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

d/Section:	REQUESTING PHYSICAN:	DATE	TIME	SSN/PEEUDO SSN:
T, FIRST,MI.				

(Hematology) CBC

ST	RESULT	REF. RANGE

10-10-03
03:51
ID: [redacted]
WB
Patient
Limits

WBC	6.3	x10^3/uL	4.5	10.5
RBC	4.32	x10^6/uL	4.00	6.00
Hgb	12.2	g/dL	11.0	18.0
Hct	38.4	%	35.0	60.0
MCV	88.9	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	313.	x10^3/uL	150.	450.
LY%	33.9	%	20.5	51.1
LY#	2.1	x10^3/uL	1.2	3.4

Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52%(M) 37-47%(F)	
Set 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

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		

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

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 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

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

UNIT	TYPE	CROSSMATCH

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

MEDCOM - 19841

b(6)-2

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted]

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

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE

ID: [redacted] 19-09-03
WB 16:33
b(6)-4

			Patient Limits	
WBC	7.0	x10^3/uL	4.5	10.5
RBC	3.88 L	x10^6/uL	4.00	6.00
Hgb	12.0	g/dL	11.0	18.0
Hct	36.5	%	35.0	60.0
MCV	94.0	fL	80.0	99.9
MCH	30.8	pg	27.0	31.0
MCHC	32.8 L	g/dL	33.0	37.0
Plt	402.	x10^3/uL	150.	450.
LY%	29.1	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

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

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

CSF

Cell Count		
Directigen		Negative

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.:

b(6)-2

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

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted]

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

DATE: 19 Sept

TIME: 1620

SSN/PSEUDO SSN: [redacted] b(6)-2

(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 (a 41-51 mmHg (ven
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ar 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

```
======= PICCOLO =======
19/09/03            16:31
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #:        3141AA4
OPER #: [redacted]  DR #: 000
SERIAL #: b(6) [redacted]
..............................
GLU   104   73-118   MG/DL
BUN    18   7-22     MG/DL
CRE   0.8   0.6-1.2  MG/DL
CK    162   39-380     U/L
NA+   ♦♦♦   128-145  MMOL/L
K+    4.4   3.3-4.7  MMOL/L
CL-   ♦♦♦   98-108   MMOL/L
tCO2   24   18-33    MMOL/L

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

I-Stat
Na - 136
Cl - 104

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		

```
======= PICCOLO =======
19/09/03            16:31
REFERENCE RANGE:     MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #:        3204AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
..............................
ALB    2.9*  3.3-5.5    G/DL
ALP    97*   26-84       U/L
ALT    55*   10-47       U/L
AMY    50    14-97       U/L
AST    <5*   11-38       U/L
TBIL   0.5   0.2-1.6   MG/DL
BUN    19    7-22      MG/DL
CA++   9.2   8.0-10.3  MG/DL
CHOL   182   100-200   MG/DL
CRE    1.0   0.6-1.2   MG/DL
GLU    110   73-118    MG/DL
TP     7.7   6.4-8.1    G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(a)-2

Ward/Section: ICW #1	REQUESTING PHYSICIAN:		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI	DATE 08Oct03	TIME 1420	SSN/PSEUDO SSN:

b(a)-4 b(a)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID:		4.8-10.8 x 10³
		Patient Limits
WBC	7.9	x10³/uL 4.5 10.5
RBC	4.06	x10⁶/uL 4.40 5.90
Hgb	11.5	g/dL 11.0 18.0
Hct	35.4	% 35.0 60.0
MCV	87.2	fL 80.0 99.9
MCH	28.3	pg 27.0 31.0
MCHC	32.4 L	g/dL 33.0 37.0
Plt	302.	x10³/uL 150. 450.
LY%	22.4	% 20.5 51.1
LY#	1.8	x10³/uL 1.2 3.4

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

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

CSF

Cell Count		
Directigen		Negative

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: 20Oct03	LAB ID NO.:

b(a)-2

Ward/Section:	...STING PHYSICIAN: b(6)-4	...STRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

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

(Misc. Chemistry)

TEST	RESULT	REF. RANGE
Troponin-I	neg	
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
b(6)-2	2 oct 03	

b(2)-2

Preliminary Report

Microbiology Request Form

Last Name: EPW	Ward: ICW 1
First Name:	Room:
Patient # or SSN:	Bed:
Collected by: DR.	Physician: DR.
Date: 18 OCT 03	Source: WOUND
Time: 1024	Site: FEMUR

b(6)-4 b(6)-2

Received by:	Specimen #
Date: 18 OCT 03	
Time:	

Preliminary Laboratory Results

Staphlococcus epidermidis

Reported Date: 22 OCT 03	
Time: 1419	
Tech:	
Reviewer:	Number of attached sheets: 1

b(6)-7

Preliminary Report

Microbiology Request Form

b(6)-4

Last Name: #
First Name:
Patient # or SSN:

Ward: ICW
Room:
Bed:

Collected by: Dr.
Date: 18 Oct 03
Time: 1024

b(6)-2

Physician: Dr.
Source: wound
Site: (R) femur

Received by:
Date:
Time:

Specimen #: Aerobic / Anaerobic

Laboratory Results

Staphylococcus epidermidis x2

Reported
Date: 24Oct03
Time: 1245
Tech:
Reviewer:

Number of attached sheets:

b(6)-2

MEDCOM - 19847

b(2)-2

Microbiology Request Form

Last Name: # [redacted] b(4)-4	Ward: ICW
First Name:	Room:
Patient # or SSN:	Bed:
Collected by: Dr. [redacted] b(6)-2	Physician: Dr. [redacted]
Date: 18 OCT 03	Source: wound
Time: 1024	Site: (R) femur
Received by:	Specimen #: Aerobic / Anaerobic
Date:	
Time:	

Laboratory Results

Staphylococcus epidermidis x2

Reported

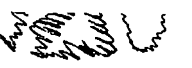
Date: 24Oct03

Time: 1245

Tech: [redacted]

Reviewer: [redacted] b(6)-2

Number of attached sheets:



b(2)-2

Microbiology Request Form

Last Name: # b(6)-4
First Name:
Patient # or SSN: b(6)-4

Collected by:
Date: 20 Sep 03
Time: 1620

Ward: ICW1
Room:
Bed:
Physician: b(6)-2
Source: Rt femur Swab
Site: Rt femur

Received by b(6)-2
Date: 20 Sep 03
Time: 1630

Specimen #:

Laboratory Results

initial gram stain – few gram positive cocci pairs
few gram negative rods
Staphylococcus xylosus
Proteus. mirabilis

Reported
Date: 23 Sep 03
Time: 0900
Tech:
Reviewer: b(6)-2

Number of attached sheets:

Microbiology Report

b(2)-2

Name: CIV
Patient ID:
Ward/Rm: /

Specimen:
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Staphylococcus epidermidis Status: Final

1 **S. epidermidis**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	16/8	R			
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	>16	R			
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Ceftriaxone (c)	>32	R			
Cephalothin	>16	R			
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
Clindamycin	>2	R			
Erythromycin	>4	R			
Gatifloxacin	<=2	S			
Gentamicin	8	I			
Imipenem (c)	<=4	R			
Levofloxacin	<=2	S			
Linezolid	>4				
Moxifloxacin	>4	R			
Nitrofurantoin	>64				
Norfloxacin	<=4				
Ofloxacin	4	I			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	>2	R			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	>16	R			

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

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

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

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

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

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

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

Name: CIV
Patient ID: b(4)-4
Ward/Rm: /

Specimen:
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Req. Phys:

b(4)-2

Microbiology Report

b(2)-2

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

Specimen:
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Staphylococcus epidermidis — Status: Final
2 Staphylococcus epidermidis — Status: Final

1 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	8	I
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	<=8	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	2	I
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	>4	R
Gentamicin	>8	R
Imipenem (c)	<=4	R
Levofloxacin	>4	R
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	>4	R
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
Vancomycin	>16	R

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

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

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

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

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

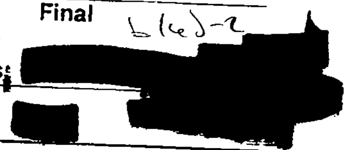
(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations.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

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

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

Specimen:
Source: Wound/Sterile site
Ward of Iso:

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



Microbiology Report

b(2)-2

Name: CIV
Patient ID: b(6)-4
Ward/Rm:

Specimen:
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1	Staphylococcus epidermidis	Status:	Final
2	Staphylococcus epidermidis	Status:	Final

1 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	8	I
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	<=8	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	2	I
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	>4	R
Gentamicin	>8	R
Imipenem (c)	<=4	R
Levofloxacin	>4	R
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	>4	R
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
Vancomycin	>16	R

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

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

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

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

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

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

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

Microbiology Report

b(2)-2

Name: CIV	Specimen:	Status: Final
Patient ID: b(a)-4	Source: Wound/non-sterile body site	Collected:
Ward/Rm: /	Ward of Iso:	Attd. Phys:

	Organism	Status
1	Staphylococcus xylosus	Final
2	Proteus mirabilis	Final

1 S. xylosus

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	
Moxifloxacin	<=2	S
Nitrofurantoin	64	
Norfloxacin	<=4	
Ofloxacin	<=2	S
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	<=4	S
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 P. mirabilis

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

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

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

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

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

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

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

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

Microbiology Report

b(2)-2

Name:	CIV	Specimen:	[redacted]		
Patient ID:	[redacted] b(6)-4	Source:	Wound/non-sterile body site	Status:	Final
Ward/Rm:	/	Ward of Iso:		Collected:	
				Attd. Phys:	

	Organism	Status
1	Staphylococcus xylosus	Status: Final
2	Proteus mirabilis	Status: Final

1 S. xylosus

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	Not Tested
Moxifloxacin	<=2	S
Nitrofurantoin	64	
Norfloxacin	<=4	
Ofloxacin	<=2	S
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	<=4	S
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 P. mirabilis

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

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

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

Blank = Data not available, or drug not advisable or tested
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(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (e) also applies to this drug.

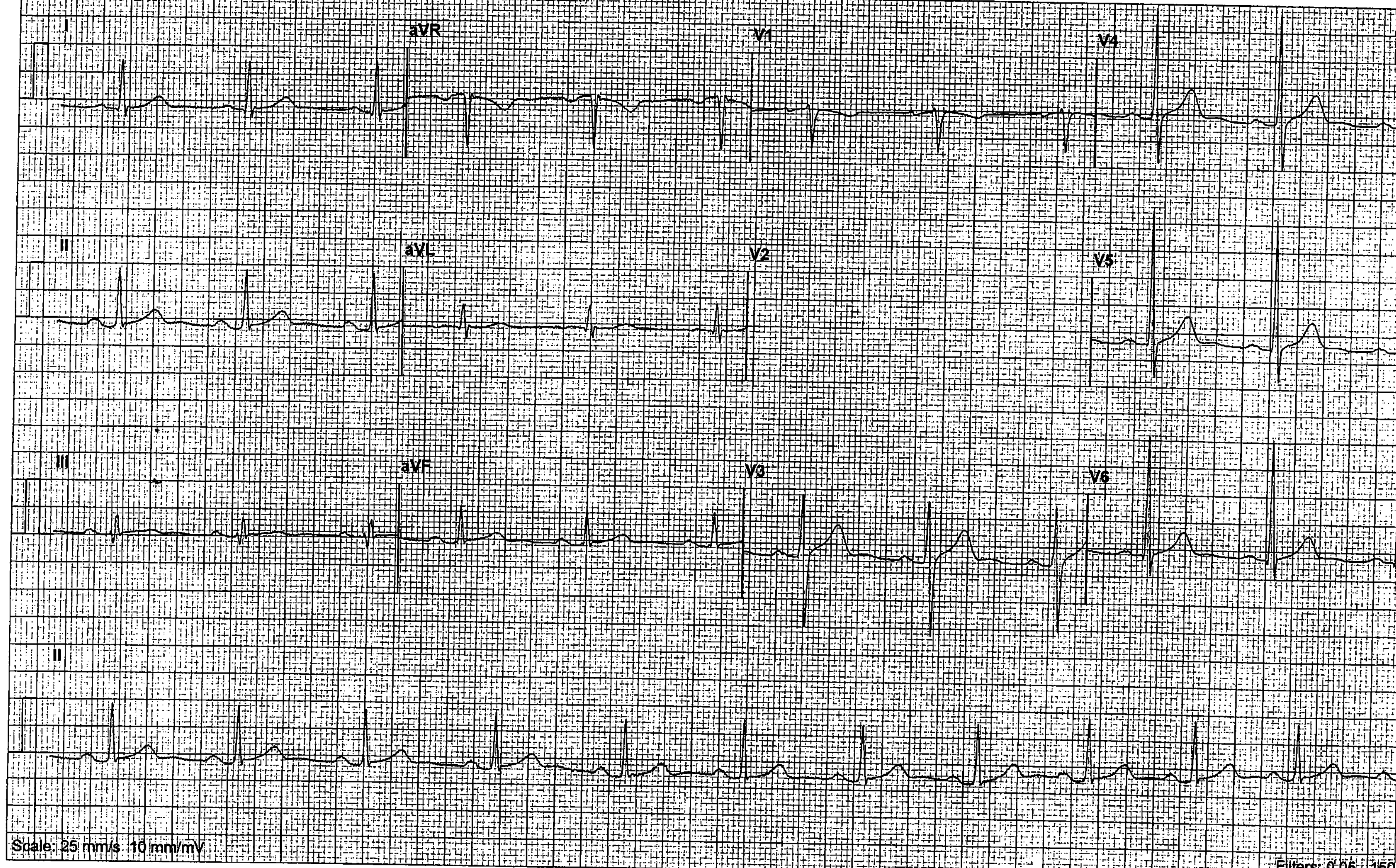
Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections,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

3x4 Simultaneous Report

Name:
Number:
Sex: Male
Date of Birth: 10/20/2003
Height/Weight: 71in / NA

Recorded: 10/20/2003 1:30:28 PM
Device: CL 131132

Interpretation (Unconfirmed)
Leads off. ECG not analysed.



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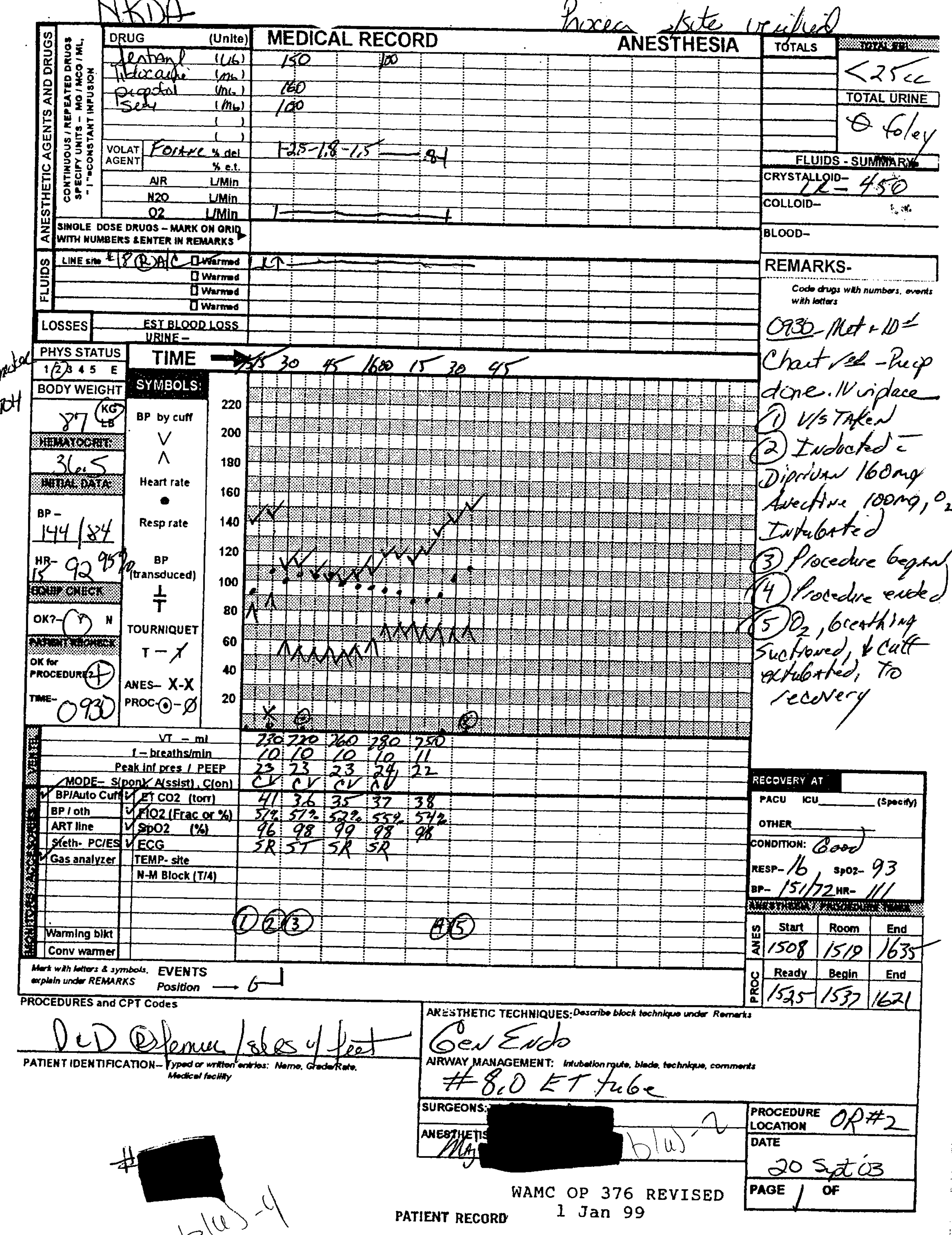
Confirmed by:


NKDA
Procedure site verified

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		
Fentanyl	(UG)	150	100
Lidocaine	(MG)		
Propofol	(MG)	160	
Sux	(MG)	100	
VOLAT AGENT Forane	% del	1.25-1.8-1.5	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	1	

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

FLUIDS: LINE site #18 Ⓡ A/C ☐ Warmed — LR

LOSSES: EST BLOOD LOSS; URINE –

TOTALS — TOTAL EBL: <25cc; TOTAL URINE: ∅ foley

FLUIDS - SUMMARY: CRYSTALLOID– LR – 450; COLLOID–; BLOOD–

PHYS STATUS: 1 ②3 4 5 E
BODY WEIGHT: 87 KG
HEMATOCRIT: 36.5
INITIAL DATA: BP – 144/84; HR – 92; 95%
EQUIP CHECK: OK? Ⓨ N
PATIENT RECHECK: OK for PROCEDURE ⓨ; TIME – 0930

TIME → 15 30 45 1600 15 30 45

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

VENT					
VT – ml	730	720	760	780	750
f – breaths/min	10	10	10	10	11
Peak inf pres / PEEP	23	23	23	24	22
MODE – S(pon), A(ssist), C(on)	CV	CV	CV	CV	
ET CO2 (torr)	41	36	35	37	38
FIO2 (Frac or %)	51%	51%	52%	55%	54%
SpO2 (%)	96	98	99	98	98
ECG	SR	ST	SR	SR	
TEMP- site					
N-M Block (T/4)					

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

Events on grid: ① ② ③ ④ ⑤

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

REMARKS- Code drugs with numbers, events with letters

0930 – Met pt ID'd. Chart rev'd – Prep done. IV in place.
① V/S taken
② Inducted c Diprivan 160mg, Anectine 100mg, O2, Intubated
③ Procedure began
④ Procedure ended
⑤ O2, breathing suctioned, ↓ cuff, extubated, to recovery

RECOVERY AT: PACU ICU ____ (Specify); OTHER ____
CONDITION: Good
RESP – 16; SpO2 – 93
BP – 151/72; HR – 111

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1508	1519	1635
	Ready	**Begin**	**End**
PROC	1525	1537	1621

PROCEDURES and CPT Codes: I&D Ⓡ femur / 8 lbs of feet

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — Gen Endo

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — #8.0 ET tube

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

SURGEONS: [redacted]
ANESTHETIST: Maj [redacted] b(6)-2

PROCEDURE LOCATION: OR#2
DATE: 20 Sept 03
PAGE 1 OF

[redacted]
b(6)-4

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

MEDCOM - 19856

1

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Fentanyl	(mcg)	250	250
Propofol	(mg)	200	
Sch	(mg)	100	
Lidocaine	(mg)	100	
Zemuron	(mg)	30	
VOLAT AGENT Iso	% del / % e.t.	2.0 – 2.0 X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 – 2 – 2 – 10	

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

TOTAL EBL: Ø

TOTAL URINE: N/A

FLUIDS - SUMMARY
CRYSTALLOID– 400
COLLOID– Ø
BLOOD– Ø

FLUIDS — LINE site: 18g (L) AC ☐ Warmed — LR ——— 400

LOSSES — EST BLOOD LOSS; URINE – Not measured

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 87 KG

HEMATOCRIT: 12/36

INITIAL DATA: BP 119/66; HR– 103

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? Okay; TIME– 1930

TIME → 45 2000 15 30 45

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENT				
VT – ml	–	750	750	1000
f – breaths/min	16	12	12	20
Peak inf pres / PEEP	–	21	21	–
MODE– S(pon), A(ssist), C(on)	S	C	C	S

MONITORS / ACCESSORIES

X BP/Auto Cuff	✓ ET CO2 (torr)	(+)	43	38	40
BP / oth	✓ FIO2 (Frac or %)	.21	.81	.81	.81
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	SR	SR
Gas analyzer	X TEMP- site Skin				
	N-M Block (T/4)		4/4		4/4 c ST
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS; Position → O– LLD →

REMARKS- Code drugs with numbers, events with letters

1940 Aid to ICW 1, chart reviewed. To OR via litter.
1950 In room, (+) monitors, (+) O2, Smooth IV induction. Easy vent, Eyes taped,
2000 Placed in LLD, neck midline, Axroll placed, padded, Eyes free pressure (+) BBS (+) ETCO2
2015 Procedure started
2030 Reversed c 5mg Neostig– (+) 0.6mg Robinul
2035 Extubated c awake, VO sax2. To PACU stable, Report to [redacted]

RECOVERY AT: 2039 — (PACU) ICU ___ (Specify); OTHER ___
CONDITION: Stable, awake
RESP– 24; SpO2– 95 RA; BP–; HR– 88

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1940	1950	2045

	Ready	Begin	End
PROC	2000	2015	2032

PROCEDURES and CPT Codes: I&D (R) Femur

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DVL x 1 attempt, #8 ETT, MAC 4, Grade 1 view, (+) BBS (+) ETCO2, Secured @ 22cm teeth, Soft bite block placed.

SURGEONS: [redacted] CCPT

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

[redacted] b(6)-4 ICW-1 2F

PROCEDURE LOCATION: OR 2

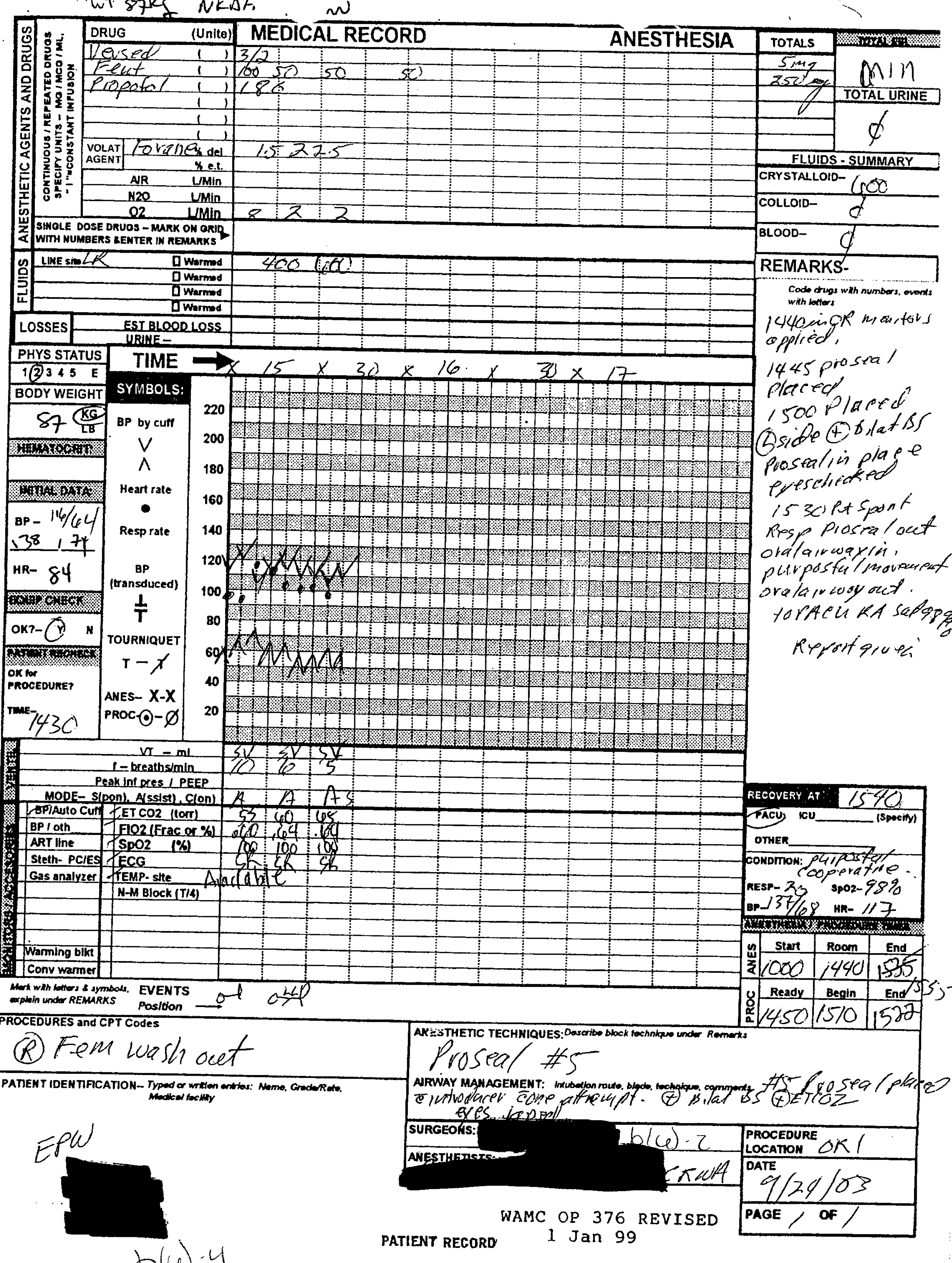
DATE: 22 Sep 03

PAGE 1 OF 1

b(6)-2

PATIENT RECORD — WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19857



WT 87kg NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)					TOTALS
Versed ( )	3/2				5mg
Fent ( )	100	50	50	50	250 mg
Propofol ( )	180				
( )					
( )					
VOLAT AGENT Forane % del	1.5	2	2.5		
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	8	2	2		

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

TOTAL EBL: MIN

TOTAL URINE: Ø

FLUIDS

LINE site		
LR ☐ Warmed	400	600
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES: EST BLOOD LOSS / URINE —

FLUIDS - SUMMARY
- CRYSTALLOID— 600
- COLLOID— Ø
- BLOOD— Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 87 (KG) LB

HEMATOCRIT:

INITIAL DATA:
- BP— 116/64, 138/74
- HR— 84

MACHINE CHECK: OK?— (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME— 1430

TIME → x 15 x 30 x 16 x 30 x 17

SYMBOLS: BP by cuff V Λ; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T — X; ANES— X-X; PROC— ⊙-Ø

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

REMARKS-

Code drugs with numbers, events with letters

1440 in OR monitors applied. 1445 proseal placed. 1500 placed (L) side (+) bilat BS. Proseal in place, eyes checked. 1530 Pt spont Resp. Proseal out, oral airway in. purposeful movement, oral airway out. To PACU RA Sat 98%. Report given.

VENTILATION

VT — ml	5V	SV	SV
f — breaths/min	10	10	5
Peak inf pres / PEEP			
MODE— S(pon), A(ssist), C(on)	A	A	AS

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	53	60	68
BP / oth	FIO2 (Frac or %)	.80	.64	.60
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	SR	SR
Gas analyzer	TEMP- site	Available		
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → 0 L ...

RECOVERY AT: 1540

(PACU) ICU ______ (Specify)

OTHER

CONDITION: purposeful, cooperative.

RESP— 20 SpO2— 98%

BP— 137/68 HR— 117

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1000	1440	1535

	Ready	Begin	End
PROC	1450	1510	1522

PROCEDURES and CPT Codes: (R) Fem wash out

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — Proseal #5

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — #5 Proseal placed c introducer one attempt. (+) bilat BS (+) ETCO2. eyes taped.

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

EPW

b(6)-4

SURGEONS: b(6)-2

ANESTHETISTS: CRNA

PROCEDURE LOCATION: OR 1

DATE: 9/24/03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 19858

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
Fentanyl (mcg)	250	250
Zemuron (mg)	40	
Propofol (mg)	180	
Lidocaine (mg)	100	
VOLAT AGENT Iso % del / % e.t.	1.0 – 1.8 – X	
AIR L/Min		
N2O L/Min		
O2 L/Min	10 – 2 – 2 – 10	

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

TOTAL URINE: not measured

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

FLUIDS — LINE site: 18g (L) Arm ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed — LR —— (800) ——

LOSSES — EST BLOOD LOSS; URINE –

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 82 KG
HEMATOCRIT: 12/36
INITIAL DATA: BP– 144/57; HR– 96
EQUIP CHECK: OK?– (Y) N
PATIENT RECHECK: OK for PROCEDURE: Okay; TIME– 0845

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

TIME → 0900 15 30 45 1000 15

VT – ml		700	710	710	800
f – breaths/min	16	12	12	10	10
Peak insp pres / PEEP	–	20	22	20	–
MODE– S(pon), A(ssist), C(on)	S	C	C	C	S
ET CO2 (torr)	⊕	38	35	36	48
FIO2 (Frac or %)	.59	.59	.59	.59	.59
SpO2 (%)	100	100	100	100	100
ECG	SR	SR	SR	SR	SR
TEMP- site skin		97	97		
N-M Block (T/4)				4/4 0 ST	

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

REMARKS- Code drugs with numbers, events with letters.

0845 Ident, ICW, chart reviewed, T.O.R., 0900 In room, ⊕monitors, ⊕oxygenation, smooth IV induction, easy ventilation. Eyes taped. 0910 turned LLD – pp padded, Axroll placed, Eyes, ears, nose free pressure. 0930 incision(?) ⊕BBS⊕ETCO2 1000 Pt awake, extubated ⓢ difficulty ⓟ PO ... To PACU stable. Report to [redacted]

RECOVERY AT 1005 — (PACU) ICU (Specify); OTHER; CONDITION: Stable/Awake; RESP– 20 SpO2– 98 – RA; BP– 144/81 HR– 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0845	0900	1020

	Ready	Begin	End
PROC	0910	0930	1000

Mark with letters & symbols, explain under REMARKS — EVENTS; Position —— 0 —— LLD → → 0

PROCEDURES and CPT Codes: I&D (R) Femur

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DL x 1 atraumatic, MAC 4, #8 ETT, Grade I view, ⊕BBS ⊕ETCO2, Secured @ 23cm teeth, soft bite block

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

SURGEONS: [redacted] b(6)-2 [redacted] CKWAEPT

PROCEDURE LOCATION: OR 2-2
DATE: 26 Sep 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 19859

ASA-2 smoking LR IR Gent aprofloxacin ② Proteus mirabilis

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)						TOTALS
morphine (mg)	10			5	5	20mg
phenergan (mg)	12.5					
propofol (mg)	200					
VOLAT AGENT Iso % del / % e.t.	2.0	2.0	2.0	1.5	1.5 X	
AIR L/Min						
N2O L/Min						
O2 L/Min	6	2	2	2	2 - 10	

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

TOTAL EBL: min

TOTAL URINE: Ø

FLUIDS - SUMMARY
CRYSTALLOID- 700
COLLOID- Ø
BLOOD- Ø

FLUIDS

LINE site	Warmed	
20g RFA	☐ Warmed	LR 700 ↑ —— 500

LOSSES

EST BLOOD LOSS
URINE -

PHYS STATUS: 1 ②3 4 5 E

BODY WEIGHT: 87 KG

HEMATOCRIT: [crossed out]

INITIAL DATA:
BP- 137/71
HR- 68

EQUIP CHECK OK?- Ⓨ N

PATIENT RECHECK OK for PROCEDURE? Y

TIME- 1330

TIME → 30 14 30 15 30 16 30

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊘

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENTIL

VT - ml	500	320	320	310	380
f - breaths/min	16	13	12	12	12
Peak Inf pres / PEEP	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	42	46	47	48	41
BP/oth	✓FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7
ART line	✓SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ECG	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 → O LLD → →

REMARKS
Code drugs with numbers, events with letters
① To room, SOC mons, preO2.
② Induction & LMA pmt.
③ Pt turned Lt lateral.
④ [redacted] removed to PACU, stable, report given.

RECOVERY AT: PACU ICU (Specify)
OTHER 968
CONDITION:
RESP- 22 SpO2- 95
BP- 132/83 HR- 76

ANESTHESIA / PROCEDURE TIMES

ANES	Start 1330	Room 1338	End 1455
PROC	Ready 1345	Begin 1400	End 1445

PROCEDURES and CPT Codes: I&D Rt femur, abx beads

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GLMA

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, LMA #4 in s trauma, ⊕ ETCO2 BBEB. Secured soft bite block & tape.

SURGEONS: [redacted] b(6)-2
[redacted] MAJ, CRNA
ANESTHESIA PROVIDER

PROCEDURE LOCATION: 1
DATE: 10/6/03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 USAPA V1.00

MEDCOM - 19860

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)						TOTALS
Propofol (mg)	200					200 mg
Fentanyl (cc)	2					
Suc (mg)	140					140 mg
( )						
( )						
phenylephrine (mcg)		100	200			
VOLAT AGENT Forane % del	3 — 2	1.5	1.5 — X			
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	8 — 3 — 2	— 2 —	2 — 8			

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

TOTAL EBL: —

TOTAL URINE: —

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID-

BLOOD-

FLUIDS

LINE site LR ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE -

REMARKS

Code drugs with numbers, events with letters

TO OR#2 - Anesth O2 - Smooth induction - ess typed start. placed L lat decub. Head/neck neutral - Awake. Sx Extubate (+) mask to 100% mask - TO PACU

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 87 KG

HEMATOCRIT: 12.2/38.4

INITIAL DATA:

BP- 104/64

HR- 77

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y

TIME-

TIME: 1000 X 1030 X 1100

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENTIL

VT - ml		930	940	890	
f - breaths/min		10	10	10	16
Peak inf pres / PEEP		25	25	25	
MODE - S(pon), A(ssist), C(on)	S/A	CV	CV	CV —	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40	36	32	32	50
BP/oth	FIO2 (Frac or %)	.76	.76	.78	.78	.78
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site skin		97	97	97	—
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS Position → (L) lat decub

RECOVERY AT 1102

(PACU) ICU ____ (Specify)

OTHER

CONDITION: Awake RA

RESP- 18 SpO2- 100%

BP- 118/53 HR- 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0955	1000	1107

	Ready	Begin	End
PROC	1005	1017	1054

PROCEDURES and CPT Codes: Washout (R) fem

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

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

[redacted] b(6)-4 J(W)1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* OETT MAC#3 (+)VC (+)B=BS (+)ETCO2 @25 cm lip Atraumatic. Grade I view

SURGEON: [redacted]

ANESTHETISTS: [redacted] b(6) 2

PROCEDURE LOCATION: OR#2-2

DATE: 18OCT03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

2 - ANESTHESIA PROVIDER USAPA V1.00

MEDCOM - 19861

PROPOSED PROCEDURE: [illegible] [illegible] feet
SURGICAL SERVICE: Orth
NPO SINCE: Midnight 19 Sept 03

Physical State 1 (2) 3 4 5 E
WT: 87 (KG)/LB HT: 68 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: (+)
DRUGS: —

CURRENT MEDICATIONS:
() = ordered as premed
() N/A
()
()
()
()
()

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A:
OTHER:
19 Sept 03
136 | 104 | 18 / 104
4.4 | 24 | 18
12
7.0 / 36.5 \ 402

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) (R) femur fx
- N Y burns to feet

Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
finger surgery - Gares compl.
∅ fx hx GETA compl.

PHYSICAL EXAMINATION
BP 144/84 HR 92 R ___ T ___
Pain Scale 0-10
HEENT - Teeth Poor dentition
Trachea midline
TMJ/Neck FROM
Oropharynx Cl 3, 3 fb TM
Nares
CHEST: BBS + / coarse
CARDIAC: S1 S2 ∅ e
EXTREMITIES: OK ∅ (R) LE
IV Access: #18 A/C (R)
Ulnar Filling: OK
BACK: OK
OTHER:

NPO Since MN 19 Sept 03

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. Via translator

The patient/legal guardian [redacted] agrees. Questions answered.
Signed: [redacted] Date: 20 Sept 03 Time: 0930 Hrs

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

Signed: ______ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ______
[redacted] b(6)-4
2F-ICW1

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.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

ANESTHESIA RECORD

Previous edition is obsolete
*U.S. GPO: 2001-629-183/40002

ICW1

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Duplex (R) LE (+) PA & LAT CXR			b(6)-4	ICW-1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY		b(6)-2		TELEPHONE/PAGE NO.
	SIGNATURE				DATE REQUESTED 20 OCT 03

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

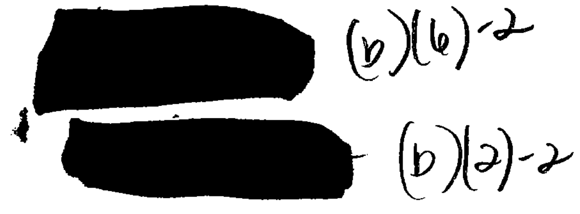
chest pain
(R) Fem Fx. R/o DVT. & Chest Pain

thanks!

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

RADIOLOGIC REPORT

No evidence of DVT.



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

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

b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDCOM - 19863

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

519-301

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

EXAMINATION(S) REQUESTED

(R) leg

AGE: 33 | SEX: M | SSN: [redacted] b(6)-4 | WARD/CLINIC: EMT | REGISTER NO.

FILM NO.

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): [redacted] b(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

GSW

DATE OF EXAMINATION *(Month, day, year)*: 19 Sept 03

DATE OF REPORT *(Month, day, year)*: 19 Sept 03

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

RADIOLOGIC REPORT

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

[redacted] EPW
b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

MEDCOM - 19864

CLINICAL RECORD - DOCTO

For use of this form, see AR 40-66, the pro... TSG

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

PATIENT IDENTIFICATION

b(6)-4

noted & transcribed 19Sep03 2030

DATE OF ORDER: 19 SEP 03 — TIME OF ORDER: 1950 HOURS

1. ADMIT TO ICW-1
2. DX - (R) FOREARM FX, FOOT BURNS
3. CONDITION - FAIR
4. VS - ROUTINE
5. BED REST
6. DRESSING CHANGE AND PIN
   CARE Q DAY
7. IV - LR AT 125 cc/hr. ~~HEP LOCK~~
8. NPO AFTER MIDNIGHT.
9. TO OR TOMORROW
10. TYLENOL 650mg P.O. Q4 HRS PRN
11. MSO4 2-8mg IVP Q 2 HRS PRN
12. PHENERGAN 25mg IV OR P.O. Q6 HRS PRN

NURSING UNIT | ROOM NO. | BED NO.

24 Ervan 19Sep03 @ 2100

b(6)-2

DATE OF ORDER: 20 SEP 03 — TIME OF ORDER: b(6)-2

1. RESUME PREVIOUS ORDERS
2. REGULAR DIET
3. IV - LR AT 125 cc/hr, HEP LOCK
   WHEN TAKING P.O. WELL
4. PERCOCET 1-2 P.O. Q 4 HRS PRN
5. ANCEF 1 GRAM IVPB Q 8 HRS
6. GENTAMICIN 500mg IVPB Q DAY
7. PIN CARE TO X-FIX BID
8. SILVADENE OINTMENT AND DRESSING
   CHANGES TO (B) FEET BID

b(6)-2

noted 20Sep03 1905

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° 20Sep03 @ 2045

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 SEPT 03 TIME OF ORDER: 2030 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PREVIOUS ORDERS
2. S/P I+D (R) [illegible], FEET BURN
3. VS - ROUTINE
4. BED REST, ROLL ON SIDE [illegible]
5. REGULAR DIET
6. IV - LR at 125cc/hr. HEP LOCK

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

[illegible] P.O. [illegible] HOURS

7. BID PIN CARE
8. BID DRY DRESSING COVER TO [illegible], DO NOT REMOVE [illegible]
9. BID SILVADENE BURN DRESSINGS TO (B) FEET.
10. NPO after MIDNIGHT 23 SEPT FOR SURGERY 24 SEPT

b(6)-2 Noted [redacted]

NURSING UNIT 2130 / 22 SEP [illegible] ROOM NO.

b(6)-2

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

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

DATE OF ORDER: 24 Sept 03 | TIME OF ORDER: 1540 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. [illegible] diet
3. N- [illegible] 125cc/hr. [illegible] [illegible] [illegible] P.O. [illegible]
4. D/C [illegible]
5. [illegible] [illegible] NKDA 12/04
6. continue BID dressing changes to feet and thigh. Do not remove packing.
7. NPO [illegible] 25 Sept 03 for OR 26 Sept 03

PATIENT IDENTIFICATION

b(6)-2 Noted [illegible] 24 Sept 03 1645

NURSING UNIT: 2nd/2345 | ROOM NO.: 24 Sept [illegible] | BED NO.:

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER: 10-5-03 | TIME OF ORDER: 1245 HOURS | b(6)-2

XR - AP+LAT (L) TIBIA

b(6)-2

Noted [illegible] 5 Oct 03 1250 [illegible]

b(6)-2

NURSING UNIT: ICW1 | ROOM NO.: 2nd V

500T @ 2100

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

b(6)-2 Noted 26SEP03 1045

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 26 SEPT 03 TIME OF ORDER 1005 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. IVF LR at 125 cc/hr. HLSP [illegible] PO well
4. Gentamicin 400 mg IVPB Q day
5. Ciprofloxacin 400 mg IVPB Q 12 hrs
6. PIN care BID.

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT 1CW | ROOM NO. 24 | BED NO.

27sep03 0930

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

SPU # b(6)-4

NURSING UNIT 1CW | ROOM NO. | BED NO.

DATE OF ORDER 5 OCT 03 TIME OF ORDER 1544 HOURS

1. NPO after midnight for surgery 6 OCT 03

5 OCT 03 1600

PATIENT IDENTIFICATION

b(6)-4

b(6)-2 Noted

NURSING UNIT 1CW#1 | ROOM NO. 2 | BED NO. F

1605

DATE OF ORDER 6 OCT 03 TIME OF ORDER 2245 HOURS

b(6)-2

1. Resume previous orders
2. Regular diet
3. IV LR at 125 cc/hr. HLSP [illegible] PO well
4. PIN care BID
5. May D/C [illegible] to [illegible]
6. AP + Lat (R) femur [illegible]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

Noted b(6)-2 1600

NURSING UNIT: KW#1 | BED NO.: F

DATE OF ORDER: 8 Oct 03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Motrin 800 mg TID

b(6)-2

24 V [redacted] /AN 8 Oct 03 1910

PATIENT IDENTIFICATION

b(6)-4

Noted b(6)-2

NURSING UNIT | BED NO.

DATE OF ORDER: 17 Oct 03 | TIME OF ORDER: 1600 HOURS

1. NPO after midnight
2. To OR tomorrow
3. CBC morning 8 a.m.

b(6)-7

17 OCT @ 2030

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER 18 OCT 03 TIME OF ORDER 1100 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Reassure [illegible]
2. Empty [illegible] record drain q shift
3. VS - routine
4. Regular diet
5. IV - LR at 125 cc/hr. Hep lock when taking P.O. well
6. Pin care BID. Do not change bandage.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-2 Noted [illegible] 18 OCT 03 1100

DATE OF ORDER TIME OF ORDER HOURS

b(6)-2

b(6)-2

NURSING UNIT 2H ROOM NO

24 ✓

19 OCT @ 0200

PATIENT IDENTIFICATION

DATE OF ORDER 20 Oct @ 0200 TIME OF ORDER HOURS

20 OCT 2003 1322

- PA/LAT CXR
- Hct [illegible]
- Duplex (R) LE - R/O DVT.
- O2 to keep sats >92% - ✓ O2 sat Room air first
- [illegible]
- Troponin I

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

- EKG
- [illegible]
- Lovenox 30 mg SQ BID

b(6)-2 HOURS

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

1KW1 | 24 ✓ 20 OCT 03 @ 2330 |

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted] b(6)-2 Noted 29 Oct 03		29 OCT 03 2045 HOURS	
	1	DISCHARGE 30 OCT 03 TO EPW CAMP.	
	2	LEVOFLOXACIN 250mg PO [redacted]	#30
	3	D/C IMOTT	
	4	D/C IV & DRN [redacted]	b(6)-2
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

.EDICAL RECORD - DOCTOR'S ORDE.

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. to keep Sat ↑ 95%		
3	Morphine / ~~Meperidine~~ 2 mg (IV) now and _____mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
~~4~~	~~Zofran_____mg IV prn N/V q 15 min, may repeat x_____.~~		
5	Metoclopramide 10 mg IV prn N/V x 1.		
~~6~~	~~Droperidol_____mg IV prn N/V x 1.~~		
7	Phenergan_____mg IV prn N/V x 1.		
~~8~~	~~Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.~~		
9	IVF:_____________@_______cc/hr. Per surgeon order or TKO if not written.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] MAJ CRNA		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted] b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis:

Height: _______ Weight: _______ Diet:

Allergies:

Nursing Unit (b)(2)	Room No.	Bed No.	Page No.
PACU, [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine _____mg IV now and _____mg q 3-5 min prn pain for a		
	max dose of _____mg.		
(4)	Zofran 4 mg IV prn N/V q 15 min, may repeat x 1.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF:____________@_______cc/hr. per surgeon		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] MAJ, CRNA		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted] b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: ________

Height: ______ Weight: ______ Diet: ________

Allergies: ________

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

(b)(2)-2

-DICAL RECORD - DOCTOR'S OR...

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	(Morphine) / Meperidine 5 mg IV now and 3 mg q 3-5 min prn pain for a		
	max dose of 20 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_______________@________cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA, CPT		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

[Diag]nosis: ________

[...]: ________ Weight: ________ Diet: ________

[...]: ________

Nursing Unit b(2)...	Room No.	Bed No.	Page No.
PACU, [redacted]			1 of 1

(b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 16 17 18 19 20 21 22 23 24 25 26 27 28 29
19 OCT 03	[redacted]	VS routine	06 18	[redacted]
19	[redacted]	BR - roll on side frequently	06 18	[redacted]
19	[redacted]	Regular diet	06 18	[redacted]
19	[redacted]	pin care to ex-fix BID (do not change bandage)	06 18	[redacted]
19	[redacted]	dry drsg Δ to femur - do not remove packing	06 18	[redacted] D/C 18OCT03
18 OCT 03	[redacted]	Empty and record drain q shift	06 18	/ / [redacted] D/C 21OCT03
20 OCT 03	[redacted]	O_2 to keep Sats > 92% ↓ O_2 Sats start = RA	6 18	/ / [redacted] PRN ORDER

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(R) FEMUR FX / FOOT BURNS
S/P I/D (R) FEMUR

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 OCT	[redacted]	NPO p MN	18 OCT	0000 noted		[redacted]
17 OCT	[redacted]	TO OR TOMORROW	18			[redacted]
17 OCT	[redacted]	CBC, MET 8 in AM	18	0500		[redacted]
18 OCT 03	[redacted]	Resume previous orders	18 OCT 03			[redacted]
20 OCT	[redacted]	PA & LAT CXR	20 OCT 03			[redacted]
20 OCT	[redacted]	Duplex RLE R/O DVT	20 OCT 03	1500		[redacted]
20 OCT	[redacted]	Troponin I	20 OCT 03	1500		[redacted]
20 OCT	[redacted]	EKG	20 OCT 03			[redacted]
29 OCT	[redacted]	D/C to EPW Camp c Rx	30 OCT			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
21 OCT 03	[redacted]	O2 to keep sats >92% / O2 sats on RA to start	

USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo. 10 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15
19	[redacted]	VS-routine	6													
			18													
19	[redacted]	BR - roll on side	6													
		frequently	18													
19	[redacted]	Regular Diet	6													
			18													
19	[redacted]	Pin care to ex-fix	10													
		BID	22													
19	[redacted]	Silvadene cream	10													
		drsg Δs to Bil feet	22				DIC 060103									
		BID	X													
19	[redacted]	Dry drsg Δ to femur	10													
		Do not remove	22													
		packing	X													

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: (R) femur fx / foot burns S/P I+D (R) femur

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 1Ø *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Ø6 OCTØ3		Resume previous orders	Ø6 OCTØ3	—	—	
Ø6	-	AP/LAT Ⓡ ~~Hum~~ KAS femur in am	Ø7	—	0505	
17 OCTØ3	-	NPO p̄ MN	18 OCTØ3	ØØØ1	note	
17	-	To OR tomorrow	18			
17	-	CBC, Metlyte 8 in am	18	Ø5ØØ		

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

b(6)-2

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED
				30
19 Sep	[redacted]	US Routine	D	
			N	
19 Sep	[redacted]	Reg diet	D	
			N	
		Pin Care to Ex-	D	
		fix BID (Do	N	
	[redacted]	not change bandage)	X	
29 Oct	[redacted]	Act Up Ad Lib	D	
		c crutches	N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) femur Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ________ Yr 2003

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29 Oct	[redacted]	D/C to EPW Camp c Rx	30 Oct			

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

b(6)-2A1

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

*Mo.*____ *Yr.*____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				20
1? Sept	[redacted]	Heplock flush	D	[redacted]
	------	Q Shift	N	
20 Sep	[redacted]	Gentamycin 400mg	20	
	------	IVPB QD	X	
24 Sep	[redacted]	Ciprofloxin 400mg	10	
	------	IVPB Q12O	22	
3 Oct	[redacted]	Motrin 800mg	08	[redacted]
	------	TID	16	
	------		24	
20 Oct	[redacted]	Lovenox 30mg	10	
	------	BID SQ	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) Femur I&D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

b(u)-2 All

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ______ Yr. ______
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
29	[redacted]	D/C ~~to~~ IV @ D/C to ?PW Comp	30 Oct			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
17 Sept	[redacted]	Tylenol 650mg PO	
		Q4° PRN	
20 Sept	[redacted]	Percocet 1-2 po	
		Q4-6 hr prn	

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

MEDCOM - 19882

b(6)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	17	18	19	20	21	22	23	24	25	26	27	28	29	30
19SEP03	[redacted]	IV: LR @ 125cc/hr, HEPLOCK	6														
		WHEN TOL. PO WELL	18														
20SEP03	[redacted]	GENTAMYCIN 400mg IVPB QD	20														
			X														
24SEP03	[redacted]	CIPROFLOXIN 400mg IVPB Q12°	10														
			22														
8OCT03	[redacted]	MOTRIN 800mg TID	08														
			16														
			24														
20OCT03	[redacted]	Lovenox 30mg BID	10	/													
			22	/													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Ⓡ FEMUR 1°D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b(u)-2 Anl

THERAPEUTIC DOCUMENTATION CARE PLAN

(MEDICATIONS)

Mo. 10 Yr. 03

Verify by Initialing						
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
28 [redacted]	[redacted]	/C IV @ D/C to SPW-camp	28 Oct			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED											
19 Sep	[redacted]	Tylenol 650mg PO Q4° PRN	D/I												
			D/I												
19 Sep		MSO4 2-8mg IVP Q2°-4° PRN	D/I	18 OCT 1430	20 OCT 1400										
			D/I	5mg [redacted]	6 [redacted]										
19 Sep		Phenergan 25mg IV/PO Q6° PRN	D/I												
			D/I												
20 Sep		Percocet 1-2 po Q4-6° PRN	D/I	17 OCT 2030	18 OCT 0300	18 OCT 1300	18 OCT 2355	19 OCT 1035	19 OCT 1611	19 OCT 2215	20 OCT 0500	20 OCT 1410	20 OCT 1930	21 OCT 0730	21 OCT 1600
			D/I	2	2	ii	2	ii	ii	ii	2	2	ii	ii	ii
			D/I	22 OCT 1630 ii	22 OCT 2345	23 OCT 1030	24 OCT 0215	24 OCT 1440	24 OCT 2210 ii	25 OCT 1020	25 OCT 1705	25 OCT 2300	26 OCT 1350	26 OCT 2000	27 OCT 1155
			D/I	[redacted]		ii	ii	ii	ii	ii	ii	ii	ii	2	2 [redacted]
				28 OCT 1650 ii [redacted]											

*U.S. GPO: 1996-454-110/95216

MEDCOM - 19884

b(6)-2 All

CLINICAL RECORD | ...EUTIC DOCUMENTATION CARE PLA... ...EDICATIONS)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. 10 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				3	4	5	6	07	8	9	10	11	12	13	14	15	16
19 Sep	[redacted]	IV: LR @ 125cc/hr	6														
		HL when tol po well	18														
20 Sep	[redacted]	Gentamycin 400mg	2														
		IVPB QD	X														
24 Sep	[redacted]	Ciprofloxacin 400mg	10														
		IVPB Q12°	22														
08 Oct 03	[redacted]	motrin 800mg TID	08														
			16														
			24														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: (R) femur I+D | B/L foot burns

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO. ______

PATIENT IDENTIFICATION:
b(6)-4

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 19885

b(6)-2A11

Verify by Initialing

THER[...]TIC DOCUMENTATION CARE PLAN

(MEDICATIONS)

Mo. 10 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
06 OCT03		[...]ay D/C Silvadene to feet	06 OCT03	—	—	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		TIME/DATE DISPENSED (INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION)												
19 Sep		Tylenol 650mg po Q4° prn	D/T													
			D/I													
19 Sep		MSO4 2-8mg IVP Q2-4° prn	D/T	3oct 2355												
			D/I	8mg												
19 Sep		Phenergan 25mg IV/PO Q6° prn	D/T													
			D/I													
20		Percocet 1-2po Q4-6° prn	D/T	3oct 0200	3oct 1100	3oct 2235	04oct 1340	04oct 1740	4oct 2315	5oct 1100	5oct 1835	06oct 1000	06oct 1745	7oct 0800	7oct 0510	07oct 1106
			D/I	II	II	II	II	II	II	II	II	II	II	II	II	II
			D/T	7oct 1840	7oct 2250	8oct03 2000	9oct03 1330	10oct 0855	10oct 1555	10oct 1935	11oct 0013	11oct 0835	11oct 1700	11oct03 2110		
			D/I	II	II	II	II	II	II	2	2	II	II	II		
			D/T	12oct 0700	12oct03 2100	13oct 0800	13oct03 2200	14oct 0900	14oct 1905	14oct 2300	15oct 2000	16oct 0940	16oct 1418	16oct 2312		
			D/I	II	II	II	II	II	2	2	II	II	II	2		
			D/T	17oct 0950	17oct 1515											

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9/26 Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 1635
Allergies: NKDA OR Intake: Crystalloid 450 Colloid
Pre-op V/S: 144/84 92 OR Output: UOP — EBL 25cc
Procedures: washout Meds/Times: 5cc Fent

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1638	1653	1658	1703
SaO2	96	95	97	96
FiO2				
Methods	RA	RA	LX	RA
240				
220				
200				
180				
160				
140	V	V	V	V
120				
100	•	•		•
80	Λ	•	Λ	
60		Λ		Λ
40				
20				
RR	20	16	16	20
T	98.9			
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	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	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.	9	9	9

Codes

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

V/S: X = A-line BP, ˇ = 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 (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,

[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

Received pt from OR. Pt sats 94% RA. VSS. Pt awake, moving around. Had washout of R leg and debridement of feet. Pt able to wiggle toes. Report given to Spc [redacted]. Pt VSS No c/o pain sats 95% [redacted] b(6)-2 LPN

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L Ext	Limited	+	UA	B	W	PK
15'	L Ext	Limited	+	UA	B	W	PK
30'	L Ext	"	+	UA	B	W	PK
45'							
60'							
90'							
D/C	Lower Ext	"	+	UA	B	W	PK

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 1638	Lower Ext	Ace band.	c/d/i
30' 1638	L Ext	" "	c/d/i
60'			
D/C 1708	Lower Ext	ace band.	c/d/i

PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1638	NSR	Ø	Ø

Discharge Criteria:
Date: **Time:** **PARS:**
BP: 147/72 **T:** 96.9 **HR:** 99 **RR:** 16 **Sa02:** 95
Pain Level at D/C (0-10): 0
Intake: 0 **Output:** 0
Additional Data: None
Transferred To: ICW I
Report Given To: Spc [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: Sgt [redacted] b(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

WAMC OP 173-E

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: 22 Sep 03
Time In: 2042
Allergies:
Pre-op V/S: 119/66 183
Procedures: EGD [illegible]

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block MAC
OR Intake: Crystalloid 400 Colloid 0
OR Output: UOP 0 EBL 0
Meds/Times: fentanyl, propofol, lidocaine

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	2040	2045	2050	2105	2120	2123
SaO2	98%	97		97	97	95
FiO2	RA	2L		2L		
Methods		NC		NC	RA	
RR	20	19	19	18	21	
T	98.[illegible]					

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2115	NS		(L) AC		100cc

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			
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, ˇ = Cuff BP, • = Pulse

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

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

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

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

(Continue on reverse)

PREPARED BY: b(6)-4

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 22 Sep 03

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

EPN 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

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	+	+	P	B	C	P
15'	(R) leg	+	+	P	B	C	PK
30'	(R) leg	+	+	P	B	C	PK
45'							
60'							
90'							
D/C	(R) leg	+	+	P	B	C	PK

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(R) ankle	gauze	Ø
~~30'~~	(R) femur	gauze	Ø
~~60'~~	(R) ankle	gauze	Ø
D/C			Ø

PACU OUTPUT			
Time	Source	Color/Appearance	Amount
2043	urine	amber	580

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2105	NSR	NO	NO

WAMC OP 173-E

NURSING NOTES

2042 Rec'd pt from OR via litter. pt maintaing own airway pt awake, able to follow commands LR infusing into (L) AC. VSS.

2115 Report given to [redacted] pt transported via litter in stable cond. VSS SGT [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 9.22.03 Time: 2115 PARS: 10
BP: 132/45 T: 98.2 HR: 93 RR: 22 SaO2: 98% RA
Pain Level at D/C (0-10): —
Intake: 1000cc Output: 580cc
Additional Data:
Transferred To: ICW [illegible]
Report Given To: SGT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted] 1LT/AN

MEDCOM - 19890

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: 24 Sep 03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 1545
Allergies: NKDA OR Intake: Crystalloid 600 cc Colloid
Pre-op V/S: 114/64 84 OR Output: UOP Ø EBL min
Procedures: I+D (R) Rom site Meds/Times: versed 5mg Fent 250 mcg

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

Pre Op Meds History

Time	1545	1550	1555	1600	1615	1630
SaO2	94	98	92	94	96	94
FIO2	RA	4L	4L	4L	2L	RA
Methods		NC	NC	NC	NC	
RR	21	13	15	26	22	17
T	96.1				97	96.1

(Vital signs graph scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

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	1	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	1	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.	8	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
^ = Cuff BP
• = Pulse

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

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

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

(Continue on reverse)

[redacted] SGT LPN b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 24 Sep 03

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

EAW [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 leg	limited	+	✓	B	W	PK
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 leg	Kerlex	C/d/i
30'			
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1550	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Received pt from OR. VSS O2 sats 95% 4LNC. No c/o pain. S/P I/D of R femur. Pt able to move all extremities (-injured leg). IV @ Arm LR @ TKO. NO S/S infiltration. 1630 - Pt O2 DC'd Sa O2 @ 92% c̄ NO S/S Respiratory distress [illegible] SG/CPK

[illegible] - 2 [illegible]

Discharge Criteria:
Date: 24 Sep 03 Time: 1636 PARS: 10
BP: 124/73 T: 99.2 HR: 106 RR: 17 Sa02: 94%
Pain Level at D/C (0-10):
Intake: 200cc LR Output:
Additional Data:
Transferred To: ICW
Report Given To: 1LT
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Anabiotic yes

Date: 26 Sep 03 — Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block

Time In: 1010

Allergies: NKDA — OR Intake: Crystalloid 400 — Colloid Ø

Pre-op V/S: 144/57/96 — OR Output: UOP Ø — EBL Ø

Procedures: I & D [illegible] — Meds/Times: 250 Fent.

Dressing D feet

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds — History

Time	10:10	10:15	10:20	10:25	10:40	10:55
SaO2	95	96	96	95	97	96
FiO2						
Methods	RA	RA	RA	RA	RA	RA
RR	20	15	16	V	18	20
T	97.5			98		97.6

(Graph scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

Time	Pain (0-10)	LOS

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1055	LR	600	[illegible]	[redacted]	50 cc

X-rays: — Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	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	Ø	Ø	Ø
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	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, * = Cuff BP, = Pulse

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

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

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

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

(Continue on reverse)

[redacted] (Signature & Title) b(6)-2

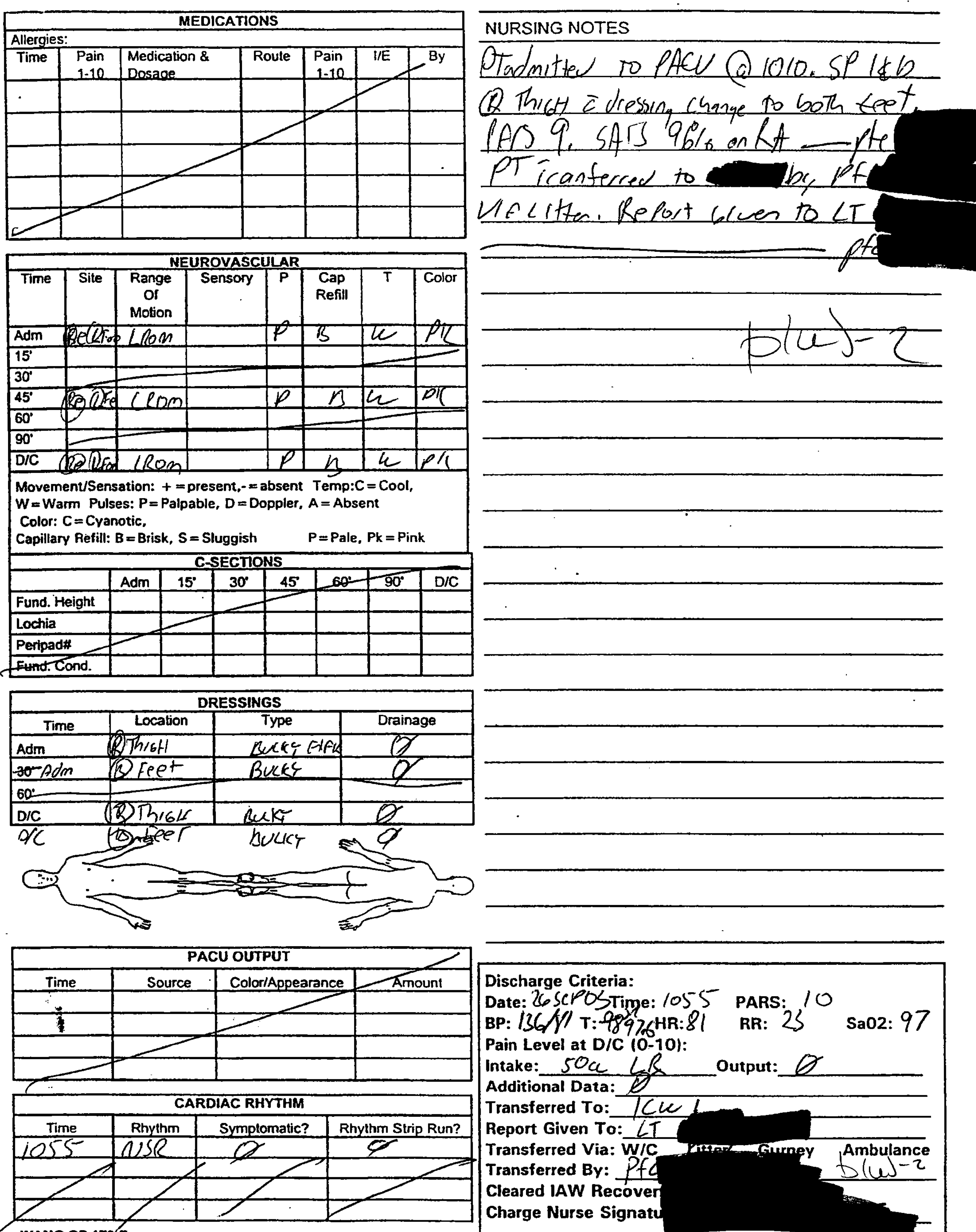
DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Sep 03

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

[redacted] b(6)-4

- [ ] HISTORY/PHYSICAL
- [x] 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	Bil (R) feet	LROM		P	B	W	PK
15'							
30'							
45'	(R) (L) Feet	LROM		P	B	W	PK
60'							
90'							
D/C	(R) (L) Feet	LROM		P	B	W	PK

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Thigh	Bucky Fluff	Ø
~~30~~ Adm	(B) Feet	Bucky	Ø
60'			
D/C	(R) Thigh	Bucky	Ø
D/C	(B) Feet	Bucky	Ø

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1055	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt admitted to PACU @ 1010. SP I&D (R) Thigh c dressing change to both feet, PAS 9, SATS 96% on RA — pfc [redacted]
PT transferred to [redacted] by PFC [redacted] via litter. Report given to LT [redacted]
— pfc [redacted]

blw-2

Discharge Criteria:
Date: 26SEP05 Time: 1055 PARS: 10
BP: 136/71 T: 98.7 HR: 81 RR: 23 Sa02: 97
Pain Level at D/C (0-10):
Intake: 50cc LR Output: Ø
Additional Data: Ø
Transferred To: ICW [redacted]
Report Given To: LT [redacted]
Transferred Via: W/C ~~Litter~~ Gurney Ambulance
Transferred By: PFC [redacted] blw-2
Cleared IAW Recover[redacted]
Charge Nurse Signatu[redacted]

NKDA

33 y/o M.

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: 10.6.03
Time In: 1456
Allergies: NKDA
Pre-op V/S: 137/71 68
Procedures: [illegible]
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP Ø EBL minimal
Meds/Times:

[illegible]

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

Pre Op Meds — History

Time	1456	15	1515	1530	1545
SaO2	96	95	94	95	95
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	12	12	10	12	10
T	96		97	95	97
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1500	LR	400	[illegible]	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

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

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)-4

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10-6-03

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

[redacted] b(6)-4

- [ ] HISTORY/PHYSICAL
- [ ] FLOW CHART
- [ ] OTHER EXAMINATION OR EVALUATION
- [ ] OTHER (Specify)
- [ ] DIAGNOSTIC STUDIES
- [ ] TREATMENT

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

received pt care from MAJ Cannady
All VSS, afebrile and in no apparent
distress @ [redacted]
N arousable by voice, appropriate Perrl
3mm sluggish.
CV NSR S1 S2 +2 radial pulse
+2 pedal pulses extrem warm to touch
Resp even unlabored CT ∅ (R) ... spO2 96-97% on RA nasal trumpet
removed upon arrival to PACU
GI hypo BS soft nontender slightly
distended. ∅N/V/D.
GU ∅U/O ∅ foley.
Lines (R) FA PIV patent

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Blat feet	full	intact	P	<3sec	warm	appr
15'	"	"	"	"	"	"	"
30'							
45'							
60'							
90'							
D/C	Blat feet	full	intact	P	<3sec	warm	appr

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	Blat feet	kerlex	∅
30'			
60'			
D/C			

PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 10-6-03 Time: PARS: 10
BP: 124/61 T: HR: 82 RR: 26 Sa02: 98%
Pain Level at D/C (0-10):
Intake: ∅ Output: ∅
Additional Data: ∅
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: KT [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatur[redacted]

WAMC OP 173-E

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: 18Oct03 Anesthesia Type (Circle) General Spinal Epidural IV Sedation Nerve Block

Time In: 1105

Allergies: NKDA OR Intake: Crystalloid 800 Colloid

Pre-op V/S: 104/64 OR Output: UOP 0 EBL min

Procedures: [illegible] Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SaO2	98	99	97	100	[illegible]
FiO2	RA	RA	RA	RA	RA
Methods					
RR	13	9	18	20	20
T		97			

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1105	LR	50	[illegible] Arm	[redacted]	

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	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	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, " = 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 [redacted] b(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 18Oct03

PATIENT'S IDENTIFICATION (For t[redacted] entries give: Name — last, first, middle; grade; date; hospital or m[redacted]ty)

[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
1120	Adm	5mg MSO4				

NURSING NOTES

male imp: Admitted to PACU s/p washout femur fx closure. RSD, 99% I/A VSS. IV (L) Arm LR @ 760 patent. Dressing CDI

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:** Ø

Additional Data:

Transferred To: ICW 1

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

1	2	3	4	5	6
A	1	1	0	1	

2. MTF LOCATION (State or Country Code.)

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15

NAME (Last, First, Middle Initial)

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
3	3	y

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION: UNK

10. LENGTH OF SERVICE

32	33	34

ETS: NA

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

ORGANIZATION (Active Duty Only): NA

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION: 1950

BRANCH / CORPS: NA

b(6)-4

14. FLYING STATUS

47	48	49
N		

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63
I	Z

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR

NO: ✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
O

WARD: ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: b(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION

73	74
2	1

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y M M D D)

81	82	83	84	85	86
0	3	1	0	2	9

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)

97	98	99	100	101	102
0	3	0	9	1	9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION (Y Y M M D D)

111	112	113	114	115	116

FOR LOCAL USE

DX: (R) FEMUR FX / FOOT BURNS

Dx: 82110
94502
E899

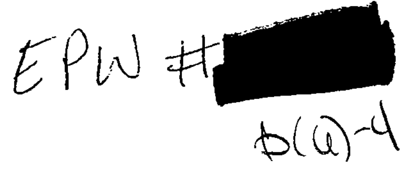
Px: 7965 X3
8622 X2

ADMITTING OFFICER (Signature, as required)

Dr

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 90



PATIENT'S DEPOSIT RECORD

For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☐ w

Witness

Patient's

FUNDS & VAL... *and date)*

b(6)-2

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

FUNDS							
DATE	DEPOSITS		WITHDRAWALS		BALANCE		
21 Sep 03	92 x 250 dinars	20,500 dinars					

b(6)-2

VALUABLES					
		DEPOSITS		WITHDRAWALS	
NUMBER	DESCRIPTION OF VALUABLES	DATE	SIGNATURE *(Custodian)*	DATE	SIGNATURE *(Patient or intermediate individual)*

b(6)-2

DA FORM 3696, DEC 77 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED. USAPPC V1.00

b(6)-2

I LT [redacted] was dispatched by Mustang base [redacted] Company to Iraqi Police Station Rabia near A co 2-3FA. Once the ...ade Contact with the Iraqi Police and LT

b(6)-2

[redacted] When we entered the Detensi... ...ell to pick up Detainee # [redacted] Named

b(6)-4

b(6)-2

[redacted] He was placed on a litter

(b)(2)-2

...nd taken to [redacted]. His Crime is ...ctions against Coalition Forces and is a ...nown Gang member, Do not release to ...y non MP/IP personal or on own recogniz...

b(6)-2

LT. [redacted]

(b)(2)-2

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☐ Offense against Coalition Forces [check one] If "Other" then describe: Kadan gang member

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☒ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☒ Other

(b)(2)-2

Apprehending Unit: [redacted]	Location Grid:	
Date of Incident: (D/M/Y) 19/09/08 / / — Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee		Key Connected Person: ☐ Victim ☐ Witness	
Detainee #:		Last Name:	
Last Name: [redacted]		First Name:	Given Name:
First Name: [redacted]			
Hair Color: Black	Scars/Tattoos/Deformities: (b)(6)-4	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: Br.	Weight: lb / Height: in	Eye-Color:	Weight: lb / Height: in
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/Sect: / Sex: ☒ M ☐ F	Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular	Ethn/Tribe/Sect: / Sex: ☐ M ☐ F	Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify)		☐ Passport ☐ Dr. license ☐ Other (specify)	
Document #:		Document #:	

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	Number of People in Vehicle:
Model:	Type:	Plate No.:	
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband	☐ Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter: b(6)-2 — Email, Phone, or Contact Info:

[redacted] First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email:	Email:
Unit Phone: Date: / /	Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? commited crime against coalition forces

Who witnes[redacted]ion? Give names, contact numbers, addresses.
[redacted] b(6)-2

(b)(6)-2

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted] b(6)-4	N/A	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
m	37y	Z	unk	N/A	N/A	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	N/A	ICU1

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	2158	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	50	30 Sep 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	19 Sep 03	

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Abd

863.50

864.02

868.03

518.0

45.73

54.4

45.94

E991.2

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	12	12

36. Total Days All Facilites b(6)-2

a. ABSENT SICK DAYS	b. [redacted]S	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	[redacted]	Ø	Ø	12	12

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

MEDCOM - 19904

DA FORM 36[redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

37 y/o I Male shot x 3 in abd under-neath Rhemi at FST. Liver lac (Minor) noted. Here for p̄ op care.

PMH ⊖ PSH ⊕ as above

meds ⊖

PHYSICAL EXAMINATION

HR 101 BP 125/83

Lungs clear T 99.4

Heart - RR

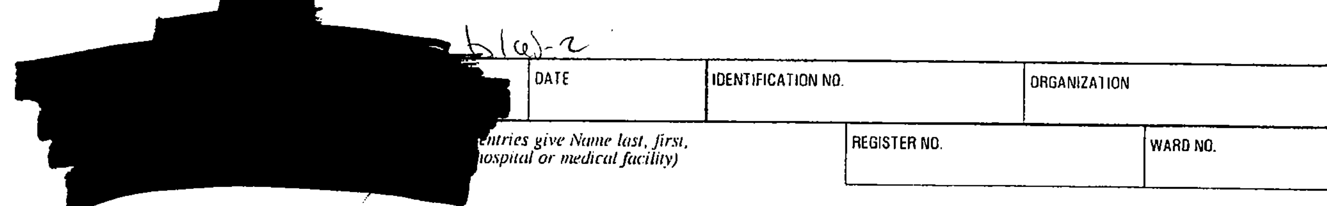
Abd midline lap + 3 holes ant

Ext ⊖

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

Imp GSW to abd s/p Rhemi

Plan - p̄ op care



b(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
...ntries give Name last, first, ...ospital or medical facility)		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

b(6)-4 [redacted] B / FST Trauma Fl[...] Sheet   37yo

Name: #[redacted] SSN________ Unit________

Blood Type
B+

Date and time of injury: 1600 **Time of Arrival** 1620

MOI: GSW to ABD

HPI:

PMHX:
PSHX:
Meds:
Allergies:

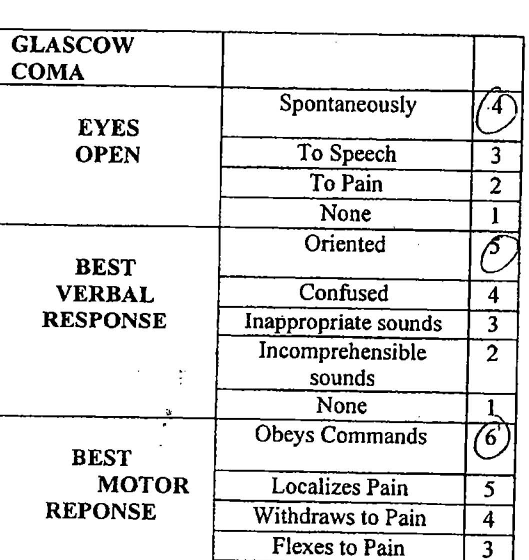
Primary Survey

Airway: (Patent) Mechanically maintained by
Breathing: (Spontaneous) Assisted by O2 15L
Circulation:
Pulse: (Present) Absent CPR
Color: (Normal) Abnormal
Cap refill: (Normal) Delayed

Secondary Survey

Intial Vital Signs: b/p 140/82 pulse 76 Resp 22 Pulse Ox 99 Temp___

GEN: Alert
HEAD: no trauma Perrla TM clear (B)
NECK: ~~PEP~~
HEART: RRR
LUNGS: Clear (B)
CHEST: Normal
ABD: 3 GSW, nR, (R) lateral, soft, ∅
PELVIS: Bowel sounds normal
EXT: no lesions
RECTAL: Hem - no gross Blood
NEURO: Alert able to move all extermities



GLASCOW COMA		
EYES OPEN	Spontaneously	(4)
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	(5)
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	(6)
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	(4)
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	(4)
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	(4)
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	16

Interventions

Airway:

Breathing: O_2 NRB 15mL

Circulation: (L) AC Nor. Saline
(R) AC Sod. Chloride

Other:
no meds in the field

MEDICATIONS

Time	Drug	Dose	Route	Initials
~~1624~~	~~IV~~	~~1000mL~~	~~LFA~~	[redacted]
~~16~~	~~IV~~		~~RFA~~	[redacted]
1626	Flagyl	400mg	IV	[redacted]
1626	Cefotetan	2g	IV	[redacted]

b(6)-2

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
1628	128/72	83		99		
	/					
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES:

Prepared By:

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Brief Op Note
19SEP03 20:00	Pre Op Dx: GSW Abdomen, Minor liver [redacted]
	Post Op Dx: GSW c̄ (R) Colon injury
	Procedure: Ex lap c̄ (R) Colectomy
	and 1° anastomosis, Omentectomy
	Surgeons: [redacted], [redacted] (b)(6)-2
	Anesth: GETA
	Comp: ∅
	EBL: 400 UOP: 600
	Fluids: 4500 ml Crystalloid 500 Hespan
	Findings: Minor liver lac. (R) Colon
	injury. Omental hematoma.
	To PACU in stable condition
	b(6)-2 [redacted]
19SEP03	Transfer Note
20:00	Pt arrived s/p c̄ multiple GSW to
	(R) Abdominal wall. CXR was negative.
	Pt taken to OR for ex lap. (R) Colectomy
	c̄ primary anastomosis performed. Medial
	visceral rotation performed, but no sig
	retroperitoneal injury. Transferred to [redacted]
	when awake

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST FIRST [redacted] | SPONSOR'S ID NUMBER (other)

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. b(6)-2

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Ø6ØØ 20Sep Ø3	Assumed care of pt EPW # [redacted] b(6)-4. VSS. Pt resting in bed c̄ eyes closed. Woke pt up to inform him of the DRSG Δ. Δ'D DRSG @ Ø615. Will continue to monitor throughout shift. SPC [redacted] b(6)-2 91WM6
20Sept03 1015	Assumed care of pt report given by SGT [redacted] See b(6)-2 assessment sheet. NC to L 1.5 O2 @ 2L/Min per NC. Will cont. to monitor — SGT [redacted]
1330	ABD DSG (R) Quads Δ'd - Old DSG: large amt bloody drain drainage noted on old DSG. Wounds (3) packed c̄ wet to dry DSG's. Applied 4x4's & covered c̄ ABD pads secure c̄ tape. ABD Midline DSG Δ'd - small amt bloody drainage noted on old DSG. Incision c̄ staples intact. Oozing small amt bloody drainage ↓ incision. Applied 4x4's & ABD pad secured c̄ tape. Will cont. to monitor — SGT [redacted]
1425	Dr. [redacted] ordered new meds informed MD of ↑ temp [illegible] tachycardia. Will cont. to monitor — SGT [redacted]
1615	T 100.6A. Tylenol 650mg RTL given. Will cont. to monitor — SGT [redacted]
1630	5mg MSO4 given per CPT [redacted] for ABD pain. Will cont. to monitor. — SGT [redacted]
1700	Pt resting in bed. Said felt better. — SGT [redacted] b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | [illegible] 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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Sep	0800 POD 2 GSW (R) colon 1° anast
	S- ō c/o some pain
	O - Tm 100.6 132 170/90 93% on nasal O_2
	↓ BS (R) UO 50-75/h NG 450
	wound clean dry
	(R) flank - brownish drainage, thin, slightly odor
	A - stable
	P - ↑ OOB, wound dressing Δ, ✓ labs
	b(6)-2
21-SEP-03 1244	PT refused Tylenol Suppository 650mg PR, T 101.5 will monitor
	PT using I.S. but can only elevate 1 ball. [redacted] cough but
	will not cough forcefully. b(6)-2 [redacted] SSG 91W M6
21SEP03 1500	PT's (R) chest wx dressing Δ'd ø drainage noted, 3 holes approx
	2cm diameter each and 1cm deep. Wd's cleaned ē NS and packed
	ē Kerlix fluff. PT tolerated dressing Δ. STATES no pain
~~21SEP03 1600~~	b(6)-2 [redacted] SSG 91W M6
21SEP03 1600	PT ↑ OOB to chair. Minimal assistance given. PT motivated
	to move. STATES there is only a "little pain" when moving.
	ABD staples intact. PT using I.S while in chair.
	[redacted] SSG
	b(6)-2

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.

[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
21-SEP-03 0630	Assumed care of PT. PT AOx3, verbalizes needs & follows commands. Assessment on DB @0700 date 21-SEP-03. VSS. Will monitor ——— [redacted] 66 91WMC
21-SEP-03 0700	PT OOB to chair. Minimal assistance needed. VSS. Will monitor ——— [redacted] 66 91WMC

b(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b(6)-2
21 Sep 03	Received report from SSG [redacted] Pt. lying in bed
1815	c̄ HOB @ 45°. c/o lower back pain, and asks
	if he can sit up in bed. Pt. sat at foot of bed
	for 15 minutes before lying back down. Pt.
	given + used IS. Pt. refused ~~to~~ Tylenol PR for
	temp of 101.8 ——— b(6)-2 SPC [redacted]
1930	NG tube pulled out 2 inches by pt., repositioned
	and placement checked by injecting air. SPC [redacted]
2200	S_aO_2 dropped to 91%. O_2 via NC @ 4LPM applied
	bringing S_aO_2 to 96%. Will continue to monitor – SPC [redacted]
0000	Pt. removed own O_2 S_aO_2 @ 94%, will continue
	to monitor ——— SPC [redacted] b(6)-2
0100	2LNC put back on for S_aO_2 of 92%, rose back
	up to 95% ——— b(6)-2 SPC [redacted]
0445	Pt. c/o pain, refuses to take Tylenol PR SPC [redacted]
0600	Pts. 0700 DRSG change performed @ this time due
	to DRSG being saturated c̄ sero-sanguinous fluid. SPC [redacted]
Ø605	Assumed care of pt. Pt resting in bed c̄ eyes closed. (L) Arm
	restrained. VSS. Will continue to monitor SPC [redacted] [signature]
	b(6)-2

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.

[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
22 Sep 03	0700 POD 3
	S- c/o flatus or BM
	O- Tm 101.6 107 O_2 sat >90% room air — WBC 6.7
	NG ~150, UO adequate — Hb 10.9
	chest - egophony both base — plt 241
	abd - mild distension wound OK (midline centrally) — 139 / 104
	ō BS — 3.7 / 24
	A- atelectasis developing pneumonia — 1.0
	P- remove NG & foley ↑ act watch wound, consider
	intra abd abscess [redacted]
	note: central ® flank wound still grayish appearance,
	will ↑ freq dressing Δ & watch closely
	[redacted]
22 Sep 03 0730	Dr. [redacted] D/C'd NG @ 0710. D/C'd Foley @ 0730. VSS.
0905	Transfer to ICW 1. SPC [redacted] 91WM6
22 Sept 03 1135	Rec'd pt from ICU 2. IV Δ in ® forearm due to infiltration. IV in Ⓛ AC patent INF. ⊖ swelling @ site. Midline abd staples intact c̄ minimal redness. ® flank dsg Δ. Fentanyl patch intact. Lungs CTA. VSS. Will continue to monitor [redacted] 91WM6
1540	Pt ↑ to BR pt voided @ 250 cc. Dsg Δ Minimal drainage noted [redacted] 91WM6
@1945	assumed care of pt @1800. VSS. Wanting H_2O to drink though NPO status. no c/o pain. IVx2 ®FA HL, ⓁFA c̄ IVFs, ø S/Sx of infection or infiltration.

cont

STANDARD [redacted]

b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 All
22Sep@1945	LS CTA, ⊕BS hypoactive ⊖flatus ⊖BM.
cont'd	Ⓡ flank drsg CDI, ecchymoses noted
	behind drsg on lower back. Voiding per urinal
	s̄ difficulty. ↑pt restraints on s̄ signs of
	skin or circulation compromise. Plan: monitor
	GI status, drsg Δs Q4°, ↑amb as tolerated.
2230 -	Drsg Δ to Ⓡ flank completed. X3 wounds noted, range
	from 2in, 1in, ½in in width. Packed c̄ saline damp
	4x4s. Wounds red c̄ patches of green noted. Sero-
	sanguinous drainage on old drsg noted. ML
	abd [redacted] incision CTA c̄ staples, CDI.
	On flank wounds, all 3 wound edges reddened &
	inflamed. Will continue to monitor.
23Sept03	Pt ↑ in bed ⊖ s/s of resp distress or discomfort
@1000	@ present time. Drsg Δ to Ⓡ flank. Minimal
	drainage on abd pad. Midline abd staples
	intact. Slight redness around stapled area.
	Pt has T 100.6. Pt given incentive spirometer,
	blankets taken off. A/C ↑. Will recheck temp
	IV D/c'd in Ⓛ arm due to infiltration. IV re

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PROGRESS NOTES
Medical Record

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

DATE	NOTES
	(R) forearm patent INF. (−) swelling or edema
	@ site. lungs CTA. hypoactive bowel sounds
	Will continue to monitor pt. condition [redacted] 1LT AN
1900	Pt A10, temp 99⁵, resp even & unlabored, ∅ c/o
	pain @ this time. LCTAB, HRRR, hypoactive BS×4
	Drsg to (R) flank D/I. D5½NS c̄ 20 KCl @ 100cc/
	hr infusing into (R) AC. ∅ edema or swelling
	@ site. TCD done. Restraint on (R) LE. Pt
	c̄ minimal swelling to (L) LE. (+) circulation.
	Will cont to monitor [redacted] 91WM6.
2000	Drsg Δ'd, sero-sang drainage noted. All 3
	wound edges reddened. midline abd. c̄
	some redness noted. [redacted] 91WM6
0001	Pt c/o pain 2/10 on inspiration, denies any
	pain meds @ this time. Abx given [redacted]
24 Sep	0630
	S- flatus (+)
	O- T100⁵
	midline wound OK BS +
	central lat wound still c̄ some pus, ō surrounding pain,
	Lar ecchymosis of flank
	A- stable
	P- cont IV AB's, dressing Δ, watch for necrotizing fasciitis,
	advance diet [redacted]

b(6)-2 AN

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24Sept03 1200	Received pt in stable condition this am. VSS, A+O x3, speaks small amt English. IV patent & intact (R) fa. (R) flank dsg D/C'd per order. small amt of serosang drainage noted. Skin around wound sites appears red + irritated. OOB and amb to BR. (+) BM and sugs. Restraint in place per EPW protocol, ∅ s/s of skin breakdown or circulation issues noted. Tol full liquid diet c this time will cont to monitor [redacted] Midline abd incision [redacted] staples [illegible] w/ edges well approximated [redacted]
	b(6)-2
24 Sep03 @ 2345	Assumed care of pt @1900. VSS. No % @ this time. Speaking some English, pleasant, alert. LSCTA, ↓ (B/L) [redacted] bases, IS encouraged & used. (+) BS, (+) flatus, ∅ BM this shift. Tol small ants of full liquid diet s̄ difficulty. (R) AC IV c̄ D5 1/2 NS + 20 KCl @ 180, flowing s̄ s/sx of infiltration. Mid abd incision c̄ staples CDI, healing well. (R) flank c̄ 3 wounds WTD drsgs, some purulent areas noted in each wound; wound borders reddened and ecchymosis to flank behind wounds. (CONT)
b(6)-2	

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

b(6)-2

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REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Sep@ 2345	(CONT-) Voiding per urinal s̄ difficulty. Plan: cont IV abx, monitor pain, monitor drsg, cont drsg Δ q4°. [redacted]
25Sept03 0900	VSS A&O Ⓡ ~~AB~~ AC IV patent & intact infusing D5½NS c̄ 20 KCl/l @ 100cc/hr. Continued multiple IV ABX. OOB to BR ambulating c̄ steady gait. Denies pain @ this time. Lungs clear Bilateral. Uses Incentive spirometer properly @ 900cc/sec. Has non productive cough. Old drsg pocket to Ⓡ flank c̄ minimal serosanguineous drainage noted, Redness noted around edges of Ⓡ flank wounds. Midline ~~Ab~~ Abd incision c̄ staples intact Ø drainage noted. Peripheral pulses +2. Will continue care as planned. [redacted] 2LT
25Sept03 1400	Pt OOB ambulated to BR c̄ assist. Had BM x1 small brown form. Tolerated well. Continues to use Incentive Spirometer @ 900cc/sec with non productive cough. Will continue plan of care. [redacted] 2679

b(6)-2 All

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
25 SEP 03 2225	VSS. AO. DSG's x'd to bullet wound @ (R) torso. Tolerated well. BS ⊕ x4. Ambulated x1 to BR c̄ c/o pain. [redacted] b(6)-2
26 Sept 03 715 AM POD#7	Surgery Tol diet Temp 100 wound O/C Stable CPM [redacted] b(6)-2
26 Sep 03	0850. assumed care of pt @ 0800. assessment completed. VSS - A+O. LS CTA (B), Resp even unlabored. Abd. soft non tender, BS x4, S1S2 present. IV (L) FA DC'd. new IV started (R) FA 18G. CDI ⊝ S/S INF. Pt. ambulated to BR. Performed AM care. midline incision c̄ staples intact. Abd drsng CDI. Pt. Resting well @ this time will cont. to monitor pt. [redacted] b(6)-2
26 Sep 03	1030 Pt. ambulated to BR. pt. started

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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
	he could not pass BM because it feels
	like his staples will come out. 2 midline
	Incision has min drainage. b(6)
27sep03@0430	Assumed care @1800; All VSS; pt A&Ox3 speaking arabic; [illegible] to BR x 1 [illegible]
	difficulty; ⊖ BM; pt c/o pain to staples to midline, staples well approximated, ⊕ s/sx
	infection, red around the site, warm to touch, moderate amt purulent
	drainage; staples cleaned c ½ sterile H_2O, ½ peroxide; dsg to Ⓡ chest wall
	Δ'd, 3 deep wounds packed c iodoform & reinforced c abd pad; dsg Δ'd Q4°
	now CDI; PIV intact, s/s/sx infection/infiltration; cont c IV abx; restraints
	in place; ⊕ circulation, ⊖ skin breakdown; cont to monitor
	b(6)-2
9/28	
9/27/3	Surgery
POD#8	⊖ N/V
	⊖ BM
	wound clean
	doing well
	MOM b(6)-2
27Sept03	0930- Assessment completed. assumed care
	of patient @ 0900. PERRLA, LS CTA Ⓑ, Resp. even unlabored,
	abd distended. MOM (30cc) given PO as ordered.
	1/2 staples removed. significant amount of
	drainage noted to mid-line incision. IV Ⓡ FA
	C.D.I. ⊖ s/s inf, restraints in place, ⊕ circulation, ⊖ skin
	breakdown. Will cont. to monitor pt.
27Sept03	1000- pt had BM.

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b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27Sept03	1734- Pt. resting in bed @ this time c̄
	(+) drainage from mid-line incision.
	4x4's placed on incision. Δ'd drsng to
	right flank. moderate drainage to wounds.
	Packed wounds c̄ Nu Gauze + covered c̄
	abd. pad. IV (R) FA s̄ s/sx inf. CDI
	c̄ D5½ 20meq KCL. Pt. tolerating PO
	well. Ambulated in hallway x 10 mins.
	2 Restraints applied (+) circulation (-)
	skin breakdown. voiding per urinal
	Will cont. to monitor pt. b(6)-2
27Sept03	1500- Changed Pt. drsng. moderate
	amount of drainage to wound + mid
	line incision. nu gauze packed into
	wounds. (-) s/sx of infection. midline
	incision (+) redness. Will continue to
	monitor pt. b(6)-2
	(1635) I concur c̄ above assessment. b(6)-2
27Sep03@2100	Assumed care @1800; All VSS, pt A&Ox3 speaking both English c̄ Arabic
	pt ↑ amb to BR x1, (-) BM s̄ difficulty; cont c̄ Q4° Dsg Δs; (R) chest wall
	packed c̄ iodoform gauze covered c̄ an abd pad; (+) purulent/sero-sang

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b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) drainage; moderate amt of drainage from midline inc - purulent sero-sanginous. PIV in (R) FA, patent & infusing D5½ NS c̄ 20 meq KCL, s̄ s/sx infection/infiltration; restraints in place (+) circ. (-) skin break ↓; cont to monitor [redacted]
	b(6)-2
9/28	Surgery
0827	(-) N/V
POD#9	+ BM
	wounds clean
	doing well
	d/c abx
	[redacted] b(6)-2
28Sept03	0946 - VSS - A+O x3 Speaking English + Arabic. Assessment completed. PERRLA, LS CTA (B), Resp. even unlabored, Abd firm, BS x4. Voiding per urinal. Ambulated to BR x2. Conducted personal hygiene (-) c/o pain. ↑ Restraints applied. (-) skin breakdown. (+) circulation. midline incision staples remove. cleaned area c̄ ½ peroxide + ½ sterile water. D/c Abx. + FL. HL to (R) FA. CDI (-) s/sx infection. Pt. resting well @ this time. Will cont. to monitor pt [redacted]
	b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
28Sept03	1500 - Conducted dressing Δ. Pt c/o pain, medicated c two percocets. Three circular GSW to (R) side of abdomen c̄ min. drainage + bleeding ⊕ redness to area packed wounds c̄ Nu Gauze + abd pad on top. Remains afebrile. Pt resting well @ this time. Will cont. to monitor
28Sept03	1515 - Pt. had BM.
	b(6)-2
28Sep.03 2030	Pt A+O x3, VSS, LS CTA (B), ⊕ BS x4, dsg (R) flank has minimal amount of drainage, denies pain, HL (R) FA intact voiding well, OOB to BR, denies pain @ this time, proper circulation + skin integrity on pts of restraint.
	RN
	b(6)-2
9/29 POD#10	Surge → doing well wounds OK cont. [illegible] care
	b(6)-2

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#

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Sept 29	0620 assumed care. pt. awake oriented speaking english PERRLA, lungs cta(B), respiration unlabored but guarded abd soft, BS x4, pt voiding clear yellow urine via urinal pt ambulated to BR without difficulty, GSW repack draining dark red blood, circulation intact around wound with some redness/pinkness and roughness around edges [illegible] [illegible] infections or infiltration, no other [illegible] [illegible]
29 Sep 03	Pt resting in bed, AtO x3, VSS, denies pain, dsg on (R) flank CDI, HLIV (R) FA intact, ø s/sx of infex, ambulates s̄ complications, voiding well, ø s/sx of poor circulation or skin breakdown on pts of restraint [illegible]
29 Sep 03	2100: I concur c̄ above assessment [illegible]
	b(6)-2 All
9/30	Surgery
0720	doing well
POD#11	cont wound care

STANDARD FORM 509 (REV. 6/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 sep 03	- Assumed care pt. A+O x3 OOB to BR ambulates
0700	s̄ difficulty. Midline incision dressing Δ'd 4X4 CDI minimal
	drainage. 3 GSW ~~holes~~ wounds to Ⓡ abdominal wall packed c̄
	2X2 surgipad abdominal dressing applied. Lung clear Hrexr
	Active BS x4 quads. OK for discharge to iraqi hospital when
	transportation is available. Will cont to mon for ——— [redacted]
	b(6)-2

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

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PROGRESS NOTES
Medical Record

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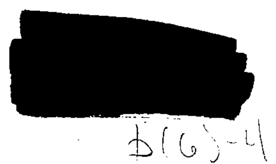

b(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/30/3	d/c summary
	admit 9/19/3
	d/c 9/30/3
	d/c dx - GSW to abd c colon injury
	hosp course - pt underwent R hemi, at FST here for recovery. Did well & d/ced 9/30
	d/c meds
	Motrin 600mg po tid prn
	[redacted] b(6)-2

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

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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)*
9/20/13	Surgery
POD#1	[illegible]
	abd soft, dressings c/d
	stable
	NPO / [illegible]
	b(6)-2

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

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

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

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

/ Cpt b(6)-2

NSN 7540-01-075-3786

MEDICAL RECORD | **EMERGENCY CARE AND TREATMENT** *(Patient)*

LOG NUMBER b(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year) 19 Sept 03 | TIME 2150

TRANSPORTATION TO FACILITY Air

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE	HOME PHONE		FLYING STATUS			
37	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			

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

CURRENT MEDICATIONS Ø

ALLERGIES Eczema

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT 3 GSW to Lower chest

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME 2150

INITIALS 2

VITAL SIGNS

TIME	2150				
BP	135/83				
PULSE	104				
RESP	14				
TEMP	99.4 p				
WT					

LAB ORDERS

X CBC DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	X UA MSCC/CATH		X CHEM: 12
X BLOOD C&S X			Lytes

X-RAY ORDERS

CXR PA & LAT/PORTABLE 2155	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	
KUB 2155	

ORDERS

☒ PULSE OX 96 | ☐ MONITOR | ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2150	6 ltr c NC		b(6)-2	2155	

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW 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)
USAPA V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	TIME SEEN

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	
APTT	BHCG	ETOH	GLU	U/A MICRO			

PROVIDER HISTORY/PHYSICAL

37 y/o ♂ s/p GSW [illegible] seen @ FST s/p lap ex ē ® nephrectomy ⊖ liver lac.

Abx given @ FST. ✓ stable preop

See Surgery H&P

O: A&O x4 ~ mod distress. VS as above

HEENT: ... char/pt   Chest CTA(B) takes full ... breaths

Abd: staples midline ... ⊕ 3x large open GSW ® flank/abd ... active bleed

Back ... lesions   5/5 strength 4 ext ē N/v intact

→ Admit ICU 2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

b(6)-2

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

① GSW x Abd
stable   Admit

CODES

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

EPW b(6)-4

EMERGENCY CARE AND TREATMENT (Doctor)
Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY					
POST- DAY					
MONTH-YEAR / DAY	27 Sep	28 Sep	29 Sept	30 Sep	
19 / HOUR	18	18	18	0700	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	16		20 / 175	
BLOOD PRESSURE	116/70	114/68	105	125/76, 123/73
		83	98	99 / H 92
		98		98 / T 98.4
HEIGHT: WEIGHT →			95	95% / 96%
	97%	97%		RA
	RA			

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] 6(a)-4

MEDCOM - 19929

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY		23 Sept			24 Sept		25 Sept		26 Sept	27 Sept		
MONTH-YEAR / DAY	22								0900	0900		
Sept 2003 / HOUR	1900	1000	1005	07	1830		0800	1800				

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 20 | 141/91 | 138/88 | 140/80 | 131/76 | 123/76 | 88

BLOOD PRESSURE: 126/83 111 | 131/86 121 98.4 | 131/80 | 101 98.1 | P 101 105 T 99.3 | 131/80 125/76 | 117/74

HEIGHT: WEIGHT →

SpO2 | 98% | 95%RA | SpO2 95% | 99% RA 95%RA | 99% RA

T 100.6

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 19930

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE: 19 Sep 03 TIME: 2150	SSN/PSEUDO: EPW [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

======= PICCOLO =======
19/09/03 21:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER # [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	56	26-84	U/L
ALT	68*	10-47	U/L
AMY	119*	14-97	U/L
AST	64*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	62	5-65	U/L
TP	4.3*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
19/09/03 21:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER # [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	143*	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	134	128-145	MMOL/L
K+	5.4*	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

b(6)-4

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: I CU 2
REQUESTING PHYSICIAN: b(6)-7

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

LAST, FIRST, MI. EPW # b(6)-4
DATE 20SEP
TIME 0418
SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		4.8-10.8 x 10³
R		
H		

ID: [redacted]

20-09-03 04:52

			Patient Limits	
WBC	5.9	x10^3/uL	4.5	10.5
RBC	4.92	x10^6/uL	4.00	6.00
Hgb	14.4	g/dL	11.0	18.0
Hct	43.1	%	35.0	60.0
MCV	87.5	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	33.5	g/dL	33.0	37.0
Plt	293.	x10^3/uL	150.	450.
LY%	16.3	*L %	20.5	51.1
LY#	1.0	*L x10^3/uL	1.2	3.4

52% (M)
47% (F)

Sed Rate		
Other		

Urinalysis

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

Cell Count	
Directigen	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

		Negative
		Negative

Urinalysis

Bank

F 518 WITH
QUESTED

F BLOOD

SSMATCH

==== PICCOLO ====
20/09/03 05:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

GLU	124*	73-118	MG/DL
BUN	8	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

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

(MUST S

UNIT

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

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

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

[redacted] b(6)-4	DATE 0914	TIME 21-Sep-03	SSN/PEEUDO SSN: [redacted] b(6)-4

BC		Urinalysis			Misc. Serology		
EF. RANGE		TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
4.8-10.8 x10		Color		N/A	RPR		Negative
4.7-6.1 x10		App		N/A	Mono		Negative
14-18 g/dl(M) 12-16 g/dl(F)		Glu		Negative	**Microbiology**		
42-52%(M) 37-47%(F)		Bili		Negative	Source		
80-94 fl(M) 81-99 fl(F)		Ket		Negative	Gram Stain		
130-500 x 10³ verified		SG		N/A	Occ Bld		Negative
20.5-51.1%		Bld		Negative	H. pylori		Negative
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	**Macroscopic Urinalysis**		
RBC Morph		HCG		Negative			

Spun Hematocrit		42-52%(M) 37-47%(F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)**		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI.	DATE / TIME	SSN/PEEUDO SSN:

(i-STAT)

```
======= PICCOLO =======
21/09/03          09:17
REFERENCE RANGE:   MALE
PATIENT #: [redacted] b(6)-2
BASIC METABOLIC
DISC LOT #:     3203AA4
OPER #: [redacted]   DR #: 000
SERIAL #: b(6) [redacted]
.........................
GLU   131*  73-118   MG/DL
BUN17 ♦♦♦   7-22     MG/DL
CA++  8.3   8.0-10.3 MG/DL
CRE   0.9   0.6-1.2  MG/DL
NA+   118*  128-145  MMOL/L
K+    4.2   3.3-4.7  MMOL/L
CL-   101   98-108   MMOL/L
tCO2  ♦♦♦   18-33    MMOL/L
      28
INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

(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^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
tCO2		18-33 mmol/l

```
======= PICCOLO =======
21/09/03           09:19
REFERENCE RANGE:    MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #:      3154AA7
OPER #: [redacted]  DR #: 000
SERIAL #: b(6) [redacted]
.........................
ALB   2.2*  3.3-5.5   G/DL
ALP   46    26-84     U/L
ALT   21    10-47     U/L
AMY   414*  14-97     U/L
AST   99*   11-38     U/L
TBIL  1.2   0.2-1.6   MG/DL
GGT   44    5-65      U/L
TP    5.3*  6.4-8.1   G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 19934

b(6)-2

Ward/Station: ICW2	REQUESTING PHYSICIAN: Dr. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST MI: [redacted] b(6)-4	DATE: 21Sep / TIME: 2040	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (art)
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
Tropoin-1		
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^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

```
======= PICCOLO =======
21/09/03            20:40
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #:       3203AA4
OPER # [redacted]   DR #: 000
SERIAL #: b(6)-2 [redacted]
.........................
GLU   111   73-118    MG/DL
BUN   ♦♦♦   7-22      MG/DL
CA++  8.1   8.0-10.3  MG/DL
CRE   0.6   0.6-1.2   MG/DL
NA+   117*  128-145   MMOL/L
K+    4.1   3.3-4.7   MMOL/L
CL-   101   98-108    MMOL/L
tCO2  ♦♦♦   18-33     MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

Ward/Section: ICW 2	REQUESTING PHYSICIAN: [redacted] b(6)-2	
LAST, FIRST, MI. [redacted] b(6)-4	DATE 21-SEP-03 / TIME 1027	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (art)
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
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/
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 m
BUN		7-22 mg/
CA^{++}		8.0-10.3
CHOL		100-200
CRE		0.6-1.2
GLU		73-118
TP		6.4-8.1

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118
BUN		7-22 mg
CRE		0.6-1.2
CK		39-380 / 30-190
NA^+		128-145
K^+		3.3-4.7
CL^-		98-108
tCO2		18-33

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

```
======= PICCOLO =======
21/09/03          10:24
REFERENCE RANGE:     MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #:        3203AA4
OPER # [redacted]   DR #: 000
SERIAL #: [redacted]
..........................
GLU   138*  73-118    MG/DL
BUN     8   7-22      MG/DL
CA++  8.2   8.0-10.3  MG/DL
CRE   0.8   0.6-1.2   MG/DL
NA+   116*  128-145   MMOL/L
K+    3.9   3.3-4.7   MMOL/L
CL-   101   98-108    MMOL/L
tCO2   33   18-33     MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
Fentanyl (mcg)	250 / 250	500
Ketamine (mg)	150	150
Sux (mg)	100	100
Vec (mg)	5 2 2	9
Ativan (mg)	5 5 5 5	20
VOLAT AGENT: Iso % del	1.0 1.0 1.0 1.0 1.0 1.0 1.0 .8 .5 .5	
AIR L/Min		
N2O L/Min		
O2 L/Min	5 2 2 2 2 2 2 2 2 2 2 5	

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

TOTAL EBL: 400

TOTAL URINE: 600

FLUIDS SUMMARY
CRYSTALLOID– 4.5L
COLLOID– 500ml
BLOOD–

FLUIDS
LINE site: 18 G (R) ☐ Warmed; 18 G (L) ☐ Warmed; ☐ Warmed; LR ☐ Warmed
1L — 2L — 3L — 4L — 4.5L; HESPAN 500

LOSSES
EST BLOOD LOSS: 300 — 400
URINE – 500 — 600

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

BODY WEIGHT: 80 (KG)

HEMATOCRIT:

INITIAL DATA:
BP – 117/83
HR– 96

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y
TIME– 1630

TIME → 1630 45 (17) 15 30 45 (18) 15 30 45 (19)

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

Scale: 220 200 180 160 140 120 100 80 60 40 20

pH 7.34
pCO2 37.2
pO2 135

REMARKS– Code drugs with numbers, events with letters

① Arrived → OR. Unknown Hx. GSW x3 to ABD.
② OR/Monitor/RSI c cricoid.
Est. FM, dual setup c PRBV.
③ ABG sent. 7.12 / 34
① 2G CEFOTAN
② 500mg FLAGYL

VENTIL

VT – ml	VPAC →
f – breaths/min	12 10 10 10 10 10 12 10 14 16
Peak inf pres / PEEP	VPAC
MODE– S(pon), A(ssist), C(on)	S C C C → → A 95 S S

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

ET CO2 (torr)	✓ 32 31 30 32 30 32 34 49 42
FIO2 (Frac or %)	.21 .81 .72 .68 .72 .71 .71 .76 .78 .79
SpO2 (%)	100 99 100 100 100 100 100 100 99 100
ECG	ST SR SR SR SR SR SR SR SR SR
TEMP- site	SKIN 100 — 99 — 97 —
N-M Block (T/4)	4/4 4/4 4/4 1/4 — 1/4 — 2/4 4/4

7.45?
5mg NEOSTIG
.8mg ROBINUL
O → Blanket upper → → →

RECOVERY AT 1905
(PACU) ICU ____ (Specify)
OTHER
CONDITION: RESP 18, SpO2 96%, BP 145/80, HR– 92

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1630	1630	1915

	Ready	Begin	End
PROC	1640	1645	1850

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

PROCEDURES and CPT Codes: EX LAP / GSW ABD x3

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: SCCS/GETA/RSI c CRICOID/HME/ES SPRAY

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x1 Sabre, 8.0 the cuff. (+)EtCO2 (+)BSBS. Taped 23 lips.

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

SURGEONS: [redacted]
ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: FST
DATE: 19 SEP 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19937

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

..ADIOLOGIC CONSULTATION REQUEST/REPORT

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

AMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR / KUB	37	M	EPW 801	EMT	

FILM NO.

PREGNANT
☐ YES ☒ NO

REQUESTED BY: Dr. [redacted]

TELEPHONE/PAGE

SIGNATURE OF REQUESTOR: b(6)-2

DATE REQUESTED: 19 Sept 03

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

GSW

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

DIOLOGIC REPORT

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

EPW [redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDICAL RECORD - DOCTOR'S ORDE

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
1988P03	Admit PT Hobl		
	Dx S/P Exlap		
	Cond: Stable		
	Vitals: Routine, q4°, ō I/O		
	Act: Ad lib		
	NKDA		
	Nurs: ① Foley to gravity		
	② NG to LIS		
	wet to dry to Abdominal wall		
	TID, 1st dressing Δ tomorrow		
	Diet: NPO		
	IV: ~~D5½NS~~ D5NS ō 20 KCl @		
	110 cc/hr		
	Meds: ① Cefotetan 1gm IV ~~on~~ q8°		
	~~start to OR~~		
	② Morphine 2-5mg IV q2-3° PRN		
	pain		
	③ Ranitidine 50mg IV q8°		
	[redacted] b(6)-2		

PATIENT IDENTIFICATION

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis:

Height: Weight: Diet:

Allergies:

Nursing Unit	Room No.	Bed No.	Page No

MC V

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

CLINICAL RECORD - DOCT[illegible] DERS
[illegible]or use of this form, see AR 40-66, the propo[illegible] agency is OTSG

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

PATIENT IDENTIFICATION

b(6)-4

EPW [redacted]

NURSING UNIT | ROOM NO | BED NO.

DATE OF ORDER: 9/19/3
TIME OF ORDER: HOURS

1) admit to ICU
2) dx - s/p [illegible]
3) VS q1° x 6 then q2°
4) NPO
5) NG to LIS
6) Pepcid 20mg IV q12°
7) MSO4 1-6mg IV [redacted]

PATIENT IDENTIFICATION

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

8) Ancef 2gm IV q8° x 5 days
9) Flagyl 500mg IV q8°
10) CBC / Chem 7 in AM
11) incentive spirometer [redacted]

NURSING UNIT | ROOM NO. | BED NO.

CATI

PATIENT IDENTIFICATION

DATE OF ORDER: b(6)-2 [redacted]
HOURS

12) LR 150cc/hr
13) W → D ~~to~~ t.i.d to abd wound
14) dry dressing on inc Δ prn

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE O[redacted]
9/20/3
HOURS

1) D5 1/2 NS [illegible] / L 100cc/hr
2) W → D tid to abd

Note: see [redacted]
b(6)-2

NURSING UNIT | ROOM NO. | BED NO

[redacted]

b(6)-2

ıCAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is [illegible]

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

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/20 TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1) Zantac 50mg IV q8°
2) d/c Pepcid
3) Tylenol 650 T p– q4° prn

b(6)-2

9:37

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 21 Sep 0800 HOURS

1. portable CXR this am
2. CBC lytes, LFT's this am
3. CBC lytes 22 Sep
4. change R flank dressing q8h – NS soaked Kerlix fluffs
5. OOB chair TID
6. culture wound - drain

b(6)-2

0800

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

21 Sep 1300

1. Δ IV to NS1000cc c̄ 20 mEq KCl at 100/h
2. lytes at 2000

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 22 Sep 0700 TIME OF ORDER ______ HOURS

1. DC NG ✓
2. DC foley ✓
3. NPO ✓
4. DBC ✓
5. ambulate
6. ↑ dressing Δ to q4h
7. Tentacle patch, change q
8. DC [illegible]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

MEDCOM - 19941

CLINICAL RECORD - DOCTOR'S C[illegible]S

[illegible]se of this form, see AR 40-66, the proponent [illegible]y is O[illegible]G

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

PATIENT IDENTIFICATION

DATE OF ORDER 22 Sept 03 TIME OF ORDER 0900 HOURS

LIST TIME ORDER NOTED AND SIGN

1) Transfer to ICW1
2) Dx: s/p GSW abd b(6)-2
3) Cond: stable
4) VS q shift
5) Act: BR
6) NKDA
7) NPO

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

noted 22 Sept 03 @ 1130 b(6)-2

b(6)-4

DATE OF ORDER TIME OF ORDER HOURS

8) ~~IVF: NS @ 100cc~~
9) Flagyl 500g IV q 8°
10) Ancef 2gm IV q8°
11) Zantac 50g IV q8°
12) drsg Δ q4°
13) D/5 ½NS c 20[illegible] b(6)-2
14) Fentanyl patch [illegible] 72°

NURSING UNIT ROOM NO. BED NO.

24° 2300 22Sep

PATIENT IDENTIFICATION

DATE OF ORDER 22SEP03 TIME OF [ORDER] 2000 HOURS

b(6)-2

1) V.O. DR
Pt may have sips of H2O. b(6)-2

NURSING UNIT ROOM NO. BED NO.

24° 2320 22 b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 24 Sep 0530 TIME OF ORDER HOURS

full liq diet b(6)-2

noted 24Sept @ 0630 b(6)-2

NURSING UNIT ROOM NO. BED NO.

24° / 2345 24Sep03 b(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

Noted 25 Sept

DATE OF ORDER: 25 Sep — TIME OF ORDER: 1500 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Reg diet
2. May ambulate

b(6)-2

NURSING UNIT: ICW — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

b(6)-4

Noted

DATE OF ORDER: 9/26 — TIME OF ORDER: 7:15 HOURS

1) Zantac to 150 mg po bid
2) Dulcolax 2 po NOW

b(6)-2

NURSING UNIT: ICW 24° 0

PATIENT IDENTIFICATION

b(6)-2

b(6)-4

DATE OF ORDER: 9/27 — TIME OF ORDER — HOURS

1) d/c staples
2) MOM 30 cc po now
3) if ⊝ BM by 4pm - Dulcolax ii pr

b(6)-2

NURSING UNIT: ICW 24° — ROOM NO.

PATIENT IDENTIFICATION

b(6)-2

DATE OF ORDER: 28 Sep 03 @0100 HOURS

1. MSO4 2-5 mg IV Q4° PRN for discomfort.
2. Percocet 1-2 tabs po Q4-6° prn.

V.O. Dr

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

NURSING UNIT: 24° — ROOM NO.: 0800 — BED NO.: 28 Sep 03

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

MEDCOM - 19943

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

Noted 28 Sept 0900 (b)(6)-2

NURSING UNIT: TCW7 | ROOM NO. | BED NO.

DATE OF ORDER: 9/28/13 | TIME OF ORDER: 0824 HOURS | LIST TIME ORDER NOTED AND SIGN

1) d/c MSO4
2) Percocet 1-2 po q4° prn pain
3) hep lock IVF
4) d/c Ancef
5) d/c Flagyl
6) cont to pack wounds w→D tid
7) d/c rest staples

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9/30 | TIME OF ORDER: 834 HOURS

1) d/c home
2) Teach wound care pack tid w→D send with few days of supplies

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | HOURS

(b)(6)-2

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

b(6)-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. ___ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
9/19	[redacted]	V.S. q 1° x6 then q 2°	06, 18	19 20 21 22 23 24 25 26 27 28 29 30 Oct 1 2 — Δ'D 22Sep03
9/19	[redacted]	Diet NPO	06, 12, 18	Rewritten
9/19	[redacted]	NG to LIS	06, 18	Δ'D 22Sep03
9/19	[redacted]	Incentive Spirometer	06, 18	
9/19	[redacted]	W→D tid to abd wound	06, 18, 22	Δ'D 22Sep03
9/19	[redacted]	Dry dressing on inc. Δ prn	06, 18	
21-Sep-03	[redacted]	Δ (R) Flank Dressing Q8h - NS soaked Kerlex Fluff	07, 15, 23	Δ'D 22Sep03
21Sep03	[redacted]	OOB chair TID	07, 15, 23	
22Sep03	[redacted]	DC NG	07	Done @ 0710
22Sep03	[redacted]	DC Foley	07	Done @ 0730
22Sep03	[redacted]	DBC exercises.	06, 18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Rhemi

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

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*	*Mo* ______ *Yr* 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/14		Admit to ICU				
9/14		CBC, chem 7 in A.M.				
9/21		Portable CXR this A.M.	21Sep03	Now	0900	
9/21		CBC, lytes, LFT's this A.M.	21Sep03	Now	0900	
9/21		Culture [illegible] drainage	21Sep03	Now	0900	
9/21		CBC, lytes 22 Sep	22Sep03	0500	0430	
9/21		Lytes @ 2000	21Sep03	2000	2030	
	- - - - -					
	- - - - -					
	- - - - -	b(6)-2 All				
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22
22Sep03	[redacted]	DRSG Δ Q4hr	07	[redacted]
			11	[redacted]
		b(6)-2	15	[redacted]
			19	[redacted]
			23	
			03	
22Sep03	[redacted]	VS Q shift	06	[redacted]
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

b(6)-4

EPW [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-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. Sept Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 22 23 24 25 26 27 28 29 30
22 Sept		NPO -	06 18	D/C'd 24 Sept 03
		Sips of H2O	18 06	
22 Sep		DBC	06 18	
			18 06	
22 Sep		ambulate	06 18	D/C'd 22 Sept
			18 06	
22 Sep		Δ dsg q 4 hrs	06	
		(R) Flank	10	Δ'd 28 Sept
		W → D	14	
		Continue	18	
			22	
			02	
22 Sep		BR	06 18	Δ'd 25 Sept 03
			18 06	
24 Sep		Full liquid diet	06 18	Δ'd 25 Sept 03
			18 06	
25 Sep		Regular diet	06 18	
			18 06	
25 Sept		May Ambulate	06 18	
			18 06	
28 Sept		Continue to pack	06	
		(R) Flank wound	14	
		W → D TID	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ABD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION: b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

MEDCOM - 19948

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 09 Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27 SEP 03	[redacted]	D/C 1/2 staples	27 SEP 03	Today	1030	[redacted]
28 Sept	----	D/C rest of staples	28 Sept	Today	[redacted]	[redacted]

	----	to(6)-2 t11				

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

b(6)-2

CLINICAL RECORD

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 19 20 21 22 23 24
9/14	[redacted]	Peplid 20mg IV q 12°	06, 18	/ / DC'd Pharmacy does not have
9/14	[redacted]	Ancef 2gm IV q 8° x 5 days	06, 14, 22	/ / Rewritten
9/14	[redacted]	Flagyl 500mg IV q 8°	06, 14, 22	/ Rewritten
9/14	[redacted]	LR @ 150cc/hr	06, 18	D/C'D 20 Sep 03
9/14	[redacted]	Ancef 2gm IV q 8° x 5 days	08, 16, 24	Rewritten
9/14	[redacted]	Flagyl 500mg IV q 8	08, 16, 24	
9/20	[redacted]	D5½NS + 20K @ 100cc/hr	06, 18	D/C'd 21 Sep 03
20 Sept 03	[redacted]	Zantac 50mg IV q 8°	08, 16, 24	Rewritten
21 Sep 03	[redacted]	Δ IV to NS 1000cc ē 20meq KCl @ 100/hr	06, 18	/ /
22/9	[redacted]	Fentanyl Patch 50ug/hr Replace Q72 hrs	07	/ / /

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Rhemi

b(6)-2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo.____ Yr.____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14SEP		MSO4 ←6mg	20SEP 4mg	20SEP 6mg	20 Sept 5mg	20 Sept 5mg	21 Sep 03 3mg									
		IV q20	NE C	NE C	1630	2130	1730									
20 Sept		Tylenol 650mg PR	20 Sept 1125	20 Sept 1615												
		q4° prn	650 PR	650 PR												
		b(6)-2														

USAPA V1.00

b(6)-2 All

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

Sep 03

ORDER DATE	CHECK/NURSE	SCHEDULED MEDICATIONS, DOSE, FREQUENCY	TIME	21	22	23	24	25	26	27	28	29	30	1
22Sept	[redacted]	Fentanyl patch 50mcg Δ q 72 hrs	18 06											
22Sept	[redacted]	Flagyl 500mg IV q 8	08 16 24							D/C Sept 28				
22Sept	[redacted]	Ancef 2.0gm IV	08 16 24							D/C Sept 28				
22Sept	[redacted]	Zantac 50mg IV	08 16 24					DC 26SEP03						
22Sept	[redacted]	D5½ NS c̄ 20meq KCL @ 100/hr	06 18 / 18 06							Δed 28 Sept 03				
26SEP03	[redacted]	Zantac 150mg po bid	10 22											
28Sept	[redacted]	Heplock IVF	06 18 / 18 06											

GSW ABD

[redacted] b(6)-4

Verify by Initials | THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

Order Date	Check Date	b(6)-2 SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26 SEP03	[redacted]	Dulcolax 2 po now	26 SEP03	—	0725	[redacted] b(6)-2
27 SEP03	[redacted]	MOM 30cc po now	27 SEP03		0748	[redacted]

Order Date	Check Date	b(6) - 2 PRN MEDICATIONS, DOSE & FREQUENCY	INITIAL PROPER COLUMN FOR EACH DOSE ADMINISTERED — TIME/DATE DISPENSED
27SEP03	[redacted]	If no BM by 4pm, Dulcolax TT pr	
28	[redacted]	MSO4 2-5mg IV q4° prn drsg Δ D/T D/I	D/Ced 28 Sept 03
28	[redacted]	Percocet 1-2 po Q4-6° PRN D/T D/I	28Sep 1417 RMY TT

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

b(6)-2

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

INITIAL SHIFT ASSESSMENT

	TIME	1015 INITIALS	2157 INITIALS	INITIALS
NEURO	PUPILS	PERRL @ 1mm	2mm reactive PERRLA	
	SENSORIUM	A+O	intact	
			pain in mid line area	
			Abd.	
RESPIRATORY	RESPIRATORY PATTERN	= rise & fall of	Bil equal - symmetrical	
	BREATH SOUNDS	Chest bil BS wheez	BS wheez	
	SECRETIONS	noted bil, No Color		
		Noted @ present time	Breathing deep BS	
		No Secretions noted	and cough encouraged	
SKIN	COLOR	W.N.L for race	NFR	
	INTEGRITY	good	good	
IV SITE	LOCATION	L AC D5½NS = 20	(R) FA D5½ NS - 20	
	CONDITION	meq K @ 100cc/hr	(L) AC	
		R AC IV HL No S/S	S/S	
		of infection or infiltration		
		noted Flushes well.		
GASTRO	ABDOMEN	ABD Soft nondistended	ABD soft nondistended	
	BOWEL SOUNDS	BS + all 4 quads.	BS active x4 quads	
		Midline DSG CDI.	midline DSG CDI	
		R ABD DSG CDI.		
GU	URINE:	Foley to gravity =	F/C to gravity	
	COLOR/CLARITY	dark amber color		
		urine		
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Tachy 130's	ST	
		+ Radial & Pedal	good pulses	
		pulses bil.	4	

LEGEND
Cr - Creatinine
F_1O_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 (*Signature & Title*)

DEPARTMENT/SERVICE/CLINIC: ICW

DATE: 20 SEPT 03

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

EPW

b(6)-4

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

VS

DATE | DX | Admit | HOSPITAL DAY

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
(hour count)					1	2	3	4	5	(6)							
VITAL SIGNS — TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
BP Arterial Line																	
BP Cuff		117/76			114/69	124/76	116/72	106/69	110/71	110/72	115/79	115/74	127/81	123/71	115/72	117/72	
Temperature					99.6 A	100.5 A	100.4 A	100.9 A	100.6 A		100.9 A	100.4 A	100				
Pulse		128			129	129	133	133	137	136	130	136	141	135	133	131	
Respiratory Rate		20			21	22	23	22	25	21	24	21	22	23	24	19	
O2		RA			2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
Method		RA			NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
SpO2		97			98	98	94	94	96	98	97	97	97	97	96	96	
Pain																	
INTAKE — D5 1/2 NS c 20K (TIME)					100	100	100	100	8° T 100	100	100	100	100	100	100	100	100
(IV)																	
Ancef next due			500								50						
Flagyl @ / Cefo[illegible]			100								100						
Zantac			50								50						
NS Flush										1630	0.5 5mg 10				2130	0.5 5mg 10 = 11cc	(11)
TOTALS									500				800	900	1000	1100	1200 (1200)
OUTPUT — URINE HOUR/TOTAL					200	50/250	50/300	50/350		50/400	50/450	50/500	30/530	50/680	50/730	50/780	50/830
URINE sp gr																	
URINE S/A																	
NG OUTPUT								300				100	50				
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS																	
TOTALS									300				530			830	930

8° T

POST-OP DAY 23 | 23 | 24 | 01 | 02 | 03 | 04 | 05 | 06

VITAL SIGNS

V	07	24	02	02	03	04	05	06	—
I	119/76								
	128	113/71	120/71	124/84		138/67		144/90	
T	24	130	130	98		99		99.7	
A	97.2	22	21	28		136		123	
L	RA	NC 22	NC 22	22		21		22	
	99°	97	96	NC		22		21	
TE	97	97	96	96		NC		NC	
S						96%		97	

INTAKE

	150	100	100	100	100	100	100	100	BRT
Ancef			50						
Flagyl			100						
Zantac			50						
		100	300	100	100	100	100	100	100
		1310	1111						2211

OUTPUT

	50/50	50/180	50/150	50/240	75	75	75	
385								
							150	
	880	930	480	1030			1180	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
PCO_2	
pO_2	
HCO_3	
SAT	
BASE	

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME	0230
MOUTH CARE	✓
BATH	✓
SKIN CARE	✓
FOLEY CARE	✓
TRACH CARE	∅
ROM EXERCISES	✓

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV		Urine:	~~1180~~
po	2211		1,180
TOTAL		TOTAL	

BALANCE (+) 1,031

NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)-2

NEUROLOGICAL ASSESSMENT

	HOURS		1800	2200
COMA SCALE – EYES OPEN	SPONTANEOUSLY	4	4	4
	TO SPEECH	3		
	TO PAIN	2		
	NO EYE OPENING	1		
COMA SCALE – BEST VERBAL RESPONSE	ORIENTED	5	5	5
	CONFUSED	4		
	VERBALIZES	3		
	VOCALIZES	2		
	NO VOCALIZATION	1		
COMA SCALE – BEST MOTOR RESPONSE	OBEYS COMMANDS	6	6	6
	LOCALIZES PAIN	5		
	FLEXION WITHDRAWAL	4		
	ABNORMAL FLEXION	3		
	EXTENSION TO PAIN	2		
	NO MOTOR RESPONSE	1		
LIMB MOVEMENT – ARMS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
LIMB MOVEMENT – LEGS	NORMAL POWER		✓	✓
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE			
PUPILS – RIGHT	SIZE		2	2
	REACTION		+	+
PUPILS – LEFT	SIZE		2	2
	REACTION		+	+
PUPIL SCALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm			
ICP				
CEREBRAL PERFUSION PRESSURE				

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- ++ Brisk
- + Slow
- − No Response
- + Intact
- − Abnormal

VASCULAR ASSESSMENT

HOURS	
	R / L
	R / L
	R / L
	R / L
	R / L

LEGEND

- ++ Normal
- + Weak
- − Absent
- D Doppler
- R Right
- L Left

INTENSIVE CARE NURSING FLOW SHEET | OA Appr 8 Mar 89

ITIAL SHIFT ASSESSMENT

b(6)-2

		Time: 0630 Initals: [redacted] b(6)-2	Time: 1820 Initals: [redacted]
NEURO	Pupils	2-3 mm Reactive Brisk	3 mm reactive + brisk
	Sensorium	AOx3, can verbalize needs	A+Ox3, can verbalize needs in English
	LOC / GCS		
CARDIAC	Cardiac Rhythm	Sinus Tach, rate 130's	ST @ 129
	PRI / QRS:		
	Pulse Strength	+3 pulses throughout	3+ pulses x4 extremities
	Cap Refil / JVD	cap refill < 3 sec x 4 extremities	< 3 sec x4 extremities
	Edema	Ø edema	⊖ edema, ⊖ JVD
	Chest Pain		⊖ CP
RESP	Respiratory Pattern	even non-labored, CTA Ⓑ	RRR, even + non-labored.
	Breath Sounds	O_2 via NC @ 2LPM SpO_2 95%	CTA to all lobes
	Secretions	Ø	⊖ secretions, ⊖ cough
	Cough	can cough, non productive	RA, SpO_2 94-96%
SKIN	Color	normal for race	normal for race
	Integrity	Abd staples intact Ø s/s infection	ABD staples, intact ⊖ s/s infection
	Backside	Ⓡ chest wall - minimal	Ⓡ flank DRSG, CDI
IV	Access Devices	Ⓛ AC - 18g,	Ⓛ AC - 18G - NS c̄ 20k @ 100 cc/HR
	Location	Ⓡ forearm - 18G,	⊖ s/s infiltration
	Condition	Both sites C/D/I	Ⓡ FA - 18G - SL, patent - ⊖ s/s infiltration
GI	Abdomen	↓ BS x 4 Quadrants	⊖ BS x4 quads.
	Bowel Sounds	ND, ⊕ TTP, soft	soft non-distended, tender
	Stoma/Ostomy		⊖ N/V, ⊖ flatus, ⊖ BM
			NG to LIS - green fluid
GU	Device	Foley to gravity	Foley to gravity 16 FR
	Color / Clarity	clear yellow	clear amber urine

[redacted] & Title) b(6)-2 SSG | DEPARTMENT/SERVICE/CLINIC (b)(6)-2 [redacted] | DATE 21 Sep 03

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

NAME: [redacted] RANK: AGE:

UNIT: [redacted] b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: (CIV) / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 19958

37 y/o ♂ Report VS q 2° Antibiotic Therapy 21 & 22 SEPT 03

PT'S NAME EPW [redacted] b(6)-4

DATE:

H.O. 19 SEPT 2150

Ø VS ③ vital signs

Neuro: Intact
CV: ST – AC 18g x2
RL Course wheezes
BS q 1°
GI: NG LIS — Zantac 50mg
NPO
GU: Fil. 16Fr

Ancef 2gm
Flagyl 500mg

18g AC
18g AC
16Fr

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP NIBP		140/78	144/83	146/78	140/70	139/83	139/80	135/85	133/86	124/76	156/75	[illegible]/79	142/79	12[illegible]/67	155/84	136/79	134/82	132/84	124/83		123/80		134/66	
TEMP		99.6	100.0	101.3	101.3	101.5	101.9	101.5	101.7	100.7	101.0	101.8	101.4		100.8	99.9	99.8	99.9	100.2		[illegible]		100.[illegible]	
PULSE		135	132	133	130	128	135	130	140	124	123	127	132	129	120	122	123	117	111		97		104	
RESP		24	22	30	30	32	12	20	24	29	24	30	27	22	28	24	24	22	29		33		30	
SP02		96	96	96	97	93	95	94	97	95	95	94	94	94	94	96	96	94	95		96		97	
FIO2		2L	2L	2L	2L	2L	2L	2L	2L	2L	RA	RA	RA	RA	RA	2LNC	2LNC	RA	2LNC		2LNC		2LNC	
Pain																								
INPUT																								
D5½NS + 20 KCl	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
Ancef		50								50								50						
Flagyl		100								100							100							
Zantac		50								50								50						
PAIN MEDS																								
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL	100	400	500	600	700	800	900	1000	1100	1400	1500	1600	1700	1800	1900	2000	2230	2400	2500	2600	2700	2800	2900	
OUTPUT																								
URINE	75	75	75	75	75	75	75	75	75	75	75		125		175		200	12[illegible]	80	150	130	—	80	
NGT		50	Ø	100	Ø	50	Ø	Ø	Ø	Ø	Ø		200	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL	75	200	275	450	525	650	725	800	875	950	1050		1375		1550		1750	1870	1950	2100	2230	2230	2310	
BALANCE																								

PT'S NAME: [redacted] b(6)-4

DATE: 22Sep03 - 23Sep03

O2 > 90% keep off NC

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV	142/		143/																				
BP NIBP	/80		/83																				
TEMP	100.5		100.5																				
PULSE	102		103																				
RESP	23		29																				
SP02	94		92																				
FIO2	RA		RA																				
INPUT																							
IV																							
PO																							
NGT																							
O.R. IN																							
SUB TOTAL																							
TOTAL																							
OUTPUT																							
URINE	300																						
NGT																							
STOOL																							
O.R. OUT																							
SUBTOTAL																							
TOTAL																							
BALANCE																							

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

			INITIALS	b(6)-2	INITIALS		INITIALS
	TIME	2300					
NEURO	PUPILS	Perrla 2m					
	SENSORIUM	lathergic					
RESPIRATORY	RESPIRATORY PATTERN	Equal rise + fall of chest					
	BREATH SOUNDS	Clear Bilat					
	SECRETIONS	Ø					
SKIN	COLOR	Normal					
	INTEGRITY	ABD Gunshot wound x3					
IV SITE	LOCATION	(L) AC, (R) AC					
	CONDITION	Ø sign of infection patent					
GASTRO	ABDOMEN	Gun wound x3					
	BOWEL SOUNDS	unable to assess due to dsg.					
GU	URINE:	Foley to Gravity					
	COLOR/CLARITY	Clear + yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus tach					

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 [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 23 Sep

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

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
BP Arterial Line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		

INTAKE

TIME	06	07	08	09	10	11	12	13	~~14~~	15	16	17	18	19	20	21	22	~~23~~
LR																		
Ancef																		
Flagyl																		
TOTALS																		

OUTPUT

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

POST-OP DAY

VITAL SIGNS

23	24	01	02	03	04	05		
114/81	110/84	120/80	124/82	114/80	119/80	117/81		
98.2			98.6					
110	117	118	114	127	124	123		
29	28	24	20	15	13	14		
100	100	96	97	98	100	97		
6L	6L	RA	3L	2L	2L	2L		

INTAKE

23	24	01	02	03	04	05	06	8° T
150	150	150	150	150	150	150	150	
	50							
		100						
150/150	200/350	250/600	150/750	150/900	150/1050	150/1200	150/1350	

OUTPUT

/	/	300/300	/	/	200/	/	/	
		500/800						

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA

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

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

IV ________

po ________

TOTAL ________

OUTPUT

Urine: ________

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE

6/6-2

MEDCOM - 19963

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — [redacted]

2. MTF LOCATION (State or Country Code.): 7 8 — I Z

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — [redacted]

NAME (Last, First, Middle Initial): EPW [redacted] b(a)-4

4. PAY GRADE: 16 17

5. SEX: 18 — m

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29 — 3 7 y

8. RACE: 30 — Z

9. ETHNIC BACKGROUND: 31 — 9

RELIGION: unk

10. LENGTH OF SERVICE: 32 33 34

ETS: N/A

11. FMP: 35 36 — 9 9

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — [redacted] b(a)-4

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS: 46 — u

HOUR OF ADMISSION: 2150

BRANCH / CORPS: N/A

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION: YEAR — ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — Ø

WARD: ICU 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — 5 Ø

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86 — Ø 3 Ø 9 3 Ø

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (YYMMDD): 97 98 99 100 101 102 — Ø 3 Ø 9 1 9

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (YYMMDD): 111 112 113 114 115 116

FOR LOCAL USE

Dx: GSW Abd.

Trauma Injury

86351
86402
E9912

Proc 1 : 450
4573

ADM[redacted] ...uired) [redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] SPC 9/2/10

DA FORM 2985, MAR 89 — MEDCOM - 19964 — USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

Field	Entry
1.	[redacted]
2. NAME (Last, First, MI)	CIV # [redacted] b(6)-4
3. GRADE	CIV
4. SEX	M
5. AGE	28y
6. RACE	unk
7. RELIGION	UNK
8. LENGTH OF SVC	—
9. ETS	—
10. PREVIOUS ADMISSION	N
11. FMP	99
12. SSN	[redacted]
13. ORGANIZATION	—
14. WARD	ICW2
15. FLYING STATUS	—
16. DSG	—
17. DEPT./BEN	K91 K70
18. BRANCH/CORPS	—
19. UIC/ZIP	—
20. TYPE CASE	WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	2S direct from ER
22. HOURS OF ADMISSION	2112
23. CLINIC SERVICE	AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	UNK
25. TYPE DISPOSITION	d/c
26. DATE OF DISPOSITION	25 Sep03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	UNK
27b. TELEPHONE NO.	UNK
28. DATE OF THIS ADMISSION	20Sep03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	[redacted] b(2)-2
30. DATE OF INITIAL ADMISSION	
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED	
ADMISSION REMARKS	
ADMITTING OFFICER	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel Ⓛ forearm, Ⓛ chest & Ⓡ leg, Grade II open Ⓛ ulna fx

903.3
955.2
813.92
891.1
880.12
E993

21Sep03
38.83
86.28
86.59
93.54

23Sep03
86.28
79.62
86.59

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	5	5

36. Total Days All Facilities

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

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

DA [redacted] MEDCOM - 19965

USAPPC V1.10

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

28 yo ♂ Iraqi civilian
ambushed @ ~9 AM today.
Shrapnel to (L) Forearm (R) Leg, (L) chest/Flank.
c/o numb ulnar (L) hand/weakness.
Seen initially @ Iraqi hospital → Transferred. Ø procedure
performed then per his Hx. presents in LUE post splint,
(R) leg post splint.

NKDA Ø PMedHx Ø PSurgHx.

PHYSICAL EXAMINATION

AAOx3 NAD
See ER admit sheet PE
Focused: LUE: Complex lac/entrance + exit wound dorso/ulnar forearm
c exposed tendons. (-) intrinsics. (-) ulnar sensation.
palpable radial pulse. otherwise NVI
RLE - NVI entrance/exit wounds posterior to midline mid leg.
compartments soft. palp DP/PT. intact sensation.
Ø active bleeding.

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

Admit
to OR for I/D of wounds today. High Risk infection (known 9°
out from injury). Ulnar NV is out.. will explore. I/D for
now, will require reconstruction @ future operative sittings.

b(6)-2

2108

CPT, [redacted]

DATE 20Sept03 | IDENTIFICATION NO. | ORGANIZATION

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

Iraqi Civilian.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21Sept03	ORTHO
1000	preop Dx: Shrapnel (L) forearm/(R) leg/(L) chest
	postop Dx: same
	I/D + Splint.
	GETA — Ulnar nv was continuous.
	∅ comp — Ulnar artery traumatically interrupted
	EBL 100 by shrapnel & ligated. palpable
	to RR stable. radial pulse [redacted]
	[redacted]
	b(6)-2
22Sept03	ORTHO POD#1
0902	~~preop Dx~~ ∅ c/o's.
	AFVSS
	exam - ulnar nv clinically out (same as preop)
	Splint c/d/i
	Stable
	to OR tomorrow for repeat I/D + Bea[redacted]
	[redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV[redacted]	AT
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	

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

REGISTER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23Sept03	ORTHO Op note
1020	Preop Dx: soft tissue shrapnel wound (R) leg
	Grade II open (L) ulna Fx 2° shrapnel
	Postop Dx: same
	repeat I/D both injuries + Abx beads
	[redacted] b(6)-2
	GETA
	∅ comp
	to RR stable
	[redacted]
24Sept03	ORTHO POD # 1/4
	∅ new c/o
	AFVSS
	exam unΔ'd
	stable
	await dispo
	cont IV Abx
	[redacted] b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S [redacted] NUMBER (SSN or Other) | LAST | FIRST | MI

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sept 03	ORTHO POD # 2/5
	Ø new c/o's.
	AF VSS
	Ulnar claw
	↓ sensation Ulnar 2 digits.
	- claw / ↓ sens 2° Ulnar NV injury + scar/damage to ulnar extrinsics. stable from preop.
	- D/C on keflex tomorrow
	- will need to F/U with civilian doc for reconstr.
	have written detailed D/C summary.
	b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25sept03 0900	Discharge Summary
	28 yo male iraqi civilian admitted 20 sept 03 with shrapnel injury to left forearm. Suffered grade II open left ulna fracture with segmental loss of ~4cm ulna, blast contusion to ulnar nerve with subsequent ulnar nv palsy (ulnar nerve was found to be continuous, though), traumatic injury to ulnar artery. Was taken to the OR on 21 sept 03 for I/D. Again went to OR on 23 sept 03 for I/D with placement of antibiotic impregnated beads at that time (tobramycin). was able to close entrance wound on dorsal forearm, but volar wound is still open (about 3cm in diameter). he was on IV kefzol while in-house here. remained afebrile.
	Also suffered soft tissue injury to Right leg (entrance laterally, exit medially) without neurovascular compromise. Was able to close medial wound, but lateral wound would not close - Approx 3cm in diameter
	→ over.

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Sept 03	Discharge Summary, cont.
	Discharge Medication:
	- Keflex 500 mg po QID x 7d.
	- percocet as needed for pain.
	-
	Disposition: Grade II open Ⓛ ulna fx c̄ segmental loss and ulnar nv palsy.
	- Discharged in sugartong splint with antibiotics x 7 days
	- will need splint off and sutures out in 10 days.
	- would consider ulnar reconstruction once skin is closed over and he proves to be free of infection
	- consider bridge plating ulna with fibular graft versus iliac crest bone graft for reconstruction.
	- Ulnar nv function may or may not return.
	will D/C to civilian care to arrange potential reconstruction.
	b(6)-4
	b(2)-2

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

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

Bed 5 Law

b(2)-7

LOG NUMBER | TREATMENT FACILITY [redacted]

NSN 7540-01-075-37

RECORDS MAINTAINED AT [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 20 Sep 03 | TIME: 1958

TRANSPORTATION TO FACILITY

SEX: M

AGE: 28

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA's

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN (Date)
IS THIS AN INJURY?			
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

CHIEF COMPLAINT: Mult. GSW

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2000

INITIALS: [initials]

VITAL SIGNS

TIME	2001	2110			
BP	155/96	145/87			
PULSE	103	68			
RESP	20	16			
TEMP oral	100.0				
WT		O2 100%			

LAB ORDERS (2010)

CBC/DIFF (circled) | ABG | PT/PTT | BHCG/URINE/BLOOD/QUANT
URINE C&S | UA/MSCC/CATH (circled) | CHEM: 12 c lytes
BLOOD C&S X
Type & Screen

X-RAY ORDERS

X CXR PA & LAT/~~PORTABLE~~ | C-SPINE
ACUTE ABDOMEN KUB | LS SPINE
SINUS | HEAD CT
ANKLE R/L
(R) Leg (L) arm (R) Pelvis

☐ PULSE OX

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	bolus 2 L NS		b(6)-2 [redacted]	2010	
	Gentamycin 50mic IV			2016	
	Ancef 1 g			2020	
	Td .5cc IM			2620	

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS/OFF DUTY ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☒ IMPROVED ☐ UNCHANGED
☒ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

Civilian
#[redacted]
[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)
USAPA V1.00

NSN 7540-01-075-3786

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 11.2	139 / 104 / 16 — 107	SUP O2	PH	PO2	RESULTS	GSW open comminuted (L) ulnar fx
	H/H 14.2/43.2	4.4 / 24 / .9	PCO2	SAT	OTHER		
	PLT 328					EKG INTERPRETATION	
PT		CK 2746	U/A	DIP			
APTT		BHCG	ETOH	GLU	MICRO		

PROVIDER HISTORY/PHYSICAL

28 y/o ♂ s/p GSW approx 8° ago to (L) arm/flank/(R) leg. Seen @ Iraqi hospital

ϕ operation ~~Zg. Anf~~

(+) language barrier

O: A&O x1 in mod distress – VS as above

~~HEENT~~: OP/NP clear/pink – PD neck supple, NT ~~Head~~ atraumatic eyes clear/dry

Chest: CTA(B) = CV: RRR ϕ(L) GT

(+) GSW (L) mid axillary line T-11 x2 (L) axillary sm wnd

A/P soft, NT on deep palp

Ext: 5/5 lower ext strength, N/V intact (R) GSW (R) calf, ϕ active bleed

Open wound (L) wnd forearm ē exposed

A/P GSW (L) ulna ē

→ ICW 2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND [redacted] b(6)-2

PROVIDER SIGNATURE AND ST[redacted]

DIAGNOSIS (1) GSW (L) arm/(R) leg/(L) flank

CODES

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

b(6)-4

EMERGENCY CARE AND TREATMENT ***(Doctor)***
Medical Record

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 2120 To ICW 2 From ______ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☑ STRETCHER

Total ER/RR/PACU time ______ Physician ______ Anesthesia (*Specify*): ______

Procedure/Diagnosis GSW (B) LE, (L) FA, (L) chest B/P 145/87 P 68 R 16 T ______

LOC ______ Neurovascular checks ______

Dressing/cast ______ Tubes ______

Intake (IV, po): ______ Output (EBL, other) ______ Voided ☐ No ☐ Yes Amount: ______

Medication Fentanyl, Ancef

Other (L) (u) 7

Report From LT [redacted] Received By LT McLean

VITAL SIGNS

TIME:	2130	0400	0740													
BP ARTERIAL LINE		/														
BP CUFF	148/72	145/76	132/[illegible]													
TEMPERATURE	99.?	98.4	98.5													
PULSE	86	95	103													
RESPIRATORY RATE	16	20	18													
OXYGEN (L/%)	/	/	/													
PULSE OXIMETER	98	99	96%													
O_2 METHOD	RA		RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	2130							
PAIN INTENSITY (0–10)	0							
MED ADMINISTERED (Y/N)								
RELIEF ACCEPTABLE (Y/N)								

SPECIAL NEEDS

TIME:	2300		
*Skin breakdown prevention	N/A		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

YESTERDAY'S WEIGHT: ______
TODAY'S WEIGHT: ______
WEIGHT CHANGE: ______

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2				TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] 6W-4

DIAGNOSIS: GSW (B) LE, (L) FA, (L) chest
DRG: ______ ADMISSION DATE: ______
LOS: ______ EXPECTED RELEASE: ______
CASE MANAGER: ______
PRIMARY CARE MANAGER: ______
ISOLATION REQUIRED (*Specify*): ______

MEDCOM - 19974

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(6)-2

	TIME: 2300 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ voids s̄ diff	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (L) FA c̄ Kerlix drsing (R) leg c̄ open dime shape wound	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ (B) chest c̄ drsing	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ c/o pain @ 2030 given 4mg MSO4	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 2300 INITIALS: [initials]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA — OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: LR @ 100cc/hr	Comments:	Comments:

(R) leg (L) chest, (L) FA

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: 2300 TIME:	2300					
COLOR	P					
CAPILLARY REFILL	2					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P/D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME:	2300		
SAFETY	ID band visible/legible	●		
	Orient to environment prn	●		
	Side rails (2/4) up	|		
	Bed position low	|		
	Call light within reach	|		
		|		
OTHER	Review & post lab results	|		
	Notify MD abnormal labs	|		
		|		
	Incontinent urine/stool	|		
	Linen change prn	|		
	Turn/reposition q2h	|		
	ROM q2h if immobile	|		
	Antiembolic hose	|		
		|		
		|		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT ____ b(6)-2	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT ____	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT ____

TEACHING

TIME: 2300 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: NPO, orientation to staff, pain management, plan of care, call for assistance	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 91WMC	N

MEDCOM - 19976

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
2300	(L) chest (L) FA (R) leg	drsing CDI drsing c Mod amt of bloody drainage swollen	assessed

SECTION IV - NOTES

2130: Admitted to ICW2 from EMT, NKDA, VSS, No c/o pain or discomfort @ this time. Will monitor. —— [redacted]

2300 - pt care assumed @ 2200, pt awaiting OB. pt resting @ this time. Will cont to monitor —— [redacted] ...wm

b(6)-2
A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 21 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY: 2

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time ____ To ____ From ____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ____ Physician ____ Anesthesia (*Specify*): ____

Procedure/Diagnosis ____ B/P ____ P ____ R ____ T ____

LOC ____ Neurovascular checks ____

Dressing/cast ____ Tubes ____

Intake (IV, po) ____ Output (EBL, other) ____ Voided ☐ No ☐ Yes Amount: ____

Medication ____

Other ____

Report From ____ Received By ____

VITAL SIGNS

TIME:	1355	1600	2000	22 Sep 0400	0800										
BP ARTERIAL LINE															
BP CUFF	146/85	130/70	109/50	114/63	132/82										
TEMPERATURE	97.5	99.1	99.5	99.2	98.8										
PULSE	92	100	101	98	97										
RESPIRATORY RATE	16	16	12	16	16										
OXYGEN (L/%)	—		—	—	—										
PULSE OXIMETER	98%	97%	96	98	95%										
O2 METHOD	RA	RA	RA	RA	RA										

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0730	1430	1600	2000	2230			
PAIN INTENSITY (0–10)	6	4	0	0	8			
MED ADMINISTERED (Y/N)	Y	Y		NA	Y			
RELIEF ACCEPTABLE (Y/N)	Y	Y			Y			

OTHER

TIME:								
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1430	2230
*Skin breakdown prevention	NA	NA
*Falls prevention protocol	↓	↓
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: ____

TODAY'S WEIGHT: ____

WEIGHT CHANGE: ____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2				TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: GSW RLE, (L) FA, (L) chest SIP IED

DRG: ____ ADMISSION DATE: 20 Sept 03

LOS: ____ EXPECTED RELEASE: ____

CASE MANAGER: ____

PRIMARY CARE MANAGER: ____

ISOLATION REQUIRED (*Specify*): ____

MEDCOM - 19978

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: 0730 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑ speaks a little English
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐ Bowel sounds hypoactive.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ moves slow	☐ Pain upon movement of ⓁUE.	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg to Ⓛ arm Ⓛ backside & Ⓡ Leg.	☐ Shrapnel wounds to Ⓛ arm, Ⓛ chest, & Ⓡ leg. Dsgs, CD+I	☐ Ⓛ arm, Ⓛ side & chest & Ⓡ leg c̄ dressings
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Gave MSO4 for pain	☐ c/o moderate pain in Ⓛ arm. MSO4 4mg IV given.	☐ c/o pain @ 2230 given ii percocet
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

b(6)-2

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0730 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
IV Site #1: LOCATION Ⓡ forearm CONDITION OK	IV Site #1: LOCATION ⓇFA CONDITION OK	IV Site #1: LOCATION ⓇFA CONDITION OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: LR @ 100cc	Comments: LR @ 100cc/hr.	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME:	0730	1930	2230
SAFETY	ID band visible/legible	[redacted]	[redacted]	[redacted]
	Orient to environment pm	[redacted]	[redacted]	[redacted]
	Side rails (2/4) up		[redacted]	↓
	Bed position low		↓	↓
	Call light within reach		↓	↓
	Review & post lab results		[redacted]	↓
	Notify MD abnormal labs		[redacted]	↓
OTHER	Incontinent urine/stool		[redacted]	↓
	Linen change pm	[redacted]	[redacted]	↓
	Turn/reposition q2h		[redacted]	↓
	ROM q2h if immobile		↓	↓
	Antiembolic hose		↓	↓

DIET

BREAKFAST	LUNCH	DINNER
TYPE: NPO	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 0%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1930 INITIALS: [redacted] b(6)-2	TIME: 2230 INITIALS: [redacted]
CONTENT: Pain control	CONTENT: Plan of care. Pain meds.	CONTENT: pain management plan of care
☐ Patient/Family Verbalizes Understanding	☐ (Patient)/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION [redacted] b(6)-4

INITIALS	SIGNATURE b(6)-2	SHIFT
[redacted]	[redacted]	

MEDCOM 19980 [partially redacted]

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
1430	(L) UE, (L) chest, (R) leg	sm amt. serousanguinous drainage noted to (L) chest. others CD&I	Reenforce PRN
2230	(L) UE (L) chest (R) leg	ā splint & ace wrap - CDI drsing CDI splint & ace wrap CDI	assessed

SECTION IV - NOTES

1200 - Pt received from PACU via gurney. VSS, Lungs CTA, HR reg, BS ⊕. Dsg to (L) arm + (R) lower extremity CDI ⊕ sensation, able to move digits, warm to touch. Dsg intact to (L) side. IV LR @ 100 to (R) forearm. Gave 4mg MSO4 for pain. Pt sleeping quietly now. Will cont. to monitor. [redacted]

1430: Asleep, easily aroused. c/o pain in (L) arm, MSO4 4mg IVP given. Splint to (L) arm. Good cap refill, fingers warm to touch. Will continue to monitor. [redacted]

b(6) - 7

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 22 Sept 03 | PATIENT ACUITY LEVEL : III | POST-OP DAY: 2 | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time ______ To ______ From ______ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ______ Physician ______ Anesthesia *(Specify)*: ______

Procedure/Diagnosis ______ B/P ______ P ______ R ______ T ______

LOC ______ Neurovascular checks ______

Dressing/cast ______ Tubes ______

Intake (IV, po) ______ Output (EBL, other) ______ Voided ☐ No ☐ Yes Amount: ______

Medication ______

Other ______

Report From ______ Received By ______

VITAL SIGNS

TIME:	1300	1600	2000	2400	0400
BP ARTERIAL LINE					
BP CUFF	142/72	138/66	123/78	130/71	102/74
TEMPERATURE	100.4	99.6	100.9	99.3	100.7
PULSE	103	85	105	88	106
RESPIRATORY RATE	22	20	20	16	16
OXYGEN (L/%)	/		/		
PULSE OXIMETER	98%	98%	96%	98	96
O_2 METHOD	RA	RA	RA	RA	

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0730	1500	1600	2000	2230
PAIN INTENSITY (0–10)	0	0	3	0	0
MED ADMINISTERED (Y/N)	N	N		NA	N
RELIEF ACCEPTABLE (Y/N)		NA			NA

OTHER

TIME:	
FINGER STICK GLUCOSE	N/A
INSULIN (Y/N)	

SPECIAL NEEDS

TIME:	1500	2230
*Skin breakdown prevention	NA	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: ______

TODAY'S WEIGHT: ______

WEIGHT CHANGE: ______

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: GSW (R) LE, (L) FA, (L) chest, S/P I&D

DRG: ______ ADMISSION DATE: 20 Sept 03

LOS: ______ EXPECTED RELEASE: ______

CASE MANAGER: ______

PRIMARY CARE MANAGER: ______

ISOLATION REQUIRED *(Specify)*: ______

MEDCOM - 19982

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check √ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0730 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ speaks a little English	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ weak gait Splint & ACE wrap to Ⓛ arm + Ⓡ ↓ leg	☐ Generalized weakness Dsg to Ⓡ leg + Ⓛ arm, ↓ ROM to those extremities.	☐ Dsg to Ⓛ arm CDI, able to move fingers strong pulses, brisk cap refill Dsg to Ⓡ leg CDI pt able to move toes, strong pulses, brisk cap refill
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ small wounds to Ⓡ arm & abd.	☐ wounds to Ⓛ arm & Ⓡ leg - Dsgs CD+I. small wounds to Ⓛ chest, dsgs CD+I.	☐ Small wounds to Ⓛ side of chest c dsgs CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑ c/o sm amt pain states medication is not needed @ this time.	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0730 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency √ q __ hr:		q 8 hr	q 8 hr
IV site care provided:			
IV tubing changed:			
IV Site #1: LOCATION / CONDITION	Ⓡ arm / OK	Ⓡ FA / ok	Ⓡ FA / OK
IV Site #2:			
Comments:	HL IV Antibiotics		LR @ 100° p MN

MEDCOM - 19983

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) LE (L) LE TIME:	1500	2230				
COLOR	P	P/P				
CAPILLARY REFILL	1	1/1				
TEMPERATURE	W	W/W				
EDEMA	0	0/0				
SENSATION	S	S/S				
MOTION	M	M/M				
PASSIVE FLEXION	0	unable to assess				
PERIPHERAL PULSE	2	2P/1DP				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME:	0730	1500	2230
SAFETY	ID band visible/legible	[redacted]	[redacted]	
	Orient to environment prn	[redacted]	[redacted]	
	Side rails (2/4) up			
	Bed position low			
	Call light within reach			
OTHER	Review & post lab results		[redacted]	
	Notify MD abnormal labs		[redacted]	
	Incontinent urine/stool		[redacted]	
	Linen change prn	[redacted]	[redacted]	
	Turn/reposition q2h			
	ROM q2h if immobile			
	Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 100%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP (CHAIR) ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Plan of Care. Pain meds.	CONTENT: Call for assist NPO p̄ MN Fluids p̄ MN	CONTENT: b(6)-2 A11
☑ (Patient)/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 0I AN	[redacted]
[redacted]	[redacted] 2CT AN	[redacted]
[redacted]	[redacted] LT/AN	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
1500	Ⓛarm, Ⓛchest, Ⓡleg	Dsgs. CD&I	NA
2230	Ⓛarm Ⓛchest Ⓡleg	DSgs CDI	assessed

SECTION IV - NOTES

1500: A&Ox3. c/o mild pain - states does not need pain medication @ this time. Bodyguard @ bedside. ——— [redacted]

22Sep03 2230 Pt sleeping, easily arousable c verbal stimuli. Ø c/o pain. Pt concerned he might have a temp, temp checked was 99! To go to OR tomorrow. Will continue to monitor ——— [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 23 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 3 | HOSPITAL DAY: 4

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time ______ To ______ From ______ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ______ Physician ______ Anesthesia (Specify): ______

Procedure/Diagnosis ______ B/P ______ P ______ R ______ T ______

LOC ______ Neurovascular checks ______

Dressing/cast ______ Tubes ______

Intake (IV, po) ______ Output (EBL, other) ______ Voided ☐ No ☐ Yes Amount: ______

Medication ______

Other ______

Report From ______ Received By ______

VITAL SIGNS

TIME:	2400	0800	1105	1600	2000	2400	0400								
BP ARTERIAL LINE	/	\	/												
BP CUFF	137/71	143/86	153/90	110/70	129/62	127/62	134/71								
TEMPERATURE	99.3	98.3	97.5	97.4	98.2	98.7	98.0								
PULSE	88	93	97	88	93	90	90								
RESPIRATORY RATE	16	20	20	20	18	20	16								
OXYGEN (L/%)	/	\			/										
PULSE OXIMETER	98	96	95%	99%	97%	96	97								
O2 METHOD		RA	RA	RA	RA										

Oxygen Method Key: NC = Nasal cannula, MT = Mist tent, NR = Non rebreather, PR = Partial rebreather, FM = Face mask, A = Aerosol, VM = Venturi mask, TC = Trach collar

PAIN

TIME:	1110	1130	1200	1600	2000			
PAIN INTENSITY (0–10)								
MED ADMINISTERED (Y/N)	Y	Y	Y	N	N			
RELIEF ACCEPTABLE (Y/N)	Y	Y	Y	Y				

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0830	1600	2230
*Skin breakdown prevention	[illegible]	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	[illegible]		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT:

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ[illegible] b(6)-4

DIAGNOSIS: GSW (R) LE, (L) FA, (L) chest s/p [illegible]

DRG: ______ ADMISSION DATE: 20 Sep 03

LOS: ______ EXPECTED RELEASE: ______

CASE MANAGER: ______

PRIMARY CARE MANAGER: ______

ISOLATION REQUIRED (Specify): ______

MEDCOM - 19986

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓ Cough, Deep Breathing Encouraged	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (R) LEFT SPLINTED (L) HAND/ARM SPLINTED	☐ (R) LE splinted c ACE, CDI (L) UE splinted c ACE, CDI	☐ (R) LE c splint et ACE wrap CDI (L) UE c splint et ACE wrap CDI
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ PELLETS IN (R) ARM & (L) SIDE OF CHEST	☐ Abrasions to (L) arm & (L) chest, Ø drng	☐ abrasions (L) chest et L arm
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓	✓	✓
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓ Brother in room c pt.	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME:	0800 INITIALS: [redacted]	1600 INITIALS: [redacted]	2230 INITIALS: [redacted]
IV patency ✓ q __ hr:	RA	8	8
IV site care provided:			
IV tubing changed:			
IV Site #1: LOCATION / CONDITION	IV. for OR	(R) FA / OK	(R) FA / OK
IV Site #2:			
Comments:	PT DUE FOR OR	LR @ 100cc/hr	LR @ 100cc/hr

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

MEDCOM - 19987

CIU [redacted] 7/11/04

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) ARM, (R) LEG TIME:	0830	1500	2230			
COLOR	N	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	2	1	1			
SENSATION	S	S	S			
MOTION	P	P	P			
PASSIVE FLEXION	0	—	—			
PERIPHERAL PULSE	2	unable to assess				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0830	1500	2230
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: NPO	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT b(6)-7	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 2230 INITIALS:	TIME: INITIALS:
CONTENT: 1. TO REPORT TIGHTNESS IN CAST 2. TO ASK FOR PAIN MED WHEN RETURN FROM OR.	CONTENT: pain management plan of care call for assistance	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted]
b(6)-4

INITIALS b(6)-2	SIGNATURE	SHIFT
		D-2
	[redacted] ...giwme	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		1. (L) ARM	FINGER SWOLLEN +1	SPLINT. CAST
		2 (R) LEG	SWOLLEN +1	SPLINT CAST

SECTION IV - NOTES

0830 Pt alert and oriented x3. Pt able to communicate with use of minimal verbal contact and gestures. Pt able to sit up in bed and perform ADLs with assistance. IV infusing as order. Due for OR today. V/S stable. [illegible] 1LWMC.

1100 Pt returned from [illegible] - V/S stable, alert and oriented x3. Pt medicated for pain, Dr RL c 100 [illegible]. (L) arm and (R) leg in [illegible] bandage - with [illegible] splint for support. Pt able to tolerate PO fluids. No s/s of distress [illegible]. Pt has cap refill in toe < 2 sec. Skin warm [illegible] to touch. Pt able to dorsi and plantar flex extremities.

1200 Pt medicated for pain, [illegible]

1300 Pt preferred to sleep. V/S stable. — [illegible] b(6)-2 A11

X-ray of (L) arm done, film at Pt bedside. [illegible]

1500 → Assumed pt care @ 1400. [illegible] 1LWMC

2300 - Pt c/o "(L) hand 3 digit & 4 digit feeling numb, c pain radiating ↑ arm. Pt given percocet @ 2315 by LT [illegible]. Informed pt through interpreter that MD will be notified in am. Will cont to monitor [illegible] 1LWMC

b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 24 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 4 | HOSPITAL DAY: 5

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time ______ To ______ From ______ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ______ Physician ______ Anesthesia (*Specify*): ______

Procedure/Diagnosis ______ B/P ______ P ______ R ______ T ______

LOC ______ Neurovascular checks ______

Dressing/cast ______ Tubes ______

Intake (IV, po) ______ Output (EBL, other) ______ Voided ☐ No ☐ Yes Amount: ______

Medication ______

Other ______

Report From ______ Received By ______

VITAL SIGNS

TIME:	0800	1600	2000	25 Sep 0400											
BP ARTERIAL LINE	—		—												
BP CUFF	149/79	140/80	104/69	133/78											
TEMPERATURE	98.2	98.4	100.6	98.3											
PULSE	101	88	101	84											
RESPIRATORY RATE	18	16	16	16											
OXYGEN (L/%)	—		—												
PULSE OXIMETER	97	97%	97%	97											
O2 METHOD	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula, MT = Mist tent, NR = Non rebreather, PR = Partial rebreather, FM = Face mask, A = Aerosol, VM = Venturi mask, TC = Trach collar

PAIN

TIME:	0800	1245	1600					
PAIN INTENSITY (0–10)	5	8	5	5				
MED ADMINISTERED (Y/N)	Y	Y	N	N/A				
RELIEF ACCEPTABLE (Y/N)	Y	Y						

OTHER

TIME:	1600	2000						
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)			N	A				

SPECIAL NEEDS

TIME:	0800	1600	2400
*Skin breakdown prevention	Q	N/A	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: ______

TODAY'S WEIGHT: NA

WEIGHT CHANGE: ______

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool		TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted]

6W-4

DIAGNOSIS: GSW (R) L.E. (L) FA, (L) chest

DRG: ______ ADMISSION DATE: 20 Sept 03

LOS: ______ EXPECTED RELEASE: ______

CASE MANAGER: ______

PRIMARY CARE MANAGER: ______

ISOLATION REQUIRED (*Specify*): ______

MEDCOM - 19990

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

D (6) - 2

	TIME: 0800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ MOVEMENT WITH (L) FINGERS PAINFUL	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (L) HAND; (R) LEG IN SOFT CAST ROM c PAIN	☐ ØROM 5th, 4th digits (L) hand, (L) wrist. RLE in cast, ↓ ROM (R) foot.	☐ (L) arm in splint & ace wrap, 4 & 5th digits numb. RLE c splint & ace wrap
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ two wounds to (L) chestwall.	☑
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ PAIN LEFT RSVSC 7 PO MSOS GIVEN	☑	☑ C/O pain @ 0020 4mg MSO4 by LT Walker RN
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	Column 1	Column 2	Column 3
TIME	800	1600	0020
INITIALS	[redacted]	[redacted]	[redacted]
IV patency ✓ q __ hr	q __ hr: HL	q 5 hr: PKN	q 8 hr: pen
IV site care provided		assessed	flushed
IV tubing changed			
IV Site #1 LOCATION	HL (R) ARM	HL (R) FA	(R) FA
IV Site #1 CONDITION	Good	OK	OK
IV Site #2 LOCATION			
IV Site #2 CONDITION			
Comments		HL	HL

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

MEDCOM - 19991

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) Hand (R) Leg TIME:	0800	1600	2400				
COLOR	P	P	P	P			
CAPILLARY REFILL	2	1	1	1			
TEMPERATURE	W	W	W	W			
EDEMA	2	2	0	0			
SENSATION	S	S	S	S			
MOTION	P	0	0	U0			
PASSIVE FLEXION	P/D	0	0	0			
PERIPHERAL PULSE	2	0	0	0			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:			
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular Diet	TYPE:
PERCENT CONSUMED: 80%	PERCENT CONSUMED: 100%	PERCENT CONSUMED:
HOW TOLERATED: Well	HOW TOLERATED: Well	HOW TOLERATED:
☐ SELF ☒ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS:	TIME: INITIALS:
CONTENT: 1. To report s/s of impaired circulation. 2. To request pain meds.	CONTENT: 1) Pain medication only 4-6°. Next dose @ 1645.	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
	/CT/AN	
	[illegible]	
	6/6/-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	(L) HAND	FINGERS SWOLLEN	SOFT CAST c SPLINT
	(R) Leg	TOES SWOLLEN	SOFT CAST c SPLINT

SECTION IV - NOTES

900 Pt complained of pain at beginning of shift. Pt given PO pain meds. Pt did ADLs with assistance. Pt ate breakfast, tolerated well. Pt (L) hand and (R) leg in soft cast with splint. Both elevated. Pt [illegible] rest after eating. Pt asleep. [illegible]

1400 Pt complained of pain at lunch time especially in (L) arm medicated with Percocet II, pt able to manage pain as evidenced by nodding [illegible] afternoon.

~~1600: Dressing to distal chest wall on (L)~~ [redacted]

1600: Dressing to (L) distal aspect chest wall removed and wound left OTA to heal. Dressing to medial aspect (L) arm CDI.

[redacted] TAN

b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 25 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 5 | HOSPITAL DAY: 6

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time ____ To ____ From ____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ____ Physician ____ Anesthesia (*Specify*): ____

Procedure/Diagnosis ____ B/P ____ P ____ R ____ T ____

LOC ____ Neurovascular checks ____

Dressing/cast ____ Tubes ____

Intake (IV, po) ____ Output (EBL, other) ____ Voided ☐ No ☐ Yes Amount: ____

Medication ____

Other ____

Report From ____ Received By ____

VITAL SIGNS

TIME:	0400	1200
BP ARTERIAL LINE	—	—
BP CUFF	133/78	134/77
TEMPERATURE	98.3	98.2
PULSE	84	93
RESPIRATORY RATE	16	18
OXYGEN (L/%)	—	—
PULSE OXIMETER	97	99
O_2 METHOD	RA	RA

Oxygen Method Key: NC = Nasal cannula, MT = Mist tent, NR = Non rebreather, PR = Partial rebreather, FM = Face mask, A = Aerosol, VM = Venturi mask, TC = Trach collar

PAIN

TIME:	0800	1200
PAIN INTENSITY (0-10)	0	0
MED ADMINISTERED (Y/N)	NO	
RELIEF ACCEPTABLE (Y/N)	NA	

OTHER

TIME:	0800
FINGER STICK GLUCOSE	
INSULIN (Y/N)	

SPECIAL NEEDS

TIME:	0800
*Skin breakdown prevention	N/A
*Falls prevention protocol	↓
*Restraint protocol	↓
*Seizure precautions	↓
*Isolation precautions	↓

YESTERDAY'S WEIGHT: N/A

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2	TOTAL IN	Urine	Stool	TOTAL OUT
	N/A						

PATIENT IDENTIFICATION

C[redacted]

b(6)-4

DIAGNOSIS: GSW RLE, BFA, chest

DRG: ____ ADMISSION DATE: 20 Sep 03

LOS: ____ EXPECTED RELEASE: ____

CASE MANAGER: ____

PRIMARY CARE MANAGER: ____

ISOLATION REQUIRED (*Specify*): ____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ b(6)-2	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ weakness to (L)UE & (R)LE. - soft cast to (L)UE & (R)LE - Ø sensation to 4 & 5th fingers on (L)UE.	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ Ø/10	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ brother @ bedside	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: ______ INITIALS: ______	TIME: ______ INITIALS: ______
IV patency ✓ q 8 hr: Good	IV patency ✓ q __ hr: ______	IV patency ✓ q __ hr: ______
IV site care provided: N/A	IV site care provided: ______	IV site care provided: ______
IV tubing changed: N/A	IV tubing changed: ______	IV tubing changed: ______
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R)FA ok	IV Site #1: ______ ______	IV Site #1: ______ ______
IV Site #2: ______ ______	IV Site #2: ______ ______	IV Site #2: ______ ______
Comments: HL flushed well c̄ 3cc NS s̄ S/S of infection.	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) [illegible] (R)	TIME: 0800					
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION 4th [illegible]	N	S				
MOTION	P	P				
PASSIVE FLEXION	[illegible]	[illegible]				
PERIPHERAL PULSE	[illegible]	[illegible]				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME:	0800		
SAFETY	ID band visible/legible	[redacted]		
	Orient to environment prn			
	Side rails (2/4) up			
	Bed position low			
	Call light within reach			
OTHER	Review & post lab results			
	Notify MD abnormal labs			
	Incontinent urine/stool			
	Linen change prn			
	Turn/reposition q2h			
	ROM q2h if immobile			
	Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLS

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) (AMBULATE) BSC (BRP) CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT ____	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT ____	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT ____

TEACHING

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: b(6)-2 -plan of care -medication	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

CIV [redacted]
b(6)-4

INITIALS	SIGNATURE b(6)-7	SHIFT
[redacted]	[redacted] 2LT/AN	06-14

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1327 Pt c̄ transfer order & summary in place. Pt to transfer to Iraqi hospital. ——— [redacted] /RN

6(6)-7

anc v

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.

1. AGE: 28
HEIGHT:
WEIGHT: 82 Kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

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

4. PROPOSED SURGICAL PROCEDURE: (L) FA I+D (R) leg I+D

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Ø Implants: Ø Medications: Ø
Jewelry removed: yes/no Family waiting: yes/(no)
NPO p 0700 Ø TOB-ETOH Ø jewelry

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

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	✓ 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. ✓ 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. ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ____ Disminished visual perception due to being injury; sedation; F.2. ____ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. ____	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ________ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.
[redacted] AN, LTC 21 Sep. 03 DATE

11. POSTOPERATIVE EVALUATION:
Dsg. clean & dry
ESU site clear & intact.

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

12. PREOPERTIVE EVALUATION PREPARED BY [redacted] CPTAN
DATE: 20 Sep 03 TIME: 2230

13. PREOPERTIVE EVALUATION PREPARED BY (Signature) [redacted] LTC AN
DATE: 21 Sep 03 TIME: 1105

REVERSE OF DA FORM 5179, JUN 91 V1.01

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: Gurney BY: Anesth.	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: LTC [redacted] b(6)-2
3. DATE: 21 Sep. 03 — TIME PATIENT ARRIVED IN SUITE: 0920	4. PATIENT IN ROOM TIME: 0920 — NUMBER: 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Body maintained in correct alignment

8. SKIN PREPARATION

HAIR REMOVAL: ☒ YES ☐ NO DONE BY: ☒ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP COMMENTS: No nicks noted	PREP SOLUTION *(Specify)*: Betadine scrub/sol SITE: Rt leg BY WHOM: LTC [redacted] SITE: Lt. arm BY WHOM: LTC [redacted] COMMENTS: b(6)-2

9. LOCATION OF EXTERNAL DEVICES

[hatched] = prep

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

10. COUNTS (C = Correct I = Incorrect) b(6)-2

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	SSG [redacted]	LTC [redacted]
Needle Sharp	☒ Yes ☐ No	✓	C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)* # [redacted] b(6)-4	12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO ☒ ESU NO: Valleylab Force 40 GROUND PAD: BRAND REM Polyhesive LOT NO: 68936 ☐ ESU NO: GROUND PAD: BRAND LOT NO: ☐ BIPOLAR NO: cut: 30 coag: 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

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
DSD = Lt flank
Rt. leg: long leg splint
Lt. arm { kerlix fluffs / kerlix roll / ACE Bandage } Rt leg

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted]
Anesth: Cpt [redacted] CRNA
b(6)-2

20. OPERATION(S) PERFORMED
I+D Rt ↓ leg + Lt. forearm
(Clean + dress 2 wounds Lt flank)

21. PATIENT TRANSFERRED TO PACU TIME 1050 METHOD Via Gurney
b(6)-2
[redacted] LTC, AN

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent ag[ency is] the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING R[OOM] VIA gurney BY anesthesia

2. PATIENT IDENTIFI[ED] [AN]D AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 23 Sep 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0810 b(6)-2 NUMBER 2-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt not english speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted], 66E	RELIEF CIRCULATOR	LTC [redacted] 0930-0945

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP
COMMENTS: —

PREP SOLUTION *(Specify)* Beta/Beta
SITE: BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES

b(6)-2

LEGEND X Ground Pad — Safe[ty strap, redacted] === Tourniquet

10. COUNTS — C = Correct I = Incorrect

	Yes	No	Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X]	[ ]	C	/	C	PFC [redacted]	CPT [redacted]
Needle Sharp	[X]	[ ]	C	/	C		
Instrument	[ ]	[X]	/	/	/		
Other	[ ]	[X]	/	/	/	/	/

b(6)-2

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

CIV [redacted] b(6)-4

[redacted] b(2)-2
23 Sep 03

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

[X] ESU NO: Valleylab Cut 45 Coag 45
GROUND PAD: BRAND Valleylab E7507
LOT NO: 700D 2005-04

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS

Surgical Simplex® P
RADIOPAQUE BONE CEMENT
Distributed by:
Stryker®
Howmedica
Osteonics Mahwah, New Jersey
Full Dose
Cat. No.
Control No.

Tobramycin lot # 2732 ...
17 SEP 03 Cement lot # 922LF Dec 2004

...S NAME: ID NUMB... ...JFACTURER

14. ... /ORDERS

IRRIGATION/MEDICATIONS G... (BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- Kerlix
- ace wrap
- Splint

19. ADDITIONAL INFORMATION

Surgeon:
Dr. [redacted]
6|W-2 All

Anesthesia
MA[redacted] CRNA

20. OPERATION(S) PERFORMED

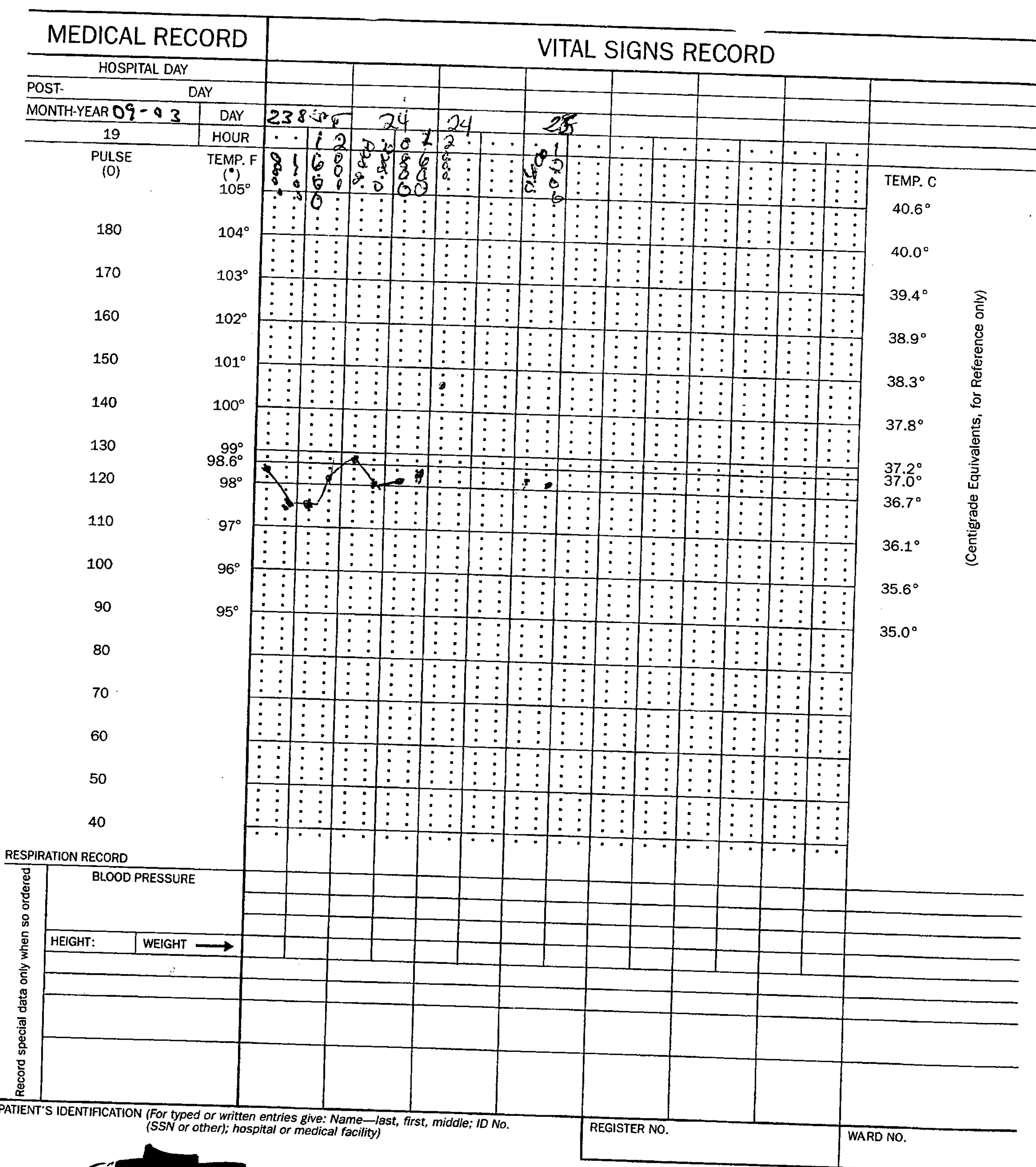
I&D (L) ulna Fx / (R) leg GSW
c̄ DPC

21. PATIENT TRANSFERRED TO: KU3 | TIME: 10:08 | METHOD: gurney.

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN [redacted] LTC, AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 20003



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 09-03 | DAY 23 24 24 25

19 | HOUR

PULSE (0) | TEMP. F (•)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: | WEIGHT →

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

REGISTER NO.

WARD NO.

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

b(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR [illegible] 19 2003 — DAY: 21, 22, 23

HOUR

PULSE (0)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO.

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(6)-2

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

Ward/Section: ER

REQUESTING PHYSICIAN: [redacted]

DATE: 20 Sep 03 TIME: 2005

SSN/PSEUDO SSN:

LAST, FIRST, MI. # [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 (a… 41-51 mmHg (ven…
PO2		80-105 mmHg (ar… N/A (ven)
TCO2		23-27 mmol/L (ar… 24-29 mmol/L (ve…
HCO3		22-26 mmol/L (ar… 23-28 mmol/L (ve…
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol…
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

```
======= PICCOLO =======
20/09/03              20:22
REFERENCE RANGE:       MALE
PATIENT #: [redacted] — b(6)-4
METLYTE 8
DISC LOT #:         3141AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
...........................
GLU    107   73-118    MG/DL
BUN     16   7-22      MG/DL
CRE    0.9   0.6-1.2   MG/DL
CK   2746*   39-380    U/L
NA+    139   128-145   MMOL/L
K+     4.4   3.3-4.7   MMOL/L
CL-    104   98-108    MMOL/L
tCO2    24   18-33     MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
20/09/03              20:22
REFERENCE RANGE:       MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #:         3154AA7
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted] b(6)-2
...........................
ALB    4.2   3.3-5.5   G/DL
ALP     72   26-84     U/L
ALT     33   10-47     U/L
AMY     43   14-97     U/L
AST    72*   11-38     U/L
TBIL   1.1   0.2-1.6   MG/DL
GGT     23   5-65      U/L
TP     7.3   6.4-8.1   G/DL

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

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

ID: [illegible]
WB

[illegible]
[illegible]

				Patient Limits	
WBC	11.2	H	x10^3/uL	4.5	10.5
RBC	4.79		x10^6/uL	4.00	6.00
Hgb	14.1		g/dL	11.0	18.0
Hct	43.2		%	35.0	60.0
MCV	90.1		fL	80.0	99.9
MCH	29.5		pg	27.0	31.0
MCHC	32.9	L	g/dL	33.0	37.0
Plt	328.		x10^3/uL	150.	450.
LY%	18.5	*L	%	20.5	51.1
LY#	2.1	*	x10^3/uL	1.2	3.4

b(6)-2

Ward/Section: ER | REQ[redacted] PHYSICIAN:

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

LAST, FIRST, MI. b(6)-4 [redacted] | DATE 20Sep03 | TIME 2005 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁹
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

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

CSF

Cell Count		
Directigen		Negative

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: b(6)-2

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

MEDCOM - 20008

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 28 DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

Physical State 1 2 3 4 5 E

WT: 82 KG/LB HT: ____ IN.

ALLERGIES: UKDA

PROPOSED PROCEDURE: (L) forarm, chest (R) leg

SURGICAL SERVICE: Ortho

NPO SINCE: 0700

Ancef
Fent
ZLEMT

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: ____

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

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

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

11.2 > 14.2 / 43.2 < 328

139 | 104 | 16 < 107
4.4 | 24 | .9

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 Schrapnel (L) forarm
- N Y chest, (R) leg

Familial HX (N) Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION

BACK: ____

OTHER: ____

NPO Since ____

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

Anesthesia plan discussed c pt pt understands english questions answered

INFORMED CONSENT/COUNSELING S[redacted]thesia including death have been explained to and discussed with the patient/legal guardian. [redacted] KNA

The patient/legal guardian seems to unders[redacted] agrees. Questions answered.

Signed: ____ Date: 9/20/02 Time: 2330 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

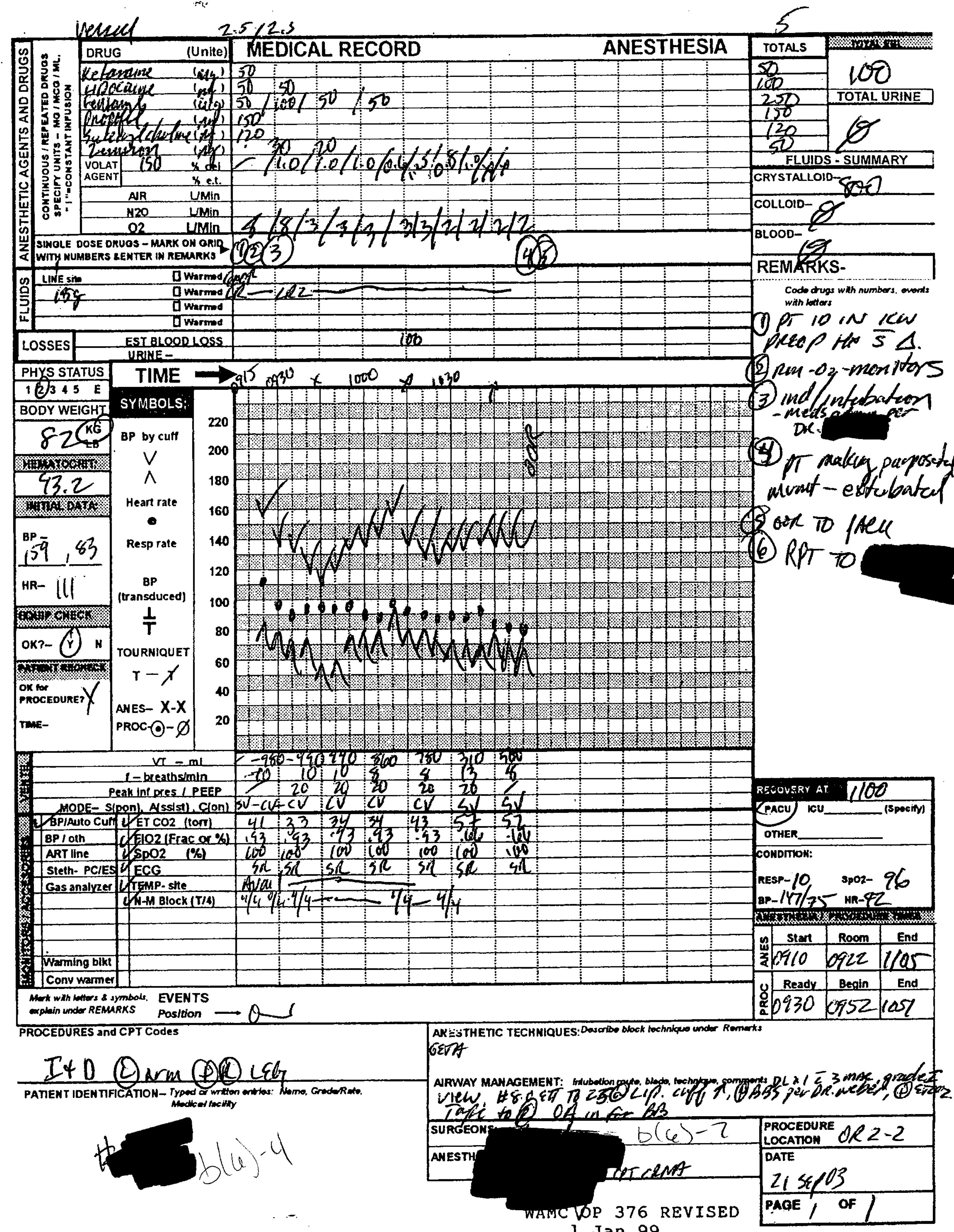
Patient Identification: (Ward) ICW 2

[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)		TOTALS
Ketamine (mg)	50	50
Lidocaine (mg)	50 50	100
Fentanyl (mcg)	50 / 100 / 50 / 50	250
Propofol (mg)	150	150
Succinylcholine (mg)	120	120
Zemuron (mg)	30 20	50
VOLAT AGENT: ISO % del	1.0 / 1.0 / 1.0 / 0.6 / .5 / .8 / 1.0	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	4 / 8 / 3 / 3 / 3 / 3 / 3 / 2 / 2 / 2 / 2	

TOTAL EBL: 100
TOTAL URINE: Ø

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "[ ]"=CONSTANT INFUSION

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1) (2) (3) … (4) (5)

FLUIDS — LINE site: 18g; ☐ Warmed: LR — 1.2 L; ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS: 100; URINE –

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

REMARKS-
Code drugs with numbers, events with letters
(1) PT ID IN ICW PREOP HX S Δ.
(2) RM - O2 - MONITORS
(3) ind / intubation - meds per DR. [redacted]
(4) PT making purposeful mvmt - extubated
(5) OOR TO PACU
(6) RPT TO [redacted]

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 82 KG
HEMATOCRIT: 43.2
INITIAL DATA: BP – 159 / 83; HR – 111
EQUIP CHECK: OK?– (Y) N
PATIENT RECHECK: OK for PROCEDURE? Y
TIME–

TIME → 915, 0930, X, 1000, X, 1030

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENT							
VT – ml	980 – 990	990	800	780	310	500	
f – breaths/min	10	10	10	8	8	13	4
Peak insf pres / PEEP	/	20	20	20	20	20	/
MODE– S(pon), A(ssist), C(on)	SV – CV – CV	CV	CV	CV	SV	SV	

MONITORS / ACCESSORIES								
✓ BP/Auto Cuff	✓ ET CO2 (torr)	41	33	34	34	43	57	57
BP / oth	✓ FIO2 (Frac or %)	.93	.93	.93	.93	.93	.100	.100
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP- site	Axial						
	✓ N-M Block (T/4)	4/4	4/4	4/4		4/4	4/4	
Warming blkt								
Conv warmer								

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

RECOVERY AT 1100 — (PACU) ICU ______ (Specify) OTHER ______
CONDITION: RESP– 10; SpO2– 96; BP– 147/75; HR– 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0910	0922	1105
	Ready	Begin	End
PROC	0930	0952	1051

PROCEDURES and CPT Codes: I+D (L) arm (R)(L) Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 c̄ 3 mac, grade I view, #8.0 ETT to 23 @ lip. cuff ↑, (+) BBS per DR. Weber, (+) EtCO2. Take to (R) OA in for BB

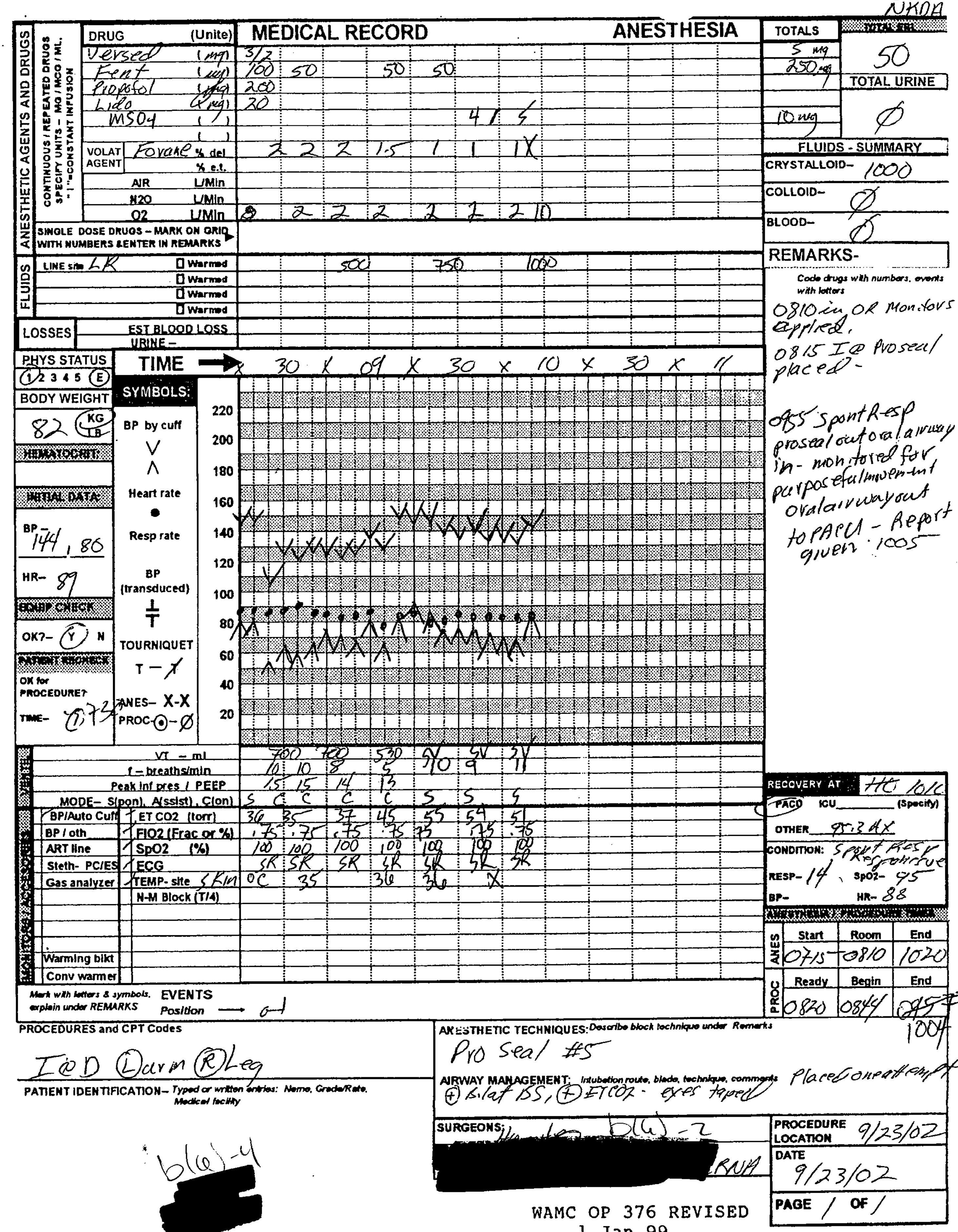
PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b(6)-4

SURGEONS [redacted] b(6)-2
ANESTH [redacted] CPT CRNA

PROCEDURE LOCATION: OR 2-2
DATE: 21 Sep 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD
MEDCOM - 20010



MP 2
ASA I
NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)	Entries	TOTALS
Versed	(mg)	3/2	5 mg
Fent	(mcg)	100, 50, 50, 50	250 mcg
Propofol	(mg)	200	
Lido	(mg)	20	
MS04	( )	4 / 6	10 mg
	( )		
VOLAT AGENT: Forane	% del	2, 2, 2, 1.5, 1, 1, 1X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8, 2, 2, 2, 2, 2, 2, 10	

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

TOTAL EBL: 50
TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID– 1000
COLLOID– Ø
BLOOD– Ø

FLUIDS

LINE site LR ☐ Warmed — 500, 750, 1000
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS / URINE –

REMARKS–

Code drugs with numbers, events with letters

0810 in OR Monitors applied.
0815 I@ Proseal placed –

0955 Spont Resp proseal out oral airway in – monitored for purposeful movement oral airway out to PACU – Report given 1005

PHYS STATUS: ① 2 3 4 5 E
BODY WEIGHT: 82 KG
HEMATOCRIT:
INITIAL DATA: BP – 144/80; HR – 89
EQUIP CHECK: OK? – Ⓨ N
PATIENT RECHECK: OK for PROCEDURE? TIME – 0734

TIME → X 30 X 09 X 30 X 10 X 30 X 11

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

Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VT – ml	700	700	530	SV	SV	SV		
f – breaths/min	10	10	8	5	10	9	11	
Peak inf pres / PEEP	15	15	14	13				
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	S	S	S
ET CO2 (torr)	36	35	37	45	55	54	51	
FIO2 (Frac or %)	.75	.75	.75	.75	.75	.75	.75	
SpO2 (%)	100	100	100	100	100	100	100	
ECG	SR	SR	SR	SR	SR	SR	SR	
TEMP- site Skin °C	35	36	36	X				
N-M Block (T/4)								

MONITORS / ACCESSORIES: ✓ 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 → [supine]

RECOVERY AT: HC 10/C
PACU ICU ______ (Specify)
OTHER 95.3 AX
CONDITION: Spont Resp Responsive
RESP– 14, SpO2– 95
BP– HR– 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0810	1020

	Ready	Begin	End
PROC	0820	0844	0957 / 1004

PROCEDURES and CPT Codes
I&D (L) arm (R) Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Pro Seal #5

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — Placed one attempt
⊕ Bilat BS, ⊕ ETCO2 – eyes taped

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

b(6)-4

SURGEONS: b(6)-2

[redacted] CRNA

PROCEDURE LOCATION 9/23/02
DATE 9/23/02
PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD
MEDCOM - 20011

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. for Sat ↓ ≤ 95% KK V10		
3	(Morphine) / Meperidine 1-2 mg IV ~~now and~~ ____ mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x____.~~		
5	Metoclopramide 10 mg IV prn N/V x 1.		
6	Droperidol ~~____ mg IV prn N/V~~ x 1.		
7	Phenergan ~~____ mg IV prn N/V~~ x 1.		
8	Benadryl 25-50mg ~~IVP q1 hr prn, itching~~ while in PACU.		
9	IVF: ____________ @ ________ cc/hr. per surg order	b(6)-2	
10	Discharge from recovery status when PACU discharge criteria met.		MAJ CKNA

PATIENT IDENTIFICATION

b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: ____________

Height: ______ Weight: ______ Diet: ______

Allergies: ____________

Nursing Unit b(2)-2	Room No.	Bed No.	Page No.
PACU,			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

All b(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

iraqi civilian.

DATE OF ORDER 20Sep03 TIME OF ORDER 2112 HOURS

✓Admit to Floor /
✓Shrapnel (L) forearm / (L) chest / R leg
✓Stable
✓Vitals q2° x 4, then
✓NKDA
✓Bedrest elevate (R) LE (L) UE
✓NPO

NURSING UNIT | ROOM NO. | BED NO.

Noted 20SEP03 2140

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

✓LR @ 100 cc/°
✓Tylenol 650 g po PRN q6° p
✓Kefzol 1g IV q8°
✓MSO4 1-4 mg IV q 20 min p
✓Percocet ī-īī po q4° p
~~Colace ī po~~

NURSING UNIT | ROOM NO. | BED NO.

ICW2 24° Chart ✓ ... 21 Sept 03 0300

TRAN 21Sept03 0400

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER 21Sept03 TIME OF ORDER 1050 HOURS

✓S/P I/D
✓FFNWB (R) LE
✓NWB LUE
✓ADAT
✓Resume other preop orders.
✓LR @ 100 cc/° until tol po / then hep lock
✓Kefzol 1g IV q8°
✓AP/LAT (L) Forearm p

Noted 21Sep03 ...

NURSING UNIT | ROOM NO. | BED NO.

ICW 2

PATIENT IDENTIFICATION

b(6)-4

24° Chart ✓ ... 22 Sept 03 0015

24 ... 0445 22Sept03

22Sept03 1135

NPO p MN for OR today
AP/LAT (L) Forearm please (if not already done postop)
LR @ 100 cc/° p MN

Noted 22Sep03 2300

MEDCOM - 20013

All b(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
b(6)-4	23 Sept 03 1020	s/p I/D (R) Leg, (L) forearm injury Stable resume preop orders ADAT to Regular XRAYS: AP + LAT (L) Forearm today	NSG
NURSING UNIT / ROOM NO. / BED NO.			
b(6)-4		LR @ 100cc/° until tol po, then hepwell [illegible] continue kefzol 1g IV q8° b(6)-2 elevate LUE, (R) LE	1100
NURSING UNIT / ROOM NO. / BED NO.			
b(6)-4	23 Sept 03 1500	Demerol 100mg IV x1 - [illegible] b(6)-2	NSG 23 Sept
NURSING UNIT: 24° Chart / ROOM NO.: b(6)-2 / BED NO.: 91W M6		24 Sept 03 0045 24h b(6)-2	24 Sept 03 0210
	25 Sept 03 1214	May d/c to Iraqi civilian medical care b(6)-2	Noted time
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 20014

b(6)-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. 9 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24	25
20SEP	[redacted]	Vitals q2° x4, then QS	D						
			E						
			N						
20SEP	[redacted]	Bedrest, elevate (R)LE (L)UE	D				/ D'C		
			E						
			N						
20SEP	[redacted]	NPO	D	/			D'C		
			E						
			N						
~~20SEP~~	[redacted]	~~LR @ 100cc/h~~	D	/					
			E						
			N						
21Sep03	[redacted]	FFNWB (R)LE, NWB LUE	D						
			E						
			N						
21Sep03 23Sep03	[redacted]	ADAT to Regular	D	/					
			E						
			N						
21Sep03	[redacted]	Diet Regular	07	/	/				
			11		/				
			17	/			see above		

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: S/P IED
Shrapnel (L) Forearm / (L) chest / R leg

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20SEP		Admit to Floor / Hugate - Stable	20SEP	Done		
21Sept		AP/LAT (L) FA please	21Sept	today	done	
22Sep		NPO p MN for OR	23Sep	2400	0800	
23Sep		Resume pre-op orders	23Sep	1100	done	
23Sep		Xray: AP + lat (L) forearm today	23Sep	1300	0300	

b(6)-2 A11

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order Exp Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED

USAPA V1

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (*NON-MEDICATION*) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* 9 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25											
23Sep	[redacted]	Elevate (L)UE & (R)LE	D	[redacted]													
			E	[redacted]													
			N	[redacted]													

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

S/p I+D (L) forearm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

Civ [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 All

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25
20SEP	[redacted]	LR @ 100cc/h until tolerating po then heplock	D	/	[redacted]		rewritten see below		
			N		[redacted]				
20SEP 23 SEP	[redacted]	Kefzol 1g IV q 8°	08	/	[redacted]				
			16	/	[redacted]				
			24	[redacted]					
22 Sep	[redacted]	LR@100cc/hr p MN 22 Sep 03 – until tolerate PO, then heplock	D	X	/	/	○		
			E	X	/	/			
			N	X	/	[redacted]			
		D/C 23Sep03							
23Sep	[redacted]	LR@ 100cc/hr until tolerating po, then heplock	D	/	/	[redacted]			
			E	/	/	[redacted]			
			N	/	/	[redacted]			

ALLERGIES: ☐ YES ☑ NO NKDA

PRIMARY DIAGNOSIS: s/p IED Shrapnel (L) Forearm/(L) chest/(R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo.______ Yr.______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	-----					

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
20SEP		Tylenol 650mg PO														
-----	-----	PR q6° PRN														
20SEP		MSO4 1-4 mg IV	21 Sept 0130 4mg	21 Sep 0720 4mg	21 SEP 1430 4mg	23 SEP 1110	23 SEP 1130	23 SEP 1200	25 Sept 1 MG							
-----	-----	q 20 min PRN														
20SEP		Percocet i-ii PO	21 Sept 1340 ii PO	22 Sept 03 2230	22 Sept 03 0430	22 Sept 03 1300	22 SEP 2045 ii PO	23 Sept 0450 ii	23 Sept 1300 ii PO	23 Sept 1630 ii PO	23 Sept 2215 ii PO	24 Sept 0045 ii	24 Sept 1245 ii			
-----	-----	q 4° PRN														
23SEP		[illegible] 100 mg IV	23 SEP 40mg 1110	23 SEP 40mg 1120	23 SEP 20mg 12											
-----	-----															
-----	-----	b(6)-2A1														
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 9-21-03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block

Time In: 1100

Allergies: NKDA OR Intake: Crystalloid 800 Colloid

Pre-op V/S: 159/83, 11 OR Output: UOP EBL 100

Procedures: [illegible] Meds/Times: [illegible]

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

Airway: Nasal, Oral, (ETT), Trach, Other

Pre Op Meds

History

Time						
SaO2	97	93	98	97	96	96
FiO2	RA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Methods						
RR		12	24	12	22	14
T	98.3				[illegible]	

(Vital signs grid: scale 240–20; BP and pulse marks plotted.)

Time	Pain (0-10)	LOS

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1100	LR	350	(R) Arm	[redacted]	<100

b(6)-2

X-rays: Labs:

Post-Anesthesia Recovery score

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

b(6)-2

(Continue on reverse)

[redacted] 717A

DEPARTMENT/SERVICE/CLINIC: 11C #13

DATE: 9-21-03

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

#[redacted] Civilian

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

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
1145	urine	Clear/yellow	250cc

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1100: Civilian Iraqi male admitted to PACU c IAD (R) leg + IAD (L) arm
PaO_2 95% RA. IV [redacted] (R) Arm
patent. Pt arousable to verbal and physical
stimulation. Pt resting [redacted]
1145 Report given to [redacted]
Pt transferred to ICW2
VS stable. Pt urinated
250cc. Pt [illegible] [redacted] 55G/Ch

b(6)-2 A1

Discharge Criteria:
Date: 2 Sep 03 Time: 1151 PARS: 10
BP: [illegible]/72 T: 97.8 HR: 82 RR: 14 Sa02: 97
Pain Level at D/C (0-10):
Intake: 1100 cc Output: 250cc
Additional Data:
Transferred To: ICW2
Report Given To: 1LT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 23 Sep 03
Time In: 1012
Allergies: NKDA
Pre-op V/S: 144/80 / 89
Procedures: Wagner / DA Blu

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid Ø
OR Output: UOP Ø EBL 50
Meds/Times: Guerson 250 mc Fent / 10mg Morphine

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | History

150
5
10

Time	1012	1020	1030	1040	1050
SaO2	96	96	96	99	97
FiO2					
Methods	RA	RA	RA	RA	RA
RR	16	21	12	17	12
T	95.3	96.2		97.6	

Graph scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Time	1016
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1055	LR	950cc	(L) forearm	[redacted]	50cc

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

b(6)-2

PREPARED BY (Signature [redacted]) 91wmb

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 23 Sep 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

MEDICATIONS

Allergies:

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

NURSING NOTES

PT ADMITTED TO PACU S/P I&D (L) ULNA (R) LL. DRESSINGS CDI. IV (R) FOREARM PATENT RUNNING LR. AROUSABLE TO STIMULUS. CAP REFILL BRISK TO DRESSING SITES (+) MOVEMENT TO (L) HAND + (R) FOOT —— PFC [redacted]

PT TRANSFERRED TO ICW2 VIA LITTER BY PFC [redacted] — PFC [redacted]

b(6)-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L)A	LROM			B	W	PK
15'							
30'	(R)L	LROM			B	W	PK
45'							
60'							
90'	(L)A	LROM	+		B	W	PK
D/C	(R)L	LROM	+		B	W	PK

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L)A (R)LL	ACE / ACE	Ø / Ø
30'	(L)A (R)LL	ACE / ACE	Ø / Ø
60'			
D/C	(L)A (R)L	ACE / ACE	Ø / Ø

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1055	NSR	Ø	Ø

Discharge Criteria:

Date: 23SEP05 Time: PARS: 10

BP: 144/86 T: 97.6 HR: 88 RR: 21 Sa02: 96

Pain Level at D/C (0-10):

Intake: 50 cc LR Output: Ø

Additional Data: Ø

Transferred To: ICW 2

Report Given To: SGT [redacted]

Transferred Via: W/C (Litter) Gurney Ambulance

Transferred By: PFC [redacted] b(6)-2

Cleared IAW Reco[redacted]

Charge Nurse Signa[redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): A | | | D | l |

2. MTF LOCATION (7–8) *(State or Country Code.)*: I Z

3. REGISTER NUMBER (9–15): [redacted]

NAME *(Last, First, Middle Initial)*: [redacted] b(6)-4 CIV# [redacted]

4. PAY GRADE (16–17): CIV

5. SEX (18): M

6. DATE OF BIRTH *(Y Y Y Y M M D D)* (19–26): [redacted]

7. AGE AT ADMISSION (27–29): 2 8 y

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

RELIGION: UNK

10. LENGTH OF SERVICE (32–34): —

ETS: —

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION *(Active Duty Only)*: —

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 2112

BRANCH / CORPS: b(6)-4

14. FLYING STATUS (47–49): —

15. BENEFICIARY CATEGORY (50–52): K ~~7 6~~ 91

16. ZIP CODE OF RESIDENCE (53–61): —

17. UNIT LOCATION *(State or Country Code)* (62–63): —

18. MOS (64–70): —

19. TRAUMA (71): 1

PREV. ADMISSION YEAR: | [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 8 b(2)-2

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*: UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

21. TYPE OF DISPOSITION (73–74): Ø 5

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION *(Y Y M M D D)* (81–86): Ø 3 Ø 9 2 5

24. CLINIC SVC - ADMITTING (87–90): A E A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION *(Y Y M M D D)* (97–102): Ø 3 Ø 9 2 Ø

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103–104):

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION *(Y Y M M D D)* (111–116):

FOR LOCAL USE

Shrapnel (L) forearm, (L) chest & (R) leg; Grade II open (L) ulna fx

DX - 81392
9552
8910
8750
E9919

PR - 7962
8622

Trauma - 1
Injury - 449

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

DA FORM 3985 MAR 89

MEDCOM - 20024

INPATIENT TREATMENT RECORD COVER SHEET

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

Field	Entry
1. REGISTER NUMBER	[redacted]
2. NAME (Last, First, MI)	Iraqi Ci [redacted] b(6)-4
3. GRADE	EPW
4. SEX	M
5. AGE	
6. RACE	
7. RELIGION	
8. LENGTH OF SVC	N/A
9. ETS	N/A
10. PREVIOUS ADMISSION	
11. FMP	99
12. SSN	[redacted]
13. ORGANIZATION	N/A
14. WARD	ICU3
15. FLYING STATUS	n/A
16. RATING/DSG	n/A
17. DEPT./BEN	K91
18. BRANCH/CORPS	N/A
19. UIC/ZIP	n/A
20. TYPE CASE	WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	direct from ER
22. HOURS OF ADMISSION	0257
23. CLINIC SERVICE	Neurosurgery
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	DOW
26. DATE OF DISPOSITION	02 OCT 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
27b. TELEPHONE NO.	
28. DATE OF THIS ADMISSION	22 Sept 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	
30. DATE OF INITIAL ADMISSION	22 Sept 03
31. SELECTED ADMINISTRATIVE DATA	
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED	
ADMISSION REMARKS	
ADMITTING OFFICER	[redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Head

Dx: 85175
486
E99112
Px: 8841

Trauma
9

Injury
569

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	12	12

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	[redacted]	0	0	12	12

SIGNATURE OF ATTENDING ME[redacted] b(6)-2 [redacted]

SIGNATURE OF [redacted] MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647, MA[redacted]

USAPPC V1.10

b(6)-4

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

HPI Teenage Iraqi male suffered a GSW head after soldiers returned fire when he and another individual initiated. On presentation exam, E0 V0 M5 (GCS 7) prior to intubation. By report, he struggled with full strength x 4 extremities.

PMH Unknown.

Exam HEENT - Midline occipital scalp penetration site with underlying crepitence, no significant bleeding.
Neck - No injury. Clear by mechanism.

PHYSICAL EXAMINATION

Chest - Clear. Benign.
Abdomen - Flat. Benign.
Pelvis - Stable. Benign.
Perineum - Uninjured.
TLS Spines - Uninjured. Clear by mechanism.
Extremities - Uninjured.

Neuro (Intubated):
Pupils 2/NR.
GCS 3T.

CT Head - Single high density fragment consistent with small

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

caliber bullet or shrapnel. Cisterns patent. No ICH.
Blood / Fragment in (R) lateral ventricle.

Impression: GSW Head, severe head injury by exam.

Plan: To ICU for ICP monitor.

b(6)-2

SIGNATURE OF PHYSICIAN	DATE 22 SEP 03	IDENTIFICATION NO.	ORGANIZATION

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

WARD NO.

EPW

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

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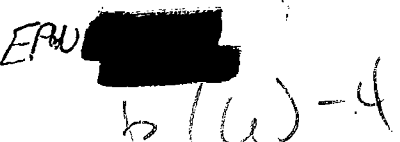
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22SEP03	Neurosurgery Progress / Procedures.
0255	(1) (R) Frontal Codman ICP monitor placed. ICP was
	45-60 mmHg. Removed.
	(2) (R) Frontal Ventriculostomy placed 1st pass. CSF
	serosanguinous. OP > 20 mmHg. Left open to
	drain @ 5 mmHg. CP 25 mmHg.
	(3) Scalp (occiput) closed c̄ stap[redacted]
	[redacted] b(6)-2

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

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

REGISTER NO.	WARD NO.



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

All b(6)-2 unless otherwise noted

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22 Sep 03	0600 Assumed care, Report given.
	See ICU 3 flowsheet for initial
	assessment. Pt 30 Hobb, ? Rowe
	Roll for support.
	0720 Dr [redacted] @ bedside. ICP reading
	recorded. Update given on Pt temp
	Drake not placed, verified by 2 RN's
	ABG taken from A-line
	0750 ABG results rcvd. PCO2 29.6.
	V rate 18
	0815 Tylenol PR given. Temp 102.
	0830 75g mannitol IV given over
	3 min. Dr [redacted] @ bedside. Tylenol
	PR given
	0900 ABG results back. Keep rate @
	18, will repeat in 1hr
	0950 ICP 34. Dr [redacted] @ bedside
	orders received
	1100 ICP 34-35. new PIV started @ R FA
	18g SL patent
	1120 26 ICP

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME — LAST | FIRST | 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.

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PROGRESS NOTES
Medical Record

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b(6)-4

All b(6)-2, unless noted otherwise

b(6)-4 EPW

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Sep03	1230 Dr [redacted] @ bedside, placed on cerebral oximeter, initial reading (L) 56, (R) 73. Floppy disk placed in to record q 30 sec. [redacted]
	1300 ICP 36, cerebral oximeter (L) 61, (R) 74.
	1400 C.O. (L) 57, (R) 67, ICP 37. [redacted]
	1530 Dr [redacted] @ bedside, update given. orders received, cool towel placed on body and temp to 96. [redacted]
	1540 Dr [redacted] paged. C.O. ↓ 44 (L), (R) 67 ICP 45. [redacted]
	1545 mannitol 12.5g IVP given c̄ mild. Dr [redacted] @ bedside, update given [redacted]
	1610 Dr [redacted] back to bedside, update given about SBP > 170's. ∅ concerns at this time. [redacted]
	1640 labs drawn per A-line sent, Tylenol PR given temp 100.5 [redacted]
	1730 labs given to Dr [redacted] received orders [redacted]
	1740 Dr [redacted] @ bedside, for central line placement. labs reviewed repeat Chem 8 for 2100 level [redacted]
	1810 Chem 8 drawn per A-line. CVL area cleansed applied a paste. started 3% sodium chloride @ 10cc/hr. report given oncoming nurse [redacted]

STANDARD FORM [redacted]

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EPW [redacted]

b(6)-4

b(6)-2 A11

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23 Sep 03 0100	Pt's ICP noted @ 50 despite repositioning; rezeroing. serum sodium 128 (0000hrs labs). Dr [redacted] notified. 3% NS increased to 30cc/hr as ordered, mannitol given as scheduled. measures to ↓ ICP reinforced. Will continue to monitor — [redacted]
23 Sep 0200	Pt's ICP reading 25mmHg. ABG drawn @ 0145 showed CO_2 @ 36.3. RR ↑ 20 by RT. Tylenol 650mg P given for ax temp 100.1. Wet towel placed over body to ~~keep~~ control temp. HOB @ 30°; head/neck maintained in neutral position. Will continue to monitor — [redacted] PT/Av
23 Sep 03 0635	Neurosurgery ND 2
	(S/O) Tm 100.1, VSS. ICP 35-50, received ↑ NaCl 3%. Paralyzed, intubated, Gaze exotropic. Pupils 2mm. I/O 2781/3426, Ventric 11-20/hr.
	14.1) 11.4 / 36.3 (236 136 / 3.5 / 103 / 21 / 5 / 0.4 (106
	CT yesterday - No major edema despite ↑ ICP.
	(A/P) Findings c/w Sinus thrombosis. Will continue aggressive ICP management. Heparin when more stable. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted]

b(6)-4

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PROGRESS NOTES
Medical Record

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b(6)-2 all unless noted otherwise

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted]			

DATE	NOTES
9/23/0700	Assumed pt care from Cpt [redacted] Pt in no apparent distress, Versed infusing @ 6mg/hr, fentanyl @ [illegible]mcg/hr, vecuronium 5mg/hr, 3/1 NS @ 300cc/hr, NS @ 50cc/hr, ETT, NG clamped, ventric drain, CSF draining, vent @ SIMV VE 600, peep 5, RR 21 FiO2 35/ no issues noted [redacted]
9/23/0900	per Dr. [redacted] ETT pulled out 1cm to 23cm @ teeth. CXR [illegible] ordered [redacted] will cont to monitor [redacted]
9/23/1400	Per Dr. [redacted] ETT pulled out to 22cm @ lip. per Dr [redacted] no CXR req'd, SpO2 96/ [redacted]
9/23/1800	Report for change of shift given to Cpt [redacted] Pt in no apparent distress all VSS/afebrile. Nursing note [redacted]
9/23/1810	ABG sent 40 mins post ↑ peep to 8 per Dr. [redacted] [redacted]
9/24/03 1650	Nursing note Assumed pt's care @ 0600, assessment done, see flow sheet Pt hemodynamically stable VSS/afebrile ICP 8 to 10 ↓ thiopental @ 100mg/hr @ 0940 Suction pt q 1 to 2 hrs, pt obtaining thick mucous secretions. Bronchoscopy @ 12:00 sample sent for Gram stain. @ 1500 ICP 23 [redacted] mannitol IVP. Dr [redacted] notified. Will continue to monitor [redacted] AN
9/25/0630	Assumed pt care from Cpl [redacted] apparent 0600 Pt hemodynamically stable & afebrile @ change of shift. NS @ 100cc/hr, 3/1 NS @ 25cc/hr, ensure @ 1cc/hr, thiopental @ 100mg/hr No issues noted, will cont to monitor. [redacted] TRN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25SEP03	Neurosurgery HD 4
0649	(S/O) Nurse reports improvement overnight.
	Tm 100.2, VSS. ICP 10.
	I/O 2860 / 2074, Ventric 10-31/hr.
	Remains in pentothal coma.
	Vent SIMV 600 / 22 / 10 / 50% ⇒ 7.37 / 30.8 / 126
	16.9) 11.6 / 32.4 (245 145 / 3.7 / 110 / 29 / 15 / 0.9 (132
	(A/P) Overall improved.
	(1) NC 3% NS
	(2) ↑ TF to 30/hr.
	(3) Will consider wean Pentothal midday today.
	(4) Continue antibiotics for pneumonia
	[redacted] b(6)-2

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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sep 1600	Nutrition Note: Pt currently receiving Perative at 30cc/hr providing 936 kcals/d. If pt remains NPO > 5days, recommend ↑ TF to goal rate of 75cc/hr. (2340 kcals)
Wt: 70Kg	to meet pts' ENN of 2100-2450 kcals/day (30-35 kcal/kg) + 84-98 g Pro/day (1.2-1.4 g/kg). [redacted] LD/LD
25Sep03 (2033)	Received report from LT [redacted] @ 1815. See DA Form 4700 OP 375 for assessment data. ICP needed correct leveling it was too high. Leveled to middle ear. ICP ↑ 20-21 CPP 63-68. Dr [redacted] called around 1935. said to watch for the hour. Pt temp slightly up. Wet towel on pt c Room A/C turned up. Hands elevated on pillows to help c swelling. TOF to Ⓛ wrist ō response. ABG checked and settings left the same. All lines flushed. [redacted] RN
(2040)	ICP 14-16 CPP 68-72. Wet cloth put on pt for temp [redacted] RN
(2125)	Pt suctioned @ 2100. ICP's went up to 30's. Approx 10 min p ICP's to 15 & CPP 70. Fan on blow-by for pt. Temp down to 98.5 Approx. K-run finished. Labs drawn. [redacted] RN
(0030)	Pt suctioned, thick yellow secretions, moderate. ICP went up to 17. Preoxygenated & sats @ 100%. p̄ suctioning pt going in and out of Bigeminy. Labs received and K+ Na+ low. 2.8/120. Pt SR at this time. More blood @ lab. Pt's mouth suctioned also, thick secretions c some blood. 7/20 2x2 placed on tongue to prevent drying. [redacted] RN
(0110)	Dr [redacted] notified of pt's labs. KCL started in Ⓡ fem. TLC. Pt still in SR. [redacted] RN

STA[redacted] FORM 509 (REV. 5/1999) BACK

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b (6) - 2 All

b(6)-2 All unless otherwise noted

MEDICAL RECORD

PROGRESS NOTES

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DATE	NOTES
26 Sep03 (0320)	Pt. suctioned. Min thick yellowish white secretion
	Tried lavaging c 3cc NS. Didn't get much more
	that way. ICP's up to 21 and back down ↓ 20
	still getting K-run. No PVC's.
(0555)	Pt given bedbath, linen Δ'd. ø BM. Pt suctioned very
	thick yellow secretions from ETT & mouth. ICP ↑35.
	Pt put back in proper alignment ø response
26 Sep03 1415	Assumed pt's care @ 0600. Pt's ICP 30's. gave thiopental 3
	IVP per Dr's order & started Thiopental drip @ 50mg/hr. @ 0900. ↑ rat
	to keep desire ICP now 20's Dr. notified. Around 1000 pt's started over
	breath the vent. ICP ↑ 30's Dr. notified. ↑ thiopental @ 200
	& start Vecuronium drip @ 10mg/hr. ICP @ 1100 23 Dr.
	notified. Pt's ICP @ this time 19-20. 1400 ↓ PEEP to 8.
	...ed ABG @ 1430. Will continue to monitor.
	...@ 2h° secretions are thick yellow. ø cough.
160...	...RN
	...IVP given & ↑ drip to 300mg/hr. per
	doctor's orde...
1715	ABG @ 1700 ... RN
	will do ↑ RR ... 7.1 mmHg. Dr. notified.

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)

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b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26SEP03	Neurosurgery ADS
0838	(S) NSSA. ICP < 15 until suction this Am.
	I/O 4190/2256.
	185 / 110 / 19 (132 18.8) 9.8 (347
	3.0 / 24 / 0.6 31.6
	Pupils 3/sluggish.
	Oculocephalic (-) Cough (-).
	No response to noxious
	Vent SIMV 18, 700, Peep 10, 50%.
	(A/P) Improving ICP s PBI.
	(1) Off NS
	(2) ↑TF to 60/hr.
	(3) Wean FiO2, Then Peep.
	(4) Await Perfetch wakeup.
	b(6)-2

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

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

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

REGISTER NO. | WARD NO.

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27SEP03	Neurosurgery
0636	(S/O) Tm 100.0, VSS. ICP > 30 yesterday, now 15-20.
	I/O 3205/2676. Ventriculostomy 10-15/hr.
	154 / 115 / 19 (141 13.7) 8.8 (237
	2.9 / 30 / 1.0 28.7
	Vent SIMV 600, 16, Peep 5, 40%
	Back into Pentothal coma for ICP problems yesterday.
	(A/P) Recurrent ICP troubles with wakeup yesterday.
	Continue pentothal @ 300/hr.
	TF @ Goal.
	Will discuss trach / feeding tube when weaning pentothal
	Vancomycin #2 for LLL pneumonia.
	ICU care.
	b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	b(6)-2 NOTES
9.27/0700	Assumed pt care from Cpt [redacted] pt in no apparent distress, Ventric intact, CSF draining, FTG, [illegible] fdg @ 60cc/hr, vec @ 10mg/hr, thiopental 300mg/hr. No issues noted, all VSS afebrile, will cont to monitor ——— b(6)-2 [redacted] LT RN.
28SEP03	Neurosurgery
0647	(S/O) Afebrile, VSS, ICP <20
	I/O ~~[illegible]~~ 3070/2658, Ventric 11-17/hr.
	157 / 115 / 20 ; 4.1 / 31 / 0.5 (138 8.9) 10.3 / 33.6 < 401
	Pentothal Cont.
	(A/P) (1.) GSW head - prolonged ↑ ICP c/w SSS thrombosis. Angiogram tomorrow. Continue Pentothal today.
	(2.) Pneumonia - On Cipro. Day 4/10. Continue ICU care [redacted]
	b(6)-2

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.

EPW [redacted] b(6)-4
ICU3

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Sep 03	Pt hemodinamically stable afebrile. ICP < 15mmHg all shift.
1730	suctioned prn large amount of thick clear mucous pt. desat.
	after suctioning but recovers immidiately. labs & ABGs drawn
	Dr. [redacted] notified. Will continue to monitor [redacted] RN
28Sep03(2100)	Received report from LT [redacted] assumed care
	of pt @ 1815. See DA Form 4700 OP375 for assessment
	data. Preoxygenated pt c̄ BVM. Suctioned pt x3. Thick whitish
	yellow secretions. Sats as low as 96%. Adjusting FiO2 per
	ABG's. Questioned Dr [redacted] about CPP's of 50-55. Only
	concerned c̄ ICP's >20. Continue to monitor [redacted]
29Sep03 (0100)	Pt suctioned @ 2110. Moderate amt of whitish yellow
	Secretions. Pt sats over the next hour went from 97%
	to 92% on 50% FiO2. Resuctioned pt @ 2220. p̄ suctioned pts
	Sats were @ 88%-90%. ICP's stayed @ 22-24. Dr [redacted] notified.
	PCXR done. Dr [redacted] tried bagging pt thinking he had a
	mucous plug. Sats p̄ bagging stayed @ 93-94%. Moved Peep
	to 10 and FiO2 to 70%. Pt's sats didn't Δ much. Gave
	pt a bolus of pentothol and increased Pentothol
	to 400mg/hr. Didn't help ICP's to much. Later gave
	pt 50mg lidocaine ā suctioning. Suctioned moderate
	amts of thick yellowish - white secretions. Adjusting
	settings on the ventilator in relationship to ABG's.
(0330)	Pt given lidocaine ā suctioning @ 0200. Kept ICP's ↓ 17
	while suctioning and after. HR ↓ from 120's to 115. BP improved
	Suction a lot from ETT. Sats from 94% to 98%. Pt tolerated
	well. Will continue to monitor. [redacted] LT
(0625)	Pt did well throughout rest of night. Sats stayed

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b(6)-2 All

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24sep03 (0625) cont.	above 97% on 70% FiO2 SIMV 20, TV 600, Peep 10. Lidocaine given c suctioning. ICP's never went above 20. HR down from 120's to 105. Temp down to 99.2. Sats now @ 99% and ICP around 10. Tube feeds stopped @ 0430 for angiogram today. Report given to LT [redacted] b(6)-2 [redacted] LT/RN
25SEP03 0625	Neurosurgery b(6)-2 Vanc/Cipro.
	(S/O) Afebrile, SBP ~ 100. ICP 12-22.
	I/O 2250/2750 Ventriculostomy ~ 10-15/hr.
	Pentothal @ 400/hr. FiO2 70%. Peep 10.
	10.8) 10.5 / 34.6 (379 133 / 114 / 23 / 4.9 / 37 / 0.6 (134
	Barb Coma. LLL Consolidation.
	(A/P) (1) PBI - problems overnight likely related to pulmonary issues. Responded to ↑ Pentobarb and pretreatment suctioning with lidocaine.
	(2) Pneumonia - LLL a bit worse. Plugging seems to be a problem. ↑ TV to 700. Vanc added to cipro.
	Angio scheduled for today [redacted] b(6)-2

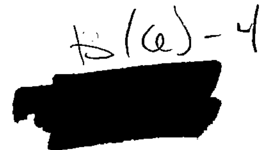
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
		[redacted]		

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

b(6)-4



PROGRESS NOTES
Medical Record

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29Sep03	Assumed pt care @ 0615. BP 90's/40's Dr [illegible] 0635 ↑ TV @ 700
on 0645	Gave 500cc NS bolus per doctor's order. Will do ABG @ 0700. Continue
	to monitor ILT/AN
0740	Called Dr. [illegible] PCO2 28.0 PO2 76 HCO3 25 SO2 97%. Will
	↓ RR to 16 & ↓ thiopental to 350mg/hr. Will continue to monitor
	ILT/AN
0820	Pt to OR for [illegible]. ABG done @ 0815 results given to OR
	nurse [illegible] ILT/AN
29Sep03	Pt a[illegible] @ 1010 BP 70's/40's Ephedra 10mg IVP given &
1210	started Dopamine drip @ 5mcg/Kg/min. Pt responded well. BP ↑ 120's/50
	O2 sat @ 92% given lidocaine 50mg IVP & suction pt, obtained
	large amount of thick greenish secretions. O2 sat ↑ 98%. Per
	CRNA report pt. given in OR a total of 625mg Penthotal, 10mg Vecuro-
	nium & 500cc NS. EBL <10cc urine output 700 cc. Pt started on
	D5NS c̄ 20mEq KCl @ 150cc/hr. & @ 1120 penthotal ↓ 300mg/hr.
	Pt hemodynamica[illegible] [illegible]le @ this moment. (R) groin puncture site c̄ no
	signs of bleed[illegible] [illegible] +2 pedal pulses bilateral. Will conti-
	nue to monitor. [illegible] ILT/AN
29Sep03 (1950)	Received rep[illegible] [illegible] and assumed
	care of pt @ 1[illegible] DA Form 4700 OP 375 for
	assessment data. RT came in and gave pt RTx
	around 1850. Placed pt on some humidified air. Pt's
	sats started dropping from 95% to 88% on same
	settings. Installed 3cc NS, preoxygenated, gave lidocaine
	50mg. Then suctioned ICP's as high as 26. Suctioned
	alot of thick whitish yellow secretions. W/ P suctioning
	Sats up to 95% or >. ICP's around 22. Monitoring to see if

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