LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	0300	0400	NOTES	0500	0600
pH	7.418	7.423 ✓		7.397	7.395
PCO_2	38.2	39.3 ✓		36.2	37.5
PO_2	59	61 ?		72	65
BE	0	1		-3	-2
HCO_3	25	26		22	23
SO_2	91	92 ?		94	92
Na^+	153	153 ?		152	
K^+	4.5	4.2 ✓		4.1	
HCT	43	43 ✓		40	
Hb	10	15 ✓		14	

* FiO_2 ↑ = 50%

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

Ward/Section: EMT	REQUESTING PHYSICIAN: DR. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: H [redacted]	DATE: 31OCT03 TIME: 1826	SSN/PSEUDO SSN: F [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		N/A
ASP		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 31OCT03	LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE: 31 OCT 03 / TIME: 1808	SSN/PSEUDO SSN: [redacted]

(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

(b)(6)-4

```
======= PICCOLO =======
31/10/03                18:31
REFERENCE RANGE:          MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #:            3153AA7
OPER #: 678          DR #: 000
SERIAL #:          0000100684
.........................
ALB   3.8   3.3-5.5   G/DL
ALP   93*   26-84     U/L
ALT   37    10-47     U/L
AMY   39    14-97     U/L
AST   61*   11-38     U/L
TBIL  0.9   0.2-1.6   MG/DL
GGT   14    5-65      U/L
TP    7.0   6.4-8.1   G/DL

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

(Piccolo) Metabolic Panel

```
======= PICCOLO =======
31/10/03                18:28
REFERENCE RANGE:          MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #:            3203AA4
OPER #: 678          DR #: 000
SERIAL #:          0000100494
.........................
GLU   96    73-118    MG/DL
BUN   9     7-22      MG/DL
CA++  9.2   8.0-10.3  MG/DL
CRE   1.3*  0.6-1.2   MG/DL
NA+   136   128-145   MMOL
K+    4.5   3.3-4.7   MMOL
CL-   100   98-108    MMOL
tCO2  21    18-33     MMOL

INST QC: OK     CHEM QC: OK
HEM 2+,  LIP 1+,  ICT 0
```

						tCO_2	18-33 mmol/l

REMARKS:

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

DATE: 31 Oct 03

LAB ID NO.:

(b)(6)-2 CBC

Ward/Section: (b)(6)-4	REQUESTING PHYSICAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 31Oct03 TIME 2000	SSN/PEEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	**Microbiology**		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Macroscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52%(M) 37-47%(F)	**CSF**			**Blood Bank**		
Set 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 WITHE EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

REMARKS:

REPORTED BY: [redacted]	DATE: 31Oct03	LAB ID NO.:

(b)(6)-4

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

Ward/Section: ICU1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 31Oct03 / TIME:	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	4.4	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.170	7.31-7.45
PCO2	50.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	45	80-105 mmHg (art) N/A (ven)
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	~~20~~ 74	95-98%
BEecf	-10	(-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	34	38-51% PCV
Hgb	12	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/
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 m
BUN		7-22 mg/d
CA^{++}		8.0-10.3m
CHOL		100-200 mg
CRE		0.6-1.2 mg
GLU		73-118 mg
TP		6.4-8.1 g/d

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
31/10/03            22:02
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #:        3325AA4
OPER #: 678      DR #: 000
SERIAL #:      0000100494
.........................
GLU   119*  73-118   MG/DL
BUN     7   7-22     MG/DL
CA++  6.7*  8.0-10.3 MG/DL
CRE   1.0   0.6-1.2  MG/DL
NA+   137   128-145  MMOL/L
K+    4.9*  3.3-4.7  MMOL/L
CL-   112*  98-108   MMOL/L
tCO2  18    18-33    MMOL/L

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

REMARKS:

SMA-10 [redacted] T-95.

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

ID: [redacted]
WB

31-10-03
22:06

			Patient Limits	
WBC	4.3 L	x10^3/uL	4.5	10.5
RBC	3.93 L	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	36.3	%	35.0	60.0
MCV	92.2	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	256.	x10^3/uL	150.	450.
LY%	38.9	%	20.5	51.1
LY#	1.7	x10^3/uL	1.2	3.4

ID [redacted]
WB

31-10-03
18:24

			Patient Limits	
WBC	14.5 H	x10^3/uL	4.5	10.5
RBC	4.96	x10^6/uL	4.00	6.00
Hgb	14.8	g/dL	11.0	18.0
Hct	46.5	%	35.0	60.0
MCV	93.6	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	416.	x10^3/uL	150.	450.
LY%	13.5 *L	%	20.5	51.1
LY#	2.0 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:07

Patient ID: [redacted]
Test Name :PT
Test Result:= 17.3 sec.
Ratio = 1.4
Calculated INR = 1.76
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:05
Card Lot :080201
Operator : JACKSON

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:09

Patient ID: [redacted]
Test Name :APTT
Test Result:= 34.3 sec.
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:07
Card Lot :030201
Operator : JACKSON

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 18:30

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.5 sec.
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :18:28
Card Lot :080201
Operator : STILLWELL

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 18:38

Patient ID: [redacted]
Test Name :APTT
Test Result:= 27.1 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :18:35
Card Lot :030201
Operator : STEWART

ID [redacted]
WB

31-10-03
20:09

			Patient Limits	
WBC	3.5 L	x10^3/uL	4.5	10.5
RBC	2.68 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	25.3 L	%	35.0	60.0
MCV	94.3	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	176. *	x10^3/uL	150.	450.
LY%	29.3 *	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] (6)(6)-7	DATE 10/31	TIME 2356	SSN/PSEUDO SSN:	

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS:

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

(b)(6)-2

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted]

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

LAST, FIRST, MI. [redacted] (b)(6)-4 | DATE 1 Nov | TIME 0027 | SSN/PSEUDO SSN:

(i-STAT)		
TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	4.6	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.197	7.31-7.45
PCO2	45.8	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	70	80-105 mmHg (art) N/A (ven)
TCO2	19	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	90	95-98%
BEecf	-10	(-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	40	38-51% PCV
Hgb	14	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)-2

Ward/Section: CU 1	REQUES[redacted]	L ORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M[redacted] (b)(6)-4	DATE 1 Nov / TIME 0026	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

			CSF			Blood Bank
Spun Hematocrit		42-52% (M) 37-47% (F)				
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)-2

Ward/Section: ICU	REQUE[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 1 NOV	TIME: 0050	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

Ward/Section: ICU | RE[redacted]

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

LAST, FIRST, MI. [redacted] | DATE | TIME 1540 | SSN/PSEUDO SSN:

(b)(6)-7

(i-STAT)

TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	4.3	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.260	7.31-7.45
PCO2	46.0	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	108	80-105 mmHg (art) N/A (ven)
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	97	95-98%
BEecf	-10	(-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	37	38-51% PCV
Hgb	13	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
01/11/03 01:08
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100494

GLU	122*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	2647*	39-380	U/L
NA+	125*	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	15*	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: [redacted] Temp: 97.2
FiO2: 100%

REPORTED BY: (b)(6)-2 | DATE: | LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4
SERIAL #005485 11/01/03 18:

Patient ID: [redacted]
Test Name :PT
Test Result:= 18.9 sec.
Ratio = 1.5
Calculated INR = 2.08
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :18:41
Card Lot :080201
Operator : DAVIS

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 18:5

Patient ID [redacted]
Test Name :APTT
Test Result:= 56.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :11/01/03
Test Time :18:52
Card Lot :030201
Operator : DAVIS

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 04:46

Patient ID: [redacted]
Test Name :PT
Test Result:= 16.3 sec.
Ratio = 1.3
Calculated INR = 1.60
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :04:45
Card Lot :080201
Operator : JACKSON

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 04:50

Patient ID: [redacted]
Test Name :APTT
Test Result:= 49.4 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :04:48
Card Lot :030201
Operator : JACKSON

(b)(6)-4

ID [redacted]
WB 01-11-03 19:31

			Patient Limits	
WBC	4.1 L	x10^3/uL	4.5	10.5
RBC	1.95 *L	x10^6/uL	4.00	6.00
Hgb	10.2 *L	g/dL	11.0	18.0
Hct	17.9 *L	%	35.0	60.0
MCV	91.7 *	fL	80.0	99.9
MCH	52.1 *H	pg	27.0	31.0
MCHC	56.8 *H	g/dL	33.0	37.0
Plt	122. *L	x10^3/uL	150.	450.
LY%	16.4 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

ID [redacted]
WB 01-11-03 18:37

			Patient Limits	
WBC	4.2 L	x10^3/uL	4.5	10.5
RBC	2.07 *L	x10^6/uL	4.00	6.00
Hgb	10.2 *L	g/dL	11.0	18.0
Hct	19.5 *L	%	35.0	60.0
MCV	94.0 *	fL	80.0	99.9
MCH	49.3 *H	pg	27.0	31.0
MCHC	52.4 *H	g/dL	33.0	37.0
Plt	125. *L	x10^3/uL	150.	450.
LY%	10.7 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

ID [redacted]
WB 01-11-03 12:51

			Patient Limits	
WBC	7.5 *	x10^3/uL	4.5	10.5
RBC	3.36 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	31.0 L	%	35.0	60.0
MCV	92.3	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	197.	x10^3/uL	150.	450.
LY%	21.5 *	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

ID [redacted]
WB 01-11-03 04:43

			Patient Limits	
WBC	4.7	x10^3/uL	4.5	10.5
RBC	4.87	x10^6/uL	4.00	6.00
Hgb	14.3	g/dL	11.0	18.0
Hct	44.6	%	35.0	60.0
MCV	91.5	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	259.	x10^3/uL	150.	450.
LY%	18.2 *L	%	20.5	51.1
LY#	0.9 *L	x10^3/uL	1.2	3.4

ID [redacted]
WB 01-11-03 01:10

			Patient Limits	
WBC	2.9 L	x10^3/uL	4.5	10.5
RBC	4.72	x10^6/uL	4.00	6.00
Hgb	13.9	g/dL	11.0	18.0
Hct	43.3	%	35.0	60.0
MCV	91.9	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	231.	x10^3/uL	150.	450.
LY%	37.3 *	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

Ward/Section: ICU1	ING PHYSICIAN: [redacted]	BORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 01NOV / TIME 1930	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU-1	F	NG PHYSICIAN: [redacted] (b)(6)-2	ORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4		DATE	TIME 1830	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS: CBC & PT/PTT & Coags

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, MI. [redacted] 15/61-4	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	NOV 1	12:50	

(i-STAT)

TEST	RESULT	REF. RANGE
Na	148	138-146 mmol/L
K	2.8	3.5-4.9 mmol/L
Cl	112	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	21	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l

======= PICCOLO =======
01/11/03 13:00
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 (b)(6)-4
DISC LOT #: 3151AA4
OPER #: 777 DR #: 000
SERIAL #: 0000100494

GLU	130*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	3159*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	3.3	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	1 NOV 03	

(5)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (5)(6)-7	DATE 1 NOV	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 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		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

(Piccolo) M

TEST	RESULT
GLU	
BUN	
CRE	
CK	
NA^+	
K^+	
CL^-	
tCO_2	

(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
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

er Panel Plus

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

ectrolyte

	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

======= PICCOLO =======
01/11/03 04:20
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)-7
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100684

GLU	124*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	3517*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	110*	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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

REMARKS:
SMA 10

REPORTED BY:	DATE:	LAB ID NO.:

T 96.7 50% O2

Ward/Section: ICU REQUESTING PHYSICIAN:

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	NOV 1	12:35	

ABG

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	150	138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K	3.1	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	7.359	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	38.5	35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2	65	80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2	93	95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
BEecf	-4	(-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		1.12-1.32 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	26	38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb	9	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	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-		98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2		18-33 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)-4	NOV 1	

** PRINT CANCELLED **

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i-STAT EG6+

Pt: [redacted]

Pt Name:_____

Na_____151 mmol/L

K_____4.4 mmol/L

TCO2_____26 mmol/L

Hct_____48 %PCV

Hb*_____16 g/dL

*via Hct

At 37C

pH_____7.410

PCO2_____39.0 mmHg

PO2_____68 mmHg

HCO3_____25 mmol/L

BEecf_____0 mmol/L

sO2*_____94 %

*calculated

At Patient Temp

pH_____7.410

PCO2_____39.0 mmHg

PO2_____68 mmHg

Patient Temp: 98.6F

FIO2_____: 55

Sample Type_: ART

02NOV03 11:31

Oper: [redacted]

Physician:_____

Ser# 42015

Ver: JAMS046A
CLEW A93

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 04:24

Patient ID: [redacted]
Test Name :PT
Test Result:= 19.4 sec.
RESULT OUT OF RANGE
Ratio = 1.6
Calculated INR = 2.12
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :04:23
Card Lot :080201
Operator : [redacted]

(5)(6)-4

66-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 04:29

Patient ID [redacted]
Test Name :APTT
Test Result:= 55.1 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :04:25
Card Lot :030201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 01:28

Patient ID [redacted]
Test Name :PT
Test Result:= 20.4 sec.
RESULT OUT OF RANGE
Ratio = 1.7
Calculated INR = 2.30
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :01:25
Card Lot :080201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 01:53

Patient ID: [redacted]
Test Name :APTT
Test Result:= 56.7 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :11/02/03
Test Time :01:49
Card Lot :030201
Operator : [redacted]

Ward/Section: ICU-1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-2	DATE 11/02	TIME 0054	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS: CBC - Coags.

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU-1	REQUESTING PHYSICIAN: [redacted] (b)(6)-7	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-7	DATE 11/2	TIME 0054	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	151	138-146 mmol/L
K	3.8	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.433	7.31-7.45
PCO2	34.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	131	80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	23	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99	95-98%
BEecf	-1	(-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~~ 3	38-51% PCV
Hgb	13 ~~38~~	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		
K		
C		
tC		

```
=======PICCOLO =======
02/11/03          01:25
REFERENCE RANGE:     MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:        3151AA4
OPER #: 013      DR #: 000
SERIAL #:      0000100684
.......................
GLU    91    73-118    MG/DL
BUN    10    7-22      MG/DL
CRE    1.0   0.6-1.2   MG/DL
CK   >5000*  39-380     U/L
NA+   138    128-145   MMOL/L
K+    4.4    3.3-4.7   MMOL/L
CL-   114*   98-108    MMOL/L
tCO2   18    18-33     MMOL/L

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

(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
A^{+}		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS: ① ABG · Chem 8
① 98.9 FiO2 55 SaO2 100%

REPORTED BY: [redacted] (b)(6)-7	DATE: 2Nov03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M: [redacted]	2N8U83 TIME 04	SSN/PSEUDO SSN: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	152	138-146 mmol/L
K	4.0	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.395	7.31-7.45
PCO2	38.7	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	76	80-105 mmHg (art) N/A (ven)
TCO2	25	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	24	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	95	95-98%
BEecf	-1	(-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	42	38-51% PCV
Hgb	14	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
A		
A		
A		
T		
B		
C		
C		
C		
G		
T		
G		
B		
C		
C		
N		
K		
C		
tC		

(b)(6)-4

```
======= PICCOLO =======
02/11/03          04:17
REFERENCE RANGE:     MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:        3151AA4
OPER #: 013      DR #: 000
SERIAL #:      0000100684
.........................
GLU    92    73-118   MG/DL
BUN     9    7-22     MG/DL
CRE   1.6*  0.6-1.2   MG/DL
CK  >5000*  39-380     U/L
NA+   140   128-145   MMOL/L
K+    4.9*  3.3-4.7   MMOL/L
CL-   114*  98-108    MMOL/L
tCO2   19   18-33     MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO2		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
CO2		18-33 mmol/l

REMARKS: ABG T: 99 FIO2 50%

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU I	REQUESTING PHYSICIAN: (b)(6)-4	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] EPW	DATE 11/0.2	TIME 1100	SSN/PSEUDO SSN:	

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		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: T 98.6 Veat +102 55%

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU I	REQUESTING PHYS: Dr [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] (b)(6)-7		DATE 11/02	TIME 1645	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		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 FIO2 55% T 96.6 Vented SIMV 16

REPORTED BY:	DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/03/03 00:01

Patient ID: [redacted]
Test Name :PT
Test Result:= 22.7 sec.
RESULT OUT OF RANGE
Ratio = 1.9
Calculated INR = 2.73
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :23:58
Card Lot :080201
Operator : [redacted]

b6-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/03/03 00:06

Patient ID: [redacted]
Test Name :APTT
Test Result:= 96.9 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :00:02
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 19:57

Patient ID [redacted]
Test Name :PT
Test Result:= 21.6 sec.
RESULT OUT OF RANGE
Ratio = 1.8
Calculated INR = 2.52
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :19:55
Card Lot :080201
Operator : [redacted]

b6-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 20:0[illegible]

Patient ID: [redacted]
Test Name :APTT
Test Result:=102.8 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :19:57
Card Lot :100208
Operator : [redacted]

---

i-STAT EG6+

Pt: [redacted]
Pt Name:_____

Na_____150 mmol/L
K_____3.7 mmol/L
TCO2_____23 mmol/L
Hct_____36 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.293
PCO2_____45.1 mmHg
PO2_____55 mmHg
HCO3_____22 mmol/L
BEecf_____-5 mmol/L
sO2*_____84 %
*calculated

(b)(6)-4

At Patient Temp
pH_____7.308
PCO2_____43.0 mmHg
PO2_____51 mmHg

Patient Temp: 96.6F
FIO2_____: 55
Sample Type_:

02NOV03 16:58

Oper: [redacted]

Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

[redacted] 03-11-02 13:52

				Patient Limits	
WBC	1.6 L	x10^3/uL		4.5	10.5
RBC	1.67 L	x10^6/uL		4.00	6.00
Hgb	11.4	g/dL		11.0	18.0
Hct	35.8	%		35.0	60.0
MCV	92.5	fL		80.0	99.9
MCH	29.4	pg		27.0	31.0
MCHC	31.8 L	g/dL		33.0	37.0
Plt	41. L	x10^3/uL		150.	450.
LY%	25.9 *	%		20.5	51.1
LY#	0.4 *L	x10^3/uL		1.2	3.4

[redacted] 02-11-03 19:39

				Patient Limits	
WBC	1.0 L	x10^3/uL		4.5	10.5
RBC	4.45	x10^6/uL		4.00	6.00
Hgb	13.0	g/dL		11.0	18.0
Hct	41.2	%		35.0	60.0
MCV	92.5	fL		80.0	99.9
MCH	29.2	pg		27.0	31.0
MCHC	31.6 L	g/dL		33.0	37.0
Plt	51. *L	x10^3/uL		150.	450.
LY%	22.4 *	%		20.5	51.1
LY#	0.2 *L	x10^3/uL		1.2	3.4

[redacted] 02-11-03 04:18

				Patient Limits	
WBC	5.1	x10^3/uL		4.5	10.5
RBC	4.86	x10^6/uL		4.00	6.00
✓ Hgb	14.5	g/dL		11.0	18.0
✓ Hct	44.8	%		35.0	60.0
MCV	92.1	fL		80.0	99.9
MCH	29.8	pg		27.0	31.0
MCHC	32.4 L	g/dL		33.0	37.0
Plt	115. L	x10^3/uL		150.	450.
LY%	8.6 *L	%		20.5	51.1
LY#	0.4 *L	x10^3/uL		1.2	3.4

[redacted] 02-11-03 01:24

				Patient Limits	
WBC	5.1	x10^3/uL		4.5	10.5
RBC	4.68	x10^6/uL		4.00	6.00
Hgb	13.7	g/dL		11.0	18.0
Hct	42.9	%		35.0	60.0
MCV	91.6	fL		80.0	99.9
MCH	29.2	pg		27.0	31.0
MCHC	31.9 L	g/dL		33.0	37.0
Plt	115. L	x10^3/uL		150.	450.
LY%	8.4 *L	%		20.5	51.1
LY#	0.4 *L	x10^3/uL		1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 01:12

Patient ID [redacted]
Test Name :PT
Test Result:= 16.9 sec.
Ratio = 1.4
Calculated INR = 1.70
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :01:10
Card Lot :080201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 01:15

Patient ID [redacted] b6-2
Test Name :APTT
Test Result:= 37.6 sec.
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :01:12
Card Lot :030201
Operator : [redacted]

ID# [redacted] 02-11-03
MR 23:50

			Patient Limits	
WBC	1.1 L	x10^3/uL	4.5	10.5
RBC	4.27 *	x10^6/uL	4.00	6.00
Hgb	12.8	g/dL	11.0	18.0
Hct	39.1	%	35.0	60.0
MCV	91.6	fL	80.0	99.9
MCH	29.9	pg	27.0	31.0
MCHC	32.7 L	g/dL	33.0	37.0
Plt	46. L	x10^3/uL	150.	450.
LY%	27.3 *	%	20.5	51.1
LY#	0.3 *L	x10^3/uL	1.2	3.4

---

i-STAT EG6+

Pt [redacted]
Pt Name:_____

Na_____150 mmol/L
K_____4.1 mmol/L
TCO2_____17 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
(b)(6)-4
_____23.9 mmHg
O2_____36 mmHg
HCO3_____17 mmol/L
BEecf_____-7 mmol/L
sO2*_____74 %
*calculated

At Patient Temp
pH_____7.476
PCO2_____22.1 mmHg
PO2_____32 mmHg

Patient Temp: 95.-
FIO2_____: 100
Sample Type_: ART

03NOV03 00:49

Oper: [redacted] b6-2
Physician:_____

Ser# 40746
Ver: JAMS046A
CLEW A93

---

i-STAT EG6+

Pt [redacted]
Pt Name:_____

Na_____148 mmol/L
K_____3.7 mmol/L
TCO2_____20 mmol/L
Hct_____36 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.285
PCO2_____40.2 mmHg
PO2_____*** mmHg
HCO3_____19 mmol/L
BEecf_____-8 mmol/L
sO2*_____*** %
*calculated

At Patient Temp
pH_____7.318
PCO2_____36.3 mmHg
PO2_____*** mmHg

Patient Temp: 94.4F
FIO2_____: 100
Sample Type_:

02NOV03 23:55

Oper: [redacted] b6-2
Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

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

LAST, FIRST, MI. [redacted]	DATE 15/6/1-4	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: CBC. PT/PTT

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU-1

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

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

LAST, FIRST, MI: [redacted]

DATE: 11/2

TIME: 2335

SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY	(b)(6)-4	
AST		1
TBIL		0.
BUN		7-
CA^{++}		8.
CHOL		1
CRE		0
GLU		7
TP		6

(Piccolo) Metly

TEST	RESULT
GLU	
BUN	
CRE	
CK	
NA^+	
K^+	
CL^-	
tCO_2	

(Piccolo) Metabolic Panel

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

.2 mg/dl
45 mmol/l
7 mmol/l
08 mmol/l
3 mmol/l

J Plus

F. RANGE
5 g/dl
4 u/l
7 u/l
7 u/l
8 u/l
1.6 mg/dl
5 u/l
8.1 g/dl

lyte

EF. RANGE
-145 mmol/l
-4.7 mmol/l
108 mmol/l
33 mmol/l

```
======= PICCOLO =======
02/11/03                 23:58
REFERENCE RANGE:         MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #:              3325A4
OPER #: 013              DR #: 000
SERIAL #:                0000100684
.......................
GLU   28*   73-118   MG/DL
BUN   14    7-22     MG/DL
CA++  7.7*  8.0-10.3 MG/DL
CRE   1.5*  0.6-1.2  MG/DL
NA+   144   128-145  MMOL
K+    4.3   3.3-4.7  MMOL
CL-   114*  98-108   MMOL
tCO2  18    18-33    MMOL

INSI QC: OK    CHEM QC: OK
HEM 0 , LIP 1+, ICI 1+
```

REMARKS:

ABC - (T) 9414 Fro2 1W 18

REPORTED BY:

DATE: [redacted]

LAB ID NO.: 3 MW3

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 14 03 / TIME 1930	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC, PT/PTT

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU	REQU[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 30 OV 03 / TIME 0245	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
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		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(i-STAT)

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		3.5-5.5 g/dl

======= PICCOLO =======
03/11/03 00:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-7
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100494

GLU	21*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	16*	18-33	MMOL/L

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

(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]	3NOV03	

(b)(6)-2

NS 14.. 46.5 \46 INR 1.18 PTT 27.1 4.5 100 1.3 TK S/P GSW (L) + R Buttocks → rectum

Flagyl 500mg IV
Gentamicin 80mg IV } EMT

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)	<250>			<250>		<250>					
MSO4 (mg)		10	5	5							
UCB (mg)	10			10							
Versed (mg)					<5>	<5>					
( )											
( )											
VOLAT AGENT — % del / % e.t.	1.0 ~ 1.0	1.5	1.5	1.5	1.5	1.5	0.6	1.0 ~ 1.0	1.0	X	
AIR L/Min											
N2O L/Min											
O2 L/Min	2	2	2	2	2	2	2	2	2	2	

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

FLUIDS

LINE site 18G (R) A ☐ Warmed	NS (500)		500	#5	#7				P	
18G (L) A ☐ Warmed	NS (500)		500	#6						
(R) SC Cordis ☒ Warmed	LR #1	#2	#3	#4	#8	6L		8L	9.5	
☐ Warmed							PRBC		PRBC #2	

LOSSES

EST BLOOD LOSS			100		200		400-500			
URINE -	total output/surgeon		500				100		100	

TOTALS: 750, 20, 20, 5 — **TOTAL EBL**: 500 — **TOTAL URINE**: 700

FLUIDS - SUMMARY
CRYSTALLOID- LR 7, NS 1 — 10L
COLLOID- Ø
BLOOD- 2 ii

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

BODY WEIGHT: 80 (KG) LB

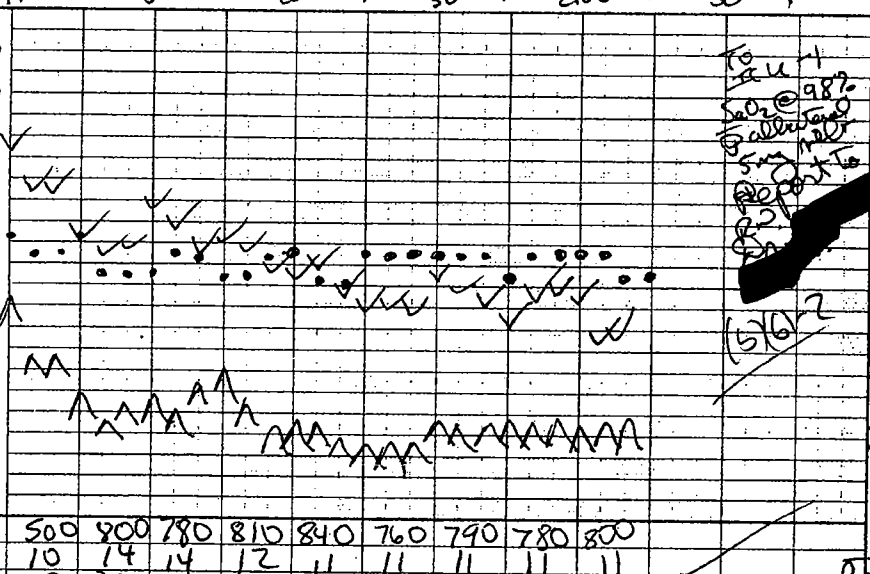
HEMATOCRIT: 46.5

INITIAL DATA
BP- 176/103
HR- 131

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 1830

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



REMARKS
Code drugs with numbers, events with letters
(1) Received pt - GSW to rectum from EMT intubated; PPV + monitors Room, monitors O2 vent
(2) Urinedrained suprapubic tube
(3) 3.5 7.8 253 176 via SC cordis
1645512
#1 PRBC per surgeon request
(5) Return easy blood HR 130s. #2 PRBC
4743806
(6) Vented · Wheezy SaO2 ↓77-80% Atrovent neb-a02% Bronchospasm Sucked ETT, Epi IV 30mg SaO2 95% Phenylephrine 100mg IV

VENTIL

VT - ml	500	800	780	810	840	760	790	780	800
f - breaths/min	10	14	14	12	11	11	11	11	11
Peak inf pres / PEEP	28	26	27	30	31	30	30	31	30
MODE - S(pon), A(ssist), C(on)	S —	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	38	32	31	33	32	31	32	33	32
BP/oth — FIO2 (Frac or %)	0.78	0.78	0.77	0.77	0.77	0.77	0.77	0.78	0.78
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer — TEMP-site Nasal	34.6 ~		35.2	35	35.2	35.0	36	36	35.9
N-M Block (T/4)	4/4	0/4	0/4	1/4	0/4	0/4	0/4		0/4
BS	T								
Warming blkt	Room warmed								
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (5) (6) low lith

RECOVERY AT 2130
PACU (ICU) 1 (Specify)
OTHER 1 - 9.5
CONDITION: Stable
RESP- 14 SpO2- 98-100%
BP- 107/54 HR- 130

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1845	1900	2210
PROC	Ready 1905	Begin 1920	End 2120

PROCEDURES and CPT Codes: - Colostomy
Ex lap: Suprapubic tube placement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] FPW
(5)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Intubated in EMT / 8.0 ETT, 21cm @ teeth, 1 BBS, Suct ETCO2

SURGEONS: [redacted]

PROCEDURE LOCATION: 2(2)
DATE: 31 Oct 03
PAGE 1 OF 1

[redacted] CRNA/MAJ

(5)(6)-2

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

MEDCOM - 22673

USO → Ship emergency Ex Lap

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)												
Epinephrine	(mg)	200											
	( )												
	( )												
	( )												
	( )												
	( )												
VOLAT AGENT	% del												
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	2	2	2	2								

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

FLUIDS

LINE site													
18G mcg/kg/min LR	☐ Warmed	4	4	4	4	1500							
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS						100							
URINE -			250										

TOTALS	
TOTAL EBL	100
TOTAL URINE	250

FLUIDS - SUMMARY

CRYSTALLOID- 1500

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

① Pre-op - Coded ICU - 4 already opened to DR c̄ OPU & SaO2 + AGP monitor

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- /

HR-

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? JR

TIME- 2030

TIME → 2000 2100 30 2200

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

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

VENTIL

VT - ml		660	590	540
f - breaths/min	16	18	20	22
Peak inf pres / PEEP	38/5	36/6	36/10	36/8
MODE - S(pon), A(ssist), C(on)	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	63	51	45	42
BP/oth	FIO2 (Frac or %)	.82	.86	.86	1.0
ART line	SpO2 (%)	94	94	90	96
Steth- PC/ES	ECG	51	51	51	51
Gas analyzer	TEMP-site				
	N-M Block (T/4)				
			ETT suctioned		
Warming blkt	Room warmed				
Conv warmer					

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

RECOVERY AT 2210

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2000	2011	2220
	Ready	Begin	End
PROC	2055	2100	2200

PROCEDURES and CPT Codes: Exp - Lap

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

[redacted] (b)(6)-2

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

INTUBATED IN ICU (+) BSS (+) ETCO2

SURGEONS: (b)(6)-4

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR 1

DATE: 2 NOV 05

PAGE 1 OF 1

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

[redacted] DCOM - 22674

NI3P TREND 11/03/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM
00:46	62	[illegible]	ERR# 15	11
00:41	100	[illegible]	[illegible] / 39 [illegible]	OFF
00:36	86	[illegible]	ERR# 15	22
[illegible]	[illegible]	90	[illegible] / [illegible] * [illegible]	18
[illegible]	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
[illegible]	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:15	[illegible]	93	[illegible] / [illegible] [illegible]	18
00:10	[illegible]	94	[illegible] / [illegible] * [illegible]	18
00:05	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:02	[illegible]	95	[illegible] / 35 * [illegible]	18
00:00	[illegible]	95	ERR# 11	18
23:55	[illegible]	96	76 / 36 * [illegible]	18
23:50	[illegible]	96	76 / 37 * 52	18
23:46	[illegible]	96	77 / 36 * 51	18
23:40	[illegible]	96	81 / 39 * 54	18
23:35	[illegible]	95	79 / 40 * 54	18
23:30	119	95	75 / [illegible] * [illegible]	18
23:25	120	95	77 / 35 50	OFF
23:21	120	96	[illegible] / 35 [illegible]	OFF
23:15	106	96	[illegible] / 38 51	OFF
23:10	120	96	79 / 40 * 54	OFF
23:05	[illegible]	[illegible]	82 / 38 * 55	20
23:00	121	[illegible]	83 / 40 * 55	17
22:57	[illegible]	[illegible]	[illegible] / [illegible]	
22:56	[illegible]	[illegible]	[illegible] / [illegible]	
22:50	120	93	[illegible] / [illegible] [illegible]	
22:45	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:40	[illegible]	93	[illegible] / [illegible] [illegible]	OFF
22:35	120	92	[illegible] / [illegible] [illegible]	OFF
22:30	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:25	119	SRCH	[illegible] / [illegible] [illegible]	OFF
22:20	[illegible]	84	[illegible] / [illegible] * [illegible]	18
22:15	[illegible]	[illegible]	84 / [illegible] [illegible]	9
22:14	[illegible]	SRCH	ERR# 2	[illegible]

ADULT

TREND 11/03/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM
00:46	63	[illegible]	[illegible] / [illegible] [illegible]	14
00:44	63	[illegible]	[illegible] / [illegible] [illegible]	25
00:42	50	[illegible]	[illegible] / [illegible] [illegible]	10
00:40	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	16
00:38	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	26
00:36	89	[illegible]	[illegible] / [illegible] [illegible]	16
00:34	117	86	[illegible] / [illegible] [illegible]	18
00:32	119	89	[illegible] / [illegible] [illegible]	18
00:30	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:28	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:26	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:24	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:22	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:20	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	21
00:18	[illegible]	[illegible]	[illegible] [illegible]	18
00:16	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:14	[illegible]	94	[illegible] / [illegible] [illegible]	21
00:12	[illegible]	93	[illegible] / [illegible] [illegible]	18
00:10	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:08	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:06	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:04	[illegible]	95	[illegible] / [illegible] [illegible]	18
00:02	[illegible]	95	[illegible] / [illegible] [illegible]	18
00:00	[illegible]	95	[illegible] / [illegible] [illegible]	18
23:58	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:56	[illegible]	95	[illegible] / [illegible] [illegible]	18
23:54	[illegible]	96	[illegible] / 35 [illegible]	18
23:52	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:50	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:48	119	96	76 / 41 53	18
23:46	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:44	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:42	[illegible]	96	[illegible] / 35 [illegible]	18
23:40	[illegible]	96	[illegible] / 35 [illegible]	18
23:38	[illegible]	96	[illegible] / 36 [illegible]	18
23:36	[illegible]	95	[illegible] / 36 [illegible]	18

[illegible]:34	119	95	[illegible] / [illegible]	[illegible]	18
[illegible]:32	119	95	[illegible] / [illegible]	[illegible]	18
[illegible]:30	119	95	[illegible] / [illegible]	[illegible]	18
[illegible]:28	157	95	[illegible] / [illegible]	[illegible]	OFF
23:26	120	96	[illegible] / [illegible]	[illegible]	OFF
23:24	120	95	[illegible] / 36	[illegible]	OFF
23:22	120	95	[illegible] / [illegible]	[illegible]	OFF
23:20	144	95	[illegible] / [illegible]	[illegible]	OFF
23:18	128	95	77 / [illegible]	67	OFF
23:16	125	96	*** / ***	***	OFF
23:14	[illegible]	95	*** / [illegible]	[illegible]	OFF
23:12	121	95	[illegible] / 36	[illegible]	OFF
23:10	120	96	[illegible] / 35	[illegible]	23
23:08	120	96	[illegible] / 35	[illegible]	18
23:06	[illegible]	96	[illegible] / 35	[illegible]	19
23:04	[illegible]	96	76 / 35	[illegible]	30
23:02	[illegible]	96	80 / 36	[illegible]	18
23:00	[illegible]	97	86 / 38	52	10
22:58	86	97	96 / [illegible]	59	OFF
22:56	[illegible]	98	107 / 45	62	OFF
22:54	[illegible]	96	143 / 64	87	OFF
22:52	120	94	[illegible] / [illegible]	[illegible]	OFF
22:50	121	94	[illegible] / [illegible]	[illegible]	OFF
22:48	[illegible]	94	[illegible] / [illegible]	[illegible]	OFF
22:46	[illegible]	94	[illegible] / [illegible]	[illegible]	OFF
22:44	[illegible]	94	[illegible] / [illegible]	[illegible]	OFF
22:42	[illegible]	93	[illegible] / [illegible]	[illegible]	OFF
22:40	[illegible]	94	[illegible] / [illegible]	[illegible]	OFF
22:38	[illegible]	93	[illegible] / [illegible]	[illegible]	OFF
22:36	[illegible]	93	[illegible] / [illegible]	[illegible]	OFF
22:34	120	91	[illegible] / [illegible]	[illegible]	OFF
22:32	[illegible]	[illegible]	[illegible] / [illegible]	[illegible]	OFF
22:30	[illegible]	82	[illegible] / [illegible]	[illegible]	OFF
22:28	120	SRCH	[illegible] / [illegible]	[illegible]	OFF
22:26	119	[illegible]	[illegible] / [illegible]	[illegible]	OFF
22:24	119	SRCH	[illegible] / [illegible]	[illegible]	24
22:22	120	84	[illegible] / [illegible]	[illegible]	12
22:20	[illegible]	SRCH	[illegible] / [illegible]	[illegible]	18
22:18	[illegible]	93	[illegible]	[illegible]	18
22:16	[illegible]	[illegible]	[illegible] / [illegible]	[illegible]	8
22:14	[illegible]	SRCH	[illegible] / [illegible]	[illegible]	17
22:12	[illegible]	SRCH	OFF OFF	OFF	OFF
22:10	121	[illegible]	OFF OFF	OFF	OFF
22:08	[illegible]	OFF	NOT ZEROED		OFF
22:06	[illegible]	OFF	126 / 56	75	OFF
22:04	[illegible]	OFF	84 / 39	53	OFF
22:02	[illegible]	OFF	87 / 39	52	OFF
22:00	25	OFF	NOT ZEROED		OFF
21:58	[illegible]	OFF	95 / 40	55	OFF

ADULT

PROTOCOL SYSTEMS, INC.

22:50	120	93	[illegible] / [illegible]	[illegible]	OFF
22:45	[illegible]	94	[illegible] / [illegible]	[illegible]	OFF
22:40	[illegible]	93	[illegible] / [illegible]	[illegible]	OFF
22:35	120	92	[illegible] / [illegible]	[illegible]	OFF
22:30	[illegible]	[illegible]	[illegible] / [illegible]	[illegible]	OFF
22:25	119	SRCH	[illegible] / [illegible]	[illegible]	OFF
22:20	[illegible]	84	[illegible] / [illegible] *	[illegible]	18
22:15	[illegible]	[illegible]	64 / [illegible]	[illegible]	9
22:14	[illegible]	SRCH	ERR# 2		[illegible]

ADULT

IBP TREND 11/01/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM
01:25	142	SRCH	103 / 52 70	14
01:21	140	SRCH	96 / 48 67	18
01:15	141	SRCH	95 / 48 66	16
01:10	143	SRCH	95 / 54 69	14
01:05	141	SRCH	100 / 52 73	17
01:00	141	SRCH	95 / 52 67	16
00:55	141	SRCH	92 / 48 66	14
00:50	141	SRCH	92 / 48 66	15
00:45	141	99	88 / 47 64	14
00:40	144	SRCH	86 / 46 63	15
00:35	145	SRCH	92 / 50 66	16
00:31	144	SRCH	94 / 44 65	15
00:26	144	99	92 / 46 65	15
00:20	144	94	89 / 47 64	15
00:15	[illegible]	SRCH	90 / 49 65	25
00:10	[illegible]	91	92 / 51 69	27
00:05	[illegible]	92	99 / 63 79	[illegible]
00:01	[illegible]	89	110 / 59 79	[illegible]
23:56	[illegible]	89	105 / 60 78	20
23:51	[illegible]	91	113 / 71 - 83	21
23:45	[illegible]	SRCH	135 / 100 - 110	18
23:40	[illegible]	95	ERR# 15	19
23:35	[illegible]	90	117 / 59 83	13
23:30	[illegible]	SRCH	109 / 64 82	20
23:25	[illegible]	90	99 / 66 - 76	21
23:20	[illegible]	91	102 / 58 74	27
23:15	[illegible]	SRCH	95 / 55 70	28
23:10	[illegible]	96	103 / 56 76	[illegible]
23:05	144	97	105 / 63 - 79	32
23:01	145	97	103 / 56 82	27
22:55	143	98	114 / 69 87	31
22:50	144	98	112 / 63 - 81	28
22:45	141	99	130 / 71 95	36
22:40	[illegible]	97	132 / 68 95	18
22:35	141	100	130 / 81 99	14
22:30	143	99	134 / 70 97	15
22:25	136	99	130 / 77 97	14
22:20	136	99	140 / 79 101	14
22:15	137	100	137 / 74 99	28
22:10	131	100	126 / 77 97	22
22:05	[illegible]	99	137 / 73 100	14
22:00	[illegible]	98	138 / 69 97	14
21:56	[illegible]	97	120 / 62 86	14
21:50	[illegible]	94	108 / 56 76	18
21:46	[illegible]	88	128 / 56 85	14
21:40	[illegible]	[illegible]	108 / 58 77	26
21:35	[illegible]	[illegible]	114 / 58 81	14
21:30	[illegible]	OFF	107 / 59 79	OFF

ADULT

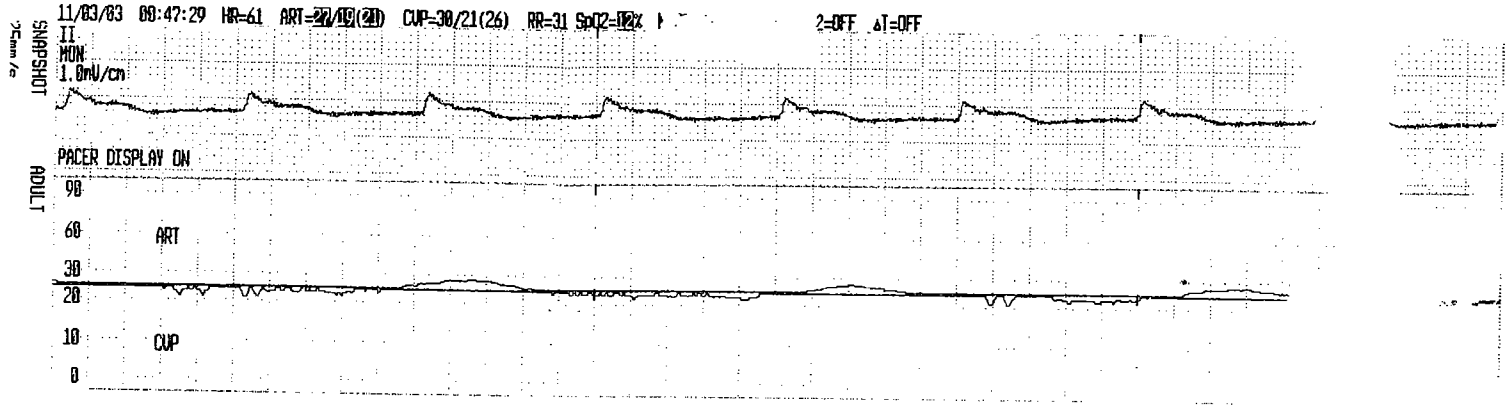
PROTOCOL SYSTEMS, INC.

NIBP TREND 11/01/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg	RR RPM
06:03	[illegible]	89	87 / 49 66	26
06:00	[illegible]	91	89 / 42 - 62	20
05:56	[illegible]	98	ERR# 15	17
05:48	[illegible]	98	96 / 52 - 70	19
05:46	[illegible]	98	84 / 49 - 63	24
05:40	[illegible]	100	87 / 48 - 65	21
05:35	[illegible]	98	110 / 48 75	14
05:34	143	96	107 / 53 76	15
05:31	144	98	99 / 51 70	16
05:26	[illegible]	97	ERR# 15	15
05:20	141	93	107 / 61 79	26
05:15	154	95	105 / 62 80	20
05:10	144	98	109 / 62 88	22
05:07	[illegible]	86	ERR# 15	24
05:00	139	98	106 / 59 77	16
04:55	139	97	116 / 52 - 79	19
04:50	138	98	109 / 55 79	14
04:45	138	95	110 / 55 77	17
04:41	138	94	105 / 51 72	15
04:38	138	SRCH	103 / 51 73	14
04:35	141	SRCH	101 / 49 71	15
04:30	140	SRCH	102 / 51 72	16
04:25	139	SRCH	101 / 49 69	15
04:21	139	SRCH	92 / 46 65	14
04:15	138	SRCH	89 / 46 63	14
04:10	139	SRCH	90 / 47 64	14
04:06	139	SRCH	86 / 47 63	14
04:03	139	SRCH	86 / 47 62	14
04:00	140	SRCH	89 / 53 65	17
03:57	139	SRCH	84 / 46 61	14
03:50	140	SRCH	88 / 49 65	17
03:45	141	SRCH	87 / 52 67	15
03:40	142	SRCH	95 / 54 71	16
03:35	144	SRCH	93 / 55 77	26
03:30	144	SRCH	103 / 60 74	14
03:25	142	SRCH	92 / 53 69	15
03:20	144	SRCH	100 / 55 74	17
03:15	142	SRCH	95 / 56 72	16
03:10	142	SRCH	96 / 56 72	16
03:05	143	SRCH	95 / 56 69	14
03:04	144	SRCH	92 / 61 71	14
03:00	144	SRCH	95 / 53 70	14
02:56	144	SRCH	ERR# 15	19
02:50	146	SRCH	98 / 60 76	18
02:45	144	SRCH	97 / 55 73	17
02:40	143	SRCH	95 / 57 73	15
02:35	144	SRCH	96 / 55 72	16
02:30	144	SRCH	95 / 53 71	17
02:25	144	SRCH	96 / 56 72	16
02:20	146	SRCH	99 / 53 70	17
02:15	144	SRCH	94 / 54 70	18
02:10	144	SRCH	96 / 56 74	19
02:05	144	SRCH	94 / 56 72	16
02:00	142	SRCH	99 / 56 72	17
01:56	143	SRCH	90 / 52 66	15
01:50	143	SRCH	99 / 53 72	17
5	140	SRCH	102 / 52 73	15
40	139	92	101 / 52 71	14
36	140	SRCH	98 / 51 70	18
01:30	141	99	102 / 53 71	16
01:25	142	SRCH	103 / 52 70	14
01:21	140	SRCH	96 / 48 67	18
01:15	141	SRCH	95 / 48 66	16
01:10	143	SRCH	95 / 54 69	14
01:05	141	SRCH	100 / 52 73	17
01:00	141	SRCH	95 / 52 67	16
00:55	141	SRCH	92 / 48 66	14
00:50	141	SRCH	92 / 48 66	15
00:45	141	99	88 / 47 64	14
00:40	144	SRCH	86 / 46 63	15
00:35	145	SRCH	92 / 50 66	16
00:31	144	SRCH	94 / 44 65	15
00:26	144	99	92 / 46 65	15
00:20	144	94	89 / 47 64	15
00:15	[illegible]	SRCH	90 / 49 65	25
00:10	[illegible]	91	92 / 51 69	27
00:05	[illegible]	92	99 / 63 79	[illegible]
00:01	[illegible]	89	110 / 59 79	[illegible]
23:56	[illegible]	89	105 / 60 78	20
23:51	[illegible]	91	113 / 71 - 83	21
23:45	[illegible]	SRCH	135 / 100 - 110	18
23:40	[illegible]	95	ERR# 15	19
23:35	[illegible]	90	117 / 59 83	13
23:30	[illegible]	SRCH	109 / 64 82	20
23:25	[illegible]	90	99 / 66 - 76	21
23:20	[illegible]	91	102 / 58 74	27
23:15	[illegible]	SRCH	95 / 55 70	28
23:10	[illegible]	96	103 / 56 76	[illegible]
23:05	144	97	105 / 63 - 79	32
23:01	145	97	103 / 56 82	27
22:55	143	98	114 / 69 87	31
22:50	144	98	112 / 63 - 81	28
22:45	141	99	130 / 71 95	36
22:40	[illegible]	97	132 / 68 95	18
22:35	141	100	130 / 81 99	14
22:30	143	99	134 / 70 97	15
22:25	136	99	130 / 77 97	14
22:20	136	99	140 / 79 101	14
22:15	137	100	137 / 74 99	28
22:10	131	100	126 / 77 97	22

ADULT

PROTOCOL SYSTEMS, INC.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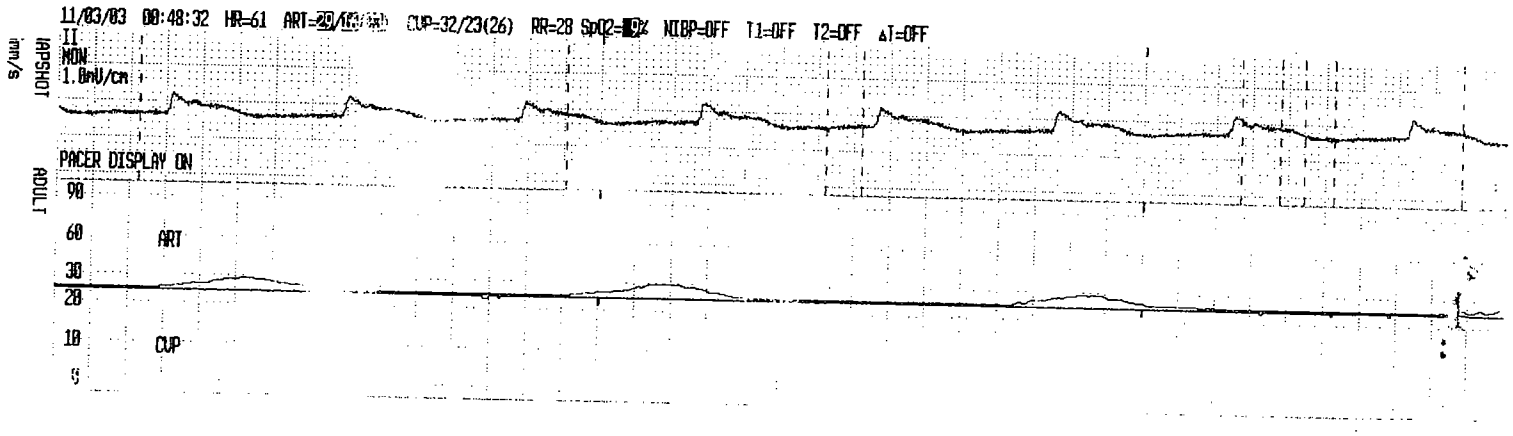
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
SNAPSHOT
90
60
30
20
10
0
ART
CVP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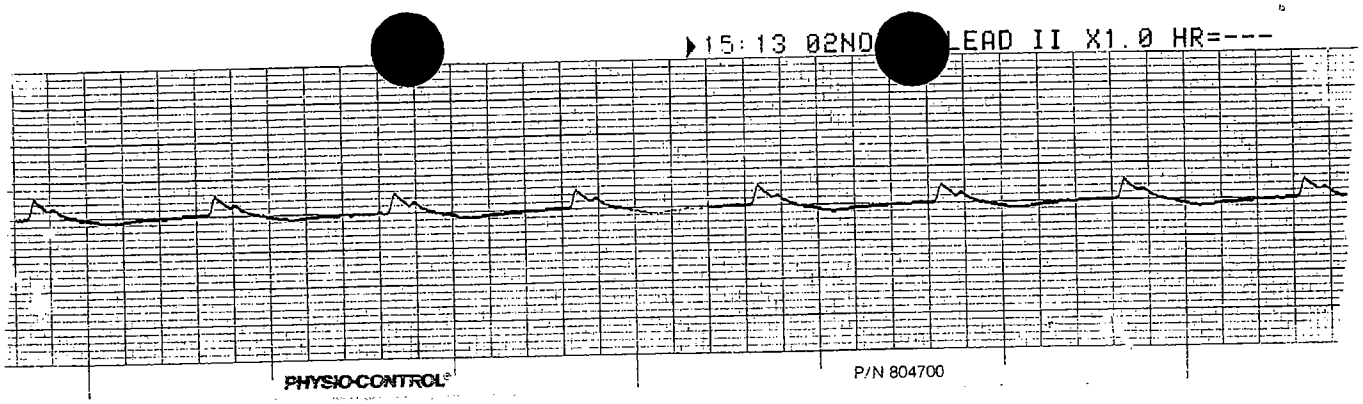
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
SNAPSHOT
90
60
30
20
10
5
ART
CVP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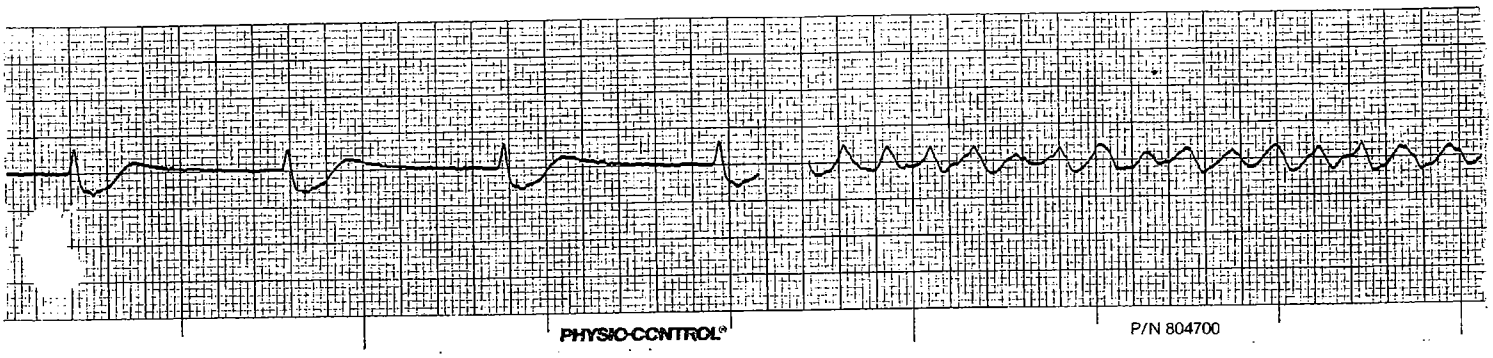
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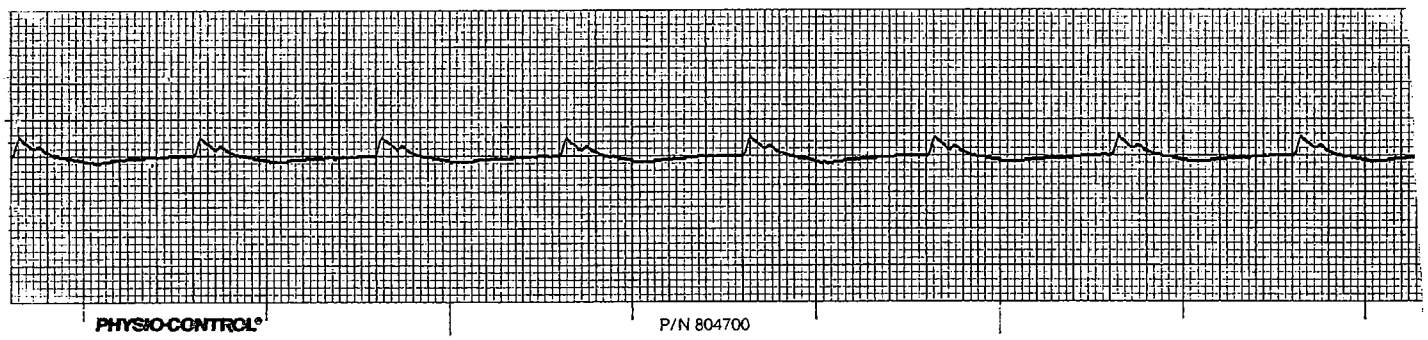
P/N 804700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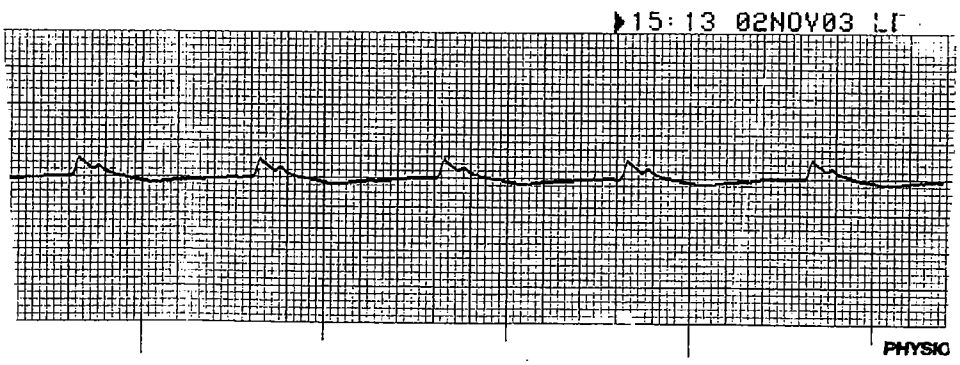
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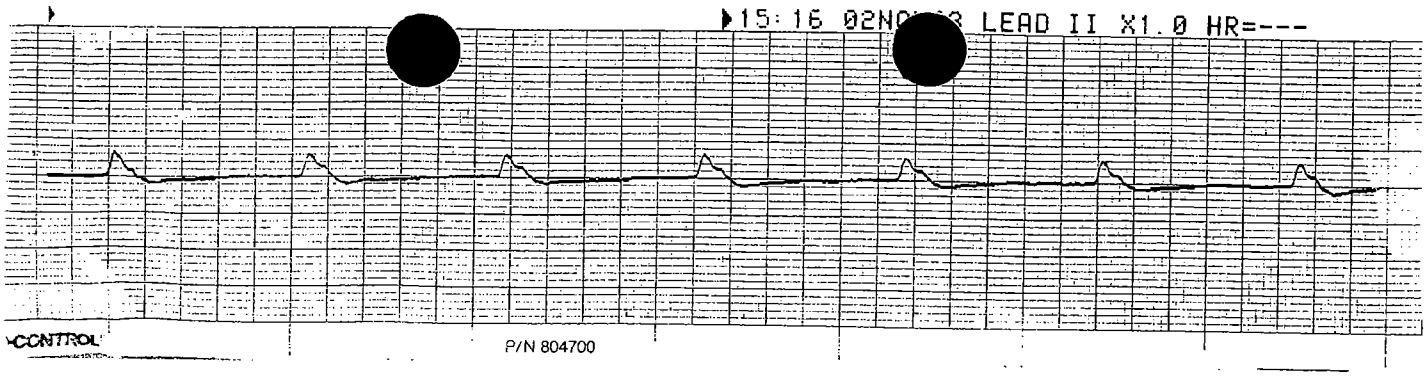
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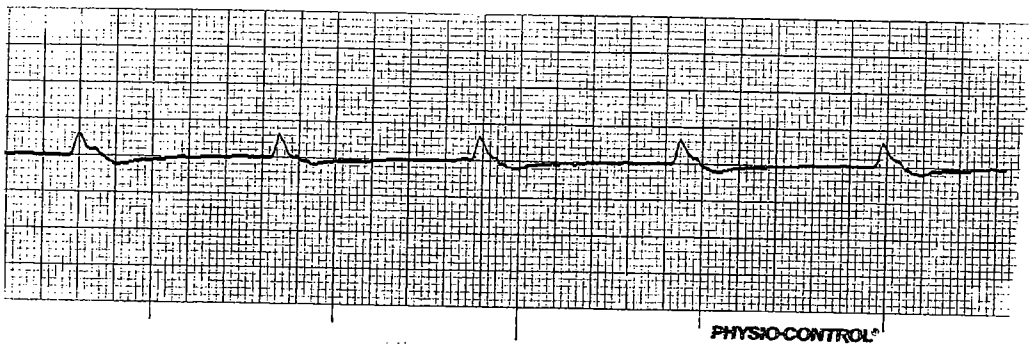
P/N 804700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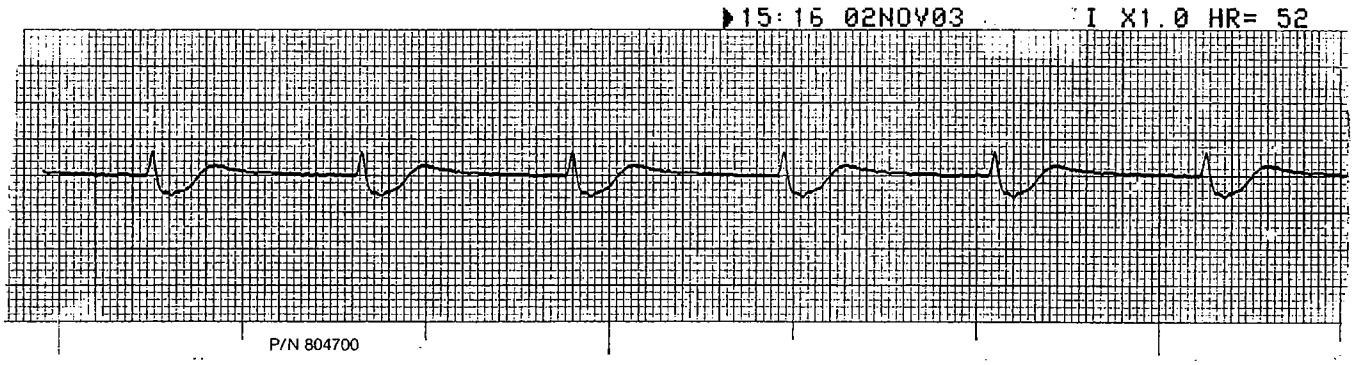
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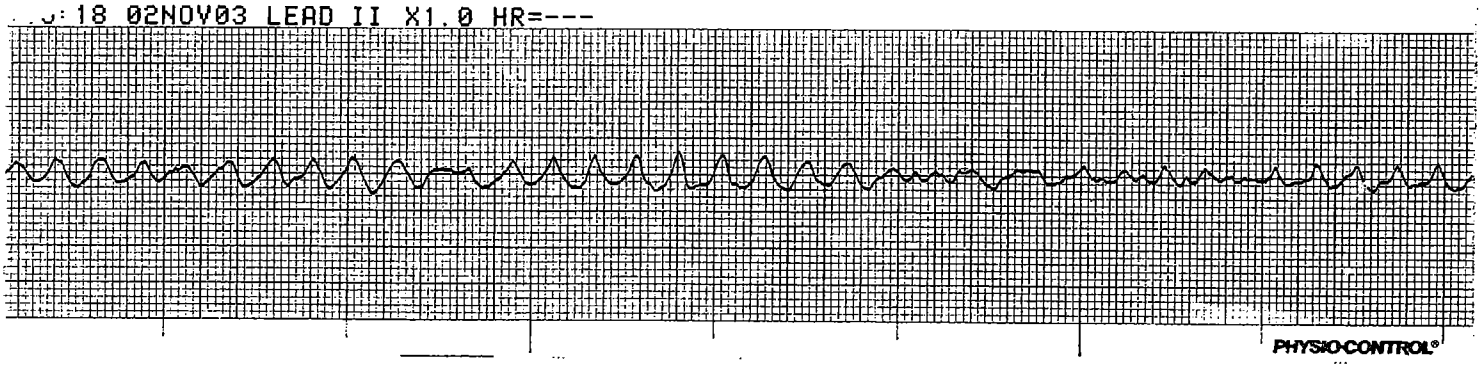
18 02NOV03 LEAD II X1.0 HR=---
PHYSIO-CONTROL®

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: 31 Oct 03 Returned @ 1910 [redacted] (b)(6)-2

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 31 Oct 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN/Print: Dr. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

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 [redacted]

DATE VERIFIED 31 Oct 03

TIME VERIFIED 1826

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
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 03, Nov 03

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 31 Oct 03

(b)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED [redacted]

AT *(Hour)* 1848 2040 ON *(Date)* 31 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 [redacted]

2nd [redacted]

PRE-TRANS [redacted]

TEMP. 36.2 PULSE 123 BP 101/41

DATE OF TRANSFUSION 31 Oct 03 TIME STARTED 2030

POST-TRANSFUSION DATA

AMOUNT GIVEN all ML

TIME/DATE COMPLETED/INTERRUPTED 31 Oct 03 2050

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 36.0 PULSE 125 BLOOD PRESSURE 102/40

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)*

SIGN [redacted] CRNA

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

SEX M WARD EMT

[redacted]

(b)(6)-1

BLOOD OR BLOOD COMPONENT TRANSFUSIO

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.201-1

MEDCOM - 22680

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 u ML

REMARKS: Informed @ 1910 31 Oct 03 GS

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 31 OCT 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GS W

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 VERIFI[redacted]

DATE VERIFIED 31 OCT 03

TIME VERIFIED 1826

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR

ABO A

Rh POS

RECIPIENT

ABO A

Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONEN[redacted] REQUESTED

DATE 31 Oct 03

REMARKS: EXP 03 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* [redacted] ON *(Date)* 31 Oct 03

IDENTIFICATION 2105 GS

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 the Transfusion Form and on the patient identificati[redacted]

1st VERIFIED [redacted]

2nd [redacted]

PRE-TR[redacted]

TEMP. 35.9 PULSE 120 BP 88/44

DATE OF TRANSFUSION 31 Oct 03

TIME STARTED 2100

POST-TRANSFUSION DATA

AMOUNT GIVEN all ML

TIME/DATE COMPLETED/INTERRUPTED 31 Oct 03 2115

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
35.9	116	92/50

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)*

SIGNAT[redacted] CNA/MAB

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

#[redacted]

(b)(6)-4

(b)(6)-2

(b)(6)-2

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 - 22681

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
- [ ] CROSSMATCH

DATE REQUESTED 10/31/03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE

GoSkl

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 10/31/03

TIME VERIFIED 2259

(5)(6)-2

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]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUE[redacted]

DATE 31 OCT 03

REMARKS:

ex 3 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECT[redacted] *(Signature)*

AT *(Hour)* 233[redacted] ON *(Date)* 31 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.

[redacted] CPT /[redacted]

[redacted] TAW

TEMP. 96.7 PULSE 150 BP 94/59

DATE OF TRANSFUSION 31 Oct 03

TIME STARTED 2340

POST-TRANSFUSION DATA

AMOUNT GIVEN 1U ML

TIME/DATE COMPLETED/INTERRUPTED 31 Oct 2350

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 96.7 PULSE 147 BLOOD PRESSURE 107/64

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] CPT /[redacted]

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

(5)(6)-2

SEX M

WARD CU

[redacted] (5)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

MEDCOM - 22682

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: 1

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

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED NOW 10/31/03

DATE AND HOUR REQUIRED NOW

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]

DIA[redacted] PROCEDURE GSK1

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 10/31/03

TIME VERIFIED 2259

SECTION II – PRE-TRANSFUSION TESTING

[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]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQU[redacted] DATE 31 OCT 03

REMARKS: ex 3 Nov 03

(b)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 2334 [redacted] ON *(Date)* 31 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] CTT/AN

[redacted] ILT/AN

TRANSFUSION TEMP. 96.7 PULSE 148 BP 101/58

DATE OF TRANSFUSION 31 OCT 03 TIME STARTED 2353

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN 450 ML

TIME/DATE COMPLETED/INTERRUPTED 1 NOV 0030

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 97.2 PULSE 146 BLOOD PRESSURE 98/62

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] ILT/AN

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

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

MEDCOM - 22683

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 1 NOV 03

DATE AND HOUR REQUIRED STAT

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]

DIAGNOSIS OR OPERATIVE PROCEDURE [redacted]

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

DATE VERIFIED 1/18

TIME VERIFIED

(b)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. 1188

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compat

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 1 Nov 03

DONOR	RECIPIENT
ABO A	ABO A
Rh pos	Rh pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS:

exp 3 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 192[redacted] ON *(Date)* 1 Nov 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2[redacted]

PR[redacted]

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE PULSE BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE

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

[redacted]

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 22684

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

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

DATE VERIFIED: 5/12

TIME VERIFIED

VOLUME REQUESTED *(If applicable)*: 1 U ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

(b)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	comp

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGN[redacted]ERSON PERFORMING TEST [redacted]

DONOR	RECIPIENT
ABO: A	ABO: A
Rh: pos	Rh: pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUES[redacted]

DATE 1 NOV 03

REMARKS: ex 3 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPEC[redacted]

AT *(Hour)* [redacted] ON *(Date)* 1 NOV 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

[redacted] *(Signat[redacted]*

TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE

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

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 22685

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 Unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 1 Nov 03

DATE AND HOUR REQUIRED STAT

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]

DI[redacted]GNOSIS OR OPERATIVE PROCEDURE [redacted]

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 page

DATE VERIFIED 5/18

TIME VERIFIED

(b)(6)-2

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQU[redacted]

REMARKS: et 3 Nov 03

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SI[redacted]FORMING TEST [redacted]

DATE 1 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 1926 ON *(Date)* 1 Nov 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd V[redacted]

TEMP. [redacted] PULSE [redacted] BP [redacted]

DATE OF TRANSFUSION

TIME STARTED

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE

PULSE

BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE

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

[redacted] (b)(6)-7

SEX M

WARD ICU

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 - 22686

Medical Record Copy

NSN 7540-00-634-4159

518-124

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

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

VOLUME REQUESTED (If applicable) 1 u ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 1 Nov 03

DATE AND HOUR REQUIRED STAT

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]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to Rectum [redacted]

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

DATE VERIFIED 1 Nov 03

TIME VERIFIED 518

(b)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH
[redacted]	PATIENT NO.	NA	Comp
DONOR ABO: A	RECIPIENT ABO: A		
DONOR Rh: pos	RECIPIENT Rh: pos		

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: or 3 Nov 03

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 1 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTOR [redacted] (Signature)

AT (Hour) 1930 ON (Date) 1 Nov 03

IDENTIFICATION

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

1st VERIFIER [redacted]

2nd VERIFIER [redacted] T/TW

PRE-TRANSFUSION [redacted]

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

TEMPERATURE PULSE BLOOD PRESSUR

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 Ba

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

[ ] NO [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE

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 1

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSF

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 2(

Medical Record Copy

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.
Icu I		

DATE OF ORDER: 31 OCT TIME OF ORDER: 2150 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ICU
S/P diverting colostomy / suprapubic tube
Perineal drainage
Critical
VS - Q2°
Act - Bed rest
Diet - NPO

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Nursing - I&O + Outs / Central line per routine / Suprapubic tube to SSD / JP to bulb / perineal to gravity / NGT to LCWS
IVF - D5 1/2 NS 120 KCL @ 125 cc/hr
Meds - Ancef 1 gm IV Q8 x 48 hrs
Gentamycin 360 mg IV QD x 48 hrs

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Flagyl 500 mg IV Q6 x 48 hrs
MSO4 100 mg in 100 cc @ 10 cc/hr
Versed drip 1-5 mg/hr titrated to sedation
Atrovent neb, 5 cc in 3 cc NS Q4°
NS @ 40 cc/hr via Dawal in suction to other end

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Labs -
CBC, SMA-10, PT/PTT
ABG in ICU now + 6AM
Send Tc-800 K-14 FiO2-100%
Pump S -
Wean FiO2 to keep sats 79%

[redacted] (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 [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	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]	31 OCT 03 — 2245 HOURS Transfuse 2 units PRBC over 1° each [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	DATE [redacted] OF ORDER 1 NOV — 0100 HOURS ✓ Hydrocortisone 50 mg IV ~~X~~ T ↑ PEEP 8 ✓ ✓ CXR - done Bolus 500cc ~~X~~ T CVP now [redacted]	[redacted]
[redacted]		
NURSING UNIT / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	DATE [redacted] TIME OF ORDER 1 NOV 03 — 0130 HOURS Album 50cc bolus ~~Albuterol neb .5cc~~ [redacted]	
[redacted]		
NURSING UNIT / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	D[redacted] OF ORDER NOW — 0230 HOURS Albuterol neb .5cc in 3cc NS Q4 [redacted] H.O of [redacted] 1 LT. [redacted] 250 NS boluses	
[redacted]		
NURSING UNIT / ROOM NO. / BED NO.		
2ND done [redacted] T 01 NOV 03 [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]

(5)(6)-7

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 NOV 03 TIME OF ORDER: 0423 HOURS

V.O. Dr [redacted] / LT. 9

[redacted]

① Neosynephrine drip 10 mcg/min titrate to effect.

[redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 NOV 03 TIME OF ORDER: 0615 HOURS

5% Albumin 500cc IV x 1 over 1. Transcribed from chart.

[redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Nov 03 TIME OF ORDER: 0900 HOURS

1) ABG q 10
2) 2 Amps Sodium Bicarb IV done
3) Warm long IVP in for Warm drip 7 mg/L
4) T Not UP done
5) CBC, ABG now done
6) 1 Amp bicarb [redacted] done

Addl 2 Amps Sod Bic

[redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

[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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Nov — TIME OF ORDER: 1053 — HOURS

(1) 2 Amps Na HCO3 1
VO Dr [redacted] CPT [redacted]
(2) 1L 5% Albumin @ 125 cc/hr
VO Dr [redacted] / CPT [redacted]
[redacted]

LIST TIME ORDER NOTED AND SIGN: Noted @ 1054 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

2 Amps Bicarb [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Nov 03 — TIME OF ORDER: 1235 — HOURS

V.O. Dr [redacted]
Epinephrine drip titrate to MAP 765
[redacted] Mag/Ave

VOID

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Nov 03 — TIME OF ORDER: 1250 — HOURS

(1) Wean ep to .15 mcg/kg/min if SBP 790 wean Neo to off
(2) 1 amp CaCl
(3) 1 amp epi
(4) Bolus 1L NS
} 10 x 1

done

[redacted]

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU[redacted] 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]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 Nov — TIME OF ORDER: 1530 HOURS — LIST TIME ORDER NOTED AND SIGN

(P) Amp Nalline

VO Dr [redacted] CP [redacted]

(2) 40 mEq KCl in 500 cc NS VO Dr [redacted] [redacted]

1 Nov 1700 noted [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 Nov — TIME OF ORDER: 1730 HOURS

(1) 1L 5% Alb over 1° [redacted]

VO Dr [redacted] / CPT [redacted]

noted [redacted] 1800

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11/1/03 — TIME OF ORDER: HOURS

Neo Epi @ 0.5cc every 10 MAP > 65

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11/1/03 — TIME OF ORDER: 1930 HOURS

40 meq/KCl in 100 cc NS over 1° VO Dr. [redacted]

Lt. [redacted]

[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]

(5)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 NOV 03 TIME OF ORDER: 23 13 HOURS

LIST TIME ORDER NOTED AND SIGN

V.O. Dr. [redacted] LT [redacted]

① ~~20 KCL in 50 cc/NS inj~~

② 1gm magnesium sulfate

[redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

2 Run Zemeghel in normal Ringer lactate IF K < 3.5 Give 2 additional KCl Run ABG 1

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

2iV 11/2/03 0145 [redacted] ~~LT/RV~~ [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS

V.O. Dr. [redacted] / LT [redacted]

Δ IVF to LR @ 125 cc/hr.

1L LR Bolus: keep CVP 7/12. If no response 500cc LR then ↑ epi to keep MAP 70-85.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

V.O. Dr. [redacted] / LT

[redacted] Dobutamine Drip.

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

2-(5)(6)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Surgery

1 Nov 03 — Patient post-op day 1 s/p diverting colostomy, perianal drainage

1300 — Afebrile HR 140 150 BP 60-90 SBP on NEO SATS - 98%

Vented SIMV 50% 800 14 PEEP 10

Pulmonary - Vented c A-A gradient

ABG 7.36 / 38.2 / 71 / 22 / 95% BE -4

lungs for wheezes RTC

Cardiac - Tachycardic despite good CVP (13-14)

Poor peripheral perfusion but good UO

Started on Epi drip + weaned off NEO.

GI - Ostomy dusky but viable, no air in bag

NGT in place, NPO

Renal - Good UO ~200 cc/hr BUN - 10 Cr 1.1

ID - No fevers WBC 2.9 on Cefuroxime / Flagyl day 2/3

Heme - Hct stable, no evidence of active bleeding

~~15.9~~ / 45.3 231 stable platelets

Nutrition - NPO - will start TF when air in ostomy

- Plan OR for washout tomorrow - may hold off til Monday if clinically does not improve

[redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted]

(b)(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

2 Nov 03 — 2210 HOURS

Admit to ACU

S/P Debridement Perineum / open abd

Critical

VS - Q1°

Act - Bed Rest

Diet - NPO

D5 1/2 NS + 20 KCL @ 125 cc/hr

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

MEDS: Amcy 1 gm IV ~~Q~~ HOURS

Gentamycin 360 mg IV QD

Flagyl 500 mg IV Q8

Epinephrine drip } titrate to

Neosynephrine drip } SBP 790

~~Also~~ Versed drip titrate to sedation

. Albuterol / Atrovent nebs Q4°

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

CBC, Chem 7, ABG in ICU @ Noon

JP to bulb sxn, JP in open abd to cont. wall sxn,

Wet to dry to perineum BID

Duval drain - Resume prior orders

Vent - SIMV 14 .75% PEEP-8 800

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

A-line / Central line per routine HOURS

Suprapubic drain to SBD

[redacted] (b)(6)-2

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2
31 Oct	[redacted]	VS q 2°	06	[redacted]		
			18	[redacted]		
31 Oct	[redacted]	Diet BR	06	[redacted]		
			18	[redacted]		
31 Oct	[redacted]	Diet - NPO	06	[redacted]		
			18	[redacted]		
31 Oct	[redacted]	Nursing I&O's / central line per routine / Suprapubic tube to straight bag drainage / JP to bulb / penrose to gravity NGT to LWS	06			
			18	[redacted]		
31 Oct	[redacted]	CBC, SMA-10, PT/PTT	04	[redacted]		
31 Oct	[redacted]	Vent = TV-800, R-14, 100% FiO2, Resp 58 wean FiO2 + Resp Sets >95% ↑ R-18	06	[redacted]		
			18	[redacted]		
01 Nov	[redacted]	CVP monitoring	06	[redacted]		
			18	[redacted]		
01 Nov	[redacted]	ABG Q 1°	06	[redacted]		
			18	[redacted]		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: diverting colostomy / suprapubic tube / perineal drainage

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Admit to ICU / critical				
	----	ABG in ICU now /				
	----	ABG in AM @ 06	1Nov	06		(b)(6)-2
	----	CXR X1	Now	01 Nov	0400	[redacted]
01Nov	[redacted]	CBC, ABG NOW	01Nov	01Nov	0900	done
	--(b)(6)-2					

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

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3
3/04	[redacted]	IVF: D5/2NS c̄ 20K @ 125 c/hr	06	[redacted]			
			18				
3/04	[redacted]	Ancef 1gm IV q8° X 48hr	06	[redacted]			
			14				
			22				
3/04	[redacted]	Gentamycin 360 mg IV QD X 48°	QD	[redacted]			
			8				
3/04	[redacted]	Flagyl 500 mg IV q6°	06	[redacted]			
			12				
			18				
			24				
3/04	[redacted]	MSO4 100 mg/100 cc @ 10 c/hr	06	[redacted]			
			18				
3/04	[redacted]	Versed gtt 1-5 mg/hr titrate to sedation	06	[redacted]			
3/04	[redacted]	Atrovent nebs 15 cc/3cc NS q4°	4	[redacted]			
			8				
			12				
~~01 NOV~~	[redacted]	~~Allo. nebs 15cc/3cc~~	16	[redacted]			
		~~NS~~	20				
			24				

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: diverting colostomy / suprapubic tube perineal drainage

PATIENT IDENTIFICATION:

[redacted] (5)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

DA FORM 1 FEB 79 4678

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 11 Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31Oct	[redacted]	Trimstura 2U PRBC over 1° each (1)	31Oct	2300	2315	[redacted]
31Oct	[redacted]	~~Hydrocortisone~~ (2)	↓	2300	2345	[redacted]
31Oct	[redacted]	Hydrocortisone 50mg IV X1	31Oct	0100	0115	[redacted]
01 Nov	[redacted]	Bolus 500 cc NS	31Oct	2300	2300	[redacted]
01 Nov	[redacted]	Bolus 1000 cc NS	1 Nov	2330	2330	[redacted]
01 Nov	[redacted]	Bolus 1000 cc NS	1 Nov	0030	0030	[redacted]
01 Nov	[redacted]	Bolus 500 cc NS	1 Nov	0100	0100	[redacted]
01 Nov	[redacted]	Albumin 5% 500 cc bolus X1	01 Nov	0130	0300	[redacted]
01 Nov	[redacted]	Albumin 5% in 500 cc NS X1	01 Nov	0615	0700	[redacted]
01 Nov	[redacted]	2 Amps Sodium Bicarb.	01 Nov	0900	done	[redacted]
01 Nov	[redacted]	Vecuronium 10mg IVP now	01 Nov	0900	done	[redacted]
01 Nov	[redacted]	1 Amp Cal. Chloride	01 Nov	0900	done	[redacted]
01 Nov	[redacted]	2 Amp Sodium Bicarb	01 Nov	0900	done	[redacted]

Order/ Expir. Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED

(7/6-2)

(7/6-2)

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4
1 Nov	[redacted]	NS @ 40 cc/hr via	06	[redacted]				
	[redacted]	darvon c̄ suction to	18	[redacted]				
		other end						
01 Nov	[redacted]	Alb. Neos .5–3cc NS	4	[redacted]				
		Q4	8	[redacted]				
			12	[redacted]				
			16	[redacted]				
			20	[redacted]				
			24	[redacted]				
01 Nov	[redacted]	Neo drip 100mg/	06	[redacted]				
		min titrate to	18	[redacted]				
		effect.						
01 Nov	[redacted]	Vecuronium drip	06	[redacted]				
		7mg/L	18	[redacted]				
1 Nov	[redacted]	Epi drip wean epi to	06					
	[redacted]	.15 mcg/kg/min if SBP > 90	18			D/Cd		
		wean neo to off						
1 Nov	[redacted]	Epi drip wean 0.5cc	06	[redacted]				
		q1H to keep MAP	18	[redacted]				
		765						

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
01 Nov	[redacted]	2 Amps. Na. HCO3	01 NOV 03	NOW	1054	[redacted]
1 Nov	[redacted]	1L 25% Albumin @ 125 cc/hr	1 Nov	now	0900	[redacted]
1 Nov	[redacted]	2 Amps Na HCO3			done	[redacted]
1 Nov	[redacted]	1 amp Ca Cl	1 Nov	done		[redacted]
1 Nov	[redacted]	2 amp epi	1 Nov	done		[redacted]
1 Nov	[redacted]	1L NS Bolus	1 Nov	done		[redacted]
1 Nov	[redacted]	1 amp Na HCO3	1 Nov	done		[redacted]
1 Nov	[redacted]	40 mEq KCl in 250 cc NS	1 Nov	1500		[redacted]
1 Nov	[redacted]	1L 5% Alb over 1°	1 Nov	1800		[redacted]
1 Nov	[redacted]	40 mEq KCl in 100 cc NS over 1°	1 Nov	2200	2200	[redacted]
2 Nov	[redacted]	40 mEq KCl in 150 cc NS	Nov 2	done	done	[redacted]
2 Nov	[redacted]	40 mEq KCl in 100 cc NS (Not given)	Nov 2	~~done~~		[redacted]
2 Nov	[redacted]	1 gm. Mg+	Nov 2	done		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
- - - - -	- - - - -															
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USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: _____ UNIT: _____

MED COM: [Y] [N] _____

ARRIVAL STATUS

TIME _____ ☐ IV x _____ ☐ O_2 _____ 1/min ☐ C-Spine Immob

Meds: ☒ UKN ☐ None ☐ Yes: _____

Allergies: ☒ UKN ☐ None ☐ Yes: _____

Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake _____ hrs

LMP: _____ ☐ _____

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☐ ETT _____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☒ Unlabored ☐ Absent

TRACHEA: ☒ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] >=< [R]

CIRCULATION

PULSE: ☒ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warn ☐ 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 ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☐ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: _____

PELVIS

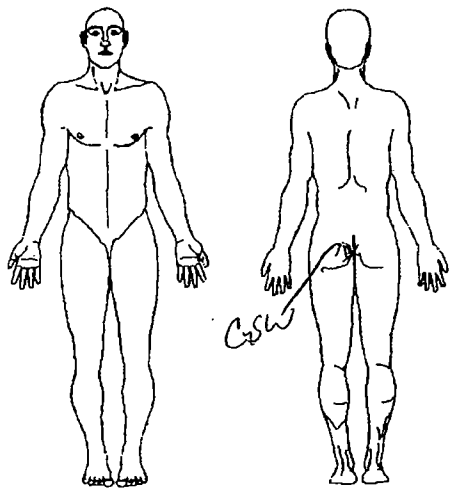
☐ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

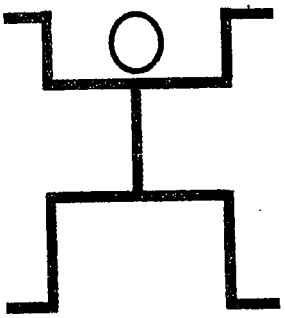
Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN: LT [redacted] (5)(6)-2

PHYSICIAN: Dr. [redacted]

(Continue on reverse)

PREPARED BY *(Signatur*: SGT [redacted]

DEPARTMENT/SERVIC: EMT [redacted]

DATE: 31 Oct 03

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

[redacted]

(5)(6)-7

☐ HISTORY/PHYSICAL (5)(6)-2 ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
1822	ET Intubation	8.0	☒ Oral ☐ Nasal Teeth	DR. [redacted]	☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
1828	Gastric Tube	18 Fr.	☐ Oral ☒ Nasal	SOC [redacted]	☐ Air ☐ Contents Verified_____ Suction: Y N
1845	Urinary	16 Fr	☐ Meatus ☐ Supra-Public	DR. [redacted]	☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed	(5)(6)-2	☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	%O_2	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☒ Chem ☒ PT/PTT
	☐ ETOH ☒ T&S ☒ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☒ Pelvis
	☐
	☐
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
0w	1	18	Y	N	(R) AC			
1814	2	18	Y	N	(R) AC			
1825			Y	N	Central Line (R) shoulder			
			Y	N				

MEDICATIONS

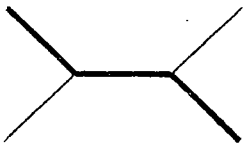
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Hrcrd	1g	18.6							
Tet.	.5	1816							
Fentnyl	100	1816							
Succ	100	1820							
Lidocaine	100	1826							
Etomidate	20	1825							
Vet	10	1825							
Gent	80	1846	IVP						
Folgal	500	1846	IVP						

BLOOD PRODUCTS

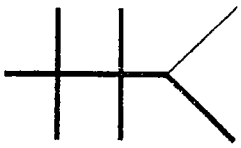
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

Accompanied By _____

☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

MEDCOM - 22703

VITAL SIGNS

Rectal Temp:

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
1810	149/118	135									
1818	129/56	125									
1826	170/69	136									
1834	144/54	134									
1842	145/52	141									
	/										
	/										
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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

[RAQ] Male s/p GSW to Brachiocephalic ⓒ ⓓ
exit @ Right Acetabulum. Active Bleeding from
wound. ⓑ Pulsed / Diminished / Guarding of Abd.
VS initially tachy to 130's, BP hold 140's / 50's
Qx: Reg / tpb ⓑ ⓜ
Hx: ⓑ wheezing ⓑ ⓛ ⓛ Rhonchi, ⓛ clear.
Ex: Pulses x4.

Medical chart Reviewed

[redacted]

(b)(6)-2

☆U.S. GOVERNMENT PRINTING

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

(b)(6)-2

	TIME	INTILAS	2130	INTILAS [redacted]	INTILAS
NEURO	PUPLIS		2mm sluggish		
	SENSORIUM		arousable but		
			mildly sedated		
			from OR. Follows		
			simple commands		
RESPIRATORY	RESPIRATION PATTERN		Vent: RR 16 Fio2 100		
	BREATH SOUNDS		PIP 41 TV 800 PEEP		
	SECRETIONS		8. Sat 92-98%.		
			Exp. wheezes > R.		
			Expansion Equal		
			BE. moderate secretion		
SKIN	COLOR		NFR.		
	INTEGRITY		Abd. incision		
IV SITE	LOCATION		1. Cordis (R) subclav & TLC ⇒ CVP		
	CONDITION		2. 18g (R) ac		
			3. 18g (L) AC	31 OCT	
			(L) A-line (R) rad		
			All site C/D/I & NO S/S of		
			infection.		
GASTRO	ABDOMEN		soft. Incision mid abdomen.		
	BOWEL SOUNDS		Colostomy: site dry		
			BS hyperactive. Jarvit drain PR		
GU	URINE		suprapubic catheter 70cc/hr		
	COLOR/CLARITY		yellow		
CARDIOVASCULAR	CARDIACRHYTHM		ST 130-150 / BP 70-90/50-60		
			ectopy.		

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

PREPARED BY *(Signature & Title)*

(Continue on reverse)

DEPARTMENT/SERVICE/CINC ICU1 | DATE 31 OCT 03

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	21	22	23	24	01	02	03	04	0	05	08	09	10	11	12	13	14	15
TIME	21	22	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line				110/59	74/54	82/54	95/53	89/53										
BP Cuff	107/59	138/69	103/56															
Temperature	92.3	95.4	96.9	97.1	97.2	96.4	97.2	98.1										
Pulse	133	131	145	152	153	143	144	140										
Respiratory Rate	14	27	36	16	14	18	14	14										
SaO2	95	98	97	89	93	93	90	93										
Source	vent	vent	vent	vent	vent	vent	vent	vent										
FiO2	100	100	100	100	100	100	100	100										
MAP	79	82	79	67	60	65	70	65										
PEEP	5	5	5	8	8	8	8	8										
PIP	34	37	39	36	38	41	38	39										
CVP																		
	21	22	23	24	01	02	03	04										

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
MIVF	125	125	125	125	125	125	125	125										
IVPB					50	—												
Bolus		1000	1000	—	1000	—	—	—										
MSO4	5	5	5	5	5	5	5	2										
Versed	5	5	5	5	5	5	5	2										
CVP					11	14	10	10										
Albumin							250											
TOTALS																		

OUTPUT		21	22	23	24	01	02	03	04	0	05	08	09	10	11	12	13	14	15
Supra-pubic cath URINE	HOUR			700	90	90	70	90	80	200	200								
	TOTAL			700	790	880	950	1040	1120	1320	1520								
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP			200	—	—	—	60											
	Dainoi									300									
Nasal suct										200									
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

16 17 18 19 20 21 22 23

INTAKE

16 17 18 19 20 21 22 23 8°T

OUTPUT

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									

ACTIVITIES DAILY LIVING

TIME			
MOUTH CARE			
BATCH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN SUCTION

TIME									

24°180 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

(b)(6)-2

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

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

INITIAL SUMMARY ASSESSMENT

NEURO	TIME	1000	INTIALS		INTILAS	1800	INTIALS
	PUPLIS	PERRLA 3mm sluggish				PERRLC 2mm sluggish
	SENSORIUM	Ø spont movement				medically paralyzed
		Vec-7mg/hr, MSO4-2,				@ vec. 7mg/hr, MSO4-2
		Versed-2,				versed-2.
RESPIRATORY	RESPIRATION PATTERN	ETT #8.5, 26.5@ hub				ETT #8.5, 26.5@ hub
	BREATH SOUNDS	SIMV-14, P-10, 50% FiO2				SIMV-14 P-7 Fio2-50
	SECRETIONS	TV-800, PIP-30,				TV-800, PIP-30
		Ø secretions, 95%				Bloody nosbleeds
		currently managing vent				97% SaO2.
		status				
SKIN	COLOR	normal for race				NFR. cool to
	INTEGRITY	Perineal pressure to gravity				touch. (T) 95°F.
		Parvon @ 40cc/hr to suction				
IV SITE	LOCATION	(R) SC 3cc @ cordis				(R) SC 3cc cordis
	CONDITION	(R) rad Aline				(R) AC 18g
		(R) PIV				(R) Rad A-line
		Ø S/S of infxn				(R) cordis. sub-cla.
						Ø S/S infection
GASTRO	ABDOMEN	midline ab incision CDI				midline incision CDI
	BOWEL SOUNDS	Colostomy Stoma beefy				colostomy stoma - red
		red. bloody drainage				BS hypo - active x4
		smell ant. hypo BSx4 qrd				
GU	URINE	suprapubic cath				suprapubic catheter
	COLOR/CLARITY	clear light yellow adequate				@ clear yellow urine
		out				200cc/hr
CARDIOVASCULAR	CARDIACRHYTHM	ST 150's, Neo titrate to				ST 140's-150's. Neo
		MAP 65, CVP-10's,				to keep MAP 65, EPI
	S/.	albumin @ 125cc/hr				to keep MAP 65
		D5½NS @ 125cc/hr				D5½NS @ 125cc/hr.

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 ICU | DATE 1 NOV 03

PATIENT'S INDICATIONS *(For typed or written entries give: Name — Last, First, middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIGNOSTIC STUDIES

☐ TRETMENT

[redacted]

DATE	DX													HOSPITAL DAY			
	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
VITAL SIGNS																	
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial line	68/45	85/64	82/57	101/59	87/50	91/42	75/44	101/63		91/59	90/48	99/50	93/44	101/46	50/27	95/57	93/63
BP Cuff		112/67															
Temperature		98.4			96.7	96.7		96.5		95.8	95.9	96	95.8	95.8	95.6	95	
Pulse	130	148	153	147	152	155	148	138		145	143	139	140	136	127	119	131
Respiratory Rate	14	14	14	18	18	17	14	14		14	14	14	14	14	14	18	18
SaO2	98	100	100	100	97	99	100	99		100	100	100	100	100	95	98	99
Source	V	V	V	V	V	V	V	V		V	V	V	V	V	V	V	V
FIO2	85	85	85	50	50	50	50	50		50	50	50	50	50	50	100	100
MAP	52	75	68	74	69	63	67	79		72	62	65	62	69	35	72	71
CVP	11	15	10	15	10	11	16	16		13	11	10	9	13	12	13	24
INTAKE																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
MIVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB	100				100				250	150		250						
Versed	2	2	2	2	2	2	2	2	16	2	2	2	2	2	2	off	off	12
MSO4	2	2	2	2	2	2	2	2	16	2	2	2	2	2	2	off	off	12
Bolus				100						100					1000	1000	—	3000
Blood																		
Darrow	40	40	40	40	40	40	40	40	—	40	40	40	40	40	40	40	40	320
Albumin 5%			50	125	125	125	500	125	1500					600				1000
neo	12.5	12.5	12.5	12.5	25	25	25	25	150	25	5	5	5	5	7.5	off	off	30
Epi								13	13	1	1	1	1	1	1	2.5	2.5	11
Vec																7	7	14
TOTALS									2945									
OUTPUT																		
URINE — HOUR / TOTAL	200	70	200	250	200	200	220	120	1620	450	200	450	250 / 1600	160	250	220	200	2700
URINE — SP gr																		
URINE — S/A																		
NG — OUTPUT																		
NG — PH																		
NG — GUIAC																		
EMESIS																		
STOOL																		
DRAINS — JP			30						30				30					30
DRAINS — Darrow					200				—				200					250
DRAINS									1650									
TOTALS								(+ | 1295)									

[redacted]

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05
	18	17	18	19	20	21	22	23
	113/57	85/47	75/51	78/46	116/58	110/63	100/60	72/57
	99/80	88/52	85/49					
	98.7	99.3	99.7	100.1	100.1	100.2	99	99.2
	144	146	143	149	157	160	159	157
	18	18	18	18	18	16	16	16
	100	100	100	100	100	100	96	98
	V	V	V	V	V	V	V	V
	100	60	55	50	50	45	50	55
	72	61	59	57	79	81	81	67
	17	15	14	14	82	11	11	12
	22	23	24	01	02	03	04	05

INTAKE	18	17	18	19	20	21	22	23	8°T
	D5	D5	D5	D5	D5	D5	D5	D5	
	50	50	50	—	—	—	—	—	
	off	off	off	off	off	off	off	off	
	off	off	off	off	off	off	off	off	
	—	—	—	—	—	—	1000	—	
	1800	—	—	—	—	—	—	—	
	40	40	40	40	40	40	40	40	
	—	—							
	off	off	off	off	off	off	off	off	
	2	1.5	1	1	1	.5	.5	.5	
	7	7	7	7	7	7	7	7	

OUTPUT								
	300/800	300/600	350/950	300/850	300/150	360/910	300/210	260/1170

ACUITY LEVEL CLASSIFICATION 630

RESPIRATORY DATA											
TIME		09	10	11	12:00	15	16		18:42	1935	20
MODE		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
F_IO_2		80	50	50	50	50	50	50	50	50	10
TV		800	800	800	800	800	800	800	800	800	
RATE		14	18	14	14	14	14	14	14		
PEEP		8	8	10	10	10	10	7	7		
ABG	pH	7.19	7.39	7.36	7.36	7.30	7.33		7.30	7.165	7.2
	PCO_2	42	31.4	37.8	38.2	36	57.4		41.5	48.7	4
	pO_2	240	59	74	71	129	181		84	60	21
	HCO_3	16	18	21	22	18	20		21	18	2
	SAT	100	92	95	93	99	100		95	86	10
	BASE	-12	-7	-4	-4	-9	-6		-6	-11	-5

LABORATORY DATA										
TIME	09									
CLUCOSE										
Na/K										
Cl/CO_2										
BUN/Cr										
WBC/PLATELET	5.6/231									
Hct/Hgb	11/35			26/9						

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

24°180 TOTALS

[redacted] TURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

[redacted]

(b)(6)-2

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1000	INTILAS [redacted]		INTILAS	1800	INTILAS [redacted]
NEURO	PUPLIS	3+ sluggish				2+ sluggish.	
	SENSORIUM	fully sedated				Paralyzed & sedated.	
						7mg/hr.	
RESPIRATORY	RESPIRATION PATTERN	BBS on the vent				Vent: RR 18 FiO2 65	
	BREATH SOUNDS	CTA & rattles				PEEP 8 TV 800 PIP 3	
	SECRETIONS	crackles on the				Ubases. movement	
		lung.				Equal. dim. bases	
		Bloody secretions				bloody secretions	
		from the nare				from nares.	
SKIN	COLOR	ecchymosis noted				Incisision to abd.	
	INTEGRITY	LE (feet) multiple				buttocks. Hemorrhagic	
		wounds, bottoms				blisters to feet.	
IV SITE	LOCATION	(R) & (L) carotids				R ac. (R) sub. (L) sub.	
	CONDITION	(L) LR open (Colum)				(L) rad.	
		(R) epinephrine drip				All sites CDI	
		LR @ 125				no sigs of infection	
GASTRO	ABDOMEN					Soft. BS hyperactive	
	BOWEL SOUNDS					JP drain. suprapubic	
						catheter.	
GU	URINE	IV NS flush SP tube				IV NS flush. Damm	
	COLOR/CLARITY	@ 40cc/hr. Foley				suprapubic cath. 40cc/hr	
		clear yellow/orange urine				urine.	
CARDIOVASCULAR	CARDIACRHYTHM	ST 147>				ST 130's. BP 90/48	
		↓ BP ~~to maintain~~				3+ Edema. Epi &	
		on epi drip to				neo drip to keep	
		maintain MAP 765				MAP 750.	

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 IC1

DATE 02 NOV 03

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	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial line	84/64	62/56	86/43	84/49	94/47			87/83		102/56	94/51	91/49	85/45	78/47	81/44			
BP Cuff		92/57	94/56	89/45	94/47	97/51	98/39	71/36										
Temperature	99	98.5	98	98.3		98°		96.6			97.0				98.3			
Pulse	154	149	147	147	144	144	141	132		134	136	133	129	129	128	128		
Respiratory Rate	16	16	16	16	16	16	16	16		16	16	16	16	18	18			
SaO2	98	97	97	94	95	95	95	92		96	93	94	91	91	93			
Source	V	V	V	V	V	V	V	V		V	V	V	V	V	V			
FiO2	55	55	55	55	55	55	55			55	55	55	55	65	75			
MAP	61	60	63	65	59	70	55	58		73	66	58	58	55	56			
CVP	11	15	13	16	15	13	20	15		15	16	15	15	12	10			
PEEP															10			

INTAKE																			
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
MIVF	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125		
IVPB	50					50							50					
Versed	off	—				—												
MSO4	off	—				—												
Neo	off	—				10	10	10	10					10	10			
Epi	.5	.8	.8	.9	1.0	1	1	1	1					1	1			
Vec	7	7	7	7	7	7	7	7	7					7	7			
NS grain	40	40	40	40	40	40	40	40	40	40				40	40			
Rehydrinit	—						Started	10.5						—	—			
LR			1000				1000							—	—			
albumin							~~125~~	~~125~~	125	125	125	125	—	—	—			
TOTALS																		

OUTPUT																			
URINE HOUR	150	160	200	160	130	120	70	70	100	100	200	100	100	130	50			
URINE TOTAL	150	310	510	690	820	940	1010	1080	1180	1280	1480	1580	1680	1810	1860			
URINE SP gr																		
URINE S/A																		
OGT ~~NG~~ OUTPUT													400					
OGT ~~NG~~ PH																		
OGT ~~NG~~ GUIAC																		
EMESIS																		
STOOL																		
DRAINS JP	40				60								30					
DRAINS Dsion	200																	
TOTALS																		

OR

PCA 2 code

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05

Expired

INTAKE	22	23	24	01	02	03	04	05	8°T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA													
TIME			00	1843									
MODE			SIM	SIMV									
F_IO_2			55	65									
TV			800	800									
RATE			16	18									
PEEP			7	8									
ABG	A	pH	7.357	7.356									
		PCO_2	37.5	41.2									
	B	pO_2	65	52									
		HCO_3	23	23									
	G	SAT	92	85									
		BASE	-2	-2									

LABORATORY DATA													
TIME			04										
CLUCOSE													
Na/K			140/4.9										
Cl/CO_2			114/										
BUN/Cr													
WBC/PLATELET			5.1/115										
Hct/Hgb			30.3/4.5										
PT/PTT			19.4/55										

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

TURN													
TIME													
SUCTION													

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

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

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE:

2. LOCATION OF RESUSCITATION EVENT

☒ MICU ☐ SICU ☐ CCU ☐ NICU ☐ ED ☐ PACU ☐ OR ☐ WARD: _____

☐ DIAGNOSTIC / PROCEDURE AREA: _____

☐ OUTPATIENT CLINIC: _____

☐ OTHER *(Specify)*: _____

3. WITNESSED ARREST?

☒ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?

☒ YES ☐ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) **COMMENTS**

☒ IV Access	☐ Time: ___:___	
☒ Endotrachael Tube	☐ Time: ___:___	
☒ Mechanical Ventilation	☐ Time: ___:___	N/A
☒ Arterial Line	☐ Time: ___:___	
☒ Central Venous Line	☐ Time: ___:___	
☐ Pulmonary Artery Catheter	☐ Time: ___:___	
☒ Nasogastric Tube	☐ Time: ___:___	
☐ Pacing Device *(Specify type)*: _____	☐ Time: ___:___	
☐ Implantable Defibrillator / Cardioverter	☐ Time: ___:___	
☐ Other *(Specify)*: _____	☐ Time: ___:___	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☐ Other: PSVT

6. RESUSCITATION ATTEMPTED

☐ YES *(Check all that were used)*
- ☐ Chest Compressions
- ☐ Defibrillation
- ☐ Airway Management

☐ NO *(Check one)*
- ☐ False alarm/arrest (BLS / ALS not needed)
- ☐ Do not attempt resuscitation (DNAR)
- ☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS
☐ Yes ☒ No

BREATHING
☒ Yes ☐ No Vent

PULSE
☒ Yes ☐ No

Site: _____

8. INITIAL RHYTHM PSVT

☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☐ Returned at: ___:___ ☐ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: ___:___

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☐ Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	___	___
CPR Started:	___	___
1st Defibrillation:	___	___
Airway Achieved:	___	___
1st Dose Epinephrine:	___	___
Code Team Called: ☐ Yes ☒ No	Time: 1900	___
Code Team Arrived: ☐ Yes ☐ No	Time: 1900	___

10. GLASGOW COMA SCALE

(Post-resuscitation)
Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
1 - No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
1 - No response

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
1 - No movement

SCORE: _____

PATIENT IDENTIFICATION

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

AGE: _____
GENDER: _____
HEIGHT (in): _____
WEIGHT (lbs): _____

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

NW

(5)(6)-4

EMERGENCY RESUSCITATION RECORD - PART 2

EPW [redacted]

	TIME (Hr/Min):	1920	1925	1935	2000	2010							
VITALS	BLOOD PRESSURE	64/33	67/23	103/52	95/58	100/57							
	HEART RATE (* = CPR)	160	154	128	119	126							
	RHYTHM	PSVT	PSVT	ST	ST	ST							
	PULSE PALPABLE (Y/N)	Y	Y	Y	Y	Y							
	DEFIBRILLATION (Joules: 200, 300, 360)	—	—	→	—	—							
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—	✓	✓	✓	—							
	PACING PERFORMED (✓)	—	200	300	360	—							
	RESPIRATIONS	16	18		14	14							
AIRWAY	BAGGED w / 100% O2 (✓)	—	—										
	INTUBATED (✓)	✓	✓										
	MASK (Specify type)	—	—										
	% OXYGEN	100	100	100	100	100							
	O2 SATS	97	95	92	98	100							
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	drip 5 mcg	~~II~~										
	ATROPINE (0.5 -1 mg - IV / ET tube)												
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)			~~II~~									
	HCO3	~~IIII~~											
	Blood					~~IIII~~							
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
LABS	POTASSIUM (K) 40 mcg					drip							
	GLUCOSE												
	CALCIUM (Ca)			T	1955								
	MAGNESIUM (Mg)				T								
ABGs	PH												
	pCO2												
	pO2												
	HCO3												

PHYSICIAN *(Signature & Title)* Dr [redacted] / Dr [redacted]

NURSE *(Signature & Title)* [redacted]

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(5)(6)-2

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: Nov 2

2. LOCATION OF RESUSCITATION EVENT

☑ MICU ☑ SICU ☐ CCU ☐ NICU ☐ ED ☐ PACU ☐ OR ☐ WARD: ICU#1

☐ DIAGNOSTIC / PROCEDURE AREA:

☐ OUTPATIENT CLINIC:

☒ OTHER *(Specify)*: ICU#1

3. WITNESSED ARREST?

☒ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?

☒ YES ☐ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) COMMENTS

☑ IV Access	☐ Time: :	
☑ Endotrachael Tube	☐ Time: :	
☑ Mechanical Ventilation	☐ Time: :	
☑ Arterial Line	☐ Time: :	
☑ Central Venous Line x 2	☐ Time: :	
☐ Pulmonary Artery Catheter	☐ Time: :	
☑ Nasogastric Tube	☐ Time: :	
☐ Pacing Device *(Specify type)*:	☐ Time: :	
☐ Implantable Defibrillator / Cardioverter	☐ Time: :	
☐ Other *(Specify)*:	☐ Time: :	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☑ Hypotension
☑ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☐ Other:

6. RESUSCITATION ATTEMPTED

☑ YES *(Check all that were used)*
- ☑ Chest Compressions
- ☐ Defibrillation
- ☑ Airway Management

☐ NO *(Check one)*
- ☐ False alarm/arrest (BLS / ALS not needed)
- ☐ Do not attempt resuscitation (DNAR)
- ☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS
☐ Yes ☑ No

BREATHING
☐ Yes ☐ No > M vent.

PULSE
☐ Yes ☑ No

Site:

8. INITIAL RHYTHM ☒ Agonal Rhythm

☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☑ Returned at: 20 : 15 ☐ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 20 : 15

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☐ Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	19	54
CPR Started:	19	55
1st Defibrillation:	N/A	N/A
Airway Achieved:	in	place
1st Dose Epinephrine:	running drip in place	

Code Team Called:
☑ Yes ☐ No Time: 19 : 54

Code Team Arrived:
☑ Yes ☐ No Time: 19 : 54

10. GLASGOW COMA SCALE

(Post-resuscitation)
Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
(1) No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
1 - No response (ETT)

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
(1) - No movement

SCORE: 2 ETT

PATIENT IDENTIFICATION

EPW [redacted]

(5)(6)-4

AGE:
GENDER: M
HEIGHT (in):
WEIGHT (lbs):

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Hr/Min):	1955	2000	2010	2014	2015	2016	2020					
VITALS	BLOOD PRESSURE	MAP↓40				178/65		149/51					
	HEART RATE (* = CPR)	60	CPR			146		136					
	RHYTHM	Agonal	Asyncl	Asyncl	vfib	ST		ST					
	PULSE PALPABLE (Y/N)	N	N	N	N	Y	Y	Y					
	DEFIBRILLATION (Joules: 200, 300, 360)	—	—	—	—	—	—	—					
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—	—	—	—	—	—	—					
	PACING PERFORMED (✓)	—	—	—	—	—	—	—					
	RESPIRATIONS	MV	—	—	—			MV 18					
AIRWAY	BAGGED w / 100% O2 (✓)	✓	✓	✓	✓	MV	—	MV					
	INTUBATED (✓)	in place	in place	in place	in place	in place	in place	in place					
	MASK (Specify type)	—	—	—	—	—	—	—					
	% OXYGEN	80	100	100	100	100	100	100					
	O2 SATS	40				96%	96%	96%					
								MV setting: SIMV RR 18 TV 800 peep 10 FiO2 100					
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)												
	ATROPINE (0.5 -1 mg - IV / ET tube)		1mg										
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
	D50			1 Amp									
	CaCl				1 Amp								
	BiCarb					1 Amp							
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
	Neo	20 mcg / min infusing prior											
	Dobutamine	N/A											
	epinephrine	1 mcg / min infusing prior											
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
							iStat						
ABGs	PH						7.35						
	pCO2						27						
	pO2						N/A						
	HCO3						15						
	BE						-10						

PHYSICIAN (Signature & Title): DR [redacted]

NURSE (Signature & Title): [redacted] CPT/ANN

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(5)(9)-2

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: 3 NOV 03

2. LOCATION OF RESUSCITATION EVENT

☐ MICU ☑ SICU ☐ CCU ☐ NICU ☐ ED ☐ PACU ☐ OR ☐ WARD: _____

☐ DIAGNOSTIC / PROCEDURE AREA: _____

☐ OUTPATIENT CLINIC: _____

☐ OTHER *(Specify)*: _____

3. WITNESSED ARREST?

☑ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?

☑ YES ☐ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) COMMENTS

☐ IV Access	☐ Time: ___ : ___	
☐ Endotrachael Tube	☐ Time: ___ : ___	
☐ Mechanical Ventilation	☐ Time: ___ : ___	
☐ Arterial Line	☐ Time: ___ : ___	
☐ Central Venous Line	☐ Time: ___ : ___	
☐ Pulmonary Artery Catheter	☐ Time: ___ : ___	
☐ Nasogastric Tube	☐ Time: ___ : ___	
☐ Pacing Device *(Specify type)*: _____	☐ Time: ___ : ___	
☐ Implantable Defibrillator / Cardioverter	☐ Time: ___ : ___	
☐ Other *(Specify)*: _____	☐ Time: ___ : ___	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☑ Myocardial Infarction or Ischemia
☐ Unknown
☐ Other: _____

6. RESUSCITATION ATTEMPTED

☑ YES *(Check all that were used)*
- ☑ Chest Compressions
- ☐ Defibrillation
- ☑ Airway Management

☐ NO *(Check one)*
- ☐ False alarm/arrest (BLS / ALS not needed)
- ☐ Do not attempt resuscitation (DNAR)
- ☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS ☐ Yes ☑ No

BREATHING ☐ Yes ☑ No

PULSE ☐ Yes ☑ No

Site: _____

8. INITIAL RHYTHM

☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☑ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☐ Returned at: ___ : ___ ☑ Never achieved

☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 00 : 54

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☑ Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	00	40
CPR Started:	00	40
1st Defibrillation:	N/A	
Airway Achieved:	00	40
1st Dose Epinephrine:	00	41

Code Team Called: ☑ Yes ☐ No Time: 00 : 40

Code Team Arrived: ☑ Yes ☐ No Time: 00 : 40

10. GLASGOW COMA SCALE

(Post-resuscitation)

Circle appropriate scores, then total.

EYE OPENING
- 4 - Spontaneously
- 3 - To voice
- 2 - To pain
- (1) - No response

VERBAL RESPONSE
- 5 - Oriented, converses
- 4 - Disoriented, converses
- 3 - Inappropriate responses
- 2 - Incomprehensible sounds
- (1) - No response

MOTOR RESPONSE
- 6 - Obeys verbal commands
- 5 - Localizes painful stimulus
- 4 - Withdraws from pain stimulus
- 3 - Flexion, decorticate posturing
- 2 - Extension, decerebrate posturing
- (1) - No movement

SCORE: 3

PATIENT IDENTIFICATION

EPW [redacted]

(5)(6)-4

0044 D[redacted]
0040 1[redacted]

(5)(6)-2

[redacted]

AGE: [redacted]

GENDER: male

HEIGHT (in): _____

WEIGHT (lbs): _____

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Hr/Min):	0040	0044	0046	0048	0050	0052	0054					
VITALS	BLOOD PRESSURE	30/10	44/19	27/18	28/19	35/17	85/17	30/9					
	HEART RATE (* = CPR)	44	63	63	69	54	56	Ø					
	RHYTHM												
	PULSE PALPABLE (Y/N)	No	N	Yes	Yes	yes	NO	NO					
	DEFIBRILLATION (Joules: 200, 300, 360)	—											
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—											
	PACING PERFORMED (✓)	—											
	RESPIRATIONS	Bagging											
AIRWAY	BAGGED w / 100% O2 (✓)	✓											
	INTUBATED (✓)	✓											
	MASK (Specify type)												
	% OXYGEN												
	O2 SATS	100%											
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	IV 1mg 0041	1mg IV 0044	IV 0047	IV 0047	IV 0048	IV 0048	IV 0048					
	ATROPINE (0.5 - 1 mg - IV / ET tube)	1mg IV 0041	1mg IV 0044	1mg IV 0047	IV 0049	IV 0050							
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
	D50	IV bolus 0042											
	Sodium Bicarb	0047	0048	0049									
	Calcium	0050											
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
	Chem 7	0042											
	ABG	0042											
ABGs	PH	7.449											
	pCO2	23.9											
	pO2	36											
	HCO3	17											

PHYSICIAN *(Signature & Title)*

NURSE *(Signature & Title)*

[redacted] TJ/AN Night Nsg Supp

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(b)(6)-2

Admission and Coding Information

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

1. Reporting MTF	2. M ...ion	3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] (b)(2)-2	IZ	[redacted] (b)(6)-4	[redacted]	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1978-07-01	25Y	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		20	[redacted] (b)(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		18:10	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
NO	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
IZ		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
b2-2 Direct from ER	ICU1	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 [redacted]q; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-02

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-31

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-31

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: DIVERTING COLOSTOMY/ SUPRAPUBIC TUBE PERINEAL DRAINAGE

Procedure Narrative(s):

90387
Dx: 86819
86355
8671
E9912

Px: 8628
5841
485

Cause of Injury Narrative: GSW BUTTOCKS

(b)(6)-2

Admitting Officer (Signature, as required): [redacted]

Signature of Admitting Clerk: [redacted] SPC, 9/6/10

Automated Facsimile - DA FORM 2985, MAR 2000

(b)(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Lo IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1984-01-01	7. Age at Admission 19Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS (b)(6)-4	11. FMP 20	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 21:51	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - [redacted]aq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-09		
24. Clinic Svc - Admitting AAA - INTERNAL MEDICINE	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-31		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-31		

b2-2

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: FRAGMENT WNDS L THIGH

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2

Admitting Officer (Signature, as required) [redacted]	Signature of Admitting Clerk

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

20yo Iraq ♂ s/p multiple fragments wounds to (R) thigh. (Rolling stones.)

Purple
Ø
PSMX
Ø
NKDA
PX
Ø

PHYSICAL EXAMINATION

Pelvis Ø Fx ~~bleeding controlled~~ (R)
Femur XRAY = Ø Fb (R) thigh
1" x 1" tissue defect

(H) 30. 8/29 261
1.3 INR
127 | 109 | 12
4.2 | 19 | 1.0 < 160
LFTwl CK=229

PROGRESS (Enter date of discharge and final diagnosis)

Admit · Abx Ancef.
· ~~return to Ump~~

[redacted] (b)(6)-2

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	31 Oct 03		

PATIENT'S IDENTIFICA[redacted] ped or written entries give Name last, first, dle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

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

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 NOV 03 2000	VSS Alert & oriented. C/O pain to (L) FA IV site upon flushing saline lock. No redness or swelling noted. (L) FA IV D/C'd. Restarted 18g 1¼ in IV to (L) FA X 1 attempt. (R) Thigh dry, dry & intact. (R) Pedal pulses palpable +2. OOB → BR (I) Consumed 75% of regular diet for dinner. Voiding clear amber urine. Will continue care as planned. [redacted] CJ A2
06 NOV 03	(1000) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. 0/10 pain. Amb to BR for personal hygiene [redacted] s̄ difficulty. Drsg to (R) thigh Δd WTD. ϕ s/sx infection. Pt OOB in chair @ this time. SL in (R) forearm flushes well s̄ s/sx infiltration. Tol. reg diet well. voiding s̄ difficulty. 2 point restraints in place while in bed s̄ s/sx complications. Will continue to monitor. [redacted] MA
06 NOV 03 2000	VSS alert & oriented. (R) FA saline lock patent & intact. (R) thigh dry, dry & intact. Consumed 80% of regular diet for dinner. Denies pain or discomfort. (B) Pedal pulses +2. Will continue care as planned [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-2

[redacted] (b)(6)-2

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7NOV03 1124	VSS. AO. Up at bed w/ difficulty to BR and to ambulate on ward. Did DSG to (R) inner thigh. Wound right appeared pink & healthy well. ∅ s/s infection @ this time. LSCHAB. BS (+)x4. CR ≤ 2 sec and (+) pulses in all extremities. Voiding light amber urine. Q5 w/ difficulty. Cont to monitor. [redacted]
7NOV03 2300	Pt AAO. Denies pain @ this time. OOB TO BR. Ambulates well w/ assistance. Dsg to (R) thigh CDI. Pt in D point restraint. Will continue to monitor. [redacted] 91WM6
8NOV03	Dsg Δ. wound pink w/ D/c; still needs Dsg Δ qd. [redacted] Awaiting Ivy Hay.
8NOV03 1012	VSS. AO. Performed self care & oral care this AM w/ difficulty. (+) pulse to RLE. DSG to wound d'd by MD (see above). Ambulated well to BR this AM w/ difficulty. [redacted]
8NOV03 1500	VSS AAO Pt OOBT BR. Ambulates well w/ assistance. (R)LE Dsg c̄ Ace Wrap CDI. (R)LE Warm & Dry to palpation. Cap refil ≤ 3 sec, (+) Pulse. Denies pain @ this time. Will cont to monitor. [redacted] 91WM1

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

MEDCOM - 22724

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
3 NOV 03 [redacted] 1945	Pt A+O×3, VSS, LS CTA (B), ⊖BS×4, OOB to BR + ambulated in the hall, ⊖ c/o pain, ace wrap on (R) thigh CDI, pedal pulses +2 equal (B), cap refill <3 sec, ambulates independently ⊼ steady gait, voiding ⊼ difficulties, SL IV (R) AC intact, ⊖ s/sx of infex, ⊃ point restraint ⊼ any complications. [redacted] GIW
4 NOV 03 1108	VSS. AM. Ambulated this AM x1 to BR to perform oral care and bathe self. ⊖ c/o pain @ this time. DSG ⊼ to (R) inner thigh performed ⊼ difficulty. Wound remains bandaged ⊼ s/s infection @ this time. ⊕ pulse to RLE. BS ⊕×4. Tolerated PO well this AM. Skin integrity intact ⊼ compromise. [redacted] RN (5)(6)-2
4 NOV 03 2000	VSS Alert & Oriented. (R) Thigh dry dry & Intact Pedal pulses palpable +2. Toes with brisk capillary refill. OOB → BR independently. (L) FA Salino lock Patent & intact. Consume 50% of Regular diet for dinner. Void clear yellow urine. No c/o pain verbal noted

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR NUMBER (SSN) [redacted]
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] (5)(6)-4

5 OCT 03 VSS. AO. Ambulatory x 2 to BR and to house for personal care.
1140 ⊕ pulse & CNS to RLE. ⊖ c/o pain @ this time. Joints light yellow urine QTY sufficient w/ difficulty. Tolerating PO well. [redacted] to RLE CDT.

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS N**

DATE	NOTES
31 OCT 03 2130	Pt recieved from EMT via litter, shrapnel wound to (R) thigh, wound covered ≅ dsg + ace wrap CDI, LS CTA (B), ⊕BS x4, A+O x3, VSS, ∅ c/o pain or discomfort, IV SL (R) AC intact, ∅ s/sx of infex, peripheral pulses +2 equal (B), pt able to move exts ≅ complications, abd soft flat nontender, cap ref < 3 sec, S1 S2 present, 2 point restraint ≅ s/sx of complications. [redacted]
1 NOV 03 0700	Assumed care of pt. A+O x 3. VSS ∅ c/o pain or discomfort @ this time. All care given. Lungs clear HRRR Active BS Tolerating PO. HL (R) AC patent flushes well. Remain afebrile ∅ s/s of infection. Will cont to monitor. [redacted]
2 NOV 03 @0100	assumed care of pt @1800. VSS, no c/o pain. alert, speaking clearly LS CTA, ⊕BS, void's diffiently to urinate. (R) thigh dsg CDI, ⊕ cms to RLE, +2 DP pulses, equal (bil). (R) AC HL flushes well, IVAPX cont. Tpt restraint on ≅ s/sx of skin/circulation compromise. Plan: cont IVAPX, monitor pain & dsg. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-1

LAST NAME	NAME	MI	ID NUMBER

DATE	NOTES
13/2/03 0915	Assumed care @ 0600. A&O able to make needs known. VSS. (R) thigh wound drsg Δ by Dr [redacted]. (+) pedal pulse. Nailbeds pink c̄ brisk capillary refill. Moves extremity purposefully. HL flushed & patent to (R) AC. Am care done. Medicated c̄ T#3 two tabs p.o. for pain control R/T drsg Δ. Will continue Abx/Therapy & pain control as ordered. 2pt restraint ∵ compromise to skin integrity/circulation. Provide emotional support — [redacted]
14/2/03 1630	FT Ambulating in room c̄ cane for exercise. Denies pain @ this time. Will continue to monitor — [redacted]
2NOV03 2000	VSS alert & Oriented. (R) AC Saline lock patent and intact. (R) Thigh dsg dry & intact. Pedal pulses +2. Toes c̄ capillary brisk. OOB → BR. Consumed 60% of Regular diet for dinner. No c/o pain or discomfort voiced or noted. Will continue care as planned. — [redacted]
3NOV03 1003	VSS. A&O. (R) AC SL. DSG d/d to (R) inner thigh c̄ WTD. (0) c/o pain. Ambulated x1 on wound this AM for 15 min. Seen by MD this AM. Ambulated PO well this AM. Wound is healing pink ∵ s/s infection. [redacted] intact. — [redacted]

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

[redacted] (b)(6)-7

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Nov 03	#3 (R) thigh GSW
	Dsg Δ today; dried Serous Sanguinous dressing.
	O/W doing well. Healing [redacted]
6 Nov 03	#7 (R) thigh GSW (b)(6)-2
	Dsg Δ by RN's = ∅ D/C ; Ambulating; ∅ Fevers.
	Pain ↓↓. Healing [redacted]

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

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

[redacted] (b)(6)-4

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

558-104

7540-01-075-378

MEDICAL RECORD

EMERGENCY [redacted] AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY: DAEPIC

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

AGE: 20

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

ARRIVAL

DATE (Day, Month, Year): 31 Oct 03 | TIME: 2200

TRANSPORTATION TO FACILITY: MEDIVAC

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: ϕ

ALLERGIES: ϕ

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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (R) Thigh

CATEGORY OF TREATMENT

☐ EMERGENT ☐ URGENT ☐ NON-URGENT

TIME: R/B

INITIALS: 2200

VITAL SIGNS

TIME	2200				
BP	112/66				
PULSE	112				
RESP	20				
TEMP	98.1				
WT					

LAB ORDERS

✓ CBC/DIFF	ABG	✓ PT/PTT	BHCG/URINE/BLOOD/QUANT
✓ URINE C&S	UA MSCC/CATH		✓ CHEM: 12 E lyts
BLOOD C&S X			

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	
✓ FEMUR AP + LAT	

ORDERS

☒ PULSE OX ☐ ECG

TIME	ORDERS	BY	TIME	PATIENT'S RESPONSE
2005	1 gm Ancef	[redacted]		
				(b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 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]

#[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)

[redacted]

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 Femur A/P/Lat – ØFB Pelvis – ØFB ØFB ØFB	
H/H			PCO2	SAT	OTHER		
PLT							
T			U/A DIP			EKG INTERPRETATION	
PTT	BHCG	ETOH	GLU	U/A MICRO			

PROVIDER HISTORY/PHYSICAL

PMH – Ø
PSH – Ø
meds – Ø
NKA.

20y/o ♂ c̄ Frequented injury to (R) thigh while Rolling Rolling stairs.

Bilat ecchymosis noted
Right NVI
(R) thigh 1" x 1" soft tissue defect

(B) PT
(R) DP > Dopplers confirmed

By myself
Dr [redacted]
Surgery
(b)(6)-2

(R) Reflexes / Pain meds / Rehab 2° sutures
Return to ER Admit on Boards

b6-2

CONSULT WITH	TIME	ACTION
Dr [redacted]		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

(R) thigh Frequented injury.

CODES (b)(6)-2

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

[redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

038

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 2 Nov 03 5 Nov 03 9 Nov 03

19 HOUR

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

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

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE: 103/49 103/59 102/46 92/46

80 79 85

HEIGHT: WEIGHT → 58 81 97

58.1 99% 58.1

RA

AB 99.2

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	31		1 NOV		2 NOV		3 NOV 03		4 NOV		5 NOV 03		6			
19	HOUR	24		0700						0755				8			

PULSE (0) / TEMP. F (°): 180 / 105°; 170 / 104°; 160 / 103°; 150 / 102°; 140 / 101°; 130 / 100°; 120 / 99°; 110 / 98.6°; 100 / 98°; 90 / 97°; 80 / 96°; 70 / 95°; 60; 50; 40

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

2-L [redacted]

(b)(6)-1

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-4

Ward/Section: EMT	REQ[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: #[redacted]	(b)(6)-2	DATE: 31 Oct 03	TIME: 2241	SSN/PSE(ID): SSN: #[redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	Acp		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	Microscopic Urinalysis		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	CSF			Blood Bank		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted]

LAST, FIRST, MI: H[redacted]

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

DATE

TIME

(i-STAT)

TEST	RESULT	REF.
Na		138-
K		3.5-
Cl		98-1
pH		7.31
PCO2		35-4 / 41-51
PO2		80-10 / N/A
TCO2		23-27 / 24-29
HCO3		22-26 / 23-28
sO2		95-9
BEecf		(-2) - mmo
AnGap		10-20
Ca		1.12-
BUN		8-26
GLU		70-10
Creat		0.7-1
Hct		38-51
Hgb		12-17

(b)(6)-4

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

31/10/03 22:42

REFERENCE RANGE: MALE

PATIENT #: [redacted]

LIVER PANEL PLUS

DISC LOT #: 3153AA7

OPER #: 678 DR #: 000

SERIAL #: 0000100494

ALB	2.5*	3.3-5.5	G/DL
ALP	71	26-84	U/L
ALT	18	10-47	U/L
AMY	35	14-97	U/L
AST	26	11-38	U/L
TBIL	0.4	0.2-1.6	MG/DL
GGT	13	5-65	U/L
TP	4.6*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

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

31/10/03 22:43

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3151AA4

OPER #: 678 DR #: 000

SERIAL #: 0000100684

GLU	160*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	279	39-380	U/L
NA+	127*	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	109*	98-108	MMOL
tCO2	19	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 1+, ICT 0

Misc. Chemistry

TEST	RESULT	REF.
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY:

DATE:

LAB ID NO.:

ID: [redacted] 31-10-03
WB 22:40

			Patient Limits	
WBC	30.1 H	x10^3/uL	4.5	10.5
RBC	3.11 L	x10^6/uL	4.00	6.00
Hgb	8.9 L	g/dL	11.0	18.0
Hct	29.1 L	%	35.0	60.0
MCV	93.5	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	261.	x10^3/uL	150.	450.
LY%	8.9 *L	%	20.5	51.1
LY#	2.7 *	x10^3/uL	1.2	3.4

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:49

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.5 sec.
Ratio = 1.3
Calculated INR = 1.47
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:48
Card Lot :080201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:52

Patient ID: [redacted]
Test Name :APTT
Test Result:= 18.0 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:50
Card Lot :030201
Operator [redacted]

(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

1A → [redacted]

NURSING UNIT | ROOM NO. 1401 | BED NO. [redacted]

DATE OF ORDER 31 Oct 03 | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

Adm = ICW 2
Dx = Frag wounds.
Cond = stable
VS = q shift
Act = EPW protocol.
ALL = NKDA
Nursing = DSG. Δ qd

PATIENT IDENTIFICATION

(5)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Diet = MRE
IV = S.L.
Special = ~~to EPW camp~~
Meds ~~Keflex 250mg QID~~
T#3 ii q 4-6° PRN pain
Ancef i jan q6°

(5)(6)-2

24°/0145 1NOV03

[redacted] MAJ MC

PATIENT IDENTIFICATION

1152

[redacted]

6NOV03

NURSING UNIT | ROOM NO. 1000 | BED NO.

24 8NO [redacted]

DATE OF OR[redacted] | TIME OF ORDER 1000 _____ HOURS

6 Nov 03

May d/c to civilian Hosp.

[redacted]

PATIENT IDENTIFICA[redacted]

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3	4	5	6	7	8	9	10		
31	[redacted]	VS QS	6	[redacted]												
			18													
31	[redacted]	ACT: EPW protocol	6	[redacted]												
			18													
31	[redacted]	Drsg Δ QD	6	[redacted]				See below)								
			18													
31	[redacted]	DIET: MRE	6	[redacted]												
			18													
31 Oct	[redacted]	Drsg Δ QD (R) Thigh	D	/	/	/	[redacted]									
		(b)(6)-2														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Frag wounds (R) Thigh

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 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31	[redacted]	admit ICUR, stable				[redacted]
06 nov	[redacted]	May dlc to civ. hospital				
		(b)(6)-2				

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10/11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	07	8	9	10
31	[redacted]	IV: SL	6	[redacted]										
	-----		18											
31	[redacted]	Ancef 1gm Q6°	6											
	-----		14											
	-----		22											

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

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Fragwounds (R) Thigh

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.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
31	[redacted]	T#3 #Q4-6° prn pain	D/T	1NOV 1200	3NOV 0945	3NOV 0200										
			D/	[redacted]												
		(b)(6)-2														

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

#1192

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe: _____

- ☐ Arson (I.P.C. 3-2)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☐ Offense against Coalition Forces [check one] If "Other" then describe: _____

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☐ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit:		Location Grid:	
Date of Incident: (D/M/Y) 31/10/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: 2151 hrs

Detainee #: [redacted]		Key Connected Person: ☐ Victim ☐ Witness	
Last Name: [redacted]		Last Name:	
First Name: [redacted]		First Name:	Given Name:
Hair Color: (b)(6)-4	Scars/Tattoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color:	Weight: lb / Height: in	Eye-Color:	Weight: lb / Height: in
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect:	Sex: ☒ M ☐ F / Phone#: / DOB D/M/Y: 20 yrs / ☐ Mobile ☐ Regular	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify)		☐ Passport ☐ Dr. license ☐ Other (specify)	
Document #:		Document #:	

Total Number of Persons Involved _____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number _____ of _____ Vehicle(s)	Owner:	
Make:	Color:	VIN:	Number of People in Vehicle:
Model:	Type:	Plate No.:	
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband ☐ Weapon		Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter:	Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email: Unit Phone: Date: / /	Email: Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? DT claims was looting in abandoned warehouse and was shot by US

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person? Al Tarif Iraq

Additional Helpful Information:

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]					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	19Y (b)(6)-X4					NO	
11. FMP	12. SSN	13. Organization				14. Ward	
20	[redacted]					ICW1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	21:51	AAA - INTERNAL MEDICINE					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-11-09					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-10-31	[redacted] (b)(6)-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
0580 [redacted] (b)(2)-2		2003-10-31					

31. Selected Administrative Data

Marital Status: DoB: 1984-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

FRAGMENT WNDS L THIGH

Dx 890.1 E991.9

Px 99.29 88.29

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

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 E-4 [redacted]

Automated Facsimile - DA FORM 3647, M[redacted]

MEDCOM - 22744

(b)(6)-2

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] NoFirstNameGiven	FGN	

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

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]		ICU2

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
N/A	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	07:30	AAJ - NEUROLOGY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF C-ACF	2003-12-09

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-01	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 [redacted] (b)(2)-2	2003-11-01	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

HEAD TRAMA

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	40	40

35. Total Days This Facility

Absent Sick Days	Other Days	Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	[redacted]	0	0	40	40

Signature of Attending Me[redacted]	Signature of PAD or Medical Records Officer
[redacted] (b)(6)-2	[redacted]

Automated Facsimile

INPATIENT TREATMENT RECORD CC[illegible] 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] NoFirstNameGiven	FGN	

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

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]		ICU2

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
N/A	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	07:30	AAJ - NEUROLOGY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF C-ACF	2003-12-09

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-01	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-01	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

HEAD TRAMA

Dx

852.30
876.0
880.01
879.4
728.87
331.3
482.0
482.1
E991.9

Px

99.29
87.44
93.94
87.03

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Da[redacted]	Lv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending [redacted] (b)(6)-2 Signature [redacted] Officer

MEDCOM - 22746

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 Dec 03	Nutrition Note: Pt continues poor po intake, unable to meet his EAN on regular diet. Calorie count reveals pt consumed approx 735 kcals one day, 1250 kcals next day, with >50% of kcal intake coming from Ensure Plus. Pt eats min food but will consume Ensure Plus + other fluids if given + if intake is monitored. Pts EAN: 2400-2800 kcals/day (30-35 kcal/kg) + 104-120 g Pro/day (1.3-1.5g/kg). Recommend continuing regular diet c̄ 2 Ensure Plus per meal. 6 Ensure Plus/day will provide 2100 kcals (78g Pro). Remainder of pt's needs can be met through other fluids (milk, juice) + food. Will continue to monitor intake + follow [redacted]
wt 80 kg	
	(b)(6)-7

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11Dec03	(0330) VSS. ∅ c/o pain. Pt turns on own. (L) sided weakness noted. Δ'ed DSG to upper back. Wound on (R) side of back is pink ō yellow layer of tissue. (L) side of back pink. Neither ∅ signs of infection. Voids clear, yellow into urinal ō difficulty. LS CTA. (+) Bowel sounds. 2 pt restraints. ∅ signs/symptoms of skin compromise. [redacted] LT/AN
11Dec.03 0700	Assumed care of pt. Alert, VSS, OOB → BR x2, BM x2, ambulates ē assistance, weakness to (L) side of body, dsg's to upper back Δ'd, wound (R) upper back appears ē s/sx of infex, minimal drainage WTD ē Dakins solution, c/o pain + head ache, adm ⅡT #3 for pain relief. LS CTA (B), (+) BS x4. [redacted] 91X
0925	Pt given Π tylenol #3 [illegible] c/o HA. [illegible] Order continue to monitor [redacted] 11WHO
11Dec03	(2100) VSS. c/o HA. Pt asleep at time. Will continue to monitor pain. Δ'ed DSG to upper back ō Dakin's solution. Wounds ∅ signs of infection. Wounds pink ē minimal drainage. Wound on (R) upper back has yellow drainage. Will monitor. Pt has (L) sided weaknesses. Pt turns on own. 2 pt restraints in

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV
Prescribed by GSA/ICMP FPMR (41CFR) 101-11.3
USA

(b)(6)-4
[redacted]

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9Dec03 1040	- Assumed care of pt. A1003. VSS & c/o pain or discomfort @ this time Lungs clear HRRR Active BS x4 quads. Urinating spontaneously into urinal Tolerates p.o. well Wound to (R) shoulder dsg CDI wet & dry c̄ 1/4 daken solution Transfer from ICW #2 per wheelchair dx s/p craniotomy has (R) side weakness Fall precautions in place Unsteady gait. 2 point restraint EPW protocol & s/s of breakdown Will cont to monitor [redacted] 9LWM
9Dec03	Assumed care of Pt @ 1800. VSS A&O c/o pain controlled c̄ T#3. LS CTA (B), HRRR. (+) pulses in all extremities Skin Warm + Dry to Palpation. (+) BS x4 quads. Pt consumed 100% of meal. Void spontaneously CYU c̄ difficulty gs. Drsg Δ to (R) shoulders c̄ Dakins solution. Wound on (R) shoulder is 3"x 5" down to muscle Tissue has yellow Brown Fatty globbular appearance. [redacted] Fall precautions in effect. Pt in 2 point [redacted] restraints. Will [redacted] monitor. [redacted] 9LWM
10Dec03	VSS. A&O Consumed 30% of breakfast. Wounds to upper back shoulder area. (L) side pink pink moist tissue. (R) side edges wound tissue dusky pink color but moist. Voids clear yellow urine (L) Sided weakness noted. Reposition c̄ assist from staff Q2 for comfort. Fall precautions in progress Will transfer c̄ +2 assist. 2 point restraints in place without compromising circulation or skin integrity. Will continue plan of care [redacted]

STANDARD FORM 503 (REV. 5/1999) BACK
USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(cont) place c̄ ϕ signs of skin compromise. [redacted]
Dec 12,03 0900	Medicated c̄ 1 #3 two tabs for c/o head pain. A&O able to make needs known. Will continue to monitor. Falls [redacted]
Dec 12,03 1100	Pt Alert, speaking [redacted] arabic, c/o moderate pain to upper back, dsg upper back s'd, wounds appear pink ϕ s/sx of infex, small amount of drainage WTD dsg c̄ Dakins solution, weakness of (L) side due to head injury on (R) side of head, ϕ complications voiding. [redacted]
1415	Pt given 1 tylenol #3 for pain Re[redacted]
12DEC03 2100	assumed care of pt @ 1800. VSS. c/o pain to (R) occipital/temporal lobe near incision site. T#3 tabs given c̄ good relief noted. LSCTA, (+) BS, tol reg diet well, void c̄ difficulty. A+OX3, PERRLA, ϕ difficulty speaking. (+) CMS to all extremities c̄ exception ↓ movement to LLE/foot. Strength equal BUE, RLE strength > LLE. LLE drags during ambulation. (R) shoulder & back wounds healing well, WTD completed c̄ Dakins soln, wound bed c̄ red granulation (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
	LAST	FIRST
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20
USAPA

[redacted] (b)(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 DEC 2100	(CONT) tissue noted. Dry dressing applied to RLE cay wound, ∅ drainage noted. 2pt restraints on ∑ S/Sx of skin/circulation compromise. Plan: monitor neuros, encpo, encOOB, enc independence. MI/monitor. [redacted]
12/13/03 1400	VSS. AO. PERRLA. OOB to BR and showered ∑ minimal assistance. ROM ∆'s performed to (R) shoulder (L) shoulder and (L) calf. Ambulated to BR ∑ minimal assistance ∆'d bruises. Voiding spontaneously. [redacted] AO ∅ S/S skin breakdown. [redacted]
14 DEC 03 0700	assumed care of pt @1800. VSS, no c/o. alert, speaks clearly in Arabic, PERRLA, BIL UE equal in strength, LLE < RLE in strength. Amb while dragging LLE. (R) shoulder & back wounds healing, all 3 wound beds ∑ pink, granulating tissue noted. Drsgs ∆d as ordered. LS CTA, ∅BS, tolerating reg diet well, voiding QS ∑ difficulty. #3 tabs given for pain ∑ good relief noted. 2pt restraints on ∑ S/Sx of skin or circulation compromise. Plan: encOOB, enc PO, monitor neuros. [redacted]
2100	assumed care of pt. @1800. VSS - HD ∅ c/o pain or discomfort @this time. II tylenol #3 given @2000 for pain. (+) relief. Pt. OOB → chair x20 mins. Pt. stated he wanted to get back in bed. (R) shoulder + back wounds healing well. ∅ S/Sx infection. WTDC ∆ 2% dakins solution. Dry dsg to (R) calf. ∅ S/Sx infection. Tel. dsg ∆ weekly. voiding over ulaurinal ∑ difficulty. ∅ II Two point restraints in place per ER physical. will cont to monitor pt. [redacted]

BACK

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
15 DEC 03 0600 entry from 12/14/03 @ 0900	VSS. AO. LSCTAB. HPP. ⊕ pulses to all extremities. PERRLA. BS ⊕ x4. OOBT ambulate to BR = moderate assistance. Placed in chair for 25°. Pt's ADL's performed to ⓡ shoulder, ⓛ shoulder and ⓡ calf ∈ difficulty. ∅ s/s infection. ∅ s/s of skin breakdown [redacted] Cont to monitor as pt. wish. —
12/15/03 0200	VSS. AO. Wound to ⓡ shoulder beefy pink ∈ s/s infection. WTD ∈ Betadine solution and covered VSD's to ⓛ shoulder and ⓡ calf. CMS intact. OOB to ambulate ∈ walker for 20 min ∈ PT. Wounds healing well. ∅ s/s skin breakdown to patient. [redacted]
0245	assumed care of pt. @ 1800. VSS-AO. ⓒ/o pain or discomfort @ this time. complete deg Δ to ⓛ + ⓡ shoulders + ⓡ calf. Pt. tolerated well. wounds beefy pink ∈ s/sx inf. Pt. voiding cyu via urinal ∈ difficulty. Pt. constantly standing up beside bed trying to walk. Placed pt in 4pt. restraints for safety. ⊖ skin breakdown ⊕ circulation will cont. to monitor pt. — [redacted]

RELATIONSHIP TO SPONSOR: 16 DEC 03 0200 | concur ∈ above

SPONSOR'S NAME: LAST | FIRST | assessment [redacted]

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 96
Prescribed by SGANCMR FORM 96 (MCR)

[redacted] (b)(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16DEC03 1100	VSS AFO OOB → BR to shower prior to dsg changes to upper back area. Tissue to wound granth pink + moist to (R) upper back. Consumed 20% of Breakfast. Ambulated to BR c walker (I) with MP supervision. C/O pain HA Tylenol #3 given and effective. 2 pt restraint replaced without compromising circulation or skin integrity. Will continue planned care. [redacted]
17DEC03 0340	- assumed care of pt @ 1800. VSS - AFO. Pt. has Ø c/o pain or discomfort @ this time. Completed dsg Δs to upper back c .025 Dakins solution. Ø s/sx inf. healing well. pt. consumed 50% dinner. Encouraging PO. voiding Dark yellow urine via urinal. c/o pain @ 2300. II Tylenol #3 given. (+) relief. Pt asleep in bed @ this time in two point restraints per eprw protocol. (-) skin breakdown (+) circulation. Will cont [redacted] to monitor pt
17DEC03 0500	VSS AFO OOB c walker to [redacted] assist to staff. Tylenol #3 2 tabs PO given for c/o pain HA. Consumed 30% of Breakfast. Dsg Δ to wound to (R) upper back. 2 pt restraints replaced without compromising circulation or skin integrity. Will continue plan of care. [redacted]

Assumed care @ 1800; VSS, pain controlled c T3's, pt alert speaking arabic; dsg to (R) shoulder Δd w → D c Dakin's sol. Ø drainage, Ø s/sx

STANDARD FORM 509 (REV. SEPTEMBER 87)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(Cont) infection; pt TOI Reg diet, voiding ~~w~~ difficulty; pt OOB to amb c̄ walker assistance ~~w~~ difficulty; Restraints in place ~~w~~ compromise to skin/circ; will cont to monitor [redacted]
18 DEC 03 0800	VSS AxO. Tylenol #3 given for c/o HA. OOB c̄ walker to BR for AM care. OOB to chair to Breakfast. Consumed 10% of Breakfast. 2 point restraints in place while in bed or up in chair. Restraints in place without compromising circulation or skin integrity. Will continue plan of care. [redacted]
19 Dec 03 @ 0525	Assumed care @ 1800; VSS, pt alert speaking English; c/o pain; pt dsg to back Δd. WTD c̄ Dakins, site pink, beefy, healing well; ⊖ drainage ⊖ s/sx infection; pt OOB to amb c̄ walker assistance; pt TOI Reg diet, voiding ~~w~~ difficulty; Restraints in place ~~w~~ compromise to skin/circ, cont to monitor [redacted]
19 DEC 03 @ 1430	Assumed care of pt. @ 0600. VSS, AxO. Pt. c/o pain to head, ⅡT 3's given PO. WTD DSG Δ to ⊙ upper back, wound pink & moist, mod. serous drainage to old dsg. Pt. OOB → BR, ⊕ BM, voids c̄ ~~w~~ difficulty. Pt. given shave & haircut. Pt. ambulates ~~w~~ walker well, ⊙ sided weakness. Pt. in 2-point restraints, ⊖ S/Sx of skin breakdown. [redacted]

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

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 51
Prescribed by DOD/OMB 1840-0003

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Dec03 0230	Assumed care @ 1800; VSS, pt alert speaking arabic; pain controlled c̄ Tylenol; dsg to (R) shoulder Δd w→D c̄ Dakin's sol. ⊖ drainage, ⊖ s/sx infection; pt OOB to amb in hall c̄ use of walker, tol well; voiding c̄ difficulty; Tol Reg diet; Restraints in place c̄ compromise to skin/circ; cont to monitor — [redacted]
20DEC03@1600	Assumed care of pt. @ 0600. VSS, A&O, Tylenol 650mg x 1 this shift for c/o HA. Pt.'s abd. hard, slightly distended, BS hyperactive. MD informed, pt. given 30cc M.O.M. @ 1100. ⊕ BM @ 1400, abd. non-distended & soft. Pt. OOB to BR c̄ assist, Ø walker. Voids C&U c̄ difficulty. WTD DSG Δ c̄ DAKINS sol. this AM, pink & moist, med. yellow drainage, Ø s/sx of infection. Pt. in 2-point restraints, Ø s/sx of skin breakdown. All other assessments WNL. — [redacted] LT, RN
21Dec03 0530	Assumed care @ 1800; VSS, [redacted] pain controlled c̄ Tylenol; pt OOB → BR XS, ⊕ loose stool D/T M.O.M. on previous shift; W→Δ dsg Δd to (R) shoulder c̄ Dakin's; ⊖ s/sx infection; pt Tol Reg diet, voiding c̄ difficulty; Restraints in place c̄ compromise to skin/circ; cont to monitor — [redacted]
21Dec03 1030	Pt A+OX3, VSS, LS CTA (B), ⊕ BS x4, OOB → ambulate, weakness of (L) side, tol well, D'd dsg on (R) upper back, scant amount of drainage, wound appears pink, Ø s/sx of infex, Dakins solution applied to dsg, voiding C&U c̄ difficulties. [redacted]
1100	Pt c/o HA given ⊕ Tylenol T-3 per MD orders. will reassess — [redacted] WMG —

STANDARD FORM 509 (REV. 5/1999) E/
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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2 DEC @ 0030	Assumed care of pt. @ 1800. VSS, pt. asleep, ii T3's for C/O pain to back & HA. WTD DSG Δ to (L) upper back c̄ Dakins sol., min. serous drainage, wound pink & moist, Ø S/S of infx. Pt. OOB to BR & ambulated in hallway c̄ assist. Pt. has mild (L) sided weakness. Pt. tol. regular diet well. Pt. in 2-point restraints, Ø S/SX of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted]
22 Dec 03 @ 0945	Pt A+Ox3, VSS, LS CTA (B), (+)BS x4, OOB → BR c̄ minimal assistance, dsg (R) upper back ↓'d, wound healing well, scant amount drainage, Ø s/sx of infex, pink appearance, voiding c̄ difficulties, weakness to (L) side of body, pt [redacted] (b)(6)-2 expressed he feels more strength to (L) side of the body than before, good appettite, Ø s/sx of skin breakdown [redacted]
3 DEC 03 @ 0050	Assumed care of pt. @ 1800. VSS. A&O during assessment. ii T3x2 this shift for C/O pain to upper back wound. Pt. asleep @ this time. Pt. reports limited or Ø vision to (L) eye. DSG Δ to (R) upper back, WTD c̄ DAKINS, pink & moist, yellow exudate to old dsg., Ø S/SX of infx. Pt. ambulates c̄ min. assist. to BR. Pt. voids CYU c̄ difficulty. (cont.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by CSA/OMB FPMR (41CFR) 101-11.203(b)(1)(i)
USAPA V1.00

(b)(6)-2

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23DEC03	(cont.) Pt. tol. reg. diet well. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. [redacted] 2LT, AN
23Dec03 1100	Pt AtOx3, VSS, LS CTA(B), (D)BSx4, c/o pain to upper (R) back, T#3 adm for pain relief, wound on (R) upper back pink + moist, healing well, Ø s/sx of infex, weakness to (L) side, strength improving, c/o vision ~~impairmen~~ [redacted] decreasing on (L) eye, unable to identify far objects, able to see from close, consumed 80% of breakfast, Ø s/sx of skin breakdown, OOB ⇒ BR by self. [redacted] 2-(b)(6)
1540	Pt had episode of (R) side chest pain, expressed that pain began on (R) upper back on wound area and radiated to the front, VSS, ↑ BP + P, SPO2-100%, BP- 131/70, P-102, cool to touch, Breath Sounds CTA (B), S1S2 present, portal CXR ordered, MD notified. [redacted]

STANDARD FORM 509 (REV. 6/1999) B

[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

23DEC03 1634 Neurosurgery

(S) VSA. Sats > 98% on RA.
4o (P) Chest discomfort in pectoral region.
(R) Sternum area granulating well.
Lungs clear
C&R clear.
Abd benign.

(A/P) Stable ~~p~~ PRN.
Chest clear - pt reassured no underlying pathology.
Continue NH care / dressings for wound.

[redacted]

(b)(6)-2

24DEC03 (0145) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c̄ T3s. Dsg to @ shoulder c/d WTD c̄ Dakin's soln soaked 2x2 and covered c̄ 4x4. Pt amb in hallway: gait becoming more steady. To). reg. diet well voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor.

[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] UMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE NOTES

24Dec03 assumed care of pt @ 0800. VSS. c/o pain to (R) back wound,
@1040 controlled c̄ T#3 tabs. neuros unchanged alert, follows
commands well, Amb c̄ slight (L) leg drag. LSCTA, (+) BS,
tol reg diet well, void s̄ difficulty. (R) shoulder/
back wound c̄ WTD dsg, wound s̄ drainage, red s̄
beefy. (R) head incision healed. 2pt restraints
on while in bed, ∅ s/sx of skin/circulation compromise.
Plan: enc po, enc OOB, monitor neuros. [redacted] RN

25 Dec 03 0300-0700 Assumed care @ 1800; VSS, pain controlled c̄ tylenol #3 tabs; pt A&O speaks
arabic; pt OOB to amb in hall, amb c̄ slow, steady, slightly shuffling
gait; pt transferred to Rm 7; dsg to (R) shoulder Δd w→D c̄ Dakins
∅ drainage, ∅ s/sx infection; ∅ Δ NV; Restraints in place s̄
compromise to skin/circulation; cont to monitor [redacted]

25Dec 03 Assume care of PT @ 0600. VSS, A+O ∅ c/o pain today.
1512 Ambulate to bathroom s̄ difficulty. Aid dress, to (R) side
upper back c̄ dakins solution. Had nose bleed earlier in the
day, was maintained. In 2pt restraint s̄ skin breakdown.
Will cont. to monitor. [redacted]
I concur c̄ above assessment [redacted]

25Dec03 (2340) VSS. c/o pain to head. Med c̄ 2 tab Tylenol #3.
3 hrs p̄ pt cont to c/o of Headache. V.O. from
Dr. [redacted] for T#3. Med given. Will continue to
monitor. PERRLA. Neuros intact. Pt amb to BR c̄
steady gait. OOBTC ~ 2 hrs. Tol Well. Δ'ed DSG
to Back c̄ Dakins solution. Wound appears pink c̄
∅ signs of infection. Will continue to monitor.
[redacted] RN/pm

STANDARD FORM [illegible] REV. [illegible]

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
26 DEC 03 @0915	Pt c/o ↑ loss of vision to (D) eye. also c/o pain moving from "back of head to front of head." & the pain "not improving." Pt states he thinks his (L) leg is weaker & "getting worse." Will notify MD. VSS. Will monitor. [redacted]
26 DEC 03 0945	MD @ BS. CT ordered for today. [redacted] (b)(6)-2
26 DEC 03 1154	Neurosurgery (S) c/o gradually ↑ HA over past several days/weeks. Subjectively, (L) VF worsening / feel more clumsy. CT head performed today. Ventricles mildly enlarged. LP performed. OP 18 cm H_2O, 50 cc clear, colorless CSF drained, CP 8 cm H_2O. Pt reports improved headache. Will send CSF + leave in bed x 6 hrs. (A/P) Post-traumatic hydrocephalus. Trials of CSF tap. Cx to be evaluated. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST FIRST MI | SPONSOR'S SOCIAL SECURITY NO. (SSN or Other)

DEPARTMENT, BRANCH | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION (For injured or ill non-military, give Name, Last, First, Middle Initial or SSN, Sex, Date of Birth, Rank/Grade) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 REV. 6/73

(b)(6)-4 [redacted]

26DEC03 1200 VSS. MD @ BS, performed LP. (See note.) Pt tol procedure well. Percocet given for back pain (near LP site). Pt states he does ∅ have HA. BR for 6°, until 1730. LSCPA, @ BS, tol reg diet well, void qs ⅋ dizziness. 2pt restraints on while in bed. (R) back shoulder wound healing, peeling ~~to~~ drainage. NTD dsg completed. Plan: BR. Pain control prn, monitor HA. Will monitor. [redacted]

26DEC03 - 1507. Neurosurgery.
CSF Gram Stain. I think this is a contaminant. Will observe. [redacted]

26DEC03 - ~~2362~~ 2240 - VSS. c/o HA. Med c̄ 2 percs. Will monitor. PERRLA. Follows directions appropriately. Amb to BR c̄ cane. ↑ weakness to (D) foot noted. Pt drags (L) foot. Dr. [redacted] notified & aware. Pt had large BM. D'ed DSG to upper back c̄ Dakin's solution. Wound appears pink. LP site covered c̄ bandaid. ~~@~~ CDT. Will continue to monitor. [redacted]

27DEC03 1200 VSS. AO. PSG d'd to (R) shoulder. Beefy pink and pink margins. ∅ s/s infection. Other wounds OTA. Wound size: 12cm x 4.5cm approximately. Med c/o HA this AM and provided ~~Tylenol~~ relief. OBTBR @ times for voiding spontaneously and oral care. Ext ≡ (B) visible weakness, upper & lower extremity. CNS intact. [redacted]

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
28 DEC 03 @ 0130	Assumed care of pt. @ 1800. VSS, A&O. ⅊ Percocet for C/O pain to back & HA. Pt. reports ⊘ vision to (L) eye & (L) sided weakness, WTD DSG Δ to (R) upper back ⊂ Betadine sol., thick yellow exudate to old dsg, wound pink & moist. Pt. C/O itching to back, pt. ⊂ back scratched & lotion applied. Pt. tol. reg. diet well, (+) BS all 4 quads. Void CYU ⊂ difficulty. Pt. in 2-point restraints ⊘ signs of skin breakdown. All other assessments WNC. Will cont. to monitor. [redacted] LT, AW
28 DEC 03 0800	VSS. AO. OOB this AM and ambulated to BR to perform oral care, wash and to toilet. Ability c/o HA and provided 2 percocets for relief. Still ability not having vision to (L) eye. Continued weakness to (L) side - arm & leg. Gait remains unsteady ⊂ use of cane. Voiding spontaneously CYU ⊂ difficulty. [redacted]
0900	c/o constipation and provided (P) Bisacodyl suppository and encouraged to drink water more often. Pt understood strength use of interventions. [redacted]
28 DEC 03 @ 2310	Assumed care of pt. @ 1800. VSS, A&O. ⅊ Percocet [illegible] pain to back and head. ⊂ Ambien given for sleep. Pt. C/O constipation early in shift. (+) BS all 4 quads, abd. firm. Pt. given DULCOLAX suppos.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S DIV NUMBER OR SS NUMBER

DEPARTMENT, UNIT | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION (Patient name or written authorization, name, date, hospital, DOB or SSN, Div, Division, Branch, Rank, Grade) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 REV 6/1/83

[redacted] (b)(6)-4

28 DEC (CONT.) PR. ⊕ BM x 2, Pt. reports relief of constipation. Pt. tol. reg. diet well. Voids C/V ∓ difficulty. WTD DSG Δ ∓ Dakins sol. to ® upper back wound, yellow exudate to old DSG, wound pink & moist, Ø S/Sx of infection. Pt. ambulates ∓ assistance, (L) sided weakness noted, ~~trips~~ (ERROR) WNL, drags toes to (L) LE. Small blister noted to (L) temporal scalp, 2 x 2 applied, scant serg. drainage. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. — [redacted] TLT, AN

12/29/03 1450 VS. AO. DSG Δ'd to ® shoulder. Redy, pink - Ø s/s infection. Slight bleeding to scalp @ (L) occipital and placed 2x2 ∓ head wrap. Ambulated x2 on ward. BR x1 for BM. Med for constipation. Cont to have trouble seeing digits distinctly ∓ (L) eye. Cont (L) sided weakness. — [redacted]

~~12/29~~ Assumed care of pt @ 1800 VSS ~~x1800~~ LS CTA

29Dec03 (PS) ⊕ BS x 4 quads. Voids QS C/V ∓ difficulty. c/o pain to head. Incision to scalp healed will cont to monitor. Drsg to Back Δ'd Wound is healing well. — [redacted] RWM

30DEC03 1100 assumed care of pt @ 0800. VSS. [illegible] tolerated this AM, controlled w/ percocet tabs. LS CTA ⊕ BS, tol reg diet well voids ∓ difficulty, maintains (L) LE weakness, noted when ambulating → pt drags foot slightly. Cont to have some vision problems to (L) eye, states vision is blurry. ® back wound drsg Δd, wound bed pink c/ granulation tissue/drainage. 2pt restraints on while in bed. Plan: encpo, encOOB, monitor HGB. — [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30DEC03	(2345) Assumed care @ 1900. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to amb in hallway. Gait slightly unsteady. Used cane to amb while in room. Dsg to (R) shoulder Δd WTD c̄ Dakin's soln. Wound pink and moist c̄ yellow exudate. Tol. reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted]
31DEC03 @1430	assumed care of pt @ 0600. VSS, ~~70~~ 96 n/a, [redacted] medicated with Percocets c̄ good relief noted. Alert, oriented, speaks arabic, PERRLA, (BIL) UE equal in strength, (L)LE < (R)LE in strength, LE shows difficulty c̄ plantar flexion, evident in gait, pt drags toes. Pt stated through interpreter he feels worse since LP, LE strength is less, s̄ n/a continues. Wished to speak to MD. LS CTA, (+)BS, tol reg diet, void s̄ difficulty. 2pt restraints on s̄ S/Sx of skin/circulation compromise. Plan: enc OOB, enc po, monitor neuros. [redacted]
	Addendum: Pt ↑ AMB in hallway, pushing roommate in W/C, tol well. [redacted] Tan

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES
Medical Record

[redacted] (5)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31DEC03 @ 1630	MD to BS, pt stated he had ⊖ issues @ this time contradictory to what pt told nursing staff. MD started pt on requestin for HA pain. [redacted] CRR
31DEC03	(2330) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. H/A pain controlled c̄ Percs. Pt ambs to amb in hallway c̄ cane - tol. well. Given Bisacodyl suppository for c/o constipation. ⊘ BM this shift. Pt sleeping @ this time. Dsg to ⓡ shoulder Δd - wound pink/moist c̄ scant yellow exudate. Tol reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
1Jan04	1410 - assumed care of pt. @ 0000. VSS - A+O well speaking arabic playing cards c̄ roommate. ambs to ambulate in hallway x30 minutes. ⊕ BM this am. Pt. tolerated breakfast well but refuses lunch. voiding clear yellow urine s̄ difficulty spontaneously. Completed dsg Δ to ⓡ side of upper back. Wound pink and moist s̄ s/sx infection. Pt has no complaints at this time. - In bed resting c̄ two point restraints @ this time ⊕. Circulation ⊖ skin breakdown. Will continue to monitor pt. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 Jan 04	(0240). VSS. Ø c/o pain. Amb c̄ steady gait. (L) ft drags slightly. PERRLA. A'ed DSG to upper back c̄ Dakin's. Ø signs of infection. Tol PO well. Voids CYU. Pt c/o Ø BM. Administered Dulcolax PR. Ø BM at this time. Will continue to monitor. [redacted]
2 Jan 04	0335 - assumed care of pt @ 0000. VSS - A+O [redacted] Ø c/o pain or discomfort. Pt. c/o constipation. 30cc mom given as ordered. Will monitor pt. Pt. ambulated in hallway x1 hr. [redacted] Tol well. Slightly drags (L) foot. Completed drg Δ. [redacted] wound moist/pink healing well Ø s/s/x infection. Voids cyu via urinal. Resting in bed c̄ two point restraint (+) circulation (-) skin breakdown. Will continue to monitor pt. [redacted]
2 Jan 04	1700 - Ø (-) BM. Gave pt. One bottle [redacted] citrate @ 1600. Pt. had (+) BM x3. [redacted]
1800	Pt c/o severe abd. pain [redacted]
03 Jan 04	(0245) VSS. c/o pain x2. Both times med c̄ 2 percs. Pt amb on ward. (L) ft drags slightly. Maintains steady gait. Voids CYU. Pt had sm. BM. Tol PO well. A'ed DSG to upper back c̄ Dakin's. Ø signs of infection. Will continue to monitor. [redacted]
3 Jan 04	1500 - assumed care of pt. @ 0000. VSS - A+O. c/o headache. 1 tylenol given. Pt. refused meds. Pt. still in bed c/o pain @ this time. ambulated in hallway this am x1 hr. drags (L) ft. slightly. Completed drg Δ to upper (R) back.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(cont'd)	pink + moist c̄ ∅ s/sx inf. voiding cyes via urinal. (+) BM today. Tolerates PO well. Pt. in bed @ this time c̄ two point restraints in place. Will continue to monitor pt. [redacted]
04JAN04	(0230) VSS. C/O pain. Med c̄ 2 percocets. Amb on ward. St ↓ mobility to (L) Ft. Tol PO well. (+) BM in PM. PERRLA. Moves extremities appropriately. Follows command. Voids clear yellow urine c̄ difficulty. Will continue to monitor. [redacted]
4JAN04 @0900	Falls risk assessmt: Due to pt's diagnosis & residual effects from surgery, pt needs stand by assist when first getting in/OOB. Pt amb well c̄ cane. Will cont. to assess. [redacted] (5)(6)-2
4JAN04	1400 assumed care of pt. @2000 VSS-NO c/o pain or discomfort @ this time. Found pt. med dilaudid 30mg in/underneath pt. mattress. Refused medication. Ambulated x 30mins. Still slightly drags foot. Tolerates Reg diet voids cyes. Will cont. to monitor pt. [redacted]

RELATIONSHIP TO SPONSOR [redacted] SPONS[redacted] [redacted]

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FIRST	MI

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

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[redacted] (5)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6Jan04 1730	Rec'd report on pt and assumed care Dsg Δ to (R) ↑ back c̄ Dakin's solution. Area pink ⊖ packing needed. Hence ext (R) BS. Pt rec'd pain med @ 1645. Ambulated in hallway c̄ pt #1428. ⊖ skin breakdown under 2-point restraints. Continue to monitor — [redacted] 9140Hb —
Jan04 @ 0100	Assumed care @ 2200; VSS, ⊘ c/o pain, pt A&O, pt OOB to amb in hallway, to wall; Dsg to upper back Δd w/ D c̄ Dakin's Soln, ⊖ drainage, ⊖ s/sx infection; pt voiding c̄ difficulty, to Regular; Restraints in place c̄ compromise to skin/circ; cont to monitor — [redacted]
1/7/04 0520	VSS. WNL. AO. Mild c/o HA. Provided ⊘ percocet fair pain. ilp at bkfst this AM. All other systems WNL. ⊘ change in in CNS status. PSG d/d to ward to on (R) stretcher. Wound is healing pink and healing well. ⊘ s/s infection. ⊘ s/s skin breakdown. — [redacted] AM
07JAN04 1553	Neurosurgery Pt suffered a seizure this evening with Todd's (L) paresis/confusion after. Will load with Dilantin. [redacted]
7Jan04 2012	Rec'd report and assumed care [redacted] @ 1400. Pt ambulated in hallway. c/o constipation given MOM per MD order. Pt had BM. Upon returning to bed Pt had seizure which lasted @ 90 sec. Dr [redacted] called Suction @ bedside VS 146/82 P130 - POX 98% Pt given dilantin per MD order. Continued bed follows instruction. Will monitor — [redacted] 9146

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 Jan 03 2100	Pt sitting ↑ in bed. c/o mild pain. Pt given percocet @ 2115 per MD order. Pt ambulated to BR ⊼ assistant. Will continue to monitor [redacted]
5 Jan 04 @ 0430	Assumed care @ 2200; VSS, Ø c/o pain, 10mg Ambien for sleep; pt OOB to amb in hallway; dsg to back Δd w→D ⊼ Dakin's 30 Restraints in place ⊼ compromise to skin/circ; will cont to monitor [redacted]
1/5/04 1470	VSS, AO. Mild c/o pain this AM. Provided relief. All other systems WNL. Encouraged PO intake. Ate <40% of AM meal. 50% of lunch. Ø s/s skin breakdown. [redacted]
5 Jan 04 @ 2400	Assumed care @ 1800; VSS, pt AEO; pain controlled c percs; pt OOB amb in hallway, tol well; dsg to back Δd w→D ⊼ Dakin's soln; Ø Δ in assessment Restraints in place ⊼ compromise to skin/circ, cont to monitor [redacted]
1/6/04 1053	VSS, AO. Mild c/o HA this AM and provided 2 percocet. OOB to ambulate ⊼ wheelchair ⊼ difficulty. Tolerating PO this AM <50%. Voiding spontaneously ⊼ difficulty. Ø s/s skin breakdown (R) shoulder dressing Δd ⊼ c/o pain. Wound in pelvis, moist ⊼ no infection. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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LAST NAME	FIRST NAME	MIDDLE IN.	ID NUMBER

DATE	NOTES
3Jan(1645)	compromise. Cont to monitor - [redacted] PN
JAN04@0330	Assumed care of pt. @ 2200. VSS. A&O at time of assessment. Pt. given ii Percocet for c/o pain to head. WTD 036 Δ c Dakins sol. to (R) upper back wound, pink & moist, mod serous drainage, Ø S/Sx of infx. Pt. sleeping c this time. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] LT, AN
09Jan04 0930	VSS. Alert & Oriented. Pt off c cane & ambulate to BR for AM care. (R) upper back wound pink & moist. Old drsg saturated with serous drainage. Consumed 100% of Breakfast. Consume 100% of Ensure. Skin intact except for wound. 2 point restraints in place without compromising skin integrity or circulation. Will continue plan of care [redacted] RN
9Jan04 1645	Pt Q10, VSS, (R) upper back drsg Δd, wound pink + moist c serous drainage. Amb. c cane x 2 in hallway. (L) sided weakness cont. Ø c/o pain. Ø seizure activity noted. 2 pt. restraints on 3 compromise. Cont to monitor [redacted] PN
10JAN04	(0010) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. H/A pain controlled c Percs. Dsg to shoulder Δd d/t pt d/c old dsg. wound pink, moist. Pt ADB to amb in hallway while pushing roommate's W/C. Drags (L) foot slightly. 2 point restraints in place c S/Sx complications. Will cont.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 JAN04 @ 0415	Assumed care of pt. @ 2200. VSS. Ø C/O pain. Pt. C/O constipation, ÷ Bisacodyl supp. PR. ⊕ BM. Pt. expressed relief of constipation. LS CTA bilat. HRR. ⊕ BS all 4 quads. Voids C/V ÷ difficulty. Pt. ambulated in hallway, slight limp, mild (L) sided weakness. WTD dsg Δ ÷ Dakins sol. to (R) upper back wound., mod. serous drainage, wound pink & moist, Ø S/S of infx. Pt. in 2-point restraints in bed, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. — [redacted] LCT, AN
8 Jan04 Ø700	VSS A&O. Ø c/o pain and discomfort. (-) Acute or noted. Ø seizure activity noted @ this time. Lungs clear. Abd soft non-distended. Voids clear yellow urine (R) upper shoulder area ÷ dry / I dsg OOB → BR. ⊕ 2pt restraints replaced without compromising circulation or skin integrity. Will continue plan of care. [redacted]
(1640)	Pt alo, VSS, Ø complaints, LCTAB, ⊕ BS×4, dsg to (R) upper back D'd WTD ÷ dakins solution. Sero-drainage noted. mild (L) sided weakness, Ø seizures, ↑ to ambulate x1. 2pt restraints on.

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10JAN04 0010	(cont) to monitor. [redacted]
10 Jan 04 0730	VSS A&O Denies c/o pain / discomfort @ this time. Lungs clear. Abd soft non-distended, BS(+) x 4 Quad. Peripheral pulses palpable +2. Continues with (L) side weakness noted c [redacted] hand grip & walks c limp. Ambulates c cane with slow steady gait. Consumed 40% of Breakfast c 100% of Ensure. 2 point restraints replaced without compromising circ/skin integrity. Will continue care as planned [redacted]
10Jan04 1800	Pt a/o, VSS, med. c percocet for c/o headache (L) sided weakness cont, OOB x 1 to BR. LCTAB, (+) BS, voiding cyu. (+) appetite, Ø seizure activity noted. dsg to (R) upper back s/d, area pink + moist c serous drainage. 2 pt restraints on 3 compromise. Cont to monitor — [redacted] PN-
11JAN04@ 0440	Assumed care of pt. @ 2200. VSS. ¨ Percocet for c/o pain to shoulder wound. WTD dsg Δ to shoulder wound, Ø s/sx of infx, mod. serous drainage. Pt. ambulated in hall 30 min. Pt. sleeping at this time, 2-point restraints, Ø signs of skin breakdown. [redacted] T, AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
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[redacted] (b)(6)-4

4/11/84 USS WN2 - ∅ c/o pain this afternoon. COB Ad Lib 5
1300 difficulty. Voiding spontaneously. PSG did to ⓡ shoulder
Wound healing pink & moist. ∅ s/s infection or skin
breakdown. [redacted]

(b)(6)-2

#1198

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13JAN04 @2115	assumed care @ 1400. VSS. Percocets given x1 for headache in (R) side of head, good relief noted. LSCTA, ⊕BS, tol reg diet, void's difficulty; cont'd (L) LE weakness c̄ plantar flexion, Pt amb c̄ slight drag in (L) foot. 2pt restraints on c̄ skin/circulation compromise. Plan: enc OOB, encpo, monitor pain & neuro checks. Will monitor. [redacted]
13JAN04 @0030	Assumed care of pt. @ 2200. VSS, A&O. [redacted] for C/O severe pain to head. Hold (L) side weakness. WTD dsg Δ to (R) upper back, mod. serous drainage, pink & moist, Ø s/sx of infx. Pt. resting quietly in bed @ this time, 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted]
13JAN04 1100	VSS WNL. Ø c/o HA this AM. Pt. comfortably in bed c̄ w/NPD. Tolerated PO well this AM. DSG Δd to (R) shoulder this AM. wound bed is pink, moist c̄ minimal serosanguinous drainage. Ø s/s of infxn or skin breakdown. All other systems WNL. [redacted]
13JAN04 @1725	assumed care @ 1400. VSS. No c/o h/a @ this time. Neuro unchanged, cont'd (L) foot plantar flexion deficit, noted when ambs c̄ dragging of (L) foot. Pt states vision to (L) eye cont's to ~~Ø~~ improve, requests to see MD. Will notify Dr Teff. 2pt restraint on while ~~out~~ in bed, Ø s/sx skin/circulation compromise. Plan: enc OOB, encpo, monitor neuros. [redacted]
14JAN04	(0200) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs, OOB to amb in hallway cont. to drag (L) foot slightly - aided c̄ cane. DSG to (R) shoulder Δd WTD. Wound red/moist c̄ S/Sx infection.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Jan 04 (1610)	Pt a/o, VSS, Ø c/o pain @ this time, ↑ to WC 2° (amb pushing WC). (L) sided weakness con't, walks c̄ slight limp. (R) upper back drsg Δd, pink + moist c̄ serous drainage. Ø seizure activity noted, good appetite, voiding cyu. 2 pt restraints on ≅ compromise. Will monitor [redacted] PN
(2030)	↑ pushing roommate around in WC. med c̄ percocet for headache. Ø new issues [redacted] PN
12 JAN 04 @ 0230	Assumed care of pt. @ 2350. VSS, ⅡⅡ Percocet for C/O pain. Pt. sleeping @ this time. WTD dsg Δ c̄ Dakin sol. to (R) shoulder wound to back, pink & moist, mod. serous drainage, Ø S/Sx of infx. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor [redacted] AN
12 JAN 04 1215	VSS WNL. Ø c/o HA this AM. COB Ad lib to perform self care. Steady gait c̄ use of cane. Voiding spontaneously ≅ difficulty. Ø d/c to (R) shoulder. Pink and moist ≅ S/S infxtn. Ø S/S of skin breakdown to patient. [redacted]

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

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

REGISTER NO. | WARD NO.

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
14JAN04 @2000	(cont.) voiding c̄ difficulty. Upper restraints in place c̄ S/Sx complications. Will cont. to monitor [redacted]
1/14/04 1205	VSS WNL. ∅ c/o pain @ this time. Tolerated PO medication. Ad. OSS ∆'d to (R) shoulder c̄ difficulty. Wound pink, healing c̄ ∅ s/s of infection. Up ad lib to BR c̄ difficulty & ambulates well. Voids light amber urine, ∅S. Retained minimal left side weakness. ∅ s/s of infection to wound ∅ s/s skin breakdown [redacted]
14JAN04 @1715	Assumed care @1400. VSS. Percocet given for (R) sided h/a, good relief noted. ⊖ ∆ in neuro exam, cont'd vision ∆ in (L) eye, noted in depth perception tasks (reaching for objects). Cont'd (L) foot plantar flexion deficit. LSCTA, (+) BS, tol reg diet c̄ good appetite, void c̄ difficulty. Pt AMB frequently, enjoys interacting c̄ roommate. Plan: enc AMB, enc independence, monitor neuro, encpo. [redacted]
15jan04 @0200	Assumed care @2200; VSS, pt A&O, pain controlled c̄ percocet; drg to back ∆ w/ ∆ c̄ Dakin's soln, site healing well + ↓ in size; ⊖ NVA ⊖ visual ∆; pt tol Reg diet; voiding c̄ difficulty; Restraints in place c̄ compromise to skin/circ; cont to monitor [redacted]

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

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[redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 JAN 04 @ 0630	Assumed care of pt sleep easily aroused A+O x 3 VSS Denies pain or discomfort. Ambulated c̄ cane to BR for am care and shower. Lungs CTA HRRR Active BS x 4 quads. Voids spontaneously c̄ diff. Wound to (R) U back shoulder wet + dry 4x4 dsg Δ'd after shower vascular healing well Ø s/s of infection will cont to monitor — [redacted]
15 JAN 04 @ 1715	assumed care of pt @ 1400. VSS; Percocet given for N/a, good relief noted. (R) shoulder wound almost healed, fibrous tissue noted, small amount of drainage. Neuroexam unchanged, cont'd (L) leg plantarflexion deficit. No other issues, all other exams WNL. 2pt restraints on c̄ signs skin/circulation compromise. Plan: enc OOB & AMB, monitor neuroexam & N/a. [redacted]
16 Jan 04 @ 0105	Assumed care @ 2200; VSS, pt A&O, Ø NV, visual Δs; pt OOB to ambulate hall c̄ use of cane; dsg to (R) upper back Δ'd, wound healing well, Ø s/sx infection; pt tol PO well, voiding c̄ difficulty; Restraints in place c̄ compromised skin/circ; cont to monitor — [redacted]
16 JAN 04 @	Assumed care of pt. sleep easily aroused A+O x 3. VSS Lungs CTA HRRR Active BS x 4 quads Tolerating PO well Voids c̄ diff. Ambulates in hall way c̄ assistance. Wound to (R) Upper Back 4x4 dry dsg healing Ø s/sx of infection Ø drainage or active bleeding Will cont to monitor — [redacted]
16 JAN 04 1800	assumed care @ 1400. VSS. Ø N/a, percocet given c̄ good relief noted. Ø drainage from shoulder wound. Neuro exam Ø Δs. AMB well c̄ cane. Enjoys interaction c̄ roommate. 2pt restraints on c̄ skin/circulation compromise. Plan: enc PO, enc AMB, plan for D/C, pain control, monitor neuros. [redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
17 Jan 04 @ 0340	Assumed care @ 2200; VSS, pt A&O, Ø c/o pain, Ø NV As; pt OOB to amb in hall c̄ minimal assistance from cane; dsg to (R) upper back Δd w/ Ø drainage, Ø s/sx infection; pt tol PO well, voiding c̄ difficulty; Rest restraints in place c̄ compromise to skin/circ will cont to monitor — [redacted]
17 JAN 04 @	0640 - Assumed care of pt. A TO x3. VSS Denies pain or discomfort. @ this time lungs CTA bilat. Active BS x4 quads. Voids spontaneously c̄ [redacted] Ambulates w/ c̄ cane assistance. DSG dry & intact to shoulder CDT Ø drainage bleeding noted Ø s/sx of infection pt. afebrile. All other assessment findings WNL. OK for discharge to camp next transport day. Will cont to monitor — [redacted]
17 Jan 04 @ 1700	assumed care @ 1400. VSS. Pt c/o n/a, Percocet given c̄ good relief noted. neuro exam unchanged. all other systems WNL. Pt ↑ AMB c̄ cane. (R) shoulder wound small, Ø drainage, healing well. Dpt restraints on c̄ skin/circulation compromise. Plan: monitor neuros, pain control, enc OOB. — [redacted]
17 JAN 04	Assumed care @ 2200 pt sleeping, pt easily roused from sleep. VSS A+O x3, pt c/o head pain 2230 given tylenol, dsg to upper posterior back Δd with dakins solution cont

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

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 JAN 04	wound is pink & signs of infection, pt c/o of mild head pain, given 2 percs @ 2340 by RN LT [redacted] Restraints x2 in place will monitor [redacted]
18	(0240) concur c above assessment. [redacted]
18 JAN 04 @0700	Assumed care of pt. A+O x3. VSS Denies pain or discomfort @ this time. Wound care given. (R) shoulder open wound wet to dry 2x2 dsg covered c 4x4 dsg CDI ø bleeding or drainage. healing well. Other assessment findings WNL will cont to monitor [redacted]
18 JAN 04 @1745	assumed care @1400. VSS. c/o h/a, percocet given c good relief noted. neuro exam: ø Δs all other systems WNL. Cont to Amb c cane, tol well. (R) shoulder wound healing well, ø drainage. 2pt restraints on c skin/circulation compromise. Plan: enc OOB, enc po, monitor neuro's, pain control [redacted]
18 JAN 04	@2355 - Assumed care of pt. @2100. ø c/o pain or discomfort @ this time. Sleeping in bed. Neuro intact ø Δs. (+) circulation (-) skin breakdown. two pt. restraints in place per EPW protocol. (R) shoulder dsg CDI. ø drainage noted. Will CAT to monitor pt [redacted]
19 JAN 04 @0615	- Assumed care of pt. A+O x3. VSS c/o pain medicated c tylenol 650 for HA. Wound to (R) shoulder wet to dry 2x2 dsg small wound healing well ø s/sx of infection lungs CTA HRRR Active BEX4 grads JAO's spontaneously per wrist amputator c cane Other assessment finding WNL OK for discharge 20 JAN W.I. monitor [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Neurosurgery Narrative Summary Discharge Note

7/19/04 18:22

20 y/o Iraqi ♂ with penetrating injuries to back, scapula, brain and flank from IED (noted to be placing EEIs during the explosion) on 11/1/03. Taken to 28th CSH with GCS 6; E1 V1 M4 (localizing). CT demonstrated Lg (R) hemisphere acute subdural hematoma, midline shift 1.5 cm, penetrating fragments into the (R) parietal lobe & hemorrhage into the sylvian fissure. He underwent an emergent (R) Frontotemporal craniotomy with evacuation of penetrating bone, metal fragments, evacuation of a acute SDH & clipping of a distal ruptured traumatic MCA aneurysm.

His pmhx significant for smoking & asthma which contributed to a post-operative course complicated by pseudomonas, klebsiella pneumonia. He underwent a tracheostomy, PEG, antibiotics and delayed removal of his ICP monitor w/ controlled ICP. He remained in the ICU for 4.5 wks until his pulmonary state improved allowing transfer. During this time he had a progressive improvement in his neurologic status. He went from a dense (L) LE monoplegia, (L) UE paresis & (L) hemineglect to currently ambulate w/ only slight weakness of (L) foot dorsiflexors. Due to a breakthrough seizure 1/8/04 he remains on Dilantin 100 TID. Additionally underwent a recent CT 2 wks ago w/ communicating hydrocephalus w/ his headaches improved with an LP.

Medications:
Neurontin 300mg po TID
Dilantin 100mg po TID
Zantac 50mg po BID
Colace 100mg po BID

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[redacted]

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

LTC, MC, USA [redacted] Commander

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

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	anesthesia Diagnosis: (1). Penetrating Brain Injury
	(2). Traumatic Brain Injury 2nd #1 with Residual (L) dorsiflexion weakness of (L) foot (uses a cane to ambulate).
	(3). Healing (R) Scapular wounds (dry dressing currently)
	(4). Pneumonia Resolved.
	(5). Seizures 2nd #1 Tx w/ Dilantin 100mg TID
	(6). Communicating Hydrocephalus tx w/ Lumbar Puncture (May require subsequent CT Head in 2-3wks with repeat LP).
	(b)(6)-2
	LTC [redacted]
	[redacted] TM
	(b)(2)-2 [redacted] Hospital
	[redacted] Hospital
	Baghdad, Iraq

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Jan 04	(1830) VSS. C/O pain to head at start of shift. Med c̄ 2 prc. Pt amb c̄ steady gait. Tol PO well. Voids CYU. Δ DSG to back c̄ Dakin's WTD. DIC orders written + summary written. [redacted]
20 Jan 04	0030 - assumed care of pt. @ 2200. A+O c/o pain or discomfort @ this time. Pt. in bed speaking in Arabic c̄ roommate. dsg Δ to upper back. ⊖ s/sx infection. Voids CYU via urinal. Two point restraints in place. (+) circulation ⊖ skin breakdown. D/C orders written + D/C summary. Awaiting D/C to camp 20. [redacted] will cont. to monitor pt. [redacted]
20	(0140) I concur c̄ above assessment. [redacted]
20 Jan 04	@ 0630 - Assumed care of pt. A+O x3. VSS Denies pain or discomfort. Lungs CTA HRRR Active BS x4 quads. Voids c̄ difficulty. Wound to (R) shoulder healing well ⊖ s/sx of infect. All other assessments WNL. OK for discharge to camp today. Will cont to monitor [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6 NOV 03	0800 Pt ate 10% of breakfast. — [redacted] CT/AN
	0930 Pt stable at this time. Alert and oriented to person & place. PERRLA. Ø C/O headache at this time. Weakness noted to (L) LE. Pt OOB to BSC. Large BM today. Dsg to back x 3 CDI. Trach dsg intact c̄ petroleum gauze. Ø C/O pain, Ø weakness noted to (L) UE. — [redacted] LT/AN
	1200 BP 116/74 P 92 R 16 T 98.8 O2 98% RA — [redacted]
	1835 Dsg Δ done. Dsg to (R) shoulder c̄ purulent drainage. W>D dsg Δ done to 3 wounds on back. Ø C/O pain. — [redacted] LT/AN
6 NOV 03 2130	Pt awake & responds appropriately intermittently. HR Regular, lungs sounds clear bilat, bowel sounds (+) x 4 quads. Wound to neck c̄ to old trach site, slight whistling sound heard when pt speaks. DSG to (R) shoulder Δd W>D c̄ NS, small amt of pseudomonas drainage noted on old dsg, wound pink & moist. Pt c̄ IV access. Pt voiding via urinal c̄ difficulty. Ø complaints @ this time. — [redacted] CT/AN

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

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

REGISTER NO.

WARD NO. ICW2

(b)(6)-4 wrong pt

EPW # [redacted]

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

USAPA V2.00

S/P Craniotomy

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 30 Oct 03 Diagnosis: GSW Head, S/P Trach, Craniotomy, multiple shrapnel injuries HD: 29 POD: 27 / 14

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	2	Mobility	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	4	3	Nutrition	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4	1	Friction and Shear	No apparent problem	3	
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	1	
	Bedfast	1					

Add the total score 6 **Total Score** 10 8

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates **HIGH RISK** –Requires immediate Ulcer prevention program.

Surgical wound (s): Yes No Location:_____ Size: _____ Drainage: _____
Tubes: _____ Appearance: _____
Dressing change: _____

Pressure Ulcer (s): Yes No
Stage I, II, III, IV-(Circle the one that applies and describe below)

[redacted] (b)(6)-2

Location: _____ Size: _____
Wound character: Pint_____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough _____
Odor _____ Purulent discharge _____ Eschar _____ Exudates _____

Type of dressing change: Wet-to-dry_____ Comfeel dressing _____ Carrasyn V-Gel_____ Alginate _____

Physician notified/consulted for wound debridement: Yes_____ No_____
CNS notified/consulted for Stage II and greater: Yes_____ No_____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes_____ No _____
Action Taken: _____ Date & Time: _____

See wound and skin assessment dated 28 NOV

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

[redacted] (b)(6)-4

PROGRESS NOTES

Medical Record
STANDARD FORM 509

Medical Record

Progress Notes

Wound and Skin Assessment

Date and Time 28 NOV 03, 1430 Wound number #1
Stage I-IV N/A Surgical or Non-Surgical shrapnel
Location (R) shoulder
Shape oblong Measurements 12cm l x 6cm w x 2cm D
Tissue Color pink, moist, ø necrotic tissue, granulating
Drains and Type ø, ø order
Drainage (amt and color) ø
Dressing Type Wet to dry
Dressing Change Frequency T.I.D Wound Cleansing NS
Additional Info (turning, elevation of extremeties, etc.)
Be sure to irrigate wound thoroughly c̄ NS, pat dry c̄ sterile gauze, pack loosely w/ all tunneling & undermining apply dry gauze over drsg. & secure c̄ tape.

Date and Time 28 NOV, 1430 Wound number #2
Stage I-IV N/A Surgical or Non-Surgical shrapnel
Location (R) shoulder
Shape oblong Measurements 6cm l x 3cm w x 1cm D
Tissue Color pink & moist
Drains and Type ø
Drainage (amt and color) ø, no order or necrotic tissue
Dressing Type wet-to-dry
Dressing Change Frequency T.I.D Wound Cleansing Same as above
Additional Info (turning, elevation of extremeties, etc.)
Healing

Date and Time 28 NOV 03, 1430 Wound number #3
Stage I-IV N/A Surgical or Non-Surgical
Location (L) shoulder
Shape oblong Measurements 3cm l x 1.5cm w x superficial
Tissue Color pink & moist
Drains and Type none
Drainage (amt and color) ø, ø order
Dressing Type comfeel
Dressing Change Frequency Q 5-7 days Wound Cleansing Clean c̄ NS, pat dry, apply Comfeel / Duoderm
Additional Info (turning, elevation of extremeties, etc.)
wound healing well

Patient ID: Unit No.

→ Cont. on back

Standard Form 509

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 28 NOV 03. 1430 Wound number #4
Stage I-IV N/A Surgical or Non-Surgical
Location mid back
Shape oblong Measurements 2cm L x 1cm W, superficial
Tissue Color pink, epithealization process evident
Drains and Type Ø
Drainage (amt and color) Ø
Dressing Type Clear-opsite
Dressing Change Frequency q 5-7 days Wound Cleansing same as previous
Additional Info (turning, elevation of extremeties, etc.)
Wound ~~heal~~ healed - site protected from friction injury.

Date and Time Wound number
Stage I-IV Surgical or Non-Surgical
Location
Shape Measurements
Tissue Color
Drains and Type
Drainage (amt and color)
Dressing Type
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Date and Time Wound number
Stage I-IV Surgical or Non-Surgical
Location
Shape Measurements
Tissue Color
Drains and Type
Drainage (amt and color)
Dressing Type
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 30 Oct **Diagnosis:** Craniotomy (GSW to head) Trach [redacted] **HD:** 29 **POD:** 27/14

Date: 28 NOV 03 Time: 1430 RN Signature: [redacted] 44J 4W

Skin breakdown as evidenced by immobility, friction, [redacted] wound, skin tear.

Wound type: Surgical wound (s) Location: (R) Shoulder (b)(6)-2 Size: ① 2cm x 6x2 ② 6cm x 3x1 ③ 2cm x 1.5 ④ 1cm x 1cm Drainage: Ø

Diabetic ulcer Tubes: Ø Pins: Ø Appearance: pink & moist, Ø exudate or order

Venous stasis ulcer Dressing change: TID

Other ✓ Describe Shrapnel wound

Burn wound (s): % BSA____ Partial____ Full____

Location:____ Size____

Appearance:____

Dressing change:____

Pressure Ulcer (s):

Stage I, II, III, IV (Circle the one that applies and describe below)

Location: (L) shoulder Size: #3

Wound character: Pink ✓ Moist ✓ Dry____ Granulation tissue ✓ Yellow slough Ø

Tunneling Ø Undermining Ø Odor Ø Purulent discharge Ø Eschar Ø Exudates Ø

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- [x] Wet to Dry Dressing #1 #2 (wound)
- [ ] Carrasyn-V GelDressing
- [ ] Alginate Dressing
- [x] Comfeel Dressing #3
- [x] Op-site #4
- [ ] Pin Site Care
- [ ] J-Tube Care
- [ ] Colostomy Care
- [ ] Chest Tube Care
- [ ] Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- [x] Sterile 4x4 gauze dressing
- [ ] Sterile 2x2 gauze dressing
- [x] Sterile gloves
- [ ] Kerlix (super sponge)
- [ ] Gauze bandage
- [x] Sterile Normal Saline
- [ ] Sterile Water
- [ ] 8 x 4 Sponge gauze
- [x] Op-site
- [ ] Tegaderm clear dressing
- [ ] Alkare skin prep
- [x] Comfeel clear
- [ ] Comfeel pressure ulcer drsg
- [ ] Carrasyn-V Gel
- [ ] Alginate
- [ ] Bacitracin
- [ ] Silvadene Cream
- [ ] Petrolatum gauze
- [ ] Hibicleanse
- [ ] Non-adhesive dressing
- [ ] Telpha Pad
- [ ] Carra-smart film
- [x] Sterile Q-tip applicator
- [ ] Xeroform 5 x 9.
- [ ] Moisture barrier cream
- [ ] 0.125% Dakins sol
- [ ] Betadine Swab sticks
- [ ] ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- [ ] b.i.d.
- [x] t.i.d

MD Signature and Date:

CNS [redacted] 44J 4W

(b)(6)-2

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

[redacted] (b)(6)-4

Medical Record

Progress Notes

Braden Scale Evaluation

Date: 12.5.03

Sensory Perception	No Impairment	4
	Slightly Limited	3
	Very Limited	2
	Completely Impaired	1
Moisture	Rarely Moist	4
	Occasionally Moist	3
	Moist	2
	Constantly Moist	1
Activity	Walks Frequently	4
	Walks Occasionally	3
	Chairfast	2
	Bedfast	1
Mobility	No Limitations	4
	Slightly Limited	3
	Very Limited	2
	Completely Immobile	1
Nutrition	Excellent	4
	Adequate (Eats >50%)	3
	Adequate (rarely eats)	2
	Very Poor	1
Friction and Shear	No Apparent Problem	3
	Potential Problem	2
	Problems	1

Total Score: 18

Score <15 requires Immediate Ulcer Prevention Program

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Date: _____

Sensory Perception	No Impairment	4
	Slightly Limited	3
	Very Limited	2
	Completely Impaired	1
Moisture	Rarely Moist	4
	Occasionally Moist	3
	Moist	2
	Constantly Moist	1
Activity	Walks Frequently	4
	Walks Occasionally	3
	Chairfast	2
	Bedfast	1
Mobility	No Limitations	4
	Slightly Limited	3
	Very Limited	2
	Completely Immobile	1
Nutrition	Excellent	4
	Adequate (Eats >50%)	3
	Adequate (rarely eats)	2
	Very Poor	1
Friction and Shear	No Apparent Problem	3
	Potential Problem	2
	Problems	1

Total Score: _____

Score <15 requires Immediate Ulcer Prevention Program

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Unit No. _____

Standard Form 509

Patient ID:

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 11.28.03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 27/14 | HOSPITAL DAY: 29

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 0954 To ICU#2 From ICU#2 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time / Physician [redacted] Anesthesia (Specify):

Procedure/Diagnosis S/P craniotomy c̄ depressed B/P 110/61 P 110-120 R 33. T 98.8

LOC S/P trach, s/p skull fx, f/o R shoulder Neurovascular checks

Dressing/cast Sutures to head. Tubes Foley catheter.

Intake (IV, po) 20 g @ hand Output (EBL, other) (b)(6)-2 Voided ☐ No ☐ Yes Amount: 200-300cc/h

Medication D5NS c̄ 20 kcl @ 125. , soft mechanical diet. * calorie count

Other GSW to head. , motor paralysis (L) side

Report From CPT [redacted] Received By LT [redacted]

VITAL SIGNS

TIME:	1028	2028	0555												
BP ARTERIAL LINE	/	—	—												
BP CUFF	101/68	103/64	95/65												
TEMPERATURE	97.7	97.6	98.8												
PULSE	114	113	95												
RESPIRATORY RATE	30	26	16												
OXYGEN (L/%)	/	—	—												
PULSE OXIMETER	RA-	99%	99												
O2 METHOD	99%	RA	99%												
			Trach												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1028	2028	0130					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	~	N					
RELIEF ACCEPTABLE (Y/N)	N/A		N/A					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1028		0130
*Skin breakdown prevention	✓3		[redacted] (b)(6)-2
*Falls prevention protocol	/		
*Restraint protocol	✓3		[redacted]
*Seizure precautions	/		N/A
*Isolation precautions			N/A

YESTERDAY'S WEIGHT:

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine 2400		Stool			TOTAL OUT

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/P craniotomy

DRG:

ADMISSION DATE: 10/31/03

LOS:

EXPECTED RELEASE:

CASE MANAGER: (b)(6)-2

PRIMARY CARE MANAGER: [redacted]

EQUIRED (Specify):

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are [redacted] brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2130 [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ ALERT	☐	☐ Alert
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐ TACHYCARDIC @ 120	☐	☐ Tachy
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ TACHYPNIC @ 35 TRACH C̄ HUMIDIFIED RA	☐	☐ Tachypnic Tracheostomy c̄ humidified O_2
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑ Foley to gravity draining clear, yellow urine
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM TO (L) SIDE	☐	☐ (R) sided paralysis
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SCALP LAC TO (R) SIDE DSG TO (R) SHOULDER/ARM LAC TO POST (R) LE OTA	☐	☐ scalp lac, Dressing to (R) scapula
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ PT DENIES	☐	☑ scuffy 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ PT TRACHED UNABLE TO SPEAK	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2130 INITIALS: [redacted]
IV patency ✓ q	5 hr:	hr:	8 hr: PRN
IV site care provided:	ASSESS		Assessed
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(R) WRIST / OK		(L) FA / OK
IV Site #2:			
Comments:	D5NS @ 20K @ 125		Flushed + NS @ 125cc/hr (R)

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1100					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	~~0~~					
SENSATION	S					
MOTION R-E	[redacted]					
PASSIVE FLEXION	~~0~~					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1100		2130
ID band visible/legible	✓		[redacted]
Orient to environment prn	JB		[redacted]
Side rails (2/4) up	✓		
Bed position low	✓		
Call light within reach	✓		
Review & post lab results	✓		[redacted]
Notify MD abnormal labs	✓		[redacted]
			N/A
Incontinent urine/stool	✓		
Linen change prn	✓		[redacted]
Turn/reposition q2h	JB		[redacted]
ROM q2h if immobile	✓		N/A
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: MECH SOFT	TYPE: MECH SOFT
PERCENT CONSUMED:	PERCENT CONSUMED: 40%	PERCENT CONSUMED: 60%
HOW TOLERATED:	HOW TOLERATED: WELL	HOW TOLERATED: WELL
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☒ COMPLETE	☐ SELF ☐ ASSIST ☒ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP (CHAIR) ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1100 INITIALS: JB	TIME: INITIALS:	TIME: INITIALS:
CONTENT: FEDB PRN HUMIDIFIED RESTRAINTS RESTRAINT PROTOCOL	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW H[redacted] (5)(6)-4	[redacted]	[redacted] T, RWMB	09-21
		[redacted] D/AW	PP/9X
		(b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2400	(R) shoulder (L) shoulder		

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 29 Nov 05 | PATIENT ACUITY LEVEL: IV | POST-OP DAY: 28/15 | HOSPITAL DAY: 50

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400												
BP ARTERIAL LINE	105														
BP CUFF	71	104/69	100/50												
TEMPERATURE	99°	99.4	99.4												
PULSE	105	114	87												
RESPIRATORY RATE	20	20	18												
OXYGEN (L/%)															
PULSE OXIMETER	98	97	98%												
O2 METHOD	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1010	0400						
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	Y	Y						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1010		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

DIAGNOSIS: S/P Craniotomy

DRG: _____ ADMISSION DATE: 31 OCT 05

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: (b)(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

(b)(6)-2

	TIME: 1010 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☒ Alert, - not oriented asking about needing to go to the hospital wondering why has weakness	☐	☐ Alert & oriented
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☒ trachyostomy c̄ humidified O_2	☐	☐ Tracheostomy c̄ humidified O_2 Productive cough
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☒ foley to gravity clear yellow urine	☐	☐ foley to grav clear yellow urine
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☒ (L) LE paralysis (L) UE able move but weak	☐	☐ Able to move all extremities weakness to (L) LE
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☒ drsg to (R) scapula scalp lac	☐	☐ (R) scapula scalp lac
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ pt able to write in arabic and understand arabic - not english	☐	☐ combative; trying to make fist and hit staff

(b)(6)-2

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1010 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr: PRN
IV site care provided:	IV site care provided:	IV site care provided: Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) FA OK	IV Site #1:	IV Site #1: (L) FA OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: NS @125	Comments:	Comments: IV ABX

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) LE TIME:	1010	2300				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	U	U				
PASSIVE FLEXION	Ø	Ø				
PERIPHERAL PULSE	2	2				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1010		2300
ID band visible/legible	[redacted]		[redacted]
Orient to environment prn	[redacted]		[redacted]
Side rails (2/4) up	/		N/A
Bed position low			
Call light within reach	/		

OTHER

Review & post lab results	/		
Notify MD abnormal labs	/		
Incontinent urine/stool	/		
Linen change prn	/		
Turn/reposition q2h	/		
ROM q2h if immobile	/		
Antiembolic hose	/		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Mech Soft	TYPE: Mech Soft	TYPE: Mech Soft
PERCENT CONSUMED: 10%	PERCENT CONSUMED: 10%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☐ SELF ☐ ASSIST ☒ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR — ☒ SELF ☒ ASSIST — # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR — ☐ SELF ☐ ASSIST — # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR — ☐ SELF ☐ ASSIST — # TIMES/SHIFT

TEACHING

TIME: 1010 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: explained - pain management - call for assist - that he's in the hospital - by interpreter	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW [redacted] (b)(6)-4	[redacted]	[redacted] (b)(6)-2	1

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1100 - Pt up to chair, shaved self, washed up, [redacted] AN

1230 - Pt offered water and food for lunch [redacted] AN

to eat anything except [redacted] AN

bread [redacted] AN

1500 - Pt found standing on (R) leg in room when asked what he was doing stated he needed to go to an Iraqi hospital [redacted] AN

1520 late entry for 1130 - Sutures removed from [redacted] AN

per MD instructions [redacted]

2-5(5)

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 30 NOV 03 | PATIENT ACUITY LEVEL: IV | POST-OP DAY: 09/16 | HOSPITAL DAY: 31

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	2000	2130	0460	12												
BP ARTERIAL LINE	/															
BP CUFF	114/62		106/48													
TEMPERATURE	99.4		98.3													
PULSE	71		105													
RESPIRATORY RATE	16		16													
OXYGEN (L/%)	/															
PULSE OXIMETER	100		100													
O2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1045	2130						
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	N/A	N/A						

SPECIAL NEEDS

TIME:	1045	2130
*Skin breakdown prevention	[redacted]	
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions	N/A	N/A
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine 885		Stool			TOTAL OUT 885

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/P craniotomy, GSW (Esophagus)

DRG: _____ ADMISSION DATE: 31 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER [redacted]

ISOLATION REQUIRED (*Specify*): _____

2-19(5)

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

(b)(6)-2

	TIME: 1045 INITIALS: [redacted]	TIME: 2130 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ follows simple commands. Communicates through writing.	☐ follows commands	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ tracheostomy. pt. c̄ productive cough whitish sputum.	☐ tracheostomy DCbl today. Dsg CD+I	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley to gravity c̄ clear yellow urine.	☐ Foley to gravity	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Partial motor paralysis (R) UE, (L) side of body. OOB c̄ assist x2	☐ ↓ motor function (R) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Shrapnel wounds to Both post. shoulders.	☐ Shrapnel wounds Both shoulders	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

(b)(6)-2

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1045 INITIALS: [redacted]	TIME: 2130 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided: assessed	IV site care provided: assess	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) AC / OK	IV Site #1: (L) AC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: IVF @ TKO	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: LUE, LLE TIME:	1045	2130					
COLOR	P	P	P	P			
CAPILLARY REFILL	1	1	1	1			
TEMPERATURE	W	W	W	W			
EDEMA	Ø	Ø	0	0			
SENSATION	S	S	S	S			
MOTION	m	m	M	M			
PASSIVE FLEXION	/	/	/	/			
PERIPHERAL PULSE	2+	2+	2+	2+			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1045	2130	
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		(b)(6)-2
Side rails (2/4) up	[redacted]		
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose	✓	✓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: See calcu	PERCENT CONSUMED: count	PERCENT CONSUMED: Count
HOW TOLERATED: Count	HOW TOLERATED: sheet	HOW TOLERATED: sheet
☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF; AMBULATE ☐ ASSIST; BSC; BRP; CHAIR; 3 # TIMES/SHIFT	BEDREST ☐ SELF; AMBULATE ☐ ASSIST; BSC; BRP; CHAIR; # TIMES/SHIFT	BEDREST ☐ SELF; AMBULATE ☐ ASSIST; BSC; BRP; CHAIR; # TIMES/SHIFT

TEACHING

TIME: 1045 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2130 INITIALS: [redacted]
CONTENT: 1.) Personal hygiene 2.) Ø visitors allowed	CONTENT:	CONTENT: . Call for assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW (b)(6)-4 [redacted]	[redacted]	[redacted] /CTAN, SPC/ [redacted]	D N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2130	(R) Shoulder	old DSG's falling off. areas pink NO S/S infection	W→D DSG Δ

SECTION IV - NOTES

1015: Pt. OOB to chair and BSC x1 hr. — [redacted] / STAN

1240: Pt. c/o severe pain to Rt. side neck radiating down to Rt. hip. MD called for pain medication order. — [redacted] / STAN

(b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 1 DEC 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 30/17 | HOSPITAL DAY: 32

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2200	0400													
BP ARTERIAL LINE																
BP CUFF	105/64	119/41	127/66													
TEMPERATURE	98.0	97.5	98.4													
PULSE	97	78	109													
RESPIRATORY RATE	16	16	20													
OXYGEN (L/%)																
PULSE OXIMETER	100	99%	99													
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0930	2240						
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	NA	N/A						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0930	2240
*Skin breakdown prevention	NA	N/A
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW # [redacted]

DIAGNOSIS: S/P Craniotomy, GSW (R) shoulder

DRG: _____ ADMISSION DATE: 31 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

(b)(6)-2

	TIME: 0930 INITIALS: [redacted]	TIME: 2240 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ Pt has times where he acts confused even using a translator 2° to head injury	☐ At times pt will speak in complete sentences and at times he will act confused per translator.	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑ Old Trach site c̄ DSG	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ foley to gravity - clear yellow urine	☐ Foley to gravity	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Pt unable to moved (L) leg; limited ROM to (L) arm	☐ Limited ROM (L) UE and (L) LE. Unequal hand grips	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Scar to (R) temporal area, DSGS x3 to back	☐ DSGS to BACK CDI SCAR to (R) temporal area	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ behavior can be confused	☐	☐

(b)(6)-2

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0930 INITIALS: [redacted]	TIME: 2240 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) AC / I	IV Site #1: (L) wrist / OK	IV Site #1:
IV Site #2: (L) wrist / OK	IV Site #2:	IV Site #2:
Comments:	Comments: HL	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0930	2240	
ID band visible/legible	[redacted]		(b)(6)-2
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg - 100% ensure	Reg	Reg
PERCENT CONSUMED:	15%	50% ensure 70% meal	75% Ensure 2240
HOW TOLERATED:	50-50	Well	Well
	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0930 INITIALS: [redacted]	TIME: 2240 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: OOB to Chair New IV Pt to drink water between meals	CONTENT: Encourage fluids (b)(6)-2	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	[redacted] II/AN	D
		[redacted] SPC/91WMG	N

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 2Dec03 | PATIENT ACUITY LEVEL: ~~II~~ | POST-OP DAY: 31/18 | HOSPITAL DAY: 33

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1500	2000	2400												
BP ARTERIAL LINE															
BP CUFF	121/52	100/64													
TEMPERATURE	95.2	99.2	97.9												
PULSE	136	100	89												
RESPIRATORY RATE	16	16	16												
OXYGEN (L/%)															
PULSE OXIMETER	98	99%	97%												
O_2 METHOD	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	2000	2200						
PAIN INTENSITY (10 / 5 / 0)	N	N						
MED ADMINISTERED (Y/N)		N						
RELIEF ACCEPTABLE (Y/N)		NA						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1200	2200
*Skin breakdown prevention	[redacted]	NA
*Falls prevention protocol		
*Restraint protocol (b)(6)-2	[redacted]	
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
	NA													

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/p Craniotomy, GSW (R) shoulder

DRG: _____ ADMISSION DATE: 31OCT03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: (b)(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

(b)(6)-2

	TIME: 1200 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐ - pt c̄ brain injury, intermittent appropriate communication - (L) sided weakness	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley D/c'd. Voiding dark yellow urine.	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ pt unable to move (L) leg.	☐ - pt c̄ (L) sided weakness - unable to move (L) LE - 2 point restraints	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ old trach site, wounds to (R) shoulder x2, (L) shoulder x1	☐ - post trach site - wounds to (L) & (R) shoulder	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑ Ø c/o pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐ - neurological injury	☐

(b)(6)-2

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1200 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr: PLO	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided: New IV.	IV site care provided: timed & dated	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1: (L) FA / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HC'd.	Comments: HL.	Comments:

NEUROVASCULAR

SITE: ELE TIME:	1200	2200				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S					
MOTION	~~M~~	U				
PASSIVE FLEXION	Ø	Ø				
PERIPHERAL PULSE	2+	2+				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 1200	2200	
ID band visible/legible	[redacted]	[redacted]	
Orient to environment prn	[redacted]	[redacted]	
Side rails (2/4) up	[redacted]	[redacted]	
Bed position low		[redacted]	
Call light within reach		[redacted]	
Review & post lab results		[redacted]	
Notify MD abnormal labs		[redacted]	
Incontinent urine/stool		NA	
Linen change prn		[redacted]	
Turn/reposition q2h		NA	
ROM q2h if immobile			
Antiembolic hose			

(b)(6)-5

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: Reg	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 100%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED: well	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC # TIMES/SHIFT BRP CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC # TIMES/SHIFT BRP CHAIR 2 point restraints

TEACHING

TIME: 1200 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2200 INITIALS: [redacted]
CONTENT: 1) Must eat or will have to get tube feeds.	CONTENT:	CONTENT: - DSG Δ's - nutrition
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW # [redacted] (b)(6)-4	[redacted]	[redacted] OT/AN	D
		[redacted] OT/AN	2100

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1900	(R) shoulder/scapula	erythem Beefy	wet ⇒ dry Δ
		(L) shoulder	erythem Beefy	wet ⇒ dry Δ

SECTION IV - NOTES

Pt (A)VPD. Ø c/o PN. (C) shoulder right ⊖ S/S of infection
Right erythem, Beefy looking. wet to dry c̄ sodium chloride.
(R) shoulder/scapula Right erythem wet to dry dress Δ
c̄ sodium chloride ⊖ S/S of infection ⊖ odor, PT
tolerated well [redacted] SPC

(b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

TE: 3 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 32/19 | HOSPITAL DAY: 34

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (ESL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS — TIME:	0400	1200	2000	0400											
BP ARTERIAL LINE				119											
BP CUFF	100/60	114/70	116/88	128											
TEMPERATURE	98.4	99.8	98.1	97.8											
PULSE	93	88	74	84											
RESPIRATORY RATE	14	14	14	16											
OXYGEN (L/%)															
PULSE OXIMETER	98%	99%	99%	98%											
O_2 METHOD	RA	RA	RA	RA											

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN — TIME:	1200	2000	0259					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	Y	Y	N					
RELIEF ACCEPTABLE (Y/N)			N/A					

SPECIAL NEEDS — TIME:	1100		
*Skin breakdown prevention	NA		
*Falls prevention protocol	✓		
*Restraint protocol	[redacted]		
*Seizure precautions			
*Isolation precautions	(b)(6)-2		

OTHER — TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/P craniotomy, GSW (R) shoulder

DRG: _____ ADMISSION DATE: 31 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): (b)(6)-2

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2259 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	☐ (b)(6)-2	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	☐	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ Trach site covered.	☐	☐ Trach site dressing D'd sutures intact
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	☐	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	☐	☐ incontinent urine x1
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling tenderness, weakness or paresthesia.	☐ increased ability to weight bear LLE but still marked ↓ in mobility LLE	☐	☐ weakness (L) side ↓ mobility
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Shrapnel wounds x2 Rt. Shoulder x1 Lt. Shoulder.	☐	☐ GSW (R) shoulder shrapnel wound (R) shoulder
8. PAIN: No complaints of pain/discomfort. *(See page 1 for documenting pain intensity.)*	✓	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	☐ (b)(6)-2	✓ language barrier

10. IV SITE ASSESSMENT: LEGEND: P - Patty I - Infiltrated R - Reddened OK - No swelling/redness * - Central line [redacted]

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2259 INITIALS: [redacted]
IV patency ✓ q 8 hr:	PRN		PRN
IV site care provided:	assessed.		Assessed
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(L) AC / OK.		(L) AC / OK
IV Site #2:			
Comments:	AC'd.		AL

NEUROVASCULAR

SITE: LLE TIME:	1100	1104	2259			
COLOR	P	/	P			
CAPILLARY REFILL	1	/	1			
TEMPERATURE	W	/	W			
EDEMA	0	/	0			
SENSATION	S	/	S			
MOTION	MU	U	MU			
PASSIVE FLEXION	0	/	0			
PERIPHERAL PULSE	2+	/	2+			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1		2259
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	NA		NA
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 30%	PERCENT CONSUMED: 60%	PERCENT CONSUMED: 70%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: 2259 INITIALS: [redacted]
CONTENT:	CONTENT:	CONTENT: Call for assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	[redacted]	1

2-0-0

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		a ① (L) shoulder	① healthy pink tissue a s/s infection	ω → D D
		② (R) shoulder	② healthy pink tissue a s/s infection	
		③ Tracheostomy	③ dry sterile dressing	D'd

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 4 DEC 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 5 | HOSPITAL DAY: 6

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (ESL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400												
BP ARTERIAL LINE		—	—												
BP CUFF	110/60	106/66	106/62												
TEMPERATURE	97.5	96.9	97.2												
PULSE	71	83	82												
RESPIRATORY RATE	16	16	16												
OXYGEN (L/%)		—	—												
PULSE OXIMETER		96	97												
O2 METHOD		RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1200	2230	0400					
PAIN INTENSITY (10 / 5 / 0)	X	0	X					
MED ADMINISTERED (Y/N)	N	Y						
RELIEF ACCEPTABLE (Y/N)	Y	Y						
Percocet		II						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

NA

SPECIAL NEEDS

	TIME: 2230		
*Skin breakdown prevention	NA		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

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

DIAGNOSIS: Abd wound washout

DRG: _____ ADMISSION DATE: 29NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: [redacted] (b)(6)-2

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1510 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑ (b)(6)-2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ ϕ c̄ N/V hyperactive BS CT scan @ 1500	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling tenderness, weakness or paresthesia.	☑ up ad lib	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ drsg covering incision site CDI	☐ ML abd incision Dsg CDI.	☐
8. PAIN: No complaints of pain/discomfort. *(See page 1 for documenting pain intensity.)*	☐ percocet providing (+) pos effect.	☐ c/o pain to abd. incision. Percocet II PO given	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ family c bs (b)(6)-2	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Patty I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1510 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: R FA / OK	IV Site #1: BAC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: DL	Comments:	Comments:

NEUROVASCULAR	SITE: TIME:					
	COLOR					
	CAPILLARY REFILL					
	TEMPERATURE					
	EDEMA					
	SENSATION					
	MOTION					
	PASSIVE FLEXION					
	PERIPHERAL PULSE					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY	TIME: 1510	2230	
	ID band visible/legible	[redacted]	
	Orient to environment prn		
	Side rails (2/4) up	/	N/A
	Bed position low	/	
	Call light within reach	/	

OTHER			
	Review & post lab results	/	
	Notify MD abnormal labs	/	
	Incontinent urine/stool	[redacted]	
	Linen change prn		
	Turn/reposition q2h		N/A
	ROM q2h if immobile		
	Antiembolic hose		✓

(b)(6)-2

DIET	BREAKFAST	LUNCH	DINNER
	TYPE: Reg	TYPE: NPO	TYPE: Reg
	PERCENT CONSUMED: 10%	PERCENT CONSUMED:	PERCENT CONSUMED: [illegible]
	HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: [illegible]
	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs		0700-1500	1500-2300	2300-0700
	BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
	TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☑ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☑ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
	CONTENT: -Bed to Asst. & shoes for safety. -pain control	CONTENT: -Plan of care	CONTENT:
	☑ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient [redacted] izes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS		SHIFT
[redacted]	[redacted]	[illegible]	1
		[illegible]	5

(b)(6)-4

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1510	Midline abd.	CDI	

SECTION IV - NOTES

2230: A+O x3. C/O pain 5/10 to ML abd. incision [redacted] IV, Ac
IV Po given. Will continue to monitor.

(b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 4 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 33/00 | HOSPITAL DAY: 35

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (ESL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0600	0800	2400												
BP ARTERIAL LINE	—	—	—												
BP CUFF	150/64	150/56	120/56												
TEMPERATURE	96.5	97.2	96.6												
PULSE	97	80	82												
RESPIRATORY RATE	16	16	16												
OXYGEN (L/%)	—	—	—												
PULSE OXIMETER	99	99	99												
O2 METHOD	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1100	0400						
PAIN INTENSITY (10 / 5 / 0)		X						
MED ADMINISTERED (Y/N)	Y							
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:	4PM							
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1000	2300
*Skin breakdown prevention	[redacted]	
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions	N/A	
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/P craniotomy; GSW to head

DRG: _____ ADMISSION DATE: 31 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

(b)(6)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2200 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ ~~X pt. complains~~ roomates complain he's senial.	☐	☐ ~~Alert, occasionally oriented~~
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐ (b)(6)-2	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ Pt. ABP soft, flat C/O constipation. Ø results from Dulcolax supp.	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑ using urinal needs ~~to~~ emptying
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling tenderness, weakness or paresthesia.	☐ ↑ mobility LLE, still ↓ strength, needs assistance for transfers.	☐	☐ weakness (D) side
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐	☑
8. PAIN: No complaints of pain/discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others. (b)(6)-2	☑	☐	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2200 INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: assord	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: GFA / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HC'd	Comments:	Comments:

(b)(6)-2

NEUROVASCULAR	SITE: LLE TIME: 1100 2300					
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	C				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	Ø	Ø				
PERIPHERAL PULSE	2+	2P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; O-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY	TIME: 1		2300
ID band visible/legible	[redacted]		[redacted]
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET	BREAKFAST	LUNCH	DINNER
TYPE:	Reg + ensure	Reg + ensure	Reg
PERCENT CONSUMED:	100% ensure	100% + ensure	50%
HOW TOLERATED:	well		
	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING	TIME: INITIALS:	TIME: INITIALS:	TIME: 2300 INITIALS: [redacted]
CONTENT:			Call for assist
	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Civ (b)(6)-4 [redacted]	[redacted]	[redacted] TAN 01-09	D

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1000: Pt. assisted c̄ oral hygiene, hair wash, facial shave. Pt. OOB x 2 hours. Will cont to monitor. [redacted] SM

(b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 5 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 34/21 | HOSPITAL DAY: 36

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE																
BP CUFF	110/78	110/80	115/61													
TEMPERATURE	98.6	97.0	98.4													
PULSE	78	95	75													
RESPIRATORY RATE	14	16	20													
OXYGEN (L/%)																
PULSE OXIMETER	95%	99%	99%													
O2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1200	2000	2230	2430				
PAIN INTENSITY (10 / 5 / 0)			X					
MED ADMINISTERED (Y/N)			Y	N				
RELIEF ACCEPTABLE (Y/N)			Y	N/A				

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	[redacted] 2430
*Skin breakdown prevention	[redacted] NA
*Falls prevention protocol	[redacted]
*Restraint protocol (b)(6)-2	[redacted]
*Seizure precautions	[redacted]
*Isolation precautions	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
		NA												

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

DIAGNOSIS: S/P Craniotomy/GSW @ shoulder

DRG: _____ ADMISSION DATE: 31 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): (b)(6)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1230 INITIALS: [redacted]	TIME: 2430 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐ Intermittently oriented (b)(6)-2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ old trach site covered c̄ 4x4.	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ encourage PO intake.	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling tenderness, weakness or paresthesia.	☐ ↓ROM, ↓ mobility c̄ LE amb. c̄ assist today	☐ - ↓ROM to (R) LE - (R) sided weakness	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ - wound to (R) shoulder - old trach site	☐
8. PAIN: No complaints of pain/discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ - 5/10 pain HA	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Patty I - Infiltrated R - Reddened OK - No swelling/redness + - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments: NO IV access	Comments:

[redacted] (b)(6)-2

NEUROVASCULAR

SITE: LLE TIME:	1200	2430				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	N				
MOTION	P	U				
PASSIVE FLEXION	/	Ø				
PERIPHERAL PULSE	2+	2P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME:	[redacted]	
SAFETY	ID band visible/legible	[redacted]	
	Orient to environment prn	[redacted]	
	Side rails (2/4)-up	NA	NA
	Bed position low		[redacted]
	Call light within reach		NA
OTHER	Review & post lab results		[redacted]
	Notify MD abnormal labs		[redacted]
	Incontinent urine/stool		NA
	Linen change prn		[redacted]
	Turn/reposition q2h		NA
	ROM q2h if immobile		
	Antiembolic hose		

(b)(6)-2

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg	Reg	Reg
PERCENT CONSUMED:	75%	75%	–
HOW TOLERATED:		Well	
	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR	BEDREST, AMBULATE, BSC, BRP, CHAIR	BEDREST, AMBULATE, BSC, BRP, CHAIR
	☐ SELF ☒ ASSIST # TIMES/SHIFT	☐ SELF ☐ ASSIST # TIMES/SHIFT	☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

	TIME: INITIALS:	TIME: INITIALS:	TIME: 2430 INITIALS: [redacted]
CONTENT:			– pain management – DSG Δ's – call for assistance
	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW [redacted] (b)(6)-4	[redacted]	[redacted] RN	D
		[redacted] RN	21-09

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2430 2000	(R) shoulder (L) shoulder	-wounds pink moist -Ø s/s of infection -Ø drainage noted	W/D DSG Ō NS

SECTION IV - NOTES

5DEC03 1340 PT FOUND ON FLOOR Ē (L) ARM RESTRAINT OFF BUT INTACT ET 2 LE RESTRAINT ON ET INTACT, DR [redacted] NOTIFIED ET NEURO CHECKS DONE [redacted] INTACT Ē Ø Δ FROM PRE FALL CHECKS. [redacted] ET 91WM6

(b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 7 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 26 | HOSPITAL DAY: 38

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400
BP ARTERIAL LINE		100	99
BP CUFF	89/52	47	49
TEMPERATURE	98.1	97.7	97.7
PULSE	52	78	76
RESPIRATORY RATE	16	16	16
OXYGEN (L/%)			
PULSE OXIMETER		100%	100%
O_2 METHOD		RA	RA

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1830
PAIN INTENSITY (10 / 5 / 0)	X
MED ADMINISTERED (Y/N)	N
RELIEF ACCEPTABLE (Y/N)	NA

OTHER

TIME:	
FINGER STICK GLUCOSE	
INSULIN (Y/N)	

SPECIAL NEEDS

TIME:	1830
*Skin breakdown prevention	NA
*Falls prevention protocol	[redacted]
*Restraint protocol	[redacted] (b)(6)-2
*Seizure precautions	NA
*Isolation precautions	NA

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

DIAGNOSIS: S/p craniotomy

DRG: _____ ADMISSION DATE: 1 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. (b)(6)-2

	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ Pt intermittently confused - per translator	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Pt voiding to urinal	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Pt c ↓ ROM to (L) LE - unable to amb 5 extensive assist	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Scar to (R) side of head DSG to pack (CS)	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

Ø access

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) LE	TIME: 1830					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	Ø					
SENSATION	A					
MOTION	U					
PASSIVE FLEXION	Ø					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 1830		
SAFETY: ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	NA		
Bed position low			
Call light within reach			
OTHER: Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h	NA		
ROM q2h if immobile			
Antiembolic hose			

(b)(6)-2

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: Well
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, (AMBULATE), BSC, BRP, (CHAIR); ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - Call for assist - Pain Managment - Dsg Δ	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW	[redacted]	[redacted] IT/AN	IV
[redacted] (b)(6)-4			

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2400	(R) shoulder	- Moderate amt purulent drainage	W→D dsg Δ
	2400	(L) shoulder	- Wound red - Ø drainage - tod sg	W→D dsg Δ

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 8Dec | PATIENT ACUITY LEVEL: III | POST-OP DAY: 2 | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400	0915											
BP ARTERIAL LINE			140	144/68											
BP CUFF	114/64	120/58	84	111/68											
TEMPERATURE		97°	97.6	98.											
PULSE	81	82	72	66											
RESPIRATORY RATE	16	20	16	16											
OXYGEN (L/%)															
PULSE OXIMETER	96%	97%	96%	97%											
O2 METHOD	RA		RA	RA											

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0900	1200	1830	09				
PAIN INTENSITY (10 / 5 / 0)			X					
MED ADMINISTERED (Y/N)	N		N					
RELIEF ACCEPTABLE (Y/N)	N		NA					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0900	1830
*Skin breakdown prevention	NA	NA
*Falls prevention protocol	[redacted]	
*Restraint protocol		NA
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW #[redacted]

(b)(6)-4

DIAGNOSIS: SIP Craniotomy

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: 1 Nov

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

(b)(6)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

(5)(6)-2

	TIME: 0900 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ A&O improving PERRLA	☐ Intermittently confused PERRLA	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (L) sided weakness ↑strength arm	☐ (L) sided weakness ↓ ROM to (L) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ ~~I~~ ✓ Amr ~~AL~~	☐ healing wound to (R) side of head	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: Access	IV Site #1: (1) access	IV Site #1:
IV Site #2: (2)	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: Cyrcadm [illegible] LE	TIME: 0900	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	C	W				
EDEMA	1	1				
SENSATION	N	A				
MOTION	U	U				
PASSIVE FLEXION	D	D				
PERIPHERAL PULSE	2P	2P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0900	1830		
ID band visible/legible	[redacted]			
Orient to environment prn	[redacted]			
Side rails (2/4) up	N/A	[redacted]		
Bed position low	✓	✓		
Call light within reach	✓	✓		
Review & post lab results	✓	✓		
Notify MD abnormal labs	✓	✓		
Incontinent urine/stool	✓	✓		
Linen change prn	[redacted]			
Turn/reposition q2h	N/A	✓		
ROM q2h if immobile	✓	✓		
Antiembolic hose	✓	✓		

(b)(6)-2

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 25%	PERCENT CONSUMED: 60%	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 1830	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: Call for assist		CONTENT: - Call for assist - restraints		CONTENT:	
☒ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW #[redacted] (b)(6)-4	[redacted]	[redacted]	06/18 N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1700	(R) shoulder	erythema, Boggy	Dressing Δ c̄ Dakins
	1700	(R) Scapula	erythema, Boggy	Dressing Δ c̄ Dakins

SECTION IV - NOTES

@ 1700 did Dressing Δ to (R) Shoulder/Scapula Pt tolerated GSLS of infection. Slight erythema Boggy looking c̄ Slight drainage brownish Scapula wound. Shoulder small wound erythema & Boggy GSLS of infection, Dressed c̄ Dakins + Combine dressing [redacted] SPC(R) 9/W

(5)(6)-7

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 9 Dec | PATIENT ACUITY LEVEL: III | POST-OP DAY: 28 | HOSPITAL DAY: 40

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0945															
BP ARTERIAL LINE																
BP CUFF	111/68															
TEMPERATURE	98															
PULSE	66															
RESPIRATORY RATE	16															
OXYGEN (L/%)																
PULSE OXIMETER	97%															
O_2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0945							
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME:		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

DIAGNOSIS: S/P craniotomy

DRG: _____ ADMISSION DATE: 1 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: (b)(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0945 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ A/OX2 ↓c/o dizziness ↓c/o HA PE-212A/EGM1 (R) side weakness (5)(6)-2	☐ -2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐ ✓	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ ✓	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ ✓	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ ✓	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (R) side weakness upt ant.	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ drsg to (R) clavicle wound site s/sx of infx w/D drsg TRO c Pakins	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ ✓	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ ✓ (5)(6)-2	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0945 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0945		
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	/		
Bed position low	/		
Call light within reach	/		
Review & post lab results	/		
Notify MD abnormal labs	/		
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h	/		
ROM q2h if immobile	/		
Antiembolic hose	/		

2-5-(6)

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	RFG		
PERCENT CONSUMED:	70%		
HOW TOLERATED:	well		
	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - OOB to chair c̄ restraints - OOB c̄ asst. - interpreter - pain control - keep A/ox	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ [redacted]/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS/[redacted]URE	SHIFT
EPW-#[redacted]	[redacted] Eqn 30	1
(5)(6)-4	(5)(6)-7	

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

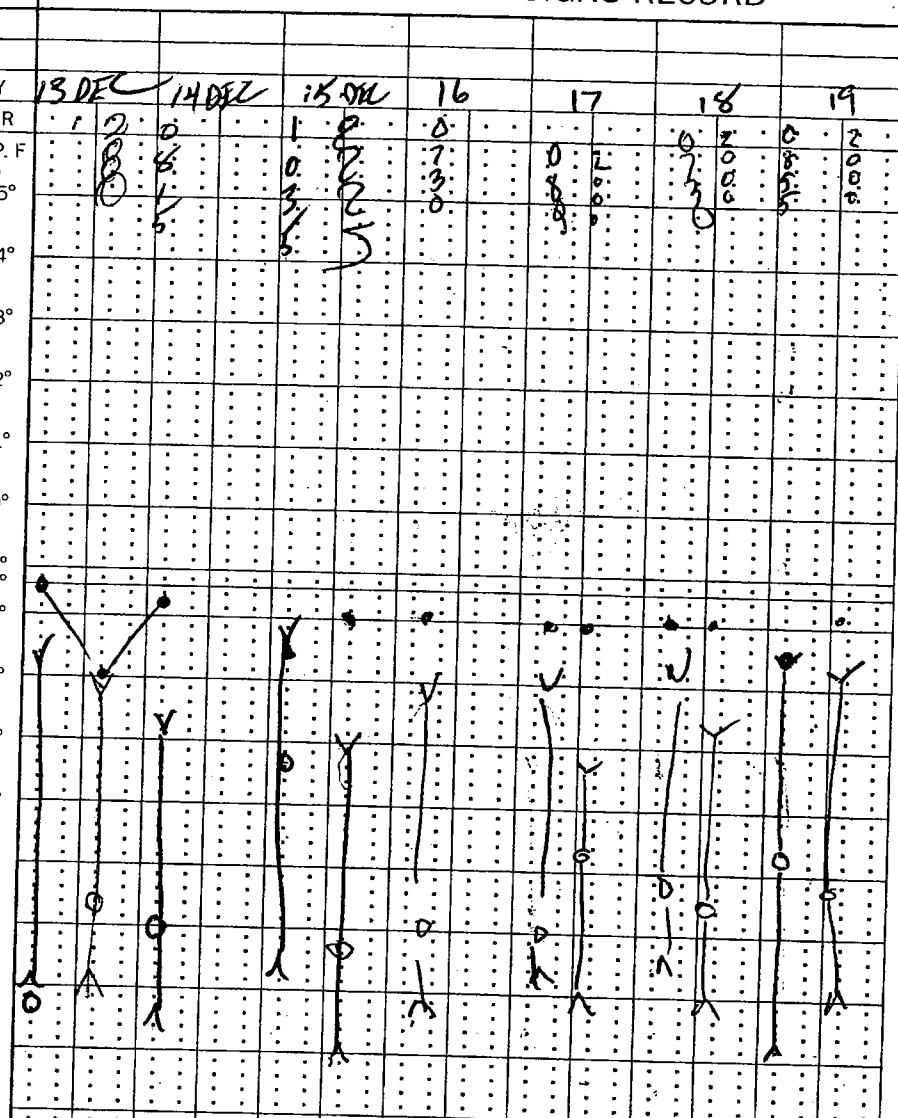
HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 13 DEC | 14 DEC | 15 DEC | 16 | 17 | 18 | 19

19 HOUR

PULSE (O) / TEMP. F (°) / TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 112/62 | 108/62 | 102/57 | 117/63 | 98/60 | 96/60 | 101/60 | 112/62

HEIGHT: WEIGHT →

57 | 70 | 49

98.6 | 98.2 | 97.3

98.1 | 97.1 | 96.1 | 98.6 | 98

RA | 98% RA | RA | RA | RA | 95% RA | 99% RA | 96% 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.

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

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

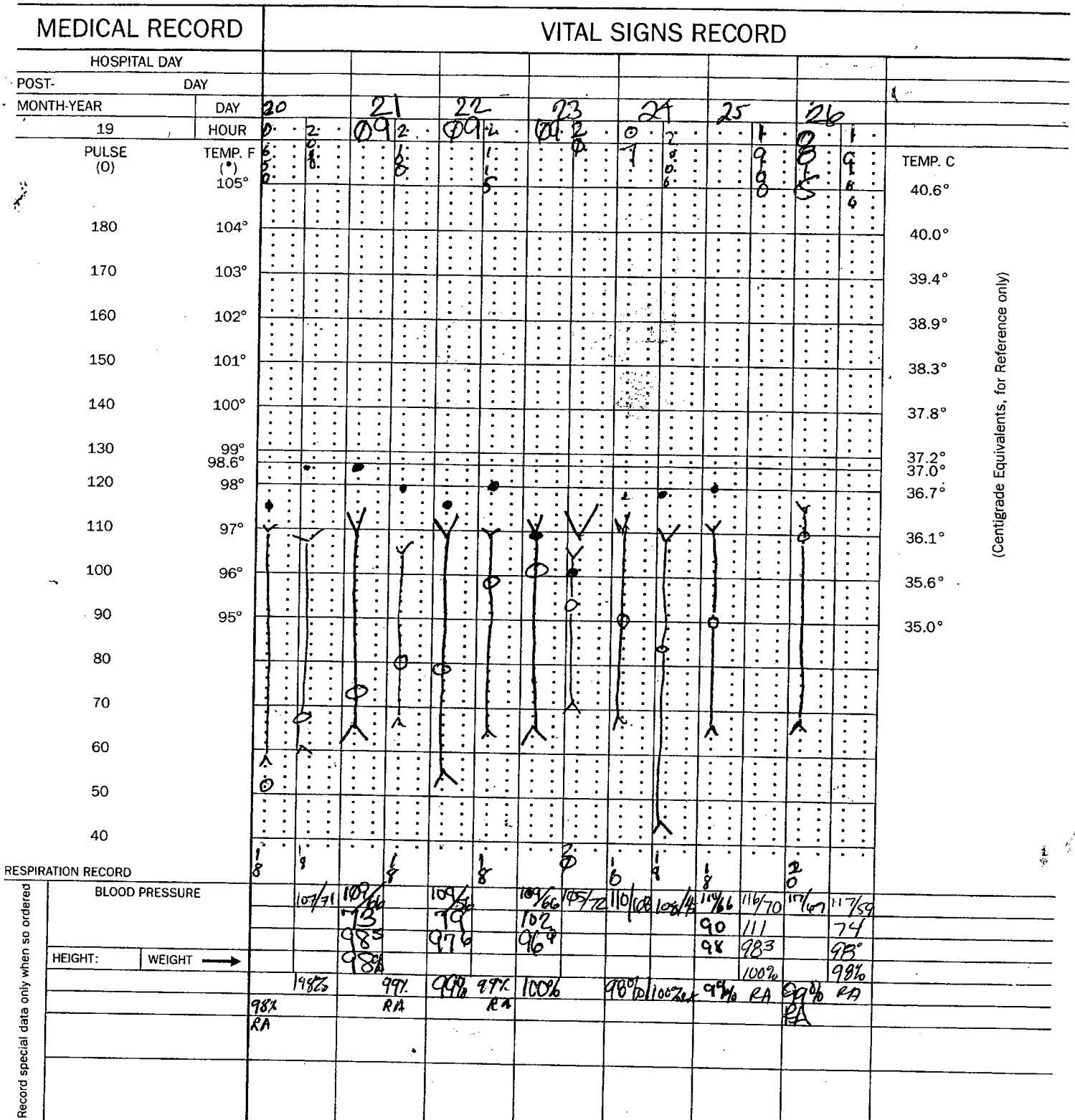
POST- DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)



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**

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 27 28 29 30 31 01 02 03

19 HOUR

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

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

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

(5)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 03 04 5 6 7 8 9

19 | HOUR

PULSE (0) | 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: 108/61, 107, 98.5, 99%; 99%, 96% RA; 100/50, 103/59, 98%, 100% RA; 100%; 100/64, 98, 99.1, 99.1; 101/52, 65, 99.5, 99%, 96% RA; 105/69, 99%, RA; 98/70, 86, 121, 99%, 98% RA

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] (b)(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 16 JAN | 17 JAN | 18 | 19 | 19

19 | HOUR: 0 1 | 0 1 2 | 1 0 | 1

PULSE (0) | TEMP. F (°)

TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE: 105/54 107/61 | 105/51 99/55 P 111 T 99.9 | 118/52 111/54

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted]

(b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR JAN 19 2004 DAY 9 10 10 11 12 13 14/15 15

HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

	9	10	10	11	12	13	14/15	15
Blood pressure	90/63	105/60		105/56	101/65	52/46 111/56	91/48 100/62	91/54
				92		54	53	
				96		47 105/63	98	105/60
				96		96	94	
Weight	02 5M	98 RA	99% RA	107/101	96% RA	100% RA	98% RA	100% RA
		98% (RA)		99% (RA)	98% MA 100% RA	104/58 98% RA		

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

REGISTER NO.

WARD NO. ICW

[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