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

NOTED AND TRANSCRIBED b(6)-2 2 [redacted]

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER 29 Oct 03 TIME OF ORDER _____ HOURS

1) Neuro Flow Ord
2) SIP End Sigmoid Colostomy
3) MEDS
MSO4 2-8mg IV q 2-4° prn
OR
Percocet 1-2 po q 4° prn
Flagyl 500mg IVPB TID #10 (0142)

PATIENT IDENTIFICATION

4) Notify Colorectal Surg HOURS

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

If fever chest ✓ 0500 30 Oct 03 [redacted] ICTAN

PATIENT IDENTIFICATION b(6)-4 [redacted]

DATE OF ORDER 31 Oct 03 TIME OF ORDER _____ HOURS

1) Transfer ICW with Bed
2) SIP Debrided Grade IV Decub/Anal Colostomy
3) Activity - roll prone q 2°
4) Vitals q Shift
5) Diet Regular
6) IV Heplock
7) TID Wet Soak with 1/4 Normal Saline

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

PATIENT IDENTIFICATION

DATE OF ORDER Sch to Debride TIME OF ORDER _____ HOURS

8) MEDS
Percocet 1-2 po q 4-6° prn
Flagyl 500mg IV q 8° X 8 Days
Keflex 1gm IV q 8° X 8 Days
Ultram 50mg PO BID

NURSING UNIT | ROOM NO. | BED NO.

9) Roll to groin
10) Notify Ortho Consult [redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE, SYSTEM IS USED, WRITE PROBLEM NU ND SIGN EACH SET OF ORDERS. IF PROF ORIENTED MEDICAL RECORD IN COLUMN INDICATED BY ARROW BELC

PATIENT IDENTIFICATION

b(6)-4

[redacted]

Noted b(6)-2 0930 03

NURSING UNIT | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

1 Nov 03

1) Transfer to 2 CSH when arrangement made.

[redacted] b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER | TIME OF ORDER | HOURS

2 Nov 03

Transfer to 2 CSH when arrangement made

noted 2 Nov 0930

NURSING UNIT | ROOM NO. | BED NO.

1 CSH | 03 Nov 03 0800

[redacted] b(6)-2 24° Chart V

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

b(6)-2

CLINICAL RECORD

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

Mo. X Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29 30 31 1 2 3 4 5 6 7 8 9 10 11
8.29	[redacted]	NPO	06	[redacted]
			18	
8.29	[redacted]	VS Q1°	06	
			18	
8.29	[redacted]	I/O Q1°	06	
			18	
8.29	[redacted]	Bedrest - Log roll -	06	
		maintain spine prec.	18	
8.29	[redacted]	Foley to gravity.	06	
			18	
8.29	[redacted]	NG to LIS	06	
			18	9.2.03
8.29	[redacted]	CT to 20cm H_2O SKN	06	
			18	
8.29	[redacted]	CBC, Chem 7, PT/PTT,	18	
		ABG Q4°,	22	
			02	
			06	
			10	
			14	
8.29	[redacted]	Call MO for HR > 105	18	[redacted]
		SBP < 90 > 140 RR > 30		
		temp > 38.5		
8/30	[redacted]	ABG Vent: 45	02	[redacted]
		16, 650/5	18	
8/30	[redacted]	CXR q AM	04	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18243

b(6)-2 AR

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8.29	[redacted]	Admit to ICU	8.29	ASAP	1720	[redacted]
8.29	[redacted]	T spine PA	8.29	ASAP	1800	[redacted]
8/29/03	[redacted]	Give 4 U FFP	8/29/03	ASAP	Done 30 Aug 03 0000 MS	[redacted]
29 Aug 03	[redacted]	✓ CBC + PT p transfusion	29 Aug 03	ASAP	0200 30 Aug 03	[redacted]
30 Aug	[redacted]	✓ CBC / Pt + PTT p transfusion	30 Aug 03	0730	done	[redacted]
30 Aug	[redacted]	Give 4 units FFP / 2 units PRBCs	30 Aug	ASAP	done	[redacted]
30 Aug	[redacted]	ABG 30 mins	30 Aug	0745	done	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
9.2	[redacted]	Neop to 7 if PR <65 and/or	D/C 9/3/03 2000 [redacted]
		Spo2 <91%	
9/3/03	[redacted]	↑ Peep - 10 when FIO2	D/C if
		for sats >92%	USAP 03 0300 [redacted]

USAPA V1.00

b(6)-2 Ant

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. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30 31 / 2 3 4 5 6 7 8 9 10 11 12
30 Aug 03	[redacted]	Chart JP drainage	06	[redacted]
		8 Shift	18	
30 Aug 03	[redacted]	Vent: FIO2 50% RR 22	06	
		TV 500 Peep 7 SIMV	18	
30 Aug 03	[redacted]	ABG, CBC, Chem 12 &	04	
		PT/PTT & Am & MET 8		
15 Sept	[redacted]	CT Y/ Hgb Stat	06	
		5X	16	
9.2.03	[redacted]	Check residuals q	08	
		6° hours	14	
			20	9.3.03/0730
			02	
9/s/n		VENTILATOR A'O TO	06	X X X X
9/s/n		ICP & PEEP @ 8 mm then	18	X X X X
		A/O to keep SATS > 90%		
9/s/n		DNR - Ø chest compressions,	06	X X X X
		Ø vasoactive drugs	18	X X X X
9.4.03	[redacted]	V/O Heparin	06	
			18	
9 Aug 03	[redacted]	NG CTS	06	
			18	
q-5-n	[redacted]	Jevity 5000 mL @ d 4.9 cc q4"	04	X X
q-703		as tolerated hold. 5	08	X X
		residual 7150 cc	12	X X
			16	X X
			20	X X
			24	X X

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: EPW [redacted]

b(6)-4

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

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

b(ce)-2 AM

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 8 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30 Aug 03	[redacted]	VABG, CBC, Chem 7 + PT/PTT NOW	30 Aug	30 Aug	1930	[redacted]
30 Aug 03	[redacted]	CVR NOW	30 Aug	30 Aug	1930	
9/3/03		UA	3 SEP 03	0800	0800	
9/3/03		Urine culture	3 SEP 03	0800	0900	
9/3/03		Blood culture	3 SEP 03	0800	0900	
9/3/03		Sputum culture	3 SEP 03	0800		
9.4.03	[redacted]	VABG, CBC, Chem 7 P XFSN	9.4.03	P XFSN 1600	1600	

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

USAPA V1.00

b7(c)-2 A11

CLINICAL RECORD

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

Mo. 9 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED (12 13 14 15 16 17 18 19 20 21 22 23)
10 Sep 03	[redacted]	Code status: full code	06	[redacted]
8.29.03	[redacted]	npo	18	
			06	
8.29.03	[redacted]	VS q1°	18	
			06	
8.29.03	[redacted]	I/O q1°	18	
			06	
8.29.03	[redacted]	Bedrest + log roll.	18	
		Maintain spinal precautions	06	
8.29.03	[redacted]	foley to gravity	18	
			K	
8.29.03	[redacted]	CXR qam	04	
30 Aug 03	[redacted]	Labs: ABG, CBC, chem 7, [redacted]	04	
		mets, [redacted] qam	18	
1 Sep 03	[redacted]	CT to suction	06	
			18	
9.1.03	[redacted]	hold heparin	06	
			K	
9.1.03	[redacted]	Jevity 400cc q4h°	06	
		as tolerated. Hold if	18	
		residual >150cc	1	
9/5/03	[redacted]	Vent settings changed to	06	
		Keep peep 8. Wean	K	
		FIO2 to keep sats >90%		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18247

b(a)-2 ALL

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 Sep 03	[redacted]	CBC, Chem 12, Chem 7, ABG in am	11 Sep 03	0400		

9/8/03	[redacted]	Sputum Cx	3 Sep 03	ASAP		
9-13	[redacted]	T&C 2 units PRBC	9-13	ASAP		
9-14	[redacted]	Chem 7	9-14	NOW	DONE	[redacted]
9-14	[redacted]	ABG & Fingerstick Sonia	9-14	1340	DONE	[redacted]
9-23	[redacted]	Sputum Cx	9-23	NOW	DONE	
9-23	[redacted]	Blood Cx x2	9-23	NOW	DONE	
9-23	[redacted]	Urine Cx	9-23	NOW	DONE	

Mo 9 Yr 2003

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
8-29-03	[redacted]	call MO for HR	
-----	-----	> 105 SBP < 90 > 170	
-----	-----	RR ≥ 30 temp ≥ 38.5	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD | THI **EUTIC DOCUMENTATION CARE PLA** **N-MEDICATION)**

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

Mo. 09 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 24 25 26 27 28 29 30
10Sep03	[redacted]	Code Status: Full Code	06	[redacted]
			18	
29Aug03	[redacted]	VS Q1°	06	
			18	
29Aug03	[redacted]	I/O Q1°	06	
			18	
29Aug03	[redacted]	Bedrest - Log roll, maintain	06	
		spinal precautions	18	
29Aug03	[redacted]	Foley to gravity	06	
			18	
29Aug03	[redacted]	~~Tube feed 500cc Q4°~~	00	
		SEE NEW ORDER	04	
			08	
			12	
			16	
			20	↓ ↓
15Sep03	[redacted]	Turn pt TID or More	06	[redacted]
			18	
15Sep03	[redacted]	Regular diet - cont TF	07	
			11	
			17	
11Sep03	[redacted]	For dressing Δ's use	09	
		Dakin's Solution instead	21	
		of NS		
21Sep03	[redacted]	DRSG Δ to ⓒ lower leg BID	09	[redacted]
		wet to Dr	21	
	[redacted]	TF TID 500cc Sol	08	
		Each Feeding	14	
			21	

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				
				Mo Sep Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23Sep	[redacted]	CXR this AM	24Sep	0400	0410	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
29Sep03	[redacted]	Call H.O. for HR >105	
		SBP <90 >140 RR >30	
		Temp >38.5	

MEDCOM - 18250 USAPA V1.00

b(6)-2 A1

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 11	12	13	14	15	16	17	18	19	20	21	22	23	24
9-11-03	[redacted]	G-tube site q shift & prn	06	✓	m												
			12	[redacted]													
9-12-03		TF 500 cc Q4°	04	x													
		(00,04,08,12,16,20)	12	x													
9/15/03	[redacted]	Wash pt TID	08	/													
		OR more	16	/													
			24	/													
9/17/03		Restart - cont TF	04	x				x									
			08	x				x									
9/20/03	[redacted]	Sob dose AES	16	/													
		use Oak'n solution	20	/													
		instead of NS															
9/21/03	[redacted]	Dose AES to 60 cc/hr	00	/													
		Reg BID	04	/													
		Start 22 Sept 03	08	/													
		Wet to dry															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION: EPW [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18251

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9-11	[redacted]	Send sputum culture	9-11-03	ASAP	1330	[redacted]
9-11	[redacted]	CXR AP per Ivy ward	9-11	ASAP	———	
9-12	[redacted]	Blood CX x2	9-12	ASAP	0940	[redacted]
9-12	[redacted]	Urine CX / UA	9-12	ASAP	0955	[redacted]
9/14/03	[redacted]	PCXR	9/14/03	ASAP	2130	[redacted]
9/14/03	[redacted]	ABG now	9/14/03	ASAP	2120	[redacted]
9/14/03	[redacted]	VT 700, RR 12, Peeps 5, FiO2 40%	9/14/03	NOW	2120	[redacted]
9/15	[redacted]	T&C for 4 units PRBCs				
		Give 2U PRBCs	9/15/03	1045	#1 1045	[redacted]
			9/15/03	1230	#2 1230	
9/15	[redacted]	CBC & Lytes	9/15/03	1400	1400	
		NPO for MR	9/21/03	2400	2400	
9/22	[redacted]	DC central line	9/22/03	Now	1200	
9/22	[redacted]	DC Arterial line	9/22/03	Now	1200	
9/22	[redacted]	DC TRACH SUTURE	9/22/03	Now	1600	
9/23	[redacted]	Sputum Culture, Blood Culture, Urine	9/23	NOW	1555	[redacted]
		Culture Now				

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

USAPA V1.00

-b1d-2 A11

CLINICAL RECORD — **THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)**

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

Mo. 9 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 29 30 1 2 3 4 5 6 7 8 9 10 11
29Sept	[redacted]	Regular diet	06 18	[redacted]
29Sept	[redacted]	Clamp NG tube	18 06	
29Sept	[redacted]	paraplegia precaution	06 18	
29Sept	[redacted]	VS Q4°	06 18	
29Sept	[redacted]	I&O q shift	06 18	
		Foley to gravity		
9/29	[redacted]	Blood cx, urine cx, + sputum cx for temp >38 >38.5°	06 18	
9/29	[redacted]	BID Dakins drsg Rs for abd & LLE	06 18	[redacted] >D/C
9/29	[redacted]	NIO: Turn q2°	6	[redacted]
		white in bed	18	
2Oct	[redacted]	NIO: (L) Femoral CL drsg Δ q 3 days.	22	[redacted]
2Oct02	[redacted]	Foley to gravity	06 18	[redacted]
3Oct03	[redacted]	VS q day	10	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW c paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b1d-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

10/6 - 2 AM

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/29	[redacted]	Admit to IMW	9/29			
10/2	[redacted]	NPO p MN	10/3	2400		
10/03	[redacted]	To OR in Am	10/4			[redacted]

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

b(6)-2A11

CLINICAL RECORD — TH — EUTIC DOCUMENTATION CARE PLA ...N-MEDICATION)

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

Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21
29 Sep 03	[redacted]	Regular diet	06	[redacted]									
			18										
29	[redacted]	Paraplegia precautions	06										
			18										
11 Oct 03	[redacted]	VS q day	10										
29 Sep 03	[redacted]	NIO: Turn q2° while	06										
		in bed	18										
04 Oct 03	[redacted]	Foley to gravity	06										
			18										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW c paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b (6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
11 OCT 03	[redacted]	No need for dressing to left leg	11 OCT 03			[redacted]	
19 OCT 03	[redacted]	NPO p MN - Surgery 10/20	20 OCT 03	0001			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
11 OCT 03	[redacted]	Blood cx, urine cx & sputum cx for temp >38.5	D/T/I

b(6)-2A1

CLINICAL RECORD | THE ...EUTIC DOCUMENTATION CARE PLA...N-MEDICATION) | Mo. Oct Yr. 2003

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

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20 21 22 23 24 25 26 27 28 29 30 31
20 Oct	[redacted]	U/S Routine Q4hr	06	[redacted]
			18	
20 Oct	[redacted]	Foley to gravity	06	
			18	
20 Oct	[redacted]	Paraplegic precautions	06	
			18	
20 Oct	[redacted]	Roll pt 180°, keep off	06	
		sacrum	18	
20 Oct	[redacted]	Reg diet +	07	
		Ensure	12	
			17	
20 Oct	[redacted]	Wet to dry dsg to	10	
		sacrum BID	22	[redacted] 3 A 10
20 Oct [redacted] 00		Stage IV pressure	06	[redacted]
		ulcer to coccix	18	
		Keep pressure off		
		to buttocks.		
		Turn Q 1-2°		
		from side to side.		
2000 [redacted] 12		Wet to dry dressing	10	[redacted]
		to coccyx. Be sure	20	
		to pack wound		
		loosely and pack		
		all tunneling &		
		undermining.		
		Dressing Δ BID		3 A 10

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: paraplegic c deep sacral decubitus; infected

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

2 CW-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20 Oct	[redacted]	Admit to ICU, condition Stable	20 Oct	—	1630	[redacted]
2500	[redacted]	CBC, chem 8 in AM	2500	Now	—	[redacted]
25 Oct	[redacted]	NPO p MN for surg on 26 Oct 03	26 Oct	MN	0000	[redacted]
2600	[redacted]	Regular Diet.	2600	Now	1335	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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b(6)-2 A11

CLINICAL RECORD — THE .UTIC DOCUMENTATION CARE PLA[...N-MEDICATION)

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

Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	31
21/10	[redacted]	VS Q1 hr (temp,	06	[redacted]										
		HR, BP) Record on chart	18											
			/											
21/10	[redacted]	Keep Pt on stomach	06	[redacted]										
		(PRONE Position) At Nighttime	18											
		during sleeping	/											
			/											
21/10	[redacted]	If PT Rolls from side ~~to~~	06	[redacted]										
		~~side~~ Position Place Pt back on	18											
		side position. check Q15 min	/											
21/10	[redacted]	KEEP PT on SIDE	06	[redacted]										
		ROLL Q1°	18											
			/											
21/10	[redacted]	Keep LLE site open	06	[redacted]										
		to air	18											
			/											
21/10	[redacted]	PT consult: ROM to	06	[redacted]										
		to LE ; obtain APO AW	18											
		feet.	/											
			/											
21/10	[redacted]	NID: Strength training	06	[redacted]										
		for UE & PT BANDS	18											
		AND weights	/											
			/											
21/10	[redacted]	DON'T D MO'S ORDERS	06	[redacted]										
		W/O Vung & MD	18											

ALLERGIES: ☐ YES ☐ NO — UNKNOWN

PRIMARY DIAGNOSIS: S/P Paraplegic - deep sacral decub.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A11

CLINICAL RECORD | THE[illegible] JTIC DOCUMENTATION CARE PLAI [illegible]N-MEDICATION)

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28	29	30	31	01	02
23Oct	[redacted]	DRSG Δ TID w to D	03	/	[redacted]									
		to coccix loosely packed.	20											
		dSg T. 1/4 Baking sol.	04											
29Oct	[redacted]	Routine Colostemy	06	/										
		Care	18	/										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: paraplegia c deep sacral decub, infected

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18260

b(6)-2 A11

CLINICAL RECORD | TH... EUTIC DOCUMENTATION CARE PLA ...N-MEDICATION) | Mo. 10/31 2003

For use of this form, see AR 40-40 the proponent agency is the Office of The Surge... ...eneral.

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3
10/31	[redacted]	Activity: Roll please Q 2°	02	✓	[redacted]		
			04	✓			
			06	✓			
			08	✓			
			10	✓			
			12	✓			
			14	✓			
			16	✓			
			18	✓			
			20	✓			
			22				
			24				
10/31	[redacted]	Vitals Q Shift	D	✓			
			N				
10/31	[redacted]	Diet: Regular	D	✓			
			N				
10/31	[redacted]	TID Wet to dry T 1/4% Dakins	08	✓			
			14	✓			
		Solution to Decub	20				
10/31	[redacted]	Foley to gravity	D	✓			
			N				
10/31	[redacted]	Ostomy Care	D	✓			
			N				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Deleride Grade IV Decub Colostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(4)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Oct/Nov Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/31	[redacted]	Transfer to ICU c bed	10/31		2100	[redacted]
01 NOV 03	[redacted]	Tx to 21st CSH when arrangements made				
2 NOV	[redacted]	Transfer to ~~Iraqi Hospital~~ ICU : continue orders	2 NOV	NLT ~~ASAP~~	0930	[redacted]

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

b(4)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	M 8 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY
8·29	[redacted]	Fentanyl 50mg/hr
		titrate for adeq rate
		pain control
8·29	[redacted]	Propofol 30mcg/kg/min
		titrate to sedation
8·29	[redacted]	Zantac 50mg IVPB
		q8°
30Aug	[redacted]	Versed @ 2mg/hr
		titrate
30Aug	[redacted]	Vecuronium for
		paralysis
30Aug B	[redacted]	LR @ 100cc/hr
30Aug B	[redacted]	Fentanyl 100mcg/hr
		titrate
30Aug B	[redacted]	Vecuronium 4mg/hr
30Aug B	[redacted]	Atrovent/AIB NEBS
		q4°
9·2·03	[redacted]	Foley 100cc q6° hold
		if residuals >100cc >150

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

HR	DATE DISPENSED 29 30 31 1 2 3 4 5 6 7 8
06	[redacted] Ted 30 Aug 03
12	
18	
06	[redacted] D/C 30 Aug 03 1800 hrs ST
12	
18	
06	[redacted] D/C 9·2·03/0720
12	
18	
06	[redacted] Ted 30 Aug 03
12	
18	
06	[redacted] D/C 9·2·03 0700 TB
12	
18	
06	[redacted]
12	
18	
00	
06	[redacted]
12	
18	
00	
06	[redacted]
12	
18	
00	
06	[redacted] D/C
12	
18	
00	
02	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted]

b(4)-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 - 18263

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. ____ Yr. ____	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
30Aug	[redacted]	V.t K 10mg SQ x 1 now	30Aug	0730	0732	[redacted]
30Aug	[redacted]	LR Bolus 500cc		1045		[redacted]
30Aug	[redacted]	~~VBG, CBC, Chem 7 & PT/PTT now~~	30Aug	ENTERED		
9/3/02	[redacted]	LR x1	9/3/02	0700	0700	[redacted]
9/3/02	[redacted]	LR x1	9/3/02	1000	1000	[redacted]
9/3/02	[redacted]	LR x1	9/3/02	1500	1500	[redacted]
9-3-02	[redacted]	ALBUMIN 25% x1 qq	9/3/02	1500	1500	[redacted]
9-3-02	[redacted]	Lasix 20mg IVP x1 now	9/3/02	1700	1700	[redacted]
9.4	[redacted]	1L LR bolus	9.4.03	ASAP	0745	[redacted]
9.4	[redacted]	2u PRBC	9.4.03	ASAP	1030	[redacted]
9.4	[redacted]	1 Amp Calcium	9.4.03	ASAP	0945	[redacted]
9.4	[redacted]	1gm Magsulf 4°	9.4.03	ASAP	Started 0915	[redacted]
9/4	-----	Lasix 80mg IVP Now				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
-----	-----		
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USAPA V1.00

bLW-2 A11

CLINICAL RECORD

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

Mo. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2 3 4 5 6 7 8 9 10 11
9-2-03	[redacted]	D5 ½ NSS 20 KCl @ 125 cc/hr.	06	[redacted]
			18	[redacted] D/C
9/3/03	[redacted]	Propofol for sedation titrate for adequate sedation.	06	[redacted]
			18	[redacted]
9/3/03	2	Unasyn 3gm IVPB q6	08	X [redacted]
	2		16	X D/C'd
			24	X
9/3/03	2	Cipro 400 mg IVPB	10	X [redacted]
	2	q12	22	X [redacted] Cipro
9/3/03	2	Zosyn 3.375 mg IVPB	04	X X [redacted]
	2	q6°	10	X [redacted] D/C
			16	X [redacted] 9-7-03
			22	X [redacted]
9/3/03	2	DOPAmine @ 3 mcg/kg/min	06	X [redacted] D/C 9-4/1630 TB
	2		18	X [redacted]
9/3/03	[redacted]	D5 ½ NS ± 20 KCL	06	[redacted] > d/c 0500
9/5/03	[redacted]	@ ~~150 cc/hr~~ 50/hr	18	[redacted]
9-4-03	[redacted]	Vanc 500mg IVPB BID	10	[redacted] Cipro
		last dose now	22	[redacted]
9-5-03	2	Fentanyl 2 mcg/hr IV	06	X X X [redacted] Cipro
	2		18	X X X [redacted]
9-4-03	2	D5NS with 20 KCl	06	X X X X [redacted] D/C'd 9-4-03
	2	@ 100/hr	18	X X X X [redacted]
9-6-03	[redacted]	NP D5NS ± 20 KCl @ 125 cc°	06	[redacted]
			18	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ~~GSW~~ GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

EPW [redacted]

bLW-1

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 18265

USAPA V1.00

b(6)-2+11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. Sep Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6Sep03	[redacted]	LR 500cc bolus x1 now	6Sep03			
9.8	[redacted]	LR 500cc bolus x1 now	~~9.8~~ 9.8	ASAP	1200	[redacted]
9.8	[redacted]	LR 1000cc bolus x1 now	~~9.8~~ 9.8	ASAP	1400	[redacted]
9.8	[redacted]	1 Amp Calcium	9.8	ASAP	1700	[redacted]
9.8	[redacted]	2gm MAG over 4°	9.8	ASAP	2100	[redacted]
9.8	[redacted]	15mmol K Phos Neutral IVPB over 4°	9.8	ASAP	0000	[redacted]
9.8	[redacted]	ABG now	9.8	now	2100	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED

b(6)-2 A21

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLA... (MEDICATIONS)

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

Mo. 9 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8 9 10 11 12 13 14 15 16 17 18 19 20 21
9-8	[redacted]	Cefaz 2gm q 8° IVPB	08	[redacted]
			16	
			24	
30 Aug 03 (Recurring)	[redacted]	Atrovent/Albut nebs q6°	00	
			06	
			12	RT
			18	RT
3 Sep 03 (Recurring)	[redacted]	Cipro 400 mg IVPB q 12°	10	/
			22	/
4 Sep 03 (Recurring)	[redacted]	Vancomycin 500mg IVPB BID	10	/
			22	/
3 Sep 03	[redacted]	Propofol for Sedation	04	/
			13	/
3 Sep 03	[redacted]	Fentanyl for Sedation	04	/
			18	/
3 Sep 03	[redacted]	IVF- D5NS + 20 KCl @ 125	06	/
			18	/
10 Sep 03	[redacted]	~~Vit K 10mg qd x 3 days~~	10	/
10 Sep 03	[redacted]	Albuterol/Atrovent nebs q4h	00	/
			06	/
			12	/
			18	/
9-11-03	[redacted]	~~D5½NSS 20 KCl @ 100cc~~	06	/ /
			12	
~~11 Sep 03~~	[redacted]	~~Reglan 10mg IVP q6h~~		

Received 0500 3 [redacted]

D/C 9/11/03

D/C 9-10

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SP Esclap R/H GSW.

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.

MEDCOM - 18267

USAPA V1.00

b(6) - 2 A11

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
9.13	[redacted]	1 Amp CA	9.13	ASAP		
9.13	[redacted]	1 Sumol Kphos over 4 hours	9.13	ASAP		
9.13	[redacted]	2 gm mag over 3 hours	9.13	ASAP		
		Turn off propofol in A.M. and place				
9.15	[redacted]	Lasix 40 mg IVP q 8 x 1	9.15	[illegible]	[redacted]	[redacted]
9/15/03	[redacted]	40 mg Lasix IVP (1600)	9/15	1600		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
9/14/03	[redacted]	MSO4 1-5mg IVP q 1° prn pain	2140 5mg 9/14/03; 0200 5mg 9/14/03; 1925 5mg 9/15/03; 2230 5mg 9/15/03; 0120 6mg 1652 [redacted]; 0230 5mg; 0245 5mg; 0800 5mg; 1430 5mg; 1615 5mg; 1500 5mg
9/14/03	[redacted]	Tylenol 650mg per G-tube for temp >101.5	9/23/03 0550 101.9; 9/23 0950 101.5; 9/23 1450 101.5
9/14/03	[redacted]	MSO4 1-5mg IVP q 1° prn pain	9/17/03 2145 5mg; 9/18 0510 5mg; 9/18 0900 2mg; 9/18 1145 4mg; 9/18 1600 3mg; 9/18 2000 5mg; 9-19 0200 5mg; 9-19 0300 5mg; 9-19 0530 5mg; 9.19 0630 5mg; 9.19 1103 5mg
9.19	[redacted]	MSO4 1-5mg IVP q 1° prn pain	9.19 1300 5mg; 9/20 0130 5mg; 9/23/03 0240 5mg; 9/23/03 0430 5mg; 9/23/03 0550 5mg; 9/23/03 1050 5mg; 1355 5mg; 1520 5mg; 2245 5mg; 0615 5mg; 1500 4mg; 1835 3mg; 2000 3mg; 1411
9/14/03	[redacted]	MSO4 1-5mg IVP q 1° prn pain	9/23 1830 5mg; 9/23 2030 5mg; 9/23 2355 5mg; 9/24 0400 5mg; 9.24 1850 5mg

6

b(6)-2A11

CLINICAL RECORD

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

Mo. 9 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23 24 25 26 27 28 29
9-11-03	[redacted]	Reglan 10mg IVPB Q6°	02	[redacted]
	-----		08	
	-----		14	
	-----		20	
9-11-03	[redacted]	Zantac 50mg IVPB Q8°	08	[redacted] / Percocet
	-----		16	
9-14-03	[redacted]	D5 1/2 NS @ 20 mEq KCl to	06	[redacted]
	-----	25 cc/hr	18	
9-14-03	[redacted]	Trach mask	06	
	-----		18	
9-15-03	[redacted]	5000 units Heparin BID	10	[redacted]
	-----		22	
9-22-03	[redacted]	ASA 325mg QD	10	[redacted]
9-23-03	[redacted]	Vanc 500mg IVPB q 12°	10	[redacted]
	-----		22	
9-23-03	[redacted]	Ceftaz 2gm q 8°	08	[redacted]
	-----		16	
	-----		24	
9/11/03	[redacted]	zantac 50mg IVPB Q8°	08	[redacted]
	-----		16	
	-----		24	
9/24/03	[redacted]	Flagyl 250mg IVPB Q8°	08	[redacted]
	-----		16	
	-----		24	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: EPW [redacted] / GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4
GSW to chest

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 18269

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Sept	Yr. 03	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given** / **Initials**
		blw-2A1			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
22 Sept 03	[redacted]	NEB Rx PRN	9/26 1605
24 Sept	[redacted]	MSO4 1-5mg IVP Q1° prn pain	9/24 2050 2.5mg [redacted]; 9/25 0120 5mg [redacted]; 9/25 2210 2.5mg [redacted]; 9/26 0030 5mg [redacted]; 9/26 0310 2.5mg [redacted]; 9/26 0730 3mg [redacted]; 26 Sep 1345 3mg [redacted]; 26 Sep [illegible] [redacted]; 26 Sep 2045 [illegible] [redacted]; 26 Sep 2230 [illegible] [redacted]; 27 Sep 0400 5mg [redacted]; 28 Sep 0940 5mg [redacted]; 28 Sep 1200 3mg [redacted]; 28 Sep 1900 5mg [redacted]; 28 Sept 2200 6mg [redacted]
24 Sept	[redacted]	Tylenol 650mg per G-Tube for T > 38.5	
28 Sep	[redacted]	MSO4 1-5mg IVP Q1°	9-28 2350 [redacted]

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

MEDCOM - 18270

bLW-2 A-1

CLINICAL RECORD

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

Mo. ___ Yr. ___

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11 12 13 14 15 16 17 18 19 20 21 22 23
9-11-03	[redacted]	Rocuronium IVPB @ 6°	08	[redacted]
			14	
			20	
			02	
9-11-03	[redacted]	Zantac 50mg IVPB @ 8°	08	
			16	
			00	
9-12-03	[redacted]	VANCOMYCIN 500mg IVPB	10	x
	[redacted]	Q12°	22	x
9-14-03	[redacted]	INF to 25cc/hr	06	[redacted]
		(D5 1/2 NS ± 20KCl)	18	
9-14-03	[redacted]	Trach mask	06	
			18	
9/14/03	[redacted]	Propofol 10mg/hr titrate	06	
		~~to decrease agitation~~	18	
9-15-03	[redacted]	5000 units Hyaluronidase SQ	10	
			22	
9/20/03	[redacted]	Albuterol/Atrovent Nebs	00	
	[redacted]	q6hr (Reapied)	06	
22-9-03	[redacted]	~~ASA 325mg QD SR~~	12	
			18	
22Sep03	[redacted]	ASA 325mg QD	10	/ / / / / / / / / / [redacted]
		Vanc 500mg IVPB q	12	
		Ceftaz 2gm q8°		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: EPW [redacted] / GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION: EPW [redacted] bLW-4 / GSW to Chest

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 - 18271

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
2/28/10	[redacted]	AERO TX PRN	
		b(6)-2	

b(6)-2 #11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 9 Y 23

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29 30 31 01 02 03 04 05 06 07 08 09 10 11
29Sept	[redacted]	Hep lock IV	06 12 18 00	[redacted]
9/29	[redacted]	Heparin 5000u SC q.12	10 22	
04 OCT 03	[redacted]	Cidace T po bid	10 22	
04	[redacted]	Flagyl 250mg po bid	10 22	
11 OCT 03	[redacted]	Apply Bacitracin to Oleg (if dry)	10 22	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW c paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] blue-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 - 18273

DLC-2A71

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Sep Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10/3	[redacted]	Start IV Fluids @ 2400	10/3	2400	2400	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
29 Sep	[redacted]	Percocet 1-2 po q 4° PRN pain	Date/Time: 29Sep 2330; 30Sep 1900; 1 Oct 2245; 2 Oct 1130; 2 Oct 1905; 3 Oct 1940; 4 Oct 1935; 5 Oct 0045; 5 Oct 1345; 6 Oct 1900; 7 Oct 1645; 8 Oct 0030; 8 Oct 1900; 9 Oct 1000 — Date: [redacted]
29 Sep	[redacted]	MS041-2mg q 1° prn break through pain	DK
01 Oct 03	[redacted]	MS04 1-2mg IDP q 2° prn pain	DT 01 Oct 1020; DI 2mg [redacted]
01 Oct 03	[redacted]	Motrin 800mg TID prn	DT 01 Oct 1020; 8 Oct 0900; DI 800mg [redacted]
29	[redacted]	Percocet 1-2 po Q4° PRN pain	DT 01 Oct 1400; 4 Oct 1020; 4 Oct 2045; 10 Oct 1000; 10 Oct 1130; 10 Oct 2225; 11 Oct 1330; 11 Oct 1620; DI 1-2 [redacted]

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12 13 14 15 16 17 18 19 20 21 22 23
29 Sep 03	[redacted]	Heplock IV	06	[redacted]
	-----		18	
29	[redacted]	Heparin 5000U SC q	10	
	-----	12°	22	
29 Oct 03	[redacted]	Colace I po BID	10	
	-----		22	
04	[redacted]	Flagyl 250mg po	10	
	-----	BID	22	
11 Oct 03	[redacted]	Apply Bacitracin to q	10	
	-----	leg (if dry)	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW & paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 18275

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 10 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		DW 2 A1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 OCT 03	[redacted]	Percocet 1-2 PO q4° PRN pain	D/T	1204 0730	1204 1130	1304 1000	1304 1450	1304 2245	1504 0000	1504 0850	1504 1540	1604 0700	1604 1345	1704 2215	1704 1720	
			D/I													
11 OCT 03	[redacted]	Mann 800mg TID PRN	D/T	2000												
			D/I	800mg [redacted]												

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

CLINICAL RECORD

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

Mo. Oct Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20 21 22 23 24 25 26 27 28 29 30 31
20 Oct	[redacted]	LR @ 75cc/hr	06	[redacted]
			18	
20 Oct	[redacted]	Heparin 5000u SQ BID	10	
			22	
		P		
22/10	[redacted]	Prenatal multivitamin	12	
		1 tab PO QD		
24/10	[redacted]	FLAGYL 500MG IVPB	08	
		TID	16	
			24	[redacted]
		b/e x 2 ATU		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Paraplegic & deep sacral decubitis; infected

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678 EDITION OF 1 MEDCOM - 18277 XHAUSTED.

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	
		b(6)-2 A11					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
21/10	[redacted]	MSO4 2-4mg IVP	2100 2mg 2300 0050 2400 4mg 0100 11:00 0200 2mg 0300 2200 0400 4mg 0500 0600 0700 0800 2400 0800 4mg 2115 29 0915 4mg DC'D
		Q1hr PRN PN	[redacted]
29/10	[redacted]	Percocet tabs 1-2 tabs	1130 21/10 2400 2/10 0530 22/10 1430 22/10 1830 22/10 2230 29/10 0730 29/10 1130 23/10 2130 24/10 0620 24/10 0520 24/10 1220 25/10 0115 25/10 0620 30/OCT 1145
		Q4-6hr PRN PN	2tabs PO 2tabs PO 2tabs PO 1TAB PO 2tabs PO 2tabs PO 2tabs PO [redacted]
			2300 2400 2700 0000 0600 1200 2400 30/10 0300 30/10 1345 3000 3 0001 05 2105 0600 5
			1400 2300 2300 2400 1130 4 [redacted]
29/10	[redacted]	MSO4 2-8MG IVP Q2-4°	2200 4mg 0400 2mg 0000 3mg 0700 30/10 0730 30/10 0930 30/10 1345 30/10 1630
		PRN PAIN	2300 2mg 0000 3mg 3mg 4mg 3mg 5mg 5mg [redacted]

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

b(6)-2 AR1

CLINICAL RECORD

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

Mo. 10/11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8
10/31	[redacted]	IV Heplock	D	[redacted]								
			N									
10/31	[redacted]	Flagyl 500mg IV	08								/	
		q 8° x 8 day	16	/							/	
			24	[redacted]							/	
10/31	[redacted]	Prenatal Vitamin	10									
		1 po. q Day		/								
10/31	[redacted]	Heparin 5000U.	10	/	[redacted]							
		SQ BID	22	[redacted]								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Debride & Graft IV Decub Colostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 18279

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Oct/Nov Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		Tab(e)-2 AM				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
10/31	[redacted]	Percocet 1-2 P.O. q 4-6° prn	Date	2300 31 Oct	1 Nov 1205	1 Nov 0820	2 Nov 0830	11/3	11/3 1330								
			Dose	1+1	1	1	1	2	2								
			Init	[redacted]													

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

MEDCOM - 18280

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: 06 00 Inital [redacted]	Time: Initals:
NEURO	Pupils	2 - sluggish	
	Sensorium	Sedated	
	LOC / GCS	b(6)-2	
CARDIAC	Cardiac Rhythm	SR	
	PRI: / QRS:		
	Pulse Strength	2+	
	Cap Refil / JVD	⊕	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	Unequal L>R	
	Breath Sounds	Coarse	
	Secretions	mm - tan	
	Cough	Ø	
SKIN	Color	NFR	
	Integrity	Mult sub sites	
	Backside		
IV	Access Devices	PIV / PIV / Aline	
	Location	(L)Bicep / (R)FA / (L)Rad	
	Condition	COI / COI / COI	
GI	Abdomen	Flat	
	Bowel Sounds	Ø	
	Stoma/Ostomy	NGT Tube	
GU	Device	Foley	
	Color / Clarity	dark yellow / [redacted]	

PREPARED BY (Name and Title): [redacted] CPT MAW

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 29 Aug 03

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

NAME: [redacted]

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

ICU Flowsheet

Patient Name: EPW [redacted]

Date: 30 Aug-y 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	98.4					100.4				98.7			96.3			98.8								
Pulse	85	81	79	85	90	90	97	104	104	97	89	89	80	80	80	81								
B/P A-Line	126	119	130	127	113	118		114	115	102	127	113	110		134									
MAP	69	67	84	55	51	55	45	43	49	43	56	51	57		74	NO								
B/P Cuff	86	85	76	74	61	66	64	67		64	75	68	73		97	99								
Respirations	10	16	10	10	16	10	10	25	32	24	28	25	19		22	22								
Sa02 %	100	100	100	100	100	100	100	98	99	94	94	100	100		97	100								
FIO2 %									45%	45	45	45	45		50	50								

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	125	125	125	D5	125	125	D5	125	125	125	off	off	1250	off	off	off	125	125								
Fentanyl	10	10	10	10	10	10	10	10	10	14	14	14	132	14	14	5	5									
Propofol	15.4	15.4	15.4	15.4	15.4	13.4	13.4	13.4	13.4	15	19	19	195	19	19	VeR	2									
IVPB								50																		
								PROC		450	450		900													
PO intake								Bolus	NS				500													
O.R. IN									LR		500	500	500													
Totals													3477			Vcc 8.										

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	70	100	100	90	40	40	35	30	30	22	26	20	~~120~~	26		200	110									
NG Tube				50				30	100	82	108	128	453	36	→	336										
Drains #1																										
CT #2	160			25							70		255	100												
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													708													

24 hour input	
24 hour output	
24 hour balance	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time:	Initals:	Time: 0530 Initals: [redacted]
NEURO	Pupils			PERRLA 3mm
	Sensorium			Sedation off. moves arms/+ LE movement
	LOC / GCS			withdraws to pain
CARDIAC	Cardiac Rhythm			Sinus bradycardia
	PRI: / QRS:			
	Pulse Strength			+1 all extremities
	Cap Refil / JVD			
	Edema			0
	Chest Pain			0
RESP	Respiratory Pattern			Pt intubated does not communicate
	Breath Sounds			Normal on SIMV 16, TV 750 PEEP 5 FiO2 35
	Secretions			CTA(B) CT to RUL SX over (R) Int chest
	Cough			0
				0
SKIN	Color			WNL
	Integrity			Intact x wound sover (R) anterior chest; abd
	Backside			Deferred
IV	Access Devices			PIV X 2
	Location			(R) FA / (L) UA 18G
	Condition			CDI
CI	Abdomen			ABD dressing in place
	Bowel Sounds			UTA
	Stoma/Ostomy			0
GU	Device			foley to gravity
	Color / Clarity			amber / clear
				adequate UOP

PREPARED BY (Signature & Title): [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 29 Aug 03

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

NAME: EPW [redacted]

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

ICU Flowsheet Patient Name: EPW 675 Date: 24 / Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Temperature																								
Pulse																			97		96		85	
B/P A-Line																			51		62	80	77	85
MAP																						123	114	88
B/P Cuff																						69	58	60
Respirations																			86	86	76	81	75	85
Sa02																			126	123	100			
																			63	66	57			
																			16	16	16	16	16	16
																			100	100	100	100	100	100
																			[redacted]					
																			FIO2 50%	→	→	→	40%	→

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																				85	85	125	85	85	125	
Propofol																										
fentanyl																										
FFP																										
PO intake																										
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly																					200	50	50	40	90	
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

'CAL RECORD-SUPPLEMENTAL MEDIC/ TA
For use of this f , AR 40-66; the proponent agency is The Offic : Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS		INTILAS		INTILAS [redacted]
NEURO	PUPLIS					F100	
	SENSORIUM					Perrla 3m	
						withdraws to pain	
						UE's only	
						Paraplegic	
RESPIRATORY	RESPIRATION PATTERN					normal on SIMV 22 FIO 50%	
	BREATH SOUNDS					CTA B	
	SECRETIONS						
						CTX2 on 20cm H2O 5X	
						over R int chest.	
SKIN	COLOR					NFR	
	INTEGRITY					Burn like lacerations c	
						topical blister over L LE.	
IV SITE	LOCATION					TL over R IJ, cordis	
	CONDITION					over L femoral skin, art	
						line over L radial artery	
						PIV over R arm.	
						Condition dry	
						& intact	
GASTRO	ABDOMEN					slipex kept @ midline	
	BOWEL SOUNDS					abd dressing c JP's x 2	
						BS absent	
						-BM witnessed.	
GU	URINE					Foley to gravity	
	COLOR/CLARITY					cl/pur/clear	
						adequate output - 40cc/hr	
CARDIOVASCULAR	CARDIACRHYTHM					NSR	
						Pulses equal & strong	

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 - Iracheostomy

(Continue on reverse)

b(6)-2

[redacted] (Title) CPT IAW DEPARTMENT/SERVICE/CINC ICU3 DATE 30 Aug 03

PATI[redacted]DICATIONS (For typed or written entries give: Name—Last, First, middl[redacted]ade; date; hospital or medical facility)

EPW [redacted] b(6)-1

- ☐ 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 - 18285

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02		04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		
O2 sats																		
mode/FIO2																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL																	
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	JP#1																	
	JP#2																	
	CT #1																	
	CT #2																	
TOTALS																		

MEDCOM - 18286

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	14	17	18	19	20	21		23
				120/61	113/64	115/62	117/56	129/58
				93.6 Orally		95.1 AX		97.6 (A)
				84	84	85	87	95
				25	24	22	22	22
				99	99	100	100	100
				SIMV 50%	SIMV 50%	SIMV 50%	SIMV 50%	SIMV 50%

INTAKE

	14	17	18	19	20	21	22	23	8°T

OUTPUT

					50	60	70	60	
					70				
					30				
							50		

RESPIRATORY

TIME		1900
MODE		SIMV
F_iO_2		50
TV		5
RATE		22
PEEP		7
ABG	pH	7.31
	PCO_2	41.5
	pO_2	66
	HCO_3	21
	SAT	91%
	BASE	-5

LABORATORY

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

ACTIVITIES

DAILY

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

EVERY TURN SUCTION

TIME

24-HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE OUTPUT

IV _____ Urine: _____

Po _____ _____

TOTAL _____ TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

For use of this fo[rm] ...CAL RECORD-SUPPLEMENTAL MEDICA... 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 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0630	INITIAS [redacted]	1830	INITIAS [redacted]		INITIAS
NEURO		PUPLIS	3mm Sluggish bila-		Pupils equal, round 3mm, very			
		SENSORIUM	teral. Sedated		sluggish. Pharmacologically sedated			
			no respond to pain		& reversed, fentanyl, paralyzed &			
			stimuli. Paraplegic		vecuronium. Spinal precautions			
			per Hx.					
RESPIRATORY		RESPIRATION PATTERN	SIMV 22 FiO_2 60%		ETT 7.0, 26cm @ teeth. SIMV			
		BREATH SOUNDS	Peep 7. Lungs ronchi		22, TV 500, Peep 7, FiO_2 50%			
		SECRETIONS	bilateral & expiratory		Rhonchi all lung fields ā + p̄			
			Wheezing. CT x2		suctioning. Thick yellow/brown/white			
			R side 2cc ult 20 Con-		secretions, CT x2 (R) lateral chest.			
			tinuous suct.		Both to 20cm H_2O continuous			
SKIN		COLOR	WNL. blisters (L)		suction. Sats 100%. WNL, cool			
		INTEGRITY	LE. Abd wounds &		BUE. Dry, open wound (L) medial			
			dressing CDI.		lower leg, white center, blister LLE.			
IV SITE		LOCATION	TL (R) IJ cordis		ML abd incision & dressing in			
		CONDITION	(R) femoral vein.		place. TLC to (R) IJ, brown port			
			A-Line (R) radial.		clotted, white port draw blood from			
			PIV (R) arm. CDI.		flush well, blue port versed/Fentanyl.			
					(L) groin & cordis LR/vecuronium			
					(L) wrist A-line, zeroed, good waveform			
GASTRO		ABDOMEN	S/P ex lap. mid line		(R) anterior forearm SL, flushed well			
		BOWEL SOUNDS	Abd dressing. JP x2		Dressings dry & intact. ML			
			BS absent. ø BM		abdominal incision, dressings in place			
					minimal (L) side of dressing, brownish/green drainage. hypoactive			
GU		URINE	Foley to gravity		bs x4. BBM NGT to LIS. Checked placement & air bolus. Secured			
		COLOR/CLARITY	amber. wt color		to nose. Foley to DD DK yellow clear urine. Foley care			
			ø sediments.		done. Secured to (R) leg. ø drainage			
CARDIOVASCULAR		CARDIACRHYTHM	Stach 110's Rachel		SR & ectopy. S_1S_2. VSS.			
			+2 pulses x4. capillary		trace generalized edema. cool BUE			
			refill <3sec. Skin		Radial (L) pulses 2+. Pedal/(R) radial pulses 3+			
			dry & warm.		cap refill <3 sec.			

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 | DATE 31Aug03

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 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line	118/50	126/53	132/71	109/55	122/76	128/50	133/55	127/54		128/58	134/54	132/53	122/50	128/51	118/55	134/60	126/62	
BP Cuff																		
Temperature			99.8 A			99.1 A				97.9				97.9				
Pulse	105	111	119	123	110	109	117	112		116	119	114	112	108	110	110	104	
Respiratory Rate	22	22	22	22	22	22	22	22		22	22	22	22	22	22	22	22	
O2 sats	99	98	97	98	96	96	99	99		99	96	98	96	97	96	96	98	
O2 delivery	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
FIO2	50%	60%	50%	50%	50%	50%	50%	60%		60%	50%	50%	50%	50%	50%	50%	50%	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	100	100	100	100	100	100	100	100	2200	100	100	100	100	100	100	100	100	800
Versed	3	3	3	3	3	3	3	3	24	3	3	3	3	3	3	3	3	24
Fent	10	10	10	10	10	10	10	10	80	10	10	20	20	20	20	20	20	140
Vecuronium	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
TOTALS									2336									996

OUTPUT

		HOUR / TOTAL	40	60 / 60	60 / 120	35 / 155	30 / 185	50 / 235	70 / 305	60	90	60	45 / 105	50 / 155	45 / 200	48 / 248	48 / 296	160 / 456	60 / 516	576
URINE		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		0			60			30				80	35					70		70
		CT 1				140						140						210		210
		CT 2				10						10						31		31
TOTALS												650								887

POST-OP DAY

	16	17	18	19	20	21		23	
VITALS	135/55	132/52	124/56	136/57	113/52	119/65	124/56	129/56	
		90.5				119/60		118/59	
						96° @	95.9 @		
	104	98	97	101	87	90	87	88	
	22	22	22	22	22	22	22	22	
	97	97	99	100	99	100	100	99	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	50%	50%	50%	50%	50%	50%	50%	50%	
SIGNS									

	14	17	18	19	20	21	22	23	8°T
INTAKE	100	100	120	100	100	100	100	100	800
	3	3	3	3	3	3	3	3	24
	20	20	20	20	20	20	20	20	160
	4	4	4	4	4	4	4	4	32
									1016

OUTPUT	50	60/110	45/155	54/209	32/241	33/274	34/308	38/346	346
								100	100
			30/10					45/10	95/10
			30					4/19	179 209
			18					47	47
									767

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0600	1030									
	MODE	SIMV	SIMV	SIMV								
	F_iO_2	60%	50%	50%								
	TV	500	500	500								
	RATE	22	22	22								
	PEEP	7	7	7								
ABG	A pH											
	A PCO_2											
	B pO_2											
	B HCO_3											
	G SAT											
	G BASE											

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

ACTIVITY/TURNING/SUCTION	TIME								TURN	TIME		
	MOUTH CARE	1645								2000		
	BATCH											
	SKIN CARE											
	FOLEY CARE	1900							SUCTION	1830		
	TRACH CARE									1930		
	ROM EXERCISES									2230		

24-180 TOTALS | NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4348	NG	1.00
		Urine:	1317
Po		225 UPI [redacted] CTI 529	
		45 JPI [redacted] CTI 208	
TOTAL	4348	TOTAL	2304
BALANCE	+2044		

[redacted] IGTIAN
blue

NEUROLOGICAL ASSESSMENT

HOURS

COMA SCALE

EYES OPEN

SPONTANEOUSLY	4
TO SPEECH	3
TO PAIN	2
NO EYE OPENING	1

BEST VERAL RESPONSE

ORIENTED	5
CONFUSED	4
VERBALIZES	3
VOCALIZES	2
NO VOCALIZATION	1

BEST MOTOR RESPONSE

OBEYS COMMANDS	6
LOCALIZESPAIN	5
FLEXION WITHDRAWAL	4
ABNORMAL FLEXION	3
EXTENSION TO PAIN	2
N0 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	
	REACTION	
LEFT	SIZE	
	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 tow sides

++ Brisk
+ Slow
– No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS

Radial	R L	
Pedal	R L	
	R L	
	R L	
	R L	

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

ICU Flowsheet

Patient Name: EPW [redacted] b(6)-4

Date: 09 / 01 / 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	96.8		97.2		98.6														98.4					
Pulse	91	97	102	102	105	107	115					110												
B/P A-Line	105/55	133/53	129/51	124/52	120/50	127/54	145/56												168/67					
MAP	76	77	75	75	77	80	84												96	95	94	102	104	102
B/P Cuff	119/58	114/59	121/56	125/56	138/61	135/59	131/58												134/71	143/72	142/73	143/74	144/74	146/76
Respirations	22	22	22	22	22	22	22												22	22	23	19	16	
Sa02	98	98	98	98	98	98	98												99	99	99	95	96	95
FiO2	50%	50%	50%	50%	50%	50%	50%												50	50	50	50	50	50
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV						SIMV						SIMV	SIMV	SIMV	SIMV	SIMV	

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 LR	100	100	100	120	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
Vecuronium	3	3	3	3	3	3	3	3	3	3	3	3	36													
Fentanyl	20	20	20	20	20	20	20	20	20	20	20	20	240	20	20	20	20	20	20	16	16	16	16	16	16	220
Versed	4	4	4	4	4	4	4	4	4	4	4	4	48	5	5	5	5	5	5	5	5	5	5	5	5	61
IVPB	50							50					100													50
PO intake																										
O.R. IN																										
Totals													1636													1527

Outputt	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	38	30	47	30	48	42							350													1571
NG Tube		94	110	152	197	269						94														
Drains JP #1					40	30																				
JP #2					10	10																				
CT#1/CT#2					14																					
Emesis/Stool																										
O.R. OUT																										
Totals													1602													

24 hour input	3134
24 hour output	1525
24 hour balance	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; 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 Initals: [redacted]	Time: 1900 Initals: [redacted]
NEURO	Pupils	2mm sluggish, PERRLA, sedated & intubated,	2mm sluggish
	Sensorium		
	LOC / GCS	pain mgmt & sedation, HR 115-72 paintul stimuli, ↓ movement, on breathing unit + 2-3.	non responsive, intubated
CARDIAC	Cardiac Rhythm	ST sec dysrhythmia	ST, ↓ ectopy
	PRI: / QRS:		
	Pulse Strength	+2 radial & pedal bilat	2+
	Cap Refil / JVD	<3 sec & JVD	<3 sec / ↓ JVD
	Edema	gen edema + & pitting	1+ pitty to extremeties
	Chest Pain	DTS	UTS
RESP	Respiratory Pattern	even unlabored unt SpO2 96% VE 5.00 resps RR 22 ETT #6 26cm @ teeth	equal use / full chest
	Breath Sounds		
	Secretions	rhonchi thru secretions from ETT, coarse BS changing bilat w/ rales, CT +2 (R) CW	small, tan c SX.
	Cough		
SKIN	Color	appropriate for race	NFR
	Integrity	midline abdominal incision stapled OTA, staples intact C/D/I, redness & drainage c bleeding	NL c staples COI
	Backside		CT x2; JP x2 - cmd c bulby drng
		see progress note for daily & wet	
IV	Access Devices	(L) Sheaths, (R) IJ TL	(L) Femoral COI | (R) Rad Aline COI | (R) IJ COI
	Location		
	Condition	all patent	
GI	Abdomen	soft rounded nondistended	soft; nontender
	Bowel Sounds	@ BS NG to CWS c grey secretions	NOT - clamped for feeds.
	Stoma/Ostomy	NG (R) nare, placement confirmed	held @ 1600 for ↑ abdmn
GU	Device	FTG @ BS.	FTG - QS.
	Color / Clarity	amber & clear	yellow / clear

(Continue on reverse)

1800-0600 PREPARED BY (Signature & Title): [redacted] LTRN

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 28 OCT 03

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

NAME: [redacted] 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

USAPPC V2.00

b(6)-2

ICU Flowsheet

Patient Name: FPN/ # [redacted] Date: 9 / 2 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11
Temperature				100.5				99.7				
Pulse	115	113	114	115	117	114	112	111	111	103	101	94
B/P A-Line	178/76	172/72	171/69	169/71	179/70			136/43				69/71
MAP	103	100	101	98	93	104	92					
B/P Cuff	144/76	144/79	147/75	135/69	138/68	149/76	134/68	136/63	44/64	132/69	137/69	146/42
Respirations	22	22	21	24	22	24	22	27	23	22	24	22
Sa02	92	91	91	93	94	91	94	94	95	94	95	95
FiO2	50	50	50	50	50	50	50	50	50	50	50	50
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV

Vital Signs	12	13	14	15	16	17	18	19	20	21	22	23
Temperature	98.9							100.7				
Pulse	101	103	99	94	92	81	85	96		101	102	106
B/P A-Line	189/74	173/70	159/69	155/61	172/64	169/62	205/76	171/91	146/69	161/72	167/70	220/73
MAP								98	95	98		103
B/P Cuff	153/68	147/65	136/60	141/68	146/70	148/68	178/64	131/61	99/61	148/62		163/71
Respirations	22	22	22	22	22	25	22	24	27	25	28	24
Sa02	97	96	99	100	98	98	91	96	94	97	95	91
FiO2	50	50	50	50	50	50	50	50	50	50	50	50
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total
IVF D5 1/2 NS 20 KCl	100	100	100	100	100	100	100	100	125	125	125	125	1300
Vecuronium	0	0	0	0	0	0	50	CRT off	–	–			
fentanyl	16	16	16	16	16	16	16	16	16	16	16	16	192
Versed	5	5	5	5	5	5	5	5	off	–	–	–	40
IVPB	50								50				100
PO intake									100	–			100
O.R. IN													1732
Totals													

Intake	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF D5 1/2 NS 20 KCl	125	125	125	125	125	125	125	125	125	125	125	125	1500
Vecuronium	–	–											
fentanyl	16	16	16	16	16	9 off							76
Versed	–	–											
IVPB	–	–	50										50
PO intake			100										100
O.R. IN													1726
Totals													

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total
Urine Hourly	110	60	60	80	135	140	50	85	45	80	60	55	1030
NG Tube	200				50								250
Drains JP #1		30			15							40	85
JP #2					10							12	22
CTs #1/#2 #3	30				135							120	455
Emesis/Stool													
~~O.R. OUT~~ Residual													
Totals													1852

Output	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	65	55	75	50	45	80	90	90	50	60	60	60	770
NG Tube													
Drains JP #1					65								
JP #2													
CTs #1/#2 #3					10								
Emesis/Stool					60							150/50	210/60
~~O.R. OUT~~ Residual													
Totals			80			150							

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 18294

M[illegible] L RECORD-SUPPLEMENTAL MEDICAL
For use of this form R 40-66; the proponent agency is The Office of [illegible]rgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME		INITIAS		INITIAS	1900	INITIAS [redacted]
NEURO	PUPLIS					unreactive 3mm round, equa
	SENSORIUM					no response to painful stimuli
RESPIRATORY	RESPIRATION PATTERN					horrigan SIMV 22
	BREATH SOUNDS					coarse throughout
	SECRETIONS					-0-
SKIN	COLOR					NFR
	INTEGRITY					Blisters over (L) LE
						abd wound staples intact
IV SITE	LOCATION					(L) groin cordis, (R) IJ
	CONDITION					triple lument C,D,I+
GASTRO	ABDOMEN					soft, nondistended
	BOWEL SOUNDS					hypo
						not clamped.
GU	URINE					Foley up <30cc/hr
	COLOR/CLARITY					Dark yellow/clear
CARDIOVASCULAR	CARDIACRHYTHM					Sinus tach

LEGEND

Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_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)

b(6)-2

[redacted] CPT IAW | DEPARTMENT/SERVICE/CINC FCM 3 | DATE 3 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)

MEDCOM - 18295

DATE 3 Sep 03 DX GSW to chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line	178/68	134/51	125/65	115/49	119/35	156/44	141/37	135/53										
BP Cuff	156/68	129/57	131/51	107/49	105/33	128/47	123/42	118/38		108/41	104/36	119/52	117/51	97/79	112/53	109/58	96/50	
Temperature	101.5		99.2				98.9	99.5					98.4					
Pulse	105	132	130	123	127	147	149	133		126	136	125	117	118	119	114	110	
Respiratory Rate	24	22	24	26	26	29	30	40		23	24	22	24	24	27	27	24	
SaO2	93	89	88	96	94	90	89	93		90	91	94	100	80	100	100	100	
FiO2	50	55	55	50	50	60	60	60		90	80	80	90	100	90	80%	70%	
CPAP											10	10	14	14	15	15	15	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½ 20KCl	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
Prop	12.6	14.	14	14	12	off	off	7.1		5.9	5.9	5.9	5.9	5.9	5.9	5.9	5.9	47.2
TF	ø	ø	ø	ø	ø	ø	ø	ø		ø	ø	ø	ø	ø	ø	ø	100	100
IVPB	50									150		200	50					450
					800 (LR)			TR										
BOLUS								1000				1000				1000	1000	4000
ALBUN 25%																	100	100
Residual				(100)								(50)				(120)		(770.9) (400)
TOTALS																		

OUTPUT

	HOUR / TOTAL	60 / 60	30 / 90	30 / 120	20 / 140	25 / 165	15 / 180	10 / 190	20 / 210		26 / 236	10 / 246	8 / 254	5 / 260	14 / 274	10 / 284	16 / 300	12 / 312	16 hour total 312
URINE	SP gr																		
	S/A																		
NG	OUTPUT																		
	~~PM~~ C11					50													
	~~GUARD~~ C12					50													
~~EMESIS~~																			
STOOL						Small x1													
DRAINS	JP1				25								30	Large x1					
	JP2				40								100		120				
TOTALS																			

MEDCOM - 18296

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	[illegible]	23
Temp	37/51	37/98.6	37/98.6	98.6	[illegible]	98.4	98.6	98.8
Apical		99.4		98.6		98.8		
Pulse	105	108	109	109	115	112	115	115
Resp	22	22	29	27	22	22	22	22
Sat %	100	100	100	100	100	100	100	100
FiO2	70	60	50	50	50	50	50	50
PEEP	15	15	15	15	15	15	15	15
CVP	22	20	17	17	17	18	18	18

INTAKE	14	17	18	19	20	21	22	23	8°T
IV	195	125	125	[illegible]	[illegible]	[illegible]	[illegible]	150	[illegible]
Po	5.9	5.9	5.9	7.8	7.8	7.8	7.8	7.8	56.7
	0	0	0	0	0	0	0	0	
	100						350	350	400
		3	3	7.3	7.3	7.3	7.3		43.8
							500		500
							(150)		290

OUTPUT	10	20	05	10	[illegible]	[illegible]	[illegible]	[illegible]	
Urine	322	342	347	358					98
Drain	q8hrs		24						24
		50							50
		200							250
		Small Stool x1							X1
		25					30		55
		50					15		65
									69

ACUITY LEVEL CLASSIFICATION

RESPIRATORY

		TIME	0040	0534
		MODE	SIMV	SIMV
		F_iO_2	100	50
		TV	550	550
		RATE	22	22
		PEEP	+10	+6
ARTERIAL BLOOD GASES	A	pH	7.37	7.43
		PCO_2	46	38
	B	pO_2	65	66
		HCO_3	27	25
		SAT	89	93
	G	BASE	1	1

LABORATORY DATA

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

ACTIVITY / DAILY / TIMELY / DIAGNOSTIC

TIME				TURN / SUCTION TIME						
MOUTH CARE										
BATH										
SKIN CARE										
FOLEY CARE										
TRACH CARE										
ROM EXERCISES										

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE | INITIALS

MEDCOM - 18297

DATE 3 Sep 03 DX GSW to Chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	174/68	134/71	125/65	115/49	119/35	156/44	134/57	135/53										
BP Cuff	156/68	129/57	131/61	107/49	105/33	128/47	123/42	116/58		98/41	104/56	119/62	119/51	97/79	112/53	109/59	96/50	
Temperature	101.5		99.2				98.9	99.5					98.4					
Pulse	105	132	130	123	127	147	149	133		126	136	125	117	118	119	114	110	
Respiratory Rate	24	22	24	26	26	29	30	40		23	24	22	24	24	27	27	22	
S9O2	93	89	88	96	94	90	89	93		90	91	94	100	80	100	100	100	
FIO2	50	55	55	50	50	60	60	60		90	80	80	90	100	90	80%	70%	
CPAP											10	10	14	14	15	15	15	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	16°T
D5½ 20KCl	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	2000
Prop	12.6	14	14	14	12	off	off	7.1		5.9	5.9	5.9	5.9	5.9	5.9	5.9	5.9	47.2
TF	ø	ø	ø	ø	ø	ø	ø	ø		ø	ø	ø	ø	ø	ø	ø	100	100
IVPB	50									150		200	50					450
					800 (LR)			NA										
BOLUS								1000				1000				1000	1000	4000
ALBUN 25%																	100	100
Residual				(100)								(20)				(120)		6770.9 (450)
TOTALS																		

OUTPUT

	HOUR / TOTAL	60/60	30/90	30/120	20/140	25/165	15/180	10/190	20/210		26/236	10/246	8/254	5/260	14/274	10/284	16/300	12/312	16°TOTAL 312
URINE	SP gr																		
	S/A																		
NG	OUTPUT																		
	~~PH~~ CT1					50													
	~~GSTRIC~~ CT2					50													
~~EMESIS~~																			
STOOL						Small x1								Large x1					
DRAINS	JP1				25								30						
	JP2				40								100		120				
TOTALS																			

MEDCOM - 18298

M[illegible] L RECORD-SUPPLEMENTAL MEDICAL
For use of this form[illegible] R 40-66; the proponent agency is The Office of[illegible]urgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6) - 2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INTILAS [redacted]		INTILAS	0815	INTILAS [redacted]
NEURO		PUPLIS	3mm Perl brisk				3mm PERRLA Brisk	
		SENSORIUM	non responsive to painful stimuli. pt on breathing vent AC 25-30. off all sedation & pain medications				unresponsive to painful stimuli pt on breathing vent	
RESPIRATORY		RESPIRATION PATTERN	Even unlabored SIMV				Even, unlabored	
		BREATH SOUNDS	VE 500 peep 5, RR 22, fio2 50% ETT #6 26cm @ teeth. Rales throughout bases, thick tan secretions ETT secretions				SIMV, VT 500, peep 10 RR 22, FIO2 50% Coarse lung sounds B/L CT x2 draining serosanguinous fluid; to H2O seal	
		BREATH SOUNDS					NFR	
		SECRETIONS						
SKIN		COLOR	appropriate for race					
		INTEGRITY	midline closed incision. Staples intact & OTA. redness, drainage.				M/L incision (closed) open to air. D/S infection	
IV SITE		LOCATION	R fem - D-line, R fem Cordis.				(R) IJ TL	(R) femoral line
		CONDITION	RIJ TL				CDI	CDI
GASTRO		ABDOMEN	S-firm, distended				non distended, firm	
		BOWEL SOUNDS	active BS. NG, Rectum cleaned stools on bed d/t residuals 750. Q. Bm or flatus. TPN @ 125 ml/hr				active BS x 4 quads. NG, US	
GU		URINE	amber, clear QS.				FTG, clear	
		COLOR/CLARITY					yellow	
CARDIOVASCULAR		CARDIAC RHYTHM	ST s ectopy rarely palpable, bilat radial pulse, +2 pedal pulse generalized edema, CT x 2 BSC to H2O seal				ST in 120's +2 radial/pedal pulses generalized edema	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - 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)

b(6)

PREPARER [redacted] (Signature and Title) CPT (AN) | DEPARTMENT/SERVICE/CINC TCU #3 | DATE 4 Sep 03

PATIENT'S INDICATIONS (For typed 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)

MEDCOM - 18299

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line								100/59		113/64	124/67	127/67	130/70	117/67	146/73	122/60	127/74	
BP Cuff	85/51	92/47	90/48	93/45	98/48	96/47				117/55	134/56	134/52	133/53			142/67	129/57	
Temperature	97.5			100				99.6					100.3					
Pulse	119	123	123	122	131	135	123	122		124	116	125	126	124	133	131	127	
Respiratory Rate	14	23	22	23	18	22	22	31		26	24	32	40	24	27	26	29	
O2 Sats	100%	100%	99%	99%	97	98	100	96		96	96	96	96	97	94	96	97	
FIO2	50	50	50	50	50	50	50	50		50	50	50	50	50	100	50	50	
CVP	21	20	19	19	19	19	19	18		19	19	15	14	15	14	14	13	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150	150	1200
IVPB	50				50					50			375	125	25	25	25	600
Propofol	7.8	7.8	7.8	7.8	7.8	7.8	7.8	off		off	—	—	—					
Dopa	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3		7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	58.4
bolus										1000 LR	—							
Colloids													350		350			700
TOTALS																		2558

OUTPUT

	HOUR / TOTAL	5	10	10	10	9	10	10	42		175	210	165	360	440	320	200	440	2240
URINE	SP gr																		
	S/A																		
NG	OUTPUT			300 out															
	PH CT1							30			45				90				135
	CLIMAX CT2							30			0				0				0
EMESIS																			
STOOL																			
DRAINS	JP#1			20		10					20					80			28
	JP#2			40		30					50					50			100
TOTALS																			2503

POST-OP DAY

PAGE 3 OF 4

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	160	147/78	132/69	145/81	138/78	134/72	128/71	132/71
	160/99			130/63	124/61	128/60	124/60	124/65
		99	99	997				995
	127	123	120	126	117	117	116	115
	28	32	30	41	33	30	29	27
	97	95	95	96	98	99	99	99
	50	50	50	50	50	50	50	50
CVP	14	15	10	12	12	11	11	12

INTAKE

	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	160	160	150	170	1200
							350		350
	113	off	off						
									1550

OUTPUT

	16	17	18	19	20	21	22	23	
	0150 / 0715	220 / 470	350 / 645	230 / 915	260 / 1230	200 / 1430	300 / 1730	430 / 2168	2168
	220								
	100		90					45	135
	0		0					0	
	0							20	20
	90			27				10	127
									2470

RESPIRATORY THERAPY

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

LAB OBTAINED

	TIME									
	GLUCOSE									
	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 SUCTION

TIME									

24 HR TOTALS

NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
Po	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

MEDCOM - 18301

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	128/78	142/78	132/69	145/81	138/78	132/72	129/71	132/76
	120/70			130/62	124/61	128/60	124/60	121/65
	98	99	98	99				99
	127	123	120	126	117	117	116	115
	28	32	30	41	33	30	29	27
	97	96	95	96	98	99	99	99
	50	50	50	50	50	50	50	50
CVP	14	15	10	12	12	11	11	12

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													

INTAKE

	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	150	150	150	150	1200
							350		350
	1/3	off	off						
									1550

OUTPUT

	250 / 75	225 / 470	350 / 845	230 / 975	260 / 1230	200 / 1430	300 / 1730	438 / 2168	2168
	220								
	100		50					45	195
	0		0					0	
	0							20	20
	90			27				10	127
									2470

ACTIVITIES DAILY

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

TURN

TIME														

SUCTION

TIME														

24-HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDCOM - 18302

MF[illegible]AL RECORD-SUPPLEMENTAL MEDICAL [illegible]

For use of this form[illegible] R 40-66; the proponent agency is The Office o[illegible]rgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET blw-2

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

INITIAL SHIFT ASSESSMENT

			INTILA[redacted]	INTILAS	INTILAS
NEURO	TIME	2100			
	PUPLIS	3 R			
	SENSORIUM	Sedated c prop/fent			
RESPIRATORY	RESPIRATION PATTERN	unregulated/full			
	BREATH SOUNDS	Coarse			
	SECRETIONS	large, tan, blood tinged; Vent-SIMV			
SKIN	COLOR	NFR			
	INTEGRITY	1/2 cm around to back.			
IV SITE	LOCATION	(R) IJ / A line			
	CONDITION	CDI / (R) fem CDI.			
GASTRO	ABDOMEN	Clear, Firm			
	BOWEL SOUNDS	Ø			
GU	URINE COLOR/CLARITY	yellow clear			
CARDIOVASCULAR	CARDIACRHYTHM	SR - ST; Ø 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 - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted], SGT, LPN

DEPARTMENT/SERVICE/CINC ICU3

DATE 05SEPT03

PATIENT'S IDENTIFICATION *(For written entries give: Name — Last, First, middle; grade; [illegible]ity)* [redacted] CPT MW

EPW [redacted] blw-4

blw-1

- ☐ 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 - 18303

DATE 5 Sep 03 | DX GSW + chest | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	08	08	09	10	11	12	13	14	15	
	BP Arterial line	NA/84	142/73	NA/77	141/78	154/81	155/80	134/71	112/58	124/59		102/53	105/57	120/60	132/76	130/70	131/70	124/70	
	BP Cuff	150/77	154/68	132/68	138/66	142/71	150/73	140/69	115/57	127/67			122/57	124/64		124/61		126/70	
	Temperature			99.7				98.5									99.6		
	Pulse	121	120	115	106	97	105	105	96	121		109	103	102	99	98	95	99	
	Respiratory Rate	37	39	44	39	44	43	43	30	22		32	22	42	33	22	22	43	
	O Sats	92	96	97	97	98	96	98	99	97		98	100	98	98	97	98	99	
	FiO_2	60	50	50	50	50	50	50	50	50		50	50	50					
	CVP	10	10	10	9	10	10	10	10	8		9	10	10	10	10	9	8	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	1200
	IVPB					50				50			250	300					550
	Propofol									5.7	5.7	7.8	7.8	7.8	7.8	7.8	7.8	7.8	55
	Dopa																		
	BOLUS																		
	COLLOIDS																		
	TOTALS									1405									1405

OUTPUT		HOUR / TOTAL	260/260	140/400	222/622	230/852	160/1012	110/1122	110/1232	130/1362	130/1492		80/1570	130/1700	260/1960	40/2000	200/2200	130/2330	100/2430	2430
	URINE	SP gr																		
		S/A																		
	NG	OUTPUT																		
		~~PH~~ CT1			70			75			145			120						120
		~~GUIAC~~ CT2						0						60						120
	EMESIS																			
	STOOL							small x1												
	DRAINS	JP 1					18				18					15				15
		JP2					8				9					5				5
	TOTALS										171									3170

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23
T				99.0				99.8
P	99	99	89	92	88	94	87	87
R	24	23	24	25	31	34	25	24
BP	100/50	98/45	97/45	95/50	96/50	97/50	99/50	98/50
CVP	8	12	12	8	8	8	8	9

RESP DIAT ATORY	TIME	0400	1900						
	MODE	SIMV	SIMV						
	F_IO_2	50%	50						
	TV	550	550						
	RATE	22	22						
	PEEP	10	6						
A	pH	7.34							
A	PCO_2	47.0							
B	pO_2	78							
B	HCO_3	25							
G	SAT	94							
G	BASE	0							

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

INTAKE	16	17	18	19	20	21	22	23	8°T
IV	50	50	50	50	50	50	50	50	400
PB	50						250/50	100	450
Ext	5	5	5	5	5	5	5	5	40
NG	7.8	7.8	7.8	10	10	10	10	10	76
	100								
TF					100				100
TF Residual					50				100

OUTPUT	140	250/390	125/390	90/600	60/600	40/800	60/800	150/1040	1040
	XDCX								
Ct			100						100
	XDC V								
	XDC X								
									1140

ACTIVITIES DAILY LIVING	TIME	1900								TIME
	MOUTH CARE	1900								
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN: 1900

SUCTION

24 HR 1800 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

WT Yesterday ____ wt Today ____

INTAKE: IV 4210 ; PO ____ ; TOTAL ____

OUTPUT: Urine: 4481 ; ____ ; TOTAL ____

BALANCE -271

10 to 2

MF[redacted]L RECORD-SUPPLEMENTAL MEDICAL D[redacted]
For use of this form[redacted] 40-66; the proponent agency is The Office of [redacted]rgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

blw-2

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

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS	1830	INTILAS		INTILAS
NEURO	PUPLIS			Pupils Equal 2mm. GCS 4T.			
	SENSORIUM			Pharmacologically sedated c			
				Fentanyl / Propofol. Responds			
				to pain @ gag reflex. Moves			
				head when suctioning.			
RESPIRATORY	RESPIRATION PATTERN			Vented ETT 7.0 @ 26cm teeth			
	BREATH SOUNDS			SIMV 22, 550, 45%, Ve. Sats			
	SECRETIONS			96 or > Slightly over breath			
				vent. 26/22. Rhonchi all lung			
				fields. Small amts of thick			
				yellow secretions @ ETT @ Patchet			
SKIN	COLOR			WNL, Warm, dry. Frag ile			
	INTEGRITY			Dft edema. Incision abd.			
				staples intact. Sutures where			
IV SITE	LOCATION			old CT was @ lat chest.)			
	CONDITION			@ IJ TLC. Proximal to CVP			
				Medial to Propfol, Distal c MIVF			
				: Fentanyl @ groin A-line. CVP			
				: A line zeroed. Dressing CDI.			
				@ groin oozing serous drainage			
GASTRO	ABDOMEN			from old Cordis. NGT to @			
	BOWEL SOUNDS			nares clamp x to feed. @ BM.			
				Tight abd. UTA tenderness.			
				Bandage c no drainage to RUQ.			
GU	URINE			Foley to OD. OK yellow			
	COLOR/CLARITY			clear urine.			
				Hyperactive BS x4			
CARDIOVASCULAR	CARDIACRHYTHM			SR c ectopy. S1 S2. Radial			
				Pedal pulses 2+. Cap refill < 3sec.			
				Anasarca 3+ pitting. Oozing @			
				some old blister sites @ Dorm			

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 | DATE 6 SEP 03

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

- ☐ 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 16 Sep 03 DX GSW to Chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	157/89	141/84	134/88	146/89	164/84	182/87	127/62	113/60		115/66	103/58	124/68	111/62	114/62	134/76	130/70	125/71	
BP Cuff	143/74	129/59	129/59	144/77	120/60	118/60	113/58	111/57			105/52		110/57		122/65		117/60	
Temperature					99.1					99.2				99.2				
Pulse	96	82	91	97	75	87	105	89		86	95	81	85	88	85	74	72	
Respiratory Rate	32	25	31	32	30	42	52	36		25	32	22	27	27	26	22	24	
CVP		12	11	12	15	15		10		8	9	6		12	16	16	17	
FIO2	50	50	50	50	50	50	50	50										
SaO2	99	98	98	99	94	91	99	100		100	98	100	100	99	100	100	100	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½+20K	50	50	50	50	50	50	50	50	400	100	100	100	100	100	100	100	100	600
IVPB							50		50			360	150	100				400
Fent	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	40
Prop	10	10	10	10	10	10	12	14	84	15	15	15	15	15	15	15	15	120
																		1380
TF			100				100		200			100				50		150
Svhs																		
Free H2O																500	1000	1500
TF Residual			50				20					100				50		3
TOTALS									774									3330

OUTPUT

		HOUR / TOTAL	90/90	140/230	200/430	160/590	130/720	90/810	120/930	50/980	480	50/50	50/100	40/140	120/260	80/340	22/362	16/378	40	468
URINE		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS	CT		160				70				230		50				50			100
TOTALS											1240									568

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
Art	120/70	120/67	134/63	154/76	150/79	100/83	168/80	114/59
cuff	114/63		123/57	137/67	145/69		146/74	110/49
(R)	97.8				98.6 (A)			
pulse	88	92	81	74	82	83	67	94
RL	22	23	24	24	28	35	26	27
CVP	17	9	8	10	10	13	13	12
Fan	45		95	45	45%	45%	45%	45%
SpO2	100	96	99	98%	96%	96%	95%	94%

INTAKE	16	17	18	19	20	21	22	23	8°T
MIVF	100	100	100	125	125	125	125	125	1240
IVPBs							150	200	350
Gent	5	5	5	8.5	2.5	2.5	2.5	2.5	34
prop	15	15	15	15.6	16.4	17.6	17.6	17.6	129.8
bolus									
TF						100			100
boluses									
H2O						50			50

TF residual: 5

OUTPUT	16	17	18	19	20	21	22	23	
	100/100	110/210	35/245	50/343	35/378	54/432	120/552	70/622	622
CT		150							
CT		150						150	300

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0400	1230	5
		MODE	SIMV	SIMV	SIMV
		F_iO_2	50%	45%	45%
		TV	550	550	550
		RATE	22	22	22
		PEEP	6	6	6
ABG	A	pH	7.38	7.40	
		PCO_2	44.8	37.3	
	B	pO_2	77	73	
		HCO_3	27	23	
		SAT	95	95	
	G	BASE	2	-1	

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

ACTIVITIES DAILY LIVING	TIME	0400	2100
	MOUTH CARE	✓	✓
	BATH		✓
	SKIN CARE	✓	✓
	FOLEY CARE	✓	✓
	TRACH CARE		
	ROM EXERCISES		
	Linen Δ		✓

TURN / SUCTION — TIME: [redacted] 1900; [redacted] 2130

24 HR TOTALS

WT Yesterday: ____ wt Today: ____

INTAKE		OUTPUT	
IV	5188	Urine:	2070
NGT/PO	500	CT	960
TOTAL	5688	TOTAL	3030

BALANCE +2658

NURSE'S SIGNATURE [redacted] INITIALS

D16-2

ME[redacted] L RECORD-SUPPLEMENTAL MEDICAL [redacted]
For use of this form[redacted] 40-66; the proponent agency is The Office of [redacted] rgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME	2400	INITIAS [redacted]	1900	INITIAS [redacted]		INITIAS
NEURO		PUPLIS			2+ Sluggish			
		SENSORIUM			Sedated c pupil + fonts Lt eye			
					sqient c pain/sx			
					& LE movement -			
RESPIRATORY		RESPIRATION PATTERN			small paradoxical			
		BREATH SOUNDS			movement - No change.			
		SECRETIONS			clear, trace, blood			
					tinged i ETT seen			
					lip.			
SKIN		COLOR			NFR			
		INTEGRITY			ML incision, CDI c/t			
					P puncture sites -			
I V SITE		LOCATION			(R) IJ TLC	(R) Fem Aline		
		CONDITION			CDI	CDI		
GASTRO		ABDOMEN			Flat, hyperactive			
		BOWEL SOUNDS						
GU		URINE			dk yellow clear			
		COLOR/CLARITY						
CARDIOVASCULAR		CARDIACRHYTHM			SR - ST, ϕ ectopy			

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)

PR[redacted] Signatur[redacted]

DEPARTMENT/SERVICE/CINC ICU-3

DATE 07Sep03

PATIENT'S INDICATIONS *(For typed or written entries give: N[redacted] First, middle; grade; date; hospital or medical facility)*

EPW #[redacted]

- ☐ 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 - 18309

DATE 07Sep03 DX GSW chest

HOSPITAL DAY

VITAL SIGNS	TIME	24	01	[illegible]	04	05	06	07		08	[illegible].0	11	12	13	14	15	
	BP Arterial line	132/77	141/78	138/78	135/79	122/66	117/65	124/72		123/69	145/78	157/81	134/74	136/73	127/71	136/80	130/82
	BP Cuff	120/60	125/65	121/60	113/58	116/62	113/50	112/51		137/67		154/61		130/60			129/65
	Temperature	96.7(A)				96.3(A)	96.4										
	Pulse	89	86	87	83	83	77	77	78	88	81	87	89	87	81	87	86
	Respiratory Rate	24	28	30	29	25	26	22	26	24	28	32	28	27	23	27	31
	SaO_2	98	94	93	97	97	94	99	98	93	94	93	97	98	97	97	94
	FiO_2	45%	45%	45%	45	45	45	45	50	45	50	50	50	50	50	50	50
	CVP	9	13	14	16	10	6	6	8	14	15	7	9	9	10	11	11

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	D5NS ⊂ 20KCl	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
	Fentanyl	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	20	2.5	2.5	3.0	3.0	3.0	3.0	3.0	3.0	21
	Propofol	21.5	21.5	21.5	21.5	22.0	22.0	23.0	16.1	129.6	16.1	20	20	22	22	22	22	22	176
	NPB					50				50				350					350
										1279.6									
	TF	100				100				200		200				200			400
	H_2O	40				30				70									
										1									
	TF Residuals	returned 55				Returned 75				1549.6		90					50		1948
	TOTALS									1549.6									1948

OUTPUT		HOUR / TOTAL	30/30	60/90	60/150	70/220	65/285	70/355	45/400	32	40	54	60/110	30/140	90/230	45/275	35/310	60/370	30/400	400
	URINE	SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	CT							135		135					80				
	TOTALS										560									400

POST-OP DAY

	16	17	18	19	20	21		23
VITAL SIGNS								
	124/62	160/80	147/62	154/64	142/82	135/79	145/79	144/67
		149/65		148/64	133/57	149/60		123/57
T	97.2					97.6		
Pulse	88	91	81	78	88	73	95	89
RR	22	38	22	20	20	26	25	25
SaO2	96	98	94	96	96	97	99	94
FiO2	50		50	50	50	50	50	50
CVP	12	9	7	9	9	9	9	9
INTAKE	14	17	18	19	20	21	22	23	8°T
MIVF	125	125	125	125	125	125	125	125	1000
Feni	3,0	3,0	3,0	3	3	3	3	3	24
TPN	22	22	18	22	22	22	22	22	110
IVPB		1600				100	250		1350
TF	100					100			200
H2O									
Residual	20					50			1854
OUTPUT	40	65	165	405	345	465	545	635	635
CT			140				60	190	
									1875

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0415	0900
		MODE	SIMV	SIMV
		F_iO_2	45	50
		TV	554	550
		RATE	22	22
		PEEP	6	6
ABG	A	pH	7.36	7.415
	B	PCO_2	41	35.7
		pO_2	65	84
		HCO_3	25	23
	G	SAT	92	97
		BASE	0	-2

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

ACTIVITIES DAILY LIVING	TIME
	MOUTH CARE
	BATH
	SKIN CARE
	FOLEY CARE
	TRACH CARE
	ROM EXERCISES
	Linen △

TURN SUCTION	TIME
	2100
	0330

24°1800 TOTALS

WT Yesterday ____ wt Today ____

INTAKE 6340

IV ~~3760~~

Po 2

TOTAL ____

OUTPUT

Urine 4785

2

TOTAL ____

BALANCE +4557

NURSE'S SIGNATURE [redacted] INITIALS

blue 2

All

M[illegible] L RECORD-SUPPLEMENTAL MEDICAL
For use of this form[illegible] R 40-66; the proponent agency is The Office of [illegible]rgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0700	INITIALS [redacted]	1900	INITIALS	[redacted]	INITIALS [redacted]
	PUPLIS	Perrl 3mm sluggish, responsive to physical stimuli		PERRL A x 2 (B).			
	SENSORIUM	sedated c propofol, pain mgt c fentanyl, moves bilat, PURE movement noted shoulders & LE movement		Continues sedated c propofol + fentanyl; (+) head/foot movement c pain/stx. & LE movement			
RESPIRATORY	RESPIRATION PATTERN	[illegible] regularized c SIMV flow SIV peep 6, VE 550, RR 22		equal rise/fall; LS coarse (B); thick secretions			
	BREATH SOUNDS						
	SECRETIONS	ETT #7.5 c mod lip. not overbreathing vent. milky/yellow mod-lg orals secretions, thick tan tracheal secretions from ETT suctioning.		ETT 21cm @ lip; vent weaning & in progress; current SaO2 @ 95% c 40% FIO2.			
SKIN	COLOR	appropriate for race.		NFR; mult surgical sites weeping SIS fluid.			
	INTEGRITY	see progress note					
I V SITE	LOCATION	(R) IJ TL and patent		(R) IJ		(R) femoral line	
	CONDITION	(R) fem - d/c'd		COT		CDT	
GASTRO	ABDOMEN	firm, mildly distended		flat, firm			
	BOWEL SOUNDS	(+) BS, NG (R) nare clamped. Q8h Hans per.		(+) BS, NG clamped for bolus feeds.			
GU	URINE	FTG QS		FTG - tea colored.			
	COLOR/CLARITY	tea colored					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR c ectopy, S, S2, brady palpable radial pulses bilat, +2 pedal pulses, gen. edema. Hemaphor.		S+ c SR; ectopy pulses weak all ext's.			

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

(Continue on reverse)

PREPA[illegible] Title) [redacted]

DEPARTMENT/SERVICE/CINC

DATE 8 Sep 13

PATIENT [illegible] written entries give: Name — Last, First, middle; grade; date; hospital or [illegible] facility)

EPW [redacted]

- ☐ 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 - 18312

DATE 8 Sep 03 DX SIP c w Chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line	151/72	152/76	146/70	142/74	153/75	137/63	142/74	141/65		146/73	132/55	129/54	114/58	112/57	114/55	122/63	131/60	
BP Cuff	135/66	135/70	133/64	124/53	142/75	149/65	149/65	129/61		136/58	126/49	126/49						
Temperature				97.9						98.5								
Pulse	91	84	71	96	91	92	83	73		76	83	86	92	99	80	77	68	
Respiratory Rate	23	27	22	25	27	23	22	22		22	22	26	24	22	22	22	22	
SaO2	97	97	93	97	96	93	96	95		96	94	94	93	93	97	96	100	
CVP	8	8	8	7	6	9	15	12		12	11	9	9	11				
FIO2	50	50	50	50	50	50	50	50		50	50	50	70	70	50	50	100	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5NS+20K	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
Fent	3	3	3	3	3	3	3	3	24	4	5	5	5	5	5	5	5	40
Prop	22	22	22	22	22	22	22	24	178	24	24	24	24	24	24	24	24	192
IVPB												300						300
TF	(100)				(200)					(200)				held				200
bolus														500 cc		(CR 1000 cc)		1500
(TF Residual)	50				25				(120)	40				50				(320)
TOTALS																		

OUTPUT

		HOUR / TOTAL	90 / 90	50 / 140	40 / 180	45 / 225	45 / 270	100 / 370	60 / 430	40 / 470		50 / 520	70 / 590	32 / 622	38 / 660	38 / 698	23 / 721	24 / 745	60 / 805	850
URINE	SP gr																				
	S/A																				
NG	OUTPUT																				
	PH																				
	GUIAC																				
EMESIS																					
STOOL							X1 (small)														
DRAINS	CT						40			40	60		50			80				170
TOTALS										(520)										(1020)	

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	142/63	119/64	124/69	135/66	137/64	135/70	122/57	157/84
					109/54	123/70	109/62	134/54
		987						
	73	88	75	83	74	67	74	92
	22	23	28	22	22	22	22	25
Sat	93	94	95	94	94%	94	98	98
	14	10		9	13	off	off	off
ap	75	75	75	100	60	80	60	60
		(MAG)			60	60	60	60
							KVO	200

INTAKE

	16	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
	5	5	5	5	5	5	5	5	40
	24	24	24	24	24	24	24	24	192
			(MAG)	60	60	60	60	60	250
							100	200	300
									1782

OUTPUT

	70/90	90/180	70/250	26/276	70/346	45/391	100/491	200/691	691
	40							120	1160
									1851

RESPIRATORY

	TIME		2400
	MODE		SMV
	F_iO_2		60
	TV		530
	RATE		22
	PEEP		8
ABG	A pH		7.39
	A PCO_2		40.6
	B pO_2		73
	B HCO_3		25
	B SAT		94
	B BASE		0

LABORATORY

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

ACTIVITIES OF DAILY LIVING

	TIME	0400
	MOUTH CARE	✓
	BATCH	✓
	SKIN CARE	✓
	FOLEY CARE	✓
	TRACH CARE	✓
	ROM EXERCISES	✓

TURN

TIME												
	2400	2400										
	0400											
	2100											

SUCTION

	2

24°180 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

WT Yesterday ____ wt Today ____

INTAKE: IV 6180 Po ____ TOTAL ____

OUTPUT: Urine: 2400 TOTAL ____

BALANCE +3780

DLW-2

M[illegible]L RECORD-SUPPLEMENTAL MEDICAL
For use of this form [illegible]R 40-66; the proponent agency is The Office of [illegible]urgeon General

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

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	07eb	INITIAS		INTILAS		INTILAS
NEURO	PUPLIS		Perrl 2mm sluggish				2 R (B) slow	
	SENSORIUM		arousable to physical				moves head to pain	
			stimuli, spont opens eyes				opens eyes; cont	
			mecs in and Shrugs				to Purposeful/fontzl	
			Shoulders on [illegible] Properly of bed chair					
RESPIRATORY	RESPIRATION PATTERN		ellen ventilated SIMV 60%				equal use/ full	
	BREATH SOUNDS		on PS VT 550 RR 22 on Breathing				Clear, secretions, tan,	
	SECRETIONS		+2 to 4/min Spo2 97-100%				blood tinged. ETT	
			Thick tan secretions occasional				26 cm @ teeth,	
			lung sounds PAP 40-60s.				lung sounds one, ↓ @	
			CTA (B) W/ bases & ETT 4 cm up				bases. (B); CT to ST	
SKIN	COLOR		appropriate for race.				NCR; one staple	
	INTEGRITY		[illegible] clot, sutures, staples				Surgical sites—wrapping	
			intact OTA, area red & slightly scarred				Sutures clean	
I V SITE	~~LOCATION~~		Serous drainage from base of incision				(R) IJ & TLC	(B) Fem
	~~CONDITION~~		PRN CT sites, redness/ swelling				CDT,	alone.
			drainage, external pump secured &				Cond., ↓	CDT, ↓
			mod-lg serous drainage (R) fem central plus site, lg serous drainage				3/4 g infusing	3/4 g infusing
	Location		RIJ TLC patent, (R) fem site					
	cond		patent.					
GASTRO	ABDOMEN		taut slightly distended				flat, hard; ML	
	BOWEL SOUNDS		Ø BS. NG (R) nare clamped				incision CDT &	
			NPO/Flatus				staples BS Ø; small	
							BM 3.	
GU	URINE		FTG QS				FTG QS	
	COLOR/CLARITY		tea colored				tea colored, clear	
CARDIOVASCULAR	CARDIACRHYTHM		NSR 3 ectopy, S&S, PVCs				ST, SR, Ø ectopy, ideto	
			+1 bilat radial pulses, +2 bilat				pulses, unk.	
			pedal pulses +3 UE & LE pitting					
			edema, scrotal edema, gen. 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 - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] (b)(6)-2 DEPARTMENT/SERVICE/CINC DATE 7 Sep 07

PATIENT'S INDICATIONS (For typed or written e... 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 9 Sep 03 | DX S/P C[illegible] to chest | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	144/75	106/85	159/73	154/72	130/71	129/63	112/54	141/71		129/57	109/62	138/64	137/61	144/68	125/58	109/54	114/53	
BP Cuff	124/56	142/56	134/57	134/57	125/51	113/46												
Temperature		96.0						97.1					97.8					
Pulse	82	69	74	74	87	83	83	89		85	90	92	63	104	98	100	106	
Respiratory Rate	25	23	17	22	22	22	22	24		24	28	24	24	26	25	22	22	
CVP	off	off	14	15	12	13	13	14		12								
fl02	60	60	60	60	60	60	60	60		60	60	60	50	50	50	100	70	
SAO2 %	100	100	98	98	99	99	100	100		97	100	100	98	99	98	98	99	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	124	125	125	125	1000	125	125	125	125	125	125	125	125	140
Fent	5	5	5	5	5	5	5	5	40	40	40	40	40	40	40	40	40	40
Prop	24	24	24	24	24	24	24	24	92	24	24	24	28	32	32	32	32	140
IVPB	288									100	60	360	60	60				480
TF						6				ϕ	200				250			450
Residuals															85			1160
TOTALS									1132									

OUTPUT

		HOUR / TOTAL	100/100	70/170	100/270	80/350	60/410	35/445	40/485	80/565	50	50/115	70/185	58/238	110/348	70/570	60/630	50/680	630
URINE		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		CT1						80			80	40		50				smear		90
TOTALS										645										700

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

POST-OP DAY	16	17	18	19	20	21		23	
	134/60	136/60	135/59	139/104	142/68	144/72	141/72	138/70	
				1					
				100.5					
	92	97	104	103	107	117	110	109	
	25	28	26	37	36	25	26	24	
FIO2	50	50	50	50	50	50	50	50	
Sat %	97	97	97	98	99	99	99	99	

RESPIRATORY

		TIME	0100	1200						
		MODE	SIMV	SIMV						
		F_1O_2	60	50						
		TV	550	550						
		RATE	22	22						
		PEEP	8	6						
ARTERIAL BLOOD GAS	A	pH	7.41	7.25						
	A	PCO_2	36.4	55.9						
	B	pO_2	98	112						
	B	HCO_3	23	25						
	G	SAT	98	97						
	G	BASE	-2	-2						

LABORATORY

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

INTAKE

	16	17	18	19	20	21	22	23	8°T
IVF	125	125	125	125	125	KVO	125	D5	1000
Pan	~~40~~ 5	~~40~~ 3	~~40~~ 3	7	7	7	7	7	50
Prop	32	32	32	24	24	24	24	24	216
IVPB	100								100
		held			held				
(cont)		158			150				1360

OUTPUT

	80	100/180	110/290	110/400	100/500	110/610	80/690	80/770	720
	85								85
									805

ACTIVITY / DAILY LIVING

	TIME	15			
	MOUTH CARE	✓			
	BATCH				
	SKIN CARE	✓			
	FOLEY CARE	✓			
	TRACH CARE				
	ROM EXERCISES				

TURN / SUCTION — TIME

24 HR TOTALS

WT Yesterday ____ wt Today ____

INTAKE: IV 1915; Po ____; TOTAL ____

OUTPUT: Urine: 1520; TOTAL ____

BALANCE +490

NURSE'S SIGNATURE | INITIALS

MEDCOM - 18317

ACLU-RDI 1646 p.77

DOD-031891

MEDICAL RECORD-SUPPLEMENTAL MEDICAL RECORD
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 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0630	INTILAS [redacted]		INTILAS	1830	INTIL [redacted]
	PUPLIS	2mm sluggish reac				2 mm sluggish	
	SENSORIUM	to to light. Seda				Responds to pain	
		ted/paralyzed respon				Stimuli	
		ds to pain stimuli					
		open eyes.					
RESPIRATORY	RESPIRATION PATTERN	Even, vent. SIMV				normal on SIMV 24,	
	BREATH SOUNDS	24 FiO_2 50% PEEP 8				TV 550, PEEP 8, FIO2 50	
	SECRETIONS	TV 550. Sats 96-99%				Thick clear wht	
		thick secretions via				ETT. Coarse BS bilat	
		ET tube. CT PRN suc					
		to cont. suctioning					
SKIN	COLOR	NFR. staples in abd.				NFR	
	INTEGRITY	well approx. no signs				Abd wound c ends well approx	
		of infection. Gene edema				staples intact → s/s inf.	
I V SITE	LOCATION	(R) IJ TLC. (R) femoral				(R) IJ TLC / (R) femAline	
	CONDITION	A-line no signs of				CDI	
		infection.					
GASTRO	ABDOMEN	Flat, tough. general				Flat, taut	
	BOWEL SOUNDS	edema. no BS				→ Bowel sounds	
		NG tube. (R) nare				NOT clamped.	
		clear. Residual q 4hrs					
GU	URINE	Foley to gravity.				Foley to gravity	
	COLOR/CLARITY	Tea colored urine.				dark yellow urine	
						adequate amount.	
CARDIOVASCULAR	CARDIACRHYTHM	NSR 5 ectopy +2				NSR. 5 ectopy	
		peripheral pulses x4				peripheral pulses palpable	
		pedal edema.				x4.	

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
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted] & Title → CPT/AN | DEPARTMENT/SERVICE/CINC ICU 3 | DATE 10 Sep 03

PATIENT [redacted] (For typed entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

[redacted]

- ☐ 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 - 18318

LTWU 61

DATE 10 Sep 05 | DX | PAGE 2 OF 4

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
		HOSPITAL DAY																	
	BP Arterial line	122/66	114/72	83/65	101/61	110/67	102/50	120/68	134/63		125/56	126/55	140/65	122/56	146/63	127/57	147/64	154/65	
	BP Cuff																		
	Temperature					98.5					100.2				99.9				
	Pulse	105	97	89	97	98	87	92	68		83	76	79	80	61	84	80	73	
	Respiratory Rate	25	26	25	30	22	24	24	24		24	24	24	24	24	24	24	24	
	SaO2	100	98	96	99	97	99	99	94		98	98	98	98	97	98	95	96	
	FIO2	50	50	50	50	50	50	50	50		50	50	50	50%	50%	50%	50%	50%	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125	125	
	Fent	7	7	7	7	14	12	12	12		12	12	12	12	12	12	12	12	
	Prop	24	24	24	24	24	24	24	24		24	24	24	24	24	24	24	24	
	IVPB										100		100	250					450
	TF						400			400	185 ~~100~~ 220								
										Resid									
	Residual				(100)														
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		80/80	70/150	30/180	190/370	50/420	40/460	50/510	160	70	50	46/96	70/166	80/246	85/331	65/396	55/451	53/504	526
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	CT	60				60			90						65				
	TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	[illegible]	23
	167/77	115/68	157/72	144/64	139/60	135/75	182/77	100/57
			97 (A)					
	77	80	77	79	82	75	83	93
	24	24	22	24	24	34	18	24
	94	95	94	96	92	93	91	96
	90%	80%	58%	58%	58%	57%	70%	70%

INTAKE

	14	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
	12	12	12	12	12	12	10	10	92
	24	24	24	24	24	24	24	24	194
	100						250	100	450
									173

OUTPUT

	100	100/200	80/350	70/320	50/400	45	110	130/690	690
GT			80						
									170

RESPIRATORY

	TIME													
	MODE													
	F_1O_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													

ACTIVITY

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

DAILY TESTING

TURN

TIME													
SUCTION													

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE | INITIALS

MEDCOM - 18320

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIAS [redacted]	b(6)-2	INITIAS	1900	INITIAS [redacted]
NEURO		PUPLIS	3mm R=L sluggish				3mm (R) (B)	
		SENSORIUM	arousable to physical stimuli moves head, shoulders & opens eyes spont. on occasion & follows simple commands.				opens eyes spontaneously & PRN; PERRL/Pupils for sedation.	
RESPIRATORY		RESPIRATION PATTERN	[illegible] ventilated on SIMV mode				equal rise/fall chest (B); clear	
		BREATH SOUNDS	SOL, PEEP 8, RR 24, VT 550				bilat; PEEP 8; RR; tracheostomy	
		SECRETIONS	mod tracheobronchial secretions thru ETT #7.5 cuffed lip. CTA (B) R lung base. CTA (R) clear to CS scant serous drainage @ air leak around				tracheostomy drainage	
SKIN		COLOR	appropriate for race				WNL; multiple surgical sites, oozing serosanguinous fluid.	
		INTEGRITY	multiple chest incisions, staples intact, no redness or drainage noted, no pressure areas					
IV SITE		LOCATION	RIJ TL portal				(B) SC	(B) Fem
		CONDITION	A-line in patent, clear, TIVEP				Cont TLC; CDI; Clear	Plate CVL Clear
GASTRO		ABDOMEN	firm, slightly distended				flat, firm; Hyperactive BS; G-tube to gravity	
		BOWEL SOUNDS	active BS, LBG @ mare OCCS.					
GU		URINE	Clear amber FTG QS				yellow; FTG clear	
		COLOR/CLARITY						
CARDIOVASCULAR		CARDIACRHYTHM	NSR ectopy, S, SR; +radial pulses, +pedal pulses, sclera & scrotal edema, [illegible] +3 pitting edema, thready				SR-ST; ectopy; pulses unchanged	

b(6)-2

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)

[redacted] CPT MAN | DEPARTMENT/SERVICE/CINC ICU3 | DATE 11 SEP 03

P[illegible]S INDICATIONS *(For typ[illegible] written entries give: Name—Last, First, middle; grade; date; hospital or mec[illegible] 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 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		0	11	12	13	14	15	
BP Arterial line	105/54	107/68	10?/51	137/50	133/63	147/69	108/54	130/59		138/64	134/64	167/76		124/58	120/66	131/61	117/54	
BP Cuff																		
Temperature	100.7				100.8			100.4						98.8				
Pulse	95	82	91	95	89	92	106	93		88	89	89		~~157~~ 119	100	105	103	
Respiratory Rate	44	34	24	47	24	43	24	24		24	24	24		24	24	24	24	
O2 Sats	97	95	95	95	95	93	97	95		95	96	94		100	100	100	97	
FIO2	55	55	55	50	50	50	80%	80%		50%	50%	50%		100	70	60	50	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125		100	100	100	100	975
IVPB	100								100	100		200						
Propofol	26	26	26	26	26	26	26	26	208	26	26	26		27	27	25	25	182
fentanyl	15	15	15	15	15	25	15	15	105	15	15	15		10	10	10	10	
tube feeds	400					400												
H2O						50												
TOTALS																		

OUTPUT

	HOUR / TOTAL	60	80 / 140	30 / 170	35 / 205	75 / 280	90 / 370	30 / 400	38	438	52	70	80		50	44	420	600	1316
URINE	SP gr																		
	S/A																		
NG	OUTPUT	40					return 35	cd				300							
	PH																		
	GUIAC																		
EMESIS PEG																			
STOOL																			
DRAINS	CT							125			15								130
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	168/46	120/55	122/56	132/42	134/54	114/59	135/54	142/62
						100.7		
	99	105	99	93	97	94	94	96
	24	24	24	24	24	24	24	24
	97	99	98	96	97	99	97½	97½
	60	60	60	70	70	50	50	50

INTAKE

	16	17	18	19	20	21	22	23	8°T
	100	800	100	100	100	100	100	100	800
	150	-					200	100	450
	25	168	168	16	14	16	16	16	140
	10	10	10	10	10	6	6	6	68

OUTPUT

	400	220	365	150	130	120	80	100	
	15							15	30

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									
	GLUCOSE									
	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

TIME									

SUCTION

24°100 TOTALS

NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

MEDCOM - 18323

ACLU-RDI 1646 p.83

DOD-031897

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 [redacted] SMENT

NEURO	TIME	1900	IN [redacted]	1665-2	INTILAS		INTILAS
	PUPLIS	3R					
	SENSORIUM	Alert; Sedated c Propofol/Fent					
RESPIRATORY	RESPIRATION PATTERN	equal use/full					
	BREATH SOUNDS	Dane (B)					
	SECRETIONS	large clear secretions amt tube; tan/brown secretions in trach					
SKIN	COLOR	NPR					
	INTEGRITY	mult sm. sites weepin serum fluid					
IV SITE	LOCATION	Dist. RLC (P) Rem					
	CONDITION	Cath Aline					
		ODT ODT					
GASTRO	ABDOMEN	Flat					
	BOWEL SOUNDS	+					
		Mt incisin Closed & bulb drsng					
GU	URINE	yellow					
	COLOR/CLARITY	clear					
CARDIOVASCULAR	CARDIACRHYTHM	ST-SR.; ø 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 - Iracheostomy

(Continue on reverse)

PR [redacted]

DEPARTMENT/SERVICE/CINC

DATE 2 Sep 2

PATIENT'S IN[redacted] *(For typed or writte[redacted] middle; grad[redacted] medical facility)*

[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 12 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line	115/69	117/55	125/61	117/57	123/60	116/55	122/60	115/59		123/61	105/52	112/52	121/58	116/64	119/56	113/55	123/65	
BP Cuff																		
Temperature	100				101.2			99.9						99				
Pulse	109	102	99	97	101	97	101	97		96	100	99	98	94	100	105	98	
Respiratory Rate	24	24	24	24	27	30	23	24		24	30	23	23	23	28	29	24	
SaO2	99	99	97	97	97	93	98	98		96	99	97	96	96	97	98	95	
FiO2	50	50	50	50	60%	50	50	50		50	50	50	50	50	50	50	50	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
Prop	25	25	25	24	27	25	25	25	204	25	25	25	25	25	25	25	25	200
Fent	7	7	7	7	7	7	7	7	56	7	7	7	2	2	2	7	7	56
IVPB	50	50							100	150		250	200					500
TF										200				200				400
TOTALS									1160									1956

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE			70	40 / 110	40 / 150	60 / 210	135 / 345	70 / 415	80 / 495	90 / 585	545	20 / 20	100 / 120	80 / 200	50 / 250	50 / 300	70 / 430	120 / 550	120 / 670	650
	SP gr																			
	S/A																			
NG	OUTPUT																			
	PH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS	CT							50		50						170				100
										605										
TOTALS																				750

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
Acute care	134/60	114/63	112/63	N9/72		151/71	N/A 126	
T	98	100.2						
Pulse	98	94	90	97		101	106	
RR	23	23	24	24		24	26	
Sats	95	100	100	99		95	92	
FiO2	50	50	50	50		50	50	

INTAKE	16	17	18	19	20	21	22	23	8°T
IVF	100	100	100	100	100	100	100	100	800
IV-P	25	25	25	25	25	25	25	25	400
Feeds	7	7	7	7	7	10	10	10	75
IVPB	150						100	200	450
TF	Hold				200				200

OUTPUT									
	100/100	120/220	50/270	60/330	100/430	100/530	200/730	200/930	930
									1725
	50							50	
									980

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
AA-G	pH								
	PCO_2								
	pO_2								
	HCO_3								
	SAT								
	BASE								

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

ACTIVITY/DAILY LIVING	TIME								
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN / SUCTION	TIME								

24 HOUR TOTALS

WT Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	3681	Urine:	~~2335~~
Po			
TOTAL	3681	TOTAL	2335
BALANCE		(+)	1346

NURSE'S SIGNATURE | INITIALS

[redacted]

bw 2

ME RECORD-SUPPLEMENTAL MEDICAL D
For use of this form s 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	0700	INTILAS [redacted]	INTILAS	1830	INTIL [redacted]
NEURO		PUPLIS	Perrl 3mm sluggish			2 mm sluggish Perrla	
		SENSORIUM	increasingly more alert, spont opens eyes, follows commands, attempts to mouth words, moves UE spont, localizes pain			Increased alertness; responsive to tactile stimuli	
RESPIRATORY		RESPIRATION PATTERN	assist control ventilation			normal on SIMV 20,	
		BREATH SOUNDS	peep 8, VT 550, RR 24 spont 10's, crackles L>R lower lobes - trace amt secretions thru #8 shiley.			TV 600, Peep 5, FIO2 40%	
		SECRETIONS				O2 sats >95%	
						BS coarse but improved @ CT	
						Secretions - copious thin yellow	
						thru trach -	
SKIN		COLOR	appropriate for race.			NFR. Pressure sores	
		INTEGRITY	no prop for wt.			over occiput x2. ABD wounds in	
IV SITE		LOCATION	LIJ TLC today and patent			(2) IJ TLC c cordis	
		CONDITION	(R) fem a-line			CIPII	
						(R) femoral art line -	
						site clean, dry & Int	
GASTRO		ABDOMEN	firm slightly distended			firm. Montgomery straps	
		BOWEL SOUNDS	hyper BS LLQ midline incision noted. Covered dressing w/ intact drainage. Ostomy intact			over abd wound.	
						BS hypo.	
GU		URINE	FTG QS. amber			dark yellow / clear	
		COLOR/CLARITY	clear			adequate UOP via foley	
CARDIAC		CARDIAC RHYTHM	NSR - ST c ectopy & SB,			NSR c ectopy	
			H radial, p bilat T2 pedal,			peripheral pulses	
			plan CPM, gen edema,			palpable.	
			moved, [redacted]				

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)

[redacted]

b(6)-2

PATIENT'S INDICATION [redacted] DEPARTMENT/SERVICE/CINC DATE

middle; grade; date; hospital [redacted] Name—Last, First,

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 - 18327

DATE 13 Sep

DX

HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line	123/54	16/14	145/65	134/72	125/54	169/79	149/90	135/66		130/61	127/57	121/55	128/62	135/65	135/65	140/63	148/25	
BP Cuff																		
Temperature								99.2						98.3				
Pulse	100	112	102	90	91	104	105	102		95	92	87	88	86	90	94	85	
Respiratory Rate	23	24	24	24	24	22	23	24		26	25	23	23	26	25	25	25	
SaO2	97	93	95	96	98	100	98	96		100	99	99	100	100	100	100	100	
FiO2	50	50	50	50	50	50	50	50		50	40	40	40	40	40	40	40	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	100	100	100	100	100	100	100	100		100	100	100	50	50	50	50	50	
Prop	29	29	29	29	29	29	29	29		29	29	29	29	29	29	29	29	
Fent	12	12	12	12	12	12	12	12		20	30	30	20	20	20	20	20	
IVPB	100	50								50		200		55	55	55		
TF	400				400					400				500				
TOTALS																		

OUTPUT

		HOUR / TOTAL	300/300	300/600	200/800	180/980	80/1060	60/1120	80/1200	150		190	150	75	139	200	280	140	110
URINE		SP gr																	
		S/A																	
NG		OUTPUT																	
		PH																	
		GUIAC																	
EMESIS																			
STOOL																			
DRAINS	CT							0										D/C	
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
V	141	140	136	141	132	147	132	133
I	71	68	68	73	65	69	61	69
T				86				
A	85	92	89	86	90	93	92	89
L	22	27	22	20	21	20	22	21
S	98	95	95	96	95	99	100	100
	40	40	40	40	40	40	40	40

RESPIRATORY

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

INTAKE

	16	17	18	19	20	21	22	23	8°T
	50	50	50	50	50	50	50	50	400
	29	29	29	29	29	29	29	29	232
	20	20	20	20	20	20	20	20	160
TF	400				500				900
KCL					5 Refer				

OUTPUT

	15	16	17	18	19	20	21	22	23	8°T
		265	310	310	170	630	615	705	705	
Foley	Incis	→				5				5

LABORATORY

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

ACTIVITY / 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

MEDCOM - 18329

ACLU-RDI 1646 p.89

DOD-031903

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

REPORT TITLE

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

INTENSIVE CARE NURSING FLOW SHEET 1-16-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0630	INITIAS [redacted]	1900	INITIAS [redacted]		INITIAS
NEURO	PUPLIS		3mm sluggish PERRL		3mm PERRL Sluggish			
	SENSORIUM		responsive to tactile		Moves BUE > R. Ø movmt			
			Stimuli + verbal		BLE. Head weak. language			
			Alert.		barrier (+) trach. Alert.			
					Agitated/aggressive			
RESPIRATORY	RESPIRATION PATTERN		normal SIMV 20		Regular, even. Frequent			
	BREATH SOUNDS		TV 600. PEEP 8 FiO_2 40%		coughing. Occasional red/			
	SECRETIONS		lungs rhonchi sucks		pink secretions from trach.			
			up son - thick		Clear to yellow thick secretions			
			clear mucous.		from around trach. Collar inflated.			
					Trach collar 100% humidified O2.			
SKIN	COLOR		NFR. Prevalent sites		Rhonchi all lung fields. #8 Shiley			
	INTEGRITY		occiput x2 Abd wound		NFR, Tight, fragile.			
			dressing change q shift		Weeping in areas. D on 2			
IV SITE	LOCATION		(R) IJ TLC c cordis.		to posterior head (blood). Wounds to			
	CONDITION		CDI. (R) femoral		(L) lower lateral leg. black & white			
			q line, CDI.		on upper mound. Drainage			
					old blister to (L) anterior FA.			
					drainage Cordis (L)			
					subclavian c TLC @ 22cm.			
GASTRO	ABDOMEN		firm, mound lovely		@ groin A-line zeroed. good			
	BOWEL SOUNDS		Bruits bad. BS ~		waves & box. Dressing CDI.			
			hypo.		Firm c mL incision. W-S			
					dressing Δ. To (L) of incision a			
GU	URINE		Foley		G-tube. ABS x4. BM x1			
	COLOR/CLARITY		dark amber		soft. Brown. Foley to DD			
					Clear/yellow. Second			
CARDIOVASCULAR	CARDIACRHYTHM		NSR to STach @ echopy		ST. ectopy. S, S2.			
			peripheral pulses ↓		Radial/Pedal pulses 2+			
					Capefill < 3 sec 3+ Anasarca			
					Slight pain			

LEGEND

Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_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 14Sep03

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

[redacted]

b(0)-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 - 18330

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	125/108	136/89	126/89	129/63	124/	111/	106/54	121/62		140/62	125/59	169/	140/71	152/78	141/70	134/66	136/67	
BP Cuff	99					99	99	99.5										
Temperature																		
Pulse	88	91	91	89	94	104	105	95		99	106	101	112	109	116	117	121	
Respiratory Rate	20	20	21	20	19	29	20	22		24	24	24	18	24	31	20	35	
O2 Sats	100	94	100%	100%	100%	100	100	100		100	98	100	100	98	100	100	100	
mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	MASK	MASK	MASK	MASK	MASK	
FiO2								40%		40%	40%	40%			40%			

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	50	50	50	50	50	50	50	50		50	50	50	25	25	25	25	25	275
IVPB	100	100	50							150		250	100					500
Propofol	29.4	29.4	29.4	29.4	29.4	29.4	29.4	29.4		29.4	29.4	29.4	OFF					
Fentanyl	10	10	10	10	10	10	10	10		10	10	10	10	10	10	OFF		
LF	500				500					500				500				
H2O																		
Residual										40cc				25cc				
TOTALS																		

OUTPUT

	HOUR / TOTAL	50	100	150	340	460	540	588	588	643	720	975	1075	1180	1205	1320	1440	1440
URINE	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
Res. DRAINS		5				5							X1					
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21		23
	14/68	134/62	141/67	127/56	128/56	150/73	139/64	
		101.0		100.3 (R)		101.0	101.6 (R)	
	114	118	110	112	108	123	117	
	20	20	25	39	39	31	27	
	99%	100%	100%	100%	100%	99%	99%	
	MASK	MASK	MASK	TC	TC	TC	SIMV	SIMV
							40%	40%

INTAKE	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
	150							200	350
							4	8.4	12
	500				500				1000
					60				60
	25				returned 30cc				

OUTPUT	100	120 / 220	110 / 330	110 / 440	310 / 750	236 / 986	420 / 1406	280 / 1436	1436
	X1	X1		X1					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME		10	20
	MODE		MASK	TC
	F_iO_2		40%	
	TV			
	RATE			
	PEEP			
ABG A	pH		7.42	7.46
ABG B	PCO_2		42.1	40.5
ABG B	pO_2		71	78
ABG B	HCO_3		28	29
ABG G	SAT		94%	96%
ABG G	BASE			

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

DAILY ACTIVITIES	TIME										
	MOUTH CARE	KH 1945									
	BATH	KH 1945									
	SKIN CARE	KH 1946									
	FOLEY CARE	KH 1915									
	TRACH CARE	KH 1915									
	ROM EXERCISES	KH 1915									

TURN	TIME										
SUCTION		1900	2300								
		2000									
		2100									
		2200									

24*180 TOTALS

NURSE'S SIGNATURE

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

[redacted] AN

[redacted]

MEDCOM - 18332

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 ASSESSMENT

	TIME	0600	INITIALS [redacted]	1845	INITIALS [redacted]		INITIALS
NEURO	PUPILS	pupils RTL. PERL		Perrl 4mm, brisk. Alert.			
	SENSORIUM	Awake. Appears		Mouths words. Obeys hand			
		aware of surroundings		gestures. Moves BUE			
		follows commands		& >R, turns head. Ø			
		Confusion —		movmt in BLE. Sensation intact			
RESPIRATORY	RESPIRATORY PATTERN	RR even, unlabored		BUE. T Trach #8. Trach			
	BREATH SOUNDS	Lungs clear. LS Ø,		collar ō humidified O2			
	SECRETIONS	Trace thick yellow		@ 40%. RR 28-30. Unlabored			
		secretions via trach		even regular. CTA			
		on 40% T collar		all lung fields ↓ RLL.			
		SpO2 94%. RT					
SKIN	COLOR	multiple ecchymotic areas		NTP. Pressure sore on buttocks			
	INTEGRITY	BUE. IV sites WDI		& head, black. Pressure sore			
		blister on R ear		@ hip. Wound @ lateral lower			
IV SITE	LOCATION	R SCC, cordis		leg w/ dressings. Warm-dry			
	CONDITION	RSG. open, intact		fragile. Old blister R ear ō			
		Nursing Note		PP, dry. T cordis ō TLC @			
		R SCC, RR @		22cm to @ subclavian.			
		Swan, A-line		Cordis infusing 25cc D5 ½NS			
		and triple lumen		@ 20 cc/hr. A-line @ femoral			
GASTRO	ABDOMEN	normal, soft		revoed ō good waveform.			
	BOWEL SOUNDS	soft, active		mL incision ō WD dressings.			
		RUQ. PEG tube		tight. NBSx4. G-tube to @			
		site, mild		of incision medial.			
GU	URINE:	redness around		Foley to DD clear			
	COLOR/CLARITY	meatus. Pt to BSC		yellow urine, Ø drainage			
		voiding ō assist		from meatus.			
CARDIOVASCULAR	CARDIAC RHYTHM	T-wave on monitor		SR-ST ō ectopy.			
		Pt noted to		S1 S2. Anasarca 2-3+.			
		have bounding		Radial pulses 2+, pedal pulses			
		pulses. Mild		3+. Caprefill <3sec			
		generalized edema					
		noted. Electronically					

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)

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

DEPARTMENT/SERVICE/CLINIC: ICU 3

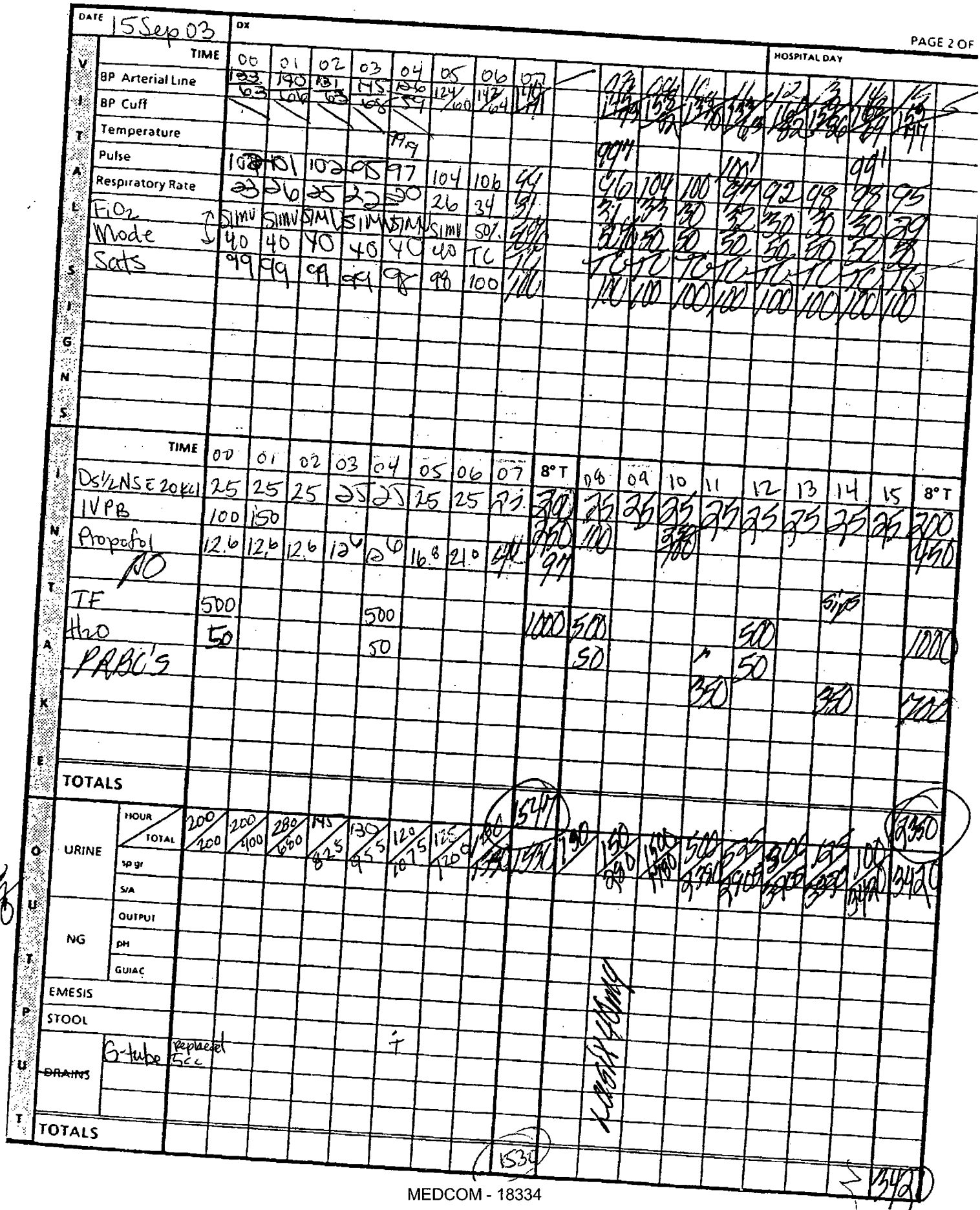
DATE: 15Sep03

PA[redacted] (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


DATE 15 Sep 03
DX
PAGE 2 OF
HOSPITAL DAY
VITAL SIGNS
TIME
BP Arterial Line
BP Cuff
Temperature
Pulse
Respiratory Rate
FiO2
Mode
Sats
INTAKE
Ds½NS E 20KCl
IVPB
Propofol
TF
H2O
PABC's
TOTALS
OUTPUT
URINE
HOUR
TOTAL
sp gr
S/A
NG
OUTPUT
pH
GUIAC
EMESIS
STOOL
DRAINS
G-tube
replaced
TOTALS

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

PAGE 3 OF 4

VITAL SIGNS

	16	17	18	19	20	21	22	23
	95/63	166/76	144/74	154/76	150/77	154/77	140/73	160/71
				99.8			99.4	
	96	84	89	91	93	97	97	77
	32	31	33	28	26	29	22	22
	50	50	60	40%	40%	40%	40%	40%
	TC	TC	TC	TC	TC	TC	TC	TC
	98	97	98	100%	100%	100%	98%	100%

RESPIRATORY DATA

	TIME	0400	1100	1940
	MODE	SIMV		TC
	F_iO_2	40%		40%
	TV	600		
	RATE	20		21-30
	PEEP	5		
A	pH	7.48	7.46	
A	PCO_2	39.5	44.5	
A	pO_2	79	153	
B	HCO_3	29	32	
G	SAT	96%	99%	
G	BASE	6	8	

LABORATORY DATA

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

INTAKE

	16	17	18	19	20	21	22	23	8°T
I	25	25	25	25	25	25	25	25	200
V	50						100	100	250
	500			500					1000
	50			40					90

OUTPUT

O	100	1500/1600	500/900	675/2775	125/2900	100/3000	75/3075	175/3250	1540
U									3250
T				Replaced 2cc					
P									
U									
T									

ACTIVITIES OF DAILY LIVING

TIME	0630	0840	TIME
MOUTH CARE	[redacted]		
BATH			
SKIN CARE	KH 0430		
FOLEY CARE	KH 0430		
TRACH CARE	KH 0430		SUCTION 0400
ROM EXERCISES			
linen Δ	KH 0530		

24°I&O TOTALS

wt Yesterday

wt Today

INTAKE		OUTPUT	
IV	1647	Urine:	8200
TF po	3290		
blood	700		
TOTAL	5637	TOTAL	8200
BALANCE	-2563		

NURSE'S SIGNATURE [redacted]

INITIALS

bld - 2

A71

MEDCOM - 18335

ACLU-RDI 1646 p.95

DOD-031909

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	0600	INITIAL [redacted]	INITIALS	1830	INITIALS [redacted]
NEURO	PUPILS		4mm Perrla			3mm perrla	
	SENSORIUM		A+O			Alert & interactive	
			pt moving head around			c stuff. Upper ext	
			can move left arm and			movements only weak	
			right hand			hand grips	
RESPIRATORY	RESPIRATORY PATTERN		clear, unlabored			normal on TC 50% F	
	BREATH SOUNDS		Trach, 50% O_2 - sats 99%			Ronchi (B) O2 sats X	
	SECRETIONS		sounds CTA with exp			Lg amt thin clear	
			wheeze, diminished			secretions	
			bases				
SKIN	COLOR		NFR			NFR	
	INTEGRITY		multiple wounds			Midline ABD c wet to dry	
						open on backside/pressure	
IV SITE	LOCATION		L SC cordis Triple			(A) SC triple lumen cordis	
	CONDITION		Lumen			+ (B) femoral aline	
			R fem A line			C,D,I + dressings	
			c/d/i			current	
GASTRO	ABDOMEN		soft, large dressing,			flat firm to touch	
	BOWEL SOUNDS		midline			hypoactive X 4 quads	
			+BS x 4 qds				
GU	URINE:		foley to gravity			foley to gravity	
	COLOR/CLARITY		clear yellow			dark yellow/clear	
CARDIOVASCULAR	CARDIAC RHYTHM		S_1S_2 HR 80's			NSR → ectopy	
			+2 pulses radial + pedal			+2 radial, pedal	
			left pedal +1			pulses (B)	
			<3 sec. 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

b(6)-2

(Continue on reverse)

PREPAR[redacted] (Title) RN

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 16Sep03

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

EPW # [redacted]

b(6)-4

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

DATE 16 Sep 03 DX GSW to chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
BP Arterial Line	152/74	159/78	168/77	143/68	161/76	153/79	156/74	165/70		141/80	146/80	158/50	153/77	154/73	141/67	153/77	157/71	
BP Cuff																		
Temperature					98.3 @													
Pulse	83	76	79	85	74	86	93	75		83	78	92	91	99.0 81	91	83	85	
Respiratory Rate	22	20	21	24	19	28	24	19		21	18	23	23	80	26	24	22	
Sats	100%	100%	99%	98%	100%	98%	98%	100		100	98	96	100	100	100	99	100	
FIO_2	40%	40%	40%	40%	50%	50%	50%	50%		50%	50%	50%	50%	50%	50%	50%	50%	
Mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5/2NS E 20KCl	25	25	25	25	25	25	25	25		25	25	25	25	25	25	25	25	
IVPB	150									150		200						
TF	250		250		ref.					ref				ref		110	390	
H20	40		40														40	
TOTALS																		

OUTPUT

	HOUR / TOTAL	150	100 / 250	100 / 350	100 / 450	100 / 550	100 / 650	75 / 725	125		100 / 225	100 / 325	150 / 475	275 / 750	80 / 830	175 / 1005	150 / 1155	150 / 1305	
Foley URINE	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
Residuals ~~DRAINS~~		0		0		0			0				0		0				
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	24
	157/80	165/80	155/75	153/79	155/73	156/71	152/77	150/80	
				97					
	89	82	92	93	91	97	96	96	
	25	22	26	27	28	26	27	26	
	99	98	99	99	97	99	100	97	
	50%	50%	50%	50%	50%	50%	50%	50%	
	TC	TC	TC	TC	TC	TC	TC	TC	

RESPIRATORY

	TIME	0445	1324
	MODE	T.C	TC
	F_iO_2	50%	50%
	TV		
	RATE		
	PEEP		
A	pH	7.47	7.47
A	PCO_2	48.0	45.3
A	pO_2	133	90
B	HCO_3	35	33
	SAT	99%	100%
G	BASE	11	9

LABORATORY

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

INTAKE

	16	17	18	19	20	21	22	23	8° T
	25	25	25	25	25	25	25	25	
	150					250			
				250					
				50					

OUTPUT

	1685	175	1765	250	200	100	125	150	
			30	0					

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	KH 0500
BATH	KH 0500
SKIN CARE	KH 0500
FOLEY CARE	KH 0500
TRACH CARE	KH 0330
ROM EXERCISES	
Lihen △	KH 0500

TURN

TIME	
	USUAL 0200
	Plat 0400

SUCTION

TIME	
	KH 0300

24°)&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	RN
	12/10 2

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)
~~OA Appr 8 Mar 89~~

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]		INITIALS	800	[redacted]
NEURO		PUPILS	Perrla 4mm				PERRLA 4mm	
		SENSORIUM	able to move left arm purposefully and right hand				moves left arm has right arm weakness, movmt in legs	
RESPIRATORY		RESPIRATORY PATTERN	even unlabored				even unlabored	
		BREATH SOUNDS	Coarse throughout				Coarse BS both sides. Coughing up thick mucous tinged c blood	
		SECRETIONS	+cough c thick mucous					
SKIN		COLOR	NFR				NFR	
		INTEGRITY	multiple wounds				multiple wounds skin breakdown to perineum	
IV SITE		LOCATION	R SC Triple Lumen				(L) SC TLC c Cordis	
		CONDITION	c/d/i R femoral radial A-line c/d/i				CDI (R) femoral A-line CDI	
GASTRO		ABDOMEN	soft nontender				Soft, Nontender	
		BOWEL SOUNDS	+BS x4qds no BM in 4days				BS x4quads	
GU		URINE: COLOR/CLARITY	foley to gravity clear yellow				FTG clear yellow	
CARDIOVASCULAR		CARDIAC RHYTHM	S1S2 NSR +2 radial & pedal pulses <3 sec cap refill +2 edema to hands feet & scrotum				S1S2 NSR +2 radial/pedal pulses +2 edema (R) hand and both feet	

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)

[redacted] PT AW

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 17 Sep 03

(Name, grade, date, hospital or medical facility) entries give: Name—last, first, middle initial.

[redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

MEDCOM - 18339

DATE | DX | HOSPITAL DAY

	TIME	0000	0100	0200	0300	0400	0500	0600	07	08	09	10	11	12	13	14	15	16	17
VITALS	BP Arterial Line	157/70	148/83	137/79	157/83	137/76	157/73	154/77	147/73	142/82	131/80	150/76	154/74	151/74	151/79	159/82	153/75	147/76	146/93
	BP Cuff	157/70																	
	Temperature	99.0				99.1													
	Pulse	99	94	88	94	95	83	87	94	118	99	92	93	85	94	96	88	95	105
	Respiratory Rate	25	31	35	16	26	31	26	26	11	28	29	27	33	29	30	23	24	26
	SpO2	96	94	99	97	96	100	99	100	99	99	97	100	97	100	100	96	99	100
	Trachcollar	50%	50%	50%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%
SIGNS																			

	TIME									08	10	11	12	13	14	15	16	17
INTAKE	D5 1/2 NS @	25	25/250	25/75	25	25	25	25	25	200	25	25	25	25	55	25	25	25	25
	Zofran IVP																		
	NPB	150																	
	Tube Feeds				500				200	350							150		
	P.O.									500				Ref.			500		
	TOTALS																		

		HOUR / TOTAL																	
OUTPUT	URINE		175	460/805	200/975	150	150/1075	125/1200	135/1335	500	1050 / 165	230/880	200/1080	200/1280	200/1480	125/1575	100/1675	375/2050	200/2250	170/1420
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	Residuals				0				13			25				0		
	TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	18	19	20	21	22	23	24	01	02
	154/41	152/19	151/18	145/47	144/69	154/71	132/62	137/64	
		99.7					99.8		
	101	97	91	96	92	93	104	101	
	26	28	22	27	24	23	26	25	
	100%	96	100	98	95	100	98	100	
	40%	40%	40	40	40	40	40	40	

RESPIRATORY

		1422
TIME		
MODE		T-collar
F_iO_2		40%
TV		
RATE		
PEEP		
ABG	pH	7.48
	PCO_2	46
	pO_2	82
	HCO_3	35
	SAT	97
	BASE	11

INTAKE

	18	19	20	21	22	23	24	01	8°T
	25	25	25	25	25	25	25	25	
		500			200		150		
		500					500		
	50								

OUTPUT

	120/50	185/185	130/365	140/500	260/185	210/1055	180/1315	224/1543
		8				9		

LABORATORY

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

ACTIVITIES DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	1900
ROM EXERCISES	2130

TURN

TIME	

SUCTION

TIME	

24*I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

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 [illegible]ET ASSESSMENT

		TIME	0600	INITIALS [redacted] b(6) -2	INITIALS	1900	INIT [redacted]
NEURO	PUPILS		PERRLA 3, 2mm				
	SENSORIUM		Comm mildly c			Alert responsive	
			Orientation x4 present			Appropriate - FROM	
			slurred speech			BLUE; LRQNs to LUE.	
			PERRLA 2-3mm			PERRLA 2-3mm	
RESPIRATORY	RESPIRATORY PATTERN		RR regular un-			equal rise full	
	BREATH SOUNDS		labored. LS (B)			35% FIO2, SpO2 100%	
	SECRETIONS		coarse, thick			LCTA (B), ↓ to LL (B)	
			scant clear			Cdm NSR	
			yellow sputum				
			suctioned minimal				
SKIN	COLOR		pink c warm dry				
	INTEGRITY		intact, appropriate			NSR, NL incum	
			for age.			cuffed c bulky dsg	
IV SITE	LOCATION		LUE, LFA, LHand			DSC c	
	CONDITION		LFA: clear, dsg			Cdis	
			LHand: clear, dsg			CDI	
GASTRO	ABDOMEN		NABS, soft, NDNT			Rt groin; tender c	
	BOWEL SOUNDS		x4 quad, active			deep palpation.	
			patient, unable			NL incum cuffed	
			to ask about last			c bulky dsg;	
GU	URINE:		void. Foley patent			FTG, Gelam, Edema,	
	COLOR/CLARITY		c amber clear				
			urine				
CARDIOVASCULAR	CARDIAC RHYTHM		S1 S2 audible, regular			SL, S2, NSR, pulses	
			rate, NSR on			palpable 2+,	
			monitor. Denies				
			CP. SBP 140's, monitored				
			q hour c action taken				
			if SBP <100. Edema				
			BUE, LLE				

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 and Title) [redacted] b(6) -2 RN

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 9/18/03

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

EPW [redacted] b(6) -4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 18 Sept 03 DX GSW to Chest PAGE 2 OF 4

HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	BP Arterial Line	133/102	137/104	148/67	139/72	147/68	147/68	154/70	140		144/90	144/90	102/51	140/78	135/67	129/69	132/62	131/69	
	BP Cuff																		
	Temperature	99.2				99.8					99.1								
	Pulse	104	101	106	110	94	96	92	96		92	92	98	104	97	96	100	97	
	Respiratory Rate	26	25	29	23	23	30	24	18		23	24	25	28	23	22	23	22	
	SpO_2	98	100	99	99	100	99	100	100		100	100	98	100	99	99	99	100	
	TRach Collar	40%	40%	40%	40%	40%	40%	35%	35%		35%	35%	35%	35%	35%	35%	35%	35%	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IDS ENSURE	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
	20 meq K										100	50	250						400
	IVPB	150								150									
	Tube feeds	500			500					1000	500				500				1000
	PO			5 ips							5 ips								
	TOTALS									1350									1600

OUTPUT																				
	URINE HOUR	260	125	160	100	148	180	250	100		250	150	200	150	100	175	100	150		
	URINE TOTAL	260	488	648	748	896	1076	1326	1426		1676	1826	2026	2176	2276	2451	2551	2701		
	FTG sp gr																			
	S/A																			
	NG OUTPUT																			
	pH																			
	GUIAC																			
	EMESIS																			
	STOOL																			
	DRAINS Residuals				<1												0			
	TOTALS								1420									2757		

POST-OP DAY

PAGE 3 OF 4

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	8°T
	144	141	150	143	148	146	146	143	
	60	111	64	70	69	69	69	70	
							100.		
	85	115	85	88	95	96	96	100	
	20	21	20	19	25	20	24	24	
	99	99	99	100	95	95	98	98	
	35	35	35	35	35	35	35	35	

RESPIRATORY

	TIME	0416
	MODE	T-collar
	F_iO_2	40%
	TV	
	RATE	24
	PEEP	
A	pH	7.47
A	PCO_2	44
A	pO_2	114
B	HCO_3	32
B	SAT	99
G	BASE	9

LABORATORY

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

INTAKE

	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	8 ω
	100	30						50/40	300
IV	500			500					1000
									2200

OUTPUT

	110	200	200	45	Void	Void	Void	Void	NGT
		310	510		360	1065	1265	1465	
									1465

ACTIVITIES OF DAILY LIVING

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

TURN — TIME

SUCTION — TIME

24° I&O TOTALS

wt Yesterday ____ wt Today ____

	INTAKE		OUTPUT
IV		Urine:	
po			
TOTAL	5150	TOTAL	4950

BALANCE +200

NURSE'S SIGNATURE — INITIALS

[redacted]

MEDCOM - 18344

ACLU-RDI 1646 p.104

DOD-031918

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIAS	[redacted]	INITIAS	1830	INITIAS
NEURO		PUPLIS	Pupils 3mm sluggish				Perrla 3mm sluggish
		SENSORIUM	a/o x3 per interpreter appropriate				alert. Interacts
			↑ staff follows all commands				appropriately c nurse
			move UE independently RUE				communicates needs
			< LUE. Encouraging RUE				Paraplegic.
RESPIRATORY		RESPIRATION PATTERN	even unlabored trach				normal on TCE 35% of 10
		BREATH SOUNDS	coarse 35/# 8 Shiley				#8 shiley trach
		SECRETIONS	CTA c rhonchi bases, mod-lg				Rhonchi to ↑ bases
			thick yellow secretions				thick yellow secretions
			Strong productive cough.				productive cough
			frequent (1-2/h) rqd.				frequent expectoration c sputum
SKIN		COLOR	appropriate for race				NFR
		INTEGRITY					Scuby pressure sore over occiput x 2
							milline abd incision c wet dry
IV SITE		LOCATION	LIJ TLC cordis				① IJ TLC cordis
		CONDITION	ace patent.				② femoral art line
			② fem - slight ↓				C,D,I
			correlating c MAP				
GASTRO		ABDOMEN	firm slightly distended				firm to touch / tender
		BOWEL SOUNDS	tender hypo BS				BS hyperactive
			midline abd incision ~~staples~~				
			~~tube~~ c 20 Oz gtts				
GU		URINE	Dulcet FTG				foley to gravity
		COLOR/CLARITY	CLS				clear yellow urine
							adequate UOP
CARDIOVASCULAR		CARDIACRHYTHM	NSR - ST ectopy				NSR — ectopy
			S, S2 ± 2 radial ②				radial pulses +1
			pedal pulses ± 1 gen				pedal pulses +2
			edema				↓ edema to scrotum
							② rare puff 1/LE IS

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)

[redacted] CPT / AW

DEPARTMENT/SERVICE/CINC: ICU 3

DATE: 14 Sep 03

middle; grade; date, hospital or ... facility)

EPW

[redacted]

- ☐ 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 - 18345

DATE 19 Sep | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	J..	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	132/57	144/67	139/67	142/69	141/68	141/72	142/69	147/70		147/72	139/70	145/73	144/71	112/52	138/67	154/79	148/84	
BP Cuff																		
Temperature				99.4						99.4					99.1			
Pulse	97	91	100	98	100	119	94	85		93	94	97	98	89	94	88	90	
Respiratory Rate	22	22	23	23	23	30	25	19		24	22	23	22	21	31	20	21	
FIO2	35%	35%	35.	35	35	35	35	35		35	35	35	35	35	35	35	35	
SAO2	99%	100%	98%	94	100	96%	98	97		98	97	97	97	96	99	98	100	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS#20	25	25	25	25	25	25	25	25		25	25	25	25	25	25	25	25	
IVPB	200									150		200						
TF	500				500					500				500				
TOTALS																		

OUTPUT

		HOUR / TOTAL	80 / 80	240 / 320	80 / 400	100 / 500	140 / 640	140 / 780	120 / 900	130		100	142	100	140	240 / 240	150	140	100
URINE		SP gr																	
		S/A																	
NG		OUTPUT																	
		PH																	
		GUIAC																	
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	142/67	147/70	147/67	132/84	139/67	136/64	137/64	137/69
				100				
	84	94	89	91	102	100	110	98
	19	25	22	22	21	25	29	22
	35	35	35	35	31	35	35	35
	100	96	98	100	98	100	99	98%

RESPIRATORY

TIME		1410	
MODE		TC	
F_iO_2		35	
TV			
RATE			
PEEP			
ABG	pH	7.43	
	PCO_2	42.5	
	pO_2	92	
	HCO_3	29	
	SAT	97	
	BASE	4	

INTAKE

	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	26	
	250						350		
	500				500				

OUTPUT

	25	100	200	300	180	125	100	180	
		325	525	825	1005	1130	1230	1410	
					5				

LABORATORY

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

DAILY ACTIVITIES

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

TURN / SUCTION

TIME

24 HOUR TOTALS

NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
Po			
TOTAL		TOTAL	

BALANCE _____

MEDCOM - 18347

ACLU-RDI 1646 p.107

DOD-031921

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

[redacted] ASSESSMENT

		TIME	0600	INITIALS	b(6)-2	INITIALS	1900
NEURO	PUPILS		pupils [redacted]				[redacted] Perrla 3 mm
	SENSORIUM		AAOX3, denies				Alert/[redacted] directs upon
			pain, no c/o				Emerse. Purposeful
			pain. Alert				
			& interested				
RESPIRATORY	RESPIRATORY PATTERN		resting (RA)				normal on TC @ 35%
	BREATH SOUNDS		CTA, diminished				CTA (B)
	SECRETIONS		scant yellow				Strong cough. Pt
			to pink tinged				able to expectorate
			sputum. Cough				most secretions by
			and suctioning				mouth. Thick blood tinged
			as required				NFR
SKIN	COLOR		pink, WNL for				wet to dry to ABD wound
	INTEGRITY		race. WNL for				(L) leg wound dressing
			condition. SR				TLC: coords (L) SC
IV SITE	LOCATION		right, distal				(R) femoral art line
	CONDITION		forearm, free				CID, IT
			from redness,				
			swelling,				
			drainage.				
			Dressing				
			intact.				
GASTRO	ABDOMEN		firm, non				Slightly distended;
	BOWEL SOUNDS		distended,				tender to touch
			active in				hypoactive. SF BM
			all quadrants.				yesterday (med)
GU	URINE:		Foley to				Foley to gravity
	COLOR/CLARITY		gravity drg				clear yellow
			clear yellow				adequate UO
CARDIOVASCULAR	CARDIAC RHYTHM		NSR on				NSR - dec to PVC
			[redacted]				peripheral pulses
			[redacted]				palpable x 4 2+
			90-110				edema to (R) hand,
			occasional				LE 1+
			PVC's				

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)

[redacted] CPT HAW | DEPARTMENT/SERVICE/CLINIC: ICU 3 | DATE: 20 Sep 03

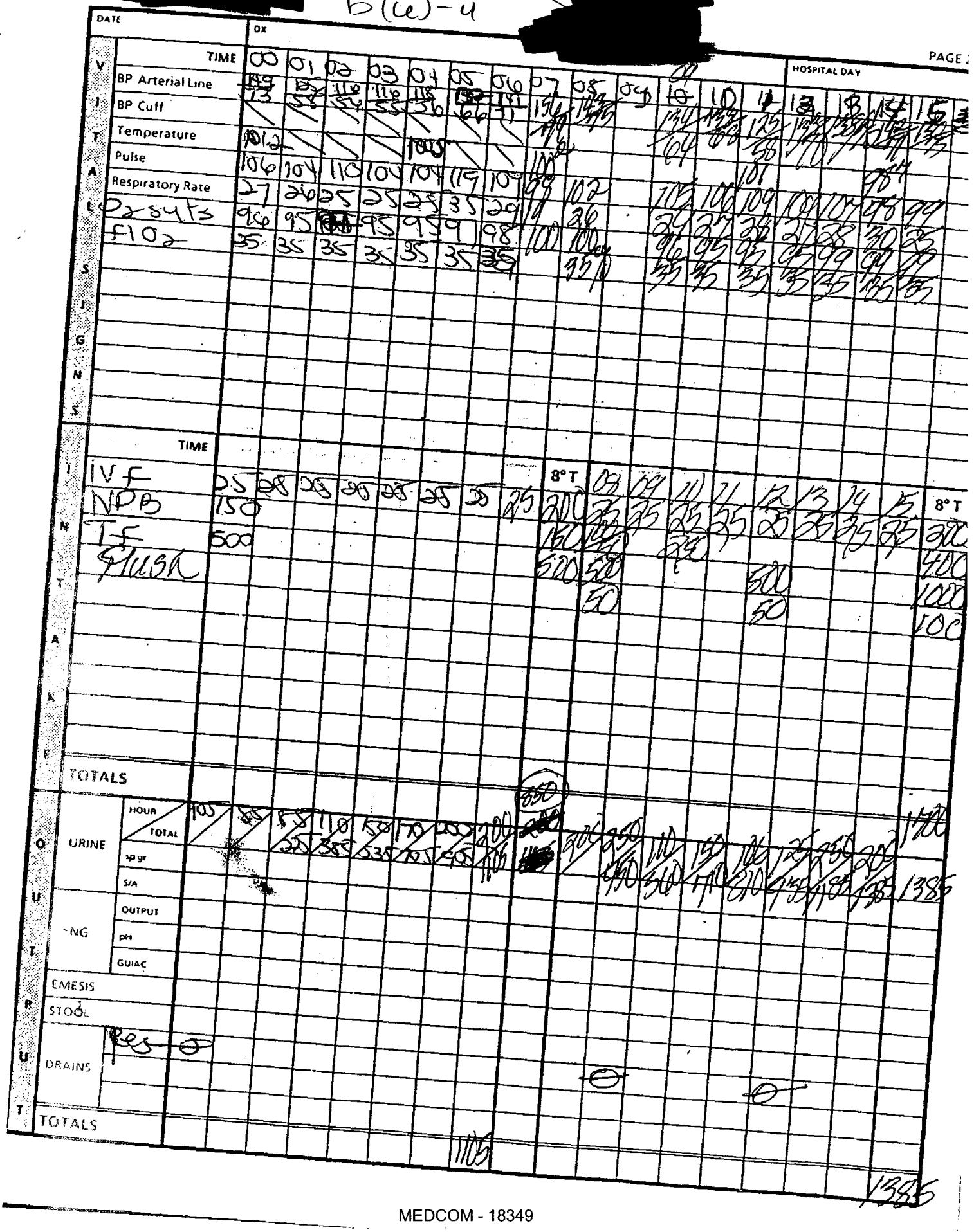
middle; grade; date; hospital or medical facility. Name—last, first,

EPW [redacted]

b(6)-4

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

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



POST-OP DAY 19

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

INTAKE

OUTPUT

RESPIRATORY
TIME
MODE
F_iO_2
TV
RATE
PEEP

ARTERIAL BLOOD GAS
A: pH, PCO_2, pO_2
B: HCO_3, SAT
G: BASE

LABORATORY
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
[redacted]

b(6)-2

For use of this f... CAL RECORD-SUPPLEMENTAL MEDIC... TA
..., AR 40-66; the proponent agency is The Office ...e Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SH... SSMENT

	TIME	0600	INTILAS		INTILAS	1840	INTIL
NEURO	PUPLIS	pupils [illegible]		DLW-2		PERRL	
	SENSORIUM	[illegible]				A&O able to squeeze both hands but only able to move ⓡ ME EFROM BUE & minimal movement	
RESPIRATORY	RESPIRATION PATTERN	RR [illegible]				Reg w/ elaborated on trach mask	
	BREATH SOUNDS	[illegible]				Coarse ⓑ	
	SECRETIONS	[illegible]				Thick white secretions from productive cough. On 31% humidified Dc via trach mask	
SKIN	COLOR	[illegible]				WNL	
	INTEGRITY	[illegible]				Drsg mid line abd & OLE CDI	
IV SITE	LOCATION	[illegible]				D5c cardis @ ⓡ Fem A-line	
	CONDITION	[illegible]				3 sites of infx & sites intact	
GASTRO	ABDOMEN	[illegible]				Flat soft nontender to light palpation	
	BOWEL SOUNDS	[illegible]				ⓑ in 4 quads	
GU	URINE	[illegible]				ⓡ a feeding tube	
	COLOR/CLARITY	[illegible]				Foley to gravity clear, yellow	
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]				BRE & S2 noted	

DLW-3

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
F_1O_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)

PREPA... CPT IAW

DEPARTMENT/SERVICE/CINC TCU3

DATE 21 Sep 03

DATE ... (For written entries give: Name —Last, First, middle; grade; date; hospital ... facility)

[redacted]

DLW-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 - 18351

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line	114/53	136/64	111/73	155/75	113/72	110/74	101/69	114/67		130/78		123/66	131/71	149/69	142/70	140/76	141/68	
BP Cuff																		
Temperature	99.3				100			99.4		98.8		98.7				99.6		
Pulse	92	104	105	91	92	95	98	97		96		94	92	86	84	81	85	
Respiratory Rate	18	31	21	22	23	22	23	25		23			16	15	18	16	18	
O2 Sats	99	97	98	99	100	100	99	100		100		100	100	100	100	100	100	
FetO2								3L		3L		3L	3L	3L	3L	3L	3L	

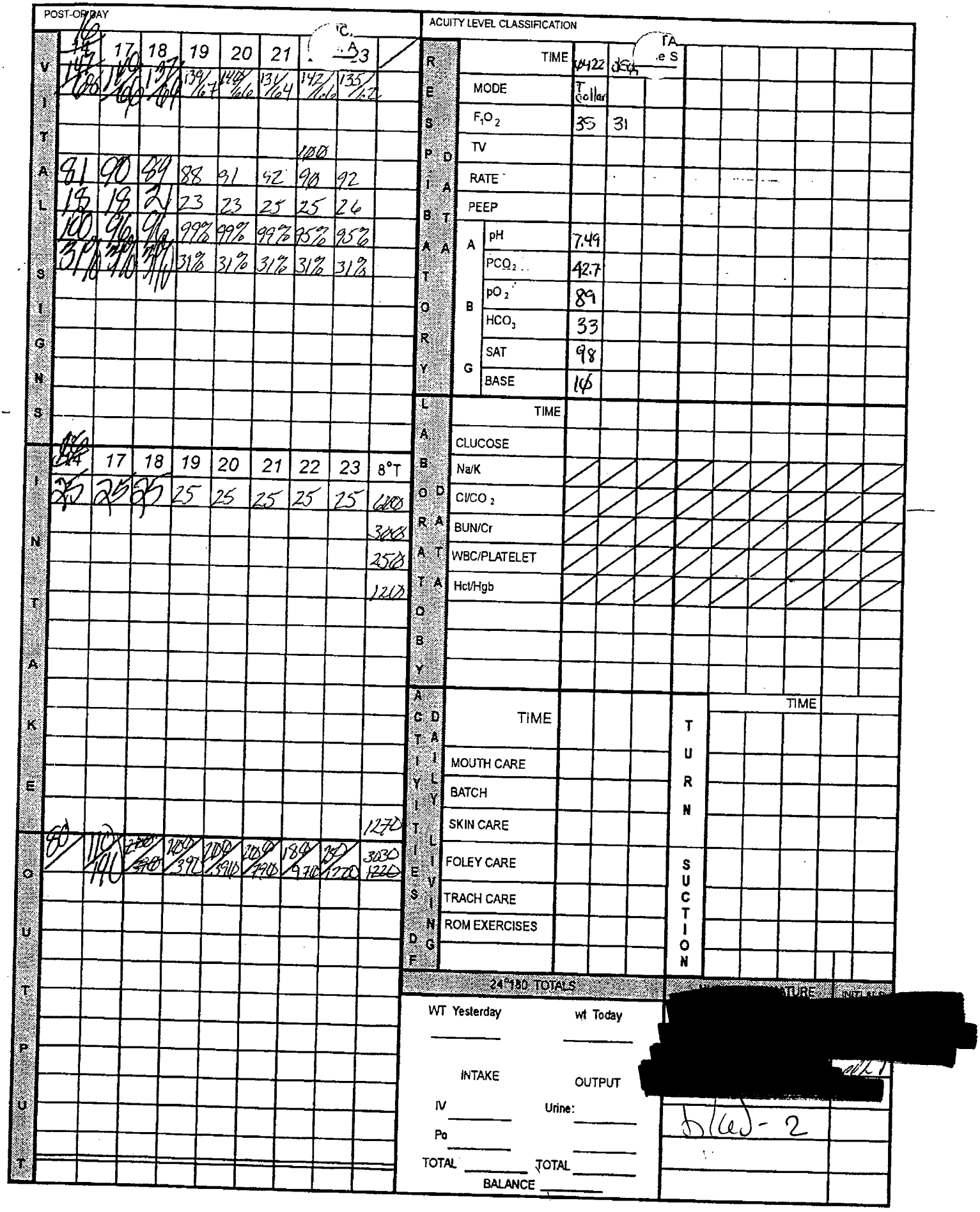
INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	25	25	25	25	25	25	25	25	20	25	25	25	25	25	25	25	25	20
IVPB	150							150	150	50								150
TF	300							250	250	180								120
PO																		
TOTALS								1000										1440

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE			100	350	100	110	100	130	90	600	450	100	200	300	90	100	110	80	240	240
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
Residual																				
~~DRAINS~~																				
TOTALS										950									1200	

1200



MEDCOM - 18353

ACLU-RDI 1646 p.113

DOD-031927

For use of this for [illegible]AL RECORD-SUPPLEMENTAL MEDICA[illegible]A
AR 40-66; the proponent agency is The Office[illegible] Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS	1930	INTIL [redacted]	b(6)-2	INTILAS
NEURO	PUPLIS	PERRLA		Pepper 4mm, brisk, Hewes			
	SENSORIUM	interacts w/ Nurse approp.		Moves BUE. Obeys some commands. Stukow. Cough strong			
RESPIRATORY	RESPIRATION PATTERN	Even UCABG'N		Even, unlabored.			
	BREATH SOUNDS	Clear top coarse bottom.		Trach # Shiley, Trach collar @ 31% O2. Freauent cough. Productive thick white/yellow secretions. Able to clear			
	SECRETIONS	Pt. Cough up Lg amount of thick white sputum.					
SKIN	COLOR	NFR.		NFR, Dry. ML abd dressing			
	INTEGRITY	Lg Abd. wound. also LLL wound. Dressing CDI		LLE c dressings. Dry lips (R) Anterior FA c black scabs.			
I V SITE	LOCATION	Triple lumen SUBCLAVIAN.		(L) AC 18g c MIVF			
	CONDITION	(R) Femoral A Line. D5 1/2 w KCal @ 25 ml/hr All LMPS Flushed. Free From S/S of infection.		infusing. CDI.			
GASTRO	ABDOMEN	Soft, distended non tender, Lg dressing. Bowel sounds x4 hypoactive. Feeding tube.		Soft. Tender RLQ, LLQ. ML abd Dressing. Odrainage. Hypoactive BS x4. G-tube (+) BM			
GU	URINE	FTG.		Foley to DD. Clear light yellow urine.			
	COLOR/CLARITY	Draining Lg amounts of CLEAR yellow urine.					
CARDIOVASCULAR	CARDIACRHYTHM	S.S. - Rules Palp Pulses (+)+2, Radial (+)+2. Capreflex <3 sec.		SR-ST Ectopy. S1S2. Radial/pedal pulses 2+. 2+ anasarca. Capreflex <3 sec.			

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
H_CO_3 - 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) [redacted] b(6)-2 | DEPARTMENT/SERVICE/CINC ICU 3 | DATE 22 Sep 03

PATIE[redacted] (For 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)

MEDCOM - 18354

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	133/63	140/66	138/67	135/65	141/71	133/66	142/72	123/67	135/58	153/74	129/71	137/63	147/68	143/76				
BP Cuff															149/94	108/55	127/68	
Temperature	99.4					99.6		99.8		99.2		98.7	98.7	98.5	99	99.6	99.5	
Pulse	93	95	91	94	91	94	103	96	87	87	89	95	86	100	97	95	92	
Respiratory Rate	22	24	22	25	25	25	29	26	25	26	20	21	25	28	30	30	27	
SPO2	97%	95%	95%	97%	97%	95%	94%	98	95	95	95	100	100	97	95	98	99	
FiO2 Touch	31%	31%	31%	31%	31%	31%	31%	31	31%	31%	31%	31%	31%	31%	31%	31%	31%	
mode								(L plus) 67										

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS@20 KCL	25	25	25	25	25	25	25	25	250	25	25	25	25	25	25	25	25	780
IV PB	50									50	30							
Jevity													500					
H2O																		
TOTALS																		7
									250									780

OUTPUT

	HOUR / TOTAL	160	100 / 260	125 / 385	122 / 507	130 / 637	125 / 762	125 / 887	130 / 1017	101	200 / 300	120 / 420	240 / 660	110 / 770	140 / 910	110 / 1020	140 / 1160	100 / 1260
URINE	SP gr																	
	S/A																	
6 tube ~~NG~~	~~residual OUTPUT~~																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL										Large amount Dark Brown								
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	17	18	19	20	21		23
122/57	124/59	128/66	124/62	126/58	127/60	113/56	113/61
99.9	99.3	99.4					
91	92	85	94	91	90	88	92
27	27	23	26	26	27	25	22
95%	100	100	100%	99%	92%	100%	98%
3 L/6	3 L/6	3 L/6	3 L%	3 L%	3 L%	3 L%	3 L%
			TC	TC	TC	TC	TC

INTAKE

	17	18	19	20	21	22	23	8°T
25	25	25	25	25	25	25	25	200
50								50
500				500				1000
				50				50
								1300

OUTPUT

10 / 140	80 / 140	180 / 160	280 / 190	175 / 207.5	90 / 216.5	70 / 223.5	105 / 234.0	2340
140								
				returned 2 cc				
					XT			

RESPIRATORY

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

LAB DATA

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

DAILY ACTIVITIES

	TIME
MOUTH CARE	KH 2250
BATH	KH 2100
SKIN CARE	KH 2100
FOLEY CARE	KH 2100
TRACH CARE	KH 2100
ROM EXERCISES	KH 2100
Linen	KH 2100

TURN

TIME

q2hr 2200

SUCTION

24 HOUR TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	780	Urine:	4577
Po	1550		
TOTAL	2330	TOTAL	4577

BALANCE -2247

NURSE'S SIGNATURE	INITIALS
[redacted] AN	KH
dlw 2	

MEDCOM - 18356

ACLU-RDI 1646 p.116

DOD-031930

For use of this for [redacted]AL RECORD-SUPPLEMENTAL MEDICA[redacted]A
AR 40-66; the proponent agency is The Office Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b6 b7C-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INTILAS [redacted]	1930	INTI[redacted]		INTILAS
NEURO		PUPLIS	Perrla 4mm		PERRL 4mm, BRISK, Alert.			
		SENSORIUM	A+O, able to move left arm + right hand		Obeys commands. Moves BUE LLR. Sensation intact.			
RESPIRATORY		RESPIRATION PATTERN	even, unlabored		Regular, unlabored			
		BREATH SOUNDS	Coarse throughout		CTA. Thick yellowish			
		SECRETIONS	thick mucous out of trach		white secretion from trach. Able to clear secretions			
					TC 31% humidified 02 #8 Shiley, cleaned.			
SKIN		COLOR	NRR		NFR, W.D. Mid incision			
		INTEGRITY	decubitus forming on bottom of R foot		2 sores @ lateral lower leg DK brown spots on bottom of foot			
IV SITE		LOCATION	LAC		Skin intact. Skin flaking off of			
		CONDITION	running D5½ i 20K c/d/i		backside. Warm, dry. IVFA infusing D5½NS @ 20 KCl @ 25cc/hr, CDI			
GASTRO		ABDOMEN	Large midline wound		M abd incision, bulky			
		BOWEL SOUNDS	hypoactive x4qds		wd c a bit of yellowish-brown ascne @ tube. Active BS x4, (P) lg BM			
GU		URINE	Foley to gravity		Foley to gravity. DK			
		COLOR/CLARITY	clear/yellow		yellow clear urine.			
CARDIOVASCULAR		CARDIACRHYTHM	TSR S1S2		SR-ST, ectopy, S1S2			
			+2 pulses		Radial 2+/Pedal 3+ pulses			
			<3 sec cap refill		Caprefill <3 sec. BLE 2+.			

LEGEND

Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_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)

PRE[redacted] & Title)
[redacted] MAN

DEPARTMENT/SERVICE/CINC
ICU3/PACU

DATE
23 Sep 03

b6 b7C-1

PATIENT [redacted] (If typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW # [redacted]

b6 b7C-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 - 18357

DATE 23 Sep 03 DX GSW to Chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line																		
BP Cuff	123/64	126/58	127/63	125/61	123/64	122/59	116/58	109/60		110/61	123/63	107/43	126/58	113/53	123/59	120/58	124/60	
Temperature		99.3 (A)				101.9 (A)	101.7				101.5			100.3		101.5		
Pulse	88	90	96	101	115	110	109	108		110	110	109	102	103	105	110	105	
Respiratory Rate	29	24	24	22	22	22	18	23		27	29	29	26	27	14	13	21	
SpO_2	98	98	91	95	94	99%	94	96		98	97	98	96	96	99	99	99	
FiO_2	31%	31%	31%	31%	31%	31%	31%	31%		31%	31%	31%	31%	31%	31%	31%	31%	
Mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	

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 NSS 20 KCl	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	50								50	50							50	100
TF	500				500				1000	240		60		240	240			1040
H_2O	50				60	60			110	240								
Tylenol					25	20			20									
TOTALS									1340									1340

OUTPUT

	HOUR / TOTAL	95	55/150	55/205	50/255	70/325	50/375	50/425	70/495		100/130	50/180	50/230	50/280	50/330	50/380	70/440	
URINE	SP gr																	
	S/A																	
G-tube ~~NG~~	Residual OUTPUT	returned 1cc				returned 130cc					40cc			40cc				
	PH																	
	GUIAC																	
EMESIS																		
STOOL						LG					X1							
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	122/61	117/57	115/53	118/60	122/60	119/57	113/53	116/57
		100.0		100.6 (R)		99.7 (A)		
	107	104	104	103	103	109	102	101
	22	14	24	18	25	24	21	22
	99	100	100	100	100	100	99	99
	31%	31%	31%	31%	31%	31%	31%	31%
	TC	TC	TC	TC	TC	TC	TC	TC

RESPIRATORY

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

LABORATORY

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

INTAKE

	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
	100		100				100		300
	300		Lock		420				720
					30				30
									1250

OUTPUT

	50/440	40/530	60/580	40/620	40/660	60/720	60/780	60/840	840
	30cc				40cc				
				Lg. x1					

ACTIVITIES OF DAILY LIVING

	TIME								
	MOUTH CARE	replaced							
	BATH	KH 1900							
	SKIN CARE	KH 1900							
	FOLEY CARE	KH 1900							
	TRACH CARE	KH 1930							
	ROM EXERCISES	KH 1900							
	Linen ∆	KH 1900							

TURN SUCTION

TIME	
supine 2400	@side 2100
@side 0200	@side 2300
@side 0400	
supine 1900	

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1350	Urine:	1335
G tube	2920	Stools	x4
TOTAL	3970	TOTAL	1335
BALANCE	+2635		

NURSE SIGNATURE	INITIALS
[redacted] RN	KH
b(6).2	

MEDCOM - 18359

ACLU-RDI 1646 p.119

DOD-031933

AL RECORD-SUPPLEMENTAL MEDICA( )
For use of this form, , AR 40-66; the proponent agency is The Office c Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0600	INTILA[redacted]		INTILAS	1800	INTI[redacted]
	PUPLIS	RTL 4MM BS				4mm PERRLA	
	SENSORIUM	Wakes easily				AAO, Moves B/L	
		pain				UE L>R	
RESPIRATORY	RESPIRATION PATTERN	RR even at 16				Regular, unlabored	
	BREATH SOUNDS	Intubated w/ BS				CTA B/L	
	SECRETIONS	Large amt thick				clear mucous	
		white mucus				TC #4 Shiley	
		suctioned prn				31% humidified FIO2	
						Sats 98%	
SKIN	COLOR	skin warm				NPK - bandage to M/L abd	
	INTEGRITY	pale, diaphoretic				and 4x4 x2 to (L) LE	
		noted				CDI	
IV SITE	LOCATION	(R) subclavian TLC				(R) femoral IV TLC	
	CONDITION	without redness				infusing D5½NSC	
		or edema				20KCl CDI	
		dressing noted					
GASTRO	ABDOMEN	soft, distended				S/H, NDnondistended	
	BOWEL SOUNDS	active BS x 4 quads				BS x 4quads	
		peg tube clear				G-tube (R) side	
		gastric					
GU	URINE	Foley patent				FTG	
	COLOR/CLARITY	yellow clear				med dark yellow	
		adequate amount					
CARDIOVASCULAR	CARDIACRHYTHM	NSR on monitor				HR in ↓100's	
		BP WNL				Occasional noted	
		Pedal pulses				S3 +2 radial	
		palpated				pulses	

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 1003

DATE 24 SEP 03

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

#[redacted]

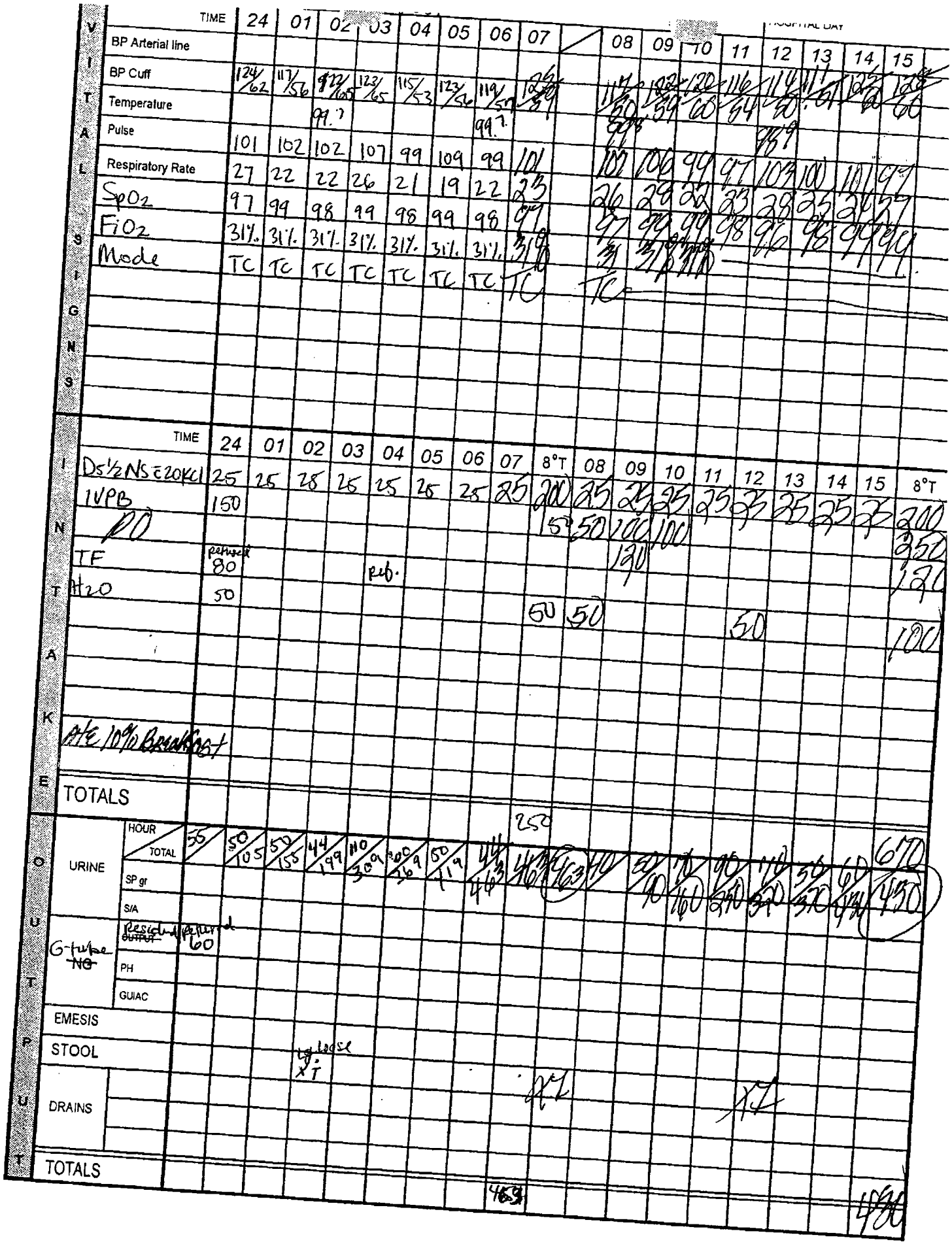
b(6)-4

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

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

MEDCOM - 18360



VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
	BP Arterial line																
	BP Cuff	124/62	117/56	122/65	123/65	115/53	123/52	119/59	124/57	114/50	122/59	120/60	116/64	114/50	111/64	122/60	129/66
	Temperature			99.7				99.7						98.9			
	Pulse	101	102	102	107	99	109	99	101	102	100	99	97	103	100	101	99
	Respiratory Rate	27	22	22	26	21	19	22	23	26	29	22	23	29	25	26	27
	SpO_2	97	99	98	99	98	99	98	97	97	99	99	98	96	95	99	99
	FiO_2	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%					
	Mode	TC	TC	TC	TC	TC	TC	TC	TC	TC							

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	D5½NS c 20KCl	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
	1VPB	150								150	50	100	100						250
	PO											120							120
	TF	primed 80				PRB.													
	H_2O	50								50	50			50					100
	ATE 10% Breakfast																		
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		55	50 / 105	50 / 155	44 / 199	HO / 309	200 / 509	50 / 559	44 / 603	250	460	463	440	50 / 490	70 / 560	90 / 650	110 / 760	50 / 810	60 / 870	670 / 1540
		SP gr																		
		S/A																		
	G-tube ~~NG~~	Residual / OUTPUT	60																	
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL					Lg loose X1														
	DRAINS																			
	TOTALS								463											1540

POST-OP DAY

AL RE
AR 40

ACUITY LEVEL CLASSIFICATION

Surgec

VITAL SIGNS

	16	17	18	19	20	21	22	23
	110/55	112/55	117/58	120/61	121/58	121/60	117/57	115/58
					1009			
	110	106	103	94	90	96	104	103
	27	24	28	26	24	26	29	26
	99	99	96	99	98	97	99	99
	100	100	38°	38°	31	31	31	31
			TC	TC	TC	TC	TC	TC

RESPIRATORY

	TIME								
	MODE								
	F_1O_2								
	TV								
	RATE								
	PEEP								
A	pH								
A	PCO_2								
B	pO_2								
B	HCO_3								
G	SAT								
G	BASE								

INTAKE

	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
							100		100
						500			500
					50				50
									880

OUTPUT

	115	110	120 335	60 295	80 95	90 85	10 635	80 715	715
						410			
	X-1								
									715

LABORATORY

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

ACTIVITY ORDERS

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

TURN

TIME	
	supine 0100
	[redacted] 0300
	supine 0400

SUCTION

24 HR TOTALS

NURSE'S SIGNATURE

[redacted]

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1720	Urine:	
Po	200		
TOTAL	1920	TOTAL	1608

BALANCE _____

0(6)-2

MEDCOM - 18362

ME[illegible] - RECORD-SUPPLEMENTAL MEDICAL
For use of this form se[illegible]R 40-66; the proponent agency is The Office of [illegible] Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

662

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

INITIAL SHIFT ASSESSMENT

			INTILAS		INTILAS
NEURO	TIME	0600	[redacted]	1900	[redacted]
	PUPLIS	R+L PERRLA		3.R PERRL	
	SENSORIUM	Cooperative,		alert, response	
		pain[illegible] c		MAE.	
		care.			
RESPIRATORY	RESPIRATION PATTERN	RR even + un-		equal rise/ fall	
	BREATH SOUNDS	Cleared, BS (+)		LCTA (B). O#4	
	SECRETIONS	Coarse tracheal		Stuley, DIL;	
		Cough, cff + Stby		teeth site CDI.	
		in place + [illegible]			
		clear, wod + sucked			
SKIN	COLOR	Ruddy WNL, [illegible]		WNL	
	INTEGRITY	Ecchymosis [illegible]		ML incision coml	
		[illegible] groin		& drsng.	
IV SITE	LOCATION	RIC, R femk		(1) fem TLC	
	CONDITION	Site WNL. Dsg [illegible]		CDT	
		Wet, all ports			
		[illegible] WNL c			
		Blood [illegible]			
GASTRO	ABDOMEN	NBS. Soft, non-t		soft, + BS	
	BOWEL SOUNDS	c [illegible] + WNL		x 4 quds, pt	
		c peg tube in		via tube - patent	
		place.			
GU	URINE	Clear, adequate		PTC, adequate	
	COLOR/CLARITY	c amber WNL		yellow, clear	
		noted			
CARDIOVASCULAR	CARDIACRHYTHM	SR, noted c		SR & ectopy	
		[illegible] ectopy, PVCs			
		noted			

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 - Iracheostomy

DLW-1

(Continue on reverse)

PREPARED BY *(Signature &* [redacted] DEPARTMENT/SERVICE/CLINIC [illegible] DATE 25 Sep 05

PATIENT'S INDICATIONS *(Fo[illegible] give: Name - Last, First, middle; grade; date; hospital[illegible] Facility)*

EPW [redacted]

DLW-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 - 18363

[redacted] b(6)-4

DATE 9-25-03 DX ash > chest

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	131/57	135/68	135/60	132/66	119/65	135/62	108/61	129/71		144/64	139/68	120/64	137/65	131/65	125/64	102/65	129/60	
Temperature	100°						99				99					98		
Pulse	103	94	94	97	94	97	97	94		101	95	98	92	91	94	99	94	
Respiratory Rate	27	21	24	23	22	23	28	12		28	20	26	27	26	27	29	20	
FiO	31	31	31	31	31	28	28	29		28	28	28	26	29	28	28	28	
SPO2	100	100	99	99	98	96	100	10		100	97	95	96	97	97	99	99	
MAcde	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC				

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NC20	25	25	25	25	25	25	25						25					
KCL																		
IVPB	200																	30
TF																		
P.O.	—	—	—				120	120	120					120				240
NAG 30%																		
Lunch 60%																		
Dinner																		
TOTALS								120										470

OUTPUT

	HOUR / TOTAL	120	100 / 40	40 / 260	160 / 420	140 / 560	110 / 670	80 / 750		110		110 / 860	100 / 960	90 / 1050	90 / 1140	200 / 1340	120 / 1460	780
URINE	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL							x1											
DRAINS																		
TOTALS								120										780

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
	134	130	134		122		122		
	61	64	60		60		64		
	96	96	86		88		102		
	22	25	21		21		23		
	28	28	28		28		28		
	99	99	99		99		96		
	TC	TC	TC		TC		TC		

INTAKE

	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
	150							100	350
	50							50	

OUTPUT

	120	300	100		150		250		850
		600	410		150		250		850

RESPIRATORY

		1	2	3	4	5	6	7	8
	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
A	PCO_2								
B	pO_2								
B	HCO_3								
G	SAT								
G	BASE								

LAB/DATA

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

ACTIVITY/TIES/DAILY/DIFF

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

TURN / SUCTION

TIME								

24 HR TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

WT Yesterday _____ wt Today _____

INTAKE

IV 1450

Po

TOTAL 1450

OUTPUT

Urine: _____

TOTAL 2580

BALANCE _____

D(6)-2

1730
-850

MEDCOM - 18365

For use of this ...DICAL RECORD-SUPPLEMENTAL MEDI... ...ATA
...e, AR 40-66; the proponent agency is The Offic... ...he Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

b(6)-2

		INITIAL SU...ASSESSMENT					
	TIME	0700	INTILA...	1400	INTILAS	1400	INTI...
NEURO	PUPLIS	PERRLA @ 3mm				Perrla @ 3mm	
	SENSORIUM	Alert & Oriented				Alert & interacts appropriately c nurse	
						Paraplegic	
RESPIRATORY	RESPIRATION PATTERN	EVN				normal on TC @ 24% FD.	
	BREATH SOUNDS	Lungs CTA				Coarse (B)	
	SECRETIONS	Diminished from trach, trach collar CPAP				Lg amt via Trach strong cough clear yellow/thin sec.	
SKIN	COLOR	NFR				NFR	
	INTEGRITY	midline ABD dressing bleeding to (L) leg				midline ABD dressing	
IV SITE	LOCATION	L femoral				(L) femoral TLC	
	CONDITION	triple lumen intact to s/s of redness & swelling to ale.				all ports patent dressing c/d/i	
GASTRO	ABDOMEN	Soft, non tender				soft non distended	
	BOWEL SOUNDS	BS x 4.				BS present x 4 quads	
GU	URINE	Foley to gravity				Foley to gravity	
	COLOR/CLARITY	Clear yellow urine				clear yellow adequate amt	
CARDIOVASCULAR	CARDIACRHYTHM	NSR S1 S2 noted.				NSR — see tele Peripheral pulses palpable x 4	

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 - Iracheostomy

b(6)-2

(Continue on reverse)

PREPAR... RN DEPARTMENT/SERVICE ICU#3 DATE 26 SEPT 03

PATIENT ... written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPIC #...

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 - 18366

DATE 26 Sep 05 DX

HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
	~~BP Arterial line~~	138		114		124		125	120										
	BP Cuff	66		91		93		91	94		115/77	114/68	130/67	130/69	120/68	128/77	122/63	133/84	
	Temperature										98.4						98.4		
	Pulse	87		89		91		97	94		83	88	92	95	85	116	89	100	
	Respiratory Rate	24		22		23		22	23		20	22	22	23	23	26	24	26	
	SaO2	100		100		97		97	97		97	97	99	98	99	98	96	98	
	FiO2	28		28		28		28	28		28	28	28	28	28	28	28	28	
	Mode	TC		TC		TC		TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	

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 + 2 NaCl	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
	IVPB	100/50								150		100	100						200
	IVPB											50							50
	IVPB											50							50
	Tube Feeding											500					500		1000
									350										150
	TOTALS									350									

OUTPUT		HOUR / TOTAL	2.00 / 200		3.00 / 300		2.00 / 100		70 / 770	70 / 840	80 / 920	40 / 40	110 / 150		120		80		490
	URINE	SP gr																	
		S/A																	
	NG	OUTPUT																	
		PH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	14	17	18	19	20	21	22	23
	131/70							
		116/60	129/64	125/60	131/71	131/64	136/75	135/75
	166	84	99	96	93	97	101	93
	31	23	25	21	21	20	21	21
	99	97	98	100	98	99	96	98
	28	28	19	29	29	28	28	24
	TC	TC	TC	TC	TC	TC	TC	TC

RESPIRATORY

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

LABORATORY DATA

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

INTAKE

	14	17	18	19	20	21	22	23	8°T
IV	25	25	25	25	25	24	25	25	200
IVPB	100						100		200
TF	500					500			1000
H_2O	50					30			80
									1480

24 hr Intake 3330

ACTIVITY/TIMED NURSING

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

TURN

TIME

SUCTION

OUTPUT

	14	17	18	19	20	21	22	23	
Urine	300	30	110	100	70	60	XS	0	670
						30			30
					XI				1696

24 hr output 1994

24 HOUR TOTALS

WT Yesterday

wt Today

INTAKE

IV

Po

TOTAL

OUTPUT

Urine:

TOTAL

BALANCE

[redacted]

b(6)-2

MEDCOM - 18368

MEDICAL RECORD-SUPPLEMENTAL MEDIC[illegible]DATA

For use of this [illegible]e, AR 40-66; the proponent agency is The Off[illegible]e Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0600	INTILAS [redacted]		INTILAS	2000	INTILAS [redacted]
	PUPLIS	[illegible]				Perrla @ 3mm	
	SENSORIUM	[illegible]				Alert + interacts appropriately c nurse & follow all commands	
		[illegible]				Purapleyic	
RESPIRATORY	RESPIRATION PATTERN	[illegible]				normal on RA	
	BREATH SOUNDS	[illegible]				O2 sats > 95%	
	SECRETIONS	[illegible]				Trach d/c'd	
		[illegible]				strong cough expectorates sputum on his own	
SKIN	COLOR	[illegible]				N/R	
	INTEGRITY	[illegible]				midline abd incis dry healing well	
IV SITE	LOCATION	[illegible]				(2) femoral TLC all ports patent	
	CONDITION	[illegible]				Dressing C/D/I	
GASTRO	ABDOMEN	[illegible]				Soft non-tender &	
	BOWEL SOUNDS	[illegible]				Present x 4 quads. BM last night/liqui	
GU	URINE	[illegible]				Soft	
	COLOR/CLARITY	[illegible]				Clear yellow u/c	
		[illegible]				-foley	
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]				Indwelling cath	
		[illegible]				NSR + ectopy	

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 - Iracheostomy

(Continue on reverse)

b(6)-2

[redacted] CPT IAN

DEPARTMENT/SERVICE/CINC ICCU

DATE 27 Sep 03

[illegible] grade; date; hospital or [illegible] typed or written entries give: Name — Last, First,

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 - 18369

DATE

DX

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	85/75	132/69	135/75	136/73	135/74	128/76	134/72	144/71		127/73	131/70	129/64	140/71	136/73	129/69	130/75	136/61	
Temperature	99.1				98.6					99.8					98.1			
Pulse	92	96	94	98	92	86	81	78		92	96	92	91	92	86	88	84	
Respiratory Rate	20	23	22	24	20	20	16	14		19	19	22	25	20	24	21	24	
FIO2	24	24	24	24	24	24	24	24		24	24	24	24	24	24	24	24	
mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	
O2 sats	94	98	98	98	100	100	100	100		100	100	98	100	100	100			

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV F	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	200								350	100/50		100						350
TF										500						500		1000
Breakfast										0								
Lunch																		
Dinner																		
TOTALS								500										1600

OUTPUT

	HOUR / TOTAL	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
URINE		55	50	65	60	80	50	130			40	120	90	100	120	100	120	140	
	TOTAL		105	170	230	310	360	490	490			160	250	350	470	570	690	830	970
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL			X1										X1						
DRAINS																			
TOTALS									490									970	

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITALS / SIGNS

INTAKE / OUTPUT

RESPIRATORY: TIME, MODE, F_iO_2, TV, RATE, PEEP, A-G: pH, PCO_2, pO_2, HCO_3, SAT, BASE

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

ACTIVITY / TESTS / DAILY / NURSING: TIME, MOUTH CARE, BATCH, SKIN CARE, FOLEY CARE, TRACH CARE, ROM EXERCISES

TURN: TIME

SUCTION

24 HR TOTALS

NURSE SIGNATURE | INITIALS

WT Yesterday ____ wt Today ____

INTAKE: IV ____ Po ____ TOTAL ____

OUTPUT: Urine: ____ TOTAL ____

BALANCE ____

[redacted]

Intake 2890 Output 2470 (+) 420

MEDCOM - 18371

MEDICAL RECORD-SUPPLEMENTAL MEDIC[illegible] DATA

For use of this [illegible]ee, AR 40-66; the proponent agency is The Of[illegible]he Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME	0615	INITIAS [redacted]	1830	INITIAS [redacted]		INITIAS
NEURO	PUPLIS	3mm reactive,		3mm PERRL, brisk. Alert			
	SENSORIUM	Alert follows commands.		follows commands.			
		paraplegic.		Moves BUE L>R			
				Paraplegic.			
RESPIRATORY	RESPIRATION PATTERN	Normal pattern @		Regular, even, unlabored.			
	BREATH SOUNDS	Ref. distress. @ RA		RA sats > 98%. CTA			
	SECRETIONS	SO2 > 95%. + Cough		all lungs fields. + ri			
				RLL. Old trach site			
				dressed & gauze.			
SKIN	COLOR	WFR		NPR MLA abd incision			
	INTEGRITY	midline abd wound		dressing. OLE dressing			
		dry dressing. CDI		old trach site.			
IV SITE	LOCATION	(R) femoral CL TLC		(L) femoral TLC. Orang			
	CONDITION	dressing CDI.		CDI. Infusing D5 1/2 NS			
				@ 20/KCl @ 25cc.			
GASTRO	ABDOMEN	Soft non tender		Soft. Tender all quadrants			
	BOWEL SOUNDS	normoactive BS		Absent. G tube to G. aid			
		x4.		dangerz feeding			
GU	URINE	foley		Foley to BD Clear			
	COLOR/CLARITY	adequate clear		yellow urine - light			
		yellow urine.					
CARDIOVASCULAR	CARDIACRHYTHM	NSR - ectopy. cap refill		SR - ectopy. Cap refill			
		<3sec to peripheral		<3sec. radial/pedal			
		pulses x4.		pulses 3+.			

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)

b(6)-2

[redacted] Title) CPT/AN | DEPARTMENT/SERVICE/CINC ICU3 | DATE 28 Sep 03

middle; grade; date; hospital or medical [illegible]ntries give: Name—Last, First,

[redacted]

b(6)-1

☐ 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 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02		04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line																		
BP Cuff			135/70	137/75			137/75			126/72				139/78				
Temperature			98.1				98			98.2	97.1			97.9				
Pulse			84	80			80			82				80				
Respiratory Rate			~~20~~ 24				24			26				24				
O2 Sats			99	100			100			100				99				
mode			RA	RA			RA			RA				RA				
				2L via NC														

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	200								200	200		100						300
TF										500					500			1000
TOTALS																		

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE				165	235	305	375	475	575	100	825	115	255	385	60	710	820	950	1035	1035
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	ee 22	23
T	141/74	145/74	136/76	136/71	141/77	142/77	132/66	128/73
A	98.8				99.0 (R)			
L	97	80	89	81	78	82	82	100
S	25	28	23	22	21	23	22	24
I	100%	99	99	99	99	99	100	98
G	RA	RA	RA	RA	RA	RA	RA	RA
N								
S								

INTAKE

	14	17	18	19	20	21	22	23	8°T
I	26	25	25	25	25	25	25	25	
N	250								
T									
A									
K									
E									

OUTPUT

O	130	250/390	300/690	310/1000	300/1300	130/1430	110/1540	115/1655	1655
U									
T									
P									
U									
T									

RESPIRATORY DAILY

	TIME									
	MODE									
	F_1O_2									
	TV									
	RATE									
	PEEP									
A	pH									
A	PCO_2									
B	pO_2									
B	HCO_3									
G	SAT									
G	BASE									

LABORATORY

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

ACTIVITIES DAILY LIVING

	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE site	KH 2140								
	ROM EXERCISES									

TURN

SUCTION

TIME									

24 HOUR TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted] RN

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

MEDCOM - 18374

For use of this DICAL RECORD-SUPPLEMENTAL MEDI ATA
ee, AR 40-66; the proponent agency is The Offic he Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL S SESSMENT

	TIME	INTIL	[redacted]	b(6)-2	INTILAS		INTILAS
NEURO	PUPLIS						
	SENSORIUM						
RESPIRATORY	RESPIRATION PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
IV SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIACRHYTHM						

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 - Iracheostomy

(Continue on reverse)

b(6)-2 [redacted] (Title) | DEPARTMENT/SERVICE/CINC | DATE 29 Sep 88

ped or written entries give: Name—Last, First, r 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 - 18375

DATE 29Sep03 DX GSW to [illegible]est HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
BP Arterial line																		
BP Cuff	139/69	147/71	135/77	139/77	130/74	133/73	146/76	144/77		144/67	134/64	139/101						
Temperature																		
Pulse	86	92	83	83	81	81	83	81		96	93	97						
Respiratory Rate	21	20	20	23	20	19	18	19		21	23	26						
SpO2	98	98	99	100	100	100	99	100		100	100	100						
mode	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
MIVF	25	25	25	25	25	25	25	25		25	26							
IVPB	450										100							
IVP			10															
Zofran											50							
Flagyl											800							
Tube Feed											500							
TOTALS																		

OUTPUT

	HOUR / TOTAL	24	01	02	03	04	05	06	07	/	08	/	09						
URINE		150/150	120/270	100/370	80/450	50/500	110/610	50/660	40/700		80		25						
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

AT

VITAL SIGNS

14	17	18	19	20	21	22	23	

INTAKE

14	17	18	19	20	21	22	23	8°T

OUTPUT

RESPIRATORY

		TIME													
		MODE													
		F_IO_2													
		TV													
		RATE													
		PEEP													
A		pH													
		PCO_2													
B		pO_2													
		HCO_3													
G		SAT													
		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 HR TOTALS

NURSE'S SIGNATURE

INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPU

Urine: _____

TOTAL _____

BALANCE _____

[redacted] b(6) L

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: 4 OCT 03
Time In: 1005
Allergies: NKDA
Pre-op V/S: 114/82 P-92
Procedures: Stent Graft, Abd Closure, Removal E-tubes
OR Intake: Crystalloid 700 Colloid
OR Output: UOP 600 EBL 50
Meds/Times: Fentanyl, MSO4

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

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

Pre Op Meds

History

Time	1005	1010	1015	1030	1045
SaO2	98	98	98	97	98
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120	V	V	V	V	V
100					
80	•	•	•	•	•
60	^	^	^	^	^
40					
20					
RR	17	17	17	19	21
T	96		98.3		

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1005	NS	300	D hand	OR	700

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

b(6)-2 [redacted] LPN | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 4 OCT 03

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

EPW # [redacted] b(6)-4

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

DA FORM 4700, MAY 78 | WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) | Previous edition is obsolete | USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

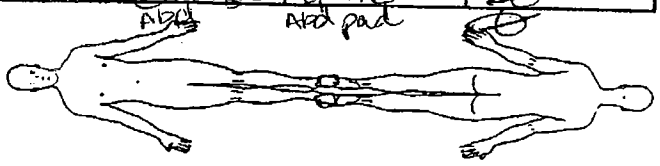
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) lower leg thigh & Abd.	Kerlix opside Abd pad	ø
30'			ø
60'			
D/C	(L) lower leg thigh & Abd.	Kerlix opsite Abd pad	ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1105	SR	ø	ø

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p skin graft Abd. Wound closure and G-tube removal. IV of NS infusing into (L) hand c ø's of redness or swelling to site. Kerlix to lower (L) leg intact. Opsite to (L) thigh intact Abd pad also intact, ø drainage noted. VSS. ø c/o @ this time [redacted] to PCU #1 via litter [redacted]

bllg-2

Discharge Criteria:

Date: 4/07 Time: 1100 PARS: 9
BP: 119/57 T: 96.3 HR: 78 RR: 19 Sa02: 97-RA
Pain Level at D/C (0-10):
Intake: 100 Output: ø
Additional Data:
Transferred To: ICU #1
Report Given To: [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recov[redacted]
Charge Nurse Signa[redacted]

bllg-2

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 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	28OCT03	IN [redacted]	28 OCT 1900	INTILAS [redacted]
	PUPLIS	2mm RRR 02			
	SENSORIUM	Alert-Disoriented		reaction to light,	
		open eyes spon		alert, knows	
				birth, responds to	
				simple commands	
RESPIRATORY	RESPIRATION PATTERN	CTA(B), ø Cough		CTA, ⊖ cough	
	BREATH SOUNDS	at Resp distress		⊖ secretions, RRR	
	SECRETIONS			⊖ rales + full of	
				the chest	
SKIN	COLOR	Stage IV Sacral		Normal for race	
	INTEGRITY	decub		Stage four IV decub	
		turn q 2°		to coccyx	
IV SITE	LOCATION	NSU IV Dac			
	CONDITION				
GASTRO	ABDOMEN	Gentle to touch		⊕BS x4, loose	
	BOWEL SOUNDS	⊕ diarrhea		stools, mid ABD	
		Mid abd sutures		sutures, ⊖ bulging	
		⊕BS			
GU	URINE	Yellow urine		Foley to gravity	
	COLOR/CLARITY	Foley Cath		⊖ Blood. Clear	
				urine.	
CARDIOVASCULAR	CARDIACRHYTHM	NSR-		NSR, ⊕ 2 pitting	
		Occ PVC		edema to (R) LE ⊖	
		2+ edema (R) LE		⊕2 pulses, cap refill	
				<3 secs.	

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 | DATE

PATIENT'S INDICATIONS *(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)*

☐ DIGNOSTIC STUDIES

☐ TRETMENT

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 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	2010 29OCT	INTILAS [redacted] b(6)-2	INTILAS	INTILAS
NEURO		PUPLIS	3MM BRISK			
		SENSORIUM	EASILY AROUSED C			
			DROWSINESS S/P			
			COLOSTOMY.			
RESPIRATORY		RESPIRATION PATTERN	NORMAL UNLABORED.			
		BREATH SOUNDS	CTA C EXPIRATORY			
		SECRETIONS	~~RATTLIGHT~~ WHEEZES			
			Ø SECRETIONS			
			BPM 116 SaO2 100			
			RA 2L NC			
SKIN		COLOR	NFR			
		INTEGRITY	HIP INCISIONS D/C'D			
			SACRAL ULCER STAGE IV			
IV SITE		LOCATION	RAC 20G			
		CONDITION	INTACT Ø S/S OF			
			INFECTION			
GASTRO		ABDOMEN	SOFT ROUND TENDER			
		BOWEL SOUNDS	BS ↓			
			COLOSTOMY IN PLACE			
			C SM AMT BLOODY DRAINAGE			
GU		URINE	FRC C AMBER URINE			
		COLOR/CLARITY	CLEAR Ø SEDIMENT			
CARDIOVASCULAR		CARDIACRHYTHM	NSR-ST 90-100S			
			S1 S2 + PULSES BUE			
			2+ BLE 2+ PT C			
			2+ EDEMA TO BLE			

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

(Continue on reverse)

[redacted] (Last, First, Middle Initial, Grade, & Title) b(6)-2

DEPARTMENT/SERVICE/CINC ICU 2

DATE 29 OCT 03

For typed or written entries give: Name - Last, First, Middle Initial, Grade, & Title of author; Name & Address of hospital or medical facility)

[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

MEDCOM - 18381

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

DATE | DX s/p CABG x 5 | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
~~BP Arterial line~~					108/53		104/50								99/57			
BP Cuff																		
Temperature								98.9							99°			
Pulse					93		92								88			
Respiratory Rate					19		12								16			
SaO_2					98		97								100			
FiO_2					RA		RA								RA			
source																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
IVPB										1170								
PO								240			240		100		100			
Meds								20%			snack		-	50%				
	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
								1000		775	850	925	1000	1075	1150		1300	1480
TOTALS								1000										

OUTPUT

URINE HOUR / TOTAL					80/1910			200		1160	1160	200	1460	200	200	200	200	14600
URINE SP gr																		
URINE S/A																		
NG OUTPUT																		
NG PH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS Redstorm								30										
DRAINS																		
DRAINS								1130										14600
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	~~23~~ 02	~~24~~ 06
							114/52	110/59	
			113/55				100	99	
			93				94	98	
			32				24	20	
			100				100	99	
			RA				RA	RA	

INTAKE

	16	17	18	19	20	21	22	~~23~~	~~24~~
I	75	75	75	75	75	75	75	75	75
	100								
N									
	240		240						
T	STOCK								
A									
K									
E									

OUTPUT

	16	17	18	19	20	21	22	23	24
O	200 Void	/	200	/	/	/	600	300	600
U	Colostomy								25
T									
P									
U									
T									

RESPIRATORY THERAPY DATA

		TIME									
		MODE									
		F_1O_2									
		TV									
		RATE									
		PEEP									
	A	pH									
	A	PCO_2									
	B	pO_2									
	B	HCO_3									
	G	SAT									
	G	BASE									

LABORATORY DATA

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

ACTIVITIES DAILY LIVING

TIME	0800								
MOUTH CARE	✓								
BATCH									
SKIN CARE	✓								
FOLEY CARE	✓								
TRACH CARE									
ROM EXERCISES	✓								

TURN

TIME									

SUCTION

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE OUTPUT

IV _____ Urine: _____

Po _____ _____

TOTAL _____ TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
blw-2	

MEDCOM - 18383

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 8Mar 89

INITIAL SHIFT ASSESSMENT

[redacted]

NEURO	TIME		INTILAS	1830	INT	INTILAS
	PUPLIS			3mm reactive		
	SENSORIUM			A+O		
RESPIRATORY	RESPIRATION PATTERN			RRR equal rise & fall		
	BREATH SOUNDS			lungs CTA B; lat		
	SECRETIONS			Ø secretions		
SKIN	COLOR			Normal for race		
	INTEGRITY			Stage IV Pressure ulcer to coccyx		
				Stage I Pressure ulcer to back of head		
IV SITE	LOCATION			RG @ wrist C/O/I		
	CONDITION			Ø S+S of infx		
GASTRO	ABDOMEN			soft NT/ND		
	BOWEL SOUNDS			Colostomy to R Flank		
				Ø S+S of infx C/O/I		
GU	URINE			Foley to gravity c		
	COLOR/CLARITY			clear yellow urine		
CARDIOVASCULAR	CARDIACRHYTHM			NSR Ø ectopy		
				Ø S1 S2 Ø murmur		

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)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CINC FCU 2

DATE 31 OCT 03

P[redacted] *written entries give: Name Last, First, mid[redacted] edical facility)*

[redacted]

b(6)-4

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

DATE | DX | HOSPITAL DAY

VITALS	TIME	24	08	09 VS	10	04	02	06 VS	07	15	08	09 VS	10	19	20	13	14	15	
	BP Arterial line			116/68								110/61	109/58		101/54				
	BP Cuff			/															
	Temperature			98.6								/							
	Pulse			81								64	72		99				
	Respiratory Rate			17								12	14		16				
	SpO^2	97	97	97	97	98	96	98	96	95	94	97	95		98				
	FiO^2	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
	LR	75	75	75	75	75	25	25	75	75	75	75	25	75	75				
	IVPB																		
	PO	25	/	/	25	5	/	50	/	/	/	/	/	/	/				
	TOTALS																		

OUTPUT	URINE HOUR / TOTAL	100/100	75/175	100/275	100/375	100/475	100/575	100/675	125/775	75/850	100/950	50/1000	100/1100		190/1290				
	URINE SP gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG PH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS Colostomy	1	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø				
	TOTALS																		

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A 1 1 0 1	7 = 3

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	b(6)-4 UNK EAW, # [redacted]	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26 1 9 7 5 0 1 0 1	27 28 29 2 8 Y	30	31 9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	NA	35 36 ~~9 9~~ 20	b(6)-4 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	46 Z	1800	NA

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49 N	50 51 52 K 7 8	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63 I Z	64 65 66 67 68 69 70	71	YEAR ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O	Ican 3	UNK
NAM [redacted] b(2)-2		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74 2 4	75 76 77 78 79 80	81 82 83 84 85 86 0 3 1 0 0 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90 A B A A	91 92 93 94 95 96	97 98 99 100 101 102 0 3 0 8 2 9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 8 2 9

FOR LOCAL USE

GSW TO CHEST

~~86414~~ 8411
LX: 8751 PX: 8622
E9912 9659
3441
7070
86411

ADMITTING OFFICER (Signature, as required)

Dr [redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK

DA FORM 3985 MAR 89

MEDCOM - 18386

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

b(6)-4

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. [illegible]	10. PREVIOUS ADMISSION
M	25	UNK	UNK			N

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
b(6)-499	[redacted]		ICU

15. FLYING STATUS	16. RATING/ OSG	17. DEP./ 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	1545	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	07 Sep 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	02SEP03	[illegible]

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) hip, jaw

802.5
802.31
873.64 V
873.41
873.63 V
873.43
883.0
890.0
V55.0
V55.1
E991.2

9/6/03 30.29, 54.12, 43.19, 86.28, 25.51, 76.76, 76.73, 27.52

9/4/03 31.1

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	5	5

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
		b(6)-2			

SIGNATURE OF [redacted] SIGNATURE OF [redacted]

DA FORM [illegible]

MEDCOM - 18387

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

25 YO MALE WOUNDED IN FACE, FLANK & RIGHT THIGH.
PATIENT UNDERWENT EMERGENT CRICOTHYROIDOTOMY, LIMITED
HISTORY OBTAINED

PMH: NONE
SH
OPEN EXTRACTION OF B/L SCDS
MEDS: Ø ALL: Ø

PHYSICAL EXAMINATION

VS: HR 100 BP 120/76 RR 30 O2 SAT 98% GCS 15
H: NC FACIAL MISSILE TRAUMA TO MAXILLA/MANDIBLE & IMPENDING LOSS OF AIRWAY
E: DONE
C: NOT EXAMINED
A: PATENT
T: OBSCURED BY BLOOD - BULGING TO TONGUE

NECK: NT
LUNGS: CTA
COR: RRR
ABD: SOFT, NT NBC PAST
PELVIS: STABLE LARGE LEFT FLANK WOUND - OUTER TABLE FX

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

NEURO OBTAINED

RP: PATIENT EMERGENTLY INTUBATED & CRICOTHYROIDOTOMY
THEN EX-LAP, G-TUBE, WASH-OUT FLANK & THIGH
& I&D FACE & SCALP REPAIR

[redacted] b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	25 FEB 03		

PATIENT (*For typed 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]

MEDICAL RECORD	PROGRESS NOTES
DATE	

OMFS Brief OP NOTE

2 Sep 03 @ 1640

Pre op dx: GSW to face, tongue w/ comminuted maxillary & mandibular fracture

Post op dx: Same

Procedure: I&D
Closure of tongue wound
Open osteosynthesis of mandible
Closure of soft tissue wounds

Surgeon: [redacted] bb-2

Assist: [redacted], [redacted]

Anesth: Cricothyroidotomy

EBL: 500 cc

U/O: 3900 cc

fluids: 1U PRBC,

findings: - multiple fragments maxilla
Anterior maxilla defect.
- comminuted mandible fracture
multiple fracture teeth
- Anterior 1/2 tongue multiple lacs
- Soft tissue facial lacs and avulsed tissue (R) commissure

(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.

CIV # [redacted]

b (6) - 4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

Complications: none
Condition: Pt stable and sedated and paralyzed ~~=~~ Bilateral Chicothyroidotomy
and transferred to ICU on standard monitors & vent.

[redacted] b (6)-2
OMFS MAJ/DC

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

MEDICAL RECORD | PROGRESS NOTES

DATE

2Sept03 (1930cont.) infection noted. LR @150cc/hr as maint. infusing. SIMV 16 TV 750 peep 5 FiO_2 40% ∫ ABG @ 1800 showed pH 7.43 pCO_2 35.7 HCO_3 24 paO_2 281 sat 100%. BE Ø turned down FiO_2 from 60%. #4 Shiley cricoidotomy, plan for return to OR in 2-3 days to convert to trach. Nasal passages packed ∫ iodoform gauze, sutured to lower lip and tongue, oral suctioned for mod amts serosanguinous drng. Midline abd dsg intact, mod amt serosanguinous drng noted G-tube to gravity drng dk brown fluid, BS hypoactive x4 quads, ØBM. Foley intact drng mod amts cl yellow drng. Dsg to (L) hip and (R) thumb intact sm amt serosanguinous drng noted. Plan to moniter secretions and hemodynamics overnight, will monitor.

[redacted] TAN

2200 T 101.4, Tylenol suppository given 650mg, Suctioned orally for sm amts serosanguinous fluid. VSS. will moniter.

(blue) [redacted] TAN

3Sept03 0100 Pt. VSS. Last ABG showed pCO_2 50, Dr. [redacted] ordered rate down to 14 on vent settings, will re-draw ABG ∫ AM labs. will monitor.

[redacted] TAN

(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] RD NO. ICU2

PROGRESS NOTES
Medical Record

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

#[redacted]

(blue)

MEDCOM - 18391

Blue-7 A11

PROGRESS NOTES

DATE	
0230 35ep05 0100	Pt bathed and linen D'd. Abd dsg and (2) hip dsg reinforced. VSS. Will monitor. [redacted] ICTAN assumed care of pt @ 0100 from ICT [redacted] Pt lying in bed @ this - sedated, tracked c #4 Shiley. SIMV RR 14 TV 750 FIO2 35%. PS. Arm ABG: 7.4/34/193/24/0/100%. AM LABS: 13.1 / 9.3 / 28.2 < 210; 139 / 3.9 / 106 / 24 / 15 / 1.4 < 139
	COAGS: PT 14.3, INR 1.29, APTT 30.10 sec. Will monitor MD as they come to unit. —CPT [redacted] AM CXR done. —CPT [redacted]
35ep05	Surgery
	Pt STABLE, INTUBATED, SEDATED
	LUNGS: CTA FIO2 40% RATE 5 TV 750 RR 14 7.45/34/163/24/0/100%
	CVR: HR ~~97~~ 97 BP 114/68
	ABD: SOFT, NT, ND G-TUBE in PLACE. WOUNDS: Healing
	Renal: 139/3.9 / 106/24 / 15 UO ~100 cc/hr. DRESSINGS: clean, dry, intact
	Heme: 13.1 / 9.3/28 < 210. Temp 101.4 TC 99°
	Resp: STABLE
	PLAN: TV TO 700
	↓ SEDATION
	TO OR in A.M.
1110	ABG on TV D TO 700 From 750. SIMV, TO 100, FIO2 35%, PS.
	ABG: 7.4/33/175/25/1/100. Dr. [redacted] Return to unit —CPT [redacted]

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

MEDICAL RECORD | PROGRESS NOTES

DATE

OMFS POD#1

3 Sep 03 @0815 Pt being weaned off of sedation and responding to stimuli. nasal packing in place c no active bleeding noted. facial wounds closed 1° c no active bleed c tongue swelling moderate but looking viable - palatal packing in place.

CN I-XII

lungs CTA c vent sounds

abd: midline wound c dressing + G tube

ext (R) thumb dressing ⊕ c/c/e

13.1	9.3 / 28.2	210	139 / 3.9	106 / 24	15 / 1.4	139	7.44	34.3	193

S/P closure of facial wounds c/R of maxillary fx + OR c wire fixation of comminuted mandible fx.

(1) Plan for Trach in Am. b(6)-2

(2) Continue to wean off sedati[redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted]

PROGRESS NOTES

Medical Record

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

[redacted] b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
	b(6)-2 A11
3Sept03 1200	Oral suctioning q 1-2° + prn. Bloody drainage noted. Wound care to face (cleaning + application of Bacitracin). Trach care done c new ties applied. Pt cont. to be stable. Sedation has been decreased to 3mg Versed q 1: 7ent @ 100 mcg/hr. Uo ~ 100 cc's — CPT [redacted]
1200	Abd + C/D/I wound c reinforced dressing intact. G Tube drng @ 10cc blood, old. q 6°. avl. Waiting call Dr. [redacted] to return to review latest ABG. — CPT [redacted]
1440	Pt [redacted] awake and desiring to get out of bed. Interpretor spoke c pt. Explained what has happened to him and where he was. Versed 2mg IVP given to increase sedation + V agitation/anxiety. Fentanyl given per abd pain per pt's reference via CDI interpretor. Pt currently resting in bed comfortably. Versed 1 to 4mg° + Fentanyl 1 125mcg. — CPT [redacted]
~~1730~~ ~~1630~~ 1600	ABG c zantac given. Lines flushed. Sedation c Versed + 7ent cont. Pt awakens when orally suctioned. GT c ~ 10cc @ q 4-6° output of dark old blood. Uo ~ 7100cc's cyclic. SP [redacted] VSS. Cont to monitor — CPT [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

FC #[redacted]

25 y.o. male b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

MEDCOM - 18394

PROGRESS NOTES

DATE	
3SEP03	Nursing Note: Assumed Care of pt. at 1800. Assessment of pt done. (see DA Form 4701, (Intensive Care nursing flow sheet) — CPT [redacted]
4Sep03 : 0000	Assumed care of pt @ 0000 from CPT [redacted] Resending ABGs + coags @ this time. VSS. Pt sedated c Fent 125mcg/hr + Versed 4mg°. A.M. CBC + Met 8: 10.6 / 7.3 / 22.8 / 174 ; 140 / 106 / 18 / 4.0 / 21 / 1.3 / 139 Coags: PT: 13.1 APTT: 25.2 INR: 1.12 ABG: 7.5/34/173/29/7/100%. SIMV RR 14 FIO2 35% TV 700 PS — CPT [redacted]
0810	pt returned to OR for I&D of mouth wounds and D/C the cric to a TRACH. PT P/U By Dr. [redacted] MAJ albutton, CPT Stas and MAJ [redacted] — CPT [redacted]
0950	pt returned from OR - VSS. cont to monitor CPT [redacted]
1350	ABGs 7.35/52.2/336/4/29/100%. ~ 10 min T-piece trial. 10L — CPT [redacted]
1418	ABGs ~ 30min T-piece trial: 7.39/51/249/6/31/100 — c 8L O2. Pt O2 ↓ to 6L — will do P/U ABGs in 30 min — CPT [redacted]
1500	ABGs on 6L O2 via T Piece: 7.39/48/270/5/30/100. RR 16 c BBS to RML/LLL, diminished. Fentanyl @ 50mcg/hr
1610	ABGs c TP TRIAL 6L O2. 7.44/42/175/5/29/100%. RR 16-20 - pt agitated c HR 130-160's. 2mg Versed c Fentanyl 25mcg bolus c 75mcg/hr infusion. Dr [redacted] reviewed earlier ABG's [redacted]

STANDARD FORM 509 (REV. 7-91) [redacted]
USAPPC V[redacted]

blw-2
All

MEDICAL RECORD	PROGRESS NOTES
DATE	
5 Sept 03 0120	Pt placed on T-piece @ 8L, sats 100%. will obtain ABG in 30 min, prior to T-piece placement. ABG pH 7.5 pCO_2 27.5 paO_2 150 HCO_3 22 BE -1 sat 100%. Will monitor. pt currently continues to be agitated [redacted] awake, attempting to climb OOB. [redacted]
0230	Sedation dropped to 2mg Versed + 50mcg Fent, pt awakens to verbal stimuli, RR 18 sats 100% on 8L T-piece. ABG pH 7.45 pCO_2 44.8 paO_2 249 HCO_3 31 BE 8. O.S/S. resp distress noted. Will monitor [redacted] CTAN
0245	Oral care performed, Xeroform gauze Ad to roof of mouth S incident. Face cleansed and bacitracin re-applied. Pt resting c periods of agitation. Will monitor [redacted] CTAN
0345	Pt placed on humidified trach collar, sats 100% on 8L. Morning labs sent. O.S/Sx resp distress. Will monitor [redacted] CTAN
0530	Pt resting. AM ABG showed paO_2 213. TC 8L turned down to 6L. O.S/Sx resp distress. Will monitor. [redacted] CTAN
0600	Assumed CARE OF PT @ 0600 FROM LT Hansen, Pt resting in bed c periods of agitation (Pt

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICU2

PROGRESS NOTES

Medical Record

[redacted]

MEDCOM - 18396

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

b(6)-2 #11

PROGRESS NOTES

DATE	
cont	pulling on a-line, picking At lines, squirming in bed crying, pointing, asking c [redacted] for water. Otherwise pt rests in between agitation periods. VSS. Pox: IV ABX, ↓O2 on TC, Δ PIV sites and ↓ agitation, possible DC on Monday to the hospital, ↓ dsgs, wound care and provide nutrition – CPT [redacted]
0035	AM LABS: ABG: 7.47 | 40 | 213 | 30 | 6 | 100% ; TC 96LO2. CBC 10.7 > 7.7 / 23.5 < 214 COAGS: PT 11.7 sec, INR 0.93, APTT <15 sec Pico 8: 129 | 107 | 13 / 4.01 | 21 | 1.1 < 156 CL 743 CPT [redacted]
0830	Dr. [redacted] pulled penrose drng to ~1cm + redressed area c sutures to ~1cm remain c dsng CDI. CPT [redacted]
1000	Pt's chair washed, face shaved + new PIV inserted 18g (L) bicept, 18g @ FA. New IV tubing placed on all gtts. Trach care done. Unit to monitor CPT [redacted]
1400	Trach care done CPT [redacted]
1500	Thirty 650mg tabs Colace @ 1200, ~~0~~ Residual. Tabs crushed c applesauce. Lorazepam to pellet top of mouth. VSS. 6 PM CPT [redacted]
1630	~~IV ABX c Zantac~~, Trach care done x2, VSS. ~~Pt ↑ 75 mcg~~ for pain mgmt. ↓ MIVF to 50cc/hr, Thirty 400 cc q 1. Residual 0. Cont to monitor – CPT [redacted]

PROGRESS NOTES

DATE	
5Sep03 @0900	OMFS POD #2 Pt laying bed c trach collar aggitated this am. facial wounds closed 1° c ↓ in facial swelling. intra oral wounds closed 1°. Xeroform gauze in place of palatal defect. tongue swelling significantly decreased. maxilla still mobile. VSS AF Plan ~~to transfer to~~ stay in hospital ~~on monday~~ for continuity of care. b(6)-7 [redacted]

b(6)-2 #1

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 SEP 03 (0700)	Assumed care of patient @ 0610hrs p receiving D-of-shift report. See flow sheet "Intensive Care Nursing Flow Sheet" for initial assessment information. [redacted]
6 SEP 03 (0800)	↑ agitation @ this time. ↑ RR 45-55, systolic ↑ 160-170's Non-invasive. Desires to void suctioning performed. Given 2cc Saline down trach tube and advanced Sx suction cath down trach x3. Removed moderate amount of thick, white mucous; ∅ mucous plug noted. Sats ↓ to 85% during initial ↑ anxiety period before suctioning. Respiratory @ bedside to assist. Respiratory rate now 30-35 c anxiety still present. Given 3cc Versed bolus, followed by ↑ Versed drip to 3mg/hr. SaO_2 now 97-98% c 31% humidified air via trach [redacted] will monitor Versed bolus & drip ↑ for effect. [redacted]
6 SEP 03 (0830hrs)	Patient now resting more comfortably. RR ~ 21-25/min. c HR currently [redacted] @ 99%. Will continue to monitor for further agitation and provide interventions accordingly. [redacted]
6 SEP 03 (1200)	Shift Update: Patient currently calm & relaxed in bed. SaO_2 @ 100%, RR → [redacted] Non-invasive. Receiving 120ml Jevity feeding; flow to peg tube. Am care completed, all suture and staple sites cleaned c ½ Sx peroxide & H_2O, then bacitracin applied. Peg tube dressing done, along c foley cath care. Will continue c current care [redacted]
6 SEP 03 (1430hrs)	Patient c/o abd pain (through interpreter). Currently receiving Versed @ 3mg/hr and Fentanyl @ 50mcg/hr. Given 4mg MSO4 IVP for abd pain. Will re-evaluate in 20min. [redacted]
6 SEP 03 (1955hrs)	Patient resting quietly & further c/o abd pain p receiving 4mg MSO4 IVP. Will continue c present care and wean off of Versed and Fentanyl [redacted]
7 Sept 03 1417	Received pt resting in bed sleeping. VSS. RN assessment on V.S. Sheet. Pt moves all extremities, awakens spontaneously, A&Ox3. Pt has continuously been

(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. ICU2

Civ # [redacted]

b(6)-1

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
cont.	agitated restless, agitated, and c/o pain to mouth q1-2°. Dylenol Elixer c Codeine given q4° c MSO4 2-5mg given for breakthrough prn. Pt also c/o nausea x1 @ ~~1200~~ 1200 c tube feeds. 1200 tube feeds held d/t pt "spitting up" Jerky through mouth. More than normal secretions via mouth. Trach care, wound care + mouth care done @ 0800 this AM. Will teach family member how to do trach + wound care. VSS. Will cont to monitor. POC: Teach pt + family members how to clean trach, wound + redress, IVABX, fluid maintance c prn mgmt, prepare for d/c to [redacted] home in AM. ——— CPT [redacted]
1430	Scripts for A/E turned into CPT [redacted] in pharmacy. EID is 0900, 8 sept 13 - CPT [redacted]
1500	Pt given 5mg MSO4 IVP + Phenergan 25mg IVP x1 for c/o pain to jaw - mouth area. Pt also c/o ~~vomiting~~ nausea p administration of MSO4.
1625	Percocet 2 tabs per g-tube for facial pain. Benadryl 50mg IVP given for insomnia per Dr. [redacted] Pt c/o pain q1-2° Ambien ordered @ HS for insomnia if Benadryl ineffective. G-tube cleaned. Chap dsing D/d. ~~Sa~~ old blood noted on wound dsing. Sero-sang drainage from wound. CTM ——— CPT [redacted]

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

b(a) - 2 #11

MEDICAL RECORD | PROGRESS NOTES

DATE

cont 1610: If pt does not tolerate tp trial she will be sedated & returned to b(6)-2 the vent. CPT [redacted]

1700 ABG: pH 7.43 | pCO2 48 | paO2 233 | BE 8 | HCO3 32 | SpO2 100. CAuscultated lungs [redacted]

Nessens return [redacted]

1730 T-Piece trial ended d/t pt cont. agitation. Began TP Trial @ 1340 c 10L O2. ~~Pt tolerating~~ Then weaned to 6L O2. Per ABG pts PaO2 175-233, PH 7.35-7.44, PaCO2 42-52, HCO3 BE 5-8, HCO3 29-32, and SpO2 100% throughout. Throughout trial of T-P. pt's RR varied from 8 to 20, c shallow breaths and some deep breaths when awake and ↑ agitation. @ 1600 2mg Versed given IVP to ↓ agitation & help ↑ oxygenation. ABG done @ 1700 c little Δ in ABG from prior ones. Pt's BPM ↓ from 12-16 to 8-13 BPM. HR has remained 125-143 throughout trial. BP has been having HR 60-80's Δ TP Trial. TBP 140-130/70-80's. Through trial. Pt cont to reach for face and face c hands and more clips around in bed. Father & Brother visited x c/hrs then left to return in am. Pt vs. Tenty [redacted] GT. GT clamped. Secured & [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. 700 F/C [redacted]

PROGRESS NOTES
Medical Record

#[redacted]

25 y.o. b(6)

MEDCOM - 18401

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

Block 24

PROGRESS NOTES

DATE	
1730	Cont. Pt returned to vent @ 1730 c Versed 2mg c 2mg Bolus. Fentanyl 75mcg/hr. SIMV. RR 14 TV 700 PS Fio2 35%. ABGs to Be done about 1800. Awaiting Dr. [redacted] return. Pt Stable @ this time. Cont to monitor — CP [redacted]
1800	ABG: c SIMV RR 14 TV 700 PS Fio2 35%. 30mg reconnected to vent: ABG: 7.50/40/133/9/32/99%. — CP [redacted]
1800	Report given to [redacted] RBS - CP [redacted]
2015	Pt continuously agitated, crying, grabbing at lines and tubes. Interpreter spoke to pt. and explained what happened, what tubes and lines were for and that pt. needed to relax, lie back and could not drink any water as pt asked for water. MAP 110's when pt agitated, 80's when pt relaxed. Sedation increased for pt. comfort and therapeutic effect. Will cont. to monitor and attempt to wean in AM [redacted] Pt
2300	Pt continues to be agitated, brief periods of rest followed by agitation and grabbing at tubes and nurse. Overbreathing vent. Will turn down sedation and attempt T-piece trial again per recommendation of [redacted] RT. Will monitor.

MEDCOM - 18402

STANDARD FORM 509 (REV. 7-91) BACK

MEDICAL RECORD	PROGRESS NOTES
DATE	

OMFS Transfer Summary

7 Sep 03 @ 0844 — 25 yo wm S/P GSW to face. Entrance wound left cheek - exit Right commissure. Avulsive wounds to face, hard tongue, palate, floor of mouth and right commissure. Pt c comminuted mandible fracture and multiple piece maxillary fracture c avulsion of hard palate. Pt also c left hip GSW.

Pt taken to the OR on 2 Sep 03 for
(1) I&D of left hip wound
(2) Gastrostomy tube
(3) exploratory laparotomy - negative
(4) repair of tongue, floor of mouth, mucosa, mouth and Right commissure.
wire osteosynthesis of mandible fracture (comminuted).
repair of mucosa maxilla
(5) awake cricothyroidotomy →

(Continued 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 - 18403

PROGRESS NOTES

DATE

Pt taken to OR on 4 Sep 03 for
① tracheostomy ⊂ #8 Shiley
② Exam under anesthesia.

DIC condition: Stable
DIC Diet: Clears as tolerated
Jevity per G tube.

Plan:

① facial sutures will need to be removed 9 Sep 03.
② fixation of maxilla needed
③ pt will need extraction of non restorable teeth once fractures are healed.
④ tracheostomy tube can be removed when surgery to maxilla is complete.
⑤ left lip sutures need to be removed in 1 week
⑥ midline staples removed in 5-7 days
⑦ G tube can be removed once fractures healed and pt can tolerate a diet.

b(6)-2

[redacted]
OMFS

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 Sept 03 1545	Pt arrived on unit via gurney accompanied by OR staff. Pupils 3mm + non-reactive. Pt responds [redacted] Unable to assess level of consciousness @ present time. NSR ~ 110 in low 90's @ palpable pulses in all extremities. Cl infusing @ 150cc/hr via 18ga in OAC. 18ga in RAC patent ~ edema or erythema. #4 Shiley trach, SIMV 16, TV 750, Resp 5, FiO_2 80%. O_2 sats 100%. Lungs coarse bilaterally ~ increased secretions noted orally + via trach. Abdomen round + hypoactive bowel sounds. Drsg to abdomen ~ moderate amt of blood tinged drainage noted. G-tube to gravity ~ small amount of brown drainage noted. Foley to gravity draining large amt of clear yellow urine. Numerous sutures around mouth ~ bacitracin applied. Nose packed by Dr [redacted] secondary to increased nasal drainage. Drsg to OHip ~ minimal amt of drainage noted. Labs sent and pt stable @ present time. Will continue to monitor [redacted]
1650	Pt placed on Fentanyl 100mcg/hr + Versed 5mg/hr for sedation. Suctioned via trach ~ moderate amt of bloody drainage noted [redacted] blew 2 [redacted]
1700	Pt ~ increased BP, MAP currently 130. Bolused [redacted] Will continue to monitor [redacted]
1930	Pt responds to touch, opens eyes, MAE. Pupils 2mm non-reactive. Sedated ~ Fent @ 100mcg/hr, versed @ 5mg/hr ~ good effect. SR 90's, ø ectopy, S_1S_2, ø murmur, 2+ radial pulses, 1+ pedal pulses, BP 180's/80's ~ 25mg Iopressor IVP to maint Diastolic <90 as ordered. Rad A-line patent, good waveform and correlation ~ cuff pressures. L and R AC 18G PIV patent, ø S/Sx

[redacted] blew 4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
02Sept03 @0810	pt arrived via Medevac, agitated & pointing to mouth. pt is Iraqi civilian who was shot in mandible & (L) hip, & mandible blown out. Airway patent, lungs CTA, VSS. Trauma team arrived immediately ONE MD. pt able to talk to interpreter and is AxOx3 per interpreter. pt sitting in High Fowlers & moved to Trauma 2. pt c GSW to (L) hip, bleeding controlled. (L) lac noted to (R) thumb. 50mg Fentanyl given [redacted]
@0825	pt moved to Trauma OR for trach pl[redacted] pt stable throughout ER visit, ske[redacted]

b(a)-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(a)-4

Iraqi

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 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER
		1932

TEST RESULTS

CBC		SMAC					ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC	23.7		133	104	7	197	SUP O2	PH	PO2	RESULTS	
H/H	12.5 / 39.6						PCO2	SAT	OTHER		
PLT	332		3.0	20	1.1						
PT			CK 536				U/A DIP			EKG INTERPRETATION	
APTT		BHCG		ETOH	GLU		U/A MICRO				

PROVIDER HISTORY/PHYSICAL

pt arrived c GSW to mandible. A x O x 3 per interpreter. pt on Hard Fowlers - airway patent. Trauma team called [redacted] 25-y/o ♂ slp GSW/blast? to face this am. pt unable to speak but indicates [redacted] ⓐ N, ⓒ pain in hip. ¢ abd pain / ¢ neck/back pain ¢ leg weakness/numbness/tingling/motion

Pelvis ⓑ renal injury? 2° stones b(4)-2
wnl. ↑ for kidneys

O: Awox4 c NAD, sitting up
Head: Atraumatic, NCAT, Face: mandible missing from ⓑ angle forward 1/3rd
OP: maintaining airway patency. PERRL, EOMI
NP: ⓐ active bleed ⓑ
Chest: CTAB ⓒ wnl RRR no m/r/g Back: ⓒ ⓑ mild kyphosis scars c ⓑ CVA.
Abd: soft, NTND, +BS Ext: 5/5 strength x4 ⓑ

Pelvis: ⓐ open wound
ⓒ h.p labral separation
T m = active bleeding
tracks to iliacus muscle

A/P: Pt stable to maintain airway sitting up. RRR/Lungs/Abdomen CTA. Pt admitted directly to OR

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP [redacted]

PROVID

DIAGNOSIS
① Facial trauma/GSW
② GSW to ⓒ hip

CODES b(4)-2

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

[redacted] b(4)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER [redacted]

RECORDS MAINTAINED AT b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY Iraq | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year) 2 Sept 03 | TIME 301

TRANSPORTATION TO FACILITY Medevac

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

CURRENT MEDICATIONS: ϕ daily

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS: DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW Saw / GSW to (L) hip — hx – renal stone, MEDEX-Iraq

CATEGORY OF TREATMENT

☒ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	0803	0815	0825			
BP	166/102	171/94	171/100			
PULSE	94	93	106			
RESP	14	15	18			
TEMP						
WT SPO2	100%	100%	100%			

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		
URINE C&S	UA MSCC/CATH		CHEM: 12		
BLOOD C&S X 1					

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
	80 mg Cipro		MLR	0815	IV bolus T + D
	50 mg Fentanyl		MLR	0820	
	Ceftriaxone 12.5 mg phenergin		MLR	0825	
	1 mg Versed		MLR	0830	
	50 mg Fentanyl		MLR	0830	

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

PATIENT DISCHARGE INSTRUCTIONS

MODIFIED DUTY UNTIL

RETURN TO DUTY

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(2)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

MEDCOM - 18408

Trauma Case

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 25 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Kidney stone removal

4. PROPOSED SURGICAL PROCEDURE: see back slip

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation;~~ surgical environment	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ ~~Maintain family interface.~~
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift [redacted] LTC, MC Family Physician	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas. b(6)-2	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

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

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

[redacted] LTC, AN 2 Sep 03 DATE

11. POSTOPERATIVE EVALUATION

Bovie Site: intact
Drsg: clear
Breathing: Tracheostomy b (w) - 2 A11

12. PREOPERTIVE EVALUATION PREPARED BY

[redacted] LTC, AN

DATE: 2 Sep 03 TIME: 08[redacted]

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 2Sep03 TIME: 1540

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDCOM - 18410

500 CBC 8500 cyp. Rome
3900 U/O IUPRB

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Gurney BY: Anesthesia
2. PATIENT IDENTIFIED [redacted] VERIFIED AND PROCEDURE VERIFIED BY: LTC [redacted]
3. DATE: 2 Sep. 03 TIME PATIENT ARRIVED IN SUITE: 0830
4. PATIENT IN ROOM TIME: 0830 NUMBER: ER/TRAUMA

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt. awake

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt. [redacted] / Spc. [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	LTC [redacted] / Cpt. [redacted]	RELIEF CIRCULATOR	CPT [redacted] (500-EDC)

7. POSITION AND POSITIONAL AIDS: Rolled sheet under Lt. hip

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

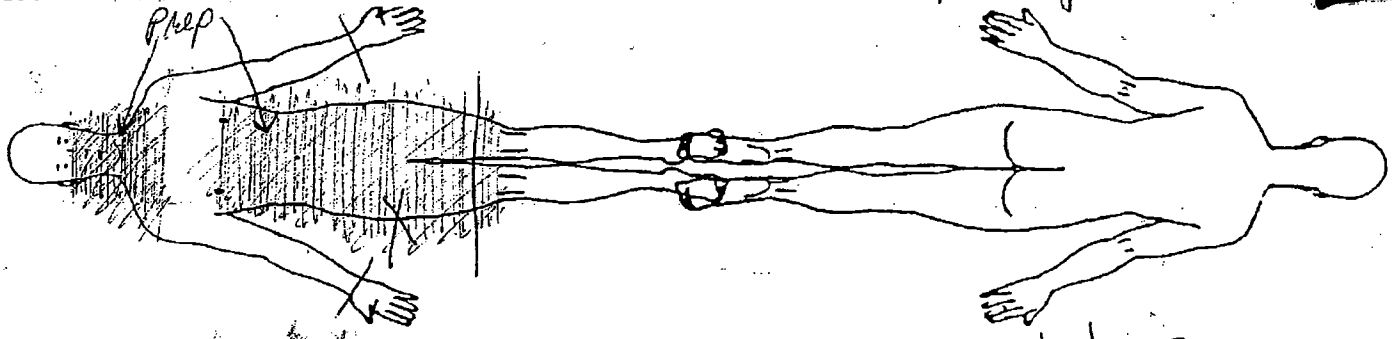
COMMENTS: Body maintained in proper anatomical alignment

8. SKIN PREPARATION b(6)-2

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

PREP SOLUTION (Specify): Betadine scrub/sol
SITE: Neck BY WHOM: LTC [redacted]
SITE: Nipples ↔ knees face BY WHOM: Cpt [redacted] LTC
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	✓	C	C
Needle Sharp	☒ Yes ☐ No	✓		
Instrument	☒ Yes ☒ ~~No~~ NA	✓		
Other	☐ Yes ☒ No			

SCRUB Spc [redacted] CIRCULATOR [redacted]

* See #19

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

Civ # [redacted] b(6)-4

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

☒ ESU NO: 00390 Valleylab
GROUND PAD: BRAND REM polyhesive
LOT NO: 689316
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

Cut: 30 Coag: 30

MEDCOM - 18411

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

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

In jaw area: CMS 0620301
Osteomed 3-hole plate 24g wire x5 pieces #4 Shiley Trach Tube
2.4 maxi 8mm Osteomed screw x2 7/8 length in neck

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Ointment	QS	1110	Topical	[redacted]	[redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NaCl - b(6)-2

OTHER ORDERS

	TIME	CARRIED OUT BY
16 Fr. 5cc foley inserted per Dr. [redacted] by LTC [redacted]	0900	LTC [redacted]

PHYSICIA[redacted] b(6)-2

15. X-RAY[redacted] YES ☒ NO ☐ IF YES, SITE AP + Lat. of Head

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	16 Fr. Malecot	1" Penrose	16F FIC
SITE	Lt. of abd. incision	Lt hip	Bladder

18. DRESSING/IMMOBILIZATION (Specify)
4x8: Abd
4x8 + ABD → Lt. hip
Xeroform + DSD → ® thumb
Xeroform Face

19. ADDITIONAL INFORMATION

Surgeons: Drs [redacted]
Anesth: Maj. [redacted] CRNA, [redacted] b(6)-2

* One counted Raytech used as dsg sponge on abd. ~~P~~ count complete + correct. I was told this by Spc. [redacted] @ end of case. [redacted]

20. OPERATION(S) PERFORMED

Tracheotomy, Exploratory Laparotomy, G-tube placement, I+D Lt. hip, I+D Rt. thumb, I+D, + Closure of GS wounds to face

21. PATIENT TRANSFERRED TO ICU 2 TIME see D47389 METHOD via Gurney

[redacted] LTC [redacted]

[redacted] CPT MC b(6)-2

REVERSE OF D[redacted] 93-1, OCT 87 MEDCOM - 18412 USAPA V1.01

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT b(6)-2 For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

2. PATIENT IDENTIFIED [redacted] OCEDURE
VERIFIED BY [redacted] CRT / AW

3. DATE 4 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN R[redacted]
TIME 0810 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies[illegible]
pt does not speak english.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) shoulder roll.

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

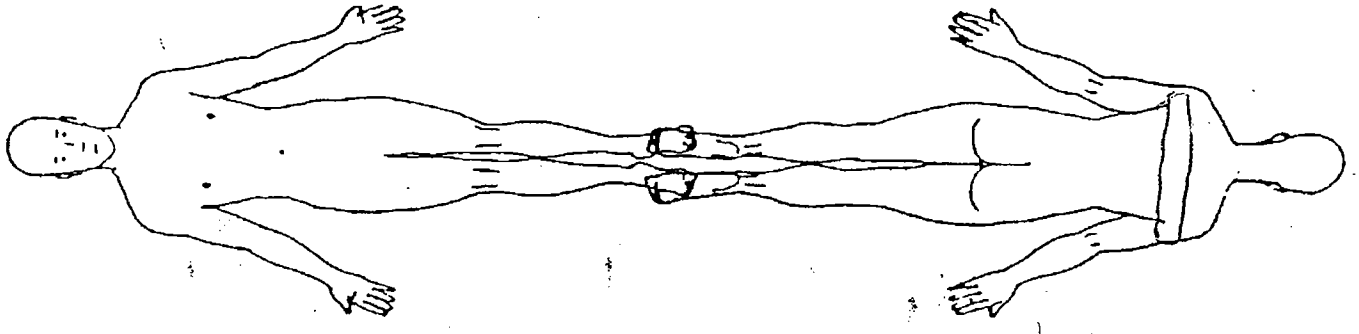
COMMENTS:

8. SKIN PREPARATION b(6)-2

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

PREP SOLUTION (Specify) Betad / Betad
SITE: BY WHOM: CP[redacted]
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

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

10. COUNTS SPC [redacted] C = Correct I = Incorrect

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

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

#[redacted] b(6)-4

3 Sep 03
[redacted] b(6)-2

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

CUT COAG
☒ ESU NO: Valleylab SN: 00047
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68248 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

LAR NO:

MEDCOM - 18413

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS

	TIME	CARRIED OUT BY
PH[redacted] b(6)-2		

15. X[redacted] IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
- 5X4
- medipore tape
- Benzoin tincture

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 8 LPC Shiley	2.	3.
SITE	throat area	2.	3.

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] Anesthesia: CRT b(6)-2 [redacted] Anesthesia Type: Gen

Bovie Pad site intact pre-op NA; post-op NA Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op Ø: post-op Ø
Tourniquet Time: Up Ø Down Ø

20. OPERATION(S) PERFORMED

Tracheostomy / Exam under anesthesia

21. PATIENT TRANSFERRED TO ICU b(6)-2 TIME 0915 METHOD gurney

22. REC[redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

[redacted] 9 160 4

2 SEP 03

171/91

	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										~~153/92~~	~~154/96~~	154/96	145/91	133/88	128/76	123/74	114/68	102/63	106/64	104/63	109/62	100/68	102/66	101/64
BP NIBP										153/92	154/96	157/99	134/86	129/82	123/76	121/73	113/68	108/62	105/61	107/60	108/60	94/60	96/58	100/58
TEMP										97.9	98.8	99.8				101.4		100.4		98.9			99.3	
PULSE										93	78	89	94	113	115	122	118	119	114	111	105	109	107	105
RESP										16	32	16	16	116	116	116	116	116	114	14	14	14	14	14
SP02										100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
FIO2										80	60	60	60	~~80~~	40	40	40	40	40	40	40	40	35	35
N/A										117	123	121	110	99	94	89	86	82	76	75	75	73	77	75
P																								25
INPUT																								
IV										150	150	150	150	150	150	150	150	~~185~~	125	125	125	125	125	125
RD										50	50							100						
NS										5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
										20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
PO																								
NGT																								
O.R. IN									9000															
SUB TOTAL									9000	225	225	175	175	175	175	175	175	250	150	150	150	150	150	125
TOTAL									9000	9225	9450	9625	9800	9975	10150	10325	10500	10750	10900	11050	11200	11350	11500	11650
OUTPUT																								
										375	940	760	380	350	150	150	175	100	100	100	100	100	100	
STOOL																							100	
Oral																							250	
O.R. OUT									3900	~~375~~	940													
SUBTOTAL									3900	375	940	760	380	350	150	150	175	100	100	100	100	100	450	
TOTAL									3900	4275	5215	5975	6075	6425	6575	6725	6900	7000	7100	7200	7300	7400	7850	
BALANCE																							(+350)	

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

[redacted] 4-5 & TRACH

1CU #2

DATE	TIME	MODE	RATE	VOLUME							PIP	pH	PaCO2	PaO2	FiO2	HCO3	SaO2	REMARKS	INT
25Sep03	1600	SIMV	16	750	60	5	30	16	86	100	172/64								
26Sep03	1850	SIMV	16	750	60	5	28	16	91	100	166/68	7.43	35.2	258	0	24	100	UTD2 40%	
	2040	SIMV	16	750	40	5	34	16	107	100	129/82							pt moving	
	2158	SIMV	16	750	40	5	33	16	121	100	120/72								
	2352	SIMV	16	750	40	5	35	16	119	100	113/64								
	0158	SIMV	16	750	40	5	38	14	110	100	103/60								
	0330	SIMV	14	750	40	5	31	14	108	100	102/66	7.44	31.2	193	0	24	100		
	0645	SIMV	14	750	35	5	26	14	103	100	104/64								
3Sep	0800	SIMV	14	690	35	5	23	14	99	100	109/65								
	1000	SIMV	14	690	35	5	24	14	96	100	111/69								
	1200	SIMV	14	690	35	5	21	14	98	100	125/73								
	1400	SIMV	14	690	35	5	26	15	97	100	125/70								
	1600	SIMV	14	690	35	5	32	15	102	100	126/70								
	1800	SIMV	14	690	35	5	29	14	99	100	119/69								
	1927	SIMV	14	690	35	5	29	14	100	100	116/63								
	2202	SIMV	14	690	35	5	31	14	92	100	111/60								
	2333	SIMV	14	690	35	5	30	15	91	100	111/64								
						5	27	20	104	90	104/76								
4Sept	149	SIMV	14	690	35	5	27	15	103	100	124/60								
	0414	SIMV	14	690	35	5	28	30	92	100	130/68								
	0617	SIMV	14	690	35	5	28	14	78	100	134/64								
	0749	SIMV	14	690	35	5	29	14	74	100	134/60								
	1010	SIMV	14	700	60%	5	23	14	65	100	135/63								
	1200	SIMV	14	700	35%	5	24	14	87	100	145/70								
	1810	SIMV	14	700	35%	5	23	14	101	100	129/66								
	1935	SIMV	14	700	35	5	26	14	106	100	144/67								
	2126	SIMV	14	700	35	5	19	14	58	100	138/67								
5Sept	0618	SIMV	14	700	35	5	21	14	81	100	138/67							d/c vent = TO [redacted]	
	0715	T piece		8 L PM															
	0940	T-collar		40%				15	111	100	149/75								
	0545	T collar		40%				22	125	100	172/90	7.47	40	213	6	30	100	SX-dark brown/[redacted]	
	0800	T-collar		30%				18	88	100	146/78								
	1000	T-Collar		30%				14	109	100	172/90								

#700 ICU2 3Sept03

FIC 3Sept03

	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	102/61	107/64	113/68	113/67	119/72	121/72	129/70	118/68	119/85	118/64	124/70	129/66	113/56	113/63	112/61	115/62	109/60	118/58	115/60	111/61	121/66	123/66	137/69	132/64
BP NIBP	105/65	104/62	107/63	104/108	110/62	115/63	118/69	119/66	119/65	123/64	118/64	118/68	113/66	113/57	110/54	112/55	104/55	109/63	113/56	113/58	113/65	124/66	124/63	134/69
TEMP		99.0				99.7		97.4										98.6		99.2			98.4	
PULSE	103	99	97	99	96	93	98	97	121	103	102	104	97	99	101	92	92	91	101	100	90	83	75	75
RESP	14	15	14	14	14	16	16	16	15	20	20	16	16	14	14	14	15	14	18	14	14	14	14	14
SP02	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
FIO2	35	35%	35%	35%	35%	35%	35%	30%	35	35%	35%	35%	35%	35	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
MAP	73	77	80	82	86	80	85	84	104	80	87	91	79	78	75	76	54	36	78			84	87	91
HR	25	24	24	23	24	24	25	24	24	24	24		29	30	24	25	32	31	28	28	29			
INPUT																								
IV	125	125	125	125	125	125	125	123	125	125	125	125	120	125	125	125	125	125	125	125	125	125	125	125
IVPB		100				12				100								50	50					
Versed	5	3	3	3	3	3	3	3	4	4	4	4	4	4	4	4	4	4	6	4	4	4	4	4
Fent	20	20	20	20	20	20	20	20	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5
PO																								
NGT																								
O.R. IN																								
SUB TOTAL	150	248	148	148	148	160	148	148	141.5	241.5	141.5	141.5	141.5	141.5	141.5	141.5	141.5	141.5	142.5	141.5	141.5	139	141.5	141.5
TOTAL											1823	1964.5	2106	2247.5	2389	2530.5	2672	2813.5	2956	3097.5	3239	3378.5	3520	3661.5
OUTPUT																								
INE	100	80	80	80	140	130	140	110	160	140	70		150	165	100	70	120	100	150	180	180	140	140	180
GT	0	0	0	0	0	10	0	0	0	0	10													90
STOOL	0	0	0	0	0	0	0	0	0	0	0													
oral	10	10	10	5	0	5	5	0	0	0	10													
O.R. OUT																								
SUBTOTAL																								
TOTAL											1330													
BALANCE											1496													

4

+IC # [redacted] E-39

4 Sept 03

ICU2

TRACHEAL

	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	130/60			143/71	121/101	147/107	124/88	144/75	140/78	132/81	151/89	154/83	145/79	133/107	144/73	144/72	129/73	140/73	124/90	133/72	112/68	178/89	182/72	144/76
BP NIBP	123/58	121/101		110/55	137/101	124/64	120/103	129/73		133/74	135/80	135/78	131/74	126/82	138/89	140/74	134/64	129/106	142/83	154/81	108/74	142/60	141/74	138/77
TEMP	98.4			98.3				98.7					98.7						98.9				97.9	
PULSE	72	73		106	109	85	85	135	143	125	128	136	127	95	94	91	83	80	129	104	96	128	92	96
RESP	16			16	16	16	16	16	16	20	12	22	24	19	14	16	14	14	17	12	16	27	15	16
SP02	100			100	100	100%	100%	100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
FIO2	35%			100%	35%	33%	35%	60%	60	60	60	35%	35%	35%	35%	35%	35%	35%	35%	8L	8L	8L	8L	6L
	30			24	24	20	24	TP	TP	TP	TP		18	19	19	18	21	22	16	TC	TC	TC	TC	TC
VN	88	85		91	84	88	78	100	97	119	103		94	87	98	109	93	88		101	88	100	95	100
INPUT																								
IV	125	125	✓	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
Versed	4	4		4	4	2	2	0	0	2	2	3	3	4	4	4	3	3	3	2	2	2	2	2
Zeva	125	125	0	125	125	10	10	5	5	5	7.5	7.5	7.5	7.5	10	10	7.5	2.5	7.5	5	5	5	5	5
IVPB		100								100								100						
Reacid						0																		
NGT					100	100				100				100				100				0		
O.R. IN																						100		
SUB TOTAL																								
TOTAL																								
OUT																								
URINE	200	100		800	100	100	200	200	200	160	140	200	310	300	240	200	214	240	270	270	100	160	180	300
NGT																								
STOOL																								
Trach Suc				✓																				
Oral Suct	✓	✓		✓																				✓
O.R. OUT													✓					✓				✓		
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 18418

ACLU-RDI 1646 p.178

DOD-031992

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

[redacted] T-Collar 31%
ICU%2
8 Shiley

DATE	TIME	MODE	RATE	VOLUME	FIO2	BEEP	PIP	PT RATE	HR	SO2	BP	PH	PCO2	PO2	BE	HCO3	SaO2	Remarks	INT
Sept	1200	TC			31				88	100	158/73								
	1400	TC			31				104	100	176/74								
	1600	TC			31				87	100	168/88								
	1800	TC			31				100	100	151/76								
	2011	TC			31			16	88	100	149/82								
	2226	TC			31			21	102	100	142/84								
	2341	TC			31			15	98	100	158/70								
Sept	0215	TC			31			20	106	98	158/80								
		TC			31			19	96	100	155/80								
	0330	TC			31 → 28%			24	110	100	121/71								
	0700	TC			24			20	97	100	120/59							Pt moving	
	0823	TC			21%			24	98	98	134/57								
	0800	Pt is on Room Air at this time 9/28 dumb line will periodically Check pt to make sure he does not need to be back on O2																	

ICU2

5 Sept 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	141/75	174/88	149/75	141/70	60/80	106/82	141/71	104/84	153/83	170/94	114/85	109/85	156/86	152/84	149/82	143/86	149/88	144/89	154/83	164/80	164/78	145/80	140/79	143/88
BP NIBP	126/80	130/70	140/91	131/72	129/76	123/81	119/64	132/87	132/76	124/76	125/79	132/76	126/96	119/99	126/80	124/71	121/70	124/71	124/84	154/83	152/80	113/76	118/72	133/63
TEMP	98.3					98.6							98.2			98.8			99			98.2		
PULSE	87	116	91	88	83	123	93	110	88	117	114	110	94	95	83	85	86	88	100	110	94	93	88	98
RESP	17	22	16	20	16	16	17	24	17	20	20	24	14	17	18	14	14	20	24	23	20	14	14	
SP02	100	100	100	100%	100	100	100	100	99	96	100%	100	100	100	100	100	100	99	94	98	99	99	100	99
FIO2	31%	31%	31%	31%	31%	31%	31	31%	31%	31%	31%	31%	31	31%	31%	21	31	31	31	31	31	31	31	31
MAP	95	105	97	95	89	98	91	100	100	100	106	110	94	96	96	89	91	91	102	110	89	84	88	
INPUT																								
IV	125	125	125	125	125	125	125	125	125	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
Flushes	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Tent	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
IVPB																		50	50					
PO						2		02		1	2	2	2	5	5		3							
NGT	-	100				100				400				400				400				400		
Rectal IN		0				0				0														
SUB TOTAL																								57
TOTAL																								
OUTPUT																								
URINE	140	130	160	180	200	150	100	150	200	200	150	200	190	200	150	170	150	90	110	190	210	100	130	90
GT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								90
BALANCE																								

MEDCOM - 18420

ACLU-RDI 1646 p.180

DOD-031994

(LOCKUP)

CIV [redacted]

blg-4

01

	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	144/81	159/88	150/72	167/88	150/72	157/81	154/80	155/83	143/80	167/89	151/76	156/86	173/78	167/80	167/69	140/	147/	147/80	144/	125/	134/	140/	165/	174/
BP NIBP	124/70	141/91	135/76	147/88	124/78	124/75	139/85	144/87	127/72	145/91	129/78	136/77	133/83	133/85	130/81	121/	134/80	132/84	137/89	98/59	129/	138/	130/	137/
TEMP	98 ax	98 ax	98 ax	98 ax	98 ax	99 ax	99 ax	98 ax	99 ax	99 ax	99 ax	99 ax							98			98		
PULSE	90	100	98	111	100	102	120	115	105	113	99	99	103	113	107	114	100	104	96	91				
RESP	22	26	21	23	21	22	29	29	20	22	21	21	25	16	22	20	22	22	22	21	20	16	16	16
SP02	98%	97%	99%	100%	100%	99%	99%	99%	99%	99%	97%	98%	98	100	100	100	100	100	100	100	100	100	100	100
FIO2	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	28%	28%	28%	28%	28%	28%	28%	28%
	97	106	99	109	93	100	104	107	97	110	103	101	103	104	105	41			109	74			95	41
INPUT																								
IV (MAINT)	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50				
IVPB		100								100														
VERSED	2	2	3	3	3	3	3	3	3	2	2	2	2	2	2	2								
FENT	5	5	5	5	5	5	5	5	5	4	4	2	1	1	1	1	4	4	4	2				
TF JEVITY FEED	—	400	-			400				400				400				900						
~~PO~~ PO								SIPS	3 SIPS 2 LIQ	2 LIQ														
~~NGT~~ RESID		0	-			0				0				0				0						
O.R. IN																								
SUB TOTAL	57	557	58	58	58	458	58	58	58	358	56	54	53											
TOTAL	114	671	729	787	845	1303	1361	1419	1477	2035	2091	2145	2198											
OUT																								
URINE	200	250	180	110	180	190	170	180	270	175	250	160	200	200	140	140	110	180	180	150	180	200	120	100
NGT	—	—	—	-	—	-	-	—	—															
STOOL	-	-	—	-	-	-	-	-	-															
O.R. OUT																								
SUBTOTAL	200	250	180	110	180	190	170	180	270	175	250	160	200	200	140	140	110	180	180	150	180	200	120	100
TOTAL	298	548	728	838	1018	1208	1378	1558	1828	2003	2253	2413	2613	2813	2953	3093	3203	3383	3563	3713	3893	4093	4213	4313
BALANCE	-43	+307	-122	-52	-122	+268	-112	-131	-242	281	-194	-106												

MEDCOM - 18421

[redacted] D/C T Sept 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	157/83	140/80	9C																					
BP NIBP	134/80	141/83	139/81	141/81		138/80		130/72	129/67					137/91		129/77		124/75				147/85		131/75
TEMP				98.3				97.4						97.3		98.1		98.6			98	98.6		98.6
PULSE	127	97	101	87		101		102	96					116		95		106				105		97
RESP	30	25	16	20		16		17	14					13		14		13				17		20
SP02	100	99	99	100	99	99		100	100					94		96		99				98		99
FIO2	RA	RA	RA	RA	RA	RA		RA	RA					RA		RA		RA				RA		RA
MAP		105							96					92										
INPUT																								
IV	0	0	0	10	10	10			20															
PO	3	3	2	1	0	0																		
NGT		400				200	(held)		100															
ROBSN		0				60			40															
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE	200	180	160	200	30	30		200		200				200	170	45		160			200	90		150
NGT	0																							
STOOL	0																							
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

128/74 94 1500 103 99% 0800

SIMV 14
FiO2 40%
peep 5
TV 750

b(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.448

PCO2_____34.3 mmHg

PO2_____193 mmHg

HCO3_____24 mmol/L

BEecf_____0 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

03SEP03 04:21

Oper: [redacted] b(6)-2

Physician:_____

Ser# 40746

Ver: JAMS046A
CLEW A93

---

b(6)-4

i-STAT G3+ SIMV 14 TV 750 peep 5 FiO2 40%

Pt: [redacted]

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.436

PCO2_____35.7 mmHg

PO2_____266 mmHg

HCO3_____24 mmol/L

BEecf_____0 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

pH_____7.435

PCO2_____35.9 mmHg

PO2_____266 mmHg

Patient Temp: 98.8F

FIO2_____: 60

Sample Type_:

02SEP03 17:57

Oper [redacted] b(6)-2

Physician:_____

Ser# 42015

Ver: JAMS046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

creatnine - 1.4

Glu_____139 mg/dL

BUN_____15 mg/dL

Na_____139 mmol/L

K_____3.9 mmol/L

Cl_____106 mmol/L

TCO2_____24 mmol/L

AnGap_____14 mmol/L

Hct_____25 %PCV

Hb*_____9 g/dL

*via Hct

pH_____7.453

PCO2_____33.3 mmHg

HCO3_____23 mmol/L

BEecf_____-1 mmol/L

Sample Type_:

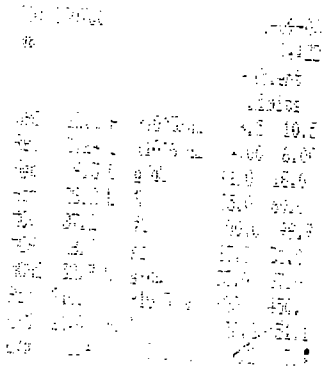
03SEP03 04:24

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42015

Ver: JAMS046A
CLEW A93



stat

Ward/Section: EMT	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. 200	DATE 25 Apr 03	TIME	SSN/PSEUDO SSN: 200

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		x10	Color		N/A	RPR		Negative
			App		N/A	Mono		Negative
			Glu		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
		itial	pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Macroscopic Urinalysis**		
			HCG		Negative			

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

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

REMARKS:

REPORTED BY: CA MEDCOM - 18424 ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
02/09/03 08:26
REFERENCE RANGE: MALE
PATIENT #: [redacted] blw-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: blw 2 0000100676

GLU	197*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	586*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	3.0*	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		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
CO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: OR

REQUESTING PHYSICIAN: [redacted]

CHEMISTRY RESULT FORM

ject to the Privacy Act of 1974)

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

DATE: 02 SEP 03

TIME: 0940

SSN/PS: [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		[redacted]

b(6)-2

Mis[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: SK

(Piccolo) Chemistry 12

---------- 2 ----------

i-STAT EG7+

Pt: [redacted]

Pt Name: b(6)-4

Na_____141 mmol/L

K_____2.7 mmol/L

TCO2_____23 mmol/L

iCa_____1.18 mmol/L

Hct_____31 %PCV

Hb*_____11 g/dL

*via Hct

At 37C

PH_____7.306

PCO2_____43.6 mmHg

PO2_____419 mmHg

HCO3_____22 mmol/L

BEecf_____-5 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.312

PCO2_____42.7 mmHg

PO2_____416 mmHg

Patient Temp: 97.8F

FIO2_____: 75

Sample Type_: ART

02SEP03 09:47

Oper: [redacted]

Physician: b(6)-2

Ser# 42015

Ver: JAMS046A
CLEW A93

(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

b(6)-2

Ward/Section: OR

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

DATE: 02 SEP

TIME: 1045

TORY RESULT FORM
...o the Privacy Act of 1974)

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

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC		
RBC		
P.		
Ly.		
O		
Segs		
Bands		
Lymph		
Atyp		1mm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 10:52 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 16.0 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.3
Calculated INR = 1.55
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :10:51 AM
Card Lot :080201
Operator [redacted] b(6)-2

Urinalysis		
	RESULT	REF. RANGE
		N/A
		N/A
		Negative
		Negative
		Negative
		N/A
		Negative
		N/A
		Negative
		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

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

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

Microscopic Urinalysis

...l Bank

...SF 518 WITH ...REQUESTED

...OF BLOOD

...ROSSMATCH

STAT

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 11:01 AM

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 29.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :10:59 AM
Card Lot :030201
Operator [redacted] b(6)-2

REMARKS:

REPORTED BY:

DA...

EV#7

b(6)-2 T=0.5' / FiO2 76% 33 ET CO2

Ward/Section: OR	REQUESTING PHY[redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST #[redacted] b(6)-4	DATE 2SEP03	TIME 1350	SSN/PSEUDO SSN:

i-STAT EG7+

Pt:[redacted]

Pt Name:_____

Na_____142 mmol/L
K_____5.6 mmol/L
TCO2_____24 mmol/L
iCa_____1.15 mmol/L
Hct_____28 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.360
PCO2_____41.1 mmHg
PO2_____419 mmHg
HCO3_____23 mmol/L
BEecf_____-2 mmol/L
sO2*_____100 %
*calculated

FIO2_____: 76
Sample Type_: ART

02SEP03 11:59

Oper:[redacted] b(6)-2

Physician:_____

Ser# 42015
Ver: JAMS046A
CLEW A93

(Piccolo) Chemistry 12

RANGE	TEST	RESULT	REF. RANGE
mol/L	ALB		3.5-5.5 g/dl
ol/L			
ol/L			
g (art)			
(vcn)			
g (art)			
(art)			
(vcn)			
(art)			
(vcn)			
L			
mol/L			

i-STAT G3+

Pt:[redacted] b(6)-4

Pt Name:_____

TCO2_____25 mmol/L

At 37C
pH_____7.336
PCO2_____44.5 mmHg
PO2_____573 mmHg
HCO3_____24 mmol/L
BEecf_____-2 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

02SEP03 13:53

Oper[redacted]

Physician:_____

Ser#[redacted]
Ver: JAMS046A
CLEW A93

(Piccolo) Metabolic Panel

TES	REF RANGE
GLU	
BUN	
CA++	
CRE	
NA+	
K+	
CL-	
tCO	
T	
Al	
A	
A	
A	

i-STAT EG7+

Pt:[redacted]

Pt Name:_____

Na_____139 mmol/L
K_____4.9 mmol/L
TCO2_____24 mmol/L
iCa_____1.11 mmol/L
Hct_____40 %PCV
Hb*_____14 g/dL
*via Hct

At 37C
pH_____7.340
PCO2_____42.7 mmHg
PO2_____522 mmHg
HCO3_____23 mmol/L
BEecf_____-3 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

02SEP03 14:04

Oper[redacted]

Physician:_____

Ser# 42015
Ver: JAMS046A
CLEW A93

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b(6)-2

[redacted] DATE: 2Sep03 LAB ID NO.:

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

i-STAT			Piccolo Chemistry 12			Piccolo Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	Alb		3.5-5.5 g/dl	GLU		73-118 mg/dl

LABORATORY FILE

SPECIMEN/LAB RPT. NO. | PATIENT STATUS ☒ BED ☐ OUTPATIENT ☐ AMB ☐ DOM ☐ NP | SPECIMEN SOURCE (Specify) A-line | LAB ID NO.

MISC | URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT | DATE 3 Sep 03

MD | TECH

REPORTED BY

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

Enter in above space

PATIENT IDENTIFICATION

REQUESTING PHYSICIAN'S SIGNATURE

REMARKS

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

RESULTS

CBC PT/PTT, Chem 7 ABG Freq 4hrs

REQUESTED

DATE 3 Sep 03 TIME 0400 A.M. P.M.

SPECIMEN TAKEN

TEST(S)

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/03/03 04:24 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.3 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.29
Sample Type:citrated wh. blood
Test Date :09/03/03
Test Time :04:23 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/03/03 04:28 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 30.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/03/03
Test Time :04:26 AM
Card Lot :030201
Operator : [redacted] b(6)-2

[redacted] ICU2
b(6)-4

Dr [redacted]

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

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 4SEP | TIME: 0618 | SSN/PSEUDO SSN:

(Hematology) CBC

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
Glu		
b		
k		
G		

CSF

ctigen	

B
(MUST SUBMIT

UNIT

Misc. Serology

TEST	RESULT	REF. RANGE
		Negative
		Negative
		Negative
		Negative

biology

rinalysis

k

18 WITH
ESTED

OOD

ATCH

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/04/03 06:21 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :09/04/03
Test Time :06:19 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/04/03 06:23 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 25.2 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/04/03
Test Time :06:21 AM
Card Lot :030201
Operator [redacted] b(6)-2

i-STAT G3+
pt: [redacted] b(6)-4
Pt Name:_____

TCO2_____30 mmol/L

At 37C
pH_____7.539
PCO2_____34.4 mmHg
PO2_____173 mmHg
HCO3_____29 mmol/L
BEecf_____7 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
PH_____7.541
PCO2_____34.2 mmHg
PO2_____173 mmHg

Patient Temp: 98.4F
FIO2_____: 35
Sample Type_:

04SEP03 06:16

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

Ser# 42011
Ver: JAMS046A
CLEW A93

FDP

REMARKS: ABG T: 98.4 FIO2 35%

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

EG-7 T- -/FiO2 76 34 ETCO2

Ward/Section: 08	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 2Sept	TIME 1445
SSN/PSEUDO SSN:		

SIMV TV 700 RR14 FiO2 35% PS

(Hematology) CBC

TEST	RESULT	REF. RANGE

Urinalysis

TEST	RESULT	REF. RANGE

Misc. Serology

TEST	RESULT	REF. RANGE

TEST(S) SPECIMEN TAKEN — DATE 5Sept03 TIME 0400 A.M. P.M. — REMARKS — Enter in above REQUESTING

---

i-STAT EG7+

Pt: [redacted] blue-4

Pt Name: _____

Na_____140 mmol/L
K_____4.6 mmol/L
TCO2_____24 mmol/L
iCa_____1.13 mmol/L
Hct_____20 %PCV
Hb*_____7 g/dL
*via Hct

At 37C
pH_____7.386
PCO2_____38.6 mmHg
PO2_____431 mmHg
HCO3_____23 mmol/L
BEecf_____-2 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

02SEP03 14:48

Oper: [redacted]

Physician: _____

Ser# [redacted] blue-2

Ver: JAMS046A
CLEW A93

---

i-STAT EG7+

Pt: [redacted] 9 1 5

Pt Name: _____

Na_____140 mmol/L
K_____3.9 mmol/L
TCO2_____26 mmol/L
iCa_____1.25 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
pH_____7.482
PCO2_____33.4 mmHg
PO2_____175 mmHg
HCO3_____25 mmol/L
BEecf_____1 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

03SEP03 11:16

Oper [redacted]

Physician: _____

Ser [redacted]

Ver: JAMS046A
CLEW A93

======= PICCOLO =======
05/09/03 04:20
REFERENCE RANGE: MALE
PATIENT #: 700
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 777 DR #: 000
SERIAL #: 0000100676

GLU	156*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	743*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

[redacted] ICU2 blue-1

MISC
URGENCY: ☐ STAT ☐ PRE-OP ☒ ROUTINE ☐ TODAY
PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ AMB ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
LABORATORY FILE

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 29 Aug 03	TIME: 1600
		SSN/PSEUDO SSN:

(Hematology) CBC

[illegible]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 04:07 PM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.9 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.38
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :04:05 PM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 04:16 PM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 32.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :04:14 PM
Card Lot :030201
Operator [redacted] b(6)-2

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank U
(MUST SUBMIT SF 518 WI
REQU

UNIT	TYI

ATE: **LAB ID NO.:**

Misc. Serology

TEST	RESULT	REF RANGE

i-STAT EG7+
Pt: [redacted] b(6)-4
Pt Name:_____

Na_____139 mmol/L
K_____4.6 mmol/L
TCO2_____27 mmol/L
iCa_____1.21 mmol/L
Hct_____34 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.271
PCO2_____54.2 mmHg
PO2_____445 mmHg
HCO3_____25 mmol/L
BEecf_____-2 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.277
PCO2_____53.3 mmHg
PO2_____443 mmHg

Patient Temp: 97.9F
FIO2_____: 70
Sample Type_: ART

025EP03 16:05

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

Ser# 42015
Ver: JAMS046A
CLEW A93

MEDCOM - 18432

LCH# 70- [redacted] b(6)-2

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

LAST, FIRST, MI: CIV [redacted] b(6)-4 | DATE: 4 Sep | TIME: 0510 | 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		

REMARKS:

REPORTED BY:

(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++		

======= PICCOLO =======
04/09/03 05:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100684

GLU	139*	73-118	MG/DL
BUN	18	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	622*	39-380	U/L
NA+	140	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 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
CO_2		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
[illegible]		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
O_2		18-33 mmol/l

Ward/Section: ICU #2 | [redacted] b(6)-2 | ORATORY RESULT FORM
ect to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-4 | DATE 45693 | TIME 0510 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
		4.7-6.1 x 10^9
		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
		80-94 fl (M) 81-99 fl (F)
		130-500 x 10^3 verified
		20.5-51.1%

al Differential

ono		
s		
so		
n		
		42-52% (M) 37-47% (F)
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.:**

T-piece trial

---

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name: [redacted]

TCO2_____31 mmol/L

At 37C

PH_____7.472

PCO2_____40.4 mmHg

PO2_____213 mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.471

PCO2_____40.5 mmHg

PO2_____213 mmHg

Patient Temp: 98.7F

FIO2_____: 45

Sample Type_:

055EP03 04:18

Oper: [redacted]

Physician: b(6)-2

Ser# 42015

Ver: JAM5046A
CLEW A93

[redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/05/03 04:13 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:< 15 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/05/03
Test Time :04:11 AM
Card Lot :030201
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/05/03 04:16 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 16.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/05/03
Test Time :04:14 AM
Card Lot :030201
Operator [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/05/03 04:11 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 11.7 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 0.93
Sample Type:citrated wh. blood
Test Date :09/05/03
Test Time :04:09 AM
Card Lot :010301
Operator [redacted]

b(6)-2

b(6)-2

Ward/Section: ICU H2 | TESTING PHYSICIAN: [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-2 [redacted] | DATE 6 SEP | TIME 1430 | SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		-10.8 x 10^3	Color		N/A	RPR		Negative
		-6.1 x 10^9	App		N/A	Mono		Negative
		-18 g/dl (M) -16 g/dl (F)	Glu		Negative	Microbiology		
		-52% (M) -47% (F)	Bili		Negative	Source		
		-94 fl (M) -99 fl (F)	Ket					
		0-500 x 10^3 rified	SG					
		.5-51.1%	Bld					
Differential			pH					
			Prot					
			Urob					

NSN 7540-00-181-8344 PREVIOUS EDITION USABLE

TEST(S) REQUESTED: HBG

SPECIMEN TAKEN: DATE 2 Sep | TIME 1800 A.M.

RESULTS

REMARKS

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

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

HBG

[redacted] b(6)-4

REPORTED BY | TECH | MD | DATE

MISC | URGENCY: ROUTINE, TODAY, PRE-OP, STAT | PATIENT STATUS: BED, OUTPATIENT, NP, DOM, AMB | SPECIMEN SOURCE (Specify): 14-Lun | LAB ID NO. | SPECIMEN/LAB RPT. NO.

557-107

PHYSICIAN'S COPY

Hematocrit		42-52% 37-47%
Sed Rate		
Other		
Coagulation Studies		
TEST	RESULT	REF. R
PT		9.8-13.6
APTT		21-34 sec
D dimer		<20 ug/m
FDP		<10 ug/m
REMARKS:		
REPORTED BY:		

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/06/03 06:06 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 11.0 sec.
RESULT NOT RANGE CHECKED
Ratio = 0.9
Calculated INR = 0.85
Sample Type:citrated wh. blood
Test Date :09/06/03
Test Time :06:04 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/06/03 06:09 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 16.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/06/03
Test Time :06:07 AM
Card Lot :030201
Operator [redacted] b(6)-2

MEDCOM - 18436

LAST, FIRST, MI.		DATE	TIME	(Subject to the Privacy Act of 1974) SSN/PSEUDO SSN:
b(6)-4 CSH [redacted]	b(6)-2 [redacted]	05SEP		

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L

(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

(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
CO_2		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
P		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
CO2		18-33 mmol/l

---

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____32 mmol/L

At 37C

PH_____7.418

PCO2_____47.5 mmHg

PO2_____142 mmHg

HCO3_____31 mmol/L

BEecf_____6 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.419

PCO2_____47.4 mmHg

PO2_____142 mmHg

Patient Temp: 98.5F

Sample Type_:

06SEP03 06:16

Op [redacted]

Physician: b(6)-2

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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

06/09/03 05:14

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: b(6)-4 3151AA4

OPER #: 702 DR #: 000

SERIAL #: 0000100676

GLU	154*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	444*	39-380	U/L
NA+	132	128-145	MMOL
K+	4.0	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

65y03

Ward/Section: [redacted] REQUESTING PHYSICIAN: [redacted] b(6)-7

b(6)-4 [redacted]

DATE 7SEP03 TIME 0435

CHEMISTRY RESULT FORM

(Pursuant to the Privacy Act of 1974)

SSN/PSEUDO SSN:

i-STAT G3+

Pt [redacted] b(6)-4

Pt Name: [redacted]

TCO2_____34 mmol/L

At 37C

pH_____7.502

PCO2_____42.4 mmHg

PO2_____99 mmHg

HCO3_____33 mmol/L

BEecf_____10 mmol/L

sO2*_____98 %

*calculated

Sample Type_:

07SEP03 04:31

Oper: [redacted] b(6)-2

Physician:_____

Ser# 43011

Ver: JAM5046A
CLEW A93

REF. RANGE
138-146 mmol/L
3.5-4.9 mmol/L
100-109 mmol/L
7.31-7.45
35-45 mmHg (art)
41-51 mmHg (ven)
95-105 mmHg (art)
(ven)
24-27 mmol/L (art)
25-29 mmol/L (ven)
22-26 mmol/L (art)
23-28 mmol/L (ven)
38-48%
-(+3)
l/L
) mmol/L
1.32 mmol/L
ng/dl
5 mg/dl
mg/dl
% PCV
g/dl
RANGE

(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		

PICCOLO
07/09/03 04:41
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8 3141AA4
DISC LOT #: DR #: 000
OPER #: 702 0000100634
SERIAL #:

GLU	109	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.8	[redacted]	
CK	676*	39-380	U/L
NA+	136	128-144	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
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
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

Troponin-I		
Drug of Abuse		

REMARKS:

ABG - temp

REPORTED BY:

D.

Ward/Section: ICU/A2 | REQUESTING PHYSICIAN: [redacted] b(6)-2 | DATE: 7 SEP | TIME: 0425

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

SSN/PSEUDO SSN:

CBC			Urinalysis			Misc. Serology		
	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
	4.7-6.1 x 10^9	App		N/A	Mono		Negative
	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
	42-52% (M) 37-47% (F)	Bili		Negative	Source		
	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
	0.5-51.1%	Bld		Negative	H. pylori		Negative
	Differential	pH		N/A	Micro Parasites		
		Prot		Negative	Malaria		
		Urob		0.2-1.0	O & P		
		Nit		Negative	Other		
		Leuk		Negative	**Microscopic Urinalysis**		
		HCG		Negative			

CSF			Blood Bank
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Directigen		Negative	ABO/Rh

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

UNIT	TYPE	CROSSMATCH

DATE:	LAB ID NO.:

ID: 000790 07:09:03
WB 04:48
Patient Limits

WBC	10.2	x10^3/uL	4.5	10.5
RBC	5.56 L	x10^6/uL	6.00	6.00
Hgb	9.6 L	g/dL	11.0	18.0
Hct	31.1 L	%	35.0	60.0
MCV	97.5	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	215.	x10^3/uL	150.	450.
LY%	25.4	%	20.5	51.1
LY#	2.6	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/07/03 05:42 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 11.6 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 0.92
Sample Type:citrated wh. blood
Test Date :09/07/03
Test Time :05:41 AM
Card Lot :010301
Operator [redacted] b(6)-6

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/07/03 05:45 AM

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 22.5 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/07/03
Test Time :05:43 AM
Card Lot :030201
Operator [redacted] b(6)-2

25/M NKDA Type X # Units

MEDICAL RECORD - ANESTHESIA

For u ...is form, see AR 40-66; the proponent agency OTSG

NKDA

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

DRUG (Units)													
Fentanyl (mcg)	25-05		50	50	100	100	100	50					
Propofol (mg)		50-20											
ICB (mg)		10				10				5		5	
Ancef (g)							4	2				4	1
Midazolam (mg)													
( )													
VOLAT AGENT 150 % del		0.4	0.6	0.8	1.5	1.8	1.9	2.0	2	2	2	2	2
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	LR 2 NS ~10	~2	2	1	1	1	1	1	1	1	1	1	

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

TOTALS	TOTAL EBL
500	
70	500
40	TOTAL URINE
120	
5	3900

FLUIDS - SUMMARY

CRYSTALLOID- 8500 mL (2.5 A 6 L)

COLLOID- 500mL Hespan

BLOOD- 1 u PRBC

FLUIDS

LINE site	☐ Warmed
NS (L)	☐ Warmed
NS (R)	☐ Warmed
ER 2L	☐ Warmed

From the ER → LR 1000 #3; LR 1000 #4; LR #5 4000 #6; Hesp 500 ml

LOSSES — EST BLOOD LOSS: 1500 — URINE: 650/2150 — 2200 — 700

REMARKS

Code drugs with numbers, events with letters

① Trauma, emergency cursory to OR - interpreter in OR room. On AC 4-Pin

② Monitors on supine pt performed cuff 0845

③ Catheter Dgm IVPB

1035 - Pt c frequent PVCs K+ on ABG was 2.7 - will give 40 meq KCl IV over 30 min

PT-16, INR-1.5 PTT-29.1 Dr. N... aware

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 75 KG LB

HEMATOCRIT: 31

INITIAL DATA:

BP- 164, 111

HR- 116

EQUIP CHECK (OK?) Y N

PATIENT RECHECK OK for PROCEDURE? TIME- 0831

TIME → 24 41 0100 30 1000 X 30 X 1100

SYMBOLS

BP by cuff V ^

Heart rate ●

Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

7.31 NA 141 PaO2 43.6 K 2.7 PO2 419 iCa 1.18 HCO3 22 Hct 31 BD -5

VENTIL

VT - ml		+	710	710	810	670	550	670	720	810	710	720	090
f - breaths/min		+	10	12	8	8	10	8	8	8	8	8	9
Peak inf pres / PEEP		+	28	28	27	26	28	33	32	28	27	27	27
MODE - S(pon), A(assist), C(on)		S	C	C	C	C	C	C	C	C	C	C	C
BP/Auto Cuff	ET CO2 (torr)		30 45	31	33	32	34	33	32	32	32	32	32
BP/oth	FIO2 (Frac or %)	0.71	0.71	0.71	0.74	0.75	0.76	0.76	0.76	.75	0.76	0.76	0.76
ART line	SpO2 (%)	96	~100	↓ 98	~100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	~ ST	~ SR		SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	Unavailable						Vessel 34.1	34.1		34.2	34.6	X
	N-M Block (T/4)				0/4		3/4		0/4		2/4	0/4	1/4
Warming blkt		↑	↓	Robert	→		→		→		→		→
Conv warmer													

MONITORS/ACCESSORIES

RECOVERY AT 1545

PACU (ICU) 2 (Specify)

OTHER T-97.9 Ax

CONDITION: Stable/Critical

RESP- 16 SpO2- 100

BP- 172/92 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0830	1010
PROC	Ready 0845	Begin 1120	End 1550

Mark with letters & symbols, explain under REMARKS. EVENTS Position → ① ② ③

PROCEDURES and CPT Codes: Cricothyroidotomy / Open gastrostomy (Exlap)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

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

[redacted]

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Fent, TTE; Propofol TTE; lidocaine; Dr. [redacted] performed Cricothyroidotomy. +BBS, SUX, ETCO2

SURGEON: [redacted] PROCEDURE LOCATION: Trauma

[redacted] RNA / MAJ

2-Sept 03

PAGE 1 OF 3

b(6)-4

DA FORM 7389, FEB 1998 MEDCOM - 18440 (...ROK W. UIT...) [redacted] PATIENT'S MEDICAL RECORD MD, CPT, MC USAPA V1.00

(1) (2) (3) (4)

ACLU-RDI 1646 p.200

DOD-032014