MEDICAL RECORD | **PROGRESS NOTES**

DATE

10 May 03

Iowa 06 admit (4/20, 4/25) DOI

0919 → Burn source, old, R/E surgical, orthotics

> Event - 2 units PRBC

Centra Wound - sedated d/c sedation analgesia for extubate

Celec ① pan 450 q

OSNs c 20 40 ② Haldol 20 mg/Scandy to IV q 4° + Lori / 40

125 cc/d CV - MAP 60-80 HR 100-120s pulses c/4 @ 1000

① Hm shells c seed H40

② TF slow per advance

Pulm - CPAP PS → 100% keep ETT

① extubate

GI - ② BS q3 TF hold restart on adv TF

① Pro / TF post extub

FEN - keep wNL

Hem - FT 2 units

141 | 115 | 9 | 106 ① CT head pulses if obt LOC 24°

3.7 | 29 | 0.4 |

M 1.7 ID - Tm 101° WBC 10 Cx 30 Jan

10 3.4 174 ① Pan Cx c fever

PT 12 Renal - better

(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5663

MEDICAL RECORD	PROGRESS NOTES
DATE	
	Disc.
5/1/03	
	PT now off all sedation. Will awaken today & if OK would d/c extubate. Continue to have L IJ CVL removed 2° proc yesterday for H/H 6.6 now 7.1 & receiving 2 U PRBC now. If stable for removal of L IJ CVL & H/H & again tomorrow AM. Abd pad ct c/d/i. Continue to monitor with pulses. GSW's look great, wound continue to dry & D/C IVF.

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO. ____ WARD NO. ____

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - **5664**

PROGRESS NOTES

DATE	
1MAY03	Medical Nutrition DX FU:
1020	O: Tubefeeding stopped @1700 4/30/03.
	4/30 - residual 10cc c Peratlve @ 60cc/°.
	4/30 - residuals of 120 & 300 cc c Peratlve @ 90cc/°.
	Labs 5/1/03: albumin 1.3↓. 141/105/16 / 3.7/29/.4/106
	ΦBM 4/29, 4/30, today.
	A/P: ~~Error KRM~~ ~~Pt. has~~ If pt. stooling & tubefeeding re-started, recommend Peratlve @10cc/° & ↑ by 10-20cc q 4-8° to goal rate of 60cc/° to provide 1872kcal & 96g protein q day to meet needs. Protein stores severely depleted - will monitor c reintroduction of tubefeeding. Other labs WNL x Creat ↓ - will monitor. RD to f/u q 2-3 days.
	[redacted] MPH, RD
	[redacted] MPH, RD
	LT, MSC, USNR 7247

PROGRESS NOTES

DATE	Surg.
5/1/03	PT now i BKS in place + splints. Ortho consult + might settle tube + nail which has a blockage free of dirt. Plan for (B) & placement right thigh tube. PT was extubated i good O2 Sats but CXR show collapse of L lobe. i inhalation therapy. will need to be intubated for procedure + would wait a day for pleural procedure. Has been taking feeds well, pedal edema i creatinine X bed rest. HCT has been stable 30%, could cont to monitor + transfuse as needed.

(b)(6)-2

[redacted]

* U.S.G.P.O 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5666

MEDICAL RECORD	PROGRESS NOTES
DATE	
pm, CJ	Icu 28 Aud (4/20, 4/28) OCT
0900	♂ 65w sacrum, abd, RUE, LE fistula, urethritis -
Swoll of Heldel to CC?	Event -
	Neuro - slightly combative, PERRLA, moves all 4
Culture	① Persist Heldel (in ICU)
Zosyn	CV - MAPs 70-80 HR 120-130s (afib) 4/4 -180c
Neuro CC CJ	① Ifn shifts c good workup.
MSC	② ~~Add Pos~~ (Re-culture Le)
TF Cm	Pulm - CTX CLEAR, sec 2/3
GU	① Pulm fxiles
	② No ++ UA yet
	GI - TF@ 65 @ 5PM
	① Bowel regimen
	Heme - stable
	FEN - Lytes (Goals extub)
	ID - Tm 100.9 WBC 7
	① Pan Cx, if fever no Abx for now
PT 11	Needs wound
7.3 F5 (27c	
140/107/10 (119	
7.3 32 ed	

(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—10% /last/middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

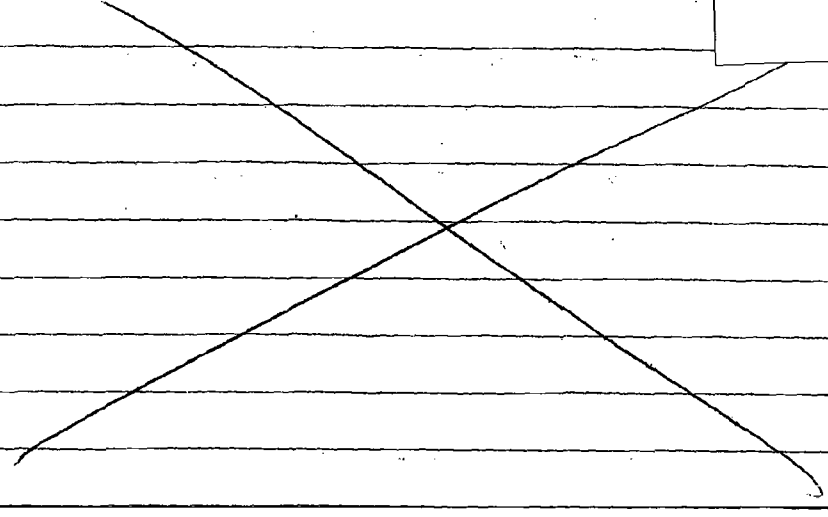
(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5667

MEDICAL RECORD	PROGRESS NOTES
DATE 5/2/03 0747	Urology POD #3 The pt has return of gross hem and now neither SP tube nor Foley will irrigate. His bladder feels distended. H/H 9.4/27 Imp rec. bleeding @ sphincteric site - most likely PLAN (B) PCN's to divert urine from lower urinary tract.

(b)(6)-2



(Continue on reverse side)

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

REGISTER NO.

WARD NO

PROGRESS NOTES
STANDARDFORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5668

PROGRESS NOTES

DATE	
3MAY03	Medical Nutrition Tx's F/U's
1105	O: Peratlve @ 60cal°. Labs 3MAY03 140 / 107 / 10 / 119 ↑ 3.3↓ / 33↓ / .5↓
	Ca^{+2} 7.4↓, P 3.2, Mg 1.6↓
	A/P: Peratlve @ 60cal° = 1872kcal + 96g protein/day.
	K^+, Creat, Ca^{+2} + Mg ↓ - will monitor ē
	Peratlve @ 60cal°. Glucose mildly elevated.
	Peratlve @ 60cal° to provide kcal + protein needs
	Recommend maintain Peratlve @ 60cal°.
	[b)(6)-2] MPH, RD
	LT, MSC, USNR 7247

U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5669

MEDICAL RECORD	PROGRESS NOTES
4 May 03 DATE	
0930	Cultures (P)
	T 101.3 WBC 11
	will start empiric Abx
	Imipenem 500 mg IV Q6°
	Vancomycin 1gm IV Q12°
	prior to Transfer
	Acetaminophen PO T 325

[b)(6)-2]

(Continue on reverse side)

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

[b)(6)-4]

[b)(6)-4]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5670

MEDICAL RECORD	PROGRESS NOTES
DATE	
4 May 0	ICU D7 RO(4/22, 4/28) OCT
0750	↑ GSW scrotum, old, RUE AV Rshld, urethr/tear
Bowels / 25 2 U GJ°	Event - vom. + x3
Endo	
	Neuro - PERRLA, mves all 4, moves,
Cardio	① sedate - L Hald. / Prn 66° endocrine, insul. gtt
Heme / 40 3 U E3°	CV - MAP 80-90 HR 100-120 pulses 4/4 - stable
Resp / 40 RTO	① Hx shelle c seed perfusion ② endocrine
Duct	② Culture via TC → yes L-F
Infect	③ Levo / Azithro / Vanco
Endocrine	Pain - legs chronic, sees 2/3 RA → 7 9 9 0
	① Pain Tolet
	②
	GI - prenatals CBS CBM soft mod
	① serine TF c endocrine
	FEN - wnl give Azithro/vanco + K
	Heme - stable
07 12	ID - Tm 102.1 wbc 7.11
11) 8.3 / 322	① Sp tx for urologic problems
139 / 106 / 13	② Pain C+
3.5 / 32 / 0.4 / 96	

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 5671

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
04 MAY 03 2300	PT AOx3. PT WILL NOT OPEN HIS EYES WHEN ASKED. PT NON COMPLIANT W CARE. LUNGS DEMINISHED THROUGHOUT BILATERALLY. SPO2 ≥ 98% ON RA. PRODUCTIVE COUGH, THICK WHITE SPUTUM. CARDIAC RRR. ACTIVE BS IN ALL QUADS, NON DISTENDED/NON TENDER ABD. NO BM REPORTED SINCE ADM. MIDLINE STAPLES C/D/I, NO ERYTHEMA HOWEVER MODERATE DRAINAGE (BLOOD TINGED) AT BASE OF INCISION SITE. 4x4 STERILE PAD Δ'd PRN. FOLEY CATH. DRAINING BLOODY URINE TO GRAVITY. (L) & (R) RENAL DIVERSIONS DRAINING TEA COLORED URINE TO GRAVITY. SP DRAINING BLOOD TINGED URINE TO GRAVITY. (R) FEM TRIPLE LUMEN IN PLACE C/D/I INFUSING D5 1/2 NS @ 100/°. SCROTAL EDEMA NOTED, ELEVATED W TOWL. NG IN PLACE DRAINING BILE TO LOW INT. SUCTION. MAINTAIN CONTACT PRECAUTIONS. BILAT LE +1/2 EDEMA. PALPABLE PEDAL PULSES BILAT. CONSULTED RT ON RESP. TX ORDERED. RT EVALUATED PT STATUS AND WILL CONSULT MD ON CROCK. WILL CONT TO MONITOR THE PT — (b)(6)-2 — LT/AN
05 May 03 0030	Resp Care Note: Consulted to Nurse on pt. regarding Neb Albuterol/Atrovent/Mucomyst I.S. CPT — (b)(6)-2 — Therapy not indicated at this time. Will consult with M.D. in A.M. on proper frequency (b)(6)-2 at GIV 3rd
0300	VSS, PT IS SLEEPING IN BED. NO ESSENTIAL Δ'S FROM PREVIOUS ASSESSMENT. WILL CONT. TO MONITOR THE PT. — (b)(6)-2 — LT/AN
0600	MORNING LABS COMPLETED. CENTRAL LINE DRSNG Δ'd. — (b)(6)-2 — LT/AT

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

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

(b)(6)-4

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

MEDCOM - 5672

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5MAY03 1700	Received patient c leather restraints to upper extremities and sedated. Pupils 4-5mm/sluggish, easily arousable. lung sounds CTA c diminished bases. CXray (-), maintaining sats >95% on RA. Received orders to hold all respiratory treatments until patient is transferred to permanent facility. ST c HR (101-110 bpm). Palpable pulses x 4; 2-3+ pitting edema to upper and lower extremities; scrotal edema - supported by chux. NGT (+) blood to NS c total of 200 ml of dark green gastric contents. Patient had 1 medium-sized liquid, green colored BM. Midline abdominal incision CDI c staples intact. Some oozing around pubic area and base of SP catheter site. Physician aware. Dressing to sacral area changed this am. Foley to gravity drained 100ml of bloody urine c clots, (+) nephrostomy tube drained 100ml of tea-colored urine, (+) nephrostomy tube drained 100ml of tea-colored urine, and suprapubic cath drained 200ml of dark colored urine. (+) femoral TL patent c D5NS @ 100ml/hr. H/H 8/27 - physician aware no intervention ordered Type/Cross completed this am per report. Will continue to monitor. [redacted] RN
05MAY03 @ 1540	340 mL CLOTTED URINE IN FOLEY. Dr. [redacted] PAGED T CAMS TO ASSESS PT. PT TO RECEIVE 2u PRBCS [redacted] CPN
@ 1600	PT BLOOD T UNIT STARTED UNIT # 1640418 c 2 NURSES
	1615 133/75 HR 101 Temp 100.0
	1630 126/66 HR 99 Temp 100.0
1800 VITALS	130/72 HR 101 Temp 100.0 100% RA
2000 VITALS	126/74 HR 84 Temp 98.6 100% RA

STANDARD FORM 600 (REV. 6-97) BACK
USGPO 2002-491 600/5061

MEDCOM - 5673

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 MAY 03 @ 16^{00}	PERRL @ 3mm MAE EOMI VERBALIZES WELL VIA INTERPRETER NO C/O PAIN @ THIS TIME. VSS, AFEBRILE. LUNGS RIGHT CTA & DIMINISHED BASES. (+) BS x 4 TOL PO WELL & N/V/D NG TUBE CLAMPED. ABD SOFT & (R) LOWER QUADRANT, TENDER UPON PALPATION. MIDLINE INCISION & STAPLES LOWER PORTION OF MIDLINE OPENED BY MD'S STUFFED SMALL OPENING & IODOFORM OPEN TO AIR, COVERED & 4x4 & TAPE. (R) UROSTOMY DRAINING SEROSANGUINOUS FLUID SUPRA PUBIC DRAINING BLOOD CLOTTED URINE (R) UROSTOMY DRAINING TEA COLORED URINE OCCASIONALLY TINGED & SCANT AMOUNT OF BLOOD. FOLEY DRAINING BLOODY URINE AS WELL. HR 90-100's $S_1 S_2$ (+) 3 EDEMA x 4 EXTREMITIES (R) FEMORAL 3-lumen all 3 flush easily D5 NS @ 100 cc/h (+) RADIAL & PEDAL PULSES & JVD HOB @ 15 DEGREES. NO COMPLAINTS OF PAIN WILL CONTINUE TO MONITOR FOR Δ's IN VS, FEVER & PAIN [redacted] CPT AT
5 MAY 03 @ 1900	OUTPUTS: FOLEY - 275 cc's (R) UROSTOMY - 100 cc's SP - none (R) UROSTOMY - 325 cc's [redacted] CONT
5 MAY 03 @ 2330	PT TOL PO WELL ATE GOOD FOOD. NO C/O N/V/D AT THIS TIME. PT RELIED TO Δ LINEN P/T SATURATION FROM SP OOZING NO OTHER Δ's TO ASSESSMENT [redacted]
5 MAY 03 @ 2200	PT C/O PAIN GIVEN SMALL AMT & LITTLE RELIEF. GIVEN 10 mg VICODIN PT IS NOW RESTING COMFORTABLY & ASLEEP WILL CONTINUE TO MONITOR FOR Δ's IN VS/PAIN [redacted] CPT AT

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT. TREATING ORGANIZATION *(Sign each entry)*
06 MAY 0015	PT RESTING IN BED C HOB @ 45°. PT REMAINS IN SOFT WRIST RESTRAINS RELEASED RESTRAINTS AND PASSIVE ROM COMPLETED. LUNGS CTA, SaO2 ≥ 99% ON RA. CARDIAC RRR, ACTIVE BS IN ALL 4 QUAD. NON DISTENDED / NON TENDER ABD. EX LAP STAPLES INTACT C MINIMAL AMOUNT OF BLOODY DRAINAGE AT BASE. (R) & (L) URETER DRAINAGE TUBES IN PLACE SP INPLACE, FOLEY TO GRAVITY ALL DRAINING TO GRAVITY, +3 SCROTAL EDEMA, PLACE TOWN TO SUPPORT SCROTUM. +3 LE EDEMA W/ PALPABLE PEDAL PULSES. (R) FEM TRIPLE LUM, CENTRAL LINE CATH, - INFUSING MAINTAINCE FLUIDS. WILL MAINTAIN CURRENT STATUS FOR VS AND MONITOR PT. [redacted] WT/JA
0600	PT SLEEPING IN BED C HOB @ 45°. NGT IN PLACE TO SUCT, NO ESSENTIAL A's FROM PREVIOUS ASSESSMENT. LABS DRAWN, MEDICATED THROUGHOUT THE NIGHT FOR AGGITATION, & PAIN, [redacted] WT/AN
06 May 03 1015	PT RESTING at this time. Administered 5MG VERSED and 5MG Valium IV for c/o pain to abdomen and increased irritability. PERLA 4-5mm / REACTIVE. LUNG SOUNDS CTA C diminished bases, SATING > 95% ON RA. NSR C HR 80's - 90's, BP 120's/70's C MAP in 80's. 2-3+ edema to upper EXTREMITIES; 3+ pitting EDEMA to LOWER EXTREMITIES. + Capillary refill. Bilateral Nephrostomy tubes C MINIMAL AMOUNT of bloody output; Supra-pubic cath C MINIMAL amount of yellow URINE; Foley to gravity C 50ml of bloody output. ~~ABDMD~~ Abdominal dressing D/d; Scrotum elevated C chux. ~~Hypo~~ PM Hyperactive BS X4, PO BN @ this time VSS, afebrile. [redacted] DU/JA

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

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

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

MEDCOM - 5675

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7MAY03 0800	Patient c soft wrist restraints. Easily arousable M, responds well to simple commands. PERLA 4mm/reactive. NSR c HR 80's. S1-S2 c Ø murmurs auscultated. Palpable pulses x 4 c BP 130's/70's. Lung sounds clear in upper lobes bilaterally c mild crackles at bases. Sat's 96% on RA. (L) nephrostomy tube c blood-tinged urine, foley c 5ml's of dark yellow urine in tube, (R) nephrostomy tube c dark yellow urine, SP cath c minimal amount of urine. Midline abdominal incision c staples and iodoform packing to lower incision area; still coming moderate amounts of bloody drainage - physicians are aware. NG tube to (R) nare clamped. Patient tolerated 40% of breakfast c difficulty. Administered 5mg MSO4 for pain. + good effect. Will continue to monitor. [redacted] LT, RN
7MAY03 1300	Patient resting peacefully at this time. Bilateral nephrectomy tubes clamped per morning round c physicians, NGT also removed. Will continue to monitor. [redacted] LT, RN
1430	Irrigated foley c 50ml of sterile water c 50ml return + 150ml of blood tinged urine. [redacted] LT, RN
1435	Administered 10mg MSO4 for c/o pain p changing bed linens d/t increased drainage from midline abdominal incision. Will continue to monitor. [redacted] LT, RN
7MAY03 @ 1500	VSS, Afebrile. Lungs B CTA occasional cough. S1 S2 Ø JUD Ø3 EDEMA x 4 EXTREMITIES SR Ø ECTOPY A+O x 3 EOMI MAE PERRLA 3mm Ø CLOTTING CLAMPED PT DRAINING SCHOSANGUINOUS FLUID VIA FOLEY + MIDLINE LOWER INCISION SITE C IODOFORM DSG. PADS CHANGED Q2° C SEROSANGUINOUS FLUID. Ø BS x 4 TX PO WELL C N/V/D Ø Formal 3-Lumen D5 1/2 NS @ 125 cc/hr x 1 VFS FLUSHED [redacted] P

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 5676

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8MAY03	ORDERS - N.S. INFUSING IN FOLEY AND OUTPUT BLOOD TINGED FROM SP CATH, STAPLES TO MIDLINE ABD. INTACT, PUBIC INCISIONAL DRAIN - OUTPUT BLOOD TINGED D/T BLADDER IRRIGATION, URETER CATH CLAMPED, TRIPLE LUMEN CATH (R) FEMORAL INFUSING N.S @ 100cc/HR, D5½ LUNG SOUNDS CTA, BOWEL SOUNDS PRESENT X 4 QUADS, +3 EDEMA TO ALL EXTREMITIES AND SCROTAL EDEMA. 1000 - 1500cc BLOOD TINGED OUTPUT FROM SP CATH. SGT [(b)(6)-2] 9/LWM6 1230 - 1575cc BLOOD TINGED OUTPUT FROM SP CATH. SGT [(b)(6)-2] 9/LWM6 1230 - PT. TOLERATED ONE CUP JELLO. SGT [(b)(6)-2] 9/LWM6 1430 - 1200cc BLOOD TINGED OUTPUT FROM SP CATH. SGT [(b)(6)-2] 9/LWM6
18MAY03 @ 1530	PT SLEEPING BUT EASILY AROUSABLE ORIENTED x3 PERRL @ 3mm EOMI, MAE S1S2 SR @ ECTOPY @ 100 HOB @ 30° (+)3 EDEMA ALL EXTREMITIES CAP REFILL < 3 SEC. (+)BS x4 TOL PO INTAKE WELL @ c/o N/V/D LUNGS BILAT CTA. FOLEY SP CATH INFUSING BLADDER IRRIGATION DRAINING U/A SP CATH. UROSTOMIES CLAMPED. MIDLINE INCISION INTACT C SP INCISION/STAPLES REMOVED DRAINING SEROSANGUINOUS FLUID. 3-LUMEN CATH @ FEMORAL INFUSING NF's AND IVPB's & ANTIBIOTICS W/ DIFFICULTY. NO c/o PAIN @ THIS TIME WILL CONTINUE TO MONITOR PT ROC A's IN VS/PAIN/BLADDER IRRIGATION [(b)(6)-2] CRYAN
08MAY03 @ 2100	PT c/o PAIN + WAS SEEN SLIGHTLY AGITATED THROUGHOUT SHIFT. PT GIVEN MSO4 + VALIUM W/ RELIEF. ↑ PAIN W/ MOVING DURING DSG A's CBP - ↓ W/ MSO4 VALIUM [(b)(6)-2]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - bat. 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

MEDCOM - 5677

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
09may03	0420-(CONT). CBC drawn 7.2/22.4. worked loose more clots in drainage tube. Δ[ED] foley bag Red tinge clear drainage out put now. VSS. 107/50 HR 74 Afebrile ø s/sx of distress or discomfort at this time. Will redraw CBC & continue to access vitals. 0700 - pt. resting Am meds. given. CBC drawn Report given VSS Afebrile. [redacted] 9mwm620
	0705 - 400cc red tinted drainage ø visiable blood clots in drainage. [redacted] 9mwm620
9mm403	Urology — also to serve as consultant Cont'd urine Leak from abd wound & intermittent severe clotting hematuria despite irrigation - now requiring blood transfusions x 11. Plan US of (B) kidneys to ensure good parenchema, then (B) antegrade pyelureterograms to ensure ureteral healing. Then urinary diversion to allow bladder to heal and possible nephrectomy if continued ureteral injury. Feel further pelvic dissection may result in life threatening hemorrhage - will unclamp per neph tube today. [redacted] 94 Re.

STANDARD FORM 600 (REV. 6-97) BACK
*U S GPO 2002 491 600/50618

MEDCOM - 5678

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
09MAY03	Pt c/o PAIN & REQUESTING MSO4. Pt GIVEN 800mg MOTRIN INSTEAD
1530	Pt STILL c/o PAIN BUT EXPLAINED TO PT THAT HE CAN NOT HAVE ANY
	MSO4 D/T LBP. Pt REMAINS AGITATED. (R) UROSTOMY (WITH)
	TUBING MILKED & STRIPPED; PT URINE CLEARED UP TO BLOOD TINGED VS.
	BLOODY URINE. Pt H/H 8/24.9 ↑ 2u PRBC's WILL TRANSFUSE
	2 MORE UNITS AS PT IS STILL BLEEDING OUT. Pt A+O3 Afebrile
	S, S2 HR 90's Ø ECTOPY Cap REFILL < 3 SEC (+) RADIAL &
	PEDAL PULSES PALPABLE LUNGS BILAT CTA HYPOACTIVE
	BS MIDLINE INCISION ENDING c FISTULA, SP/PRN IRRIGATION
	LOWER PORTION OF ABDOMEN REMAINS HARDENED. SP/FOLEY DRAINING
	SEROSANGUINOUS FLUID/URINE. (D) UROSTOMY DRAINING CC yellow
	URINE. (R) WILL CONTINUE TO MONITOR VS/PAIN LEVEL WHILE
	TRANSFUSE ~~IT~~ U PRBCS [(b)(6)-2] CPT, AN
09MAY03	2770481 T unit PRBCs transfusing PRE TRANSFUSION VS
15:50	114/47 HR 99 TEMP 99.3 Sat 98% FiO2 RA
15:55	118/50 97 99.2 98% RA
16:00	116/49 96 99.3 98% RA
16:15	116/45 95 99.4 99% RA
16:30	117/47 99 99.3 100% RA
16:45	109/48 94 99.4 100% RA
17:00	110/48 93 99.6 100% RA
17:30	110/49 95 98.4 100% RA
18:00	110/50 94 97.2 99% RA
1830	120/53 95 97.6 ~~F~~ 100% RA
~~1900~~	T UNIT INFUSED W/O DIFFICULTY [(b)(6)-2] CPT

STANDARD FORM 600 (REV. 6-97) BACK

'US GPO: 2002 - 491-600/50618

MEDCOM - 5679

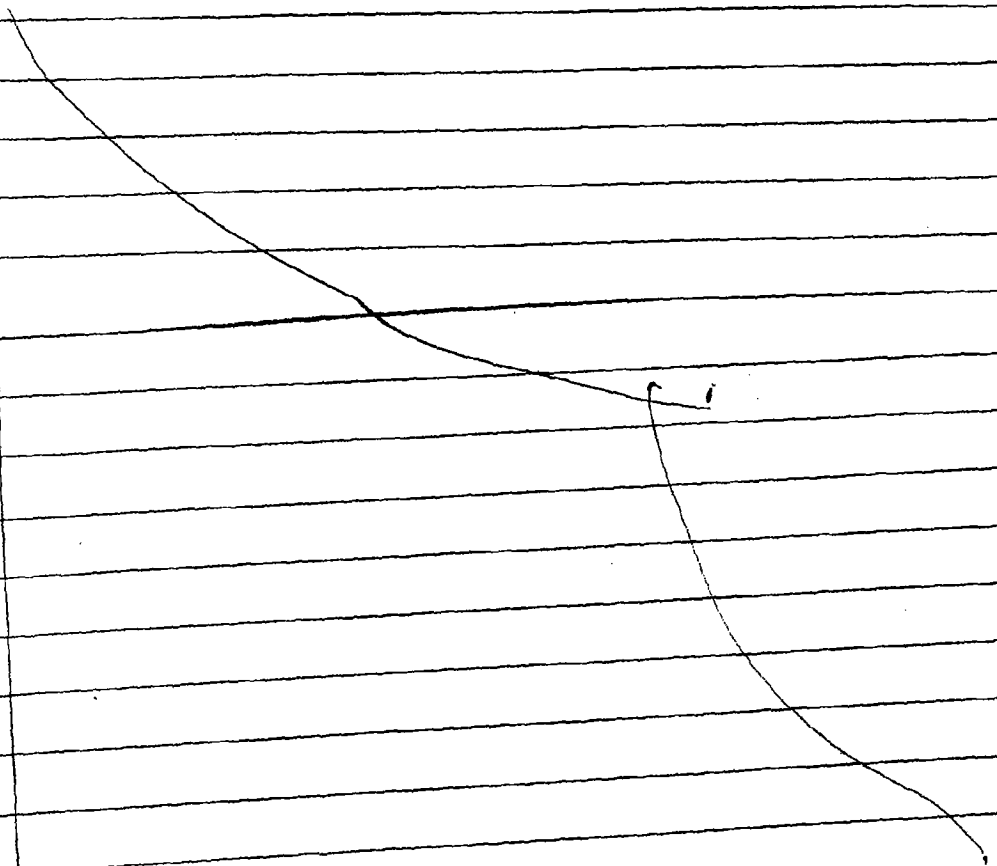
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 MAY 03	UNIT # 1260438 ~~TI~~ UNIT PRBCs
1845	HR 88 114/49 Temp 98° Sat 100% RA
1900	87 121/59 97.7 100% RA
1915	102 110/50 " "
1930	103 95/47
	8,000cc out suprapubic
	6000cc in
	(R) neph - 700cc (L) neph -
1950	HR 114 78/34 Dr. [b)(6)-2] NOTIFIED
1955	HR 110 62/23 [b)(6)-2]
2000	1700 cc Bright Red Gelatin-consistency bloody drainage from (L) suprapubic catheter [b)(6)-2] 91C3H
2013	1000 cc bright red drainage from suprapubic catheter, [b)(6)-2] 91C3H
2015	1000 cc bright red drainage from suprapubic catheter, consistency clearing to sero sanguinous [b)(6)-2] 91C3H
2019	1 1000 cc NS - CAT
2021	96/48 89 O2 100
19 MAY 03	Urology - Pt acutely dropped pressure & put out 7000cc urine replaced in addition to considerable bleeding from bladder. Plan urgent (R) nephrostomy & urinary diversion. [b)(6)-2]
0900 MAY 03	
2031	Pt to OR for Emergency Surgery [b)(6)-2]

STANDARD FORM 600 (REV. 6-97) BACK

US GPO 2002 - 491-600/50618

MEDCOM - 5680

DATE	S	OMS, DIAGNOSIS, TREATMENT, TREA	RGANIZATION *(Sign each entry)*
0 May 03	RT Note: Vent ✓. Pt intubated ⌀ 8.0 ETT @ 23 @ Teeth BS coarse		
1655	all fields. Sat 97% SIMV 12 ≈ 40% 2 Lpm Bleed in PEEP: 5		
	VT 700 mL Ex VT 469 ml PIP: 23 Pave 11 Alarms 50/5		
	SpO_2: 100% HR: 113 BP 105/53. Pt Revived Post Up Last		
	Night. Will Continue to monitor. [redacted] (b)(6)-2		9 May 03 1811



STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 5681

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

0 May 03
0100

Resp Care Note: Vent settings simv RR 12, Vt 700, Peep 5cm H2O, FIO2 40%, PIP 25, Mean 12, I:E 1:2 SpO2 100% (b)(6)-2 9N3F

0100- received report from OR. pt. stable on vent. (L) Nephrostomy tube draining clear yellow urine. JP to bulb suction draining Bloody drainage, suprapubic foley draining bloody fluids. foley cath @ drainage. foley cath must be tight/tension taped to legs. (R) Red Robin in bag draining bloody fluids. SpO2 100% T: 93.6 blankets placed on pt. central line (R) neck propofol @ 11cc/hr. VSS. ~~NS~~ (R) AC IV NS @ 125 pm Meds given. 0200- VSS. 60cc out from JP. 0245- pt. BP↓ to 105/68 - 500cc NS given BP ↑ 119/71 102 HR, 0330- pt. waking ↑ propofol from 11cc/hr to 13cc/hr for effect. 0400- 100/58 bolus 500cc LR poss. propofol reaction. 0600- ↓ 11 @ 0510 overall out put 800cc (L) nephrostomy . 225cc Suprapubic. @ foley cath. 140cc JP. (R) red robin @ 200cc @ 0550 ↑ propofol to 13 pt. waking while doing blood draw. DSG on ABDO CDI. pt has small amount of edema to scrotum gauze elevating scrotum NG tube to LIS 13cc Risidual Green Bile. (b)(6)-2 9/NOME

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 envies, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

REGISTER NO.	WARD NO.

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

MEDCOM - 5682

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0700 10 MAY 2003	Received report on patient. [redacted] (b)(6)-2 1ST JAN
1400	Administered 500ml bolus of LR due to patients BP 70-90s/30-40's & MAP of 50's. Propofol titrated off, patient awakened and extubated @ 0900 & complications. (Vent settings: SIMV, TV 700, Peep 5, 40%, #8ETT 22cm @ bottom lip). PERLA 4mm (sluggish; patient responds well to verbal commands (understands English). ST & HR 105-126's, S1-S2 Ø murmurs or abnormal heart sounds auscultated. 2+ pulses x 3 & weak thready pulse to (L) UE. Patient received 1gm Calcium gluconate over 2' and 2gm Mag Sulfate over 4' due to Ca of 6.3. Ø Ectopy noted. Lung sounds CTA & diminished bases; satins 96% on RA. Midline abdominal wound & Kerlix dressing and ABD pads reinforced x 2. Hypoactive BS x 4 quads. (L) NGT to WS & minimal amount of gastric content. (L) Nephrostomy tube total output -230ml of CYU; SP cath (100ml of bloody drainage; FTC & 15ml of CYU; urostomy/stent & 340 ml of blood tinged urine. (R) EJ (single poert) Cordis; IBC (R) FA @ LR @ 125ml/hr. Patient received total 14mg NSO4 & complications. Patient resting peacefully, will continue to monitor. [redacted] (b)(6)-2 1D, AN
10 May 1555	Received care of pt. Arouses to verbal command, follows simple instruction PERRL briskly at 3mm. MAE. Room Air Sat 100%. Resp full + Regular. BBS CTA, diminished in bases. Heart sounds $S_1 S_2$, Ø ectopy. Rt groin pulses palp all 4 ext. Some edema to b/l LE (left) 2+. Cordis to Rt IJ. Patent. IBC to Rt & RL @ 125 cc/hr. Lg Abd dressing dry + intact RUQ ileo conduit & red catheter exiting - covered & ostomy bag - No bag on - old one loose + leaking. Supra-pubic catheter & red dunge in tubing - foley cath & red tinged dunge. Nephrostomy tube from Lt Post T & cl. yellow fluid in tubing. JP drain in Lt Side - Red dunge in tubing [redacted] (b)(6)-2 Cont

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 5683

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 MAY 03 1245	OP NOTE — FLUIDS 5L PRBC 7L cryo 400cc UO EBL = 500 Procedure - Right Nephrectomy - ileal conduit - Evacuation of pelvic hematoma - Reconstruction of A BLADDER NECK Surgeon - Petrosky + Harris. Anesthesia - LUND + Archibald Indications - removed right kidney because of severe hemorrhage from per neph tube and associated right ureteral injury - found approximate 2cm laceration of bladder neck - closed c interrupted 3-0 vicryl - Large pelvic hematoma with diffuse pelvic wall oozing. - performed urinary diversion to allow pelvic bleeding to stop - unable to close inferior portion of wound and left open to granulate in. - Left ureter anastamosed in ~~to~~ refluxing manner.

OR for picture

[b)(6)-2]

OSPITAL OR MEDICAL FACILITY | STATUS | DEPART | D AT

'ONSOR'S NAME | SSN/ID NO. | RELATI

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

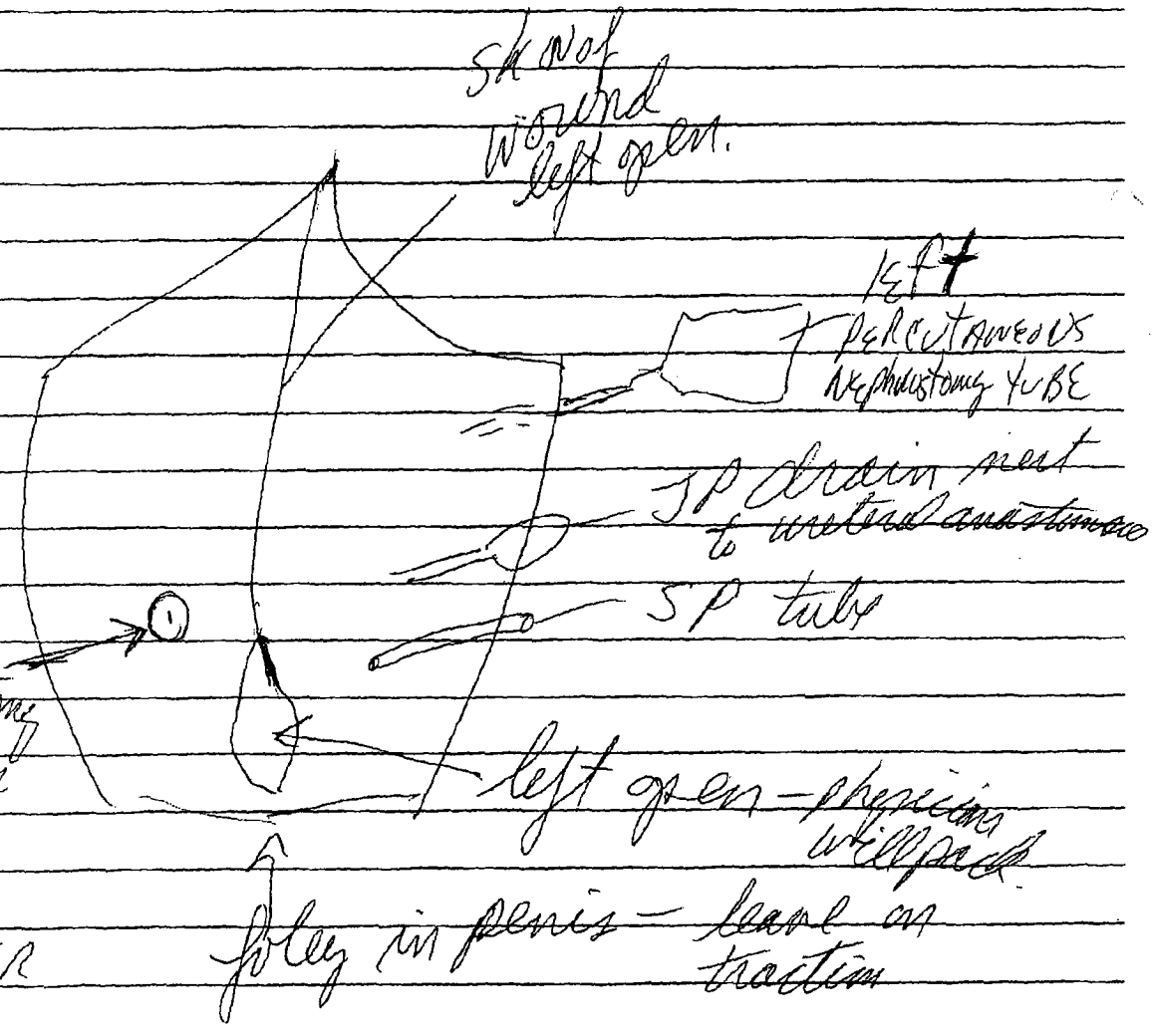
[b)(6)-4]

[b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
RD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.2

MEDCOM - 5684

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



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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 May 1855	NG to LIS Suction. Cl. Lt Brown fluid in tubing. O BS heard.
Cont.	A) Currently Stable S/P Nephrectomy & Bladder wreck Repair.
	P) Monitor Multi Tube out put. VSQ 1°; Meds as ordered (b)(6)-2
1930	Back dressing D'd. Both areas pink in color Chux & Bunn pads under pt changed. — Lg Amount of Urine leakage from around Ileal conduit — 2 saturated Chux. Dr Petroski to see pt. No New orders Requiring MSDs for Apn approx q 60-70 min (b)(6)-2
2200 —	Minimal out put from foley & Supra Pubic cath. Urine from nephrostomy cl. Yellow Ileal Conduit cont to leak urine 1 more saturated chux changed (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.)*

(b)(6)-4

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR 141 CFR) 201-9.202-1

MEDCOM - 5686

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10MAY03	Urology POD #1 s/p (R) nephrectomy, ileal loop, pelvic hematoma evacuation and bladder neck closure. - Pt able to be easily extubated this AM - BP good but tachy, RR good - wound with expected serous drainage. Pain controlled on Dilaudid PCA. Foley intact, draining UO, will leave Foley → [b)(6)-2] re-eval pelvic wound tomorrow - cont to hold DVT prophylaxis until risk of renewed pelvic bleeding subsides. - Main part of visit - apnea & wound failed trial to pass minutes bc w TPN suspension available [b)(6)-2] 9HK

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

[b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

MEDCOM - **5687**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	foley - draining ~~Cotton~~ blood tinged urine.
	0930 - 1st bag of PRBC hung. T-98.7. P: 142.
	B/P 132/77. Pt received bag w/ Ø
	c/o more pain, SOB.
	1030. 2ND bag PRBC hung per MD order. T 99.8
	P 117, BP 128/66. Ø c/o SOB - c/o pain in leg and
	scrotal area, cool pack. Repositioned. VS and
	chest to support blanket support. (b)(6)-2
	1215 - Unasyn IV (b)(6)-2 Pharm
	1330 - Axillary temp 99.2 - will monitor. ABD dressing
	reinforced. Central line - CDT's line dry clean
	and changed. 2ND bag of PRBC complete.
	650 mg Tylenol given. (b)(6)-2
1600 -	Initial assessment. Sleepy - responds to tactile stimuli. BS ~~CH~~ - diminished
	Bases, SR-ST 5 ectopy. Peripheral pulses palp x4. Alleviating factors + abdominal
	Lg Abd dsg intact - Ostomy bag over ileal conduit leaking Clear urine -
	very slightly pink - Nephrostomy tube c/d yellow urine. Supra-pubic
	foley catheter draining in tubing - scant amount ? VS to
	HS; minimal drainage. Rt AC IV - clot noted, Rt IJ condition
	LEVEL. Both sites w.n.l. A) Stable post op - P) Cont to
	Monitor. MSO4 IV for pain (b)(6)-2
1815	5 mg MSO4 IVP for c/o pain (b)(6)-2
2200	4 mg MSO4 IVP for Pain. Unchanged throughout shift. Ambulate. Leg
	pain MSO4 for pain. Drainage from foley, Urostomy + Nephrostomy
	c/d clear urine. Supra-pubic cath putting out Red drainage.
	VSS, but tachy - D. (b)(6)-2 Haines. P) Cont to Monitor.
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT	ING ORGANIZATION (Sign each entry)
10 May 03 2335	Report received verbal consent pt intubated today Propofol d/c'd alert x3 Intermittent c/o moderate to severe pain will continue to monitor	(b)(6)-2 KCT/AN
11 May	Pt c/o severe pain pt intubated Received 4mg of MSO4 and Vomited 5mg. Pain relieved will continue to monitor	(b)(6)-2 KCT/AN
11 MAY 03	Urol POD #2 ileal loop-ect Pt doing well - pain controlled O: lungs - CTA, THR, THR abd - wounds clean - pelvic & serous drainage. O2 support BS, good sounds Hct 31, good UO A/P: Pt Urinary in 3rd space fluid, D/C IVF, transfer to PACU	(b)(6)-2
	Pt premedicated w/ 5mg MSO4 for dressing change. Tolerated procedure well. Cortis in RIJ w/ CVP @ 14cm. NG Tube LIS - draining dark green liquid. Nephrectomy - draining 50cc. Suprapubic Foley - draining blood tinged urine.	(b)(6)-2 9mm

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

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(b)(6)-4

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

MEDCOM - 5689

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 May 05 2300	assumed care of pt. Noted all drains & Tubes (see intake flow sheet). Foley cord (R) IJ. ~~To~~ LR @ 75 cc NG TUBE to LIS. Red. ROBIN to (R) side draining into bag. Reinforced DSG to ABD. Foley cath. & slack taped to (R) thigh. Supra pubic intact. Drainage Bloody Minimal amounts. JP to Bulb suction (L) side holding suction. Sero sang Out. (L) Nephrostomy intact. CYU out. moved pt. up in bed elevated heals to prev breakdown. VSS Afebrile. LS CTA ↓ sounds in lower lobes. IS x 10. pt - teacher barier, language, pt. did best he could. ARMS FA, has edema (B). had pt. do ARM raises x 5 and reaches x 5. encouraged movement c arms & hands. Scrotal edema, testicals elevated & Supported c gauze. ORAL hygiene conducted c pt. Bs (+) RUQ only. pt had request Bed pan for BM c ∅ results. 2330 pt c/o pain 5mg MSO4 given. pt. resting. 0030 - pt. awoke agitated moving hands and arms 5mg Valium given pt. calmed and eventually fell to sleep VSS. 0210 - pt. WAKES c/o pain 4mg MSO4 given pt. fell back to sleep. 0440 - pt. awoke agitated. touching DSGs pt. signals like he wants to void in urinal explained tube is in penis pt. gestured confirming understanding - (b)(6)-2 given

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(b)(6)-4

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

MEDCOM - 5690

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 May 03	0445 - (cont.) pt. trying to sit up in bed. pt. request morphine @ s/sx of pain. pt. displays increased levels of agitation 5mg Valium given. Pt. calm and sleeping now. [redacted] (b)(6)-2 9 IVMB20.
	0650 - Δ Bedding. Hygene. Care complete. Ø[ed] all fluids. up on (R) side 5mg MSO4 given for pain instructed to rotate extrimities X4. Reinforced ABD DSG. VSS 98.7 AX. Ø730 - CORDIS (R) IJ WITH CVP 20 cc/HR, RED ROBIN (R) SIDE, SUPRA PUBIC AND FOLEY TO GRAVITY, JP (L) SIDE TO BULB SUCTION, (L) NEPHROSTOMY INTACT, LUNG SOUNDS DECREASED IN LOWER LOBES, SCROTUM ELEVATED DIT SCROTAL EDEMA, PT. SLEEPING AT PRESENT TIME. SGT [redacted] (b)(6)-2 9 IVMG
12 MAY 03	Urology POD #3 - Half skin edge separation from pelvic wound - bed @ 2000 cc - ØBM O: awk mild tachy, good BP, good vs Heart Lungs: CTAB, abd - wound S/I open, no drainage bleeding at this time (+) hyperactive BS - erupted unofficial to mild macro A/P: Doing well - Pantos feels no need for Rx at this time [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 5691

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EDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12MAY03	0830 - DR IRRIGATED RED ROBIN TUBE FROM UROSTOMY WITH N.S. - RETURN URINE WITH PUS, 450cc OUTPUT FROM UROSTOMY AT THIS TIME. 0845 - 40cc OUTPUT FROM JP, BLOODY DISCHARGE FROM ABD. INCISION - DR. DID DRESSING CHANGE AND AT.S LINEN CHANGED. SGT [(b)(6)-2] 9/WMC 0945 - ABD. DRESSING REINFORCED AND SCROTAL EDEMA INCREASED FROM YESTERDAY. SG [(b)(6)-2] 9/WMC 1245 - 325 cc OUTPUT FROM UROSTOMY AND 35cc JP OUTPUT. T. 99.2 RN NOTIFIED AND 650mg TYLENOL GIVEN. SGT [(b)(6)-2] 9/WMC 1400 - 300cc CLEAR YELLOW URINE OUTPUT FROM NEPHROSTOMY. SGT [(b)(6)-2] 9/WMC 1415 - 30cc OUTPUT FROM JP AND 200cc OUTPUT FROM UROSTOMY. SGT [(b)(6)-2] 9/WMC 1500 - 650cc GREENISH OUTPUT FROM NG. SGT [(b)(6)-2] 9/WMC
1604	report received from outgoing staff; pt. care assumed. [(b)(6)-2] 9/WMC
1605	pt. c/o pain given 1mg MSO4 [(b)(6)-2] 9/WMC
1747	pt c/o pain given 1mg MSO4 [(b)(6)-2] 9/WMC
1929	pt c/o pain given 1mg MSO4 [(b)(6)-2] 9/WMC
2000	pt. resting, no c/o pain [(b)(6)-2] 9/WMC
2237	WTD dsg & on back wound, previous bandage had greenish drainage on it. changed burn pad and chux under pt. no other changes in pt. condition or assessment. pt c/o pain. Given

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

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

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

[(b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 5-87)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.102-4

MEDCOM - 5692

5mg MSO4 IV. (b)(6)-2 given to
2240. 80 cc drainage from JP. Hoarding drainage from NG tube unable to measure ileostomy drainage due to leakage of bag. ~~stopped pump~~ 70cc out nephrostom
(b)(6)-2 given to

2300. received report. assumed care of pt. pt. sleep ø s/sx of distress or discomfort. 0030. Meds given pt. wakes c/o pain 5mg MSO4 given. Shift pt. in bed 98.4. T covered c blanket reinforced. DSG to ABD. LS CTA. ⊕ BS (L) QUAD ø BM. 110cc Water in 100 cc out NG TUBE. rotated ankles and legs. streached arms. VSS 98%. SpO2 curtains closed (R) IJ. patient to fluids LR@70cc/hr. (L) nephrostomy 80 cc c/u output. Supra pubic Foley 60 cc serosang output. JP 80cc serosang output. Foley cath 5cc bloody output. Red ROBIN 425cc out put. C/U. 0200 - T: 99.0 removed 1 blanket. 979. then reassessed.
(b)(6)-2 given to

0730: Nt report received. pt in bed in semi fowlers position. C/O pain requesting MSO4. Seen IVP given ordered c position (& pain). VSS. draining to midline intact. Will change c MD. (R) Ureatory drainage clear urine. (L) Ureatal tube draining clear urine. Supra pubic & Foley draining blood tinged urine/blood. Pt c Hct 21.9 Hgb 7.1 - MD notified. ↑ bilateral flank edema. MD aware continue to monitor. Skin breakdown ~~done~~ noted @ (R) heel. (R) & (L) ~~heel~~ foot. Consult PT for up to chair (b)(6)-2 MMT/n

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EDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13 MAY 03	POD #4 – [illegible] S: adequate pain mgt, asking for food. O: Lungs – CTAB abd – wound granulating, cont mild oozing of blood in pelvis – good BS, stoma good. Hct [illegible] down [illegible] less tachy than assessed & is mobilizing 3rd spacing fluid. A/P: Doing well, will start clear liq today due to poor nutrition & no TPN – D/C prot – follow Hct – Anticipate AE to mgt several days.

(b)(3)-1

(b)(6)-2

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
IENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD NO.

(b)(6)-4

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

MEDCOM - 5694

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MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13MAY03 1445 hrs. pt Note	pnt POD #4. POM exs performed to (B) LEs. pnt sup ⇔ sit at EOB max (A) x 2 c tubes (B)s/etc. pnt sat EOB x 4 min w/c c c. pnt able to ambulate. pnt pnt BFB. (b)(6)-2 MTC CPT SP
13MAY03 @ 1600	Pt VSS, Afebrile. AOx3 PERRLE 2mm EOMI, MAE. WDWN EXTREMITIES UNABLE TO BEAR WEIGHT S ASSIST. ↑ OOB c PT @ 15⁰⁰. LUNGS BILAT CTAE DIMINISHED BASES Sat 100% RA. (+) BS x4 (+) FLATUS ⊖ Nsg BM @ THIS TIME. SP DRAIN x Ileoconduit intact draining SEROSANGUINOUS FLUID - (P) UROSTOMY DRAINING CLEAR YELLOW URINE. (D) JP draining SEROSANGUINOUS FLUID. MIDLINE ABD INCISION DSG D/I SATURATION. WORLIE ROLL USED WT-BEARING. (+) PERIPHERAL PULSES x4 SCROTAL EDEMA RESOLVED STILL HAS DEPENDENT EDEMA BILAT LE x SOME EDEMA IN FOREARMS - TOL PO WELL @ C/O N/V/D. PT PALE & HAS 3 BLANKETS ON FOR WARMTH. PT LAST H/H 7.1/21.9 @ 0605 13MAY03. WILL CONTINUE TO MONITOR FOR BLEEDING. PT HAS NO PAIN @ THIS TIME & IS SLEEPING S AID OF MEDICATION. WILL CONTINUE TO MONITOR VS/FOLEY/ PAIN/ BLEEDING (b)(6)-2 CPT,AT
2300	received report. assumed care of pt. pt. sleeping. @ s/sx of distress or discomfort. VSS. (R) red robin draining CYU. ABDO DSG CDI foley cath @ slack taped to (L) leg scrotum elevated on (b)(6)-2 9 w/m/62 chuck

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

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

MEDCOM - 5695

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2300	-(cont) (L) Nephrostomie tube CYU out. suprapubic tube serosang out Pot. Some blood clots JP drain serosang out. more clear tonight. 0030- meds given p.t. awoke c/o pain 5mg MSO4 given IV. Cortis Cord (R) FT CDI. patent to fluids LS CTA x5 lobes BS(+) pt. able to move extremities x4 c c/o pain in legs T 98.1 0245: pt. woke c/o pain 5mg MSO4 given Δ(ED) RED ROBIN bag because of leak. Reinforced ABD DSG. 5mg MSO4 given upon completion. pt. sleep after IS x10 SpO2 > 97-98%. 0620- All fluids zeroed. AM meds given pt woke c/o pain 5mg MSO4. Suprapubic tube has bloody drainage. Red Robin ø output since DSG Δ. (L) Nephrostomy 925 out CYU. JP 280 total pt VSS afebrile - will continue to Monitor. (b)(6)-2 q1w mbz
14 MAY 05	Urol POD #5 S: tol clears, sat in chair yesterday O: amb mild tachy. 120/70, good UO lungs: CTAB abd: good BS, wound granulating Hct 31 A/P: Doing well, cont to mobilize/ambulate, transfer d/c Hct 7/05 regular diet, cardiopulm clearance to (b)(3)-1 tomorrow

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVIC (b)(6)-2

SPONSOR'S NAME | SSN/ID NO.

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

#423

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

MEDCOM - 5696

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 MAY 03	pvt supine iw bid c dressings to abdomen/chest/arm.
1430 hrs	supine → sit max (A) x 2. sat at EOB ~2 min c/o dizziness. pvt put BTB. (b)(6)-2 MP, CHS

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

PATIENT'S IDENTIFICATION: (For type or ~ ~ entries, give: Name - hat. 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) 201-8.202.1

MEDCOM - 5697

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
1100 14 May.	Pt received this a.m. S/P from 13 May 03. MD rounds done. abdominal wound dry changed noted pink granulating tissue & small amount of bleeding HLH 6.9 121.1. Pt to receive 2u PRBC each once 2h Post transfusion CBC @ 1900. Per MD D/C cum CBC. Pt started on percent TI q 4hr per pain & tolerated reg diet today. Colace p.o B.i.d. IV LR @ KVO. Pt for possible transfer.
14 May 03 @ 1600	RECEIVED PT. VSS. AFebrile. NO Δ's TO PRIOR ASSESSMENT. PT ASSD DSG SATURATED & SOILED SANG. FLUID + Δ'ED. 5mg VERSED & 5mg MSO4 GIVEN FOR PAIN. PT CRYING OUTLOUD @ TIME OF DSG Δ UNTIL VERSED WAS GIVEN. WILL CONTINUE TO MONITOR FOR Δ's IN PT STATUS/RSI ASSD. (b)(6)-2
14 May 03 @ 1800	PT TOL PO WELL @ BSRM. NO C/O N/V/D. LUNGS BCTA. AFEBRILE MAE EQUAL PURPLE 2mm. WOUND NOT ABLE TO FEED SELF. C/O PAIN GIVEN 5mg MSO4 & RELIEF (b)(6)-2 CRIT
14 May 03 @ 1900	H/H 9.6/28.2 POST CRIT (b)(6)-2
14 May 2030	PT AAOX3. C/O HA/pain. VSS; BBS CTA; DSG dry & intact; had changed under ileal conduit bag. 2° leaking; Urine = cl. yellow urine; Sequa pump & foley cath'd = scant red drainage. IV-Cordis @ RT IJ - intact patent. RL TKO. A-Stable ass'g. P) Maintain. Recs ctd for pain. (b)(6)-2 (b)(6)-2

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

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

(b)(6)-4

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

MEDCOM - 5698

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 NOV 03	Under POD# 6 – ileal loop – bowel rest – Urology – pelvic – Bladder mech closure S: pain stable, tol reg diet well now on oral pain meds. O: stable mild tachy lungs: CTAB abd: wound granulating good BS strong pink-tan mucus. Hct → pending good UO A/P: Doing well Hct pnd to transfer switch to PO Abx

(b)(6)-2

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9 202-1

MEDCOM - 5699

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0250 –	Pt awake to pain - given 2 pcns cet PO. (b)(6)-2
0400 –	Pt awake & screaming – Unplugged Jr tubing from cath's. Tubing re-connected - flushed Bed Pads changed Dressing around supra-pubic catheter saturated - reinforced. Versed 5 mg IVP given (b)(6)-2 (b)(6)-2
0600 –	All Incontinent & PS crying in pain upon awakening. 2 pcns cet po given. JP drain cont & 1g Amt Sero-Sang. drng. Pens appears more edematous & Pt Pulling at foley. Morning leg. Hgb 12, VSS. (b)(6)-2 mat

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

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

(b)(6)-4

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

MEDCOM - 5700

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 MAY 03 @ 1500	A+O x3 PERRL @ 2mm EOMI MAE LUNGS BILAT CTA. S1 S2 (+) PERIPHERAL PULSES x4 (+) 2 EDEMA BILAT LE. Ø JVD HOB @ 30° (+) BS x4 Ø BM MIDLINE ABD INCISION DSG CDI. (+) JP ō SEROS FLUID (+) NEPHROSTOMY - CYU. JP SEROSANG FLUID FOLEY BLOODY ILEO CONDUIT CYU. PT dx PAIN + GIVEN PO PERCOCET. VSS, AFebrile WILL CONTINUE TO MONITOR FOR Δ's IN VS/PAIN [redacted] CPT A
15 MAY 03 1815	(+) IJ PATENT + FLUSHES EASILY Ø S/S INFECTION OR INFILTRATION [redacted] CPT A
15 MAY 03 @ 1900	PT ↑ AGITATION AND dx PAIN. PT GIVEN 5mg VALIUM HR 120 BP 155/88 PT STILL AGITATED + YELLING. PT GIVEN PO PERCOCET FOR PAIN. [redacted] CPT A
15 MAY 03 2300	PT HAD 2 ADDITIONAL EPISODES OF ↑ AGITATION ō YELLING + REQUEST FOR MSIV. PT WAS INSTRUCTED HE COULD RECEIVE PERCOCET ONLY FOR PAIN + ACES. RECEIVED 5mg VALIUM ō EACH INCIDENT FOR AGITATION. PT IS SLEEPING COMFORTABLY SINCE 2030 @ THIS TIME. NO S/S OF AGITATION VSS, Afebrile [redacted] CPT A
16 May 0345	- PT Agitated + Restless immediately after change of Shift. Appears to want foley taken out - informed must stay in. Next dose of Percocet given. BBS CTA. Sinus RR/Sinus tach - Bowel sounds present + Irr - cardiac to VCT IV, intact. RLE TKA. Lt Nephrostomy tube ō cl-yell. urine. Rt ileal conduit ō cl-yell urine in drainage device. Supra-pubic Cath ō red drainage; foley ō scant amt Red drainage. Periph pulses palp all 4 extr. ↓ edema from yest. Pen & legs swollen. Heels ō Pressure areas - Blanket under calves to keep heels off bed. A-Stable - but ō ? pain issues. 1) Percocet + Valium for pain/sedation. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 5701

USAPA V1.00

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 MAY 03 0700	Received report on patient. ——— (b)(6)-2 LT, AN
15 MAY 03 1000	Patient alert/oriented, pupils 3-4mm reactive; understands simple commands - responds appropriately. SB-NSR @ HR 90-110, BP 120-130's/60-70's; 2+ pulses x 4 @ ⊕ capillary refill. Generalized edema to upper/lower extremities; scrotal edema which has increased over last 2 days - supported @ chux. ⊕ JP cordis patent. ~~The~~ Pm Abdominal dressing changed by physician and urostomy tube flushed. Patient @ hyperactive BS x 4 quads; ⊕ BM @ this time. ⊕ Nephrostomy tube @ 20ml of CVU; SP cath @ 410ml of blood tinged urine; foley to gravity @ 410ml of urine; urostomy @ 1400ml of CVU. Patient medicated @ 10mg MSO4 prior to dressing change @ good effect. Interpreter explained to patient that he was being transferred to another medical facility today or tomorrow and that he would only receive MSO4 as premedication for disp II, pt verbalized understanding. (b)(6)-2 MP
15 MAY 03 1245	Patient @ increased agitation and demand for MSO4. Med translator explain to patient pain that he would no longer be receiving MSO4 for pain control. Patient @ episodes of yelling and screaming for MSO4 @ emesis x 1. Administered 5mg versed. Patient now sleeping. Will continue to monitor (b)(6)-2 MP

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

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

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

MEDCOM - 5702

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 May 0400	Pt awake again agitated - given 2 percocet PO. Very difficult to calm down. Screaming + Yelling — threw all blankets off bed.
0515	finally calmed down. Resting quietly. — (b)(6)-2 RN
0730 16 May	Patient alert / oriented WNS and appropriate. ST & HR 101-110, BP 120's/70-80's. Hyperactive bowel sounds x 4 & BM (soft brown and formed) x 1. ~~Voided~~ Emptied 200ml of CHU from (A) Nephrostomy tube; 10ml of bloody drainage from foley cath. (B) abdominal JP and urostomy pigtail removed by physician. Patient still awaiting transfer to 28th CSH. Will continue to monitor. — (b)(6)-2 RN, BSN
16 May 03 1300	Patient had BMX2; soft-formed brown stool & complication. JP site dressing d/d due to increased bloody drainage. Currently CDI. Will continue to monitor. (b)(6)-2 LT, AN
16 May 03 1530	Report received / initial assessment complete no Hx of SOB, pain intermittent, pt. on clear d/t possible withdrawals from MSO4 will continue to monitor. (b)(6)-2 LT, AN
16 May 1930	Pt. prepare for transport to Landstuhl will get 5mg Valium or 5mg Versed. (b)(6)-2 1257 AN
16 May	Pt. has occasional loud outburst possible MSO4 withdrawal Pt. has ~~tattoo~~ AKO pain reads "SUICIDE BOMBER" (b)(6)-2 RN

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

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

REGISTER NO

WARD NO

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV 6 97)
Prescribed by GSA/ICMR
FIRMR 41 CFR 201-8.202-1
USAPA V2.00

MEDCOM - 5703

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 May 2200	Pt is no longer scheduled for d/c ed. Pt had been turned & boxed during K'ed. Has occasional periods of loud out burst. Will continue to monitor. [redacted] LPT/ANJ LPT/ANJ
2230	BM x 1 during shift. [redacted]
17 May 0130	Pt awakened - c/o Pain - Assessment: oriented x3. Resp full + regular; BPs CTA, $S_1 S_2$. Periph pulses palpable x4 extr. Abd ↓ bs x4 quad - Dark red drainage - Urine-soaked - ↓ Nephrostomy ↓ d. Yellow drainage, Foley - scant amt Red drainage. J-P drain ↓ bs x4 amt serosanguinous drainage emptied. Rt side Fecal ostomy - ostomy appliance loose - [redacted] 475cc emptied. Bed + pads urine-soaked - changed. ↓ Re-padded IV - RL TKO to Rt IJ Cordis, patent - A) - stable. Pt given Versed 5mg IVP + Percocet 2 PO for pain + Ay [redacted] mg
0415	Pt awakens - calm - dark red effluent into ileopp apparatus. Hx of Abd pain stating he want to defecate. Placed on commode. Did not pass gas or stool. BM. Returned to bed. Given 5mg [redacted] mg
0530	Versed for sedation. [redacted] Pt resting quietly - all lines/devices explained. [redacted] [redacted]
17 MAY 03	Shift Note #8 S: Having bladder spasms, otherwise tol PO & doing well. Ostomy appliance leaks despite multiple manipulations. O: abd: wound granulating, ostomy pink & drain clear, urine. A/P: Doing well add dexpan for bladder spasms, awaiting transfer. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 5704

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18MAY03	Urology POD #9 S: pt very Rational, have BM, eating well O: VSS, AF abd: wound granulating but evidence of pseudomonas in open would. A/P: D/c'ed central line, start 1/4 strength Dakins dressing BID awaiting PE.

(b)(6)-2

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
IENT'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 660 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 5705

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DICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 MAY 03	Urology POD #7 - S/P ileal loop - (R) nephrectomy - evacuation pelvic hematoma - closure bladder neck laceration S: pt agitated - suspect MSO4 withdrawal also pain bladder spasms O: cat mild tach, AF Hct 31.9 abd: stoma good, soft, clear UO pulled loop Red rubber and SP tube today - A/P: Skin suture D/C - Spoke to Dr (b)(6)-2 - Urology 28th yesterday and denies CVA - Add Detrol XL & atarax prn.

(b)(6)-2

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
NSOR'S NAME	SSN/ID NO. --	RELATIONSHIP TO SPONSOR	
IENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 5706

DICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0945	PT had ~~63~~ 3 bouts of agitation throughout day. Thought to be attributed to bladder spasms. OOB to BSC @1100 - remain OOB for an hour. Reinforced abd dressing b/c blood draining from wound. Add'l dressing on back. 1430 - when doing dressing change - Desitin applied where skin irritated. (b)(6)-2
17 May 05 1500	Assumed care - Assessment completed - Lungs CTA - Pt whines during inhalation - foley - dd dilaudid 1mg - ~~ssd~~ → Synapadin Qhs - intact - sympathetic - 2 done dilaudid (1) Nephrostomy tube draining clear urine - foley intact - Red Rubber drainage tube from suprapubic cystotomy - (2) multivitamin 2 tabs Valium 5mg po per DO. (3) Colace - 2 CAPS PO
17 May 05 1715	1/2 Ativan po - Pt wants to get up & walk - advised pt he will walk w PT - due to WBC - Weakness (b)(6)-2 Pt asks for water - passed with ice chips - ~~X~~ Cool himself off - (b)(6)-2 CCU not working on one end (b)(6)-2
1800	Adm 2 TM percent for c/o pain -
2100	Serves sheet, 5mg Valium po per DO given, suction & pain, Ambulate by A'd w/ O + Dester, placed Medicine on (1) Hyp — start of Dressing. Placed new Kerlix over Abd wound + taped — (b)(6)-2

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(b)(6)-1

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

MEDCOM - 5707

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 MAY 2400	PT AOX3, RESTING IN BED POSITIONED ON (L) SIDE. NO C/O PAIN. VSS, AFEBRILE. PERRL, LUNGS CTA, SPO2 ≥ 98% ON RA. CARDIAC RRR, ACTIVE BS IN ALL QUADS, ABD TENDER TO TOUCH, NON DISTENDED. ABD DRESSING C/D/I. JP TO BULB SUCTION DRAINING SEROUS DRAINAGE. (R) ICONDUIT DRAINING CYU TO GRAVITY INTO COLOSTOMY BAG. FOLEY TO GRAVITY. RESOLVING SCROTAL EDEMA, ELEVATED & TOWL. HEELS OFF BED & TAWL, TOLERATING PASSIVE ROM. PALPABLE PEDAL PULSES EQUAL BILAT. PT HAD ONE EPISODE OF EMESIS AFTER DRINKING 2 CUPS OF TEA. NO FUTHER C/O N/V. TOLERATING SIPS/CHIPS WELL. (R) CENTRAL LINE FLUSHED AND LR INFUSING @ TKO. WILL CONT TO MONITOR. THE PT THROUGHOUT THE NIGHT. [redacted] ILT/AN.
0300	PT AOX3 CONSUMED ORAL FLUIDS, NO C/O OF N/V. COMPLAINT OF PAIN, ADMIN ×1 PERCOCET. [redacted] ILT/AN
0400	PT SLEEPING IN BED & NO C/O PAIN. VSS. [redacted] ILT/AN
0600	NO ESSENTIAL Δ's FROM PREVIOUS ASSESMENT. LINEN Δ'd. PT DRANK MORE WATER, REFUSED AM CARE. [redacted] ILT/AN.
0700	Received report on pt. Pt resting in bed & c/o pain. [redacted] 9/UMG
	0815 - Pt Lung sounds clear bilaterally - bases slightly diminished. Dsg has blood at bottom. feet slightly swollen, +1 Pulses @ lower extremities. Ø c/o pain. will Continue to monitor. [redacted] 9/UMG

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

MEDCOM - 5708

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DICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 MAY 03 0800	Dressing d'd by MD. Pt premedicated w/ 5mg Versed. Wound had white pus around the tissue & foul odor. MD dc'd Cortis and all IV orders. Pt very agitated during procedure
1050	- PT had episode of emesis x1. 200 cc of fluid/food. 12.5 phenergan given. Pt given sips of water when he asked for water. Tolerated sips. [redacted] Gaume
1215	- Pt OOB to BSC - no BM - Pt ambulated w/ assistance in ward. C/o pain during ambulation. Tolerated more water + juice with 0 c/o N/V. [redacted] Gaume
1440	- Pt resting in bed. No significant A since am assessment. All drains emptied. [redacted] Gaume
18 MAY 03 Q 1500	RECIEVED REPORT @ 1445 - PT VSS, AFEBRILE. PT SLEEPY BUT AROUSEABLE ORIENTED x3, EOMI, PERRL @ 3MM MAE. LUNGS BCTA @ 65x4, TOL PO WELL NO ↓ NVID @ THIS TIME. MIDLINE INCISION SITE DSG CDI. @ NEPHROSTOMY DRAINING CLR TO GRAVITY DRAIN. @ JP TO BULB SUCTION & SANG. FLUID. FOLEY @ OUTPT. @ ILEO CONDUIT SITE CLR TO GRAVITY DRAIN. CORDS SITE DSG CDI. @ PEDIHERAL PULSES x4 @ SCROTAL EDEMA BLE @ 1 EDEMA @ JUD HOB @ 30°. WILL CONTINUE TO MONITOR PT FOR A'S INVS/ @ c/o PAIN, PT SLEEPING / BLEEDING [redacted] CPT, AN

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

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

MEDCOM - 5709

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD

CHRONOLOGICAL RECORD OF EDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 May 03 2000	PT TO COMMODE C LARGE BM, WELL FORMED STOOL. PT AMBULATED FROM BED TO END OF WARD AND BACK C ASSIST FROM 2 STAFF. GAIT UNSTEADY + PT WEAK BUT PT STATED VIA INTERPRETER THAT HE FELT "GOOD" IN REGARDS TO WALKING. PT TOL PO INTAKE ↑ 30% OF HUMANITARIAN MEAL. NO c/o PAIN @ THIS TIME, SLIGHT PAIN (ABDOMINAL INCISION SITE) C AMBULATION BUT NO REQUEST FOR PAIN MEDS. (b)(6)-2 MK
2300	- received report. assumed care. LS CTA. (+) BS x 4 quads. (+) BM in shorts. changed and cleaned pt. Rolled to (L) side pt. able to move extremities x 4. pain when moving (L) leg. Ø c/o pain at this time. 0400- pt. (R) ~~foley~~ DRAIN leaked on to chuck unmeasurable amount. Pt. rolled back onto back pt. sleeping well. 0600- AM meds given. Ø c/o pain. MID-line INCISION DSG CDI. Foley taped to left leg Ø output. (b)(6)-2 9/WME.

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

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

IENT'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. 8-85)
PRESCRIBED BY DA/AFMD
FPCN 0100-00-L-5600

MEDCOM - 5710

MEDICAL RECORD | **PROGRESS NOTES**

DATE 21MAY03

TRANSFER NOTE

Pt s/p MVC c GSW through pelvis. Had right ureteral injury and life threatening pelvic hematoma and hematuria. Was initially treated with observation of distal ureteral injury complex and pubectomy and partial urinary diversion from bilateral pelvic nephrostomy tubes. - Done on Comfort. Pt then transferred to [redacted] (b)(3)-1 with infected & draining massive pelvic hematoma and continued life threatening hematuria, also developed severe bleeding from (R) nephrostomy and required urgent (R) nephrectomy, ileal loop diversion, evacuation of pelvic hematoma and repair of a large Bladder neck laceration, the inferior portion of the wound was unable to be closed. DOS = 09MAY03. Wound left open to granulate in and Plastic Surgery felt this was

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

MEDCOM - 5711

PROGRESS NOTES

DATE

Best option and no stops were indicated. Pt has recovered but is in a weakened nutritional state & poo PO intake available. He is taking PO & will occas have emesis if eats large volume of food. He has developed a drug seeking behavior. He bladder spasms are under control with Detrospan.

NEEDED INTERVENTIONS:

- Nephrostogram & stent removal on POD #14
- drain removal POD #15
- Foley removal
- Continued wound care
- PT and nutritional support.

(b)(6)-2

MD, MC, USA

URO Surg.

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

1 Jan 08 Cipro PO D#10

S: has developed some nausea & diarrhea otherwise doing well

O: VSS AF

abd: wound granulating - seems to be responding to DAKINS

JP creatinine = elevated

A/P: 1) Post AGE - if becomes dehydrated will restart IVF - stop Cipro

2) plan AE, if still neg on POD #14 then nephrostogram for urine.

[redacted]

0830 - Dressing d'd by MD. Pt premedicated w/ 10mg Valium IM (L) Deltoid. Wound had white patches and slight foul odor. MD used Dakins solution on upper portion. Pt tolerated procedure w/ slight agitation. Ate 25% of breakfast. Ø c/o N/V. [redacted] qwomb

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)

[redacted] | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

MEDCOM - 5713

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
19 MAY 1405	PT OOB + ambulated w crutches + assistance on the ward. PT/OT assisted pt back to bed. Drains emptied. No significant Δs since the assessment this am. (b)(6)-2
19 May 03 1505	Pt A+O x 3, PERRLA 2mm, EOMI, MAE, Lungs B CTA, S1S2, Cap Refill <2sec (R) IJ Edema BLE (R) Peripheral Pulses x 4 @ 65 + 4 Tol PO well & c/o NVID (L) Ureostomy draining cyu (R) Ileoconduit draining cyu (R) SP draining ~~serosan~~ sanguinous & slightly blood tinged urine. Foley to gravity drain bloody drainage scant. No c/o pain @ this time. VSS, Afebrile (N)ill continue to monitor pt for Δs in vs/pain Midline Abd Dsg CDI (b)(6)-2 CPT, A
19 MAY 03 2000	Pt woke up from dreaming this evening + told the interpreter that an angel came to him and told him to "eat rice before you die". Pt was crying and moaning aloud. Pt given Ativan and was able to calm down. Pt requested to eat rice + lentils which the interpreter brought to the bed side. Pt tol ~ 7 cups of rice & c/o NVID or distension. (b)(6)-2 CPT, AN
19 MAY 03 2100	Mid Abd upper Dsg A'ED. Dsg saturated & yellow sanguinous fluid no odor, Lower back Dsg A'ED Dsg saturated & sanguinous fluid & odor. (b)(6)-2 CPT AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART /SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO	WARD NO.	

(b)(6)-4

Medcom 5714

PROGRESS NOTES
Medical Record

STANDARD FORM **509** (REV 5-99)
Prescribed by GSA/ICMR **FPMR** (41 CFR) 101-11.203(b)(10)

DATE | NOTES

20 May 2200 - received report pt. sleeping ø s/sx of distress or discomfort. T: 99.4 Δ Bedding due to ILEAC CONDUIT LEAK measurable amount. Bag changed. Pt. up to chair tol well. Midline incision CDI DSG. ø c/o pain. pt. slept well through out night. pt. rolled to (L) side & (R) side on own. AM dose meds given VSS T. 99 LS CTA, (+) BS. move extremities x4 ē c/o pain to (R) leg ø sig. changes this shift. ILEAC CONDUIT - INTACT SEE OUT PUT FLOW Sheet. —— [redacted] 91WM6

0745 - Premedicated pt w/ 5mg IM of Valium. Adjusted dose because pt received 5mg @ 0600. Resting comfortably in bed. ø c/o pain. will monitor. [redacted] 91WM6

0830 - Dressing changed by MD. white patches through top 2/3 of wound. MD advised to use Dakins to areas with white patches. Pt was agitated through the procedure. [redacted] 91WM6

1450 Pt had BMx2 - 1st - formed stool - 2nd episode small amount of formed stool - Pt had an episode of diarrhea in shorts before going to BSC.

20 May 05 RSW Assumed care. Assessment Completed - Client awake and alert to self, situation, and place. Small amount of clear yellow drainage noted on dressing. Foley intact - client is voiding adequate amounts of clear yellow urine. Bowel sounds active in all four quadrants. Client denies pain at this time. Will continue to monitor. [redacted]

MEDCOM - 5715

DATE	NOTES
20 MAY/03	(1800) Recieved pt from ICU2. Pt transfered to bed. HOB↑ 30° pr orders. Pt awake
HR 85	alert. Talking to other pt's in Arabic. VSS. Midline ~~dressing~~ dressing intact
Sats 100% RA	& drainage noted. (P) urostomy draining Clear yellow urine. (L) SPC
BP 108/77	serang. drainage ~25cc. (R) conduit ~~stoma~~ intact ~~stoma~~ pink. Foley in place & min bloody
T. 98.9 oral	drainage. Lungs CTA bilat. Anasarca. HR reg. (+)S1S2 (+) PPx4.
~~20 may~~	CTR Dressi. [(b)(6)-2]
1945	Pt complaint of pain. frequently asking for different things, percept: ativan given. Pt had a lg BM, Bath given, bottle placed on sacrum Stage III ulcer, bleeding noted on cuff from lower ABD wound [(b)(6)-2] msm
~~20 may~~	
2000	VS BP 118/72 HR 86 O2SAT 100% T 95.3 ~~F~~ C additional blankets placed on pt. Pt out of room 25 mins, temp was taken & pt was placed back on bed [(b)(6)-2] msm
2110	Pt awake. C/O of pain, gen weakness. noted BS CTA, & cough, OR on RA WNL, S.S2 RR, & edema PPP x4 strong. ABD incisional wound 2cm ~~width~~ width. & extended in lower ABD lg open cavity noted DSG Δ done per D.O. bloody fluid & open cavity edges granulating. pt expressed pain & DSG Δ. Conduit draining CL yellow urine, 22F foley draining CL amber urine. JP draining serous fluid & urostomy & output. & BM, diarrhea noted, [(b)(6)-2] msm
2230	DSG Δ done, & assistance of ICU staff 1 1/4 pillow sets used ↑ wound. NS & wound WSD. dsg [(b)(6)-2]

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

20 MAY 08 Unstable POD #1

S: no fever/chills, pain well controlled on PO

O: VSS afeb

abd: wound granulating, staples & clean wound vac

A/P: doing well, plan negative to 125 on POD #14 if no leak then pull staples

cont BID wet-dry dressing changes c 1/4 strength Dakins to colonized portion of wound.

[(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; in No or SSN; Sex; Date of Birth; Rank/Grade)

[(b)(6)-4]

REGISTER NO. | WARD NO'

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101.11 203(b)(10)

MEDCOM - 571 7

DATE	NOTES
21 MAY 1100	out 1300: Urostomy: 800cc, nephrectomy: 100cc: foley: Ø, JP: 30cc
12	oral: 500cc, IVF out 930cc in: 2000cc [redacted] CTA
1200	Pt is A+Ox3, full sensation in all ext. Pain complaints often managed c oral medication c moderate relief. Lungs CTA, O_2 sats >95%, $S_1 S_2$ heard +2 pulses all ext. <3sec cap refill tolerating regular diet +BS all 4 quadrants, abd snd, Ødist. abd dsg Δ this AM wound beefy red, large amount of bloody drainage on bottom part of wound. Urostomy draining large quantities of clear yellow with sediment. Nephrectomy drain small amounts clear yellow fluid. JP drain small amount of thick serous drainage (30cc). foley no drainage present. Skin is cool and dry sacral ulcer dsg C/D/I. No Family present at bedside VSS [redacted]
1200	Pt was up in chair AM care given c mod amt of assistance [redacted]
1600	Pt sat up in chair for 10 minutes and returned back to bed dressing on lower abd wound was reenforced. Dressing had large amount blood drainage. illeostomy bag was replace and destatin applied to excoriated area under wafer. Pt vomitted x1 2000cc of undigested food. Pt was screaming and extremely upset prior to vomitting episode. 60cc out of old ostomy bag [redacted]
1800	out: JP-30cc Nephrectomy drain-600cc, foley-Ø out 1630 in: 1000cc TOTAL (0700-1800) in: 3000cc out: 1560 [redacted] LT, AN

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
2300	I 500cc H2o, Lg emesis; Urine Foley 900cc / Condom 100cc JP 50cc PO 40cc Levo at c Jemy 1 98.8 (b)(6)-2
0200	ORAL INTAKE 500cc H_2O. Urine to foley 20cc / Condom 1300 JP 30 cc. ~~PT~~ released to CSF Breakfast. (b)(6)-2
24 May 0700	127/76, 71, 97.0, 18, 99%
24 MAY 03 0800	Urology POD # 12 S: Episode ~~of~~ emesis after dinner last evening - ate lunch and no emesis today after breakfast. O: VSSAF Abd: wound granulating (per nurse report) - dry and changed dressing yesterday. Incis nearly healed. A/P: Suspect pt overeating & causing emesis - will try smaller meals & snacks. - stop PO Diazepam, start FE 50cc. (b)(6)-2

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

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

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

PROGRESS NOTES
Medical Record

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MEDCOM - 5719

MEDICAL RECORD	PROGRESS NOTES

DATE 21 MAY 03

TRANSFER NOTE

Pt is a (b)(3)-1 GSW through pelvis. Had Right ureteral injury and life threatening pelvic hematoma and hematuria. Was initially treated with overseeing of dorsal venous complex and pubectomy and partial urinary diversion from bilateral perc. nephr. tubes. - Done on Comp. Pt then transferred to (b)(3)-1 with infected & draining massive pelvic hematoma and continued life threatening hematuria, also developed bowel bleeding from (R) nephrostomy and required urgent (R) nephrectomy, ileal loop diversion, evacuation of pelvic hematoma and repair of a large Bladder neck laceration, the inferior portion of the wound was unable to be closed. DOS = 09 MAY 03. Wound left open to granulate in and Plastic Surgery felt this was

(Continue on reverse side)

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

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WARD NO.

(b)(6)-4

PROGRESS NOTES
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MEDCOM - 5720

PROGRESS NOTES

DATE

best option and no stops were indicated. Pt has recovered but is in a weakened nutritional state & goo / IV was available. He is taking PO & will occas have emesis if eats large volume of food. He has developed a drug seeking behavior. He bladder spasms are under control with Detrotan.

NEEDED INTERVENTIONS:

- Nephrostogram & stent removal on POD #14
- drain removal POD #15
- Foley removal
- Continued wound care
- PT and nutritional support.

(b)(6)-2

MD, MC, USA

[illegible]

☆U.S. GPO: 1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5721

PROGRESS NOTES

DATE

22May03 0618 nursing Entry: pt slept throughout night. c/o pain, medicated c IV percocet. Drains: JP put out 240 cc, foley Ø, (L) PCN 50 and ileo conduit 1100. pt back to sleep @ this time. will continue to monitor [b](6)-2 SSG 9W

22May 0700 119/71, 92, 12, 98.9 99%, Pt resting in bed tolerating reg diet OUT: 300 cc = 500 cc ileal conduit IN: PO: 500cc

[b](6)-2 ILTAN

22May03 Urology POD #13

S: still with intermittant emesis passing flatus/stool - minimal amount at this time.

O: USSAP

abd: non-distended, wound granulating c continued sero-sang D/C from open pubis

A/P: Plan cont small vol feeds and nephrotogram tomorrow.

[b](6)-2

22May 1030 Pt is A10x3 full sensation all ext. lungs clear, O2 sats >95%, Ø evidence of labored breathing, 12 pulses all

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S. GPO: 1995-397-405

[b](6)-4

MEDCOM - 5722

MEDICAL RECORD | **PROGRESS NOTES**

DATE

ext. 33 sec cap refill tolerating regular diet
ØNausea or vomiting episode BS all 4 quadrants
Pt is passing gas. Abdominal wound clean by Dr
Petroski (see note) dsg c/d/i. foley draining nothing,
ileal conduit draining clear yellow fluid c
mucos. JP drain serosanguinous fluid. Nephrostomy not draining
clear yellow liquid Pt dressed in care, sat in
chair for 4hrs. and ambulated c walker x 1
pain managed w/ percocet and ativan c mod relief
w family at bedside [redacted] VT, AN

1230 ileo conduit: 300cc JP: 30cc nephrostomy drain: 100cc
IN: 300cc total: 300+30+100 = 430cc out: 930cc
[redacted] VT, AN

22 May 03
1300 Pt resting in bed. resting after meal. H2O. Tol well ØN/V.
T. 99.3 HR. 95 BP 99/58 RR 18 O2 97% (RA) R/S: lungs CTA bilat
H2O 120cc ØCough. Encouraged use of IS. HR 109 BP 132/85 @ PPX4 @BS x4 @gas.
midline dressing: c/d/i. @ nephrostomy tube c clear yellow urine.
H2O 120cc @JP to bulb suction. @ ileo conduit intact. c yellow fluid + mucous
H2O 100cc Foley ø output. Pt able to MHE x4. Will cont. to monitor. [redacted]
1630 Pt resting, + resting dinner. Tol well. ØN/V. Will cont. to monitor. [redacted]
JP = 10 1900 Pt sleeping. ileo conduit bag leaking. Pt OOB to chair. Pt cleaned
IC = 800. when Ad. in 300 Out 690cc Pt tol well. Will continue to monitor.
N. = 80cc [redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted]

PROGRESS NOTES
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[redacted]

MEDCOM - 5723

MEDICAL RECORD	PROGRESS NOTES
DATE	
	ext. 4.3 SNC Cap refill 3 sec. Ileo conduit draining regular diet ØNausea or vomiting 1 episode. +BS all 4 quadrants Pt is passing gas. abdominal wound change by Dr [redacted] (see note) dsg c/d/I. Foley draining nothing, ileal conduit draining clear yellow fluid c mucos. JP drain serous fluid. Nephrectomy tube draining clear yellow liquid. Pt received NG care, sat in chair for 4 min. and ambulated c walker x 1 pain managed w/ percocet and ativan c mod effect no family at bedside [redacted] (b)(6)-2 LCT, AN
1230	ileo conduit: 300cc, JP: 30cc, nephrectomy drain: 100cc in: 500cc totals since 0700 in: 1000cc out: 930cc
	[redacted] (b)(6)-2 LCT, AN
29 May 03 1300	Pt resting in bed. Resting flat head + H2O. TM well ØN/V. T. 99.3 HR. 95 Sat 99% RA BP 117/67 (85) R 18. Lungs CTA Ø lat
H2O 120cc	Øcough. Encouraged use of IS. NR reg (+)S1 S2 (+)PPx4 (+)BSx4. (+)gas.
	midline dressing CDI. (+) nephrectomy tube c clear yellow urine.
H2O 120cc	(+)JP to bulb suction. (+) ileo conduit intact c yellow fluid + mucous
H2O 100cc	Foley Ø output. Pt aba to MAE x4. Will cont. to monitor [redacted] (b)(6)-2
	1630 Pt resting + eating dinner. TM well ØN/V. Will cont. to monitor [redacted] (b)(6)-2
JP: 10	(1900) Pt sleeping. 1 conduit bag leaking. Pt OOB to chair. Pt cleaned
IC = 800.	linen &d. in: 300 Out 690cc Pt tol well. Will continue to monitor.
N. = 80cc	(Continue on reverse side)

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

REGISTER NO. [redacted] (b)(6)-2

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[redacted] (b)(6)-4

MEDCOM - 5724

DATE	NOTES
Cont	noted @ lower wound site, site reopened & healing edges, ↓ blood noted @ jp Cavity [redacted] MD/A
@ 300 23 May	pt Temp 99.6 @ 1 removed 1/3 wool blankets [redacted] MD/A
23 May 03 @	0100 - Report received, care of pt assumed. Pt currently sleeping. @ distress noted. Will contin to monitor. [redacted] CPT, AN
23 May 03 @	0400 - Pt continues to sleep. Medicated with Percocet at 0315hrs for pain. @ issues noted. Will contin to monitor. [redacted] CPT AN
23 May 03 @	0630 - Emptied 1200 clear yellow urine out of ileal conduit & some leaking around appliance. Pt taken to X-Ray by [redacted] & MP escort. Will continue to monitor. [redacted] CPT AN
23 May 03	Urology POD# 14 S: eating well, @ energy for 7th° continue to have pain & leaking urostomy O: VSS AF abd: wound granulating, non-distended nephrostogram today - @ extravasation at ureteral anastomosis A/P: Removed JP & FT stent today - Clamped Nephrostomy tube - if JP output increased overnight plan to D/C JP and Nephrostomy tube tomorrow [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22 May 83 2200	assumed care of pt. Pt awake, alert, low
	slowly
	demanding this evening. Pt walked from
	bed # 2 to bed # 4 & assistance of 2 to walker
2300	and back to bed #2. Pt assisted back to
	bed & putting in chair 20 mins. BS CTA, Ant post
	O2 sat 100/RM. breathing quiet/unlabored. CV HR 80's
	S1 S2 0 edema; PPP x 4 strong =, cap refill < 3 sec,
	color WNL. GI pt has a heavy appetite. + N/V
	0 BM, last BM . unable to assess BS R/T
	injury GU - L nephrostomy tube draining dk amber
	urine, 22F Foley 0 drainage, dried blood noted
	in collection bag. L flank pt on admission
	noted; dual crotch maxi-med @ 1 stain
	amber mucus/urine. Pt has gen weakness.
	Wife over & stage II sacrum area. Pt c/o
	some pain @ IV & entire site when touched.
	[(b)(6)-2] maj
midnight 2200	Pt received one percocet 10 mg from pre-op
	A, bottom & DSG SAT & Brown/Dry blood stain.
	W-O clear & Dakins to wound/NS to wound, white drainage

(over)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDCOM - 5726

MEDICAL RECORD	PROGRESS NOTES
DATE 24 MAY 03	Urology POD # 15

S: Ø further emesis

O: Tm 100.3 ↓ thereafter VSS

abd: continued problems c urine leaking from appliance into pelvic wound.
- non-distended, wound granulating.
- no urine in JP fluid
- Ø good BS from both stoma.
JP drainage = 65 today.

A/P: 1) DVT (L) lower extremity → has developed probable seroma at old saphenous vein harvest site - Dopplerama.

2) urine diversion - pulled P.O. tube and JP today. Cont levofloxacin x 2d.

3) wound seroma - will not manipulate unless enlarges or develops fever.
→ replace appliance.

[b)(6)-2]

(Continue on reverse side)

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

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[b)(6)-4]

PROGRESS NOTES
STANDARD FORM 508 (Rev. 11-77)
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509.111

PROGRESS NOTES

DATE	
24may03 1945	nursing Entry: pt A&O. 5', 5² present. distal pulses palpable x 4. Caprefill < 3 sec. wheeze ~~no~~ auscultated to (B) upper lobes lungs. lower lobes CTA. Respirations unlabored. Abdominal dressing intact. dsk brown drainage noted to lowest part of dressing. conduct draining adequate. cyu. Stoma pink, moist. Strength to upper extremities strong (B), weakes to lower extremities. pt encouraged to do as much as possible for self. able to move up in bed ~~3~~ assest. Will continue to monitor — (b)(6)-2 SG 9140
2205	nursing Entry: dressing changed to abdominal wound. upper midline site red beefy, closing well. pelvic wound c lrg clots noted. wound irrigated c NS, dry gauze dressings applied. Bacatracin oint to peril rectus. Temp @ 2055 101.7 pt notified. physcian paged c no response. VS@ this time T ↓ to 100⁴ P102 R24 BP 125/74 SaO² 99% RA. Respiratory auscultated lung. CTA. pt ate small portion of dinner c no emesis. Sitting up in bed watching video. Will continue to monitor — (b)(6)-2 SG 9140

(b)(6)-4

PROGRESS NOTES

DATE	
25 APR 03	Op NOTE
	Proc: Mentotomy, CYSTO clot Evacuation Urethral injury fulguration, SPT placement,
	Surgeons COSTA / OLIS Anes Minim.
	Comps & Drains zzf to by
	[b)(6)-2]
	Op Note
4/25/03	Preop Dx: GSW
	Postop Dx: SAME
	Procedure: I+D Urethral wound
	Anesth: GETA
	EBL: minim
	Comp: NONE
	Drains: Foley
	[b)(6)-2]
	[b)(6)-4]

* U.S.G.P.O.: 1986-491-248/20615

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5729

MEDICAL RECORD	PROGRESS NOTES

DATE

5/28/03 0630 NEURO: PT A+O, but due to language barrier unable to assess Orientation to Time. PT Did not require any pain meds during the night. Last dose was given at 05/24/03 @ 2000.

RESP: PT Sating 98% on RA O2 & NO Signs of Trouble.

CV: PT has 2+ Pulses & Cap Refill < 3 sec.

GI/GU: PT Voiding via Foley Catheter to PT Lower Abdomen. 1000 cc collected since 0100AM This morning.

PHYSICAL: PT Sleeping Well during the night. NO Facility into to PT. PT Starting to Concern himself with his Appearance. PT has started to become more Verbally/Audibly Expressive of Pain, Almost to the point in which he did Later Before Arrive. which would be a progression for him. [redacted] (b)(6)-2 [redacted]

25May03 0700 126/70, 97, 18, 98%, 98.9. Pt resting in bed at shift change. VSS, C/O pain, tolerating regular diet Cont N/V [redacted] (b)(6)-2 [redacted] USAN

(Continue on reverse side)

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

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WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
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MEDCOM - 5730

PROGRESS NOTES

DATE 5/11/03

Urology POD # 16

S: single episode of vomiting after large meal yesterday, ambulating had not BM.

O: Had Tm. 101° last evening, now AF VSS
lungs CTA(B)
- no signs of infection at old tube or G site.
- sacral wound healing
- Ø peri-anal abcess
- Left thigh seroma - Ø signs infection
- abd wound - clean per nursing, D/I, N/D
- aspirated thigh seroma & has clear fluid.

A/P: Fever may be due to removal of line yesterday, pyocystis remote possibility
- continue levoflox, if fever returns consider bladder irrigations with gentamicin.
- VCBC
- awaiting A.E.

(b)(6)-2

DATE	NOTES
4 May 03 @ 2100	Abd dsg d'd per md order. Upper portion cleaned with 1/4 Dankins solution. Lower portion packed with sterile moist Kerlix roll. Clots removed from lower abd wound. ⊖ odor noted. Tissue red and moist with some small areas of white eschar noted on lower portion of wound. Dry Super Sponge & Surgical Combine dsg used to cover wet gauze and secured with tape. Pt tolerated procedure well. Will continue to monitor closely, especially lower portion of wound because gauze was completely saturated with sanguinous fluid. [redacted] CPT, AN
5 May 03 @ 0030 hrs	- Pt's appliance bag leaking - bed soaked with urine. Linen changed & pt given a partial bath. Pt emesized x 1 got 0.05 → 1 HR x 5 mins. Pt tolerated transfer well. Will continue to monitor. Report given to MAJ [redacted] (b)(6)-2 [redacted] CPT AN
5 May 03	0450, pt desiring 1 cup of tea. Crackers were given to pt. Assessment done. @ 0100 Pt's VSS V. R > L. Cipro mill L 3 sec c, ABD DSG C/D/I 2 x 2 A & L nephrostomy site, Duoderm Dab was placed on excoriated area. ↓ ∆ in appearance of the ulcer. Pt responds appropriately to staff [redacted] MAJ
25 @ 0420 May	pt finally settled to sleep. Pt c/o pain throughout the night, crackers + juice was given & pt @ 0700 [redacted] MAJ

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

23MAY03 0930 BL | 123/70 P99 R18 T99.2 HRRR/S2 noted A&O. BS CTA b/lat. BUE x4 wnl. MAE. Mvts d/p with MLE c some d/f on Passive ROM done c pt. C/o pain c full ext/flex. Stm w/o/l & Abd wound drsg Δ per Dr Petrosky, stent DC'd Nephrostomy clamped per Dr Petrosky. Heal c Foley DC'd JP drain intact. Ileal conduit pink moist c signs of strangulation. Bag Δ'ed b/c of leakage [b)(6)-2] c/t

23MAY03 1330 JP-25 Neph-25 Ileal cond-350+ 350cc BL | pt T to BSC & to chair; Ileal conduit leakage x 4 chgs bed Δ'ed pt to BSC @ 8pm large dark brown hard. @ stoma prompt. ≈ 300cc clot noted in BSC. Oozing from abd wound; ≈ 50cc from dressing. Notified Dr [b)(6)-2] to evaluate. Colace added to meds. no other Δ to POC. Dressing on back Δ'ed @ drainage noted odor. ≈ 3cm diameter wound moist pink, 1.1cm diameter wound to the R side of larger wound. pink moist. [b)(6)-2] c/t

1830 JP=50cc Nephro 200cc Ileal conduit 250cc | pt OOB to chair, encouraged leg exercises to straighten out legs; dressing to abdomen remains intact; dressing (dry gauze applied to back stage III decub pt tolerated regular diet, no other changes at this time [b)(6)-2] c/t/a

23May03 | 1850hrs - Report received, care of pt assumed. Assessment done - see ICU flowsheet for details. Will continue to monitor

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST [b)(6)-2] | SPONSOR'S ID NUMBER | c/t/a

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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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MEDCOM - 5733

PROGRESS NOTES

DATE	
5-26-03 1900	Rsg. IV started in RFA. Site flushes + returns blood. T-99.3° HR-107 BP-115/62(83) POX-100% on R-32. Pt responsive & follows commands A/ox3 through interpret. Tachypneic resp c 32 lungs CTA. Heart rate Tachy 100's s1s2, BSAx3 quads unable to auscultate RLQ. Ostomy to RLQ stoma pink ō bag intact. Dsg to lower midline abdomen intact ō drainage. Pt eating + drinking ō complaints/ problems @ this time. Will continue to monitor + assess. [redacted] EPT/RN
2130	Pt typed + crossed for 2 units PRBCs — CS
2230	Pt c/o pain in abdomen. Medicated pt ō 2 - percocets po. [redacted] EPT/RN
2245	Emptied 1100cc of yellow urine ō mucous. CS
27 May 03 @ 0100	- Report received, care of pt assumed. Pt c/o feeling hot. Oral temp 99.1 - 2 blankets removed. Will continue to monitor. [redacted] EPT/RN
27 May 03 @ 0150	- Pt had large formed BM in bedpan. Pt given a partial bath. 200 cc clear yellow urine emptied from ileal conduit. [redacted]
27 May 03 @ 0600	- Pt continues to sleep. 250cc yellow urine ō mucous emptied from ileal conduit. Will continue to monitor. [redacted] EPT

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5734

MEDICAL RECORD | **PROGRESS NOTES**

DATE

26 May 09 1130 Pt A+O×3 full sensation all ext. Lungs CTA O_2 Sats 95%. Ø evidence PUMB. +2 pulses all ext <3 sec cap refill. Tolerating regular diet. ØN/V during morning. BS all 4 quad. Last BM 3 days ago. Ileal conduit draing adequate amounts clear yellow urine c mucous sediment. Pt ambulated hallways and ambulated outside XI c assist. Patient sat at end of bed for 25 minutes Pt put himself into bed. Dr. [(b)(6)-2] Δ'd ABD dressing. Dressing C/D/I. Sacral ulcer 4×4 applied c tegaderm applied C/D/I. Nephrostomy drain dressing removed. site healing well no draining. Ø c/o pain during shift. awaiting A/E, VSS afebrile [(b)(6)-2] VSS, AN

26/MAY/09 1500. Pt awake + alert. Resting in bed. Eating MRE. ØN/V. ABD. dressing Δ'd large clot found. Dr. [(b)(6)-2] called to bedside to examine. Nonadherent Pt. Cleaned. OOB to chair. 1200cc of urine + mucous emptied from ileal conduit. Bag Δ'd. Sacral dressing Δ'd. Pt ambulated hallways c staff assistance. Returned to bed c min. assistance. [(b)(6)-2]

HR 105-110 (1600) Pt resting. Dr. [(b)(6)-2] aware of CBC results. ØNewOrders.
BP 102/59 Dressings CDI. Will continue to monitor [(b)(6)-2] (1930) Pt sleeping
R 19 awakened during conduit check. 700cc UOP + (Teaching on Linen) Pt cleaned
T 99.3 + linen Δ'd. OOB to chair to eat dinner. Abd dressing CDI. Sacral ulcer
Sat 99% RA dressing CDI. Will cont to monitor. (Continued on reverse) [(b)(6)-2]

UOP = 1900cc + H2O = 1500cc

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

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

MEDCOM - 5735

DATE	NOTES
26 MAY 03 0200	Pt awake request something to eat, attempt to explain to pt to last pt can't to request food. as an bowl of rice - water was given to pt, pt request more, & additional food was R/T time & night. [redacted] mg/m
26 MAY 03 0330	Pt request to sit on the side of the bed. pt was able to pick his legs up and place them on the side of the bed in accordance. [redacted] msgt
26 MAY 03 0409	Pt still awake. Sitting up in bed, Conduct empirical 500 cc bolus of saline. pt Cleaned genital area with baby wipes) WBM, on exit wound drainage. @ the bottom of the [redacted] msgt [redacted]
26 MAY 0745	125/73, 109, 12, 99.0, 98%
26 MAY 03	Urology PID #17 S: no events, eating well, ambulating better, has increased sero sang drainage from pelvic wound when ambulates. O: [redacted] (as stated) AF abd: wound granulating well, some pelvic hematoma, stoma pink-clear UO (L) thigh - unchanged lymphocele, no erythema A/P: Urinary diversion/pelvic wound - D/C dotrapen, cont dressing D's - awaiting A'E. [redacted]

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 May 1530	Pt is A&Ox3 full sensation all ext. +2 pulses all ext. <2sec cap refill. Lungs CTA O2sats >96% Ø evidence of ↑ WOB. Pt tolerating regular diet c ØN/V +BS all 4 quadrants Ileal conduit draining clear yellow liquid w/mucous present. UO 900cc. Pt ambulating c assist x2 up in chair x2. Pt's abdominal wound had large amounts of bright red blood. abdominal dressing was reinforced x2 with ABD pads. Sacral decub ulcer healing pink tissue c granulated edges. Wound covered c ABD pad. C/O/I. No family visiting patient. Pt only complains of pain during dressing change and ambulation — [redacted]
1730	Tmax 100.2 — [redacted]
2125	Pt UR. ine out 375 cc via orostomy bag. Dressing Δ due to abdominal
25 May 03	due to ↑ saturation of Dark red drainage. Wound dark pink and no signs of Necrotic Tissue. Edges of wound granulated. Pt Vitals: RR 21 SpO2 100%, BP 119/71 MAP 83, HR 105, Temp 98.5 Orally. 1000 mL on IS. Pt up to chair while eating. Hygiene care conducted and bed linens changed. Pt Affect Somewhat Bright today than yesterday. Pt interaction c STAFF improved. PRN Pain meds given to Pt. Will continue to assess. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | (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) [redacted] | REGISTER NO | WARD NO

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR **FPMR** (41 CFR) 101-11 203(b)(10)

MEDCOM - 5737

PROGRESS NOTES

DATE	
27 May 03 0800	116/63, 105, 12, 98.9 Pt weighed in bed. 4x4x3 Dressing changed this AM by [b)(6)-2] Wound has moderate amount drainage steady. Packing with 4x4's noted around edges. Dressing C/D/I. 2 units PRBC started at 0800 this AM premedicated w/ Tylenol & Benadryl. VSS tolerated regular diet this AM. [(b)(6)-2] AN
0830	125/13, 107, 13, [(b)(6)-2] KT, AN
0900	117/70, 97, 12, 97.8, 99% [(b)(6)-2] KT, AN
0930	2 units 131/10, 105, 13, 99% [(b)(6)-2] KT, AN
1000	127/73, 107, 18, 98.9 99% [(b)(6)-2] KT, AN
1030	127/74, 109, 16 [(b)(6)-2]
1100	122/66, 116, 18, 99.1 [(b)(6)-2] KT, AN
1130	2u PRBC finished 125/67, 112, 16, 99.2 [(b)(6)-2] KT, AN
1230	Pt finished 2 units PRBC, CBC sent to lab. @ 18 gauge IV still patent. 800cc output from illual conduit. Pt sat on edge of bed c out assist. awaiting A/E VSS [(b)(6)-2] KT
1430	Pt had a large amt of blood in perineum. Area cleaned up and peri pad placed in shorts to absorb any additional bleeding. Pt crying and c/o pain. Medicated c Percocet 1 tab PO. [(b)(6)-2] CPT
5-27-03 1930	T-99.3 HR 107 POx 99% BP 127/71 (92) R-2nd. Pt resting in bed. Alox3 per translator. Follows commands. Lungs CTA, Heart rate ST 100's s, s2 reg. BSAx4. Pt has firm area below ileal conduit. Ostomy site pink + bag changed. 300 cc of yellow urine c mucous drained from site.

STANDARD FORM 509 BACK (Rev. 11-77)

☆U.S. GPO: 1995-397-405

Dressing change to abdomen completed. Layer abdominal wound packed. Dr sg to buttocks changed. Will continue to monitor & assess. [(b)(6)-2] CPT

MEDICAL RECORD	PROGRESS NOTES

DATE

27MAY03 Urology POP#18

S: Has been having intermittent moderate volume bleeding from pelvic wound - exacerbated by ambulation.

O: ⊕ tachy, otherwise VSS AF- abd: no definite bleeders, seems to be coming from cancellous open pubic bone. - wound granulating well L ue - unchanged per nsg - stoma pink - good co

A/P: Hx of hemorrhage from open bone with base excess Hct q 8 tubegrades transfuse to pRBC, stop aspirin, heparin and Lovenox products. - awaiting PT.

(Continue on reverse side)

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

REGISTER NO.

(b)(6)-2

(b)(6)-4

PROC
STANDA
Prescribed b

FIRMR(41CFR)201-45.505

509-111

86th CSH

MEDCOM - 5739

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 MAY 03	Urology POD #19
	S: tol diet ~ emesis, eating well had firm BM yesterday followed by recurrent pelvic bleeding.
	O: VSS AF abd - wound healing/granulating well - ⊕ sero-sang drainage + clot - no obvious bleeders - still appears to be coming from open pubic bone - ostomy pink ~ good UO Hct ~ 25
	A/P: Pelvic bone bleeding - packed with gelfoam, stop Dakins A & D dressing changes and saturate. Total 1 MU FFP (only single dose available) - add MOM to metamucil stools - D/C levofloxacin - Awaiting PT eval

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST) | (b)(6)-2 | R'S ID NUMBER (Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD **FORM 509** (REV 5-99)
Prescribed by GSA/ICMR **FPMR** (41 **CFR**) 101-11.203(b)(10)

MEDCOM - 5740

DATE	NOTES
1200 29 May 03	PNV FE PO bowel ↑ MN 30cc AS ORDERED
1800	Pt resting in bed A+Ox3. Lungs CTA. +2 pulses all ext <3sec cap refill. Tolerating regular diet. PIV for dilaudid abd dsg c/d/i. Heat cordut draining 600 cc of clear yellow urine + nausea present. Able to ambulate to chair x2 + no assist. Ostomy bag changed due to leakage from wafer. Afebrile
5.28.03 1930	[redacted] LT, AN P 100 HR 100 T 98.7° BP 128/73 (97) R 20. Pt resting in bed c complaints @ this time. VSSA. A/Ox3 follows commands. Breathing regular unlabored sats 100%. Lungs CTA. HR tachy pulses 2+ all extrem. Capreft < 3 sec, BSAx4 quads clear pain to abdomen @ this time. Now drng bag to RLQ. Heal cordut draining yellow urine + mucous. Drsg to abdomen CDI @ this time. Heplock IV to RFA 18g patent to flush ∅ s/s of infection. — [redacted] CPT/AN

PROGRESS NOTES

DATE	
Cont	pt is agreeable. Based on pt's hx, Cont blood loss (+ BP) NS started @ 125cc hr, will consult c primary nurse c MD in a.m. [redacted] MSN
0500 28 MAY	Pt's VS HR 103 BP 131/73 RR SAT 98° T-98.5
	Pt's Buddy, PSY RN at bedside under tape CBC to be done. Lisa E Cruz MSN
0600 28 MAY	Conduit 500cc, 300cc NS infused / 500cc bag H·H 8.4 / 25.4 ↓ *500cc Wide [redacted] MSN
0630 28 MAY	Pt ate 5m portion of 2400 for BREAKFAST [redacted] MSN
28 MAY 03 0730	B/P 127/71 P 110 SATS 99%, T 98.2, AxOx3 LUNGS CLEAR ↓ BASES, (+) PULSES x4, 600 CAPACITY REFILL <3SEC (+) BS - HAD TWO LARGE BM'S IN LAST 24 HRS, HEMOCUE 186 ON (R) FA, SEROMA SITE INTACT c NO CHANGES ON (L) INNER THIGH, DENIES PAIN NOW, EMPTIED APPLIANCE 300cc OF CLEAR / YELLOW URINE, COLACE 100mg PO GIVEN, AS WELL 10mg OF VALIUM IM. DRESSING ON ABDOMINAL AREA MODERATELY SATURATED c SEROSANGUINEOUS FLUID. MD VERBAL DO CHANGE DRESSING THIS AM. D/C CONTINUE TO MONITOR.
1600	5mg of VIT K GIVEN IM NOW. PATIENT ASKED FOR WATER DRESSING CHANGE DONE BY DR [redacted] THIS AM, CHANGE ORDER TO ONCE A DAY, USING ANTIBIOTIC OINTMENT. CONTINUE ON BEDREST D/C ANTIBIOTICS TO, ADD MOM 30cc PO 96 UNTIL SOFT STOOLS, THEN PRN [redacted]
1045	400cc of clear/yellow urine emptied from appliance -

MEDICAL RECORD	PROGRESS NOTES
DATE	
5-27-03	Pt dsg change done & noted on previous page.
1930	Clot 6 inches by 1½ inches removed from wound. CS
2200	Pt placed on bedpan. While pt bearing down blood poured out of wound into bedpan. Emptied appox 50cc of red blood from bedpan. Dsg required changing again. Clots in wound again removed & clots were removed from out from under dsg. Wound continued to ooze blood while dsg change occured. Repacked wound & reinforced dsg. T-98.5 HR100 BP 125/66 (86) POX 99% RA RR-28. [redacted] [b](6)-2 RT/RN
27 May 03 @ 2215	- Discussed findings c Primary MDs and received new order to draw CBC @ 0500 on 5/28/03. Will then determine if blood transfusion is required. [redacted] [b](6)-2 CPT AW
5-28-03	0026 - Emptied 400cc of yellow urine c mucous. Pt c/o pain. Medicated @ 2300hrs c 2 tabs Percocets. 0033 Pt used bedpan. Had two large foul stools out. Applied pressure to lower abdomen site during pt excretion. [redacted] [b](6)-2 RT/RN
5/28/03 0115	VS 133/73 T 98.6 (O) P 99 O2 Sat 99 (RA) RR 28
	Pt sleeping, conduct emptied 500cc yellow urine (mucous). Pt felt warm, but @ present time ⇒
	(Continue on reverse side) cont

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

[b](6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

MEDCOM - 5743

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DATE: 22 mar 03

VITAL SIGNS	TIME:	2300													
	BP ARTERIAL LINE														
	BP CUFF	122/65													
	MAP	78													
	TEMPERATURE	96													
	PULSE	94													
	RESPIRATIONS														
	PULSE OXIMETER	99													
	CVP														
	PAIN (0 – 10)	0													
RESPIRATORY	OXYGEN (L/%)														
	O2 METHOD														
	VENT SETTINGS:														
	FIO2														
	MODE														
	TV														
	RATE														
	PEEP														
	PS														
	Respiratory Treatments														
	24 HOUR I & O:	TOTAL IN													
		TOTAL OUT													
INTAKE	TIME:	2300													
	PO 1900-2300	600													
	TOTALS	600													
OUTPUT	URINE														
	L NePhD	450													
	JP														
	Conduit	50													
	STOOL														
	TOTALS	500													

MEDICAL RECORD - ICU FLIGHT SHEET

PATIENT NAME: (b)(6)-4

SECTION II - PATIENT ASSESSMENT DATA — REVIEW OF SYSTEMS

DATE: 23 May 08

	TIME: 1930 / INITIALS: (b)(6)-2	TIME: / INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	A&O x 3, speaks Arabic but understands English. Follows commands. MAE x 4 gen. Weakness. Pupils reactive.	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	SR rate 90s, 0 mIRIG 0 mIVF, cap refill <3secs VSS. Afebrile. 0 edema (+)2 pulses x 4	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Lungs CTA B ↓bases IS used - pt able to raise level to 1000. O2 RA sat 100%, 0 cough or SOB noted.	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Abd sft, Tender, ND, hypoactive bs x 4. ~~0 N+V~~ BM earlier today. Tol reg diet c good appetite. 0 JP drain x 1 (L) LQ abd.	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Ileal conduit (R), (L) nephrostomy tube. Pt voiding via conduit - clear yellow urine Quantity sufficient	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Generalized weakness - able to MAE. Pt able to bear full weight (R) leg somewhat contracted - ROM done by Pt. 2 person assist needed for ambulation.	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	WD, intact except for: Sacral decub - Stage III c comfeel intact and abd wound c drainage noted on lower portion.	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Pt c/o discomfort @ surgical site - gave 2 tabs Percocet.	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Anxious at times - easily calmed by staff members. Interacts well with other pts.	

MED L RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 23 May 03

IV SITE ASSESSMENT

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

LOCATION	CONDITION	LOCATION	CONDITION
IV SITE # 1 N/A		IV SITE # 1	
IV SITE # 2		IV SITE # 2	
IV SITE # 3		IV SITE # 3	

	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED			IV PATENCY CHECKED		
IV SITE CARE PROVIDED			IV SITE CARE PROVIDED		
IV TUBING CHANGED			IV TUBING CHANGED		

COMMENTS:

COMMENTS:

AM STRIP

N/A

PM STRIP

N/A

SECTION III - SHIFT NOTES

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 05/24/03

DIAGNOSIS: 25H 1003 PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

VITAL SIGNS

TIME:	0745	1330	2100	0700																					
BP ARTERIAL LINE																									
BP CUFF	117/68	113/64		126/70																					
MAP	86	80																							
TEMPERATURE	100.3oz	100.4	101.7	98.9																					
PULSE	96	98		97																					
RESPIRATIONS	24	22		18																					
PULSE OXIMETER	98%	99%		98%																					
CVP	—																								
PAIN (0 – 10)	0-10	2-10		0-10																					

RESPIRATORY

TIME:	0745	1330	2100	0700																					
OXYGEN (L/%)	RA	RA		RA																					
O2 METHOD																									
VENT SETTINGS:																									
FIO2																									
MODE																									
TV																									
RATE																									
PEEP																									
FS																									
Respiratory Treatments																									

Oxygen Method Key: NC = Nasal cannula NR = Nonrebreather mask FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE

TIME:	0745	1230	1645	1945	2230																				
PO	80	100	300	240	100																				
TOTALS	80	100	300	540	640																				

OUTPUT

TIME:	0745	1230	1645	1945	2230																				
URINE Conduit	200	220	350	600	275																				
PN	20	—	—	—																					
SP	5	—	—	—																					
STOOL																									
TOTALS	225	220	350		(Ne 76)																				

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME (b)(6)-4 DATE: 05/24/06

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION		LOCATION	CONDITION
IV SITE # 1	D		IV SITE # 1		
IV SITE # 2			IV SITE # 2		
IV SITE # 3			IV SITE # 3		

	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED			IV PATENCY CHECKED		
IV SITE CARE PROVIDED			IV SITE CARE PROVIDED		
IV TUBING CHANGED			tv TUBING CHANGED		
COMMENTS:			COMMENTS:		

A M STRIP

PM STRIP

SECTION III - SHIFT NOTES

0800. CREATINE URINE TEST DONE NOW .5, 02. PETHOSKI D/C JP AND FOLEY TUBE NOW, ALSO D/C COCCY DRESSING. DRESSING CHANGE DONE WET TO DRY ON BOTTOM PART OF WOUND. NEW APPLIANCE PUT IN ILEOSTOMY DRAINING URINE WELL. SEROMA NOTED ON (L) THIGH MEDIAL ASPECT. DR (b)(6)-2 ALSO AWARE OF IT. 10mg OF VALIUM GIVEN PRIOR TO DRESSING CHANGE (b)(6)-2
12:30 ADL PM INJECTION GIVEN AS PRESCRIBED, FOLEY CONDUCT BAG EMPTIED 200cc OF CLEAR YELLOW URINE DUMPED. BED CHANGED, DENIES ANY PAIN NOW. (b)(6)-2
PATIENT ATE HIS OWN FOOD, BROUGHT BY VISITORS
1645: PT AMBULATED IN HALLWAY, DID EXERCISES 350cc (b)(6)-2
1730, PT VOMITED x1, 25 mg of PHENERGAN IM GIVEN

M...L RECORD - ICU FLOWSHEET

SECTION II - ...NT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: (b)(6)-4 DATE: 5/24/03

	TIME: 0830 INITIALS (b)(6)-2	TIME: INITIALS:
NEUROLOGICAL **Alert** and Oriented to **time, place and name;** Responds **appropriately; Communication is** adequate to **express** needs; Pupils equal and resctlve lo light.	AxOx3, PERLA, COMMUNICATES WELL & APPROPRIATE. UNDERSTANDS SIMPLE COMMANDS AND ENGLISH	
CARDIOVASCULAR Age **appropriate** Rate, Rhythm, and **Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous** membranes **pink. No** calf tenderncss. **Pressure monitoring**	SR, CAPILLARY REFILL <3SEC +2 PULSES x4, ⊘EDEMA VSS.	
PULMONARY **Respirations within** normal **limits for age; Breath** sounds quiet and regular; **Depth is** regular; No **dyspnea; No cough; Suction;** Secretions; Oxygen; ETT; **Trach**	LUNGS CTA, ES q 1 hour SATS 98% OR ABOVE AT RA Ø COUGH OR SOB	
G.I. Abdomen **soft** and nondlstended: Bowel sounds active In ail **quadrants;** No **difficulty chewing or** swallowing; No **abdominal pain;** Frequency and type of stool; No **diarrhea;** No **constipation;** No N/V; NG **Tube** placement; Type of secretions	SOFT, TENDER, BS x4 ⊘N x V, NO BM NOTED DURING SHIFT. EATING REGULAR DIET. D/C SR/PN NOW WITH IVF.	
G.U. Voiding; Catheters; Urine clear **yellow/amber** No odor, discharge, frequency, **urgency,** nocturia	I Heal Condom Ⓡ grossly JP, RN D/C. VOIDING SPONTANEOUSLY TOO. D/C FOLEY OVERNIGHT	
MUSCULOSKELETAL: **Normal muscle mass** and **development** for age; No **deformities; No assistive** devices needed; Normal movement end tone; Normal active ROM without pain; No **joint** swelling, tenderness, weakness, or **paresthesia**	AMBULATES STRAIGHT, ABLE TO AMBULATE & HELP, MILD CONTRACTION TO Ⓡ KNEE, ROM EXERCISE DONE THIS AM.	
SKIN Color: warm; dry; intact; Turgor; No Wounds; lesions; **rashes, inflammation,** ulcers, **breaks** in skin; No **redness, blanching,** irritation, pver bony prominences; **Mucous** membranes **moist;** Wounds– **location,** condition, **drainage,** dreuirg	W x D TO ABD WOUND, SACRAL DECUB STAGE III & DRESSING CHANGES BID. APPLIED ALSO CHANGED TODAY ON ILEAL - STOMA. MADE REFERRAL NOTES ON SAPHENOUS VEIN DONOR SITE Ⓛ LEG	
PAIN No **complaints** of **pain/discomfort;** Note **Location; Duration;** Intensity	↑ PAIN / DISCOMFORT DUE TO DRESSING CHANGE, GIVEN 10mg DIZ VALIUM PER PO PRIOR TO DRESSING CHANGE.	
PSYCHOSOCIAL: Behavior is appropriate **to** the **situation;** Anxiety **is** controlled or mild and appropriate to the situation; **Interacts** appropriately with others	SOMETIMES ↑ ANXIETY VALIUM 10mg & AM CARES INTERACTS & OTHER PATIENTS WELL.	

MEDICAL RECORD - ICU FLOW SHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DATE: 28 MAR 03

VITAL SIGNS

TIME:	1930
BP ARTERIAL LINE	/
BP CUFF	113/63
MAP	80
TEMPERATURE	98.7
PULSE	94
RESPIRATIONS	21
PULSE OXIMETER	100%
CVP	/
PAIN (0 – 10)	0

RESPIRATORY

OXYGEN (L/%)	/
O2 METHOD	RA
VENT SETTINGS:	/
FIO2	
MODE	
TV	
RATE	
PEEP	
PS	
Respiratory Treatments	/

24 HOUR I & O: TOTAL IN _____
TOTAL OUT _____

INTAKE

TIME:	0700	1900	totals	0100	0130	600
H20				480		
Juice				600		
PO					180	
TOTALS				1080	1260	

OUTPUT

URINE						
JP	25	20	45	15		5
NGT+O	250	0	250	35		0
L Conduit	350	200	550	400+		700
				*bed soaked Foley - appliance leaking		
				linen changed + pt bathed		
STOOL						
TOTALS			845	1295		1990

511-118

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

15 Nov 03

15 MAY 03

ONS

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°	37.2"
	98.6°	37.0"
120	98°	36.7"
110	97°	36.3."
100	96°	35.6"
90	95°	35.0'
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

pulse

HEIGHT: | WEIGHT →

Sig

Temp

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.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 5751

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS	TOTAL HOURS COVERED	DATE
TO ____ HOURS		

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
	(b)(6)-4	50	50			[illegible]	100		100

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1 00

MEDCOM - 5752

OUTPUT

LT Nephrostomy URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
06	250				250

J-Pan ~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
00-06		100 75+40	215

Suprapubic ~~CHEST~~

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
06	100				100

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

Red Rubber ~~STOOLS~~

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
00-06	220 1550			770

Foley ~~OTHER OUTPUT~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
06	8		8

REMARKS

GRAND TOTAL OUTPUT

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

792, JAN 74

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

USAPPC V1.00

MEDCOM - 5753

ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
925			
1525			
1925			

TIME	AMOUNT	TYPE	ACCUM TOTAL
0030	90	Serosang	90
2230	100	Serosang	190
0600	90	Serosang	280
0640	50	Sero Sang	330
0744	240	Sero Sang	570
230	200	Sero Sang	770
	80		850

~~CHEST~~ Foley

ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
30 Blood			
80 Urine			

~~EMESIS~~ NG

TIME	AMOUNT	TYPE	ACCUM TOTAL

~~STOOLS~~

CHARACTER	AMOUNT	ACCUM TOTAL
—	275	275
	1000	1275
clear	500	1775

Foley ~~OTHER OUTPUT~~ CATH

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	0		0
0744	10		10
230	0		10
GRAND TOTAL OUTPUT			10

...ped or written entries give: Name - last, first, middle.
...y)

INTAKE EQUIVALENTS (Serving levels cc)

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

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

MEDCOM - 5754

OUTPUT

(L) NEPHROSTOMY URINE TUBE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0430	800	800			
1400	250	1050			
2200	150	1200			
		3050			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
0130	10cc	GRN BILE	10cc
0430	3cc	" "	13cc
2200	200		213
		356	

SUPRAPUBIC FOLEY ~~CHEST~~

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0430	250	250			
1400	100	350			
2200	10	360			
		960			

JP DRAIN EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	210	@60cc + 80cc, 70cc @0200 @0430 0630	210
1400	120		330
	70	18 22 / 30 60	400
		940	

RED RUBBER ~~STOOLS~~

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0600	Bloody	Watery	200cc	200cc
1400	3 Large clumps	- leaky bag	340	540
2200				540 +++
			1280	

~~JP~~ FOLEY OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	Ø cc	~~60cc, 80cc, 0250 - 0430~~	Ø cc
1400	15		15
2200	10	240	25

GRAND TOTAL OUTPUT

REMARKS

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

Fh)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	URGE SOUP BOWL	240
COFFEE CUP	180	URGE WATER GLASS	740
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

MEDCOM - 5755

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	NPO	0	0

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
22-07	2000cc	LR, NS	2000	0500	2000
	150cc	100 TIMENTIN, 50 ZOFRAN	150	0200	2,150.cc
	200	50 zofran, 100 Timentin, 50 zantac	200		2,350cc
	500	50 zof 50 Unasyn 100 Tim 250 Vanc 50 zan	500		2850
	1000	NSLR	1000		3850
2100	1000	LR			

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 5756

1 May

INTAKE

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	~~350~~ 350	350			
0800	400	750			
1435	200	950			
2200	3 Chux	~~950 + ?~~			
↓	175	1125			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600	5-10cc	G-Type	~~Tcc~~
1435	30	Dark green	35cc
2200	100	Brown	135
2300	100	light Brown/dk	235

~~CHEST~~ SUPRAPUBIC FOLEY

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	20	20			
1430	100	120			
2200	3 Chux	~~120 + ?~~ 220			

EMESIS JP DRAIN

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600	30	serosang	30
0800	5	serosang	35
1030	60	serosang	95
1330	40	serosang	135
1420	20	serosang	155
2200	100		255
2300	30	Serosang	285

~~STOOLS~~ RED RUBER

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0600	serosang.		60	60
1430	serosang.	~~Hard~~	200	260
2200	3 Staked			260 + H
2300	Serosang.		60	~~320~~ a

~~OTHER OUTPUT~~ FOLEY

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600	~~25~~	Blood tng	25
1430	10	Blood tinge	35
	5		35

GRAND TOTAL OUTPUT

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

MEDCOM - 5757

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS
TOTAL HOURS COVERED
DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0000	Oral care H_2O	60	60

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2307	70cc/hr	LR	560	07	560

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 5758

OUTPUT

(L) Nephrostomy

ME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
~~07~~	~~725 error~~	~~725.~~			
07	100cc	100cc			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	75	lt. GRN.	75
0630	25	lt. GRN	100
2330	400	lt. GRN	500

URRAPUBIC ~~CHEST~~ FOLEY

IE	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
07	50	50			

~~EMESIS~~ JP DRAIN

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	100	serosang.	100
2330	40		140

~~STOOLS~~ RED RUBBER

E	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
5	Amber urine		625	625
30	CAU		200	825

~~OTHER OUTPUT~~ FOLEY CATH.

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	0	0	

GRAND TOTAL OUTPUT

ARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

MEDCOM - 5759

TWENTY-FOUR HOUR PATIE. .TAKE AND OUTPUT WORKSHEET

FRC
TO

HOURS
HOURS

TOTAL HOURS COVERED

DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2330	H_2O	110	110
0200	H_2O	120	330
0400	H_2O	60	390
0600	H_2O	240	630
1130	H_2O	180	810
1230	Jello / H_2O	240	1050
1400	milk.	200	1250
1600	H_2O / OJ TANK	400	1650
2000	Jello	120	1770

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include medications)	AMOUNT INFUSED	TIME COMPL	ACCUM TOTAL
2300	70	LR @ 100cc/hr	560	0700	560
0600	~~500~~	LR	500	1000	1060
~~0700~~					
1200	100	IVPB:	100		1160
1400	70	LR	560		1720
2100	70	LR @ TKO	420		2140

IRRIGATIONS (N/G, Bladder, etc)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

MEDCOM - 5760

INTAKE

OUTPUT

Nephrostomy URINE **Tube**

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	80	80			
07	60	140			
0800	70	210			
1400	250	460			
2100	950	~~950~~ 1310			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600	800	grn tint H2O	800

Suprapubic ~~CHEST~~ **Foley**

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	60	60			
0800	50	110			
1400	150	260			
2130	50	310			

~~EMESIS~~ **JP**

TIME	AMOUNT	TYPE	ACCUM TOTAL
0030	40	Serosang	40
0200	40	Serosang	80
0600	90	Serosang	170
0700	50	Serosang	220
0800	45	Serosang	265
1400	400		665
2130	340	Serosng	

Red Robin ~~STOOLS~~

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
23-07	CTU		425	425
0600	CTU		150	575
1400			400	975
2130		CTU	150	1125

~~OTHER OUTPUT~~ **FOLEY CATH**

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	5cc	Bld.	5cc
1400	10	Bloody	15
2130	10	Bloody	25

GRAND TOTAL OUTPUT

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 792, JAN 74

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

USAPPC

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0230	H_2O	240	240

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
23-07	70cc/hr	LR@70cc/hr	560	07	560
0330	100cc	Unasyn	100	0900	660
2400		Unasyn	100		760

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

MEDCOM - 5762

14 may 03

OUTPUT

(L) Nephrostomy ~~URINE~~ Tube

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
~~0245~~	~~275~~	~~27~~ error			
0600	925	925			
~~0400~~	600	~~1525~~			
2300	400	1925			

JP DRAIN ~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0030	90	Serosang	90
0330	100	Serosang	190
0600	90	Serosang	280
0640	50	Sero Sang	330
0744	240	Sero Sang	570
2330	200	Sero Sang	770
	80		850

Suprapubic ~~CHEST~~ Foley

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
23-07	30	30 Blood			
0744	50	~~80~~			
2300	100	180 Urine			

~~EMESIS~~ JP

TIME	AMOUNT	TYPE	ACCUM TOTAL

RED ROBIN ~~STOOLS~~

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0245	Cyu	—	275	275
0744			1000	1275
2300	Cyu	clear	500	1775

Foley ~~OTHER OUTPUT~~ CATH

TIME	AMOUNT	TYPE	ACCUM TOTAL
23-07	0		0
0744	10		10
2300	0		10

GRAND TOTAL OUTPUT

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

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LAB FLOW SHE

PATIENT NAME 0400 1700 5/5 5/4

Date/Time	5/2	5/2	0400	0500												
CBC																
WBC (4.8-10.8) K/UL	10.7	8.1	7.3	11.3												
RBC (4.7-6.1) 1X10 6/UL	3.1	2.9	2.8	2.9												
HGB (14.0-18.0) g/Dl	9.7	8.6	8.2	8.3												
HCT (42-52) %	27.3	25.6	24.2	25.2												
PLT (150-450) 1x10 3/UL	238	255	276	372												
NEUT%			75.6	79.0												
CHEMISTRY																
NA+ (137-145) mmol/L	140	143	140	139												
K (3.6-5.0) mmol/L	3.4	3.9	3.3	3.8												
CL- (97-107) mmol/L	109	112	107	106												
CO2 (22-31) mmol/L	32	32	33	33												
BUN (9-21) mg/Dl	11	12	10	13												
GLUCOSE (76-110) mg/dL	144	137	119	96												
CREAT (0.8-1.5) mg/dL	0.4	0.4	0.5	0.4												
CA (8.8-10.4) mg/dL			7.4													
PHOSPHORUS (2.5-4.5) mg/dL			3.2													
URIC ACID (3.3-8.4) mg/dL																
PROTEIN TOTAL (6.3-8.3) g/dL																
ALBUMIN (3.5-5.0) g/dL																
AST (15-46) U/L																
LDH (313-618) U/L																
ALK PHOS (70-250) U/L																
TBILI (1.0-10.5) mg/dL																
GGT (8-78) U/L																
CK (0-203) U/L																
MG (1.7-2.2) mg/dL			1.6													
AMYLASE (30-110) U/L																
LIPASE (23-300) U/L																
ALT (11-66) U/L																
ABG																
pH																
pCO2																
pO2																
HCO3																
BE																
sao2																
COAG																
PTT (23.8-35.5) Seconds	23.2	22.0	21.5	22.2												
PT (11.6-14.4) Seconds	11.9	11.6	11.7	12.0												
INR	1	1	1.0	1.1												
OTHER																

MEDCOM - 5764

Fentanyl —

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 197[illegible] AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 22[illegible]

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
2020	2030		9 MAY 03

OPERATION PERFORMED: Ex lap

SURGEON(S): Harris / Petros

TOTS	SURG START	DRESSING	OR NO
2040	2050		

PREOPERATIVE

☒ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
☒ CHART REVIEWED ☐ NPO SINCE
☐ PRE-OP MEDICATION

Drug	Dose	Route	Time

Pre Anesthetic State
☐ CALM ☐ AWAKE
☐ APPREHENSIVE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☒ ANES. MACHINE # ☒ & EQUIP. CHECKED
☒ NON-INV B/P ☐ PNS
☒ CONT EKG ☐ VLEAD EKG
☒ ESOPH STETH ☐ PRECORD STETH
☒ PULSE OXIMETER ☒ O2 ANALYZER
☒ END TIDAL CO2 ☐ MASS SPEC.
☐ TEMPERATURE
☐ WARMING BLANKET ☐ FLUID WARMER

AIRWAY HUMIDIFIER
☐ N / G TUBE ☐ O / G TUBE
☐ TVT

☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN
☒ FOLEY INSERTED ☐ OR ☐ FLOOR
EYE CARE taped
PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

☒ GENERAL ☐ LOCAL / MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☒ PREOXYGENATION ☒ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

☐ INTUBATION ☐ ORAL ☐ NASAL
☐ DIRECT VISION ☐ BLIND ☐ AWAKE
☐ FIBER OPTIC ☐ STYLET USED
ATTEMPTS 1 ☐ BLADE Mac 2
ETT SIZE ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☐ CUFFED 6 ML AIR INJECTED
☐ UNCUFFED, LEAKS AT ____ CM H2O
ETT SECURED AT 20 CM
BREATH SOUNDS Bilat
AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
LMA SIZE

RECOVERY

TIME IN PACU	CONDITION			
		PULSE	RESP	O2 SAT
REMARKS				TEMP
PORT TO			PARRS:	

FLUIDS TOTALS

IN		OUT	
Crystalloid		EBL	
		Urine	
		Gastric	
000			

AGENTS / FLUIDS / MONITORS

	2030		2100		30		2200		30		2300		30		2400
Versed	3														
Fentanyl	100	100	50	50	50	50	50		50		50		50		
Ancef	1500														
Flow	100														
Flow		30		20		50		10		20					
Cefotetan	20	20	10												
Neostigmine mg			10												
MSO4														3	3
ISO Flow %		1.2	.6	.5	.5	.6	.7	.8	.6		.6				
N2O L/min															
O2 L/min	2	2	2												
LR				1000							2000			2500	
RR/SC	#1	#2		#3		#4									
NS				1000			2000				3000			1700	
O.R. Bag (Weight)			600				1000		1000		1400				
Urine									200		350			400	
EBL			50		200		50		200		400			500	
EKG	SR	SR	ST	ST	ST	SR	ST	SR	ST	ST	ST	ST	ST	ST	ST
% O2 Inspired	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
O2 Saturation	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
End Tidal CO2	50	40	36	34	36	37	35	35	37	37	37	37	37	38	38
Temperature	Shiv		36			36									
PNS															

SYMBOLS: X ANESTH; ● OPERAT; V; ^; B/P CUFF PRESS; ⊥ T ARTER LINE PRESS; ● PULS; C SPONT. OUS R; q ASSIS RES; ⊠ CONTRC RES; T TOURNI; F CRYS LOID F; E DLC

VITAL SIGNS

TIME 2030 × 2100 × 30 × 2200

PRE-OP VALUES															
89/46 B/P															
126 P															
24 R															
99 SAT															
8.7/26 H/H															

RESP

Tidal Volume	.5	.5	.6	.6	.6	560	.56	.54	530	530	530	530			
Resp Rate	13	12	14	12	11	12	12	13	12	12	12	12			
Peak Pressure		36	31	31	28	24	24	24	24	24	24	22			

Symbols for Remarks: ①

Position: supine → → → → → → → →

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation.
☐ Significant changes from preop plan / evaluation.

#9 French R IJ Cordis x 1 attempt. Three Lumen, Arrow @ 2310 4653081
Technique.
① Calcium Gluconate 1 gm over 10 min IV
@ 2120 4660769 @ 2137 4651295
@ 2205 P 4 units of PRBC H/H 9/28
1 Gm Vancomycin IVPB ↑ @ 2300
Zantac 50 mg IVPB ↑ 2336
Tourniquet Time N/A

(b)(6)-2 (b)(6)-2 PATIENT'S IDENTIFICATION (b)(6)-4

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[THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM. IT IS COVERED BY DO 22(

ANESTHESIA RECORD

ANES. START	IN OR	ANES. END	DATE
TOTS	SURG START	DRESSING	OR NO

OPERATION PERFORMED

SURGEON(S)

PREOPERATIVE

☐ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
☐ CHART REVIEWED ☐ NPO SINCE
☐ PRE-OP MEDICATION
Drug Dose Route Time

Pre Anesthetic State
☐ CALM ☐ APPREHENSIVE ☐ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☐ ANES. MACHINE # ☐ & EQUIP. CHECKED
☐ NON-INV. B/P ☐ PNS
☐ CONT. EKG ☐ V LEAD EKG
☐ ESOPH. STETH. ☐ PRECORD STETH
☐ PULSE OXIMETER ☐ O2 ANALYZER
☐ END TIDAL CO2 ☐ MASS SPEC.
TEMPERATURE
☐ WARMING BLANKET ☐ FLUID WARMER
☐ AIRWAY HUMIDIFIER ☐ O/G TUBE
☐ N / G TUBE
4 ☐ ARTERIAL LINE
☐ CENTRAL LINE
☐ SWAN-GANZ
☐ FOLEY INSERTED ☐ O.R ☐ FLOOR
☐ EYE CARE
☐ PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

☐ GENERAL ☐ LOCAL ☐ MAC
☐ REGIONAL ☐ NERVE BLOCK

INDUCTION

☐ PREOXYGENATION ☐ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

☐ INTUBATION ORAL ☐ NASAL
☐ DIRECT VISION BLIND ☐ AWAKE
☐ FIBER OPTIC STYLET USED
☐ ATTEMPTS # ☐ BLADE
☐ ETT SIZE ☐ DOUBLE LUMEN
☐ STRAIGHT ☐ RAE ☐ ANODE
☐ CUFFED ML AIR INJECTED
☐ UNCUFFED, LEAKS AT CM H2O
☐ ETT SECURED AT CM
☐ BREATH SOUNDS
☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
☐ MASK CASE ☐ VIA TRACHEOSTOMY
☐ NASAL CANNULA ☐ SIMPLE O2 MASK
☐ LMA SIZE

RECOVERY

TIME IN PACU 0100 CONDITION

B/P	PULSE	RESP	O2 SAT %
126/87	125		100

REMARKS TEMP

REPORT TO. PARRS:

IN FLUIDS TOTALS OUT

IN		OUT	
Crystalloid	LR 200	EBL	500
	NS 500	Urine	1100
Blood		Gastric	100cc

Events

	1400	30	0100	TOTAL
AGENTS: Reglan / MSO4	20/20 / 4/1			
AGENTS: 2% of	0.6	0.6		
N2O L/min				
O2 L/min	2	2		
FLUIDS: NS				
FLUIDS: LR				
Urine				
EBL				
MONITORS: EKG	SR	SR	SR	
MONITORS: % O2 Inspired	1.0	1.0		
MONITORS: O2 Saturation	100	100		
MONITORS: End Tidal CO2	37	37		
MONITORS: Temperature				
MONITORS: PNS				
TIME				
VITAL SIGNS: PRE-OP VALUES				
VITAL SIGNS: B/P				
VITAL SIGNS: P				
VITAL SIGNS: R				
VITAL SIGNS: SAT				
VITAL SIGNS: H/H				
RESP: Tidal Volume	550	550		
RESP: Resp Rate	12	12		
RESP: Peak Pressure	33	33		
Symbols for Remarks				
Position				

VITAL SIGNS chart: 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

SYMBOLS: X ANESTH; ⊙ OPERAT; V / ^ B/P CL PRESS; ⊥ T ARTER LINE PRESS; ● PULS; C SPONT. OUS R; ASSIS RES; ⊗ CONTRC RES; T TOURN; F CRYS LOID; E BLC

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation. ☐ Significant changes from preop plan / evaluation.

Hct 32 p 5th PRBC

Pt to ICU #2 for recovery per Anbu Bag FiO2 1.0 Intubated.
O2 Sat 100%, 123/87. 123. FiO2 100% RR 12 Vent TV 600ml Setting
MSO4 1 mg IV slow push q 1 hr prn

Tourniquet Time

PATIENT'S IDENTIFICATION

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