[redacted]		/		
	[redacted]	1000 cc c̄ 20 mEq	18 06	[redacted]		/	SEE D BELOW	
	-----	KCl to 40cc	/	[redacted]				
24	[redacted]	Cefotetan 2gms	8	/ /	[redacted]			
	-----	IVPB q8°	16	/ /				
	-----		24	/	[redacted]			
26 OCT03	[redacted]	IV LR @ 150cc/hr @	06 18	/ /	/ /	[redacted]		
	-----	MN for OR	18 06	/ /	/ /	25		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SACRAL-RECTAL GSW c̄ VAC DRAIN AND COLOSTOMY & OPEN MIDLINE INCISION

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
23 OCT03	[redacted]	↑IV to 100cc/hr @ that time (0400 24OCT03)	24 OCT03	0400	0400	[redacted]	
26 OCT03	[redacted]	IV LR @ 150cc/hr @ MN for OR	27 OCT03	0001	0001	[redacted]	

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23OCT03	[redacted]	Percocet 2po q4° prn pain	Dt	23 1355	23 1910	25 0015	25 2000	26 0000	26 1136	26 1850	27 0440					
			Dt	[redacted]												
10/24	[redacted]	MS 2-5 mg IV q 2-4h prn breakthrough pain	Date	2400	[redacted]	[redacted]	26	27	27							
			12mg	2000	2000	0000	1850	0000	0440							
			Dose	5mg	5mg	5mg	5mg	5mg								
			[redacted]													
			1/E	E	E	E	E	E								

*U.S. GPO: 1996-454-110/95216

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 27	28	29	30	31	1	2	3
27	[redacted]	D5 1/2NS c̄ 20meq KCl	6	/	[redacted]						
	-----	@40cc/hr	18	[redacted]							
27	[redacted]	MSO4 5-10mg IV QD	10	/							
	-----	prior to drsg Δ	/								
27	[redacted]	FESO4 300mg po BID	6	/							
	-----	(N10:c̄ Meals)	18	/							
27	[redacted]	Heparin 5000u SQ q12°	10	/							
	-----		22	[redacted]							
29	[redacted]	Cefoxitin 1GM IVPB	8	/							
	-----	q 8°	16	/							
	-----		24	/							
29	[redacted]	Colace BID PO	10	/							
	-----		22	/	/						
31OCT	[redacted]	Benadryl 50mg PO	22	→							
	-----	QHS @2200	X								
31 OCT	[redacted]	MSO4 10mg IV	10	→							
	-----	before drsg change	X								
31OCT	[redacted]	IVLR @ 125cc/hr.	06 18	/	/	/	/				
	-----		18 06	/	/	/	/				

Order Held 31OCT

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Sacral-rectal GSW c̄ vac drain
Open ML incision (EX-LAP)

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

b(6)-2

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
28	[redacted]	Ambien 10mg po QHS x 1 tonight	28OCT	2200	2200	[redacted]
30 OCT03	[redacted]	MSO4 10mg IV for drsg Δ today	30 OCT03	—	0900	[redacted]
30	[redacted]	MSO4 5mg IV p drsg Δ	30	—	0940	[redacted]
31	[redacted]	↑ IVF TO 125cc/° @ 2400	31OCT	2400	2400	[redacted]

b(6)-2

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27	[redacted]	Ibuprofen 400mg po Q4° prn pain	D/T	28oct 2115												
			D/I	400mg AA												
28 OCT	[redacted]	Percoset ½ ½ Q4° prn pain	D/T	29oct 0910	30oct 0015	30oct 1020	31oct 1900	1Nov 1946	2Nov 1045	2Nov 2025	3Nov 1925					
			D/I	2	½	½	½	½	2	½	2					
				[redacted]												
29 OCT	[redacted]	Maalox 30cc PO Q6° for gastric pain	D/T	29oct 1600	30 1900	1100 1950	2030	30GN 0925								
			D/I	30cc	30cc	½	30mg	30cc								
				[redacted]												

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

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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	0600	INTILA [redacted]		INTILAS		INTILAS
NEURO	PUPLIS	Perrla 4mm					
	SENSORIUM	A+O					
RESPIRATORY	RESPIRATION PATTERN	even, unlabored					
	BREATH SOUNDS	CTA-b					
	SECRETIONS	0					
SKIN	COLOR	NFR					
	INTEGRITY	multiple wounds					
I.V. SITE	LOCATION	L SC Triple Lumen					
	CONDITION	c/d/i					
GASTRO	ABDOMEN	mildly abd distending					
	BOWEL SOUNDS	colostomy					
		+BS x 4 qds					
GU	URINE	clear yellow					
	COLOR/CLARITY	Foley to gravity					
CARDIOVASCULAR	CARDIACRHYTHM	TSR					
		+2 pulses					
		<3 sec cap refill					
		Dedema					

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

(Continue on reverse)

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

PATIENT'S INDICATIONS *(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)*

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	109/55				109/56					100/54								
Temperature	98.7				99.4													
Pulse	102				104					102								
Respiratory Rate	18				18					21								
SpO2	100				99					100%								

INTAKE																			
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	40	40	40	40	40	40	40	40		40								
IVPB	50																	
TF	100	100	100	100	100	100	100			100								
TOTALS																		

OUTPUT																			
URINE	HOUR	200					200		200										
	TOTAL	200					400												
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

b(2)-2

[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: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 0450 ETA: 0455 UNIT: [redacted]

MED COM: Y [N]

b(6)-4

ARRIVAL STATUS

TIME 0457 ☐ IV x 2 ☐ O_2 _____ l/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☐ Yes: _____

Allergies: ☐ UKN ☐ None ☐ Yes: _____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake _____ hrs

LMP: ☒ Colostomy implice

PRIMARY SURVEY

AIRWAY
☐ Natural Patient [Y] [N]
ETT 8.0 @ 22
☐ Secretions _____

BREATHING
☐ 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 _____
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 @ 95
PULSES: ☐ Central ☐ Peripheral

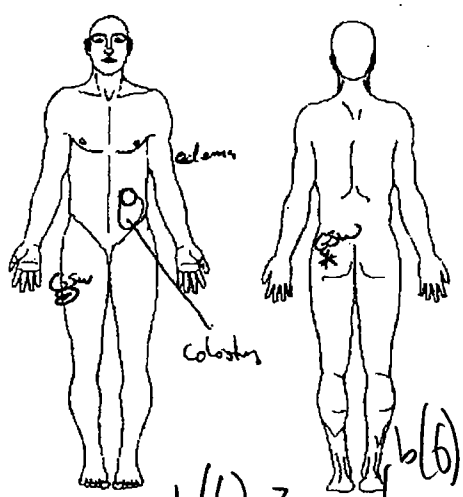
LUNGS
BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☒ Soft ☐ Rigid ☐ Non-Tender
☐ Tender: _____

PELVIS
☐ Stable ☐ Unstable ☐ _____
Blood at meatus/vagina: [Y] [N]
Heme +/- Prostate: ☐ WNL ☐ Abnl

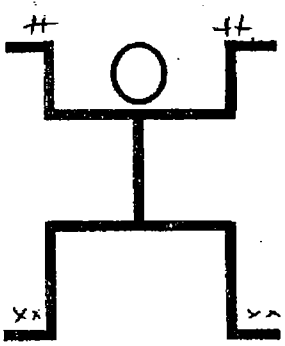
USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(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



b(6)-2

VASCULAR ASSESSMENT



b(6)-2

+ + Strong [redacted] D Dopler

b(6)-2

RN [redacted]

PHYSICIAN [redacted]

PREPARED BY (Signature & Title) Sgt [redacted]

DEPARTMENT/SERVICE/CLINIC [redacted]

DATE 10 Oct 03

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

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

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

b(6)-2

VITAL SIGNS

Rectal Temp: 96.5 GCS: unch

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0500	114/82	99	Sinus	27	98%						
0525	110/77	101	Sinus	16	100%						

GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	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

b(6)-2

Staff note

S/p GSW/ RT eval/ post ex lap. trans pelvis GSW / ② femur GSW. ⌀ the eval

A: ETT in place B: CTA(B) symmetric C: ② in ext IV in place ② in abduction ext stripped ⌀ evaluation this noted for weeks

D: pulsed E: See note Foley in place ⌀ clear yellow urine ⌀NGT/OG

~~Hemodynamically~~ neck: ⌀ stepoff

⊕ edema non pitting ⊕ in extremity

~~⊕ 2 pulses w/ ext symmetric~~ ⊕ leg

s/p stable hemodynamically. ⌀ note on transfer chart adding ext and RT leg managed by surgery Dr [redacted]

See note

[redacted]

☆U.S.GOVERNMENT PRINTING OFFICE 1987-571-7000

(page 3)

7420

ORDERS

Work Surg AV [redacted] 0500

NGT [redacted] 0510

Keep as another [redacted] 0540

ABG [redacted] 0545

b(6)-2

[redacted]

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0610	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS			Perrl 2mm, brisk. Easy			
	SENSORIUM			to arouse. Moves all			
				extremities. Opens eyes			
				on command. Fentanyl			
				for sedation.			
RESPIRATORY	RESPIRATORY PATTERN			Vent #80, 25cm @ teeth.			
	BREATH SOUNDS			SIMV 16 TV 650 FiO2 40%.			
	SECRETIONS			Peep 5. CTA all lung			
				fields. ABG's good WNL			
				Ø secretions.			
SKIN	COLOR			WNL, NFR. Bandage c̄ serosanguineous			
	INTEGRITY			drainage on (R) thigh medial lateral			
				dressing to back & ML abdomen			
I.V. SITE	LOCATION			Cordis to (R) subclavian.			
	CONDITION			Infusing LR & Fentanyl			
				(R) subclavian TLC & CVP to			
				proximal port. Dopamine LR			
				A-line (R) radial, Ø S/S infection			
				good circulation, zeroed good waveform			
GASTRO	ABDOMEN			Slightly distended. Ileostomy			
	BOWEL SOUNDS			to (L) medial quadrant. NGT to			
				LWS to (R) nares. ~~hyp~~ Absent			
				BS x4.			
GU	URINE:			Foley to gravity. Adequate			
	COLOR/CLARITY			UOP. Clear, light yellow.			
CARDIOVASCULAR	CARDIAC RHYTHM			ST, ectopy, 120's. S1 S2.			
				Radial/pedal pulses			
				2+. Cap refill <3 sec.			
				Trace edema in LLE.			

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

(Continue on reverse)

PREPARED BY [redacted]

DEPARTMENT/SERVICE/CLINIC ICU

DATE 10 Oct 89

PATIENT'S IDENTIFICATION [redacted] last, first, middle; grade [redacted] hospital or medical facility [redacted]

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

b(6)-2

DATE 10/6/03 | DX [illegible] | HOSPITAL DAY [redacted]

VITALS	TIME	0400	7	8			10	11	12		13	14	15						
	BP Arterial Line	102/67	123/63	[illegible]			95/56	95/56	87/60		81/50	86/42	95/57						
	BP Cuff			93/82			103/93	98/85			114/52	97/44	112/50						
	Temperature	96.3	94.1	94.4			98.0					94.5							
	Pulse	103	106	122			117	125	126		120	125	129						
	Respiratory Rate	14	20	14			18	30	31		16	16	16						
	Sats	100	100	100			100	100	100		100	100	100						
	F.O2	40	40	40.			40	35	35		40	40	40						
SIGNS	PEEP						5	5	5		5	5	5						
	MAP (A)																		
	CVP								5		5	7	9						

INTAKE	TIME																		8° T
	IV F	1000	100		1400		100	125	150	2875	150	150	150			3325			3325
	~~Dopamine~~																		
	IVPM	100							100	200									200
	DOPamine										113	113	158						27
	Bmy							100		1000	1000								2000
	Hep											500							500
	Albumin																	4725	
	PRBC																	40	
	TOTALS									4015									5125

OUTPUT		HOUR / TOTAL		650	250 / 900	150 / 1050		300 / 1350	180 / 1530	150 / 1680		200 / 1880	350 / 2230	300 / 2230						2230
	URINE	sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

	16	17	18	19	20	21	22	23	24
V	77/47	87/42	83/43	96/45	89/43	93/45	92/46	77/45	
	85/48	102/49	87/45	94/45	97/44	93/46	83/42	75/43	
			101.7			101.9 (R)		77.8	
	125	119	120	117	117	122	120	120	
	16	19	18	16	16	19	16	17	
	100	100	100	100	100	100	100	100	
	40	40	40	40	40	40	40	40	
	5	5	5	5	5	5	5	5	
	6	10	10	9	9	9	11	16	
				58	57	59	60	54	
I	150	200	200	200	200	250	250	250	8° T 3507
			100						100
	15.9	15.9	15.8	18.0	18	18	19	6.8	126.2
	5	5	5	5	5	5	5	5	40
	1000			1000				1000	3000
		500							500
							100	100	200
								300	300
									7713
	150/	220/390	220/390	265/835	300/1035	270/1405	135/1530	80/1610	1610

ACUITY LEVEL CLASSIFICATION

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

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

DAILY ACTIVITIES/DOCUMENTING	TIME	12m	b(6)-2
	MOUTH CARE	[redacted]	
	BATH		
	SKIN CARE		
	FOLEY CARE	[redacted]	
	TRACH CARE		
	ROM EXERCISES		

TURN	TIME					
SUCTION	[redacted]					
	12m					

24°I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	12898	Urine:	3840
po			
TOTAL	12898	TOTAL	3840

BALANCE +9058

NURSE'S SIGNATURE | INITIALS

[redacted] 21580

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

DATE: 10 OCT 03 0330

TIME IN:

PROCEDURE: Ex-lap

PRE-OP VS: 110/50 95

TYPE ANESTHESIA: GEN SAB EPIDURI NERVE BLOCK IV SED.

OR INTAKE: Crystalloid: 3000 Colloid 300

OR OUTPUT: Urine Output 400 EBL 200

INTAKE						OUTPUT			
TIME	SOLUTION	Amt Hung	SITE	BY	Amt. Infused	TIME	SOURCE	COLOR	AMT
ADM.	[redacted]	250	(R) LA	[redacted]		0413	Foley	Amber	450
0320		250	(R) UA						
0350									
0350	LR								

① PRBC

② PRBC

X-RAYS DONE:

LABS DRAWN:

TIME	0345	0350	0355	0410	0420
FO_2	40	40	40	40	40
O_2 SAT	100	100	100	100	100
TEMP					
RESP	10	10	10	10	14
LOS	Unk	Unk	Unk	Unk	RAM

BP by Cuff V Heart Rate ^

240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 0

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	Ø		
(E)nergy	0 Does not move legs 1 Moves legs, cannot sustain head lift 2 Sustains head lift, moves legs	Ø		
(A)rtiness	0 Awakens only with vigorous stimulation 1 Awakes only when stimulated gently 2 Awake, seldom dozes	Ø		
(C)irculation Adults	0 BP 20% pre-anesthesia level 1 BP 20-50% pre-anesthesia level 2 BP 50% pre-anesthesia level	2		
Infants	0 Carotid only reliable pulse palpable 1 Axillary pulse felt faint but not wrist 2 Pulse can be felt easily at wrist			
(T)emperature	0 Axillary temp. <95 F 1 Temp. 95-98 F 2 Temp. >98 F	2		
		4		

* 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)

Iraq.

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

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

INITIAL ASSESSMENT:

LEVEL OF CONSCIOUSNESS: Vent
- Alert
- Responsive
- Unresponsive

AIRWAY:
- Nasal
- Oral
- Endotracheal
- Tracheostomy

b(6)-2

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

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

SIGNATURE:

MEDICATIONS

ALLERGIES:

Time	Medication/AMT.	Route/Site	BY
0355	Valium 5mg	IVP	[redacted]
0410	Valium 5mg	IVP	[redacted]

NURSES NOTES: 0340 Pt to PACU S/P Ex-lap monitors attached, vent attached Rate 10 TV 800 FIO2 40% PEEP 5, 1st PRBC ĉ during OR. 2nd start 0350 0410 ABG drawn SR 90's Foley drainage clear pale yellow (R)T thigh lateral ĉ drainage bld reinforced dsg

DRESSINGS

	SITE	TYPE	DRAINAGE

1-START GS+

Pt: [redacted]

Pt Name:_____

0400

TCO2_____22 mmol/L

Art ST

pH_____7.382

PCO2_____35.3 mmHg

PO2_____*** mmHg

HCO3_____21 mmol/L

BEecf_____-4 mmol/L

SO2*_____*** %

*calculated

Sample Type_: ART

Oper

CBI INFORMATION

TIME	CBI IN	URINE OUT	COLOR	URINE BAL

PACU FLUID TOTALS

CRYSTALLOID IN		URINE OUTPUT	
COLLOID IN		EMESIS	
P.O		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:

1150 Hrs

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: 11 Oct
Time In: 1150 hrs
Allergies: NKA
Pre-op V/S: 140 HR
Procedures: Laminectomy / Fusion / Decompression / Laminectomy
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid 100 mcg
OR Output: UOP 400 EBL 75
Meds/Times: Versed 10

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1150	1200	1210	1220	1230	1240	1250	1300	1310	1320	1330	1340	1350	1400
SaO2	97	98	98	98	98	98	98	98	97	97				
FiO2	100%													
Methods	Patient													
240														
220														
200														
180														
160														
140														
120														
100														
80														
60														
40														
20														
RR	16	16	16	16	16									
T	97		97.8											
Time														
Pain (0-10)														
LOS														

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1150	LR	1000	Blankets		

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		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	Vent		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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.	6		

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, * = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

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] PA
DEPARTMENT/SERVICE/CLINIC: ICU-3
DATE: 11 Oct 03

PATIENT'S IDENTIFICATION (Name — last, first, middle; grade; date; hospital or medical facility)
b(6)-2
[redacted] b(6)-4

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

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

b(6)-2

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

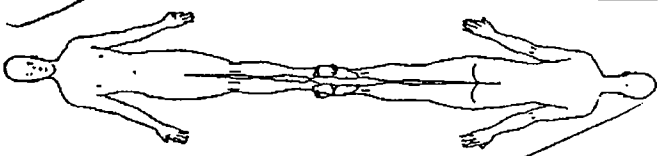
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

See TCW 3 Surgical for assessment [redacted]

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

b(6)-2

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0600	INITIALS [redacted]	INITIALS	1900	INITIALS [redacted]
	PUPILS	pupils 2mm RTL			2mm sluggish	
	SENSORIUM	alert semi-arousable follows commands TRACH. orally intubated T-tube			A/O; FC; verbalizes ≥ interpreter; MAE	
RESPIRATORY	RESPIRATORY PATTERN	EH pattern @			LCTA (B)↑; ↓ to	
	BREATH SOUNDS	25+26 cm @ rate			bases (B); SaO2 96%	
	SECRETIONS	non productive cough, see track, @ stock box, suctioned			RR 30's; recently	
					Extubated; Ø ↑ WOB	
SKIN	COLOR	Ø cyanosis, pallor			NFR;	
	INTEGRITY	intact. Skin warm appropriate color			multiple surgical	
					wounds.	
IV SITE	LOCATION	R/L (R) scalp			RSC	(L)SC
	CONDITION	in use, (R) clots in use, clots site intact on IV, IV site seal, tunnel in place			Cndio	TLC
					COT	COT
GASTRO	ABDOMEN	(R) side flat distended			flat; large dressing	
	BOWEL SOUNDS	hyper, (R) lat ↑ colostomy, stoma pink & pouched			over NG; minimal	
					drainage early colostomy	
					soft, NGT LIS	
GU	URINE:	drainage in bag			PTG	
	COLOR/CLARITY	(R) SPT (R) side			clear, yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]			ST Ø ectopy;	
		[illegible]			pulses 2+ to all	
		[illegible]			extremities.	
		[illegible]				
		[illegible]				

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

(Continue on reverse)

PREPARED [redacted] RN | DEPARTMENT/SERVICE/CLINIC ICU-B | DATE 11 OCT 03

PATIENT'S IDENTIF[redacted] entries give: Name—last, first, middle; grade; [redacted] facility)

b(6)-2

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

b(6)-4

[redacted] b(6)-2

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	79	91/65	85/49	96/52	95/51	105/54	99	120									
BP Cuff	76/50	84/53	85/51	85/48	83/53	102/52	50	49		103/60	122/44	136/48		116/66	112/54	112/50	115/42
Temperature							99					100/54	100	97.6			
Pulse	122	120	116	117	114	125	115	110		110	112	111		99	97	98	107
Respiratory Rate	16	16	16	16	16	16	16	16		16	16	16		16	16	16	16
O2 Sat-s	100	100	100	100	100	100	100	100		100	100	100		100	97	98	99
~~MAP~~ FIO2	40	40	40	40	40	40	40	40		40	40	40		40	40	40	40
CVP	18	16	15	17	14	15	14	14		16	15	15		16	16	16	14
MAP	59	66	61	68	67	72	69	74		75	72	73		81	78	75	72

Surgery

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T									8° T
LR	250	250	250	250	250	250	250	250	1500	250	250	250	250	250	250	250		
Dopamine	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	544	6.8	6.8	6.8	6.8	6.8	6.8	6.8	350	2000
Fentanyl	5.0	5.0	5.0	5.0	5.0	5.0	10.0	10	50	10	10	10	10	10	10	10		
Levophed	3.8	3.8	3.8	3.8	3.8	3.8	off	off	138		30	30	40	50	60	70	101	80
IVPB	100						100	10	200									
PRBC	300								300				300	300				
LR 0.15 mg KCL													300 cc blood	300 cc blood				600
																	150	150
TOTALS									3467									3830

OUTPUT

		HOUR / TOTAL																	
URINE			80	100/180	115/295	110/405	42/447	42/489	110/599	130/729	1019	110/110	120/190	40/230		100/100	130/130	110/240	60/300	1310
	Sp gr																		
	S/A																		
NG	OUTPUT								50		50								
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS										1069									1310

~~1400~~ ~~66.8~~ ~~73.8~~ ~~54.4~~ ~~73.8~~

2467

[redacted] b(6)-2

POST-OP DAY

VITALS	16	17	18	19	20	21	22	23
	118/48	108/46	138/53	119/61	131/64	125/60	116/60	134/64
	100/51	102/65	108/60	105/55	106/55			
				101.3	100.9	104/56	100.4	
	110	110	133	129	131	119	117	121
	16	16	32	34	37	35	32	34
	99	100	99	96%	98	99	97	95%
	40%	40	40%	FM	FM	FM	FM	FM
	16	16	11	10	10	40%	40%	40
	72	72	83		40%	40%	10	10

b(6)-2

INTAKE									
	125	150	[redacted]						8° T
	150	150	150	150	150	150	150	150	1750
	10	10	5	5	5	5	3	3	46
				[redacted] b(6)-2					
	100			500					600

OUTPUT									
	80	100	50	80	55	60	45	32	502
		110	200	310	365	425	470	502	
	100								100
									602

2447
2530
2396

1310
1069
492

ACUITY LEVEL CLASSIFICATION

RESPIRATORY												
	TIME		06		1910							
	MODE		SIMV		SM							
	F_IO_2		40%		40%							
	TV		650									
	RATE		16		32							
	PEEP		5									
ARTERIAL BLOOD GAS	A	pH			7.38							
		PCO_2			49.9							
		pO_2			91							
	B	HCO_3			29							
		SAT			96%							
	G	BASE			5							

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	7698	TOTAL	3081

BALANCE _____

NURSE'S SIGNATURE [redacted] INITIALS

b(6)-2

b(6)-2

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	06 00	INITIALS [redacted]	1900	INITIALS [redacted]		INITIALS
NEURO	PUPILS	[illegible]		Perrl 3mm, brisk [illegible]			
	SENSORIUM	[illegible]		Able to move all extremities.			
		[illegible]		Sensation intact.			
		[illegible]		gag reflex			
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		3L NC sats >94%.			
	BREATH SOUNDS	[illegible]		Regular, even,			
	SECRETIONS	[illegible]		unlabored. CTA all			
		[illegible]		lung fields.			
		[illegible]		Lbs sec. Ø cough.			
SKIN	COLOR	[illegible]		WNL, NFR, ML Abd dressing			
	INTEGRITY	[illegible]		Post op retention sutures.			
		[illegible]		(P) thigh (D) buttock dressing			
IV SITE	LOCATION	[illegible]		Cordis to (P) subclavian			
	CONDITION	[illegible]		infusing Fentanyl drip			
		[illegible]		(D) subclavian TLC infusing			
		[illegible]		(P) 5% mea KCl & CVP proxd			
		[illegible]		to distal. (P) radial A-line			
		[illegible]		proxd correlating.			
GASTRO	ABDOMEN	[illegible]		Soft, tender all quadrants			
	BOWEL SOUNDS	[illegible]		(P) medial colostomy, NOT to			
		[illegible]		LWS (D) Drains. Green drainage			
		[illegible]		Absent BS.			
GU	URINE:	[illegible]		Foley to DD Clear			
	COLOR/CLARITY	[illegible]		yellow urine.			
		[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		ST ectopy, S1S2 110-120's.			
		[illegible]		Radial/Pedal pulses			
		[illegible]		Cap refill < 3sec.			
		[illegible]		Tachycardia			
		[illegible]					

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

b(6)-2

(Continue on reverse)

PREPARED BY (Signature [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU-3

DATE: 12 Oct 03

PATIENT'S IDENTIFICATION [redacted] last, first, middle; grade; date; [redacted] or medical facility)

[redacted] b(6)-4

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

b(6)-4

[redacted]

DATE 12 Oct | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	125/61	131/62	122/66	133/69	115/65	123/60	135/69	123/60		124/60	122/60	120/60	116/57	129/59	123/67	140/67	132/60	
BP Cuff	112/54	110/60	108/56	107/55	111/52	110/57	111/60	108/56		108/51	108/50	107/50	105/50	105/54	100/58	104/55	109/51	
Temperature			100.5				100.0							102.4				
Pulse	117	117	121	132	122	123	119	121		124	125	125	124	122	119	115	112	
Respiratory Rate	34	30	32	30	35	31	34	34		34	33	34	34	34	31	33	30	
SaO2	94	99	93	92	97	98	98	99		99	99	99	99	99	97	97	96	
Mode	FM	FM		FM	3L	3L	3L	3L		3L	3L	3L	3L	3L	31	30	30	
FIO2	40%	40%		40%	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
CVP		9	10	10	9	8	8	10		10	9	9	10	9	8	8	8	

INTAKE																		
TIME									8° T									8° T
LR+15Kcal	150	150	150	150	150	150	150	150	120	150	150	150	150	150	150	150	150	120
Fent	5	5	5	5	5	5	5	5	20	5	5	5	5	5	5	5	5	20
IVPB	100								100					100				100
TOTALS									1340									1340

OUTPUT																			
URINE	HOUR	180	80	80	90	65	30	30	100	90	110	150	150	200	150	110	70		
	TOTAL	180	265	335	425	490	520	550	650	750	860	1010	1160	1360	1510	1620	1690		1150
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH															50			50
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS									750										1200

POST-OP DAY

	16	17	18	19	20	21	22	23	
VITAL SIGNS			113/78	113/60	119/62	113/58	133/65	123/61	
			103/57			103/49	111/57	105/59	
							99.4		
			115	107	112	105	106	95	
			22	17	26	17	16	17	
			97	97	97	98	98	97	
			3L	3L	3L	3L	3L	3L	
			NC	NC	NC	NC	NC	NC	
			11	12	10	8	10	12	
INTAKE			18	19	20	21	22	23	8° T
				150	150	150	150	150	750
				6.0	6.0	6.0	6.0	6.0	30
					100				100
									880
OUTPUT				110/110	95/205	105/310	46/356	48/404	404
									404

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	3560	Urine:	2304
po		NGT	50
TOTAL	3560	TOTAL	2354

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted] AN [redacted]

b(6)-2

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS	[illegible]		Pearl 3mm			
	SENSORIUM	[illegible]		can move all extremities			
		[illegible]					
		[illegible]					
		[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		Reg even			
	BREATH SOUNDS	[illegible]		CTA-B/L Diminished Bases			
	SECRETIONS	[illegible]		O2 @ 24 lm via NC			
		[illegible]		O2 SAT 100%			
		[illegible]					
		[illegible]					
SKIN	COLOR	[illegible]		WNL			
	INTEGRITY	[illegible]		Drsgs to wounds on Abd			
		[illegible]		line and buttocks. T 70/6			
IV SITE	LOCATION	[illegible]		(R) subclavian line			
	CONDITION	[illegible]		NS pump infusing fent			
		[illegible]		100cc/hr (R) subclavian infusing			
		[illegible]		LRC 15ml/hr K+ @ 150ml/hr			
		[illegible]		A-line zeroed and correlating			
GASTRO	ABDOMEN	[illegible]		ABd soft Tender to			
	BOWEL SOUNDS	[illegible]		touch BS hypoactive			
		[illegible]		mid-line abd dressing clean			
		[illegible]		intact			
GU	URINE:	[illegible]		foley to gravity			
	COLOR/CLARITY	[illegible]		clear yellow urine			
		[illegible]		colon ostomy bag intact			
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		stoma pink &			
		[illegible]		BM @ present			
		[illegible]		NSR			
		[illegible]					
		[illegible]					

LEGEND

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

b(6)-2

(Continue on reverse)

PREPARED [redacted] RN

DEPARTMENT/SERVICE/CLINIC ICU-3

DATE 13 Oct 00

PATIENT'S [redacted] (When entries give: Name—last, first, middle; [redacted]le; hospital or medical facility)

[redacted]

BPW # [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 13 OCT 03 DX GSW to buttocks

HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
	BP Arterial Line	125/57	140/64	153/70	142/64	151/67	117/69	151/73	118/84								
	BP Cuff	101/61	112/63	110/69	112/68	115/62	118/62	115/72									
	Temperature			100.4 (A)				101.3 (A)	103					104			
	Pulse	91	93	106	115	99	125	100	101					98			
	Respiratory Rate	20	22	22	25	21	40	25	24					102	101	101	100
	Sats	98	92	92	96	97	83/91	96	97					21	15	14	14
	Mode	NC	NC	NC	NC	NC	NC	NC	NC					96	97	99	99
	FiO2	3L	2L	2L	3L	3L	3L	3L	3L					NC			
	CVP	14	14	15	12	12	10	12	14					4L		3L	3L
														16	10	14	14

INTAKE	TIME	24	01	02	03	04	05	06	07	8° T									8° T
	LR	150	150	150	150	150	150	150	150	120	150	150	150	150	150	150	150	150	120
	Fentanyl	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	48	6	6	6	6	6	6	6	6	48
	IVPB		100	100				100		200					100				100
	TOTALS									1448									1348

OUTPUT		HOUR / TOTAL	130	150 / 280	200 / 480	230 / 710	250 / 960	230 / 1190	170 / 1360	180 / 1540	1448 / 1540	110	90 / 210	120 / 330	200 / 530	50 / 580	200 / 780	90 / 870	80 / 950	90 / 1040
	URINE	sp gr																		
		S/A																		
	NG	OUTPUT							550		550								100	100
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS									2040									1040

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	110/65	109/72	102/70	122/70	109/62			
				119/57	112/50	117/57	119/62	117/62
	100			101.6		100.6	100.5	
	106	108	110	107	105	105	101	86
	20	19	15	13	14	20	17	18
	99	100	100	100	102	94	94	100
	2L	2L	2L	2L	2L/m	2L/m	2L/m	2L/m

INTAKE									8°T
	150	150	150	150	150	150	150	150	1200
			100						

OUTPUT									
	90	120/210	200/410	120/580	140/70	120/840	130/970	160/1130	1130

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE										
	F_iO_2										
	TV										
	RATE										
	PEEP										
ARTERIAL BLOOD GAS	A: pH										
	A: PCO_2										
	A: pO_2										
	B: HCO_3										
	SAT										
	G: BASE										

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

ACTIVITIES OF DAILY LIVING	TIME	2100									
	MOUTH CARE										
	BATH	[redacted]									
	SKIN CARE	[redacted]									
	FOLEY CARE	[redacted]									
	TRACH CARE										
	ROM EXERCISES										
	Linen △	[redacted]									

TURN / SUCTION	TIME										
TURN											
SUCTION											

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted] MN	[redacted]
[redacted] 9/020	

b(6)-2

b(6)-2

14OCT03

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL/SHIFT ASSESSMENT

	TIME	0718	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Perrla		Perrla 3 mm			
	SENSORIUM	A+O x 3		Alert x 3			
		purposeful movement		moves all extremities			
		x4 ext		x4			
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		Resp even			
	BREATH SOUNDS	CTA - B		CTA - B, L Dim Bases			
	SECRETIONS	Ø		Ø			
SKIN	COLOR	NPR		WNL for Race			
	INTEGRITY	multiple wounds					
IV SITE	LOCATION	R SC		(D) subclavian Triplelumen			
	CONDITION	L SC Triple Lumen		Patent @ S/S infiltration			
		c/d/i		or infection			
GASTRO	ABDOMEN	large midline incision		large mid-line incision			
	BOWEL SOUNDS	colostomy		colostomy - BS (+)			
				hypoactive			
GU	URINE:	clear yellow		clear yellow			
	COLOR/CLARITY	Foley to gravity		Foley to gravity			
CARDIOVASCULAR	CARDIAC RHYTHM	S, S2		S, S2 NSR			
		NSR		Radial pulses +2			
		+2 pulses		Pedal +2			
		<3sec cap refill		<3 sec cap refill			

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

(Continue on reverse)

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

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

[redacted] b(6)-4

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
BP Arterial Line																		
BP Cuff	113/68	115/63	109/61	114/67	123/72	119/68	107/59	118/64		108/61	114/72							
Temperature	99			99	101.5						99.7				102.0			
Pulse	86	89	97	88	106	102	105	90		92	92							
Respiratory Rate	10	15	13	20	22	20	17	12		16	15							
SpO2	100	100	100	95	96	96	97	97		99	98							
~~LR 15 mg K+~~	150	150	2L/m	2L/m	2L/m	2L/m	2L NC	2L NC		2L NC	2L NC							
IVP	100																	

INTAKE

TIME									8°T	08	09	10	11	12	13	14	15	8°T
LR 15 mg K+	150	150	150	150	150	150	150	150		150	150	100	100	100				
IVP	100																	
Fent							6 mcg	6 mcg		6 mcg	6 mcg	D C'd						
TOTALS																		

OUTPUT

	HOUR / TOTAL	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
URINE		95	200/295	120/415	150/565	100/665	130/795	125	130/925		200/125	110/245	180/345	200/545	200/745	180/925	200/1125	200/1325
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	24
	107/69	112/63		112/63			114/66		
	101.7	105		101.5	101°			100°	
	93	96		96			112		
	25	28		26			27		
	100	100		100			96		
	2LNC	2L/m NC		2L/m NC			2L/m		

INTAKE	16	17	18	19	20	21	22	23	8°T
	100	100	100	100	100	100	100	100	800

OUTPUT									
	200/125	600/125	100/25	100/25	200/25	500/10	80/25	120/27	

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN / SUCTION	TIME										
TURN											
SUCTION											

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 15 OCT 03
Time In: 1625
Allergies: NKDA
Pre-op V/S:
Procedures: W PROLOPT RECTAL ANA

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 50 EBL
Meds/Times: Fentanyl ; Versed

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

Pre Op Meds History

Time	1605	1625	1635	1645
SaO2	98	96	98	97
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				
100	•	•	•	•
80				
60	^	^	^	^
40				
20				
RR	22	19	20	14
T	97			

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
1625	LR	700	TL	OR	800

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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		

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

PROC[redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 OCT 03

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

b(6)-2

EPW

#[redacted] b(6)-4

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

b(6)-2 [redacted]

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

NURSING NOTES

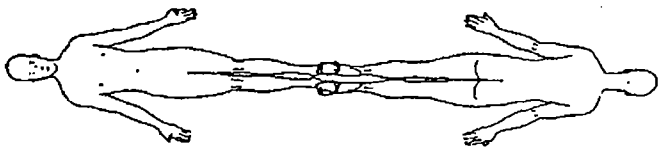
Transferred to PACU

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	Abd	Abd pads	∅
30'	Bilateral	Abd pad	min
60'	Bilateral	Drain to suction	
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
11:25	SR	∅	0

WAMC OP 173-E

Discharge Criteria:
Date: Time: PARS:
BP: 112/61 T: 97 HR: 104 RR: 25 Sa02: 96 RA
Pain Level at D/C (0-10):
Intake: _____ Output: _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

15OCT03

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS	1930	INITIALS		INITIALS
NEURO	PUPILS	PERRLA @ 3mm	[redacted]	PERLA RCISK	[redacted]		
	SENSORIUM	Alert & Oriented		940 Proper motion Limited due to PAIN			
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored		even unlabored			
	BREATH SOUNDS	BBS CTA		upper lobes sem Lungs Rhales lower CTA			
	SECRETIONS	Ø Secretions		Ø secretions			
SKIN	COLOR	Normal for race		WFR			
	INTEGRITY	Multiple wounds to buttocks		(R) Thigh (L) buttocks Dressing Ø to (R) Thigh			
CVS SITE	LOCATION	Triple lumen		TRIPLE lumen			
	CONDITION	to (L) subclavian Dsts of redness Dr. Dwelling		TOQ Subclavian brown Port Patent white Port Patent blue non-patent site CDI free S/S of infect			
GASTRO	ABDOMEN	Midline Abd		EXLAP wound			
	BOWEL SOUNDS	wounds, colostomy		wounds colostomy			
GU	URINE:	Foley to gravity		Ftn			
	COLOR/CLARITY	draining yellow urine		clear yellow urine in adequate amount			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 & S2 noted BUN, ESR		S1 S2 Sinus Tach CAP refill Rcisk Radial Pulses Present +2 Pedal Pulses Present +2 Skin is warm			

LEGEND

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

(Continue on reverse)

[redacted] (Title) RN

DEPARTMENT/SERVICE/CLINIC ICU #3

DATE 15 OCT 03

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

b(6)-2

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 15 oct 03 | DX | HOSPITAL DAY

VITAL SIGNS																			
TIME	24	01	02	03	04	05	06	07	08	08	09	10	11	12	13	14	15		
BP Arterial Line		100	102	110	112														
BP Cuff		57	55	57	59	110	112/56	112/59		100/50	115/61	113/62	109/62	106/62	105/60	104/60		D	
Temperature		99.2				102.5	102.3	102.9		102	102.2	101.2	101.9	101.4	101.6	100.9			
Pulse	100	96	99	96	102	107	114	111		110	106	101	110	99	94	94		R	
Respiratory Rate	29	25	20	16	18	15	23	15		22	22	26	26	19	23	23			
SPO2	97	97	98	97	93	96	96	93		94	97	95	96	95	97	98			

INTAKE																			
TIME									8° T										8° T
D5½NS c 20	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	D	700	
K+																			
IVP	50						50		100								R		
TOTALS									900									700	

OUTPUT																			
URINE HOUR			100	90	70	140	130	170	120		130	70	200	130	100	50	80	D	
URINE TOTAL							530	700	821	821	130	200	400	530	630	700	780		780
URINE sp gr																		R	1600
URINE S/A																			
NG OUTPUT																			
NG pH																			
NG GUIAC																			
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	116/61	107/57	94/52	89/49	95/51	96/47	95/49	94/52	
	97	99	99	9	98.2				
	108	101	102	92	88	88	87	90	
	23	21	22	21	22	20	17	21	
	96	96	97	96	95	97	98	99	
INTAKE									8° T
	100	100	100	100	100	100	100	100	800
				50					50
OUTPUT	100/100	40/40	60/30	110/40	122/42	209/82	200/82	170/52	850
									102
								200	200

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN	TIME										
SUCTION											

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	2450	Urine:	2652
po		Drain	200
TOTAL	2450	TOTAL	2852

BALANCE -402

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

b(6)-2

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0645	INITIALS [redacted]	1900	INITIALS [redacted]		INITIALS
NEURO	PUPILS	3mm PERRL brisk		Perrl, 3mm, brisk.			
	SENSORIUM	Alert & follows		Moves all extremities			
		simple command		Obeys simple commands			
		none ~~SPO~~ English		Little English. Sensory			
		speaker		intact			
RESPIRATORY	RESPIRATORY PATTERN	No respiratory distress		Regular, Even, unlabored.			
	BREATH SOUNDS	unlabored. Lung		RA & sats ≥ 98%. CTA			
	SECRETIONS	sounds clear &		all lungs skin bases.			
		diminish in bases		Ø cough ~~ett tube~~			
		bilaterally. Ø secre-					
		tions.					
SKIN	COLOR	NPR. wounds to		NPR. ML incision to abd.			
	INTEGRITY	R leg (upper) R side		Bilateral thigh, buttocks			
		both dressing A'd.		vacuum.			
IV SITE	LOCATION	TLC (R) Sub Clav.		(R) subclavian, TLC, all			
	CONDITION	CDI. Patent. D5½		Ports flush. Infusing			
		NS & 40mEq KCl		D5½NS & 40 KCl @100cc/hr.			
		@ 100cc/hr.					
GASTRO	ABDOMEN	Tender to touch flat		Tender all quadrants.			
	BOWEL SOUNDS	Abd wound A'd		Hyperactive BS x4. Colostomy			
		3rd Colostomy		(R) medial abd. bag, draining			
		bag. BS(+) x4.		healthy. Minimal sero drainage.			
GU	URINE:	Foley to gravity		Both off to (R) nares. Infusing			
	COLOR/CLARITY	Clear amber.		Pentive @ 60cc/hr. Foley			
				to DP. Clear yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	S, S2 Ø ectopy		SR ectopy S, S2. Radial			
		NSR to Stach.		pulses 3+, Pedal pulses 2+.			
		+2 peripheral pulses		Capr fill < 3 sec. Warm			
		x4, Cap refill < 3sec		extremities, (R) foot 2+			
				edema.			

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

(Continue on reverse)

PRE[redacted]D BY [redacted] (Title)

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 1600 TO

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

[redacted]

b(6)-4 b(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	2400	0100	0200	0300	0400	0500	0600	0700	X	0800	0900	1000	1100	1200	1300	1400	1500	X
BP Arterial Line																		
BP Cuff	99/51	101/57	105/52	103/51	112/54	106/51	104/51	114/58		99/51	101/52	100/48	109/46	104/52	102/49	104/46	108/51	
Temperature	100	100.4				101.8	101.4				100.6					101.3		
Pulse	92	96	101	102	102	106	101	90		80	90	88	94	102	102	103	97	
Respiratory Rate	16	20	18	19	20	23	21	15		21	21	17	17	25	24	26	23	
PULSE OX.	97	99	99	96	96	97	95	98		98	97	97	99	99	100	98	98	
	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

TIME									8° T									8° T
IV F	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
IVPB	50						50		100					50				50
TF												20	20	20	20	40	40	160
TOTALS									900									1010

OUTPUT

URINE	HOUR	140	220	150	210	160	220	158	210		80	260	150	175	200	130	90	180	
	TOTAL	140	360	510	720	880	1100	1258	1468	1478		340	490	665	865	995	1085	1270	1270
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Wound vac						75		75										
TOTALS									1553									1270	

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	103/50	102/48	104/49		105/51		102/49	102/52
	100.2				100.7		101.1	
	100	100	91		94		96	94
	25	27	23		23		20	20
	97	97	100		97		98	100
	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE									
									8° T
I	100	100	100	100	100	100	100	100	800
			50						50
N	40	40	60	60	60	60	60	60	440
									1290

OUTPUT									
	300	200/50	120/600	200/62°	254/107°	200/127°	170/140°	190/168	1630
P	425								425
U									
T									2055

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

TURN	TIME				
SUCTION					

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2600	Urine:	4378
TF	600	NGT	500
TOTAL	3200	TOTAL	4878

BALANCE −1678

NURSE'S SIGNATURE	INITIALS
[redacted] TAN	[redacted]
(b6)-2	

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS	3mm PERRL brisk		PERRL 3 mm			
	SENSORIUM	Alert follows simple		Alert-x3 follows			
		commands. moves		simple verbal commands			
		all extremities.		able to move all extrem			
RESPIRATORY	RESPIRATORY PATTERN	unlabored no respir		even reg			
	BREATH SOUNDS	hoy dyspnea sounds		CTA B/L - Diminishd			
	SECRETIONS	Clear w Bases bilat.		@ bases			
		Healy.					
SKIN	COLOR	NFR.		NFR			
	INTEGRITY	wounds to (R) thigh		wounds to Abdmid-line			
		(R) buttocks.		(R) thigh (L) buttock			
IV SITE	LOCATION	TLC (L) Sub clav.		(L) sub clav patent all			
	CONDITION	C.D.I. Patent Ds 1/20		ports flush easily			
		NS c 40 mEq KCl @		D5½ NS c 40 meq KCl			
		125cc/hr		@ 40 cc/hr			
GASTRO	ABDOMEN	Tender, bad wound		tender - BS (+) x 4 quad			
	BOWEL SOUNDS	CDT Colostomy		colostomy stoma pink			
		LUQ hyperactive		small amts of stool			
		BS x 4					
GU	URINE:	Foley to gravity		foley to gravity			
	COLOR/CLARITY	Clear amber		clear yellow urine			
		urine w/sediment.					
CARDIOVASCULAR	CARDIAC RHYTHM			NSR S_1 S_2			

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | DATE 17 Oct 89

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

EPA [redacted] b(6)-4

DATE 17 Oct 03 | DX | PAGE 2 OF | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	100/53	105/52	108/58	105/50	106/50	107/53	104/52	102/54		110/58	107/57	108/56	106/53	109/49	111/58	100/55	104/51	
Temperature	101°		100°	1	101.7 (A)	101.7 (A)	101.° (A)			100.5								
Pulse	104	101	102	103	104	109	99	97		95	96	100	105	104	97	91	89	
Respiratory Rate	26	25	23	19	20	28	20	23		17	17	12	20	23	23	20	19	
SPO2	98	97%	97	96	96	95	98	97		97	98	98	98	97	98	98	97	
Mode	RA	RA	RA	RA	RA	RA	RA	RA		RA	M	M	RA	RA	RA	RA	RA	

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	100	100	100	100	100	100	100	40		125	125	125	125	125	125	125	125	
IVPB	50						50							50				
TF	60	60	60	60	60	60	60	80		OFF	OFF	OFF						
TOTALS																		

OUTPUT																		
URINE HOUR	180	150	170	200	140	130	70	290		185	100	190	190	200	360	20	400	
URINE TOTAL		330	500	700	840	970	1040	1246			565							
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH							Ø											
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS	N																	
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	106/54	104/48	104/49	109/53	110/51	107/51	107/49	105/53
	100.5	98.7		100.0				
	97	83	89	93	99	101	102	105
	18	16	21	19	21	19	20	20
	100	100	98	99	99	98	98	98
	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE									8° T
	125	125	125	125	125	125	125	125	
	60								

OUTPUT									
	180	98 / 160 / 278	160 / 138	140 / 58	150 / 128	100 / 88	100 / 98	200 / 125	

ACUITY LEVEL CLASSIFICATION

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

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

DAILY ACTIVITIES OF LIVING										
	TIME									
	MOUTH CARE									
	BATH	[redacted]								
	SKIN CARE	0430 [redacted]								
	FOLEY CARE	[redacted]								
	TRACH CARE	[redacted]								
	ROM EXERCISES									

TURN	TIME				
SUCTION					

24°I&O TOTALS	
wt Yesterday	wt Today
INTAKE	OUTPUT
IV	Urine:
po	
TOTAL	TOTAL
BALANCE	

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

18OCT03 b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	INITIALS	1815	INITIALS [redacted]
NEURO	PUPILS	PUPILS [illegible]			PERRL (R)	
	SENSORIUM	OR [illegible]			A&O, pt moves UE well,	
		FOLLOWS COMMANDS			LE's slowly	
		& GRAS FOR				
		PRECAUTIONS				
RESPIRATORY	RESPIRATORY PATTERN	RR CNW & UNL			Reg, even & unlabored	
	BREATH SOUNDS	MOVED. L/S (B)			CTA (B)	
	SECRETIONS	COARSE. Ø SECRETIONS			Ø	
		COUGHS PRODUCE				
		CONSIDERABLY ON				
		RIGHT				
SKIN	COLOR	SKIN PINK (R)			NFR	
	INTEGRITY	TEMP. ROM. FULL			Drsg midline abd (R) thigh	
		NO [illegible]			CDI, (R) buttock to vac.	
IV SITE	LOCATION	(R) SCALP &			(R) SC triple lumen	
	CONDITION	SILVER STUD,			patent & s/s of infx infusing	
		well dressed			D5½ & 40 mEq of KCL	
		& site dry				
GASTRO	ABDOMEN	FLAT soft, tender			Flat, soft & tender	
	BOWEL SOUNDS	& dry, [illegible]			(A) in 4 quads, colostomy	
		[illegible]			stoma pink, small amount of	
		& [illegible]			stool	
GU	URINE:	urine, stoma			Foley to gravity	
	COLOR/CLARITY	pink. FCO			yellow/clear	
		BSD intact				
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]			ST & S1, S2 noted & Ø added	
		noted [illegible]			(B) peripheral pulses &	
		90-100's Ø			cap refill <3 sec.	
		ECG [illegible]				
		noted				

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

(Continue on reverse)

PREPARED BY (Signature & [redacted] RN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 18OCT03

PATIENT'S IDENTIFICATION (For [redacted] name—last, first, middle; grade; date; hospital [redacted] EPW b(6)-4 b(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 18 OCT 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
BP Arterial Line																	
BP Cuff	104/51	104/48	102/52	102/52	102/62	104/54	102/56	118/80		116/56	106/65	106/60	96/50	112/56	110/51	104/49	100/44
Temperature	101.5	102		100.9		100.4	101	99			99		99.8			100.6	
Pulse	107	110	110	102	107	98	97	106	104	101	100	98	97	99	94	95	99
Respiratory Rate	21	15	23	19	21	28	27	22	26	22	26	25	24	26	22	27	19
SpO2	96	97	97	98	98	98	98	94	95	98	98	99	97	98	98	99	98

INTAKE

TIME									8° T								8° T
D5½NS@	40	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	320
40 mEq KCL							50						50				
IVP	50																
IV	80	80	80	80	80	80	80	80	160	80	80	80	80	80	80	80	80
TOTALS									480								860

OUTPUT

URINE HOUR	140	150	90	125	80	90	210	120		100	170	200	120	90	80	100	120
URINE TOTAL		290	380	505	585	675	885	1015	1015		1185	1385	1505	1595	1675	1775	1895
URINE sp gr																	
URINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS (Chip)						850											
TOTALS									1015								1095

18OCT03

POST-OP DAY

VITAL SIGNS	17	18	19	20	21	22	23		
	115	106							
	50	54	109/53	110/53	~~110~~				
	100	104	~~101~~ 97.2						
	94	94	~~92~~ 98						
	98	98	~~20~~ 22						
	98	10	98%	98%					

INTAKE	17	18	19	20	21	22	23		8° T
	40	40	40	40	40	40	40		960
		50							2080
	80	80	80	80	80	80	80		1920

OUTPUT									
	90	100/400	110/300	90/390	100/490	70/560	70/630		2675
	200 [redacted] b(6)-2								

ACUITY LEVEL CLASSIFICATION

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

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

b(6)-2

ACTIVITIES OF DAILY LIVING	TIME	08/1200	1600							
	MOUTH CARE	[redacted]								
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									
	[redacted]									

TURN / SUCTION	TIME									

24° I&O T[redacted]	NURSE'S SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____	SG T[redacted]	[redacted]
INTAKE: IV 1160; po ____; TF 1920; TOTAL 3080	OUTPUT: Urine: 2675; Qhip 200; TOTAL 2875	b(6)-4
BALANCE _____		

b(6)-2

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INTILAS	INTILAS	1815	INTILAS
NEURO	PUPLIS	[illegible]			PERRL (R)	
	SENSORIUM	Commands			A&O, moves UEs well, weak	
		Sedation			movement LEs	
		& [illegible]				
		present				
RESPIRATORY	RESPIRATION PATTERN	Regular, un-			Reg, even & unlabored	
	BREATH SOUNDS	labored, Ø			CTA (R)	
	SECRETIONS	diecrease/50%			Ø	
		noted. [illegible]				
		[illegible]				
		on RA & SAT				
SKIN	COLOR	97%-98%			WFR	
	INTEGRITY	Skin warm, [illegible]			Deg midline abd & (R) thigh CDI	
		[illegible]			(L) buttock & wound vac & ioban	
IV SITE	LOCATION	Left [illegible]			(L) SC triple lumen	
	CONDITION	(L) [illegible]				
		site [illegible] redness				
		noted (L) [illegible]				
		[illegible]				
		[illegible]				
GASTRO	ABDOMEN	ND (R) soft, tender			Flat, soft, tender to touch	
	BOWEL SOUNDS	[illegible] mild			(R) in all 4 quads	
		[illegible]			No epigastric pain	
		[illegible]				
GU	URINE	[illegible]			Foley to gravity	
	COLOR/CLARITY	[illegible]			yellow & sediment	
		[illegible]				
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]			ST & Si, Se noted, (R) ectopy	
		noted. [illegible]				
		[illegible]				
		[illegible]				

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

(Continue on reverse)

PREPARED BY [redacted] | DEPARTMENT/SERVICE/CINC ICU #3 | DATE 19 Oct 03

PA[redacted] written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

b(6)-2

#[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	104/53				107/51			111/57		110/56		107/52		107/54	107/52		105/50	
Temperature	99.5				100.2			100.4										
Pulse	97				99			105		94		101		102	105		106	
Respiratory Rate	17				16			22		14		23		17	24		20	
SPO2	99%				99%			99%		99		99		99	99		99	

INTAKE TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	40	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	40	320
IVPB	50						50		100					50				50
TF	80	80	80	80	80	80	80	80	640	80	80	80	80	80	80	80	80	640
PO										5,15				5,15				
TOTALS									1060									1010

OUTPUT																			
URINE HOUR	140	120	100	100	200	160	125	140	105	180	150	200	150	100	110	150	240	1010
URINE TOTAL		240	340	440	640	800	925	1065			330	530	680	780	890	1040	1280	1330
URINE SP gr																		
URINE S/A																		
NG OUTPUT																		
NG PH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS	KS																	

POST-OP DAY

VITAL SIGNS	16/17	17	18	19	20	21	22	23
	111/54	111/55			119/59		113/55	119/59
				100		99.4		
	96	100			97		95	93
	38	24			29		21	18
	99	96			100%		100%	99

INTAKE	16/17	17	18	19	20	21	22	23	8°T
I	40	40	40	40	40	40	40	40	960
			50						200
N	80	80	80	80	80	80	80	80	1920

OUTPUT	16/17	17	18	19	20	21	22	23	8°T
U	200	100 500	200 500	120 620	135 755	100 855	115 850	100 950	3585

ACUITY LEVEL CLASSIFICATION

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

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

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

24/180 TOTALS | NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)-2

WT Yesterday _____ wt Today _____

INTAKE

IV 1160

OUTPUT

Urine: 3585

TOTAL 2480 TOTAL 3585

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: [illegible]
Time In: 1040
Allergies: NKA
Pre-op V/S: 113/61; 96;
Procedures: [illegible]

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP 200 EBL N/A
Meds/Times: [illegible]

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

Airway: Nasal Oral ETT Trach Other

History

Pre Op Meds

Time	1100	1105	1110	1120												
SaO2	99	[illegible]	[illegible]	[illegible]												
FiO2	M	RA	RA	RA	RA											
Methods																
240																
220																
200																
180																
160																
140																
120																
100	V	V	V	V	V											
80																
60	^	^	^	^	^											
40																
20																
RR																
T	98.7				98.7											

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY (Sign [redacted] LT RN.

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10-24.

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

b(6)-2

[redacted] b(6)-4

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

b(6)-2

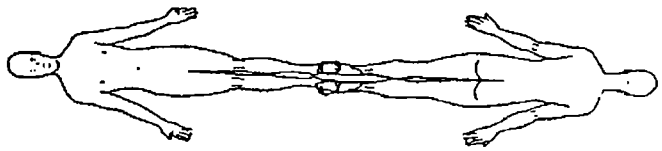
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LE/LE	full	full	P	cbsed	warm	NFR
15'							
30'	LE/LE	full	full	P	cbsed	warm	NFR
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	abd	abd pad	c/d/I
30'	abd	abd pad	c/d/I
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Assumed pt care from LT [redacted] pt hemodynamically stable & in no apparent distress. Alert responsive to voice non combative, follows commands MAE.
CVS NSR S ectopy S1 S2 +2 radial +1 pedal pulses c̄
Resp even unlabored CTA (R) Extremities w/ open DSD, or PAS.
GI hyper BS x 4 ABD/U/D colostomy (D) quad sama pouch midline dressing c/d/I. (D) drainage from colostomy.
GU FTG straw colored QS. ⊼ sediment.
Lines (D) SCTL patent.

Discharge Criteria:
Date: 10/24 Time: 1200 PARS: 10
BP: 100/60 T: HR: 87 RR: 16 Sa02: 100
Pain Level at D/C (0-10):
Intake: 0 Output: 220 cc
Additional Data:
Transferred To: 3CCU
Report Given To: LT [redacted]
Transferred Via: W/C [redacted] / [redacted] Ambulance
Transferred By: LT [redacted] / [redacted]
Cleared IAW Recovery Room SOP: [redacted]
Charge Nurse Signature: [redacted]

b(6)-2

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	[illegible]	INITIAS [redacted]		INITIAS	1815	INITIAS [redacted]
NEURO	PUPLIS	[illegible]				PERRL (B)	
	SENSORIUM	[illegible]				A&O, moves all extremities	
		[illegible]				UEs c stronger movements	
		[illegible]				than LEs	
		[illegible]					
RESPIRATORY	RESPIRATION PATTERN	[illegible]				Reg, even & unlabored	
	BREATH SOUNDS	[illegible]				CTA (B)	
	SECRETIONS	[illegible]				Ø	
		[illegible]					
		[illegible]					
		[illegible]					
SKIN	COLOR	[illegible]				WFR	
	INTEGRITY	[illegible]				Midline abd & Ø thigh drsg	
		[illegible]				CDI, Ø buttock & sacral area	
IV SITE	LOCATION	[illegible]				Ø SC triple lumen	
	CONDITION	[illegible]				Patent 3 sts of infx @ insertion	
		[illegible]				site, infusing D5NS c 40KCL	
		[illegible]					
		[illegible]					
		[illegible]					
GASTRO	ABDOMEN	[illegible]				Flat, soft, tender	
	BOWEL SOUNDS	[illegible]				Ø in all 4 quads, colostomy	
		[illegible]				stoma pink & beefy	
		[illegible]					
GU	URINE	[illegible]				Via foley to gravity	
	COLOR/CLARITY	[illegible]				yellow/clear	
		[illegible]					
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]				ST c Sr Sc noted, Ø peripheral	
		[illegible]				pulses c cap refill 2 sec	
		[illegible]				sens.	
		[illegible]					
		[illegible]					

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)

P[redacted] CPT | AW | DEPARTMENT/SERVICE/CINC ICU 3 | DATE 30 Oct 03

PATIEN[redacted]ATIONS (For typed or written entries give: Name — Last, First, middle, [redacted] date; hospital or medical facility)

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff	113/59	113/55	112/57		116/56			112/57		113/57	113/55	114/56	113/54	112/52		112/60	100/57	
	Temperature		99.2								98.8					99.1	99		
	Pulse	97	92	91		91	94	91	92		93	92	101	88	90	X	102	99	
	Respiratory Rate	19	19	20		19		21	12		22	25	20	25	22	X	12	20	
	O2 sats	98	99	99%		99%		100	96		100	100	100	94	96	X	100	100	
	mode	RA	RA			RA		RA	RA		RA								

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	40	80	40	40	40	120	100	100	500	100	100	100	100	100	100	100	100	800
	TF	80	80	80	80	80	100	100		320						50			400
	NPB	50						50		150						50			50
	TOTALS									970									850

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		110	60	170	100	100	60	70	110	130	160	100	110	140	200	230	80	110	930
				170	340	440	540	600	670	780			260	370	510	710	940	1020	1130	
		Sp gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			

780
930
710
840
2550

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23	
	112/66	104/48	114/53						
				108/51 →			100/50		
							100		
	98	103	100	91 →			95		
	96	96	21	14 →			18		
	98	98	98	99% →			98%		
	RA	RA	RA	RA →			RA		

INTAKE	14	17	18	19	20	21	22	23	8°T
	100	100	100	40	40	40	40	40	1800
			50	80	80	80	80	80	800
			50						200

OUTPUT	14	17	18	19	20	21	22	23	
	40	40	40/250	100/350	200/550	150/700	50/750	90/840	2550
		100							

ACUITY LEVEL CLASSIFICATION

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									
	CI/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

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

24°180 TOTALS

SES SIGNATURE [redacted]

WT Yesterday _____ wt Today _____

INTAKE

IV 2000

OUTPUT

Urine: 2550

b(6)-2

MEDCOM - 21618

0440

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIAS		INITIAS	1830	INITIAS [redacted]
NEURO	PUPLIS					1mm brisk Perrla	
	SENSORIUM					Alert/follows all commands	
						Full strenght on all extremities	
RESPIRATORY	RESPIRATION PATTERN					normal on RA. O2 sats >95%	
	BREATH SOUNDS					LCTA B	
	SECRETIONS					~~O~~ cough	
SKIN	COLOR					hf R	
	INTEGRITY					Intact x ABD/ ⊕ thigh/ buttock wounds. wound vac in place	
IV SITE	LOCATION					② SC TLC	
	CONDITION					site clean free of signs of infection	
GASTRO	ABDOMEN					bridlike abd wound c̄ w-D dress.	
	BOWEL SOUNDS					⊕ BS x4 quadrants	
						Colostomy ptr LLQ. soft formed stool noted. abd non distended	
GU	URINE					foley to gravity	
	COLOR/CLARITY					yellow/clear	
						Odequate UOP	
CARDIOVASCULAR	CARDIACRHYTHM					Sinus tach 100s-110s occasional	
						peripheral pulses radial & pedal +②	

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

(Continue on reverse)

[redacted] 9MAR86 | DEPARTMENT/SERVICE/CINC ICU# 3 | DATE 21 Oct 85

PATIENT'S INDICATIONS (If typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

b(6)-2

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DATE 2 OCT 03 | DX Rectal GSW | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	104/45	104/44			135/57		112/52					109/50				107/52		
Temperature		99.2										98.6				98.1		
Pulse	98	99			101	96	96					85				91		
Respiratory Rate	14	22			16	19	19					13				19		
SpO2	99%	99%			100%	99%	99%					100				99		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	40	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	40	320
IVPB	50						50							50				50
TF	80	80	80	80	80	80	80	80	640	80	80	80	80	80	80	80	80	640
TOTALS									960									1010

OUTPUT

URINE HOUR	100	110	50	70	100	100	110	100	740	100	36	200	320	105	71	90	165	1087
URINE TOTAL		210	260	330	430	530	640				136	336	656	761	832	922	1087	
URINE SP gr																		
URINE S/A																		
Drainage wound vac OUTPUT							500					100				100		200
~~NG~~ PH																		
GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		

POST-OP DAY

VITAL SIGNS	16 ~~14~~	17	18	19	20	21	22	23	
				112 / 54			~~111~~		
			101 / 57	100 / 61			111 / 58		
			98.8				101.5		
			111	106 / 114			111		
			15	18 / 18			24		
			99	99 / 99			99		

INTAKE	16 ~~14~~	17	18	19	20	21	22	23	8°T
	40	40	40	40	40	40	40	40	320
			50						50
	80	80	80	80	80	80	80	80	640
									1010

OUTPUT									
	130 / 130	80 / 210	42 / 252	50	85	105	105	80	677
			25						25

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES DAILY LIVING	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME					
SUCTION						

24 180 TOTALS | NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

[redacted]

b(1)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS		INTILAS		INTILAS
NEURO	PUPLIS						
	SENSORIUM						
RESPIRATORY	RESPIRATION PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
I.V. SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIACRHYTHM						

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

(Continue on reverse)

PREP[redacted]ture & Title) CPT HAW

DEPARTMENT/SERVICE/CINC ICU3

DATE 31 Oct 03

[redacted]TIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW

b(6)-2

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DATE 2201203 DX SLP [illegible] HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff			111/54			109/52				125/54		109/51		122/60			105/60	
	Temperature			99.2			98		98.8				98.2		98.6			98.1	
	Pulse			101			89				91		99		103			106	
	Respiratory Rate			22			15				19		17		18			18	
	O2 SATS			100			98				100		100		100			100	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NF	40	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	40	320
	NPB	50						50		100				50					50
	TF	80	80	80	80	80	80	80	80	640	80	80	80	80	80	80	80	80	640
	TOTALS									1040									1030

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		80	40	50	100	80	80	90	100	480	20	100			50				750
				120	170	270	350	430	490				490			750				
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	Wound VAC						50												

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23	
			110/58				103/46		
			P.2				98 B		
	101		103				92		
	18		10				16		
	100		100				100		
			RA				RA		

INTAKE	16	17	18	19	20	21	22	23	8°T
			40	40	40	40	40	40	340
			80	80	80	80	80	100	520
									860

OUTPUT									
			40/40				120/120		720
							Ø		
			STOP						

ACUITY LEVEL CLASSIFICATION

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

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

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

24-130 TOTALS	NURSE'S SIGNATURE	INITIALS
WT Yesterday ____ wt Today ____		
INTAKE: IV ____	OUTPUT: Urine: ____	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

DTSG APPROVED (Date)

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

Date: 27OCT03
Time In: 2020
Allergies: NKDA
Pre-op V/S: BP/SO 89
Procedures: rectal washout dsg change

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

OR Intake: Crystalloid 200 Colloid
OR Output: UOP 50 EBL min
Meds/Times: 100 prop 200mcg fent

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

Pre Op Meds

History

Time	2020	2025	2030	2035	2050	2100
SaO2	100	100	100	100	100	100
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100	V	V	V	V	V	V
80						
60	•	•	•	•	•	•
40	^	^	^	^	^	^
20						
RR	14	12	12	14	14	14
T	98.6	98.8	98.8	98.6	98.6	98.6
Time	2020		2050		2100	
Pain (0-10)	5		5		2	
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
	LR		LSC TLC		

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] LTAN b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 27OCT03

PATIENT'S IDENTIFICATION [redacted] 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

b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
2035	~5	MSO4 3mg	IVP	5+	I	[redacted]
2040	5+	MSO4 2mg	IVP	5+	I	[redacted]
2045	5+	MSO4 2mg	IVP	5	I	[redacted]
2055	5+	MSO4 3mg	IVP	2	E	[redacted]

NEUROVASCULAR

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

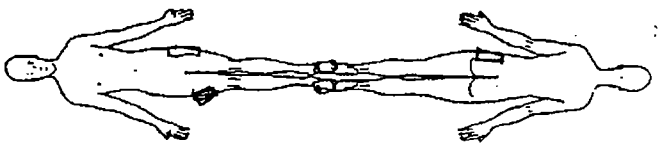
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Rthigh Lbuttocks	4x4 abd	Ø Ø
30'	Rthigh Rbutton	Abd 4x4	Ø
60'			
D/C	Rthigh Rbuttock	Abd 4x4	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2100	foley	Cl yellow	400

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
~~2000~~ 2020	NSR	Ø	Ø

NURSING NOTES

2025 Pt rec'd from OR via gurney. Pt aroused to voice, able to move all extr. C/O pain in buttocks given 3mg MSO4 IVP. VSS. Monitored continuously. Dsg's C/D/I - Augusta
2100 - Pt C/O buttocks pain repeatedly. given a total of 10mg MSO4 IVP. Report given to ICW1. Pt cont. stable - [redacted] (TAN)

b(6)-2

b(6)-2

Discharge Criteria:
Date: 27 OCT 03 Time: 2100 PARS: 10
BP: 103/53 T: 98.1 HR: 73 RR: 13 Sa02: 100
Pain Level at D/C (0-10):
Intake: Ø Output: 1000
Additional Data: Ø
Transferred To: ICW 1
Report Given To: SPC
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted] 91620
Cleared IAW Recovery R[redacted]
Signature: [redacted] (TAN)

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 02Nov03
Time In: 0840
Allergies: 1
Pre-op V/S: 104/55 96 96%
Procedures: IJD Washout (R) Hip

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

OR Intake: Crystalloid 150 Colloid
OR Output: UOP 850 EBL min
Meds/Times:

Right Forearm

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	0830	0845	0855	0855	0840
SaO2	99%	99	99	100	99
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					✓
80	✓	✓	✓	✓	
60	o	o	o	o	o
40					^
20	^	^	^	^	
RR	24	22	24	18	13
T					
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0840	LR	200	R Subclav	[redacted]	

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	0	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	0	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			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	5	9	9

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY [redacted] SSG/PW

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 02Nov03

PATIENT'S IDENTIFICATION (For typed or writ[redacted] Name – last, first, middle; grade; date; hospital or medical [redacted]

b(6)-2

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

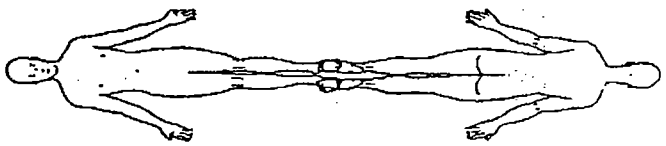
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

male Tragi admitted to PACU S/P I&D (R) Hip. PO, 99% c̄ OPA. USS. No sig respiratory distress. Pt extremely sedated. IV KR @ TKO. Foley to drainage. Will continue to monitor [redacted] SSG/USA

b(6)-2

b(6)-4

Discharge Criteria:
Date: 02 Nov 03 Time: 0945 PARS: 9
BP: 110/59 T: HR: 73 RR: 13 SaO2: 99%
Pain Level at D/C (0-10):
Intake: 100 Output:
Additional Data:
Transferred To: ICU
Report Given To: ICU / SIX [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

b(2)-2

Admission & Coding Information

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

1. Reporting MTF 0580 - [redacted]	2. MTF Local IZ		4. Pay Grade FGN	5. Sex M
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-4			
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 20Y	8. Race X	9. Ethnicity 9	Religion ISLAMIC
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 05:30	Branch / Corps: ARMY
14. Flying Status NO	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICU3	Name / Relationship of Emergency Addressee Address of Emergency Addressee Telephone Number of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided				
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-03		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-10		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-10		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P EX LAP WOUND DEBRIDEMENT

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer (Signature, as requ

[redacted]

9	10	11	12	13	14	15

NAME (Last, First, Middle Initial)

4. PAY GRADE: 16 17

5. SEX: 18

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACKGROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86

24. CLINIC SVC - ADMITTING: 87 88 89 90

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (YYMMDD): 97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (YYMMDD): 111 112 113 114 115 116

FOR LOCAL USE

Dx 99832 0083
86814 8900
8771 8760
0413 V443
0416 E9912

Pr 8302
8659
8604
4610
8840
8744

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK 9904(4)

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

Inj Trauma
1
456

Automated Facsimile

INPATIENT 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]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		Z				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted] b(6)-4					ICW1	
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			20:23	AEA - ORTHOPEDICS			
24. Name/Relation of Emergency Addressee			25. Type Disp	26. Date of Disp			
			TRF-OTH	2003-10-19			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm:		AdmittingOfficer:	
				2003-10-16		[redacted] b(6)-2	
29. ReportingMTF				30. Date Init Adm		32. Units Blood Components	
[redacted] b(2)-2				2003-10-16			

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

844.9
E927

RIGHT ANKLE SPRAIN

b(6)-2

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	3	3

35. Total Days This Facility

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

Signature of Attending Medical Officer [redacted] Signature of PAD or Medical Records Officer [redacted]

MAJ [redacted]

Automated Facsimile - DA FORM 3647, May 79

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18OCTØ3 (1440)	(cont) am. Pt tol. reg diet well. Voiding s difficulty. 2-point restraints in place s s/sx complications. Awaiting trans. to EPW camp. Will cont to monitor. [redacted]
18OCTØ3 @ 1849	Pt sitting up in bed. (L) ankle wrapped c̄ ace bandage. (+) Pedal pulses B/L LE. Lung sounds clear through all lobes. Abdomen soft + nontender. Amb c̄ crutches. [redacted]
	b(6)-2
12-19-03	D/C Summary Pt has sprained ankle. Weight bearing as-tolerated. [redacted]
19OCTØ3	(ØØ45) Assumed care of pt @ ØØØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol/Motrin. Amb well c̄ crutches. (L) ankle wrapped c̄ Ace wrap. Pt tol reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Awaiting trans. to EPW camp. Will cont. to monitor. [redacted] (1110) Pt d/c to EPW camp - amb c̄ crutches - escorted by MPs. [redacted] b(6)-2
	b(6)-4

[redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(6)-2

16Oct03@2300 Pt admitted to ICW1 from EMT via litter in stable condition; All VSS, pt A&Ox3 ⊕ CMS, +2PP, brisk cap Ref; SS2; LS CTA ⊕ equal & unlabored; ⊕ BS X4, abd soft non-tender to palpation; pt voiding QS, clear yellow urine ∅ difficulty; ⊕ ankle wrapped in Ace wrap, mild swelling to [redacted] lateral malleolus; Rest restraints in place ⊕ circ, ⊖ skin break ✓; cont to monitor [redacted]

17OCT03 (1230) Assumed care of pt @ 0000 ∅ report from night shift. Pt alert, speaking Arabic. VSS. ⊖ c/o pain. Pt amb well ∅ cane c̄ crutches. Ace wrap to ⊕ ankle intact. Mild swelling noted. Pt able to move toes. ⊕ pedal pulses equal bilat. 2 point restraints in place ∅ s/sx complications. Pt tol. reg. diet well. Voiding ∅ difficulty. Will continue to monitor. [redacted] MA

17Oct03@2015 Assumed care @ 1800; All VSS, pt A&Ox3, ⊕ CMS, +2 PP, Brisk cap Ref, pt OOB to BR c̄ crutch assistance ∅ difficulty; ace wrap to ⊕ ankle intact, pt denies pain, mild swelling noted, cont c̄ anti inflammatories; 2 point restraints in place, ⊕ circ, ⊖ skin break ✓; will continue to monitor [redacted]

18OCT03 (1900) Assumed care of pt @ 0000 ∅ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol/motrin. ⊕ ankle slightly swollen - wrapped c̄ ace wrap. Pt amb well c̄ crutches. To shower this

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
b(6)-4 [redacted]		

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

21 yo ♂ s/p (L) ankle pain from twisting it. Arrived via Ambulance pt's other complaints

PMH - Asthma ?HTN
PSH - Ø
Fm - ?
NKDA
ATBs

Gen: ceb, cw, NAD, Ambs3
Ext: NVI (+) AP > Medial L zone > TB.
Ø ecchymosis, crepitus, Ø instability
(+) Tenderness. (+) pain upon ambulation
(-) Sprain / Accelerating fracture

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] Hallie MD 7/26

DIAGNOSIS (L) Ankle sprain

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-98)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 16 Oct 03 | TIME: 2045

TRANSPORTATION TO FACILITY: AIR MEDIVAC

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 21

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: NEBULIZER

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (L) ANKLE PA b(6)-2 (+) ASTHMA

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: [redacted]

INITIALS: [redacted]

VITAL SIGNS

TIME	2045				
BP	124/53				
PULSE	79				
RESP	18				
TEMP	97.9 PO				
WT					

b(6)-2

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3
POST-DAY			
MONTH-YEAR OCT 2003 / DAY	16	17	18
HOUR	12 4 8 12	12 4 8 12	12 4 8 12

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

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

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

RESPIRATION RECORD: 8 8 8 8

BLOOD PRESSURE: 122/60 | 124/59 | 122/65 | 128/59 | 111/59 | 96 | 63

HEIGHT: | WEIGHT →: 5802

97 | 99(RA) | 98%(RA) | 99(RA) | 99

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER: 16 Oct 03 TIME OF ORDER: 2135 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ICW - EPW

Dx: L Ankle sprain

Condition: stable

VS: per Routine

Allergies: NKDA

Meds: 650 mg tylenol p.o. Q.D

500 mg motrin p.o. T.I.D

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b(6)-2

DATE OF ORDER: TIME OF ORDER: HOURS

Diet: Regular

Activity: Ambulatory

PLAN: return to EPW camp ASAP.

Meds: Tyl & motrin Already written. b(6)-2

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 10-19-03 TIME OF ORDER: 0830 HOURS

D/C pt to EPW camp.

[redacted] b(6)-2

b(6)-2

b(6)-2

[redacted]

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

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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19									
16	[redacted]	VS: Routine	6	[redacted]												
			18													
16		Regular DIET	6													
			18													
16		ACT: as tolerated	6													
			18													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: (L) ankle sprain

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 — USED. — USAPA V1.00

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Verity by Initialing: Order Date	Verity by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16	[redacted]	Admit ICWL, stable.	16 OCT03			[redacted]
16	[redacted]	Return to EPW ASAP DC to SRN/Comp				
16	[redacted]	meds: motrin/tylenol given to P.T.	16 OCT03			[redacted]

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

b(6)-2 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. Oct Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19
16Oct03	[redacted]	650mg tylenol PO QID	06	[redacted]		
	-----		12			
	-----		18			
	-----		24			
16Oct03	[redacted]	800mg Motrin PO TID	06			
	-----	(NIO: give c̄ meals)	14			
	-----		22			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

(L) ankle sprain

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 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.