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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 June 03	1015 Pt arrived via litter from ICU #2. Airway is intact, breathing is even and unlabored, lung sounds clear to all fields ̄x bases (diminished there). Abd is soft, nontender (̄x tenderness with), and ̄c slight distention near abd wound. BS ⊕ x4, tolerating PO. Ostomy to Ⓡ flank passing flatus & some stool. Abd wound to center of wound covered ̄c large ABD & clean, dry, intact. IV to Ⓡ hand flushes well. LR ̄c 20K @ 50cc/hr via pump. Neurovascularly intact to all extremities. Mild weakness to all extremities. PT and nutrition informed of needed consults. ———— [redacted]
01 June 03 1400	Nutrition Note
	b(6)-2
	S: Pt referred for Kcal count and Poor PO intake.
	O: Iraqi male, estimated wt: 75 kg
	Dx: GSW to abdomen Diet: Reg ̄c Ensure
	A: Due to extremely limited supply of ensure pt will receive carnation instant breakfast TID instead of ensure. Explained to pt through translator the importance of adequate PO intake to promote healing. Estimated nutritional needs:
	2600-3000 kcal/day (35-40 kcal/kg)
	97-113 gm protein (1.3-1.5 gm/kg)
	P: 1) Kcal count x 48°
	2) Supplements TID
	b(6)-2
	3) Encourage PO intake [redacted] MAJ, SP RD/LDN

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

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

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

REGISTER NO. | WARD NO. ICW2

CIV # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 June 03	PT Note
	Hx: Request ROM/strength/amb;
	Per ICU 2 - Pat amb 2x - today
	Tx: Pat ostomy bag/Abd dressing
	Pat performed 1x10 shld flex
	1x10 biceps
	1x10 fist
	Pat (I) bed mobility - slow
	Pat SBA c stand s AD
	~ p 30 sec pat NOT actively keep head up c'
	allowed self fall to attempt fall - slowly
	unable have actively extend legs,
	extend neck
	Diag: Not willing amb/stand - actively
	Intx: edu/As above
	Cont PT
	G: (I) UE ex - 1day
	Stand 40 sec (I) - 4 days
	b(6)-2 28 CSH
	[redacted] CPT, SP
1Jun03 2005	assumed care @1300 - VSS - colostomy c loose stool 150cc output - IS done q1° this shift c great encouragement needed - IV patent - abdominal dsg Δ wet to dry, 3 areas of necrosis noted on upper right side of wound - Report given on pt. need to be OOB to chair c PT assist in Am ——— [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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ACLU-RDI 1629 p.2

DOD-028231

MEDICAL RECORD	PROGRESS NOTES

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DATE	NOTES
01June03 2115	Pt stable at this time. PERRLA. Mucous membranes pink, moist & intact. Neck supple, FROM. Lungs clear bilaterally. Abd c drsg from Ⓛ side across abd. Very tender R/T surgical site. Bowel sounds present x4 quads. Voiding to urinal s̄ assist. Strong pulse x4 extremities, brisk cap refill x4 extremities. Pt c̄ axillary temp of 102.6. Given Tylenol x2. Will recheck temp in 1 hr. b(6)-2 [redacted]
02Jun03 0430	Minimal output (80cc) liquid stool to ostomy. Voiding qs to urinal. Ø complaint of pain at this time. Drsg CDI. VSS. Will do and send labs. b(6)-2 [redacted]
6/1/03	Surgery
	Pt tolerating diet
	Tm 101.8 now 98.6 VSS — 9.16 / 31 (9.8) 388
	abd - dressing clean
	Ostomy looks good — 134 / 3.3 / 100 / 8 / 97
A/P	Concern c̄ WBC ↑ing, temp spike yest. now fine. Will plan take to O.R. tomorrow for washout / skin c̄ debridement

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] | ID NUMBER

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

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

CIV # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 14843

ACLU-RDI 1629 p.3

DOD-028232

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02June03 1124	Pt resting in bed. VSS: BP 120/70, RR24, P97, sats 93%, T98.8. Pt. very lethargic. IVLR c̄ 20meqKCl @ 50cc/hr site Ⓡ wrist s̄ s/s infection or infiltration. Abdominal dressing Δ'd c̄ colostomy bag changed. Abdominal wound is approximately 6x7 inches box shaped, pink, moist, slight bright red bloody drainage s̄ signs of infection. Stoma pink c̄ moist. Pt. NPO p̄ MN awaiting wound washout c̄ debridement. Pt. intake c̄ output adequate for shift. Urine clear c̄ yellow. All other assessment findings WNL. Pt. c/o pain once during shift. No other complaints @ this time. b(6)-2 [redacted] /Ar
1230	Pt. wrapped with ace bandages c̄ up to chair. Pt. has macular rash on entire back. Bed c̄ clothing changed. Will continue to monitor [redacted]
1300	Pt. back in bed c̄ asleep. b(6)-2 [redacted]
2June03 1300	Pt. vitals taken BP 120/70, P.80, R.20 [redacted] 98.0 SPC [redacted]
02 June 03	Nutrition Note F/U b(6)-2
	PO intake for past 24° was poor. Results of kcal count: 600-700 kcal
	20 gm protein
	Will track intake for one more day.
	b(6)-2 [redacted] MAJ, SP RD/LD
2Jun03 2010	assumed care @ 1300 - VSS - IV patent - IS encouraged & used throughout shift - lung sounds ↓ throughout - abd. dsg Δ'd - pt. to go to OR in AM, npo p̄ mn, LR c̄ 20KCl @ 125cc/hr to start @ mn - pt. OOB to chair x1 hour, tolerated it c̄ encouragement - stool remains

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b(6)-2
3 June 03	0750 MSO 2mg IVP adm by Maj [redacted] prior to dsg change.
	[redacted] SMMB b(6)-2
6/3/03	Surgery Op note
	Preop Dx: Open Skin/fascia of abdomen s/p GSW (old).
	Post op Dx: Same
	Procedure - washout of skin c debridement.
	Surgeon: [redacted] b(6)-2
	Anesthesia: General
	EBL: Ø
	Findings: minimal dead tissue in SubQ debrided & wound washed c NS and redressed.
	Will start TID dressing Δ's c plan to STSG later this week.
	[redacted]
	b(6)-2

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ACLU-RDI 1629 p.5

DOD-028234

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2Jun03	loose from colostomy, bag intact - pt. ate
2010	small amount of dinner, fed self s assistance
con't	no c/o pain @ this time b(6)-2 [redacted] CBA??
2330	Pt care assumed @ 2100. 650mg tylenol given PO for
	temp @ 101.7, other VSS, Alert and awake without c/o
	pain. Lung sounds CTA, pulses palpable x4, bowel sounds
	present ~~x4 quadrants~~, RUQ only quadrant auscultated. Abd
	drsg Δ'd, wound is moist and pink. Pt NPO, surgery in
	AM. Colostomy bag has a small amount of drainage this
	shift. Pt voided 700cc clear yellow urine. IV site @ LAC
	CDI, infusing well. Will continue to monitor. SPC Seeley 91WM6
3Jun03 0240	UOP 540cc CYU → [redacted] 91W b(6)-2
0400	IV infiltrated, restarted @ R wrist. Phlebitis noted on
	(L) bicep, will continue to monitor SPC [redacted] 91WM6 b(6)-2
0630	Assume pt care @ 0500. Pt awake and alert. 650mg tylenol adm
	for temp. 101.8. Other vitals stable. Wound to back of head healing
	well, cleaned and left open to air. PERRLA, HR regular. Lungs CTA
	throughout. Pulses palpable, strong x4. Bowel sounds active RUQ. Colostomy
	bag intact sm. amt brown drainage. Abd. CD&I. pt void per urinal 300cc
	CYU this am. IV LR @ 125cc c̄ 20mEq KCL added to (R) hand. Site free
	of s/s redness/infection. Plan to go to OR this AM. b(6)-2 [redacted] 91WM6

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

CIV b(6)-4 [redacted]

REGISTER NO. | WARD NO. ICW 2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 JUN 03	PT NOTE
	HX: AMBUL
	T/M: PNT AWAKE, DISPLAYED MODERATE STRENGTH IN (B) UE (B) LE. ASSISTED PNT TO SEATED POSITION
	& SIT-STAND POSITION. PNT AMBUL c̄ ASSISTANCE ~ 2X ICW2 AREA. PNT ASSISTED TO CHAIR. PAT
	SAT ~ 10MIN PRIOR TO BEING ASSISTED TO BED.
	DIAG: AMBUL
	INTERV: SAME
	G: ↑ AMBUL TO 5X ICW2 AREA X 1WK.
	SPC [redacted] b(6)-2
	SIGNING PT TECH.
	b(6)-2 [redacted] 28 CSH ICT, SP
03 JUN 03	PT NOTE
	HX: AMBUL
	T/M: PNT UNDERWENT SURGERY TO DEBRIDE WOUND. ASSISTED PNT TO SIT UP IN BED ~ 5MIN. AMBUL
	DEFERRED 2° MEDS & PAIN.
	DIAG: AMBUL
	INTERV: ASSISTED PNT SITTING
	G: AMBUL PAT ~ 10'-15' X 1WK.
	SPC [redacted] b(6)-2
	SIGNING PT TECH

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

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

REGISTER NO. | WARD NO.

\# [redacted] b(6)-4

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
03 June 03	0800 pt medicated c 2mg MSO4 IVP adm by Maj [redacted] b(6)-2 prior to dsg change. Dsg change done by Maj [redacted] immediately following pt went to OR. b(6)-2
	b(6)-2 [redacted] 91Wm
	1130 pt returned from recovery @ approx [illegible]. Awake. Orders resumed from pre-op. pt sitting in chair. VSS. Abd. dsg CD&I. Colostomy bag changed in OR. draining sm. amount red drainage. IV (R) hand 50cc/hr LR c 20 meq KCl added. No c/o pain @ this time.
	b(6)-2 [redacted]
3 June 03 1300	Pt vitals taken BP 90/60, P. 99, R. 20, Temp 98.8
	SPC [redacted]
3 June 03 1400	assumed pt care @ 1300. VSS. airway [illegible], lung sounds CTA. abd c drsing CDI. ostomy bag intact draining scant amt of reddish brown drainage. BS (+) x RUQ. pulses palpable x 4. IV (R) hand infusing LR @ 125cc c 20mg KCL s diff, Ø s/sx of infiltration. wound to back of head OTA, healing s s/sx of infection. will cont to monitor b(6)-2
	b(6)-2 [redacted] SGT, 91WM6
3 June 03 1600	Pt vitals taken BP 98/63, P. 96, R. 16, Temp 98.2
	SPC [redacted]

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | [redacted] | SPONSOR'S ID NUMBER (SSN or Other) b(6)-2

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW2

CIV # [redacted] b(6)-4

BED #13 ICW2

PROGRESS NOTES
Medical Record

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

MEDCOM - 14848

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
June 03 2000	Pt vitals taken BP 110/52, P. 106, R. 16 Temp 100.7 SPC [redacted] b(6)-2
June 03 21:30	Pt. awake + resting in bed c̄ feet elevated. Perrla@WNL. Skin PWD. [illegible] Colostomy draining loose brown stool. ABD dsg. intact. LLQ serous drainage, sm amt. I.V Ⓡ FA patent c̄ LR c̄ 20KCL @ 50cc/hr Voiding cl yellow urine ⊕PPP WNL. Cap refil <3 sec. @ ~~20:00~~ 21:00 temp 101.0 tylenol ii given @ 20:00. Will cont. to mon. [redacted] b(6)2
00:00	Pt given MSO4 ā dsg Δ. Old dsg yellow in color c̄ some areas of sanguinous drainage. All edges of ABD wound well approximated c̄ granulous tissue pink. New dsg. c̄ sterile water applied. 1 roll Kerlex to inside ABD wound and 3 ABD pads to cover sterile W→D dsg. New dsg is C/D/I. [redacted] b(6)-2
4 June 03 0630	Assume pt care @ 0500. pt asleep. easily arousable. temp 99.6. BP 127/80 P 102 R 20. Wound to back of head open to air. PERRLA. IV LR c̄ 20 KCL @ 50cc/hr to Ⓡ hand, HR regular. Lung CTA. BS active RLQ. Colostomy bag in place. draining loose brown stool. Abd dsg intact, clean and damp. Full ROM to u/l extremities. Will continue to monitor. b(6)-2 [redacted]
4 June 03 0915	2 mg of MSO4 adm prior to dsg Δ IVP by Lt. Jinch. Old dsg. yellow and red drainage mostly to Ⓛ side. Area cleaned with sterile water and packed with Super sponges. W→D dsg done. covered with Abd. dsg. Dsg CDI. b(6)-2 [redacted]

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

DATE	NOTES
4 June 04	0915 Labs returned WBC 17.4 will let MD know. pt resting now. no s/s pain, discomfort b(6)-2 [redacted]
	1240. IV restarted in (R) FA. pt sat up for approx 15 min. VSS @ 1200 Stable temp 99.2°. pt didn't eat much lunch, encouraged carnation shake @ bedside. pt resting no s/s pain b(6)-2 [redacted]
	1240 Colostomy bag emptied approx 300cc loose brown stool. b(6)-2 [redacted]
4 June 03 1430	assumed pt care @ 1300. VSS. Temp 100.7 pt given ii Tylenol per prn orders. airway patent, lungs CTA, abd dsing CDI, ostomy bag intact draining brown drainage. BS (+) RUQ. BLE c̄ strong (+) pulses. BUE c̄ strong (+) pulses. IV (R) FA infusing s̄ diff. (-) s/sx of infiltration. Will cont to monitor b(6)-2 [redacted] 91WM6
2345	Assumed Pt. care @ 2100. Temp 99.8. 30mg Toradol given IV for pain. HR Reg, Lungs CTA, UTA BS 2° drsng x (R)LQ. BS (R) LQ (+). Ostomy bag intact draining brown, soft stool. Drsng to ABD changed wound is beefy red. Hematoma to (R) LQ noted, MD and SOD notified. Pt. examined by both. MD instructions to continue with previous orders.

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

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CIV # [redacted] b(6)-4

REGISTER NO. | WARD NO. ICW2

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/4/03	b(6)-2
cont....	Will continue to moniter. ——— [redacted]
6/5/03 0745	Drsng to (L)LQ A&D reinforced 2° small
	amt. serosanguinous drainage. ——— [redacted] b(6)2
05JUNE03 0150	ASSUME PT CARE @ 0500. Pt Awake and alert. 3mg MSO4
b(6)2	adm IVP by LT [redacted] @ 0600, for pain. IV LR c̄ 20KCl
	to (R) wrist no s/s infiltration/redness. Abd. dsg. yellow drainage
	mostly to (L) side. INTACT. VSS HR regular. Lungs CTA (B).
	BS RUQ active. Colostomy bag (R) side, draining brown
	loose stool. Voids per urinal s̄ difficulty. Pulses strong. Ate
	sm. amt @ breakfast. Zantac NOT GIVEN, pharmacy is out will
	see what MD would like to order. ii percocet adm @ 0800
	for pain. Will Change Dsg. and continue to monitor [redacted]
	b(6)-2
	b(6)-2 [redacted]

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

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ACLU-RDI 1629 p.11

DOD-028240

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 June 03	1300 pt had convulsion this am around 0910, while OOB to chair, lasting approx 15 sec. MD notified 1 L NS Bolus adm. Dsg Δ'd @ 0845 - hematoma to (L) side. pt taken to OR to have hematoma removed. Pt recovered well. VSS. Dsg CD&I. LR c̄ 20 KCL @ 50cc/hr to (R) wrist. HL to (L) hand placed in OR. —— [redacted] b(6)-2
5 June 03 1300	Pt vitals taken BP 122/62, P. 106, R [redacted] Temp 98.4 —— SPC [redacted]
5 June 03 1405	assumed pt care @ 1300. VSS. assessm[redacted] WNL. b(6)-2 abd drsing CDI. Ostomy bag intact draining brown stool. IV (R) wrist infusing s̄ diff ∅ s/sx of infiltration HL to (L) hand flushes s̄ diff. ∅ redness or edema noted. will cont to monitor —— b(6)-2 [redacted] 91WM6
5 June 03 1800	Pt vitales taken BP 118/70 P. 112, R-22, Temp 100.0 —— SP[redacted]
2330	Assumed pt. care @ 2100. Pt. alert. [redacted] Lungs b(6)-2 CTA, BS ⊕ to (R)LQ & (L)LQ. Ostomy bag intact, draining loose brown stool, ⊕ flatus. Dsng to ABD changed W→D. SOD consulted 2° dsng adhered to wound. wound beefy red. Pt premedicated for dsng Δ c̄ 4mg MSO4 IV. Will continue to monitor [initials]

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

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 14852

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1200 T 99.4	Assumed care of pt @ 0500. Pt was asleep. VSS.
P 97	Lungs CTA. Pt had 4 mg of MSO4 @ 0830 before
R 16	dsg Δ. Dsg is dry + intact. Pt had Percocet ii
BP 116/74	@ 0935 for c/o pain. Will continue to monitor.
SpO2 97%	b(6)-2 [redacted], 91WM6, SGT
6 Jun 03	assumed care @ 1300 - VSS - IV patent -
2015	abdominal dsg Δ'd as ordered p̄ pt medicated
	c̄ 4 mg MSO4 IVP - pt. out of bed to chair
	for 30 minutes then 60 minutes p̄ dinner -
	pt. will eat more if he is fed by a
	male, will only eat a few bites if fed by
	a female or made to feed himself -
	Only gas output from ostomy - pt. able to
	get himself OOB to chair c̄ minimal
	assistance - pt. used IS q1° this
	shift c̄ encouragement - [redacted] CRNAW b(6)-2
2230	Pt care assumed @ 2100. VSS, alert and awake,
	pt had c/o small amount of pain during dressing
	change. Lung sounds CTA, pulses palpable x4. IV @
	RFA patent, LR w/20 meq KCL running @ 50 cc/hr.
	Dressing change done, wound is pink and moist, looks
	to be improving. Will continue to monitor. SPC [redacted] 91WM6 b(6)-2
7 June 03 0400	Colostomy site CDI, bag drained about
	200 cc feces. SPC [redacted] 91WM6
	b(6)-2

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 June 03	0630 Assume pt care @ 0500. Pt asleep. easily arousable. Alert to surroundings. VSS. No c/o pain or discomfort. Abd dsg CD&I. IVF LR c̄ 20 KCL @ 50cc/hr to Ⓡ wrist free of s/s redness/infiltration. Colostomy bag intact, brown drainage noted. HR regular. Lungs CTA. BS audible ⓇLQ. Pulses palpable x4. Will encourage pt ~~to~~ OOB to chair and DSG Δ this Am. — [redacted] b(6)-2
7 Jun 03	Surgery
	No complaints requires encouragement for
	Po with colostomy functioning
	VSS Afeb
	wound C/D well cared for.
	A/P open Abd. good granulating Await
	further closure prior to STSG b(6)-2
	Continue [redacted] b(6)-2 [redacted]

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

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

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

CIV# [redacted] b(6)-4

1CW2

PROGRESS NOTES
Medical Record

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

MEDCOM - 14854

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7June03 1100	Dsg Δ done. Area healing well. Sm amt of red drainage on right side. Area cleaned c̄ sterile water packed W→D Dsg applied. 4mg MSO4 IVP prior to dsg Δ by Maj Howell. MD advised not to pack as much gauze under skin edges. Just one layer. UA and
T 100.6	CXR done. CBC ordered for AM. [redacted] 91WM6
P 111	1400. pt's colostomy bag Δ'd. Pt OOB to chair. ii tylenol
R 20	given for elevated temp. Old colostomy bag draining brown. Pt an
BP 108/70	stool. Pt attempted to amb. approx. 5 steps then
96%	needed to sit. Sat in chair approx 15 min. b(6)-2 [redacted]
	1610 Dsg Δ. Old dsg moderate amt of yellow drainage
	present. Area pink and moist sm amt bleeding present. 4mg MSO4 IVP adm by Lt Tinch prior to b(6)-2
	Δ. Pt resting now no s/s discomfort [redacted]
2000	Pt care assumed @1700. VSS, pt alert and awake, no complaints at this time. Pt had 55% 100% of dinner, fed himself. IV c̄ abx infusing to RFA Ø s/s infiltration. Lung sounds CTA, pulses palpable x4. Pt had 450cc u/o this shift. Dressing on Abd C/D/I, Δ to be done @2300. Colostomy bag draining brown feces. Will continue to monitor. SPC [redacted] 91WM6 b(6)-2
8 June03 0100	Dressing Δ done @ 2400. Site appears to have small colonies of infection, faint foul odor noted. SPC [redacted] 91WM6 b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDCOM - 14855

ACLU-RDI 1629 p.15

DOD-028244

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 Jun 03	Assumed care of pt @ 0500. Pt is asleep. VSS.
1045	Lungs CTA. Dsg Δ done. Pt hygiene done. Pt received
	4 mg MSO4 IVP before dsg Δ. Pt has ø c/o pain
	ø discomfort @ this time. Pt states to Nabil (interpreter)
	that he is "skinny". Pt also asks about when he
	will get the skin graft. Will continue to monitor
	pt. ——— b(6)-2 [redacted] 91WM6, SGT.
1330	Ambulated pt up to chair. Pt had a syncope episode
1300 T 99.4	Assisted pt to the floor and back in bed. Pt Sats
P 108	were 99 then dropped to 89. Pt was put on O_2 @
R 24	2 L. Pt sat are now @ 99%. Pt will be given
BP 118/60	2 L of blood. ——— [redacted] 91WM6, SGT
O_2 95%	Surgery b(6)-2
8 Jun 03	Fell today probably syncope when standing
1515	VSS ↑HR over 24 hrs ø [illegible]
	Chest CBNA
	cor RRR 2HPP
	Abd serosal rent — Bowel Held from fall
	No EC [illegible] Δ dressing no [illegible] / [illegible]
	Gauze to protect Bowel.
	[illegible] [illegible] 909

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	A/P DoD ok. Wound ok x for next now covered
	(1) D Activity to OOB → Chair BID
	(2) 2u PRBC for symptomatic orthostasis
	(3) ✓ LABs today.
	(4) Stop Abx. b(6)-2 [redacted]
8 JUN 03 1620	PRBC transfusion initiated. VSS. ∅ signs or symptoms of reaction noted. IV site ̄s redness or edema. b(6)-2 [redacted] b(6)-2
1625	BP-118/78, T-99.1, P-96, Sats-94%, R-18 [redacted] 91WM6
1630	BP-118/78, T-99, Sats-94%, P-95, R-18 [redacted] 91WM6
1635	BP-118/78, T-98.8, Sats-95%, P-89, R-18 [redacted] 91WM6
1650	P-91, Sat-94%, T-99.1, R-18, BP-118/78 [redacted] 91WM6
1705	Sats, 98%, P-97, R-18, T-99.1, BP-118/74 [redacted] 91WM6
1720	Sats 99% P-94 R-16 T 98.7 BP 116/64 [redacted] 91WM6
1750	SATS 98% P 97, R 16 T 98.7 BP 112/70 [redacted] 91W
1820	100% P 90 R 16 T 97.8 BP 114/74 [redacted] 91WM6
2015	2nd Bag RBC hung. VSS @ temp 99.1, HR 96 BP 116/72 O_2 Sat 96% RR 16 b(6)-2
2020	BP 118/74, SPO_2 97% HR 94, RR 18, T 99.2 [redacted] 91WM
Late entry 2021	BP 116/72 SPO_2 98% P-96 R 16 T 99.2 [redacted] 91WM
2032	BP 114/68 SPO_2 96% P-96 R 16 T 99.4 [redacted] 91WM
2047	BP 116/70 SPO_2 98% P-95 R-14 T 98.7 [redacted] 91WM6 b(6)-2
2117	BP 112/68, 97%, P 98 R 16 T 99.1 [redacted] 91WM6
2147	BP 119/76, 98%, P 90 R 16 T 99.4 b(6)-2 [redacted] 91WM6

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8June03	Blood infusing complete @ 2340. Pt w/o signs of complications
errors 2340 2345	vitals after infusing are R18, P100, BP 120/72, T100.1, SPO2 98%,
	blood bags brought back to lab. Labs to be drawn @ 0130.
9June005	Dressing Δ done @ 2330. Wound appears red and moist, with
	section near top showing peristalsis, no bowel seen. Pt has
	had VSS throughout shift, SPO2 dropped to 89%, O2 applied
	via face mask for 1/2 an hour, SPO2 raised to 96%-99%. Pt has
	been resting throughout shift, awakened by verbal stimuli.
	Pt lung sounds CTA, pulses palpable x4, bowel sound present
	in ®UQ. IV @ RFA infiltrated, started again @ L wrist,
	infiltrated, started again in RFA. IV infusing LR w/20 meq KCL @
	50cc/hr, Ø s/s infiltration. Colostomy bag has had gas throughout
	shift, little stool noted. No complications are noted at this
	time, will continue to monitor. SPC [redacted] b(6)-2 91W MCO
9June03 0815	Assume pt care @ 0500. Pt asleep easily aroused
	by verbal stimuli. Alert to surroundings. No S/S pain
	or distress. temp 100.0 650mg adm. Old. dsg CD+I.
	HR regular. Lungs CTA. BS present RUQ. Colostomy bag
	in place Sm amt brown stool present. Pulses strong. IV
	LR c̄ 20meq KCL @ 50cc/hr to ® AC. no s/s redness
	infiltration. Will change dsg and colostomy bag (cont)

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

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

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

EPW # [redacted] b(6)-2

REGISTER NO. | WARD NO. ICU 2

PROGRESS NOTES
Medical Record

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

MEDCOM - 14858

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7June03 0815	this am. Labs from 0300 reviewed by MD. were encourage pt OOB to chair. b(6)-2 [redacted] 91WM6
1035	dsg Δ and ostomy bag Δ. Abd site red and moist no ↑ bleeding noted. One layer of Vaseline gauze applied c̄ abdominal dsg to cover site. Colostomy site b(6)-2 pink. free of infection. [redacted] 91WM6
7June03 1345	Pt vitals taken. BP 112/70, P. 100, R. 16 Temp. 98.5 [redacted] b(6)-2
9Jun03	1525 Surgery No complaints OOB to chair today tol PO well ⊕ stool. Bag VSS Tm 101 wound: open good granulation; No signs of infx. 30/30 897 b(6)-2 [redacted] Dorgwell will follow for poss site of infx.
9June03 1800	Pt vitals taken BP 120/70, P ~~98~~ 98. R. 16 Temp 99.4 [redacted] b(6)-2

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

MEDCOM - 14859

ACLU-RDI 1629 p.19

DOD-028248

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 June 03	0800. pt alert and awake. Abd dsg c/n/d amt yellow drainage noted. Colostomy bag intact. brown stool noted. IV fluids LR to (R) FA. no s/s redness/infiltration. No c/o pain @ this time. Lungs CTA. HR reg. BS RUQ active. Will continue to monitor. b(6)-2 [redacted]
10 Jun 03	Surgery NO complaints stoma out put good VSS Afeb. off Abx wound open good granulation contracting A/P Doing well. cont dressing Δ awaiting skin flap stick prior to STSG. b(6)-2 [redacted]
10 Jun 03 1930	assumed pt care @ 1300 - VSS - OOB to chair x 45 min ̄p dsg change - IV patent - pt. ate small amount of dinner c̄ assistance - pt - cooperative - ∅ output from stoma this shift [redacted] b(6)-2

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

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

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

[redacted] CIV
b(6)-4

REGISTER NO. | WARD NO. ICW 2

PROGRESS NOTES
Medical Record

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

MEDCOM - 14860

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Jun 03	10 Jun 03 21:00 - Pt. sleeping c̄ blanket over head. awakened easily. VS b(6)-2
0417	WNL x̄ temp 101.8. Pt given ii tylenol. will reevaluate. Pt [redacted]
	WNL LCA (B). BS (+) x2 good & 4 quads. Colostomy bag draining
	soft brown stool. ABD. drsg Δ'd. Old drsg c̄ yellow tinged
	drainage outlining boarder of drsg edges. Ø odor
	noted. New drsg C/D/I. Pt voiding cl yellow urine. PIV
	(R) Hand patent. Will cont to mon. [redacted] /AU
	b(6)-2 0330 - PIV (R) hand d/c'd. (L) Hand PIV initiated and
	patent c̄ LR c̄ 20 meq KCL @ 50cc/hr. Will cont to mon
b(6)-2	[redacted] /AU
11 Jun 03	Assumed care of @ 0500. Pt resting quietly. VSS.
1100	Lungs CTA. Dsg Δ'd at 1100. Colostomy bag emptied
	@ 1045. Pt voiding cl yellow urine. pt was given
	percocet ii @ 1045. Pt sat up in bed for about
	10 min. Washed and lotioned pts back. Pt has Ø
	c/o pain or discomfort @ this time. - [redacted] PN, SGT
	b(6)-2

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

MEDCOM - 14861

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Jun03	Surgery
	No complaint
	VSS AFeb
	wound c/D contracting
	A/P Doing well
	No Δ plan.
	b(6)-2
12Jun03	assumed care of pt @1300 - VSS - IV patent,
1620	LR c 20 mEq KCl infusing as ordered into
	(R) AC IV - dsg D/I, (R) upper corner of wound
b(6)-2	c brown tinged fluid in pocket, Dr.
	aware, W-D dsg placed in that area spot & in
	original entrance wound, petrolatum gauze
	placed on abdomen and covered c 8x7 in
	gauze dsg, minimal tape used - pt: OOB x30 min
	Only due to heat in unit -
	b(6)-2
11Jun03	Pt. sleeping under blanket. Awakens easily. Alert. Skin PWD
21:15	c "goosebumps". VS WNL x temp 99.4°. LCAB. IV (R) FA intact
	and patent c LR 20meq KCL @ 50cc/hr c Alaris pump. ABD
	dsg. C/D/I. Colostomy bag intact and draining liquid brown
	stool. (+) PPP(B). Skin dry and pt. feeling itchy, will apply lotion.

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. ICW2

CIV

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 - 14862

ACLU-RDI 1629 p.22

DOD-028251

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12June03	cont'd. Will cont. to mon [redacted] /AN b(6)-2
0200	Drsg to ABD Δ'd. Old drsg c̄ little to no drainage. New drsg c̄ 3 xeroform sterile drsgs applied to skin and 3 ABD pads to cover. 1 kerlix fluff sponge ~~used to~~ dampened c̄ sterile water used to pack LUQ wound. Colostomy emptied 80cc liquid brown stool c̄ foul odor. Will cont. to mon. [redacted] /AN b(6)-2
0530	Pt. awake & alert resting comfortably in bed. VSS: BP 114/60, P96, sats 9[illegible] T99.8, RR14. Abdominal dressing CDI. Pt c̄ colostomy on (R) side. Pt. voided 400cc clear yellow urine. IV in (L) FA going @ 50cc/hr LR c̄ 20meq KCL, s̄ s/s of infection or infiltration. All other assessment findings WNL. Pt. s̄ complaint @ this time. Will continue to monitor [redacted] b(6)-2
12 JUNE03	General Surgery
1000	[illegible]
	[illegible] P 96 BP 114/60
	[illegible]
	[illegible]
	[illegible]
	[redacted] b(6)-2
1145	Abdominal dressing Δ'd. Small amt of light brown fluid draining and pooling on bottom (R) side of wound. Quarter size black area on (L) upper side of wound. Otherwise wound looks like its healing well, moist, pink, s̄ signs of infection. MD observed dressing Δ so is aware of wound condition. ——— [illegible]

MEDCOM - 14863

ACLU-RDI 1629 p.23

DOD-028252

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 June 03 1300	Pt. vitals taken BP 110/70 P-104 R-20 Temp 100.8 ——— b(6)-2 SPC [redacted]
13 June 03 1900	assumed pt care @ 1300, pt sleeping easily aroused to verbal stimuli. airway patent, lung sounds CTA throughout. abd drsing Δ'd per orders, Ⓡ upper corner c̄ brown drainage MD aware, other areas healing well, Ø S/Sx of infection noted. Ostomy bag draining brown stool. BLE c̄ FROM c̄ strong ⊕ pulses. BUE c̄ FROM c̄ strong ⊕ pulses. IV ⓇFA infusing s̄ diff. Ø S/Sx of infiltration. pt given ii percocet sitting ↑ in chair @ BS x 45 mins. tol well. Will cont to monitor ——— b(6)-2 [redacted] 2100
13 Jun 0144	12 Jun 2145 Pt sleeping, easily awakened and alert. VS WNL x ↑ temp 101.6 ii tylenol given ↓ temp to 100.2. Skin W/D. LCA Ⓑ ⊕ BS x4. ⊕ PPP Ⓑ. Colostomy Bag draining stool. ABD drsg C/D/I. Will Cont to mon [redacted] b(6)-2
0500	

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted]

Civ. b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 June 03	General Surgery
0915	Doing well [illegible] complaint.
	febrile last pm to 101.6 & 100.2 this am
	BP 130/70 HR 90-110 RA
[illegible]	looks well
[illegible]	chest CTA [illegible] -> [redacted] b(6)-2
	[illegible], [illegible] - ostomy functioning well
	wound - granulating well - only concern
	is (R) [illegible] [illegible] aspect - one dark
	[illegible] - [illegible]? - no debridement necessary
	@ this time
	[illegible] [illegible] [illegible] not completely [illegible]
	[illegible]
	Doing well
	cont wound care
	grafting planned for after better [illegible] &
	[illegible] [illegible] of [illegible]
	[redacted] b(6)-2
1000	Pt. resting comfortably in bed. Pt VSS: BP 104/62, T98.7, P102, 96%. Pt voiding adequately c̄ clear yellow urine. Colostomy draining soft stools, bag changed ostomy s̄ s/s of infection. Abdominal dressing Δ'd while MD observed. Small amt of light brown liquid draining & pooling on bottom (R) side of wound. Quarter size black area on (L) upper side of wound. Wound looks like it's healing well, moist, pink, s̄ signs of infection. Pt. has 50cc/[illegible] LR infusing c̄ 20 KCl in (R) arm s̄ s/s of infection or infiltration. Pt. up out

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

MEDCOM - 14865

ACLU-RDI 1629 p.25

DOD-028254

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Jun 03	of bed to chair for 30 minutes, tolerated well. Pt. bathed while
1000	out of bed. Pt. has no complaints @ this time. All other
cont'	assessment findings WNL. Will continue to monitor b(6)-2 [redacted]
13 Jun 03	assumed care @ 1300 - T 100.6°F, will monitor,
1610	other VS stable - dsg Δ'd, granulation tissue
	over most of wound, small black area
	noted in upper (R) corner - colostomy c̄
	soft brownish/yellow stool ~100cc - IV b(6)-2
	patent, fluids running as ordered [redacted]
14 Jun 03	13 Jun 03 21:15 - Pt awake and alert in bed. VS WNL. PERRLA. WNL
0146	LCA(B). BS ⊕ x4. ⊕ PPP(B). PIV (R) FA c̄ 50cc/hr LR c̄ 20
	meq KCl. ABD dsg C/D/I. Colostomy draining brown
	stool. Skin W+D. Will cont to mon b(6)-2 [redacted]
error ...	0030 - Dsg Δ'd. Old drsg. c̄ yellow drainage. Wound
	well approximated c̄ granulation tissue. New drsg C/D/I.
b(6)-2	[redacted]
14 Jun 03	General Surgery
0930	Pt doing well. ⊘ complaints, very [illegible] - [illegible]
	T 100.2 P 98 108/60 [illegible]
	[illegible]
	[illegible]
	- [illegible] care b(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

b(6)-4

[redacted]

CIV

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* [redacted] SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 14866

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Jun03	assumed care @1300 - VSS - ∅ colostomy
~~1800~~ RS	output - dsg Δ'd - IV patent - pt. OOB
1900	to chair x1° - fed himself ½ of dinner
	plate - pt. was able to get himself back
	into bed s̄ assistance - in good spirits,
	had conversation c̄ translator [redacted] CRNA b(6)-2
2100	650 mg tylenol given for temp @ 101.1, will check temp
	again @2200. SPC [redacted] b(6)-2 91WM6
2200	Pt care assumed @2100. VSS, AOx3, no complaints of
	pain at this time. Lung sounds CTA, pulses palpable x4,
	bowel sounds present x4 quads. Dressing to Abd CDI, to be
	done @2400. IV patent, running LR w/KCL @ 50cc/hr. No
	complaints at this time, continue to monitor. SPC [redacted] b(6)-2 91WM6
15June03 0715	Pt. asleep in bed easily aroused by verbal stimuli. VSS: BP 104/65,
	P92, T99.3, sats 99%. Colostomy draining soft stool. ABD dressing CDI
	Pt. s̄ complaints @ this time. Initial assessment completed & all
	other assessments WNL. Will continue to monitor. b(6)-2 [redacted] 2LT AN
01100	ABD dressing Δ'd, wound pink moist & healing well. MD observed & is
	aware of wound condition. Colostomy bag cleaned & stoma is
	pink & moist s̄ signs of infection. Pt. up to chair for 35 minutes,
	tolerated well. b(6)-2 [redacted]
15June03 1440.	pt resting easily aroused to verbal stimuli. VSS.
	lung sounds CTA. abd drsing CDI. Ostomy bag
	intact. IV RFA infusing s̄ diff. ∅ S/Sx of infiltration.
	∅ complaints voiced @ this time. Will cont to monitor
	[redacted] 91WM6
	b(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 14867

ACLU-RDI 1629 p.27

DOD-028256

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 MAR 03	General Surgery
1530	Pt continues to do well. [illegible]
	[illegible]
	T max 101. [illegible] 100.2 [illegible] 90-100 [illegible]
	Abd: soft, [illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	b(6)-2

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

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

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

CIO # [redacted] b(6)-4

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

MEDCOM - 14868

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2300	HR Reg. Lungs CTA. ABD drsng CDI. Colostomy intact. (+) BS (x) Q. Pt alert & cooperative. Will cont. to monitor. [redacted] b(6)-2
16 June 03 0645	Pt. awake & alert laying in bed. VSS: BP 110/74, sats 95%, P95, T 98.8. ABD dressing CDI. LR c 10meq KCl infusing in (R) FA s S/S infect and/or infiltration. Colostomy draining soft light brown stool. Pt. voiding adequately. All other assessments findings WNL. Pt. has no complaints @ this time. Will continue to monitor. [redacted] b(6)-2
16 JUNE 03 0925	General Surgery
	Pt doing well
	(-) complaints
	Tm 100 ↓ 98 HR 90s BP 110/74
	ABD wound - looks good
	[illegible] 100% [illegible]
	(-) signs of infection.
	[illegible]
	Doing well
	- ✓ [illegible] CBC [illegible] b(6)-2
	- plan [illegible] [redacted]
16 June 03 1130	Pt. abdominal dressing Δ'd while MD observed. Colostomy bag Δ'd c small pustules noted where tape was removed around the stoma. [redacted]

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

MEDCOM - 14869

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 JUN 03 1900	Assumed care of Pt @ 1300. VSS. A+O x 3. ABD DRSG CDI, ∆'D Ø s/sx of infection. Colostomy draining soft light brown stools. Cream applied to rash on back. LR c 20 meq/L KCL @ 50cc/hr via (R) FA PIV. OOB → chair x 1hr. O/W Assess WNL. Will Monitor b(6)-2 [redacted]
2300	Pt care assumed @ 2100. Temp @ 101.1, 650 tylenol given. At 2400 temp was 98.6. Other VSS, pulses palpable x4, lung sounds CTA. Dressing ∆ done, wound is red + moist w/o s/s infection. IV @ RFA infusing well. Pt w/o complaints at this time, will continue to monitor. SPC [redacted] b(6)-2
17 JUNE 03 1045	General Surgery
	Pt [illegible] to do well. No complaints
	febrile [illegible] for to 101 ↓ 98.6 [illegible]
109/33 - 483	Wound - unchanged - good granulation tissue
	[illegible]
137 97 8 / 37 94 1.1 (95)	[illegible]
	[illegible] - unchanged + [illegible]
	[illegible] - [illegible] end of week.
	[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 14870

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Jun 03	Assumed care of pt @ 0500. Pt is OOB to chair.
1200	Pt Lungs CTA. Diminished bowel sounds. Dsg Δ
	done @ 0945. Pt had c/o itching. Pt was given
	benadryl 50 mg po. Pt has been resting quietly.
	Ø c/o pain or discomfort b(6)-2 [redacted] 91WM6, SGT
17 June 03	Pt vitals taken BP 108/58, P. 112, R. 16, Temp 100.8 b(6)
1335	SPC [redacted]
17 June 03	Assumed ℞ care @ 1330. ℞ resting, easily aroused
1345	to verbal stimuli. VSS. Assessment WNL x̄ diminished
	bowel sounds. Drsg to abd CDI. IV infusing s̄
	diff. Will cont to monitor b(6)-2 [redacted] 91WM6 SGT
17 Jun 03	Pt. received sleeping in bed easily awakened. Skin W/D. PERRLA ⊕ WNL
21:31	VS WNL x̄ temp 100.4. Temp ↓ from 100.8 @ 13:00. LCA ⓑ. BS ⊕ x4
	@ flanks. Colostomy draining brown stool. ABD dsg. CD/I. # PIV 0.9m
	Ⓡ AC patent c̄ LR 20meq KCl @ 50cc/hr. ⊕ PPP ⓑ. Will cont. to
b(6)-2	mon. [redacted] 2LT/AN b(6)-2
02:16	Pt. awake and itching with an uncomfortable look on face. Benadryl
	50mg given. 4mg MSO4 given for dsg Δ. Will monitor [redacted]
18 Jun 03	Assumed pt. care @ 0500: Pt. A+O x3. VSS. lungs CTA,
0600	⊕ pulses x4. Drsg to Abd. CDI. Colostomy bag to Abd intact
	c̄ brown stool. IV to Ⓡ AC c̄ LR 20 meq @ 50cc/hr infusing
	s̄ difficulty. Will continue to monitor [redacted] 91W
0830	Colostomy bag emptied c̄ brown stool. Drsg Δ done. Wound b(6)-2
	healing well. Ø foul odor noted. [signature] 91WM6
0930	Pt. out of bed and sat up in chair for 30 mins. Tolerated
	well. Ø signs of distress noted [redacted] 91WM6

b(6)-2

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

MEDCOM - 14871

ACLU-RDI 1629 p.31

DOD-028260

MEDICAL RECORD	PROGRESS NOTES

DATE	
18 June 03 1330	Pt vitals taken, BP 102/62, P. 96, R. 20 b(6)-2 Temp. 99.2.
18 June 03 1345	VSS. pt resting quietly easily [redacted] to verbal stimuli. lung sounds CTA abd soft diminished BS drain C/D/I. ostomy bag intact draining brown stool. BLE c full ROM strong ⊕ pulses. IV to RFA infusing s diff ⊘ s/s of infiltration noted. cream applied to back per orders. pt denies pain or b(6)-2 discomfort @ this time. Will cont to monitor [redacted]
19 JUN 03 2230	Pt. awake + alert in bed. VS WNL. Skin WD. PERRLA⊕. LCA⊕ BS⊕ @ flanks. Colostomy draining stool. ABD dsg C/D/I. PIV patent. ⊘ complaints @ this time. Will cont to mon [redacted] Dsg Δ done to ABD. wound well approximated c granulation b(6)-2 tissue. Scant amt drainage on old dsg. New dsg C/D/I. Colostomy bag Δ'd. Skin @ ↓ portion of adhesive of colostomy bag weeping serous drainage. Dr. [redacted] notified. Hydrocortisone creme @ bedside. Stoma beefy red and healthy looking. Ambien given d/t pt. c/o ⊘ being able to sleep. New PIV initiated Ⓛ FA patent. ⊘ further complaints. Will cont. to mon [redacted] 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. ICW 2

CIV [redacted] b(6)-2

PROGRESS NOTES
Medical Record

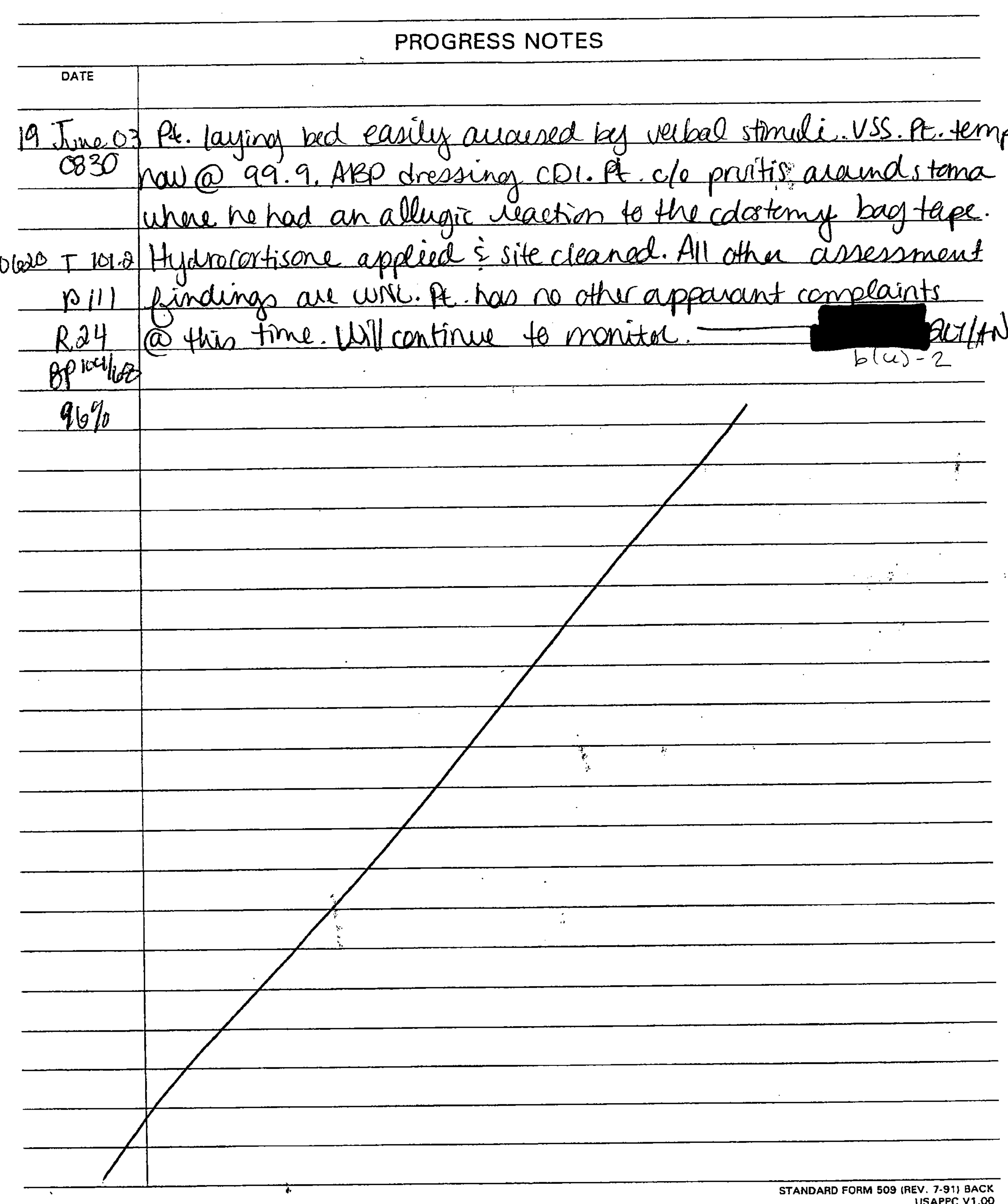
STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 14872

ACLU-RDI 1629 p.32

DOD-028261

PROGRESS NOTES



DATE	
19 June 03 0830	Pt. laying bed easily aroused by verbal stimuli. VSS. Pt. temp now @ 99.9. ABP dressing CDI. Pt. c/o pruritis around stoma where he had an allergic reaction to the colostomy bag tape.
0620 T 101.0 P 111 R 24 BP 104/68 96%	Hydrocortisone applied ~~s~~ site cleaned. All other assessment findings are WNL. Pt. has no other apparent complaints @ this time. Will continue to monitor. ——— [redacted] 2LT/AN b(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDCOM - 14873

ACLU-RDI 1629 p.33

DOD-028262

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 JUNE 03	General Surgery
0855	Pt continues to do well.
	∅ complaints
	[illegible] on back
	- low grade temps < 101. HR 90s BP 110/68 [illegible]
	Abdominal wound - granulating well
	[illegible] right [illegible]
	[illegible] - nearly resolved
	Left lateral flap not yet [illegible]
	- Plan STSG - from thigh (donor) [illegible]
	as long as flap is [illegible]
	[redacted] b(6)-2
	[illegible] MC
19 JUNE 03	General Surgery
1410	No complaints
	Continues to do well
	Wound unchanged
	[illegible] at
	[redacted] b(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

b(6)-2

CIV# [redacted]

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Jun03 2000	assumed care @1300 - VSS - IV patent - abd dsg Δ'd as ordered - pt. did not get OOB this shift - no c/o pain @ this time - cream applied to back and hand as ordered ——— [redacted] cn
19Jun03 2300	Assumed care of pt @21:00. Pt sleeping easily awaken. VS WNL. Skin W/D. Perrla⊕ WNL. LCA B. BS⊕ x4. ⊕PPP B. ABD. dsg CDI. ∅ complaints @ this time [redacted] /AW
0330	C/O pain ABD 4mg MSO4 given [redacted] /AW
20Jun03 0630	Pt. asleep in bed easily aroused by verbal stimuli. VSS: BP 108/62, sats 97%, P100, T 100.2. ABD dressing CDI. Colostomy draining liquid stool. IV LR c̄ 20KCl @ 50cc/hr in Ⓛ FA infusing s̄ s/s infection or infiltration. Pt. with no apparent complaints at this time. [redacted] All other assessment findings WNL. will continue to monitor. [redacted]
20 JUNE 03 1010	[illegible signature] Pt continues to do well. Low grade fever @ night. No apparent etiology. Wound granulating well. Same erythema Ⓡ side [illegible]. CEFT [illegible] - [illegible] - getting [illegible] - ? venous [redacted] [illegible]
0900	IV placed in Ⓛ FA. ——— [redacted]

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 14875

ACLU-RDI 1629 p.35

DOD-028264

MEDICAL RECORD	PROGRESS NOTES
DATE	
20Jun03	assumed care @1300 - Tmax 101.2, current
1815	100.9°F - area of redness noted on (R) FA
b(6)-2	@ old IV site, will make Dr. [redacted] aware -
	IV site new today & patent - dsg Δ'd -
	pt. up to chair and ambulated this
	shift - tolerated regular diet - no c/o
	pain @ this time ——— [redacted] cn
	b(6)-2
2230	Pt care assumed @ 2100. VSS, A+Ox3, no c/o pain. Lung
	sounds CTA, pulses palpable x4, IV c̄ 20 mEq KCL patent.
	Hydrocortisone applied to RLQ, ∅ c/o pain @ site. Abd dressing b(6)-2
	CDI, Δ to be done @ 12. Will continue to monitor. Spc [redacted] 91WM6
21Jun03	Pt. care assumed @ 0500. TEMP: 99.4, A+Ox3. Lungs
	CTA, pulses palpable x4. Drsg mid abd. CDI. Colostomy
	bag intact. IV LR c̄ 20 mEq KCL infusing @ 50cc/hr
	through alaris pump s̄ any problems. Denies any
	discomfort @ this time. will continue to monitor.
	b(6)-2 [redacted] 91WM6
0730	950cc clear yellow urine output - Davidson [redacted] 91WM6
0850	Drsg Δ'd complete. ∅ s/s of infection or foul odor noted
b(6)-2	will continue to monitor [redacted] 91WM6
0920	Pt. OOB sit-up in chair. ∅ distress noted. Pt. tolerated
	well ——— [redacted] 91WM6 ———
	[redacted] 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)

CIV [redacted] b(6)-4

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
21JUNE03	General Surgery
1128	Pt continues to do well
	OOB to chair - min movement
	Tm 101.2 yest VSS today
	Looks well
	- wound unchanged
	will wait for 100% adherence
	of skin flap prior to grafting
	b(6)-2 [redacted]
21June03	assumed pt care @ 1300. pt resting quietly easily
1920	aroused to verbal stimuli. VSS. lung sounds
	CTA, abd drsing CDI. ostomy bag intact. ↑ & ↓ ext
	c̄ full rom strong ⊕ pulses. ↓IV Ⓛ FA infusing LR
	c̄ 20 meq KCL s̄ diff. ∅ S/S of infiltration noted. pt
	denies "alarm" pain @ this time. Will cont to
	monitor b(6)-2 [redacted] 91WM6
2345	Pt C/o pain @ abd, 4mg MSO4. SPC [redacted] 91WM6
0100	Pt care assumed @ 2100. VSS, pt awake and alert,
22JUNE	4mg MSO4 given for pain. Lung sounds CTA, pulses
	palpable x4. IV @ LFA infusing LR c̄ 20 meq KCL @ 50cc/hr,
	∅ S/S infiltration. Dsg Δ, wound is pink and moist. Pt has
b(6)-2	no complaints will continue to monitor. SPC [redacted] 91WM6
22June03	Pt. laying in bed awake & alert. ABD dressing CDI. Colostomy care
0930	completed, hydrocortisone applied to edge of colostomy adhesive, no
	irritation noted. Pt. c/o itching about 0700, Benadryl 25mg given.
	Pt. nauseous 20 min after Benadryl given. Pt. spit up clear, colorless

MEDICAL RECORD	PROGRESS NOTES
DATE	
22June03 0930	liquid. Pt. currently ̄s complaints @ this time. All other assessment findings WNL. LR ̄c 20meq KCl @ 50cc/hr infusing in (L) FA ̄s s/s of infection or infiltration. Will continue to monitor. — [redacted] /AN b(6)-2
22JUNE03 1120	General Surgery
	Pt ̄c ? [illegible] following [illegible] this AM. Now feels better. [illegible] @ this time.
	[illegible] 99.8 [illegible] 122/76 HR 80-100 [illegible]
	[illegible] good.
	CHEST [illegible]
	[illegible]
	[illegible] - 100% [illegible] - good
	granulation tissue - (-) [illegible]
	[illegible]
	- [illegible]
	- check [illegible]
	- [illegible]
	- [illegible]
	- ↑ [illegible] [redacted] MD b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
22 Jun 03	Assumed care of Pt @ 1300. VSS. Ambulate x10 min s̄ assistance.
2010	OOB to chair x1°. ABD drsg CDI, O/C for graft in AM. Colostomy
	bag Δ'd, stoma looks healthy, soft brown formed stool.
	LR c̄ 20 KCl @ 50 cc/hr. Pain controlled c̄ Percocet - [illegible]
	Assessment WNL. Will Monitor b(6)-2
2210	Pt. care assumed @ 2100. VSS. Pt NPO for
	surgery in a.m. IV to (L) UE flushed, infusing
	IVF s̄ difficulty. HR Reg, Lungs CTA. Drsg to
	ABD CDI. Drsg Δ'd by evening shift x2, will
	not Δ drsg this shift. Colostomy draining soft b(6)-2
	semi-liquid stool. Will cont. to monitor
b(6)-2 0430	Dr. [redacted] notified of CBC results. [redacted]
23 Jun 03	Pt. awake & alert in bed. ABD dressing CDI. Colostomy on pt (R) side
0600	is draining soft brown stool. IV infusing in (L) AC c̄ LR c̄ 20 meq KCl @
	50cc/hr s̄ s/s infection or infiltration. VSS: BP 110/66, P96, Sats 96%, T99.8.
	All other assessment findings WNL. Pt. has no complaints @ b(6)-2
	this time. Pt. on call to OR this AM. Will continue to monitor [redacted]
0900	Pt. to OR via litter
1100	Pt back from OR via litter.

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23JUNE03	General Surgery
935	Brief Op Note
	preop dx: open granulating wound [illegible] 2° [illegible] to [illegible]
	postop dx: same as above
	procedure: split thickness skin graft to [illegible], donor right thigh
	surgeons: [illegible], [illegible]
	anesthesia: GET.
	EBL: min
	fluids 1100 cc LR
	specimens none
	complications none [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO. BCW2

CIV [redacted] b(6)-4

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

MEDCOM - 14880

ACLU-RDI 1629 p.40

DOD-028269

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 JUN 03	Assumed care of Pt @ 1300. VSS. A+O x 3. (B) LS CTA, (+) BS
1930	Ostomy draining liquid Brown stools - TOL PO WELL. (R) thigh
	Donor site under warm lamp dsg intact. ABD graft dsg
	to suction drain CDI. Ø dopplw. Pt ACT FLAT ON BACK
	(R) UE PIV patent. O/w assessment WNL - will
	Monitor ——— b(6)-2 [redacted]
24 Jun	Pt care assumed @ 2100. VSS, Alert and awake,
0140	T3 ss given for pain @ 0100. Lung sounds CTA, pulses
	palpable x4, bs present. Ostomy site CTA, Ø stool.
	(R) thigh CDI under heat lamp. Abd dsg CDI, JP suction @
	bedside. (R) Heplock flushes well, will continue to monitor.
	——— b(6)-2 [redacted] 91WM6
0430	Colostomy bag emptied, 100cc brown semi-formed stool, site
	intact. Nothing drained from JP. ——— [redacted] 91WM6
24 JUNE 03	General Surgery
0945	POD #1 [illegible] from (R) thigh [illegible]
	[illegible]
	[illegible]
	[illegible] dressing [illegible]
	[illegible] [redacted]
	Δ dressing in 23 [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			b(6)-2
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	

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

REGISTER NO.

WARD NO. BEW2

[redacted] b(6)-4

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

MEDCOM - 14881

PROGRESS NOTES

DATE	
24 Jun 03 2130	Pt vitals taken BP 108/62, P. 110, R. 16, Temp. 104.6 —— SPC [redacted]
25 Jun 03 0000	Pt temp @ 0000 is 99.8 —— [redacted] b(6)-2
25 Jun 03 1005	General Surgery [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] Pt [illegible] [illegible] [illegible] [illegible] [illegible] BP 118/72 [illegible] dressing [illegible] - [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] Donor site - [illegible] [illegible] [illegible] looks good. [illegible] : [illegible] [illegible] [illegible] - [illegible] dressing - [illegible] [illegible] [illegible] [illegible]. [redacted] b(6)-2
25 Jun 03	Assumed care of pt @ 0500. Pt is awake. VSS. Pt was given 50 mg Benadryl for itching. Pt tolerated all of breakfast and lunch. Lungs CTA. Pt was given T-3 ii tabs at 1105 for pain. b(6)-2 [redacted] 91W M6, 86T
1220	D/C'd pt's colostomy bag b(6)-2 [redacted] 91W M6, 86T
1700	Assumed care @ 1300. VSS. ATOx3. ABD graft site dsg CDI to suction donor site (R) LE under heat lamp, ostomy bag draining formed brown stools. (-) c/o pain. Benadryl given prn itching. Tol PO well. O/W assessment will monitor b(6)-2 [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
	Assumed care of pt @ 0500. Pt is alert. Pt had
24 Jun	a c/o itching. MD change order from PO Benadryl to
1100	IV Benadryl 50 mg. Δ'd pt's ostomy bag @ 0700.
	VSS. Lungs CTA. Pt has been sleeping most of the
	day. Pt has ø c/o pain/discomfort @ this time.
	b(6)-2 [redacted] 91WM6, SGT
24Jun03	assumed care @ 1300 - VSS, Tmax 100.3° -
1920	pt's ostomy bag Δ x3 this shift, skin around
	stoma appears macerated, weeping, ostomy
	bag not adhering to skin as well as it
	should - heat lamp remains above the
	donor site - drain at graft site remains
	on LIS, scant amount of drainage - pt.
	was fed dinner - IV patent - no c/o
	pain @ this time b(6)-2 [redacted] CPT, AN
2140.	Pt care assumed @ 2100. Pt c/o ABD pain, T's 0/4
	given. HL to (R) AC D/C'd because site leaking. IV
	to (L) FA flushed, ø s/s infection or infiltration. HR
	Reg, Lungs CTA, BS ⊕ x4 quadrants. Graft dressing
	to ABD CDI, drain to suction draining rust brown fluid.
	Graft donor site ~~CTA c heat lamp~~ 4x3 dsng intact c heat
	lamp applied, CSMTS to (R)LE WNL. will cont. to
	monitor. b(6)-2 [redacted]
0400	ø output from colostomy 20cc from drain - [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW 2

CIV

[redacted] b(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) USAPPC V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
25Jun03 2300	Pt care assumed @2100 VSS, AOX3, MD notified because pt complained T3 was of no help after the surgery, and he was in pain. MD order obtained for 4mg MSO4, 12.5mg of phenergan. Lung sounds CTA, pulses palpable x4, bowel sounds present. Graft site to JP suction @abd CDI, donor site @ thigh c̄ heat lamp CDI. Pt w/o complaints at this time. [redacted] 91WM6 b(6)-2
0300	JP drain found at pt's bedside. Dr [redacted] notified b(6)-2 will shut off suction and report to next shift. [redacted] 91WM6 b(6)-2
0430	200 output from JP drain, pt had large amount of semiformed feces @ ostomy. [redacted] 91WM6 b(6)-2
26 June 03 1100	Pt. laying in bed awake & alert. JP drain no longer in place, awaiting orders from MD. Colostomy bag Δ'd & cleaned. Heat lamp in place over donor site. Pt c/o itching, 50mg PO Benadryl given. Site on ABD c̄
1000 T99.9	clear dressing. Gauze under dressing c̄ dark grey saturation noted. Donor
P100	site on Ⓡ thigh c̄ yellowish drainage noted. Pt. eating & voiding well.
R20	All other assessment findings WNL. Pt. s̄ any complaints @
BP 122/76	this time. Will continue to monitor. [redacted] 91W/ADN b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW2

Civ # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 JUNE 03	General Surgery
1945	POD#3 s/p STSG to [illegible]
	Doing well. [illegible] reportedly
	[illegible]
	[illegible]
	[illegible]
	Looks well
	[illegible] dressing removed
	gauze [illegible]
	Looks v. good
	[illegible] STSG
	- Xeroform gauze [illegible]
	- [illegible]
	[redacted] b(6)-2
26 Jun 03 2000 b(6)	assumed care @1300 - VSS - graft dsg removed by Dr. [redacted] petrolatum gauze placed on graft site - heat lamp removed from (R) thigh & dry edges cut from dsg - no c/o pain - area around graft site cleaned, skin irritated - tolerated regular diet - colostomy emptied of soft loose stool ——— [redacted] b(6)-2

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

MEDCOM - 14885

MEDICAL RECORD	PROGRESS NOTES
DATE	
26JUN03	Rec'd pt @ 21:00. Pt. sleeping easy to awaken. Skin W/D
23:03	VS WNL according to flow sheet. PERRLA ⊕ LCA ⊕ BS ⊕ x4
	⊕ PPP ⊕ PIV Ⓛ FA & patent. new PIV initiated Ⓛ wrist
	s̄ difficulty. c/o pain. pt. tearing up and writhing in pain
	MD w/ m notified. 5mg MSO4 given IM Ⓛ thigh c̄
	new PIV initiated. MSO4 controlled pain per pt. Pain was
	in ABD area. Colostomy intact draining stool. Graft site @
	ABD c̄ petroleum gauze intact. Donor site c̄ dsg intact.
b(6)-2	to Ⓡ thigh. Will cont. to mon [redacted] 2LT/AN
24:00	c/o itching 50mg Benadryl given c̄ relief will
b(6)-2	cont. to mon. [redacted]
27JUNE03	General Surgery
0915	POD #4 F/P ASG to ABD wound - donor from Ⓡ thigh
	% [illegible] ⊕ ostomy output - [illegible]
	AFEB VSS
	ABD soft ND, [illegible]
	graft site - looks good
	donor site - drying well
	imp/plan: [illegible]
	- Colace 100mg po BID
	- dressing [illegible] c̄ [illegible]

(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] WARD NO. b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
27 Jun	Assumed care of pt @ 0500. Pt is asleep. Pt had c/o pain abdominal area. Pt was given colace @ 0900. Pt was given T-3 ii @ 0710 for c/o pain. Pt is now resting soundly. Dsg Δ done. MD says abdominal graft is doing well. Tolerated breakfast.
b(6)-2	Lungs CTA. Will continue to monitor [redacted] SGT
27 Jun 03 2000	assumed care @ 1300 - USS - colostomy c̄ semi-formed stool - graft doing well, Small area of yellow green drainage in lower (R) corner, petroleum gauze Δ'd - IV HL patent - medicated for pain c̄ ii Tylenol PO - thigh dsg trimmed - lungs CTA (B) -
b(6)-2	pt. slept most of shift [redacted] CPT, AN
2130	Pt alert - HRR, Lungs CTA, BS (+) x4. Colostomy draining soft brown non-formed stool. Vaseline gauze to ABD clean, intact. colostomy bag intact. Will cont. to monitor. [redacted] LTC, AN
	b(6)-2
28 JUNE 03	General Surgery:
0715	POD# 5 s/p STSG to abd wound
	Doing well
	NFSC VSS
	Abd looks good. 90-100% take - skin graft.
	Healing well
	Plan transfer to Iraqi hospital.
	b(6)-2
	[redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUNE 03	Transfer Summary
0930	DATE OF ADMISSION: 14 May 03
	DATE OF TRANSFER: APPROX. 28 JUNE 03
	HPI: 40 yo Iraqi male sustained GSW to abdomen
	on 14 May 03.
	Hospital Course:
	14 May - OR small bowel resection c̄ anastomosis x2
	[illegible] repair, loop sigmoid colostomy - FST
	17 May - OR fascial dehiscence, intra-abdominal
	abscess -> Hartmann procedure end sigmoid
	colostomy, [illegible], repair abdominal wall
	defect
	23 May - OR attempted closure abdominal wall defect
	IV bag closure [illegible] large defect
	22 May - OR - IV bag removed, plan for peritoneal
	surface to granulate followed by skin graft.
	3 June - OR [illegible] & debridement of [illegible]
	& fascial tissue.
	22 June - OR split-thickness skin graft placed
	on abdominal wall, donor from right thigh
	28 JUNE 03 - Transfer - skin graft 90-100% take
	Needs [illegible]

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

b(6)-2

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

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

MEDCOM - 14888

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03 1100	Pt. awake & alert in bed. Dressing Δ'd c̄ MD observing. Wound healing well, c̄ s/s of infection or drainage. Pt. bathed & colostomy bag Δ'd. Lung sounds clear bilat. Pt. eating well & voiding adequately. Pt. c/o pain x1, MSO4 4mg given. All other assessment findings WNL. Will continue to monitor. b(6)-2
2000	Assumed care of Pt @ 1900. VSS. A+Ox3. Graft healing well no S/SX of infection. Donor site BANDAGE CDI. (B)LS CTA. Ø c/o pain. Awaiting transfer to CIV HOSP in AM. All assess. WNL. Will Monitor. b(6)-2
29 Jun 0030	Pt care assumed @2100. VSS, alert and awake c̄ slight c/o pain. ~~At 2400 Temperature was 100.3, blanket taken off and ice applied, @0100 Temp is 99.7.~~ Lungs CTA, pulses palpable x4, bs ⊕ x4 quads. Skin graft site and donor site CTA, colostomy bag intact. Pt resting, no complaints at this time. Pt w/ evac orders, awaiting evac @ 0630 to Iraqi hospital. Will continue to monitor. 91WM6 b(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

CIV # b(6)-2

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 14889

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT [redacted] b(2)-2

LOG NUMBER

ARRIVAL — DATE: DAY 14 MONTH MAY YR. 03 — TIME 0815

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): PRIVATE VEHICLE / AMBULANCE / [X] OTHER (Specify) AIR

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Gunshot wound

SEX: M

AGE

POSSIBLE THIRD PARTY PAYER? YES / NO

VITAL SIGNS

TIME	0815	0830
BP	144/79	151/72
PULSE	96	90
RESP.	24	20
TEMP.	96.8	96.8
WT. (Child)		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Gunshot wound to Abdomen
IV Bag started 0820
2 Liter Bolus
3gms Unasyn
Pulse ox 93

TIME SEEN BY PROVIDER: 0815

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT b(6)-2

ORDERS	INITS.	TIME
3 gm Unasyn	[redacted]	0830
2 liter bolus	[redacted]	0830
X-ray chest	[redacted]	0920
Arm chest	[redacted]	0920
Belly	[redacted]	0920
CBC & METC 7	[redacted]	0855

ASSESSMENT/DIAGNOSIS: SpO2 100% @ RA

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

CONDITION UPON RELEASE
IMPROVED | UNCHANGED
DETERIORATED

TIME OF RELEASE: ICW

(CONTINUE ON SF 507, IF NEEDED)

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

ID b(6)-4 [redacted]

SIGNATURE OF PROVIDER AND ID STAMP

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

EMERGENCY CARE AND TREATMENT

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

MEDCOM - 14890 Copy

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

b(6)-2

10. OR [redacted] ONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] ert (AN 17 May 03 DATE

11. POSTOPERAT[redacted]

Pt [illegible] procedure well. transferred to ICU2 - USS.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
b(6)-2 [redacted] MAJ AN DATE: 17 May 03 TIME:	DATE: 17 May 03 TIME:

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDCOM - 14891

ACLU-RDI 1629 p.51

DOD-028280

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

4. PROPOSED SURGICAL PROCEDURE:

Repair abd wall hernia, possible loop colostomy takedown

5. ADDITIONAL INFORMATION: Pt does not speak English

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

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

b(6)-4

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

MEDCOM - 14892

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ✓ 4) Safety Devices ___ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ~~✓ Place and take down legs from stirrups with slow bilateral motion.~~ ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ✓ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. [redacted] INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 [redacted] /RN 22 May 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] /RN
DATE 22 May 03 TIME: 1010

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
DATE: TIME:

REVERSE OF FORM 5179, JUN 91 MEDCOM - 14893 USAPA V1.0

ACLU-RDI 1629 p.53

DOD-028282

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 40

HEIGHT: } unknown
WEIGHT: }

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex. Lap

4. PROPOSED SURGICAL PROCEDURE:
Ex. Lap

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition good
Tobacco ___ ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ______ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures. (e.g., warm blanket, touch). Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	Ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress. Ø Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

[redacted]

b(6)4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0700 ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

DA FORM 5179, JUN 91 Previous editions are obsolete USAPA V1.0

MEDCOM - 14894

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ___ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse [redacted] b(6)-2	o ~~Check for support stockings or ace wraps. If none, check with doc~~ N/A o Check that safety straps are [redacted] correctly applied. o Offer pillow for under knees. b(6)-2 o ~~Place and take down legs from stirrups with slow bilateral motion~~ N/A o Check that rings and all body piercing has been removed. [redacted]
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ___ 2) Intraoperative Hazards ✓ 3) Prosthesis ✓ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort. [redacted]	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. [redacted] o Offer support (i.e., pillows, bath towels, etc.) for positioning. b(6)-2
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier Intubated F.3. N/A Potential injury due to dentures: ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR tab[redacted] o Pt. will be able to understand instructio[redacted] o Minimize danger of injury during intraop period.	~~o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt from ____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.~~ N/A
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b(6)-2 [redacted] MAJ, AN   27 MAY 03 DATE

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

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

LEVEL OF ACTIVITY: ☐ ~~Moves All Extremities~~ ☐ ~~Moves Upper Extremities~~ BREATHING EASY. (Y) (N)

☐ ~~Transferred to liner with roller due to spinal~~

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) b(6)-2

[redacted] MAJ, AN

DATE: 27 May 03 TIME: 0945

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

DATE: 27 MAY 03 TIME: 1145

REVERSE OF FORM 5179, JUN 91

MEDCOM - 14895   USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 40
HEIGHT:
WEIGHT: 75 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Exp Lap, Colostomy, Multiple washouts of abd

4. PROPOSED SURGICAL PROCEDURE:
I+D washout of abd

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco____ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM________ ASA/Motrin w/72 hrs (Y) (N)
ETOH____________ Implants__________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures__________ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ____Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ____ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxie[redacted] o Pt. Exhibits relaxed body posture[redacted] b(6)-2	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., war[redacted] blanket, touch). o Explain all nursing procedures be[redacted] they are done. o Remain with pt. whenever possible. ~~o Maintain family interface. Parents to stay with pt.~~ N/A b(6)-2
B. AERATION ✓ Potential for respiratory dysfunction due to: ____ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative[redacted] phase. b(6)-2	[redacted] Offer to elevate head of litter or offer [pil]low. N/A Observe pt. while awaiting surgery for signs of distress. N/A o Assist anesthesia during intubation and extubation. N/A
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ____ 2) ESU Pad Placement ____ 3) Positional Aids ____ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impa[redacted] skin integrity (e.g., reddened areas[redacted] b(6)-2	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignm[redacted] o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling. b(6)-2

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

[redacted]
Civ # [redacted] b(6)-4

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION: ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ___ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ___ Potential for decreased communication due to: ___ 1) Diminished Hearing ___ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt from ______ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b(6)-2 [redacted] MAJ AN   5 Jun 03 DATE

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

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

LEVEL OF ACTIVITY: ☑ Moves All Extremities ☐ Moves Upper Extremities

☑ Transferred to litter ~~with roller due to spinal~~ by OR staff

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) b(6)-2 [redacted] MAJ AN

DATE: 5 Jun 03 TIME: 0955

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

DATE: 5 Jun 03 TIME: 1050

REVERSE OF FORM 5179, JUN 91

MEDCOM - 14897 USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 40

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition good
Tobacco____ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM________ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures________ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g.. warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ___ 1) Positioning ___ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

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

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

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0
MEDCOM - 14898

ACLU-RDI 1629 p.58

DOD-028287

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOME	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ___ Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Upper side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

b(6)-2 [redacted] CPT IAN

23 June 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
b(6)-2 [redacted] CPT IAN
DATE: 23 June 03 TIME: 0720

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) b(6)-2
[redacted] CPT IAN
DATE: 23 June 03 TIME:

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 30's
HEIGHT:
WEIGHT: 65 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex lap, I+D Abd.

4. PROPOSED SURGICAL PROCEDURE:
STSG to Abd. Wall

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition open abd wound
Tobacco ___ ppd X ___ yrs. Body Piercing ______ Diabetes (Y) (N) ROM ______ ASA/Motrin w/72 hrs (Y) (N)
ETOH ______ Implants ______ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ______ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

CW [redacted] b(a)-4
ICW-2

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

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 14900

ACLU-RDI 1629 p.60

DOD-028289

MEDICAL RECORD — **INTRAOPERAT[...] DOCUMENT**

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

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

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

3. DATE: 17 May 03 b(6) TIME PATIENT ARRIVED IN SUITE: 1453

4. PATIENT IN ROOM TIME: 1453 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Does not speak English

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] b(6)-2	RELIEF SCRUB	PFC [redacted] b(6)-2
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	CPT [redacted]

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Foam Headrest, padded

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: By [redacted] b(6)-2 Abdomen / Dr. [redacted]

PREP SOLUTION *(Specify)*

SITE: ABD BY WHOM: CPT [redacted] b(6)-2

SITE: Nipple line to pubis, table to table BY WHOM:

COMMENTS: (including groin)

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS

C = Correct I = Incorrect Initial: [redacted] MAJ [redacted] Spc

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	Spc [redacted]	CPT [redacted]
Needle Sharp	☒ Yes	☐ No		C	C	Spc [redacted]	CPT [redacted]
Instrument	☒ Yes	☐ No					
Other	☐ Yes	☒ No					

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

#[redacted] b(6)-4

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

☒ ESU NO: Valley Lab #4

GROUND PAD: BRAND 3M

LOT NO: 2005 10 07

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

COAG: 55 CUT: 1

DA FORM 5179-1, OCT 87 REPLACES DA [...] IS OBSOLETE. MEDCOM - 14901 USAPA V1.01

ACLU-RDI 1629 p.61

DOD-028290

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

b(6)-2 A1)

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY
NA		

PHYSICIAN'S SIGNATURE

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16FR/5cc [redacted] Catheter	[redacted] Ostomy wafer & pouch	
SITE	Urethra	Abdomen	

18. DRESSING/IMMOBILIZATION *(Specify)*

Benzoin, ABD

19. ADDITIONAL INFORMATION

Surgeons:
[redacted] LTC, MD
[redacted] LTC, MD

Anesthesia
CPT [redacted] CRNA

20. OPERATION(S) PERFORMED

Exploratory Lap, Abdominal wall hernia repair, Colostomy takedown, Hartman ~~pouch~~ procedure.

21. PATIENT TRANSFERRED TO ICU 2 | TIME 1830 | METHOD Gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT [redacted] [redacted] 7 May 03

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

MEDCOM - 14902

ACLU-RDI 1629 p.62

DOD-028291

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

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

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: 1LT [redacted] b(6)-2

3. DATE: 22 May 03 — TIME PATIENT ARRIVED IN SUITE: 1104

4. PATIENT IN ROOM TIME: 1104 — NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: Pt. speaks only Arabic. Translator present. NPO p 0200. NKDA.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. in supine position on padded OR table. BUE on padded arm-boards <90°. Pillow under knees, safety strap across mid thigh.

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: Nipple line to pubis BY WHOM: 1LT [redacted]

SITE: side to side BY WHOM: b(6)-2

COMMENTS: No pooling or reaction noted.

9. LOCATION OF EXTERNAL DEVICES

<90° — pillow — <90°

LEGEND: X Ground Pad (b(6)-2 KM) -- Safety Strap (KM) === Tourniquet N/A [hatched] = prep

Initial: SPC [redacted] 1LT [redacted]

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No					
Needle Sharp	[X] Yes	[ ] No					
Instrument	[X] Yes	[ ] No					
Other	[X] Yes	[ ] No					

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

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: # 1 cut 30 coag 30

GROUND PAD: BRAND 3M LOT NO: 2005-10 OT

[ ] ESU NO:

GROUND PAD: BRAND LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1, DEC 82, WHICH IS OBSOLETE. — MEDCOM - 14903 — USAPA V1.01

ACLU-RDI 1629 p.63

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs. ABD. tape

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] Dr. [redacted], Dr. [redacted]
Anesthesia: LTC [redacted]
b(6)-2 All

DA5179 dated 17 May03 in chart.

20. OPERATION(S) PERFORMED
Ex Lap

21. PATIENT TRANSFERRED TO ICU 2 | TIME 1333 | METHOD Litter c̄ O_2

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 8 USAPA V1.01

MEDCOM - 14904

ACLU-RDI 1629 p.64

MEDICAL RECORD - INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: gurney BY anesthesia

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

3. DATE 23 May 03
TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 0930 b(6)-2 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt intubated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E, AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pillow under knees. Bilateral arms <90° on padded arm boards.

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

COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta/Beta
SITE: ABD (nipple to groin area) BY WHOM:
SITE: BY WHOM:
COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES

pillow

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

b(6)-2

initial count - SSG [redacted] CPT [redacted] b(6)

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB b(6)-2	CIRCULATOR b(6)-2
Sponge	☐ Yes	☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Instrument	☐ Yes	☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Other	☐ Yes	☒ No					

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

EPW [redacted]
b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
CUT 50 COAG 50

☒ ESU NO: #1
GROUND PAD: BRAND 3M 9165
LOT NO: 2005-10 OT

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 14905

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP Drain x2	2.	3.
SITE	1. ABD	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- 8x4
- fluffs
- ABD
- silk tape.

19. ADDITIONAL INFORMATION
Surgeon:
[redacted] b(6)-2

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

20. OPERATION(S) PERFORMED
- Silo bag replacement.
- Debridement abdominal wall.
- colostomy revision

21. PATIENT TRANSFERRED TO ICU 2 TIME 1110 METHOD gurney c̄ resp.

22. REGISTERED NURSE SIGNATURE b(6)-2 [redacted] CPT, AN

REVERSE OF DA FORM 517[redacted] USAPA V1.01

MEDCOM - 14906

ACLU-RDI 1629 p.66

DOD-028295

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: CPT [redacted], CRNA b(6)-2
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: MAJ [redacted] b(6)-2
3. DATE: 27 May 03 — TIME PATIENT ARRIVED IN SUITE: 1105
4. PATIENT IN ROOM — TIME: 2-1 — NUMBER: 1105

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt intubated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted], AN, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* (B) arms abducted less than 90° on padded armboards.

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

COMMENTS:

8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Abdomen BY WHOM: [redacted] b(6)
SITE: nipples to pubic symphysis BY WHOM:
COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES

LEGEND: X Ground Pad — -- Safety Strap — === Tourniquet — N/A

10. COUNTS

C = Correct I = Incorrect

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

Init by [redacted] & [redacted]

SCRUB: [redacted] — CIRCULATOR: [redacted] b(6)-2

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

[redacted]
Civ # [redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO — Settings 40/40

☒ ESU NO: #3
GROUND PAD: BRAND: VL REM
LOT NO: 68936 EXP 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA ... WHICH IS OBSOLETE. — MEDCOM - 14907 — USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluff
ABD Pad Silk Tape
Ostomy Bag

19. ADDITIONAL INFORMATION

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

Bovie Cut 40 Coag 40 Bove plate site clear, dry intact

20. OPERATION(S) PERFORMED

Wound Exploration & Debridement
Removal of Silo Bag, Packing/Dressing
Ostomy Bag

21. PATIENT TRANSFERRED TO ICU2 TIME 1145 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ

REVERSE OF DA FORM 5179-1, OCT 8 b(6)-2

MEDCOM - 14908 USAPA V1.01

ACLU-RDI 1629 p.68

DOD-028297

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

2. PATIENT [redacted] VIEWED AND PROCEDURE VERIFIED [redacted] CPT AN

3. DATE: 3 June 03

TIME PATIENT ARRIVED IN SUITE: ICW → OR

4. PATIENT [redacted] ROOM TIME 0823 b(6)-2 NUMBER 1-1 / 1

5. PREOPERATIVE EMOTIONAL STATUS

- [x] CALM
- [ ] ANXIOUS
- [ ] EXCITED
- [ ] CRYING
- [ ] ANGRY
- [ ] WITHDRAWN
- [ ] OTHER *(Specify)*

COMMENTS: NKDA - NPO p MN

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

- [x] SUPINE
- [ ] LITHOTOMY
- [ ] PRONE
- [ ] KRASKE

LATERAL:
- [ ] LEFT SIDE UP
- [ ] RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL: [ ] YES [x] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: Ø

PREP SOLUTION *(Specify)*: Betadine S/S

SITE: Abd BY WHOM: CPT [redacted] AN

SITE: BY WHOM:

COMMENTS: Ø poolings of sol.

9. LOCATION OF EXTERNAL DEVICES

Prep area

<90°

<90°

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

10. COUNTS

C = Correct I = Incorrect

	Yes	No	Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[x] Yes	[ ] No		C	C	Spc [redacted]	CPT [redacted]
Needle Sharp	[x] Yes	[ ] No					
Instrument	[ ] Yes	[x] No					
Other	[ ] Yes	[x] No					

b(6)-2

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

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [x] YES [ ] NO

[x] ESU NO: Valley Lab #1

GROUND PAD: BRAND Polyhesive

LOT NO: 54179

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

1 Coag 30, Cut 30

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 14909 H IS OBSOLETE. USAPA V1.01

ACLU-RDI 1629 p.69

DOD-028298

ESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANU TURER

MEDICATIONS/ORDERS

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

IONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

ID IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9% NaCl

ER ORDERS	TIME	CARRIED OUT BY

HYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix
ABD's & Δ colostomy bag

19. ADDITIONAL INFORMATION
D.A form 5179 Reviewed & Nsg care implemented.
Surgeon: [redacted] b(6)-2

20. OPERATION(S) PERFORMED
I & D, c̄ Colostomy bag Δ

21. PATIENT TRANSFERRED TO b(6)-2 ICU TIME 0930 METHOD Litter c̄ O2

22. REG [redacted] CPT AN

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

MEDCOM - 14910

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY CPT [redacted] / CPT [redacted]

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

3. DATE 5 Jun 03 TIME PATIENT ARRIVED IN SUITE 0955 b(6)-2

4. PATIENT IN ROOM TIME 0955 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Povidone scrub & solution
SITE: abd BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS

C = Correct I = Incorrect Initial Count: SPC [redacted] b(6)-2

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C		
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☐ Yes ☐ No		C	C	SPC [redacted]	MAJ [redacted]
Other	☐ Yes ☑ No				SPC [redacted]	MAJ [redacted]

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

[redacted] EDW # [redacted] b(6)-4

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

☑ ESU NO: Valleylab #1
GROUND PAD: BRAND Valleylab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix roll x2
Lap pad.
Tape

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted]
Anes: CPT [redacted] b(6)-2

20. OPERATION(S) PERFORMED

Evacuation of abdominal hematoma

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU #2 b(6)-2	1045	Litter

22. REGISTERED NURSE SIGNATURE
[redacted] MAJ AN

REVERSE OF DA FORM 5179-1, OC

USAPA V1.01

MEDCOM - 14912

ACLU-RDI 1629 p.72

DOD-028301

MEDICAL RECORD — **INTRAOP[ERATIVE] D[OCUMENT]**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

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

3. DATE 23 June 03 — TIME PATIENT ARRIVED IN SUITE 0755

4. PATIENT IN ROOM TIME 0755 — NUMBER 1-1 1 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

b(6)-2 ATL

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained,

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted] / Dr [redacted]

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Beta / Beta (Hibiclens)

SITE: Abdomen → Hibiclens BY WHOM [redacted]

SITE: (R) thigh BY WHOM [redacted]

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES

☒ prep area

LEGEND X Ground Pad SH — Safety Strap SH === Tourniquet

10. COUNTS — C = Correct I = Incorrect — Initial: [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

CW [redacted] b(6)-4

ICW-2

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

☐ ESU NO: Valleylab Force II #1

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 69652 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 14913

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

b(6)-2 All

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
NaCl c Epi 1:1000 (1:100,000 solution)	QS	I10	Topical	[redacted]	[redacted]
					b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
Replace ostomy bag	I10	[redacted]

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

15. X-RAY IN [redacted] IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Colostomy	10mm JP	
SITE	RUQ	Abdomen	

18. DRESSING/IMMOBILIZATION (Specify)
Vaseline gauze (Xeroform)
Ioban
Benzoin Tincture
Mineral oil soaked fluffs

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op yes ; post-op yes Bovie Settings: Coag/Cut - not used
Tourniquet Site intact pre-op ____: post-op ____
Tourniquet Time: Up____ Down____ → N/A

20. OPERATION(S) PERFORMED
Skingraft Abdomen for thigh donor site

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-1	see DA7389	litter c safety strap on

22. REGISTERED NURSE SIGNATURE
[redacted] CPT 1A

REVERSE OF DA FORM 5179-1, OCT MEDCOM - 14914 USAPA V1.01

ACLU-RDI 1629 p.74

DOD-028303

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY 1

MONTH-YEAR DAY 14 MAY 15 MAY

19 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD RR 16 16 20 18 20 16 16 16 20 20 18

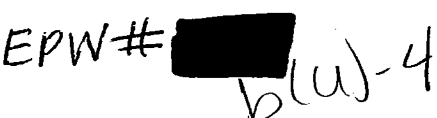
BLOOD PRESSURE 140/74 140/80 144/86 126/82 120/100 136/72 130/74
140/76 150/80 130/88 132/88 124/84 120/84

SpO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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



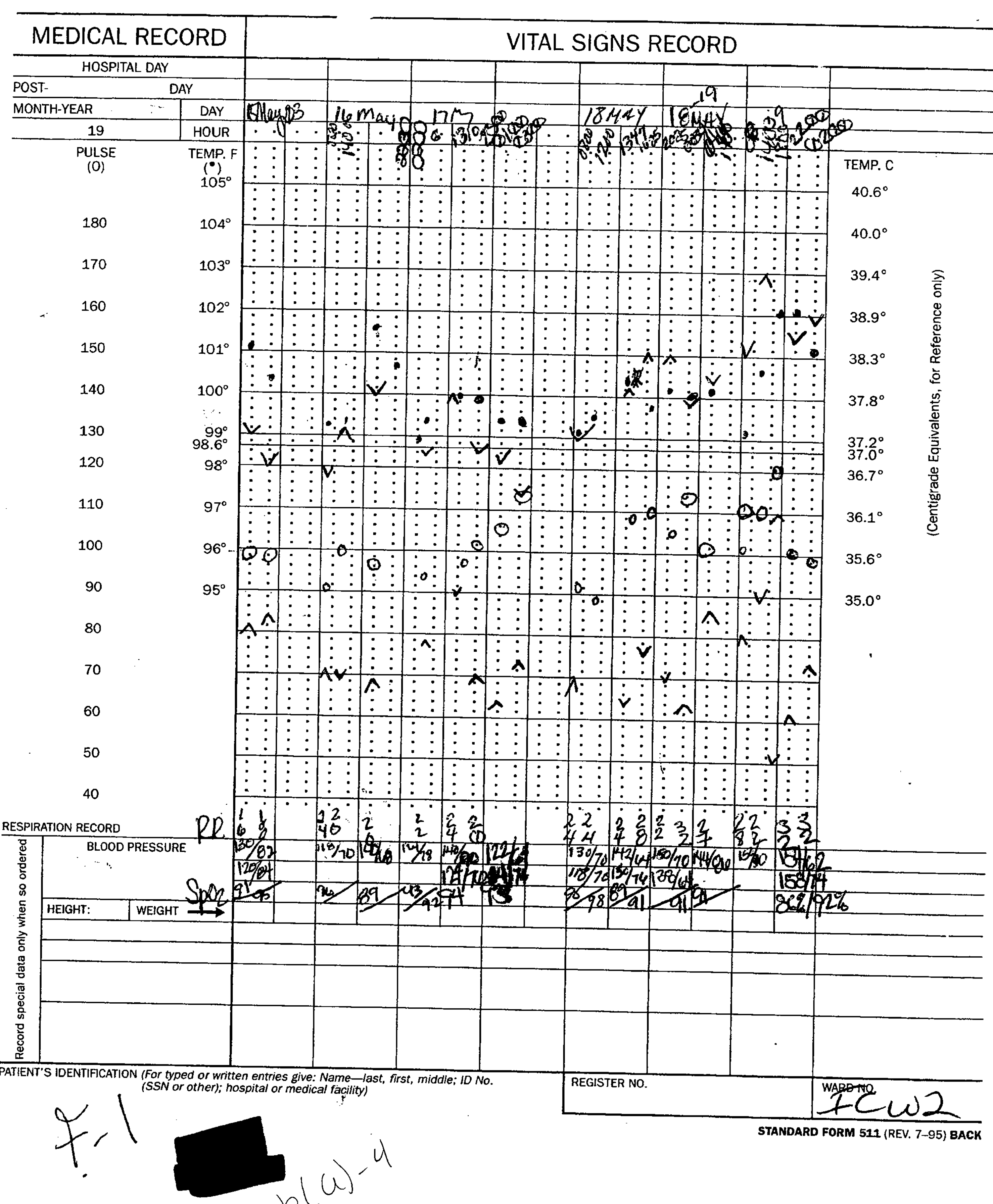
EPW # [redacted] b(u)-4

VITAL SIGNS RECORDS

Medical Record

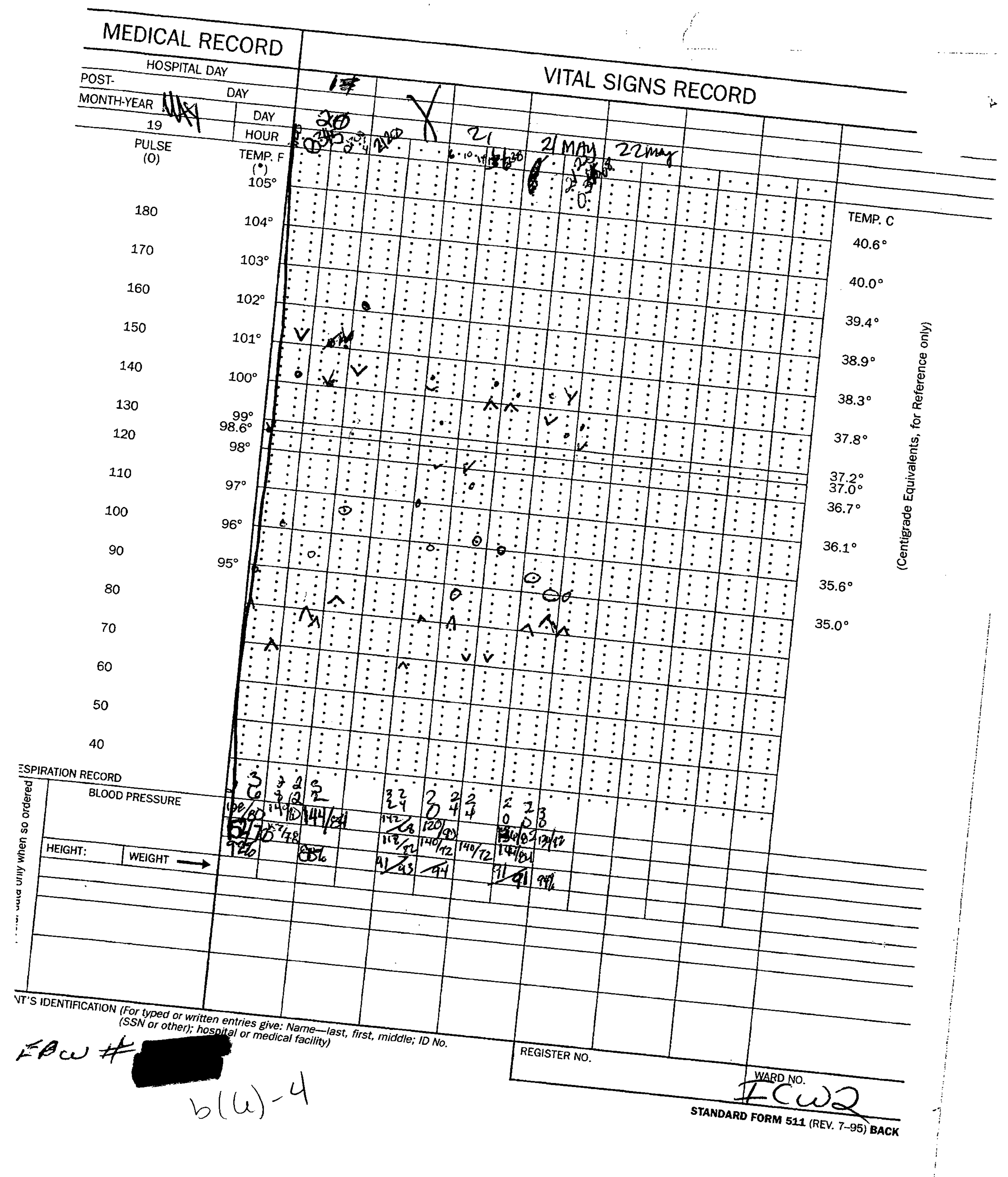
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 14915



b(6)-4

MEDCOM - 14916



b(6)-4

MEDCOM - 14917

ACLU-RDI 1629 p.77

DOD-028306

511-119

MEDICAL RECORD

VITAL SIGNS RECC

HOSPITAL DAY

POST- DAY

MONTH-YEAR June DAY

19 2003 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

SaO2

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. ICW 2

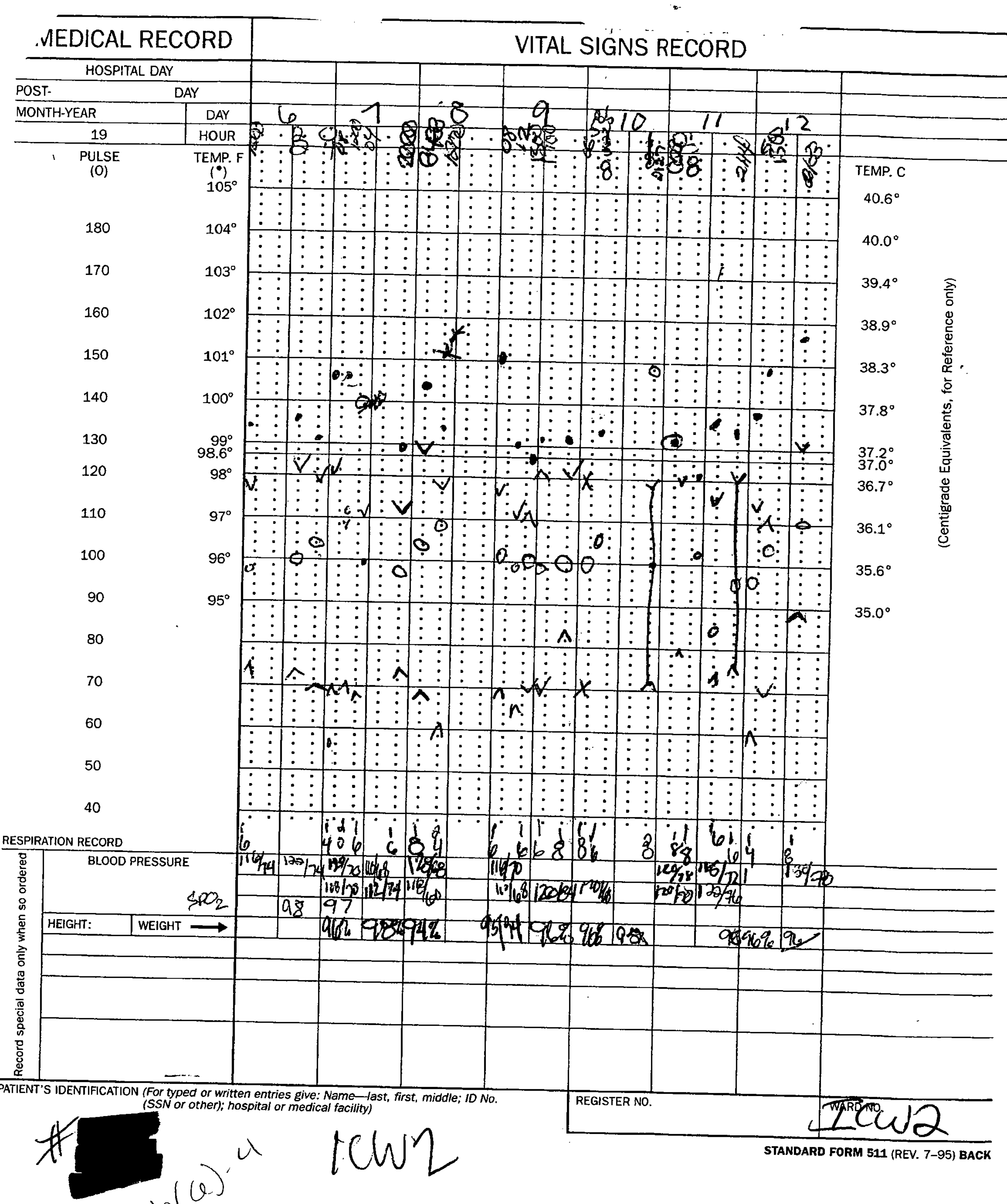
b(W)-4

VITAL SIGNS RECORDS

Medical Record

RM 511 (REV. 7-95)
GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 14918



MEDICAL RECORD

VITAL SIGNS RECORD

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

SpO2

HEIGHT: | WEIGHT →

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7–95) BACK

[redacted] b(6)-4 ICW2

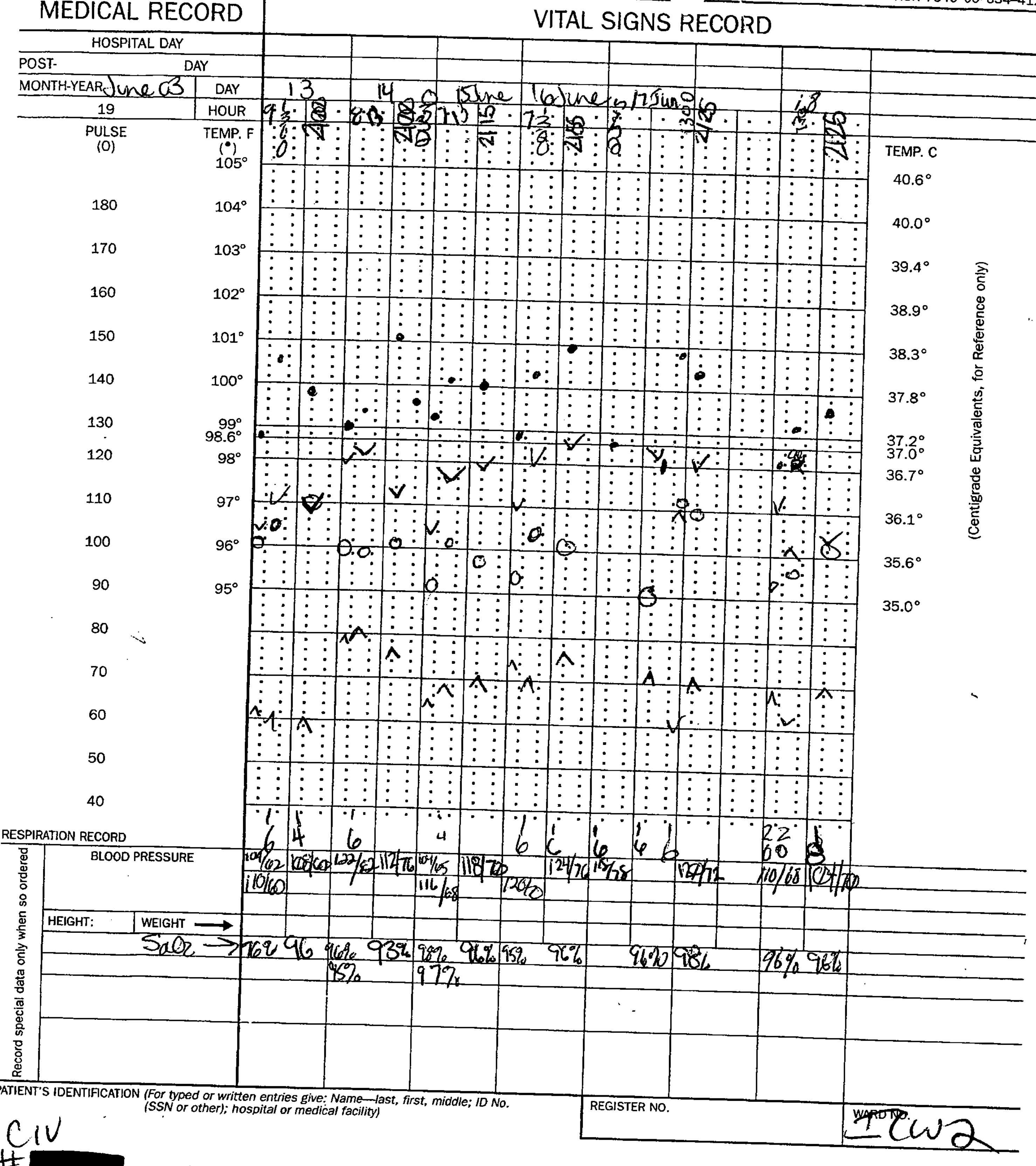
MEDCOM - 14919

1-119

MEDICAL RECORD

NSN 7540-00-634-4124

VITAL SIGNS RECORD



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. ICW2

CIV
[redacted] b(6)-4

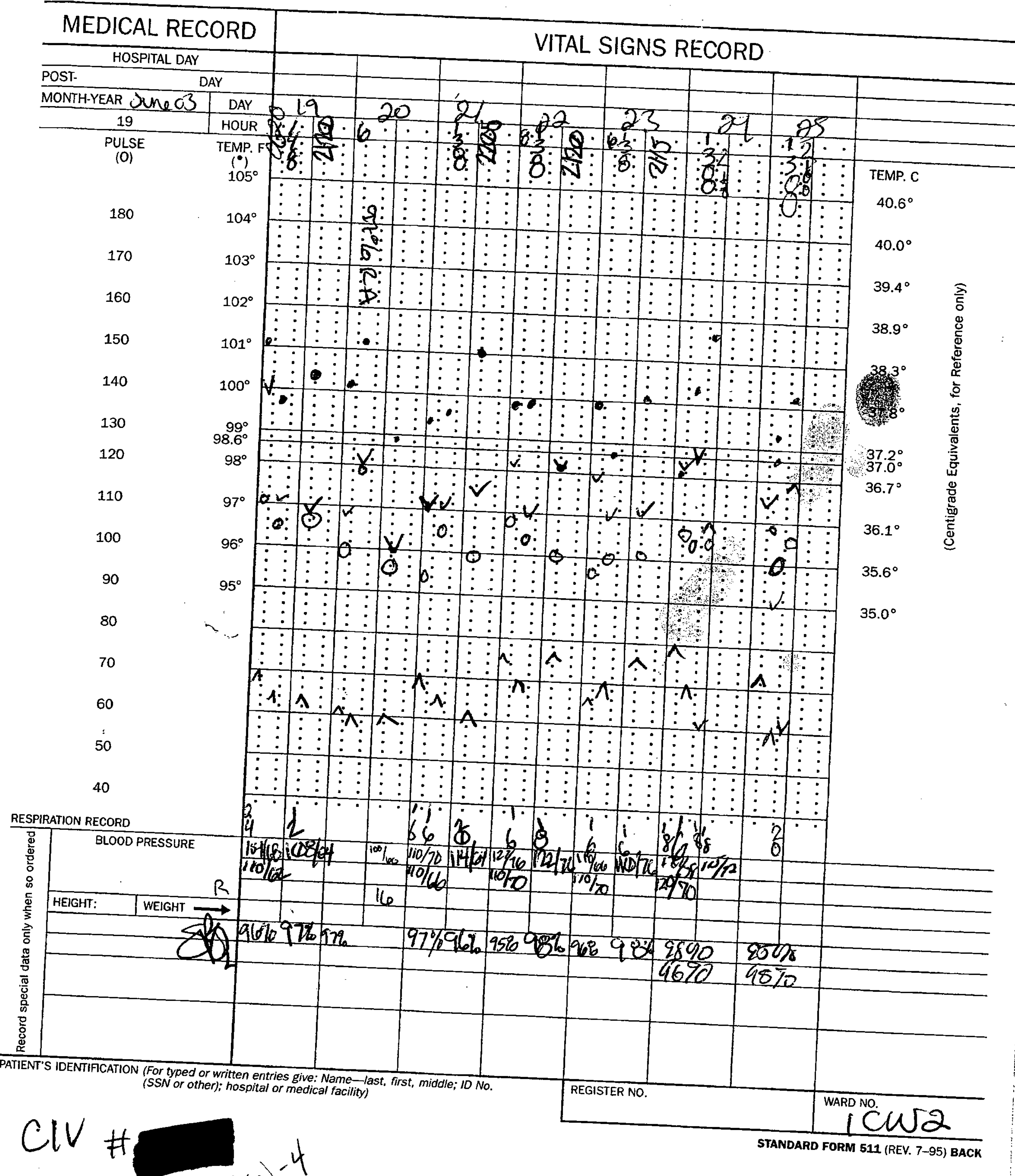
ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 14920


MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 03 | DAY 19 20 21 22 23 24 25

19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

CIV # [redacted] b(6)-4

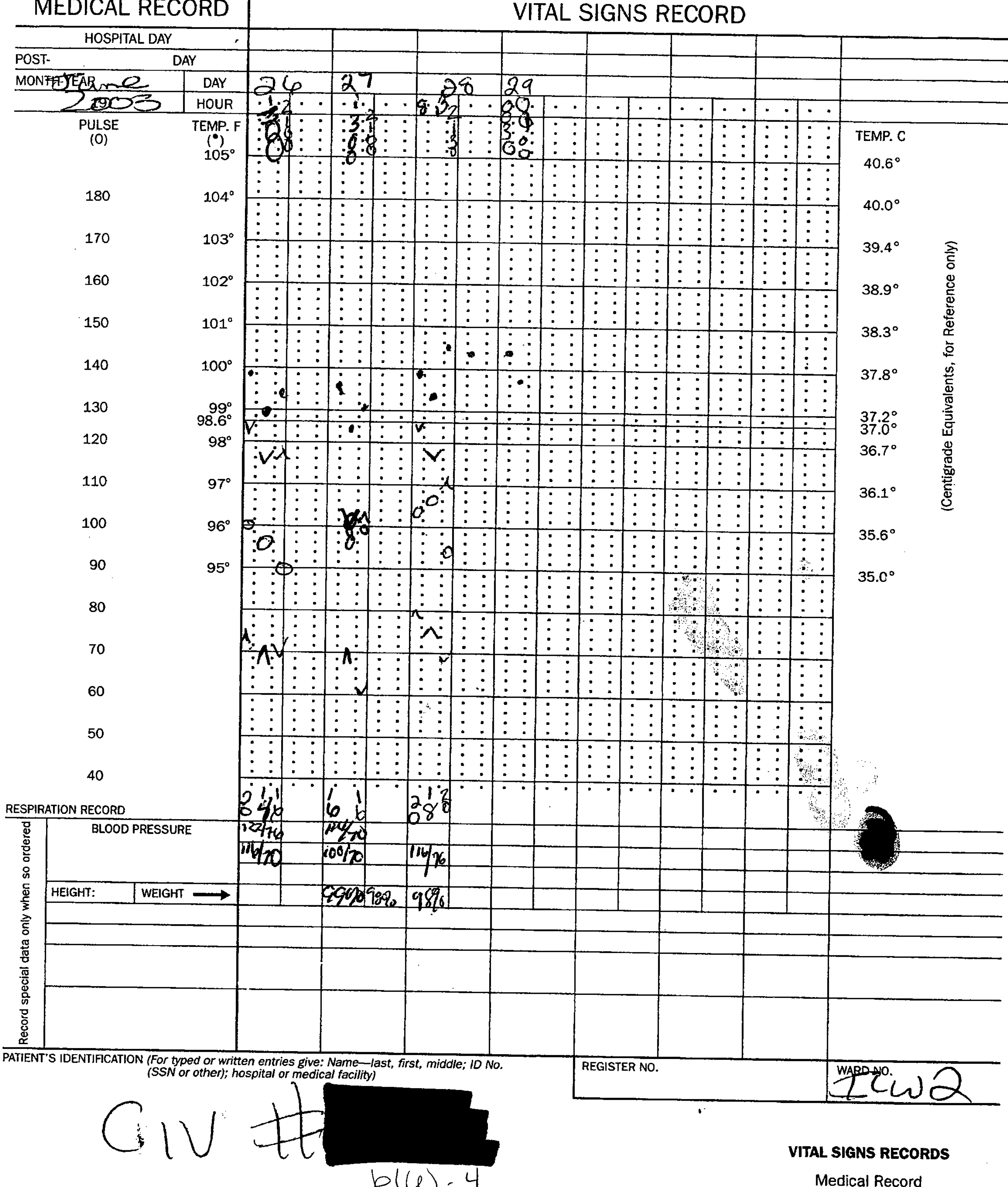
MEDCOM - 14921

ACLU-RDI 1629 p.81

DOD-028310

511-119

NSN 7540-00-634-4124



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. ICW2

CIV # [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 14922

RT Vent Flow Sheet

#[redacted] b(6)-4

8.0 ETT
22@lip

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	SPONT RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITAIL
22may	1343	SimV	12	700	50	5	23	1:2	2	—						
22may	1616	SimV	12	700	50	5	23	1:2	2	—	107	100	137/75	8	MLT	
22May	1905	SimV	12	700	50	5	23	1:2.1	3	—	115	100	118/65	8	MLT	
22May	2000	SimV	12	700	50	5	22	1:2.1	1	—	128	100	105/57	8	MLT	
22May	2145	SimV	12	700	50	5	23	1:2.1	4	—	130	100	98/61	8	MLT	
22May	2330	SimV	12	700	50	5	14	1:2.1	4	—	137	100	101/53	8	MLT	
23May	0200	SimV	12	700	50	5	23	1:2.1	0	—	175	100	97/52	8	MLT	
23May	0400	SimV	12	700	50	5	23	1:2.3	0	—	118	100	103/53	8	MLT	
23may	0622	SimV	12	700	50	5	24	1:2.1	0	—	113	100	109/61	8	MLT	
23may	0807	SimV	12	700	50	5	23	1:2.1	0	—	108	100	106/58	8	MLT	
23may	1055	PC	Taken	To	OR					—	106	100	103/54	8	MLT	
23may	1205	SimV	12													
23may	13:54	SimV	12	700	50	5	28	1:2.1	0	—	107	100	119/68	8	MLT	
23may	1554	SimV	12	700	50	5	25	1.2.1	—	—	100	100	107/58	8	MLT	
23May	1740	SimV	12	700	50	5	25	1.2.1	0	—	106	100	100/61	8	MLT	
23May	2000	SimV	12	700	50	5	24	1.2.1	0	—	109	109	117/61	8	MLT	
23May	2200	SimV	12	700	50	5	25	1.2.1	0	—	115	100	108/61	8	MLT	
24May	0000	SimV	12	700	50	5	25	1:2.1	0	—	120	100	123/58	8	MLT	
24May	0200	SimV	12	700	50	5	25	1:2.1	0	—	118	100	101/53	8	MLT	
24May	0400	SimV	12	700	50	5	24	1:2.1	0	—	110	100	107/54	8	MLT	
24may	0600	SimV	12	700	40	5	27	1:2.1	0	—	109	100	112/57	8	MLT	
24may	0800	SimV	12	700	40	5	23	1:2.1	0	—	115	100	193/59	8	MLT	
24May	1000	SimV	12	700	40	5	23	1:2.1	0	—	104	100	108/62	8	MLT	
24may	1200	SimV	12	700	40	5	23	1:2.1	0	—	114	100	150/59	8	MLT	
24may	1400	SimV	12	700	40	5	25	1:2.1	0	—	112	100	103/57	8	MLT	
24may	1600	SimV	12	700	40	5	20	1:2.1	0	—	104	100	119/53	8	MLT	
24May	1800	SimV	12	700	40	5	30	1:2.1	0	—	100	100	111/55	8	MLT	
24May	2000	SimV	12	700	40	5	39	1:2.1	0	—	105	100	103/54	8	MLT	
24May	2200	SimV	12	700	40	5	36	1:2.1	0	—	98	100	114/53	8	MLT	
25May	0000	SimV	12	700	40	5	36	1:2.1	0	—	119	95	104/69	8	MLT	
25May	0200	SimV	12	700	40	5	27	1:2.1	0	—	117	99	104/68	8	MLT	
25May	0400	SimV	12	700	40	5	26	1:2.1	0	—	103	131/56	100	8	MLT	
25may	0613	SimV	12	700	40	5	87	1:2.1	0	—	101	121/56	100	8	MLT	
25may	0803	SimV	12	700	40	5	26	1:21	0	—	102	114/52	100	8	MLT	
											108	100	133/57	8	MLT	

b(6)-2

MEDCOM - 14923

ACLU-RDI 1629 p.83

DOD-028312

Pt # [redacted] b(6)-4

8.0 ETT
22cm @ lip

DATE	TIME	MODE	RATE (PH)	VOLUME (PCO2)	O2 (PO2)	PEEP (HCO3)	PIP (BE)	I:E TIME (SO2)	SPONT	PLATEAU	HR	SpO2	BP	ET	
25may	0955	SimV	12	700	40	5	26	1:2.1	Ø						
25May	1210	SimV	12	700	40	5	35	1:2.1	Ø	—	97	99	127/61	8	MLT
21may	1400	Simv	12	700	40	5	29	1.2.1	Ø	—	97	100	128/61	8	MLT
25may (Tx)	1420				↑50					—	112	99	121/60	8	ML
25may	1550	simV	12	700	50	↑8	88	1:2.1	20	—	116	95	129/60	8	MLT
~~25may~~	~~1637~~	SimV	~~12~~	~~700~~	~~50~~	8									
25may	1637	ABG	7.426	38.8	67	25	[illegible]	94							
25May	1900	SimV	12	700	50	8	25	1:2.1							
25May	2000	SimV	12	700	50	8	33	1:2.1	8	—	112	97	119/52	8	MLT
25 May	2200	SIMV	12	700	50	8	35	1:2.1	16	—	110	98	143/69	8	MLT
26 May	0000	SIMV	12	700	50	8	22	1:2.1	11	—	119	98	152/51	8	MLT
26 May	0200	SIMV	12	700	50	8	25	1:2.1	Ø	—	110	100	104/48	8	MLT
26 May	0400	SIMV	12	700	50	8	31	1.2.1	19	—	118	98	107/53	8	MLT
26may	0630	SimV	12	700	50	8	25	1:2.1	12	—	117	97	107/51	8	MLT
26may	0808	SimV	12	700	50	8	28	1:2.1	15	—	111	98	106/68	8	MLT
26may	0956	SimV	12	700	50	8	19	1:2.1	1	—	118	100	129/51	8	MLT
26may	1150	SimV	12	700	50	8	26	1:2.1	6	—	123	98	115/47	8	MLT
26may	1410	SimV	12	700	50	8	27	1:2.1	Ø	—	119	100	93/40	8	MLT
26may	1411	ABG	7.437	30.5	46	21	-4	84			125	91	144/65	8	MLT
26may	1458	ABG	7.400	26.2	64	16	-4	93							
26may	1538	SimV	12	700	50	8	25	1:2.1							
26 May	1800	SimV	12	700	50	10	30	1:2.1	Ø	—	117	100	80/31	8	MLT
26 May	2000	SimV	12	700	50	10	20	1:2.1	8	—	120	96	104/41	8	MLT
26may	2200	SimV	12	700	50	10	19	1:2.1	8		95	99	96/51	8	MLT
27May	0000	SimV	12	700	50	10	25	1.2.1	9		96	100	94/56	8	MLT
27May	0200	SimV	12	700	50	10	24	1:2.1	0		88	100	103/56	8	MLT
27 May	0400	SimV	12	700	50	10	21	1:2.1	0	—	89	100	103/57	8	MLT
27may	0611	SimV	12	700	50	10	31	1:2.1	Ø	—	85	100	101/55	8	MLT
27may	0750	SimV	12	700	50	10	31	1:2.1	Ø	—	99	100	120/63	8	MLT
27may	1000	SimV	12	700	50	10	30	1:2.1	Ø	—	93	100	113/60	8	MLT
27may	1230	SimV	12	700	50	10	26	1:21	Ø	—	105	99	148/75	8	MLT
[illegible]may	1400	SimV	12	700	50	10	26	1:2.3	Ø	—	78	99	[illegible]/92	8	[illegible]
1May	1600	SimV	12	700	50	10	29	1:2.3	Ø	—	91	100	133/67	8	MLT
	1800	SimV	12	700	50	10	22	1:2.1	4	—	101	100	129/61	8	MLT
											117	100	117/57	8	MLT

b(6)-4

MEDCOM - 14924

VENT FLOW SHEET

#[redacted] b(6)-4

8 ETT
24 lip

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
27May	2000	SimV	12	700	50	↓2.5 5	23	1:2.1	Ø	—	115	100	121/49	8	MLT	[redacted]
27May	2200	SimV	12	700	↓48	5	20	1:2.1	Ø	—	115	100	122/50	8	MLT	[redacted]
28May	0000	SimV	12	700	45	5	24	1:2.1	1	—	114	100	131/58	8	MLT	[redacted]
28May	0200	SimV	12	700	↓40	5	28	1:2.1	3	—	123	100	133/59	8	MLT	[redacted]
28May	0400	SimV	12	700	40	5	30	1:2.1	3	—	125	100	112/59	8	MLT	[redacted]
28May	0547	SimV	12	700	40	5	29	1:2.1	3	—	114	100	95/59	8	MLT	[redacted]
28May	0750	SimV	12	700	40	5	22	1:2.1	Ø	—	110	100	114/63	8	MLT	[redacted]
28May	1017	SimV	12	700	40	5	23	1:2.1	Ø	—	90	100	91/73	8	MLT	[redacted]
28May	1230	SimV	12	700	40	5	22	1:2.1	Ø	—	85	100	114/69	8	MLT	[redacted]
28May	1430	SimV	8↓	700	40	3	22	1:2.1	Ø	—	81	100	121/71	8	MLT	[redacted]
28May	1600	SimV	12	700	40	5	22	1:2.1	0	—	99	100	125/74	8	MLT	[redacted]

b(6)-2

TWENTY- ...RKSHEET

FROM 0500 HOURS TO 0500 HOURS | TOTAL HOURS COVERED 24° | DATE 2 June-3 June

TIME	TYPE	AMOUNT	TOTAL
0730	chocolate milk	50cc	50
0730	water	50cc	100
1045	Ensure	180cc	280
1215	water	50cc	330
1700	H_2O	50cc	
2000	H_2O	20	
1			

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0500	300cc	LR c̄ 20Kcl	300	1045	300
0630	50cc	Ampicillin in NC	50cc	0700	350
0700	50cc	Zosyn in NS	50cc	0730	400
1100	100cc	Gent in NS	100cc	1200	500
1100	1000cc	LR c̄ 20KCl			
1300	100	Zosyn, amp	100		
1800	50/50	amp/Zosyn	100		

~~IRRIGATIONS (N/G, Bladder, etc.)~~ Urine out

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	Clear yellow urine	500cc	500cc
0800	c/ear yellow urine	525cc	1025cc
1045	CYU	500cc	1525cc
1500	urine	600	2125
1800	urine	400	2525
0300	urine	700	3225
~~0200~~			
0230	CYU	540	540cc
~~0600~~	~~urine~~	~~300cc~~	

~~BLOOD/BLOOD DERIVATIVES~~ Stool

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
1630	Stool-loose	50		50

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

CIV# [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 EDITI 1 JUL MEDCOM - 14926 REPLACES DA FORM 3630(TEMP) *U.S.GPO:1998-404-613/?

TWENTY-FOUR ... INT ...

DATE 6/1/03

ORAL			
TIME	TYPE	AMOUNT	ACCUM TOTAL
1200	H2O	100	100
1800	H2O	60	160

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1100	1000	LR @ 50cc/hr			
1200	100	Gentamycin	100	1230	
1330	50	205/hr	50	1400	
1830	50	amp	50	1900	
1900	50	205/hr	50	1930	

Voids ~~IRRIGATION, NG, BLADDER~~ TEAD

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1200	200	200	200
1600	500	700	900
1930	300	[illegible]	1200

Stool ~~BLOOD/BLOOD DERIVATIVES~~ out

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
1400	Stool-loose	/	100	100
2000	Stool-loose	/	50	150

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

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

MEDCOM - 14927

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

TWENTY-FOUR HOUR PATIENT IN[...]E AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 0500 HOURS | TOTAL HOURS COVERED 24° | DATE 3 JUN

INT[AKE]

ORAL			
TIME	TYPE	AMOUNT	ACCUM TOTAL
0500	NPO for ~~SH~~ OR		
1200	water	80cc	80cc

INTRAVENOUS					
TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	1000cc	LR c̄ 20 Kcl	300	0800	300
0600	50/50	Ampicillin/Zosyn	100	0700	400
0800	1000cc	LR	600	1100	1000
1130	1000cc	LR c̄ 20 meq KCL	50cc/hr		
1200	50/50	Ampicillin / Zosyn	100		1100
1000	100cc	Gent	100		1200
1800	error ~~100~~ 50cc	Ampicillin	50cc		1250

~~IRRIGATIONS (N/G, Bladder, etc.)~~ OUTPUT			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0600	urine	300cc	300cc
1100	urine	500cc	800cc
1200	urine	300cc	1100cc
2146	urine cl yellow	225	1325cc
0400	CYU	500cc	1825cc

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

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

Civ # [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

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

MEDCOM - 14928

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

OUTPUT

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM HOURS	TO 0359 HOURS	TOTAL HOURS COVERED 0400	DATE 4 Jun 0?

INTAKE

URINE ~~ORAL~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
[illegible]	Urine Cl yellow	375	375
0300	Cl yellow	275	650

EMESIS ~~INTRAVENOUS~~

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

STOOL ~~(IRRIGATION (S/O, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0300	Soft Brown	100cc	100cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 1 JAN 74 792 — EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. *U.S.GPO:19

MEDCOM - 14929

INTAKE

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0410	H2O	200cc	200cc
0700	MILK	240cc	440cc
1200	H2O	50cc	490cc
1700	H2O	50cc	540

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
00:00	50cc	Ampicillin	50cc		50
00:00	50cc	Zosyn	50cc		100
~~00:15~~	~~950cc~~	~~LR c 20 KCl~~	~~900~~		~~350cc~~
0600	100cc	Amp / Zosyn	100cc		250cc
1800	50cc	Ampicillin	50cc		300
1800	50cc	Zosyn	50cc		350cc

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	urine	400cc	400cc
1100	urine	300cc	700cc
1830	urine	375	1075cc
2130	CYU	220	1295cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

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

MEDCOM - 14930

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 2359 HOURS | TOTAL HOURS COVERED 24° | DATE 6/5/03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	120cc milk	120cc	120
0930	H2O	60cc	180
1750	Choc milk	120	300.

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Ampicillin	50cc		50
		Zosyn	50		100.
		LR c 20K	400		500.
		Zosyn	50		550
		Ampicillin	50		600

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

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

MEDCOM - 14931

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE

INTAKE

~~ORAL~~ Urine -

TIME	TYPE	AMOUNT	ACCUM TOTAL
01	Urine	150	150
0430	Urine	250	350

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0430	100cc brown stool	100	100

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

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

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

MEDCOM - 14932

Y-FOUR HOUR PATIENT ... E AND OUTPUT WORKSHEET

FR... HOURS TO ...HOURS	TOTAL HOURS COVERED 24	DATE 6/6/03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0715	Eggs	3 bites	
0715	Breakfast sausage	1 whole	
0715	H_2O	100cc	100cc
0715	Choc. Milk	120cc	220cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06		Zosyn	50		50
06		Ampicillin	50		100
		LR c 20 k Cl	400		500
12		Zosyn/amp	100		650
18		Zosyn/amp	100		750
13		LR c 20 meq KCL	400	2100	1150

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
01	urine	200	200
04	"	500	700
06	"	400	1300
0745	"	400	1200
1800	"	425	2125
~~1800~~	~~urine~~	~~400~~	~~2525~~
~~350~~			
200	CYU	350	2475

BLOOD/BLOOD DERIVATIVES

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

~~OTHER INTAKE~~ Colostomy

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	Ø	0cc	Øcc
18	Ø	Ø	Ø

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

MEDCOM - 14933

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	H2O	120cc	120
0700	milk	200cc	320

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	CYUOP	400cc	400
1000	CYUOP	325cc	725
1950	urine	400cc	1125

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (*Serving levels cc*)

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

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

MEDCOM - 14934

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO 24 HOURS | TOTAL HOURS COVERED | DATE 7 Jun

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	MILK	240cc	240
0730	H2O	40cc	280 cc
1000	H2O	40cc	320cc
1000	H2O	100cc	420cc
0930	H_2O	240cc	660cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000	50	Zosyn	50	0045	50
0060	50	Ampicillin	50	0130	100
0000	400	LR c 20meq KCL	400		400
0600	100cc	IV MEDS	100	0600	650
1000	100cc	IV MEDS	100	1000	750
0630	500cc	LR c KCL	400	1600	1150
1800	50	Zosyn	50	1850	1650
1900	50	Ampicillin	50	1950	1700
0600	50	Zosyn	50	063	1750

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0300	CYU	600cc	600
0400	Colostomy drained	200cc	800
0530	CYU OP	400cc	1200
0900	UOP	300cc	1500
1200	UOP	200cc	1700
1450	UOP	400cc	2100
1830	CYU	450cc	2550
0045	CYU	350cc	2900
0240	CYU	420cc	3320
~~300~~	~~CYU~~	~~200~~	
500	CYU	200	3520

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EDW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

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

MEDCOM - 14935 *U.S.GPO:1996-404

TWENTY-FOUR HOUR PATIENT IN... AND OUTPUT WORKSHEET

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

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	50	IV meds	50	0630	50
1000	50	Ampicillin	50	1030	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

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

INTAKE EQUIVALENTS (Serving levels cc)

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

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

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

MEDCOM - 14936

June 3

Breakfast

NPO

Lunch

mash potatoes / gravy (4 bites)
peas (2 bites)
turkey (4 bites)
pears (5 bites)
cake (3 bites)

Dinner

June 4

Breakfast

2 waffles
1 orange
mix fruit 3 bites

Lunch

1/2 piece cake w/ peaches
2 bites beef/noodles.

Dinner

2 bites of chicken
2 bites of cake

5 JUNE

KFAST

Jello - 2 bites
Waffle
box milk

Dinner

Shrimp - 1 bit
peas - 1 bit
Cake - 3 bits

Calorie Count (Record Foods/Bev, and Quantities)

June 1

Breakfast

Lunch

Dinner

5 Vegetables (2-3 bites)
10 Cake (1 Bite)
125

June 2

Breakfast

3 1 waffle 90 + 60
1 2 bites of cake 40
5 bites of apple 15
2 50cc chocolate milk 35
50cc water
8 snack: 180cc Ensure 180

Lunch

4 bites of cranberry sauce 30
1 3 bites of cake 40
1 6 bites of mashed potatoes 40
3 2 bites of chicken 60
3 bites of peas 10
2 bites of fruit 10
19 50cc Water

Dinner

1 jello cup
1/2 scoop potatoes c̄ salt
2 bites apple
2 bites chicken

MEDCOM - 14938

ACLU-RDI 1629 p.98

DOD-028327

540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
	INTAKE	OUTPUT
06-13		
	Ice Chips - 100cc	Foley 600cc
	# IV meds - 150cc	N/G 500cc
	LR - 1L	~~Pt voided 350cc @ 1500~~
	IV meds - 200cc	
	Ice Chips - 50cc	
13-21	50cc - IV meds 1400	void 350cc amber 150
	ICE CHIPS 100cc @ 1410	VOID 325cc amber 1830
	ICE CHIPS 100cc @ 1515	VOID 500 cc amber 2330
	100cc - IV med 1800	void 440 cc amber 0120
	TOTAL 460cc @ DINNER	06-04
	IV bag replaced @ 0400	5/19 2715
	~~1000cc LR hung @ 0400~~	
5/19	06-04 3310	
* NOTE:	1 LQ CUP = 240 cc *	
	1 CUP JELLO = 100 cc *	

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. ICW2

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

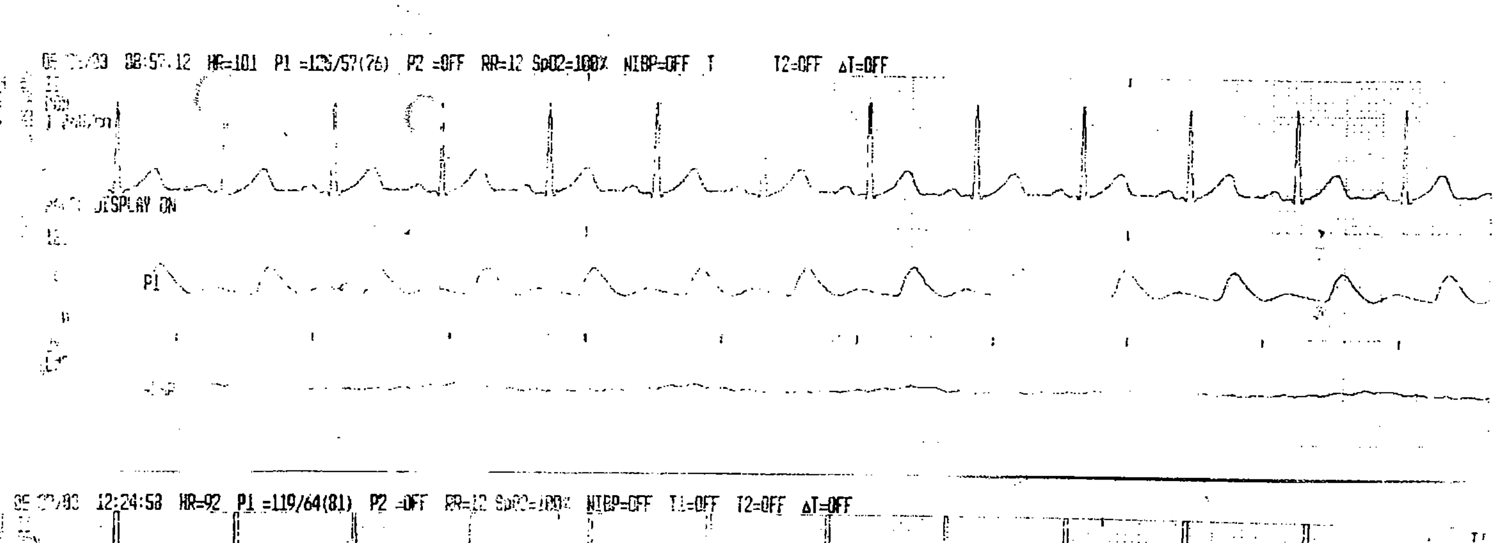
MEDCOM - 14939

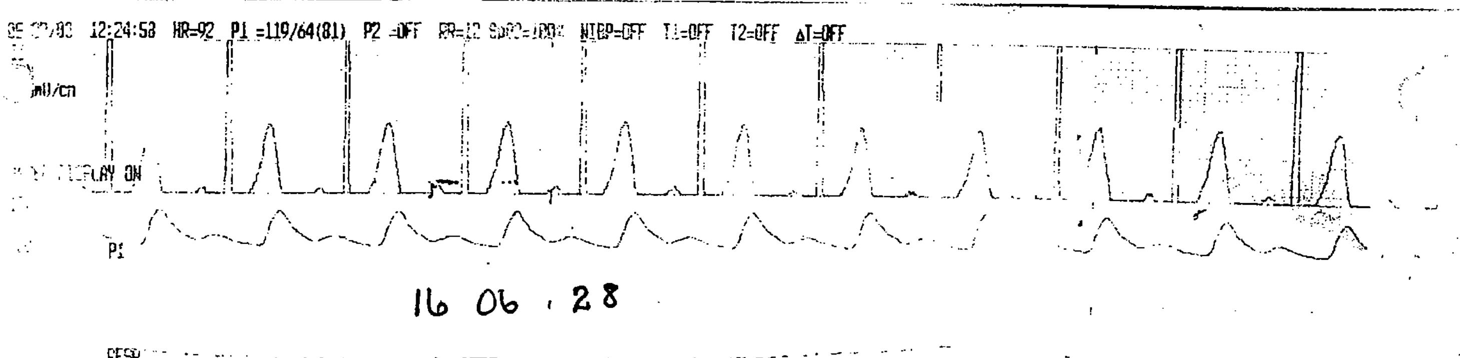
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	5/19 06-04 INput 3310cc OUTPUT 2715cc
	5/20 06am-13 INput 1790cc OUTPUT 1750cc
	13- 21 360cc
	21 - 05 1000cc IV bag Δ'd @0100 1350cc
5/21	06-13 → 200+300+ +400cc+300 Intake 350cc + 300 IV
	13-21 Output 300cc
	21-05 13-2100 Output 200cc
	Ice Chips 100cc IV fluids LR 400 1900 400cc
	ice Chips 100 cc 900-O-
	unasyn 100 ml
	Zantac 50 ml
	750 I-
	Zantac 50 2200 300cc
	Unasyn 100. 300
	LR 875 300
	1025 420
	1320

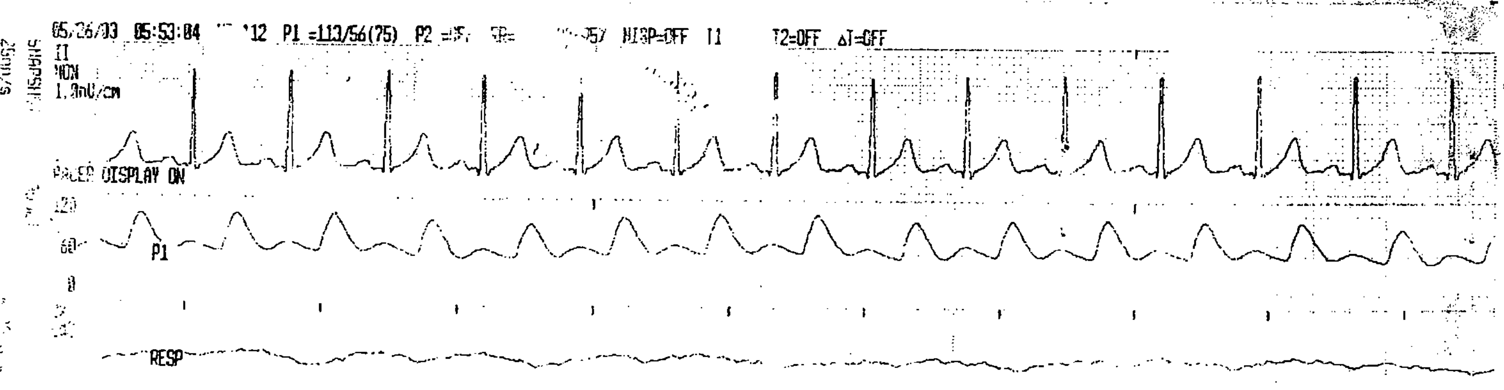
FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 14940



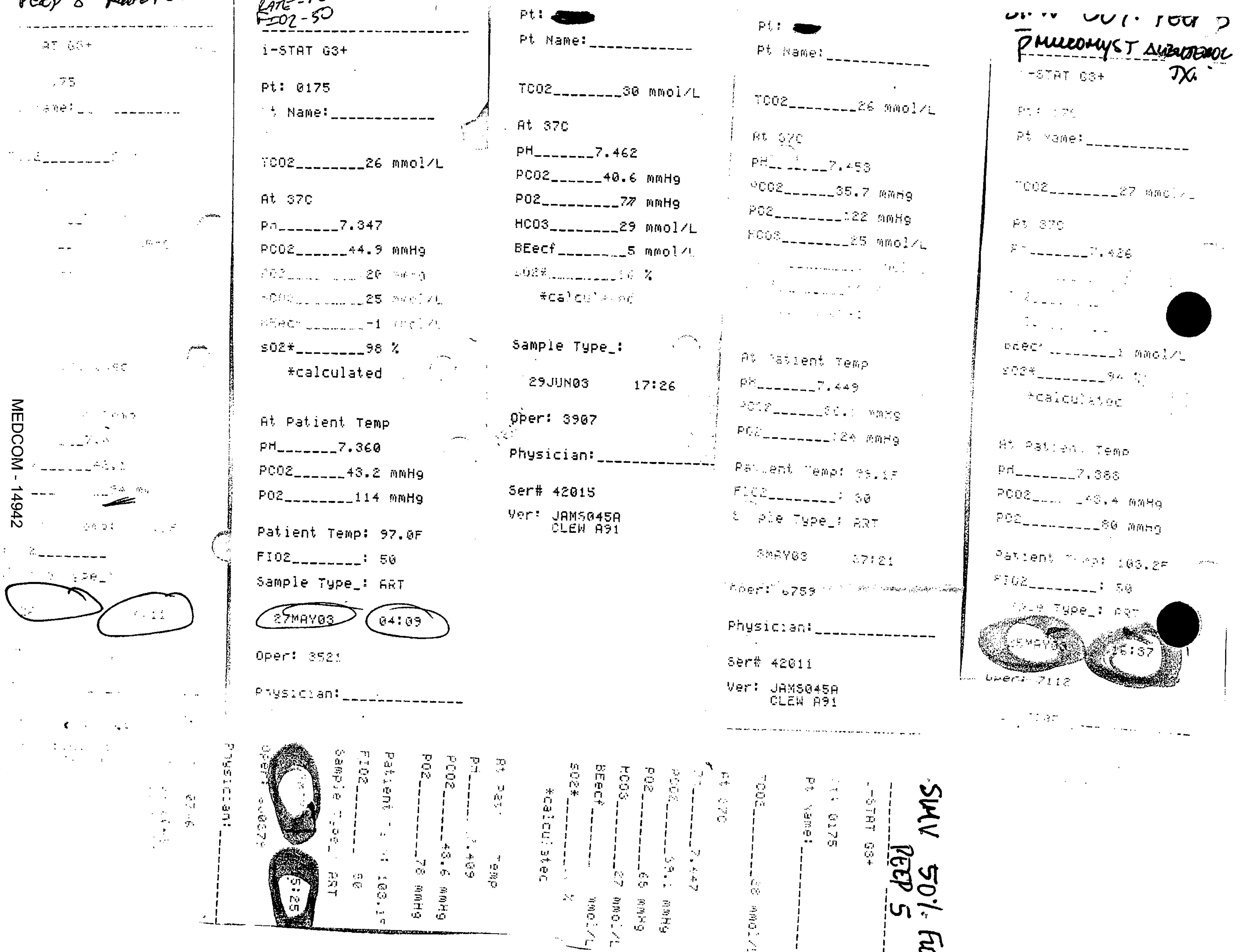




TIME	HR/PR	SpO2
H:MIN:S	BPM	%
LAST BREATH:		
12:10:00	94	100
RESUMED BREATHING:		
12:10:55	93	99
ELAPSED TIME:		
00:00:55		

ADULT

MEDCOM - 14941



PEEP 8 Rate 1?

...AT G3+

Rate - 1?
FIO2 - 50

i-STAT G3+

Pt: 0175

Pt Name:____________

TCO2________26 mmol/L

At 37C

PH_______7.347

PCO2______44.9 mmHg

PO2__________20 mmHg

HCO3__________25 mmol/L

BEecf_________-1 mmol/L

sO2*_________98 %

*calculated

At Patient Temp

PH_______7.360

PCO2______43.2 mmHg

PO2________114 mmHg

Patient Temp: 97.0F

FIO2_________: 50

Sample Type_: ART

27MAY03 04:09

Oper: 3521

Physician:______________

Pt: [redacted]

Pt Name:____________

TCO2________30 mmol/L

At 37C

PH_______7.462

PCO2______40.6 mmHg

PO2__________77 mmHg

HCO3_________29 mmol/L

BEecf________5 mmol/L

sO2*_________96 %

*calculated

Sample Type_:

29JUN03 17:26

Oper: 3907

Physician:______________

Ser# 42015

Ver: JAMS045A
CLEW A91

Pt: [redacted]

Pt Name:____________

TCO2________26 mmol/L

At 37C

PH_______7.453

PCO2______35.7 mmHg

PO2________122 mmHg

HCO3_________25 mmol/L

At Patient Temp

PH_______7.449

PCO2______36.1 mmHg

PO2________124 mmHg

Patient Temp: 99.1F

FIO2_________: 50

Sample Type_: ART

8MAY03 17:21

Oper: 6759

Physician:______________

Ser# 42011

Ver: JAMS045A
CLEW A91

... OUT. 100? ?
Phillcomyst albuterol Tx.

i-STAT G3+

Pt: 175

Pt Name:____________

TCO2________27 mmol/L

At 37C

PH_______7.426

BEecf________1 mmol/L

sO2*_________94 %

*calculated

At Patient Temp

PH_______7.388

PCO2______48.4 mmHg

PO2__________80 mmHg

Patient Temp: 103.2F

FIO2_________: 50

Sample Type_: ART

MAY03 16:37

Oper: 7112

SIMV 50% FiO2
PEEP 5

i-STAT G3+

Pt: 0175

Pt Name:____________

TCO2________28 mmol/L

At 37C

PH_______7.447

PCO2______39.1 mmHg

PO2__________65 mmHg

HCO3_________27 mmol/L

BEecf________ mmol/L

sO2*_________ %

*calculated

At Patient Temp

PH_______7.409

PCO2______43.6 mmHg

PO2__________78 mmHg

Patient Temp: 103.1F

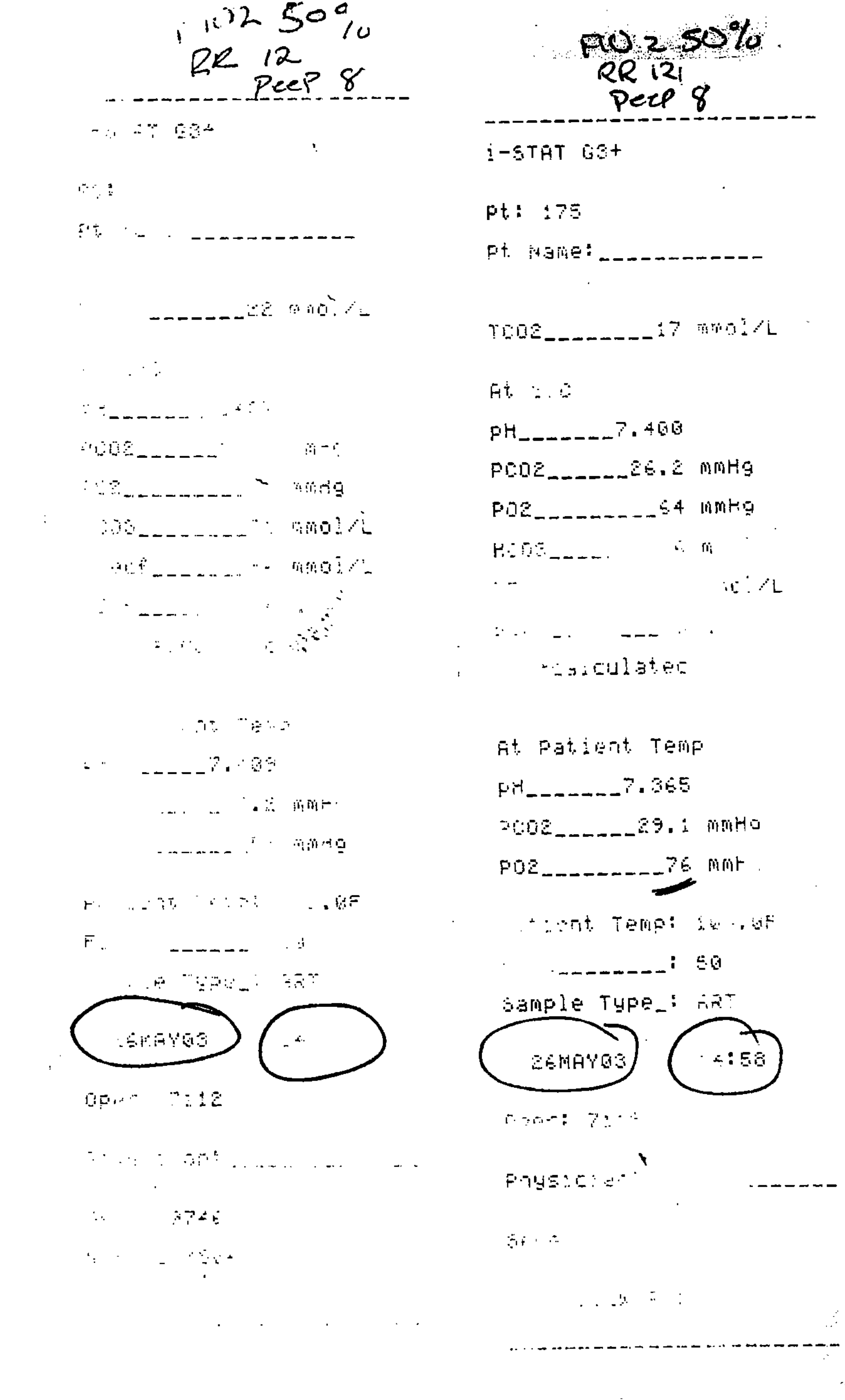
FIO2_________: 50

Sample Type_: ART

5:25

Oper: 0079

Physician:______________



FiO2 50%
RR 12
Peep 8

22 mmol/L

7.409

ART

6MAY03

Oper 7112

FiO2 50%
RR 121
Peep 8

i-STAT G3+

Pt: 175

Pt Name:____________

TCO2________17 mmol/L

At 1.0

pH_______7.400

PCO2______26.2 mmHg

PO2_________64 mmHg

Calculated

At Patient Temp

pH_______7.365

PCO2______29.1 mmHg

PO2_________76 mmHg

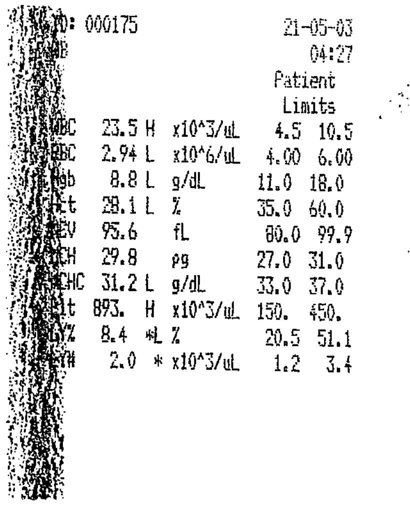
Patient Temp:

_________: 50

Sample Type_: ART

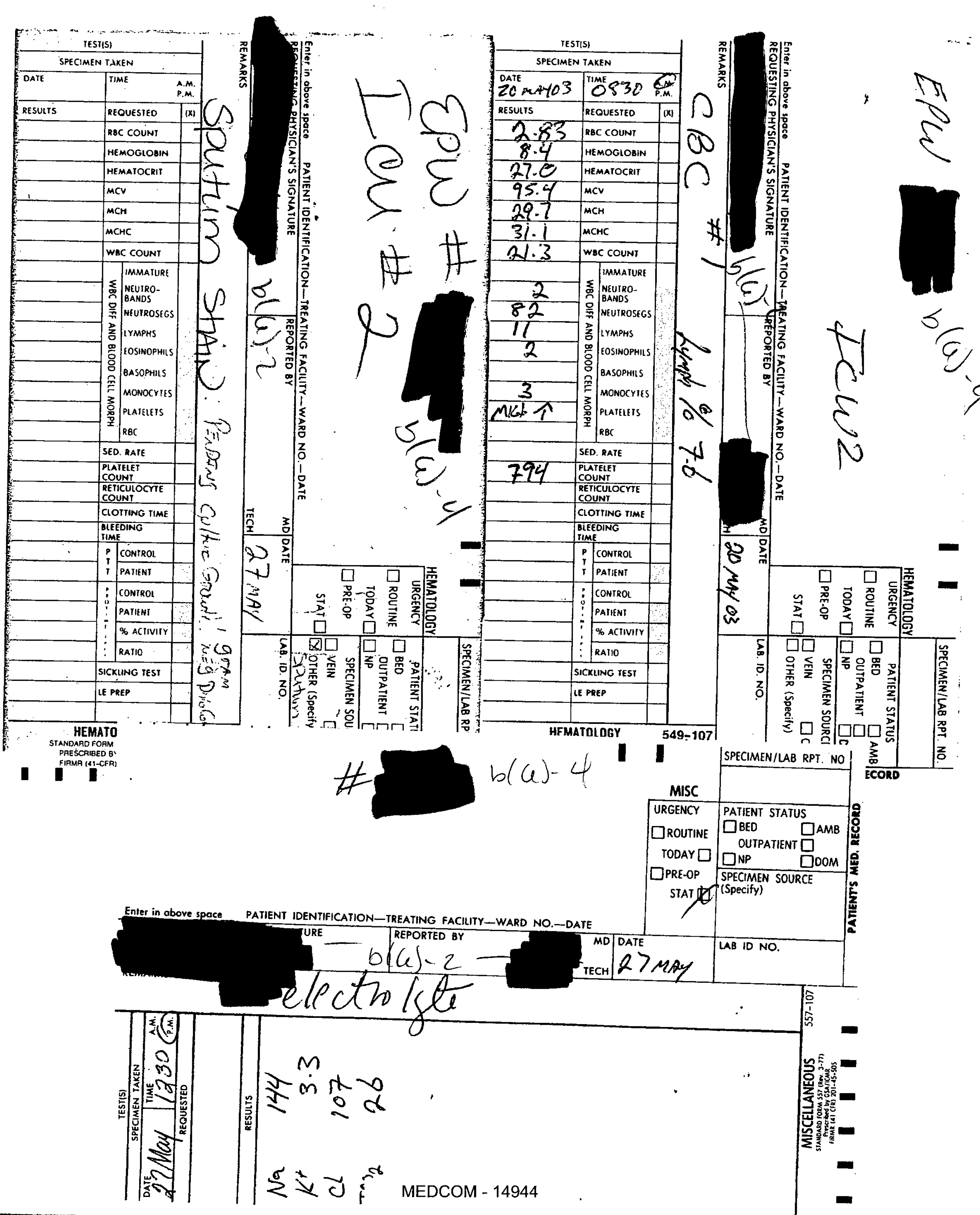
26MAY03 4:58

Physician _______



ID: 000175 21-05-03 04:27

				Patient Limits	
WBC	23.5	H	x10^3/uL	4.5	10.5
RBC	2.94	L	x10^6/uL	4.00	6.00
Hgb	8.8	L	g/dL	11.0	18.0
Hct	28.1	L	%	35.0	60.0
MCV	95.6		fL	80.0	99.9
MCH	29.8		pg	27.0	31.0
MCHC	31.2	L	g/dL	33.0	37.0
Plt	893.	H	x10^3/uL	150.	450.
LY%	8.4	*L	%	20.5	51.1
LY#	2.0	*	x10^3/uL	1.2	3.4



HEMATOLOGY — Standard Form, Prescribed by FIRMR (41-CFR)

TEST(S) — SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.

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

REMARKS: Sputum Stain: Pending Culture [illegible] Gram Neg Diplo[illegible]

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

REQUESTING PHYSICIAN'S SIGNATURE b(6)-2 — REPORTED BY — MD / TECH — DATE 27 MAY

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

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

PATIENT STATUS: ☐ BED, ☐ OUTPATIENT, ☐ NP

SPECIMEN SOURCE: ☐ VEIN, ☒ OTHER (Specify) Sputum

LAB. ID. NO. — SPECIMEN/LAB RPT.

HEMATOLOGY 549-107

TEST(S) — SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
20 MAY 03	0830	A.M.

RESULTS	REQUESTED	(X)
2.83	RBC COUNT	
8.4	HEMOGLOBIN	
27.0	HEMATOCRIT	
95.4	MCV	
29.7	MCH	
31.1	MCHC	
21.3	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	
2	NEUTRO-BANDS	
82	NEUTROSEGS	
11	LYMPHS	
2	EOSINOPHILS	
	BASOPHILS	
3	MONOCYTES	
MGL ↑	PLATELETS	
	RBC	
	SED. RATE	
794	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT — CONTROL	
	PT — PATIENT	
	PTT — CONTROL	
	PTT — PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: CBC #1 [redacted] b(6) lymph % 7.6

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

REQUESTING PHYSICIAN'S SIGNATURE — REPORTED BY — MD / TECH — DATE 20 MAY 03

EPW [redacted] b(6)-4 ICW2

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

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

SPECIMEN SOURCE: ☐ VEIN, ☐ OTHER (Specify)

LAB. ID. NO. — SPECIMEN/LAB RPT. NO. — PATIENT'S MED. RECORD

[redacted] b(6)-4

MISC

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

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO — LAB ID NO. — PATIENT'S MED. RECORD

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

[redacted] SIGNATURE b(6)-2 — REPORTED BY [redacted] — MD / TECH — DATE 27 MAY

REMARKS: electrolyte

TEST(S) — SPECIMEN TAKEN: DATE 27 May, TIME 1230 P.M. — REQUESTED

	RESULTS
Na	144
K+	3.3
Cl	107
[illegible]	26

MISCELLANEOUS 557-107 — Standard Form 557 (Rev. 3-77), Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45-505

MEDCOM - 14944

EPW # [redacted] b(6)-4
ICU #2

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

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

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE	REPORTED BY	MD / TECH	DATE	LAB. ID. NO.
b(6)-2 [redacted]			27 MAY	

REMARKS: Sputum Stain: Pending culture Growth! gram NEG Diplococ

TEST(S)	SPECIMEN TAKEN	TIME (A.M. / P.M.)	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PTT CONTROL	PTT PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	DATE		RESULTS																													

WBC DIFF AND BLOOD CELL MORPH

549-107

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

MEDCOM - 14945

Section: IT | REQUEST. PHYSICIAN: DR. b(6)-2

LAST, FIRST, MI. b(6)-4 | DATE 14MAY03 | TIME

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

SSN/PSEUDO SSN: b(6)-4

(iSTAT)

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

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	117	73-118 mg/dl
BUN	23	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	* >5000	39-380 u/l (M) 30-190 u/l (F)
NA+	~~14~~ 144	128-145 mmol/l
K+	4.9	3.3-4.7 mmol/l
CL-	108	98-108 mmol/l
tCO2	26	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: MET 8 ## 7 STAT

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

MEDCOM - 14946

LAST COPY DO NOT TAKE

Ward/Section: EMT | REQUEST: DR. | PHYSICIAN: [redacted] b(6)-2

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

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 14MAY03 | TIME: 0935 | SSN/PSEUDO SSN: [redacted] b(6)-4

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10³
RBC	3.88	4.7-6.1 x 10⁹
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.5	42-52% (M) 37-47% (F)
MCV	94.0	80-94 fl (M) 81-99 fl (F)
Plt	190	130-500 x 10³ verified
Lymph %	14.7%	20.5-51.1%

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

Cell Count		
Directigen		Negative

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC

REPORTED BY: [redacted] b(6)-2 | **DATE:** 14 MAY 03 | **LAB ID NO.:**

MEDCOM - 14947

ICW #2 b(a)-2 ICW #2

DC [redacted]

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
# [redacted] b(a)-4	EPW	5/15/03	# [redacted] b(6)-4

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na	155	138-146 mmol/L
K	3.2	3.5-4.9 mmol/L
Cl	122	98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	18	8-26 mg/dl
GLU	71	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	8	12-17 g/dl

Chemistry (Piccolo Analyzer)

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

Hematology

TEST	RESULT	REF. RANGE
WBC	8.0	4.8-10.8 x 10^3
RBC	2.86	4.7-6.1 x 10^9
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.0	42-52% (M) 37-47% (F)
MCV	94.6	80-94 fl (M) 81-99 fl (F)
Plt	186	130-500 x 10^3 verified
Lymph%	18.9	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer	1	<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Other			

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Urinalysis

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

Microbiology

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

☺ "SHADOW" PJR

MEDCOM - 14948

[redacted] b(6)-2

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	STATUS	DATE	SSN
[redacted] b(6)-4 — 1CW2			

Chemistry (i-STAT)

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

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	0.4	0.6-1.2 mg/dl
BUN	12	7-22 mg/dl
GLU	109	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	141	128-145 mmol/L
K^+	4.6	3.3-4.7 mmol/L
Cl^-	103	98-108 mmol/L
$^+CO_2$	26	18-33 mmol/L
CK	2201	39-380 u/L

Hematology

TEST	RESULT	REF. RANGE
WBC	11.6	4.8-10.8 x 10^3
RBC	3.28	4.7-6.1 x 10^6
Hgb	9.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.9	42-52% (M) 37-47% (F)
MCV	94.2	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10^3 verified
Lymph%	13.7	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Urinalysis

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

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Microbiology

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

☺ "SHADOW" PJR

MEDCOM - 14949

ICU 2 • 0900

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-4 | STATUS | DATE 19MAY03 | SSN

Chemistry (i-STAT)

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

Chemistry (Piccolo Analyzer)

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

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	20.1	4.8-10.8 x 10^3
RBC	2.89	4.7-6.1 x 10^9
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	96.4	80-94 fl (M) 81-99 fl (F)
Plt	765	130-500 x 10^3 verified
Lymph%	9.4	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs	73	Mono	14
Bands	6	Eos	2
Lymph	6	Baso	
Atyp	1	Imm	

RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt	mod increased platelets	130-500 x 10^3 verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Urinalysis

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

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microbiology

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

Microscopic Urinalysis

rgl

☺ "SHADOW" PJR

MEDCOM - 14950

Chemistry Un[illegible] M.D. b(6)-2

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

Ward/Section: 7CU2 | REQUESTING PHYSICIAN:

LAST, FIRST, MI.: EPW #[redacted] b(6)-4 | DATE: 20 MAY | TIME: 0830 | SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
~~Na~~		138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	7	8-26 mg/dl
GLU	139	70-105 mg/dl
Creat	0.4	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8,1 g/dl

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

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

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

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

REMARKS:
~~CBC~~ BUN, CREATNINE, LYTES

REPORTED BY: | **DATE:** | **LAB ID NO.:**

MEDCOM - 14951

Chemistry Un[illegible] (handwritten)

Ward/Section: ICW2	REQUESTING PHYSICIAN: [redacted] b(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE	TIME	SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	3.0	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH	7.504	7.31-7.45
PCO2	31.2	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	26	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	1	95-98%
BEecf		(-2) – (+3) mmol/L
AnGap	14	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	[struck out]	8-26 mg/dl
GLU	122	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	28	38-51% PCV
Hgb	10	12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	139	73-118 mg/dl
BUN	18	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	163	39-380 u/l (M) 30-190 u/l (F)
NA⁺	135 (~~40~~)	128-145 mmol/l
K⁺	4.0 (~~112~~)	3.3-4.7 mmol/l
CL⁻	112	98-108 mmol/l
tCO₂	24	18-33 mmol/l

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

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

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

REMARKS:

REPORTED BY: [redacted] b(6)-2	**DATE:** 21 MAY 03	**LAB ID NO.:**

MEDCOM - 14952

b(a)-2

[redacted] Section: 1CW2 | REQUESTING PHYSICIAN: | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(a)-4 | DATE | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	23.5	4.8-10.8 x 10^3
RBC	2.94	4.7-6.1 x 10^9
Hgb	8.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.1	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	893	130-500 x 10^3 verified
Lymph %	8.4	20.5-51.1%

(Hematology) Manual Differential

Segs	69	Mono	9
Bands	15	Eos	1
Lymph	5	Baso	2
Atyp		Imm	
RBC Morph	hypochromasia increased platelet		

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation Studies

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

Blood Bank (continuation) MUST SUBMIT SF 518 FOR EACH UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS: b(a)-2

REPORTED BY: [redacted] | DATE: 21 May | LAB ID NO.: 8835

MEDCOM - 14953

Ward/Section: ICW #2

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

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

LAST, FIRST, MI: # [redacted] b(6)-4 | **DATE:** 5/22 | **TIME:** 0400 | **SSN/PSEUDO SSN:** # [redacted] b(6)-4

(iSTAT)

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

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible]

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

[illegible]

TEST	RESULT	REF. RANGE
GLU	90	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	377	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	NA	128-145 mmol/l
K^{+}	3.8	3.3-4.7 mmol/l
CL^{-}	104	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

ACLU-RDI 1629 p.114

DOD-028343

Ward/Section: ICU #2

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

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

LAST, FIRST, MI: # [redacted] b(6)-4 | DATE: 5/22 | TIME: 0400 | SSN/PSEUDO SSN: # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	19.8	4.8-10.8 x 10³
RBC	2.80	4.7-6.1 x 10⁹
Hgb	8.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.8	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	845	130-500 x 10³ verified
Lymph %	11.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

TEST	RESULT	REF. RANGE
Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 14955

Icu #2

Ward/Section:	REQUE... HYSICIAN: Dr. [redacted] b(6)-2	LAB... (Sub... /	...TORY RESULT FORM the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] b(6)-4	... 22 Nov	TIME 1405	SSN/PSE... SN: # [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	17.5	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.99	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct	28.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	94.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	921	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	11.7	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	Micro...		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	CSF					
Sed Rate			Cell Count			MUST SU... EVERY U...		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

[redacted] b(6)-2 | DATE: 22 Nov 03 | LAB ID NO.: P7

MEDCOM - 14956

ACLU-RDI 1629 p.116

DOD-028345

Ward/Section: ICU #2	REQU	PHYSICIAN: b(6)-2	LAB…TORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI b(6)-4	DATE 23MAY03	TIME 0043	SSN/PSEUDO SSN: b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	23.8	4.8-10.8 x 10³
RBC	3.28	4.7-6.1 x 10⁹
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.1	42-52% (M) 37-47% (F)
MCV	95.0	80-94 fl (M) 81-99 fl (F)
Plt	1020	130-500 x 10³ verified
Lymph %	7.9	20.5-51.1%

(Hematology) Manual Differential

Segs	85	Mono	4
Bands	4	Eos	1
Lymph	6	Baso	
Atyp		Imm	
RBC Morph	plt - severly increased occ gaint giant		

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

Urinalysis

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

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: b(6)-2	DATE: 23may03	LAB ID NO.:

MEDCOM - 14957

ction
[handwritten]

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

, FIRST, MI

[redacted] b(6)-4

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

DATE: 23-MAY03 | TIME: 0400 | SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	101	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	332	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	131	128-145 mmol/l
K^{+}	4.4	3.3-4.7 mmol/l
CL^{-}	104	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: b(6)-4 [redacted]

DATE: 23MAY03

LAB ID NO.:

MEDCOM - 14958

Ward/Section	RE	G PHYSICIAN	STRY RESULT FORM (Subject to the Privacy Act of 1974)
ICU #2		b(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
Elw b(6)-4		0430	b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	201	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	843	39-380 u/l (M) 30-190 u/l (F)
NA+	120	128-145 mmol/l
K+	4.2	3.3-4.7 mmol/l
CL-	99	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
b(6)-2	24MAY03	

MEDCOM - 14959

Ward/Section: ICU #2
REQUESTING PHYSICIAN: b(6)-2

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC 30.1	~~31.2~~	4.8-10.8 x 10³
RBC 2.42	~~2.52~~	4.7-6.1 x 10⁹
Hgb 7.0	~~7.4~~	14-18 g/dl (M) 12-16 g/dl (F)
Hct 23.5	~~24.4~~	42-52% (M) 37-47% (F)
MCV 97.0	~~96.7~~	80-94 fl (M) 81-99 fl (F)
Plt 781	~~576~~	130-500 x 10³ verified
Lymph %	~~9.7~~	20.5-51.1%

(Hematology) Manual Differential

Segs	85	Mono	4
Bands		Eos	
Lymph	6	Baso	
Atyp		Imm	5
RBC Morph	Hypersegmented neutrophils 1+ Target cells elevated platelet count 2+ Polychromasia normocytic GNR seen		

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

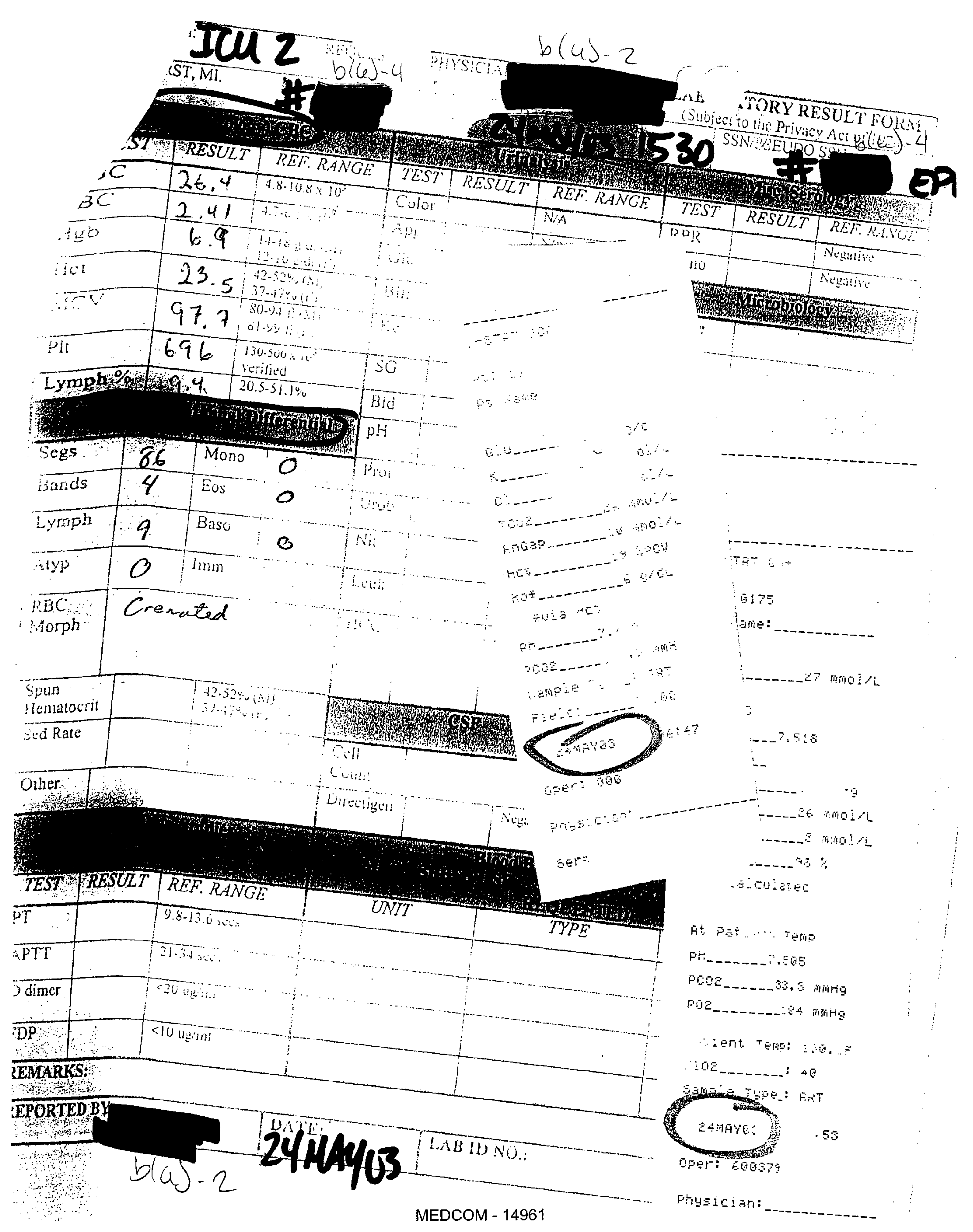
Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: First specimen clotted. specimen resubmitted.

REPORTED BY: b(6)-2 **DATE:** 24 MAY 03 **LAB ID NO.:**

MEDCOM - 14960



ICU 2

REQUE... b(6)-4

...ST, MI.

PHYSICIAN b(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of ...) b(6)-4

SSN/PSEUDO SSN

24 MAY 03 1530 EP

Chem/CBC

TEST	RESULT	REF. RANGE
WBC	26.4	4.8-10.8 x 10³
RBC	2.41	[illegible]
Hgb	6.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	23.5	42-52% (M) 37-47% (F)
MCV	97.7	80-94 fl (M) 81-99 fl (F)
Plt	696	130-500 x 10³ verified
Lymph %	9.4	20.5-51.1%

Manual Differential

Segs	86	Mono	0
Bands	4	Eos	0
Lymph	9	Baso	0
Atyp	0	Imm	
RBC Morph	Crenated		

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

Urinalysis

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

CSF

Cell Count	
Directigen	Neg

Misc/Serology

TEST	RESULT	REF. RANGE
RPR		Negative
HO		Negative

Microbiology

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

Blood ...

REMARKS:

REPORTED BY: b(6)-2

DATE: 24 MAY 03

LAB ID NO.:

STAT ...
Pt Name
Glu
K
Cl
TCO2 ... mmol/L
AnGap ... mmol/L
Hct ... %PCV
Hb* ... g/dL
*via Hct
pH
PCO2 ... mmHg
Sample Type: ART
Field ...
24MAY03
Oper: 000
Physician:
Ser

STAT 6+
0175
Name:
TCO2 ... 27 mmol/L
pH ... 7.518
... 9
... 26 mmol/L
... 3 mmol/L
... 98 %
Calculated

At Patient Temp
PH ... 7.505
PCO2 ... 33.3 mmHg
PO2 ... 104 mmHg
Patient Temp: 100. F
FIO2 ... : 40
Sample Type: ART
24MAY03 .53
Oper: 600379
Physician:

MEDCOM - 14961

ACLU-RDI 1629 p.121

DOD-028350

b(6)-2

Ward/Section: ICU #2 | REQ[redacted]

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

LAST, FIRST, MI. E/W [redacted] b(6)-4 | DATE/TIME [redacted] 1930 | SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	30.1	4.8-10.8 x 10^3
RBC	2.87	4.7-6.1 x 10^9
Hgb	8.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.4	42-52% (M) 37-47% (F)
MCV	95.4	80-94 fl (M) 81-99 fl (F)
Plt	714	130-500 x 10^3 verified
Lymph %	6.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

8 mono 71 segs
11 lymph polychromasia
10 band

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

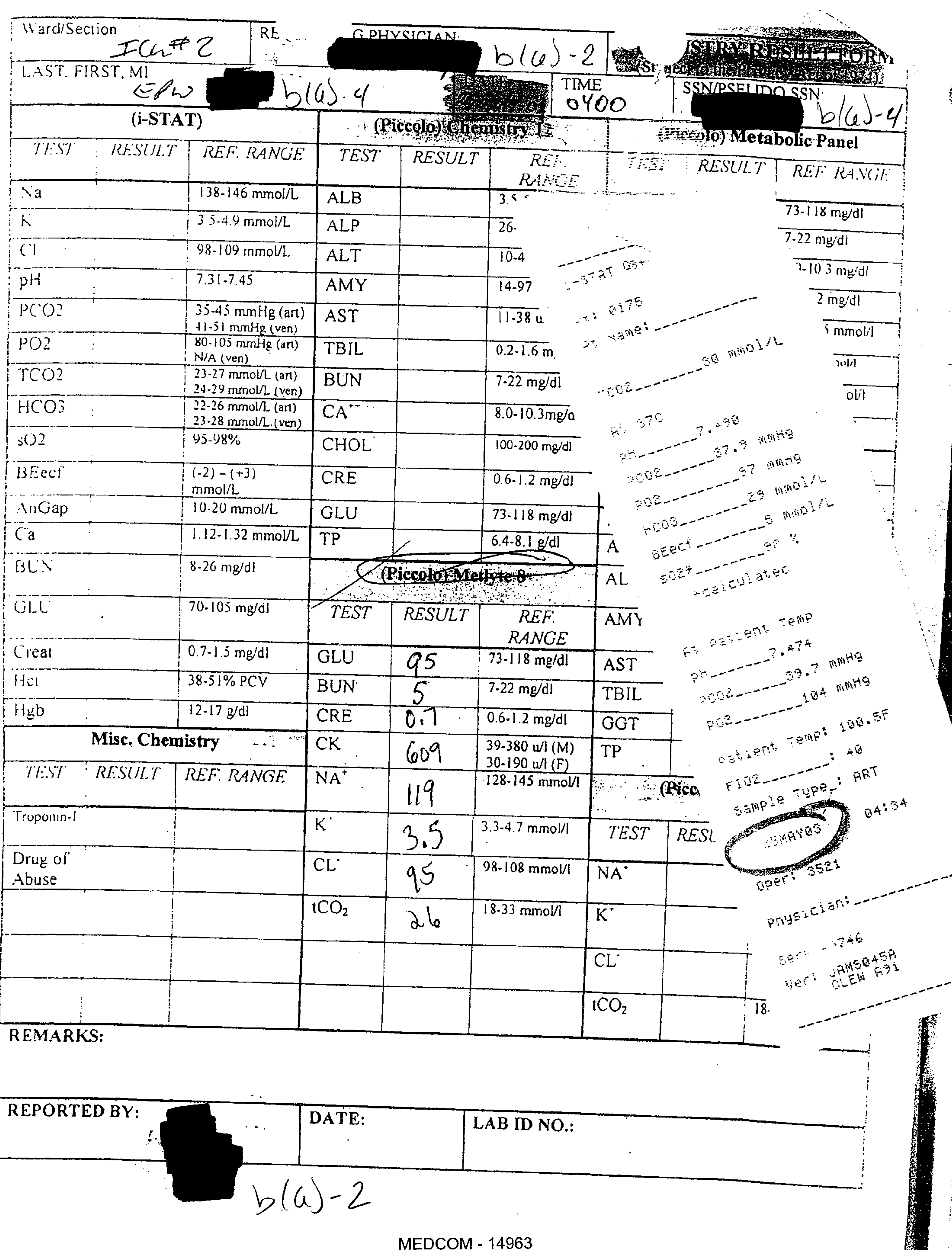
Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 14962



Ward/Section: ICu#2 | RE... G PHYSICIAN: [redacted] b(6)-2 | ...ISTRY RESULT FORM (Subject to the Privacy Act of 1974)

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

(i-STAT)

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

(Piccolo) Chemistry 13

TEST	RESULT	REF. RANGE
ALB		3.5...
ALP		26-...
ALT		10-4...
AMY		14-97
AST		11-38 u...
TBIL		0.2-1.6 m...
BUN		7-22 mg/dl
CA++		8.0-10.3mg/d
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	5	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	609	39-380 u/l (M) 30-190 u/l (F)
NA^+	119	128-145 mmol/l
K^+	3.5	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		...-10.3 mg/dl
		...2 mg/dl
		... mmol/l
		...ol/l
		...ol/l

(Piccolo) ... (partially covered)

TEST	RESULT
A...	
AL...	
AMY	
AST	
TBIL	
GGT	
TP	

(Picc... (partially covered)

TEST	RESULT	REF. RANGE
NA^+		
K^+		
CL^-		
tCO_2		18...

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

i-STAT G3+
Pt: 0175
Pt Name: ____
TCO2 ____30 mmol/L
At 37C
pH ____7.490
PCO2 ____37.9 mmHg
PO2 ____57 mmHg
HCO3 ____29 mmol/L
BEecf ____5 mmol/L
sO2* ____[illegible] %
*calculated
At Patient Temp
pH ____7.474
PCO2 ____39.7 mmHg
PO2 ____104 mmHg
Patient Temp: 100.5F
FIO2 ____: 40
Sample Type: ART
[illegible]MAY03 04:34
Oper: 3521
Physician: ____
Ser: [illegible]746
Ver: JAM5045A CLEW A91

REMARKS:

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

MEDCOM - 14963

Ward/Section: ICU #2 | REQUEST | PHYSICIAN b(6)-2

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

LAST, FIRST, MI. b(6)-4 EPW | DATE | TIME 0400 | SSN PSEUDO SSN: b(6)-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	9.8	4.8-10.8 x 10^3
RBC	2.82	4.7-6.1 x 10^9
Hgb	8.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.7	42-52% (M) 37-47% (F)
MCV	94.8	80-94 fl (M) 81-99 fl (F)
Plt	639	130-500 x 10^3 verified
Lymph %	8.8	20.5-51.1%

(Hematology) Manual Differential			
Segs	67	Mono	13
Bands	15	Eos	
Lymph	6	Baso	
Atyp		Imm	
RBC Morph			

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

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

REMARKS:

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

MEDCOM - 14964

b(6)-2

Ward/Section: ICU 2	REQUEST... PHYSICIAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI # [redacted] b(6)-4	TIME 0700	SSN/PSEUDO SSN:

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	21.4	4.8-10.8 x 10^3
RBC	2.69	4.7-6.1 x 10^9
Hgb	7.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	25.7	42-52% (M) 37-47% (F)
MCV	95.2	80-94 fl (M) 81-99 fl (F)
Plt	646	130-500 x 10^3 verified
Lymph %	8.6%	20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

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

REMARKS:

REPORTED BY: [redacted]	DATE: 25 MAY	LAB ID NO.:

b(6)2

MEDCOM - 14965

b(6)-2
I-7-Q
b(6)-2

Ward/Section: b(6)-4	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.: EPW #	DATE	TIME 1250	SSN/PSEUDO SSN:

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	27.5	4.8-10.8 x 10³
RBC	3.47	4.7-6.1 x 10⁹
Hgb	10.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.9	42-52% (M) 37-47% (F)
MCV	91.9	80-94 fl (M) 81-99 fl (F)
Plt	659	130-500 x 10³ verified
Lymph %	6.6	20.5-51.1%

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE: 25 May 04	LAB ID NO.: 007

b(6)-2

MEDCOM - 14966

b(6)-2

Ward/Section: ICU#2 | REQUEST[redacted] PHYSIC[redacted] LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4 | DATE/TIME: 25 MAY 03 1530 | SSN/PSEUDO SSN:

Hematology (CBC)			Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	22.7	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.58	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	10.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	33.1	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	92.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	647	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	4.2	20.5-51.1%	Bld		Negative	H. pylori		Negative

(Hematology) Manual Differential				Urinalysis (cont.)			Microbiology (cont.)	
				pH		N/A	Micro Parasites	
Segs	29	Mono	12	Prot		Negative	Malaria	
Bands	48	Eos	1	Urob		0.2-1.0	O & P	
Lymph	0	Baso	0	Nit		Negative	Other	
Atyp	8 5F	Imm	8	Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph				HCG		Negative		

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

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

REMARKS:

REPO[redacted] | **DATE:** 25 May | **LAB ID NO.:** [signature]

b(6)-2

MEDCOM - 14967

b(a)-2

LABORATORY RESULT FORM (Subject to Privacy Act of 1974)

LAST, FIRST, MI. ICG #2 [redacted] 0930 | STATUS | DATE 26-MAY-03 | SSN [redacted] b(a)-4

Chemistry (i-STAT)

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

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	0.6	0.6-1.2 mg/dl
BUN	4	7-22 mg/dl
GLU	99	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	133	128-145 mmol/L
K^+	4.3	3.3-4.7 mmol/L
Cl^-	97	98-108 mmol/L
$^+CO_2$	23	18-33 mmol/L
CK	396	39-380 u/L

Hematology

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁹
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adul
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Other			

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10
Manual Plt		130-500 x 10 verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Urinalysis

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

Microbiology

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

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

[signature] 26 May 03

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MEDCOM - 14968

Ward/Section: ICU #2 | REQUEST. PHYSICIAN: b(6)-2 | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 | DATE: 26-MAY-03 | TIME: 0400 | SSN/PSEUDO SSN: b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	34.5	4.8-10.8 x 10³
RBC	3.48	4.7-6.1 x 10⁹
Hgb	10.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.5	42-52% (M) 37-47% (F)
MCV	93.2	80-94 fl (M) 81-99 fl (F)
Plt	608	130-500 x 10³ verified
Lymph %	1.7	20.5-51.1%

(Hematology) Manual Differential

Segs	91	Mono	3
Bands	2	Eos	
Lymph	2	Baso	
Atyp		Imm	2

RBC Morph	Giant Platelets seen 2+ Hypochromasia normocytic slightly elevated platelet count	
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation Studies

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

Blood Bank Unit Crossmatch (MUST SUBMIT SF518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: No microorganisms seen

REPORTED BY: b(6)-2 | **DATE:** 26 May 03 | **LAB ID NO.:**

MEDCOM - 14969

b(6)-4

Ward/Section: ICU #2 RANK: PHYSICIAN: b(6)-2

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

LAST, FIRST, MI: DATE: 26-MAY-03 TIME: 1910 SSN/PSEUDO SSN: b(6)-4

CBC

TEST	RESULT	REF. RANGE
WBC	39.7	4.8-10.8 x 10³
RBC	3.15	4.7-6.1 x 10⁶
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.7	42-52% (M) 37-47% (F)
MCV	94.4	80-94 fl (M) 81-99 fl (F)
Plt	442	130-500 x 10³ verified
Lymph %	0.7	20.5-51.1%

Manual Differential

Segs	61	Mono	8
Bands	28	Eos	
Lymph	3	Baso	
Atyp		Imm	
RBC Morph	ANISO 2+ Hypochrom 2+ MICRO 2+ CYTIC		

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation / Blood Bank Units Crossmatched — WHOLE BLOOD

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: DATE: 26 MAY 03 LAB ID NO.:

b(6)-2

MEDCOM - 14970

Ward/Section ICU #2 | [redacted] b(6)-2 | ...STRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST # [redacted] b(6)-4 | DATE 26 MAY 03 | TIME | SSN/PSEUDO SSN

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

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

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

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

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

(Piccolo) Liver Panel Plus		
TEST	RESULT	REF. RANGE
ALB	1.4	3.3-5.5 g/dl
ALP	89	26-84 u/l
ALT	38	10-47 u/l
AMY	74	14-97 u/l
AST	73	11-38 u/l
TBIL	7.5	0.2-1.6 mg/dl
GGT	51	5-65 u/l
TP	5.2	6.4-8.1 g/dl

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: 26 MAY 03 | LAB ID NO.:

MEDCOM - 14971

ICU [handwritten] b(6)-2

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	STATUS	DATE	SSN
EPW b(6)-4		26MAY03	b(6)-4

Chemistry (i-STAT)

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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

WBC - 5-10
RBC - 30-50
Epi - 10-20
Bacteria - Many
Amorphous sediment - Present
RBC clumping

CS 26MAY03

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^tCO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc	Neg	Negative
Bili	Lg	Negative
Ketone	Neg	Negative
SG	1.030	N/A
Blood	4+	Negative
pH	6.0	N/A
Protein	1+	Negative
Urob	0.2	0.2-1.0
Nitrite	Neg	Negative
HCG		Negative
Color	Amber	
App	Cloudy	

Hematology

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

RBC Morph	
Other	

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

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

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SA- pos

MEDCOM - 14972

ACLU-RDI 1629 p.132

DOD-028361

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
b(6)-4	27-MAY-03		b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	146	73-118 mg/dl
BUN	12	7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}	141	128-145 mmol/l
K^{+}	4.3	3.3-4.7 mmol/l
CL^{-}	106	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Liver Panel Plus

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

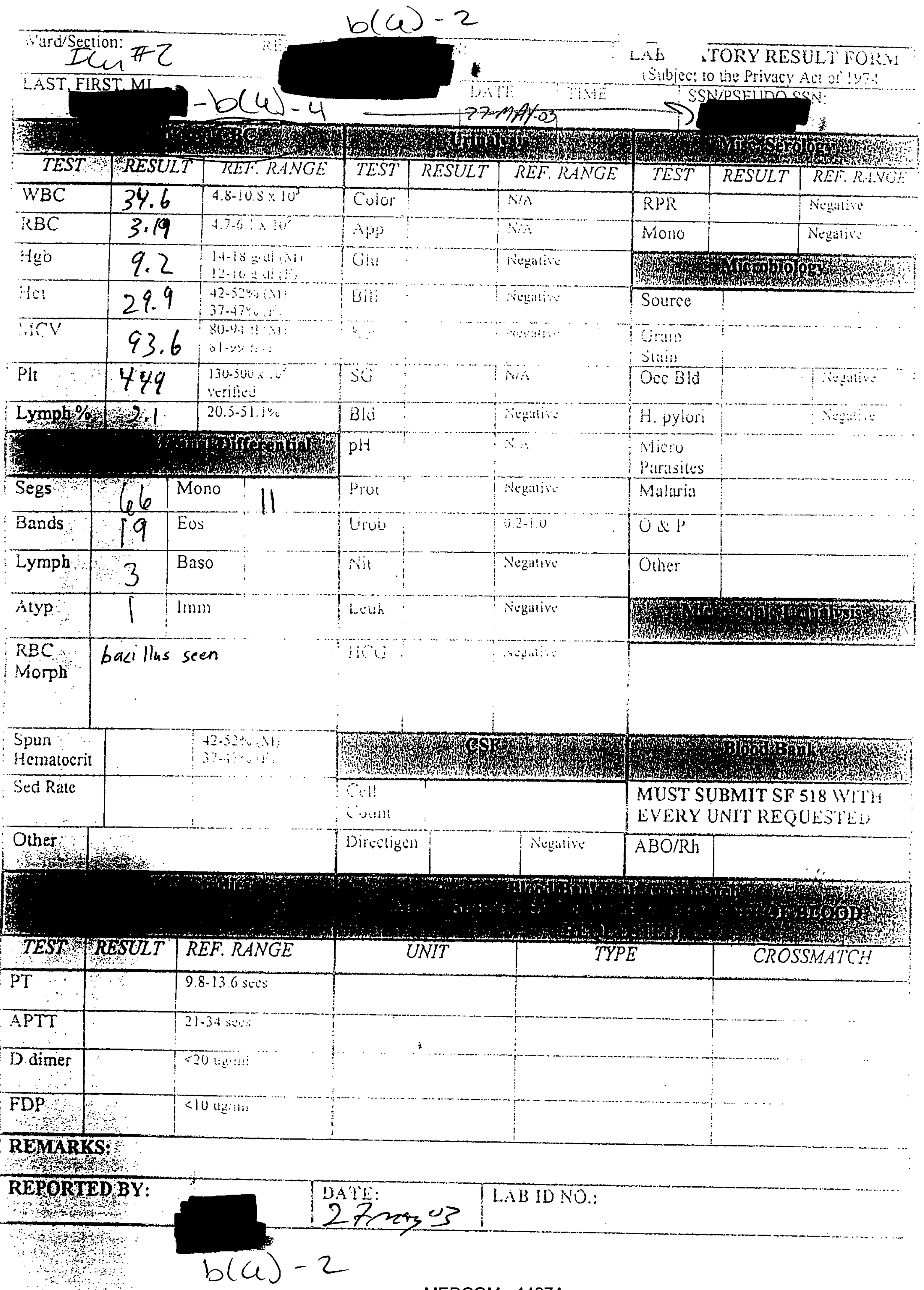
(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
b(6)-2	27 may 03	

MEDCOM - 14973



b(6)-2

Ward/Section: ICU #2 | RE[redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI [redacted] -b(6)-4 | DATE 27 MAY 03 | TIME | SSN/PSEUDO SSN: [redacted]

CBC

TEST	RESULT	REF. RANGE
WBC	34.6	4.8-10.8 x 10³
RBC	3.19	4.7-6.1 x 10⁶
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.9	42-52% (M) 37-47% (F)
MCV	93.6	80-94 fl (M) 81-99 fl (F)
Plt	449	130-500 x 10³ verified
Lymph %	2.1	20.5-51.1%

Manual Differential

Segs	66	Mono	11
Bands	19	Eos	
Lymph	3	Baso	
Atyp	1	Imm	
RBC Morph	bacillus seen		

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

TEST	RESULT	REF. RANGE
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation / Blood Bank — MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: 27 may 03 | LAB ID NO.:

MEDCOM - 14974

b(6)-2

Ward/Section: ICU#2 REQUESTOR: [redacted]

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

LAST, FIRST, MI. EPW# [redacted] b(6)-4 DATE 28MAY03 TIME 05 SSN/PSEUDO SSN:

Hematology/CBC			Urinalysis			Misc/Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	13.9	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	3.33	4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct	30.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	91.4	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	360	130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %	[illegible]8	20.5-51.1%	Bld		Negative	H. pylori		Negative
Differential			pH		N/A	Micro Parasites		

Differential				Urinalysis			Microbiology	
Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		nrbc		Leuk		Negative		
RBC Morph				HCG		Negative		

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

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

REMARKS:

REPORTED BY: [redacted] DATE: 28May03 LAB ID NO.:

b(6)-2

MEDCOM - 14975

ICU #2

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

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

STATUS	DATE	SSN
	28MAY03	

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L

```
Pt: 0175
Pt Name:____________

TCO2_________24 mmol/L

At 37C

PH_______7.455
PCO2______33.4 mmHg
PO2_________78 mmHg
HCO3________23 mmol/L
BEecf________0 mmol/L
sO2*________96 %
  *calculated

Sample Type_:

28MAY03     04:12

Oper: 3315

Physician:_____________

Ser# 40763
Ver: JAM5045A
     CLEW A91
```

```
PICCOLO
28/05/03              04:52
REFERENCE RANGE:       MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:          3141AA4
OPER #: [redacted]    DR #: 000
SERIAL #: [redacted]
............................
GLU    86   73-118   MG/DL
BUN     8   7-22     MG/DL
CRE   0.6   0.6-1.2  MG/DL
CK   1086*  39-380   U/L
NA+   134   128-145  MMOL/L
K+    3.8   3.3-4.7  MMOL/L
CL-   107   98-108   MMOL/L
tCO2   21   18-33    MMOL/L

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

Hematology

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

RBC Morph	
Other	

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Microbiology

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

☺ "SHADOW" PJR

MEDCOM - 14976

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

Unit/Section: ICU #2 REQ. MS: PHYSICIAN: Dr. [redacted]

LAST, FIRST, MI. # [redacted]

DATE: 29 MAY TIME: 0338

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

SS. PSEUDO SSN:

HEMATOLOGY/CBC

TEST	RESULT	REF. RANGE
WBC	9.2	4.8-10.8 x 10³
RBC	3.98	4.7-6.1 x 10⁶
Hgb	11.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.1	42-52% (M) 37-47% (F)
MCV	90.6	80-94 (M) 81-99 (F)
Plt	261	150-500 x 10³ verified
Lymph%	7.8	20.5-51.1%

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

CSF

TEST	RESULT	REF. RANGE
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation

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

Blood

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

MEDCOM - 14977

Ward/Section: ICU#2

LAST, FIRST, MI: #

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

TIME 0355

SSN/PSEUDO SSN:

i-STAT G3+
b(6)-4

Pt:

Pt Name:____________

TCO2________21 mmol/L

At 37C

pH_______7.453

PCO2 ______29.5 mmHg

PO2_________146 mmHg

HCO3________21 mmol/L

BEecf_______-3 mmol/L

sO2*________99 %

*calculated

Sample Type_:

29MAY03 02:59

[illegible] 5

Physician:______________

Se 40763

Ver: JAM3045A
CLEW A91

TEST	RESULT	REF. RANGE
Na		138-14
K		3.5-4.9
Cl		98-10
pH		7.31-7
PCO2		35-45 41-51
PO2		80-10 N/A
TCO2		23-27 24-29
HCO3		22-26 23-28
sO2		95-9
BEecf		(-2) mm
AnGap		10-2
iCa		1.12
BUN		8-2
GLU		70-
Creat		0.7
Hct		38
Hgb		12-17 g/dl

REF. RANGE
3.5-5.5 g/dl
26-84 u/l
10-47 u/l
14-97 u/l
11-38 u/l
0.2-1.6 mg/dl
7-22 mg/dl
8.0-10.3mg/dl
100-200 mg/dl
0.6-1.2 mg/dl
73-118 mg/dl
6.4-8.1 g/dl

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

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^{+}	136	128-145 mmol/l
K^{+}	3.6	3.3-4.7 mmol/l
CL^{-}	106	98-108 mmol/l
tCO_2	22	18-33 mmol/l

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

REMARKS:

REPORTED BY:

DATE: 29 MAY 03

LAB ID NO.:

MEDCOM - 14978

b(6)-2

[illegible]

				Patient Limits	
WBC	10.6	H	x10^3/uL	4.8	10.8
RBC	3.2[illegible]	L	x10^6/uL	4.00	5.[illegible]
Hgb	[illegible]	L	g/dL	12.[illegible]	18.0
Hct	26.0	L	%	35.0	60.0
MCV	90.0		fL	80.0	99.9
MCH	28.5		pg	27.0	31.0
MCHC	31.7	L	g/dL	33.0	37.0
Plt	251.		x10^3/uL	150.	450.
LY%	13.6	#L	%	20.5	51.1
LY#	1.4	*	x10^3/uL	1.2	3.4

[redacted] b(6)-4

b(6)-2

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

SPECIMEN/LAB RPT. NO

MISC

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

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

REQUESTING PHYSICIAN'S SIGNATURE	REPORTED BY	MD / TECH	DATE	LAB ID NO.
Dr. [redacted] [redacted]				

REMARKS

CBC

557-107

TEST(S)				
SPECIMEN TAKEN			REQUESTED	RESULTS
DATE 30MAY03	TIME 04	A.M. (circled) P.M.		

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

Ward/Section ICU#2 | D. | G PHYSICIAN: b(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI # b(6)-4 | DATE 30MAY03 | TIME 04 | SSN/PSEUDO SSN

(i-STAT)		
TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L

30MAY03@0415

i STAT G3+

Pt:

Pt Name:___________

TCO2________24 mmol/L

At 37C

pH_______7.532

PCO2______ .1 mmHg

PO2________88 mmHg

HCO3________23 mmol/L

BEecf________0 mmol

sO2%________98 %

%calculated

Sample Type_:

30MAY03 04:20

er:

ysician:_____________

#

: JAM0045A
CLEW A01

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

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
GLU	108	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	155	39-380 u/l (M) 30-190 u/l (F)
NA^+	131	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	23	18-33 mmol/l

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

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

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

KS:

ED BY: | DATE: 3? May 03 | LAB ID NO.:

b(6)-2

MEDCOM - 14980

Chemistry Unit

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

Ward/Section: ICW#2
REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2
LAST, FIRST, MI: # [redacted] b(6)-4
DATE: 31 MAY
TIME: 0430
SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	133	138-146 mmol/L
K	3.1	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	10	8-26 mg/dl
GLU	101	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	29	38-51% PCV
Hgb	10	12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.4	3.5-5.5 g/dl
ALP	133	26-84 u/l
ALT	72	10-47 u/l
AMY	172	14-97 u/l
AST	—	11-38 u/l
TBIL	2.3	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	7.6	8.0-10.3mg/dl
CHOL	176	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	106	73-118 mg/dl
TP	5.8	6.4-8.1 g/dl

(Piccolo) Lyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

MEDCOM - 14981

ICU#2 REQUEST PHYSICIAN: Dr. [redacted] b(6)-1

H [redacted] b(6)-4

DATE: 31 MAY TIME: 0930

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

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
	10.7	4.8-10.8 x 10³
	3.09	4.7-6.1 x 10⁶
	8.6	14-18 g/dl (M) 12-16 g/dl (F)
	27.8	42-52% (M) 37-47% (F)
	90.0	80-94 fl (M) 81-99 fl (F)
	356	130-500 x 10³ verified
Lymph %	21.1	20.5-51.1%

(Hematology) Manual Differential

		Mono	
		Eos	
		Baso	
		mm	

		42-52% (M) 37-47% (F)

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.0 secs
		21-34 secs
		<20 ug/ml
		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 31 May 03

LAB ID NO.:

MEDCOM - 14982

b(6)-2

Ward/Section	I C U #2	R... Org	...G PHYSICIAN:	...ISTRY ...SULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, M...	# b(6)-4	DATE 15 JUN	TIME 0930	SSN/PSEUDO SSN

(i-STAT)

TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	3.1	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	9	8-26 mg/dl
GLU	105	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	28	38-51% PCV
Hgb	10	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	~~105~~	73-118 mg/dl
BUN	~~9~~	7-22 mg/dl
CRE	+	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

...MARKS:

...ORTED BY:	DATE: 15 Jun 03	LAB ID NO.:

b(6)-2

MEDCOM - 14983

ICUH2 Dr. [redacted] b(6)-2 LAB [RESULT FORM] (Subject to Privacy Act of 1974)

DATE: JUN TIME: 0430 SSN/PSEUDO SSN:

(Hematology) CBC

RESULT	REF. RANGE
12.8	4.8-10.8 x 10³
2.94	4.7-6.1 x 10⁶
8.3	14-18 g/dl (M) 12-16 g/dl (F)
26.5	42-52% (M) 37-47% (F)
90.0	80-94 fl (M) 81-99 fl (F)
372	130-300 x 10³ verified
17.4	20.5-51.1%

(Hematology) Manual Differential

Mono	
Eos	
Baso	
Imm.	
	42-52% (M) 37-47% (F)

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
		20 ug/ml
		10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] DATE: 10 Jun 03 LAB ID NO.:

b(6)-2

MEDCOM - 14984

b(6)-2

Ward/Section: ICU #2

[REDACTED] PHYSICIAN:

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

LAST, FIRST, MI: CIV - # [REDACTED] b(6)-4

DATE: 02JUN

TIME: 0500

SSN/PSEUDO SSN:

(iSTAT)

TEST	RESULT	REF. RANGE
Na	134	138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	8	8-26 mg/dl
GLU	97	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	31	38-51% PCV
Hgb	11	12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Piccolo Chemistry

TEST	RESULT	REF. RANGE
ALB	1.6	3.5-5.5 g/dl
ALP	116	26-84 u/l
ALT	58	10-47 u/l
AMY	126	14-97 u/l
AST	38	11-38 u/l
TBIL	1.9	0.2-1.6 mg/dl
BUN	6	7-22 mg/dl
CA^{++}	8.0	8.0-10.3mg/dl
CHOL	216	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	106	73-118 mg/dl
TP	6.4	6.4-8.1 g/dl

[illegible]

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

Piccolo Metabolic Panel

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

Piccolo Liver Panel Plus

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

Piccolo Electrolyte

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

REMARKS:

REPORTED B[REDACTED]

DATE: 2 June 03

LAB ID NO.: 8835

b(6)-2

MEDCOM - 14985

ACLU-RDI 1629 p.145

DOD-028374

ICW #2

CIV-# [redacted] b(a)-4

[redacted] b(a)-2

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

DATE	TIME	SSN/PSEUDO SSN:
02JUN	0500	

(Hematology) CBC

	RESULT	REF. RANGE
	16.6	4.8-10.8 x 10³
	3.93	4.7-6.1 x 10⁶
	9.8	14-18 g/dl (M); 12-16 g/dl (F)
	31.2	42-52% (M); 37-47% (F)
	91.1	80-94 fl (M); 81-99 fl (F)
	388	130-400 x 10³ verified
...mph %	11.3	20.5-51.1%

(Hematology) Manual Differential

		Mono	
		Eos	
		Baso	
		Imm	
		42-52% (M); 37-47% (F)	

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.6 secs
		...-34 secs
		<20 ug/ml
		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(a)2

REPORTED BY: [redacted]	DATE: 02 Jun 03	LAB ID NO.:

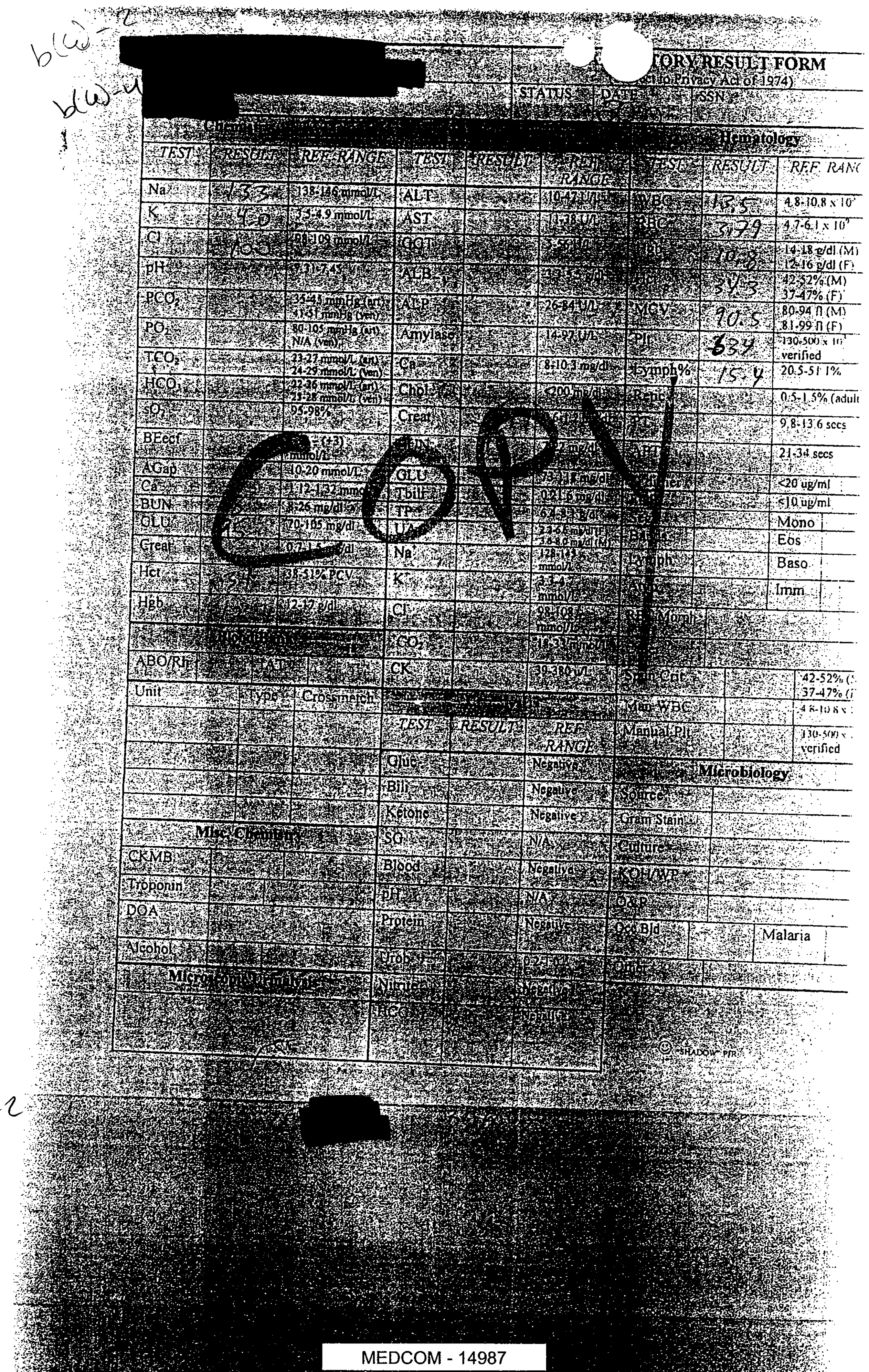
MEDCOM - 14986

ACLU-RDI 1629 p.146

DOD-028375

b(6)-2

b(6)-4



LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

STATUS	DATE	SSN

Chemistry / **Hematology**

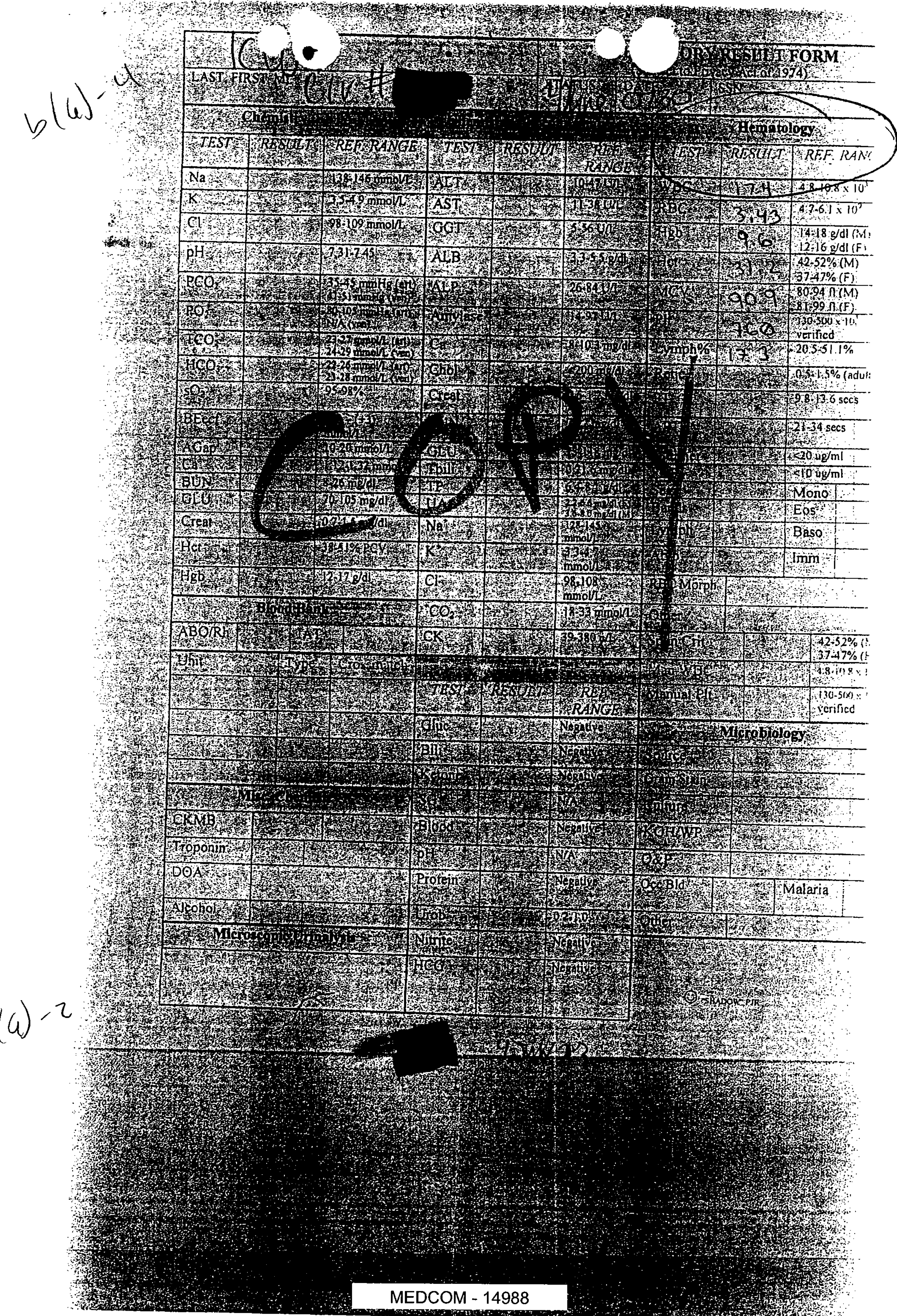
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	133	138-146 mmol/L	ALT		10-47 U/L	WBC	13.5	4.8-10.8 x 10³
K	4.0	3.5-4.9 mmol/L	AST		11-38 U/L	RBC	3.79	4.7-6.1 x 10⁶
Cl	103	98-109 mmol/L	GGT		5-50 U/L	Hgb	10.8	14-18 g/dl (M) 12-16 g/dl (F)
pH		7.31-7.45 (ven)	ALB		[illegible] g/dl	Hct	34.3	42-52% (M) 37-47% (F)
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)	ALP		26-84 U/L	MCV	90.5	80-94 fl (M) 81-99 fl (F)
PO_2		80-105 mmHg (art) N/A (ven)	Amylase		14-97 U/L	Plt	634	130-500 x 10³ verified
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)	Ca		8-10.3 mg/dl	Lymph%	15.4	20.5-51.1%
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)	Chol		<200 mg/dl	Retic		0.5-1.5% (adult)
sO_2		95-98%	Creat		[illegible]	PT		9.8-13.6 secs
BEecf		(±3) mmol/L	BUN		[illegible] mg/dl	APTT		21-34 secs
AGap		10-20 mmol/L	GLU		73-118 mg/dl	[illegible]		<20 ug/ml
Ca		1.12-1.32 mmol	Tbili		0.2-1.6 mg/dl	[illegible]		<10 ug/ml
BUN		8-26 mg/dl	TP		6.4-8.3 g/dl	[illegible]		Mono
GLU	115	70-105 mg/dl	UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)	Bands		Eos
Creat		0.7-1.5 mg/dl	Na		128-145 mmol/L	Lymph		Baso
Hct		38-51% PCV	K		3.5-5.1 mmol/L	Atyp		Imm
Hgb		12-17 g/dl	Cl		98-108 mmol/L	RBC Morph		
Blood Bank			CO_2		18-33 mmol/L			
ABO/Rh	DAT		CK		39-380 U/L	Spun Crit		42-52% (M) 37-47% (F)
Unit	Type	Crossmatch	**Urinalysis**			Man WBC		4.8-10.8 x 10³
			TEST	RESULT	REF. RANGE	Manual Plt		130-500 x 10³ verified
			Gluc		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ketone		Negative	Gram Stain		
Misc. Chemistry			SG		N/A	Culture		
CKMB			Blood		Negative	KOH/WP		
Troponin			pH		N/A	O&P		
DOA			Protein		Negative	Occ Bld		Malaria
Alcohol			Urobili		0.2-1.0	Other		
Microscopic Urinalysis			Nitrite		Negative			
			LEU		Negative			

COPY

© SHADOW PTR

b(6)-2

MEDCOM - 14987



LABORATORY RESULT FORM
(Privacy Act of 1974)

LAST, FIRST, MI: Civ # [redacted] | SSN

b(6)-4

Chemistry

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALT		10-47 U/L
K		3.5-4.9 mmol/L	AST		11-38 U/L
Cl		98-109 mmol/L	GGT		5-56 U/L
pH		7.31-7.45	ALB		3.3-5.5 g/dl
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)	ALP		26-84 U/L
PO_2		80-105 mmHg (art) N/A (ven)	Amylase		14-97 U/L
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)	Ca		8-10.3 mg/dl
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)	Chol		<200 mg/dl
sO_2		95-98%	Creat		[illegible]
BEecf		(-3)-(+3) mmol/L	[illegible]		[illegible]
AGap		10-20 mmol/L	GLU		[illegible]
iCa		1.12-1.32 mmol/L	Tbili		0.2-1.6 mg/dl
BUN		8-26 mg/dl	TP		6.4-8.1 g/dl
GLU		70-105 mg/dl	UA		[illegible]
Creat		0.2-1.6 mg/dl	Na		128-145 mmol/L
Hct		38-51% PCV	K		3.5-4.9 mmol/L
Hgb		12-17 g/dl	Cl		98-108 mmol/L
			CO_2		18-33 mmol/L
			CK		39-380 U/L

Blood Bank

ABO/Rh		DAT	
Unit	Type	Crossmatch	

Urinalysis

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

Misc Chemistry

Test	Result
CKMB	
Troponin	
DOA	
Alcohol	

Microscopic Urinalysis

Hematology

TEST	RESULT	REF. RANGE
WBC	17.4	4.8-10.8 x 10³
RBC	3.43	4.7-6.1 x 10⁶
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.2	42-52% (M) 37-47% (F)
MCV	90.9	80-94 fl (M) 81-99 fl (F)
Plt	160	130-500 x 10³ verified
Lymph%	17.3	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
PTT		21-34 secs
[illegible]		<20 ug/ml
[illegible]		<10 ug/ml
		Mono
		Eos
		Baso
		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Manual WBC		4.8-10.8 x 10³
Manual Plt		130-500 x 10³ verified

Microbiology

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

COPY

b(6)-2

[redacted] [illegible date]

MEDCOM - 14988

b(6)-4

Ward/Section: ICW2 | REQUESTING PHYSICIAN

CHEMISTRY RESULT FORM

LAST, FIRST, MI: CIV# [redacted] | DATE: 4 June | TIME: [illegible] | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.35-7.45
PCO2		35-45 mmHg (art) [illegible]
PO2		[illegible]
TCO2		[illegible]
HCO3		[illegible]
sO2		95-98%
BE ecf		[illegible] mmol/L
AnGap		[illegible] mmol/L
Ca		[illegible] mmol/L
BUN		8-26 mg/dl
Glu		[illegible] mg/dl
Creat		0.6-1.3 mg/dl
Hct		38-51% PCV
Hb		[illegible]

Misc. Chemistry

TEST	RESULT	REF RANGE
[illegible]		
Drug of Abuse		

(Piccolo) [illegible]

TEST	RESULT	REF RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CHOL		100-200 [illegible]
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) MetLyte 8

TEST	RESULT	REF RANGE
GLU	132	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	37	39-380 u/l (M) 30-190 u/l (F)
NA	124	128-145 mmol/l
K	[illegible]	3.6-[illegible]
CL	93	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

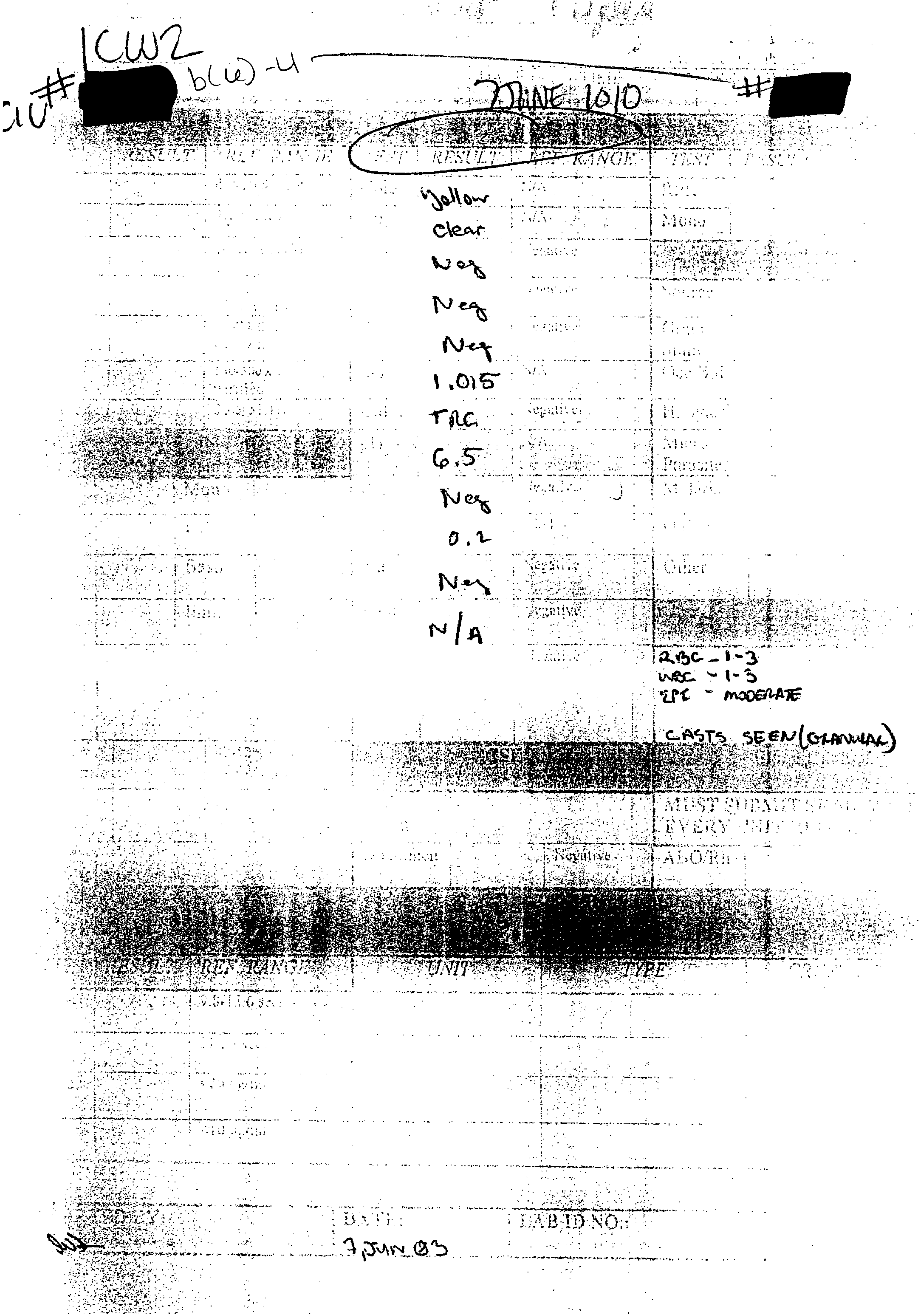
REMARKS:

REPORTED BY:	DATE:	LAB ID NO:
[illegible]	4 June 03	

CW2 b(6)-4

#[redacted] #[redacted]

7 JUNE 1010



TEST	RESULT	REF RANGE	TEST	RESULT
	Yellow			
	Clear		Mono	
	Neg	Negative		
	Neg	Negative		
	Neg	Negative		
	1.015			
	TRC	Negative		
	6.5			
	Neg	Negative		
	0.2			
	Neg	Negative	Other	
	N/A	Negative		

RBC - 1-3
WBC - 1-3
EPI - MODERATE

CASTS SEEN (GRANULAR)

MUST SUBMIT ... EVERY ...

ABO/Rh

RESULT	REF RANGE	UNIT	TYPE

DATE: 7 JUN 03

LAB ID NO.:

MEDCOM - 14990

ACLU-RDI 1629 p.150

DOD-028379

Ward/Section: ICW#2

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

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

LAST, FIRST, MI: EPW # [redacted] b(6)-4 | DATE: 8 Jun 03 | TIME: 0400 | SSN/PSEUDO SSN: STAT

Hematology Panel

TEST	RESULT	REF. RANGE
WBC	14.1	4.8-10.8
RBC	2.42	4.7-6.1
Hgb	6.6	14-18 / 12-16
Hct	21.9	42-52% / 37-47%
MCV	90.5	80-94 / 81-99
Plt	990	130-500 verified
Lymph %	25.1	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% / 37-47%
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 sec
APTT		21-34 sec
D dimer		<0.5
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: DATE: ID NO.:

MEDCOM - 14991

ACLU-RDI 1629 p.151

DOD-028380

b(6)-2

b(6)-4

Ward/Section	REQUESTING PHYSICIAN		CHEMISTRY RESULT FORM
ICW 2	[redacted]		
LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
[redacted]			

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
Na	135	138-146 mmol/L	ALB	2.7	3.5-5.5 g/dl	GLU		73-118 mg/dl
K	3.6	3.5-4.9 mmol/L	ALP	72	26-84 u/l	BUN		7-22 mg/dl
Cl	99	98-109 mmol/L	ALT	29	10-47 u/l	CA		8.0-10.3 mg/dl
pH	7.443	7.35-7.45	AMY	78	14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	38.0	35-45 mmHg (art) 41-51 mmHg (ven)	AST	14	11-38 u/l	NA		128-145 mmol/l
PO2		80-105 mmHg (art) NA (ven)	TBIL	1.6	0.2-1.6 mg/dl	K		3.3-4.7 mmol/l
TCO2	28	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN	7	7-22 mg/dl	CL		98-108 mmol/l
HCO3	27	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA	8.7	8.0-10.3 mg/dl	tCO2		18-33 mmol/l
sO2%		95-98%	CHOL	215	100-200 mg/dl			
BEecf	3	(-2)-(+3) mmol/L	CRE	2.0	0.6-1.2 mg/dl			
AnGap	13	10-20 mmol/L	GLU	106	73-118 mg/dl			
iCa		1.12-1.32 mmol/L	TP	6.8	6.4-8.1 g/dl			

(i-STAT)			[illegible]			(Piccolo) Liver Panel Plus		
TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
BUN	10	8-26 mg/dl				ALB		3.3-5.5 g/dl
Glu	95	70-105 mg/dl				ALP		26-84 u/l
Crea		0.6-1.3 mg/dl	GLU		73-118 mg/dl	ALT		10-47 u/l
Hct	29	38-51 %PCV	BUN		7-22 mg/dl	AMY		14-97 u/l
Hgb	[illegible]	[illegible]	CRE		0.6-1.2 mg/dl	AST		11-38 u/l
			CK		39-380 u/l (M) 30-190 u/l (F)	TBIL		0.2-1.6 mg/dl
			NA		128-145 mmol/l	GGT		5-65 u/l
						TP		6.4-8.1 g/dl

Misc Chemistry						(Piccolo) Electrolyte		
TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
[illegible]			K		3.3-4.7 mmol/l	NA		128-145 mmol/l
Drug of Abuse			CL		98-108 mmol/l	K		3.3-4.7 mmol/l
			tCO2		18-33 mmol/l	CL		98-108 mmol/l
						tCO2		18-33 mmol/l

REMARKS: Chem 8, Chem 12

REPORTED BY:	DATE:	LAB ID NO.
[redacted]	1 [illegible]	

MEDCOMM - 14992

b(6)-2

Ward/Section: ICW2

LAST, FIR[redacted]

b(6)-4

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

ATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.8	4.8-10.8 x 10³
RBC	3.27	4.7-6.1 x 10⁶
Hgb	9.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.7	42-52% (M) 37-47% (F)
MCV	91.1	80-94 fl (M) 81-99 fl (F)
Plt	906	130-500 x 10³ verified
Lymph %	16.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

REMARKS: CBC

REPORTED BY: [redacted] AT 9 Dec 03

b(6)-2

REF. RANGE
N/A
N/A
Negative
Negative
Negative
N/A
Negative
N/A
Negative
0.2-1.0
Negative
Negative
Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

Negative	ABO/Rh	

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

TYPE	CROSSMATCH

LAB ID NO.:

MEDCOM - 14993

ACLU-RDI 1629 p.153

DOD-028382

CBC b(6)-2

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

Ward Section: ICW#2

ATTENDING PHYSICIAN: [redacted]

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

DATE: 6/9

TIME: 0300

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.3	4.8-10.8 x 10³
RBC	3.33	4.7-6.1 x 10⁶
Hgb	9.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.2	42-52% (M) 37-47% (F)
MCV	90.8	80-94 fl (M) 81-99 fl (F)
Plt	897	130-500 x 10³ verified
Lymph %	15.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 9 Jun 03

LAB ID NO.:

MEDCOM - 14994

Ward/Sect: ICW 2 Dr. [redacted] b(6)-2

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
# [redacted] b(6)-4	11Jun	0400	b(6)-4 [redacted]

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	11.7	4.8-10.8
RBC	3.48	
Hgb	9.8	14-18 g/dl; 12-16 g/dl
Hct	31.9	42-52%; 37-47%
MCV	91.8	
Plt	812	verified
Lymph %	19.3	20.5-51.1

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp			
RBC Morph			

Spun Hematocrit		42-52%; 37-47%
Sed Rate		
Other		

Urinalysis

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

Misc Serology

TEST	RESULT	REF. RANGE
RPR		
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 sec
APTT		
D dimer		
FDP		

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MEDCOM - 14995

C amp 8, CRC b(6)-4 A11

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: [redacted] #2 | STATUS: CIV | DATE: 6/17/03 | SSN: # [redacted]

Chemistry (i-STAT)

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

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	~~0.4~~ 1.1	0.6-1.2 mg/dl
BUN	~~18~~ 8	7-22 mg/dl
GLU	~~102~~ 95	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+ 137	~~125~~	128-145 mmol/L
K^+ 3.7	~~4.4~~	3.3-4.7 mmol/L
Cl^- 97	~~104~~	98-108 mmol/L
$^tCO_2$ 24	~~22~~	18-33 mmol/L
CK 13	~~250~~	39-380 u/L

Hematology

TEST	RESULT	REF. RANGE
WBC	10.9	4.8-10.8 x 10³
RBC	3.72	4.7-6.1 x 10⁶
Hgb	10.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.3	42-52% (M) 37-47% (F)
MCV	89.7	80-94 fl (M) 81-99 fl (F)
Plt	483	130-500 x 10³ verified
Lymph%	22.8	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Other			

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10³
Manual Plt		130-500 x 10³ verified

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Urinalysis

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

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Microbiology

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

MEDCOM - 14996

Chem 7

Ward/Section: FCW#2 | REQUESTING PHYSICIAN: [redacted] b(6)-2

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

LAST, FIRST, MI: # [redacted] b(6)-4 | DATE: 6-23 | TIME: 0230 | SSN/PSEUDO SSN: # [redacted]

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Piccolo Chemistry 12

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

[illegible] (circled)

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	17	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	128	128-145 mmol/l
K^{+}	3.6	3.3-4.7 mmol/l
CL^{-}	95	98-108 mmol/l
tCO_2	25	18-33 mmol/l

Piccolo Metabolic Panel

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

Piccolo Liver Panel

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

Piccolo Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: 23 Jun 03 | LAB ID NO.:

MEDCOM - 14997

CBC b(6)-2

ard/Section: ECW #2	REQ...TING PH... [redacted]	...BORATORY RESULT FORM (Subject to the Privacy Act of 1974)

...ST, FIRST, MI. # [redacted] b(6)-4	DATE 6-23	TIME 0230	SSN/PSE... # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.2	4.8-10.8 x 10^3
RBC	3.15	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.2	42-52% (M) 37-47% (F)
MCV	89.6	80-94 fl (M) 81-99 fl (F)
Plt	455	130-500 x 10^3 verified
Lymph %	17.4	20.5-51.1%

(Hematology) Manual Differential

...gs		Mono	
...nds		Eos	
...mph		Baso	
...typ		Imm	
...BC ...orph			

...un ...ematocrit		42-52% (M) 37-47% (F)
...d Rate		
...ther		

Coagulation Studies

TEST	RESULT	REF. RANGE
...T		9.8-13.6 secs
PTT		21-34 secs
...dimer		<20 ug/ml
...DP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANG...
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	B pos

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

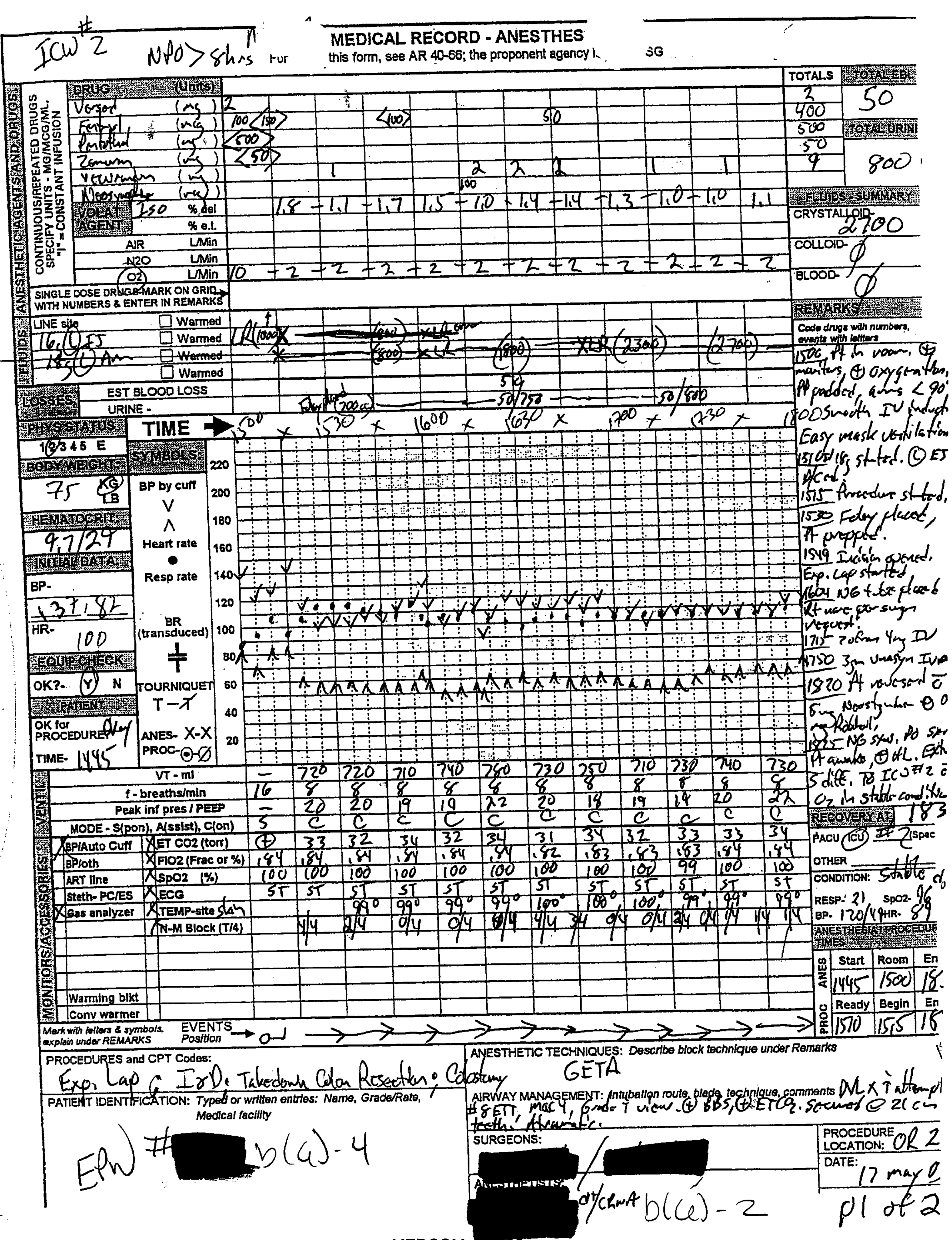
UNIT	TYPE	CROSSMATCH

...EMARKS:

[redacted] 23 Jun 03

b(6)-2

MEDCOM - 14998



ICW #2 NPO > 8hrs

MEDICAL RECORD - ANESTHES

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

ANESTHETIC AGENT(S) AND DRUGS

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

DRUG (Units)													TOTALS
Versed (mg)	2												2
Fentanyl (mcg)	100 ⟨150⟩		⟨100⟩			50							400
Pentothal (mg)	⟨500⟩												500
Zemuron (mg)	⟨50⟩												50
Vecuronium (mg)		1			2	2	2		1		1		9
Neosynephrine (mcg)					100								
VOLAT. AGENT Iso % del		1.8	1.1	1.7	1.5	1.0	1.4	1.4	1.3	1.0	1.0	1.1	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	10	2	2	2	2	2	2	2	2	2	2	2	

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

TOTAL EBL: 50

TOTAL URINE: 800

FLUIDS SUMMARY

CRYSTALLOID- 2700

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site

16 (L) EJ — Warmed — LR (1000) X — (600) X LR — (1800) — X LR (2300) — (2700)

18 (L) Arm — Warmed — X — (800) X LR

Warmed

Warmed

LOSSES

EST BLOOD LOSS — 50

URINE - Foley placed (200cc) — 50/250 — 50/800

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 9.7/29

INITIAL DATA: BP- 137/82 HR- 100

EQUIP CHECK OK?- (Y) N

PATIENT OK for PROCEDURE- Okay TIME- 1445

TIME ➡ 1500 x 1530 x 1600 x 1630 x 1700 x 1730 x 1800

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

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

VENTIL.

VT - ml	—	720	720	710	740	780	730	750	710	730	740	730
f - breaths/min	16	8	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP	—	20	20	19	19	22	20	18	19	14	20	22
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	⊕	33	32	34	32	34	31	34	32	33	33	34
BP/oth	X FiO2 (Frac or %)	.84	.84	.84	.84	.84	.84	.82	.83	.83	.83	.84	.44
ART line	X SpO2 (%)	100	100	100	100	100	100	100	100	100	99	100	100
Steth- PC/ES	X ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
X Gas analyzer	X TEMP-site skin			99°	99°	99°	99°	100°	100°	100°	99°	99°	99°
	X N-M Block (T/4)		4/4	2/4	0/4	0/4	4/4	4/4	3/4	0/4	0/4	2/4 0/4	1/4 1/4 1/4
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position ➡ o-J → → → → → → → → → →

REMARKS

Code drugs with numbers, events with letters

1500 Pt in room, ⊕ monitors, ⊕ oxygenation, Pt padded, arms < 90°

1500 Smooth IV induct. Easy mask ventilation

1510 16g started (L) EJ placed.

1515 Procedure started,

1530 Foley placed, Pt prepped.

1549 Incision opened. Exp. Lap started

1604 NG tube placed Rt nare per surgn request.

1715 Zofran 4mg IV

1750 3gm Unasyn IV

1820 Pt reversed c̄ 5mg Neostigmine ⊕ 0 ... Robinul,

1825 NG sxn, Pt sp... awake, ⊕ HL. Ext... S diff, to ICU #2 c̄ O2 in stable condition

RECOVERY AT: 183... PACU (ICU) #2 (Spec...)

OTHER

CONDITION: Stable c...

RESP- 21 SpO2- 96

BP- 120/49 HR- 89

ANESTHESIA/PROCEDURE TIMES

	Start	Room	En...
ANES	1445	1500	18..
	Ready	Begin	En...
PROC	1510	1515	18..

PROCEDURES and CPT Codes: Exp. Lap c̄ I&D, Takedown Colon Resection, Colostomy

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x 1 attempt #8 ETT, MAC 4, Grade I view. ⊕ BBS, ⊕ ETCO2. Secured @ 21 cm teeth. Atraumatic.

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

EPW # [redacted] b(6)-4

SURGEONS: [redacted] / [redacted]

ANESTHETISTS: [redacted] CPT/CRNA b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 17 May 0...

p1 of 2

MEDCOM - 14999

p2

MEDICAL RECORD - ANESTHE[illegible]

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)			TOTALS
Fentyl (mg)	50	50	500
( )			
( )			
( )			
( )			
( )			
VOLAT AGENT ISO % del	.06 X		
% e.t.			
AIR L/Min			
N2O L/Min			
O2 L/Min	2 → 10		

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

TOTAL EBL

TOTAL URINE

FLUIDS SUMMARY
CRYSTALLOID-
COLLOID-
BLOOD-

FLUIDS

LINE site	
☐ Warmed	
☐ Warmed	
18, (L) Arm ☐ Warmed	(2700)
☐ Warmed	

REMARKS
Code drugs with numbers, events with letters

LOSSES
EST BLOOD LOSS
URINE -

PHYS STATUS: 1 2 3 4 5 E

TIME → 1800 15 30

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA:
BP- see p1
HR-

EQUIP CHECK: OK? - Y N

PATIENT: OK for PROCEDURE? TIME-

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

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

VENTIL

	1800	15
VT - ml	730	400
f - breaths/min	8	16
Peak insp pres / PEEP	23	—
MODE - S(pon), A(ssist), C(on)	C	S

MONITORS/ACCESSORIES

		1800	15
X BP/Auto Cuff	X ET CO2 (torr)	35	36
BP/oth	X FIO2 (Frac or %)	.84	.84
ART line	X SpO2 (%)	100	100
Steth- PC/ES	X ECG	ST	ST
X Gas analyzer	X TEMP-site	99°	99
	X N-M Block (T/4)	4/4 c ST	c 50
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS EVENTS Position → [illegible]

RECOVERY AT: PACU ICU ______ (Spec)
OTHER ______
CONDITION:
RESP- SpO2-
BP- HR-

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Ex Lap

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* see p1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

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

EPW # [redacted]
b(6)-4

SURGEONS: [redacted] / Matsumoto b(6)-2

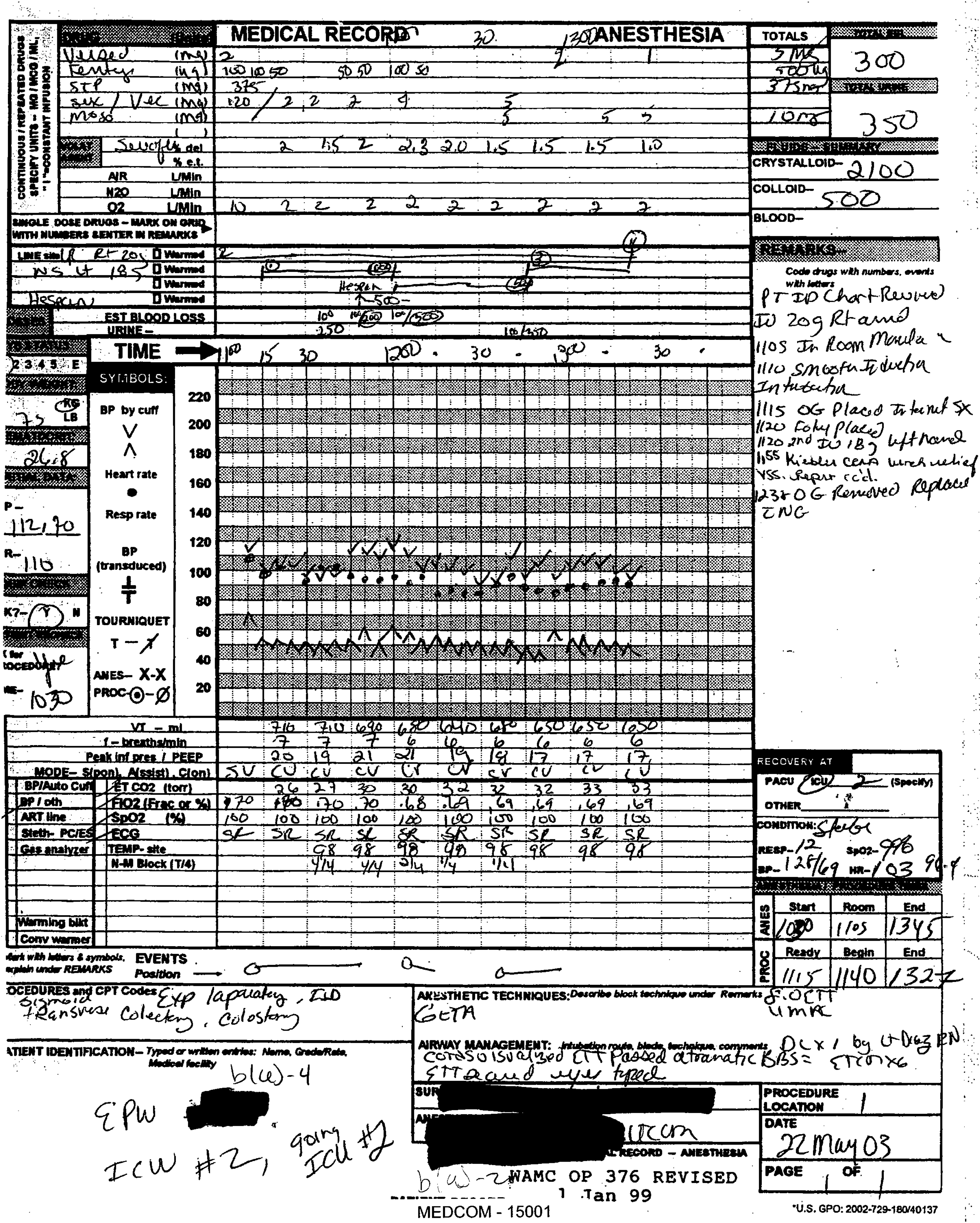
ANESTHETISTS: [redacted] CPT/CRNA

PROCEDURE LOCATION: OR [illegible]

DATE: 17 May 03

p2 of 2

MEDCOM - 15000



MEDICAL RECORD — ANESTHESIA

DRUG	(Units)		TOTALS
Versed	(mg)	2 ... 1	5 mg
Fentanyl	(mg)	100 100 50 50 50 100 50	500 ug
STP	(mg)	375	375 mg
sux / Vec	(mg)	120 / 2 2 2 4 5	
Midaz	(mg)	5 5 5	10 mg

Sevoflurane % del: 2 1.5 2 2.3 2.0 1.5 1.5 1.5 1.0

O2 L/Min: 10 2 2 2 2 2 2 2 2 2

TOTAL EBL 300 — TOTAL URINE 350

FLUIDS SUMMARY: CRYSTALLOID– 2100; COLLOID– 500; BLOOD–

LINE site: R Rt 20g; NS LR 18g; Hespan

EST BLOOD LOSS: 100 100/200 100/300

URINE– 250 100/350

TIME: 1100 15 30 1200 30 1300 30

Weight 75 kg; BP 112/70; P 110; NPO

REMARKS — Code drugs with numbers, events with letters

PT ID Chart Reviewed
IV 20g Rt arm
1105 In Room Monitors
1110 Smooth Induction Intubation
1115 OG Placed to Intermit SX
1120 Foley Placed
1120 2nd IV 18g Left hand
1155 Kibbler cera ... relief VSS. Repair ...
1230 OG Removed Replaced ENG

VT – ml	710	710	690	680	640	680	650	650	650
f – breaths/min	7	7	7	6	6	6	6	6	6
Peak inf pres / PEEP	20	19	21	21	19	18	17	17	17
MODE	CV	CV	CV	CV	CV	CV	CV	CV	CV
ET CO2 (torr)	26	27	30	30	32	32	32	33	33
FIO2	.70	.70	.70	.70	.68	.69	.69	.69	.69
SpO2 (%)	100	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP		98	98	98	98	98	98	98	98
N-M Block (T/4)		4/4	4/4	2/4	1/4	1/4			

RECOVERY AT: PACU ICU 2; CONDITION: Stable; RESP– 12; SpO2– 99%; BP– 125/69; HR– 103

	Start	Room	End
ANES	1030	1105	1345
	Ready	Begin	End
PROC	1115	1140	1327

PROCEDURES and CPT Codes: Exp laparotomy, ILD Sigmoid Transverse Colectomy, Colostomy

ANESTHETIC TECHNIQUES: GETA

AIRWAY MANAGEMENT: ... ETT passed atraumatic BBS= ... ETT taped and eyes taped

PATIENT IDENTIFICATION– b(6)-4 EPW [redacted] ICU #2, going ICU #2

SURGEON [redacted] ANESTHETIST [redacted]

PROCEDURE LOCATION 1; DATE 22 May 03; PAGE 1 OF 1

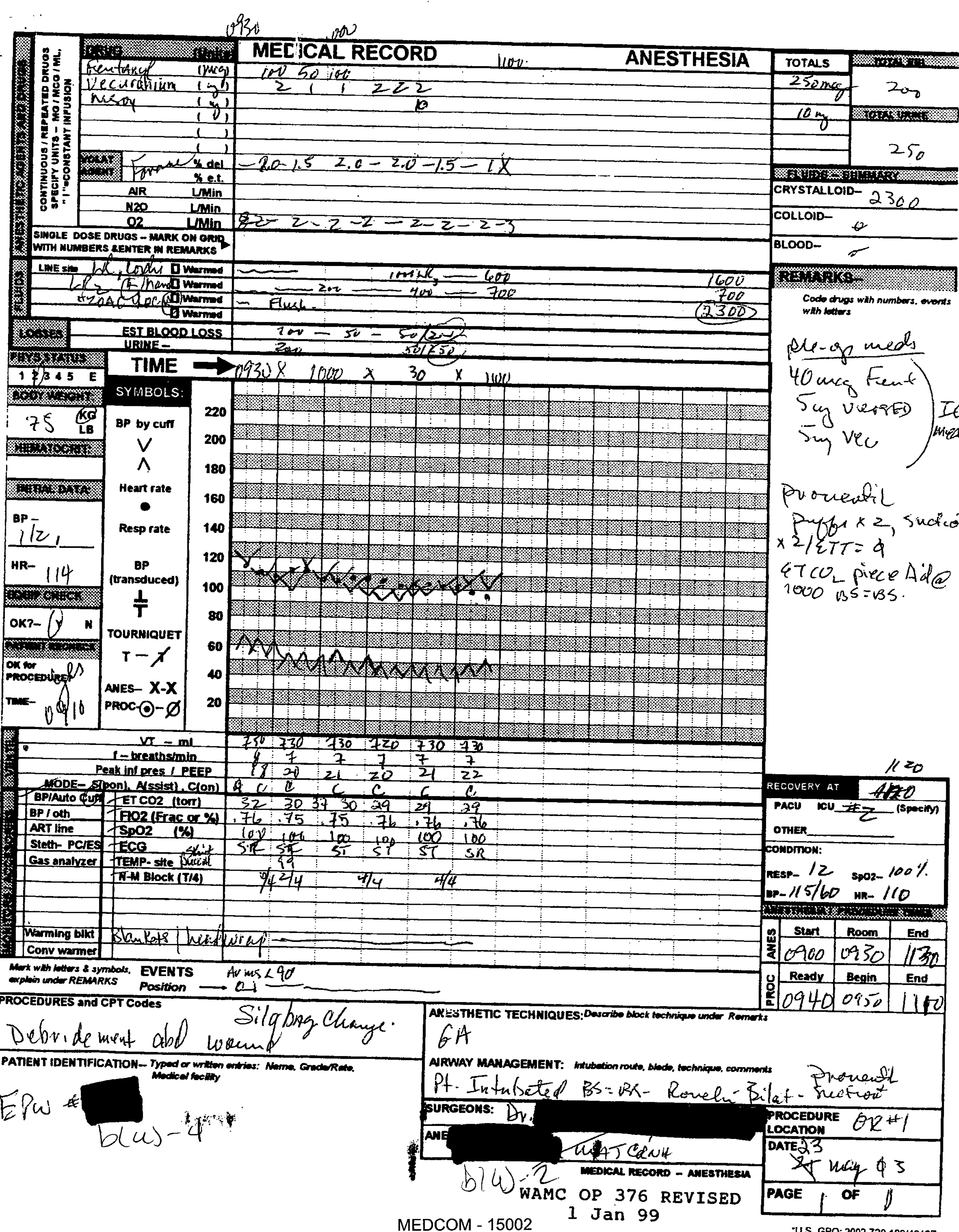
b(6)-2 WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 15001

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

ACLU-RDI 1629 p.161

DOD-028390



MEDICAL RECORD — ANESTHESIA

DRUG (Units)		TOTALS
Fentanyl (mcg)	100 50 100	250mcg
Vecuronium (mg)	2 1 1 2 2 2	10mg
Neosy (mg)	10	
VOLAT AGENT Forane % del	2.0 1.5 2.0 2.0 1.5 1X	
O2 L/Min	2 2 2 2 2 2 2	

TOTAL EBL: 200
TOTAL URINE: 250

FLUIDS SUMMARY: CRYSTALLOID 2300; COLLOID 0; BLOOD 0

FLUIDS:
- LINE site: Lt. Lodis — 1000 LR — 600 — 1600
- Lt. (F) hand — 200 — 400 — 700 — 700
- Flush
- Total: 2300

LOSSES: EST BLOOD LOSS 100 — 50 — 50 / 200; URINE 200 — 50 / 250

TIME: 0930 X 1000 X 30 X 1100

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 75 KG
INITIAL DATA: BP 112/— ; HR 114
EQUIP CHECK OK? Y
OK for PROCEDURE; TIME 0910

VT — ml	750	730	730	720	730	730
f — breaths/min	8	7	7	7	7	7
Peak inf pres / PEEP	18	20	21	20	21	22
MODE	A	C	C	C	C	C
ET CO2 (torr)	32	30 37	30	29	29	29
FIO2	.76	.75	.75	.76	.76	.76
SpO2 (%)	100	100	100	100	100	100
ECG	ST	ST	ST	ST	ST	SR
TEMP-site	Buccal	99				
N-M Block (T/4)	4/4	2/4	4/4	4/4		

Warming blkt: Blankets / headwrap
EVENTS: Av ms < 90; Position — O

REMARKS:
Pre-op meds 40 mcg Fent, 5 mg Versed, 5 mg Vec — IC
Proventil puffs x 2, suction x 2 / ETT = 0
ETCO2 piece Add @ 1000 BS=BS.

RECOVERY AT 1120 — ICU #2
CONDITION: RESP 12; SpO2 100%; BP 115/60; HR 110

	Start	Room	End
ANES	0900	0930	1130
	Ready	Begin	End
PROC	0940	0950	1110

PROCEDURES and CPT Codes: Debridement abd wound. Silg bag change.

ANESTHETIC TECHNIQUES: GA

AIRWAY MANAGEMENT: Pt. Intubated BS = RR — Ronchi — Bilat — Proventil Suction

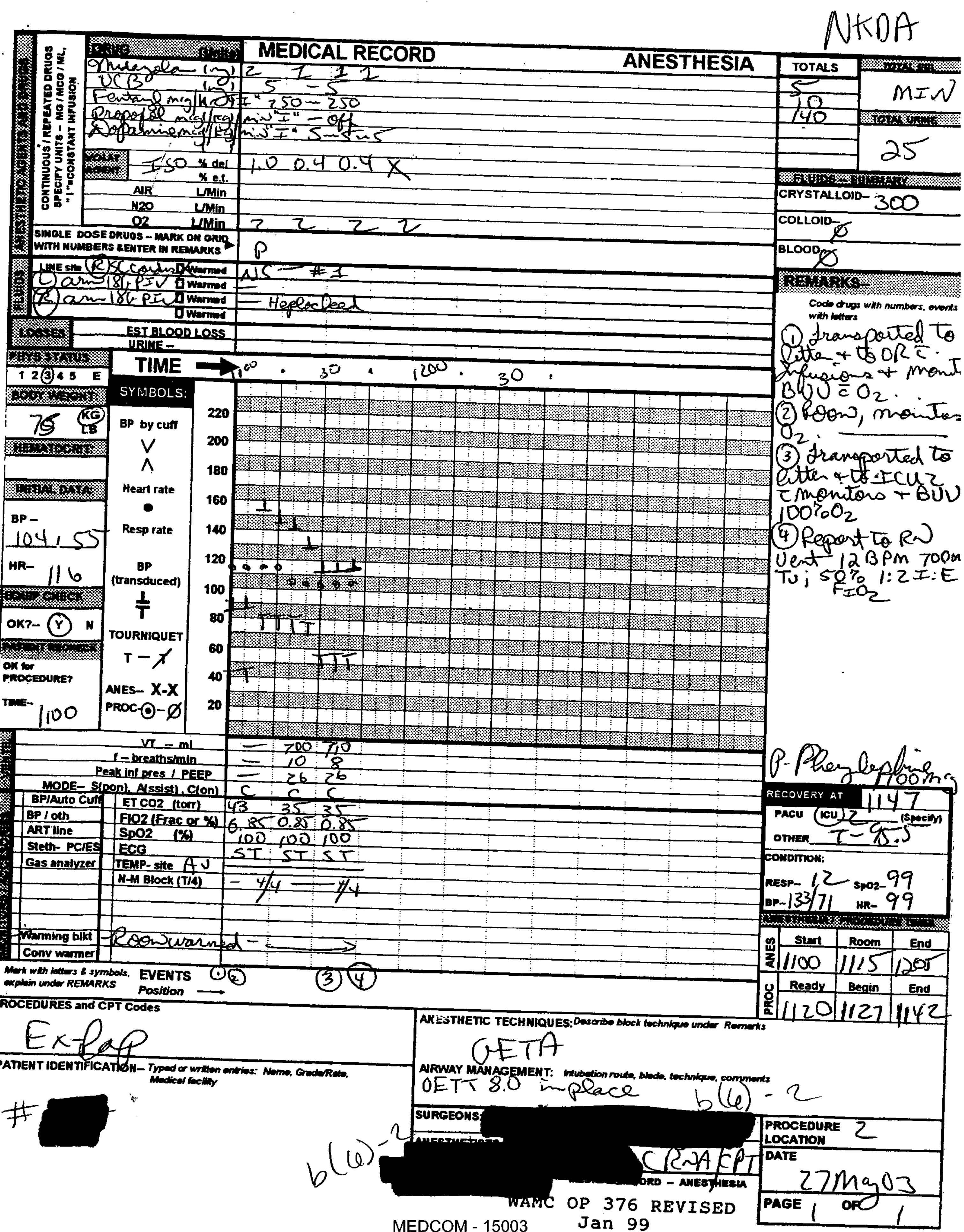
PATIENT IDENTIFICATION: EPW # [redacted] b(6)-4

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

PROCEDURE LOCATION: OR #1
DATE: 23 May 03
PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 15002
*U.S. GPO: 2002-729-180/40137

NKDA



MEDICAL RECORD — ANESTHESIA

DRUG (Units)		TOTALS
Midazolam (mg)	2 1 1 1	5
VCB (mg)	5 — 5	10
Fentanyl mcg/kg/hr "I"	250 — 250	140
Propofol mcg/kg/min "I"	— off	
Dopamine mcg/kg/min "I"	5 — 5	
VOLAT AGENT Iso % del	1.0 0.4 0.4 X	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	2 2 2 2	

TOTAL EBL: MIN
TOTAL URINE: 25

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

FLUIDS — LINE site:
- (R) SC cordis — Warmed — NS — #1
- (L) arm 18 PIV — Warmed
- (R) arm 18 PIV — Warmed — Heplock
- Warmed

LOSSES: EST BLOOD LOSS / URINE —

FLUIDS — SUMMARY: CRYSTALLOID — 300; COLLOID — Ø; BLOOD — Ø

PHYS STATUS: 1 2 (3) 4 5 E

TIME → 1100 · 30 · 1200 · 30

BODY WEIGHT: 75 (KG)

HEMATOCRIT:

INITIAL DATA: BP — 104/55; HR — 116

EQUIP CHECK: OK? — (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME — 1100

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

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

REMARKS — Code drugs with numbers, events with letters
1. Transported to litter + to OR 2 infusions + monitors BVV c O2.
2. Room, monitors O2.
3. Transported to litter + to ICU 2 c monitors + BVV 100% O2
4. Report to RN. Vent 12 BPM 700ml TV; 50% 1:2 I:E FIO2

P - Phenylephrine 100mcg

VENTILATION:

VT — ml	—	700	710
f — breaths/min	—	10	8
Peak insp pres / PEEP	—	26	26
MODE — S(pon), A(ssist), C(on)	C	C	C

MONITORS:

BP/Auto Cuff	ET CO2 (torr)	43	35	35
BP / oth	FIO2 (Frac or %)	0.85	0.85	0.85
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	ST	ST	ST
Gas analyzer	TEMP- site AJ			
	N-M Block (T/4)	— 4/4	—	4/4
Warming blkt	Room warmed — →			
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS ① ② ③ ④; Position →

RECOVERY AT 1147 — PACU (ICU) 2 (Specify); OTHER T - 95.5

CONDITION: RESP — 12; SpO2 — 99; BP — 133/71; HR — 99

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1100	1115	1205
	Ready	Begin	End
PROC	1120	1127	1142

PROCEDURES and CPT Codes: Ex-lap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — OETT 8.0 in place

PATIENT IDENTIFICATION — Typed or written entries: Name, Grade/Rate, Medical facility — # [redacted]

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] CRNA CPT b(6)-2

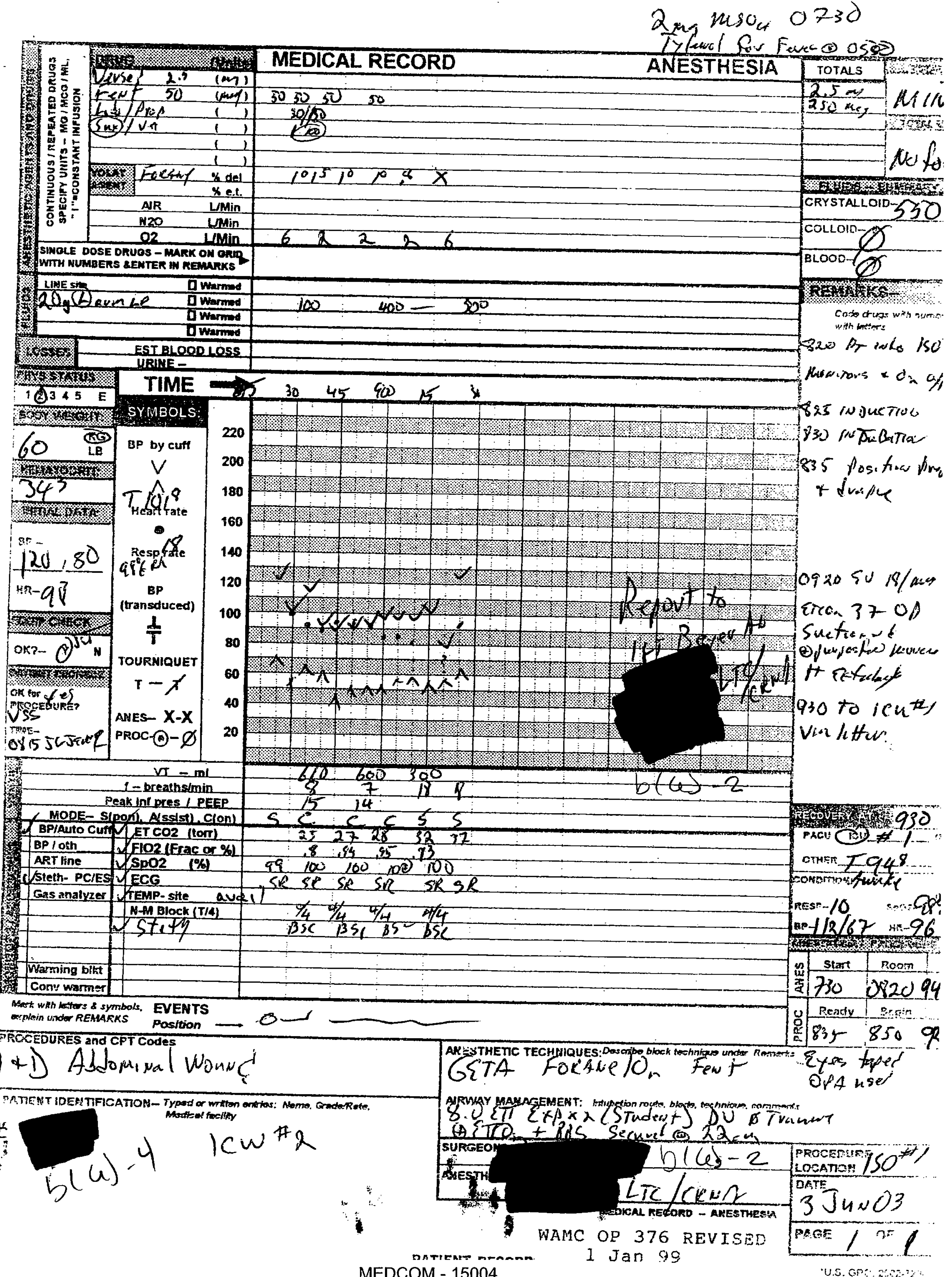
PROCEDURE LOCATION 2

DATE 27 May 03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA
WAMC OP 376 REVISED Jan 99
MEDCOM - 15003

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



2mg MSO4 0730
Tylenol for Fever @ 0500

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	Units		TOTALS
Versed 2.5	(mg)		2.5 mg
Fent 50	(mcg)	50 50 50 50	250 mcg
Lido/Prop	( )	30/150	
Sux/Vec	( )	100	
VOLAT AGENT Forane	% del / % e.t.	1.0 1.5 1.0 1.0 .4 X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6 2 2 2 6	

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

FLUIDS — LINE site: 20g (L) hand LR ☐ Warmed — 100 400 — 500

LOSSES: EST BLOOD LOSS; URINE –

FLUIDS – SUMMARY: CRYSTALLOID – 550; COLLOID – Ø; BLOOD – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 34?

INITIAL DATA: BP – 120/80; HR – 98; T 101.9; Resp rate 18; 98% RA

EQUIP CHECK: OK? – (Y) N

PATIENT IDENTIFICATION: OK for procedure? Yes; VSS; TIME – 0815

TIME: 30 45 900 15 30

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

Report to 1st Breen LTC/CRNA

b(6)-2

VT – ml	610 600 300
f – breaths/min	8 7 18 8
Peak insp pres / PEEP	15 14
MODE – S(pon), A(ssist), C(on)	S C C C S S
✓ BP/Auto Cuff ✓ ET CO2 (torr)	33 27 28 32 32
BP / oth ✓ FIO2 (Frac or %)	.8 .44 .45 .73
ART line ✓ SpO2 (%)	99 100 100 100 100
✓ Steth- PC/ES ✓ ECG	SR SR SR SR SR SR
Gas analyzer ✓ TEMP- site	aural
N-M Block (T/4)	4/4 4/4 4/4 4/4
✓ Stim	BSC BSC BSC BSC
Warming blkt	
Conv warmer	

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

REMARKS: Code drugs with numbers with letters
820 Pt into 150
Monitors & O2 on
825 Induction
830 Intubation
835 Position Pt & drape
0920 SV 18/min
Etco2 37 OD
Suction
...
930 to ICU #1
Via litter

RECOVERY AT 930: PACU (ICU) #1; OTHER I948; CONDITION Awake; RESP – 10; SpO2 98; BP – 112/67; HR – 96

ANESTHESIA PROCEDURE: ANES Start 730, Room 0820 94; PROC Ready 835, Begin 850, 92

PROCEDURES and CPT Codes: I+D Abdominal Wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA Forane 10 Fent. Eyes taped OPA used

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 8.0 ETT Exp x 2 (Student) DV Trauma ETCO2 + BBS Secured @ 22cm

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: # b(6)-4 ICW #2

SURGEON b(6)-2

ANESTHETIST LTC/CRNA

PROCEDURE LOCATION: 150 #1

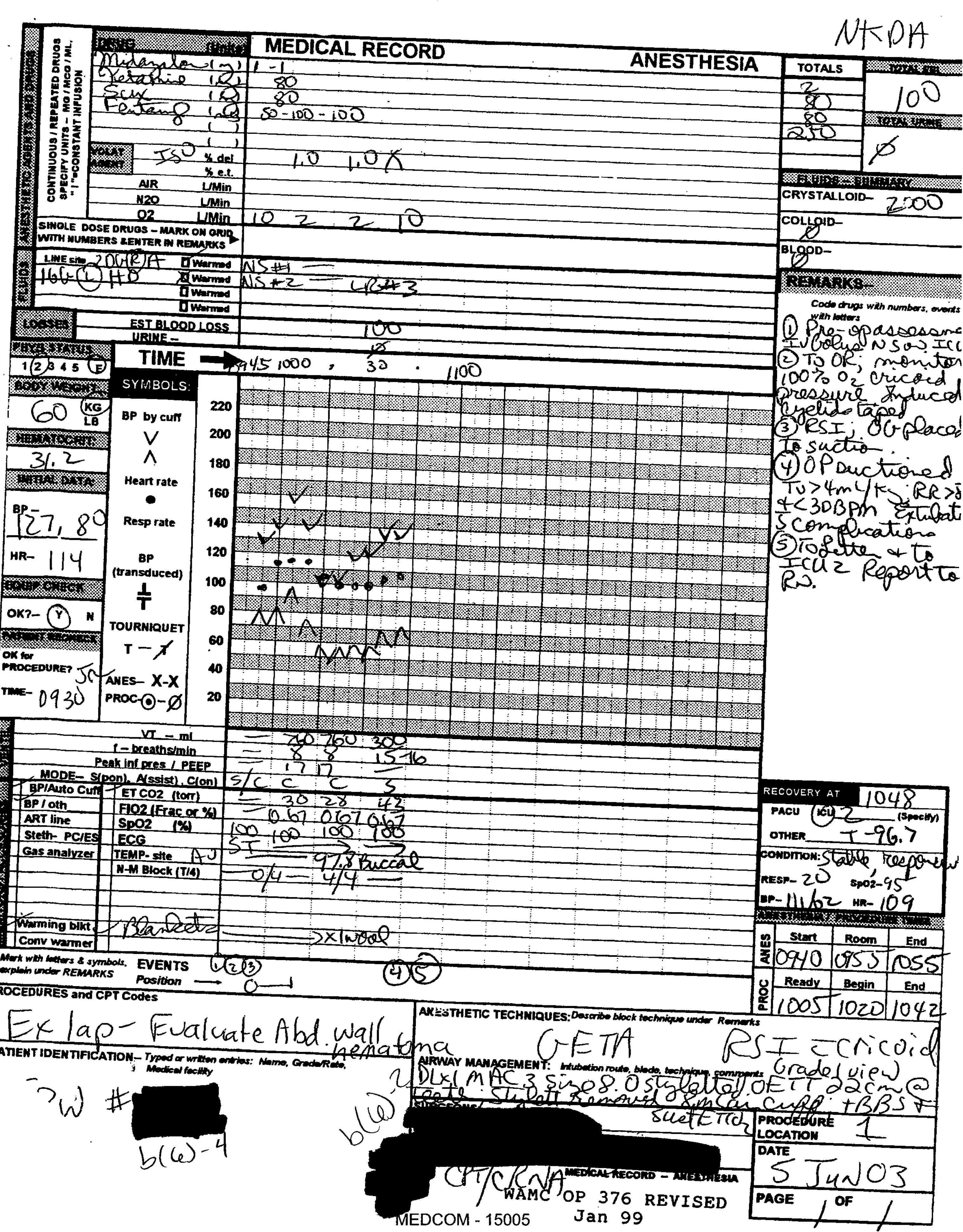
DATE: 3 JUN 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
PATIENT RECORD
MEDCOM - 15004
U.S. GPO: 2002

ACLU-RDI 1629 p.164

DOD-028393



NKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
Midazolam (mg)	1-1	2
Ketamine (mg)	80	80
Sux (mg)	80	80
Fentanyl (mcg)	50-100-100	250
VOLAT AGENT ISO % del	1.0 1.0	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	10 2 2 10	

TOTAL EBL 100
TOTAL URINE Ø

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

FLUIDS
LINE site 20G (R) A ☐ Warmed — NS #1
16G (L) HD ☒ Warmed — NS #2 — LR #3

FLUIDS SUMMARY
CRYSTALLOID– 2500
COLLOID– Ø
BLOOD– Ø

LOSSES
EST BLOOD LOSS 100
URINE – Ø

PHYS STATUS 1 (2) 3 4 5 (E)
BODY WEIGHT 60 (KG)
HEMATOCRIT 31.2
INITIAL DATA: BP– 127/80 HR– 114
EQUIP CHECK OK?– (Y) N
PATIENT RECHECK OK for PROCEDURE? [initials] TIME– 0930

TIME → 0945 1000 , 30 . 1100

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

VT – ml	—	760	760	300
f – breaths/min	—	8	8	15-16
Peak insp pres / PEEP		17	17	
MODE– S(pon), A(ssist), C(on)	S/C	C	C	S
ET CO2 (torr)	—	30	28	43
FIO2 (Frac or %)		0.67	0.67	0.67
SpO2 (%)	100	100	100	100
ECG	ST			
TEMP- site	AJ	97.8 Buccal		
N-M Block (T/4)	0/4	4/4		

MONITORS: BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt — Blankets — 2x Wool; Conv warmer

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

REMARKS– Code drugs with numbers, events with letters
(1) Pre-op assessment IV bolus NS on ICU
(2) To OR; monitors 100% O2 cricoid pressure Induced eyelids taped
(3) RSI; OG placed to suction
(4) OP suctioned TV > 4mL/kg RR > 8 & < 30 BPM Extubated s complications
(5) To Letter & to ICU 2 Report to RN.

RECOVERY AT 1048
PACU (ICU) 2 (Specify)
OTHER T-96.7
CONDITION: Stable, responsive
RESP– 20 SpO2– 95
BP– 111/62 HR– 109

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0940	0955	1055
	Ready	Begin	End
PROC	1005	1020	1042

PROCEDURES and CPT Codes
Ex lap – Evaluate Abd. wall hematoma

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA RSI c cricoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 MAC 3 size 8.0 styletted OETT 22cm @ teeth. Stylett Removed & m cuff. +BBS + suct ETCO2. Grade I view

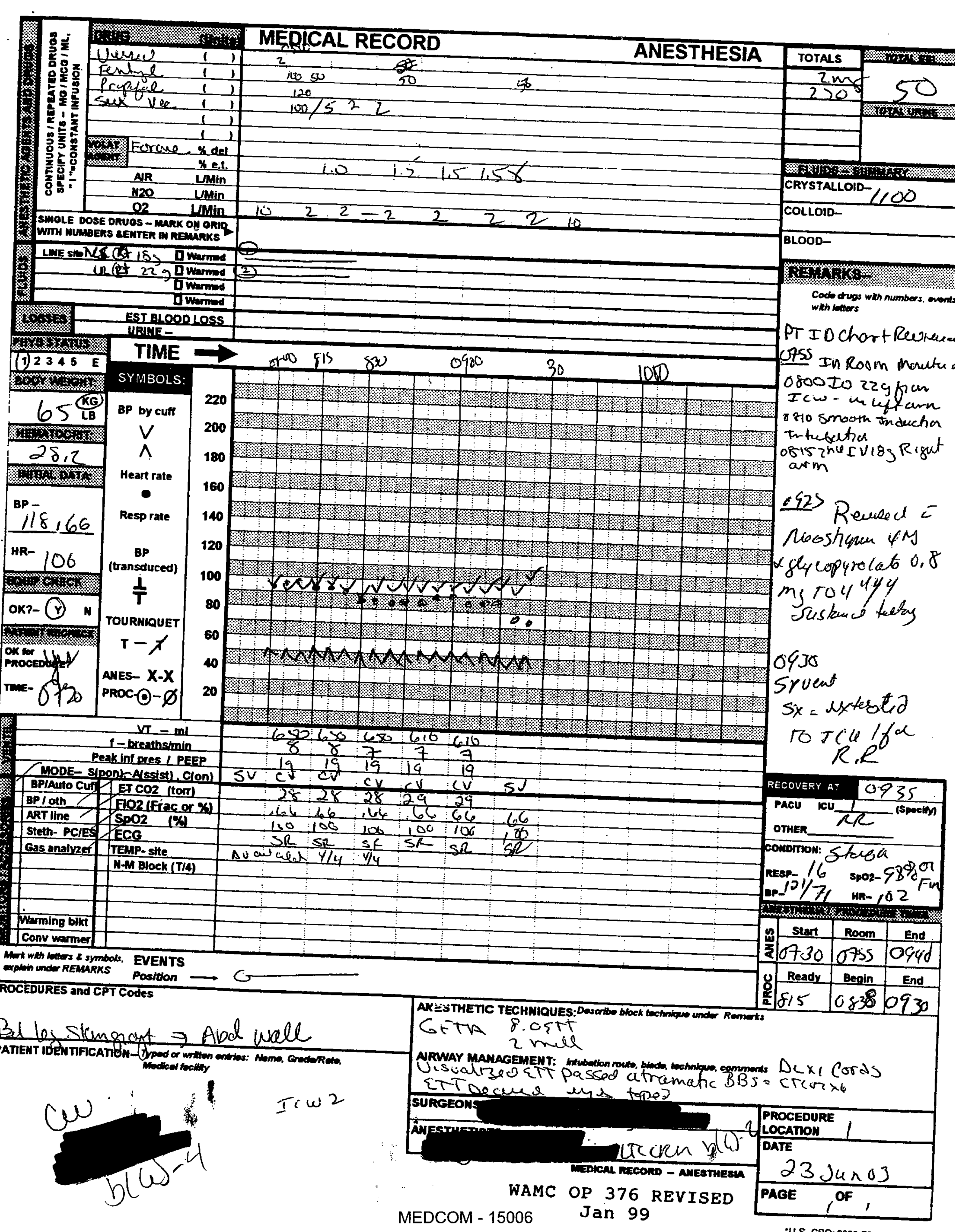
PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
7W # [redacted]
b(6)-4

b(6)-2
SURGEON [redacted]
CPT/CRNA [redacted]

PROCEDURE LOCATION 1
DATE 5 JUN 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED Jan 99
MEDCOM - 15005

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



MEDICAL RECORD — ANESTHESIA

DRUG (Units)		TOTALS
Versed ( )	2	2mg
Fentanyl ( )	100 50 50 50	250
Propofol ( )	120	
Sux Vec ( )	100/5 2 2	
VOLAT AGENT Forane % del		
% e.t.	1.0 1.5 1.5 1.58	
AIR L/Min		
N2O L/Min		
O2 L/Min	10 2 2 — 2 2 2 2 10	

TOTAL EBL 50

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 1100
COLLOID–
BLOOD–

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

FLUIDS
LINE site (1) 18g ☐ Warmed
(2) 22g ☐ Warmed
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS / URINE –

PHYS STATUS: (1) 2 3 4 5 E
BODY WEIGHT: 65 (KG) LB
HEMATOCRIT: 28.2
INITIAL DATA: BP – 118/66; HR – 106
EQUIP CHECK: OK? – (Y) N
PATIENT RECHECK: OK for PROCEDURE? [initials]; TIME – 0720

TIME → 0740 815 830 0900 30 1000

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

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

VT – ml	650	650	650	610	610	
f – breaths/min	8	8	7	7	7	
Peak inf pres / PEEP	19	19	19	19	19	
MODE– S(pon), A(ssist), C(on)	SV CV	CV	CV	CV	CV	SV
ET CO2 (torr)	28	28	28	29	29	
FIO2 (Frac or %)	.66	.66	.66	.66	.66	
SpO2 (%)	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR
TEMP- site						
N-M Block (T/4)	Not available	4/4	4/4			

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

Mark with letters & symbols, explain under REMARKS. EVENTS; Position → G

REMARKS– Code drugs with numbers, events with letters

PT ID Chart Reviewed
0755 In Room Monitors
0800 IV 22g from ICW – in left arm
0810 Smooth Induction Intubation
0815 2nd IV 18g Right arm

0925 Reversed c Neostigmine 4 mg & glycopyrrolate 0.8 mg TOF 4/4 Sustained head lift

0930 Sx uneventful
Pt extubated
To ICU/for RR

RECOVERY AT 0935
PACU / ICU / (Specify) RR
OTHER
CONDITION: Stable
RESP– 16; SpO2– 98% O2 FM
BP– 121/71; HR– 102

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0730	0755	0940

	Ready	Begin	End
PROC	815	0838	0930

PROCEDURES and CPT Codes

Bil leg skin graft → Abd wall

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA 8.0 ETT 2 mall

AIRWAY MANAGEMENT: intubation route, blade, technique, comments
DL x1 Cords visualized ETT passed atraumatic BBS = ETCO2 x6
ETT secured and taped

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

CW [redacted] ICW 2
BLW-4

SURGEON [redacted]

ANESTHETIST [redacted] [signature] BLW-2

PROCEDURE LOCATION 1

DATE 23 Jun 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 15006

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

ACLU-RDI 1629 p.166

DOD-028395

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 **DAYS MOS (YRS)** **Sex** (X) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: Ex Lap I&D
SURGICAL SERVICE: [redacted] (Gen. Surg)
NPO SINCE:

ASA Physical State (1) 2 3 4 5 E
WT: 75 (KG)/LB **HT:** ____ **IN.**
ALLERGIES: NKDA

HABITS:
- **TOBACCO:** Ø
- **ETOH:**
- **DRUGS:**

CURRENT MEDICATIONS:
( ) = ordered as premed
- ( ) Toradol 30mg IV q8° LD 0600
- ( ) Unasyn 3g IV q6° LD 0600
- ( ) Gentamycin 450mg QD LD 1200 5/21
- ( ) Zantac 50mg IV q8° LD 0600
- ( )
- ( )

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

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

0400 5/22 T&C pending
H.B 8.2 / 26.8 845
NA 104 | 6 | 90 / 3.8 | 25 | 0.5

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

System		N	Y	
Cardiovascular:	Hypertension	N	Y	~~Unknown~~
	Angina	N	Y	
	MI	N	Y	PMHx:
	CVA	N	Y	
	Other	N	Y	
Pulmonary System:	Asthma	N	Y	Denies per interpreter
	Bronchitis/URI	N	Y	
	COPD	N	Y	
	Other	N	Y	
Renal System:	Acute/Chronic RF	N	Y	
Gastrointestinal:	Hepatitis	N	Y	GSW to abdomen
	Hiatal Hernia	N	Y	~12 May →
	PUD/GERD	N	Y	surgery @ FST
Endocrine System:	Diabetes	N	Y	
	Steriods	N	Y	
	Thyroid	N	Y	
Neurological:	Seizures	N	Y	
	Neuropathy	N	Y	
	Other	N	Y	
Gynecological:	Pregnancy N/A	N	Y	
Other Significant Hx:		N	Y	
		N	Y	
Familial HX		N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
FST → Ex Lap
28th CSH → Ex lap / I+D } 17 MAY
colostomy takedown

PHYSICAL EXAMINATION 94% RA
BP 130/80 **HR** 90 **R** 30 **T** 99°
Pain Scale 0-10
HEENT - Teeth intact
Trachea Midline
TMJ/Neck FROM
Oropharynx MP II
Nares Patent
CHEST: CTA (B)
CARDIAC: S1S2 RRR
EXTREMITIES:
IV Access: LR - Baseline - 20g AC
Ulnar Filling:
BACK:
OTHER:

*clear liq breakfast
NPO Since 0700 this AM

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] CPT/CRNA **Date:** 22 MAY 03 **Time:** 1010 **Hrs**

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

Signed: ____ **Date:** ____ **Time:** ____ **Hrs**

Patient Identification: (Ward)
EPW # [redacted] b(6)-4
ICW #2

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~40 DAYS MOS (YRS)

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Debride Abd
SURGICAL SERVICE: Gen
NPO SINCE: on Vent

ASA Physical State 1 2 (3) 4 5 E
WT: 75 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Fent gtts
( ) Unasyn
( ) Gent
( ) Zantac
( ) Versed gtts
( )

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

LABORATORY STUDIES:

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

~~CBC pending~~
23.8 > 9.4 / 31.1 < 1020
131 | 104 | 8 < 101
4.4 | 23 | 0.7

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y

Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y

Renal System:
Acute/Chronic RF N Y

Gastrointestinal:
Hepatitis N Y GSW to Abd
Hiatal Hernia N Y 12 MAY
PUD/GERD N Y

Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological:
Pregnancy N Y

Other Significant Hx:
N Y
N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Mult Surg
on ZZ's adm't

PHYSICAL EXAMINATION

BP 104/55 HR 116 R 13 T 98.9
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck Pt
Oropharnyx Intubated
Nares on Vent
CHEST: S.S. / Rhonchi
CARDIAC: S.S.
EXTREMITIES: (R) AC #20g
IV Access: (L) Hand 18g
Ulnar Filling:
BACK:
OTHER:

NPO Since on Vent

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: 23 MAY 03 Time: 0600 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Update 27 May 03
Has received 3u PRBCs since 5/23 surgery
Labs 27 MAY 03:
34.6 > 9.2 / 29.9 < 449
141 | 106 | 12 < 146
4.3 | 26 | ?

SEDATION KEY:

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

Patient Identification: (Ward)

#[redacted] ICU #2

b(6)-4

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

MEDCOM - 15008

PATIENT RECORD COPY

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

Propofol 40mcg/kg/min

Fentanyl 250mcg/hr

Dopa 5mcg/kg/min

NS c̄ 20KCl @150cc/hr

VS 156/87 97 100%

SIMV R 12 TV 700 FiO_2 50%

I:E =1:2 PEEP 10

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ? DAYS MOS YRS

PROPOSED PROCEDURE: I/D Abd

SURGICAL SERVICE: POS STSG

NPO SINCE: p MN

Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5

WT: 60 (KG)/LB HT: ____ IN

ALLERGIES: unk ?

HABITS:
TOBACCO:
ETOH: ?
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Gent q day
( ) Cosyn q6°
( ) Amp q6°
( ) Zosyn q12°
( ) Lovenox BID
( )
( )

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

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

133 / 100 / 8 < 95
4.0

13.5 > 10.8 / 34.3 < 634

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y ?

Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y ?

Renal System:
Acute/Chronic RF N Y

Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y ?

Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y ?

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y ?

Gynecological:
Pregnancy N Y

Other Significant Hx: N Y Irrigated wound which is not closed @ present

Familial HX N Y

s/p GSW to Abdomen

ASSESSMENT
PAST SURGICAL/ANESTHETIC
?

PHYSICAL EXAMINATION
BP 120/80 HR 98 R 18 T 101.8
Pain Scale 0-10
HEENT - Teeth Intact, miss. (L) front
Trachea Midline
TMJ/Neck FROM
Oropharynx MP II
Nares
CHEST: S S → CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: #20g (L) Arm
Ulnar Filling:
BACK:
OTHER:

NPO Since p MN

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

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

The patie[redacted]dian seems to understand and agrees. Questions answered.

Signed: [redacted] LTC/CRNA Date: 3 Jun 07 Time: 0800 Hrs

POST-A[redacted] EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
bw-2

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward)
#[redacted] ICW 2
bw-4

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

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

MEDCOM - 15010

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 7_ DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Ex Lap - Evacuate Abdominal Wall Hematoma

SURGICAL SERVICE: Gen

NPO SINCE: 0800

ASA Physical State 1 (2) 3 4 5 (E)
WT: 60 KG/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: Ø

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

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

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

17.1 > 9.6 / 31.2 < 760

133 | 100 | 8 < 95
~~0.40~~

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological:
- Pregnancy N Y

Other Significant Hx: (N) Y Syncopal Episode this a.m.
N Y
Familial HX N Y

See Anesthesia pre-op 3 Jun 03

ASSESSMENT
PAST SURGICAL/ANESTHETIC
3 Jun I & D Abdominal Wound GE

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth Intact - risk ... teeth
Trachea MP I-II
TMJ/Neck FROM
Oropharnyx
Nares
CHEST: (+) BBS - CTA
CARDIAC: RRR
EXTREMITIES:
IV Access: #20 (R) Arm
Ulnar Filling: 5
BACK:
OTHER:

NPO Since 0800

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ (X) General: Mask Intubation RSI

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

The patient [redacted] seems to understand and agrees. Questions answered.

Signed: [redacted] CPT/CRNA Date: 5 Jun 03 Time: 0945 Hrs

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

Signed: ______ Date: ______ Time: ______ Hrs

rd) ______

[redacted] ICW
b(6)-4
M

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

ESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

: 36 DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

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

POSED PROCEDURE: Graft ... ⇒ Abd
GICAL SERVICE: ____
SINCE: ____

ITS:
BACCO: Ng
ETOH: Occasional
DRUGS: ____

RENT MEDICATIONS:
ordered as premed
Lovenox 30mg SQ
Hydrocodone

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
— · ____ mg IV IM PO
— · ____ mg IV IM PO
— · ____ mg IV IM PO

ORATORY STUDIES:
HCT: 8.9 / 28.2
IER: ____

128 | 95 _ 95
3.6 | 25 \ 9
.9
T > S

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ex lap
... Abd ...

PHYSICAL EXAMINATION
BP 118/66 HR 100 R ___ T 95.4
Pain Scale 0-10
HEENT - Teeth intact
Trachea mh
TMJ/Neck 3 FB
Oropharnyx MII
Nares
CHEST:
CARDIAC:
EXTREMITIES:
IV Access: Left Arm
Ulnar Filling:
BACK:
OTHER:

NPO Since 2400

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to cussed with the patient/legal guardian.

patient/legal guardian seems to understand and agrees. Questions answered.

ned: [redacted] LTC ... Date: 23 Jul 03 Time: 0730 Hrs

b(6)-2

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

ned: ____ Date: ____ Time: ____ Hrs

ient Identification: (Ward) ____

CIV
EPW [redacted] ICW-2
b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 15012

ANESTHESIA PLAN OF CARE : PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age (40) DAYS MOS YRS
Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Exploratory Lap, Colostomy closure
SURGICAL SERVICE: General
NPO SINCE: > 8 hours

ASA Physical State (1) 2 3 4 5 E
WT: 75 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Denies
ETOH: Denies
DRUGS: Denies

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Meropenem (3gm) due @ 1800
( ) Zantac 50mg IV 1400
( ) Gentamicin
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ____/____
U/A:
OTHER:
11 > 9.7 / 30.9 < (5/15) 8.5 / 27 < 186
141 | 103 | 12 < 105
4.6 | 26 | .4

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	GSW to Abdomen
Angina	N	Y	Approx May 12?
MI	N	Y	Surgery @ FST
CVA	N	Y	(Exp Lap)
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	unknown
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Exploratory Laparotomy 5/14?

PHYSICAL EXAMINATION O2 sat 9?
BP 161/76 HR 90 R 22 T ____
Pain Scale 0-10
HEENT - Teeth Intact
Trachea
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA
CARDIAC: $S_1 S_2$
EXTREMITIES:
IV Access: (L) EJ
Ulnar Filling:
BACK:
OTHER:
Foley / ostomy

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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

Pt 175

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS
MEDCOM - 15013
PATIENT RECORD COPY
Previous edition is obsolete

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

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

- [X] TYPE AND SCREEN (crossed out)
- [X] CROSSMATCH

DATE REQUESTED: 5/20/03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: Ex Lap

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

SIGNATURE OF VERIFIER: See previous SF 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.: b(6)-4

PATIENT NO.: EPW # [redacted]

	DONOR	RECIPIENT
ABO	B	B
Rh	Pos	Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD b(6)-2

SIGNATURE [redacted] ... TEST

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE [redacted] 03

REMARKS: Exp: 27 MAY 03

303 ml's

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 0741 hrs ON *(Date)*: 24 MAY 03

IDENTIFICATION

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

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

[redacted] b(6)-2

TEMP. 100.2 PULSE 107 BP 115/54

DATE OF TRANSFUSION: 24 May 03

TIME STARTED: 0800

POST-TRANSFUSION DATA

AMOUNT GIVEN: 303 ML

TIME	DATE	COMPLETED	INTERRUPTED
1005	24 May 03	COMPLETED	

REACTION

- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER

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

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

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

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

EPW # [redacted] b(6)-4

SEX: M

WARD: ICU #2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 15014

MEDICAL RECORD COPY

518-124

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-4159

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ______ units)
- [ ] CRYOPRECIPITATE (Pool of ______ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ______

VOLUME REQUESTED (If applicable) 1 unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 24 May 03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN (Print) [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE ex lap

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

SIGNATURE OF VERIFIER See previous 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

TRANSFUSION NO.

PATIENT NO.: 0175

DONOR: ABO B; Rh pos

RECIPIENT: ABO B; Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS:
Exp Date: ~~277~~ 27 May 2003

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE [redacted]

DATE 24 may 03

SECTION III – RECORD OF TRANSFUSION

INSPECTED A[redacted]

AT (Hour) 1750 Hrs ON (Date) 24 May 03

IDENTIFICATION

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

1st VERIFIER (Signature) [redacted] CPT, AN

2nd [redacted] 40 91W30M6

PRE-T[redacted]

TEMP. 100 | PULSE 102 | BP 102/52

DATE OF TRANSFUSION 24-MAY-03 | TIME STARTED 1800

POST-TRANSFUSION DATA

AMOUNT GIVEN 450 ML

TIME/DATE (COMPLETED)/INTERRUPTED 1930 24 MAY 03

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 100 | PULSE 101 | BLOOD PRESSURE 122/53

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

DESCRIPTION OF REACTION:
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [ ] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE [redacted] 556 91W30M6

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

EPW # [redacted]

b(6)-2

b(6)-4

SEX M

WARD ICU 2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 15015

Medical Record Copy

518-124

MEDICAL RECORD | NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ______ units)
- [ ] CRYOPRECIPITATE (Pool of ______ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ______

VOLUME REQUESTED (If applicable) 1 UNIT ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 25 MAY 03

DATE AND HOUR REQUIRED 25 MAY 03 / 09 AM

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN (Print) [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE S/P EXLAP

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

SIGNATURE OF VERIFIER SEE PREVIOUS 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. b(6)-4 [redacted]

DONOR: ABO B; Rh pos

RECIPIENT: ABO B; Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS: Exp Date: 27 May 03 b(6)-2

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNA[redacted]

DATE 25 May 03

SECTION III – RECORD OF TRANSFUSION

INSPECTED A[redacted]

AT (Hour) 0855 ON (Date) 25 MAY 03

IDENTIFICATION

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

1st VERIFIER (Signature) [redacted] ...IGTON [redacted]

PRE-[redacted]

TEMP. 100.9 PULSE 100 BP 123/57

DATE OF TRANSFUSION 25May03

TIME STARTED 0900

POST-TRANSFUSION DATA

AMOUNT GIVEN Complete

TIME/DATE COMPLETED/INTERRUPTED 25 May 03 1000

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 101.0 PULSE 100 BLOOD PRESSURE 119/58

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE [redacted]

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

MALE

WARD ICU #2

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 C...

MEDCOM - 15016

Medical Record Co...

518-124 NSN 7540-00-634-41

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (*Check one*)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (*Pool of ________ units*)
- [ ] CRYOPRECIPITATE (*Pool of ________ units*)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (*Specify*)

VOLUME REQUESTED (*If applicable*) 1 UNIT ML

REMARKS:

TYPE OF REQUEST (*Check ONLY if Red Blood Cell Products are requested.*)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 25 MAY 03

DATE AND HOUR REQUIRED 25 MAY 03/[illegible] AM

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (*Specify*)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN:
HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN (*Print*)

DIAGNOSIS OR OPERATIVE PROCEDURE S/P EXP LAP

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

SIGNATURE OF VERIFIER SEE PREVIOUS 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO. b(6)-4

PATIENT NO.

DONOR	RECIPIENT
ABO B	ABO B
Rh pos	Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS: Exp Date: 27 may 03

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST b(6)-2

DATE 25 May 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPE[CTED]

AT (*Hour*) 0950 ON (*Date*) 25 MAY 03

IDENTIFICATION

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

1st VERIFIER (*Signature*)

PR[E-TRANSFUSION]

TEMP. 101.0 PULSE 100 BP 112/58

DA[TE OF TRANS]FUSION TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN Complete ML

TIME/DATE COMPLETED/INTERRUPTED 25 May 03 11:00

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 101.3 PULSE 107 BLOOD PRESSURE 130/60

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

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

OTHER DIFFICULTIES (*Equipment, clots, etc.*)
- [X] NO
- [ ] YES (*Specify*)

—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; [d]ate; hospital or medical facility)

SECTION I—REQUIS[ITION] COMP[LETED]

b(6)-4

9/UMC

SEX MALE WARD ICU#2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 15017

Medical Record Copy

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

REMARKS:

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

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

DATE REQUESTED 8JUN03

DATE AND HOUR REQUIRED 8JUN03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)* DR. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE Low HGB + Hct

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 8JUN03

TIME VERIFIED 1430 / 8JUN03

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh positive

RECIPIENT

ABO B

Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatable

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 8JUN03

REMARKS: EXP DATE 10JUN03 b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1610 ON *(Date)* 8JUN03

IDENTIFICATION

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

1st VERIFIER *(Signature)* James . Howell MAJ/AN

2nd VERIFIER *(Signature)* [redacted] SGT, 91WM6

TEMP. 99. PULSE 94 BP 118/78

DATE OF TRANSFUSION 8JUN03

TIME STARTED 1628

POST-TRANSFUSION DATA

AMOUNT GIVEN 361 ML

TIME/DATE COMPLETED/INTERRUPTED 6/8/03 2000

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE 99.1 PULSE 96 BLOOD PRESSURE 116/72

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON [redacted]

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

, # [redacted]

b(6)-4

SEX M

WARD ICW2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 15018

Medical Record Copy

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ______ units)
- [ ] CRYOPRECIPITATE (Pool of ______ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify)

VOLUME REQUESTED (If applicable) 1 UNIT ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 8 JUN 03

DATE AND HOUR REQUIRED 8 JUN 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN:
HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN (Print) DR [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE Low Hgb & HCT

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

SIGNATURE OF VERIFIER [redacted]

8 JUN 03

TIME VERIFIED 1430 / 8 Jun 03

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO O Rh positive

RECIPIENT ABO B Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatable

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP DATE 10 JUN 03

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 8 JUN 03

b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

b(6)-4

INSPECTED AND ISSUED BY (Signature) [redacted]

AT (Hour) 2010 ON (Date) 8 Jun 03

IDENTIFICATION

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

1st VERIFIER (Signature) [redacted]

2nd VERIFIER (Signature) [redacted] RT/AN

PRE-TRANSFUSION
TEMP. 99.1 PULSE 96 BP 116/72

DATE OF TRANSFUSION 6/8/03

TIME STARTED ~~1620~~ 2015

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 6/8/03 ~~2000~~ 2340

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 100.1 PULSE 100 BLOOD PRESSURE 119/72

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [x] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON [redacted]

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

EPW # [redacted]

b(6)-4

SEX Male. WARD ICW2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9 202-1

MEDCOM - 15019

Medical Record Copy

NSN 7540-01-165-7294

b(6)-4

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
#175 PORTABLE CXR AP PER MAJ [redacted]		M	[redacted]	ICW#2	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE [redacted] b(6)-2				DATE REQUESTED 5/16/03

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

Atelectasis vs. Pneumonia

↑ temp

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

RADIOLOGIC REPORT

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 15020

...ON REQUEST/REPORT

STANDARD FORM ... Prescribed by GSA...

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/14/03 TIME OF ORDER 0835 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Dx: S/p Exploratory lap POD #3
2. Vitals q 1° x 14, then q 2°
3. Foley to DD
4. activity ~~bedrest~~ T.C. OOB TID
5. allergy: NKMA
6. Diet: NPO
7. IV LR @ 150/hr

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

8. MSO4 1-5mg IV q 1° prn pain
9. Toradol 15-30mg IV q 8° prn pain
10. Unasyn 3gm IV q 6°
11. Gentamycin 500mg IV on arrival to floor
12. Gentamycin to be dosed daily per pharmacy calculation
13. Zantac 50mg IV q 8°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

14. O2 2 liters NC titrate to off to keep Sat >94%
15. Labs: CBC, lytes, BUN/cr q day
16. Call HO T >102.5, P >125, U.O. <30/hr.
17. Place abd. drain to DD. (drain bag)

NURSING UNIT | ROOM NO. | BED NO.

18. Ostomy appliance placed over ostomy.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

[redacted]

b(6)-2

(178 Lbs)

19. Wet → Dry dressing TID to open wound

NURSING UNIT | ROOM NO. | BED NO.

24° VS GBW/ICU/TAN 5/15/03 0700

Noted 1045 14May03 [illegible]

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

☆ U.S. GOV MEDCOM - 15021 10

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

① DC foley
② Clears advance as tolerate to reg.
③ Ambulate TID.
④ If tolerates po Heplock IV
⑤ Cough & Deep Breath q 30 [redacted]

15 May 03 0900

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

Δ VS to q shift

15 May 03 0900

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 15 May 02 | TIME OF ORDER b(6)-2 HOURS

① Change Gentamicin 500mg QD IV to Gentamicin 450mg QD IV.
(5-7mg/kg QD, Approx pt wt ~ 75 kg)

b(6)-2 [redacted] PharmD, MS
MAJ, MS
Chief, [redacted] Pharmacy

NURSING UNIT | ROOM NO. 24 Vs | BED NO.

SPC Seeley 16 May 03 0100

PATIENT IDENTIFICATION

DATE OF ORDER 16 May 03 | TIME OF ORDER 0730 HOURS | Noted & signed

CXR today
V.O. Dr. [redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

SPC [redacted]

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

MEDCOM - 15022

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4		16 MAY 03 2150 HOURS	
	(1)	TYLENOL 650 mg PER	noted SPC
		RECTUM Q6° PRN	0800
		T ≥ 101.5 b(6)-2	16 May 03
			MD
NURSING UNIT / ROOM NO. / BED NO. 24° VS		2400 16 May 03 SPC 91WM4	b(6)-2
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 15023

2700
800
50

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume preop orders for Abx.
2. Diagnosis: Hartmans procedure, take down colostomy, Repair of abdominal defect.
3. Condition stable
4. NPO
5. NG to LIS
6. Foley to DD
7. VS q 1° x4, then q 2° x4, then q 4°
8. I/O
9. MSO4 2-5mg IV q 1°
10. Toradol 30 mg IV q 8°
11. Resume Unasyn and Gentamicin as ordered previously
12. Zantac 50mg IV q 8°
13. Call T>102; P>125, U.O. < 30/hr.

NURSING UNIT | ROOM NO. | BED NO.

Noted 17 may 03 2300 SPC [redacted] b(6)-2

b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

1. Δ VS to q 2° x 4 then as above
2. Δ MSO4 to q 1° prn

b(6)-2

24° Vs [redacted]

1(4) AN 5/18/03 0150 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE US[ED] b(6)-2

MEDCOM - 15024

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

1. NPO
2. Surgery today for abd wall Hernia Repair
3. IV LR @ 125/hr

19 May 03

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

1. IV LR @ 150/hr
2. Bolus 1 liter LR now
2. Pt may have ice chips

b(6)-2

18 MAY 03
0535

NURSING UNIT | ROOM NO. | BED NO.

24° V/S ... 1 ... 5/19/03 0130

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

19 May 03 0900

1. CBC today
2. DC NG
3. DC dressings to abd → dress ...
4. DC Foley
5. ambulate
6. Start ice chips, sips of clear
7. Hard candy ad lib

NURSING UNIT | ROOM NO. | BED NO.

ICW #2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° V/S ... 20 May 03 0100

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

MEDCOM - 15025

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

(1) CBC, lytes, BUN, Cr this AM and q day x 3

(2) Advance diet to Reg as tolerated

(3) ↓ IV to 40/hr.

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

24° VS 0100 21 May 03

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

(1) Heplock IV b(6)-2

(2)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 21 May 03 | TIME OF ORDER 0900 HOURS

NPO

V.O. Dr.

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 5/21 | TIME OF ORDER 1525 HOURS

(1) Sips of clears.

(2) IV LR @ 120/hr

(3) Iodoform gauze to abdominal wounds TID

(4) Ambulate TID.

NURSING UNIT | ROOM NO. | BED NO.

24° VS [illegible] 5/21/03 2310 5/21/03

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

MEDCOM - 15026

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

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

DATE OF ORDER: 5/22/03 | TIME OF ORDER: 0830 HOURS | LIST TIME ORDER NOTED AND SIGN: Noted ... 22 May 03 0740

Heplock IV.
Advance diet as tolerated
MD will to this ... drsg Δ.
V.O. Dr. ...

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO | BED NO

DATE | TIME OF ORDER | HOURS

① NPO ✓
② LR @ 120/hr ✓
③ Type & Cross for O-R today ✓

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER: 22 MAY 03 | TIME OF ORDER: 2145 HOURS | Noted ... 2255

① LR bolus 500cc XT now
LR bolus 500cc XT 1° ago.
↑ LR 150 cc/hr p̄ bolus.

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

MEDCOM - 15027

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

EPW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5/22 TIME OF ORDER: 1335 HOURS

Dx: S/P Exploratory lap; Transverse colectomy and colostomy c̄ I&D

Condition: Serious

Vitals q 1° x 4, then q 2° x 4, then q 4°

I/O

Foley to DD

NG to LIS

Δ dressing PRN

IV LR @ 130/hr

Fentanyl gtt: titrate to pain free

Versed gtt. titrate to pt. comfort

Unasyn 3.0 gm IV q 6°

Gentamycin 450 mg IV q day

Pantac 50 mg IV q 8°

Vent. FIO2 50% 750 TV; Rate 12; PEEP 5

ABG, CBC on arrival to ICU

ABG, CBC, lytes, BUN/cr q AM

CXR on arrival to ICU and q AM

Call HO if T > 102, P > 120, U.O. < 30/hr

[redacted] b(6)-2

LIST TIME ORDER NOTED AND SIGN: 1410 [redacted] b(6)-2; 1430 [redacted]; 1430 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 MAY TIME OF ORDER: 1930 HOURS

(1) TYLENOL 650mg PR Q4-6° PRN T > 101.5

[redacted] b(6)-2

Noted 22 MAY @ 2040

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER: 23MAY

TIME OF ORDER: ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume preop Orders.
2. JP's to wall Sxn. continuous lo
3. Δ dressings starting tomorrow BID.

b(6)-2

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ 24MAY 0330

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 # b(6)-2 noted

DATE OF ORDER 5/24 TIME OF ORDER 0730 HOURS LIST TIME ORDER NOTED AND SIGN

1. CXR now - DC'd — DONE
2. 1 unit pRBC now — DONE
3. Cipro IV 400 mg q12°
4. Pharmacy to advise Gentamycin based on level

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 # b(6)-2 noted 24 May 03 1418

DATE OF ORDER 5/24 TIME OF ORDER 0950 HOURS b(6)-2

1. Gentamicin 450mg IV QD to remain as is. - Done

PharmD

b(6)-2 PharmD, MS
MAJ, MS
Chief, Clinical Pharmacy

NURSING UNIT | ROOM NO. b(6)-2 | BED NO.

PATIENT IDENTIFICATION

b(6)-4 # noted 24 May 03 1418

DATE OF ORDER 5/24 TIME OF ORDER 1400 HOURS

1. DC Unasyn + Cipro IV
Start Zosyn 3.375 gm Q6hr IV

PharmD

b(6)-2 , PharmD, MS
MAJ, MS
Chief, Clinical Pharmacy

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 24 May 03 TIME OF ORDER 0730 HOURS noted

1. Transfuse 1 unit pRBC's over 4°

CPT

b(6)-2

@ 1738 2'

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 REPLACES EDITION OF 1 JUL 77

7447 , CPT, AN

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DOD-028419

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
CIV 25 MAY 03 0820 NOTED b(6)-4 b(6)-2	① ② ③	T.C. ~~2~~ 1 unit of pRBC now NS c̄ 20 meq KCl @ 100/h Lovenox 30 mg SQ q12 b(6)-2	HOURS	DONE
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION 25 MAY 03 b(6)-2		25 MAY 03 VO FROM DR. CARMODY, T. MUCOMYST 20% q 4° 2cc c̄ .5 ALBUTEROL CXR NOW b(6)-2	1445 HOURS	
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION 25 MAY 03 NOTED b(6)-2		25 MAY 03 ↑ PEEP TO 8 VO FROM DR. CARMODY ~~650MG TYLENOL PR~~ ERROR	1545 HOURS	b(6)-2
NURSING UNIT / ROOM NO. / BED NO.				
PATIENT IDENTIFICATION 25 MAY 03 NOTED b(6)-2		5/26 Propofol gtt @ 30 µg/kg/min titrate to sedative effect b(6)-2	1236 HOURS	
NURSING UNIT / ROOM NO. / BED NO.				

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DOD-028420

AL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION b(6)-4

26 MAY 03 NOTED

NURSING UNIT ICU2 | ROOM NO. | BED NO. b(6)-2

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

① Ampicillin 500 mg IV q 6°

b(6)-2

PATIENT IDENTIFICATION b(6)

26 MAY 03

DATE OF ORDER b(6)-2 | TIME OF ORDER 1605 HOURS | b(6)-2

① VO FROM DR [redacted] 1 LITER @ 1345 OVER 30 MINUTES

② VO FROM DR [redacted] 1 LITER OVER 30 MINUTES 1605

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 26-MAY-03 | TIME OF ORDER 1900 HOURS | 26 MAY 03

① V.O. from Dr [redacted] 500cc NS bolus IV

② CBC Now

b(6)-2

DONE @ 1900

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION b(6)-4

DATE OF ORDER 26 MAY 03 | TIME OF ORDER 1930 HOURS

① DOPAMINE stat - INFUSE at 3 mcg/kg/min titr to keep MAP 65.

b(6)-2

Noted @ 1930

NURSING UNIT | ROOM NO. | BED NO.

[redacted], MD
MAJ, MC USA
CHIEF, DOS

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

b(6)

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER 5/27 TIME OF ORDER 12N HOURS

LIST TIME ORDER NOTED AND SIGN 27May

1. S/p Bay Removal
2. Resume previous orders, RN meds
3. Dressing: Wet-Dry with Kerlix 1420 Supersponge and ABD BID
4. O2 ... b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24W CPT b(6)-2 @0430

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS b(6)-2 28 May

1. Wean propofol & let awake and begin to wean ventilator
2. Start TF Jevity @ 20 cc an hour ↓NG. Check residuals q4°, hold for >100 cc
3. Keep HOB @ 30°

✓ Chart ... @0430 24 May

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 29 MAY 03 NOTED b(6)-2

DATE OF ORDER b(6)-2 TIME OF ORDER 1230

1. TYLENOL 650MG NGT FOR FEVER >101.5
2. TYLENOL PR D/C

b(6)-2

✓ Chart @0430

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 30 MAY 03 NOTED

DATE OF ORDER 30 May 03 1400 HOURS

1. Phenergan 12.5-25 IV q4° b(6)-2 NOTED

NURSING UNIT | ROOM NO. | BED NO.

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b(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: b(6)-4 #

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

DATE OF ORDER: 5/30 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

1) Reg diet
2) Tray as tolerated

b(6)-2

✓ Chart

Noted b(6)-2 ... 5/30 ... RN

PATIENT IDENTIFICATION: b(6)-4 #

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER: 5/31 | TIME OF ORDER: 2150 HOURS

V.O. MSO4 2-4mg IVP
Ā each dressing Δ
PRN/pN

b(6)-2

VO. Dr

Done / Noted 2352 ... 5/31

2400 CPT ... JUN 0 0439

PATIENT IDENTIFICATION: b(6)-4 #

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

DATE OF ORDER | TIME OF ORDER | HOURS

1) Transfer to ward
2) Condition stable
3) Vitals q 4°
4) I/O
5) Activity: ambulate c̄ assistance TID
6) PT consult for above (strength & conditioning)

b(6)-2

Noted ... 6/1/0? 1120

PATIENT IDENTIFICATION: b(6)-4 #

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

DATE OF ORDER | TIME OF ORDER | HOURS

7) Nutrition consult to see today.
8) Calorie count.
9) Diet: Reg c̄ III can Ensure (+) (one b/t meals)
10) IV LR @ 50/hr c̄ additional 20 meq KCl per bag.
11) Toradol 30mg IV q 6° prn (priority)
12) MSO4 2-4 mg IV q 1° prn.

Cont...

b(6)-2

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CAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

31 MAY 03 NOTED

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 31 MAY 03 | TIME OF ORDER: 0550 HOURS | LIST TIME ORDER NOTED AND SIGN

40 MEQ K+ IN 100CC NS OVER 4° VO FROM DR. DIXON

b(6)-2

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

b(6)-2

31 MAY 03 NOTED

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2

(1) Ensure (+) b/w meals TID and III can/day

(2) Wrap binder on abdomen and up to chair TID.

(3) DC ABG

PATIENT IDENTIFICATION

b(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

(4) Δ VS to q 4°

(5) DC FOLEY

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

31 MAY 03 NOTED

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

DATE OF ORDER: 31 MAY 03 | TIME OF ORDER: 1600 HOURS

(1) V.O. FROM DR. b(6)-2 ~~D/C FENTANYL~~ ~~D/C FOLEY~~ ERROR

START PERCOCET I-II TABS Q 4-6°.

b(6)-2

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DOD-028424

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

(13) Percocet I-II po q 4-6° prn pain.

(14) Tylenol I-II po q 4-6 prn Temp >101.5 (Do not combine c Percocet)

(15) Gentamycin 450mg IV q day

(16) Zosyn 3.375 IV q 6°

(17) Ampicillin 500 IV q 6°

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

(18) Zantac 150 mg po q 12°

(19) Lovenox 30 mg SQ BID

(20) O_2 NC 2-4L prn Sat <90%. Call HO if need >4L.

(21) CBC, lytes, BUN/Cr q day x3

(22) Δ Dressings to abd wet → dry BID.

(23) Δ Ostomy Bag prn.

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

(24) ACE WRAP abd circumferentially to abdomen over dressing & bag before getting out of bed TID.

b(6)-2 [redacted]

b(6)-2 [redacted] 6/1/03

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2 noted [redacted] 0020

(1) NPO p Midnight

(2) IV LR @ 125/hr p NPO. ↳ c 20meq KCl added.

b(6)-2 [redacted]

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

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CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

[TH]E DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD [SYS]TEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

b(6)-2

[PA]TIENT IDENTIFICATION: # [redacted] b(6)-4
[NU]RSING UNIT: ICW2 | ROOM NO.: | BED NO.: 13

DATE OF ORDER: 6/2/03 | TIME OF ORDER: 2355 | LIST TIME ORDER NOTED AND SIGN

V.O. Dr. [redacted]
2mg MSO4 IVP x1 now [redacted]

[PA]TIENT IDENTIFICATION: # [redacted]
[NU]RSING UNIT: ICW2 | ROOM NO.: | BED NO.: 13

DATE OF ORDER: 6/3 | TIME OF ORDER: 0930 HOURS

6/3 G.S.
1. Resume preop orders
2. Dressing Δ's TID to abdomen

noted 1100 6/3 [redacted] b(6)-2

24° VS GRAM [illegible] 6/5/03 0045

[redacted]

[PA]TIENT IDENTIFICATION: # [redacted] b(6)-4
[NU]RSING UNIT: ICW2 | ROOM NO.: | BED NO.:

DATE OF ORDER: 5 Jun 03 | TIME OF ORDER: 0915 H[OURS]

1. NS 1 liter bolus

[redacted]

b(6)-2

[redacted]

[PA]TIENT IDENTIFICATION: # [redacted]
[NU]RSING UNIT: ICW2 24° VS G | ROOM NO.: | BE[D NO.]: [redacted]

DATE OF ORDER: 5 JUN 03 | 2045 HOURS

1. D/C Zantac

[redacted] b(6)-2

b(6)-2

noted [redacted] 5 June 03 2017

FORM 4256, 1 APR 79 | REPLACES EDITION OF [illegible] ... D.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 6 Jul 03 TIME OF ORDER: 0900 HOURS

Zantac 150mg PO bid ✓ noted KW 0906 7/7/03

b(6)-2

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

PATIENT IDENTIFICATION: # [redacted]

DATE OF ORDER: 7 Jun 03 1000 HOURS

1. CBC tomorrow AM ✓
UA ~~tomorrow~~ today ✓
CXR PA + LAT today ✓

noted 1000 7 Jun 03

Noted 1530 [redacted]

b(6)-2

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

24°/s 2000 7 Jun 03 b(6)-2

PATIENT IDENTIFICATION: # [redacted]

DATE OF ORDER: 7 Jun 03 TIME OF ORDER: 1430 HOURS

1. Transfuse 2u PRBC
Premed with 650 mg Tylenol done 1500
✓ CBC 2hrs post Tx

Noted 8 Jun 03 [redacted]

b(6)-2

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

b(6)-2

PATIENT IDENTIFICATION: # [redacted]

DATE OF ORDER: 8 Jun 03 TIME OF ORDER: 1515 HOURS

1. D/C Ampicillin, Gentamycin And Zosyn
2. CBC Chem 8 and Chem R today
Δ Activity to OOB → chair BID

Noted 1530 8 Jun 03 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24°/s 0100 08 Jun 03

b(6)-2

FORM 4256 REPLACES EDITION OF ... WHICH MAY ...

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 9 Jun 03 — TIME OF ORDER: 1825 HOURS — LIST TIME ORDER NOTED AND SIGN

1. CBC in AM b(6)-2
2. vitals QS
3. D/C IBO [redacted]

noted [redacted] 1345

NURSING UNIT: ICW2 — ROOM NO.: — BED NO.: 12

24° V done [redacted] /AN

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

DATE OF ORDER: 14 JUNE 03 — 1020 HOURS — b(6)-2

clotrimazole cream to back rash BID → QID. please try & keep pt off back during part of the day.

Thanks [redacted] b(6)-2 not MC.

noted [redacted] 1145

NURSING UNIT: ICW2 — ROOM NO.: — BED NO.: 12

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

DATE OF ORDER: — TIME OF ORDER: — HOURS

→ If no clotrimazole any antifungal cream will do.

b(6)-2 [redacted]

24° V's GRAM 1KTAN [redacted] 6-15-03 0100

NURSING UNIT: ICW2 — ROOM NO.: — BED NO.: 12

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

DATE OF ORDER: 16 Jun 03 — TIME OF ORDER: 0715 HOURS

Benadryl 25-50mg PO q6° PRN itch

[redacted] b(6)-2

noted 16 Jun 03 0745 [redacted] b(6)-2

NURSING UNIT: ICW2 — ROOM NO.: — BED NO.: 12

24° V done [redacted] /AN

b(6)-2

FORM 4256 1 APR 79 — REPLACES EDITION OF ... ED.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] b(6)-4	DATE OF ORDER: 16 JUNE 03 TIME OF ORDER: 0930 HOURS CBC, Chem 7 in am 17 JUNE 03 [redacted] b(6)-2	16 Jun 03 0942 [redacted] b(6)-2
NURSING UNIT: ICW 2 ROOM NO.: 55 BED NO.:	Pt care 0324 2300 16 Jun 03	
EPW [redacted] b(6)-4	DATE OF ORDER: 18 JUN TIME OF ORDER: 00:30 HOURS V.O. Hydrocortisone 1% creme apply topically to effected area t.i.d. b(6)-2 [redacted]	noted 18 JUN 00:30 [redacted] b(6)-2
NURSING UNIT: ICW 2 ROOM NO.: 15 BED NO.:		
EPW [redacted] b(6)-4	DATE OF ORDER: 19 Jun 03 TIME OF ORDER: 0145 HOURS V.O. Ambien 10 mg PO PRN b(6)-2 [redacted]	noted 0145 [redacted]
NURSING UNIT: ICW ROOM NO.: 15 BED NO.:	24° [redacted]	
EPW [redacted] b(6)-4	DATE OF ORDER: 19 JUNE 03 TIME OF ORDER: 1410 HOURS [illegible] Ambulance b(6)-2 [redacted] b(6)-2	b(6)-2
NURSING UNIT: ICW ROOM NO.: 15 BED NO.:	2300 20 June 03 [redacted]	

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