b(4)-2

All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TR...
Verdun	small area to sacrum c scant amt. bloody drainage. appears like an abrasion. ~~Covered~~ cleansed c Sterile NS and DSD applied. Will mon [redacted] 200/AD
T is B0530 Aug 03	Nursing Assessment: Assumed pt care. AAOx3. Army stat, breathy even and unlabored LS CTA (B). Abd soft, nontender, ~ distention, BS(+)x4. Urine per Foley, amber urine, from and removable intact to (B)LE. PROM only and voluntary intact to (B)LE. Pt continues to have no sensory or motor function to (B)LE. Dsg to sacral region has scant amount of serosanguinous drng. Ø IV access. [redacted]
14 Aug 03 1400	assumed pt care @ 1300. Temp 101.4, pt given PO Tylenol 650mg per prn order. Lungs CTA, and Soft, nontender BS(+)x4. Foley, cath intact draining golden yellow urine. Vent pulses (+). Vent c/ from (+) pulses. (-) IV access noted. Drsng to upper back CDI. Drsng to sacrum c small amt of pinkish red drainage noted. (-) active bleeding noted, drsng Aid. (-) complaints voiced. Pt turned on (R) side. Will cont to [redacted] alarm monitor
14 Aug 03 21:41	Rec'd c/o pt @ 21:00. Awake and alert in bed. Lying on (L) side. VS WNL x 1 temp. 100.5 PO Tylenol given. Skin W/D. Pupils (-) PERRL slightly larger than (R). Lungs wheezing and rhonchi expiratory + inspiratory (B) throughout lobes. Productive cough whitish sputum noted. Dr. [redacted] aware. Order obtained for PT and Robitussin. BS(+)x4. Foley cath intact draining amber colored urine. (+) PPRB(+)2. C/O pain to (L) shoulder. Will cont. to mon. [redacted] PT/AD

STANDARD FORM 600 (REV. 6-9

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b(4)-2 A1

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14AUG03 2220	Rt note: Pt awake, breathing even & unlabored. Pre tx HR 86, RR 18, SPO_2 99% on RA. UD Alb given via HHN. Post tx HR 82, RR 20, SPO_2 100% on RA. BBS slight wheezing exp. otherwise diminished. Pt tol tx well. ϕ cough. Will continue to monitor — Sgt [redacted] 91V2ϕ
14Aug03 2230	Rt temp 99.9 @ 2230 — [redacted]
15Aug03 0208	Pt. given Robitussin @ 21:50 coughing ceased. T-max for shift 100.9°. Temp @ 0200 99.1°. FTG draining Amber colored urine. 200cc @ 0200 noted. Encouraged pt to drink fluids. Will mon [redacted] SGT/AN —
15Aug 0233	RT NOTE: Eval pt to start Q4 RT schedule BBS clear Pt is Quad. pt doesn't appear to have any difficulty Breathing Will Start Nebs at 0330 — SGT [redacted] R
15Aug 0338	Pre Tx HR 69 SPO2 99% on RA RR 16 BBS clear UD Alb Tx given. Pt Able to cough during tx. Post tx HR 100 SPO2 100% on RA BBS clear — SGT [redacted] 91V2ϕ
15Aug03	1230 - Pt alert & oriented lying on (R) side of body. Turned Q2° + ROM Q4°. VSS, temp 101° this AM. Tylenol given, temp now 98°. Stage II ulcer to sacral area. Duoderm placed over area. Scdg intact. Voiding ϕ complaints Will cont to monitor — [redacted]

b(4)-2

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

[redacted]

b(4)-4

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle initial)* ICW2		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 - 15242

STANDARD FORM 600 (REV. 5-84)
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FIRMR (41 CFR) 201-45.505

b(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug 03 1310	Assumed pt care @ 1300. Pt resting quietly easily aroused to verbal stimuli. VSS temp 98.6. pt turned on (L) side. Airway patent, lungs CTA abd soft flat nontender BS(+) x4, foley cath intact draining CYU 3 diff. ↓ ext c (+) pulses. ↑ ext c full ROM (+) pulses. (-) IV access. Stage II ulcer to sacrum area c duoderm, (-) drainage noted. (-) complaints voiced @ this time. Will cont to monitor [redacted] 9/WM
1630 1700	temp 101.2, pt given ⅰ Tylenol. will recheck temp. [redacted] 9/WM notified RT of neb tx, RT aware but no one had come yet. Talked c SGT [redacted] @ 2ⁿᵈ 1945, she stated "I will be there @ 2000". [redacted] 9/WM
2020 15 Aug 03	RT note: Pt breathing even + unlabored. Pre tx HR 88, SpO_2 98% on RA RR 16. BBS CTA. Pt states he coughed earlier thru translator UD AIB neb given via HHN. Post HR 104, RR 18, SpO_2 99% on Pt tol tx well. IS done. Sgt [redacted] 9/V
~~15 Aug 03 21:15~~	~~Rec'd c/o pt @ 21:00. VS wdl per flowsheet. Awake and alert lying on (R) side. Repositioned to supine pos. Pupils equal.~~ [redacted] see below
15 Aug 03 2341	RT note: Pt's breathing even + unlabored. BBS CTA. Pre tx HR 86, RR 16 SpO_2 99% on RA. UD AIB given via HHN. Post tx HR 99, RR 20, SpO_2 99% on RA. Pt has no c/o SOB a dyspnea. Sgt [redacted]
late entry 15 Aug 03 21:15	Rec'd c/o pt @ 21:00. VSWDL per flowsheet. Awake and alert in bed lying on (R) side. Repositioned to supine pos. Pupils (L) larger than right. Dr [redacted] aware. LCA (R). (+) BS x 4 (+) PPB. FTG intact draining yellow urine. DSG to ML post. GSW's x'd. Wounds healing (-) S/S infection. DSD applied. c/o pain. ⅰ Percocet given. (-) further c/o will cont to mon. [redacted]

STANDARD FORM 600 BACK (RE

*U.S. Government Printing Office: 1996 - 404-763/40

b(6)-2 All

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)*
0309	Duoderm intact to pt. sacrum. temp @ 98.4. Will mon. [redacted] SPC/AN
0347 16 Aug 03	RT NOTE: Pt refused Neb tx. Listen to pt lungs BBS CTA Informed nurse that pt refused tx ——— SGT [redacted] RT 91W2X
0743 16 Aug 03	Pre Tx HR 90 RR 14 SPo2 99% on RA BBS CTA UD Alb tx given Post Tx HR 100 RR 16 SPo2 99% BBS CTA. Please have Doctor ReEval for Neb Tx ——— Spc [redacted] ET
16 Aug 03	0920 - Pt alert & oriented lying on (R) side of body Duoderm to sacral area. 2×2 to: wound on upper back, wound almost closed, ~~no~~ small amount of drainage on old dsg. Foley intact. LBS, temp 99.7, lungs CTA, HR reg, BS(+), Pulses (R)x4. Voicing Ø complaints. Will cont to monitor ——— [redacted]
16 Aug 03 1320	Pt care assumed @ 1320. pt turned prior to report being given. pt awake & alert. temp 99.2. lungs CTA, abd soft, nontender, nondistented BS(+). Foley cath intact draining C/C/I 3 diff. ↓ ext ⊂ (R) ROM (R) pulses. ↑ ext ⊂ full ROM (R) pulse. dressing to ↑ back CDI. Duoderm to Stage II ulcer in sacrum area intact. (R) Complaints voiced @ this time. Will cont to monitor ——— [redacted] 91WMR

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

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

REGISTER NO. [redacted]

WARD NO. ICU2

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 15244

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 1930	Pt awake, breathing even + unlabored. Pre tx HR 94, RR 16, SpO_2 100% on RA. BBS CTA. UD Alb neb via HHN given. Post tx HR 96, RR 20, SpO_2 99 on RA. IS Done —— Sgt [redacted] RLRT
16 Aug 03 2128	Rec'd c/o pt @ 21:00. VSs wnl x ↑ temp 99.5 ↑ Tylenol given + blanket removed. Skin ↑ warm to touch/dry. Awake and alert in bed. PERRLA - (L) pupil larger than (R), reactive to light. LCA (R). APPR SpO2 [redacted]. BSO x4. FTG draining CYU. (+) PPB. Repositioned to (R) side from supine. DSG to mid back ⊿d. Wound healing c scant amt. old blood & odor. Applied DSD. ∅ c/o pain @ this time [redacted] BLT/AIO
01:22	Pt c/o pain radiating from neck to arms. ↑ Percocet given for pain will mon. Pt c/o feeling dizzy. BP 110/60. Asymptomatic. ↑ HOB 30°. Will mon [redacted] BLT/AIO
17 0730 Aug 03	Nursing Assessment: Assumed pt care AAOx3. Airway wnl, breathing even and unlabored, LS CTA (B). Abd soft, nontender, (5) quadrants. BSO x4. Voids per void to gravity, urine clear + sediment. NH amt. Pain and neurovascularly wnl to (B) UE. (B) LE feels motor and sensory sensation from to (B) LE. (+) IV access. Stage II/III ulcer to sacral region c duoderm dsg. applied. Duoderm dsg loose. [redacted]
17 0730 Aug 03	Nursing Note: Pt had bowel movement x 200 cc emesis. This occurred ½ hr after Zofran & Colace. Neither pill was emitted but some food particles were. It states that he was not hungry today & did not eat breakfast. BSO x4 still but a little lighter pink/red than before. [redacted]
17 Aug 03 1315	Assumed pt care @ 1300. VSS. Temp 100.5. pt given ↑ Tylenol. pt lying on back, turned to (L) side. Lungs CTA: abd soft nontender BSO x4. foley cath intact. BLE c (+) pulses. BUE FC full ROM (+) pulses. dsging to upper back CDI. Stage two ulcer to sacrum area c duoderm covered by a 4x4 gauze. (-) c/o pain voiced. Will cont to monitor [redacted] qwarm

b(4)-2 All

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 2028	RT note: Pt resting. BBS CTA HR 84, RR 16, SpO_2 on RA 98%. c/o Alb via HHN given. Post tx HR 91, RR 18, SpO_2 98 on RA. BBS CTA. IS done c ease. Recommend stop tx ——— Sgt [redacted] 91V2P
17 Aug 03 2030	temp 100.5 pt given ∴ Tylenol. Will cont to monitor ——— [redacted] 91WM6
17 Aug 03 21:29	Recd clo pt @ 21:00. Awake and alert on ⓓ side. Positioned pt to supine/semi fowler's. Skin w/d/I. Pupils- OD smaller than OS reactive to light. ⊖ apparent MS Δ's. ICA ⓑ HRRS, S2 WNL BS ⊕ x4. FTG intact/patent draining CHU. ⓓ PP ⓑ. Pt. c/o pain in arms. ∴ Tylenol were given @ 20:30. Will cont to mon [redacted] DLT/AD
0555	Pt c/o pain to mid ↑ back upon log roll ∴ Percocet given will mon [redacted] DLT/AD
18 Aug 03	1200 - Pt. Alert & oriented lying in bed. VSS, Lungs CTA HR reg, BS ⊕, pulses ⊕ x4. Duoderm D/d to sacrum & ischium intact. One open ~~bed~~ wound remains on upper back area. Small amount of drainage on old dsg, 2x2 applied ROM completed, Am Care done. Rolled Q2. Voiding ⊖ complaints. Will Cont to monitor ——— [redacted]

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

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

EPW

[redacted] b(4)-4

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

MEDCOM - 15246

b(6)-2 ATH

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18Aug03 2000	pt. rolled q2°, ROM x1 this Shift - duoderm intact on Sacrum - foley to gravity - tol. regular diet - ⊕BS - lungs c slight crackles cleared c coughing - VSS — [redacted] CP
2211	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS⊕ X4. Foley → gravity c c/y/u. Dsng Δ'd to back, dsng CDI. Pt. c ∅ complaints @ this time. Will cont. to monitor — [redacted] /CTAw
19Aug03	1200 - Pt alert & oriented lying on back side now. Rolled Q2°. VSS, temp 100.5, Tylenol given. Lungs CTA, HR reg, BS⊕, pulses⊕ x 4. Duoderm Δ'd to sacrum area. Foley intact. ROM done. Will cont to monitor — [redacted]
19Aug03 1320	pt care assumed from previous shift @ 1300. VSS temp. 99.9. pt just given Tylenol @ 1200. pt turn to (L) side. lungs CTA, abd soft nontender BS⊕ x4 quads. pulses⊕x4. dsng to back CDI. duoderm to sacrum intact foley cath intact draining c/y/u 3 diff. ∅ c/o pain voiced @ this time. Will cont to monitor — [redacted] 911WM
19Aug03 20:03	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Awake and alert in bed. Skin WD/I. LCA⊕ Hell S1 S2. BS⊕x4. ABD soft to palpation. FTG intact / patent draining c/y/u. ∅c/o pain @ this time. DSG to Mid ↑ back c/d/i. will Δ next log roll @ ~~12~~ 23:00. Duoderm to sacrum intact c 4x4 dsg over top. Will cont to mon [redacted]
0123	c/o pain in arms ↑ paresthesia will mon [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Aug03	1200-Pt alert oriented. VSS, afebrile, lungs CTA HR reg, BS@, pulses@x4. Pt on stomach for 2°. Wound to sacrum, open to air now. Will apply duoderm. Foley intact. Voicing ∅ complaints. Rom done. Will cont to monitor b(6)-2 [redacted] 2L+AM
20Aug03 1400	pt care assumed @ 1300. pt lying on stomach, awake & alert. pt turned to (R) side; lungs CTA abd soft BS@. foley cath intact, pulses@x4. wound to upper back OTA, healing s/sx of infection. Stag II ulcer to sacrum OTA @this time. ∅ complaints voiced. Will cont to monitor b(6)-2 [redacted] 91WM6
20Aug03 21:39	Rec'd c/o pt@ 21:00. VS WNL per flowsheet. Awake and alert in bed & lying on (R) side. Repositioned to supine skin W/D/I x sacrum c duoderm & gauze dsg c/D/I and mid & back wounds s/sx of OTA. PERRLA&WNL. LCAB. HRRS;S1S2. BS@x4/hyperactive ABD soft/non-tender. FTC intact/patent draining c/y/o@ c/o pain to [redacted]. Elavil given @ 22:00. Will cont to mon.
b(6)-2 [redacted]	92YF/AW

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

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

REGISTER NO.

WARD NO. DCW2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 15248

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 AUG 03 @	1100 — Assumed care of pt. transfer from ICU #2 to ICU #1 A+Ox3 VSS pt. paraplegia @ LE. Wound to upper back 2x2 dressing Δ. Breakdown of sacrum duoderm dressing Δ. Lungs CTA — HRRR S1 S2 present. c/o pain medicate) will cont to monitor — b(6)-2 [redacted]
21 AUG 03 1930	Pt A+Ox3, VSS, LS CTA (B), +BS x4 quads, S1, S2 present, skin warm + dry, cap ref <3sec. peripheral pulses palpable, Δ position q2h, dsg on sacrum CDI, Ø c/o pain, GSW on upper back healing well open to air, abd soft flat nontender, urinating well. b(6)-2 [redacted] 91WM6
21 AUG 03 2110	Pt c/o pain, adm pain med. [redacted] 91WM6
2300	- I concur c above assessment. b(6)-2 [redacted] CPT
22 Aug 03 @ 0730	— Assumed care of pt. awake A+Ox3 VSS. denies c/o pain or discomfort @ this time. Lungs CTA bilat HRRR S1 S2 present. Active BS x4 quads. Breakdown to sacrum dressing Δ'd c duoderm CDI. Wound to upper back dressing Δ'd CDI will cont to monitor — b(6)-2 [redacted] 91WM6
22 AUG 03	Pt A+Ox3, VSS, LSCTA (B), +BS x4 quads, Dsg on lower back c some drainage noted, c/o pain and requested med, will adm 11 percocet. b(6)-2 [redacted] 91WM6
0800	I concur c above assessment. [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 Aug 03	@ 0700 – Assumed care of pt. awake A+Ox3. VSS. AM + Foley care complete this shift. Dressing to sacrum done. Wound to upper back open to air Ø drainage Lungs CTA. H,KRR S1S2 present. Active BS. Tolerating PO. Well. Will cont to monitor b(6)-2 qtwmc
23 Aug 03 1123	I concur w/ the above assessment b(6)-2
23 AUG 03 1950	Pt awake, A+Ox3, VSS, LS CTA Ⓑ, ⊕ BS x4, foley to gravity, voiding proper amount of urine yellow, clear, Ø odor or sediment, Dsg on lower back CDI, Ø drainage, S1 S2 present, skin warm + dry, c/o pain on back and Headache, adm meds as per orders, ROM on LE x2 Δ position q2h. b(6)-2 qtwmc
@2200	I concur w/ above assessment:
24 Aug 03 @ 0800	– Assumed care A+Ox3 condition stable. Lungs CTA S1S2 present HRRR Active BS Tolerating PO well. Foley to gravity draining AS clear yellow urine. Foley and AM care complete. Dressing to sacrum CDI. Upper back GSW open to air W.D. cont to monitor b(6)-2 mg.

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. ICU

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 15250

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 Aug 03	Pt received awake in bed. A&Ox3. PERRLA@, Rpk 3mm in size. LS CTA ~~BS~~ through out. $S_1 S_2$ Present, +1 DRR, +BS, Denies Pain N/V. Will continue to monitor.
25 Aug 03 0750	Pt received sleeping, awoke spontaneously alert. $S_1 S_2$ noted ± @ peripheral pulses, lungs CTA bilat, @ bowel sounds, foley to gravity draining yellow urine ± sediment. Will cont to monitor.
25 AUG 03 1935 ~~1935 2035~~	b(6)-2 [redacted] awake ~~Concour ± the above assesment~~ b(6)-2 [redacted] Pt AtOx3, LS CTA(B), @ BS x4, $S_1 S_2$ present, skin warm + dry, Foley to gravity, clear yellow urine, ROM LE x2, position Δ q2h, medicated for pain.
26 Aug 03 0745	b(6)-2 [redacted] awake Pt received sleeping, awoke spontaneously alert, $S_1 S_2$ noted @ peripheral pulses, lungs CTA, bilat, @ bowel sounds, foley to gravity draining yellow urine ± sediment. Will cont to monitor.
26 Aug 03 1000	[redacted] awake I concur ± above assessment. Skin integrity & circulation intact to all extremities.
26 AUG 03 1940	b(6)-2 [redacted] awake Pt AtOx3, VSS, LS CTA(B), @ BS x4, $S_1 S_2$ present, foley draining clear yellow urine, dsg Δ on lower back, BM formed small, bed bath given to pt, ROM on LE x2, Δ position q2h, assessed for circulation + skin break down on points of restraint.
	b(6)-2 [redacted] awake

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26AUG03 1455	Neurosurgery Discharge History: EPW who suffered paraplegia after multiple shrapnel wounds to the upper thoracic spine. Hospital Course: Pt was admitted to ICU. Spine images showed a stable fracture pattern, so no bracing was required. A lumbar drain was placed until a spinal fluid leak resolved. He was treated with routine paraplegia care including Foley catheter and bowel program for neurogenic bladder/bowel, frequent turns (q 2°) to prevent bed sores, and assistance with activities of daily living. Disposition: Static paraplegic will require assistance to perform activities of daily living. Foley catheter to be changed monthly. Medications: Colace 100 mg po BID. Percocet 1-2 po q 4° prn Bisacodyl Suppository q D prn constipation b(6)-2 [redacted] MD Neurosurgery Service [redacted] (b)(2)-2 Bagdad

HOSPITAL OR MEDICAL FACILITY		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
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MEDCOM - 15252

b(6)-2 A11

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Aug 03 1400	Received pt resting in bed, VSS, alert & speaks Arabic. LSCTAB, MAE, BSx4, Small amt feces cleaned during am care. Pt turned q2°, sacral decub dsg CDI. Restraints in place. Will cont to monitor. [redacted]
27 AUG 03 1845	Pt A+Ox3, VSS, LSCTA(B), +BSx4, foley draining c/y urine, dsg sacral decub CDI, assessed for proper circulation + skin breakdown on point of restraint. [redacted] 91WM6
27 AUG 03 2150	Adm. pt a supository @ 2015 but had ø BM, N'd dsg on sacral area. [redacted] 91WM6
28 Aug 03 0100	Received pt resting in bed, VSS, Alert & oriented. Foley draining clr yellow urine, sacral decub dsg CDI, no changes noted in decub from yesterday. Three small liquidy BMs this shift. Turned q2°. Restraints in place, checks for circulation & skin integrity done, intact. No c/o pain this time. No remarkable assessment findings @ this time. Will cont to monitor. [redacted]
28 Aug 03 1900	Assumed care @ 1800; VSS, pt A+Ox3 speaking only Arabic; SS2, LSCTA(B);

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

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

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 15253

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	(cont.) ⊕BSx4, foley to gravity draining QS clear yellow urine; 0% pain or discomfort @ this time; dsg to sacral area CDI ∃ drainage; pt turned Q2°; restraints in place, circulation ⊕ skin integrity intact, Cont to monitor b(6)-2 [redacted]
28 Aug 03 0810 b(6)-2	Pt received awake & alert, x3, 52 noted ⊕ peripheral pulses, restraint in place, lungs CTA bilat, ⊕ bowel sounds, foley to gravity draining clear yellow urine, sacral dsg CDI & d'd. will cont to monitor [redacted]
29 Aug 03 @ 2200	Assumed care @ 1800; AM VSS, pt A&Ox3; S, S2, ⊕ pulses x4; LS CTA ⊕; ⊕ BS x4; 0% c/o pain or discomfort @ this time; pt turned Q2°; dsg to sacral area N.d. ∃ complications; restraints in place; circulation ⊕ skin integrity intact; foley to gravity draining QS yellow urine ~~& red~~ white sediments! Continue b(6)-2 to monitor [redacted] OPR
30 Aug 03 @ 0700	- Assumed care of pt. A+Ox3. 0% c/o pain or discomfort at this time. Foley and AM care complete. Lungs CTA HRRR Active BS Bleeding PO well Dressing change to sacrum CDE. Q2° position change. Will cont to monitor b(6)-2 [redacted] GSW to sacrum
30 AUG 03 0000	VS. AO. ⊕ pulses. S, S. LS CTAB. HRR. BS ⊕ x4. Voiding light amber urine quantity sufficient FTG. DSG d/s to sacrum and foley insertion site. Foley site: coagulated BBB @ head of penis, wrapped in coban. Placed fluff 4x4 gauze sponges under shaft for absorption. Turned @ 2° hours as ordered. b(6)-2 [redacted]
31 Aug 03 @	0700 - Assumed care of pt. A+Ox3 VSS, +foley + AM care complete. Lungs CTA - HRRR Active BS x 4 quads Foley draining Clear yellow urine. Dressing to penis taken off ∅ evidence of cont bleeding. Dressing to sacrum d'd CDI. GSW to

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Cont	31 Aug 0700 - TH open to air ø bleeding or drainage noted. ROM exercises completed this morning. W.I.l cont to monitor [redacted] b(6)-2 9/WMC
31 Aug 03 2300	VSS. A&O. Turned per 2° schedule. c/o pain along back @ & @ shoulders. Repositioned for comfort. Duoderm (thin) placed over sacral ulcer to be left for 5 days for healing. Pt verbalized understanding. FTG cont'g light yellow urine, quantity sufficient. [redacted] Aug AM
1 Sept 03 0130	Pt A&O Turned q 2° & c/o pain [redacted] sacral area LS CTA Through out, S1 S2 Present, +BS [redacted] Draining To gravity clear yellow urine QS. Spc 9/WMC
1 Sep 03 0900	Pt AM care completed up to cha[redacted] became light headed and Dizzy. Was also [redacted] as. W.I.l continue to monitor [redacted] b(6)-2 Spc 9/WMC
1Sep03@1900	Assumed care@1800; ~~Pt~~ VSS, pt A&Ox3 speaking arabic; S1S2, LS CTA@; +@BSX4, FTG draining QS, clear, yellow urine, pt TOLPO; HOBt, pt ~~TURN~~ log rolled Q2°, restraints in place, circulation: skin integrity intact; Ø c/o pain or discomfort @ this time, cont to monitor [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.
E# [redacted] b(6)-2		

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2Sept 03	Rec'd report and assumed care of pt. AM care complete @ c/o pain or discomfort @ present Heme lungs CTA BS(+). Pulse strong & equal. Foley to gravity Continue to monitor [redacted] 91WM
1600	Pt had digital disimpaction of stool per Spc. [redacted] Stool was hard and formed. Pt b(6)-2 turn to (L) side and cleaned [redacted] 91WM6
2Sep03@2345	Assumed care@1800; pt A&Ox3 speaking arabic; denies pain or discomfort @this time; FTG patent draining QS yellow urine c sm amt of sediment Dsg to sacral area CDI @ for drng; DQ stage II to (R) hip Bound, duoderm placed, CDI; @ this blood drng from penis; 2-point restraints in place, skin integrity & circulation intact, cont to monitor [redacted] b(6)-2
3 Sep 03 0615	Pt A&Ox3 Denies [redacted] Pain at this time. FTG Patent Draining QS clear yellow urine c sediment Dsg to Sacrum CDI. Dsg to (R) hip CDI Will continue to monitor [redacted] b(6)-2 91WM6
3Sep 03	1845 = VSS, A+Ox3, Q [redacted] pain, Dry Dsg Δ'd to sacral area CDI. Did ROM exercises to (B) LE's. Continuing Q4: Pt has foley to gravity draining clr urine. 2+ pulses to (B) LE's. Pt. states (in Arabic) that was feeling/

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[redacted] b(6)-4

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b(a)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Sensation from chest area up. & other remarkable assessment findings. Restraint to (R) arm in place. Will continue to monitor. [redacted]
4Sep03 0400	Pt A+O. S1, S2 present, LS CTA(B), BSS x4 quads UE strength +2. +2 pulses all extremities. Dress to Sacral area CDI. D-sg (L) Hip CDI. (D) Sensation chest up. Pt uncooperative c A/I care. Will continue. [redacted] Monitor. [redacted]
4 SEP 03 2005	VSS. AO. Placed OOBTC and tolerated well after HR went from 150 → 105 after 15 min. in chair. Ate c/o dizziness and then subsided. Provided fluids and tolerated well. No c/o w/d/b or CP. Lesion on back d'd. [redacted]
5Sept03 1440-	assessment completed @ 0930 this am. Pt. resting well @ this time. A+O, VSS, pt. speaking arabic. PH. has no c/o pain. perrld, lungs CTA(B), Resp. no distress, even unlabored, S1S2 present. dod, firm, nontender, BS x4. Pulses +2. Duoderm applied to coccyx area. CDI. Foley to gravity draining clear yellow urine. Foley CDI will cont. to mont. pt [redacted]
5Sep03@2000	Assumed care @ 1500; pt A+Ox3 speaking only arabic; pt in bed on (L) side, being turned q 2° c HOBT; FT6, draining clear yellow urine; duoderm on coccyx c/d/i (R) hip CDI; restraints in place, circulation & skin integrity intact; Cont to monitor [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sept 03 0800	VSS A&Ox4 & Oriented. Continual Restless dist fr Breakfast. Reposition in bed for Comfort. Pressure ointment to (R) hip & coccyx area. Allowed Q 2hr & prn for Comfort. Foley to gravity. Draining clear yellow urine. Bloody note for penis @ the tip. Foley care done. Q c/o pain or discomfort noted. Removal restraints and reapplied. Skin intact under restraints. Will check restraints, skin integrity and [redacted] and extremities frequently 2hr
6 SEP 03 1502	VSS. AO. Opriented. FTG during light yellow urine quantity sufficient. CDI. Placed in chair x1 for 2° and tolerated well. Performed ROM as ordered prior to sleep. Stage II ulcer on sacrum healing and cleansed CDI. Q c/o pain @ this time. b(6)-2 [redacted]
7 Sept 03 0800	VSS AxO. Continual Restless dist fr Breakfast AM Care & foley care done. Q 2hr turned to sacral decubitus. Repositioned to relieve pressure to bony prominences. Foley draining clear yellow urine. Restraints removed & reapplied. Skin intact under restraints. Removed [redacted] b(6)-2

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[redacted] b(6)-4

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
07SEP03	Neurosurgery.
1315	(Fo) Skin inspection today: 3 cm Stage III decubitus on Sacrum. 1-Cm Stage II decubitus (2) hip. (AA) Will order hospital bed on ICU admit.
7SEP03	VSS. AO. OOB TC for 72° and [redacted] b(6)-2
2100	performed ROM on BLE and feet. Tolerated well. Voiding light yellow [redacted] FTG + draining. Coupel instruct to stage III 3CM sacral ulcer and 1 cm stage II @ (F) hip. [redacted]
2330	Provided bisacodyl suppository per patient to stat. Noted stool @ base of rectum upon digital stimulation. Chux placed. [redacted]
8SEP03 0000	Stool noted @ base of rectum and not [redacted]
8Sep03	[redacted]
0630	Pt A&O, VSS, SS, Present @BS x4 quads, LS CTA(B). FTG Draing clear amber urine. Denies pain at this time. [redacted] 91WA
8Sep03	1945: VSS, 0/10 pain, A+OX3, OOB & in chair c kitty strap in place. A'ing Dsg to sacral area BID (dry). Foley to gravity draining clear yellow urine, tolerates PO well, @BS x 4. Continuing ROM exercises to (B) LE's. Other remarkable assessment findings. Continue to monitor. [redacted]
8Sep03	2200: Dsg to decub (sacral) x'd, x1 restraint in place, restrained extremity's skin integrity intact. [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	patient to perform ROM to UE's. Returned demonstration for understanding. DSG's to sacrum and (R) hip c/d/i. No s/sx of infection. Voided 400cc light yellow urine from FTG. [redacted]
11 Sept 03 0915	Assume duty of Pt. A+Ox3, VSS. Regular diet. No complaint of pain. Needs to be logged roll thru out the day. 1 point restraint in place. S s/sx complications of skin break/circulation. DSG's changed. Will cont to monitor. [redacted]
12 Sept 03	Assume duty of Pt. VSS, A+Ox3. DSG's intact. Set up in chair for an hour. Logged rolled thru out day. Bathed by self. c/o pain, treated with perc. Urine was clear of ~~[redacted]~~ blood, yellow color 350 cc. Pt recieved an suptository. Will cont. to monitor. [redacted]
12 Sept 03 2030	- assumed care of pt @ 1800. VSS, slightly fevered @ 99.7. Tylenol 650mg po given. A+O, LS CTA, HRR, (+) BM today per pt. (Refused pm dose of wafe). Foley draining clear yellow urine. Sacral decub Stage II dsg D/d d/t old dsg coming off. new dsg placed. (R) hip decub Stage I → Stage II c some open sores noted. Duoderm D/d also d/t coming off. Wound care nurse notified of Δ in (R) hip. Continue turn q2° c proper anatomic position. Plan: cont turn q2°, monitor pain control. [redacted]
12 Sept 2100	- ROM exercises completed [redacted]
12 Sept 2330	- Pt c/o not able to breathe & stomach pain. (Thru interpreter). Pt (+) vomit ~ 75cc. Phenergan ordered & given. O2 sats = 98% RA. Will monitor [illegible]

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9 Sept 03 1030	pt A&Ox3, VSS. pts morning care completed c/o pain from sacral decub Δ'd, also each from Lt buttock. Foley drained 350 cc clear yellow urine. Other quantifiable findings
9 SEP 03 0205	VSS. AO. Patient turned to left side and tolerated well. Refused to be placed in chair this PM and requested to do it tomorrow. Provided nursing and displayed knowledge of adjusting bed angle with remote. Voiding light yellow urine, quantity sufficient ~ b(6)-2 ETG. 5 bin @ continuous NDI. @ pulse. [redacted]
10 SEP 03	(1245) Assumed care of pt A) ϕdϕϕ ~ report from night shift. Pt alert, speaking Arabic. VSS. ϕc/o pain. am care done by pt ~ min. assist from staff. Pt cont. to be turned q2° - log roll. Pt able to assist ~ turns. Drsgs to decubs on sacral area and @ hip Δd this am. ϕ S/Sx Infection. Foley draining quantity sufficient clear yellow urine. Pt td. reg diet well. 1 point restraint in place ~ S/Sx complications of skin breakdown/circulation. Will cont. to monitor. b(6)-2 [redacted] (NAD)
10 SEP 03 1923	VSS. AO and speaking in arabic. Placed in supine and performed ROM to lower extremities. Encouraged

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13Sep03 0900	Pt Awake in bed. A&O. Drsg to sacrum and ⓡ hip dsg. CSS. Am care completed. LS CTA ⓡ. S_1 S_2 present. HRRR, ⊕BS x 4 [redacted] Ds. W/C continue to monitor. [redacted] b(6)-2
13Sep03 1330	Pt Foley not draining. Foley changed. Foley strapped to leg. Large amounts of sediment in urine. Will continue to follow [redacted] monitor [redacted] b(6)-2
	(1705) I concur w above assessment. [redacted]
13Sep03 2110	– assumed care of pt @ 1800. VSS. ⊖ nausea ⊕ emesis approx. 100cc. Trnl interpreter pt stated he has not eaten all day, emesis x 3 today. Phenergan 25mg po given, will monitor effect. ⊕BS x 4 quads, LS CTA, HSR, ace wrap, foley draining clr urine c some sediment noted. Prom completed. ⊖ Phenergan, pt tol sm amt of solid food. 1pt restraint on S/SX of skin breakdown or circulation impairment. Plan: monitor n/v, Turn q2°. [redacted] b(6)-2

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b(6)-2
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Sept 03 1100	Oral temp 102°. Tylenol 650 mg p.o. given by pt's nurse. Will monitor for effect. [redacted]
15 Sept 03 1600	Oral temp. 99°. Encouraged deep breathing & continue c pt. turning. Pt refused to chair. Wants to wait til dinner @ 1800 - [redacted]
15SEP@2115	- Assumed care of pt @ 1500. T 100.4. Pt c/o s c/o. Dsg to sacral area d&i. Dry and dsg peeling off. Cont Turn Q2°. ROM exercises completed. Pt to chair x 1 hour this pm. Plan: cont TQ2°, monitor temp. [redacted]
@2300	- Pt had large BM. Pericare completed. Footcare comp. No c/o @ this time. [redacted]
16 Sept	Pt awake + alert x3, VSS stable pt dsg CDI intact, c/o pain from old mid shoulder wound, ROM exercise completed, skin intact two restraints in place no other remarkable findings
16SEP03@2000	- assumed care of pt @1800. VSS currently afebrile No acute care issues @ this time. Sacral dsg & hip dsg-duoderm intact. Pt to chair s difficulty. PROM completed. Plan: cont turn Q2°, monitor decub dsg, monitor pain, addendum: Foley draining clear yellow urine. Lines monitor. [redacted]
16SEP@2015	- Pt back to bed. + pt restraint m. Skin integrity; circulation good. Foot care done. Will monitor. [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Sep 03 0900	USS. A&O. Lungs clear Bilateral. BS+ X 4 quadrants. @ 40 NIV @ this time. Foley to gravity. Draining clear Amber urine with sediment noted in tubing. Will encourage PO fluid intake OOB to ambulate c +2 assistance. PROM completed. AM care (partial) done. Dry bed to Sacrum & L. Hip. Restraints removed and reapplied. Skin intact under restraints [redacted] b(6)-2
14 SEP 03 2125	VSS. AO. T @ 100° and purrilal 2 bylateral. Stated feels better today. Turned to (R) side and performed digital stimulation and rectal disimpaction and removed large amount of soft formed brown stool. Coupel to sacrum and (L) hip CDI. Skin intact non-pressure areas noted. [redacted] b(6)-2 Nurse
15 Sep 03 0930	Pt Awake A&O. Pt refuse to cat. Denies pain at this time. Turned on Back. Duoderm to Back and (R) Hip CDI VSS. Will continue to monitor. [redacted] SIWMC
15 Sep 03 1000	I concur c above. Circulation: skin integrity assessed throughout shift. 2 pt. Ist. restraint to upper extremity. [redacted] mos b(6)-2

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b(6)-3 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Sept	"no other remarkable findings, skin integrity intact → [redacted] SPC
18SEP03 2032	VSS. AO. S, S, LSCLAB. c/o pain to back of neck & thoracic vertebrae region. ⊕ pulses to all extremities. Sacral stage II decubitus DSG CDI turned to float position and tolerated well. [redacted]
19 Sept	Pt. awake, alert x3 pt c/o mild pain to thoracic back region around area of old GSW, VSS, given 1 tab percocet, dsg Δ'd @ hip 2"x1" reddish pink, white around the edges with some drainage, old dsg replaced with duoderm, also with sacral dsg, pt rotated and exercise as per schedule, restraint x1 in place skin integrity intact, no other remarkable findings [redacted]
19 sep @ 2200	- assumed care of pt @ 1800. VSS. No c/o @ this. No acute issues. Foley to gravity c clear yellow urine. ⊕ hip & sacral dsgs CDI. Pt ↑ chair x 2 hours, tol well. ROM completed. Plan: T q2° while in bed, monitor pain control. [redacted]
20 Sept	pt awake + alert x3 pt ∅ c/o pain at this time dsg to hip Δ'd with duoderm, pt rotated and exercised as per orders, skin integrity intact no other remarkable findings. restraint x1 in place [redacted]
	(1BA∅) I concur c above assessment [redacted] SPC
20 sep @ 1930	- assumed care of pt @ 1800. no acute issues. Sacral dsg & ⊕ hip dsg CDI. ROM completed. Pt ↑ to chair @ this time. Plan: cont T q2° while in [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17Sep03	(1340) Assumed care of pt. & done report from night shift. Pt alert, speaking Arabic. VSS. Dsgs to sacral decub and decub on ® hip d/d this am. Foley draining quantity sufficient clear yellow urine. Pt tol. reg diet well. ⊕small BM this am. Pt being turned q2-3°. ROM done. 1 point restraint in place ∃ s/sx. b(6)-2 complications. Will continue to monitor. [redacted] KWH
17Sep03	1930: VSS, ⌀c/o pain, A+OX3, ROM exercises done to ⓑLE's, log rolling &2 turns to keep pressure off of sacral area, Dsg to sacral decub CDI, Will change Dsg tonight @ Bedtime. DOB to chair ∃ difficulties. Foley to gravity draining clear yellow urine. ×1 restraint when in bed – skin Mtegrity intact to extremity restrained. ⌀ other remarkable assessment findings. Will monitor. b(6)-2 [redacted] KWH
17Sep03	2100: Dsg's to sacral decub & ®hip d/s CDI. Will d/reinforce as needed. [redacted] KWH
18Sept	1230 VSS, pain c/o pain from old injury in upper posterior back area, pt also admitted twice pt bleeds at on the breakfast, dsg d'd on sacral decub, pt voiding clear yellow urine

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#[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
@1930 cont'd.	Plan: cont ↑CH, monitor pain, monitor activity. [redacted]
23 Sept 03 0600	VSS A+O x3 Foley to gravity drng clear yellow urine. PROM to Lower extremities done. HOB ↑ 30°. Ensure regular diet for breakfast. Dsg to sacral dry, intact. Lg roll @ 2hrs for comfort. Bony prominences padded to prevent pressure ulcers. Full continue care as planned. [redacted]
23 Sept 03 @ 2015	- assumed care of pt @1800. VSS. No c/o @ this time. Foley to gravity & clear yellow urine. ↑CH, tol well. (-)pt restraint on while in bed.) Both sacral & (R) hip dsg CDI. ROM completed. Plan cont turn q2° while in bed, monitor pain. [redacted]
24 Sept 03 0700	VSS - A+O. OOB to chair for breakfast. Foley to gravity drng clear yellow urine. No acute care needs at this time. Will continue plan of care. [redacted]
24 Sept @ 2345	- assumed care of pt @1800. VSS. Sitting up in bed, pleasant. no c/o. Refused OOB to chair this pm. Foley to gravity & clear/yellow urine. PROM completed. (R) hip; sacral dsg CDI. Plan: monitor skin breakdown; pain. Turn q2°. [redacted]
25 Sept 03	Assume care of PT 0600. A+O x3, VSS. Turned over on side several times. Sat up in chair for an hour. C/O minimal pain. NO signs of infection from wound. Dsg Δ. No irritation from restraints x2. SPC Wesley RN
25 Sep 03 1211	I concur & assume care of pt w/ pain @ this time. [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20 Sep @1930	bed, monitor for skin breakdown.
cont'd	ROM exercises as ordered, pain control, ngtube
	@2100- Foot care done. Pt back to bed, ↓ pt restraint on ; skin integrity uncompromised. will monitor. ngtube
21 Sep @0530	Pt c/o pain in (R) upper back. Medicated c percocet will monitor. [redacted]
21 Sep 03	1930: VSS, A+O x3, c/o pain, Dsg d'd to sacral decub c new duoderm CDI. Dsg to (R) hip CDI. Pt. ↑ in chair & walking c difficulty. ROM exercises done to (B) LE's. Foley to gravity draining clear yellow urine. Continue to monitor Restraint x1 - Skin integrity intact. b(6)-2 [redacted]
22 Sep 03	Pt A+O x 3 CTA (B). S1 S2 present. (+) BS x 4 quads. DSG d'd to (R) Hip decub CDT. Am care completed. ~~FOC~~ FTG ~~Draining~~ Draining clr u. [redacted] will continue to monitor. [redacted] Spc glw mb
@1930	- assumed care of pt @1800. VSS, no c/o @this time. Pt ↑ to chair @this time. Foley to gravity - clr urine. Dsg to sacral area & (R) hip CDI. ↓ pt restraint on in bed, ↑ S/Sx of skin or circulation compromise. Cont-

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			
	LAST	FIRST	MI	[redacted]
		b(6)-2		

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#[redacted] b(6)-4		ICW#1

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25Sep03	1945= VSS, A+Ox3, ∅ c/o pain @ present, ↑ in chair sitting 3 difficulty, Δ'ing DSG's to sacral region & hip @ bedtime. Foley to gravity draining clear yellow urine. ROM exercises to (B) LE's when in bed-assisted, Q2 turns - log rolling, HOB↑ 30-45. Restraint x 1 when in bed, @ skin breakdown, continue to monitor. [redacted]
26 Sept	VSS pt awake/alert x3, ∅ c/o pain four old b(6)-2 back injury, pt given 2 tabs pm, pt rotated as scheduled, foley draining clear yellow urine, dsg to sacrum and right hip Δ'd, restraint x1 in place circulation to extremities intact [redacted]
26sep@2125	- assumed care of pt @ 1800. VSS. no c/o. Alert speaking some English. Pt ↑ to CH, tol well. Sacral & hip dsg CDI. Foley to gravity c clear yellow urine. PROM completed encourage pt to assist c ROM. Foot care provided. Plan: monitor skin breakdown and pain control. 1 pt restraint on while in bed, 3 S/Sx of skin or circulation compromise. [redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sept03	Foley to gravity c yellow urine. No signs of skin irritation from restraint. Will continue to monitor. SPC [redacted] qlw b(6)-2
29Sept03	2030: VSS, 0/10 pain @ this time, OOB and in chair c difficulty, D'ing Dsg's to R hip & buttock and @ HS. + Restraint when in bed, skin integrity intact; JTG draining clear yellow urine. Other remarkable finding - Continue to monitor. b(6)-2 [redacted]
30 Sept03 1200	Assume care of PT 0600. VSS, A+Ox3 Δ Dsg's on R hip and buttocks. Skin integrity intact x 1 restraint. Foley to gravity clear yellow urine. Exercise consits of lying in bed and sitting in chair. Will continue to monitor. SPC [redacted] qlw b(6)-2
30SEP03 2125	ENBTWC c complaints. Dsg to sacrum CDI to be d'd in AM. Placed on backside in bed. Performed well in ambulation on ward. FTG, clear yellow urine, quantity sufficient. b(6)-2 [redacted]
Oct 1	VSS, AOx3, Δ dsg on R hip AND sacrum, minimal drainage, wounds healing well, skin integrity intact with + signs of [redacted], restraint x 1 foley to gravity, clear yellow urine (1735) I concur c above assessment. [redacted]

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

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

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

REGISTER NO. b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2030(10)
USAPA V1.00

H [redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sept	VSS, A+O, alert + oriented x3, pt c/o pain from old injury site, pt given tylenol but decided to tough it, rotated as scheduled, leg draining clear yellow urine, restraint x 1 in place, circulation to extremities intact — [redacted] RN
27 Sept @ 2115	assumed care of pt @ 1800. No c/o @ this time but refusing to OOBTC @ change of shift. (R) hip ? sacral dsg - Δ & now CDI. PROM completed. Turn q2° while in bed. Left restraint on S/SX of skin or circulation compromise. Plan cont TQ2°, PROM q4° Will monitor. — [redacted] RN
28 Sept 03 0922	Assumed care of PT @ 0600. A+Ox3, VSS Skin integrity present @ restraint site. Needs to be turned over on side through out day. Dsg's on hip and buttocks Δ c/o pain given tylenol. Will continue to monitor. — [redacted] 9/4
28 Sep 03 1202	I assumed c alive. Will continue to monitor. — [redacted] mab
28 Sep 03	2100: VSS A+O, c/o pain, dsg's to buttocks & (R) hip CDI. Q2° turns & log roll - pt. can do this pretty much on his own. Foley to gravity draining clear yellow urine. Other remarkable findings - Continue to monitor. — [redacted] RN
29 Sept 03 1113 hrs.	Assumed care of PT @ 0600 hrs. VSS, A+Ox3. 1 dsg's on buttocks and Rt. hip. Log rolled x2. exercised in bed. Performed own personal hygiene. (cont.)

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10CT03 2007	Stable. AO. OOBTWC c complaint of pain. FTG draining guarded sufficient light yellow urine. (+) pulses. Robul for suppository to be placed @ 2200 hours. Acknowledged. OOB. instruct to secure dentate. No other s/s infection or skin breakdown. to attention. Provided magazine to read. b(6)-2 [redacted]
20CT03 0200	Rinsed & suppository placed c digital stimulation b(6)-2 [redacted] RN
20CT03	1319 - VSS-A+O - Pt. had BM this AM. Assumed care of pt. @ 0200. Assessment completed. LS CTA (B) resp. even unlabored. abd. soft non-tender, BSX4. FTG draining clear yellow urine. Drsng D to decubs/ on coccyx + (R) hip. Cont. c (-) s/s infx. Cont. to turn pt. OOB. Pt. tolerating PO well. Will cont. to monitor pt b(6)-2 [redacted]
20Oct03 1440	Assumed care of above assessment. Pt continues c foam heal pads to prevent skin breakdown. One pt. restraint on c compromise to circulation or skin integrity. Will continue to monitor [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | (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.

[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

b(6)-2
AR

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 OCT 03 2210	Stable. AC. Pt'd in chair and tolerated for 2°. Pt'd on stomach for skin. DSG's intact to sacrum and (R) hip. (+) pulses. Performed ROM on BLE and tolerated well for 15 min. Had one episode of HA and light headedness and provided 2 percocet. Foot board. Cont to monitor [redacted]
3 OCT 03 0700	Assumed care of pt. A+O x 3 VSS & c/o pain or discomfort @ this time. ADL care self & assistance complete. Foley to gravity clear yellow urine QS. Q2° turn cont. Breakdown to sacrum dressing intact stage II. Redness to (R) hip bony prominence. (L) hip dressing stage I. ROM exercises b/lat lower extremities stiff. Will cont to monitor [redacted]
3 OCT 03 1940	Assumed care of pt @ 1800. A+O, speaking arabic. Pt ↑ OOBTC, c/o some dizziness & pain to old GSW site. Foley to gravity draining clear yellow urine. (R) hip & sacral dsgs CDI. (L) hip redness noted. Reinstructed pt in cont. to turn Q2°, pt verbalized understanding. PROM completed. P.T. consult submitted Dt ↑ joint/muscle stiffness. Foot care completed. Plan: monitor skin breakdown, cont TQ2°. [redacted] CPT Addendum: Pt in ↓ pt while in bed & S/St of skin or circulation compromise. [redacted] CPT
2130-	(R) hip & sacral dsgs CDI & DTE wrinkling of duoderm. Will monitor. [redacted] CPT

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
50703 2105	VSS- AO- Refused OBTC. Husband take 5' shuttle. lb c/p pain @ this time. S'd saw dry dsg - wanted left in place to sacrum and right hip. Noticy light yellow urine to FCG = shuttle [redacted] b(6) - 2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 Oct 03 0700	-Assumed care of pt. A+O x 3. VSS. Ø c/o pain or discomfort @ this time. Cont c Q2h position change breakdown to sacral area. stage II healing dressing A+D duoderm applied. (L) hip duoderm applied. (R) hip c redness. Ø break in skin to (R) hip. PT consult today stiffness to bilat lower extremities. ROM exercises will cont to monitor — [redacted] (1540) I concur c above assessment. [redacted]
HOCTOB @2045	-assumed care of pt @ 2000. NO c/o. A+O, speaking Arabic. Pt ↑ CH, tol well. PROM to BLE completed (R) hip's sacral dsgs CDI. Foley c clear yellow urine. Plan: TQ2° while in bed, cont PROM, follow-upon P.T. consult. — [redacted] addendum: 1 pt restraint [redacted] c/s/sx of skin / circulation compromise — [redacted]
5 OCT 03- 0700	Assumed care pt. A+O x3 VSS Ø c/o pain or discomfort @ this time Lungs clear HRRR Active RS x 4 quads BLE x 1 today. Tolerating PO well. Foley to gravity clear yellow urine QS. Breakdown to sacrum stage II healing Ø s/s of infection W.I. cont to monitor — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(2)-2

103 (See Instructions on Back of this ... NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] b(2)-2

LOG NUMBER

ARRIVAL DATE MONTH	YR.	TIME
07	03	1330

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

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

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): pk GSW to back @ 1330 +LOC tob(+) ETOH(+)

SEX: M AGE: 26

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1331	1345
BP	91/37	99/45
PULSE	123	107
RESP.	34	22
TEMP.	105.3	
WT. (Child)	60kg	

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

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)

18 gauge IV Bolus (R) wrist.
Came in with chest tube
2L O2 Nasal canula
GSW (L) chest below scapula
Shrapnel injury to posterior midline
Came in with IV (L) AC
2L O2 NRB mask
Came in with Foley catheter

25% Trqi s/p GSW + back. Seen in Trqi hospital, CT planned (L) side. Unclear by notes how much fluids/units given. 1 unit blood given pr Trqi hospital note

Unclear amt of fluid out of CT. Pt clo SOB & 55 cp and ↓ foley below acp

ORDERS	INITS.	TIME
CBC/Chem12		
Electrolyte (Piccolo)		
UA/Type + Cross x4		

1° A Airway clear/pat maint'd ↓ facial trauma (R) small wound (L) mid scapular
B: CTA (R), (L) min decr fin (R), CT in place (L) T-4/5
C: (+)2 pulses ↓ 4 ext, ↓ obv exsanguination
D: GCS 15
E: Back (+) 3 open shrapnel wounds mid spine @ T2 level ↓ massive pulp
(+)GSW superior mid scapular area
Foley in place & clear yellow urine x 100cc

2° Head atraumatic PERRL 2-4mm EOMI Speech clear, articulate
neck ↓ midline bony stepoffs
Chest CV: NSR 122 ↓ murmurs/gallops/rubs
Abd: +bs, SFGI, NT, ↓ masses/guarding rectal: tone heme neg
Ext: 5/5 sym (+) strength & ROM
Lower ext: flaccid (R), areflexic
(+)2 bounding pulses

A/P (L) GSW to back chest Hable
(2) (R) Low ext neuro exposure 2° to spinal cord injury likely
→ OR Neurosurgery/Surgery c/s

Shane Wilcox

(CONTINUE ON SF 507, IF NEEDED)

ASSESSMENT/DIAGNOSIS
(1)

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:

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

EPW # [redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP [redacted] b(2)-2 8790

INSTRUCTIONS TO PATIENT (Include medications and follow-up plans)

Admit ICU

MEDCOM - 15276 TREATMENT
Medical Record Copy

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

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)			
			20	21	22	23
		HR	91	80	61	58
	CVP	BP	138/67	118/53	114/50	122/65
		MAP	92	78	75	81
		RR	23	23	16	16
		SaO_2	94	91	91	92
			RA	RA	RA	RA
INS						
IVF:	D5½ 20K		100	100	100	100
	DOPamine		27	27	27	27
outs		Foley	110	70	50	170
		Lumbar	5	5	4	0

(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.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR. FIRMR (41 CFR) 201-9.202-1

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			1730 29JUL03 – Resumed pt care. Pt resting comfortably on bed. Assessment as follows: (N) No spont movement from upper extr bilat UE movement; PERRL 3mm; 2+ UE weakness from c/o pain c/o pain in UE. (N) CVA: JVD 90's c/o chest pain; [CV] + pulses x4; S1,S2; NSR; denies pain to touch; (-) edema; [GI] (N) BS hyperactive x4 quad; (-) N/V; regular consistency diet; minimal amount x24hrs; [GU] (N) O/P, clear yellow [SKIN] C1 site c/d/i; epidural site c/d/i [MISC] (L) SC; (N) PIV to UE; Safety
			b(6)-2 [redacted] 1127
			30JUL 0600 pt alert; MAP >60, SBP>95; SaO2 minus UE only; Lung sounds Vc to LLL; CTA; (+) Bowel sounds, Flat abdomen; Foley to
30JUL03	0657		Neurosurgery (S/O) Lumbar drain Failed yesterday. Dressing Δ – minimal serosanguinous drainage Prophylaxis per S.S. Dopamine @ 11 μg/kg/min. (A/P) GSW T-spine. May be up ad-lib. b(6)-2 Wean Dopamine off. [redacted]

510-112

b(6)-2
All

MEDICAL RECORD — NURSING NOTES (Sign all notes) — NSN 7540-00-6

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30 Jul	0730		Am care; breakfast setup; HOB ↑; pt eats well per self; assist under pm [redacted]
	0800		dressing dry; SBP > 90; meds c order [redacted]
	1200		on hour noted x taken to dressing; no [redacted]
	1400		no change in status; no [redacted] SBP > 90; UOP 30/hr, no [redacted] ↓ UOP.
30 Jul 01	1710		fed pt c HOB/sleeping (in NAD). ∅ Complaints voiced. clear to back/∅ chest CD + I. fluids [illegible] running. Pt alert/coherent. Lungs ↓ to LLL otherwise clear. BS +, foley ↑ gravity → cl yellow. Po intake highly encouraged. VSS/Afeb. RN to ∅ bkcp patent/benign. Will cont to mntr [redacted] Sgt/LPN
31 Jul	0400		Pt. slept through entire shift. Med. PRN c effect. relief. Turned. PRN's. ∅ comfort measures. VSS/Afeb. [redacted] Sgt/LPN
31 Jul	0500		Assumed care. Pt. sleeping comfortable c no complaints @ this time. Will continue to monitor and follow plan of care [redacted]

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

REG [redacted] WARD NO.

NURSING NOTES
Medical Record

MEDCOM - 15279

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4

510-112

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 JUL 03	0637		Neurosurgery (3/0) Tm 101.5 this Am. Stable off drips. Central line out. Cough week ↓ chest tube. Dressing on back – minimal serosanguinous drainage. Plegia pers. 5/5. (+) Bm 4:15 Am. (1/0) (1) Stable GSW T-Spine c Flaccid plegia. (2) New fever. Will need workup. b(6)-2 [redacted]
31 Jul 03	0645		Pt Alert & follows simple commands. Afebrile this 101.5 Dr. Tef notified. CTA to auscultation. S NSR +2 pulses x4 +BS BM this am. Foley Clear yellow urine. Dressing on back changed. puncture open to air no signs of infection.
	0700		AM care done. Pt ate < 50% of breakf
	0745		CBC & UA & micro sent.
	0815		Pt to XRay. Will continue to monitor [redacted] (LT/AW)

(continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries gi... hospital or medical facility)

...e; rank; rate:

REGISTER NO.

WAR

NURSING NO

Medical Re

b(6)-2

STANDARD FORM 510 (REV. 7-...
Prescribed by GSA/ICMR, FIRMF

MEDCOM - 15280

b(6)-2 ANL

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 Jul 03	1030		Encouraged IS q 1h while awake. Pt able to move up 2 ½ bolts. Turned pt q 2hrs [redacted]
	1300		4mg MSO4 given IV push, pt c/o arms pain [redacted]
31 Jul 03 1715			Ø Significant hx from day shift note. Temps - LLE otherwise CTA. BS(+) Foley → clear q.s. Temp 101.
D: CT a/t & OTA Ø SKS d/c'd note			@ bkg. afeb. Pt. IS use/fld intake highly encouraged. Positioned for dinner. PIV to Ø bicep pt/ benign. Prescribed Rx nursing. Max. Emotional Support provided. [redacted] Sgt/LPN
01 Aug 03 0430			Pt medicated TFN c effect. Chilly. T max 101.0 current temp 99.5. PO fluids (max) drank throughout the night. TS used well. Repositioned for comfort. [redacted] Sgt/LPN.
01 Aug 03	0800		Pt resting comfortable in bed c no complaints. Alert + follows simple commands. CTA Lungs S1-S2 +2 pulses x4. + BS Foley draining clear yellow urine. No skin breakdown [redacted] Saline Lock IV Ø to D5½c 20KCl. Will continue to monitor [redacted] LT
01 Aug 03	0850		Neurosurgery (Ø) Temp 101.2 @ 4:5 Am. Foot workup (-) yesterday. Dressing Δ - Scant serosanguinous. Plegia per 5.5.5. (A/P) (1) FU - observe/repeat W/U @ 24-48° (2) T3 Paraplegia - Stable, no CSF leak. (3) Placement Pending. [redacted]

U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Aug 03	0700		VSS pt A&Ox3. follows commands. Lungs CTA. BS hypoactive x4 quads. +2 pulses x4 quads. pt ate 10% of breakfast. Pt b(6)-2 has no @10 pain at this time. Will continue to monitor - [redacted] CON
3 Aug 03 @	1050		pt c/o pain. Medicated c 5mg Morphine - pt nauseas. pt Vomited. No on order for nausea. Will not [redacted] Dr [redacted] 2U.11 Con't to monitor b(6)-2 [redacted] LPN
03 Aug 03	1730		Rec'd pt. resting in NAD HOB T. Care plan reinforced; meds - side effects, pain control, Nutrition/healing. I-S. use/fluid intake; needs reinforcement. See flowsheet for further assessment [redacted] Eff/EN b(6)-2
04 Aug 03	0530		Pt. slept on/off. ∅ complaints voiced other than H/A Insomnia. Will pass on to oncoming shift. VSS [redacted] b(6)-2
04 Aug 03	0630		Neurosurgery.
			(S) Tm 101.5, Currently 99.5. VSS.
			Dressing Δ - Back slowly healing.
			Plegia pers. 3/5 - remains flaccid.
			(A/P) Subgaleal T-Spike c SCI.
			Continue dressings / supportive care.
			Placement.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; hospital or medical facility) b(6)-4 [redacted] REGISTER NO. [redacted] b(6)-2 WARD NO. ICU2

EAW

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR. FIRMR (41 CFR) 201-9.202-1

MEDCOM - 15[illegible]

NURSING NOTES
(Sign all notes)

HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	1230	Pt Alert x Oriented follows commands. Temp wnl today 100.°F. BM x1. Ambulate. Ate ½ apple. verbalized wants to go [redacted] eat naqui food plan to transfer to LCW2 [redacted] ILT/AN b(6)-2

STANDARD FORM 510 (REV. 7-91) BACK

*U.S. Government Printing Office: 1995 - 404-763/20065

MEDCOM - 15283

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 AUG.		1500	- Received PT from ICU 3. PT WAS Alert + Responsive. PT's temp was 100.9. Breath sounds are clear B. bilateral. PT has ⊖ Use Breathing. BS x 4. PT has ⊖ ROM, c ⊕ Pulse B. bilateral on Lower extremity. PT has ⊖ sensation Below apple Cap. PT has Foley Cath c Yellow color urine. PT has correctly voided 120cc. PT has ⊕ ROM + Good Pulse Match sensory to upper extremity. HL to (R) Arm flushed well c 3cc N/S. Dressing to Back CDI c ⊖ S/S of infection. Will cont to monitor PT. [redacted] b(6)-2
4 AUG 03		1800	- PT Temp 101.8. Cont Tylenol T. Will cont to monitor.
4 AUG 03		1900	- VS (T 101.9) Reposition (R) side
4 AUG 03		1915	- Drew CBC + UA As per MD order Awaiting X-ray chest. Will cont to monitor. G/N VASE
4 AUG 03		2020	- VS CT 100.4). Will cont to monitor. [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)

Ehw [redacted] b(6)-4

REGISTER NO.

WARD NO. ICU

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 15284

[redacted] [redacted]

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
note cont'd			noted on old dsgs. Wounds c healing tissue noted. DSD applied CDI. Pt TNP to supine position. Will mon. [redacted] SCT/AW
7 Aug 03	0259		Emptied 925cc CVU from FTE [redacted] SCT/AW
	0803		c/o pain in arms 11 Tylenol given will mon. [redacted] SCT/AW b(6)-2
@0730 Aug 03			NURSING ASSESSMENT: Pt awake, alert, Ox3. Airway intact, breath even and unlabored, LS clear to all fields (B). Abd soft, nontender, c mild distention. BS(+)x4, somewhat hyperactive. Pt is noticeably a stomach breather. Voids per foley, draining clear, yellow urine. Passive ROM to (B) LE, reports intact. No neurological function to (B) LE. FROM and neurovascularly intact to BU. IV access. Drsgs to (L) sacral-area & back are CDI. Pt turned q 2hrs c Pt tol q 4hrs. b(6)-2 [redacted]
@1020 Aug 03			NURSING NOTE: Pt give Bisacodyl suppository @ 0900. No results c/hours. Performed digital disimpaction of small amount of stool in rectum. Stool was pebble-like and hard. [redacted]
7 Aug 03		1330	assumed pt care @ 1300. Pt sitting up in bed awake & alert. VSS (+) temp noted @ this time. pt turned per orders, (+) lungs CTA, abd soft non-tender BS(+)x4. Drsing to ↑ back CDI. (+) IV access. BUE c full ROM (+) pulses. (-) c/o pain voiced @ this time. Will cont to monitor [redacted] 9 Hrs

(Continue on reverse side) b(6)-2

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

REGISTER NO. ICW2 WARD NO.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 15285

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 03		2140	Pt turned on (R) side. Dressing change to upper back. Padding or redress to wound. Small amt of drainage (blood) on dressings. b(6)-2 Sgt [redacted]
7 Aug 03		0209	Rec'd c/o pt @ 21:00. ⊕ Restraints. VS [redacted] per flow sheet x temp 100.4°. will retake temp x1 now. Temp 99.1 6Ax 98.7 orally. Skin W/D. Error on Re PERRLA ⊕ WNL. HRRSS2 BS ⊕ x4. ⊕ PPB. c/o H/A. II Tylenol given will cont. to mon. [redacted] 20)/AV
b(6)-2			
8 Aug 03	0600		Assumed pt. care @ 0500. Pt. awake laying on back. A&Ox3. Lungs CTA. ⊕ pulses BSx4. ⊘ rom in legs. dsg on back CDI. Foley to gravity c cyo. ⊘ complaints @ this time. [redacted]
b(6)-2			
8 Aug 03	1300		assumed pt care from previous shift. VSS temp 99.5 pt given II Tylenol per Drs Orders. pt awake & alert. lungs CTA, abd soft BS ⊕ foley to gravity intact, draining C yellow urine, ROM exercise done on pt, pt also turned per orders. BUE c full ROM ⊕ pulses. ⊘ IV access noted. dsg dry & I back CDI. ⊘ complaints voiced @ this time. Will cont to monitor b(6)-2 [redacted] 9 work
8 Aug 03		21:39	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. pt lying in supine position asleep; easily awakened. Skin Posterior diaphoretic Anterior W/D. Sheets x'd. PERRLA ⊕ WNL. LCTABS. BS ⊕ x4 hyper active. Patchy de Flatus in ABD. ABD firm. ⊕ PPB. DSD x'd

*U.S. Government Printing Office: 1998 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

[redacted]

MEDCOM - 15286

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

06OCT03

Discharge Summary

History EPW Suffered Gunshot Wound 27 JUL03 with durecutaneous Fistula and paraplegia.

Course Fistula treated with spinal drainage and dressings. Spine was not unstable. Paraplegic Patient treated with routine plegic care. Placement was delayed until a suitable nursing home facility could be found

Disposition Patient has no restrictions.
Foley catheter to be changed monthly.

Medications Celebrex 100 mg po BID
Lovenox 40 mg SQ q Day
Elavil 25 mg Po q HS.

Questions to 28th Combat Support Hospital.

[redacted] b(6)-2 MD [redacted] @US-Army.mil

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

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

blw-2

TIME: 2144 SIGNA: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: (Loose) / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 99.9
Color: Pale / Cyanotic / Jaundiced WNL
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: (None) Location: Size:

NEUROLOGICAL

Loc / (Alert) / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: 3mm ERRLA
Extremity Movement: Full / (Limited) / None SLO progress note

CARDIOVASCULAR

Pulse (0 - 4): 3 Radials +3 --- Pedals +3
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1S2
Rhythm SR/ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / (Symmetrical) / Asymmetrical
Respiration / (No Distress) / SOB / Labored / Use of Access Muscles
Breathing Patterns: Regular
Cough: (Productive) / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor None
Chest Drainage System Gravity: Suction cm: 20
Air Leak (No) Yes --Crepitus Ø
Character of Drainage: serosanguinous
Trachea / (Midline) / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	Ø	
Wheezes	Ø	
Diminished	Ø bases	Ø bases
Absent	Ø	

GASTROINTESTINAL

Abdomen: (Soft) / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / (Absent)
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate:
Stool: Character Ø
Drains:

GENITOURINARY

Urine Color: Clear/Yellow/SS Character: clear
Voiding: Continent / / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

AFTER ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: (Loose) / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Cool
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: Moist / (Dry) / Cracked
Skin Breakdown: (None) Location: Size:

NEUROLOGICAL

Loc / (Alert) / Lethargic / Unresponsive GCS:
(Orientated) / Disoriented Pupils: 3mm PERRLA
Extremity Movement: Full / (Limited) / None LLE only

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals 2
Capillary Refill: <3 Seconds Homan's Sign (-)
Jugular Venous Distension (-) Edema (-)
Heart Sounds S1S2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion (Symmetrical) / Asymmetrical
Respiration (No Distress) / SOB / Labored / Use of Access Muscles
Breathing Patterns: normal
Cough: Productive / Nonproductive / (None)
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm: 20
Air Leak (No) Yes Crepitus (-)
Character of Drainage:
Trachea (Midline) Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	(L) base	
Absent		

GASTROINTESTINAL

Abdomen: (Soft) / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / (Hypoactive) / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: light yellow Character: clear
Voiding: Continent / Incontinent / Catheter yes

EMOTIONAL/PSYCHOSOCIAL

no issues this time
Pt calm, cooperative

OTHER: [redacted]

blw-2

MEDCOM - 15289

Date: 28 JUN 03 Bed#: 5

Patients Name: EPW [redacted]

ne	00 05	01 06	02 07	03 08	04 09	05 10	06 11	07 12	08 13	09 14	10 15	11 16	12 17	13 18	14 19	15 20	16 21	17 22	18 23	19 24
BP	106	111	103	101	102	122	114	124	114	118	129	117	122	114	100	112	114	124	107	112
	54	53	53	53	44	53	51	58	47	48	47	53	47	53	46	52	54	60	96	49
TEMP			98.3					98.3							98.8					
PULSE	52	54	51	53	51	56	53	60	53	57	53	62	60	60	68	58	66	71	107	63
RR	18	10	12	20	12	15	15	16	19	15	16	20	22	23	15	15	20	24	18	21
SAO2	98	99	99	100	99	97	99	99	98%	98	98	93%	92	93	93	92	94	95	94	94
O2	4L	4L	4L	4L	4L	4L	2L	2L	2L	2L	1L	RA	RA	RA	RA	RA	RA	RA	RA	RA
MAP							76	82	72	76	74	78	77	77	68	79	77	87	90	75
PUT																				
IVF	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
DOPA	26.3	26.3	26.3	26.3	26.3	34.1	31.5	31.5	31.5	31.5	28.9	30.2	30.2	27.6	27.6	28.9	27.6	27.6	27.6	27.6
IVPB																				
ORAL											100		250							
TAL																				
TPUT																				
INE	140	110	100	90	100	120	150	100	60	50	120	155	145	140	160	210	290	90	160	150
CT																	20			
STOOL																				
LP drain	15	15	20	10	15	20	18	06	10	09	09	06	20	15	11	05	20	12	12	8
TAL																				
LANCE																				
RN Q 2																				

EPW
30 Jul 03
Emesis
Stool
O.R. OUT
24 hour input
24 hour output

ICU 1 EPW [redacted]

ICU Flowsheet Patient Name: Date: 3/31 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Temperature			[illegible]				101.5				100.4				100.8				105				93	
Pulse			78				81				70				81				104/76				53	
B/P ~~A-Line~~			95/63				93/46				96/51				95/46				81				88	
MAP			63																				100.5	
B/P Cuff																								
Respirations			18				16				15				13				18				16	
Sa02			95				97				98				99				98				96	
			RA				RA				RA				RA				RA				RA	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IV	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
PO intake	240				60		190	250	250				800	250												
O.R. IN																			200		200		200	200	200	1000
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	30	30	100	150	300		90	60	40	90	180	130	1380	70	210	290	430	640	720	800	900	1000	1050	1100	1300	1300
NG Tube					400																					
Drains #1																										
#2																										
#3																										
Emesis																										
Stool								X1																		
O.R. OUT																										
Totals																										

meal BFast

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15293

	24	01	02	03	04	05	06	07	08	09	10	11	Total
HR	87	61	64	69	64	60	63	63	67	65	72		
BP	125/64	104/45	115/53	125/[illegible]	95/42	107/50	143/58	140/63	132/61	89/35	98/44	100/45	
Resp	22	17	18	17	19	18	20	20	22	18	17	19	
SpO2	94	93	92	98	94	93	97	97	96	97	97	98	
	RA	RA	RA	RA	RA	RA	1L NC	1L NC	1L NC	1L NC	1L NC	1L NC	
MAP	86	68	75	75	63	73	89		87	56	62	66	
tck	100	100	100	100	100	100	100	100	100	100	100	100	
DOD ante	28.2	28.9	28.8	28.9	28.9		18.4	19.7	19.7	9.2	13.1	13.1	
PB											50		
PO intake								400			200		
O.R. IN													
Totals													
Output													
Urine Hourly	50 / 50	65 / 115	55 / 170	65 / 235	60 / 295	75 / 365	70 / 435	400 / 835	270 / 1105	350 / 1655	125 / 1810	110 / 1910	
NG Tube													
Dr. #1 (chest tube)					7		∅	18					
#2	∅	8	0	4	0	0	5		15		15		
#3													
Emesis													
Stool													
O.R. OUT													
Totals													

	12	13	14	15	16	17	18	19	20	21	22	23	Total
HR	59	76	74	79	67	64	68	118	124	105	129	83	
BP	107/52	106/58	106/50	99/48	99/65		99/39	118/57	124/70	105/44	129/54	98/43	
Resp	18	19	29	17	18	22	18	28	32	18	20	20	
SpO2	98	99	93	98	97	95	98	98	98	99	98	98	
	1L NC	1L NC	RA	1L NC	1L NC	1L NC	1L NC	1L NC	1L	1L	1L	1L	
MAP	70	72	71	67	65		62	105	92	68	83	65	
tck	100	100	100	100	100	100	100	100	100	100	100	100	
DOD ante	13.1	11.8	11.8	11.8	11.8	11.8	11.8	11.8	13.1	13.1	13.1	98	
PO intake	200	350	150	200	150	200	200						
Urine Hourly	115 / 2025	130 / 2325	220 / 2545	310 / 2855	160 / 2915	290 / 3205	200 / 3405	70 / 3475	70 / 3550	180 / 1730	500	145	
Dr. #2	2	3											

post x-ray

24 hour input

24 hour output

1220/6800 ... 1210/800 ... 700

1200 / 1700

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 2003 DAY 4 5 6 7 8 9-10

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

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)*

CPW [redacted] 5100-1

REGISTER NO.

WARD NO. ICU2

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

MEDCOM - 15295

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 18 2003

DAY 10 11 11-12 12-13 13 14 15 16

HOUR

PULSE (O)

TEMP. F (°)

105° 104° 103° 102° 101° 99° 98° 97° 96° 95°

TEMP. C

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

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

98.6°

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.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15296

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY | HOUR

16 17 17 18 19 20 21

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted]

b(6)-4 EPW

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15297

MEDICAL RECORD

VITAL SIGNS RECORD

Start 22 Aug 03

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 22 Aug 23 23 25-26 27 27 29 Aug

19 | HOUR: 0930 20 19 20 20 08 08 20 1100 0930 1500 0800

PULSE (0) | TEMP. F (°): 105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

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

(Centigrade Equivalents, for Reference only)

BP 88/42
HR 78
SpO2 99
T 97.7

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

RA

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

REGISTER NO.

WARD NO.

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

[redacted] BLU-V

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 31 Aug | 1 Sep | 2 Sept | 3 Sept | 4 Sept | 5 Sept | 06 Sep

19 | HOUR: 0700 | | 0730 | 1840 | 0800 | 0745 | 080

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

BLOOD PRESSURE

92/50 | 41/27 | 94/50 | 91/58 | 96/56 | 98/53 | 104/57

83 | 67 | 75 | 81 | 72 | 77 | 92

100% | 146 | R-16 | 16 | 98.1 | R-18 | 97°

HEIGHT: | WEIGHT → | RA | 49.1 | 1059O | R-16 | 98.6 RA | 98%

98% | RA | 99% | 98.9 RA

T-97.8 RA

96/57

103

97%

97.8

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.

#[redacted] 511-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15299

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (0) TEMP. F (°)

180 104°
170 103°
160 102°
150 101°
140 100°
130 99° / 98.6°
120 98°
110 97°
100 96°
90 95°
80
70
60
50
40

Sept 9 | 8Sep03 9Sept | 10Sep03 | 11 Sept03 | 12Sep03

TEMP. C

40.6°
40.0°
39.4°
38.9°
38.3°
37.8°
37.2° / 37.0°
36.7°
36.1°
35.6°
35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BAC

MEDCOM - 15300

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

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

TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] b(6)-4

MEDCOM - 15301

NSN 7540-00-634-4124

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° 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 →

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.

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15302

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR

19

DAY

HOUR

PULSE (O)

TEMP. F (•)

TEMP. C

105° 40.6°

104° 180 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

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.

[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 - 15303

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY									
POST- DAY									
MONTH-YEAR	DAY	3 Oct	4 Oct	5 Oct					
19	HOUR	0645	0700	0700					

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered				
RESPIRATION RECORD		16	16	
BLOOD PRESSURE		105/54	104/64	105/57
		H 80	H [illegible]	H 81
		T 98.4	T 97.9	T 98.2
HEIGHT:	WEIGHT →	99%	98%	97%
		RA	RA	RA

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

REGISTER NO.

WARD NO.

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

[redacted] b(6)-4

MEDCOM - 15304

EMT

b(6)-2

b(6)-4 EPW [redacted]

DATE 27JUL03 TIME 1337

(i-STAT)

RESULT	REF. RANGE
	138-146 mmol/L
	3.5-4.9 mmol/L
	98-109 mmol/L
	7.31-7.45
	35-45 mm Hg (mmHg)
	80-105 mm Hg (mmHg)
	95-98%

Misc. Chemistry

RESULT	REF. RANGE

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE	
ALB	2.7*	3.3-5.5	G/DL
ALP	36	26-84	U/L
ALT	21	10-47	U/L
AMY	35	14-97	U/L
AST	43*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CHOL	130	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	104	73-118	MG/DL
TP	4.9*	6.4-8.1	G/DL

======= PICCOLO =======
27/07/03 13:53
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		
CA		
CRE		
NA		
K		
CL		
tCO2		
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
GGT		
TP		
A/G		
LDH		
TRIG		
NA+		
K+		
CL-		
tCO2		

======= PICCOLO =======
27/07/03 13:53
REFERENCE RANGE: MALE
PATIENT #: [redacted]
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	133	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

ALLERGIES:

DOCTOR'S SIGNATURE [redacted] b(6)-1

DATE 27JUL03

CLASSIFIED NO.:

EMT

ORDERING PHYSICIAN

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

NAME
EPW [redacted]

DATE 27JL03 | TIME 1333 | SSN/PSEUDO SSN:

Hematology / CBC

TEST	RESULT	REF. RANGE
		4.8-10.8 x10

ID: [redacted]
MB 27-07-03 14:01

			Patient Limits	
WBC	8.8	x10^3/uL	4.5	10.5
RBC	3.72 L	x10^6/uL	4.00	6.00
Hgb	10.8 L	g/dL	11.0	18.0
Hct	34.0 L	%	35.0	60.0
MCV	91.4	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	172.	x10^3/uL	150.	450.
LYZ	7.1 *L	%	20.5	51.1
LYN	0.6 *L	x10^3/uL	1.2	3.4

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

CSF

Cell Count		
Direct gen		Negative

Misc. Serology

TEST	RESULT	REF R
RPR		Negat
Mono		Negat

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

RESULT	REF. RANGE
PT 16.0	9.6-13 sec
PTT 29.9	21-34 sec
~~PTT~~	20 sec m
	10 sec m

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

UNIT	TYPE	CROSSMATCH

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

2731

MEDCOM - 15306

15.9/16.0 = 16-0
29.7/30.1 = 29.9 -

Ward/Section: FCH #1 | REQUESTING PHYSICIAN: b(6)-4 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW [redacted] | DATE: 28JUL03 | TIME: 0400 | 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) Metabolic Panel

TEST RESULT REF. RANGE

GI
BU
C/
CI
N.
K
CI
tC
A
A
A
A
A
T
G
T
N
K
C
P

(Piccolo) Mellyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-330 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
28/07/03 04:11
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	172*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	1111*	39-380	U/L
NA+	133	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	23	18-33	MMOL

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: 28July03 | LAB ID NO.:

Ward/Section: ICU #1 | REQUESTING PHYSICIAN: b(6)-4 | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW [redacted] | DATE: 25Jul03 | TIME: 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6

ID: [redacted]
WB
28-07-03
04:15

			Patient Limits	
WBC	11.7 H	x10^3/uL	4.5	10.5
RBC	3.76 L	x10^6/uL	4.00	6.00
Hgb	11.0 L	g/dL	11.0	18.0
Hct	34.6 L	%	35.0	60.0
MCV	92.0	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	199.	x10^3/uL	150.	450.
LYM	9.3 *L	%	20.5	51.1
LYM	1.1 *	x10^3/uL	1.2	3.4

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		
Direct gen		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: 28Jul03 | LAB ID NO.:

b(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: Dr. [redacted] b(6)-1	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted]	DATE 7-29 / TIME 0650	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		
Hgb		
Hct		
MCV		
Plt		
Lym		
(E		
Segs		
Ban		
Lym		
Atyp		Imm
RBC Morph		

ID: [redacted] WB 29-07-03 07:20

				Patient Limits	
WBC	9.1		x10^3/uL	4.5	10.5
RBC	3.87	L	x10^6/uL	4.00	6.00
Hgb	11.3		g/dL	11.0	18.0
Hct	35.2		%	35.0	60.0
MCV	91.0		fL	80.0	99.9
MCH	29.3		pg	27.0	31.0
MCHC	32.2	L	g/dL	33.0	37.0
Plt	194.		x10^3/uL	150.	450.
LY%	7.7	*L	%	20.5	51.1
LY#	0.7	*L	x10^3/uL	1.2	3.4

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

Urinalysis b(6)-1

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: b(6)-2

REPORTED BY: [redacted] **DATE:** 29 July **LAB ID NO.:**

Ward/Section: ICU

REQUESTING PHYSICIAN: [redacted] blu-2

LAST, FIRST, MI: EPW [redacted] blu-4

DATE: 7/29

TIME: 0652

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

SSN/PSEUDO SSN:

(i-STAT) | (Piccolo) Chemistry 12 | (Piccolo) Metabolic Panel

TEST | RESULT | REF. RANG

---

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____132 mg/dL
BUN_____3 mg/dL
Na_____135 mmol/L
K_____3.3 mmol/L
Cl_____102 mmol/L
Hct_____32 %PCV
Hb*_____11 g/dL
*via Hct

Sample Type_:

29JUL03 07:50

Oper: 7210

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

======= PICCOLO =======
29/07/03 07:35
REFERENCE RANGE: MALE
PATIENT #: [redacted] blu-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.8*	3.3-5.5	G/DL
ALP	46	26-84	U/L
ALT	44	10-47	U/L
AMY	32	14-97	U/L
AST	27	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CHOL	141	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	138*	73-118	MG/DL
TP	5.9*	6.4-8.1	G/DL

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

======= PICCOLO =======
29/07/03 07:31
REFERENCE RANGE: MALE
PATIENT #: [redacted] blu-4
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	♦♦♦	128-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	26	18-33	MMOL

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

REMARKS: blu-2

REPORTED BY: [redacted]

DATE: 29JUL03

LAB ID NO.:

Ward/Section: ICU | REQUESTER: [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 12/29 | TIME: 0850 | SSN/PSEUDO SSN:

(Hematology) CBC

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%

(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	Straw	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1015	N/A
Bld	Neg	Negative
pH	6.5	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count			
Directigen		Negative	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

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:** 29 Dec 03 | **LAB ID NO.:**

b(6)-4

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. | TIME: 7-30 03 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WB		
RB		
Hgl		
Hct		
MC		
Plt		
Ly		
S		
B		
L		
Atyp		Imm
RBC Morph		

ID: [redacted] WB 30-07-03 04:07

			Patient Limits	
WBC	8.2	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.1 L	g/dL	11.0	18.0
Hct	28.7 L	%	35.0	60.0
MCV	91.4	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	183.	x10^3/uL	150.	450.
LY%	11.5 #L	%	20.5	51.1
LY#	0.9 #L	x10^3/uL	1.2	3.4

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:** 30Jul03 | **LAB ID NO.:**

b(6)-2

MEDCOM - 15313

b(6)-2

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 7-30-03 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/l

======= PICCOLO =======
30/07/03 04:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.2*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	53*	10-47	U/L
AMY	39	14-97	U/L
AST	39*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	120	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	125*	73-118	MG/DL
TP	5.1*	6.4-8.1	G/DL

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

Bun 5

(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
[redacted]		30-190 u/l (F)
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

G		
BI		
C		
Cl		
N		
K		
C		
tC		
A		
A		
A		
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

i-STAT 6+
Pt: [redacted]
Pt Name:_____

Glu_____118 mg/dL
BUN_____5 mg/dL
Na_____136 mmol/L
K_____3.3 mmol/L
Cl_____101 mmol/L
Hct_____27 %PCV
Hb*_____9 g/dL
*via Hct

Sample Type_:
30JUL03 04:06
Oper: 13
Physician:_____
Ser# [redacted]
Ver: JAMS046A
CLEW A93

REPORTED BY: [redacted] b(6)-2 | **DATE:** 30Jul03 | **LAB ID NO.:**

b(6)-4 [redacted]

IC-41

b(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN: DR. [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 31 Jul 03	TIME: 0745
		SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³

ID: [redacted] 31-07-03
HB 08:05

			Patient Limits	
WBC	6.7	x10^3/uL	4.5	10.5
RBC	2.90 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	27.0 L	%	35.0	60.0
MCV	93.1	fL	80.0	99.9
MCH	29.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	196.	x10^3/uL	150.	450.
LY%	10.2 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	7.5	N/A
Prot	Neg	Negative
Urob	4	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

0-2 WBCs
0-2 RBCs

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: b(6)-4

REPORTED BY: [redacted]

DATE: 31 Jul 03

LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRS [redacted] b(6)-4	DATE 8/4	TIME 1945	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI		
RE		
Hg		
Hc		
MI		
Ph		
Ly		
Se		
Bi		
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted] 04-08-03
MB 19:24

			Patient Limits	
WBC	8.8	x10^3/uL	4.5	10.5
RBC	3.77 L	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	34.7 L	%	35.0	60.0
MCV	91.9	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	483. H	x10^3/uL	150.	450.
LY%	16.2 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	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: [redacted] **DATE:** 04 Aug 03 **LAB ID NO.:**

b(6)-2

MEDCOM - 15316

Ward/Section: Iow 2	REQUESTING PHYSICIAN: TF [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 6 AUG 03 / TIME 0737	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
		4.7-6.1 x 10^9

[redacted]

WBC	9.4	x10^3/uL		4.8	10.8
RBC	5.00 L	x10^6/uL		4.70	6.10
Hgb	9.5 L	g/dL		11.0	16.0
Hct	29.4 L	%		35.0	60.0
MCV	91.0	fL		80.0	99.0
MCH	29.7	pg		27.0	31.0
MCHC	32.3 L	g/dL		33.0	37.0
Plt	430.	x10^3/uL		150.	450.
Lym%	15.4	% L		20.5	51.1
Lym	1.4	x10^3/uL		1.2	3.4

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:	**DATE:**	**LAB ID NO.:**

Ward/Section: ICW2	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
FOW [redacted] b(6)-4	7 Aug 03	0400	

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hg			Glu		Negative	**Microbiology**		
Hc			Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
Pl			SG		N/A	Occ Bld		Negative
Ly			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
S.			Prot		Negative	Malaria		
B			Urob		0.2-1.0	O & P		
L			Nit		Negative	Other		
At			Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

[redacted] 07-08-03 04:18 Patient Limits
WBC 6.9 x10^3/uL 4.5 10.5
RBC 3.39 L x10^6/uL 4.00 6.00
Hgb 9.9 L g/dL 11.0 16.0
Hct 31.1 L % 35.0 60.0
MCV 91.8 fL 80.0 99.9
MCH 29.4 pg 27.0 31.0
MCHC 32.0 L g/dL 33.0 37.0
PLT 492. H x10^3/uL 150. 450.
LYM# 1.5 x10^3/uL 1.2 3.4

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

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 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:	**DATE:** 7 Aug 03	**LAB ID NO.:**

[redacted] b(6)-2

Ward/Section: ICW2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-2	DATE 13Aug03 TIME 2204	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Cloudy	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.015	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.5	N/A	Micro Parasites		
Segs		Mono	Prot	neg	Negative	Malaria		
Bands		Eos	Urob	8.0	0.2-1.0	O & P		
Lymph		Baso	Nit	Pos	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	Bacteria - 4+ 20-30 WBC 10-20 RBC		
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 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: b(6)-2

REPORTED BY: [redacted] **DATE:** 13Aug03 **LAB ID NO.:**

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR		M			
	FILM NO. b(6)-2				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE [redacted]				DATE REQUESTED 2 Jul 03

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

NOW ! please
√ line placement
Sgt ILTN

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
FCH1 b(6)-4 FPW [redacted]	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 15320 I TATION STANDARD FORM 519-R (...) Prescribed by GSA ... CFR...

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.

ICU 1

DATE OF ORDER 27 July 03 TIME OF ORDER 1525 HOURS

LIST TIME ORDER NOTED AND SIGN

1520 done

1530 done

Dopamine 5mg/IV bolus-done

Phenergan 125 mg/IVP-done

[redacted] b(6)-2

2 hr cc Done 27JUL03 [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 27JUL03 TIME OF ORDER 1830 HOURS

1. MSO4 2-10 mg IV q 1° PRN severe pain.

2. Lumbar D[redacted] to drain 20 cc/hr.

[redacted] 1197 b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted]ME OF ORDER HOURS

3. Patient is not to sit up. Not to be manipulated in anything other than a log roll UNLESS NEUROSURGERY WRITES AN ORDER OTHERWISE.

4. CXR post line insertion. TONITE or Before 7 AM.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

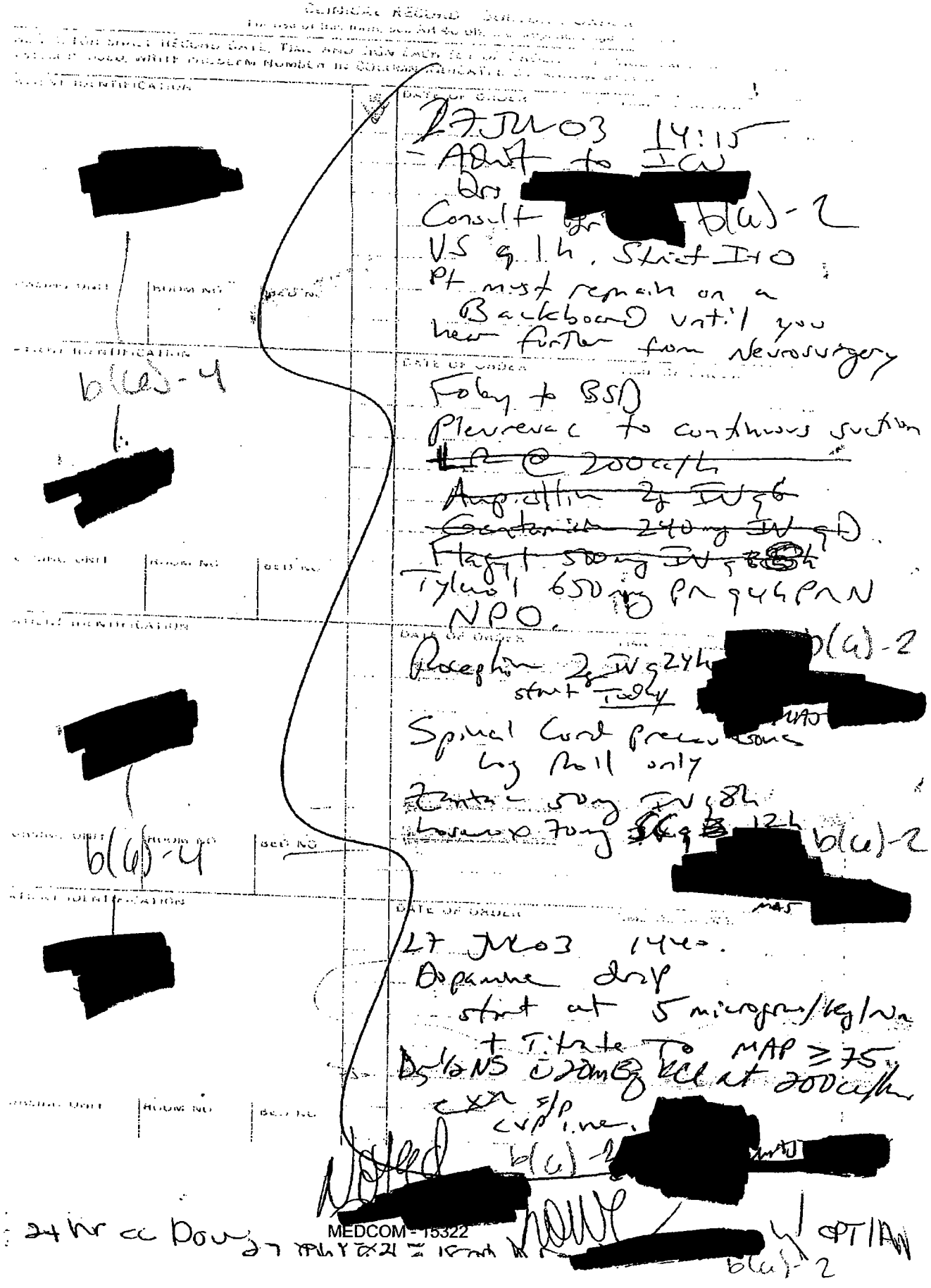
DATE OF ORDER TIME OF ORDER 4 AM 28 JULY 03 HOURS

5. BMP, CBC

[redacted] b(6)-2

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

MEDCOM - 15321


SURGICAL RECORD
DATE OF ORDER
27 JUN 03 14:15
Adm to ICU
Dr
Consult
b(6)-2
VS q 1 h. Strict I+O
Pt must remain on a Backboard until you hear further from Neurosurgery
b(6)-4
Foley to BSO
Pleurevac to continuous suction
@ 200cc/h
Ampicillin 2g IV q6
Gentamicin 240mg IV qD
Flagyl 500mg IV q8h
Tylenol 650mg PR q4h PRN
NPO.
Rocephin 2g IV q24h
start Tue 24
Spinal Cord Precautions
Log Roll only
Zantac 50mg IV q8h
Lovenox 40mg SC q 12h
27 JUN 03 1440
Dopamine drip
start at 5 micrograms/kg/min
+ Titrate To MAP ≥ 75
D5 1/2 NS @ 20mg KCl at 200cc/h
CXR s/p
CVP line.
24 hr cc Dow
MEDCOM - 15322
OPT/AN

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 July 03 TIME OF ORDER: 1645 HOURS

LIST TIME ORDER NOTED AND SIGN

Place CT on water seal-done OH

CXR in 6° p on water seal. 28 July 1100

5pm

Regadiff.

Please turn pt and leave orders for 2° staff

[redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29JUL03 TIME OF ORDER: 0835 HOURS 0640

1. CBC, Lytes 5° Am.

[redacted] 1757

b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30JUL03 TIME OF ORDER: 0659 HOURS

1. may elevate HOB Ad-Lib.
2. D/C 5° Am CBC/Lytes - diet, IS off.
3. Weight off for enema

[redacted] 1757

b(6)-2

[redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30JUL03 TIME OF ORDER: 0745 HOURS

1. Colace 100 mg po BID.
2. Bisacodyl Suppository / Digital Rectal Stimulation 5° Day
3. Fleet's Enema prn.

[redacted] 1757

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU[redacted] WHICH MAY BE USED.

MEDCOM - 15323

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 29 July 03 TIME OF ORDER 0650 HOURS — LIST TIME ORDER NOTED AND SIGN 0655

(1) Wean dopamine to keep SBP > 90

(2) Have translator ask pt why he is not eating

(3) Encourage p.o. intake

[redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29 TIME OF ORDER 0850 HOURS — 0900

UA per u/o Dr. [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29 JUL 03 TIME OF ORDER 15:20 HOURS — 1525

(1) D/C Chest Tube - done

(2) CXR AP inspiratory

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

MEDCOM - 15324

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

DATE OF ORDER: 30 Jul 03 TIME OF ORDER: 1020 HOURS

LIST TIME ORDER NOTED AND SIGN

1. VS q 4°
2. [redacted] b(6)-2

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 JUL 03 TIME OF ORDER: 1151 HOURS

1. D/C Central Line
2. Change ranitidine to 150 mg po BID
3. ↓ Lovenox to 40 mg SQ q 24°
4. [redacted] b(6)-2 1797

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [illegible] ORDER HOURS

1. D/C Lumbar Drain Orders — removed.
2. D/C log roll / Spine precautions — may be up ad-Lib. 31 Jul 03 0700
3. UA + micro.
4. CBC. b(6)-2 1797
5. CXR.
6. Tylenol 650 mg q 4° prn

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 AUG 03 TIME OF ORDER: 0654 HOURS

1. Oxycodone (Abdominal Thrust Support) q 4°
2. Percocet 1-2 po q 4° prn Pain.
3. D/C IVF. S/L IV [redacted] 1797 b(6)-2

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

MEDCOM - 15325

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: 04AUG03 TIME OF ORDER: 0633 HOURS — LIST TIME ORDER NOTED AND SIGN

1. D/C MSO4
2. D/C Reglan

0400 04 Aug 03 ORT

[redacted] b(6)-2 4797

PATIENT IDENTIFICATION

[redacted] b(6)-4

EP CW

NURSING UNIT	ROOM NO.	BED NO.
ICU2		

DATE OF ORDER: 04AUG03 TIME OF ORDER: 1132 HOURS

1. Transfer ICU2 - Neuro - Teff
2. Dx Shrapnel T4 with paraplegia
3. Condition Good
4. Vitals q 8°
5. Activity HOB Ad-Lib.
6. Nursing Foley.
   Leg roll - pressure reduction q 2°
   - Dressing Δ back dry BID.
   - Range Lower extremities q 4°
7. Diet Regular.
8. IV Saline Lock.
9. Meds Celebrex 100 mg po BID
   Zantac 150 mg po BID
   Lovenox 40 mg SQ q day

150 mw 4w

PATIENT IDENTIFICATION

EP CW

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU2		1

DATE OF ORDER: TIME OF ORDER: HOURS

- Bacitracin/Support/Digital rectal Suppository q D pm.
- Tylenol 650 mg po q 4° pm
- Percocet 1-2 po q 4° pm.
- Float's cream pm.

PATIENT IDENTIFICATION

EP CW

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU2		1

10. Lab/X-ray none.

[redacted] 4797 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 [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 Aug 04 TIME OF ORDER: 1900 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) CXR
(2) UA, CBC
(3) Tyl #3 ~~#4~~ #II ~~BRRoa~~ 12
(4) Tylenol 1000mg PO now

24°/done [redacted] TC

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/6/03 TIME OF ORDER: 1635 HOURS

(1) CBC done ✓ b(6)-2 noted
(2) D/C IV [redacted]

9 Aug 03 1612

24°/done [redacted]

PATIENT IDENTIFICATION b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 ~~JUN~~ Aug 03 TIME OF ORDER: 0154 HOURS

b(6)-2

V.O.
50 mg Benadryl PO x 1 now
for sleep
Dr [redacted]

24°/done [redacted]

Note 0154 13 Aug

PATIENT IDENTIFICATION b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 Aug TIME OF ORDER: [redacted] HOURS

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

Note 2102 13 Aug

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

MEDCOM - 15327

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 | ROOM NO. | BED NO.

DATE OF ORDER 13 Aug TIME OF ORDER 0050 HOURS

V.O

Levaquin 500mg PO QD

Dr. [redacted]

b(6)-2

24° done

LIST TIME ORDER NOTED AND SIGN

noted 0050 13 Aug

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 Aug

Levaquin 500 mg qd x5d

b(6)-2

noted 0900 14 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 Aug 03 TIME OF ORDER 2150 HOURS

V.O.

Robitussin elixir 2tsp q4° PO PRN coughing

RT q 2° for [redacted] tx

Dr. [redacted]

24° done

noted 2150 14 Aug 03

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 Aug 03 2040 HOURS

Please re-evaluate pt for Resp. tx.

Pt's BBS are CT pt coughs up secretions c ea

b(6)-2

noted 0900 17 Aug 03 2040

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

☆ U.S. GOV MEDCOM - 15328 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: b(6)-4 [redacted]

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

DATE OF ORDER: 15 Aug | TIME OF ORDER: 2200 HOURS | LIST TIME ORDER NOTED AND SIGNED: 15 Aug 22:14

1. Elavil 25 mg tab po qhs
2. Ambien 10 mg tab po qhs x 1 PRN [redacted] b(6)-2 [redacted] DT/AD
3. Resp. tx Neb to PRN q4 [redacted]

PATIENT IDENTIFICATION: [redacted] b(6)-2 #[redacted] b(6)-4

DATE OF ORDER: 1503 | TIME OF ORDER: 26AUG03 HOURS

Discharge to FRW Camp [redacted] b(6)-2 [redacted] b(6)-2 Noted [redacted] 26 Aug 03 1530

NURSING UNIT: ICU #1 | ROOM NO.: 2P/ [redacted] | BED NO.: [redacted]

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

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

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.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—405-924

"USE BALL POINT PEN—PRESS FIRMLY / NO CARBON PAPER REQUIRED"

MEDCOM - 15329

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4			07SEP03	1318 HOURS	
NURSING UNIT	ROOM NO.	BED NO.	1. Hospital Bed IF none, transfer to ICU.		
ICU		[redacted]	[redacted] b(6)-2 7747		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4			12SEP03	2330 HOURS	
NURSING UNIT	ROOM NO.	BED NO.	1. Phenergan 25mg po Q4-6° prn N/V. V.O. Dr [redacted]		
7N/21	00 13	SEP03			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4			1 OCT 03	[redacted] b(6)-2 2200 HOURS	
NURSING UNIT	[redacted] NO.		V.O. DR [redacted] VS Q DAY		
7N/			[redacted] b(6)-2 0001		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

MEDCOM - 15330

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]			↓	06OCT03	0849 HOURS	
			1	Discharge to prison hospital		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			b(6)-2	
ICU						
PATIENT IDENTIFICATION				DATE OF OR	TIME OF ORDER	
					HOURS	b(6)-2
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.

MEDCOM - 15331

b(6)-2 A11

CLINICAL RECORD

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

Mo. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27 28 29 30 31 01 2 3 4 5 6
27Jul	[redacted]	VS Q4h Strict I&O	05	[redacted]
		Dsd 30 Jul 03	17	
27Jul	[redacted]	Foley to BSD	05	[redacted]
			17	
27Jul	[redacted]	Pneumovac IM	05	[redacted]
		Continuous suction to RD	17	D/C 7-28 PVLT [redacted]
27Jul	[redacted]		05	[redacted] open
			17	JMM K9
27Jul	[redacted]	Spinal cord precaution log roll only	05	[redacted] 7/3
			17	
27Jul03	[redacted]	Lumbar drain to drain 20cc/hr	05	[redacted]
			17	D/C 7/31
27Jul 03	[redacted]	Pt is not to sit up not to be manipulated in anything other than log roll, unless neuro-surgery writes order	05	
			17	[redacted] D/C 7/31
28Jul 03	[redacted]	Reg diet	05	[redacted]
			17	
28Jul 03	[redacted]	Please turn pt and leave on side for 2° at a time	05	[redacted]
			17	
7/29	[redacted]	CBC electrolytes q am	04	[redacted]
7/29	[redacted]	Wean dopa to keep	05	[redacted]
7/30	[redacted]	SBP > ~~90~~ > 80	17	[redacted]
7/29	[redacted]	Enc PO intake	05	[redacted]
			17	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SIP GSW to Back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 b(6)-3

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]	[redacted]	[redacted]			1745	[redacted]
[redacted]	[redacted]	[redacted]				[redacted]
		[redacted]			1950	[redacted]
[redacted]	[redacted]	[redacted]			1455	[redacted]
		[redacted]				[redacted]
		[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		to night or before 7AM				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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

USAPA V1.00

b1c2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 01 02 03 04
01Aug03	[redacted]	Quad Cough (Abdominal thrust support) q 4°	03	[redacted]
			07	
b1c2-2			11	
			15	
			19	
			23	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

EPW # [redacted] b1c2-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b1 (b)-2 AII

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/31/03	[redacted]	D/C Lumbar Drain Orders - removed	31 Jul 03	ASAP	0900	[redacted]
7/31/03	[redacted]	D/C log roll/spine precautions - may be up ad lib	31 Jul 03	ASAP	0700	[redacted]
7/31/03	[redacted]	UA & micro	31 Jul 03	ASAP	0745	[redacted]
7/31/03	[redacted]	CBC	31 Jul 03	ASAP	0745	[redacted]
7/31/03	[redacted]	CXR	31 Jul 03	ASAP	0830	[redacted]

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

USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo. AUG Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9 10 11 12 13 14 15 16 17
4 AUG 03	[redacted]	Vitals q 8°	05	[redacted]
			13	
			21	
4 AUG 03	[redacted]	Activity ↑ HOB Ad Lib	05	
			17	
			24	
4 AUG 03	[redacted]	Log Roll-preserve reducin q 2°	05	
			13	
			21	
4 AUG 03	[redacted]	Dressing Δ back dry BID	10	
			22	
4 AUG 03	[redacted]	ROM Lower extremity q 4°	05	
			13	
			21	
4 AUG	[redacted]	Diet Regular	07 05	
			12 15	
			17	
4 AUG	[redacted]	IV Saline Lock @	05	
			13	
			21	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Surgical T-4 c Paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

Eph [redacted] HCS-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6	[redacted]	CBC	7 Aug	0400	0400	[redacted]
13	[redacted]	CXR and urinalysis	13 Aug	now	0130	[redacted]
17	[redacted]	Re-evaluate for Resp tx	18 Aug	AM	0810	[redacted]
	.....					
	.....					
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	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
.....	.....		
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USAPA V1.0(

MEDCOM - 15337

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15 16 17 18 19 20 21 22 23 24 25 26 27 28
8/7	[redacted]	Q8° VS	6	[redacted]
			18	
8/7	[redacted]	ACT ↑ HOB, Ad lib	6	
			18	
8/2	[redacted]	LOG ROLL Q2° pressure	6	
		reduction	18	
8/2	[redacted]	ROM (B) LE Q4°	6	
			18	
8/2	[redacted]	DISC ABID To Back	10	
		(Dry)	22	
8/2	[redacted]	Regular Diet	6	
			18	

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Para

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

PATIENT IDENTIFICATION:

EPW b(6)-4

[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1 2 3 4 5 6 7 8 9 10 11 12 13 14
8-17	[redacted]	VS: Q8°	6	[redacted]
			8	
8-17	[redacted]	ACT ↑ HOB, ad lib	6	
			18	
8-12	[redacted]	Log roll q2°, pressure reduction	6	
			18	
8-12	[redacted]	ROM (B) lower ext q4°	6	
			18	
8-12	[redacted]	Drsg Δ BID to back (dry)	10	
			22	
8-12	[redacted]	Regular DIET	6	
			18	
9/7	[redacted]	Hospital bed. Pt none transferred to ICU		See back of sheet

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 para

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: ___

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 15339

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 09 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/7	[redacted]	Hospital Med. Ofnone Transfer to ICU	10 SEP 03	—		[redacted]

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

USAPA V1.00

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

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)* | Mo. 10 Yr. 2003

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2	3	4	5	6	7	8
30 AUG 03	[redacted]	VS Q8H DAY (recopied)	06										
			18										
30	[redacted]	Act: HOBT, ad lib (recopied)	06										
			18										
30	[redacted]	Log Roll Q2 Passive Reduction (recopied)	06										
			18										
30	[redacted]	ROM (B)LE Q4 (recopied)	06										
			18										
30	[redacted]	DSG Δ BID to back (Dry) (recopied)	06										
			18										
30	[redacted]	Regular Diet	06										
			18										

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel, T4 para

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4077-1 OCT 78 — MEDCOM - 15341 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	b(6)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/6	[redacted]	D/C to prison hospital	10/6			

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

USAPA V1.00

b(6)-2 ↓ b(6)-2 ↓

CLINICAL RECORD

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

Mo. Yr

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28 29 30 31 01 02 03 4 5 6
28/Jul	[redacted]	Morphine 2g IV Q2h Start Today	16	[redacted] D/C 0700 01
28/Jul	[redacted]	Zantac 50mg IV q8h	08 16	Retired 27 JUL 03 @ 1400 hrs DT
28/Jul	[redacted]	Lovenox 70mg SQ Q12h	04	URMC
28/Jul	[redacted]	Dopamine @4 Start @ 5mcg Keflin + Flagyl to map 75	12	[redacted]
28/Jul	[redacted]	d/c IVF @ 2nd NS i 30K to Dr Kirchhoff	15 17	[redacted] D/C @ 1400 01
27JUL03	[redacted]	Zantac 50mg IVP q8h	08 10	[redacted]
30Jul	[redacted]	Colace 100mg po BID	10 22	[redacted] reunited
		Bisacodyl Supp =		
		digital rectal stimulation	20	
30JUL	[redacted]	Zantac 150mg po BID	10 22	[redacted]
	[redacted]	Lovenox 40mg SQ q 24°	10	[redacted]
30JUL	[redacted]	Bisacodyl Suppt digital Stimulation	20	/ / / / / / / [redacted]

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS: S/P GSW to Back | ADDITIONAL PAGES IN USE: ☐ YES ☐ NO | PAGE NO.

PATIENT IDENTIFICATION: EPW [redacted]

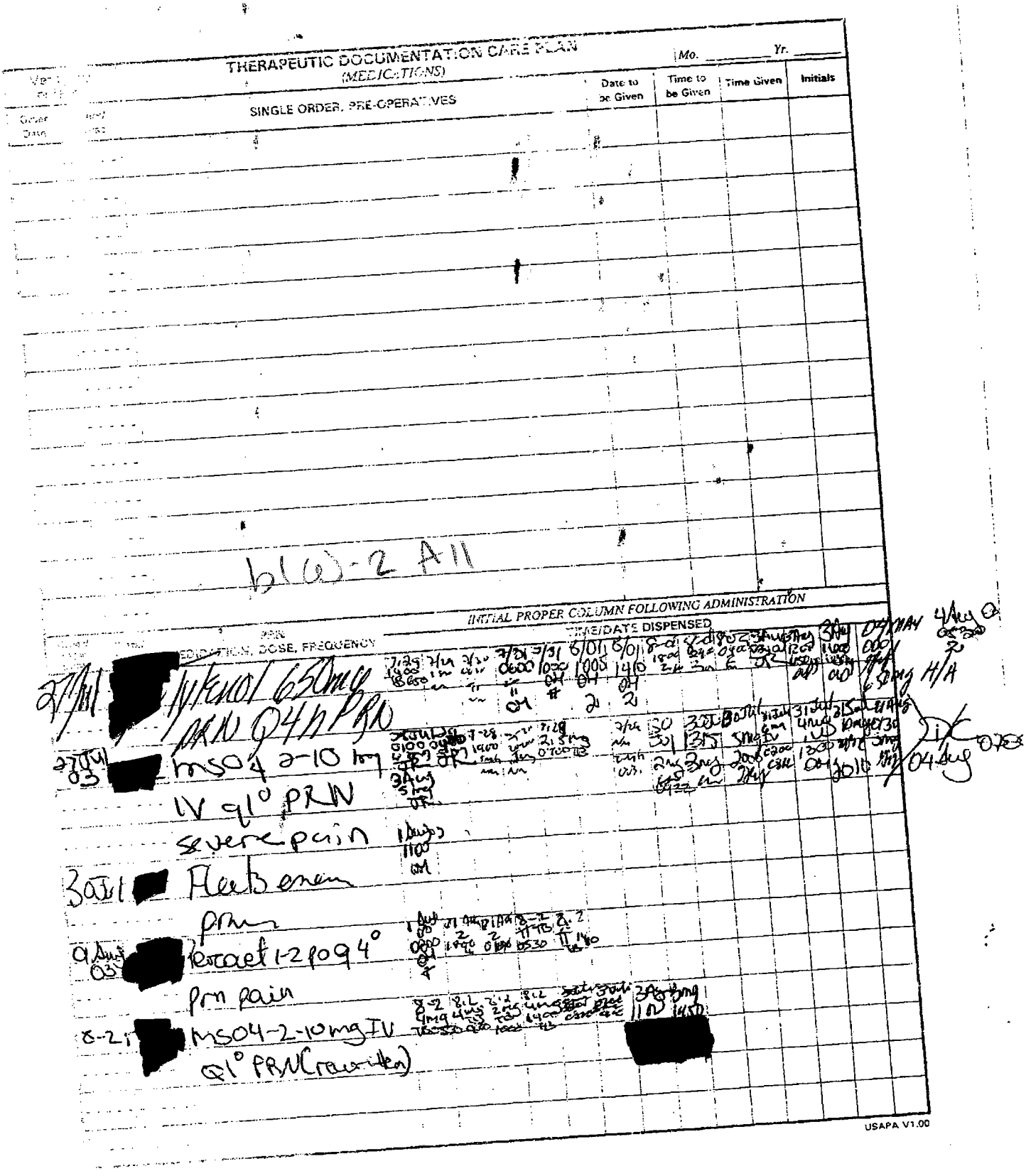
b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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



THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

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

b1(6)-2 A11

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
27JUN [redacted] Tylenol 650mg PRN Q4h PRN	7/29 7/30 7/31 6/01 6/01
27JUN 03 [redacted] MSO4 2-10 mg IV q1° PRN severe pain	7-28 7/29 2/Hr 30 30 30 31 31 31
30JUN [redacted] Flexeril prn	1 Aug 03
9 Aug 03 [redacted] Percocet 1-2 p o q4° prn pain	1 Aug 2 2 2 2 2
8-2 [redacted] MSO4-2-10mg IV q1° PRN (raw milk)	8-2 8-2 8-2 8-2 8-2 30JUL 2 Aug 3mg

USAPA V1.00

CLINICAL RECORD

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

Mo. AUG Y 05

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4 5 6 7 8 9 10 11 12 13 14 15 16 17
4 AUG	[redacted]	Colace 100mg PO BID	10	/ [redacted]
			22	[redacted]
4 AUG	[redacted]	ZANTAC 150 mg PO BID	08	/ [redacted]
			20	[redacted]
4 AUG	[redacted]	Lovenox 40mg SQ q Day	08	/ [redacted]
4 Aug	[redacted]	IV Saline Lock	05	/ [redacted] DC'd
			13	/ [redacted]
			2	[redacted]
13 Aug	[redacted]	Levaquin 500mg PO QD X5 days	22	[redacted]
13 Aug	[redacted]	Albuterol ~~nebulizer~~ inhaler treatment q 4°	02	
			06	
			10	5 Times
			14	
			18	
			22	
14 Aug	[redacted]	Albuterol neb treatments q 4°	04	[redacted]
			08	
			12	[redacted]
			18	
			20	
			24	
17 Aug	[redacted]	Elavil 25mg PO qHS	22	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Syncope/ T-4 c [illegible]

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

CPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 15345

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	b(6)-2				b(6)-2
	Benadryl 50mg PO x1 now for sleep	13 Aug	0130	0130	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
	Bisacodyl/Suppository/ DISD	10 Aug 0158
	Digital rectal stimulation	
	ĪD PRN.	
	Tylenol 650mg PO q4° PRN	1 AM 1 AM 4 Aug 5 Aug 10 Aug 6 Aug 6 Aug 7 Aug 8 Aug 8 Aug 9 Aug 10 Aug 10 Aug 10 Aug 10 Aug 11 Aug 0708 im
	Percocet 1-2 PO q4° PRN.	2 AM 5 Aug 5 Aug 5 Aug 5 Aug 8 Aug 8 Aug 15 Aug 16 Aug 17 Aug 17 Aug 18 Aug 18 Aug 19 Aug AM
	Fleets Enema PRN.	0080 x1
	Tylenol 650mg PO q4° PRN	12 Aug 12 Aug 13 Aug 13 Aug 15 Aug 16 Aug 16 Aug 17 Aug 17 Aug 18 Aug 18 Aug 19 Aug

USAPA V1.00

b(6)-2 AM

CLINIC RECORD

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

Mo. ___ Yr. ___

VERIFY ... ING

INITIAL PROPER COLUMN FOLLOWING EACH ~~ADMINISTRATION~~ Completion

ORDER DATE	CLERK/ NURSE	RECURRING ~~MEDICATIONS~~ ACTIONS, DOSE, FREQUENCY	HR	DATE ~~DISPENSED~~ Completed 18 19 20 21 22 23 24 25 26 27 28 29 30 31
17 Aug	[redacted]	Vitals q 8°	5	[redacted]
			13	
			21	
17 Aug	[redacted]	Activity ↑ HOB ad lib	5	
			13	
			21	
17 Aug	[redacted]	Log Roll q 2° - Pressure	5	
		reduction	13	
			21	
17 Aug	[redacted]	ROM (B) lower extremities	5	
		q 4°	13	
			21	
17 Aug	[redacted]	DSG △ BID to	10	
		back, dry	05	
17 Aug	[redacted]	Regular diet	07	
			12	
			17	

ALLERGI... ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Shrapnel T-4 Paraplegic

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

NKDA

PATIENT ... TION:

EPW b(6)-4 [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

FORM AG 771 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo. 8 Y 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18 19 20 21 22 23 24 25 26 27 28 29 30 31
17 Aug	[redacted]	Colace 100mg po BID	10	[redacted]
			22	
17 Aug	[redacted]	Zantac 150mg po BID	08	
			20	
17 Aug	[redacted]	Lovenox 40mg SQ QD	08	
17 Aug	[redacted]	Levaquin 500mg po qd x5d	22	DC'd
17 Aug	[redacted]	Albuterol neb 4x q4°	04	
			08	
			12	17 Aug 03 0815 EM
			16	qid
			20	
			24	
17 Aug	[redacted]	Elavil 25mg i PO qhs	22	[redacted]
		Errors		
		— September —		1 2 3 4 5 6 7 8 9 10 11 12 13 14
30 Aug	[redacted]	Colace 100mg PO BID	10	[redacted]
			22	
30 Aug	[redacted]	Zantac 150mg PO BID	10	
			22	
30 Aug	[redacted]	Lovenox 40mg SQ QD	08	
30 Aug	[redacted]	Elavil 25mg i po QHS	22	

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Paraplegic

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: [redacted] b(6)-1

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 78 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

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

CLINICAL RECORD

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

Mo. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29 30 1 2 3 4 5
30Aug	[redacted]	Colace 100mg PO BID (recopied)	10	[redacted]
			22	
30Aug	[redacted]	Zantac 150mg PO BID (recopied)	10	[redacted]
			22	
30Aug	[redacted]	Lovenox 40mg SQ BID (recopied)	10	[redacted]
			22	
30Aug	[redacted]	Elavil 25mg PO QHS (recopied)	22	[redacted]

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
Sheapnel, T4 paraplegic

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 15349

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 10 Yr. 03

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED								
20 Aug	[redacted]	Percocet 1-2 PO q4 PRN (recopied)	D/T/I	9/28/03 2300 [redacted]	9/29/03 2300 [redacted]	1011 2027 [redacted]	2001 2126 [redacted]	3rd 2000 2c	ALCT 0000	East 2145	
12 Sep	[redacted]	Phenergan 25mg PO Q4-6 PRN (recopied)	D/T/I								
	[redacted]	Tylenol 650mg PO Q4 PO PRN (recopied)	D/T/I	0001 2003 1335 [redacted]							
		~~Percocet~~									

USAPA V1.00

b(a)-2 b(a)-2

CLINICAL RECORD

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

MO. SEP YR. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15 16 17 18 19 20 21 22 23 24 25 26 27 28
30 AUG	[redacted]	Celebrex 100mg PO BID	10	[redacted]
			22	
30 AUG	[redacted]	Zantac 150mg PO BID	10	
			22	
30 AUG	[redacted]	Lovenox 40mg SQ BID	10	
			22	
17 AUG	[redacted]	Elavil 25mg PO qhs	22	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Paraplegic

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW b(a)-4

#[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 15351

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6) 2 - A1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
29 Aug -	[redacted]	Percocet 1-2 PO q 4° prn	29 Aug 1215 0430 3 Sep 0900 3 Sep 0330 5 Sep 1545 7 Sep 2343 7 Sep 1621 9 Sep 0507 9 Sep 2130 11 Sep 1100 13 Sep 2045
			[redacted]
12 Sep -	[redacted]	Phenergan 25mg po q4-6° prn	D/T 12 Sep 2340 13 Sep 0700 13 Sep 1845
			D/I 25mg 25mg 25mg
	[redacted]	TYLENOL 650mg PO q4° PRN	D/T 13 Sep 0700 13 Sep 1900 13 Sep 0000 15 Sep 1100 15 Sep 2115 18 Sep 1300
			D/I 650mg 650 650 650 650 650
14 Sep -	[redacted]	Percocet 1-11 po q4° prn	D/T 16 Sep 1430 16 Sep 2303 17 Sep 1325 18 Sep 0500 18 Sep 1530 19 Sep 0420 19 Sep 1530 19 Sep 2210 20 Sep 2200 21 Sep 0540 21 Sep 0950 22 Sep 2115 23 Sep 0550
			D/I T 2 11 2 [redacted]
4 -	[redacted]	Percocet 1-11 po q4° PRN	D/T 23 Sep 0SK 24 Sep 2130 25 Sep 2045 28 Sep 1200 28 Sep 29 Sep 2000
			D/I [redacted]

USAPA V1.00

Verified Initials

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
17 Aug [redacted]	Ambien 10mg po qhs x1 PRN	17 Aug	AS	NOT given	[redacted]
	b(6)-2				

Order/ Expir Date	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
15 Aug [redacted]	Robitussin elixir 2 tsp q 4° PO PRN coughing	15 Aug 2150 2 tsp [redacted]
17 Aug [redacted]	~~Ambien 10mg PO~~ Error em Δ Resp tx neb to PRN q 4°	
19 Aug [redacted]	Tylenol 650mg PO Q4° PRN	19 Aug 1200 650mg 1950 1330 650 650 650 650 650 2115 1300 1900 1845
20 Aug [redacted]	Percocet 1-2 PO q 4° prn	20 Aug 0125 2115 2005 2345 1957 0500 1845 0307 2020 0400 2245 0857 1400 2058 0552
20 Jan [redacted]	PERCOCET +-11 pr q4° PRN	1320 0445 1332 0425 0741 2215 1820 2045 1900 1429 2110

USAPA V1.00

[redacted]

ØZAUC

0600
3mm perrl
a/o x3 followed
commands appropriate
c staff, moves UE bilat
UE weakness, bilat LE paralysed.
ellen stable, o2 sat 97-99% @ RA
Ø SOB, CTA diminished basesbilat
Ø cough

1730 CBC
3mm perrl bilat
A+O x 3 moves
upper extremities
verbalizes needs
to staff
RR 12-20 c sats
@ 95-97% on RA
CTA bilat
Ø secretions

appropriate for race
tx progress note

Normal for Race
dsg's to (R) shoulder

(R) brachial
patent.

(R) Brachial H/L
patent Q.S/S
of infection

hypo BS x 4
Ø fluids per doctor
discomfort N/V/P

BS (+) x 4 quads
tol Ø fluids
[redacted] b(6)-2

FTG char stanker.
Ø BS.

Foley to gravity
QS clear yellow
urine.

NSR sr ectopy
S1 S2 +2 pulses bilat
UE & LE capref 4
<3sec

NSR sr ectopy
S1 S2 (+)
2+ pulses x 4 distal
extremities
Ø edema noted

b(6)-4

EPIC [redacted]

ØzAUG

	108/50	113/54	104/42	90/37
	108	102 101		101
	87	76	81	78
	18	20	18	14
SPO2	97	99	99	98
	RA	RA	RA	RA

T Max
PO
PR

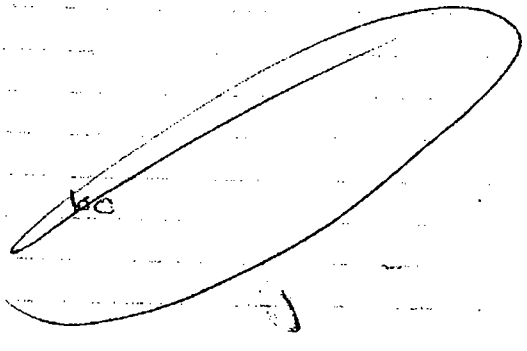
240 240

48 200 200 200

1500 225/170

240

210 200 190



20

107/50 101/49

18 16

73 93

96 98%

101 101.8

PB

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

		INITIAL SHIFT ASSESSMENT			
		Time:	Initals:	Time:	Initals:
N E U R O	Pupils				
	Sensorium				
	LOC / GCS				
C A R D I A C	Cardiac Rhythm				
	PRI: / QRS:				
	Pulse Strength				
	Cap Refil / JVD				
	Edema				
	Chest Pain				
R E S P	Respiratory Pattern				
	Breath Sounds				
	Secretions				
	Cough				
S K I N	Color				
	Integrity				
	Backside				
I V	Access Devices				
	Location				
	Condition				
G I	Abdomen				
	Bowel Sounds				
	Stoma/Ostomy				
G U	Device				
	Color / Clarity				

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU #1, [redacted]

DATE
(b)(2)-2

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

NAME: RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW
OTHER:

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

DA FORM 4700, MAY 78

MEDCOM - 15358

ICU Flowsheet	Patient Name:												Date: / / 2003												
Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature			99.9				100.0				100.0				100.2											
Pulse			76				80				79			78												
B/P A-Line																										
MAP																										
B/P Cuff			104/53				102/61				102/55															
Respirations			18				16				18			14												
02			94				100				100			100												
			RA				RA				RA			RA												
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF																										
PO intake			200		150	240	240				200															
O.R. IN																										
Totals																										
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly				800/850			1000		170/1170	125/295	150/445	250/695	1685	730												
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool												x1														
O.R. OUT																										
Totals																										

[redacted] b(6) - 4

24 hour input	
24 hour output	
24 hour balance	

1F00

Pupils Sensorem — Pearla 3 mm
Alert - x 3

Reg - even
CTA B/L
Ø

NFR
Intact warm dry

Saline lock @ FA
Patent c/s/s infiltration

soft - Flat - NT
BS ⊕ x 4 quad s

clear yellow

S1 S2 NSR

(b)(6)-2

Sgt [redacted] 9/C ⇒

[redacted] b(6)-4

APPROVED (Date)
ADDT 3 Mar 83
INITIALS

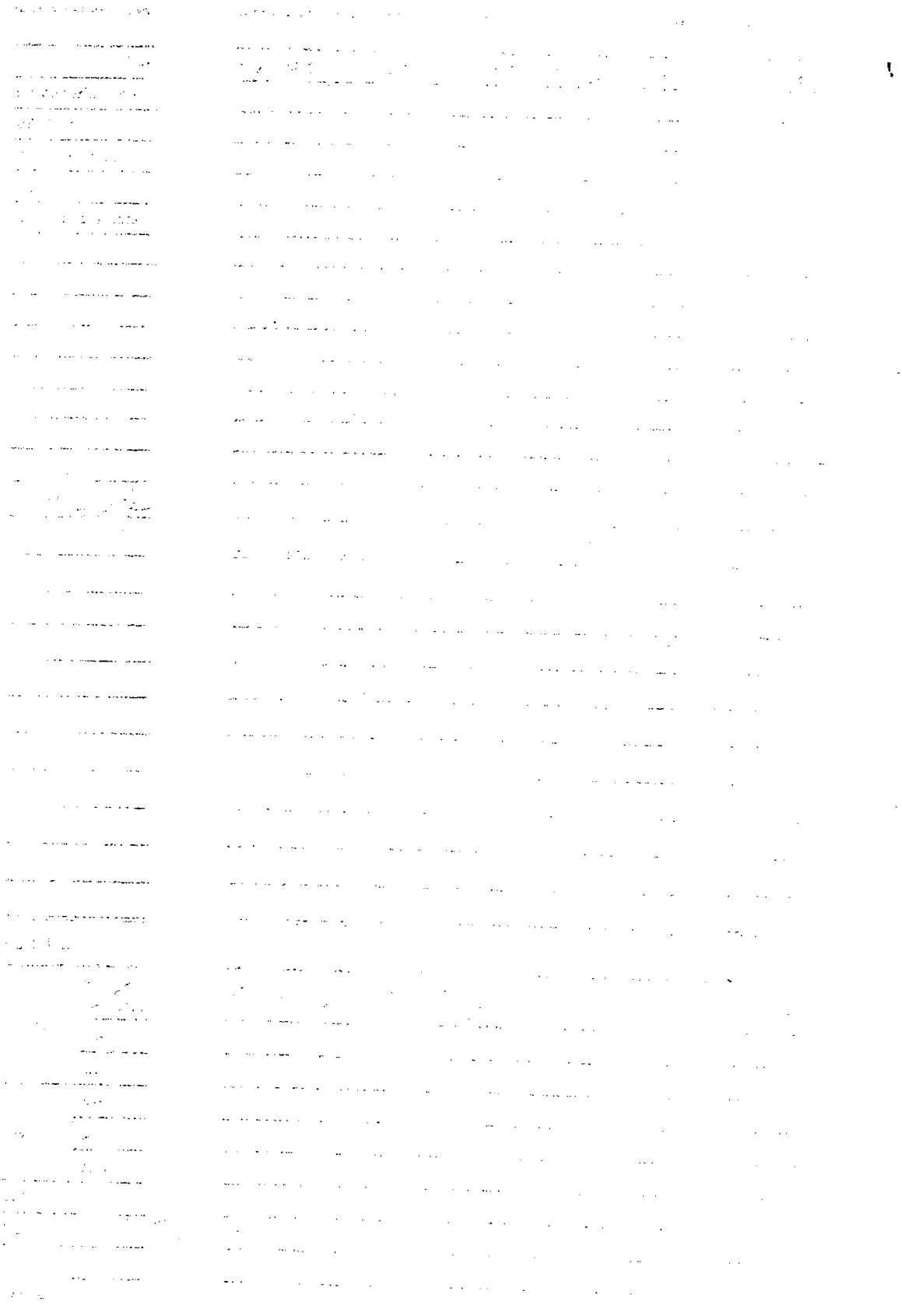
- Fractional
- Saturation
-CN - Tracheostomy

DATE
01 AUG 83

☐ FLOW CHAR
☐ OTHER (Spec

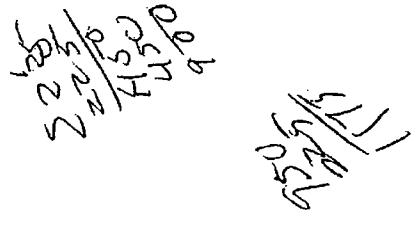
MEDCOM - 15360

ignated)
KC-NU)



	17	18	19	20	21	22	23
BP	98/47						98/47
T	101.2						100.9
P	82	86					73
R	16	16					18
SpO2	98	96					97

URine 450 225 225 950 225 115



MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		Time: 0530 Initals: [redacted] b(6)-1	Time: Initals:
N E U R O	Pupils	3 Reactive	
	Sensorium	Follows simple commands	
	LOC / GCS	A&O	
C A R D I A C	Cardiac Rhythm	NSR	
	PRI: / QRS:	$S_1 S_2$	
	Pulse Strength	+2 x4	
	Cap Refil / JVD	< 3sec	
	Edema	Ø	
	Chest Pain	Ø	
R E S P	Respiratory Pattern	WNL	
	Breath Sounds	Clear diminish throughout	
	Secretions	dry cough	
	Cough		
S K I N	Color	normal for race	
	Integrity	Intact	
	Backside	dressing CDI	
I V	Access Devices	R arm PIV	
	Location		
	Condition	CDI	
G I	Abdomen	Soft not distended	
	Bowel Sounds	Hypoactive x4	
	Stoma/Ostomy	Ø	
G U	Device	Foley	
	Color / Clarity	Clear yellow urine	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC b(2)-2
ICU #1, [redacted]

DATE 08/04/03

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

NAME: [redacted] b(6)-1 RANK: AGE:

UNIT: GENDER:

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

OTHER:

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

DA FORM 4700, MAY 78

MEDCOM - 15365

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE	OTSG APPROVED (Date)
INTENSIVE CARE NURSING FLOW SHEET	QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(6)-2	Time: 1730 Initals: [redacted] b(6)-2
NEURO	Pupils	3mm Reactive	
	Sensorium	follows Commands	Alert/Oriented
	LOC / GCS	A1Ox3	coherent/cooperative
CARDIAC	Cardiac Rhythm	NSR	NSR Ectopy
	PRI: / QRS:	S1S2	S1S2 only
	Pulse Strength	+2	
	Cap Refil / JVD	<3sec	
	Edema	Ø	Ø
	Chest Pain	Ø	Ø
RESP	Respiratory Pattern	Unlabored regular	eunl/unlabored
	Breath Sounds	CTA	CTA bilat
	Secretions		
	Cough		
SKIN	Color	WNL	NTR
	Integrity	Intact	intact
	Backside		
IV	Access Devices	(R) Bicep	(R) bicep
	Location		
	Condition	CDI	patent/benign
GI	Abdomen	Soft Not Distended	soft, NT, ND
	Bowel Sounds	Quadrant hypoactive	(+)X4
	Stoma/Ostomy		
GU	Device	Via foley	foley
	Color / Clarity	clear/yellow	cl/yellow

(Continue on reverse)

2/9/12

PREPARED BY (Signature & Title) [redacted] LDN

DEPARTMENT/SERVICE/CLINIC: ICU #1, [redacted]

DATE: (b)(2)-2

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

NAME: #[redacted] b(6)-4

RANK: AGE:

UNIT: ICU

GENDER:

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

OTHER:

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

DA FORM 4700, MAY 78

MEDCOM - 15366

ICU Flowsheet

Patient Name: EPW [redacted]

Date: 3 / Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	101.3				100.8				99.8					100.2				101.5		101.3				98		
Pulse	86				89				77					81				85		75				84		
B/P A-Line	104/53				105/51				99/52					95/47				109/53		114/59				118		
MAP	73				71				69					66				71						99.0		
B/P Cuff																										
Respirations	18				20				20					17				20		18				18		
Sa02	100				100				100					97				98		97				97		
	RA				RA				RA					RA				RA		RA				RA		

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF																										
PO intake																				200		100				
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	800/500				600/1320									1005				450						300/1250		058
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 0 1	I Z	(b)(6)-4		M

3. REGISTER NUMBER	6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]			Z	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		~~9~~ 9 26	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	1415	NA b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I Z			YEAR ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE [illegible]	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
2 4		0 3 1 0 0 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
		0 3 0 7 2 7

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

FOR LOCAL USE

DX: SHRAPNEL T-4 PARA

b(6)-2

ADMITTING OFFICER (Signature, as required): [redacted] MD per DR [redacted] b(6)-2

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

DA FORM 3985 MAR 89

MEDCOM - 15368

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW F[redacted] b(6)-4	NO	

SEX	AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	37y	unk	Muslim	NO	NO	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	unk	unk	ICU2

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO		K78	NO	unk	Surg

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Ø	0110	ABOA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	21	030803

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
	unk	030730	

29. NAME AND LOCATION OF [redacted] b(6)-2	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030730	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to abdomen

863.52
863.1
863.31
866.10
863.99
782.4
E991.2

782.3
782.4
780.5
263.9
288.0
287.5

Complications
998.0
518.5
998.59

30 Jul 03
45.74
42.6
45.62
55.51
54.75
96.72
99.04
1 Aug 03
86.28

Blood given - yes

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	5	5

36. Total Days All Facilites

a. ABSENT SICK DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	[redacted]	5	5

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

DA FORM 3647, MAY 79 MEDCOM - 15369

USAPPC V1.10

ABBREVIATED MEDICAL RECORD

[redacted] b(6)-4

ADMISSION DATE *(YYYYMMDD)*: 30 July 03

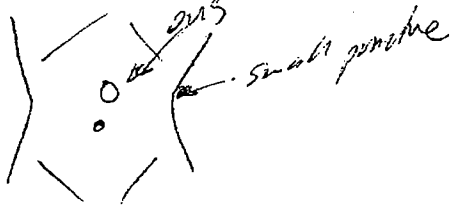
2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

GSW L & GSW to abdomen & extremities. Shot @ marines who returned fire until wounded.

[redacted] b(6)-2

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

lungs CTA, bilateral
RRR, no MRG
Abd soft, NT, ND, + BS
legs cool/dry
pulses palpable
legs move/sensate
Back/spine



4. IMPRESSION *(Enter admission note with plan on progress notes)*

GSW abdo & extremities
Neurologically intact
Plan to OR for ex lap
CXR clear
NPO
Pain control
Plan for bilateral chest tube insertion

5. ADMITTING OFFICER

a. SIGNATURE: [redacted] 2LT b(6)-2

b. DATE SIGNED *(YYYYMMDD)*: 30 July 03

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

b(a)-2

NSN 7540-00-634-4176 — THORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
30 Jul 03 0530	Pt rec'd in ICU2 for recovery phase. See OR 4700 PACU flowsheet for information during recovery. — [redacted]
30 Jul 03 0700	Pt remains sedated vent SIMV R12 P5 TV 800 50%. IVF @ infusing @ 150/hr. Auscultating BBS CTA c minimal secretions faint palpable distant pulses. T 91.3 Abd c midline abdominal dressing c blood to midline area. OGT LIS c bloody secretions. (R) SC cordis, (L) EJ and (L) AC 18G. NS flds infusing. JP drains to (L) lateral abd area to bulb suction. foley cath to BSO SBP ranging from 80-90's c DBP 50-70's. No movement by patient. Copious amt nasal secretions. Will cont to monitor — [redacted]
30 Jul 03 0730	Pt rec'd 2u FFP per Dr [redacted] Continuously emptying JP drains. output from JP#1 > JP#2. Tachycardic HR 100's SBP 90's Will continue to monitor — [redacted]
30 Jul 03 0925	Started versed gtt @ 3mg/hr titrating to effect and MSO4 gtt @ 3mg/hr titrating for pain control. Rec'd 500cc bolus @ 0825 — [redacted]
30 Jul 03 1040	Labs drawn, 1 amp NaHCO3 given @ 1020. Vent currently @ TV 800 R14, 40% SIMV P5 Continuing to receive bolus of flds. Angel Weston
30 Jul 03 1255	Pt receiving 1U PRBC VSS throughout transfusion. Remains Tachy 120-130's SBP 110's. No distress noted — [redacted]
30 Jul 03 1300	T 97.2 BP 113/76 HR 122 1305 T 97.3 BP 116/74 HR 121 [redacted]
30 Jul 03 1500	Pt received 2u FFP Tolerated transfusions c complication. Remains on versed @ 3mg/hr MSO4 3mg/hr. JP output reported to surgeons — [redacted]

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

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

REGISTER NO.	WARD NO.

b(a)-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 - 15371

b(6)-2 AM

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
30 Jul 03 1600	Pt c Tmax 99', BP 116/63 HR 120's. RR 14 SpO2 100% on vent IVF NS @ 150/hr. NGT 200cc output urine concentrated dark yellow in color Lab results reported to MD. Flds infused via Fld warmer (Level 1) throughout the day until temp greater than 97°F Level 1 discontinued @ 1600. 518's submitted for SUPPSC — [redacted] JLTAN
30 Jul 03 1640	Pt taken to OR per anesthesia service — [redacted] JLTAN
2155	Pt returned from OR @ 2050, bolus 500cc LR Started NS @ 150cc/hr. labs sent - CBC, Met 12, Coags ABGs. Pt had 700cc UOP, 210cc out of JP#1. Pt sedated c Versed + MSO4, Pupils 3mm, non-reactive, sclera edematous withdraws from painful stimulis. ST 120's S, S2 ø murmur ø ectopy, B/P 110's/60's pulses 2+ all extremities skin cool + dry, placed under warming light. #8 ETT 24cm @ lip SIMV R-20 TV 550 FiO_2 80% Sats 99%. Lines (R) subclavian cordis, (L) EJ, (L) AC 18G, (R) Femoral A-line. Abdomen covered c bulky dsg to be packed W/L BID Starting tomorrow. Ostomy c bag in place drng sanguinous fluid. (L) Jejunostomy tube, (L) duodeobstr tube, JP x2 to (L) lat abdomen. Foley drng dk amber urine sufficient amts. Will monitor [redacted] JLTAN
2200	Vent settings Δ'd to SIMV R-22 and lamp Bicarb given as ordered. Will obtain ABG in 30min. Will monitor — [redacted] JLTAN.
2220	Warming bags placed under pt arms to ↑ temp. Will monitor. [redacted] JLTAN
2330	Pt MAP 59-60, bolus NS 500cc given Pt temp up to 96.5. LS bilat exp wheezes c rhonchi. Will monitor. — [redacted] JLTAN

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 15372

b(6)-2 +11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Jul 03 0000	18G @ AC not flushing - pulled. BP 77/41, 2nd 500cc NS bolus given, sedation down to 1mMSO4 1ml Versed - pressures up to 88/46. Will cont. to monitor. [redacted] ILTAN
0200	Pt more responsive, spont. movement of arms + legs, versed gtt up to 2ml/hr. VSS. Will monitor. [redacted] ILTAN
0400	Pt moving extremeties, sedation increased, labs + ABG done, AM care done. VSS. Will monitor. [redacted] ILTAN
1 Aug 03 0825	Surgery #1 Atbrite mAPs < 60: responded to vol 97/57 128 veg 1/0 @ 0600 2400
3 Aug 3:375	edematous conjunctiva, anuretic Mg 55-75 cc/h
	lungs clear / sym vent rate 20/600/60/5 73/36/51/17-6
3 Aug Fri 8/8	0815 / 0820 / 0830 6 > 44 70
	OBS, Rin, wound clean, serosang drainage 149 / 3.4 | 119 / 17 | 28 / 1.5 | 114 | 5.5 | 29 / 47
Mon 4 Aug 04	Legs w/D / sensation / pulses sym on @ 0945
IVF NS 150/h	hyp. Intravascularly dry hyperbilirubinemia / amylasemia - 2° manipulation / blunt injury
	Plan Sedation / Vent ventilation / Nutrition feeds / Follow Labs [redacted]

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

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

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 July 03 10:00	Pt S/P (L) nephrectomy, Colon, resection, Gastric resection, ex-Lap. Pt unresponsive due to sedation, VSS. HR Tachy @ 130's & 140's, Bp 90's/50's, Map 60's, 70's. To 3L Bolus of NS, 1gm $CaCl_2$, 1/amp Bicarb. Sats 100% on vent. Settings: S;MV RR 20, Peep 5, TV 600, FiO_2 60%. Lung Sounds present in all fields. Pupils 2mm Non-Reactive. Heart Sounds S_1, S_2 present & Murmur. Bowel Sounds hypoactive in LLQ, Not present in RUQ, RLQ, LUQ. Colostomy in RUQ Draining Brown liquid @ 50cc/hr, Duodenostomy draining brown liquid @ approximately 25cc/hr. 2 Jp drains in place on (L) side. #1 Draining blood tinged fluid at approximately 13cc/hr, #2 Draining blood tinged fluid approximately 20cc/hr. ~~Foley in place~~ [redacted] ~~PM~~ Drsg to Large midline abdominal incision d/d this am by Dr. [redacted]. Incision closed c staples. Foley in place draining approximately 55cc/hr of Amber urine. 2+ ~~pitting~~ Non-pitting throughout all extremities. Pedal pulses unable to palpate, present c doppler. Radial pulses 1+ barely palpable. Ng tube in place draining Approximately 12cc/hr brown fluid to Low intermittant suction. Pt c (L) EJ patent & 3 S/S [redacted] Continued

b(6)-2

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

DEPART./SERVICE ICU #2 | HOSPITAL OR MEDICAL FACILITY 28th CSH | RECORDS MAINTAINED AT b(6)-2 [redacted]

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Continued	of infection. (R) subclavian cordis patent & 3 s/s
31 July 03	of infection. (R) Femoral A-Line patent & 3 s/s of infection. 10:30 pt recieved 5% Albumin in 500cc NS. Suction ET Tube and Nares PRN HOB 15°. Will Continue to Monitor. [redacted] LPN
31 July 03 11:45	Jevity started in J-Tube @ 5/cc/hr. Will Continue to Monitor [redacted] LPN
31 July 03	Addendum: Patient given 5% Albumin 500cc NS @ 1030hrs followed by 2g MgSO4 in 100cc NS IVPB. [redacted] CPT/LPN
31 July 03 @ 1145	Given 40mg KCL in 100cc NS over 2hrs for K+ of 3.6. Will F/u w chem panel to check pt response.
31 July @ 1300hrs	Given 500cc LR bolus to address ↓ intravascular fluid load → third spacing @ this time [redacted] RT/LPN
31 July @ 1430hrs	K+ now 4.7 p KCl over 2hrs (1145-1345hrs). [redacted] RT/LPN
1745	Pt. sedated Versed @ 4 ml/hr, MSO4 3ml/hr, pupils 2mm non-reactive Sclera edematous, withdraws from painful stimuli. ST 120's B/P 98/48, MAP 67. Hespan 500cc infusing NS @ 150 ml/hr to (R) SC cordis. (L) EJ + (R) fem A-line intact. pulses 2+ all palpable, 3+ pitting edema. #8 ETT 24cm @ lip SIMV R-20 FiO_2 60% Peep 5 TV 600 sats 96% LS coarse c exp wheezes bilat. (R) nare NGT → LIS drng dk green fluid. (R) colostomy drng sanguinous drng, JP x 2 (L) lat abdomen drng serosanguinous fluid, J-tube infusing Jevity @ 5cc/hr tol well, Duodenostomy tube drng sm amt dk yellow drng. Foley drng dk amber sufficient amts. Abd dsg intact & dr's noted - to be c'd BID w → D. Will monitor. [redacted] LPN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2 AIV

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31Jul03	Pt Sats 93% suctioned for sm amt thin clear secretions,
1920	RT called to admin. neb tx. Will monitor [redacted] LTAN
2020	ABG done paO2 56 - FiO2 turned up to 80%
	Sats 93% RT gave Atrovent neb. NGT flushed
	and suctioned 425 cc fluid - possible clog? VSS
	at this time, will monitor: [redacted] 1LTAN
2145	TLC placed through cordis by Dr. [redacted], CVP
	transduced to be 18. Vent settings Δ'd ↑ peep 12.
	obtained ABG- paO2 73 Dr. [redacted] aware.
1Aug03	Pt dsgs Δ'd, abd staples intact, open area packed
0100	W→D, appears necrotic c foul smelling odor.
	ETT holder changed, pt bathed. NGT flushed
	and returned 340cc foul smelling drng. Will
	moniter. VSS. [redacted] 1LTAN
0400	Pt sedated, VSS. labs sent. will moniter. [redacted] JAN

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	Nursing Notes Cont:
1400	Temp 101.6 Dr [redacted] aware. Tylenol 650 mg PR & colostomy open
1415	Blood drawn for abg. results & aware Pt was bed made comfortable
1430	Bed changed to reg hospital bed and placed on Vent #2
1635	Dr [redacted] aware of Pt's Lab results. FiO2 50% IMV 16 Pt sat 93-95%
1700	via pulmonary tube 1 amp Sodium Bicarb given PH 7.32 PCO2 38.4
1720	HCO3 19, ABG, Chem 7 to be repeated at 1750 & Pt's bed of bed #30 AM distressed. Versed drip at 4mg/h MSO4 at 3mg/h Continues IV abx at 12 each continues. Report given to relief nurse [redacted]
1 Aug 03 1810	Received report from RT [redacted]. Pt in supine position. Neuro Sedated c Versed @ 4mg/hr and MSO4 @ 4mg/hr. 3mm bilaterally and brisk ∅ response to painful stimuli. Resp Vent SIMV 16 TV 600 FiO2 40% PEEP 10 RR 16-20 c pt spontaneously breathing 2-4 over the vent SaO2 currently @ 93%. ETT #8 24@ LIP inline suction resulting in minimal yellowish tan secretions. BS are clear @ apices c diminished bases. CV Pt currently ST c HR of 130s-140s ∅ ectopy S1, S2 present c BUE pulses 2+-3+ BLE 2+-3+. Cap Ref. U Brisk throughout c warm extremities. Generalized Edema c injected sclera and 2+ pitting edema throughout 3+ scrotal edema. GI NGT to (R) nare draining to LIS. c greenish yellow drainage. Midline incision c dressing intact. (R) colostomy c liquid brown drainage. J-tube c feeding @ 55cc/hr of Perative. Duodenum draining to gravity to foley green yellow drainage. GU Foley to Gravity draining > 55cc/hr of dark amber urine. Skin Midline incision

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

#[redacted] b(6)-4

RECORDS MAINTAINED AT:

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

RELATIONSHIP TO SPONS[redacted] — STATUS — RANK/GRADE

SPONSOR'S NAME — ORGANIZATION

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 15377

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

b(6)-2 Att

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	dressing intact no drainage noted at this time. Lines (R) Cordis c TLC to RIJ c CVP monitoring and NSOL / Versed to proximal port Cordis c NS @ 125cc/hr. LEJ. (R) Femoral A-line. Pt currently sedated and stable will continue to monitor. [redacted]
1730	ABG Sent c Met B. Results attached to chart. M.D. [redacted] notified of ABG. Vent Δ FiO_2 ↑ to 50% and second ABG drawn. [redacted]
1827	ABG Sent. Results attached to chart. M.D. [redacted] notified of ABG. Vent Δ FiO_2 ↑ to 60% and monitor to keep SaO_2 > 95% per Monitor. [redacted]
1900	Tmax 102. [redacted] Pt given Tylenol 650 mg per colostomy and did not work. The Tylenol was not absorbed. Tylenol 650 mg per PR given. Will monitor Temp [redacted]
1935	VENT changed per [redacted] secondary to inadequate delivery of TV. Pt setting @ 600 and pt receiving b/t 450 - 465. Pt oxygenated c BVM on 100% FiO_2 during VENT change, VENT changed successfully and pt placed back on VENT c adequate TV delivery. [redacted]
2000	↑ new NS 1000cc bag @ 125cc/hr. [redacted]
2100	Tmax 101.4. Will continue to monitor [redacted]
2330	Pt dressing Δs to abdomen and JP sites changed. Abd dressing removed. Staples intact c wound open centrally to staples. Tissue is ashen c few areas of pink/red tissue; Area packed c 4x4 soaked in Dakin's solution and covered c abd pads. JP sites to (L) side x2 and (L) Flank x1 covered c 2x2 (2) and 4x4 (1). All JP sites are free of redness / signs and symptoms of infection. Midline wound intact will monitor for drainage [redacted]
2350	Oral care done, ETT E-Tab changed. Pt has foul malodorous breath c traces of greenish brown particles suctioned c yankauer.

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1Aug03	Received Pt #512 in Icu 2 Bed #3. No response to deep pain noted.
0900	Pupils 3 mm. Cardiac monitor shows Sinus tachycardia. HR 120's. BP 90/60 110/70 MAP ≥60 CVP 17-23. Skin all pale/dusky pulses ⊖ Introduced 7 FTLC to right SC. Blk intact ⊖ S/S of infection or infiltration. IV NS at 125 cc/h infusing thru side port. Versed dripping Y/gtt infusing to left External Jugular IV access Blk intact. IV MSO4 at 3 mg/h infusing to ⊖ ES Skin intact. Arterial line to right femoral artery. Blk intact. arterial bleeding and NIBP correlates CVP and Arterial lines Zeroed. Pt has generalized edema. Pt orally intubated #8 ETT at 24 cm lip line Vent SIMV 20 TV 600 Resp 12 FiO2 60% Bilateral breath Sound clear with diminished lower lobes Equal Chest Expansion noted. Resp 20 Sat 99% via pulse oximeter. NO Signs of any distress noted. Foley Temp Tube in place thru Right naris Low intermittent suction. greenish Noted in drainage Bag in commister. Blkd Abdominal dressing dry and intact. (Midline abdominal Duodenostomy drain to left lower abdominal quadrant draining yellowish bile to bag jejunostomy tube to left mid abdominal wall intact with Jevity 60 cc/h infusing. Two JP drainages to Right side of Abdomen Dressing to Right side of abdomen covering JP Tubes Duodenostomy and jejunostomy tubes. Dressing clean dry and intact. Bowel Sounds not heard Skin intact except for Surgical wound to [redacted] LT Bk
0730	Pt's condition unchanged Dr [redacted] Visited and examined Pt. Discussed with Pt's
0900	family Lab results. Pt Continued Post Surgical Care Instructions noted. [redacted]
1030	Dr [redacted] Visited and examined Pt. Midabdominal dressing changed Dr [redacted] Debrided abdominal wound. Both JP's discontinued by Dr [redacted] Dressings applied to the
1700	Pt's condition unchanged FiO2 @ 60% Bleeding well suffused via endotracheal exam [redacted]

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

EPW# [redacted]

RECORDS MAINTAINED AT:

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 15379

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)
1 August 03	Surgery Required more oxygenation last PM, otherwise stable
1030	Admit 100-120/50-60 126 mg/kg/min 8653/4014
	pancreas SP 155 (10cm/5° yest) A_1 → 100 cm/0
	nephrectomy SP 345 (35cm/3° yest)
Adriamycin	duodenostomy rod rubber 575cc; D/ing last 10 hours.
Zantac 50/8	anuric, edematous 43 → 33 → 69 PT/PST 27/40
MSO4/Versed	lungs CTA & exp wheeze @ / Sym 151/3.5/18 | 120/2 | 151/<2> 2-3 89/42
IVF 125cc/° NS	Resp ⊖n any 1200
Zosyn 3375/6°	⊖ns, right 20/600/.6/12 732/37/126/19/-7
	wound & necrotic margins; fascia intact
	legs w/ 0/pulses symmetrical, anasarca 9-1.3 = 5 / 2.7 / 8 / 2.16 / 5.8
	Ca - 8.96
Mean AP 17-19	Lungs: Coarse rhonchi - CTA except c Rales c/ Y gastrojej
	Shock & third space - seems nearly over now
	sedated/analgesed adequately - moved & SP removed early
	A/Sm - lungs wet extravascularly 2° 3rd space
	CV - stable; euvolemic
	GI - tol trophic feeds only; duodenostomy tube not draining,
	? wether has been pulled out of duodenum.
	renal: Cr stable, good UO, Ca+ corrects to 8.96
	ID - afebrile
Plan:	Continue MSO4/Versed/Abx Admitted neuro checks @ bedside.
	add albuterol to adverse resps q 4°
	Cont trophic feeds
	d/c JPs
	add mvi/Pepcid
	Wean Fio2 to keep Sao2 ~ 95%, does not retain CO2
	Cont in prep with "shock" phase over 5(a)-6
	D Dalton subq w→p ankle dsgs BID. [redacted]

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

TAN[redacted] 10 FORM 600 BACK (REV. 5-84)

MEDCOM - 15380

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23 to (CONT'D)	Pt tolerated mouth care well. SaO_2 maintained > 94% during oral care and E-Tab change. Will continue to monitor. [redacted]
2 AUG 03 0200	ABP 89/48 MAP 63 NIBP 98/44 MAP 66. Pt FiO_2 ↑ to 70% for SaO_2 of 94%. Will continue to monitor. [redacted] blw-2
0221	Dr. [redacted] notified of Pt SaO_2 @ 9[redacted] of FiO_2 to 70% and PEEP of 10. PEEP ↑ to 12. Will monitor for ↑ in SaO_2 [redacted]
0500	Summary of shift. At 0300 pt ABP 85/49 HR 1[redacted] RR 20 SaO_2 92%. Dr. [redacted] notified of ABP and SaO_2. At 0300 PEEP ↑ 15 IMV ↑ to 20 and pt received a 500cc Bolus ~ VS @ 0315 128 82/52 MAP 65 RR 20. ~~(At 0330)~~ SaO_2 94%. At 0330 Pt PEEP ↓ to 13 and Dopamine started @ 5mcg/kg/min ~ VS @ 0345 124 81/53 MAP 66 RR 20 SaO_2 96. At 0400 pt Dopamine ↑ to 10mcg/kg/min d/c to ↓ MAP of 59-60. 1g Calcium Chloride IV over 5 minutes for ↓ BP and ↓ response to dopamine. Pt received 2nd 500cc Bolus per MD and MEVF ↑ to 150cc/hr. Vent changes made ↓ IMV to 16 and ↓ Dopamine to 3mcg/kg/min for VS @ 0405 125 110/61 MAP 82 RR 20 SaO_2 95%. Currently Pt VS 133 99/52 MAP 71 RR 16 SaO_2 94%. Continue to monitor and maintain MAPS > 60 and SaO_2 > 95%. Dr. [redacted] will return to see pt @ 0700.
CE 0330	Duodenum feeding stopped and tube to gravity w/ foley bag 2° to Clogged tube. ~~CCT~~ Attempts made to unclog tube by

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] blw-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
	Dr. [redacted] without success. Tube to remain to gravity until further notice from Doctor [redacted].
0520	Report given to day shift c update. [redacted] b(6)-2
28 Aug 03	Surgery
0900	① Pt had L CVP & MS bottom, responded well to volume.
	② However, oxygenation continues to worsen; on 100 % & 13 PEEP
MSO4/Versed 4/4	last PM to keep Sats >95% ③ Feeding jej closed-opened.
Zantac 50/8	T max 102.2 → 101.6 80/15/90 130 reg to 337.2/285
Zosyn 3.375/6	amniotic, injected, PRN MS 50-100 q1°
Albut/Atrov q4	lungs clear, distant; Symm accelerations min
MVI	RRR, Sm edost 160 cc/24°
Fe	Abd, tight, 2.6 → 29.6 80 156/3.7 129/16 35/2.7
dopamine 3 mcg/kg/min	wound c necrotic fat & necks 21/5% 69/14 amy
INF 150/0 NS 125	legs c/d/ anasarcic, pedal pulses dop @ Symm
	imv 20/600/100/13 7.34/30/65/17/-9
	Impr: Cardiac sig SOSW c multiple viscus injuries
	febrile - etiology; wound? intraabdominal? pulmonary? - on Abx
	respiratory failure / decomp.
	shock / malnutrition / leukopenia / thrombocytopenia
	Improving hyperbilirubinemia improving & anyloscemia
	Plan: 1. Keep sedated -
	2. Restart TF, add flushes q 4°
	3. Colloid resuscitation - use salt poor albumin
	4. May add pressor if oxygenation worsens b(6)-2
	5. Wean vent slowly - lost ground will be hard to recover.
	6. Debride wound & continue Dakins
	7. Read by [redacted] MEDCOM - 15382 iron toxicity [redacted]

STANDARD FORM 509 (REV. 5/1999) BA
USAPA V

NSN 7540-00-634-4178 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03	Received Pt #572 in Den 2 Bed #2 c A responds only to deep pain from suctioning
0530	Rapid 3 pm breaths. Cardiac Monitor shows sinus tachycardia HR 130's. BP 90/40-50's MAP 60 @ 500. Pt has generalized edema 3+ pitting. TL C with Sidepart to R/J 18 Fr
	IV NS 150 cc infusing to sidepart. Versed drip at 4 mg/hr and Morphine drip at 4 mg/hr infusing to whiteport. Dopamine drip at 3 mcg/kg/min infusing to 3 lumen
	site intact. No signs of infection/infiltration noted. A-line to right femoral site
	& the intact A-line correlates with NIBP. All peripheral pulses @ 5/5. Pt
	orally intubated #8 ETT 24 cm at lip line Vent Setting SIMV 16. TV 600 Resp 13 FIO2 100
	Bilateral breath sounds clear but diminished Equal chest expansion
	noted. Resp Rate 16 Sat 95% via pulse oximeter. Suctioning produces scanty &
	secretions, beige. @ bowel sounds. Foley catheter to bedside draining amber urine. Pt has
	jejunostomy tube to left lower abdominal wall connected to gravity drainage.
	Duodenostomy tube to left upper abdominal wall to gravity drainage. Colostomy
	to Right abdominal wall intact. Midline abdominal surgical wound covered
	with Dry dressing. Dressing covering jejunostomy and Duodenostomy Site. Old Sero
0700	sites oozing fluid covered. Dr Sam visited Pt & is aware of Pt's labs results. He
	ordered Dopamine drip @ 5 mcg/kg/min. Albumin 5% in 250 cc NS ordered and
0800	given. HR 129 BP 96/53 MAP 72 Dopamine drip increased to 7 mcg/kg/min to
b(6)-2	Keep SBP > 100 mm Hg. Tylenol Supp 600 given at 6 am for temp 101.6 [redacted] CT
0830	Dr [redacted] visited and examined Pt. Fio2 @ 80. Pt tolerating changes and 95-97% via
0930	pulseox. Mid abdominal dressing changed. Tube feeding restarted at work. Blood
1000	drawn and sent to Lab for ABG and chem 7. ABG at 95-97%. PH 7.261 PCO2 45.4
b(6)-2	PO2 168 HCO3 18. Chem 7 Na 139 K 3.6. Dr [redacted] informed. [redacted]

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

[redacted] b(6)-4

RECORDS MAINTAINED AT:

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 15383

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)
3 Aug 03	NSG Notes Cont'd.
1045	D50. 1 amp SBP given. Rec'd TV #620. FiO2 2 70 %. ABG and chem 7 to be drawn
11:15	at 11:15. Labs drawn for ABG PH 7.24 PCO2 46.1 PO2 107 HCO3 18 Na 157 Cl 124
	DR [redacted] aware. 1 amp Sodium Bicarbonate IV given Pt is IV fluid changed to LR 150 cc
1215	then to D5 [redacted] 3 amps NaHCO3 @ 150. BP Labetalol 10/55 Dopamine drip 4.5 mcg
	kg/min. then 7.5 mcg/kg/min DR [redacted] to bedside MSO4 and Versed drip
1300	up to 3 mg/hr. Dopamine drip @ 10 mcg/kg/min. ABG 7.347 PCO2 29.1
1400	HCO3 16 DR [redacted] aware of Pt's condition and labs. [redacted] ICT
1430	BP 84/48 increased to 92 Dopamine drip @ 15 mcg/kg/min [redacted] ICT
1600	T 101.2 Tylenol supp. 650 mg given. Pt to OR. BP 115/60 (65) Labs drawn ABG,
	chem 7. awaiting results. Pt's antibiotics changed started on cipro
	flagyl and ampicillin. ABG 7.346 PCO2 35.7 PO2 75 HCO3 20. FiO2 42%
1600	Na 156 Glu 94. Pt to OR 1605 BP 89/46 (65) Dopamine drip tapered down to 10 mcg
1635	kg/min. AC out Room (cont'd) Very hot. Temp Taken 107. Ice placed on
	groin, jugular vein, armpits. Sponge bath given will retake Temp in an
1700	hour. Pt's condition unchanged Versed & MSO4 continues at 3 mg/hr Dopamine
	continues at 10 mcg/kg/min IVD5W 1/2 3 Amp NaHCO3 at 150 cc/hr. Family at
	bedside. Report given to relief Nurse who will follow up with Pt's temp.
	[redacted] ICT
2030	Pt sedated c MSO4/Versed 3+3 ml/hr, pupils 2mm non-
	reactive, sclerea edematous + jaundiced. ST 130's
	c frequent PVC's @ murmur, Levophed @ 4 mcg/min,
	Neo Synephrine @ 250 mcg/min, Dopamine @ 5 mcg/kg,
	D5W c 3 amps NaHCO3 @ 150 ml/hr, B/P 70/40's MAP's
	60, titrating gtts to maintain MAP >60. 3+ pitting
	edema, pulses 2+ all extremeties. T max 105.3, given
	Tarodol 15mg IVP as ordered, 500 cc NS bolus, 250 mg
	5% Albumin. (D) ET, (R) SCTLC + cordis, (R) Fem
	A-line, (R) nare NGT to LIS, J-tube infusing

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

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 15384

NSN 7540-01-075-3786

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

LOG NUMBER [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 37

ARRIVAL

DATE *(Day, Month, Year)*: 30 JUL 03 | TIME: 0110

TRANSPORTATION TO FACILITY

MILITARY STATUS

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

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: None PMH Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to ABD

CATEGORY OF TREATMENT

- ☒ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

TIME: 0110

IN: [redacted]

VITAL SIGNS

TIME	0110	0118				
BP		75				
PULSE	116					
RESP	24					
TEMP						
WT						

LAB ORDERS

- ☒ CBC/DIFF
- ☐ URINE C&S
- BLOOD C&S X
- 0118 foley
- ☒ PT/PTT
- UA MSCC/CATH
- ☒ BHCG/URINE/BLOOD/QUANT
- ☒ CHEM: met 8
- X Quality Types & Cross

X-RAY ORDERS

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

ORDERS

☒ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0118	100mg Lidocaine	[redacted]	PMR		Pt Sedated
0120	50mg Fentanyl		PMR		
	Ancef 1gm IV				
	Foley to gravity				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☒ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] EPW

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP O2	PH	PO2	RESULTS	
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

37 y/o ♂ GSW to RUE x 2 ORIF JPTA. Pt VSS & HR,

P

A: OP/oro clear/pat comp'd, neck spnl, pressure
B: CTA (P) = symmetric
C: (+)2 rad pulses (P), ϕ active ext exsanguination.
D: AGrt to eyes/f GCS 15
E: (+) GSW (L) ant T-12 flank, (+) entry mid abd
Foley placed = clear/yellow.

Labs (P)
Xrays (P)
(C) Tues of
OR admit

S: Heart rate, BPs wnl Head atraumatic
~~Ext~~ S/T dysmetria (R)
Abd: (+)distention ↓ BS, rectal NL tone, ϕ gross blood
~~Ext~~ RT lower ext dysmetria, (+)2 dors pedis pulses (P)

A/P GSW to RUE → [redacted] b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL ST[redacted] AND STAMP b(6)-2

PROVIDER SIGN[redacted]

DIAGNOSIS

GSW to RUE

CODES

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

b(6)-4 [redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted] b(6)-4

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: 37
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKA

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

4. PROPOSED SURGICAL PROCEDURE:

Exp. Lap

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

None

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

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

[redacted] b(6)-4

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

MEDCOM - 15387

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ϕ 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. ϕ Check that safety straps are correctly applied. ϕ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ϕ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to sedation; pain; injury E.2. X Potential discomfort due to injury; pain	ϕ Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	ϕ Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. ϕ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. ϕ Pt. will be transferred safely to OR table. ϕ Pt. will be able to understand instructions. Need interpreter o Minimize danger of injury during intraop period.	ϕ Introduce self. Keep pt. informed as to where he/she is and what is happening. ϕ Inform pt. in which direction to move and assist if necessary. ϕ Speak clearly and slowly. ϕ Address pt. from other side. ϕ Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

[redacted] CPT/AN 30JUL03 DATE

11. POSTOPERATIVE EVALUATION:

b(6) - 2 AM

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted], CPT/AN DATE: 30JUL03 TIME: 0200	DATE: TIME:

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

b(6)-2

MEDICAL RECORD — INTRAOPERATIVE RECORD

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY [redacted]

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

3. DATE 30 Jul 03 TIME PATIENT ARRIVED IN SUITE 1640

4. PATIENT IN ROOM TIME 1640 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	SPC [redacted] b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] LTC	RELIEF CIRCULATOR	CPT [redacted] b(6)-2

7. POSITION AND POSITIONAL AIDS (S... pillow under knees ; HT under heels

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

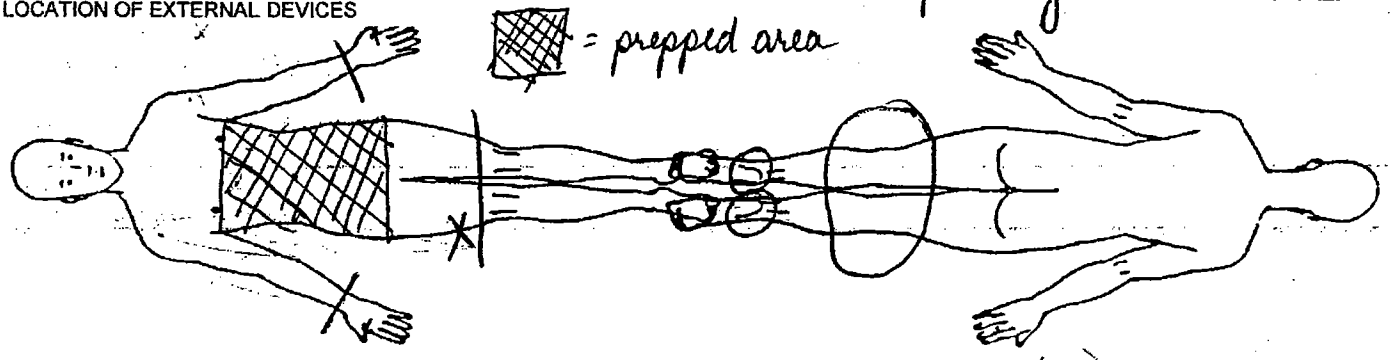
COMMENTS: Body maintained in proper alignment

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine scrub & paint
SITE: Abd. nipple → pubis BY WHOM: LTC [redacted]
SITE: BY WHOM:
COMMENTS: No pooling noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial 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			

SCRUB: PFC [redacted] (I+1st) SPC [redacted]
CIRCULATOR: CPT [redacted] (I+1st) CPT [redacted]

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

#[redacted]

b(6)-2

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

☒ ESU NO: 000411 Valleylab Force 2
GROUND PAD: BRAND Reem Polyhesive
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 20 coag: 20

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 15389 IS OBSOLETE. USAPA V1.01

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
None		

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

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	18. DRESSING/IMMOBILIZATION (Specify)

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16F RedRob	2. 16F RedRob	3. both stv foley bags
SITE X	1. duodenum	2. Jejunum Feeding tube	3.

18. DRESSING/IMMOBILIZATION (Specify)
Ostomy dsg/bag
Kerlix Lg ABD
4x8's Tape

19. ADDITIONAL INFORMATION
WC III
Surgeons: Drs [redacted] Anesthesia: Maj. [redacted] CRNA
Dr. [redacted] LTC CRNA
Anesthesia Type: General
2 JP drains from prev. surg. (L) side
Bovie Pad site intact pre-op ✓; post-op ____ Bovie Settings: Coag/Cut 20/20 → 30/30
~~Tourniquet Site intact pre-op ____; post-op ____~~ NA
~~Tourniquet Time: Up ____ Down ____~~ NA

20. OPERATION(S) PERFORMED
1. Roux-en-Y
2. Gastrojejunostomy
3. Rt. Colostomy
4. Feeding tube
5. Tube duodenostomy
6. Wound Debridement

21. PATIENT TRANSFERRED TO ICU 2 TIME 2045 METHOD via Gurney

22. REGISTERED [redacted] URE TC, AN [redacted] PT, AN

REVERSE OF DA FORM 5179-1, OCT [redacted] MEDCOM - 15390 USAPA V1.01

b(6)-2

b(6)-2A11

MEDICAL RECORD — **INTRAOPERATIVE [redacted]MENT**

For use of this form, see AR 40-66, the proponent ag[redacted]he office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY [redacted]

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

3. DATE 30 Jul 03 TIME PATIENT ARRIVED IN SUITE 0200

4. PATIENT IN ROOM TIME 0200 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

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

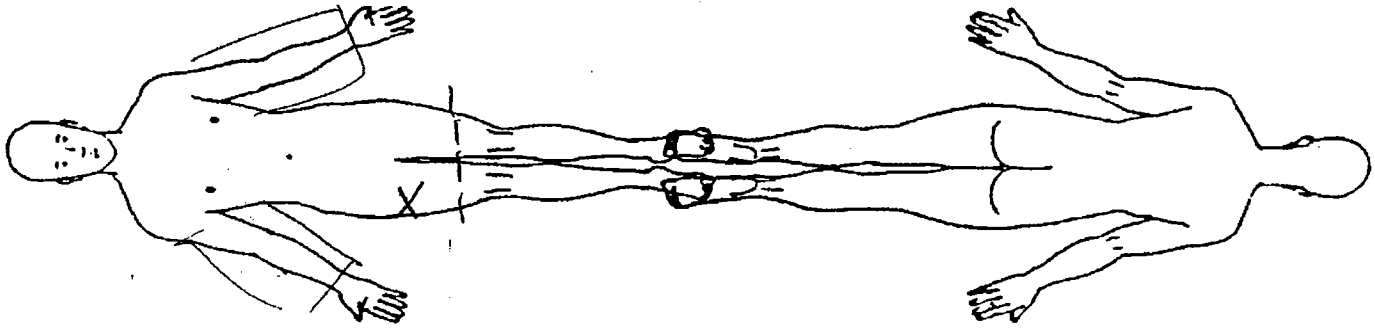
COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Abd BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect Initial C [redacted]

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

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

[redacted] b(6)-4

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

☒ ESU NO: #3 50/50 → 30/30
GROUND PAD: BRAND Valley lab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 15391 I IS OBSOLETE. USAPA V1.01

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% NS

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1. 10mm JP x2	2.	3.
SITE	1. (L) side	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8's Kerlix
ABD's
Silk tape

19. ADDITIONAL INFORMATION

WC

Surgeons: Saum, Carmody

Anesthesia: Fidele, Watters

Anesthesia Type: Gen.

Foley in place from EMT

Bovie Pad site intact pre-op_____; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____: post-op_____
Tourniquet Time: Up____ Down_____

Unicyn in ORT
TD given EMT

20. OPERATION(S) PERFORMED

(L) Nephrectomy
Distal Gastric Dissection
Transverse Colectomy
Jejunal Resection
Femoral Art line Placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	0420	Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT [redacted] CRNA

REVERSE OF DA [redacted] OCT 87 USAPA V1.01

b(6)-2 MEDCOM - 15392

PT'S NAME: #[redacted] b(6)-4 ID#: DATE: 30 Jul 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP			100/79	112/75	117/76	78/56	105/63	137/78	112/72	98/56	119/64	116/63						108/59	90/52	77/41	85/46	94/53	94/53	91/51
TEMP			98.3	92.1		93.1	94.3	95.9	97.3	97.4	98.7	99.1						94.7	96.5	96.9				97.9
HR			109	104	109	117	109	120	121	131	133	136						125	124	122	125	131	135	140
RR			12	12	12	12	14	14	14	14	14	16						20	20	20	20	20	20	20
SP02			100	100	100	100	100	100	100	100	100	100						99	100	100	100	100	100	100
FIO2			50	50		40	40	40	40	40	40	40						80	80	80	80	80	100	100
INPUT																								
PO																								
IV F								IVPB 50		IVPB 50	300							150	150	150	150	150	150	150
NGT																								
Bolus		1000		500		2000	1000	1500	1500	300								600		1000				
FP			499						IVPB 250		531													
1504				2	4	4	4	4	3	3	3	5						5	5	1	1	1	1	3
Versed				3	5	6	5	3	3	3	3	3						3	3	1	1	2	2	4
B TOTAL		1000		505	9	2010	1009	1557	1756	356	837	8						808	158	152	152	153	153	157
TAL		1000	1499	2004	2013	4023	5032	6589	8345	8701	9538	9546						10354	10512	11664	11816	11969	12122	12279
ITPUT																								
URINE				100	30	30	38	22	26	30	70	40						815	100	50	80	70	50	40
NGT												200										100		100
STOOL																								
JP1		120		200		100	170		220	140	110	70						260		35	40	40		30
JP2		70		50		70	20		150	100	100	50						30				20		10
J tube																		25		25		25		0
duodenostomy																		75		125		25		25
Ostomy																						100		
SUBTOTAL		190		350	30	200	228	22	396	270	280	360						1255	100	235	80	380	50	205
TOTAL		190		540	570	770	968	990	1386	1656	1936	2296						3551	3651	3886	3966	4046	4096	4301
BALANCE																								

MEDCOM - 15393

+7978

0615
TV 800
R12, P5

0630 - Tamp HCO3

1020 - Tamp HCO3
R↑14

1016 ABG, CBC done

0925:
1504 Versed gtt started

1040 - ABG drawn
~~1300~~ 1255 = 1U PRBC
1310 = 1500cc Bolus

ABG:

0545	0645	1016	1050	1218
pH 7.23	pH 7.29	pH 7.20	pH 7.33	pH 7.38
pCO2 40.3	pCO2 36.7	pCO2 43.3	pCO2 33.1	pCO2 33.1
pO2 200	pO2 274	pO2 130	pO2 190	pO2 166
HCO3 17	HCO3 18	HCO3 17	HCO3 18	HCO3 16
sO2 100	BE -9	BE -11	BE -8	BE -10
BE -4	sO2 100%	sO2 98	sO2 100%	sO2 99%

PT'S NAME: [redacted] CPW b(6)-4 ID#: DATE: 31 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV		89/49	80/43	93/55	98/56	101/59	102/55	96/51	103/54	102/54	104/53	93/51	92/47	100/50	103/50	104/48	109/52	106/48	104/47	93/45	106/50	109/42	94/42	89/41
BP NIBP		101/52	106/52	104/58	133/78	121/66	121/71	119/68	122/67	124/76	120/70	116/66			128/60	119/57			119/57					105/53
TEMP		98.8	98.5	98.7	98.3	98.6	97.3	97.3	97.4	97.8	98.0	98.7			99.2				99.4				99.6	
HR		139	131	128	125	128	120	122	133	125	125	126	127	128	131	132	134	131	131	127	126	129	126	128
RR		20	20	20	20	11	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
SP02		99	100	98	99	100	99	100	99	99	99	100	96	96	93	92	95	98	98	99	98	98	99	99
FIO2		60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	80	80	80	60	60	60	60	60
Map INV		58	56	72	71	73	73	71	73	74	71	69	64	70	72	69	74	67	65	62	70	62	58	58
Non INV		71	71	76	95	82	90	87	88	91	89	84			86	80			81					73
CVP																		20	22	20	19	19	18	18
INPUT																								
PO																								
IV	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	125	125	125	125	125	125	125
NGT																								
LR/D5		1000	1000	1000		500			500cc					500										
3cc	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Used	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
PPB		100						50	50	150				50				100						
J-Tube							5	5	5	5	5		5	5	5	5	5	5	5	5	5	5	5	5
B TOTAL	157	1257	1157	1157	157	657	157	207	707	707	157	157	162	712	162	162	162	237	137	137	137	137	137	137
TAL	157	1414	2571	3728	3885	4542	4699	4906	5613	5920	6077	6234	6396	7108	7270	7432	7594	7831	7968	8105	8242	8379	8516	8653
TPUT																								
URINE	75	50	55	110	55	60	70	75	1100	110	60		110	45	85	100	1100	34	90	80	80	100	60	70
NGT	50			50		25			85		15					125					340			50
STOOL																								
Sp1	25	10	10	10	10	10	0	15	0	0	10				15						30			10
Sp2	20	25	10	20	20	10	20	15	15	15	15		30		20		40	40			40			35
J-Tube	75			75		25	10																	
Duodenostomy	225			150		50	50			50	25		25		0						0			0
Ostomy					100						25										50			
SUBTOTAL	470	85	75	110	465	180	150	105	700	175	150		165	45	120	225	1160	74	90	80	540	100	60	165
TOTAL	470	535	630	770	1230	1410	1560	1665	1865	2040	2190	2190	2355	2400	2520	2745	3905	3979	4069	4149	4689	4789	4849	5014
BALANCE	-313	+1172	+1082	+1017	-303	+477	+657	+1027	+507	+1132	+707													

MEDCOM - 15394

PT'S NAME: GPW [redacted] b(6)-4 ID#: DATE: 1 Aug 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV	99/48	117/57	135/62	119/61	118/68	117/64	129/66	135/68	109/57	118/58	138/68	107/61	137/68	108/56	99/51	99/60	102/59	104/100	100/56	113/74	97/85	89/48	89/46	99/50
~~BP NIBP~~ MAP	62	74	80	80	x2	83	87	80	75	76	72	74	77	75	72	75	76	78	71	90	71	63	63	74
TEMP	97	100.7				100.2				101.6					102[2]		101.4		101[b]			101[a]		100[4]
HR	127	132	130	126	127	126	126	129	136	137	137	138	139	140	139	133	131	132	134	131	131	131	130	123
RR	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	18	18	17	15	19	19	20	16
SP02	99	99	99	100	100	99	100	99	99	99	98	96	95	94	94	95	96	95	94	94	94	94	92	95
FIO2	60	60	60	60	60	60	60	50	50	30	40	40	40	40	50	60	60	60	60	60	65	70	70	100
CVP	23	19	17	16	16	18	19	19	19	19	19			22	19	17	19	17	17	16	15	16	20	20
INPUT																								
PO																								
IV NS	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	150
~~LR~~	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
MIVF	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4	4	4	4	4	4	4	4	4
D5W	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
D5LR		50				50				50		50		5	5	5	5	5	5	5	5	5	OFF	OFF
D5W																		100					500	500
																							25	25
B TOTAL	137	187	137	137	137	187	137	137	137	187	137	187	137	137	138	138	138	238	138	138	138	138		
TAL	137	324	461	598	735	922	1059	1196	1333	1520	1657	1844	1981	2118	2256	2394	2532	2770	2908	3046	3174	3312		
TPUT	~~160~~	~~180~~																						
URINE	160	180	100	140	120	100	100	120	100	140	120	140	120	85	55	95	90	75	80	70	50	50	50	50
NGT													900											600
STOOL ~~Bwod~~																								
JP #1						25																		
JP #2						50																		
~~Colostomy~~																								
													100											60
SUBTOTAL	160	180	100	140	120	175	100	120	100	140	120	140	620	85	55	95								
TOTAL	160	340	440	580	700	875	975	1095	1195	1335	1455	1595	2215	2300	2355	2450	2540	2615	2695	2765	2815	2865		
BALANCE	23	7	37	-3	-17	12	37	17	37	47	17	47	+983											

MEDCOM - 15395

BOWLS

Shaw 16
TY 600
Resp 43
FiO_2 100

Date: 2 AUG 03 Bed#: 2

Patients Name: SIZ

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
ABP	100/53	91/53	94/50	96/53	91/53	94/53	95/55	81/55	87/50	115/59	112/60	85/40	89/49	77/46	78/45	78/47	80/49	81/50	82/52	86/55
BP MAP	71	70	66	72	71	71	67	67	65	65	63	65		56	58	59	62	63	64	66
TEMP		101.6				101.6							98.4 02	105.3		105.3			103.2	
HR	133	131	130	129	130	130	128	127	131	131	102	130	149	143	142	131	131	127	123	115
RR	16	16	16	16	16	16	16	20	20	20	20	20		24	84	20	20	20	20	20
SAO2	94	94	95	96	97	96	96	97	98	95	95	93	94	94	93	93	92	91	91	93
FIO2	100	100	100	100	90	90	70	70	70	60	60	70	90	70	70	70	70	70	70	70
CVP	16	23	20	16	15	18	19	23	22	23	23	23	?	19	19	20	21	20	22	23
INPUT																				
PO NGT																				
IV NS/blood	150	150	150	150	150	150	150	150	150	150	150	150	150	10	30	10				
NGT Albumin			250		250									150	150	150	150	150	150	150
VERSED	4	4	4	4	4	4	4	4	4	3	3	3	3	3	LEVO	1.9	1.25	37.5	37.5	37.5
MSO4	4	4	4	4	4	4	4	4	4	3	3	3	3	3	3	3	3	3	3	3
~~Potassium~~	~~OFF~~	NEO								3	3	3	3	3	3	3	3	3	3	3
IVPB				50		50				50		150		150	187	62.5	50	12.5	31.3	31.3
DOPAMINE	45	4.5	7.5	10.5	4.5	4.5	4.6	7.5	7.5	15	22.5	15	15	4.5	4.5	7.5	7.5	7.5	7.5	7.5
TOTAL	166.5	233	652.5	871	1285.5	1500	1625	1848	2013.5	2234.5	2413	2734	2905	3225.5	3653	3640.9	3619	3756	3806.7	3839
Subtot					414.5	214.5	125	175.5	165.5	221	178.5	321	171	320.5	427.5	987.9	721	874.4	932.3	932.3
OUTPUT																				
URINE (FC)	100	100	80	60	60	80	40	50	60	40	25	40	40		40	12	8	16	10	14
NGT							10						100							
STOOL																				
COLOSTOMY																				
DUODENUM						200		50				600								
												500						450		
Subtot	100	100	80	60	60	280	50	100	60	40	25	640	140		40	12	8	466	10	14
TOTAL	160	200	280	340	400	680	730	830	890	930	955	1595	1735		1775	1787	1795	2261	2271	2285
BALANCE																				
TURN Q 2																				

1800
0645

i-STAT G3+

Pt: [redacted] (b)(6)-4

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.294

PCO2_____36.7 mmHg

PO2_____274 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

30JUL03 06:54

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

Physician:_____

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

Ver: JAMS046A
CLEW A93

(b)(6)-4

ID: [redacted] 30-07-03
WB 03:53

			Patient Limits	
WBC	5.3	x10^3/uL	4.5	10.5
RBC	2.30 L	x10^6/uL	4.00	6.00
Hgb	6.5 L	g/dL	11.0	18.0
Hct	20.7 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.5 L	g/dL	33.0	37.0
Plt	58. *	x10^3/uL	150.	450.
LY%	28.3	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

---

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____149 mmol/L

K_____5.2 mmol/L

TCO2_____18 mmol/L

iCa_____0.75 mmol/L

Hct_____17 %PCV

Hb*_____6 g/dL

*via Hct

At 37C

PH_____7.179

PCO2_____43.7 mmHg

PO2_____342 mmHg

HCO3_____16 mmol/L

BEecf_____-12 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

30JUL03 03:53

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 30-07-03
WB 01:30

			Patient Limits	
WBC	17.7 H	x10^3/uL	4.5	10.5
RBC	2.55 L	x10^6/uL	4.00	6.00
Hgb	7.0 L	g/dL	11.0	18.0
Hct	22.5 L	%	35.0	60.0
MCV	88.2	fL	80.0	99.9
MCH	27.4	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	279.	x10^3/uL	150.	450.
LY%	33.1 *	%	20.5	51.1
LY#	5.9 *H	x10^3/uL	1.2	3.4

ID: [redacted] 30-07-03
WB 05:01

			Patient Limits	
WBC	6.8	x10^3/uL	4.5	10.5
RBC	4.39	x10^6/uL	4.00	6.00
Hgb	12.3	g/dL	11.0	18.0
Hct	39.9	%	35.0	60.0
MCV	90.8	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	58. *L	x10^3/uL	150.	450.
LY%	30.5	%	20.5	51.1
LY#	2.1	x10^3/uL	1.2	3.4

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____13 mmol/L

At 37C

PH_____7.040

PCO2_____43.6 mmHg

PO2_____235 mmHg

HCO3_____12 mmol/L

BEecf_____-19 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

30JUL03 05:02

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

MEDCOM - 15397

ID: [redacted] 30-07-03
WB - 05:59

				Patient Limits	
WBC	3.5	L	x10^3/uL	4.5	10.5
RBC	3.81	L	x10^6/uL	4.00	6.00
Hgb	10.8	L	g/dL	11.0	18.0
Hct	34.1	L	%	35.0	60.0
MCV	89.5		fL	80.0	99.9
MCH	28.3		pg	27.0	31.0
MCHC	31.6	L	g/dL	33.0	37.0
Plt	59.	L	x10^3/uL	150.	450.
LY%	22.0	*	%	20.5	51.1
LY#	0.8	*L	x10^3/uL	1.2	3.4

ID: [redacted] 30-07-03
WB 03:02

				Patient Limits	
WBC	12.1	H	x10^3/uL	4.5	10.5
RBC	3.23	L	x10^6/uL	4.00	6.00
Hgb	9.1	L	g/dL	11.0	18.0
Hct	29.4	L	%	35.0	60.0
MCV	91.1		fL	80.0	99.9
MCH	28.3		pg	27.0	31.0
MCHC	31.0	L	g/dL	33.0	37.0
Plt	103.	L	x10^3/uL	150.	450.
LY%	24.3	*	%	20.5	51.1
LY#	2.9	*	x10^3/uL	1.2	3.4

ID: [redacted] 30-07-03
10:35

				Patient Limits	
	[illegible]		x10^3/uL	4.5	10.5
	[illegible]	L	x10^6/uL	4.00	6.00
	[illegible]	L	g/dL	11.0	18.0
	30.0	L	%	35.0	60.0
	89.1		fL	80.0	99.9
	28.7		pg	27.0	31.0
MCHC	32.2	L	g/dL	33.0	37.0
Plt	64.	L	x10^3/uL	150.	450.
LY%	15.1	*L	%	20.5	51.1
LY#	0.7	*L	x10^3/uL	1.2	3.4

NIBP TREND 08/02/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
04:24	131	95	121 / 49 75	33
04:23	131	95	119 / 50 76	[redacted]
04:23	130	95	117 / 48 74	29
04:21	131	92	126 / 84 100	[redacted]
04:00	123	95	109 / 53 * 76	20
03:58	121	94	114 / 48 * 72	20
03:52	123	94	94 / 46 65	20
03:00	130	93	102 / 44 64	20
02:12	131	94	98 / 44 64	16
00:27	131	93	106 / 44 68	17
21:20	131	98	94 / 46 65	16

ART TREND 08/02/03

TIME	HR/PR	SpO2	SYS / DI[redacted] N	RR
HH:MM	BPM	%	mmHg	RPM
04:40	132	95	105 / 56 76	16
04:38	131	95	104 / 56 75	16
04:36	132	95	106 / 56 76	16
04:34	132	95	107 / 57 77	16
04:32	133	94	111 / 57 79	16
04:30	131	95	108 / 58 78	16
04:28	131	95	107 / 58 78	16
04:26	131	95	109 / 58 79	19
04:24	131	95	108 / 59 79	[redacted]
04:22	131	94	125 / 69 91	[redacted]
04:20	129	96	133 / 80 101	[redacted]
04:18	128	95	113 / 60 81	16
04:16	127	95	112 / 61 82	16
04:14	127	95	114 / 62 83	16
04:12	127	95	114 / 63 83	16
04:10	125	94	112 / 63 83	18
04:08	125	94	112 / 62 82	20
04:06	125	94	110 / 61 82	0
04:04	124	95	[redacted] / [redacted] [redacted]	20
04:02	123	95	100 / 60 78	20
04:00	123	95	96 / 58 74	20
03:58	121	94	93 / 54 70	20
03:56	123	94	88 / 54 69	20
03:54	123	94	83 / 53 67	20
03:52	123	94	81 / 52 66	20
03:50	[illegible]		78 / 50 63	20
03:48	[illegible]		[redacted] / 49 60	20
03:46	123		81 / 53 66	20
03:44	124	96	82 / 53 67	20
03:42	123	96	86 / 55 69	18
03:40	123	96	87 / 53 68	22
03:38	124	96	88 / 54 69	20
03:36	124	96	89 / 54 69	20
03:34	124	96	91 / 55 71	20
03:32	124	95	[redacted] / 70	110 20
03:30	124	95	90 / 54 70	20
03:28	124	96	92 / 56 [illegible]	[illegible]
03:26	124	96	89 / 54 [illegible]	[illegible]
03:24	125	[illegible]	[illegible]	[illegible]
03:22	125	96	88 / [illegible]	[illegible]
03:20	125	96	86 / [illegible]	68 20
03:18	126	95	85 / 53	67 20
03:16	123	94	82 / 52	65 20
03:14	123	94	168 / [redacted]	[redacted] 20
03:12	12[illegible]	[illegible]	93 / 55	72 13
03:10	[illegible]	[illegible]	94 / 54	71 17
03:08	[illegible]	92	83 / 48	62 19
03:06	129	92	85 / 49	63 20
03:04	129	93	85 / 49	63 20
03:02	130	92	85 / 49	63 20
03:00	130	92	85 / 49	63 20
02:58	130	93	86 / 48	63 19
02:56	130	93	86 / 49	63 16
02:54	130	94	86 / 48	63 16
02:52	130	93	85 / 48	63 16
02:50	130	94	85 / 48	63 16
02:48	130	94	87 / 48	63 16
02:46	131	94	87 / 48	63 17
02:44	130	94	87 / 48	63 16
02:42	131	94	87 / 48	64 16
02:40	130	94	87 / 48	63 16
02:38	131	94	87 / 48	63 16
02:36	131	94	89 / 49	65 18
02:34	131	94	88 / 48	63 15
02:32	131	94	87 / 48	63 16
02:30	131	94	89 / 49	64 16
02:28	131	94	88 / 48	63 16
02:26	131	94	90 / 49	65 16
02:24	131	94	89 / 49	65 16
02:22	131	94	88 / 49	64 16
02:20	131	94	89 / 48	64 16
02:18	131	94	89 / 48	64 16
[illegible]	[illegible]	[illegible]	[illegible] 9	64 17
[illegible]	[illegible]	[illegible]	[illegible] 6	63 16
02:12	131	94	89 / 48	64 16

02:08	132	94	90 / 48	63	16
02:06	132	94	89 / 48	64	16
02:04	132	94	89 / 48	63	16
02:02	132	94	89 / 47	63	16
02:00	132	94	89 / 48	63	16
01:58	132	[illegible]	89 / 47	63	16
01:56	132	94	88 / 48	63	13
01:54	132	94	90 / 47	63	16
01:52	133	94	89 / 47	63	16
01:50	133	94	90 / 48	63	16
01:48	135	94	90 / 48	63	16
01:46	133	94	92 / 48	64	15
01:44	133	94	93 / 48	64	16
01:42	133	95	94 / 48	65	16
01:40	132	95	93 / 48	65	16
01:38	133	94	93 / 48	65	16
01:36	135	94	94 / 49	65	16
01:34	132	95	93 / 49	65	16
01:32	133	94	94 / 50	66	16
01:30	133	95	94 / 49	66	16
01:28	132	94	95 / 49	67	16
01:26	132	94	97 / 50	68	16
01:24	132	94	96 / 50	68	16
01:22	132	94	96 / 51	69	16
01:20	132	94	97 / 51	69	16
01:18	132	94	97 / 52	70	16
01:16	131	94	97 / 52	70	[redacted]
01:14	131	94	96 / 53	71	17
01:12	131	94	97 / 53	71	18
01:10	131	94	97 / 54	72	17
01:08	131	94	96 / 54	72	18
01:06	131	93	96 / 54	72	18
01:04	131	93	99 / 55	72	18
01:02	132	93	97 / 55	72	20
01:00	131	94	98 / 55	74	18
00:58	132	93	98 / 56	74	19
00:56	131	93	97 / 55	72	19
00:54	131	93	100 / 56	74	19
00:52	131	93	98 / 55	73	20
00:50	131	93	97 / 56	73	20
00:48	131	93	97 / 55	73	19
00:46	130	93	98 / 56	73	20
00:44	130	93	98 / 57	74	21
00:42	129	93	100 / 59	76	17
00:40	131	94	83 / 54	68	[redacted]
00:38	131	94	90 / 56	72	16
00:36	140	95	89 / 56	71	39
00:34	131	95	85 / 53	67	16
00:32	132	95	84 / 52	66	16
00:30	131	93	86 / 51	67	21
00:28	131	93	94 / 53	70	18
00:26	131	93	94 / 53	70	14
00:24	131	94	94 / 53	70	20
00:22	131	93	96 / 54	71	30
00:20	132	93	95 / 54	71	22
00:18	132	93	94 / 53	69	25
00:16	133	93	94 / 53	70	20
00:14	132	92	97 / 54	72	20
00:12	132	92	93 / 52	69	14
00:10	132	91	94 / 53	70	28
00:08	132	92	96 / 54	72	19
00:06	132	92	94 / 54	71	28
00:04	135	92	90 / 52	67	15
00:02	136	91	108 / 70	84	36
00:00	132	91	113 / 74	90	21
23:58	132	94	96 / 54	71	16
23:56	132	94	96 / 54	71	17
23:54	132	94	98 / 55	72	18
23:52	133	94	98 / 55	72	17
23:50	132	94	98 / 56	73	19
23:48	132	94	97 / 55	72	16
23:46	132	94	96 / 54	71	16
23:44	132	94	98 / 55	72	22
23:42	133	94	99 / 56	73	16

b(6)-2

Ward/Section: MU2

ATTENDING PHYSICIAN: [redacted]

CHE[illegible]RY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted]

b(6)-2

DATE: 30 Jul 03

TIME: 1220

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
ALP		26-84 u
ALT		10-47 u
AMY		18-97 u
AST		11-38 u
TBIL		0.2-1.6
BUN		7-22 mg
CA^{++}		8.0-10.3
CHOL		100-200
CRE		0.6-1.2
GLU		73-118
TP		6.4-8.1

(Piccolo) Mellyte 8

TEST	RESULT	REF RANGE
GLU		73-118
BUN		7-22 mg
CRE		0.6-1.2
CK		39-380 30-190
NA^+		128-145
K^+		3.3-4.7
CL^-		98-108
tCO_2		18-33 m

(Piccolo) Metabolic Panel

======= PICCOLO =======
30/07/03 12:24
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-2
DTSC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	119*	73-118	MG/DL
BUN	18	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	441*	39-380	U/L
NA+	135	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	116*	98-108	MMOL
tCO2	15*	18-33	MMOL

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

REMARKS:

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

DATE: 30Jul03

LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 30 Jul 03 / TIME 1025	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	4.1	4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(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: b(6)-2 [redacted]	DATE: 30JUL03	LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 30Jul03 TIME: 0757	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	7.230	7.31-7.45
PCO2	40.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	200	80-105 mmHg (art) N/A (ven)
TCO2	18	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	17	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	100	95-98%
BEecf	-4	(-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

[redacted] PICCOLO [redacted]
30/07/03 05:57
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.7*	3.3-5.5	G/DL
ALP	36	26-84	U/L
ALT	36	10-47	U/L
AMY	442*	14-97	U/L
AST	69*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	16	7-22	MG/DL
CA++	6.3*	8.0-10.3	MG/DL
CHOL	49*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	112	73-118	MG/DL
TP	2.9*	6.4-8.1	G/DL

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

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 30Jul03	LAB ID NO.:

1300

[redacted] 30 July 03 OR#2

b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
BC		4.8-10.8 x 10^3
C		4.7-6.1 x 10^6
b		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
V		80-94 fl (M) 81-99 fl (F)
		130-500 x 10^3 verified
nph %		20.5-51.1%

Hematology) Manual Differential

gs		Mono	
nds		Eos	
nph		Baso	
p		Imm	
C rph			

n natocrit		42-52% (M) 37-47% (F)
Rate		
ier		

Congulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
limer		<20 ng/ml
P		<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

MARKS:

PORTED BY:	DATE:	LAB ID NO.:

Last Copy

b(6)-4

[redacted] b(6)-2

30 July 03 [redacted] b(6)-4

Manual Differential

Urinalysis

Microscopic Urinalysis

Misc. Serology

Microbiology

CSF

Blood Bank

MUST SUBMIT SF 518 W

EVERY UNIT REQU

ABO/Rh

Smear

Blood Bank Daily Log (Patient

RESULT | REF. RANGE | UNIT | TYPE | CROSSMATCH

PT 20-3

PTT 46.3

RKS:

[redacted]

30 July 03

b(6)-2

Ward/Section:		ESTING PHYSICIAN:			CHEM. RY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI:				DATE: 30 Jul 03	TIME: 0500	SSN/PSEUDO SSN:	

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

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**
b(6)-2	30Jul03	

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted]	DATE 30 JUL 03	TIME 0345	SSN/PSEUDO SSN:

(Hematology) CBC

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%

(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	28.9	9.8-13.6 secs
APTT	61.0	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis b(6)-4

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 30 JUL 03	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRS[redacted]	DATE 30 JUN 03	TIME 0116	SSN/PSEUDO SSN: [redacted]

b(6)-1

(Hematology) CBC

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%

(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	18.5	9.8-13.6 secs
APTT	33.4	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

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

REMARKS:

REPORTED BY: [redacted]	DATE: 30 Jun 03	LAB ID NO.:

b(6)-1

b(6)-2

EMT

b(6)-4

b(6)-4

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

TING PHYSICIAN: [redacted]

LA[redacted]

DATE 30JUL03 TIME 0110

SSN/PSEUDO SSN: [redacted]

TEST	RESULT	REF. RANGE
(Piccolo) Chemistry 12		
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		
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/
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

PICCOLO

30/07/03 01:26

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3151AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	356*	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	344	39-380	U/L
NA+	135	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	11*	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 1+, ICT 0

R

R BY: [redacted] DATE: 30Jul03 LAB ID NO.:

b(6)-2

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted] b(6)-4	DATE 30JUL03 TIME 0500	SSN/PSEUDO SSN:

(Hematology) CBC

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%

(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	25.8	9.8-13.6 secs
APTT	63.8	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

======= PICCOLO =======
30/07/03 05:04
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-4
DISC LOT #: 3151AA4
OPER # [redacted] DR #: 000
SERIAL #: [redacted]

GLU	154*	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	187	39-380	U/L
NA+	138	128-145	MMOL
K+	6.1*	3.3-4.7	MMOL
CL-	117*	98-108	MMOL
tCO2	13*	18-33	MMOL

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

rce		
m n		
Bld		Negative
ylori		Negative
ro sites		
aria		
P		
r		

Microscopic Urinalysis

Blood Bank

ST SUBMIT SF 518 WITH
RY UNIT REQUESTED

/Rh

ossmatch
ERY UNIT OF BLOOD
))

TEST	RESULT	REF. RANGE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2	**DATE:** 30JUL03	**LAB ID NO.:**

b(6)-4

Ward/Section: O2

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

CHEM[illegible]Y RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted]

DATE: C345 | TIME: 30Jul03

SSN/PSEUDO SSN:

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

REMARKS: b(6)-2

REPORTED BY: [redacted]

DATE: 30Jul03

LAB ID NO.:

b(6)-2

Ward/Section: ICU 2

[redacted]

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

LAST, FIRST, M: [redacted]

397

TIME 2102

SSN/PSEUDO SSN:

b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RAN
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======

30/07/03 21:06

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3204AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	♦♦♦	3.3-5.5	G/DL
ALP	30	26-84	U/L
ALT	31	10-47	U/L
AMY	779*	14-97	U/L
AST	70*	11-38	U/L
TBIL	2.1*	0.2-1.6	MG/DL
BUN	19	7-22	MG/DL
CA++	6.4*	8.0-10.3	MG/DL
CHOL	64*	100-200	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
GLU	95	73-118	MG/DL
TP	♦♦♦	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
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: 12 Met / Liver Panel

REPORTED BY: [redacted]

DATE: 30Jul03

LAB ID NO.:

b(6)-2

b(6)-4 [redacted] 30/7/03 1700

(Hematology) CBC		
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%

(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	19.6	9.8-13.6 secs
APTT	43.4	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: COAGS / CBC

REPORTED BY: [redacted] **DATE:** 30Jul03 **LAB ID NO.:**

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-2	DATE 9 MAY 03	TIME 1220	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

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%

(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	17.3	9.8-13.6 secs
APTT	28.7	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

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: JP [redacted]	DATE: 30 May 03	LAB ID NO.:

b(6)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b(6)-4	DATE 30 Jul 03	TIME 1535	SSN/PSEUDO SSN:

(Hematology) CBC

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%

(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	15.9	9.8-13.6 secs
APTT	29.9	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: b(6)-2

REPORTED BY: [redacted] **DATE:** 30 Jul 03 **LAB ID NO.:**

Ward/Section: ICU 2 | ATTENDING PHYSICIAN: [redacted] b(6)-2 | CHEM[illegible]Y RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.: [redacted] b(6)-4 | DATE: 30 Jul 03 | TIME: 1535 | SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF.	TEST	RESULT	REF. RANGE
Na		138-146 m						
K		3.5-4.9 m						
Cl		98-109 m						
pH		7.31-7.45						
PCO2		35-45 mm 41-51 mml						
PO2		80-105 mm N/A (ven)						
TCO2		23-27 mm 24-29 mm						
HCO3		22-26 mm 23-28 mm						
sO2		95-98%						
BBecf		(-2) - (+ mmol/L						
AnGap		10-20 m						
Ca		1.12-1.3						
BUN		8-26 mg						
GLU		70-105						
Creat		0.7-1.5						
Hct		38-51%						
Hgb		12-17 g						

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

======= PICCOLO =======
30/07/03 15:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.0*	3.3-5.5	G/DL
ALP	42	26-84	U/L
ALT	40	10-47	U/L
AMY	1151*	14-97	U/L
AST	89*	11-38	U/L
TBIL	3.0*	0.2-1.6	MG/DL
BUN	21	7-22	MG/DL
CA++	6.4*	8.0-10.3	MG/DL
CHOL	61*	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	118	73-118	MG/DL
TP	3.6*	6.4-8.1	G/DL

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

======= PICCOLO =======
30/07/03 15:49
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	144	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	122*	98-108	MMOL/L
tCO2	13*	18-33	MMOL/L

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

REMARKS: b(6)-2

REPORTED BY: [redacted] | DATE: 30 Jul 03 | LAB ID NO.:

ICU < b(6)-4 DI [redacted] b(6)-2

EPW [redacted] 1 Jul 03 0400

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		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	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies		
TEST	*RESULT*	*REF. RANGE*
PT	23.2	9.8-13.6 secs
APTT	34.7	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**
[redacted]	31 Jul 03	

b(6)-9

ICU 2
EPW [redacted] b(6)-4
Dr [redacted] b(6)-2
31Jul03 0400

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

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

(i-STAT) | (Piccolo) Chemistry 12 | (Piccolo) Metabolic Panel

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 =======
31/07/03 04:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.2*	3.3-5.5	G/DL
ALP	29	26-84	U/L
ALT	47	10-47	U/L
AMY	1349*	14-97	U/L
AST	89*	11-38	U/L
TBIL	5.3*	0.2-1.6	MG/DL
BUN	28*	7-22	MG/DL
CA++	6.3*	8.0-10.3	MG/DL
CHOL	52*	100-200	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
GLU	114	73-118	MG/DL
TP	2.6*	6.4-8.1	G/DL

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

======= PICCOLO =======
31/07/03 04:15
REFERENCE RANGE: MALE
PATIENT #: [redacted]
ELECTROLYTE b(6)-4
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	149*	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	119*	98-108	MMOL
tCO2	17*	18-33	MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	31Jul03	

b(6)-2

Ward/Section: ICU #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: 31 July	TIME:	SSN/PSEUDO SSN: #1 [redacted] b(6)-4

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 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	NT	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: FROM JP #1 Unable to Run, Machines only run Whole blood, Plasma and Serum

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

DATE: 31 Jul 03

LAB ID NO.:

b(6)-2

Ward/Section: ICU 2 | ATTENDING PHYSICIAN: DR [redacted] | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

b(6)-4

LAST, FIRST, MI: SPW [redacted] | DATE: 31Jul03 | TIME: 2000 | 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		25-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BBecf		(-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

======= PICCOLO =======
31/07/03 20:12
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	87	73-118	MG/DL
BUN	25*	7-22	MG/DL
CRE	2.1*	0.6-1.2	MG/DL
CK	2508*	39-380	U/L
NA+	144	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	121*	98-108	MMOL
tCO2	20	18-33	MMOL

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

REMARKS:

REPORTED BY: [redacted] | DATE: 31Jul03 | LAB ID NO.:

b(6)-2

i-STAT

Pt: [redacted] SIMV R-20 PEEP 5 FiO2 60

Pt Name: [redacted]

TCO2_____19 mmol/L

At 37C

PH_____7.278

PCO2_____38.8 mmHg

PO2_____56 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____85 %

*calculated

Sample Type_:

31JUL03 20:08

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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i-STAT

Pt: [redacted] FiO2 80%

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.279

PCO2_____38.4 mmHg

PO2_____73 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____93 %

*calculated

Sample Type_:

31JUL03 21:39

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

ID: [redacted] 30-07-03
WB 15:44

				Patient Limits
WBC	5.1		x10^3/uL	4.5 10.5
RBC	3.76	L	x10^6/uL	4.00 6.00
Hgb	10.2	L	g/dL	11.0 18.0
Hct	33.5	L	%	35.0 60.0
MCV	89.2		fL	80.0 99.9
MCH	27.3		pg	27.0 31.0
MCHC	30.6	L	g/dL	33.0 37.0
Plt	77.	*L	x10^3/uL	150. 450.
LY%	13.5	*L	%	20.5 51.1
LY#	0.7	*	x10^3/uL	1.2 3.4

ID: [redacted] 30-07-03
WB 12:25

				Patient Limits
WBC	3.9	L	x10^3/uL	4.5 10.5
RBC	3.38	L	x10^6/uL	4.00 6.00
Hgb	9.5	L	g/dL	11.0 18.0
Hct	30.1	L	%	35.0 60.0
MCV	89.0		fL	80.0 99.9
MCH	28.2		pg	27.0 31.0
MCHC	31.6	L	g/dL	33.0 37.0
Plt	66.	L	x10^3/uL	150. 450.
LY%	16.2	*L	%	20.5 51.1
LY#	0.6	*L	x10^3/uL	1.2 3.4

ID: [redacted] 31-07-03
WB 20:10

				Patient Limits
WBC	3.8	L	x10^3/uL	4.5 10.5
RBC	3.72	L	x10^6/uL	4.00 6.00
Hgb	10.5	L	g/dL	11.0 18.0
Hct	32.9	L	%	35.0 60.0
MCV	88.6		fL	80.0 99.9
MCH	28.2		pg	27.0 31.0
MCHC	31.8	L	g/dL	33.0 37.0
Plt	72.	L	x10^3/uL	150. 450.
LY%	12.4	*L	%	20.5 51.1
LY#	0.5	*L	x10^3/uL	1.2 3.4

ID: [redacted] 31-07-03
WB 04:15

				Patient Limits
WBC	5.7		x10^3/uL	4.5 10.5
RBC	4.91		x10^6/uL	4.00 6.00
Hgb	14.0		g/dL	11.0 18.0
Hct	43.7		%	35.0 60.0
MCV	89.0		fL	80.0 99.9
MCH	28.4		pg	27.0 31.0
MCHC	31.9	L	g/dL	33.0 37.0
Plt	69.	*L	x10^3/uL	150. 450.
LY%	11.4	*L	%	20.5 51.1
LY#	0.7	*L	x10^3/uL	1.2 3.4

ID: [redacted] 30-07-03
WB 21:08

				Patient Limits
WBC	4.1	L	x10^3/uL	4.5 10.5
RBC	3.98	L	x10^6/uL	4.00 6.00
Hgb	11.3		g/dL	11.0 18.0
Hct	35.6		%	35.0 60.0
MCV	89.4		fL	80.0 99.9
MCH	28.3		pg	27.0 31.0
MCHC	31.7	L	g/dL	33.0 37.0
Plt	56.	L	x10^3/uL	150. 450.
LY%	16.5	*L	%	20.5 51.1
LY#	0.7	*L	x10^3/uL	1.2 3.4

R14
T amp NaHCO3
40%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.332

PCO2_____33.1 mmHg

PO2_____190 mmHg

HCO3_____18 mmol/L

BEecf_____-8 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

30JUL03 10:56

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

P 7500 L
R12 800 TV 932

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.203

PCO2_____43.3 mmHg

PO2_____130 mmHg

HCO3_____17 mmol/L

BEecf_____-11 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

PH_____7.243

PCO2_____38.0 mmHg

PO2_____113 mmHg

Patient Temp: 98.2F

Sample Type_:

30JUL03 10:16

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 31-07-03
WB 09:16

			Patient Limits	
WBC	5.7	x10^3/uL	4.5	10.5
RBC	4.34	x10^6/uL	4.00	6.00
Hgb	12.5	g/dL	11.0	18.0
Hct	38.6	%	35.0	60.0
MCV	88.8	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	65. L	x10^3/uL	150.	450.
LY%	10.5 *L	%	20.5	51.1
LY#	0.6 *L	x10^3/uL	1.2	3.4

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____16 mmol/L

At 37C

PH_____7.207

PCO2_____38.1 mmHg

PO2_____117 mmHg

HCO3_____15 mmol/L

BEecf_____-13 mmol/L

sO2*_____98 %

*calculated

Sample Type_:

30JUL03 15:39

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 31-07-03
WB 12:13

			Patient Limits	
WBC	5.5	x10^3/uL	4.5	10.5
RBC	4.26	x10^6/uL	4.00	6.00
Hgb	12.0	g/dL	11.0	18.0
Hct	38.4	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	72. *L	x10^3/uL	150.	450.
LY%	9.8 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

R14
TV 800
PS
40%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____17 mmol/L

At 37C

PH_____7.304

PCO2_____33.1 mmHg

PO2_____166 mmHg

HCO3_____16 mmol/L

BEecf_____-10 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

30JUL03 12:18

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____61 mg/dL

BUN_____34 mg/dL

Na_____154 mmol/L

K_____3.8 mmol/L

Cl_____125 mmol/L

TCO2_____17 mmol/L

AnGap_____16 mmol/L

Hct_____30 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.317

PCO2_____32.3 mmHg

HCO3_____16 mmol/L

BEecf_____-10 mmol/L

Sample Type_:

01AUG03 08:23

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.303

PCO2_____35.7 mmHg

PO2_____95 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

31JUL03 12:04

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

SIMV RATE-20 FIO2@60% PEEP-5 TV-

pH_____7.284

PCO2_____36.6 mmHg

PO2_____100 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

31JUL03 09:15

Oper: [redacted]

Physician: [redacted]

Ser# [redacted] b(6)-2

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.372

PCO2_____36.0 mmHg

PO2_____91 mmHg

HCO3_____17 mmol/L

BEecf_____-10 mmol/L

sO2*_____96 %

*calculated

FIO2_____: 60

Sample Type_: ART

31JUL03 04:06

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

MEDCOM - 15421

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: 2Lt [redacted] b(6)-4	DATE: 31/Jul/03	TIME: 2000
		SSN/PSEUDO SSN:

(Hematology) CBC

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%

(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	25.7 37.7 Rx	9.8-13.6 secs
APTT	43.8 45.9 Rx	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
~~Appr~~		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:

REPORTED BY: [redacted]	**DATE:** 31 July 03	**LAB ID NO.:**

b(6)-2

ICU#2 [redacted] b(6)-4 E 3am 31JUL03 [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		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	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 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] **DATE:** 31JUL03 **LAB ID NO.:**

b(6)-2

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. SPC [redacted]	DATE 2Aug03 / TIME 1900	SSN/PSEUDO SSN:

(Hematology) CBC

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%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

b(6)-2 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: 2Aug03	LAB ID NO.:

b(6)-2

ICU #2 Dr b(6)-2

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

LAST, FIRST, MI: # b(6)-4 | DATE: 30 Aug 03 | TIME: 1700 | SSN/PSEUDO SSN: 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

======= PICCOLO =======
31/07/03 12:11
REFERENCE RANGE: MALE
PATIENT #: b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: DR #: 000
SERIAL #:

ALB	1.7*	3.3-5.5	G/DL
ALP	35	26-84	U/L
ALT	55*	10-47	U/L
AMY	1164*	14-97	U/L
AST	74*	11-38	U/L
TBIL	4.4*	0.2-1.6	MG/DL
BUN	27*	7-22	MG/DL
CA++	6.2*	8.0-10.3	MG/DL
CHOL	26*	100-200	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
GLU	95	73-118	MG/DL
TP	3.0*	6.4-8.1	G/DL

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

(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
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

ERROR

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
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: | DATE: 31 Aug 03 | LAB ID NO.:

Ward/Section: ICU#2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)-2	DATE: 31 Jul 6	TIME: 0910
		SSN/PSEUDO SSN: [redacted] b(6)-4

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

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

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: b(6)-2

REPORTED BY: [redacted] **DATE:** 31 Jul 06 **LAB ID NO.:**

ICU #2 b(6)-2

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

LAST, FIRST, MI: # [redacted] b(6)-4 | DATE: 31 JULY 03 | TIME: 1415 | SSN/PSEUDO SSN:

(i-STAT) | (Piccolo) Chemistry 12 | (Piccolo) Metabolic Panel

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

Misc. Chemistry

TEST	RESULT	REF. RAN
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
31/07/03 14:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.7*	3.3-5.5	G/DL
ALP	33	26-84	U/L
ALT	61*	10-47	U/L
AMY	1131*	14-97	U/L
AST	78*	11-38	U/L
TBIL	4.3*	0.2-1.6	MG/DL
BUN	26*	7-22	MG/DL
CA++	6.6*	8.0-10.3	MG/DL
CHOL	41*	100-200	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
GLU	95	73-118	MG/DL
TP	3.1*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 1+

======= PICCOLO =======
31/07/03 14:26
REFERENCE RANGE: MALE
PATIENT #: 512
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	148*	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	120*	98-108	MMOL/L
tCO2	15*	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] DATE: 31 MAY 03 LAB ID NO.:

b(6)-2

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.182

PCO2_____46.7 mmHg

PO2_____89 mmHg

HCO3_____17 mmol/L

BEecf_____-11 mmol/L

sO2*_____94 %

*calculated

FIO2_____: 80

Sample Type_:

30JUL03 21:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

ID: [redacted]

WB 01-08-03
04:15

			Patient Limits	
WBC	4.3 L	x10^3/uL	4.5	10.5
RBC	3.71 L	x10^6/uL	4.00	6.00
Hgb	10.7 L	g/dL	11.0	16.0
Hct	33.2 L	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	69. L	x10^3/uL	150.	450.
LY%	10.8 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

At 37C

pH_____7.066

PCO2_____54.6 mmHg

PO2_____81 mmHg

HCO3_____16 mmol/L

BEecf_____-15 mmol/L

sO2*_____90 %

*calculated

At Patient Temp

pH_____7.096

PCO2_____49.2 mmHg

PO2_____69 mmHg

Patient Temp: 94.3F

FIO2_____: 80

Sample Type_: ART

30JUL03 21:03

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____72 mg/dL

BUN_____32 mg/dL

Na_____153 mmol/L

K_____3.6 mmol/L

Cl_____126 mmol/L

Hct_____27 %PCV

Hb*_____9 g/dL

*via Hct

Sample Type_:

01AUG03 15:19

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

pH_____7.304

PCO2_____33.5 mmHg

PO2_____105 mmHg

HCO3_____17 mmol/L

BEecf_____-10 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

30JUL03 22:34

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

PH_____7.257

PCO2_____43.4 mmHg

PO2_____55 mmHg

HCO3_____19 mmol/L

BEecf_____-5 mmol/L

sO2*_____83 %

*calculated

FIO2_____: 40

Sample Type_:

01AUG03 17:35

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

PH_____7.236

PCO2_____45.8 mmHg

PO2_____60 mmHg

HCO3_____19 mmol/L

BEecf_____-8 mmol/L

sO2*_____86 %

*calculated

FIO2_____: 50

Sample Type_: ART

01AUG03 18:27

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____77 mg/dL

BUN_____35 mg/dL

Na_____156 mmol/L

K_____3.8 mmol/L

Cl_____127 mmol/L

TCO2_____18 mmol/L

AnGap_____16 mmol/L

Hct_____27 %PCV

Hb*_____9 g/dL

*via Hct

PH_____7.325

PCO2_____33.2 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

Sample Type_:

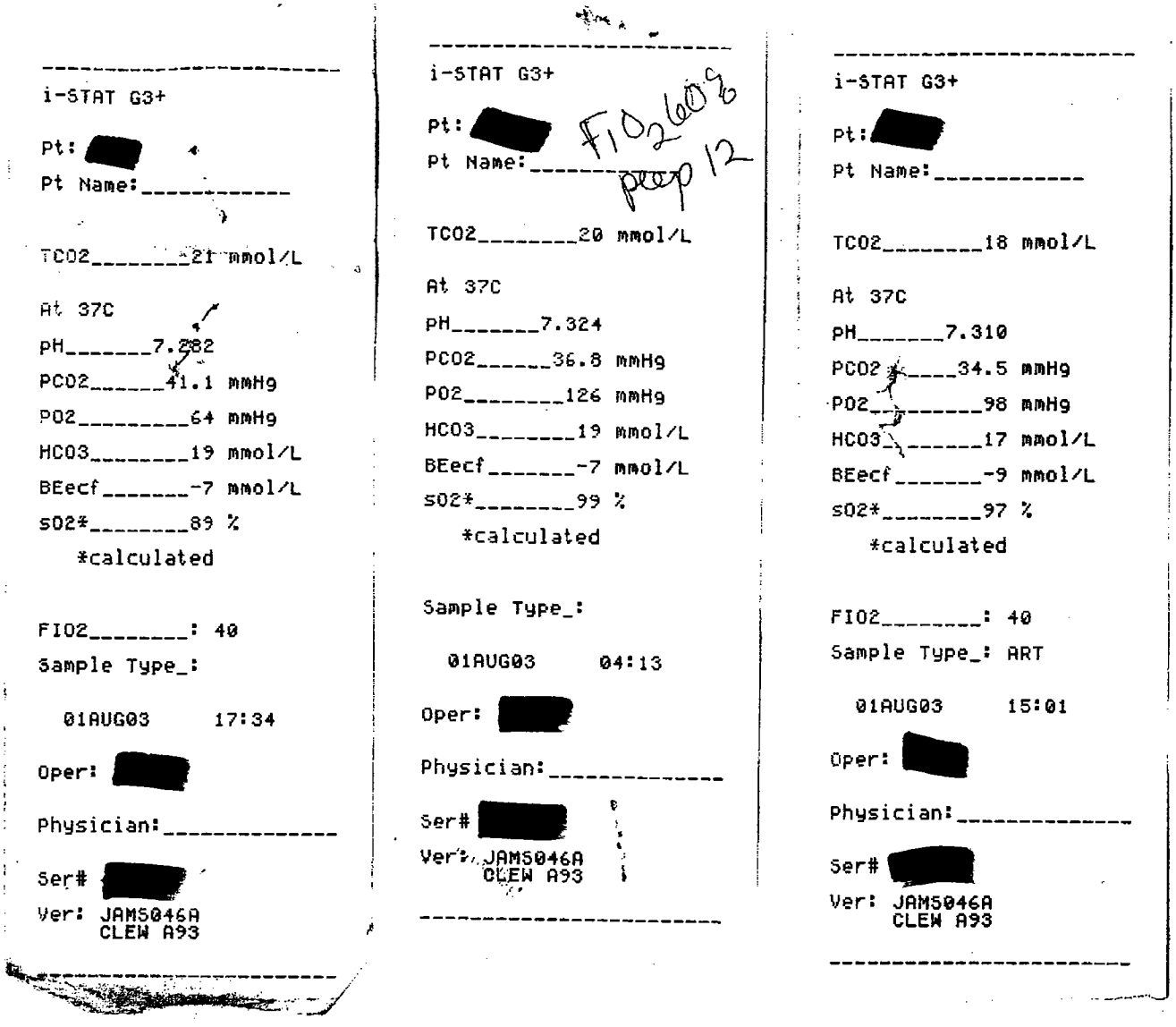
01AUG03 17:41

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93



i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

pH_____7.282

PCO2_____41.1 mmHg

PO2_____64 mmHg

HCO3_____19 mmol/L

BEecf_____-7 mmol/L

sO2*_____89 %

*calculated

FIO2_____: 40

Sample Type_:

01AUG03 17:34

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted] FiO2 60%

Pt Name:_____ peep 12

TCO2_____20 mmol/L

At 37C

pH_____7.324

PCO2_____36.8 mmHg

PO2_____126 mmHg

HCO3_____19 mmol/L

BEecf_____-7 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

01AUG03 04:13

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

pH_____7.310

PCO2_____34.5 mmHg

PO2_____98 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

sO2*_____97 %

*calculated

FIO2_____: 40

Sample Type_: ART

01AUG03 15:01

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

Ward/Section: Ecu 2

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

CH[redacted]ISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

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

DATE: 1Aug

TIME: 0500

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
01/08/03 08:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	69*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	2.5*	0.6-1.2	MG/DL
CK	1735*	39-380	U/L
NA+	128*	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	120*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(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: b(6)-2

REPORTED BY: [redacted]

DATE: 1Aug03

LAB ID NO.:

b(6)-2

Ward/Section: ICU 2 | REQUESTING PHYSICIAN: DR. [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 [redacted] | DATE: 01 Aug 03 | TIME: 1730 | 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

PICCOLO
01/08/03 17:38
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-4
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	83	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	2.6*	0.6-1.2	MG/DL
CK	1279*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	124*	98-108	MMOL/L
tCO2	♦♦♦	18-33	MMOL/L

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

(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
BIL		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:

ABG b(6)-2

REPORTED BY: [redacted] | **DATE:** 1 Aug 03 | **LAB ID NO.:**

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 1Aug03 TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

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%

(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	22.2	9.8-13.6 secs
APTT	40.4	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: b(6)-2

REPORTED BY: [redacted]	**DATE:** 1Aug03	**LAB ID NO.:**

b(6)-2

Ward/Section:	RE[illegible]STING PHYSICIAN:	CH[illegible]ISTRY RESULT FORM (Subject to the Privacy Act of 1974)
ICU2	DR [redacted]	
LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
b(6)-2 EPW [redacted]	1 Aug 03	0500	

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-147
K		3.5-4.9
Cl		98-109
pH		7.31-7.4
PCO2		35-45 m 41-51 mm
PO2		80-105 m N/A (ven
TCO2		23-27 mm 24-29 mm
HCO3		22-26 mm 23-28 mm
sO2		95-98%
BEecf		(-2) – (+3 mmol/L
AnGap		10-20 mn
Ca		1.12-1.32
BUN		8-26 mg/c
GLU		70-105 mg
Creat		0.7-1.5 mg
Hct		38-51% P(
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RA
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		.5 g/dl
		u/l
		u/l
		u/l
		u/l
		mg/dl
		g/dl
		3mg/dl
		mg/dl
		mg/dl
		mg/dl
		g/dl
		F.
		GE
		ng/dl
		dl
		g/dl
		l (M)
		l (F)
		nmol/l
		nol/l
		mol/l
		ol/l

======= PICCOLO =======
01/08/03 04:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.3*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	42	10-47	U/L
AMY	1200*	14-97	U/L
AST	89*	11-38	U/L
TBIL	2.3*	0.2-1.6	MG/DL
BUN	27*	7-22	MG/DL
CA++	6.8*	8.0-10.3	MG/DL
CHOL	70*	100-200	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
GLU	73	73-118	MG/DL
TP	3.2*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
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: b(6)-2 [redacted]	DATE: 01 Aug 03	LAB ID NO.:

Ward/Section: Ecu

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

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

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

DATE: 1 Aug 03

TIME: 1917

SSN/PSEUDO SSN: #1 [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
01/08/03 15:01
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-4
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	77	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	2.5*	0.6-1.2	MG/DL
CK	1316*	39-380	U/L
~~NA+~~	~~124*~~	~~128-145~~	~~MMOL~~
~~K+~~	~~3.8~~	~~3.3-4.7~~	~~MMOL~~
~~CL-~~	~~121*~~	~~98-108~~	~~MMOL~~
tCO2	♦♦♦	18-33	MMOL

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

(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:

ABG. SIMV20 TV600 FiO2 40% Resp 12

REPORTED BY: [redacted]

DATE: 1 Aug 03

LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 1 Aug 6	TIME: 1951	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

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%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. 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: b(6)-2

REPORTED BY: [redacted] **DATE:** 1 Aug 6 **LAB ID NO.:**

i-STAT G3+

Pt: [redacted]
Pt Name:_____

TCO2_____19 mmol/L

At 37C
pH_____7.344
PCO2_____32.3 mmHg
PO2_____97 mmHg
HCO3_____18 mmol/L
BEecf_____-8 mmol/L
sO2*_____97 %
*calculated

FIO2_____: 70
Sample Type_: ART

02AUG03 12:48

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB 02-08-03
19:04

				Patient Limits	
WBC	1.6	L	x10^3/uL	4.5	10.5
RBC	2.95	L	x10^6/uL	4.00	6.00
Hgb	8.1	L	g/dL	11.0	18.0
Hct	26.5	L	%	35.0	60.0
MCV	89.8		fL	80.0	99.9
MCH	27.3		pg	27.0	31.0
MCHC	30.4	L	g/dL	33.0	37.0
Plt	58.	L	x10^3/uL	150.	450.
LY%	20.4	*L	%	20.5	51.1
LY#	0.3	*L	x10^3/uL	1.2	3.4

Pt: [redacted]
Pt Name:_____

TCO2_____21 mmol/L

At 37C
pH_____7.346
PCO2_____35.7 mmHg
PO2_____75 mmHg
HCO3_____20 mmol/L
BEecf_____-6 mmol/L
sO2*_____94 %
*calculated

Sample Type_:

02AUG03 15:17

Oper: [redacted]

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i-STAT G3+ SIMV 20
TV 670
FiO2 70%

Pt: [redacted]
Pt Name:_____

TCO2_____19 mmol/L

At 37C
pH_____7.334
PCO2_____34.2 mmHg
PO2_____67 mmHg
HCO3_____18 mmol/L
BEecf_____-8 mmol/L
sO2*_____92 %
*calculated

Sample Type_:

02AUG03 19:02

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS0[illegible]P
CLEW [illegible]3

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i-STAT 6+

Pt: [redacted]
Pt Name:_____

Glu_____94 mg/dL
BUN_____39 mg/dL
Na_____156 mmol/L
K_____3.5 mmol/L
Cl_____129 mmol/L
Hct_____21 %PCV
Hb*_____7 g/dL
*via Hct

Sample Type_:

02AUG03 15:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB 01-08-03
15:02

				Patient Limits	
WBC	3.7	L	x10^3/uL	4.5	10.5
RBC	3.[illegible]	L	x10^6/uL	4.00	6.00
Hgb	10.4	L	g/dL	11.0	18.0
Hct	33.[illegible]	L	%	35.0	60.0
MCV	89.3		fL	80.0	99.9
MCH	27.5		pg	27.0	31.0
MCHC	30.8	L	g/dL	33.0	37.0
Plt	81.	L	x10^3/uL	150.	450.
LY%	11.2	*L	%	20.5	51.1
LY#	0.4	*L	x10^3/uL	1.2	3.4

i-STAT EG7+

Pt: [redacted]

Pt Name:_____ (calculated Values)

Na_____158 mmol/L
K_____3.7 mmol/L
TCO2_____19 mmol/L
iCa_____1.08 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
PH_____7.201
PCO2_____45.4 mmHg
PO2_____161 mmHg
HCO3_____18 mmol/L
BEecf_____-10 mmol/L
sO2*_____99 %
*calculated

FIO2_____: 90
Sample Type_: ART

02AUG03 09:50

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____49 mg/dL
BUN_____40 mg/dL
Na_____158 mmol/L
K_____3.6 mmol/L
Cl_____129 mmol/L
TCO2_____18 mmol/L
AnGap_____15 mmol/L
Hct_____24 %PCV
Hb*_____8 g/dL
*via Hct
PH_____7.196
PCO2_____44.1 mmHg
HCO3_____17 mmol/L
BEecf_____-11 mmol/L

Sample Type_:

02AUG03 09:46

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____86 mg/dL
BUN_____39 mg/dL
Na_____157 mmol/L
K_____3.5 mmol/L
Cl_____129 mm
TCO2_____17 mm
AnGap_____16 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct
PH_____7.347
PCO2_____29.1 mmHg
HCO3_____16 mmol/L
BEecf_____-10 mmol/L

Sample Type_:

02AUG03 12:47

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB 02-08-03 21:38

				Patient Limits
WBC	2.7	L	x10^3/uL	4.5 10.5
RBC	3.40	L	x10^6/uL	4.00 6.00
Hgb	9.5	L	g/dL	11.0 18.0
Hct	30.5	L	%	35.0 60.0
MCV	89.6		fL	80.0 99.9
MCH	28.0		pg	27.0 31.0
MCHC	31.3	L	g/dL	33.0 37.0
Plt	46.	L	x10^3/uL	150. 450.
LY%	20.5	*L	%	20.5 51.1
LY#	0.6	*L	x10^3/uL	1.2 3.4

ID: [redacted]
WB 02-08-03 15:19

				Patient Limits
WBC	3.3	L	x10^3/uL	4.5 10.5
RBC	3.37	L	x10^6/uL	4.00 6.00
Hgb	8.9	L	g/dL	11.0 18.0
Hct	30.4	L	%	35.0 60.0
MCV	90.1		fL	80.0 99.9
MCH	26.3	L	pg	27.0 31.0
MCHC	29.2	L	g/dL	33.0 37.0
Plt	72.	L	x10^3/uL	150. 450.
LY%	11.8	*L	%	20.5 51.1
LY#	0.4	*L	x10^3/uL	1.2 3.4

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____62 mg/dL
BUN_____37 mg/dL
Na_____156 mmol/L
K_____3.7 mmol/L
Cl_____129 mmol/L
TCO2_____16 mmol/L
AnGap_____16 mmol/L
Hct_____25 %PCV
Hb*_____9 g/dL
*via Hct
pH_____7.349
PCO2_____27.6 mmHg
HCO3_____15 mmol/L
BEecf_____-10 mmol/L

Sample Type_:

02AUG03 04:10

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____98 mg/dL
BUN_____41 mg/dL
Na_____157 mmol/L
K_____3.7 mmol/L
Cl_____129 mmol/L
TCO2_____19 mmol/L
AnGap_____15 mmol/L
Hct_____25 %PCV
Hb*_____9 g/dL
*via Hct
pH_____7.204
PCO2_____44.3 mmHg
HCO3_____17 mmol/L
BEecf_____-11 mmol/L

Sample Type_:

02AUG03 11:25

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____158 mmol/L
K_____3.8 mmol/L
TCO2_____20 mmol/L
iCa_____1.09 mmol/L
Hct_____21 %PCV
Hb*_____7 g/dL
*via Hct

At 37C
pH_____7.210
PCO2_____46.1 mmHg
PO2_____107 mmHg
HCO3_____18 mmol/L
BEecf_____-9 mmol/L
sO2*_____97 %
*calculated

At Patient Temp
pH_____7.188
PCO2_____49.5 mmHg
PO2_____118 mmHg

Patient Temp: 101.6F
FIO2_____: 70
Sample Type_: ART

02AUG03 11:26

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

RR 20 TV 600
FIO2 100%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.343

PCO2_____30.5 mmHg

PO2_____65 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

sO2*_____92 %

*calculated

Sample Type_:

[redacted]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

02-08-03
04:11

			Patient Limits	
WBC	2.6 L	x10^3/uL	4.5	10.5
RBC	3.30 L	x10^6/uL	4.00	6.00
Hgb	9.4 L	g/dL	11.0	18.0
Hct	29.6 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	80. L	x10^3/uL	150.	450.
LY%	15.7 *L	%	20.5	51.1
LY#	0.4 *L	x10^3/uL	1.2	3.4

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i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____20 mmol/L

At 37C

PH_____7.211

PCO2_____47.1 mmHg

PO2_____68 mmHg

HCO3_____19 mmol/L

BEecf_____-9 mmol/L

sO2*_____89 %

*calculated

At Patient Temp

PH_____7.191

PCO2_____50.2 mmHg

PO2_____75 mmHg

Patient Temp: 101.2F

FIO2_____: 70

Sample Type_: ART

[redacted]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____65 mg/dL

BUN_____40 mg/dL

Na_____156 mmol/L

K_____3.8 mmol/L

Cl_____128 mmol/L

TCO2_____19 mmol/L

AnGap_____15 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

PH_____7.210

PCO2_____43.8 mmHg

HCO3_____18 mmol/L

BEecf_____-10 mmol/L

Sample Type_:

[redacted]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93
