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. 6 Yr. 83

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8
4 June 83	[redacted]	NS @ 120cc/hr	05	[redacted]				
			17	[redacted]				
4 June 83	[redacted]	Zantac 50mg IV BID	10	[redacted]				
			22					
4 June 83	[redacted]	Fentanyl drip to sedation	05	[redacted]				
			17	[redacted]				
4 June 83	[redacted]	Versed drip to sedation	05	[redacted]				
	b(6)2		17	[redacted]				
4 June 83	[redacted]	Ancef 1gm IV q 8°	08	[redacted]				
		16	16	[redacted]				
			24	[redacted]				
4 June 83	[redacted]	Zantac 50mg IV BID	03	[redacted]				
			15	[redacted]				
4 Jun	[redacted]	Vent: SIMV R14 P5	05	[redacted]				
		TV 700 FIO2 50%	17	[redacted]				
5 June 83	[redacted]	Titrate FIO2 to O2	05	[redacted]				
		Sats	17	[redacted]				

b(6)2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW to Face

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 6 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													
4 June	[redacted]	Tylenol 650mg PR	2 Jun 03 [redacted]	16 June 0430												
- - - - -	- - - - -	q T > 101	1610	101.16 [redacted]												
4 June 03	[redacted]	PRN Vecuronium 5mg														
- - - - -	- - - - -	IV q 1°														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

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 06	7	8	9	10	11								
6June03	[redacted]	Bactrocin to wounds	08	[redacted]													
		TID	16	[redacted]													
			24	[redacted]													
6June03	[redacted]	NS @ 120cc/hr	05	[redacted]													
			17	[redacted]													
6June03	[redacted]	Ancef 1gm IV q8°	08	[redacted]													
			16	[redacted]				b(6)2									
			24	[redacted]													
7June03	[redacted]	Afrin nasal spray	10	[redacted]													
		ii sprays q nostril	22	[redacted]													
		BID															
7June03	[redacted]	Irrigate w/NS TID	08	[redacted]													
			16	[redacted]													
			24	13													

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P wound closure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ____

PATIENT IDENTIFICATION:
#[redacted] b(6)4 [redacted]
31 y.o.

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**
7June03	[redacted] b6 b7c	Albuterol NUB X1	7June03	0730	0730	[redacted]
						b6 b7c

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED												
6June03	[redacted]	Tylenol 650mg PR /	6June 1230	6June 1605											
	b6 b7c	PO q4° prn T>101	[redacted]	[redacted]											
6June03	[redacted]	Morphine 24mg q1°	6June 03	7Jun 03											
		IV prn pain	4mg 2300	0700 4mg											
7June03	[redacted]	Phenergan 12.5mg													
		IV q4° prn N/V													

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. 6 Y 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10	11
8 June 03	[redacted]	IV: Heplock	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
						b(6)2	
8 June 03	[redacted]	Ancef 1 Gm IV q 8°	6	[redacted]			
			14	[redacted]			
	b(6)2		22	[redacted]			
		~~Infiltrated~~					
8 June 03	[redacted]	Afrin nasal spray	08	[redacted]			
		2 sprays q nostril BID	20	[redacted]			

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW to face

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: b(6)f

EPW # [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 6 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														
3Jun03	[redacted]	tylenol #3 1-2 tabs	09 Jun 0934														
	b(6)2	po q4° PRN pain	[redacted]	b(6)2													
3Jun03	[redacted]	Phenergan 12.5mg IV															
		q4° PRN N/V															

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: 4 Jun 03
Time In: 1040
Allergies: NKDA
Pre-op V/S: BP 75, 86, 18
Procedures: I&D

Anesthesia Type (Circle)): General Spinal Epidural
NS IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 350 EBL 200
Meds/Times:

100 Fent
0/35 Ancef
5 versed
500 mg Fent
100 mg Benadryl

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

Airway: Nasal, Oral, ETT, Trach, Other — Nasal

Pre Op Meds

History

Time															
SaO2	100	100	100	100	100	100	100	100	100	100	100	100			
FiO2															
Methods															
240															
220															
200															
180															
160															
140															
120															
100															
80															
60															
40															
20															
RR	16	16	20	16	26	14	14	14	14	14	14	14			
T	99														
Time															
Pain (0-10)															
LOS															

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1040	NS	300	CFA	[redacted]	300
				b(6)	2

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	paralyzed BB 2mm	paralyzed 2mm	paralyzed
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	vent	vent	vent
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	Sedative	Sedative	Sedative
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	3	4	4

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)

[redacted] b(6)2

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

#[redacted] b(6)4

DEPARTMENT/SERVICE/CLINIC: PACU/ICU #2

DATE: 4 Jun 03

☐ 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
		See NN				

NEUROVASCULAR

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

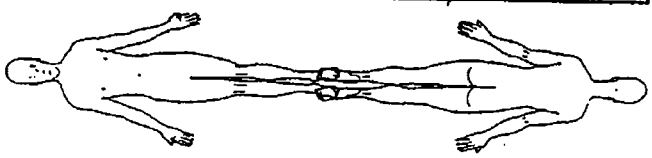
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1045	Deltoid Facial DSG	Deltoid 4x4 Facial - w-D Kerlix	Ø
30' 1110	Deltoid face	4x4's w-D Kerlix	Ø
60' 1140	Deltoid face	4x4 w-D Kerlix	Ø
D/C 1150	Deltoid face	4x4 w-D Kerlix	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	See NN		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1045 Arrived to PACU/ICU#2 from Surgery. Pt sedated, D5NS FA 1 NS @120 cc/hr - 3 s/s of infection or inflammation. RAC HL 3 s/s of infection. Foley cath clear yellow urine in foley bag. Ribs present in all 4 extremities. Vent SIMV R14 TV 700 50% P5 — Sgt [redacted]
1100 Started Versed & Fent drip to sedation, Pt raising off bed. Gave PRN Vecuronium 5mg IV per CRT. [redacted], HOB @ 30° SHH
1205 CBC & ABG's done. Sgt [redacted]
1210 Pt to stay in ICU#2. Sgt [redacted] 6/6/2

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: _____

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: 16 June 03
Time In: 1025
Allergies: NKDA
Pre-op V/S: 148/120
Procedures:

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000cc Colloid
OR Output: UOP 250 EBL Min
Meds/Times:

160 mcg Narcan
Proventil x3
1 mg Morphine

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1025	1030	1035	1040	1045	1050	1055	1100	1105	1110	1115	1120	1125	1130
SaO2	93	90	93	91	[illegible]	96	96	99	99	99	99	100	99	99
FiO2	15	15	15	15	15	15	15	15	15	15	15	15	15	12
Methods	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
240														
220														
200														
180														
160														
140														
120														
100														
80														
60														
40														
20														
RR	20	25	25	25	19	20	21	20	20	19	19	17	16	16
T	A 102													102.5
Time														
Pain (0-10)														
LOS														

Anesthesia Equipment Check Off Sheet
Recovery Phase
Discharge Phase

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1025	LR	120	(R) FA	[redacted]	LR
				b(6)2	

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	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	9

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] b(6)2

DEPARTMENT/SERVICE/CLINIC: PACU / ICU #2

DATE: 16 June 03

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

Name – last,

X [redacted] b(6)4

☐ 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							
15'							
30'							
45'							
60'							
90'							
D/C							

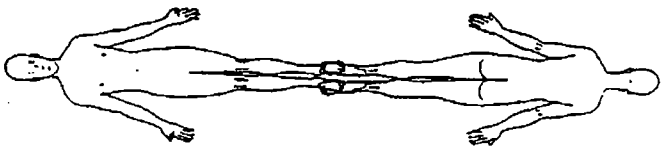
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1025	(L) deltoid	4x4's	Ø
30' 1055	(L) deltoid	4x4's	Ø
60' 1125	(L) deltoid	4x4's	Ø
D/C 1130	(L) deltoid	4x4's	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1025 Pt admitted from Surgery. SPO2 ↓ 80%. Nasal trumpet applied to (R) nare per surgical staff. @ 1030 Albuterol NEB tx done per RT. due to Dr. Perkins order & bil. ronchi. Pt sat ↑ @ 1050 98's. Will monitor closely. — Sig [redacted]

1050 Pt has sutures noted (L) ~~chee~~ cheek area to (L) ear across top of ear & behind top of (L) ear. sutures on (R) beside the mouth. (L) scalp area c̄ sutures no active bleeding noted. Suction x2. Will monitor — Sig [redacted] b(6)2

1100 Ancef 1gm given. Pt resting in bed. SPO2 99% FM @ 15. Will monitor closely. — Sig [redacted]

1130 Pt staying in ICU #2 Sig [redacted]

Discharge Criteria:
Date: before **Time:** 1130 **PARS:** 9
BP: 119/67 **T:** 101.5 **HR:** 109 **RR:** 18 **SaO2:** 99
Pain Level at D/C (0-10):
Intake: 120 NR **Output:**
Additional Data: sutures on face & head
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

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	1040	INITIALS	1800	INITIALS		INITIALS
NEURO	PUPILS	sluggish @ 2mm		2mm sluggish reaction			
	SENSORIUM	Pt sedated unable to		sedated on versed &			
		access		Fentanyl			
RESPIRATORY	RESPIRATORY PATTERN	= chest expansion, Pt		symmetrical rise & fall			
	BREATH SOUNDS	on vent SIMV 14 TV 700		VENTED SIMV R14 TV 700			
	SECRETIONS	FIO2 50% Bloody secretions		PS FIO2 40%			
		po noted.		BS clear			
				ETT 7.5 27cm @ nare			
SKIN	COLOR	normal		normal			
	INTEGRITY	Scars across chest &		lg bleeding area around			
		welts on ABD area		head, gauze @ shoulder			
IV SITE	LOCATION	(R) AC HL (L) FA		(R) AC & (L) forearm			
	CONDITION	CDI S/S of infection		sites intact			
				NSC 120cc/hr			
GASTRO	ABDOMEN	Soft, NT, ND		Soft, flat			
	BOWEL SOUNDS	hyperactive		BS (+)			
GU	URINE:	Clear yellow = Foley		Foley — clear yellow			
	COLOR/CLARITY	Cath.		urine			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR noted 5 ectopy		NSR 5 ectopy			
				S1 S2			
				palpable pulses x4			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 4 Jun 03

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

[redacted] b(6)4

[redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DS 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS																		
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
BP Arterial Line																		
BP Cuff								131/66		124/61	132/89	134/69	131/85	127/76	126/80	125/77	123/79	
Temperature								96.0 A		96.5 A	99.2 A	100.3 A	101	100.7			100.1	
Pulse								75		76	82	82	88	85	81	82	77	
Respiratory Rate								14		14	14	14	14	14	14	14	14	
SPO2								100	100	100	100	100	100	100	100	100	100	
FIO2 vent										40	40%	40	40	40	40	40	40	
INTAKE																		
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	8° T	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	8° T
Versed							5	5		5	5	5	5	5	5	5	5	
Fent							10	10		10	10	10	10	10	10	10	10	
NS							120	120		120	120	120	120	120	120	120	120	
Zantac												50						
										135	135	185	135					
							135	135		135	270	455	590					
TOTALS							135	270	270									
OUTPUT																		
URINE HOUR / TOTAL								525	525			450 / 450	150 / 600	100	110	120	75	
URINE 10 gr																		
URINE S/A																		
URINE OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

Foley

POST-OP DAY

	21	22	23	24	01	02	03	04
	16	17	18	19	20	21	22	23
VITAL SIGNS	137/79	132/83	139/81	136/82	134/82	130/80	130/78	120/74
			100.0					
	84	88	86	86	87	88	83	81
	14	14	14	14	14	14	14	14
	100	100	100	99	100	100	100	100
	40	40	40	40	40	40	40	40
INTAKE	16	17	18	19	20	21	22	23	8°T
	5	5	5	5	5	5	5	5	90
	10	10	10	10	10	10	16	10	180
	120	120	120	120	120	120	120	120	2160
				50			50		75
									2505
	100	120	100	150	120	75	100	120	
									2415

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA											
	TIME	1330									
	MODE SIMV	SIMV									
	F_IO_2	40									
	TV	700									
	RATE	14									
	PEEP	5									
ABG	pH 1240	7.44									
	PCO_2	33.3									
	pO_2	260									
	HCO_3	23									
	SAT	100									
	BASE	-1									

LABORATORY DATA											
	TIME										
	GLUCOSE										
	Na/K										
	Cl/CO_2										
	BUN/Cr										
	WBC/PLATELET										
	Hct/Hgb										

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

TURN	TIME										
SUCTION											

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday 220 75 295	wt Today		
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		
BALANCE			

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	0540 sluggish to light	[redacted]	1800 2mm sluggish	[redacted]	b(6)-2	
	SENSORIUM	mik. Pt sedated on Versed & Fent.		MAE, arouses easily sedated on versed & fentanyl			
RESPIRATORY	RESPIRATORY PATTERN	= Chest expansion		= expansion			
	BREATH SOUNDS	clear bil. Pt on vent		CTA bil			
	SECRETIONS	TV 700 SIMV 14 FIO2 40% PS ETT 7.5 @ 27cm (R) nare		VENTED 7.5 ETT @ nare 27cm SIMV Tv 700 R14 PS FIO2 30%			
SKIN	COLOR	normal Large DSG		nml			
	INTEGRITY	(Kerlix) around head & L deltoid area DSG CDI		1g gauze dbsg around head, intact			
IV SITE	LOCATION	(L) FA IV & (R) AC HL		(D) FA & (R) AC			
	CONDITION	CDI & S/S of infiltration		NSC 120 via (D) IV			
GASTRO	ABDOMEN	soft, nondistended. BS		nod soft + (+) BS			
	BOWEL SOUNDS	present in all 4 quads.		x4			
GU	URINE: COLOR/CLARITY	Foley - clear yellow urine		Foley clear urine			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR - noted ectopy Pulses present in all 4 extremities		NSR HR 70s-80s palpable pulses x4 cap refill brisk			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 5 June 03

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

EPW # [redacted] b(6)2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	127/83	120/82	130/72	123/79	117/73	116/76	113/72	116/71		113/69	109/63	113/65	115/63	103/56	105/61	97/57		
Temperature	99.2	99A	99A	99A	98A	98A	98A	98A		98A	99A	98A	98A	99A		98.8		
Pulse	77	80	81	78	76	78	78	78		78	78	85	97	85	77	80		
Respiratory Rate	14	14	14	14	14	14	14	14		14	14	14	14	14	14	14		
O_2 SATS	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100		
FIO_2	40	40	40	40	35	30	30	30		30	30	30	30	30	30	30		
INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV NS	120	120	120	120	120	120	120	120		120	120	120	120	120	120	120	120	
Versed	5	5	5	5	5	5	5	5		5	5	5	10	10	10	10	10	
Fent	10	10	10	10	10	10	10	10		10	10	15	20	20	20	20	20	
IVPB				50								50	50	50		66.2		
TOTALS																		
OUTPUT																		
URINE Foley — HOUR / TOTAL	150		425		450		300			450		225		250		300		
URINE — sp gr																		
URINE — S/A																		
NG — OUTPUT																		
NG — pH																		
NG — GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	21	22	23	24	01	02	03	04	
	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	
	104/62	103/58	110/60	111/62	103/60	97/57	116/63	114/69	
								101.6	
	77	80	80	84	82	86	83	105	
	14	14	14	14	14	14	14	14	
	100	100	100	100	100	100	100	100	
	30	30	30	30	30	30	30	30	

INTAKE	16	17	18	19	20	21	22	23	8°T
	120	120	120	120	120	120	120	120	2880
	10	10	12	15	15	15	15	10	209
	20	20	20	25	25	25	25	25	310
				50			50		250
									3649

OUTPUT									
	250			300		200		250	3000

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES 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:	
po			
TOTAL		TOTAL	

BALANCE _____

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

66-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0518	INITIALS [redacted]	1300	INITIALS [redacted]	1730	INITIALS [redacted]
NEURO	PUPILS	Sluggish @ 2mm		Sluggish @ 2mm		Opens eyes	
	SENSORIUM	Sedated on Versed & Fent		Pt still sedated p surgery		Pt arousable to touch. Tried to make gestures	
RESPIRATORY	RESPIRATORY PATTERN	= bil expansion		= bil expansion		equal rise and fall	
	BREATH SOUNDS	Clear bil Pt on vent		clear bil		⊖ wheezes (B), (R) Rhonchi	
	SECRETIONS	TV 700 SIMV 14 FiO2 30% PS		no secretion noted @ present time. Will monitor		⊕ cough / bloody yellow sputum O2 @ 8 LPM via venturi mask SpO2 98-99%	
SKIN	COLOR	Normal color DSG Kerlix around head & (L) deltoid DSG intact.		normal sutures on (L) cheek area to (L) ear across (L) deltoid - suture, (L) sp intact. top of ear & behind top of (L) ear noted c/d/I		(R) scalp - staples, (L) cheek sutures	
	INTEGRITY						
IV SITE	LOCATION	(L) FA & (R) AC CDI		sutures on (L) beside the mouth (L) scalp area c/d/I		(R) FA I.V. site c 120 cc/hr NS	
	CONDITION	∃ S/S of infection.		Sutures. No active bleeding noted. (L) FA IV ∃ S/S of infection or infiltration.			
GASTRO	ABDOMEN	Soft, Nondistended		Soft nondistended		Soft, nondistended, (R) TTP	
	BOWEL SOUNDS	present in all 4 quads		BS present in all 4 quad hypoactive		↓ BS x 4	
GU	URINE: COLOR/CLARITY	Foley c clear yellow urine		Foley c clear yellow urine		Foley to gravity, draining clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR ∃ ectopy pulses present in all 4 extremities.		NSR ∃ ectopy. Pedal pulses present in all 4 quads.		NSR, pulses present x 4 extremities	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SaT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 6 JUN 05

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

EPW # [redacted] b(6)4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS																		
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	12	13	14	15	
BP Arterial Line																		
BP Cuff	~~99/52~~	~~95/53~~	~~114/60~~					~~114/62~~		~~111/58~~	~~109/61~~	~~109/55~~	~~109/58~~	~~112/61~~	113/61	119/73	122/76	
Temperature	A 101.8	101.6 A	103.4 A					101.3 A		100.5 A	100.3 A	99.6 A	101.2 A	99.7 A	100.8			
Pulse	98	95	109					109		98	92	92	92	92	101	92	83	
Respiratory Rate	14	14	14					18		19	19	19	20	21	19	23	22	
SPO2	100	100	95					99		97	97	97	96	98	100	99	96	
FIO2	30	30	100															
pain																		
intervention																		
INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	~~08~~	~~09~~	~~10~~	~~11~~	12	13	14	15	8°T
NS IV	120	120	120				120	120		120	120	120	120	120	120	120	120	
Versed	10	10	10												0/30			
Fent	10	10	10												0/30			
IVPB							50											
TOTALS															120	120	120	
															2380	2500	2620	
OUTPUT																		
URINE (Foley) HOUR	100		300				250	150			425		415				120	
URINE TOTAL																	1125	
NG SIA																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY	21	22	23	24	01	02	03	04
VITAL SIGNS	16	17	18	19	20	21	22	23
	125/77	133/84	138/76	133/88	124/71	131/78	124/76	124/61
	100.8		100.8			100.6		100.3
	98	120	96	97	95	112	100	100
	26	27	28	29	29	22	22	26
	93	95	96	97	95	96	97	96
INTAKE	16	17	18	19	20	21	22	23 / 8°T
	120	120	120	120	120	120	120	120
					60			
	120	120	120	120	120	120	120	120
	2740	2860	2980	3100	3220	3340	3460	3580	3580
OUTPUT	300/1925	300/2025		300/2350		300/2900		300/3000
	200							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

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

24 I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	3580	Urine:	
po	60		
TOTAL	3580	TOTAL	3000
		BALANCE	580

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

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	17
EYES OPEN	SPONTANEOUSLY	4	3
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	
BEST VERBAL RESPONSE	ORIENTED	5	
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	
	LOCALIZES PAIN	5	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		2
	REACTION		+
PUPILS — LEFT	SIZE		2
	REACTION		+
PUPIL SCALE			2 3 4 5 6 7 mm
ICP			
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		
	R L	
	R 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 66-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0515	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS		PERRL @ 3mm					
	SENSORIUM		obeys verbal commands					
			makes gestures to					
			make needs known					
RESPIRATORY	RESPIRATORY PATTERN		~~Abn~~ rise & fall bil					
	BREATH SOUNDS		clear bil					
	SECRETIONS		Ø secretions noted					
SKIN	COLOR		normal (-) scalp area					
	INTEGRITY		c staples. (-) check to					
			ear & top of ear & behind					
IV SITE	LOCATION		top of ear c sutures (-)					
	CONDITION		deltoid area c sutures					
			CDI.					
			IV @ FA c S/S of infection					
			or infiltration NS @					
			120cc/hr					
GASTRO	ABDOMEN		soft, nondistended					
	BOWEL SOUNDS		BS present in all 4					
			quads.					
GU	URINE:		Pt voids spontaneously					
	COLOR/CLARITY		will ask to void in					
			own language.					
CARDIOVASCULAR	CARDIAC RHYTHM		NSR c ectopy. Pulses					
			present in all ext-					
			remities					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 7 Jun 03

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

[redacted] b(6)4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	04	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	120/77	~~125/66~~	~~125/61~~	~~135/72~~														
Temperature	98.7	95.2 A	98.2 A	97.9 A														
Pulse	87	82	88	89														
Respiratory Rate	0	22	18	20														
SpO2	99	99	100	99														
FiO2	RA	RA	RA	RA														
pain																		
situation																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NG	120	120	120	120														
	120																	
TOTALS	120																	

OUTPUT

		TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		HOUR / TOTAL																		
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8°T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF 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	_____	TOTAL	_____

BALANCE _____

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

66-2

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

INITIAL SHIFT ASSESSMENT

	TIME	0515	INITIALS [redacted]	1830	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Sluggish @ 2mm. PA		3mm brisk			
	SENSORIUM	Sits up in bed @ 45's,		PO AOX3, Verbal			
		talks unable to		obeys commands			
		understand due to		interacts & speak able			
		language barrier will		to make needs known			
RESPIRATORY	RESPIRATORY PATTERN	get interpeter.		even unlabored			
	BREATH SOUNDS	= rise & fall bil.		(R) diminished sounds			
	SECRETIONS	ronchi (L) side (R) diminish		(L) clear			
		lung sounds noted					
				Sats 96-100% on RA			
SKIN	COLOR	Normal (L) scalp area		Normal, wks so hard will			
	INTEGRITY	= staples CDI. (L) cheek		area CDI			
		to ear & top of ear & behind					
IV SITE	LOCATION	top of ear = sutures (L)		(R) forearm, patent CDI			
	CONDITION	deltoid area = sutures		120 ml/hr NS			
		(R) beside mouth area					
		= sutures CDI. No					
		active bleeding noted					
		IV ~~OR~~ s/s of infection					
GASTRO	ABDOMEN	or infiltration noted. AOO		soft, ØTT,			
	BOWEL SOUNDS	soft, nondistended.					
		BS present in all 4		BS x 4			
		quads.					
GU	URINE:			clear yellow, self voids			
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM	NSR = ectopy noted		NSR = ectopy			
		Pulses present in all		Pulses present x4			
		4 extremities noted					

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU 2 West

DATE: [redacted]

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

[redacted] b(6)4 [redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DX													HOSPITAL DAY				
VITAL SIGNS																		
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	112/68	130/78	128/82	130/79	126/75	115/69	140/87	126/84		135/76	116/62	120/66	130/76	98/69	116/67	145/75	120/73	
Temperature	100.2	99.3 A	98.9 A	99.2 A	99.2 A	98.8 A	98.1 A	98.9 A		99.2 A	99.1 A	97.9 A	98.9 A	99.1 A	99.0	99.6		
Pulse	96	110	102	105	109	88	115	109		97	92	83	94	90	93	93	91	
Respiratory Rate	96	29	27	17	25	22	24	29		16	27	26	25	21	23	19	28	
	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
SPO2	99	99	100	95	95	98	100	95		100	98	97	99	100	98	100	100	
pain																		
intervention																		
INTAKE																		
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
NS	120	120	120	120	120	120	120	120		120	120	120	120	120	120	120	120	
IVPB				50									50					
PO						500	30			300					60			
	120															120		
TOTALS	120															2790	2910	
OUTPUT																		
URINE — HOUR / TOTAL	100/100			150		450	450				400		350		300/750			
URINE — sp gr																		
URINE — S/A																		
NG — OUTPUT																		
NG — pH																		
NG — GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS									
	21	22	23	24	00	01	02	03	
	124/70	129/80	120/74	117/67	125/74	124/75	123/73	109/61	
			100°					99	
	87	92	96	97	87	85	88	91	
	28	23	31	25	26	26	28	26	
	RA	RA	RA	RA	RA	RA	RA	RA	
	99	94	98	97	98	100	99	100	

INTAKE									
	21	22	23	24	00	01	02	03	8° T
	120	120	120	120	120	120	120	120	
	3030	3150	3330	3450	3570	3690	3710		

OUTPUT									
	0 / 2350	/	/	/ 300	/	/	/ 450	/	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

DAILY ACTIVITIES DF LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24*I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	3830	Urine:	3000
po			
TOTAL		TOTAL	

BALANCE +830

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

B 872

b(6)4

1. DATE AND TIME OF CAPTURE

2. [illegible] NO. 0424990 A

3. NAME [redacted]

4. DATE OF BIRTH

5. RANK

6. SERVICE NO.

7. UNIT OF EPW

8. CAPTURING UNIT 147 MPC

b(2)2

9. LOCATION OF CAPTURE (Grid coordinates) MA

10. CIRCUMSTANCES OF CAPTURE Mine Attack

11. PHYSICAL [illegible] [redacted]

12. [illegible] EQUIP. [illegible] DOCUMENTS

DD FORM 2745, MAY 96 REPLACES [illegible] JAN [illegible] TABLE UNTIL [illegible]

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: [redacted] b(6) 4

RANK / GRADE

MALE / HOMME

FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ: [redacted] b(6) 2

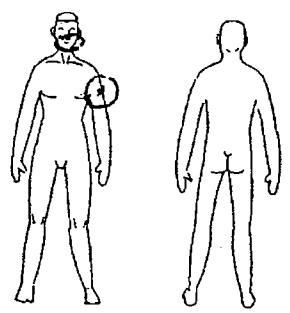
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ

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

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



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

GSW x 2

Probable Facial Scar

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS | TIME / HEURE

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

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

8. IV / IV | TIME / HEURE

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

occurred ~ 2100

Vision Intact x2

Facial TGI IV @ 0426

Airway Intact - no difficulty

Arm pulses intact

C-Spine Clear

2nd Pay Pd. DSMC 0416

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. [redacted]

DATE/DATE (YYMMDD) 04 Jan 05

DD [redacted] replaces previous editions
DEC 5 [redacted] DD Form 1380 and DD Form [redacted] 1380 (TEST), which are obsolete.

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

b(6) 2

b(6) 2

[redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A 1 1 D 1	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
0 0 1 3 3 4 5	EPW [redacted] 66-4		m

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		X	9	Unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	Unk	9 9	

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	Ø725	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K M 9	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	1Cu2	—
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE —

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 Ø		Ø 3 Ø 6 Ø 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B F A		Ø 3 Ø 6 Ø 4

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)

FOR LOCAL USE

Dx: GSW to face + (L) shoulder

DX: 87350
88313
E9912

Px: 8345
8622
2319

Trauma
9

Injury
569

ADMITTING [redacted], as required) — b6-2

[redacted] MAJ DC

SIGNATURE OF ADMITTING CLERK

[redacted], PFC, 91G10

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NUMBER: P3414
2 NAME (Last, First, MI): EPW [redacted] b(6)4
3 GRADE: N/A
4 SEX: M
5 AGE: 47y
6 RACE: 9
7 RELIGION: unk
8 LENGTH OF SVC: N/A
9 FTS: N/A
10 PRIORITY ADMISSION: NO
11 TMP: 90 20
12 SSN: [redacted] 06-4
13 ORGANIZATION: N/A
14 WARD: ICU
15 ETHNIC STATUS: N/A
16 NATIONAL DSG: [redacted]
17 DEPT OF ADM: ~~K79~~ K78
18 BRANCH/CORPS: N/A
19 DIG ZIP
20 TYPE CASE: NBI
21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER
22 HOURS OF ADMISSION: 0633
23 CLINIC SERVICE: AAJA
24 NAME, RELATIONSHIP OF EMERGENCY ADDRESSEE: —
25 TYPE DISPOSITION: 05
26 DATE OF DISPOSITION: 09 Jun 03
27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —
27b TELEPHONE NO: —
28 DATE OF THIS ADMISSION: 09 Jun 03
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)(2)
30 DATE OF INITIAL ADMISSION: 09 Jun 03
31 [redacted]
32 ADMITTING OFFICER: Dr. [redacted] b(6)2
33 UNITS OF [redacted] COMPONENT TRANSFUSED
34 CAUSE OF INJURY
35 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES
Check if Continued on Reverse

ADMISSION REMARKS

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. [redacted] DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

SIGNATURE OF ATTENDING [redacted] b(6)2

SIGNATURE OF PAID OR MEDICAL RECORDS OFFICER [redacted] SPC b(6)2

DA FORM 3647, [redacted]

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.00

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

47 y/o male beaten about the face and head after he shot and killed an American soldier at a guard station. Pt arrived awake/alert/stable.

PMH (R) Femur repair - motorcycle accident.
ALL None
MED None

PHYSICAL EXAMINATION

Head (L) Supraorbital Lac. (B) Orbital ecchymosis.
Eyes uninjured Globes. (B) Corneal Abrasions.
Ears (B) bloody drainage
Nose uninjured
Oropharynx Clear
Neck uninjured
TLS Spine Uninjured.

Lungs Clear
Abd Benign
Ext No injury seen.
Perineum normal.

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

Skull X-rays nasal Fx.
C-Spine X-rays normal C1-6.
(R) Humerus (-) Fx. (L) Forearm (-) Fx. CXR (-).
Impression: Concussion.
Plan: 24° OBS. MP to PER.

$>^{15}_{45}$ $\left\langle \begin{matrix} 143 \\ 4.0 \end{matrix} \middle| \begin{matrix} 2 \\ 26 \end{matrix} \right|$ $\langle 118$

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
[redacted] b(6)4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF [redacted] AL CARE

DATE	SYMPTO[redacted]DIAGNOSIS, TREATMENT, TREATING O[redacted]IZATION (Sign each entry)
7-9-03	S- Trauma ↑ w
	hematoma forehead pt response to painful stimuli
	(+) ttp (R) upper arm (R) orbital Minor abrasions to face
	O2 via NRB @ 15 LPM (+) ttp (L) forearm
	Pupils responsive + reactive both sides
	0210 - p-88 spO2 97 3 inch laceration (L) foreh-
	0213 - spO2 96 above hairline
	0217 - BP 148/88 resp - 18 p- 84 SpO2 98
	2000L of LR
	applied splints to Both arms
	0230 - p-87 spO2 97 resp 16 BP 145/85
	0256 - p-87 SpO2 97 resp 18 BP 140/80
	(+) CSF in blood AU (+) DPMS (B) LE
	0314 p-85 SpO2 96 resp 16 BP 140/80
	0329 p-86 SpO2 96 resp. 16 BP 142/78
	0345 p-76 SpO2 94 resp 15 BP 138/82
	0400 p 74 SpO2 94 resp 16 BP 140/75
	pt. placed spine board c collar
	0415 BP 140/80 p 75 resp. 14
	over

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

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

[redacted] b(6)4

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

pt arrived unresponsive c̄ edema + dried blood on forehead. Aroused c̄ pn ⊖ stepoffs ⊖ crepitus to head ⊕ TTP ⓡ orbit multiple lacs to face + forehead ⊕ bld + clear fluid in ⓡ EAC ⊖ trach. dev. ⊖ chest wall crepitus ⊕ wheezing ⓑ, ⊖ ABD TTP ⊖ pelvis instabil. minor TTP upper ⓡ ext ⓡ lower ext. ⓛ upper ext.

Splinted extremities, c-collar, board & IV d/c'd enroute by medic not re initiated due to stable vitals, PT in and out of consciousness. Afb ? fx ⓡ humerus ⓡ femur ⓛ ulna/rad ⓡ orbit ? skull fx evac to [redacted] b2-2

[redacted]

b(6)2 [redacted] PA-C

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9May03 0900	- Pt. amitted to TCU1 from ER. Pt. stable. (R) eye swollen - closed shut. (L) eye reactive. Pt. has IV (R) AC + (L) wrist. Both clean, dry, intact ⊂ ⊖ swelling ⊖ redness. Pt. A+O x3. Foley to gravity. Pt. on spine board + C-collar. Pt. has active bs. wheezing noted left lower base. Resp - CTA. - BS x4, soft nontender. VSS [redacted] radio
9May03 1020	- VSS - Pt. resting well, cleaned Pt. face ⊂ soap + water. Added bacitras to abrasions. [redacted] - 9LWE4
9May03 1400	- VSS - Pt. resting well [redacted] Pt. tolerated lunch very well. Pt. had 100cc juice + 100 cc soup. - [redacted] 9LWE4 b(6)2
09MAY03 1458	Neurosurgery - CTLS spines nontender. Cleared clinically. With advance diet. D/c spine precautions. Out of bed tomorrow.
1544.	IV 18G D/C at [redacted] (R) AC. [redacted] S Redness/swelling Sign [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	[redacted] b(6)2	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		[redacted]	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.

EPW # [redacted] b(6)4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

05JUN03 Discharge Note
1853 Admit Diagnosis Closed - head injury
Discharge Diagnoses (1) Concussion with nasal fracture
(2) Multiple abrasions & contusions
(3) S/P repair of facial lacerations
(4) No fractures of extremity bones.

History 47 y/o male was beaten about the face and head after he participated in the attack on a guard station, resulting in the GSW death of an American Soldier. He arrived at [redacted] b2-2 awake, oriented, and following commands. Spines were cleared clinically. X-rays of skull, C-Spine, (R) humerus, and (L) Ulna/Radius showed only a nasal fracture. Diet was advanced to regular and he was deemed clear for transport to military holding.

Medications Tylenol/Percocet orally prn.

Disposition (1) Remove facial sutures (L) brow/(R) cheek on/after 12JUN03.
(2) Cleanse/Bacitracin abrasions BID.
(3) Erythromycin Ointment OU BID x 3days for corneal abrasions.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART[redacted]	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	[redacted] TO SPONSOR Neurosurgery, 28 CSH	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or S[redacted] Date of Birth; Rank/Grade.)*		REGISTER NO. Camp Dogwood	WARD NO.

[redacted]LOGICAL RECORD OF MEDICAL CARE
Medical Record
[redacted]ARD FORM 600 (REV. 6-97)
[redacted] by GSA/ICMR
[redacted]1 CFR) 201-9.202-1 USAPA V2.00

Ward/Section	REQUESTING PHYSICIAN	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
Emr	May [redacted] b(6)2	

LAST, FIRST, ML	DATE	TIME	SSN/PSEUDO SSN:
[redacted] b(6)4	09 Jun 03	0653	

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	12.0	4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC	5.18	4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb	15.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	[redacted]		
Hct	47.2	42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV	91.8	80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt	228	130-500 x 10^3 verified	SG	1.030	N/A	Occ Bld		Negative
Lymph %	15.5	20.5-51.1%	Bld	Neg	Negative	H. pylori		Negative
[redacted]			pH	5.0	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk	N/A	Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]					
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

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

REMARKS:

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

Ward/Section

PHYSICIAN: [redacted] b(6)2

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

DATE: 09 JUN 03 TIME: 0633 SSN/PSEUDO SSN: —

(i-STAT)

TEST	RESULT	REF. RANGE
Na+	138	135-146 mmol/L
K+	5.9	3.5-5.3 mmol/L
Cl-	109	98-108 mmol/L
pH	7.507	7.31-7.41
HCO2	34.8	35-45 mmol/L (art) 21-31 mmol/L (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	29	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	28	22-26 mmol/L (art) 23-28 mmol/L (ven)
SO2		95-98%
Base Def	4	(-2) – (+3) mmol/L
Anion Gap	7	10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN	18	8-26 mg/dl
Glucose	118	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	45	38-51% PCV
Hb	15	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Drug of Abuse		

(Piccolo) Chemistry-12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		20-86 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.0 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metals-8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		70-115 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		20-86 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.0 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

b(6)4

PERFORMED BY: [redacted]

DATE: 9 JUN 03

LAB ID NO.:

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 9, MONTH JAN, YR. 03 — TIME: 06:33

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

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☒ PATIENT ☒ OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Head Trauma / Bilateral Arm Fractures

SEX: M AGE: 42

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	0633	0650	
BP	131/72	142/96	
PULSE	74	72	
RESP.	16	14	
TEMP.	99		
WT. (Child)			

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

ORDERS	INITS.	TIME
X-ray Head, C-spine	[redacted]	
(B) Arms, Chest	[redacted]	
2 iv boluses		
Foley Hpcw	b(6)2	
Fentanyl 50mcg IV		
repeat		

ASSESSMENT/DIAGNOSIS
1. Open head injury
2. Corneal abrasions (B)
3.

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

CONDITION UPON RELEASE
- ✓ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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)

(B) ~~of~~ EPW SHOT US Soldier Then was Beaten. Has Head Laceration (B) Lateral Possible Arm Fractures. Head trauma, came in on C-spine + spine Board. Staff agree c above. Pt VSS ~~at~~ Evac. ~~Pt~~ @ AMS / @ LOC.

orders: eyes open (B)

A: speech clear/ort. ⊘ posity of sec
B: CTA (B) =
C: ⊘ IV access, @ 2 pulses x 4, skin warm/dry cap ref <2 sec
D: Alert to name/place/month
E: ⊘ spinal/pelvic stiffness
F: ⊘ cuts, 300cc clear/yellow urine
G:

2° Head: Head: @ 2cm lac (B) fund sq (B) lac sq (B) check ⊘ bony stiffness
PERRL 3-5 (B) corn abrasion (B) c̄ Pldge
Tm (B) hemotympanum (B) unable to view 2° to blood
neck c-spine ⊘ bony stiffness NT
Chest: CTA (B) = CW: nml quality
Abd: soft, NT, FAST exam neg for fluid
Ext: 5/5 strength w/L (B) N/V intact

5	+2	5
5	+1	5

138 | 09 | 18 / 29 / 118 / 4.3
120 | 15 / 46 / 228
UA 1.030 neg

Xrays neg for acute injury

Dx: Stable Head injury (B) corn abrasions ⊘ CT Avail

Admit

[redacted] b(6)2

(CONTINUE ON SF 507, IF N[redacted]

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).

EPW b(6)4

[redacted]

SIGNATURE OF PROVIDER AND ID ST[redacted]

INSTRUCTIONS TO PATIENT (Incl[redacted]d follow-up plans)

→ Adm / ICU

EMERGENCY CARE AND TREATMENT

MEDCOM - 10278 Copy

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER (HOURS)	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)4	NURSING UNIT: ICU	ROOM NO.	BED NO.	1 Admit ICU 2 Dx Concussion 3 Condition Fair 4 Vitals q 2° 5 Activity Bed Rest Flat 6 Nursing Soft Restraints – CPU	
[redacted] b(6)4	NURSING UNIT: ICU	ROOM NO.	BED NO.	Foley C-Collar Venage / Backtrack Harness BID 7 Diet Liquids Only	
[redacted] b(6)4	NURSING UNIT: ICU	ROOM NO.	BED NO.	8 IV N5 @ 150/hr. 9 meds: MSO4 2-10 mg IV q 1° pm Tylenol 650 mg PO q 4° pm Kaytheny Cin Ointment OU q 4°	
[redacted] b(6)4	NURSING UNIT: ICU	ROOM NO.	BED NO.	10 Lab None. 11 X-Ray None. 9 June	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

done @ 1500

#[redacted]

b(6)4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 09JUN03 TIME OF ORDER: 1456 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D/C C-Collar - Clear clinically.
2. D/C TLS Spine precautions.
3. Elevate HOB Ad-Lib.
4. Regular Diet.
5. D/C Foley at nurse's Discretion.
6. Saline Lock IV when taking po well.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] ORDER HOURS

[redacted] b(6)2

9Jun03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 09JUN03 TIME OF ORDER: 1653 HOURS

1. D/C IV
2. Discharge to MP custody.

[redacted]

b(6)2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] E OF ORDER HOURS

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11
9 Jun	[redacted]	VITALS Q 2°	02	/		
			04	/		
			06	/		
			08	/		
			10	[redacted]		
			12	[redacted]		
			14			
			16			
			18			
			20			
		b(6) 2	22			
			24			
9 Jun	[redacted]	ACTIVITY: BEDREST FLAT	05	[redacted]		
			17			
9 Jun	[redacted]	NURSING: Soft Restraints	05	[redacted]		
			17			
9 Jun	[redacted]	FOLEY CATH.	05	[redacted]		
			17			
9 Jun	[redacted]	C-COLLAR	05	[redacted]		
			17			
9 Jun	[redacted]	DIET: LIQUIDS ONLY	07	/		
			11	[redacted]		
			17			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Concussion

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted] b6 2

EPW # [redacted] b(6) 4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo ____ Yr 2003
Order Date	Clerk Nurse	b(6)2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
9 Jun	[redacted]	Admit ICU, Dx Concussion	9 Jun	[illegible]	—	[redacted]	b(6)2
9 Jun	[redacted]	Condition FAIR	9 Jun	—	—	[redacted]	
9 J	[redacted]	Lab / X-Ray Neuro					
9 Jun	[redacted]	D/C TLS Spine precautions	—				

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. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11
9June03	[redacted]	Diet: Regular	07	/		
			11	/		
			17			
9June03	[redacted]	SL when taking	05	[redacted]		
	b(6)2	PO well	17		b(6)2	
9June03	[redacted]	D/C foley @ nurses	05	[redacted]		
		discretion	17			
9June03	[redacted]	Elevate HOB Ab-Lib	05	[redacted]		
			17			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

b(6)4

[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11
9 Jun	[redacted]	IV NS @ 150cc/hr	05	[redacted]		
			17			
9 Jun	[redacted]	Levofloxacin Ointment	02	✓		
		OU QD	06	✓		
			10	[redacted]		
		b(6) 2	14	[redacted]		
			18			
			22			
9 Jun	[redacted]	Cleanse / Bacitracin to	10	[redacted]		
		Abrasions BID	22			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Concussion

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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**
9Jun	[redacted]	Solu-IV when taking pills				
		b(6)2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
9Jun	[redacted]	MSO4 2-10mg IV q1° PRN														
9Jun	[redacted]	Tylenol 650mg PO q4° PRN														

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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0840	INITIALS [redacted]	b6-2	INITIALS		INITIALS
NEURO	PUPILS	(L) Reactive (R) Closed Shut					
	SENSORIUM	A+O x 3, speaks					
		some English.					
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored					
	BREATH SOUNDS	ETA (+) wheezing in					
	SECRETIONS None	Blood from					
		eyes ears nose					
		[illegible]					
		[illegible]					
SKIN	COLOR	normal for race					
	INTEGRITY	(-) edema, WNL					
IV SITE	LOCATION	(L) wrist, (R) AC					
	CONDITION	clean, dry, intact					
		(-) swelling					
		(-) Redness					
GASTRO	ABDOMEN	soft, NT					
	BOWEL SOUNDS	BS x4					
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	dark orangish					
		Brown					
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Rhythm					
		[illegible]					
		[illegible]					
		[illegible]					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PRE[redacted] (Title) SST, LPN

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 9 Jun 03

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

b(6)2

b(6)4

EPW # [redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITALS SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff											108/50	117/67		123/72	124/71	→		
	Temperature											97.8				98.7	→		
	Pulse											60	69		59	60	→		
	Respiratory Rate											16	17		16	14	→		
	SpO2											97%	99% 100%		97%	99%	→		
	pain intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL												400/400		0/400		400/800		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	P 64								
	64								
	16								
	98%								

INTAKE	16	17	18	19	20	21	22	23	8° T

OUTPUT									
	25/25								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

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

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday _____	wt Today _____		
INTAKE	OUTPUT		
IV _____	Urine: _____		
po _____	_____		
_____	_____		
TOTAL _____	TOTAL _____		
BALANCE _____			

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	A 1 1 D 1
2. ADMISSION LOCATION (State or Country Code.)	I Z
3. REGISTER NUMBER	0 0 1 3 4 1 4
NAME (Last, First, Middle Initial)	EPW [redacted] b(6)4
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (YYYYMMDD)	
7. AGE AT ADMISSION	4 7 y
8. RACE	X
9. ETHNIC BACKGROUND	9
RELIGION	Unk
10. LENGTH OF SERVICE	
ETS	N/A
11. FMP	~~9 9~~ 20
12. SOCIAL SECURITY NUMBER	[redacted]
ORGANIZATION (Active Duty Only)	N/A
13. MARITAL STATUS	U
HOUR OF ADMISSION	0633
BRANCH / CORPS	N/A
14. FLYING STATUS	
15. BENEFICIARY CATEGORY	~~K 7 9~~ K78
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	
18. MOS	
19. TRAUMA	9
PREV. ADMISSION	YEAR [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	0
WARD	ICU1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	—
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	—
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	[redacted] b(6)2
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	—
21. TYPE OF DISPOSITION	0 5
22. MTF TRANSFERRED TO	
23. DATE OF DISPOSITION (YYMMDD)	0 3 0 6 0 9
24. CLINIC SVC - ADMITTING	A A 3 A
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (YYMMDD)	0 3 0 6 0 9
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (YYMMDD)	

FOR LOCAL USE

Dx: Concussion

Dx: 8509
4781
9348
8052
8499

ADMITTING OFFICER [redacted] b(6)2

SIGNATURE OF ADMITTING CLERK [redacted] b(6)2

DA FORM 209 [redacted] DEC 91 G10

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER 0013421	2. NAME (Last, First, MI) EPW [redacted] b(6)4			3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE Z	7. RELIGION MUS	8. LENGTH [redacted]	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP —	12. SSN [redacted]		13. ORGANIZATION —		14. WARD —
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN 1178 b(6)4	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22. HOURS OF ADMISSION 1705	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION EPW Camp	26. DATE OF DISPOSITION 11 Jun 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 8 Jun 03	ADMITTING OFFICER DR. [redacted]
29. [redacted]				30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED b(6)2

31. SELECTED ADMINISTRATIVE DATA [redacted]

b(2)2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: S/p (L) neck Exploratory

Dx: 8749 Px: 8628
E9919

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

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

SIGNATURE OF A[redacted] OFFICER

DR [redacted]

DA FORM 3647, MAY 79 [redacted] EDITION OF 1 AUG 76 IS OBS[redacted] USAPPC V1.10

b(6)2

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

34 yo male EPW reported to have fainted ? GSW or fall while course to CFT week 4 prior to presentation. Pt complains of "fatigue". Denies HA, dizziness, respiratory difficulty. Denies any explosion, injury to persons.

PHYSICAL EXAMINATION

PROGRESS (Enter date of discharge and final diagnosis)

[redacted] b(6)2

PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	9 June 03		

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

REGISTER NO.	WARD NO.

[redacted] b(6)4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

DOCTOR'S ORDERS (Date and sign all orders)

[illegible] 1700 Rise & Shine

PREOP DX: PENETRATING - SCALPEL INJURY LEFT NECK - ZONE II

POSTOP DX: NEGATIVE NECK EXPLORATION, SCALPEL REMOVED

PROCEDURE: LEFT NECK EXPLORATION, REMOVE FOREIGN BODY

SURGEONS: [redacted] 1LT ASSISTANT: [redacted]

ANESTHESIA: [redacted] b6-2

EBL: 30

FLUIDS: 1000 cc

COMPLICATIONS: NONE

NOTES: LEFT IT, CHOPS, SEPARATED & TUCKED EXPLORED - NO INJURY

F.B. LOCATED NEXT DOOR TO SCM OUTSIDE CHOPS SEPARATE

[redacted] b(6)-2

[redacted] MO 7984

MAT MC

TEMPERATURE-PULSE-RESPIRATION						NURSE'S NOTES
DATE AND TIME	T	P	R	STOOLS	WEIGHT	MEDICATION AND NURSE'S NOTES
						10 [illegible] 03 0600
						MO TRANSFER NOTE
						700 #1 s/p LEFT NECK EXPLORATION - [illegible]
						& REMOVE OF F.B. [illegible], DONE W/ SURGERY
						[illegible] & [illegible]
						ATTEN VS WHL 7DT
						NECK: [illegible] c/d/i OEDEMA/[illegible], NO
						[illegible] FROM PERIPHERAL [illegible]. - [illegible]
						[illegible] RING [illegible] - [illegible]
						[illegible] - REMOVE STAPLES [illegible] POD #4-5
						[redacted] MO MC
						b(6)2 MAT

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 JUN 03	Assumed care of Pt @ 1300. VSS, A+O x3. Ø dysp.
1830	D/c'd neck drsg. Staples CDI. O/W assessment WNL.
	Finished IV ABX via PIV, patent. Will cont. to
	monitor — [redacted]
10 Jun 03	Assumed care of pt @ 2100hrs. Resting comfortably in bed ⊼ Ø discomfort. ⊕ neck incision
2145hrs	dry & intact c̄ staples in place. Pt. ready for transfer — [redacted]
11 Jun03	0832 - Pt A+O x3. VSS. T-R, regular, lungs CTA, b(6)2
	⊕BS x4. Staples intact to ⓛ side of neck Ø
	drainage noted. IV to ⓛ arm flushes
	well. - Will cont to monitor - [redacted] 24hr

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.

EPW [redacted] b(6)4

PROGRESS NOTES
Medical Record

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

Ku ipp Trodl @ 20

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT [redacted] b(6)2

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)		☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.				ALLERGIES
8	Jun	03	1443			NKDA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW (L) neck

SEX: ♂ AGE: 34

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1649

VITAL SIGNS			
TIME	1435		
BP	144/92		
PULSE	101		
RESP.	18		
TEMP.			
WT. (Child)	98#		

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

ORDERS	INITS.	TIME
IV bolus TLRS	[redacted]	1450
.5 tetanus		1451
1g ancef		1451
CBC		1449
Id & Sc Tm		1455

ASSESSMENT/DIAGNOSIS 662
Zone II GSW neck

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)

34 yo ♂ s/p GSW @ 1120 today in neck.
Pt denies SOB/CP/difficulty breathing. No difficulty swallowing; not pooling
ROS neg otherwise

Last meal 0800

Ø food
Ø EtOH

O: AAO x4 in NAD speech clear/articulate
HEENT: OP/NP clear/pink no PO neck: ⊕ wound C5 level
(L) side
Ø pulsatile masses
Ø active bleed
Chest: CTA B —
CV: NSR
Abd: soft, NT
Ext: 5/5 x4

14.7
11.2 / 48.2

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

A/P Zone II neck GSW. Stable

→ OR

CONDITION UPON RELEASE
- ☒ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEED[redacted]

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).

EPW [redacted]
b(6)4

SIGNATURE OF PROVIDER AND ID STAM[redacted]

INSTRUCTIONS TO PATIENT (Include [redacted] any limitations and follow-up plans)

→ OR

[redacted] b(6)2

EMERGENCY CARE AND TREATMENT

MEDCOM - 10295 Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
(L) Neck exploration

5. ADDITIONAL INFORMATION: Last PO: 0800 Medical Hx: Ø Implants: Ø Medications: Ø
Jewelry removed (yes/no) Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION X Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT X Potential impairment of skin integuity due to bovi e pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. 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)

EPW # [redacted] b(6)4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. ~~o Place and take down legs from stirrups with slow bilateral motion.~~ o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to sedation; pain; injury E.2. X Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. N/A Disminished visual perception due to being injury; sedation; F.2. N/A Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. non	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. 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. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

b(6)2 [redacted] MAJ AN 9 Jun 03 DATE

11. [redacted] EVALUATION: Pt awake. VSS. Dsg to left neck dry and intact. bovie pad site intact.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN DATE: 9 Jun 03 TIME: 1720 b6 2	[redacted] DATE: 9 Jun 03 TIME: 1725 b(6)2

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

INTRAOPERA . DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] Maj IAR

3. DATE 09 JUN 03 TIME PATIENT ARRIVED IN SUITE 1545

4. PATIENT IN ROOM TIME 1545 b(6)2 NUMBER 1-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt speaking some English, calm.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) both arms tucked to sides, thumbs up, shoulder roll in place, foam donut + folded sheet under head, head slightly turned to his right, warm sheets given.

☒ 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: Left side face + neck shaved by Dr. [redacted] no cuts noted.

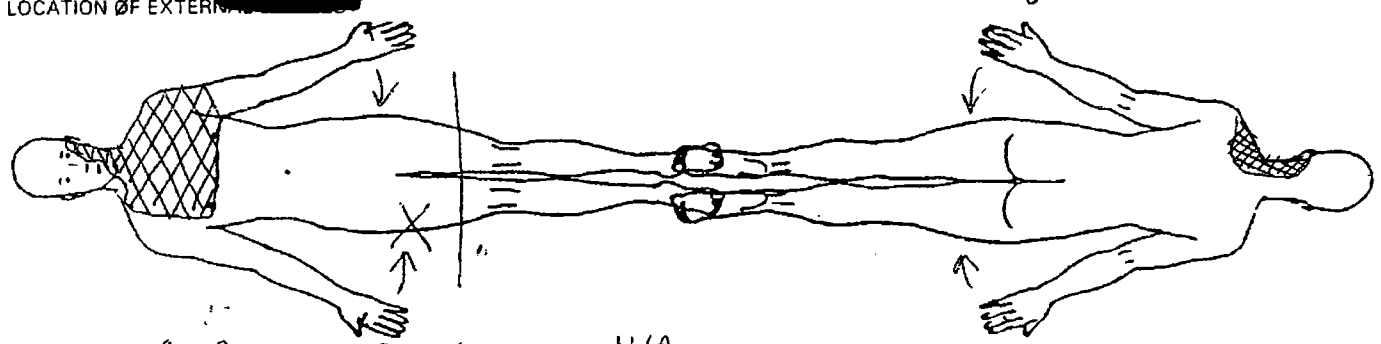
PREP SOLUTION (Specify) Betadine scrub + paint

SITE: see legend #9 BY WHOM: CPT [redacted]

SITE: BY WHOM: b(6)2

COMMENTS: No pooling noted.

9. LOCATION OF EXTERN[redacted]



LEGEND X Ground Pad (EaPV) -- Safety Strap (EaPV) = = = Tourniquet (N/A) ▨ = skin prep

C = Correct I = Incorrect Initial Count: SPC [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	N.A.	C	C	[redacted]	b(6)3 [redacted]
Needle Sharp	☒ Yes ☐ No	N.A.	C	C		
Instrument	☐ Yes ☐ No	N.A.	C	C		
Other	☐ Yes ☒ No	N.A.	N.A.	N.A.	N.A.	N.A.

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

EPW # [redacted] Iraq

b(6)4

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

☒ ESU NO: Valleylab Force 2 #000390

GROUND PAD: BRAND Valleylab Rem II

cut 30 coag 30 LOT NO: E7507, 68936, 2005

☐ ESU NO: Ø

GROUND PAD: BRAND Ø

LOT NO: Ø

☐ BIPOLAR NO: Ø

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
0.5% Marcaine (P)	10 cc	1710	Inj.	Mfr	[redacted]
					b(6)2

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] b(6)2		

PHYSI[redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Steristrips
gauze 4x8

19. ADDITIONAL INFORMATION
Surgeons = Dr. [redacted] Dr. [redacted]
Anesthesia = CPT [redacted]
b(6)2

20. OPERATION(S) PERFORMED
Left Neck Exploration
b(6)2

21. PATIENT TRANSFERRED TO ICU Expv 1 TIME 1720 METHOD Litter [redacted]

22. REGISTERED NURSE SIGNATURE [redacted]

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) — TEMP. F (•)

105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

EPW [redacted] 564

[redacted]	R[redacted]	[redacted]	**BORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
RS[redacted]	[redacted]	DATE	TIME	SSN/PSEUDO SSN: [redacted]

[redacted]

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
11.2	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
5.42	4.7-6.1 x 10^9	App		N/A	Mono		Negative
14.7	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
48.2	42-52% (M) 37-47% (F)	Bili		Negative	Source		
88.9	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
3.14	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
19.0	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]		pH		N/A	Micro Parasites		
	Mono	Prot		Negative	Malaria		
	Eos	Urob		0.2-1.0	O & P		
	Baso	Nit		Negative	Other		
	Imm	Leuk		Negative	[redacted]		
		HCG		Negative			
	42-52% (M) 37-47% (F)	[redacted]			[redacted]		
		Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
		Directigen		Negative	ABO/Rh		

[redacted]

RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
	9.8-13.6 secs			
	21-34 secs			
	<20 ug/ml			
	<10 ug/ml			

S:

ED BY:	DATE:	LAB ID NO.:

GSW (L) neck

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG (Units)								TOTALS
Midazolam (mg)	2							2
Fentanyl (mcg)	50-50-150	100						350
STP (mg)	250	100						350
Sux (mg)	80							80
UCB (mg)		4	1					5
(mg)								
(mg)								
INHALAT AGENT: ISO % del	1.3	1.4	1.5	1.3	0.4X			
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	10	2	2	2	2	10		

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

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

LINE site			
18G (R) AC	☒ Warmed	LR – #1	700 – 800
14G (L) HD	☒ Warmed	LR – #2	200 – 200
	☐ Warmed		
	☐ Warmed		

LOSSES		
EST BLOOD LOSS	20 – 30	
URINE –	Ø	

TOTAL FLUID	TOTAL URINE
30	Ø

FLUIDS – SUMMARY
CRYSTALLOID – 1000 ML
COLLOID – Ø
BLOOD – Ø

VALVE STATUS – (1) 2 3 4 5 (E)

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 48.5

INITIAL DATA: BP – 123, 73 HR – 103

EQUIP CHECK: OK? – (Y) N

PATIENT RECORDS: OK for PROCEDURE? JL TIME – 1540

TIME → 1545 1600 · 30 · 1700 · 30 · 1800

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	770	770	740	720	400	500	
f – breaths/min	10	9	7	6	10		
Peak inf pres / PEEP	18	20	19	18			
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	S	
BP/Auto Cuff							
ET CO2 (torr)	+	30	33	32	34		
BP / oth							
FIO2 (Frac or %)	0.78	0.78	0.78	0.72	0.78	0.78	
ART line							
SpO2 (%)	100	99	99	98	98		
Steth- PC/ES							
ECG	SR →	→	→	→			
Gas analyzer							
TEMP- site	available →						
N-M Block (T/4)	0/4	1/4	4/4	4/4			
				SubTet			
Warming blkt	Blankets		Dxlwool				
Conv warmer							

REMARKS – Code drugs with numbers, events with letters

(1) Pre-op assessment pt speaks English Counselled. PTOC
(2) OR, monitors 100% O_2 Cricoid pressure + RSI Reglan 10mg IV 1611
(3) Bupivacaine 0.5% 10mL injected by surg
(4) Neostigmine 4 Glycopyrrolate 0.8mg IV
(5) OP Functional Extubated. S Complications
(6) Report to RN

RECOVERY AT 1720
PACU ICU 1 (Specify)
OTHER T = 98.2 A/x
CONDITION: Stable; respon
RESP – 16 SpO2 – 98%
BP – 128/64 HR – 86

ANES	Start	Room	End
	1530	1545	1725
PROC	Ready	Begin	End
	1555	1617	1702

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4) (5) (6)
Position → O → lawn chair

PROCEDURES and CPT Codes
(L) neck exploration Zone II

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
OETA RSI cricoid

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b(6)4
EPW # [redacted]

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Dexl MAC 3 Grade I view; 8.0 stylet; 8mL air cuff 22cm @ tooth + BBS + Sust $EtCO_2$

SURGEONS: [redacted]
[redacted] CRNA

PROCEDURE LOCATION 1
DATE 9 Jan 03
PAGE 1 OF 1

(8)

[redacted] b(6)2 WAMC [redacted]576 REVISED 1 Jan 99

MEDCOM - 10302

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 34 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Neck Exploration
SURGICAL SERVICE: Gen Surg
NPO SINCE: 0800

ASA Physical State 1 2 3 4 5 E
WT: 65 KG/LB HT: 180 IN. cm
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ø
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 14.7 / 48.2
U/A:
OTHER:
PLT 314

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary System:		
Asthma	N	Y
Bronchitis/URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
Acute/Chronic RF	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
PUD/GERD	N	Y
Endocrine System:		
Diabetes	N	Y
Steriods	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Other	N	Y
Gynecological :		
Pregnancy	N	Y
Other Significant Hx:		
	N	Y MP chest EPW in
	N	Y (L) neck @ 1100
Familial HX	N	Y family anesthesia hx

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 103/74 HR 106 R 20 T L SaO2 97
Pain Scale 0-10
HEENT - Teeth Top front chipped
Trachea midline supple
TMJ/Neck (L) neck
Oropharnyx MP2
Nares
CHEST: CTA (B)
CARDIAC: RRR (-)
EXTREMITIES:
IV Access: 18G (R) arm
Ulnar Filling:
BACK:
OTHER:

NPO Since 0800

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (✓) 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 pati[redacted]guardian seems to understand and agrees. Questions answered.
Signed [redacted] Date: 9 Jan 03 Time: 1542 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
b(6)2

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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

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.

0

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO.

DATE OF ORDER: 9 JUNE 03 | TIME OF ORDER: 1705 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ~~[redacted]~~ ICU-1 FOR CARE
   PR [redacted] - surgery — AWAIT TRANSFER TO FLOOR ICW2
2. S/P LEFT NECK EXPLORATION
3. STABLE
4. VITALS PER ICU - PROTOCOL
5. ACTIVITY: AS LIB
6. NKDA

PATIENT IDENTIFICATION

EPW

[redacted]

b(6)4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

7. DIET: ADVANCE TO REGULAR
8. IVF: LR @ 125 ml/° IFC
   WHEN TOL PO
9. MEDS: ANCEF 1 gm IV q 8 ° x 2 doses
   (LAST DOSE 1500 - 9 JUNE 03)
   PERCOCET 1-TT TABS PO q 6° PRN
   MSO4 1-5 MG IV q 2° PRN

PATIENT IDENTIFICATION

EPW

[redacted]

b(6)4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

TYLENOL 650 MG PO q 4° PRN
10. VOB's q

[redacted] MD

PATIENT IDENTIFICATION

EPW b(6)4

[redacted]

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. 244

DATE OF ORDER: 10 JUNE 03 | TIME OF ORDER: 0605 HOURS

1. TRANSFER WHEN BEDS AVAILABLE
2. NO STAPLES ON POD #4

10 June 03 1230 [redacted]

[redacted]

[redacted]

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

CLINICAL RECORD

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

Mo. 6 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12
9	[redacted]	Vitals per routine	5	/	[redacted]		
			13		[redacted]		
	b(6)2		21		[redacted]		
9	[redacted]	Activity ad lib	5	/	[redacted]		
			13		[redacted]		
			21		[redacted]		
9	[redacted]	Diet: advance to regular	6	/	[redacted]		
			11	/	[redacted]		
			17	/	[redacted]		

b(6)2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P ⓛ neck exploratory

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

PATIENT IDENTIFICATION:
EPW [redacted] b64

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 Jun Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9	[redacted]	TRANSFER ICW 3 STABLE	9	1845	1845	[redacted]
10	[redacted]	Transfer next availability				b(6)2
10	[redacted]	D/C Staples on POD #4 (13 Jun)	13 Jun			
	b(6)2					

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				10	11	12											
	------	IVF: LR@120cc/HR	5	[redacted]													
	------	HL when tol P.O.	13														
	------		21	[redacted]			6/6/2										
	------	Ancef 1gm IV Q8°	08	[redacted]													
	------	X 2 doses - last	14	[redacted]													
	------	dose 1500 9 Jun 03	22	/													

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P (L) NECK EXPLORATION

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

PATIENT IDENTIFICATION:
EPW [redacted] L/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. JUN 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													
9 Jun 03	[redacted]	Percocet 1-11 tabs	23:40 [redacted]													
---	---	PRN Q4°	[redacted]													
9 Jun	[redacted]	MSO4 1-5 mg Q2°														
---	---	PRN														
---	---	Tylenol 650 mg PO														
---	---	Q4° PRN														
---	---															
---	---															
---	---															
---	---															
---	---															
---	---															
---	---															

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: 09 JUN 03
Time In: 1734
Allergies: NKSA
Pre-op V/S: 12/73
Procedures: Neck explor / Hemorrhoid removal

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

OR Intake: Crystalloid _____ Colloid _____
OR Output: UOP _____ EBL: minimal
Meds/Times: Fentanyl, Versed - Marcaine local

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other RA
TLS	

Pre Op Meds History

Time	1730	1745	1800	1815	1830	1845	1900	1915	1930	1945	2000	2015	2030	2045	2100	2115
SaO2	98	99	100	99	99											
FiO2																
Methods	RA		RA	RA	RA											
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	16	20	18	22												
T	99															
Time	1730															
Pain (0-10)	0															
LOS	Sedat															

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	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: [redacted] b(6)2
DEPARTMENT/SERVICE/CLINIC: ICU 2
DATE: 09 JUN 03

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

[redacted] b(6)4

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

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1730	Ø	Ø		Ø		

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
1730 Adm		FROM	Intact		brisk		warm
15'							pink
30'							
45'							
60'							
90'							
D/C							

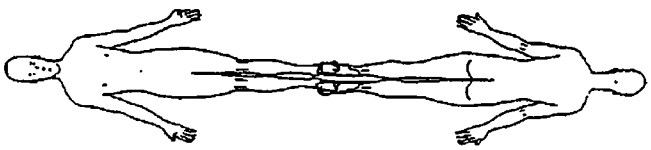
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Ⓓ neck	dry/fluffy	Ø noted
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1730	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

1750-Rec'd pt @ 1730 from O.R.
Pt A&OX3, coherent & cooperative MAE.
Ø neurodeficits noted. lungs CTA(B)
BS+hypo ↓, Ø Drains in OR/here.
dsg to Ⓓ neck C,D I, DVS to
Ⓓ wrist / RPA patent, benign care
plan reinforced; post-op care pain management,
meds-side effects, act level/diet
adm. process, voiced understanding [redacted]
1755 Pt A+O cooperative Lungs CTA
+2 Pulses UE + LE Bilateral BS x [redacted]
1818 Pt Bathroom to rest quite [redacted]
1825 Pt Transferred to ICW2 [redacted]

b(6)2

Discharge Criteria:
Date: 09Jun03 **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW2 [redacted] b(6)2
Report Given To: LT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: CPO [redacted]
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. [illegible] LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	0 0 1 3 4 2 1	b(6)4 EPW # [redacted]	—	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		Z	9	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	—	b(6)4 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1705	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 B	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 [redacted]	b(6)2	

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. [illegible]RRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
EPW Camp		0 3 0 7 1 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A A A A		0 3 0 7 0 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)

FOR LOCAL USE

DX: S/P Neck Exploratory

b(6)2

ADMITTING OFFICER (Signatu[redacted]

[redacted] OF ADMITTING CLERK

DR: [redacted]

DA FORM 3005, MAR 90 [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER 0013422		2. NAME (Last, First, MI) EPW [redacted]			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 23y	6. RACE Z	7. RELIGION unk (b)(6)	8. DATE OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION N/A		14. WARD ICW 2
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN KFG		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE N/A

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION: 1440	23. CLINIC SERVICE: AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 16 Jun 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —	27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 09 Jun 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]		30. DATE OF INITIAL ADMISSION

ADMITTING OFFICER b(6)2 Dr. [redacted]

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted] b(2)2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P I+D (L) ankle

DX: 8912
E9912
DX: 8087

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	8	8

SIGNATURE OF ATTENDING MEDICAL [redacted] Dr. [redacted] b(6)2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

ICW2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible] in [illegible] [illegible] [illegible]
[illegible] this EPW at ≈1100 today,
no other history
was [illegible] in (L) [illegible],
admits [illegible]

PHYSICAL EXAMINATION

[illegible] in NAD
AT/NC [illegible]
[illegible]
small [illegible] [illegible] (L) [illegible]
[illegible] [illegible] [illegible] (L) [illegible]

PROGRESS (Enter date of discharge and final diagnosis)

b(6)2

[redacted]	DATE 9 JUN 03	IDENTIFICATION NO.	ORGANIZATION
PATIENT IDENTIFICATION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO. ICW2

EPW [redacted] b(6)4

ABBREVIATED MEDICAL RECORD
Standard Form 600

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

509-113

NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	(S) 22 y/o (M) presents GSW to (R) thigh and (L) ankle.
Ancef	(O) WD / AOx3 H - N/C N - ∅ JVD
1gm.	∅ Stridor - ~~SFS~~. Lungs - CTA (B)
	ABD: soft, ND, (+) BS. heart RRR
Morphine	pelvis - stable. (R) leg - GSW over
(12.01)	vastus medialis (above knee). (R) popliteal
1153	2+ neuro-vascular intact (L) ext. GSW
B/P - 110/65	(L) med malleolus. ∅ exit
P - 80	(A) GSW (R) thigh (L) ankle
	(P) dressings 0.9% NS
	Ancef 1gm - IV
	Morphine 10mg
	X-Rays
X-Rays	b(6)2 [redacted]
(L) ankle	[redacted]
small	
fragment	
but to med	
malleolus	

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b(6)7

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 JUN 03 1640	Pt admitted from scut via litter. VSS. A+O x3. Dsg to (L) ankle CDI. PIV (R) wrist with LR @ 100cc/hr. Pt NPO awaiting OR. Will cont to monitor [redacted] b(6)2
9 JUN 03 1820	Author Op Note:
	Pre Op Note: GSW to (L) ankle Post Op Note: GSW to (L) ankle Procedure: I+D, ~~[illegible]~~ debridement (L) ankle Surgeon [redacted] b(6)2 ASL, MD Findings - 3x3 mm metal fragment embedded in ankle joint capsule not in bone. Cultures performed, see blood in joint, Lavaged. b(6)2 [redacted]

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

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

EPW

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			000-00-0279

DATE	NOTES
10Jun03 1815	assumed care @ 1300 - T max 100.4°F orally, VSS - dsg intact on (L) foot, drainage marked @ 2120 9Jun, unchanged since then, <2 sec cap refill in (L) toes, pt. can wiggle toes in (L) foot - IV patent, abx continue - tolerated regular diet - no c/o pain @ this time [redacted] b(6)2 CPT AN
11Jun03 0354	10 June 21:15 Pt. sleeping easily awakened. Abnt. VS WNL Skin PWD. Perrla (+) WNL. LCA (B). BS (+) x4 (+) PPA (B). (P) [redacted] (L) foot dressing C/D/I & complaints @ this time. Will cont to mon [redacted] /AN b(6)2
	00:00 New PIV placed in (L) hand patent. (R) hand PIV d/c'd. Will cont. to mon [redacted] SLT/AN
0405	[redacted] & further complaints @ this time [redacted] SLT/AN b(6)2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
~~1600~~ error	Out of order
~~T 100.4°~~	
10 Jun 03	Ortho Note
1920	(S) N/A
	(O) VSS afebrile
	dressing changed, slight bloody Penrose removed. No evidence of infection.
	(A) doing well
	(P) Quality dsg change every 72 hours IV antibiotics, then DC to EPW camp
	b(6)2 [redacted]
11 June 03	Assumed care of pt @ 0500. Pt is resting quietly VSS. Lungs CTA. Bowel sounds x 4 quads. Pt has bandage on (L) foot. Dsg is dry & intact. Pt is able to wiggle toes. Cap refill less than 3 sec. Pt has ø % pain or discomfort @ this time.
	[redacted] 91WM6, SGT

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

EPW b(6)4

[redacted]

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 JUN 03 1700	Assumed care of Pt @ 1300. VSS, A&O x 3. (L) LE Drsg CDI. Pt c/o pain. NADX via PIV patent. O/W assessment WNL. Will Monitor [redacted] b(6)2
12 Jun 03 @ 0055h	Assumed duties and care of patient @ 2100hrs (11 Jun). Pt alert, active in cot. No verbalized discomfort while lying still. Some facial grimacing when moving (L) LE (L) leg dressing intact & without drainage noted. Lungs CTA, Abd soft, nondistended & bowels throughout all quads. Voiding in urinal s̄ problems. IV heplock patent - continues to receive abx. Will continue to assess & monitor for now — [redacted] CPL/AN b(6)2
12 Jun 03	Assumed care of pt @ 0530. Pt is sleeping. VSS. Lung CTA. Bowel Sounds x4 quads. Pt HL in (L) hand. Patent. Pt has Dsg to (L) ankle - dry and intact. Pt has ∅ c/o pain or discomfort @ this time. — [redacted] GROMG, SGT b(6)2
12 Jun 03 1830	assumed care @ 1300 - VSS - IV site D'd due to catheter being pulled out, old site s s/s of infection - dsg D'd, minimal drainage noted on 4x4 - pt. performed own ADLS this evening — [redacted] CPL/AN b(6)2
12 June 03 (2320hrs)	Assumed care of pt. @ 2100hrs. VSS. Alert, active in cot. HL patent (L) hand. Lungs CTA; Abd. soft, nondistended & BS (+) all quadrants. (L) LE dressing dry & intact. (-) drainage noted. Metatarsals warm to touch & capillary refill < 3 secs. Will continue to monitor throughout the night. — [redacted] CPL/AN b(6)2
13 June 03 0530	Pt. awake & alert sitting up in bed. VSS: BP 100/68, Sats 99, P87, T96.9. Pt. dressing on (L) LE clean, dry & intact. Pt has no complaints @ this time. Initial assessment completed & all assessment findings WNL. IV heplock in (R) hand flushes well s̄ s/s of infection or infiltration. Pt. continues on IV antibiotics. Will continue to monitor — [redacted] ACE/AN b(6)2

STANDARD FORM 509 (REV. 5/1999) BACK

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AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13Jun03 2005	assumed care @ 1300 - VSS - dsg d'd on (L) ankle, no drainage from wound - medicated for pain @ 1900 c̄ Tylenol #3 c̄ good results [redacted] b(6)2 CRA
14Jun03 00:23	13 Jun 03 21:30 Pt awake and alert in bed c̄ restraints x2 applied VS WNL. PERRLA (+) WNL. Skin W+D. LCA (B). BS (+) x4. (+) PPP (B). Dsg to ankle C/D/I. Pt. able to move toes c̄ c/o Numbness or tingling. HL (R) hand patent. Will cont. to mon. [redacted] RT/AD b(6)2
0030	PIV d/c'd New PIV placed (R) FA [redacted] RT/AD
0630	Pt. asleep in bed easily aroused by verbal stimuli. VSS: BP 98/60, 79 T5, sats 98%, P72. HL in (R) FA c̄ signs of infection. Dressing to (L) ankle CDI, pedal pulses nml & palpable, cap refill <3sec. All other assessment findings WNL. Pt. c̄ complaints @ this time. Will continue to monitor [redacted] RT
14Jun 1915	assumed care @ 1300 - VSS - IV patent - pt. D'd dsg on (L) ankle, stitches in tact, no drainage noted - pt. did personal hygiene [redacted] CRA b(6)2
2215	Pt care assumed @ 2100 - VSS, A+O x3, no complaints at this time. Lung sounds CTA, pulses palpable x4, bowel sounds present

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)*

EPW b(6)4 [redacted]

REGISTER NO.

WARD NO. LCW2

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
	x4 quadrants. [redacted] Heplock to RFA not patent, replaced in RFA. Dressing on L ankle CDI, pt has (+) sensation, (+) ROM, able to wiggle toes on L foot. No complaints at this time, will continue to monitor. SPC [redacted] 91WM6
15 June 03 0900	Pt. sleeping in bed easily arousable to verbal stimuli. VSS: BP 109/62, T97.2, sats 97%, P70. MD have to remove staples. Staples removed, wound is approximating well ĉ s/s of infection. Ace bandage applied to (L) ankle p̄ steri strips applied to wound. (+) L pedal pulses NML, cap refill <3 sec. Pt has no complaints @ this time. All other findings WNL. b(6)2
0930	IV D/C'd. [redacted]
15 June 03 1430	assumed pt care @ 1300. pt AAO x3. VSS. assessment WNL. (+) ankle c̄ ace bandage. pt able to move toes cap refill <3 secs. pt on EPW protocol. ÷ leather restraint to (L) wrist & ÷ restraint to (R) ankle. (-) complaint of pain voiced @ this time — [redacted] 91WM6
2200.	Pt. C/O pain ÷ percocet given. Dsng to (L) LE CDI (+) sensation, (+) ROM, cap refill <3 sec (L) LE. Will cont. to monitor. [redacted] 91WM6
16 June 03 1100	Pt. stable. Waiting to Evac to EPW camp. [redacted] 91WM6 b(6)2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)2

558-103 [redacted] [redacted] (Instructions on Back of this Sheet) [redacted] 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] b6

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
9	Jun	03	1440

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

CURRENT MEDS. (tetanus immunization and other data): Adramine

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify)

ALLERGIES: Ø

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

HOME TELE. NO. (Inc. area code): 1pk/day ethol ½ bottle/day

CHIEF COMPLAINT(S) (Include symptom(s), duration): Gunshot (L) ankle & knee

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? ☒ YES ☐ NO

TIME SEEN BY PROVIDER: 1440

VITAL SIGNS			
TIME	1440		
BP	91		
PULSE	105/35		
RESP.	14		
TEMP.			
WT. (Child)	160 lb		

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

ORDERS	INITS.	TIME
IV	[redacted]	1450
ankle series		
femur, knee		
CBC, Lytes	[redacted]	1450
Fentanyl	[redacted]	1450
Ancef 1Gm	[redacted]	1450
15cc Tetanus	MSH	1450

ASSESSMENT/DIAGNOSIS: GSW x 2

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): OPTO

EMERGENCY / TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: ✓ IMPROVED / UNCHANGED / DETERIORATED

TIME 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)

S: Gunshot wound to (L) ankle & knee + 2 pedal pulses, circulation good. Pain 7/10. Possitive babinski

PMH: Ø surgery

PA note: As above unremarkable ballistics (L) medial ankle & (R) medial distal thigh. @ 1100 hrs also (L) knee

(O) vitals NAD

PE: (L) ankle small punctate entry & exit medial malleoli bleeding controlled light pressure

(R) thigh entry puncture & exit & edema & discoloration

Pulses NVI distal distal

(A) cap < 2 sec full pulses.

Xray - (L) ankle fragment noted medial malleoli extra articular

(R) thigh soft tissue Ø fx

(P) OPTO consult [redacted]

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

b(6)4

SIGNA[redacted] PA-C BRIGADE SURGEON

[redacted] ations ordered, any limitations and follow-up

b(6)2

[redacted]

EMERGENCY CARE AND TREATMENT

MEDCOM - 10321 Copy

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [✓] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I & D Lt. Ankle

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: _____1) Surgical Procedure & Operating Room Environment _____2) Separation Anxiety (Child) _____3) Surgical Outcomes Emergency	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). 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 ✓ Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. 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)

EPW # [redacted] b(6)7

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. NURSING INTERVENTIONS
. CIRCULATION ✓ Potential for inadequate tissue erfusion due to: ____1) Intraoperative Mobility ____2) Positioning ____3) Existing Disease ____4) Safety Devices ____5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ____1) Pain ____2) Intraoperative Hazards ____3) Prosthesis ____4) Positioning ____5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ____1) Length of Surgery ____2) Positioning ____3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. 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. ____ Potential for decreased communication due to: ____1) Diminished Hearing ____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 table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. 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. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY (Y) (N)
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities
☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Titl[redacted]

DATE: TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT b(6)2

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 Amb. Staff

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY [redacted] (PC AN)

3. DATE 8 June 03 TIME PATIENT ARRIVED IN SUITE EMT → OR

4. PATIENT IN ROOM TIME 0800 NUMBER 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO A

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC. [redacted] (91D)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj [redacted] (66E) / CPT. [redacted] (66E)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

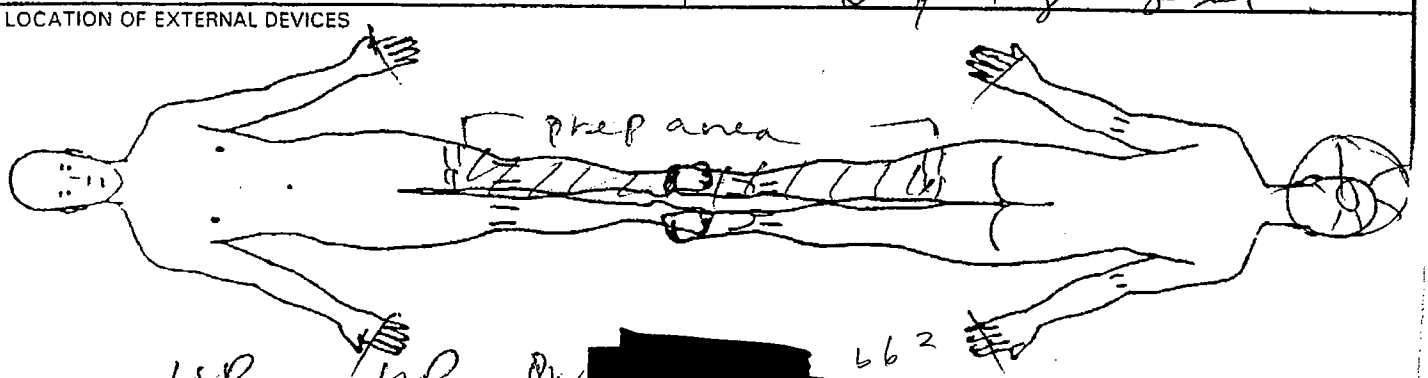
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine S/S
SITE: (L) leg BY WHOM: Pam / Maj [redacted] assist
SITE: BY WHOM:
COMMENTS: ⊗ povidone & sol

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet [redacted] b6 2

10. COUNTS

C = Correct I = Incorrect

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

EPW # [redacted] b(6)4

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND Polyhesive 4
LOT NO: 6 80936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Coag 2:30
Cut 4:30

13. PROSTHESIS, IMPLANTS [ES ☑ NO IF YES NAME: ID NU R; 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):

0.9% Nacl

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☐

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

	1.	2.	3.
TYPE/SIZE	penrose drain		
SITE	(Lt) Ankle		

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Kerlix
webril
Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] b(6)2

Anes: LTC [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Lt. Ankle I & D

21. PATIENT TRANSFERRED TO b(6)2 ICU TIME 0835 METHOD Litter

22. REGISTER[redacted] NURSE SIGNATURE

[redacted] CPT AN

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

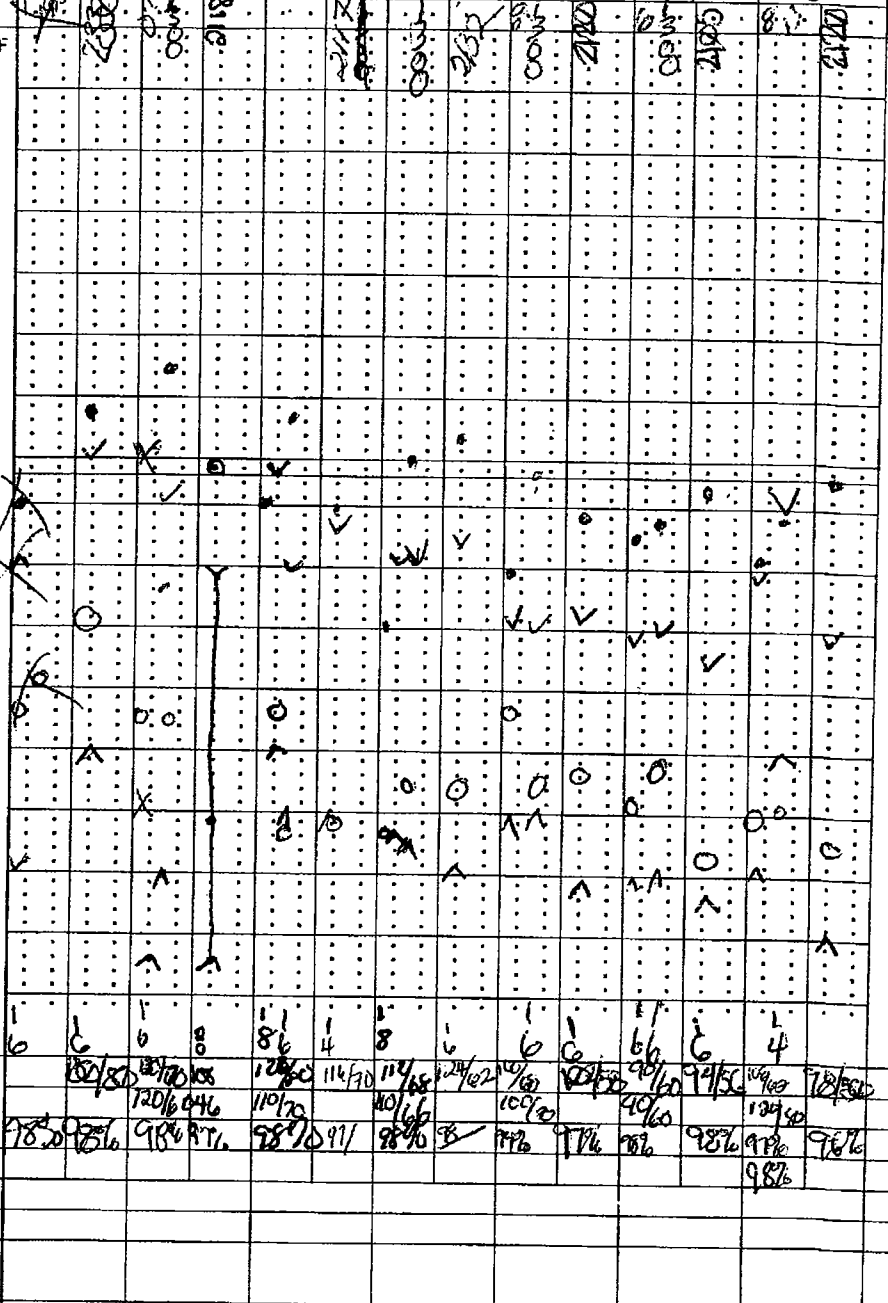
HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 9 | 10 | 11 | 12 | 13 | 14 | 15

19 | HOUR

PULSE (O) | TEMP. F (•)



RESPIRATION RECORD

BLOOD PRESSURE

SPO2

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

PW# [redacted] b(6)4

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT	Requesting Physician: [redacted] b(6)2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974) b(6)4	
LAST, FIRST, MI: [redacted] b(6)2	DATE: 9 Jun	TIME: 1445	SSN/PSEUDO SSN: [redacted]

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	9.9	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	4.24	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	12.7	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	40.8	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	86.3	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	164	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	32.8	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]			[redacted]		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

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

REMARKS: b(6)2

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

b(6)2

Ward/Section	QUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
EMT	[redacted]	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
[redacted] b6 4	9 Jun 2	1445	[redacted] b(6)4

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

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

(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

(Piccolo) Electrolyte		
TEST	RESULT	REF. RANGE
NA+	129	128-145 mmol/l
K+	3.3	3.3-4.7 mmol/l
CL-	106	98-108 mmol/l
tCO_2	22	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b62		

MEDICAL RECORD — ANESTHESIA

1738 END

ANESTHETIC AGENTS AND DRUGS	DRUG (Units)
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "( )"=CONSTANT INFUSION	Versed 1mg/cc)
	fentanyl 25ug/cc)
	( )
	( )
	( )
	( )
VOLAT AGENT	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶	

FLUIDS	
LINE site	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed
LOSSES	EST BLOOD LOSS
	URINE –

TOTALS	TOTAL EBL
	mi
	TOTAL URINE
	∅

FLUIDS – SUMMARY
CRYSTALLOID – iR
COLLOID – ∅
BLOOD – ∅

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – / ; HR –

COMP CHECK: OK? – Y N

PATIENT REQUEST: OK for PROCEDURE? TIME –

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

TIME → 1730 15 30 45 1800 15 30 45

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

VENTILATION	
VT – ml	
f – breaths/min	20 16 20 20 20
Peak inf pres / PEEP	
MODE – S(pon), A(ssist), C(on)	S S S S S

MONITORS		
BP/Auto Cuff	ET CO2 (torr)	
BP / oth	FIO2 (Frac or %)	NRB
ART line	SpO2 (%)	99 100 100
Steth- PC/ES	ECG	NSR NSR
Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

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

REMARKS – Code drugs with numbers, events with letters

Fem-Sciatic Block:
Fem N. localized by Nerve stim needle 40cc 50:50 mix 0.5% bupiv c̄ 2% lido 40cc @ 4ma
Sciatic N. localized @ 0.4ma. 30cc Bupiv/lido mix.
@ 1745 b(6)2
[redacted] M.D.
[redacted], NC
OR Sedated
at home.

97.2° @ 1842

RECOVERY AT 1845
PACU ICU #2 (Specify)
OTHER
CONDITION: AAOx3
RESP – 16 SpO2 – 100%
BP – 112/68 HR – 77

ANESTHESIA PROCEDURE TIME

	Start	Room	End
ANES	1700	1800	1830
PROC	Ready	Begin	End
	1805	1811	1833

PROCEDURES and CPT Codes: I & D ⊕ ombl

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: b(6)2

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

SU[redacted]

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR 2

DATE: 9 JAN 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
R.Y. MALLARI (LT/AN)
WAMC OP 376 REVISED
1 Jan 99

(13)

PATIENT RECORD

MEDCOM - 10329

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

Great, T
Fr. t

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 23 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: Lft Foot I & D
SURGICAL SERVICE: ortho
NPO SINCE: _____

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) _____
( ) _____
( ) _____
( ) _____
( ) _____
( ) _____

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	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

_____
_____
_____
_____
_____
_____

PHYSICAL EXAMINATION
BP ___ HR 77 R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth NR 99% on RA
Trachea _____
TMJ/Neck MUCQ I
Oropharnyx _____
Nares _____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES:
IV Access: RA 18g
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: [redacted] LT CRNA Date: 9 Jun 03 Time: 1600 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted] 6604

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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		13

DATE OF ORDER 9 Nov 03 TIME OF ORDER _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1. NO LGW'2
2. S/P ETO (D) EVLW
   CONTINUE STABLE
3. VS - ROUTINE
4. BED REST - RESPIRATORY PRN
   GPW ROUTINE

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

5. GLUCOSE (L) ~~FREE~~ HOURS
6. RESPIRATORY DIET
7. IV - L2 AT 100 cc/hr, KVO
   LEAVE WITH TOLERANCE
   PIO: WEEK
8. GLUCOSE, + GRAM EVIB @ 8 HRS
9. PENICILLIN, 1'2 PO Q 4-6 HRS PRN
10. MSO4 2-4 mg IVP Q 2 HRS PRN

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

12. TYLENOL 650 mg PO. Q 4 HRS PRN

b(6)2 [redacted]

[redacted] CDR 4Q

Noted [redacted]

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9 Nov 03 TIME OF ORDER 1835 HOURS

6. RESUME ALL ABOVE ORDERS

9 Nov [redacted]

b(6)2

NURSING UNIT	ROOM NO.	BED NO.

24° Chart [redacted] 12 Jan @ 0000 hrs

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] EPW b(6)4			16 JUN 03	1920 HOURS	
			(1) DAILY DRS DRESSING CHANGE		[redacted]
NURSING UNIT	ROOM NO.	BED NO.			
ICW2		13	24V Chest Chest [redacted]	12 Jun 03 0005hrs	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW b(6)4 [redacted]			[redacted]	[redacted] HOURS	b(6)2
NURSING UNIT	ROOM NO.	BED NO.			
ICW2		13			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW b(6)4 [redacted]			15 Jun 03	0830 HOURS	
			(1) DISCHARGED TO EPW CAMP TODAY		
			(2) KEFLEX 250 mg QID x 10 DAYS		
NURSING UNIT	ROOM NO.	BED NO.	(3) D/C N.		b(6)2 [redacted]
ICW2		13			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW b(6)4 [redacted]			24 JUN 03 [redacted]	10 AM 6-15-03 HOURS 2315	
NURSING UNIT	ROOM NO.	BED NO.			
ICW2		13			

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

CLINICAL RECORD

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

Mo. 06 Yr. 2003

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
9	[redacted]	VS ROUTINE	5	/	[redacted]						
			13								
			21								
			1								
9	[redacted]	Bed Rest - Restraints	5	/	[redacted]						
		per EPW ROUTINE	13								
			21								
			1								
9	[redacted]	Elevate (L) Foot	5	/	[redacted]						
			13								
	b(6) 2		21								
			1								
9	[redacted]	REGULAR DIET	6	/	[redacted]						
			11	/	[redacted]						
			17	[redacted]							
			1								
10	[redacted]	daily dsg Δ - dry	18	/ done	[redacted]						
											/ No dressing to change

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I+D (L) ankle

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW b(6) 7

#[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 06 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9	[redacted]	TO ICW 2 ; COND STABLE				
9 Jun	[redacted]	Resume all above orders	9 Jun	—	[redacted]	
15 June 03	[redacted]	Discharge Pt. to EPW camp today	15 June	today		b(6) 2
15 June 03	[redacted]	D/C IV	15 June	NOW		[redacted]
	-----	b(6) 2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13	14	15	16						
9	[redacted]	~~IV LR @ 100cc/hr~~ [redacted]	5	[redacted]													
		HEP LOCK WHEN TOL	13	[redacted]								IV	D/C'd 15 June 03				
		P.O. WELL	21	[redacted]									0900 dt				
						b(6)2											
9	[redacted]	Ancef 1 gram IVPB Q8hrs	8	[redacted]													
			16	[redacted]									D/C'd				
	b(6)2		24	[redacted]									15 June 03 0900 dt				
15 June 03	[redacted]	Keflex 250mg QID x	4														
		10 days	10								[redacted]						
			16							[redacted]							
			22							[redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I+D (L) ankle

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW# [redacted] b(6)4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. JUN 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													
9	[redacted]	Percocet 1/1 PO	1300 1900	2200												
- - - -	- - - - -	Q4-6hrs PRN	[redacted]	[redacted]												
- - - -	b(6)2			b(6)2												
9	[redacted]	MSO4 2-4mg IVP														
- - - -	- - - - -	Q2° PRN														
- - - -	- - - - -															
9	- - - - -	Tylenol 650mg														
- - - -	[redacted]	PO Q4hrs PRN														
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															

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Hx Alcohol Abuse
Smoker
70 Ky

3L 100%

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

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

OTSG APPROVED (Date)

Date: 9 JUN 03
Time In: 1435
Allergies: NKA
Pre-op V/S: 164/45 / 60/20
Procedures: I&D (L) FOOT

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 cc Colloid
OR Output: UOP 0 EBL min
Meds/Times:

ISS versus Femoral Cutaneous Block (R) WRIST

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1435	1445	1500	1600
SaO2		99%	100%	99%
FiO2	3L			
Methods				
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	12	12	12	12
T	97			
Time	1435			
Pain (0-10)	0	8		
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
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	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	\	\	\
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY: [redacted] b(6)2

DEPARTMENT/SERVICE/CLINIC

DATE: 9 JUN 03

PATIENT'S IDENTIFICATION (For typed or written en[redacted] Name – last, first, middle; grade; date; hospital or medical facility)

b(6)4

23 y/o EPLer [redacted]

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

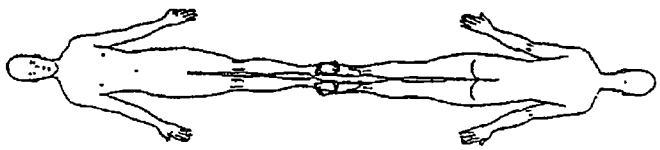
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1850 Received from OR in company of anesthesia. Oriented to C.C. nurse. O2 via 3L MASK O2 SAT 97%. (B) CTA. Abd flat soft. Active BS x 4 quadrants.

1920. VSS. PT awake & alert, tries to ⓪ feet warm, unable to move toes. PT pt gurney on floor for safety d/t antibiotic going off. May possibly move to new location. Will monitor [redacted] b(6)

1945 IV dislocated. VSS. resting comfortably [redacted]

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	T Z	0 0 1 3 4 2 2	EPW [redacted] b(6)4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	2 3 y	Z	9	Unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	1440	N/A b(6)4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 9	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW 2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 6 1 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 6 Ø 9

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

FOR LOCAL USE

Dx: S/P 1+D (L) ankle

EX41.25 (a)
DX: 8912 0
PX: 8081

b62

ADMITTING OFFICER (Signature, a [redacted]

SIGNATURE OF ADMITTING CLERK

b(6)2

[redacted], SPC, 9/6/10

DA FORM 2085, MAR 80

INPA[redacted] TREATMENT RECORD COVER SHEE[redacted]

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

1. SERVICE NUMBER 00134131	2. NAME (Last, First, MI) EPW #[redacted]				3. GRADE	ADMISSION REMARKS
4. AGE M 34Y	5. RACE —	6. RELIGION —	8. [redacted] SVC b(6)4	9. ETS	10. PREVIOUS ADMISSION NO	
[redacted]	12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICW2	
[redacted]	16. [redacted] 030	17. DEPT./BEN —	18. BRANCH/CORPS —	19. UIC/ZIP	20. TYPE CASE VSI	
[redacted] OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION	23. CLINIC SERVICE AAAA	
[redacted] RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 18 June 2003	
[redacted] OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 10 June 2003	ADMITTING OFFICER
[redacted] LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)2					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

[redacted] ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

[redacted] DIAGNOSIS

[redacted] OPERATIONS AND SPECIAL PROCEDURES

DX → GSW ABD S/P x-Lap 48° ago/(D) Hip fx

TOTAL [redacted] This Facility					
a. [redacted] DAYS	b. OTHER DAYS ~~0~~	c. CONV. LV/COOP CARE DAYS ~~0~~	d. SUPPLEMENTAL CARE DAYS ~~0~~	e. BED DAYS 8	f. TOTAL SICK DAYS 8

[redacted] Facilities					
a. [redacted] DAYS	b. OTHER DAYS [redacted]	[redacted] CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

[redacted] ATTENDING MEDICAL OFFICER [redacted] b(6)2 [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] SPC USARmy

[redacted] PREVIOUS EDITION OF [redacted] IS OBSOLETE b(6)2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

34 yo - graphic male s/p GSW to Back 2 days
Ago under went ex LAP & colostomy & (B) Drain
placement → PTC → USH for fever 102°F

NKDA | PMH Ø | PSH | meds: Tylenol, Mrcy, Nebacin | TDA ?

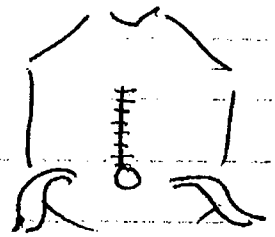
PHYSICAL EXAMINATION

125 BPM 114/74 16 99.4

NCAT

Chest CTA

Abd



TTP Abdn
No Guarding by
Ostomy visible

Rectal nelaton line (P)
ext occ stool
Back ~~ext~~ entrance wounds
Cxr ~~CBA~~ cl
Pelvis (-) clinical wing fx

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

A/P S/P exlp presumed rectal/colon injury &
open pelvic fracture

① c/s - ortho
② IUA IV ABX
③ Admit to ward

SIGN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted] b(6)2	10 Mar 03		

PAT[redacted] ...ed or written entries give Name last, first, ...; grade; date; hospital or medical facility).

REGISTER NO.	WARD NO.

[redacted]

b(6)4

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

282

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(cont)
10 JUN 03 1620	25cc green drainage via NG Tube. (R) Temp - 102.5 HR 141, R-24 mod/shallow, B/P 120/81, O_2 Sat ranging from 84-90 on RA., linen change done. Pt. Sleeping at this time 1750. -D. [redacted] b(6)2 LPN 91WML
10 JUN 03 1730.	I.V. NS was run wide open to deliver the Mefotin in 300cc. New bag hung ↓ rate back to 200cc/hr [redacted] b(6)2 LPN 91WML6
1820	NG Flushed c̄ 35cc water, placed on 2L O_2 NC. SaO_2 ↑ to 97%, BP 118/83 R-18 HR-134.
1925	Dressings changed on back x2, temp. 102.4(R), BP 114/76, HR 130, R-20, SaO_2 97% 1.5. Pt. dmedevacked to [redacted] b(2)2 [redacted] b(6)2 SGT 91WML6

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 June 03 03:29	10 June 03 21:45 – Pt. received via stretcher from EmT. Pt sleeping. Somewhe difficult to awaken. Pt transferred self c̄ ~~assistance~~ assistance to bed from stretcher. VS: BP 106/58, P-110, T-99.4, R-16, O2 sat-95%. Pt. O2 sat ↓ off O2. O2 c̄ NC remains @ 2L. PERRLA⊕WN/ NG tube intact ~~and~~ c̄ intermittent suction on low. Central line intact and patent. TLC drsg op-site C/D/I. TLC c̄ LR @ 150cc/hr. PIV ⓛ ↑ Ext HL c̄ triple port stopcock. Midline ABD incisi c̄ staples C/D/I to air. Colostomy intact @ midline ↓ ABD draining sm amt bloody drainage. ⓡ Drains ~~patent and~~ to ABD patent and draining serosanguinous fluid. Indwelli foley cath. draining dark yellow urine c̄ strong odor. Bullet entry wound to ⓛ ↓ mid ~~R~~ flank covered c̄ 4x4 and reinfoced c̄ 2nd 4x4. Draining serosanguinous fluid. 2nd entry wound to ⓡ mid flank covered c̄ 4x4x1. ⊘ reinforcement necessary. Draining sm. amt. serosang. fluid. ⓡ lung c̄ rhonchi throughout lobes ⓛ lung CTA. BS absent x4 quad. ⊕ PPP ⓑ. Skin W/D. Will cont. to mon [redacted] 24T/AN
~~0300~~	0300 – NG tube ⊕ placement. Flushed c̄ 25cc sterile H2O ⊕ Gastric ~~ton~~ contents. Will cont to mon [redacted] 24T/AN
	late entry 01:15 Pt. medicated c̄ 4mg MSO4 for pain in ABD. [redacted] 24T/AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST b(6)2	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. [redacted] b(6)4 | WARD NO. JCW2

[redacted] b(6)4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Jun 03	0820 - Pt Alert communicating c̄ nurse and other patients. VSS Central line intact c̄ opsite, patent infusing LR @ 150cc/hr. HL to (D) arm flushing well c̄ infiltration or redness. Foley patent draining dark yellow urine. Bilat drains to abd intact draining serosanguinous fluid. Dsg Dressing to ABD intact. Midline incision intact open to air c̄ s/s of infection. HR regular ⊖ BS x4. Will cont to monitor [redacted] 2Lt AN
	0900 - (R) lung c̄ rhonchi throughout lobes. (L) lung CTA. Dsgs Δ'd to lower back entry wound draining serosanguinous fluid. Will cont. to monitor [redacted] 2Lt AN
	1200 - Pt has temp 101.6 Tylenol supp given. Will cont to monitor [redacted] 2Lt AN
1300	Pt CAOX3 in semi-fowler posit. Pt has IC tube c̄ contact [redacted] Pt NC 2L c̄ 95% O2 sat. BP 87/70.4 110/60 R 20 T 100.2 P 112 R [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11Jun03	Surgery No complaint VSS Tm 103 Chest CBOA Abd ⊕ BS wound CDI/I Dr- [redacted] A/P Doing well Ambulate Advance Diet. b(6)2 [redacted]
11JUN03 2000	Assumed care of Pt @ 1300. VSS x ↑temp 100°, encouraged IS use. (B) LS CTA, (+) BS hypo Ø flatus in ostomy bag. Cyx to foley cath. Ø NG tube to suction drainage. D/C'd NG Tube. Pt tol Clear Liquid Diet. Δ'd dressings on Back x2. Both saturated with serous fluid, small amount of blood. New Dsg CDI. D/C PIV (L) FA cath intact. Bilat abd drains to ~~abd~~ gravity draining serosang. fluid. See 1400's Δ'd dsg to (L) abd drain, (R) side dsg CDI. D/C'd O2 pt SATS ↓ to 89, use IS, NO Δ, Put 1L LO2 via

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REGISTER NO. | WARD NO. TCW2

EPW [redacted] b(6)4

PROGRESS NOTES
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DATE	NOTES
cont	NC, O_2 SATS 97%. Central line triple lumen patent & CR and IVABX. Ø c/o pain. Q/W assessment and [redacted] b(6)2 will monitor [redacted]
12 Jun 03 @ 0120hrs	Assumed care of patient @ 2100hrs (11 Jun). Pt alert & on bed rest. Lungs CTA all fields, abdominal region c̄ ↓ bowel sounds throughout. Midline abdominal incision intact c̄ staples. No drainage noted. Abd non-distended, soft. O_2 @ 1½ liters → 94% sat s̄ O_2 @ 2300hrs. O_2 removed @ this time; will recheck @ 0200hrs. (B) abd. drains remain in place c̄ minimal drainage (bloody) from each. Foley cath patent & collecting cloudy, yellow urine. Back dressing D & 2 c̄ shows sanguinous/bloody tinged drainage. Colostomy bag intact. Triple lumen central line intact into (B) neck (dressing C, D, I). Received 4g MSO4 IVP @ 2245hrs for c/o abd discomfort. Resting comfortably now. Will continue monitoring & obtain labs @ 0400hrs [redacted] b(6)2
0400	UA, CBC, chem/met panel sent [redacted]
12 Jun 03 0430	Pt c̄ 550cc emesis (green bile) p̄ c/o abdomen feeling tight. Continues to have very little → none p̄ bowel sounds. Very minimal collection of bile in colostomy bag. Physician on call notified; ordered Reglan 10mg IV now — given. Pt resting better s̄ further abd. complaints [redacted]
12 Jun 03 0500	Pt SAT ↓ 90% on RA. placed on 2L O_2 via nasal cannula. [redacted] b(6)2
12 Jun 03 0530	Assumed care of pt @ 0500. Pt is resting quietly. Pt is on O_2 @ 2L. Pt has a Foley catheter draining cloudy yellow urine. 2 abd. drains draining minimal blood from each. Lungs are CTA. Minimal bowel sounds x 1 upper quad. Pt has a colostomy bag. Pt has c̄ c/o pain or discomfort @ this time. Will continue to monitor. [redacted] 91WM6, SGT b(6)2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 JUNE 03	General Surgery
0820	20004 y/o EX-CAP - 20 yrs to SICK - previous recent abdom injury - pelvic ring fx - colostomy/pelvic drains. (+) emesis this am. c/o abdom left of incision
	Tm 100.6 generally T 98.2 HR 84 118/78 99% on 2 LNC
65 / 25 / 227	3000 cc serosanguinous fluid drains 2
	1500 po / 2200 cc.
	CHEST CTA B/L
136 / 105 / 17 / 88	CVS RRR
37 / 25 / 0.7	ABD firm - tender to palp. wound T equivocal drainage
	stump drain c bloody d/c fluid (+) stoma
	flank wound - open - packed - minor drainage
	Extremities
	ext. pelvic ring fx -
	multiple trauma injury, pelvic ring fx.
	- assess failure to determine weight bearing status &
	musculoskeletal disorders I/O Re. Alteration
	- CMT. NPO/IVF 2° to stump output
	- CMS ABX x 7-10 days. [redacted] b(6)2
	- PCC Cons for now.

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WARD NO. ICW

EPW

b(6)4

[redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 June 1145	Pt is awake. Pt has 6/10 pain in abd. Pt 1200 VSS. Pt is NPO. Dr. says it is ok for him to sip water. Dr. wants pt to ambulate with PT. [redacted], 91WM6, SGT
12 Jun 1245	Pt just vomited; greenish liquid. Approximately 500 cc's [redacted], 91WM6, SGT
12Jun03 1945	assumed care @ 1300 - VSS, Tmax 100.6°F - IV patent, abx continue - colostomy bag in place, no output - (2) & (1) abdominal dsg drains intact and dsg in place - Foley to gravity, output QS - pt. had one episode of emesis despite NPO status - pt. pulled off colostomy bag in anger, restraint length shortened and (1) arm restraint placed - sats 91% on RA, IS encouraged & pt. used q 2° this shift [redacted]
12Jun03 2030	pt. vomited 400cc green emesis yellow particulate & being NPO since 0930 - Dr. [redacted] consulted and NGT to be placed to LIS - pt. has no BS, no gas or stool in colostomy bag [redacted]
2100 5Jun03	~~Pt stable~~ Pt care assumed @2100. VSS, a+o x3. Pt has been recieving MSO4 for pain throughout the shift. Pt has central line in place, line and insertion site appear CDI, fluid is running well. Pt had NG tube insertion @2100. Insertion w/o diff, draining green fluid upon insertion. Insertion confirmed with air

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	insertion. Pt c/o pain and diff breathing after insertion, interpreter brought to bedside. Pt explained to the normal after effects of NG insertion, and that he would get used to the feeling in his throat. At 2400 200cc green fluid was drained from NG tube. Pt has foley catheter inserted, 200cc drained this shift, site CDI. Drains to abdomen drained 25cc each @2400, sites at RLQ and LLQ CDI. Colostomy bags empty, site CDI. Pt stable, O2>90%, npo at this time. Will continue to monitor. SPC [redacted] 9lumen ——— b(6)2
0400	300cc drained from NG tube, 50 from R abd drain, 50 from L abd drain, will continue to monitor. SPC [redacted] 9lumen
13 Jun	0548 - Pt Alert. VSS, lung CTA, ⊖ BS, HR regular, central line patent infusing LR @ 150cc/hr. Dsg intact to backside with moderate drainage. Foley patent. Bilat drains to abd intact draining serosanguinous fluid. Staples to midline abd ⊘ s/s of infection/drainage. Colostomy intact. NG to LIS. Will cont. to monitor. ——— [redacted] 2Lt AN
	b(6)2

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[redacted] b(6)4		

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 JUNE 03	General Surgery
0835	POD #5 - GSW - Ex-lap rectal hospitalization
	presents recent rectal injury, ileostomy fx
	(+) colostomy b/c flank/perineal drain.
	Ht & wt (est pm - NBS phone to good result
	pt c/o some theart stiff mm. some nausea and
	pending anesthesia.
	T 100.6 ↓ 99 140/88 HR 70-80 Lab 96% RA
	Assess 2030/1180
	CHEST CTA-B/L - pulmonary rales; mechanical - decongestion
	COR RRR (-) fluid 390 tonne
	ABD: ↑ BS. soft, flat.
	wound - covered midline (-) erythema/drainage
	ostomy - pink loop pink c fecal effluent
	(-) output.
	EXT (-) edema.
	Impression: S/P ex-lap - rectal injury
	(+) ileus - no real return of bowel function
	- cont NPO - follow surgery
	↓ wbc in am
	- cont. antibiotics - today day # 5
	- discuss to surgery b(6)2
	[redacted] MS

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DATE	NOTES
13 JUN 03 2000	Assumed care of Pt @ 1300. VSS ⊼ mild temp. A+O x3 (B) LS CTA, (+) BS hyperactive (+) flatus and liquid brown stool per ostomy bag, NGT LIS draining dark green liquid. Pt NPO ⊼ sips, lips tube irritating throat. (+) foley draining adequate amount urin. (B) abd drains intact Ø drainage on shift. ABD incision ⊼ staples CDI. Ø c/o pain. Rest. Mostly Day. ~~C/W~~ Cheer IV ABX and NS @ 125cc/hr via ES triple lumen. C/W assessment WNL. Will flow. [redacted]
2200	Pt. care assumed @ 2100. Pt. resting quietly. b(6)2 HR reg. Lungs CTA. NG to LIS, draining dark green brown liquid ABD soft ⊼ midline incision ⊼ staples CTA. Urostomy drains to gravity. Foley to gravity draining clear yellow urine. Colostomy bag intact. will b(6)2 continue to monitor. [redacted] CTK
14 June 03	0530 Assume pt care @ 0700. pt asleep, easy to awake for assessment. VSS. HR regular. ~~Pt~~ Central line to (R) side infusing LR @ 125cc/hr. no s/s redness/infiltration pulses x4 palpable. Abd soft midline incision, sutures intact. (B) abd drains intact Ø drainage @ this time. Colostomy bag intact Ø drainage. NGT to LIS intact draining green/brown liquid. Foley to gravity draining. CYU (Cont. Urinary)

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EPW [redacted] b(6)7

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 JUN 03	0550 (cont). pt has no c/o pain. Resting quietly. Dsg's to lower back Dry and intact. Old drainage noted. Will discuss dsg Δ with MD. — [redacted] SSG
	0750 40 mcg ĉ 250 ml NS started ofor 4°. to distal line of central line @ 62 ml/hr. — [redacted] SSG
14 JUN 03	General Surgery
1000	POD #6 Doing better, ↓ fever w/c. not ĉ [redacted]
	Tm 100.6 ↓ 99 RR/20 78 99% RA not ĉ [illegible]
LNB	(+) stool bowel → ostomy UO 1600/24°
	Lungs clear - coarse - decreased significant sounds
	chest clear B/L Chest - 35 Fr/Jp serosanguinous fluid
	CV RRR S ⓪
	ABD soft, flat, ↓ bsp (+) of mistake
	tender (+) left/groin 2° f. posterior wound - clean
	ostomy - functioning - dark stool.
	Impression: Renal injury s/p ex-lap/ostomy - hemodynamically
	(+) ileus - resolving - (+) ostomy output
	cont not adequate - giving in AM.
	- cont NPO
	- cont NF/TPN - [illegible] #6
	- replace K ... ✓ cxr - in AM
	[redacted]
b(6)2	[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 June 03 1340	assumed pt care @ 1300. VSS. pt resting quietly. NGT to LIS draining 3 diff, et intact. lung sounds CTA. abd c̄ midline incision c̄ sutures ∅ s/sx of infection. central line to ® side infusing 3 diff ∅ s/sx of infiltration. ® abd drains intact. Foley cath to gravity intact draining urine 3 diff. Ostomy bag intact. L ext c̄ strong ⊕ pulses. drsng to lower back CDI. U ext [redacted] c̄ strong ⊕ pulses. pt on EPW protocol leather restraints on ® wrist. ∅ s/sx of distress noted. Will cont to monitor — [redacted] 9 mm b(6)2
2215	Pt. care assumed @ 2100. Pt. resting quietly. No to LIU draining dark brown liquid. Urostomy X2 to gravity. Foley to gravity. Central line drsng s/d. ∅ redness @ site, ⊕ purulent drainage (scantamt). HR Reg, lungs CTA BS hyperactive but ⊕ X4. Midline ABD incision c̄ sutures OTA. Pulses 2⊕ X4. Will cont. to monitor. b(6)2 [redacted]
15 Jun 03	0830 - Pt alert voicing ∅ complaints about pain. Central line patent infusing LR @ 125 c̄/hr. NG to LIS draining light brown fluid. Bilat drains to abd patent/intact. Incision to middle abd c̄ staples intact c̄ ∅ s/s of infection. — Cont. —

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REGISTER NO. | WARD NO. ICW 2

EPW # [redacted] b(6)4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	cont. — Colostomy intact. Some bleeding noted to bowel after cleaning. Dsgs CDI to posterior wounds. Resting quietly. Will cont. to monitor. — [redacted] AN
15JAN03	General Surgery b(6)2
	pt #2 - A/ fell [illegible], Mis NGT output [illegible] - no more
CABG	guice (+) fluid for NG - 28 [illegible] NGT pat [illegible]
	(OD blood) type fluid - denied immediately. [illegible] (+) [illegible]
13	smell but of [illegible]
263 15JAN	Co [illegible] fever 100.5 Tm 99 BP 80/50 HR 70 RR 16 96% RA
27	[illegible] family [illegible] [illegible] 100/100 [illegible]
164	[illegible] NGT 500
15	
27 11 [illegible]	
87 105/15	[illegible]
36/26/0.7	NGT flow [illegible] [illegible] [illegible] (+) [illegible]
02 CPT	[illegible] (+) [illegible]
AB 2.4	[illegible]
NGT	
[illegible]	
	MIS/PMH: [illegible]
	- [illegible]
	if [illegible]
	- [illegible]
	- ↑ WBC - [illegible] - D/C [illegible] → PIU b(6)2
	- [illegible]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Jun03	1220- Central line pulled c minimal bleeding PIV placed in ® forearm c LR @ 125 cc/hr. NG s LIS. Will turn suction on @ 1600. Pt requested Ø medication for pain relief Will cont to monitor — [redacted] 2LAN
15Jun03 1945	assumed care @ 1300 - NGT to LIS @ 1600, b(6)2 100cc output, dark liquid - abdominal drains c̄ no output - Foley draining QS > 700cc this shift - IV patent - pt. ambulated ~10 minutes - colostomy bag Δ'd, small amount of soft stool output - NGT pulled @ ~1800, pt. given 30cc H_2O - very demanding and loud throughout shift, talked c translator several times, mood did not improve. Staples intact - ⊕ BS [redacted] CAN b62
2140	Foley D/c'd per MD order. Pt. c/o symptoms disproportionate signs. Pt. uncooperative. — [redacted] b62
2300	HR Reg, Lungs CTA, BS ⊕ x4. ABD drains to gravity intact. Colostomy intact. Will cont to monitor. — b(6)2 [redacted] 1-97AN

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REGISTER NO.

WARD NO. 2CW2

[redacted] b(6)4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 MAR 03	General Surgery
0800	[illegible] General. Pt very cooperative - wants to go home. Not sure if can't [illegible] diff. [illegible] feels sure if improving. Plans to eat. Tolerating clear diet. Denies [illegible] pain
[illegible] - pain	T [illegible] 100.5 F 98 HR 80 115/65 [illegible]
[illegible]	Looks well — No [illegible]
	chest clear
	CVS RRR [illegible]
	Abd flat, soft & [illegible]
	wound [illegible] w/ [illegible] [illegible]
	[illegible] present [illegible]
	[illegible] [illegible]
	[illegible] [illegible] - [illegible]
PLAN	Doing well
	- resume diet
	- HC [illegible]
	- [illegible] now [illegible]
	- Ambulate
	- [illegible] Antibiotics
	- [illegible] today, - follow [illegible]
	[illegible] HCF [illegible]
	b(6)2
Admission:	[illegible] 27 [illegible]
	[illegible] HCF - [illegible]
	[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Jun 03	1143- Pt alert OOB x1, SAT in chair and ambulated once through ward. IV fluids d/c. Colostomy intact. Bilat drain intact. Posterior Dsg intact c minimal drainage. Voiding adequately in urinal. Lung sounds clear BS⊕, HR reg. Will cont. to monitor- [redacted]
16 June 03 1300	Pt vitals taken BP 120/80, P. 82, R. 20, Temp. 98.4 SPO [redacted] b(6)2
16 June 03 1600	Pt vitals taken BP 110/82, P. 84, R. 20, Temp. 100.2 SPO [redacted]
1930	Assumed care of Pt @ 1800. VSS, AAOx3. (B) Abd drains CDI. Ostomy Bag intact. (R) OE PIV HL. (B) Surgon Back CDI. (B) BS x 4 (B) LSCTA. Pt c/o pain. OOB to chair x1hr o/w assessment WNL. [redacted] b(6)2 Monitor
2200	Pt care assumed @ 2100. Temp @ 101.9, 650mg tylenol given @2200. AAOx3, no complaints at this time. lung sounds CTA, pulses palpable x4, bowel sounds x4 quadrants. Ostomy site with bag intact. IV HL @ RA patent. Dressing on back CDI. Bilateral abd drains intact, minimal drainage noted. Pt voiding c/w personal, will continue to monitor. SPO [redacted] b(6)2

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Pt epw [redacted] b(6)4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Jun 03 0530	Pt alert easily arousable from sleep temp 101.6. Gave tylenol & pdx worked on IS. [redacted] Will ambulate p breakfast. Lungs clear, BS⊕, HR reg. Colostomy intact, Bilat drain intact covered c̄ Dsg. HL to (L) forearm. Voiding adequately ∅ any difficulties. Will cont to monitor- [redacted]
0700	Temp down to 99³. Encouraging IS. [redacted]
1030	Bilat drains removed. Sites covered c̄ 4x4s. b(6)2 Incision to abd c̄ steri strips. [redacted]
17 June 03 1900	assumed pt care @ 1300. VSS. lung sounds CTA Abd, BS⊕ x 4 quads. dressing to previous drain sites CDI. [redacted] ostomy bag intact. HL to (L) FA ∅ S/Sx of infection noted. ∅ c/o pain expressed @ this time. Will cont to monitor — [redacted]
2135	Pt. care assumed @ 2100. Pt. alert & compliant c̄ care. Pt. denies pain @ this time. HR Reg, lungs CTA. ABD soft c̄ active BS x 4. midline incision CTA, ∅ s/s infection. Ostomy c̄ s/s infection, bag intact. Bag burped, ∅ odor noted. ABD dsngs Δ'd. Packing left intact, outer dsngs only Δ'd. Will cont. to monitor. — [redacted] b(6)2
2200	Pt. given 650mg Tylenol for temp 101. — [redacted]

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PROGRESS NOTES

DATE	
18 Jun 03	Assumed care of pt @ 0500. Pt was asleep.
1045	Lungs CTA. Pt is alert. D/C'd IV. Dog Δ with
	doctor. Pt has ø c/o pain/discomfort. Pt will be
	d/c'd back to EPW Camp today — b(6)2 [redacted] 91WM6
	86T
18 June 03	assumed pt care @ 1300. VSS. pt awake & alert
1315	awaiting transportation to EPW camp. Drains CDI.
	assessment WNL. ⊘ complaints voiced @ this time. Will
	cont to monitor — b(6)2 [redacted] 91WM6 —
18 Jun 03	Pt care assumed @ 2100. Pt awake and alert. c/o complaints.
2130	Lung sounds CTA, bowel sounds present x4, pulses palpable
	x4. Drgs on Abd bilaterally CDI, staples & [redacted] on
	midline abd CDI. Colostomy site has minimal
	output, site CDI. Pt c̄ evac orders awaiting b(6)2
	transportation. Will continue to monitor. SPC [redacted] 91WM6
2200	Pt refused zantac. SPC [redacted] 91WM6 b(6)2
19 June 03	Assumed pt care @ 0500. Pt awake and alert.
0540	No c/o pain @ this time. No PIV. VSS. HR reg. Lungs
B/P 110/60	CTA throughout. Abd soft. Colostomy bag intact. Dsg to
P 78	BUQ CDI. Dsg to ⊕ side of back sm amt of red
R 18	drainage noted. BS active x4. Pt waiting for transport b(6)2
T 98.1	sitting on side of bed. Will continue to monitor [redacted] 91WM
19 June 03	assumed pt care @ 1300. VSS. pt awake & alert.
1415	lung sounds CTA, abd soft, colostomy bag intact.
	drains to abd CDI. ⊕ BS. BUE & BLE c̄ full ROM strong
	⊕ pulses. Pt awaiting discharge transportation to EPW b(6)2
	Camp. ⊘ c/o pain voiced @ this time. Will cont to monitor [redacted] 91WM

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MEDICAL RECORD	PROGRESS NOTES
DATE	
	General Surgery
17 JUNE 03	POD #9. Doing well. Tolerating regular diet.
1000	good strong cough - bowels good. no N/V
	still having daily fever to 100.5, good UO.
	Tm 100.5 & 99 HR 90, BP 150/79 RR & RR
	looks well
	chest CTA B/L
	CVS RRR
	ABD soft, flat
	Minimal incisional ecchymosis/serosanguinous
	drains B/L c/g - ↓ output
	strong pulses ⊕ edema
	Ext - ⊕ edema c/b ⊕ thrombosis & ⊕
	Impression: Doing well - fevers unclear etiology
	① D/C drains - pelvis - ↓ & bilateral drains
	② ambulate
	③ check CBC in AM
	④ follow fevers - no apparent source - ALL cultures out
	⑤ sutures are removed. [redacted] b(6)2
	⑥ plan D/C next few days. [redacted]
	MAJ MC

(Continue on reverse side)

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	
20Jun03 0145	Assumed pt care @2100. VSS, AAOx3, c/o pain in throat after eating. Lung sounds CTA, pulses palpable x4, bs present x4 quads. Pt awaiting transportation for eac. Colostomy bag intact with minimal output, bilateral abdominal dsg's CDI. Pt refused zantac, explained through interpreter why hes getting it, he still refused. Pt very abnoxious and uncooperative. T3 withheld for pain. Will continue to monitor. SPC [redacted] 91WM6 b(6)2

(Continue on reverse side)

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[redacted] b(6)4		

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USAPPC V1.00

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 June '03 1600 hrs	Iraqi soldier arrived via FLA from Jordanian hospital, w/ mid-line laparotomy incision/-ostomy, and (R) + (L) drainage tubes, foley cath bag w/ ~400cc, and BP = 125/85 and HR > 130/min and T° > 10[illegible] Exam of back → small/tiny wound in (L) flank/back and larger wound in (R) flank/back. Imp. GSW S/P laparotomy/-ostomy, Febrile and Tachycardic Plan. admit while awaiting med-evac → CSI ↑ IV fluids, Antibiotics IV and monitor clinical course closely [redacted] b6
10 JUN 03 1620	Iraqi soldier arrived from HILS Section to recovery. DC'd IV in (L) forarm, cleaned & retaped triple lumen insertion site, removed soiled dressing @ (L) and (R) flank/back redressed w/ 2x2. I.V. NS ↓ to 200cc/hr, 2mg MSO4 via IVP given @ 1650. Pt reaction: ↓ O2 sat ranging from 84% 90% on RA. 1mg Meforin IVPB given at 1700hrs into 300cc NS. Output - urin [redacted] 500cc dark yellow urin (CONT

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

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

[redacted]

DOB 1967 b(6) 4

SN: [redacted]

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

USAPA V2.00

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 JUNE 03 0845	Discharge Summary
	34 yo Single male Airborne Ranger to back on 8 June 03. Ex-lap performed @ Landstuhl Hospital. Presents recent injury - no reports available. Colostomy - b/c abdominal gauze dress. Pt also describes left ilium wing fracture.
	Was PWD #10. Pt doing well. Following regular diet. Drains removed, sutures are removed. Pt ambulates slowly. Unfortunately no crutches available.
	- D/C to RAW camp today
	- colostomy supplies - extra bags - plates
	- 4x4 to b/c lower quadrant after sites after application of Bacitracin - BID
	- 4x4 to b/c back wounds after application of Bacitracin - BID
	- regular diet
	- no restrictions on ambulation.
	[redacted] b(6)2
	[redacted] MD
	MTF NE

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

EPW# [redacted] b(6)4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Station): GMT

LOG NUMBER:

ARRIVAL — DATE: DAY 12 MONTH June YR. 03 TIME 2014

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

CURRENT MEDS. (tetanus immunization and other data):

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

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

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW abdomen

SEX: ♂ AGE: 34

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER:

VITAL SIGNS			
TIME	2016	2034	
BP	114/74	⊘	
PULSE	125	139	
RESP.	16	16	
TEMP.	99.4		
WT. (Child)	94	2060	

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

ORDERS	INITS.	TIME
CBC ~~[illegible]~~ chem 10		
abdominal xray		
chest xray		
2mg morphin	[redacted]	2033
2mg MSO4		

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)

34 y/o ♂ w c/o GSW to abdomen
0x99 2037

GSW ABD 2 days ago; operated on @ Jordain Hospital. Arrived @ FST today c̄ c̄ have & Fever / Tachycardia.
c/o pain moderate in ABD

Tachy 99.4
P = tachy
Lungs = CTA (B).
ABD = x-lap wound c̄ drains. NABS. Tender in all quads c̄ guarding (grabs hands)
Colostomy bag
Ext = pulses distally. (B) feet
Back = (R) lower one 1.5cm circular Frag wound.
Flank (L) 0.5cm Frag wound.
urine dark yellow in bag / triple lumen line (R) neck

ASSESSMENT/DIAGNOSIS
(L) 4/1 GSW ABD
hip FX.

OXR = nl
hip = (L) 2 Fractures

10.5 9/31 232
150 112 23 / 28 103
4.5 1.4
U/A
Nitr = neg

DISPOSITION (Check all that apply): ☐ HOME ☐ FULL DUTY

QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic):

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICW

CONDITION UPON RELEASE: ☐ IMPROVED ☒ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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).

[redacted]
DOB 1969 b(6)4

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] b(6)2 MAJ, MC FAMILY PRACTICE

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	11	12	13	14	15	16	17
POST- DAY							
MONTH-YEAR / DAY	17	18	19	19	20	21	22
19 / HOUR							

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		

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT

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

REGISTER NO.

WARD NO.

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

epu[redacted] b(6)4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: ADM

POST- DAY

MONTH-YEAR: June 15 2003

DAY: 10 | 11-12 | 12 Pure | 13 | 14 | 15

HOUR

PULSE (O) / TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

PULSE (O)	TEMP. F
180	
170	
160	
150	
140	
130	
120	
110	
100	
90	
80	
70	
60	
50	
40	

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

96% 2L C
97% RA
RA @ 2300 94%

99% O2
91% RA
92% RA

TOTAL In: 4,060

TOTAL OUT: 3,005

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

REGISTER NO.: Civ- 0283

WARD NO.: ICW2

Civ #[redacted] 3440 ♂

b(6)4

VITAL SIGNS RECORDS

Medical Record

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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 1630 HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 10 Jan 03

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
				1630	500	~~500~~ NS			500
				1930	500	NaCl			1000

IRRIGATIONS *(N/G, Bladder, etc.)*			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1815	NG Flush	35cc	35cc

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

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1630	600cc	600				1633	25cc	Green drainage	25-

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE MUG	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0830	H_2O	240	240
0830	Milk	240	480

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0120	CYU	280	280cc
0345	CYU	340	620cc
~~0510~~	~~CYU~~	~~320~~	~~940cc~~
100	CYU	400	1340
130	CYU	200	1540
2230	CYU	240	1780

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

OUTPUT

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

[redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830 (TEMP) 1 JUL

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0000 HOURS TO 2359 HOURS	TOTAL HOURS COVERED 24	DATE 10 Jun 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
21:30	NPO	0	0

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
EMT	1 Liter	LR x 1	1000	0225	1000
0225	1 liter	LR x 2	~~1000~~ 800	04:17	~~2000~~ 1800
00:30	100cc	Unasyn 3gm	100	01:30	~~2100~~ 1900

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0300	NG	20cc	20cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

b(6)4

#[redacted] 3440 ♂

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 7

MEDCOM - 10370

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTA[illegible] [illegible]ND OUTPUT WORKSHEET

FROM ______ HOURS TO ______ HOURS	TOTAL HOURS COVERED	DATE

IN[illegible]

~~ORAL~~ urine

TIME	TYPE [illegible] [redacted]	AMOUNT	ACCUM TOTAL
~~0245~~	~~dk yellow [illegible] odor~~	~~725~~	~~725~~

~~INTRAVENOUS~~ colostomy

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

NG **~~IRRIGATIONS (N/G, Bladder, etc.)~~**

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
~~0300~~	~~[illegible]~~	~~[illegible]~~	~~60cc 30cc~~	~~90cc~~

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP..............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...18

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO [illegible] HOURS | TOTAL HOURS COVERED 24 | DATE 11 JUN 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0000	NPO		
1400	H_2O	500	500
1800	H_2O	500	1000
2000	Juice	500	1500
0930	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
~~0000~~ ~~0585~~	100	Unasyn 3gm	100	0130	100
0585	1000	LR	200	0447	300
06	100	Unasyn	100	07	400
05	800	LR	750	12	1250
12	1000	LR	1000	2286	2250
12	100	Unasyn	100	~~1500~~	2350
18	100	Unasyn	100	1900	2450
06	100	Unasyn	100	0700	2550
12	100	Unasyn	100	1300	~~3850~~ 2650

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0000	NG	20cc	20cc
0600	NG	20cc	40cc
1000	NG	20cc	60cc

N/G D/C'D

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE 4,060

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP.....160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE & OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE

INT

URINE ~~STOOL~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
0005	Urine straw yellow	725	725
08	dark yellow	500	1225
12	clear yellow	375	1600
19	cloudy	700	2300
23	clear, yellow	400	2700

~~INTRAVENOUS~~

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

Drains ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	60cc (R) drain 30cc (L) drain	90cc	90cc
1245	15 cc (R) drain 10cc (L) drain	25	115
2030	70 cc (L) 70 cc (R)	140	255
2355	(L) 25cc (R) 15cc	40	295

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE 3,005

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP.....160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO [illegible] HOURS | TOTAL HOURS COVERED 24 | DATE 12 JUN 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0001	800	LR	800	0442	800
0001	100	Unasyn c 100cc NS	100	0030	900
0442	1000				
12/18	200	Unasyn	200		
~~1800~~					
24	100	Unasyn	100	0100	100
06	100	Unasyn	100	07error	[redacted]
					b6-2

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW # [redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION 1 JUL 7: MEDCOM - 10374 PLACES DA FORM 3830(TEMP) *U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT I	OUTPUT WORKSHEET	FROM 4 TO 2400	HOURS 19	DATE 12 JUN 03

IN

Foley CATH OUTPUT

TIME	TYPE	AMOUNT	ACCUM TOTAL
04	URINE	350	
19	"	500	850
24		200	1050

INTRAVENOUS

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

DRAINS ~~IRRIGATIONS (IVAC, Drainage, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0400	(R) Bloody	120	120
	(C) Bloody	50	170
19	(A) Blood tinged	40	210
	(R) Bloody	30	240
2400	R Abd	25	265
	L Abd	25	290
	NG-tube	200	490
0400	R Abd	50	50
	L Abd	50	100
	NG Tube	300	400

BLOOD/BLOOD DERIVATIVES

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

Output ~~OTHER INTAKE~~

TIME	~~TYPE~~ emesis	AMOUNT	ACCUMULATIVE TOTAL
0430	Emesis (GREENISH Blk)	550	550
0730	FEW SIPS		
19	emesis	200	750
~~2030~~	~~GRAND~~ TOTAL INTAKE 4	400	1150

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

EPW # [redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDIT: 1 JUL REPLACES DA FORM 3630(TEMP)

MEDCOM - 10375

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 2400 HOURS | TOTAL HOURS COVERED 24 | DATE 13 Jun 03

IN

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	100	Unasyn	100	07	100
08	1000	LR @ 125			
14	100	Unasyn	100	15	
~~MN~~	~~100~~	~~Unasyn~~	~~100~~	~~MN~~	

NG IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
12	dark green	450	450
20	dark green	500	950

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP.....160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

INT

Foley ~~GRAF~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
07	urine	350	
12	urine	450	800
1930	urine	800	1600

INTRAVENOUS

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

Drains ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	(R) Abd	50	
	(L) Abd	50	100
	NG tube	300	400
12	(R) 15cc (L) 20cc	35	435

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP.....160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM / TO — HOURS COVERED 24 — DATE 6-13-03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2000	Sips of H2O	—	—

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	100	Unasyn	100	0030	100
		LR	950	0801	1050
		LR	525	1230	1575
		Unasyn	100	0630	1675
		Unasyn	100	1300	1775
		Unasyn	100	1900	1875
		LR	402	—	2277

IRRIGATIONS (N/G, Bladder, etc.)

66-2

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
~~0300~~	~~DARK Green~~	~~600cc~~	~~500cc~~
08			
2000	brown fluid	600	
~~0338~~	~~DARK Green~~		

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ___ HOURS TO ___ HOURS	TOTAL HOURS COVERED	DATE

INT

~~ORAL~~ Urine

TIME	TYPE	AMOUNT	ACCUM TOTAL
03	urine	600	600
0430	urine	100	700
1145	urine	250	950
1700	urine	900	1850

INTRAVENOUS

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

NG ~~IRRIGATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0300	DARK GREEN	5000cc	5000cc
0145	Dark Green	450cc	950cc

Colostomy

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
03				
0300	feces		200cc	200cc

~~OTHER INTAKE~~ Urostomy

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
03	(4) oce (6) coffee	60cc	60cc

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL [illegible] WHICH MAY BE USED.

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 0001 HOURS TO 2400 HOURS	TOTAL HOURS COVERED 24	DATE 15 JUN 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H_2O	30	30
1900	H_2O	30	60

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Unasyn	100		100
		KCl	200		350
		LR	925		1275
06	100	Unasyn	100		1375
08	50	Zantac	50		1425
08	1500	LR	500		1923
14	50	Zantac	50		1973
18	100	Unasyn	100		2073
18	1000	↑ NS			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

INTAKE

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

#[redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630 (TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTA ND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 2400 HOURS | TOTAL HOURS COVERED 24 | DATE 16 Jun 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

Output [redacted]

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0335	DARK GREEN NG	500	500
0335	CYU	200	700
0800	Urine	500	1200
1300	"	375	1575
1900	urine	200	1775
1900	abd drg x2	Ø	1775
1800	NGT	100	1875
2130	Urine	500	2375

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

OUTPUT

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

#[redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL [illegible] MAY BE USED.

*U.S.GPO:1986-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 12 HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6 16 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Zantac	50		50
		Unasyn	100		150
		LR	800		950
06	100	Unasyn	100		1050
07	50	Zantac	50		1100
12	100	Unasyn	100		1200

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

WTW

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

[redacted] b(6)4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP..............160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

OUTPUT

TWENTY-FOUR HOUR PATIENT INT. AND OUTPUT WORKSHEET

FROM ___ HOURS TO ___ HOURS | TOTAL HOURS COVERED | DATE

INT

ORAL ABD drain				INTRAVENOUS Colostomy					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0800	Ø cc	Ø cc		0300		gas	Ø	stool	
				08		gas			
				1230		stool	100		

~~PROSTHESIS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0030	CLEAR AMBER FLUID	200	200
0230		120	320
0530	clear amber	200	520
0830	"	275	795
1100	cloudy	400	1195

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 — EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630 (TEMP) 1 JUL

MEDCOM - 10383

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FR 01 HOURS
TO 0000 HOURS

TOTAL HOURS COVERED 24

DATE 17 Jun 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1715	Water	600cc	600cc
1730	H2O	400	1000cc

INTRAVENOUS

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

Urine output ~~(IV's, bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
05	clear yellow	475	475
1615	clear yellow	300	775
2015	clear yellow	450	1225 662
2200	clear yellow urine	480	1705
2300	"	175	1880

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP.....160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-18-03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0140	CYU	480	480 cc
0450	Clear Amber Urine	320	800 cc
0750	CYU	420	1220 cc
	CYU	800	
	CYU	400	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL [illegible]

*U.S.GPO:1996-404-613/30343

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FC (Subject to the Privacy Act of 19		
LAST, FIRST, MI: [redacted] b(6)4	DATE 6-18	TIME 0300	SSN/PSEUDO SSN: [redacted] b(6)4	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.0	4.8-10.8 x 10^3
RBC	2.96	4.7-6.1 x 10^9
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.6	42-52% (M) 37-47% (F)
MCV	101.3	80-94 fl (M) 81-99 fl (F)
Plt	404	130-500 x 10^3 verified
Lymph %	20.1	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI EVERY UNIT REQUESTE

ABO/Rh	

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

UNIT	TYPE	CROSSMATC

REMARKS: [redacted] b(6)2

IW#2.

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	STATUS	DATE	SSN
#[redacted] b(6)4	ERW	6·16	#[redacted] b(6)4

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Blood Bank

ABO/Rh		IAT	
Unit	Type	Crossmatch	

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	9.2	4.8-10.8 x 10^3
RBC	2.74	4.7-6.1 x 10^3
Hgb	8.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.7	42-52% (M) 37-47% (F)
MCV	100.9	80-94 fl (M) 81-99 fl (F)
Plt	313	130-500 x 10^3 verified
Lymph%	19.9	20.5-51.1%
Retic		0.5-1.5% (adul
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (37-47% (
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source		
Gram Stain		
Culture		
KOH/WP		
O&P		
Occ Bld		Malaria
Other		

Fw #2.

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
#[redacted] b(6)4	E/U	6-15	[redacted] b(6)4

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT	22	10-47 U/L
AST	24	11-38 U/L
GGT		5-56 U/L
ALB	2.4	3.3-5.5 g/dl
ALP	46	26-84 U/L
Amylase	75	14-97 U/L
Ca	8.0	8-10.3 mg/dl
Chol	134	<200 mg/dl
Creat	0.7	0.6-1.2 mg/dl
BUN	15	7-22 mg/dl
GLU	88	73-118 mg/dl
Tbili	0.6	0.21.6 mg/dl
TP	5.5	6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	137	128-145 mmol/L
K^+	3.6	3.3-4.7 mmol/L
Cl^-	105	98-108 mmol/L
$^+CO_2$	27	18-33 mmol/L
CK	337	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	13.7	4.8-10.8 x 10^3
RBC	2.62	4.7-6.1 x 10^3
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.9	42-52% (M) 37-47% (F)
MCV	102.6	80-94 fl (M) 81-99 fl (F)
Plt	297	130-500 x 10^3 verified
Lymph%	15.0	20.5-51.1%
Retic		0.5-1.5% (adul
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (37-47% (
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source		
Gram Stain		
Culture		
KOH/WP		
O&P		
Occ Bld		Malaria
Other		

b(6)4

EPW [redacted]

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
HZWN03 1830			

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	12.1	4.8-10.8 x 10^3
RBC	2.73	4.7-6.1 x 10^6
Hgb	8.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.7	42-52% (M) 37-47% (F)
MCV	101.5	80-94 fl (M) 81-99 fl (F)
Plt	327	130-500 x 10^3 verified
Lymph%	16.7	20.5-51.1%
Retic		0.5-1.5% (adu
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (37-47% (
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source			
Gram Stain			
Culture			
KOH/WP			
O&P			
Occ Bld		Malaria	
Other			

Ward/Section: ICW#8	QUESTING PHYSICIAN:	LABORATORY RESULT FC (Subject to the Privacy Act of 19		
LAST, FIRST, MI: #[redacted] b(6)4	DATE 6/14	TIME 0300	SSN/PSEUDO SSN: #[redacted] b(6)4	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.6	4.8-10.8 x 10^3
RBC	2.60	4.7-6.1 x 10^9
Hgb	8.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.4	42-52% (M) 37-47% (F)
MCV	101.3	80-94 fl (M) 81-99 fl (F)
Plt	296	130-500 x 10^3 verified
Lymph %	17.9	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono.		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI
EVERY UNIT REQUESTE

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATC

REMARKS:

28 14 Jun03

+ CW# 2.

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
#[redacted] b(6)4	ERW	6/14/03	#[redacted] b(6)4

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT	23	10-47 U/L
AST	32	11-38 U/L
GGT		5-56 U/L
ALB	2.1	3.3-5.5 g/dl
ALP	43	26-84 U/L
Amylase	60	14-97 U/L
Ca	6.7	8-10.3 mg/dl
Chol	98	<200 mg/dl
Creat	0.8	0.6-1.2 mg/dl
BUN	15	7-22 mg/dl
GLU	78	73-118 mg/dl
Tbili	0.6	0.21.6 mg/dl
TP	4.6	6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	147	128-145 mmol/L
K^+	2.7	3.3-4.7 mmol/L
Cl^-	102	98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Hematology

TEST	RESULT	REF. RAN
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adu
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (37-47% (
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	Malaria
Other	

JS 14 Jun 03

© "SHADOW" PJR

Ward/Section: ICU#2

R[redacted]STING PHYSICIAN: [redacted]

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

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

DATE: 6/12

TIME: 0400

SSN/PS[redacted]O SSN: #[redacted] b(6)4

[redacted]

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

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[redacted]

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^{++}		3.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[redacted]

TEST	RESULT	REF. RANGE
GLU	85	73-118 mg/dl
BUN	17	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	2316	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	136	128-145 mmol/l
K^{+}	3.7	3.3-4.7 mmol/l
CL^{-}	105	98-108 mmol/l
tCO_2	25	18-33 mmol/l

[redacted]

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

[redacted]

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

[redacted]

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

REMARKS:

b(6)2

REPORTED BY: [redacted]

DATE:

LAB ID NO.:

b(6)2

Ward/Section: Icu #2	TESTING PHYSICIAN: [redacted]	LABORATORY RESULT FO (Subject to the Privacy Act of 197
LAST, FIRST, MI: # [redacted]	DATE: b(6) 4/6/12	TIME: 0400	SSN/PSEUDO: # [redacted] b(6)4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.5	4.8-10.8 x 10^3
RBC	2.53	4.7-6.1 x 10^6
Hgb	8.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	25.6	42-52% (M) 37-47% (F)
MCV	101.4	80-94 fl (M) 81-99 fl (F)
Plt	221	130-500 x 10^3 verified
Lymph %	17.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clr	N/A
Glu	n	Negative
Bili	n	Negative
Ket	mod	Negative
SG	1.020	N/A
Bld	trace	Negative
pH	7.0	N/A
Prot	n	Negative
Urob	n	0.2-1.0
Nit	n	Negative
Leuk	/	Negative
HCG	/	Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serolo

TEST	RESULT	REF. RA
RPR		Negative
Mono		Negative

Microbiolo

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

Microscopic U

Light mucous
0-2 RBC
0-2 WBC

Blood

MUST SUBMIT SE
EVERY UNIT REQUE

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch
(MUST SUBMIT SE
REQUIRED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Ward/Section: ICW #2	REQUESTING PHYSICIAN: Dr [redacted] b(6)2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)4		DATE: 6/11	TIME: 0330	SSN/PSEUDO SSN:

[redacted]

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.21	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[redacted]

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

[redacted]

TEST	RESULT	REF RANGE
GLU	93	73-118 mg/dl
BUN	20	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	3538	39-380 u/l (M) 30-190 u/l (F)
NA^+	142	128-145 mmol/l
K^+	4.6	3.3-4.7 mmol/l
CL^-	111	98-108 mmol/l
tCO_2	26	18-33 mmol/l

[redacted]

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

[redacted]

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

[redacted]

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

REMARKS:

REPORTED BY: [redacted] b(6)2	DATE: 11Jun03	LAB ID NO.:

Ward/Section	REQUESTING PHYSICIAN	LABORATORY RESULTS
DAW #2	Dr. [redacted] b6b2	(Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
# [redacted] b6b4	6/4	0530	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.4	4.8-10.8 x 10^3
RBC	2.72	4.7-6.1 x 10^9
Hgb	8.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.6	42-52% (M) 37-47% (F)
MCV	101.7	80-94 fl (M) 81-99 fl (F)
Plt	227.0	130-500 x 10^3 Verified
Lymph %	10.9	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	Small	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	Neg	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

(CSF)

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Exam

3-5 RBC
1-2 BPF
Hi mucus

Blood Bank

MUST SUBMIT SERUM WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

Blood Bank (MUST SUBMIT SERUM WITH EVERY UNIT REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	11 Jun	

b6b2

/Section: EMT

STING PHYSICIAN: [redacted] b(6)2

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

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

DATE: 10 Jun 03 | TIME: 2020 | SSN/PSEUDO SSN: [redacted] b(6)4

ST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
3		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
f		(-2) – (+3) mmol/L
ap		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
t		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

ST	RESULT	REF. RANGE
min-l		
of se		

TEST	RESULT	REF. RANGE
ALB	2.5	3.5-5.5 g/dl
ALP	41	26-84 u/l
ALT	31	10-47 u/l
AMY	28	14-97 u/l
AST	91	11-38 u/l
TBIL	0.5	0.2-1.6 mg/dl
BUN	23	7-22 mg/dl
CA^{++}	7.7	8.0-10.3mg/dl
CHOL	56	100-200 mg/dl
CRE	1.4	0.6-1.2 mg/dl
GLU	103	73-118 mg/dl
TP	4.9	6.4-8.1 g/dl

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

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

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

TEST	RESULT	REF. RANGE
NA^+	150	128-145 mmol/l
K^+	4.5	3.3-4.7 mmol/l
CL^-	112	98-108 mmol/l
tCO_2	28	18-33 mmol/l

MARKS:

b(6)2

ORTED BY: [redacted] | DATE: 10 Jun 03 | LAB ID NO.:

Section: ENT	REQUE[redacted]	PHYSICIAN b(6)2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
FIRST, MI [redacted] b(6)4	DATE 10 Mar 03	TIME 2020	SSN/PSEUDO SSN: [redacted] b(6)4

(Hematology) CBC

T	RESULT	REF. RANGE
WBC	10.5	4.8-10.8 x 10^3
RBC	3.07	4.7-6.1 x 10^9
Hgb	9.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.4	42-52% (M) 37-47% (F)
MCV	102.2	80-94 fl (M) 81-99 fl (F)
Plt	232	130-500 x 10^3 verified
Ly %	9.6	20.5-51.1%

(Hematology) Manual Differential

		Mono	
		Eos	
		Baso	
		Imm	
			42-52% (M) 37-47% (F)

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
Sp	1.030	N/A
Bld	small	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA - lt
5-7 RBC
0-2 EC
light mucus

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
		< 20 ug/ml
		< 10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)2 DATE: 10 Mar 03

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) 7

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	18 JUNE 03	0845 HOURS	
1	D/C IV		18 Jun 0930
2	D/C TO PAIN CLINIC		
3	PLEASE SEND WITH		[redacted]
	- COLOSTOMY SUPPLIES		
	SMALL BAGS, PLASTES ETC		
	- SUCTION FOR CLEANING		b(6) 2
	- 4X4 GAUZE FOR CLEANING		

PATIENT IDENTIFICATION

24 95 2200

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	[redacted]	b(6) 2 HOURS	
		MH ME	
18	Jun 03	Lesley	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		HOURS	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		HOURS	

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

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION: [redacted] b(6)4

DATE OF ORDER: 16 JUNE 03 TIME OF ORDER: 0300 HOURS

1. Regular diet
2. NL IVF
3. D Zantac to 150 mg po q hs
   D/C IV Zantac
4. Tylenol #3 ? - II tabs po q 6 PRN - if must ambulate
5. D/C Dilaudid after next dose

LIST TIME ORDER NOTED AND SIGN: 16 Jun 03 0300 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

6. D/C MSO4
7. D Reglan to 10 mg po q 6° PRN

[redacted] b(6)2 [redacted] MD
MHO NE

b(6)2

NURSING UNIT | ROOM NO. | BED NO.

24° VS 2300 16 Jun 03 [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 17 JUNE 03 TIME OF ORDER: 1000 HOURS

1. Drains D/C'd
2. CBC in AM 18 June

[redacted] b(6)2 [redacted] MD
MHO NE

17 Jun 03 1030 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° VS [redacted] LT AN 6-18 03 2350.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b(6)4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 14 JUNE 03 | TIME OF ORDER: 0710 HOURS | LIST TIME ORDER NOTED & SIGN

(1) 40 mg KCL in 250 cc LR over 4° IV

b(6)2

[redacted] MD

MAJ MC

PATIENT IDENTIFICATION

#[redacted] b(6)4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 14 JUNE 03 | TIME OF ORDER: 1815 HOURS

(1) Repeat 40 mg KCL in 250 cc LR over 4° - done tonight @ 1900 hrs.

(2) Resume antibiotics - ancefotaxin & 2gC/4gA q 6hr.

(3) MD MAJ MC [redacted]

[redacted] 1830 14 Jun

PATIENT IDENTIFICATION

#[redacted] b(6)4

EPW

NURSING UNIT: ICW2 | ROOM NO.: 240 V3 | BED NO.: [redacted]

DATE OF ORDER: 14 JUNE 03 | TIME OF ORDER: 1845 HOURS

(1) CBC now - done

(2) Zantac 50 mg IV q 8°

(3) CBC in AM

Chem 7 in AM

b(6)2

[redacted] MD

[redacted] CBAN 6-14-03 2210

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 15 JUNE 03 | TIME OF ORDER: 0905 HOURS

✓ (1) CBC in AM

✓ (2) PN x 1 & then D/C central line

✓ (3) Turn duration off NGT - turn back on @ 1600 if < 300 cc output. Leave duration off.

✓ (4) NPO no exceptions after this time

b(6)4

Thanks -

[redacted] Vincente

[redacted] Dr Talen

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted] b(6)4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 Jun 2003 TIME OF ORDER: 0730 HOURS

10 mg Reglan IV

[redacted] b(6)2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

[redacted] b(6)4

EPW

NURSING UNIT: ICW2 | ROOM NO.: 249/5 | BED NO.: 9

DATE OF ORDER: 12Jun03 TIME OF ORDER: 2030 HOURS

V.O. per Dr. [redacted] b(6)2

NGT to LIS

Taken by [redacted] [redacted] MD

13Jun03 0100 [illegible]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13JUN03 TIME OF ORDER: 0437 HOURS

V.O.

25mg Phenergan IVP x1

now

[redacted] MD b(6)2

0437 13JUN03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 JUNE 03 TIME OF ORDER: 0830 HOURS

1. NPO
2. IVF TO 125 cc/h
3. CBC in AM 14 JUNE 03
4. CHEM METABOLICS in AM 14 JUNE 03
5. REGLAN 10 [redacted] 60 PRN NAUSEA

[redacted] MD MAS

[redacted] 6-13-03 2145.

13Jun03 0900 [redacted] b(6)2

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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] b(6) 4			↓	11 Jun 03	1500 HOURS	
				(1) DC NGT		
				(2) Clear Liquid Diet		
				(3) CBC in AM		
				(4) Wean O2 to off [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
ICW #2				24 hr chart [redacted]	12 Jun 03 @ 0100 hrs	
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b(6) 4				12 June 03	0930 HOURS	
			(1)	NPO	b(6) 2	
				[redacted]		noted [redacted] 12 Jun 1150
NURSING UNIT	ROOM NO.	BED NO.				
ICW #2						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b(6) 4				12 June 03	1940 HOURS	
			(1)	At any emergence [illegible] if available		
			(2)	Please have PT see pt		
				thank you		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
ICW #2						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b(6) 4					HOURS	
				b(6) 2		
NURSING UNIT	ROOM NO.	BED NO.				
ICW #2						

DA FORM 1 APR 79 4256 REPLACES [redacted] WHICH MAY BE USED. 24 hrs [redacted] 11 JAN 6 18 03 2143

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)4

NURSING UNIT: ICW #2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 10 Jun 03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

- Adult = 1 & W 2
- Dx = GSW ABD s/p x-lap 48° ago
- VS = q 4°
- ALL = NKDA
- Act = Bed rest
- Nursing = Flush NG tube q 4°
- NG to low suction intermit

(1) hx/Fx

PATIENT IDENTIFICATION

[redacted]

b(6)4

NURSING UNIT: ICW #2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER | TIME OF ORDER | HOURS

- IS cough/deep breath
- Cond = stable
- Diet = NPO
- Labs = CBC / n/A / chem Metabolics in AM
- IV = ~~250 cc/hr NS~~ 150 cc/hr LR
- Special = I & O's
- Meds = Ulcasyn 3.0 q 6° IV
- Tylenol 650 PR q 6° PRN fever >101

10 Jun 03 [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)4

NURSING UNIT: ICW #2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER | TIME OF ORDER

MSO4 1-4 mg q 1° PRN pain HOURS

[redacted] b(6)2

PATIENT IDENTIFICATION

b(6)4

[redacted] 3440 ♂

NURSING UNIT: ICW #2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 10 Jun 03 | TIME OF ORDER: 2125. HOURS

(1) Drains to Gravity drainage

(2) Foley to Gravity

10 Jun 03 [redacted]

[redacted] b(6)2

24° [redacted] 12 Jun 03 @ 0110 hrs

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

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. 6 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20
12 Jun	[redacted]	NPO – no exceptions	05	✓	[redacted]							
15	[redacted]		14	[redacted]								
		b(6)2	21	[redacted]								
12 Jun	[redacted]	Ambulate c̄ crutches	06	✓	[redacted]							
		PT if available	14	[redacted]								
			22	[redacted]								
12 Jun	[redacted]	NGT to LIS	05	✓	✓	[redacted]						
			13	✓	✓	[redacted]						
			21	✓	✓	[redacted]						
14 Jun	[redacted]	Posterior wounds	10	✓	✓	[redacted]						
		Bacitracin @ 2x2 & 4x4										
14 Jun	[redacted]	May have sips often	5	✓	✓	[redacted]						
			13	✓	✓	[redacted]						
			21	✓	✓	[redacted]						
		NPO no exceptions	5			[redacted]						
			13									
			21									
10 Jun	[redacted]	Diet: Regular	08	✓	✓	✓	✓	[redacted]				
			12	✓	✓	✓	✓	[redacted]				
			17	✓	✓	✓	✓	[redacted]				

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSWABD / S/P ex-lap ~~[illegible]~~ ago / (2) hip ex

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

CIV [redacted] b6

34 y/o ♂

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 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
13 Jun	[redacted]	CBC in Am (14 Jun)	14 Jun	AM		[redacted]	
13 Jun	[redacted]	Chem metabolic in Am	14 Jun	AM		[redacted]	b(6)2
		b(6)2					

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12	13	14	15	16	17	18	19	20
10 Jun 03	[redacted]	VITAL SIGNS q 4hr	02	[redacted]										
			06	[redacted]										
			10	[redacted]										
			14	[redacted]										
			18	[redacted]										
			22	[redacted]										
10 Jun 03	[redacted]	ACTIVITY: BEDREST	06	[redacted]										
			14	[redacted]								DC 16 Jun		
			22	[redacted]										
10 Jun 03	[redacted]	NG TO LOW, INTERMITTENT SUCTION	06	[redacted]										
			14				DC 11 Jun 03							
			22	[redacted]										
10 Jun 03	[redacted]	I.S.: COUGH DEEP BREATH	06	[redacted]										
	b(6)2		14	[redacted]										
			22	[redacted]										
10 Jun 03	[redacted]	DIET: ~~NPO~~ Clear Liquid	06	[redacted]										
		Diet (illegible)	14	[redacted]										
			22	[redacted]										
10 Jun 03	[redacted]	SPECIAL: I&O's	06	[redacted]										
			14	[redacted]										
			22	[redacted]										
10 Jun 03	[redacted]	DRAINS TO GRAVITY DRAINAGE	06	[redacted]										
			14	[redacted]								DC'd		
			22	[redacted]										
10 Jun 03	[redacted]	Foley TO GRAVITY	06	[redacted]										
			14	[redacted]								DC'd		
			22	[redacted]										

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: GSW ABD / S/P EX-LAP x 48° AGO (8 Jun) / (L) Hip FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

b(6)4

Civ # [redacted] 34 40 0

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 Jun Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 Jun	[redacted]	ADMIT: ICW #2	10 Jun		2145	[redacted]
10 Jun	[redacted]	DX: GSW ABD; S/P EX-LAP x 48' AGO / (L) Hip FX	10 Jun		2145	[redacted] b(6)2
10 Jun	[redacted]	ALLERGIES: NKDA	10 Jun			[redacted]
10 Jun	[redacted]	CONDITION: STABLE	10 Jun			[redacted]
10 Jun	[redacted]	LABS: CBC, U/A, CHEM METOBOLICS IN AM	10 Jun	AM	done	[redacted]
11	[redacted]	CBC in Am	12	AM	0400	[redacted]
11	[redacted]	D/C NGT	11	Now	1700	[redacted]
12	[redacted]	NGT to LIS	12	2100	2100	[redacted]
6-12	[redacted]	Please have Pt see pt	6-12			
14	[redacted]	CBC/Chem 7 in Am	15	04		[redacted]
15 Jun	[redacted]	CBC in AM (16 Jun)	16 Jun			[redacted]
15 Jun	[redacted]	Place PIV + D/C central line	15 Jun	done		
15 Jun	[redacted]	turn suction off - turn back on at	15			[redacted]
	----	1600 if <300 - output leave suction off				
17 Jun	[redacted]	CBC in AM (18 Jun)	18 Jun	AM	0300	[redacted]
18	[redacted]	D/C IV, DC to prison camp				
18	[redacted]	Give colostomy supplies, bacitracin, & Y/M				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION / TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19										
16Jun	[redacted]	HL IV	5	/	[redacted]												
			13	/	[redacted]												
			21	[redacted]													
10 Jun	[redacted]	Wean off O_2 sat>90%	5	/	[redacted]												
			13	/	[redacted]												
	b(6)2		21	[redacted]													
16Jun	[redacted]	Zantac 150 mg PO	22	QHS	[redacted]												
		Qhs															

DC'd [redacted] 18Jun 03

DC'd

b(6)2

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: GSW/SP exlap on 8Jun/Chpex

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted] 3H y/o ♂

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													
10Jun	[redacted]	Tylenol 650mg PR	4504 2200	T1016 17Jun 0530	T.10 17Jun 1700											
		q6° prn fever >101°	16Jun [redacted]	[redacted]	2200 [redacted]											
16Jun	[redacted]	Tylenol 3 ÷ 1 - ÷ 11 tabs		b(6)2												
	b(6)2	PO Q6° prn (pt must ambulate)														
16Jun	[redacted]	Reglan 10mg PO														
		Q6° PRN														

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12	13	14	15	16	17	18	19	20	21	22	23
10 Jun	[redacted]	FLUSH NG TUBE q 4hrs	02	/	[redacted]												
			06	/	[redacted]												
			10	/	[redacted]				D/C			11 Jun 03					
			14	/													
			18	/													
			22	/					b(6)2								
10 Jun	[redacted]	IVF: LR @ 150cc/hr	06	/	[redacted]												
			14	/	[redacted]				D/C			13 Jun 03					
			22	[redacted]													
10 Jun	[redacted]	UNASYN 3gm IVPB q 6hrs	06	[redacted]													
			12	[redacted]													
			18	[redacted]								D/C					
	b(6)2		24	[redacted]								16 Jun					
10	[redacted]	Wean off O_2 for SAT	5	/	/	[redacted]											
		>90%	13	[redacted]													
			21	/	[redacted]												
13 Jun	[redacted]	IVF to 125cc/hr	06	/	/	/	[redacted]										
			14	/	/	/	[redacted]					D/Cd					
			22	/	/	/	[redacted]										
							/										
14	[redacted]	Zantac 50mg	06	—	—	—	/	[redacted]									
		IV q8°	14	—	—	—	/	[redacted]				D/Cd					
			22	—	—	/	[redacted]										
16 Jun	[redacted]	Zantac 150 mg PO QHS	22	/	/	/	/	/	/	[redacted]							
		~~Reglan 10mg PO~~ error [redacted]															

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

GSW ABD / S/P EX-LAP x 48° AGO (8 Jun) / (L) Hip Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Civ #[redacted] 34400

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. Jun Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/12	[redacted]	10mg Reglan IV x1 now	6/12	0445	0448	[redacted]
6/14	[redacted]	40 MEQ KCL in 250cc LR over 4°	6/14	0710	0750	[redacted]
6/14	[redacted]	Repeat 40 MEQ KCL IN 250cc LR				
	-----	over 4° @ 1900	6/14	1800		[redacted]
16 Jun	[redacted]	D'C IV → HL	16	done		[redacted]
16 Jun	[redacted]	D'C IV Zantac	16	done		[redacted]
16 Jun	[redacted]	D'C Urmazpa p next dose (1200)	12 Jun	12		

	-----					

b(6)2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Jun	[redacted]	Tylenol 650mg PR q 6° PRN	11 Jun 1215													
10 Jun	[redacted]	FEVER > 101°	DM													
10 Jun	[redacted]	MSO4 1-4mg q1° PRN PAIN	11 Jun 0115 4mg MSO4	11 Jun 0720 4mg	11 Jun 2045 4mg	12 Jun 0900 2mg	12 Jun 2000 2mg	12 Jun 2330 3mg	13 Jun 0100 2mg	14 June 0100 4mg	14 June 2045 11mg	14 June 2330 [illegible]				
	-----		[redacted]													
13 Jun	[redacted]	Reglan 10mg IV														
	-----	Q6 PRN nausea			D'C					b(6)2						
16 Jun	[redacted]	Tylenol 3 T-II tabs														
	-----	PO Q6° PRN														
	-----	Reglan 10 mg PO														
	-----	Q6° PRN														

DCd

USAPA V1.00

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

HEMODYNAMIC VITAL SIGN FLOW SHEET

OTSG APPROVED (Date) **7 May 85**

Time	TEMP	PULSE	RESP RATE Patient / *IMV	Cuff BP	*A-line BP	CVP or RAP	PAP	PAP Mean / *C.O.	*PAWP	OTHER	PROVIDER INITIALS
1621	R 102.9	141		116/83	24 - shallow				88%	IV ↓ to 200 cc/hr	[redacted]
1650										2mg MSO4 via IVP	[redacted]
1700										1gm Mefoxin IVPB	[redacted]
1800										2mg MSO4 via IVP	[redacted]
1820		134		118/83	18	shallow			96%	IV NaCl 200cc/hr.	[redacted]
1840										2mg MSO4 IV push	[redacted]
1915										2mg MSO4 IV push	[redacted]

b(6)2

*(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

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

[redacted] (EPW)

SR # [redacted] b(6)2

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☒ OTHER (Specify) SF 510
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700

MCEUL OP 319, 1 Jun 85

TEMPERATURE CONVERSIONS:

C°	F°
36.0	96.80
36.5	97.7
37.0	98.6
37.5	99.5
38.0	100.4
38.5	101.5
39.0	102.2
39.5	103.1
40.0	104.0
40.5	104.9

CARDIAC PRESSURES:

	Range	Mean
RA	0-5	3
RV	17-32/1-7	24/4
PA	17-32/4-13	24/9
LA	2-12	8
LV	90-140/5-12	130/9
Aorta	90-140/60-90	125/70

TEMP

R = Rectal
O = Oral
AX = Axilla

PULSE

AP = Apical

LEGEND FOR ABBREVIATIONS

IMV = Intermittent Mandatory Ventilations
A-line = Arterial line
C.O. = Cardiac Output
PAWP = Pulmonary Artery Wedge Pressure

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A 1 1 D U	I 2

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
0 0 1 3 4 3 1	EPW [redacted] b(6)4	—	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—	3 4 Y	X	9	unknown b(6)4

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

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	R 7 8	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø Direct from ER	JCW2	unknown

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b(2)2	unknown	unknown

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 0 other: Return to EPW Camp		0 3 0 4 1 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A A A A		0 3 0 6 ~~1 8~~ 10

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

FOR LOCAL USE

DX ⇒ GSW ABD S/P X-Lap 48° ago / (L) Hip Fx

Dx: 808.59
863.55
863.54
V443 E991.2

Proc: 87.44

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
	b6 2 [redacted] SPC, USARMY

DA FORM 2085, MAR 89

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 13434	2. NAME (Last, First, MI): EPW [redacted] b(6)4				3. GRADE: N/A	ADMISSION REMARKS
4. SEX: M	5. AGE: 45y	6. RACE: Z	7. RELIGION: unk	8. LENGTH OF SVC: N/A	9. ETS: N/A	10. PREVIOUS ADMISSION: No
11. FMP: 99	12. SSN: [redacted]		13. ORGANIZATION: N/A			14. WARD: ICU1
15. FLYING STATUS: N/A	16. RATING/DSG	17. DEPT./BEN: KMG KTS	18. BRANCH/CORPS: N/A	19. UIC/ZIP		20. TYPE CASE: DNBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER				22. HOURS OF ADMISSION: 1030	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —			25. TYPE DISPOSITION: 50		26. DATE OF DISPOSITION: 21 Jun 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —			27b. TELEPHONE NO.: —		28. DATE OF THIS ADMISSION: 11 Jun 03	ADMITTING OFFICER: b62 Dr [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]					30. DATE OF INITIAL ADMISSION	32. UNITS OF COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DA[redacted] b(2)2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P Ex lap

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	11	11

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	11	11

SIGNATURE OF ATTENDING MEDIC[redacted] Dr [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

b(6)2

b(6)4

[redacted] b6-4

Multiple shell injs

45 years old man presented with multiple shell injuries by a gunshot. O/E conscious pale, bleeding from urethral meatus, abd soft, heart pulses difficult.

PR - blood on digital rectal examination

ECG - cardiac rapid Atrial fibrillation at a rate of 180/min. We started on amiodarone 300 mg iv bolus over 20 minutes with ECG monitoring then IV infusion of 600 mg over 6-8 hrs. (12 drops/min).

The patient planned to do surgery as multiple bullet

injuries causing possibly injury
to kidneys, ureters, urethra.
~~He~~
We prepare blood for him
cross matched.
He need surgery for life
saving of him if medical
condition permit.

[redacted] b(6) 4

[redacted]
medical department
of Medical City
Baghdad

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

48 yo ♂ GSW s/p multiple fragment wounds from gun fire to chest + abd, legs, + back, s/p exploratory laparotomy, open suprapubic catheter to decompress bladder, c̄ intraoperative findings of (2) flank retroperitoneal hematoma, no bowel, liver, spleen, or major vessel injury. Pt transferred here for further evaluation of GU system. s/p blood transfusion

Social Hx: (P) Tob+ NVRA PSurg Hx: prior scars RLQ + LUQ

17.9 / 44.5 | 14.1 / 287 | 134 / 107 / 8 / 271 | 4.9 / 16 / 0.9

UA/ TNTC Red cells

PHYSICAL EXAMINATION

BP - 164/98 HR 115 RR - 26

HEENT - Clear

CV - Tachy

Lungs - CTA (B)

Abd - Vertical incision c/D/I/suprapubic appropriately TTP catheter in place

Ext - (R) lower ext ~~wound~~ superficial wound

Back - (2) thigh 7 cm wound

(1) flank wound x3 1st 3 cm - minimal drainage

Preop 15 / 15 / 24 / 40

Postop

PROGRESS (Enter date of discharge and final diagnosis)

A/P: POD #0, s/p ex/op f GSW schrapnel injury

(1) Admit for continued post op care

(2) Consider IVP for evaluation (1) renal system

b(6)2

SIGN [redacted] DATE 11 June 03 | IDENTIFICATION NO. | ORGANIZATION

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

[redacted] b(6)4

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
539-106

152

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 JUNE 03	45 y/o ♂ EPW C̄ MULTIPLE (D) FRAGMENT WOUNDS FROM
0335	GUN FIRE TO CHEST, AB, (B) LEGS, BACK
BP 115/74	1 I.V. D.C (L) HAND, I.V. 2 LG BORE NORMAL SALINE 1500 ML
P 140	X-RAY: 0340 BY SGT [redacted], CHEST, ~~A~~ AB, (R) LEG
O2 95	PT WAS TAKEN TO IRAQ HOSPITAL AND CAME IN WITH IV. (B) HAND
0330	DEXTROSE 5%
BP 115/74	0400: RECTAL EXAM DONE BY LTC [redacted] b6-2
P 129	0405: LABS BLOOD DRAWN BY SPC [redacted]
O2 95	0405: 1000 ML NORMAL SALINE GIVEN
0335	0415: 1000 ML NORMAL SALINE GIVEN
BP 115/74	
P 134	
O2 91	
0340	
BP 115/74	
P 136	
O2 94	
0345	
BP 115/74	
P 138	
O2 95	

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

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

[redacted]

b(6)4 [redacted]

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

b2-2

[redacted]

MEDCOM - 10419

35

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0350	
BP 135/74	
P 134	
O_2 95	
0355	
BP 115/74	
P 128	
O_2 94	
0400	
BP 115/74	
P 120	
O_2 94	
0405	
BP 115/74	
P 140	
O_2 94	
0410	
BP 132/75	
P 132	
O_2 94	
R 24	

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 June 03	BRIEF OP NOTE:
0610	PROCEDURE: Exploratory laparotomy, open suprapubic catheter (16 Fr.) to decompress bladder.
	PRE-OP DIAGNOSIS: Shrapnel/multi-fragment injury (L) flank
	POST-OP DIAGNOSIS: Same, ± (L) retroperitoneal hematoma
	SURGEON: [redacted] b(6)2 ASSISTANT: [redacted] b(6)2
	EBL: minimal.
	FLUIDS:
	UOP: 2 liters, burgundy
	TT: ii units blood, from local civilian hospital.
	~~POST-OP TEAM:~~ Findings: 2 large wounds (L) flank, smaller one (L) posterolateral thorax, w/no exit wounds; KUB clw multiple retained fragments, (L) of midline. Unable to pass Foley catheter due to (?) stricture, + urinary bladder palpable 2/3 up from symphysis to umbilicus. Laparotomy = no free blood, succus, stool, bile or free air. (+) large, nonexpanding (L)-of midline retroperitoneal hematoma, ±D'd & partially mobilized (L) colon. No urinary extravasation. Ran small ⇒

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.

LOG#:
SSAN#:
NAME:

PROGRESS NOTES
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 June 03	Post-Op
0745	Remains hemodynamically stable.
	HR 90s - 100s
	no ↓ in SBP.
	uo excellent, somewhat clearer.
	Abdomen nondistended, soft,
	Drsg ε minimal drainage.
	(L) Flank drsg reinforced.
	b2-2
	AP: stable for transport to [redacted],
	for further eval, including IVP/CT
	post-op H/H = 14/40 (intra-op) = 5/15
	LTC [redacted] b(6)2
6/11/03 0815	BP 151/83 RR24 P100 SAO2 100% RA [redacted]
	released to Medevac 565 for transport [redacted]
	Tex 28 C&D, [redacted]

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6/11/03 0600	RR 28 P108 BP 125/81 T98.5 Rec'd approximately 40yo ♂ from OR c̄ c/o (R) flank GSW. Pt had an exploratory lap c̄ removal of any FB. A supra-pubic catheter was placed 2° urethral stricture & blood at the meatus. Pt has a dressing over wound to the (R) flank, which was reinforced at arrival. A surgical pad c̄ abd dressing is in place. Pt has bilateral IV's (.) NS & 1 (R) at 150cc/hr. A foley to BSP is present c̄ 2L of tea colored urine. Lungs are clear & bowel sounds are hyperactive. All drains are patent. We continue to observe pt, monitor ABG's until transport to Landstuhl. [redacted]
0615	143/76 P108 RR28 SAO2 99 on mask. Urine is now cherry colored. Pt cleaned c̄ H_2O/H_2O_2. b(6)2
0700	NA (R) in pt status BP 135/94 P97 RR24 SAO2 99 LTC [redacted] here to see pt, order repeat H&H. lab notified [redacted]
0712	Lab here for blood draw. — [redacted]

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

EPW

[redacted] ?

b(6)4

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 June 03@1200	received pt from EMT. pt seems alert follows commands once demonstrated. NG Tube in place. lungs CTA. placed on monitor. abd drsg in place. drainage noted on ~~placed~~ pad. IV intact + patent infusing LR ~~5~~ difficult in (R) AC. IV in (L) hand D/C due to infiltration. hand swollen (puffy). drsg to lower left back changed. ∂ open wound c̄ jagged edges noted. ∅ active drainage @ this time. drsg replaced. a hole noted to upper left thigh. bruising noted. open to air. drsg noted to lower Rt leg. foley in place draining blood tinged tea colored [redacted] urine. EPW placed in restraints. ∅ O_2 supplement @ this time. Sats @ 95%. ↓ 93% but recovers to 95-96%. antibiotics administered as ordered. will continue to monitor. [redacted] CPT b(6)2
11 June 03@	1700 pt SATS remained 92-94% 2L via NC started. SATS ↑ 97-98% will continue to mon. for
11JUN03 1780	Pt drowsy; eyes open spontaneously; lungs CTA; O_2 on @ 2LNC c̄ sats in mid 90's; Pt running ST in low 110's c̄ ∅ ectopy; Pt has wound to (L) side abdomen; Drsg intact / oozing bld; Wound to mid abdomen - drsg intact c̄ ∅ drainage; Suprapubic catheter in place; uop quantity sufficient - tea colored; NGT in place to (R) nare; clamped; Restraints in place; will continue to assess and monitor; [redacted] CPT/AN 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.

EPW # [redacted] b(6)4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11Jun03 2300	Pt alert; Eyes open spontaneously; Pupils equal and reactive to light; BS CTA; O_2 @ 2L/m and Sats 95-98%; Pt running ST c̄ Ectopy; Mid abdominal drsg CDI; (L) Side drsg reinforced; uop quantity sufficient; Pt c/o abdominal pain and given total of 5mg MSO4 IVP; pt stable @ this time; will continue to assess and monitor; [redacted] CPT/
12Jun03 0430	Pt stable overnight; alert and following simple commands; Pt continues on 2L O_2 per NC c̄ sats 95-98%; Running ST c̄ Ectopy; BP 140's/80-90's; Tmax 100.8; LR infusing @ 125cc/hr; IV heplock to (R) AC intact and patent; Midline abdominal drsg CDI; (L) flank drsg Δd due to moderate/large amount bld oozing; uop quantity sufficient; CBC sent Qb° and stable; will continue to assess and monitor — b(6)2 [redacted] CPT/
12 Jun 0515	pt appears stable. c/o mouth dry. place swabs in mouth to wet. follows simple commands. pt remains on 2L of O_2 via NC. sats 96-98%. abdominal drsg clean dry intact. (L) flank drsg c̄ drainage noted. will reinforce as needed. will continue to monitor. [redacted]

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

EPW # [redacted] b(6)4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 June 0900	pt requesting some thing for pain. 2mg MSO4 given for pain. pt resting @ this time. [redacted] SI b(6)2
12 June 1145	Reinforced drsg to (L) flank. will continue to mon. for [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 June 03	1800 Pt. alert, opens eyes when spoken to, c/o thirst, dry mouth, lemon glycerin swabs given, PERRLA, 3cm, O2 @ 1.5 Lpm, Spo2 96%, LR @ 125cc/hr at (R) AC, site ⊼ S/S inf, patent. Pt. stable @ this time Will continue to monitor. — [redacted]
	2100 Pt complains of pain, Gave 3mg MSO4 IVpush and 25mg Phenargan IV. Pt. resting quietly in bed. NG tube hooked up to LIS, Small amt. of H2O given per VO Dr. [redacted] — [redacted]
	CB 2300020 DRSG Δ to (D) side/buttock completed. Moderate amount of serosanguinous fluid noted on prior DRSG. Medicated pt. @ 2.5mg morphine — [redacted]
	0300 Pt. complains of cold, visibly shivering, placed additional blankets. Pt. resting quietly — [redacted]
13 June 0	0530 assumed care of pt. pt resting - sleeping easily aroused. c/o complaints @ this time. appears calm cooperative. abdominal drsg CDI. (L) flank drsg some draining noted, will reinforce as needed. antibiotics given as ordered. NG Tube in place to LIS. pt able to take sips of H_2O for dry mouth. will continue to monitor. VSS. low grade temp noted. O_2 via NC 2.5L sats maintained above 95%. MSO4 given for pain. will continue to mon. for. — [redacted] b(6)2

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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)*
13 June 03 @ 0800	Blood drawn and sent to lab per Dr [redacted] request for Repeat Chemistry and CBC. NG tube d/c'd. 30cc noted in canister. Some AM care done. pt tolerating PO fluids, hyperactive Bowel sounds noted. will put in for clear liquid for lunch. continue to monitor. — [redacted] b(6)2
13 JUN 03	Progress note Patient Stable Labs this AM ☐ Na + 111 — Suspect Lab error No Hct this AM PE: afebrile VSS Old Sift NT (+) BS Dx: Ileus Repeat chem 8 + CBC (tomorrow AM) DC NG tube advance to clears [redacted] b(6)2
13 June @ 1100	pt sleeping comfortably. Gent S/d to Cipro. NS infusing @ 100cc/hr. will continue to monitor. — [redacted] b(6)2
13 June @ 1600	Dr [redacted] made round on patient. removed abdominal drsg. Staples intact. replaced drsg over wet mess. otherwise open to air. drsg to ⓡ flank changed. Serosanguinous drainage noted. ⊖ S/S of infection. [redacted] 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.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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)*
13 June 03	1700 - Assumed care of pt. See ICU Flowsheet. Pt. resting quietly in bed will continue to monitor - C. Blanton
14 June 03	0400 - Labs drawn, Dressing DRSG changed. Prior DRSG - moderate amt Serosanguinous fluid. [redacted] TIWNG
14 June 03 @	0500 Assumed care of pt. assessment done. @ changes in care plan. will continue to monitor. VSS. afebrile. [redacted]
14 JUN 03	Progress Note b(6)2
	Patient c/o abd pain - diffusely tender (-) rebound (+) rebrity guarding
	tolerating clear J N/V Act J 31.4 WBC 8.6
	afebrile
	Non distended soft
	tender diffuse (+) rebound/guarding
	Dx: GSW flank - retroperitoneal hematoma
	- IVP today
	- to ward after IVP
	- CBC in AM [redacted] b(6)2
14 July 03 @	1015 pt in for IVP request [redacted]
14 July 03 @	1220 pt returned from XRAY. monitors back on will continue to monitor until transferred to ICW. [redacted]

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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)*
13 June	1700 Received report from Cpt [redacted] b(6)2. Assessment done, see ICU flowsheet. Pt. resting quietly in bed. No complaints @ this time [redacted] 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.

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

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Jun 03	Pt transferred to ICW #2 from ICU #1 via stretcher. VSS, A+Ox3. (B) LS CTA, (H) BS x 4 hypoactive. (G) S, S2 palpable pulses x 4, (E) 1 Edema Bilat LE, Elevated @ 30°. ABD DRSG CDI, Staples. OTA CDI, Supra pubic cath/dressing CDI draining reddish amber urine. O2 SAT 90% on RA, put on 1L via NC. (D) c/o pain. (F) AC PIV patent LR @ 75cc/hr. IV ABX. S/W assessment WNL. W/ Cool. to MONITOR [redacted]
14 Jun 03 21:23	Pt sleeping in bed easily awakened. VSWNL. Skin w + D b(6) ICA (B) PERL (H) BS hypoactive x4. (+) PPPB. ABD dsg CDI Staples to midline incision intact and clean S/S infection. (L) Flank dsg. saturated c̄ pink serosanguinous drainage. New Dsg. CDI. Foley patent draining cherry colored urine. Will cont. to mon [redacted]
23:32	Pt c/o ABD pain 4mg MSO4 given [redacted]
15 Jun 03 0330	UP CLEAR cherry colored fluid 450cc → [redacted] b6 2
Addendum	+1 pitting edema (L) foot will monitor [redacted]
15 June 03	0353 Assume pt care @ 0500. Pt awake and alert no c/o pain. VSS. HR regular. Lungs CTA. BS x4. Abd dsg CDI Staples intact. (L) Flank dsg CDI. Foley to gravity. 1000cc output @ 0830 Clear yellow c̄ large amts of blood. Will continue to monitor. — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EPW
[redacted] b(6) 4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 June 03	0905 500cc UOP Clear yellow urine c̄ dg amt of blood. [redacted] 9/WM6
	1000 dsg Δ done to abd and (D) flank. New dsg CD3 I. Staples to midline intact. b(6)2
15 June 03 1330	Pt. vitals taken BP 130/80, P. 90, R. 20, TEMP 99.8 [redacted] b(6)2
15 June 03 1600	Assumed care of Pt @ 1300. VSS x̄ mild temp. (B) LS CTA, (F) palpable pulses x4, (F) 1+ edema (B) LE. (F) BS x 4 advanced to Reg Diet. (F) S. prapubic cath draining yellow urine c̄ slight red tinge 800cc drained. (D) flank and abd dsg CDI. Pt OOB to chair s̄ difficulty. UPC 75cc/hr via (R) Rc PIV. Pc/o pain. O/W Assessment WNL. Will MONITOR [redacted] b(6)2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 JUN 03	Program Note No complaints / Patient clean and sift NMP Dx: S/P RP hernia repair — Regular Diet — O/P Drs [redacted] b(6)2
16 Jun 03	15 Jun 03 21:37 - Pt. awake and alert in bed. Restraints x2. VS WNL
0145	T temp 100.0, PERRLA ⊕. Skin W/D. LCA ⊕. BS ⊕ x4. ML ABD incision approx. staples intact S/S/S infection, minimal amt. drainage noted and drsg @ bottom of incision, [redacted] PPP ⊕ ⊕. LR @ 75cc ⊕ FA patent [redacted]. 2+ pitting edema ⊕ foot. ⊕ foot elevated c̄ blanket will cont to mon [redacted]
0150	Temp ↓ 99.2 will monitor [redacted] b(6)2
late entry	15 Jun 21:37 - Pt c/o pain @ ML ABD incision 2mg MSO4 given relief [redacted]
16 June 03	0600. Assumed pt care @ 0500. Pt asleep, easy to wake for assessment. VSS. KL @ 75cc/hr to ⊕ AC site free s/s redness/infiltration. HR regular. Lungs CTA throughout. Abd. soft. Midline incision staples intact dsg CD&I. Dsg to ⊕ flank CD&I. Suprapubic cath draining Cillar Amber [redacted] UOP. 700cc out @ this time. Edema noted to ⊕ foot. Encouraged pt (unt)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)* b(6)2

EPW #[redacted]

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

MEDCOM - 10433 OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 June 03 0600	(cont) to keep (L) foot elevated. No c/o pain @ this time. Will continue to monitor [redacted] SWMP b(6)2
16 June 03	1010 Dsg Δ done this am. Pt to (R) flank wounds. Old ⓐ pus. Sm amt of drainage noted to old dsg. Dsg applied to midline incision @ cath site. Tylenol #3 adm for pain ⅟ @ 0900. pt OOB to chair for approx 35 min. [redacted] SWMP b(6)2
	Progress Note Pt ⅟ ambulant Urine clear afebrile abd soft NTP Sp: [illegible] Plan DC IV med heparin [illegible] ambulate PRN [redacted] b(6)2
16 June 03	1250. HL placed in (L) AC. (R) AC IV DC'd. MD will consider removal of suprapubic cath tomorrow. [redacted] SWMP
16 Jun 03 2050	assumed care @ 1300 - VSS - no c/o pain - IV patent - pt. does not like PO abx, they upset his stomach, explained he would continue to get them PO - staples intact - suprapubic catheter dsg intact, catheter to gravity - tolerated regular diet [redacted] b(6)2

DATE	SYMP.	IAGNOSIS, TREATMENT, TREATING ORG.	ATION (Sign each entry)

6-16-03 2200. Pt. care assumed @ 2100. VSS. Pt. c/o ABD pain 7/10 T#3 given. HR Reg, lungs CTA, ABD rotund, soft. BS ⊕x4. Midline ABD incision c̄ staples OTA, ∅ s/s infection. Suprapubic cath to gravity draining dark orange urine. Dsng over suprapubic insertion site CDI. will cont. to monitor. [redacted]

0400 875cc orange colored urine out [redacted]

17June03 0545 pt care assumed @ 0500. pt asleep easy to awake for assessment. VSS. HL to (L) AC no s/s redness/infiltration c̄ flush. No c/o pain @ this time. HR reg, Lungs CTA throughout, Abd soft BS x4 active midline incision staples intact dsg CD+I no signs of drainage noted. (L) flank dsg CD+I. Suprapubic cath insertion site clean no s/s infection. draining clear amber urine. Full ROM to U/L extremities. Plan today DSG Δ, ambulate pt and discuss cath d/c c̄ MD. Will continue to monitor. [redacted] b(6)2

17June03 1055 pt ambulated this am. ⅋ difficulty. Attempt BM, no success. Encouraged H_2O. OOB to chair approx 30min. 475cc clear amber urine via Suprapubic cath. [redacted]

17Jun03 1700 assumed care @ 1300 - VSS - Suprapubic catheter draining QS - medicated for pain c̄ good results - using IS q/o c̄ encouragement ambulated this shift - dsg intact on abdomen - lungs CTA (B) - (+) BS [redacted]

NSN 7540-00-834-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0100 18Jun03	Assumed pt care @2100. VSS, aox3, no complaints at this time. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quadrants. HL to LFA CDI, flushes well, Ø s/s infiltration or infection. Midline incision stapled, CTA CDI. Dsg midline CDI, Dsg on Ⓡ flank CDI, no leakage noted. S/p pubic catheter site CDI, draining cyu. Will continue to monitor. SPC [redacted] 9lwxMD b(6)2

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

FPW b(6)4

[redacted]

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MF

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 Jun 03	0646 - Pt Alert OOB x 1. VSS, lungs CTA x all lobes. BS ⊕ x 4. Staples to ABD intact. Suprapubic Catheter in place draining 500cc dark yellow urine this AM. Dsgs Δ'd. HL to (D) arm. typo [redacted] AM care completed. Voicing no complaints at this time. Will cont. to monitor. [redacted] JL AN
	1230 - Suprapubic catheter clamp. 300cc sterile water to bladder. Will cont to monitor [redacted]
1500	Assumed care of Pt @ 1500. VSS. A+O x 3. (B) LS CTA, (P) BS x 4. Suprapubic cath clamped. Pt voided, but urine was not measured. MD aware of c/o pain, Ambulate ī assistance. Dsg CDI O/W assessment WNL. Will monitor [redacted] b(6)
2000	Pt c/o pain in (R) arm. Old IV site was red, warm, and painful. No increase in temp (99.4), MD notified. Warm compress applied, arm elevated, red outlines. Will monitor [redacted]
2210	Pt. care assumed @ 2100. VSS. Pt. ambulated length of ward x4 ī assistance. Catheter place to gravity per MD orders for nighttime. Voiding trials to start again in A.M. Pt. alert & compliant. HR Reg Lungs CTA, BS ⊕ x4. ABD soft. Midline ABD incision ī staples CTA. (R) UE has erythema & TTP, warm to touch. Hot pack applied & arm ↑ on blanket. Will cont. to monitor. [redacted]

(continue on reverse side)

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

REGISTER NO. b(6)2

WARD NO. TCWR

PROGRESS NOTES
Medical Record

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

EPW [redacted] b(6)4

PROGRESS NOTES

DATE	
	Assumed care of pt @ 0500. Pt is up
19 June 03	talking. ~~Pt Lungs are diminished. Pt has ambulated~~
1125	~~twice. Pt. keeps complaining of shoulder~~ Lungs CTA.
0000 98.9	Bowel sounds x 4 quads. Pt has ambulated twice.
86	Pt had 100cc's residual in bladder. Ø c/o pain/
18	discomfort — [redacted] SGT
118/76	b(6)2
95%	
19 JUN 03	Urology Note
	Drywell - 1 PVR / yesterday 800cc
	afebrile
	Voiding
	Dx: SP Fink GSW / Exchg
	Ø - if PVR ≥ 500cc Reinsert SP tube
	- Remove staples in AM (Day #10)
	b(6)2
	[redacted]
19 JUN 03	Assumed care of Pt @ 1300. VSS ✗ low grade fever. A+O x 3.
1515	Pt c/o abd pain controlled ✗ T#3. M10 ABD incision ✗ staples OTA CDI,
	suprapubic cath/drsg CDI. cath clamped. Pt spontaneous void DARK
	yellow urine, residuals checked Q void. BS CTA ⊕ BS x 4. ↓ in
	redness/pain BAC. Ambulates ✗ assistance. O/W assess
	CWN. Will Monitor — [redacted]
5130	Pt care assumed @ 2100. VSS, Alert and aware, c/o small b(6)2
	amount of pain at abd, ✗ T3 given @ 2130. Lung sounds
	CTA, pulses palpable x4, bowel sounds present x4 quads. Cont -

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
CRNT's	replaced for O_2 @ 5L. Sats remain above 95% with continue to monitor — [redacted] SPT
	L(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.

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	midline abd incision c̄ staples o̅ta CDI, Suprapubic catheter site CDI, cath clamped. HL @ LAC flushes well, pt has pinkness + tenderness @ RAC, c̄/o mild pain. Will continue to monitor. SPC [redacted] 91WM6
2140	Pt voided 400 cc dark urine. SPC [redacted] 91WM6 b(6)2
2145	Residual urine is 100cc. SPC [redacted] 91WM6
20 June 0935	Assumed care of pt @ 0500. VSS. Alert and oriented. Pt did personal hygiene. Tolerated breakfast well. Pt urinated 300 cc / residual 1cc. Lungs CTA. Bowel sounds x 4 quads. Pt has suprapubic cather. Midline abd incision c̄ staples intact - Ø drainage. HL in (L) arm - patent. Pt has pinkness + tenderness in (L) arm. Pt has Ø c̄/o pain/discomfort @ this time. Will continue to monitor. [redacted] PN SG1
	b(6)2
20 June	Begin Dry gauze Splint arm Sling out in AM to Ft Lewis from [redacted] b(6)2
20 June 1025	Dr. [redacted] d/c'd pt's suprapubic cather. Removes staples on midsection removed. Will remove remaining staples in am. [redacted] 91WM6, 88T b(6)2

(Continue on reverse side)

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

[redacted] b(6)4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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