Ward/Section: EMT

UESTING PHYSICIAN: Jr [redacted] b(6)-2

LAST, FIRST, MI

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

DATE: 23MAY03 TIME: 1500

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	535	39-380 u/l (M) 30-190 u/l (F)
NA+	140	128-145 mmol/l
K+	3.9	3.3-4.7 mmol/l
CL-	103	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(4)-2	23 may 03	

LAST COPY DO NOT MAKE MAKE COPIES

Ward/Section: EMT

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

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

LAST, FIRST, MI:

DATE: 23 MAY03 TIME: 1500

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10
RBC	3.26	[illegible]
Hgb	8.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.6	42-52% (M) 37-47% (F)
MCV	90.9	80-98 fl (M) 81-99 fl (F)
Plt	242	150-500 x 10 verified
Lymph %	27.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Immat	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.0 secs
APTT		23-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

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

DATE: 23 may 03

LAB ID NO.:

RSA II
NCBA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
midazolam	(mg)	3
fentanyl	(mcg)	25 50 100 100
propofol	(mg)	180
SUCC	(mg)	120
MgSO4	(mg)	
	( )	
VOLAT AGENT	% del	1.5 1.0 1.4 1.4 1.2 1.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 2 2 2 2 2 2 6

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML "1" = CONSTANT INFUSION

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

TOTALS	
5mg	
250mcg	
200mg	
100mg	
10mg	
X	

TOTAL URINE: 500

FLUIDS – PRIMARY
CRYSTALLOID – LR = 800cc
COLLOID –
BLOOD – X

FLUIDS: LINE site R(cc) 20g IV — Warmed — 800

LOSSES: EST BLOOD LOSS — URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 180 KG LB

HEMATOCRIT: 24

INITIAL DATA: BP – 120/64 HR – 79

SONIP CHECK: OK? – (Y) N

PATIENT TRANSFER: OK for PROCEDURE? Yes TIME – 0845

TIME → 0930 45 1000 15 30 45 1100 15 30 45 1200

SYMBOLS: ↓ arm BP by cuff (Adult cuff) V; ∧ Heart rate; ● Resp rate; BP (transduced) ⊥T; TOURNIQUET T – X; ANES – X-X; PROC – ⊙ – Ø

0952 BP 130/79 (R thigh) 1051 >64 pm

I:E = 1:2 VT = ml	700	600	500	500	500	>400	>400	
f – breaths/min	18	10	8	8	12	15	22	18
Peak inf pres / PEEP	16	15	15	15	14	–		
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	S	S
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	35	29	29	29	38	42	–	
BP / oth / ✓ FIO2 (Frac or %)	.86	.82	.81	.82	.82	.82	RA	
ART line / ✓ SpO2 (%)	100	100	100	100	100	100	96	
Steth- PC/ES / ✓ ECG	SR	SR	SR	SR	SR	SR	SR	
✓ Gas analyzer / ✓ TEMP- site Axil								
✓ N-M Block (T/4)	4/4	4/4						
Warming blkt								
Conv warmer	✓							

Mark with letters & symbols, explain under REMARKS. EVENTS — Position: Arms out <90° secured on pad and armboards

REMARKS – Code drugs with numbers, events with letters

0900 Greeted in ICW #2. Non English speaking. Preop complete. Chart labs reviewed. NPO confirmed.
0933 TO OR 1-1 via gurney. To OR bed by self. Monitors on. Pre O2. IV induction. Eyes taped shut. See airway note below.

1100 Resp even/reg. TV 400cc. Airway refluxes into ct. VSS. Over sys. Extubated CB press breath. Spont resp ensue.
1109 To ICU 2 via litter. VSS. Report to nursing staff.

X

RECOVERY AT 1109
PACU ICU #2 (Specify)
OTHER T=96.4 Ax
CONDITION: Stable
RESP – 18 SpO2 – 96% RA
BP – 109/69 HR – 107

ANESTHESIA PROVIDER TIME

	Start	Room	End
ANES	0900	0933	1115
	Ready	Begin	End
PROC	0945	0952	1051

PROCEDURES and CPT Codes: I+D & DPC (R) foot wound.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA – O2/1/50

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Early mask ventilation. DL #1 c MAC 3. Vocal cords. Inview by MAJ Orth. ETT secured @ 23cm @ teeth. (+) Shrill (+) ETCO2 sustained. BBS = (+) Bilat b/(cc) (sq+)

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

EPW # [redacted] b(6)-4

ICW #2 b(6)-4?

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA

[redacted] b(6)-2

PROCEDURE LOCATION: OR 1-1
DATE: 26 MAY 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 9243

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I/D (R) foot
SURGICAL SERVICE: Ortho
NPO SINCE: > MN

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB) HT: ____ IN.
ALLERGIES: ?

HABITS:
TOBACCO: ?
ETOH: ____
DRUGS: ?

CURRENT MEDICATIONS:
( ) = ordered as premed
() Gent
() Cleocin
()
()
()
()

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____

7.1 / 7.5 / 24 / 226
140/1074 / 3.7 / 240.8 / 95

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	Foley Cath
Gastrointestinal:			
Hepatitis	N	Y	Tender Abd.
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	

(L) foot Fx

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Had surgery yesterday

PHYSICAL EXAMINATION
BP 134/90 HR 82 R 16 T 97.6
Pain Scale 0-10 ____
HEENT - Teeth Intact (but poor)
Trachea Midline
TMJ/Neck FROM
Oropharnyx MPH
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: (Poor IV)
IV Access: (L) Hand #20g
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since > MN

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] CRT/CRNA Date: 26 MAY 03 Time: 0900 Hrs

b(6)-2

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

EPW #[redacted] ICW #2

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

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.

II (morphine sulfate given for wound)

Unknown allergies

MEDICAL RECORD — ANESTHESIA

DRUGS	(Units)	
M-diazepam	(mg)	3/1
Fentanyl	(mcg)	100/150
Propofol	(mg)	160
Succinylcholine	(mg)	100
( )		
MSO4	(mg)	10
VOLAT AGENT: FSO	% del	1.5 2.0 2.2 1.8 1.8 X
	% 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

FLUIDS — LINE site 14g (L) LR ☐ Warmed — 300 — 700 — 1100

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES — EST BLOOD LOSS

URINE – Foley 100 Emptied 200 150

TOTALS	
TOTAL EBL	100
TOTAL URINE	Foley 1100

FLUIDS – SUMMARY

CRYSTALLOID– LR 1100

COLLOID– 0

BLOOD– 0

REMARKS – Code drugs with numbers, events with letters

0755 NPO x 8 hours.

0808 Room. Monitors on.

0837 TA RLE @ 275 mmHg

TJ

TT = 55"

0940 OT SC & extubated T (+) pressure to ICU

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT: 29.6

INITIAL DATA: BP – 130/80 HR– 86

SCRUB CHECK: OK?– (Y) N

PATIENT ID CHECK: OK for PROCEDURE? YES TIME– 0730

TIME → 0730 0800 0830 0900 0930 1000

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	700	700	700	540	400	350	400
f – breaths/min	7	6	22	10	10	10	12
Peak inf pres / PEEP	14	14					
MODE– S(pon), A(ssist), C(on)	S-C	C	S	S	S	S	S
ET CO2 (torr)	37	38	44	48	50	50	48
FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	1.0	1.0
SpO2 (%)	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR
TEMP- site Skin	Avg						
N-M Block (T/4)	4/4	SEST TR1					

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → Arms tucked LAB, supine

RECOVERY AT 0942	
PACU ICU (Specify)	
OTHER	
CONDITION: Awake talking	
RESP– 16	SpO2– 100%
BP– 177/84	HR– 110

ANES	Start	Room	End
	0750	0808	0945
PROC	Ready	Begin	End
	0810	0820	0936

PROCEDURES and CPT Codes

(R) Foot Wound Debridement.

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

EDW # [redacted] b(6)-4

ICW 2 b(6)-4?

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments Pt prepped & draped. OK x1 T Miller 3. Airway clear. 8.0 cuffed ETT to 24 cm @ Lip. BBS (+) ETCO2. Eyes taped shut.

SURGEONS: [redacted] b(6)-2

ANESTHE[redacted] CRNA

b(6)-2

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION	OR 1
DATE	24 May 03
PAGE	1 OF 1

WAMC OP 376 REVISED Jan 99

MEDCOM - 9245

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Debrid (R) Foot
SURGICAL SERVICE: ortho
NPO SINCE: p Midnight

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB HT: ____ IN.
ALLERGIES: ?

HABITS:
TOBACCO: (X)
ETOH: ?
DRUGS: ?

CURRENT MEDICATIONS:
( ) = ordered as premed

() Ancef 1Gm q 8°
() Tylox
( )
( )
( )
( )

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

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: ____

9.0 > 8.8 / 29.6 < 242

140 | 103 | 11 / 3.9 | 22 | 1.0 < 100

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 130/80 HR 86 R 11 T 99.9
Pain Scale 0-10 ____
HEENT - Teeth Chipped
Trachea Midline
TMJ/Neck FROM
Oropharnyx MP II
Nares ____
CHEST: ~~S.S.~~ CTA
CARDIAC: S.S.
EXTREMITIES:
IV Access: 18g (L) AC
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: ____ Date: ____ Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

II [redacted] b(6)-4 ICW #2 b(6)-4

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.

*U.S. GPO: 1992-316-809/60175

NSN 7540-01-185-7294

619-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

Fac.
Facesial

AGE	SEX	SSN (Sponsor) b(6)-4	WARD/CLINIC	REGISTER NO.
31		[redacted]	EMT	
FILM NO.				PREGNANT ☐ YES ☒ NO
REQUESTED BY Dr [redacted] b(6)-2				TELEPHONE/PAGE NO.
SIGNATURE OF REQUESTOR [redacted]				DATE REQUESTED 23 MAY 03

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

R/O Retro pharyngeal shrapnal

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

b(6)-4
[redacted]

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

[redacted]

b(6)-4

NURSING UNIT: ICW#2 | ROOM NO.: F | BED NO.: 1

DATE OF ORDER | TIME OF ORDER | HOURS | LIST THE ORDERS NOTED AS SICK

23MAY03 1550

ADMIT CLOGMANNUNE

OPEN FX (R) FOOT

CONN STABLE

VS ROUTINE

ACT BTL-RESTRAIN

ANA

BEDREST NPO PMN

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: F | BED NO.: 1

DATE OF ORDER | TIME OF ORDER | HOURS

LR @ 75CC/HR

ANCEF 1 GM IV Q8°

MS 2MG IV Q15' PRN UP TO 16MG IN 4°

TYLOX 1 TAB Q 4-6° PRN

b(6)-2

PATIENT IDENTIFICATION

24MAY03 [redacted] 5/23/03 1030

b(6)-2

[redacted]

DATE OF ORDER | TIME OF ORDER | HOURS

ADDITIONAL ORDERS

ADMIT CLOGMANNUNE

DX ADDITIONAL INJ (R) FOOT

CONN FAIR

VS ROUTINE

ACT - PW RESTRAINTS [redacted]

ALL - UNKNOWN

b(6)-2

Noted + Sent

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOUR

ACT BED

LR @ 75CC/HR

D/C FOLEY

MED CEFOTAN 1GM IV Q8°

GENTAMICIN 400MG IV QD

MS 2MG IV Q15' PRN UP TO 16MG IN 4°

TYLOX 1 TAB Q 4-6° PRN [redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW-2		

DATE OF ORDER: 24 MAY 03 TIME OF ORDER: 1900 HOURS

STR CATH Q 6° PRN
LEAVE AS FOLEY IF
RESIDUAL > 600 ml

[redacted] b(6)-2

LIST TIME ORDER NOTED AND SIGN: noted b(6)-2 [redacted] 24 May 03 1903

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24 MAY 03 TIME OF ORDER: 2000 HOURS

① Place foley catheter
② foley to gravity [redacted] MD

noted [redacted] 24 May 03 2010

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

noted & pharmacy informed 25 MAY 03 0900 CT

DATE OF ORDER: 5-25-03 TIME OF ORDER: 0846 HOURS

1) Tylox to Percocet

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

CPT [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 25 MAY 03 TIME OF ORDER: 0745 HOURS

TYLENOL 650 MG AD PRN Q4°
KCL, METLYTE 8
TPD PRN

noted 1005 25 May 03 [redacted]

b(6)-2

[redacted] b(6)-2

LTC, MC ORTHOPEDIC SERVICE [redacted] 25 May [redacted]

b(6)-2

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

U.S. GOVERNMENT PRINTING OFFICE: 2002-466-061

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.: F | BED NO.: 1

DATE OF ORDER: 27 May 03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

~~dc Coley - DTV in 60 55~~

~~DC IVF - Salinelock~~

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 May 03 | TIME OF ORDER: 2130 HOURS

DC cefoxin & gentamicin

NS 60mg IV NOW - GIVEN

[redacted] b(6)-2

30 May 03 0230 [redacted] b(6)-2

MC ORTHOPEDIC SERVICE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 31 May 03 | TIME OF ORDER: 0800 HOURS

DC TO ASMC ✓

MOD TRACTION 3 HRS ✓

BRT PRECAUTION ✓

PLN ~~ASMC FOR~~ GWK ✓

FOR CAST REMOVAL, SUTURE REMOVAL & XRAY

noted [redacted] 91WM6 31 May 1330

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [redacted] HOURS

b(6)-2

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

MEDCOM - 9250

U.S. GOVERNMENT PRINTING OFFICE: 2002-498-041

Doctor's Orders—Post-OP

126th OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☒	1. Admit to: ☐ OR ☒ PACU ☐ ICW ☒ Patient Holding within criteria met
☐	☒	2. Diagnosis: S/P I&D of GSW (R) Foot
☐	☒	3. Condition: ☐ Critical ☐ Guarded ☒ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☐	☒	5. Vitals: ☒ Unit SOP ☒ Notify Dr. for SBP < ___ or > ___, DBP < ___ or > ___, HR < ___ or > 130, RR < ___ or > ___, or Temp > ___
☐	☒	6. Activities: ☒ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☒ Other: Elevate (R) LEG above heart
		7. NRSG:
☐	☒	a. Propaq monitor w/ Pulse-ox
☐	☒	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE= ___ Vt= ___ RR= ___ PEEP= ___ FIO_2= ___
☐	☒	d. ☒ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☐	e. I's & O's
☐	☐	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at
☐	☒	8. Diet: ☐ NPO ☐ Clear fluids as tolerated ☒ Other: NCG
☐	☒	9. IV: ☒ NS or ☒ LR TRA 50 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then ___ cc/hr ☐ Albumin 100cc X ___ TRA ___ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C ___ units ☐ Transfuse ___ units ☐ PRBCs or ☐ Whole Blood
		11. Medications: Gentamycin 80mg IV q8° (0045 1st Dose → Next 0845)
☐	☒	a. ~~Tobramycin 300mg IV Q12hrs X~~
☐	☐	b. Clindamycin 600mg IV
☐	☒	c. Cefazolin 1 gram IV q8° (0100 1st Dose Next Dose 0900)
☐	☒	d. Phenergan 12-25mg Titrate ☒ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☒	h. MSO_4 1-3mg Titrate ☒ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☒	k. Tetanus Immune Globulin (if not already given) 0100 given
☐	☒	l. Toradol ☒ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		EPW – Restrain/Guard b(6)-4)
		b(6)-2
		[redacted] [redacted]
		Signature: [redacted] LPC Mc 4332

LOG#

PT NAME.

PT SSAN#

10JAN03

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 05 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25
23	[redacted]	VS Routine	5	/		
			13	[redacted]		
			21	[redacted]		
23	[redacted]	Act: BR c Restraints	5	/ [redacted]		
			13	[redacted]		
			21	[redacted]	b6-2	
23	[redacted]	Reg Diet	6	/ [redacted]		
			11	/ [redacted]		
			17	[redacted]		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Open Fx (U) Foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

1

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 05 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23	[redacted]	ADMIT c/o [redacted] b/c -2 A/N i STABLE				
23	[redacted]	NPO p midnight	23	2359		[redacted]

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

USAPA V1.00

POST-U.

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. 05 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 24	25	26	27	28	29	30	31
24	[redacted]	Vitals Routine	06	[redacted]							
b(6)			13	[redacted]							
			21	[redacted]							
24	[redacted]	PW Restraints	06	[redacted]							
b(6)-2			13	[redacted]							
			21	[redacted]							
24	[redacted]	Regular diet	06	[redacted]							
25	[redacted]	~~NPO p MN~~	11	[redacted]							
b(6)-2			17	[redacted]							
24 May	[redacted]	Straight cath q 6° prn	06								
		leave as foley if	13								
		residual > 600 ml	21								
b(6)-2											
24 May	[redacted]	Foley to gravity	06	[redacted]							
			13	[redacted]							
			21	[redacted]							
		b(6)-2									

Foley D/C 24 May 03 Intermittent Catheter

ALLERGIES: ☐ YES ☐ NO — unknown

PRIMARY DIAGNOSIS: Blast injury (R) foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: 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

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

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 05 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
24	[redacted]	Admit w/o [redacted] b(6)-2	24	Now		[redacted]	
24	[redacted]	Condition: Fair	24	Now		[redacted]	b(6)-2
24	[redacted]	DC foley	24	Now	Done	[redacted]	
25	[redacted]	NPO @ MN	25	0000	Done	[redacted]	
25	[redacted]	CBC, Metabolic 8	25	Now	1100	[redacted]	
31	[redacted]	DC to ASMC					

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

USAPA V1.00

b(6)-2 A11

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 05 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25
23	[redacted]	LR @ 75 cc/hr	5	/	[redacted]	
			13			
			21			
23	[redacted]	Ancef 1gm Q8°	08	/	[redacted]	
			16	/		
			24			

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: open fx ⓥ FOOT

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

EPW

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													
23	- - - - -	MSO4 2mg IV Q15														
- - - - -	- - - - -	min PRN ~~[illegible]~~ up														
- - - - -	- - - - -	TD 16mg IN 4°														
- - - - -	- - - - -															
- - - - -	- - - - -	Tylenol ~~[illegible]~~ PO	23mg 2125													
- - - - -	- - - - -	Q4-6° prn pain	1 po AGS													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

Post-op

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. 05 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 24	25	26	27	28	29
24	[redacted]	Morphine 2mg/hr	06	[redacted]					
27	[redacted]	Flush SL QS	13	[redacted]					
			21	[redacted]					
24	[redacted]	Gentamycin 400mg IV, q day	12	[redacted]					
24	[redacted]	Cleocin 600mg IV, q8°	08	[redacted]					
			16	[redacted]					
			24	[redacted]					

SL 27 May 03 b(6)-2

D/C 29 May 03 b(6)-2

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS: Blast injury (R) foot

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. 05 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														
24	[redacted]	Morphine Sulfate 2mg IV	21MAY 1130 4mg IVP ok	21MAY 0130 4mg IVP [redacted]													
	b6-2	q15min prn up to															
		16mg in 4hrs															
24	[redacted]	Tylox I-II PO q4-6hrs	[redacted]														
	b6-2	prn															
25MAY		Percocet I-II tabs PO	25MAY 0130 [redacted]	21MAY 1440 [redacted]	26MAY 0130 [redacted]	30MAY 2145 [redacted]											
		q4-6hrs PRN															
25MAY	[redacted]	Tylenol 650mg po prn q4	25MAY 1440 [redacted]														
	b6-2																

Δ Tylox to Percocet 25MAY03 0900 ok

b(6)-2

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: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: S/P T-10 ESW (R) foot

PHYSICIAN: [redacted]

ANESTHESIA BY [redacted] b(6)

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Prongs Face Tent Blow-By

Liter/min. Strong %

ASA History

Cardiac Rhythm NSR

IV#1 LR Patent Infiltrated

Site (R) PIC Rate Gauge 18g

IV#2 Patent Infiltrated

Site Rate Gauge

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAD
PRE-OP	[illegible]	[illegible]		[illegible]									Blanche Warm Pulse Moves Y N
0030	[illegible]	[illegible]	22	[illegible]	37	1	2	2	1	2	8	[illegible]	Blanche Warm Pulse Moves Y N
0040	[illegible]	101	15	[illegible]	37	2	2	2	1	2	9	[illegible]	Blanche Warm Pulse Moves Y N
0050	[illegible]	99	16	98%	37	2	2	2	2	2	10	RA	Blanche Warm Pulse Moves Y N
0100	[illegible]	[illegible]	16	98%	37	2	2	2	2	2	10	[illegible]	Blanche Warm Pulse Moves Y N
0110	[illegible]	104	16	99%	37	2	2	2	2	2	10	[illegible]	Blanche Warm Pulse Moves Y N
0120	[illegible]	100	16	98%	37	2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
0150	[illegible]	93	16	97%	37	2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
	/	Total	Input			EW 2700							Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/			Output		Urine Ø							Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/					EBL - 350							Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

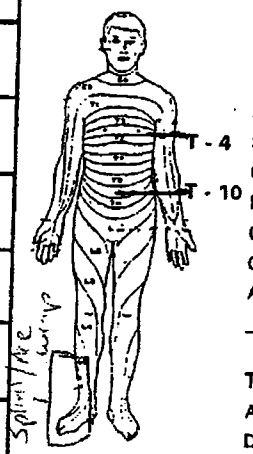
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Skin temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	Dry/Intact	(R) Foot/Leg

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

[redacted] b(6) - 2

DEPARTMENT/SERVICE/CLINIC: 126 FST

DATE: 22 May 03

(Continue on reverse)

[redacted] b(6) - 4

SSAN#:

NAME:

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

Report to pt Hold @ 0115

Pt to pt Hold 0130

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Revised) 1 Oct 94

MEDCOM - 9260

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: 0950 5/24/03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 0950

Allergies: _____ OR Intake: Crystalloid 100 Colloid _____

Pre-op V/S: _____ OR Output: UOP 100 EBL 100

Procedures: (R) foot washout Meds/Times: _____

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

Pre Op Meds History

Time	0955	1000	1005	1010
SaO2				
FiO2 21	RA			
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	22	20	18	16
T	98			
Time				
Pain (0-10)				
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	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

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

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

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

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

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: FCU #1

DATE: 24 May 03

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

EPW # [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	(R) foot	present	(+)	(+)	<3sec	98°F	Pink
15'							
30'							
45'							
60'							
90'							
D/C							

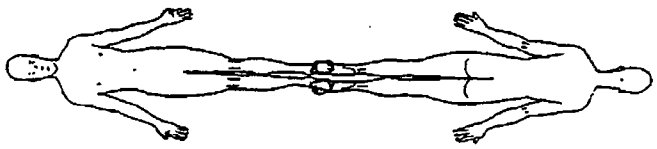
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) foot	Bulky.	none.
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

In OR received 50mcg fent 10mg MSO4 IV 2mg versed. Input IV fluid 100 EBL 100, U/O (50). Demerol 12.5mg given IVP-X1 for shivering @ 1000HRS.
Transfer Note: Pt transferred to 1W2 via litter. VSS. Bulky (R) leg dressing intact [redacted] b(6)-2

Discharge Criteria:
Date: 24 MAY 03 **Time:** 1045 **PARS:**
BP: 129/59 **T:** 98.4 **HR:** 102 **RR:** 16 **Sa02:** 96%
Pain Level at D/C (0-10):
Intake: 100cc IV LR **Output:** 100cc Foley
Additional Data: Telemark
Transferred To: 1W2
Report Given To: 2LT [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Ro [redacted]
Charge Nurse Signature: [redacted] /AO
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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 26 MAY 03
Time In: 1114
Allergies: NKDA
Pre-op V/S:
Procedures: Ex GSW foot (R)

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block Colloid
OR Intake: Crystalloid (LR)
OR Output: UOP <50 EBL minimal
Meds/Times: NINE IN PACU
last dose MSO4 @ 1000
10 mg BUP

See sheet (OR)
5 versed
2 versed
Fen 2 10 mg
MSO4 10 mg @ 1000

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

Pre Op Meds History

Time	1114	1116	1120	1125	1135	1145	1150	1155	1159	1205	1215	1225	1230	1240
SaO2	95	96	97	93	93	99	99	97	100	98	100		100	
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA	
Methods														
240														
220														
200														
180														
160														
140														
120														
100														
80														
60														
40														
20														
RR	10	13	12	14	13	12	14	12	12	12	12	12		
T	98.4					97.4			97.2			97.4		
Time														
Pain (0-10)	7	7	7	7	7	7	7							
LOS														

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1114	LR	1000cc	L posterior hand		IV (TKO)

X-rays: 1114 Labs: 1145 1214

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, ˆ = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

Language

Patient teaching done; Wound Care, Pain Management, Arabic via Translator
T, C, & DB,. Incentive Spirometer, Comfort Measures 45 minutes
Safety: SR up X 2, Falls Precautions. Privacy Maintained Yes.

(Continue on reverse)

PREPARED [redacted] Title) 91WM6 b(6):2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 26MAY03

[redacted] or typed or written entries give: middle; grade; date; hospital or medical facility)

Name – last,

[redacted] b(6)-4

GSW foot (R)

EPW SIP T & D GSW FIC DJ

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

27 yr 10 ♂ ASA II Antibiotics @ 0800

Sweat / Urine 80 kg.

MEDCOM - 9263

NONE in PACU

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1000	7	MSO4 10 mg	IV	7	OR	Anesthesia

NEUROVASCULAR

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

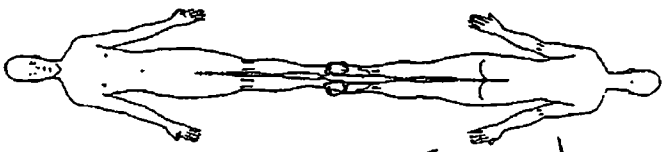
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R foot	Cast	∅
30'	R foot	Cast	∅
60'	R foot	Cast	∅
D/C			



PACU OUTPUT (F/C)

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Ryn?
1100	SR	∅	Continuous monitored

WAMC OP 173-E

NURSING NOTES @ 1100 hrs 26 MAY 03
pt. arrived PACU (ICU 2) awake
cold temp 97.6°F procedure
S/P I & D (R) foot GSW —
can move all extremities good
pulses X4 cap refill in (R)
foot < 3 seconds 1st dose MSO4
in OR @ 1000 hrs MSO4 10 mg IV
b(6)-2 [redacted] 9/WM
@ 1145 pt awake but directed
to keep 1 hour for monitoring —
O2 sats b(6)-2 [redacted] WM
@ 1200 Sensation & L Finger as regard
& motor patent PO on tolerating
PACU @ b(6) [redacted] 9/WM
@ 1215 pt awake transferred to ICU 2
L Finger — [redacted] 9/WM
[redacted] b(6)-2

Discharge Criteria: IN 1100
Date: 26 MAY 03 Time: 1215 PARS: —
BP: 128/77 T: 97.6 HR: 94 RR: 12 Sa02: 99
Pain Level at D/C (0-10): (10)
Intake: ∅ ORAL Output: F/C
Additional Data: Cast on (R) foot
Transferred To: ICU 2 [redacted] L
Report Given To: ICU 2 L [redacted]
Transferred Via: WC Litter Gurney Ambulance
Transferred By [redacted] 9/WM
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted] MAT [redacted]
b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						MTF LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX	
9	10	11	12	13	14	15	EPW [redacted] b(6)-4	16	17	18	
0	0	1	3	1	9	0	b(6)-4?		EPW	M	1

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								2	3	4	X	9	UNK

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
				9	9	[redacted] b(6)-4								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46 UNK	1450	

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
			K	7	6									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICW 2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b(2)-2		

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
2	1							0	3	0	5	3	1

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	E	A	A							0	3	0	5	2	3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (YYMMDD)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

OPEN FX 52° TO EXPLOSIVE DEVICE

(R) AND METACARPAL, CUBOID, [illegible]

b(2)-2 [redacted] Inj Trauma

450 1

Dx: 82535 Pr: 7967(2)
82534
82533
E9912

LTC, MC
ORTHOPEDIC SERVICE

ADMITTING OFFICER (Signature and Grade)	SIGNATURE OF ADMITTING CLERK
[redacted] b(6)-2	[redacted] b(6)-2

DA F[redacted] MAR 90 [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTRATION NUMBER: 00132661	2. NAME (Last, First, MI): CIV # [redacted] b(6)-4				3. GRADE: —	ADMISSION REMARKS
4. SEX: M	5. AGE: 24Y	6. RACE: —	7. RELIGION: —	8. LENGTH OF SVC: —	9. ETS: —	10. PREVIOUS ADMISSION: no
11. FAMILY: 20	12. SSN: [redacted] b(6)-4		13. ORGANIZATION: —			14. WARD: ICU1
15. DEPENDENCY STATUS: NO	16. DSG: —	17. DEP. BEN: K91	18. BRANCH/CORPS: —	19. UIC/ZIP: —		20. TYPE CASE: SI

21. DATE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22. HOURS OF ADMISSION: 1100

23. CLINIC SERVICE: BURNS

24. RELATIONSHIP OF EMERGENCY ADDRESSEE: Unknown

25. TYPE DISPOSITION: Discharge

26. DATE OF DISPOSITION: 2003 June 10

27. NAME OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b. TELEPHONE NO.:

28. DATE OF THIS ADMISSION: 2003 May 28

29. ADMITTING OFFICER: [redacted] b(6)-2

31. LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

30. DATE OF INITIAL ADMISSION:

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:

☐ Check if Continued on Reverse

33. DIAGNOSIS OR INJURY:

945.36
948.2
945.8
5.86, 486
276.7
780.6
V46.1
E990.9
E993

34. OPERATIONS AND SPECIAL PROCEDURES

Dx → 2° Burns to 40% of BSA
Acute Renal Failure
Pneumonia
(1) Wound debridement / (R) subclavian central line placement / A-line placement
(2) Tracheostomy / wound debridement 5 JUN 03 28 May 03
(3) Intubation 3 JUN 03
(4) Change central line 6 JUN 03

8632
8628
31.12

35. TOTAL TIME IN THIS FACILITY

a. 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	14	14

36. [redacted]

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

37. [redacted] b(6)-2

38. SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: [redacted] b(6)-2 SPC, USAMC

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER 00132 61 6042			2. NAME (Last, First, MI) [redacted] b(6)-4			3. GRADE CIV	ADMISSION REMARKS
4. SEX M	5. AGE 22y	6. RACE X	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION	
11. FMP 99		12. SSN [redacted] b(6)-4		13. ORGANIZATION N/A		14. WARD IC	
15. FLYING STATUS N	16. RATING/ DSG	17. DEPT./ BEN K991	18. BRANCH/CORPS N/A	19. UIC/ZIP unk		20. TYPE CASE WBI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER		22. HOURS OF ADMISSION 0911	23. CLINIC SERVICE AAAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk	25. TYPE DISPOSITION Q1	26. DATE OF DISPOSITION 10 June 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) unk	27b. TELEPHONE NO. unk	28. DATE OF THIS ADMISSION 28 May 03 06 June 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Blast Injury
1. 45% BSA Burn - 2nd degree
2. Acute renal failure
3. Pneumonia

Procedures: Tracheostomy
Burn debridement
Placement of central line

V 45.1
V 42.1

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	4	4

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

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

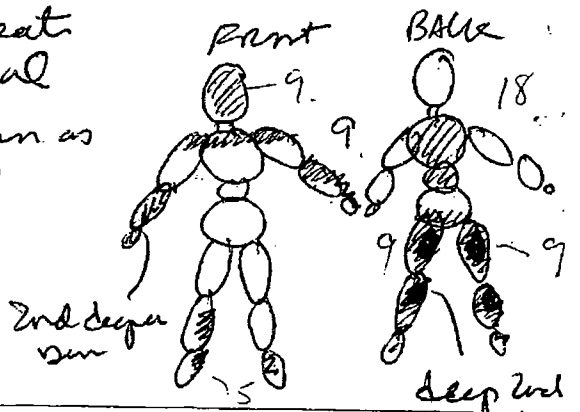
24yo Iraqi male who sustained 40% 2° BSA BURN for Blast injury

PMHx Ø PSHx Ø meds Ø NKDA

PHYSICAL EXAMINATION

WD/WN Ø NAD.
Eyes - conjunctiva injected
Nares clear
throat clear
neck supple Ø mass
lungs clear
int RRR-1m
abd soft NTTP Ø mass

no penis meatus
testicles ++
Ext - burn as indicated



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

Dx: 40% BSA 2nd Burn
IVF: Rate 600cc/hr (+ 300cc 2nd degree)
to OR f debridement
Pleural 15g MSO4 in PMT

40 X 4 X 60
40
2400
4
9600
8 | 9600
72
240

[redacted] b(6)-2

[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION

PA[redacted]ION *(For typed or written entries give Name last, first, [redacted]; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

[redacted] b(6)-4

[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	PROGRESS NOTES
DATE	NOTES
28 May 03	Procedure Note
	(1) Debridement of burn wounds
	(2) ~~Start~~ Central line placement (R) Subclavian
	(3) Place A-line (R) Radial art.
	(4) Place Doppler
	Surg Dr Tezen
	EBL min
	Fluid 2000 cc LR
	Cyclox ∅
	to ICU intubated
	[redacted] b(6)-2
29 May 03	Progress note
	- BD#2 - changed IVF & UREC 300 cc/h
	to D5W @ 150 + 50 cc/h 5% Albumin
	will holds. & monitor adequate hydration
	Will remain intubated & R.
	Cont drains s'.
	[redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

#[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

29MAY03 1000 Burn dsg Δ's done Face: continued debridement pink, bac. applied Ears: pink Sulfamylon applied Back: pink edges c̄ white center Buttock: beefy red BUE: cont. debridement pink, painful BLE: cont. debridement ⓡLE c̄ post burns to calf ⓛLE posterior from ankle to thigh beefy red painful to touch. Linen Δ'd tolerated rolling. Fent/Versed gtt titrated for dsg Δ. BUE's ↑ on blankets. HOB↑'d. Silvadene cream applied to all burned areas c̄ burning dsg ⊕ Kerlix applied ⊖ s/s of infection noted — [redacted] MAYAN — b(6)-2

29May03 2030 Burn dsgs Δ'd Face: cont. debridement, bac. applied Sulfamylon to Ears. Back: White c̄ pink edges Buttock: Beefy red RUE/Hand: posterior to shoulder white / pink painful to touch cont. debridement. LLE/hand: posterior cont. debridement beefy red hard/pink painful to touch BUEs elevated Head of bed ↑ c̄ donut ↓ head. Silvadene Cream applied to all burns burn dsg/Kerlix applied / placed on burn pads — Pain management Versed/Fent gtts Unit Watched ↑ during dsg Δ — [redacted] MAYAN

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. ICU1

#[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
29MAY03	PT ASSESSMENT COMPLETE (SEE OP 375). VSS. DSC Δ'D BY MAJ [redacted]
2015	PT TRANSFERRED WARD. [redacted] (CRNA)
S-30/0600	Assumed pt care from ept stipsitis. pt in no apparent distress @ change of shift.
	A) pt easily arousable c̄ light physical stimuli. Pupils 3mm sluggish sedated c̄ 4mg/hr versed, 100mcg/hr fentanyl, GCS 8/5/5.
	CV ST 100s S ectopy, BP 120s/70s, LUE pulse weak, bilat LE pedal pulses weak. Cap refill 3 secs.
	Resp SpW 15 fio2 40% VE 700 resps, not overbreathing vent @ TH 8 2/cm @ lip spec 99%. breaths even sounds above & lungs s CTA bilat
	GI BS absent distended R wall will advance w/ ventr Dr. Bogust per CXRAY. d V/D.
	GU FTG urine amber.
	Lines LSC SC central, R femoral central TL all patent.
	Labs. WNL. [redacted] S-30
S-30/0800	Burn dsg Δ done. Face area debrided (albumin areas deemed viable) & forehead c̄ hibiclens solution & rinsed c̄ plain water, area bacitracin applied, area bagged red. Ears pink, silvadene applied. Back pink edges c̄ white center silvadene applied, Bottom bagged red silvadene applied. Bilat UE pink (R) hand macerated in appearance. silvadene applied. Bilat LE pink. Shoulder area very tender silvadene applied. All areas debriding well. Versed drip titrated for pt's comfort. Burn dressings applied to all areas & covered c̄ kerlix. Pt tolerated dressing well. [redacted] S-30

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5-29/1500	Pt continues sedated on 5mg/hr versed 100mcg/hr fentanyl, D5W infusing @ 80cc/hr, albumin infusing @ 50cc/hr. ~~Pt found 500~~ is sedated c̄ aforementioned drugs, pt arousable c̄ light physical stimuli, able to move all extremities, PERRL 3mm sluggish [redacted] b(6)-2 S/R.
	CV ST 100s s̄ ectopy BP 140/70s weak pulses bilat LE, weak LUE, strong RUE radial pulse cap refill >3secs all extremities.
	Resp SCMV @ VT 700 f̄ 40 peep5 ETT @ 22cm @ lip ~~not~~ not overbreathing vent, breaths even & unlabored.
	GI hyperBSCE distended. Anasarc advanced 10cm per KUB/meji diran, Dobhoff noted bilaterally will consult c̄ Dr. [redacted] b(6)-2 during rounds.
	GU FTG urine output 7l urine clear
	Lines Rfemoral central TL, LSC central all patent. See wound note for dressing changes note [redacted] 29 1500. b(6) [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO	WARD NO.

[redacted] b(6)-4

FCW #1

PROGRESS NOTES
Medical Record

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

CR232 b(6)-4 [redacted] [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5:30	per Dr. [redacted] 1Gm tylenol elixir given via dobhoff per 102.1 temp per Dr. [redacted] b(6)-2
1730	Received report from daysHFT. Assessment Completed (see CR 375). VSS. Pt resting quietly — [redacted] b(6)-2
5/31 0030	A-line malfunction. DSW learned. A-line D/C'D — [redacted] b(6)-2
0430	T: 104.4. Pt shaking. Tylenol suppository given [redacted] b(6)-2
31 MAY 03 0830	Pt continued on Versed & sedated on Versed & fentanyl. ~~A-line to (R) radial intact.~~ Triple lumen to (R) femoral area & single lumen to (L) subclavian remain intact. Elevated temp 106.7. Notified physician. Body cooling techniques done. Foley to gravity continues to drain dark colored urine. ↑ Versed to [redacted] for agitation. Will continue to monitor — [redacted] SST, LPN b(6)-2
31 MAY 03 1200	Dressing Δ done. Temp down to 99.9. IV Bolus of LR 500 cc ordered. NG tube ordered. Jevity ↑ to 50cc/hr per physician's ordered. Will continue to monitor [redacted] b(6)-2
31 MAY 03 1500	NG tube placed. Jevity ↑ 50cc/hr. LR bolus completed. Single lumen cath to (L) subclavian & triple lumen cath to (R) femoral area remains intact w/ s/s of redness or swelling. Foley cath continues to drain dark colored urine. VS: BP 113/55 P-131 R-15 T-101.6 SPO2 98% on [redacted] b(6)-2 SST, LPN
1715	Received report from daysHFT. Assessment Completed (see CR 375). VSS - Pt febrile 103°. Blankets removed. — [redacted] b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 May 03	Nutrition Note
O:	Dx: 40% BSA Burns (2nd degree) WT: 70 kg estimated
	Diet: NPO
A:	Nutritional requirements estimated at:
	3150 kcal (45 kcal/kg)
	105-140 gms protein (1.5-2.0 gms/kg)
	Needs can be met c̄ tube feedings of Jevity Plus
	@ 110 cc/° to provide:
	3168 kcal
	148 gms protein
P/R	Recommend starting feedings @ 30 cc/° and advance q̄ 12 hours if tolerated. Rate can be advanced 10 cc/° until goal of ~~130~~ (WK) 110 cc/° is reached.
	[redacted] MAJ, SP
	s(6)-2 RD/LDN
5:30/(6)	Pt remains sedated. TSB throughout stupid, no changes in assessment in day shift. Pt currently on 0.5cc/hr DSW, 4mg/hr versed, 100mcg/hr fentanyl, 50cc/hr albumin 30cc/hr Jevity. pt rcvd 500cc hespan for ↑ HR 120-130s ↓ BP 90/40-50s. Pt responded well to hespan below HR ↓ Hes BP 100s/50s. Jevity started at approx 1600 @ 30cc/hr

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
13 June/0800	Assumed pt care at approx 0500, pt resting quietly in bed in no apparent distress, DSW infusing @ 150 cc/hr, albumin @ 50 cc/hr, versed 5 mg/hr, fentanyl 100 mcg/hr, jevity @ 500 cc/hr
13 June/0900	Burn dressing change: ~~face~~ all areas covered prior to burn dressings during burns ~~can~~ all burned areas cleansed c̄ hibiclens & rinsed c̄ ~~water~~ NS all areas also debrided c̄ 4x4's c̄ hibiclens solution. Face continues to debride, bacitracin applied, scant bleeding throughout face, tissue red. silvadene applied to ears. Back white c̄ pink edges, small amount of bleeding noted throughout back but mostly along ~~edges~~ margins, Buttock beefy red c̄ mod bleeding, Rt/L hand posterior to shoulder white, shoulder area very sensitive, mod-lg [redacted] small-mod bleeding, hands ~~&~~ to include fingers appear macerated. Lt/hand posterior to ~~wrist~~ mid upper arm white c̄ small amount of bleeding along margins, hand to include fingers appear macerated pain mgt increased 10 mg/hr. fentanyl 500 mcg/hr pt tolerated dressings changes well. [redacted] b(6)-2 b(6)-2
13 June/1600	Attempted to wean pt by ↓ RR to 8, pt over-breathing @ RR of 18-21, however, pt is non responsive to ~~physical~~ verbal or physical stimuli, barely opens eyes c̄ firm sternal rub, will not wean tonight per Dr. [redacted] & will resume tube feedings as tolerated, ABG done & all values WNL.
1700	Received report from LT Bryan. Assessment conducted (see OP 375) 500 cc Burns LR given per Dr. [redacted] w/ in cont. c̄ plan of care [redacted] b(6)-2 CPS
2300	Received @ 120 cc. TF stopped [redacted] b(6)-2 CPS

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MEDICAL RECORD	PROGRESS NOTES
DATE	
2JUN03 0830	TF RESTARTED @ 50cc/hr — [redacted] CPRS b(6)-2
2 JUN03	Pt remain on vent @ full support pattern SIMV VT 700, RR 8 PEEP 5, FIO2 35%, spontaneous breaths @ 18 HR 104, B/P 108/78 P.O. 98%, ET tube 8; b.s. slightly ↓ in lower otherwise clear, alert not & functions well — [redacted] CRT b(6)-2
2JUN03	Assumed pt care at approx 0800 from Cpt Esposito, pt in no apparent distress, pt & CMO present, no sign of theft.
2JUN/1500	Pt remains hemodynamically stable & no issues other than only responding to noxious stimuli for Dr Zeman pt's treatment of pt's sedation & will exhibit inhibiting behavior & response to arousal. & also report movement of pt's [redacted] b(6)-2
1715	- Received report from DAYSHIFT. Assessment completed (See @ 373) Pt resting quietly [redacted] b(6)-2 CPRS
3JUN03 0740	Pt intubated per physician's ordered. Pt started on [redacted] b(6)-2 non-rebreather @ 15L. SPO2 - 93-95%. [redacted] SGT, LPN
3JUN03 0845	Pt given a neb tx and switched over to a venturi mask. SPO2 - 88-92% — b(6)-2 [redacted] SGT, LPN
3JUN03 1215	Pt re-intubated @ 1030 by Anesthesia. ~~Dressing A done.~~ [redacted] b(6)-2 Intubated c̄ #8.0 ET tube. Medicated c̄ Versed & Fentanyl (Continue on reverse side) cont'd

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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[redacted] b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
3 JUN 03	Intubation Note
	Patient, HD#7, Abx day #2 c̄ gent/Zosyn who was doing quite well in my attempts to wean him. He tolerated a T-piece overnight c̄ respiratory distress. Following extubation he had T difficulty c̄ deep breathing and ↓ O_2 sat. A CXR obtained demonstrates pneumonia (R/LL). We elected to reintubate.
	[redacted] b6-2 was called and she promptly versed and sympathetic and successfully intubated the patient c̄ 8.0 ET @ 23 cm @ the lip.
	The patient's tube was confirmed by CO_2 monitor and bilateral breath sounds. Repeat CXR pending.
	Dr. [redacted] agreed c̄ [redacted].
	b6-2
	Anesthesia [redacted] b(6)-2
1010	Called to intubate Pt. SaO2 95% [redacted] Assisted Ventilation c̄ Ambubag. 2 versed given by Dr [redacted] Sx mouth 160mg Propofol, Ventolate intubated 3 mill 8.0 CTT ahramatic @ 23cm at lips BBS = ETCO2 confirmed c̄ easy capn b(6)-2 on Vent. TV 700 FiO2 60% PEEP 5 SaO2 - 98% [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD [redacted]

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
3JUN03 1200hrs.	pt remains on vent @ SIMV, TV 700, RR 16, FIO2 50%, and PEEP of 5cm H2O, MD ordered ET pulled back ~~[illegible]~~ 2cm. ABG ordered, & pt ordered neb tx Q6° P.O. 98%, PR 94 Alarm set + functio well — [redacted] b(6)-2
3JUN03 1300hrs	pt given neb tx via vent inline, 5cc Alb/3cc NSS x duration of neb b.S. & tx cough bi-lat, p̄ tx CTA ~~x~~ small amount of thick white secretion, HR 94-99 ~~[illegible]~~ P.O. 98% tolerated tx well — [redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Con't

3 Jun 03 1215 ABG ordered. Neb tx ordered q6°. Vent settings Mode - SIMV, F_iO_2 - 50%, Tidal volume - 700, Rate - 16, Peep - 5. VS - BP - 120/55 P - 92 R - 15 - SPO_2 98%. Will continue to monitor. [redacted] SJT, RN b(6)-2

3 Jun 03 1645 Dressing Δ completed. Vent settings changed. Mode SIMV F_iO_2 40% TV - 700 Rate 16 Peep 5. VS - BP 101/71 P - 125 R - 16 T - 99.6 SPO_2 98%. Pt Nodding @ 4hr time. Will continue to monitor [redacted] RN b(6)-2

1720 RECEIVED REQUEST FROM DAYSHIFT. VSS - ASSESSMENT COMPLETED (SEE CP 375). ET #8 [illegible] @ BITE BLOCK. DIFFICULTY SUCTIONING WILL NOTIFY MD [redacted] CPT b(6)-2

1745 - PT REINTUBATED ET #8 24cm @ BITE BLOCK. OLD ET TUBE KINKED. SATS 98%. WILL CONT TO MONITOR [redacted] CPT b(6)-2

2100 PT C SHAKES - BLANKETS APPLIED T: 104.7. COOLING PROCEDURES INITIATED. T: TYLENOL PO (CRUSHED) TO NGT per V.O [redacted] CPT b(6)-2

[illegible] Assumed pt care from CPT [illegible], pt in no apparent distress, pt sedated c̄ ~~[illegible] fentanyl, Calyxsing @ 200cc/hr, Ensure infusing @ 200cc/hr via NG, dobutamine drip [illegible] pt remains intubated c̄ no vasopressors will continue to monitor [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	Progress Note NOTES
4 JUN 03	Cardiopulmonary:
	BP 135/71 HR 81 RR 16 O2 Sat 98%
	SIMV R16 TV 700 FiO2 40% PEEP 5
	Patient reintubated x2 yesterday c̄ copious amount of green discharge
	CXR clw pneumo RMC improved
	F/E/N
	In 5420 Out 2660 Tube feed 330cc or 500cc
	150/115/86/163 Alb 1.6
	4.7/18/3.9
	I/D T↑ 104 despite Gent/Zosyn
	CXR improved RLL pneumo
	Wounds Pist tract deep (R) deep 2nd vs 3rd degree.
	Dx: ① Pneumonia requiring ventilatory support
	② ARF (likely 2nd to meds/hypotension) - ATN
	③ Inadequate nutritional support (total 500cal)
	④ 2nd/3rd degree Burns BSA 40-50%
	Plan: DC gent — Δ to renal dose Cipro IV
	Repeat chem 8
	Start Levaquin
	Advance dobhoff again
	[redacted] b(6) -2

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Progress Note

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MEDICAL RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/5/03 0940	Burn dressing to burned areas cleaned & debrided & irrigated c̄ NS, All burned area covered c̄ silvadene c̄ the exception of area of alternaflex applied, Bacitracin applied to penis. All areas ok & debrided. Face continues to deteriorate tissue pink & bled slightly, white bearing. Back white c̄ pink margins, bleeding along margins. Buttock keeping c̄ incontinent and bleeding. RUE/hand posterior to shoulder white shoulder area very sensitive, sm-mod bleeding, hands to include fingers appear macerated. LUE/hand posterior to mid UA white c̄ small areas of bleeding along margins, hands to include fingers appear macerated, pain not [illegible] long/hr, yesterday 50mg/hr, pt tolerated dressing changes well. [redacted] b(6)-2
	Pre op
6/5/03 0817	Pt transported from ICU I to OR group assisted by Anesthesia. Pt is bagged & being taken off the vent on way to OR. Am Abx given [redacted] OR Nurse for infusion & the OR. [redacted] b(6)-2
6/5/03	HHN Tx Given .5cc Atr. 2.5cc NS HR 129 BP 121/85 RR 26
12/8/ RT	SO2 94% BBS coarse Post Tx SO2 95% BBS No change [redacted] RT SGT 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.

[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6/5/03	Brief op note
	Procedure ① Tracheostomy
	② Wound Irrigation/debridement
	Surgeon Dr [redacted] b(6)-2
	Dr [redacted] b(6)-2
	EBL min
	Anesthesia GETA
	Cylinder ¢
	[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 MAY 03 1400	b(6)-2 Pt Admitted to ICU from OR. [redacted] 2ND Burns to 40% BSA. S/P Debridement. Pt had burns to face, back & buttocks, Also to lower extremities. Intubated in ER - ~~6.0 ET~~ 7.0 ET tube. Vent setting SIMV mode, rate 12, tidal volume - 700, PEEP-5, FIO2-30% Single Tunnel to (R) subclavian area intact S/S of redness or edema. LR infusing @ 300 cc/hr into (L) subclavian area. 1/2 NS infusing into (R) forearm area S/S of redness or edema. A-Line in (R) radial artery. S/S of swelling. Versed drip started @ 2mg/hr. Fentanyl drip infusing @ 75 mcg/hr. VS - BP-100/78 P-60 R-24 T-96.0, Silvadene applied to burns on face. Foley with intact draining clear, yellow urine. Dressings to burns intact. Will continue to monitor. [redacted] SPT USN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted] b(6)-2	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.

CIV # [redacted] b(6)-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 May 03	RECEIVED PT FROM DAYSHIFT. ASSESSMENT COMPLETED (SEE CP 375). VSS.
1730	PT AROUSABLE TO VIGOROUS STIMULI. BURN PAD ON BACK. (B) UE + LE WRAPPED TO XGLUX. (D) DSG D THIS P.M PER DAYSHIFT. [redacted] b(6)-2
1830	PT BITING ON ET TUBE. EMESIS X 1. VERSED 6mg IV BOLUS GIVEN. BITE BLOCK PLACED. PT TOLERATED. [redacted] b(6)-2
29 May 03 0500	Rcd pt lying in bed sedated. Pt has blast injuries to face and Bilat UE & LE. DSG intact to extremities, line (L) subclavian infusing LR
	b(6)-2
29 May 03 0600	Assumed pt care from Cpt [redacted] approx 0500. Pt resting in bed quietly. Pt sedated c Zyprexa 1mg/hr, fentanyl 75mcg/hr. LR infusing @ 200ml/hr.
	N pt's 3mm sluggish, responsive to light physical stimulation, noncommunicative @ this time. GCS 8/15.
	CV ST 100s BP 100/60s normotensive, palpable weak CE, dorsalis pedis, weak LE radial. Strong RUE radial, cap refill <3 secs all extremes.
	Resp SIMV 15 FiO2 40%, peep 5 VT 700, not overbreathing vent. ABGs WNL. Clear CTA bilat. ETT 23 2cm @ lip. SpO2 99-100% / breaths even unassisted
	GI hyper BS x4 (-) V/D. Soft abd (B) nave. abd soft. [illegible]
	GU amber urine FTG 28-50 cc/hr
	Lines RFA PIV R Radial - all line CSC central.
	[redacted] 8-29

b(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 May 03	Progress Note
	Post burn day # 4 s/p 40% 2nd° BSA burn
	started on Zosyn / Gent yesterday f T > 104°
	through AM hours
	LABS 136/101/18 < 153 12.1 / 179
	4.5/24/0.9 2.9/38.2
	UOP 30-50 cc/hr
	Tachycardic now BP stable
	Dx: ① 40% BSA BURN
	② Fever T 106
	③ tachycardia
	Plan → ↑ pressors / Na bicarb f RRR Resuscitation
	Blood culture now SVO cult
	Extubate tomorrow ?
	[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.

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 MAY 03	PT NOTE
	HX: ROM ② UE, E/W/H, LE
	T/M: MINIMAL EDEMA IN HANDS, FEET. PROM ③ UE (4WAY), ② E/W/H (6WAY + MP/DIP/PIP), ③ LE (4WAY) X 15 REPS EACH.
	DIAG: ROM
	INTERV: SAME
	G: Ø Δ
	SPC [redacted] b(6)-2
	SIMONS PT TECH

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.)*

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#[redacted] b(6)-4

ICU1/BED6

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 JAN 03	Progress Note
	HD# 5 s/p 40% 2° BSA BURN
	Cardiopulmonary:
	Vented SIMV R 15 TV 700 FiO2 30% Sats 99%
	HR 101 BP 114/63
	Stable today
	F/E/N 136/100/25 / 4.2 / 1.9 < 147 Getty 50 cc / hr Ensure & manual vacuum
	UOP 50-75 cc/h 24° IN 5313 out 2935
	I/D
	10.7 / 31.1 (85) Tmax 101.8 Tmax 100.1
	2 days / post day #2
	Ag: stable
	Needs weaning for extubation trial
	[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.

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 JUN 03	PT NOTE
	HX: ROM (B) UE (B) LE
	T/M: GOOD MM TONE ; JT FLEXIBILITY, PAT ASLEEP DURING RX, PROM (B) UE (4WAY) (B) LE (6WAY) X 15 REPS EACH.
	DIAG ROM
	INTERV: SAME
	G: Ø Δ
	SPC [redacted] b(6)-2
	SIWIONG PT TECH
03 JUN 03	PT NOTE
	HX: ROM
	T/M: PROM (B) UE (4WAY) (B) LE (6WAY)
	DIAG: ROM
	INTERV: SAME
	G: Ø Δ
	SPC [redacted] b(6)-2
	SIWIONG PT TECH

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

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

#[redacted] b(6)-4

REGISTER NO. | WARD NO.

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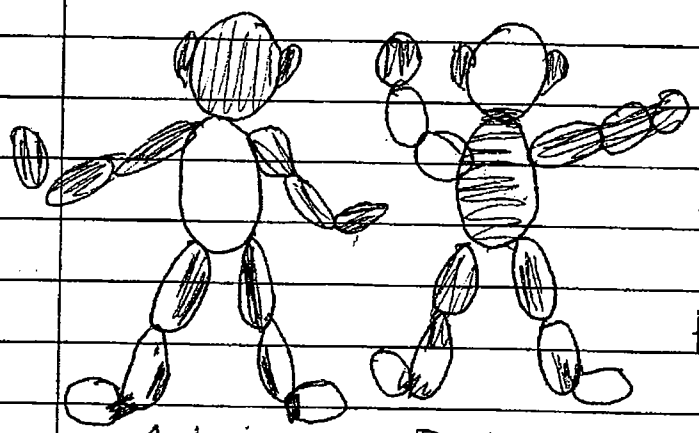
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 JUNE 03	IN OR dsg Δ completed after Trach procedure.
@ 0930-	Dr [redacted] assessed burns. BUE's pink/blanching
1030	c̄ small areas of cheesy yellow eschar —
b(4)-2	Back white around edges pink tissue noted
	Buttocks white c̄ pink edges. BLE's: ↑ thigh RLE c̄
	white/brown eschar lge area c̄ cheesy white
	areas & pink areas c̄ blanching Hair growth noted
	to lower extrem. LLE c̄ pink area/blanching
	Both ankles pink noted blackness to Both heels
	pressure ulcers. Face: cheesy eschar removed —
	free bleeding noted/shaved NGT/DHT inserted in OR
	secured well c̄ trach ties.



Anterior Posterior

* Silvdene cream applied to all burn areas d/t one deg Δ done per day burn deg c̄ Kerlix

Q S/S of infection noted to wounds —

[redacted] LAN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE b(6)-2	RECORDS MAINTAINED AT 28th CSH Burn Nurse
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. ICU # 1

[redacted] b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Jun 03 1255	Pt returned from OR c̄ trach in place. DHT & NG tubes replaced in OR. Dressing Δ also done in OR. (D) [redacted] A-line intact. Single lumen cath to (L) subclavian area remains patent and intact. ⊖ s/s of infx to site. Triple lumen cath to (R) femoral area also remains intact. ⊖ s/s of infx to site. BP ↑. Fenantyl drip & vasoactive drip increased. ⊖ other changes noted. Will continue to monitor [redacted] BT, RN
b(6)-2 1700	Received report from Sgt [redacted] 66-2. Pt. VSS. No apparent distress. Pt has fentanyl @ 30cc/hr, Versed @ 5cc/hr, [redacted] @ 7cc/hr and NS @ 75cc/hr. Pt's central line dressing changed. Pt waiting for CXR + KUB. No other issues at this time. — Sgt [redacted] LPN
b(6)-2 1900	CXR & KUB done. Dr. [redacted] said to resume tube feedings. — [redacted] LPN
2000	Tube feedings started Enrone @ 30cc/hr — Sgt [redacted] (LPN) b(6)-2
2130	Pt starting to shiver and spike fever. Tylenol given rectally. [redacted]
2400	Pt resting in bed. VSS. No change in assessment. — Sgt [redacted] LPN b(6)-2
2445	Pharmacy gave fentanyl @ 1000mg instead of 500. Pt now getting 15ml/hr instead of 30ml/hr — [redacted] LPN b(6)-2
0400	Pt resting in bed. Labs drawn. VSS. No change in assessment. [redacted] LPN
6 Jun 0639 RT	Pt continues on mechanical ventilation size 8 Shiley trach. Parameters SIMV RR 16 VT 700 PEEP 5 FIO2 40% HR 111 BP 133/64 SaO2 99%. BBS coarse. Pt received 50cc Alb 2-50cc N.S Neb tx pt tx no change SaO2 100% — b(6)-2 [redacted] RT

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 JAN 03	ICU Progress Note
meds	Cardiopulmonary: Tachycardia c̄ P = 160-115 — Lines
Zosyn	Stable BP 142/70 — (L) subclavian
Cipro	Trach placed yesterday c̄ complicated — (R) femoral
Zantac	CXR today RML atelectasis vs pneum. — (L) femoral a. line
Fentanyl	Vent TV 700cc FiO2 40% Rate 14
Versed	PEEP 5
	F/E/N UOP = 100cc/h — H/H 9.2/29
	151 / 118 / 91 < 220 — plt 207
	5.4 / 20 / 4.5
	Dobhoff @ 30 c/h c̄ Residual 25-40cc
	wound: Burns evaluated yesterday in OR
	Post thigh c̄ Deep burns Pm
	expected - will need escar +
	grafting
	ID Gradual ↑T now 101.5 Tmax 102.4
	WBC 7.2
	Diagnosis: (1) 40% BSA c̄ deep 2nd degree post thigh (5) hyponatremia
	(2) ARF likely 2nd hypotension + gent Rx (6) hyperkalemia
	(3) ~~Anemia Hct 29~~
	(4) Pneumonia
	Plan (1) TKO IVF (2) ↑ oral intake to 60 cc/h
	(3) Lasix D C-lines today

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

b(6)-2

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

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/6/03	Nebulizer tx Give .5cc Alb c̄ 2.5cc NS BBS coarse
1210 RT	HR 125 BP 140/70 RRR SpO2 98% Post tx BS clear
	HR 128 BP 126/59 SPO2 98% [redacted] RT SGT b(6)-
6 Jun 03 1300	Pt resting in bed c̄ trach collar in place. Medicated c̄ Tylenol 650mg for elevated temp. T-103.2. Physician notified. A-line intact to (R) femoral area. Single lumen cath to (L) subclavian and Triple lumen to (R) femoral intact. ⊘ S/S of redness or infx. ⊘ skin changes noted. Will continue to monitor [redacted] b(6)-
6 Jun 03 1530	Physician in to place a triple lumen cath to (L) subclavian area. X-ray ordered to check for placement. ⊘ changes noted. Will continue to monitor for any significant changes. [redacted] SGT, LR
6 Jun 03 1650	Triple lumen to (R) femoral area d/c'd. [redacted] SGT LR b(6)-2
	1700 - Received report from SG [redacted] b6-2 Pt. VSS. Patient alert and trying to talk. Pt requires a lot of oral suctioning. Pt assessment done. Pt 1800 residuals 130cc/hr turned off tube feeding [redacted] CPN b(6)-2
	2100 - Pt agitated. Versed ↑ to 7mg/hr. [redacted] CPN
	2200 - Pt residuals only 5cc. Enoxa resumed [redacted] CPN 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.

Pt # [redacted] b(6)-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

6 JUN 03 — Central line d
Triple lumen placed over wire @ patent subclavian site.
Cryptococcus
X ray pending
[redacted] b(6)-2

7 JUN 03 — Cardiopulmonary
Zosyn — Tachycardia 110-115 / BP 125/66 — Lines
Cipro — Rate 16/14 SIMV 40% FIO2 Sat O2 100% — Subclavian (R)
Fentanyl — CXR pending — Femoral (L)
Propofol — P/E/N — Art line
Mlenol — UOP = 100 cc/h — peripheral line
Levarox — 161/127/90 < 198 Ca 7.1 — Foley
Empendys — 5.6/20/4.7 — tracheostomy
Zantac — Feeds only 30 cc/hr (24 / 0)
I/D
Tmax q/h central line 103.2 yesterday @ 1/2 hr
now 101.6
Plan: 50% BSA BURN — ↑ Free H2O / + NS fluids
ARF. — ↓ cals in 2/2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPA[redacted]	RECORDS MAINTAINED AT b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RE[redacted]	

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. | WARD NO.

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07 June 03 0115	Nursing Note: Receiving Transfer Note Blast Injury patient c̄ 40% burn, admitted to ICU I 28 May 03. Transfered to ICU 3 via litter, alert c̄ trach collar intact. Central line (R) chest wall intact, maintenance fluid D5W & NS infusing. Sedation drips versed & Fentanyl titrated to effect. Vent setting: SIMV, TV 700, FIO2 40%, PEEP 5 Sat 100%. Burn dressing reinforce on arrival. Aline c̄ good waveform. VS: 100.2 152/79 - 121 - 28, Pt hooked up to monitor. Refer to DA 4700 for pertinent assessment. And flow sheets I & O. Foley intact put out q5 clear yellow urine [redacted] Maj IAW b(6)-2
07 Jun 03 0300	Sleeping and no s/s of distress noted. [redacted]
07 June 03	H. note: administered breathing tx consisting of .5cc albuterol & 2.5cc NS. Pt was restless at this time with a temp close to 104°F HR in 160s. administered tx and he calmed down. ice packs were also placed in axpits & groin During tx vital signs HR 131, BP 114/61, RR: 16, SPO2: 100% Pt is resting fine now. Will continue to monitor pt — CM [redacted] SIMV20/CRT b(6)-2
1713 HRS	PT NOTE HX: ROM T/M: PNT AWAKE DURING RX. PNT D/N TOLERATE RX WELL DUE TO EXCESSIVE PAIN. PNT MINIMAL AROM, ALL LIMBS. PROM PRODUCED MM TREMORS, ↑ BP, ↑ HR. PTT ↓ # reps

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. ICU 3

#[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07 JUN 03	PT NOTE CONT
	TE B/EXTREMITY. PNT PAIN & MM TREMORS ELEVATED WHEN PTT ATTEMPTED TO APPLY
	SPLINTS, D/C SPLINTS APPLICATION, 2° PAIN PROM ⓐLE (4WAY) ⓐE/W/H & ⓐLE (6WAY).
	DX: ROM
	I: SAME
	G: Ø Δ
	Sgt [redacted]
	91W1CNS PT TECH
7 JUN Ø3 1830	RT note: Pt on mech. vent c̄ 8 shiley trach. Vent settings: SIMV 16, 700, +5, 40%. Alb UD given suctioned 10cc yellow discharge from mouth & nose, Sec bloody discharge around trach. Pt sat 100%, HR 121 RR 16. Pt tolerate tx well [redacted] occasionally waking up. Sgt [redacted] 91W2Ø
8 JUN Ø3 Ø1Ø	RT note: Pt on mech vent c̄ 8 shiley trach; settings SIMV 16, 700, +5, 40%. Alb UD given Pt sats 97-99% HR 125 RR 16-18, Pt tol tx. Pt had coughing episode sats ↓ 92 suctioned & cleaned trach, sats ↑ 97%. Will continue to monitor [redacted] 91W2
8 JUN Ø3 Ø23Ø	RT note: Pt had coughing episode c̄ PIP at 40-50. Sx LSce. Pt PIP ≈ 25. Noticed rash on upper chest area Pt also spiking fever Sgt [redacted] 91W2Ø

b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Jun 03	Received report from CPT [redacted] b(6) b2. Patient sedated
0530	connected to continuous cardiac monitor. Easily arousable to voice + light stimuli. Eyes open spontaneously + ⊕ tracking. Pt ∅ respiratory distress while on ventilator via trach 8.0 Shiley. Spontaneous respirations 4-6x over SIMV 14, PIP <24 O_2 Sat 100% on FIO_2 .4. Pt has Fentanyl 1000 mcg/hr + Versed 2mg/hr infusing via (L) SC TEC; site
0630	∅ redness, swelling ⊗ drainage. All ports flush ∅ difficulty. Pt has NGT clamped. ✓'d placement Pt has act'l BS + 10 cc residual.
0730	Pt axillary temp > 102 Pt received tylenol via NGT. ↓ Versed drip 5 → 2 mg/hr. No Δ VS continues to be easily arousable. A-line zero'd + ⊕ correlation ∅ NBP.
0830	Pt versed changed to Propofol 15 mcg/kg/hr. Chem 8 re-sent + repeated am CXR. Pt temp continues > 102 Axillary. Suction thick tenacious blood tinged secretions. ⊕ cough. Pt able to cough secretions ∅ minimal suctioning. ⊗ change in O_2 Sat → 100%.
1000	Pt requiring ↑ Propofol during am dressing changes. Pt received 2nd dose tylenol via NGT for Temp > 102. Applied ice pack to arm pits. Pt started shivering with removal of dressing to lower extremities. Pt HR ↑ 160 + RR 20-23. After ⊗ stimulation x 5" pt VS ↓.

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1130	Dressing change complete. Pt has PROM to all extremities. Pedal + radial pulses palpatable. LE turns 2°-3° located (D) posterior thigh. New hair growth noted to both extremities, removed c̄ minimal bleeding. Skin pink/white (+) odor + minimal bleeding c̄ Hibiclense wash. Applied Silvadine burnpads + KERlex. Extremities elevated. Pt had soft brown Bowel movement during dressing Δ.
1330	Pt tolerated trach care. Moderate amount dry mucous noted around trach + on inner cannula. Pt positioned on (R) side ∃ distress.
1430	NO change status. Temp ↓ 100.9 (A). Continue to monitor. UOP remains > 70cc/hr. Pt sedated + easily arousable on 15mcg/kg/hr of propofol + 100 mcg Fentanyl. Continues to shiver with light stimuli
1700	END of Shift NOTE: Pt Temp 100.9 (A) received 2 doses tylenol via NGT for T > 103.4 (A). Did not tolerate ice packs noted by ↑ movement to remove packs. tolerated position changes + suctioning q 2-3° for minimal blood tinged secretions. Pt dressing changes required additional Fentanyl + Propofol for ↑ VS + shivering. Calmed ↓ ⊘ stimuli + sedation.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	b(6)-2 Mayo
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
08 JUN 2003 1205	Cont'd... IV, 20 mg lasix IV, Ca++ ~~carbonate~~ [redacted] gluconate, and 30cc kayexalate per Dr. Order. RT started albuterol neb. Will cont to assess pt. b(6)-2 [redacted] 10/SN
1300	Washed pt face c̄ NS and shaved pt. Applied bacitracin to face and sulfamylon cream to Bilat ears. D'd NGT and dophoff tes. Will cont. care. [redacted] 10/SN
1400	Pt BP Low 80s/40s. Dr [redacted] b(6)-2 notified. 500cc bolus of DSW ordered. Held TF since 0900 due to pt red glucose level. Will assess B/P. [redacted] b(6)-2 10/SN
1425	red fentanyl rate to 100mcg and red versed rate to 2mg in attempt to wean pt off the vent. Pt sats @>95%, RR high teens to low 20s. Will cont to assess pt. b(6)-2 [redacted] 10/SN
1530	Completed trach care. Pt sat 95% on RA. Cleaned trach using sterile technique. Pt coughed blood tinged sputum. Will cont. care. b(6)-2 [redacted] 10/SN
1540	Drew ABG and chem 7 per MD order. Results: HH (23, 8), pH 7.325, PCO2 37.6, PO2 112, HCO3 20 SO2 98%, K+ ↓5.1, Na+ 165, CRE 6.3, Glu 180. Dr. [redacted] notified. Maint fluid rate red 150cc/hr 10/SN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
b(6)-2			

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
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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 JUNE 03 1640	cont'd... and TF D/C'd. Will cont. care. [redacted]
1700	Gave report to night shift. — [redacted]
1915	RT note: will place pt on t. collar trials. Pt on mechanical vent now: setting SIMV 16 700 40% +5. Placed pt on t collar @ 40% @ 1925 pt sat 100%, RR 20, P 121 @ 1930 - Will continue to monitor. — Sgt [redacted] 91V20
8 June 03 2300	@ 1800 physical assessment done and no s/s of distress noted. JVD, Temp 102.8 and Rash across chest was notified to MD and order to continue to monitor. @ 1925 Trach collar test was started VS 104/50 P119, R18, pox 98%. No use of accesory muscle noted or s/s of distress. @ 2200 T 103.8 and 650 mg Tylenol was admin. @ 2300 T 103.8 will continue to monitor. [redacted]
8 Jun 03 2340	Addendum @ 2000 Dressing change and wound care offer. Wound to UE are white & pink edges draining ~~serous~~ serous nonpurulent drainage. (R+) LE have big yellow patches & edges pink. (L+) is pink. Both wound to LE are draining serous nonpurulent drainage. — Trach care done [redacted]
9 Jun 03 0430	@ 0200 T 103.6 and 650 mg Tylenol was admin. [redacted] 0400 T 102.5. Will continue to monitor. [redacted]
10 JUN 03 1120	Gave fentanyl 50mcg IVP for agitation. — [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 Jan 03 2300	@ 1800 Physical assessment done and no ds of distress noted. T 101.3 and Tylenol was admin. @ 1900 T 100.6 @ 2000 Dressing was done. wound to [redacted] white patches to pinkish edges. LE wound draining moderate amount of serous purulent drainage. wound are white c̄ pink edges. Wound cleaned c̄ hydrolens. Sylvadene was applied and cover c̄ burn dressing. Sulfamylon was applied to ear and bacitracin to face. @ 2200 Sleeping and no sx of distress noted. [redacted] CPT/AN
8 Jan 03 0400	@ 0300 T 103.8. Tylenol was admin. Will continue to monitor. [redacted] CPT/AN
0500	Received report from previous shift. Pt resting quietly c̄ eyes closed. All IV lines are intact. Trach in place. Vent: SIMV, RR 16, TV 700, FiO2 40%, peep 5, peak 22. [redacted] IGT/AN
0520	Pt has temp 103.3. Gave tylenol 650 mg via NGT. Will cont to assess temp. [redacted] IGT/AN
0620	Reviewed labs: Results: RBC 2.69, H&H 7.9, 24.6, Na+ 164, K+ 6.5, pH 7.299 TCO2 26, HCO3 24, BUN 118, GLU 235. Will notify MD of abnormal results. [redacted] IGT/AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.

CJ [redacted] [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
8 JUNE 03 0630	Dr. [redacted] b(6)-2 and Dr. [redacted] b(6)-2 notified. Repeat labs. No new orders given @ this time. Will cont. care. [redacted] b(6)-2
8 June 03 0800	Pt. Note: administered one neb. Ipra / NS 2.5cc at this time. Pt is resting comfortably & in no distress. Pt received tx without adverse reactions. HR 115 RR 16 SpO2 97% will continue to monitor pt's respiratory status — [redacted] b(6)-2 91W20/CCT.
8 June 03 1300	Pt Note: administered 1st of 3 Q2 hour tx's. pt is in no distress at this time. took pt off vent for 5 mins or so showed no sign of distress and sats stayed 95% on RA throughout trach care procedure. Pt received tx with no adverse reactions. HR: 130 BP 85/57 SpO2 95% on RA RR: 18 off of vent. will continue to monitor resp. status & suggest removal from vent and placing a trach collar as pt permits — [redacted] b(6)-2 CCT 91W20
0830	Gave pt 1/2 AMP D50, 10U Reg insulin, 20mg lasix IV per MD order. Gave pt 2mg versed IVP for agitation. Will cont. to monitor pt. [redacted] b(6)-2
0910	A-line not reading correctly. Cather is dislodged. D/C'd A-line. Dr [redacted] b(6)-2 reinserted A-line in (L) femoral artery. Zeroed A-line. Waveform is good. Will cont. care. — [redacted] b(6)-2
1000	Pt red versed rate to 7.0mg due to pt agitation. Pt had large watery brown BM. cleaned pt and d'd bilat upper leg and (L) arm drsg. Applied silvadene to these areas and wrapped wound c̄ kerlex and burn drsg.
1200	Pt has temp 103°. Gave tylenol 650mg via NGT. Will cont to assess temp. [redacted] b(6)-2
1800	Drew Chem 7 lab. Results: Glu 131, cre 6.7, Na+ 16, K+ 6.3. Gave ½ AMP D50, 10 units Reg insulin

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 JUN 03	Transfer Summary
	Young Iraqi Male who sustained 40-50% 2nd-3rd
	degree BSA (Body Surface Area) Burn on 27 MAY 2003
medications	From an unexpected explosion collecting wood.
Zantac 50mg	Current Active Problems
98°	1. 40-50% BSA Burn to face, arms, back, and legs
E-mycin drg	with 3rd degree burns to post. Thigh
to (B) Eyes	
96°	— Needs Excision & STSG when stable
(Died 9 an)	2. Acute Renal Failure thought secondary to
Lovenox	Gentamycin antibiotic Rx + Hypotension (Cr 7.1)
30mg	
SQ q 12°	Renal U/S (-) hydronephrosis (non obstructive)
Lasix 20mg IVP	Recieving Lasix 20mg IVP q 8°
98 hi	3. Severe Azotemia (BUN ↑ 128) c̄ mod
Insulin per	Edema
glucose	
	4. Hyperkalemia managed c̄ Kayexolate,
Albuterol neb PRN	Insulin/glucose & albuterol neb
Kayexolate PRN	K+ 5.6
Zosyn	5. Febrile 103-104° F s/p pneumonia
3.375gm	on Zosyn + Vancomycin — last dose ?
IV q6°	
	Vancomycin 1gm @ 0900 9 JUN 03
Vanc 1gm	6. Tracheostomy dependent ⇒ Breathing spontaneous
X1 dose	
Fentanyl/versed	on 8L O_2

HOSPITAL OR MEDICAL FACILITY	STATUS (on ⅱ)	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

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(Cont)
	Plan
	① Transfer to Baghdad facility for
(R) Femoral	Dialysis
a-line	② Needs detailed cultures for sputum / urine / blood
placed 8 JUN 03	to isolate cause of fever (possibly pneumonia)
	③ Needs Excision of 3rd degree burned skin &
(L) Subclavian	skin grafts when stable
c-line	62-2
changed on 6 JUN 03	[redacted] Hospital) LTC [redacted]
over wire	Point of Contact b(6)-2
Do blood	
tests &	
feed - Held	
to ↓ Nasal intuki	

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[redacted] b(6)-4

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b(a)-4

[redacted]

Date: 10 Jun. 04

Na	160	pH	7.329
K^+	4.8	pCO2	34.6
Cl	127	pO2	114
PCO2	17	BE	-8
BUN	135	Bicarb	18
Glu	158	TCO2	19
Hct/Hb	40/14	Sats	97 2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Jun 2003	report taken by night shift. Pt had bowel movement prior
0530	condition stable — [redacted] b(6)-2
0700	pt hyperkalemic given glucose & insulin — [redacted] b(6)-2
0900	pt dressing change on bilateral complete had bleeding granulation tissue
	on leg bilateral pt expressing pain & care fatigue. Most of bilateral
	healing & difficulty some areas on buttock & thighs with tissue
	needing further debridement. NG & coffee ground consistent [redacted]
1000	PRBC 1 unit started & difficulty — [redacted] b(6)-2
1400	2nd unit started & difficulty — [redacted] b(6)-2
1500	bowel movement dressing on buttock & upper thighs [illegible]
1700	2nd unit PRBC finished — [redacted]
1810	PT NOTE b(6)-2 [redacted]
	HX: ROM @ UE @ LE @ E/W/H
	T/M: PNT APPEARED IN SEVERE PAIN. D/N TOLERATE RX WELL. PNT EXPERIENCED
	EXCESSIVE MM TREMORS & PROM. D/C RX P 5 REPS @ UE.
	DX: CONSULT PT D/C RX PENDING TRANSFER TO INTQ FACILITY.
	I: ATTEMPTED PROM !
	G: Ø Δ
	SPC [redacted] b(6)-2
	SIMIONS PT TECH
1700	Took report from off going shift. Pt on
	40% O2 Ø Trach collar, Foley to gravity. Dobhoff

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.**

Civ [redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	NG tube in place. VSS, will continue to monitor. — [redacted] b(6)-2
1900	Hospital within Range of ammo explosion. Entire Hosp to be evac'd. Pt VSS, maint fluids flowing. Continue to do pain management will continue to monitor — [redacted] b(6)
2300	Pt appears to be sleeping peacefully. VSS. Transferred c̄ to. Will continue to monitor — [redacted] b(6)-2
2400	Pt had large BM. VSS, will continue to monitor.
0200	Pt appears to be sleeping comfortably VSS. Will continue to monitor. — [redacted] b(6)-2
0400	Pt VSS. Will continue to monitor — [redacted] b(6)-2
~~0800~~ 10 Jun 03 0530	Reported off to on coming shift — [redacted] b(6)-2
	Report taken from night shift patient condition stable pt awake + responsive c̄ adequate pulse on 40% trach collar — [redacted] b(6)-2
10 Jun 03 0730	T- 101.6 condition stable patient appears more alert — [redacted] b(6)-2
0900	pt prepared to return to hospital bed by temporary bedding & difficult transport via stretcher/ambulance — [redacted] b(6)-2
1000	Pt transported via ambulance 28th CSH for temporary care etc. condition stable — [redacted] b(6)-2
1030	pt doing a condition stable fair gait & ambulant on own authority
1130	preparing patient for transport to Iraqi hospital in Baghdad. condition stable, dressing & drains Abs — [redacted] b(6)-2
1200	pt transferred to Iraqi hospital via ambulance — [redacted] b(6)

STANDARD FORM 600 (REV. 6-97) BACK

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

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

PFC [redacted], Lt [redacted], Lt [redacted]

Dr [redacted] b(6)-2

2-104

7540-01-075-375

MEDICAL RECORD

b(6)-4 [redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT [redacted] b(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME [redacted]ESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

AGE: 20

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

DATE *(Day, Month, Year)*: 28 MAY 03

TIME: 1100

TRANSPORTATION TO FACILITY: Ambulance

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM: Pt

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: None

ALLERGIES: NKDA

CHIEF COMPLAINT: 2° Burns

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?	✓		28 May 03
INJURY/SAFETY FORMS	✓		WHERE
HOW	?		

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN: ☒ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INITIAL SERIES: ☐ YES ☐ NO

CATEGORY OF TREATMENT

☒ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME: 1100

INITIALS: [redacted] b(6)-2

VITAL SIGNS

TIME	1110	1125	1135	1145
BP	98/52	133/64	148/70	140/71
PULSE	69	66	70	71
RESP	20	25	28	32
TEMP	—	98.8 ORAL		
SpO2	100	100	100	100

LAB ORDERS

X	CBC/DIFF	ABG	X	PT/PTT	BHCG/URINE/BLOOD/QUANT
	URINE C&S	X	UA MSCC/CATH		X CHEM: 14
	BLOOD C&S X				
X	Type + Screen				
X	PT/PTT				

X-RAY ORDERS

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

ORDERS

☒ PULSE OX: 100 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1115	Morphine 10mg IV PUSH		[redacted]	1120	
	~~Fentanyl 50mg~~ Percocet Tetanus 0.5cc			1155	
1130	Morphine 5mg IV Push			1130	
1135	Cefoxitin 2gm				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS b(6)-2

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

038

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC				SUP 02	PH	PO2	RESULTS	
H/H				PCO2	SAT	OTHER		
PLT								
PT				U/A	DIP		EKG INTERPRETATION	
PTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

Pt 29 y/o ♂ presents c̄ 2°&3° burns to face, neck, back, & upper & lower extremities

PMHX ∅

Q- USS. LLTA BILAT. ⊕ BS x 4 quadrants. ⊕ tenderness to palp. ⊖ rigidity noted to abdomen. Resp even, unlabored. Pt alert & Awake, c/o pain.

PSHX ∅

Pt received 1000mL LR in the EMT.

40
50
2000
8000
12 ⟌ 4000
36

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

2° Burns to 40% of BSA.

CODES

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

[redacted] b(6) - 4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

038

MEDICAL RECORD

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: unknown

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

4. PROPOSED SURGICAL PROCEDURE:
Burn Debridement, back, (B) LE's, (B) UE's

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition: 2nd degree burns
Tobacco___ppd X___yrs. Body Piercing (Y) Diabetes (Y) (N) ROM: moving all ASA/Motrin w/72 hrs (Y) (N)
ETOH___ Implants___ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures___ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes X Language Barrier	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Skin - dirty/dusty all over foley in place.	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.~~ N/A
B. AERATION X Potential for respiratory dysfunction due to: ___ 1) Positioning X 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase [redacted] b(6)-2	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 integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened area [redacted] b(6)-2	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. 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)

[redacted] b(6)-4

Iraqi civilian

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~~ N/A
~~! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon~~
~~! Contact Precautions (Y) (N)~~
~~! Family/Friend:~~ None

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: ____ 1) Intraoperative Mobility X 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. X Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis X 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: ____ 1) Length of Surgery X 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table 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. X Potential for decreased communication due to: ____ 1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR tabl[redacted] o Pt. will be able to understand instruction[redacted] o Minimize danger of injury during intraop period. b(6)-2	o Introduce self. Keep pt. informed as [redacted] where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. b(6)-2 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] MAJ, AN b(6)-2 28 MAY 03 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

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liner with roller due to spinal

BREATHING EASY: (Y) (N)

12. PR[redacted] EVALUATION PREPARED BY (Sig[redacted] MAJ, AN b(6)-2

DATE 28 MAY 03 TIME: 1355

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

DATE 28 MAY 03 TIME: 1355

MEDICAL RECORD | **INTRAOPERATIV[redacted]CUMENT**

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

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

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

3. DATE: 28 MAY 03 TIME PATIENT ARRIVED IN SUITE: 1200

4. PATIENT IN ROOM TIME: 1200 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert. Speaks Iraqi.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC S. [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN, 66E b(6)-2 MAJ [redacted] 66E b(6)-2	RELIEF CIRCULATOR	MAJ [redacted] AN, 66E (START 1240) error

7. POSITION AND POSITIONAL AIDS (Specify) (B) arms extended at sides of head. Pillow under lower legs, hips, and chest. Penis and scrotum checked by Dr. [redacted] and MAJ [redacted] b(6)-2

☐ 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 groin & lt chest, upper

COMMENTS:

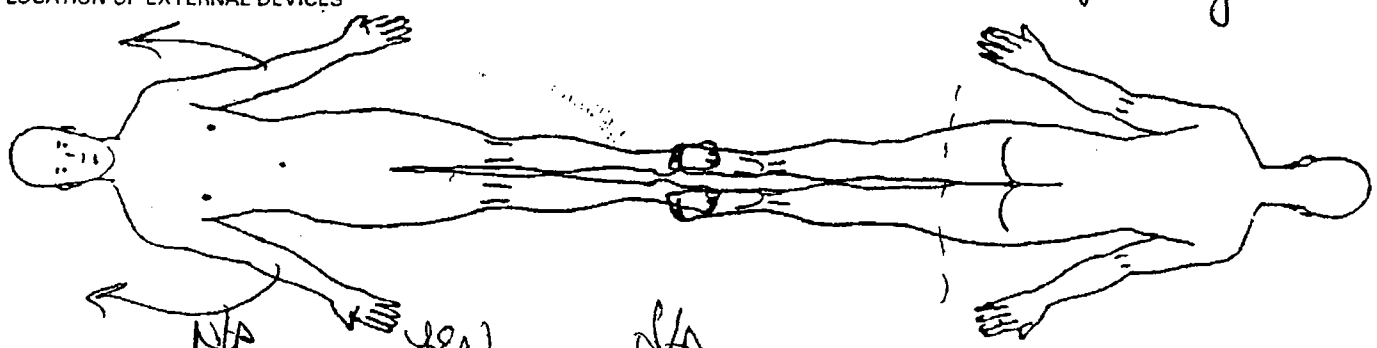
PREP SOLUTION (Specify): Betadine & NSS

SITE: Back, buttocks, BY WHOM: [redacted] b(6)-2

SITE: (B) LE, (B) UEs, BY WHOM: [redacted] b(6)-2

COMMENTS: Chux used copiously. b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

Iraqi civilian

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

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

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

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Silver Sulfadiazine Cream	1 jar	intra-op	topical	manufact.	Dr [redacted] b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION (Specify)

Legs	Arms	Back
Kerlix	Fluffs Kerlix	Burn Dressing

19. ADDITIONAL INFORMATION

Dr. [redacted] b(6)-2 MAJ [redacted], RNA b(6)-2

Bacitracin ointment to facial burns.

20. OPERATION(S) PERFORMED

Burn wounds debridement Back, Buttocks (B) LE's, (B) UE's, face Central line placement

21. PATIENT TRANSFERRED TO ICU-3 TIME 1355 METHOD Litter

[redacted] SIGNATURE [redacted] MAJ, AN b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V2.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Amb Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT, AN

3. DATE: 5 Jun 03 TIME PATIENT ARRIVED IN SUITE: 1417 OR

4. PATIENT IN ROOM [redacted] b(6)-2 TIME: 0818 NUMBER: 2-1/1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Unconscious, Intubated & Monitor.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (91D) b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (66E) b(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Anatomical position maintained during the procedure.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

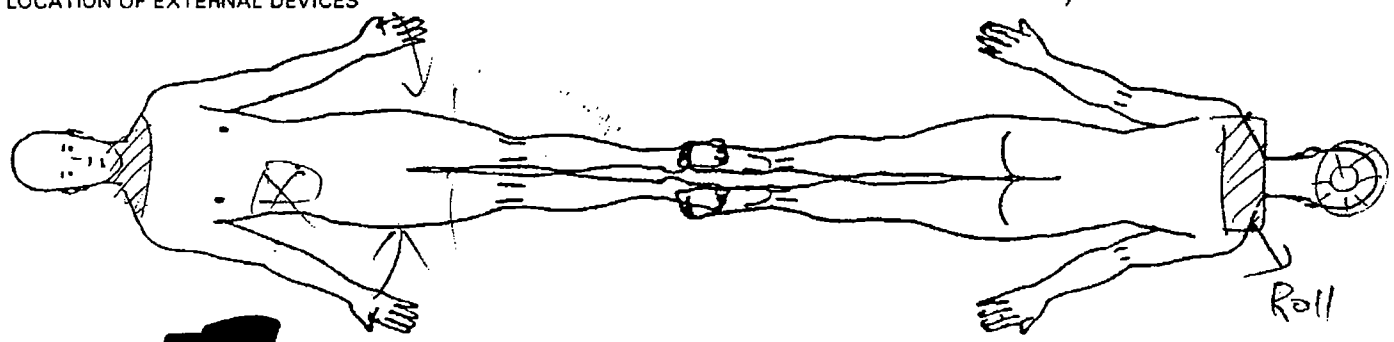
PREP SOLUTION (Specify) Betadine S/S

SITE: neck BY WHOM: [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: Pooling & sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- Safety Strap = = Tourniquet

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

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

☑ ESU NO: Valleylab FT4

GROUND PAD: BRAND Polyhesive II

LOT NO: 10528

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag: 30
Cut: 30

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
1% Silver Sulfadiazine Cream	Q.S	intra-op	topical use	SSD	MAJ Dr [redacted] b(6)-2

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	Trach #8 Spc		
SITE	Neck		

18. DRESSING/IMMOBILIZATION *(Specify)*

QX8 Burn Sheet
Fluffs & Kelix Rolls
op site.

19. ADDITIONAL INFORMATION

O.A From 5179 Reviewed & NSG Lane implemented.

Surgeon: Dr [redacted] b(6) / Dr [redacted] b(6)-2 Maj [redacted] b(6)-2 / SPC [redacted] b(6)-2

Anes: Maj [redacted] b(6)-2 (CRNA)

20. OPERATION(S) PERFORMED

Tracheostomy & Burn Dressing Change.

21. PATIENT TRANSFERRED TO 1 cu² TIME 0915 METHOD Litter [redacted]

22. REGISTERE[redacted] CPT AN

Pt # [redacted] b(6)-4

8.0 ETT
24cm @ lip

			PH	PCO2	PO2	HCO3	BE	SO2								
28may	1400	SIMV	12	700	50	5	20	1:20	0	—	51	100	108/76	8.0	MLT	ORT
28may	1600	SIMV	12	700	50	5	22	1:20	0	—	98	—	134/66			
28may	1649	ABG	7.231	48.9	266	21	-1	100								
28may	1650		(↑14)		(+40)											
28May	1800	SIMV	14	700	40	5	25	1:2	0	—	90	99	112/60	8	MLT	[redacted]
28May	2000	SIMV	15	700	40	5	24	1:2	1	—	85	99	117/67	8	MLT	
28May	2200	SIMV	15	700	40	5	23	1:2	2	—	96	100	125/68	8	MLT	
29May	0000	SIMV	15	700	40	5	24	1:2	3	—	97	99	114/62	8	MLT	
29May	0200	SIMV	15	700	40	5	22	1:2	0	—	122	98	89/66	8	MLT	
29May	0400	SIMV	15	700	40	5	23	1:2	0	—	120	98	91/62	8	MLT	
29May	0604	SIMV	15	700	40	5	23	1:2	0	—	115	100	105/63	8	MLT	
29May	0814	SIMV	15	700	40	5	24	1:2	0	—	118	100	99/63	8	MLT	
29May	1030	SIMV	15	700	40	5	23	1:2	0	—	110	99	100/55	8	MLT	
29May	1200	SIMV	15	700	40	5	24	1:2	0	—	109	97	104/66	8	MLT	
29May	1420	SIMV	15	700	40	5	24	1:2	0	—	107	100	127/74	8	MLT	
29May	1611	SIMV	15	700	40	5	23	1:2	0	—	117	100	130/75	8	MLT	
29May	1800	SIMV	15	700	40	5	26	1:2	0	—	124	98	117/68	8	MLT	
29May	2000	SIMV	15	700	40	5	2[illegible]	1:2	0	—	137	100	98/58	8	MLT	
29May	2200	SIMV	15	700	40	5	24	1:2	0	—	135	100	114/76	8	MLT	
30May	0000	SIMV	15	700	40	5	25	1:2	0	—	117	100	117/72	8	MLT	
30May	0202	SIMV	15	700	40	5	24	1:2	0	—	106	100	138/87	8	MLT	
30May	0400	SIMV	15	700	40	5	23	1:2	0	—	107	100	104/84	8	MLT	
30May	0546	SIMV	15	700	40	5	24	1:2	0	—	106	99	121/81	8	MLT	
30May	0805	SIMV	15	700	40	5	26	1:2	0	—	113	98	114/75	8	MLT	
30May	1005	SIMV	15	700	40	5	22	1:2	0	—	106	99	127/76	8	MLT	
30May	1200	SIMV	15	700	40	5	25	1:2	0	—	125	98	117/70	8	MLT	
30May	1400	SIMV	15	700	40	5	24		0	—	125	99	111/67	8	MLT	
30May	1609	SIMV	15	700	40	5	23	1:2	0	—	115	100	98/59	8	MLT	
30May	1833	SIMV	15	700	40	5	24	1:2	0	—	101	99	119/66	8	MLT	
30May	2030	SIMV	15	700	40	5	26	1:2	0	—	91	100	140/70	8	MLT	
30May	2202	SIMV	15	700	40	5	29	1:2	0	—	92	100	158/74	8	MLT	
31May	0000	SIMV	15	700	40	5	30	1:2	0	—	102	100	134/71	8	MLT	
31May	0200	SIMV	15	700	40	5	16	1:2	0	—	122	100	130/73	8	MLT	
31May	0400	SIMV	15	700	40	5	19	1:2	0	—	144	100	1[illegible]/86	8	MLT	[redacted]

b(6)-4

MEDCOM - 9315

IAU #3

Chemistry Only

Ward/Section: EMT

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

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

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

DATE: 27-M-02 | TIME: 1135 | SSN/PSEUDO SSN: [redacted] b(6)-4

[redacted]

TEST	RESULT	REF. RANGE
Na	148	138-146 mmol/L
K	3.6	3.5-4.9 mmol/L
Cl	108	98-109 mmol/L
pH	7.301	7.31-7.45
pCO2	44.9	35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
HCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	-4	(-2) – (+3) mmol/L
AnGap	21	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	9	8-26 mg/dl
GLU	198	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	49	38-51% PCV
Hgb	17	12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB	3.7	3.5-5.5 g/dl
ALP	54	26-84 u/l
ALT	25	10-47 u/l
AMY	45	14-97 u/l
AST	24	11-38 u/l
TBIL	1.3	0.2-1.6 mg/dl
BUN	7	7-22 mg/dl
CA^{++}	8.7	8.0-10.3mg/dl
CHOL	120	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	189	73-118 mg/dl
TP	6.8	6.4-8.1 g/dl

[redacted]

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

[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: [redacted] b(6)-2

EMT

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

RATORY RESULT

(Subject to the Privacy Act)

NAME: FIRST, MI. [redacted] b(6)-4 | DATE 28 MAR 09 | TIME 1135 | SSN/PSEUDONYM [redacted] b(6)-4

[redacted] Serology

	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	24.6	4.8-10.8 x 10^3	Color	yellow	N/A	RPR		Negative
	5.30	4.7-6.1 x 10^6	App	hazy	N/A	Mono		Negative
	15.5	14-18 g/dl (M) 12-16 g/dl (F)	Glu	ng	Negative	[redacted] Microbiology		
	48.9	42-52% (M) 37-47% (F)	Bili	ng	Negative	Source		
	92.4	80-94 fl (M) 81-99 fl (F)	Ket	ng	Negative	Gram Stain		
	39.2	130-500 x 10^3 verified	SG	1.020	N/A	Occ Bld		
%	13.6	20.5-51.1%	Bld	ng	Negative	H. pylori		
[redacted]			pH	6.0	N/A	Micro Parasites		
		Mono	Prot	ng	Negative	Malaria		
		Eos	Urob	ng	0.2-1.0	O & P		
		Baso	Nit	ng	Negative	Other		
		Imm	Leuk	N/A	Negative	[redacted] Microscopic Urinalysis		
			HCG		Negative			
		42-52% (M) 37-47% (F)	[redacted] Blood Bank					
			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
			Directigen		Negative	ABO/Rh		

[redacted] WHOLE BLOOD

TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
	13.4	9.8-13.6 secs			
	26.0	21-34 secs			
		<20 ug/ml			
		<10 ug/ml			

REMARKS: /

[redacted] b(6)-2 | DATE: 28 Mar 09 | LAB ID NO.: 007

[redacted]

Chemistry Only

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

LAST, FIRST, MI. CIV [redacted] b(6)-4	DATE 29MAY03	TIME 0400	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Serum

TEST	RESULT	REF. RANGE
GLU	151	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	217	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	5.0	3.3-4.7 mmol/l
CL^-	111	98-108 mmol/l
tCO_2	20	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 29 MAY '03	LAB ID NO.:

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
[redacted] b(6)-4	29 May 03	0400	[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	12.1	4.8-10.8 x 10³
RBC	5.66	4.7-6.1 x10⁹ (M)
Hgb	16.7	14-18 g/dL (M) 12-16 g/dL (F)
Hct	52.2	42-52% (M) 37-47% (F)
MCV	92.3	80-94 fl (M) 81-99 fl (F)
Plt	267	130-500 x10³ verified
Lymph %	1.8	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

1 CW1

CW [redacted] b(6)-4

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

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

DATE	TIME	SSN/PSEUDO [redacted] b(6)-4
30 May 03	0400	

(i-STAT)

TEST	RESULT	REF. RANGE
Na+	137	133-146 mmol/L
K+	4.9	3.5-4.9 mmol/L
Cl-	106	96-106 mmol/L
pH	7.420	7.350-7.450
pCO2	26.5	35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
HCO3	18	23-27 mmol/L (art) 24-29 mmol/L (ven)
TCO2	17	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2(%)		95-98%
BE	-7	(-2)-(+2) mmol/l
iCa++	19	16-20 mmol/L
iCa++		1.12-1.32 mmol/L
BUN	27	8-26 mg/dl
Glucose	206	70-105 mg/dl
Creatinine		0.7-1.5 mg/dl
Hematocrit	46	38-51% PCV
Hemoglobin	16	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE

(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) Cardiac Markers

TEST	RESULT	REF. RANGE
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
tCO2		16-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118
BUN		7-22
CA++		8.0-10.3
CRE		0.6-1.2
NA+		128-145
K+		3.3-4.7
CL-		98-108
tCO2		16-33

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		16-33 mmol/l

REMARKS:

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

DATE: 30 May 03

LAB ID NO.:

Ward/Section: ICU	REQUES[redacted] PHYSICIAN: [redacted] 3(6)-2	LAB[redacted]TORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. CIV [redacted] 1(6)-4	DATE 30 May	TIME 0400	SSN/PSEUDO SSN: [redacted] 1(6)-4

[redacted] CBC

TEST	RESULT	REF. RANGE
WBC	4.1	4.8-10.8 x 10^3
RBC	5.06	4.7-6.1 x 10^9
Hgb	14.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	46.5	42-52% (M) 37-47% (F)
MCV	91.9	80-94 fl (M) 81-99 fl (F)
Plt	194	130-500 x 10^3 verified
Lymph %	28.3	20.5-51.1%

[redacted] Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

[redacted] 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

[redacted] Micro/Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

[redacted] Hemostasis

[redacted] BLOOD

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.:

ICU

[redacted] PHYSICIAN: b(6)-2

[redacted] CHEMISTRY RESULT
(Subject to the Privacy Act of

[redacted] b(6)-4

DATE	TIME	SSN/PSEUDO SSN
31 Mar 03	0450	[redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-107 mmol/L
		[illegible]
		35-45 mmHg (art) 31-41 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		3-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE

(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) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		[illegible]
BUN		[illegible]
CA^{++}		[illegible]
CRE		[illegible]
NA^+		[illegible]
K^+		[illegible]
CL^-		98-106 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	153	73-118 mg/dl
BUN	18	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	783	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	4.5	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	24	18-33 mmol/l

Remarks:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	31 MAR 03	

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

LAST, FIRST, MI: Sw #[redacted] b(6)-4	DATE: 21 May 03	TIME: 0400	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	2.9	4.8-10.8 x 10^3
RBC	4.13	4.7-6.1 x 10^9
Hgb	12.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.2	42-52% (M) 37-47% (F)
MCV	92.6	80-94 fl (M) 81-99 fl (F)
Plt	179	130-500 x 10^3 verified
Lymph %	22.6	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 31 May 03	LAB ID NO.:

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
[redacted] b(6)-4	1 Jun 03	0400	[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.1	4.8-10.8 x 10³
RBC	3.79	4.7-6.1 x10⁹ (M)
Hgb	11.0	14-18 g/dL(M) 12-16 g/dL(F)
Hct	34.7	42-52 % (M) 37-47%(F)
MCV	91.4	80-94 fl (M) 81-99 fl(F)
Plt	85	130-500 x10³ verified
Lymph %	8.6	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative

Microbiology

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

Microscopic Urinalysis

Est. platelet count of 78
no platelet clumping
normal sized platelets.

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

ICU

[redacted] b(6)-2

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

CIV [redacted] b(6)-4

DATE	TIME	SSN/SERVICE NO.
13 Jan 03	0400	[redacted] b(6)-4

(i-STAT)

RESULT	REF. RANGE
	138-146 mmol/L
	3.5-4.9 mmol/L
	98-109 mmol/L
	[illegible]
	35-45 mmHg (art) 41-51 mmHg (ven)
	80-105 mmHg (art) N/A (ven)
	23-27 mmol/L (art) 24-29 mmol/L (ven)
	22-26 mmol/L (art) 23-28 mmol/L (ven)
	95-98%
	[illegible] mmol/L
	16-26 mmol/L
	1.12-1.32 mmol/L
	8-26 mg/dl
	70-105 mg/dl
	0.7-1.5 mg/dl
	38-51% PCV
	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	~~1.6~~ 2.0	3.5-5.5 g/dl
ALP	~~94~~ 50	26-84 u/l
ALT	~~79~~ 25	10-47 u/l
AMY	~~43~~ 139	14-97 u/l
AST	~~94~~ 97	11-38 u/l
TBIL	~~0.4~~ 2.7	0.2-1.6 mg/dl
BUN	~~7~~ 25	7-22 mg/dl
CA++	~~7.9~~ 6.8	8.0-10.3mg/dl
CHOL	~~123~~ 47	100-200 mg/dl
CRE	~~0.5~~ 1.9	0.6-1.2 mg/dl
GLU	~~120~~ 147	73-118 mg/dl
TP	~~5.9~~ 4.6	6.4-8.1 g/dl

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/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
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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
GGT		9-85 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+	136	128-145 mmol/l
K+	4.2	3.3-4.7 mmol/l
CL-	100	98-108 mmol/l
tCO2	—	18-33 mmol/l

REMARKS:

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

DATE: 13 Jan 03

LAB ID NO.:

Civ # [redacted] 5/6/-4

[redacted] 5/6/-4

ICU 25 Jun 03

TEST(S)		
SPECIMEN TAKEN		
DATE	TIME	A.M.
Jun	0400	P.M.
RESULTS	REQUESTED	(X)
108	GLUCOSE	
56	UREA N.	
	CREATININE	
	URIC ACID	
139	SODIUM	
4.6	POTASSIUM	
104	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
35	HCT	
12	Hgb	

REMARKS [redacted] Methylpred 8 gr Simvar 5/6/-2

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE [redacted] 5/6/-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY [redacted] MD DATE 25 Jun 03

CHEM 1

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

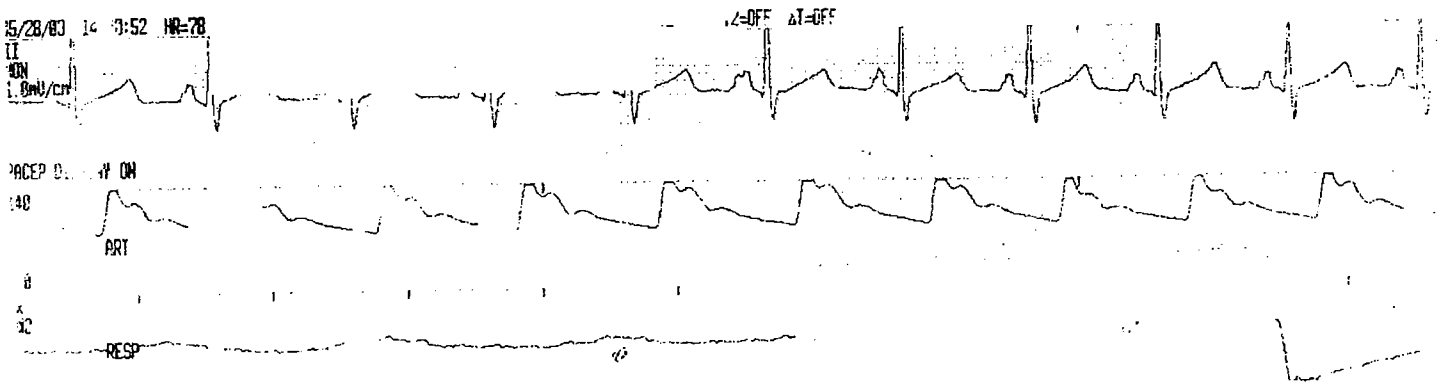
LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

546-107



LAST CAD! DO NOT TAKE make COP

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
CAV [redacted] b(6)-4	2Jan03	0400	[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.5	4.8-10.8 x 10^3
RBC	3.82	4.7-6.1 x 10^6
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.2	42-52% (M) 37-47% (F)
MCV	92.2	80-94 fl (M) 81-99 fl (F)
Plt	36	130-500 x 10^3 verified
Lymph %	15.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph	Plt estimate count of 41 adequate size platelets no platelet clumping seen		

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	

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 SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

BLOOD BANK SERVICES (MUST SUBMIT SF 518 FOR EACH UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	02 Jan 03	

ICU 1

[redacted] b(6)-4

PHYSICIAN: [redacted] b(6)-2

DATE: 30JUN03 TIME: 0400

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

[redacted] b(6)-4

(i-STAT)		
TEST	RESULT	REF. RANGE
		138-146 mmol/L
		[illegible] mmol/L
		98-109 mmol/L
		[illegible]
		75-45 mmHg (art) [illegible] mmHg (ven)
		83-108 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		23-26 mmol/L (art) 23-28 mmol/L (ven)
		[illegible]
		[illegible] mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-20 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry		
TEST	RESULT	REF. RANGE

(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE
ALB	1.6	3.5-5.5 g/dl
ALP	44	[illegible]
ALT	34	10-47 u/l
AMY	39	24-97 u/l
AST	62	[illegible]
TBIL	1.1	0.2-1.0 mg/dl
BUN	74	7-22 mg/dl
Ca^{++}	7.5	8.0-10.3mg/dl
CHOL	119	100-200 mg/dl
CRE	3.5	0.6-1.2 mg/dl
GLU	~~122~~	73-118 mg/dl
TP	5.1	6.4-8.1 g/dl

(Piccolo) Metabolic 8		
TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
~~CK~~		~~39-386 u/l (M)~~ 30-190 u/l (F)
Na^+		128-145 mmol/l
K^+		[illegible] mmol/l
Cl^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE
GLU		[illegible] mg/dl
BUN		7-22 mg/dl
Ca^{++}		[illegible] mg/dl
CRE		[illegible] mg/dl
Na^+		[illegible]
K^+		[illegible]
Cl^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus		
TEST	RESULT	REF. RANGE
ALB		[illegible] g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		[illegible]
AST		[illegible]
TBIL		[illegible] mg/dl
GGT		[illegible] u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte		
TEST	RESULT	REF. RANGE
Na^+	145	128-145 mmol/l
K^+	4.7	[illegible] mmol/l
Cl^-	111	98-108 mmol/l
tCO_2		18-33 mmol/l

COMMENTS:

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

DATE: 30Jun03

LAB ID NO.:

LAST CADV DO NOT TAKE MAKE COP

Ward Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
1CW1	[redacted] b(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
CW [redacted] b(6)-4	30JAN03	0400	[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.9	4.8-10.8 x 10^3
RBC	3.48	4.2-5.4 x 10^6
Hgb	10.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.5	42-52% (M) 37-47% (F)
MCV	93.5	80-94 fl (M) 81-99 fl (F)
Plt	60	130-500 x 10^3 verified
Lymph %	11.0	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	platelets decreased	

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	30JAN03	

ICU

CW # [redacted] b(6)-4 [redacted] b(6)-2

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

DATE	TIME	SSN/PSEUDO SSN:
4Jan03	2115	[redacted] b(6)-2

(i-STAT)

TEST	RESULT	REF. RANGE
		135-146 mmol/L
		[illegible] mmol/L
		[illegible]
		[illegible]
		[illegible]
		60-105 mmol/g (art) [illegible]
		23-27 mmol/l (art) 24-29 mmol/L (ven)
		22-26 mmol/l. (art) 23-28 mmol/L (ven)
		95-98%
		[illegible] mmol/l
		19-26 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		[illegible] mg/dl
		0.7-1.5 mg/dl
		36-51% PCV
		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		[illegible]
[illegible]		[illegible]
AMY		14-97 [illegible]
AST		[illegible]
TBIL		0.2-1.0 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CK		0.6-1.2 mg/dl
CL		75-118 mg/dl
TP		[illegible] g/dl

(Piccolo) Metabolic 8

TEST	RESULT	REF. RANGE
GLU	106	73-118 mg/dl
BUN	60	7-22 mg/dl
CRE	3.1	0.6-1.2 mg/dl
CK	300	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	154	128-145 mmol/l
K^{+}	4.1	3.5-5.7 mmol/l
CL	92	[illegible] mmol/l
tCO_2	19	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		[illegible]
CA^{++}		[illegible]
CRE		[illegible]
NA		[illegible]
K^{+}		[illegible]
CL		95-106 mmol
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		[illegible]
ALP		26-84 [illegible]
ALT		[illegible]
AMY		[illegible]
AST		[illegible]
TBIL		[illegible]
GGT		[illegible]
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		[illegible]
K^{+}		[illegible] mmol/l
CL		[illegible] mmol
tCO_2		[illegible] mmol/l

COMMENTS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	4Jan03	

Ward/Section: 1231	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 5JUN03	TIME: 0400	SSN/PSEUDO SSN: [redacted] b(6) 4

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB	1.6	3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP	41	26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT	26	10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY	101	14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST	42	11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL	0.8	0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN	88	7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}	7.0	8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL	105	100-200 mg/dl	[redacted]		
BEecf		(-2) – (+3) mmol/L	CRE	4.2	0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU	143	73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP	5.2	6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	[redacted]			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+		128-145 mmol/l	[redacted]		
Troponin-I			K^+		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-		98-108 mmol/l	NA^+	154	128-145 mmol/l
			tCO_2		18-33 mmol/l	K^+	6.1	3.3-4.7 mmol/l
						CL^-	114	98-108 mmol/l
						tCO_2	24	18-33 mmol/l

REMARKS:

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

b(6) - 2

Ward/Section: 1W 1	RE[redacted]TING PHYSICIAN: [redacted] b(6)-2	LA[redacted]ATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4	DATE: 5JUN08	TIME: 0400	SSN/PSEUDO SSN: [redacted] b(6)-4

Hematology: CBC			[redacted]			[redacted]		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	7.6	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.27	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	29.9	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	91.4	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	128	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	16.4	20.5-51.1%	Bld		Negative	H. pylori		Negative
Hematology: Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			[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: [redacted]

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

b(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] 6(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW	DATE: 06 June	TIME: 0400	SSN/PSEUDO SSN: [redacted] 6(6)-4

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	[redacted]		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	[redacted]			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU	220	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	91	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE	4.5	0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			CK	594	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+	151	128-145 mmol/l	[redacted]		
Troponin-I			K^+	5.4	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-	118	98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2	20	18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

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

Ward/Section: ICU1	REQUESTING PHYSICIAN: [redacted] 560-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW	DATE: 06 June	TIME: 0400	SSN/PSEUDO SSN: [redacted] 604

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	7.2	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.18	4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	29.0	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	91.2	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	201	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	[illegible]	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]			Blood Bank		
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: [redacted] 560-2	DATE: 6 JUN 03	LAB ID NO.:

TEST(S)

SPECIMEN TAKEN

DATE 7JUNE TIME 0745 A.M. P.M.

RESULTS	REQUESTED	(X)
198	GLUCOSE	X
90	UREA N.	X
4.7	CREATININE	X
	URIC ACID	
161	SODIUM	X
5.6	POTASSIUM	X
127	CHLORIDE	X
20	CO_2	X
	PHOSPHATE	
7.1	CALCIUM	X
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS METABOLIC PANEL

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

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

REPORTED BY [redacted] b(6)-2 MD 7 JUNE 03 TECH DATE

CHEM I: URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒ Need

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

SPECIMEN SOURCE ☒ BLOOD ☐ OTHER (Specify)

LAB. ID. NO. CT

SPECIMEN/LAB. RPT. NO.

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

PATIENT'S MED. RECORD

ICU #3

[redacted] b(6)-4

TEST(S)

SPECIMEN TAKEN

DATE 7 June 03 TIME 0230 A.M. P.M.

REQUESTED

RESULTS

Glu 161
Bun 101
Na 160
K 5.2
Cl 124
Hct 26
Hgb 9

REMARKS Chem 8

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY b(6)-2 MD ECH DATE

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

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

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO

MISCELLANEOUS
STANDARD FORM 557 (Rev 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

PATIENT'S MED. RECORD

ICU 3

[redacted] b(6)-4

CHEM I: URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH DATE

LAB. ID. NO.

REMARKS CBC

TEST(S)

SPECIMEN TAKEN DATE 7 June 03 TIME 0230 A.M. P.M.

RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

[redacted] b(6)-4

Pt Name:_____

Na_____164 mmol/L

K_____5.0 mmol/L

TCO2_____21 mmol/L

iCa_____1.16 mmol/L

Hct_____23 %PCV

Hb*_____8 g/dL

*via Hct

At 37C

pH_____7.325

PCO2_____37.6 mmHg

PO2_____112 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

SO2*_____98 %

*calculated

FIO2_____: 40

Sample Type : ART

08JUN03 15:46

Oper: [redacted]

Physician:_____

Ser# 40746

Ver: JAMS0450
VER P91

Chemistry Only

Ward/Section: ICU3	REQUESTING PHYSICIAN:		**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)	DATE [redacted]	TIME 1600	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		1.12-1.32 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		

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	180	73-118 mg/dl
BUN	101	7-22 mg/dl
CRE	6.3	0.6-1.2 mg/dl
~~CK~~		~~39-380 u/l (M)~~ 30-190 u/l (F)
NA^+	165	128-145 mmol/l
K^+	5.1	3.3-4.7 mmol/l
CL^-	132	98-108 mmol/l
tCO_2	21	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

[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: (b)(6) [redacted]	DATE: [redacted]	LAB ID NO.:

[redacted]

Chemistry Only

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)	DATE: [redacted]	TIME: 0710	SSN/PSEUDO: # [redacted] b(6)-2

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	[redacted]		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	[redacted]			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU	215	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	100	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE	5.8	0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			CK	X	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+	162	128-145 mmol/l	[redacted]		
Troponin-I			K^+	6.0	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-	130	98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2	21	18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 8 Jan	LAB ID NO.:

[redacted]

Ward/Section: ICU 3

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

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

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

DATE: 8 Jun 03 | TIME: 0410 | SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	4.6	4.8-10.8 x 10^3
RBC	2.69	4.7-6.1 x 10^9
Hgb	7.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	24.6	42-52% (M) 37-47% (F)
MCV	91.4	80-94 fl (M) 81-99 fl (F)
Plt	343	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. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 8 Jun 03

LAB ID NO.:

Chemistry Only

Ward/Section: ICU 5	REQUESTING PHYSICIAN: [redacted] b(6)-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4		DATE: [redacted]	TIME: 0410	SSN/PSEUDO SSN: [redacted] b(6)-4

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	164	138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K	6.5	3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl	127	98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH	7.299	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	39.0	35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	[redacted]		
BEecf	-7	(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap	24	10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN	118	8-26 mg/dl	[redacted]			ALT		10-47 u/l
GLU	235	70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct	22	38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb	7	12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+		128-145 mmol/l	[redacted]		
Troponin-I			K^+		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-		98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2		18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

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

Chemistry Only

Ward/Section: 1C43	REQUESTING PHYSICIAN: DR. [redacted] 66-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted]	66-4	DATE: 6 JUN 98	TIME: 1155	SSN/PSEUDO SSN:

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	[redacted]		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	[redacted]			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU	131	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	98	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE	6.7	0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			~~CK~~		~~39-380 u/l (M)~~ ~~30-190 u/l (F)~~	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+	162	128-145 mmol/l	[redacted]		
Troponin-I			K^+	6.3	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-	124	98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2	20	18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: 66-2 [redacted]	DATE: 8 JUN 98	LAB ID NO.:

Chemistry Only

Ward/Section: ICU # 3

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

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

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

DATE: [redacted] TIME: 0330

SSN/PSEUDO 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		

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	156	73-118 mg/dl
BUN	108	7-22 mg/dl
CRE	6.4	0.6-1.2 mg/dl
CK	327	39-380 u/l (M) 30-190 u/l (F)
NA+	151	128-145 mmol/l
K+	6.1	3.3-4.7 mmol/l
CL-	121	98-108 mmol/l
tCO2	20	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
tCO2		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
tCO2		18-33 mmol/l

REMARKS:

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

DATE: 9 [illegible]

LAB ID NO.:

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. Ch[redacted] b(6)-4	DATE 9Jan03	TIME 0330	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	4.8	4.8-10.8 x 10^3
RBC	2.48	4.7-6.1 x 10^9
Hgb	7.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	22.8	42-52% (M) 37-47% (F)
MCV	92.1	80-94 fl (M) 81-99 fl (F)
Plt	386	130-500 x 10^3 verified
Lymph %	26.9	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. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

BLOOD

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 9 Jan03	LAB ID NO.:

Chemistry Only

Ward/Section: ICU-3	REQUESTING PHYSICIAN:		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: #[redacted]	DATE: [redacted]	TIME: 1200	SSN/PSEUDO SSN: [redacted]

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	[redacted]		
BEecf		(-2) -- (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
CL		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	[redacted]			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Crea		0.7-1.5 mg/dl	GLU	176	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	128	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE	7.1	0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			CK	1364	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+	136	128-145 mmol/l	[redacted]		
Troponin-I			K^+	5.6	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-	117	98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2	19	18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

Piccolo o istat

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Ephedrine	(cc)	25
Omeprazole / Sux	(mg)	100/100
Induction	(mg)	5 2 1 2
VERSED	(mg)	2.5
Atropine	(mg)	
Ephedrine	(mg)	10 10
Volatile Agent	% del	Forane
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8-2-2-2-2-2-2

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

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

FLUIDS		
LINE-site	LL	1L
USC	NS	2

LOSSES	
EST BLOOD LOSS	
URINE –	450

TOTALS	
5cc	
2.5 mg	
10 mg	
TOTAL FLUID	min
TOTAL URINE	450

FLUIDS – SUMMARY
CRYSTALLOID– 2000
COLLOID– 0
BLOOD– 0

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70.7 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 140/59 HR– 61

SIGN CHECK: OK?– Y N

PATIENT CHECK: OK for PROCEDURE? Yes TIME– 1200

TIME → 1200 30 1300 30 1400

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

220 200 180 160 140 120 100 80 60 40 20

	1200	30	1300	30	1400
VT – ml	730	760	780	790	790	790	790
f – breaths/min	8	10	12	10	10	10	10
Peak inf pres / PEEP	16	15	15	16	15	15	15
MODE– S(pon), A(ssist), C(on)	S C	C	C	C	C	C	C
ET CO2 (torr)	45	37	35	34	31	31	30
FIO2 (Frac or %)	.69	.68	.68	.66	.66	.66	.68
SpO2 (%)	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR
TEMP- site							
N-M Block (T/4)		4/4	4/4	4/4	4/4		

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer

Warming blkt: Warm Room
Conv warmer:

Mark with letters & symbols, explain under REMARKS

EVENTS — Position: ai ai-ioA — ai

REMARKS– Code drugs with numbers, events with letters

(L) Subclavian pert. M.D. [redacted] b(6)-2

1300 Ancef 1 Gm IV

Silvadene Creme to Body Burns

1315 CKR

(W) Subclavian proper position R/L lung

RECOVERY AT 1400
PACU ICU #1 (Specify) OTHER
CONDITION: Intact resp
RESP– 12 vent SpO2– 100%
BP– 173/78 HR– 68

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1150	1200	1415
	Ready	Begin	End
PROC	1205	1240	1345

PROCEDURES and CPT Codes: Debridement Burns

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

[redacted] b(6)-4 IRAQ CIV

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Tube taped, Eyes taped, SCUI, DVOE x1, RSI, atraumatic, cuff ↑, BS=B

SURGEONS: Dr. [redacted] b(6)-2

ANESTHETIST: [redacted] MAJ CRNA b(6)-2

PROCEDURE LOCATION: OR #1

DATE: 28 May 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 9345

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE:
SURGICAL SERVICE:
NPO SINCE:

HABITS:
TOBACCO: unknown
ETOH:
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: ____/____
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	IRAQ BORN VICTIM
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	Ø MED HX
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	interpret of
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	Blast Injury
	N	Y	from Bomb
Familial HX	N	Y	explosion

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION

BP ___ HR ___ R ___ T ___
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck
Oropharnyx
Nares
CHEST: S1 S2 Clr
CARDIAC:
EXTREMITIES: Chest Scattered Ronchi
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b(6)-2

The patie[redacted]ian seems to understand and agrees. Questions answered.
Signed: [redacted] MAJ CRNA Date: 28 May 03 Time: 1200 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward)

[redacted] b(6)-4

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.

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)							
Vecuron	(mg)	5	5					5
Fentanyl	(MCG)	100		50/50	50			
	( )							
	( )							
	( )							
	( )							
VOLAT AGENT	% del	1.5	1.5	1.5	1.5	1.5	X	
	% e.t.							
AIR	L/Min							
N2O	L/Min							
O2	L/Min	2	2	2	2	2	6	6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1) (2) (3) (4)

LINE site			
Lt SCL	☐ Warmed	NS	600 — 800
versed gtt	☐ Warmed	3mg/hr	
fent gtt	☐ Warmed	25µg/hr	
	☐ Warmed		

LOSSES	
EST BLOOD LOSS	
URINE –	50 — 150

TOTALS	
250µg	

TOTAL TIME: min

TOTAL URINE: 150

FLUIDS – SUMMARY
CRYSTALLOID – 800
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

Pt & chart ✓. Lab confirmed. OK
(1) To room fully monitored, hand vent 100% O2 via ambu bag.
(2) 2 syn 3.375 gm
(3) Trach in place, ETT removed.
(4) To ICU stable, full monitors, vent by ambu, 100% O2.

PHYS. STATUS: 1 2 3/4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 325.00

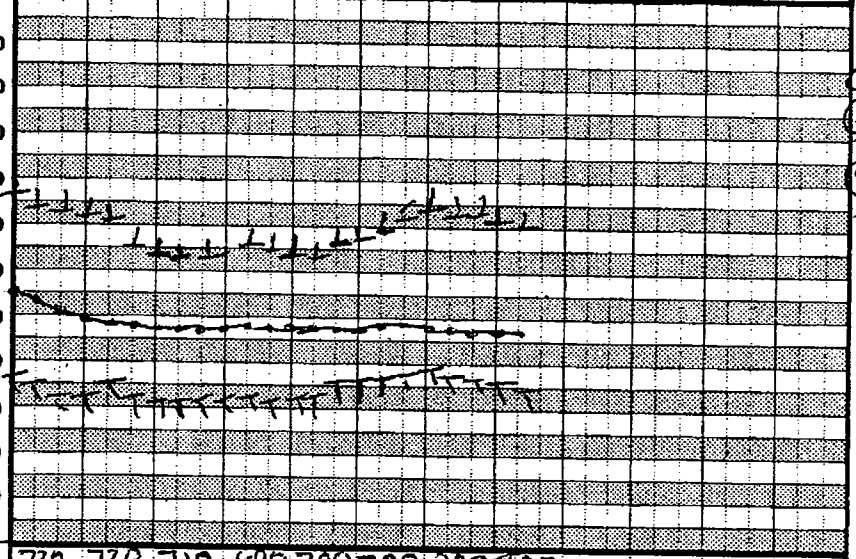
INITIAL DATA: BP – 152, 74 HR – 110

TEMP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? Y TIME – 0750

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

TIME → 30 × 09 × 30 × 10 × 30 × 11



VT – ml	720	720	710	690	700	700	700	800
f – breaths/min	12	12	12	12	12	12	12	12
Peak inf pres / PEEP	22	22	22	24	24	25	25	25
MODE – S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C
✓ BP/Auto Cuff — ✓ ETCO2 (torr)	36	34	34	36	36	32	34	32
BP / oth — ✓ FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	0.7	0.8	0.8
ART line — ✓ SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES — ✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP- site								
N-M Block (T/4)								
Warming blkt								
Conv warmer								

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

RECOVERY AT: PACU (ICU) 1 (Specify) OTHER

CONDITION: RESP – V/O SpO2 – 100 BP – 167/85 HR – 100

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	0805	0815	1020
PROC	Ready	Begin	End
	0825	0845	1005

PROCEDURES and CPT Codes
(1) Tracheostomy
(2) Bilat [redacted] dssg Δs, multiple

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Intub from ICU, (4) ETCO2, BJEB.

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

SURGEONS: [redacted] b(6)-2

[redacted] MAJ, CRNA

PROCEDURE LOCATION: 2-1
DATE: 6/5/03
PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ?25 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Trach, ? dssg Δ in OR
SURGICAL SERVICE: GS
NPO SINCE: 0400

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

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
() Fent gtt 25mg/hr
() versed gtt 3mg/hr
() lovenox
() Gent
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 10.1 / 32.5
U/A: ____
OTHER: ____

SIMV 16
700 VT
40%
5 PEEP

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

Burns from bomb blast, see prior preop record

ASSESSMENT
PAST SURGICAL/ANESTHETIC
multiple

PHYSICAL EXAMINATION
BP 160/81 HR 98 R ✓ T ____
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 0400 tube feeds stopped

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 gu[redacted]o understand and agrees. Questions answered. intubated & sedated
Signed: [redacted] CRNA Date: 6/5/03 Time: 0715 Hrs

POST-ANE[redacted]A EVALU[redacted]ION ASU)
{ } NO APPARENT ANESTH[redacted]NS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU 1

[redacted] (1st case)
(b6)-4

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

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

DATE REQUESTED 9 June 03

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE 45% BSA Burn

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER [redacted] b(6)-2 May AN

REMARKS: Urgent

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 9 June 03

TIME VERIFIED 0820

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. FH08351 FH08351

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatable

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DONOR

ABO O

Rh positive

RECIPIENT

ABO AB

Rh positive

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 9 JUN 03

REMARKS: EXP DATE 13 JUN 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 1342 ON *(Date)* 9 June 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] b(6)-2 May AN

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION TEMP. 102.1 (AN) PULSE 119 BP 122/55

DATE OF TRANSFUSION 9 Jun 03

TIME STARTED ~~1400~~ 1345

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 9 June 03 1700

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE 103 ORAL

PULSE 114

BLOOD PRESSURE 122/57

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] b(6)-2 By AN

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

SEX M

WARD 10U-3

#[redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 9349

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

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

DATE REQUESTED 9 Jun 03

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* Dr [redacted] b(6)-2

DIAGNOSIS OR [redacted]URE

45% BSA burn

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER [redacted] b(6)-2 AN

REMARKS: Urgent

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 9 Jun 03

TIME VERIFIED 0520

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 5304276

5304276

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Compatable

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DONOR

ABO O

Rh Positive

RECIPIENT

ABO AB

Rh positive

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 9 JUN 03

REMARKS:

EXP DATE 12 JUN 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 1025 ON *(Date)* 9 JUN 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] b(6)-2

[redacted] b(6)-2

TEMP. 101.7 PULSE 119 BP 120/54

DATE OF TRANSFUSION 9 June 03

TIME STARTED 1035

POST-TRANSFUSION DATA

AMOUNT GIVEN 330 ML

TIME/DATE COMPLETED/INTERRUPTED 1336 / 9 Jun 03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 102.2

PULSE 117

BLOOD PRESSURE 124/60

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES [redacted]t, clots, etc.)

- [x] NO [redacted]

SIGN[redacted]ABOVE b(6)-2 [redacted]

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

m

WARD ICU3

[redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 9350

Medical Record Copy

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 28 May 03 TIME OF ORDER 1125 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to BURN ward
Dx 40% 2nd° BSA burn
Condition Stable
IVF LR @ 300 cc/hr X 6 hrs
Meds: [redacted]
~~MSO4 2-10mg IVP PRN q 4h~~
~~Versed 1-2mg IVP PRN q 2h~~

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Silvadene to burns B/O b(6)-2
c̄ Therm chgs
CPM
On't pulse oximetry [redacted]
Foley to gravity drainage
~~4L O2 NC keep O Sat >~~
Eyemm drops to (B) Eyes q 8o

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

VS q 1h / Strict I/O
NKDA
keep ambient temp warm use warming blanket for showers [redacted]
Bacitracin to face [redacted]
ABG on arrival [redacted] b(6)-2
CXR qAM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

CBC, chem 7 in AM
Vent settings
TV 700 cc
FiO2 50%
Rate 14
PEEP 5
Adhere to continuous phenobarbitone
Fentanyl drip 50mg/hr titrated to effect
~~Versed 2mg/hr titrated to effect~~
Dobhoff - need KUB [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE: 2007 [illegible]

"USE ONLY I NO CARBON PAPER REQUIRED" [redacted] b(6)-2

MEDCOM - 9351

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

CIV # [redacted]

b(6)-4

NURSING UNIT: ICU I | ROOM NO. | BED NO.

DATE OF ORDER: 5/28/03 | TIME OF ORDER: 1420 HOURS | LIST TIME ORDER NOTED AND SIGN

~~① Please start Fentanyl drip start @ 50mcg/hr titrate to effect~~

~~② Versed drip start @ 2mg/hr also titrate to effect.~~

[redacted] b(6)-2

PATIENT IDENTIFICATION

CIV # [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5/28/03 | TIME OF OR[redacted] 1800 HOURS

Zantac 50 mg IVPB q 8°

[redacted] b(6)-2

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 May | TIME OF ORDER: 1600 HOURS

clarification: Continue IV LR @ 300cc/hr V.O DR. [redacted] b(6)-2

[redacted] b(6)-2

24° [redacted] 5/28/03

PATIENT IDENTIFICATION

CIV # [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 May 03 [redacted] HOURS 1130

① Δ IVF to D5W @ 150 cc/h + 50 cc/h 5% Albumin [redacted]

② Give 500cc boluses [redacted]

③ Needs KUB for Dobhoff placement [redacted]

④ CXR, chem [redacted] GAM [redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION [illegible] USED.

MEDCOM - 9352

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: ICU #1 | ROOM NO. | BED NO.

DATE OF ORDER: 30MAY03 | TIME OF ORDER: 1630 | HOURS | LIST TIME ORDER NOTED AND SIGNATURE

V.O. from Dr. [redacted] b(6)-2

No dsg Δ tonight [redacted] b(6)-2

[redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

DATE OF ORDER: 30 03 b(6)-2 | TIME OF ORDER: 1500 | HOURS

(1) Per Dr. [redacted] V/O 500cc Hespan bolus

(2) Infuse Isolyte plus @ 300cc/hr per Dr. [redacted] V/O. b(6)-2

(3) K-Vit w/ Wound Elixir via dobhoff for 102°F temp per Dr. [redacted] V/O b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

DATE OF ORDER: 31 May 03 | TIME OF ORDER: 0530 | HOURS

(1) Zosyn 3.375gm IV q 6°

(2) ~~Gentamycin 70mg IVq 24 [illegible]~~

Gentamycin 350mg IV q 24°

Noted SMD [redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

DATE OF ORDER: 31 May 03 | TIME OF ORDER: 0908 | HOURS

(4) ~~Irrig to 50 cc th~~

~~✓ Residual after 2 hrs~~

~~if Residual > 50 cc~~

~~DC infusion and notify Dr.~~ [redacted] b(6)-2

[redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF [illegible] 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: ICU 1 | ROOM NO. | BED NO.

DATE OF ORDER: 31 May 02 | TIME OF ORDER: 0932 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Place NG tube
(2) ↑ Jevity to 50 cc/hr
✓ Residual q 2°
DC if residual >100 cc
(3) Give 500 [redacted] LR now b(6)-2
[redacted] NR
[redacted] Noted 31MAY03

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

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

DATE OF ORDER: 1 JUN 03 | TIME OF ORDER: 0715 HOURS | 0725

— DC Albumin / DC D5
— Start LR @ 200 cc/hr
— ↑ Jevity to 75 cc/hr
— ✓ residuals
— Wean vessel for urbat after chery [redacted]

PATIENT IDENTIFICATION

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

DATE OF ORDER: 6/2/03 | TIME OF [redacted] HOURS | b(6)-2

Hold all sedation
[redacted] b(6)-2
[redacted]
Noted 3 Jun 03 1415

PATIENT IDENTIFICATION

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

DATE OF ORDER: 3 Jun 03 | TIME OF ORDER: 1630 HOURS

(1) SIMV 16 TV 700 PEEP
FIO2 - wean to keep Sats > 95%
(2) Resume tube feeds after advancing Dobhoff 5 cm @ close 30 cc/hr. (Flush line) Elevate h
(3) Resume Sedation [redacted]
50 mg/hr [redacted] b(6)-2
and Vecuronium @ 2 mg/hr [redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 JUN 03 TIME OF ORDER: 1134 HOURS

LIST TIME ORDER NOTED AND SIGN

Albuterol Neb UD q 6°

~~Chest PT~~

ABG NOW [redacted]

STAT [redacted]

b(6)-2

b(6)-2 [redacted] STAT

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: 1430 HOURS

① order to Ensure 20 hosp

out of facility

Sphl film - ay

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 June 03 TIME OF ORDER: 2100 HOURS

① V.O. Tylenol ii 325mg via

NG tube, - Dr [redacted]

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

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 JUN 03 TIME OF ORDER: 0815 HOURS

DC gent

start Cipro 200mg IVPB

q 12 @ 1000 today

Regent chem 8

Lovenox [redacted] 5Q q 12

Advance doble [redacted]

is cm

b(6)-2

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

Repeat KUB in 2 hr.

[redacted] STAT 1430

b(6)-2

MEDCOM - 9355

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: ICU | ROOM NO.: 6 | BED NO.:

DATE OF ORDER: 4 JUN 03 | TIME OF ORDER: 1010 HOURS | LIST TIME ORDER NOTED AND SIGN

Δ IVF to NS @ 150 cc/h
PC LR
Chem 8 @ [redacted] b(6)-2 [redacted]

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

NURSING UNIT: ICU | ROOM NO.: 6 | BED NO.:

DATE OF ORDER: 4/6/03 | TIME OF ORDER: 1751 HOURS

Hold tube feed @ 0400 [redacted]
to OR in am [redacted] b(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 JUN 03 | TIME OF ORDER: 1000 HOURS

- Resume previous orders
- Δ IVF to D5W @ 75 cc/h and NS @ 75 cc/h
CXR, KUB on Return to ward [redacted] 1030
Do not start Dobhoff feed until placement confirmed

PATIENT IDENTIFICATION: 24 [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 JUN 03 | TIME OF ORDER: 0911 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) ↓ IVF to TKO

(2) ↑ tube feeds to 60cc/h

1/2 Ensure plus @ 30cc/h

and 1/2 Water @ 30cc/h

[redacted] b(6)-2

6 JUN 03 [redacted] b(6)-2

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 JUN 03 | TIME OF ORDER: 1570 HOURS

CXR for line placement

DC femoral vein line

(R) femoral vein

[redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

#[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

DATE OF ORDER: 7 JUN 03 | TIME OF ORDER: 0700 HOURS | LIST TIME ORDER NOTED AND SIGN

- Use Propofol @ 15 mcg/kg/hr titrate to effect
- D all fluids to skull water not Saline to include TKO flush

[redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

DATE OF ORDER: 7 Jun 03 | TIME OF ORDER: 0800 HOURS

↑ Dobhoff feeds to 90 cc/h
45 cc Ensure (+) / 45 cc
Free H2O

[redacted] b(6)-2

[redacted] b(6)-2

7 Jun 03 1500

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Once Propofol is completed D/C Start Vased IV and titrate to effect

- VD [redacted] / [redacted] b(6)-2
- 24 hrs then check flow by [redacted] CPT/RN 8 Jun 03

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 June 03 | TIME OF ORDER: 0830 HOURS

1. ~~D50 ½ NNP~~
2. ~~Free insulin 10 units SQ~~
3. albuterol neb now
4. chem 7 @ 1200
5. ~~Lasix 20 mg IV now~~

noted 8 JUN 03 1645 [redacted] b(6)-2

[redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8 June 03 TIME OF ORDER: 1300 HOURS

LIST TIME ORDER NOTED AND SIGN

1. T/and D50 — 1330
2. regular insulin 10 u sq IV — 1330
3. Lasix 20 mg IV — 1330
4. 10% Ca Cl IV over 3 minutes — 1330
5. albuterol neb q2° x 3
6. chem 7 + ABG @ 1600
7. Kayexalate 30 g [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8 JUNE 03 TIME OF ORDER: 1425 HOURS

1. D5W 500cc bolus x 1 now. b(6)-2
V.O. Dr [redacted] b(6)-2

noted 8 JUN 03 [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8 JUN 03 TIME OF ORDER: 1635 HOURS

DC Ensure feeds
D5W @ 150 cc/hr
[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8 JUN 03 TIME OF ORDER: 1640 HOURS

1. Wean off vent
2. Pt on trach collar trial
3. ABG 1° p trach collar trial b(6)-2
V.O. Dr. [redacted] b(6)-2 [redacted] b(6)-2

noted 8 JUN 03 1700 [redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 JN 03 TIME OF ORDER: 0711 HOURS

LIST TIME ORDER NOTED AND SIGN

DC Cipro

Give single dose of Vancomycin 1 gm now

D50 1/2 Amp 0715 noted

Reg insulin 10 u IV 0715 0715

Albuterol neb

Lasix 20 mg IV now then 0730

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 8° X 24° HOURS

Repeat Chem 8 @ 1200

Transfuse 2 u PRBC over 8 hrs

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 June 03 TIME OF ORDER: 0720 HOURS

Klonopin 30 gm per DHT neb q 120 noted

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 JN 03 TIME OF ORDER: 1842 HOURS

OK for transfer to Iraqi Hospital

[redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

NT IDENTIFICATION

CIV #[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9 June 2003 TIME OF ORDER: 0830 HOURS

LIST TIME ORDER NOTED AND SIGN

① Please reassess pt & decide whether or not to continue alb nebs. Alb Q2x3 given yesterday need new order for nebs if continued. — [redacted] 21 USA/CRT

b(6)-2

PATIENT IDENTIFICATION

Civ b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 Jun 03 TIME OF ORDER: 0615 HOURS

① Pt's leaving

② albuterol neb q 6°

noted 0630 10 Jun 03 [redacted]

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME O[redacted] HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

FORM APR 79 4256

S EDITION OF 1 JUL 77, WHICH MAY BE USED.

b6-2 all

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. 05 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	31	1	2	3	4	5	6	7	8	9	10
28 May 03	[redacted]	Dx 40% 200° BSA burn	05	/	[redacted]												
			17														
28 May	[redacted]	CPM	05	/													
			17														
28 May	[redacted]	Cont pulse oximetry	05	/													
			17														
28 May	[redacted]	Foley to gravity	05	/													
			17														
28 May	[redacted]	VS q 1°	05	/													
			17														
28 May	[redacted]	Strict I's & O's	05	/													
			17														
28 May	[redacted]	Keep ambant temp	05	/													
		warm, use warming	17														
		light for shivering															
28 May	[redacted]	CXR q AM	05	/	[redacted]												
		vent settings	17														
		TV 700cc															
		FiO2 50% > Δ'd FiO2 40%															
		Rate 14 / rate 16															
		Peep 5															
28 May	[redacted]	A-line to cont monitor	05	/	[redacted]												
			17														
5-29	[redacted]	CXR, CBC, Chem 8 QAM	05	/	[redacted]												

D/C'd

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: 40% BSA 2° Burns
Blast injury c̄ Burns

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: 1

PATIENT IDENTIFICATION:

CIV. # [redacted] b6-4

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

66-2 ml

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo May Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22 May	[redacted]	Admit to Dim Ward	22 MAY	Done		
22 May	[redacted]	ABG on arrival	22 May	Done		
22 May	[redacted]	CBC chem 7 in Am	23 May	CHED		
22 May	[redacted]	KUB upon arrival	22 May	Done		
5-29	[redacted]	KUB for debriefing placement	5-29	Done		
31 MAY	[redacted]	NG tube	31 MAY	Done		[redacted]
3 Jun	[redacted]	ABG AF 7A	3 Jun	Now	Done	[redacted]
3 Jun	[redacted]	ordering D to Ensure 2° hosp out of Jev.				
4 Jun	[redacted]	Repeat Chem 8	4 Jun	due		
4 Jun	[redacted]	Advance Dobhoff 15cm	done			
5 Jun	[redacted]	Repeat KUB in 2hrs	1300	4J		
5 Jun	[redacted]	CXR for line placement	6 Jun	Now	done	[redacted]
5 Jun	[redacted]	D/C Femoral Vein line @ left vein	6 Jun	Done		[redacted]
8 Jun	[redacted]	ABG 1° trach trial	8 Jun			
9 Jun	[redacted]	repeat chem 8 @ 1200	9 Jun	1200		

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

USAFA 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. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3	4	5	6	7	8	9	10
31 MAY03	[redacted]	Check Residuals Q 2°	02	/	[redacted]									
		D/C if Residuals > 100cc	04	/										
		Place NG Tube	06	/										
			08	/										
			10	/										
			12	/										
			14	/										
			16	[redacted]										
			18	[redacted]										
			20											
			22											
			24											
3Jun	[redacted]	Resume Tube feeds	05	/	/	/	[redacted]							
		p advancing Dobb	17	/	/	/								
		Hoff 5cm @ 30cc/hr												
		Ensure												
5Jun	[redacted]	Do not start	03	/					[redacted]					
		Dobbhoff feed	11	/					[redacted]					
		until placement												
		confirmed												
6Jun03	[redacted]	↑ Tube FEED to 60cc/hr	05	/	/	/	/	/	/	[redacted]				
		1/2 ENSURE plus @ 30cc/	17	/	/	/	/	/	/	[redacted]				
		hr And 1/2 water @ 30cc/hr												
7Jun	[redacted]	↑ Dobbhoff Feeding to 90cc/hr	10	/	/	/	/	/	/	/	[redacted]			
		45cc Ensure + 45cc Free H_2O	22	/	/	/	/	/	/	/	[redacted]			

b6-2 all

AD 6Jun03

D/C'd 8Jun03

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	Blast Injury & Burns	PAGE NO: 2

PATIENT IDENTIFICATION:

[redacted]

JCU

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 A1 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4 Jun	[redacted]	Chem 8 @ 1900	4 Jun	1900	2100	[redacted]
5 Jun	[redacted]	Hold TF @ 0400 To OR in Am	5 Jun 03	0400	0400	[redacted]
8 Jun 03	[redacted]	Chem 7 @ 1244	8 Jun 03	done	1244	[redacted]
8 Jun 03	[redacted]	Chem 7 & ABG @ 1600	8 June 03	done	1545	[redacted]

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10											
8JUN03	[redacted]	Wean off vent	05	/	[redacted]		Jet off vent at 9 June 03										
			17	[redacted]													
8JUN03	[redacted]	Pt on trach collar trials	05	/	[redacted]		trial successful										
			17	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Blast injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b6-2 all

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 05 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	31	1	2	3
28 May	[redacted]	Zantac 50mg IVPB	06	/	[redacted]					
		q8°	14	[redacted]						
			22	[redacted]						
28 May	[redacted]	LR @ 300cc/hr x 6hr	05	/						
		~~d/c @ 2130 28 may 03~~	17							
28 MAY	[redacted]	Silvadine to Burns	08	/	[redacted]					
		BID c̄ dressing Change	20	O						
28 MAY	[redacted]	Erythromycin drops	06	/						
		to (B) eyes q 6°	12	/						
			18							
			24							
28 May	[redacted]	Bacitrin to facial	08	/						
		area Bid	20							
28 may	[redacted]	Versed 2mg/hr	05	/						
		titrate to effect	17							
28 may	[redacted]	Fentanyl drip 50mcg/hr	05	/						
		titrate to effect.	17							
28 MAY 03	[redacted]	Fentanyl drip 75mcg/hr	05	/	[redacted]					
		titrate to effect	17	[redacted]						
28 MAY 03	[redacted]	LR @ 300 cc/hr	05	/						
		(continue IV LRB 300 cc/HR)	17							
5-29-03	[redacted]	↑ IV to D5LR 500cc/hr +	05	/	/	[redacted]				
		50cc/hr 5% Albumin	17	/	[redacted]					
5-30-03	[redacted]	Increase Jevity to 30cc/hr	05	/	/	/	[redacted]			
			17	/	/	[redacted]				
30-31 MAY	[redacted]	↑ Jevity to 50cc/hr	05	/	/	/	/	[redacted]		
			17	/	/	/	[redacted]			

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Blast injury c̄ Burns

ADDITIONAL PAGES IN USE: ☐ ~~YES~~ ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION: 70kg

CIV # [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. May Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5-29	[redacted]	500cc bolus x/ hespan	5-29	ASAP	1200	[redacted]
5:30	[redacted]	500 cc bolus x/ hespan	5:30	ASAP	1530	[redacted]
5:30	[redacted]	650mg Tylenol Elixir	5:30	ASAP	1530	[redacted]
3/MAY	[redacted]	LR 500 cc Bolus NOW	3/MAY	NOW		[redacted]
1pm	-----	D/C Albumin / DC D5.	[redacted]			
1pm	-----	Welcom Vensed for Extubation	[redacted]			
	-----	of the Day D				
	-----	Avoid all Sedation				

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

66-2 all

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo 5 Yr 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
28 May	[redacted]	Zantac 50 mg IVPB	06	[redacted]													
		q8°	14														
			22														
28 May	[redacted]	Erythromycin drops	06														
		to (B) eyes q 6°	12														
			18														
			22														
4 Jun	[redacted]	Start Cipro 200 mg	10	/	4												
		IVPB q12 e100	22														
		7 days															
4 Jun	[redacted]	Lovenox 30 mg	10	/	4												
		SQ Q12	22	/													
4 June	[redacted]	Δ IVF to NSQ 50 cc/hr	05	/	/												
			17	/													
5 Jun	[redacted]	Resume previous	05	/	/												
		orders	17	/	/												
		~~Δ IVF to DSW~~															
		~~and NSQ~~															
5 Jun 03	[redacted]	Δ IVF to DSW	05	/	/												
		@ 75cc/hr and	17	/	/												
		NS @ 75cc/hr															
6 Jun 03	[redacted]	↓ IV Fluid to TKO	05	/	/	/											
			17	/	/	/											
7 Jun	[redacted]	PROPOFOL 15 mcg/kg/hr	06	/	/	/	/	/									
		Titrate to effect	14	/	/	/	/	[redacted]									
			22	/	/	/	/	[redacted]									

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Blunt Trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO. 3

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

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	

Page #1 In Record SAMC 3 June 03 Orders

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

662 - all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8 JUN 03	[redacted]	Tylenol II Tabs per NGT (325 mg ea)	8 JUN 03	2100	2100	[redacted]
8 JUN 03	[redacted]	D50 ½ Amp	8 JUN 03	done	0845	[redacted]
8 JUN 03	[redacted]	Reg Insulin 10 units SQ	8 JUN 03	done	0845	[redacted]
8 JUN 03	[redacted]	Albuterol neb now	8 JUN 03	done	by RT	[redacted]
8 JUN 03	[redacted]	Lasix 20 mg IV now	8 JUN 03	done	0845	[redacted]
8 JUN 03	[redacted]	+ Amp D50	8 JUN 03	done	1330	[redacted]
8 JUN 03	[redacted]	Regular Insulin 10 unit IV	8 JUN 03	done	1330	[redacted]
8 JUN 03	[redacted]	Lasix 20 mg IV	8 JUN 03	done	1330	[redacted]
8 JUN 03	[redacted]	10 E. (Calcium gluconate) (all in over in 3 minutes)	8 JUN 03	done	1350	[redacted]
8 JUN 03	[redacted]	Albuterol Neb 02 x 3	8 JUN 03	done	on RT	[redacted]
8 JUN 03	[redacted]	Kayexalate via NGT now	8 JUN 03	done	1350	[redacted]
8 JUN 03	[redacted]	D5W 500 cc Bolus x + now	8 JUN 03	done	1430	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
8 JUN	[redacted]	Tylenol 325 mg I-II	CB + 2100 8 JUN	8 JUN 2100 ++	9 JUN 0900 450 mg	9 JUN 1100 [redacted]	[redacted]	9 JUN 1900 ++ 2000	9 JUN 0500	9 JUN 1200	[redacted]	9 JUN 0820	9 JUN 1200	9 JUN 1600	9 JUN 2200	9 JUN 0200
-----	-----	via NGT		[redacted]	[redacted]	[redacted]										
-----	-----		Tylenol II 11													
-----	-----		9 JUN 1630													
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USAPA V1.00

5 b(4)-2 All

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8	9
31May	[redacted]	Zosyn 3.375gm	06	[redacted]									
		IV q6°	12										
			18										
			24										
31May	[redacted]	Gentamicin 350mg	10										
		IV q24								D/C 4Jun			
6/3/03	[redacted]	Resume Sedation @	05			105	[redacted]						
		Fentanyl @ 50mcg/hr	17										
		Titrate to effect											
		and Versed @ 2mg/hr											
		titrate to effect.											
3Jun03	[redacted]	Albuterol NEBS	06	/	/	/	/	[redacted]					
			12	/	/	/	[redacted]						
			18	/	/	/	[redacted]						
			24	/	/	/	[redacted]						
3Jun03	[redacted]	Versed 2mg/hr, Titrate	05	/	/	/	[redacted]						
		to effect	17	/	/	/	[redacted]						
3Jun03	[redacted]	Start LR @ 200cc/hr	05	/	/	/	[redacted]						
			17	/	/	/	[redacted]			D/C			
3Jun	[redacted]	SIMV 16, TV 700	05	/	/	/	[redacted]						
		Peep, FiO2 when	17	/	/	/	[redacted]						
		to keep Sats > 95%											
		See Vent. Sheet.											

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Blast Injury c̄ Burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO. 3

PATIENT IDENTIFICATION: [redacted] b(6)-4 70kg

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b(6)-2 A1

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 7	8	9	10									
7 Jun	[redacted]	Versed IVP titrate	08	/	[redacted]											
		to effect	17	[redacted]												
9 Jun	[redacted]	albuterol neb	05	/	/	[redacted]	/	DC 10 Jun 03 [redacted]								
			17	/	/	[redacted]	/									
9 Jun 03	[redacted]	Kaysevalate 30 gm per	08	/	/	[redacted]										
		DHT now + q 12°	20	/	/	[redacted]										
10 Jun 03	[redacted]	albuterol neb q 6 hr	06	/	/	/	[redacted]									
			12	/	/	/	/									
			18	/	/	/	/									
			24	/	/	/	/									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Blast Injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Civ [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. June Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9 June	[redacted]	D50 ½ amp	9 June	0830	0830	[redacted]
9 June	[redacted]	regimalin 10 units IV	9 June	0830	0830	[redacted]
	-----	lasix ~~q8h x 24°~~ 20mg IV now then	9 June ①	0730	0730	[redacted]
	-----	q8h x 24° after lasix	9 June ②	1530	1530	[redacted]
	-----		9 June ③	2330	not given	[redacted]
9 June	[redacted]	give single dose of vancomycin 1gm now	9 June	0930	0930	[redacted]
9 June	[redacted]	transfuse 2 units PRBC over 8 hrs	9 June ④	1000	1000	[redacted]
10 June	[redacted]	DC lasix	9 June ②	1400	1400	[redacted]
10 June	[redacted]	DC lasix	10 June	noted		[redacted]

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1630	INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
NEURO	PUPILS	SEDATED		SEDATED PINPOINT			
	SENSORIUM	FENTANYL @ 200 MCG/HR, VERSED @ 2 MG/HR		DOES NOT FOLLOW COMMANDS			
RESPIRATORY	RESPIRATORY PATTERN	INTUBATED		EVEN & UNLABORED			
	BREATH SOUNDS	CLEAR BREATH		COARSE LS THROUGHOUT			
	SECRETIONS	MINIMAL MODERATE WHITE MUCUS		SIMV 14 TV 700 FIO2 40%, PEEP 5 ET # 8 24 cm @ LIP			
				⊘ SECRETIONS			
SKIN	COLOR	~~40% Burn~~ Burned - 40%		40% BURNS TO BACK FACE, ARMS.			
	INTEGRITY	PER, OTHER SKIN NORMAL FOR RACE					
IV SITE	LOCATION	SINGLE LUMEN (R)		(R) RADIAL A-LINE ⊂			
	CONDITION	SUBCLAVIAN ⊘ S/S LEAKS OR INFILTRATION. IV TUBING DRESSING ⊘ S/S LEAKING. A-LINE TO (C) radial - INTACT		GOOD SQUAWAVE. (L) SC ⊂ 30 cc/hr LR ⊘ S/S INFILTRATION / INFECTION			
GASTRO	ABDOMEN	Soft, nondistended		SOFT, NT BS HYPOACTIVE			
	BOWEL SOUNDS	BSX 4 QUADS					
GU	URINE:	FREELY TO GRAVITY		FOLEY YELLOW URINE ⊂ SEDIMENT			
	COLOR/CLARITY	CLEAR, yellow urine					
CARDIOVASCULAR	CARDIAC RHYTHM	S1 + S2 noted		S1, S2 NOTED ⊘ EDEMA ⊘ JVD (+) RP			

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; SA1 - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] SGT. LPN

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 28 MAY 03

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

CIV # [redacted] 467-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																	~~14~~	
BP Cuff																	149/88	
Temperature																	96	
Pulse																	58	
Respiratory Rate																	18	
pain																		
sedation																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR																	300	
NS																	20	
Fentanyl																	10	
Versed																	2	
Zantac																	50	46-2
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																400/400	
	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	
					100/70	118/72	130/73	73/57	
	141/70	87/80	118/50	137/73	107/58	110/61	117/63	98/46	
	96.2		96.4	100.8					
	69	92	91	98	92	91	97	99	
	10	14	14	15	15	15	14	18	
			100	100	100	100	100	100	

INTAKE	16	17	18	19	20	21	22	23	8° T
	300	400/1000	300/1300	300/1600	300/1900	300/2200	300/2500	300/2800	2800
	20	20/60	30/90	30/120	20/140	20/160	20/180		180
	15	15/30	15/55	15/70	15/85	15/100	15/105	15/115	115
	2	2/4	4/12	4/16	4/20	4/24	4/28		28
	50	50/50							

OUTPUT	16	17	18	19	20	21	22	23	
	600/1000 EMPTIED		125/125	50/175	175/350	100/450	100/550	130/680	1680

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	1636								
	MODE	SIMV								
	F_iO_2	50								
	TV	700								
	RATE	12								
	PEEP	5								
ABG	pH	7.23								
	PCO_2	48.9								
	pO_2	266								
	HCO_3	21								
	SAT	100								
	BASE	-7								

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

ACTIVITY	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 [redacted] INITIALS

[redacted] ept

66) 2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	1730	INITIALS [redacted] b(6)-2	INITIALS		INITIALS
	PUPILS	3-4mm (B) Round (Sluggish)				
	SENSORIUM	Alert-able to Verbal				
		Stimuli. Sedated &				
		Versed. Does not				
		Follow Commands				
RESPIRATORY	RESPIRATORY PATTERN	Even & Unassisted				
	BREATH SOUNDS	CPA & Vent Noise				
	SECRETIONS	Ø				
SKIN	COLOR	40% Burns Each Back,				
	INTEGRITY	Burns, Legs				
IV SITE	LOCATION	(D) SC. Subclav Lumen				
	CONDITION	(R) Radial A-Line				
		(L) TLC Femoral				
		Ø S/S Infiltration/				
		Infection				
GASTRO	ABDOMEN	Soft, NT				
	BOWEL SOUNDS	BS Hypo x4				
GU	URINE:	Ruby - Dark Amber				
	COLOR/CLARITY	Urine				
CARDIOVASCULAR	CARDIAC RHYTHM	NSR/ST Ø Ectopy				
		Ø JVD Edema				
		+1 PP				

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) [redacted] PT, AN b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 29 May 03

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

Civ [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 29 MAY 03 | DX BLAST INJURY C BURNS | HOSPITAL DAY 2

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	115/70	100/63	102/65	88/59	88/54		107/66	92/64		107/65	102/65	101/63	106/66	139/76	145/80	124/69	129/72	
BP Cuff	110/57	96/53	101/66	101/65	97/66		97/66											
Temperature							101.3						100.2					
Pulse	99	80	111	112	121		114	121		117	110	109	107	108	107	113	110	
Respiratory Rate	16	15	15	13	7		14	15		15	15	15	15	15	15	15	15	
SATS	100	99	99	99	97		99	100		100	100	99	99	99	99	99	99	
FiO2	40%	40%	40	40	40	40	40	40		40	40	40	40	40	40	40	40	
pain	Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed		Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed	
intubation	0	0	0	0	0	0	Sent	Sent		Sent	Sent	Sent	Sent	Sent	Sent	Sent	Sent	

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR@300	300	300/600	300/900	300/1200	300/1500	300/1800	300	300		300	300	300	150	150	150	150	150	
FENTANYL	7.5	7.5/15	7.5/22.5	7.5/30	7.5/37.5	7.5/45	1.5	1.5		1.5	1.5	1.5/30	2.0	2.0	2.0	2.0	2.0	
VERSED	3	3/6	4/10	3/13	3/16	3	2.5	3		3	3	3	5	5	5	5	5	
IVPB							50						500					
Albumin														50	50	50	50	
[illegible]																		
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL	100/100	150/250	50/300	25/325	35	35	30	40		30	30	50	50	100	100	100	200
	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		
111/68	110/76	112/88	75/46	121/74	117/77	114/74	117/78		
101°		100³							
110	117	124	113	138	121	115	113		
15	15	16	15	26	13	15	14		
99	99	97	100	100	100	100	100		
40	40	40	40	40	40	40	40		
Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed		
fent	fent	6	fent	fent	fent	fent	fent		

INTAKE

16	17	18	19	20	21	22	23	8° T
150	150/2550	150/2700	150/2850	150/3000	150/3150	150/3300	150/3450	3450
20	20/200	20/220	20/240	20/260	20/280	20/300	20/320	320
5	5/50	5/55	5/60	5/65	5/70	5/75	5/80	80
	50							
50	50/300	50/350	50/350	50/400	50/450	50/500	50/550	550
	3100							4410

OUTPUT

35	40	40	100/140	65/205	70/275	75/350	25/375	375
+2295								
805								375

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME	0001								
	MODE	SIMV								
	F_iO_2	40%								
	TV	700								
	RATE	15								
	PEEP	5								
ABG	pH									
ABG	PCO_2									
ABG	pO_2									
ABG	HCO_3									
ABG	SAT									
ABG	BASE									

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

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

TURN

SUCTION

TIME					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE ______

NURSE'S SIGNATURE	INITIALS
[redacted]	
4/6-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1745	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	4mm Round Sluggish					
	SENSORIUM	Sedated. Opens Eyes					
		To Verbal Stimuli					
		Does not Follow					
		Commands					
RESPIRATORY	RESPIRATORY PATTERN	Even & Unassisted					
	BREATH SOUNDS	CTA & Vent Noise					
	SECRETIONS	Ø					
SKIN	COLOR	40% Bruns - Back					
	INTEGRITY	Arms, Face, Legs					
IV SITE	LOCATION	(L) SC Single Lumen					
	CONDITION	(R) Fem TLC					
		(R) Rad A-Line					
		Ø S/S Infection					
		Infiltration					
GASTRO	ABDOMEN	NGT (Ø) NAG F					
	BOWEL SOUNDS	Sensy (Ø) 30cc/hr					
		BS x4 Hyperactive					
GU	URINE:	Foley Dark Amber					
	COLOR/CLARITY	Urine					
CARDIOVASCULAR	CARDIAC RHYTHM	SR Ø Ectopy					
		Ø JVD, Edema					

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
SA1 - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY (Name, Grade, Title)

[redacted] CPT, [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2 West

DATE: 30 May 03

(AUTHENTICATION OF typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Cu[redacted] b(6)-4

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

DATE 30 May 03 | DX BLAST INJURY + BURNS | HOSPITAL DAY

VITALS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line	117/77	114/73	117/80	131/89	124/82	125/80	126/80	136/82		103/59	97/58	124/73	132/80	120/81	121/74	110/69	99/71	
	BP Cuff																		
	Temperature								99.3						100.9				
	Pulse	113	112	114	109	110	106	103	102		105	125	111	127	128	127	125	127	
	Respiratory Rate	16	15	15	13	13	15	15	15		15	15	15	15	15	15	15	15	
	SATS	99	100	100	100	100	100	100	99		99	99	98	98	98	98	99	98	
	FiO2	40	40	40	40	40	40	40	40		40	40	40	40	40	40	40	40	
SIGNS																			
	Sedation	Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed		Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed	
	Intubation	O	O	O	O	O	O	Prolon			Prolon	Prolon	Prolon	Prolon	Prolon	Prolon	Prolon	Prolon	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	D5W @ 150	150/150	150/300	150/450	150/600	150/750	150/900	150	150		150	150	150	150	150	150	150	150	
	FENTANYL	20/20	20/40	20/60	20/80	20/100	20/120	20	20		20	20	20	20	20	20	20	20	
	VERSED	4/4	4/8	4/12	4/16	4/20	4/24	4	4		4	4	4	4	4	4	4	4	
	ALBUMIN	50/50	50/100	50/150	50/200	50/250	50/300	50	50		50	50	50	50	50	50	50	50	
	IVPB	50/50						50											
	Jevity																		
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	URINE		85/85	100/185	100/285	100/385	150/535	80/615	150/765	150/915		80/995	70/1065	50/1115	50/1165	90/1255	80/1335	40/1375	30/1405	1405
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			1185

MEDCOM - 9381

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	89/57	110/61	109/60	112/62	136/69	153/74	151/73	140/84
	102	99.5						
	122	104	105	98	90	88	91	98
	15	15	15	15	15	15	15	15
	98	99	96	98	98	97	98	97
	40	40	40	40	40	40	40	40
		SBD	SBD	SBD	SBD	SBD	SBD	SBD
		FENT	FENT	FENT	FENT	FENT	FENT	FENT

INTAKE	16	17	18	19	20	21	22	23	8° T
	150	150	150	150	150	150	150	150	
	10	10	10	10	10	10	10	10	
	4	4	4	4	4	4	4	4	
	5	5	5	5	5	5	5	5	
	50	50	50	50	50	50	50	50	
	30	30	30	30	30	30	30	30	

OUTPUT									
	30/1215	50/1265	50/1315	50/1365	100/1465	100/1565	100/1665	75/1740	1740
									17[illegible]

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									

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

TURN	TIME									

SUCTION	TIME									

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

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

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0645	INITIALS [redacted]	1720	INITIALS [redacted]	b(6)-2	INITIALS
NEURO	PUPILS	PERRLA - Pupils	b(6)-2	4mm (B) Sluggish (Sluggish)			
	SENSORIUM	Sluggish, PE		Sedated - Opens Eyes			
		Sedated		to verbal stimuli. Does			
				not follow commands.			
RESPIRATORY	RESPIRATORY PATTERN	BI	Clear breath	CTA to vent noise			
	BREATH SOUNDS	sounds upper		throughout. Engine			
	SECRETIONS	lobe. CTA lower		unassisted			
		lobe.		∅ secretions			
SKIN	COLOR	Burned to 40% BSA		40% BSA burns to back			
	INTEGRITY	(back, face, legs		face, arms, legs)			
		arms)					
IV SITE	LOCATION	~~A-line (R) Femoral~~		(R) Fem Tlc			
	CONDITION	Triple lumen (R)		(L) SC SLC			
		femoral ALL		∅ s/s of infection/			
		Single lumen (L)		infiltration			
		subclavian, All					
		sites s s/s of inf/x					
GASTRO	ABDOMEN	Non-distended		Soft, NT			
	BOWEL SOUNDS	BSX4 ~~hy~~ quads		BS x4 hyperactive			
		hyperactive. NG		not (R) used to Jejunal			
		tube to jejunal feeding @ 50cc/hr					
GU	URINE:	Foley to gravity		Foley to gravity			
	COLOR/CLARITY	draining dark		Dark Amber urine			
		concentrated urine					
CARDIO-VASCULAR	CARDIAC RHYTHM	S_1 + S_2 noted		S_1, S_2 ∅ murmur			
		sinus rhythm		∅ JVD, Edema			
				+1 (R)			

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

b(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] CPT N

DEPARTMENT/SERVICE/CLINIC ICU Quest

DATE 31 May 03

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

Cw [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	130/71	104/64	135/72	59/89	115/85	120/55	122/64	100/60		114/60	100/49	82/40	100/48	122/54	102/54	109/50	113/55	
Temperature				104.4	103.7		103.9	103.7		102.7	102.7	100.7	99.9			101.6		
Pulse	103	121	120	148	127	152	118	121		199	147	115	114	133	129	133	131	
Respiratory Rate	15	15	13	15	15	15	15	15		28	19	15	15	34	15	15	15	
SATS	98	98	97	95	97	98	96%	100%		100%	100%	100%	100%	100%	99%	99%	98	
F.O2	40	40	40	40	40	40	40	40		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
Propofol	5cc	5cc	5cc	5cc	5cc	5cc												
intravitin	Fent	Fent	Fent	Fent	Fent	Fent												
D5 @ 150	150/150	150/300	150/450	150/600	150/750	150/900	150/1050	150/1200		150/1350	150/1500	150/1650	150/1800	150/1950	150/2100	150/2250	150/2300	2300
Fent	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80		10/90	50/140	50/190	10/200	10/210	10/220	10/230	10/240	240
Versed	4/4	4/8	4/12	4/16	4/20	4/24	4/28	4/32		4/36	10/46	10/56	5/63	5/68	5/73	5/78	5/83	83
IVPB (Gent)												100						
TF	30/30	30/60	30/90	30/120	30/150	30/180	0/180	60/240		50/290	30/320	0/320	50/370	50/420	50/470	50/520	50/570	570
ALBUMIN	50/50	50/100	50/150	50/200	50/250	50/300	50/350	50/400		50/450	50/500	50/550	50/600	50/650	50/700	50/750	50/800	800
ZANTAC							50							16-2		50		100
ZOSYN							50						50	50				100
IL													500					500
TOTALS																		

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		75/75	75/150	75/225	100/325	50/375	100/475	150/625	150/775		175/940	175/1115	50/1165	50/1215	125/1340	125/1465	125/1585	125/1710	
	sp gr							BMPH												
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	114/90	105/61	114/64	109/53	110/53	103/51	104/51	110/53	
		103	103	103		102	102		
	132	144	125	135	134	131	130	133	
	16	18	19	18	16	15	15	18	
	99	99	99	98	99	99	97	98	
	40	40	40	40	40	40	40	40	
		SGD							
		EGM							

INTAKE	16	17	18	19	20	21	22	23	8° T
	150/350	150/350	150/350	150/350	150/305	150/350	150/350	150/350	3500
	10/300	10/360	10/360	10/360	10/370	10/380	10/390	10/390	300
	5/88	5/93	5/98	5/103	5/108	5/113	5/118	5/123	123
							50/50		50
	50/600	50/650	50/700	50/750	50/800	50/850	50/900	50/950	950
	50/250	50/90	50/140	50/190	50/240	50/290	50/340	50/390	390
									5313

OUTPUT	16	17	18	19	20	21	22	23	
	135/2035	250/2285	175/2460	75/2535	100/2635	100/2735	100/2835	100/100	2935
	EMPTIED								
									2935

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE	SIMV								
	F_IO_2	40								
	TV	700								
	RATE	15								
	PEEP	5								
	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									

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

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

MEDCOM - 9385

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						
	SENSORIUM						
RESPIRATORY	RESPIRATORY PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
I.V. SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE:						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM						

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 Quest

DATE

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

#[redacted] b(2)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	159/80	148/95	129/69	109/52	118/63													
BP Cuff																		
Temperature	99.0	100.9	100.3															
Pulse	130	120	115	104	118													
Respiratory Rate	21	16	16	16	16													
S_pO_2	99	98	100	99	100													
O_2	40%	40%	40%	40%	40%													
pain																		
sedation																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS	30/240	30	30	30	30				360									
D5W	30/240	30	30	30	30				360									
Fent.	20/135	20	20	20	20				215									
Versed.	7/48	7	7	7	5				74									
Ensure	60/240		60	60	60				420									
Zantac		50							50									
Cipro																		
Zosyn	50								50									
N&T			20						20									
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	50/1000		100/1100		100/1200												
	sp gr																	
	S/A																	
NG	Residual output	125		30														
	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	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

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

TURN	TIME					
SUCTION						

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	5394	Urine:	3550
po	1250		
TOTAL	6604	TOTAL	3550
BALANCE	+3054		

NURSE'S SIGNATURE	INITIALS

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	0800	INITIALS [redacted]	1745	INITIALS [redacted] b(6)-2	INITIALS
NEURO	PUPILS		3mm sluggish b(6)-2		3mm SLUGGISH PERRLA		
	SENSORIUM		Sedated & unresponsive		SEDATED & UNRESPONSIVE		
			flutters/ opens to voice		DOES NOT FOLLOW		
			bed rest		COMMANDS		
RESPIRATORY	RESPIRATORY PATTERN		ventilator		ventilator		
	BREATH SOUNDS		CTA bilat diminished		CTA (B) Dim. BASES		
	SECRETIONS		bases, small mod		MOD BROWN CRM		
			brown crust of small		SECRETIONS		
			deep suctioning				
			ET 8 22cm @ lip				
SKIN	COLOR		40% burns, marked wound		40% BSA		
	INTEGRITY		areas appropriate				
			for race. See wound care note.				
IV SITE	LOCATION		L femoral line		(L) Fem A-line GOOD WEAN		
	CONDITION		R Femoral central TL		(R) Fem TLC		
			L SC SL central		(L) SC SL		
					PATENT & S/S INFECTION/INFILTRATION		
GASTRO	ABDOMEN		soft nontender		SOFT, NT		
	BOWEL SOUNDS		BS absent, NG		BS ABSENT		
			& drainage of blood		NGT TUBE & DRAINAGE		
			bothersome dumped side		OF BLOOD VIA NG		
GU	URINE:		Clouded, + sediment		CLOUDY + SEDIMENT.		
	COLOR/CLARITY				FOUL SMELLING CLOUDY		
					URINE		
CARDIOVASCULAR	CARDIAC RHYTHM		NSR - ST, PP		SR -ST @ 62 BPM		
			stable pulses +2 all		+1 PP		
			extremities +2 pitting		@ JVD, @ EDEMA		
			edema bilaterally.				

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

PREPARED [redacted] b(6)-2

(Continue on reverse)

PATIENT IDENTIFICATION (For typing [redacted] name: last, first, middle; grade; date; hospital [redacted] b(6)-4

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 4 Jun 03

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

...C OP 375 (Redesignated)

DATE [redacted] 9JUN | DX | HOSPITAL DAY

VITALS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line	120/63	138/79	136/70	139/56	155/80	156/78	135/71	134/69			124/62							
	BP Cuff	120/56	124/54	124/54	121/56	110/51	144/78	125/56	134/61		134/62	141/71	147/70	134/67	141/71	144/76	147/71	149/73	
	Temperature	100.1		110.3	99	99		100.9						99.4				99.6	
	Pulse	98	95	85	91	94	94	81	94		91	91	93	89	87	90	89	90	
	Respiratory Rate	16	20	20	10	24	16	16	16		16	16	16	16	16	16	16	16	
	SATS	99	98	98	99	98	99	98	98		98	98	98	98	100	100	100	98	
	FiO2	40	40	40	40	40	40	40	40		40	40	40	40	40	40	40	40	
SIGNS																			
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR @ 200	200	200/40	200/60	200/80	200/100	200/120	200	200		200	200	200	200	200	200	200	200	
	FENT	10	10/20	10/30	10/40	10/50	10/60	7	50		50	50	50	25	25	25	25	25	
	VERSED	5	5/10	5/15	5/20	5/25	5/30	50	10		10	10	5	4	4	4	4	4	
	NPO							100					100		50		250		
	TF	30/30	30/60	30/90	30/120	30/150	30/180	30	30 hold		hold	hold	30	30	30	30	30	30	
	Residual										40				60				
	TOTALS																		

OUTPUT		HOUR / TOTAL	25/25	25/50	50/100	25/125	50/175	50/225	175	50		50	50	50	100	100	75	50	50	
	URINE	SP GR						E												
		S/A						m												
	NG	OUTPUT						p												
		pH						t												
		GUIAC						y												
	EMESIS							E												
	STOOL							D												
	DRAINS																			
	TOTALS																			

[redacted] 06-2

POST-OP DAY

VITAL SIGNS

16	17	18	19	20	21	22	23	
149/71	143/78	151/79	174/91	141/76	158/81	159/82	151/85	
		[illegible]	105/56	131/64	124/59		133/65	
		99.9						
	87	89	102	117	104	100	97	
16	16	16	16	17	20	16	16	
99	99	98	99	98	99	98	98	
40	40	40	40	40	40	40	40	
		560 →						
		6 →						

INTAKE

16	17	18	19	20	21	22	23	8° T
200	200	200/600	200/800	150/950	150/1100	150/1250	150/1400	1400
25	25	25/25	25/100	25/125	25/150	25/175	25/200	200
4	4	4/12	4/16	4/20	4/24	4/28	4/32	
30	30	30/90	30/120	30/150	30/180	30/210	30/240	240
							+	3260
30								

OUTPUT

			50/200	100/300	100/400	100/500	100/600	600
50	75	75/150						
							+	1125
								1-25

ACUITY LEVEL CLASSIFICATION

RESPIRATORY

PD/A		TIME	0001	08	16
		MODE	SIMV	SIMV	SIMV
		F_iO_2	40	40	40
		TV	700	700	700
		RATE	16	16	16
		PEEP	5	5	5
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	

ACTIVITIES OF DAILY LIVING

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

	TIME
TURN	
SUCTION	

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE ______

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
461 - 2	

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	
EYES OPEN	SPONTANEOUSLY	4	4
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	
BEST VERBAL RESPONSE	ORIENTED	5	
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	T
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		RL
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LIMB MOVEMENT: LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		RL
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
PUPILS: RIGHT	SIZE		3
	REACTION		+
PUPILS: LEFT	SIZE		3
	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

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1730	INITIAL [redacted]	1730	INITIAL [redacted]	b(6)-2	INITIALS
NEURO	PUPILS	PERRLA 3mm b(6)-2		Perrla 3-4mm			
	SENSORIUM	Sedated c̄		Sluggish			
		Vaised & Fentanyl		~~sedated~~ c̄ vased & Fent.			
RESPIRATORY	RESPIRATORY PATTERN	unlabored		unlabored			
	BREATH SOUNDS	BBS - coarse		CTA - B			
	SECRETIONS	throughout.					
		Oral secretions					
SKIN	COLOR	Burns - 40% BSA		Burns on 40% BSA			
	INTEGRITY			dressings intact			
IV SITE	LOCATION	~~L Axillary~~ R Axillary line		~~L Axillary - A line~~			
	CONDITION	R subclavian - single		L femoral - A line			
		lumen cath (R) fem.		L femoral - triple lumen			
		triple lumen.		L sub clav.			
		All sites s/s of		all c/d/i no s/s			
		infx.		infection			
GASTRO	ABDOMEN	nondistended		soft nondistended			
	BOWEL SOUNDS	BS x4 - absent		absent bs x4 quad			
		NG + DHT in place		NG + DHT in place			
GU	URINE:	Foley to gravity		Foley to gravity			
	COLOR/CLARITY	drainage cloudy		cloudy yellow			
		yellow urine		urine			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 + S2 noted.		S1S2			
		ST		no edema noted			
				+1 pedal pulses			
				<3 cap refill			

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

b(6)-2

(Continue on reverse)

[redacted] (Signature & Title) SSG, USA

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 5 JUN 03

[redacted] 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	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	159/50	164/70	166/82	160/81	154/70	156/79	165/81	157/79		158/78								
BP Cuff											0	0	166/85	142/90	132/64	130/61	132/50	
Temperature	99.4												97.9					
Pulse	96	99	94	92	100	96	99	98		97	R	R	116	120	117	109	107	
Respiratory Rate	16	16	16	16	16	16	15	16		16			19	31	19	19	16	
SaO2	96	99	98	99	98	90	97	98		98			92%	95%	97%	98%	98%	
FIO2	40	40	40	40	40	40	40	40					50%	50%	50%	50%	50%	
open	560 →																	
intubation	0 →																	

INTAKE

TIME @ 20	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
VS ~~@150~~	150	150/300	150/450	150/600	150/750	150/900			1050	150	0	0	AD	20/110	20/140	20/214	20/235	230
FEED	25	25/50	25/75	25/100	25/125	25/150	75/225	75/300	300	25			30/30	30/60	30/115	30/145	30/175	175
VERSED	3	3/6	3/9	3/12	3/15	3/18	3/21	3/24	24	3	R	R	0/8	5/13	5/18	5/23	5/28	28
VPB	100/100																	
ZANTAC																		
TF	30/30	30/60	30/90	30/120	HELD									50/50		50/100		100
NS													75/75	75/150	75/225	75/300	75/375	375
D5W													75/75	75/150	75/225	75/300	75/375	375
Cipro													250					250
Zosyn													50					50
TOTALS									1274									1583

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE			75/75	75/150	100/250	100/350	100/450	100/550	100/650	150/800	800	100/900				350/450	75/525	75/600	100/700	700
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				700

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	123/55	153/76	139/68	148/72	142/68	159/79	139/65	131/63	
	101	100.7	100.3			100.7	101.3		
	102	105	103	102	101	103	107	103	
	16	16	16	16	16	16	16	16	
	98%	98%	98%	98%	98	98	98	98	
	60%	50%	50%	50%	50%	58%	40%	48%	

INTAKE	16	17	18	19	20	21	22	23	8° T
I	20/20	20/20	20/20	20/20	20/20	20	20/20	20/20	
	30/30	30/30	30/30	30/30	30/30	30/30	30/30	30/30	
N	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	
								60	
					30/30	30/30	30/30	30/30	
A	75/75	75/75	75/75	75/75	75/75	75/75	75/75	75/75	
K	75/75	75/75	75/75	75/75	75/75	75/75	75/75	75/75	
E							100		
			50					50	
	DHT								
O	100/100	105/105	105/105	100/100	100/100	100/100	100/100	100/100	
			[illegible]		10 cc		70		
T									
P									
U									
T									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	1300								
	MODE	SIMV								
	F_IO_2	50%								
	TV	700								
	RATE	16								
	PEEP	5								
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY										
	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 I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	[redacted]
		b(6) - 2	
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		

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	1600	INITIALS [redacted]	1700	INITIALS [redacted]	0120	INITIALS
NEURO	PUPILS	PERRLA 3mm	b(6)-2	Perrla 3m	b(6)-2	See neuro flowsheet	
	SENSORIUM	Sedated on versedat		sedatia c̄ Fent. + Versed		Low on Versed and	
		Fentanyl				Fentanyl drip	
RESPIRATORY	RESPIRATORY PATTERN	TRACH COLLAR on		ventilated through		Trach & Shiley cuffed	
	BREATH SOUNDS	Vent.		trach.		Vent SIMV 18 bpm	
	SECRETIONS	BBS - coarse throughout		could only auscultate		Peep TV 700 FiO2	
		All lobes		vent sounds		40% Coarse throughout	
		Oral secretions, thick		thick oral + tracheal		Suction from trach & oral	
				secretions		moderate amount of thick white	
SKIN	COLOR	Burns 40% BSA		Burns on 40%		secretions.	
	INTEGRITY	Dressing intact		dressings intact		40% BSA Burn Dressing	
						reinforced	
IV SITE	LOCATION	A-line (D) leg		left femoral A line		TLC in (L) jug SC	
	CONDITION	Single lumen cath (D)		left sub clavian		infusing Fentanyl 200 mg/hr	
		subclavian, triple lumen		triple lumen.		Versed 7mg/hr, D5 and N	
		(D) flushed		c/d/i, no s/s infect.		@30cc/hr. A-line in (L)	
						femur. Both site c̄ od	
						sign of infection.	
GASTRO	ABDOMEN	Soft, nondistended		soft, non tender		Soft Nontender	
	BOWEL SOUNDS	BS - Absent		hypoactive bs in		hypoactive x4 RLQ	
		NG + DHT intact		upper quads. + bs		in (L) Nare and Patent	
				sounds in lower qds		Dobhoff in (R) nare	
GU	URINE:	Foley to gravity		Foley to gravity		Foley draining clear	
	COLOR/CLARITY	Cloudy yellow		cloudy yellow		yellow quantity	
		urine		urine		sufficient urine.	
CARDIOVASCULAR	CARDIAC RHYTHM	S1 + S2 noted		S.S. slight edema		S.S. ST HR 120 Pedis	
		(D) Edema		in feet. + (2) pulses		edema +2 to all	
				in feet. <3 sec		extremities.	
				cap refill			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SA1 - Saturation; TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PRE[redacted] (Signature & Title)

[redacted] SGT UN

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 6 JUN 03

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 | HOSPITAL DAY

VITALS SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line	136/60	140/68	146/73	144/73	152/74	153/74	153/72	147/70		140/77	133/71	130/70	140/74	125/61	131/64	131/66	131/62	
	BP Cuff																		
	Temperature	101.0		101.6		101.4		102.7	101.5			102.1		103.8		102.8		101.8	
	Pulse	104	118	109	111	111	110	116	112		111	131	122	125	119	118	117	108	
	Respiratory Rate	16	16	16	16	16	16	16	16		23	23	16	16	16	16	16	16	
	S_pO_2	99	98	99	99	99	98	98	98		98	99	99	98	98	98	98	98	
	O_2	40%	40%	40%	40%	40%	40%	40%	40%		40	40	40	40%	40%	40%	40%	40%	
	pain																		
	intuition																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	NS	75/740	75	75	75/965	75/1040	75/1115	75/1190	75/1265	1265	75/75	30/105	30/135	30/165	30/195	30/225	30/255	30/285	285
	D5W	75/600	75	75	75/825	75/900	75/975	75/1050	75/1125	1125	75/75	30/105	30/135	30/165	30/195	30/225	30/255	30/285	285
	Fent.	30/240	15	15	15/285	15/300	15/315	15/330	15/345	345	15/15	15/30	15/45	15/60	15/75	15/90	15/105	15/120	120
	Versed	5/40	5	5	5/55	5/60	5/65	5/70	5/75	70	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
	Ensure	30/150	30	30	30/240	30/270	30/300	30/330	30/360	360	30/30	60/90	60/150	60/210	60/270	60/330	60/390	60/450	450
	Zantac	0/50						50		100								50	50
	Cipro	0/100								100				100					100
	Zosyn	50/100						50/150		150					50/50				50
										3515									
	TOTALS																		1380

OUTPUT		HOUR / TOTAL																	
	URINE		100/850	100/950	100/1050	100/1150	100/1250	100/1350	100/1450	150/1600	1600	100/100	50/150	100/250	100/350	100/450	100/550	150/700	50/750	750
		sp gr																	
		S/A																	
	NG	residual ~~output~~	25cc		35cc		31cc		40cc		131	60cc		50cc		70cc		50cc		230
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	132/75	154/87	149/76	154/77	132/65	159/88	141/70	145/86	
		101.1		101.5		101.7			
	106	128	121	131	120	128	110	169	
	17	28	20	19	16	19	14	27	
	99	98	99	100	99	97	99	99	
	40%	40%	40%	40%	40%	40%	40%	40%	

INTAKE	16	17	18	19	20	21	22	23	8°T
	30/30	30	30	30	30	30	30/180	30	
	30/30	30	30	30	30	30	30/180	30	
	15/15	15	15	15	15	15	20/95	20	
	5/5	5	5	5	5	7	7/34	7	
	60/60	60	60	0	0	0	0/120	60/180	
							100		
			50				50		

OUTPUT	16	17	18	19	20	21	22	23	
	50/50	225	225	100	100	120	100	60	
			130		120		5cc		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE	SIMV									
	F_IO_2	40									
	TV	700									
	RATE	16									
	PEEP	5									
ABG	pH										
	PCO_2										
	pO_2										
	HCO_3										
	SAT										
	BASE										

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

ACTIVITIES DAILY	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	

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

5/6 - 2

NEUROLOGICAL ASSESSMENT

		HOURS	01
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	✓
		TO SPEECH 3	
		TO PAIN 2	
		NO EYE OPENING 1	
	BEST VERBAL RESPONSE	ORIENTED 5	Trach
		CONFUSED 4	
		VERBALIZES 3	
		VOCALIZES 2	
		NO VOCALIZATION 1	
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	UTR
		LOCALIZES PAIN 5	
		FLEXION WITHDRAWAL 4	
		ABNORMAL FLEXION 3	
		EXTENSION TO PAIN 2	
		NO MOTOR RESPONSE 1	
LIMB MOVEMENT	ARMS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	✓
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
	LEGS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	✓
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
PUPILS	RIGHT	SIZE	3
		REACTION	+
	LEFT	SIZE	3
		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	01
UE	R		A
	L		A
LE	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

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800	INITIALS [redacted]	b(6)-2	INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	Pupils +3cm RX				See Neuro Flowsheet	
	SENSORIUM	opens eyes spont.					
		MAE, responsive					
		to light stimuli					
		+gag +cough					
RESPIRATORY	RESPIRATORY PATTERN	trach 7.0 Bil BS				7 cuff Shiley cuffed	
	BREATH SOUNDS	coarse rhonchi				Vent SIMV 16 Bilm	
	SECRETIONS	O_2 Sat 100%				Rate 5 TV 700 FiO2 4	
		Vent SIMV 14-TV 700				Coarse throughout	
		FIO_2 .4 2-6 breaths					
		above vent PIP <24					
SKIN	COLOR	40% BSA burn;				40% BSA Burn	
	INTEGRITY upper ext (+) hair growth	Back + thighs White				Dressing CDI	
		painless					
I.V. SITE	LOCATION	(L) TLC c Fent/Versed				TLC in (R) SC infusing	
	CONDITION	+ D5W & (L) fem				D5 3/4 Fentanyl 200mcg/	
		A-line (+) dicrotic				midazolam 5mg/hr.	
		notch (+) correlation				A-line in (R) fem. Both	
						sites (-) for s/s of	
						infection	
GASTRO	ABDOMEN	Soft Non-tender				Soft nontender and	
	BOWEL SOUNDS	NGT ✓ placement				not distended BS+4	
		(+) green bile <10cc					
		residual (+) BS					
GU	URINE:	Foley clear amber				Foley draining clear	
	COLOR/CLARITY					amber quantity sufficient	
						urine.	
CARDIOVASCULAR	CARDIAC RHYTHM	ST RR				ST 120's	
		generalized				Pitting edema +2 to all	
		edema all pulses				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

b(6)-2

PR [redacted] CPT/RN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 7 Jun 03

PATIENT'S IDENTIFICATION (For typed or [redacted] es give: Name—last, first, middle; grade; date; hospital or m[redacted]ity)

Liv [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

dressing Δ
Fentanyl ↑
propofol ↑

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	147/76	155/79	128/64		126/65		123/65	100/44			155/86	125/60	138/67	129/66	133/70	138/60	132/51	
BP Cuff		149/53																
Temperature		101.3		101.6	101.5		103.2	102.6		102.1	100.9		101.3	101	103	100.6		
Pulse	116	114	112	111	114		131	140			136	122	121	123	121	125	129	
Respiratory Rate	16	16/14	16/14	16/14	16		17	-			17	16	16	16	16	14	16	
Pox	100%	100	100	100	99		100	99			100	100	100	100	100	100	100	

SIGNS

pain
intervention

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	14	15	8° T
D5	30	30	30	30	30	30	30	30	240	30	30	30	30	30	30	30	30	
~~Ars~~	~~30~~	30																
Versed	5	2	2	Δ'd					9									
Fentanyl	15	15	15	15	15	15	20	15	125	34	34	10	10	10	20	15	15	
IVP		50	50				100	50	250						50			
Ensure	60	60	60	60	60	60	60	60	480	60	90	90	90	90	90	90	90	
Propofol				6	6	6	6	6	30	8.4	8.4	6	6	6	5	5	5	
TYLENOL			20				20		40						20			
TOTALS									1174									

OUTPUT

URINE	HOUR	200	150	100	100	100	–	225	100		75	75		225	200		200	100
	TOTAL	200	350	450	550	650		875	975	975								
	sp gr																	
	S/A																	
NG	RESIDUAL OUTPUT		20		10		10		0		10					10		
	pH																	
	GUIAC																	
EMESIS																		
STOOL							⊕ soft brown											
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS									
	21	22	23	24	06	07	03	04	
	100/57	136/71	125/64	106/57	115/61	120/64	109/57	115/58	
	100.8			100.5			103.8		
	114	128	136	127	128	133	136	124	
	16	16	16	16	16	16	22	21	
	99%	101%	100%	96%	99%	96%	98%	99%	

INTAKE									
	16	17	18	19	20	21	22	23	8°T
	30	30	30	30	30	30	30	30	720
					6	6	6	6	33
	15	15	15	15	15	15	15	15	393
		150		50					500
	90	90	90	90	90	90	90	90	1840
	5	5	5	5	D/C				88.8
							20		80
									3665.8

OUTPUT									
	100		100	100	100	100	100	100	
	15			15		35			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	0600								
	MODE	SIMV								
	F_IO_2	.40								
	TV	700								
	RATE	16								
	PEEP	5								
ARTERIAL BLOOD GAS	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

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

DAILY ACTIVITIES DOCUMENTING										
	TIME	1000								
	MOUTH CARE									
	BATH	VG								
	SKIN CARE	VG								
	FOLEY CARE	VG								
	TRACH CARE	VG								
	ROM EXERCISES	VG								

TURN / SUCTION	TIME					
TURN						
SUCTION						

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	2550
PO			
TOTAL	3665.8	TOTAL	2250

BALANCE 1415.8 ~~+3054~~ (+4169.8)

NURSE'S SIGNATURE	INITIALS
[redacted]	
66-2	

NEUROLOGICAL ASSESSMENT

			HOURS	18
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4		✓
		TO SPEECH 3		
		TO PAIN 2		
		NO EYE OPENING 1		
	BEST VERBAL RESPONSE	ORIENTED 5		Trach
		CONFUSED 4		
		VERBALIZES 3		
		VOCALIZES 2		
		NO VOCALIZATION 1		
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6		UTA
		LOCALIZES PAIN 5		
		FLEXION WITHDRAWAL 4		
		ABNORMAL FLEXION 3		
		EXTENSION TO PAIN 2		
		NO MOTOR RESPONSE 1		
LIMB MOVEMENT	ARMS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		✓
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
	LEGS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		✓
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
PUPILS	RIGHT	SIZE		3
		REACTION		+
	LEFT	SIZE		3
		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	18
UE	R		H
	L		H
LE	R		H
	L		H
	R		
	L		
	R		
	L		
	R		
	L		

LEGEND

- + + Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0515	INITIAL [redacted]	b(6)-2	INITIALS		INITIAL [redacted]	b(6)-2
NEURO	PUPILS		2mm, sedated & versed					See Neuro Flowsheet	
	SENSORIUM		and versed. Open eyes					Cont on Versed 2mg/hr	
			spontaneously					and Fentanyl 100 mcg/hr	
RESPIRATORY	RESPIRATORY PATTERN		Trach in place. 7.0					Trach 8 Shiley cuffed	
	BREATH SOUNDS		Coarse throughout chrnchi					Coarse throughout	
	SECRETIONS		Thick white secretions					SIMV 16 bpm Peep 5	
			noted through mouth and					TV 700 FIO2 40%	
			nose. Vent SIMV RR 16,					Drawing moderate amount	
			FIO2 40%, TV 700, peep 5					thick yellowish secretions	
SKIN	COLOR		WNL for RACE					40% BSA Burn	
	INTEGRITY		40% 2nd degree BSA burns					Dressing drainage serous	
								purulent drainage.	
IV SITE	LOCATION		(L) 3-lumen SC central					TLC in (L) SC infusing	
	CONDITION		line, (L) Femoral A-line.					Versed 2mg/hr and fentanyl	
			(L) S/S of infection. A-line					100mg/hr. A-line in	
			rather outside of body					(R) fem. Both sites	
			and tube kinked. Wound					are free of S/S of	
			present					infection	
GASTRO	ABDOMEN		soft					soft	
	BOWEL SOUNDS		BS 3x4 quad. Ensure +					BS 4. NPO Dobhoff	
			@ 90cc/hr via dobhoff					in (R) Nare. NGT in	
			NGT in place					(L) nare and placement	
GU	URINE:		Foley to gravity draining					Foley drainage amber	
	COLOR/CLARITY		dark yellow urine					quantity sufficient	
								urine & sediment.	
CARDIOVASCULAR	CARDIAC RHYTHM		ST & 0 ectopy, pulses					ST HR 120's. Pitting	
			palpable 2+ on all ext.					edema +2 to extremities	
			Pitting edema +2 on all						
			4 ext.						

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: 8 JUNE 03

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

CIV [redacted] b(6)-4

☐ 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	106/55	102/63	109/62								91/47	109/55	120/58	124/48	120/50	104/50	120/60	
BP Cuff				122/60	125/40	137/50	140/57											
Temperature	103.3		101.9		101.3		102.1	103.9		103.3	103.3			103.9	102.8		102.5	
Pulse	123	119	117	120	112	109	122			123	129	120	123	121	122	119	126	
Respiratory Rate	18	18	16	23	16	17	16			16	16	16	16	18	16	18	26	
O2 Sats	99%	98%	99%	100%	98	100	96%			97%	100%	100	100	96%	96%	98%	100%	
Trach collar																	40%	
open suction																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
D5W	30	30	30	30	30	30	30	30		30	30	30	150	150	150	150	150	
Fent	15	15	15	15	15	15	15	15		15	10	10	10	10	10	10	10	
Versed	6	6	6	6	6	7	7	7		7	2	2	2	2	2	2	2	
IVPB		50	50			100		50			50				50			
Nitro dopHoff flush	80				12		100	100			60	25	50		40			
Bolus											500							
TF	90	90	90	90	hold	hold	hold	hold	360	hold	hold	hold	hold	>D/C'd				
TOTALS																		

OUTPUT

URINE	HOUR	100	100	100	150	150	150	150	100		100	67	112	113	70	200	100	
	TOTAL	100	200	300														
	sp gr																	
	S/A																	
NG	Residual OUTPUT	25	42		52		60		100			60		60		25		30
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS									
	20	22	24	24	00	02	03	04	
	124/54	128/60	125/61	125/59	112/57	112/56	110/50	104/52	
		103.8	125 4	103.2		103.6		102.5	
	130	126	126	125	122	119	119	117	
	34	22	14	22	28	29	28	17	
	99%	100%	100%	100%	99%	99%	99%	99%	
	40%	40%	40%	40%	40%	40%	40%	40%	

INTAKE									
	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	150	150	150	150	2250
	10	10	10	10	10	10	10	10	285
	2	2	2	2	2	2	2	2	58
		150		50					550
		40				40			467
									500
									4170

OUTPUT									
	100	100		200	100		200		2424
		10		10		5			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	1005	1920	2027						
	MODE	SIMV	Tcollar							
	F_IO_2	40	40%							
	TV	700								
	RATE	16	18							
	PEEP	5								
A	pH			7.34						
A	PCO_2			34.3						
A	pO_2			145						
B	HCO_3			19						
B	SAT			99%						
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	3703	Urine:	2424
PO	467		
TOTAL	4170	TOTAL	2424

BALANCE 1746 + 4170 = 5915.8

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
5(6) - 2	

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	0518
EYES OPEN	SPONTANEOUSLY	4	4
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	
BEST VERBAL RESPONSE	ORIENTED	5	
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	T T
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	UTA
	LOCALIZES PAIN	5	
	FLEXION WITHDRAWAL	4	
	ABNORMAL FLEXION	3	
	EXTENSION TO PAIN	2	2
	NO MOTOR RESPONSE	1	
LIMB MOVEMENT: ARMS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		1
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LIMB MOVEMENT: LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		1
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		sedated can't measure
PUPILS: RIGHT	SIZE		2 3
	REACTION		+ +
PUPILS: LEFT	SIZE		2 3
	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		18
UE	R	+
	L	+
LE	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

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0500	INITIALS [redacted]	1100	INITIALS [redacted]	b(6)-2	INITIALS
NEURO	PUPILS		b(6)-2				
	SENSORIUM	Conscious but sedated		Conscious but sedated, moving extremities in pain, eyes open upon command especially c̄ pain		pt sedated, opens eyes to pain	
RESPIRATORY	RESPIRATORY PATTERN	reg		reg		RR + Rhythm.	
	BREATH SOUNDS	coarse		coarse		coarse c̄ Bronchi Bilat.	
	SECRETIONS	blood tinged white		white thick c̄ some blood tinged c̄ mucus		Pt treached. collar to 40% O2 RL. Secretions frothy Blood tinged.	
		trach & trach collar		trach collar to 40% O2			
SKIN	COLOR	burns 2 + 3°		burns 2-3° BSA 45%		2° + 3° Burns to 45% BSA.	
	INTEGRITY	non intact over 45%		non intact 45%			
				pink in burn area c̄ some hair growth			
IV SITE	LOCATION	central line 3 lumen		central 3 lumen cath Lt subclavian		IV to (R) SC patent (R) flush. c̄ LR @ 150 cc/hr	
	CONDITION	cath in & subclavian		patent + intact			
GASTRO	ABDOMEN	+ bowel sounds		+ bowel sounds		(+) BS x 4 quad.	
	BOWEL SOUNDS	abd soft non distended		abd soft non distended		NG clamped coffee ground Residuals. Dobhoff clamped.	
		NG clamped		NG clamped drainage coffee ground			
		NHT tube clamped.		NHT tube clamped			
GU	URINE:	clear c̄ sediment		clear amber colored		Dark yellow urine Foley draining to gravity.	
	COLOR/CLARITY	straw colored					
CARDIOVASCULAR	CARDIAC RHYTHM	sinus tach c̄ ectopy		sinus tach c̄ ectopy			

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)

b(6)-2

PREPARED BY [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 9 Jun 03

PATIENT'S IDENTIFICATION [redacted] —last, first, middle; grade; date; hospital or medical facility)

Civ [redacted] b(6)-4

☐ 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	106/53	107/54			125/62	125/59	117/56	120/57		129/62	125/65	115/56	120/55	122/57	107/54				
BP Cuff																			
Temperature	102.2	102.1			101.5	101.2	101.3	101.3		102.1		103.5	104.2	103.2	102.2				
Pulse	116	117			123	119	118	117		119	117	122	121	114	106				
Respiratory Rate	36	34			30	34	40	30		30	33	40	42	38	30				
															97				
pain																			
intervention																			

INTAKE																			
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
NSW	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150	150	
neud	2	2	2	2	2	2	2	2		2	2	2	2	2	2	2		
fentanyl	10	10	10	10	10	10	10	10		10	10	10	10	10	10	10		
IV adep		50						50										
Zantac		50									50							
neuro					250													
fresh FPRBC						250					↓							
Kayexalate				30 gm														
NG					coffee ground	40 cc		coffee ground 30 cc										
PRBC						250					250			↓				
TOTALS	162	262	162	192	412	662	202	182	2236	162	462	162	162	162 / 110				

OUTPUT																			
URINE	HOUR		250	100	100	100	150	150	100		100	100	100		100	50	75	50	
	TOTAL		250	350	450	550	700	850	950		1050	1150	1250		1350				
	sp gr																		
	S/A																		
NG	OUTPUT																		
	Bloodtinged		5cc		5cc		5cc		5cc					5cc		0			
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

dry Δ completed

PRBC #1 1035hrs

hydrocortisone supp given

oxygen lage bulline Δ

POST-OP DAY

VITALS SIGNS	21	22	23	24	01	02	03	04	
		110/95	110/97	115/53	110/96	112/97	111/97		
							104	103	
		102	96	100	102	110	108		
		23	23	19	25	23	35		
		97	95	97	95	97	98		
		8L	8L	8L	8L	8L	8L		

INTAKE	21	22	23	24	01	02	03	04	8°T
	150	150	150	150	150	150	150		
					20	20	20		
					20	20	20		
				50					
				50					

OUTPUT	21	22	23	24	01	02	03	04	
	100	100	50	75	25	25	20		
				X1		X1			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0330								
		MODE	TC								
		F_IO_2	40%								
		TV									
		RATE	8L								
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY DATA	TIME	0330	12							
	GLUCOSE	156	176							
	Na/K	151/6.1	136/5.6							
	Cl/CO_2	121/20	117/19							
	BUN/Cr	108/6.4	128/[illegible]							
	WBC/PLATELET	CA	7.1							
	Hct/Hgb									

DAILY LIVING ACTIVITIES	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		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
06)-2	

NEUROLOGICAL ASSESSMENT

		HOURS		
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4	
		TO SPEECH	3	
		TO PAIN	2	
		NO EYE OPENING	1	
	BEST VERBAL RESPONSE	ORIENTED	5	
		CONFUSED	4	
		VERBALIZES	3	
		VOCALIZES	2	
		NO VOCALIZATION	1	
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6	
		LOCALIZES PAIN	5	
		FLEXION WITHDRAWAL	4	
		ABNORMAL FLEXION	3	
		EXTENSION TO PAIN	2	
		NO MOTOR RESPONSE	1	
LIMB MOVEMENT	ARMS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
	LEGS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
PUPILS	RIGHT	SIZE		
		REACTION		
	LEFT	SIZE		
		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			
[illegible]	R	++	++
	L	++	++
[illegible]	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

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

INITIAL SHIFT ASSESSMENT

	TIME	0945	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	equal & reactive 3mm					
	SENSORIUM	oriented appropriate					
		eye opening grimaces					
		& pain movement of					
		legs & arms strong & bilat.					
RESPIRATORY	RESPIRATORY PATTERN	regular tachypnea					
	BREATH SOUNDS	coarse adeq air movement					
	SECRETIONS	TC @ 40% O2					
		tracheotomy #8					
		minimal tan/brown colored					
		thick secretions					
SKIN	COLOR	warm dark colored skin					
	INTEGRITY	broken c̄ 45% BSA burn					
IV SITE	LOCATION	L subclavian & skin control					
	CONDITION	line all lumens patent					
		A line, femoral c̄					
		adeq wrapping patch					
		+ intact					
GASTRO	ABDOMEN	soft, non distended					
	BOWEL SOUNDS	present hyperactive					
		NG tube clamped					
		Foley tube clamped					
GU	URINE:	clear amber c̄ some					
	COLOR/CLARITY	sediment					
		foley patent to gravity drain					
CARDIOVASCULAR	CARDIAC RHYTHM	sinus tachycardia					

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
SVA - Fractional
SAT - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] by Hm

DEPARTMENT/SERVICE/CLINIC ICU Quest

DATE 10 Jun 2002

PATIENT'S IDENTIFICATION (For typed or printed 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	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line						129/60		135/66										
BP Cuff																		
Temperature						101.4		101.2										
Pulse						100		110										
Respiratory Rate						40		86										
open intubation																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
D5W	150	150	150	150	150	150	150	150	1200									
fentanyl	20	20	20	20	20	20	20	20	160									
versed	2	2	2	2	2	2	2	2	16									
									1376									
TOTALS																		

OUTPUT

		TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
URINE	HOUR / TOTAL							350		200 / 550	550									
	sp gr																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	21	22	23	24	01	02	03	04	

INTAKE	21	22	23	24	01	02	03	04	8° T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
TIME		0930								
MODE		40%								
F_IO_2		TC								
TV										
RATE										
PEEP										
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

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

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

TURN					
TIME					

SUCTION					

24*8O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
VG-2	

NEUROLOGICAL ASSESSMENT

			HOURS	09
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4	4
		TO SPEECH	3	
		TO PAIN	2	
		NO EYE OPENING	1	
	BEST VERBAL RESPONSE	ORIENTED	5	NT A
		CONFUSED	4	
		VERBALIZES	3	
		VOCALIZES	2	
		NO VOCALIZATION	1	
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6	
		LOCALIZES PAIN	5	✓
		FLEXION WITHDRAWAL	4	
		ABNORMAL FLEXION	3	
		EXTENSION TO PAIN	2	
		NO MOTOR RESPONSE	1	
LIMB MOVEMENT	ARMS	NORMAL POWER		
		MILD WEAKNESS		✓
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
	LEGS	NORMAL POWER		
		MILD WEAKNESS		✓
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
PUPILS	RIGHT	SIZE		3
		REACTION		+
	LEFT	SIZE		3
		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	0900
hand pulses	R		+
	L		+
upper extremities	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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 28 MAY 03
Time In: 1400
Allergies: _____ OR Intake: Crystalloid 2L Colloid _____
Pre-op V/S: _____ OR Output: UOP _____ EBL Min.
Procedures: Debridement Meds/Times: _____

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

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

Pre Op Meds / History

Time	1400	1405	1410	1420	1440	1450
SaO2	100	100	VENTED			
FiO2						
Methods						
240						
220						
200						
180						
160	✓	✓	✓	✓	✓	✓
140						
120						
100						
80	^	^	^	^	^	^
	•	•		•		•
60						
40						
20						
RR	26	22	22	22	21	21
T	98.0					

Time								
Pain (0-10)								
LOS								

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)

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	0		[redacted]
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	VENTED		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic			
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.			

PT MEDICATED @ 10MG VOL + 5MG VOL

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

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

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

CIV # [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

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

NURSING NOTES

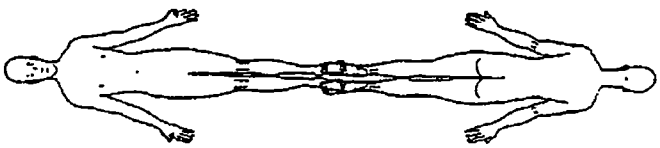
SEE SF 600

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?

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:_____

WAMC OP 173-E

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. 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	[redacted]	Civ # [redacted] b(6)-4	—	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
U n K n o w n	2 4 Y	9	—	—

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1100	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K91	—

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
0 Direct from ER	ICU1	Unknown

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	Unknown

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
Unknown

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
0 0 (Discharged) Other		0 3 0 6 0 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B M A Burns		0 3 0 5 2 8

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

FOR LOCAL USE

Dx → 2° Burns to 40% of BSA

Dx: 94833, 5849, 486, 7806, 7850, 94530, 94662, 2768, E993

PA: 311, 8628, 3873, 3591, 9357, 9701

ADM[redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] b(6)-2 SPC, USARmy

DA FORM [redacted]

MEDCOM - 9418

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		[redacted]	TOKY b(6)-4	CIV	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	22Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
N/A	N/A	20	[redacted] b(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	S	0911	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N	K91	UNK

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
F2	UNK	9		✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
X	FCU7	UNK

[redacted]EDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
b(2)-2	UNK	UNK

[redacted] TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
X1		030610

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030528

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

FOR LOCAL USE

DX: Blast injury

Dx: 94536 94224 94244 94520 5849 4589 276 486 94120 94320

PR: 93557 9904x2

Bleeding

ADMITTIN[redacted] (as required) b(6)-2

OR [redacted]

SI[redacted] b(6)-2

DA FORM 2085, MAR 80

MEDCOM - 9419

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 13273	2. NAME (Last, First, MI): EPW # [redacted] b(6)-4				3. GRADE: —	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE	7. RELIGION: muslim	8. LENGTH OF SVC: —	9. ETS: —	10. PREVIOUS ADMISSION: NO
11. FMP	12. SSN: [redacted]		13. ORGANIZATION: —			14. WARD: ICU1
15. FLYING STATUS: —	16. DSG: —	17. DEPT./BEN: b(6)-4 K76	18. BRANCH/CORPS: —	19. UIC/ZIP: —		20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from ER				22. HOURS OF ADMISSION: 1535	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION: EPW camp		26. DATE OF DISPOSITION: 14 Jun 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO.: UNK		28. DATE OF THIS ADMISSION: 29 May 03	ADMITTING OFFICER: [redacted] b(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION:	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P EXR-LAP

S/P RIGHT COLECTOMY

DX
5678
8792 E922.9

Proc T I
459 1 450
5188
503

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	16	16

36. Total Days All Facilites

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

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

DA FORM 3647, M[redacted] EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 9420

INPATIENT TREATMENT RECORD COVE... SET

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

13273 | NAME (Last, First) EPW [redacted] b(6)-4 | GRADE | ADMISSION REMARKS

M 24Y IRAQI | 1(6)-4 | ORGANIZATION | EMERGENCY ADMISSION NO

99 [redacted] | WARD ICW1

K49 | BRANCH OF SVC | DR. ZIP | TYPE CARE VSI

Direct from ER | 1145 | CLINIC SERVICE Internal Medicine

TYPE DISPOSITION RTN to EPW Camp | DATE OF DISPOSITION 2003 June 19

TELEPHONE NO | DATE OF THIS ADMISSION 2003 June 10 | ADMITTING OFFICER [redacted] b(6)-2

DATE OF INITIAL ADMISSION | DATES OF WHICH PERIODS CONFINED TRANSFERRED

[redacted] b(2)-2

DX → s/p EXP-LAP/ Placement of J tube / Trach

35. Total Days This Facility

ACTIVE CARE DAYS	OTHER DAYS	CONVALESCENT CARE DAYS	SUPPLEMENTAL CARE DAYS	BED DAYS	TOTAL SICK DAYS
0	0	0	0	9	9

36. Total Days All Facilities

ACTIVE CARE DAYS	OTHER DAYS	CONVALESCENT CARE DAYS	SUPPLEMENTAL CARE DAYS	BED DAYS	TOTAL SICK DAYS
[redacted]	[redacted]	[redacted]	[redacted]		

[redacted] SPC

DA FORM 3647, MAY [redacted] EDITION OF 1 AUG 76 IS OBSOLETE

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

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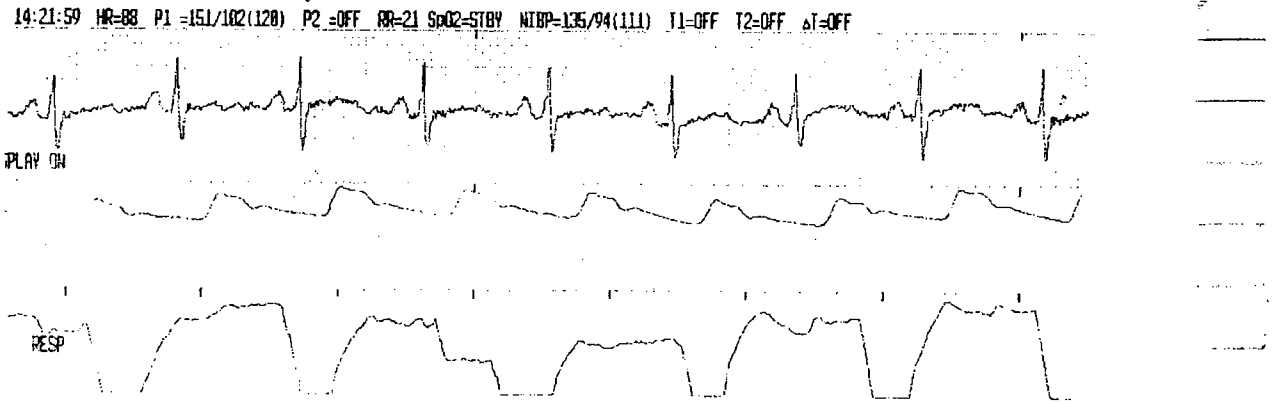
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5/28/03	Nursing: Admission / Recovery from OR
1400	Received from OR via litter accompanied with Anesthesia and OR Staff. Pt is drowsy and being bagged via secured ETT.
	Sn & #8. Bulky dsg @ shoulder, c̄ minimal spotty serosanguinous



	Mid line Axl dsg c̄ minimal drainage. Spotty area is circled. About ¼ coin size dressing around @ iliac c̄ drainage noted also spotty drainage. Pt has @ radial aline @ IJ HL, @ FA HL and @ ac. line PIV c̄ RL running @ TKO. Ngt @ nare clamped immediately connected to LIS. VSS on Admission Sat's 100% BP 158/69 Resp 32. Pt is put on vent immediately ABG to follow. See Assessment Sheet. Temp 96°F. will continue to monitor [redacted]
5/29/03	Nursing. ABG
1700	Pt remained 7.2 despite ↑ resp rate from 12-14 and decreasing FiO2 from 80% to 50%. MD Notified. An Order to give an Amp Bicarb given

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

ICU I

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5/29/03	Continuation: Nsg Note: ABG
1700	Will Repeat Abg later etc, see if there is any Correction in Metabolic Acidosis. [redacted] b(6)-2
5/29/03	Nursing Ind g Shift note
1700	Pt is stable. Sedated comfortably c̄ Versed 4mg/h. Lung Coarse. Sat 98-100 on Vent FiO2 80% Resp 5 Rate 14. Ø tracheal deviation from Axis. #8 ETT Seen @ the lip line. Pt breaths above the vent rate by +6 breaths. Vent changed @ 1400 c̄ ↑ in Resp rate from 12-14 and ↓ FiO2 from 60 to 9% c̄ posture effect in Resting ~~resp~~ @ metabolic acidosis. H.O notified an Order to give Pt One Amp of Sodium Bicarb done @ 1700. Abg to be repeated later. (D) Shoulder Bully dsg d+I (D) AROM (D) UE fingers also (D) Rem. Cold c̄ Cap refill <3secs. Mid Abd incision has Spots of Sero drainage circled. Foley to gravity Clear yellow urine. Pt is cold and shivering warm blanket was used to cover pt x2. Will Continue to monitor pt. [redacted] b(6)-3

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

ICU #1

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5/29/03	H+P / Adam
	25yo Rip GSW Abd (C) shoulder ⊖ peritonitis
	All prev med hx unknown.
	In ED VSS
	Chest CTA.
	Abd ⊕ peritoneal signs
	Wnds: (L) shoulder T/T mid abdomen.
	(R) buttock scar superficial
	Brat 2+ pulses
	Legs (1)
	A/ GSW abdomen penetrating, (L) shoulder wound
	(R) buttock superficial wound
	P/ OR (exploratory, medical [redacted] b(6)-2
5/29/03	OR Note
	Procedure: Exp; Liver Lac Resection; (R) hemicolectomy colostomy
	Surgeon: Carroll T. Matthews
	Anes: Palmquist
	EBL: 600 (1st case) bb-2
	Fluids (1st case: 3 Ringers, 1L Hespan) [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont)
	Finding ① Liver laceration Ant portion / Inf of Seg 4 extending to GB fossa
	② (R) colon mesenteric area at Hep Flexure
	To cont OR for prodcr. in OR [redacted]
	b(6)-2
	MATCHED. 3
EMMYOS	PREOP DX GSW (L) SCAPULA
	POSTOP DX SAME
	PROCEDURE DEBRIDEMENT
	SURG EMANUEL
	EBL 200 FLUIDS 1L 2ND CASE UP 100
	ANGIOS KEFUX
	CKD
	FINDINGS
	COMMINUTED FX CORACOID & INF NECK
	GLENOID STABLE JOINT CLOSED
	CONJOINT TENDON & SUBSCAP INTACT
	TO ICU SERIOUS
	b(6)-2
	[redacted] b(6)-2
	LTC, MC ORTHOPEDIC SERVICE

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	1355
	Exp Rap i Partial Gen Anesth.
	Two fent – lost gang Major Raccoonin ØBrown
	6L R1, 1L Hespen / 250 / 800 4/0 900 ASA 2E
	Inst 155/9 155/81 90Kg / 5'9/0 /
	GAS – Acedotin – Amp of Brach @ OR
	Need
	Abg
	3mg versed @ 1400
3m✓	Vent 12 VT 800 PEEP 5 FIO2 60% Sat 99%
5/30	Gurgen POD #1
	Pt sedated on Propofol.
	Tm 100.4 VSS ABG 7.2/34/160 on Vent.
	Abd Soft, dressing clean
	Shoulder dressing clean.
	A/P (1) Resp – Can't vent for now, met acidosis?
	cause, ✓ CPK's, await morning labs.
	(2) CV stable, await Hct.
	(3) ID – ØTemp, await WBC, cont IV Abx.
	(4) GI – Stable
	Concern now for pts. acidosis and concentrated
	urine. Bolusing fluids. [redacted]

5/1999) BACK
USAPA V1.00

b(6) - 2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29May03	1740: Received report + assumed care of pt @ 1700. Pt remains sedated on Versed gtt + mechanically ventilated. Dsg to (L) shoulder c̄ serosanguinous drainage. Midline abdominal dsg c̄ marked serosanguinous drainage. Small 2x2 gauze dsg to lateral side of (R) thigh c̄ serosanguinous drainage. Will continue to monitor closely. b(6)-2 [redacted] CPT/AN
29May03	1820: Pt c̄ frequent episodes of agitation, attempt[redacted] to pull @ abdominal dsg, and fighting vent. Versed gtt ↑ but pt c̄ increasing agitation. Dr [redacted] aware + received v.o. to start Propofol gtt. Will continue to monitor + assess effectiveness of sedation. b(6)-2 [redacted] CPT/AN
29May03	1850: Propofol gtt started @ 20mcg/kg/min. Will titr[redacted] to effect. b(6)-2 [redacted] CPT/AN
29May03	2200: VSS; pt now resting quietly while [redacted]ted on Versed + Propofol. Will continue to monitor closely. [redacted] CPT/AN
30May03	0200: VSS, pt quiet, remains sedated. Will continue to mon[redacted] closely. b(6)-2 [redacted] CPT/AN
30May03	0400: Dsg to (R) buttock D'd. Iodoform packing removed. Wound cleansed c̄ NS. New Iodoform packing placed + wound covered c̄ 4x4 gauze dsg + secured c̄ tape. [redacted] CPT/AN b(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
[redacted] b(2)-2			
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
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30May03	1750: Dr [redacted] notified of UOP=0@ 1700. Received V.O. to flush foley & continue to monitor. — [redacted]
30May03	1815: Dsg to (L) shoulder c̄ shadow drainage. Dsg to midline a[redacted] CDI. Dsg to (R) hip/buttock area c̄ serosanguinous drainage. Will continue to monitor closely. — [redacted]
30May03	1945: 500cc bolus LR given, MIVF ↑ to 175cc/hr, & [redacted]mine gtt started @ 3mcg/kg/min. Will cont. to monitor. [redacted]
30May03	2000hrs: Pt becoming agitated, biting on ETT, BP 180-200s syst[redacted]ly & HR ↑ to 160-170s. Per MD order from Dr [redacted] will start propofol gtt & titrate for adequate sedation. — [redacted]
31 May 2003	@ 1700 assumed care of patient. pt sedated & intubated c̄ #8 ETT [redacted] @ lip mark, FIO_2 - 50%, SIMV - 14, PEEP - 5, TV - 800, Resp - 14. CTA Breath Sounds. Bulky dsg to left shoulder. ABd dsg to abdomen. and dsg to left buttock area. CXray done this AM. Blood work drawn and taken to lab, antibiotics administered as ordered. Dopamine & propofol continuous drip, will continue to monitor — [redacted]
31 May @ 0815	Dsg to (L) Shoulder c̄ bloody drainage. Dsg reinforced. Abdominal dsg CDI. Dsg to (R) hip c̄ serosanguinous drainage. pt to OR this AM. will continue to monitor. — [redacted] — RC
	0830 pt became agitated. BP 140-150's / 90-100's HR - 170-180's. Propofol gtt increased for adequate Sedation. will contine to monitor — [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 May 03	pt being transported to surgery by OR team at this time b(6)-2 [redacted] [illegible]
31 May @ 1300	pt received from OR in stable condition. RT @ bedside for vent transfer + vent settings. Sats @ 95%. BP 149/82, pulse 130, Resp 19. Temp 98°. ABG done by RT. Propofol restarted for sedation. Dopamin stopped @ this time. BP stable. Foley in place quantity sufficient. dark yellow urine noted. [redacted] (CPT) b(6)-2
31 May @ 1400	Drsg changed on abdomen. staples intact underneath. changed drsg to (R) buttocks. repacked opening, cleaned site, ant. biotics administered as ordered. [redacted] b(6)-2
31 May 03	1735: Received report + assumed care of pt @ 1700. VSS. Bulky drsg to (L) shoulder CDI, JP to (L) shoulder c̄ serosanguinous drainage. Midline abdominal incision CDI. Drsg to (R) upper thigh/buttock c̄ large amts of serosanguinous drainage. Will continue to monitor closely. b(6)-2 [redacted] CPT/Hr
31 May 03	2000hrs: Temp = 102° ax. 650 mg Tylenol give per NOT. [redacted] cont. to monitor closely. [redacted] CPT/Hr b(6)-2
1 June 03	@ 0600 assumed care of pt. assessment [redacted] See WMC of 3B pt sedated c̄ propofol & treated morphine for pain. pt vented RT @ bedside to assess settings. settings confirmed. Sats 95-98% on FIO_2 50% (L) shoulder bulky drsg CDI. abdominal drsg CDI. Drsg to (R) hip c̄ serosanguinous drainage. will continue to mon. for. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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EPW #[redacted] b(6) 4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

31 MAY 03 OP NOTE

PREOP DX GSW (L) SHOULDER C̄ CORACOID FX, SUBSCAP TENDON TEAR & CONJOINT TENDON AVULSION, LAC CLAVICULAR HEAD PECTORALIS MAJOR

POST OP DX SAME

PROCEDURE - DEBRIDEMENT (L) SHOULDER WOUND C̄ EXCISION COMMINUTED CORACOID FX, SUBSCAP REPAIR, REPAIR CONJOINT TENDON TO CC & ~~CA~~ LIGAMENTS & PEC MINOR TENDON. DELAYED PRIMARY CLOSURE.

SURG GRANVILLE / QUIZENO

ANES GEN CASTRO

FLUIDS 2L LR EBL 100 cc CXP

DRAINS JP X1 SITE CORACOID PROCESS

FINDINGS (1) COMMINUTED CORACOID FX

(2) LAC SUPERIOR 1/2 SUBSCAP (a) MT JUNCTION

(3) AVULSION CONJOINT TENDON

(4) AVULSION CLAVICULAR HEAD PEC MAJOR

(5) CLEAN WND C̄ MIN SM BULLET FRAGS

(6) VIABLE MUSCLE [redacted] b(6) 3

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	[redacted] INTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

6/1/03 Surgery Pro# 3, 1

Pt. sedated.

ABC

AVSS I/O good u.o.

11.9 / 8.6 / 27 / 233 132 / 109 / 12 / 3.7 / 24 / 0.8 / 92 alb 1.7 GGT 35

abd soft, Dressing clean

left shoulder dressing clean.

A/P

① ✓ ABG → plan wean to extubate.

② CV - Hct stable, VSS

③ Renal - BUN/cr stable, good u.o.

④ Id - ↓WBC, cont Abx until all drains out

⑤ GI - start p.o. as tolerate

[redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 June 03 @ 0900	Start to wean pt for extubation per doctor order. pt appears stable. moves legs and (R) arm. will continue to monitor closely. [redacted] CPT b(6)-2
1 June 03 @	TPeeTRiAH done by RT. sats @ 99%. Propofol stopped. order to Extubate noted. LTC [redacted] ~~LTC~~ @ bedside to assist. RT - SGT [redacted] @ bedside. [redacted] CPT b(6)-2
1 June 03 RT	pt placed on T-piece trial @ 20LPM. pt RR 24 SaO2 98% HR 148 BP 103/65 BBS diminished coarse. pt very agitated. Plan to DO ABG in 30min - 1hr. [redacted] SGT RT b(6)-2
1200 1 Jun 03 RT	Pt Placed on ~~50~~ Venturi mask 10LPM 50% FiO2 Gas Taken Results PH 7.421 PCO2 38.1 PO2 99 HCO3 25 BE 0 SO2 98% BBS coarse HR 144 RR 24. [redacted] RT SGT b(6)-2
1400 1 June	pt extubated. suctioned by RT. nonrebreather face mask placed @ 10L. 97% sats. pt has not opened eyes. but moves head side to side moves all extremities except (R) arm. Foley + JP drainage emptied. antibiotics hung as ordered (R) ET access flushed. intact + patent. will continue to monitor. [redacted] CPT b(6)-2
1700 1 June	Received report on patient. Pt sleeping in bed. LP running at 175. O2 via FM @ 10L. All dressings c/d/i. Ronchi in upper lobes, will suction via nasal trumpet. VSS. No c/o pain. [redacted] CPN b(6)-2
1820	Tried to suction via NT. Did not get any returns. Pt sats dropped to

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

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

REGISTER NO.	WARD NO

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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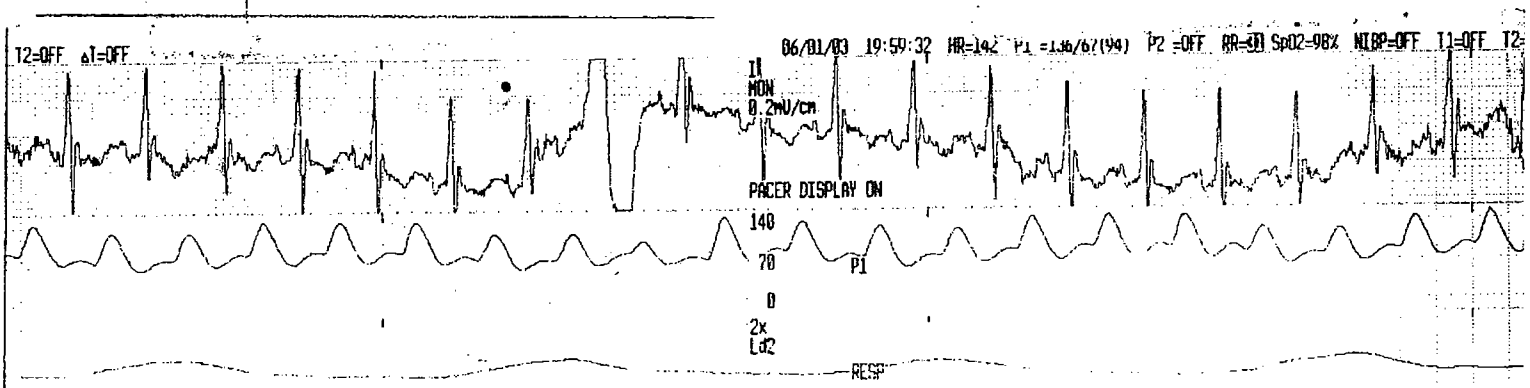
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	80's. Pt. put on NRB. Pt ~~sats~~ ↑ 90's. Will continue to monitor [redacted] CPN b(6)-2



2000	Pt having PVC's. Rhythm strip taken at 1959. [redacted] b(6)-2
2050	Pt given Tylenol supp. for fever 101.7 [redacted] CPN
0100	Pt. urine turning red again. Dr. [redacted] notified. [redacted] b(6)-2
0200	Gave pt a bath. Changed sheets. Pt still not cognizant. [redacted] Continue to monitor [redacted] CPN
0400	No change in assessment. VSS. b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

2 June 03 @ 0600 assumed care of pt. pt agited, moving around in bed. occassionally opening eyes. still seem sedated. litter restraints placed over him. (R) hand wrapped to perserve the A-line & peripheral line. MSO4 given for pain. A-line D/C'ed. medication administered as ordered. will continue to monitor. [redacted]

b(6) - 2

6/2/03 Surgery POD#4, 2
Pt. extubated yesterday, ~~pt~~ no distress, comfort AVSS
F/U good u.o. >200/hr
8/24 139/103 14/3.0
Lungs clear ~~Heart~~ RRR abd soft, NT, incision healing well.
(1) Resp - ↓ MSO4 & start VS/VS for pain to help c̄ his mental status.
(2) CV - VSS, Hct 24, will give 1 unit pRBC
(3) Renal - good u.o., BUN stable
(4) ID - Cont Abx, ✓ CBC.
(5) GI - Start TF in AM 6/3 [redacted]

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

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

[redacted] b(6) - 4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 June 03	@ 0830 labs drawn. PRBC ordered. will continue to mon for. will give Lasix c̄ Blood administration. [redacted] b(6)-2
2JUN03 0945	ORTHO AGITATED, SEDATED P 125 121/75 99.1 25 CVE NVI 1 MMOB IN PLACE JP 70cc/12 HR A JP OUTPUT TOO MUCH TO RIL P CONT ABX RIL AGAIN TOMORROW
	[redacted] b(6)-2 LTC, MC ORTHOPEDIC SERVICE
2 June 03 1440	Dr [redacted] stated does not want patient to have MSO4. Just motrin. will [redacted] to mon. for ABG done by RT [redacted] b(6)-2
2 June 03	Received pt. 1700. Pt. agitated, c̄ RR 36 ↑, bp. 162/89, p 135, [redacted] b(6)-2
1800	DRSG Δ on peripheal IV line, flushed. A-line, added ABD dressings to suture (staple) site midline. Rhonchi present, Pt was suctioned c̄ 18 french, Oral trachea, less Rhonchi present. Thick, tan/brown secretions noted [redacted] b(6)-2
1930	Pt. orotracheal/nasogastric tube suctioned c̄ 14F Suct. cath. Lung sounds clearer. 800mg Motrin given via NG

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

2 June 03 2330 Repositioned NG tube, verified proper placement by 10cc air into stomach.

3 June 03 0030 DRSG Δ completed to (R) buttock/hip area; Serosanguinous drainage noted. No S/S infection noted. Will continue to monitor — [redacted] b(6)-2 9 [illegible]

3 June 03 ~~0400 Sc~~ 0200 Washed pt. and put new linen on bed, 0400 Suctioned PT. via NG tube. Brownish tinged secretions moderate amount, Pt. has rhonchi bilaterally, decreased significantly post suctioning. — [redacted] b(6)-2 9 [illegible]

3 June 03 @ 0615 report received. assumed care of pt. ∅ alert. ∅ reactive to light does not follow commands, opens eyes. moans. moves in bed, ven. mask on @ 8 L O_2. Sats 98%. Bulky (R) shoulder drsg in place. CDI. JP bulb in place. Staples to abdomen intact. ∅ drainage noted, drsg to (R) hip draining serosanguinous fluid ↓ in copious amounts. Will continue to monitor. — [redacted] b(6)-2

3 June/03 Surgery
Pt. mental status still ↓, moves all 4 extremities
AVSS
I/O work.

2.5 11/35 141/3.3 103/24 14/0.8 114

Cont →

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
June 3	Surgery PE abd soft, incision healing well Shoulder - drains in place. A/P ① Mental status still a concern, metabolic vs. CHI. Cont to observe. ② Resp - ABG ok, cont Sx'ing c pulm toilet ③ CV - VSS ④ Renal - good U.O. BUN/cr stable ⑤ ID - WBC ↓↓ - concerning neutropenia - will re✓ CBC to confirm & if accurate will broaden Abx. ✓ X-Ray chest, abdomen. ⑥ GI - Start TF's ↓ NG tube. [redacted] b(6)-2
3 June @ 0800	CBC drawn + sent to lab. NG feeding done c Ensure. will check residual before next feeding. X-Ray done as requested. will continue to monitor. [redacted] b(6)-2
3 June @ 0830	mouth care done for pt. — [redacted] b(6)-2
3 June @ 1045	<100c residual. #2 tube feeding c Ensure given. Foot splints are being given by PT for feet. — [redacted] b(6)-2
3 June @ 1400	<100c residual. #3 TF done. pt tolerated well. HOB @ 30°. will continue to monitor. — [redacted] b(6)-2
3 June @ 1645	TF done c Ensure. 0 residual noted. Motrin given @ this time. — [redacted] b(6)-2

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USAPA V1.00

PROGRESS NOTES

DATE	
SEP 03	ORTHO POD 3
	SELF CONFIRM
	VSSA
	JP < 30 CC / 12° NEURO
	WELL PERFUSED LUE. C SPONT. HAND NOW
	IMMOBILIZER IN PLACE
	A (L) SH GSW POD 3 DPC REPAIR
	(1) SUPERIOR 1/2-1/3 SUBSCAP
	(2) DEC MINOR TO CC TO CA TO CONJOINT TENDON
	(3) EXCISION COMMINUTED UNACCOMP
	P PT WILL BE FOLLOWED BY DMS [redacted] b(6)-2
	[redacted] MY ABSENCE. b(6)-2
	[redacted] b(6)-2
	[redacted]
	FTC, MO ORTHOPEDIC SERVICE

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

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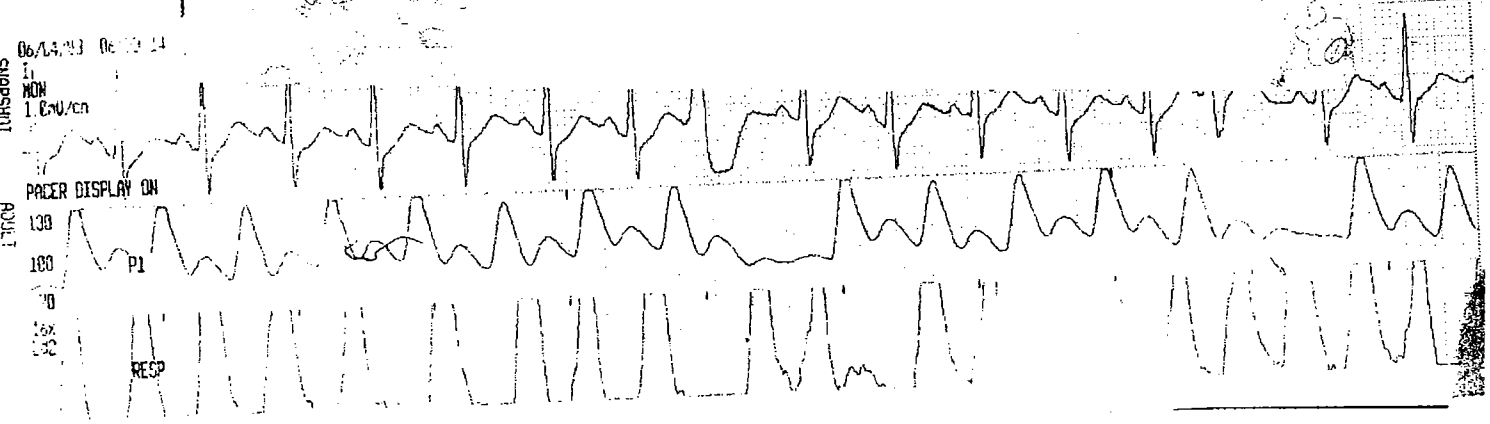
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Jun 03	0500 Resumed care. Report given. See III-7 flowsheet for initial assessment [redacted] b(a)-2



4 Jun 03	0630 Resp distress noted. Call sent OR's & anesthesia staff. HR 120, RR 40-50's. Exp. wheezing noted. 0640 40mg Lasix IVP given. SpO2 97-98% remains in resp distress, use accessory muscles noted. Ex. [redacted] b(a)-2 RN @ bedside. 0655 Anesthesia @ bedside. 20mg Etomidate IVP given. 1mg Vecuronium 150mg Fentanyl. 120mg Succinylcholine order by MOT [redacted] RNA!

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

SPONSOR'S NAME [redacted] | RELATIONSHIP TO SPONSOR | b(a)-2 [redacted]

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* b(a)-2 | REGISTER NO. | WARD NO.

[redacted] b(a)-2 4 Jun 03

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Jun 03	0930 Fentanyl gtt 50mcg/hr — [redacted] b(6)-2
	1000 UOP 150cc amber color
	1030 notified Dr [redacted] for cvl placement pt
	1145 cvl placed by Dr [redacted] b(6)-2 PCXR
	taken for line placement — [redacted] b(6)-2
	1230 okay to use cordis. O/P transduce
	reading 9-10. 1L NS bolus given — [redacted] b(6)-
	1300 labs reviewed by Dr [redacted] b(6)-2
	Echo done: HR 115-120's ∑ occ. PVC's
	noted. BP 90's. Fentanyl gtt @ 40mcg/h,
	1315 A-line site redness pt resting
	quietly. NSS — [redacted] b(6)-2
	1330 vent setting: AC rate 16,
	FIO2 0.40 TV 450, peep 5cm. SpO2 98. — [redacted] b(6)-2
	1330 TF ing Ensure bolus. 600cc. Sims
	tube. Tolerate well. — [redacted]
	1450 oral care given, along T bed
	bath. — [redacted] b(6)-2
	1630 Report given to Drs. orders
	received. — [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.

[redacted] b(6)-4

4 Jun 03

CHRONOLOGICAL RECORD OF MEDICAL CARE
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