(b)(3)-1

.IENT TREATMENT RECORD COVER SHEE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION N/A		14. WARD ICW	
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN K78		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE BC	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0				22. HOURS OF ADMISSION 0615	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFER EPW HOLD	26. DATE OF DISPOSITION 06 SEP 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 08 JUL 03		ADMITTING OFFICER DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ FRACTURE LEFT PROXIMAL ULNAR ~~E922.3~~ E991.2
959.1 903.3

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	62	62

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
		0	0	62	62

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

COL, MC SSG, NCOIC, PAD

.TIENT TREATMENT RECORD COVER SHEE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		X	UNK	N/A	N/A	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4	N/A	ICW

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
0	0615	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFER EPW HOLD	06 SEP 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		08 JUL 03	DR (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ FRACTURE LEFT PROXIMAL ULNAR ~~E922.3~~ E991.2
959.1 903.3

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0	0	0	0	62	62

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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	62	62

(b)(6)-2

(b)(6)-2 COL, MC

(b)(6)-2

(b)(6)-2 SSG, NCOIC, PAD

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDCOM - 6412

.IENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A		10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION N/A			14. WARD ICW	
15. FLYING STATUS N/A	16. RATING/ OSG	17. DEPT./ BEN K78		18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE BC	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION 0					22. HOURS OF ADMISSION 0615	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFER EPW HOLD		26. DATE OF DISPOSITION 06 SEP 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 08 JUL 03		ADMITTING OFFICER DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: INTRA-ABDOMINAL, GSW, SMALL BOWEL & COLON INJURY, OPEN ~~TO~~ FRACTURE LEFT PROXIMAL ULNAR ~~E922.3~~ E991.2
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0	0	0	0	62	62

36. Total Days All Facilites

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		0	0	62	62

SIGNA (b)(6)-2

(b)(6)-2 COL, MC

(b)(6)-2 SSG, NCOIC, PAD

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

: 40 yo ♂ sp GSW Abdomen

Bib A/E - Awake, alert HD stable % Abd pain

No sig pmhx

PSHx : (R) hip replacement

$ fb

PHYSICAL EXAMINATION

116/60 P80

NAD

Chest CTA

CV : RRR

Abd : (+) peritoneal sign

Ext : (L) VEX wound

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

A/GSW Abd / (L) Arm

1/ emergent OR

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	2/8/07		

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Sep 03 1900	NARRATIVE SUMMARY 50 yo IRAQ, male civilian who suffered gunshot wound to the (L) ELBOW & abdomen as a bystander 08 JULY 2003. He suffered fracture of the Left Olecranon and Small Bowel perforation requiring Peritoneal Small bowel resection on Exp LAP and ORIF Left Olecranon. He developed an abdominal wound dehiscence 15 July 03. He was treated w/ an open abdomen with retention Sutures and allowed to heal by Secondary intention. He developed a grade IV Sacral Decubitus ulcer requiring operative Debridement and is currently undergoing BID wet-to-dry dressing chgs.
	ALLEGIES - None MEDS PMH
	TOB Ø CELEXA 20mg/day Depression
	PSH
	(R) Hip replacement
	VS - ✓. BP - 130/82 97.8°F T.
	ACTIVITY - AMBULATES WITHOUT ASSISTANCE
	DIET - REGULAR w/ Supplements

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		

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 July 03	Time arrived to ER @ 0617
	arrived c̄ O2 @ high flow
0613 BP 124/81	4 (GSW) to lt ↓ quad
pulse ox 99%	1 (GSW) to lt elbow
	~~foley cath~~ (b)(6)-2
BP 116/68 @0625	Chest + abd X-Ray ordered @ 0614
pulse @ 90	(b)(6)-4
O2 @ 98	IV 9% Sodium Chloride (R) arm
	Type + Cross, blood gas ordered (b)(6)-2
	femoral stick for bloodgas @ 0620
	labs drawn @ 0620, CBC, Chem 12, ~~UA~~ lytes, ABG, Type + Cross
	patient (b)(6)-4
	(L) elbow splinted @ 0620
	0624 pt put into trendelburg
	taken to OR by anesthesia
	@ 0631
	elbow X ray @ 0628 lateral
	ABG results - PH 7.332
	CO^2 38.7 PO^2 251 Bicarb HCO^3 21
	BE -5 SO^2 100% @ 0630
	.5cc tetanus given @ 0630 IM
	to OR @ 0631 1 gram ANCEF IV @ 0630

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

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed GSA/ICMR
FIRMP (3) 201-9.202-1

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 JUL 03	PREOP DX (L) OLECRANON GS FX
	POST OP DX SAME C̄ CORONOID FX
	PROCEDURE ORIF
	SURG (b)(6)-2 ANES (b)(6)-2
	TOTAL
	FLUIDS
	EBL 650 CRYST 5500 HESP 500 2u PC TT 106 @ 250mm
	IMPLANTS 2X 0.062 KWIRES TENSION BAND
	& CIRCLAGE C̄ #2 STERNAL WIRE STRANDS
	BRAIDED
	FINDINGS - COMMINUTED OLECRANON FX C̄
	EXTENSION RADIALLY INTO CORONOID PROCESS
	GROSS CONTAMINATION FROM MULTIPLE BULLET
	FRAGMENTS. NO NOTABLE SOIL CONTAMINATION
	CASE FOLLOWED 2X RAP C̄ SB RESECTION X2
	TO ICU FOR RECOVERY

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

LTC, MC
ORTHOPEDIC SERVIC

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.)*

(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

MEDICAL RECORD	PROGRESS NOTES
DATE	
8 JUL 1300	Admitted to ICU 50 yo Iraqi male c̄ dx of Ex lap, ORIF (C) elbow & bowel resection. Transferred from OR. Pt sedated but is Alert to verbal & tactile stimuli. Pupils pinpoint at this time 2mm c̄ ⊖ reaction. Resps even unlabored c̄ O2 @ 15L via non rebreather mask. Lung sounds diminished bilat bases. SpO2 100%. Color WNL skin warm/dry to touch. Mid abdominal incision covered c̄ DSD ⊘ drng noted. Drsg to LLQ c̄ bloody drng, mod amt. S1 S2 c̄ NSR. Peripheral pulses ⊕ 2 cap refill < 3 secs. Arterial Line inserted in (R) radial artery, zeroed on admission, line patent. 20 G IV in (R) AC ⊘ S/S infiltration, line patent. (L) arm wrapped c̄ gauze & ACE wrap, ⊘ S/S bleeding. BS ⊖ all quads, 18 Fr Foley catheter inserted drng dark amber urine. Moves all extremities. Will monitor per ICU protocol. (b)(6)-2 EPM
1315	c/mg MSO4 given IV for pain. (b)(6)-2 EPM
1330	Labs drawn via A-line & sent to lab. (b)(6)-2 EPM
1340	NG tube inserted, placement verified via gastric aspiration & air bolus. Hooked up to low intermittent Sx. (b)(6)-2 EPM
1415	2mg MSO4 given IV for pain (b)(6)-2
1430	Pt becoming more Alert. Opens eyes to verbal stimuli

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
cont	& tactile stimuli ——— (b)(6)-2 [redacted] CR
1515	4 mg MSO4 given IV for pain ——— (b)(6)-2 [redacted] CR
1520	O2 has been weaned ↓ to 7 LPM via mask. SPO2 remained 100% throughout. Will switch to N/C @ 6 LPM at this time. Continue to monitor SPO2 ——— (b)(6)-2 [redacted] CR
1615	4 mg MSO4 given IV for pain. O2 ↓ to 4 LPM via N/C @ 1545. SPO2 remains 100% ——— (b)(6)-2 [redacted] CR
1830	Pt. resting quietly in bed, NG tube flushed = 30 cc H2O, A-line zeroed, LR @ 150 cc/HR to (R) AC, (L) arm in splint, DRSG to (L) ABD has blood soaking through, midline ABD DRSG is CDI, O2 @ 4 LPM to NC, SaO2 100%, an ↓ O2 to 2 LPM, will monitor. ——— SPC (b)(6)-2 [redacted]
2030	NG flushed = 30 cc H2O. Pt. sats have stayed >98% = 2L via NC. Will titrate to RA. Will continue to monitor. ——— SP (b)(6)-2 [redacted]
2235	500 cc bolus of LR started for ↓ urine output. SaO2 has remained > 95% on RA. SP (b)(6)-2 [redacted]
9/21 0045	Pt. given 30 cc H2O via NG, SaO2 has remained >96% on RA ——— SPC (b)(6)-2 [redacted]
0300	Pt resting quietly in bed, responds to verbal stimuli. VSS. SPC (b)(6)-2 [redacted]
0400	Pt. given 30 cc H2O via NG tube ——— SPC (b)(6)-2 [redacted]
0410	100 cc output from NG over the note of a like-brown color ——— SPC (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/9/03 0500	Assumed care of patient. Labs sent @ 0530. assessment done see critical care flowsheet. Will continue to monitor (b)(6)-2 CPT/AN
7/9/03 1200	2mg MSO4 given for pain. Small amount of drainage noted to (R) elbow. CMS √s WNL. Will continue to monitor (b)(6)-2 CPT/AN
7/9/03 1300	4mg MSO4 given for pain c̄ mild increase in HR (b)(6)-2 CPT/A
7/9/03 1600	4mg MSO4 given for pain, patient resp is well c̄ encouragement (b)(6)-2 CPT/A
7/9/03 1700	Report given to oncoming shift (b)(6)-2 CPT/A

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES

DATE 9/21/03

1830 Received pt this pm in bed. Responsive to touch. Assessment done see DA 4700. NGT flushed c̄ 30cc water. SaO2 96% c̄ 2L NC. Foley to gravity. IV site patent c̄ LR @ 150cc/hr. A-line good wave form. will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 2000 Pt is sleeping. No distress noted at this time. SaO2 95% c̄ 2L NC. Unasyn started 3gm in 100ml NS IVPB. IV site patent. Will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 2100 Unasyn infusion complete. Pt is sleeping at this time. will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 2200 Zantac 50mg in 50ml NS IVPB started. NGT flushed c̄ 30cc water. SaO2 95% c̄ 2L NC. Pt is currently sleeping no signs of distress noted. Will continue to monitor (b)(6)-2 [redacted] 91WM6 (b)(6)-2 [redacted] 2230 Zantac infusion complete. USS. will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0045 Pt is sleeping. SaO2 97% HR104 Pt denies pain and discomfort. will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0200. Unasyn started IVPB USS. Swelling noted in pts (R) arm. Arm elevated. IV site patent. Will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0230 Unasyn infusion complete. Pt denies any pain at this time. SaO2 98% c̄ 4½L NC. NGT flushed c̄ 30cc water. Will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0400 Labs drawn A-line has (+) wave form. Pt USS SaO2 97% 4½L NC no distress noted (b)(6)-2 [redacted] 91WM6 SPC

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
10Jul03	0445 Pt is currently sleeping. VSS. SaO2 97% 4½L NC labs done. Will give report to ~~[illegible]~~ shift (b)(6)-2 [redacted] 91W M6 SPC
10Jul03 @ 0500	Received report from off-going shift. Pt lying in bed c̄ eyes closed. Resp even, unlabored. ~~IV~~ Arterial Pressure line into (R) Radial artery zeroed & flushed. HL in (R) AC infusing NS @ 150cc/hr. c̄ s/sx of infx. NGT to LIS draining ~~dark green/brown~~ drainage. Foley to gravity draining amber/clear urine. Surg incision dsg to mid abd CDI. (L) arm splinted and ACE wrapped. Some drainage (blood) noted @ site. Pt receives IVPB abx. P1 143/67 BP 155/65 P107 ~~R 32 SpO2 98%~~ 4.5L NC. Will try weaning pt from O2 ↓ to 4L @ this hour (b)(6)-2 [redacted] 91W20 M6
10Jul03 @ 0800	AM Labs Hct 24.1/Hgb 8.2 Dr. (b)(6)-2 [redacted] ordered 20mg Lasix IVP NOW. Given. UOP at this time 375cc clear/yellow. Will cont to monitor. Bed bath given. received 4mg MSO4 IVP for discomfort and tenderness @ surg site. Tolerated well. Foley care done ∅ s/sx of infection. SpO2 97% O2 ↓ to 3.5Lpm NC. IVF ~~LR~~ ↓ to 100cc/hr. (b)(6)-2 [redacted] 91W20M6
10Jul03 @ 0915	Pt OOB to chair c̄ assist x2, able to support weight but unstable. 300cc Clear, yellow urine emptied @ 0900. ~~Ater~~ Arterial line D/C'd per orders, pressure dsg applied over site. ~~HL~~ Δ'd to ~~AC (R) D/T noted~~ adema to (R) fa. LR infusing @ 100cc/hr. Pt. given 4mg MSO4 IVP for pain. O2 ↓ to 3L NC SpO2 96%. Will cont' to monitor (b)(6)-2 [redacted] 91W20 M6
10Jul03 @ 10:00	O2 ↑ to 4L D/T SpO2 of 94%. O2 sat p̄ Δ 96%. Pt' encouraged to deep breath. Emptied 725cc clear/yellow urine. CBC due @ 15:00 (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD

PROGRESS NOTES

DATE

10 July 03 Nutrition Note

O: 40 y/o ♂ S/P GSW; SB Resection

Diet: CL WT: estimated 15 kg

A: Pt c̄ increased nutritional needs 2° GSW and surgery. Portions of bowel resected should not pose a problem for digestion and absorption. Pt will benefit from nutrition supplementation p̄ diet progresses to regular.

P: 1) Will provide CIB as supplement TID p̄ diet progresses

2) Will monitor intake (b)(6)-2 MAJ, SP RD/LD

10 Jul 03 @ 1200 ~~10:30 O2 ↑ to~~ error SpO2 100% on 4LNC, O2 ↓ to 3.5L. Consumed 720 cc of CL diet. Ø c/o N/V. UOP ~~for p~~ since 10:00. 100 cc amber/clear. Will cont' to monitor (b)(6)-2 91W21 M6

10 Jul 03 @ 1500 CBC drawn taken to lab. Hct ↑ 25.3 from 24.1 and Hgb ↑ 8.3 from 8.2. Will notify Dr. (b)(6)-2 when he rounds. O2 @ 4LNC, SpO2 97%. Pt resting in bed. Resp even, unlabored. Infusing LR @ 100 cc/hr. into (R) AC c̄ s/sx of infx. Will cont' to monitor. (b)(6)-2 91W20M6

10 Jul 03 @ 1700 UOP 50 cc this hr. Report given to SPC (b)(6)-2 91WM6. (b)(6)-2 91W20

10 Jul 1730 Received pt this pm awake and responsive. Assessment done see DA 4700. Pt had c/o pain. Given 2 mg MS IVP as

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES

Medical Record

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

PROGRESS NOTES

DATE

10/21

ordred. Will continue to monitor pain level. Pt denied dinner plate at this time. Pt USS. SaO2 96% c̄ 4L NC. Pt has foley to gravity c̄ dark yellow urine. HR 104 RR 26 will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 1830 Pt currently sleeping. SaO2 dropped to 91% pt o2 turned from 4½L to 5L NC. SaO2 now 96%. HR 101 RR 26 will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 1915 Pt denies pain at this time. Pt is resting comfortably will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 2000 Unasyn infusion started pts USS SaO2 95% c̄ 5L NC will continue to monitor. 2030 Unasyn infusion complete. IU site patent c̄ no s/s of infiltration. Pt is currently sleeping no distress noted at this time will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 2230. Pt placed on NR mask @ 15L. Pt SaO2 dropped to 84%. Pt given 4mg ms for pain. Zantac in 50ml Ns given IUPB. Pt SaO2 now 99%. Will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0100 Pt on 40% 12L Vm. SaO2 97%. Pt denies pain at this time. HR 91 RR 23. Will continue to monitor. (b)(6)-2 [redacted] 91WM6 SPC 0200 Unasyn started 100ml IUPB. Pt is currently sleeping no distress noted SaO2 97% c 40% 12L VM. will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0300 Unasyn infusion complete. IU site patent c̄ no s/s of infiltration. Pt SaO2 97% c̄ 40% 12L VM. HR 92 Pt is sleeping at this time. No signs of distress noted will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0400 labs drawn on pt. Pt is currently sleeping no signs of distress noted. (b)(6)-2 [redacted] 91WM6 (b)(6)-2 [redacted] 0445 Pt is resting comfortably will give report to oncomming shift

4mg ms signs to oncomming s... (b)(6)-2 [redacted] 91WM6 SPC

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 6424

MEDICAL RECORD	PROGRESS NOTES

DATE

11Jul03@0500 Received report from off-going shift. Accepted partial carpuject c̄ 4mg MSO4 from SPC (b)(6)-2 91WM6. Pt lying in bed with eye closed, resp even unlabored. O2 @ 40% VM, SpO2 97%. Foley to gravity draining amber/clear urine, 80cc this hr. LR infusion @ 100cc/hr into (R) AC, s̄ s/sx of infx. (L) arm splinted & ACE wrapped c̄ small amt of dried blood noted around elbow. Inspiratory wheeps noted in lower right lobe. Ø cough Ø secretions. Encouraged to cough, deep breath. IS used while awake. Will cont' to monitor (b)(6)-2 91WZOMC

11Jul03@0630 CXR done. IS used, pt able to maintain 900cc/sec for ≈ 1.5 sec. x 6 before pt became fatigued. O2 Sat ↓ to 90% during use. VM replaced @ 35% SpO2 returning to 94% @ this time. Will cont' to monitor. Ø S/Sx of distress. (b)(6)-2 91WZO

11Jul03@0700 Feed pt breakfast consumed 50% Reg diet c̄ 370cc fluid intake and CIB. SpO2 ↓ to 87% while off VM, placed O2 5LNC SpO2 ↑ 95%. Pt seen by Dr. (b)(6)-2 & Dr. (b)(6)-2, ordered 20mg Lasix IVP, given @ 0700 and ↓ LR to 50cc/hr, done. UOP @ this hour 60cc dark yellow/clear urine. Pt to be seen by surg today for removal of (L) arm dsg then casted. Ø % discomfort @ this time. Will cont' to monitor (b)(6)-2 91WZ

11Jul03@0800 UOP 600cc light yellow/clear urine. Given 2mg MSO4 IVP for pain. P 104 R 29 SpO2 96% on 5L NC. Will cont' to monitor (b)(6)-2 91W

(continue on reverse side)

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

REGISTER NO.

ICU

PROGRESS NOTES
Medical Record

(b)(6)-4

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
11July03@09:00	Dsg Δ'd to (L) lateral abd. Small amt of serosanguinous fluid on dsg. site s̄ s/sx of infx. Redressed c̄ 4x4's. 800 cc UOP. SpO2 @ 99% on 5LNC. ↓ flow to 4L. (b)(6)-2 [redacted]
11Jul03@10:00	Pt ↑ OOB to chair c̄ assist of one. SpO2 ↓ 89% while transferring, returned to 97% ⊼ exertion. Pt encouraged to cough, deep breath. IS used @ ~~900~~ 900cc/sec x 4 600cc/sec x 6. UOP 325cc this hr. Will cont' to monitor (b)(6)-2 [redacted]
11Jul03@11:00	Dr. (b)(6)-2 [redacted] removed (L) arm dsg. site appeared s̄ s/sx of infection. Ortho tech rewrapped site and casted. (+) pulses ~~cell~~ cap refills <3 secs, pt can 'wiggle' fingers. Pt returned to bed prior to procedure. SpO2 ↓ to 94% during exertion returned to 98%, O2 4L NC. Will cont' to monitor (b)(6)-2 [redacted]
11Jul03@12:15	Pt consumed 30% of Reg diet and 300cc of fluids. Ø CIB this meal. Given 2mg MSO4 IVP for pain. P 100bpm R 29 SpO2 95% on O2 4LNC. UOP 40cc this hr. Will cont' to monitor. (b)(6)-2 [redacted]
11Jul03@1500	Pt given IS, encouraged to cough, unable to bring up mucous. Took in 120cc H2O @ this time. SpO2 ↓ to 93% during IS use, has returned to 95%. (b)(6)-2 [redacted]
11Jul03@1550	Got pt ↑ OOB, amb approx 40 ft. c̄ assist x2 unsteady, shuffle. Returned to bedside noticed foul odor, brown (tan) discharge from abd surg site. Dr. (b)(6)-2 [redacted] notified pt returned to bed. MD removed staples from around ~~s/c~~ drainage and removed approx 3-5cc of drainage. Packed c̄ 2x2 and covered. pt placed on NPO. Given 4mg MSO4 IVP for pain. SpO2 ↓ 90% unable to ↑ c̄ 40% VM, ↑ to 50% VM SpO2 @ 96% P102 R 24 127/64. Temp 101.1 T. UOP 100cc this hour. Will cont' to monitor (b)(6)-2 [redacted]

STANDARD FORM 50

MEDICAL RECORD	PROGRESS NOTES

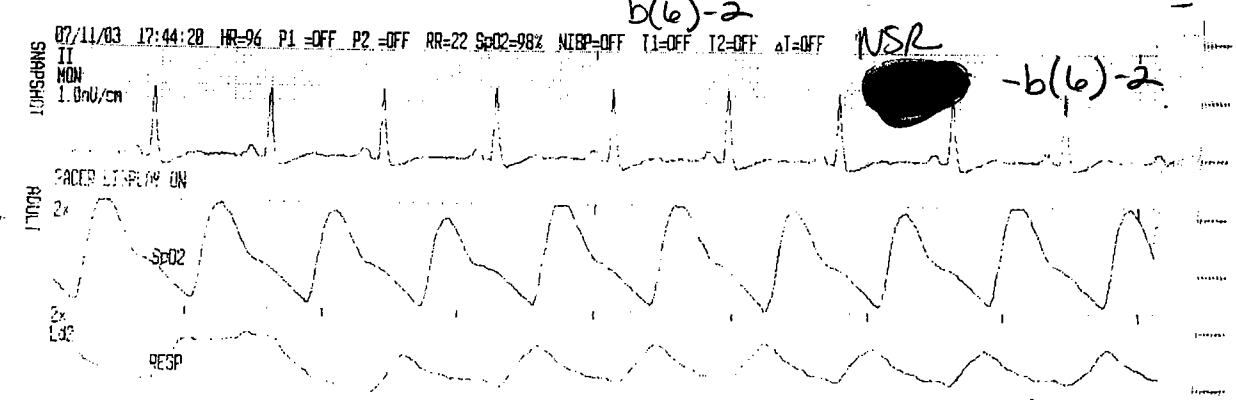
DATE

11 Jul 03 @ 1735 Report given to on-coming shift. Handing off remain (b)(6)-2
MSO4 (4mg) to 1LT [redacted] (b)(6)-2 [redacted] acu m

1735 client in bed connected to cardiac monitor, on 50% VM
O2 sat 98%, LR infusing via (R) AC PIV, Foley patent and
draining dark yellow urine, client c̄ eyes closed b(6)-2 [redacted]

1800 Complete assessment done, see DA form 4700, client c̄ coarse
crackles bilat lungs, good pulmonary toilet done, O2 sat ↓91%
on 50% VM, will monitor closely. Abdomen c̄ large midline
dressing, also drsg to left lower abdomen, all dry + intact.
Cast type drsg to left hand, unable to palpate left radial pulse
due to cast, cap refill to fingers 2secs, able to wiggle fingers.
[redacted] 1LT AN

b(6)-2



[redacted] -b(6)-2

b(6)-2

1830 O2 sat 95% on 50% VM, client resting quietly [redacted] 1LT AN

1930 Dr [redacted] @ bedside, removed staples x3 from lower abdomen, small amt thick
tan drainage noted, medicated c̄ 4mg MS for pain, drsg change done by MD, notifie
of thick yellow sputum, orders obtained. ~~Continue on reverse side~~ [redacted] 1LT AN

b(6)-2

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

REGISTER NO. b(6)-2

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PROGRESS NOTES
Medical Record

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b6-2

#0034

PROGRESS NOTES

DATE	
11 July 03 2000	pulmonary toilet done, good effort c̄ deep breathing and cough moderate amt thick yellow sputum, lungs clear p̄ coughing — (b)(6)-2
2100	O2 sat 96% on 50% v/m, decreased O2 to 40% at this time — (b)(6)-2
2115	O2 sat 97% on 40% v/m. — (b)(6)-2 LTX
2200	OOB c̄ one assist, ambulated, gait slightly unsteady and slow, up in chair. — (b)(6)-2 LTXN
2330	Back to bed @ 2320, wet to dry dressing done to abdominal wound. after premedicated c̄ 4mg MS IVP for pain. wound appears pink and tan. Large amount of blood tinged tan drainage noted on old dsg. client tolerated well. IS done c̄ good effort, productive strong cough c̄ large amt thick yellow sputum. lungs cleared post cough. — (b)(6)-2 LTXN.
2400	No changes in previous assessment, lungs clear bilat O2 Sat 95% on 40% vm. — (b)(6)-2 LTXN
12 July 03 0200	Client asleep at this time, VSS — (b)(6)-2 LTXN
0400	Client awake, c/o pain to abdomen, medicated c̄ 4mg MS IVP, IS x10 c̄ good effort, C&DB done, productive cough c̄ large amount thick yellow/greyish sputum. O2 sat 90% on 40% vm. oxygen decreased to 35% on venti mask at this time — (b)(6)-2 LTXN.
0415	O2 sat ↓ 89% on 35% venti mask, increased FiO2 to 40% will monitor. — (b)(6)-2 LTXN
0430	O2 sat ↑ 95% on 40% venti mask — (b)(6)-2 LTXN
0450	blood drawn from right hand and sent to lab — (b)(6)-2 LTXN
0500	Report given to oncoming shift, 2mg MS handed over to SSG Irby, client in bed c̄ eyes closed connected to monitor and oxygen. — (b)(6)-2 LTXN

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USAPPC-V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

11 JULY 03 ORTHO

S NO C/O

O WOUND CLEAN

NVI

LAC PLACED

A STABLE

P CASTING FOR 3WK, THEN SPLINTING C̄ P.T.

FOR ROM EXERCISES UNTIL UNION. WILL

NEED STAPLES REMOVED BETWEEN 15 & 18 JULY.

(b)(6)-2

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

7/15/03 Op Note

Procedure Washout / Escap

incidental appendectomy

Sing Matrix

Air WEA

Flush, 2000LR

EBL 100

Findings = ϕ abscess,

ϕ leak

? hypermic appy - taken out

To Tech, Arch

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES

Medical Record

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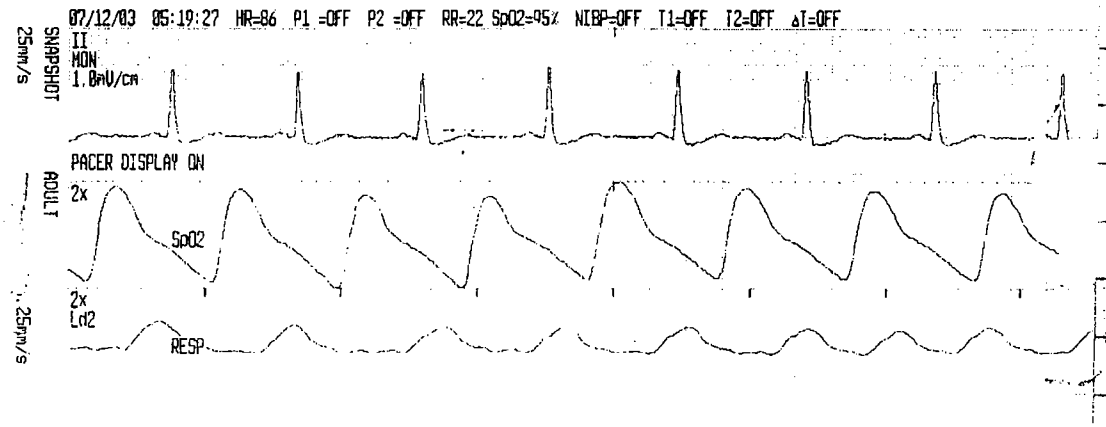
MEDICAL RECORD	PROGRESS NOTES

DATE

12 Jul 03



0605 - Report recieved from LT (b)(6)-2 Pt sleeping in bed. VSS see above and DA 4700 for assessment (b)(6)-2

0700 - Pt OOB to chair. Pt denies any pain. AM care done. Incentive spirometer done. O_2 ↓ to 25% pt maintained S_aO_2 @ 90%. O_2 ↑ to 40% S_aO_2 92%. Pt now sitting in chair comfortably (b)(6)-2 SSG/LPN

0730 Pt back into bed. Pt OOB for about 50 min. Pt tolerated well. Pt now resting comfortably. PS S_aO_2 94% (b)(6)-2 SSG/LPN

0900 - Pt resting in bed, denies pain. RS done - DT heard productive cough, thick yellow sputum. (b)(6)-2 LPN

0910 - 20mg Lasix given per Dr. (b)(6)-2 order. (b)(6)-2 SGT/LPN

1000 - Dressing Δ performed - 2mg MSO_4 administered. When old dressing was removed, bloody green & brown thick exudate was noted. Pt tolerated dressing Δ well. (b)(6)-2 SGT/

1100 - Pt OOB to chair - Δd to NC @ 6lpm - did not maintain sats >90%, switched back to Venti mask @ 40%. (b)(6)-2 SG LP

Continue on reverse side

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

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WARD NO. ICU

PROGRESS NOTES
Medical Record

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(b)(6)-4

(b)(6)-4

PROGRESS NOTES

DATE	
12Jul03 1300	Pt resting comfortably in bed. Ø c/o pain or discomfort at this time. (b)(6)-2 SGT/LPN
1500	Pt awake - IS performed. O_2 ↑d to 50%. 2° sats ↓ to 90% on 40% O_2 (b)(6)-2 LPN
1630	Type & cross drawn for transfusion of 2 units of blood. Taken to lab. (b)(6)-2 SGT/LPN
1700.	Report given to oncoming shift. ↓d O_2 back to 40%, still sats > 95% (b)(6)-2 SGT/LPN
1815	First bag PRBC hung. Y-tubing primed c̄ NS. IV site patent no s/s of infiltration. Will monitor VS for 30min q5min. Lungs clear to auscultation. VS T 100.9 HR 100 BP 134/68 SaO2 96% c̄ 40% VM. Will continue to monitor (b)(6)-2 (b)(6)-2
	1820 - BP 123/70 HR 102 SaO2 96% T 99.3 1825 BP 130/64 HR 97 SaO2 97% T 99.5 Maintenance fluid Δ from LR to NS to infuse over duration of transfusion. (b)(6)-2 (b)(6)-2 SPC
	1915 Pt T is 99.2. New IV started 18g @ hand LR @ 50cc/hr infusing. IV sites are patent. VS 1830 BP 129/73 HR 101 T 99.3 1845: BP 131/74 HR 97 T 99.5 1900 BP 131/71 HR 99 T 99.5 1915 BP 132/70 HR 92 SaO2 97% T 99.2 VS now q30min will continue to monitor. (b)(6)-2 SPC 1945 Pt resting in bed. Blood infusing. IV site patent. Pt has no s/s of reaction / distress. SaO2 96% c̄ 40% VM. Will continue to monitor (b)(6)-2 SPC 2000 VS 127/70 HR 97 RR 30 SaO2 97% c̄ 40% VM Pt in no signs of distress at this time. Will continue to monitor (b)(6)-2 SPC 2030 Unasyn infusion started. IV site patent no s/s of infiltration VS BP 124/68 HR 95 SaO2 97% c̄ 40% VM T 99.5 →

W0018 03 002270 Y

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES

DATE

12/2/03 will continue to monitor. (b)(6)-2 9/1 MG SPC 2100 VS BP 129/72 HR 96 SaO2 97% T 99.2° pt has no signs of discomfort at this time will continue to monitor. (b)(6)-2 9/1 MG SPC 2130 Completed first PRBC c̄ no complications. pt given 40 mg lasix IV as ordered. Will continue to monitor (b)(6)-2 (b)(6)-2 9/1 MG SPC 2200 Second bag PRBC started VS 137/76 HR 94 T 99.5 SaO2 97%. Hyperm 5000 U given 2nd bag PLPB infusion started.

2453913 IV sites are patent c̄ no s/s of infiltration will continue to monitor (b)(6)-2 9/1 MG SPC 2215 VS 136/70 HR 95 SaO2 97% T 99.6 no s/s of distress/reaction will continue to monitor. (b)(6)-2 9/1 MG SPC 2220. Pt urine output P lasix 900 cc clear yellow urine. will continue to monitor (b)(6)-2 9/1 MG SPC 2230 VS 130/70 HR 96 T 99.4 will continue to monitor (b)(6)-2 9/1 MG SPC 2245 VS 128/72 HR 91 T 99.3 Will continue to monitor (b)(6)-2 9/1 MG SPC 2300 VS 131/73 HR 95 SaO2 96% c̄ 40% VM. Pt no s/s of distress at this time. Urine output this hr 1400 cc clear yellow urine. Will continue to monitor (b)(6)-2 9/1 MG SPC 2330 VS 126/71 HR 93 SaO2 97%. No s/s of distress at this time will continue to monitor (b)(6)-2 9/1 MG SPC 2400 VS 131/70 HR 94 T 99.3 no signs of distress noted. IV site patent will continue to monitor (b)(6)-2 9/1 MG SPC 2430 Dsg Δ done on midline incision site. Drainage noted from top of incision white in color and malodorous. drainage also

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
13 Jul 03	noted in med drainage site. Site irrigated and packed c̄ moist dsg's and covered. Urine output this hour 700cc clear yellow urine. Will continue to monitor. (b)(6)-2 91WMG 0130 VS 128/72 HR 90 T 97.9 No signs of distress noted at this time. SaO2 97% c̄ 40% VM. Will continue to monitor (b)(6)-2 91WMG SPC 0145 2 unit PRBC complete. Pt has no S/S of reaction, Afebrile HR 88 127/72 IV site D/C after infusion 18g sit in (R) hand remains patent. Lung sounds clear to auscultation. Will draw CBC. pt has no complaints at this time will continue to monitor (b)(6)-2 91WMG SPC 0200 Mannitol infusion started IV site patent will continue to monitor (b)(6)-2 91WMG SPC 0245 pt taken out of bed and sat in chair. SaO2 95% c̄ 40% VM. CBC drawn and sent to lab pt has no signs of distress at this time will continue to monitor (b)(6)-2 91WMG SPC 0315 Pt placed back in bed. VSS SaO2 95% c̄ 40% VM. No distress noted will continue to monitor (b)(6)-2 91WMG SPC 0445 Pt is currently sleeping VSS SaO2 95% c̄ 40% VM no signs of distress noted at this time. Will give report to oncomming shift (b)(6)-2 91WMG SPC
13 Jul 03 @ 0500	Received report from SPC (b)(6)-2 91WMG. Pt lying in bed c̄ eyes closed, resp even, unlabored. VM @ 40% SpO2 95% Pt awakens easily. Ø A.M. labs drawn. Placed on VM @ 35% SpO2 @ 95% will cont' to wean from O2. IVF ~~NS~~ LR @ 50cc/hr. infusing into (R) wrist Ø s/sx of infx/infiltration @ site. Foley to gravity draining amber/clear urine UOP 100cc this hour. Will cont' to monitor (b)(6)-2

STANDARD FORM 50

MEDICAL RECORD	PROGRESS NOTES

DATE

13 Jul 03 @ 0650 Pt given bed bath. Dsg Δ'd to surg sites. Dr. [(b)(6)-2] present removed ≈ 10 staples from upper incision. Draining ≈ 2cc light tan drainage. Opening packed c̄ sterile 2x2's and covered. Pt given 4mg ~~for~~ MSO4 IVP for discomfort. SpO2 97% pt placed on O2 4L NC. Will cont' to monitor. [(b)(6)-2] 91W20 MG

13 Jul 03 @ 0715 Pt ↑ OOB to chair c̄ assist of x 1. (L) arm in sling + pulses to extremity. Given 2mg MSO4 IVP for discomfort. Consumed 50% of Reg diet c̄ 240cc milk & CIB + 250cc H2O. SpO2 95% while up. [(b)(6)-2] 91W20 MG

13 Jul 03 @ 0845 Pt returned to bed c̄ assist x1. SpO2 95%. O2 ↓ to 3.5L NC. Will cont' to monitor [(b)(6)-2] 91W20 MG

13 Jul 03 @ 10:00 Pt lying in bed c̄ eyes closed. Resp even, unlabored. SpO2 @ 97% on 3.5L NC. [(b)(6)-2] 91W20 MG

13 Jul 03 @ 10:10 Given 2mg MSO4 IVP for discomfort [(b)(6)-2] 91W20 MG

13 Jul 03 @ 11:20 SpO2 98% on 3.5L NC. O2 ↓ to 3L NC Will cont' to monitor [(b)(6)-2] 91W20 MG

13 Jul 03 @ 12:00 Consumed only ~~of~~ a few bites of Reg diet. Took in 240cc milk c̄ CIB. O2 Sat ↓ to 93% on 3.5L NC while eating. O2 ↑ to 3L NC. Will cont' to monitor [(b)(6)-2] 91W20 MG

13 Jul 03 @ 12:15 SpO2 96% @ 3L NC. O2 ↓ to 2.5L NC [(b)(6)-2] 91W20 MG

13 Jul 03 @ 13:00 Pt ↑ OOB to chair c̄ assist x1 SpO2 95% on 3L NC. Given 2mg MSO4 IVP for pain [(b)(6)-2] 91W20 MG

13 Jul 03 @ 14:00 Pt @ BSC producing ~~fat~~ flatus Ø BM. Returned to bed O2 3L NC SpO2 95%. Took in 250cc H2O [(b)(6)-2] 91W20 MG

(Continue on reverse side)

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

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WARD NO.

[(b)(6)-4]

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
13Jul03 @ 1530	O_2 ↓ 2LNC, SpO_2 95%. Pt lying in bed, quiet. Resp even, unlabored. 0 % discomfort @ this time — [redacted] 91W20 MG
13Jul03	1800 Received pt this Pm in bed resting. Assessment done See DA4700. Pt ate small amount of dinner and had 400ml PO water and CIB. Pt has no s/s of distress at this time will continue to monitor [redacted] 91WMG SPC 1900 Pt ambulated OOB to chair. USS SaO_2 95% IS done 10x. No distress noted at this time will continue to monitor [redacted] 91WMG SPC 2100 Unasyn infusion started IU site patent c̄ no s/s of infiltrat Pt is currently resting SaO_2 97% c̄ 3LNC no signs of distress noted. Will continue to monitor [redacted] 91WMG SPC 2230 Dsg Δ preformed. Pt given 2mg ms as ordred prior to Δ and 2mg @ 2230 P̄ Dsg Δ. Pt denies any pain at this time. Site clean mild drainage no odor noted. Dsg initialed and dated. Zantac started at 2200. IU site patent no s/s of infiltration will continue to monitor [redacted] 91WMG SPC 2430 pt is currently sleeping SaO_2 98% c̄ 2LNC. USS. No signs of distress noted will continue to monitor [redacted] 91WMG SPC 0200 Unasyn infusion started IU site patent. Pt is sleeping USS SaO_2 97% c̄ 2L NC. will continue to monitor [redacted] 91WMG SPC 0300 Unasyn infusion complete IU site patent flushed. Pt stated pain at incision site. 4mg ms given as ordred for pain IVP. USS. SaO_2 96% 2LNC. Will assess pain level [redacted] 91WMG SPC 0335 Pt currently sleeping USS SaO_2 97% c̄ 2LNC. No signs of distress noted will continue to monitor [redacted] 91WMG SPC 0430 Labs drawn Pt is resting no signs of distress noted. Pt ↓ pain at incision site given 2mg ms as ordred used 10mg ms throughout

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

14 JUN shift. Will continue to assess pain level (b)(6)-2 [redacted] 91WM6 SPC (b)(6)-2 [redacted]

0445 Pt is currently sleeping no distress noted USS will give report to uncomming shift (b)(6)-2 [redacted] 91WM6 SPC

0525 Pt being transferred to ICW report given to ICW staff (b)(6)-2 [redacted] 91WM6 SPC

15 July 03 @ 0120 Nsg shift assessment: Pt dressing was changed last evening at approx 2100. Midline (unsutured area) dressings had drained a moderate amt of serosanguinous fluid. Area appears reddish pink. Pt did not c/o pain during dressing change, but at approx 1830, required 4mg PRN morphine. O_2 Sats are above 98%, resps are even and unlabored. Appears to be asleep at this time, will continue to monitor (b)(6)-2 [redacted] AN

0150 NSg: Pt foley bag emptied of 1200 cc of dark tea colored urine (b)(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

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

DATE	NOTES
16 July 03	Report recieved from dayshift - Pt lying in bed awake
1800	follows commands - VSS 122/68 P-100 R-26 shallow P.O. 96%
	3L NC IVF LR @ 100cc/hr into (R) 18G IVcath NGT to
	LIS (suction on) IS at bedside Dsg to midline abd
	Ad today by surgeon C, D and I - absent BS Pt NPO
	c̄ sips - Peripheral Pulses Palpable (+) pedal edema
	1600 Lasix given IV (1200cc out time now 1800) Lungs CTA
	coughing episode x1 (non-productive)
1900	Pt. used IS c̄ good results Temp 100.7 (T)
	Dayshift states surgeon aware ∅ tylenol order written
	MSO4 for pain @1830 — (b)(6)-2 [redacted] SGT1WMS
2000	Pt tolerating sips H2O - Foley to Gravity draining clear dark
	yellow urine NGT LIS - Pt using IS while awake
	Pt OOB - moving slowly guarding stomach - Dsg still
	intact ∅ gross blood will continue to monitor (b)(6)-2 [redacted]
2100	Pt. enc. to cough and deep breath - Temp still 100.7 (T)
	HOB ↑ 30° - Pt seems comfortable in this position
	Heparin SQ and IV unasyn started - Pt awake
	Vital Signs Stable 125/72 P-116 P.O. 96% 3L NC (b)(6)-2 [redacted] SGT1WMS
2230	IS used - IV LR 100cc/hr infusing - NGT LIS
	apparatus on - Foley draining ∅S urine - (b)(6)-2 [redacted] SGT1WMS

RELATIONSHIP TO SPONSOR: 2245 - Cap

SPONSOR'S NAME: LAST refill to fingers on FIRST cast arm brisk MI - fingers

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE: warm - not painful - Pt's complaints

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)

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

(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)

MEDCOM - 6437

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0030 17JUL03	Dsg to abd incision Δd - wound packed by staff earlier in the day - 4x4 and tape to wound - NGT flushed c̄ 60 cc sterile water tube patent (+) return ϕ blood noted Zantac IVPB infused into IV site s̄ difficulty Pt tolerating sips of water - (−) BS noted IS enc - pt consistently raises the 900 per sec ball on IS - Pt positioned in bed for comfort (b)(6)-2
0200	Pt sleeping, VSS, NGT LIS minimal output, Foley to Gravity draining QS urine will continue to monitor - Temp 99.7 (T) 4mg MSO4 for pain (b)(6)-2
0245	Pt positioned in bed - Temp 99.5 (T) - Pt. used incentive Spirometer still 900 cc per second 2 balls - NGT LIS - Pt still tolerating sips the BS noted. Dsg to abd CDI (b)(6)-2
0300	Neuro checks to (L) fingers cap refill brisk < 2 sec. fingers pink warm, ϕ pain Pt. s̄ complaints to (L) arm (b)(6)-2
0400	Labs acquired sent to Laboratory CBC, Chem 8 - IS used at time of blood draw. weak effort, 600 cc one ball raised NGT flushed 30 cc sterile water (b)(6)-2
0500	Pt report given to day shift - Pt. awake ~~sleep~~ error Vital signs stable 120/64 HR-94 Pulse ox 94% Lungs CTA - diminished bases shallow breaths

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(−) BS - ϕ in this shift ϕ [illegible] ce stated Thru interp (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17 July 03 @ 0500.	Received report from off-going shift. Received Tmg MSO4 from SGT (b)(6)-2 91WM6 Pt lying in bed c̄ eyes closed, resp even, unlabored. SpO2 96% on 3L NC. NGT c̄ green drainage @ LIS. Foley to gravity, draining clear, ~~yl~~ yellow urine. LR infusing into (R) AC @ 100cc/hr. Pt uses IS s̄ difficulty unable to lift 3rd blue completely. Encourage to cough, expectorated sputum c̄ dark ~~flect~~ flecks. Dsg to midline abd site c̄ pink drainage visible in cover dsg, awaiting MD for dsg Δ. (+) pulse in all extremeties (L) arm cast c̄ (+) pulses, ~~call~~ cap refills <3 sec. (−) bowel sounds. Ø flatus or BM per pt statement via 1 interepreter. Will cont' to monitor (b)(6)-2
17 July 03 @ 0730	Encouraged use of IS, unable to move 3rd blue. Ø c/d SOB or discomfort. Will cont' to monitor (b)(6)-2 91W20
17 July 03 1000	Nutrition Note F/V A: Pt currently NPO and has had marginal intake since admission. Given trauma and surgeries pt has undergone he is at high nutritional risk and a good candidate for nutritional support. We have a number of formulas available if feedings are needed

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)*

(b)(6)-4

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 July 03 1000	Nutrition Note (cont)
A:	to improve nutritional status.
P/R	Recommend Tube feedings to promote wound healing if intake doesn't improve p̄ feedings resume.
	(b)(6)-2 MAJ, SP RD/LDN
17 Jul 03 @ 1030	Pt ↑ OOB → chair c̄ assist x'l. Dsg Δ per Dr. (b)(6)-2
	Pt given 4mg MSO4 IVP for discomfort. SpO2 95% on 3LNC
	(b)(6)-2
17 Jul 03 @ 1300	Pt returned to bed. Ø c/o discomfort. SPO2 95% of 3LNC.
	(b)(6)-2
17 Jul 03 @ 1645	Radiology for abd x-ray as ordered. (b)(6)-2
1740	Received report from SGT (b)(6)-2 pt. resting in bed c̄ eyes open. Responds appropriately to verbal commands despite language barrier. Pupils 3mm + Θ, O2 @ 2LPM via NC, NG to LIS c̄ brown fluid coming out, pt. is NPO c̄ sips of H2O allowed. ↓ Respon to bases of both lungs, wet-crackling sound can be heard. Pt. used incentive spirometer @ this time c̄ some encouragement. IV to (b)(6)-2 (R) AC, 18 G c̄ LR @ 100 cc/HR. (L) arm is in a cast up to the bicep, unable to feel for pulse. Midline incision saturated serro-sanguinous fluid, changed by Dr. (b)(6)-2 this time. (+) pulses x1 ↑ extremity + x2 ↓ ext., cap. refill <3 sec x4 ext. DRSG to (L) ABD CDI. Foley to gravity draining dark yellow urine. SPC (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 July 03	
1740	⊖ BS, ⊖ BM, ⊖ flatus @ this time also.
	USS. 3PC (b)(6)-2
2000	Pts. O_2 ↑ to 4LPM due to SaO_2 dropping to 78,
	SaO_2 increased to 98%. Pt. spitting up large
	amounts of phlegm of a dark brown, thick
	nature. Dr. (b)(6)-2 notified due to Dr. (b)(6)-2
	not being found. UO taken from Dr. (b)(6)-2
	@ this time. USS. Will notify Dr. (b)(6)-2 to
	when he is found. Pt. encouraged to use
	IS @ this time, which he did. 3PC
2110	Dr. (b)(6)-2 informed of pts. phlegm being thicker
	brown + of Dr. (b)(6)-2 UO for basis. 3PC (b)(6)-2
17 July 03	Patient c/o pain to midline incision. Medicated c̄ 2mg morphine
2200	IVP. Encouraged use of incentive spirometer, elevated 2 balls
	c̄ effort. Lungs CTA to anterior fields post basis. Response with
	urine output of 500cc this hour. O_2 sats remain 95% and greater
	on 4LN/C. Remains in NSR c̄ ectopy. Will continue pulmonary
	toilet and medicate for pain as needed. (b)(6)-2 mgm
0030	Patient repositioned in bed. Coughing up brown tinged sputum. Given
	Yankauer suction for use. Dressing reinforced c̄ 8x4" gauze due
	to excessive serous, sanguinous drainage. Medicated c̄ 2mg MSO4 (b)(6)-2 mgm

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)*

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(b)(6)-4

(b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1811	Pt. resting quietly in bed, easily awakens, USS.
0200	Ø% pain, Ø% coughing ——— SPC (b)(6)-2
0440 ~~0340~~	Pt. resting quietly in bed, Ø% pain, Ø% coughing, incentive spirometer was encouraged c this time. USS. ——— SPC (b)(6)-2
0500	4/mg MSO4 + report given to CPT (b)(6)-2 ——— SPC (b)(6)-2
18 July 03 0600	NN: assumed care of patient. Neuro: patient awake, follows basic commands, pupils 3-4mm brisk reaction to light, pain control c̄ MSO4 Q 2-3°. Resp: lung sounds coarse esp on expiration. Improve slightly c̄ TCDB. Using IS Q 2° c̄ encouragement. Productive cough c̄ thick brownish secretions. Resp rate slightly increased, at times mildly labored, sats 95-97% on 4L NC. CV: Skin warm + dry, afebrile. HR 80-90's, pulses palpable, B/P stable. GI: Abd firm, slightly distended, tender to touch esp. @ incision. BS hypoactive, Ø stool. NGT to LIS with moderate to large amounts thin green/brown drainage. Flushing Q 4° c̄ 30cc NS. GU: foley c̄ clear dark yellow urine approx .5-1 cc/kg/hr. Lines: 18g to (R) FA c̄ LR @ 100cc/°. Skin: Midline abd dsg, saturated c̄ foul smelling brownish drainage, outer dsg Δed. Cast to (L) UE over ORIF, CMSV's to distal ext WNL. Meds: Zantac, cefotetan 10PB, Fluconazole PO, Heparin SQ. Plan: continue to monitor (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 July 03 0800	NN: Patient O2 sats worsening. Now needs NRB @ 10L to maintain sats >90%. Lung sounds clear on (L), absent on (R) RT here, gave neb, performing chest PT. (b)(6)-2
18 July 03 0810	NN: Sats improved, now 98% on 6L NC, productive cough c̄ thick clear sputum. Will recommend CPT c̄ nebs Q 4°, next due 1200. (b)(6)-2
18 July 0800 Resp Therapy	HHN Tx given c̄ 0.5 Albuterol and 2.5 NSS. BBS for improved to (R) lobes and clear on Left. HR 104-109, O2 SAT on 12 L/min NRB mask 91%. P̄ Tx BBS for improved to (R) but decreased. CPT done to (R) lung segments. Pt c̄ weak effective cough for small amount thin clear secretions. Pt instructed on deep cough with splint to abdomen. Pt effort weak. Returned to NRB @ 12 L/m. HR 106 O2 SAT 92-93% RR 20-24. Pt in no obvious Resp distress. (b)(6)-2
18 July 03 0830	4mg MSO4 given for incisional pain post CPT; patient up to chair (b)(6)-2 CPT/A
18 July 03 0910	Sats still in Low 90's c̄ 12L O2 via NC, gave 40mg Lasix IVP. (b)(6)-2 CPT/AN
18 July 03 1010	Good uop from lasix. Given diflucan per NGT clamped x 30 min (b)(6)-2 CPT/AN
18 July 03 1030	AM care done (b)(6)-2 CPT/AN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: 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.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 July 03 1100	Small liquid brown stool, NGT D/C per Dr (b)(6)-2 Will continue to monitor (b)(6)-2
18 July 03 1200	IVF to 30cc/°, started on clear liquid diet. CPT + neb done per RT (b)(6)-2
18 July 03 1200	HHN Tx given c̄ 0.5 Alb/2.5 NS via aeromask. HR 109-112
Resp Therapy	RR 30's stable. BBS for ↓↓ to R lobes and clear on (L). CPT given x 5 mins to (R) lung segments. Pt c̄ strong productive cough for small amount thick brown secretions. P̄ Tx BBS for bilat breath sounds coarse throughout, HR 112 RR 34 O2 SAT 96% on 6L/min NC NAR (b)(6)-2 CRT
18 July 03 1500	Resting quietly. Sats 98% on 6L. Tolerated PO fluids, will advance slowly. Plan to switch to PO pain meds. Using IS (b)(6)-2 CPT AN
18 July 03 1600	CPT done, foley D/C will give tylox pm pain per order (b)(6)-2 CPT/AN
	DTV NLT 2200 (b)(6)-2 CPT/AN
18 July 03 1600	HHN Tx given c̄ 0.5 Alb/2.5 NS via Aeromask. BBS for
Resp Therapy	Coarse to (R) lung segments. HR 112 O2 SAT 97% on 5L/min NC CPT done to (R) lung segments x 5 mins c̄ postural drainage Pt c̄ productive wet cough. Pt performed IS x 15 c̄ 1200cc/sec continuously. P̄ Tx BBS for coarse. O2 SAT 96% on 4L/min NC HR 120. NAR (b)(6)-2 CRT
	(b)(6)-2

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DATE

18 Jul 03 1730 Pt. A+O x3, was able to speak to pt. through translator. O_2 @ 4LPM via NC, pt. has cast to (L) arm from bicep to wrist, unable to palpate (L) pulse due to cast. 18G IV to (R) AC ē LR @ 30cc/HR. Coarse crackles heard on expiration to (R) side of lungs, (L) side CTA. IS use encouraged and observed. DRSG to midline ABD CDI, DRSG to (L) ABD CDI. Foley dc'd @ 1600, pt. due to void @ 2200, BS ⊕x4, hypo-active. Pt. consumed ī Carnation instant breakfast mix ē ⊖N/V. ⊕ pulses x3, cap refill <3sec. Color normal for race, skin warm + dry. Pt has a pillow to splint ABD when coughing ⊖ cough or ⊖ sputum observed @ this time. SPC (b)(6)-2

2000 Pt. given ii tabs of tylox in preparation for getting up to chair and for % pain. Neb. treatment also given @ this time. VSS. Will continue to monitor. SPC (b)(6)-2

2030 Pt. had a small, tan, runny bowel movement ē 300 cc's clear, yellow urine. Remained seated @ bedside chair. O_2 was taken off @ this time and percussion therapy performed. SaO_2 @ 94%, pt had a thick cough ē white, stringy phlegm. SPC (b)(6)-2

(Continue on reverse side)

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

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(b)(6)-4

PROGRESS NOTES

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MEDICAL RECORD	PROGRESS NOTES
DATE	
19July03 0800 cont	Skin: Abd incision dressed by MD. Large amount of brownish drainage on old dsg. Cast to (L)UE for ORIF intact. Lines: new 20g IV (R) wrist started this am c̄ LR @ 50cc/° infusing. Plan: ~~contin~~ continue ABX, chest PT, well continue to monitor (b)(6)-2 CPT/AN
19July03 0900	Up to chair x 2° Bath done, linen changed. IS done (b)(6)-2 CPT/AN
1200	4 mg MSO4 IV given for C/O Ab pain. (b)(6)-2
1210	Pt gesturing he needs to have BM. Assisted to bedside commode c̄ minimal assist. (b)(6)-2 (b)(6)-2
1230	Ø BM at this time. gesturing to have pillow pt behind back, Asked if pt wants to get into bed & he shook head no (b)(6)-2
1410	Incentive spirometer given to pt & was able to do the 900cc/sec chamber. Encouraged to deep breath but didn't. (b)(6)-2
19July03 1600	Chest PT done per RT, Ø change in condition. Well cont. to monitor (b)(6)-2
19July03 1600 Resp Therapy	HHN Tx given c̄ 0.5 Alb/2.5 NS via Aeromask. BBS for ↓'d to RLL c̄ Rhonchi. HR 88 RR 20 O2SAT 97% on 2 L/min NC. CPT done to RLL x 5 mins c̄ drainage. P̄Tx BBS for unchanged. HR 89 O2SAT 96% on 2 L/min NC RR 20. NCAP (b)(6)-2 CPT

(Continue on reverse side)

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PROGRESS NOTES

DATE	
1700	Recieved report from dayshift 1700 Pt awake recieving nebulizer tx from RT - alert and cooperative Perrl <3mm brisk c̄ light - Pt coughing/deep breathing c̄ pain 4mg IV msoy to enc. cough/deep breath - IS at bedside - Dsg to abd clean ∅ gross blood or discharge (+) radial pulses (R) ha Lungs: see RT note - Pt afebrile 98°(T) + cap refill (L) hand - ext pink ∅ swelling noted Pt does c/o itching inside cast - slightly edematous feet bilat (+) pedal edema improved c̄ COB activity - will contine to monitor ——— (b)(6)-2 [redacted]
1900	Pt ate small amt of dinner - ∅ appetite 200 cc H2O LR infusing 30 cc/hr into 20 cr (R) hand IV cath IS use x 3 minutes good effort - CPT done by RT (b)(6)-2 [redacted] Pt medicated c̄ Lortab per Dr (b)(6)-2 [redacted] (∅ Tylox) for dressing Δ by Dr (b)(6)-2 [redacted] Pt s complaints at this time (b)(6)-2 [redacted]
1930	Dsg Δ done by MD - Pt tolerated procedure well O2 sat > 97% on 2L NC Vital Signs Stable 126/70 P-85 R-12 Temp 98°(T) hypoactive BS x 2 quadrants Lungs expiratory wheezes (R) LL ∅ BM This shift ∅ urine output This shift
2200	200 cc urine output dark yellow urine Pt s complaints ——— (b)(6)-2 [redacted] (b)(6)-2 [redacted] 91CWM

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MEDICAL RECORD	PROGRESS NOTES
DATE	
2110	Pt. ambulated up and down ward x2. c̄ assistance. Returned to bedside chair. — SPC (b)(6)-2
19 July 03 0005	Pt. resting quietly in bed. 2L NC O2 was put back on pt for S.O2 dropping down to 92-94% returned to 98-100 — SPC (b)(6)-2
0300	Pt. resting quietly in bed. USS — SPC (b)(6)-2
19 July 03 0800	HHN Tx given c̄ 0.5 Alb/2.5 NC. BBS ~~for~~ clear slightly decreased to RLL, HR 92 O2 SAT 96% on 2 L/min NC
Resp Therapy	RR 24 stable. CPT performed while Pt was sitting up in chair. Pt c̄ ⊖ cough during Tx. P Tx BBS clear L'd to RLL RR 20 O2 SAT 97% on 2 L/min NC HR 86 ~~NAR~~ — (b)(6)-2
19 July 03 0800	NN: assumed care of patient @ 0500. Neuro: awake, alert, pupils 3mm brisk reaction to ~~bra~~ light. Minimal pain, moves all extremities well, 5/5 strength in all x ⊖ UE. Resp: lungs clear diminished LLL. Occasional productive cough c̄ much clear sputum. Sats 97-99% on 2L NC. CPT c̄ albuterol nebs Q 4° ~~per RT~~. CV: HR 70-90's, BP stable. Pulses palpable, afebrile. GI: BS⊕, ØN/V/D, tolerated 240cc ensure, 1/2 box ~~[illegible]~~ cereal. GU: Voiding in urinal. NO bladder distention noted.

(Continue on reverse side)

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

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MEDICAL RECORD

PROGRESS NOTES

20Jul03 Nebulizer Tx by RT - pt tolerated treatment
0100 well - CPT performed by Spc (b)(6)-2
Pulse ox 97% on RA - Cefotan antibio
infused - LD still infusing 30 cc/hr.
200 cc water intake PO (b)(6)-2
0200 Pt sleeping - c complaints - (b)(6)-2
0230 Pt requesting pain medication 4mg MSO4 IV
Pt also c/o (L) arm itching inside of
cast enc not to scratch - will consult
TC Dr about PO Benadryl for itching
(b)(6)-2
0500 Pt sleeping - c complaints Vital Signs
Stable 118/61 P-80 R-17 Pulse ox 100%
2L NC (b)(6)-2
0515 8mg MSO4 signed over from SGT (b)(6)-2 - pt resting
comfortable - arousable to voice. Pupils 3mm & PERLA, on
2L O2 via NC sats 99-100%, lungs CTA except (R) ↓ diminished
breath sounds, PIV to (R) wrist @ KVOT LR, NSR all pulses
palpable, dressing to midline abd CDI, BS hypoactive
x 4 quads, reg. diet, urinal @ BS, ∅ urine yet this shift.
Will monitor for I/O. (b)(6)-2 SGT/LAN
0730 Pt bathed & Dd, Ate 70% of breakfast. ∅ complaints
at this time. (b)(6)-2 SGT/LAN

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MEDICAL RECORD

PROGRESS NOTES

DATE

~~0830~~

20 July 03 HHN Tx given c̄ 0.5 Alb/2.5 NS via mask. BBS for ↓'d in
0800 lower lobes but fairly clear. HR 90 RR 24 O2 SAT 97% on 2L/min NC
Resp Therapy CPT done to (R) lung segments x 5 mins. Pt c̄ weak non-
productive cough. P̄ Tx BBS unchanged HR 94 O2 SAT 98%. IS
done. Good Pt effort 1000cc x1 sec x10. NAR (b)(6)-2

1015 Pt OOB to chair, linens Δd, sating >95% c̄ O2 NC still
on @ 2 lpm. (b)(6)-2 SGT/CPT

1030 Pt had large formed BM x1 (b)(6)-2 SGT/CPT

20 Jul 03 ORTHO POD 11
1240 S NO ELBOW C/O IN LAC
O WND CLEAR, STAPLES OUT LAC REAPPLIED
A DOING WELL
P CUT DOWN CAST TO LAS & BEGIN ROM OOA 24 Jul
XR A BEGINNING ROM

(b)(6)-2

(b)(6)-2
LTC, MC
ORTHOPEDIC SERVICE

20 July 03 HHN Tx given c̄ 0.5 Alb/2.5 NS, BBS for ↓'d bases
1200 but fairly clear. HR 90 RR 24 O2 SAT 100% 2L/min NC
Resp Therapy P̄ Tx BBS unchanged. NAR (b)(6)-2 CRT

(Continue on reverse side)

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MEDICAL RECORD	PROGRESS NOTES
DATE	
20 Jul 03 1400	Dr. (b)(6)-2 performed dressing Δ, Montgomery straps applied, pt urinated 575cc dark yellow urine, ate about 10% of meal + one carnation - logged onto calorie count being kept for MAJ (b)(6)-2. Pt lying in bed c̄ complaints of pain at this time. (b)(6)-2 SGT/[illegible]
20 July 03 1600	HHN Tx given c̄ 0.5 Alb/2.5 NS. BBS for ↓'d bases bilat but clear. HR 100 RR 24 O2 SAT on 2 L/min NC 98%.
Resp therapy	Pt refused CPT c̄ c/o pain in abdomen. P̄ Tx BBS for unchanged HR 97 RR 24 O2 SAT on 2 L/min NC 99%. NAR (b)(6)-2
1700	Pt resting in bed - Ø c/o pain at this time. (b)(6)-2 SGT/[illegible]
	1800 Received pt this pm in bed resting. Awake appropriate, able to move ext x4. Pt has patent airway c̄ no difficulty breathing. Pt on 2L NC SaO2 100%. S1/S2 sounds present c̄ no extra sounds NSR @ 90 BPM. Pulses equal and palpable. No skin break down noted w/o to touch. Dsg to midline incision OF. Caston (L) UE. BS (+) x4 quads abdomen soft tender non distended. Pt had Bm this Pm. Pt voids via urinal c̄ difficulty. Pt on regular diet c̄ CIB. Pt activity is OOB. Lung sounds clear c̄ diminished bases. Will continue to monitor (b)(6)-2 9 Jul 03 SPC
	1900 Pt sat up in chair and washed face. pt had bm on bed side commode. VSS SaO2 100% c̄ 2L NC. Will continue to monitor (b)(6)-2 9 Jul 03 SPC 1945 Pt placed back in bed no complaints noted at this time. Will continue to monitor

(Continue on reverse side)

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

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PROGRESS NOTES
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PROGRESS NOTES

DATE	
20Jul03	2200 Pt is resting comfortably no distress noted at this time. Pt given heparin 5000 SQ and had 300 ml urine output. Will continue to monitor (b)(6)-2 91WM6 SPC 2400 Zantac Infusion complete. IV site patent no s/s of infiltration. SaO2 98% c̄ 2LNC. Albuterol given by RT. No distress noted at this time. Will continue to monitor (b)(6)-2 91WM6 SPC 2430 Ceflotetan infusion started (b)(6)-2 91WM6 SPC 0100 pt given II tabs percocet for pain as ordred. Pt c/o pain at incision site. Will continue to monitor pain level (b)(6)-2 91WM6 SPC 0130 Ceflotetan infusion complete IV site remains patent. No s/s of infiltration. VSS SaO2 98% c̄ 2LNC. Pt is currently sleeping no signs of distress noted at this time will continue to monitor (b)(6)-2 91WM6 SPC 0300 Pt is sleeping at this time no signs of distress noted VSS SaO2 99% c̄ 2LNC Will continue to monitor (b)(6)-2 91WM6 SPC 0445 Pt is currently sleeping no distress noted at this time VSS A-febrile SaO2 99% on 2LNC Will give report to oncomming shift (b)(6)-2 91WM6 SPC
21JUL03	Report received from SPC (b)(6)-2 assessment performed.
0500	Pt asleep but easily arousable, pupils 3mm & briskly reactive, on 2L O2 via NC satting 99-100%, resp unlabored, rate 15-20, lungs CTA, ↓ bases, heart sounds audible, pulses palpable x4, midline abd incision, dressed c̄ Montgomery straps in place, cast to (L) arm, circ ✓ good, BS hypoactive x 4 quads, reg. diet c̄ calorie count, BM x 1 last evening, no urine out yet this shift. Pt denies pain at this time. Will continue to monitor. (b)(6)-2 SGT/CPN

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MEDICAL RECORD	PROGRESS NOTES
DATE	
21 July 03	HHN Tx given c̄ 0.5Alb/2.5 NS, BBS for b'd bases but
0800	clear. RR 20 O2SAT on 2L/min NC 97% HR 97. CPT refused by
Resp Therapy	Pt c̄ c/o pain in abdomen. P̄ Tx BBS unchanged. HR 96 O2SAT 97 NAE — (b)(6)-2
0830	Pt ate 30% of breakfast + one Ensure. Dr (b)(6)-2 performed dressing Δ. Pt placed NPO for debridement in OR today. IVF ↑'d to 100cc/hr, pt bathed, sitting up in bed. — (b)(6)-2 SGT/LP
21 July 03 0900	Nutrition Note F/U Performed calorie count for past 24°. Results as follows: 1200 kcal — estimated needs 3000-3400 kcal 40-45 kcal/kg 60-70 gm protein — estimated needs 110-150 gm 1.5-2.0 gm/kg Pt meeting <50% of nutritional needs. Pt is consuming all of carnation instant Breakfast. Will increase supplement of carnation Instant Breakfast to 5-6 times/day. Will continue calorie count. (b)(6)-2 MAJ, SP RD/LDN
0915	Pt's sats ↓ to 76%, after encouraging him to take deep breaths, only ↑'d to 89, ↑'d O2 to 4 lpm, sats went back up to 98%. Will monitor. — (b)(6)-2 SGT/LPN
0900	Pt pulled out IV catheter. Unknown exact time. only ½ of Zantac went in. Will restart IV. (b)(6)-2 SGT/LPN
1000	Held Diflucan because pt is NPO — (b)(6)-2 SGT/LPN
0930	Started 20g IV to (R) FA, flushed & patent. (b)(6)-2 SGT/LPN

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PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO.

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PROGRESS NOTES

DATE	
21 July 03	HHN Tx given c̄ 0.5 Alb/2.5 NS, BBS for ↓'d bilat bases
1200	but clear. HR 90 RR 20 O2 SAT on 2 ½ min NC 99%. Pt
Resp Therapy	refused CPT c̄ c/o pain. P̄ Tx BBS for unchanged. NAR (b)(6)-2 CKT
7/21	Operation Note
	Procedure: Exp Lap
	Wound debridement
	Am GETA
	Findings: - Necrotic edges of tissue
	- Fluid collection pelvis
	- JP placed in pelvis
	- wound mobilized / approximated
	- skin open
	Fluids 1600, UOP 200 EBL 150
	To ... stable, not ... (b)(6)-2
	WATTERSON

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

21 July 03 1700

S/P Abdominal wound exploration c̄ JP drain. Titrated c̄ 20mg Morphine 150 EBL, 200 cc U.O. 1600 Crystalloid, IVS: 20G to (R) Arm, 16 G EJ to (L) external jugular vein. N/G to (R) Nares Patient transferred from litter to bed c̄ assessment as follows: Neuro: Sedated + Paralyzed with Vecuronium, One twitch noted using nerve stimulator, Versed + Morphine ordered to be infused, pending pharmacy orders. GI: N/G to (R) Nares clamped. Jewelry ordered to infuse @ 10cc/hr with residuals to be checked every four hours GU: Foley to Gravity, clear yellow urine, CV: Remains on Sinus Tachycardia, rate 100-104 beats per minute, Pulses 1+ to (R) Upper extremity 2+ to lower extremities, (L) Arm Casted due to previous fracture to elbow, excellent cap refill. A line placed by anesthesia @ bedside, zeroed c̄ excellent waveform, Respiratory, Lungs CTA c̄ copious amounts of white secretions noted, TV: 850 rate 9 peep 3, FiO2 50 ETT 8.0 at 23 cm at the lip, taped + secure. Dr (b)(6)-2 Instructed all nursing staff to keep Train of 4 1 or less and to maintain paralytic status at all times. ~~Plan of Ca~~ Abdominal Dressing to exploratory lap Covered c̄ 8x4's and Hypafix Dsg Dry and Intact JP to bulb suction. Plan (1) Keep patient Train of four less than one twitch, (2) Utilize aggressive pulmonary toilet to decrease copious amounts of secretions (3) Observe Abdominal dressing for drainage and reinforce pro Call H.O for excessive sanguinous output from JP. ~ (b)(6)-2 MAJ

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

27 July 03 1815 Patient waking up c̄ obvious movement. Given 5 mg Vecuronium bolus by Mag Nocum and Versed 5 mg IVP by Mag Nocum. B/P before bolus 235/111, after bolus B/P 135/67, Remains in Sinus Tachycardia. Versed drip infusing @ 2 mg/hr, Vecuronium infusing @ 4 mg/hr, Morphine infusing @ 4 mg/hr, to ~~titrate~~ drips to effect. [redacted] (b)(6)-2 magn

27 July 03 1830 Report given to CPT [redacted] (b)(6)-2 by SGT [redacted] (b)(6)-2 Cx Pay ordered and completed. Remains paralyzed as ordered. Will continue to monitor Team of Fam. [redacted] (b)(6)-2 magn

01 July 2003 1835: Received report on pt @ 1800. Assumed care. Pt sedated & paralyzed c̄ vecuronium @ 4 cc/hr, MSO4 @ 5 cc/hr & versed @ 2 cc/hr. LR infusing @ 50 cc/hr as PB. LR infusing to (L) EJ @ 50 cc/hr. Foley to gravity, clear yellow out. (+) JP to (R) LQ serous sanguinous drainage, minimal amt. out. (+) dressing to midline incision. (+) serous drainage noted. (+) L arm casted, A-Line to (R) wrist. (+) PIV 18g to (R) F (~~[illegible]~~ errorgy) (+) NGT to (R) Nare - secured, clamped. Bilateral eyes taped closed. Assessment as follows: Neuro: As per above, pt remains sedated c̄ versed, vecuronium as skel. muscle relaxant and MSO4 as analgesic. (+) pupillary reaction to light c̄ pupil size @ 1mm/1mm. (+) PNS use, 1 twitch @ this time. CV: NSR, (+) Tachycardia c̄ HR ~ 101-108 BPM. BP 115/120's/60's. Bilat dorsalis pedis pulses 1+, (R) Radial 1+, cap refill to (L) index ≤3 sec. (+) generalized (B) LE edema @ 1+. A-line to (R) radial artery, secured, (+) ~~zeroed transducer~~ (errorgy) transducer leveled & zeroed. Resp: (+) Vent. SIMV; VR 10 BPM, Sd, TV: 8 ml, FiO2 @ 50%; Peep = 5. ETT tube @ 25 @ lip, #8.0, secured. (+) Suctioning per RT [redacted] (b)(6)-2 q.s. Lung sounds clear throughout. GI: (+) abd dsg from distal sternum to pubic area dressing c̄ l, (+) serous drainage, minimal amt. JP drain to (R) LQ. (+) serous sanguinous drainage ~10-15 (-) abd distention, abd soft. ↓BS to BUQ. unable to assess lower quadrant sounds R/T dressing. GU: (+) Foley to gravity - clear yellow urine out, app 75-100 cc/hr. Foley secured to (R) thigh. Skin: slight jaundiced, cool to touch, good turgor, (+) cast to (L) Arm. CDI. Cap refill to index ≤3 sec. fingertip color, normal for race, unable to assess radial pulse.

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

21 July 03 1855 (NSG CONT) (P) PT NS infusing @ 50 c/hr. (-) evidence of infiltration. (+) IDs (R) PA - infusing prescribed relaxant, analgesic, sedative. PB & ET LR & Soc/hr. GI cont. (P) NGT, clamped, hr (P) Vent, (-) aspirate. Plan: Monitor cardiac/resp status carefully, Monitor temperature drainage from wound, UOP and JP drain. Maintain well sedated. (b)(6)-2

1850: PT thermocom @ BS. ETT pulled back to 23 cm @ lip, tube secured - vent settings unchanged. VS stable. (b)(6)-2 CPT

PNS = 2 twitches 1900: PNS (+) 2 twitches - Vecuronium ↑ to total of 6 mg/hr from 4 mg/hr per recommendation of MAJOR Morgan. BP 154/78 HR 103 RR 10 SaO2 100%. VERSED ↑ from 2 mg/hr - 4 mg/hr. PT remains sedated & no response to external stimuli. (b)(6)-2

2030: (-) ET dressing Δ'd, (+) flush, sluggish BR. Ice cap infusing @ 50 cc/hr. Jejunal tube feedings started @ 10 cc/hr. Residual V = Ø - next ✓ @ 0000 hrs.

PNS = 1 twitch 2100 Dr (b)(6)-2 @ BS, PT stable. No new orders or actions. (b)(6)-2

2200 Zantac ↑, Cipro pending receipt from pharmacy. (b)(6)-2

PNS: 1 twitch 2230 ↑ 2300: Cipro infusing per orders, No Δ in pt status. (+) T 100.1 will cont to monitor (b)(6)-2

2400: PT remains sedated. NO Δ's from previous assessment. (b)(6)-2

PNS: 1 twitch 0100: NGT residual = 5 cc yellowish drainage. 5 cc's replaced. Tube feedings cont. @ 10 cc/hr.

0200: PT VS stable. Tube feedings cont. (b)(6)-2

0325 A-line 77/44 112 0300: VS NOTED ↓ via A-Line w/ systolic pressure 70-100 diastolic 40-50's,

NIBP 115/52 113 HR = 110+ T = 101.6 RR remains 10 & SaO2 @ 100%. A line transducer

10 100 zeroed, realigned & BP ↑ to 70's systolically, 30-40's diastolically.

101.6 HR remains @ 110+ NIBP taken BP 115/52 HR 113. PT remains

NIBP 102/52 70 sedated & vec @ 6 mg/hr. MSO4 ↓ from 5 mg/hr to 0 mg/hr. Versed remains

90/51 113 @ 4 mg/hr. Ice packs placed under armpits bilaterally

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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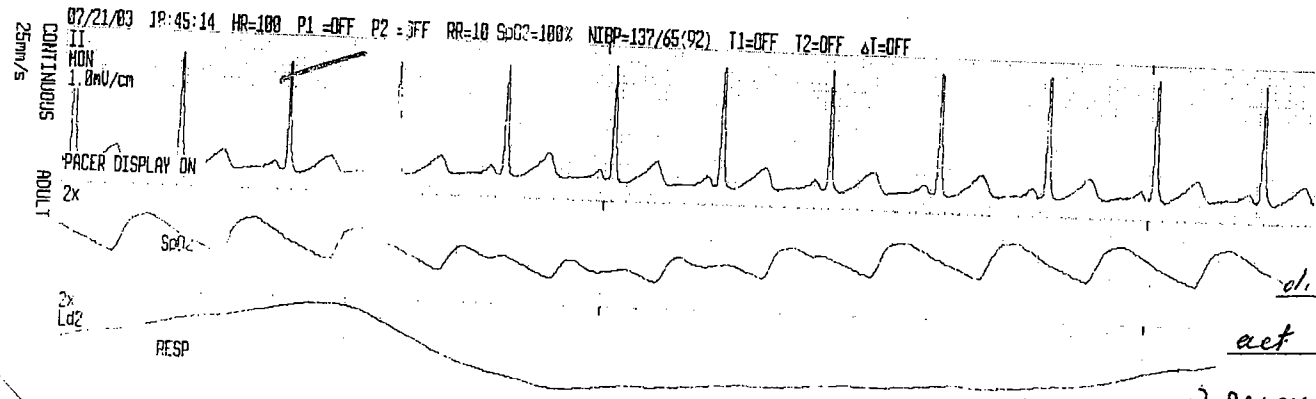
USAPPC V1.00



PROTOCOL SYSTEMS, INC.

rect.
dically
act
D serous

drainage noted seeping from dressing, in sewer eye and scrotum. Pt washed, chucks placed under back and butbocks, app 100 cc's saturating sheet. Super sponge external dressings to abd removed and replaced c̄ CD dressings. Residual ✓ @ 0400 = 120 cc+ output, bile color, residual replaced. Tube feedings discontinued. Yellowish drainage noted under neck and shoulders. App 50 cc's out from oral cavity. HOB increased from 30° to ~40°, suction applied to ETT & oral cavity c̄ Ø OP noted. NGT placed on LIS, Pt cleaned, chucks placed under body, VS stable, BS clear, diminished bases, sats 100% RR 10, T↓ 101.0, 0600 - Report given to SGT [redacted] b(6)-2 MAJ [redacted] b(6)-2 VS stable. Pt remains sedated & paralyzed. T = 101.0. UOP TOTAL OP 830 cc clear yellow; JP total = 98. NGT Residual 125+; Intake totals: IV maintenance 1300 cc/12°; IVPB = 450 cc/12°.

830
98
928 OW
* dwnd drainage

1700: Intake

(b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
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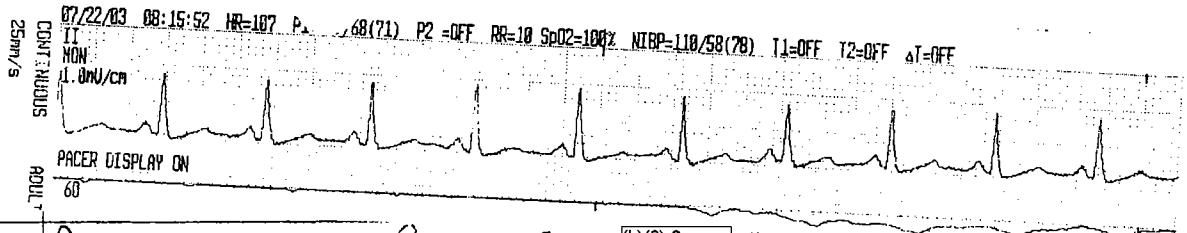

22Jul03 0620	Report received from CPT (b)(6)-2 /Assessment performed upon use of electrical nerve stimulator, one twitch was obtained - Vecuronium @ 6cc/hr, Versed @ 6cc/hr, Morphine @ 2cc/hr, vented, SIMV, rate-10, TV-850, FiO2-50%, ETT-23cm @ lips, lungs CTA bilaterally, ↓ bases, sats-100%, (L) EJ PIV c̄ LR infusing @ 50cc/hr, (R) FA PIV c̄ LR infusing @ 50cc/hr and all other drips infusing to that line, (R) ulnar A-line reading pressures inconsistent c̄ NIBP, heart sounds audible, sinus ↑ tach, rate 110-120, ~~all~~ pulses palpable, unable to assess (L) radial 2° cast (full arm) covering wrist, mild edema to both feet (worse in (R) foot), color normal for race, Ø diaphoresis noted at this time, midline abd dressing, CDI, c̄ JP drain draining clear sanguinous fluid, BS hypoactive x 4 quads, NG to LIS (tube feeds held due to excessive residuals), Foley to gravity draining approx. 5cc (this hour) clear yellow urine. Will monitor UO due to significant ↓ in amount. Pupils 2mm and briskly reactive. Will continue to monitor for Δs, (b)(6)-2 SGT/LA
	Plan of care: (1) Assess neuro status/paralysis q1 to ensure train-of-four one or less, (2) Suction prn to maintain sats >95%, (3) address nutrition care status this AM c̄ MD. (b)(6)-2 SGT/LA

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
0700	Dr. (b)(6)-2 performed dressing Δ, addressed tube feeds - will restart @ 1200. IVF ↑d to 150cc/hr, 500cc NS bolus given (b)(6)-2 SGT/LPN
(b)-2 0930	Dr. [redacted] informed of low urine output of 7cc. An additional Bolus 500cc NSS infusing as ordered. Will recheck U.O and inform
(b)-2	Dr. [redacted] of response. LR remains @ 150cc/hr, Vent Settings unchanged TV 850, Rate 10, FiO2 50%, Peep 5. N/G to LIS as ordered - (b)(6)-2
1100	Given Complete AM Care by SGT (b)(6)-2 O2 sats 98%, Vent Settings unchanged. Neuro: Pupils 2mm brisk, ~~Hitch~~ as per Peripheral Nerve Stimulator. Versed @ 4mg/hr, MSO4 @ 2mg/hr/ Vecuronium @ 6mg/hr. No movement of extremities present. Lungs CTA in all fields, diminished to bases. Surrounded by RT ē secretions present, O2 sats 98%. N/G to LIS with bile drainage noted, Foley to gravity ē urine output, will inform Dr (b)(6)-2 of response CV: remains in Sinus Tachycardia, pulses ↑ to lower extremities ↑ edema noted to both feet. A line ē respiratory variation, waveform adequate. Will continue to reassess and inform HO of changes (b)(6)-2 [illegible]
1200	Tube feeds started - rate of 20cc/hr, still minimal urine output for shift. (b)(6)-2
1380	1000cc NS bolus given for minimal urine output, still no urine - MD notified. Pt VS remain unchanged, electronic nerve stimulator only producing one reaction, pupils 2mm & briskly reactive, ETT 23cm @ teeth ē holder in place, SIMV of 10, FiO2 50%, TV-850, PEEP-5, last ABG drawn this AM (0725), lungs CTA ē ↓ bases, all lines flushed & patent. IVF ↑d to 150cc/hr, mid line abd dressing CDI, JP draining small amts serous fluid, bowel sounds absent (b)(6)-2 SGT/LPN

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES
DATE	
22 Jul 03 1500 SS	Another 500 cc NS bolus started per Dr. (b)(6)-2 Still no increase in UO noted. IVF ↑d to 200 cc/hr. Residual vs performed for TFs, <5cc drawn out, TFs continued @ 20cc/hr (b)(6)-2 SGT/LPN
1630	Ad. BP cuff to (R) arm - pressure now correlates to A-line pressures. ~~One~~ SS 500cc Bolus complete, still ∅ UO after one hour. Albumin infusion started, BP 92/49. Will monitor (b)(6)-2 SGT/LPN
1800	Report given to CPT (b)(6)-2 Still minimal urine output after Albumin transfusion, A-line pressures 90s/50s (unchanged), JP drained 15 cc serous fluid over shift. (b)(6)-2 SGT/LPN
22 July 2003	1810: Received report assumed care of pt. Pt remains sedated &
T: 101.1	paralyzed c vecuronium @ 6mg/hr, MSO4 @ 2mg/hr and
BP: 102/53 94/61 - NIBP	versed @ 4mg/hr, LR PBing needs @ 100cc/hr, LR to (D) EJ @ 100 cc/hr
HR: 106	(+) mechanical ventilation: SIMV, TV: 850; VR: 10; FiO2: 50% PEEP 5
RR: ~~90~~ 10 assisted	SaO2 99%. ETT 8.0, 25cm @ lip, secured. (+) NGT to (R) nare in place
SaO2: 98%	Jevity infusing 20cc/hr, Residual ✓ q 2°. (D) EJ c LR @ 100cc/hr. (-) infiltrate
MAP: 62	placed 21 July (-) infection. (R) 18g to FA c vec/MSO4/versed/LR @ 100cc
vec: 6mg/hr	(-) infiltration, - infection. A-Line to (R) radial artery, leveled & zeroed.
MSO4: 2mg/hr	NIBP cuff to (R) Brachial. Leads in place, (+) cardiac cont. monitoring.
versed: 4mg/hr	foley to gravity intact, secured (R) thigh. Minimal UOP cloudy concentrated
LR @ 100 → (D) EJ	(+) Abd dressing from distal sternum to pubis, c/o/l, (+) JP drain (R) LQ (+) cast to (L) arm
LR @ 100 → (R) FA	CPI (+) cap refill ≤ 3 sec (continue on reverse side) unable to assess pulse, cool to touch

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

JP - 5cc serous
foley 20 cc concent

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
22 July 2003	Physical assessment. ✓ STANDARD form 511 for all VS/I-O's/Mod monitors
1810	Neuro: Sedated, paralyzed, pupils 1mm/1mm PERRL. Peripheral nerve stimulator
WSG	0/4 vecuronium remains @ 6mg/hr. ⊕ Tetanus. ATWH TEAMS applied Bilat eye
	eyes taped shut.
	Resp: ⊕ mechanical ventilation; SIMV, ⊕ ETT ⊕ chest movement = symmetrical
	Breath snds clear throughout, ⊕ diminished bases. ⊖ central/peripheral
	cyanosis.
1430: Turned	CV: NSR, BP monitoring via A-Line / NIBP Systolic avg 90's / diastolic
(L) side	avg 45. MAP: >65 HR: Tachy ~ 103. ⊕ diaphoresis head, trunk
	& legs. >T: 100.3. ⊕ generalized edema, pitting 2+-1+ to right LE.
	1+ to hands. cap refill ≤ 3 sec fingertips, toes. Pedal pulses DIMINISHED
	palpable, thready 1+. (R) Radial palpable 2+. ⊖ JVD.
	GI: ⊕ Midline open incision ~ 45cm long heavily packed & dressed.
	⊖ drainage to superficial external dressings. Ø drainage noted from
	distal end between legs. JP drain to (R) LQ serous drainage 2-3cc/hr
	out. Abd soft, unable to det. presence of BS R/T ENV. NOISE & VENT.
	GU: Foley draining to gravity concentrated, cloudy urine UOP <30cc, avg op 15cc.
	Foley secured to (R) thigh. G.I.: ⊕ NGT (R) nare Feeding @ 20cc/hr. Tube secured to nose.)
	Skin: Slightly jaundiced, warm to touch ⊕ fever >100°. Ice packs
	placed under axillae, woolen blankets removed from around body
	Disposable light weight sheet placed. Skin turgor normal. Ø ulcers,
	lesions or other skin anomalies noted aside from those mentioned.
	Plan: Closely monitor VS to include BP/HR/O_2 Sats/T.
	Maintain strict I/O protocol. Maintain sedated & paralyzed.
	Continue tube feeding - monitor Residuals. Induction Pen. Consider fluid
	resuscitation PRN - per MD order
2000:	Pt resting. No Δ's from previous assessment. UOP ↑ to 50cc's/hr.
	cont. concentrated, dark amber.

(b)(6)-2

(b)(6)-2

STANDARD FORM 509 (REV. 7-91) BA
USAPPC V1.00

21-22 July (b)(6)-4 ICU, Tik

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1620	Pt head turned, suctioned small amt of thick white sputum from mouth. (b)(6)-2 SGT/CH
1700	Pt turned onto right side. Bright red blood coming from NG tube in small amts - MD notified - flushed c̄ 60cc Saline x3 - appears to be clear now. Will continue to monitor. Temp still 101. (b)(6)-2 SGT/BDN
1710	EJ PIV dc'd, dressing applied. (b)(6)-2 SGT/CPN
1800	Pt temp ↓ to 100.4, a little more arousable - will give report to oncoming shift. (b)(6)-2 SGT/LA
1815	Received report assumed care of pt @ 1000. Cs supine, awake, alert oriented (~~answering~~ error gaf) following single commands stated via translator. Pt restless attempting to pull on ETT. ⊕ Close monitoring provided. ⊕ Bedbath, ic Pt remains ventilated SIMV c̄ TV @ 850, VR @ 6, FIO_2 @ 50% Peep 5, ETT = 8.0, 25cm @ lip - secured. ⊕ NGT to LIC c̄ bile color drainage mod. amt out. NGT to (R) Nare. ⊕ (L) arm cast, CDI, cap refill ≤3 sec unable to palpate radial pulse R/T dust position. ⊕ NIBRcuff to (L) thigh. A line to (R) radial, leveled, zeroed good wave form. 18 g placed 21 July to (R) FA 50cc LR infusing ∅ evidence infection or infiltration. ⊕ 18 g proximal to 1st PIV on (R) FA, placed 23 July ∅ evidence infiltration infection. Opsite to Bilat IV's. LR infusing IV #2 @ 50 cc/h. ⊕ foley to gravity clear yellow out, secured to (R) thigh. ⊕ Midline abd incision dressing c/D/I ∅ evidence drainage to dressing ⊕ JP drain to (R) LQ

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.)*

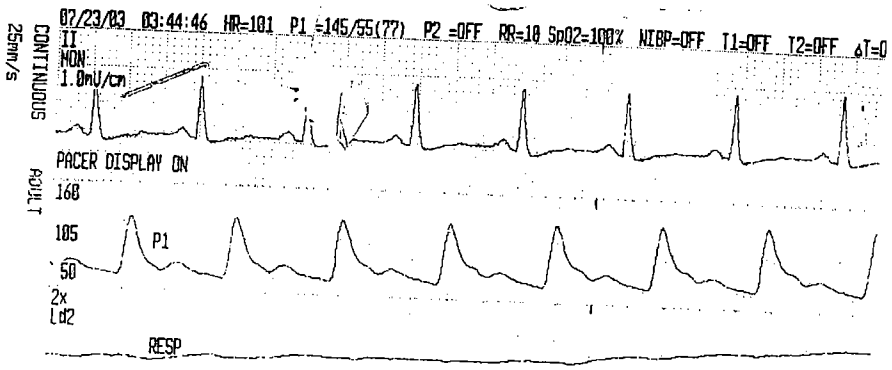
(b)(6)-4

REGISTER NO.

WARD NO. ICU

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



PROTOCOL SYSTEMS, INC.

N (Sign each entry)

...u yellow. JP drain
noted to dressing.
...ess amt of dressing.
...-99% VENT
Cipro, Zantac

administered per orders @ 2200°. NGT feedings cont. Residuals < 3 cc. T° ↓ from 100.9 @ 1800° to 100.1°F. Anasarca present c̄ ↑ edema centrally, peripheral. Monitoring to cont. (b)(6)-2 CRT

22 July 0015 RT (b)(6)-2 @ BS providing sectioning, ⊖ op. confirms clear lung snd. No Δ's to mech vent. settings. Px repositioned from (L) to (R) side. (b)(6)-2 CRT

22 July 0215 ⊕ Gurgling noted, BS coarse throughout. NIBP ↑ 138/85 HR 106 sats 100% A-line 151/58 HR 97 ~~SpO2~~ 100%. RT (b)(6)-2 notified. Major (b)(6)-2 @ BS. Deep suctioning performed to ETT, yankee suctioning to oral cavity c̄ moderate amt of white secretions drained. Pt hyperventilated via ambu ~~to~~ O_2 @ 15L throughout suctioning procedure. Sats avg 100% RR between 14-22 BPM. Lung snds clear ↓ intervention. VS STABLE (b)(6)-2 CRT

22 July 0300: No Δ's. Px remains sedated paralyzed; vent settings unchanged. (b)(6)-2

0415: Gentamicin infusing over 1 hr to (L) EJ. maintenance

0450: LABS: CBC Chem 8 drawn from A-line, walked to lab results pending. CXR pending (b)(6)-2

0510: CXR - portable done. No other changes (b)(6)-2

0600: Report given to SBT (b)(6)-2 ; MAJ (b)(6)-2 Care of pt assumed by oncoming shift. (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

21-22 July # 1 ... Tik

MEDCOM - 6464

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23Jul03 0645	Report received from night shift - electronic nerve stimulator produced only one muscle twitch - Vecuronium infusing @ 6cc/hr, pupils 2mm & PERLA (brisk), ETT-25cm @ lips, vent SIMV @ rate of 10, TV-850, PEEP-5, FiO2 50%, lungs CTA c̄ diminished bases, Ø secretions noted at this time, heart sounds audible, NSR (see rhythm strip), pulses palpable, good cap refill (<3sec) on (R) hand where full arm cast covers, (L) EJ PIV infusing LR @ 100cc/hr, (R) FA PIV infusing LR @ 100cc/hr, Vec @ 6cc/hr, Morphine @ 2cc/hr, Versed @ 4cc/hr, (R) ulnar A-line, pressure not correlating to NIBP, (approx 20 mmHg systolically higher), +2 pitting edema in lower extremities +1 pitting in upper, Jevity tube feeds infusing @ 20cc/hr, residual √s 92°, BS hypoactive X 4 quads, midline abd dressing CDI, JP draining serous fluid (minimal), Foley to gravity draining adequate amounts of clear, yellow urine. Will monitor for Δs — (b)(6)-2 SGT/LPN
23 July 03 1730	Dr (b)(6)-2 at bedside. Dressing changed to abdominal wound. Incision clean, no evidence of odor or drainage. Dressing covered c̄ serous sanguinous fluid. Wound packed with Kerlix swabed with NSS and covered with Dry Kerlix. Abdominal wound covered with ABD pads and Hypafix. Lower (L) abdominal wound with small dime sized opening packed c̄ Kerlix, Type + Cross for 2 units sent to the lab. — (b)(6)-2

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

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

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23Jul03	(cont). 1240: 138/60, 105, 99% (b)(6)-2 SGT/LPN
23 Jul 03 1300	Nutrition Note F/u Pt currently receiving tube feeding of Jevity Plus at 30 cc/° Based on caloric needs of 3000-3400 Goal rate should be 110 cc/° which will provide: 3200 calories 148 gms protein Recommend increasing rate over 24-36° to final rate. (b)(6)-2 MAJ, SP RD/LD
1430	Residuals checked - still <5cc. 2nd transfusion complete. Preparing to draw labs. Pt turned onto left side, BP ↓d to 118/64. Breakdown noted to sacral area & mid back (between scapula), Plan to turn completely off of back everytime Pt is turned. Will continue to assess. (b)(6)-2 SGT/LPN
1440	Pt gurgling - suctioned by RT, approx 15cc thick white secretions suctioned. Pt moving slightly. (b)(6)-2 SGT/LPN
1500	Labs drawn, pt opened eyes when interpreter spoke his name. Appears to be waking up. All drips have been stopped. Will notify MD @ rounds. Pt still putting out ample amts clear urine. Temp rose to 101.4° - ice packs placed under arms, to neck & groin. Will monitor for Δs (b)(6)-2 SGT/LPN
1600	Tylenol suppository administered. Pt becoming more active - still not following commands. Dr. (b)(6)-2 performed dressing Δ. Wound still appears clean & excessive drainage (JP emptied - 25cc/shift). Will monitor temp. (b)(6)-2 SGT/LPN

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Breakfast	eggs 240 ensure
	1/2 Biscuit
Lunch	1/2 Rice 240 Ensure
	1/4 Stew 180 water
1500	240 ENSURE
2000	Juice one cup
2200	Carnation one packet

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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(b)(6)-4

23 July 03

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	(+) serosanguinous drainage app 1-2cc out.
	Pt bathed, ice packs placed, heals elevated. Plan: Cont cardiac/resp cont. monitoring. Provide comfort measures to extubation & support to weaning process for mech vent ex. Monitor temperature. Maintain body position off of sacral decub and to ↓ heal skin breakdown. Monitor UOP & abd drainage ✓ NGT OP - Restart Tube feedings ASAP c̄ MD order. (b)(6)-2
1845:	Physical ASSESSMENT:
	NEURO: Awake, alert, oriented, obeys commands. Moves extremities spontaneously. Ø sedatives, analgesics or paralyzing agents in use @ this time. Pupils (+) PEARL 1mm-1mm
	RESP: Lung ends ~~c~~ medium expiratory crackles to bilat upper/middle (R) Lobe, upper (L) Lobe, (+) diminished bases bilaterally. (+) use accessory muscles. RR 30's c̄ VR set @ 6 SaO_2 @ 98%. (+) white secretion moderate amt c̄ suctioning.
	CV. NSR, (+) Tachycardia >100's BP per A-line & NIBP Systolic reading avg 120's diastolic 50-60's. Dorsalis pedis pulses bilaterally palpable, but weak and thready - 1+. (R) radial pulse 2+. (+) generalized edema c̄ 2+ pitting to bilat lower extremities, 1+ to (L) fingers, 1+ to (R) UE. (-) JVD. Cap refill to fingers & toes ≤ 3 sec.
	GI: (+) Midline incision from distal end of sternum to pubic area WHeavily dressed c̄ gauze Ø drainage noted. JP drain to (R) LQ, serosanguinous drainage <1cc/hr. NGT intact to LIS.
	GU: Foley to gravity intact, in place draining clear yellow urine >30 cc/hr. VS & I/O's noted on Standard form 511.
	Skin: warm to touch. Abd incision noted per GI assessment. 1° decub to sacral area & (L) heal. Pt turned, propped off buttocks. Heal elevated off cot. (+) cast to (L) arm. IV's as noted earlier - (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BAC

USAPA V2.00

ICU

MEDCOM - 6468

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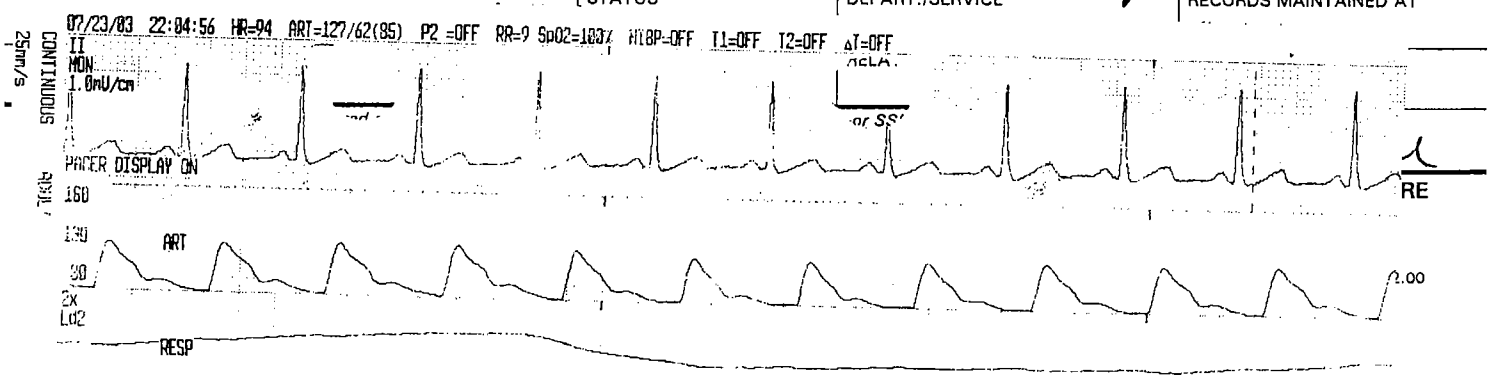
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 July 2000 ° 1: NSG	Pt disconnects ex tube. RR @ 16. VS Remain stable. RT (b)(6)-2 called to BS. ⊕ Suctioning per RT, Reinflation of balloon. ETT @ 25 cm @ lip. Pt repositioned. SaO_2 98%. (b)(6)-2
2100°:	Versed restarted @ 2 cc/h for sedation overnight. Tube feeding restarted @ 30 cc/hr c̄ residual v's q2 VS monitored BP per A-L 122/62 HR 103 SaO_2 @ 100% VR ↑ to 10 BPM ⊕ intermittent spontaneous respiration. Close monitoring to continue (b)(6)-2
2300:	RT (b)(6)-2 @ BS, ⊕ suctioning small aut white secretions c̄/drawn. Resp status remains stable. Pt resting, ∅ signs agitation. (b)(6)-2
0045:	No Δ's from previous assessment. Pt sleeping quietly. (b)(6)-2
0230:	⊕ coarse lung ends on expiration, ⊕ grunting. Deep suctioning provided by RT (b)(6)-2. VS remain stable. LATE NOTE VERSED ↑ from 2mg to 3mg for improved sedation @ 2300
0300:	VERSED held. Tube feeding stopped. Residual v pending. Pt repositioned off buttocks, heals elevated. No Δ's VS. 9+F
0400:	Pt moving arms, legs, opens eyes spontaneously, ⊕ attempts to pull at ETT EBC/chem 7 drawn, taken to lab. CXR ordered, pending. Gent started to 10g @ PIV #2. NR cont @ 100 cc/hr. foley draining clear amber urine >75 cc/hr oq. Abd dressing ~~CDI~~ error (b)(6)- intact w̄ undeterminable amt of serous drainage

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT



(b)(6)-4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 July 2003	1/2cc/serosanguinous drainage to VP drain. (b)(6)-2
0500	- 1cc Residual from NGT. L19 restarted. VS 143/67 90 HR RR 12 SaO_2 100%. FIO_2 @ 50%; VR @ 10 TV 850 LR @ 100 cc - 50 cc per PIV. A Line zeroed, leveled. Ø sedative, analgesic or paralytic administering @ this time. Q6 (b)(6)-2
0630	Pt responsive, moving all extremities, sometimes follows commands, pupils 2mm & briskly reactive to light. Still intubated, ETT 25 cm @ lips, Simv rate 10, TV-850, FIO_2 50%, PEEP 5, at points of activity, pt breaths up to 18 over the vent. Lungs CTA bilat ↓ bases, Sats 100%, heart sounds audible, NSR, rate 90-100, +2 pitting edema to both LE, all pulses palpable except (L) hand 2° full arm cast, caprefill {3 secon that hand, PIV in (R) FA infusing LR @ 100 cc/hr, (R) ulnar ~~radia~~ (b)(6)-2 A-line reading pressures correlating to non-invasive, Evidence of skin breakdown (approx 4cm) to mid-back, Sacral decubitus the size of 50 centpiece c̄ blistering to area and oozing. NG to LIS, BS hypoactive x 4 quads (cont.)
0500:	LATE NOTE NSG: Pt slightly restless, continues to attempt D/C'ing ETT tube. Reassurance provided. @ PIV infiltrate. IV removed. Sheets changed. No new IV placed @ this time. - Report given to SGT (b)(6)-2 @ 0600 Qu questions answered. Care of pt transferred to (b)(6)-2
0630	(cont.) Foley to gravity draining adequate amts clear, dark yellow urine. Will monitor for alertness, pain, discomfort (b)(6)-2 SGT/LR
0700	Lung sounds crackly on (R) side, 40mg Lasix given prior to extubation trial (b)(6)-2 SGT/L

STANDARD FORM 600 (REV. 6-97) BACK
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(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0810	Transfusion vital signs: First unit 009176
	0810: 99⁴, 152/75, 105
	0825: 99⁶, 137/62, 103,
	0840: 99⁴, 145/65, 101
	0855: 99⁴, 134/61, 103 — (b)(6)-2 [redacted] SGT/LA
2 agency 03 0830	ABG @ 0810: TV: 850 FiO_2 50% Peep 5 Rate: 10, ph. 7.481, pCO_2 34.3, PaO_2 138, HCO_3 26, BE 2 SaO_2 99%. 1st Unit Infusing 5' infiltration. No signs of reaction noted — (b)(6)-2 [redacted] MAGN
0930	30 min VS: 141/59, 99⁵, 103 - Ø irritation noted @ site. Pt bathed and turned onto (R) side. BP now correlating to NIBP since it was placed on leg. (b)(6)-2 [redacted] SGT/LA
1000	Residuals Vd - minimal. — (b)(6)-2 [redacted] SGT/LA
1030	B/P 144/58 p= 102 Blood transfusion almost completed. No reaction noted. — (b)(6)-2 [redacted] MAGN
1050	Blood transfusion completed. Given Lasix 40mg IVP. Vital Signs Post transfusion Vital 98'-96-10 154/70. Will obtain second unit for transfusion. — (b)(6)-2 [redacted] MAGN
1140	Transfusion vitals - second unit: (b)(6)-4 [redacted]
	1140: 130/66, 103, 98⁵
	1155: 145/67, 104, 99
	1210: 141/67, 103, 99'
	1225: 147/64, 108, 99² — (cont.)

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

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

(b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
29 July 03	2245 (Nsg cont)
	CV: NSR, BP 110+/60's HR 80's-90's ⊖ c/o chest pain
	⊖ edema, cap refill ≤3 secs all extremities (digits)
	(L) radial, Bilat pedal pulses = 2+, 1+ to (R) radial
	pulse.
Abd	GI: (+) ABD dressing midline, CDI, Dr. (b)(6)-2
(+) Pain -	provides dressing Δ's. PM Δ pending. ⊖ abd distention
2 percocets	(+) abd tenderness on palpation. Percocet 2 tabs
	(⅔ PO) administered @ this time for pain,
	(+) abd clutching, (+) facial grimmacy & Eval pending —
(+) VOP:	GU: Urinal @ BS - pts ambulates to ward comode.
475 clear	(+) 475 cc VOP prior to assessments —
yellow	Skin: (+) decubit to coccyx, ⊖ necrotic tissue, drying
	healing. ⊖ evidence of drainage, ⊖ infection.
	Dressing Δ performed, washed w/NS, dried w/
	sterile gauze, zinc oxide applied topically,
	covered c̄ gauze and taped. Same steps used
	for 2cm x 1cm to T6 - T7 on back. —
	Plan: Cont to encourage quality and quantity nutrition
	c̄ main meal and snacks, breakfast drink, fruit, nut
	pudding. Encourage IS. c̄ maximum inspiratory effort.

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	monitor 1/0 s.s. (b)(6)-2
2315	- Px to bed and rest. No needs @ this time (b)(6)-2
0200:	Px restly, quietly ø. evidence discomfort. Will cont to monitor. (b)(6)-2
0420:	VS STABLE, Px sleeping, Cardiac freq cont. N1 monitoring continuing (b)(6)-2
	LATE NOTE: Assessment 2200° - ⊕ Reddness to Adenoids ↑ over yesterday's assessment. ø thrush noted. Viscous lidocain swish and spit pcc wq
30 Jul 03	administered. Pt slept after intervention (b)(6)-2
0630	Assumed care of pt, Rcvd report for outgoing shift. Pt in bed c̄ eyes closed ø complaint
30 Jul 03	Voice at this time (b)(6)-2 SGT [illegible]
0700	Pt OOB → commode ø void. Pt ate a gd break
NRG note	fast. MD in to Δ Abd. drsg. Pt c/o pain to Abd ∓ percocet given PO. Am care performed. Intial assessment complete. Neuro: Pt alert awake & oriented. pt appear sadden appearance Resp. LS-CTA RR 20's SAO2 98% on RA. Pt maintain >95% when ambulates. Skin: MD Δ c̄ ABD drg. Stage II decubidi on coccyx c̄ drsg. intact, Stage I to upper back. drsg intact. Gastro. ⊕ BS x 4 quads Abd soft, non-distended. Incision site ø s/s reddness or infection @ site. GU. Pt able to urinate c̄ difficulty urine clear yellow urine ø sediment noted, Cardiac: NSR HR 78 ⊕ peripheral pulses ⊕ color, sensation & movement

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

BP 115/70 HR-81 SaO2 96% (RA) RR 12

30 Jul 03 1900 Received pt this pm in bed awake and responsive. Airway Patent c̄ no difficulty breathing. SaO2 97% c̄ (RA) Chest expansion equall and full. Lung sounds clear to auscultation x4 lobes. S1/S2 sounds present c̄ no extra sounds. Skin is warm and dry to touch. Skin breakdown on upper buttocks. Dsg CDI. No other breakdown. Pulses equall and palpable. Able to move ext x4. Dsg to midline incision CDI Δ'd by Doc. BS (+) x4 quads. Abdomen soft non-distended. Pt voids via urinal c̄ diff. (L) arm splinted. Pt preformed by pt tech (b)(6)-2 [redacted] 91WM6 SPC 1930 Pt consumed 50% of dinner no discomfort at this time (b)(6)-2 [redacted] 91WM6 SPC 2200 BP 115/69 HR-83 SaO2 96% c̄ (RA) RR-12 will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 2200 Heparin and Lantac given (b)(6)-2 [redacted] 0200 103/54 HR 82 SaO2 96% c̄ (RA) RR-14 Pt is resting comfortably no signs of distress noted at this time will continue to monitor (b)(6)-2 [redacted] 91WM6 SPC 0500 Pt rested comfortably throughout shift No distress noted will give report to next shift (b)(6)-2 [redacted] 91WM6 SPC

0615 Assumed care of pt Recd report from SPC Back LPN. Pt in bed lying on side. HOB 30° angle NAD at this time (b)(6)-2 [redacted] SGT USA 91WM6

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.

PROGRESS NOTES
Medical Record

(b)(6)-4 [redacted]

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 July 03 0900	0830 Pt OOB → Chair am care performed ō minimal assistance. Intial assessment. complete. Neuro: alert + oriented able to communicate via translator. Skin - warm & dry to touch. drsg. to coccyx Δ'd clean ō NS, zinc oxide applied ō guaze drsg. drg to Mid back Δ'd clean ō NC zinc oxide ō guaze drsg applied. MD Δ drsg to Abd incision, drsg CDI ø s/s of infection @ drsg. Resp RR 20 non-labored SaO2 >95% on RA LS: CTA ø SOB noted. Cardiac NSR HR 100 (+) peripheral pulses x 4 (+) color, sensation & movement to extremities, gd Cap refill < 3sec Gastro: Abd soft, non-distended (+) BS x 4 quad. ate gd breakfast, tolerated well ø bm this Am. ø nausea ø direhhea noted GU Pt able to urinate ō difficulty urine ark. yellow urine. Pt BTB Resting on (R) side will monitor — (b)(6)-2 SGT USA [illegible]
1030	Pt OOB Ambulate + commode pt walking @ ward. Am meds given. Pt BTB is encouraged. 1200cc/sec x 10 Pt resting will monitor (b)(6)-2 SGT USA [illegible]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Jul 03	to all extremities. Skin: warm & dry
NRS. Note	acute distress noted. Will continue to monitor
Cont'	(b)(6)-2 SGT USA
0745	Late Note: 0630 Pt c/o sore throat. Throat
	appears red Dr. (b)(6)-2 notified. Capacol
	suggested to relieve. Will monitor
	(b)(6)-2 SGT USA
0810	Pt splint removed at 0 am. Pt able to
	ROM on self. Pt ambulating @ ward 0830
	splint reapplied pt BTB & complaint voiced
	at this time (b)(6)-2 SGT USA [redacted] b(6)-2
30 Jul 03 1000	Nutrition Note F/U
	Results of 48 hour calorie count:
	Pt taking in approximately 1500 kcal and
	60 gms protein. Given his wounds pt needs
	closer to 3000 kcal and 150 gms protein. Pt is
	eating well given his current situation. In an
	effort to ↑ his intake I spoke c him through
	translator and explained the importance of ↑
	intake especially protein. Pt will start drinking

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

continued

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 July 03 1000	Nutrition Note (cont) 5 cans/day of ensure plus in addition to regular diet. (b)(6)-2 MAJ, SP RD/LDN
1015	Am med given. Cepacal given for sore throat. afebrile. Dietitian in to do F/U. Pt had 240 milk c̄ carnation tolerated well. Pt awake in ~~bed~~ will monitor (b)(6)-2
1200	Pt OOB → Chair ate lunch seem to tolerate well. Pt → commode voided 200cc drk yellow clear urine. Pt BTB Δ'd dsg to coccyx, clean c̄ NS Zinc oxide cream applied c̄ guaze ~~dsg~~ ~~o~~ complaint voiced at this time — (b)(6)-2
1500	~~P~~ 1400 Pt OOB → commod pt had a med loose formed stool Brown. Pt BTB 1500 pt c/o pain to ADd. ii percocets given po. Pt appears to be resting at present time. will monitor — (b)(6)-2
1800	Pt refused dinner wants to wait for Pt c̄ (L) arm. ii percocets PO given to premedicate for pain patient request. Will report given to on coming shift — (b)(6)-2

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USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31Jul03 1300	Pt ~~OOB~~ in bed resting c/o sore throat Cepacal lozenger pt appears comfortable will monitor (b)(6)-2 SGT USA
1500	Pt OOB Ambulated @ ward c/o sore throat T 99.6 po salt water gargle. Pt on commode c/o constipation will inform MD at rounds (b)(6)-2 SGT USA 91WM6
1505	VS: BP: 124/70 RR: 20 P: 89 T: 99.6 (b)(6)-2 SPC 91WM6
1700	Pt request pain med for Physical therapy at 1720. ~~tt~~ percocets given po. Pt in bed resting at present time will monitor (b)(6)-2 SGT USA 91WM6
1800	Physical therapy in to do PT to (L) arm report given to oncoming shift ~~with~~ (b)(6)-2 91WM6 SGT USA
1830	Received pt this pm in bed resting. Drousable and appropriate. Airway patent no difficulty breathing. Chest expansion equal and full. Lung sounds clear to auscultation X4 lobes. S1/S2 sounds present c̄ no extra sounds. Pulses equal and palpable Cap refill <3sec. Skin warm dry to touch. Skin breakdown on upper buttocks c̄ DSyCDI. BS(+) X4 quads pt on regular

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30Jul03	diet and tolerates. Pt voids un urinal. (D) arm splinted able to move ext x4. pt ambulates c̄ steady gait c̄ assistance. Will continue to monitor [redacted] (b)(6)-2 91WM6 SPC ~~0100~~ 2100
	Pt is currently resting SuO2 95% c̄ (RA) No distress noted at this time. Will continue to monitor [redacted] (b)(6)-2 91WM6 SPC 2200
	Heparin and Zantac given no distress noted will continue to monitor [redacted] (b)(6)-2 91WM6 SPC 0200 Pt is sleeping VSS SuO2 97% c̄ (RA) no distress noted will continue to monitor [redacted] (b)(6)-2 91WM6 SPC
	0515 Pt slept comfortably throughout shift No distress noted A-febrile SuO2 95% c̄ (RA) will give report to oncoming shift [redacted] (b)(6)-2 91WM6 SPC
01Aug03 0630	Pt sleeping - arousable to voice, follows commands, pupils 3mm & briskly reactive to light, resp even & unlabored, lungs CTA bilaterally, sats >95%, heart sounds audible, NSR, all pulses palpable, skin intact except for sacral area decubitus dressed, BS (+) x 4 quads (hyperactive), regular diet + calorie count - Pt voids on own - no urine yet this shift. [redacted] (b)(6)-2 SGT/CA
0720	Dressing to sacral decubitus Δd. Zinc oxide applied & covered c̄ 2x2s. [redacted] (b)(6)-2 SGT/CA
0730	Dr. [redacted] (b)(6)-2 performed dressing Δ - wound pink c̄ Ø signs infection, Ø drainage. [redacted] (b)(6)-2 SGT/CA
0930	Pt had small, formed BM x 1. [redacted] (b)(6)-2 SGT/CA
1130	Pt ate 50% of lunch + 1 Ensure. [redacted] (b)(6)-2 SGT/CA
1330	Pt sleeping. Had small, formed BM x 1. [redacted] (b)(6)-2 SGT/CA
1530	Pt resting comfortable in bed. Ø % pain. [redacted] (b)(6)-2 SGT/CA
1645	Pt drank Ensure [redacted] (b)(6)-2 SGT/CA

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(b)(6)-4 3 Jul 03
	Calorie Count
-Breakfast	2 pancakes 240 ENSURE
	120 tea c 4 sugar
	180 Juice
~~10 am~~	
10am	240 ENSURE
Lunch	1/2 spaghetti 240 Ensure
	3/4 apple 60 H_2O
Dinner	1 apple 250 H_2O
	100% peaches
	100% green beans
	25% mashed potatoes
2200	250 ensure

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

(b)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 AUG 03	Breakfast
	1 1/2 pancakes
	100% eggs
	1 juice
	1 milk
	1 Ensure
1000	1 Ensure
	Lunch
	100% veggies
	1/2 potatoes
	3/4 chicken breast
	1 juice
1700	1 Ensure
1900	1/4 potatoes
	1/4 veggies
	1 Ensure
2100	1 Ensure

3 Aug — Breakfast
100% fruit
50% eggs
1 milk
1 Carnation milk
Lunch
100% corn
1/2 stuffing
1 Carnation milk

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	A: (1) SP GUNSHOT WOUND to (L) ELBOW AND ABDOMEN –
	(2) GRADE IV SACRAL DECUBITUS ULCER
	P: TRANSFER FOR Flap coverage of Sacral Decubitus Ulcer to (b)(3)-1
	(b)(3)-1
	(b)(6)-2 MD
	MAJ, MC USA
	CHIEF, DOS
	(b)(6)-2
	(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	1 AUG 03
1900	Received pt this pm in bed c̄ physical therapy working c̄ pt. Pt awake and alert. Pupils 3mm brisk reactive. Airway patent c̄ no difficulty breathing. Chest expansion full and equal. Lung sounds clear to auscultation x4 lobes. Ø cough. S1/S2 sounds present c̄ no extra sounds. Pulses equal and strong. Skin warm and dry to touch. Skin breakdown noted on upper buttocks dsg CDI. Dsg to midline incision CDI. no odor noted. BS (+) x4 quads. Abdomen soft non distended c̄ tenderness. Pt voids via urinal c̄ difficulty. Pt ambulates c̄ a steady gait c̄ assistance. Able to move ext. x4. will continue to monitor (b)(6)-2 [redacted] 91WMC SPC
	2200 Pt ambulated and set up in chair. Pt had 1 Ensure 250 ml. Heparin and Zantac given. VSS SaO_2 98% c̄ (RA) Pt now back in bed and resting comfortable. No distress noted at this time. will continue to monitor (b)(6)-2 [redacted] 91WMC SPC 0200
	Pt ambulated to toilet and had small BM c̄ 500 cc urine output. Pt now back in bed resting comfortably. VSS SaO_2 97% c̄ RA No signs of distress noted will continue to monitor (b)(6)-2 [redacted] 91WMC SPC
	0515 Pt resting comfortably no distress noted through out shift will give report to oncomming shift (b)(6)-2 [redacted] 91WMC SPC

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] (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
2 AUG 03 0620	Assumed care of pt. Rcvd report from off going shift. Pt in bed resting on side. Intial assessment done. Neuro: easily arousable c̄ verbal stimuli alert, able to communicate needs via translator or gestures. Pupils 2mm Pearl. Resp RR 20 even; non-labored, SpO2 97% on RA LS: CTA ∅ SOB Cardiac. NSR HR 85 S1 S2 normal ∅ murmur NAD (+) peripheral pulses x4 (+) color, sensation & movement to all extremities, gd cap refill. Skin: warm & dry. drsg to ABD Δ'd by MD CDI drsg to coccyx intact Gastro (+) BS Abd soft, flat, non-distended. GU: Pt able to urinate w̄ difficulty. Will monitor throughout shift — (b)(6)-2 SGT USA
0900	Pt OOB → chair am care performed Stage II decubid drsg Δ'd area cleanse c̄ NS decubid pink @ edges c̄ white tissue drsg had yellow discharge. left open to air, Pt position on side. Will monitor (b)(6)-2 SGT USN CPTO
1030	Pt in bed on side Am meds administered will monitor — (b)(6)-2 SGT USA

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG03	Pt OOB ambulated @ ICU, pt ate
1230	fair breakfast & lunch drank 24 vcc
	of ensure c̄ each meal - (b)(6)-2 [redacted] 9WM6 SGT USA
1600	Pt in bed resting on side ∅ SOB
	NAD will monitor — (b)(6)-2 [redacted] SGT USA 9WM
1620	TT Percocets given PO for Physical therapy
	at 1700 hr — (b)(6)-2 [redacted] SGT USA
1700	Pt in to do Physical therapy on (U) elbow
	pt. appear not to tolerate well. Will
	monitor — (b)(6)-2 [redacted] 9WM SGT USA
1800	Report give to on coming shift pt
	stable lying on side c̄ eyes closed
	∅ SOB, NAD — (b)(6)-2 [redacted] 9WM SGT USA
1900	Pt OOB to commode (+) BM hard, formed stool
	+ void 200 cc clear yellow urin.
2000	Wet to Dry Dsg to buttocks decubitus
	(Stage II resolving) 9loe gel c̄ saline dsg
	and cloth tape - Back Decubitus
	1½ inch scab (resolving) ∅ dressing - Saltham
2200	Carnation Instant Breakfast c̄ one cup
	Juice — (b)(6)-2 [redacted] SGT USA
2300	OOB to commode 300 cc dark yellow urin

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

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

REGISTER NO.	WARD NO.

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9 [illegible]-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1330	Pt seems depressed and/or lethargic compared to earlier in the week. Pt c̄ no complaints of pain. Cap refill to (D) hand brisk <2 second. Vital Signs Stable. See flow sheet. [(b)(6)-2] SGT W
0130	Pt medicated c̄ 2 percocet for pain c/o (D) elbow pain [(b)(6)-2] SGT W
0300	Pt sleeping c̄ no complaints [(b)(6)-2]
0600	Received report from SGT [(b)(6)-2] Pt asleep but arousable, obeys commands, moves all extremities. Pupils 3mm & briskly reactive to light. Resp even & unlabored. Sats 96% on RA, lungs CTA bilaterally. Heart sounds audible, NSR, all pulses palpable, skin warm dry, & intact except for bmm decubitus to sacral area, dressing Ad, aloe applied & wet to dry. RS(P) x4 quads, regular diet, pt voids on own (no urine yet this shift). Will monitor [(b)(6)-2] SGT LP
0900	Pt ate approx 10% of breakfast + one carnation instant breakfast. Dr. [(b)(6)-2] Ad dressing - wound pink & still healing. [(b)(6)-2] SGT
1100	Pt up walking to sink to clean up. Ø c/o pain. [(b)(6)-2] SGT
1300	Pt sleeping. Ate very little of lunch. [(b)(6)-2] SGT
1600	Dr. [(b)(6)-2] Ad dressing to decubitus. Pt resting comfortably. [(b)(6)-2] SGT
1630	Assumed care of pt. Pt in Med. Physical therapy in to do therapy (D) arm/elbow. Pt pre-medicate w/ percocet by SGT [(b)(6)-2] at 1630 →

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Aug 03	cont Pt appears to be tolerating well
1730	will report to oncoming shift
	(b)(6)-2 SGT USA [illegible]
1750	Pt awake. Refuses dinner - will give Carnation. Report will be given to oncoming shift. (b)(6)-2 SGT/USA
1800	Report recieved from dayshift - Pt sleeping on side (D) arm (T) on stomach - Pt medicated for pain @ 1630 - perract - Dsg to coccyx intact - Respiratory rate shallow even & unlabored - Pulse ox 97% on RA (+) BS x 4 quadrants - Distal Digits to (D) hand - warm, ∅ numbness or tingling ⊕ cap refill brisk c 2 seconds (b)(6)-2 SGT USA
1850	Pt still refuses to eat - "not hungry" as stated to interpreter - will keep meal at bedside (b)(6)-2
1910	Sitting up @ bedside eating evening meal consumed one whole milk, 1/2 spaghetti, green beans, oreo cookies and 200 cc water (b)(6)-2 SGT USA
1930	Dsg to buttocks Δd - wound looks improved resolving stage II - wet to dry dressing Δ c duoderm gel (b)(6)-2 SGT USA
2000	Pt sleeping c no complaints (b)(6)-2 [illegible]

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.)* (b)(6)-4

REGISTER NO. | WARD NO.

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2200	Dr. (b)(6)-2 Δ'd abd dressing - reinforced incision
112/60	c̄ 2 staples at the top - packed c̄ dry
P-88	gauze ∅ S/S of infx noted - ∅ discharge
R-12	or ful odor to old dressing (b)(6)-2
2230	Pt s̄ complaints ∅ pain - Pt stated thru
Temp 98.7	interpreter appetite ↓ due to elbow pain
	from physical therapy (b)(6)-2
0300	Pt sleeping c̄ no complaints - Scotha
0600	Pt sleeping, Vital Signs Stable - Pt
	c̄ no complaints (b)(6)-2
0600	Report from last shift, client in bed asleep - (b)(6)-2
0700	Assessment done, client oriented x3, sleepy but
	easily arousable. Lungs clear bilat. Apical pulse
	regular. Abdomen c̄ large midline dressing appears
	D+I. (+) BS x4 quad. Small gauze dressing to left
	lower abdomen D+I. Client voids in bedside commode
	cast to LUE intact, digits to left hand pink + warm
	good cap refill < 2 secs, mobile c̄ good strong grasp.
	(b)(6)-2 LT AN
0730	Medicated c̄ percocet x1 for pain to abdomen.
	client ate < 25% of breakfast and drank an
	ensure shake, denies Nausea. (b)(6)-2 LT AN
0830	Dr (b)(6)-2 at bedside, dressing change done.
	Old drsg removed c̄ moderate amt of tan and blood
	tinged drainage, wound appears beefy red, wound
	packed c̄ gauze then 4x4's over gauze secured c̄ tape.
	left hip drsg removed (b)(6)-2 LT AN

continue on next page

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Aug 03 cont. 0830	small circular tan wound c̄ two staples intact, left
	open to air per Dr (b)(6)-2 (b)(6)-2
1000	Medicated per order. (b)(6)-2
1115	Drank one ensure shake, tol well. (b)(6)-2
1230	Client ate 60% of lunch, tolerated well. (b)(6)-2
1430	1 Ensure shake @1400. bath done c̄ assistance (b)(6)-2
1600	Medicated c̄ 2 tabs percocet for dsg change + pending ortho
	visit for left hand. Dr (b)(6)-2 changed dsg to
	abdomen, old dsg c̄ small amt tan drainage, wound
	beefy red, new dry gauze applied c̄ 4x4 then secure c̄ tape.
1610	Dsg change done to decubitus on buttock, wound edges slightly
	dark c̄ yellow inside of wound. dsg cleaned c̄ saline, aloe
	vera gel applied to wound, 4x4 c̄ sterile H2O over the
	then ABD pad applied on top and secured c̄ tape. (b)(6)-2
1715	Physical therapy to left hand done. old cast removed
	and new one applied. (b)(6)-2
1800	Report recieved from LT (b)(6)-2 - Pt. lying in bed, HAD
	ϕ complaints - ϕ IV access - will assess pt later
	for meal (b)(6)-2
1900	Pt ate 100% of meal - chicken, rice, 200 cc H2O
	Pt a+o, vital signs stable 110/66 P-80's
	Temp 98.7 Sats 98% RA Dressing to abd

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

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

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Report recieved from dayshift - Pt 9+0x3, VSS
5AUG-03	Dsg to abd C,D & intact < Dsg to buttocks
	C,D & intact (L) elbow splinted and wrapped
	c̄ ace wrap (+) cap refill to (L) hand brisk
	< 2 seconds - c/o pain (L) elbow and
	wrist - (+)BS x 4 quadrants - Lungs CTA
	bilat ——— (b)(6)-2 [redacted] sorrow
2000	Splint to (L) arm removed for comfort
	Pt may take splint off a short time while
	ambulating/standing per Dr (b)(6)-2 [redacted] - must be
	kept on white arm is unprotected or
	sleeping - medicated c̄ percocet x 00/11 for
	elbow pain - Dsg to buttocks wet to
	dry Δd - resolving stage II ulcer
	∅ S/Sx of infx pink c̄ white edges
2200	Fentanyl Patch ordered (Dr (b)(6)-2 [redacted]
	50 mcg Q3 days Δ @ 2200 3rd day
	(L) chest area first patch) - Splint back on
	c̄ ace wrap (+) cap refill ——— (b)(6)-2 [redacted] sorrow
0000	Pt medicated percocet x 11/11 for pain
	(+) ambulation (+) void (+) fruit and carnation
	instant breakfast
0200	Pt. sleeping s̄ complaints, VSS (b)(6)-2 [redacted] sorrow
0600	Pt sleeping s̄ complaints, VSS (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	C,D & intact ϕ gross discharge - cast and gcewrap to (L) elbow (+) cap refill - fingers warm pink - Pt able to move all extremities Dsg to buttocks intact Ad @ 1610 - did not Δ at this time - Blister to (L) lateral heel intact ϕ S/Sx of infx - closed quarter sized blister resolving (b)(6)-2 SGT USA
2000	Pt medicated c 2 percocets for (L) elbow pain (b)(6)-2 SGT USA
2100	Pt OOB to commode 200cc void (-) BM Pt, walking on ward and stretching (b)(6)-2 SGT USA
2300	Sleeping on side ϕ complaints (b)(6)-2 SGT USA
0100	Pt OOB - stretching left arm HAD walked to commode 300 cc void (-) BM (b)(6)-2 SGT USA
0200	Pt medicated c 2 percocet for pain (b)(6)-2 SGT USA
SAug 03 0600	Received report from offgoing shift. Pt in bed lying on side. 0630 Pt OOB → commode → BTB resting on side will monitor (b)(6)-2 SGT USA Guthrie
1000	0730 Pt in Bed MD in to do DRSG Δ. Initial assessment Neuro: Pt alert + oriented x3 Amm Pearl brisk. able to move all extremities denies pain at present time. Resp: RR 18 non-labored even, LS CTA SAO2 98% on RA (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6Aug03 0615	Pt in bed sleeping, arousable to voice, responds appropriately, pupils 2mm & briskly reactive to light. Resp equal & unlabored, Sats 98% on RA, lungs CTA bilaterally, heart sounds audible, NSR, all pulses palpable, ∅ edema noted, skin intact except for midline abd dressing (CDI), dressing to sacral decubitus CDI, cast to (L) arm, elbow fracture. Fentanyl patch to (L) upper chest, due to be Δd on Friday. Will monitor pt for Δs — (b)(6)-2 SGT/LPN
0715	Dr. (b)(6)-2 in to do dressing Δ. Wound dark-still healing well. Pt tolerated dressing Δ well. — (b)(6)-2 SGT/LPN
0930	Pt resting comfortably. Ambulated to BSC to urinate. ∅ c/o pain. — (b)(6)-2 SGT/LPN
1200	Pt awake-eating lunch. Appears comfortable-denies pain. — (b)(6)-2 SGT/LPN
1400	Pt resting comfortably — (b)(6)-2 SGT/LPN
1630	Pt pre-medicated for PT c̄ 2 percocet. Δd dressing to sacrum. Pt tolerated well. — (b)(6)-2 SGT/LPN
1800	Report given to oncoming shift. — (b)(6)-2 SGT/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.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1800	Report from day shift - Pt stable - Dsg Δ x 2 done (Dr (b)(6)-2 & SA (b)(6)-2) Pt lying in bed sleeping at Δ of shift - will assess later (b)(6)-2 SOTAW
2000	Pt OOB to commode - ambulates c̄ steady gait - guards stomach - Pt ate corn, vegetables and water c̄ one milk - medicated for pain c̄ Percocet x ⁰⁰/₁₀ - Lungs CTA bilat - (+) BS x 4 quadrants - Dsg to abd CDI - Dsg to buttocks left untouched done late in day during day shift - Pt s̄ concerns (b)(6)-2 SOTAW
2200	Pt consumed one breakfast shake Heparin SQ administered to (R) tricep region Vital Signs Stable (b)(6)-2 SOTAW
0010	Pt asked for pain medication - (L) elbow and wrist pain - (+) cap refill to left ~~lower~~ error 62 distal hand - warm to touch pink - Dr (b)(6)-2 Δd abd dsg wound is beefy red ⊕ S/SX of infx wound closing daily - 2 weeks estimate by Dr (b)(6)-2 closure time (b)(6)-2 SOTAW
0400	Pt sleeping s̄ complaints USS (b)(6)-2 SOTAW

STANDARD FORM 509 (RE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Calorie Count
	7 Aug
6 Aug	Breakfast ... Breakfast
	100% eggs
	100% hash browns
	1 chocolate milk
	1 Ensure
	1 Ensure
Dinner	Corn
	vegetables
	water
	1-milk
2200	Carnation Breakfast

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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(b)(6)-4

(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)*
7Aug03 0615	Report recewed from SGT (b)(6)-2 Pt resting comfortably in bed, arousable to voice, pupils 3mm & briskly reactive to light. Respirations even & unlabored, rate 15, sats 98% on RA, lungs CTA bilaterally, heart sounds audible, NSR, all pulses palpable, cap refill <3 seconds, Ø edema noted, midline abd dressing CDI, dressing to sacrum CDI, half cast to (L) arm c̄ ACE wrap will remove when pt wakes up. BS (+) x 4 quads, regular diet + 5 Ensures/day, pt ambs on own (no urine yet this shift). Will assist pt c̄ ambulation PRN. Will monitor for adequate pain control. — (b)(6)-2 SGT/LPN
0700	Pt refused breakfast, c̄o nausea, tried to vomit but couldn't, 12.5 mg Phenergan administered IM. Will monitor for effect. — (b)(6)-2 SGT/LPN
0845	MD in to Δ ABD dresg. wound beefy red c̄ Ø S/S infection. ~~wound~~ packed c̄ guaze and cover c̄ guaze & tape ~~pt tolerated well~~ Pt resting at present time — (b)(6)-2 (b)(6)-2 SGT
1000	Pt in bed resting on side 1000 meds given NAD, Ø SOB noted — (b)(6)-2 SGT USA
1200	Pt ate a fair lunch tolerated well ~~refused~~ ensure resting on side NAD at this tim (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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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.

(b)(6)-4

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Report recieved from dayshift
7AUG03	Pt sleeping, VSS - 75% eaten tray @ bedside P.O. intake (1/2) Gatorade
	(b)(6)-2 [redacted] SGT
1900	Pt medicated c̄ percoct x 00/11 - Dr (b)(6)-2 [redacted] c̄ abd dsg Δ - discharge to abd dsg described as soupy (1 matsumoto) - Serous discharge minimal amt - Pt Vital Signs Stable
	(b)(6)-2 [redacted] SGT
2000	Dsg Δ to buttock done - wet to Dry resolving stage II ∅ slsx of infx - pink c̄ white tissue edges - Pt ambulated to commode 300 cc dark yellow urine
8Aug03	(b)(6)-2 [redacted] SGT
0200	Pt sleeping s̄ complaints - slept thru night 100.3 (R) Temp Pt does not feel warm ∅ diaphoresis
	(b)(6)-2 [redacted] SGT
0400	Pt sleeping - will continue to monitor
	(b)(6)-2 [redacted] SGT
0700	Pt resting comfortably, arousable, follows commands, pupils 2mm & briskly reactive to light, resp even & unlabored, lungs CTA bilaterally, sats 98% on RA, heart sounds audible, NSR, all pulses palpable, cast removed, dressings to midline abd & sacrum Δd, BS(+)X 4 quads, ate 50% of regular diet. Pt bathed & shaved, will monitor.
	(b)(6)-2 [redacted] SGT/CRA

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8Aug03 0900	Pt resting in bed, Ø % pain — (b)(6)-2 SGT/LPN
1180	Pt's cast removed, pt up in bed ate nutri grain bar, some potato chips, 1 juice & 1 Ensure. (b)(6)-2 SGT/LPN
1330	Pt's cast reapplied (pt % discomfort to elbow). Pt still denies any pain. — (b)(6)-2 SGT/LPN
1600	Generator went down - pts taken outside off monitor, given cold packs then moved to EMT. Pt ate 80% of dinner
1830	Received pt this pm in bed resting. A rousable and responsive. Airway patent & no difficulty breathing. Chest expansion equal and full. Pupils 3mm brisk. Lung sounds clear to auscultation x4 lobes. S1/S2 sounds present & no extra sounds. Pulses equal and palpable. Skin warm and dry to touch. Skin breakdown on upper buttocks dry CDI (L) arm splint and wrapped. BS(+) x4 lobes. Abdomen soft non distended. Pt on regular diet and tolerates. Pt voids via urinal. Pt ambulates & stands out of assistance will continue to monitor. (b)(6)-2 SPC 2000
	Pt resting comfortably no signs of distress noted will continue to monitor (b)(6)-2 SPC 2230
	Heparin and Zantac given fentanyl patch changed VSS no

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

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

(b)(6)-4

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/1/003	of distress noted at this time will continue to monitor — (b)(6)-2 [redacted] 91W SPC 0500 Pt sleeping no signs of distress noted will continue to monitor (b)(6)-2 [redacted] 91W SPC (b)(6)-2 [redacted] 0545 VSS Pt is resting no signs of distress noted at this time will give report to oncoming shift — (b)(6)-2 [redacted] 91W SPC
0630	Pt resting comfortably in bed, arousable to voice, follows commands, moves all extremities, pupils 3mm & PERLA, respirations even & unlabored, lungs CTA bilaterally, heart sounds audible, NSR, all pulses palpable, cap refill <2sec, skin intact other than midline abd dressing (CDI), & sacral decubitus dressed (CDI) BS(+) x4 quads. Will monitor pt for pain & discomfort. — (b)(6)-2 [redacted] SGT/LPN
0900	Pt up & bathed, linens Δd, dressing to sacral area Δd c̄ wet to dry saline dressing. Dr. (b)(6)-2 [redacted] in to Δ abd dressing, Pt tolerated well. — (b)(6)-2 [redacted] SGT/LPN
1100	Pt ate very little for lunch. Ø% pain (b)(6)-2 [redacted] SGT/LPN
1400	Pt resting, cool cloth to forehead, lost AC for 30min, backup now will monitor pt for Δs. — (b)(6)-2 [redacted] SGT/LPN
1745	Pt resting comfortably c̄ complaints. Will report to oncoming shift. — (b)(6)-2 [redacted] SGT/LPN
1800	Report from day shift - Pt stable - Dss to abd by Dr (b)(6)-2 [redacted] - packed c̄ dry gauze - beefy red ø slst of infx — (b)(6)-2 [redacted] SGT/LPN

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0500	Pt's complaints VSS (+) void QS urine no appetite. This pm - afebrile - Pt. slept throughout the night Dsg Δ to bottocks wet to dry (b)(6)-2
0700	Assumed care of pt. Rcvd report from offgoing shift. Pt OOB ambulate to commode breakfast at bedside Ø acute distress noted. Ø complaints voiced (b)(6)-2 SGT USA
0800	PT OOB AM care perform, intial assessment Neuro: pt alert easily arouse c̄ verbal stimuli Ø complaint voiced: Resp: RR 14 SAO2 ↑ 90's on RA LS: clear, RR even, unlabored. Ø secretions. Cardiac, S¹ S² normal, Ø murmur noted (+) peripheral pulses x4 (+) color, sensation, c̄ movement. to extremities, splint to (L) arm (+) pulse to distal pulse. Gastro Abd drsg CDI, abd soft non-distended (+) BS x4 quad. GU: pt walks to commode and urinates c̄ difficulty. Color dark yellow. Skin: stage II decubitus on coccyx - drsg d'd at 0600 by last shift drsg. CDI. Pt BTB resting on side

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

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

(b)(6)-4

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 AUG 03	Ø complaints voiced. will monitor
0800	(b)(6)-2 [redacted] SGT USA
1100	Pt in bed resting NAD at this time
	(b)(6)-2 [redacted] SGT USA
1500	Pt in bed, ambulates on own & complaints voice. ate a gd. lunch NAD at this time (b)(6)-2 [redacted] SGT USA
10 Aug 03 1930	Assessment done, client awake/alert oriented x3 denies pain, fentanyl patch intact to right upper chest. lungs clear bilat, respirations easy nonlabor, NAD, on room air, O2 sat 97%. heart regular ē ectopy. Pulses palpable to bilat pedal + radial pulse Abdomen (+) BS x4 quads. large midline drsg intact and dry. ~~Cast~~ Drsg to left hand ī immobilizer digits to left hand mobile/warm ī good cap refill. Drsg to decubitus on buttock changed, old drsg removed ī moderate amt of tan drainage, wound appears ī pink tissue around edge, inside yellow, no odor noted. (b)(6)-2 ~~drsg~~ wound cleaned ī sterile H_2O, aloe vera gel applied then wet sterile 4x4's ī H_2O then ABD pad and secured ī tape. USS client tolerated procedure well. (b)(6)-2 [redacted] 1LT AN
	2200 Pt given Zantac and Heparin USS no distress noted at this time will continue to monitor (b)(6)-2 [redacted]
2200	Medicated per order, in NAD (b)(6)-2 [redacted] 1LT AN
	0200 BP 93/57 HR 67 SaO2 96% Pt is resting comfortably ī no signs of distress noted will continue to monitor (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6500

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11AUG03	Assumed care of pt. pt in bed resting
0630	initial assessment complete. Neuro: Pt
	easily arouse c̄ verbal stimuli, A&O x 3
	able to move all extremities. Resp. RR Reg
	non labored, even bi-lat. LS CTA. Ø SOB
	Ø secretion noted. Cardiac NSR (+) peripheral
	pulses x 4 (+) color, sensation & movement to
	all extremities. Gastro: ABD. soft non-distended
	ABD drg C&I (+) BS x4 quad. GU. pt able to urinate
	in commod c̄ difficulty. Skin. STAGE III decubidi
	on coccyx, sacrum drsg Δ'd c̄ lge amount of drainge on
	drsg. area pink around edges hard center
	thick white skin. Brownish-yellow drainage
	when pressing edges. Area cleanse c̄ sterile
	H_2O and wet & dry sterile drsg applied.
	NAD. will inform MD about decubidi will
	monitor (b)(6)-2
1030	MD in to see coccyx, Pt NPO, will start
	LR @ 125cc hr. & complaints voiced at this
	time (b)(6)-2
1200	20G IV started to RAC c̄ excellent blood return LR infusing
	@ 125 cc/hr. (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	MAINTAINED AT
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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.

(b)(6)-4

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 AUG 03	Pt in bed, denies pain at this time
1400	IV 20g to (R) forearm infusing LR @ 125cc/hr
	⊼ difficulty (b)(6)-2 SGT USA
1430	Pt to OR for debridment. (b)(6)-2 SGT USA
1545	Pt back from OR. Pt BTB VSS. Bulk dsg
	to coccyx. (+) numbness to lower extremities
	(+) pulses. Pt alert. Plan Reg Diet tonight, Clear
	liquids in AM back to surgery in AM. Pt
	on side understands needs to stay off
	wound to coccyx. (b)(6)-2
1730	Pt stable on side appears comfortable
	NAD Ø SOB (+) numbness to lower extremities
	will report to oncoming shift (b)(6)-2 SGT USA
1800	Pt stable 18g to (R) forearm infusing LR
	@ 125cc/hr Ø S/S infiltration. Report given to
	SGT (b)(6)-2 (b)(6)-2 SGT USA 91WM6
1830	Pt report recieved - a:0 x 3 - Vital Signs Stable
	Dsg to abd Δd daily by surgery - Pt S/P wound
	debridement to coccyx - Dsg C,D & intact
	Pt ⊼ complaints at this time (b)(6)-2
2000	Pt on side - cast to (L) FA intact + sensation
	to fingers (+) cap refill - Pt ⊼ (+) BS x 4 quadrants
	Lungs CTA bilat. - ambulatory to commode
	earlier in the shift (+) void 300cc
	dark yellow using (−) BM - (b)(6)-2
2100	Pt ⊼ LR infusing 125cc/hr into
	(R) FA IV site (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2200	Pt. (b)(6)-2 Δd abd dsg — ∅ gross discharge to packing — wound healing ∅ s/sx of infx — IV to (R) FA HL — Pt s complaints of pain — (b)(6)-2 [redacted] [illegible]
0100	Pt. sleeping s complaints — (b)(6)-2 [redacted] [illegible]
0300	Dsg Δ to buttocks on hold — Pt will go back to OR in am for debridement by surgery — Pt s complaints — (b)(6)-2 [redacted] [illegible]
0500	Pt has not eaten since 2100 — P.O. intake only — Diet clear liquid for procedure in am — Pt s complaints Vital Sign Stable — (b)(6)-2 [redacted] [illegible]
12 AUG 03	
0600	Assumed care of pt. Report rcvd. Pt in bed. IV 20g (R) forearm infusing LR @ 125cc/hr pt appears comfortable — (b)(6)-2 [redacted] SET USA [illegible]
0730	Pt ~~vo~~ gagging, vomitted sm. amount clear liquid into basin. afebrile. Pt refused clear liquids. Intial assessment complete noted on DA form 4700. NAD at this time. Plan: Pt → back to OR for additional debridment of decubid: wound. — (b)(6)-2 [redacted]

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REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1200	Pt resting in bed awaiting debridment. Pt urinate dk yellow clear urine. IV 20g to (R) forearm infiltrated d/c IV / (b)(6)-2 SGT USA 91WM6
1235	New IV started 20g IV to (R) hand infusing ~~(LR)~~ LR @ 125cc/hr / (b)(6)-2 SGT USA 91WM6
8/12	Op Note Procedure: Debridement Sacral decubitus Surgeon: [illegible] Findings: Large S.D. Bilateral area of sacrum c̄ exudate no purulence Would debridement sharply Will need grafting most likely (b)(6)-2
8/12	1300 Pt → OR for debridement [illegible] and drsg
1350	Δ: Pt back to ICU via Litter @ 1350. Recd Sing versed 250mcg fent. Transfer to bed monitors on VS 110/70 - 89 - 20 - stor 95% RA. ABD wound Δ'd in OR. NAD at this time Pt resting on side will monitor / (b)(6)-2 SGT USA 91WM6
1620	Pt on side saline lock IV flushe s̄ difficulty drsg on sacral area bulk drsg c̄ tape CDI π percocet given PO for physical therapy of (L) arm at 1700hr. Pt ate grapes & drank juice tolerated well. will monitor / (b)(6)-2 SGT USA 91WM6

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 AUG 03	Physical therapy here to do ROM to (L)
1730	arm, splint removed, ROM perform Pt
	seem to be in pain, but tolerated
	well. Pt refuse dinner at present time
	left at bedside for later. Pt on side
	resting. Appears comfortable will report to
	oncoming shift. (b)(6)-2 SGT USA 91WM6
1930	Received pt this pm in bed awake and responsive.
	Assesment done see DA 4700. Day's CDI will continue
	to monitor (b)(6)-2 91WM6 SPL 2100 pt consumed 75%
	of dinner plate. No complaints noted at this time
	will continue to monitor (b)(6)-2 91WM6 SPL 0100
	Pt sleeping USS stable SaO2 96% ⊙ (RA) no distress
	noted at this time will continue to monitor (b)(6)-2 91WM6 SPL
	0400 Pt is sleeping. USS no distress noted will
	continue to monitor (b)(6)-2 91WM6 SPL 0530 pt
	is resting in bed no distress noted SaO2 97% will
	give report to oncomming shift (b)(6)-2 91WM6 SPL
18 B:	Assumed care of pt s/p receipt of report. Ox sleeping Ø/VF's. O2 sur
VS: 105/66 71	RA. Cont. cardiac monitoring in place. Physical assessment pending.
96% RA 14	to be recorded on DA Form 4700 (b)(6)-2

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REGISTER NO.	WARD NO.

(b)(6)-4

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 0830	Assumed care of pt. Pt on clear liquid for breakfast drank 360cc of juice. ↑ ambulate to commode void 300cc yellow urine. 20g IV to (R) hand saline locked. Pt BTB resting on side. Intial assessment done noted on DA 4700. Plan NPO 'til patient goes back to OR for drsg Δ will monitor / (b)(6)-2 SGT USA 91WM6
13 Aug 03 1030	Assumed care of pt from SGT (b)(6)-2 Pt sleeping quietly c̄ out evidence of discomfort or pain. Pt awakens spontaneously to verbal/environmental stimuli. Up OOB to BR for washing/shave & oral care. Sheets Δ'd. Ø drainage noted to dressing on butt-ock. dressing CDI. (+) splint to (L) arm CDI. cap refill ≤ 3 sec Ø edema noted good sensation, good movement.
1100	Pt returns to bed, states feeling weak, dizzy. Pt assisted to chair. BT Taken WNL RR 16 SaO2 96-97%. Pt returned to bed LR started @ 100 cc/h to 18 g PIV to (R) hand. (+) infiltrate. 22 g PIV placed to (R) hand c̄ LR infusing @ 100cc/h. Ø S. of infiltration, line secured will watch. Pt remains NPO for 1 & 0 @ 1300 in OR.
1230	VS: BP 109/67 (L) HR 96 SaO2 HR 71 96.7-T Tymp
	Pt sleeping quietly error (b)(6)-2 (b)(6)-2
1300:	Pt transferred from bed to litter c̄ assist of OR staff x 2. c̄/out problems. Pt escorted to OR per staff. (b)(6)-2

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*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6506

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG03	1000 PT ↑ ambulating @ ward. Drsg to coccyx
1130	saturate re-enforce c̄ guaze c̄ combine drsg
	c̄ tape. pt. on side. 1000hr meds administer
	on time. Pt resting c̄ eyes close NAD
	at this time / (b)(6)-2 SGT USA 91WM6
1400	Salinelock 20g to (R) AC flushed c̄ difficulty
	pt denies pain at present time
	awaiting surgery / (b)(6)-2 SGT 91W MB
1500	Pt to OR 1530 Pt back from OR
	VS 83/64-83-10 Sto2 99% RA T 98°. family member
	at bedside. Pt awake and speaking c̄
	family member. NAD at this time
	pt denies pain / (b)(6)-2 SGT USA 91WM6
1730	Pt in bed awake visiting c̄ family relative
	pt HR ↑ 100's denies pain, NAD
	& Complaints voiced /
	(b)(6)-2 SGT USA 91WM6
1820	Pt appears comfortable ~~Report~~ given
	to on coming shift / (b)(6)-2 SGT USA 91WM6
1930	Received pt this pm in bed arousable. Pt is lethargic. Assessment
	done see DA 4700. Dsg CDI to Abd. and coccyx. Will
	continue to monitor (b)(6)-2 91WM SPC

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(b)(6)-4

(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Aug03 1930	Received pt this pm in bed awake. Responsive ∅ no difficulty breathing. (b)(6)-2 Assesment done see DA 4700 Pt is lathargic. Able to move all ext.
2200	Heparin, zantac, cipro and celexa given as ordred. VSS no distress noted will continue to monitor (b)(6)-2 [redacted] 0100 pt sleeping no distress noted will continue to monitor (b)(6)-2 [redacted] 0400 Pt sleeping VSS no distress noted will continue to monitor (b)(6)-2 [redacted] 0530 Pt is sleeping no distress noted will give report to oncomming shift (b)(6)-2 [redacted]
0600	Assumed care of pt. Report given by Spec (b)(6)-2 [redacted] pt in bed. IV 20g to (R) AC. Lr put on at KVO. Pt set up for breakfast, Ensure given. Pt tolerated well ate a fair breakfast. NAD noted, afebrile Intial assessment noted on DA 4700 will monitor / (b)(6)-2 [redacted] SGT USA
0730	Labs drawn by Maj (b)(6)-2 [redacted] An and sent to Lab / (b)(6)-2 [redacted] SGT USA
0930	Am care performed at sink pt ambulated @ ward. Ensure given pt tolerated well. pt ↑ chair. NAD ∅ complaints voiced, denies pain at present time / (b)(6)-2 [redacted] SGT USA

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6508

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1550 13 Aug 03	Pt returns from OR accompanied by staff. Pt sedated minimally responsive to verbal stimuli. O_2 per (b)(6)-2 @ L. RR 20-21 BPM, SaO_2 @ 100%. VS taken recorder q 5°, notation on VS Record sheet.
1515	145/96 96-21-100% O_2 Δ'd to NC @ 5L RR 23 SaO_2 100% pt arousable. Obeys simple commands, wiggling fingers bilaterally, moved bilateral toes on command. Cont cardiac monitoring per Propag continues. IVF's d/c'd PW SL'd c̄ 7cc NS.
1530	Cousin @ BS, concerned about pts present state. Interprete requested for translation. Pt continues lethargic, is responsive VS 154/89 HR 98 RR 13 SaO_2 @ 100%. ↓ O_2 to 2L.
1545.	Pt. c/o nausea, ~3cc mucous (clear) ~~discharge~~ error (b)(6)-2 expectorated. Phenergan 25mg SIVP administered per order Dr (b)(6)-2 No c/o N/V ⊖ emesis ΔP administration. Pt sleepy, alert, oriented x3 @ this time. Will cont to monitor (b)(6)-2
1615	Cousin states desire to take pt home in 2 wks. Pt's health status discussed c̄ cousin understanding need for cont tx (b)(6)-2
1710	Pt remains sleeping on side c̄/out evidence of discomfort. VS stable (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG	1930 Received pt this pm in bed asleep arousable. Assesmt done see DA 4700. Pt had procedure done to coccyx for skin breakdown and is scheduled for procedure again tommorow. Will continue to monitor (b)(6)-2 [redacted] 91WM SPC 2030 Pt is lethargic, arousable. Pt voices no complaint at this time. VSS SaO2 98% c̄ RA. Dsg's CDI. Will continue to monitor (b)(6)-2 [redacted] 91WM SPC 2200 Pt is sleeping, Pt easily arousable. Heparin and Zantac, citrogiven. No distress noted will continue to monitor (b)(6)-2 [redacted] 91WM SPC 0100 Pt sleeping arousable VSS SaO2 100% c̄ RA. Will continue to monitor (b)(6)-2 [redacted] 91WM SPC 0300 Pt sleeping No distress noted will continue to monitor (b)(6)-2 [redacted] 91WM SPC 0500 Pt is sleeping VSS SaO2 98% c̄ RA will continue to monitor (b)(6)-2 [redacted] 91WM SPC 0545 Pt is sleeping. No distress or discomfort noted throughout shift will give report to uncomming shift (b)(6)-2 [redacted] 91WM SPC
0630	Assumed care of pt Rcvd report from Spc (b)(6)-2 [redacted] Pt OOB ambulate → com mode wash up at sink. Pt BTB. Appears to be depressed (−) eye contact made c̄ staff. Intial assessment complete noted on DA 4700 New IV started 20g saline lock to (R) AC. Drsg to Sacral area soaked through c̄ drainage pt denies pain at present time Plan: Clear liquid for breakfast, NPO ~~til~~ 1300 SET US OR for debridment c̄ drsg AC / (b)(6)-2 [redacted]

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/13	Op Mt
	Procedure, Second Debridement
	Surgeon - Martinez (Dean
	Anesthesia Sedation → GA
	Finding - necrotic muscle extensive caudally
	debrided sharply. Facies exposed, exudative
	tissue on fascia. Wound irrigated,
	packed.
	Tolerance, Stable
	(b)(6)-2
	MATTHEWS

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(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 AUG 03	Pt in bed on side. Ø complaints voiced
1130	NAD at this time. (b)(6)-2 SGT USA
1400	Pt ↑ ambulated to commode
	had a large brown formed stool
	Pt BTB, NAD, Denies pain will
	monitor / (b)(6)-2 SGT USA
15 Aug 03	Nutrition Note F/V
1430 A/P	Pt referred again for worsening decubitis ulcer.
	Carnation Instant breakfasts were d/c 2° to
	intolerance. Current wt: 130# (taken today)
	In an effort to ↑ protein intake will provide
	pt c̄ double meat portions and 4-5 ensures per day
R:	Recommend Double meat portions and ensure 4-5/day
	(b)(6)-2 NAJ, SP RD/LDN
1730	Pt stable, in bed on side. Pt denies
	pain at present time. IV infusing LR @ KVO
	↓ difficulty, VSS, afebrile, drsg to 4BD CDI, drsgs
	not Δ'd this shift, Several drsg CDI, plan: pt
	will return to OR 16 Aug 03 in am. NPO af to
	MN will report to oncoming shift /
	(b)(6)-2 SGT USA

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(b)(6)-4

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Pt sitting up in bed - 9+0 Vital Signs Stable
	20GIV to (R) wrist infusing LR @ 20cc/hr (KVO)
	Dsg to abd intact - Dsg to buttocks
	intact ϕ discharge - Pt instructed to
	stay NPO p̄ midnight for an procedure
	Pt c̄ no complaints — (b)(6)-2 [redacted] SGT
1900	Pt. ate 2 pieces of chicken and vegetables
	one carnation shake 200 cc water
	(b)(6)-2 [redacted] SGT 91WM1
2000	Pt OOB to commode (+) void -
	dark yellow urine — (b)(6)-2 [redacted] SGT
2200	Pt vital signs stable See Flow
	sheet afebrile 97° — (b)(6)-2 [redacted]
0200	Pt vital signs stable - sleeping - no % pain
	will monitor pain (b)(6)-2 [redacted]
0600	Pt NPO p̄ midnight - ϕ % pain
	(b)(6)-2 [redacted]
16 Aug 03 0915:	Assumed care of pt @ 0600 s/p receipt of report from SGT (b)(6)-2 [redacted]
0900: 125/61 72 HR	Pt in bed (R) side lying, sleeping quietly. O_2 per RA
95% RA	WF's infusing KVO to (R) AC. ϕ evidence infiltration or
95.6 TT^tm	infection @ IV site. Pt remains NPO @ this time awaiting 1 c̄ ϕ
16 RR	in OR this Am. Will monitor and ready for surgery — (b)(6)-2 [redacted]
0800:	VS taken and noted. (+) WNP. MAJOR [redacted] (b)(6)-2, CPT [redacted] @ OBS
	readying pt for OR. Pt awake, alert oriented ×3 & assisted OOB
	to stretcher. VVF's @ TKO, Pt w/o complaints, ϕ evidence discomfort
	or problems (b)(6)-2 [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1500	1 Brother-in-law and son @ Bedside c̄ tea c̄ food.
	[redacted] b(6)-4 appears contrit. (b)(6)-2
1800	Percocet ii tabs po administered as premed
	for PT. 1630 PT @ BS for PT to (L) arm.
WT TODAY:	CATE note: 1500 Blister to (L) lateral malleolous
	drains app 1cc blood, remains otherwise intact. Blister
134 lbs.	washed rinsed c̄ wet to dry dressing applied.
1730	Family members gone. pt resting quietly in bed.
2000	BP 126/80 HR 81 SaO2 98% RR 14 Received pt this
	pm awake in chair. Assessment done see DA 4700 Pt
	has no SOB SaO2 98% on (RA). Pt consumed food brought
	by family members. Will continue to monitor (b)(6)-2 (b)(6)-2
	2100 Pt given 4 mg ms DUP for pain in (L) arm. Pt is
	resting in bed will continue to monitor (b)(6)-2
	2200 Zantac, Heparin, celexa and cipro given. VSS
	no distress noted will continue to monitor (b)(6)-2 (b)(6)-2
	2400 Pt sleeping no distress noted will continue
	to monitor (b)(6)-2 91WMO SPL USA 0400 pt
	sleeping. No distress noted will continue to
	monitor (b)(6)-2 91WMO SPL USA 0530 Pt is
	sleeping no distress noted will give report to oncoming
	shift (b)(6)-2 91WMO SPL USA

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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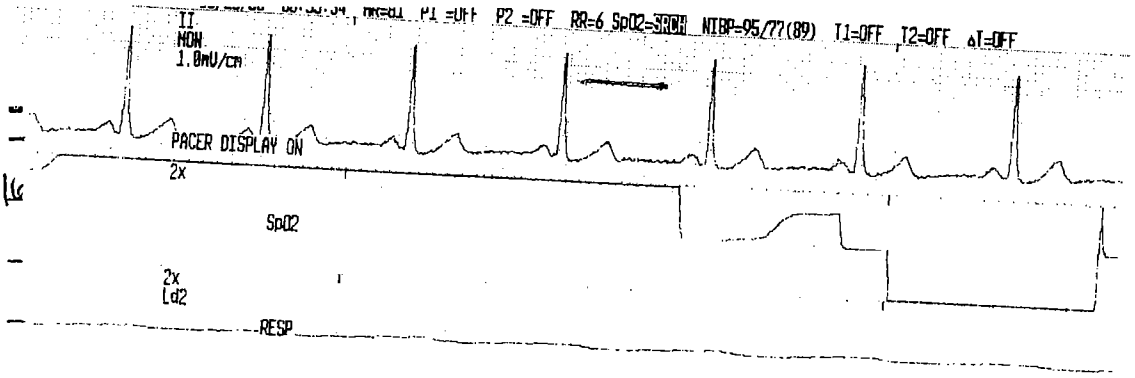

1 each entry)

Ts LRB
nonverbal
commands.
peripherally.

	Moves all extremities, good sensation.
	lung sounds clear throughout - slightly diminished on (R) side
0845: 95/77	lower lobe. LV: NSR, VS WNP. ↓ BS x 4 (+) abd dry c̄ 10 ¢ piece
HR: 67	size reddish drainage noted to (R) Midline area, inferior to underwire.
SaO2: 99%	Drainage is small, does not saturate through to ~~superior~~ (error) surface (b)(6)-2
RR: 6-8	dressing. Will cont. to monitor. Cap Refill ≤ 3 sec Bilat
T: 95.8	U/L Lights. (R) radial pulse 1+. All other pulses - Doppler
	pedis/radial = 2+. (+) 1+ edema to (L) hand - good strength
0900: 101/69	good ROM, good sensation to hand/arm. Pt c̄ out foley
HR: 77	will notate void and BM activity. Pt (+) (L) arm splint CDI.
RR: 9	Large dressing to buttocks over sacral area - CDI. Pt
SaO2: 100%	placed on (R) side. presently sleeping. Will cont. to
T: 96.1	monitor. (b)(6)-2 cpt/h
	1000: Zantac, Heparin, Cipro administered per orders. Pt
0915 BP: 109/48	sleeping quietly. (b)(6)-2
HR: 69	1005: Pt drinks 6 oz Carnation Instant Breakfast. c/o c/o N/V
RR: 9	abd discomfort. (b)(6)-2
SaO2: 100%	1100: Pt OOB for 'bird bath' and Δ of pj's. ~~Sitting in chair~~ (b)(6)-2
T: 95.7	1200: Pt consumed app 95% NOON meal w/o c/o N/V.
	Pt up and around ward back to chair. Pt presently
Chili x 2 portions	resting, watching ward activities from overhead chair
1 cucumber	1330: Pt in bed side lying (R) side. No complaint @ this
1/2 M&B crackers	time (b)(6)-2
8 oz Instant Breakfast	1335: PIV restarted @ TKO to maintain patency.
4 oz tea c̄ sugar	
1 can soda	

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG03	Assumed care of pt. Rcvd report from Spc (b)(6)-2
0600	pt in bed on side resting. 20g IV to (R) AC infusing
	LR at KVO. NAD at this time (b)(6)-2
0730	Pt ate thus breakfast c/o pain to
	(L) elbow ⊤ percocet give no for pain
	will monitor (b)(6)-2 SGT USA GIWMC
1030	Pt ↑ ambulate @ ward Am care performed
	by pt c̄ ø assist. Reinforce dsg to sacral
	wound c̄ guaze & tape. Pt denies pain
	at this time will monitor (b)(6)-2 SGT USA GIW
1400	Pt resting - appears sad, dressing reinforced c̄
	4x4s, no Δs in assessment (b)(6)-2 SGT/LAN
1720	Pt lying in bed, no discomfort or c/o pain. pre-
	medicated c̄ ⊤ Percocet for PT (b)(6)-2 SGT/LAN

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

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

(b)(6)-4

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Aug 03	OP NOTE
0835	PRE-OP DX - SACRAL DECUBITI
	POST-OP DX SAME
	PROCEDURE - DRESSING CHANGE
	SURGEON - Dr. (b)(6)-2 Anesth - Cpt (b)(6)-2
	FINDING: Grade IV Sacral Decub
	Description - Cuisine sedation - Removed during
	Lateral aspects of wound granulating - Fascia
	overlying Sacrum upon movable. No evidence
	of infection. Cleansed w/ Hibiclens. Packed
	w/ Saline soaked Fluff - Dressed. Pt tol
	Procedure well. Transported to (b)(6)-2
	stable condition.
	Keep $ IV Fluids in - 100 cc NS
	No Antibiotics. No Jaws.
	(b)(6)-2 (b)(6)-2, MD MAJ, MC USA CHIEF, DOS

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03	OP NOTE
0850	PRE-OP Dx - Sacral Decubitus / Open Abdom Wound
	POST-OP Dx - Same
	PROCEDURE - I+D Sacral Decubitus / Dressing change
	Surgeon - Dr. Conway Anstn - Cpt [redacted] b(6)-2
	Findings - Sacral Decubitus - Excavation / Deviation. Fascia over Sacrum
	Abdom - Granulation bed -
	Description - Cerebrum Sedation - Debridement of Sacral
	Decubitus of infection over fascia, Unroofed w/ Hibiscus
	then packed w/ Saline Sacral Flaps. Cavity w/ Flaps.
	Abdom - Removal drainage - Sagittal [redacted] CHIEF DOS [redacted] (b)(6)-2 MD
	Granulation bed - No exposed [redacted]
	Cavity w/ Saline Sacral Flaps Tol well +
	Transported to ICU in Stable cond.
	Cup Ø IV LR in - 200cc [redacted] (b)(6)-2 MD
	EBL Ø - [redacted] (b)(6)-2 MAJ, MC USA CHIEF, DOS

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 0900	Pt returned from OR, arousable, lying on side in bed, debridement of abd wound & buttocks Δd dressing, pt appears sad. Resp even & unlabored, lungs CTA bilaterally, NSR, Post op vital signs stable - see flowsheet. All pulses palpable, no edema noted, dressings to abd & buttocks CDI, Will monitor. (b)(6)-2 SGT/LPN
1000	Fentanyl patch not Δd last PM, Δd today will Δ time for next patch Δ (b)(6)-2 SGT/LPN
1730	Pt refused lunch - drank 1 Ensure (b)(6)-2 SGT/LPN
1450	Pt resting comfortably, Ø c/o pain (b)(6)-2 SGT/LPN
1830	Received pt this pm. In bed awake. Airway patent SaO2 97% RA ⊖ SOB. Lung sounds CTA. x4 lbs S1/S2 sounds present. Pulses palpable. cap refill <3 sec Dsg to Abd. CDI D'd by MD. Dsg to coccyx CDI. No other breakdown noted. BS ⊕ x4 quad. Pt ambulates to wrd commode. Pt on cardiac diet. Will continue to monitor (b)(6)-2 SGT USA.
1900	Pt consumed 2 pcs chicken and some vegetables for dinner. Pt now resting in bed will continue to monitor (b)(6)-2 SGT USA 2200 VS 110/63 HR-80 RR 12 SaO2 96% T 96.3. Meds given pt had 6oz ensure c̄ meds. Pt sleeping easily arousable

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.)* (b)(6)-4 (b)(6)-4

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG	No distress noted at this time will continue to monitor. (b)(6)-2 [redacted] 91WMO SPL USA 2400 Pt sleeping at this time. No distress noted will continue to monitor (b)(6)-2 [redacted] 91WMO SPL USA 0200 Pt sleeping easily arousable VS - 108/69 HR 71 - RR - 12 SaO2 96% c̄ (RA) - Dsg CDI. No distress noted at this time will continue to monitor (b)(6)-2 [redacted] 91WMO (b)(6)-2 [redacted] 0400 Pt sleeping no distress noted at this time will continue to monitor (b)(6)-2 [redacted] 91WMO SPL USA 0600 VS 113/67 HR 66 RR 12 SaO2 95% Pt is resting in bed no distress noted will give report to oncoming shift (b)(6)-2 [redacted] 91WMO SPL USA
18 Aug B 0730	0600 assumed care of pt. Pt sleeping in bed on (L) set. Ø IVF's infusing, O2 per RA. Ø evidence of resp or other discomfort. Assessment and plan to follow (b)(6)-2 [redacted]
0830	Pt up OOB to ward bathroom for complete bath, self accomplished. Khalafa encouraged to walk around ward and throughout hospital for exercise and to ↓ amt of sleeptime q d. Plan ↑ activity, ↑ nutritional intake c̄ concentration on protein. ↓ sleeptime and inactivity time, ↑ activities, promote self-care. (b)(6)-2 [redacted] Pt taken outside, 1/2 liter plastic bottle filled c̄ pebbles to be used for PT to (L) arm. (b)(6)-2 [redacted] Pt assisted/
(b)(6)-2 [redacted] 0900	
(b)(6)-2 [redacted] 1000	
0900 Percocet	accompanied to Physical Therapy for PT to (R) Arm.
1000 PT 1245	Returns to ward tired and in pain. 0900 Percocet ii
1200 Unit/sleep	tabs given for (L) arm pain.
MSO4	1230: Pt c/o pain to (L) arm, (+) facial grimacing, (+) inability to raise, move arm c̄/out assist. (b)(6)-2 [redacted] error
	M30 2 mg IVP administered per 18 g (R) PIV c̄/o evidence

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*					
DATE:	Quantity (cup.) & Description					
	*Breakfast	Snack	*Lunch	Snack	*Dinner	Snack
16 Aug.	NPO	6 oz. Carnation Instant Breakfast	95% meal - chili con carne 1 MRE cracker 1 cucumber 8 oz Instant Breakfast	Ø	1 cucumber 250 ml tea 3 servings rice tomato soup 1 cup	
17 Aug	240 milk 1/2 eggs 1/4 potatos 240 Ensure	240 ensure				
18 Aug	NPO		1 Ensure		1 ensure 2 pc chicken	
19 Aug	1/2 Double Portion of eggs 1 milk (240) Potatoes	Breakfast Gatorade drink	1 cup stew & veggies 3 cookies 1 Instant Breakfast 1	1 instant Breakfast 1430°	1/2 Noodles 1/8 Stew	
WT 133 lbs						

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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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

(b)(6)-4

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AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20AUG03	Report recieved - Pt. sitting in bed - A+O x3
1830	Pt c̄ ØIV access - D/c'd during day shift - Pt c̄ multiple bouts of defecation Ø diarrhea - soft formed stools - Δ in diet today - local food consumed from family - Pt c̄ no other complaints Dsg to abd C.D and intact - Dsg to buttocks Δ'd at 1600 - will monitor and change if saturated or unsecure - Lungs CTA bilat, Ø cough (+)BS hyperactive - Pt ambulating s̄ problems (b)(6)-2 [redacted] alwmk
2000	one choc carnation instant breakfast c̄ water small amt beef c̄ rice H2O (b)(6)-2 [redacted]
2100	Pt sitting in bed - 2200 meds given - 122/68-72 (b)(6)-2 [redacted]
2200	Pt sleeping will monitor (b)(6)-2 [redacted]
0200	Pt sleeping, VSS - Ø c/o pain - Ø BM since 1800 (b)(6)-2 [redacted]
0700	Pt resting comfortably - refused breakfast. Assessment performed (see DA4700). Plan: Pt will ambulate to back for bath & daily weight - will give Ensure to supplement diet. (b)(6)-2 [redacted] SGT/LPN
0900	Pt in back shaving & bathing - ambulated to BR & urinated approx 300cc clear yellow urine. (b)(6)-2 [redacted] SGT/LPN
1000	Pt ate chicken c̄ bread, drank 1 Ensure (b)(6)-2 [redacted] SGT/LPN
1500	Pt ate 1/2 lunch + watermelon & 1 Ensure (b)(6)-2 [redacted] SGT/LPN

131/81, 75, 18, 95%

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 Aug 03 1400	Pt resting comfortably in bed - sats 100% on RA. VS 106/58, 74, 17, 97.6 (b)(6)-2 SGT/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.

PROGRESS NOTES
Medical Record

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USA

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0730	Breakfast
	10% eggs
	10% hashbrowns
	250cc milk (full cream)
1000	Shake (Carnation) c̄ 250cc milk (full cream)
1130	Lunch
	1/4 spaghetti
	1 can peaches
1320	Shake (Carnation) c̄ 250cc milk (full cream)

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Aug 03	Breakfast 0750 Snack 1000 ~~Lunch~~ Lunch 1400
Weight:	1/4 chicken 1030: 1/2 MRE cracker 1300° 2 meat patties
133 lbs	1/2 orange 2-4 oz chicken Breakfast drink small piece
m/h BFD	8 oz instant Breakfast 1 instant Breakfast chicken - 2-2
Carb: 5.7g/27	8 oz 8 oz Instant Break
Prot: 3.7g/5	Snack - 1600 Dinner Snack
Fat: 1.6/0g	1 instant Breakfast 1/4 small portion meat
Cal: 52/130	1/2 portion rice
21 Aug 03	Ø Breakfast
	Chicken c̄ pita (mod. amt)
	2 Ensure shakes
	1/4 watermelon
	1/2 double portion meat (lunch) c̄ rice

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22AUG03 2024S	Nsg: Pt dressing was changed last night at approx 2200 to sacral region. 2 distinct decub ulcers seen. Both ulcers have marked tunnelling, purulent drainage, grey areas to periphery of wounds, and granulation tissue towards the center. Pt is being turned away (position on bed) from lying on this wounded area. Encouraging fluid intake. VS are WNL, w/ Sats 95% or greater. No labored breathing noted. Will cont to monitor (b)(6)-2
22AUG	PT AAOx3, PERRLA, VSS, DPP x4 extremities, bilat equal/strong, BBS CTA c̄ = EWE SAO2 95%, voiding via BSC, Ø complaints, A dressing, will continue to monitor (b)(6)-2 SGT 9/WMG
22AUG03	ASSESSMENT - 2230. AAOx3 PERRLA, LUNGS CTA BILAT, S.S2 STRONG AND REG. (+) BS x4 Ø % PAIN, A'd ABSG C.M.I, TOLERATED REG DIET. CARNATION INSTANT BREAKFAST x1. WILL CONTINUE TO MONITOR (b)(6)-2 SGT
23Aug03 1520	Nursing: Shift Pt. bright + alert, Ø signs of resp. distress, speaks clearly in native tongue. Lung CTA, (+) BS x4 Quds. (cont.)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	comfortable. BOD pt consumed meal, cont taking c̄ dad. (+) Instant Breath first # 3 ~~BMX2~~ today large well formed stools. Rt urinary c̄ out problems. (b)(6)-2
	1430: Brother, dad & Khalaf @ BS conversing. Brother shared chicken c̄ Khalaf. % intake unsure @ this time.
	1500: Dressing Δ to buttocks wet to dry. Large gaping decubitus stage IV, bilat buttocks. Deep, red. No necrotic tissue noted, ∅ fail smell (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.

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USA

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Aug 03 1520	Nursing (cont.) BM x1, fentanyl patch changed this shift, no other pain relief needed. Drsg to small of back, change c̄ op-site. Sacral dressing changed W/D. Carnation x2 thus far today. Meals on calorie count for today. Ambulation with much encouragement. Favors (R) side. Continue to encourage AROM. (b)(6)-2 CPT Au
23 Aug 03	- 200 - ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REG, (+) BS x4. ∅ % PAIN. CARNATION x2, TOLERA REG DIET. TURNING PT @ 2°. DRSG TO ABDOMEN C.D.I. WILL CHANGE DRSG TO BUTTOCKS @ 2200. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT. CPT
23 Aug 03	- ASSESSMENT - 2200 - DRSG A/d. C.D.I. WOUND SHOWS NO SIGNS OF INFECTION NO DRAINAGE. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT CPT
25 Aug 03 @ 0200	NSG shift assessment: Dressing change was done last night at 2230. Bilat decubs to buttocks appear to have some damaged tissue (darkening) at the entrance. Significant tunnelling noted. Good granulation tissue seen. Pt denied any pain this shift. Ate majority of dinner, and appears to enjoy his carnation instant breakfast drinks. VS. WNL. Keeps are event calibered. Will cont to monitor (b)(6)-2

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USAPA V1.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 AUG 03 -	KCAL COUNT - 1820 - PT ATE 100% DIET WHICH CONSISTED OF BAKED CHICKEN x2 PIECES, RICE, COLE SLAW, MIXED VEGETABLE, MILK ... (b)(6)-2 SGT LPN
26 AUG 03 -	2230 ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BLAT, S1 S2 STRONG AND REG. ⊕BS x4. ARSG A'd. C, D, I NO SIGNS OF INFECTION, Ø DRAINAGE. Ø C/O PAIN OOB TO BR CARNATION x2. WILL CONTINUE TO MONITOR (b)(6)-2 SGT LPN
27 AUG 03 2230	RN wound care note: Pt dressing changed: less tunnelling noted bilat, fresh granulation tissue is apparent (beefy-red). Diameter of wounds also appear smaller. Tolerated dressing change S difficulty (b)(6)-2
27 Aug 03	Nursing Notes: Pt stable. Ate OK. Ambulate without assistance. Slow steady gait. Pt sat in PX for about 20 minutes. Ø c/o pain. Will continue to monitor status. (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26AUG03 @0410	Nsg shift assessment: Pt continues on 3000 cal diet w/ Carnation instant breakfast supplements. Appears to be tolerating this diet 5 difficulty. Voiding QS med colored yellow urine. Dressing change done to bilat dumbs in sacral region. Tunneling does not appear to be progressing, and granulation tissue appears more abundant. Denied need for pain meds this shift. Sats are >96% on RA, VSWNL. (b)(6)-2
26Aug 03 1000	General Surgery SVC SC Pt [illegible] Tolerating Diet / Ambulatory [illegible] VS [illegible] Sacral Decubitus - Grade IV - Still w/ substantial defect undergoing Wets to [illegible] NS gauge [illegible] [illegible] Clinical Sup/inf granulation A: Sacral Decubitus - P: (1) Plastic Surgery consult to evaluate for flap coverage - will ask for [illegible] for [illegible] Tomorrow (2) Continue Mortuitus. (b)(6)-2 (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPAR	MD
SPONSOR'S NAME	SSN/ID NO.	RELAT	CHIEF, DOS

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

(b)(6)-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Aug 03	Nutrition Note Results of kcal count: Pt consuming approx 2100 - 2400 kcal / day 120 - 130 gms protein Pt's needs based on wt of 135 # is 2700 kcal/d Do not expect pt will be able to ↑ volume of food/supplements as he is currently at his maximum intake. If further supplementation is needed Night time tube feedings should be considered or ↑ carnation instant breakfasts to 6x/day. (b)(6)-2 MAJ, SP RD/LDN
28 Aug 03	PT AAOx3, VSS, BBS CTA SaO_2 96%, PPP bilat equal/strong, BS active last BM this AM voiding via latrine, sacral wound improving, ∅ complaints, will continue to monitor (b)(6)-2 GIWMG
29 AUG 03 @ 0330	Nsg shift assessment: Pt had a hearty appetite this shift, continues to readily drink his carnation breakfast/milk supplements. Wound care done - bilat sacral wounds appear to be smaller in diameter w/ less drainage. Tunnelling still significant, granulation tissue is a bufy red color. Voiding and having BM's 5 d/f. - (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Aug 03	1450: Dressing changed to sacral area with sterile Super Sponges soaked c̄ NSS covered with three 4x4's utilizing sterile technique. Decubitus to upper (L) glutea maximus with no drainage noted, yellow escar present in the center of tissue. (R) decubitus packed c̄ sterile super sponge, beefy red tissue present c̄ signs of infection. Patient tolerated procedure without discomfort. CPT (b)(6)-2 informed of tissue appearance. (b)(6)-2
29 Aug 03 1505	Nursing Assessment: Pt awake, ø c/o pain (at am) at 4hrs + inv. Lungs CTA, ø SOB, Osats 96% on RA. HR 84, reg, ø edema noted, ø IV access. Abd soft, nontender abd drsg CDI, will ask MD if drsg is to be Δ'd. Drsg to buttocks CDI. Pt ↑, amb self. Encouraging pt to drink shakes, pt mixing shakes himself. (b)(6)-2
29 Aug 1905	Nursing Notes: Assumed care of Pt A+O. Pt ambulated to BR ø complaint. Breathing intact ø SOB or laboured breathing. Abd sofr and nontender dressing clean dry and intact. Voids spontaneously will continue to monitor status (b)(6)-2
2250	Dressing change completed. Wound looks ok ø drainage or foul smell noted ø significant change, will continue to monitor status (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Aug 03 1050	Nursing Assessment: Pt awake, ϕ c/o pain. Pt alert, Lungs CTA, Co Sats 97% on RA. HR 82, reg, ϕ edema, ϕ IV access. Abd soft, nontender, hyperactive BS, ϕ BM so far today. Pt voiding well, ↑ OOB amb ⊼ assist. Drsg to ML abd intact Drsg to Bil. buttocks. (L) Buttock beefy red c̄ tunneling ϕ active drainage noted. (R) Buttock beefy red c̄ tunneling. (L) side of area has small area yellow tissue. ϕ active drainage noted. Replace c̄ saline soaked gauze & covered c̄ 4x4.
	——— 1 UT (b)(6)-2 AV
30 Aug 03 @ 2300	Nsg shift assessment: Pt A+O x 4 Reports some pain to left wrist given percocet Dress Δ done, right decub area appears beefy red, some drainage noted, tunneling still the same. Left decub appears to be healing better (less drainage, more granulation tissue). Poor appetite for dinner, did not appear to like the main entree (fish). No other skin integrity issues noted. Fluid intake appropriate, voiding ⊕ urine. VS WNL and POX >98% on RA — (b)(6)-2

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

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

#34

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 AUG 03 -	0838 - ASSESSMENT - A+O x3, PERRLA, LUNGS CTA: S_1-S_2 STRONG AND REG, ⊕ BS x4. TOLERATED REG DIET, CARNATION x1. DRSG TO BE A/d @ 1000. ~~[illegible]~~ Ø C/O PAIN. DRSG TO ABD. C, D, I. WILL CONTINUE TO MONITOR (b)(6)-2
31 AUG 03 -	1020 - NURSING - DRSG A/d. C, D, I. WOUND SHOWS NO SIGNS OF INFECTION, BEEFY RED COLOR. PT C/O Ø PAIN WILL CONTINUE TO MONITOR (b)(6)-2 SGT LPN
31 AUG 03	PT AAO, PERRLA, ~~[illegible]~~ BBS CTA 95% on RA, PPP bilat equal/strong, ~~PPP~~ BS active x4, voiding via latrine, dressing A, Ø complaints, will continue to monitor. (b)(6)-2 SGT 91WMS
Ø1 SEP 2003 1040	Nursing Assessment: Pt sleeping, easily aroused, Ø C/O Pain @ present. Lungs CTA, O_2 SAT 97% on RA. HR 82, reg, Ø edema noted. ⊕ BS x4, abd soft, nontender. BM x ÷ today. Pt voiding s̄ difficulty. ↑ OOB, amb s̄ assist. Drsg to abd, CDI. Drsg to bil buttocks CDI (b)(6)-2 AR
1 SEP	PT AAO, PERRLA 3m, BBS CTA 97% on RA, BS active in all 4 quadrants void via latrine, dressing A (improved), Ø complaints, will continue to monitor (b)(6)-2 91WMS
2 Sep 03 1100	Nursing Assessment: Pt awake, Ø C/O pain @ present. Lungs CTA, O_2 SAT 97% on RA. HR 84, reg, 12 pulses x4, Ø edema noted. Abd soft, nontender ⊕ BS x4. Pt reports Ø diarrhea (through interpreter) & voiding s̄ difficulty. ↑ OOB, amb s̄ assist. Drsg to buttocks c̄ sero-sang drainage. Wound is beefy red c̄ dime size area of yellow tissue to center of (L) buttock wound & smaller area yellow tissue to (L) edge of (L) buttock wound. W→D drsg c̄ normal saline & superspongy gauze. Pt tolerated well. (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	hearty. Voiding w/o diff., and pt VS WNL. will cont to monitor — (b)(6)-2
3 SEP 03 @ 2220	NSG: Dressing Δ done. (B) decub continues to appear to be improving (less drainage more granulation tissue, (C) Decub appears the same as last night's dressing Δ. Pt tolerated the change. 5 difficulties (b)(6)-2
4 Sep 03 1800	Nursing: Shift Note Pt remains the same. Eating + hydrating well. Encouraged to ambulate more. VSS, ∅ signs of resp. distress. Cont to mon (b)(6)-2 CPTD
5 Sep 03 1045	Nursing: - performed dressing change @ 1040. ∅ drainage noted. ∅ signs of infection. Wound has healthy beefy red color. Wound site appears to be healing. Site is smaller. Ensured pt was turned to his side to stay off of dressing. Dressing to buttocks CDI will continue to monitor throughout. (b)(6)-2
5 Sep 03	Assessment - 1400 - AHOX3, PERRLA, ∅ c/o pain. LUNGS CTA BILAT, S1-S2 STRONG AND REG, ORIENTATION ∅3, TOLERATED PEG DIET UP AD LIB. DRSG ACL PEEPING ON SIDE WILL CONTINUE TO MONITOR (b)(6)-2
6 SEP 03 @ 0430	NSG shift assessment: Dressing changed to decubs on sacrum. Areas distal to wounds appear to be getting some minor breakdown (where tape normally is). Taped area was made smaller to help alleviate this. No complaints at this time (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3SEP03 @ 0745	NSG shift note: Pt denies dressing change. Diameter of (R) sacral decub appears smaller, less drainage noted to (L) decub. Pt had a good appetite at dinner. Ambulating of own volition, and gait remains steady. Continues to take in adequate PO and voiding QS urine. (b)(6)-2
3Sep03 @ 1015	Nursing Assessment: Dressing change performed, dressing clean, dry and intact. Small amount of drainage. Pt tolerated dressing change with Ø pain. (b)(6)-2 PC
3Sep03 1450	Nursing Shift note: Pt. alert, bright, quiet & pleasant facial gesture of content. Ambulating w/o difficulty. Encouraged to increase intake of shakes. Concur c̄ above note regarding dressing changes. Continue to monitor. (b)(6)-2
3SEP03 @ 2100	NSG shift assessment: Pt continues to ambulate around ward + PT X cane w/ a good gait and no apparent difficulties. Dressing to be changed at 2200. Pt appetite @ dinner was

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

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

(b)(6)-4

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
8	7	03	0613

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☑ OTHER (Specify) Air Evac

CURRENT MEDS. (tetanus immunization and other data)
⊖.

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
WKDA.

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

HOME TELE. NO. (Inc. area code)

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

SEX M AGE 50

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	0613		0625
BP	124/81	-8 (b)(6)-2	116/68
PULSE			90
~~RESP~~ O2	99%		98%
TEMP.			
WT. (Child)			

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

ORDERS	INITS.	TIME
CBC, CHEM 12	(b)(6)-2	0620
Lyte's ABG		0620
Type + Cross		0620
Chest Xray		0614
elbow Xray		0614
Abd Xray		0614

ASSESSMENT/DIAGNOSIS
GSW LLQ
GSW ⓛ olecranon.

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0630.

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

TIME SEEN BY PROVIDER
0615.

TO I this AM Last meal 2300.
S: Pt is a 50 yo Iraqi ♂ EPW s/p GSW to LLQ and ⓛ elbow

PMHx ⊖
PSHx
Leg.

⊖ Tob.

O: wom in mod dist A+O No Respir dist.
HEENT: wnl.
Lungs: ⓐ LTA
Cor Amo ⓐ
Abd: ⊕ BS. Tense, distended. ↑ tend globally
Ext: GSW x 3 to ⓛ ASIS area + above.
open ⓛ olecranon 2° to GSW.
⊕ pulses

~~Stw~~

Abd Xray.
Mult frags across entire Abd.

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

(b)(6)-4

SIGNA (b)(6)-2

INSTR ... rdered, any limitations and follow-up plans)

To OR.

MEDCOM - 6537 ...ATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24Jul03	1730		Pt OOB to chair, tolerated well other than elevated HR. (b)(6)-2 [redacted]
24 July 2003		1845	Received report, assumed care of pt @ 1800: Pt up
O_2 NC 4L ✓			in chair @ side of bed, awake, alert oriented, calm,
NGT			flat saddened affect. VS 81/59:BP/127:Hr // RR:39/SaO2
(R) FA PIV	✓		98%. Ø evidence of respiratory distress or discomfort.
LR @ 50			Pt denies gain. (+) NGT clamped, to (R) rare IVF's = LR
Foley to gravity ✓			@ 50cc/h to (R) 18g PIV to FA. (-) evidence infection
JP drain ✓			infiltration, IV place 23 July. O_2 per NC @ 4L.
Cast-(L) arm			(+) foley to gravity clear yellow urine out. (+) Dressing
Abd incision ✓			to abd incision - midline app 45cm extending
			from lower sternum to pubic region, CDI JP drain to
			(R) L O_2 - Ø drainage noted @ this time. (-) Arm cast
			CDI. Cap refill to index ≤3 sec. skin color to
			Pinzi type NFR. unable to palpate pulse related to
			casting material.
			Pt placed on BSC, BM x 1, large soft dark
			brown. Pt cleaned, zinc oxide applied
			to decubitus on sacral area and on T6-T7
			of spinal process. Pt assisted to bed, placed on
			(R) side, comfort measures provided, Pt resting.
			Physical Assessment:
			NEURO: Pupils 1-2mm / 1-2mm PEARLA.
			A/A/O x 3 Moves all extremities purposely
			and spontaneously. Denies gain @ this time.
			Resp: (+) O_2 per NC @ 4L 98-100%, SaO2 RR 730
			Dr (b)(6)-2 [redacted] aware. (-) use of accessory muscles

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MEDCOM - 6538

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24Jul03	0800		Pt extubated c̄ difficulty, Suctioned a small amt thick white secretions - Pt sating @ 93-94% on NRB. RT at bedside monitoring. (b)(6)-2
	0845		Pt given neb treatment & CPT, coughed up more thick white sputum. Lungs still sound crackly on (R) side.
	1000		Pt turned & bathed. Coughed up large amt thick white sputum - sats ↑d to 100%, resp effort improving, pt in NAD c̄ a resp rate of 30-35, still on NRB @ 15lpm, Zinc oxide applied to both sores on back & sacrum - Sacral wound appears to be tunneling now, pt turned onto (L) side - continues to try to lay on back - appears much more comfortable on back. Will monitor resp status (b)(6)-2
	1200		Pt had episode of hiccups, turned NG suction down. MD notified. (b)(6)-2
	1500		25mg Thorazine given for continued hiccups - resolved immediately. Pt changed to NC @ 6lpm still sating > 98%. (b)(6)-2
	1600		A-line DC'd, tube feeds resumed, this hour 60cc given (30cc at a time). Pt sitting up in bed. IS done, pt still coughing up large amts thick white sputum. (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

REGISTER NO.

WARD NO.

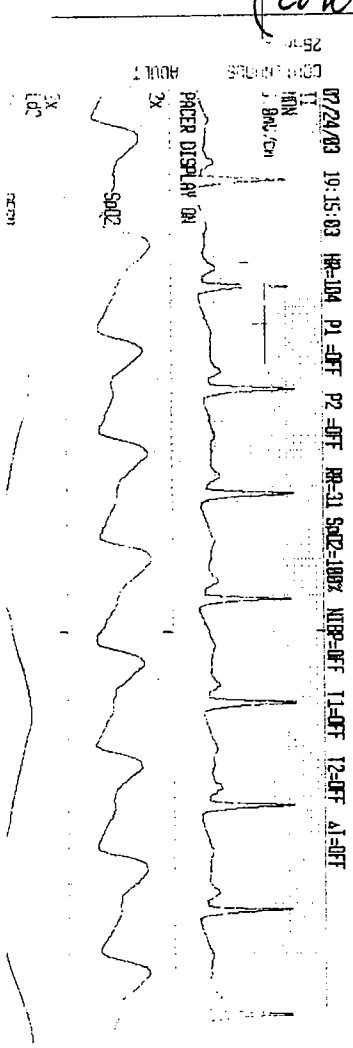
NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

CC

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 July 03	1845	—	zinc oxide applied.
			Plan: Monitor resp & cardiac status continuously. Encourage REST. Monitor T and I/O's. Cont. IVF's encourage incentive spirometer deep breathing and coughing. Reposition pt. off ulcers AMAP. Cont tube feeds, titrating from 30-60 cc/hr. Monitor residuals. Encourage PO H_2O intake. Provide comfort measures. WATCH stage 1 ulcers to bilateral heals, maintain elevated. — (b)(6)-2
	(Cont.)		Provide good pain control and emotional support c̄ much encouragement. — (b)(6)-2
			1900: Pt c/o abd pain MSO_4 2mg IVP administered. Pt appears comfortable s/p administration. — [redacted]
			2030 Pt vs stable as noted on standard form 511. b(6)-2 Residual check for tube feedings @ 1900 = 75 cc/hr feeds held. Dr (b)(6)-2 @ BS 2000 Requests feeding to cont @ 30 cc/hr - slow titration to ↑ as tol. Feeds resumed @ this time. Residual ✓ @ 2200: Pt resting comfortably.
			2130: Pt decubitus to coccyx tx'd c̄ wet gauze Base, covered c̄ tegaderm. Back ulcer tx'd c̄ tegaderm; Pt turned on (R) side c̄ coccyx off mattress. Heals elevated, donut in place. MSO_4 2mg IVSP administered pre wnd intervention. — (b)(6)-2
			2200 Residual ✓ = 10 cc, (+) 30 cc H_2O flush. BS noted



-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 July 2003		1845	NSG Cont. Breathing shallow, non labored. Breath snds clear c̄ diminished bases bilaterally. ⊖ JVD. ⊕ white sputum, small amt, pt able to cough up c̄/out aid of suctioning. ~~cough~~ (error (b)(6)-2
			CV: NSR, Tachy c̄ HR > 100 BPM. BP WNP @ this time = 106/40 102 (R) radial pulse 1+. Bilateral dorsalis pedis pulses 2+. ⊕ Edema bilat. lower extremities @ 1+. BP per N1 to (R) brachial. ⊕ Cont Cardiac monitoring.
			GI: Abd dressing CDI, JP drain intact, minimal serosanguinous output. abd soft, tender on palpation ⊕ ↓ BS (R) U/LQ (L) UQ - unable to assess (L) LQ R/T dressing/position.
			GU: Foley to gravity clear yellow >50 cc UOQ, Ø swelling noted to zeros or scrotum, Ø discharge from meatus.
			MS: Pt stands w/assist, weak and hunched over. ⊕ ↓ strength to bilat U/L extremities; ⊕ cast to (L) ARM from proximal end of humerous to hand. ⊕ CDI.
			Skin: ⊕ stage 2 decubitus ulcer to sacral area ~ 15 cc diameter, ⊕ cozing. Zinc oxide applied, pt placed on side. ⊕ 3cm diam stage 1 ulcer to T6-T7 area on back.

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-4 25 July

510-112 NSN 7540-00-634-412

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 July 2003		2200	(NSG Cont.) ⊖ abd distention. Pt tol. ~250 cc PO H_2O intake ≈ 120 cc @ this time. IVF's cont infusing. foley draining. VS stable (b)(6)-2
		2300	⊕ Facial grimacing ⊕ c/o abd pain MSO4 2mg IVP administered. Pt returns to sleep (b)(6)-2
25 July 2003		2415	Residual ✓ = 75 cc feeding's held. (b)(6)-2
			LATE NOTE: ⊕ use IS ≈ 20 Breaths completely 900 cc/sec. (b)(6)-2
		0200	Residual ✓ = 30cc out. Feeding cont. @ 30cc/hr. (b)(6)-2
		0300	Pt repositioned to ⓛ side. Tegaderm to dorsal decubiti intact. MSO4 2mg administered prior Repositioning. O_2 ↓ 3L SaO_2 remains @ 95% RR ↑ 30+ BPM. O_2 @ 4L SaO_2 100% BPM = 20-22. O_2 ↑ to 4L via NC. Will attempt weaning later. ⊕ H_2O per oral pt. 60 cc ≈ I/out c/o N/V (b)(6)-2
BP 107/58		0445	CBC, chem 7 drawn, walked to lab - results pending. CXR - portable ordered - pending. Pt resting comfortably Gentamicin infusing. (b)(6)-2
HR 78			
RR 22			
SaO_2 100%		0515	CXR TECH @ BS Pt sleeping quietly VS STABLE (b)(6)-2
2L O_2		0545	Zantac ↑. Pt cont. sleeping quietly (b)(6)-2
NC		0600	Report given to SGT (b)(6)-2 Pt care assumed per
T 98.8°F		Δx.	SGT (b)(6)-2 (Continue on reverse side) (b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) RE (b)(3)-1 WARD NO. ICU

NURSING NOTES
Medical Record

(b)(6)-4

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

[redacted] (b)(6)-4

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July	0615		LATE NOTE: PT WEANED from 4L O_2 to 3L @ 0300
			Pre weaning sats = 99-100% RR 20-21 BPM. Post
			WEANING SATS 98% RR 22 BPM. 0400 Pt WEANED from
			3L to 2L NC c̄ sats remaining @ 98% RR @ 22.
			Will continue to monitor and recommend weaning to dry st/ [redacted] (b)(6)-2 CPT
25 July	0630		assumed care of pt. Report given by CPT [redacted] (b)(6)-2 AN
			Pt in bed c̄ HOB ↑ 30° angle. IV infusing @
			50cc/hr of LR. VS WNL will monitor —
			[redacted] (b)(6)-2 91W20M6
25 July 03	0730		Dr. [redacted] (b)(6)-2 at bedside Δ'd dressing to abd. remove
			JP drain. Initial assessment complete:
			Neuro: pt easily arrousable, pupils 2mm Pearl
			Alert, able to move all extremities.
			Resp: RR 25 SAO2 99% on 2L O_2 via NC. LS - Crackles
			heard throughout inspiratory/expiratory halations
			Pt coughs up thick yellow sputum
			Skin: Warm & dry color: Normal for Race. Abd drsg
			Δ'd by Dr. [redacted] (b)(6)-2 this Am. JP drain removed
			Tegaderm on upper back intact. ~~W~~ [redacted] (b)(6)-2 weit to dry.
			drsg to coccyx intact will Δ c̄ Am care.
			Gastro: NGT (+) placement c̄ 50cc/of residual
			flush c̄ difficulty, Jevity plus infusing @ 30cc/hr
			at this time. Pt seems to tolerate feedings well
			(+) BS x 11 quad. Abd soft non distended —
			GU - Foley → gravity draining drk. yellow urine
			Cardiac: NSR HR 80's (+) peripheral pulse x 3
			unable to asses (L) radial/brachial #/T cast. →

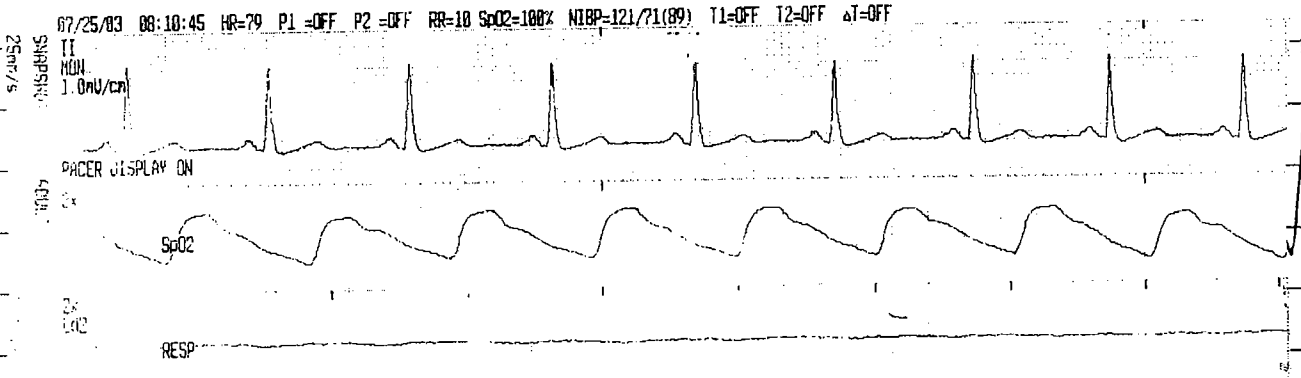
*U.S. Government Printing Office: 1995 - 404-763/20065 STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6543

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July	0730		cont Pt able to wiggle finger w difficulty, gd. capillary refill. See rythm strip



			Plan: Pt OOB → Chair, Ambulate Pt, DBC and incentive spirometer (b)(6)-2 SGT USA
25 Jul 03	0900		Residual 10cc T'd Jevity feedings to 60cc/hr. Am care done Pt oob → chair Ineffective deep breath & cough w Incentive spirometer 600mL 2 1sec. Pt able to produce thick yellow sputum will continue to monitor (b)(6)-2 SGT USA Glume
25 Jul 03	1030		Pt ambulated 50ft maintain SaO2 of 98-100% on 2L O2 via NC. PT → BTB HOB ↑, pt position on side will monitor (b)(6)-2 SGT USA Glume
25 Jul 03	1100		50cc of residual, jevity @ 60cc/hr pt in bed resting appears comfortable will monitor (b)(6)-2 SGT USA Glume
	1200		SaO2 ↓ 84% O2 ↑ 4L encourage to take deep breath SaO2 ↑ 98-100%. Pt position on back w HOB ↑ 30% angle (b)(6)-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

Glume

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July 03		1480	Dr (b)(6)-2 at bedside c̄ pt c̄ translator
			discussing PO intake. Diet advance to
			clear liquids. Drsg to coccyx Δ'd
			Cleanse c̄ NS c̄ stoma wafer applied
			pt on side with monitor
			(b)(6)-2 SGT USA 91W MC6
		1442	Late note 1300 MSO4 2mg given IVP for pain
			c̄ gd effect pt resting comfortable
			(b)(6)-2 SGT USA 91W MC6
		1600	Dr (b)(6)-2 at bedside to do drsg Δ
			MSO4 2mg IVP given for pain. patient on
			(L) side. Jevity Δ to 90cc/hr @ 1500
			pt tolerates well. will continue to
			monitor (b)(6)-2 SGT USA 91W MC6
		1730	Report given to Capt (b)(6)-2, AN
			(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July		1800	Assumed care of pt from SGT (b)(6)-2 Pt in bed awake, alert oriented, ~~[illegible]~~ (error (b)(6)-2) lying on (L) side O_2 per NC @ 2.5 L SaO_2 98% RR ~ 20 SPA ∅ evidence resp. distress. NGT to (R) nare infusing fluid @ 90 cc/hr c/ow evidence of n/v or abd discomfort. Abd dressing to midline incision CDI. LR infusing @ 50 cc/hr to (R) AC 18g PIV placed 23 July 03 ∅ evidence infiltration (+) redness noted to insertion site. D/c of PIV and reestablish new one - pending (L) arm cast intact CD: (b)(6)-2
		1815	Pt care assumed by SGT (b)(6)-2, CPT (b)(6)-2 off ward for staff meeting (b)(6)-2
		1900	Reassumed care of pt. Ox remains on (L) side. Q wet, calm ⊖ evidence of discomfort Physical Assessment:
			Neuro: as above. Responds appropriately to simple commands, gestures needs appropriate
		Pupils	3mm/3mm - pearl A. Moves all extremities purposefully good muscle strength all ext. c̄ ↓ strength to (L) arm. (+) sensation
		Resp:	Lungs not clear, ↓ bilateral lower lobes. Sats 98-99. RR 20-22 BPM (Continue on reverse side) O_2 @ 2.5 L via NC

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

REG (b)(3)-1

WARD NO. ICU

(b)(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6546

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July 2003	Cont	1900	NSG: (Resp) ⊕ productive cough, small amt of white thick sputum. (b)(6)-2
		CV:	NSR, HR ~80-90 BPM, BP ~100-115/50-60's ~. Cap refill to all digits u/l ext. ≤ 3 sec. pedal pulses strong @ 2+ Bilat, (R) radial 1+ weak, wable to assess (L) pulse r/T cast material. ⊖ JVD. ⊕ 1+ edema to ankles
		GI	dressing to abd incision intact, ∅ drainage noted. Abd soft, tender on palpation, ⊕ guarding c movement from sitting to lying c vice versa. ⊕ BS x 4 q. NGT ~~(R) nare 90 cc Jevity refusing~~.
		GU:	Poly to gravity light yellow urine out >150 cc/hr. ∅ discharge (purulent) from meatus ⊖ swelling @ this line
		MS:	AS stated in CV section. Pt pending OOB - dbar
		Skin:	Warm to touch, pale, poor skin turgor.
		IV:	18g PIV to (R) AC pending Δ this evening ⊖ evidence infiltration ⊕ redness ⊖ warmth ⊖ tenderness, ⊖ purulent d/c.
		Plan:	Monitor Resp/cardiac status. Maintain ✓ on T/I's c O's, Abd. drainage. Encourage PO intake of H_2O, include yellow cont Jevity - ↑ Rate to target rate 110 cc/hr. ✓ Residuals q 2°, Maintain IVF's LR @ 50cc/hr, Δ PIV site, D/C old site. Encourage ambulation, escort outdoors

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MEDCOM - 6547

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July (cont N56)			1900: Encourage IS, slow deep breathing and coughing. Maintain duoderm to coccyx keep off back and buttocks as much as possible. Provide emotional support, self care and comfort measures (b)(6)-2
		1940:	MSO_4 2mg IV for c/o abd pain. (+) Insentive spirometer, 9 breaths @ 1200 cc/sec. Pt prepped for excursion outside. MSO_4 2mg IV administered. Pt assisted OOB to chair, pt stands c̄ assist, encouraged to ambulate, (+) walking 10 slow, calculated steps. Pt assisted to litter. IV HL'd, O_2 per NC and portable tank. NGT clamped. Padding, sheets placed on litter. Pt secured HOB @ 45°. Ø complaint of pain or discomfort. Pt assisted out doors x 45 minutes, accompanied by 3 staff members
		2050	Pt returns to ward, placed in bed, O_2 @ 2.5 c IUF's → 50cc/hr - LR; NGT cont @ 90cc/hr. Pt tol 250 cc H_2O and 4 oz Jell, prior to trip outside. Consumes 250cc H_2O on arrival to ward. Ø c/o N/V. Pt posted on (R) side off decub. (b)(6)-2
		2130	PIV placed 18 g to (R) wrist per 2hr (b)(6)-2
			Old PIV d/c'd - IUF's cont @ 50cc/hr (b)(6)-2
		2200	Heparin SQ 5000 administered per order

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

(b)(6)-4

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

(b)(6)-4

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 July 03		2200	Zantac infused over 15', Cipro follows for infusion to run over 30 min. PIV intact — (b)(6)-2
26 July		2400	Pt sleeping on (L) side. VS stable, breath sounds clear. Pt appears comfortable — (b)(6)-2
			LATE NOTE: pt c/o sore throat — (+) redness to adenoids. Cepacol lozenge PO administered c little ↓. — (b)(6)-2
		0140:	Pt awake intermittently throughout shift. Repositioning onto (L) side and ↓ light on ward, ↑ pt's ability to sleep. Will cont. to monitor (b)(6)-2
		0420:	Pt awake, denies pain, H_2O refuses; appears tired, saddened — (b)(6)-2
26 July 2003		1545:	Report on pt given to oncoming shift (resting w/o evidence of discomfort). Pt care responsibilities to be passed to on coming shift @ 0600 AM — (b)(6)-2

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MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Jul 03	0600		Assumed care of pt. Rec'd report from Cpt [(b)(6)-2] Pt in bed w/ HOB ↑ 30° angle
			W infusing LR @ 50cc/hr. Zantac infusing'
			Levity infusing at 110cc/hr. Pt appears to
			be comfortable. [(b)(6)-2] SGT USA 91WM
	0700		Pt on bedside commode am care given.
			Pt had a Med formed brown stool. IV site
			Heplocked per order, unable to flush, New
			site 18g Heplock to (R) forearm flushes w/
			difficulty. Pt walk w/ assistant outside
			about 200 ft maintain SpO2 @ 98% on 2L
			O2 via NC Pt BTB resting at this
			time [(b)(6)-2] SGT USA 91WM
	0800		Dr [(b)(6)-2] at bedside to do drsg.
			Δ on Abd. MSO4 2mg IVP given for
			pain. Intial Assessment complete:
			Neuro: Pt alert, awake, able to follow
			commands. Pupil 2mm Pearl, Move all
			extremities.
			Resp. RR 22 SpO2 98% on 2L via NC.
			LS Crackles heard. IS 600mL > 1sec x 4
			Pt able to produce thick yellow
			0830
			Sputum. SpO2 95% on Room air. Ø SOB

(Continue on reverse side)

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

[(b)(6)-4]

REGISTER NO.

WARD NO.

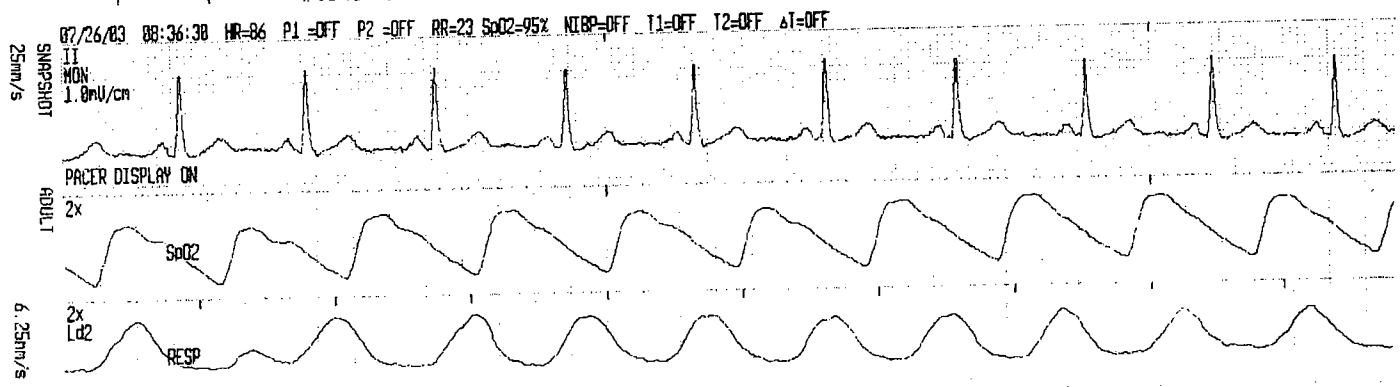
NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-

MEDCOM - 6550

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0800		cont' skin: warm and dry to touch. Dr (b)(6)-2
			in to do Abd. drsg. drsg to upper back clean &
			intact. drsg on stage II decub. coccyx Δ'd
			IV: Heplock 18g to (R) forearm
			Gastro: NGT (+) placement < 10cc residual
			flushes ≥ difficulty. Jevity infusing @ 110cc/hr
			Pt ate sm amt of breakfast this am
			tolerated well. BS x4 quads med brown
			formed stool this am.
			GU: foley + gravity draining 300cc of
			urine. Foley d/c'd this am. pt has
			not voide at this time.
			Cardiac NSR HR 80's + peripheral
			pulses able to move all extremities
			gd cap refill. slight edema noted to lower
			extremities. See rythm strip.



			Will continue to monitor
			(b)(6)-2 SGT USA 91WM6

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STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6551

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Jul 03	1000		Pt in bed resting at present time
	NSG		SaO2 maintain 95% on RA. IS 900 1sec.
			Produces sputum, thick yellow, Will cont'
			to monitor (b)(6)-2
	1100		SGT (b)(6)-2 ortho tech in to remove
			cast. Pt OOB → chair. Pt walk 25Ft
			maintain SaO2 95%↑ on RA. X-Ray
			to (L) elbow. ortho reapplied a splint
			to (L) arm. Pt BTB position on (R)
			side appears comfortable
			(b)(6)-2 SGT USA 91WM
	1145		Rt in to do chest Pt c̄ pt
			(b)(6)-2 SGT USA 91WM6
26 July 03			HHN Tx given c̄ 0.5 Albuterol/2.5 NS. BBS for
1200			↓↓'d to RLL c̄ Rhonchi throughout. HR 102
Resp Therapy			RR 26 O2SAT on R.A. 96%. P̄ Tx Vs stable. CPT
			performed to RLL x 6 mins. Pt c̄ productive cough
			dirry CPT for moderate amount thick white secretions.
			P̄ Tx BBS for ↓↓ RLL c̄ Rhonchi to LLL, clear to apical
			regions. NAR (b)(6)-2
		1300	Pt c/o pain to abd. MSO4 2mg give IVP
			pt appears comfortable Will monitor
			(b)(6)-2 SGT USA 91WM6

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES

Medical Record

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Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
		1600	Pt in bed, on side, able to produce thick white sputum. Ø complaints of pain at this time. Residual 10cc ⊕ placement verified by air bolus. Will monitor (b)(6)-2 SGT USA
26 July 03 1600 Resp Therapy			CPT performed to RLL c̄ patient in lateral declined position. HR 96 O_2SAT on R.A. 96% RR 26. BBS for b'd to bases but clear. Pt c̄ ⊖ cough during CPT. C/o Pain to abdomen NAR (b)(6)-2 CRT
		1655	Pt in bed appears comfortable, able to reposition self c̄ minimal assistance IS 900+mL for 1 sec. Pt coughs & produces thick white sputum. Pt denies pain at this time (b)(6)-2 SGT USA
		1715	Pt nibbled at dinner tray ate ½ apple & a few bites of main meal. Seem to tolerate well. Pt able to void x 3 p̄ foley been removed. Will monitor (b)(6)-2 SGT USA
		1850	Pt in Bed c̄ HOB + 45° angle pt appear comfortable will report to oncoming shift (b)(6)-2 SGT USA

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26JUL03		1815	Received report assumed care of pt @ 1800. Pt awaken, alert oriented x3 lying on (L) side in bed. NS infusing @ 20 cc/hr to 18 g to (R) PIV placed 26 July 03. Ø evidence of infiltration. Oz per RA, SaO2 98 RR 22, Ø evidence Resp distress. (+) NS 12, AK [illegible] BP WNB. NI cont cardiac monitoring in place. (+) splint to (L) arm, moves all fingers, (+) sensation, normal skin color, cap refill ≤3 sec. (+) ↓ strength. (+) Abd dressing CDI, Urinal @ BS. No evidence of distr @ this time (b)(6)-2
		1845+	Pt OOB to chair c̄ assist. (+) BM - Mod, well
		2000	formed, VOQ aqq 250 clear yellow. Oz error (b)(6)-2 ~~HELD~~ NS held, PIV SL'd. TF held. Pt assisted outside ambulating 3/4 way around hospital. Returned to ward, sacral decubitus care provided - washed w/NS, dried, skin protective barrier from ostomy pouch placed over wound. Reinforced with tape. Upper back ulcer redressed c̄ tegaderm. See physical assessment for ulcer description. Pt returned to bed, placed on (L) side, NS restarted @ 20 cc/hr. TF restarted at 110cc target rate. Pt appears tired, allowed to rest (b)(6)-2
		LATE	Note: Physical Assessment

(Continue on reverse side)

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

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WARD NO.

NURSING NOTES

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STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDCOM - 6554

NURSING NOTES
(Sign all notes)

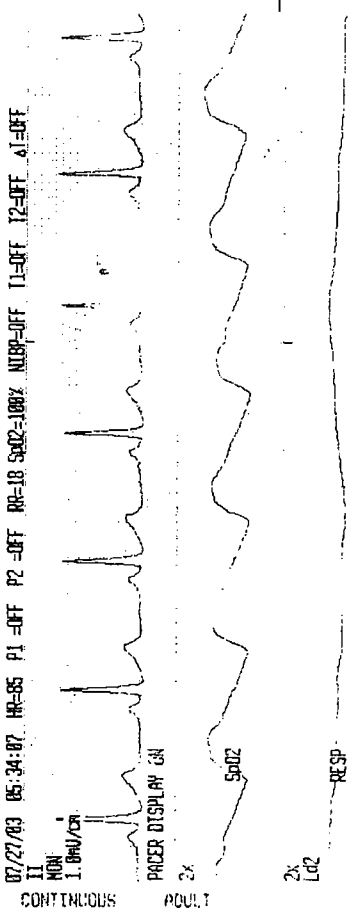
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 July 2003		1820	Physical Assessment:
2		—	Neuro: Alert, oriented x 3, flat affect, sad looking. Pupils: 3m-3mm PEARLA; (+) redness to adenoids, pt c/o sorethroat. Aqacol lozenges @ BS — pt given one @ time of assessment. (+) movement, spontaneously of all extremities, good sensation
			Resp: O_2 per RA: SaO_2 ~98° RR 22-28 BPM. (+) Crackles upper Righ/middle lobes, diminish (R) base; (+) crackles upper (L) lobe c̄ fine exp. crackles to base. (+) intermittent cough w/ sm amt thick clear-white sputum production.
			Cardiovascular: NSR Hr: 90's - low 100's BP: 140 systolically 50-60's diastolically, (-) JVD, SOB @ Rest c/o chest pain, (-) palpitations. 1+ edema Bilat ankles. (Resp skin color normal for race) Cap refill ≤3 sec. R/L up-low ext.
			Gastrointestinal: (+) ABD incision dressed heavily c̄ gauze dressing CDI. (+) BS x 4 q. (-) abd distention (+) tendemen on palpation, NGT (R) N c̄ Jevity infusing @ 110 cc/h. Residuals ≤10 cc/h. (b)(6)-2
			to 1 solids & liquids. (b)(6)-2
			GU: Pt urinating via urinal good UOP - clear yellow
			MS: Ambulates w/ assist. (+) steady gait (L) upper ext. ↓ strength.
			Skin slightly jaundiced; warm to touch. 2cm x 1cm 2° decubitus to T6-T6 on back. (+) skin break down to sacral area - (L) Buttock ≤8cm x 3cm decub. -

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 July 2003	1820		Physical Assessment (Neg cont):
			necrotic inner aspect, redding @ periphery (R) buttock
			3"x4" stage 2° decubitus. Wnd care performed as
			described earlier, STAGE 1 decub to heals Bilat Mantan e
		lines:	18g (R) FA NS @ 20 cc/hr ⊖ evidence infiltration
			Plan: Monitor respiratory/cardio status. Chest pt, IS
			deep slow Breathing, ambulation, coughing. Encourage
			PO solid & liquid intake, continue tube feeds @
			110 cc/hr = target date cont. residual V's.
			Encourage side-lying - off of decubitus; encourage
			self care; provide distractionary resources - i.e.
			magazines, TV in PLX to promote emotional health.
			(b)(6)-2
		530:	Pt (b)(6)-2 @ BS for CPT. (+) productive
			cough c̄ small amt of clear sputum productio
			(b)(6)-2
		100	TS x 5 @ 900 cc/sec. Pt appears tred. (b)(6)-2
		130:	Dr. (b)(6)-2 @ BS performing dressing Δ to
			abd. MSO, ⊼ 2mg administered pre dressing Δ (b)(6)-2
		300	PIV infiltrates. 22g placed to (R) AC, NS
			TKO @ 20cc hr. (b)(6)-2
		0100:	Pt awake, lying in bed, denies pain, pef PO fluid
			intake (+) UDP clear yellow - 400 cc's. O2 per NC @ 1L to ↓ RR 30
		0315:	Pt resting. VS STABLE. SaO2 98% RR 22-24 BFM



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

REGISTER NO.

WARD NO. ICU

NURSING NOTES

Medical Record

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Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6556

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003	←	0535	Pt sleeping quietly. NS infusing TKO @ 20 cc/h. Feedings coming @ 110 cc/hr. HOB @ 35°. Pt appears comfortable. Ø evidence of resp difficulties. (b)(6)-2

510-112 NSN 7540-00-634-412

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22Jul03	0600		Assumed care of pt. Rcvd report from Cpt (b)(6)-2 AN. Pt in bed appear to be sleeping. ~~LR~~ NS @ 20cc/hr, Zantac infusing NAD at this time — (b)(6)-2 9PM
	0630		Pt in bed Intial assessment done: Neuro: easily arousable, Alert moves all extremities. denies pain. Resp: RR 20 SpO2 100% on 2L O2 via NC LS: (+) crackles. Productive cough c clear, thick white sputum. Skin: color normal for Race, skin warm and dry. Drsg to Abd CDI, Tegaderm to Mid back intact, drs to coccyx intact. AM care done at bedside, c̄ minimal assistance. IV - 22g IV patent flushes c̄ difficulty infusing NS @ KVO. Ø s/s infiltration present tm Gastro- Abd Soft Pt had large soft brown stool this am. (+) BS x4 quads. NGT (+) placement 140cc Residual Jevity stopped. Ate little at breakfast. 240cc PO Liquid. GU. Pt able to void → urinal c̄ difficulty urine clear yellow 400cc this am

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO.

(b)(6)-4

NURSING NOTES
Medical Record

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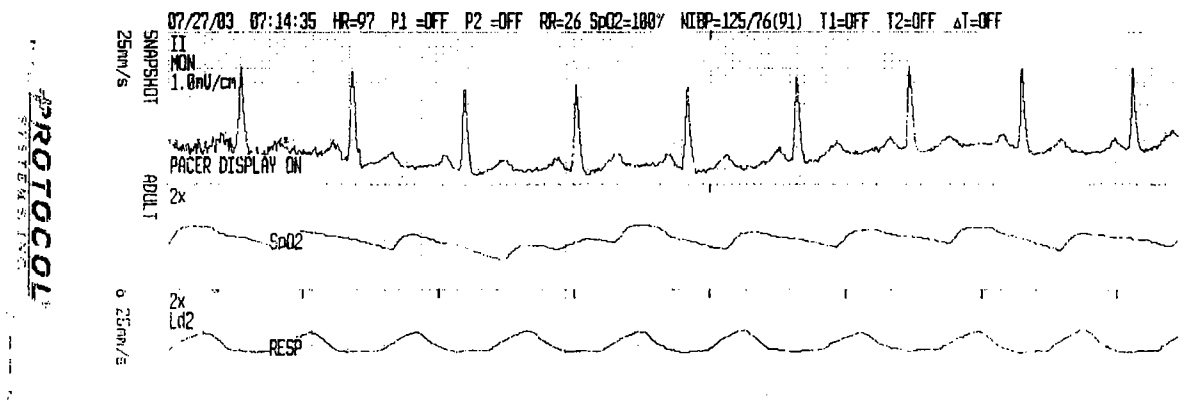
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 03	0630		con't Cardiac: NSR (+) peripheral pulse (+) sensation to all extremities. HR 84 See rythm strip



			will monitor — (b)(6)-2 SGT 91WM6
27 July 03 0800 Resp Therapy			HHN Tx given c̄ 0.5 Albuterol / 2.5 NS. BBS for ↓'d bases c̄ Rhonchi and Exp wheeze (L) Lung segments. HR 97 O2 SAT on 2L/Min NC 100% RR 22. CPT performed to RLL x 5 mins c̄ Pt in lateral recumbent. P̄ Tx BBS for ↓'d bases but clear. Pt c̄ ⊖ cough. Performed IS c̄ Nurse for 1200 cc/sec x 10. HR 94 RR 24 O2 SAT on 2L/min NC @ 100%. NAR — (b)(6)-2 CRT
	0830		NGT (+) placement 20cc residual levity infusing @ 110cc/hr. Pt was OOB and ambulated: 50 ft c̄ difficulty maintain SAO2 ≥ 92% on RA. IS done in charge 1200cc/sec x10 pt tolerated well. pt BTB - RT performed chest pt. Appears Comfortable — (b)(6)-2 91WM6 SGT

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MEDCOM - 6559

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 03	1010		0930 Dr. (b)(6)-2 at bedside to Δ abd drsg. Pt OOB → chair. Pt had a lg loose formed Brown BM. IV to (R) forearm infitrated: new IV site 20g (R) underside of fore arm. unable to flush. New site to (R) Hand (+) flush ∓ difficulty. Cipro infusing ∓ difficulty IV site ∅ S/S Infiltration Pt BTB appears comfortable will monitor (b)(6)-2 SG
		1200	Cipro leaking @ IV site. IV site Heplocked. ~~New~~ Changed orders PO Cipro 500mg q 12°, Δ Fluconazole 100mg po qd and Δ Zantac 150mg po Per Dr. (b)(6)-2 Pt ↑ on commode had a loose formed brown stool. Pt able to take PO med ∓ difficulty. Pt BTB, Pt refused Chest Pt V.S. 118/68 P 89 R 21 SaO2 100% on RA LS clear Bilat ↓ in Bases. Pt refused lunch. 1230 Pt in bed at present time appears comfortable. ∅ complaints at this time (b)(6)-2 SG

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
Medical Record

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NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 04		1400	Pt c/o pain in ~~dd~~ unable to flush IV
			New order PO Percocet 1-11 q 4-6 prn for pain.
			Pt recieve 11 PO Percocet for pain c̄ gd
			effect. 1430 Pt looks "sad" ask
			how he was feeling via translator
			State that he is sad. Pt OOB Ambulate
			to PLX corridor O2 sats remain > 95%
			on RA. PT BTB. 1500 Pt OOB sitting
			in chair drinking tea, looks sad. Tolerated
			Po fluid. NAD at this time —
			(b)(6)-2 SGT USA
		1600	Family member in at bedside. Dr. (b)(6)-2
			in c̄ translator to explain injuries
			New order d/c Gentamicin. Pt sitting
			in chair visiting family member NAD
			at this time — (b)(6)-2 SGT USA
		1630	Pt ↑ in chair c̄ family member Chest Pt
			Refused VS. 137/80, 94, 22, SAO2 100% on RA
			LS clear on (L) side, slight Rhonchi on (R)
			↑ base LS. IS 1200mL/sec x10 NAD at
			this time — (b)(6)-2 SGT, USA
		1730	Pt appetite ↑ ate chicken, potatoe & some
			corn. family member c̄ pt. Pt tolerate meal
			well. SAO2 remains 100% on RA —
			(b)(6)-2 SGT USA

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STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 Jul 03		1800	Pt on commode. Had sm loose formed stool. Pt BTB. (+) placement on NGT ē ø residual at this time. VS 135/75 - 91 - 19 SA 02 99% - 100% this shift, Jevity infusing @ 110cc/hr Report given to oncoming shift
			(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
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NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003			I/O's cont to monitor. Ø edema to penis, scrotum. —
			MS: Pt strength good in all extremities ↓ to (L)
UOP: 2000	375	clear yellow	arm. Pt requires assist on ambulation, ambulating
NIBP: 123/78			outside pending.
98			Skin: Normal for race. Abd incision mentioned
100% SaO_2			in GI assess. Skin turgor normal for pt. age.
24 RR			(+) decubitus to sacral area, dressed c̄ ostomy skin
			protective barrier. (+) decub to T6-T7 back
			covered c̄ tegaderm.
			Ø PIV:
			- Plan: Cont cardiac resp monitoring
			- Encourage IS; cont CPT, deep ~~coughing~~ (errors (b)(6)-2 breathing
			coughing; ambulate amap
2000 - ambulate			- Promote good pain control c̄ Percocet and
S/P 47% SaO_2			abd clutching on exertion.
107			- Encourage PO fluids to include milkshakes
28-30 RR			and PO solid intake. Cont Tube feedings
			✓ residuals. Monitor for BM, flatus, abd
			distention.
			- Monitor decubitus ulcer status encouraging
			side lying while in bed, cont use of
			Alpha Fleece Bed pads, ↓ friction shear while
			in bed.
			- NHO of sorethroat, ↑ reddness and complaint
			c̄ swallowing — (b)(6)-2 CPT
	?	[illegible]	

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MEDCOM - 6563

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003		1815	Assume care of pt s/p receipt of report from SGT (b)(6)-2 Pt supine in bed HOB @ 75°, awake, alert and oriented x3. Pt smiling, in
BR: 135/76 m95			good spirits. NGT to (R) nare intact, in place, Jevity
RR: 21 SaO2 100%			infusing @ 110 cc/hr. Placement ✓ performed, (+) results.
			O_2 per RA SaO_2 100% RR 20-24 DPM previous
			resp discomfort. Abd drug in place CDI. (L) arm
			cast-splint in place, intact. Complete physical assess-
1900:			ment to follow. Plan of care discussed via
			translator, pt questions answered.
			Physical Assessment:
1900 15 x 5	003	chair	Neuro: awake, alert oriented x3, spontaneous movement
			@ sensation to all extremities.
			Resp: Lung sounds clear throughout, diminished bases
1915: Milkshake		240	bilaterally. RR/SaO_2 WNP, as noted on form 511-119.
H_2O	120		IS @ BS, CPT q 4° - 2000: O_2 per RA will supplement PRN
			QV: NSR; HR ~ 94. BP WNP. Bilat pedal pulses strong
			@ 2+ cap refill good @ ≤ 3 sec (R) Radial pulse
1934 Percocet ÷ PO			1+, weak - (L) radial 2+, palpable. 1+ Edema to BLE.
			GI: (+) Midline abd. incision dressed c̄ Super sponge - CDI
			@ BS q+G. (+) abd tenderness on palpation, Percocet ÷ PO
			administered as per order. Eval pending. NGT in
			place c̄ Jevity cont. TFing @ 110 cc/hr. 1800 Residual
			V = Ø out. (-) abd distention
			GU: Urinal @ BS. (Continue on reverse side) Good UOP on previous shift

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6564

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27 July 2003		2030	Pt c/c sore throat. Previous administration of cepacal lozenge @ 1830 ¢ work. Hurricane spray x 2 sprays administered c̄ relief indicated s/p administration (b)(6)-2
PLX - Milkshake	240cc	2045	Pt assisted to PLX - ambulating, (+) Television watching, 240 cc milkshake consumed, few peanuts and 2-3 tsps pudding tolerated. Pt returns to warm in chair x ½ hr. No complaints needs. Oral care performed, pm hygiene complete. Pt assisted back to bed. (+) (R) side lying. Pt presently resting — (b)(6)-2
		2200	Dr (b)(6)-2 @ BS performing ABD dressing A. ~~Heavy~~ Energy (b)(6)-2 coughing dislodged NGT. Replacement held ~~(partially)~~ per rec. (b)(6)-2
UOP - 250		2300	UOP - 250 cc clear yellow, Pt to chair. (+) 240 cc
ORAL: Milkshake 250			intake Milkshake, 120cc H_2O and 2 oz. rice. (-) c/c N/V. Pt returned to bed and rest (b)(6)-2
HJU: 120		0100	Pt sleeping VS STABLE — will cont. to monitor (b)(6)-2
Rice: 2oz		0215	UOP 400 cc clear yellow urine to urinal. No Δ's in pt status (b)(6)-2
		0315	Pt oob to BSC. BM x 1 - moderate amt of soft brown stool.
			LATE NOTE: BM x 1 large dark brown, soft @ 0015. (b)(6)-2
		0515	Pt oob to BSC. BM, UOP x 1 moderate amt of brown, soft stool out. Attempt to place NGT failed

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICU

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

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

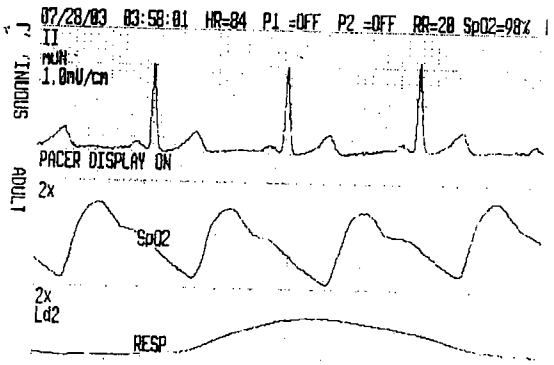
MEDCOM - 6565

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 July		0515	Dr (b)(6)-2 @ BS, aware of NGT status VO given to discontinue insertion. Calorie count strict to begin (b)(6)-2
Jevity 120 cc		0345	Intake as noted @ side = 480cc. Pt aware of need to ↑ PO intake (b)(6)-2
Milk 120 cc			
1 packet instant		breakfast	0600: Report given based pt care assumed by SGT (b)(6)-2
Jevity 240 cc		PO	
28 July NSG Note		0000	Assumed care of Pt. Rcvd Report from CPT (b)(6)-2 AW. Pt in bed on (L) side appears to be sleeping VS. 105/51, 88, 22, 97.7 SaO2 95% on RA. Appears Comfortable. Plan: Strict Calorie count, for PO intake (b)(6)-2
28 July 03 Resp Therapy	0800		CPT Not performed. Pt up in chair bathing BBS for ↓ bases but fairly clear. HR 92 RR 22 O2SAT 96% on RA (b)(6)-2
28 July Resp Therapy	0845		CPT performed to RLL x 10 mins. BBS for ↓ bases c̄ scattered Rhonchi. HR 89 O2SAT R.A. 96 RR 22. P̄ Tx BS for ↑'d in bases c̄ crackles, NAR (b)(6)-2
28 July		0900	Late entry - 0730 Pt OOB → chair-ate breakfast, and perform am care c̄ minimal assistance. Pt had small loose formed Brown stool Intial assessment complete (b)(6)-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 1-91) BACK


07/28/03 03:58:01 HR=84 P1 =OFF P2 =OFF RR=20 SpO2=98%
II
mVA
1.0mV/cm
SINUSOUS
PACER DISPLAY ON
ADULT
2x
SpO2
2x
Ld2
RESP

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 July	0950		Dr. (b)(6)-2 at bedside to Δ drsg to Abd. Abd. incision open tissue red c̄ sm. amout of white tissue noted. Wet → Dry drsg applied. Entry wound to (L) Lower abd. 2 staples put in at bedside total of three at entry wound. 3 staples removed from wounds @ entry wound. Ø S/S of infection or reddness @ wounds Gauze drsg. applied. Pt denies pain at this time. will monitor — (b)(6)-2 SGT USA 91WM6
	1030		Pt ↑ Ambulated to PIX corridor sat in chair for ½ hour Ambulate back to ICU O2 sat maintain > 95% on RA BTB - Am meds taken ≤ difficulty will monitor — (b)(6)-2 SGT USA 91WM6
	1140		Pt OOB → chair eating lunch at present time. NAD at this tim (b)(6)-2 SGT 91WM6
28 July 03 Resp Therapy	1200		CPT not performed. Pt sitting in chair in PIX. Pt Ambulated x 5 mins. HR 100 O2 SAT on R.A. 98% RR 20. BBS for ↓'d to bases but clear — (b)(6)-2
	1220		Pt % upset stomach new order 30cc Maalox given per oder. Pt ambulat to PIX corridor to watch TV. will monitor SAT 98% RA (b)(6)-2 SGT USA 91WM6

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-41

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 Jul 03	1430		1330 Pt O_2 sat ↓ 92% on RA, RR ↑ 26
			O_2 2L via NC SAO2 ↑ 98%-100% ↓ RR 22
			Pt appear to be comfortable. in bed
			c̄ eyes closed will monitor
			(b)(6)-2 SGT USA 9lwh
28 July 03 Resp Therapy	1600		CPT performed to RLL x 5 mins. BBS for ↓ to
			bases but clear. HR 89 RR 24 O2 SAT on R.A. 97%
			P̄ Tx BBS for ↑'d bs to lower lobe. O2 SAT on
			R.A. 97%. NAR (b)(6)-2 CRT
28 Jul 03	1655		Dr (b)(6)-2 in to do Rounds. told
			Him about Pt upset stomach. Pt had
			Ø relief c̄ Maalox New orders: see DA
			Form 4256-1730. Pt OOB on commode Pt
			BTB Drsg to coccyx removed. Wound
			has foul smell clean c̄ NS. Healthy
			red edge c̄ nacrotic tissue in center
			See by Dr (b)(6)-2 reccomended
			Dry sterile drsg and position Pt on
			side will monitor
			(b)(6)-2 SGT USA 9lwm
	1730		SGT (b)(6)-2 Ortho Removed splint, π Percocet
			for pain. Pt will back at 1800 to do
			physical therapy to (L) arm. Will report

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202

MEDCOM - 6569

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			to oncoming shift of status of
			Pt (b)(6)-2 SGT USA
28 July 2003		1805	Received report on pt: Assumed care @ 1800 hrs. Pt
			supine in bed, awake alert oriented. Pt @ BS performing
			physical therapy on (L) arm. (+) Grimmacing, pt cooperative
1800 127/68 101			NIBP monitoring to (R) Brachial. HR during therapy >120's
24 98%			BP 127/68 98% SaO_2 39 RR. No evidence respiratory distress
			Pt s/p percocet. SSG recommendation: cont pronation &
			supination of wrist & elbow flexion ~~BID~~ 10-20x BID
1900 ~~2000~~ 105/66 88			Physical Assessment;
30 RR 96%		-	Name: AAOx3, speaks in Arabic, knows few English words
			- speaks clearly & appropriately. Pupils (R) 3mm (L) 3mm (+) PEARLA.
2000 100/54 87			Ø c/o pain, moves all extremities purposefully, spontaneously
4 96%		-	CV: NSR; VS q 4° WNP BR ~100's/60's HR 80-90's
			Ø chest pain, SOB, dyspnea. 2+ Radial/pedal pulses bilat.
2100			Cap refill <3 sec. R/L U/L Ext.; 1+ edema bilat ankles.
		-	Resp: Breaths sounds clear throughout c̄ diminished (L) bases
2200 114/58 p: 92			bilaterally. Pt per RA RR ~20-25 SaO2 96%-98%
			(-) accessory muscle use, good skin color - NFR.
			(+) intermittent productive cough clear/whitish, thick
			small amt of sputum products.
		-	GI: Abd dressing - midline intact, in place
			Ø drainage. (+) BS x 4q. (-) abd distention, (+) abd
			discomfort on palpation.
		-	GU: VOP per urinal clear, yellow 1/0's; bag record
		-	MS: (+) (L) Arm splint good movement, ROM c̄ PT
			earlier. (+) sensation movement all digits cap refill

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BAC

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 July 03			23 Sec.
		–	Skin – ⊕ decubitus to sacral area dressing in place
			⊕ small amt brownish drainage. Decubitus to T6-T7
			open to air 3cm in length 1.5cm width ⊖ drainage noted
		–	Plan: continue cardiac resp monitoring
		–	encourage ambulation / self care; keep off decubiti
		–	monitor intake solids and liquids –
		–	strict calorie ctn. encourage nutritious
		–	snacks – Breakfast drink c̄ milk, fresh/
			canned fruit and vents. Request consult
			c̄ dietician.
		–	Monitor BM's and UOP. (b)(6)-2
28 July 2003		2100	Pt OOB to BR UOP = 350cc clear, yellow
			⊖ BM @ this time. Pt consuming PM meal
			c̄ 1 bite hamburger, 1/2 roll, ∅ potatoes,
			4oz vanilla pudding; 95% MRE minestrone
			stew, 4oz can mixed fruit; (error) ~~440~~ (b)(6)-2 H_2O
			120cc – Breakfast drink c̄ milk c̄ 120cc levitis
			Pt returns to sleep (b)(6)-2
		2350	Pt sleeping on (R) side, completely off decubitus, ∅ evidence
			discomfort or distress. VS stable (b)(6)-2
		2200	LATE NOTE: Dr (b)(6)-2 @ BS performing dressing ∅
			MAJOR (b)(6)-2 Assisting (b)(6)-2
		0215	Pt OOB to BSC. ⊕ clear yellow UOP – 400 total

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDCOM - 6571

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			⊕ milkshake = 1 Breakfast drink c̄ 240 cc milk consumed 100%, 120 cc H_2O. PT c/o abd pain s/p milkshake. Administered Percocet 1 tab PO Eval Pending. Pt returns to sleep on (R) side off of sacral decubitus. (b)(6)-2
			0430: Pt sleeping quietly VS STABLE BP 101/5 79 HR RR 12 SaO_2 95% (b)(6)-2
29 July 03	0620		Rcv'd Report from CPT (b)(6)-2 AN, Assumed care of pt. Pt in bed appears to be sleep on (R) side. VS 111/63-78-20 SAO2 99% on RA T 96.7, NAD, appear comfortable at this time will monitor (b)(6)-2 91WM SGT USA
	0730		Pt OOB → commode had med loose formed stool. Pt in chair am care perform c̄ minimal assistance. Intial assessment complete. Neuro: Alert, oriented able to move all extremities. denies pain at this time. Resp: RR 22 SAO2 99% on RA. LS. Clear IS-1200cc/sec x 10. Ø SOB, Resp. even, unlabored. Skin: Warm to touch. Stage II Decubidi on coccyx clean c̄ NS & drsg c̄ guaze stage I on upper back clean c̄ NS zinc oxide applied c̄ guaze drsg. Blister on heel drained c̄ sm. amt. of seroussangious drainage clean c̄ NS guaze drsg applied →

*U.S. Government Printing Office: 1995 - 404-763/20065
STANDARD FORM 510 (REV. 7-91) BAC

MEDCOM - 6572

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 July 03	0730		cont. Gastro: Abd. drsg clean, dry & intact initial assessment/ abd. soft, non-distended (+) BS (x)4 quad. Pt had med loose formed stool this AM, Pt Denies discomfort, nausea GU: Pt able to urinate w/ difficulty urine clear yellow color. Cardiac. NSR HR 82 VS q 4° SaO2 98% on RA. (+) peripheral pulse x4 (+) Color, sensation, & movement to all extremities. NAD at this time. will monitor — (b)(6)-2 SGT USA
	1030		VSS, Pt resting on (L) side w/ eyes closed. Ø complaint voiced at this time — (b)(6)-2 SGT USA
	1245		Pt OOB → chair ate a gd lunch tolerated well NAD at this time (b)(6)-2 SGT USA
	1555		1530 Pt OOB - commode had lg foam stool slight cramping but tolerable pt SAid. RTB on (R) side Ø complaints voiced. VS WNL — (b)(6)-2 SGT USA

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 July 03		1730	Physical therapy in to do ROM to (L) arm. Ortho removed & reapply Splint. Pt. tolerate well. (b)(6)-2 [redacted] SGT USA
		1745	Pt appear to be in pain c̄ physical therapy grimane & moans but denies pain p̄ pt. MD d/c'd antibiotics will report to oncoming shift (b)(6)-2 [redacted] SGT USA
29 July 2003		1845	Received report assumed care of pt @ 1800°. Pt in bed on (L) side sleeping. O_2 per RA, Ø IVF's, Ø IV, Px resting c̄ evidence discomfort or distress. (b)(6)-2 [redacted]
BM x 1 (+) UOP		1930	Pt OOB to Bathroom, (+) large ~~BM~~ (error) (b)(6)-2 brown soft stool & cup app 200 cc's clear yellow. Pt ambulating c̄/ou assist in ward and to Px to watch television.
Milkshake			Pt consumed 240cc Milkshake (Breakfast - instant sh
(+) JS - 1	cc/sec		while watching television. Px returned to ward and rest @ 2030°. No complaints, needs @ this hi
Dinner: consumed ½ cup chili c̄ rice		2130	Pt oob to chair to consume evening meal. (-) c/o nausea, (-) vomiting. Px remains oob x 4°. Ur watching ward activity. (b)(6)-2 [redacted]
½ cup "pasta in Alfredo Sauce" ½ roll		2245	Physical Assessment: Neuro: A.A.O x 3, (+) spontaneous movement, (+) sensation to all extremities. Pupils (+) PEARLA, 3mm/3mm. Speech appropriate - primary language arabic. Resp: Lungs sounds clear throughout, chest movement equal, symmetrical; RR 16-18 BPM SaO_2 ~95% on RA. (-) c/o dyspnea, SOB.
4.5 oz canned fruit-mixed			
(+) Viscous Lidocaine			

*U.S. Government Printing Office: 1995 - 404-763/20065 STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6574

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [ ] YES (type): Emergency- Dragi

4. PROPOSED SURGICAL PROCEDURE: Ex Lap Lt elbow ORIF

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

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

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

(b)(6)-4

Emergency

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

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

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

(b)(6)-2 MAJ, AN 8 JUL 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O X Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: X Moves All Extremities X Lt arm ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

SKIN INTEGRITY: Bovie Pad Site: X Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 MAJ AN

DATE: 8 JUL 03 TIME: 1245

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Stretcher BY CPT (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2 A~ (EMERGENCY)

3. DATE 8 JUL 03 TIME PATIENT ARRIVED IN SUITE Ø638

4. PATIENT IN ROOM TIME Ø638 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert. Speaks Iraqi-Arabic.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 9 ID (START-0640)	RELIEF SCRUB	SPEC (b)(6)-2 9 ID (0640-0720) SSG (b)(6)-2 9 ID (0720-END)
ASSIGNED CIRCULATOR	CPT (b)(6)-2 AN, 66E (START-0700)	RELIEF CIRCULATOR	MAJ (b)(6)-2 AN, 66E (0640-END) CPT (b)(6)-2 AN, 66E (0700-END)

7. POSITION AND POSITIONAL AIDS (Specify) (R) arm abducted less than 90° on padded armboard, (L) arm (broken) abducted less than 90° on padded armboard.

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

COMMENTS: AMSCO bed c̄ pads.

8. SKIN PREPARATION

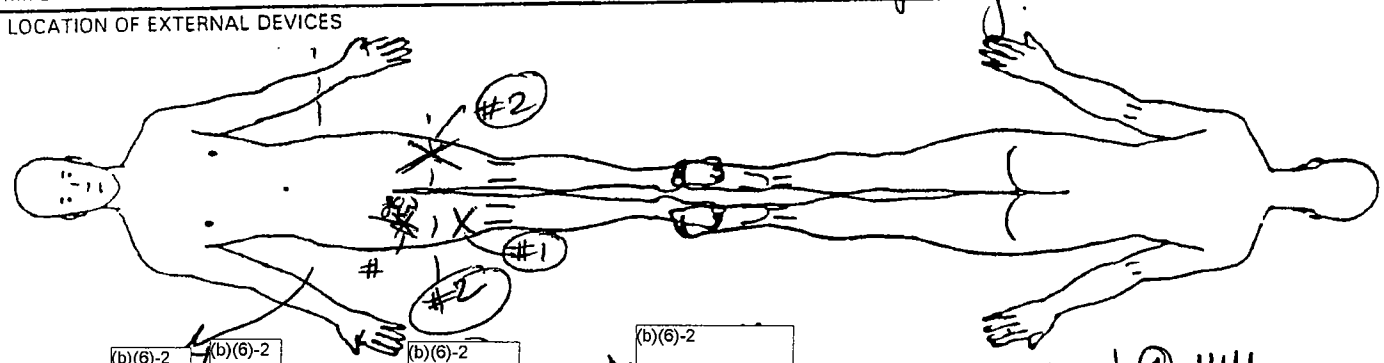
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Beta 7.5% + NSS / Beta 10%
SITE: Chin → (B) upper thighs BY WHOM: (b)(6)-2
SITE: BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 === Tourniquet (b)(6)-2 Dr. ↑ at 0955 to 250 mmHg ↓ @ 1141 (b)(6)-2

C = Correct I = Incorrect Init by (b)(6)-2

10. COUNTS			Relief Other (b)(6)-2	First Closing Count		Final Closing Count		SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes	☐ No	C	C	C	C	C		
Needle Sharp	☒ Yes	☐ No	C	C	C	C	C		
Instrument	☒ Yes	☐ No		C		C			
Other	☐ Yes	☐ No							

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

(b)(6)-4

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

50/50 → 40/40

☒ ESU NO: 000442
GROUND PAD: BRAND Valleylab Polyhesive
LOT NO: EXP 05-92 H9462-4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 6577 ICH IS OBSOLETE. USAPA V1.01

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

K-wires
LOAD # 0413303 0.062 x 2ea
+ Surgical Steel Suture #2 Ethicon

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS warm

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Foley 16FR		
SITE	bladder		

18. DRESSING/IMMOBILIZATION (Specify)

① 4X8 dressings, 2X2 dressings, 4X4 dressings, Coverall

② Xeroform, fluff, Kerlix/Webril, Plaster Splints, Ace wraps

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2 (b)(6)-2 (b)(6)-2

20. OPERATION(S) PERFORMED

① Ex Lap, Small Bowel Resection X2

② Lt elbow ORIF

21. PATIENT TRANSFERRED TO ICU TIME 1245 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJAN (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE [illegible]UMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

2. PATIENT IDENTIFIED [illegible] AND PROCEDURE VERIFIED BY (b)(6)-2

3. DATE 15 July 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0925 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 66E 1Lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

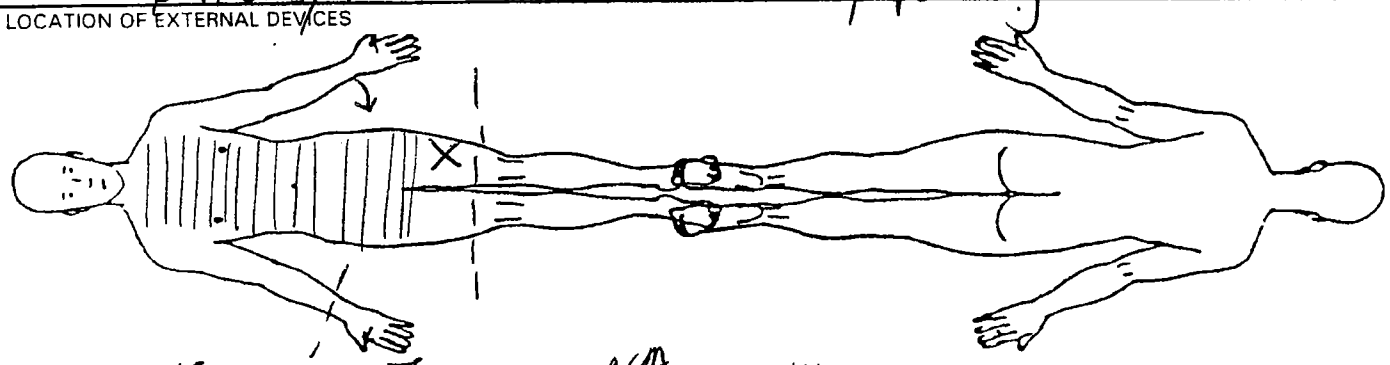
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR (b)(6)-2 ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Ø nicks/cuts

PREP SOLUTION *(Specify)* Beta/Beta
SITE: ABD - Thorax to pubis BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (JS) -- Safety Strap (JS) = = = Tourniquet (N/A) ||| = prep

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C	C		
Other	☒ Yes ☐ No	C	C	C		

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

(b)(6)-4

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

☒ ESU NO: #1 cut/coag = 50/50
GROUND PAD: BRAND Valley lab
LOT NO: 10527 2003-10

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU (b)(6)-2

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8s

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 fr Foley	2. Iodoform Gauze	3.
SITE	1. Bladder - arrived in place -	2. ABD Incision	3.

19. ADDITIONAL INFORMATION
Dr (b)(6)-2

Maj (b)(6)-2 CRNA / CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
1) Ex-lap
2) appendectomy, incidental

21. PATIENT TRANSFERRED TO ICU TIME 12 30 METHOD litter

22. REGISTERED NURSE SIGNATURE
(b)(6)-2 Ut/An

REVERSE OF DA FORM 3775-1, OCT 87 USAPA V1.01

MEDCOM - 6580

MEDICAL RECORD | **INTRAOPERAT[illegible]CUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: [illegible] BY OK [illegible]	2. PATIENT IDE[illegible] (b)(6)-2 [illegible] AND PROCEDURE VERIFIED BY [illegible]
3. DATE 21 July 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME 1420 NUMBER (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	ILT (b)(6)-2 66E	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 66E SPC (b)(6)-2 91D	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

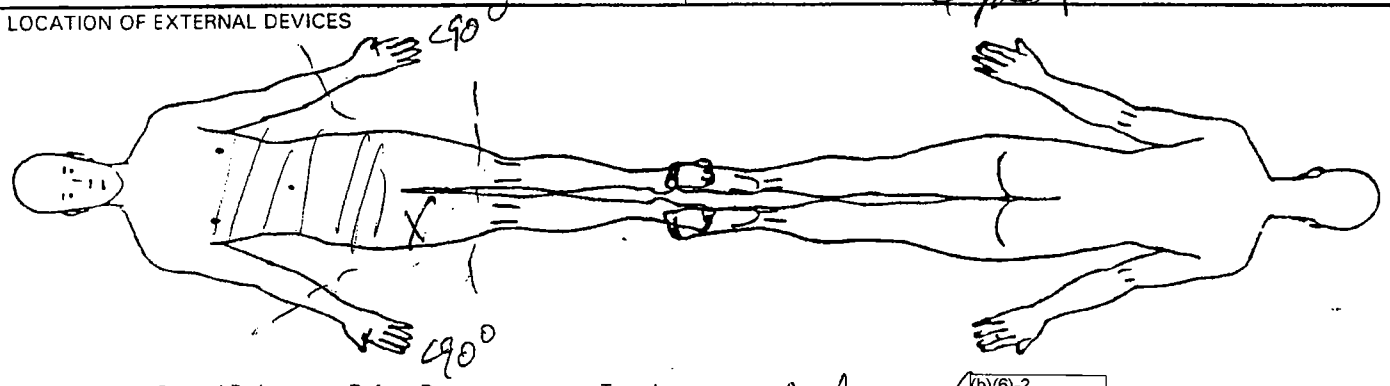
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta
SITE: Abdomen nipple to groin BY WHOM: SPC (b)(6)-2 / (b)(6)-2
SITE: BY WHOM:

COMMENTS: Ø pedi

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial (b)(6)-2 / (b)(6)-2

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No				(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☑ Yes ☐ No					
Other	☐ Yes ☑ No					

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

(b)(6)-4

(b)(6)-4

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

☑ ESU NO: Pr C-1 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: 69671

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 6581 [illegible]CH IS OBSOLETE.

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NACL

OTHER ORDERS	TIME	CARRIED OUT BY
16 Fr Foley Cath hr c̄ clear yellow urine	Post Induc	Dr (b)(6)-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 Fr Foley Cath	2. 10 mm JP	3.
SITE	1. Bladder	2. Abd	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

~~Bulky Bag~~

4x8

Kerlix Tape

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

Exploratory laparotomy wound debridement c̄ closure (primary)

21. PATIENT TRANSFERRED TO ICU TIME 1640 METHOD Cath

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDCOM - 6582

MEDICAL RECORD — INTRAOPERA... DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

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

3. DATE 11 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1420 NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt accompanied by interpreter

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SGT (b)(6)-2 66E	RELIEF CIRCULATOR	CPT (b)(6)-2 (1520 - close)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: pillows under legs + body; arm boards up towards head

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

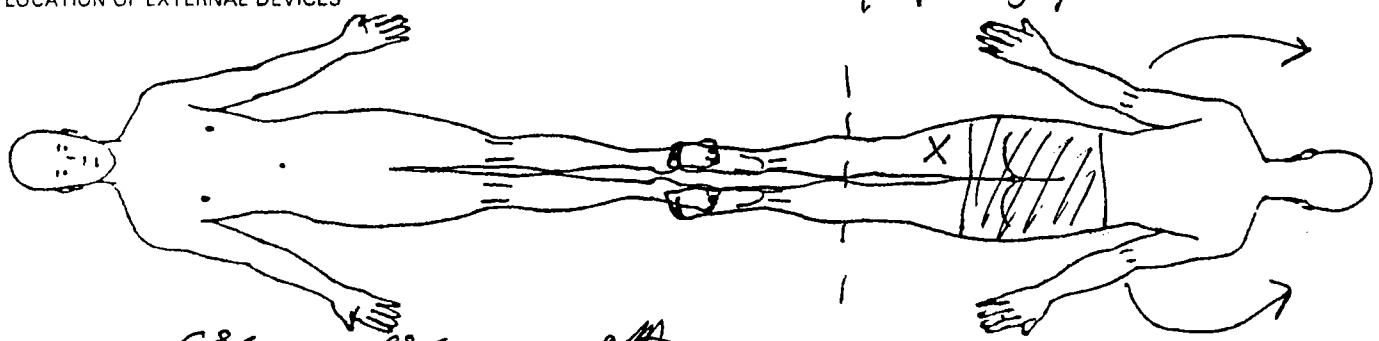
PREP SOLUTION (Specify) Beta Sol

SITE: lumbar to mid thigh BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: ∅ pooling / irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (esc) -- Safety Strap (esc) = = = Tourniquet (NA) ||| = prep

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

(b)(6)-4

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

[ ] ESU NO: #1 cut/coag = 30/30

GROUND PAD: BRAND Valley lab

LOT NO: 65706 exp 2004-11

[ ] ESU NO:

GROUND PAD: BRAND (b)(6)-2

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	Iodoform gauze	x2 bottles 1/4" x 5yds	
SITE	buttocks		

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs

19. ADDITIONAL INFORMATION
Dr (b)(6)-2

Maj (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
I+D of Sacral decubiti

21. PATIENT TRANSFERRED TO ICU TIME 1540 METHOD litter

22. REG (b)(6)-2

REVERSE

USAPA V1.01

MEDCOM - 6584

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY MAJ (b)(6)-2 AN/66E

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 MAJ/AN

3. DATE 12 AUG 03 TIME PATIENT ARRIVED IN SUITE 1255

4. PATIENT IN ROOM TIME 1255 NUMBER 141

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Iraqi Speaking. Helpful.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN/66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* (B) arms extended at side of head resting on padded armboards. Pillows under chest, hips, and lower legs.

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

COMMENTS:

8. SKIN PREPARATION

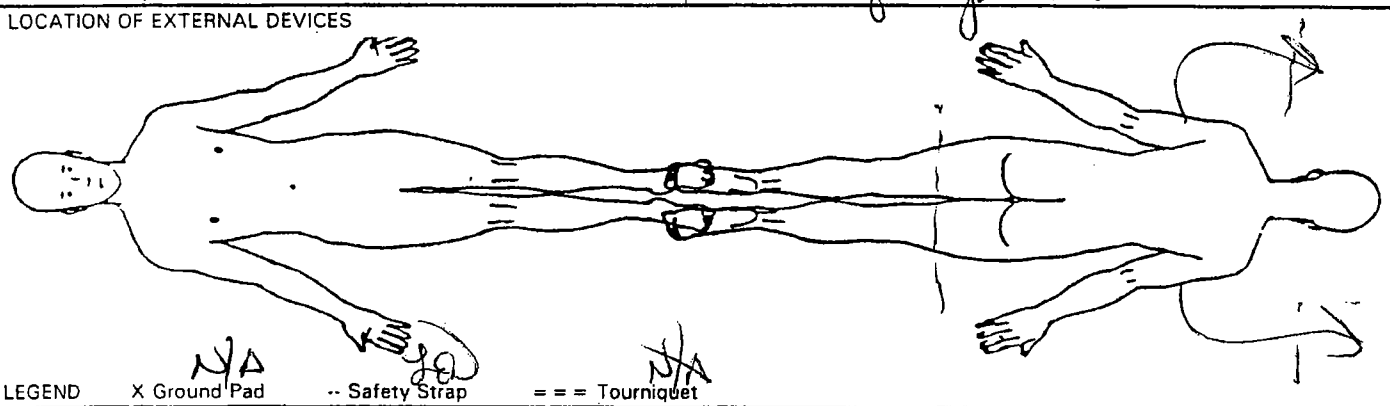
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadyne 10% Paint
SITE: Sacral region + BY WHOM: (b)(6)-2
SITE: Surrounds BY WHOM:

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A -- Safety Strap N/A = = = Tourniquet

C = Correct I = Incorrect

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

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

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

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Iodoform Gauze	2.	3.
SITE	1. Sacral Decub	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 dressing sponges
Coverall

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2 MAJ (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

Sacral Decubitus D-FI + Dressing Abdominal Wound

21. PATIENT TRANSFERRED TO ICU TIME 1335 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 N TAN

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

MEDCOM - 6586

MEDICAL RECORD — **INTRAOPER[illegible] DOCUMENT**

For use of this form, see AR 40-66, the pr[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia	2. PATIENT ID (b)(6)-2 [redacted] D PROCEDURE VERIFIED BY [redacted] cut/AW
3. DATE 13 Aug 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME 13⁰⁰ NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: pillows under legs + torso; arms up towards head

8. SKIN PREPARATION

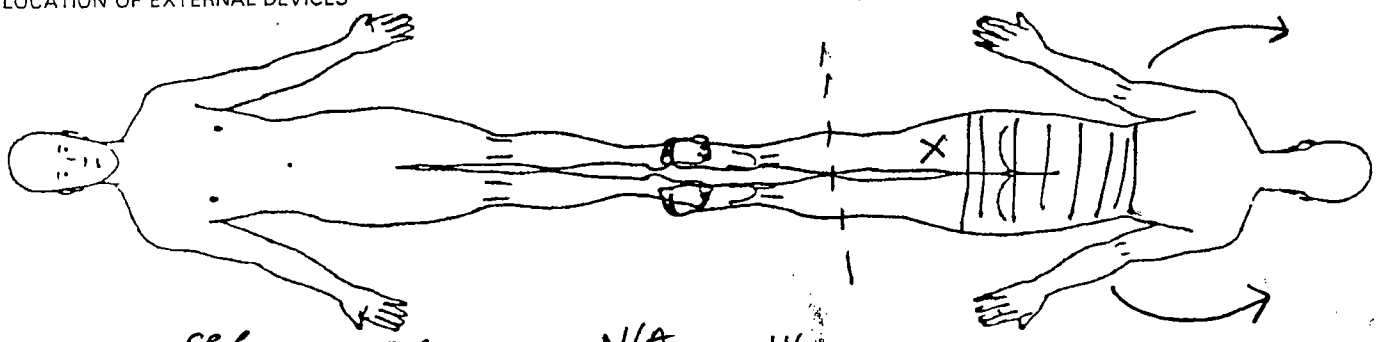
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Buttocks - lumbar to upper thigh BY WHOM: (b)(6)-2 [redacted]
SITE: BY WHOM:

COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ESC -- Safety Strap OC = = = Tourniquet N/A ||| = prep

C = Correct I = Incorrect

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

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

(b)(6)-4 [redacted]

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

☐ ESU NO: #1 cut/coag = 40/40
GROUND PAD: BRAND Valley lab
LOT NO: 65706 exp2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 6587

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
(b)(6)-2		

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs

19. ADDITIONAL INFORMATION
Dr (b)(6)-2
Dr (b)(6)-2

CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
I+D Sacral decubitus

21. PATIENT TRANSFERRED TO ICU TIME 1450 METHOD litter

22. REGISTERED NURSE SIGNATU (b)(6)-2

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

MEDCOM - 6588

MEDICAL RECORD — **INTRAOPERA... DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: OR Staff	2. PATIENT I... (b)(6)-2 VERIFIED BY ... CEDURE CM, R
3. DATE: 14 AUG 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME: 1435 NUMBER: 1-1 #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 66E lt (b)(6)-2, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Pillows x 3

8. SKIN PREPARATION

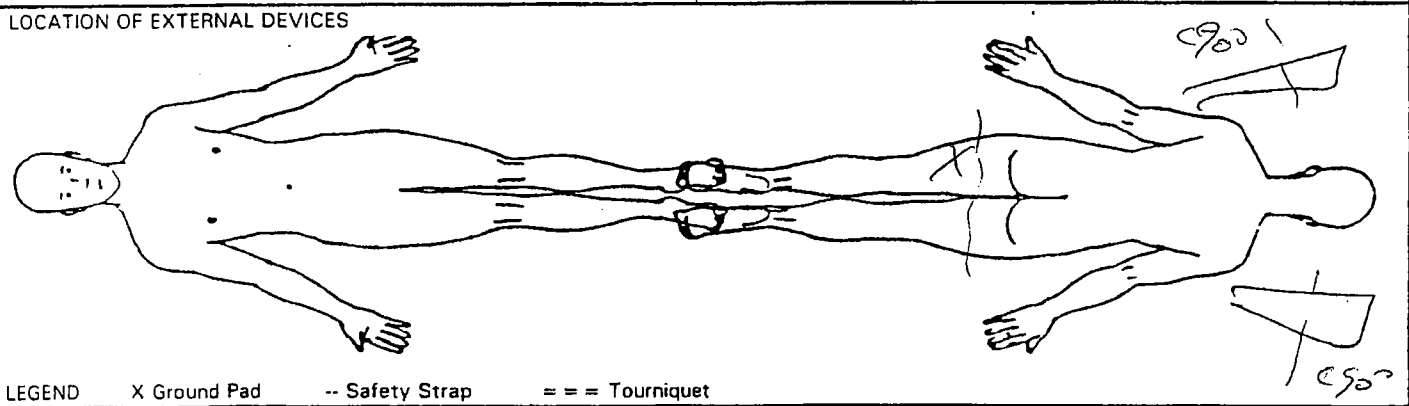
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclase
SITE: buttocks BY WHOM: (b)(6)-2 / (b)(6)-2
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	/	/	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No	/	/	/	/	/
Instrument	☐ Yes ☑ No	/	/	/	/	/
Other	☐ Yes ☑ No	/	/	/	/	/

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

(b)(6)-4

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

☑ ESU NO: 1-1 30/30
GROUND PAD: BRAND Valley lab
LOT NO: 65706 ap 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Not in use

DA FORM 5179-1, OCT 87 REPLACES ... CH IS OBSOLETE. USAPA V1.01

MEDCOM - 6589

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU (b)(6)-2

15. X-RAY IN OPERATI IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs / Kerlex

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. fluffs Kerlex	2.	3.
SITE	1. Sacral decub.	2.	3.

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

Dr (b)(6)-2

CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

I+D/Dressing Δ to Sacral decubitus

21. PATIENT TRANSFERRED TO Jen TIME 15:15 METHOD litter

22. R (b)(6)-2 (PT. A)

REVERSE OF DA FORM 3179-1, OCT 87 USAPA V1.01

MEDCOM - 6590

MEDICAL RECORD — **INTRAOPERA... ...OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY anesthesia

2. PATIENT I... (b)(6)-2 VERIFIED BY [redacted] ...OCEDURE UA/AV

3. DATE 16 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ... TIME 0815 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2 [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt (b)(6)-2 [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: pillows under legs + torso; arms towards head

8. SKIN PREPARATION

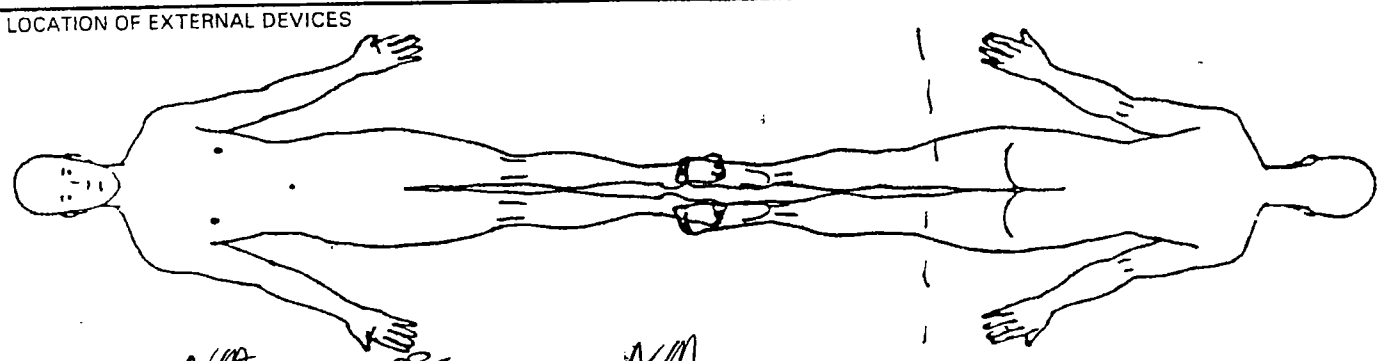
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

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

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A -- Safety Strap ESC = = = Tourniquet N/A

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

(b)(6)-4 [redacted]

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

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

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

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 6591 ...ICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
1) NSS c̄ Hibiclens
2) NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S (b)(6)-2

15. X-RAY IN
YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Fluffs	2.	3.
SITE	1. Sacral Decub.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Wet to dry c̄ Kerlex and Fluffs + ABD Band Aid

19. ADDITIONAL INFORMATION
Dr (b)(6)-2

CPT (b)(6)-2

20. OPERATION(S) PERFORMED
Dressing change

21. PATIENT TRANSFERRED TO ICU TIME 0840 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

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

MEDCOM - 6592

MEDICAL RECORD — **INTRAOPERA[illegible]OCUMENT**

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

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

2. PATIEN[redacted] (b)(6)-2 VERIFIED B[redacted] AND PROCEDURE MAJ, AN

3. DATE 18 AUG 03 TIME PATIENT ARRIVED IN SUITE Ø81Ø

4. PATIEN[redacted] TIME Ø81Ø NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p̄ MN. confirmed by nursing staff

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 [redacted] AN, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* (B) arms extended at head of bed on padded armboards. Pillows under chest, hips, and lower legs. Toes free from pressure.

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

COMMENTS:

8. SKIN PREPARATION

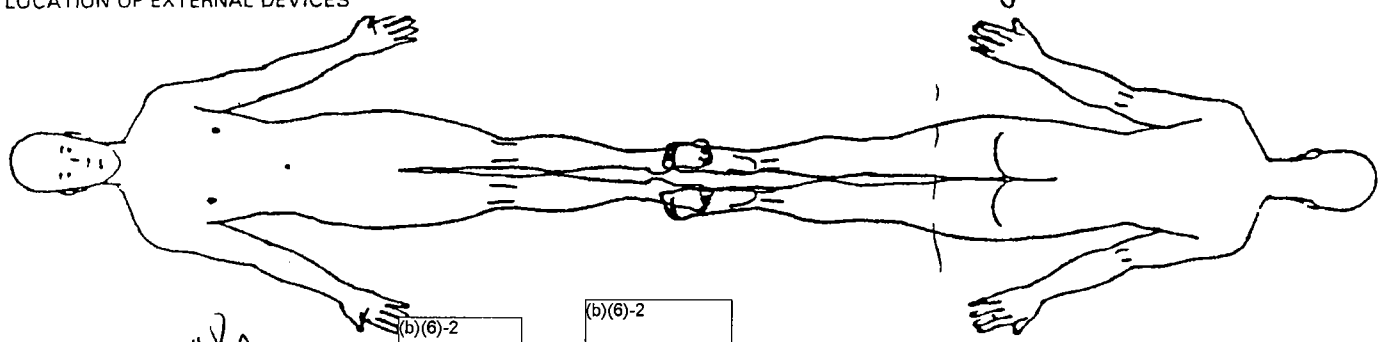
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Sacral decub. BY WHOM (b)(6)-2 [redacted]
SITE: BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect N/A

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

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

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D[illegible] MEDCOM - 6593 [illegible] IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)

Buttocks	Abd
Fluffs	Fluffs
ABD Pad	Coverall
Coverall	

19. ADDITIONAL INFORMATION (b)(6)-2 (b)(6)-2

20. OPERATION(S) PERFORMED

Sacral Decubiti Dressing Change

21. PATIENT TRANSFERRED TO ICU TIME 0850 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 16 Jul 03 DAY

19 HOUR

PULSE (O)	TEMP. F (°)	05	06	07	08	09	10	11	12	13	14	15	16	17	18	TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
60																
50																
40																

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	05	06	07	08	09	10	11	12	13	14	15	16	17	18
Resp →	32	30	33	34	32	33	37	37	40	42	42	37	38	35
BLOOD PRESSURE →	126/73	127/70	128/70	127/75	129/79	119/69	119/66	120/65	118/65	123/71	117/60	117/61	121/68	121/67
SpO_2 →	94%	94%	96%	94%	95%	94%	95%	94%	93%	94%	94%	95%	95%	95%
O_2 →	2LNC	2LNC	2LNC	2LNC	2LNC	2LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC
HEIGHT: WEIGHT →														

Record special data only when so ordered

		05	06	07	08	09	10	11	12	13	14	15	16	17	18	Totals	
Output	NG		10	30	30	30	40	15	40	5	20	40	60	50	20	320	820
	Foley	?	70	30	40	50	30	30	50	80	40	50	30	800	400	500	
Intake	IV	150	150	250	250	150	150	150	250	150	150	150	250	100	150	2200	2290
	Flush NGT				30				30				30			90	

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. ICU

(b)(6)-4

Totals x 24 hr.

NGT 720 Foley 3550

IV 3600 Flush

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6595

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 16 Jul 03 DAY

19 HOUR

PULSE (O)	TEMP. F (•)	17	18	19	20	21	22	23	24	01	02	03	04	05	TEMP. C
	105°														40.6°
180	104°														40.0°
170	103°														39.4°
160	102°														38.9°
150	101°														38.3°
140	100°			•				•	•	•	•	•	•	•	37.8°
130	99° 98.6°														37.2° 37.0°
120	98°			^ O	^ O	^ O	^ O	^ O	^ O	^ O	^ O	^ O	^ O	^ O	36.7°
110	97°														36.1°
100	96°														35.6°
90	95°														35.0°
80															
70															
60				V	V	V	V	V	V	V	V	V	V	V	
50															
40															

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	17	18	19	20	21	22	23	24	01	02	03	04	05
Resp →	26		26	37	30	30	36	30	30	32	30	31	29
BLOOD PRESSURE →	121/67		121/67	125/65	123/69	124/68	125/71	117/68	117/66	113/61	126/80	112/66	113/69
SpO_2 →	96%		96%	96%	96%	96%	96%	96%	96%	96%	96%	96	96
O_2 →	3L NC		3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC	3L NC
HEIGHT: WEIGHT →													
Output NG	20		20	10	20	50	20	100	20	30	20	20	20
Foley	200		200	200	100	200	100	100	50	100	100	100	100
Intake IV	100		100	100	100	100	100	150	100	100	100	100	100
Flush NGT			30cc					60cc				30cc	

Record special data only when so ordered

NGT 400
Foley 2550
IV 1400
Flush 120

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

REGISTER NO.

WARD NO.

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

50cc hot tea @ 2200

60cc NGT Flush 0010

Totals x 24 hr

NGT 720 | IV 3600

Fl. 2550 | Flush

MEDCOM - 6596

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR 17 Jul DAY
19 2003 HOUR

(b)(6)-2

HOUR	18	19	20	21	22	23	24	01	02	03	04	05
RESPIRATION RECORD Resp →	29	35	36	32	27	30	28	20	24	20	21	
BLOOD PRESSURE →	121/64	117/64	127/71	139/73	122/71	114/67	2?/60	122/70	108/67	120/60	117/64	
SpO_2 →	100	100	98	99	99	98	98	100	100	99	100	
O_2 →	3LNC	3LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	4LNC	
HEIGHT: WEIGHT →												
NG	380	180	220	✓	600	280	260	100	80	50	30	
Foley	120	40	60	1000	500	220	60	50	40	60	30	
IV	160	100	100	P.Lock 100	100	100	300	100	100	100	100	
Flush NGT	30		30				30				30	
PO												

Totals
3475
2680 > 6155
2700
270 > 3[illegible]
150

output
intake

Record special data when so ordered

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

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

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

(Centigrade Equivalents, for Reference only)

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. ICU

STANDARD FORM 511 (REV. 7-95) BACK

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR 17 Jul DAY
19 2003 HOUR

HOUR	06	07	08	09	10	11	12	13	14	15	16	17		
RESPIRATION RECORD Resp →	26	27	26	29	30	17	30	31	29	30	33			
BLOOD PRESSURE →	118/60	114/62	114/63	114/60	128/65	114/63	110/63	118/68	117/65	113/64	117/67			
SpO_2 →	96%	95%	95%	95%	93%	95%	96%	99%	100%	98%	99%			
O_2 →	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC			
HEIGHT: WEIGHT →														Totals
Output NG	40	120	110	130	175	Ø	90	200	80	350	350			
Foley	40	70	60	60	60	20	30	40	30	50	40			
Intake IV	200	100	200	100	150	100	150	100	100	100	100			
Flush NGT			30				30				30			
PO				60			30		60					

Record special data only when so ordered

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

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

TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

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. ICU

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	20 Jul													
19	HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20
PULSE (O)	TEMP. F (°)														
	105°														
180	104°														
170	103°														
160	102°														
150	101°												V		
140	100°											V			V
130	99°		V					V	V	V				V	
	98.6°	V									V				
120	98°			V	V	V	V								
110	97°									•					
100	96°				0										
90	95°									0	0	0			
80		0	0	0		0	0	0	0					0	0
70															
60															
50															
40															

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	21	20	20	28	21	26	27	23	22	25	28	24	24	26	
BLOOD PRESSURE	126/71	132/72	129/68	117/71	122/71	133/76	135/84		139/80	134/80					
RO_2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
HEIGHT: WEIGHT →					99	99	99	100	100	99	99	100	100	100	
PO	100	Ø	Ø	Ø	50	Ø	Ø	Ø	Ø	150	Ø	500	Ø	Ø	
RV	30	130	30	30	30	30	30	30	30	130	30	30	30	30	530 in
Output	Ø	Ø	Ø	Ø	Ø	Ø	575	Ø	Ø	Ø	Ø	300	Ø	Ø	
					200										775 out

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6599

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	20 Jul														
19	HOUR	21	22	23	24	01	02	03	04	05	06	07	08	09	10	
PULSE (0)	TEMP. F (°)															TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°	V	V	V	V	V	V				V					37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°	•				•		V		V		V	V	V	V	36.7°
110	97°									•						36.1°
100	96°								V							35.6°
90	95°	o	o	o	o	o		o		o			o	o	o	35.0°
80														V		
70		^	^	^	^	^	o ^		o	^	o ^	o				
60								^	^			^	^	^	^	
50																
40																

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE R-	24	18	20	21	24	14	14	14	20	14	20	22	25	21	
O2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
HEIGHT: SLQ WEIGHT →	98	98%	98%	100%	98%	99%	99%	99%	100	99	99	99	84	98	
PO	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø						
IV	30	30	30	130	130	30	30	30	1030		530		in		1560
Output	Ø	300	Ø	Ø	350	Ø	Ø	Ø	950		775		out		1725
								I	30	30	210	100	100	100	−165
								O	Ø	Ø	575	Ø	Ø	500	

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	21 Jul														
19	HOUR	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
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		O	O	O												
70		^	^	^												
60																
50																
40																

(Centigrade Equivalents, for Reference only)

TO OR

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	20	18	21	
	2L	2L	2L	
	NC	NC	NC	
HEIGHT: Sat WEIGHT →	100	99	99	
PG	Ø	Ø	Ø	
IV	100	100	100	
output	Ø	Ø	100	625

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

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

b(6)-4

Pt # [redacted]

ETT 8.0

24cm @ lip

VENT FLOW SHEET

	DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
	21July03	1640	SIMV	10	850	50%	+5	33	1:2.0	Ø	—	103	100%	129/58	8.0	MLT	[redacted]
ABG	21July	1720	pH 7.513	PCO2 36.9	PO2 158	HCO3 30	BE 7	SO2 100%									
	21Jul	1934	SIMV	10	850	50	5	30	1:2	Ø	—	100	100	154/62	8	MLT	
	21Jul	2200	SIMV	10	850	50	5	31	3H1:2	—	—	102	100	140/60	8	MLT	
	22Jul	0040	SIMV	10	850	50	5	30	1:2	Ø	—	114	100	133/61	8	MLT	
	22Jul	0230	SIMV	10	850	50	5	29	1:2	Ø	—	107	100	125/58	8	MLT	
	22Jul	0440	SIMV	10	850	50	5	29	1:2	Ø	—	106	100	116/49	8	MLT	
	22July	0545	SIMV	10	850	50%	+5	28	1:2.0	Ø	—	116	100%	104/65	8.0	MLT	
ABG	22July	0725	pH 7.513	PCO2 38.1	PO2 119	HCO3 30	BE 8	SO2 99%				110					
	22July	0745	SIMV	10	850	50%	+5	26	1:2.0	Ø	—	109	100%	74/61	8.0	MLT	
	22July	1010	SIMV	10	850	50%	+5	30	1:2.0	Ø	—	107	100%	80/52	8.0	MLT	
	22July	1215	SIMV	10	850	50%	+5	28	1:2.0	Ø	—	109	98%	74/50	8.0	MLT	
	22July	1350	SIMV	10	850	50%	+5	27	1:2.0	Ø	—	103	99%	97/54	8.0	MLT	
	22July	1550	SIMV	10	850	50%	+5	28	1:2.0	Ø	—	105	98%	93/51	8.0	MLT	
	22Jul	1800	SIMV	10	850	50	5	28	1:2	Ø	—	105	98	102/51	8	MLT	
	22Jul	2040	SIMV	10	850	50	5	29	1:2	Ø	—	97	100	94/55	8	MLT	
	22Jul	2150	SIMV	10	850	50	5	30	1:2	Ø	—	99	100	140/57	8	MLT	
	23Jul	0130	SIMV	10	850	50	5	31	1:2	Ø	—	97	100	139/63	8	MLT	
	23Jul	0220	SIMV	10	850	50	5	31	1:2	Ø	—	97	97	160/60	8	MLT	
	23Jul	0515	SIMV	10	850	50%	+5	30	1:2.0	Ø	—	102	100%	138/56	8.0	MLT	
	23Jul	0610	SIMV	10	850	50%	+5	31	1:2.0	Ø	—	101	100%	135/53	8.0	MLT	
ABG	23Jul	0745	pH 7.481	PCO2 32.2	PO2 130	HCO3 26	BE 2	SO2 99%									
	23Jul	0800	SIMV	10	850	50%	+5	30	1:2.0	Ø	—	101	100%	144/60	8.0	MLT	
	23Jul03	1000	SIMV	10	850	50%	+5	30	1:2.0	Ø	—	102	100%	151/47	8.0	MLT	
	23July	1150	SIMV	10	850	50%	+5	28	1:2.0	Ø	—	103	100%	141/67	8.0	MLT	
	23July	1350	SIMV	10	850	50%	+5	31	1:2.0	Ø	—	112	100%	140/59	8.0	MLT	

b(6)-4

MEDCOM - 6602

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 21 Jul 22 July

19 HOUR 17 18 19 20 21 22 23 24 01 02 03 04 05 06

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE	117/68														
A-line	115/61	124/68	154/68	139/59	140/56	126/64	144/64	132/52	123/59	117/59	105/56	NIBP 107/55	NIBP 106/54	82/49	
HEIGHT: WEIGHT →															
SaO_2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Foley	—		125	100	75	100	125	75	75	75	50	50	40		890 : OUT
JP ~~NG~~	—		10cc	~~[illegible]~~	15	10	10	15	5	5	6	3	5		98 : OUT
LR	100	100	100	100	100	100	100	100	100	100	100	100	100		1300 : IN
IVPB	Ø	Ø	Ø	Ø	Ø	100	250	Ø	Ø	Ø	Ø	100	Ø		450: IN ~~TOTAL~~

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. ICU

Vec	Ø	4	6	6	6	6	6	6	6	6	6	6	6
MSO_4	Ø	5	5	5	5	5	5	5	5	5	5	2	2
Versed	Ø	2	4	4	4	4	4	4	4	4	4	4	4
NGT Residuals				Tube food				Resid. 5cc				Res. 120+	

VITAL SIGNS RECORDS

Medical Record

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

125: OUT

MEDCOM - 6603

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	22 Jul													
19	HOUR	06	07	08	09	10	11	12	13	14	15	16	17	18	19
PULSE (O)	TEMP. F (•)														
	105°														
180	104°														
170	103°														
160	102°														
150	101°		•		•										
140	100°							•	•		•			•	•
130	99°										V				
	98.6°														
120	98°														✓
110	97°	o	o		V	V	V	V	V	V		V			
100	96°			V	o	o			o	o	o	o	o	o	o
90	95°		V				o								V
80		V											V		
70															
60															
50			^	^	^	^	^	^	^	^	^	^	^		
40		^												^	^

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	10	10	10	10	10	10	10	10	10	10	10	10	10	10
BLOOD PRESSURE NBP	108/49	111/61	113/58	112/63	116/58	119/58	113/58	110/55	114/54	132/52	115/54	86/52	91/49	92/58
Sao2	100%	100	100	100	100	100	99%	98	98	98	98	98	98	99%
Foley	40	Ø	Ø	10	7	Ø	10	Ø	15	20	15	5	10	15
HEIGHT: WEIGHT TOF	1	1	1	1	1	1	1	1	1	1	1	1	1	
JP	—	3	—	—	—	—	—	—	—	—	—	—	15	3
Maint IV	100	100	600	150	150	150	150	575	575	575	200	200	200	200
Vec		6	6	6	6	6	6	6	6	6	6	6	6	6
Versed		6	4	4	4	4	4	4	4	4	4	4	4	4
MSO4		2	2	2	2	2	2	2	2	2	2	2	2	2
IVPB	100				100	250			100				100	Ø
							20	20	20	20	20	20	20	20

Output

Intake

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)

Jevity

REGISTER NO

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

(b)(6)-4

(b)(6)-4

(b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

22 July 2003 | 23 July 2003

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	18	19	20	21	22	23	24	01	02	03	04	05	06	—
19	HOUR														

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

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

	18	19	20	21	22	23	24	01	02	03	04	05	06	—
HR			101	98	98	99	99	97	99	102	97	104		
MAP	67	66	66	69	82	86		81	82	85	84	88		
BLOOD PRESSURE Aline	96/52	92/58	102/54	104/52	136/65	101/51	128/56	145/61	149/57	154/60	153/61	134/59		
NIBP	94/51	98/47	99/49	100/47	105/56	111/58	105/54	107/59	114/64	113/63	110/62	115/61		
S_aO_2	96%	99%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
HEIGHT: WEIGHT: VR →	10	10	10	10	10	10	10	10	10	9	11	10		
SIMV-VENT: TV	850	848	850	850	860	850	850	850	850	850	850	850		
FIO_2	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%		
Peep	5	5	5	5	5	5	5	5	5	5	5	5		
Lip 8.0 ETT	25	25	25	25	25	25	25	25	25	25	25	25		
LR	200	200	200	200	200	200	200	200	200	200	200	200		
Vec	6	6	6	6	6	6	6	6	6	6	6	6		
MSO4	2	2	2	2	2	2	2	2	2	2	2	2		
Versed	4	4	4	4	4	4	4	4	4	4	4	4		

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.

	18	19	20	21	22	23	24	01	02	03	04	05	06	—
Levity	20	20	20	20	20	20	20	20	20	20	20	20		
IVPB	Ø	Ø	Ø	Ø	Ø	350	Ø	Ø	Ø	Ø	Ø	100		
Foley	10	15	50	32	70	90	125	250	125	140	105	155		
JP	15	3	3	2	2	1	2	1	1	1	2	1		
NGT Residual	—	—	3cc	—	2cc	—	—	4cc	—	—	10cc	—		
Abd	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	min	Ø	Ø		
OTHER	—	—	—	—	—	—	—	—	—	—	—	—		
(TOF) PNS	1	Ø/4	Ø/4	Ø/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4		

WARD NO.: 240, 450

2400 IN
72
24 2544
48 24v 450 3234
1196
OUT

~~1152~~ FOLEY = 1167

VITAL SIGNS RECORDS 34 - JF
Medical Record 19 Incidents

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

MEDCOM - 6605

b(6)-4
Pt #0034
ETT 8.0
23 @ lip

VENT FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
23Jul03	1610	SIMV	10	850	50%	+5	26	1:2.0	13	—	119	100%	113/55	8.0	MLT	[redacted]
23Jul03	1740	SIMV	6	850	50	5	24	1:3.0	+13	—	115	97	110/52	8	MLT	[redacted]
23Jul	2030	SIMV	6	850	50	5	32	1:3	13		100	100	123/60	8	MLT	[redacted]
23Jul	2230	SIMV	6	850	50	5	31	1:3	13	—	103	100	127/58	8	MLT	[redacted]
23Jul	2300	SIMV	10	850	50	5	27	1:1.6	1	—	100	100	128/57	8	MLT	[redacted]
23Jul	0230	SIMV	10	850	50	5	27	1:1.6	Ø	—	96	100	134/62	8	MLT	[redacted]
23Jul	0430	SIMV	10	850	50	5	26	1:1.6		—	96	100	146/72	8	MLT	[redacted]
24Jul	0630	SIMV	10	850	50%	+5	29	1:1.6	Ø	—	88	100%	132/66	8.0	MLT	[redacted]
ABG 24July	0730	PH 7.512	PCO2 37.8	PO2 165	HCO3 31	BE 7	SO2 100%									
24July	0805	PT Extubated placed on NRB Mask @ 12 L/min									102	97%				

b(6)-2

MEDCOM - 6606

(b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

23 July 2003 — Begin Cooling

VITAL SIGNS RECORD

i-STAT G3+ — Vt 850, Rate 10, FiO2 50%, Peep +5

Pt: 0034

Pt Name:_____

TCO2_____27 mmol/L

At 37C

pH_____7.481

PCO2_____34.3 mmHg

PO2_____138 mmHg

HCO3_____26 mmol/L

BEecf_____2 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.602

PCO2_____32.2 mmHg

PO2_____130 mmHg

Patient Temp: 96.1F

FIO2_____: 50%

Sample Type: ART

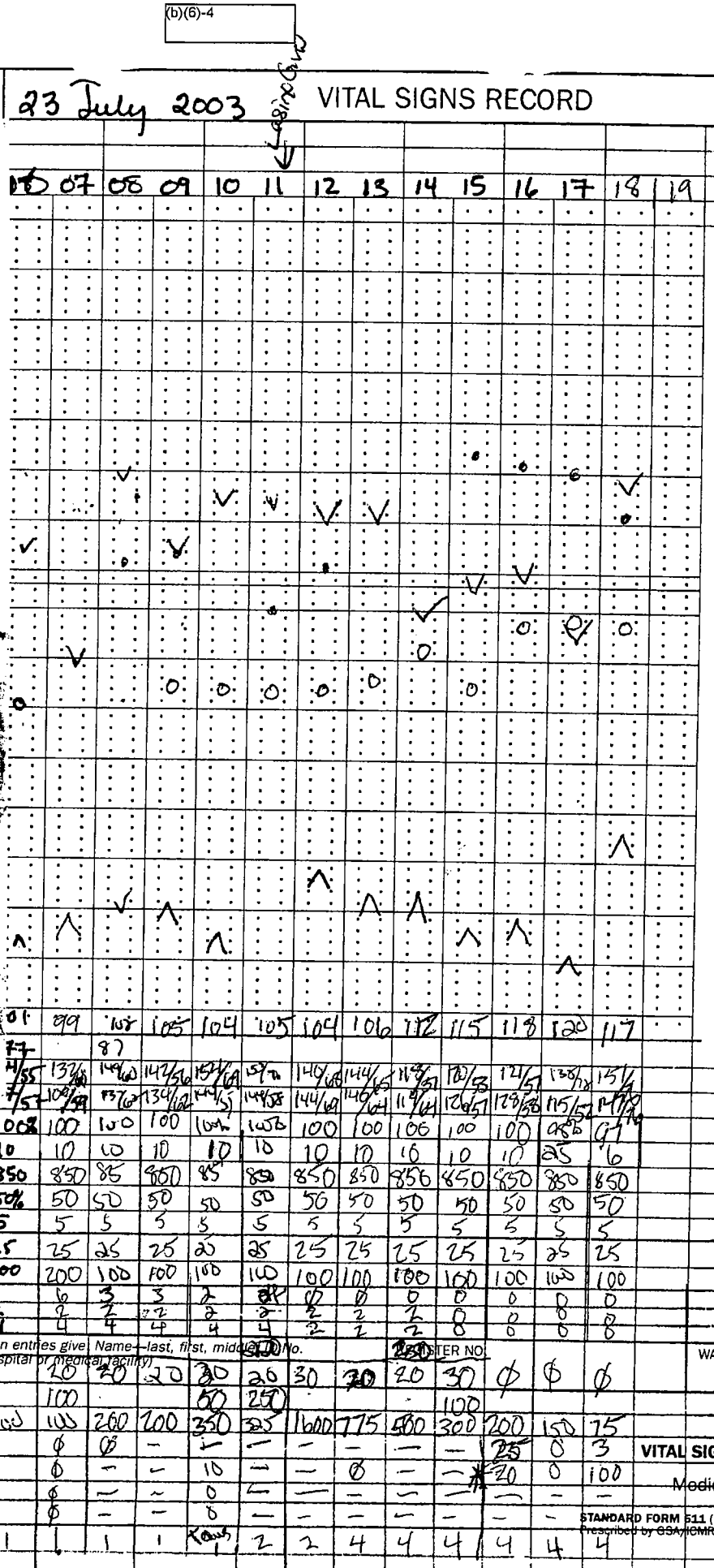
23JUL03 @ 17:53

Oper: (b)(6)-2

Physician:_____

Ser# 4[illegible] 90

Ver: JAMS045A
CLFW A91



	06	07	08	09	10	11	12	13	14	15	16	17	18	19
Pulse	101	99	108	105	104	105	104	106	112	115	118	120	117	
Resp	77		87											
BP	135/55	132/60	149/60	142/56	154/64	157/70	140/60	144/65	139/51	130/53	121/51	138/58	151/64	
MAP	75	109/59	137/60	134/62	144/5	144/58	144/60	146/64	119/64	126/57	128/58	115/52	117/60	
SaO_2	100%	100	100	100	100%	100%	100	100	100	100	100	98%	97%	
HEIGHT: / WEIGHT / VR	10	10	10	10	10	10	10	10	10	10	10	25	6	
Simv : VENT : TV	850	850	85	850	85	850	850	850	850	850	850	850	850	
FIO_2	50%	50	50	50	50	50	50	50	50	50	50	50	50	
Peep	5	5	5	5	5	5	5	5	5	5	5	5	5	
~~Exp B.O~~ elig ETT	25	25	25	25	25	25	25	25	25	25	25	25	25	
LR	200	200	100	100	100	100	100	100	100	100	100	100	100	
Vcc	6	6	3	3	2	2	0	0	0	0	0	0	0	
MSOV	2	2	2	2	2	2	2	2	2	0	0	0	0	
Versed	4	4	4	4	4	4	2	2	2	0	0	0	0	
Fentanyl		20	20	20	20	20	30	30	20	30	0	0	0	
IVPB		100			50	250				100				
Foley	100	100	200	100	350	325	1600	775	500	300	200	150	75	
JP		0	0	—	—	—	—	—	—	—	25	0	3	
NGT Resids		0	—	—	10	—	—	0	—	—	*20	0	100	
Abd		0	—	—	0	—	—	—	—	—	—	—	—	
Other		0	—	—	0	—	—	—	—	—	—	—	—	
(TOF) PNS	1	1	1	1	1	2	2	4	4	4	4	4	4	

Record special data only when so or:

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

REGISTER NO.

WARD NO.

*NG to LIS

MEDCOM - 6607

VITAL SIGNS RECORDS

~~Medical Record~~

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

Cui pt

(b)(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

23 July 2003 — 24 July 2003

HOSPITAL DAY														
POST-DAY														
MONTH-YEAR	DAY	18	19	20	21	22	23	24	01	02	03	04	05	06
19	HOUR													
PULSE (O)	TEMP. F (•)													
180	105°													
170	104°													
160	103°													
150	102°													
140	101°													
130	100°													
120	99° 98.6°													
110	98°													
100	97°													
90	96°													
80	95°													
70														
60														
50														
40														
	HR	125	109	103	109	93	101	98	97	94	94	91	92	96
	MAP	99	78	67	83	83	73	78	66	84	85	86	91	
RESPIRATION RECORD	BLOOD PRESSURE A Line	133/65	119/58	102/48	122/62	122/62	124/53	125/56	104/50	130/62	131/60	140/68	147/65	144/71
	NIBP		124/53	100/48	122/54		136/56	115/54	102/45	121/47	124/44	145/61	154/61	—
	RR	36	23	26	10	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
HEIGHT: WEIGHT	VR	6	6	6	10	10	10	10	10	10	10	10	10	10
	SaO_2	98%	98%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	FiO_2	50%	50%	50%	50%	50%	50%	50%	50%	60%	50%	50%	50%	50%
	PEEP	5	5	5	5	5	5	5	5	5	5	5	5	5
	T:	100.1	—	98.1	98.9	99.1	99.8	—	99.8	99.7	99.9	99.5	99.6	—
	8.0 ETT	25	25	25	25	25	25	25	25	25	25	25	25	25
	FOLEY:	-	125	75	75	105	120	70	110	90	100	125	145	100
	SP:	-	—	—	—	7	—	—	—	2	—	—	—	1cc
	OTHER:		—	—	—	—	—	—	—	—		—	—	—
	NGT: (Rec)		—	—	Ø	Ø	Ø	4cc	—	—	Clamped	/	145	25
INPUT	MAINTENANCE LR/100		100	100	100	100	100	100	100	100	100	100	100	100
	Tube feedings		Held	Held →	30	15	30	30	30	30	30	Ø	Ø	Ø	Ø
	IVPB				Ø	300 →		Ø	Ø	Ø	Ø	100	Ø	Ø
	vancomycin				1mg	2mg	3mg	3mg	3mg	3mg	Held	Ø	Ø	

Record special data only when so ordered

OUTPUT		1160	10	1170 OUT
				WARD NO.
		1200	1200	1200
		165		
		420	TOTAL IN	805
		160		
		1781		

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

REGISTER NO.

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 6608

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 24 July 2003

POST- DAY

MONTH-YEAR 19 — DAY / HOUR

PULSE (O)	TEMP. F (°)	07	08	09	10	11	12	13	14	15	16	17	18	TEMP. C
	105°													40.6°
180	104°													40.0°
170	103°													39.4°
160	102°						✓							38.9°
150	101°			✓		✓					✓			38.3°
140	100°	✓			✓			✓	✓	✓				37.8°
130	99°													37.2°
	98.6°													37.0°
120	98°		✓										✓	36.7°
110	97°											✓		36.1°
100	96°													35.6°
90	95°													35.0°
80														
70														
60														
50														
40														

(Centigrade Equivalents, for Reference only)

		07	08	09	10	11	12	13	14	15	16	17	18
	T	99			98.9					99.9		99.9	
RESPIRATION RECORD	RR	35	11	33	40	37	41	31	28	30	32	31	41
BLOOD PRESSURE	A-lin	145/71	115/65	123/72	134/65	135/67	141/69	136/64	138/66	133/63	134/66		
	NIBP	141/66	121/71	146/69	142/70	146/69	156/74	141/63	142/67	140/69	148/62	111/60	120/62
	HR	100	92	105	109	96	101	104	103	109	106	107	120
HEIGHT: WEIGHT	MAP												
	SaO_2	100	100	~~100~~									96
Vent Simv:	TV	850	850	~~850~~				NC	NC@6	NC@6			
	VR	10	10	~~10~~									
	FIO_2	50	50	~~50~~									
	Peep	5	5	~~5~~									
	Foley	100	1100	1200	550	400	200	200	200	150	150	100	
	JP	—	—	—	—	—	—	—	—	—	—		

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.

IVF's	100	100	50	50	50	50	50	50	50	50	50	50
WPB's	100	Ø	Ø	50	250	Ø	Ø	100	Ø	Ø	Ø	
NGT	20	50	50	100	100	120	50	30	40*	120	60	

MEDS:

VITAL SIGNS RECORDS

Medical Record

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

* NG tube INPUT

MEDCOM - 6609

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY															
19	HOUR	19	20	21	22	23	24	01	02	03	04	05	06	07		
PULSE (O)	TEMP. F (°)															TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
60																
50																
40																

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD R

BLOOD PRESSURE

HEIGHT: WEIGHT ~~Sol~~ HR

Record special data only when so ordered

O2	6L														
Mechel	NC														
Foley															
JP															
IVF															
NG															

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

REGISTER NO.

WARD NO.

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

(b)(6)-4

MEDICAL RECORD — 25 July — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

HEIGHT: WEIGHT

	06	07	08	09	10	11	12	13	14	15	16	17	18
BLOOD PRESSURE NIBP	110/59	116/69	124/71	120/69	101/57	109/61	118/70	125/70	129/70	129/68	111/58	111/57	
HR	84	85	85	86	92	86	81	89	87	88	91	90	
RR	22	24	23	22	24	12	20	18	20	22	22	23	
~~SaO2~~	98%	98%	98%	98%	100%	97%	100%	100%	100%	99%	99%	99%	
O2 MODE	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	N/C	NC	
L	2	2	2	2	2	2	3	3	3	3	3	3	
Ti		96.7		97.7		97.4	97.4		97	97.7	97.7		
NGT	30	30	30	60	60	60	60	60	60	90	90	90	
Resid		50		10		50		12		5		35	
PO							240						
LR	50	50	50	50	50	50	50	50	50	50	50	50	

Total intake 2470

total 1250

1220

1020

240

600

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. 400

	06	07	08	09	10	11	12	13	14	15	16	17	18
IVPB	50	50	50		50	50	50	50	50				
MSO4								2			2		
NGT Flushes		30		50		30		30		40		50	
Foley	100	100	100	100	75	75	50	175	100	75	150	150	
JP						D/C'd							
BM													

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 6611