(b)(2)-2

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4	CIV	

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

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	14:20	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-09-17

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-09	(b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 - (b)(2)-2	2003-09-09	

31. Selected Administrative Data

Marital Status: Z

In/Out Patient: Inpatient

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

MOS:

33. Cause Of Injury: Sustained injuries while firing at US ammo storage in North Tikrit

34. Diagnosis / Operations and Special Procedures:

Left chest wall GSW, intraartricular GSW to elbow, Left ulnar nerve contusion

Debridement & primary closure: left chest wall, lefft elbow GSW, ulnar nerve decompression

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
(b)(6)-2 COL, MC	(b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date ... tion)*

SEE DR WOSNOWSKI'S
558 FOR HX & GSW PE.
NEURO EXAM @ ISCD1. ↓ LT
SF

PHYSICAL EXAMINATION

A INTRAARTICULAR (L)
ELBOW GSW & ULNAR PARESIS
P DEBRIDE IN OR, POSSIBLE
NEUROPRAXIA ONLY

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

(b)(6)-2
LTC, MC
9 SEP 03

SIGNATURE OF PHYSI...	DATE	...ENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION	...ten entries give Name ... ...e; date; hospital or ...	REGISTER NO.	WARD NO.

(b)(6)-2

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.506
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL REC[illegible] MEDICAL CARE**

DATE	S, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/9/03	21 y/o GSW to (R) Foot, Chest, (L) elbow
14 14	O.2. Sat 99% NC. CXR to (L) elbow, Chest
allergies	L.R. I.V. (R) arm #1 1420. (L) foot.
NKDA	(-) FAST 1421. L.R. 2nd bag 1446
tob 1PK	Foley was put in @ 1426
alcohol yes	EKG. 1417.
PSHX Ø	Cincef 1gr piggyback I.V. 1429
PMHX Ø	Tetanus I.M. 1430
	on a PN scale from 1-10 Pt states 9/10
1415 118/62	femoral draw 1432.
P 97	1435. Morphine 10mg I.V.
Pox 99	
Res 28	All drawn
	LABS. U/A (-) blood in Urine
LMI 0800	type inspection
TOI 1300	CBC
	Chem 7
MPO	L/U splint
1445 131/55	BP 119/63 1500 BP 119/63 P 94 R 18 POX 9[illegible]
P 87	P 93
RR 21	RR 28
POX 100	POX 99

(b)(6)-2 [redacted] 9/1800

(b)(6)-4 [redacted]

09-09-03
14:34
Patient
Limits

[illegible]	10.5	4.5	10.5
[illegible]	5.54	4.00	6.00
[illegible]	[illegible]	11.0	18.0
[illegible]	[illegible]	35.0	60.0
[illegible]	[illegible]	80.0	100.0
[illegible]	93.3	27.0	31.0
[illegible]	30.8	33.0	37.0
[illegible]	27.1	100.	450.
[illegible]	26.3	36.5	51.1
[illegible]	22.5		

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

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

(b)(6)-4 [redacted]

CI[illegible] CARE

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09 Sep 03	1530 - ADMISSION - 21 y/o ♂ RECEIVED FROM EMT VIA LITTER. Dx: GSW TO (R) FLANK & (L) SUPRACONDYLAR FRACS. VSS, AAOx3, PERRLA, LUNGS CTA BILAT C̄. SYMMETRICAL RISE + FALL IN CHEST. S1-S2 STRONG AND REGULAR. CAP REFILL <3 IN ALL EXTREMITIES, PULSES PALPABLE (BRACHIAL) IN (B) UE. HYPO ACTIVE BOWEL SOUNDS x4. SPLINT TO (L) FOREARM. C.D.I. MOTOR, SENSORY SKILLS INTACT. DRSG TO (L) FOOT C.D.I. CBC SENT TO LAB. C&R @ 1900. PATIENT NPO DUE TO (b)(6)-2 PRE-OP. WILL CONTINUE TO MONITOR THROUGHOUT — SGT [illegible]
9 Sep 03 1830	Nursing: Elimination Pt. void 600cc via foley. Clear yellow. Pt. in pre-op status. — (b)(6)-2 CPT [illegible]
9 Sep 03 2005	OP NOTE PREOP Dx (L) ELBOW GSW C̄ OPEN FX & ULNAR NERVE LESION. (L) CHEST WALL GSW POSTOP Dx (L) ELBOW GSW C̄ OPEN FX & ULNAR NERVE CONTUSION. (L) CHEST WALL GSW PROCEDURE - DEBRIDEMENT (L) ELBOW FX & ULNAR NERVE DECOMPRESSION. DEBRIDEMENT (L) CHEST WALL BURN EMANUELE/KOMOWSKI FURDS 600 LR ERL MIN TOT SL @ 250 ML HR 200 CXR ORDERED & SPECIMEN BULLET FRAGMENTS (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.)*

(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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9SEP03	FINDINGS: POST GSW (L) ELBOW C̄ FRAGMENTS IN OLECRANON FOSSA. CONFUSED VRAN N. MIN CONTAMINATED SUPERFICIAL CHEST WALL WOUND.
	TO ICU TO NEUROM STABE
	(b)(6)-2
	LTC, MC ORTHOPEDIC SERVICE
9Sep03 22:12	Received care of patient @ 21:00 upon return from OR via litter. Pt. awake and alert. Able to transfer self from litter to bed c̄ some assistance. Pt. responses appropriate for situation. VS BP-143/83 - P-86 - T-98.7 - O2Sat 97%. PERRLA (+) WNL EOM (+) WNL. Skin warm/dry/intact. Buccal mucosa moist. Lung sounds clear to auscultate throughout (B). Bowel sounds (+) x 4 quadrants. Abdomen soft/non-tender, HR regular S1 S2 WNL. Dressing to (R) chest wall/flank intact c̄ scant amount bloody drainage noted. Border drawn around drainage will reassess for further drainage. (L) arm ACE wrap dressing clean/dry/intact. NVV's to (R) digits WNL. PIV to (R) forearm patent LR infusing @ 125cc/hr. (B) pedal pulses (+) 2 WNL. C/o pain @ 21:26 iī Percocet given c̄ (+) results. Will continue to monitor — (b)(6)-2
0001	(R) chest wall dressing ~~inch~~ error em intact. Amount of drainage unchanged from initial assessment. — (b)(6)-2
0438	Pt c/o pain to (R) arm. iī Percocet given — (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
10 Sep 03 0645	Nursing: Void - Pt c/o pain, ~~hard~~ due to void post-op. Assist pt to OOB to ward latrine, Pt void 475 cc clr, amber urine — IV (b)(6)-2 AN
10 Sep 03 1345	1345 - Assessment - AO x3, PERRLA, lungs CTA bilat, S1 S2 strong and reg, (+) BS x 4. Refused breakfast and ate approx 30% of lunch. OOB to BR. Splint to (L) arm, C,D,I. Ace to (L) foot C,D,I. Continues IV Ancef. Ø c/o pain since A.M. Will continue to monitor — (b)(6)-2 SSgt USA
10 Sep 03 1500	POD 1 S NO/CO O VSSA Dressing & intact Hand well perfused A stable P 72° IV ABX (b)(6)-2 MC ORTHOPEDIC SERVICE

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Sep 03 1815	Nurses Notes: Assumed care of Pt A&O x3 Pt answers appropriately to questions asked by saying Yes/No or Nod of head. Breathing intact ∅ SOB or Labored breathing. Lying in bed appears comfortable ∅ c/o pain at this time W Sk flushes well. Dressings dry/clean and intact. Abd soft and non tender. Pt tolerated about 10 % of meal. Ancef therapy continues. Pt Ambulates to BR tolerates it well. will continue to monitor — (b)(6)-2
2030	Pt awake sitting up in bed. c/o pain ↑ Percocet PO given for Pain. will continue to monitor Pain status — (b)(6)-2
2250	Pt c/o pain ↑ percocet and 4mg Morphine given Pt Temp 100.8 will reassess. Encourage Pt to ↑ PO fluids. gave cool wash cloth to pt to wipe self/face — (b)(6)-2
2305	Temp at this time 100.6 will continue to monitor — (b)(6)-2
2330	Temp = 99.0 ∅ fever present Pt ate and complied c drinking water. will continue to monitor — (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Sep 2003 0950	Nursing Assessment: Pt sleeping, easily aroused. C/O pain, medicated c̄ percocet. Pt alert, Lungs CTA, O2 sats 98% on RA. HR 68, reg. HL to (L) ac patent. mild edema to (L) fingers. Abd soft, flat, (+) BS x4. (L) UE c̄ splint & ace wrap CDT. (L) fingers c̄ brisk cap refill, warm, dry. Pt able to move all fingers. Drsg to (L) flank c̄ quarter size area drainage marked, & additional drainage noted. (b)(6)-2
11 Sep 03 1818	Nursing Notes: Assumed care of pt AFO. ∅ c/o pain breathing intact ∅ SOB or labored breathing pt able to move all extremities except (L) arm in splint. Pt able to wiggle fingers on affected arm c̄ delayed movement of (L) ring finger and pinky. Cap refill brisk on affected arm warm to touch c̄ normal coloration. Abd soft and non tender pt tolerated regular diet ∅ N/V voids spontaneously ambulates to outside BR tolerates it well. IVSL flushes well ∅ S/S of infiltration at site. IV Ancef therapy continues. will continue to monitor status (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.

(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)*
12 Sep 03	ADL S LOCAL PAIN O VSSA WNL CLEAR ELBOW ROM 30 – 110° A DONE WELL P FINISH 72° IV ABX BID ROM (b)(6)-2
12 Sep 03 1515	Nursing: Pt awake, ¢ c/o pain, pt had some pain c̄ ROM exercise before splint placed. Lungs CTA, ¢ SOB, O2 sats 96% on RA, HR 84, ¢ edema to extremities. Hx to (R) fa leaking DIC Hx, placed 20g. catheter to (R) hand on 1st attempt, pt tolerated well. Abd soft, nontender, pt tolerating reg diet well. GSW to (L) elbow has staples intact. Dried drainage at incision site, ¢ active drainage. Mild swelling & redness @ site. Skin is warm, dry, pt able to move elbow c̄ ↑ pain. ROM exercises ordered BID by MD. ¢ difficulty c̄ void, ↑ to BRC MP @ cont (b)(6)-2
1630	Pt awake alert in c/o pain. ∅ SOB ∅ N/V. Splint in place on (L) arm. ∅ edema noted. (+) pulses. (+) sensation. Pt on reg diet and tolerates. Splint CDI ∅ drainage noted. Pt able to move ext x4. Will continue to monitor (b)(6)-2 qiuma SA USA
12 Sep 03 2051	Pt c/o pain to (L) arm ii Percocet given will monitor (b)(6)-2
2200	Acet given pt asleep arousable. IV patent no c/o pain will continue to monitor (b)(6)-2 qiuma SPC USA

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)*
13Sep03	0530 Pt asleep easily, arousable. No c/o pain. Meds given for 0600. IV patent to rt sk at infil [illegible] will give report to oncoming shift (b)(6)-2 [illegible]
13Sep03 1630	Nursing: Shift Note Pt. drowsy at beginning of Shift. Pain x1 p̄ exercises. Alert at present, Eating & hydrating well, tolerating po. Voiding w/o difficulty. c/o ∅ being able to fully wiggle 4th & 5th finger of injury (L) hand cum. Dressing D&I Bling removed x1 for exercise. ∅ signs of distress. Continue to assess. (b)(6)-2 CPT/AN
13Sep03	SIGNAL PAIN @ VSSA DSES DRY FINGERS IT PRESENT BUT ↓ (L) SF A ULN. NEUROVASCULAR INTACT P DC SOON
	(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.

(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 Sep 03 2319	Nursing Notes: Assumed care of Pt asleep but easily aroused. Breathing intact ∅ SOB or labored breathing. ∅ c/o pain or discomfort. ∅ IV access. Pt able to move extremities able to move fingers on affected arm. Splint dry and intact ∅ bleeding or drainage noted. Will continue to monitor status. (b)(6)-2 RN/AN
0525	Pt c/o pain ⊼ Percocet PO given for pain. Will continue to monitor status (b)(6)-2 RN
14 Sep 2003 0915	Nursing: ROM: Pt drsg & splint remove, pt perform ROM exercise to elbow X 10 minutes. Medicated pt ⊼ ⊼ Percocet for pain. Old drsg ⊼ sec 2X3 in area of serous drainage. P exercise replace drsg of xeroform gauze, 4x4 & Kerlix wrap. splint & ace wrap reapplied. LT (b)(6)-2 AN
14 Sep 2003 0935	Nursing Assessment: Pt awake & alert. Lungs CTA, O_2 sat 96% on RON. HR reg, reg, mod. edema to all fingers on (R) hand. HL to (R) hand patent. ~~Abd~~ Abd soft, flat, nontender, (+) BS x4. Pt tolerate reg breakfast this am. (R) UE ⊼ ace wrap & splint CDI. (R) UE warm, dry, +2 radial pulse, brisk cap refill to fingers. Pt. ↑ OOB ⊼ mp escort, amb well. WTL RN, AN
14 Sep 03 2546	Pt. performed ROM ⊼ assistance. Pt tolerated ~~procedure~~ procedure well. premedicated ⊼ ⊼ Percocet ~~given~~ will continue to monitor (b)(6)-2 (b)(6)-2 (b)(6)-2 RN/AN

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Sep 03 1115	Nursing: ROM/Drsg Δ: Premed pt w Percocet. Removed old drsg. Dime size area of drainage from scab to (D) of wound of sero-sang fluid. Pt perform ROM exercise to (D) LE x 10 minutes, ↑ pain, but pt tolerated well. Apply new drsg of Xeroform & 4x4, & Kurlix roll. Splint reapplied w ace wrap. — LT (b)(6)-2
15 Sep 03 1120	Nursing: Hx 3 days pd, D/C Hx to (R) hand. — (b)(6)-2
15 Sep 03	ASD 6 S NO C/O O VSSA WOUNDS CLEAN ELBOW ROM 30–100° UNABLE TO ASSESS URMN & FXN. A DOING WELL P STAPLES OUT & D/C IN 48°
	(b)(6)-2 LTC MC ORTHOPEDIC SERVICE
15 Sep 03 19:37	Received care of patient @ 18:00 Pt. awake in bed. Alert x3. Pt. assessment @ 19:37 - Skin warm, dry, intact. PERRLA bilat. Buccal mucosa moist/pink. Lung sounds clear to auscultate (B) throughout

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Sep 03	Bowel sounds ⊕ x 4 quadrants. Abdomen soft & tender. ⊕ Radial pulses
note continued	(B) ⊕ 2 strength. 5 staples to (D) chest wall clean/dry/intact c̄ opsite
19:35	over them. incision well approximated. ∅ s/s infection. ACE wrap/+
	kerlix dressing to (D) arm clean/dry/intact. ⊕ NVS's to (L) digits. ⊕
	non-pitting edema noted to top of hand. ∅ c/o pain @ this time.
	pt. performed AROM c̄ some assistance. improvement noted in
	extension/flexion + strength squeezing to (D) arm/hand. will continue
	to monitor — (b)(6)-2 [redacted] SPC/AN
20:06	Pt. c/o pain to (D) arm. ⊕ Percocet given. Will monitor
	(b)(6)-2 [redacted] AN
16 Sep 2003 0905	Nursing: Pt awake, ∅ c/o pain. A&A. NPO CTA, O2 sat 97% on RA. HR reg, rate. ∅ IV access. Mod edema to fingers on (D) hand, +2 radial pulse both extremities. Abd soft, nontender, ⊕ BS x 4. Drsg to (D) elbow Δ'd. Old drsg c̄ small amt sero-sang drainage. Wound c̄ staples, old, dried drainage present. ∅ active drainage noted. Elbow plus proximal + distal to elbow swollen, tender to touch. (D) fingers/arm warm, dry, brisk cap refill. Pt perform ROM exercises x 10 minutes. Reapply drsg of 4x4, Kerlix + bandage to ace wrap. — LT (b)(6)-2 [redacted] AN
16 Sep 03 1852	Nurses Notes: Assumed care of Pt ATD. Pt breathing intact ∅ SOB or Labored breathing. dressing to (L) arm clean dry and intact. Pt able to perform ROM c̄ pain. Encouraged Pt to wiggle fingers more often and perform ROM more often. Pt verbalize understanding per interpreter. Pt urates spontaneously. ∅ c/o pain. Abd soft and non tender. Swelling noted to fingers and arm on (L) — (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-800/50618

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 SEP 03	NARRATIVE SUMMARY
(b)(6)-2 [redacted]	ADMITTED 9 SEP 03 D/C'D 17 SEP 03
TIKMT	DX ① (L) CHEST WALL GSW
	② INTRAARTICULAR GSW (L) ELBOW
	③ (L) ULNAR NERVE CONTUSION
	PROCEDURES - DEBRIDEMENT & PRIMARY
	CLOSURE (L) CHEST WALL WOUND
	DEBRIDEMENT & PRIMARY CLOSURE
	(L) ELBOW GSW
	(L) ULNAR NERVE DECOMPRESSION
	HISTORY - 20 y/o RAD IRAQI MALE
	ENGAGED BY US FORCES C 5.56 MM
	WHEN HE ENGAGED TARG. SUSTAINED
	PENETRATING GSW THROUGH TRICEPS
	TENDON C FRAGMENT IN OLECRANON
	FOSSA. HAD DENSE ULNAR N. DYSFUNCTION
	HAD SUPERFICIAL (L) CHEST WALL WOUND
	S PULMONARY CONTUSION OR PNEUMO-
	UNDERWENT ABOVE PROCEDURES EMERGENTLY
	UNDER GETA. RECEIVED 72° IV ABX. HAD
	A SINGLE FEVER SPIKE WHICH RESOLVED
	C PULMONARY TOILET.

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)*
	STAPLES REMOVED & WOUNDS SCENISTENAPED
	ON POD 8. ELBOW ROM 25 - 110°. ULNAR
	NEURA S/S & SENSATION RECOVERING
	(NERVE FOUND INTACT BUT CONCUSED AT
	SURGERY).
	DISP - D/C IN MP CUSTODY
	MED - VICODIN #40
	F/U - CONFINEMENT MEDICAL ASSETS
	ACT - INSTRUCTED TO DO ROM (EXERCISE).
	(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)*
17Sep03	OCTAO PN S/P (L) ELBOW I&D, (L) FLANK I&D
	(S) PT DENIES WEAK. NO COMPLAINTS
	(O) AF, TACHY, STABLE
	(L) ELBOW INCISION WELL APPROX, STAPLES REMOVED/ STERI STRIPS
	(L) FLANK INCISION WELL APPROX. STAPLES REMOVED/ STERI STRIPS.
	(A/P) (1) NO EVIDENCE POST OP INFECTIONS.
	(2) D/C TO EPW CONFINEMENT FACILITY.
	(3) WORK ROM (L) ELBOW.
	(b)(6)-2
	(b)(6)-2 MAJ MC
17Sep03 1500	Nursing: Discharge pt. d/c to responsible guards. Pt. meds given to escorting unit. Advised on exercises. Ambulatory ward C unit & X-rays (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.

(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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Comp) CMT

LOG NUMBER

ARRIVAL

DATE: DAY 9 | MONTH 9 | YR. 03 | TIME

TRANSPORTATION TO HOSPITAL (see enroute sheet): ☒ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDICATION and dosage

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): EPW [redacted] b(6)-2 Last Meal 0800 TOI 1300

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Indicate complaint, pain, location): GSW ⊕ FOOT, Chest ⊕ Elbow

SEX: M | AGE: 21

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1415

VITAL SIGNS

TIME	1415		
BP	118/62		
PULSE	84		
RESP.	10		
TEMP.			
WT. (Child)			

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
~~CXR Chest~~ Foot	BMS	1415
CXR L Elbow	BMS	
CXR Chest	BMS	
Anvel 1gm IV	W	1440
Td .5cc IM	MM	1440
MSO4 10mg IV	MM	1445

ASSESSMENT/DIAGNOSIS
(L) Thru/thru flank Supf GSW.
(L) elbow post-supracondylar fracture

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)

S: 21 y/o Iraqi male was shot in elbow x 1 36 hrs ago (L) flank by M-16 from US Forces as he fired upon them at an Ammo Storage site N of Tikrit. Also reported GSW to (L) foot.

PMHX ∅
SHX ∅
tob
1 pack
Alcohol

O: WDWN in Mod dist 2° to elbow & flank pn. ⊖ Respir dist.
HEENT: NC/AT PERRL EOMI. 5mm
Chest: Thru/thru GSW to (L) posterolat lower chest/upper abd flank area. ⊖ Sq emphysema. ⊖ Crepitus.
(B) eq CTA. Cor: RRR ⊖
Abd: (+) BS.S. NT ND ⊖ Rebs.

EAST ⊖

(L) foot: ⊖ fracture
(L) elbow fragments po to distal humerus supracondylar area
(L) thoracic thorax: CXR: ⊖ PTX ⊖ Rib fx

CBC, Chem 8, UA.
Foley.

Ext: (L) elbow ⊖ ⊖ Swelling ↑ pn & frag usurd to post aspect of distal humerus. N/V intact.
(L) lat foot ⊖ Supf abrasion. N/V intact.

13.5 > 17 < 263
52
135 | 107 < 10
3.7 < 25 < 9
95

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): Ortho

- EMERGENCY
- ☒ TODAY
- 72 HOURS
- ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICW

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1530

TIS

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

b(6)-2

SIGNATURE

INSTRUCTIONS (Medications ordered, any limitations and follow-up plans)

To ICW preop.

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev.
Prescribed by GSA and ICMR

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: 21

HEIGHT:

WEIGHT: 90

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
[X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD
REACTION: per EMT record

3. PREVIOUS SURGERY [X] NO [ ] YES (type):
per EMT record

4. PROPOSED SURGICAL PROCEDURE: ulnar nerve repair - Lt elbow debridement + irrigation

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco 1 ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH yes 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) ___ 3) Surgical Outcomes X Arabic speaking	o Pt. verbalizes any specific anxiety. (b)(6)-2 o Pt. Exhibits relaxed body posture. Iraqi Male Semi-Emergent	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). (b)(6)-2 o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 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 X 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

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
Last meal 800
! ~~UHCG/LMP~~ N/A ! Body Pierce Removed
~~! Consent/Blood Transfusion~~
~~Signed/Witnessed/Dated~~ N/A
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon (b)(6)-2
! Contact Precautions (Y) (N)
~~! Family/Friend~~ N/A

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility X 2) Positioning ____ 3) Existing Disease X 4) Safety Devices ____ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse (b)(6)-2	o ~~Check for support stockings or ace wraps. If none, check with doctors.~~ N/A o Check that s (b)(6)-2 correctly applie ~~o Offer pillow for under knees.~~ N/A ~~o Place and take down legs from stirrups with slow bilateral motion.~~ N/A o Check that rings and all piercing has been removed. (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis X 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: ____ 1) Length of Surgery X 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table w difficulty. (b)(6)-2 o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. (b)(6)-2 o Allow patient to lie in position of 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 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. o Pt. will be transferred safely to OR tab (b)(6)-2 o Pt. will be able to understand instructi o Minimize danger of injury during intra period.	o Introduce self. Keep pt. informed where he/she is and what is happeni (b)(6)-2 o ~~Inform pt. in which direction to move and assist if necessary.~~ N/A o Speak clearly and slowly. o Address pt. from ____ side. o Validate pt.'s understanding of verbal communication. N/A o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES: Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. (b)(6)-2 ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

(b)(6)-2 MAJ, AN 9SEP03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: X Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O X Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: X Moves All Extremities ☐ Moves Upper Extremities X immobilized L+ elbow ☐ Transferred to litter with roller due to spinal

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (b)(6)-2 MAJ, AN

DATE: 9 SEP 03 TIME: 1825

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

DATE: 9SEP03 TIME:

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 CRNA

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

3. DATE 9 SEP 03 TIME PATIENT ARRIVED IN SUITE 1845

4. PATIENT IN ROOM TIME 1845 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Arabic-speaking.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN, bloc	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Beanbag, pt placed in floppy lateral-mostly supine position. Pillow under left leg. Rt arm abducted less than 90° on padded armboard.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

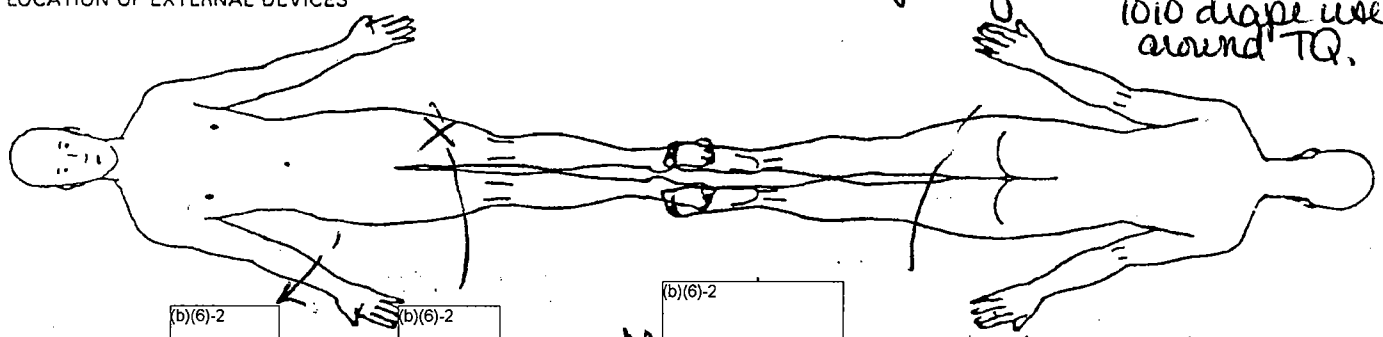
PREP SOLUTION (Specify) Betadine (b)(6)-2

SITE: Lt chest/abd wall BY WHOM: (b)(6)-2

SITE: LUE BY WHOM: (b)(6)-2

COMMENTS: No pooling noted. Chux used. 1010 drape used around TQ.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 = = = Tourniquet (b)(6)-2 ↑ to 250 mm Hg for 51 minutes

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

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(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

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

☒ ESU NO: 000442 VL FORCE II Setting

GROUND PAD: BRAND VL REM

LOT NO: 69671 EXP 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☒ BIPOLAR NO: 000442 VL FORCE II Setting: 5

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH 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) NSS

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATING ROOM
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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Webril
Plaster splints
Ace Wraps

19. ADDITIONAL INFORMATION
Dr (b)(6)-2, Dr (b)(6)-2
MAJ (b)(6)-2 CRNA
→CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
Lt elbow GSW D+I, Debridement, Lt lateral chest wall wound.
Lt ulnar nerve exploration

21. PATIENT TRANSFERRED TO ICU TIME METHOD litter

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

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

MEDCOM - 7194

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3 4 5 6 7

POST- DAY: 1 2 3 4 5 6 7

MONTH-YEAR: 9/2003 DAY: 9 10 11 12 13 14 15

HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Spo2

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)

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		8														
POST- DAY																
MONTH-YEAR	DAY	16		17												
19	HOUR	8	12	0												
PULSE (O)	TEMP. F (°)	84	82	80												TEMP. C
	105°	88	80	80												40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
60																
50																
40																

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE		102/85	108/68	101/54											
		114/57													
HEIGHT:	WEIGHT →														
	Spa 7	97		97											
		99	99 90												

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: ICW

Requ[illegible] g[illegible] an: (b)(6)-2

LA[illegible]ATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Name (b)(6)-4

Date: 9 Sept 03

Time: 1530

Patient #

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	14.6	4.8 - 10.8 x 1E3
RBC	4.96	4.7 - 6.1 x 1E6
Hgb	15.3	14 - 18 g/dL (M); 12-16 (F)
Hct	46.1	45 - 52% (M); 37 - 47% (F)
MCV	93.0	80 - 99 fL
Plt	247	130 - 500 1E3
Lymph%	10.0	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By (b)(6)-2

Date 9 Sept 03

Lab ID # (b)(6)-4

Ward/Section:

Requesting Physican:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 9/9/03

Time: 1415

Patient #

Chemistry 7

Test	Result	Ref. Range
GLU	95	73 - 118 mg/dL
BUN	10	7 - 22 mg/dL
Creat	0.9	0.6 - 1.2 mg/dL
Na	135	128 - 125 mmol/L
K	3.7	3.3 - 4.7 mmol/L
Cl	107	98 - 108 mmol/L
tCO2	25	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color	yellow	N/A
App	clear	N/A
Glu	ng	Negative
Bili	ng	Negative
Ket	ng	Negative
SGav.	1.030	N/A
Bld	small	Negative
pH	ng	N/A
Prot	ng	Negative
Urob	norm	0.2 - 1.0
Nit	ng	Negative
Leuk	ng	Negative
Micro UA		

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	135	4.8 - 10.8 x 1E3
RBC	5.54	4.7 - 6.1 x 1E6
Hgb	17.0	14 - 18 g/dL (M); 12-16 (F)
Hct	51.7	45 - 52% (M); 37 - 47% (F)
MCV	93.3	80 - 99 fL
Plt	263	130 - 500 1E3
Lymph%	22.5	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	~~15.0~~	9.8 (b)(6)-2
aPTT	~~15.9~~	21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Report (b)(6)-2

Date 9/9/03

Lab ID # (b)(6)-4

MEDICAL RECORD — ANESTHESIA

DRUG	(Dosing)	
Versed	(mg)	2
Sentanyl	4 (ml)	(150) 100
Propofol	(mg)	130
Ceft / Vec	(mg)	100
Lidocaine	1 (ml)	
Neo / Robinul	(mg)	
VOLAT. AGENT	% des	
Sevo	% e.t.	2.0 2.0 1.5 1.0
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 2 2 8

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

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

TOTALS	
2	
250	

TOTAL BP: MM

TOTAL URINE: 200

FLUIDS – SUMMARY
CRYSTALLOID: 600
COLLOID: 0
BLOOD: 0

FLUIDS — LINE site: UR #18 G (R) FA — Warmed / Warmed / Warmed / Warmed

LOSSES — EST BLOOD LOSS / URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 50 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 118/62 HR – 84

BOXER CHECK: OK? – Y N

PATIENT REFUSED: OK for PROCEDURE? Y TIME – 1846

TIME → 1845 1900 30 2000 30 2100 30

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

220 200 180 160 140 120 100 80 60 40 20

VITALS								
	I:E	1:2	VT – ml	280	710	690	680	
	HME		f – breaths/min	8	8	6	6	12 14
			Peak inf pres / PEEP	17	15	15	15 –	
			MODE – S(pon), A(ssist), C(on)	S	C	C	C	C A S
	BP/Auto Cuff		ET CO2 (torr)	–	30	29	31	34 32
	BP / oth (R)		FIO2 (Frac or %)	.21	.25	.24	.25	.25 .25
	ART line		SpO2 (%)	100	100	100	100	100 100 100
	Steth- PC/ES		ECG	SR	SR	SR	SR	SR SR SR
	Gas analyzer		TEMP- site	Skin	35	35	35	35 35
			N-M Block (T/4)	4/4	4/4	0/4	1/4	2/4 4/4
	Warming blkt							
	Conv warmer							

REMARKS – Code drugs with numbers, events with letters

(1) from ICW → OR
(2) re-O2/monitors I.T. by MA (b)(6)-2
(b)(6)-2 CRNA, 1900 P. Kiebell CRNA relief.
(3) Pt. Sed / extubate c p.p. ↑ SV TV 5cc/kg SpO2 98% → ICU via stretcher c O2 - patent. Report given.

TQ LLE 250 MM Hg
↑ 1907
↓ 1958
+ time 51 min

RECOVERY AT 2020
PACU ICU (Specify)
OTHER 96.7
CONDITION: awake 97
RESP – 16 SpO2 – 97
BP HR 110 BP 129/72

ANES	Start	Room	End
	1830	1845	2025
PROC	Ready	Begin	End
	1900	1909	2016

Mark with letters & symbols, explain under REMARKS — EVENTS: pressure pts padded BUS<90 SCA wrap
Position → ⊙ on taped c intubation (b)(6)-2

PROCEDURES and CPT Codes: exploration I/D (L) debridement (L) [illegible] wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: MOV ↑ attempt #2 mx #8.0 @ 22 cm lip + ETCO2 + BBS. Cuff ↑. ETT (b)(6)-2 intubated

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

(b)(6)-4

SURGEON: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CRNA

(b)(6)-2

PROCEDURE LOCATION: OR 1-1

DATE: 04 Sep 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

CPT, AN — WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7199

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

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 21 HRS DAYS MOS (YRS) SEX: [X] MALE ( ) FEMALE

PROPOSED PROCEDURE: debridement possible [illegible] SURGICAL SERVICE: Ortho

ASA PHYSICAL STAUS 1 (2) 3 4 5 (E)
WEIGHT: 50 KG/LB. HEIGHT: ____ IN.
ALLERGIES: NKDA

HABITS:

TOBACCO: (F)
ETOH: (F)
DRUGS: 0

CURRENT MEDICATIONS:

([ ] = ordered as premed)

[ ] Amicl 1410
[ ] 0
[ ] ____
[ ] ____
[ ] ____
[ ] ____

PREMEDICATION:

None Yes (@ ____ Hrs) /OC
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____
U/A: ____
OTHER:
13.5 / 17/52 < 263
135 | 107 | 10 < 90
3.7 | 25 | 0.9

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

PAST SURGICAL/ANESTHETIC HISTORY

____
____
____
____

PHYSICAL EXAMINATION

BP 118/62 HR 84 RESP 14
HEENT – Teeth: Intact
Trachea: Midline
TMJ/Neck: FROM
Oropharynx: MPI
Nares: ____
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: Fx/GSW (L) Arm
IV Access: #18g (L) Forearm
Ulnar Filling: ____
BACK: ____
OTHER: ____

ANESTHETIC PLAN: [ ] Local [ ] MAC – [ ] Regional (Specify): ____ [X] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alt[redacted]ng death have been explained to and discussed wih the patient/legal guardian.
The patient/legal guardian seems to understand and agree. Questions answered.
Si[redacted] CPT, AN CHINA DATE: 9/9/03 TIME: 1800 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ____
VITAL SIGNS: BP ____ HR ____ RESP ____ SuO_2 ____
RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd
MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep
[ ] Responsive [ ] Unresponsive Block Level ____
REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE

[X] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER
N'a interpreter
[redacted] DATE: 9/10/03 TIME: 1205 Hrs

PATIENT IDENTIFICATION: (Ward: ____)

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

DATE OF ORDER: 9 Sep 03 TIME OF ORDER: 1500. HOURS

LIST TIME ORDER NOTED AND SIGN

✓ (1) Admit to ICW - Ortho.
✓ (2) Dx GSW (1) flank, (2) supracondylar frags
✓ (3) Cond: stable.
✓ (4) VS q 2°
✓ (5) NKDA.
✓ (6) BR.
✓ (7) NPO PreOp.

noted (b)(6)-2 9 Sep 03 1520

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

✓ (8) IV NS @ 200 cc/hr HOURS
✓ (9) MSO4 5-10 mg IV q 2-4° prn.
✓ (10) CXR PA+Lat @ 1900, PCXR if unable to go to xray
✓ (11) CBC @ 1600.

(b)(6)-2

(b)(6)-2

9 Sep 03 2020

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ ADMIT ICW C/O
✓ Dx GSW (L) elbow JT & chest wall

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

✓ E urinary neuroprophylaxis HOURS
✓ Cond stable
✓ VS routine
✓ Act ICW restraint OOB ≥ TID
✓ NWA
✓ Bed rest
✓ IV @ 75cc/hr heplock when PO OK
✓ Meds ancef 1gm IV Q8°

noted 2126 9 Sep 03

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

✓ MS 2-4 mg IV Q15' prn up to 20 mg/3 hrs HOURS
✓ Percocet 1-2 PO Q4° prn
✓ Phenergan 12.5-25 mg IV Q8° prn
✓ VS Q1° W/A
✓ XR - (L) elbow AP & LAT done prior to ICW

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

ER ✓ done (b)(6)-2 2000 09 Sep 03

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
12 SEP 03	1805 HOURS	

REMOVE SPLINT FOR
BID ROM EXERCISES
X 10 MIN

(b)(6)-2

NURSING UNIT: 24V | ROOM NO.: Dance | BED NO.:

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

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
13 SEP 03	1720 HOURS	

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

D/C ANCEF

NURSING UNIT | ROOM NO. | BED NO.

24° Chart 14 Sep 03 @ 02

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

(b)(6)-2

1. D/C TO MP done
CUSTODY
2. OUTPT Rx
VICODIN 1 TB PO, q 6 H PRN
3. FLU CONFINEMENT
MEDICAL ASSETS

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

THE[illegible]EUTIC DOCUMENTATION CARE PLAN[illegible]ON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeo[illegible]

Mo. ____ Yr. ____

VERIFY BY INITIALING [illegible] INITIAL PROPER C[illegible] [illegible]LOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12
9Sep	(b)(6)-2	VS q2°	06	✓			
			08	✓			
			10	✓			
			12	✓			
			14	✓			
			16	(b)(6)-2			
			18				
			20				
			22				
			24				
			02				
			04				
9Sep	(b)(6)-2	BR	06	(b)(6)-2			
			18				
9Sep	(b)(6)-2	NPO : PRE OP	06				
			14	(b)(6)-2			
			22				

Δ'd See other sheet (b)(6)-2 01:26 9Sep03

Δ'd See other sheet (b)(6)-2 01:26 9Sep03

Δ'd see other sheet (b)(6)-2 01:26 9Sep03

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

① FLANK, ② SUPRACOROYLAR FRACS

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9Sep	(b)(6)-2	ADMIT TO KW	9SEP	1800	1515	(b)(6)-2
9SEP		Dx: RSW (L) FLANK, (R) SUPRACONDYLAR FRACS	9 Sep	1800	1525	
9 SEP		COND: STABLE	9SEP	1820	1515	
9SEP		CXR PATIENT @ 1900, PCXR IF UNABLE	9 SEP	1900		
		TO GO TO X-RAY				
9Sep		CBC @ 1600	9 Sep	1600	1600	(b)(6)-2
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. 9 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12	13	14	15	16	17
9Sep	(b)(6)-2	IV LR @ 75cc/hr	06	(b)(6)-2								
		HD when PO ok	18									
9Sep		Ancef ÷ gm IV q 8°	06	(b)(6)-2								
			14									
			22									

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS: GSW Elbow + chest wall T
Ulnar neuropraxia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 9 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED														
9Sep	(b)(6)-2	MSO4 2-4mg IV	10Sep 2310			12Sep 1540	12Sep 1710										
- - - -	- - - - -	q 15 min. PRN up	(b)(6)-2			4mg		(b)(6)-2									
- - - -	- - - - -	to 20mg/3 hrs.															
9Sep	(b)(6)-2	Percocet II PO q 4°	9Sep 2120 II PO	10Sep 0430 II PO	10Sep 2030 II	11Sep II 0600		12Sep II PO 1040	12Sep II PO 1900	12Sep II PO 0145	12Sep II PO 1340	13Sep II PO 0050	13Sep 0200 II PO	13Sep 1240 II	14Sep 0530 II	14Sep 0910 II	
- - - -	- - - - -	PRN	(b)(6)-2		(b)(6)-2			(b)(6)-2				(b)(6)-2					
9Sep	(b)(6)-2	Phenergan 12.5-															
- - - -	- - - - -	25mg IV q 8° PRN	14Sep 0007														
14Sep	(b)(6)-2	Percocet II PO q 4°	14Sep II PO	15Sep II PO 1040	16Sep 0006	16Sep 0530 II PO	16Sep 0930 II PO	16Sep 2220 II	17Sep 0620 II								
- - - -	- - - - -	PRN	(b)(6)-2	(b)(6)-2	(b)(6)-2												
- - - -	- - - - -																

USAPA V1.00

CLINICAL RECORD

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

Mo. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12	13	14	15	16	17
9Sep	(b)(6)-2	VS Routine	06	✓	(b)(6)-2							
			14	✓								
			22	(b)(6)-2								
9Sep	(b)(6)-2	Activity: EPW restraint	06									
		COBZ TID	18									
9Sep	(b)(6)-2	Diet Reg	07	✓								
			12	✓								
			17	✓								
9Sep	(b)(6)-2	IS q1° while awake	06	✓	(b)(6)-2	(b)(6)-2						
			18	(b)(6)-2				D/CD				
12Sep	(b)(6)-2	Remove splint for	10	✓	✓	✓	(b)(6)-2					
		BID ROM exercises	22	✓	✓	✓						
		X 10 min										

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS:

GSW Elbow + Chest wall C
Ulnar neuroproxia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 9 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9Sep	(b)(6)-2	Admit to ICW c/o [redacted] (b)(6)-2	9Sep	2100	2100	(b)(6)-2
9Sep		Cond: stable	9Sep	2100	2100	
9Sep		X-ray (D) elbow AP + Lat	9Sep	Done		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12										
9Sep	(b)(6)-2	IV NS @200cc/hr	06	(b)(6)-2													
			18														

See other white sheet

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

① FLANK ② SUPRA CONDYLAR FRACS

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr. _____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
9Sep	(b)(6)-2	MSO4 5-10mg IV	9Sep 1550	9Sep 4m												
- - - - -	- - - - -	q 2-4° PRN	6mg (b)(6)-2	(b)(6)-2 1640												
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USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9 Sept 03
Time In: 0219
Allergies: NKA
Pre-op V/S: BP 102/84
Procedures: I+D L Elbow; I+D Chest

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP 200 EBL 0
Meds/Times: Ancef 1gm 1900

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | History

Time	0200	0215	0230	0245	0300	0315
SaO2	93	96	97	97	100	96
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	16	22	13	24	14	10
T	96				98.0	
Time	2019					
Pain (0-10)	8/10					
LOS	N/A					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0115	~~Ancef~~ FLR	150	RArm	1130	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (b)(6)-2 CPT/AN DEPARTMENT/SERVICE/CLINIC ICU DATE 9 Sept 03

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

(b)(6)-4

21 yr old

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

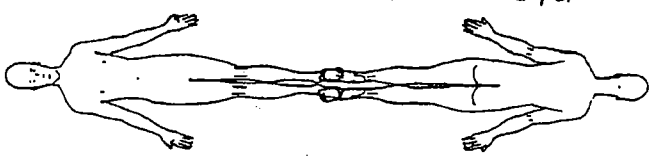
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L Arm L Chest		CDI
30'	" "		CDI
60'			
D/C	" "		CDI



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

2014 Pt From OR VS WNL (Trachy), Rpt From CRNA, Piv (R) Arm LR @ TKO. Dressing (L) Arm, (L) Chest Wall (b)(6)-2 RN/A

2111 Rpt to RN (CW) (b)(6)-2 RN/A

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. NATION (State or Country Code.)
(b)(2)-2	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4 EPW	CIV	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
(b)(6)-4 [redacted]	20 Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 9	(b)(6)-4

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 POW / INT	0 9 3 2 3 0 0 0 0

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR
I Z		1 BC	NO ☑

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
0 5 TRF-OTH		2003091 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A B A A		20030909

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

FOR LOCAL USE

(L) chestwall GSW intraarticular GSW to (L) Elbow (L) ulnar nerve contusion
Debridement & primary closure: (L) chestwall, Left GSW
ulnar nerve decompression
Sustained injuries while firing @ US ammo storage in (N) Tikrit

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

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 7213

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission (b)(6)-2	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 14:20	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-09-17		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-09		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-09		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: Left chest wall GSW, intraartricular GSW to elbow, Left ulnar nerve contusion

Procedure Narrative(s): Debridement & primary closure: left chest wall, lefft elbow GSW, ulnar nerve decompression

Cause of Injury Narrative: Sustained injuries while firing at US ammo storage in North Tikrit

DX. 8751 88401 9571 E9229

Proc 0449 8628 8659

I T 1 450

(b)(6)-2

Admitting Officer (Signature, as required) DR (b)(6)-2 (b)(6)-2 (b)(6)-2	Signature of Admitting Clerk

(b)(2)-2

Automated Facsimile

INP/ .ENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4	CIV	

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

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	08:00	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-08

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-13	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(2)-2	2003-09-13	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: TRYING TO STEAL AMMO

34. Diagnosis / Operations and Special Procedures:

RIGHT LEG GRADE 3 OPEN TIBIA FRACTURE, 2ND TO GSW RIGHT LEG

823.92 891.1

IRRIGATION AND DEBRIDEMENT OF RIGHT LEG FRACTURE, EXTERNAL FIXATION TIBIA FRACTURE, VASCULAR REPAIR

86.28 36.10 38.00

35. Total Days This Facility

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

35. Total Days This Facility

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

(b)(6)-2

Signature of Attending Medical Officer | Signature of PAD or Medical Records Officer

(b)(6)-2 MAJ, MC (b)(6)-2 SSG, PADNOCOIC

MEDCOM - 7215

Automated Facsimile - DA FORM 3647, May 79

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4	CIV	

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

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	08:00	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-08

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-13	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(6)-4	2003-09-13	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: TRYING TO STEAL AMMO

34. Diagnosis / Operations and Special Procedures:

RIGHT LEG GRADE 3 OPEN TIBIA FRACTURE, 2ND TO GSW RIGHT LEG

823.92 891.1

IRRIGATION AND DEBRIDEMENT OF RIGHT LEG FRACTURE, EXTERNAL FIXATION TIBIA FRACTURE, VASCULAR REPAIR

86.28 36.10 38.00

35. Total Days This Facility

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

35. Total Days This Facility

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

(b)(6)-2

Signature of Attending Medical Officer

(b)(6)-2 MAJ, MC

Signature of PAD or Medical Records Officer

2 SSG, PAD NCOIC

MEDCOM - 7216

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

25yo Male Iraqi who was shot by US Forces in Right Lower extremity at ~0700 today. He presented with arterial bleeding from the GSW.

NKDA

MEDS: Ø

PMH: Ø

PSH: Ø

147 / 141 / 42 / 315

+e

UA - (-)

PHYSICAL EXAMINATION VS - P 100 121/66 R- Wt ?

Gen - Thin Male in AD for pain.

HEENT - Ø NECK - Ø LUNGS - CTA CVS - Ø

Abdomen Ø

Ext - Ø

RLE - GSW distal leg - No distal pulses to DP, PT

Neuro - GSC - 15

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

A: GSW w/ vascular injury RLE

P: to OR for exploration

(b)(6)-2 MD

(b)(6)-2 MAJ, MC USAR

DATE	IDENTIFICATION NO.	ORGANIZATION
3 Sept 03		

(b)(6)-4

(When entries give Name last, first, middle initial, grade, date; hospital or medical facility)

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Sept 03	0815 Pt Arrives
	0820 - Labs Drawn CBC, Chem 12
	0822 - ABG Drawn
	0826 — BP: 96/52 P: 100 R: 13 O2: 100 BVM
	0830 — 10 mg Morphine IV
	0832 — BP: 118/47 P: 136 R: 26 O2: 100 BVM
	0833 — Foley Secured Good Flow
	0834 — Central line secured
	0836 — 100 mg Fentynol IV
	0836 — 5 mg Versed IV, 100 mg Succs IV 8 F ET tube secured
	0837 - BP: 121/66 P: 92 R: 13 O2: 100 BVM
	0842 - 10 mg Vec. IV
	0842 - BP: 139/76 P: 87 R: 18 O2: 100 Int.
	0843 - Temp. 98.9
	0848 - Tetanus given
	0847 - BP: 117/58 P: 88 R: 12 O2 100 Vent.
	0851 - Total 250 Fentynol
	0852 - BP: 118/63 P: 85 R: 12 O2 100 Vent.
	0857 — 50% FI O2
	0858 - Pamaxin 500, Amikacin 1g
	0859 - 1000 ml LR #3

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	09/13/03 15:48:00 HR=94 P1 =151/54(78) P2 =OFF RR=15 SpO2=96% NIBP=118/59(81) T1=OFF T2=OFF ΔT=OFF PRL 16 aus-08 PLAY ON P1 LA2 RESP
1600 13 Sept 2003	Given 50 mg Levanor instead of 40 mg Levanor as ordered by Dr (b)(6)-2 Pr. (b)(6)-2 Informed that pharmacy is out of original dose of 40 mg. (b)(6)-2 mgn
1800 13 Sept 03	Patient given complete bed bath and shave. Turned and positioned with all OR linen removed. (R) leg c̄ noted bloody drainage around ace bandage. Posterior tibial pulse remains palpable. Patient in SR c̄ telemetry. (b)(6)-2 mgn
1930 13 Sept 03	Patient c/o pain to (R) lower leg. Given 5 mg Morphine IVP. Nausea episode c̄ emesis immediately following pain and attempted Phenergan administration. Nausea resolved. Patient sitting up at 45°, sleeping, q a 4L N/C sat 100%. (b)(6)-2 mgn
2100 13 Sept 03	Patient given 2 mg Morphine IVP for c/o pain. (R) tibial ace bandage. (b)(6)-2 mgn
13 Sept 03 2120	Patient c/o severe pain to (R) leg given ATC additional 2 mg Morphine IVP. Resting comfortably c̄ BP decreased from 168/70 to 145/69. Will continue to monitor pt for pain. (b)(6)-2 mgn
2200	Primacin infusing as ordered. Patient report given to ICU (b)(6)-2 Patient resting comfortably at present. Pulses remain dopplerable to posterior tibial area of (R) ankle. O2 via 4L N/C c̄ sats @ 97%. BP 134/60, NIBP 116/54. Temp 99°. Will continue to monitor and notify MO of any complaints. (b)(6)-2 mgn

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.01

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1500 13 Sept 03	S/P I&D (R) Lower Leg GSW c Vascular Repair. Arrived to ICU @ 1500 assisted to bed c 4 personnel. Received 5 liters Crystalloid, 500 cc Hespan, 2 units PRBC's. 2 liters U.O. EBL 400cc. (L) Sciatic nerve placed in ER. Received 250 mg Fentanyl, 10 mg Morphine, 2 mg Versed prior to arrival to ICU. Received antibiotics in EMT Primaxin 500 mg, Amikacin 1gm @ 0830. No known allergies. Patient assessed upon arrival, handoff as per DA Form 4700. Alert oriented c good neurologic, BP 127/60, O2 sats 100% c ventimask @ 45% FiO2. Central line c UR infusing @ 125 cc/hr. Site c redness or infection, OP site intact. IV 18G to (L) Ac, opsite placed, site c redness or drainage, flushed. Foley to gravity c clear yellow urine. (R) Tibial c ace wrap covering external fixator (R) ankle. Unable to palpate pulse after cutting small window through bandage. Able to hear strong (R) posterior tib pulse via doppler. O2 sats via pulse ox to (R) extremity 99%. No evidence of excessive drainage to wound. Toes cool to touch. Plan: (1) Monitor vital signs, LOC post anesthesia and call H-U c changes in assessment (2) Check pulses Q1° as ordered to (R) lower extremity (3) Encourage frequent pulmonary toilet and attempts to wean patient as tolerated to maintain O2 sats @ 90% [redacted]
15 Sept 02 1530	Lab results received placed on chart. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13 Sep 03
1500

OP NOTE

PRE-OP DX - GSW to R LE w/ Vascular injury

POST-OP DX - GSW to (R) PT requiring resuscitative - (R) TIB/FIB fx

PROCEDURE - (R) FEMORAL ARTERIOGRAM, (R) PT reverse w/ jump graft RSV.

SURGEONS - Dr. (b)(6)-2 / (b)(6)-2 ANESTH - MAJ (b)(6)-2

FINDINGS - COMMINUTED DISTAL TIB/FIB FX (R), (R) PT INJURY w/ TRANSECTION

DESCRIPTION - GETA - RIGHT FEMORAL artery anterior aspect occlusion - cutoff at Distal Right Post tibial artery. Triphasic intact w/ 3 vessel runoff Hemming - DP non dominant. Proximal/Distal ends of post Tib artery dissected thru controlled with vascular clamps. TIB/A bone stabilized w/ External fixator (Hoffman II). 8 cm segment of Saphenous vein harvested from ipsilateral leg and flushed w/ Heparinized saline; Femoral artery flushed w/ hep. saline as well as PT. Vessels were spatulated and fashioned Head fashioned, Anastomosis made w/ Double armed 6-0 Prolene suture x 2. Good pulsatile flow seen. At conclusion of procedure thermal flow thru PT in Foot - triphasic doppler signal lost. Wounds closed in layers - thru Staples / Prolene - Drains x 1. Pt tolerated procedure well - then awakened thru extubated & transported to ICU in stable condition

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST (b)(6)-2	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)

(b)(6)-4

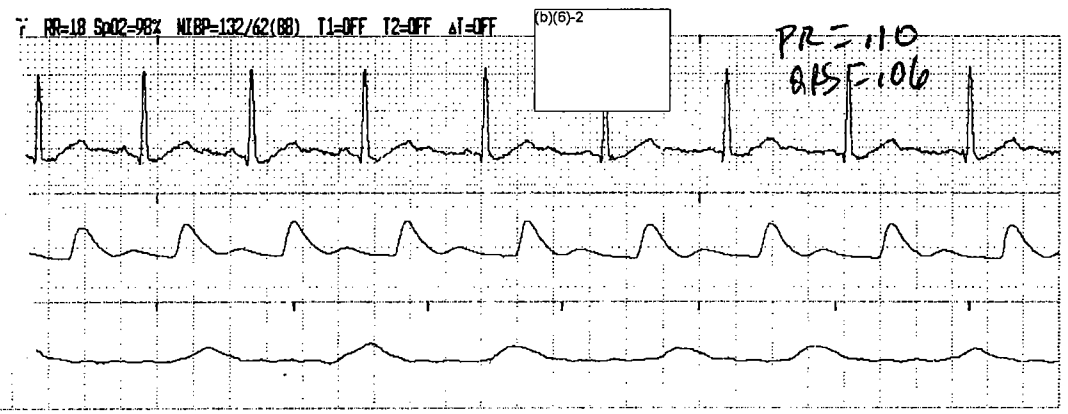
REGISTER NO. | WARD NO.

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 (b)(6)-4

DATE	NOTES
13 Sep 03 2200	Report from MAJ (b)(6)-2 client in bed awake, connected to cardiac/resp. monitor. IVF infusing via (L) SC cordis. Oxygen via N/C @ 4L per min. Foley patent and draining, (R) ~~foot~~ lower extremity c̄ external fixator and drsg intact. Some bloody drainage noted to drsg, will monitor closely. pulse doppled to (R) posterior tibial, none noted to (R) pedal, pulses verified c̄ another RN (MAJ (b)(6)-2), doctor already aware. Drsg d/w (L) LE D+I. (b)(6)-2
2230	Complete assessment done, see DA form 4700. (b)(6)-2



2400	Client asleep in NAD, O2 sat 99%. decreased Oxygen to 3L NC. No changes in previous assessment to pulses. (b)(6)-2
14 Sep 03 0030	O2 sat 97% on 3L NC, client in NAD, RR 18. (b)(6)-2
0200	no changes in previous assessment at this time. (b)(6)-2
0230	client c̄ c/o pain to (R) leg. medicated c̄ 4mg MSO4 IV at this time. (b)(6)-2
0430	client c̄ c/o pain, medicated c̄ 6mg Morphine IV for pain to (R) leg. (b)(6)-2
0500	medicated c̄ 25mg Phenergan for nausea, drsg c̄ large amt drainage, reinforced c̄ kerlex and ABD pads. blood drawn from art line sent to lab. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.01

LAST NAME (b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER (b)(6)-4

DATE	NOTES
14 Sep 03 0530	client in bed asleep, appears comfortable at this time. (b)(6)-2 14 HN
0600	Report given to next shift, (R) Post tib pulse verified c̄ SAT Smith. Client on 3L NC, connected to cardiac/resp monitor. (R) radial art line intact c̄ good waveform, Foley patent and draining clear yellow urine. (R) LE c̄ drsg DTI. (L) LE drsg DTI. (b)(6)-2 14 HN.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.01

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES (BP – P – R – SAO2 – T)	
14 Sept 03	0840 159/68 – 104 – 18 – SAO2 98% 3L O2 – T 98.4	(b)(6)-2 SGT 91WM6
	0845 137/69 – 102 – 21 – SAO2 98% 3L O2 – T 98.2	(b)(6)-2 SGT 91WM6
	0850 146/67 89 – 17 – 96% T 98.1	(b)(6)-2 SGT 91W
	0900 140/64 83 – 14 – 97% T 98.0 pt	
	appears to be resting comfortably, NAD report given to CPT AF. 1st Unit PRBC infusing s difficulty NAD, & adverse reaction noted /	(b)(6)-2 91WM6
0930	151/61 BP; 79 – HR; 15 RR; 98% SaO2; 97.5 T – pt sleeping quietly – no evidence of resp difficulties	(b)(6)-2
1000	VS: 160/67 – 76 – 16 – 98% 98.° Pt awake – No complaints –	(b)(6)-2
1020	VS 161/66 – 74 – 15 – 98% 96.8, transfusion completed at 1026 & adverse reactions noted. VS 162/64 – 74 T. 97.7 NO SOB or Resp distress noted /	(b)(6)-2
1030	2nd Unit B+ PRBC verified c̄ Cpt AF, AN transfusion started at 1039 VS 151/62, 80, 15, SAO2 98% 3L O2 T 97.3 /	(b)(6)-2 (b)(6)-4 SGT USA 91WM6
	1045 162/63 – 78 – 15 SAO2 98% 3L O2 T 97.0	(b)(6)-2 SGT USA
	1050 156/61 – 78 – 15 SAO2 98% 3L O2 T 97.4	(b)(6)-2 SGT USA
	1055 157/62 – 77 – 13 – SAO2 97% 3L O2 T 97.6	(b)(6)-2 SGT USA
	1110 156/61 – 78 – 16 SAO2 98% 3L O2 T 98.6	(b)(6)-2
	& adverse reaction, Appears Comfortable /	(b)(6)-2 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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Sept 03 0700	0700 Assumed care of pt. Rcvd report from 1Lt (b)(6)-2 pt in bed HOB ↑ 20° angle. O2 3L via NC SaO2 98% LR infusing 125cc/hr → central line ∅ difficulty. A-Line zeroed. Foley ↓ gravity draining clear yellow urine. Posterior tib pulse ⊕ verified ⓒ doppler ⓒ 1Lt Garrick, AN. Initial Assessment completed. noted on DA form 4700. Will continue to monitor / (b)(6)-2 SGT USA Gnumo
0700	pt C/o pain. MSO4 4mg given IVP ⊕ Dorsalis Pedis pulse verified ⓒ doppler. Will continue to monitor / (b)(6)-2 SGT USA Gnumo
0945	Dr (b)(6)-2 ⓒ Dr. (b)(6)-2 in verified pulses to Dorsalis pedis ⓒ posterior tib ⓒ doppler ⊘ distress noted / (b)(6)-2 SGT USA Gnumo
0824	O+ PRBC unit verified ⓒ 1Lt Af, AN baseline VS. 153/63 - 87 - 97.7 started at 0824 (b)(6)-4 stopped transfusion @0826 medicate ⓒ benadryl 25mg IVP ⓒ 650mg tylenol PO. 0835 restarted transfusion 146/64 - 84 - 97.4 ⊘ S/S of adverse reaction / (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Antibiotics - Primaquin 500mg. / Amikacin 1gm
IV Fluids in - LR 4000cc, NS 1000cc HESPAN - 500cc
BLOOD PRODUCTS - 2u PRBC's RBL - 400cc UO - 2000cc
Drains - Foley cath.

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS
(b)(6)-2

14Sept03 1438 Surg SUC
S: No C/O - Sleepy - Comp
O: Afebrile, VS noted

LOVENOX 8.8 → 8.7 / 25.6 < 181 133 / 102 / 41 < 0.7 / 110 ABG 7.397/45.1/92/28/3/97
PRIMACIN
AMIKACIN

RLE - Trophic ulcer by Doppler in both PT and DP - not palpable. Foot warm. Brisk cap refill
A: POD #1 s/p FIX/Revascularization - Anemia
P: D with transfuse 2u PRBC's to max oxygen O2 Del w/ improved healing.
(2) Plan OR - Cimo for wound washout.

(b)(6)-2

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

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PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES						
DATE		BP	P	R	NOTES	SAO2	T
14 Sep 03	1125:	154/64	82	15		98% 3LNC	97.6
	1140	139/61	84	18		96% 3LNC	97.2

(b)(6)-2 SGT 91WM6

(b)(6)-2

1135 ~~[illegible]~~ Pt c/o pain to (R) leg 4mg MSO4 NP administer to (R) AC c (+) effect will continue to monitor / (b)(6)-2 SGT USA 91WM6

1200 VSS 144/61 81 15 98% 3LNS T 98.1

1230 Transfusion complete VS 97.7 - 162/64 - 76 - 17 SAOL 98% ∅ adverse reaction noted, pt tolerate transfusion well ∅ SOB, or Resp distress noted will monitor / (b)(6)-2 SGT 91WM6

1410 Pt in bed resting NAD ~~noted~~ USS report given to CPT AP / (b)(6)-2 SGT 91WM6

1500: Received Report assumed care of pt. Pt sleeping supine HOB @ 30° O_2 per NC 3L SaO2 99% RR 17 BPM ∅ s/s resp distress. (+) NSR BP 146/59 HR: 83. (~~RR 17 97% [illegible]~~ error (b)(6)-2). Pt sleeping quietly awakens spontaneously verbal stimuli ; pain. LR infusing @ 125 cc/hr through (+) subclavian cath. s - SL. ∅ evidence of infiltration. (+) A Line to (R) radial. (+) RS PIV to (L) AC - SL'd. (+) ex fix to (R) L Ext. minimal drainage noted. (+) gauze to (L) lower extremity, dimi size red drainage to dorsal side of calf. (+) movement to (L) LE. (+) movement big toe (R) foot, (+) swelling

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PROGRESS NOTES
Medical Record

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

(b)(6)-4

2500 / 2650
m / mt

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(R) digits x 5 (R) LE. cap refill 3 sec. Monitoring to cont. will encourage IS use, po fluid intake. VOP WNP (b)(6)-2
1700	MSO4 3mg SIVP administered for c/o pain. Pt relaxed, ∅ facial grimacing. HR WNL s/p administration, (+) sterile dressing Δ to (L) sub. cont's. (+) flush (+) blood return, LR cont. infusing @ 125 cc/hr.
1730	SaO2 ↓ 92%-93% - Deep breathing encouraged. (+) IS use. SaO2 ↑ 95-96% will cont to monitor. No s/s Resp distress (b)(6)-2
1750	O2 ↑ 5L per NC for SaO2 93% - SaO2 ↑ 95-96% (b)(6)-2
1810	Report given to LT (b)(6)-2 Pt care transferred (b)(6)-2
1830	Assessment done, see DA form 4700. Client c̄ good effort on incentive spirometry, client c̄ wheeze + rhonchi bilat, MD notified, orders obtained. Drsg to RLE c̄ moderate amt of bloody drainage. LLE c̄ quarter size bloody drainage on drsg. (R) groin drsg intact. (b)(6)-2 LT AN.
1900	Respiratory therapy completed albuterol breathing treatment. lungs clear bilat. RR 16, humidity added to nasal cannula. HR ↓ 74, O2 sat ↑ 98%. (b)(6)-2 LT AN
1940	Client c/o pain to leg, medicated with 5mg morphine IVP for pain. (b)(6)-2 LT AN.
2000	Client calm at this time, no ~~c/o~~ complaints, repositioned (b)(6)-2 LT AN.

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

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PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Sep 03 2005	58(80) P2 =OFF RR=16 SpO2=95% NIBP=OFF T1=OFF T2=OFF aT=OFF
2200	no changes in pulse checks, ⊕ dopple to ⓡ pedal and post tib. client c̄ clear breath sounds bilat, no distress noted. (b)(6)-2 1LT AN
2400	teeth brushed, NPO status begin. (b)(6)-2 1LT AN
15 Sep 03 0100	client c/o pain, medicated c̄ 5mg morphine IVP. (b)(6)-2 1LT AN
0130	client asleep in NAD (b)(6)-2 1LT AN
0300	decreased oxygen + 4L NC @ this time, O2 sat 98%. (b)(6)-2 1LT AN
0400	assessment done, no changes, wiggle ⓡ great toe. ⊕ dopplad pulses to RLE. (b)(6)-2 1LT AN
0500	~~O2 seg~~ reinforced to RLE. ⊕ Doppled pulses. fiO2 decreased to 3L NC, O2 Sat 97%. (b)(6)-2 1LT AN.
0520	Labs drawn from ⓡ radial art line and sent for analysis (b)(6)-2 1LT AN
0600	Report given to MAJ (b)(6)-2, client in bed connected to monitor IVF @ 125cc/hr. O2 @ 3L NC c̄ humidity. (b)(6)-2 1LT AN

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

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(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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

0615

15 Sept 2003 Received report on pt, assumed care. Pt sleeping quietly. No evidence resp difficulties or generalized discomfort. VS: 127/53 76 17 96% on 3L O2 via NC. O2 humidified. (+) A-line (L). (+) LR @ 125cc/hr to (L) subclavian cath. Ø evidence infiltration @ insertion site. (+) PIV 18g (L) AC sl'd (+) flush (+) blood return. Ø infection or infiltration @ insertion site. (+) foley to gravity clear yellow urine out. (+) (L) LE dressing from knee to ankle. Minimal, dime size drainage to dorsal (calf) area. (+) Ex fix (R) LE for tib/fib fx. (+) drainage @ pin sites, serous-sm drainage to dorsal aspect. (+) movement only of big toe (R) foot. Pulses Ø palpable (R) foot (+) dorsalis pedis per doppler, (+) posterior tibial pulse per doppler. Pt denies pain @ this time. Non english speaking — guard on duty for cover of OPW status. Plan: cont monitoring ; cardiac resp function, UOP, wnd healing, and (R) LE pulse checks. Cont fluids via IV route. Cont O2, encourage IS, attempt weaning. Maintain NPO status prep for OR this am. Continue OPW protocol. (b)(6)-2

0905: Complete bed bath provided c̄ pt contributing to 75% of own care. Pt off O2 c̄ SaO2 maintaining @ 96% & RR @ 16. (b)(6)-2

0945: OR staff prepping pt for transport to OR via litter. A-line secured. O2 per RA, LR @ TKO. Pt AOx3 aware of operation, gives "thumbs up" and states "Thank you" prior to transfer off ward accompanied by

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

RECORDS MAINTAINED AT

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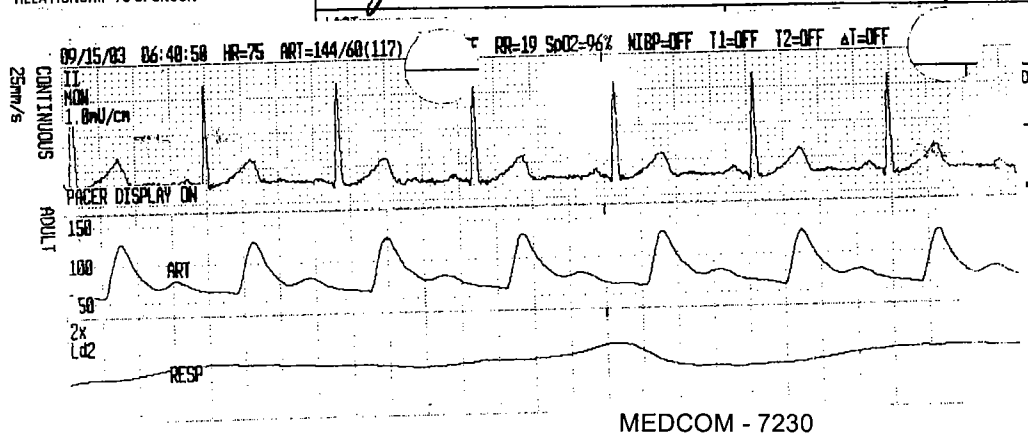

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

15Sept03
1240

OP NOTE

PRE-OP DX – Clotted Graft
POST-OP DX – Same
PROCEDURE – Arteriogram, Fogarty Thrombectomy, Graft revision, TEP
SURGEONS – Dr (b)(6)-2 / (b)(6)-2 (b)(6)-2
Findings – Thrombosed graft – good run off p Thrombectomy/graft revision.

DESCRIPTION – GETA – BETADINE PREP OF BLE – RLE usual gown w/ finding of graft thrombosis. A small venotomy was made in the SVG and Fogarty thrombectomy performed w/ removal of clot – good back bleeding resulted as well as antegrade. Usual flushing w/ Hep Saline w/ cm of graft was excised for venous secondary for anastomosis – anastomosis created w/ Spatulation – 6-0 Prolene. Pt was heparinized w/ 5000 Units Heparin IV. Arteriogram showed patent graft w/ good runoff. To facilitate wound closure – skin edges undermined. Wound irrigated w/ Pulse Lavage 4-L NS. Closed w/ subdermal sutures of 2-0 Vicryl followed by Mattress w/ 0-Prolene. (+) Doppler flow distal to graft afterward (tryptin). LLE – 2 units ischemia – Skin edges closed w/ Vicryl/Prolene. Pt tol procedure well – awakened, extubated and transported to CCU w/ Stable condition.

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	LAST	FIRST	MI	
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PROGRESS NOTES
Medical Record

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

(b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	45. (b)(6)-2
15 Sept 03	OR Staff x2.
	1400: Pt returned to unit on stretcher accompanied by OR staff
0100 LR	x2. Pt asleep, responds spontaneously to painful stimul.
1100 UOP	O_2 per V. mask @ pour, c 10-45% x, afire 10 L. SaO_2 = 98-100%
500 cc UOP	RR 12-14 BPM. Ø evidence resp distress. LR c TKO via cath's
12 mg Morphine	(L) LE c̄ ace Ø discharge evident. (R) LE (+) ex fix - dressing
2 mg versed	ODI. (+) movement toes only - difficult to assess
250 Mcg fent.	sensation @ this time. (+) movement, (+) full ROM to (L) LE
5000 units	(+) sensation. LSC throughout, Ø cough, chest movements
Hep: 1000	even, breathing non-labored. NSR, BP 140's systolically
Phenergan	50's diastolically HR 80's, afebrile @ 98.7 US.
	consistent c̄ baseline. 18g PIV to (L) AC D/C'd RT
A-line 139/48 92	3 day /72° Δ protocol. 20g PIV placed to (L) PA
13 RR	Heparin started @ 1000 units/h = 20cc/hr to
NIBP 127/65	PT, Coags, CBC, Chem 8, ABG drawn, sent to lab
100%	values pending. (+) LR to cath's & to 100 cc/hr from
T 97.6 HSO	previous 125 cc/hr order. A-line zeroed, leveled c̄
	good waveform. NIBP to (L) Brachial. Pt cont to sleep
	c̄/out evidence of discomfort noted. (b)(6)-2
	1530: Pt awakened to consume lunch. ↑ HR to 120-140:
	c̄ no other v/s. Pt denies pain, dizziness N/V.

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

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PROGRESS NOTES
Medical Record

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

(b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

15 Sept 1530. Pt in good spirits. Translator @ BS to translate plan of care, all questions answered, concerns addressed. Pt encouraged ↑ consumption of food. Completing app 60% solids c̄ 1 ~~carnation~~ primitive mixed c̄ 8 oz milk. Pt shaved, performed oral hygiene HR cont tachy. Dr (b)(6)-2 notified. LAB values return w/ H/H 8.1-26.1 / PT/PTT - 13.4 - 56.1. No action taken. Monitoring cont. — (b)(6)-2

1645: Pt remains tachy between 120-130s — T&C ordered c̄ premedx 5/8x2, CBC, ABC chem 8 - coag. T&C taken to lab 1730. 1735 - Pt premedicated. Procedure explained to pt. Pt verbally agrees to infusion of PRBC's. Possible reactions explained per translator. (b)(6)-2

1810: Report given to LT (b)(6)-2. Cmd pt [redacted] (b)(6)-2

(b)(6)-2

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DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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(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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

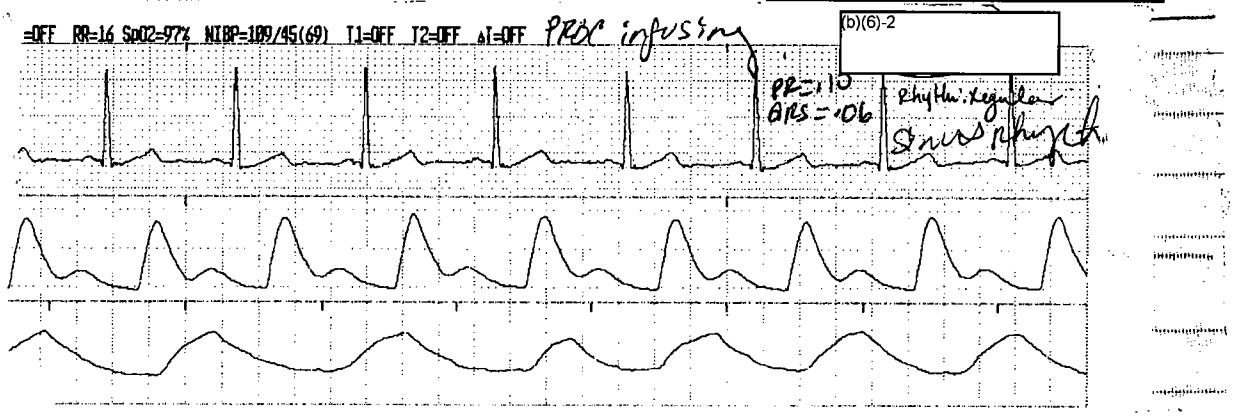
15 Sep 03 1816 Report received from day shift RN CPT [redacted] client in bed awake + alert, connected to cardiac/resp monitor. IVF infusing via (L) SC Cordis @ 100 cc/hr. Heparin infusing via (R) forearm PIV @ 20cc/hr (1000 units/hr). Foley patent + draining. Pulse checks to RLE done via doppler c̄ (R) auscultation to (R) pedal and post tib pulses. Client able to wiggle (R) great toe. Swelling noted to ~~RLE~~ toes or (R) foot. [redacted] LT A

1900 Complete assessment done, see SA form 4700. [redacted]

1925 Dr [redacted] notified of coag results. PT: 12.8 APTT 37.7 orders obtain, Heparin 1000 units bolus IV done and Heparin infusion rate increased to 1200 units/hr. [redacted]

1950 1st unit PRBC infusion started, LR infusion held until blood infusion completed. PRBC unit # 1 [redacted]

2015 Remained c̄ client for 25 minutes, no infusion reaction noted at this time, see SF 511 Vital Sign ~~sheet~~ record for vital signs [redacted] LT A



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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 (b)(6)-4

DATE	NOTES
15 sep 03 2140	First unit PRBC completed at this time. Primaxin 500mg. IV infusion started IVPB to Heparin infusion — (b)(6)-2 LT Hn
2145	2nd unit PRBC infusion initiated. PRBC#2 (b)(6)-4 - (b)(6)-2 LT A.
~~2215~~ 2215 (b)(6)-2	Infusion of PRBC continues, no reactions noted at this time — (b)(6)-2
2230	Assessment done, moderate drainage to dsg on RLE. LLE c̄ gauze dsg D+I. (R) groin dsg intact, ⊖ drainage. — (b)(6)-2 LT Hn —
2345	2nd unit PRBC completed, no transfusion reaction noted. (b)(6)-2
16 sep 03 0015	blood drawn from (R) radial site for coags and sent for analysis. Late entry @ 2345 LR infusion restarted after completion of PRBC. — (b)(6)-2 LT Hn
16 sep 03 0030	Coag results PT 12.7, APTT 35.9 will recheck in one hour then notify MD of results. — (b)(6)-2 LT A
01	Blood drawn from (R) radial A-line and sent to lab for post transfusion analyses of ABG, CBC, Chem 8, and coags — (b)(6)-2
0135	client awake c/o pain, medicated c̄ 5mg morphine IVP for pain — (b)(6)-2 LT A
0200	Lab results back, Dr (b)(6)-2 notified, orders obtained, 2500 units Heparin bolus given and heparin infusion increased to 1400 units/hr. — (b)(6)-2 LT A
0400	Medicated per order, client asleep in NAD — (b)(6)-2 LT A
0430	c/o pain medicated c̄ 5mg morphine — (b)(6)-2 LT Hn.
0600	Report given to Sat Sale. Client in bed connected to cardiac/resp monitor. IVS @ 100 cc/hr + Heparin @ 1400 units/hr infusing. Foley patent + draining. Doppler check done c̄ (R) dopplied pulses to RLE. (R) rad art line intact c̄ good pulses + warm and pink fingers to (R) hand. — (b)(6)-2 LT A

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
[illegible]	0400 Labs drawn A-line patent (+) wave form. No s/s of infection. Pt asleep easily arousable. Pt has no c/o pain at this time. Pulses on (R) LE auscultated & Doppler. VSS SaO2 99% ō RA Δ No distress noted. Will continue to moni for [(b)(6)-2] given [illegible] 0530 Premarin infusion started Cordis patent. CDI ō no s/s of infection. VSS SaO2 99% ō RA. No distress noted. Will continue to monit [(b)(6)-2] [illegible] [(b)(6)-2] 0545 Pt awake No c/o pain at this time. IV patent VSS SaO2 100% ō RA. Will give report to oncomming shift [(b)(6)-2] given [illegible] [illegible] [(b)(6)-2]
0650	Report received from SPC [(b)(6)-2] - pt lying in bed comfortably. Assessment performed (see DA4700), VSS, sats 98-99% on RA, Ø c/o pain or discomfort. Will monitor [(b)(6)-2] SGT/USN
0850	Pt resting comfortably - bathed & linen Δd. Δd dressing to central line. [(b)(6)-2] SGT/USN
0845	Pt turned himself onto (L) side. [(b)(6)-2] SGT/USN
1100	Pt [(b)(6)-] Dr [(b)(6)-2] & Dr [(b)(6)-2] in to Δ dressing to ex fix. Incision sites actively bleeding, site otherwise free from s/sx infection. Redressed ō combine, super sponge & ACE wrap. Proximal pins left open to air - pin care done. Pt experienced moderate pain only during pin cleaning. Ortho shoe applied & resistance band tied to ex fix so pt can exercise ankle. This was explained to pt through the interpretor. Pt verbalized understanding. No pain medication was given, pt tolerated well. Pt now sitting up in bed ō magazine. [(b)(6)-2] SGT/USN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.01

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16Sep03	1930 Received pt this pm awake in bed VSS SaO2 100% ⊂ RA. Assessment done see DA 4700. Ex-Fix on (R) LE. ⊖ drainage noted. Pt has no c/o pain at this time. Pulses auscultated ⊂ doppler on (R) LE. IV sites patent ⊂ no s/s of infiltration. Will continue to monitor (b)(6)-2 g1hns SPC USA 2100 Pt resting in bed at this time. Pulses auscultated ⊂ doppler on (R) LE VSS. SaO2 100% on RA. Pt does DS on own. Foley draining QS clear yellow urine. No distress noted will continue to monitor (b)(6)-2 g1hns SPC USA 2200 Premarin infusion started. Cordis patent no s/s of infection. VSS SaO2 100% ⊂ RA. Pt is sleeping at this time. No distress noted will continue to monitor (b)(6)-2 g1hns SPC USA 2400 Pt had c/o pain, headache. Pt given 5mg IVP Ms as ordered for pain. VSS SaO2 98% ⊂ RA RR 15. IV site patent ⊂ no s/s of infection. Will continue to monitor for pain (b)(6)-2 g1hns SPC USA 2415. Pt has no c/o pain at this time. Ms (+) effect. SaO2 98% ⊂ RA RR 18. Pt is in bed awake. No distress noted will continue to monitor (b)(6)-2 g1hns SPC USA 0200 Pt sleeping at this time. VSS SaO2 98% ⊂ RA. DSG CDI. No distress noted Will continue to monitor (b)(6)-2 g1hns SPC USA

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(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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

17 Sept 03 GENERAL SURGERY

1045 S: Pt states - unable pain is very well controlled

O: Afebrile T-98.6 P-70 BP-110/51 R-14-18 98% RA

Coags - 13.8/45.2 132/105 (5/0.6) 98 4.7 9.3/28.3 (145)

RLE - Normal Dressing - Bleeding from - Pale crusted skin - Superficial epidermolysis of midpoint of incision. Dry brisk Erythema flow in both DP/PT. Foot warm, cap refill < 2 sec. Pain site cure, New dry applied.

A: POD # 4

P: (1) Continue IV heparin for 5 days until bridge to ASA/Coumadin

(2) continue wound care, antibiotics, Antiplatelet.

(b)(6)-2 MD

(b)(6)-2 MAJ, MC USA CHIEF, DOS

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
Medical Record

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

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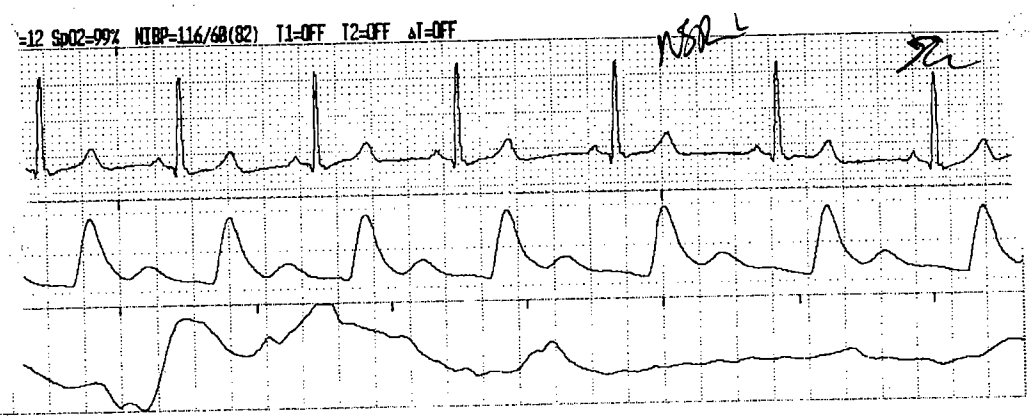
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17 Sep 03 1530	Pt c/o pain to (R) leg, 5/10. 5mg MSO4 given. Will monitor for effect. (b)(6)-2 SGT/LPN
1730	Pt sitting up in bed reading. c/o boredom. Pt denies pain or discomfort. Actively doing IS - will report to oncoming shift (b)(6)-2 SGT/LPN
17 Sep 03 1900	Report received from SGT (b)(6)-2 client in bed awake, connected to cardiac monitor, (R) radial art line zeroed + calibrated c̄ good waveform on monitor. Assessment done, see flow sheet DA form 4700 for assessment. Denies pain at this time (b)(6)-2 LPN



2100	client awake, alert, talking c̄ interpreter, appears happy client talking + laughing. denies pain at this time. (b)(6)-2 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

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

DATE	NOTES
17 Sep 03 2200	Medicated per order, External fixator pins cleaned c̄ 1/2 peroxide and sterile water mixture, tol. well. blood drawn from (R) radial art line + sent to lab. (b)(6)-2
2380	Dr (b)(6)-2 aware of PT 13.4 + APTT 35.9, bolus of 1000 units Heparin given then rate increased to 1800 units/hr (b)(6)-2
2400 18 Sep 03 0100	Medicated c̄ 5 mg morphine IV for pain. (b)(6)-2 Assessment done. Good relief from pain c̄ morphine no changes in other assessments. (b)(6)-2
0300	client asleep at this time in NAD. (b)(6)-2
0430	PIV to (R) FA DC'd, found out. Heparin infusion to (L) SC Cordis. (b)(6)-2
0540	Labs drawn and sent. (b)(6)-2
0600	Report given to SGT (b)(6)-2 (b)(6)-2
0620	Report received, assessment performed, pt now sleeping in bed. 5 c/o pain. PTT still ↓ parameters, Will monitor & recheck as ordered. (b)(6)-2 SGT/LPN
0830	Pt resting comfortably, ate 50% of breakfast + 1 Carnation Shake (b)(6)-2 SGT/LPN
1030	New PIV started in (L) FA for administration of abx (not compatible c̄ Heparin). 18G to (L) FA, flushed & heplocked. (b)(6)-2 SGT/LPN
1230	Pt ate 50% of lunch, did IS afterward. Requested to "hang leg off of bed" for comfort. Reading a book in bed. Denies pain. (b)(6)-2 SGT/LPN

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Antibiotics - Primaxin / Amikacin IV flush in 1200 cc LR
UO - 1100 cc Drains - Fully

(b)(6)-2 (b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS
(b)(6)-2 (b)(6)-2

18 Sept 03 GENERAL SURG SVC
1100 S1 NG <100 ml
O1 T 97.3 113/51 P-88 R-20
7.1 → 9.9/29.5 <141 COAG - 12.7/45 on Hep gtt 1400 U/hr

RLE - Triphasic doppler flow in DP/PT
Drains intact - Foot warm - Cap refill <1 sec
A: HD #3 - SP Revascularization/Extensive Fasciotomy RLE (5N)
P: Continue therapy, antibiotics -
(2)

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS
(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

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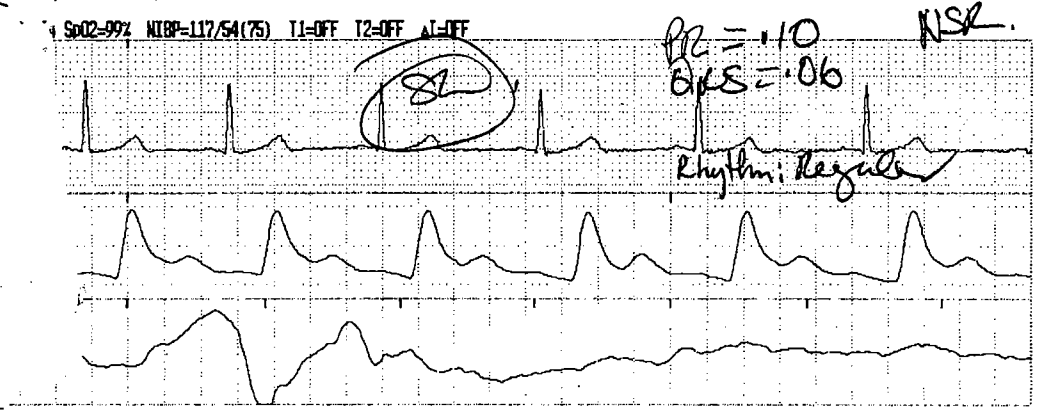
.AL RECORD | PROGRESS NOTES

DATE	NOTES
18Sep03	Sent coags to lab, pt resting comfortably in bed 5-
1400	complaints (b)(6)-2 SGT/USA
1600	Coag results well within parameters outlined by Dr.
	(b)(6)-2 Pt sitting up in bed, Ø c/o pain (b)(6)-2 SGT/USA
1800	Pt sitting up in bed reading, states that he is hungry. No Δs since assessment. VSS, gave report to ILT (b)(6)-2 (b)(6)-2 SGT/USA
1500	Report from SGT (b)(6)-2, client in bed awake, connected to cardiac monitor, A line zeroed + calibrated & good waveform. Dressing and site intact. Soaks patent + draining. (b)(6)-2 USA
1900	See Det Form 4700 for assessment (b)(6)-2 USA



1945	c/o pain, 5mg MSO4 IV given (b)(6)-2 USA

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

PROGRESS NOTES
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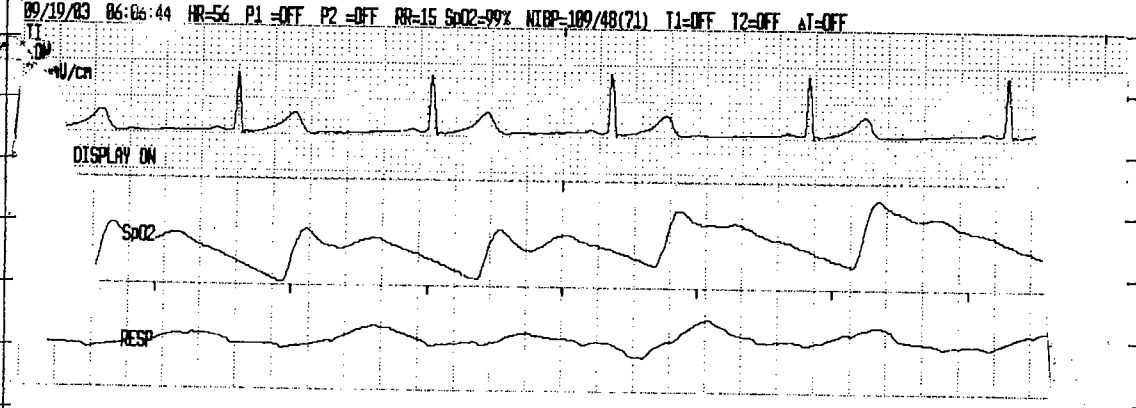
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 sep 03 2200	Pin care done to RLE Ext. fixator c ½ sterile H2O and Peroxide mixture, tol well. (b)(6)-2
2250	blood drawn from (R) radial art line sent to lab. (b)(6)-2
2340	complete bath given, assessment done, foley care given, art line fell out, pressure held until all bleeding stopped, no hematoma noted at site, pressure dsg applied c̄ gauze and tape to secure. (b)(6)-2
0200	client asleep at this time in NAD (b)(6)-2
0400	client asleep, medicated c̄ pain meds IV, no changes (b)(6)-2
0500	blood drawn from (R) hand and sent to lab. (b)(6)-2
0600	lab results back, PT 13.4, PTT 66.1, results therapeutic for heparin drip at this time. Report given to MAT (b)(6)-2 client asleep. (b)(6)-2

09/19/03 06:06:44 HR=56 P1=OFF P2=OFF RR=15 SpO2=99% NIBP=109/48(71) T1=OFF T2=OFF aT=OFF



19 Sept 03 0630	Received report from the previous shift. Patient denies pain or discomfort at this time. Sleeping in bed, RR is 30 shallow. Monitor shows Sinus bradycardia ∓ ectopy. Sutureless site to be changed or discontinued once heparin is d/c'd. Site ∓ effective. Will perform dressing change today. Heparin infusing @ 2000 u/hr, LR infusing @ 100 c/hr. IV to (L) FA, well D/C, unable to flush.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0630 19 Sept 03	(R) foot & Dorsalis Pedis and Posterior Tibial pulses all Quadrant - via doppler. Plan: (1) Monitor pulses Q 1° as ordered (2) Perform P in Care as ordered (3) Call H O for changes in assessment — (b)(6)-2
19 Sept 03 0900	c/o Pain, Medicated IV 5 mg Morphine IVP as requested. Patient resting comfortably at present — (b)(6)-2
19 Sept 03 1200	Patient refused lunch stated he didn't like Dressing. Given Compazine unsuccessful breakfast tolerated 3 GI episodes. Will continue to encourage pt intake. — (b)(6)-2
1400 19 Sept 03	Patient informed that Dr (b)(6)-2 departed to U.S. Patient noncompliant with crying episode. Assured patient Dr. (b)(6)-2 is an excellent physician. New IV placed to (R) FA 18G — (b)(6)-2
1600 19 Sept 03	Prescription filling as ordered. Pulses 2+ to upper & lower extremities, (R) foot & excellent Doppler quality to Dorsalis Pedis + Posterior Tibial — (b)(6)-2
1800 19 Sept 03	Patient report given to LT Harrick — (b)(6)-2
19 Sep 03 1800	Report from MAJ walker, client in bed awake connected to cardiac monitor, FVF infusing via (R) SC cordis, Heparin drip @ 2000 units/hr @ 40 cc/hr infusing, no active bleeding noted at IV sites or incision site to (R) groin, or surgical sites to BCE. — (b)(6)-2
1900	Assessment done, see DA form 4700 — (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

ATIENT'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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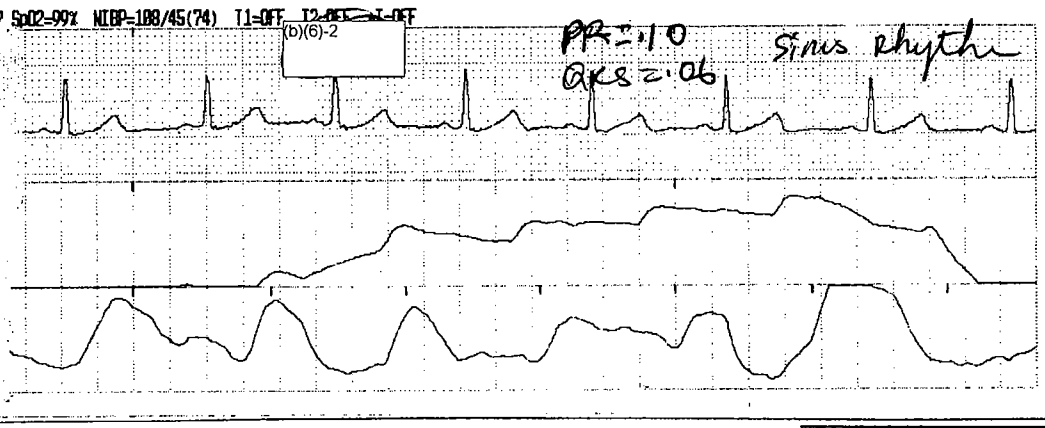
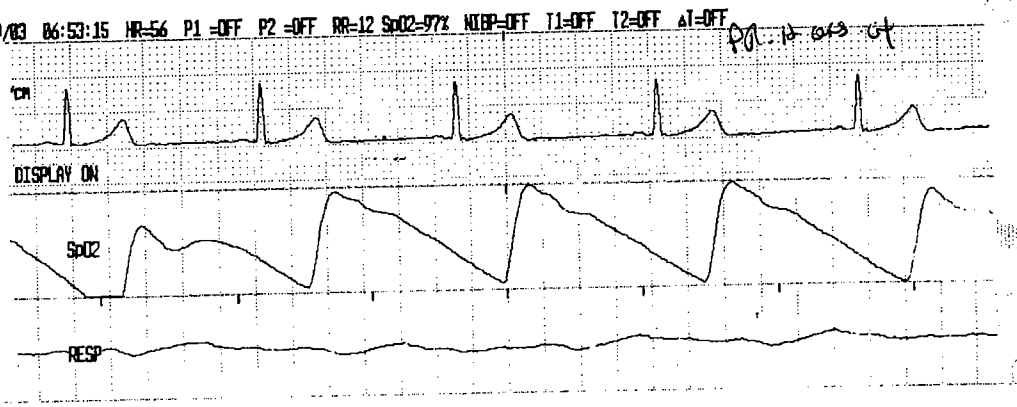
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
(b)(6)-4			(b)(6)-4

DATE	NOTES
19 Sep 03 1910	=17 SpO2=99% NIBP=108/45(74) T1=OFF T2=OFF ΔT=OFF (b)(6)-2 PR=.10 QRS=.06 Sinus rhythm



2100	Client in bed asleep at this time. — (b)(6)-2 LCSA
2200	Pin care done to external fixator insertion sites c̄ 1/2 mixture of peroxide and sterile water. Medicated c̄ pain meds as ordered, tol. well. — (b)(6)-2 LCSA
2400	Assessment done, no changes from previous assessment. — (b)(6)-2 LCSA
0200	Client asleep in NAD — (b)(6)-2 LCSA
0355	c/o pain to (R) leg, medicated c̄ 5mg morphine IV, no other changes in previous assessment. (b)(6)-2 LCSA
0550	Blood drawn from (R) hand, sent to lab. — (b)(6)-2 LCSA
0600	Report given to MAJ [redacted] (b)(6), client in bed asleep, connected to cardiac monitor. Heparin @ 2,000 units/hr (40cc/hr) + LR @ 100cc/hr, Soleq patent + draining. — (b)(6)-2 LCSA



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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 Sep 03	ORTHO PN
	(S) PT C/O SEVERE PAIN THIS AM.
	ACUTE ONSET.
	(O) (+) FOOT C̄ INTACT CAP REFILL,
	PAIN ON PALPATION DIFFUSELY
	DRESSING REMOVED C̄ JET OF BLOOD
	FROM MEDIAL SIDE. NO SUBSEQUENT
	ARTERIAL BLEEDING; ~~NO~~ DIFFUSE
	OOZING FROM SKIN INCISIONS.
	DOPPLER PULSES OK DP/PT BEYOND
	ZONE OF INJURY.
	(A) (1) PAIN LIKELY 2° TO HEMATOMA
	PRESSURE.
	(2) CONT. CURRENT CARE FOR F/O.
	PLAN D TO PTB IN ≈ 4-6 WK IF
	POSSIBLE (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

ATIENT'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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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21 Sept 03 — GENERAL SURGERY SVC

1100 — S: No c/o of pain. No fever or chills

O: Afebrile, VS stable.

6.6 > 8.4/25.9 < 348 — 127/98/4.5/24 — COAG - 12.4/27.4

RLE - ⊕ DP/PT - Cyanotic, rapid < 2 sec.

A: PVD s/p 6/8 Revascularization / Ext Amputation RLE

(2) ANEMIA

P: (1) Transfusion of 2 u PRBC's to optimize O2 delivery for healing.

(2) Drug Multivitamin

(b)(6)-2 MD

(b)(6)-2 MAJ, MC USA
CHIEF, DOS

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
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21Sep03	Transfusion complete - VS: 111/43, 64, 14, 98%, Sats 100%
1400	still monitoring for reaction. (b)(6)-2 SGT/LPN
1405	Second unit transfusing, VS: 116/48, 84, 98
	1410: 109/45, 86, 98%
	1415: 109/43, 79, 98%
	1420: 113/48, 71, 98%
	1435: 109/54, 92, 98%
	1450: 115/62, 97, 98%
	1505: 110/57, 74, 98%
	1510: Transfusion complete. Dr. (b)(6)-2 in to do dressing Δ. Left distal pin sites open for pin care. Pt medicated c̄ 4mg MSO4. post transfusion VS: 116/45, 64, 98%
	Will monitor (b)(6)-2 SGT/LPN
1715	Pt resting, PIV started in (R) FA, flushed & heplocked, Pt c̄ c/o pain or discomfort (b)(6)-2 SGT/LPN
1900	NAD. Pt. sitting up in bed, (R) leg elevated, monitor, BP, SpO2 in place - Vital Signs Stable - afebrile 97.4 Lungs CTA bilat x all lobes - normo-active Bowel sounds - Pt able to move all extremities palpable pulses x both UE's & (L) LE - (R) LE c̄ dsg to leg - pins exposed on ex fix ø Sx of infx noted — will continue to monitor (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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USAPA V1.0C

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2000	Pt. tolerated reg diet 100% — Percocet for pain new order written by Dr. (b)(6)-2 — sitting up at bedside listening to music and playing checkers no complaints (b)(6)-2
2100	Pt care complete 50% H_2O / 50% hydrogen Peroxide Pt consuming water / gatorade — QS and D Foley removal — (b)(6)-2
2300	Pt sleeping — no C/O pain (R) leg elevated (b)(6)-2
0200	Pt — no complaints, VSS — (b)(6)-2
0400	No Lt in status — Labs drawn (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

Physicians at bedside with patient. Cleaned dressing and reinforced c̄ kaltex. Heparin SQ to be ordered by Dr [(b)(6)-2] No other new orders [(b)(6)-2] Report given to CCT [(b)(6)-2]. No changes in assessment [(b)(6)-2] Care Assumed. Physical Assessment Completed & recorded on Flow Sheet [(b)(6)-2] CPT/AN

VO For Bowel Routine Received [(b)(6)-2] CPT/AN

Pin Care Completed, Foot Released [(b)(6)-2] CPT/AN

2200 Meds given [(b)(6)-2] CPT/AN

Pt C/O Pain MSO4 4mg IV given [(b)(6)-2] CPT/AN

0200 Pt resting c̄ eyes closed [(b)(6)-2] CPT/AN

24° I+O IV 2300 PO 940. U/O 4075 Balance -655

Pt C/O Pain MSO4 4mg IV [(b)(6)-2] CPT/AN

0640 Report received, assessment performed, pt resting comfortably 5 c/o pain. Will monitor for Δs [(b)(6)-2] SGT/LPN

0830 Pt bathed & Δd, resting comfortably 5 c/o pain. Will monitor. [(b)(6)-2] SGT/LPN

1030 Pt c/o pain to leg, given 3mg MSO4; Will monitor for relief. [(b)(6)-2] SGT/LPN

1230 First unit PRBCs started infusing (premedicated c̄ 25mg Benadryl & 650mg Tylenol - pre transfusion VS: 110/46, 67, 98¹

1235: 115/53, 92, 98³ - up eating lunch

1240: 104/44, 94, 98³

1245: 116/57, 83, 97⁸ - pt lying back down

1300: 121/45, 83, 98⁰

1315: pt moved injured leg and told [(b)(6)-2] that it began to hurt badly, 2mg MSO4 given through Ⓡ heard PIV. VS: 124/49, 67, 97⁹ [(b)(6)-2] SGT/LPN

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
0630 20 Sept 03	Reports received from ICU (b)(6)-2 Patient laying supine c/o pain. Given 5mg Morphine IVP. Monitor shows SBrady & ectopy. IV D5 infusing to LSC via @ 100cc/hr. Heparin @ 40u/hr, 20000. PTT returned & results 16.4/66.4 IV site (R) FA ~ infiltration or redness. R extend fingers upon. P on sites cleansed & peroxide. Foot ~ Doppler pulses to Dorsalis Pedis and Posterior Tibial Art.
0730 20 Sept 03	Patient ~ severe pain to (R) lower leg, yelling in agony. Given 5mg Morphine IVP unrelieved. Dr (b)(6)-2 called. Given an additional 5mg Morphine 2 minutes later. No relief from patient. Dressing removed and huge clots & leaks ~ blood squirting from incision. Dr (b)(6)-2 redressed incision, pulses ~ good quality noted. Patient expressed relief from pain after 30 minutes. Heparin stopped and patient comfortable at 0845. (b)(6)-2
20 Sept 2003 1000	Patient given complete bath. Dressing to (R) TIB/FIB reinforced with Kerlex due to excessive draining. (b)(6)-2
1200 20 Sept 2003	Patient c/o pain, given 5mg Morphine IVP. Appetite improved from breakfast eating 1/3 of contents. Extremity elevated as ordered. Noted bloody drainage seeping through and layer of Kerlex. Pulses remain by doppler ~~palpable to~~ (R) dorsalis Pedis and posterior tibial area. (b)(6)-2
Available 1600 20 Sept 03	Patient still pain given 5mg Morphine IVP. IV site to LSG reinforced ~ new opsite, flushed + patent. (b)(6)-2

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

BRANCH OF 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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Sep 03 0630	Report received from ILT (b)(6)-2 - pt resting in bed. Assessment performed (see DA4700). Pt on regular diet c̄ supplement - will consult MAJ (b)(6)-2 for alternatives to Derative shakes. (b)(6)-2 SGT/LPN
0800	Pt ate 10% of breakfast, drank 1 Carnation, pt bathed and rolled, labs drawn. Pt now resting comfortably - denies pain (b)(6)-2 SGT/LPN
0825	PTT came back from lab @ 45.2. Heparin ↑d to 1500 u/° per Dr. (b)(6)-2 (b)(6)-2 SGT/LPN
1030	Pt resting comfortably - antibiotics administered. Pt denies pain. (b)(6)-2 SGT/LPN
1230	Pt ate 50% of lunch c̄ c/o nausea. Pt has been resting comfortably all day. (b)(6)-2 SGT/LPN
1430	Aline no longer correlating - poor wave form. Re-zeroed & still unable to detect correct pressure. Will notify MD (b)(6)-2 SGT/LPN
1615	Pt resting comfortably - legs elevated for comfort. (b)(6)-2 SGT/LPN
1730	Pt sitting up in bed, denies pain. Will give report to oncoming shift. (b)(6)-2 SGT/LPN

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22Sep03 0700	Report received from SGT (b)(6)-2, assessment performed, pt resting comfortably, Bd dressing to (R) groin, Ø abscess, hematoma, or pain noted. Will monitor. (b)(6)-2 SGT/LPN
0705	Pt c/o pain - II Percocet given (b)(6)-2 SGT/LPN
0900	Pt bathed, dressings to (L) lower leg Bd, sites cleaned c̄ betadine, small (approx 2in) incision c̄ staples & smaller incision to rear of calf, pt resting 5 c/o pain. Will continue to monitor. (b)(6)-2 SGT/LPN
1100	Pt sleeping, Ø c/o pain, pin care done. (b)(6)-2 SGT/LPN
1300	Pt transferred to ICW per drs order - Report given to SGT (b)(6)-2 (b)(6)-2 SGT/LPN
1405	Admission - Received from ICW via litter. Dx: GRHC TIBIA Fx, A+O×3, Pupils 3mm, Lungs CTA bilat & symmetrical rise and fall in chest. S1-S2 strong and regular, Cap refill <3, Pulses palpable in all extremities, Doppler to (R) LE - foot. Motor skills / neuro intact. Given Percocet x II for pain. Antibiotic - Ancef continues q8°. External fixator to (R) LE. Incisions approx 2 inch with staples to shin and calve. (b)(6)-2 Will continue to monitor throughout. SGT, USN

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

ATIENT'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
22 Sep 03	ORTHO PN (S) S/P (R) GR III C TIBIA Fx c̄ REVASCULARIZATION. DONE WRM (O) AF, JSS GRAY SKIN OVERLYING Fx. PALPABLE PT PULSES. A/P (1) CONT DAILY DSG D's. (2) HEPARIN 5000 u SQ. (b)(6)-2
22Sep03 21:45	Received care of pt @ 1500. Pt. Awake and alert in bed. ⊕PERRLA WNL. ⊕EOM WNL. Buccal mucosa Pink/moist. Skin warm/dry/intact. Lungsounds clear to auscultation throughout. HR regular S1S2 noted. Bowel sounds ⊕x4. Abdomen soft/non-tender. ⊕radial pulses ⊕2 strength (B). ⊕(R) pedal pulse detected c̄ use of doppler device. External fixator in place/intact. ACE wrap dressing applied to ex-fix. Superior pinsite #1 well approximated c̄ s/s infection. Pt able to move/feel digits to (R) foot < 3sec cap refill noted to (R) digits. ∅ complaints of pain @ this time HL to (L) forearm patent/intact will continue to monitor. (b)(6)-2
23Sep 0120 PM	Nursing: Pt awake, alert. Lung CTA, ∅ SOB, O2 sat 97% on RA. HR ST, reg, ∅ edema noted. Abd soft, nontender. Pt attempt BM this am c̄ results. Dsg to (R) LE c̄ ex-fix intact. Old drsg c̄ ½ dollar size area serous drainage. Several dime size area open wounds. Proximal end of wound gray-black in color, staples intact. Distal end c̄ stitches intact. Drsg of 4x4 c̄ Kerlix wrap + ace applied. Ex fix cleansed c̄ ½ H2O2/NS mixture. Dsg to (R) LE CDI, staples intact, skin →

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES

DATE	(b)(6)-2 NOTES
22Sep03 1120 (cntd)	Well approximated. ϕ drainage noted. 4x4 gauze & Kerlix applied. Pt received percocet for pain — (b)(6)-2
23Sep03 19:38	Received care of pt. @ 1800. Pt. Awake/alert in bed. PERRLAE WNL. (+)EOM WNL. Buccal mucosa pink/moist. Skin warm dry/intact. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+)x4 quadrants. Abdomen firm & distended. BM Pt. attempted to have BM unsuccessfully. Crutch walked NWB to (R) leg. Pt unsteady c̄ crutches. Needs reinforcement c̄ PT for crutch walking. (R) leg external fixator intact. 1st 2 superior pins OTA's s/s infection. all other pins wrapped c̄ ace wrap dressing. Dressing C/D/I (+) pedal pulses (B) c̄ doppler device. Pt. has limited ROM to (R) lower extremity digits. (+)NV ✓s WNL. to (R) foot. no complaints of pain @ this time. Will continue to monitor — (b)(6)-2
2024	Pt. c/o pain to (R) leg ii Percocet given will monitor for results — (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Sep 2003 805	Nursing: Pt in bed, gasping for breath ✓ clinching bedside table. Possible seizure. O_2 applied 6L via N/C. MD notified. Interpreter in, attempt to talk to pt, pt unresponsive. Eyes rolled back in patient head, unresponsive to sternal rub. Pt foaming @ mouth. ~~Activity last~~ VS TBP, O_2 Sat 78% before O_2 applied, ↑ HR. Activity last approx 10-12 minutes. —— ILT (b)(6)-2
0820	Nursing: Pt. pupils unequal (R) pupil 5mm / (L) pupil 7mm —— ILT (b)(6)-2
~~24 Sep 2003~~ ~0827	Nursing: Pt HR begin to increase again, activity resumes of pt clinching fist ✓ thrashing around. Pt c ~~deep~~, quick, shallow breaths, ↑ O_2 back up to 6L from 5L to mnt O_2 Sat. Sat's at 98% c 6L O_2 NC. MD notified, in to see pt, pt to post-ictal phase. Labs drawn for chem/CBC. Lungs clr, encourage pt to take slow, deep breaths. Pt reports recent history of seizure last 4-5 months. Pt unsure if had childhood hx of seizure. Valium ordered for pt if another seizure occurs. Dilantin po started c loading dose today, start mnt dosing 25 Sep. —— ILT (b)(6)-2
	Seizure last approx 5 minutes —— ILT (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
~~2400~~	Medicine
24Sep03	Pt witnessed to have short episode - generalized
0900	T/C seizure this AM x 2. followed by short post-ictal period. No B/B incontinence. Hemodynamically stable.
	Labs drawn p 2nd episode - electrolytes NL.
	By Hx - he has had similar episodes in recent past - was started on Rx - but has had none recently + doesn't know the name.
	Imp: Possible epilepsy (Sz D/o) unknown etiology can't easily do imaging or EEG.
	- Empiric Tx w/ phenytoin - oral load + daily dosing
	(b)(6)-2
24Sep2003 1230	Nursing: Pt experience episode #3 seizure/possible psychotic episode. Pt thrashing around, scratching self, ↓ blood drawn from scratching; attempt choke self, pulling at hair. Pt pulled IV out. NC CO_2 @ 6L started, pt grabbed & clenched between teeth. Attemp

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
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24 SEP 2003 1720 (cont'd)	to apply O_2 Mask, pt c↑ gasping for air & thrashing. Mask removed, pt remained @ 94-97% O_2 sat on RA. 15Mg Valium given IVP, 10mg Haldol (5mg x 2) IM given & 50mg Benadryl IM given. Pt begin to calm & all meds given. (b)(6)-2 AW
24 SEP 03 1625	DATA PN (S) Pt c new onset "seizure" episodes today. Subjective Hx of seizure D/O. Witnessed elements both genuine and contrived components. (O) AF, VSS (R) LRG wounds ~~5~~ D. PN sites OK. (AP) (1) (R) LRG ~~5~~ D. Cont Ex Fix / Daily Dsg d's (2) Defer SZ mgmt to Dr (b)(6)-2 (b)(6)-2 (b)(6)-2
24 SEP 2003 1630	Nursing: Pt Drsg to (R) LEX 2 removed. Staples removed from both sites, steri-strips placed, OTA. Pt tolerated well (b)(6)-2 AV

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 Sep 03 1911	Nursing Notes: Assumed care of Pt A&O x3. Pt sometimes appears drowsy but easily aroused. Vitals stable Ø c/o pain or discomfort Ø repeat of seizure activities. Pt able to move all extremities without complaint or complication. IVSL flushes well Ø S/S of infection at site. Pt voids spontaneously via bedside urinal. ambulates c̄ assistance to outside bathroom. will continue to monitor status. [redacted] (b)(6)-2 [redacted] RN/LPN
25 Sep 03 1730	Nursing: Ship note Pt. bright & alert. PERRL Ø seizure activity noted. Sats range 95-98%, ambulated to inside bathroom c̄ assist using crutches. Ø SOB noted. Dressing changed & reviewed by Dr. [redacted] (b)(6)-2 to continue current tx. Pt. interacting c̄ staff + peers. [redacted] (b)(6)-2
26 Sep 03 1900	Nursing Notes: Assumed care of Pt A&O tolerated regular diet Ø N/V. Ø seizure activities from last recorded vitals. patient stable Ø complaints. Breathing unlabored Ø SOB or labored breathing. Able to wiggle toes on affected (R) leg. Coloration normal for ethnicity. IVSL flushes well Ø S/S of infection at IV site. Will continue to monitor. Dressing to (R) leg clean, dry and intact. [redacted] (b)(6)-2 [redacted] RN/LPN

[redacted] (b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 Sep 2003 1150	Nursing: Pt awake, alert. ∅ c/o pain @ present. Lungs CTA, O2 Sats 98% on RA. HR 68, reg, mild edema to (R) LE. HL to (L) ac, Patent. Abd soft, nontender, (+) BS x4. Pt tol. reg diet. Voiding is difficult, ↑ OOB c̄ crutches to latrine. (R) LE c̄ ext fixator intact. Drsg Δ + pin care performed. (R) LE c̄ multiple open wounds draining sero-sang fluid. Area of gray-black skin @ proximal end of prosthesis site. — [(b)(6)-2]
26 Sep 03 20:48	Received care of pt @ 18:00. Awake and alert in bed. Restraints x2 (L) wrist/ankle. PERRLA (+) x (L) pupil larger than (R) pupil. (+) EOM WNL. Buccal mucosa pink/moist. Skin warm/dry/intact. Lungs clear to auscultate (B) throughout. HR regular S.S.a present. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x 4 quadrants. Ex-fix to (R) lower extremity intact c̄ proximal pins OTAS s/s infection. ACE wrap dressing clean/dry/intact to all other pin sites. (+) NV ✓'s to (R) foot digits. (+) Pedal pulses (B) c̄ dopplers. ∅ complaints of pain @ this time. HL (L) AC patent/intact. will continue to monitor — [(b)(6)-2]
27 Sep 03 0800	Pt. complained of pain x2 @ 22:30 ÷ Percocet given. @ 0300 ÷ Percocet given. will continue to monitor [(b)(6)-2]
27 Sep 03 1410	Nursing: Pt awake, ∅ c/o pain. Pt alert. Lungs CTA, O2 Sats 98% on RA. HR 64, reg, mild edema to (R) LE. (+) pulse via doppler to (R) DP. HL to (R) ac, Patent. Abd soft, nontender (+) BS x4. Pt tolerating reg diet. Pt ↑ OOB c̄ crutches to BR. Ext fix intact, Drsg ↓ complete. Drainage continues from multiple open wound sites. — [(b)(6)-2]

STANDARD FORM 600 (REV. 6-97) BACK

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

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27 Sep 03 21:32	Received care of pt @ ~~21:00~~ 18:00 (3rd) (b)(6)-2 . Pt. Awake/alert in bed. PERRLA ⊕ WNL EOM ⊕ WNL Buccal mucosa ⊕ WNL Pink/moist. Skin warm/dry/intact. Lung sounds clear to auscultate (B) throughout. Bowel sounds ⊕ x4 quadrants. Abdomen soft/non-tender. ⊕ Radial pulses (B) ⊕ 2 strength. HL to (R) AC patent/intact (R) external fixator in place to (R) leg. Proximal pins ⊖ s/s infection. Distal pins ⊖ ACE wrap bandage clean/dry/intact. ⊕ NVV's to (R) foot. ⊕ Pedal pulses (B) feet ⊖ dopplers. c/o pain x1 ⊖ Percocet given. Dressing to (R) ↑ thigh clean/dry/intact. will continue to monitor — (b)(6)-2
28 Sep 03 0530	Nursing: Sleep Pt. slept 7 6° this shift — (b)(6)-2 CPT/AD
28 Sep 2003 0858	Nursing: Pt awake, alert. c/o little pain. Lung CTA, O2 Sats 98% on RA, ⊘ SOB. HR 74, reg, (R) LE ⊖ mild edema. HL to (R) AC, flush ⊖ difficulty. ⊖ Homan's. Abd soft, nontender ⊕ BS x4. Pt tolerating reg diet. ↑ OOB ⊖ crutches to latrine. Ext fix to (R) LE intact, drsg Δ will be complete later. Steri-strips to (L) LE CDI. Drsg to (R) inguinal area Δ'd. ⊘ drainage noted. (R) LE warm, dry, ⊕ Doppler pulse @ DP. ⊕ sensation, brisk cap refill. — CLT (b)(6)-2
28 Sep 03 15:42	Received care of pt @ 14:00 Pt. awake and alert in bed. Restraints x2 (L) ankle/(R) wrist. PERRLA ⊕ WNL ⊖ (L) pupil larger than (R) pupil. EOM ⊕ WNL Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds ⊕ x4 quadrants. Abdomen soft/non-tender. Radial pulses ⊕ (B) ⊕ 2 strength. HL to (L) Forearm intact/patent. (R) lower leg ex fix intact. Proximal pin sites OTA ⊖ s/s infection all other pinsites ⊖ ACE wrap dressing clean/dry/intact. ⊕ Pedal

(b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	pulses (B) c̄ dopplars (+) NV √'s to (R) foot digits. Dressing to (R) groin area Δ'd. clean/dry/intact. Staples intact c̄ s/s infection. Ø complaints of pain @ this time. will continue to monitor (b)(6)-2
28 Sep 03 21:40	complained of headache ⅱ̄ Tylenol given. will continue to monitor (b)(6)-2
28 Sep 03 2340	Nurses Notes: Assumed care of Pt ⅱ̄ lying in bed Ø c/o pain or discomfort breathing intact Ø s/s of distress Ø. Seizure activity noted. Pt ambulates c̄ use of crutches. Cords spontaneously. Vitals stable. will continue to monitor Pt (b)(6)-2
0150	Pt c/o pain ⅱ̄ Tylenol PO given for pain will continue to monitor (b)(6)-2
29 Sep 2003 1050	Nursing: Pt sleeping, easily aroused. Ø c/o pain. Pt alert lungs CTA O2 sats 96% on RA. HR reg, HL to (R) foot patent. Mild edema to (B) LE. Abd soft, flat, nontender. (+) BS x4; pt tolerating reg diet. ↑ OOB to latrine c̄ crutches. Ø difficulty c̄ void. Ext fix to (R) LE intact. (B) LE c̄ (+) Dopplerpulses, brisk cap refill, warm, dry, (+) sensation to all toes. (b)(6)-2
29 Sep 03 19:50	Received care of pt @ 1400. Pt. awake/alert in bed. PERRLA (+) WNL. EOM (+) WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender. HR regular S1S2 WNL. HL to (R) wrist intact, patent. Dressing to staples on (R) ↑ thigh clean/dry/intact. External fixator in place. Proximal 2 pins OTA c̄ Δ s/s infection. All other pins c̄ ACE wrap dressing clean/dry/intact

STANDARD FORM 600 (REV. 6-97) BACK

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Sep 03 19:56 continued	NV ✓'s to feet WNL. (B) pedal pulses (+) c̄ dopplers. complaine of a headache. ii tylenol given will continue to monitor (b)(6)-2 [redacted]
29 Sep 03 2315	Nurses Notes: Assumed care of pt sleepy but easily aroused. ø c/o pain or discomfort at this time. Ancef therapy continues ø S/S of distress. ø seizure activities vitals stable. will continue to monitor status (b)(6)-2 [redacted]
30 Sep 2003 0800	Nursing: Pt awake ø c/o pain. Lung CTA, O_2 Sats 97% on RA, ø SOB. HL ✗, reg, mild edema to (R) LE. HL to (R) wrist, plus 1 ⊖ difficulty. Abd soft, flat, nontender (+) BS x4, pt tolerating reg diet. ↑ OOB c̄ crutches to latrine, denies any difficulty c̄ void. Stim-strips to posterior (L) leg, CDI. Drsg to (R) LE CDI, ext fix intact. (R) LE c̄ (+) Doppler D/P pulse, warm dry. (b)(6)-2 [redacted]
30 Sep 03 16:19	Received care of pt. @ 14:00 pt. A+O×3 PERRLA (+) WNL. FEMG WNL. Buccal mucosa pink/moist. Lungs clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender. (+) pedal pulses (B) c̄ dopplers. ⊖ complaints of pain will continue to monitor (b)(6)-2 [redacted]
30 Sep 03 2400	Nurses Notes: Assumed care of Patient Sleepy but easily aroused breathing intact ø SOB or labored breathing vitals stable ø S/S of seizure activities or distress. able to move all extremities ambulates with use of crutches to restroom antibiotic therapy continues (b)(6)-2 [redacted]

(b)(6)-4 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
@ 10 Oct 2003 1040	Nursing: Pt awake, alert @ c/o pain. Respirs even, O2 Sats 99% on RA, HR 62, reg, mild edema to ~~RLE~~ (+) Dopplr pulse. Abd soft, nondistended, (+) BS x4. ↑ COB, amb c̄ crutches. Drsg Δ to RLE. Old drsg c̄ small amt. sero-sang drainage. Multiple wounds have started to scab. Steri-strips intact, sm. amt serous drainage noted. 4x4 Kerlix, Kerlix roll & ace wrap applied. Pin care completed. — KT (b)(6)-2 AN
01 OCT 03 1500	Received care of pt @ 1400. Pt awake/alert in bed. Appears comfortable. PERRLA (+) WNL. EOM (+) WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. HR reg, S1S2 WNL. Bowel sounds (+) x4 quadrants. Abdomen soft/nontender. Dressing to (R) thigh Δ'd. Staples intact. mild erythema @ staple insertion sites. New dressing clean/dry/intact. External fixator intact c̄ proximal pins OTA. Other pins covered c̄ ACE wrap dressing clean/dry/intact. (+) Pedal pulses (B) c̄ (+) dopplers. ∅ complaints of pain @ this time will continue to monitor — (b)(6)-2 SOAN
Addendum	NS WNL per flowsheet — (b)(6)-2 OCT/AN
10 Oct 03 2215	Assumed care of Pt. A+Ox3, VS stable. Staples intact, dressing clean, dry intact. External fixator intact. ∅ complaints of pain. Ambulating to latrine with crutch assists. IV Patent. Continuing antibiotics. Hosp. Continuing Heparin SQ Bid. — (b)(6)-2
	Concur c̄ above assessments — (b)(6)-2 KT/AN

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Oct 2003 1020	Nursing: Pt awake, Ø c/o pain. Alert, Lungs CTA, O2 sat 97%, HR 74, reg, mild edema to (R) LE. IV to (R) wrist, patent. Abd soft, flat, nontender (+) BS x4. Pt tol reg diet. ↑ OOB amb c̄ crutches. Denies any constipation n/V. Denies any difficulty c̄ void through translator. Drsg CDI. IV (b)(6)-2 AN
20 Oct 03 1805	Nursing: Shift note Pt. bright & alert. Pt. ambulated to latrine w/o SOB, difficulty. IV infusing for antibiotics only. Communication via translator. Per physician, pt. will possibly have x-fix removed ≤ 1 week. Pt. remain c̄ non weight bearing. Ø swelling or infection noted. Pt. encouraged to stay up during the day to promote better night sleep. Continue to assess infection, mobility & impaired coping c̄ long-term hospitalization which are WNL at present. (b)(6)-2
20 Oct 03 2215	A scanned note of Pt @ 2200. A+O x3 VS stable c/o pain x1 given Tylenol #1 PO, distal pulses intact, dressing clean, dry, intact, ambulates with crutch assistance, antibiotic therapy continues. (b)(6)-2 Concur c̄ above assessment. (b)(6)-2
30 Oct 2003 0940	Nursing: Pt awake, Ø c/o pain. ↑ OOB to chair for AM care. Lungs CTA, O2 sat 98% on RA, Ø SOB. HR 58, reg, mild edema to (R) LE. IV to (R) FA, patent. Abd soft, nontender, (+) BS x4. Pt tol reg diet. ~~Det~~ ↑ OOB to outside latrine c̄ crutches. Drsg to (R) LE c̄ ext fix intact. Pin care complete. Old drsg c̄ ½ dollar size area of serosanguinous drainage. Reapply 4x4, Kerlix & ace wrap

(b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Oct 2003 0710 (cont)	Pt tolerated well. ——— IG (b)(6)-2
3 OCT 03 16:11	Received care of pt. @ 14:00. Pt awake/alert in bed. Ambulate to BR x 1 c̄ crutches NWB to (R) leg. PERRLA (+) WNL. EOM (+) WNL. Skin pink/warm/dry. Lung sounds clear to auscultate (B) throughout. HR regular. S1S2 present. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x4 quadrants. (+) Radial pulses (B) (+)2 strength. HL to (R) wrist patent/intact. Dressing to (R) upper thigh changed. Staples intact s̄ s/s infection new dressing applied. Clean/dry/intact. External fixator intact. Proximal 2 pins OTA s̄ s/s infection. All other pinsites wrapped c̄ ACE wrap dressing clean/dry/intact. NVVS to (B) feet WNL. (+) pedal pulses c̄ doppler reading. ∅ complaints of pain @ this time. Will continue to monitor (b)(6)-2
3 oct 03	Assumed care of Pt @ 2200 A+O x3 VS stable c/o pain x1 given ~~tt~~ PO Tylenol @ 2225 continues antibiotic therapy External Fixator intact dressing clean, dry, intact distal pulses ~~[illegible]~~ to latino with with assistants ——— (b)(6)-2 GJU Concur c̄ above assessments ——— (b)(6)-2
4 Oct 2003 0700	Nursing: Patient awake, c/o WHL pain. AUA, Lungs CTA, O2 Sats 99% on RA, ∅ SOB. HR 68, reg, ∅ edema noted. HL to (R) wrist patent. Abd soft, flat, nontender, (+) BS x4. Pt tol reg diet. ↑ OOB to outside latrinus s̄ difficulty. Drsg to (R) LE CDI. Ext fix intact. ~~Pulse to R~~ D/P pulse palpable by hand, +1. (B) LE warm, dry, c̄ brisk cap refill, pt indicates (+) sensation to all toes — (b)(6)-2
4 OCT 03 1945	Received care of pt @ 1400. Pt awake and alert in bed. (+) PERRLA WNL. (+) EOM WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. HR regular. S1S2 present. Bowel sounds (+) x4 quadrants. Abdomen (+)

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 OCT 03 1945 note continued	(b)(6)-2 [redacted] Abdomen soft/non-tender x 4 quadrants. ⊕ Radial pulses (B) ⊕ 2 strength. WL to (B) Forearm patent/intact. Staples to (L) upper thigh c̄ sterile 4x4 clean/dry/intact noted. Ex-fix intact c̄ 2 proximal pins OTA & s/s infection noted. all other pins covered c̄ kerlix wrap. NV's to (B) feet WWL. ⊕ Doppler pulses (B). & complaints of pain @ this time. Will continue to monitor — (b)(6)-2
4 Oct 03 0915	Nurses Note: Assumed care of Pt Sleepy but easily aroused. Slept most of Shift & c/o pain or discomfort. (U Ancef Therap. Continues. Vitals Stable. Ex-Fix Replace & bleeding or drainage. Able to move all extremities & complaints or complication. Will continue to monitor status — (b)(6)-2 [redacted]
5 Oct 03 1400	Nursing: Shift Note Pt. bright + alert most of shift. One episode of going to bathroom, being assisted to ground, requiring litter carry back to bed. Pt. responsive to stimuli, mild pressure. Pt. able to eat lunch & ambulate outside afterward. Pt. stats were 98% - 100% during interaction. Pt. dressing c̄ scant amount of dry dark brown drainage. Continue to ambulate to restroom WL site w/o s/s infection. — (b)(6)-2 [redacted]
5 OCT 03 1445	Error (b)(6)-2 ~~Pt. resting~~ Received care of pt @ 1400. Pt resting in bed. Awake and alert. ⊕ PERRLA WWL. ⊕ EOM WNL. Buccal mucosa pink/moist. Skin warm/dry/intact. Lung sounds clear to auscultate (B) throughout. HR regular

STANDARD FORM 600 (REV) 6-87) BACK

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 OCT 14:45 note cont'd	S1 S2 present. Bowel sounds ⊕ x 4 quadrants. Abdomen soft/non-tender. ⊕ Radial pulses (B) ⊕ & strength. Ex-fix intact to (R) leg. 2 proximal pins OTA. Other pins c̄ kerlix wrap clean, dry, intact. ⊕ NV ✓'s to (R) foot digits. ⊕ Doppler pulses (B) feet. Dressing to upper (R) thigh clean, dry, intact — (b)(6)-2
Addendum	Will continue to monitor. & complaints of pain @ this time — (b)(6)-2
1803	Staples removed to upper (R) thigh. Pt. tolerated well. Cleansed c̄ Sterile H2O. Bacitracin applied to staple sites. — (b)(6)-2 5 OCT/AM
5 OCT 03 2300	Nurses Notes: Assumed care of Pt sleepy but easily aroused. Pt states OK. & c/o pain or discomfort at this time. Able to wiggle toes on affected (R) leg. Ambulates [illegible] c̄ assistance of crutches. IV Antibiotic therapy [illegible] continue to monitor status [illegible] (b)(6)-2 5/OCT/AM
2330	Pt c/o pain after returning from Rad. Tylenol PO given & 0500 [illegible] for pain. [illegible]
	(b)(6)-2
(b)(6)-2	
6 OCT 03 16:07 EAROR [redacted] (b)(6)-2	Received care of pt @ 1600. Pt. in bed awake and alert. PERRLA ⊕ WR. FOM ⊕ WR. Buccal mucosa pink/moist. Skin warm/dry/intact. Lung sounds clear to auscultate (B) throughout. HR regular S1 S2. Bowel sounds

STANDARD FORM 600 (REV. 6-97) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6 OCT 03 -	ASSESSMENT - A&O x3, PERRLA, LUNGS CTA BILAT, S1 S2 STRONG AND REG, (+) BS x4. ∅ C/O PAIN, ∅ C/O CONSTIPATION, DRSG Δ'd @ 0915 C.D.I. PT TO OR IN A.M. WOB T CRUTCH ASST, TOLERATING REG DIET. A.M CARE PERFORMED (SEE ...) WILL CONTINUE TO MONITOR THROUGHOUT. (b)(6)-2 SGT, USA
6 OCT 03	OUTPAT OP NOTE Dx: (R) GR III C TIB FIB FX, 4 wk OUT SURGEON: (b)(6)-2 ASSIST: ∅ PROCEDURE: D/C EX FIX, TRANSITION TO WC FINDINGS: SERIOUS DRAINAGE, MINIMAL FROM VASCULAR REPAIR INCISION, MINIMAL CALLUS ON FIBULA. NO GROSS INSTABILITY @ D/C EX FIX. PLACED IN WC i 30° KNEE FLEXION. COMPLICATIONS: NONE DISPOSITION: SPACE TO RR ANESTHESIA: GEN EBL: MIN, FLUIDS: 600 LR

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
	LAST	FIRST

(b)(6)-2

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
6 OCT 03 1607	Received care of pt @ 14:00. Pt. awake and alert in bed PERRLA⊕WNL. EOM⊕WNL. Buccal mucosa pink/moist. Skin warm/dry, intact. Lung sounds clear to auscultate ⊕ throughout. Bowel sounds ⊕ x4. Abdomen soft/non-tender x4 quadrants ⊕ radial pulses ⊕ ⊕ x2 strength. HL to ⊕ forearm patent/intact. ⊕ leg c̄ long leg cast (b)(6)-2 intact. Small amount of serosanguinous (b)(6)-2 drainage noted below patellar area. Border drawn around drainage. ⊘ complaints of pain @ this time. Will continue to monitor — (b)(6)-2
1753	1700 - Dr. (b)(6)-2 notified of drainage. Second border drawn around additional drainage. Will continue to monitor — (b)(6)-2
6 OCT 03 2240	Nurses Notes: Assumed care of Pt sleepy but easily aroused. ⊘ c/o pain or discomfort. IV antibiotic therapy continues. Heparin 5000 u. given SQ. Vitals stable. Dressing to ⊕ leg c̄ small amount of drainage. Pt had Ex-Fix removed today. Will continue to monitor status — (b)(6)-2
7 OCT 03 — 800	Assessment - 0915 - A+O x3, PERRLA, Lungs CTA Bilat, S1-S2 Strong and Reg, BBS x4. ⊘ c/o pain. Cast to ⊕ LE C.D.I. No c/o constipation. Cobra BR c̄ assist. Tolerates Reg Diet. Continues Antibiotic therapy Clindamycin 450 mg q8. Will continue to monitor progress — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7OCT03	PT AAO, PERRLA, USS, Lungs CTA 98% on RA, Pulses palpable in 3 ext, Bowel sounds present in a 4 quad, Ø N/V, Ø complaints of pain, (b)(6)-2 SGT 91WM6
7OCT 03 20:52	I concur with the above assessment (b)(6)-2
8 OCT 03	Pt c/o s/s diarrhea ii Immodium given will monitor (b)(6)-2
8OCT 03	PT AAO PERRLA USS Lungs CTA SaO_2 98%, pulses palpable in 3 ext, bowel sounds present all 4 quad, voiding via latrine, Ø complaints of pain will continue to monitor (b)(6)-2 SGT 91L-A6
9Oct03 0600	Nursing: Shift Observation Pt. slept throughout night Ø problems noted (b)(6)-2 SPC RN

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. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 OCT 03	NARRATIVE SUMMARY
	DOA: 13 SEP 03 DOD: 8 OCT 03
	DX: (R) LE-6 GR III C OPEN TIBIA FX 2° GSW, FPW
	PROCEDURES:
	13 SEP 03: I+D TIBIA FX, EX FIX TIBIA FX; VASCULAR REPAIR POST TIB C̄ SAPHENOUS GRAFT.
	16 SEP 03: THROMBECTOMY POST TIB ARTERY C̄ GRAFT REVISION
	6 OCT 03: REMOVAL EX FIX, TRANSITION TO LONG LEG CAST
	HOSP COURSE: INITIAL GRAFT THROMBOSIS TX C̄ THROMBECTOMY, GRAFT REDUNDANCY EXCISION. SMALL AREA OF SEROUS DRAINAGE @ TIME OF EX FIX D/C → PLAN WEEKLY PLASTER CAST Δ. MINIMAL RADIOGRAPHIC CALLUS @ TRANSITION TO LLC.

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

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
8 OCT 03	CONDITION: STABLE
	DISPOSITION: D/C TO MP CUSTODY
	RETURN TO (b)(2)-2 FOR CAST
	Δ IN 4 DAYS. PLAN WEEKLY
	Δ'S UNTIL DRAINAGE STOPS.
	REMAIN ON CLINDAMYCIN 450 mg
	PO TID AND ASA FOR ONE MONTH.
	MEDS: PERCOCET 1 PO q 4-6H PRN
	CLINDAMYCIN 450 mg PO TID x 30d
	ASA 1 PO qd x 60d.
	(b)(6)-2
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 3 | MONTH Sept | YR. 03 | TIME 0800

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Include dosage, frequency, last administration and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA.

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): 0139

HOME TELE. NO. (Inc. area code)

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

SEX: M | AGE: 28

POSSIBLE THIRD PARTY PAYER: ☐ YES ☒ NO

VITAL SIGNS

TIME	0830		
BP	148/50		
PULSE	120		
RESP.	24		
TEMP.			
~~URE (Cath)~~	100 NRB		

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

ORDERS	INITS.	TIME
CBC, Chem 12	(b)(6)-2	0822
UA		0830
Morphine 10mg		0830
15gm ~~[illegible]~~ pramoxin		
1gm Ambacin		
Td		

ASSESSMENT/DIAGNOSIS: RLE GSW arterial bleeding

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 HRS. | 48 HR. | 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

DATE OF RELEASE:

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: 0808

25 y/o Iraqi M who was stealing 57mm rounds from an ammo collection point and was shot with a 556 mm round in his (R) ankle. ~~Pt [illegible]~~ from 4000 m. Pt had arterial bleeding and tourniquet placed @ 0700. Pt brought to ER at 0800. Pt resuscitation begun. Pt in pain (R) LE. Last meal yesterday. Has not eaten since 0900

100 Lactated Ringers + Lactated Ringers 100g
5 Versed
100 SUCC
10 vecu
D.O prepped

HEENT PERRLA EOMI
Neck supple
Chest lungs clear
Card RRR
Abd. bowel NT.

(R) LE arterial bleeding
when tourniquet released x 3-4 minutes pressure over wound.
tourniquet replaced.
DP pulse ; tourniquet released

UA: ~~(R) large blood. BUN 48~~ RBC
XRay: Comminuted fracture distal fibula & tibia
arterial bleeding intraarticular fragment.
tibia plateau OK
GIF nail and bolt
cleared neuro and sole pulses to OR.
Cannula line placed
Foley placed

ABG: 7.433 pH 3.8 WBC 14.7
pCO2 25.5 CR 1.0 HH 14/42
pO2 133 BUN 17
SO2 99 GLU 123

UA: 561-030

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) OR 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).

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 LTCMC (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

To OR for cleaning debridement and definitive treatment for comminuted tib (R) LE.

(b)(6)-4

[redacted] (b)(6)-4

(b)(6)-4

EMERGENCY CARE AND TREATMENT
Medical Record Copy

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

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 anesthesia

2. PATIENT IDENTIFIED VERIFIED BY (b)(6)-2 PROCEDURE Ut/Ap

3. DATE 13 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0915 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt arrived intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Mt (b)(6)-2 66E	RELIEF CIRCULATOR	CPT (b)(6)-2 66E

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

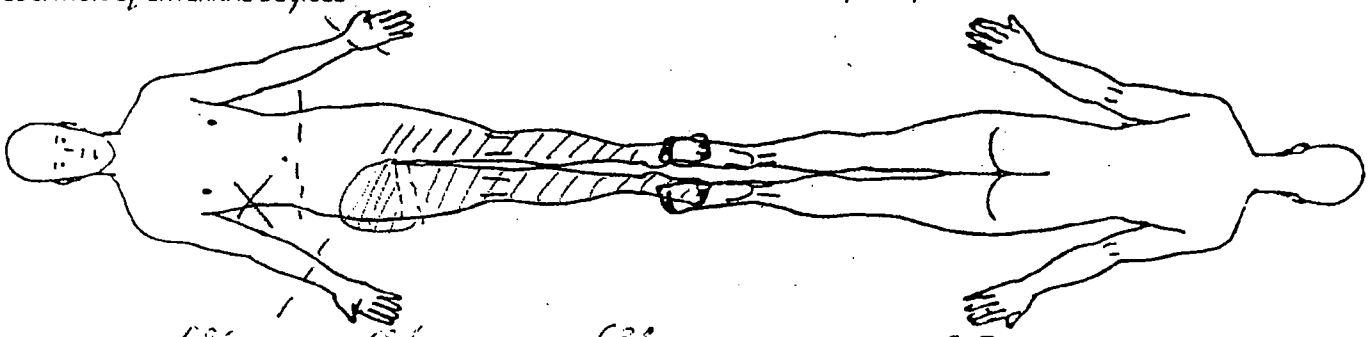
COMMENTS: (L) leg frogged out; padded c̄ egg crate + secured.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta / Beta BY WHOM: [redacted] (b)(6)-2
SITE: RLE + LLE
SITE: (R) inguinal area BY WHOM:
COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (ESC) -- Safety Strap (ESC) = = = Tourniquet (ESC) (a) 275 for 87 min /// = prep

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C		
Needle Sharp	☒ Yes ☐ No	C	C	C	(b)(6)-2	(b)(6)-2
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 cut/coag = 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: 69671 exp 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

Hoffman II lot# 4804

5mm pins x 4

Blue/Blue x 4920-1-010

Blue/Green 2 4920-2-020

Curve Bar x 4 4920-2-140

Bars x 2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Carran	QS	I/O	Inj. Artery	[redacted]	(b)(6)-2
Heparin (1cc in 1000cc .9%NaCl)	QS	I/O	Inj. Artery	[redacted]	(b)(6)-2
Surgical	QS	I/O	Topical	[redacted]	(b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): b(6)-2

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATI YES ☒ NO IF YES, SITE RLE

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	16 fr Foley		
SITE	Bladder - yellow urine + blood prior to arrival -		

18. DRESSING/IMMOBILIZATION *(Specify)*

xeroform 4x8 kerlex wedge Ace

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

Dr (b)(6)-2

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

20. OPERATION(S) PERFORMED

1) Arteriogram RLE

2) Vascular Repair RLE

3) Ex-Fix RLE

4) I + D of RLE WD

21. PATIENT TRANSFERRED TO ICU TIME 1500 METHOD litter

22. REGISTERED NURSE SIGNA (b)(6)-2 UTSW

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

MEDCOM - 7276

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 anesthesia
2. PATIENT ID VERIFIED BY (b)(6)-2 PROCEDURE [illegible]
3. DATE 15 Sep 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 0900 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	PFC (b)(6)-2 91D (11:35-EOC)
ASSIGNED CIRCULATOR	Lt (b)(6)-2 66E Maj (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

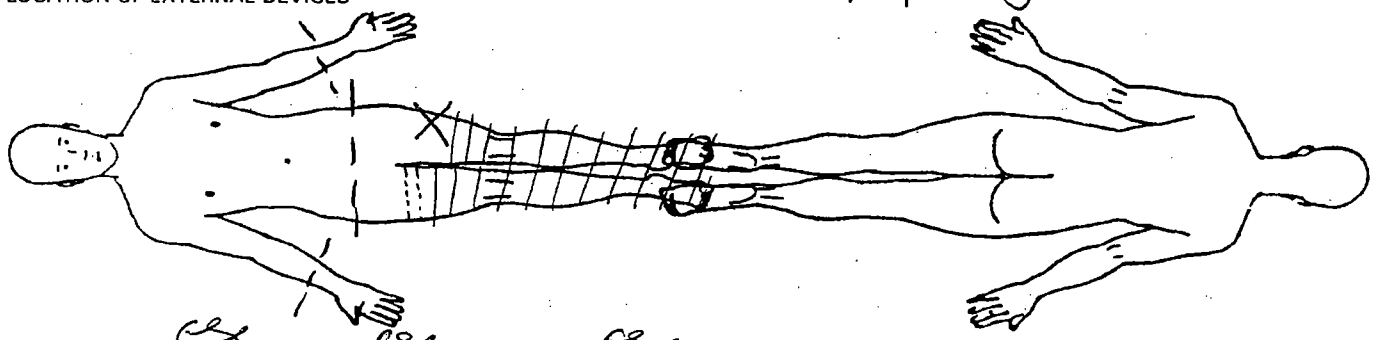
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine Brandt's Sol.
SITE: RLE to TQ BY WHOM: (b)(6)-2
SITE: LLE to groin BY WHOM: (b)(6)-2
COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad — Safety Strap = = = Tourniquet @ 275 for Ø min ///= prep

10. COUNTS — C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C		
Needle Sharp	☒ Yes ☐ No	C	C	C	(b)(6)-2	
Instrument	☐ Yes ☒ No					(b)(6)-2
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: ~~X~~ 1 cut/coag = 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: 69671 exp 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUME UFACTURER

Hoffman (in place prior to arrival)

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Heparin 1000u (.1cc in 100cc .9% Na Cl)	QS	I/O	intra graft	(b)(6)-2	(b)(6)-2
Conray	QS	I/O	A-Gram	[redacted]	(b)(6)-2

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

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYS (b)(6)-2

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

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	Foley	2.	3.
SITE	1. Bladder pt arrived c̄ in place	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, kerlex, webril, ace, xeroform, 4x8s

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

Maj (b)(6)-2 CRNA / SSG (b)(6)-2, RT

20. OPERATION(S) PERFORMED
I+D RLE WD
RLE Vascular repair revision
A-gram
LLE wounds I+D

21. PATIENT TRANSFERRED TO ICU TIME 1125 METHOD litter

22. REGISTERED NURSE SIGNAT (b)(6)-2 CH/RN

REVERSE OF DA FORM 5179-1, O

USAPA V1.01

MEDCOM - 7278

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 amb BY my (b)(6)-2

2. PATIENT IDENTIFIED PROCEDURE
VERIFIED BY (b)(6)-2 ut/AN

3. DATE 6 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1130 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2 910	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt (b)(6)-2 66E	RELIEF CIRCULATOR	CPT (b)(6)-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

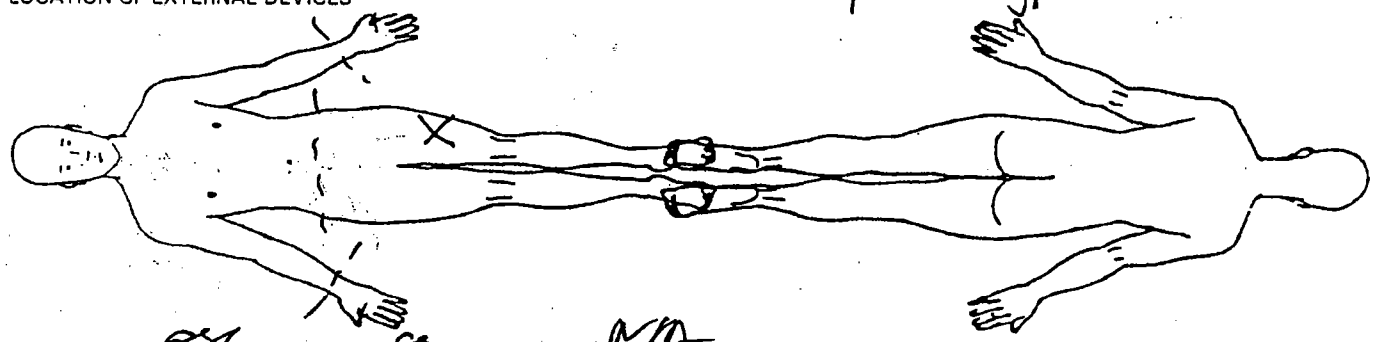
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens
SITE: R-E ex-Fix pin sites BY WHOM: (b)(6)-2
SITE: BY WHOM:

COMMENTS: ∅ pooling / irritation

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		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

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

☒ ESU NO: ~~X~~ 1 cut/coag = 30/30
GROUND PAD: BRAND Valley lab
LOT NO: 69263 exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ 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 (b)(6)-2 (b)(6)-2 May MC

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

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)*
Telfa xeroform
fluffs
plaster cast

19. ADDITIONAL INFORMATION
Dr (b)(6)-2 SSG (b)(6)-2 - ortho Tech

May (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
Removal of Ex-fix RLE

21. PATIENT TRANSFERRED TO ICU TIME 1255 METHOD litter

22. R (b)(6)-2 WM

2

Blood Transfusion

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		5		
POST-	DAY	15Sep03		
MONTH-YEAR	DAY	Monday		
19	HOUR	2245	2300	2345

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

	2245	2300	2345
RESPIRATION RECORD	20	18	20
BLOOD PRESSURE	137/53	121/49	109/48
O2 Sat	100%	98%	97%
HEIGHT: / WEIGHT →			
Infusion Rate	200	200	200
			2nd unit PRBC completed

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

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

*U.S.GPO:1996-404-763/40069

15 Sep 03

511-14

Blood Transfusion

15 Sep 03

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY		15Sep03													
MONTH-YEAR	DAY	Monday													
19	HOUR	1950	1955	2000	2015	2030	2045	2100	2140	2145	2150	2155	2200	2215	2230
PULSE (O) / TEMP. F (•)		1st unit								2nd unit					
180	104°	(b)(6)-4									(b)(6)-4				
170	103°														
160	102°														
150	101°														
140	100°														
130	99°														
	98.6°														
120	98°														
110	97°														
100	96°														
90	95°														
80															
70															
60															
50															
40															
RESPIRATION RECORD		16	18	12	18	18	17	16	16	18	18	16	15	19	22
BLOOD PRESSURE		105/49	108/49	119/54	119/52	106/52	107/53	109/51	108/47	119/52	121/50	127/60	114/52	125/49	130/54
O2 Sat		98%	96%	99%	100%	98%	97%	99%	99%	100%	100	100	100	96%	100%
HEIGHT: WEIGHT →															
Infusion rate		50	50	50	↑200	200	200	200		50	50	50	↑200	200	200
Record special data only when so ordered		First unit initiated							first unit complete	Second unit initiated.					

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)*

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

NSN 7540-00-634-4124

VITAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4	5	6	7
DAY (YEAR 19)	22	23	24	25	26	27	28
HOUR	12 1 2	12 1 2	12 1 2	12 1 2	12 1 2	12 1 2	12 1 2

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered: Doppler Pulse

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD 17 — VITAL SIGNS RECORD

HOSPITAL DAY	~~17~~ 18	18	19	20	21	22	23
POST- DAY	14						
MONTH-YEAR / DAY	29	30	1 Oct	2 Oct	3	4	5
19 / HOUR	0 | 2	0 | 2	0 | 2	0 | 2	0 | 2	2 | 1	0 | 2

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 114/?? 114/52 | 108/51 | 111/46 114/47 | 103/47 | 105/? 124/53 | 111/54 | 112/49 112/52 | 106/53 | 110/52 100/50 | 113/54 | 126/? 106/? | 118/51 113/51 | 113/? 103/48 | 110/? (b)(6)-2

HEIGHT: WEIGHT → 97% | 97% | 97% | 99 | 98% | 98% | 98 | 98

SpO2: 96 | 97% | 98% | 97% | 97% | 97% | 99 | 99 | 99 | 99% | 99 | 97%

Doppler Pulse: +1 | +1

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.

(b)(6)-4

MEDCOM - 7284

NSN 7540-00-634-4124

EDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																							
DAY			24			25																	
TH-YEAR October	DAY		6			7			8			9											
2003	HOUR		0	1	2	0	1	2	0	1	2	0	1										
PULSE (O)	TEMP. F (•)		99	98	97	99	98	97	99	98	97	99	98										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)

ESPIRATION RECORD

Record special data only when so ordered	BLOOD PRESSURE		100/51	167/51		165/58		127/63															
			112/56	114/55		113/49	107/58	106/59															
	HEIGHT:	WEIGHT →																					
			99	177	98	98	98	98	99														
			99%		98%		98%		98%														
	Dontrpulse		+																				

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section:	Requestir ician:	ORATORY RESULT FORM ct to the Privacy Act of 1974)

Name: (b)(6)-4	Date: 13 Sept 03	Time: 1000	Patient #

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.462	7.31 - 7.45
PCO2	34.5	35 - 45: Art
PO2	535	80 - 105
HCO3	25	22 - 26
TCO2	26	23 - 27
BE	1	(-2) - 3
sO2	100	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	12.7	4.8 - 10.8 x 1E3
RBC	3.71	4.7 - 6.1 x 1E6
Hgb	11.1	14 - 18 g/dL (M); 12-16 (F)
Hct	33.0	45 - 52% (M); 37 - 47% (F)
MCV	89.0	80 - 99 fL
Plt	225	130 - 500 1E3
Lymph%	10.8	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #

Ward/Section: ICU

Requesting Physician: DR (b)(6)-2

Laboratory Result Form

LAST FIRST M] (b)(6)-4

DATE 13 Sept 03

TIME 1515

S

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	16.1	4.8-10.8 x 10
RBC	3.57	4.7-6.1 x 10
Hgb	10.6	14-18g/dl (M) 12-16 g/dl (F)
Hct	32.1	45-52% (M) 37-47% (F)
MCV	89.9	80-94 fl (M) 81-99 fl (F)
Plt	229	130-500 x 10 Verified
Lymph %	15.8	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	16.5	9.8-13.6 secs
APTT	40.3	21-34 secs
INR		

Urinalysis

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

Chem 7 [redacted] 8

TEST	RESULT	REF. RANGE
GLU	116	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
[redacted]		
NA*	136	128-145 mmol/l
K*	4.9	3.3-4.7 mmol/l
CL*	108	98-108 mmol/l
CO2	21	18-33 mmol/l

Microscopic UA

i-STAT EG7+

Pt: (b)(6)-4

Pt Name:_____

Na_____140 mmol/L
K_____4.4 mmol/L
TCO2_____23 mmol/L
iCa_____1.19 mmol/L
Hct_____25 %PCV
Hb*_____9 g/dL
*via Hct

At 37C
pH_____7.238
PCO2_____50.1 mmHg
PO2_____150 mmHg
HCO3_____21 mmol/L
BEecf_____-6 mmol/L
sO2*_____99 %
*calculated

At Patient Temp
pH_____7.264
PCO2_____46.2 mmHg
PO2_____139 mmHg

Patient Temp: 95.2F
FIO2_____: 45
Sample Type_: ART

13SEP03 15:15

Oper: [redacted] b(6)-2

Physician:_____

Ser# (b)(6)-4

Ver: (b)(6)-2

Results:

Remarks: ABG For all future ABG, Please Submit New Lab Sheet!

Reported (b)(6)-2

DATE: 13 SEP03

LAB ID NO. (b)(6)-4

CBC + ABG ICU

(Su ... o the Privacy Act of 1974)

LAST, FIRST, MI.	(b)(6)-4	DATE 13 SEP	TIME 1150	SSN/PSEUDO SSN: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.3	4.8-10.8 x 10^3
RBC	3.28	4.7-6.1 x 10^9
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.3	42-52% (M) 37-47% (F)
MCV	89.3	80-94 fl (M) 81-99 fl (F)
Plt	168	130-500 x 10^3 verified
Lymph %	9.4	20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		
pH		
Pro	35.6	
Uro	10.6	
Nit	31.7	
Leu	13.4	
HC		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative

TEST(S) SPECIMEN TAKEN — DATE 13 Sept TIME 1300 A.M. P.M.

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

ABG's CBC

REMARKS (b)(6)-2

Enter in above space REQUESTING PHYSICIAN SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE (b)(6)-4 (b)(6)-4

REPORTED BY

TECH MD DATE 13 Sept 03

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

pH	~~7.65~~	7.465
pCO2		34.5
pO2		547
BE		-1
HCO3		23
tCO2		24
SO2		100%
Ca2+		1.15

Ward/Section: EMT | Requestsician: (b)(6)-2

ORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: | Date: 13 Sept | Time: 0816 | Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT

ALB	3.8	3.5 - 5.5 g/dL
ALP	70	26 - 84 µg/dL
ALT	22	10 - 47 µg/dL
AMY	39	14 - 97 µg/dL
AST	39	11 - 38 µg/dL
Tbili	1.0	0.2 - 1.6 mg/dL
TP	6.7	6.4 - 8.1 g/dL
Ca	8.5	8.0 - 10.3 mg/dL
Chol	132	100 - 200 mg/dL
Creat	1.0	0.6 - 1.2 mg/dL
BUN	7	7 - 22 mg/dL
GLU	123	73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color	yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SGav.	1030	N/A
Bld	mod	Negative
pH	5.0	N/A
Prot	mod	Negative 55+ - 2+
Urob	norm	0.2 - 1.0
Nit	neg	Negative
Leuk	neg	Negative

Micro UA

3-5 H. casts

some amorp

Blood Gas

ph	7.433	7.31 - 7.45
PCO2	29.5	35 - 45: Art
PO2	133	80 - 105
HCO3	20	22 - 26
TCO2	21	23 - 27
BE	-5	(-2) - 3
sO2	99	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	14.7	4.8 - 10.8 x 1E3
RBC	4.71	4.7 - 6.1 x 1E6
Hgb	14.1	14 - 18 g/dL (M); 12-16 (F)
Hct	42.0	45 - 52% (M); 37 - 47% (F)
MCV	89.2	80 - 99 fL
Plt	315	130 - 500 1E3
Lymph%	11.7	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions: T+S

(b)(6)-2 | Date: 13 Sept 03 | Lab ID # (b)(6)-4

Ward/Section: | ues | sican:

ORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name:	Date:	Time:	Patient #

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.410	7.31 - 7.45
PCO2	34.4	35 - 45: Art
PO2	274	80 - 105
HCO3	22	22 - 26
TCO2	23	23 - 27
BE	-3	(-2) - 3
sO2	100	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	7.5	4.8 - 10.8 x 1E3
RBC	3.37	4.7 - 6.1 x 1E6
Hgb	10.1	14 - 18 g/dL (M); 12-16 (F)
Hct	29.7	45 - 52% (M); 37 - 47% (F)
MCV	88.3	80 - 99 fL
Plt	196	130 - 500 1E3
Lymph%	11.8	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #
(b)(6)-2	13 Sept 0	(b)(6)-4

Post - infusion

Ward/Section: (b)(6)-4	Requesting Physician: Dr (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

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

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	9.3	4.8-10.8 x 10
RBC	3.69	4.7-6.1 x 10
Hgb	11.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	32.7	45-52% (M) 37-47% (F)
MCV	88.6	80-94 fl (M) 81-99 fl (F)
Plt	161	130-500 x 10 Verified
Lymph %	9.4	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

Chem 7 [redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 14 Sept 08	LAB ID NO: (b)(6)-4

/ard/Section: I Clk

Requesting Physican: Dr (b)(6)-2

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

ame: (b)(6)-4

Date: 14 Sep 03

Time: 0800

Patient # 1 (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	110	73 - 118 mg/dL
BUN	7	7 - 22 mg/dL
Creat	0.9	0.6 - 1.2 mg/dL
Na	133	128 - 125 mmol/L
K	4.1	3.3 - 4.7 mmol/L
Cl	102	98 - 108 mmol/L
tCO2	24	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	2828	39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph	7.397	7.31 - 7.45
PCO2	45.1	35 - 45: Art
PO2	92	80 - 105
HCO3	28	22 - 26
TCO2	29	23 - 27
BE	3	(-2) - 3
sO2	97	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	8.8	4.8 - 10.8 x 1E3
RBC	2.90	4.7 - 6.1 x 1E6
Hgb	8.7	14 - 18 g/dL (M); 12-16 (F)
Hct	25.6	45 - 52% (M); 37 - 47% (F)
MCV	88.3	80 - 99 fL
Plt	181	130 - 500 1E3
Lymph%	16.3	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Iditional Instructions:

:ported By (b)(6)-2

Date 14 S

Lab ID #

MEDCOM - 7293

/ard/Section: ICU

Requesting Physican: Dr (b)(6)-2

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

ame (b)(6)-4

Date: 15 Sep 03

Time: 0520

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	91	73 - 118 mg/dL
BUN	6	7 - 22 mg/dL
Creat	0.7	0.6 - 1.2 mg/dL
Na	135	128 - 125 mmol/L
K	4.1	3.3 - 4.7 mmol/L
Cl	97	98 - 108 mmol/L
tCO2	25	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	>5000	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.387	7.31 - 7.45
PCO2	49.3	35 - 45: Art
PO2	148	80 - 105
HCO3	29	22 - 26
TCO2	31	23 - 27
BE	4	(-2) - 3
sO2	99	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	7.2	4.8 - 10.8 x 1E3
RBC	2.96	4.7 - 6.1 x 1E6
Hgb	8.8	14 - 18 g/dL (M); 12-16 (F)
Hct	26.0	45 - 52% (M); 37 - 47% (F)
MCV	88.1	80 - 99 fL
Plt	127	130 - 500 1E3
Lymph%	12.6	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By (b)(6)-2

Date 15

Lab ID #

MEDCOM - 7294

1° Post Heparin Infusion

Ward/Section: ICU	Requesting Physician: Dr (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE 15 Sept 03	TIME	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	2.9	4.8-10.8 x 10
RBC	2.89	4.7-6.1 x 10
Hgb	8.7	14-18g/dl (M) 12-16 g/dl (F)
Hct	26.1	45-52% (M) 37-47% (F)
MCV	90.1	80-94 fl (M) 81-99 fl (F)
Plt	134	130-500 x 10 Verified
Lymph %	17.7	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	13.4	9.8-13.6 secs
APTT	56.1	21-34 secs
INR		

Urinalysis

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

Chemis [redacted]

TEST	RESULT	REF. RANGE
GLU	97	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
[redacted]		
NA*	138	128-145 mmol/l
K*	4.2	3.3-4.7 mmol/l
CL*	102	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results: ABG, CBC, Chems & Coag Panel

1° after Heparin Infusion

Remarks:

Report (b)(6)-2 DATE: LAB ID NO:

pH 7.424

PCO2 - 44.0

PO2 102

BE 4

HCO3 - 29

TCO2 - 30

SO2 98%

[redacted]

[redacted]

* Please SUBMIT New Lab Forms when requesting ABG

(b)(6)-2

Ward/Section: ICU	Requesting Physician: Dr (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE J	TIME 1700	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	5.4	4.8-10.8 x 10
RBC	2.77	4.7-6.1 x 10
Hgb	8.4	14-18g/dl (M) 12-16 g/dl (F)
Hct	24.5	45-52% (M) 37-47% (F)
MCV	88.5	80-94 fl (M) 81-99 fl (F)
Plt	142	130-500 x 10 Verified
Lymph %	12.6	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	12.8	9.8-13.6 secs
APTT	37.7	21-34 secs
INR		

Urinalysis

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

CHEM 8 [redacted]

TEST	RESULT	REF. RANGE
GLU	192	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
[redacted]		
NA*	133	128-145 mmol/l
K*	4.0	3.3-4.7 mmol/l
CL*	103	98-108 mmol/l
CO2	30	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results: ABG →

Microscopic UA

Results:

ABG, CBC, Chem 8 Type & Cross Coags 2 units

Remarks:

Reported by: (b)(6)-2 | DATE: 15 SEP 03 | LAB ID NO:

1730 — Temp 99.9 Tympanic

pH	7.446
pCO_2	41.3
pO_2	100
BE	4
HCO_3	28
TCO_2	30
SO_2	92%

[redacted]

[redacted]

2500 bolus 1400 u/hr Rem .6°

/ard/Section: ICU

Requesting Physican: Dr (b)(6)-2

ame: (b)(6)-4

Date: 16 Sep 03

Time: 0130

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	104	73 - 118 mg/dL
BUN	7	7 - 22 mg/dL
Creat	0.6	0.6 - 1.2 mg/dL
Na	132	128 - 125 mmol/L
K	4.0	3.3 - 4.7 mmol/L
Cl	101	98 - 108 mmol/L
tCO2	24	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	486	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.432	7.31 - 7.45
PCO2	43	35 - 45: Art
PO2	83	80 - 105
HCO3	29	22 - 26
TCO2	30	23 - 27
BE	4	(-2) - 3
sO2	96	95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	8.5	4.8 - 10.8 x 1E3
RBC	3.4	4.7 - 6.1 x 1E6
Hgb	~~29.3~~ 9.7	14 - 18 g/dL (M); 12-16 (F)
Hct	29.3	45 - 52% (M); 37 - 47% (F)
MCV	58.6	80 - 99 fL
Plt	128	130 - 500 1E3
Lymph%	12.9	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	13.0	9.8 - 13.6 sec
aPTT	32.8	21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported (b)(6)-2

Date

Lab ID #

MEDCOM - 7299

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	16 Sep 03	0015	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	12.7	9.8-13.6 secs
APTT	35.9	21-34 secs
~~INR~~		

Urinalysis

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

CHEM 7 [redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

(b)(6)-2	DATE: 16 Sept 03	LAB ID NO: (b)(6)-4

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	16 Sep 03	0800	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	7.1	4.8-10.8 x 10
RBC	3.29	4.7-6.1 x 10
Hgb	9.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	29.5	45-52% (M) 37-47% (F)
MCV	89.5	80-94 fl (M) 81-99 fl (F)
Plt	141	130-500 x 10 Verified
Lymph %	20.4	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	12.7	9.8-13.6 secs
APTT	45.2	21-34 secs
INR		

Urinalysis

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

CHEM 7 [redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results: Repeated.

Remarks:

Reported by:	(b)(6)-2	DATE: 16 Sep 03	LAB ID NO:

Ward/Section: ICU	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 16 Sep 03	TIME 1200	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	13.6	9.8-13.6 secs
APTT	49.2	21-34 secs
INR		

Urinalysis

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

CHEM 7 [redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 16 SEP 03	LAB ID NO:

Ward/Section: ICU	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 17 Sep 03	TIME 1515	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	13.3	9.8-13.6 secs
APTT	45.9	21-34 secs
INR		

Urinalysis

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

MET

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 17 SEP 03	LAB ID NO:

Ward/Section: ICU	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 17 Sep 03	TIME 0400	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	4.7	4.8-10.8 x 10
RBC	3.16	4.7-6.1 x 10
Hgb	9.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	28.3	45-52% (M) 37-47% (F)
MCV	89.5	80-94 fl (M) 81-99 fl (F)
Plt	149	130-500 x 10 Verified
Lymph %	25.9	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	13.8	9.8-13.6 secs
APTT	45.2	21-34 secs
INR		

Urinalysis

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

CHEM 7 [redacted]

TEST	RESULT	REF. RANGE
GLU	98	73-118 mg/dl
BUN	5	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
[redacted]		
NA*	132	128-145 mmol/l
K*	3.8	3.3-4.7 mmol/l
CL*	105	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

R (b)(6)-2	DATE: 17 Sep 03	LAB ID NO: (b)(6)-4

bolus 1000
↑ rate to 1800 units / hr

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	17 Sep 03	2200	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	13.4	9.8-13.6 secs
APTT	35.9	21-34 secs
INR		

Urinalysis

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

MET [redacted] 7

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	DATE:	LAB ID NO:
(b)(6)-2	17 Sep 03	(b)(6)-4

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
FCU	Dr (b)(6)-2	

LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	18 Sep 03	2250	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	15.1	9.8-13.6 secs
APTT	57.3	21-34 secs
INR		

Urinalysis

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

(b)(6)-4	DATE: 18 Sep	LAB ID NO: (b)(6)-4

Ward/Section: ICU	Request[illegible] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
Name: (b)(6)-4	Date: 18 Sep 03 / Time: 1400	Patient (b)(6)-4

Chemistry 7			Urinalysis			Hematology (CBC)		
Test	Result	Ref. Range	Test	Result	Ref.Range	Test	Result	Ref. Range
GLU		73 - 118 mg/dL	Color		N/A	WBC		4.8 - 10.8 x 1E3
BUN		7 - 22 mg/dL	App		N/A	RBC		4.7 - 6.1 x 1E6
Creat		0.6 - 1.2 mg/dL	Glu		Negative	Hgb		14 - 18 g/dL (M); 12-16 (F)
Na		128 - 125 mmol/L	Bili		Negative	Hct		45 - 52% (M); 37 - 47% (F)
K		3.3 - 4.7 mmol/L	Ket		Negative	MCV		80 - 99 fL
Cl		98 - 108 mmol/L	SGav.		N/A	Plt		130 - 500 1E3
tCO2		18 - 33 mmol/L	Bld		Negative	Lymph%		20.5 - 51.1 %
Chemistry 12/LFT			pH		N/A	**Hematology Manual Diff**		
ALB		3.5 - 5.5 g/dL	Prot		Negative	Segs		Lymph
ALP		26 - 84 µg/dL	Urob		0.2 - 1.0	Bands		Atyp
ALT		10 - 47 µg/dL	Nit		Negative	Mono		Imm
AMY		14 - 97 µg/dL	Leuk		Negative	Eos		RBC Morph
AST		11 - 38 µg/dL	Micro UA			Baso		~~Plt. Est~~
Tbili		0.2 - 1.6 mg/dL				**Coagulation**		
TP		6.4 - 8.1 g/dL				PT	12.9	9.8 - 13.6 sec
Ca		8.0 - 10.3 mg/dL				aPTT	56.6	21 - 34 sec
Chol		100 - 200 mg/dL				INR		N/A
Creat		0.6 - 1.2 mg/dL				**MISC**		
BUN		7 - 22 mg/dL	**Blood Gas**			Malaria		Negative
GLU		73 - 118 mg/dL	ph		7.31 - 7.45	Gram Stain		N/A
Other Chem			PCO2		35 - 45: Art	UA Tox:		Negative
Troponin		Negative	PO2		80 - 105	HCG		Negative
GLU Only		73 - 118 mg/dL	HCO3		22 - 26			
CK		39 - 380 µg/L - Male	TCO2		23 - 27			
		30 - 190 µg/L - Female	BE		(-2) - 3			
			sO2		95 - 100%			

Additional Instructions:

Reported By (b)(6)-2	Date 18 SEP 03	Lab ID #

MEDCOM - 7307

/ard/Section: ICU | Reque. Physican: Dr (b)(6)-2

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

ame: (b)(6)-4 | Date: 18 Sep 03 | Time: 0540 | Patient # (b)(6)-4

Chemistry 7

est	Result	Ref. Range
GLU	96	73 - 118 mg/dL
BUN	7	7 - 22 mg/dL
Creat	0.5	0.6 - 1.2 mg/dL
Na	131	128 - 125 mmol/L
K	3.7	3.3 - 4.7 mmol/L
Cl	101	98 - 108 mmol/L
EC O2	23	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

oponin		Negative
LU Only		73 - 118 mg/dL
CK	970	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.423	7.31 - 7.45
PCO2	42.0	35 - 45: Art
PO2	87	80 - 105
HCO3	28	22 - 26
TCO2	29	23 - 27
BE	3	(-2) - 3
sO2	97	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	3.8	4.8 - 10.8 x 1E3
RBC	3.14	4.7 - 6.1 x 1E6
Hgb	9.4	14 - 18 g/dL (M); 12-16 (F)
Hct	27.6	45 - 52% (M); 37 - 47% (F)
MCV	87.9	80 - 99 fL
Plt	182	130 - 500 1E3
Lymph%	22.3	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	12.8	9.8 - 13.6 sec
aPTT	43.1	21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #

Ward/Section: ICU

Requesting Physician: Dr (b)(6)-2

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 19 Sep 03

Time: 0500

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	98	73 - 118 mg/dL
BUN	8	7 - 22 mg/dL
Creat	0.7	0.6 - 1.2 mg/dL
Na	133	128 - 125 mmol/L
K	3.9	3.3 - 4.7 mmol/L
Cl	102	98 - 108 mmol/L
tCO2	26	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	559	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	5.3	4.8 - 10.8 x 1E3
RBC	3.15	4.7 - 6.1 x 1E6
Hgb	9.4	14 - 18 g/dL (M); 12-16 (F)
Hct	28.2	45 - 52% (M); 37 - 47% (F)
MCV	89.6	80 - 99 fL
Plt	222	130 - 500 1E3
Lymph%	18.6	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	13.4	9.8 - 13.6 sec
aPTT	66.1	21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #

MEDCOM - 7309

Ward/Section: ICU

Requesting Physician: Dr (b)(6)-2

LAST, FIRST, MI (b)(6)-4

Laboratory Result Form

(Subject to the Privacy Act of 1974)

20 Sep 03 TIME 0550

SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	6.1	4.8-10.8 x 10
RBC	3.12	4.7-6.1 x 10
Hgb	9.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	28.2	45-52% (M) 37-47% (F)
MCV	90.4	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10 Verified
Lymph %	17.9	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
ymph		
typ		
BC		
orph		
an		
natocrit		42-52% (M) 37-47% (F)
Rate		
er		

Coagulation Studies

Result	Ref. Range
14.4	9.8-13.6 secs
66.4	21-34 secs

Urinalysis

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU	55	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
[redacted]		
NA*	137	128-145 mmol/l
K*	4.4	3.3-4.7 mmol/l
CL*	101	98-108 mmol/l
CO2	25	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

s:

(b)(6)-2

DATE: (b)(6)-2

Ward/Section: ICU	Requesting Physician: Dr. (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

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

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	7.1	4.8-10.8 x 10
RBC	3.32	4.7-6.1 x 10
Hgb	10.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	30.2	45-52% (M) 37-47% (F)
MCV	90.8	80-94 fl (M) 81-99 fl (F)
Plt	352	130-500 x 10 Verified
Lymph %	16.8	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 20 Sep 03	LAB ID NO: (b)(6)-4

d/Section:	Requesting Physician:	Laboratory Result Form
ICU	(b)(6)-2	(Subject to the Privacy Act of 1974)

ST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	21 Sep03	1615	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	10.6	4.8-10.8 x 10
RBC	3.36	4.7-6.1 x 10
Hgb	10.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	30.7	45-52% (M) 37-47% (F)
MCV	91.3	80-94 fl (M) 81-99 fl (F)
Plt	358	130-500 x 10 Verified
Lymph %	11.2	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

MET[redacted]7

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
[redacted]		
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	DATE:	LAB ID NO:
(b)(6)-2	21 Sep 03	

Ward/Section: ICU	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE: 20 Sept	TIME: 0500	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	6.6	4.8-10.8 x 10
RBC	2.86	4.7-6.1 x 10
Hgb	8.4	14-18g/dl (M) 12-16 g/dl (F)
Hct	25.9	45-52% (M) 37-47% (F)
MCV	90.7	80-94 fl (M) 81-99 fl (F)
Plt	348	130-500 x 10 Verified
Lymph %	15.1	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

Test	Result	Ref. Range
PT	12.4	9.8-13.6 secs
APTT	27.4	21-34 secs
INR		

Urinalysis

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

MET[redacted]7

TEST	RESULT	REF. RANGE
GLU	103	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.3	0.6-1.2 mg/dl
[redacted]		
NA*	127	128-145 mmol/l
K*	4.5	3.3-4.7 mmol/l
CL*	96	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

(b)(6)-2	DATE: 21 Sept	LAB ID NO:

Ward/Section: ICU	Requesting Physican (b)(6)-2		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
Name: (b)(6)-4	Date: 22 S	Time: 0530	Patient # (b)(6)-4 EPW

Chemistry 7

Test	Result	Ref. Range
GLU	108	73 - 118 mg/dL
BUN	10	7 - 22 mg/dL
Creat	1.0	0.6 - 1.2 mg/dL
Na	136	128 - 125 mmol/L
K	4.5	3.3 - 4.7 mmol/L
Cl	97	98 - 108 mmol/L
tCO2	22	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	7.1	4.8 - 10.8 x 1E3
RBC	3.37	4.7 - 6.1 x 1E6
Hgb	10.0	14 - 18 g/dL (M); 12-16 (F)
Hct	30.6	45 - 52% (M); 37 - 47% (F)
MCV	90.9	80 - 99 fL
Plt	346	130 - 500 1E3
Lymph%	18.2	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	14.4	9.8 - 13.6 sec
aPTT	27.6	21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By (b)(6)-2	Date 22 S	Lab ID # (b)(6)-4

Ward/Section: ICW

F... ...ing ...can: (b)(6)-2 (b)(6)-2

...RATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 24 Sep 03 Time: 0837

Patient # (b)(6)-4

Chemistry 7		
Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na	135	128 - 125 mmol/L
K	3.5	3.3 - 4.7 mmol/L
Cl	100	98 - 108 mmol/L
CO2	29	18 - 33 mmol/L

Chemistry 12/LFT		
ALB	3.1	3.5 - 5.5 g/dL
ALP	82	26 - 84 µg/dL
ALT	58	10 - 47 µg/dL
AMY	39	14 - 97 µg/dL
AST	54	11 - 38 µg/dL
Tbili	0.7	0.2 - 1.6 mg/dL
TP	7.1	6.4 - 8.1 g/dL
Ca	8.9	8.0 - 10.3 mg/dL
Chol	192	100 - 200 mmol/L
Creat	1.0	0.6 - 1.2 mg/dL
BUN	16	7 - 22 mg/dL
GLU	107	73 - 118 mg/dL

Other Chem		
Troponin		Negative
Glucose		73 - 118 mg/dL
		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis		
Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)		
Test	Result	Ref. Range
WBC	7.5	4.8 - 10.8 x 1E3
RBC	3.91	4.7 - 6.1 x 1E6
Hgb	11.6	14 - 18 g/dL (M); 12-16 (F)
Hct	36.2	45 - 52% (M); 37 - 47% (F)
MCV	92.6	80 - 99 fL
Plt	562	130 - 500 1E3
Lymph%	13.8	20.5 - 51.1 %

Hematology Manual Diff	
Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

(b)(6)-2

Date: 24 Sep 03

Lab ID #

MEDCOM - 7315

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)						TOTALS
Fent	(mcg)	100		50	50	50	
Nimbex	(mg)		4	4		2	
	( )						
	( )						
	( )						
	( )						
VOLAT AGENT: ISO	% del / % e.t.	X ~ 2.0 ~ 2.0 ~ 2.0 ~ 1.0 ~ 1.0 ~ 1.2 ~ 1.4 ~ 1.4 ~ 1.4 ~ 1.4					
AIR	L/Min						
N2O	L/Min						
O2	L/Min	X ~ 2 ~ 2 ~ 2 ~ 2 ~ 2 ~ 2 ~ 2 ~ 2 ~ 2 ~ 2					

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

TOTAL EBL

TOTAL URINE —

FLUIDS — SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

FLUIDS

LINE site		
LR	☐ Warmed	(1000) ... (2000)
NS	☐ Warmed	X ... (1000)
Hespan	☐ Warmed	X ~ (500)
Blood	☐ Warmed	X #1 ~ #2 ~ X

LOSSES
EST BLOOD LOSS — 400
URINE — 300 ... 150/450

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

BODY WEIGHT 70 (KG) LB

HEMATOCRIT

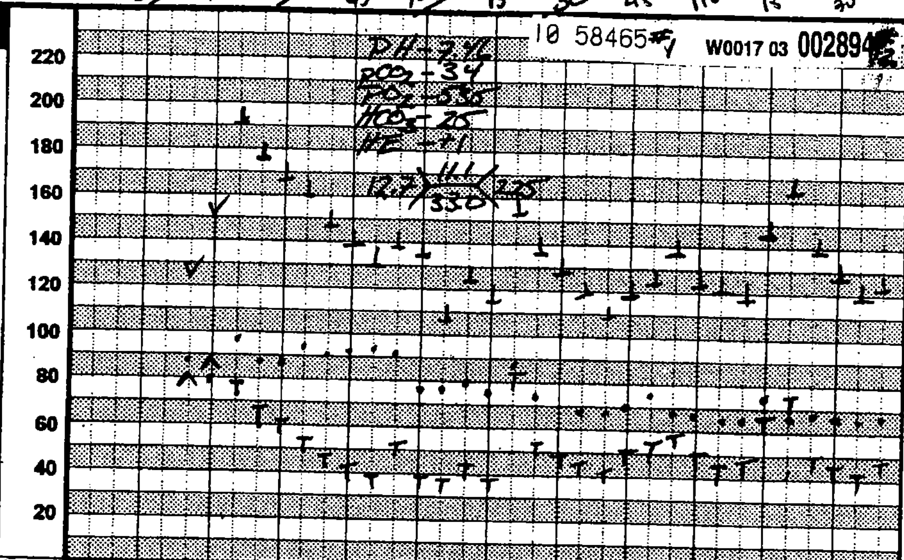
INITIAL DATA: BP – 130/84 Ambu Bag; HR – 88

EQUIP CHECK OK? – (Y) N

PATIENT RECHECK OK for PROCEDURE? Y; TIME – 0910

TIME → 0900, 15, 30, 45, 1000, 15, 30, 45, 1100, 15, 30

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



	0900	15	30	45	1000	15	30	45	1100	15
VT – ml	930	920	950	950	1000	1010	1000	1000	1000	1000
f – breaths/min	8	8	8	10	8	8	8	8	8	8
Peak inf pres / PEEP	19	20	20	23	23	23	23	23	23	23
MODE – S(pon), A(ssist), C(on)	A	C	C	C	C	C	C	C	C	C
✓ ET CO2 (torr)	(+)	32	29	29	34	26	27	25	23	25	27
✓ FIO2 (Frac or %)	.83	.83	.83	.83	.83	.82	.83	.84	.84	.84	.84
✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
✓ TEMP- site skin				96.8		96.8					
✓ N-M Block (T/4)		0/4		1/4		3/4	0/4			1/4	

MONITORS / ACCESSORIES: ✓ BP/Auto Cuff; BP / oth; ✓ ART line (L) rad; Steth- PC/ES; ✓ Gas analyzer; Tourniquet @ 275 mmHg — total time 87 mins; Warming blkt; Conv warmer

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

REMARKS– Code drugs with numbers, events with letters

0830 In EMT, to asst c airway manag and c sedation SEE EMT sheet for Meds; V.S.
0910 to OR c (R) thigh Tourniquet ↑ @ 275 mmHg total of 2.5 L Crystalloid ∴ EMT gave last 50mcg Fent from EMT
0930 Surg aware of 60 mins Tourniquet time
1145 Cont to Page #2

RECOVERY AT PACU ICU ____ (Specify) OTHER SEE Page #3; CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0910	1510

	Ready	Begin	End
PROC	0910	0935	1455

PROCEDURES and CPT Codes
I&D (R) lower leg c Vascular Repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: intubation route, blade, technique, comments — Intubated in EMT

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

(b)(6)-4

(b)(6)-4

SURGEONS: (b)(6)-2 / (b)(6)-2

ANESTHETISTS: (b)(6)-2

MAJ (b)(6)-2 AN, CRNA — Certified Registered Nurse Anesthetist

PROCEDURE LOCATION 1-1

DATE 13 Sept 03

PAGE 1 **OF** 3

WAMC OP 376 REVISED 1 Jan 99

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)												
Nimbex	(mg)	4	4	2									
MSO4	(mg)							5			3	2	
VOLAT AGENT: ISO	% del / % e.t.	~1.4	~1.0	~1.0	~1.0	~1.0	~1.0	~1.0	~1.0	~1.0	~2.0	~1.5	~1.2	~0.8
AIR	L/Min													
N2O	L/Min													
O2	L/Min	~2	~2	~2	~2	~2	~2	~2	~2	~2	~2	~2	~2	~2

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

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

FLUIDS		
LINE site 2000 LR	☐ Warmed	3000
1000 NS	☐ Warmed	
500 Hespan	☐ Warmed	
500 Blood	☐ Warmed	

LOSSES	
400	EST BLOOD LOSS
450	URINE – 550 / 350 / 300 / 400 / 1700 / 100 / 1900

TOTALS	
	TOTAL IN
	TOTAL URINE
	FLUIDS – SUMMARY
	CRYSTALLOID–
	COLLOID–
	BLOOD–

REMARKS... Code drugs with numbers, events with letters

1145 Cont From Page #1

1445 Cont to Page #3

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

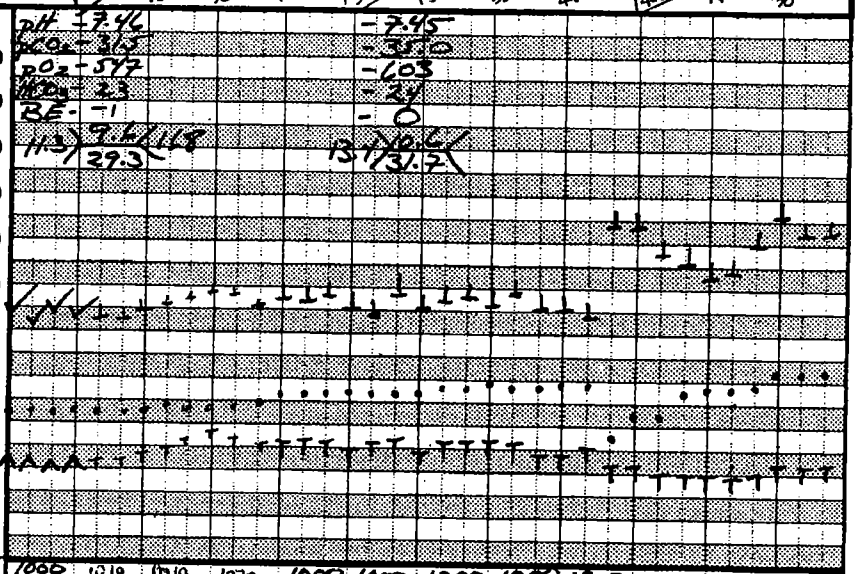
INITIAL DATA: BP – 130/84 Ambu Bag; HR – 88

COMP CHECK: OK? – (Y) N

PATIENT TROUBLE: OK for PROCEDURE? Y; TIME – 0910

TIME → 1200, 15, 30, 45, 1300, 15, 30, 45, 1400, 15, 30

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



VENTILATION												
VT – ml	1000	1010	1010	1030	1000	1000	1000	1000	1000			
f – breaths/min	8	8	8	8	8	8	8	8	8	10	9	16
Peak inf pres / PEEP	23	23	23	23	23	23	23	25	25			
MODE – S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	S	S	S
ET CO2 (torr)	24	23	23	24	24	24	25	25	25	38	39	37
FIO2 (Frac or %)	.84	.84	.84	.84	.84	.84	.83	.83	.83	.82	.82	.82
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site Skin	96	96	96	96	96	97	97	97	97	97	97	97
N-M Block (T/4)	3/4	4/4	4/4	4/4		4/4		4/4				

MONITORING & EQUIPMENT: ✓ BP/Auto Cuff; BP / oth; ✓ ART line; Steth- PC/ES; ✓ Gas analyzer; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS — Position: arms <90°, secured on padded armboards

RECOVERY AT: PACU ICU ____ (Specify); OTHER SEE; CONDITION: Page #3; RESP– SpO2– BP HR–

	Start	Room	End
ANES	0830	0910	1510
	Ready	Begin	End
PROC	0910	0935	1435

PROCEDURES and CPT Codes: I&D (R) lower leg & Vascular Repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SEE EMT sheet

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

SURGEONS: (b)(6)-2 / (b)(6)-2

ANESTHETISTS: (b)(6)-2 (b)(6)-2 MATT AN, CRNA Nurse Anesthetist

PROCEDURE LOCATION: 1-1

DATE: 13 Sept

PAGE 2 OF 3

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 7317

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

MEDICAL RECORD — ANESTHESIA

DRUG	Dosage	
Versed	(mg)	2
	( )	
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT	ISO % del / % e.t.	X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	R

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

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

FLUIDS		
LINE site 400 LR	☐ Warmed	
(1000) NS	☐ Warmed	
(500) Hespan	☐ Warmed	
(500) Blood	☐ Warmed	

LOSSES	
400	EST BLOOD LOSS
1900	URINE –

TOTALS	
TOTAL IN	400
TOTAL URINE	2000

FLUIDS – SUMMARY

CRYSTALLOID– 5000

COLLOID– 500

BLOOD– 500

REMARKS – Code drugs with numbers, events with letters

1445 Cont From page #2

1455 pt sr good TV pt MAEW Extubated c̄ pos. pics p̄ suctioning

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT:

INITIAL DATA: BP – 130/84 Amber Bray; HR – 88

TEMP CHECK: OK? – Y N

PATIENT READINESS: OK for PROCEDURE? Y; TIME – 0910

TIME → 1500

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

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

VENTILATION	
VT – ml	
f – breaths/min	12
Peak inf pres / PEEP	
MODE – S(pon), A(ssist), C(on)	S

MONITORING		
BP/Auto Cuff	ET CO2 (torr)	44
BP / oth	FIO2 (Frac or %)	.83
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	SR
Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS

Position → on

RECOVERY AT 1500

PACU (ICU) _____ (Specify)

OTHER _____

CONDITION: stable

T-95.2 RESP-24 SpO2-96 BP-190/62 HR-150

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0830	0910	1510
PROC	Ready	Begin	End
	0910	0935	1455

PROCEDURES and CPT Codes: I/D R/lower leg c̄ Vascular Repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SEE EMT sheet

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

(b)(6)-4

(b)(6)-4

SURGEONS: (b)(6)-2 (b)(6)-2

ANESTHETISTS: (b)(6)-2 (b)(6)-2 MAJ AN/CRNA

Attending Anesthetist

PROCEDURE LOCATION 1-1

DATE 13 Sept03

PAGE 3 OF 3

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7318

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

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Versed	(mg)	2												
Fent	(mcg)	250												
STP	(mg)	300		200										
Sux//Roc	(mg)	100		35/20				10		10		10		
MSO4	(mg)				4				4	2 2				
	( )													
VOLAT AGENT	Iso % del	X	1.5	2.0	2.0	2.0	1.5	1.5	1.5	1.5	1.5	1.0	0.6	
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	X-8	2	2	2	2	2	2	2	2	2	2	2	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 1000 Ancefin 1GM over 20 mins; 1020 Primaxin 500mg 20 mins

FLUIDS — LINE site: LR ☐ Warmed (250) (500) (800) (1000); ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE - 200 80/200

MEDICATIONS — 1 2 3 4 5 E

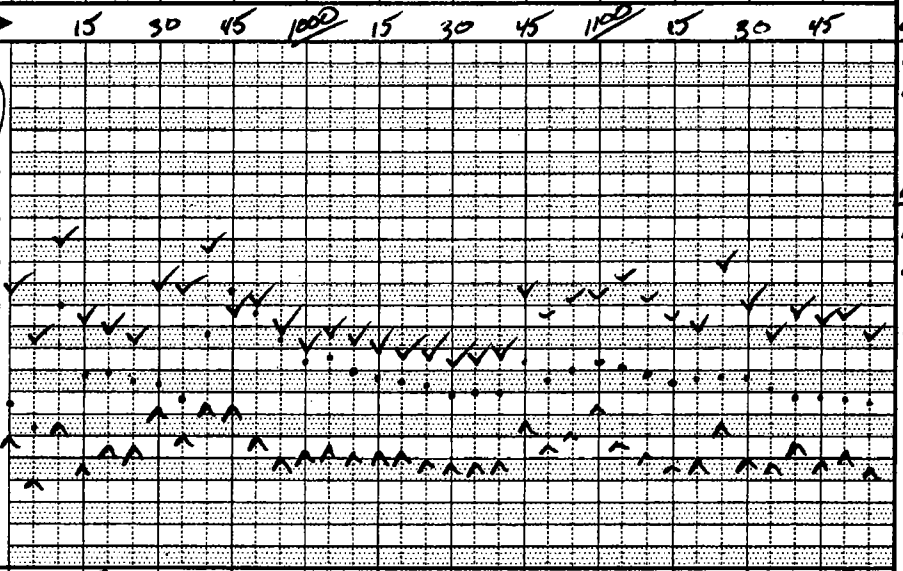
BODY WEIGHT — 70 KG (LB)

HEMATOCRIT

INITIAL DATA — BP- 128/60 R-14; HR- 78

EQUIP CHECK — OK?- (Y) N

PATIENT RECHECK — OK for PROCEDURE? Y; TIME- 0900



VENTIL.

VT - ml		900		1000	1000	1000	1000	1000	1020	960	900	850
f - breaths/min		8	6	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP		19		22	22	22	22	23	23	21	20	26
MODE - S(pon), A(assist), C(on)	S/A	C	A	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	(7)	34	40	32	28	28	28	28	28	27	28	29
BP/oth / FIO2 (Frac or %)	.82	.82	.82	.81	.81	.81	.82	.82	.82	.82	.83	.83
ART line / SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site												
N-M Block (T/4)	0/4		1/4	2/3	0/4	0/4	2/4	1/4		4/4	0/4	1/4
Warming blkt												
Cooling blanket												

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

TOTALS	TOTAL EBL
	TOTAL URINE
	-

FLUIDS SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

0845 ~~In Rm~~ MPT ID'd; chart Reviewed

0900 In Rm Monitors On

0905-0910 Induction; Intubation

1005 5,000 u Heparin IV per Surg.

1200 Cont. to page #2

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0845	0900	1235
	Ready	Begin	End
PROC	0910	0935	1205

PROCEDURES and CPT Codes: I&D/Washout of (R) lower leg GSW/Art Graft Revision

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

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

(b)(6)-4

(b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLX 1½ Mil Vis/Tred Cords; Intubated c 8.0 to 24 cm @ lip Bilat BS; ETCO2 X5 waves, Eyes taped

SURGEONS: (b)(6)-2 / (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 AN, CRNA; (b)(6)-2 Nurse Anesthetist

PROCEDURE LOCATION: 1-1

DATE: 15 Sept

PAGE 1 OF 2

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)
	( )
	( )
	( )
	( )
	( )
Neostig/Glyco(mg)	
Iso % del	X
% e.t.	
AIR	L/Min
N2O	L/Min
O2	L/Min 4-8-8

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

FLUIDS

LINE site AR 18G	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS 400 / URINE - 1100

PHYSIOLOGICAL MONITORING — 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

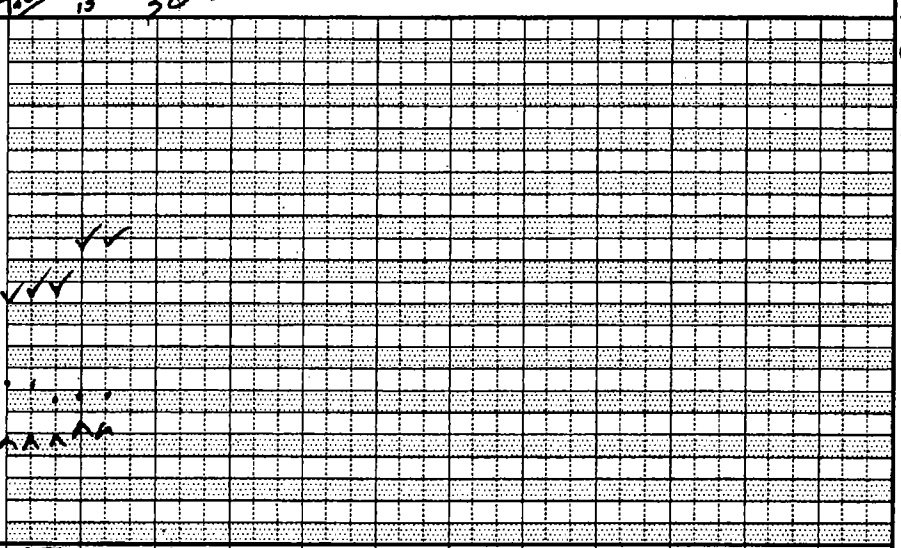
INITIAL DATA: BP- 128/60 P-14 HR- 78

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0900

TIME 200 15 30

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



VENTIL

VT - ml	650	
f - breaths/min	8	10
Peak inf pres / PEEP	17	
MODE - S(pon), A(assist), C(on)	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	31	54
BP/oth	FIO2 (Frac or %)	.83	.83
ART line	SpO2 (%)	100	100
Stath- PC/ES	ECG	SR	SR
Gas analyzer	TEMP-site		
	N-M Block (T/4)	T/4 ZST	
Warming blkt			
Conv warmer			

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

TOTALS	
TOTAL EBL	50
TOTAL URINE	1100

FLUIDS - SUMMARY
CRYSTALLOID- 1200
COLLOID- ∅
BLOOD- ∅

REMARKS
Code drugs with numbers, events with letters

1200 Cont From Page #1
1220 pt SR good TV pt Following Commands Extubated pos. pres Suctioning

RECOVERY AT 1225
PACU (ICU) (Specify)
OTHER
CONDITION: Stable
RESP- 16, SpO2- 100
BP- 123/47 HR- 103

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0845	0900	1235
PROC	Ready	Begin	End
	0910	0935	1205

PROCEDURES and CPT Codes: I&D / Washout of (R) lower leg GSW / Art Graft Revision

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

(b)(6)-4

(b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SEE Page #1

SURGEONS: (b)(6)-2 / (b)(6)-2 / (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 AN, CRNA (b)(6)-2 Nurse Anesthetist (b)(6)-2

PROCEDURE LOCATION: 1-1

DATE: 15 Sept 03

PAGE 2 OF 2

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Versed	(mg)	3
Fent	(mcg)	100, 50
Propofol	(mg)	150
	( )	
	( )	
	( )	
VOLAT AGENT: Iso	% del / % e.t.	X-1.0-2.6-0.6-X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-8-2-2-2-2-8

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

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

TOTALS	
TOTAL BP	MIN
TOTAL URINE	∅

FLUIDS – SUMMARY
CRYSTALLOID– 700
COLLOID– ∅
BLOOD– ∅

FLUIDS
LINE site LR ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

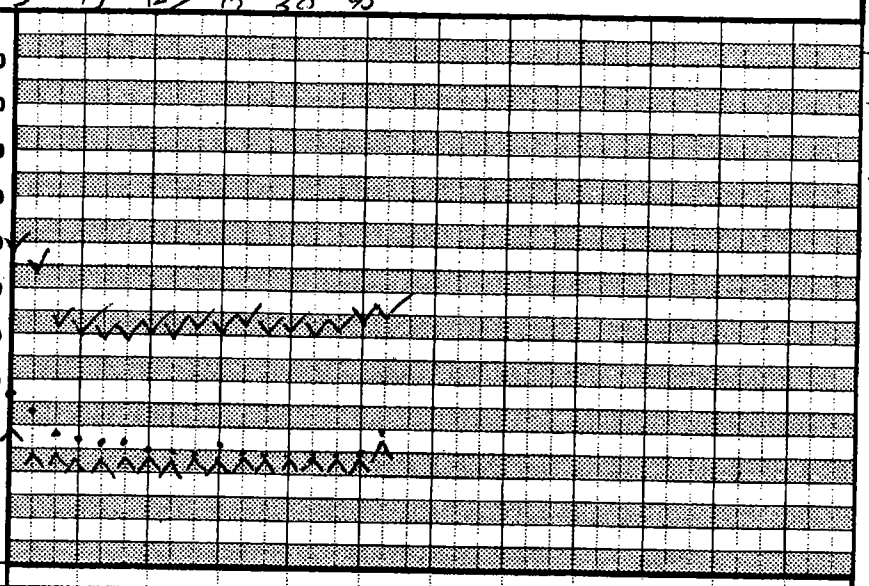
INITIAL DATA: BP – 136/60 R-18; HR – 76

TEMP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? ✓; TIME – 1130

SYMBOLS: BP by cuff V ^; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✗; ANES – X-X; PROC – ⊙ – ∅

TIME → 30 45 1200 15 30 45



VT – ml						
f – breaths/min	12	6	7	10	10	14
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S
BP/Auto Cuff / ET CO2 (torr)	(+)	50	50	45	43	(+)
BP / oth / FIO2 (Frac or %)	.90	.90	.90	.89	.89	.89
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ECG	SB	SB	SB	SB	SB	SB
Gas analyzer / TEMP- site						
N-M Block (T/4)						
Warming blkt						
Conv warmer						

REMARKS–
Code drugs with numbers, events with letters
1120 pt. IDD & pla of Care Reviewed w pt
1130 IV Rm Monitors
1132-1134 Induction & LMA placement
1250 pt. Following commands LMA Removed & pos. pres.

RECOVERY AT 1253
PACU ICU _____ (Specify)
OTHER _____
CONDITION: stable
RESP– 18 SpO2– 100
BP– 114/66 HR– 75

	Start	Room	End
ANES	1120	1130	1300
	Ready	Begin	End
PROC	1135	1150	1245

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

PROCEDURES and CPT Codes
Remove Ex Fix

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
G.A.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
#4 LMA X1, Bilat BS ETCO2 X 5 waves

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

SURGEONS: (b)(6)-2
ANESTHETISTS: MAJ (b)(6)-2 (b)(6)-2 AN, CRNA
Nurse Anesthetist

PROCEDURE LOCATION 1-1
DATE 6 Oct 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99
MEDCOM - 7321
*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 25 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 (E)
WT: 70 KG/LB HT: 69 IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I/D (R) Vascular Repair
SURGICAL SERVICE: Gen/ortho (R) lower leg
NPO SINCE:

HABITS:
TOBACCO: Yes
ETOH: ø
DRUGS: ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Pramaxin 500mg
( ) Amikacin / Gm
( )
( )
( )
( )

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

LABORATORY STUDIES:

HB/HCT: ____/____
U/A:
OTHER:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	?
MI	N	Y	
CVA	N	Y	ø
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	?
COPD	N	Y	
Other	N	Y	ø
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	?
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	ø
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	?
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	?
Other	N	Y	
Gynecological :			ø
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	GSW to (R)
	N	Y	Ankle Art
Familial HX	N	Y	Inj.

ASSESSMENT
PAST SURGICAL/ANESTHETIC

?
ø

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth Dentate
Trachea Midline
TMJ/Neck FROM
Oropharnyx MPI
Nares
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since ?

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: (b)(6)-2 MAT/CRNA Date: 13Sept03 Time: 0830 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

SEDATION KEY:

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

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW. RLE

DATE REQUESTED: 13 SEP 03

DATE AND HOUR REQUIRED: 0945

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: Specimen in Lab

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: See previous

TIME VERIFIED: SF 518

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

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

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

DONOR
ABO: B
Rh: pos

RECIPIENT
ABO: B
Rh: pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 13 Sept

REMARKS: Exp: 16 Sept 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 1025 ON *(Date)* 13 Sept 2003

IDENTIFICATION

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

1st VERIFIER *(Signature)* (b)(6)-2 CPT CRNA

2nd VERIFIER *(Signature)* (b)(6)-2 MAJ/CRNA

PRE-TRANSFUSION
TEMP. 96.6 PULSE 75 BP 123/54

DATE OF TRANSFUSION: 13 Sept 03

TIME STARTED: 1055

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME/DATE COMPLETED/INTERRUPTED: 1130 13 Sept 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE: 96.6 PULSE: 69 BLOOD PRESSURE: 121/41

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

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

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 MAJ/CRNA

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

(b)(6)-4

(b)(6)-4

SEX

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 7323

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH X 2U

DATE REQUESTED: 13 Sep 03

DATE AND HOUR REQUIRED:

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW RLE

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

VOLUME REQUESTED *(If applicable)*: ____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

SIGNATURE OF VERIFIER: Specimen in lab

REMARKS:

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

DATE VERIFIED: See previous SF 518

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.:

PATIENT NO.: [redacted]

DONOR
ABO: B
Rh: pos

RECIPIENT
ABO: B
Rh: pos

TEST INTERPRETATION
ANTIBODY SCREEN: N/A
CROSSMATCH: Comp

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

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 13 Sep 03

REMARKS: Exp: 16 Sept 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1025 ON *(Date)*: 13 Sept 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: (b)(6)-2 MAJ/CRNA

2nd VERIFIER *(Signature)*: (b)(6)-2 CPT AN

PRE-TRANSFUSION
TEMP. 96.8 PULSE 74 BP 127/50

DATE OF TRANSFUSION: 13 Sept 03

TIME STARTED: 1030

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME DATE COMPLETED: 1055 13 Sept 03

INTERRUPTED

REACTION
- [x] NONE
- [ ] SUSPECTED

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

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

T-96.6 B/P-123/54 HR-75

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

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 MAJ/CRNA

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

SEX

WARD

(b)(6)-4

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

DATE REQUESTED: 13 Sept 03

DATE AND HOUR REQUIRED: ASAP

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Art Repair (GSW)

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: SEE 1st

TIME VERIFIED: 5190

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

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

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

DONOR (b)(6)-4

ABO: O

Rh: POS

RECIPIENT

ABO: B

Rh: pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 13 Sept 03

REMARKS: Exp Date: 15 Sept 2003.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 0510

ON *(Date)*: 14 Sept 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: (b)(6)-2 CPT/AN

2nd VERIFIER *(Signature)*: (b)(6)-2 SGT USA

PRE-TRANSFUSION

TEMP. 97.7 | PULSE 87 | BP 154/63

DATE OF TRANSFUSION: 14 Sept 03

TIME STARTED: 0824

POST-TRANSFUSION DATA

AMOUNT GIVEN: 325 ML

TIME/DATE COMPLETED/INTERRUPTED: 1026 14 Sept 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE: 97.7 | PULSE: 76 | BLOOD PRESSURE: 162/64

If reaction is suspected—IMMEDIATELY:

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

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

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

SIGNATURE OF PERSON MAKING ISSUE: (b)(6)-2 SGT

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

(b)(6)-4

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 7325

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

DATE REQUESTED 13 Sept 03

DATE AND HOUR REQUIRED ASAP

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE (GSW) Art. Repair

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

RI (b)(6)-4

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED SEE 1st

TIME VERIFIED 518

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

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

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

DONOR ✓

ABO B

Rh pos

RECIPIENT

ABO B

Rh pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 13 Sept 03

REMARKS:

Exp Date: 16 Sept 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT (Hour) 1025 ON (Date) 14 Sept 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 SGT 91W Me

PRE-TRANSFUSION

TEMP. 97.3 PULSE 80 BP 157/62

DATE OF TRANSFUSION 14 Sept 03

TIME STARTED 1039

POST-TRANSFUSION DATA

AMOUNT GIVEN 370 ML

TIME/DATE COMPLETED/INTERRUPTED 1239 14 Sept 03

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 97.9 PULSE 95 BLOOD PRESSURE 159/70

If reaction is suspected—IMMEDIATELY:

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

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

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

(b)(6)-2 SGT USA 91WM6

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

(b)(6)-4

SEX M

WARD ICW

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 13 Sept 03

DATE AND HOUR REQUIRED: ASAP

REQUESTING PHYSICIAN *(Print)*: DR (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: (b)(6)-2

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 15 Sept 03

TIME VERIFIED: 1710

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP

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

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

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

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 15 SEP 03

REMARKS: EXP 15 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 2145 ON *(Date)*: 15 Sept 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: (b)(6)-2 SPC

2nd VERIFIER *(Signature)*: (b)(6)-2 1LT AN

PRE-TRANSFUSION TEMP. 98.6 PULSE 82 BP 108/47

DATE OF TRANSFUSION: 15 Sep 03 TIME STARTED: 2145

POST-TRANSFUSION DATA

AMOUNT GIVEN: All ML

TIME/DATE COMPLETED/INTERRUPTED: 15 Sep 03 @ 2345

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 99.6 PULSE: 85 BLOOD PRESSURE: 109/48

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 1LT AN

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

SEX: M WARD: FCU

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

DATE REQUESTED 15 Sept 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

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

REQUESTING PHYSICIAN *(Print)* DR (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE Anemia

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

SIGNATURE OF VERIFIER (b)(6)-2

DATE VERIFIED 15 Sept 03

TIME VERIFIED 1710

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR
ABO O
Rh Pos

RECIPIENT
ABO B
Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

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

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 15 Sep 03

REMARKS: Exp 15 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 1945 ON *(Date)* 15 Sept 03

IDENTIFICATION

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

VERIFIER *(Signature)* (b)(6)-2 SSG Wm6 RCW

2nd VERIFIER *(Signature)* (b)(6)-2 1LT AN

PRE-TRANSFUSION
TEMP. 99.8 PULSE 117 BP 119/53

DATE OF TRANSFUSION 15 Sep 03

TIME STARTED 1950

POST-TRANSFUSION DATA

AMOUNT GIVEN ~~Entire~~ All ML

TIME/DATE COMPLETED/INTERRUPTED 15 Sep 03 0 2140

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.6	82	108/47

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

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

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 1LT AN

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

(b)(6)-4

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 7328

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

DATE REQUESTED: 21 Sep 03

DATE AND HOUR REQUIRED:

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P revas of RLE + I&D/Ab ex fix R/T GSW

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

SIGNATURE OF VERIFIER: (b)(6)-2 SGT/LPN

VOLUME REQUESTED *(If applicable)*: _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 21 Sep 03

TIME VERIFIED: 1240

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

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

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

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: Pos	Rh: Pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 21 Sep 03

REMARKS: Exp: 22 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)* 1224 Hrs ON *(Date)* 21 Sep 03

IDENTIFICATION

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

(b)(6)-2

2nd VERIFIER *(Signature)*: (b)(6)-2

PRE-TRANSFUSION

TEMP. 98.1 PULSE 67 BP 110/46

DATE OF TRANSFUSION: 21 Sep 03

TIME STARTED: 1230

POST-TRANSFUSION DATA

AMOUNT GIVEN: _____ ML

TIME/DATE COMPLETED/INTERRUPTED:

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98°	87	110/47

If reaction is suspected—IMMEDIATELY:

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

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

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

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 SGT/LPN

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

(b)(6)-4

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 7329

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 21 Sep03

DATE AND HOUR REQUIRED:

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P Revas of RLE Hdfib Rxfix R/T GSW

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

SIGNATURE OF VERIFIER: (b)(6)-2 SGT/LPN

DATE VERIFIED: 21 Sep03

TIME VERIFIED: 1210

VOLUME REQUESTED *(If applicable)*: _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK: [✓] RECORD [ ] NO RECORD

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

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 21 Sep 03

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

REMARKS: EXP: 22 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1401 ON *(Date)*: 21 Sep 03

IDENTIFICATION

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

VERIFIED *(Signature)*: (b)(6)-2 CM

(b)(6)-2 SGT/LPN

PRE-TRANSFUSION

TEMP. 98° PULSE 64 BP 116/48

DATE OF TRANSFUSION: 21 Sep03 TIME STARTED: 1405

POST-TRANSFUSION DATA

AMOUNT GIVEN: 459 ML

TIME/DATE COMPLETED/INTERRUPTED:

REACTION: [✓] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98°	64	116/45

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*: [✓] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 SGT/LPN

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

1410 108/45 – 86 - 99% 13 98.8

SEX: M WARD: ICU

1415

1420

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 7330

Medical Record Copy

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 Sep 03 TIME OF ORDER: 1500 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1. T ICU — Dr.
2. Dx - SP - Revascularization RLE/TIB ex fix
3. Cond - Stable NKDA
4. VS q 1°, MONITOR, PULSEOX, F+O, Aline, PT Doppler check
5. ACTIVITY - BEDREST

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

6. IVLR TKO 125cc/hr
7. AMIKACIN ~~75mg~~ 500mg IVPB q 12° 10-28
8. PRIMAXIN 500mg IVPB q 6° 04-10-16-22
9. MORPHINE 2-8 mg IV q 2° PRN/Pain
10. DIET - Advance as tolerated
11. LOVENOX 40mg SC now then q day

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

12. INCENTIVE SPIROMETRY 10-20X/hr TCDB q 1°
13. PHENERGAN 25mg IV q 4° PRN/Nausea
14. CBC, chem 8, ABG on arrival then q AM
15. Call MD for T > 101°, P < 60, > 110, SBP < 100, > 160, UO < 30cc/hr Sat < 92%

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

16. Foley to

MAJ, MC USA
CHIEF, DOS

NO.

Sep 03 @ 0440

MEDCOM - 7331

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 Feb 03 TIME OF ORDER: 1570 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1. Give 50 mg Fent IV now

(b)(6)-2

MATERNA

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

1. Change Lovenox to 30 mg SC q day
2. Change Amikacin 1 gm IV q day

(b)(6)-2

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

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

MAJ, MC USA
CHIEF, DOS

24 ✓ 14Sep03 @0440 (b)(6)-2

PATIENT IDENTIFICATION

EPW

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Sept 03 TIME OF ORDER: 0758 HOURS

1. Transfuse 2 units PRBC's IVPB over 2 hrs
2. CBC 1° p transfusion

(b)(6)-2

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Sept TIME OF ORDER: 0825 HOURS

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

1. Premed date pt. c Tylenol PO 650 mg Benadryl 25 mg IVSP prior to Blood transfusion

(b)(6)-2

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

(b)(6)-2

0300

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

MEDCOM - 7332

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

(b)(6)-4

(b)(6)-2

Noted 14 Sep 03 @ 1830

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Sep 03 TIME OF ORDER: 1830 HOURS

LIST TIME ORDER NOTED AND SIGN

① Albuterol VD breathing treatments q4° PRN

② change Pulse checks c̄ doppler to RLE to q2°

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

(b)(6)-2 MAJ, MC USA CHIEF (b)(6)-2

PATIENT IDENTIFICATION

EPW

(b)(6)-2

Noted 14 Sep 03 @ 0228 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 15 Sep 03 TIME OF ORDER: 2222 HOURS

① NPO p̄ MN

(b)(6)-2 MD

(b)(6)-2 MAJ, MC USA CHIEF, DOS

20° ✓ 15 Sep 03 @ 0300 (b)(6)-2 INT

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 15 SEP 03 TIME OF ORDER: 1230 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) To ICU. Dr. (b)(6)-2 (b)(6)-2

(2) DX – SP FOGARTY EMBOLECTOMY, Graft Patency

(3) Cond. Stable! NKDA

(4) VS – q 1°, BP, Pulse Ox, Monitor, A-line, Pulse check

NURSING UNIT | ROOM NO. | BED NO.

(5) ACT – BCDEST

(6) DIST – Adenosine to Reptin, Supplement w/ Ensure/Carnation

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(7) IV LR to run at 100 cc/hr

(10) HEPARIN BOLUS 2500 units IV hr

HEPARIN gtt – to infuse at 1000 units/hr

(11) PRIMAXIN 500 mg IV q 6°

(12) AMIKACIN 1 gram IV q 24°

NURSING UNIT | ROOM NO. | BED NO.

(13) MORPHINE 2-8 mg IV q 2° PRN/PAIN

(14) PHENERGAN 25 mg IV q 4°/PRN/Nausea

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(15) Foley to gravity

(16) INCENTIVE SPIROMETRY 10-20 X/hour

TCDB q 1°

(17) CBC, Chem 8, COAGPANEL, ABG

1° After begin infusion started

NURSING UNIT | ROOM NO. | BED NO.

(18) Call MD for T > 101°, PC 60 > 110, SBP < 100 or > 160, Urine < 30 cc/hr

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS

Sat < 92%,

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

MAJ MC US
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

349 Chart ✓ (b)(6)-2 cpt/AW 16 Sept 03 @ 8243

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-2 (b)(6)-2

Transcribed 15 Sept 1730 # (b)(6)-4 1730 1735

DATE OF ORDER: 15 Sept — TIME OF ORDER: 1700 HOURS — LIST TIME ORDER NOTED AND SIGN

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

(1) T & C for 2 units PRBC's

(2) Premedicate: 25 mg Benadryl IV, Tylenol 650 mg

(3) Administer 2 units over 2° q unit

(4) CBC, ABG, Chem 8, Coags 1°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: s/p transfusion — TIME OF ORDER — HOURS

Taken by (b)(6)-2 (b)(6)-2 MD

X (b)(6)-2 MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

noted 15 Sep 03 @ 1920

DATE OF ORDER: 15 Sep 03 — TIME OF ORDER: 1920 HOURS

(1) bolus 1000 u heparin IV now

(2) increase Heparin to 1200 u/hr

V.O. Dr (b)(6)-2 / (b)(6)-2

(3) Recheck coags in 4 hrs

V.O Dr (b)(6)-2 / (b)(6)-2 (b)(6)-2

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

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

noted 16 Sep 03 @ 0200

DATE OF ORDER: 16 Sep 03 — TIME OF ORDER: 0200 HOURS

(1) give bolus of 2500 units heparin now then increase infusion to 1400 units/hr.

(2) Recheck coags in 6 hours.

V.O Dr (b)(6)-2 / (b)(6)-2

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

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1

Sept 03 @ 2247

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 16 Sep 03 TIME OF ORDER: 0830 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Increase Heparin to 1500 cc/°

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

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

MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

Noted 16 Sep 03 (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 16 Sep 03 TIME OF ORDER: 1100 HOURS

(1) Repeat PT/PTT @ 1200

(2) Am labs: CBC, Chems, Coags

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

MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

Off Chest tube (b)(6)-2 Cpt 16 Sept 03 @ 2350

PATIENT IDENTIFICATION: (b)(6)-4

(b)(6)-2 Noted @ 1500 17 Sep 03

DATE OF ORDER: 17 Sep 03 TIME OF ORDER: 1000 HOURS

Pin Care to exposed proximal site

½ strength peroxide and Sterile Water

B.I.D

V.O. Dr (b)(6)-2 (b)(6)-2 mg

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

(b)(6)-2 Noted @ 2330 (b)(6)-2

DATE OF ORDER: 17 Sep 03 TIME OF ORDER: 2330 HOURS

(1) give bolus 1000 units of Heparin

(2) then increase infusion rate to 1800 units/hr

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

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

MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-2

(b)(6)-4

NURSING UNIT | ROOM NO.

DATE OF ORDER: 17 Sept 03 TIME OF ORDER: 2340 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Call MD for PTT <45 or >90.
2. Cont pmt. 6 oz po Hepsi chyle

(b)(6)-2 MD

(b)(6)-2 MAJ, MC USA CHIEF, DOS

24V 18Sep03 @ 0425 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Sept 03 TIME OF: 0840 HOURS

1. BOLUS HEPARIN 1000 units then INCREASE gtt to 2000 units/hr

noted 18Sep 0845

(b)(6)-2 MD SS

(b)(6)-2 MAJ, MC USA CHIEF, DOS

24V 19 Sep 03 @ 0400 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 SEPT 03 TIME: 0940 HOURS

1. D/C Amikacin per V/O Dr (b)(6)-2

(b)(6)-2 CPT, MSC (b)(6)-2 Pharmacy

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

MAJ, MC USA CHIEF, DOS

24V 20 Sep 03 @ 0420 (b)(6)-2

PATIENT IDENTIFICATION

EPW

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 Sept 03 TIME OF ORDER: 0820 HOURS

1. DC IV Heparin
2. ELEVATE RLE on pillow

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

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

MAJ, MC USA CHIEF, DOS

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

FORM 4256 1 APR 79 REPLACES EDITION OF 1 JUL [illegible] BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 20 Sept 03 TIME OF ORDER: 0900 HOURS — LIST TIME ORDER NOTED AND SIGN

Heparin 5000 u SQ BID
First Dose Tonight
V.O. Dr (b)(6)-2 (b)(6)-2 mg/gm (b)(6)-2

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Sept 03 TIME OF ORDER: 1900 HOURS

1. Docusate Sodium 100mg PO BID
2. MOM 60 ml PO PRN Constipation
VO: Dr (b)(6)-2 (b)(6)-2

Acted 20 Sept @ 1940 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° / 20 Sept 03 @ 1445 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Sept 03 TIME OF ORDER: 2213 HOURS

1. Tylenol 650 mg PO PRN for Pain or T > 101.5
VO: Dr (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 21 Sept 03 TIME OF ORDER: 1045 HOURS

1. Transfuse 2 units PRBC's
2. Premedicate w/ Benadryl 25mg IV and Tylenol 650mg p.o.
3. CBC one hour p̄ transfusion
4. DC cordis p̄ transfusion
5. Hep lock IV
6. DC Foley 7. Pulmonary Art-Tipped Cath

21 Sept 1100 (b)(6)-2

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED (b)(6)-2

MEDCOM - 7338

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 Sep 03 | TIME OF ORDER: 1710 HOURS | LIST TIME ORDER NOTED AND SIGN

1. DC: PRIMAXIN
2. ANCEF 1 gram IVPB q 8°

b(6)-2

[redacted] MD

MAJ, MC USA
CHIEF DOS

[redacted] CPT, MC 21 Sep 03 @ 2045

b(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 Sep 03 | TIME OF ORDER: 2058 HOURS

1. PERCOCET - one 1-2 po q 4° PRN/PAIN

Noted 21 Sep 03 @ 2112

[redacted] MD

USA
DOS

b(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 Sep 03 | TIME OF ORDER: 1245 HOURS

1. TRANSFER TO ICW
2. DX (R) GR III C TIBIA FX
3. CONS: STRAUSS
4. VITALS Q ROUTINE & DOPPLER PT PULSE
5. ACT: NON WB (R) LEG.
6. NKA

b(6)-2 noted [redacted] 22 Sep B3K

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

7. DIET REG.
8. PERCOCET 1-TI PO q 4-6 H PRN
9. ANCEF 1g IV q 8H
10. DAILY DRESSING D'S.
11. SUPPORT LEG/ [redacted] & EGG CRATE.
12. HEPARIN 5000 u SQ BID

b(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24 Sep 03 TIME OF ORDER: 0900 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Load Phenytoin 400mg po x 1 now then 300mg po 2hrs after that, then 300mg po (b)(6)-2 after that then 100mg po tid starting tomorrow
2. Valium 5mg IVP for seizures and notify M.D. (b)(6)-2

NOLAN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24 Sep 2003 TIME OF (b)(6)-2 1230 HOURS

VO: Dr (b)(6)-2 / LJ (b)(6)-2

1. Valium 2.5mg IVP x 1 NOW
2. Valium 7.5mg IVP x 1 NO
3. Valium 5.0mg IV x 1 NO
4. Haldol 5mg IM x 1 NOW
5. Haldol 5mg IM x 1 NOW
6. Benadryl 50mg IM x 1 NO

Noted 1400 24 Sep 2003 AN (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24 Sep 2003 TIME OF ORDER: 1735 HOURS

1. Colace 100mg 1 po bid
2. MOM 30 cc PO Q4° until BM.

VO: Dr. (b)(6)-2 / LG (b)(6)-2 AN

2° chart / 24 Sep 03 @ 2240 (b)(6)-2 forwarded

Noted 1710 24 Sep 2003 AN (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 28 Sep 03 TIME OF ORDER: 2132 HOURS

1. D/C Phenytoin
2. Tylenol 650mg po now + q6° prn.

(b)(6)-2

2° chart / 29 Sep 03 @ 0802 (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 2 OCT 03 TIME OF ORDER: 1720 HOURS

LIST TIME ORDER NOTED AND SIGN

D ~~Dc Cor~~ D Course

TO T PO BID.

(b)(6)-2

2nd chart 0820 3 Oct 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 5 OCT 03 TIME OF ORDER: 18:03 HOURS

NO

noted 1802 5 Oct

Remove staples from upper (R) thigh

(b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

2nd chart 6 Oct 03 @ 0202 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 7341

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

(b)(6)-2

DATE OF ORDER: 5 OCT 03 TIME OF ORDER: 2110 HOURS

LIST TIME ORDER NOTED AND SIGN

1. NPO. p MIDNIGHT
2. TO OR IN AM.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

4th chart 6 Oct 03 @ 0210 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 6 OCT 03 TIME OF ORDER: 1305 HOURS

1. ADMIT RR → KW
2. DX (R) LEG GR III C
   DISTAL NB Exp → S/P REMOVAL
   w/o Fix
3. COND: STABLE
4. VITALS: Q RR ROUTINE
5. ACT: NON WB (R) LEG, EPW
   RESTRAINTS, ELEVATE (R) LEG c PILLOWS
6. NKA
7. DIET REG
8. IVF NS @ 100 cc/HR, HEPLOCK WHEN TOL PO
9. CLINDAMYCIN 450 mg PO Q8H
10. HEPARIN 5000 u SQ BID
11. MSO_4 I-IV mg IV q 2-4H

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: PRN SEVERE PAIN TIME OF ORDER: HOURS

- PERCOCET I-II PO q 4-6H PRN PAIN
- TYLENOL 325-Tq q 4-6 HR PRN FEVER, MILD PAIN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED. (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 OCT 03	0910 HOURS	
D/C TO HP CUSTODY		
NON WEIGHT BEARING		
(R) LEG		
FOLLOW UP 28TH CSH		
≈ 4 DATS	(b)(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
8 OCT 03	17:07 HOURS
VO	
Immodium 2mg 1-11 PO	
PRN	
Do (b)(6)-2 (b)(6)-2	

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

NURSING UNIT | ROOM NO. | BED NO.

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

9 Oct 03 0015

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256 REP ... WHICH MAY BE USED.

MEDCOM - 7343

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15
13 Sept 03	(b)(6)-2	VS: Q1°, Mon to, Pulse ox	06	(b)(6)-2		
		I+O / Alive, PT Doppler checks	18			
13 Sept 03		Act: Bedrest	06			
			18			
13 Sept 03		Diet: Advance as tolerated	06			
			18			
13 Sept 03		Incentive Spirometer	06			
		10-20x / hr TCDB Q1°	18			
13 Sept 03		CBC, Chem 8, ABG	06			
		Q am				
13 Sept 03		Call MD for T > 101	06			
		P < 60, > 110, SBP < 100 > 160	18			
		UO < 30 cc/hr, Sat < 92%				
13 Sept 03		Foley to Gravity	06			
			18			
14 Sep 03		Change pulse checks to	06			
	------	doppler to RLE to q2°	18			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Pt. S/P Revascularization RLE/TIB/PB
Ex Fix

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

PATIENT IDENTIFICATION: CAND: STABLE

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13 Sept	(b)(6)-2	Tx to ICU Dx [redacted] b(6)-2	13 Sept	1500	—	(b)(6)-2
13 Sept		OR:- S/P Revascularization RLE/TIB/FIB Closed Stable	13 Sept	1500	—	
13 Sept 03		CBC, Chems ABG on arrival	13 Sept	1500	1500	
14 Sept		CBC 1° p̄ transfusion	14 Sept	1100	1430	
14 Sept 03		NPO p̄ MN	14 Sept	2400	2400	
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22
15Sep03	(b)(6)-2	VS Q1°, I+O, pulse ox	06	(b)(6)-2							
		Monitor, Alive, Pulse checks	18								
15Sep03		Act: Bedrest	06								
			18								
15Sep03		Diet: Advance to Regular,	06								
		Supplement with Ensure/	18								
		Carnation									
15Sep03		Foley to Gravity	06	(b)(6)-2						DC'd 21Sep03	
			18							(b)(6)-2	
15Sep03		Incentive Spirometry	06						(b)(6)-2		
		10-20 x/hour, TCDB Q1°	18								
15Sep03		Call MD for T > 101	06						(b)(6)-2		
		P < 60 or > 110, SBP < 100 or	18								
		> 160, U.O. < 30cc/hr									
		Sat < 92%, loss of pulses									
16Sep03		AM labs: CBC, Chem8, Coags	06	/	/	(b)(6)-2					
17Sep03		Pin Care to exposed	06	/	/						
		proximal site - ½ strength	18	/	/						
		peroxide and sterile water									
		BID									
17Sep03		Call MD for PTT < 45 > 90	06	/	/	/	(b)(6)-2				
			18	/	/	(b)(6)-2					
20Sep03		Elevate RLE on pillow	06	/	/	/	/	(b)(6)-2			
			18	/	/	/	/				

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:
Dx: S/P Fogarty Embolectomy, Graft Repair / I+D
Cond: Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) — Mo Sep Yr 2003 — SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15 Sep 03	(b)(6)-2	Dx: S/P Fogarty, Embolectomy, Graft repair	15 Sept	1230	1230	(b)(6)-2
		IJD, Cond: Stable Dx: ICU Dr. (b)(6)-2	15 Sept	1230	1230	
15 Sep 03		CBC, Chem 8, Coag Panel, ABG	15 Sept		DONE 1230	(b)(6)-2
		P after Heparin infusion started				
15 Sept		T & C for 2 units PRBCs	15 Sep	1700	1730	(b)(6)-2
15 Sept		Premedicate: Tylenol 650mg PO	15 Sept	1730		
		Benadryl 25mg IV	15 Sept	1730	ERROR 15 Sept	(b)(6)-2
15 Sept		CBC, Chem 8, Coags, ABG	15 Sept		16 Sep 03 0130	(b)(6)-2
		1° post 2 unit PRBC transfusion				
15 Sept		Administer: Unit #1 PRBC over 2°	15 Sep 03		1950	(b)(6)-2
		Unit #2 PRBCs over 2°				(b)(6)-2
15 Sep 03		Bolus 1000 u heparin IV	15 Sep 03	now	1925	(b)(6)-2
15 Sep 03		Recheck coags in 4 hours	15 Sep 03		16 Sep 03 0015	(b)(6)-2
16 Sep 03		Recheck coags in 6 hours	16 Sep 03	0800	0800	
16 Sep 03		Repeat PT/PTT @ 1200	16 Sep 03	1200	1200	
17 Sep 03		Coag Panel 6° after Heparin change	18 Sep 03	0600	0540	
15 Sep		CBC one hour P transfusion	15 Sep	Done		

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

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27
21 SEPT 03	(b)(6)-2	IV : Heplock	06	(b)(6)-2						
			18							
21 SEPT 03		Heparin 5000 SQ	10							
		BID	22							
20 SEPT		Docusate Sodium	10							
			22							
21 SEPT		Prenatal Vitamins	10							
		P.O. Q Day	/							
21 SEPT		Ancef 1 gram	08							
		IVPB Q 8°	16	/						
			24	(b)(6)-2						

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P revis ex fix (R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo ____ Yr ____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21 Sep 03	(b)(6)-2	DC cordis ⊽ transfusion	21 Sep 03	⊽ trans		(b)(6)-2
21 Sep 03		Heplock IV	21 Sep 03	1400	1400	
21 Sep 03		D/C Foley	21 Sep 03	1045	1045	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
20 Sep 03	(b)(6)-2	Morphine 2-8 mg	D	21 Sep 03												
		IV q 8° prn pain	T	4 ms 2200												
			I	(b)(6)-2												
			E	(b)(6)-2												
20 Sep 03	(b)(6)-2	Phenergan 25 mg	D													
		IV q4 prn/nausea	T													
			I													
			E													
20 Sep 03	(b)(6)-2	Tylenol 650 mg PO														
		Prn for pain or T > 101.5														

USAPA V1.00

CLINICAL RECORD

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

Mo. 10 Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10
22Sep	(b)(6)-2	Vitals Routine c̄	6	(b)(6)-2					
		Doppler to pulse	14						
			22						
22Sep		Act: Non WB	6						
		(R) leg	18						
22Sep		Diet: Regular	6	(b)(6)-2	D/C				
			12						
			18						
22Sep		Daily Dressing Changes	10	(b)(6)-2			D/C 04 OCT 03		(b)(6)-2
22Sep		Support leg and heel c egg crate	6	(b)(6)-2					
			18						
050CT03		NPO Past Midnight	06	(b)(6)-2		D/C'd 05 OCT 03			(b)(6)-2
			12						
			18						
6OCT		Diet: Reg	07	(b)(6)-2					
			12						
			18						

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: (R) GR III c Tib Fx
S/P Removal Ex Fix

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

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

USAP

DA FORM 4677, 1 OCT 78 MEDCOM - 7350

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22Sep	(b)(6)-2	Vitals Routine =				
		Doppler to Pulse Error				
5OCT		Remove Staples to upper (R)	05OCT	1800	1800	(b)(6)-2
		Thigh				
5OCT		To OR in AM.	06OCT	AM		
8OCT		D/C To MP custody	8OCT	0910	0910	(b)(6)-2
8OCT		NWB (R) LEG	8OCT	0910	0910	
8OCT		Follow up @ (b)(2)-2 in 4 DAYS	8OCT	0910	0910	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. SEP Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30	1	2	3	4
22 Sep	(b)(6)-2	VS q Routine &	06	✓ (b)(6)-2												
		Doppler Q Arse	14													
			22													
22 Sep	(b)(6)-2	Dict: Non WB (R) Leg	06	(b)(6)-2												
			18													
22 Sep	(b)(6)-2	Dict: Leg	06	✓ (b)(6)-2												
			12	✓												
			18													
22 Sep	(b)(6)-2	Daily Dsg A's	10	✓ (b)(6)-2												
22 Sep	(b)(6)-2	Support Leg & Heel with egg crate	06	(b)(6)-2												
			18													

ADDITIONAL PAGES IF ☐ YES ☐ NO

PAGE NO: ____

ALLERGIES: ☐ YES ☑ NO

NKA

PRIMARY DIAGNOSIS:

(R) Grade C Tibia Fx

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION

D	8	9	10	11	12	13
E	16	17	18	19	20	21
N	24	01	02	03	04	05

MEDCOM - 7352

...N OF 1 DEC 77 MAY BE USED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sep Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initial
22Sep.	(b)(6)-2	TRANSFER TO ICW	22Sep	1245	1300	(b)(6)-2
22Sep		Dx: (D) SEPTIC TIBIA FRACTURE	22Sep	1245	1300	
22Sep		CON D: STABLE	22Sep	1245	1300	

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
		Ancef 1 gram IVPB	21	
		Q8°		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P Fogarty Embolectomy, Graft Repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

USAPA V1.00

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
20Sept	(b)(6)-2	MOM ~~[illegible]~~ PO PRN														
		Constipation														
20Sept	(b)(6)-2	Tylenol 650mg PO	(b)(6)-2													
		PRN for Pain or T > 101.5	(b)(6)-2													

Recorded

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ___ Yr. ___

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17
3Sept03	(b)(6)-2	IV: LR TKA 125cc/hr	06	/	(b)(6)-2			
			18	(b)(6)-2				
3Sept03		Amikacin 500mg IVPB	10	/	Discontinued 13 Sept03			
		Q 12°	22					
3Sept03		Primaxin 500mg IVPB	04	/	(b)(6)-2			
		Q6°	10	/				
			16	(b)(6)-2				
			22					
13Sept03	(b)(6)-2	Lovenox 40mg SC Q day	10	/	Changed 13 Sept03			
3Sept03		Lovenox 30mg SC Q day	10	/	(b)(6)-2			
13Sept03		Amikacin 1gm IVPB Q day	10	/				

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Dx: S/P Revascularization RLE/TIB/FB

Cond: Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Sep Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
13 Sep 03	(b)(6)-2	Give 50 mg Lasix IV now	13 Sep 03	1500	1500	(b)(6)-2
14 Sept 03		transfuse 2 units PRBC's IVPB	14 Sept.	~~1900~~ 0800	1239	
		over 2 hrs.	14 Sept	0800		
14 Sept		Premedicate w Benadryl 25 mg IV	14 Sept	0825	0825	(b)(6)-2
		Tylenol 650 mg PO	14 Sept	0825	0825	
		prior to Blood transfusion				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
13 Sep 03	(b)(6)-2	Phenergan 25mg IV	D	14 Sep 03													
		Q4° prn / nausea	T	0500													
			I	82													
			E	(P)													
13 Sep 03	(b)(6)-2	Morphine 2-8mg IV	D	13 Sept	13 Sept	13 Sept	14 Sep 03	14 Sep 03	14 Sept	14 Sept	14 Sept		14 Sep 03	15 Sep 03			
		Q2° prn Pain	T	0100	0400	0930	0230	0430	0700	1155	1600		1940	0100			
			I	5mg	2mg	2mg	4mg	6mg	4mg	4mg	3mg		5mg	5mg			
			E	(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)		(P)	(P)			
14 Sep 03	(b)(6)-2	Albuterol UD breathing	D	14 Sep 03													
		treatment q4° PRN	T	1900													
			I	HT													

USAPA V1.00

Verify by Initialing

TI APEUTIC DOCUMENTATION CARE PL
(MEDICATIONS)

Mo. Sept Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21 Sep	(b)(6)-2	Percocet 1-2x po	D	21 SEPT	22 Sep											
		q4° PRN/PAIN	T	2115	0700											
			I	(b)(6)-2												
			E													

USAPA V1.00

LINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-407: the proponent agency is the Office of The Surgeon General.

Mo. Sep Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

GY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	15	16	17	18	19	20	21	22
Sept 03	(b)(6)-2	IV: LR to Run @ 100 cc/hr	06								
			18								
Sept 03		Heparin gtt – To infuse at 1000 units/hr = 20 cc/hr	06								
			18								
Sept 03		Primaxin 500mg IV Q6	04								
			10								
			16								
			22								
			10								
Sept 03	(b)(6)-2	Amikacin 1 gram IV Q 24°	06								
5 Sep 03		Heparin gtt ↑ 1200 u/hr	18								
Sep 03		↑ heparin to 1400 u/hr	06								
6 Sep 03		Increase Heparin to 1500 u/	18								
7 Sep 03		Increase Heparin to 1800 u/ hour	06								
			18								
18 Sep 03		~~Bolus~~ Increase gtt to 2000 u/hr	06								
			18								
20 Sept 03		Heparin 5000 u SQ BID	10								
			22								
20 Sept 03		Docusate Sodium 100mg PO BID	10								
			22								
21 Sep 03		Prenatal Vitamin-T PO a day	10								
		Ancef 1 gram IVPB q 8°	08								
			16								
			24								

Date Ad 15 Sep 03

DC'd 21 Sep 03 1700

Ad 14 Sep 03

Ad 16 Sep 03 0830

Rate Change Ad. 17 Sep 03

Ad 18 Sep 03

Dcd 20 Sep 03

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Dx: SIP Fogarty Embolectomy, Graft Repair

Cond: Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

USAPA V1.00

DA FORM 4678, 1 FEB 79

MEDCOM - 7359

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Sept Yr. 2003

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
15 Sept	(b)(6)-2	Heparin Bolus 2500 units IV	15 Sept 03	1300	1325	(b)(6)-2
15 Sep		Bolus 1000 u heparin IV now	15 Sep 03	Now	1425	
15 Sep		Premedicate Tylenol 650 mg	15 Sept	1735	1735	
		— Benadryl 25 mg	15 Sept	1735	1735	
15 Sep		Transfuse Unit #1 PRBC	15 Sept		1950	
		" Unit #2 PRBC	15 Sept		2145	
16 Sep 03		2500 units heparin bolus	16 Sep 03		0200	
17 Sep 03		bolus 1000 units Heparin	17 Sep 03		2330	
17 Sep 03		Bolus heparin 1000 units	18 Sep 03	0540	0540	
21 Sep 03		Transfuse 2 units PRBCs	21 Sep 03	40	1230-1330 1400-1500	
21 Sep 03		Premedicate c̄ Benadryl 25 mg IV and	21 Sep 03		1220	
		Tylenol 650 mg PO				
21 Sep 03		DC Primaxin	21 Sep 03	1710	—	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15 Sep 03	(b)(6)-2	Morphine 2-8 mg IV	D	16 Sep 03	16 Sep 03	16 Sep	17 Sep	17 Sep	18 Sep	19 Sept	19 Sept	20 Sep 03	20 Sep	20 Sept	20 Sept
		Q2° prn / pain	T	0135	0400	2400	1000	1530	2400	1945	0900	2215	0035	0600	0700	0715
			I	(b)(6)-2	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg
			E	P	P	P	P	P	P	P	(b)(6)-2	(b)(6)-2				
15 Sep 03	(b)(6)-2	Phenergan 25 mg IV	D													
		Q4° prn / nausea	T													
			I													
			E													
15 Sep 03	(b)(6)-2	Morphine 2-8 mg IV	D	20 Sept	20 Sept	20 Sept	20 Sept	21 Sept	21 Sep	21 Sep	21 Sep					
		Q2° prn / pain	T	1300	1600	2000	2300	0400	0800	1315	1445					
			I	(b)(6)-2	5mg	5mg	5mg	4mg	4mg	3mg	2mg	5mg				
			E	P	P	P										

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

M 09 Y 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 22	23	24	25	26	27	28	29	30	01 OCT	02	03	04	05
22Sep	(b)(6)-2	ANCEF 1 gm q8°	06	/	(b)(6)-2												
			14														
			22														
22Sep	(b)(6)-2	HEPARIN 5000u SQ BID	10	/	(b)(6)-2												
			22														
24Sep	(b)(6)-2	Load phenyton 400mg PO x 1 now	09	/	/	(b)(6)-2											
24Sep	(b)(6)-2	Phenyton 300mg PO 2° p that	11	/	/	(b)(6)-2											
24Sep	(b)(6)-2	Phenyton 300mg PO 2° p that	15	/	/	(b)(6)-2											
24Sep	(b)(6)-2	Phenyton 100mg PO tid starting tomorrow	06	/	/	/	(b)(6)-2										
			14	/	/	/											
			22	/	/	/											
24Sep	(b)(6)-2	Colace 100mg PO BID	06	/	/	/	(b)(6)-2										
			18	/	/												
24Sep	(b)(6)-2	MOM 30cc PO Q4° until BM	02	/	—	/											
			06	/	—	/	①										
			10	/	—	/	①										
			14	/	—	/	①										
			18	/	/	(b)(6)-2	Q										
			22	/	/	(b)(6)-2											

DC

ALLERGIES: ☐ YES ☑ NO

NKA

PRIMARY DIAGNOSIS:

① GATIC TIBIA FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

MEDCOM - 7361

EDITION OF ... 77 WILL BE USED UNTIL EXHAUSTED.

US

Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Sep Yr. 2002

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
24Sep	(b)(6)-2	Haldol 5mg IM x 1 Now			1300	(b)(6)-2
24Sep		Haldol 5mg IM x 1 Now			1310	
24Sep		Benadryl 50mg IM x 1 Now			1310	
?						

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
23Sep	(b)(6)-2	Percocet 1-2 PO q 4-6° PRN	23Sep 0550 PO; 23Sep 1120 PO; 23Sep 1449 PO; 23Sep 0857 PO; 23Sep 0300 PO; 23Sep 21:16 PO; 24Oct 2320 PO; (b)(6)-2
24Sep	(b)(6)-2	Valium 5mg IVP for seizure and notify MD	24Sep 1200 5mg IVP; 24Sep 1210 5mg IVP; 24Sep 1510 5mg IVP; (b)(6)-2
25Sep	(b)(6)-2	Tylenol 650mg PO q 6° PRN	25Sep 2100 PO; 25Sep 0150 PO; 25Sep 1956 PO; 26Oct PO; 26Oct PO; 26Oct PO; 26Oct 2245 PO; 26Oct 1849 PO; 26Oct 2225 PO; 26Oct 0340 PO; 26Oct 2230 PO; 26Oct 2241 PO; (b)(6)-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9
5	(b)(6)-2	Ancef 1 gm q 8°	6	(b)(6)-2			
			14		D/C'd		
			22			(b)(6)-2	
5	(b)(6)-2	Heparin 5000 u SQ BID	10	(b)(6)-2		08 Oct 03	
			22	(b)(6)-2		(b)(6)-2	
6	(b)(6)-2	IVF NS @ 100cc/hr	06	(b)(6)-2		08 Oct 03	
		Heparin when PO tol	18	(b)(6)-2	D/C	(b)(6)-2	
6	(b)(6)-2	Clindamycin 450 mg	06	(b)(6)-2			
		PO Q 8H	14	(b)(6)-2	D/C'd	(b)(6)-2	
			22	(b)(6)-2			

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: (R) Cl III c Tibia Fracture S/p removal ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
6 Oct	(b)(6)-2	MSO4 II-IV mg IV														
		q 2-4 Hours Per Severe Pain														
6 Oct	(b)(6)-2	Percocet I-II PO 4-6H														
		PRN PAIN														
6 Oct	(b)(6)-2	Tylenol 325 mg-1 g q														
		4-6H PRN Fever,														
		mild pain														
8 Oct	(b)(6)-2	Immodium 2mg I-II	8 Oct 0700 1100 1700 (b)(6)-2													
		PO PRN														

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1500	INITIALS (b)(6)-2	2230	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 3 mm fixed		PERRL			
	SENSORIUM	Sedated c̄ Fentanyl, Versed		alert awake, responds			
		in OR. Response to		appropriately c̄			
		noxious stimuli. MAE4		interpreter.			
		Been sling cast upper ground to L					
RESPIRATORY	RESPIRATORY PATTERN	Even + unlabored.		easy, non laborded			
	BREATH SOUNDS	Lungs CTA in all fields.		clear bilat.			
	SECRETIONS	O2 45% venturimask O2		4LNC, O2 sat 97%.			
		Sats 99%. Coughing c̄		incentive spirometry			
		suction		done c̄ good effort			
SKIN	COLOR	All Denture skin area		WNL.			
	INTEGRITY	areas c̄ dress. (R) lower		drsg to R+L LEs.			
		leg wrapped c̄ Ace		see notes.			
IV SITE	LOCATION	18G Hplock to (L) A/C.		(R) AC hep lock (L) SC cordis			
	CONDITION	(L) Subclavian c̄ D5W at		drsg c̄ s/k intact c̄ LR infusing			
		LR infusing @ 125cc/hr.		patent, flushes @ 125cc/hr			
		Sites c̄ redness or drainage		easily — site patent &			
				flushes easily			
GASTRO	ABDOMEN	Flat c̄ distension		flat, nontender.			
	BOWEL SOUNDS	BS Hyperactive x4.		(+) BS x 4 quadrants			
		No flatus as measured					
		vomiting @ present					
GU	URINE:	Foley to gravity. clear		foley → gravity			
	COLOR/CLARITY	yellow urine		clear yellow urine			
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Tachycardia.		sinus rhythm → tachy.			
	Radial	Pulses 2+. (L) Dorsalis		see vascular assessment for			
		Pedis, Posterior tib.		pulses. (R) radial artline			
		(R) Dorsalis Pedis always		intact, zeroed + calibrated			
	(R)	Posterior Tib via Doppler +		(R) blood return, good waveform			
				on monitor.			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] MPN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 13 Sept 2003

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | From OR | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line										158/87	134/47	164/63	164/73	164/73	173/78	160/79
BP Cuff										138/76	137/69	139/74	144/57	138/62	128/69	135/64
Temperature										98.8	97.4			99.4		99.2
Pulse										106	97	101	96	85	95	95
Respiratory Rate										19	15	17	16	15	17	16
Sat										99%	98%	99%	100%	100%	100%	100%
Ox Source										VM 45%	45%	45%	SLNC	SLNC	SLNC	SLNC
BS										134/60						
HR										99						
30										127/68						
HR										96						
45										159/59						
HR										105						
Popplex PT Q20 checks										Pad Tight	Pad Tight					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
LR											125	125 250	125 375	125 500	125 625	125 750	125 875	
OR										4000 5000								5000
PRBCs										500 500								500
Hespan										1500 500								500
IVPB			20 20						200				30 250					

TOTALS

OUTPUT

		06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
URINE	HOUR / TOTAL										3000 3000	—	40 340	300 2200	150 2850	120 3020	300 3320	100 3420	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05
	147/65	127/60	150/68	148/62	137/64	129/54	150/60	142/59
	118/54	123/57	126/63	126/62	119/56	120/59	120/55	117/61
	99²				98⁴			98⁶
	98	100	94	102	114	94	94	121
	19	18	16	19	20	16	15	22
	98%	97%	99%	96	96	95	96	96
	4LNC	4LNC	3LNC	3LNC	3LNC	3LNC	3LNC	3LNC

	22	23	24	01	02	03	04	05	8° T
	125	125	125	125	125	125	125	125	
	1000	1125	1250	1375	1500	1625	1750	1875	1875
									500
									500
									500
	150 350						100 450		450
									8225
	50 / 370	50 / 520	50 / 570	100 / 670	100 / 770	75 / 845	200 / 1045	175 / 1220	~~10,220~~ 4220

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	1500
		MODE	VM
		F_IO_2	45%
		TV	
		RATE	
		PEEP	
ARTERIAL	A	pH	7.24
		PCO_2	44.8
		pO_2	139
	B	HCO_3	21
		SAT	99%
	G	BASE	-6

LABORATORY	TIME	1500
	GLUCOSE	116
	Na/K	136/4.9
	Cl/CO_2	108/21
	BUN/Cr	6/0.7
	WBC/PLATELET	16.1/339
	Hct/Hgb	32.1/10.6
	PT/PTT	16.5/40.3

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

24 hr I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	~~10,220~~ 8225	TOTAL	4220

(P) 05

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2

NEUROLOGICAL ASSESSMENT

		HOURS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4													4				✓				✓			
		TO SPEECH 3										2														
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5													5				✓				✓			
		CONFUSED 4																								
		VERBALIZES 3										3														
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6													6				✓				✓			
		LOCALIZES PAIN 5										5														
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO MOTOR RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER										R/L			R/L				✓				✓			
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER										L			L				L				L			
		MILD WEAKNESS										R			R											
		SEVERE WEAKNESS																	R				R			
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE										3			3				3				3			
		REACTION										++			++				++				++			
	LEFT	SIZE										3			3				3				3			
		REACTION										++			++				++				++			
PUPIL SCALE			2		3		4		5		6								7 mm							
CP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

	HOURS	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
Dorsalis Pedis	R	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	L	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
Posterior Tib	R	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
	L	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
	R																
	L																
	R																
	L																
	R																
	L																

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) – QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INIT (b)(6)-2	1830	INITIAL (b)(6)-2		INITIALS
NEURO	PUPILS	reactive Pearl		PERRL			
	SENSORIUM	alert, medicated c̄		awake + alert.			
		MSO4 4mg for pain		no c/o pain.			
		arousable c̄ verbal					
		stimuli.					
RESPIRATORY	RESPIRATORY PATTERN	RR Reg RR: 20		tachypneic			
	BREATH SOUNDS	SA O2 98% on @ 3L O2		(+) wheezes + rhonchi bilat			
	SECRETIONS	LS: CTA even ↑ ↓		nonproductive cough.			
		chest. ⊘ SOB ⊘		RR 24, O2 sat ↓ 91% on			
		tachypnea noted		5L nasal cannula.			
				MD notified			
SKIN	COLOR	normal for race		WNL.			
	INTEGRITY	drsg (R) leg edema		see notes			
		Foley (+) drainage moderate					
IV SITE	LOCATION	A line (R) wrist zeroed		left SC Cordis	Lt. heplock	A line (R) radial	
	CONDITION	central line (L) clavicle		intact drsg + site	drsg + site	site clean	
		infusing LR @ 125cc/hr		intact. LR @ 125cc/hr	intact patent	intact	
		18g III heplocked		infusing.	flushes easily	zeroed calibrated	
						patent, blood return	
GASTRO	ABDOMEN	flat, nondistended		flat, nontender			
	BOWEL SOUNDS	(+) BS x4 quads		(+) BS x4 quads - hyperactive			
		↓ active		decreased appetite			
GU	URINE:	Foley → gravity		Foley → gravity			
	COLOR/CLARITY	draining clear yellow		clear yellow urine			
		urine					
CARDIOVASCULAR	CARDIAC RHYTHM	HR NSR HR 84		sinus tachycardia. HR 108			
		S1 S2 normal ⊘		see vascular assessment for pulses			
		⊘ extra sounds ⊘ murmur					
		(+) pedal Dorsalis pulse ± doppler					
		able to move all extremities					
				skin warm. ⊘ cap refill			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (b)(6)-2 1LT AN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 14 Sep 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line									A Line	146/61	145/61	147/61	159/59	148/67	158/68	138/56	129/38
~~BP Cuff~~ A-Line	131/61	151/63	159/66	153/69					NIBP	116/57	125/58	113/58	133/67	124/60	130/65	125/56	102/47 (BP)
Temperature	98.4		98.3	98.2							99.0	99.6	99.3	98.6		98.5	
Pulse	94	82	86	92						81	83	87	82	87	74	77	78
Respiratory Rate	17	15	15	13						16	16	16	18	17	16	16	15
SAO2	98%	98%	97%	98%						99%	96%	96%	96%	95%	98%	95%	96
O_2	3L	3L	3L	3L						3L	3L	3L	3L	5L	5L	5L	5L

Primaxin
3mg MSO4

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR / HC TOTAL	125 / 125	125 / 250	125 / 375	0	0	0	0	125 / 500		125 / 625	125 / 750	125 / 875	125 / 1000	125 / 1125	125 / 1250	125 / 1375	125 / 1500	
IVPB					150				150	100 / 250	Ø	Ø	Ø	Ø / 250				
Blood			2 units				700		700	Ø	Ø	Ø	Ø	250				
PO		250											250			350 / 490		
TOTALS																		

OUTPUT

	HOUR / TOTAL	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR	400	400	400	400	325	225	300	350	2800	350	300	350	325	200	150	175		
	TOTAL	400		700	1100	1425	1650	2450	2800		3150	3450	3800	4125	4325	4475	5760		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05
	145/57	152/62	142/65	145/72	138/62	124/61	133/68	109/51
	123/60	124/53	127/54	129/61	126/55	112/44	116/58	99/37
	98.4				98.6			98.3
	72	75	76	97	75	77	100	74
	19	16	16	19	16	15	14	15
	97	96	96	96	98	98	100	97%
	5L	5L	5L	5L	5L	4L	4L	3L

	22	23	24	01	02	03	04	05	
	125	125	125	125	125	125	125	125	8° T
	1625	1750	1875	2000	2125	2250	2375	2500	2500
	100 350						100 450		450
		250 740							740
									3690
	200 5960	400 6360	350 6710	300 7010	300 7310	400 7710	200 7910	200 8110	8110

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	0600								
	MODE	NC								
	F_IO_2	3L								
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	pH	7.397								
	PCO_2	45.1								
	pO_2	92								
	HCO_3	28								
	SAT	97								
	BASE	3								

LABORATORY										
	TIME	0500								
	GLUCOSE	110								
	Na/K	133/4.1								
	Cl/CO_2	102/24								
	BUN/Cr	7/0.9								
	WBC/PLATELET	8.8/181								
	Hct/Hgb	25.6/8.7								

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

TURN	TIME				
SUCTION					

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	1400 1800
po			
TOTAL	3690	TOTAL	10810
BALANCE			-7120

NURSE'S SIGNATURE | INITIALS

(b)(6)-2

(b)(6)-2

(b)(6)-2

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS
EYES OPEN	SPONTANEOUSLY	4
	TO SPEECH	3
	TO PAIN	2
	NO EYE OPENING	1
BEST VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	VERBALIZES	3
	VOCALIZES	2
	NO VOCALIZATION	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	ABNORMAL FLEXION	3
	EXTENSION TO PAIN	2
	NO MOTOR RESPONSE	1
LIMB MOVEMENT: ARMS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
LIMB MOVEMENT: LEGS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
PUPILS: RIGHT	SIZE	
	REACTION	
PUPILS: LEFT	SIZE	
	REACTION	
PUPIL SCALE		2, 3, 4, 5, 6, 7 mm
CP		
CEREBRAL PERFUSION PRESSURE		

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record separately if there is a difference between the two sides.

+ + Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

	HOURS	06	07	08	09	10	11	12	18	19	20	21	22	23	24	01	02	03	04	05
Dorsalis Pedis	R	-	D	D	D	D	D	D	D		D		D		D		D		D	
	L	++	++	++	++	++	++	++	++	++	++		++		++		++		++	
Posterior Tib	R	D	D	D	D	D	D	D	D		D		D		D		D		D	
	L	++	++	++	++	++	++	++	++		++		++		++		++		++	
	R																			
	L																			
	R																			
	L																			
	R																			
	L																			

LEGEND

+ + Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) _
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0645	INITIALS (b)(6)-2	INITIALS	1900	INITIALS (b)(6)-2
NEURO	PUPILS	3mm 3mm. Pearl			PERRL	
	SENSORIUM	aaOx3 (+) movement, sensation, strength			A+O x3, denies pain	
		to all extremities minus (R) LE.			Moves RUE, LLE.	
		(+) movement to Big toe only (R) LE			unable to move RLE but	
					wiggles (R) great toe.	
RESPIRATORY	RESPIRATORY PATTERN	Nonlabored, even			easy, nonlabored.	
	BREATH SOUNDS	Clear throughout			Clear bilat. O2 sat	
	SECRETIONS	Ø Sputum			on RA = 100%. client	
		chest movement			with excellent effort	
		symmetrical			on incentive spirometer.	
					able to sustain 1200cc/per sec for 4 sec	
SKIN	COLOR	NFR - (+) Ex Fix To			WNL	
	INTEGRITY	(R) LE dressing c̄ minimal serous			See notes *	
		drainage dorsal side, (+) dressing to (L) LE				
IV SITE	LOCATION	Rt Pulm Art (+) AC - placed			(R) forearm PIV	ESC Cardis
	CONDITION	13 Sept 03, site d (+) flush			site + dsg intact	site + dsg intact
		(+) blood return (-) infiltration			(+) blood return	(+) blood return, flushes
		infiltration. (+) (-) subclavian			flushes easily	easily. LR @
		sclerosis cortisone infusing			Heparin @ 20cc/hr	100 cc/hr infusing
		1.25 cc/hr. Ø infiltration infection @ vein			(1000 units/hr).	
GASTRO	ABDOMEN	soft, non tender			soft nontender	
	BOWEL SOUNDS	BS x 4			(+) BS x 4 quads.	
		last BM, unknown			denies nausea, decreased	
					appetite, refused dinner.	
GU	URINE:	foley to gravity			foley → gravity	—
	COLOR/CLARITY	clear yellow			clear yellow	—
					good out put	—
CARDIOVASCULAR	CARDIAC RHYTHM	NSR. Radial R L palpable 2+			sinus tachycardia, regular rhythm	
		(L) dorsalis pedis palpable 2+			(R) radial art-line site +	
		(R) dorsalis pedis & posterior			dsg intact. good waveform	
		tibialis non palpable - (+) Doppler x 2. (+) 2+ Edema (R) LE. cap refill < 3 sec			on monitor, zeroed +	
					calibrated.	

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
F/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 1LT AN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 15 Sep 03

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

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☐ HISTORY/PHYSICAL ☐ FLOW CHART
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