M AL RECORD-SUPPLEMENTAL MEDI ATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET (6)(6)-2

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0630 INITIALS: [redacted]	TIME: INITIALS:
NEURO	PUPILS	3mm PERRL Brisk	3mm PERRL
	SENSORIUM	A/wake responds to Commands	A+O x 3
	EXTREMITY MOVEMENT	appropriately. LUE unable to	able to follow simple
	SEDATION	move. All other extremities	commands. External
	PAIN CONTROL		fixator to LUE. MAE to other 3 extremities
RESP	RESPIRATORY PATTERN	RRR symmetrical rise & fall	RRR
	BREATH SOUNDS	of chest CTA bilat.	CTA Bilat
	SECRETIONS	& secretions	
	O2 SOURCE/FLOW/SAO2	RA. 95-98% SaO2	
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	S1S2 Cap refill <3 sec	S1S2 @ pulses to all
	CAPILLARY REFILL	+2 pulses X4 extremities	4 extremities. <3 sec
	PULSES		Cap refill.
	EDEMA		
GI	ABDOMEN	+BS X 4 quads. Soft non	@ BS X 4 quads. ABD
	BOWEL SOUNDS	tender & distention	soft round non distended
	BOWEL MOVEMENT		non tender.
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to gravity	Pt voiding spontaneously
	COLOR/CLARITY	clear yellow	clear yellow urine.
SKIN	COLOR	NFR Dsg's to Dppr	NFR DSG to (L) UE
	INTEGRITY	legs bilat CDI	& Legs Bilat DSG is
			c/d/I
ACCESS	#1 TYPE/LOCATION/SIZE	20ga to (R) Forearm	HL to (R) FA @
	DRESSING CONDITION	patent to flush	flush & S/S of
	IV FLUID/RATE	& Erythema	infection
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

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

DEPARTMENT/SERVICE/CLINIC (6)(6) DATE

ICU #1 [redacted] 16 Sep 03

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

NAME [redacted] (6)(6)-4 RANK: AGE:

UNIT: GENDER: M

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17041

USAPPC V2.00

ICU1

Patients Name: #[redacted] (b)(6)-4

Date: 16SEP03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line																								
NBP			134/65				129/75				118/60				110/68				108/68				113/61	
TEMP			100.2				98.5				100.1			101.9		100.1								
HR			104				93				98				92				96				96	
RR			19				21				15				20				21				[illegible]	
SaO2			99%				99				100				100%				99%				100%	
FiO2																								
Source			RA				RA				RA				RA				RA				RA	
MAP																								

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF																										
IVPB	100		50				100				50		200													
NGT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	125/125	125/250	125/375	200/575	125/700	70/770	70/840	260/1100	260/1360	260/1620	260/1880		1800													
NGT																										
STOOL																										
DRAIN																										

MEDCOM - 17042

DOD-030631

ACLU-RDI 1640 p.2

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	16
BP Arterial line																		
BP Cuff	114/60	115/60	106/60	112/58	111/59	124/65	111/59	114/63		120/63	101/62	110/56	120/72	122/67	131/75	115/61	118/63	108/64
Temperature	99.3	—	—	98.1	—	99.3	99.2	98.9		99.6								
Pulse	82	85	94	84	86	87	92	88		88	91	88	90	92	101	89	84	91
Respiratory Rate	24	12	22	20	23	25	28	25		(50)	21	23	26	23	21	20	20	12
SaO2	98%	97%	96%	95%	95%	97%	96%	93		95	96	94	97	97	99	95	97	96
O2 Method	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5 1/2 NSC 20K	120	120	120	120	120	120	120	120		120	120	120	120	120	120	120		
IVPB	50									50								50
MSO4	7	7	7	7	7	7	7	7		7	7							
TF	—															30	30	
TF flush												10					10	
TOTALS																		

OUTPUT

		TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR		130			250		140	95				200			140			200	
	TOTAL		130			380		520	615											
	SP gr																			
	S/A																			
NG	OUTPUT																			
	PH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

VITAL SIGNS

POST-OP DAY	17	18	19	20	21	22	2[illegible]	24	
	~~14~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	[illegible]	~~23~~	
	1[illegible]/71		159/43	104/46	110/62	127/71	127/62	122/72	
			95	94	93	94	90	93	
			13	15	14	18	20	16	
			99	98	97	96	98	99	
			RA	RA	RA	RA	RA	RA	

RESPIRATORY DATA

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA

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

INTAKE

17/~~14~~	~~18~~	19	20	21	22	23	24	8°T	
	120	120	120	120	120	120	120		
		3	4	4	4	4	4		
30	40	40	40	40	40	40	40		
							50		

OUTPUT

200	100	170	200	80	200	220	180

ACTIVITIES OF DAILY LIVING

TIME		
MOUTH CARE		
BATCH		
SKIN CARE		
FOLEY CARE		
TRACH CARE		
ROM EXERCISES		

TURN / SUCTION

TIME

24°180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE
IV ______
Po ______
TOTAL ______

OUTPUT
Urine: ______
______
TOTAL ______

BALANCE ______

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

MEDCOM - 17044

ACLU-RDI 1640 p.4

DOD-030633

M .L RECORD-SUPPLEMENTAL MEDIC ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (5)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0600 INITIALS: [redacted]	TIME: 1825 INITIALS: [redacted]
NEURO	PUPILS	3mm PERRLA, able to follow	3mm Perrla
	SENSORIUM	commands + express needs	follows commands & expresses
	EXTREMITY MOVEMENT	SPEAKS SOME ENGLISH, LIMITED	needs. Speaks some english
	SEDATION	ROM @ ARM DUE TO EX-FIX. MSO4	√ROM to @ arm r/t
	PAIN CONTROL	+ percocet for pain control	Ex-fix, MSO4 + percocet for pain control
RESP	RESPIRATORY PATTERN	RRR, RR wnl, equal chest rise	RRR
	BREATH SOUNDS	CTA throughout	Clear Bilat
	SECRETIONS		—
	O2 SOURCE/FLOW/SAO2		—
	VENTILATOR SETTINGS		—
CV	CARDIAC RHYTHM	SR ± Ø ectopy HR 88, Cap refill	SR Ø ectopy HR 98
	CAPILLARY REFILL	< 3 sec, +2 pulses in all ext ± Ⓛ	Cap Refil < 3 sec.
	PULSES	radial +4 bounding. Ø edema	+pulses in all ext X Ⓛ radial
	EDEMA	noted	+3-+4 Ø edema
GI	ABDOMEN	soft, nontender	Soft, nontender
	BOWEL SOUNDS	(+) in all 4 quadrants	+ in all 4 quads
	BOWEL MOVEMENT	Ø noted	Ø noted
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	urinal	to urinal
	COLOR/CLARITY		
SKIN	COLOR	Ex-fix Ⓡ upper arm. Ⓡ arm in sling	Ex-fix Ⓡ upper arm.
	INTEGRITY	Dsg C,D,I. Ⓡ arm elevated	Sling in plc Dsg C D I
ACCESS	#1 TYPE/LOCATION/SIZE	Ⓡ FA H.L. ± Ø s/s of infection.	Ⓡ FA, ~~IV~~ HL
	DRESSING CONDITION	Flushes well.	Ø s/s of infection
	IV FLUID/RATE		Flushes well
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (5)(2)-2 ICU #1 [redacted]

DATE 17Sept03

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

NAME: [redacted] (5)(6)-4 RANK: AGE:

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17045

USAPPC V2.00

U1 Patients Name: [redacted] (b)(6) Date: 17 SEPT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
Time																										
BP	116/58				117/58				106/54					131/74				129/65				117/60				
TEMP	98.8				99.6	99.4	99.6	99.2	99.4					99.7				99				99.0				
	88				98				96					103				88				88				
	16				18				16					16				18				16				
O2	99%				99%				99%					100%				100				100				
O2	—				—				—					—				—								
Source	RA				RA				RA					RA				RA				RA				
MAP	—				—				—					—				—								

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
PO																				150						450
IVF/PB	1000		500				1000				500		3000	1000												
NGT																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE			X2					X1			X1		X III													
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17046

DOD-030635

ACLU-RDI 1640 p.6

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 (6)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS [redacted]		INITIALS	1815	INITIALS [redacted]
NEURO	PUPILS		PERRL 2+				PERRL, Pt is awake & tries to verbalize.	
	SENSORIUM		A&O unable to evaluate.					
			Movement to All Ext.					
			Does not Follow Commands					
RESPIRATORY	RESPIRATORY PATTERN		RR-25 SPO_2-96%				RR, non-labored Pt	
	BREATH SOUNDS		on Humidified RA to				for tan color.	
	SECRETIONS		trach collar. Trached				Lung sounds same bilat.	
			blood tinged Sputum					
			∑ productive cough					
			BS. CTA (B) ↑ lobes ↓ inferior (B)					
SKIN	COLOR		Normal for Race				NFR, moist on B/L	
	INTEGRITY		Open Wound to Abd, Burns				legs, abdomen	
			T-99.1					
IV SITE	LOCATION		(R) Forearm 20g				IV, (R) wrist, ½NS	
	CONDITION		infusing ½NS @ 50cc/hr				@ 50cc/hr & MSO4 @	
			& MSO4 @ 8cc/hr				8cc/hr.	
GASTRO	ABDOMEN		Large open wounds				abdomen wound ∑ ABD	
	BOWEL SOUNDS		JP drains dressing				dressing WNL	
			CDI					
			B.S. - Normoactive					
GU	URINE:		clear yellow				to foley BS, clear/yellow	
	COLOR/CLARITY		draining via Foley					
			to gravity					
CARDIOVASCULAR	CARDIAC RHYTHM		HR-106 BP-134/81				S1, S2 normal, no	
			Pulses strong x4				ectopy/murmurs noted.	
			Capillary Refill ∈ 3sec				Pedal pulses x 4	
							extremities.	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SaT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 17 Sep 03

NAME, GRADE AND TITLE (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

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

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS [redacted]		INITIALS	1815	INITIALS [redacted]
NEURO	PUPILS		PERRL 2+				PERRL, Pt is awake & trying to verbalize.	
	SENSORIUM		A&O unable to evaluate.					
			Movement to All Ext.					
			Does not Follow Commands					
RESPIRATORY	RESPIRATORY PATTERN		RR-25 SPO_2-96%				RR, non-labored Pt	
	BREATH SOUNDS		on Humidified RA to				for tracheal colon.	
	SECRETIONS		trach collar. Trached				Lung sounds course bilat.	
			blood tinged Sputum					
			& productive cough					
			BS. CTA (B) ↑ bases ↓ where (B)					
SKIN	COLOR		Normal for Race				NFR, wound on B/L	
	INTEGRITY		Open Wound to Abd, Burns				leg, abdomen	
			T-99.1					
I.V. SITE	LOCATION		(R) Forearm 20g				18g (R) wrist, 1/2NS	
	CONDITION		infusing ½NS @ 50cc/hr				@ 50cc/hr & MSO4 @	
			& MSO4 @ 8cc/hr				8cc/hr.	
GASTRO	ABDOMEN		Large open wounds				abdominal wound c ABD	
	BOWEL SOUNDS		JP drains dressing				dressing WBS.	
			CDI					
			B.S. - Normoactive					
GU	URINE:		clear yellow				to foley QS, clear yellow	
	COLOR/CLARITY		draining via Foley					
			to gravity					
CARDIOVASCULAR	CARDIAC RHYTHM		HR-106 BP-134/81				S/S, normal, no ectopy/murmurs noted.	
			Pulses strong x4				Pulses palpable x 4	
			Capillary Refill ≤ 3sec				extremities.	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 17 Sep 03

(Typed or printed entries give: Name—last, first, middle; grade; date; hospital or medical facility)

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

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

DATE 17Sep03 DX Multiple GSW HOSPITAL DAY

VITAL SIGNS																			
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21		
BP Arterial Line																			
BP Cuff	146/77	134/81	127/89	139/74	143/86	102/81	107/60	128/67		117/63	140/87	135/77	151/77	137/79	129/82	129/78	136/74		
Temperature		99.1	—	99.9		98.4				98.9			98.4	98.7		98.3	98.1		
Pulse	113	105	113	104	111	98	92	94		92	107	98	103	101	102	105	99		
Respiratory Rate	18	25	26	27	24	25	27	27		30	24	26	18	28	14	19	21		
SaO2	97%	96	97	96%	95%	97%	94%	93%		94%	94%	98%	99%	98	98	98	98		
method	HRA	H-RA	H-RA	H-RA	HRA	HRA	HRA	HRA		HRA	HRA	HRA	HRA	HRA	HRA	HRA	HRA		

INTAKE																			
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°	
.45% NS	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50		
MSO4	8	8	8	8	8	8	8	8		8	8	8	8	8	8	8	8		
IVPB	100	/	50	/	100	0	100	/		/									
TF	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100		
J-Tube flush/Meds					20														
	258	158	208	158	278	158	258	158		158	158								
TOTALS	258	416	624	782	1060	1118	1376	1584		1692	1850								

OUTPUT																			
HOUR / TOTAL	0/0	0/0	0/0	525/525	180/705	180/885	150/935	150/1085	1085	120/	170/290	170/460	120/580	120/700	100/800	100/900	120/1020		
URINE 10 gr																			
S/A																			
NG OUTPUT																			
NG pH																			
NG GUIAC																			
EMESIS																			
STOOL				275															
DRAINS JP-1																			
DRAINS JP-2																			
DRAINS JP-3																			
TOTALS																			

[redacted]

POST-OP DAY

VITAL SIGNS

	22	23	00	01	02	03	04	05	
BP	143/73	154/88	130/88	157/80		176/88	162/80	152/80	
T		98.8	98.3	98.3		98.9	98.8	98.8	
P	107	103	115	116		113	120	112	
R	24	12	22	18		28	24	15	
O2	95	97	98	97		96	100	100	
Signature	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	

INTAKE

	22	23	00	01	02	03	04	05	8° T
½NS	150	150	150	150	150	150	150	150	
MSO4	8	8	8	8	8	8	8	8	
[illegible]		150	~~150~~						
TF	100	100	100	100	100	100	100	100	
[illegible]		10							

OUTPUT

100	150 / 250	100 / 350	120 / 470	80 / 550	100 / 650	150 / 750	100 / 850	850

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TIME					
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
______
TOTAL ______

OUTPUT
Urine: ______
______
______
TOTAL ______

NURSE'S SIGNATURE	INITIALS

MEDCOM - 17050

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 [redacted] FT ASSESSMENT

		TIME	Q630	INITIALS [redacted]		INITIALS		INITIALS
NEURO		PUPILS	3mm PERRL				3mm PERRLA	
		SENSORIUM	Awake, Moves extremities x 4 c purposeful movement				Awake, able to follow some simple commands, moves all 4 extremities SM	
RESPIRATORY		RESPIRATORY PATTERN	RRR symmetrical				RRR pt treated	
		BREATH SOUNDS	chest wall expansion				CTA Bilat equal	
		SECRETIONS	thick white secretions clears c cough				rise & fall of chest Bilat. pt has thick white secretion c cough.	
SKIN		COLOR	NFR				NFR, wound to	
		INTEGRITY					midline abd. Dressing c/d/f.	
IV SITE		LOCATION	18 ga IV to (L)				18G IV to (L)	
		CONDITION	wrist site CDI & erythema				Wrist site is CDI & S/S of infection. (+) flush c NS @ 50cc/hr, MSO4 @ 3mg/hr	
GASTRO		ABDOMEN	+BS x 4 quads				(+)BS x4 quad	
		BOWEL SOUNDS	Soft non tender				Soft round non distended pt on Sengstaken @ 50cc/hr.	
GU		URINE:	Foley to Gravity				Foley to gravity.	
		COLOR/CLARITY	clear yellow				Clear yellow urine	
CARDIOVASCULAR		CARDIAC RHYTHM	S1,S2 +2 Pulses x 4 extremities, <3 sec cap refill				S1,S2 (+) Pulses x4 extremities. <3sec Cap refill.	

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPAR[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC | DATE 29 SEP 93

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

[redacted] (b)(6)-4

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff		139/82	121/70	119/73	132/72	113/62	106/80	108/65			143/80	119/86	154/89	139/88	147/91	168/92	154/89
Temperature		100.1	99.2		99.9		99.8	99.7			99.1			99.2			
Pulse		110	102	101	103	92	102	92		103	104	103	108	107	110	108	108
Respiratory Rate		41	21	45	27	37	35	33		23	38	41	20	28	29	26	32
$S_{A}O_2$		99	97	97	97	97	99	97		99	98	99	97	99	99	99	99
Method		RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IV	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
IVPB	50		50			100						50		100				
TF	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
M_3O_4	8	8	5	5	5	5	5	3		3	3	3	3	3	3	3	3	
TOTALS																		

OUTPUT

	HOUR / TOTAL	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
URINE		150/150	150/300	160/460	140/600	150/750	120/870	120/990	100/1090	1090	150/150	110/260	60/320	60/380	80/460	88/	100/	75/	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

22	23	24	01	02	03	04	05
118/69	163/93	111/62	125/71	138/93	157/90	134/92	159/90
110	~~98~~	91	92	104	110	106	117
36	28	26	30	22	26	33	21
99	99	92	99	99	99	99	99
RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

								8° T
50	50	50	50	50	50	50	50	
100	100	100	100	100	100	100	100	
3	3	3	3	3	3	3	3	

OUTPUT

66	150	88	75	200	180	162	180

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE: IV ______ po ______ ______ TOTAL ______

OUTPUT: Urine: ______ ______ ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

MEDCOM - 17053

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9/18
Time In: 1705
Allergies: PCN
Pre-op V/S: 149/109 85
Procedures: I&D Left arm

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: —

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1705	1710	1715	1730	1745	1800
SaO2	96	96	97	97		
FiO2						
Methods	RA	RA	RA	RA		
240						
220						
200						
180						
160				V		
140						
120	V	V	V			
100						
80	•	•	•	^		
60	^	^	^			
40						
20						
RR	12	13	10	12		
T	96.8					
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LArm	limited	+	+	<3	W	PK
15'	LArm	"	"	"	"	"	"
30'	LARM	"	"	"	"	"	"
45'							
60'							
90'							
D/C	LARM	limited	+	+	<3	W	RK

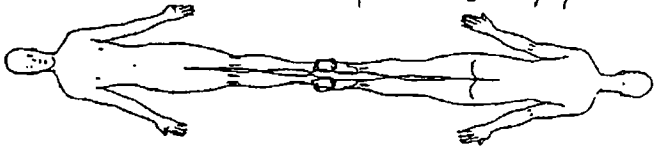
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L Arm	exfix/ace bandage	c/d/i
30'	LARM	" " "	c/d/i
60'			
D/C	LARM	exfix/ace bandage	c/d/i



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1705	NSR	Ø	Ø

NURSING NOTES

Pt arrived from OR. O_2 Sats 98%. A+O VSS No c/o pain. Report given to Sgt [redacted] (b)(6)-2. O_2 sats 99% other VSS stable

Discharge Criteria:
Date: 9/18 Time: 1743 PARS: 10
BP: 154/97 T: 97.9 HR: 111 RR: 12 Sa02: 99%
Pain Level at D/C (0-10): Ø
Intake: ~~Ø~~ 240cc Output: Ø
Additional Data: Ø
Transferred To: ICU 7
Report Given To: Sgt [redacted] (b)(6)-2
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date):

Date: 9-19
Time In: 1055
Allergies: NKDA
Pre-op V/S:
Procedures:
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid Colloid
OR Output: UOP EBL
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1055	1100	1105	1115	1120	1130
SaO2	98	98	98	98	98	98
FiO2	35	35	35	35	35	35
Methods						
240						
220						
200						
180						
160	V	V				
140						
120			V	V	V	
100	•	•	•	•		
80						
60	A	A		M	M	
40						
20						
RR	29	30	45	30	28	
T	98					
Time	1055		1120	1140		
Pain (0-10)	0/10		5/10	0/10		
LOS						

1055
HR 102
BP 160/68
RR 29
SpO2 100
96%
1100
HR 110
BP 168/60
RR 30
SpO2 100
1105
HR 97
129/67
RR 25
SpO2 100
1115
HR 95
137/76
RR 30
SpO2 100
1120
HR 93
136/77
RR 28
SpO2 100
Temp 98.1
1130
HR 94
136/59
RR 26
SpO2 100
Temp 98.2

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 9-19

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

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

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

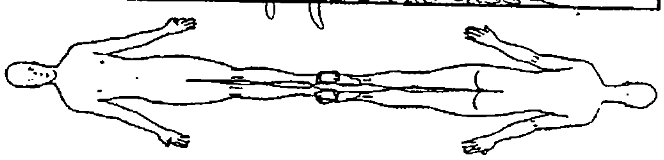
MEDICATIONS						
Allergies: NKDA						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1100	UTA	2.5mg Versed	IV	UTA		[redacted]
1100	UTA	2.5mg Versed	IV	UTA	(b)(6)-2	
1110	UTA	3 mg Versed	IV	UTA		
1145	UTA	3mg Versed	IV	UTA		
1110		2mg [illegible] JP flushed				

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	[illegible] C/D/I		
30'	[illegible] C/D/I		
60'			
D/C	No change from admission		



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1150	Foley	amber	120cc

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Assumed pt care from OR. pt in no apparent distress @ time of XFR. [illegible] @ time of XFR. JP placed to cont suction [illegible] placed to gravity pt on trach collar 35/[illegible]
N agitated [illegible] MAE independently.
CV NSR-ST [illegible] $S_1 S_2$ +2 radial & pedal pulses
Resp even [illegible] Coarse BS [illegible] trach collar [illegible] [illegible] secretions.
GI [illegible] JP [illegible]
GU [illegible]
No [illegible] noted

[redacted] (b)(6)-2

Discharge Criteria:
Date: 9/19 Time: 1210 PARS:
BP: 135/75 T: 98 L HR: 97 RR: 28 Sa02: 100.
Pain Level at D/C (0-10):
Intake: Output: 120 cc
Additional Data:
Transferred To: [illegible]
Report Given To: [redacted]
Transferred Via: W/C [redacted] mbulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Signature: [redacted]

MEDCOM - 17057

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	0700	INITIALS		INITIALS	1830	INI
NEURO		PUPILS	PERRL				PERRLA 3mm (b)(6)-2	
		SENSORIUM	follows simple command				Follow simple commands	
			cooperative				moves all extremities	
							MSO4 5mg/h	
							& Restraint x 2	
RESPIRATORY		RESPIRATORY PATTERN	RRR				RRR RA 97%	
		BREATH SOUNDS	mild crackles				crackles clear ē suction	
		SECRETIONS	thin/light				thick white secretions	
			thick secretions placed				from Trach	
			on humidified air				#8 Shilley Trach ē	
							Trach collar	
SKIN		COLOR	normal for race				Normal for Race	
		INTEGRITY	abd wound packed ē				Suction Vac to abd wound	
			W-D BLE pressure				intact, to 125mmHg vacuum	
IV SITE		LOCATION	superficial scars of back				Drsg BLE intact J	
		CONDITION	of the head (W-D)				Drsg Posterior Head Intact	
							PIV 18G @ Wrist	
		IV	@ arm D5 1/2 NS				D5 1/2 NS ē 20K @ 125cc/h	
			@ 50, MSO4 @ 3 mg/hr					
GASTRO		ABDOMEN	soft non tender				Soft, Round, Nontender	
		BOWEL SOUNDS	active				(+)	
			ostomy draining loose				Ostomy to RUQ draining	
			stool				loose stool	
GU		URINE:	foley				foley to gravity	
		COLOR/CLARITY	clear yellow				light yellow ē small	
							amount of sediment	
CARDIOVASCULAR		CARDIAC RHYTHM	$S_1 S_2$ NSR – ST				SR, S1/S2	
			↓ 100				Pulses +2 x 4 extremities	
			No edema noted				Ø edema noted	
							Cap Refill < 3 sec	

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(b)(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] Maj (AN)

DEPARTMENT/SERVICE/CLINIC

DATE 19SEP03

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

[redacted] (b)(6)-4

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

NEUROLOGICAL ASSESSMENT

		HOURS	07	08	09	10	11	12	13
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	4						
		TO SPEECH 3							
		TO PAIN 2							
		NO EYE OPENING 1							
	BEST VERBAL RESPONSE	ORIENTED 5	4						
		CONFUSED 4							
		VERBALIZES 3							
		VOCALIZES 2							
		NO VOCALIZATION 1							
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	6						
		LOCALIZES PAIN 5							
		FLEXION WITHDRAWAL 4							
		ABNORMAL FLEXION 3							
		EXTENSION TO PAIN 2							
		NO MOTOR RESPONSE 1							
LIMB MOVEMENT	ARMS	NORMAL POWER	✓						
		MILD WEAKNESS							
		SEVERE WEAKNESS							
		ABNORMAL FLEXION							
		ABNORMAL EXTENSION							
		NO RESPONSE							
	LEGS	NORMAL POWER	✓						
		MILD WEAKNESS							
		SEVERE WEAKNESS							
		ABNORMAL FLEXION							
		ABNORMAL EXTENSION							
		NO RESPONSE							
PUPILS	RIGHT	SIZE	3						
		REACTION	++						
	LEFT	SIZE	3						
		REACTION	++						
PUPIL SCALE			2	3	4	5	6	7 mm	
ICP									
CEREBRAL PERFUSION PRESSURE									

LEGEND

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

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

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

VASCULAR ASSESSMENT

HOURS		
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	

LEGEND

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

M AL RECORD-SUPPLEMENTAL MEDI DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0700 INITIALS [redacted]	TIME: 1930 INITIALS [redacted]
NEURO	PUPILS	PERRLA	Perrla
	SENSORIUM	Alert, confused	Alert, Confused
	EXTREMITY MOVEMENT	Active in all extremeties	Full movement in all extremities
	SEDATION	Receiving Morphine + Ativan	MSO4, Ativan, Haldol
	PAIN CONTROL	Morphine Skip	MSO4 gtt @4cc/hr
RESP	RESPIRATORY PATTERN	Regular, unlabored	Regular, unlabored
	BREATH SOUNDS	Coarse in all lobes	Coarse throughout
	SECRETIONS	Thick Yellow	
	O2 SOURCE/FLOW/SAO2	Room Air, Trach Collar	Humidified air via trach collar
	VENTILATOR SETTINGS	Humidified Air	
CV	CARDIAC RHYTHM	SR to ST	SR - ST
	CAPILLARY REFILL	<3 secs	<3sec
	PULSES	+3 in all extremeties	+3 all extremities
	EDEMA	None	
GI	ABDOMEN	Soft, Nondistended	Soft, nondistended
	BOWEL SOUNDS	Absent	(-)
	BOWEL MOVEMENT	Liquid Brown BM in Colostomy	
	NGT/OGT	J-tube Clamped	J-Tube Clamped
	TUBE FEDDINGS		
	DRAINS	JP Drains x 4 to Gravity	JP Drains x 4 to b/b suction
		JP Drain from Wound Vac to Cont. Suction	Wound vac to cont. suction
GU	VOIDING	Foley to Gravity	Foley cath to gravity
	COLOR/CLARITY	Clear, Golden	Clear yellow
SKIN	COLOR	Normal for Race	Normal for race
	INTEGRITY	Dressings to Back of Head (R)	Dsg to back of head, (R) flank
	(R) flank	(R) Shoulder, BLE CIOI	(R) shoulder, BLE
ACCESS	#1 TYPE/LOCATION/SIZE	PIV (L) FA	PIV (R) wrist
	DRESSING CONDITION	(S) S/S of infection	(S) S/S of infection
	IV FLUID/RATE	DS1/2 NS @ 20 meq KCl @ 125cc/hr	DS1/2NS @ 20 meq kcl @ 120
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY: [redacted] (b)(6)-2 ILT/AN

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

DATE: 20 SEP 03

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

NAME: EPW [redacted] (b)(6)-4 RANK: AGE:

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17060

USAPPC V2.00

CU1 Patients Name: CIV [redacted] (b)(6)-4 Date: 20 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	150/84	134/60	135/74	103/75	162/71	152/74	117/82	135/80	126/87	104/57	117/70	132/67		114/64	141/72	111/67	138/73	132/73	153/83	158/77	147/83	154/82	144/76	167/87		
TEMP			97.8																							
HR	85	89	89	83	102	85	86	87	92	81	88	81		75	83	80	83	82	107	94	102	103	97	112		
RR	22	25	23	23	27	24	27	34	29	22	22	23		25	34	23	21	27	42	36	27	29	19	22		
SaO2	96	94	98	96	97	98	96	98	97	95	100	98		96	97%	99%	98%	98%	96%	99%	96%	96%	99%	96		
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		
Source																										
MAP	112	95	100	85	115	106	96	111			97	91		85	88	85	99	95	109	104	109	106	100	119		

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF D5½ NS +20K	120	120	120	120	120	120	120	120	120	120	120	120		120	120	120	120	120	120	120	120	120	120	120	120	
IVPB			50								50															
NGT																										
Morphine	5	5	5	5	5	5	8	8	8	8	8	8		4	3	3	3	3	3	3	3	2	2	2	2	
J Tube					60	60																				
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100	100	250	300	125	140	185	210	110	170	120	190		200	180	170	290	200	200	170	170	150	125	125	170	
NGT																										
STOOL																										
DRAIN JP JAC																										
JP # 1																										
JP # 2																										
JP # 3																										
JP # 4																										
Total																										

MEDCOM - 17061

DOD-030650

ACLU-RDI 1640 p.21

MED RECORD-SUPPLEMENTAL MEDICAL DA
For use of this form s 40-66; the proponent agency is The Office of T jeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800 INTIL [redacted]	1800 INTIL [redacted]	INTILAS
NEURO	PUPLIS	PERR	PERRL	
	SENSORIUM	awake daily arouse	awake + responsive to	
		c mild sedation	comments. mild sedation	
		q MSO4.	c MSO4	
		unable to follow commands		
RESPIRATORY	RESPIRATION PATTERN	RRR no SOB	= rise + fall of chest	
	BREATH SOUNDS	CTA c scattered rhonchi	diffusely CTA b/l +	
	SECRETIONS	@ LL,	trach open to air	
		O2 sat @ 95-96%	O2 sat 97-100% shall	
		whitish secretions	amount of tannish secretion	
		in moderate to scant		
SKIN	COLOR	WDL, wound (R) side	NFR burn (R) axillary	
	INTEGRITY	abd wound, LE +	abd surgical wound dry LDI	
		heel pressure sore, dressing to upper abdomen		
IV SITE	LOCATION	(R) arm	(R) arm	
	CONDITION	D+I 3 redness c	CDI no erythema or	
		infection	swelling IV D5, 45 NS c KCL	
		IVF D5-5 c 20k	@ 120 ml/hr @ 3 ml/hr	
		@ 120, MSO4 titrated		
		for sedation		
GASTRO	ABDOMEN	soft nontender	soft flat. Ostomy c	
	BOWEL SOUNDS	BS. Ostomy not	brown loose stool RQ	
		draining 2° NPO	TP Y4 (R) QU+L Q	
		status	Q BS	
GU	URINE	Foley draining q S	Foley to gravity	
	COLOR/CLARITY	clear yellow urine	clear yellow urine	
CARDIOVASCULAR	CARDIACRHYTHM	NSR - ST mid 80's	S1 S2 no extra sounds	
		90's	pulses +2 U+L extremities	
		no edema noted	cap refill <3 secs	

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CINC | DATE

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

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

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

ME RECORD-SUPPLEMENTAL MEDICAL D
For use of this form 40-66; the proponent agency is The Office of geon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS		INTILAS	1845	INTILAS [redacted]
NEURO	PUPLIS					PERRL	
	SENSORIUM					Pt lightly sedated c MSO4 + Ativan. Responsive + arousable to voice + touch stimuli.	
RESPIRATORY	RESPIRATION PATTERN					Reg R+R	
	BREATH SOUNDS					CTA throughout	
	SECRETIONS					thick Yellow From trach	
						Shiley trach #8	
						O2 Sats @ 92-99% on RA	
SKIN	COLOR					NFR	
	INTEGRITY					Dressings C/D/I	
IV SITE	LOCATION					RFA 20G, dressing	
	CONDITION					C/D/I, ØNtd erythema/edema	
						Receiving D5 ½ NS @ c	
						20 Kcl @ 120 + MSO4 @ 2	
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE					Voiding clr Yellow urine	
	COLOR/CLARITY					Via Foley to gravity	
						In adequate Amounts	
CARDIOVASCULAR	CARDIACRHYTHM					NSR ; HR - 86 BP 163/53	
						+2 radial + Pedal Pulses c	
						brisk cap refill. ØNtd	
						edema	

LEGEND

Cr - Creatinine
F_iO - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(b)(6)-2

(Continue on reverse)

[redacted] 6/WARD | DEPARTMENT/SERVICE/CINC ICU | DATE 2/Sep 03

(Last name, First, middle; grade; date; hospital or medical facility)

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

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17063

DATE 21 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	167/92						170/92		136/87	118/64	124/73	142/74	116/72	127/68	109/57	167/55	108/57	
Temperature	99.5						99.1					99.8				99.6		
Pulse	113						112		113	92	89	92	92	90	90	89	88	
Respiratory Rate	34						36		19	21	23	44	35	obb		30	20	
SaO2	98						95		98	92	92	92		(89)	(89)	93	94	
O2 Meth	RA						RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

TIME	24	01	02	03	04	05	06	07	8A	08	09	10	11	12	13	14	15	8°T
D5½ 20kcl							120		130	120	120	120	120	120	120	120	120	
IVPB										50								
M504							7	7	1	7	7	7	7	7	7	7	7	
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL						220				200						190	
	SP gr																	
	S/A																	
wound vac. NG	OUTPUT									100								
	PH																	
	GUIAC																	
EMESIS																		
STOOL										Ø								
DRAINS	1									5								
	2									5								
	3									10								
TOTALS 4										Ø								

POST-OP DAY

VITAL SIGNS									
	16	17	18	19	20	21	22	23	
	93/52	102/54	106/55	103/53	114/60	98/52	133/71	117/[illegible]	
	99.7		—	99.3	—	99.6	—	—	
	83	81	89	88	83	89	78	84	
	27	8	20	14	23	21	22	23	
	92	91	94%	94%	95%	96%	96%	96%	
	RA	RA	N-RA	RA	RA	RA	RA	RA	

INTAKE									
	14	17	18	19	20	21	22	23	8°T
			120	120	120	120	120	120	
			?	?	?	?	?	?	

OUTPUT									
					210	45		220	

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES OF DAILY LIVING	
TIME	
MOUTH CARE	
BATCH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN / SUCTION — TIME

24°180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE — IV ______ Po ______ TOTAL ______

OUTPUT — Urine: ______ ______ TOTAL ______

BALANCE ______

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

ME . RECORD-SUPPLEMENTAL MEDICAL D
For use of this form . 40-66; the proponent agency is The Office of geon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800 INTILAS [redacted]	INTILAS	2000 INTILAS [redacted]
NEURO	PUPLIS	PERRL		Perrla
	SENSORIUM	Intermittent restlessness		Pt agitated when awake.
		MSO4 4-7mg for pain sedation & Ativan 1mg PRN		
RESPIRATORY	RESPIRATION PATTERN	RRR		RRR
	BREATH SOUNDS	CTA & scattered rhonchi		Clear Bilat &
	SECRETIONS	cleared up & coughing & suctioning initial thick		coughing or suction
SKIN	COLOR	WNL, multiple wounds		Normal to Race
	INTEGRITY	abd, flank, head & LE W-D dressing		Multiple wounds
IV SITE	LOCATION	(R) arm		(R) wrist
	CONDITION	D & I		D & I
GASTRO	ABDOMEN	Ostomy draining watery		Colostomy (R) side
	BOWEL SOUNDS	stools, normal BS		BS normoactive
		TF @ 100cc/hr		TF @ 100 cc/hr
GU	URINE	foley		foley
	COLOR/CLARITY	clear yellow urine		clear yellow urine
CARDIOVASCULAR	CARDIACRHYTHM	NSR ↑ 90s - ST ↑ 100's		SR 90's
		S, S2 no noted ectopy		S, S2 No ectopy

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(b)(6)-2

(Continue on reverse)

PRE [redacted] IAN | DEPARTMENT/SERVICE/CINC | DATE 23 Sep 03

PATIENT [illegible] (Typed or [illegible] give: Name—Last, First, middle; grade; date; hospital or medical facility)

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

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17066

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line	00	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
BP Cuff	125/67	147/78	115/66	124/73	142/74	119/72		113/64	120/63	114/71	120/63	114/75	111/66	124/64		115/67	139/68	
Temperature	98.6				98.7					98.9								
Pulse	105	115	105	89	92	92		95	93	96	93	96	119	99		96	97	
Respiratory Rate	25	(43)	28	23	(44)	35		28	(40)	25	20	25	31	10		26	26	
~~FIO2~~ Osat	92	98	97	92	92	98		95	100	96	97	96	98	99		96	96	
source	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA		RA	RA	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5.5 E 20 KCl	600	120	120	120	120	120	120	120	120	120	120	75	75	75	75	75	75	
H504	31												5	5	5	5	5	
Zantac			50								50							
IFC (acetyl)													100	100	100	100	100	
												pt ate own dinner						
TOTALS																		

OUTPUT

	HOUR / TOTAL	210/210	90/300	90/390	80/470	60/530	70/600	70/670		60/730	70/800	50/850	60/910	60/970	140/1110	120/1230	160/1390	100/1490
URINE	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL ostmy						writing stool						writing stool						
DRAINS 1			2															
DRAINS 2			3															
DRAINS 3			2															
TOTALS 4			3			300						160						

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	14	17	18	19	20	21	22	23
	23	24	01	02	03	04	05	
	134/64	164/88	135/95	97/53	107/50	113/54	122/57	
	100	125	122	104	99	98	95	
	24	35	36	28	28	27	28	
	96	94	95	100	100	100	96	
	RA	RA	RA	RA	RA	RA	RA	
	23	24	01	02	03	04	05	

INTAKE

	14	17	18	19	20	21	22	23
	75	75	75	75	75	75	75	
	5	5	5	5	5	5	5	
		50						
	100	100	100	100	100	100	100	

OUTPUT

100	100	40	100	100	100	100	

RESPIRATORY

TIME													
MODE													
F_iO_2													
TV													
RATE													
PEEP													
A pH													
A PCO_2													
B pO_2													
B HCO_3													
G SAT													
G BASE													

LABORATORY

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

ACTIVITIES DAILY LIVING

TIME													
MOUTH CARE													
BATCH													
SKIN CARE													
FOLEY CARE													
TRACH CARE													
ROM EXERCISES													

TURN

TIME													

SUCTION

24 HOUR TOTALS

NURSE'S SIGNATURE

INITIAL

[redacted]

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

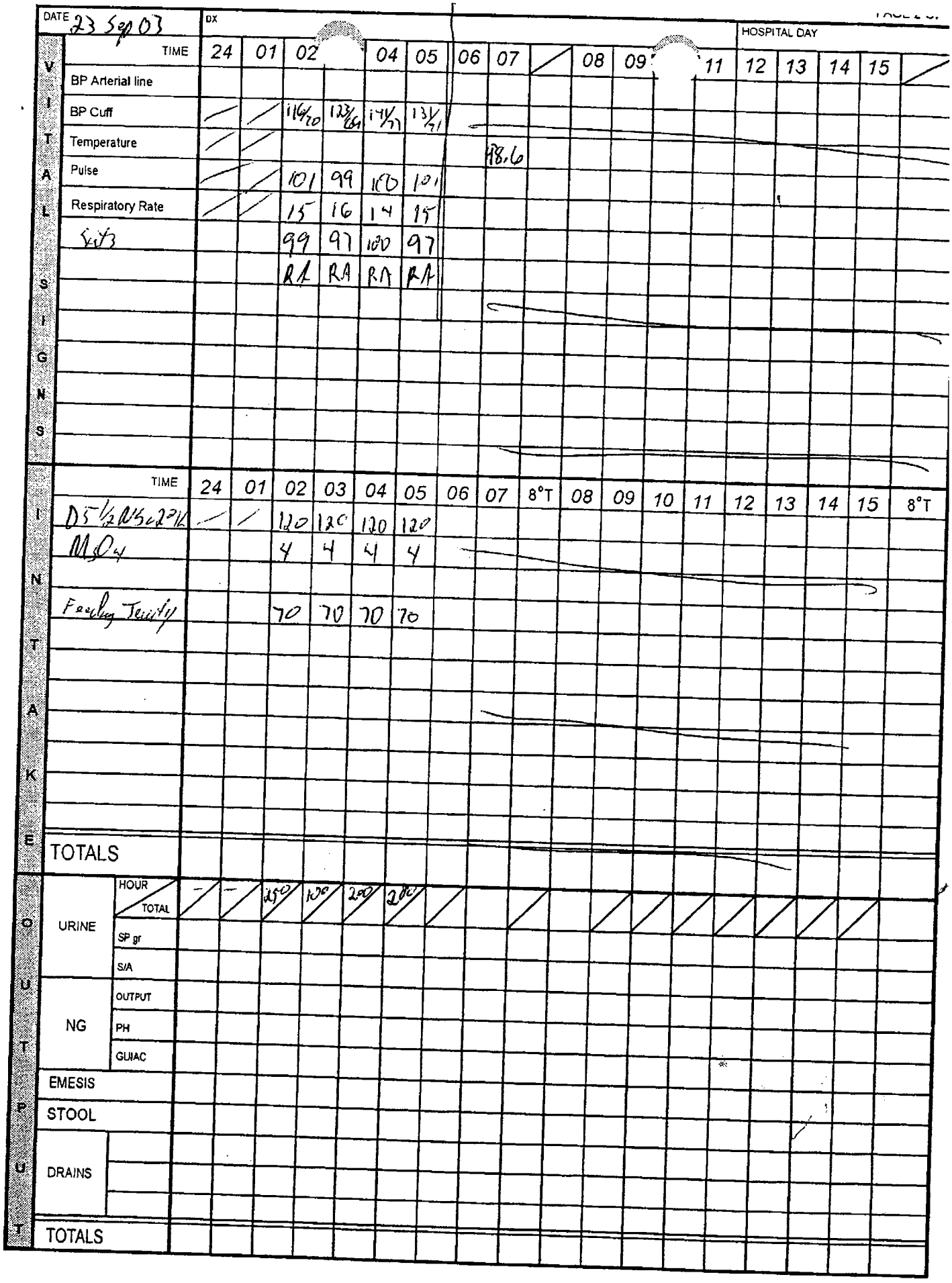
_____

TOTAL _____

BALANCE _____

(b)(6)-1

MEDCOM - 17068



MEDCOM - 17069

ACLU-RDI 1640 p.29

DOD-030658

ME RECORD-SUPPLEMENTAL MEDICAL D
For use of this form s 40-66; the proponent agency is The Office of T geon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INTILAS		INTILAS	2000	INTILAS
NEURO		PUPLIS						
		SENSORIUM	pt A&O - unable to assess				Unable to assess	
			pt medicated & attrans!				mental status	
			Haldol a.s. per Dr's orders					
			Purposefull movement x4					
RESPIRATORY		RESPIRATION PATTERN	RR- 20 Spo2- 98				RRR	
		BREATH SOUNDS	(2L) Humidified RA via				Breath sounds	
		SECRETIONS	trach. (B) Expiratory				clear & coughing &	
			sounding thick				suction	
			mucoury secretion					
			From trach					
SKIN		COLOR	Normal For Race				NTR	
		INTEGRITY	Abd wound burns				ABD wound & Burns	
			(R) forearm (R)LE					
IV SITE		LOCATION	(R) Forearm infusing				(L) wrist	
		CONDITION	D5 1/2 NS @ 20K & MSO4				D5 1/2 NS @ 20 kcl + MSO4	
			site CDI & S/S of					
			infection / infiltration					
GASTRO		ABDOMEN	mid line Abd wound				Midline Abd wound	
		BOWEL SOUNDS	soft flat non-distended				active BS	
			bowel sound (+) x4					
GU		URINE	clear yellow voiding				Foley cath	
		COLOR/CLARITY	via foley to cath				clear/yellow	
CARDIOVASCULAR		CARDIACRHYTHM	HR- 83 BP- 115/63				ST-100's	
			cap refill ≤ 3sec				cap refill ≤ 3sec	
			Peripheal pulses x 4					

LEGEND

Cr - Creatinine
F_iO - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CINC ICU

DATE 25 Sep 03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

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

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

DATE 25Sep | DX | HOSPITAL DAY

		TIME	~~24~~	~~01~~		~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	~~08~~		~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
VITALSIGNS			06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
	BP Arterial line																			
	BP Cuff		118/63	91/62	93/58	109/57	96/57	97/80	99/55	108/53		91/49	104/53	136/71	104/55	92/49	91/52	120/61	122/63	
	Temperature		98.1			99.1							98.1							
	Pulse		83	87	83	83	80	85	82	85		78	80	87	77	77	76	97	103	
	Respiratory Rate		20	24	25	18	25	26	27	20		14	27	22	15	12	11	15	37	
	SpO2		98	100	99	97	98	96	98%	98		98	98	96	97	95	100	98	100	
INTAKE		TIME	~~06~~ 24	~~07~~ 01	~~08~~ 02	~~09~~ 03	~~10~~ 04	~~11~~ 05	~~12~~ 06	~~13~~ 07	~~8T~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~ 12	~~13~~ 13	~~14~~ 14	~~15~~ 15	8°T
	IVF		75	95	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
	TF																			
	J-Tube				60											100	100	100	100	400
	MSO4		5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	7	
	IV PB				50									50						
	TOTALS		80	160	300	380	460	540	620	780										
OUTPUT	URINE	HOUR / TOTAL	80/80	80/160	80/240	80/320	80/400	80/480	80/560	80		80	40	50	40	80	70	70	70	
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	22	23	24	01	02	03	04	05
	113/59	134/71	142/78	142/75	131/82	132/76	172/85	165/79
	93	97	98	101	105	105	121	114
	20	21	19	22	26	17	10	26
	100	97	94	100	98	100	98	98

INTAKE

	22	23	24	01	02	03	04	05	8°T
	75	75	75	75	75	75	75	75	
	100	100	100	100	100	100	100	100	
	7	5	5	5	5	5	5	5	

OUTPUT

	80	80	80	200	200	200	100	100

RESPIRATORY

	TIME												
	MODE												
	F_iO_2												
	TV												
	RATE												
	PEEP												
A	pH												
A	PCO_2												
B	pO_2												
B	HCO_3												
G	SAT												
G	BASE												

LABORATORY

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

ACTIVITIES OF DAILY LIVING

	TIME												
	MOUTH CARE												
	BATCH												
	SKIN CARE												
	FOLEY CARE												
	TRACH CARE												
	ROM EXERCISES												

TURN SUCTION

TIME												

24°180 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

(b)(6)-2

WT Yesterday _____ wt Today _____

INTAKE OUTPUT

IV _____ Urine: _____

Po _____ _____

TOTAL _____ TOTAL _____

BALANCE _____

M[illegible]AL RECORD-SUPPLEMENTAL MEDI[illegible] ATA

For use of this [illegible], see AR 40-66; the proponent agency is the Office [illegible] Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

SHIFT ASSESSMENT

		TIME: [illegible] INITIALS: [redacted] (b)(6)-2	TIME: INITIALS:
NEURO	PUPILS	PERRLA 3mm brisk	
	SENSORIUM	Alert	
	EXTREMITY MOVEMENT	Moves all ext.	
	SEDATION	[illegible]	
	PAIN CONTROL	[illegible]	
RESP	RESPIRATORY PATTERN	Trach Resp 20-[illegible]	
	BREATH SOUNDS	B/L Breath sounds clear Equal [illegible]	
	SECRETIONS	Ø	
	O2 SOURCE/FLOW/SAO2	Room air	
	VENTILATOR SETTINGS	Ø	
CV	CARDIAC RHYTHM	ST HR 116. BP 167/84	
	CAPILLARY REFILL	Good < 3 sec	
	PULSES	all (+)	
	EDEMA	(−)	
GI	ABDOMEN	Nondistended Nontender	
	BOWEL SOUNDS	(+) x4	
	BOWEL MOVEMENT	Colostomy drainage [illegible]	
	NGT/OGT	Ø	
	TUBE FEDDINGS	J Tube [illegible]	
	DRAINS	JP	
GU	VOIDING	Foley	
	COLOR/CLARITY	yellow clear	
SKIN	COLOR	Normal	
	INTEGRITY	Surgical wound [illegible] abdomen.	
		Multiple [illegible]	
		and [illegible]	
		[illegible] side of chestwall.	
ACCESS	#1 TYPE/LOCATION/SIZE	(L) hand.	
	DRESSING CONDITION		
	IV FLUID/RATE	D5½NS [illegible] NS [illegible]	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION	DRY	
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(6)-2
ICU #1, [redacted]

DATE
26 Sep 03

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

NAME: EPW [redacted] (b)(6)-4   RANK: AGE:

UNIT: GENDER:

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

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

DA FORM 4700, MAY 78

MEDCOM - 17073

USAPPC V2.00

ICU1

Patients Name: EDW [redacted] (b)(6)-4 Date: 26 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	167/94	164/90	152/77	146/83	116/64	120/66	109/53	97/55	110/55	110/53	108/65	98/51		95/51				141/75			154/85				177/98	
TEMP	98.0				98.3			0	98.3						98.1			98.0			99.9				98.2	
HR	115	116	111	106	103	96	94	84	86	89	86	91		89				100			105				113	
RR	23	23	25	23	27	22	20	24	24	23	24	22		27				20			27				24	
SaO2	98																	95%			100%				100%	
FiO2	—	97	98	97	97	97	98	99	99	99	97	97		97												
Source	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA				RA			RA				RA	
MAP	—	117	103	105	84	88	75	78	77	73	75	69		67				105			110				129	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	
IVPB			50								50									150						
~~NGT~~ TF	100	0	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
MFH	5	5	5	5	5	5	5	5	5	5	5	5		5	5	5	5	5	5	5	5	5	5	5	5	
PO																										
Total	180/180	80/260	150/410	140/550	180/730	180/910	180/1090	180/1270	180/1450	180/1630	230/1860	180/2040	2040	100												

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100/100	120/220	60/280	100/380	100/480	180/660	180/840	90/930	60/990	80/1070	100/1170	70/1240	1240	85/85	60/145	140/285	130/415	110/525	110/635	110/745	215/960	140/1100	180/1280	250/1530	158/1688	1688
NGT																										
STOOL (wl			250																							
DRAIN																										
Total	100/100	120/220	410/630	150/780	150/930	180/1110	180/1290	90/1380	60/1440	80/1520	100/1620	70/1690	1540	85	60											

ACLU-RDI 1640 p.34

MEDCOM - 17074

DOD-030663

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

DATE 24 Sep 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								137/57
NIBP																								97
MP																								25
PULSE																								97%
RESP																								RA
SP02																								
FIO2																								
																								75
INPUT																								100
IV																								5
IF																								
MSO4																								
EVPB																								
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
																								90
OUTPUT																								
URINE																								
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								

MEDCOM - 17075

MI .L RECORD-SUPPLEMENTAL MEDIC ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

(b)(6)-2

SHIFT ASSESSMENT

		TIME: 0600 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]
NEURO	PUPILS	Rt 3mm Brisk	Perrla +3
	SENSORIUM	alert, follow Commands	Alert
	EXTREMITY MOVEMENT	Moves all extremities	
	SEDATION	Ativan IV prn Haldol	
	PAIN CONTROL	MSO4 5mg/h	MSO4 gtt 5CC/hr
RESP	RESPIRATORY PATTERN	Trach Resp 20-30's	Trached RRR
	BREATH SOUNDS	Breath sounds clear bil. Equal chest	Clear Bilat
	SECRETIONS	Expansion. Ø	
	O2 SOURCE/FLOW/SAO2	Room Air Sat 97-100% RA	Room air
	VENTILATOR SETTINGS	pulse oxemeter.	—
CV	CARDIAC RHYTHM	ST	SR-ST
	CAPILLARY REFILL	<3 sec	≤ 3 sec
	PULSES	all ⊕	Pulses +2 all ext.
	EDEMA	Ø	Ø
GI	ABDOMEN	Soft Non tender and Non distended	Soft, non distended
	BOWEL SOUNDS	+ x 11	+ all quads
	BOWEL MOVEMENT	colostomy draining to bag	colostomy to drain bag
	NGT/OGT	Ø / J-Tube @ Jevity 100cc/h	J-Tube @ Jevity @ 100 cc/hr
	TUBE FEDDINGS		
	DRAINS	JP x4	JPs x4
GU	VOIDING	foley	Foley cath
	COLOR/CLARITY	yellow clear	clear/yellow
SKIN	COLOR	Normal	NTR
	INTEGRITY	Surgical wound to mid abdomen	Surgical to ABD midline open
		Multiple open areas to Lower	area below and to Rt of wound
		extrs, Right upper arm. Rt 2nd	Burns to Rt chest, shoulder, BUE
		Rt of chest Wall.	Breakdown to head
ACCESS	#1 TYPE/LOCATION/SIZE	(L) hand Ø (HC)	Rt hand, Hep lock
	DRESSING CONDITION	intact	Intact
	IV FLUID/RATE	Ø	—
	#2 TYPE/LOCATION/SIZE	Right fore Land	Rt Forearm
	DRESSING CONDITION	Intact Ø SIS infection/infiltration	Intact
	IV FLUIDS/RATE	D5½NS 7LC 20KCL 75h MSO4 @ 5ah	D5½NS @ 20 meq KCl @ 75 cc/hr MSO4 gtt @ 5 cc/hr

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] 9 W MS

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

DATE 27 Sep

PATIENT'S ID [redacted] (If typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

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

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17076

USAPPC V2.00

ICU1

Patients Name: # [redacted] (b)(6)-4 Date: 27 Sep

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	101/80				144/63				130/76					94/48				101/52				97/62				
TEMP	99				98.7				98.5																	
HR	112				111				99					84				95				92				
RR	29				23				25					26				19				28				
SaO2	100%				97				98					99				97				98				
FiO2					RA				RA					RA				RA				RA				
Source																										
MAP	112				103				100					84												

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	25		75	75	75	75	75	75	75	75	75	75	75	75	
IVPB			50								50									50						
~~NOT IF~~	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
M504	5	5	5	5	5	5	5	5	5	5	5	5		5	5	5	5	5	5	5	5	5	5	5	5	
PO																										
Total	180	180	230	180	180	180	180	180	180	180	230	180	2160	180	180	180	180	180	180	280						

URINE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
NGT																										
STOOL																										
DRAIN																										
58																										
Total																										

MEDCOM - 17077

DOD-030666

ACLU-RDI 1640 p.37

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-7

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: 2000 Initals: [redacted]
NEURO	Pupils		
	Sensorium / LOC / GCS	A&O – unable to assess pt more all extremities doesn't follow commands	A&O moves all extremities
CARDIAC	Cardiac Rhythm	HR 101 BP 119/65	SR-ST
	PRI: / QRS:		
	Pulse Strength	Pulses	+3
	Cap Refil / JVD	Capillary Refill	cap refil ≤ 3sec ⊖ JVD
	Edema	No swelling noted	Ø
	Chest Pain	Ø chest pain	Ø
RESP	Respiratory Pattern	RR-10 Spo2 - 99%	RNR Tracked
	Breath Sounds		Clear Bilat
	Secretions	thick yellow, green sputum	
	Cough	spiratic productive cough	spiratic productive cough
SKIN	Color	Normal for Race	NTR
	Integrity	break down healing burns & Abd wound	intact X wounds
	Backside		
IV	Access Devices	® wrist infusing 75 DS½NS	®wrist PIV
	Location	@ 30K and 5 cc/hr MSO4	DS½NS @ 20 meq kcl @ 75 cc/hr
	Condition	No S/S infection, CDI	
GI	Abdomen		normo active
	Bowel Sounds		
	Stoma/Ostomy	J-tube dressing CDI Ostomy draining Runny Brown	Colostomy, J-Tube
GU	Device	Foley to gravity draining	Foley to gravity
	Color / Clarity	clear yellow urine	

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 DATE

ICU #1 [redacted] 29 Sep 03

PATIENT'S 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: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

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

DATE: 24 sep 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV.																126/70	144/84	112/65	140/74	144/79	132/70	126/66	125/65	
NIBP	149/85	125/63	128/62	135/72	110/70	119/66	98/53	149/89	136/60	116/63	116/55	127/74	124/66	146/81										
°	98.4		98.6			98.7			98.3															
PULSE	98	90	95	94	96	97	92	105	99	99	93	90	95	103	99	100	114	102	94	107	101	96	94	
RESP	99 10	28	28	26	24	32	35	28	32	33	29	27	43	10		44	35	29	26	29	30	42	45	
SP02	99	98	98	41.	98	97	96	95	96	97	97	97	96	94	98	98	97	96	100	99	99	98	99	
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
INPUT																								
IV	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
TF	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
MSO4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	
IV PB																								
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE	80	90	30	80	130	100	30	80	120	80	80	110	180	140	140	110	110	290	210	130	130	130	180	
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 17079

N AL RECORD-SUPPLEMENTAL MEDI ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0600 INITIALS: [redacted] (b)(6)-2	TIME: INITIALS:
NEURO	PUPILS	Reactive 3mm to 2mm	PERRL
	SENSORIUM	alert follow commands	Pt awake able to follow simple commands
	EXTREMITY MOVEMENT	Moves all extremities	moves x4 extremities
	SEDATION	MSO4 5mg/hr	MSO4 ↓
	PAIN CONTROL	MSO4 5mg/hr	
RESP	RESPIRATORY PATTERN	Reg.	RR
	BREATH SOUNDS	wheeze to upper lobes. Equal bilat	CTA Bilat
	SECRETIONS		white frothy secretions from
	O2 SOURCE/FLOW/SAO2	Room air	ETT/TRACH 40%
	VENTILATOR SETTINGS	ø	ø
CV	CARDIAC RHYTHM	ST. HR 107-120's	SR
	CAPILLARY REFILL	<3sec	<3sec
	PULSES	all (+)	NSR
	EDEMA	ø	(+) x 4 extremities
			ø
GI	ABDOMEN	Soft Nontender	Soft round nontender
	BOWEL SOUNDS	(+) x4	(+) x 4 Quad
	BOWEL MOVEMENT	Colostomy	Colostomy Draining
	NGT/OGT	ø	liquid stool
	TUBE FEDDINGS	Pevisy J. Tube	
	DRAINS	JP x4	JP x 4
GU	VOIDING	Foley	Foley to gravity
	COLOR/CLARITY	yellow/clear	clear yellow
SKIN	COLOR	Intact except for Abdominal	Abd incision midline
	INTEGRITY	Surgical wound Heal wound 1/8	pressure sores to head, back
		Right upper arm Burn Right chest/	(+) L arm/chest
		burn with lower leg burn	
ACCESS	#1 TYPE/LOCATION/SIZE	Right femoral 20G	L FA 20G (+) flush
	DRESSING CONDITION	Dressing /	DSY2 NSC 20KCl
	IV FLUID/RATE	D5 1/2 NS IL 2 KCl @ 75cc/hr MSO4 5mg/hr	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 DATE

ICU #1 [redacted]

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: EAW [redacted] (b)(6)-4 Date: 29 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	185/96				124/64				150/77					154/91				150/88				157/98				
TEMP	97.6				96.4									96.8				96.9				97.9				
HR	111				100	~~100~~			100					96				102				94				
RR	22				18				35					25				21				24				
SaO2	100				100				96					97				97				97				
FiO2	RA				RA				RA					RA				RA				RA				
Source																										
MAP	128																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	~~75~~	900	75	75	75	75	75	75	75	75	75				
IVPB																										
~~NGT~~ TF	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100				
MSO4	5	5	5	5	5	5	5	5	5	5	5	5	60	5	10	10	10	10	10	10	10	10				
PO																										
Total													2160													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	~~100~~ 100				~~1100~~ 800							500 300	230		150		150		200		150	150				
NGT												23														
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17081

DOD-030670

ACLU-RDI 1640 p.41

M AL RECORD-SUPPLEMENTAL MEDI ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSE NT

		TIME: INITIALS: [redacted]	TIME: 1855 INITIALS: [redacted]
NEURO	PUPILS	3mm PERRL	Perrla 3mm
	SENSORIUM	Awake Moves extremities	
	EXTREMITY MOVEMENT	x4 c purposeful movement	
	SEDATION		
	PAIN CONTROL	MSO4 @ 10mg/hr	
RESP	RESPIRATORY PATTERN	RRR 8 Shiley Trach	RRR #8 shiley trach
	BREATH SOUNDS	RA CTA bilat.	Clear Bilat
	SECRETIONS		
	O2 SOURCE/FLOW/SAO2		RA Sats 98-100
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	S1S2 +2 pulses x4 extremities	S1S2 no ectopy
	CAPILLARY REFILL	<3 sec cap refill	<3 sec
	PULSES		+2
	EDEMA		
GI	ABDOMEN	+BS x4 quads Abd soft	Soft non distended
	BOWEL SOUNDS	non-distended	+BS x 4 quads
	BOWEL MOVEMENT	TF Jevity @ 100cc/hr	
	NGT/OGT	Colostomy to RUQ	
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to gravity	Foley to gravity
	COLOR/CLARITY	Clear yellow Urine	Clear yellow Urine
SKIN	COLOR	NTR	NTR
	INTEGRITY		
ACCESS	#1 TYPE/LOCATION/SIZE	18ga IV to (R) FA	18 guage IV to (R) FA
	DRESSING CONDITION	D5 1/2NS + 20KCL at 75cc/hr	D5 1/2NS + 20 meq kcl @ 75cc/hr
	IV FLUID/RATE	Site CDI	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC (b)(2)-2

ICU #1 [redacted]

DATE 30 Sept 01

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

NAME: RANK: AGE:

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

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

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

ICU1

Patients Name: [redacted] (b)(6)-4 Date: 3 Sept 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			147/92				153/55				123/93															
TEMP			98.3				98.6																			
HR			111				99				106															
RR			21				17				26															
SaO2			97				96				100															
FiO2																										
Source			RA				RA				RA															
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	25	25	25	25	25	25	25	25	25	25	25	25	900	25	25	25	25	25	25	25	25	25				
			50								50		100													
IVF	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100				
SOL	10	10	10	10	10	10	10	10	10	20	10	10	120	10	10	10	10	7	7	5	3	3				
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							825							525	66	66	67 200	80	80	80	80	80	80	100	100	
NGT																										
STOOL																										
DRAIN																										
Total							825						825-525													

N AL RE D-SUPPLEMENTAL MED DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: INITIALS:	TIME: 1930 INITIALS: [redacted]
NEURO	PUPILS		PERRLA 3mm brisk (b)(6)-2
	SENSORIUM		opens eyes and follows simple
	EXTREMITY MOVEMENT		commands, moves/repositions
	SEDATION		self. ϕ sedation
	PAIN CONTROL		MSO4 3mg/°
RESP	RESPIRATORY PATTERN		RRR
	BREATH SOUNDS		CTA (B) c rhonchi that clear w/ cou
	SECRETIONS		thick white secretions
	O2 SOURCE/FLOW/SAO2		RA/>95%
	VENTILATOR SETTINGS		trach #8 Shilley
CV	CARDIAC RHYTHM		RRR SR S1/S2
	CAPILLARY REFILL		<3 sec x 4 extremities
	PULSES		+2 x 4 extremities
	EDEMA		ϕ
GI	ABDOMEN		Round, soft, nontender
	BOWEL SOUNDS		(+) x 4 quads
	BOWEL MOVEMENT		colostomy, liquid light brown
	NGT/OGT		ϕ, Drsg mid abd
	TUBE FEDDINGS		J-tube Jevity 100cc/°
	DRAINS		JP drains x 3 to abd, minimal
			serous drainage noted
GU	VOIDING		foley to gravity
	COLOR/CLARITY		
SKIN	COLOR		Normal for race, warm, dry
	INTEGRITY		Drsg mid abd CDI, (R) arm/chest
			CDI, RUQ CDI, RLE CDI
ACCESS	#1 TYPE/LOCATION/SIZE		PIV @ RFA
	DRESSING CONDITION		CDI
	IV FLUID/RATE		D5.45NS @ 20K @ 100cc/°
	#2 TYPE/LOCATION/SIZE		MSO4 @ 3mg/°
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 [redacted] LT/RN

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

DATE: 01 OCT

PATIENT'S 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: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: EPW [redacted] (b)(6)-4 Date: 1 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	125/96				169/88				131/69			139/64					133/69				124/60				118/60	
TEMP	98.9								98.6			98.4					98.8				98.2				97.9	
HR	112				119				92			91					95				92				91	
RR	27				30				28			27					13				28				25	
SaO2	98				98				98			100					99				98				98	
FiO2	—				—				—			—														
Source	RA				RA				RA			RA					RA				RA				RA	
MAP	—				—				—			—					92				82				84	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	75	75	75	75	75	—	—	—	—	—	—	75	450	75	75	75	75	75	75	75	75	75	75	75	75	900
IVPB	100						100		100				300													
NGT TF	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
MSO4														3	3	3	3	3	3	3	3	3	3	3	3	36
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE						200	165	140	55	55	100	110	725				600				400				450	1450
NGT																					1000				1450	
STOOL				100cc														150								
DRAIN																										
Total																										

MEDCOM - 17085

DOD-030674

ACLU-RDI 1640 p.45

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	98.7	98.7		98.6	99.2	99.3																				
Pulse	118	120	119	116	114	115																				
B/P A-Line	111/67	112/64	110/61	107/60	98/58	94/57																				
MAP		80		75	71	67																				
~~B/P Cuff~~ CVP				17	15	13																				
Respirations	16	16	16	16	16	16																				
Sa02	100%	100%	100%	100%	100%	100%																				
Mode	vent	vent	vent	vent	vent	vent																				
FiO2	60%	100%	60%	60%	60%	55%																				

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	200	800	200	200	200	200							1200													
IVPB		50											50													
Bolus	400 MBOC												400													
Vec	12	12	12	12	12	6																				
Versed	3	3	3	3	3	3							18													
~~PO intake~~ Tent.	125	12.5	12.5	12.5	12.5	10																				
O.R. IN																										
Totals													1699													

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	90 640	95 735	50 785	70 855	60 915	36 951							951													
NG Tube													75													
Drains #1																										
#2																										
EBL #3													1600													
Emesis/Stool																										
O.R. OUT													125													
Totals													2751													

24 hour input	16992
24 hour output	2751
24 hour balance	+14241

CAL RECORD-SUPPLEMENTAL MED DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date): QA Appr 8 Mar 89

		SHIFT ASSESSMENT	
		TIME: 0740 INITIALS: [redacted]	TIME: 1900 INITIALS: [redacted]
NEURO	PUPILS	PERL	Perrla
	SENSORIUM	Alert + responsive	A+ responsive
	EXTREMITY MOVEMENT	moves all extremities well	moves all extremities well
	SEDATION		
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	RR 23 unlabored	RRR - unlabored (Trached)
	BREATH SOUNDS	wheezing	
	SECRETIONS	Coughed up thick red-tinted sputum	
	O2 SOURCE/FLOW/SAO2	RA	RA
	VENTILATOR SETTINGS	ϕ	ϕ
CV	CARDIAC RHYTHM	HR 92	SR-ST
	CAPILLARY REFILL	Good cap refill	≤ 3sec
	PULSES	+pulses	+2 pulses
	EDEMA	Edema noted @ present time	ϕ
GI	ABDOMEN	Soft & nondistended	Soft, non distended
	BOWEL SOUNDS	Colostomy - Q4 quads.	Colostomy - Q 4 quads
	BOWEL MOVEMENT		
	NGT/OGT		
	TUBE FEDDINGS	Jevity @ 100cc/hr	Jevity @ 100 cc/hr
	DRAINS	JP drains x 3 to abd.	JP drains x 3 abd
GU	VOIDING	F/C to BS	F/C to BS
	COLOR/CLARITY	dark yellow	dark yellow urine
SKIN	COLOR	Burn to (R) shoulder area, wounds	Burn to (R) shoulder &
	INTEGRITY	to B-legs.	RLE
ACCESS	#1 TYPE/LOCATION/SIZE	PIV to (R) FA	PIV to (R) FA
	DRESSING CONDITION		
	IV FLUID/RATE	IVF: @ D5 1/2 NS c 20Kcl @ 75cc/hr	D5 1/2 NS c 20 Kcl @ 75 cc/hr
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE: 02 Oct 03

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

NAME: EPW # [redacted] RANK: AGE:

UNIT: (b)(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17087

USAPPC V2.00

ICU1

Patients Name: [redacted] (b)(6)-2 Date: 02 Oct 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP		159/83				139/74			130/64					163/77												
TEMP		97.7							97.3																	
HR		92				77			78					81												
RR		23				10			18					18												
SaO2		100				96			100					100												
FiO2																										
Source		RA				RA			RA					RA												
MAP																										
TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75	900	75	75	75	75	75	75	75						
IVPB		100					100					100	300													
NGT																										
TF	100	108	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100						
MSO4	3	3	3	3	3	3	3	3	3	3	3	3	36	3												
P.O.		360			480			480			360		1680													
Total													4116													
OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		500				500					600									380						
		500				500					1400															
NG																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17088

DOD-030677

ACLU-RDI 1640 p.48

CAL RECORD-SUPPLEMENTAL MEI DATA

For use of t.. orm, see AR 40-66; the proponent agency is the Offic. The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0900 INITIALS: [redacted]	TIME: 1900 INITIALS: [redacted]
NEURO	PUPILS	3m PERL	PERRL
	SENSORIUM	WNL	A+O X3
	EXTREMITY MOVEMENT	MAEW x4	MINIMAL
	SEDATION	minimal	0
	PAIN CONTROL	adequate	adequate
RESP	RESPIRATORY PATTERN	reg unlabored	RRR
	BREATH SOUNDS	CTA	CTA
	SECRETIONS	thick white	white phlegm (spit)
	O2 SOURCE/FLOW/SAO2	RA	RA
	VENTILATOR SETTINGS	Trach (Trach Dcd 1500)	
CV	CARDIAC RHYTHM	NSR	NSR
	CAPILLARY REFILL	<3 sec	<3 secs
	PULSES	palpable x 4 edema	palpable x4 extremet
	EDEMA		0
GI	ABDOMEN	soft	Soft Incision warmed
	BOWEL SOUNDS	present	active
	BOWEL MOVEMENT	via colostomy	colostomy
	NGT/OGT	0	0
	TUBE FEDDINGS	J tube feeds @ 100cc/hr	Jevity J tube 100cc/hr
	DRAINS	JP to bulb suction	JP to bulb suction
GU	VOIDING	foley to gravity drain (D/C'd @ 1700	spontaneous voiding
	COLOR/CLARITY		dark yellow
SKIN	COLOR	WNL	NFK
	INTEGRITY	abd wounds x 2 dressing	abd wound dressing CDI
		L + R leg wounds x 2 dressing	(L)(R) legs neck
ACCESS	#1 TYPE/LOCATION/SIZE	20G peripheral IV R Arm @ 0700	(L) Wrist 0 erythema or swelling
	DRESSING CONDITION	20G peripheral IV L arm @ 1730	LR @ 75cc/hr
	IV FLUID/RATE	LR @ 75cc/hr	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE 30 Oct 03

PATIENT'S 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: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17089

USAPPC V2.00

ICU1

Patients Name: EPW [redacted] (b)(6)-4 Date: 3 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	142/83						11	140/72						134/68						150/91						
TEMP																										
HR	91							79						83						85						
RR	21							18						17						17						
SaO2	97							98						97						98						
FiO2	/																									
Source	RA							RA						RA						RA						
MAP	/																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	25	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75		
IVPB	100						100																			
NGT TF	100	100	100	100	100	100	100	100		100	100	100		100	100	100	100	100	100	100	100	100	100	100		
PO	0																									
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100						250					300			200			275				200					
NGT																										
STOOL												Rag														
DRAIN												2nd														
												0														
Total																										

MEDCOM - 17090

DOD-030679

ACLU-RDI 1640 p.50

CAL RECORD-SUPPLEMENTAL MED DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0730 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]
NEURO	PUPILS	PERRLA	PERRLA 3mm brisk
	SENSORIUM	Alert, Does not follow commands	Alert, confused, ↓ follow cmds MAE x4
	EXTREMITY MOVEMENT	Active	
	SEDATION	None	
	PAIN CONTROL	Morphine	
RESP	RESPIRATORY PATTERN	Regular + Unlabored	even + unlabored
	BREATH SOUNDS	coarse	Coarse crackles = good strong cough
	SECRETIONS	Thick White	
	O2 SOURCE/FLOW/SAO2	Room Air	RA 96%
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	———	
	CAPILLARY REFILL	Cap Refill < 3 secs	Cap refill < 3 sec
	PULSES	+3 in all extremeties	+2 x 4 ext
	EDEMA	BLE +2 edema	resolving edema
GI	ABDOMEN	Soft, Nondistended	Soft, round, ND
	BOWEL SOUNDS	Hypoactive	hypoactive
	BOWEL MOVEMENT	Colostomy	colostomy bag replaced
	NGT/OGT	J-Tube	J-tube (quantity confirmation)
	TUBE FEDDINGS	Jevity @ 100 cc/hr	Jevity on hold
	DRAINS	~~JP x 3~~ JP x 4 0800	JP x 4
GU	VOIDING	Voiding	voiding well
	COLOR/CLARITY	Clear Yellow	
SKIN	COLOR	Normal for race	normal for race
	INTEGRITY	Midabdominal wound, R flank wound, Burns to R shoulder, BLE	mid-abd wound, (R) flank, (R) axilla/shoulder burns, (B) LE burns
ACCESS	#1 TYPE/LOCATION/SIZE	18 G PIV (R) AC	~~18g (R) AC~~ [redacted] RAC PIV
	DRESSING CONDITION	C I D I	
	IV FLUID/RATE	D5 1/2 NS 20 meq KCl @ 100 cc/hr	D5/1/2 NS + 20 meq KCl
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE	(b)(6)-2	

(Continue on reverse)

PREPARED [redacted] DEPARTMENT/SERVICE/CLINIC (b)(6)-2 DATE

ICU #1, [redacted] 4 Oct 03

PATIENT'S 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: GENDER:

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

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

DA FORM 4700, MAY 78 MEDCOM - 17091 USAPPC V2.00

ICU1

Patients Name: [redacted] (b)(6)-4 Date: 4Oct03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP		128/80 →					156/79				143/80					153				136/59				140/60		
TEMP		97.7 →					98.3				97.5				98	96				98.1				98		
HR		75 →					83				80					84				80				76		
RR		-																		18				19		
SaO2		98% →					98				96					96				96				95		
FIO2		RA →					RA				RA					RA				RA				RA		
Source																										
MAP							109				106					105				90						

NTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF D5 1/2 20KCl		75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	
IVPB			100				100					100								100						
NGT																										
J Tube			80																							
TF																		100	100	100	100	100	100	100	100	
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		200			250						250									500						
NGT																										
STOOL			300							250		50														
DRAIN																										
JP #1																										
#2																										
#3																										
Total																										

MEDCOM - 17092

DOD-030681

ACLU-RDI 1640 p.52

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

REPORT TITLE
INTENSIVE CARE NURSING FLO[illegible]HEET

OTSG APPROVED (Date)
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils		PERRL
	Sensorium	A&O unable to assess	Pt disoriented
	LOC / GCS	Purposefull movement x4	able to move all 4 extremities
		Does not follow commands	will not follow commands
CARDIAC	Cardiac Rhythm	HR- 80 BP- 151/82	HR 78
	PRI: / QRS:		
	Pulse Strength	Peripheral pulse (+)(+) x4	(+) Pulses to peripheral
	Cap Refil / JVD	Cap Refill ≤3sec	pulses < 3 sec cap
	Edema	slight. edema (B)↓ Extremities	refill
	Chest Pain	Ø chest pain	
RESP	Respiratory Pattern	RR-28 SPO2 - 98 on RA	RR+R
	Breath Sounds	(R) clear (L) stightly wheezy	SPO2 @ 97%
	Secretions		CTA Bilat
	Cough	productive cough spontaneous	productive cough white
			frothy sputum.
SKIN	Color	Normal For Race	NPR
	Integrity	Burn near (R) shoulder open Abd	incision to midline abd.
	Backside	wound (B) lower extremity burns	healing, burn to (R) axillary
		Dressing CDI	area. Dressings C/D/I
IV	Access Devices	18g IV in (R) forearm infusing	20g to (L) FA @ 50 dextrose
	Location	D5 1/2 NS @ 20K @ 75cc/hr	1/2 NS @ 20K @ 75cc/hr
	Condition	Flushes well.	
GI	Abdomen	J-tube infusing 100cc/hr	Sp drain to (R) side abd x3.
	Bowel Sounds	of Jevity.	J-tube infusing Jevity
	Stoma/Ostomy	Ostomy draining brownish	@ 100cc/hr. Ostomy draining
		stool/liquid	brownish liquid stool.
GU	Device	normal	urinating via urinal
	Color / Clarity	clear yellow	clear yellow urine
	(b)(6)-2		

(Continue on reverse)

PREPARED BY [redacted] CRT/PT

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU3, [redacted] DATE 5 OCT 03

PATIENT'S IDENT[illegible] (For typed or written entries give: Name – last, first, middle; grade; [illegible]ospital or medical facility)

[redacted] (b)(6)-7

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

DA FORM 4700, MAY 78

USAPPC V2.00

1603 Patients Name: [redacted] (5)(6)-4 Date: 5/04/03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP			151/82				143/77				158/80					144/83				186/69				192/87	
TEMP			98.3				97.6				98.2					98.5				97.9				98.4	
HR			80				71				78					75				82				78	
RR			28				24				28					26				24				28	
SaO2			98				98%				97					98%				99%				97%	
FiO2			RA				RA				RA					RA				RA				RA	
Source																									
MAP																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	Hep-Lock*	75	75	75	75	
IVPB	100	~~100~~																							
NGT																									
PO	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	Hep-Lock*	100	100	100	100	
Total																									

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	[illegible]	05
URINE	⊕					225											325								
NGT																									
STOOL																									
DRAIN																									
IVA 1	10cc																								
2	20cc																								
3	30cc																								
Total																									

*Pt WALKING w/the use of walker.

MEDCOM - 17094

DOD-030683

ACLU-RDI 1640 p.54

N AL RECORD-SUPPLEMENTAL MEDI DAT

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

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

SHIFT ASSESSMENT

		0630	TIME: 0630 INITIALS: [redacted]	TIME: 1930 INITIALS: [redacted]
NEURO	PUPILS		PERRLA 3mm brisk	PERRLA 3mm Brisk
	SENSORIUM		alert	Alert, follows simple commands
	EXTREMITY MOVEMENT		Moves all extrem, fx	Moves independently
	SEDATION		Ø	Ø
	PAIN CONTROL		Ø	Ø
RESP	RESPIRATORY PATTERN		Reg - unlabored.	RRR
	BREATH SOUNDS		Clear Equal chest expansion	Rhonchi throughout, Clears ε cough
	SECRETIONS		Ø	None
	O2 SOURCE/FLOW/SAO2		Room Air	RA / >96%
	VENTILATOR SETTINGS		Ø	N/A
CV	CARDIAC RHYTHM		SR. HR 70-80's	SR, S1S2
	CAPILLARY REFILL		ε 3 Sec	< 3sec x 4
	PULSES		all ⊕	+2 x 4
	EDEMA		Ø	Ø
GI	ABDOMEN		Non distended Soft.	Flat, soft
	BOWEL SOUNDS		⊕	⊕
	BOWEL MOVEMENT		colostomy.	Colostomy RUQ
	NGT/OGT		Ø	Ø
	TUBE FEDDINGS		~~Jevity~~ low	J-tube, Jevity 100cc/°
	DRAINS		JP	JP
GU	VOIDING		Use urinal	Voiding spontaneously
	COLOR/CLARITY		Yellow, clear.	
SKIN	COLOR		Normal	Normal for Race
	INTEGRITY		Surgical wound to Mid abdomen	Mid Abd drsg CDI
			Burn to upper right arm and right	Burn drsg to RUE/R Upper chest CDI
			Side of chest. Burn to left lower leg	
ACCESS	#1 TYPE/LOCATION/SIZE		Hep left arm	PIV (L) FA
	DRESSING CONDITION		LR TKL	CDI
	IV FLUID/RATE			LR 75cc/°
	#2 TYPE/LOCATION/SIZE			
	DRESSING CONDITION			
	IV FLUIDS/RATE			

(Continue on reverse)

PREPARED BY *(Signature & Title)*

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

DATE
6 OCT 03

PATIENT'S 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: GENDER:

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

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

DA FORM 4700, MAY 78

MEDCOM - 17095

USAPPC V2.00

ICU1

Patients Name: [redacted] (5)(6)-4 Date: 6 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	151/73				132/85				141/77					136/81				134/86				119/71				
TEMP	97.6				98				98					97.5				97.6				98.6				
HR	77				70				72					70				76				69				
RR	30				27				30					24				26				22				
SaO2	97				96				100					96				97				97				
FiO2	RA				RA				RA					RA				RA				RA				
Source																										
MAP	106				109									101				~~105~~								

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	960
IVPB							100							100				100								
NGT	100	120	120	60	120	120	120	120	120	120	120	120		120	100	100	100	100	100	100	100	100	100	100	100	1200
																	240							240		480
Total	175 / 175	195 / 370	195 / 565	135 / 700	195 / 895	195 / 1090	295 / 1385	195 / 1580	195 / 1775	195 / 1970	195 / 2165	295 / 2460		295 / 295	175	175	415	275	175	175	175					2580

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		350 / 350	450 / 800		100 / 900		200 / 1100	100 / 1200			400 / 1600	100 / 1700					500 / 500				450 / 950			875 / 1825		1225
NGT																										
STOOL																										
DRAIN																										
Total													1300				500 / 500				450 / 950			875 / 1825		1225 / 2525

MI L RECORD-SUPPLEMENTAL MEDIC ATA

For use of this 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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	Perrl 3mm Brisk	
	Sensorium	Alert follows commands	
	LOC / GCS	Moves all ext able to ambulate	
CARDIAC	Cardiac Rhythm	SR. HR 70-80's	
	PRI: / QRS:		
	Pulse Strength	4/4 ⊕	
	Cap Refil / JVD	<3 sec	
	Edema	∅	
	Chest Pain	∅	
RESP	Respiratory Pattern	Reg 20's	
	Breath Sounds	Clear. B. Bilaterally Equal chest exp	
	Secretions	∅	
	Cough	∅	
SKIN	Color	Normal	
	Integrity	Surgical wound Mid Abdomen. Burns	
	Backside	① Lt upper arm and Rt side of chest -	
IV	Access Devices	① Hand. PIV	
	Location	① Hand	
	Condition	Intact, ∅ S/S of infect / infiltration D5 1/2 NS @ 20 cc/hr	
GI	Abdomen	Nondistended Soft to touch.	
	Bowel Sounds	⊕ Colostomy. BAG J Tube	
	Stoma/Ostomy	Jejunum with JPOX	
GU	Device	Foley 42 Fr	
	Color / Clarity	Yellow clear.	
		(b)(6)-7	

(Continue on reverse)

PREPARED BY *(Sig* [redacted] 1LT/AN

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU3, [redacted]

DATE 90CT03

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

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17097

1003 Patients Name: EPW [redacted] (b)(6)-4 Date: 7 04 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	139/76				135/67				135/81																	
TEMP	98.8				98.6				98.1																	
HR	76				72				76																	
RR	22				20				24																	
SaO2	96				97				96																	
FiO2	RA				RA				RA																	
Source																										
MAP																										

NTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
:	75	75	75	75	75	75	75	75	75	75	75															
PB	100						100																			
IT	100	100	100	100	100	100	100	100	100	100	100															
PO		360																								
Total	275	535	175																							

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE	200		200		300		400				350															
NGT																										
STOOL																										
DRAIN																										
Total																										
	200		200		300		400				350															

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 23 Oct 03 Anesthesia Type (Circle)): General Spinal Epidural
Time In: 1049 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 1300 LR Colloid
Pre-op V/S: 145/75 90 OR Output: UOP — EBL Min
Procedures: Skin graft donor L thigh Meds/Times: 5mg Versed · Sufenta 40 mcg

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

Pre Op Meds

History

Time	1049	1057	1107	
SaO2	99	100	99	99
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140	V		V	V
120	V	V		
100				
80				
60	A	A	•	•
40			^	^
20				
RR	23	19	19	16
T	98.4			

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2	V/S X = A-line BP * = Cuff BP • = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1	/	1	LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10	

Time										
Pain (0-10)										
LOS										

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

(Continue on reverse)

[redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 23OCT03

Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

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

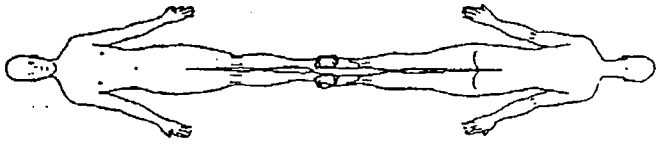
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic.
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1049	multiple	Kerlex, 4x4	0
30' 1120	multiple	4x4	0
60'			
D/C 1125	multiple	4x4	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1058	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p skin graft. Maj [redacted] gave 5mg MSO4 while here. Pt SpO_2 100% RA. Pt c/o little pain. Pt transferring to ICW 1. Report given to Spc. [redacted] Pt has no c/o pain SpO_2@100? [redacted] CPW (b)(6)-7

Discharge Criteria:
Date: 23Oct03 Time: 1120 PARS: 10
BP: 137/64 T: 95.6 HR: 75 RR: 18 Sa02: 100%
Pain Level at D/C (0-10):
Intake: — Output: —
Additional Data: —
Transferred To: ICW 1
Report Given To: SPC [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (b)(6)-7
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICA

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

OTSG APPROVED (Date)

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

Date: 11/17/03
Time In: 1010
Allergies:
Pre-op V/S: 150/80 BR-76
Procedures: 57 59 RLE + DEBRIDEMENT

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1600 cc Colloid
OR Output: UOP EBL MIN
Meds/Times: 2MG MVP 0910

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1015	1025	1035	1050	1105
SaO2	96	98	100	99	98	98
FiO2					
Methods	RA	RA	RA	RA	RA

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

RR	31	21	15	11	11	10
T	96.9				98.3	
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1010	RL	300	(A) Arm		150

Labs:

X-rays:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2	V/S X = A-line BP ^ = Cuff BP = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10	

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/17/03

[redacted] (b)(6)-4

Name — last, first, middle

ed or written entries give:
or medical facility)

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is ob

US

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1040	5	Morphine 4mg	IVP			[redacted]
					(b)(6)-2	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
1010							
Adm	(R) LEG	⊕	⊕	P	B	W	PK
15'	(R) LEG	⊕	⊕	P	B	W	PK
30'	(R) LEG	⊕	⊕	P	B	W	PK
45'				P	B	W	PK
60'							
90'							
D/C							

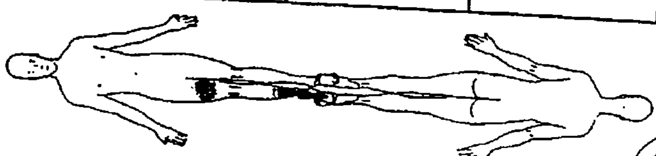
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1010	(R) LEG	ACE + Kerlex	⊖
30' 1040	(R) LEG	ACE + Kerlex	⊖
60' 1110	(R) LEG	ACE + Kerlex	⊖
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1010	S. Sr	⊖	

WAMC OP 173-E

NURSING NOTES

1010: Pt admitted from PACU. Pt has dressing on (R) leg: from instep to below (R) knee - ace bandage, and Kerlix around thigh. Pt alert and oriented x3. Pt able to move all extremities and follows commands. Pt has bilateral pedal and radial pulses. Pt has clear breath sounds, and abdominal sounds present. Pt has colostomy (R) side of abdomen. Pt (R) leg elevated with placement of blanket from below (R) knee, away from (R) calf. [redacted]

1020: Pt remains alert and oriented, deep breathes and coughs on his own. [redacted]

1040 Pt VS stable, Pt able to relax and rest quietly. Pt given morphine. Pt VS stable. [redacted]

1055: Pt remains calm. No bleeding from dressing noted. [redacted]

1105: Pt discharged to ICW, transported from [illegible] via litter [redacted] [illegible] to stay in bed for [illegible] [redacted]

Discharge Criteria:
Date: 11/17/03 Time: 1110 PARS: 10
BP: 133/71 T: 96.5 HR: 68 RR: 20 SaO2: 98
Pain Level at D/C (0-10):
Intake: 1100 cc Output: ∅
Additional Data:
Transferred To: ICW 1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Rec[redacted]
Charge Nurse Signat[redacted]

(b)(6)-2

MEDCOM - 17102

ACLU-RDI 1640 p.62

DOD-030691

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — A

2. MTF LOCATION (State or Country Code.): 7

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

NAME (Last, First, Middle Initial): EPW # [redacted] Unknown ~~Iraqi~~ civilian

4. PAY GRADE: 16 17 — EPW

5. SEX: 18 — M

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

7. AGE AT ADMISSION: 27 28 29 — 5 6 Y

8. RACE: 30 — X

9. ETHNIC BACKGROUND: 31 — 9

RELIGION: (b)(6)-4

10. LENGTH OF SERVICE: 32 33 34 — ——

ETS: ——

11. FMP: 35 36 — ~~9 9~~ ~~20~~ 20 (99)

12. SOCIAL SECURITY NUMBER: SSN — 37 38 39 40 41 42 43 44 45 — [redacted]

ORGANIZATION (Active Duty Only): ——

13. MARITAL STATUS: 46 — Z

HOUR OF ADMISSION:

BRANCH / CORPS: ——

14. FLYING STATUS: 47 48 49 — ——

15. BENEFICIARY CATEGORY: 50 51 52 — ~~K 7 8~~ K78

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

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

18. MOS: 64 65 66 67 68 69 70 — ——

19. TRAUMA: 71 — 0

PREV. ADMISSION ازالة ونبر ... YEAR: — NO ☑

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — 0

WARD: ICU1 — Dr. orders 4256 (Arabic handwriting)

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: ——

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): ——

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: ——

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

21. TYPE OF DISPOSITION: 73 74 — 0 5

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

23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86 — 0 3 1 1 3 0 (Arabic handwriting)

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

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

26. DATE THIS ADMISSION (YYMMDD): 97 98 99 100 101 102 — 0 3 1 1 1 6 (Arabic handwriting: القدوم)

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

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

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

FOR LOCAL USE [redacted]

DX S/P STSG to abd.

8810B 8750
8681B
Dx: 8631
863.54
E9912

Px: 4673
8622
5472
8628
311

[redacted] (b)(6)-2

ADMITTING [redacted] (signature, as required)

Dr. [redacted]

SIGNATURE OF ADMITTING CLERK

DA FORM 3985 MAR [redacted]

MEDCOM - 17103

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW# [redacted]	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	18		(b)(6)-4			NO

11. EMP	12. SSN	13. ORGANIZATION	14. WARD
~~RA~~ 20	[redacted]		ICW2

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1140	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	18 aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	16 aug 03	DR.

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] Bagrdad		

31. SELECTED ADMINISTRATIVE DATA

(b)(6)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Cslw to (R) foot

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilities

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

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG [illegible] IS OBSOLETE USAPPC V1.10

MEDCOM - 17104

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

18 Y.O. ♂ SHOT IN (R) FOOT, BITTEN ON (R) NECK, 4 DAYS AGO BY AN IRAQI CAB DRIVER.

PMH ⊝

PSH - ⊝

[illegible] [illegible]?

PHYSICAL EXAMINATION

WDWN

NECK - BITE MARK CONTUSION (R) SIDE OF NECK

CHEST - NT

EXT: SMALL ENTRANCE WOUND LATERAL ASPECT OF (R) FOOT. [illegible] [illegible] [illegible] IT. N/V INTACT,

XRAYS - ~~[illegible]~~ BULLET APPEARS TO BE IN [illegible] [illegible],

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

(1) GSW (R) FOOT

(2) [illegible] - [illegible] [illegible]. WILL NOT REMOVE BULLET UNLESS FAILS TO RESPOND TO [illegible]

[redacted] (b)(6)-2

SIGNATURE OF [redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	16AUG03		

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-106 [redacted]

MEDCOM - 17105

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15Aug03	gunshot injury x3 days ago, increase in swelling and pain
	S) ® foot c marked swelling. Has open wound lat foot inferior lat malleolus 2° GSW. Marked pain c palp. limited ROM 2° pain
Allergy PCN	Xray. shows bullet in ® ankle + talus appears somewhat shattered 2° GSW
	A) GSW Ankle
	P) Hold for night
	Percocet 1 tab PO q 4-6° prn Pain
	transfer to CSH in AM Ortho consult [redacted] 2LT, SP
	(b)(6)-2

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

[redacted]

EPW

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

X-ray foot

MEDCOM - 17106

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Aug08 1720	BP 125/70. HR 72 Resp 14 pOx 99 VSS. Pt A+Ox3. follows commands. S1S2 Auscultated. NSR. Lungs CTA Bilaterally equal. [redacted] Present X4 quads. Peripheral pulses +2 pedal +2. GSW @ foot. Dressing CDI IV @ FA cot. NO c/o pain at this time [redacted] PIV
1830	Pt A+O, follows commands + gestures. 2+ pulses all extremeties, S1, S2 ø murmur, LSCTA, resp reg unlabored. VSS. 18G @ FA intact ø S/Sx infection Bandage CDI to (R) foot. Voiding via urinal sufficient amts. Plan to monitor until [redacted] ward bed available. [redacted] LTAN
17Aug08 0030	Old IV site leaking 18G started @ wrist Pt sleeping ø C/O pain. will monitor. [redacted] LTAN
ø83ø	Pt awake A+Ox3, VSS HR 67; RR 17; BP 117/66; O^2 100%; Temp 98.ø, + Peripheal Pulses + Pedal Pulses, Skin turgor brisk, Cap ref. 1-2 secs, ORSO c/o/I, free of s+s of infection, (R) [redacted] wrist restraint removed for breakfast then placed back on, Pt resting in bed. ORP [redacted] 9/WM16-
1145	Pt voided 550cc clear yellow urine. 9/WM65 [redacted]
1890	Assumed care @ 1815. VSS. pt sitting up in bed [redacted] c HOB ↑ to 45°. See Assessment on back [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.)*

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

REGISTER NO.	WARD NO.

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

MEDCOM - 17107

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG03 2145	Neuro: A+O pt c min c/o pain MAE. follows commands CV: S1 S2 present. Ø edema. 2+ pulses x 4. dusky/ extremities Resp: even & unlabored. Lungs CTA bilat. c Sats @ 98% on RA. GU: pt voids via urinal @ bedside. GI: BS @ x4 quads. tol Reg diet. IV H/L @ wrist. flushes well. Ø S/S of infection. Integ: dsg to (R) foot CDI. will continue to monitor. [redacted] (b)(6)-2
18 Aug 03	d/c Summary 18 yo Ø shot XT in (R) foot & bitten on back 4 days prior to admission. Complained of pain & swelling of foot on admission. Hospital course consisted of pain meds & PO Antibiotics with dressing changes. No surgical intervention. Pt ready for d/c 18 Aug 03. d/c meds: ① Tylenol 650 mg PO q6° prn ② Percocet 1 tab PO q4° prn #10 ③ Cipro 500 mg PO BID x 7 days d/c treatment: ① ~~Dressing changes~~ Bandaids to foot QD & prn c dry sterile ② (R) leg/foot elevation when not ambulating. Vitals on d/c: Afeb / VSS. Follow up prn only. [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
~~18 Aug 03~~	~~1000 Received report. See ICU-2 flowsheet for initial assessment. 0900 VSS. Afebrile. Dr [redacted] @ bedside orders received. 1550 Dr. [illegible] @ bedside orders received. Pt cast placement today~~
18 Aug 03 1700	Transferred from ICU 2. VSS. Lung sounds clear. BS x4. GSW to lateral portion of Ⓡ foot. Dressed c̄ Band-aid. Will continue to monitor. [redacted]
8.19.03 0026	Pt. care assumed @ 2100. VSS. Pt. has Ø complaints. Ⓡ LE cast intact. Pt. c̄ ⊕ sensation, ⊕ ROM, brisk cap refill toes Ⓡ LE. Will cont. to monitor. [redacted]
19 0530 Aug 03	Nursing Note: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTAⒷ. Abd soft, nontender, s̄ distention. BS⊕x4. Voids spontaneously. Motor and neurovascular intact to all extremities. ROM limited to Ⓡ ankle 2° cast; however, neurovascularly intact. IV to Ⓛ hand/wrist, secured c̄ tape. IV flushes well s̄ s/s infection. [redacted]
19 Aug 03 1555	DC'd to EPW camp @ 1545. VSS. X-rays, meds and discharge summary c̄ pt. [redacted]

(b)(6)-2

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

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

[redacted] (b)(6)-4

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

MEDCOM - 17109

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED [redacted] (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 16 AUG 03 | TIME: 1030

TRANSPORTATION TO FACILITY

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

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

CURRENT MEDICATIONS: NKA

ALLERGIES: Benzolyn

CHIEF COMPLAINT: GSW

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN (Date)
IS THIS AN INJURY?		X	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

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 1030

INITIALS: SJ

VITAL SIGNS

TIME	1030					
BP	143/66					
PULSE	84					
RESP	18					
TEMP	96.6					
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1130	Percocet Tab	[redacted]	1130		
1130	Xray C foot				

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted] (b)(6)-4

[redacted]

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

MEDCOM - 17110

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

18 y/o Iraqi male aerovac. Presents with GSW to (R) foot 4 days ago EPW c/ [illegible]
Lungs clear
PMH Ø
PSH Ø
FH Ø

O. Right foot edematous DP 2+
able to flex & ext foot
unable to move toes 2° pain
neck purple mark (L) side [illegible]
bite mark ecchymosis - [illegible]

A. GSW (R) foot

P (1) Consult ortho
(2) Percocet tab 1 now
(3) admit to ICW

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[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

MEDCOM - 17111

CLINICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/15/03		2000	Pt was c/o pain in (R) foot prn [redacted] (b)(6)-2
			Med was given

Continue on reverse side

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

[redacted]

EPW

REGISTER NO

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101–11.806–8—October 1975
510–109

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST- DAY																			
MONTH-YEAR	DAY	8/15/03		8/16/03			8/17/03			19 AUG03		19 Aug							
19	HOUR	1600		0736	1830		0836	2030		0400	1700	2.6							
PULSE (O)	TEMP. F (●)																		
	105°																		
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																			
RESPIRATION RECORD		16		16	18		17	18		16									
BLOOD PRESSURE		120/80		120/70	131/50		117/66	118/68		135/80		124/74							
Temp								98.8		98.8		98.8							
HEIGHT:	WEIGHT:																		
O2		96		100			100%	100 RA		96% RA		99%							
UOP								500											

Record special data only when so ordered

Temp 98.2 98.6 98.8 98.8 98.8

Did 19 Aug 03 1545 [redacted]

(Centigrade Equivalents, for Reference only)

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°

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

REGISTER NO. | WARD NO.

511-112.

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

[redacted]

EPW (b)(6)-4

MEDCOM - 17113

ICU1

Patients Name: EPW [redacted] (b)(6)-4 Date: 18 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	114						1130																			
NBP	68						1130																			
TEMP	98.6																									
HR	75						80																			
RR	74						14																			
SaO2	98%						98%																			
FiO2	RA						RA																			
Source																										
MAP																										

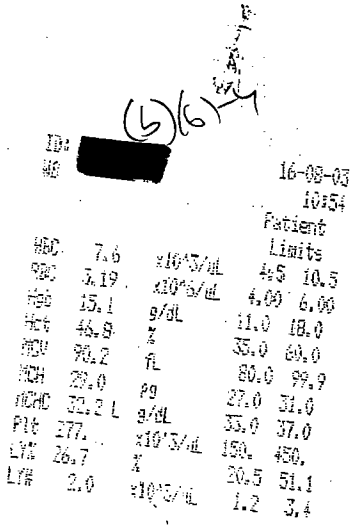
INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF																										
IVPB					50																					
NGT																										
PO			240				240																			
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							300				600		1400													
NGT																										
STOOL																										
DRAIN																										
Total													1400													

MEDCOM - 17114

DOD-030703

ACLU-RDI 1640 p.74



ID: [redacted] (b)(6)
40

16-08-03
10:54

			Patient Limits	
WBC	7.6	x10^3/uL	4.5	10.5
RBC	3.19 L	x10^6/uL	4.00	6.00
Hgb	15.1	g/dL	11.0	18.0
Hct	46.8	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	277.	x10^3/uL	150.	450.
Lym	26.7	%	20.5	51.1
L/#	2.0	x10^3/uL	1.2	3.4

(5)(6)2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (5)(6)4	TIME: 1036	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 =======
16/08/03 10:51
REFERENCE RANGE: (5)(6)4 MALE
PATIENT #: [redacted] (5)(6)2
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] (5)(6)2 DR #: 000
SERIAL #: [redacted]

ALB	3.8	3.3-5.5	G/DL
ALP	69	26-84	U/L
ALT	29	10-47	U/L
AMY	56	14-97	U/L
AST	39*	11-38	U/L
TBIL	1.0	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	9.8	8.0-10.3	MG/DL
CHOL	134	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	100	73-118	MG/DL
TP	8.4*	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: [redacted]	DATE: 16 Aug 03	LAB ID NO.:

(5)(6)2

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: Ortho | [redacted] | DATE OF REQUEST: 16 Dec 03

REASON FOR REQUEST *(Complaints and findings)*

Gunshot wound to right foot

(b)(6)-2

PROVISIONAL DIAGNOSIS

Gunshot wound right foot

[redacted] | APPROVED | PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)*

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

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 17117

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

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: 15 Aug 03 1600

DATE OF ORDER	TIME OF ORDER (HOURS)	LIST TIME ORDER NOTED AND SIGN
	Keflex 500 mg po q id	
	Percocet 1 tab po q 4 to 6 H PRN for pain	
	Diet: Regular. As tolerated.	
	Dr [redacted]	
	(b)(6)-2	8/15/03 1600 [redacted]

NURSING UNIT: [redacted] ROOM NO.: (b)(2)-2 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.

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

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 - 17118

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: 16 AUG 03 TIME OF ORDER: 1140 HOURS

LIST TIME ORDER NOTED AND SIGN

TO ICW-2 MW

1) ADMIT ICW-2 [illegible]
2) DX: GSW (R) FOOT
3) CONDITION [illegible]
4) VS Q SHIFT
5) JP TO LIB [illegible] EPW [illegible]
6) ELEVATE (R) FOOT

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

7) REGULAR DIET
8) HEP LOCK
9) TYLENOL 650 mg P.O. Q 4 hrs PRN
10) PERCOCET 1-2 P.O. Q 4-6 hrs PRN
11) ANCEF 1 GM IVPB Q 8 HRS
12) CIPROFLOXACIN 500 mg P.O. BID

NURSING UNIT | ROOM NO. | BED NO.

[redacted] Noted @ 1430 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

18 Aug 03 1615 HOURS

TO ICW 2

[illegible] same orders

V.O. DR [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

249 V5 [redacted] JAN 8 19.03 0032

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

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

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. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4/15/16
	-----	Cephalexin qid 500mg po	07	X 0730 ES
	-----		12	X
	-----		17	1620
	-----		22	2200 CRW

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

E Pw

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 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 17120

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)			Mo _____ Yr _____	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
8/15	[redacted]	q 4-6 (Para) Percocet 1 tab PO	8/15/05 2000 JRN
	(5)(4)-2		

☆ U.S.G.P.O.: 1985 - 491-003/43119

MEDCOM - 17121

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 16 17 18 19
16Aug03	[redacted]	Condition Stable	ao	[redacted]
			18	
16Aug03	[redacted]	VS Q Shift	ao	
			18	
16Aug03	[redacted]	Elevate (R) Foot	ao	
			18	
16Aug03	[redacted]	Regular Diet	ao	
			18	
16Aug03	[redacted]	UP ADLIB per	ao	
		EPW protocol	18	

(b)(6)-2

DC'd 19 Aug 03 1545 [redacted]

(b)(6)-2

ALLERGIES: ☑ YES ☐ NO — Benzocaine

PRIMARY DIAGNOSIS: GSW (R) Foot

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

PATIENT IDENTIFICATION: EPW A [redacted]

(b)(6)-1

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

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
		Admit to ICU-2	DC'd 9 Aug 03 1545 [redacted]			

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

USAPA V1.00

CLINICA[redacted] EUTIC 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 INI[redacted]IN

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLI[redacted] NURSE	[redacted]ECI[redacted] D[redacted]SE MEDICATIONS, REQUENCY	HR	DATE DISPENSED 16	17	18	19										
16Aug03	[redacted]	Amef 1Gm IVPB Q 8hrs	08 16 24	[redacted]				DC'd 19Aug03 1545 [redacted]									
~~16Aug03~~	[redacted]	~~CIPRO 500mg~~															
16Aug03	[redacted]	Cipro 500mg PO BID	10 20														
16Aug03	[redacted]	Hep lock	06 18														

(b)(6)-2

(b)(6)-2

ALLERGIES: [X] YES [ ] NO
Benzolyn

PRIMARY DIAGNOSIS:
GSW (R) foot

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO
PAGE NO. ________

PATIENT IDENTIFICATION:
EPW #[redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 17124

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
[redacted]	[redacted]	Tylenol 650mg Q4° prn	Date / Time / Dose / Init
(5)(6)-2		Remeret 1-2 Tab PO Q4-6°	16 Aug 1915 / 17 Aug 2110 / 18 Aug 1730 / DC'd 19 Aug 03 1545
[redacted]			(5)(6)-2 [redacted]

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A 1 1 D 1	I Z

3. REGISTER NUMBER: [redacted]

NAME (Last, First, Middle Initial): EPW# [redacted] (b)(6)-4 Hamd Sh-hab

4. PAY GRADE: EPW

5. SEX: M

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

7. AGE AT ADMISSION: 61

8. RACE: Z

9. ETHNIC BACKGROUND: Z

RELIGION: UNK

10. LENGTH OF SERVICE:

ETS:

11. FMP: 99

12. SOCIAL SECURITY NUMBER: [redacted]

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: Z

HOUR OF ADMISSION: 1140

BRANCH / CORPS: —

14. FLYING STATUS:

15. BENEFICIARY CATEGORY: K 78

16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or Country Code): 1

18. MOS:

19. TRAUMA: Q

PREV. ADMISSION: YEAR: [ ] NO: [X]

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0 (b)(2)-2

WARD: ICW#2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

[redacted] MEDICAL TREATMENT FACILITY: Baghdad

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION: 50

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): 030818

24. CLINIC SVC - ADMITTING: AFAA

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): 030816

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: 8920
8760
8772
E9065

Px. 8628 (x2)

ADMITTING OFFICER (Sig[redacted]): DR[redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FO[redacted], MAR 89

USAPPCV1.0

MEDCOM - 17126

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4.	5. RACE	7. RELIGION	8.	9.	10. PREVIOUS ADMISSION
M	unk	7	unk	N/A	N/A / NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
9930	[redacted]	N/A	

15. FLYING STATUS	16. DSG	17. BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K78	N/A	[redacted]	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER C	2315	AAJA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
unk	41	16 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
unk	unk	16 Aug 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted]		

31. (b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel to head

Dx 873.9 E991.9

Trauma 9

Inj 569

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

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

DA FORM 2647 [redacted] IS OBSOLETE

MEDCOM - 17127

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [illegible] LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1 [redacted]	I Z	EPW (b)(6)-7 [redacted]	1	M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	J O	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2315	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	[redacted]

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø C (b)(6)-7		Unk

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: Unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
~~5~~ Ø 41		~~Ø~~ 3 Ø 8 1 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A A J A		Ø 3 Ø 8 1 6

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

FOR LOCAL USE

Dx: Shrapnel to head

(b)(6)-21

ADMITTING OFFICER (Signature, as required): [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted] SPC, 9/6/16

MEDCOM - 17128

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	GRADE	ADMISSION REMARKS
[redacted]	EP [redacted]	NA	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	55	UNK	UNK	NA	NA	NO

11. FMP	SSN	13. ORGANIZATION	14. WARD
99	[redacted]	NA	ICU K

15. FLYING STATUS	16. DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NA		(b)(6)-7 NA	NA		NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from Emt	0147	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	9/15/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK		8/18/03	(b)(6)-7 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted]		

31. [redacted]

(b)(6)-7

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

I & D (L) HIP WOUND

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	28	28

36. Total Days All Facilites

a. ABSENT [redacted]	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	0	0	0	28	28

SIGNATURE OF MEDICAL OFFICER [redacted] SIGNATURE OF R[redacted] FOR [redacted]

(b)(6)-7

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 17129

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

55 EPW [illegible] Shrapnel to (L) [illegible]
[illegible] (L) [illegible]
[illegible] – [illegible]
[illegible]

PHYSICAL EXAMINATION

[illegible]
[illegible]
[illegible] (L) [illegible]
[illegible]

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

[illegible] Shrapnel to (L) [illegible]
[illegible] / [illegible]

[redacted]

DATE	IDENTIFICATION NO.	ORGANIZATION
18 [illegible]		

typed or written entries give Name last, first, ...; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

[redacted]

MEDCOM - 17130

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Aug 03	Received report earlier from ongoing shift. Pt in bed resting.
0815	Afebrile VSS from the previous shift. IVF DS.5 20k @ 125 cc/hr.
	Pt was reported to have mild respiratory difficulty but is
	NAD. MD aware. Ordered CXR + KUB portable xray today.
	Continue c current POC. H.C. IV [redacted] Maj Hw
1000	Pt taken to X-ray for Chest + pelvic via gurney. Tolerated
	procedure well. [redacted] Maj Hw
1300	Pt c/o shortness of breath + c/o fatigue. Noted to
	have SOB on Activity i.e OOB. Hands + leg edema
	noted. MD made aware. Ordered Lasix 20mg IVP
	and started Aggrox in 0.25 mg q day. First dose
	given @ this time. On examination noted (R) JVD.
	Continue on O2 3L NC, sat 91-93%. Continue
	to monitor status closely. [redacted] Maj Hw
1430	Pts foley put out 725 cc clear yellow urine from
	1300 - 1430 and continue to drain. [redacted]
1700	Continue to put out large amt of urine. Pt remain
	in bed resting for most of the day. States feeling
	better. O2 sat @ 96% c 2L NC. Albuterol neb
	put on hold 2° patients SOB c getting out of bed today.
	[redacted] Maj Hw
2350	PT note: Pt awake Pre tx HR 97, RR 22, SPO_2 97 on 4L NC. UD
	Alb given via aerosol mask. Post tx HR 103, RR 24, SPO_2 97-99%
	BBS CTA c slight diminished at base. [redacted] Sgt
26 Aug 03 0540	PT note: Pt panting requests water. Breathing labored SPO_2 96% on 4L
	RR 28, HR 100. Water given pt calming. UD Alb neb given. BBS coarse
	@ bases. Post tx HR 109, RR 32, SPO_2 98%. [redacted] SGT

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
24 Aug 03	Ø distress noted @ present time. Will cont.
2010 cont.	to monitor. [redacted]
2206	Pt. resting in bed c̄ eyes closed. Ø distress noted.
	SpO_2 94%. RR 22. Easily aroused. Will con[redacted]
	monitor.
0002	Pt. resting c̄ eyes closed. Easily aroused. Sp[redacted]
	RR 27. Will continue to monitor.
0211	Pt. resting in bed s̄ discomfort voiced. Ø distress noted
	@ present time. SpO_2 95%. Will continue to monitor.
	[redacted]
0454	Pt. resting in bed s̄ distress. SpO_2 94%. W[redacted]tinue
	to monitor. [redacted]
25 Aug 03	Progress Note
	Patient s̄ complaints
O2 sat on	afebrile
4L	[illegible] soft NTTP [illegible]
94%	(+) small [illegible]
	[illegible] soft
(ALT / AST [illegible])	WBC ↑ 28.8 69% Segs c̄ 6 Bands 14% [illegible] (+) [illegible] cells
	Hb ↓ 12.8 Ct 92101
	[illegible]

(b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUMBER (SSN or Other)

LAST [redacted] (b)(6)-2 | FIRST | MI

DEPART./SERVICE | 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. 5/199[illegible])
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1[illegible])
USAPA V1.[illegible]

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

MEDCOM - 17132

PROGRESS NOTES

DATE	
26 Aug 03 1603	Pt started on Dobutamine Drip @ 5mcg/kg/min. ABG + VBG done 30 mins after. Results shown to Drs [redacted] and [redacted]. Dobutamine Drip DC'd @ 1550 and pt placed back on 4L NC. Sats 96-98%. RR 25-30s Breathing remains fast + labored. [redacted]
26 Aug 03 1809	Nursing: Pt started on 1L NS bolus @ 1605. ABG + VBG results shown to Drs. [redacted] Pt Typed + Crossed for 2u PRBC. Pt having occasional multifocal PVCs since Dobutamine drip started. Dr. [redacted] notified, no new orders written. Report given to night shift [redacted] nurse.
1830	Received report from off going nurse. Pt resting in bed c/o complaints @ present time. Two UPRBCs ordered. Noted labored breathing @ this time. Edema noted [redacted] extremities.
2018	Blood Transfusion started @ this time. BP 160/64 Pulse 83 Temp 97.5 & reaction noted. Will m[redacted]
2023	BP 103/63 Pulse 109 Temp 97. & Reaction noted @ present time. Will continue to monitor for S/S of adverse reaction. [redacted]
2028	BP 111/65 Pulse 117 Temp 97.4 SpO2 98% 2L NC. & adver[redacted] reaction noted. [redacted]
2033	BP 96/57 Pulse 112 Temp 97.4. [redacted]
2038	BP 103/54 Pulse 110 Temp 97.3. & adverse reaction noted. Will continue to monitor for S/S of adverse reac[redacted]

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

MEDCOM - 17133

MEDICAL RECORD	PROGRESS NOTES
DATE	
26 Aug 03 0740	Nursing: BP 92/69, MAP-77, HR-119, R-37, T-97.2, Sats 96% on RA. See ICU flowsheet for nursing assessment. Pt ~~assisted~~ assisted up to BSC. (+) flatus. Pt had [redacted] 2755 small smear of BM. Pt sat up on BSC x 30 mins. Sats 96-98%. Moderate amount of serosanguinous drainage noted from mid-abdominal incision. Pt assisted back to bed c assistance from [redacted] 0800 5 staff members. Pt unable to bear weight on legs and c/o feeling tired. Foley to gravity. Voiding >100cc/hr. Dr. Jenson notified of pt's lab results and current condition. 0 new orders written @ this time. [redacted] RN
26 Aug 03 1240	Nursing: (R) subclavian cordis c swan catheter inserted by Dr. [redacted] (b)(6)-7 PA 53/17, PCWP-27. Swan catheter 47cm @ hub. CXR done @ 1230. Swan catheter secured c Op Site and tape. HOB ↑ 45°. Dr. [redacted] attempting A-line. [redacted] RN
26 Aug 03 1414	Nursing: (R) radial A-line secured c tape. Swan + A-line [redacted] 1417 leveled + zeroed per protocol. ABG + Venous Gas Drawn and shown to Dr [redacted] (b)(6)-7 C.O. calculated to be 3.4 based on Fick formula. [redacted] RN
26 Aug 03 1450	Nursing: Pt placed on 100% NRB, sats 100%, RR 26. ABG + VBG done. Results shown to Drs. [redacted] RN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2

MEDCOM - 17134

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27Aug03 0510	Resting in bed. C/o stomach pain. MD [redacted] (b)(6)-2 complaints voiced. Will monitor.
27 Aug 03 0830	Nursing: VSS, afebrile. See ICU flowsheet for VS and nursing assessment. Sats 95-97% on 4L NC. RR-28-33. Respirations less labored. Lungs CTA. A-line and PA line (b)(6)-2 [redacted] 0843 leveled and zeroed. Waveform sharp. A line and R IJ cordis c swan catheter patent + intact. ϕ S/S of infection noted. PIV Heplock in R AC. Patent to flush c S/S of infection. Pt had large black tarry stool. Sent to lab for Guiac. Hemoccult positive. Dr. [redacted] (b)(6)-2 notified. Serial CBCs ordered. Bath and foley care completed. Moderate amount of serosanguinous drainage noted from mid-line abdominal [redacted] 0855 incision and incision in LLQ. Incision [redacted] 0857 sites cleaned c NS and abdominal dressings applied. Pt refusing to eat. Pt highly encouraged to drink ensure for nutrition. Pt sleeping quietly @ this time c complaints. [redacted] RN/ANC
27 Aug 03 1121	Nursing: Sats 98%, RR 20. Respirations regular and unlabored while pt sleeping. [redacted] RN/ANC
27 Aug 03 1259	Nursing: Pt had large black tarry stool. Pt cleaned and repositioned in bed. Pt refusing lunch but drinking ensure + water. Hgb- 8.1 Hct- 26.7. [redacted] 0900 Attempted to locate Dr. [redacted] or (b)(6)-2 [redacted] c success. Message left to have either MD notify ICU! [redacted]

(1999) BACH

MEDCOM - 17135

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
26 Aug 03 2049	BP 105/60 Pulse 111 ~~HR~~ regular Temp 97.3. 0 adverse reaction noted. Will monitor.
2114	2nd Unit of PRBCs started @ present time. BP 112/56 Temp 97.7 Pulse 108 0 adverse reaction noted. Will monitor.
2127	BP 109/49 Pulse 109 Temp 97.2 0 adverse reaction noted @ present time. Will monitor.
2136	BP 111/61 Pulse 107 Temp 98°. 0 adverse reaction noted @ present time.
2200	2nd unit of PRBCs completed S adverse reaction. Will continue to monitor.
27 Aug 0001	US Alb/Atr tx given HR 106 RR 28 SpO2 95% on RL NC BBS Clear and Ut Bases
0009	Alb. tx @ this time. Pt. resting S complaint. BM this Am; moderate amount of semi-solid brown stool noted. Will continue to monitor.
0120	Resting in bed S complaint. 0 distress noted. Will continue to monitor.
0347	BM x 1 moderate semi-formed stool. Resting in bed c eyes opened @ present time. 0 acute distress noted, will monitor.

(b)(6)-2

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

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW (b)(6)-7

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27 AUG 2003	Pulmonary / Critical Care
08[30]	50 year old Iraqi male s/p ex-lap and pulmonary
	embolism. Improvement in dyspnea overnight. Had bowel
	movement → reported as melena with ⊕guaiac
	106/65 98[3] 90 28 4L NC PA - 48/17
	General: able to speak in full sentences
	LUNGS: CTA(B)
	CV: RV heave nl S1 S2
	Ext: 2+ edema
	(Labs) Albumin 2.6 ALT-164 53/13 149 7.54/26
	37.1) 8.6 / 28.4 < 109 AST-69
	T.Bili-1.7
	(2g bands)
A/P	① Neuro → awake, alert talks with interpreter. Less dyspnea
	② Pulmonary → lower PA pressures, still requiring 4L NC.
	Chronic pulm HTN with development of PE postop
	making pulm HTN difficult to manage. Needs
	Greenfield filter in the face of PE and GI bleed
	③ GI → melena with Hct unchanged after 2 units
	✓ serial CBCs Will need to stop Lovenox if
	persists. Will not use VAsodilators in face of GI bleed at this time

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

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

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

EPW-[redacted]

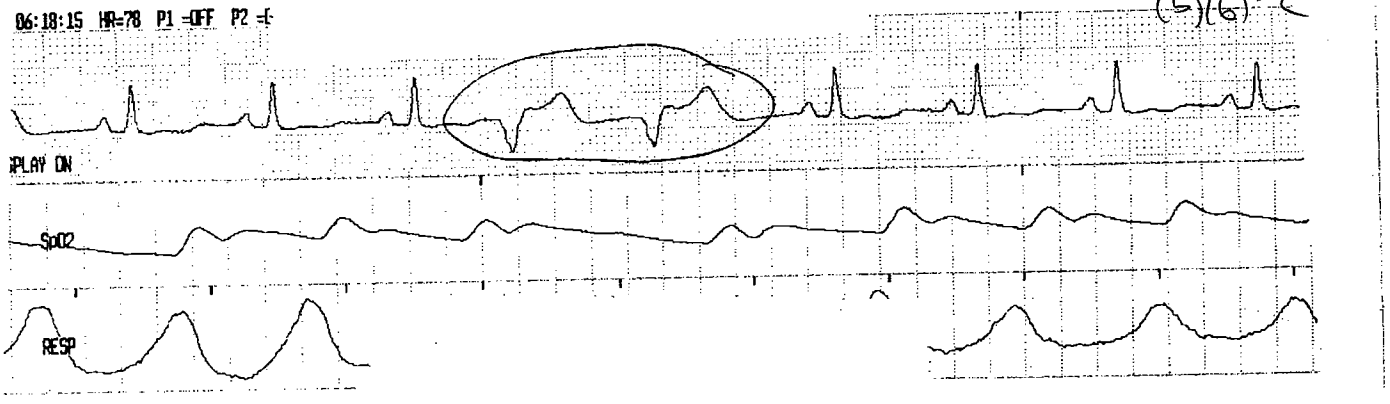
PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted]

MEDCOM - 17137

PROGRESS NOTES

DATE	
28 AUG 03 0600	Received report from previous shift. Pt awake and receiving BT tx. HL Oz NC in place c Oz sats 96%. NGT (-) nare @ HS. Swan in place c balloon deflated. All IV lines intact. Pt temp 97.6. Placed blanket on pt. Pt UO 38cc. Will cont to monitor temp. Noted multifocal PVCs + couplet PVCs. Viewed labs: Alb 2.3, Ca+ 7.3, CK 515, K+ 3.7, WBC 25.0, H+H (7.8, 25.4), Plt 104. Will notify MD of abnormal results. [redacted] (b)(6)-2



0700	Pt resting quietly. Oz sats 96-97%. UO 175cc. Will cont. care. [redacted]
late entry 0600	Pt one point 1 restraint @ ankle. Cap refill < 3 sec. Will cont. care [redacted] (b)(6)-2
0830	Dr. [redacted] saw pt. New orders written. Pt now on MIVF NS c 20KCl @ 75cc/°, 1 UNIT PRBC, lab draw CBC BID + Vit K SQ x 3 days. Will cont. care. [redacted]

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

MEDICAL RECORD | (5)(6)-2 | PROGRESS NOTES

DATE	
27 Aug 03 1500	Nursing: Dr. [redacted] notified of ↓ H/H. Pt made NPO and started on PO pritobec 502 Prilosec [redacted] EKG done per MD orders. [redacted]
27 Aug 03 1626	Nursing: Pt had large black tarry stool. Stool shown to Dr. [redacted] (5)(6)-2 & [redacted] Pt cleaned up & repositioned in bed. HOB ↑ 45°. Plan to do NG lavage. [redacted]
27 Aug 03 1706	Nursing: 16Fr NG inserted via (R) nare ~ resistance. Lavaged ~ 180cc of Sterile Water. Suctioned back 180cc of clear fluid ~ small brown particles. Ø blood noted. NG set to LIS per (5)(6) Dr [redacted]. Ø further lavage required per Dr [redacted] NG secured. Interpreter @ BSD to explain procedure to pt and provide ~~sp~~ support during procedure. [redacted]
28 Aug 03 0020	Pt asleep. Pre tx HR 76, RR 16, SpO_2 98% on 4L NC. UD Alb neb given via face mask. Post tx HR 78, RR 20, SpO_2 98-100%. BBS CTA but diminished @ base, Pt taking shallow breaths — Sgt [redacted] USAF
28 Aug 03 0624	Pt awake. Pre tx HR 78-87, RR 20, SpO_2 98% on 4L NC. BBS diminish 2° shallow breathing. UD Alb neb given HR-76-86, RR 18-22, SpO_2 98-100% on 4L NC. — Sgt [redacted] USAF

(5)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 17139

(5)(6)-7 [redacted]

ACLU-RDI 1640 p.99

DOD-030728

PROGRESS NOTES

DATE	
28 Aug 03 1800	Pt resting quietly. Orsats 98% on 4L O2 via NC. Gave report to night shift. Will cont. care. [redacted]
28 Aug 03 1800	Received report from day shift. Pt appears to be sleeping comfortably in bed foley to gravity. NG tube to O Vac (clamped) cordis to R IJ, A line to R radial @ flush. zeroed. 4L NC sats @ 98% Will continue to monitor. [redacted] SPC, 91 WMG
2110	Dr [redacted] (b)(6)-2 requested NG tube be removed. Pt tolerated removal of NG tube well, VSS Will continue to monitor. [redacted] SPC, 91 WMG
29 Aug 03 0100	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] SPC, 91 WMG
29 Aug 03 0500	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] SPC, 91 WMG
29 Aug 03 0716	Nursing: VSS, afebrile. See ICU flow sheet for nursing assessment. Ø respiratory distress noted. RR 20s, Sats 98% on 4L NC. ØSOB. Skin warm + dry. R IJ Swan intact. Proximal ports x 2 and cordis line all patent. Swan 47cm [redacted] (b)(6)-2 0724 @ hub. PA leveled and zeroed. Waveform slightly dampened. R radial A line intact, leveled + zeroed. Waveform sharp. Mid-line abdominal + LLQ dressing c/d/I. Dressing to R buttock intact. Receiving KS @ 20 KCl @ 75 cc/hr infusing through cordis line. BLE elevated. Pt tolerating PO fluids and jello 5 N/V. [redacted] 97/An
29 Aug 03 0950	Nursing: Swan D/C'd by Dr. [redacted] Cordis remains in place. 40 meq KCl PO given. Ø complaints voiced @ this time. [redacted] 97/An

STAMP [redacted] 11) BACK
OSAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE									
28 AUG 03 0958	Started 1 unit PRBC. Unit # 1435937. [redacted] RT/SAW								
	1003	1000	103	100	1033	1018	1003	1145	
NIBP	102/71	118/69	116/67	105/60	115/61	122/67	117/63		
A-line	134/71	146/74	127/66	137/69	126/70	135/72			
temp	98.3	98.3	98.3	98.3	98.3	98.1	97.9		
pulse	75	74	74	76	76	85	76		

1115 - transfusion completed s any difficulties.

1050 Crushed meds + clamped NGT. Will place on LIS in ≈ 15 min. Will cont. care. [redacted] RT/SAW

1300 Pt resting comfortably c no complaints. Wet lips periodically due to dry mouth. Maintain NPO status. O2 sat 97-98%. 4L O2 NC. Will cont. care. [redacted] RT/SAW

1585 Completed bed bath. Noted dark tarry stool small amt. Pt able to move + hold up body to side c little assistance. Pt O2 sats remained in 96-98%. Completed foley care + D/C'd IV @ AC due to infiltration. D'd dsg midabd. Staples in place and wound pink and c little S/S of infection. Wound @ flank scant amt brownish fluid. Placed abd pad on wound. Will cont care. [redacted] RT/SAW

1555 Clamped NGT per Dr. [redacted]. D/C'd meds. Plan to D/C sun + have pt OB tomorrow. [redacted] RT/SAW

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

MEDCOM - 17141

ACLU-RDI 1640 p.101

DOD-030730

MEDICAL RECORD | PROGRESS NOTES

DATE	
28AUG03	Internal medicine
0830	No events overnight. Resting comfortably with ↓ PA pressures
Prilosec	116/66 97.9 P-76 18 100% -4RK UO ✓
Albuterol	General: Resting comfortably awake, alert
Atenolol	LUNGS: CTA
Zosyn	CV: ⊕ ventricular heave
Digoxin	EXT: 2+ edema
	25 > 7.8 / 25.4 < 104 123 / 3.7 | 103 / 19 | 32 / .9 > 120
A/P	① GI bleed → Hct 28-25 past 24 hrs + 2 dark stools. Will transfuse 1 unit. Give Vit K x 3 days for nutritionally depleted. Pan NPO. If more aggressive bleeding, consider endoscopy but high risk from cardiac standpoint. Revers clot
	② CV → ↓ PA pressures, less dyspnea. Swan out tomorrow. Hopefully with ↓ PA pressures clot resolving. Hemodynamics improved despite GI bleed

[redacted]
(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 17142

LAST NAME	JAME	MI.	ITIAL	ID NUMBER

DATE	NOTES
29 Aug 3 1858	Received report from off going nurse. HC exchanged via off going nursing. Pt. c/o pain to scrotum area. Will notify MO of complaints. ∅ actual distress noted. Will continue to monitor for s/sx of distress. Sgt [redacted]
2020	c/o pain from urethra area. BMx2 black tarry stool noted. Dr. [redacted] (b)(6)-2 notified. Tylenol relayed for pain. Will continue to monitor. Sgt [redacted]
2048	Pt. resting c eyes closed. RR 17 ∅ distress noted. Will continue to monitor. Sgt [redacted]
2200	Pt. cont to rest c eyes closed. ∅ distress noted @ present time. VSS. Will continue to monitor. Sgt [redacted]
0004	Pt. lying in bed c eyes opened c/o pain. Explained to Pt that it was too early to get more pain medication. ∅ distress noted. VSS. Will monitor. Sgt [redacted]
0200	VSS. Pt. resting in bed c eyes closed. Easily aroused. RR 15+even. ∅ distress noted @ present time. Will continue to monitor. Sgt [redacted]
0401	∅ complaints voiced @ present time. Thick white secretion noted to penis. Dr [redacted] (b)(6)-2 inform earlier of discharge from penial area. ∅ orders noted for Pt at this time. VSS. ∅ distress noted. SpO2 100%. Will monitor. Sgt [redacted]
0501	Pt. alert & Oriented. Resting in bed c eyes opened. No complaints. Will monitor. Sgt [redacted]

(b)(6)-2

STANDARD FORM 509 (REV. [redacted]) USAPA V1.00

MEDCOM - 17143

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
29 Aug 03 1330	Nursing: VOP 18-20 cc/hr. Attempted to locate Dr. [redacted] success. Message given to Dr. [redacted] about low ~~UOP~~ VOP, no new orders written @ this time. Bath completed, foley care done. Attempted to flush VOP ~~success~~ foley success. Will continue to monitor. [redacted]
29 Aug 03 1511	Nursing: Dr. [redacted] notified of ↓ VOP. ↓ new orders written. Bath completed, foley care done. Pt had small smear of black tarry BM. Pt assisted up to chair. BLE elevated on stool. Dressings d/d at mid abdomen and c/c, small amount of serosanguinous drainage noted on mid abdominal dressing. Moderate amount of serosanguinous drainage noted on c/c dressing. Will continue to monitor. [redacted]
29 Aug 03 1826	Nursing: Pt c/o pain and pointing to foley. VOP remains 5cc/hr. Foley DC'd. Catheter obstructed. Pt voided ≈500cc of amber urine prior to foley insertion. New ~~16~~ 18 16 Fr catheter inserted. Pt cleaned and repositioned in bed. Report given to oncoming nurse. [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.

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] (6)(6)-4

MEDCOM - 17144

[redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Aug 03 0927	Nursing: VSS, afebrile, see ICU flowsheet for nursing assessment. O2 @ 2L NC, sats 92%. Respirations regular + unlabored. Dr. [redacted] notified of purulent discharge from penis and lab results. BLE elevated. No complaints voiced @ this time. [redacted]
30 Aug 03 1045	Nursing: ~~Sats 9~~ 1045 O2 DC'd. Sats 92-94% on 2L NC. RR-17. Respirations regular and unlabored. Sleeping quietly @ this time. [redacted]
30 Aug 03 1320	Nursing: Sats 97%, RR 20-28. Pt sitting up in bed eating lunch. Pt ate 50% of ~~food~~ 1322 lunch. Voiding ~50cc/hr. [redacted]
30 Aug 03 1532	Nursing: Bath and foley care completed. Bacitracin applied to penis. Dressing change completed. Moderate amount of serosanguinous drainage noted ~~of~~ 1540 on mid-line abdominal incision & LLQ incision. Sites cleaned c Steile Wate and 4x4 gauze and abdominal pad applied usin sterile technique. Spc [redacted] from Physical Therap along c ICU staff assisted pt to sit up in chair Pt currently sleeping in chair c complaints [redacted]
30 Aug 03 1755	Nursing: Pt assisted back to bed x 5 staff member. Pt very weak and having difficult time bearing weight. Skin tear noted on R side of back. Opsite dressing applied. Pt sitting up in bed eating dinner BLE elevated. Sats 95% on 2L NC. RR 30. Breathing slightly labore Report given to night shift nurse. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACI

[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 Aug 03	Internal medicine
0815	Pt resting comfortably OOB yesterday did well
Prilosec 20	168/96 70 27 74 98.2 4L NC
NS 75cc/hr	Overall: asleep, awake interactive yesterday
Vit K 10	LUNGS: CTA
Atenolol 50	CV: RRR (-) ventricular heave
Zosyn 3.375g q6	Ext: (+) edema
Digoxin .25	Abdomen: ecchymosis
	Labs: albumin - 2.2 ALT - 53 AST - 69 135/4.5 105/24 25/.6 109
	143 / 29 88
A/P	(1) Neurologically → awake/alert doing well
	(2) CV: → ↑ BP today. Add ace inhibitor if BP > 150. Tolerating Dig/Atenolol
	PA catheter pulled yesterday
	(3) Pulm → ↓ PAP. Doing much better.
	Will wean O2 as tolerated
	(4) ... no current issues

(b)(6)-2

[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.0

MEDCOM - 17146

PROGRESS NOTES

DATE	
31 Aug 03 0900	Pt up on the chair, tolerated transfer by pivoting. A. line and foley D'ced @ this time. Then the interpreter explained POC to pt. to include increase activities and to void w/in 8 hours. [redacted] May 1 Aug
1105	Pt up to gradually ambulate per PT, unable to tolerate @ this time. Returned to bed to rest. Will try again today. [redacted] May 1 Aug
1500	Pt remain in bed, awoken from sleep. Ate lunch VSS, voided 200 cc clear yellow urine post foley discontinuation. [redacted] May 1 Aug
31 Aug 03 1845	Pt sitting up in bed c feet hanging off the side, SAO2 94-95% @ 2L via NC. Pt helped to ~~get~~ lie down & one point restraint in place. Will continue to monitor. [redacted] 1846

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

EPW

[redacted] (6)(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
30 Aug 03 1814	Nursing: A-line positional. Able to draw blood back by repositioning A-line. Aline remains intact. Report given to night shift. — [redacted]
1800	Received report from day shift. Pt resting comfortably in bed VSS. Afebrile Pt on 2L NC Sats @ 97%. With [redacted] Cordis to @ D5 @flush. NS @ 20 cc/hr @ 75 cc/hr. Foley to gravity draining minimal amounts of clear yellow fluids. Will continued to monitor. — (b)(6) [redacted] SPC, 91WM6 —
2200	Pt resting comfortable on bed. VSS. Will continue to monitor. [redacted] SPC, 91WM6
31 Aug 03 0300	Pt sleeping in bed, VSS. Will continue to monitor. [redacted] nsonde
	(0300) T gm Tylenol given @ 0230 for pain & good effect. Pt now sleeping again. VSS. — [redacted] Barons
	(0500) Pt sleeping in bed VSS, D/C's from above [redacted] 9 wound
0700	Received report from ongoing shift. pt asleep but in no apparent distress. VSS.
0745	Pt up on the side of the bed for breakfast. Able to tolerate getting up c one assisting. Breathing better, remain on O2 2L NC, sat 97%. Afebrile VSS. Plan: Increase activities gradually + [redacted] Hg/Spin

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR 141
CFR) USAPPC V1.00

[redacted] (b)(6)-4

MEDCOM - 17148

(b)(6)-2

ACLU-RDI 1640 p.108

DOD-030737

PROGRESS NOTES

DATE	
01SEP03	(2300) Pt resting in bed, VSS, Ø c/o pain. Zosyn given IVPB. will continue to monitor [redacted]
02SEP03	(0115) Pt uses QS to urinal, Ø c/o pain. resting in bed. VSS, will continue to monitor. [redacted]
	(0300) Pt's VSS, Ø c/o pain sleeping in bed [redacted]
	(0600) Gave report to day shift. [redacted]
2 Sep 02 0600	report received from night shift patients condition stable, resting c O2 per NC, peripheral IV in L hand patent + intact.
2 Sep 02 1100	pt stable, IV heplocked, BM x1 small amount of black tarry stool, voiding in adequate amount 300-400 cc. bearing weight c assistance ambulating c assistance + walker, strength improving everyday for transfer to ward [redacted] AW

(b)(6)-2

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

[redacted] (b)(6)-4

MEDICAL RECORD | PROGRESS NOTES

DATE

(b)(6)-2

01Sept03 (0600) Pt care Report Received from
SGT [redacted] Pt c̄ ∅ noted/Reported
acute episodes. [redacted] 9LWM

01Sept03 (0645) ↑ chair for Breakfast. Assisted c̄
↑ active ROM/transfer. Supports weight
c̄ standing/pivoting. To commode p̄
eating for lg. Black tarry stool
Dangling @ Bedside p̄ care. [redacted] 9LWM

(0830) Back to Bed s̄ incident. [redacted] 9LWM

(1130) To chair for lunch. Remains active c̄
transport. [redacted] 9LWM

(1300) Back to Bed s̄ incident. [redacted] 9LWM

(1700) PIV 18g to (L) post Hand by Maj [redacted]
Pt s̄ adverse effects noted. [redacted] 9LWM

(1715) (R) Coding D/C per Maj [redacted] Pt c̄ ∅
noted/Reported adverse effects.
NS c̄ 20K to (L) Hand PIV via pump s̄
incident. [redacted] 9LWM

(1745) To chair for dinner s̄ incident. [redacted] 9LWM

(1900) Pt in bed after BSC eating. Pt consumed 95% of meal.
VSS. will continue to monitor. [redacted] 9LWM

(2100) Pt resting in bed. Urine QS clear/yellow & odorless.
will continue to monitor. [redacted] 9LWM

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 17150

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
23Aug03(0645) cont.–	tolerated 1L so went to RA. Pt would stay around 93%. Had occassional drops down to 88%. Around 0600 bumped pt up to 0.5L. Sats dropped down to 90-94%. Put pt on 1L & sats up to 98%. Tolerates well. Pt getting very hungry. Wants food. Straightened sheets on pt. ØBM. Circulation & movement ✓ good beyond restraints. [redacted] /AN (b)(6)-2
23 Aug 03	Progress Note
	Patient is hungry this AM Abx # 2 Zosyn
	NO other complaints
	weaned to 4L NC Lovenox → Therapeutic dose
Hct 11.8	afebrile overnight
	old soft nontender
	CXR Fluid (R) fissure ? vs pneumonia
	Dx: NO Δ in current course
	Repeat CBC
	[redacted] en. (b)(6)-2
24 Aug 03 0630	RT note: BBS CTA but diminished @ bases pt breathing shallow. UD Alb neb given HR-72-79, RR 22-26, SPO_2 97-99, on 2L NC + 6L nebs. [redacted]

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

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

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

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Aug	(0700) Assessment complete (noted); report received; pt Alert, responsive; MAO, 2LNC SAT 98% — [redacted]
	(1200) no change in assessment; no new POC — [redacted]
	(1400) no @ OS for assessment; new abs noted; no change in POC [redacted]
	(1700) 500NS over 2° per MD 4mg dA & comp [redacted]
23Aug03 (2150)	Received report from offgoing shift and assumed care of pt @ 1915. Pt's NS bolus was just finishing. Pt c/o pain in lower abdomen. Very minimal draing from foley. Abdomen hard and painful to press on. Tried to irrigate foley. Wouldn't irrigate. Took out foley. Tip clogged. Pt voided some before foley replaced. Another foley inserted sterile. Adequate drainage. Pt not c/o lower abd. pain. Washed pt's perineum and back. Δ'd sheets. Applied petroleum gauze c̄ tegaderm over top to skin breakdown of Ⓡ buttocks/hip. HOB elevated. See DA Form 4700 for assessment data. Pt resting. Had to Δ out pulse ox for better readings. Pt does have periods of sleep apnea. [redacted] AN
24Aug03 (0550)	Pt has done OK throughout the shift. Pt still having periods of apnea. Recovers quickly. Still on 2L O2 per NC. Pt states that he is dying. VSS. Abx infused. Blood drawn @ 0425 and walked to lab. Pt has had 2 point restrains Bilateral ankles. Circulation and movement intact. Pt has been restless throughout the night. Foley draining adequately. [redacted] LT/AN

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17AUG03 0130	554.0. IRAQI EPW ADMITTED from ER for shrapnel wounds [redacted] to (L) hip - Hank. [Neuro] AOX3, moves all extremities to pn to LLE when moved. PU 4-5mm brisk. (+)sensation throughout. [RESP] RR 20-24, SPO2 ~99% RA, CTA throughout. Even PnUat. ↑↓. [CV] SR 50-60's, SB. no MSR. 2+ pulses c CR <3sec throughout. [GI/GU] Flat, soft, tender abd to LLQ, UQ upon palpation. BSx4 - hypoactive. U/O via Foley c 500cc upon admit - cyu. ϕ BM. [Lines] 18g (R) hand + (L) hand c LR TKO @ this time. [IV Neg] (L) femur/thigh/flank - dark blood seeping from wounds. Dsngs covering - drainage ↓ since arrival [POC] Eplap + F/O wounds. CPT [redacted]
0240	TO OR. CPT [redacted]
0415	PT returned from OR - VSS - SPO2 95 5 RA - pt put on O2 @ 6LPM for SPO2 ~90% when sleeping - CPT [redacted]
0500	PT sleeping in bed c FM WL to obtain SPO2 ≥95%. Drsngs to (L) iliac crest area, (L) flank, ABD midline. HR SB - Asymptomatic. Pt denies pn + able to communicate needs via English + gestures. See PACU recovery sheet for VS. cont to monitor. PO/IV to CLD for a.m. meal — CPT [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINT.
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] EPW

(5)(6)-7

(5)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17Aug 03 0730	Pt resting c eyes closed. A+Ox3. HR 58; O2 100%; B/P 124/65; Temp 98.6; RR 16; Clear yellow urine draining to foley; LR @ 150ml/hr. DRSG to (R) Hip C/D/I free of s+s of infect. [redacted] Cap Refill <3 x4 extremities Skin turgor brisk. [redacted] PERL4. SPC [redacted] 91WM6
0800	HR 69; BP 128/71; O2 100%, 15 RR SPC [redacted] 91WM6
0915	Emptied foley; foley @ 300ml. SPC [redacted] 91WM6
1055	Emptied foley; foley @ 300 ml. SPC [redacted] 91WM6
1900	T 99.4 B: 130/68 HR: 90 RR: 28
2200	T: 99.5 B: 132/76 HR: 94 RR: 28 urine: [redacted] (5)
2200	Nursing Note: Pt. is A+O. (L) side of lung c Rhonchi, (R) lung is clear. Hyperactive BS x4 quad. DSG to Ex Lap is D+H. DSG to (L) flank area c drainage noted & complaints of pain. palpable pulses x4, cap refill <3 sec x4, Foley to gravity c clear + yellow urine. IV to (R) hand patent. IV to (L) hand c LR c 150cc/hr will continue to monitor. [redacted] cpt
2400	T: 99 BP: 131/69 HR: 69 RR: 24
2200	T: 99.2 BP: 130/66 HR: 70 RR: 26 Urine = 1000
2300	T: 99 BP: 133/67 HR: 62 RR: 24
2400	T: 98.2 BP: 134/67 HR: 63 RR: 22 Urine = 100
01	T: BP: 130/70 HR: 64 RR: 20
02	T: 98.4 BP: 124/68 HR: 64 RR: 20 Urine WNL
03:	T: 98.2 BP 136/70 HR 70 RR: 22
04:	T: 98.4 BP 130/72 HR: 74 RR: 20
05:	T: BP 136/70 HR 64 RR 20
06:	T: BP 142/66 HR: 97 RR: 22 Urine WNL

STANDARD FORM 600 (REV. 6-97) BACK

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/18/03 2148	Progress Note Called to see patient for ↓ O2 sat 75% on RA placed on 6L PM ↑ 92% RR - 18 shallow Tachycardic 110 No complaints of pain Lungs poor inspiratory effort but (B) breath sounds upper 1/2 lung. Crackles COPD Marginal
8/19/03 0332	Pt resting breathing pattern slightly labored pre tx HR 98 SPO2 98% on 8L Non-rebreather Mask BBS Diminished Post tx HR 93 SPO2 98% on 6L Non rebreather BS No change — Sat [redacted] Pt
0338	325cc orange colored urine from Foley — [redacted]
1905-30 Aug 03	Nursing Assessment: Assumed pt care, AAOx3. Airway intact, breathing shallow and tachy. Sats 97% on 6L per non-rebreather mask. LS clear to upper fields (B) but significantly diminished to bases during deep breathing. Abd soft, tender to palp over midline incision and drsg to (L) CVA. BS (+) x 4 but hypoactive. Foley cc dark. Drsg to midline incision has seeping shading to superior most 1½ inches. Remainder of drsg is CDI. Drsg to (L) CVA is CDI. Foley to gravity draining clear amber urine at ≈30 cc/hr. Pt is currently on cardiac monitor c pulse 80-100 bpm

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.

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

(b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
190530 Aug 03	NURS NG (cont'd): HR is irregular c sporadic PVCs, and what appears to be excess p-waves. No evidence of QRS interval or atrial flutter/fib noted. Normal neurovascularly intact to all extremities. IV of NS c 40K @ 125 to (R) hand. HL to (L) hand. Both sites well and are c s/s infection or infiltration. [redacted]
0807 19 Aug 03	Pt [redacted] Vitals Pre tx HR 97 SpO2 94% on 5L NC BBS clear. Diminished in Bases UO Alb tx given Post tx HR 100 RR 22 SpO2 96% on 5L NC [redacted]
190600 Aug 03	NURS NG LATE ENTRY: Pt 98% per mask (non-rebreather) @ 6L O2, ↓ to 4L per NC [redacted]
190730 Aug 03	NURS NG LATE ENTRY: Pt 95% on NC c O2 @ 4L. Pt [redacted]
19 Aug 03	1420: Assumed care @ 1300. VSS. Telemetry on. SR @ 97 c PVCs, O2 Sats: 93% on 4L/NC. NS @ 125 cc/hr infusing in (R) FA. Abd large, ~~non tender~~ firm, BS x4. Drsg to midline abd, CD&I. Drsg to (R) iliac crest CD&I. Trace edema noted in lower extremities. 9/10 pain in abd. 4mg MSO4 IVP given [redacted] Will continue to monitor.
2208	A: Care assumed @ 2100. VSS. Patient sats 93% - 95% on 6L O2 via NC. HR irregular, monitor shows occasional PVCs. Lungs CTA throughout, resp. are unlabored. ABD rotund, soft c hypoactive BS x2. ML ABD incision c staples OTA c s/s infection. (L) flank incision c sutures OTA c s/s infection. LR infusing c diff to (R) hand. Will cont. to monitor. [redacted]
	Discussed POC.

STANDARD FORM 600 (REV. 6-97) BACK

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 Aug 03	Pt resting c eyes closed. Awakens upon
0730	stimuli. VSS. Mid ABD wound DRSG C/D/I.
	Pt ate 70% of Breakfast. Will continue to
	monitor throughout shift. SPC [redacted] 91WM6
0845	Pt complained of stomach pains. Pt was given
	3mg MS04 for pain. SPC [redacted] 91WM6
0930	Urine output 75ml Amber urine. SPC [redacted]
1215	Urine output 125ml Amber urine SPC [redacted]
1510	Urine output 100ml Amber urine. SPC [redacted]
1430	Pt complained of pain, was given 3mg MS04.
	SPC [redacted] 91WM6
	Pt nauseated during shift was given 4mg Zofran
	by CPT [redacted] for Nausea. SPC [redacted] 91WM6
1800	Pt voided 75cc Amber Urine. NS @ 200cc/hr. SPC [redacted]
18 Aug 03	Assumed care @1900, transfered from ICU 2. VSS. Stage
	2 decubitus ulcer noted on buttocks. Other breakdown
	beginning on back and buttocks. Dressing to @ Flank
	saturated c serous sanguinous drainage - reinforced c additional
	gauze. SL in (R) hand. LR @ 125cc/hr infusing in (R)
	hand. Foley patent - draining tea-colored urine [redacted]
	Will continue to monitor.

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

REGISTER NO. | WARD NO.

(b)(6)

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2134	Pt. Sats 78% RA. Pt. placed on 10L face mask, sats ↑ 91% c encouraged deep breathing. MD aware. [redacted]
2140	RT note: Pt breathing shallow but even ≈ 18-20 BPM. HR 90-110. Pulse is irregular to palpation. BBS CTA. Pt now on 10 LSM sat 91-93. UD Alb given. Pulse HR 93-118 RR 20. SpO_2 93 on 8L SM. Will is c good effort + able to follow simple commands. — Sgt [redacted]
2327	MD@BS by 2145. CXR PA & lat obtained EKG obtained CBC, chem 8 drawn and sent. Neb tx done by RT. Pt placed on monitor. 5mg Lopressor given IVP, 20mg Lasix IVP. MD@ Bedside. ABG drawn and sent. Pt. O_2 ↓ 8L, O_2 sat 97%. Dr [redacted] into to discuss to D plank. Pt. alert, slightly diaphoretic. Will cont to monitor. — [redacted]
19 Aug 03 0010	RT note: Pt resting awakes to gentle stimuli breathing shallow RR 24, HR 100, SpO_2 97 on 7L SM. Will BBS CTA but ↓ 2° shallow breath. UD Alb neb via face mask given HR still irreg ≈ 90-100. RR 26, SpO_2 94% on 40% Venti Mask. IS c great effort. — Sgt [redacted]
0039	Pt. c HOB @ 45°. Pt. sat @ 95% HR 89. Pt. resting quietly. Foley → gravity c dark yellow urine. HR cont. to be irregular. — [redacted]
0300	Pt having ↑ PVCs. BP 115/73, O_2 97% HR 88. MD aware. — [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 2003	Internal med
2245	55 yo EPW s/p ex-lap and flank exploration / I&D
	less than 24 hrs ago. This evening developed SOB / hypoxemia
	requiring oxygen. (CXR) → portable poor inspiratory effort
	and (EKG) c/w sinus tachycardia frequent PVCs. Unknown
	PMHx. Received IV fluids in ER as well as 1600 LR in OR
	Impression ① Sinus tachycardia with PVCs
	② periods of irregularity
	Plan ① Lopressor 5 mg IV now then po BID
	② ✓ electrolytes suspect low K or mg
	③ diurese 500-1000cc given volume
	④ if persists request Echo
	⑤ most likely due to volume and electrolyte
	abnormalities
	⑥ needs DVT prophylaxis Risk for PE/MI
	as well [redacted]
	(b)(6)-2

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

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

REGISTER NO. | WARD NO.

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

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/19/04	Brief note
	Afebrile VSS [illegible]
	[illegible]
	[illegible]
	[redacted] (b)(6)-2
20Aug03	0722 Assume pt care @ 0500. VSS. LR @
	050 to (L) FA. s̄ redness/infiltration. HL to (R)
	FA (+) flush s̄ redness/infiltration. 2.5L O2 via NC. [illegible]
	[illegible]. Lungs CTA. resp unlabored equal rise and fall
	of chest. [illegible] ML incision staples intact ~~OTA~~. [illegible]
	@ (L) ~~[illegible]~~ OTA sutures intact. Tolerating clear liquids
	Foley to gravity c̄ CYUOP. No c/o pain or
	discomfort @ this time. Will cont to monitor [redacted]
20 Aug 03	Progress Note
	∅ complaints ∅ flatus
	afebrile overnight
	hypoactive but present BS
	[illegible]
	[illegible]: s/p [illegible] (+) [illegible]
	Plan (1) [illegible] x 7-20
	(2) Advance diet
	[redacted] (b)(6)-2

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

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

[redacted] (b)(6)-4

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

MEDCOM - 17160

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 Aug 03	1505: Assumed care @ 1300. A+O. VSS. SpO2 94-96% on 4 L O2/NC. BSX4. No c/o pain or discomfort @ this time. Staples intact to midline abd. incision, no drainage @ this time. Incision to R flank intact c no drainage. Trace edema to lower extremities. Will monitor for SOB and pain. [redacted]
2200	Pt. care assumed @ 2100. VSS. HK reg, lungs CTA, BS@x4 but hypoactive @ 1 quad. No c/o pain or discomfort. Foley to gravity c dark orange/tea colored urine. ML AGD incision c staples CTA, c/s/s infection. Incision to @ flank CTA, CDI. AL to R hand intact. Will cont. to monitor. [redacted]
2300	Pt. assist. OOB ⇒ BSC x 2 person assist. Pt had scant amt. diarrhea. Pt. assisted back to bed x3 person assist c becoming diaphoretic, asking for help and moaning. Pt. bleeding from wound to @ flank. Pressure dsng applied to area where it appears pt. tore out 1 suture. Bleeding stopped c dressing. Pt O2 sats 89%, O2 ↑ 6L to bring O2 sats to 94-96%. VSS @ HR 98-108, BP 109/70, RR 22. Will cont to monitor. [redacted]
21 Aug 03 0700	Pt awake and alert. Lungs CTA bilat, ø resp distress. O2 sat @ 94% on 4L via NC. NSR-Abd soft, non-tender, bowel sounds active x4 quads. Midline incision to abd CDI. Staples open to air. Dsg to R hip CDI. Foley draining clear yellow urine. Strong pulses and brisk cap refill x4 extremities. [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/21/03	Surgery (b)(2)-2 Pt Tx'd today from [redacted] on Rounds to be hypoxic and Tachypnic Vs HR N100 SAT 86% RA Chest - CBTA (Ant Pna - only) ABG - 7.48 / 25.6 / 68 / 19 / -4 / 890 FmO2 22 / 41.6 Exam - No effusion poor effort (R) LL infiltrate A/D ① Probable pneumonia Hypoxia, infiltrate, fever Start Zosyn ② Cannot R/O PE but low suspicion start Lovenox 80 BID ③ Dehydration from NPO [redacted] (b)(6)-2

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02SEP03	(1345) Pt admitted to unit from ICU #1 via WC in stable cond. Pt alert, speaking some English. VSS. Pt on 2L O2 per NC. ϕ C/O SOB. Pt using IS ⊼ difficulty. Lungs CTA®. ⊕bs X4 quads. Staples to abd midline. CDI - covered ⊼ bandage. Pt voiding ⊼ difficulty. SL in ⓛ hand flushes well ⊼ S/Sx infiltration/infection. Pt tx to bed from WC ⊼ assist of walker. Tol reg lunch well. 2 point restraints in place - ϕ S/Sx complications of circulation/skin breech. Will cont. to monitor. (b)(6)-2 [redacted] DAW
2Sep03 @ 1920:	Pt sleeping, easily aroused. VSS O2sat @ 97% ⊼ O2 2L by NC. HOBT. Resp. even & unlabored. Lungs CTA®, ⊕bs x4 qd. +2 pulses, staples to mid-abdomen CDI & covered ⊼ bandage. Brisk cap refill. 2 pt restraints on, circulation assessed HL to ⓛ hand flushing easily. Will cont to monito [redacted] qlwn6
2400	Pt ⊼ some edema to extr. O2sat 97% 2pt restraints on. circulation assessed. Will mon [redacted] qlwn6 SPC

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

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

REGISTER NO.

WARD NO. ICU 1

[redacted]

(b)(6)-7

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 - 17163

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
03SEP03	(1225) Assumed care of pt @ bedside report from night shift. Pt alert, speaking sm amount of english. VSS. lungs CTA(B). +BS x4 quads. O_2 sat 96-97% on 2L O_2 per NC. ϕ c/o SOB. Pt amb in room shortly c assist of walker. Pt ↑ in chair @ this time. Tol reg diet well. Voiding ∃ difficulty. SL in @ hand flushes well ∃ S/Sx infiltration/infection. Staples to midline abd CDI - covered c 4x4 dsg. Small amount sero-sang drainage noted on old dsg. 2 point restraints in place while pt is in bed - ϕ S/Sx complications c circulation/skin breaks. Will continue to monitor. [redacted] PA (1420) Pt to BSC. Had mod amount dark brown BM - formed. Pt back to bed ∃ difficulty [redacted] PA
3Sep03 @ 1900	Pt lying in bed. HOB ↑30°. VSS, lungs CTA(B), +BS x4 qd. O^2 sat 97%. 2L NC. Unlabored resp. even & unlabored. HL @ hand flushing easily. ϕ S/Sx infection or infiltration. 2 pt restraints on, circulation assessed. +2 pulses to extr. voiding adeq. c/o ∃ difficulty. Will cont to monitor [redacted]
2100	amb. around room c walker/assistance. Will monitor [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 17164

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 Sept 03 0830	A & O appropriately. Eating breakfast. VSS. Lungs CTA(B) Resp. even/unlabored. (+)BS x4 quads. Voiding dark amber urine per urinal. MAE. +2 pedal pulses. (B) feet c nonpitting edema. Nailbeds pink c < 2 sec cap refill. Staples to mid abd c&i c packing to small opening near base of incision. ABD dsg applied. 2x2 to (2) lower quad (lateral) fold ground. Small amount light yellow drainage. Various drainage wounds to back healing. Beginning redness & chafing of skin to abd skin folds & groin area. Sacral pressure point dark brown. Complete bed bath given. Will get OOB to walker for ambulation. Dr @ 2L. Sat 97% [redacted]
4 Sept 03 1600	OOB to chair. Ambulated in room then hallway using walker. Tolerated well. Will continue monitoring. Dr @ 2L NC Sat 97%-98% [redacted]
4SEP03 1547	VSS. AO. Voiding light amber urine, quantity sufficient. 2L NC @ 95%. Ambulated x1 around 3 units. DSG d'd to abdomen. (+)BS x4. (+) pulses in all extremities. Staples and sutures and packing to incision abdomen. Sacral wound stage I. [redacted]

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

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

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

MEDCOM - 17165

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Sep 03 0700	- Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort at this time HOB elevated facilitate breathing O2 SAT 98% 2L NC. Good skin turgor. cap refill and skin color WNL Ø signs @ Edema to B/lat lower extremities. Lung CTA RRRR Active BS. Tolerating PO well. Voiding into urinal QS c difficulty Will cont to monitor [redacted] Cont. Wound to abd. c dry dressing Ø drainage staple ODE [redacted]
5 Sep 03 -	- Ambulated pt. O2 SAT prior to 98% RA. O2 was wheezy off. walker assisted c ambulation steady gait voiced being tired. instructed to deep breath. Upon completion of ambulation maintaining 94% on RA - Will cont to monitor [redacted]
5 Sep 03	1845 = VSS O2 sats @ 95% RA, Ø S/S of respiratory distress, LCTAB, (=) rise & fall of chest, Reaps WNL, weaned off O2 via NC, continuing to monitor resp status closely, A+O X3 - speaks good English to communicate needs/questions. Staples to midline Abdomen c Dsg CDI over it. Dsg Δ's BID. Pt. sleeping @ present but will set pt. OOB to ambulate this evening. IV Hl to (L) brachial c 3 way stopcock - flushed and patent c good blood return. 2+ pitting edema to (B) feet, 2+ pulses (B) feet. Ø c/o pain. Will continue to monitor [redacted]
5 Sep 03	1925 = feet (B) elevated on rolled blanket to ↓ edema. Restraints X2 in place. [redacted]
6 Sep 03	0530 = Dsg to abdomen wound Δ'd - CDI. [redacted]

(5)(6)-N

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MEDCOM - 17166

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Sept 03	Pulmonary / Critical Care
0815	EPW S/p ex-lap and pulmonary embolism. Walked to end
Pulmex	of hallway with walker. Resting well
Atrovent	132/72 98% 5L 99% RA
Digoxin	General: pleasant good spirits
Colace	LUNGS: CTA(B)
Heparin 5000 SQ BID	Abd: BS+
	Abdomen → small amount brown serosanguinous drainage
	Ext: (-) edema
	Labs: 129/101/9 97 5.4/10/32 <132
	3.8/24/.9
A/P	(1) Pulmonary → weaning O2 to off. Clot resolved. Continue DVT prophylaxis. Long term problem needs 3-6 months of anticoagulation but GI bleed.
	(2) Physical therapy → continues to work with
	(3) Abdomen → small amount of drainage. Enjoy pulling

[redacted] (b)(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

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

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep 03	- Pt. resting in bed A to x3 VSS Ø c/o pain or discomfort
0730	@ this time. Orders to wean off O2. SAT of 96% RA. Encouraged
	to deep breath IS @ bedside Lung CTA bilat. HRRR S1 S2 present
	Active BS tolerating PO well surgical incision to abdomen dressing
	Δ'd CDI stapled [redacted] (b)(6)-2 . Breakdown to groin area and GSW to
	Ⓛ hip fold of abd. Will cont to monitor [redacted]
	(1045) I concur c̄ above assessment. [redacted]
6 Sep 03	Pt resting. VSS O2 Sat 94-96% RA. Lungs CTA Ⓑ,
@ 2055	resp. even & unlabored, HRRR, ⊕ BS x4 quads, +2
	pulses to all extr. 2+ pitting edema to Ⓑ feet.
	Staples to midline c̄ 2x2 drsg covering open
	area. Ø c/o pain. voiding adequate qty. Will amb-
	ulate c̄ walker later tonight. Will cont to
	monitor [redacted] (b)(6)-2
6 Sep Ø3	Drsg (2x2) to abdomen Δ'd. [redacted]
7 Sep @ (0330)	temp. 102.2 ↑ Tylenol given. [redacted]
0550	temp ↓ to 98³ [redacted]

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

REGISTER NO. | WARD NO.

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

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

MEDCOM - 17168

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 Sep 03	Assumed care pt A+O x3. state being tired spiked temp
0700-	c sweating and chills last night temp ↓ 97.5 orally. Lungs
	CTA HRRR Active BS x4 quads. Tolerating PO well. Wound
	care dressing changed. surgical incision to abd. c staples CDI c 2x2
	dressing applied to site of drainage. Will cont to monitor — [redacted]
7 Sep 03	- Upon accessing pt notice evidence of skin break down to his
1600-	back. Redness and peeling of skin found. Dead skin removed
	by washing back further prevention measure taken. Resting on
	side @ this time. Will cont to monitor — [redacted]
7 Sep 03	Pt sitting ↑ in bed. O2 Sat 96%. VSS, lungs CTA B
1830	HRRR, +BS x4 qds. abd incision c staples.
	CDI. 2x2 applied to open area. ϕ drainage noted.
	Resp. even + unlabored. Pt OOB to chair @
	1900, new linen + mattress put on bed to
	prevent further skin breakdown. 2 pt re-
	straints put back on. circulation intact.
	Will monitor — [redacted] 9Nov06.
1900	Pt ambulated c walker 3 assistance. steady
	gait. Pt back in bed O2 Sat @ 96% RA. ϕ c/o
8 Sep @	SOB. Restraints on — [redacted] 9Nov06,
0500	labs drawn — 9Nov06
08SEP03	(KHS) Assumed care of pt @ 0700 c report from night
	shift. Pt alert, speaking some English. VSS. ϕ c/o pain
	Pt amb in hallway x2 this shift c min. assist of
	walker. ϕ c/o SOB. Staples to midline abd CDI. Drsg
	to open area of staples Δd. Sm. amount sero-sang
	drainage noted on old drsg. Pt OOB to chair for
	2°. Tol. well. AM care done by pt c some assist.

(6) (9) - 2

FPI, LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
08SEP03	(cont) Pt tol reg diet well. Voiding s difficulty. BBM. 2 point restraints in place s S/Sx complications from skin breakd/circulation. Will cont to monitor. [redacted] RN
8 Sep 03 1955	Pt resting in bed, A+OX3, VSS, LS CTA (B), +BS x4, T-101.4, adm 2 Tylenol tabs as per orders, dsg midline abd CDI, staples on incision Ø s/sx of infex, Ø c/o pain @ this time, voiding c/y urine, proper circulation & skin integrity on pts of restraint [redacted]
~~9 Sep 03~~	~~Assume care of Pt, alert, VSS, A+OX3.~~
09SEP03	(1200) Assumed care of pt & Ø Ø Ø report from night shift. Pt alert, speaking some English. VSS. Ø c/o pain. Pt OOB to amb in hallway, c min assist from walker. Gait steady. Dsg to staples abd this am. Sm amount sero-seng drainage noted on old dsg. Staples CDI. Pt tol reg diet well. Voiding s difficulty. Pt ↑ in chair @ this time. SL in @ ac, flushes well s S/Sx infection/infiltration. 2 point restraints in place, while in bed s S/Sx complications of circulation/skin breakd. Will continue to monitor. [redacted] RN

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

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

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

REGISTER NO. | WARD NO.

#[redacted] (6)(6)-1

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

MEDCOM - 17170

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9sep0350 2015	Assumed care @ 1800; All VSS, pt afebrile & A&Ox3 speaking both english & arabic; Ø c/o pain or discomfort @ this time; midline dsg c staples Ad; sm amt sero-sang. drainage on old dsg; staples intact & well approximated; pt voiding QS, clear, yellow urine & difficulty; Tol. diet; pt amb x1 in hallway c minimal assistance from walker, pt has slow, steady gait, Ø c/o dizziness during amb; 2 point restraints in place; ⊖ SKin breakd; circ. intact. will Cont to monitor [redacted]
10Sep03 0630	Pt c/o being cold. Temp 103.7°F (O). Blankets removed. [redacted] (b)(6)-2 x3 episodes of emesis. Pt BS x4 decreased. Dr. [redacted] notified. Blood cx, urine cx, UA, cx ordered. NS 75cc/h via 20 G [redacted] @ FA. [redacted] pc 91WM6
10Sep03 0600	Pt A&O c/o being tired. S1 S2 present, RR, LS CTA (B). VSS Temp 99.1°F (O) Pt Ambul[redacted]. Will continue to Monitor. [redacted] 6x 91WM6 (15Sep) I concur c above assessment [redacted] (b)(6)-2
10Sep03	1830: VSS, A+Ox3, Ø c/o pain, Sats[redacted] RA, pt. does IS exercises well - encouraged to do every hour while awake. Ø s/s of resp distress, LCTAB, ⊖ ↑ & ↓ movement of chest (B). Pkg to Abd wound CDI, D'ing BID IV to (R) FA running NS @ 75cc/. Tolerates PO, ⊖ BS x4. Gets OOB & ambulates as tolerated. Ø other remarkable assessment finding. Will monitor. [redacted]
10Sep03	2000: pt. OOB & ambulated in hall x30 MINS c difficulty. Restraints x2 in place, extremities restrained & skin integrity intact. [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

MEDICAL RECORD | PROGRES)TES

DATE

10Sep03 2200: IV to (R) FA came out (intact), restarted to (R) AC 20G, running NS @ 75cc/h. [redacted]

11Sep03 0940 Pt Awake A&Ox3 LS CTA(B) S, S, present (+)BS x4 quads. Ambulated to walker. Denies pain at this time. VSS. [redacted] monitor. [redacted]

11Sep03 1930: VSS, sats@98% RA c/o SOB 2/2 respiratory distress, encouraging IS, exercises QI while awake, Dsg Δ'ing to midline Abd BID, Dsg CDI. IV to (R) AC running NS @ 75cc/h, Ambulating in hallway prn c difficulty. Verbalizes need [redacted] prn. Continue to monitor. [redacted]

12Sep03 (1725) Assumed care of pt c/o c/o/o p' report from night shift. Pt A/O, speaking some English. c/o 10/10 pain. Pt OOB to shower this am and amb x2 in hallway this shift c walker. Pt OOB to chair for c. Steri strips to abd incision CDI. Dsg to (L) hip CDI - applied by MD. IVF infusing into IV in (R) arm c S/Sx infection/infiltration. a/p/t restraints in place c S/Sx complications of circulation/skin breakdown. Will cont. to monitor. [redacted]

Continue on reverse side

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

REGISTER NO.

[redacted]

(5)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
12Sep03	1930 = VSS, A+O X3, Ø c/o pain, O2 sats @ 96% RA and ↑ to 98% RA after IS exercises. Encouraged IS exercises QI while awake. IV to (R) AC patent and running NS @ 75cc/hr. Midline abdominal wound has Steri-strips CDI. (L) hip Dsg CDI, being c'd QDay or PRN. Restraints x2. Skin integrity intact to extremities restrained. Ambulates in hall as needed. Ø other remarkable findings. Continue to monitor. [redacted]
13Sep03	(1445) Assumed care of pt c Ø c/o p report from night shift. Pt alert, speaking some English. VSS. Ø c/o pain. Pt amb in hallway X3 this shift and OOB to chair for a°. Pt tol well. Dsg to (L) hip D/d this am. small amount yellow/green drainage noted on old dsg. Pt tol reg diet well. Voiding s difficulty. (+) BM. IVF infusing into IV in (R) AC. S s/sx infection/ infiltration. 2 point restraints in place S s/sx complications. will continue to monitor [redacted] 2A
2000	Rt OOB to chair. VSS, Ø c/o pain. ambulated x1 IVF to (R) AC Ø s/sx infection/infiltration. O2 sat @ 97% (RA). Ø SOB. (+) BS x4. HRRR. Will continue to monitor [redacted] 911 M6.
2200	ambulated in hallway for 5 min. steady gait, Ø dizziness or SOB. OOB to chair for 1 hour. Will monitor [redacted] 911 M6

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

MEDCOM - 17173

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9/14/03	Discharge Summary
	Admit 8/18
	D/C 9/15
	Diagnosis: ① Shrapnel wound ② iliac crest ± Fracture
	③ Shrapnel wound abdomen
	④ pneumonia
	⑤ GI bleed.
	Procedure: ① Exploratory Laparotomy Evacuation for injury)
	② left iliac crest fracture washout
	③ Swan-Ganz catheter.
	Hospital Course:
	Pt is a 60yo Iraqi male wounded in Iraqi mortar or prison camp 8/18. pt taken to OR where we found a negative laparotomy, and a fracture of his left iliac crest. Post operatively pt developed respiratory compromise / failure requiring prolonged intubation etiology pneumonia v. P.E. Pt anticoagulated, but developed GI bleed Eventually ± diverticulosis and pulmonary status of pt improved and GI bleed stopped : D/C of Lovenox. Pt continued to improve clinically and remained stable. Wound on left iliac crest still draining serosanguinous fluid, no evidence of widespread infection.
	* Pt to have Xeroform ready dressing changed for ① his wound
	Meds: Atenolol 50 mg po qd.
	~~Digoxin .125mg po qd~~
	Keflex 250mg po qid
	Disposition: Continue [redacted] (5)(6)-2

(5)(6)-4

MEDCOM - 17174

9 (REV. 5/1999) BACK
USAPA V1.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Septem a.m.	Received pt resting in bed, VSS, OOBTC and amb x2. New IV 20g @ Rfa. LSCTAB, Ø respiratory distress noted. [redacted] Drsg intact. Ø c/o pain. Tol po well SVQS. Ø other remarkable assessment. [redacted]
14 Sept 03 1935	Rt a/o, VSS, Ø c/o pain. Lungs: [redacted] +BSx4, O2 sat @ 96-97%. Ø SOB ambulated in hallway for 30 min c steady gait. IVF infusing into (R) arm Ø s/s extravasation/infection. (L) hip wound drsg A/D. Ø drainage noted. 2 pt restraints on. Circulation intact. Will monitor [redacted]
15 Septem 0425	Received pt resting in bed, VSS, a+ox3, speak, arabic. Amb x2, OOBTC. Steady [redacted] gait and Ø assist. +BM. SVQS. IVF infusing via acces IV (R) fa, 20g c 75 cc/hr, WNL. (L) hip wound drsg A/D, no S/S infection noted, serous drainage noted. Restraints per CPU protocol, Ø skin breakdown or [redacted] issues noted. Ø other remarkable assessments or [redacted] noted. Will cont to monitor.

(5)(6)-2

HOSPITAL OR MEDIC [redacted]		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. ICW 1

[redacted] (5)(6)-4

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

MEDCOM - 17175

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16sep03 0245	Assumed care @ 1800; All VSS, pt SATS in constant 96-98%; pt A&OX3, Ø c/o pain or discomfort @ this time; pt ↑ OOB to chair for 2°; amb x1 in hall s̄ difficulty, slow steady gait; dsg to (L) hip CDI s̄ drainage; HL patent (+) BS x4; (+) BM x1 - Ø Δs in assessment; restraints in place; (+) circulation, Ø skin break; cont to monitor [redacted]
16 Sept 03 0800	VSS alert & oriented. OOB to BR to shower tolerated well. Lungs clear BS (+) X4 quad. Abd large soft non-distended. Peripheral pulses +2. Consumed regular diet for breakfast HL P/C ... Pt [redacted] awaiting d/c to EPW camp. Skin under restraint intact. (L) hip drsg changed. Will continue plan of care [redacted] LT A...
16 Sept 03 1320	Escorted by MP's to ~~..~~ transport to EPW camp. [redacted] LT A...

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 17176

ACLU-RDI 1640 p.136

DOD-030765

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 16 Aug 03 | TIME: 2315

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
M			PRP			✓	ADDITIONAL INSURANCE		✓
AGE	HOME PHONE		FLYING STATUS			✓	DD 2568 IN CHART		✓
55	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☒ NO
IS THIS AN INJURY?		✓	WHERE	TETANUS	
INJURY/SAFETY FORMS		✓		DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2325

INITIALS: (b)(6)-7 [redacted]

VITAL SIGNS

TIME	2330				
BP	112/56				
PULSE	86				
RESP	15				
TEMP	98.6				
WT					

LAB ORDERS

☒ CBC/DIFF	ABG	☒ PT/PTT	BHCG/URINE/BLOOD/QUANT		
☒ URINE C&S	UA MSCC/CATH		☒ CHEM: 8		
BLOOD C&S X					

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	1 gm Ancef	[redacted]	(b)(6)-7		
	.5 cc Tetanus				
	IV 18 gauge				
	IV 18 gauge				

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 ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-7

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

55 yo male [illegible] mortar attack c/o (L) hip pain. No c/o back, legs, torso and pain.
No [illegible]
past history of frag wound in [illegible]
? 112/60 P80 [illegible] [illegible] (L) [illegible] 2 [illegible] [illegible]
NAD. A+Ox3?
[illegible] (L) [illegible] 3-4 [illegible]
[illegible]
[illegible]
[illegible]

5 mg morphine 2330 KG

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

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

MEDCOM - 17178

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Aug 05		1820	EPW [redacted] age unknown transferred for ICU monitoring for respiratory distress according to nurse taking care of the patient. pt was experiencing acute respiratory distress. SaO_2 ↓ to 90% in room air. Tachypneic, RR labored - rate @ 36-38 per minute. placed on 100% NRB on ward. SaO_2 ↑ to 99%. RR 35 breath/min. portable CXR done. M.D.'s @ bedside. Lung - upper airway. CTA - ↓ breath sounds to base R > L. Ø coughing or wheezes noted. Pt received albuterol TX on ward. ABG obtained. ABG pH 7.485 pCO_2 25.6, pO_2 68, HCO_3 19, BE -4, SaO_2 95% M.D. suspects pt may have an pneumonia CXR shows (R) lower lobe infiltrates pt fully awake and cooperative despite language barrier. No signs of agitation or restlessness noted @ this time. Placed pt on heart monitor. Monitor displays NSR rate @ 88, Ø ectopy. S1 S2, Ø murmurs. Skin cool to touch, diaphoretic. Temp 97.7 °F. Ø peripheral edema noted, Capillary refill <2 sec. Radial pulses strong and regular. Dorsalis pedal pulses strong and equal @ 2+. pt able to move extremities but unable to raise up or turn side to side. - cont.

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

[redacted]

(L)(6)-2

MEDCOM - 17179

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
21 aug 03		1835	(R) antecubital PIV site intact. Site free of infiltration or signs of infection. Receiving 1 L LR bolus for now. Foley intact - draining dark amber color urine. abd. large - non tender - c/o slight tenderness to palpation. Hypoactive bowel sounds x4 quad. ↑ HOB to 45°. abd incision - staples intact. Incision 30 cm. Ø erythema or drainage noted on incision. Ø dressing on.
		1845	V/S HR 97, 100/68, RR 30, SaO2 99%, pt continues to be tachypneic. will need to monitor resp. status closely. pt [redacted] skin dry.
		1800	

(Continue on reverse side)

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

[redacted] (5)(6)-4

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

MEDCOM - 17180

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22 Aug (cnt)		1400	no change in assessment status; no new orders written; CTM; SM O_2 4L - SaO_2 97%, RR 20 — [redacted]
		1700	Pt assessed by MD. CXR in AM noted & noted no change in assessment — [redacted]
		1720	RT note: Pt resting awake to verbal commands, somewhat understanding. Pre tx HR 65, RR 23, SpO_2 97% on 6L SM ud Alb tx given via aerosol mask. BBS CTA but diminished at bases Post tx HR 70, RR 26, SpO_2 97% on 6L SM. Will continue to monitor. — Sgt [redacted] 1V2Φ
		1900	report given; pt unchanged, WNL — [redacted]
22 Aug 2003		2015	Pt resting in bed. Received report from CPT [redacted] and assumed care of pt @ 1915. Pt arouses easily. Even regular breathing on 4L NC. Continuous pulse ox. See OA form 4700 for assessment data. Pt asking for H_2O to drink. Swallows c difficulty. NF bag c.d. Infusing c problems. [redacted] IAN
		2130	2 point leather restraints applied to L wrist and @ ankle. [redacted] AN
		2400	No chg in pt assessment. Wakes up occasionally asking for water. Good circulation beyond restraints. RT in working c pt giving tx [redacted]
		0330	Pt started dry heaving. Pt had questions. Interpreter brought in to answer questions. Pt stated not feeling nauseated just hungry. Pt stated having passed gas. Abdomen soft. [redacted] IAN
		0645	Started weaning pt's oxygen around 0430. Pt

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 17181

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
22 Aug 03	0800		assessment complete/charted; pt alert responsive appropriate
			NAD; RR rate 20-25; SM placed @ 6L; SaO2
			97%; pt tolerating well; new orders noted;
			K+ run from Rx due; interpreter called to communicate
			c pt; MD [redacted] (b)(6)-2 has assessed pt [redacted]
		0900	SM @ 6L then 8L d/t ↓ SAT 94%; will CTM; PIV in (L)
			A/C attempted x1; will attempt later; pt tol well [redacted]
22 Aug	0940		Surgery
			Breathing easier still on 8L FM
			VS HR 83 Tm 95.6 106/74 98%
			UO: 100 cc/hr
			exam
			Chest clear ↓ BS @ (R) Base
			ALS 29
			LABS 13.2/37.7 > 107 136 | 103 | 90 / 2.9 | 24 | 1.7 < 186 ALT 676
			A? 36
			AST 1297
			A/P (1) Pneumonia improving TB 1.2
			clinically CXR this am
			(2) ↑ LFT prob low flow from
			yesterday will follow [redacted]

(b)(6)-2

(Continue on reverse

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

[redacted] (b)(6)-4

NURSING NOTES
Medical Record

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23AUG03			Internal medicine
22[20]			Resting comfortably in minimal O2. No
			complaints
			96.8 70 20 95/69
			General: pleasant
			Neuro: Cooperative
			LUNGS: CTA(B)
			CV: RRR
			Ext: Oedema
			Labs 136/25 / 118/17 / 18 7.52/29/122
	A/P		(1) Pulmonary - bedside Echo reveals dilated RV
			with ↑ pressures suggestive of clinical PE
			post-op day ... Placed on ... BID
			Slow clinical improvement. Will require 3-6
			months of anticoagulation. Difficult with
			... status (b)(6)-2
			[redacted]

MEDICAL RECORD

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 17183

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
			1900 21 AUG03: Assumed care for patient. PT
			resting in bed with HOB ↑ 30°. Assessment as
			follows: [N] PERRL @ 2mm; follows commands;
			purposeful movements; [illegible]; [R] RR 30↑
			(~28-36); sats 99 on [illegible]; Auscultation
			reveals [illegible] in bases; ULL > URL; (+)
			Acc muscl use; (-) cyanosis [CV] NSR w/ occasional
			PVCs noted; HR 80-90; S1 S2; [illegible] edema to (B) LE;
			[illegible] pulses x4 ([illegible]); ≥ 3 sec
			[illegible] cap refill; [illegible] [GI] distended
			abdomen [illegible]; [GU] moderate
			urine output of dark amber urine ([illegible]);
			[illegible] midline abd inc [illegible] with
			staples [illegible] running [illegible] @ 125; foley
			[illegible] possible [illegible] if
			[illegible] not resolving [illegible] as
			[illegible]. will continue to monitor.
			[redacted] [illegible]
			(b)(6)-2
			0315 22 AUG03: Pt weaned to [illegible] sats 97%;
			↑ in activity sats ↓ to 88 w/ multiple, frequent PVCs;
			noticeable agitation / ↑ work of breathing with [illegible] (none
			[illegible]). placed back on [illegible]; sats 100%; PVCs continue
35 [illegible]			although ↓ in frequency. Continue on [redacted] [illegible] [redacted]

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

EPW [redacted] (b)(6)-7

NURSING NOTES

Medical Record

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

MEDCOM - 17184

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Aug 03			infusing @ 125 cc/hr. Assume care as planned.
0630			[redacted] Am
1015			Pt tolerating large amt of p.o. fluids. IVF D/C @ 1500 Plan: Ambulate, HD to change catheter to p.o.
			[redacted] May 1Am
1300			Pt room air off O2, observe, give O2 if Sat D/C <95%.
1600			0013 BSC c assistance, sat on the commode for an hour, unable to produce stools. Pt became diaphoretic. BP and SAO2 unchanged from baseline. Pt request to go back to bed. Returned to bed c assistance, asked to rest @ this time.
1700			Pt refused to ambulate states tired from getting out of bed & sitting on the chair. Pt remained in bed, appeared to be sleeping all this time. Respirations even slightly labored but in no apparent distress [redacted] May 01 Am
1730			Pt has stage II bed sore @ buttocks approx 3x2 cm. Applied duoderm gauze c tegaderm. Encourage turning pt. accurately or out of bed [redacted] May 01 Am
04 Aug 03 1800		1800	Received report from Major [redacted]. Pt. alert and aware of place. 2L O2 via NC. Staples noted to abd. Edema noted to extremities. 0 complaints voiced. 0 distress noted @ present time. Will continue [redacted] monitor.
2010		2010	C/O bed being uncomfortable for back. Explained that there isn't anymore beds like the new. Out pt. Sp02 96% 0 Other complaints voiced.

DATE

MEDICAT

*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
24 Aug 03			Progress Note
			Patient did well overnight
			ECHO completed yesterday c̄ dilated (R) A/RV
			c/w PE
			Respiratory status improved: weaned to 2L NC
			c̄ O_2 sats > 90 this am (97% @ Rest)
			Developed small decubitus ulcer
			VS HR 74 RR 21 124/76 T 98 afebrile
			[illegible]
			Labs 138 / 98 / 25 (138 21.1 11.5 (101 AST 243
			3.9 / 21 / 1.3 x.3 ALT 367
			Imp: Stable after PE s/p shotgun injury
			to (L) thigh
			Cont anticoagulation
			Cont antibiotics @ this time, Δ to
			oral antibiotics [redacted]
			[redacted]
			(b)(6)-2
24 Aug 03			Received report from outgoing shift. Pt on O_2 2L NC for
0630			occasional desaturation, SaO_2 97-98%. Pt appears to be
			drowsy but awakens intermittently to request needs.
			Verbalizes being very thirsty, had water 100cc. Foley
			draining 750cc/hr clear yellow urine. IVF D5 .5 20K

(Continue on reverse side)

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

NURSING NOTES

Medical Record

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

MEDCOM - 17186

ACLU-RDI 1640 p.146

DOD-030775

(b)(6)-2

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Wheeled litter BY CPT [redacted]
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 17 AUG 03 TIME PATIENT ARRIVED IN SUITE 0300
4. PATIENT IN ROOM TIME 0300 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA (Ancef 1gm given)

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D (b)(6)-2	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	CPT [redacted] RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR Bed, Head on foam doughnut, Arms extended out to sides <90 in CAP secured to padded armboards

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

COMMENTS: 2 Safety straps. Folded towels under heels. Correct Body Alignment maintained

8. SKIN PREPARATION

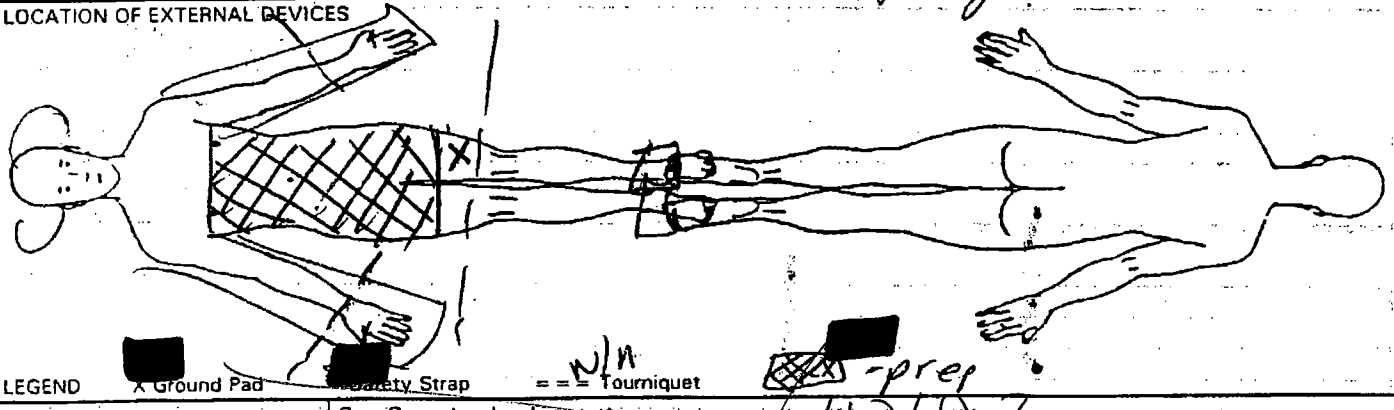
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR by CPT [redacted]
☐ CLIP

COMMENTS: No Cuts or kinks noted

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Abdomen - [redacted] BY WHOM: CPT [redacted]
SITE: (as below) BY WHOM:

COMMENTS: no pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND [redacted] X Ground Pad [redacted] Safety Strap = = = Tourniquet [redacted] -prep

(b)(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Others	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Needle Sharp	☑ Yes ☐ No	C	C	C	"	"
Instrument	☑ Yes ☐ No	C		C	"	"
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: 4
GROUND PAD: BRAND Rem Polyhesive II Valleylab
LOT NO: 68936 / 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - QS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	3/8" penrose		
SITE	surgical wound (L) hip		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8 plain sponges, Kerlix Fluffs, Silk tape

19. ADDITIONAL INFORMATION
WC - IV (b)(6)-2
Dr [redacted] + Dr [redacted] Anesthesia - CRNA [redacted] CRNA - Gen/Endo
Bovie 50/50 Blend 1 - pad site pre-op - CI post-op CI

20. OPERATION(S) PERFORMED
Exp. Laparotomy, I & D (L) Hip wound.

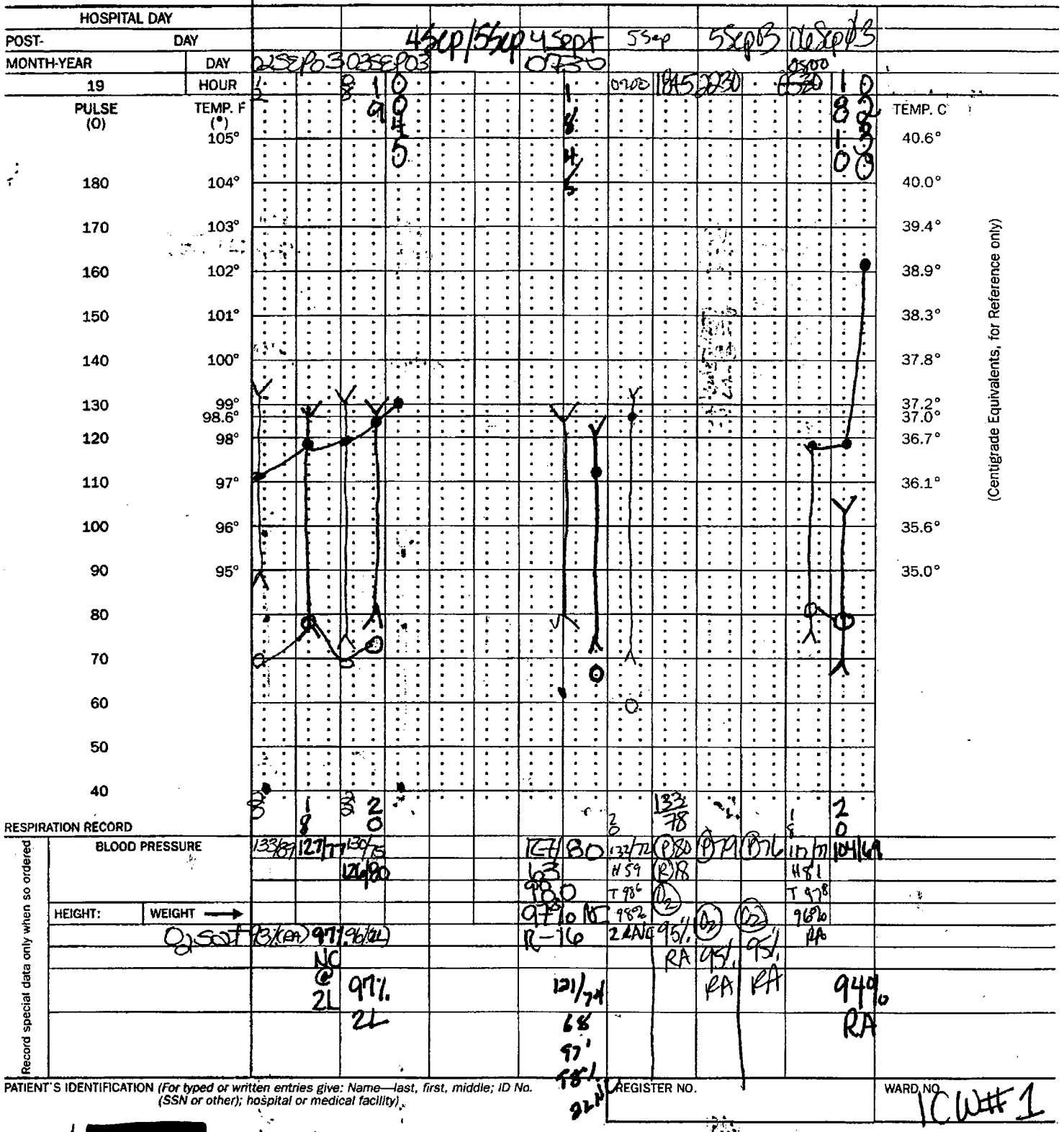
21. PATIENT TRANSFERRED TO ICU 2 TIME 0400 METHOD wheeled litter

[redacted] condition

(b)(6)-2

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD



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

#[redacted] (5)(6)-4

REGISTER NO.

WARD NO. ICU #1

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY | HOUR

7Sep03 | 7Sep | 08Sep03 | 08Sep03 | 10 | 10Sep03 | 11Sep03

0200 | 0700 | 1830 | 1930

PULSE (0) | TEMP. F (°)

105° | 104° | 103° | 102° | 101° | 100° | 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

O2Sat: 94% RA | 96% RA | 94% RA | 97% 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. ICU 1

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

MEDCOM - 17190

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 23

MONTH-YEAR: Aug 2003 DAY: 8

~~18~~ 9 HOUR: 8

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

sats: 98

RESPIRATION RECORD: 20

BLOOD PRESSURE: 95/69

HEIGHT: WEIGHT →

UOP: 100

Fluids

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW# [redacted] (b)(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 - 17191

511-119 NSN 7540-00-634-41

MEDICAL RECORD — VITAL SIGNS RECORD

	12SEP03	13SEP03	14Sept	15Sept	16 Sep
HOSPITAL DAY					
POST- DAY					
MONTH-YEAR / DAY	12SEP03	13SEP03	14Sept	15Sept	16 Sep
19 / HOUR	8 / 1930	8 / 1900	1800	0800	0800

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: 8 | 115/66 | 8 | 111/69 | 18 | 18

Record special data only when so ordered

BLOOD PRESSURE: 116/73 | (P) 59 | 113/66 | (P) 64 | 123/62 | (P)R | 111/68 | (T) 97.8 | 114/63

HEIGHT: | WEIGHT →

(O2) O2 Sat 96 (RA) | 96.1 RA | 97 (RA) | 97 (RA) | 97% | 98% | 97% RA | 98

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 - 17192

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August 2003 | DAY | HOUR

19

PULSE (0) | TEMP. F (°)

105° | 104° | 103° | 102° | 101° | 100° | 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)

18 | 19 | 20 | 21

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)*

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

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 - 17193

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR AUG 03 DAY 18

19 HOUR 0400 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800

PULSE (O) — TEMP. F (°) — TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 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 Systolic	125	123	139	143	141	136	136	133	123	157	140	130	124	
Diastolic	68	67	67	72	76	72	78	75	80	73	77	73	66	
	97	97	97	96	97	95	95	94	95	95	95	96	95	
HEIGHT: WEIGHT →	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

MEDCOM - 17194

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY -	Admit												
POST- DAY													
MONTH-YEAR: AUG 2003 / DAY	16 Aug						17 Aug						
HOUR	0130	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	
TEMP. F (written)	Admit 98.0				Return OR 96: 96		98.6	98.3	98.5	98.9	99.1	98.6	<99

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

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)

RESPIRATION RECORD

Record special data only when so ordered													
BLOOD PRESSURE systolic	119	123			123	119	124	128	132	131	146	137	132
diastolic	118	104			71	107	65	71	92	72	79	77	71
	98%	99%			100	100	100	100	100	100	100	100	97
HEIGHT: / WEIGHT →	RA	RA			4LPM	4LPM	4LFM	4LFM	4LFM	4LFM	4LFM	4LFM	RA

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] EPW

REGISTER NO.

WARD NO. ICU 2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 17195

NRB

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.614

PCO2_____23.2 mmHg

PO2_____95 mmHg

HCO3_____24 mmol/L

BEecf_____2 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.619

PCO2_____22.9 mmHg

PO2_____93 mmHg

Patient Temp: 98.0F

FIO2_____: 100

Sample Type_: [redacted]

26AUG03 14:42

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

(b)(6)-4

(b)(6)-2

NRB

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____25 mmol/L

At 37C

PH_____7.523

PCO2_____29.7 mmHg

PO2_____22 mmHg

HCO3_____ mmol/L

BEecf_____2 mmol/L

_____46 %

*calculated

At Patient Temp

PH_____7.526

PCO2_____29.2 mmHg

PO2_____22 mmHg

Patient Temp: 98.0F

FIO2_____: 100

Sample Type_: [redacted]

26AUG03 14:49

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

STANDARD FORM 545 (rev. 10-75)
545-108

LABORATORY REPORT DISPLAY

Baseline
[redacted]

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____23 mmol/L

At 37C

pH_____7.612

PCO2_____21.9 mmHg

PO2_____56 mmHg

HCO3_____22 mmol/L

BEecf_____1 mmol/L

sO2*_____94 %

*calculated

At Patient Temp

pH_____7.617

PCO2_____21.6 mmHg

PO2_____54 mmHg

Patient Temp: 98.1F

Sample Type_:

26AUG03 13:35

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

[redacted] (b)(6)-4

MV BASELINE

i-STAT G3+

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

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.510

PCO2_____27.2 mmHg

PO2_____18 mmHg

HCO3_____22 mmol/L

BEecf_____-1 mmol/L

sO2*_____34 %

*calculated

At Patient Temp

pH_____7.514

PCO2_____26.8 mmHg

PO2_____18 mmHg

Patient Temp: 98.1F

FIO2_____: 4

Sample Type_: [redacted]

26AUG03 (b)(6)-2 13:43

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

Baseline

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37C

pH_____7.539

PCO2_____26.8 mmHg

PO2_____19 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol/L

sO2*_____37 %

*calculated

At Patient Temp

pH_____7.543

PCO2_____26.5 mmHg

PO2_____18 mmHg

Patient Temp: 98.1F

FIO2_____: 4

Sample Type_: [redacted]

26AUG03 13:58

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

BASE LI
ED ON
MISTRY
MISTRY
MISTRY
ATOLO

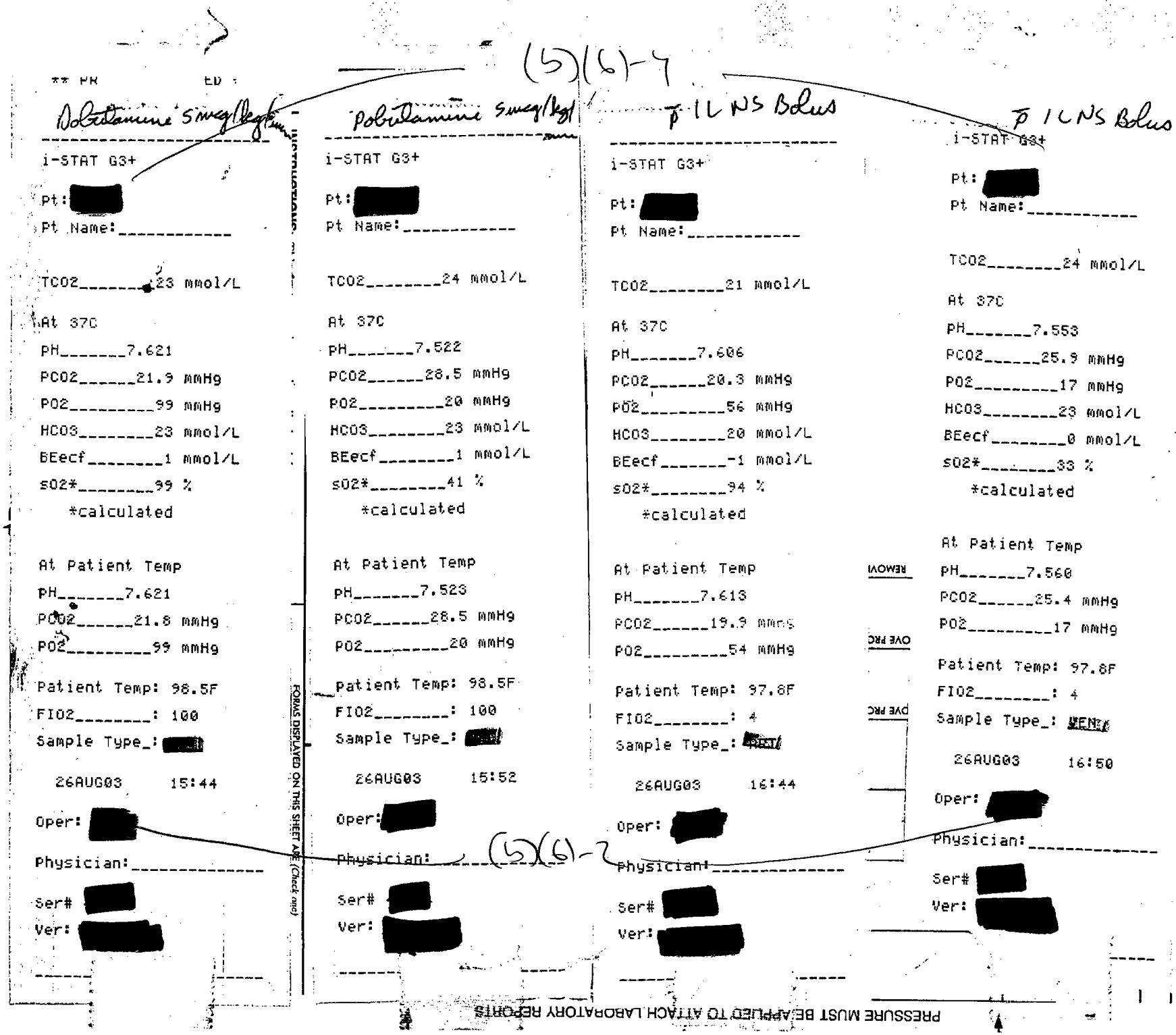
URINALYSIS
MICROBIOLOGY
SPINAL FLUID (CSF)
MISCELLANEOUS (Blood)
ASSORTED FORMS

PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

LABORATORY REPORT DISPLAY

★U.S. GOVERNMENT PRINTING OFFICE 2001-660-043

MEDCOM - 17197



** PR ED :

Dobutamine 5mcg/kg/min

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____23 mmol/L

At 37C

PH_____7.621

PCO2_____21.9 mmHg

PO2_____99 mmHg

HCO3_____23 mmol/L

BEecf_____1 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.621

PCO2_____21.8 mmHg

PO2_____99 mmHg

Patient Temp: 98.5F

FIO2_____: 100

Sample Type_: [redacted]

26AUG03 15:44

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

Dobutamine 5mcg/kg/min

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.522

PCO2_____28.5 mmHg

PO2_____20 mmHg

HCO3_____23 mmol/L

BEecf_____1 mmol/L

sO2*_____41 %

*calculated

At Patient Temp

PH_____7.523

PCO2_____28.5 mmHg

PO2_____20 mmHg

Patient Temp: 98.5F

FIO2_____: 100

Sample Type_: [redacted]

26AUG03 15:52

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

(5)(6)-1

1 L NS Bolus

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

PH_____7.606

PCO2_____20.3 mmHg

PO2_____56 mmHg

HCO3_____20 mmol/L

BEecf_____-1 mmol/L

sO2*_____94 %

*calculated

At Patient Temp

PH_____7.613

PCO2_____19.9 mmHg

PO2_____54 mmHg

Patient Temp: 97.6F

FIO2_____: 4

Sample Type_: [redacted]

26AUG03 16:44

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

1 L NS Bolus

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.553

PCO2_____25.9 mmHg

PO2_____17 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol/L

sO2*_____93 %

*calculated

At Patient Temp

PH_____7.560

PCO2_____25.4 mmHg

PO2_____17 mmHg

Patient Temp: 97.6F

FIO2_____: 4

Sample Type_: [redacted]

26AUG03 16:50

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

(5)(6)-2

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

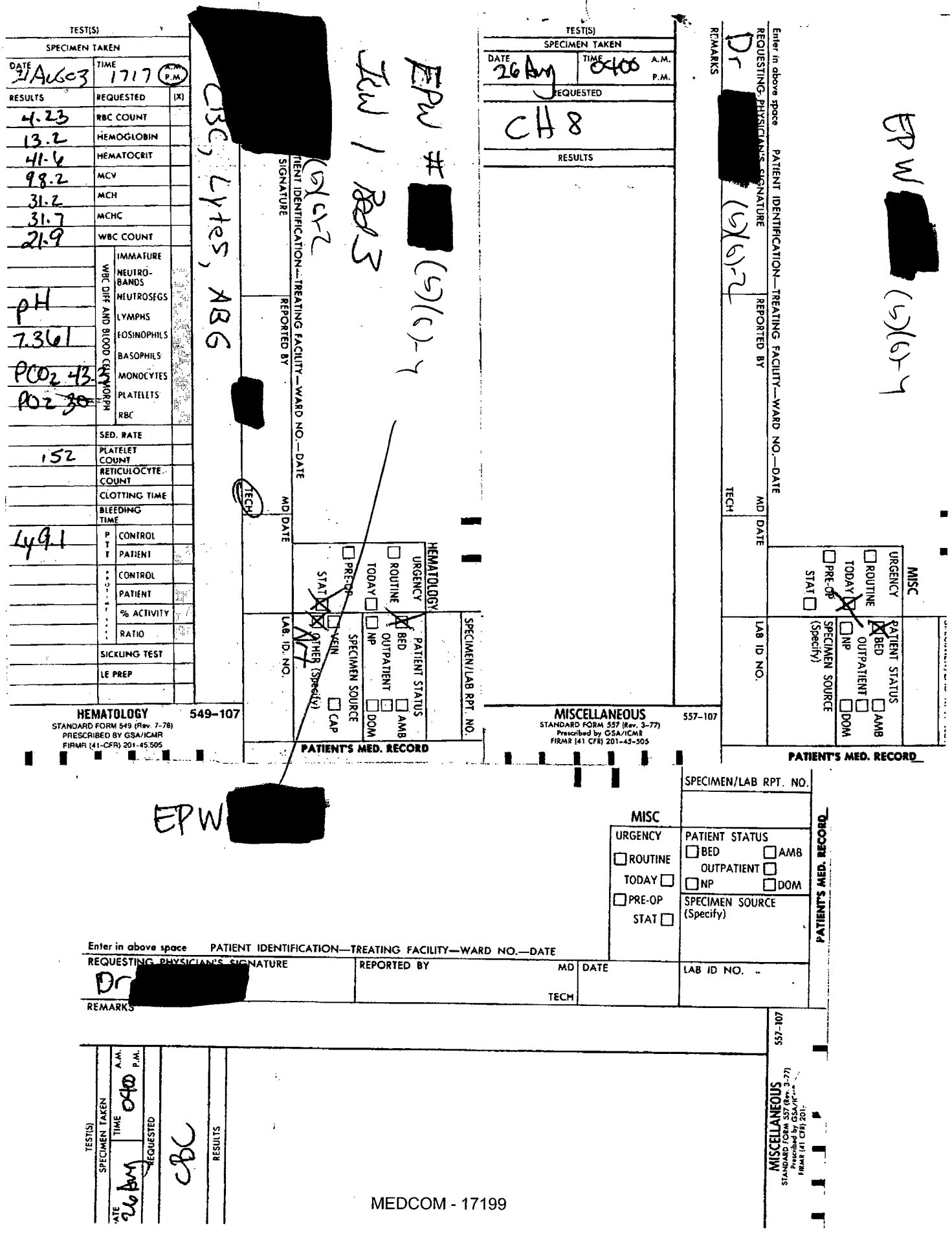
STANDARD FORM 545 (rev. 10-75)

* U.S. GOVERNMENT PRINTING OFFICE 2001-660-043

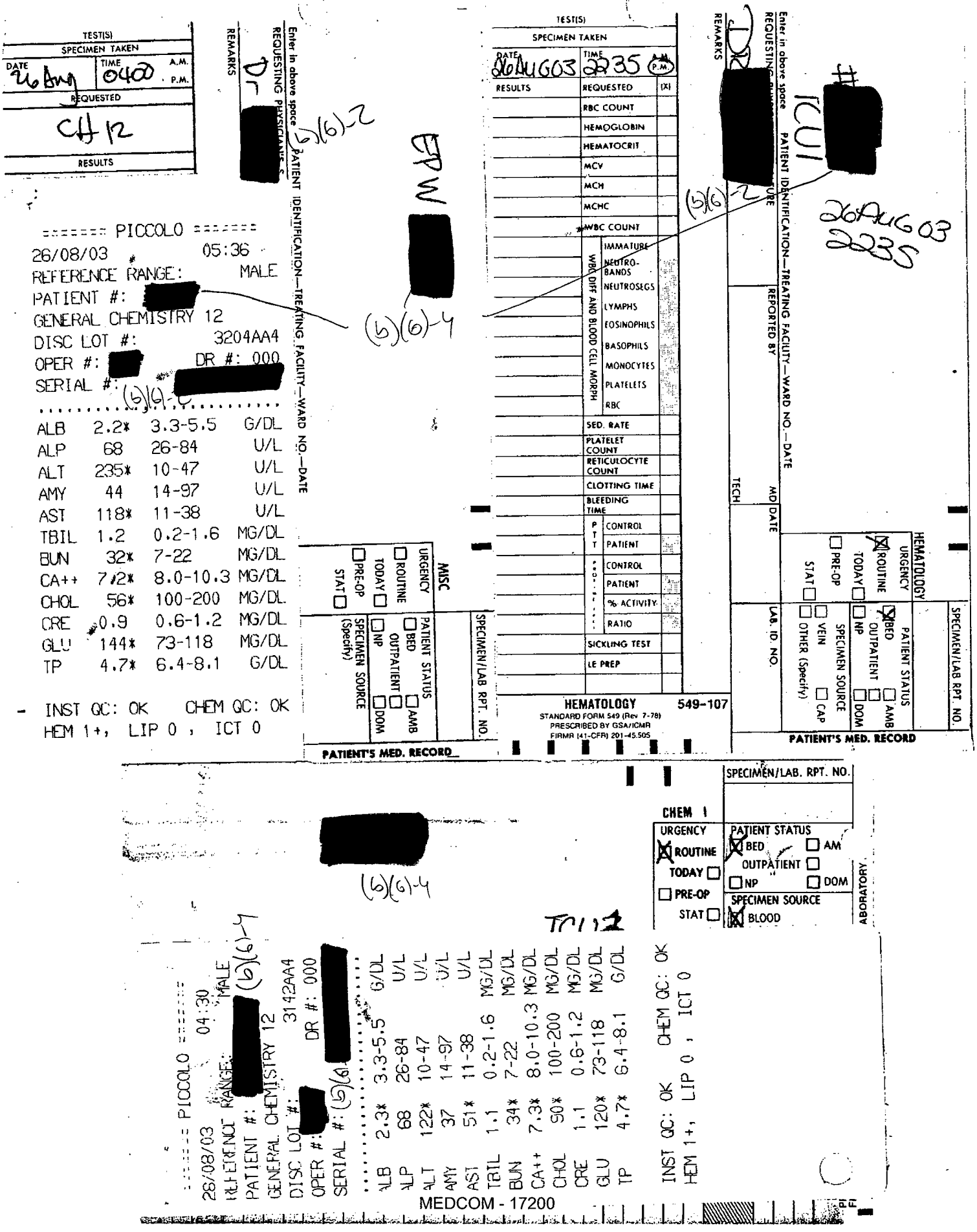
[redacted] MEDCOM - 17198

DOD-030787

ACLU-RDI 1640 p.158



MEDCOM - 17199



TEST(S)
SPECIMEN TAKEN
DATE 26 Aug
TIME 0400 A.M. P.M.
REQUESTED
CH 12
RESULTS

REMARKS DR [redacted]

Enter in above space REQUESTING PHYSICIAN'S (5)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(5)(6)-4

======= PICCOLO =======
26/08/03 05:36
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: (5)(6)-2

ALB	2.2*	3.3-5.5	G/DL
ALP	68	26-84	U/L
ALT	235*	10-47	U/L
AMY	44	14-97	U/L
AST	118*	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	32*	7-22	MG/DL
CA++	7.2*	8.0-10.3	MG/DL
CHOL	56*	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	144*	73-118	MG/DL
TP	4.7*	6.4-8.1	G/DL

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

MISC
URGENCY: ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS: BED ☐ OUTPATIENT ☐ NP ☐ DOM ☐ AMB ☐
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

TEST(S)
SPECIMEN TAKEN
DATE 26AUG03 TIME 2235 A.M. P.M.

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

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS [redacted] ICU1

Enter in above space REQUESTING PHYSICIAN'S [redacted] (5)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

26AUG03 2235

REPORTED BY
TECH MD DATE
LAB. ID. NO.
HEMATOLOGY
URGENCY: ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS: BED ☒ OUTPATIENT ☐ NP ☐ DOM ☐ AMB ☐
SPECIMEN SOURCE: VEIN ☐ CAP ☐ OTHER (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

[redacted] (5)(6)-4

CHEM 1
URGENCY: ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS: BED ☒ AM ☐ OUTPATIENT ☐ NP ☐ DOM ☐
SPECIMEN SOURCE: BLOOD ☒
SPECIMEN/LAB. RPT. NO.
LABORATORY

TCH 12

======= PICCOLO =======
28/08/03 04:30
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: (5)(6)-2

ALB	2.3*	3.3-5.5	G/DL
ALP	68	26-84	U/L
ALT	122*	10-47	U/L
AMY	37	14-97	U/L
AST	51*	11-38	U/L
TBIL	1.1	0.2-1.6	MG/DL
BUN	34*	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	90*	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	120*	73-118	MG/DL
TP	4.7*	6.4-8.1	G/DL

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

MEDCOM - 17200

PICCOLO

27/08/03 03:52

REFERENCE RANGE: MALE

PATIENT #: [redacted] (5)(6)-2

GENERAL CHEMISTRY 12

DISC LOT #: [redacted] (5)(6)-4 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.6*	3.3-5.5	G/DL
ALP	69	26-84	U/L
ALT	164*	10-47	U/L
AMY	44	14-97	U/L
AST	69*	11-38	U/L
TBIL	1.7*	0.2-1.6	MG/DL
BUN	53*	7-22	MG/DL
CA++	7.1*	8.0-10.3	MG/DL
CHOL	53*	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	149*	73-118	MG/DL
TP	4.9*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

ICU

27 Aug 03 0326 (5)(6)-4

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY MD DATE

HEMATOLOGY

URGENCY: ROUTINE, PRE-OP, STAT, TODAY

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

SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

TEST(S) | SPECIMEN TAKEN: DATE, TIME A.M. P.M. | RESULTS | REQUESTED | (X)

RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT

WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS 2, NEUTROSEGS 80, LYMPHS 12, EOSINOPHILS, BASOPHILS, MONOCYTES 6, PLATELETS, RBC Nucleated 3

SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT: CONTROL, PATIENT
PT: CONTROL, PATIENT, % ACTIVITY, RATIO
SICKLING TEST
LE PREP

HEMATOLOGY 549-107

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

PATIENT'S MED. RECORD

REMARKS: CBC [redacted] (5)(6)-2

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH DATE 27 Aug 03 1200

LAB. ID. NO. Attorney

HEMATOLOGY

URGENCY: ROUTINE, PRE-OP, STAT X, TODAY

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

SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify) X

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

[redacted] ICU (5)(6)-4

[redacted] (5)(6)-4

(ICU)

MISC

URGENCY: ROUTINE, TODAY, PRE-OP, STAT X

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

SPECIMEN SOURCE (Specify): Stool

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH DATE 27 Aug 03 LAB ID NO.

REMARKS Hemoccult

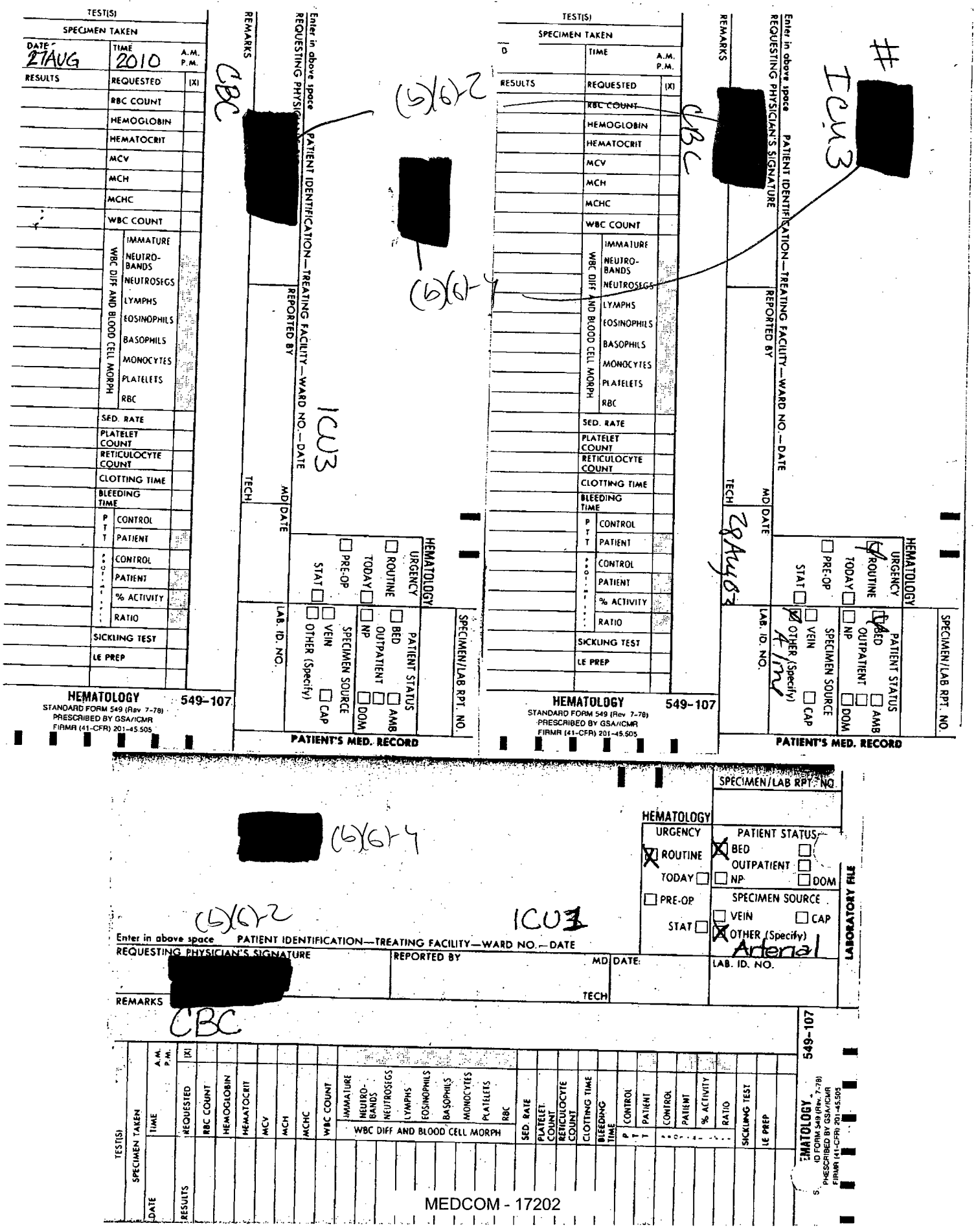
TEST(S) | SPECIMEN TAKEN: DATE, TIME A.M. P.M. | REQUESTED | RESULTS

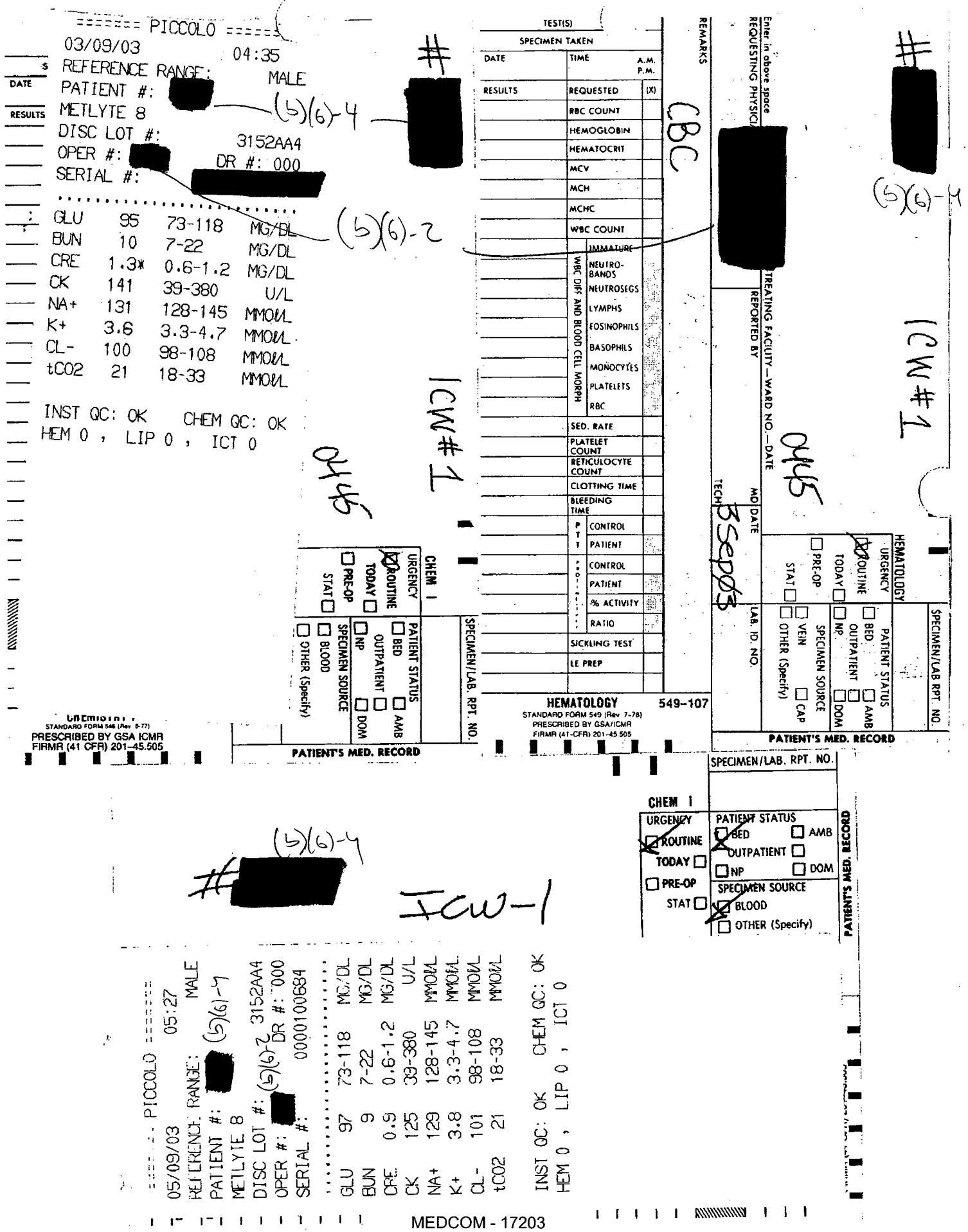
SOD

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 2-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 17201


TEST(S)
SPECIMEN TAKEN
DATE 27AUG
TIME 2010
A.M. P.M.
RESULTS
REQUESTED
(X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
HEMATOLOGY
549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
REMARKS
CBC
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
ICU3
REPORTED BY
MD
DATE
TECH
LAB. ID. NO.
HEMATOLOGY
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
OUTPATIENT
NP
DOM
AMB
SPECIMEN SOURCE
VEIN
CAP
OTHER (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
(5)(6)2
(5)(6)4
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M. P.M.
RESULTS
REQUESTED
(X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
HEMATOLOGY
549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
REMARKS
CBC
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
ICU3
REPORTED BY
MD
DATE
TECH
28 Aug 07
LAB. ID. NO.
HEMATOLOGY
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
OUTPATIENT
NP
DOM
AMB
SPECIMEN SOURCE
VEIN
CAP
OTHER (Specify)
A/line
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
#
ICU3
(5)(6)2
(5)(6)4
SPECIMEN/LAB RPT. NO.
HEMATOLOGY
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
VEIN
CAP
OTHER (Specify)
Arterial
LABORATORY FILE
(5)(6)2
ICU3
Enter in above space
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD
DATE:
TECH
LAB. ID. NO.
REMARKS
CBC
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M. P.M.
RESULTS
REQUESTED
(X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT
CONTROL
PATIENT
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
HEMATOLOGY
549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
MEDCOM - 17202



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

03/09/03 04:35

REFERENCE RANGE: MALE

PATIENT #: [redacted] (5)(6)-4

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted] (5)(6)-2

GLU	95	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	141	39-380	U/L
NA+	131	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	21	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

[redacted] (5)(6)-4

ICW#1

0445

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

CHEM 1
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

TEST(S)
SPECIMEN TAKEN
DATE / TIME / A.M. P.M.
RESULTS / REQUESTED / (X)

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

REMARKS
Enter in above space
REQUESTING PHYSICIAN
TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MO DATE
LAB. ID. NO.

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

HEMATOLOGY
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
SPECIMEN/LAB RPT NO.

PATIENT'S MED. RECORD

[redacted] (5)(6)-1

ICW#1

0445

8Sep03

[redacted] (5)(6)-4

ICW-1

CHEM 1
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

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

05/09/03 05:27

REFERENCE RANGE: MALE

PATIENT #: [redacted] (5)(6)-7

METLYTE 8

DISC LOT #: [redacted] (5)(6)-2 3152AA4

OPER #: [redacted] DR #: 000

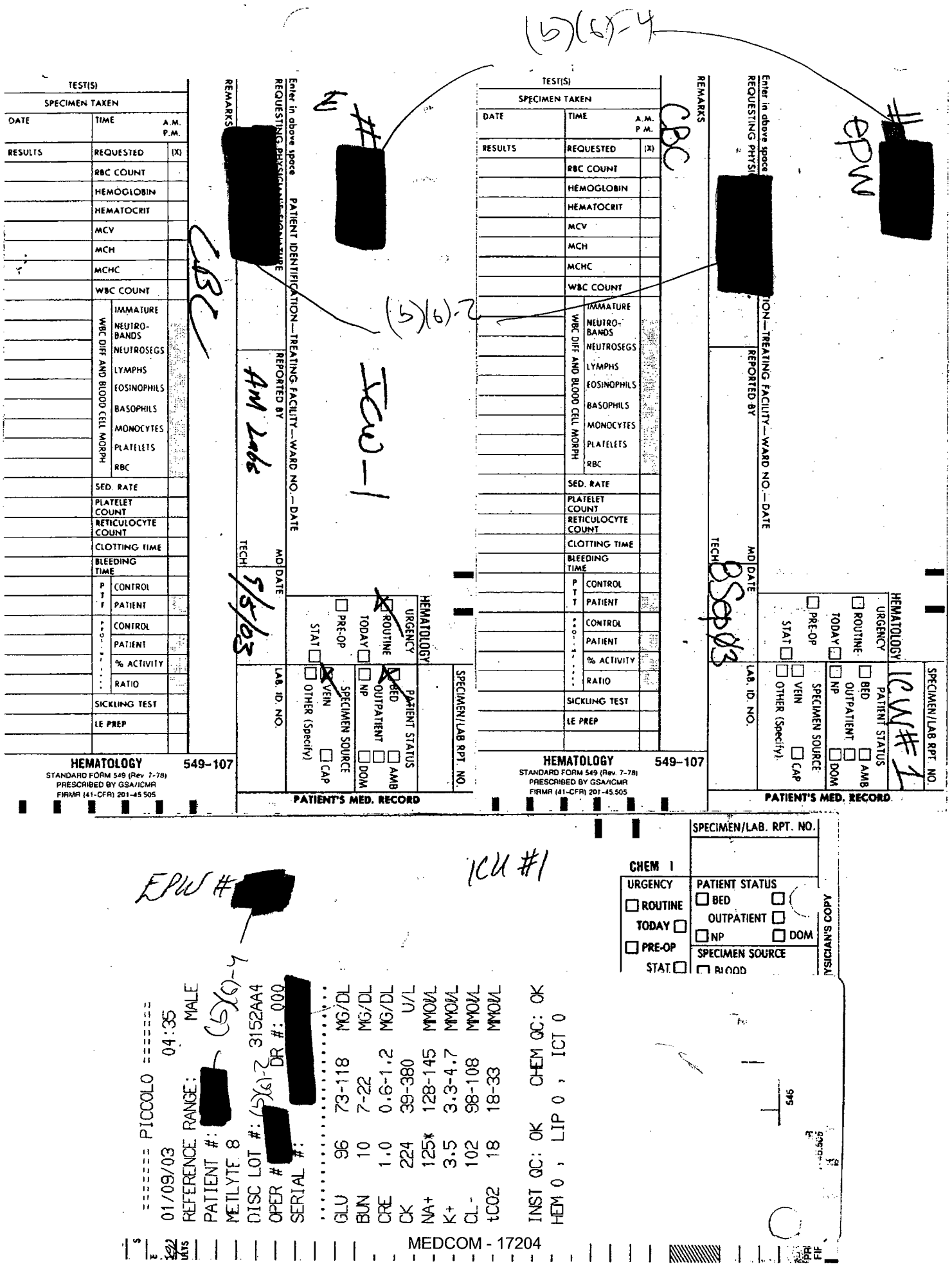
SERIAL #: 0000100684

GLU	97	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	125	39-380	U/L
NA+	129	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	21	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

MEDCOM - 17203



TEST(S)
SPECIMEN TAKEN
DATE
TIME A.M. P.M.
RESULTS
REQUESTED (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT: CONTROL, PATIENT
PT: CONTROL, PATIENT, % ACTIVITY, RATIO
SICKLING TEST
LE PREP
REMARKS
Enter in above space REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH MD DATE
LAB. ID. NO.
HEMATOLOGY URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, OUTPATIENT, NP, DOM, AMB
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
SPECIMEN/LAB RPT. NO.
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107
PATIENT'S MED. RECORD

CBC
AM Labs
5/5/03
ICU-1
ICU #1
EPW #
(5)(6)-4
(5)(6)-2
BSep03

CHEM 1
SPECIMEN/LAB. RPT. NO.
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD
PHYSICIAN'S COPY

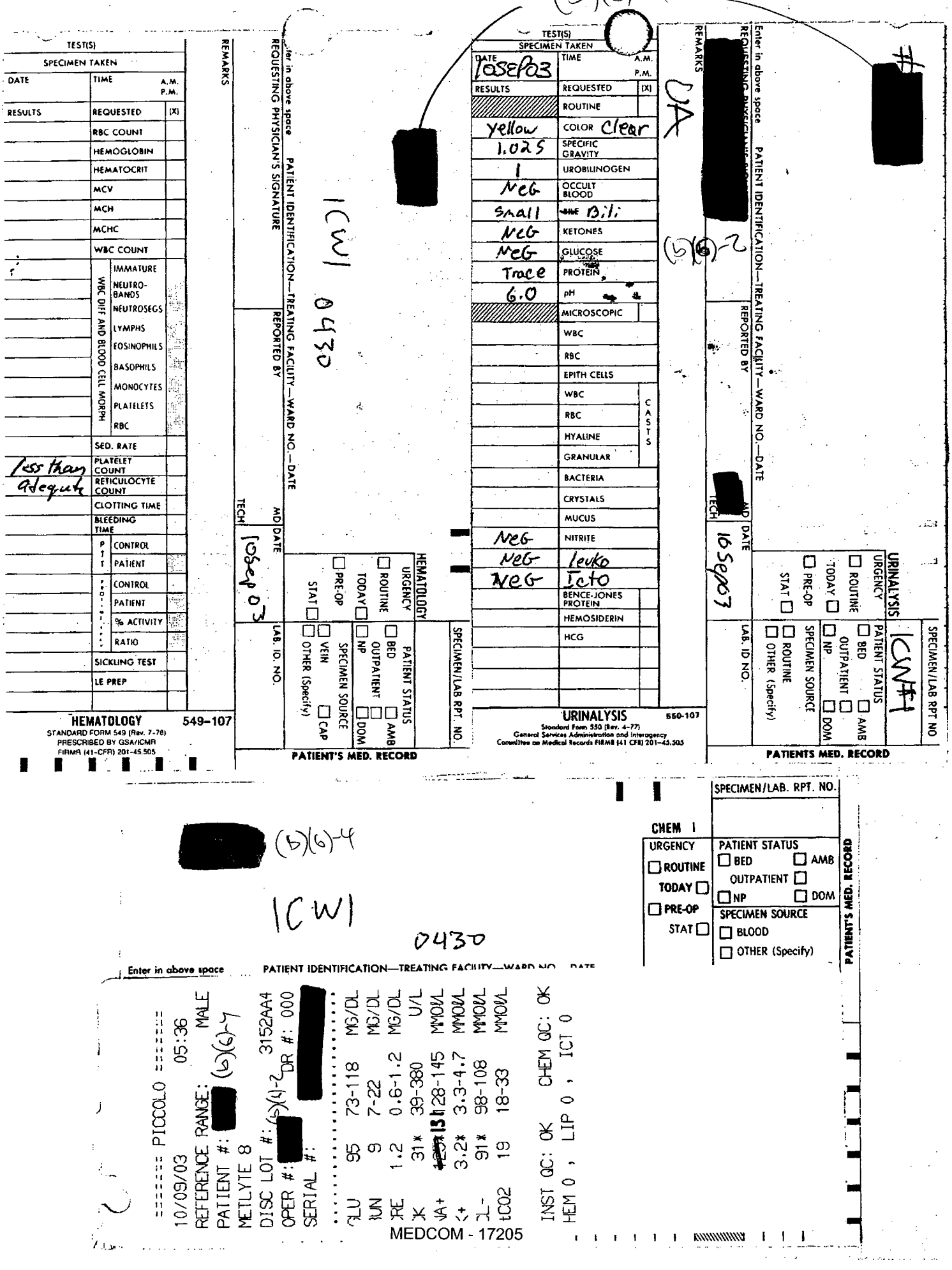
EPW #
(5)(6)-4
(5)(6)-2

====== PICCOLO ======
01/09/03 04:35
REFERENCE RANGE: MALE
PATIENT #:
METLYTE 8
DISC LOT #: 3152AA4
OPER #:
SERIAL #:

GLU	96	73-118 MG/DL
BUN	10	7-22 MG/DL
CRE	1.0	0.6-1.2 MG/DL
CK	224	39-380 U/L
NA+	125*	128-145 MMOL
K+	3.5	3.3-4.7 MMOL
CL-	102	98-108 MMOL
tCO2	18	18-33 MMOL

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

MEDCOM - 17204



HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

PATIENT'S MED. RECORD

URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency
Committee on Medical Records FIRMR (41 CFR) 201-45.505
550-107

PATIENTS MED. RECORD

CHEM 1

PATIENT'S MED. RECORD

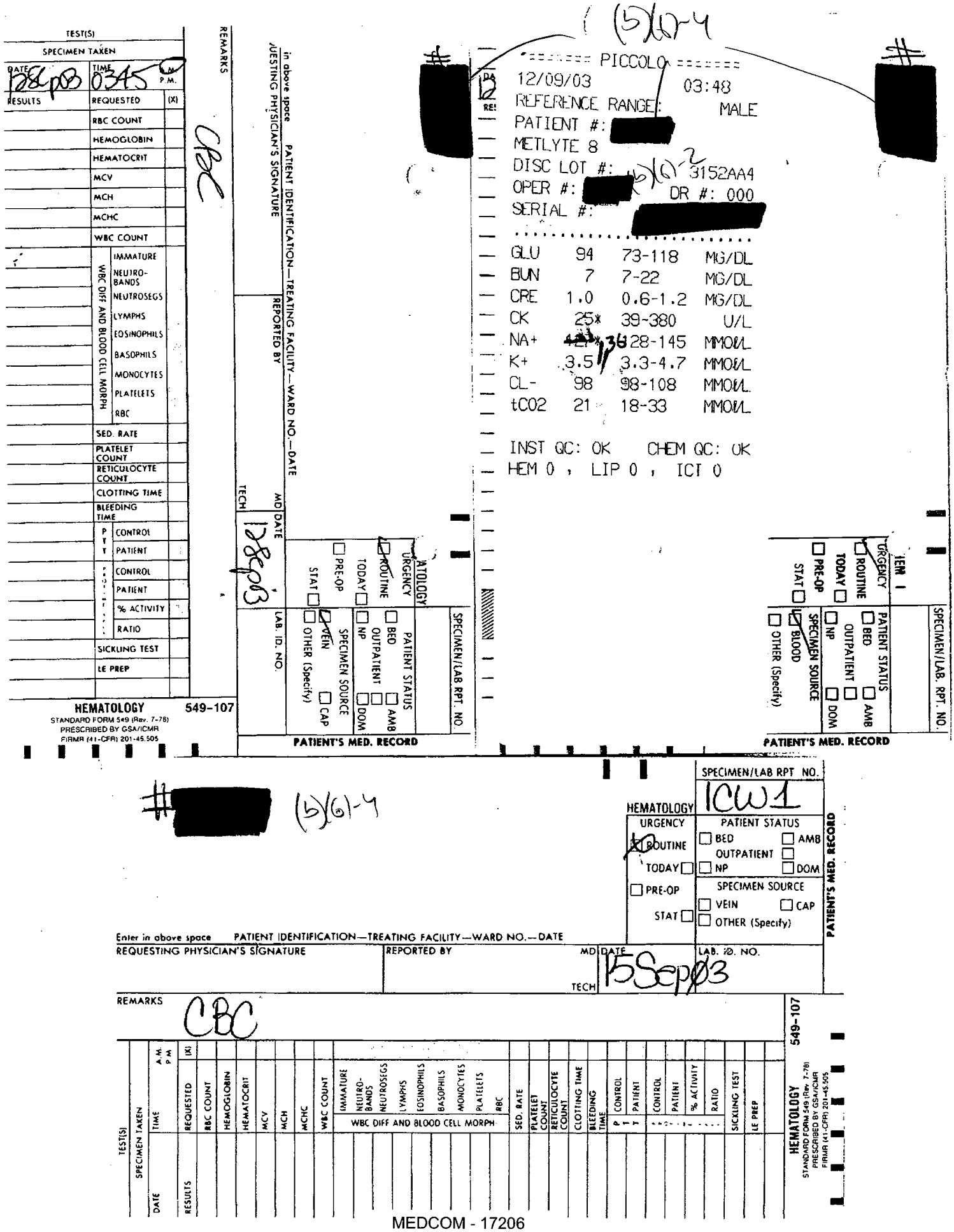
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.

10/09/03 05:36 MALE
REFERENCE RANGE: (b)(6)-4
PATIENT #:
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: DR #: 000
SERIAL #:

GLU	95	73-118 MG/DL
BUN	9	7-22 MG/DL
CRE	1.2	0.6-1.2 MG/DL
K	31*	39-380 U/L
NA+	138	128-145 MMOL
CL+	3.2*	3.3-4.7 MMOL
CL-	91*	98-108 MMOL
tCO2	19	18-33 MMOL

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

MEDCOM - 17205



PICCOLO
12/09/03 03:48
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	94	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	25*	39-380	U/L
NA+	136	28-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	21	18-33	MMOL

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

TEST(S)
SPECIMEN TAKEN
DATE 12Sep03 TIME 0345 A.M. P.M.
RESULTS | REQUESTED | (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT: CONTROL, PATIENT
PT: CONTROL, PATIENT, % ACTIVITY, RATIO
SICKLING TEST
LE PREP
REMARKS: CBC

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD TECH
DATE 12Sep03
LAB. ID. NO.

URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
SPECIMEN/LAB RPT. NO.

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107
PATIENT'S MED. RECORD

(5)(6)-4

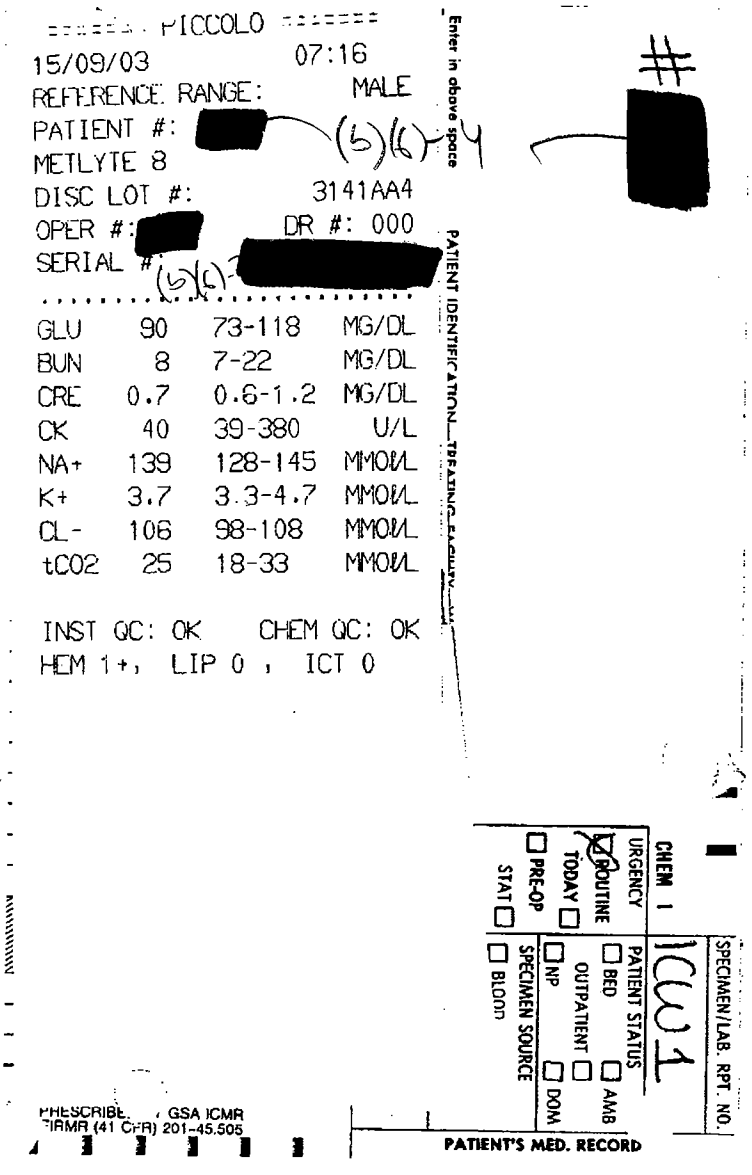
HEMATOLOGY
SPECIMEN/LAB RPT NO. ICW1
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD TECH
DATE 15Sep03
LAB. ID. NO.
REMARKS: CBC

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

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

MEDCOM - 17206



PICCOLO
15/09/03 07:16
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: (5)(6) [redacted]

GLU	90	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	40	39-380	U/L
NA+	139	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

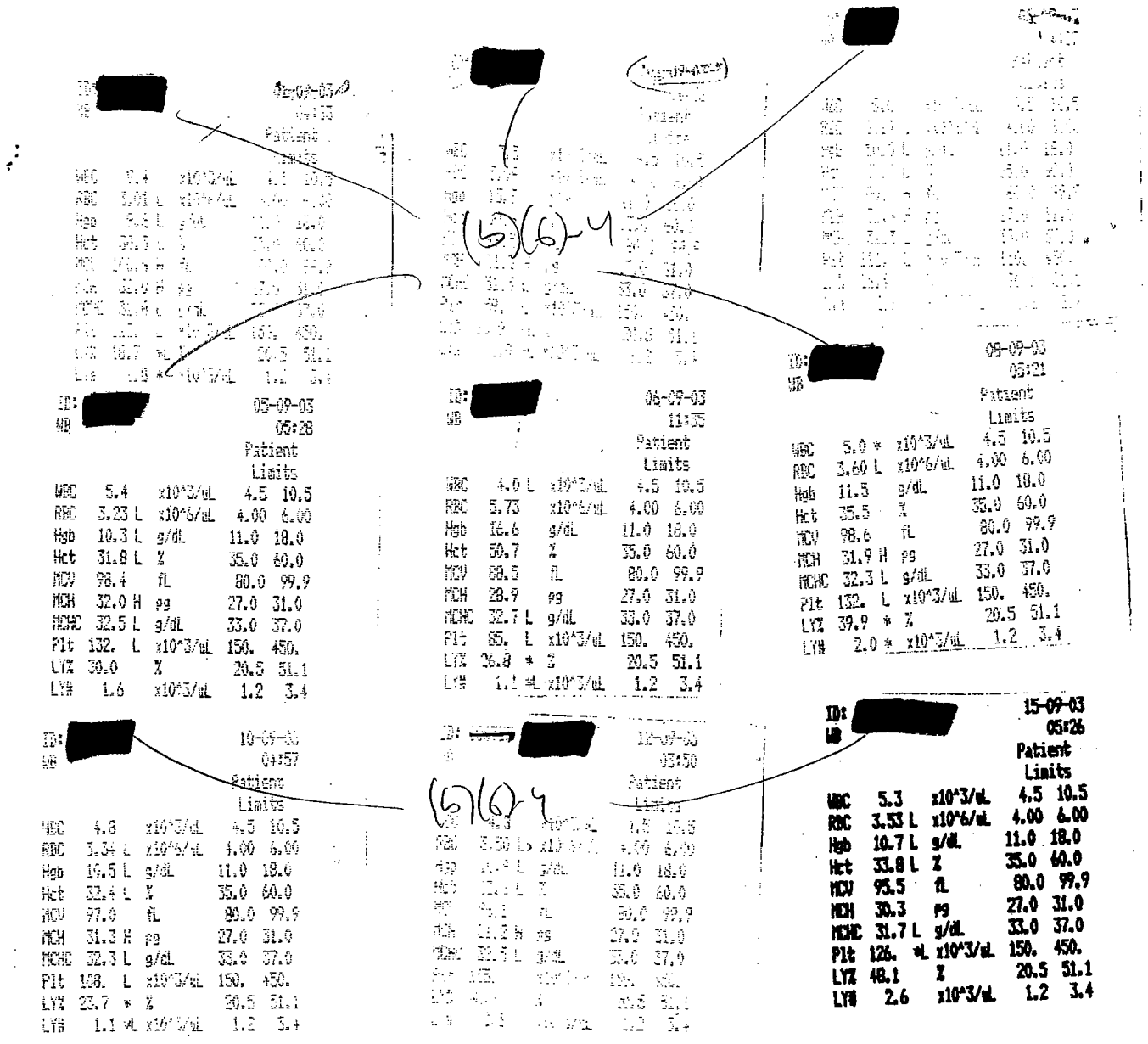
INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

Enter in above space

PATIENT IDENTIFICATION

CHEM 1
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD
ICU1
SPECIMEN/LAB. RPT. NO.

PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
PATIENT'S MED. RECORD



ID: [redacted]
WB

05-09-03
05:28

			Patient Limits	
WBC	5.4	x10^3/uL	4.5	10.5
RBC	3.23 L	x10^6/uL	4.00	6.00
Hgb	10.3 L	g/dL	11.0	18.0
Hct	31.8 L	%	35.0	60.0
MCV	98.4	fL	80.0	99.9
MCH	32.0 H	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	132. L	x10^3/uL	150.	450.
LY%	30.0	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

ID: [redacted]
WB

06-09-03
11:35

			Patient Limits	
WBC	4.0 L	x10^3/uL	4.5	10.5
RBC	5.73	x10^6/uL	4.00	6.00
Hgb	16.6	g/dL	11.0	18.0
Hct	50.7	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	32.7 L	g/dL	33.0	37.0
Plt	85. L	x10^3/uL	150.	450.
LY%	36.8 *	%	20.5	51.1
LY#	1.1 L	x10^3/uL	1.2	3.4

ID: [redacted]
WB

09-09-03
05:21

			Patient Limits	
WBC	5.0 *	x10^3/uL	4.5	10.5
RBC	3.60 L	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	35.5	%	35.0	60.0
MCV	98.6	fL	80.0	99.9
MCH	31.9 H	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	132. L	x10^3/uL	150.	450.
LY%	39.9 *	%	20.5	51.1
LY#	2.0 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

10-09-03
04:57

			Patient Limits	
WBC	4.8	x10^3/uL	4.5	10.5
RBC	3.34 L	x10^6/uL	4.00	6.00
Hgb	10.5 L	g/dL	11.0	18.0
Hct	32.4 L	%	35.0	60.0
MCV	97.0	fL	80.0	99.9
MCH	31.3 H	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	108. L	x10^3/uL	150.	450.
LY%	23.7 *	%	20.5	51.1
LY#	1.1 L	x10^3/uL	1.2	3.4

ID: [redacted]

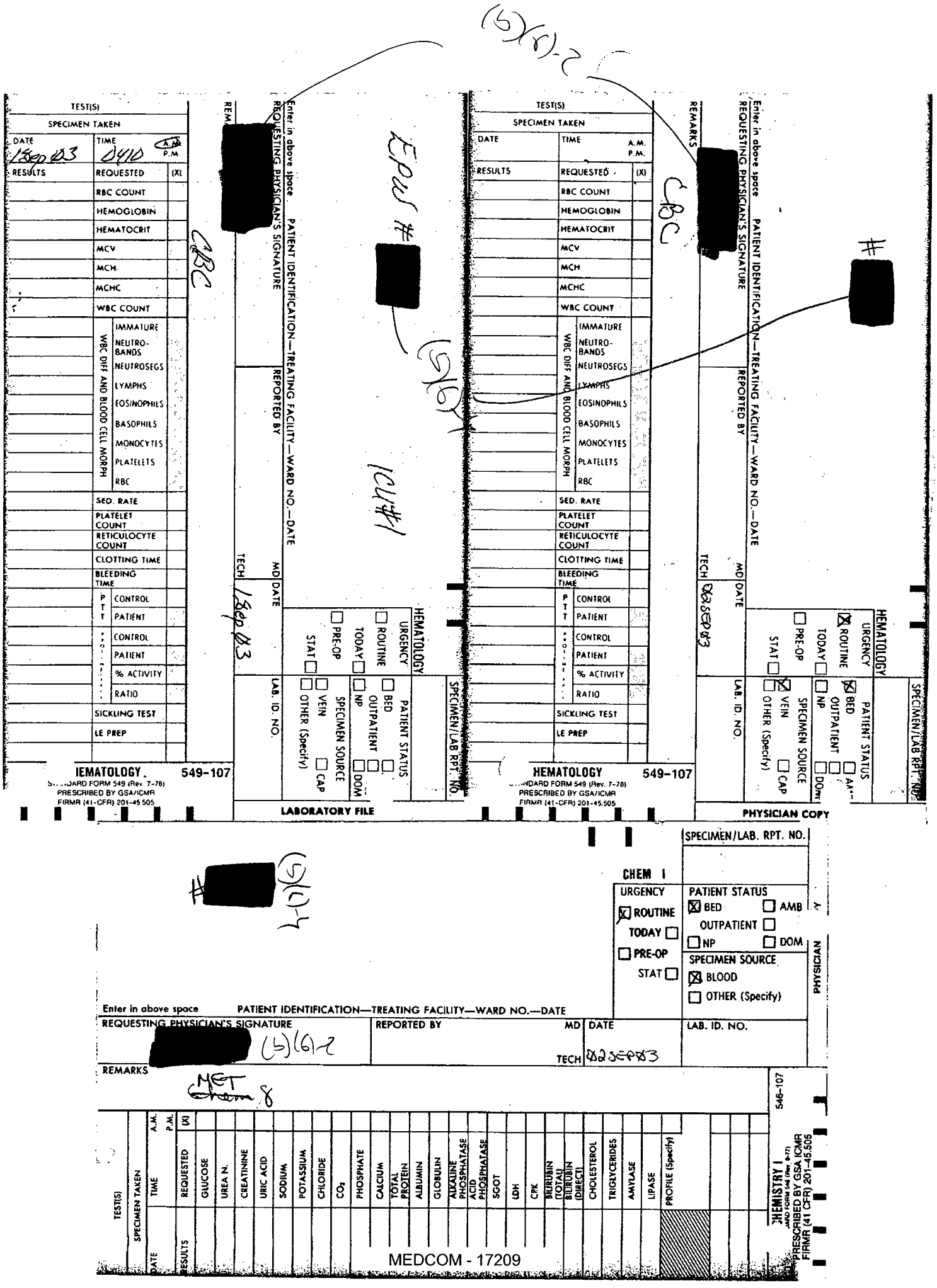
12-09-03
05:50

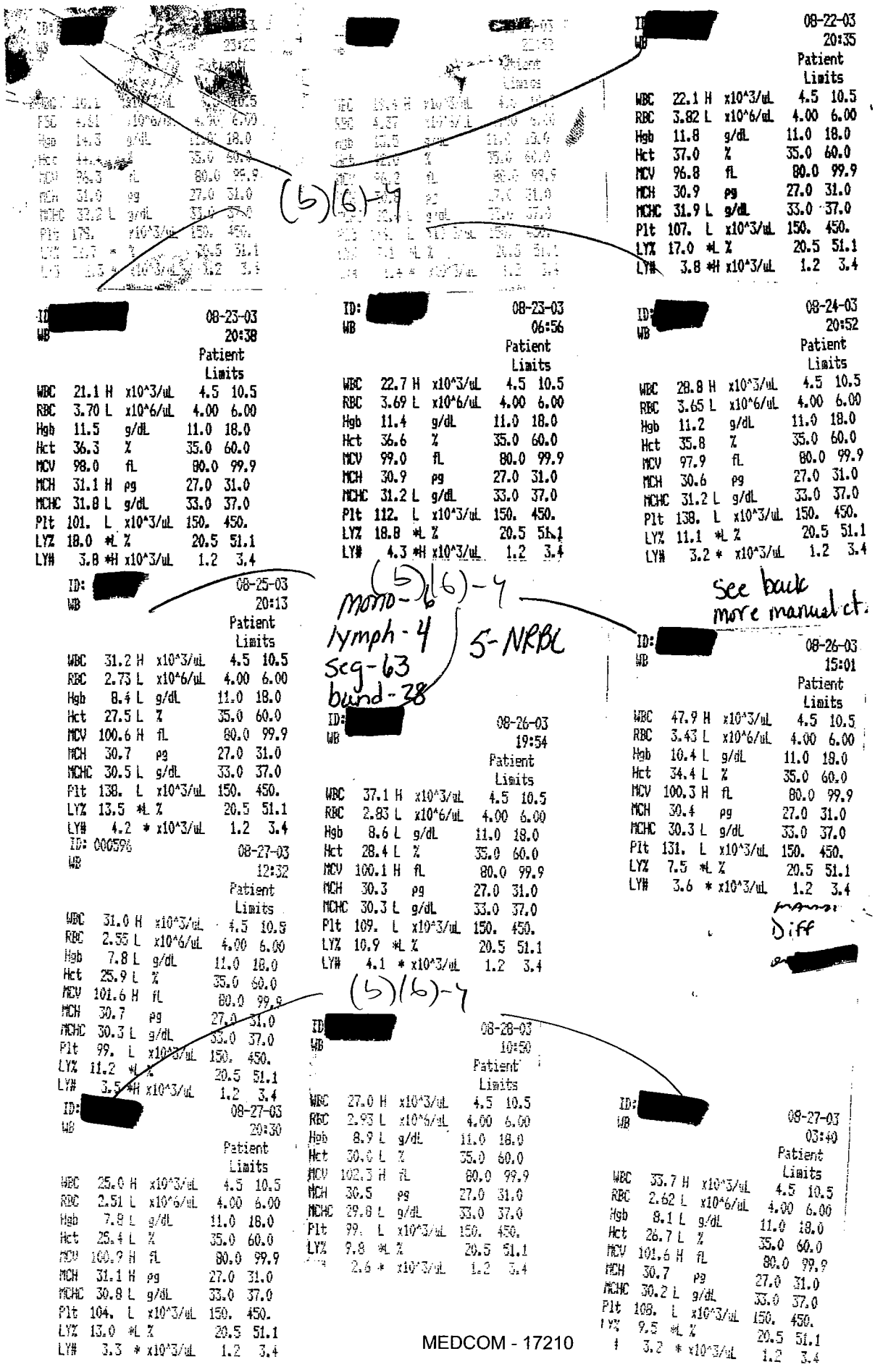
			Patient Limits	
WBC	4.3	x10^3/uL	4.5	10.5
RBC	3.50 L	x10^6/uL	4.00	6.00
Hgb	10.7 L	g/dL	11.0	18.0
Hct	33.8 L	%	35.0	60.0
MCV	96.5	fL	80.0	99.9
MCH	30.6	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	126. L	x10^3/uL	150.	450.
LY%	48.1	%	20.5	51.1
LY#	2.6	x10^3/uL	1.2	3.4

ID: [redacted]
WB

15-09-03
05:26

			Patient Limits	
WBC	5.3	x10^3/uL	4.5	10.5
RBC	3.53 L	x10^6/uL	4.00	6.00
Hgb	10.7 L	g/dL	11.0	18.0
Hct	33.8 L	%	35.0	60.0
MCV	95.5	fL	80.0	99.9
MCH	30.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	126. L	x10^3/uL	150.	450.
LY%	48.1	%	20.5	51.1
LY#	2.6	x10^3/uL	1.2	3.4


(b)(6)-2
EPW #
(b)(6)-2
ICU#1
CBC
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M. P.M.
RESULTS
REQUESTED
(X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT
CONTROL
PATIENT
PROTHROMBIN TIME
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
TECH
DATE
LAB. ID. NO.
HEMATOLOGY
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
OUTPATIENT
NP
DOM
AMB
SPECIMEN SOURCE
VEIN
CAP
OTHER (Specify)
SPECIMEN/LAB RPT. NO.
HEMATOLOGY 549-107
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
LABORATORY FILE
PHYSICIAN COPY
15Sep03
0410
(b)(6)-2
(b)(6)-4
CHEM 1
PHYSICIAN
MET
CHEMISTRY 1
546-107
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
MEDCOM - 17209



ID: [redacted]
WB

08-22-03 20:35

			Patient Limits	
WBC	22.1 H	x10^3/uL	4.5	10.5
RBC	3.82 L	x10^6/uL	4.00	6.00
Hgb	11.8	g/dL	11.0	18.0
Hct	37.0	%	35.0	60.0
MCV	96.8	fL	80.0	99.9
MCH	30.9	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	107. L	x10^3/uL	150.	450.
LY%	17.0 *L	%	20.5	51.1
LY#	3.8 *H	x10^3/uL	1.2	3.4

(5)(6)-4

ID: [redacted]
WB

08-23-03 20:38

			Patient Limits	
WBC	21.1 H	x10^3/uL	4.5	10.5
RBC	3.70 L	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	36.3	%	35.0	60.0
MCV	98.0	fL	80.0	99.9
MCH	31.1 H	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	101. L	x10^3/uL	150.	450.
LY%	18.0 *L	%	20.5	51.1
LY#	3.8 *H	x10^3/uL	1.2	3.4

ID: [redacted]
WB

08-23-03 06:56

			Patient Limits	
WBC	22.7 H	x10^3/uL	4.5	10.5
RBC	3.69 L	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	36.6	%	35.0	60.0
MCV	99.0	fL	80.0	99.9
MCH	30.9	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	112. L	x10^3/uL	150.	450.
LY%	18.8 *L	%	20.5	51.1
LY#	4.3 *H	x10^3/uL	1.2	3.4

ID: [redacted]
WB

08-24-03 20:52

			Patient Limits	
WBC	28.8 H	x10^3/uL	4.5	10.5
RBC	3.65 L	x10^6/uL	4.00	6.00
Hgb	11.2	g/dL	11.0	18.0
Hct	35.8	%	35.0	60.0
MCV	97.9	fL	80.0	99.9
MCH	30.6	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	138. L	x10^3/uL	150.	450.
LY%	11.1 *L	%	20.5	51.1
LY#	3.2 *	x10^3/uL	1.2	3.4

See back more manual ct.

(5)(6)-4
mono-6
lymph-4
seg-63
band-38
5-NRBC

ID: [redacted]
WB

08-25-03 20:13

			Patient Limits	
WBC	31.2 H	x10^3/uL	4.5	10.5
RBC	2.73 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	27.5 L	%	35.0	60.0
MCV	100.6 H	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	30.5 L	g/dL	33.0	37.0
Plt	138. L	x10^3/uL	150.	450.
LY%	13.5 *L	%	20.5	51.1
LY#	4.2 *	x10^3/uL	1.2	3.4

ID: 00059%
WB

08-27-03 12:32

			Patient Limits	
WBC	31.0 H	x10^3/uL	4.5	10.5
RBC	2.55 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	25.9 L	%	35.0	60.0
MCV	101.6 H	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	99. L	x10^3/uL	150.	450.
LY%	11.2 *L	%	20.5	51.1
LY#	3.5 *H	x10^3/uL	1.2	3.4

ID: [redacted]
WB

08-26-03 19:54

			Patient Limits	
WBC	37.1 H	x10^3/uL	4.5	10.5
RBC	2.83 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	28.4 L	%	35.0	60.0
MCV	100.1 H	fL	80.0	99.9
MCH	30.3	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	109. L	x10^3/uL	150.	450.
LY%	10.9 *L	%	20.5	51.1
LY#	4.1 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

08-26-03 15:01

			Patient Limits	
WBC	47.9 H	x10^3/uL	4.5	10.5
RBC	3.43 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	34.4 L	%	35.0	60.0
MCV	100.3 H	fL	80.0	99.9
MCH	30.4	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	131. L	x10^3/uL	150.	450.
LY%	7.5 *L	%	20.5	51.1
LY#	3.6 *	x10^3/uL	1.2	3.4

manual Diff

[redacted]

(5)(6)-4

ID: [redacted]
WB

08-28-03 10:50

			Patient Limits	
WBC	27.0 H	x10^3/uL	4.5	10.5
RBC	2.93 L	x10^6/uL	4.00	6.00
Hgb	8.9 L	g/dL	11.0	18.0
Hct	30.0 L	%	35.0	60.0
MCV	102.3 H	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	29.8 L	g/dL	33.0	37.0
Plt	99. L	x10^3/uL	150.	450.
LY%	9.8 *L	%	20.5	51.1
LY#	2.6 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

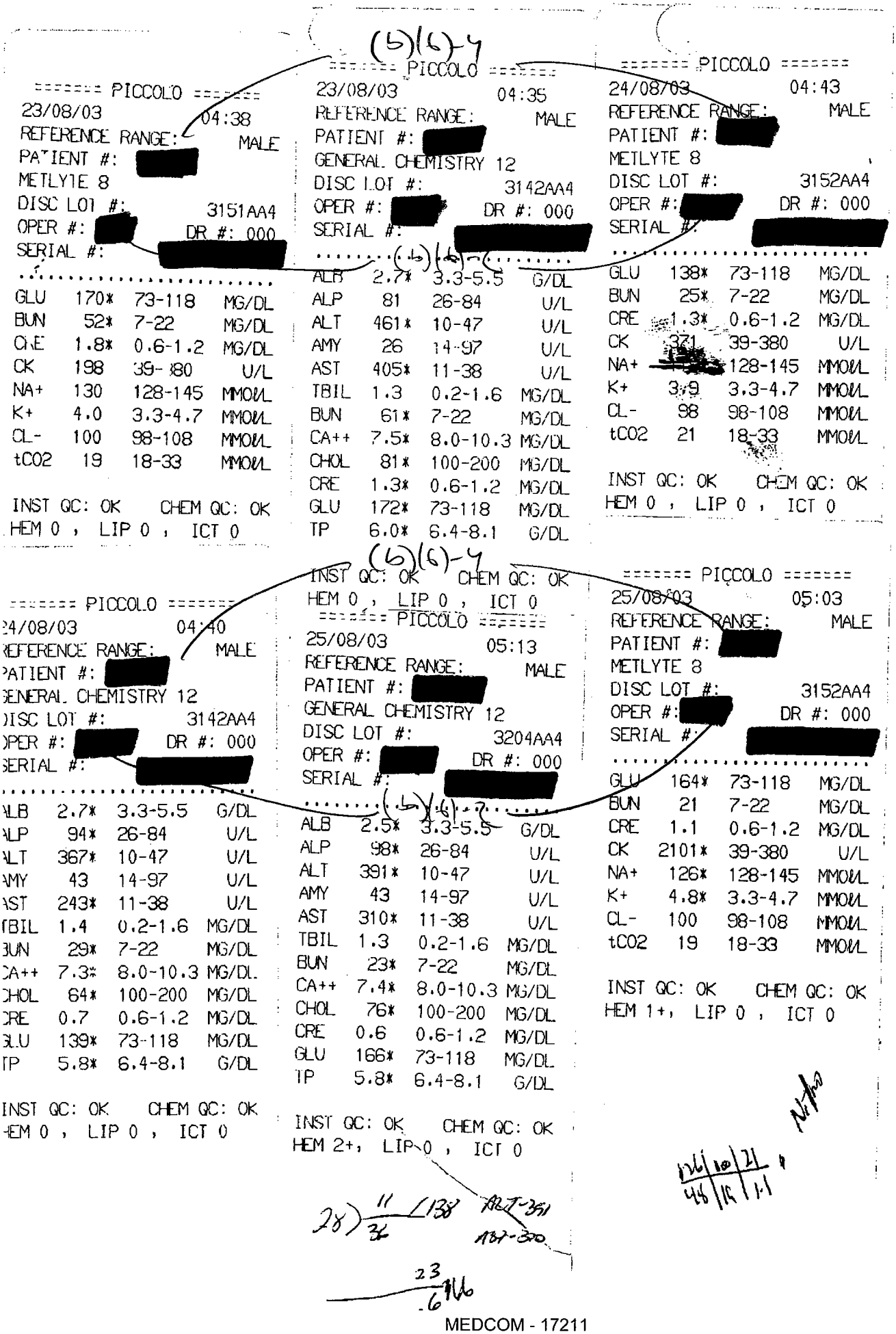
08-27-03 20:30

			Patient Limits	
WBC	25.0 H	x10^3/uL	4.5	10.5
RBC	2.51 L	x10^6/uL	4.00	6.00
Hgb	7.9 L	g/dL	11.0	18.0
Hct	25.4 L	%	35.0	60.0
MCV	100.9 H	fL	80.0	99.9
MCH	31.1 H	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	104. L	x10^3/uL	150.	450.
LY%	13.0 *L	%	20.5	51.1
LY#	3.3 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

08-27-03 03:40

			Patient Limits	
WBC	33.7 H	x10^3/uL	4.5	10.5
RBC	2.62 L	x10^6/uL	4.00	6.00
Hgb	8.1 L	g/dL	11.0	18.0
Hct	26.7 L	%	35.0	60.0
MCV	101.6 H	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	30.2 L	g/dL	33.0	37.0
Plt	108. L	x10^3/uL	150.	450.
LY%	9.5 *L	%	20.5	51.1
LY#	3.2 *	x10^3/uL	1.2	3.4



======= PICCOLO =======
23/08/03 04:38
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	170*	73-118	MG/DL
BUN	52*	7-22	MG/DL
CRE	1.8*	0.6-1.2	MG/DL
CK	198	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(5)(6)-4

======= PICCOLO =======
23/08/03 04:35
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	81	26-84	U/L
ALT	461*	10-47	U/L
AMY	26	14-97	U/L
AST	405*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
BUN	61*	7-22	MG/DL
CA++	7.5*	8.0-10.3	MG/DL
CHOL	81*	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	172*	73-118	MG/DL
TP	6.0*	6.4-8.1	G/DL

(5)(6)-4

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

======= PICCOLO =======
24/08/03 04:43
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
BUN	25*	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	371	39-380	U/L
NA+	[redacted]	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

======= PICCOLO =======
24/08/03 04:40
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	94*	26-84	U/L
ALT	367*	10-47	U/L
AMY	43	14-97	U/L
AST	243*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	29*	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	64*	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	139*	73-118	MG/DL
TP	5.8*	6.4-8.1	G/DL

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

(6)(6)-4

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

======= PICCOLO =======
25/08/03 05:13
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	98*	26-84	U/L
ALT	391*	10-47	U/L
AMY	43	14-97	U/L
AST	310*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
BUN	23*	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CHOL	76*	100-200	MG/DL
CRE	0.6	0.6-1.2	MG/DL
GLU	166*	73-118	MG/DL
TP	5.8*	6.4-8.1	G/DL

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

======= PICCOLO =======
25/08/03 05:03
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	164*	73-118	MG/DL
BUN	21	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	2101*	39-380	U/L
NA+	126*	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

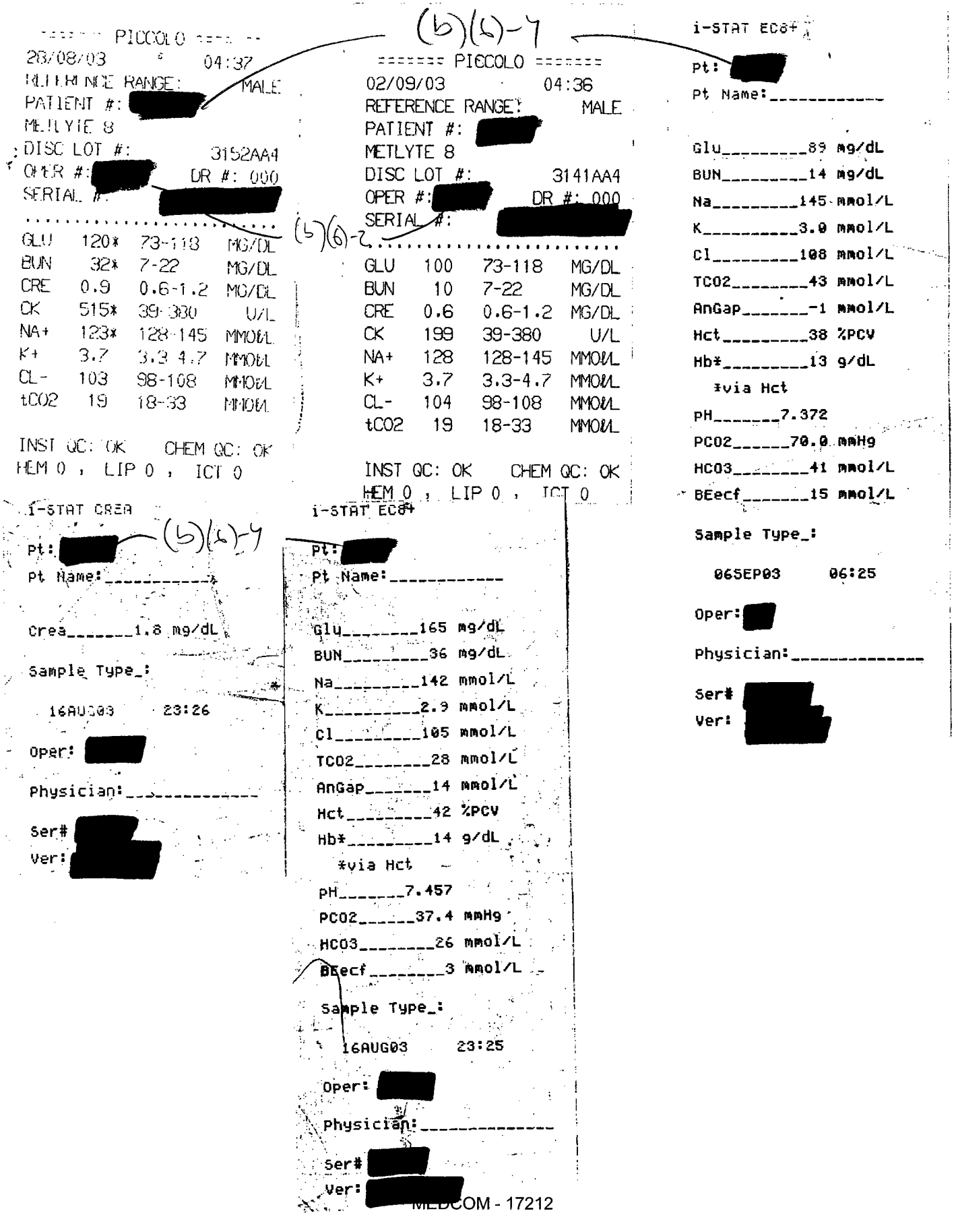
INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

126 | 100 | 21
48 | 19 | 1.1

28) 11 / 138 ALT-351
32 AST-310

23
6

MEDCOM - 17211



PICCOLO
28/08/03 04:37
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	120*	73-118	MG/DL
BUN	32*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	515*	39-380	U/L
NA+	123*	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(b)(6)-7

PICCOLO
02/09/03 04:36
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

(b)(6)-7

GLU	100	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	199	39-380	U/L
NA+	128	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

i-STAT EC8+
Pt: [redacted]
Pt Name:_____

Glu_____89 mg/dL
BUN_____14 mg/dL
Na_____145 mmol/L
K_____3.0 mmol/L
Cl_____108 mmol/L
TCO2_____43 mmol/L
AnGap_____-1 mmol/L
Hct_____38 %PCV
Hb*_____13 g/dL
*via Hct
pH_____7.372
PCO2_____70.0 mmHg
HCO3_____41 mmol/L
BEecf_____15 mmol/L

Sample Type_:
06SEP03 06:25
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

i-STAT CREA
Pt: [redacted]
Pt Name:_____

Crea_____1.8 mg/dL

Sample Type_:
16AUG03 23:26
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

(b)(6)-7

i-STAT EC8+
Pt: [redacted]
Pt Name:_____

Glu_____165 mg/dL
BUN_____36 mg/dL
Na_____142 mmol/L
K_____2.9 mmol/L
Cl_____105 mmol/L
TCO2_____28 mmol/L
AnGap_____14 mmol/L
Hct_____42 %PCV
Hb*_____14 g/dL
*via Hct
pH_____7.457
PCO2_____37.4 mmHg
HCO3_____26 mmol/L
BEecf_____3 mmol/L

Sample Type_:
16AUG03 23:25
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

MEDCOM - 17212

(b)(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____25 mmol/L

At 37C

PH_____7.544

PCO2_____26.2 mmHg

PO2_____21 mmHg

HCO3_____24 mmol/L

BEecf_____2 mmol/L

sO2*_____44 %

*calculated

At Patient Temp

PH_____7.566

PCO2_____26.6 mmHg

PO2_____19 mmHg

Patient Temp: 96.1F

FIO2_____: 37

Sample Type_: VEN

27AUG03 03:40

Oper:

Physician:_____

Ser# [redacted]

Ver: [redacted]

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.647

PCO2_____21.3 mmHg

PO2_____66 mmHg

HCO3_____23 mmol/L

BEecf_____2 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

PH_____7.665

PCO2_____20.3 mmHg

PO2_____61 mmHg

Patient Temp: 96.6F

FIO2_____: 37

Sample Type_: ART

27AUG03 03:43

Oper:

Physician:_____

Ser# [redacted]

Ver: [redacted]

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____143 mg/dL

BUN_____47 mg/dL

Na_____134 mmol/L

K_____3.5 mmol/L

Cl_____102 mmol/L

TCO2_____21 mmol/L

AnGap_____15 mmol/L

Hct_____23 %PCV

Hb*_____8 g/dL

*via Hct

PH_____7.582

PCO2_____21.6 mmHg

HCO3_____20 mmol/L

BEecf_____-2 mmol/L

Sample Type_:

27AUG03 03:48

Oper: [redacted] (b)(6)-7

Physician:_____

Ser# [redacted]

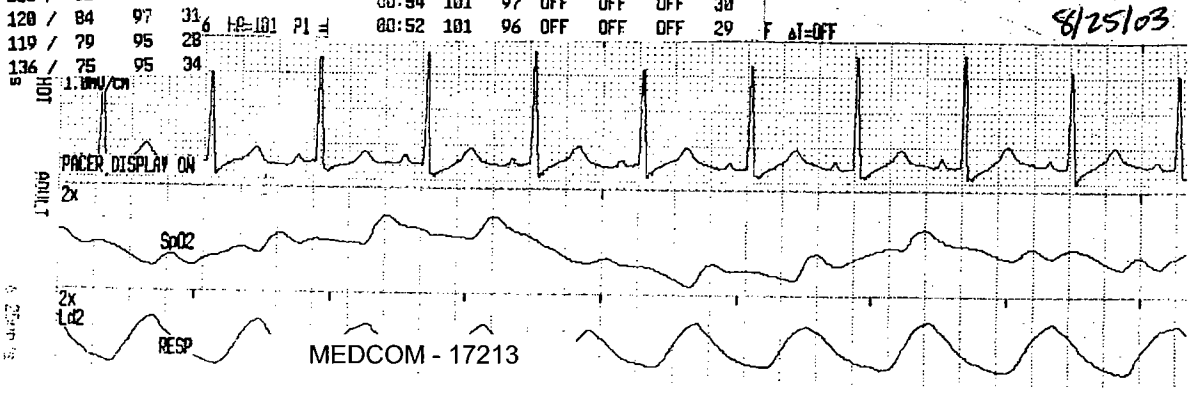
Ver: [redacted]

NIBP TREND 08/25/03

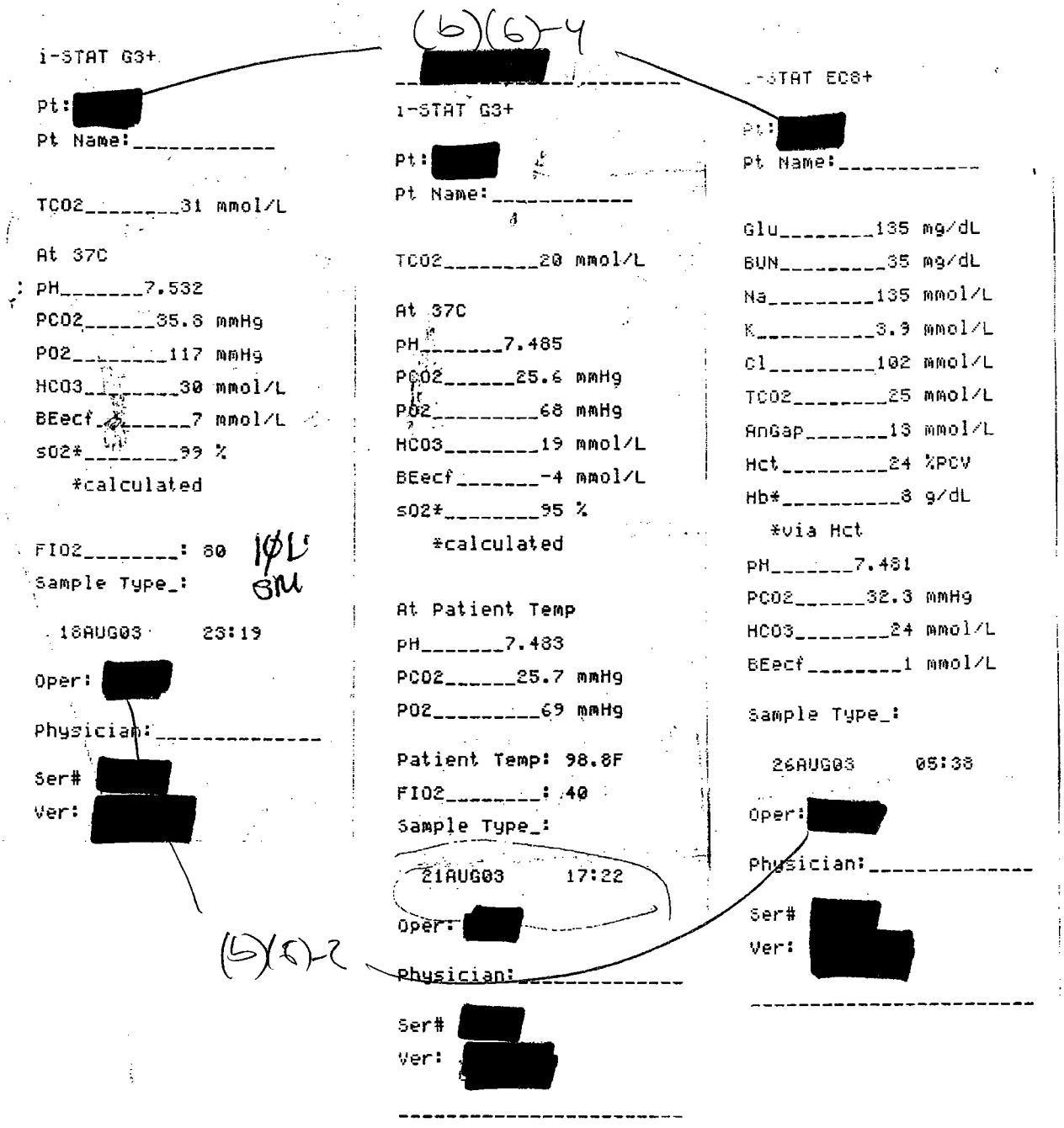
TIME HR:MM	HR/PR BPM	SpO2 %	SYS / DIA - MEAN mmHg			RR RPM
05:00	107	93	137 /	85	104	37
04:00	103	95	112 /	79	91	29
03:00	105	94	129 /	88	96	31
02:00	103	94	123 /	84	98	30
01:00	103	94	123 /	82	97	32
00:00	103	97	120 /	84	97	31
23:00	102	96	119 /	79	95	28
22:00	103	94	136 /	75	95	34

01:14	106	94	OFF	OFF	OFF	25
01:12	103	94	OFF	OFF	OFF	32
01:10	103	95	OFF	OFF	OFF	31
01:08	104	94	OFF	OFF	OFF	32
01:06	104	93	OFF	OFF	OFF	30
01:04	105	94	OFF	OFF	OFF	34
01:02	104	93	OFF	OFF	OFF	32
01:00	103	94	OFF	OFF	OFF	33
00:58	102	97	OFF	OFF	OFF	31
00:56	101	97	OFF	OFF	OFF	28
00:54	101	97	OFF	OFF	OFF	30
00:52	101	96	OFF	OFF	OFF	29

8/25/03



MEDCOM - 17213



i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____31 mmol/L

At 37C

PH_____7.532

PCO2_____35.8 mmHg

PO2_____117 mmHg

HCO3_____30 mmol/L

BEecf_____7 mmol/L

sO2*_____99 %

*calculated

FIO2_____: 60

Sample Type_:

18AUG03 23:19

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

(b)(6)-4

[redacted]

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____20 mmol/L

At 37C

PH_____7.485

PCO2_____25.6 mmHg

PO2_____68 mmHg

HCO3_____19 mmol/L

BEecf_____-4 mmol/L

sO2*_____95 %

*calculated

At Patient Temp

PH_____7.483

PCO2_____25.7 mmHg

PO2_____69 mmHg

Patient Temp: 98.8F

FIO2_____: 40

Sample Type_:

21AUG03 17:22

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

(b)(6)-2

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____135 mg/dL

BUN_____35 mg/dL

Na_____135 mmol/L

K_____3.9 mmol/L

Cl_____102 mmol/L

TCO2_____25 mmol/L

AnGap_____13 mmol/L

Hct_____24 %PCV

Hb*_____8 g/dL

*via Hct

PH_____7.481

PCO2_____32.3 mmHg

HCO3_____24 mmol/L

BEecf_____1 mmol/L

Sample Type_:

26AUG03 05:38

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

(b)(6)-2

Ward/Section: 1000	REQUESTING PHYSICIAN: [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-2	DATE: 23 Apr	TIME: 1415
		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	68	Mono	6
Bands	1	Eos	
Lymph	24	Baso	1
Atyp		Imm	
RBC Morph	6NRBC		

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:** 4-23-03	**LAB ID NO.:**

(b)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted] (b)(6)-1	DATE 8/23	TIME 0425	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	22.1	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.82	4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb	11.8	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	37.0	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	96.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	107	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	17.0	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)
Sed Rate		
Other		

CSF		
Cell Count		
Directigen		Negative

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Patients Name: EPW # [redacted] (b)(6)-4 Date: 24Aug2003

PM 24Aug03 AM 24Aug

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																									98.8	
NBP																				116/70	114/78	114/73	109/74	108/66	124/76	108/70
TEMP																										
HR																				71	78	75	76	75	74	77
RR																				20	20	17	24	18	21	20
SaO2																				98%	96%	97%	96%	96%	97%	97
FIO2																				2L	2L	2L	2L	2L	4L	2L
Source																				NC	NC	NC	NC	NC	NC	NC
MAP																				93	92	91	88	85	95	88
~~FiO2~~																										
~~Source~~																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF	~~125~~																			125	125	125	125	125	125	125
IVPB																						50				
NGT																										
PO																				120			240			
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
URINE	~~100~~																			105	56	100	134	175	90	
NGT																										
STOOL																										
DRAIN																										
Total																										

(b)(6)-7

Ward/Section: ICUI	REQUESTING PHYSICIAN: [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 18 Aug 04	TIME 0945
		SSN/PSEUDO SSN: [redacted] (b)(6)-4

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) 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		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: Chem 8

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

Ward/Section:	REQUESTING PHYSICIAN: [redacted] (6)(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted] (6)(6)-4	DATE 18 Aug	TIME 2240	SSN/PSEUDO SSN: [redacted] (6)(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		

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.:**

(b)(6)-4

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] EPW	DATE 4 Aug	TIME 2245
		SSN/PSEUDO SSN: EPW [redacted]

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(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

======= PICCOLO =======
18/08/03 22:56
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-2
METLYTE 8
DISC LOT #: (b)(6)-4 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	153*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	811*	39-380	U/L
NA+	129	128-145	MMOL
K+	3.4	3.3-4.7	MMOL
CL-	94*	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: 4 Aug 03

LAB ID NO.:

(b)(6)-2

Ward/Section: 11CW+1	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 8/22	TIME: 0433	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	2.9	3.5-4.9 mmol/L
Cl	103	98-109 mmol/L
pH	7.522 ~~7.515~~	7.31-7.45
PCO2	29.1	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	122	80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	24	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99%	95-98%
BEecf	3	(-2) – (+3) mmol/L
AnGap	13	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	90	8-26 mg/dl
GLU	156	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	35	38-51% PCV
Hgb	12	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.9	3.5-5.5 g/dl
ALP	76	26-84 u/l
ALT	676	10-47 u/l
AMY	28	14-97 u/l
AST	1297	11-38 u/l
TBIL	1.2	0.2-1.6 mg/dl
BUN	78	7-22 mg/dl
CA^{++}	7.9	8.0-10.3mg/dl
CHOL	112	100-200 mg/dl
CRE	1.7	0.6-1.2 mg/dl
GLU	164	73-118 mg/dl
TP	6.6	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

(5)(6)-2

(b)(6)-2

Ward/Section: ICU # 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-7 [redacted]	DATE 4/12	TIME 0450	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	13.2	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.90	4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb	12.3	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	37.7	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	96.9	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	107	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	14.1	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 [redacted] **DATE:** **LAB ID NO.:**

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 16 Aug	TIME: 2315

(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	Hazy	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	1.025	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	trace	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	5.0	N/A	Micro Parasites		
Segs		Mono	Prot	Trace	Negative	Malaria		
Bands		Eos	Urob	norm	0.2-1.0	O & P		
Lymph		Baso	Nit	neg	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	WBC - 5-8 RBC - 1-3 HYALINE CAST - 8-10 LPF		
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	14.9	9.8-13.6 secs			
APTT	22.3	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted]	DATE: 16 Aug 13	LAB ID NO.:

(b)(6)-7

(5)(6)-4

(5)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 05Sept	TIME 1105
		SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		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	Yel	N/A
App	Hzy	N/A
Glu	N	Negative
Bili	N	Negative
Ket	N	Negative
SG	1025	N/A
Bld	Large	Negative
pH	6.0	N/A
Prot	30+	Negative
Urob	N	0.2-1.0
Nit	N	Negative
Leuk	Large	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

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

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

SSA: 3+
WBC: <50
RBC: <50
Bact: Many

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:	DATE:	LAB ID NO.:

(b)(6)-4

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

LAST, FIRST, MI: [redacted] (b)(6)-2 | DATE: 05Sep | TIME: 1103 | 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

======= PICCOLO =======
06/09/03 (b)(6) 11:47
REFERENCE RANGE MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-2.....

ALB	3.4	3.3-5.5	G/DL
ALP	78	26-84	U/L
ALT	22	10-47	U/L
AMY	48	14-97	U/L
AST	21	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	11	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CHOL	211*	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	95	73-118	MG/DL
TP	7.1	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
		3.3-4.7 mmol/l
L-		98-108 mmol/l
O2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O2		18-33 mmol/l

REMARKS:

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

3x4 Simultaneous Report

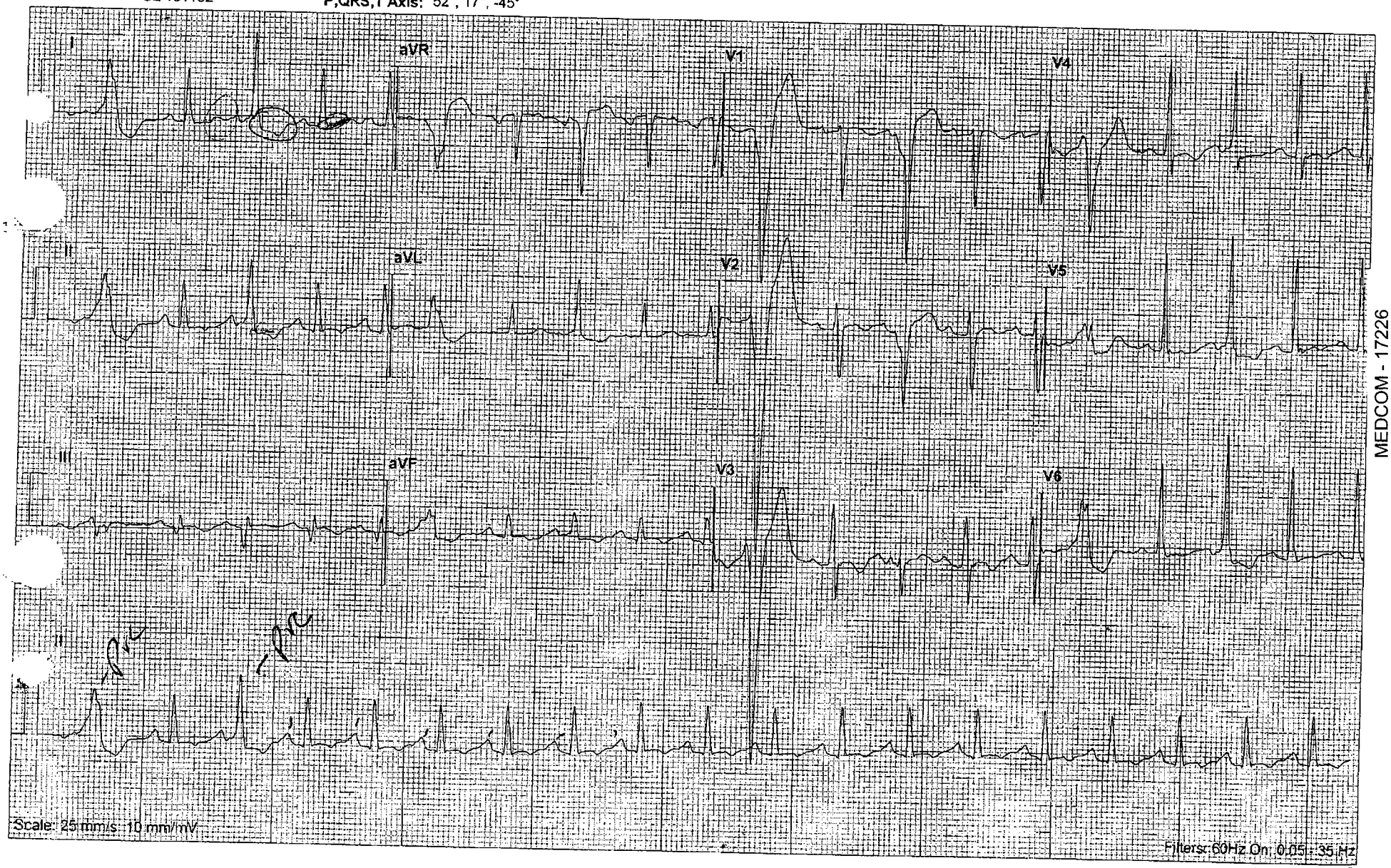
Name: [redacted] (b)(6)-7
Number:
Sex: Male
Date of Birth: 8/18/1948 (55 years)
Height/Weight: 67in / 223lb

Recorded: 8/18/2003 10:23:21 PM
Device: CL 131132

Measurements

Heart Rate:	116 bpm
P Duration:	122 ms
PR Interval:	184 ms
QRS Duration:	78 ms
QT Interval:	314 ms
QTc Interval:	437 ms
P,QRS,T Axis:	52°, 17°, -45°

Interpretation (Unconfirmed)
Sinus tachycardia
Atrial flutter with a variable block cannot be ruled out
Abnormal repolarisation, possible coronary ischemia



MEDCOM - 17226

Page 1 of 1 File: viewECG.scp Printed: 8/18/2003

(Data must be reviewed by a qualified physician)

Confirmed by:

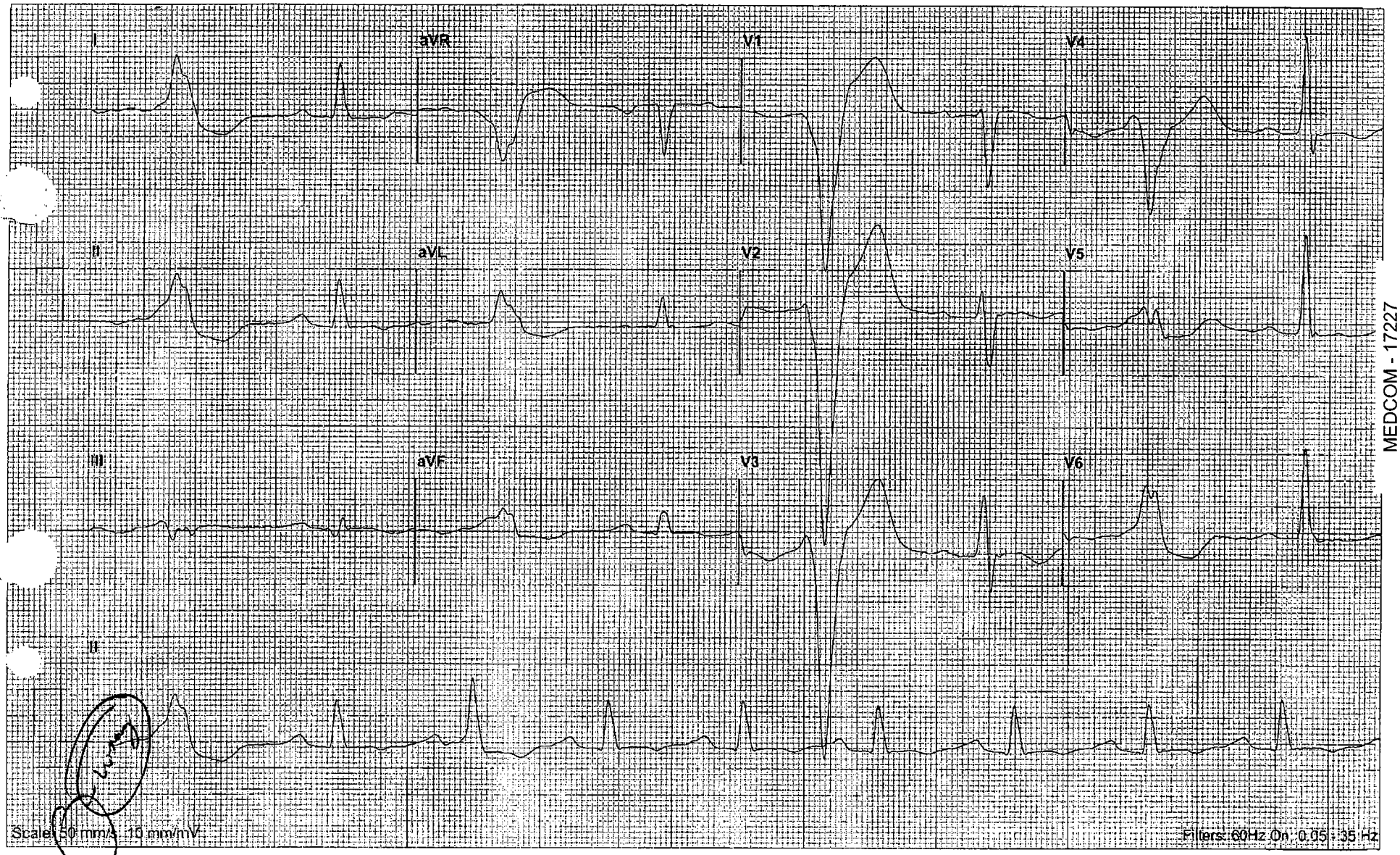
ACLU-RDI 1640 p.186

DOD-030815

3x4 Simultaneous Report

Name:	[redacted] (b)(6)-4	**Measurements**	
Number:		**Heart Rate:**	116 bpm
Sex:	Male	**P Duration:**	122 ms
Date of Birth:	8/18/1948 (55 years)	**PR Interval:**	184 ms
Height/Weight:	67in / 223lb	**QRS Duration:**	78 ms
		QT Interval:	314 ms
Recorded:	8/18/2003 10:23:21 PM	**QTc Interval:**	437 ms
Device:	CL 131132	**P,QRS,T Axis:**	52°, 17°, -45°

Interpretation (Unconfirmed)
Sinus tachycardia
Atrial flutter with a variable block cannot be ruled out
Abnormal repolarisation, possible coronary ischemia



MEDCOM - 17227

(Data must be reviewed by a qualified physician)

Confirmed by:

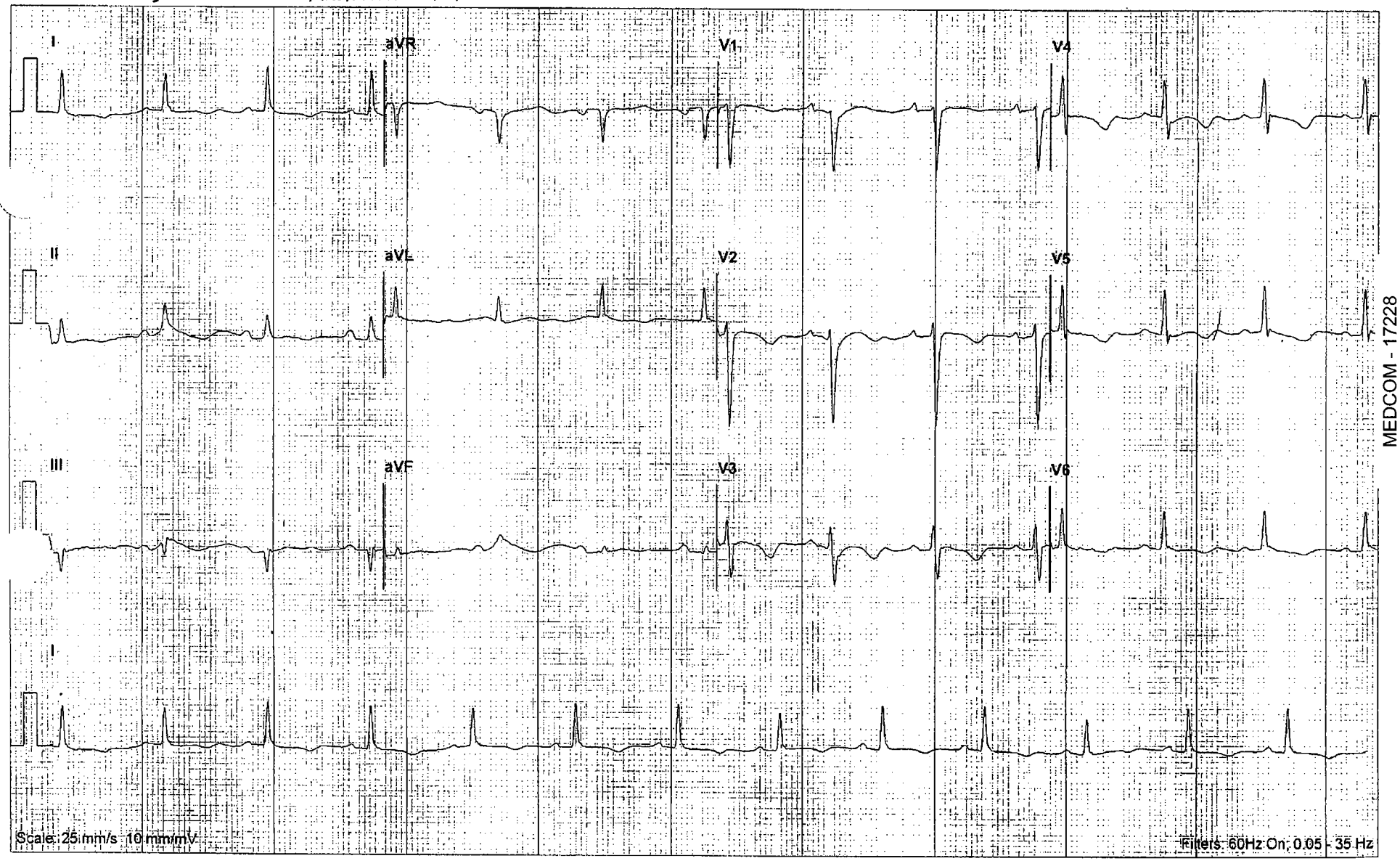
3x4 Simultaneous Report

(5)(61-4

Name:	[redacted]
Number:	
Sex:	Male
Date of Birth:	2/27/2000 (3 years)
Height/Weight:	71in / 229lb
Recorded:	8/27/2003 3:17:54 PM
Device:	CL 131132

Measurements	
Heart Rate:	78 bpm
P Duration:	92 ms
PR Interval:	160 ms
QRS Duration:	80 ms
QT Interval:	450 ms
QTc Interval:	511 ms
P,QRS,T Axis:	57°, 8°, 143°

Interpretation (Unconfirmed)
Normal sinus rhythm
Abnormal repolarisation, possibly non-specific
QRS within the normal limits



MEDCOM - 17228

(Data must be reviewed by a qualified physician)

Confirmed by:

ICU 2

MEDICAL RECORD - ANESTHESI

For [illegible] his form, see AR 40-66; the proponent ager[illegible], OTSG

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

DRUG (Units)					TOTALS
Versed (mg)	2				20
Fentanyl (mg)	50 50/100	50			250
Propofol (mg)	100				100
SCH (mg)	120				120
Vecuronium (mg)		10			10
Esmolol (mg)			40		
VOLAT AGENT Iso % del		1.2-1.8	-0.8X		
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	10 - 2 - 2 - 2 - 10				

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

TOTAL EBL: 100

TOTAL URINE: 450

FLUIDS - SUMMARY
CRYSTALLOID- 1600
COLLOID- 300
BLOOD- Ø

FLUIDS

LINE site		
18g (L)	Warmed	LR ——— X Hespan ———
	Warmed	
	Warmed	——— 1600
18g (R)	Warmed	LR ———

LOSSES: EST BLOOD LOSS
URINE - Foley 450

PHYS STATUS: 1 2 3 4 5 (E)

TIME: 0300 15 30 45 0400 15 30

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 112/57; HR- 57

EQUIP CHECK: OK?- ✓ N

PATIENT RECHECK: OK for PROCEDURE? Okay; TIME- 0245

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

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

VENTIL

	0300	15	30	45	0400
VT - ml	—	740	750	750	1.1
f - breaths/min	20	8	8	8	16
Peak inf pres / PEEP	—	18	20	20	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	(+)	33	31	31	38
BP/oth	X FIO2 (Frac or %)	.70	.70	.70	.70	.70
ART line	X SpO2 (%)	100	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	X TEMP-site	36.5	36.4	36.4	36.4 X	
	X N-M Block (T/4)		0/4	0/4		1/4 4/4 5T@50
Warming blkt						
Conv warmer						

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

REMARKS
Code drugs with numbers, events with letters
0250 Pt to ICU 2 chart reviewed, 0300 Induction, [illegible] O2. IV induction. Eyes taped. OG placed, stomach sxn. 0324 Procedure started. 0350 Procedure complete. 0355 Pt reversed c̄ [illegible] Neostigmine & 0.9 mg Robinul. 0405 Pt PO sxn x 2. Extubated c̄ difficulty. To ICU 2 in stable condition. Report to [redacted]

RECOVERY AT: 0410
PACU ICU 2 (Specify)
OTHER
CONDITION: Stable
RESP- 20 SpO2- 95% A
BP- 136/84 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0250	0300	0415
	Ready	Begin	End
PROC	0312	0324	0350

PROCEDURES and CPT Codes: Ex lap; I&D (L) Hip

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
RSI (+) Cricoid pressure, DL x 2 attempts, Grade I view c̄ MIL 3, #8 ETT placed @ 22cm teeth, (+) BBS, (+) ETCO2 [illegible]

SURGEONS: [redacted] / [redacted]

ANESTHETISTS: (b)(6)-2

PROCEDURE LOCATION: OR 1

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 17229 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

PRE-ANESTHETIC ASSESSMENT AND PLAN OF CARE

AGE: 55 Days Mos Yrs | GENDER: (X) Male ( ) Female | ALLERGIES: | PS: 1 2 3 4 5 E | WT: 85 Kg/Lb HT: In.

PROPOSED PROCEDURE: Ex Lap
SURGICAL SERVICE: Gen
NPO SINCE:

PREOP DX / MECHANISM OF INJURY: S/P Blast Injury - Shrapnel wounds (L) Hip Flank

HABITS:
Tobacco: Ø
EtOH:
Drugs:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef > EMT
( ) Fentnyl
( )
( )
( )
( )

PREMEDICATIONS:
None / Yes @ Hrs

LABORATORY STUDIES:
14.3 / 44.4 / 178
10.1
Other: PT 14.9 PTT 22.3

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	?
MI	N	Y	
CVA	N	Y	
Other	N	Y	1
Pulmonary:			
Asthma	N	Y	?
URI	N	Y	
COPD	N	Y	
Other	N	Y	1
Renal System:			
ARF/CRF	N	Y	Foley
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	?
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	?
Steroids	N	Y	
Thyroid	N	Y	1
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	N/A
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

SURGICAL HISTORY
7
1

PHYSICAL EXAMINATION
BP: 112/57 HR: 57 RR: T: 99
Pain (0/10 Scale):
Airway Exam:
Dentition
Trachea
TMJ/C-spine
Oropharynx
Chest: CTA
Lungs
Heart
IV Access: 18g x 2
Ulnar Filling:
Back:
Other:

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: (X) General Intubation / Mask-LMA Notes:

INFORMED CONSENT / COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient/legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] (b)(6)-2 CRNA CRT Date: 17 Aug 03 Time: 0235

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

POST-ANESTHESIA EVALUATION AND NOTE:
( ) No apparent anesthetic complications.
( ) Other (see progress notes)
Signed: Date: Time:

Nursing Unit: MEDCOM - 17230 RT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*: _____ ML

REMARKS: 1 UNIT

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 28 AUG 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P EX LAP, @ Iliac Fx

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct. (b)(6)-2

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 28 Aug 03

TIME VERIFIED: 0850

SECTION II – PRE-TRANSFUSION TESTING

UI: [redacted]

PATIENT NO.: [redacted]

TRANSFUSION NO.:

DONOR: ABO O Rh positive

RECIPIENT: ABO O Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMPATABLE

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 3, Sept 03

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

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

DATE: 28 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)*: [redacted] ON *(Date)*: 28 Aug 03

IDENTIFICATION

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

1st VERIFIER *(Sig.)*: [redacted] LTJG

2nd VERIFIER *(Sig.)*: [redacted] SGT

PRE-TRANSFUSION

TEMP.	PULSE	BP
97.8	75	136/68

DATE OF TRANSFUSION	TIME STARTED
28 Aug 03	0958

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

[redacted] (b)(6)-2

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME/DATE COMPLETED/INTERRUPTED
350 ML	1115 28 AUG 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	97.9	75	109/64

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

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

[redacted] LT/SN

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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

MEDCOM - 17231

Medical Record Copy

[redacted]

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*: _____ ML

REMARKS: 1 unit

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 26 AUG 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: SIP EX LAP

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

[redacted] CT/AW

DATE VERIFIED: 26 Aug 03

TIME VERIFIED: 1713

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O Rh POS

RECIPIENT: ABO O Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compatible

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: CS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: T&S 02 Sep 03 T&S ~~27 Aug 03~~ [redacted] @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] AUG 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted]

TEMP. 97.7 | PULSE 108 | BP 112/56

DATE OF TRANSFUSION: 27 Aug 03

TIME STARTED: 26 Aug 03 @ 2114

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 2200 @ 26 Aug 03

REACTION
- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.6	107	BP 117/56

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

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

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

[redacted] 91WM6

SEX: M

WARD: ICU

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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

MEDCOM - 17232

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:
1 unit

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED
26 Aug 03

DATE AND HOUR REQUIRED
ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*
[redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE
S/P EX LAP

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

*SIGNATURE OF VERIFIER
[redacted] CT/AN

DATE VERIFIED
26 Aug 03

TIME VERIFIED
1713

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
[redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compatible

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

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

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS:
EXP: 27 AUG 03 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSP[redacted]re)

AT (I[redacted]) ON (Date) 26 Aug 03

IDENTIFICATION

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

1st V[redacted]

2nd V[redacted] 1st/AN

PRE-TR[redacted]

TEMP.	PULSE	BP
97	83	100/64

DATE OF TRANSFUSION
26 Aug 03

TIME STARTED
2018

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

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN
450 ML

TIME/DATE COMPLETED/INTERRUPTED
26 Aug 03 @ 2114

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
97	108	112/56

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

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

[redacted] 9 WUMG

(b)(6)-2

SEX
M

WARD
ICU

(b)(6)-2

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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

MEDCOM - 17233

Medical Record Copy

NSN 7540-01-165-7294 591-301

RADIC IC CONSULTATION REQUEST/F RT
(Radiology/Nucl. .edicine/Ultrasound/Computed Tomography . .nations)

EXAMINATIONS (S) REQUESTED	AGE / SEX	SSN *(Sponsor)*	WARD/CLINC	REGISTER NO.
CXR	M		ICW#4	
	FILM NO.			PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* DV [redacted]			TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2			DATE REQUESTED 10SEP03

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

↓ O2 sat
fever

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE 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
# [redacted] (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1—MEDICAL RECORD

STANDARD FORM 519-B (6-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 17234

NSN 7540-01-165-7294 591-301

RADI[illegible]GIC CONSULTATION REQUEST[illegible]ORT
(Radiology/N[illegible] [illegible]edicine/Ultrasound/Computed Tomograph[illegible] [illegible]inations)

EXAMINATIONS (S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINC	REGISTER NO.
p CXR		ICU	
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR Dr [redacted] (b)(6)-7		DATE REQUESTED 26 Aug 200

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

swan ganz line placement

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE 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
EPW [redacted] (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT 1—MEDICAL RECORD

STANDARD FORM 519-B (6-83) **Prescribed by GSA/ICMR** FPMR (41 CFR) 101-11.806-8

MEDCOM - 17235

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	Noted 19Aug03 1450 [redacted] (b)(6)-2	19 Aug 03 ______ HOURS 1- [illegible] 2- [illegible] 3- [illegible] [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		[redacted]	(b)(6)-2
PATIENT IDENTIFICATION	8/20 0010	DATE OF ORDER ______ HOURS V.O. Dr. [redacted] Lt [redacted] ① 30cc Mylanta [illegible] [redacted]	
NURSING UNIT / ROOM NO. / BED NO.	2220	8/23/03 ① CBC [illegible] Q Day	Noted [redacted] 08/23/03 2310
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF [redacted]	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

U.S. GOVERNMENT PRINTING OFFICE: 1986—405-824

"USE BALL POINT PEN. PRESS FIRMLY. NO CARBON PAPER REQUIRED"

MEDCOM - 17236

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER 8/18/03 TIME OF ORDER 2145 HOURS — LIST TIME ORDER NOTED AND SIGN

- Albuterol ~~treatment~~ q4° ✓
  overnight then prn
- CXR, PA/LAT tonight after ✓
  treatment
- wean O_2 ~~[illegible]~~ to keep Sat ✓
  >92%
- Incentive Sp[redacted]q hr while ✓
  awake
- Please get ✓
  phys[redacted]valuation
- Send CBC, chem ✓

(b)(6)-2

NURSING UNIT — ROOM NO. [redacted] — BED NO.

PATIENT IDENTIFICATION

Noted 18/03 2216 [redacted]

NURSING UNIT — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 8/18/03 TIME OF ORDER 2240 HOURS

1. Lopressor 5mg IVP now ✓
2. Lopressor 25mg po BID ✓ unavailable
3. Lasix 20mg IVP now ✓
4. Lovenox 40mg SQ QD → 1st dose tonite ✓
5. ABG tonite ✓ [redacted]

NURSING UNIT — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 19 Aug 03 TIME OF ORDER [illegible] HOURS

1. Atenolol 50mg po QD

(b)(6)-2 [redacted]

Noted 19 Aug 03 1445 [redacted]

NURSING UNIT — ROOM NO. — BED NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8/19	CSP Note
	Possible [illegible] Lac
	(L) [illegible] iliac crest (L) Rx
	Suture · mattress / [illegible]
	Anes GETA
	[illegible] · 800 [illegible]
	Findings (L) Lac (?)
	(L) iliac crest Rx. [illegible] clean
	[illegible] placed
	[illegible] [redacted]
	(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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 18 AUG 03

TIME OF ORDER ___ HOURS

LIST TIME ORDER NOTED AND SIGN

1) Admit [illegible]
2) Dx [illegible] Ofe[illegible]
3) [illegible]
4) Vitals Q10
5) [illegible]
6) NPO
7) [illegible] [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] OF ORDER ___ HOURS

8) [illegible] to [illegible]
[illegible]

9) MEDS
MSO4 [illegible]
[illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER Ancef 1g [illegible] TIME OF ORDER [illegible] HOURS

6) [illegible] T > [illegible] SBP > 180 [illegible]
[illegible]

✓chart 0147 CPT [redacted] noted/done

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER ___ (b)(6)-2 HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1990—403-924

"USE BALL POIN[T] ... CARBON PAPER REQUIRED"

MEDCOM - 17239

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)-7

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8/18 TIME OF ORDER 0360 HOURS

LIST TIME ORDERS NOTED AND SIGN

1. Admit ICU postop
2. Sup exp Lap, Ileac wing Rsn
3. Stable
4. VS routine
5. Foley
6. Morphine 2-6mg IV q 1°
7. Ancef 1g IVP q 8°
8. CR @ 150 c/h
9. Clears
10. Zofran 4mg inj q 6° prn nausea
11. Incentive Spirometer

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

8/18/07 DATE OF ORDER 1613 TIME OF ORDER HOURS

NPO

500

(b)(6)-7

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 Aug 07 TIME OF ORDER 1719 HOURS

Transfer to ICU IVF SLP Ex Lap

VS q 4° x 48° then q 8°

WF UOP 125 cc/h

NPO, clears in am

Foley to gravity drainage

NSO q 2-0 q 20 PRN pharyn 12 5 IVP q 6° PRN

Ancef 1gm q 8°

Incentive Spirometer

OOB TID

[redacted]

(b)(6)-7

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