AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
18NOV03 0830	DIC Summary CPW sp superficial schrapnel injuries to chest, s/p ~~48°~~ Adx c̄ Ancef. Will f/c to camp c̄ q 72° dressing Δ's + Keflex x 7 days.

(b)(6)-2

[redacted]

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

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

(b)(6)-4

#[redacted]

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 08 | 09 | 10

19 | HOUR | 12 | 12 | 12

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE: 123/60 | 100/58 | 108/63 | 104/64 | 98.3 | 112/62 | 98.9 | 120/64 | 78 | H76 | 99.3

HEIGHT: | WEIGHT →

O2 Sat 99(RA) 98 | 98 | 98% | 98% | 98%

Pulse 78

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)

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMS	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 8NOV03	TIME	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		

LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.0	3.3-5.5	G/DL
ALP	88*	26-84	U/L
ALT	35	10-47	U/L
AMY	36	14-97	U/L
AST	36	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	13	5-65	U/L
TP	7.3	6.4-8.1	G/DL

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		
B		
C		
CI		
NA		
K+		
CL-		
CO_2		
R1		

======= PICCOLO =======
08/11/03 11:04
REFERENCE RANGE: (b)(6)-MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	112	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	9.7	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	147*	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, 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
T		11-38 u/l
L		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] (b)(6)-4

[redacted]

(b)(6)-2

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	neg	Negative
pH	7.0	N/A
Prot	neg	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 DATE: 9 Nov 03 | LAB ID NO.:

RAPIDPOINT COAG ANALYZER
SERIA

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.5 sec.
Ratio = 1.3
Calculated INR = 1.47
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :11:01
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 11:04

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 25.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :11:02
Card Lot [redacted] (b)(6)-2
Operator [redacted]

[redacted] (b)(6)-4

WB 08-11-03 10:50

				Patient Limits	
WBC	11.9 H		x10^3/uL	4.5	10.5
RBC	5.48		x10^6/uL	4.00	6.00
Hgb	15.7		g/dL	11.0	18.0
Hct	49.8		%	35.0	60.0
MCV	90.8		fL	80.0	99.9
MCH	28.7		pg	27.0	31.0
MCHC	31.6 L		g/dL	33.0	37.0
Plt	231.		x10^3/uL	150.	450.
LY%	11.1	*L	%	20.5	51.1
LY#	1.3	*	x10^3/uL	1.2	3.4

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 NOV 03	1188 HOURS	
(1) Admit to ICW #1		
(2) Dx - Subrenal injury (L) Chest		
(3) Condition - Stable		
(4) Vitals - per flow		
(5) Allergies - NKDA		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	
(6) Activity - OPW prefred		
(7) Nursing - notify MD for temp > 100.4 / BP > 160/90 or < 90/50 HR > 120 or < 50 RR > 25 or < 10		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Noted [redacted] (b)(6)-2 08NOV03

DATE OF ORDER	TIME OF ORDER	
	HOURS	
(8) Diet - Regular		
(9) IVF - heplock		
(10) LABS - Q		
(11) Meds - Avert i/ron IVPB q 8°		

NURSING UNIT 3CD | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	
(12) BID Dressing [redacted]		

NURSING UNIT 24V | ROOM NO. 10 | BED NO. NOV 03 @ 0100 [redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10NOV03	0838 HOURS	
① D/C to conf ō Pkg		[redacted]
[redacted]		

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				[redacted]	[redacted]	[redacted]		(6)(6)-2								
Ø8 Nov 03	[redacted]	Vitals per floor	Ø6 18	[redacted]												
			18 Ø6													
Ø8	[redacted]	Activity - EPW protocol	Ø6 18													
			18 Ø6													
Ø8	[redacted]	Diet - Regular	Ø6 18													
			18 Ø6													
Ø8	[redacted]	BID dressing Δs	1Ø													
		(L) chest (R) Buttocks	22													

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	SHRAPNEL INJURY @ CHEST	PAGE NO:

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 all

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
08 NOV	[redacted]	Admit to ICW! Condition-stable	08			[redacted]
08	[redacted]	Labs - 0	08			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
08 NOV	[redacted]	Notify MD for temp > 100+ BP > 160/90 or < 90/50	DH/I													
		HR > 120 or < 50 RR > 25 or < 10														

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. 11 Yr. 93

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED												
				[redacted]	(b)(6)-2											
04 Nov 93	- [redacted]	IVF-heplock	06	[redacted]												
	-----		10													
			12													
93	- [redacted]	Ancef 1gm IVPB q8°	06													
	-----		16													
	-----		24													

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

SHRAPNEL INJURY @ CHEST

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 IS OBSOLETE. HAUSTED.

MEDCOM - 23650

@ 140/65 P-88
0923 SPO2: 98%

1. LAST NAME [redacted]	RANK / GRADE	MALE / HOMME ☒ / FEMALE / FEMME
SSN / NUMÉRO MATRICULE	SPECIALTY CODE / GRADE	RELIGION / RELIGION

2. UNIT / UNITÉ

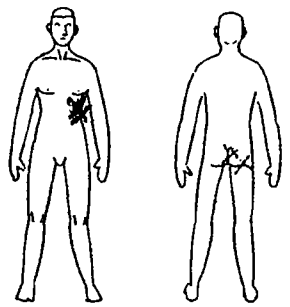
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ: Iraqi

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



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

Shrapnel (L) clavicle
(L) buttock
pt 2: no pressure

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS: 129 — TIME / HEURE: 0850

6. TOURNIQUET / GARROT: ☒ NO / NON — YES / OUI — TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON — ☒ YES / OUI — DOSE / DOSE — TIME / HEURE

8. IV / IV: yes — TIME / HEURE

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

50 hrs
BP-136/63 → Morphine 2 mg @ 0900 hrs
P- 89 — Fentanyl 25 mg @ 0910
Polyox 99% RA — Ignatia 200 @ 0930
0932 BP 155/64
P-16 SPO2 = 100% on 2

10. DISPOSITION / DISPOSITION: [redacted] RETURNED TO DUTY / RETOUR À L'UNITÉ (b) — TIME / HEURE: 0910

11. PROVIDER: [redacted] — DATE/DATE (YYMMDD): 02 11 [illegible]

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

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

(b)(6) -4 all

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6 7 8: A		9 10 11 12 13 14 15: [redacted]	[redacted]	16 17:	18: m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: [redacted]	27 28 29: 2 7 4	30:	31:	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34:		35 36: 9 9	37 38 39 40 41 42 43 44 45: [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46:		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49:	50 51 52: K 7 8	53 54 55 56 57 58 59 60 61:

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74:	75 76 77 78 79 80:	81 82 83 84 85 86 87 88: 2 0 0 3 1 1 1 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92:	93 94 95 96 97 98:	99 100 101 102 103 104 105 106: 2 0 0 3 1 1 0 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108:	109 110 111 112 113 114:	115 116 117 118 119 120 121 122:

FOR LOCAL USE

Dx 8751
E9919

Ing Trauma
[redacted]

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Admission and Coding Information

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

1. Reporting MTF [redacted] (b)(2)-2	2. MTF Locati... IZ			
3. Register Number [redacted] (b)(6)-4	Name (Last, First, MI) [redacted] (b)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 27Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 10:35	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-11		
24. Clinic Svc - Admitting -	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-08		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-08		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SHRAP INJURY L CHEST

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required) [redacted] (b)(6)-2	Signature of Admitting Clerk [redacted] (b)(6)-2

Automated Facsimile - DA FORM 2 [redacted]

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	27Y	X (b)(6)-4				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
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	10:35	AAA - INTERNAL MEDICINE

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

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-08	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-08	

31. Selected Administrative Data

Marital Status: Z

In/Out Patient: Inpatient

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

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

INTRATHORACIC SHRAPNEL

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	3	3

Signature [redacted] Officer

Signatu [redacted]

Automated F [redacted] y 79

(b)(6)-2

ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE *(YYYYMMDD)*: 2003 11 08

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

27y, EPW pt s/p IED injury c̄ resultant schrapnel wounds to back x 3 c̄ T-11 superficial and T intrathoracic. & other Co. ⊕ SOB or chest pain

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

BP - 133/89 HR - 92 RR - 24 T - 97.6

At ex
Heart - Clear
Cor RRR
Lungs CTA (B)

Abd benign
Back - Multiple superficial wounds

(B) ext
(N)

15.6 / 8.1 / 49.4 / 315

U/A - (N)

130 / 103 / 8 / 8.8 / 21 / 1.4 / 114

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

IED injury c̄ schrapnel to chest
- Admit
- CT scan
- ICU observation

5. ADMITTING OFF[redacted]

a. SIG[redacted] (b)(6)-2

b. DATE SIGNED *(YYYYMMDD)*: 2003 11 08

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

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

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

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

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

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

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8NOV 03 1400	- Assumed care of pt transfer from EMT per wheelchair. DX shrapnel wounds to upper back wall Denies pain CBC drawn results at bedside. Foley removed urinating spontaneously lungs clear SPO2 98% on RA Ø SOB noted. HRRR Active BS Remains NPO PIV @ AC LR @ 125 cc/hr patent Ø s/s of infection will cont to monitor [redacted] (b)(6)
8NOV03 2100	Pt A+Ox3, VSS, LS CTA(B), (D)BS x4, S1S2 present, Ø c/o pain, shrapnel wounds to the upper back, tender around wound minor swelling noted, peripheral pulses +2, IV (R) ~~FA~~ AC infusing LR @ 125cc/hr, NPO OOB to BR ≡ complications, IV abx, 2 point restraint, Ø complications. [redacted]
9NOV @ 1600	Pt. resting quietly in bed. V.S.S. A+O x3, Ø c/o pain. (b)(6)-2 DRSN to shrapnel wounds on back, Pt. reports Ø SOB or vertigo Pt. ambulates ≡ difficulty to BR ≡ in hallway. (D) BR This AM, Void ↑ volume, clear yellow urine, LR infusing at 125cc/ to (R) AC. Pt.'s NPO status Δ'd to regular for lunch and

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.0C

(b)(6)-2-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont.) dinner; Pt. not going to OR today. Pt. will be NPO ∓ MN, Pt. in 2-point restraints, Ø signs of skin breakdown. Will cont. to monitor. [redacted] CT, RN
9NOV.03 1900	Pt A+O x3, VSS, dsg to wounds on back L'd, minimal blood drainage on old dsg, Ø active bleeding, tender around wound, minor swelling around wound on (R) side, OOB→ BR ∓ diff, IV (R) AC intact, infusing LR @ 125 cc/hr, Ø c/o pain or discomfort, IV abx, Diet advanced to Regular, tol. well, possible discharge tomorrow, 2 point restraint ∓ any complications. [redacted] I Cencan with above assessment [redacted]
10NOV03 0945	VSS. A0. Up ad lib. Ass AM to BR to perform self and oral care. HRR. LSC/AS. DSG's to back CDI ∓ s/s infection. Waiting for D/C today by attending physician. [redacted]
10NOV.03 1930	Pt A+Ox3, VSS, LS CTA(B), ⊕BSx4, OOB to BR, voiding ∓ complications, pain controlled ∓ MSO4 4mg, dsg to back CDI, tender around wounds, Ø s/sx of infex, HL IV (R) AC intact, flushes well, possible d/c tomorrow, ate most of diet, 2 point restraint, Ø complications [redacted]
11NOV03 1045	Assumed care of pt. @0600, Pt. A+O, V.S.S., c/o [redacted] mild pain to abdomen & shrapnel wounds on back. Abdomen soft, non-distended, ⊕ BS all four quads. Shrapnel wounds to back scabbed over, Dressings removed, Ø drainage. Pt. OOB to

STANDARD FORM 509 (REV. 5/1999) BAC

MEDCOM - 23657

USAPA V1.C

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11NOV03@1045	(cont.) shower this AM. ⊕BM this AM. Pt. given 4mg MSO4 for pain @ 1030. Pt. resting quietly in bed at this time, 2-point restraints, ∅ signs of skin breakdown. All other assessments WNL. Pt. to be D/C'd to EPW ramp today. [redacted] 2CT, AN (b)(6)-2

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

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

REGISTER NO. | WARD NO.

[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

AUTHORIZED FOR LOCAL REPRODUC

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

D/C Summary

18 NOV 03

0830 EPW s/p superficial scraped injuries to chest, s/p 48 hr Abx (Ancef). Will d/c to Camp C q 72 hr dressing changes x 7 days at Reflex.

(b)(6)-2

[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 11-8-03 Diagnosis: Intrathoracic Shrapnel HD: 4 POD: 4

Braden Scale Evaluation (See Braden Evaluation Table for Details)

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

Add the total score Total Score 22

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: BACK Size: 2-3 cm Drainage: Ø
Tubes: Ø Appearance: CDI
Dressing change: Ø

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

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: _____

REGISTER NO. | WARD NO.

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

PROGRESS NOTES

Medical Record
STANDARD FORM 509

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

[redacted]

(ASSESSED 11 NOV 03)

(-) smoker

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 8 NOV 03 | TIME 1045

TRANSPORTATION TO FACILITY

SEX: M

AGE: 27

DUTY/LOCAL PHONE		HOME PHONE	
AREA CODE	NUMBER	AREA CODE	NUMBER

MILITARY STATUS			
ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

CHIEF COMPLAINT

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1045

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

VITAL SIGNS

TIME	1045				
BP	133/85				
PULSE	77				
RESP	24				
TEMP	97.6				
WT					

LAB ORDERS

☒	CBC/DIFF	ABG	☒ PT/PTT	☐	BHCG/URINE/BLOOD/QUANT
	URINE C&S	UA MSCC/CATH		☒	CHEM: 12 C 14 HS
	BLOOD C&S X				
		TES			

X-RAY ORDERS

☒	CXR PA & LAT/PORTABLE	C-SPINE
☒	ACUTE ABDOMEN	LS SPINE
	SINUS	HEAD CT
	ANKLE R/L	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1045	Sec Tetanus IM	[redacted]			
1100	IV N.R Bolus x2				
1200	Amb Tq IM				
1220	Ribey				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS [redacted]: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(b)(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER [redacted] (b)(6)-2

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 8.1			SUP O2	PH	PO2	RESULTS	CXR ⊕ shrapnel in chest ⊕ T9 bone
H/H 14.4			PCO2	SAT	OTHER	Abd/Pelvis CT	
PLT							
PT			U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

27 yo Cir detainee arrived via medevac ambulatory, NAD ØSOB. ⊖ smoker

IED while on convoy

Ø head inj ØLOC

Cmed: Ø

PSH: Ø

Ø tobacco

OS AOx4, NAD, VS

HENT unremarkable

Chest, LTA ⊕ takes full breaths symmetrically

CV RRR Ø m/r/g Abd soft, NT on deep palp

Back ⊕ shrapnel noted T9/10 paraspinous ⊕ shrapnel noted

gait NL

UA 1.025 neg blood

A/P ⊕ Shrapnel to back into chest cavity ⊕ side

Chest/Abd CT ⊕ → Admit ICU

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP [redacted]

PROVIDER SIGNATURE AND STAMP [redacted]

DIAGNOSIS ⊕ GSW/Shrapnel ⊕ chest

CODES (b)(6)-2

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	8		9		10	10/03								
19	HOUR	1150													

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: 123/69 128/72 8 4

BLOOD PRESSURE: 98 68 121/66 118/72 132/81; 98H 98 77 68; T98.4 98.5 97.3 97.1; 96 98 98 98 98 98; RA RA 98% O2 97%; O2; Pulse 58

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

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

HEMATOLOGY

SPECIMEN/LAB RPT. NO. ICW1

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

PATIENT STATUS: ☐ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

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

PATIENT'S MED. RECORD

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

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

REPORTED BY [redacted] (b)(6)-2 MD TECH

DATE 8 NOV 03

LAB. ID. NO. 1400

REMARKS CBC

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

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

ID: [redacted] (b)(6)-4
WB

08-11-03
14:07

			Patient Limits	
WBC	8.6	x10^3/uL	4.5	10.5
RBC	5.80	x10^6/uL	4.00	6.00
Hgb	16.2	g/dL	11.0	18.0
Hct	50.7	%	35.0	60.0
MCV	87.3	fL	80.0	99.9
MCH	27.9	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	243.	x10^3/uL	150.	450.
LY%	23.5	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

(b)(6)-2

Ward/Section: EMT

[redacted]

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

LAST [redacted] (b)(6)-4 | DATE 8 NOV | TIME 1102 | SSN/PSEUDO SSN [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		

ID: [redacted] (b)(6)-4
WB 08-11-03 11:03

			Patient Limits	
WBC	8.1	x10^3/uL	4.5	10.5
RBC	5.66	x10^6/uL	4.00	6.00
Hgb	15.6	g/dL	11.0	18.0
Hct	49.4	%	35.0	60.0
MCV	87.2	fL	80.0	99.9
MCH	27.6	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	315.	x10^3/uL	150.	450.
LY%	26.8	%	20.5	51.1
LYM	2.2	x10^3/uL	1.2	3.4

(Hematology) Diff

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	yellow	N/A
App	Cla Stg	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	0.1	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: [redacted]

LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 7NOV / TIME 1103	SSN/PSEUDO SSN [redacted] (b)(6)-4

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L				BUN		7.22 mg/dl
Cl		98-109 mmol/						
pH		7.31-7.45						
PCO2		35-45 mmHg (41-51 mmHg (v						
PO2		80-105 mmHg (a N/A (ven)						
TCO2		23-27 mmol/L (a 24-29 mmol/L (v						
HCO3		22-26 mmol/L (a 23-28 mmol/L (v						
sO2		95-98%						
BEecf		(-2) – (+3) mmol/L						
AnGap		10-20 mmol/L						
Ca		1.12-1.32 mmo						
BUN		8-26 mg/dl						
GLU		70-105 mg/dl						
Creat		0.7-1.5 mg/dl						
Hct		38-51% PCV						
Hgb		12-17 g/dl						

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

======= PICCOLO =======
08/11/03 11:27
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-7
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.5	3.3-5.5	G/DL
ALP	105*	26-84	U/L
ALT	60*	10-47	U/L
AMY	52	14-97	U/L
AST	37	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	38	5-65	U/L
TP	8.9*	6.4-8.1	G/DL

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

======= PICCOLO =======
08/11/03 11:1< AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-7
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	114	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	233	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

REPORTED BY:	DATE:	LAB ID NO.:

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

CT chest / abd

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER N

FILM NO.

PREGNANT ☐ YES

REQUESTED BY (Print) (b)(6)-2 TELEPHONE

SIGNATURE OF REQUESTOR [redacted] DATE REQUE

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Shrapnel in chest Pt. Shrapnel in Peritn

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, ye

RADIOLOGIC REPORT

Both and (L) axillary shrapnel

chest/A/P normal.

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION (Inst. Date of Birth, Gender, Unit, Room, Bed, Medical Facility)

(b)(6)-4

[redacted]

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT 3 — RADIOLOGY

STANDARD FORM 513-2 Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.204

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: 9 Nov 03 TIME OF ORDER: 1200 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU #7
2. Dx - intrathoracic schwannoma
3. Condition - stable
4. Vitals - per routine
   NC O2 titrate to maintain
   Pox > 95%

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

5. Allergy - NKDA [redacted]
6. Activity - ~~bedrest~~ [redacted] / CPW protocol
7. Foley to gravity
8. Nursing - notify MD for temp > 100.4, BP > 160/90 or < 90/50 HR > 120 or < 50 RR > 25 or < 10

PATIENT IDENTIFICATION [redacted] (b)(6)-2 Noted 09NOV03 1356

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Pox < 95% or SaB

9. Diet - NPO
10. LABS - Repeat CBC on admission to unit
11. IVFs 125 cc/hr CR
12. Meds - MSO4 2-4 mg IVP q 3-4 hr prn
    Ancef 1 gram IVPB q 8 hr

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24 OR CCU		9 NOV 03

DATE OF ORDER: TIME OF ORDER: HOURS

13. Remove Foley on floor (b)(6)-2
14. Regular Diet [redacted]

Noted 09NOV03 0100

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 [redacted]				10 NOV 03	0830 HOURS	(b)(6)-2 [redacted]
				(4) D/c to comp c Abx		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
ICU	240	[redacted]		(b)(6)-2 AN 11NOV03@0335		10 NOV 03 0833

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

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

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

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 08	9	10	11									
08 NOV 03	[redacted]	Vitals per routine	06	[redacted]												
			18													
			19													
08	[redacted]	Act: EAW protocol	06													
			18													
			19													
08	[redacted]	Foley to gravity	06													
			18													
			19													
08	[redacted]	Diet: NPO	06													
			18													
			19													
09 NOV	[redacted]	Diet: Regular	D													
			N													

8 NOV 03 1400

C 9 NOV 03

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
INTRATHORACIC SHRAPNEL

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 all

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
08 NOV	[redacted]	Admit to KW!	08 NOV03	—	—	[redacted]
08	[redacted]	Cont-stable	08	—	—	[redacted]
08	[redacted]	Repeat CBC on adm to unit	08	1400	—	[redacted]
08	[redacted]	Remove foley on floor	08	1400	—	[redacted]
ID	[redacted]	D/C to camp ĩ Abx	ID			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
08 NOV	[redacted]	NCO2 titrate to maintain POX >95%.	D/T/I													
08	[redacted]	Nrsg: notify MD for temp >100.4 BP >160/90 or <90/50 HR >120 or <50 RR >25 or <10 POX <95% or SOB	D/T/I													

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11
08 NOV 03	[redacted]	IVFs: 125cc/hr LR	08	[redacted]			
	-----		12				
			20				
08	[redacted]	Ancef 1gm IVPB q	08				
	-----	8°	16				
	-----		24				

(b)(6) -2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	INTRATHORACIC SCHRAPNEL	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. 11 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												
28NOV	[redacted]	MSO4 2-4mg IVP q 3-4° pm	D/T	10 NOV	10NOV 2100	11NOV 0035	11NOV 1030									
			D/T	1616 4mg	4mg	4mg	[redacted]									

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

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2 [redacted]	2. M [redacted] (b)(6)-2			
3. Register Number [redacted] (b)(6)-4	Name (Last, First, MI) [redacted] (b)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 27Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 10:35	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] Iraq; No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-11		
24. Clinic Svc - Admitting AAA - INTERNAL MEDICINE	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-08		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-08		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: INTRATHORACIC SHRAPNEL

Procedure Narrative(s): T: 1 Dx: 8750 8760 Inj: 443 E993

876.1
875.1
E991.9

Cause of Injury Narrative:

Admitting Officer (Signature, as [redacted] (b)(6)-2 PONDER	Signature of Admitting Clerk [redacted] (b)(6)-2

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	[redacted]	E4	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	—	Z	UNK	UNK	UNK	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99730	[redacted]	(b)(6)-4	—

15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	BC NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	2345	XXXA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	41	030816

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	030816	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(2)-2	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted]			

31.

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX Shrapnel to head

Dx 873.9
E9919

~~873.8~~

Inj Trauma

549 9

DX 873.9 Injury
9-599

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	0	0

36. Total Days All Facilites

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

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

DA FORM 3647, MAY 79 EDITION OF 1 APR 75 IS OBSOLETE USAPPC V1.10

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—		Z	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	2345	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K78	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0		
NAME AND LOCATION OF MTF [redacted] (b)(2)-2		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
~~5X~~ 41		20030816

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
XXXA		20030816

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

FOR LOCAL USE

DX: Shrapnel to head

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

[redacted] TURE OF ADMITTING CLERK (b)(6)-2

MEDCOM - [redacted]

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

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

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted] (b)(6)-4		ICU1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	09:20	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-11-23

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

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

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R CHEST/ ABDOMEN RENAL FAILURE

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	6	0	13	13

Signature of Attending Medical Officer

SUNDBORG [redacted]

MEDCOM - 23677

[redacted] (b)(6)-2

Automated Facsimile

...IENT TREATMENT RECORD CO...R SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted] (b)(6)-4	[redacted] (b)(6)-4	FGN	

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

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted] (b)(6)-4		ICU1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	09:20	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-11-23

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

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

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R CHEST/ ABDOMEN RENAL FAILURE

Blood Y

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	13	13

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

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

≅ 4Ø yo Iraqi male shot in the Right back @ 173Ø last PM. Taken to a nearby FST. Found to have a Right tension PTX; diaphragm injury and liver laceration. Chest tube placed & ex lap done. Pt transferred in stable condition this AM. Pt. arrived sedated & on the ventilator

PHYSICAL EXAMINATION: 98% Sat 142/8Ø 93=HR

HEENT = WNL
CV = RRR
Lungs = intubated; coarse bilat; CT in place w/o airleak; 1ØØcc fluid in pleur-avac
Abd = dressing in place; soft; quiet
Ext = WNL
Back = WNL other than puncture wound Right lateral to spine
No exit wound

PROGRESS (Enter date of discharge and final diagnosis)

A = GSW to Right back c̄ injury to lung, diaphragm and liver

Plan = CT scan of Chest + Abd; Admit to ICU; follow exam; wean off vent + extubate as soon as possible

(b)(6)-2

[redacted] DATE 11NOVØ3 | IDENTIFICATION NO | ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give name (last, first, middle), 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
FPMR 101-11.4 OFR 201.48 SUB
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Nov 03	Drogi of GSW thoracic abdomen + liver injury.
11 30	back injury. CXR, CT scan done. Sedated c̄
CIV VS EPW	Versed + MSO4 on the vent. SIMV14, TV 750,
T 93.4	Peep 5, FIO2 to keep > 95%. ET #8 placement
~~Turned~~	NGT, foley, CT (R) axillary. 2° dx lesion +
	bleeo pneumothorax. VS 94.5 - 111 - 19 - 177/93, sat 99%
	@ 100%
1430	T 97.2 - 114 - 152/94 - 29 - 96% SAO2 70%. MD aware of
	↑ BP. Increase sedation nitrate to effect ↓ BP
1500	Skin Care Assessment.
	Braden scale done, pt score 12 high
	risk. Turn pt q2°. Turned left side from
	1330 - 1500. Pt lays on his back @ this time
	Turn to (R) side @ 1700. BP ↓ 148/92 - RR 35
	Versed @ 15 mg MSO4 12. Continue to monitor BP. A line
	started @ 1530 c̄ good waveform. ABG. Lytes + CBC
	sent. [redacted] (b)(6)-2
1700	FIO2 ↓ 50% per MD. BP under control 130/90. Serial
	ABG @ 1830.
1900	Report given to oncoming shift [redacted] (b)(6)-2

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

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

REGISTER NO. | WARD NO.

(b)(6)-4

[redacted] EPW / CI

PROGRESS NOTES
Medical Record

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

(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 AUG 03	Received report on EPW 1275. Bed #4. PT
1830	moves extremities occasionally. PT at this time
	tachycardic 120's. ABG PH 7.188 PCO2 59.2. MD.
	Aware & vent settings Δd to RR 20 from 14 &
	FIO2 55 from 50. Will monitor and report as
	appropriate. [redacted] 1LT/AN
1900	Assessment:- PT is sedated on versed & MSO4
	titrated to effect. NS @ 20K infusing at 175 cc/hr.
	↑ K+ level and orders changed to NS @ 175 cc/hr.
	PT is vented @ 8.0 ETT 26 cm lip. Settings are
	now FIO2 55 PEEP 5 RR 20 TV 750 PEAK
	45. Breath sounds coarse but diminished R>L.
	CT to 20cm H2O suction & dressing reinforced
	periodically due to bleeding at site. PT
	remains tachycardic 120's. BP 100's/80's. Pulses
	are 2+ palpable U/L Ext. No ectopy noted.
	NG Tube to LIS & minimal secretions. BS
	hypoactive. Abdomen soft & distended. midline
	incision dry & intact. Foley to Gravity
	draining clear yellow urine >100 cc/hr!
2130	PT positioned to (R) side. Late Entry:
	1943 ABG results. PH: 7.33 CO2 43.1 PO2 83
	BE -3 HCO2 23 SaO2 95. Will continue
	to monitor until next ABG check. [redacted]
2200	ABG results PH: 7.334 PCO2 41.2 PO2 90
	BE -4 HCO3 22 SO2 96. FIO2 ↓ 50%. [redacted]
2220	T. 101.? Tylenol suppository given. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6)-2 all except bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12NOV03 0036	ABG drawn. Results are Ph 7.346, PCO2 39.6 PO2 96. BE -4 HCO3 22 SaO2 96. WILL titrate FIO2 to goal rate 40% — [redacted] LT/AN
0125	PT urine output drop to 30 cc over 2hr period. MD notified and ordered 1L NS bolus WILL initiate orders and report post bolus urine output. [redacted] LT/AN
0225	PT start putting out urine about 800cc/hr. WILL continue to monitor progress. [redacted] LT/AN
0400	ABG results pH 7.343 PCO2 40.9 PO2 84 BE -3 HCO3 22 SO2 96. WILL ↓ RR to 15 to prevent excess blowing off CO2 [redacted]
0615	Report & Care of pt received from previous shift. VSS VENT Settings PEEP-5 TV-750 RR-15 FIO2-35% SaO2 98% HR-120's T. 101.1. Sedated on MSO4 3mg/hr Versed 2mg/hr. Chest tube to (R) chest [redacted] LPN
1000	Pt DSG to abdomen changed. Wound appears to be healing well & s/s of infection/redness or swelling. T-100.7 VSS will cont to monitor [redacted] LPN

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. ICU

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12NOV03	Surgery HD #2 ICU #2 POD #2 Vent D #2
0821	Ancef D #2
129/100/20/93	Neuro = sedated
51/18/2.7	HEENT = intubated; No issues
8.4/26.5/177	Lungs = Coarse BS bilat. FiO2 down to 35% c̄ sat ≥ 95% / CXR pending
	CV = RRR. no issues
	Abd = benign, dressing place, quiet c̄ <500cc NG out
	Ext = No issues
	FEN = Stopped all K+ in fluid; Now on NS @ 175cc/hr. Cr has increased from 1.8 on admission to 2.7 this AM. Likely ATN from low flow c̄ injury. UOP = 50-170/hr for last 3 hours
	A = 1) diaphragm injury; tension PTX + liver lac 2) Now with bilat pulmonary infiltrates; possibly contusions and non oliguric renal failure with Cr increasing to 2.7 from 1.8. Will d/w Medicine
	Plan = Vent support as needed follow electrolytes + adjust fluids as need[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6)-2 all except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 Nov 03 1900	PT. T-101.5 VSS. Will cont to monitor [redacted]
1700	PT temp ↑ 101.9. Pt given Tylenol Suppository. VSS will cont to monitor [redacted] (DN)
1800	PT turned to left side S.O.2 ↓ 89%. Report cont. to pt given to oncoming shift [redacted] (LA)
1805	Received report from day shift. Pt vented TV 750, 15 BPM, PEEP 5, FIO2 35%. NG to (R) Nare on LIS, CT to (R) Flank on wall suction. Foley to gravity. Cordis to (R) ES (P) flush, A-Line to (R) Radial. Will continue to monitor. [redacted]
2000	Pt desaturating, bagged and suctioned. SATS ↑ to 94% [redacted] SPC, 9 WMG
2200	Pt de-SATing ↓ to 78. Bagged and called RT. RT ↑ FIO2 to 100%. Suctioned pt vigorously. Results of ABG as follows. PH of 7.249, PCO2 of 49, PO2 of 110, BEef -6, HCO3 of 21, TCO2 of 23, SO2 of 97%. Informed [redacted] Ordered BPM ↑ to 18. RT ↓ FIO2 to 85%. Will continue to monitor. [redacted] SPC, 9 WMG
13 NOV 03	(0100) Pt rested well VSS. FIO2 @ 64% ē O2 sat ≥ 95%. Will continue to monitor. [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)

REGISTER NO.

WARD NO. ICU 2

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13NOV03	(0800) Pt temp 100.4, FiO_2 @ 64% to O_2 sat of 100%. Pt hr rate 18. VSS. will continue to monitor. [redacted]
	(0500) Pt's labs came back Hgb of 7.1 & Hct of 22.4. called MD on call Dr. Davis. ordered 2 units PRBC & PT/PTT. ref down. VSS. UOP 25. chest tube put out 130, NG tube put out 300. Temp. 100.7. Pt F1581 on fluids on shift. T&C done & labs @ 0500. [redacted]
13Nov03 0615	Received report & care of patient from previous shift VSS VENT settings - PEEP-6 TV-750 RR-18 FIO2-65 will cont to monitor [redacted] PC ZPX
0730	18ga IV started to (L) bicep. VSS CBC reduction will cont. to monitor [redacted] ZPX
0830	10mg Vecuronium IVP given to pt per MD. [redacted]
13NOV03	Surgery HD#3 ICU#3 POD#3 Vent#3 Lines#3
	Pt. has had increased peak pressures throughout the day in spite of adequate sedation & pain control. Was planning to decrease vent requirements but unable to @ this time.
	Placed a new L SC line + Right radial A-line. Old lines removed
	CT to water seal
	Hct this AM was 22 so given 2 units PRBCs. Will continue support. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE 13 NOV	NOTES
0900	TLC placed to (L) SC all lines patent. VSS will cont to monitor — [redacted]
0930	A-line started to (R) radial — [redacted]
1030	Transfusion of 1st Unit PRBC's started at this time. VS - T-100.1 HR-125 BP 157/77. will continue to monitor — [redacted] SPC LPN
1035	18ga IV to (L) bicep DC'd — [redacted] SPC LPN
1155	1st unit of PRBC's transfusion completed at this time & reaction noted. VS - BP 154/79 HR-140 T-101.2 — [redacted] SPC LPN
1245	Transfusion of 2nd Unit of PRBC's started at this time. VS - BP 144/88 HR-141 T-101.1. will cont to monitor — [redacted] SPC LPN
1330	Cordis to (R) IJ DC'd & A-line to (L) radial DC'd. 2nd unit PBBC's finished transfusing at this time. VS - BP. 169/89 HR-146 T-101.9. Versed increased to 10mg/hr and Morphine increased to 7mg/HR. will cont to monitor — [redacted] SPC LPN
1600	Pt Temp @ 102.2. ~~Tea~~ Cold packs placed to bilat pits & groin. will cont to monitor — [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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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 1

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1800	Report & care of pt. given to oncoming shift VSS [redacted]
1800	Received report from day shift. Are flow sheet for physical assessment. [redacted]
2000	Started pt on Vec drip. ZLT simple pushed Imy advan. Titrated versed ↓ to 8mg/hr. Will continue to monitor [redacted]
2005	RT advanced ETT 2cm. 27 at lip. Will continue to monitor. [redacted]
2200	Pt resting comfortably in bed VSS. Will continue to monitor. [redacted] SPC
2330	Pt BP @ 212/85. Rechecked manually still elevated. Contacted Dr. [redacted] Versed to 8mg/hr. Will continue to monitor. [redacted]
14Nov03 0100	Pt BP ↓ to 112/67. VSS. Will continue to monitor. [redacted] SPC 91WM6
0300	Results of pt ABG as follows: PH of 7.262, PCO2 of 42.7, PO2 of 117, BEecf of -8, HCO3 of 19, TCO2 of 21, SAO2 of 98%. Will continue to monitor. [redacted] SPC, 91WM6
0430	Contacted MD [redacted] about ABG Results. Dr. [redacted] came but did not assess pt, requested pt be [redacted] raised to 20 vap a min. Will repeat ABG in 1hr. [redacted] SPC, 91WM6

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

DATE	NOTES
14NOV03	Contacted Dr. [redacted] over pt
0445	H+H 7.6/24.1. Dr [redacted] said "Fine," and
	No new orders given. [redacted] SPC, 910 MG-
0500	Held due to [redacted]
0500	Held ativan due to ↓ BP 96/52. Pt already
	on Versed @ 6mg/hr. [redacted] SPC 910 MG
0600	Reported [illegible] to day shift. [redacted] SPC 910
14NOV03	Surgery HD#4 ICUD#4 POD#4 Vent D#4 Chest D#4
8.0 7.6/24.1 159	Received 2 Units of PRBC's yesterday with increase from
	22 to 27; this AM = down to 24.1! will transfuse again.
128/113/29/88	If continue to have blood requirement, will CT Abd
75/18/3.2	or re-explore to check liver injury or missed injuries.
32/35.5/125/18/-8	Has episodes of decreased UOP which have responded to fluids.
99%	Cr has decreased from high of 3.8 to 3.2 today. BUN
	con't to increase slightly. Will follow renal function.
	Tolerated light CT for hourly seal x 24 hours, so removed
	this AM. Will check CXR. Pt fighting the vent
	yesterday in spite of sedation so started on Vec with
	mild improvement in peak pressures. Will switch
	from Versed to Ativan since pt. likely to require sedation
	for several more days

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted]

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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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Nov 03 1125	accept pt @ 0600 from night shift. pt had drainage fr CT site and evaluated by [redacted] CT pulled @ 0830 and packed c̄ petrolatum + gauze. The site below CT insertion was pack c̄ W→D dressing. ABG done FiO2 ↓ to 45% will reassess @ noon. CXR to be done @ 1130 to eval for PTX. last H/H this am @ 0900 was 23/7.5 a Type & Cross done at pt to receive 2 units PRBCs. Benadryl 25mg IV and Tylenol 650mg PR given prior to 1st Unit. PIP @ mid 30's. UA @ 0900 was 20 Thru next hour 40. Foley was flush c̄ 30cc NS. Pt Urine has increased since 0800. Will continue to monitor — [redacted]
14 Nov 03 1520	Given 25mg Lasix IVP. Art BP 160/56 HR 97 SpO2 98 Am to S. Art pressures 190's-180's. @ 1520 pt Art SBP 163/95 MAP (115) and Auto BP Cuff @ 150/54 MAP (115) will continue to monitor Pt. Hemodynamics. Pt continues to get PRBC and on 2nd Unit c̄ no adverse Rxn Thus far — [redacted]
14 Nov 03 1520	At 1345 pt SaO2 ↓ to low 90's ABG done and PO2 @ 73. ↑ FiO2 from 45% to 50%. will repeat Gas @ 1600. lungs were auscultated ~~[illegible]~~ and lungs were unchanged from previous assessment @ noon — [redacted]
14 NOV 03 1600	Received report from previous shift. Pt intubated c̄ ETT #8.0 28.5cm @ lub SIMV 24, TV 750, PS, FiO2 45%, PIP 40, O2 sat 96%. HOB ↑ 30°. (R) nare NGT to LIS. 3 lumen central line + A-line intact. Drsg intact. Foley present UO 100cc. will cont care [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14NOV03 1900	Transduced CVP per Dr. [redacted] order. CVP 11-14. Deep suctioned pt x III. Thick yellowish secretions noted. PIP 44 → 38 p suctioning. Frequent suctioning prn. — [redacted]
2200	Drew ABG per Dr. [redacted] will report results. Reported CVP + HO levels. Ø new orders given [redacted]
2230- 2300	Completed drsg Δ. Dry drsg c̄ bacitracin on staples on midline abd incision. Wound well approximated c̄ staples intact. Little sanguinous drainage noted. Wet → dry drsg (R) flank wound. Sanguinous drainage noted. Replaced petroleum gauze on CT wound. Wet to dry drsg entrance wound on back. Ø drainage noted. New orders. ↓ed FiO2 45%, 1 L NS bolus, fluid Δ to DSNS @ 250cc/°. CVP 8, O2 sat 98-99%. Versed bolus 3mg for ↑ed BP. [redacted] longer correlate c̄ cuff. 40 point difference systolically. ↑ed versed rate to 5mg/°. Will turn pt to (R) side. Will cont. care. [redacted]
15NOV03 0100	O2 sats remain 99-100%. ↓ed FiO2 40%. Will cont to monitor. CVP 8-13. Will cont to monitor. [redacted]

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

DATE	NOTES
15 NOV 03 0215	Deep sxn pt x III c̄ RT. Thick yellow secretions noted. Will cont care. CVP 13-15 while on back. [redacted]
0500	Redid drsg (R) flank due to saturation c̄ serous drainage. Wet to dry drsg. Turned pt into (L) side. Noted scrotal edema + tighter abd. Elevated scrotum. Deep suctioned pt x III using saline bullets + manually ventilating pt. Thick yellowish sputum noted. O2 sats 94%. PIP 46. Will cont. care. Abnormal ABG + labs. Notified Dr. [redacted]. No new orders given. Will show primary doctor. [redacted]
0600	Gave report to next shift. [redacted]
15 NOV 03 0950	Surgery HD #5 ICU D #5 Vent #5 POD #5 Aug HD #5 Continues to have high peak pressures at 40-50. CXR unaltered c̄ bilat. contusions / infiltrates. Also continues to have HTN in spite of Versed 10 mg/hr c̄ good sedation. Will discuss possible β-blockade c̄ Dr. [redacted] Received 2 units PRBC's yesterday Hct is 30.5. CVP transduced + is 14 on PEEP of 5. Will hold Vec this AM until pt. overbreaths vent + check peak pressures [redacted]
7.7 / 9.9 / 30.5 / 192	
137 / 120 / 4.3 / 21 / 3.2 / 138	
7.295 / 39 / 81 / 19 / -7 / 94%	

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MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
15 NOV 03 1830	Received report on pt. 1257. PT lying supine c̄ HOB ↑ 30°. At this time pt is vented c̄ 8.0 ETT c̄ 29.5 cm to securing device SIMV - RR 20 TV 750 FiO2 40 PEEP 5 PIP 30's. PT is sedated on Versed 10mg and pain control c̄ morphine sulfate c̄ 8mg. Pupils are 2mm sluggish to light. OBT to LD and Dobhoff pending verification by MD. Khan is aware. Pt has (+) gag reflex to suctioning. Breath sound rhonchous. Moderate amount of light yellow secretions suctioned from ETT and bloody secretion orally. Breath sounds are coarse & diminished to bases bilaterally. Equal expansion noted. HR 90's c̄ S1S2 ectopy. Pulses are palpable c̄ cap refill <3 sec. Generalized edema c̄ 1+ pitting to ankles. BS hypoactive, distended c̄ midline incision c̄ drsg. C/D/I. Foley to gravity draining yellow urine 730cc/hr. [redacted]
1920	PT suctioned. Thick bloody secretion orally and light yellow secretion to ETT. [redacted]

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

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NOTES

PT suctioned. Q1H suctioned removed [redacted] LT/AN

PT ~~o~~ gurgling breathing pt suctioned. SaO2 remained at 94%. [redacted] LT/AN

PT continues to have gurgling breath sound. ETT securing device removed & PT suctioned c̄ yankauer. PT also suctioned through ETT and SaO2 improved to 95% then decreased back to 92-93%. ABSQ Δ done to (R) side. Wound bed pink. [redacted]

1400 100 mg Labetalol given per NGT. Tube clamped for 1hr. [redacted] LT/AN

1415 PT suctioned. ABD ABSQ Δ. done. Sutures intact. minimal leakage to site. PT turned to (R) side. MD. at bedside states Dobhoff & NGT O.K & will re-verify in am. [redacted] LT/AN

0100 PT. suctioned. [redacted]

0200 PT suctioned [redacted] LT/AN

0300 ETT securing device removed. Oral care done and new securing device placed. [redacted] LT/AN.

0400 morning Labs done. ABG results PH: 7.256 PCO2 46 PO2 57 HCO3 20 SaO2 85 BE -7. MD. notified and vent Δ's. are RR ↑24 & FiO2 ↑50. Will redraw Gas at 0600. [redacted] LT/AN.

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DATE	NOTES
15 NOV 03 1030	Pt had increasing art SBP and DBP and MAPs in 130's. Notified Dr [redacted] which wanted to try reversal to increase sedation. MAPs stayed the same. Dr [redacted] notified @ 0930 and came to assess pt. IVF changed to D5 1/2 NS @ 200cc/hr at Vecuronium on hold due to some PIP pressures or prior to on Vec. PIP @ 30-50 CVP bn 12-16. UOP today has been >100cc/hr and Amylase. CXR from this am was noted and Dr notified. H/H adequate for today. Secretions from ETT have been thick and yellow. Oral/nasal secretions have been copious and yellow. Continue to monitor respiratory + UOP [redacted] CPT/[illegible]
15 NOV 03 1200	Pt SBP + DBP continues to trend upwards. Pressures ↑ 150's SBP and DBP 110 MAP ↑ 140's. Will contact MD [redacted] CPT/[illegible]
15 NOV 03 1330	Given @ 1210 labetalol 20mg IVP through TLC. BP now 150's over ↑ 90's HR mid 90's. Pt to get labetalol q6. Will continue to monitor [redacted] CPT/[illegible]
15 NOV 03 1530	Dobhoff inserted into (L) NARE. Rubs clear and patency. Dr [redacted] to see film. Distal port TLC not flushing. Will notify next shift. [redacted] CPT/[illegible]

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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 NOV 03 0850	Surgery HD#6 ICUD#6 Vent D#6 POD#6 Aucet D#6
7.9 / 16.2 / 181 / 31.6	Started on Lipitabat + Tedalat per recs from Dr. [redacted] with decrease of BP to 150/70 - 160/80 which is a significant improvement. DHT placed + will slowly start TF.
124 / 117 / 94 / 113 / 4.1 / 22 / 3.1	Neuro = off vec, backvent + moves extremities will continue to Vered for relaxation
7.28 / 39.7 / 74 / 19 / -8 / 93%	Pulm = required increase in FiO2 and RR last PM for ↑pCO2 and ↓pO2. Responded well peak pressures now in the 30's to low 40's which is an improvement. CXR w/o improvement but stable
I/O = +1532	CV = responding to BP control w/ CVP = 14-18
	Abd = incision intact, distended but soft will slowly start TF
	FEN = UOP stable @ 55-110cc/hr Up 1500cc yest Cr stable @ 3.1 K+ stable @ 4.1
	H/H = stable Hct @ 31.6
	ID = Tmax = 99.2 on Aucet, will d/c Abx tomorrow if no fevers.
	Pt. continues to have increased pulmonary / vent. requirements. Will track tomorrow. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16NOV03 1000	Nutrition Note: Osmolite HN TF started this am via DHT. 11/16 labs: Hgb: 10.2↓, Hct: 31.6↓, BUN: 34↑, Creat: 3.1↑, Na: 124↓, Cl: 117↑. ENN based on 75 kg ~~body~~ weight: 2250-2625 Kcal/day (30-35 ~~kg~~ Kcal/kg) + 105-112.5 g Pro/day (1.4-1.5 g/kg). Recommend continuing TF at low rate 2° lung + renal function. Will continue to monitor + follow. [redacted] RD/LD
16NOV03 1025	SpO2 ↓ to 88% pt bagged and suctioned ETT. Thick beige secretions removed. Thick oral secretions beige also removed. PIP @ 40. Dr [redacted] notified and FiO2 to 65%. SpO2 @ 91%. [redacted] sounds ± inspiratory [redacted] wheezes in upper lobes as well as lower. Respiratory to give nebulizer treatment [redacted] CMT/a
16NOV03 1310	@ 1130. ↑ peep to 8 from 5. FiO2 @ 70%. Gas done @ 1220 T 29/37.7/162/18/89%. Base -7. Pt has rhonchi throughout and diminished in the bases. Rales heard in [redacted] will notify physician [redacted] CMT/a
16NOV03 1330	Dr [redacted] Dr [redacted] both come to evaluate the pt. Pt has not responded to suction nor to either side positioning. Peep to 10 FiO2 ↑ 100%
16NOV03 1600	Dr [redacted] ordered albuterol/atrovent. 1st dose of albuterol given. Pt still agitated on ventilator

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	due to Med. Pt fighting Vent. Empedoctor cultured ~~from~~ results from Micro Come back. The cx was from pt sputum ETT. Stored/ordered by Dr [redacted] Cipro 400mg IV be @ 2000 - will give report to next shift [redacted]
11 NOV 03 1800	

11/16/03 18:24:38 HR=104 ART=139/72(93) CVP=14/8(13) RR=24 SpO2=93% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm
COLOR DISPLAY ON

	Received report from previous shift. Pt vented #8.0 ETT 28.5cm@ hub. SIMV 24, P-10, TV 750, FiO2 70%, O2 sats 95%. Pt HOB 30° c̄ osmolite @ 10cc/° infusing via dobhoff. Pt turned onto (L) side. (B)UE + (B)LE elevated due to edema. Vec, versed, MSO4 + NS infusing into medial port. CVP + A-line zeroed. A-line 20 ~~cm~~ values different from NIBP value systolically. NGT to LIS c̄ large amt yellowish fluid. [redacted]
1900 2200	Deep suctioned pt x III. O2 sats ↓ 80s. Manually ventilated pt c̄ RT @ bedside. Copious amt yellowish sputum noted. O2 sats ↑ 91% for ≈ 1 minute then desat to 86%. Notified surgeon on call. Lasix 40mg ordered + NS ↓ 25cc/°. no p̄ lasix ↑ by 50cc/°. Dr [redacted] also notified. Ventilated pt ≈ 10 min. c̄ no ↑ in SaO2. Dr [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16 NOV 03 1900-2200	cont'd... + Dr. [redacted] notified. No new orders written. Will cont. to monitor. — [redacted]
0245	Dr. [redacted] to see pt. Fed peep to 15. O2 sats ↑ 93-94%. Will draw abg in 30 hr. Will cont to monitor [redacted]
2305	Drew ABG. Showed results to Dr. [redacted] Vent Δ's made. Pt O2 sats ↑ 94-96%. Will cont to monitor. — [redacted]
17 NOV 03 0030	Completed dsg Δ on midline abd + (R) flank. Staples intact midline abd. Small section low belly button open. Serous drainage noted on old dsg. Applied bactroban + covered c̄ 4x4. (R) flank open wound saturated c̄ serous drainage. Wound beefy red c̄ minimal yellow exudate. Cleaned c̄ NS. Wet to dry dsg covered in tegaderm. Will cont. care. — [redacted]
0045	Completed foley care. Elevated scrotum + applied bactroban to penile area. Deep suctioned pt x iii. Copious amt yellow tinged sputum from nose, mouth, + ETT noted. PIP ↓ 43 from 46. Will cont. care. — [redacted]
0345	Drew am labs + ABG. Due to results, ↓ FIO2 90%. cont'd.

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 NOV 03 0845	cont'd... O2 sats 100%. Will cont to monitor. — [redacted]
0515	↓ed FiO2 85%. Due to SaO2 100%. Will cont. to monitor. [redacted]
0545	↓ed FiO2 75% due to O2 sats 99-100%. Deep suction done by RT p̄ neb tx. PIP 41-42. CVP 12. Will cont. care. [redacted]
0600	Gave report to next shift. — [redacted]
0605	Called MD concerning Na+ level + low UO 35cc/1°. Dr. [redacted] notified. N's to be made by primary MD. [redacted]
17 NOV 03 0830	Surgery Cipro D#2 for E. cloacae bacteremia in pt. Pt. had a significant decline in his pulmonary status yesterday and required PEEP increase to 15, rate ↑ to 24 and FiO2 now @ 75%. CXR still c̄ bilat. infiltrates.
	Neuro = sedated + paralyzed
	Pulm = SIMV Rate 24 PEEP 15 FiO2 75%
	7.272/37.9/97/18/97%/-9
	Will try to wean support. trach cancelled
	CV = BP stabilized but CVP only 10 - 11 c̄ a PEEP of 15. will give volume
	GI = distended but soft. started TF @ 10cc/hr
	Renal = Cr ↑ to 3.5. likely due to ↑ PEEP and low volume. will holds + increase fluids
	ID = Cipro D#2 WBC = 10.2
	Will continue c̄ support in this pt. c̄ ARDS picture. Realize the mortality is high.

[redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	NURSING NOTES
17Nov03 0615	Received Pt # 275 in Icu 1 Bed #4. Pt unresponsive to verbal stimuli. See Intensive Care nursing flow sheet for assessment and VS. IV NS 25 cc/h Vecuronium drip 4 mg/h. Versed drip 10 mg/h. MSO4 8 mg/h in pump. A-line to right radial artery. Pt has generalized edema. Intubated.
0730	Dr [redacted] visited and examined Pt. he is aware of Pt's labs results and Pt's current condition. Pt sedated. [redacted]
0830	Dr [redacted] visit Pt. He ordered IV NS TL Bolus and IV NS rate to 250. Tube feeding restarted to 25 mL/hr to 60 cc/h. He ordered cancellation of planned tracheotomy for today. FiO2 ↓ to 70% Sat 98-99 via pulse oximeter.
0900	Temp 96.2 Sat 98% via pulse oximeter. FiO2 ↓ to 65% via pulse oxim [redacted]
1100	Temp 96. Oral care ET Tube care. Foley cath care and skin care done all dressings changed. TGR. Extra blankets used to cover Pt will Repeat temps.
1330	Dr [redacted] visited Pt. He is aware of Pt's condition. He ordered chest xray. Chest xray
1400	done Dr [redacted] reviewed xray. He ordered Dobutamine drip at 5 mcg/kg/m
1500	Dobutamine drip started at 5 mcg/kg/m. FiO2 70%. Sat 96% via pulse oximeter.
1745	Pt's condition unchanged. Zosyn 3.375 gram IVPB given. Versed 10 mg/h MSO4 8 mg/h Vecuronium 4 mg/h NS 250 cc/h continues. No distress noted. Report given to relief nurse [redacted]
17NOV03 1800	Received report from previous shift. Pt intubated ETT # 8.0 26cm @ teeth SIMV 24, TV 750, p-15, FiO2 65%, PIP 42. All IV lines in place. CATH.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	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)	REGISTER NO.	WARD NO.
		Icu 1

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[redacted]

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 NOV 03 1800	cont'd... A-line (R) radial c̄ good waveform but does not correlate c̄ BP cuff. Will record both values. (D) SC TLC c̄ versed @ 10mg/h, MSO4 @ 8mg/h, vecuronium @ 4mg/h NS @ 250cc/h infusing in medial port, CVP monitor in proximal port + dobutamine @ 5mcg/kg/min infusing in distal port. NGT to LIS c̄ some beige colored drainage. Dobhoff c̄ osmolite @ 10cc/h infusing. Replaced (R) flank drsg wet → dry due to saturated drsg c̄ serous fluid. HOB 30°. (B) UE (B) LE + scrotum elevated due to edema. Will cont. care. [redacted]
2000	Deep sxn pt x III due to PIP 46. Thick yellowish secretions noted from mouth, nares, + ETT.
2200	Pt no ↓ 15cc. Dr. [redacted] notified. ÷ liter NS bolus ordered. CVP currently 17, O2 sats 96% on 100% FiO2. Will titrate O2 to keep sats >93%. Will monitor UO. [redacted]
2230-2400	Completed Foley care + drsg Δ to midline abd, (R) flank + back. Midline abd incision staples well approximated c̄ small amt drainage from belly button area. Bactracin applied + dry drsg. Wet to dry drsg on (R) flank. Large amt serous fluid from (R) flank wound. Yellowish exudate noted but mostly beefy red. Xeroform gauze over CT incision c̄ ∅ drainage noted. Suture in place. Wet → dry drsg on back. ∅ S/S of infection. UO remains low 14cc p̄ 30 of ½ liter bolus. Will cont to monitor. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Nov 03	HHN Tx given c̄ 0.5 Alb/ATRovent /2.5 NS. BBS for
1400	Rhonchi throughout. HR 92-90, O2 SAT 94%. P Tx
Resp Therapy	BBS unchanged. NAR [redacted] CRT
1802	Neb tx given to pt pre tx HR 98 RR 24 SpO2 94% BBS coarse Rho
	Post tx HR 99 RR 24 SpO2 94% BBS No change Sgt [redacted] 91V2Ø
17 NOV 03 2206	UD Alb/Atrn given pre tx HR 93 RR 24 SpO2 96% on 100% FIO2
	BBS coarse Post tx HR 95 SpO2 97% on 100% FIO2 RR 24
	BBS No change pt sx by nurse [redacted]
18 NOV 03 Ø15Ø	UD Alb given. Pre tx HR 91, RR 24, SpO2 93% on 8Ø% FO2.
	BBS coarse rhonchi + faint wheezing. Post tx HR 88 RR 24, SpO2 93%
	back on 8Ø%. Suctioned pt c̄ 1Ø cc NS thin secretions.
	BS unchanged [redacted] Sgt [redacted] 91V2Ø
18 NOV Ø3 Ø85Ø	UD Alb & Atro given. Pre tx HR 98, RR 24 SpO2 92% on 1ØØ% FIO2
	BBS coarse. Post tx HR 1Ø3 RR 24 SpO2 95% on 100%. Suction
	by nurse. [redacted] 91V2Ø
1010	Pt. given UDAIB via inline neb @6L/min x 15 min.
	Pulses 92-95 RR 24-24 BBS c̄ CTA p̄ CTA Pt.
	Sx for minimal amount of clear yellow sputum [redacted] CRT
1400	TX given by nurse. Pt. suctioned for minimal
	amount of clear to yellow secretions. [redacted] CRT
1805	Tx given by nurse [redacted] Sgt [redacted] 91V2Ø
2145	PL given Neb tx c̄ .5cc Alb/Atrovent pre tx HR 122 [redacted]
	24 SpO2 92% on 85% FIO2 BBS coarse Rhonchi throughout
	Post tx HR 122 RR 24 SpO2 93% on 100% FIO2 BBS no change
	Pt lavaged + suction ≤ 3cc secretions removed Sgt [redacted]
19 NOV Ø1ØØ	Alb tx given. Pre tx HR 117, RR 24, SpO2 9Ø%, on 9Ø FIO2. BBS
	coarse. EMT called. Tx taken off per nurse. Sgt [redacted]

MEDCOM - 23702

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16 NOV 03	UD Alb Neb given pre tx HR 101 RR 24 SpO2 93%
1854	BBS coarse Post tx HR 102 RR 24 SpO2 95%
	BBS coarse pt SX — Sgt [redacted] 91U20
2225	UD Alb Neb given pre tx HR 98 RR 24 SpO2 87% on
	100% FIO2 Post tx HR 98 SpO2 94% RR 24 BBS no change
	pt SX — [redacted] Sgt [redacted] 77U20
17 NOV 03 0230	UD Alb+Atro neb given. HR 94-100, RR 24, SPO2 98-100%. BBS
	coarse c̄ faint wheezes. Suction scant amount — Sgt [redacted]
0530	UD Alb given. HR 110, SPO2 98%, RR 28. BBS coarse. Post
	tx HR 109, RR 24, SPO2 95. Suctioned pt. — Sgt [redacted]
17 Nov 03	Pt was Extubated @ 0955 and placed on 100% NRB. Pt c̄ ⊖
0920	resp distress, BBS for Scattered Rhonchi. O2 SAT 98%.
Resp Therapy	Δ'd to 40% Venti mask @ 0920 RR [redacted] O2 SAT 96%. BBS
	for Scattered Rhonchi. Pt c̄ strong [redacted] Productive cough
	No Resp distress noted. — [redacted] CRT
17 Nov 03	HHN Tx given c̄ 0.5 Alb/2.5 NS. BBS for coarse
1000	c̄ Exp wheeze. HR 96-97, O2 SAT @ 65%, 94%.
Resp Therapy	

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			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)

[redacted] (b)(6)-4

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PROGRESS NOTES
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Alb Q4
Atro Q8

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18NOV03 0010	UO 27cc p bolus. Notified Dr. [redacted] i liter NS bolus ordered. MIVF rate ↑ed 300cc/°. Temp ↓ 95.5 Place extra blankets + heating lamp on pt. CVP 26. Deep suction pt x iii. Copious amt yellowish secretions noted from mouth, nose + ETT. O2 sats 93%. Will cont to monitor. [redacted] (7/7a)
0300	UO ↓ 10cc. Temp ↑ 96.1 O2 sats remain 90-91%. Dr [redacted] aware. Lasix 40 mg ordered. MIVF ↓ed 200cc/°. Will cont to monitor. — [redacted]
0445	Reported abnormal ABG results to Dr. [redacted]. Ø vent Δ's made Ø new orders. [redacted]
0500	Ø improvement in UO. Will cont to monitor. [redacted] (7/7a)
0600	Gave report to next shift. — [redacted] (7/7a)
18NOV03 0730	Upon shift change this am pt on back i thorax 30° TIC 3 all ports in use. NS @ 200cc/h, NC @ 4cc/h Dobutamine @ 5cc/h 4 mcg/kg/h; Versed 10cc/h, MSO4 @ 8cc/h. Tube through OBT in (L) nare @ 10cc/h i no gas sats. Ø BSM since admission. Not to (R) nare. ~~Wounds are~~ Surgical incisions to (R) axilla and from CT site are weepy and reinforced i dressings. Dependent edema. Scrotum very large and elevated.

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

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[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Cont - Set to rate @ 94 c̄ current vent setting on flow sheet. Will titrate vent ↓ FiO2 to keep O2 sats >93%. Will continue Urine OP is decreased. Cont @ 3.6 physician aware. Will continue to monitor respiratory status — [redacted] CPT/[illegible]
1030 18 Nov 03	pt UOP continues to trend ↓. 20-28cc/h Notified physician — [redacted] CPT/[illegible]
18 Nov 03 1200	Non assessment. No changes to report. UOP continues to trend in 20's. Physician aware — [redacted] CPT/[illegible]
18 Nov 03 1400	for 14hrs UOP @ 16cc. Dr [redacted] notified ordered 80 mg Lasix IVP. Will monitor response — [redacted] CPT/[illegible]
18 Nov 03	Received report on 1275. Presently heavily sedated c̄ versed, Vecuronium, + MSO4 gtt. Will continue to work on wean O2 down. Lungs: coarse rales. Ventilator beeping off c̄ delivered tidal vol. not equal set TV. Respiratory aware. SIMV c̄ rate 24 Ratio 1:1 TV 750 PEEP 15. FiO2 85% c̄ O2 sats 92%. [redacted] CPT/[illegible] Respiratory admin treatments c̄ loosening of secretions. Unable to get O2 sat ↑89 ∴ Resp. ↑ O2 to 100% Several attempts to get O2 back to 85% c̄ resulting desat 89%. Finally @ 400 FiO2 ↓90% c̄ sats 91-92% 0430 ↓ 85% c̄ sat 93% Obtained ABG. — [redacted]
0600	Reported off to day shift [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19NOV03	General Surgery [redacted]
	HR# 9 / FCUP# 9 Vent D# 9 POD# 9 ~~Fecal D# 7~~
129/106	Cipro d# 4 for Enterobacter pneumonia
5.6/16	Pt. continues to have very poor pulmonary status
	still c a PEEP of 15 and FiO2 of 80%
HR 9/28.3	and PaO2 of 66 peak pressure of 50
	ABG this AM = 7.041/53.1/66/14/-16/81%
	given Bicarb and one blood
	CXR = no A's
	~~This patient~~
	Renal = Cr has increased to 5.2 and UOP still 450
	cc/hr on Lasix 40mg/hr. Will give blood
	today and see if it helps
	This patient continues to have a severe decline
	with no obvious source other than his pneumonia
	which we are treating with continued c aggressive
	support. If he continues to decline, I will
	consider a DNR order.
	(b)(6)-2
	[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			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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PROGRESS NOTES
Medical Record

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Pt 1275 (b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 NOV 03 1530	Phis Am received report. Pt ABG ↓ c̄ pH @ 7.041 /53.1/66/14/-16 SaO2 81. Received 6 Amps BiCarb 2u PRBCs. Noon Blood Gas 7.16/49.7/61/18/-11 c̄ 84%. Received then 4 Amps BiCarb and Charged MLVF to BiCarb drip @ 100cc/h. Pt suctioned c̄ bloody thick mucous c̄ thick plugs suctioned out p̄ treatments from RT. Sats are currently @ 95% c̄ FiO2 @ 87%. will ↓ FiO2 @ 1600 if sats remain above 93%. Medications were Charged over today/to renal doses. (R) Femoral Cath begun for more access. Will do another ABG. — [redacted] CPT
19 NOV 1735	@ 1545 plane Bladder pressures ↑ R/O ABD Compartment Syndrome. Pt presents @ 23. Dr [redacted] aware. Set up of ABD monitor @ Bedside. — [redacted]
20 NOV 03 0925	This Am LABS 21.1 / 9.6 / 30 / 332 PT/PTT repeated and PT 39 / PTT 102. ABG 7.278/51.2/137/24/-3/99%. CHEM 144/114/99/146 / 4.4/23/5.9. Dr [redacted] aware of all labs. Pt continues to be on MV c̄ peep 15 RR30 TV 690 and FiO2 @ 87 c̄ keeping sats ↑ 93%. Rales/scattered Rhonchi heard throughout. Rales auscultated in middle to upper lung fields. Pt has ∅ BS and distended. UOP has been no more than 20 cc/h since shift b. Continue on ABX. When Pt suctioned secretion bloody/beige. Skin tears and weepy. Pt is non DNR. Will continue to monitor resp/renal status — [redacted] CPT/RN

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 Nov 03 0600	Pre tx HR 115, RR 24, SPO2 90 on 85% FiO2. UD Alb & Atro given BBS coarse. Post tx HR , RR , SPO2 on 85% FiO2. ——— Sg[redacted] 91W 20
1000	Pt. given UD Alb via inline neb @ 6 L/m x 15 min. Pulse 119-114 RR 30-30 BBS ⊕ I&Ws & Exp wheezing P NOD Pt. suctioned for moderate amount of bloody sputum and large bloody plug [redacted] CRTT
1400	Pt. tx given by nurses. CRTT [redacted] ———
1814	Pt tx given by nurse Sgt [redacted] 91W 20
2200	Pt given SCC Alb/Atro neb tx Pre tx HR 114 RR 30 SpO2 94%, 80% FiO2 BBS coarse insp + exp wheeze
20 Nov 03 0200	Pre tx HR 115, 92 SPO2 on 75% FiO2, RR 30, BBS ⊕ coarse ⊕ wheezes. UD Alb neb given. Post tx 117, RR 30, SPO2 90 on 75%, suctioned thin bloody-tinged sputum ——— Sgt [redacted] 91W 2
0600	Pre tx HR 111, SPO2 91% on 90% FiO2, RR 30. BBS coarse & wheezes UD Alb + atrovent given. Post tx HR RR SPO2 on 90% FiO2 Suction.
1000	Pt. given UD Alb via inline neb @ 6 L/m x 15 min Pulse 107-110 RR 30-30 BBS ⊕ insp. & Exp. wheezing P NOD pt. suctioned for small amount of brown to clear secretions. [redacted] CRTT ———

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

DATE	NOTES
Nov 20 03	Pt. given UD AIB & UD Atro. via inhlr neb @ 6 L/m
1400	x15 min. Pulse 114-112 RR 30-30 BBS ā exp
	wheeze p̄ no D. [redacted] CRTT
1830	pt Given UD Alb tx pre tx HR 109 RR 30 SpO2 95%
	BBS insp + exp wheezing. Post tx HR 112 RR 30 SpO2
	94% BBS No change pt SX — Sgt [redacted]
2147	Pt Given UD Alb/Atro pre tx HR 102 RR 30 SpO2 92% on 87% FIO2
	BBS coarse insp + exp wheezing Post tx HR 102 RR 30
	SpO2 94%, BBS No change pt SX — Sgt [redacted] 91W2Ø
NOV 21 Ø3 Ø3ØØ	UD Alb neb given. Pre tx HR 94, RR 3Ø, SpO2 89 on 87% FIO2.
	BBS coarse ī wheezes. Post tx HR 1Ø2, RR 3Ø, SpO2 9Ø on 9Ø%.
	No Δ's in BS — Sgt [redacted] 91W2Ø
Ø4ØØ	Suctioned pt ī 5cc NS scant blood tinged mucus.
	PIP remain @ 53. — Sgt [redacted] 91W2Ø
Ø545	Pre tx HR 111, RR 3Ø, SpO2 9Ø on 9Ø% FIO2. BBS coarse ī wheezed
	watery sounding. UD Alb & Atro given. Suctioned pt ī 5cc NS lavage
	blood tinged secretions - thin. Post tx HR 1Ø7, RR 3Ø, SpO2 89
	on 9Ø% FIO2, BBS same. — Sgt [redacted] 91W2Ø
1000	Pt. given UD AIB & UD Atro via inhlr neb @ 6 L/m x 15 min.
	Pulse 119-119 RR 30-30 BBS ā a little wet sound.
	p̄ CTA Pt. suctioned using 20cc NS for thick
	bloody secretions. [redacted] CRTT
1400	Pt. given 5cc AIB & UD Atro via inhlr neb @ 6 L/m x 15 min.
	Pulse 121-115 RR 30-30 - BBS ā a little coarse p̄ less
	coarse - Pt. sy for moderate amounts of bloody sputum.
	[redacted] CRTT

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Notes
19 Nov 03 1830	Received PAT 1275 in Icu 1 Bed # 4 Pt chemically paralyzed pt movement of any extremities noted. Pt PERRL 3mm Slow reaction. Pt grossly edematous scrotum and Penis grossly edematous. Pt Orally intubated ETT 24cm Lip line Vented Rate 30 SIMV TV 620 FiO2 75% Peep 15. Bilateral breath sounds has scattered rhonchi with rales to mid lobes. Equal chest expansion noted. Sat 94-96 Diaphoresis noted. Cardiac Monitor shows ST HR 110-120's BP grossly edematous. Pulses ⊕ TLC to left SC cvp monitoring done CVP 18-22. Pt on levophed drip 10 mcg/h. Hydralazine drip at 8 mcg/h Vecuronium at 4 mcg/h. Dopamine drip at 3 mcg/kg/min Dobutrex drip at 10 mcg/kg/min. Lasix drip at 40 mg/h. and D5NTLC 3 amp Sodium Bicarbonate at 150 cc/h. Cordis to Right groin. Arterial to right radial art. Foley Suprapubic tube thru Right Nare to suction. Dryshoff tube thru Left nare with osmolite 10 cc infusing. Bowel sounds very hyperactive. Foley Cath in place draining scant yellow urine to bag. Mid abdominal surgical wound covered with dry dressing. Old chest tube site to right chest wall covered with dry dressing.
1900	Pt transferred to unit and continued. Pt dropped to HR 40's after suctioning HR 40's Pt bagged for approximately 1 min. Placed back on vent at 60% FiO2. HR 118 VSS [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2
	LAST	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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WARD NO. ICU 1

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Nursing Notes Cont.
19 NOV 03 2200	VS: FiO2 titrated down to 80% PA [redacted] visited Pt. Le is aware of Pt's most ABG results and of Pt's condition. Pt turned and positioned.
2300	FiO2 titrated to 75% Sat 93-95% via pulse oximeter. No dilution noted [redacted]
0100	VS: Pt turned, turned and positioned
0300	Pt Sat 93% via pulse oximeter FiO2 to 80% then 85% [redacted]
0430	Chest xray done. Blood drawn and sent to lab [redacted]
0500	Sat 91% via pulse oximeter. FiO2 to 90%. Pt turned, washed. Sat of 93%
0600	via pulse oximeter. Pt's condition unchanged. Continue to monitor [redacted]
20 NOV 03	Surgery HD#10 ICU#10 Vent D#16 POD#16
	Cipro D#5 Imipenem Day #1
PT=39	Pt. still doing very poorly. Still requiring PEEP
PTT=102	and FiO2 for oxygenation. Peak pressure of 50.
INR=7.66	CXR unchanged.
21.4 / 9.6 / 332 / 30	So far this patient so far has pulmonary failure and
7.278/51.2/137/24	renal failure. He is developing liver failure and
-3 / 99%	hematologic failure with his LAEs going up and his
144/114/99/146	coagulation studies going out. And his WBC continues
4.4/23/5.9	to increase in spite of broad coverage c̄ Zosyn
bilirubin 5.8	and focused coverage for his pneumonia with
bilirubin 59	Ciprofloxacin.
	This patient is now developing 4 system failure
	and is on maximal ventilatory support and
	dopamine and dobutamine. I do not feel it will
	be appropriate to continue escalating his care in
	light of his very high mortality. I will continue what
	supportive care we have him on and make him a
	DNR. I have discussed this c̄ Dr [redacted] and
	he agrees.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
201800 Nov 03	Received report from day shift. Assumed pt care. Ambu bag at bedside. O2 tank full. All medications infusing appropriately. Drsg to (R) femoral cordis is loose, c̄ serous fluid leaking out around cordis and into creases of groin. Bed saturated c̄ serous fluid. ~~Groin~~ Scrotum swollen to size of football. Penis also very swollen, c̄ superficial layer of skin along (R) lateral side and anterior portion of penis sloughing off. Pink white tissue visible beneath sloughed skin. [redacted]
202000 Nov 03	Assessment and medications completed. Turned pt to left side. Drsg Δ to (R) flank and middle of back completed. Ø skin breakdown noted to sacral area or other bony prominences. All of bed linens and moisture pads changed. ~~Ha~~ Ankles elevated on towels, keeping heels off of bed. Scrotum elevated on towel. Drsg to (R) femoral cordis changed using sterile technique, replacing op site & cleaning c̄ ~~ETO~~ alcohol & iodine. Noted significant facial swelling, tie for ETT digging into face. ETT tie replaced c̄ bite-block. ETT holder. Skin breakdown noted to (R) cheek and (L) corners of mouth. MD will be notified. Wool blanket & warmer lamp placed over pt to aid in keeping warm. [redacted]
210400 Nov 03	Suctioning through ETT produces small amounts of thick, brown tinged mucus. RT has completed after each treatment (which is being done q 2hrs). [redacted]
210440 Nov 03	Labs drawn. ABG/Lytes stat ~~take~~ drawn. Specimen keeps clotting. Machine cannot pull blood through cartridge. Will inform MD. [redacted]
210500 Nov 03	O2 Sats ↓. RT suctioned small amount of clear mucous (c̄ slight blood tinge) c̄ placing 5cc NS down ETT. No ↑ S_pO_2. RT ↑ FiO_2 to 90%. [redacted]
210530 Nov 03	ABG or Chem 7 redrawn & sent to lab. Results pending. [redacted]

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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Civ [redacted]

PROGRESS NOTES
Medical Record

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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
210500 Nov 03	LATE ENTRY: New bag of Lasix retrieved. I asked that lasix be put in 50mL bag rather than 250mL bag to reduce amount of fluid entering body. New concentration is 5mg/cc lasix. New IV rate will be 8cc/hr. [redacted]
21 NOV 03	Surgery HD#11 ICU D#11 Vent D#11 POD#11
22.5/16/31.7 / 31.5	Cipro D#6 Ingepenem D#2
7.243/63.5/58/27 BE=0 / 84%	Continues c̄ downward course. UOP <10cc/hr BUN + Cr continue to increase and oxygenation decreases and he has a low temperature requiring heat lamps. Will continue current care c̄ no escalation and no CPR if needed [redacted]
1181/112/155 / 4.7/22/6.5	
21Nov03 0600	Initial assessment complete see DA4700, pt VSS, ETT #8, 27cm @ hub, SIMV 30, PEEP 15, TV 690, FiO2 90% O2 Sats 88-91%, patient draining serous fluid throughout body, (+) 3 pitting edema generalized, sedation c̄ Versed and morphine, paralyzed c̄ Vecuronium; pupils are equal round, non reactive to light @ 2mm [redacted]
0700	Dr [redacted] @ bedside updated on pt condition no new orders, continue palliative care [redacted]
0805	Dobhoff flushed c̄ 100cc NS c̄ complications TF placed back to 30cc/hr. [redacted]
0900	Pt turned to back. [redacted]
21Nov03 1015	Pt sx c̄ scant blood tinged thick secretions. VSS O2 sat 92% after suctioning. [redacted]
21Nov03 1150	Pt VSS, no change in pt status. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21aB 0010	(cont) PIP ≥ 60, ETT #8, SIMV 30, PEEP 15, FiO_2 90%, TV 690, c̄ suction, bright red secretion, ⊖ gag, scanty amounts of drainage from foley catheter c̄ blood tinged urine, NGT to (R) nares c̄ dark brown drainage, Robinoff to (L) nares c̄ Jevity @ 30cc/hr + q4° 60cc flushes, Sedation c̄ Versed, MSO4, + Vec, MIVF D5W c̄ 3 amp Bicarb @ 100cc/hr. [redacted]
21aB 0750	Pt sx due to PIP ≥ 66, sx c̄ bright red secretions O_2 sat 83% prior to sx c̄ O_2 sat 85% after suctioning. [redacted]
21aB 0800	RT aware of PIP. [redacted]
21aB 0830	PIP remain > 65, RT paged and aware [redacted]
21aB 0930	Dr [redacted] aware of PIP and secretions, no new orders at this time. [redacted]
21aB 1100	Dr [redacted] @ bedside, updated on pt status, no new orders noted. [redacted]
22NOV03	Surgery
8.4 / 25.9 / 345	Pt's condition continues to worsen with peak pressures of 60 and FiO_2 requirement of 100%. Also c̄ oliguric renal failure and Cr of 6.8, and liver failure c̄ coagulopathy.
136/103/126/156 4.6/24/6.7	I fear of his continued decline in spite of maximal support. I feel it is most appropriate to stop all antibiotics, stop his bicarbonate drip and his tube feedings. I will leave him on the ventilator and give him IV fluids, sedation + pain meds. I have discussed this c̄ Dr. [redacted] and he agrees.
7.24/61.4/57/ 30/+3/85%	

[redacted] 5/1999) BACK

USAPA V1.00

(b)(6)-2 except bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21NOV03 1420	Pt sx x 2 c̄ bright red secretions c̄ expiratory crackles post suction. [redacted]
21NOV03 1530	Pt bathed c̄ linens changed, no signs of skin breakdown, pt repositioned to (L) side. Drsg Δ to (R) back, (R) side, and midline abd. New dressing applied to (R) femoral cordis due to drainage. [redacted]
21NOV03 1600	Dr [redacted] @ bedside, updated on pt status, new orders noted. [redacted]
21NOV03 1700	Pt VSS, no change in current status [redacted]
21 1800 Nov 03	Assumed pt care & received report from day shift. [redacted]
21 1830 Nov 03	Weeping from all wounds continues. Bedding saturated c̄ serous fluid. Bed linen changed. Pt turned to (L) side. Wounds to mouth remain from ETT tube. Ø new orders regarding treatment of those wounds. Stain to penis continues to slough off. Significant weeping from sloughed areas. Scrotum elevated on towel. [redacted]
21 1830 Nov 03	LATE ENTRY: Noted during assessment that sclera to both eyes are yellow and swollen. Akwa tears applied to both eyes. Some purulent drainage noted [redacted]
22 0400 Nov 03	Ventilator began annotating very high peak inspiratory pressures. RT [redacted]
22 0500 Nov 03	Noted to have blood tinge to pt's urine. [redacted]
22NOV03 0610	Initial assessment complete see DA4700. Noted sclera edema c̄ jaundice color to sclera, weeping serous fluid all over body. (cont) SS

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-2 except bottom

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

DATE	NOTES
21NOV 03 1755	RT Note Pt given uD Alb Neb pre tx HR 109 RR 30 SpO2 94% BBS Coarse Rhonci throughout post tx HR 110 RR 30 SpO2 94% BBS No change pt Sx Bright red blood suctioned stoped ——— Sgt [redacted] S1V20
2235	uD Alb / Atro Given to pt pre tx HR 110 RR 30 SpO2 ~~[illegible]~~ 91% on 90% FiO2 BBS coarse Post tx HR 106 RR 30 SpO2 92% BBS No change ——— Sgt [redacted] 91V20
22NOV03 0150	uD Alb given, pre tx HR 104, RR 30, SPO2 94 on 90% FiO2, BBS coarse, Post tx HR 107, RR 30, SPO2 92. ——— Sgt [redacted] 1V9
0600	uD Alb & Atrovent given. Pre tx HR 90, RR 30, SPO2 90% on 90% FiO2. Post tx HR 111, RR 30, SPO2 91% on 90% FiO2. Suctioned pt bloody secretion c̄ plug ——— Sgt [redacted] 1V20
1000	Pt given uD Alb via inline neb @ 6L/m x 15 min pulses 112-107 RR 30-30 BBS à coarse p̄ NO2 [redacted] CRTT ———
1400	Pt. given uD Alb c̄ uD Atrovent via inline neb @ 6L/m x 15 min Pulse 105-111 RR 30-30 BBS à coarse p̄ NO2 [redacted] CRTT ———
1757	uD Alb tx given pre tx HR 106 RR 30 SpO2 89% on 90% FiO2 BBS Diminished Post tx HR 117 RR 30 SpO2 92 BBS: ~~[illegible]~~ coarse expiratory Pt Sx Bright red blood tinged sputum ——— Sgt [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)*

REGISTER NO. | WARD NO.

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22NOV03	Pt Given .5cc Alb/Atro nebs inline pre tx HR 105 RR 30
2149	SpO2 88% on 100% FIO2 BBS Coarse Rhonci throughout
	Post tx HR 105 RR 30 SpO2 85% BBS Coarse
	Pt Sx Red blood sgt [redacted] (b)(6)-2 91U 20

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

(b)(6)-2 except bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

22Nov03 1400 Bed padding changed due to saturation; drsg Δ to back, abd, and old chest tube sites; pt positioned on backside; pt tolerate ō much change in status.

22Nov03 1500 Dr [redacted] @ bedside, updated on pt status, new orders noted. [redacted]

22 1800 Nov03 Assumed pt care. Received report from day shift. Noted significant oral drainage, DC of antibiotics and tube feeding. BP ranging lower than yesterday. Scrotum still significantly swollen ō sloughing to penis continuing. Drainage from penis continues. Drsg to abd and R flank minimal at this time. Drsgs to these areas are intact. [redacted]

22 1930 Nov03 Completed oral care. Brushed teeth, tongue. Noted bleeding to gums after brushing. Suctioned large amounts of mucous from oropharynx, some blood-tinged. Replaced bite block/ETT holder. Placed backtrack to nares where NG & Dobhoff had irritated. NG & Dobhoff moved to different area of nares. Just as I finished the oral care, noticed S_aO_2 ↓ to 83%. Suctioned lungs. Ø significant drainage. ↑ F_iO_2 to 100% ī RT recommendation. [redacted]

222300 Nov03 Urine output was 14cc. However, urine appeared to be 100% blood. [redacted]

230113 Nov03 At ~~0100~~ error 0030, noticed that pts HR had significantly dropped to mid-fifties. S_aO_2 was 78% ī SIMV at 30 b/m, F_iO_2 100%, PEEP 15, TV 690. A-line showed smaller and smaller waves ī lengthening pulse waveforms. ECG demonstrated widening QRS interval ī a weaker amplitude on the QRS wave. By 0100, pulse had reduced to twenties, ī QRS wave weakening and interval widening further on ECG. S_aO_2 dropped to 70% ī no changes to (over)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	ventilator settings. At this time, Surgeon on call was notified. Dr [redacted] asked that we notify Dr. [redacted] the attending for the pt. At 0113, the ECG was asystolic. Ventilation continued via mechanical ventilator at previous settings. Dr [redacted] pronounced the patient at 0113. Ventilator was turned off and breathing stopped. Absence of a heart beat was verified by myself via auscultation and ECG after ventilator stopped. Pt was cleansed. All tubes and wires were removed from the patient. The dressings to the abdomen, the right flank, and the back were also removed. Sutures were placed in the left subclavian area and the right femoral area to close of bleeding arteries that had central lines in place. Wound to right flank also sutured closed. Pt photographed for identification purposes by TOC personnel. Pt bound at hands, feet, and tied a band around his head to keep the mouth shut. Placed in body bag and taken to morgue c̄ toe tag in place. Nursing supervisor notified and aided c̄ transfer to morgue. Death packet completed by Dr. [redacted] and taken to PAD — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

1447 HH+7 IV 1838

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
10 Nov 03	1759 pt arrives by MP's on litter	1826: 5 bags 1000 ll
	1802 IV (R) intercostal arm Bolus LR O2 15 lts.	: 86 pulse Ox
B/P	1803 IV (L) intercostal arm " "	131 pulse
P	palpable deformity (R) thorax	98 SPO
T	pt is alert & O x 3	1827 130 pulse
R	entrance wound posterior (R) shoulder	98 SPO
O2 SAT	positive bowels sounds, belly soft	1828 127 pulse
ALLERGIES	Lungs: good breath sounds on (L), wheezes on (R)	
LMP	ext clear x 4 c̄ 2+ pulses x 4	
MEDS	C spine clear non tender	
	10mg morphine IM in field	
1812 Morphine	-heat packs applied to chest area + groin area	
5mg. by 18	-pt. states by head shake, no longer cold	
IV (R) arm	182 -1gm Ancef given by IV push	
13) 130/80	182 -leads applied to pt. from defib.	
96 SPO2	18 sinus Tack on monitor	
117 pulse	829 chest tube attempt. c̄ xylocaine 1831 tube no	
Resp. 30	c̄ drainage, 1837 condom placed on end of chest tube	
18: Pulse 114	Chest tube secured c̄ #2 suture	1832 81, 132
19: SPO 90	1843 Midazolam 5ml ~~by IV (R) arm~~	
P. 123	1847 Midazolam 5ml by IV (R) arm 76 151	1831 SPO 76 132p
20: SPO 89 p. 126		1830: 79 SPO
		1833 74 SPO, 135p. 133 pulse
		70, 138
		1834 62 SPO, 139p.
		1835 65, 136 p 1836 68, 135 p.
		1837 69, 134 p 1839: 68, 132 p.

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.) [redacted] (6)(6)-4		REGISTER NO.	WARD NO.

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	1843- [illegible], 136p.
	1844- [illegible]ction
	1845 [illegible]t. being resistant, pt. calm 1846 63sat pulse 155
	Lungs (R) side wheezing heard, (L) side clear
	1848 5ml morphine by IV 1849 74sat 141p.
	1850 [illegible]ed blankets XZ applied to pt. (L) back side, leg + thoracic area
	1852 J tube inserted, suction then O_2 by BVM reapplied 1854 76sat 133p.
	1856 5ml morphine by IV (R) arm 1858 79SPD 135p.
	1859 J tube out
	1903 Pt. [illegible] sit up position by head board 1900: 78 142p / 65sat 143p
1330, 150	[illegible]pplied to litter 1904: 66 151, 1908: 78, 137p.
	Pulse Ox applied to (L) middle toe 1906: 72, 142p.
1926: pulse strong	1913 Morphine 5ml by IV
	1912 [illegible]uction 1914: 44, 153
	1915 Bagging c̄ O_2 1915: 30, 157p. 1916: 43, 146p
	1918 Ø Resp. being assisted c̄ BVM + O_2 @ 15 lit. 1917: 53, 144p c̄ Bagging
	1919 Suction 1918: 60, 137 c̄ BVM
	1922 pt. [illegible] back Ø elevation board removed 1920: 67, 134p. 1922: 49, 136p.
	1923 oral airway (Stule) inserted, BVM c̄ O_2 reapplied 1924: 68, 129p. 1926: 82, 123
	1927 oral airway removed, BVM replaced by non rebreather 1928: 90, 141
	1928 pt. breathing on own 1929: 66, 142
	1929 BVM reapplied c̄ O_2 1930 55, 140, 1931: 69, 139
	1935 suction 1932: 72, 139
	1937 pt. struggles 73, 105p 1934: 72, 139

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
1943	Succinylcholine 90mg/4½cc slow push by IV	1939 62, 145
1942	demerol by IV	1940: 40, 150
		1941: 54, 144
1945	ET tube c̄ stylet ~~app~~ inserted c̄ laryng. scope.	~~1944: 45~~, 132
	1945: suction through tube	
1946	tube removed	1945: 22, 73
1946	BVM c̄ O2, J tube inserted	1947: 23, 112 / 57, 120
1947	suction c̄ J tube in place	1948: 61, 92p. 1949: 53, 118
1948	NG tubing inserted	1950: 50, 118
1950	Combi tube inserted, BVM applied	1951: 47, 112, 1953: 38, 111
2000	Combi tube deflated	1954: 44, 109, 1956: 65, 108
2000	ET tube inserted 78, 111	1957: 71, 106, 1958: 74, 113
	and taped in place	2002: 74, 133, 2003: 70, 133
2001	bite block inserted	2006: 83, 132 /
2014	succinylcholine 30mg by IV	2009: 85, 125
2016	(2ml/ml) 500ml NS c̄ lgn. succinylcholine hung	2010: 84, 124
	20gtt/min.	2014: 82, 132
2021	(+) dead. detention	2018: 77, 125
2028	suction c̄ tube in place	2020: 84, 128
2030	midazolam 5mg pt. has strong reg. pulse	2028 82, 133
2032	chest seal applied to (R) thorax entry wound	2030 81, 123p.
2031	hand restraints applied 91, 139p.	

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

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Nov 03	2038: 0,145
2039	still, SVM c̄ O_2 20 Lit.
2054	suction
2058 BP 110/64	2102: lungs (B) breath sounds good
2112	pt. hooked to ventilator
2112	pt. moving around
2114	BUN after removal from ventilator
218	blood withdrew from cath. (D) arm for ISTAT 2cc
2129	midazolam 5mg given by IV
2129	suction
(b)(6)-2 [redacted]	
2133	4?/144
2136	6?, 150
2140	6?, 137
2145	6?, 150
2148	4?, 114
2153	6?, 132
2155	500 cc NaCl c̄ succinylcholine

2043: 77,149
2045: 77,148
2053: 76,147
2055: 79,150
2056: 80,148
2058: 83,151
2059: 69,153
2101: 56,155p
2103: 59,154/65,153
2105: 71,154
2106: 72,153
2109: 70,151
2111: 72,150
2114: 46,120
2115: 38,137
2116: 50,140
2118: 71,131
2120: 79,129
2121: 78,127
2127: 73,132
2130: 45,141
2123: 83,128
2126: 78,131
2132: 58,143
2133: 65,145
2133: 61,145
2135: 63,143
2158 75,143
2201 81,126
2209: 82,126p

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 NOV 03	[redacted] (b)(6)-4
2045	TREATMENT SUMMARY
	APPRO 40 Y/O IRAQI MALE SHOT BY MP'S WHILE FLEE[redacted] IN A MV@170. BULLET STRUCK IZ IN RIGHT UPPER BACK Ø EXIT WOUND. Ø OTHER INJURY. TAKEN TO [redacted] IN RESP. DISTRESS. O2 SAT INITIALLY 90% ON 15L O2 PER MASK. PT GIVEN AMLEF I GM P 2 LARGE BORE IV'S PLACED. ¿ 2L LR. RT CT PLACED (32 Fr) C̄ REMOVAL OF ~ 4L BLOOD. CT TO WATER SEAL OVER PERIOD OF ~ 1 HR. O2 SATS GRADUALLY ↓ TO 50'S. PT WAS PARALIZED ¿ INTUBATED. O2 SATS ↑ TO HIGH 80'S LOW 90'S ON 100% O2. CONTINUED TO FLUID RESUSITATE. TOTAL FLUID ~ 10L. PLACED ON SUCCINOCHOLINE GTT @ ~ 4mg/min. AND DOSED C̄ VECURONIUM 10mg Q 1°. ALSO ~~RECEIVED~~ RECEIVED 5mg MSO4 IN FIELD ¿ 100mg DENAROL PRIOR TO INTUBATION. UNABLE TO FLY IZ TO 3° CARE 2° TO POOR WEATHER.
	[redacted] (b)(6)-2
	[redacted] MD
	MAJ, MC, USA
	FIELD SURGEON
	[redacted] (b)(2)-2
0 NOV 03 -	Pt presented to EMERS off Helo 2304L/ Pt on ET Tube, ~~One~~ Two IV lines to Antecubital space on (L) & (R) arm. Pt on Atropine @ 2305L. Pt on chest tube (R) intercostal space VS. BP - 191/114, P-131 O2% - 87% @ 2318 Great distal pulses. Pt placed on foley 2309L. NG tube placed in pt @ 2318L. Chest X-ray taken @ 2320.

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

Closing

0228 Surg ends 1 Blade 10 1 Blade 15
6 needles
2 sm needles Complete

OR Pam called @ 2319

2322: O2 SAT 78, P-135
2323: 100cc blood in suction unit
~~23~~ 23 MAR: 2nd clot ~~replace~~ tube inserted @ 2327
2326: 1200cc urine output
2328: 192/14
2329: 59 29%
2329: 187/13

Pt placed on O2 @ 2330
2332 Abdominal x-ray taken
2333 - 177/20 P-114 O2% - 84
2334 90 O2 SAT P-106
2334 - Another liter placed on pt. 9% Sodium Chloride WO
2336 184/23 O2 - 94% P-104
2337 179/21 P-104 O2 - 93%
2338 183/22 O2 - 94% P-103
2339 95 29%
2341 160cc urine
2342 2nd suction applied off NG tube
2343 Ultrasound done on abdomen
2343 Urine bag drained 1300cc slightly yellow urine Ø blood
2344 Pleovac suction applied
2345 96% P-112 BP
2350 blad pt to tup for laparotomy

2352 181/12
2352 Cut into pt abdomen 159th aeromed.
2352 72/111
2353 Ambu bag taken off pt
2353 - Stomach clear
2354 - Good bilateral breath sounds after hooked up to ventilator
2356 - Pt being prepared to be taken to OR
2356 - 181/118 P-107 02%-92
2356 - Pt placed on ambu bag
2359 - P-144
2359 - O2-9[illegible]% 189/114 P-104
0001 - Securing ET tube
0005 - 97 02% 161/108 P-107
0007 - Pt taken into ER 181/125 P-106 O2-89%
0008 Pt Being prep Lower AB and Shave Above/below
0009 1st Count 15 LaB 10 raypec umb. ~~Nipple~~ line
3 Blade 2 Bovie tips 1 Scratch pad
0016 Bullet wound expose Centermeter wide.
rt/below ~~nipple~~ umb.
#10 Blade.
0020 excision begins using Bovie to Coag
Lap Pack x15 two retractor Army & Navy
Yank. Suct +5 =20+5
(2) 0-prolene tapered x2
0023 Intestine exposed 2 prolene x 2 =4
10 raypec 7 pieces Balfour
0145 (interim) Count lap pack 20+5+5+5+5
7 pcs Balfour 0- Prolene tapered x2 +4
0125 2- Prolene " " x2 + 1 xy

OP NOTE

Pre-op Dx: GSW (B) hemi x 1

Post-op Dx: Diaphragmatic Injury / minimal superficial liver abrasion on top of dome

Proc: Ex. Lap & Diaphragmatic Injury Repair

Surgeon: [redacted] Asst: [redacted]

EBL: 750cc

NF: 4

Spec: 1

Findings: Small Diaphragmatic Injury, minimal

Disp: A[illegible] p rapidly when BE-10 to ~90

[redacted]

(b)(6)-2

Diaphragmatic Injury / Superficial liver abrasion on top of dome Repair

LAB	1017 - OP
NM	9/27
BE	-7
Cl	41
Na	139
K	5.2

pCO2 41

O2 sat 100%

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P: 110003

R: 0300

TEMP:

Pox:

PATIENT COMPLAINT:

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

Physicians Orders:

1.
2.
3.
4.
5.
6.

Surgery

(occurred 6 p.m.) Unknown Iraqi man SIO GSW to (R) back by security forces. Treated initially at [redacted] (b)(2)-2 c̄ chest tube, subsequent intubation 2° to declining pulm. status. Unable to transport 2° to weather. Pt dropped off at [redacted] (b)(2)-2 (MIDNIGHT)

On arrival here, tachycardic, O2 sat 50% on 100% O2, BP approp. Coarse BS on R, abdomen firm, distended. 11/19/22. x-ray c̄ (R) CT out of position. Entry (R) lat. W/ CT placement release of quch of air, fluid. NGT/Foley placed. O2 sat improved. Unable to initially identify bullet and trajectory by x-ray. CXR and US revealed fluid, DPL grossly positive. To OR. Exp. lap. and liver c̄ injury to (R) diaphragm. No other obvious injuries. Intraoperative base deficit -10, hypothermia (90°F), developing coagulopathy, x small bowel injuries; further exploration terminated pt. closed and taken for further warming in ICU. Pt. will be monitored overnight then sent to CSH in a.m.

[redacted] (b)(6)-2

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

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX
TENT NUMBER	STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK	ORGANIZATION HERE	
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P:

R:

TEMP:

Pox:

PATIENT COMPLAINT:

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

PA. SIP GSW to (R) back. (L) CT for tension PTX, exp lap i
and diaphragmatic injury, minimal superficial liver trauma. Pt done
& [illegible] events overnight.
NEURO sedated i Propofol
AVM: L [illegible] RT upper airway. O_2 sat 97% on 60% FiO2.
CT: 60cc
CVS: RSR, P.88 BP 157/103
GI: abd: sl dist, quiet BS, NGT: minimal
RENAL: U.O 30ml/h UA: NIQ 125ml/h
ID: Tm: 96 [illegible]
(A1) Arrange for transfer to the [redacted] (b)(6)-2
Discussed i Dr. [redacted]
(b)(6)-2

Physicians Orders:

1. 5mg IV MSO4 - done
2.
3.
4.
5.
6.

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

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX
TENT NUMBER	STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK		ORGANIZATION HERE
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(sign each entry)*

DATE:

TIME:

BP:

P:

R:

TEMP:

Pox:

PATIENT COMPLAINT:

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

Resp:

Abd

Urine: normal

Neur: ③ NG → LIS ⑧ CT to 20 cm H_2O suction

⑧ Foley → gravity

Dieet: NPO

IVF: LR @125cc/

MED: ① Dilaudid gtt

② MSO_4 / Versed gtt

Vt: 700 R: 12 FiO_2 60% PEEP 5

Physicians Orders:

1. 5mg Morphine IV. Gm
2. [redacted]
3. (b)(6)-2
4.
5.
6.

[redacted] (b)(6)-2

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX
TENT NUMBER	STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK		ORGANIZATION HERE
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

(b)(6) - 2 all.

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE: 11 NOV 03 | PATIENT COMPLAINT: John Doe - Iraqi National

TIME: 0250L | ALLERGIES: Unknown | CURRENT MEDS:

BP: see below | LMP: N/A | SMOKER: YES NO | FLYING STATUS: YES NO

P:

R: 0250 - Pt returned from OR to Rec. Area VS - 164/88 P=86

TEMP: SaO2 100 ~~Rotat to~~ Temp=97.7 NSR on monitor.

Pox: ET tube in place, placement verified.

0310 - 50 g Phentanyl / 2mg Versed given for sedation.

Physicians Orders:

(B) sites patent and benign. Abd dsg CDI. CT to LWS patent - 56 cc bloody output. Foley patent and intact - Clear yellow urine present. DEJ patent IVF ng @100cc/hr

0315 150/90 P=76 NSR SaO2=100 16 BPM SIMV

0320 14[illegible]/92 =82 NSR SaO2=100 16 BPM SIMV

0330 145/95 P=87 NSR SaO2=100% 16BPM SIMV

0345 1[illegible]/97 P=88 NSR SaO2=98% 16BPM SIMV. Pt remains sedated. 5cc DT given (R) Deltoid - [redacted]

0350 Pt remains sedated. Vent settings as follows. 16BPM, SIMV TV 900 FIO2 60%. ET tube in place LL=26 cm, Lungs slightly rhonchorous, Sxn c̄ bloody sputum. Foley patent

ABG: Na 138 K=5.2 Cl=111 TCO2=21 BUN=16 Gl=96 Hct=28

Ph=7.279 PCO2 41.3 Bicarb=19 Be=-7 AnGAP=14 Hgb=10

U/O=400cc CT output since exiting OR = ≈4cc [redacted]

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (Last, First, Middle Initial) Unknown - Iraqi National		SEX
TENT NUMBER EMEDS	STATUS / SERVICE	RANK / GRADE
SUPERVISOR: Cpt [redacted]		ORGANIZATION HERE
DATE ARRIVED AOR	[redacted]N/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

(b)(6) - 2 all

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P:

R:

TEMP:

Pox:

PATIENT COMPLAINT: DG #2

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

0420 - Additional blankets placed on pt. Temp ↑ 97.9°
all IVF Δ'd to .9NS per Dr [redacted] order. NGT placed
to int. sxn. Scant amt of brown/tan drainage -
142/96 P-94 SaO2=97. Lungs CTA(B). RRR NSR
Abd dog CDI. [redacted] patent. Remains sedated [redacted]

Physicians Orders:

0458 - 164/104 - P=101 RR=16 SaO2 = 97%.
Given 5mg IVP by Capt [redacted]. Lungs slightly rhonchorous
ET tube in place Vent settings c̄ no Δ. Propofol
gtt ↑ @ 0505 - 25mcg/kg/min ≅ 12gtt/min. 5mg MSO4
given per Capt [redacted] order - IV sites patent and
benign. VSS. Full monitor [redacted]

0525 - 142/96 SaO2=97 HR=91 RR=16. Remains sedated.
Sxn for scant bloody sputum. ET tube in place @ 26 cm
Abd dog CDI Foley patent, clear yellow urine.
NG to int. sxn - scant tan drainage. Propofol gtt cont
@ 25mcg/kg/min. IVF @ 100 cc/hr. Full monitor [redacted]
0600 VS 150/98, HR91, Ventilated 16bpm, SaO2 99% [redacted] CRW

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

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX
TENT NUMBER	STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK		ORGANIZATION HERE
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

(b)(6) - 2 of 1

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE: 11 Nov 03

TIME: 0700

PATIENT COMPLAINT: Pg #3

ALLERGIES:

CURRENT MEDS:

BP:

LMP:

SMOKER: YES NO

FLYING STATUS: YES NO

P: 0700 - U/O = 400cc - ≥ 2cc out of CT - bloody

R: drainage. VSS, slightly hypertensive. Core temp

TEMP: na esoph. = 34.0°C - NBT int oxn - CT dog occlusive

Pox: will monitor [redacted]

Physicians Orders:

1. 07/12 34.0 C, BP 156/104, HR 85, RR 12, SpO2 98
2. Pc SIMV T.V. 900, Rate 16 Scant bloody
3. drainage, Normal Sinus Rhythm, Lungs Clear,
4. +3 radial & peripheral pulses, Abdomen dressing intact.
5. L & R antecubital normal saline locked & flushed, urine
6. output 75-100 cc/hr, Slightly hypertensive. [redacted]
   Chest Tube bloody drainage 50cc [redacted]
   0730 Given Morphine 5mg I.V. [redacted]

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

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX
TENT NUMBER	STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK		ORGANIZATION HERE
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

SKIN AND WOUND ASSESSMENT

PROGRESS NOTES

MEDICAL RECORD

Admission Date: 10 Nov 93 **Diagnosis:** Bx 2 to Abdo Diaphragm **HD:** D **POD:** 2

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

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

Add the total score

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

Total Score: 12

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes ✓ No__ Location: Abd midline
Size:_____ Drainage: ∅
Tubes: ∅ Pins: ∅ Appearance: CDI
Dressing change:
Location: (R) chest
Size:_____ Drainage: serosanguinous fluid
Tubes: Chest tube Pins: ∅ Appearance:
Dressing change: none

Burn wound (s): Yes__ No ✓ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:
Dressing change:
Location:_____ Size_____
Appearance:
Dressing change:

Pressure Ulcer (s): Yes___ No ✓
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____ Tunneling_____
Undermining_____ 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____ Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes____ No_____
Nutrition Referral: Yes_____ No_____
Physical Therapy Referral: Yes_____ No_____
Action taken:
Date & Time

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

PLAN OF C. E. N BREAKDOWN AND D N EMENT

PROGRE OTES

MEDICAL RECORD

Admission Date: 10 Nov 03 Diagnosis: GSW to ABD HD: 2 POD: 2

(b)(6)-2

Date: 12 Nov 03 Time: 1200 RN Signatur [redacted] C LPN

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location: Abd midline

Drainage: none

Size:

Diabetic ulcer Tubes: Pins: Appearance:

Venous stasis ulcer Dressing change:

Other Describe

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: Size:

Wound character: Pink Moist Dry Granulation tissue Yellow slough

Tunneling Undermining Odor Purulent discharge Eschar Exudates

Refer to SOP for Dressing Change Instructions.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ 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:

- ☒ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ 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.
- ☐ t.i.d
- ☒ qd

MD Signature and Date:

CNS Signature and Date:

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

Medical Record, SF 509

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 11/11/03 **Diagnosis:** GSW abd, diaphragm, liver **HD:** 1 **POD:**

Date: 11/11 Time: 1500 RN Signature: [redacted] (b)(6)-2

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) ✓ Location: abd Size: 12(L) Drainage: ∅
Diabetic ulcer ∅ Tubes: CT Pins: ∅ Appearance: dressing
Venous stasis ulcer Dressing change: NA
Other ∅ Describe ∅
Burn wound (s): % BSA N/A Partial ____ Full ____
Location: ____ Size ____
Appearance: ____
Dressing change: ____
Pressure Ulcer (s): ∅
Stage I, II, III, IV (Circle the one that applies and describe below)

Location: NA Size: ____
Wound character: Pink ____ Moist ____ Dry ____ Granulation tissue ____ Yellow slough ____
Tunneling ____ Undermining ____ Odor ____ Purulent discharge ____ Eschar ____ Exudates ____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ 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:

- ☐ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ 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.
- ☐ t.i.d

MD Signature and Date: ____

CNS Signature and Date: ____

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

Medical Record, SF 509

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date:_____ **Diagnosis:**_____ **HD:** _____ **POD:**_____

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4		**Mobility**	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	(2)	2		Very limited	2	1
	Completed	1			Completely immobile	(1)	
Moisture	Rarely moist	(4)		**Nutrition**	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2	6		Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	(1)	1
Activity	Walks frequently	4		**Friction and Shear**	No apparent problem	3	
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	(1)	1
	Bedfast	(1)	1				

Add the total score

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

Total Score: 12

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: abdomen
Size: 12" Drainage: dressing
Tubes: CT Pins: — Appearance: dressing
Dressing change: NA
Location: (R) mid axillary
Size: NA Drainage: CT 20 cm H20 CS
Tubes: — Pins: — Appearance:
Dressing change: —

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

NA

Pressure Ulcer (s): Yes___ No X
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink___Moist___Dry___ Granulation tissue___ Yellow slough ___ Tunneling___
Undermining___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___ Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes___No___
Nutrition Referral: Yes ✓ No___
Physical Therapy Referral: Yes___ No X
Action taken:_____
Date & Time_____

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

(b)(2)-2

ICU #1
BED# 4

PT# [redacted]

(b)(6)-4

[redacted]

VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
14 Nov 03	2015	SIMV	20	750	50%	+5	38	Ø	111	91%	166/85							(b)(6)-2
14 Nov	2210	SIMV	20	750	50%	+5	39	Ø	111	99%	162/85							[redacted]
	2330	SIMV	20	750	45	+5	40	Ø	109	100	157/86							[redacted]
15 Nov	0200	SIMV	20	750	40	5	46	Ø	111	99	150/100							[redacted]
	0500	SIMV	20	750	40	5	47	Ø	115	94%	180/86							[redacted]
	0600	SIMV	20	750	40	5	46	Ø	114	93	152/87							[redacted]
	0830	SIMV	20	750	40	5	40	25	114	95	147/102							[redacted]
	1000	SIMV	20	750	40	5	40	20	110	98	176/93							[redacted]
	1200	SIMV	20	750	40	5	40	20	89	98	161/101							[redacted]
	1400	SIMV	20	750	40	5	39	20	92	99	166/100							[redacted]
	1546	SIMV	20	750	40	5	40	20	91	97	161/95							[redacted]
	1846	SIMV	20	750	40	5	41	Ø	92	95	153/85							[redacted]
	2000	SIMV	20	750	40	5	40	Ø	93	95	173/95							[redacted]
	2203	SIMV	20	750	40	5	48	Ø	91	92	177/97							[redacted]
16 Nov	0010	SIMV	20	750	40%	+5	38	Ø	94	94%	159/62							[redacted]
16 Nov	0205	SIMV	20	750	40%	+5	39	Ø	91	94%	160/57							[redacted]
16 Nov	0410	SIMV	24	750	50%	+5	42	Ø	101	94%	175/97							[redacted]
16 Nov	0640	SIMV	24	750	50%	+5	44	Ø	98	96%	161/93							[redacted]
	0830	SIMV	24	750	50	5	38	24	95		154/74							[redacted]
	1000	SIMV	24	750	50	5	38	24	102	91	179/62							[redacted]
	1200	SIMV	24	750	70	80	39	25	102	93	149/74							[redacted]
	1400	SIMV	24	750	80	80	36	25	101	93	149/74							[redacted]
	1658	SIMV	24	750	75	10	37	Ø	103	95	148/72							[redacted]
	1848	SIMV	24	750	70	10	42	Ø	101	93	147/75							[redacted]
	2018	SIMV	24	750	100	18	45	Ø	101	86	148/72							[redacted]
	2237	SIM	24	750	100	10	45	Ø	95	89	134/70							BBS coarse.
Oct	0030	SIMV	24	750	100	15	45	Ø	91	94	150/75							TX SI CHAIT
	0230	SIMV	24	750	100	15	47	Ø	94	98	147/78							[redacted]
	0400	SIMV	24	750	90	15	48	Ø	105	100	138/74							· nurse suctioned albuterol
	0530	SIMV	24	750	75	15	46	Ø	110	98	126/71							nurse suction
17 Nov	0800	SIMV	24	750	75%	15	41	Ø	106	100%	132/71							[redacted]
17 Nov	1000	SIMV	24	750	65%	15	40	Ø	94	97%	108/65							[redacted]
17 Nov	1210	SIMV	24	750	60%	15	41	Ø	88	93%	133/71							Neb
17 Nov	1400	SIMV	24	750	70%	15	42	Ø	91	96%	144/83							[redacted]
	1540	SIMV	24	750	70%	15	42	Ø	95	95	151/81							Neb
																		BS coarse

MEDCOM - 23738

(b)(2)-2 Pt # [redacted] (b)(6)-4 BEU

25@hp

27@hp

[redacted] VENTILATOR FLOW SHEET

ICU 1

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
11 Nov	1200	SIMV	14	750	80	5	42	14	106	97	163/103							[redacted]
	1400	SIMV	14	750	60	5	43	29	114	95	182/94							[redacted]
	1805	SIMV	14	750	50	5	44	23	122	95	153/							[redacted]
	1740	SIMV	20	750	55	5	36	27	130	98	158/88							[redacted]
	2010	SIMV	20	750	50	5	37	22	122	100	148/92	7.33	41.2	90	-4	22	96	[redacted]
	2345	SIMV	20	750	45	5	49	20	118	100	112/71							[redacted]
	0210	SIMV	17	750	40	5	44	17	114	99	112/75							[redacted]
	0510	SIMV	15	750	40	5	48	15	115	100	161/88							[redacted] -suction dark brown ≈ 5cc
	0000	SIMV	15	750	39	5	34	16	128	98	132/73							[redacted]
	0815	SIMV	15	750	32	5	35	20	130	98	113/104							[redacted]
12 Nov 03	1040	SIMV	15	750	35%	+5	40	4	137	97%	124/110							[redacted]
	1400	SIMV	18	750	35	5	41	18	138	95%	125/108							[redacted]
	1756	SIMV	18	750	35	5	34	18	142	95	111/53							[redacted]
	1946	SIMV	15	750	35	5	42	21	141	95	118/98							[redacted]
	2203	SIMV	15	750	100	5	28	30	144	100	104/96							[redacted] suction thick dark chunks 7cc
	0000	SIMV	18	750	70	6	40	30	129	100	150/86							[redacted]
	0120	SIMV	18	750	65	6	37	18	124	100	138/80							[redacted]
	0400	SIMV	18	750	65	6	40	20	128	96	144/70							[redacted] suction pt,
	0800	SIMV	18	750	65	6	39	19	120	100	129/109							[redacted]
	1040	SIMV	18	750	65	6	41	31	128	100	135/81							[redacted]
13 Nov 03	1210	SIMV	18	750	60%	5	43	6	141	96%	143/85							[redacted]
13 Nov 03	1415	SIMV	18	750	60%	+5	40	5	141	98%	156/88							[redacted]
	1556	SIMV	18	750	60	+5	42	8	136	100	181/92							[redacted]
	1742	SIMV	18	750	60	5	37	0	131	100	145/75							[redacted]
	2009	SIMV	18	750	60	5	38	0	127	100	146/79							[redacted] advanced 2cm OOH
	2156	SIMV	14	750	60	5	36	0	121	100	121/70							[redacted]
14 NOV	0050	SIMV	18	750	60	5	32	0	129	96%	115/61							[redacted]
	0230	SIMV	18	750	60	5	32	0	114	98	85/55							[redacted]
	0400	SIMV	18	750	55	5	38	0	112	100	95/63							[redacted] ↑RR 20 per Matamoto, PaO2 98%
	0630	SIMV	20	750	50	5	37	0	100	100	114/73							[redacted]
	0815	SIMV	20	750	50	5	39	20	102	100	143/83							[redacted]
	1030	SIMV	20	750	46	5	36	20	106	100	172/93							[redacted]
	1400	SIMV	20	750	50	5	39	20	98	99	160/94	7.29	35.6	73	-9	17	93	[redacted]
14 Nov 03	1545	SIMV	20	750	50%	+5	38	0	104	100%	165/88							[redacted]
14 Nov 03	1755	SIMV	20	750	45	+5	38	0	106	96%	154/89							[redacted]

MEDCOM - 23739

[redacted] (b)(6)-4

FiO2 65%

T 100.1

ICU 1

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

MISC

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

PATIENT STATUS
- ☐ BED ☐ AMB
- OUTPATIENT ☐
- ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PHYSICIAN'S COPY

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

REPORTED BY

MD

TECH

DATE 13 Nov 03

LAB ID NO.

REMARKS

TEST(S) REQUESTED: ABG

SPECIMEN TAKEN: DATE 13 Nov 03 TIME 0800 A.M. P.M.

RESULTS

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

557-107

MEDCOM - 23740

i-STAT EG6+

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

Pt Name:_____

Na_____141 mmol/L
K_____5.3 mmol/L
TCO2_____23 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.270
PCO2_____47.9 mmHg
PO2_____91 mmHg
HCO3_____22 mmol/L
BEecf_____-5 mmol/L
sO2*_____96 %
*calculated

At Patient Temp
pH_____7.269
PCO2_____48.0 mmHg
PO2_____91 mmHg

Patient Temp: 98.7F
FIO2_____: 55
Sample Type_:

11NOV03 19:55

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

** PRINT CANCELLED **

[redacted]

---

i-STAT EG6+

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

Pt Name:_____

Na_____139 mmol/L
K_____6.2 mmol/L
TCO2_____24 mmol/L
Hct_____31 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
pH_____7.182
PCO2_____59.2 mmHg
PO2_____77 mmHg
HCO3_____22 mmol/L
BEecf_____-6 mmol/L
sO2*_____91 %
*calculated

At Patient Temp
pH_____7.189
PCO2_____57.8 mmHg
PO2_____74 mmHg

Patient Temp: 97.6F
FIO2_____: 75
Sample Type_:

11NOV03 16:25

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 19:55

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.1 sec.
Ratio = 1.2
Calculated INR = 1.41
Sample Type:citrated wh. blood
Test Date :11/11/03
Test Time :19:53
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 20:01

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 32.4 sec.
Sample Type:citrated wh. blood
Test Date :11/11/03
Test Time :19:59
Card Lot [redacted] (b)(6)-2
Operator [redacted]

[redacted] (b)(6)-4 11-11-03 09:35

			Patient Limits	
WBC	3.4 L	x10^3/uL	4.5	10.5
RBC	3.90 L	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	34.2 L	%	35.0	60.0
MCV	87.7	fL	80.0	99.9
MCH	27.3	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	236.	x10^3/uL	150.	450.
LY%	18.8 *L	%	20.5	51.1
LY#	0.6 *L	x10^3/uL	1.2	3.4

ID: 001275 11-11-03
WB 19:56

			Patient Limits	
WBC	6.3	x10^3/uL	4.5	10.5
RBC	3.63 L	x10^6/uL	4.00	6.00
Hgb	10.2 L	g/dL	11.0	18.0
Hct	32.1 L	%	35.0	60.0
MCV	88.3	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	234.	x10^3/uL	150.	450.
LY%	17.7 *L	%	20.5	51.1

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 09:39

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 16.0 sec.
Ratio = 1.3
Calculated INR = 1.55
Sample Type:citrated wh. blood
Test Date :11/11/03
Test Time :09:38
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 09:42

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 37.9 sec.
Sample Type:citrated wh. bloc
Test Date :11/11/03
Test Time :09:40
Card Lot [redacted] (b)(6)-2
Operator [redacted]

[redacted] (b)(6)-4 11-11-03 16:23

			Patient Limits	
WBC	6.1	x10^3/uL	4.5	10.5
RBC	3.81 L	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	33.8 L	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	255.	x10^3/uL	150.	450.
LY%	14.8 *L	%	20.5	51.1
LY#	0.9 *L	x10^3/uL	1.2	3.4

MEDCOM - 23741

(b)(6)-4 all except if otherwise indicated

ID [redacted] 12-11-03
WB 04:02

			Patient Limits	
WBC	8.1	x10^3/uL	4.5	10.5
RBC	3.00 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	26.5 L	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	177.	x10^3/uL	150.	450.
LY%	16.7 L	%	20.5	51.1
LY#	1.3	x10^3/uL	1.2	3.4

[redacted] 13-11-03
17:17

			Patient Limits	
WBC	11.7 *	x10^3/uL	4.5	10.5
RBC	3.13 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	27.7 L	%	35.0	60.0
MCV	89.6	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	220.	x10^3/uL	150.	450.
LY%	10.8 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

ID [redacted] 13-11-03
WB 07:48

			Patient Limits	
WBC	8.3 *	x10^3/uL	4.5	10.5
RBC	2.54 L	x10^6/uL	4.00	6.00
Hgb	7.1 L	g/dL	11.0	18.0
Hct	22.6 L	%	35.0	60.0
MCV	88.9	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	168.	x10^3/uL	150.	450.
LY%	15.2 *L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

ID [redacted] 13-11-03
WB 04:51

			Patient Limits	
WBC	6.9	x10^3/uL	4.5	10.5
RBC	2.32 L	x10^6/uL	4.00	6.00
Hgb	6.5 L	g/dL	11.0	18.0
Hct	20.7 L	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	149. L	x10^3/uL	150.	450.
LY%	19.2 L	%	20.5	51.1
LY#	1.3	x10^3/uL	1.2	3.4

ID [redacted] 13-11-03
WB 03:47

			Patient Limits	
WBC	8.0 *	x10^3/uL	4.5	10.5
RBC	2.52 L	x10^6/uL	4.00	6.00
Hgb	7.1 L	g/dL	11.0	18.0
Hct	22.4 L	%	35.0	60.0
MCV	89.1	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	169.	x10^3/uL	150.	450.
LY%	16.4 *L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

1-STAT EG7+

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/13/03 04:57

Patient ID: [redacted]
Test Name :PT
Test Result:= 16.2 sec.
Ratio = 1.3
Calculated INR = 1.58
Sample Type:citrated wh. blood
Test Date :11/13/03
Test Time :04:55
Card Lot [redacted]
Operator : [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/13/03 05:00

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.8 sec.
Sample Type:citrated wh. blood
Test Date :11/13/03
Test Time :04:57
Card Lot [redacted]
Operator [redacted] (b)(6)-2

Pt: [redacted]
Pt Name:_____

Na_____144 mmol/L
K_____4.3 mmol/L
TCO2_____23 mmol/L
iCa_____1.01 mmol/L
Hct_____18 %PCV
Hb*_____6 g/dL
*via Hct

At 37C
pH_____7.259
PCO2_____48.1 mmHg
PO2_____127 mmHg
HCO3_____22 mmol/L
BEecf_____-6 mmol/L
sO2*_____98 %
*calculated

At Patient Temp
pH_____7.247
PCO2_____49.9 mmHg
PO2_____133 mmHg

Patient Temp: 100.1F
FIO2_____: 65
Sample Type_:

(b)(6)-4 all

[redacted]

			Patient Limits	
WBC	16.1	x10^3/uL	4.5	10.5
RBC	3.47 L	x10^6/uL	4.00	6.00
Hgb	9.9 L	g/dL	11.0	18.0
Hct	31.3 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	181.	x10^3/uL	150.	450.
LYM	10.2 * L	%	20.5	51.1
LYM	1.0 * L	x10^3/uL	1.2	3.4

[redacted]

			Patient Limits	
WBC	8.6 *	x10^3/uL	4.5	10.5
RBC	2.61 L	x10^6/uL	4.00	6.00
Hgb	7.5 L	g/dL	11.0	18.0
Hct	23.4 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	146. * L	x10^3/uL	150.	450.
LYM	10.4 * L	%	20.5	51.1

[redacted]

			Patient Limits	
WBC	8.9	x10^3/uL	4.5	10.5
RBC	2.69 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	24.1 L	%	35.0	60.0
MCV	89.6	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	15[illegible]	x10^3/uL	150.	450.
LYM	7.1 * L	%	20.5	51.1
LYM	4.0 *	x10^3/uL	1.2	3.4

[redacted]

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	1.40 L	x10^6/uL	4.00	6.00
Hgb	7.9 L	g/dL	11.0	18.0
Hct	30.5 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	195.	x10^3/uL	150.	450.
LYM	10.1 * L	%	20.5	51.1
LYM	0.8 * L	x10^3/uL	1.2	3.4

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____148 mmol/L

K_____4.5 mmol/L

TCO2_____16 mmol/L

iCa_____0.92 mmol/L

Hct_____36 %PCV

Hb*_____12 g/dL

*via Hct

At 37C

pH_____7.041

PCO2_____53.1 mmHg

PO2_____66 mmHg

HCO3_____14 mmol/L

BEecf_____-16 mmol/L

sO2*_____81 %

*calculated

At Patient Temp

pH_____7.045

PCO2_____52.4 mmHg

PO2_____64 mmHg

Patient Temp: 98.0F

FIO2_____: 85

Sample Type_:

19NOV03 05:19

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.272

PCO2_____37.9 mmHg

PO2_____97 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

17NOV03 06:07

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

ID: [redacted]
NB

19-11-03
05:41

			Patient Limits	
WBC	19.8 H	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.0 L	g/dL	11.0	18.0
Hct	28.3 L	%	35.0	60.0
MCV	90.1	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	298.			
LYM	5.1			
LYM	1.0 * L	x10^3/uL	1.2	3.4

(b)(6)-4 all unless indicated otherwise

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 08:33

Patient ID: [redacted]
Test Name :PT
Test Result:= 39.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 3.5
Calculated INR = 7.66
Sample Type:citrated plasma
Test Date :11/20/03
Test Time :08:31
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 08:51

Patient ID: [redacted]
Test Name :APTT
Test Result:=102.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :11/20/03
Test Time :08:46
Card Lot [redacted] (b)(6)-2
Operator [redacted]

ID: [redacted]
WB

22-11-03
04:44

			Patient Limits	
WBC	20.4 H	x10^3/uL	4.5	10.5
RBC	2.95 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	25.9 L	%	35.0	60.0
MCV	87.9	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	315.	x10^3/uL	150.	450.
LY%	5.8 *L	%	20.5	51.1
LY#	1.2 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

21-11-03
04:57

			Patient Limits	
WBC	23.5 H	x10^3/uL	4.5	10.5
RBC	3.56 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	31.5 L	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	317.	x10^3/uL	150.	450.
LY%	4.4 *L	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

i-STAT EG7+
Pt: [redacted]
Pt Name:_____

Na_____145 mmol/L
K_____3.8 mmol/L
TCO2_____32 mmol/L
iCa_____0.78 mmol/L
Hct_____31 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
pH_____7.294
PCO2_____61.4 mmHg
PO2_____57 mmHg
HCO3_____30 mmol/L
BEecf_____3 mmol/L
sO2*_____85 %
*calculated

At Patient Temp
pH_____7.294
PCO2_____61.6 mmHg
PO2_____58 mmHg

Patient Temp: 98.7F
FIO2_____: 90
Sample Type_:

22NOV03 04:35
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

i-STAT EG7+
Pt: [redacted]
Pt Name:_____

Na_____147 mmol/L
K_____4.0 mmol/L
TCO2_____29 mmol/L
iCa_____0.91 mmol/L
Hct_____24 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
pH_____7.248
PCO2_____63.5 mmHg
PO2_____58 mmHg
HCO3_____27 mmol/L
BEecf_____0 mmol/L
sO2*_____84 %
*calculated

Sample Type_:

21NOV03 05:53
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

(b)(6)-4

NAME: [redacted]

17NOV03

RESPIRATORY DATA

	DATE	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV			
	TIME	03	0345	0515	0545	0607	0830	0900	1000	1300	1600	1725	2100	2225	2300	0005	0035	0100	0210	0325	0336	1000	1200	1300			
VENT	Mode	SIMV					SIMV	SIMV	SIMV	SIMV	SIMV	SIMV									SIMV	S					
	FiO2	100%	↓90%	↓85%	↓75%		70	65	60	70	65	65	↑100	↓90	↓80	↑100	↓90	↓80	↑85	100	100	↓90	↓80	90			
	TV	750					750	750	750	750	750	750									750	750					
	Rate	24					24	24	24	24	24	24									24	24					
	PEEP	15					15	15	15	15	15	15									15	15					
ABG	pH	7.326				7.272															7.178						
	pCO2	36.0				37.9															42.7						
	pO2	104				97															60						
	HCO3	19				18															16						
	SaO2	98				97															89						
	BE	-7				-9															-13						

LABORATORY DATA

DATE	17NOV	18NOV																								
TIME	0356	0418																								
Glucose	99	109																								
Na / K	151/4.6	149/4.6																								
Cl / CO2	116/19	118/18																								
BUN / Cr	58/3.6	58/3.8																								
WBC / Platelet	10.7/187	13.2/234																								
Hct / Hgb	31.0/10.2	29.9/9.5																								

MEDCOM - 23745

(b)(6) - 4 all

Ward/Section: | REQUESTING PHYSICIAN:

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

REMARKS:

REPORTED BY:

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.005	N/A
Bld	2+	Negative
pH	5.0	N/A
Prot	H	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Blood Bank

JUST SUBMIT ON [illegible]

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA neg
WBC - 4-6
RBC - 8-12
EP - 0-2

======= PICCOLO =======
11/11/03 09:36 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	101	73-118	MG/DL
BUN	15	7-22	MG/DL
CA++	6.6*	8.0-10.3	MG/DL
CRE	1.8*	0.6-1.2	MG/DL
NA+	138	128-145	MMOL/L
K+	5.6*	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

======= PICCOLO =======
11/11/03 0::0: AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.7*	3.3-5.5	G/DL
ALP	41	26-84	U/L
ALT	57*	10-47	U/L
AMY	41	14-97	U/L
AST	65*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	3.8*	6.4-8.1	G/DL

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

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. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 13

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.:

Ward/Section: ICU I	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 11/11/03	TIME: 1620	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		
BUN		
CA^{++}		
CRE		
NA^+		
K^+		
CL^-		
tCO_2		

(Pi

TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
GGT		
TP		

TEST	RESULT	REF. RANGE
NA^+		
K^+		
CL^-		
tCO_2		18-33 mmol/l

======= PICCOLO =======
11/11/03 10:2? AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	87	73-118	MG/DL
BUN	16	7-22	MG/DL
CA++	6.5*	8.0-10.3	MG/DL
CRE	2.1*	0.6-1.2	MG/DL
NA+	136	128-145	MMOL
K+	6.4*	3.3-4.7	MMOL
CL-	110*	98-108	MMOL
tCO2	20	18-33	MMOL

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

REMARKS: FIO2 75% T97.6

REPORTED BY:	DATE:	LAB ID NO.:

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

Ward/Section: Ken1	REQUESTING PHYSICIAN: (b)(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted]	DATE 4/4	TIME	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: [redacted] (b)(6)-2 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] (b)(6)-4	DATE: 11/11 TIME: 1943	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		
CA^{++}		
CHOL		
CRE		
GLU		
TP		
TEST		
GLU		
BUN		
CRE		
CK		
NA^+		
K^+		
CL^-		
tCO_2		

======= PICCOLO =======
11/11/03 19:51
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	92	73-118	MG/DL
BUN	17	7-22	MG/DL
CA++	7.0*	8.0-10.3	MG/DL
CRE	2.3*	0.6-1.2	MG/DL
NA+	134	128-145	MMOL/L
K+	5.7*	3.3-4.7	MMOL/L
CL-	111*	98-108	MMOL/L
tCO2	22	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
		98-108 mmol/l
		18-33 mmol/l

ccolo) Liver Panel Plus

RESULT	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

(Piccolo) Electrolyte

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

REMARKS: ABG : (T)
Chem8

sO_2 98.7

REPORTED BY: DAT

(b)(6)-4 all

Ward/Section: ICU-1	REQUESTING PHYSICIAN:		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	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. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
A		
A		
A		
A		
T		
B		
C		
CI		
CF		
GL		
TP		
TI		
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
NA⁺		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	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

(Piccolo) Electrolyte

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

======= PICCOLO =======
12/11/03 04:19 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	93	73-118	MG/DL
BUN	20	7-22	MG/DL
CRE	2.7*	0.6-1.2	MG/DL
CK	771*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	5.1*	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	18	18-33	MMOL/L

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

REMARKS: [illegible] Chem 8 [illegible] [illegible]

REPORTED BY:	DATE:	LAB ID NO.:

Chem 8 & CBC only

Ward/Section: ICU-1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 12/11	TIME 0400	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 10^3	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

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:

REQUESTING PHYSICIAN:

LAST, FIRST, MI.

DATE

TIME

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
UN		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
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

======= PICCOLO =======
13/11/03 04:02 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	91	73-118	MG/DL
BUN	22	7-22	MG/DL
CRE	3.4*	0.6-1.2	MG/DL
CK	827*	39-380	U/L
NA+	128	128-145	MMOL
K+	4.8*	3.3-4.7	MMOL
CL-	113*	98-108	MMOL
tCO2	18	18-33	MMOL

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

REMARKS:

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

DATE: 13Nov03

LAB ID NO.:

Ward/Section: CU 1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 13 Nov 03	TIME:	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(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: SMA-7

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, M: [redacted] (b)(6)-4	DATE: 13 Nov	TIME:	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(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	REQUESTING PHYSICIAN: (b)(6)-2 [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 13Nov / TIME	SSN/PSEUDO SSN: [redacted] (b)(6)-4

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

(b)(6)-2

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 15 Nov 93 / TIME 0730	SSN/PSEUDO SSN:

(Hematology) CBC			(b)(6)-4 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 10^3	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

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

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

DATE: 12 Nov 13 TIME: 1928

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

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

(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

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

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

DATE: 14Nov

TIME:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

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

(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 Un

(MUST SUBMIT SF 518 WIT

REQUE

UNIT	TYP.

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

14/11/03 04:04

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	88	73-118	MG/DL
BUN	29*	7-22	MG/DL
CRE	3.2*	0.6-1.2	MG/DL
CK	587*	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	113*	98-108	MMOL/L
tCO2	18	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

REMARKS: SMA 7

REPORTED BY:

DATE:

LAB ID NO.:

Ward/Section: ICU #1 | REQUESTING PHYSICIAN: [redacted] (b)(6)-2 | T+C MATCH

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: NOV 13 03 | TIME: 09:10 | SSN/PSEUDO SSN:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

(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

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: B POS

Blood Bank Unit Crossmatch

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

UNIT	TYPE	CROSSMATCH
[redacted]	B POS	comp
[redacted]	✓	✓

REMARKS:

REPORTED BY: | DATE: NOV-13, 03 | LAB ID NO.:

[redacted] (b)(6)-4

ICU #1

Ward/Section: Wu El

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

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

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

DATE 14 NOV 03 | TIME 1920 | 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

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

DATE: 14 NOV 03

LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	16 NOV	0400	

(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

```
======= PICCOLO =======
16/11/03              04:23
REFERENCE RANGE:        MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #:          3152AA4
OPER #: [redacted]     DR #: 000
SERIAL #: [redacted]
.........................
GLU    113   73-118   MG/DL
BUN    34*   7-22     MG/DL
CRE    3.1*  0.6-1.2  MG/DL
CK     209   39-380    U/L
NA+    124*  128-145  MMOL/L
K+     4.1   3.3-4.7  MMOL/L
CL-    117*  98-108   MMOL/L
tCO2   22    18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 2+,  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
CO_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
CO_2		18-33 mmol/l

REMARKS: Metlyte 8.

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted] (b)(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 15NOV03 | TIME: 0330 | SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L				GLU		73-118 mg/dl
K		3.5-4.9 mmol/L				BUN		7-22 mg/dl
Cl		98-109 mmol/L				CA++		8.0-10.3 mg/dl
pH		7.31-7.45				CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)				NA+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)				K+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)				CL-		98-108 mmol/l
HCO3		22-25 mmol/L (art) 23-28 mmol/L (ven)				tCO2		18-33 mmol/l
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						

(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		5-85 u/l
TP		6.4-8.1 g/dl

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

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
15/11/03 04:27 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
~~BUN~~	~~+++~~	7-22	MG/DL
CA++	7.9*	8.0-10.3	MG/DL
CRE	3.2*	0.6-1.2	MG/DL
NA+	137	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	120*	98-108	MMOL
tCO2	21	18-33	MMOL

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

REMARKS:

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

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 15NOV03	TIME: 0330	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.3-13.5 secs
APTT		21-34 secs
D-dimer		<[illegible] ug/ml
FDP		<[illegible] ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
Appr		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: ICU1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 17NOV03 / TIME 0334	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	151	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	19	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	58	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		

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

17/11/03 03:56

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	99	73-118	MG/DL
~~BUN~~	~~+++~~	7-22	MG/DL
CRE	3.5*	0.6-1.2	MG/DL
CK	121	39-380	U/L
~~NA+~~	~~123*~~	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	116*	98-108	MMOL
~~tCO2~~	~~+++~~	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 2+, 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
O_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU (b)(6)-2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI [redacted]	DATE 18NOV03	TIME	SSN/PSEUDO SSN:

(Hematology) CBC			(b)(6)-4 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	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 18NOV03	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	149	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
AI		
AI		
AI		
AI		
AI		
T		
B		
C		
C		
C		
C		

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

```
======= PICCOLO =======
18/11/03          04:18
REFERENCE RANGE:
PATIENT #: [redacted] (b)(6)-4 MALE
METLYTE 8
DISC LOT #:          3152AA4
OPER #: [redacted]3  DR #: 000
SERIAL #: [redacted]
.......................
GLU   109   73-118   MG/DL
BUN   58*   7-22     MG/DL
CRE   3.8*  0.6-1.2  MG/DL
CK    62    39-380   U/L
NA+   ***   128-145  MMOL
K+    4.6   3.3-4.7  MMOL
CL-   118*  98-108   MMOL
tCO2  18    18-33    MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4 unless indicated otherwise

T98 F702-88

Ward/Section: ICU4H	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE NOV 19 / TIME 6:00	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
19/11/03 05:31
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	♦♦♦	3.3-5.5	G/DL
ALP	70	26-84	U/L
ALT	14	10-47	U/L
AMY	76	14-97	U/L
AST	90*	11-38	U/L
TBIL	6.5*	0.2-1.6	MG/DL
GGT	12	5-65	U/L
TP	♦♦♦	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
19/11/03 06:02 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	106	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CRE	5.2*	0.6-1.2	MG/DL
NA+	♦♦♦	128-145	MMOL/L
K+	5.6*	3.3-4.7	MMOL/L
CL-	120*	98-108	MMOL/L
tCO2	16*	18-33	MMOL/L

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

CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ABG CBC Chem12

Ward/Section: ICU #1	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-1	DATE Nov 19	TIME 4:00	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.:

T 98.1 FiO2 85

Ward/Section: TCU #1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI [redacted] (b)(6)-4	DATE 21 Nov 07	TIME 0415	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(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: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE: 21 Nov 03 / TIME: 0415	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
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:

No greentop'.

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4 unless otherwise indicated

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: 21 Nov 03 / TIME: 0530	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

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
tCO_2		18-33 mmol/l

======= PICCOLO =======
12/11/03 06:0> AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	155*	73-118	MG/DL
~~BUN~~	~~***~~	7-22	MG/DL
CRE	6.5*	0.6-1.2	MG/DL
CK	362	39-380	U/L
~~NA+~~	~~***~~	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

Bun 112

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6) - 4 unless otherwise indicated

Ward/Section: ICU #1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. SL [redacted]	DATE 22 Nov 03 / TIME 0415	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

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
G		
BI		
CI		
CI		
NA		
K+		
CL		
tCC		

==== == PICCOLO =======
22/11/03 04:55
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	130*	73-118	MG/DL
~~BUN~~	~~***~~	7-22	MG/DL
CRE	6.7*	0.6-1.2	MG/DL
CK	790*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

Bun 120

(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
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
T		10-47 u/l
TY		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS: T = 98.7 ~~[illegible]~~ F_iO_2 = 90%

REPORTED BY:	DATE:	LAB ID NO.:

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)-4	DATE: 20NOV	TIME: 0730	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 10^3	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: PT / PTT

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20 MW	TIME: 0730	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: PT / PTT

REPORTED BY:	DATE:	LAB ID NO.:

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

Name: (b)(6)-4
Patient ID: [redacted]
Ward/Rm: U1/

Specimen: [redacted]
Source: Sputum
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1A Empedobacter (F.) brevis Status: Final

1A E. brevis

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

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

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

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

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

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

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

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

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: U1/

Specimen: [redacted]
Source: Sputum
Ward of Iso:

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

Printed 11/16/2003 9:03:57 AM

Tech: [redacted]

(b)(6)-2 unless otherwise indicated

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Preliminary Report

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

First Name:

Patient # or SSN:

Collected by: SPC [redacted]

Date: 13 Nov03

Time: 1910

Ward: ICU

Room:

Bed: 4

Physician: [redacted]

Source: sputum

Site: ETT

Received by: [redacted]

Date: 13Nov03

Time: 1918

Specimen #: [redacted]

Preliminary Laboratory Results

Good specimen
No organisms seen

Reported

Date: 13NOV03

Time: 2017

Tech: [redacted]

Reviewer: [redacted]

Number of attached sheets:

Preliminary Report

MEDCOM - 23778

[redacted] (b)(2)-2
[redacted]
Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN:
Collected by: SPC [redacted] (b)(6)-2
Date: 13NOV03
Time: 1900

Ward: ICU
Room:
Bed: 4
Physician [redacted] (b)(6)-4
Source: Sputum
Site: ETT

[redacted]

Received by: [redacted] (b)(6)-2
Date: 13NOV03
Time: 1918

Specimen #: [redacted]

Laboratory Results

Enterobacter (F.) brevis

Reported
Date: 16 NOV 03
Time: 1000
Tech: [redacted]
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 23779

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

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

First Name:

Patient # or SSN:

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

Date: 13 NOV 03

Time: 1245

Ward: ICU 1

Room:

Bed: 4

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

Source: Foley

Site:

[redacted]

Received by: [redacted]

Date: 13NOV03

Time: 1918

Specimen #: [redacted]

Laboratory Results

No Growth

Reported

Date: 14 NOV 03

Time: 1000

Tech: [redacted]

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

Number of attached sheets:

MEDCOM - 23780

(b)(6)-2 unless otherwise indicated

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

(b)(6)-4

Last Name: [redacted]

First Name:

Patient # or SSN:

Collected by: SPC [redacted]

Date: 13Nov03

Time: 1830

Ward: ICU 1

Room: Bed 4

Bed:

Physician: [redacted]

Source: Venous

Site: (O) FA + (O) Brach

[redacted]

Received by: [redacted]

Date: 13NOV03

Time: 1918

Specimen # [redacted]

Laboratory Results

No Growth

Reported

Date: 18NOV03

Time: 1000

Tech: [redacted]

Reviewer:

Number of attached sheets:

MEDCOM - 23781

PRE-ANESTHESIA EVALUATION

M F | in/cm. | ≈90 Kg lb

Proposed Procedure: Ex Lap Diaphragm Repair

Pre-Procedure Vital Signs: B/P 194/110 P 15's R 40 T

Previous Anesthesia/Operations: unk (None o)

Current Medications: unk

Family History of Anesthesia Complications: (None o)

Allergies: unk

AIRWAY/TEETH/HEAD & NECK: Intubated

History From: o Patient o Parent/Guardian o Significant Oth o Chart o Poor Historian

SYSTEM	WNL	COMMENTS	PERTINENT STUDY RESUL
RESPIRATORY Asthma, Pneumonia, Bronchitis, Productive Cough, COPD, Recent Cold, Dyspnea, SOB, Orthopnea, Tuberculosis	o	Tobacco Use: o Yes o No ____ Packs/Day for ____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, MI, Arrhythmia, Murmur, CHF, MVP, Exercise tolerance, Pacemaker, Hypertension, Rheumatic Fever	o		EKG
HEPATO/GASTROINTESTINAL Bowel Obstruction, N&V, Cirrhosis, Reflux/heartburn, Hepatitis, Ulcers, Hiatal Hernia, Jaundice	o	Ethanol Use: o Yes o No Frequency ____	
NEURO/MUSCULOSKETAL Arthritis, Paralysis, Back problems, Paresthesia, CVA/Stroke, Syncope, DJD, Seizures, Headaches, TIAs, Loss of Consciousness, Weakness, Neuromuscular disease	o		
RENAL/ENDOCRINE Diabetes, Weight loss/gain, Renal Failure/Dialysis, Thyroid Disease, Urinary Retention, Urinary tract infection			
OTHER Anemia, Transfusion history, Bleeding tendencies, Pregnancy, Hemophilia, Sickle cell trait			

Problem List/Diagnosis: EPW GSW Chest

ASA PS: 1 2 3 4 5 E

Other

LAB STUDIES: Hgb/Hct/CBC, Electrolytes, Urinalysis

Planned Anesthesia/Special Monitors: GETA

Pre-Anesthesia Medications Ordered

Evaluator Signature(s) Date

POST-ANESTHESIA NOTE

DATE	NO.		SOLUTION	MEDICATIONS ADDED	RATE	TIME START	INITIAL	TIME STOP1	INITIAL
							(6)	(6) - 2	
11Nov03	1	9	NS	Ø	KVO	0420	[redacted]		
	2	4	NS	Ø	KVO	0420	[redacted]		
	3	4	NS	Ø	100cc	0420	[redacted]		

(b)(6)-2 all

ANESTHESIA RECO[redacted]

Procedure: [illegible] Lap / Displa[illegible]

Date [illegible] | Ck No. [illegible]

[redacted]

	START	STOP
Anesthesia	0000	0245
Procedure	0005	0230

PRE-PROCEDURE

☐ Identified ☐ ID Band ☐ Questioning
☐ Chart Review ☐ Permit Signed
☐ NPO Since

Pre-anesthetic State: ☐ Calm
☐ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☒ Unresponsive

PATIENT SAFETY

☐ Anes. Machine # ______ Checked
☐ Safety Belt On ☐ Axillary Roll
☒ Arm Restraints ☐ Arms Tucked
☒ Pressure points checked and padded
☒ Eye Care: ☐ Ointment ☐ Saline
☒ Taped ☐ Pads ☐ Goggles

MONITORS & EQUIPMENT

☒ Steth ☒ Esoph ☐ Precord ☐ Other
☒ Non-invasive B/P ☐ Nerve Stimulator
☒ Continuous EKG ☐ V Lead EKG
☒ Pulse Oximeter ☐ Oxygen Analyzer
☒ End Tidal CO_2 ☐ Resp Gas Analyzer
☒ Temp Esoph ☐ EEG
☐ Warming Blanket ☐ Fluid Warmer
☐ Airway Humidifier ☐
☐ OG Tube ☒ Foley Catheter
☐ Line
☐ Line #18D [illegible]

ANESTHETIC TECHNIQUE

Method: ☒ General ☐ Spinal
☐ Epidural ☐ Caudal ☐ Brachial
☐ Bier Block ☐ Ankle Blk ☐ M.A.C.
General: ☐ Pre-O_2 ☐ LTA
☐ Rapid Sequence ☐ Cricoid Pressure
☐ Intravenous ☒ Inhalation
☐ Intramuscular ☐ Rectal
Regional: ☐ Position ______
☐ Prep ______ ☐ Local ______
☐ Needle ______
☐ Drug(s) ______
☐ Dose ______ ☐ Attempts x ___
☐ Site ______ ☐ Level ______
☐ Catheter ______ ☐ See Remarks

AIRWAY MANAGEMENT

☐ Intubation ☐ Oral ☐ Nasal
☐ Direct Vision ☐ Magill's ☐ Blind
☐ Diff. see Rmks ☐ Fiber Op ☐ Stylet
☐ Attempts x ___ ☐ Blade ______
☐ Tube size ___ ☐ Endobronchial
☐ Regular ☐ RAE ☐ Armored ☐ Laser
☐ Cuffed ☐ Min. occ. pres. ☐ Air ☐ NS
☐ Uncuffed, leaks at ___ cm H_2O
☐ Secured at ______ ☐ ET CO_2 Present
☐ Breath Sounds ______
☐ Circuit: ☐ Circle ☐ Non-rebreathing
☐ Airway: ☐ Oral ☐ Nasal ☐ Natural
☐ Mask Case ☐ Via Tracheostomy
☐ Nasal Cannula ☐ Simple O_2 Mask

RECOVERY ROOM

Time	B/P	O_2 Sat.
☐ PACU	P	R	T
☐ ICU ☐ L&D		

☐ Awake ☐ Spont Resp ☐ Oral Airway
☐ Asleep ☐ Ventilator ☐ Nasal Airway
☐ Stable ☐ Extubated ☐ Face Shield O_2
☐ Unstable ☐ Intubated ☐ T-Piece O_2

CONTROLLED DRUGS

Drug	Used	Destroyed	Returned
Fentanyl			

Provider ______ Witness ______

TIME: 0000 x 30 x 0100 x 30 x 0200 x 30 x 0300

													TOTALS
☐ Hal ☐ Enf ☒ Iso (%)	1.0	.8	.	.8	.8	.8	.8	.8	.8	.8	.8	x	
☐ N_2O ☐ Air (L/min)													
Oxygen (L/min)	2	2	2	2	2	2	2	2	2	2	2	x	
Fent (µg)	50	50		50		50		50	50	50	100		450
Vec (mg)	5				5			5			5		20
Versed (mg)									3				3
Ancef (g)					1								1g
LR	#1 1000			2000				3000					
NS	#1 1000			2000 #3				3000					6000
Urine (ml)											2000		2000
EBL (ml)													250
EKG	ST	ST	ST	ST	SB	SB	SB	SR	SR	SR	SR		
%O_2 Inspired (FIO_2)	1.0	1.2	1.2	1.2	1.0	1.0	1.0	1.0	1.0	1.0	1.0		
O_2 Saturation (SaO_2)	95	98	98	99	100	100	100	100	100	100	RR		
End Tidal CO_2	[illegible]	[illegible]	31	30	25	29	28	27	27	28	28		
Temp: ☒ °C ☐ °F	32.6	32.5	32	32.7	32.9	32.7	32.9	32.9	32.9	33.0	33.0		

Baseline Values: B/P 194/110; 150's; P; R

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

Tidal Vol. (ml)	850	850	850	850	850	850	850	850	800	850
Resp. Rate	12	10	10	10	10	10	10	10	12	12
Peak Press. (cm H_2O)									27	
PEEP (cm H_2O)										

Symbols for Remarks
Position
Anesthesia Provider(s)

[redacted]

SYMBOLS: X ANESTHESIA; ⊙ OPERATION; ∨ ∧ B/P CUFF PRESSURE; ARTERIAL LINE PRESSURE; ▲ MEAN ARTERIAL PRESSURE; • PULSE; ○ SPONTANEOUS RESP; Ø ASSISTED RESP; ⊠ CONTROLLED RESP; TOURNIQUET

REMARKS

0005 Received pt already intubated, unresponsive → to OR
monitors, O2. 0100 (R) IJ introducer placed s̄ difficulty
0245 pt x-ported to ICU. Monitors, placed on vent
RR=16, TV=900 FiO2 1.0 - pt stable

MEDCOM - 23784

AMC FORM 143 JUL [illegible]

WARD COPY

(b)(6)-2 all except very bottom

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)* 1u ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 13 Nov 03

DATE AND HOUR REQUIRED 13 Nov 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to ABD

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 13 Nov 03

TIME VERIFIED 0445

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO B Rh pos

RECIPIENT ABO B Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted] DATE 13 NOV 03

REMARKS: ex 14 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND I[redacted]

AT *(Hour)* 1024 ON *(Date)* 13 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 VERIFIER *(Signature)* [redacted]

PRE-TRANSF[redacted]

TEMP. 1[redacted] PULSE [redacted] 125 BP 157/77

DATE OF T[redacted]ON 13 [redacted] 03 TIME STARTED 1030

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED 1155 13 Nov 03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.2	146	157/79

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)*

[redacted]

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

[redacted]

M

WARD ICU 1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23785

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

(b)(6)-2 except for very bottom

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)* 14 ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 13 Nov 03

DATE AND HOUR REQUIRED 13 Nov 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to ABD

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 13 Nov 03

TIME VERIFIED 0445

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO B
Rh pos

RECIPIENT
ABO B
Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: ex 13 Nov 03

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 13 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted]

AT *(Hour)* 1157 ON *(Date)* 13 NOV 03

IDENTIFICATION

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

[redacted]

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION [redacted]

TEMP. 101.1 PULSE 141 BP 144/88

DATE OF TRANSFUSION 13 Nov 03

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1530 13 NOV 03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 101.9 PULSE 146 BLOOD PRESSURE 169/87

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]

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

[redacted] (b)(6)-4

M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23786

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

(b)(6)-2 except very bottom

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

DATE REQUESTED: NOV 14, 03.

DATE AND HOUR REQUIRED: NOV 14, 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE

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: [redacted]

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B; Rh POS

RECIPIENT: ABO B; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH: comp

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

SIGNATURE OF PERSON PERFORMING TEST: [signature]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 14 NOV 03

REMARKS: [illegible] 17 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 1030 ON *(Date)*: 14 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] CPT AN

[redacted]

PRE-TRANSFUSION

TEMP. 97.1 PULSE 107 BP 172/89

DATE OF TRANSFUSION: 14 NOV 03

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN: 300 ML

TIME/DATE COMPLETED/INTERRUPTED: 14 NOV 03

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE: 98.4 PULSE: 111 BLOOD PRESSURE: 190/97

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/AN

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

[redacted] (b)(6)-4

SEX: M

WARD: ICU #1

ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23787

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

(b)(6)-2 except very bottom

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: NOV 14, 03

DATE AND HOUR REQUIRED: NOV 14 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: Chest TUBE 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: [redacted]

DATE VE[redacted]

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR

ABO B

Rh POS

RECIPIENT

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH COMP

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: C—

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 14 NOV 03

REMARKS: [illegible]

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: [redacted]

AT *(Hour)* 1324 ON *(Date)* 14 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] CPT/AN

2[redacted] RN/AN

PRE-TRANSFUSI[redacted]

TEMP. 98[redacted] PULSE 114 BP 157/93

DATE OF TRANSFUSION 14 NOV 03

TIME STARTED 1336

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 1605 14 NOV

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 98.5 PULSE 101 BLOOD PRESSURE 189/92

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] CPT/P

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

[redacted] (b)(6)-4

SEX

WARD

ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23788

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

(b)(6)-2 all except very bottom

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

DATE REQUESTED: 19 Nov 03

DATE AND HOUR REQUIRED: 19 Nov 03 ASAP

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERA[redacted]ROCEDURE: GSW to back

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.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: [redacted]

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 19 Nov 03

TIME VERIFIED: 0830

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: POS	Rh: POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 Nov 03

REMARKS: Exp 19 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 0947 ON *(Date)*: 19 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] CRT/AC

[redacted] CRT/AN

PRE-TRANSFUSION

TEMP. 98.3 PULSE 117 BP 123/75

DATE OF TRANSFUSION: 19 Nov 03

TIME STARTED: 1000

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME/DATE COMPLETED/INTERRUPTED: NN 19 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.2	114	135/64

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] CRT/AN

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

[redacted] (b)(6)-4

SEX: M

WARD: ICU-1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23789

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

(b)(6) -2 except very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

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

DATE REQUESTED 19Nov03

DATE AND HOUR REQUIRED 19Nov03 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 OPERA[redacted]OCEDURE

GSW to back

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.

[redacted]

DATE 19Nov03

TIME VERIFIED 0830

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B

Rh pos

RECIPIENT

ABO B

Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 19Nov03

REMARKS: Exp 19Nov03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 1045 ON *(Date)* 19Nov03

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] CPT

2nd VERIFIER [redacted]

PRE-TRANSFUSION

TEMP. 98.2 PULSE 115 BP 137/67

DATE OF TRANSFUSION 19Nov03 TIME STARTED 1042

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 19Nov03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 117 PULSE 98.2 BLOOD PRESSURE 137/61

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 [redacted]

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

SEX M WARD ICU-1

(b)(6)-4 [redacted]

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23790

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

EXAMINATION(S) REQUESTED

CX-RAY in 2 hours to evaluate for PTX — C.T. Removal

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)

TELEPHONE/PAGER

SIGNATURE OF REQUESTOR

DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Plan: 11:30 AM

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION (For types or printed names give: Name — last, first, middle, Medical Facility)

#[redacted] ICU #1

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 510 B
Prescribed by GSA/ITMR
FPMR (41 CFR) 101-11.205

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
KUB		M	[redacted]	ICU 1	
	FILM NO.		(b)(6)-4		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)		[redacted] (b)(6)-2		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR		[redacted]		DATE REQUESTED 15Nov03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

Placement of Dobhoff

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION

MEDCOM - 23792

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

(b)(6)-4 except very bottom

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]

ICU I

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
11 NOV 03	0943		
(1) Admit to ICU for [redacted]			
(2) Mx: GSW to back c diaphragm & liver injury			
(3) Condition - stable			
(4) Activity c Bed Rest c HOB elevated @least 30°			
(5) Vitals = per ICU protocol			
(6) NKDA (unknown)			

PATIENT IDENTIFICATION

[redacted]

ICU I

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	
(7) Vent Settings = SIMV Rate = 14 TV 750 PEEP 5 FiO2 = titrate down as low as possible to keep sat % ≥ 95%			
(8) CXR q AM			
(9) CT to Drain, Vent suction			
(10) Foley to Gravity			
(11) NGT to LCDS or LIVS, whichever is available			
(12) I+O's			

PATIENT IDENTIFICATION

[redacted]

ICU I

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	
(13) Diet = NPO			
(14) IVF = NS c 20 MEQ KCl/Liter @ 175 c/hr			
(15) Tagamet 400 mg IVPB q 6h			
(16) Tylenol 650 mg Supp. PR as needed temp ≥ 100.5 °			
(16) Ancef 1 gram IVPB q 8°			
(17) MSO4 Drip; titrate to effect			
(18) Versed Drip; titrate to effect			

PATIENT IDENTIFICATION

[redacted]

ICU I

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	
(19) CBC; SMA-7 and ABG q AM			
(b)(6)-2			
[redacted]			

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

(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11NOV03 TIME OF ORDER 1737 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) N/C Tegaret

(2) Zantac 50mg IVPB q8h

[redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11NOV03 TIME OF ORDER 1900 HOURS

(1) Δ IVF to NS (No K+ added)

(2) ↑RR to 20.

[redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 12 NOV 03 TIME OF ORDER 0125 HOURS

V.O: Dr. Ellison to LT Karl Stewart: 1L NS bolus.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER: 13 NOV 03 TIME OF ORDER: 0425 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Transfuse 2 units PRBC

V.O. Dr. [redacted]

Noted 13 NOV 03 0545 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

2160 V

0545 13 NOV 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 13 NOV 03 TIME OF ORDER: 1000 HOURS

(1) CXR now for Line placement

(2) Increase RL to 200 per minute

(3) Place CT to Water seal

(4) D/C II Central line

(5) May use LSC Line

(6) D/C all Peripheral IV's

(7) Infuse each unit of blood over 2 hours

Noted 13 NOV 03 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

(8) Vecuronium 10 mg IVx1 now

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

ICU 1

PATIENT IDENTIFICATION

DATE OF ORDER: 13 NOV 03 TIME OF ORDER: 1600 HOURS

(1) Vecuronium Drip 2-5 mg/hr

(2) Ativan 1-2 mg/hr and titrate to wean off vented

Noted 13 NOV 03 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

DA FORM 1 APR 79 [redacted] REPLACES EDITION OF 1 JUL 77 WHICH MA[redacted]

14 NOV 03 0220 [redacted]

(b)(6)-2 unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 14 NOV 03 TIME OF ORDER: 1553 HOURS

(1) Lasix 10mg IV x 1 now [redacted] LIST TIME ORDER NOTED AND SIGN: 1600

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19 NOV 03 TIME OF ORDER: 1612 HOURS

(1) D/C Nitro

(2) Versed Drip; titrate to effect [redacted] noted

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 14 NOV 03 TIME OF ORDER: 1816 HOURS

(1) Heparin 5000 Units SubQ BID

(2) transduce CVP. [redacted] noted 14 NOV 03 1900

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 14 NOV 03 TIME OF ORDER: 2231 HOURS

(1) 1 Liter bolus of NS

(2) Δ IVF to D5NS @ 250cc/hr [redacted] noted 14 NOV 03 2230

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 1[illegible] WHICH MAY BE U[illegible]

MEDCOM - 23796

(b)(6)-2 unless otherwise indicated

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 14 NOV 03 TIME OF ORDER 0820 HOURS

LIST TIME ORDER NOTED AND SIGN

1. PC Versed Drip ~ this has complete
2. Ativan 2-5 mg/hr ; titrate to appropriate sedation
3. CXR in 2 hours to evaluate for PTX ~ CT Removal
4. BID W → Dry Dressing Δ's to Rt CT chest wound + back wound [redacted]

PATIENT IDENTIFICATION

Pa

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

5. Transfuse 2 units PRBCs; each over 2 hours
6. ½ Liter NS Bolus x ½ hour [redacted]
7. Tylenol 650 mg PR prior to 1st Unit PRBCs [redacted]
8. Benadryl 25 mg IV prior to 1st unit of blood

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 NOV 03 TIME OF ORDER 1300 HOURS

1. Give Ativan 10 mg IVPx1 NOW
2. VO DR [redacted] / CPT [redacted] / 1300

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 1345 HOURS

1. Labetal 20 mg x1 NOW
V/O DR [redacted] / CPT [redacted] / 1345

[redacted]

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 15 NOV 03 TIME OF ORDER: 0956 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Hold Vecuronium drip.
2. ΔIVF to D5 1/2 NS @ 200cc/hr

done 15 Nov

NURSING UNIT: ICU 1 ROOM NO. BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 15 NOV 03 TIME OF ORDER: 1225 HOURS

1. Labetalol 20mg IV x 1 now and q6° note for [illegible]

NURSING UNIT: ICU #1 ROOM NO. BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 15 Nov 03 TIME OF ORDER: 1300 HOURS

1. ~~Labetalol gtt e 2mg/min~~
2. ~~Call Dr if SBP <110~~

NURSING UNIT: ICU 1 ROOM NO. BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 15 Nov 03 TIME OF ORDER: 1415 HOURS

1. Labetalol 100mg po NGT q8° 1st dose now
2. hold IV labetalol for SBP <150

15 Nov

NURSING UNIT: ICU ROOM NO. BED NO.

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH [redacted]

(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER: 15 NOV 03 TIME OF ORDER: 1625 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Place DHT
2. Abdominal X-ray to check placement
3. Reglan 10mg IV q 6° — noted done 1650

NURSING UNIT: ICU 1 ROOM NO. BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER: 16 NOV 03 TIME OF ORDER: 0730 HOURS

1. D Labetalol to 200mg per NGT BID
2. Adalat 30mg po per NGT BID

noted done 0730

NURSING UNIT: ICU 1 ROOM NO. BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER: 16 NOV 03 0846 HOURS

1. Start TF with Osmolyte @ 10cc/hr
2. Do Not Advance TF
3. Flush DHT c̄ 60cc H_2O every 4 hours
4. Δ IVF to NS @ 175cc/hr
5. Hold TF p̄ MN tomorrow

NURSING UNIT: ICU 1 ROOM NO. BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT ROOM NO. BED NO.

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

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(b)(6)-2 unless otherwise indicated

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 1000 HOURS | LIST TIME ORDER NOTED AND SIGN

1 Macumyst 2x 3o = 3cc = 600mg
x1 VO Dr [redacted] / CPT [redacted]
[redacted] 1030

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 16 NOV 03 | TIME OF ORDER 1230 HOURS

1 D/C IV Labetalol / Noted 1230
[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 16 NOV 03 | TIME OF ORDER | HOURS

1) Albuterol 2.5/3.0 cc neb Q4G
2) Atrovent neb Q8G
[redacted] 1730

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 16 NOV 03 | TIME OF ORDER | HOURS

Cipro 400mg IV Q12 ~~start now~~
Nacu 10mg 20 min after Nebs
4mg Iv
[redacted] 1600

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(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
16NOV03			
Lasix 40mg IVx			
↓ MIVFs to 25cc/hr			done 2047
[redacted]			

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	
16NOV03	2240		
(1) Increase PEEP to 15			
(2) ABG in 30 minutes			
[redacted]			

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	
17NOV03	0826		
(1) Bolus 1 Liter NS now			
(2) ↑ IVF to 250cc/hr			
(3) Restart TF @ 10cc/hr			
(4) Flush DWT ē 60cc H_2O q 4			
(5) Cancel bronchoscopy today			
(6) ↑ FiO_2 to keep Sat% ≥93%			
[redacted]			

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	
17NOV03	1407		
(1) Dobutamine drip @ 5mcg/kg/min			NJR
(2) Zosyn 3.375grams IVPB q 6°			NJR
[redacted]			

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

(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 17NOV03 TIME OF ORDER: 2232 HOURS

2230 (1) 1 Liter NS bolus x 1 now

LIST TIME ORDER NOTED AND SIGN: noted 17NOV03 2305 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18NOV03 TIME OF ORDER: 0024 HOURS

0025 (1) 1 Liter NS bolus x 1 now

(2) ↑ MIVF to 300cc/°

V.O. [redacted]

240 ✓ 18NOV03 0315 [redacted]

LIST TIME ORDER NOTED AND SIGN: noted 18NOV03 0055 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18NOV03 TIME OF ORDER: 0311 HOURS

(1) Lasix 40 mg IV x 1 now

(2) ↓ IVF to 200 cc/h

LIST TIME ORDER NOTED AND SIGN: noted 18NOV03 0315 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 Nov 03 TIME OF ORDER: 0930 HOURS

(1) D/C Adalat ✓ Now Done

LIST TIME ORDER NOTED AND SIGN: HMD [redacted]

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(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Nov 03 TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Lasix 80mg IVP x1 V.O

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Nov 03 TIME OF ORDER: HOURS

1) Dopa 3mg/kg/min

[redacted]

Note done 1600

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Nov 03 TIME OF ORDER: 1600 HOURS

(2) D/C Labetalol

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 NOV 03 TIME OF ORDER: 1630 HOURS

(3) Lasix 35mg IV x 1 now

[redacted]

34° check 1159 19 Nov 03

[redacted]

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

19 NOV 03 1810

(6) Levik drip @ 40 mg/hr

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

19 Nov 03

1) 2U PRBC now ✓
2) T&C if necessary ✓
3) 6 Amps Bicarb now ✓
4) ↑30 breath/min
5) repeat ABG after Amp cycle ✓

[redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

19 Nov 03 HOURS

Pharm Consult

Pt. est wt = 80kg; age = 30yrs.

Cr = 5.2 (19 Nov 03)

Est CLcr = 23 ml/min

Rec: ① Zosyn 2.0gm q6°

② Cipro 400 mg q24

③ Zantac 50mg IVPB q24°

[redacted]

Pharm noted [redacted] see following orders.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

19 NOV 03 1647

(1) Δ Zosyn to 2 grams IVPB q6° ✓
(2) Δ Cipro to 400mg IVPB q8° ✓
(3) Δ Zantac 50mg IVPB q24° ✓
(4) ~~Levik~~ Decrease IVF to 150cc/hr and Δ to ~~D5/1/2NS~~ D5W with 4 amps [redacted] NaHCO3 per liter [redacted]

3 amps

Done @ 1300

[redacted]

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU1		

DATE OF ORDER: 19 Nov 03 TIME OF ORDER: 1250 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Cipro Δ to 400mg IVPB q 24° from 96°
2. D5W c̄ 3 Amp NaHCO3 per (L) @ 150cc/h VO Dr [redacted]
3. GIVE 4Amps NaHCO3 VO Dr [redacted]

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

1. Increase Dobutamine to 10mcg/kg/min

Done @ 1500 Note / [illegible]

19 Nov 03 1259 qs [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 NOV 03 TIME OF ORDER: 0725 HOURS

1. Increase TF to 30cc/hr Done [redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 NOV 03 TIME OF ORDER: 0902 HOURS

1. No CPR. No chest compressions, No increase in pressors; No defibrillation; pt is A DNR

[redacted]

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

(6)(6)-4 [redacted]

DATE OF ORDER: 20NOV03

TIME OF ORDER: 1908 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D/C Dopamine + Dobutrex
2. D/C Zosyn
3. Imipenem 250mg IVPB q6°

N [redacted] 1930 20 NOV03

[redacted] (6)(6)-2

2400/2345 20 Nov 03 [redacted]

NURSING UNIT: ICU1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994—363-710

(b)(6) - 2" unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 21 NOV 03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Maximally concentrate all drips & fluids
2. Decrease
3. Decrease Bicarb drip to 100cc/hr [redacted]

Noted 1600 21 Nov 03 [redacted]

24°✓/ 21 Nov 03 2245 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 22 NOV 03 TIME OF ORDER: 1604 HOURS

1. D/C Ancef
2. D/C Cipro
3. D/C Imepenem
4. Change IVF to D5NS @ 100cc/hr d/c bicarb drip
5. D/C qAM CXR
6. D/C Tube Feeds [redacted]
7. D/C Lasix drip

Noted 1630 22 Nov 03 [redacted]

24°✓/ 22 2050 Nov 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

(b)(6)-2 except very bottom

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 18	12	13	14	15	16	17	18	19	20	21	22
14/11	[redacted]	Diet: NPO	06	[redacted]											
			18												
14/11	[redacted]	CBC, SMA-7,	04	[redacted]											
		ABG in AM													
11/11	[redacted]	↑ RR to 20	06	[redacted]											
			18												
13 Nov	[redacted]	CT to Water Seal	06	/	/	[redacted]									
			18	/	/										
14 AM		B.O.W → Dry Dsg	10	/	/	/	[redacted]								
		Δs to (R) chest wound	22	/	/	/									
		+ back wound													
11 NOV	[redacted]	CXR q AM	01	/	/	/	/	[redacted]							
14 NOV	[redacted]	Transduce CVP	06	/	/	/	/	[redacted]							
			18	/	/	/	[redacted]								
~~14 NOV~~	[redacted]	START TF c Cimdyte	06	/	/	/	/	/	[redacted]						
17 NOV	[redacted]	@ 10cc/L. DO NOT	18	/	/	/	/	/							
		ADVANCE TF @													
		30cc/H													
16 Nov	[redacted]	Flush DHT c 10cc	04	/					/	[redacted]					
17 Nov	[redacted]	H2O q 4hrs	08												
			12												
			16												
			20												
			24												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

(b)(6)-2 all

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
11/14	[redacted]	Diet Place DHT	15MN	1620	1620	[redacted]
11/15	[redacted]	ASAP XRAY - KUB for placement	15MN	ASAP		
11/16	[redacted]	Hold TF p MN 9/16	11/16	[illegible]	2400	[redacted]

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

(b)(6)-2 except very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23
11/11	[redacted]	Activity: Bedrest	06	[redacted]												
		c̄ HOB elevated 30°	18													
11/11	[redacted]															
11/11	[redacted]	Vitals Q 1°	06	[redacted]												
			18	KS												
11/11	[redacted]	~~NKDA (unknown)~~														
11/11	[redacted]	NKDA (unknown)	06	[redacted]												
			18	KS												
11/11	[redacted]	Vent settings: SIMV	06	[redacted]												
		RR 14 TV 750 PEEP 5	18	KS	[redacted]											
		FiO2 titrate ↓ as low														
		as possible to keep sats														
		% ≥ 95%														
11/11	[redacted]	CXR 9 AM	06	[redacted]												
			18													
11/11	[redacted]	CT to 20cm wall	06	[redacted]												
		suction	18													
11/11	[redacted]	Foley to gravity	06	[redacted]												
			18													
11/11	[redacted]	NGT to LCWS or	06	[redacted]												
		LIS; whichever is available	18													
11/11	[redacted]	I/O	06	[redacted]												
			18	KS												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

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

EPW vs CI

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

(b)(6)-2 all

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
11/11	[redacted]	Admit to ICU | DR [redacted]	11/11	ASAP		[redacted]
11/11	[redacted]	Dx GSW to back c̄ diaphragm/liver	11/11	~~ASAP~~		[redacted]
	----	injury				
11/11	----	Condition stable	11/11	Now		[redacted]
13Nov	[redacted]	CXR for Line Placement	13Nov	Now	1130	[redacted]
13Nov	[redacted]	DC to Central Line	13 Nov	Now	1215	[redacted]
13 Nov	[redacted]	DC all peripheral IVs [redacted]	13NOV	done		
14 NOV	[redacted]	↑ RR to 20 ~~minutes~~ per minutes	13NOV	done		
14 NOV	[redacted]	May use LSC line	13NOV	done		
14 NOV	[redacted]	CXR in 2hr to eval pt for PTX	14NOV	1400	1130	[redacted]
	----	p̄ CT removal				
16NOV	[redacted]	↑ peep to 15	16NOV	done	2244	[redacted]
16NOV	[redacted]	ABGs in 30min	16NOV	done	2304	[redacted]
17NOV	[redacted]	cancel tracheostomy today	17NOV	done		[redacted]
19Nov	[redacted]	Repeat ABGs p̄ transfuse	19Nov	ASAP	Done	[redacted]

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 (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 16	17	18	19	20	21	22	23
16 Nov 03	[redacted]	Vent: See RT sheet for	06	/	[redacted]						
		setting Δs	18								
17 Nov	[redacted]	↓ FiO_2 to keep Sat ≥ 93%	06	/							
			18	/							
10 Nov Reapplied 11 Nov	[redacted]	CBC, SMA-7, ABG in AM	04	/	/	/	/	/	/		
10 Nov Reapplied 14 Nov	[redacted]	W→D q 4 hrs Δs to chest	10	/	/	/	/	/	/		
		wound + back wound BID	22	/	/	/	/	/	/		
10 Nov Reapplied 14 Nov	[redacted]	Transduce CVP	06	/	/	/	/	/	/		
			18	/	/	/	/	/	/		
10 Nov Reapplied 17 Nov	[redacted]	Flush Dobhoff c̄ 60cc	04	/	/	/	/	/	/		[redacted]
		H_2O q 4°	08	/	/	/	/	/	/		
			12	/	/	/	/	/	/		
			16	/	/	/	/	/	/		
			20	/	/	/	/	/	/		
			24	/	/	/	/	/	/		
10 Nov Reapplied 11 Nov	[redacted]	Activity: Bedrest c̄	06	/	/	/	/	/	/		
	[redacted]	HOB elevated 30°	18	/	/	/	/	/	/		
10 Nov Reapplied 11 Nov	[redacted]	Vitals q 1°	06	/	/	/	/	/	/		
			18	/	/	/	/	/	/		
10 Nov Reapplied 11 Nov	[redacted]	Foley to gravity	06	/	/	/	/	/	/		
			18	/	/	/	/	/	/		
10 Nov Reapplied 11 Nov	[redacted]	NGT to LCWS or LTS;	06	/	/	/	/	/	/		
	[redacted]	whichever is available	18	/	/	/	/	/	/		
10 Nov Reapplied 11 Nov	[redacted]	I/O	06	/	/	/	/	/	/		
			18	/	/	/	/	/	/		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				20	21	22	23									
10 NW	[redacted]	NO CPR NO CHEST	04	[redacted]				(b)(6)-2								
		COMPRESSIONS,	18	[redacted]												
		NO INCREASE IN														
		PRESSURES. NO														
		DEFRIBILLATION;														
		PT IS A DNR														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 except very bottom

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 11	12	13	14	15	16	17	18	19	20	21	22	23	24
11/11	[redacted]	1VF = NS c 20 MEQ	06	/	[redacted]												
		KCl / L @ 175cc/h	18	KS	[redacted]				Δd		14 NOV 03						
11/11	[redacted]	TAGAMET 400mg IVPB	03	/													
		Q6	09	/													
			15	/				D'CD									
			21														
N 11/11	[redacted]	Ancef 1 gram IVPB	06	[redacted]													
		q 8°	14														
			22														
11/11	[redacted]	MSO4 drip Titrate	06	[redacted]													
		to effect	18	[redacted]													
11/11	[redacted]	Versed Drip titrate	06	[redacted]					14 Nov 03								
		to effect (Wean)	18	[redacted]													
C 11/11		Zantac 50mg DUP	16	[redacted]													
		Q8°	24	[redacted]													
			08	[redacted]													
13 Nov 03	[redacted]	Vecuronium Drip	06	/	/	/	[redacted]										
		2.5mg/hr	18	/	/	[redacted]											
13 Nov 03	[redacted]	Ativan 1-2mg/hr and	06	/	/	[redacted]			14 Nov 03								
		try to wean off versed	18	[redacted]													
14 Nov 03	[redacted]	Ativan 2-5mg/h,	06	[redacted]	/	/	[redacted]		D/C		14 Nov 03						
		titrate to appropriate sedation	18														
14 NOV	[redacted]	ΔIVF to DSNS @ 250cc/°	06	/	/	/	[redacted]		D/C 25 NOV 03								
			18				[redacted]										

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:

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

(b)(6)-2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
12Nov	[redacted]	IL NS boluS	12Nov	Now	0175	[redacted]
13Nov	[redacted]	Transfuse 2units PRBCs'	(1) 13Nov	ASAP	1030	[redacted]
~~13Nov~~	[redacted]	over 2°	(2) 13Nov		1245	[redacted]
13Nov	[redacted]	Vecuronium 10mg IVPT now	13Nov	Now	0830	[redacted]
14Nov	[redacted]	D/C Versed Drip p̄ bag complete	14Nov	Now	1015	[redacted]
14Nov	[redacted]	Transfuse 2units PRBCs; each over	14Nov	ASAP	(1) 1030 (2) 1300	[redacted]
	-----	2 hours				
14Nov	[redacted]	1 Liter NS BoluS x 1 Now	14Nov	ASAP	0800	[redacted]
14Nov	[redacted]	Tylenol 650mg PR prior to 1st	14Nov	ASAP	1030	[redacted]
	-----	unit of PRBCs				
14Nov	[redacted]	Benadryl 25mg IV prior to 1st	14Nov	ASAP	1030	[redacted]
	-----	Unit PRBCs				
14Nov	[redacted]	Ativan 10mg IVP x1 Now	14Nov	1700	1300	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
[redacted]	[redacted]	Tylenol 650mg/Supp D	11 Nov	13 Nov											
-----	-----	PR as need temp I	2220 KS	1000 CP											
-----	-----	≥ 100.5 T													
-----	-----														
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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. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22	23
14Nov	[redacted]	Versed Drip, titrate	06	[redacted]									
		to effect	18	[redacted]									
14Nov	[redacted]	heparin 5000 units SQ	08	[redacted]									
		BID	20	[redacted]									
15Nov03	[redacted]	D5 ½NS @200cc/h	06	[redacted]									
			18	[redacted]				D/C 11/16/03					
15Nov03	[redacted]	labetalol 20mg IVP q6°	06	[redacted]									
		Hold IV labetalol for	06	[redacted]									
		SBP <150	12	[redacted]				D/C 11/16/03					
			18	[redacted]									
15Nov	[redacted]	labetalol 100mg	06	[redacted]									
		per NGT q 8°	14	[redacted]				see MS					
			22	[redacted]				D/C 11/16/06					
15Nov	[redacted]	Reglan 10mg IV q6°	06	[redacted]									
			12	[redacted]									
			18	[redacted]									
			24	[redacted]									
16Nov	[redacted]	Labetalol 200mg	08	[redacted]				D/C 11/16/03					
		per NGT BID	20	[redacted]									
16Nov	[redacted]	Adulat 30mg per	08	[redacted]				D/C 11/18/03					
		NGT BID	20	[redacted]									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

(b)(6)-2 all

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
14Nov	[redacted]	labetalol 20mg IVP x1 Now	14Nov	1800	1800	[redacted]
14Nov	[redacted]	Lasix 10mg IV x 1 Now	14Nov	1600	1600	[redacted]
14Nov	[redacted]	D/C Ativan	14Nov	1615	1615	[redacted]
14NOV	[redacted]	1 liter boluS of NS	14NOV	2230	2300	[redacted]
15Nov	[redacted]	Hold Vecuronium Drip	15Nov	1000	1000	[redacted]
15Nov	[redacted]	Labetalol 20mg IVP Now	15Nov	Now	Now	[redacted]
15Nov	[redacted]	Labetalol 100mg tab NGT Now	15Nov	1400	Now 1400	[redacted]
16Nov	[redacted]	Mucomyst-20 600mg = 7cc x 1 Now	16Nov	1030	1030	[redacted]
16Nov	[redacted]	Vecuronium Gtts 10mg Boles Now	16Nov	1545	1600	[redacted]
16NOV	[redacted]	Lasix 40mg IV x 1 now	16NOV	2045	2047	[redacted]
17Nov	[redacted]	1 Liter NS bolus x 1 now	17NOV	2230	2230	[redacted]
18NOV03	[redacted]	1 Liter NS bolus x 1 now	18NOV03	0025	0025	[redacted]
18NOV	[redacted]	Lasix 40mg IV x 1 now	18NOV03		0314	[redacted]

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

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(b)(6)-2 all

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 16	17	18	19	20	21	22
11/16	[redacted]	IVF to NS @	06	[redacted]						
		175 cc/h	18	[redacted]						
11/16	[redacted]	Albuterol 2.5/3.0cc	02	[redacted]						
		Neb Q4°	06	[redacted]						
			10	[redacted]						
			14	[redacted]						
			18	[redacted]						
			22	[redacted]						
11/16	[redacted]	Atrovent Neb Q8°	06	[redacted]						
			14	[redacted]						
			22	[redacted]						
11/16	[redacted]	Cipro 400mg IV Q12	08	[redacted]						
			20	[redacted]						
11/16	[redacted]	Vecuronium @ 4mg/h	06	[redacted]						
			18	[redacted]						
11/16/03	[redacted]	↓MIVF (NS) to 25cc/°	06	[redacted]						
			18	[redacted]						
		1 IVP NS to 250cc/h	06	[redacted]						
	[redacted]	300Dec/° 200Dec/°	18	[redacted]						
17 Nov	[redacted]	Dobutamine drip at	06	[redacted]						
		5 mcg/kg/min	18	[redacted]						
		10 mcg / Kg / min								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO. ___

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
17NOV	[redacted]	Bolus 1 liter NS now	17NOV	NOW		
	- - - - -					
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23
19 Nov	[redacted]	Zosyn 2.gm IVPB	06	/	[redacted]			
		q6°	12	/	[redacted]		DC'd	
			18	[redacted]			20 Nov 03	
			24	[redacted]			1920	
	[redacted]							
19 Nov	[redacted]	Cipro 400 mg IVPB	20	[redacted]				
		q 24°						
19 Nov	[redacted]	Zantac 50mg IVPB	08	/	[redacted]			
		q 24°						
19 Nov		D5W c̄ 3 Amps NaHCO3	06	[redacted]				
		per Liter @ 150cc/h	18	[redacted]				
18 Nov	[redacted]	Dopamine 3mcg/kg/hr	06	[redacted]		DC'd		
			18	[redacted]		20 Nov 03		
						1930		
18 Nov	[redacted]	Lasix 40mg/hour	06	[redacted]				
			18	[redacted]				
		Imipenem						
20	[redacted]	~~Cilpenem 750mg IVPB q6~~	06	X	X	[redacted]		
			12	X	X	[redacted]		
			18	X	X	[redacted]		
			24	X	[redacted]			
21 Nov	[redacted]	1) NaHCO3 gtt to 100cc/hr	06	/	[redacted]			
			18	/	[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

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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

(b)(6) - 2 all

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**
18Nov	[redacted]	Lasix 80mg IVP x 1	18Nov	1400	1400	[redacted]
18Nov	[redacted]	Lasix 350mg IVP x 1 NOW	18Nov	NOW	1700	[redacted]
19Nov	[redacted]	T+C if necessary	18Nov	NOW	0800	[redacted]
19Nov	[redacted]	2 U PRBC NOW	18Nov	NOW	(1) 1000 (2) 1100	[redacted]
19Nov	[redacted]	6 Amps Bicab NOW	18Nov	0815	0815	[redacted]
19Nov	[redacted]	4 Amps Bicab NOW	18Nov	1200	1200	[redacted]

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22
21 Nov	[redacted]	Maximally concentrate	06	[redacted]	
		all drips & fluids	18	[redacted]	
22 Nov	[redacted]	Δ IVF to D5NS @ 100cc/hr	06	/	[redacted]
			18	/	[redacted]
22 Nov Reapplied 14 Nov	[redacted]	Zantac 50mg IVPB	08	/	/
		q24°			
22 Nov Reapplied 14 Nov	[redacted]	Mary gtt titrate to	06	/	/
		effect	18	/	[redacted]
22 Nov Reapplied 14 Nov	[redacted]	Versed gtt titrate to	06	/	/
		effect	18	/	[redacted]
22 Nov Reapplied 14 Nov	[redacted]	Heparin 5000 Units sq	08	/	/
		BID	20	/	[redacted]
22 Nov Reapplied 15 Nov	[redacted]	Reglan 10mg IV q6°	06	/	/
			12	/	/
			18	/	[redacted]
			24	/	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

MEDICATION ADMINISTRATION RECORD

(ALL ENTRIES MUST BE PRINTED)

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use Blanket PAS - DD Form 2005)

DATES		MEDICATION, DOSE, FREQUENCY	HOUR	DATE GIVEN
ORDER	RENEWAL			
11 Nov 03		Diprivan - 25mcg/kg/min	start	
		Dose 12 gtts/min	0505 L	11 Nov 03
11 Nov 03	—	MSO4 5mg IVP X1	0610 L	—
11 Nov 03	—	MSO4 5mg IVP X1	0625 L	—
11 Nov 03	—	Vecuronium 10mg IVP X1	0600	—
11 Nov 03		Morphine 5mg IV P X1	@0730	
11 Nov 03		Fentanyl 1mg I.V X1	@0830	
11 Nov 03		Morphine 5mg I.V. X1	0835 L	

PLATE IMPRINTER

BED NAME

CHECK IF A SECOND PAGE IS IN USE

P - PASS

* - REFER TO NURSING NOTES

ALLERGIC TO

DIAGNOSIS

TIME																								
24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	

AF FORM 3069, OCT 84 *(EF-V (PerFORM PRO)* PREVIOUS EDITION WILL BE BE USED.

RECORD-SUPPLEMENTAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0645 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]
NEURO	PUPILS	2mm PERRL	2mm PERRL. Pt has scleral
	SENSORIUM	Sedated c̄ Morphine + Versed	edema greater in left eye. Pt
	EXTREMITY MOVEMENT	to effect	has 4mg/hr versed for sedation
	SEDATION		& 4mg/hr of MSO4 for pain control
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	VENT: PEEP 5 TV 750 RR 15	Vent. RRR equal rise / fall
	BREATH SOUNDS	FIO2 35% SaO2 98%	of chest. Lung sounds course in
	SECRETIONS	ETT 26 at lips	all fields. Vent set @ 750 TV,
	O2 SOURCE/FLOW/SAO2		PEEP of 5. FO2 of 35%, RR 15. Pt's
	VENTILATOR SETTINGS		ET tube in 26 @ lips.
CV	CARDIAC RHYTHM	S1S2 HR 120's	S1S2 normal ∅ ectopy / murmur noted.
	CAPILLARY REFILL		Pt has strong pulses in all 4 extremities
	PULSES		cap refill < 2 sec. Pt has generalized
	EDEMA		edema throughout.
GI	ABDOMEN	Hyperactive BS x 4 quads	Pt does not respond when stomach is
	BOWEL SOUNDS	NG tube to LIS	palpated. BS x 4 quads. no BM
	BOWEL MOVEMENT	Abd soft + non distended	on shift. Pt has NG tube to LIS
	NGT/OGT		NPO.
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to Gravity	Pt has foley to gravity QS, clear
	COLOR/CLARITY	clear yellow urine	yellow urine. no S/S of infection of
			foley
SKIN	COLOR	NFR DSG to midline	NFR c̄ chest tube in (R) side, dressing
	INTEGRITY	abdomen CDI	CDI. mid line abdominal wound,
			dressing CDI.
ACCESS	#1 TYPE/LOCATION/SIZE	A line to (L) Radial	Pt has (R) cordis c̄ NS @ 175 cc/hr.
	DRESSING CONDITION	Cordis to (R) IJ NS @ 175 cc/hr	Pt has (L) radial A-line zeroed.
	IV FLUID/RATE	Site CDI	site shows no signs of infection.
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

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

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

DATE 12 Nov 93

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

NAME: [redacted] (b)(6)-4 RANK: AGE:

UNIT [redacted] GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 23824

USAPPC V2.00

ICU1

Patients Name: Date:

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	128/77	124/77	134/70	129/76	146/76	139/74	145/73	133/75	140/76	132/71	132/74	140/80		130/70	119/94	128/81	134/70	140/79	134/74	141/76	133/81	144/78	131/81	134/81	130/80	
TEMP	100.1	100.1	100.4	100.4	100.7	101.3	101.3	101.3	101.5	101.4	101.6	101.9		101.8	101.5	101.8	101.3	101.9	101.5	101.2		100.2	100.4	100.4	100.7	
HR	125	125	128	128	134	136	139	136	136	135	138			139	142	144	144	145	134	131	125	123	120	117	120	
RR	15	19	18	24	21	17	21	13	15	16	16	17		12	18	27	26	30	22	27	18	17	18	18	16	
SaO2	98	97	97	98	98	97	97	98	98	100	96	97		94	94	95	94	100	100	100	100	100	100	100	100	
FiO2	40	35	35	35	35	35	35	35	35	35	35	35		35	35	35	35	100	85	80	64	64	64	64	64	
Source	V	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT		VENT	V	V	V	V	V	V	V	V	V	V	V	
MAP	98	100	99	99	98	99	102	97	101	100	96	104		94	103	105	99	102	101	101	100	110	100	111	98	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF	175	175	175	175	175	175	175	175	175	175	175	175	2100	175	175	175	175	175	175	175	175	175	175	175	175	2
IVPB	0	0	50	0	0	0	50	0	0	0	50	0	150	0	0	50				50				50		1
NGT	0	0	0	0	0	0	0	0	0	0	0	0	0	0												
MSO4	3	3	3	4	5	5	5	5	4	4	4	4	49	4	4	4	4	4	4	4	4	4	4	4	4	4
Versed	2	2	2	4	6	6	6	6	4	4	4	4	52	4	4	4	4	4	9	9	9	9	9	9	9	8
Boluses	0	0	0	0	0	0	0	0	0	0	0	0	0	0					1000							1
Total													2351													3381

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	50/50	85/85	170/35	120/125	160/80	135/120	160/80	160/104	100/140	145/150	170/145	145/162	1620	150	120/70	70/140	120/160	100/160	110/60		170/100	200/150	120/170	120/150	120/170	1370
STOOL																									300	300
DRAIN																								250		
CT①																								130		
																								80		
																								130	130	
																										1800
Total																										

24 hr +2312

2351 - in
-1620 - out
75 cc

+731

12 hr 1581

MEDCOM - 23825

RECORD-SUPPLEMENTAL ME[illegible]TA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSES[redacted]

		TIME: 0730 INITIALS: [redacted]	TIME: INITIALS:
NEURO	PUPILS	PUPILS 2mm PERRL	2mm PERRL
	SENSORIUM	pt sedated c̄ Morphine +	pt on 10mg/hr versed,
	EXTREMITY MOVEMENT	Versed	7mg/hr morphine, will
	SEDATION		continue to monitor
	PAIN CONTROL		sedation
RESP	RESPIRATORY PATTERN	VENT - PEEP-5 TV-750 RR-18	Vented PEEP 5, TV
	BREATH SOUNDS	FIO2-65%. Ronchi throughout	750, RR 18, FIO2 60%.
	SECRETIONS		SAT's @100%.
	O2 SOURCE/FLOW/SAO2		thick white secretion
	VENTILATOR SETTINGS		through ETT. Ronchi
			throughout Bilat
CV	CARDIAC RHYTHM	S1 S2 + 2 pulses x4 extremities	S1 S2 (+) pulses to ↑ UE
	CAPILLARY REFILL		extremities. <3sec
	PULSES		cap refill.
	EDEMA		
GI	ABDOMEN	Hypoactive BS x 4 quads	(+) BS x4 quad
	BOWEL SOUNDS	Abd soft + non-distended	hypoactive
	BOWEL MOVEMENT	NGT to LIS to (R) nare	soft round non distended
	NGT/OGT		NGT to LIS.
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to gravity	Foley to gravity
	COLOR/CLARITY	clear yellow	clear yellow urine
SKIN	COLOR	NFR CT tube to 20cm	NFR
	INTEGRITY	Suction (R) side chest	Midline stitches to abd,
		Midline Abd DSG site CDI	Dressing CDI. CT to
			(L) Flask on water seal.
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis to (R) IJ NS @	TL to (L) SC (P) flush all
	DRESSING CONDITION	175 cc/hr SITE CDI &	ports, NS to Blue port c̄
	IV FLUID/RATE	redness	NS @ 175 cc/hr c̄ fentanyl
	#2 TYPE/LOCATION/SIZE	A-line to (L) Radial site	IVPB, flushed to White port.
	DRESSING CONDITION	CDI & redness	Brown port clamped. A line
	IV FLUIDS/RATE		to (R) Radial (+) [illegible]

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU #1 [redacted] (b)(6)-2

DATE 13 Nov 03

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

NAME: [redacted] (b)(6)-4 RANK: AGE:

UNIT: [redacted] GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 23826

USAPPC V2.00

ICU1

Patients Name: [redacted] (b)(6)-4 Date: 13 Nov 03

14 Nov 03 TO pm

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line																								
NBP	144/70	141/74		147/66	157/78	165/79	148/87	164/89	137/76	135/78	135/83	134/78	130/74	137/80	118/71	127/66	127/68	117/66	111/64	173/90	165/83	116/67	96/61	90/60	88/55	97/65	97/61	93/62
TEMP	99.8		99.9		100.2	100.4	101.3	101.9	102.3	101.5	102.2		101.5		101.0		99.5		99.6		99.8		99.1	
HR	175	123	120	130	123	135	142	144	140	134	138	138	131	132	127	121	120	130	138	127	116	113	111	106
RR	18	34	18	18	31	20	25	28	27	20	37	28	19	18	18	18	18	20	19	18	18	18	16	20
SaO2	99	100	100	100	100	100	97	96	99	100	100	99	100	99	100	100	100	95	93	97	98	99	97	99
FiO2	60	65	65	65	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	55
Source	V	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	V	V	V	V	V	V	V	V	V	V	V
MAP	97	99		97	108	111	121		102	103	104	99	96	123	86	86	88	124	116	74	70	65	71	73

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	175	175	175	175	175	175	175	175	175	175	175	175	2100	175	175	175	175	175	175	175	175	175	175	175	175	2100
B	0	0	50	0	0	0	50	0	0	0	0	50	150	0	0	0	0	50	0	50	0	0	0	0	0	100
T	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Seed	9	9	9	9	9	9	9	9	10	10	10	10	112	10	10	10	6	6	4	4	8	8	8	6	6	74
04	4	4	4	4	4	4	4	7	7	7	7	7	63	7	7	7	7	7	7	7	7	7	7	7	7	84
Ins	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C	0	0	0	0	0	372	370	0	0	0	0	0	742	0	0	0	0	0	0	0	0	0	0	0	0	0
c															2	2	2	2	2	2	2	2	2	2	2	24
Ativan													3167		1	1	1	1								4
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	140	140	140	150	140	100	100	150	100	100	95	100	1455	120	100	100	100	100	120	100	100	100	100	100	100	1
	140	280	420	570	710	810	910	1060	1160	1260	1355	1455		120	220	320	420	520	640	740	880	1000	1100	1210	1310	
	150																								150	
STOOL																										
DRAIN																										
CT																										
Total																										

3167 in
1455 out
+1712

IN 2386
out 1780
+606

MEDCOM - 23827

(b)(6)-4

ICU1 Patients Name: [redacted] Date: 15NOV03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																				147/93	14/94	150/100	148/95	155/85	151/92
NBP																									
TEMP																				98.2	98.3	98.5	98.7	98.7	98.6
HR																				107	112	111	116	112	117
RR																				19	10	16	20	26	20
SaO2																				100%	100%	100%	99%	97%	96%
FiO2																				45%	40%	40%	40%	40%	40%
Source																				vent	vent	vent	vent	vent	vent
MAP																				113	118	120	116	112	110
C P																				5	5	5	5	5	5
																				42	41	44	40	47	46
P																				12	9	14	13	13	19

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF																					250	250	250	250	250	5
IVPB																				500						12
NGT																										
MSO4																				7	7	7	7	7	7	2
Versed																				5	5	7	7	7	7	3
Vec																				3	3	3	3	3	3	3
bolus																				bolus cont'd						
Total																										130

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
URINE																				95/95	100/195	115/310	85/395	120/515	70/585	58
T																									405	40
STOOL																										
DRAIN																										
Total																										

Total in: 7116 Total out: 2313 (+4803)

MEDCOM - 23828

RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 1200 INITIALS: [redacted]	TIME: 1820 INITIALS: [redacted]
NEURO	PUPILS	2+	1+ slow
	SENSORIUM	fully sedated	Sedated on versed 2mg
	EXTREMITY MOVEMENT		No voluntary movement
	SEDATION	Versed + MSO4 titrate to sedation	versed 2mg, MSO4 1mg
	PAIN CONTROL		MSO4
RESP	RESPIRATORY PATTERN	BBS ET #8 26 @ the	BBS. ETT #8.0 26cm lip
	BREATH SOUNDS	lip CTA ↓ BS (R) side	URight. dim. left.
	SECRETIONS	thick brownish	
	O2 SOURCE/FLOW/SAO2	Vent	vent: FIO2 50% PEEP 5 RR 14
	VENTILATOR SETTINGS	SIMV 14 Peep 5 FIO2 100% ↓ to maintain sat ≥ 95%.	to keep SaO2 ≥ 95%.
CV	CARDIAC RHYTHM	ST 119 c pelopy	ST 128
	CAPILLARY REFILL	sluggish	<3sec
	PULSES	weak but palpable	2+ palpable.
	EDEMA	insignificant on admission	Generalized 1+
GI	ABDOMEN	hyperactive BS, abd wound	hyperactive. soft c
	BOWEL SOUNDS	soft	DRSG. midline C/D/I.
	BOWEL MOVEMENT	0	BS hypo. c no BM
	NGT/OGT	LWIS	LWIS
	TUBE FEEDINGS	0	Ø
	DRAINS	CT to CWS	CT CWS
GU	VOIDING	foley to gravity g S	foley clear yellow
	COLOR/CLARITY	>100cc/hr clear yellow urine	>100cc/hr.
SKIN	COLOR	WNL for race	NFR.
	INTEGRITY	Abd dressing 2° wound (R) med axillary CT dressing.	ABD. Dressing CDB CT dressing reinforced
	Bedsore	Baseline skin assessment (−)	
ACCESS	#1 TYPE/LOCATION/SIZE	(R) SC cordis sedation	(R) Cordis NS c 20K
	DRESSING CONDITION	+ maintenance fluid	(L) AC 18g heplock
	IV FLUID/RATE	@ 175 cc/hr NS c 20kcl	(R) AC 18g heplock
	#2 TYPE/LOCATION/SIZE	Bilateral IV AC heplocked	No S/S infection
	DRESSING CONDITION	D+I	D&I
	IV FLUIDS/RATE		175 cc/hr NS c 20K cl

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU #1 [redacted] (b)(2)-2

DATE

(Continue on reverse)

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

NAME: [redacted] RANK: (b)(6)-4 AGE:

UNIT: [redacted] GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

MEDCOM - 23829

USAPPC V2.00

ICU1

Patients Name: Eqw [redacted] (b)(6)-4

Date: 11/11/03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line						163/107	191/114	153/92	154/98	154/91	106/72	117/79		143/87			140/88	132/85	112/81	112/74	102/67	108/72	—	—	103/90	
NBP									154/98	154/91	146/90	119/79			129/72	126/81			112/74	—	—	117/65	104/40	132/88	115/67	
TEMP						93.4	94.1	95.1	96.6	97.1	98.6	98.6			99.4	100.2	100.4	101.2	99.6	100.7	100.6	100.5	100.3	100.2	100.1	
HR						116	108	105	116	115	117	117		121	131	129	123	122	121	116	114	118	116	115	115	
RR						14	14	21	19	41	30	30		30	29	21	16	20	22	20	14	16	20	20	15	
SaO2						100	98	96	96	97	92	96		92	95	100	100	100	100	100	99	99	99	99	100	
FiO2						100	86	75	75	75	65	50		50	55	55	55	50	45	45	40	40	40	40	40	
Source						Vent	Vent	Vent	Vent	Vent	Vent	Vent		Vent	V	V	V	V	V	V	V	V	V	V	V	
AP											111	95		100	99	101	106	104	91	86	81	86	92	96	84	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tc
IV						300	175	175	175	175	175	175	200/1550	175	175	175	175	175	175	175	175	175	175	175	175	2
IVPB						300					50					50				50	—			50		1
NGT																										
MSO4						4	8	5/8	10	6	4/4	1	1	1	1	1	4	4	4	4	4	4	4	4	3	3
Versed						4	4	4	6	8	10	2	2	2	2	2	3	3	3	3	3	3	3	3	2	3
Bolus																						100				10
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							950/950					700/1650	1650		600/600	100/700	120/820	90/910	60/970		30/1000	34/1034		50/1084	50/1134	193
													300													
STOOL																										
DRAIN																										
CT												222	222												25	25
NGT												300	300													
Total																										

MEDCOM - 23830

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	1930	INITIALS [redacted]		INITIALS
NEURO	PUPLIS	PERRLA @ 2mm, sluggish		2, minimal reactivity, PERRLA.			
	SENSORIUM	intubated & versed & MSO4, paralyzed & VEC, ⊖ gag, ⊖ corneal, ⊖ grimace to pain, ⊖ eye opening		Sedated & MSO4, Vecuronium, Versed. ⊖ gag, ⊖ cough, ⊖ corneal reflexes. Non reactive to pain. Scleral edema & jaw tone present			
RESPIRATORY	RESPIRATION PATTERN	ETT #8, 27cm @ hub, lung fields & bil crackles & wheezes in upper lobes & diminished bases, SIMV 30, PEEP 15, F$_i$O$_2$ 90%, TV 690, O$_2$ sat 89-90%		Lungs expand evenly bilat. Lungs wheezy, diminished to all fields (B). ETT #8, 28cm at hub, SIMV, 30 b/m, F$_i$O$_2$ 90%, PEEP=15. O$_2$ sats = 91-92 %. Tidal volume 620			
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR	Warm, weeping serous drainage from old IV site and current IV sites		Warm, normal color for race. Weeping serous fluid from any open wounds. 3+ pitting edema.			
	INTEGRITY						
IV SITE	LOCATION	(C) SCTLC & MIVF, Versed, VEC, MSO4, Ivax, (R) femoral CordIS & MIVF, sites intact & no sts of infection, drsg intact		(C) subclavian TLC continues, & CVP no one port. ⊖ s/s infection. (R) femoral cordis continues & D5NS @ 100 cc/hr, ⊖ s/s infection. (R) radial art line continues & good blood return & flow, ⊖ s/s infection			
	CONDITION						
GASTRO	ABDOMEN	large, round, distend, firm, hyperactive to absent BS		Rotund, firm, ⊖ BS. ⊖ flatus. Abd wound drsg intact. Continues to leak serous fluid from abd sutures.			
	BOWEL SOUNDS						
GU	URINE	Foley to gravity & dark amber & blood tinge		Foley to gravity, draining dark brown colored urine. Sediment present. Occasional blood clots.			
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIACRHYTHM	Sinus tach ~ 130 to gravity, HR WNL, ⊖ S3 murmur (+) pulses all ext, +3 pitting edema generalized		Tachycardia, difficult to distinguish if pure flutter or atrial flutter. 3+ pitting edema to all of body.		Pulses (+) to all extremities. ⊖ JVD noted. ⊖ S3, S4 murmurs.	

LEGEND
Cr - Creatinine
F$_i$O - Fraction of inspired O$_2$
F$_i$O$_2$ - Bicarbonate
ICP - Intracranial Pressure
PCO$_2$ - PRESSURE OF ARTRIAL CO$_2$
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

PREPAR[redacted] (b)(6)-2 LCT, AN

(Continue on reverse)

DEPARTMENT/SERVICE/CINC TCU #1

DATE 72 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

22 Nov 03

DX

HOSPITAL DAY 12

VITAL SIGNS

TIME	06 24	07	08	09	00	05	02	03		08	09	10	11	12	13	14	15
BP Arterial line	142/70	130/50	135/60	145/80	134/52	110/47	113/41	105/44		138/46	130/57	130/55	130/44	130/35	123/53	100/40	113/48
BP Cuff																	
Temperature	98.6				99.7					99.6				99.2		99.8	
Pulse	117	113	112	112	116	117	115	111		112	108	111	111	107	112	111	112
Respiratory Rate	30	30	30	30	30	30	30	30		30	30	30	30	30	30	30	30
Vent Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	S		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
PIP	60	63	65	53	51	55	57	55		54	51	50	51	49	50	47	49
PEEP	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15
F_iO_2	90	90	90	90	100	100	100	100		100	90	90	90	90	90	100	100
CVP	22	20	21	22	21	24	23	24		25	20	15	16	14	14	13	21
MAP	90	74	86	91	74	69	65	66		65	76	74	63	54	74	60	66
S_aO_2	93	90	85	81	82	91	99	99		100	98	85	87	94	88	92	87

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
~~NaHCO3~~ MIVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
IVPB	102		50						152									
Versed	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	80
Vecuronium	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
MSO_4	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	64
Lasix	4	4	4	4	4	4	4	4	32	4	4	2	—	—	—	—	—	10
Tube feeding	30	30	90	30	30	30	90	30	600	30	30	15	—	—	—	—	—	75
Tube Flush																30		30
TOTALS									1760 / 1960									0. / 1091

OUTPUT

	HOUR / TOTAL	15/15	7/22	13/35	14/49	4/53	7/60	3/63	2/65	65	3	4/7	5/12	4/16	0/16	0/16	2/18	6/24	24
URINE	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS									0										
STOOL									0										
DRAINS																			
TOTALS																			

POST-OP DAY 11

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	22	23	24	00	02	03	04	05	
	98/38	103/37	98/35	30/20					
	100.4		100.6	100.6					
	112	112	110	29					
	30	30	30	30					
	SIMV	SIMV	SIMV	SIMV					
	53	47	48	42					
	15	15	15	15					
	100	100	100	100					
	18	15	16	21					
	58	59	56	19					
	93	81	79	70					

INTAKE	18	17	18	18	20	21	22	23	8°T
	100	100	100	100					400
	10	10	10	10					40
	4	4	4	4					16
	8	8	8	8					32
									128

OUTPUT									
	5/5	14/19	0/19	0/19					19
									19

RESPIRATORY			
	TIME		0400
	MODE		SIMV
	F_IO_2		90
	TV		690
	RATE		30
	PEEP		15
ARTERIAL BLOOD GAS	A	pH	7.294
		PCO_2	61.4
	B	pO_2	57
		HCO_3	30
	G	SAT	85
		BASE	3

LABORATORY		
	TIME	0400
	GLUCOSE	130
	Na/K	136/4.6
	Cl/CO_2	103/24
	BUN/Cr	120/6.7
	WBC/PLATELET	28.4/315
	Hct/Hgb	25.9/8.4

ACTIVITIES DEFINING ACUITY LEVEL		
	TIME	1900
DAILY	MOUTH CARE	[redacted]
	BATCH	
	SKIN CARE	[redacted]
	FOLEY CARE	
	TRACH CARE	
	ROM EXERCISES	

TURN	TIME			
	[redacted]	[redacted]	[redacted]	

SUCTION				
	[redacted]	[redacted]	[redacted]	[redacted]

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

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INTILAS [redacted]	1830	INTILA [redacted]		INTILAS
NEURO	PUPLIS	PER non reactive @ 2mm,		Pupils 4 2mm, slightly reactive (B).			
	SENSORIUM	pt sedated c̄ Versed, MS04,		Versed, MS04, Vecuronium continue.			
		4 Vec., Ø grimace to pain,		Ø response to painful stimuli			
		Ø MAE, (-) corneal, (-) gag		Ø posturing. (-) corneal reaction			
				or gag reflex. Atrium tracheostomy applied			
RESPIRATORY	RESPIRATION PATTERN	Even, unlabored chest expansion		Even, unlabored chest expansion			
	BREATH SOUNDS	lungs c̄ coarse rhonchi &		Coarse sounds to all fields (B).			
	SECRETIONS	crackles, ETT #8 27cm @		Wheezing c̄ inspiration & expiration			
		lip, SIMV 30, PEEP 15,		ETT #8 @ 27cm @ lip. SIMV 30			
		TV 690, FiO2 90%, sx c̄ blood		bpm, PEEP=15, TV=690, FiO2 90%.			
		tinged secretions		Blood tinged secretions c̄ suction			
SKIN	COLOR	Warm, dry, (+) 3 pitting		Skin color normal for race. Generalized Skin to penis is slightly			
	INTEGRITY	edema generalized, midline abd		3+ pitting edema. Skin warm, Surgical Scrotum smaller to size of			
		incision drsg to (R) flank		wound midline abd, (R) flank, back, testicle (cleaned). Weeping noted to all			
IV SITE	LOCATION	(R) femoral cordis c̄ drsg		(R) femoral cordis. Drsg soaked. (-)		open wounds on body.	
	CONDITION	intact, Ø s/s of infection;		for s/s infection (L) Subclavian			
		(L) SCT TLC drsg intact, Ø s/s of		TLC intact, dated dry (R) Mon			
		infection; (R) radial A-line		(R) radial art line patent, Ø s/s			
		patent c̄ drsg intact, Ø s/s of		infection. Zeroed, CVP to			
		infection		(L) Subclavian zeroed.			
GASTRO	ABDOMEN	large, round, distended,		large, round abd. Firm.			
	BOWEL SOUNDS	firm, BS absent, (R) nares		(-) pain with palpation BS (-), NG			
		NGT to LIS, (L) nares c̄ Dobhoff		to LIS, Brown drng, to (R) nare.			
		c̄ 3 ml/hr osmolite		Dobhoff to (L) nare, continuous @ 30 ml/hr			
GU	URINE	Foley to gravity c̄ dark		Foley to gravity. Pattiy out			
	COLOR/CLARITY	clear yellow urine in scant		small amounts of dark brown			
		amounts		urine c̄ sediment.			
CARDIOVASCULAR	CARDIACRHYTHM	Sinus tach c̄ ectopy,		Sinus tach continues. (-) ectopy,			
		HR 110s, Ø S3 murmur,		S1 S2 audible c̄ auscultation,			
		CVP 23-26, (+) pulses all		(+) peripheral pulses. Edema 3+			
		ext.		to all portions of body. (-) JVD noted.			

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)

PR [redacted] (b)(6)-2 LT, AN

DEPARTMENT/SERVICE/CINC CCU #1

DATE 21 Nov 03

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

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

- [ ] HISTORY/PHYSICAL
- [x] FLOW CHART
- [ ] OTHER EXAMINATION OR EVALUATION
- [ ] OTHER (Specify)
- [ ] DIGNOSTIC STUDIES
- [ ] TRETMENT

DATE 21 Nov 05 | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	06 24	07	08	09	10	05 11	06 12	07 13	1	08 14	09 15	10	11	18	19	20	21	
BP Arterial line	144/72	150/65	138/60	133/69	115/56	124/59	123/57	114/52	137/60	138/60	138/62	117/50	115/51	131/60	125/58	119/50	120/62	
BP Cuff																		
Temperature	96.8			97.5						98.5			98.3	98.4	98.4	98.3		
Pulse	115	110	110	113	115	112	113	116	115	115	111	114	111	112	107	105	109	
Respiratory Rate	29	30	30	30	30	30	30	36	31	31	32	30	30	30	30	30	30	
Vent Type	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
PIP	53	51	52	54	56	51	50	50	52	52	51	54	53	54	42	49	52	
PEEP	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	
FiO2	90	90	90	90	90	90	90	90	90	90	90	100	100	90	100	90	90	
CVP	23	26	25	22	23	24	22	24	22	22	21	20	21	20	18	17	22	
MAP	85	86	84	87	76	80	77	74	80	80	83	76	73	80	82	77	80	
SaO2	91	89	89	88	87	92	54	91	91	91	90	95	96	95	99	95	92	

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NaHCO3	150	150	150	150	150	150	150	150	1200	150	150	150	100	100	100	100	100	950
IVPB	102		50					100	250	50				102				152
Versed	10	10	10	10	10	10	10	10	120	10	10	10	10	10	10	10	10	80
Vecuronium	4	4	4	4	4	4	4	4	48	4	4	4	4	4	4	4	4	32
MSO4	8	8	8	8	8	8	8	8	96	8	8	8	8	8	8	8	8	64
Lasix	8	8	8	8	8	8	8	8	96	40	40	40	40	40	4	4	4	212
Tube Feeding	30	30	90	30	30	30	90	30	360	30	30	90	30	30	30	30	30	300
																		2590
TOTALS								21	2172									2590

OUTPUT																			
URINE	HOUR / TOTAL	14/14	4/15	15/33	15/48	10/58	7/65	8/73	7/80	8/88	9/	7/10	7/23	6/29	9/38	7/45	7/52	5/57	57
	SP gr																		
	S/A																		
NG	OUTPUT													900					900
	PH																		
	GUIAC-																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			957

POST-OP DAY

VITAL SIGNS

	22	23	24	01	02	03	04	05	
	140/68	108/43	132/65	131/65	158/81	119/51	122/58	140/71	
	[illegible]	98^2			98^3		98^7		
	101	112	108	106	109	110	107	109	
	30	30	30	30	30	30	30	30	
	SIMV	SIMV	SIMV	SIMU	SIMV	SIMV	SIMV	SIMV	
	54	58	50	51	47	59	60	56	
	15	15	15	15	15	15	15	15	
	90	90	90	90	90	90	90	90	
	23	20	18	16	20	21	22	19	
	91	66	85	83	100	75	81	90	
	90	92	90	93	86	98	91	91	

INTAKE

16	17	18	19	20	21	22	23	8°T
100	100	100	100	100	100	100	100	800
50		102						152
10	10	10	10	10	10	10	10	80
4	4	4	4	4	4	4	4	32
8	8	8	8	8	8	8	8	64
4	4	4	4	4	4	4	4	32
30	30	60	30	60	30	60	30	330
								1490

OUTPUT

16/16	10/26	5/31	8/39	12/51	4/55	7/62	8/70	70
		600					500	1100

1490
2172

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0530
MODE	SIMV
F_iO_2	90
TV	650
RATE	30
PEEP	15
ABG pH	7.283
PCO_2	63.5
pO_2	58
HCO_3	27
SAT	84
BASE	Ø

LABORATORY DATA

TIME	0530
CLUCOSE	155
Na/K	4.7
Cl/CO_2	103/22
BUN/Cr	112/2.8
WBC/PLATELET	23.5/317
Hct/Hgb	34.5/10.0

ACTIVITIES OF DAILY LIVING

TIME	0400
MOUTH CARE	[redacted]
BATCH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

	TIME				
TURN	2000 [redacted]	2200 [redacted]	2400 [redacted]	0200 [redacted]	0400 [redacted]
	0600 [redacted]				
SUCTION	2000 [redacted]	2200 [redacted]	2400 [redacted]	0200 [redacted]	0400 [redacted]
	0600 [redacted]				

24° 180 TOTALS

WT Yesterday — wt Today —

INTAKE		OUTPUT	
IV	6252	Urine:	207
Po	—		2000
TOTAL	6252	TOTAL	2207
		[BALAN]CE	6045

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

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0730	INTILAS [redacted]	1830	INTILA [redacted]		INTILAS
NEURO	PUPLIS	2.5 mm sluggish		2.5 mm, sluggish. PERRLA			
	SENSORIUM	paralyzed chemically		Neuromuscular blockade. Versed @ 4 mg/hr			
		c̄ Vec. 4 cc/h. Q mg/h		for analgesia. Versed @ 10 mg/hr.			
		Sedation: Versed @ 10 cc/h		MSO4 @ 8 mg/hr.			
		Analgesia: MSO4 gtt 1:1 concentrate					
RESPIRATORY	RESPIRATION PATTERN	Bilateral : MV		Equal Bilaterally			
	BREATH SOUNDS	~~[illegible]~~ Rhonchi scattered		Coarse lung sounds to lobes			
	SECRETIONS	c̄ Coarse lung sounds/rales		(B). ↓ breath sounds to bases.			
		to middle upper lobes. Bloody		beige. ETT @ 24 at lip. #8. SIMV			
		Secretions from ETT		572 F_iO_2, PEEP=15, SaO_2 95%, P.P. 51			
		ETT 8 24 @ lip SIMV TV 650		RR 30 peep 15 FiO2 to keep SaO2 90%			
SKIN	COLOR	Normal for race		Skin color normal for race.			
	INTEGRITY	Mult. Skin tears. Surgical		3+ pitting edema generalized. Generalized			
		Skin wound + 3 edema		wounds to abd & extremities. Surgical wounds to midline abd, (R) flank.			
IV SITE	LOCATION	(R) Fem Cath Start 11/19/03		(R) femoral cath. Started yesterday			
	CONDITION	(L) SC TLC		(L) subclavian TLC.			
		(R) RAO aline		(R) Radial art line. All lines			
		see notes for fluid		in tact. Art line & CVP record.			
		infusion + Pt's		All lines flushing & functioning			
		intact lines		c̄ s/s infection. Drsg to (R) femoral cath redressed 70 to body loose.			
GASTRO	ABDOMEN	large hard distended		Abd rotund, distended. (+) BS			
	BOWEL SOUNDS	~~[illegible]~~ (+) BS		Dobhoff to (L) nare. Tube feeds			
		DBH - (L) nare - TFF 30 cc/h		@ 30 cc/hr. NG to (R) nare. LIS,			
		NGT (R) nare - LIS - brownish drainage		drainage, dark brown drainage.			
GU	URINE	Foley + gravity		foley to gravity drainage, tea			
	COLOR/CLARITY	10-20 cc/hr yellow c̄		colored urine. UOP @ 10-20 cc/hr.			
		sediment		Lasix continues. Stool (+)			
CARDIOVASCULAR	CARDIACRHYTHM	S1 S2 distant (+) echo		S1 S2 audible, (-) ectopy noted.			
		ST 110's (+) pulses using		HR @ 110's. Pulses (+) x 4 c̄ edema.			
		Doppler due to edema		CVP & MAP stable.			
		Aline c̄ good waveform					

LEGEND
Cr - Creatinine
F_iO - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(b)(6)-2

(Continue on reverse)

[redacted] (Signature & Title) CPT /AN

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

DATE 20 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

ICU

	DX	06	07	08	09	10	11	12	13		14	15	16	17	HOSPITAL DAY 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	142/62	151/64	149/64	144/64	143/65	140/65	143/63	148/66		145/64	144/65	144/65	144/65	142/61	142/64	138/68	141/72		
BP Cuff																			
Temperature	97.4											95.7		95.8	95.8	95.7	95.7		
Pulse	111	113	115	110	110	114	112	106		112	107	108	110	115	111	106	104		
Respiratory Rate	30	30	30	30	30	30	30	24		28	30	13	28	13	30	30	30		
MAP	87	92	89	87	88	88	86	85		88	89	87	88	86	91	86	92		
CVP	17	18	19	18	19	16	18	23		19	23	19	21	18	21	20	26		
O_2 SAT	93	94	94	93	92	93	96	95		95	95	95	94	95	94	95	93		
FiO_2	90	90	90	87	87	87	87	87		87	87	87	87	87	87	87	87		
MODE	S	S	S	S	S	S	SIMV	SV		SIMV	SIMV	SIMV	S	SIMV	SIMV	SIMV	SIMV		
PEEP	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15		
PIP	48	48	47	48	47	50	47	46		46	45	47	47	51	48	47	49		
INTAKE																			
TIME	23 24	00 01	01 02	02 03	03 04	04 05	05 06	06 07	8°T	07 08	08 09	09 10	10 11	11 12	12 13	13 14	14 15	15	8°T
MIVF	150	150	150	150	150	150	150	150	1200	150	150	150	150	150	150	150	150	150	1200
IVPB	100		50						150	50				50		200			300
Dobutamine	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	—	—		60
Dopamine	9	9	9	9	9	9	9	9	72	9	9	9	9	9	9	—	—		54
VERSED	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10		80
VECURONIUM	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4		32
MSO4	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8		64
LASIX	40	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	40		320
T.P. OSMOL/HR	10	10	90	30	30	30	90	30	320	30	30	60	30	30	30	60	30		300
TOTALS									2318										2410
OUTPUT																			
URINE — HOUR	18	24	24	20	16	17	15	24	157	→	20	25	22	20	21	10	15		
URINE — TOTAL																			133
URINE — SP gr																			
URINE — S/A																			
NG — OUTPUT																			
NG — PH																			
NG — GUIAC																			
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			133

POST-OP DAY	22	23	24	01	02	03	04	05	
VITAL SIGNS	16	17	18	19	20	21	22	23	
	141/68	142/66	139/68	136/68	139/68	134/67	150/74	127/64	
		95.2	95.7	95.7	95.9	96.0	96.4		
	107	103	106	106	106	108	117	111	
	30	30	30	30	30	24	30	30	
	87	89	89	88	89	86	96	84	
	19	21	21	18	18	25	25	21	
	94	93	93	93	94	91	90	87	
	87	87	87	87	87	872	87	90	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	15	15	15	15	15	15	15	15	
	51	48	48	48	52	52	57	51	
JNTAKE	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	150	150	150	150	1200
	50		50						
	—	—	—	—					
	—	—	—	—					
	10	10	10	10	10	10	10	10	80
	4	4	4	4	4	4	4	4	32
	8	8	8	8	8	8	8	8	64
	40	40	40	40	40	40	40	40	320
	30	30	60	30	30	30	60	30	360
									1990
OUTPUT	— / —	24 / 24	19 / 43	2 / 45	19 / 64	9 / 73	17 / 90	7 / 97	97
			300					150	450
									547

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
TIME	0600									
MODE	SIMV									
F_IO_2	90									
TV	600									
RATE	30									
PEEP	15									
ABG pH	0422 7.228									
ABG PCO_2	57.2									
ABG pO_2	137									
ABG HCO_3	24									
ABG SAT	99									
ABG BASE	-3									

LABORATORY										
TIME	0422									
GLUCOSE	118									
Na/K	144 / 4.4									
Cl/CO_2	114									
BUN/Cr	99 / 5.9									
WBC/PLATELET	21.4 / 832									
Hct/Hgb	9.6 / 30.0									
PBSC	340									
PT	>150									
APTT	730									

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

TURN	TIME				
	2000	2200	2400	0200	0400
	0600				
SUCTION	2000	2200	2400	0200	0400
	0600				

24°180 TOTALS		NURSE'S SIGNATURE	INITIALS
WT Yesterday	wt Today	[redacted]	
INTAKE	OUTPUT	(b)(6)-2	
IV 6724	Urine:		
Po 0			
TOTAL 6724	TOTAL 837		
BALANCE +5887			

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

NEURO	TIME	0650	INTILA[redacted]		INTILAS	0815 INTILAS
	PUPLIS	2.5 mm sluggish				PERL 2 mm slow
	SENSORIUM	Vec. 4cch O Mort				chemically paralyzed
		MS04 8cc/h Versed/Ord.				
		Sclera - yellow				
RESPIRATORY	RESPIRATION PATTERN	(B) Equal: MV				VENTED Orally Intubated
	BREATH SOUNDS	Coarse Rales/Rhonchi				#8ET 24cm lip
	SECRETIONS	ETT via tube - thick secr				Breath Sounds diminished
	MODE	SIMV RR24 ETT 24cm lip				rhonchi rales to Mid
		FiO2 TV 750 peep 5 PO2				lobes. Sat 94% vigorous
		85% Sats 90-91				
SKIN	COLOR	normal for race				Normal
	INTEGRITY	dependent edema, +3 pitting				Multiple skin tears
		penis + scrotal edema, stump				Surgical wound Hidradenitis
IV SITE	LOCATION	(L) Sub TLC				(R) groin cordis
	CONDITION	Prox - CVP line				(D) SE TLC
		Distal: 9NS 20cc/h D5W @				(R) Rad a line.
		30cc/h/Kcl. Dobut.				See Notes for fluids & Pigs
		Medral Versed 10mg/h. Morphine 2mg/h				Sites intact.
		VOC 9mg/h. (R) Radial line				
GASTRO	ABDOMEN	loose distended gen				Salem Sump Tube [redacted]
	BOWEL SOUNDS	hypoactive BS				Now to suction Dopsy
		TF @ 10cc c Phrase [redacted]				tube then Right Nare with
		XRT Nare → LIS bilateral				Gastrostomy tube. BS hyperactive
GU	URINE	foley to gravity				Foley Cath
	COLOR/CLARITY	Amber c Sediment				14 Fch. yellow/clear
		<30°/ lasix @ 40 [redacted]				cm'
CARDIOVASCULAR	CARDIACRHYTHM	S1 S2 Distant c Rhythm				ST. HR 110-120's BP 75
		ST MAPS 160's-170's				Pulses [redacted] grossly edematous
		Pulses Dopplered in [redacted]				A-Lines (R) Radial and
		[redacted] all extremities				Dopamine drips. Dobutrex drip

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

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

DATE 19 NOV 03

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

[redacted] (b)(6)-4

ICU#1

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT