[redacted] RECORD-SUPPLEMENTAL ME[redacted] DATA

For use of [redacted]rm, 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

SHIFT ASSESSMENT b(6)-2

		TIME: 0600 INITIALS: [redacted]	TIME: INITIALS:
NEURO	PUPILS	3mm PERRLA, ABLE to	
	SENSORIUM	Follows commands + express	
	EXTREMITY MOVEMENT	Moves, Limited R/T (6)	
	SEDATION	arm due to ex-fix, MSO4	
	PAIN CONTROL	IVP MSO4 + MSO4 PCA pain control	
		Alert + oriented for this q A	
RESP	RESPIRATORY PATTERN	RRR 18, equal chest rise	
	BREATH SOUNDS	CTA + tracheostomy	
	SECRETIONS		
	O2 SOURCE/FLOW/SAO2		
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	SR, S1S2 (-) murmurs, cap refill	
	CAPILLARY REFILL	<3 sec in all ext. +2 palpable	
	PULSES	pulses in all ext. (-) edema	
	EDEMA	noted.	
GI	ABDOMEN	Soft, non-tender, (+) BS in all	
	BOWEL SOUNDS	4 quadrants, normal, active	
	BOWEL MOVEMENT	@ 4pm this time	
	NGT/OGT		
	TUBE FEEDINGS		
	DRAINS		
GU	VOIDING	Urinal, OOB to Bathroom	
	COLOR/CLARITY	& assistance	
SKIN	COLOR	(L) arm ex-fix splint & ex-fix upper	
	INTEGRITY	arm Dsg C, D, I + arm clean/dry	
		Dsg (L) upper thigh C, D, I	
ACCESS	#1 TYPE/LOCATION/SIZE	(R) FA S.L & (L) S/S (-) infection	
	DRESSING CONDITION	Pulses well	
	IV FLUID/RATE		
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC b(6)(2)-2

DATE 19 Sept 03

ICU #1 [redacted]

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

NAME: [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER: M

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: Civ [redacted] p1&2

Date: 19Sep03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	115/67																									
TEMP	98.6																									
HR	84																									
RR	14																									
SaO2	100%																									
FiO2	/																									
Source	RA																									
MAP	/																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
F																										
PB			50								—															
GT																										
PO																										
Total																										

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

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER: [redacted]

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

4. PAY GRADE:

5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D): [redacted] b(6)-4

7. AGE AT ADMISSION: 23y

8. RACE: UK X

9. ETHNIC BACKGROUND: 9

RELIGION: UNK

10. LENGTH OF SERVICE:

ETS: N/A

11. FMP: 20

12. SOCIAL SECURITY NUMBER: [redacted] b(6)-4

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS: U

HOUR OF ADMISSION: 0600

BRANCH / CORPS: N/A

14. FLYING STATUS:

15. BENEFICIARY CATEGORY: K 7 8 (b)(6)-4

16. ZIP CODE OF RESIDENCE: [redacted]

17. UNIT LOCATION (State or Country Code): I Z

18. MOS:

19. TRAUMA:

PREV. ADMISSION: YEAR: [redacted] NO ✓

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

WARD: ICU 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND LOCATION OF [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION: T 05

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): 080330

24. CLINIC SVC - ADMITTING: A F A A

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): 080903

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

DX: SHRAPNEL (2) ARM / GSW (2) LEG

b(6)-4

ADMITTING OFFICER: [redacted] COL MC

SIGNATURE OF ADMITTING CLERK: [redacted] SPC, MED

DA FORM 2965, MAR 89 MEDCOM - 18643 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	UNK - NAME # [redacted] b(6)-4	Civ	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	25Y	X	MUSLIM			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	b(6)-4	ICU1

15. FLYING STATUS	16. DSG	17. 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	1430	Orthopedics

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	D/C TO CAMP	13 OCT 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		8 Sep 2003	

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.

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW

(a) S/P I+D of leg wounds.

Dx:
821.10
959.7
958.8
959.6
959.5
E991.2

Px:
78.15
89.62
38.80 (x4)
83.09
99.04

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	36	36

36. Total Days All Facilites b(6)-2

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	36	36

SIGNATURE OF ATTENDING MEDICAL OFFICER

DR. [redacted]

MEDCOM - 1864

MEDICAL	ABBREVIATED MEDICAL RECORD

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

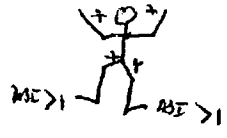
25 yo ~~M~~ CIV MA/2 PRESENTS TO ED S/P LEFT EXT FIX OF FEMUR & IED OF LEFT CALF & RIGHT THIGH. PT A&O X 3 GOOD PAIN CONTROL D/W NO COMPLAINT GCS = 15

PMH: ∅ PSH: ∅ MED: ∅ NKA: ∅

PHYSICAL EXAMINATION

GCS = 15 VS HR 130 BP 126/70 RR 14

HEENT: NC
Lungs: CTA
CV: TACHYCARDIC
ABD: SOFT, NT, ND BS NBG FART
Pelvis: STABLE
Rectal: GUAC TONE & BLOOD
Neck: NT C-COLLAR
NEUR: CN II-XII INTACT
MOTOR STRENGTH APPROPRIATE FOR INJURIES
SENSORY: LIGHT TOUCH INTACT



EXT FIX - LEFT FEMUR
DRESSINGS OVER LEFT CALF WOUND & RIGHT THIGH.

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

Dx: LEFT FEMUR FX
LEFT LE SOFT TISSUE INJURY
RIGHT THIGH SOFT TISSUE INJURY
RIGHT ANKLE INJURY

b(6)-2 [redacted]

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
	8 SEP 05		

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

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Sep 03	24 yo ♂ arrived via FLA ① 0945 from FSB.
0845	Ex-Hx on ① Femur c blood soaked Kerlix
	Ace wrap to ① Femur and Bg to ① L Ankle.
	Foley in place c clr yellow urine. 1g
	IV to ① hand c infusing. VSS ST 138 HR.
	99% RA. 124/35 / 16. Pt AAOx3.
	Drsg's reinforced on LLE and ① Femur.
	Dr. [redacted] in for AAST Exam. Pt Rolled &
	abris imp to neck / back. LBAS Served
	and Portable X-Ray in for PA and Lat
	of Bilat Femur and ① Tib Fib. Pt Stable
	@ this time. Will continue to monitor.
	[redacted]
0920	X-Ray complete. Pt ready for transport. Report
	sent to LCU3 [redacted]
	b(6)-2

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

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

[redacted] b(6)-4

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

MEDCOM - 18646

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Sept 03 1430	Ortho Op Note Pre-Op Dx - (1) Grade III open (L) femur fracture (2) (L) calf wound (3) (R) posterior thigh wound Post-Op Dx (1) Grade III open (L) femur fracture (2) (L) thigh compartment syndrome (3) (L) calf wound (4) (R) posterior thigh wound Procedure: (1) I+D all wounds (2) Release (L) thigh compartment syndrome (3) Adjust (L) femoral K-wire, Surgeon: [redacted] b(6)-2 OR: 100 cc's EBL: 2 units PRBC Findings - Large hematoma in thigh w/ apt. thin wall SQ abscess removed, which communicated compartment syndrome. Good alignment

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

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

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

MEDCOM - 18647

(same as previous page)

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

8 Sept 03
1430

Ortho Op Note

Pre Op Dx -
(1) (L) Grade III open femur fracture
(2) (L) calf wound
(3) (R) patella thigh wound

Post Op Dx
(1) Grade III open (L) femur fracture
(2) (L) thigh compartment syndrome
(3) (L) calf wound
(4) (R) patella thigh wound

Procedure: (1) I+D calf wound
(2) Reduction (L) thigh compartment syndrome
(3) Adjust (L) femoral ex-fix,
Surgeon: [redacted] blw-2
QBC 100 cc's
Cefazolin 2 gm PRN
Findings - Large hematoma in thigh compt.
Thin out SQ adipose removed, which
relieved compartment syndrome. Good adjust

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

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

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

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

MEDCOM - 18648

after 3 wks adjustment. Added 1 pin to each bracket/clamp. Added 2nd bar to improve stability

[redacted]

b1(a)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
08Sep03	Pt arrived from EMT @ 1030 via litter accompanied by
1100	EMT staff. Pt alert & follows commands. HR 130's - 140's. Temp 96.0°F. lungs CTA, no respiratory distress. hypoactive BS x4 Q. Foley to gravity draining clear amber urine. hands & feet cold to touch cap. refill >3sec. +1 radial pulses. pedal pulses doppler. Started NR @ 125cc/hr @ hand IVP. Dressings to legs wounds reinforced, c large amount [redacted]. Pt to go to OR later today. Will continue to monitor [redacted] T/AN
1145	Pt. to OR. b(a)-2
1435	Pt came back from OR via litter intubated, placed on vent. SIMV 16 TV 700, FiO_2 50%, PEEP 4, ETT @ 22cm lip. CL @ LS infusing the 3rd PRBC's. A-Line @ femoral. Temp. 92.2. Pt. over c blanket & heatlamp on. HR NSR BPs. skin cold & dry capillary refill >3sec. +1 radial pulses. doppler pedal pulses. Per report. pt. given 3000cc crystaloids. 1000cc hespan OV 200cc. Given 2U PRBC's for H&H 4-14. Sedated c 50 mcg Fentanyl, 3mg versed & 100mg ketamine. minimum blood lost. VS HR 101 BP 151/77 O_2 sat 100%. Will continue to monitor.
1500	4th U PRBC's started. Temp. 92.2 b(a)-2
1615	4th Unit PRBC's finished BP 179/79 HR 85 [redacted] SO_2 100% Temp 94.5. Pt was given a total of 4 units [redacted] LS.
1620	Pt awake. extubated & placed on nonrebreather [redacted] 15/min O_2 sat 100%. Tolerated well.

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b(a)-4

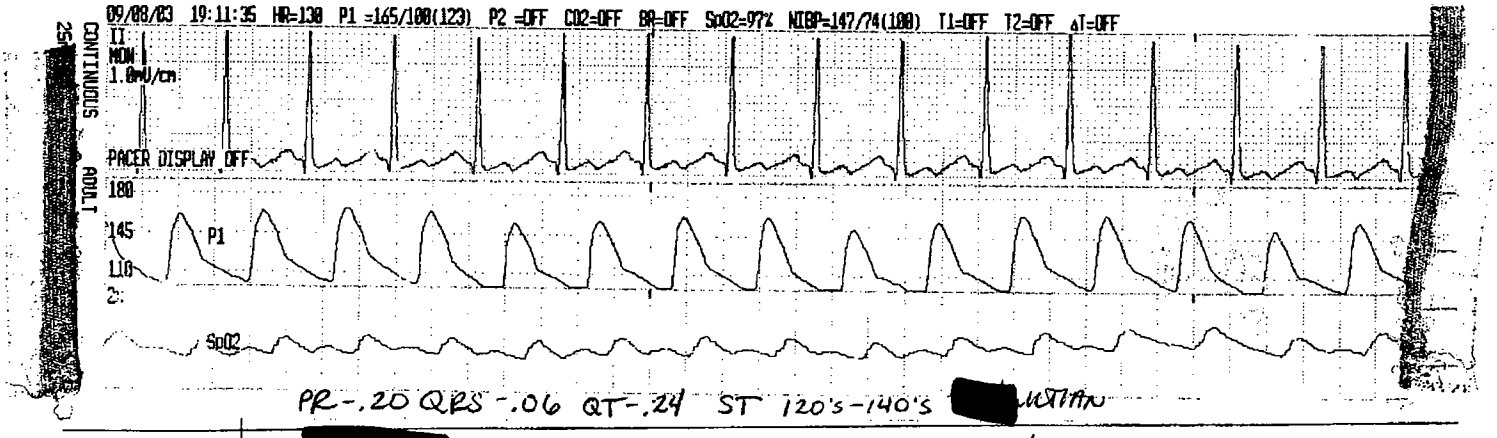
PROGRESS NOTES
Medical Record

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

b(6)-2 AR

PROGRESS NOTES

DATE	
08Sep03 1730	Pt's temp [redacted] heat lamp turned off. Will continue to monitor. [redacted]
08Sept 2003	(1915) Received [redacted] from LT [redacted] and assumed care of pt @1815. See OA form 4700 OP 375 for assessment data. Hard time assessing pt R/t language barrier. Pt stated being in a little pain. HR T in 130's to 140. 4mg MSO4 given as ordered to see if that would help HR. HR ↓ to mid 120's-130. Pt was weaned from a NRB 15L to RA & sats 96% or greater. Pt could move BLE. Had to use doppler for pedal pulses. Cap refill < 3sec. Cool extremities (feet) L > R. UTA full sensation. Opened eyes when touched feet. Hard to tell if drainage (Sanguineous) is coming from R groin of a-line or bandage on R thigh. Continue to monitor [redacted]



PR-.20 QRS-.06 QT-.24 ST 120's-140's [redacted] NSTMI

(2045) Dr [redacted] came to see pt @2000. New orders. Informed about ↑ HR and BP ↓ gradually and Temp gradually ↑. 2 amps bicarb given. [redacted]

(2110) ABG drawn as ordered. PO_2 56. Pt placed on 4L NC. Ambulatory sats 96% up to 100%. Had pt use I.S. x10. Tolerated well. Pt HR down to around 125 BPM. [redacted]

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

b(6) - 2 ANN

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9Sep03	1630 - dressings changed on L leg. Wounds red and leaky looking. R leg dressing not changed [redacted] LPN
09Sep03 2000	USS-Alert x3 cards to (R) Joshua; A-Pt to Room - Report rec'd to (L) Hunt LRC Basal hr all ven patent @ SLS infiltrate. dress to legs dry & intact @ drainage. Pulses intact, Pt c/o 3/10 - HR - NSR - Lungs CTA BL RSR - ewr Rx Spo2 99% on 1L/m O2 via NC BS (+) x4 quads Pedal pulses +2 doppler used. Radial +3: cap Refill <3sec. Able to move U and L Extremities, (L) leg drop to ankle toes. Rely to Grant pt's current level of pain. 100 cc/hr. MSO4 4mg/1ml for c/o (R) leg pain. [redacted] RN/CO
09 Sep 03 2000	MSO4 4mg/IVP/1ml for c/o (L) leg pain. [redacted]
09 Sep 03 2400	USS - Resting quietly in HOB. LRC @ 5 ml/hr to KVO heparin patent. Pt rpt'd getting cloudy yellow urine output. O2 @ 1L/m via NC. Spo2 98-100%. [redacted]
09 Sep 03 2200	MSO4 4mg/IVP/1ml for c/o leg pain. dressing clean/dry/intact. Pulses in place @ active bleeding soaked through pads [redacted] SGT [redacted] RN/CO
10 Sep 03 0030	MSO4 2mg/IVP/1ml for c/o (L) leg pain. - SGT [redacted]
10 Sep 03 0200	Resting quietly in bed. Further c/o (L) leg pain. O2 @ 1L/m via NC SPO2 98-100%. T-99°. Will continue to monitor. [redacted] SGT [redacted] RN/CO
10 Sept 03 0300	MSO4 4mg/IVP/1ml for c/o (L) leg pain. - SGT [redacted] RN/CO

STANDARD FORM 509 (REV. 5/1999) BACK

MEDCOM - 18652

USAPA V1.00

b(6)-3

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
*8Sep03 (2225)	ABG redrawn. PO_2 140. O_2 turned down to 1L NC. ABG to be redrawn. Pt bathed and linen/chux s'd from underneath pt. 2mg MSO4 given prior to turning. Pt tolerated well. Interpreter talked c pt and went over pt. care (I.S., pain medicine, operation). Pt worked on Incentive Spirometer again. Did better this time. Pt given H_2O. No problems. Temp going down 100.2°F [redacted]
(2300)	ABG results. PO_2 66. Turned up to 2L NC. [redacted] TAN
(2345)	Pt woke up c/o pain in legs. 2mg MSO4 given. [redacted] AN
(0430)	Pt been sleeping all night. Arouses easily if needed. Woke up stating having pain in legs. MSO4 given as ordered. Labs drawn and sent to lab. Pt worked c I.S. Got ABG results. Turned O_2 from 2L down to 1L. Pt went back to sleep. [redacted] AN
9Sep03	0600 - Received pt from Alt Hyg. VSS. Assessment done. A+O×3, bandage to right thigh has small amount of drainage. Ex fix on left femur. IV in L Hand LR@125c/hr. R IJ saline locked, [redacted] site c/d/i. R femoral A line, site oozing blood. Pt has +2 edema in hands and groin. Pt sats 95-98% 1L NC. Pt refused breakfast. 1000 - Pt ate 50% of lunch. Tolerated well. Pt pain controlled c MSO4 q 1½°. [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 SEP 03 1526	Ortho Op Note Pre Op Dx: (1) Open (L) femur fracture with ↓ BK (2) (L) thigh compartment syndrome (3) (L) calf wound (4) (R) posterior thigh wound Post Op Dx: same Procedure: I+D of wounds, vessel loop shunt ≈ 50%, (L) thigh at cuff. Surgeon: [redacted] b(6)-2 Anes: MAC Findings: Wounds clean. No muscle necrosis of (L) thigh. Irrigated 6 liters. Vessel loop shunt ≈ 50%, thigh at cuff. Plan: IV antibiotics. Transfer to ICU. ↓ BK in OR. Repeat I+D in 48 hours, continue shunt attempt.

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

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

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 SEP 03 1200	Author Op Note Pre-Op Dx - (1) OPF (L) femur fx with compartment syndrome (2) (L) calf wound (3) (R) partial thickness burn Post Op Dx - same Procedure (1) I+D (L) calf wounds (2) IMPC (R) thigh wound ANES - MAC EBL - MIN FLUIDS - 1200 cc COMPLICATIONS - None DISPO - (L) thigh wound closed over (L) thigh. (R) thigh wound closed w/ 2-3 cms with vessel loops Calf wound closed to 1cm with vessel loops PLAN: Repeat I+D in 48 hours. Trial of VAC. [redacted] b(6)-2

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

(b)(6)-2 AR

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 Sep 03 1330	- Recieved pt. from recovery s/p I+D of (L) LE. Leg c external fixator minimal drainge to bandages. Kerlix and ace bandage wrap. Lungs CTA. HRRR SI S2 present. Active BS x 4 quads. Urinating per foley to gravity clear yellow urine QS. PIV site (L) AC infusing LR@ 125 cc/hr. Good circulation to LLE AEB. strong pedal pulse, able to wiggle toes. cap refill < 3 secs - will cont to monitor — [redacted]
12 Sept 03 1400	I concur c above assessment. Restraint x 2. Skin integrity & circulation intact & assessed throughout shift. — [redacted]
13 Sep 03 0700	Assumed care of pt. AFO x3 VSS. AM care complete. Ø c/o pain or discomfort @ this time Ø signs of SOB O2 SAT 95% on RA. Lungs CTA c productive cough. HRRR Active BS x4 quads Tolerating PO poor appetite. Foley to gravity QS clear yellow urine will be NPO @ MN for surgery 14 sep 03 will cont to monitor — [redacted]
13 Sep 1600	Pt c/o pain to abd felt distention foley cath d/c'd due to occlusion will cont to monitor VOP — [redacted] (b)(6) I concur c above assessment — [redacted]
15 SEP 03 2021	VSS. AO. Speaking some broken and small amount of English. (R) purses to BLE - (L) EX Fix intact = PSG

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	REGISTER NO.	WARD NO.
# [redacted] (b)(6)-4		ICU #1

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

MEDCOM - 18656

[redacted]

[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b(2) -2
	Orthopaedic Trauma Note - [redacted]
13 Oct 03 0745	26 y.o. ♂ with GSW to (L) femur, (L) calf and (R) thigh - been out on PST on 8 Sept, had external fixator applied there on (L) femur, and sent here. Found to have thigh compartment syndrome, wound opened, ESP. Afterwards had multiple I+Ds with eventual wound closure.
	Currently, with acceptable alignment, but minimal healing of bone.
	Plan:
	(1) PO/IV/OS 1-2 PO. Q 4-6 hrs prn #20
	(2) Crutches, toe touch weight bearing
	(3) Pin care BID with hydrogen peroxide
	(4) Return as out patient in 4 weeks for repeat X-Rays.
	[redacted]
	COL MC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

#[redacted]

PROGRESS NOTES
Medical Record

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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 AR
14 Sep 03 0200 -	Assumed care of pt. A+O x3 c/o for surgery this am remained NPO. External fixator to LLE secured c ace bandage. GSW to R thigh secured c ace bandage. Ø c/o pain or discomfort @ this time. IV ABX therapy cont. LR @ 125 c/hr. Foley to gravity 1000 cc emptied this am light amber colored urine. Will cont to monitor. [redacted]
14 Sep 1030	- Off floor to OR [redacted]
14 Sep	1320 - Returns from recovery post I+D to L LE external fixator. Also I+D of GSW to R thigh. LR @ 125 to IV Ac. Foley to gravity. Resume previous orders. Will cont to monitor [redacted]
14 SEP 03 2101	VSS. AO A&O to R thigh S/d. CDI intact. wound is clean. R pulses to BLE. Child c/o pain and provided c Percocet. O2 sat remains to R knee. Encouraged to level R knee @ times. [redacted]
15 SEP 03	(0600) Assumed care of pt @ 0700 report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Dsgs to R thigh and LE CDI this am. Wet → dry dsg applied to wound on R thigh. All wound sites s/s/sx infection. Pt OOB to chair c assist of staff. Pt tol well. Pt able to move BLE. Cap refill < 3 secs. Pedal pulse equal bilat. Skin warm to touch. 18g IV started in L forearm. IVF infusing s difficulty. IV in Loc dlcd d/t infiltration - catheter intact. Pt tol. reg diet well. Foley draining quantity sufficient clear yellow urine. 2 point restraints in place s s/sx

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15SEP03	(cont) complications. Will continue to monitor [redacted] WDAU b(6)-2
15Sep03	1940: VSS, ∅ c/o pain, A+O X3, external fixator to ⓛ LE intact c Dsg & ace wrap CDi. 2+ pulse and 2+ edema to ⓛ LE. Dsg to Ⓡ upper thigh CDi. 2+ pedal pulse and 2+ edema to Ⓡ LE. IV to ⓛ arm running LR@125cc/h. Foley to gravity draining orange/amber colored urine. Continuing IV antibiotics around the clock. Skin integrity intact to extremities restrained. Encouraged RR [redacted] b(6)-2 Will continue to monitor.
16SEP03	(1435) Assumed care of pt @ bedside c report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. NFS SLD in IV in ⓞ forearm. ∅ S&Sx infiltration/infection. Foley to gravity draining quantity sufficient clear yellow urine. Ex fix in place on ⓞ thigh. Dsg to ex fix dcd - ∅ S&Sx infection. Dsgs to Ⓡ thigh and ⓞ calf dcd. Sm amt sero-sang drainage noted on old dsgs. Ⓑ pedal pulses equal bilat. Cap refill <3secs. Pt able to move toes on bilat feet. Pt OOB to chair c assist of walker and staff. Tol. well. Pt tol. reg diet.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16SEP03	(cont) well. 1 point restraint in place 5 sisx complications. Will continue to monitor. [redacted]
16SEP03 19:15	VSS. AO. (+) pulses to (R) LE. DSG CDI. c/o mild pain to stomach and provided pain coverage. CMS intact to BE's. Noting light yellow wire @ FTG 5 pain. [redacted]
17Sep03 0700	Pt AAO LS CTA (B), S1 S2 present (+) BS x 4 quads (L) LE External Fixator pins CDI. (R) LE Dsg CDI. (+) Pulses in all extremities. FTG [redacted] Draining CYU. Pt c/o "small" pain. Will continue to monitor. [redacted] 9/WM6
	(AAO) Pt to OR via gurney. [redacted]
17Sep03	Pt [redacted] recieved from ICU 3 p/o I&D of (R) LE + Readjustment of Ex Fix on (L) LE Dsg CDI, Pt c/o "small" pain in (B) L.E. Denies N/V. S1 S2 present Tachycardic. Temp 99.7 LS CTA (B), (+) BS x 4 quads. Will continue to monitor. [redacted] 9/WM
17SEP03 2016	VSS. AO. DSG's to L&R LE's CDI. Pt [redacted] lay trial from surgery. (+) pulses & CR x 2 seconds. HCV since tolerating PO fluids. Encouraged to increase H2O intake FTG noting light amber wire & drainage. Abdomen SNTD. Denies complaints. [redacted]
18Sep03 0800	PT A&O x3. LS CTA (B) S1 S2 Present (+) BS x 4 quads. (R) LE Thigh Dsg C Ace wrap CDI. Extremity C edema non Pitting. (L) LE Ex Fix Dsg CDI LLE C edema non pitting (+) pulses x 4 Extremities Denies pain. [redacted] 9/WM

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MEDICAL RECORD	PROGRESS NOTES

DATE | NOTES

17 Sep 03
1630

Ortho Op Note

Pre-Op Dx: (1) (2) open fracture (s)

(3) Post-Op Dx: same

Procedure: (1) closed x KTX

(2) I+D, DPC (3) splint

[redacted]

OSC RN

FORBS: 1000 cc

Findings: head elevated, splint x proximal <60° apex anterior on lateral xr views/ radiographs. Wound closed with 0 prolene OO nylon

Plan: IV ABX

[redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 A[illegible]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Sep 03 1600	Ortho Op Note
	Pre Op Dx - (L) forearm fx w/ (L) calf wound
	Post Op Dx - Same
	Procedure: I+D, suture removal, adjust [redacted] fix
	Surgeon: [redacted]
	EBL Ø
	Findings: forearm in good position at [illegible]. Granulating at pin sites. Wounds clean.
	Plan: D/C to EPW hospital when available. (L) forearm x-ray [redacted]

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DOD-032237

b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18Sep03	Pt post op day #1. Waiting for M.D. To change ~~A~~ Dsg. [redacted] pv 91WML
19Sep0300245	Assumed care @1800; VSS; pt tiox3, ⊕CMS throughout, ⊕pulses x4, brisk cap Ref x4, NV intact; Ex-fix in place, dsg CDI, some pitting edema still persists; Dsg to R thigh CDI; S, Sz, LSCTAB; ⊕BSx4, ⊖BM this shift, pt voiding QS, c/o urine, ⊖ complaints @ this time; ~~with~~ HL to ⊕ FA patent; cont IV Abx; restraints in place, ⊕ circulation, ⊖ skin breakd; cont to monitor [redacted]
19Sep0615	Received pt resting in bed, USS, oriented x3 AM. A+Ox3, and able speaking. ⊕ for IV patent ⊕ intact, flushes easily. Ex fix ⊕ thigh intact, dsg bulky intact from thigh to ankle c/d. ⊕ thigh dsg changed c/d/i. ⊕ LET, ⊖BM, sugs. ⊕ circulation, ⊕ pulse, legs warm & able to wiggle. Restraints in place, ⊖ skin breakdown circulation issues noted. Will cont to monitor - pt. [redacted]
20Sep0115	Assumed care @1800; All USS; [redacted] ⊕CMS throughout, brisk cap ref, ⊕pulses x4, NV intact; medicated x perc for pain x2; Ex-fix in place, dsg's CDI ⊕ LET x blankets; pt voiding QS, clear dark yellow urine, ⊖BM this shift; IV infiltrated; new one started in ⊕ wrist; patent; infusing Wabx; restraints in place ⊕ circulation, ⊖ skin breakd; cont to monitor [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI

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

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

REGISTER NO. | WARD NO.

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Sept 03 0802	VSS alert & Orient. Conscious regular dull fx breath sounds. OOB to chair for HK care. Isolated well c Lungs Clear. BS(+) x 4 good. Abd - soft non-distended. Peripheral pulses +2. Will continue plan of care [redacted]
20SEP03 2101	VSS. AO. (+) pulses to BLE and CNS intact. DSG d/d to (R) medial thigh. Wound intact @ 2.5 cm in diameter. Minimal serosanguinous drainage. (+) fat color on tunnelly. Pins & DSG intact to Bryant skin traction and ex fix. Pins are clean, dry & intact. [redacted]
21 Sept 03 0800	VSS. Alert & oriented. Lungs clear. BS (+) x 4 good. Peripheral pulses palpable +2. Abd soft non-distended. Pin care done to (L) knee Ex fix. Extend fx: Verbally grants sufficient clear urine. Will continue plan of care [redacted]
21 SEP 03 2141	VSS. AO. DSG to R & L leg CDI. DSG to R medial thigh CDI. Placed on BSC and had BM x 1 = soft formed brown stool. No complaint. (+) pulses to BLE. BS (+) x 4. LSCTAB. Verbally quantity sufficient light yellow urine. [redacted]
22 SEP 03	VSS AxO. Assumed care @ 0800. Assessment completed. Lungs CTA (B), NSR, Respirations unlabored. Abd soft non-tender. IV (T) hand CDI. (-) S/S of inf. Voiding per urinal. BM x 1. OOB to chair. (L) > (R) leg drang D.

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b(6)-2 A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0 OCT 03	(cont.) drainage. Pin care done. Wet ⇒ dry drsg on @ thigh 2d. SL in @ hand flushes well ⊼ s/sx infection/infiltration. Pt td. reg diet well. voiding ⊼ difficulty. @ BM. 2-point restraints in place ⊼ s/sx complications. Will cont. to monitor [redacted] MD
1 OCT 03 1949	VSS. AO. CMS intact to RLE. Pin care performed and stay strips remain intact. WTD placed @ upper and lower pin sites. Tkpk @ R. inner thigh. Both wound site beefy pink and ∅ s/s of infection. H2N. [redacted]
2 Oct 03 1308	Assume care of PT @ 0600 hrs. Pin care performed site shows ∅ signs of infection. Ambulatory, c/o pain was treated for it. Drsg A innerc (R) thigh. Skin integrity intact ⊼ x2 restraints. Will continue to monitor. [redacted] MD
2 Oct 03 1500	I concur ⊼ above assessment note. Strips intact to LLE wound. ∅ drainage. Heplock patent. Circulation ⊼ skin integrity intact to extremities ⊼ 2pt restraint. [redacted] MD
2 OCT 03 2113	VSS. AO. Pin care ⊼ WTD's 2d. Tpukes to R&LLE's. H2N. Wounds beefy pink ⊼ s/s infection. Tolerated wd. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 AW

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02OCT03	(1650) Assumed care of pt @ 0000 IAW report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Ex fix in place on LLE. +pedal pulse equal bilat. Cap refill <3 secs. Steri strips to incisions on LLE CDI. Dsg to back of R thigh CDI. Pt tol. reg diet well. Voiding s difficulty. 2 point restraints in place [redacted] s s/sx complications. Will continue to monitor. [redacted] AW
03OCT03 1900	Pt resting in bed, A+Ox3, VSS, HL IV R Hand intact s s/sx of infex, LS CTA R, + BS x4, dsg posterior R thigh CDI, Ex Fix L thigh in place, dsg's on pins CDI, denies pain @ this time, pedal pulses equal B, moves toes B, cap ref <3 sec, steri strips to incisions on LLE CDI, voiding s diff, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] RW
04OCT03	(0005) Assumed care of pt @ 0000 IAW report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt OOB to BR this am for personal hygiene. Pt ↑ to chair for 2°. Ex fix in place on LLE. Pt able to move LLE. +pedal pulse equal bilat. Cap refill <3secs. Pin care done. Steri strips to incisions on LLE CDI. Dsg to R thigh ad. ø s/sx infection. S in R hand flushes well s s/sx infection/infiltration. Tol. reg diet well. Voiding s difficulty. 2 point restraints

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
04OCT03 (2205)	(cont) in place & sx complications. Will continue to monitor. b(6)-2 [redacted]
4OCT.03 1915	Pt A+Ox3, VSS, LS CTA (B), (R) BSX4, voiding well, abd soft & flat non-tender, IV HL (R) Hand intact, Ø s/sx of infex or infiltration, dsg on posterior (R) thigh CDI, pain controlled c perc, Ex Fix on (R) thigh dsg on pins CDI, pt able to move toes, pedal pulses equal (B), Ø s/sx of poor circulation or skin breakdown on pts of restraint. b(6)-2 [redacted]
5OCT03@1200	Received pt resting in bed, VSS, LSCTA(B), A+Ox3, FTG drainage dk yellow, urine, arabic speaking. Colostomy to (LQ) intact, soft semi-formed stool, ~~HL to open~~ DSD NS 20 meq/K infusing w/o apparent complication. Dress to (R) hip and buttock intact. Midline abd incision OTA. (R) SC central line intact w/o erythema or swelling noted. NPO c Meds time for CR today. Other unchanged assessments, restraints per EPW protocol. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	SPONSOR'S ID NUMBER (SSN or Other) b(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

REGISTER NO.

WARD NO. ICW#4

\# [redacted] b(6)-4

PROGRESS NOTES
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b1c) - 2 AIR

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6Oct03	2130=VSS, C/O pain, PO percocets PO given as ordered, Dsg to ⓟ thigh (back) Δ'd small ~~sang dra~~ serous drainage noted, ex fix to ⓛ LE, pin care done, Dsg's put over pin sites CDI, ⓛ LE neurovascularly intact, 2+ pedal pulse Steri strips to wounds on ⓛ LE CDI. ×2 restraints when in bed, ⊖ skin breakdown. POC: Wound Care, Infection Control, pain mgt. Continue to monitor [redacted] ITAR
7Oct03 1245	VSS. Assumed care @ 0600. A&O. Able to make needs known. HRRR. ⊖ resp distress. ⊖ SS. BM x1. Voiding clear yellow urine. Limited ROM due to ⓛ LE ex. fix. Wound around pin site red. Aggressive pin care completed & dressed. Pt up to BR for shower. Used crutches. Medicated @ 0945 c [redacted] tabs p.o. Will continue to monitor [redacted]
7Oct03 1700	Medicated c percocet two tabs po [redacted] Will continue monitoring [redacted]
8Oct03 0000	VSS. AO. Pt performed own VSS [redacted] sites proximal and distal pins pink & s/s infection. Dressed spelt around by self & complains. Voiding light yellow urine, quantity sufficient. [redacted]
8Oct03	Pt AOX3, VSS. Pt has ⊖ c/o pain at this time, pt self-conducted pincare, around the pins ~~skin~~ and flesh is pink/reddish with ~~some~~ little pus like drainage, pt ambulated with some difficulty (crutches), dsg CDI, 2 × restraints, ⊖ circulation [redacted]

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(1735) I c rcvr MEDCOM - 18669 & sent. [redacted] MA

b(6)-3 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
05 OCT 05 1120	Received pt resting in bed, VSS, NAD x3, speaks Arabic. Ⓡ ex-fix intact, pin care done, incisions Left OTA on Ⓡ thigh + Ⓛ shin. Ⓡ post thigh dsg c/d/i, Amb w/ walker to BR. IV to Ⓡ hand intact + patent, flushes easily. Restraints in place per CPW protocol, & shows breakdown noted @ this time. Will cont to monitor [redacted]
5 OCT 05	2100: VSS, 0/10 pain @ present time, AAOx3, OOB & uses crutches w difficulty. IV Hx to Ⓡ arm flushed & patent. Taught pt how to do pin care to ex fix to Ⓛ LE, had pt do return demonstration, covered insertion sites w dry dsg's CDI. Δ'd dsg to back of Ⓡ thigh CDI. Ⓛ LE ↑, 2+ pedal pulse Ⓛ foot, neurovascularly intact. POC: Pain Mgt, wound care, infection control. Will continue to monitor for acute Δ's. [redacted]
6 OCT 05 0100	Received pt resting/sleeping, VSS, Tol PO, AAOx3, amb w/ crutches to BR, Ⓞ BM, am care. Self demonstrates pin care to Ⓡ thigh ex-fix. Steri-Strips to Ⓡ thigh & Ⓓ shin OTA, intact. IV flushes easily Ⓡ hand [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, [redacted]) | [redacted]

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

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

E# [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 A

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8Oct03 0350	VSS. AO. D'd DSG's to pin sites @ inner thighs. Wounds to pin sites pink and dry c s/s infection. No c/o pain @ this time. Voiding. light yellow urine quantity sufficient. @ pulse to LLE. Rest [redacted] completely in bed.
9 Oct 03 1400	Assumed care of pt @ 0600. A & O able to make needs known. RRR. Nailbeds pink c brisk capillary refil. @ Pedal pulses. Dresp ssues. CT BM x 1. GU voiding clear yellow urine. KDM V to LLE due to external fixators. Ambulates well c crutch asst. Skin warm & dry. LE wounds c steristrips dry & intact. Pt completed own pin care appropriately. @ High drsg's done. Site healing. Pt medicated c percocet two tabs [redacted] MAG SON Will continue to monitor
9 Oct 03 1405	Restraint x one c compromise to skin/circulation [redacted] MAG SON
90ct03 1732	Pt resting in bed. Offers no complaints [redacted] MAG SON

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

[redacted] b(6)-2

PROGRESS NOTES
Medical Record

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b(6)-2 All.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 Oct 03	2030= VSS, ✗10 pain @ present time, A+O, L ex fix to ⓓ LE intact, pin care done - pt. assisted, Dsg Δ'd to back of ⓔ thigh. Neurovascularly intact, OOB & crutch walks to toilet. ⓓ LE ↑, ⓔ edema noted. Continuing PO Cipro, pain mgt, wound care, infection control. Continue to monitor. x2 restraints, ⓔ skin breakdown. [redacted]
10 Oct 03 1014	Received pt resting in bed, ambul/crutches to OR, in hallways. Pt does own pin care, upper pin site wrap w/ gauze, lower pin site left ota. Steri strips in place on ⓔ thigh + shin, dsg to post ⓔ thigh c/d/i. ⓓ LE ↑, pt w/o noted skin breakdown. Tol po, sugs, A+Ox3, mainly arabic speaking, cooperative w/ care and restraints per ep's protocol. ✗ skin breakdown ✗ sites ✗ other remarkable assessments @ this time. Will continue to monitor pt. [redacted]
10/11/03 0330	VSS. A+O Performed pin care to self and encouraged more aggressive pin care & patient understood. Applied dsg DSG to medial ⓡ thigh site. Healing well ✗ s/s infection. Refused to walk during PM. No c/o pain @ earlier evening. Scrubs, light amber urine, quantity sufficient. [redacted]

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b(6)-2 All

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11 Oct 03 0700	- Assumed care of pt A+O x3. VSS Ø c/o pain or discomfort @ this time. LLE c external fixator intact pin care self c assistance clean technique taught. Ambulates crutches c difficulty. Lungs clear. Encouraged OOB Ø evidence of skin breakdown Will cont to monitor [redacted] (15-Ø) I concur c above assessment. [redacted]
11 Oct 03	1930: VSS, Ø c/o pain @ present time, A+O X3, OOB and Crutch walks PRN c difficulty, ex-fix to (L) LE in place, pt. doing pin care independently - gave supplies @ BS & supervising, Dry Dsg's Δ'd over pin insertion sites, Dsg to back of (R) thigh CDI, pt. neurovascularly intact, (L) LE ↑, edema noted, tolerates PO well, voiding adequate UOP via urinal @ BS, Ø other remarkable findings, pain met, Continue PO Cipro, x2 restraints, Ø skin breakdown, continue to monitor. [redacted]
12 Oct 03	- Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort @ this time. Ambulates per ward c crutches c difficulty. EX fix to (R) LE intact pin care given self c assistance. Lungs clear HRRR Active BS Ø evidence skin compromise Will cont to monitor [redacted]

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

b(6)-4

#[redacted]

PROGRESS NOTES
Medical Record

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b(6) - 4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12Oct03	2030: VSS, A+OX3, medicating c percs for pain mgt, ex fix to (L)LE in place, pin care done, Dsg Δ's to pin care sites & back of (R) thigh. Neurovascularly intact, OOB c crutches PRN, continuing PO Cipro, x2 restraints s skin breakdown noted, ∅ other remarkable findings. Continue to monitor [redacted]
13OCT03	(1325) Assumed care of pt @ ∅∅∅∅ p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt amb c crutches to radiology this am for AP/LAT (R) femur. Amb well. Pin care done by pt. Dsgs applied to pins. wound to back of (R) thigh CDI - left open to air. Tol. reg diet well. Voiding s difficulty. 2 point restraints in place s skx complications. Awaiting trans. to Iraqi hospital. Will continue to monitor. [redacted] DAS
13Oct03	@ 1930 = VSS, A+OX3, ∅10 pain, pt. doing own pin care & Dsg Δ's - supervised & gave supplies, (L)LE c ex fix in place, neurovascularly intact, (+) edema (L)LE ↑, Dsg to back of (R) thigh Δ'd CDI, continuing PO Cipro, pain mgt, X2 restraints s skin breakdown, will continue to monitor [redacted]
14Oct03	(1000) Pt stable for tx to Iraqi hosp. - amb c crutches - escorted by MPs. [redacted]

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

MEDCOM - 18674

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted]TY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS CAV [redacted] b(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 8 APR 03 | TIME 0800

TRANSPORTATION TO FACILITY POV

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: PCN

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

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0800

INITIALS: [redacted] b(6)-4

VITAL SIGNS

TIME	0800	0845	0900		
BP	126/35	134/73	139/76		
PULSE	136	128	131		
RESP.	16	16	16		
TEMP	97	99% RA	98% RA		
WT					

LAB ORDERS

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

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

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL: 24 yo Dragon Civ ? S/P Ex-Fx to (L) [illegible] S/P GSW. last night.

See pt. Chart

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted]

MP

DIAGNOSIS

CODES

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

[redacted]

b(6)-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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 10 SEP 03 | PATIENT ACUITY LEVEL: | POST-OP DAY: POS | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1604 To ICU2 From OR ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☑ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis S/P I&D to leg wounds B/P 139/77 P 118 R 20 T 97.4

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes Foley

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication Demerol Cipro Ancef

Other _____

Report From SGT [redacted] b(6)-1 Received By 2LT McLean

VITAL SIGNS

TIME:	1604															
BP ARTERIAL LINE																
BP CUFF	138/77															
TEMPERATURE	97.4	98.6														
PULSE	116	102														
RESPIRATORY RATE	22	20														
OXYGEN (L/%)	2L	2L														
PULSE OXIMETER	97%	96%														
O2 METHOD	[redacted]	b(6)-2														

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	1700								
PAIN INTENSITY (10 / 5 / 0)	0								
MED ADMINISTERED (Y/N)	NA								
RELIEF ACCEPTABLE (Y/N)	NA								

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)	NA								

SPECIAL NEEDS

	TIME:	1700	2300
*Skin breakdown prevention		Am	
*Falls prevention protocol		NA	
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			
		SH	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted]

b(6)-1

DIAGNOSIS: S/P I&D of Leg wounds

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1700 INITIALS: [redacted]	TIME: 2300 INITIAL: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Communicates via interpreter	☑ Speaks Eng well	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑ Foley cath intact draining 5 diff. cl yellow urine	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ex fix to (L) LE. Large Dsg & ACE wrap to (L) LE. sm amt drainage noted.	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Wounds to (L) LE (R) pinky. Dsgs CDI x sm amt drainage to (L) LE	☑	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1700 INITIALS: AVM	TIME: 2300 INITIALS: LO	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ___ / OK	IV Site #1: LKA / OK	IV Site #1: ___ / ___
IV Site #2: ___ / ___	IV Site #2: ___ / ___	IV Site #2: ___ / ___
Comments:	Comments: LR @ 125 cc/hr	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: DCE TIME:	1700	2300				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	1	1				
SENSATION	N	N				
MOTION	R	R				
PASSIVE FLEXION	S	S				
PERIPHERAL PULSE	2	2				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1700	2300				
ID band visible/legible	Avm	VM				
Orient to environment prn	Avm	VM				
Side rails (2/4) up	NA	/				
Bed position low						
Call light within reach						
Review & post lab results	Avm					
Notify MD abnormal labs	Avm					
Incontinent urine/stool	NA					
Linen change prn	Avm					
Turn/reposition q2h	NA					
ROM q2h if immobile						
Antiembolic hose	V	V				

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☑ TOTAL	☐ SELF ☑ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	~~BEDREST~~ AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1700 INITIALS: Avm	TIME: INITIALS:	TIME: INITIALS:
CONTENT: Plan of Care Orient to room	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C [redacted] b(6)-4	[redacted] b(6)-1	[redacted] Avm	2
		[redacted] Iwmle	N

b(6)-2A11

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND DATE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
11Sep	1700	DLE	Ex-Fix to femur, clear day + AC Range to left	CDT + S sn ant
12Sep	0200	LLE R punkel, R side groin -	ex-fix - med amt of drainage LLE -	continuous drainage to three LLE drains - reinforced

SECTION IV - NOTES

1700: Awake and alert. Denies pain @ this time. Transferred to ICU Z from ECU - OR. VSS. Will continue to monitor [redacted] 1/2

11Sep 03 0045 - CBC - Met-8 drawn from OR x 1 stick - diff. pt c/o pain +, percocet given per PO per PCA demo - will cont to monitor [redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 11 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 1 | HOSPITAL DAY: 2

ADMISSION/TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1000	2115													
BP ARTERIAL LINE	/	/	/													
BP CUFF	135/74	151/71	129/64													
TEMPERATURE	98.7	98.6	98.4													
PULSE	111	114	123													
RESPIRATORY RATE	20	18	20													
OXYGEN (L/%)	2L	2L	2L													
PULSE OXIMETER	99	100	98%													
O2 METHOD	NC	NC	NC													

Oxygen Method Key: NC = Nasal cannula | NR = Non rebreather | FM = Face mask | VM = Venturi mask | MT = Mist tent | PR = Partial rebreather | A = Aerosol | TC = Trach collar

PAIN

TIME:	0430	1200	1430													
PAIN INTENSITY (10 / 5 / 0)																
MED ADMINISTERED (Y/N)	Y		NA													
RELIEF ACCEPTABLE (Y/N)	Y		NA													

OTHER

TIME:		1200														
FINGER STICK GLUCOSE		NA														
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:	1430	2000
*Skin breakdown prevention	Aww	WD
*Falls prevention protocol	NA	
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

#[redacted] CV

blue-4

DIAGNOSIS: 9PI & D/ Leg wounds

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1000 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐ HR-114 BP 150/	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ Voiding adequate	☑ Voiding adequate large void	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ to gastric drainage clear yellow urine	☐ Foley to gravity draining clr yellow	☑ Foley to gravity, draining clr yellow urine
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ext fix (L) thigh & DSG Ds to (R) thigh limited ROM	☐ Ex fix to lower extremity, ↓ ROM to BLE.	☑ ex-fix (L) thigh drsng CDI (R) thigh drsng CDI
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness; blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ Multiple wounds to (L) LE, DSG c sm. amt. serosanguinous drainage.	☑
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ No c/o pain now.	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1000 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]	
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr: DRN	
IV site care provided:	IV site care provided:	IV site care provided: flushed	
IV tubing changed:	IV tubing changed:	IV tubing changed:	
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) AC / OK	IV Site #1: (L) AC / OK	IV Site #1: (L) AC / OK	
IV Site #2:	IV Site #2:	IV Site #2:	
Comments: IV Antibiotics	Comments:	Comments: Hl'd	

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE	N					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1430	2200
ID band visible/legible	AM	LD
Orient to environment prn	AM	LD
Side rails (2/4) up		NA
Bed position low		
Call light within reach		
Review & post lab results		
Notify MD abnormal labs		
Incontinent urine/stool		NA
Linen change prn	AM	
Turn/reposition q2h		NA
ROM q2h if immobile		
Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☑ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ~~ASSIST~~ ☐ TOTAL	☐ ~~SELF~~ ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: / INITIALS:	TIME: 1430 / INITIALS: AM	TIME: 2200 / INITIALS: LD
CONTENT: -pain scale -ROM	CONTENT: Plan of Care	CONTENT: plan of care
☐ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

#[redacted] CIV

blue-4

INITIALS	blue-2 SIGNATURE	SHIFT
[redacted]	[redacted]	D
	[redacted]	2
	[redacted]	N

blood-2 AM

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND/INCISION/SITE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		RLE	Large leg + ACE wrap applied, ice, + ergonomic change	

SECTION IV - NOTES

11 Sept 03 0430 - C/O pain given 1 percocet with effect. Orders will cont to monitor [redacted] 91WM6

11 Sept 03 0500 - AP & Lat X-ray done [redacted] 91WM6

1315 - Ext fix intact. D/S to thigh. Bulk needed no reinforcement. IV fluids DC'd. Pt drinking adequate fluids. Will cont to monitor [redacted] from 1930. Awake & alert. No c/o pain @ this time. Will cont to monitor [redacted]

12 Sept 03 0800 - Pt. will be up for transfer to AC. Will cont to monitor [redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 12 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 2 | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200														
BP ARTERIAL LINE																
BP CUFF	115/55															
TEMPERATURE	101.5															
PULSE	79															
RESPIRATORY RATE	28															
OXYGEN (L/%)	2L															
PULSE OXIMETER	98															
O2 METHOD	NC															

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0800															
PAIN INTENSITY (10 / 5 / 0)	5															
MED ADMINISTERED (Y/N)	N															
RELIEF ACCEPTABLE (Y/N)																

OTHER

TIME:																
FINGER STICK GLUCOSE	144															
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:	0800		
*Skin breakdown prevention	☑		
*Falls prevention protocol	☑		
*Restraint protocol			
*Seizure precautions	☑		
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ

#[redacted]

DIAGNOSIS: GSW I & D of leg, wounds

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(6) - 2

	TIME: 0800 INITIAL [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. **NEUROLOGICAL:** Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☐
2. **CARDIOVASCULAR:** Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. **PULMONARY:** Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. **G.I.:** Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ round + soft non-tender.	☐	☐
5. **G.U.:** Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ Voids to urinal dark yellow urine	☐	☐
6. **MUSCULOSKELETAL:** Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ ext to ⊖ lg Rt. CDI @ KOA to DLE	☐	☐
7. **SKIN:** Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐	☐
8. **PAIN:** No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ ⊖ c/o pain or discomfort	☐	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ⊖ Ac / well	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: IV with BOTTLE	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:			
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: NPO	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - pain scale - ROM - pressure care	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION - # [redacted] Civ DLW-1

INITIALS	b(6)-4 SIGNATURE	SHIFT
[redacted]	[redacted] 9/11/06	N
	9/11/06	6x2

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
			b(6)-2 ATL	

SECTION IV - NOTES

12 Sept 03 0500 - pt c/o abd & lt leg pain, pt given ii percocet for pain per prn order. pt is NPO for OR this am. Pt only took ii sips of water. [redacted] 9 WMC

12 Sept 03 0800 Pt will be NPO for transfer to O.R. will call ors to receive. [redacted] 9 WC

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

0-112

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
9-10-03	0640		Recieved report from off going shift. Pt resting comfortably in bed. HOB @. [D5] Foley (clear); PERRLA @3mm; GCS 15, (-) paresthesia, (-) paralysis distal to (B) LEs; Pain relieved with Morphine; [ELT] S_1, S_2 RR (12-20s-100s); cool extr (UEs>LEs) (R>L); palpable (3) UEs (+3); dopplerable LEs (L>R); temp: [G7] NPO - anticipate surgery this AM; ♦ BS×4; ABD is soft NT, ND; [G10] fair to guarded. Sees I+O for amt (adequate); clear, yellow urine; (Skin) (B) LE dsg.; (L) C/D/I - Silk; (L) LE ext fix in place; (R) ACE wrap has marked amt of serous drainage; Δ ant line dsg; (Lines) (R) TLS; (R) fem. art line; (L) UE PIV infusing LR @ 125/hr; [Plans] ~~[illegible]~~; infusing Ancef 1gm as ordered, [Plans] to d/c this AM for I+O; H/H is 28/9; hemo monitor; [redacted] 1 L/hr

b(6)-2

Addition to report: [R] CVL, ↓ in base; dsg CDI; 95% on 2 L/NC; (R) TLS use [redacted] 1 cm

b(6)-2

(Continue on reverse side)

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

[redacted]

b(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

MEDCOM - 18689

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9/10/03	1400		Pt transferred to gurney. OR staff transported pt to/from [redacted] b(6)-2

MEDCOM - 18690

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

STANDARD FORM 510 (REV. 7-91)

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: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication):
	3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
4. PROPOSED SURGICAL PROCEDURE:	
5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications: Jewelry removed: yes/no Family waiting: yes/no	

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

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

[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 _____ 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. Ø b(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. Ø	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. Ø

10. OR NURSING INTER[redacted]NTEROPERATIVE INTERVENTIONS NOTED.

8 Sep 03 DATE

11. POST[redacted]TIVE EVALUATION:

Dressing clean + dry

b(6)-2

b(6)-2

12. PREOPERTIVE EVALU[redacted]ON PREPARED BY

[redacted] LTC, AN

DATE: 8 Sep 03 TIME: 1155

13. PREOPERTIVE EVALUATION PREPARED BY

[redacted] LTC, AN

DATE: 8 Sep. 03 TIME: 141[redacted]

REVERSE OF DA FORM 5179, JUN 91

MEDCOM - 18692

USAPA V1.01

MEDICAL RECORD | MEDCOM - 18693 | **INTRAOPERATIVE DOCUMENT**

proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth.

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

3. DATE 8 Sep 03 TIME PATIENT ARRIVED IN SUITE 1200

4. PATIENT IN ROOM TIME 1200 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: b(6)-2 NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt. [redacted] LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

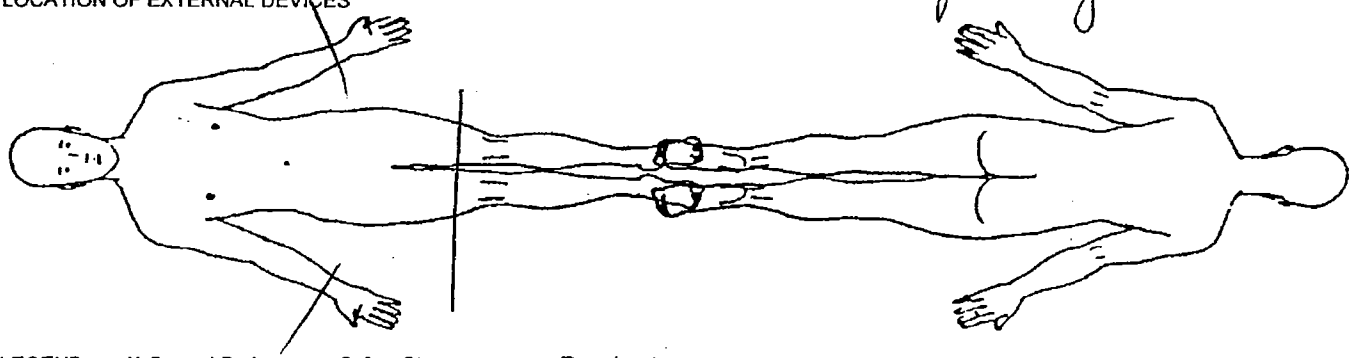
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol.
SITE: BY WHOM:
SITE: BY WHOM:

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

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

SCRUB Spc [redacted] CIRCULATOR LTC [redacted]

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

b(6)-4
[redacted]

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

☒ ESU NO: Valleylab Force 4
GROUND PAD: BRAND Polyhesive REM II
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: coag:

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

Medcom: 18693

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☒ [redacted] IF YES, SITE C-arm, legs

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)
kerlix fluffs
kerlix Rolls
ACE x 3-6"

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1" Penrose	2.	3.
SITE	~~Lt.~~ Post. thigh		3.

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

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

20. OPERATION(S) PERFORMED
b(6)-2 I & D Wounds Bil. legs

21. PATIENT TRANSFERRED TO PACU TIME 1430 METHOD via Gurney

[redacted]

MEDCOM - 18694

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 anesthesea

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

3. DATE 10SEP03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1410 b(6)-2 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA
pt not english speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CRT [redacted] 66E	RELIEF CIRCULATOR	CRT [redacted] (1500-EOC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

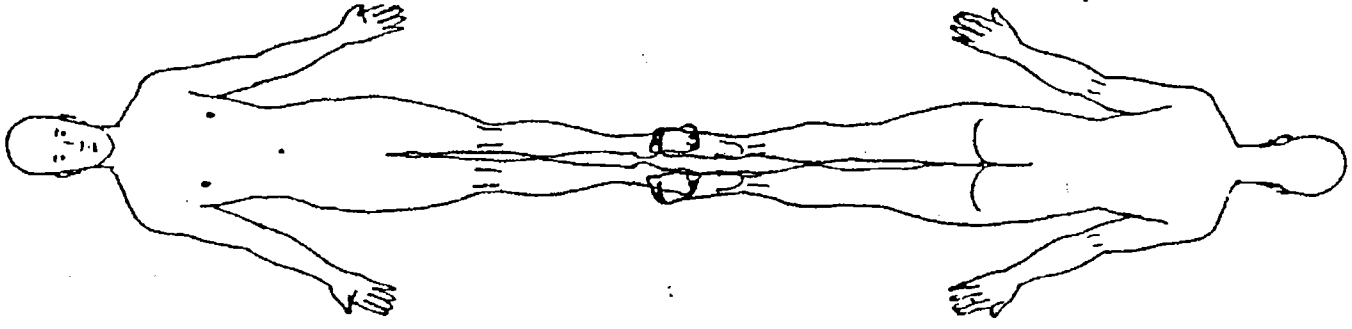
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta
SITE: Bilateral BY WHOM: CRT [redacted]
SITE: Legs BY WHOM:

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS		C = Correct I = Incorrect: Initial / Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C		C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No	C		C		
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

10SEP03 [redacted] b(2)-2

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

CRT 30 COA 6 30

☒ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* – Staples C Vessel loop. – Jelonet – Perlex – ace wrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
WC b(6)-2
Surgeons: DR. [redacted] Anesthesia: DR. [redacted] Anesthesia Type: General

[redacted] Bovie Pad site intact pre-op 30 [redacted]; post-op 30 Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op ___: post-op ___
Tourniquet Time: Up ___ Down ___ N/A

-5179 on chart, OA's noted

20. OPERATION(S) PERFORMED
Irrigation ® thigh wound
I & D Left Femur Fx

21. PATIENT TRANSFERRED TO ICU b(6)-2 TIME see DA7389 METHOD gurney C O2 mask

22. REGISTERED NURSE SIGNATURE [redacted] CPT/A. MEDCOM - 18696 [redacted] CPT USN

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 Cutter BY Anesthesia (SPAS)	2. PATIENT ID VERIFIED BY [redacted] REVIEWED AND PROCEDURE CPT A
3. DATE 12 Sept 03 TIME PATIENT ARRIVED IN SUITE 1035	4. PATIENT TIME 1035 NUMBER T.O. # 2 Routine Case

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] OET b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AT	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transfered to OR table, anatomically aligned for surgical procedure c pad under head (B) arms on padded arm boards less 90°

☒ 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:

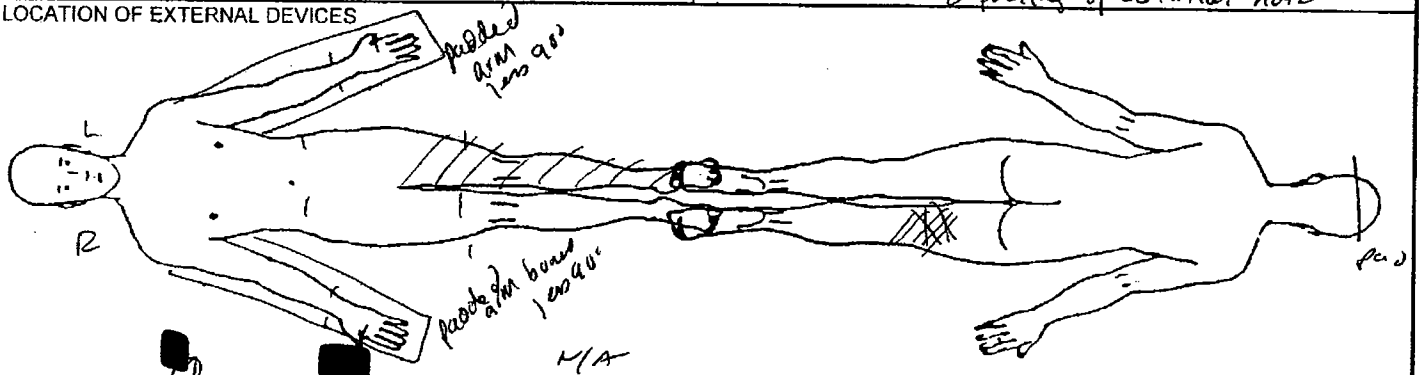
PREP SOLUTION (Specify) Betadine/Betadine

SITE: (R) leg (Thigh) BY WHOM: Dr. [redacted]

SITE: (L) leg (Femur) BY WHOM: CPT [redacted]

COMMENTS: ** See H & P pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No					
Needle Sharp	☐ Yes ☐ No					
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

#[redacted] ICW-2 blood

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/50

☒ ESU NO: #1 FDE00039 NOT used

GROUND PAD: BRAND Valley Lab

LOT NO: 68935

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Dressings Kerlix ACE

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

b(6)-2

Bovie Pad site intact pre-op yes; post-op _____ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op N/A; post-op N/A

5179 Noted on chart & changed

20. OPERATION(S) PERFORMED
I + D (R) + (L) Legs

21. PATIENT TRANSFERRED TO PACU TIME [illegible] METHOD Litter EDz

22. REGISTERED NURSE SIGNATURE [illegible]

MEDCOM - 18698

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

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

3. DATE 14 Sep 03 TIME PATIENT ~~ARRIVED~~ IN SUITE

4. PATIENT IN R... TIME 1030 b(6)-2 NUMBER 2-2 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Ø
pt not english speaker. ALL: PCN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2 9ID	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	MAJ [redacted] (10:30-10:45)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

8. SKIN PREPARATION

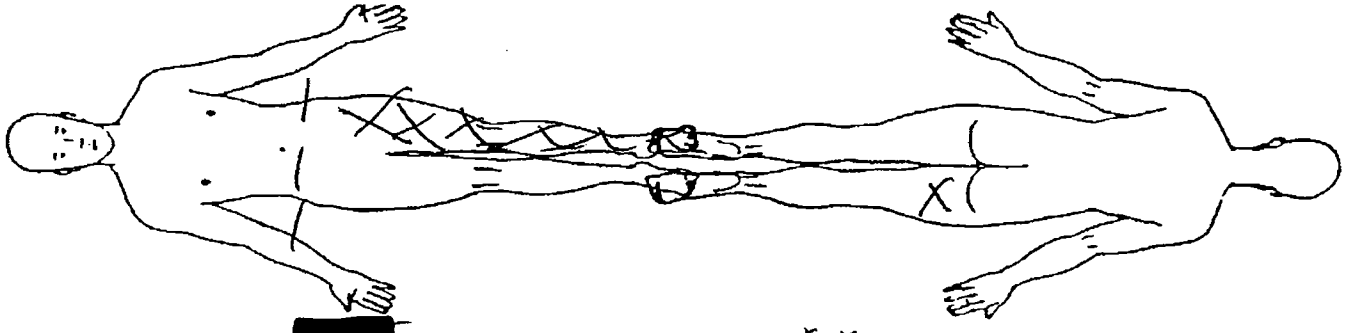
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Beta/Beta
SITE: L leg BY WHOM: maj [redacted]
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Strap === Tourniquet XXX prep.

C = Correct I = Incorrect

10. COUNTS		Initial Count	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C		C
Needle Sharp.	☒ Yes ☐ No	C		C
Instrument	☐ Yes ☒ No	/	/	/
Other	☐ Yes ☒ No	/	/	/

SCRUB	CIRCULATOR
SPC [redacted]	CPT [redacted]
/	/

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

[redacted] b(6)-4

[redacted] b(2)-2

14 Sep 03

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

- fluff
- kerlix
- ace wrap

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: MAC [redacted] esthesia Type: general
4(a)-2

Bovie Pad site intact pre-op YES; post-op YES Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ____ post-op ____
Tourniquet Time: Up____ Down____

20. OPERATION(S) PERFORMED
I&D (L) leg; DPC Wound.

21. PATIENT TRANSFERRED TO ICU 3 TIME 1150 METHOD gurney

22. REGISTERED NURSE SIGN [redacted]

MEDCOM - 18700

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY anesthesia

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

3. DATE 17 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN [redacted] TIME 1515 NUMBER P-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	SPC [redacted] (1500)
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	1LT [redacted] (1500)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Normal anatomic body alignment maintained

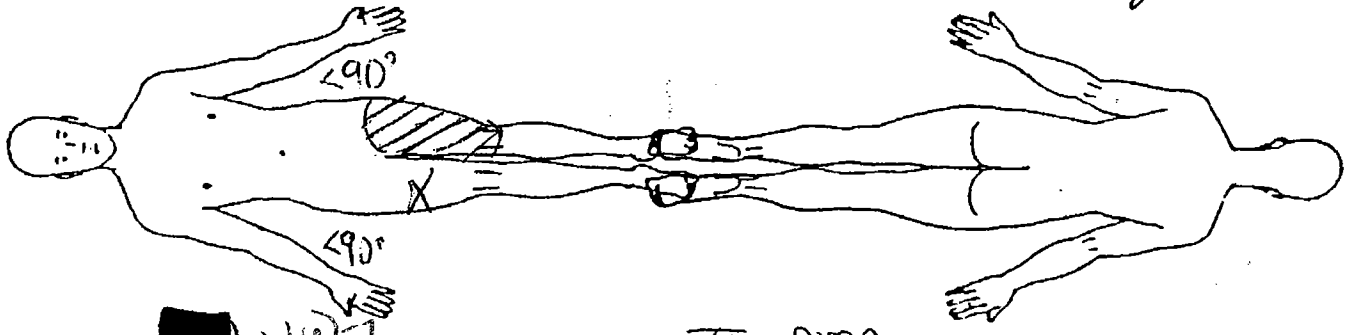
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta / Beta
SITE: L leg BY WHOM: CPT [redacted] b(6)-2
SITE: BY WHOM:

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad b(6)-2 = Safety Strap === Tourniquet VI - prep

Initial: SPC [redacted] b(6)-2
1LT

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

#[redacted] b(6)-1

[redacted]

17 Sep 03 b(6)-2

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

☒ ESU NO: VL FORCE 40 cut 30 coag 30
GROUND PAD: BRAND VL REM POLYHESIVE II
LOT NO: 6X245 Exp 2005-06

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

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

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-Arm IF YES, SITE Left thigh.

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)* fluffs Kerlix ACE

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION
WC ☒
Surgeons: Dr. [redacted] Anesthesia: MA [redacted] Anesthesia Type: GETA

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op N/A; post-op ____
Tourniquet Time: Up____ Down N/A

b(6) -2

20. OPERATION(S) PERFORMED
DPC (L) thigh wound

21. PATIENT TRANSFERRED TO PACU TIME See DA7389 METHOD Litter o2

22. REGISTERED NURSE SIGNATURE [redacted] MEDCOM - 18702 RN

VIA litter	BY [redacted]	VERIFIED BY ILT [redacted] b(6)-2	
3. DATE 30SEP03	TIME PATIENT ARRIVED IN SUITE 1520	4. PATIENT IN ROOM TIME 1528	NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted]	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

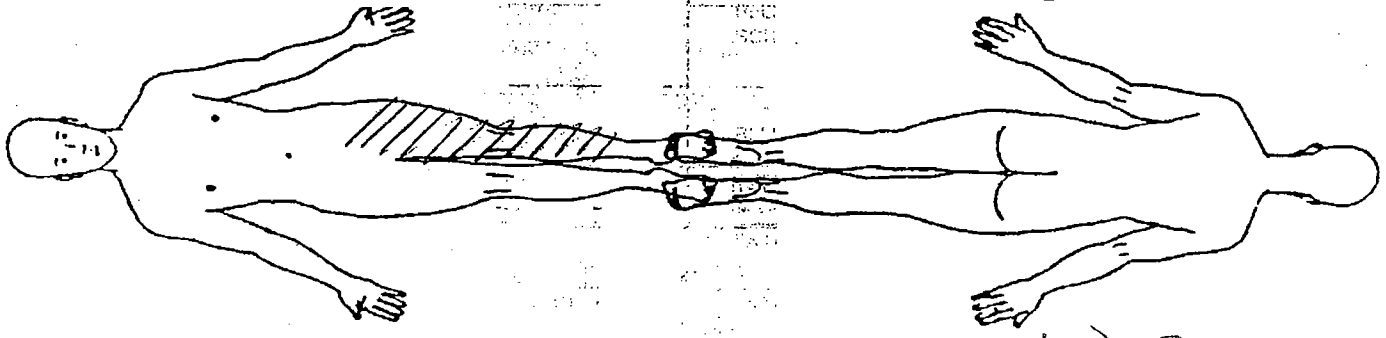
COMMENTS: b(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* [redacted]
SITE: Left leg
SITE:
BY WHOM: ILT [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS (C = Correct I = Incorrect)

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

SCRUB: SGT [redacted]
CIRCULATOR: ILT [redacted]

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

[redacted] b(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

14. MEDICATIONS/ORDERS

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

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

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl-Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A b(6)-2 [redacted]		

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE C-Arm Left Leg

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)* sten-strips, Fluffs, Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted]
Anesthesia: MAS [redacted] b(6)-2
WC: III
GETA

20. OPERATION(S) PERFORMED

Suture removal
I & D of wounds

21. PATIENT TRANSFERRED TO PACU TIME See DA 7389 METHOD Litter to OR

22. REGISTERED NURSE SIGNATURE [redacted] RN b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 18704

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

2Octo3 30Oct03 31Oct03 5am 6am 7 8Oct

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Q SOF

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

STANDARD FORM 511 (REV. 7–95) BACK

511-119

NSN 7540-00-634-41.

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR SEP DAY: 25 | 26 | 27 | 28 | 29 | 30 | 01 OCT 03

15 2003 HOUR: 1900 08 | 1900 08 | 1900 08 | 1900 08 | 1900 08 | 1900 08 | 1900 08

PULSE (O) / TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

MEDCOM - 18706

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

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

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

98.6°

TEMP. C

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

(Centigrade Equivalents, for Reference only)

9 OCT 03 | 9 OCT 03 | 10 OCT | 11 OCT 03 | 12 OCT | 13 OCT 03 | 14 OCT 03

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

EPUH

[redacted]

b(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18707

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

(Hematology) CBC

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

Coagulation Studies PT PTT

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank (MUST SUBMIT SF 518 W REQ

UNIT	

Misc. Serology

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 01:24 PM

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. blo
Test Date :09/08/03
Test Time :01:23 PM
Card Lot :010301
Operator : ROMERO

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 01:27 PM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 40.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :01:25 PM
Card Lot :100212
Operator : ROMERO

REMARKS:

REPORTED BY: [redacted] **DATE:** 8 Sep 03 **LAB ID NO.:**

b(6)-2

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

---

i-STAT EG7+

Pt: [redacted] b(6)-4

Pt Name:_____

Na_____142 mmol/L
K_____6.3 mmol/L
TCO2_____19 mmol/L
iCa_____1.16 mmol/L
Hct_____18 %PCV
Hb*_____6 g/dL
*via Hct

At 37C
pH_____7.192
PCO2_____46.1 mmHg
PO2_____382 mmHg
HCO3_____18 mmol/L
BEecf_____-10 mmol/L
sO2*_____100 %
*calculated

FIO2_____: 100
Sample Type_: ART

08SEP03 13:17

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver:

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

b(6)-2

REPORTED BY: [redacted]	DATE: 8Sep03	LAB ID NO.:

b(6)-2

Ward/Section: ICU-3	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. CIV [redacted] b(6)-4	DATE 08Sep03 / TIME 2235	SSN/PSEUDO-SSN: CIV [redacted] b(6)-4

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____27 mmol/L

At 37C

pH_____7.418

PCO2_____39.4 mmHg

PO2_____68 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____94 %

*calculated

At Patient Temp

pH_____7.404

PCO2_____40.9 mmHg

PO2_____72 mmHg

Patient Temp: 100.2F

Sample Type_:

08SEP03 22:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

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

	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: 10J #3	REQUESTING PHYSICIAN: [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 8 Sep 03 / TIME 1630	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
Spun Hematocrit		37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANG
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

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 (MUST SUBMIT SF 518 W/ REQ)

UNIT	

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 04:53 PM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 17.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.4
Calculated INR = 1.74
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :04:52 PM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 04:57 PM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 54.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :04:54 PM
Card Lot [redacted]
Operator

REMARKS:

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

b(6)-2

Ward/Section: ICU #3	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 8Sep03	TIME 1630	SSN/PSEUDO SSN:

(i-STAT)

---

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____18 mmol/L

At 37C

pH_____7.165

PCO2_____46.3 mmHg

PO2_____150 mmHg

HCO3_____17 mmol/L

BEecf_____-12 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.195

PCO2_____41.9 mmHg

PO2_____137 mmHg

Patient Temp: 94.5F

FIO2_____: 40

Sample Type_: ART

08SEP03 16:56

Oper: [redacted]

Physician: _____

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA		
CHOL		
CK		
CRE		
GLU		
HDL		
TP		

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

08/09/03 17:05

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: b(6)-2 3151AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	122*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	126*	128-145	MMOL/L
K+	5.3*	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	16*	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REPORTED BY:	DATE:	LAB ID NO.:

94.5

40 %

EMT b(6)-2

Ward/Section: [redacted]	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 05 Sept	TIME: 0830
		SSN/PERSONAL ID: [redacted] b(6)-4

(Hematology) CBC

[redacted]

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	mod	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	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	

Macroscopic Urinalysis

RBC - 0-2
WBC - 1-3

CSF

Cell Count	
Directigen	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: O pos

Set Rate		
Other		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH
W825450	O pos	comp SF
2455844	O pos	comp SF

REMARKS: b(6)-2

REPORTED BY: [redacted]

DATE: 9-8-03

LAB ID NO.:

Ward/Section: EM7	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 9/08/03 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 (ve
HCO3		22-26 mmol/L (art 23-28 mmol/L (ar
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

blw-4

======= PICCOLO =======
08/09/03 08:44
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: blw 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	188*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	5.0*	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, 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
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

REQUESTING PHYSICIAN: [redacted] b(6)-2		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
124	DATE 9/9 / TIME 1600	SSN/PSEUDO SSN: [redacted] b(6)-4

CBC				Urinalysis			Misc. Serology		
		REF. RANGE		TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		1.8-10.8 x 10^3		Color		N/A	RPR		Negative
		1.7-6.1 x 10^9		App		N/A	Mono		Negative
		4-18 g/dl (M) 2-16 g/dl (F)		Glu		Negative	**Microbiology**		
		2-52% (M) 7-47% (F)		Bili		Negative	Source		
		0-94 fl (M) 1-99 fl (F)		Ket		Negative	Gram Stain		
		30-500 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		
Bands		Eos		Urob		0.2-1.0	O & P		
Lymph		Baso		Nit		Negative	Other		
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph				HCG		Negative			

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

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

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

LAST, FIRST, MI. [redacted] | DATE 9-9-03 | TIME 0630 | SSN/PSEUDO SSN:

99 Ax
FiO2

(i-STAT)

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

(Piccolo) Chemistry 12

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

(Piccolo) 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) Methyte 8

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

(Piccolo) 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

istry

REF. RANGE

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

[redacted]*
---
i-STAT G3+
Pt: [redacted]
Pt Name:_____

TCO2_____31 mmol/L

At 37C
pH_____7.519
PCO2_____37.0 mmHg
PO2_____149 mmHg
HCO3_____30 mmol/L
BEecf_____7 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.515
PCO2_____37.5 mmHg
PO2_____150 mmHg

Patient Temp: 99.1F
FIO2_____: 24
Sample Type_:

09SEP03 06:42

Oper: [redacted]
Physician:_____

Ser# [redacted]
Ver: [redacted]
---

b(6)-2

Ward/Section: ICU-3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 9 Sep 03	TIME 0410
		SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
		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)
		150-500 x 10^3 Verified
		40.5-51.1%

Differential

		Estimate adequate

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 18717

Ward/Section: 1113 | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

DATE: 09Sept03 | TIME: 0410 | SSN/PSEUDO SSN: CIV # [redacted]

[redacted]

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____108 mg/dL
BUN_____10 mg/dL
Na_____137 mmol/L
K_____4.0 mmol/L
Cl_____103 mmol/L
TCO2_____29 mmol/L
AnGap_____10 mmol/L
Hct_____28 %PCV
Hb*_____10 g/dL
*via Hct
pH_____7.428
PCO2_____42.3 mmHg
HCO3_____28 mmol/L
BEecf_____4 mmol/L

Sample Type_:

095EP03 04:26

Oper: [redacted]

Physician:_____

Ser# 42011
Ver: JAM5046A
CLEW 993

(Piccolo) Chemistry 1/2

REF. RANGE	TEST	RESULT	REF. RANGE
138-146 mmol/L	ALB		3.5-5.5 g/dl
3.5-4.9 mmol/L	ALP		26-84 u/l
98-109 mmol/L	ALT		10-47 u/l
7.31-7.45	AMY		14-97 u/l
35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l
80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl
23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl
22-26 mmol/L (art) 23-28 mmol/L (ven)			
95-98%			
(-2) – (+3) mmol/L			
10-20 mmol/L			
1.12-1.32 mmol/L			
8-26 mg/dl			
70-105 mg/dl			
0.7-1.5 mg/dl			
38-51% PCV			
12-17 g/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
		18-33 mmol/l

(Piccolo) Liver Panel Plus

T	RESULT	REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

======= PICCOLO =======
09/09/03 04:22
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	112	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	~~124~~ 139	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

REMARKS:

REPORTED BY:

P_{CO2} ARK 35-45 ACID [redacted]
HCO_3 ACID 22-26
BE +-2
pH ACID 7.35-7.45 [redacted]

Ward/Section: PCU A3 | REQUESTING PHYSICIAN: [redacted] b(6)-2 | CHEMIST...Y RESULT FORM (Subject to the Privacy Act of 1974)

LAST, [redacted] b(6)-2 | DATE 10SEP | TIME 0900 | SSN/PSEUDO SSN [redacted] b(6)-4

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA++		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l			
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l			
PO2		80-105 mmHg (art)			0.2-1.6 mg/dl			
TCO2					7-22 mg/dl			
HCO3					8.0-10.3mg/dl			
sO2					100-200 mg/dl			
BEecf					0.6-1.2 mg/dl			
AnGap					73-118 mg/dl			
Ca					6.4-8.1 g/dl			
BUN								
GLU								
Creat								
Hct								
Hgb								

(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		0.6-1.2 mg/dl
		39-380 u/l (M) 30-190 u/l (F)
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: | DATE: | LAB ID NO

======= PICCOLO =======
10/09/03 04:08
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	106	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	2208*	39-380	U/L
NA+	114*	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

Ward/Section: ICW2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-2	DATE: 10 SEP	TIME: 1736
SSN/PSEUDO SSN: [redacted] b(6)-4		

			Urinalysis			Misc. Serology		
		E	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
			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
		tial	pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	Macroscopic Urinalysis		
			HCG		Negative			

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

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

Ward/Section: ICW2 b(6)-4	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. C[redacted]	DATE 10SEP03 / TIME 1730	SSN/PEEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
[illegible]		[illegible]

PICCOLO
10/09/03 17:48
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

GLU	92	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	2291*	39-380	U/L
NA+	128	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 10 Sep 03	LAB ID NO.:

Ward/Section: ICW 2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, [redacted] b(6)-4	DATE 10 SEP	TIME 1736	SSN/PERUDO SSN: [redacted]

				Urinalysis			Misc. Serology		
			E	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
				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			

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

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

Ward/Section: ICU 2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI. # [redacted] b(6)-4	DATE 11Sept03	TIME 0055	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
		14-18 g/dl(M) 12-16 g/dl(F)
		42-52%(M) 37-47%(F)
		80-94 fi(M) 81-99 fi(F)
		130-500 x 10³ verified
		20.5-51.1%

tal Differential

ono		
s		
iso		
im		
		42-52%(M) 37-47%(F)

Urinalysis

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

CSF

Cell Count		
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		

Macroscopic 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 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW 2	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. # [redacted] b(6)-4	DATE 11 Sept	TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AS		
TB		
BI		
C		
C		
C		
T		

======= PICCOLO =======
11/09/03 01:11
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

GLU	113	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	1756*	39-380	U/L
NA+	+++136	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	27	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
$\backslash^+$		128-145 mmol/dl
		3.3-4.7 mmol/l
		98-108 mmol/l
:02		18-33 mmol/l

(Piccolo) Liver Panel Plus

EST	RESULT	REF. RANGE
.B		3.3-5.5 g/dl
.P		26-84 u/l
LT		10-47 u/l
ST		14-97 u/l
MY		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-4

E# [redacted] ICW-1

b(6)-2

SPECIMEN/LAB RPT. NO.

MISC

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

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY MD TECH

DATE

LAB ID NO.

REMARKS CBC

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS

ID: [redacted] WB

15-09-03 07:20

			Patient Limits	
WBC	14.2 H	x10^3/uL	4.5	10.5
RBC	2.98 L	x10^6/uL	4.00	6.00
Hgb	8.7 L	g/dL	11.0	18.0
Hct	27.3 L	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	556. H	x10^3/uL	150.	450.
LYZ	17.3	%	20.5	51.1
LYM	2.5 *	x10^3/uL	1.2	3.4

b(6)-4

E# [redacted] ICW-1

SPECIMEN/LAB. RPT. NO.

CHEM 1

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

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

15/09/03 07:48

REF# ICE RANGE: MALE

PATIENT #: b(6)-4

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-2 [redacted]

GLU	81	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	324	39-380	U/L
NA+	♦♦♦	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	26	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

Instr

Na+ 134

MEDICAL RECORD - ANESTH

...se of this form, see AR 40-66; the proponent a... is the OTSG

Allergic - PCN

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)											
KETAMINE	(mg)			50		50						
PROPOFOL	(mg)											
VERSED	(mg)	1		1							3	
FENTANYL	(ucg)					50					200	
LIDOCAINE	(mg)											
SUCCINYLCHOLINE	(mg)								NIMBEX - 20			
VOLAT AGENT	150 % del	X	2.0	2.0	2.0	1.5	1.5	1.5	2.0	2.0	2.0	0.6
	% e.t.											
AIR	L/Min											
N2O	L/Min											
O2	L/Min	10	2	2	2	2	2	2	2	2	2	2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ① ② ③ ④ ⑤

FLUIDS

LINE site	☐ Warmed
18g (L) WRIST	☐ Warmed
pRBCs	☐ Warmed
IV Central Cordis	☐ Warmed

LR2 — LR3 — 1★ E 2★ E 3 ★ 3 E →

LR2 — HESP1 — HESP2 — LR3

LOSSES — EST BLOOD LOSS — URINE — 150

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT 75 (KG) LB

HEMATOCRIT 28

INITIAL DATA

BP- 128/60

HR- 135

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? JM

TIME- 1140

SYMBOLS: BP by cuff V ^ — Heart rate ● — Resp rate — BR (transduced) ╪ — TOURNIQUET T—T — ANES- X-X PROC- ⊙-∅

TIME → 1145 1200 · 30 · 1300 · 30 · 1400

200 mg Phenylephrine

200 mg Phenylephrine

200 mg Phenylephrine

Lunch Dr. [redacted] giving [redacted]

7.19 142
46 63
382 1.16
18 18
-10 6
100%

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

VENTIL

VT - ml	+	800	170	220	220	200	150	220	210	240	760
f - breaths/min	↓	8	32	33	29	31	30	22	26	26	16
Peak inf pres / PEEP	—	/	/	/	/	/	/	—	/	/	/
MODE - S(pon), A(assist), C(on)	S	C	C	S	S	S	S	S	S	S	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	38	41	40	44	46	46	44	47	46	32
BP/oth	FIO2 (Frac or %)	0.58	0.58	058	0.58	0.58	58	.58	.57	.57	.57	.57
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST		ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site PO	35°		35°	35°	35°	34.7	34.6	34.4°	34.2	34	33.9
	N-M Block (T/4)	0/4					4/4					
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position →

TOTALS

TOTAL EBL	TOTAL URINE
100 / 5 min	250 / 200

FLUIDS SUMMARY

CRYSTALLOID- 3000

COLLOID- 1000

BLOOD- 2 units

REMARKS

Code drugs with numbers, events with letters

① PT ID, PREOP Hx DONE. (see PREOP)

② RM, O2 - MONITORS

③ A-line (R) + (L) Radial attempts x 5. (R) femoral A-line x 2 Central line x 3. DR. CARMODY I success for CVC with Femoral A-line

④ IVFS 1250

CBC @ 1318

11 > 4/14 < 142

1★ [redacted] pRBCs given to 40 V O2 carrying capacity

2★ [redacted]

3★ [redacted]

⑤ [redacted]

RECOVERY AT 1438

PACU (ICU) 3 (Specify)

OTHER

CONDITION: intubated

RESP- 16 SpO2- 100

BP- 140/90 HR- 101

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1138	1145	1440
	Ready	Begin	End
PROC	1250	1310	1420

PROCEDURES and CPT Codes: Ex Fix (L) Fib/Tib/Line placements

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

G-ETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

DL x 1 Miller 2, GRADE I view. #8 ETT @ 22. cuff ↑ @ lips. Secure, BB in place. eyes taped

SURGEONS: [redacted] b(6)-2

ANES: [redacted]

PROCEDURE LOCATION: 8 Sept 03

DATE: 8 Sept 03

PAGE 1 OF

DA FORM 7389, FEB 1998

4825450

MEDCOM - 18726

PATIENT'S MEDICAL RECORD

USAPA V1.00

ACLU-RDI 1648 p.86

DOD-032300

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)	
propofol	(mg)	200
Fentanyl	(mcg)	100 50 50 50
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT	1.50 % del	2.0-1.5-1.0-2.0-1.5-1.0-.8 ff
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8-2-2-2-2-8 ff

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site		
LR	☐ Warmed	200-400-500-(500)
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	
URINE -	(150)

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 75 (KG) LB

HEMATOCRIT 28

INITIAL DATA:

BP- 135, 73

HR- 118

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? ff

TIME-

TIME 00 X 30 X 500 X 30

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) ╪ | TOURNIQUET T—T | ANES- X-X PROC- ⊙-Ø

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		5	270	370	330	330	410
f - breaths/min			11	14	14	17	16
Peak inf pres / PEEP							
MODE - S(pon), A(ssist), C(on)		S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	52	48	49	50	49
BP/oth	FIO2 (Frac or %)	.9	.9	.8	.8	.8	.9
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	Available					
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS Position → OK → Prep'd → Closure

PROCEDURES and CPT Codes: I&D (B) thighs / DPC / (L) thigh

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA with LMA Prosed #4 - placed on 1st att

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Pre-O_2 - IV induction

SURGEONS: [redacted] b(6)-2

[redacted], M.D.

TOTALS

TOTAL EBL	TOTAL URINE
Minimal	150mL

(250mg)

FLUIDS - SUMMARY

CRYSTALLOID 500mL

COLLOID None

BLOOD None

REMARKS

Code drugs with numbers, events with letters

Pt transported to OR Preview of pre-op assess

Eyes Taped Arms secured

Pt with regular sport vent - to ICU 3 - LMA in place removed there - patent airway - Report give

RECOVERY AT:

PACU (ICU) 3 (Specify)

OTHER Stable

CONDITION:

RESP. 20 SpO2- 96%

BP- 140/80 HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1405	1410	1530
PROC	Ready 1417	Begin 1420	End 1518

PROCEDURE LOCATION: 2

DATE: 10 SEP 03

PAGE 1 OF 1

MEDCOM - 18727

MEDICAL RECORD - ANESTHESIA

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

Allergic: PCN

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "T" = CONSTANT INFUSION

DRUG (Units)														
Fentanyl (mcg)	100	50	50	50										
PROPOFOL (mg)	150													
SUX (mg)	100		~~5~~	~~5~~ 5 mg										
MgSO4 (mg)			6	5										
( )														
( )														
VOLAT AGENT 1.5 % del	2.5	2.5	2.0	.8										
% e.t.														
AIR L/Min														
N2O L/Min														
O2 L/Min	6	2	2	2										

SINGLE DOSE DRUGS-MARK ON GRID → WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site														
LR 18g (R) AC ☐ Warmed														
☐ Warmed														
☐ Warmed														
☐ Warmed														

LOSSES — EST BLOOD LOSS; URINE -

TOTALS: TOTAL EBL 250 min; TOTAL URINE 10

FLUIDS SUMMARY: CRYSTALLOID 800; COLLOID 0; BLOOD 0

REMARKS: *Code drugs with numbers, events with letters*

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 26.7

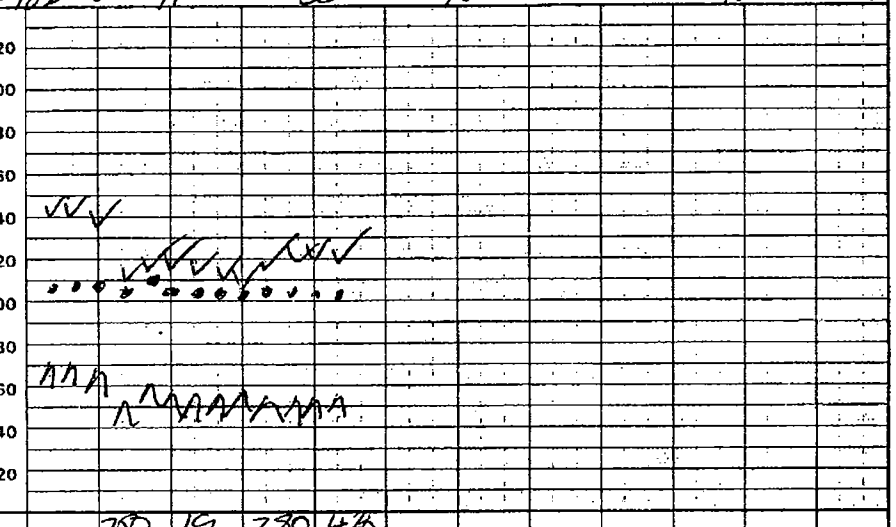
INITIAL DATA: BP- 139 / 69; HR- 98

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? [illegible]; TIME- 1040.

TIME → 10[00] • 11[00] • 30 • 12[00] • 30 • 13[00] • 30

SYMBOLS: BP by cuff V ^; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊙



VENTIL

VT - ml	700	19	280	448	
f - breaths/min	10	10	16	16	
Peak inf pres / PEEP	24				
MODE - S(pon), A(ssist), C(on)	S/C	C	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	41	34	55	47	42
BP/oth	FIO2 (Frac or %)	89	89	.89	.98	.90
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	ST-	ST	ST	ST
Gas analyzer	TEMP-site	AXIL	AXIL			
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS Position → 0-1

RECOVERY AT 1145

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 19 SpO2- 96

BP- 144/78 HR- 117

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1020	1035	1200
PROC	Ready	Begin	End
	1045	1045	[illegible]

PROCEDURES and CPT Codes: ITP treatment (R) [illegible]

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA/IA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Pre-ox Sux- 100% FIO2, RSI, VL XT MILLER 2 Grade II w/ cric, 8.0 ETT, block 22cm @ lip (+) BBS

SURGEONS: (+) ITPDoc.

[redacted]

PROCEDURE LOCATION: OR

DATE: 12 SEP 05

PAGE 1 OF 1

MEDCOM - 18728

[redacted] 1 PATIENT'S MEDICAL RECORD USAPA V1.00

ACLU-RDI 1648 p.88

DOD-032302

Pt's Δ in status since prior A. Chart reviewed. To proceed GLMA. Pt understands.

MEDICAL RECORD — ANESTHESIA

DRUG	(units)	
phenergan	(mg)	2.5
MSO4	(mg)	5 5 4 2 2 2
Propofol	(mg)	200
	( )	
	( )	
	( )	
ISOLAT Agent	% del	1.5 2.0 2.0 2.0 1.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: #1 #2

LINE site 18g LAC — Warmed — NS 600cc — #2

EST BLOOD LOSS
URINE – 200 400

TOTALS: 25 / 20 / 200 — TOTAL MIN: 155 min — TOTAL URINE: 400

FLUIDS – SUMMARY
CRYSTALLOID – 600
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters
1. To room via litter SpO2 mon, preO2.
2. Induction & LMA insertion
3. 1135 MAC Chew for lunch break
4. TV >4mL/kg RR >8 & <30 BPM Responsive (LMA removed) complications
5. PACU Report to RN.

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 70 KG LB
HEMATOCRIT: 34.9
INITIAL DATA: BP – 125/67 HR – 110
SBAR CHECK: OK? – (Y) N
PATIENT RECORDS: OK for PROCEDURE? TIME – 1020

SYMBOLS: BP by cuff (V ^) · Heart rate (●) · Resp rate · BP (transduced) (+ T) · TOURNIQUET T – ✗ · ANES – X-X · PROC – ⊙ – Ø

TIME → 1030 1100 1130 1200 1230

VT – ml	300	2100	380	360	300	340
f – breaths/min	26	24	22	21	18	11
Peak inf pres / PEEP						
MODE – S(pon), A(ssist), C(on)	S	S	S	S	S	S
✓ BP/Auto Cuff / ✓ ETCO2 (torr)	36	42	40	46	40	45
BP / oth / FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	.8
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ✓ ECG	ST	ST	ST	ST	SR	SR
Gas analyzer / TEMP- site AXIL						
N-M Block (T/4)						
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position →

RECOVERY AT 1152
PACU ICU (Specify) OTHER T-98.
CONDITION: Stable; Resp
RESP- 20 SpO2- 94-97% O2 RA
BP- 127/81 HR- 110

	Start	Room	End
ANES	1020	1030	1155
PROC	Ready	Begin	End
	1035	1100	1145

PROCEDURES and CPT Codes
1) I&D Lt thigh & calf wound, DPC
2) DSG Δ Rt thigh

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Eyes taped, #4 LMA 5 trauma, ETCO2, ESB, Secured, soft bite block & tape

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
EPW # [redacted] b(6)-4
[redacted] yo ♂
Smoker

SURGEON [redacted] b(6)-2
ANES [redacted] CRNA

PROCEDURE LOCATION 2-2
DATE 9/14/03
PAGE 1 OF 1

[redacted] RECORD – ANESTHESIA WAMC [redacted] REVISED [redacted] 99
MEDCOM - 18729
*U.S. GPO: 2002-729-180/40137

S/P GSWs BLE. 2° Sep, has ex Fix'd ... Multiple GA for washouts 5 ... Ø Δ in PA sta... ...lar. GA.

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)														
Fentanyl (UG)	250	100	50	100										
Versed (MG)	30													
Propofol (MG)	200													
Sux (MG)	100													
MS04 (MG)														
( )														
VOLAT AGENT 1.50 % del			1.5	1.5	1.5	X								
% e.t.														
AIR L/Min														
N2O L/Min														
O2 L/Min	6	2	2	2	6	6								
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	Induction													

FLUIDS

LINE site														
RA (G) ☐ Warmed	LR													
PA ☐ Warmed														
☐ Warmed														
☐ Warmed														

LOSSES — EST BLOOD LOSS; URINE

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 27.3

INITIAL DATA: BP- 129/53 ___/___ HR- 104

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? (+) TIME- 1430

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) ╪ | TOURNIQUET T—T | ANES- X-X PROC- ⊙-Ø

TIME → 1515 30 45 (1600) x 30 x (1700)

VENTIL: VT - ml		550	650	550	700	700	310	
f - breaths/min		10	10	10	18	18		
Peak inf pres / PEEP		21	21	21	—	—		
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	S	S		
MONITORS/ACCESSORIES: BP/Auto Cuff / ~~ET CO2 (torr)~~		36	45	45	36	36		
BP/oth / FIO2 (Frac or %)	.67	.67	.67	.69	.69	.69		
ART line / ~~SpO2~~ (%)	100	100	100	100	100	100		
Steth- PC/ES / ~~ECG~~	S	ST	ST	ST	ST	ST		
~~Gas analyzer~~ / ~~TEMP-site~~	Fem	35	35	35	35	X		
~~CO2~~ / N-M-Block (T/4)		4/4 ST						
Warming blkt / Conv warmer	Blanket/drape							

Mark with letters & symbols, explain under REMARKS — EVENTS Position → cl — arms 90 abducted/padded

TOTALS: 500/16 — TOTAL EBL: MCS

TOTAL URINE: 600

FLUIDS - SUMMARY: CRYSTALLOID- U - ; COLLOID- ___ ; BLOOD- ___

REMARKS (Code drugs with numbers, events with letters)

1430 Rec'd 10th Chart rev'd preop done - IV & IV in place. 1515 Pt to room - monitors on Induction

1609 - post-resp - Suction opened eyes Extubated TO PACU VSS

RECOVERY AT: PACU (ICU) ____ (Specify) OTHER stable

CONDITION: RESP- 17 SpO2- 98% BP- 118/78 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1430	1515	1609
PROC	Ready	Begin	End
	1505	1538	1620

PROCEDURES and CPT Codes: I&D, DPC wounds

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

EPW # [redacted]

25 yo ♂ 0(0)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA #8.0 ETT by Miller, taped 22 cm teeth

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — Eyes taped; OGT ↓ & ↑ return. Soft bite block DSI - Pre-ox - DL x 1 ⇒ Gd 1 View ⇒ ETT easily passed. Bilat BS, Atraumatic Technique

SURGEONS: [redacted] blk 1-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION:

DATE 9/17/03

PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 18730 — PATIENT'S MEDICAL RECORD — USAPA V1.00

Smoker

ACLU-RDI 1648 p.90

DOD-032304

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fentanyl	(mcg)	50-50 (50)
Lidocaine	(mg)	100
Propofol	(mg)	200
	( )	
	( )	
	( )	
VOLAT AGENT	% del / % e.t.	1.5-1.5 1.2 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10-2 2 10

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS — LINE site 18G (R) HD ☐ Warmed (R) —; ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE –

TOTALS	TOTAL MEDS
150	450
100	TOTAL URINE
200	Ø

FLUIDS - SUMMARY
CRYSTALLOID– 400
COLLOID– Ø
BLOOD– Ø

REMARKS-

Code drugs with numbers, events with letters

(1) Pre-op. Lunge equal & IA; HRR-Ex to Litter TO OR.
(2) Room, monitors, O2 eyeglide taped closed
(3) LMA removed no complication
(4) TOPACU. Report to nurse.

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 70 (RG) LB
HEMATOCRIT: 27.3
INITIAL DATA: BP – 135/66; HR– 110
EQUIP CHECK: OK?– (Y) N
PATIENT PROBLEM: OK for PROCEDURE? JR; TIME– 1500

TIME → 1530 . 1600 . 30 . 1700

SYMBOLS: BP by cuff V ^; Heart rate ●; Resp rate; BP (transduced) ⊥ T; TOURNIQUET T – X; ANES– X-X; PROC– ⊙–Ø

220 200 180 160 140 120 100 80 60 40 20

MONITORS / ASSESSMENTS / TREATMENTS

VENTIL	VT – ml	200	250	270	380
	f – breaths/min	25	19	21	22
	Peak inf pres / PEEP	—	—	—	—
	MODE– S(pon), A(ssist), C(on)	S	S	S	S
BP/Auto Cuff	ET CO2 (torr)	+	58	52	50
BP / oth	FIO2 (Frac or %)	0.5	0.5	0.5	0.50
ART line	SpO2 (%)	100	99	99	100
Steth- PC/ES	ECG	SR	→	→	→
Gas analyzer	TEMP- site Ax	adeq	→	→	→
	N-M Block (T/4)				
	BS	+	+	+	
Warming blkt	Wool x1	→	→	→	
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4)

RECOVERY AT 1615
PACU ☐ ICU ☐ (Specify)
OTHER T-98.3
CONDITION: Stable
RESP– 24 SpO2– 99
BP– 135/64 HR– 128

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1515	1525	1620
PROC	Ready	Begin	End
	1535	1550	1605

PROCEDURES and CPT Codes: I&D (L) leg wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4 seated BBS; sust ETCO2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical Facility

EBW # [redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] MAJ J CRNA

PROCEDURE LOCATION 2(1)

DATE 30 Sept 03

PAGE 1 OF 1

WAMC OD 376 REVISED 1 Jan 99

MEDCOM - 18731

PRE-ANESTHETIC ASSESS T AND PLAN OF CARE

AGE: 25 Days Mos (Yrs) GENDER: (X) Male ( ) Female ALLERGIES: PCN

PS: 1 2 3 4 5 E
WT: 75 (Kg/lb) HT: ____ In.

PROPOSED PROCEDURE: EX FIX (L) TIB/FIB
SURGICAL SERVICE: ORTHO
NPO SINCE: ____

PREOP DX / MECHANISM OF INJURY: GSW

HABITS:

Tobacco: ____
EtOH: ____
Drugs: ____

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ancef 1g q 8°
( ) Zantac 50mg q°
( ) ____
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES:

9AUG03

132	104	9	188
5.0	17	0.8	

10
28

8 SEP 03 POST SX.

Other: ____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	(Y)	GSW (L) & (R) LES.
Familial Hx	N	Y	

SURGICAL HISTORY

• EXP. (L) TIB/FIB 8 SEP 03

PHYSICAL EXAMINATION

SpO2 100%
BP: 128/60 HR: 135 RR: ____ T: 96°

Pain (0/10 Scale): SLEEPING/RESTING

Airway Exam:
Dentition: MISSING TEETH UPPER + LOWER
Trachea: MIDLINE
TMJ/C-spine: STABLE
Oropharynx: MP IC
• GRADE I VIEW 2 PREVIOUS SX < 24 HOU AGO
Chest:
Lungs: CTA
Heart: S1S2

IV Access: 18g (L) WRIST

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: (Intubation) Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] CPT CRNA Date: 8SEP03 Time: 1010

PATIENT IDENTIFICATION:

#[redacted]

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)
Signed: ____ Date: ____ Time: ____

Nursing Unit: ICU 3

ANESTHESIA PLAN OF CARE – PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 25 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 75 KG/LB HT: ____ IN.
ALLERGIES: PCN

PROPOSED PROCEDURE: I&D Bilat leg wounds
SURGICAL SERVICE: Ortho
NPO SINCE: MN

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) Ceftriaxone
( ) Zantac
( ) MSO4
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____
U/A: ____
OTHER: ____

9.8 / 28.7 9.4 / 147

114 / 3.8 95 / 23 15 / 1.2 106

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	S/P GSW bilat legs
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
exp wounds 8 Sept 03

PHYSICAL EXAMINATION
BP 73 HR 118 R 20 T ____ A-line 9/7
Pain Scale 0-10 ____
HEENT - Teeth MP 2 - Intact
missing teeth Trachea IM-3FB oral 2.5 FB
upper Oropharynx ____
lower Nares ____
CHEST: CTA bases
CARDIAC: ST RRR
EXTREMITIES: Fem A-Line
IV Access: ____
Ulnar Filling: ____
BACK: Foley
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ X General: Mask Intubation
pt understands he will go to surg. then intubated

INFORMED CONSENT/COUNSELING STATEMENT – Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal gua[redacted] MRT CKN b(6)-2
The patient/legal guardian seems to u[redacted] s answered.
Signed: ____ Date: 9/10/03 Time: 0900 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

CIV
[redacted] b(6)-2

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

ANESTHESIA PLAN OF CARE- PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS YRS Sex (~~)~~ MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 78 (KG)/LB HT: ____ IN.
ALLERGIES: PCN

PROPOSED PROCEDURE: ORTHO.
SURGICAL SERVICE: I+D/Washout (L) leg.
NPO SINCE: PMN

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: ____

Hb 4.6
9.0 > 8.9 / 26.7 < 181

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary System:		
Asthma	N	Y
Bronchitis/URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
Acute/Chronic RF	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
PUD/GERD	N	Y
Endocrine System:		
Diabetes	N	Y
Steriods	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Other	N	Y
Gynecological :		
Pregnancy	N	Y
Other Significant Hx:		
	N	Y
	N	Y
Familial HX	N	Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
EXD WOUND'S 8/5/2003
I+D (L) thigh 10/3/2003

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth missing teeth.
Trachea WNL.
TMJ/Neck Stable.
Oropharynx unremarkable.
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: 18G (L) AC
Ulnar Filling: ____
FOLEY
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {X} General: Mask Intubation

INFORMED [redacted] UNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discu[redacted]ent/legal guardian.

Th[redacted]ian seems to understand and agrees. Questions answered.

Signed: [redacted] Date: 12 SEP 03 Time: ____ Hrs

POST-A[redacted]STHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ____

IF [redacted] PCA(L)-4

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH 2

DATE REQUESTED: 8 Sept

DATE AND HOUR REQUIRED: 0830

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted] b(6)-3

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW femur

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 8 Sept b(6)-2

TIME VERIFIED: 0830

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DONOR	RECIPIENT
ABO O	ABO O
Rh pos	Rh pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 8 Sep 03

REMARKS:

Exp: 9 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)*: 1335 ON *(Date)*: 8 Sep 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient

1st [redacted] b(6)-2 CRT CLNA

2d [redacted] MD

PRE-T

TEMP. 37 PULSE 112 BP 95/48

DATE OF TRANSFUSION: 8 SEP 03

TIME STARTED: 1350

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle initial; rate; hospital or medical facility)

CIV [redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: All ML

TIME/DATE COMPLETED/INTERRUPTED: 8 SEP 03 1400

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
37	101	91/57

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit, Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [ ] NO
- [ ] YES *(Specify)*

[redacted] MD

b(6)-2

SEX: M

EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 18735

Medical Record Copy

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH x 2

DATE REQUESTED 08 Sept

DATE AND HOUR REQUIRED 0830

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW femur

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

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

DATE VERIFIED 08 Sept

TIME VERIFIED 0830

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. b(6)-4

PATIENT NO. [redacted]

DONOR
ABO O
Rh POS

RECIPIENT
ABO O
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE [redacted]

REMARKS: b(6)-2

Exp - 9Sep03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 1335 ON *(Date)* 8Sep03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

[redacted] CPT CRNA b(6)-2

[redacted] MD

P 34.4 PULSE 112 BP 92/48

DATE OF TRANSFUSION 08 SEP 03 TIME STARTED 1343

POST-TRANSFUSION DATA

AMOUNT GIVEN ALL ML

TIME/DATE COMPLETED/INTERRUPTED 8 SEP 03 1415

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 34°

PULSE 109

BLOOD PRESSURE 90/60

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES (clots, etc.)
- [X] NO
- [ ] YES

SIGNATURE [redacted] b(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] M

WARD EMT

CIV [redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 18736

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

REMARKS: EXP: 9 Sep 03

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 9/8/03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: b(6)-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE: [redacted] b(6)-2 CRT CRNA

DATE VERIFIED: 9/8/03

TIME VERIFIED: 1310

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: b(6)-4 [redacted] 780

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O Rh POS

RECIPIENT: ABO O Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 8 Sep 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND [illegible] Signature: [redacted] b(6)-2

A[illegible] 1911 ON (Date) 8 Sep 03

I[illegible]TION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Comp[illegible] Form.

1st V[illegible] [redacted] ID

2nd VE[illegible] [redacted] b(6)-2

PRE-TRANSFUSION
TEMP. 33.6 PULSE 104 BP 93/58

DATE OF TRANSFUSION: 9/8/03

TIME STARTED: ~~1430~~ 1500 1415

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME DATE COMPLETED: 8 Sep 03 ~~1510~~ 1500

INTERRUPTED: 1450

REACTION
- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [x] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)* b(6)-2

SI[illegible]URE OF PERSON NOT[illegible]OVE: [redacted] CRT CRNA

SEX: [illegible] WARD: CC

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 18737

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS: EXP: 9 Sep 03

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 9/8/03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: [redacted] b(6)-2

DIAG[redacted]ROCEDURE: S/P GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted] b(6)-2 CRNA

DATE VERIFIED: 9/8/03

TIME VERIFIED: 1310

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted] b(6)-4

TRANSFUSION NO.

PATIENT NO. [redacted] V

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

DONOR	RECIPIENT
ABO O	ABO O
Rh pos	Rh pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 8 Sep 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)*: 1417 ON *(Date)*: 8 Sep 03

IDENTIFICATION

I have examine[redacted] Component co[redacted] label and this form and I find all info[redacted]ing the co[redacted]th the intended recipient matches i[redacted]cipient i[redacted]on named on this Blood Compon[redacted]nd on[redacted]tification tag.

1st VERI[redacted] RL/AN

[redacted] b(6)-2

TEMP 98.6 PULSE 98 BP 136/89

DATE OF TRANSFUSION: 8 Sep 03 TIME STARTED: 1500

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
1U ML	1615 8Sep03	

REACTION
- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DI[redacted]*(equipment, etc.)*
- [x] NO
- [ ] YES

b(6)-2

SIGNATU[redacted] RL AN

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] V

WARD: OR

[redacted]LOOD COMPONENT TRANSFUSION
[redacted] FORM 518 (REV. 8-86)
[redacted]ices Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 18738 MEDICAL RECORD COPY

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

CIV [redacted] IRAQI b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 8 SEPT 03 TIME OF ORDER 1430 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICU-3
2. S/P I+D OF WOUNDS
3. CONDITION STABLE
4. ASSUME PHENOBARB 32.4 MG
5. IVF LR AT 125 CC/HR
6. ADVANCE TO REGULAR DIET

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

7. TRANSFUSE 11 UNITS PRBCS HOURS OVER 1 HOUR EACH UNIT, TO TOTAL OF 4 UNITS.
8. CBC, PT, PTT, METABOLYTE 8 AND ABG AFTER LAST UNIT.
9. CBC, ABG, METABOLYTE 8 IN AM
10. ANCEF 1 GRAM IVPB Q 8 HRS
11. GENTAMYCIN 500 MG IVPB Q DAY

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER b(6)-2

[redacted]

08Sep03 @ 2000

1) 2 amps of bicarb XT IV
2) ABG in 30 min.
3) IS. 10 times Q1° 4) [redacted] in the give 1 gm bolus XT V.O. DR [redacted]

[redacted] 2330 08Sep03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER

j

b(6)-2 HOURS

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

MEDCOM - 18739

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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 Sep 03 TIME OF ORDER ____ HOURS

LIST TYPE OF ORDER AND FULL NAME, GRADE AND TITLE OF PERSON TAKING ORDER

1. Admit to ICU
2. NPO
3. VS q 1°
4. IO q 1°
5. Bed Rest
6. IVF LR @ 125 cc/hr
7. CBC & Chem 7 @ 1500

8 Sep 03 1030 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

8. MSO4 1-2 mg q 1° PRN pain
9. Zantac 50 mg IVPB q 8°
10. Prilosec 1 gm q 8°
11. CBC & Chem 7 q A.M.
12. Phenergan 25 mg IVPB q 4° PRN nausea

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

TCW2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10 SEPT 03 TIME OF ORDER 1522 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW WHEN STABLE
2. S/P I+D OF LEG WOUNDS
3. CONDITION - STABLE
4. VS - ROUTINE
5. BSO NOST
6. LOVENOX 30mg SQ BID

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

7. REGULAR DIET HOURS
8. IV - LR @ 125cc/hr, HEP LOCK WHEN TAKING PO WELL
9. ANCEF 1 gram IVPB Q 8 HRS - GIVEN 1600
10. GENTAMICIN 500mg IVPB Q DAY
11. MSO4 2-8mg IVP Q 1 HR PRN
12. TYLENOL 650mg PO Q 4 HRS PRN
13. PERCOCET, 1-2 PO Q 4-6 HRS PRN

10 SEP 03 1645 KAN b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

14. XP BKD LLE (L) FEMUR HOURS IN + K 2½ IN AM
15. CBC, METLYTE PQ AM x 3.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/10/03 TIME OF ORDER 1600 HOURS

1. O_2 NC 1-2 lpm prn to keep S_aO_2 > 93%

T 14 HOURS

[redacted] CAMP

b(6)-2

24° chart V [redacted] 11SEP03 0030 11SEP03 0015

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

Amcs 1600
Zandac 1600

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] b(6)-4				10 SEP 03	1530 HOURS	
				① Demerol 25mg IVx one prn shivering		
				② D/C femoral [redacted] b(6)-2 @ RIJ Line		MD
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

MEDCOM - 18743

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
12 SEP 03	1200 HOURS	
(1) RESUME PREVIOUS ORDERS		
(2) REGULAR DIET		
(3) N-LR @ 125 CC/HR. HOB LOCK WHEN FEEDING D.O. WBM		
(4) NPO AFTER MIDNIGHT 13 SEP 03 FOR SURGERY	14 SEP 03 HOURS	

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 18744 MAY BE USED.

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

EF [redacted]

NURSING UNIT	ROOM NO.	BED NO.
		24

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13 Sept 03	1915 HOURS	

1. [redacted]
2. [redacted]
3. [redacted]

[redacted] 1914 9/13/03

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
14 Sept 03	1200 HOURS

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
9-17-03	0900 HOURS

- [redacted]
- Colace 100mg BID [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
17 Sept 03	1030 HOURS

1. NPO
2. O/C for OR for washout Lt leg wounds this evening
3. V.O Dr [redacted]

[redacted] 0230 9/18/03

DA FORM 1 APR 79 4256 REPLAC[redacted] 1 JUL 77, WHICH MAY BE USED.

☆ U.S. G MEDCOM - 18745 3-710

MEDICAL RECORD - DOCTOR'S C...

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	30 Sept 03 1550 POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. (for SaO_2 < 95%)		
(3)	Morphine / Meperidine 2 mg IV ~~now~~ PRN and 2 mg q 3-5 min prn pain for a max dose of 8 mg.		
(4)	Zofran 4 mg IV prn N/V q 15 min, may repeat x ____.		
(5)	Metoclopramide 10 mg IV prn N/V x 1.		
~~(6)~~	~~Droperidol ____ mg IV prn N/V x 1.~~ JPL		
~~(7)~~	~~Phenergan ____ mg IV prn N/V x 1.~~ JPL		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: LR @ TKO cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] MAJ/CRNA b(6)-2		

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD - DOCTOR'S C...
For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	30 Sept 03 1550 POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. (for SaO_2 < 95%)		
(3)	Morphine / Meperidine 2 mg IV ~~now~~ PRN and 2 mg q 3-5 min prn pain for a max dose of 8 mg.		
(4)	Zofran 4 mg IV prn N/V q 15 min, may repeat x ____.		
(5)	Metoclopramide 10 mg IV prn N/V x 1.		
~~(6)~~	~~Droperidol ____ mg IV prn N/V x 1.~~ JR		
~~(7)~~	~~Phenergan ____ mg IV prn N/V x 1.~~ JR		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: LR @ TKO cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] MAT/CRNA b(6)-2		

PATIENT IDENTIFICATION

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

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

30 SEP 03 1605 HOURS

1. REGULAR PREVIOUS ORDERS
2. D/C NPO
3. D/C GLUCOMETER
4. CIPRO 500MG P.O. BID
5. UP AD LIB, CRUTCHES, PCU EPW, ROUTINE

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted] WAS 30SEP03 1710

DATE OF ORDER | TIME OF ORDER

6. 1) PIN CARE BID WITH 2ND DRESSINGS, DAILY REMOVE LARGE DRESSINGS IN AM
7. IVF @ 125 CC/HR. D/C IV WHEN TAKING P.O. WELL

NURSING UNIT | ROOM NO. | BED NO.

10/1/03 2108 24 [redacted] PN

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

[redacted] b(6)-2

HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

	DATE OF ORDER	TIME OF ORDER	LIST TIME OF ORDER NOTED & SIGN
	13 OCT 03	0745 HOURS	
1	DISCHARGE TO PRISON CAMP W/ HOSPITAL		
2	PROCRIT 1:2 P.O. Q4-6 HRS PRN "D"		
3	CRUTCHES, TOE-TOUCH WEIGHT BEARING		
4	OP + LOT OF 1 FLOOR TODAY		
5	PIW CLNT BID		

PATIENT IDENTIFICATION

[redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

MEDCOM - 18749

b(6)-2 AR

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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 08	09	10
8Sep03	[redacted]	~~ATP~~ Advance to Reg diet	06	[redacted]		
			18	[redacted]		
8Sep03	[redacted]	VS q 1°	06	[redacted]		
			18	[redacted]		
8Sep03	[redacted]	IO q 1°	06	[redacted]		
			18	[redacted]		
8Sep03	[redacted]	Bed rest	06	[redacted]		
			18	[redacted]		
8Sep03	[redacted]	~~IVF LR @ 125 cc/hr~~	06			
			18			
8Sep03	[redacted]	CBC & Chem 7 q AM	04	[redacted]		
8 Sep 03	[redacted]	S/P I&D of Wounds	06	[redacted]		
			18	[redacted]		
8 Sep 03	[redacted]	Cond: Stable	06	[redacted]		
			18	[redacted]		
8 Sep 03	[redacted]	Resume previous orders	06	[redacted]		
			18	[redacted]		
8 Sep 03	[redacted]	CBC, ABG, metabolic 8 in AM	04	[redacted]		
9Sep03	[redacted]	Incentive Spirometer 10 x q1°	06	[redacted]		
			18	[redacted]		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW bilat legs S/P I&D of Wounds

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

PATIENT IDENTIFICATION: [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18750

b(6)-4

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
9/8/03	[redacted]	Admit to ICU	9/8/03 NOW	1000	1000	[redacted]
9/8/03	[redacted]	CBC & Chem 7 @ 1500			1630	[redacted]
9/8/03	[redacted]	CBC, PT, PTT, Metalyte 8, and ABG after last unit			1630	[redacted]
9/8/03	[redacted]	Transfuse 4 units PRBC's over hours each unit, to total of 4 units			3 units given in OR 4th unit 1500	
8Sep03	[redacted]	ABG in 30 min	08Sep	2030	2100	[redacted]
09Sep03	[redacted]	CBC, ABG, Metalyte 8 in A.M.	09Sep	0400	0410	[redacted]

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

USAPA V1.00

b(6)-2 & 11

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 10 11 12 13 14 15 16 17 18 19 20 21 22 23
10SEP	[redacted]	VS - Routine	D	/ [redacted]
			E	[redacted]
			N	
10SEP	[redacted]	Bed Rest	D	/ [redacted]
			E	[redacted]
			N	
10SEP	[redacted]	Regular diet	D	/ [redacted] 17Sep03
			E	[redacted]
			N	10 11 [redacted]
13Sep	[redacted]	Q2° Restraint check (Nursing order)	D	— / [redacted]
			E	— / [redacted]
			N	— / [redacted]
14Sep03	[redacted]	Daily dry dressing changes to Right thigh	20	/
			22	/
17Sep	[redacted]	NPO on call for OR	06	— → [redacted] DC 17Sep03
		~~Resume previous DIS~~	12	→
17Sep03	[redacted]	Regular diet	06	// [redacted]
			18	//

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D of Leg Wounds

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18752

bcw-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
10SEP	[redacted]	To ICW when stable - stable	10SEP	Done			
10SEP	[redacted]	AP + LAT @ Femur ; xt-ray in AM	11SEP		0500	[redacted]	
10SEP	[redacted]	CBC, Metlyte 8 @ 8 hrs X3 ①	10SEP	1700	1700		
	-----		②	11SEP	0100	0055	
	-----		③	11SEP	0900		
12/Sep	[redacted]	Resume previous orders	12 Sep	—	—	[redacted]	
9/12	[redacted]	NPO p MN 13 Sept for Surgery	13 Sep	2400			
	[redacted]	14 Sept 03					
9/13	[redacted]	To OR in AM	9/14/03				
9/13	[redacted]	NPO p MN	9/14/03	0000			
9/13	[redacted]	I&O cath Leave in if >500cc	9/13/03	1930	1938	[redacted]	
9/14	[redacted]	Resume Previous Order	9/14/03	~~1300~~	1300		
9/14	[redacted]	CBC, Metelyte 8 in Am	9/15/03	0400	0412		
9/17	[redacted]	D/C for OR for @ Leg I/D	9/17	—			
17 SEP 03	[redacted]	Resume previous orders	17 SEP 03	—			
17	[redacted]	D/C foley in am	18 SEP 03	0500	—		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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USAPA V1.00

b(6)-2 MM

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 7 8 9 10 11 12 13 14
10Sep03	[redacted]	VS ROUTINE (recopied)	06	[redacted]
			18	
10Sep03	[redacted]	Restraint checks Q2°	06	[redacted]
			18	
10Sep03	[redacted]	DAILY DSG Δ'S to (R) thigh	22	[redacted]
10Sep03	[redacted]	Regular diet	08	[redacted]
			12	
			18	
10Sep03	[redacted]	Up ad lib - Auths per EPW routine	06	[redacted]
			18	
10Sep03	[redacted]	(L) thigh pin care C DRY DSG'S BID	10	[redacted]
			22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I+D of Leg Wounds

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

PATIENT IDENTIFICATION: EPW # [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 | MEDCOM - 18754 EDITION OF 1 DEC 77 MAY BE USED. | USAPA V1.00

blue - 2

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
13 OCT 03	[redacted]	AP/LAT @ FEMUR	13 OCT 03	—	0900	[redacted]

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

USAPA V1.00

b(6)-2
AM

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. SEP Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 24 25 26 27 28 29 30 1 2 3 4 05 06
10SEP	[redacted]	VS Routine	D	[redacted]
			E	[redacted]
			N	[redacted]
10SEP	[redacted]	Bed Rest	D	[redacted]
			E	[redacted] SDIC 30SEP03
			N	[redacted]
18SEP	[redacted]	Q2° Restraint Checks	D	[redacted]
			E	[redacted]
			N	[redacted]
14SEP	[redacted]	Daily DSG Δ's to (R) Thigh	D	[redacted]
			E	[redacted]
			N	[redacted]
17SEP	[redacted]	Regular Diet	6	[redacted]
			12	[redacted]
			18	[redacted]
30SEP03	[redacted]	up ad lib - crutches	06	
		per PPW routine	18	[redacted]
30	[redacted]	Ethicon pin care BID	6	[redacted]
		with dry dsgs	18	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D of Leg Wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

E # [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

MEDCOM - 18756

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

bleed-3
AM

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo Sept Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
/	-/-	DC Foley in OR	/	/	/	/
9/30	[redacted]	NPO	9/30	—	—	[redacted]
9/30	[redacted]	TO OR 4 this pm	9/30	—	—	[redacted]
30 Sep03	[redacted]	Resume previous orders	30 Sep03	—	—	[redacted]
3p	[redacted]	May remove large dressings in am	01 Oct03	—	—	[redacted]

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

Mo. 09 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08 09 10
8Sep03	[redacted]	Zantac 50mg IVPB	08	/ [redacted]
		q 8°	16	[redacted]
			24	[redacted]
8Sep03	[redacted]	Ancef 1mg q 8° IVPB	08	/
			16	[redacted] / Rewritten
			24	
8Sep03	[redacted]	IVF LR @ 125cc/hr	06	[redacted]
			18	[redacted]
8Sep03	[redacted]	~~Gentamicin 500mg~~ ~~IVPB Q Day~~		
8Sep03	[redacted]	Gentamicin 500mg IVPB Q Day	20	[redacted]
08Sep03	[redacted]	Ancef 1gram IVPB q8hrs	08	/ [redacted]
			16	/
			24	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW bilat. legs S/P I&D of Wounds

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	

TIL EXHAUSTED.

DA FORM 4678, 1 FEB 79 ED MEDCOM - 18758 USAPA V1.00

b(6)-2
All

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
08Sep [redacted]	2 amps of bicarb x T IV	08Sep03	2000	2020	[redacted]
08sep [redacted]	UOP <100cc/hr give LR 500cc bolus x T				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
09/08/03	[redacted]	MSO4 1-4mg q1° prn pain	8Sep03 1700 4mg; 8Sep03 1905 4mg; 8Sep03 2200 2mg; 9Sep03 2340 2mg; 9Sep03 0220 2mg; 9Sep03 0410 3mg; 9Sep03 0555 3mg; 9Sep 0740; 9Sep 0915; 9Sep 1030; 9Sep 1135; 9/9 1730; 9/9 1503; 9/9 1553 [redacted]
09/08/03	[redacted]	Phenergan 25mg IVPB q8° prn nausea	
09Sep03	[redacted]	MSO4 1-4mg q1° PRN pain	09Sep 0400 4mg 2000; 9Sep 2200 4mg; 10Sep 0030; 10Sep 0300; 9-10 4mg; 9-10 3mg; 9-10 4mg [redacted]

b(a)-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.	Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10 11 12 13 14 15 16 17 18 19 20 21 22 23
10SEP	[redacted]	Lovenox 30mg SQBID	10	✓ [redacted]
			22	
10SEP	[redacted]	IV LR @ 125cc/Hr	D	✓ [redacted]
		(HL when taking PO well)	E	[redacted] D/C
			N	
10SEP	[redacted]	Ancef 1 gram IVPB Q8 hours	8	✓ [redacted]
			16	
			24	
10SEP	[redacted]	Gentamycin 500mg IVPB Q Day	20	[redacted]
10SEP	[redacted]	O2 NC 1-2 LPM PRN to keep SaO2 >93%	D	✓ on RA
			E	[redacted] D/C
			N	[redacted]
17 SEP 03	[redacted]	NLR @ 150cc/hr (HL when tol. PO well)	06	D/C
			18	
17	[redacted]	Cotace 100mg BID	10	[redacted]
			22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D of Leg wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted]

b(a)-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 4673, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 18760

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
17 SEP03	[redacted]	Biscodyl supp. 10mg PR now	17 SEP03			[redacted]
		bld-2 AM				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
10SEP	[redacted]	MSO4 2-8mg IVP	12Sep 6mg 1730; 13Sep 6mg 1336; 13Sep 6mg 2006; 13Sep 5mg 1120; 13Sep 8mg 1610
		Q 1 hr PRN	[redacted]
10SEP	[redacted]	Tylenol 650mg PO	
		Q 4 hrs PRN	
10SEP	[redacted]	Percocet 1-2 PO	10Sep 1145; 11Sep 0046; 11Sep 0611; 11Sep 2110; 12 Sept; 12Sep 1500; 12Sep 2650; 13Sep 0330; 13Sep 1010; 13SEP 1521; 14SEP 0510; 14Sep 1510; 14Sep 1900; 15SEP 0110
		Q4-6 hrs PRN	TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA; TiPO AHA
10SEP03	[redacted]	Percocet 1-2 po q4-6° prn	15SEP 0745; 15SEP 1215; 15SEP 1615; 15SEP2003 2100; 16SEP2003 0100; 16SEP2003 0530; 16SEP 0945; 16SEP 1439; 16SEP 2022; 17SEP 0200; 17SEP 1020
			KAS; KAS; KAS; PO; PO; PO; KAS; KAS; AK; AK; AHB
10SEP03	[redacted]	Percocet 1-2 PO q4-6°	17Sep 1740; 17SEP2003 2146; 18SEP 0039; 18SEP 0430; 18Sep 1740; 18SEP 2009; 19SEP 0200; 19SEP 0522; 19SEP 0945; 20SEP 1525; 21Sep 1316; 22Sep 0300; 22Sep 0900
		PRN	PO; PO; PO; 3; 2; 2; PO; 1; 3; 2; PO; PO; PO; 2
17SEP03	[redacted]	Biscodyl supp. 10mg PR q6 PRN	D/C
			D/C

USAPA V1.00

b(6) - 2 AM

CLINICAL RECORD

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

Mo. SEP Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 24 25 26 27 28 29 30 01 2 3 4 5 6 7
10 SEP	[redacted]	Lovenox 30mg SQ BID	10	[redacted]
10 SEP	[redacted]	Ancef 1gm IVPB q8° hours	22 8 16 24	[redacted] DIC 30 SEP 03
10 SEP	[redacted]	Gentamycin 500mg IVPB QD	20	[redacted]
17 SEP	[redacted]	Colace 100mg BID	10 22	[redacted]
30 SEP 03	[redacted]	Cipro 500mg po BID	10 22	[redacted]
		PRN MEDS:		
10 SEP	[redacted]	MSO4 2-8mg IVPB Q1° PRN	D/T D/I	8 0SEP 8 0SEP 10 MG 4mg 6mg KCRS KCS
10 SEP	[redacted]	Tylenol 650mg PO Q4° PRN	D/T D/I	rewritten per pg #2
10 SEP	[redacted]	Percocet 1-2 po q4-6° PRN	D/K	[redacted]
17 SEP	[redacted]	Bisacodyl supp 10mg PRN q6°	D/T D/I	
10 SEP	[redacted]	Percocet 1-2 PO Q4-6pm	D/T/I	[redacted]

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS:

S/p I&D of Leg Wounds

PATIENT IDENTIFICATION:

PAGE NO. 1

E[redacted] 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 - 18762

b(6)-2

CLINICAL RECORD

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

Mo. 09 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30 01 02 3 4 5 6 7 8 9 10 11 12 13
30 SEP 03	[redacted]	IV LR @ 125cc/hr d/c		[redacted]
		IV when tol. po well		
10 SEP	[redacted]	Levenox 30mg SQ BID	10	/
			22	/
17 SEP	[redacted]	Celace 100mg PO BID	10	/
			22	/
30 SEP	[redacted]	Cipro 500mg PO BID	10	/
			22	/

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D OLE

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

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

MEDCOM - 18763

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(a)2 AM				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
10	[redacted]	MSO4 2-8mg IVP Q1° PRN	D/T
			D/I
10	[redacted]	Tylenol 650mg po Q4° PRN	D/T 6 Oct 1030
			D/I 11 Qam
10	[redacted]	Percocet 1-2 po Q4°-6° prn	D/T 30Oct 0530; 8Oct 1605; 8Oct 2100; 8Oct 0135; 8Oct 1530; 4Oct 1935; 5Oct 1205; 5Oct 2330; 6Oct 0300; 7Oct 0945; 7Oct 1700; 9Oct 1420
			D/I 2 11 11 11 11 11 11 11 [redacted]
10	[redacted]	Bisacodyl supp 10mg PRN Q6°	D/T
			D/I
10	[redacted]	Percocet 1-2 PO Q4-6° PRN	D/T/I 9Oct 0315 2215; 11Oct 2115; 12Oct 0300 2100; 13Oct 0305; 13Oct 0340; 13Oct 0300 2200 [redacted]

USAPA V1.00

CLINICAL RECORD

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

Mo. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16
10 SEP 03	[redacted]	Lovenox 30mg SQ BID	10			
	-----	b(6)-2	22			
10	[redacted]	Celebrex 100mg PO BID	10			
	-----	b(6)-2	22			
30 SEP 03	[redacted]	Cipro 500mg PO BID	10			
	-----		22			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D WE / Ex Fix

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 3

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 - 18765

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
		b/a-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
10/28/03	[redacted]	morph 2-8mg IVP q1° prn	D/T													
			D/I													
10	[redacted]	Tylenol #3 mg po q 4° prn	D/T													
			D/I													
10	[redacted]	Percocet 1-2 po q4-6° prn	D/T													
			D/I													
10	[redacted]	Bisacodyl supp 10 mg prn q6°	D/T													
			D/I													

*U.S. GPO: 1998-454-110/95218

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: 14 Sep 05
Time In: 1144
Allergies: NKA
Pre-op V/S:
Procedures: Unilat TKR

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP 400 EBL n/a
Meds/Times:

Drains: Hemovac, NG, JP, T-tube, ~~Foley~~, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds: History

Time																								
SaO2																								
FiO2																								
Methods																								
240																								
220																								
200																								
180																								
160																								
140																								
120	✓			✓		✓																		
		✓	✓																					
100					✓																			
80	^																							
60		^	^	^	^	^																		
40																								
20																								
RR	12	20	12	16	16																			
T	96			97.6																				
Time	1144	1200	1215	1230	1245																			
Pain (0-10)	0	0	0	0	0																			
LOS																								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1152	NS	900	DSA	[redacted]	b(6)-2

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	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	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	10	10

Codes

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

V/S: X = A-line BP; ✓ = Cuff BP; = Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] RN

DEPARTMENT/SERVICE/CLINIC: PACU (3)

DATE: 14 Sep 05

PATIENT'S IDENTIFICATION (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)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

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

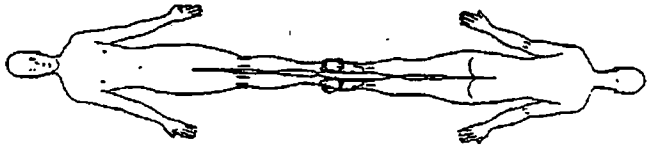
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

[redacted]

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: **Output:**
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 12 Sept 03 Anesthesia Type (Circle): General Spinal Epidural
Time In: 1150 IV Sedation Nerve Block
Allergies: NKA OR Intake: Crystalloid 800 Colloid 0
Pre-op V/S: 134/69 98 OR Output: UOP 0 EBL 0
Procedures: I&D, washout Meds/Times: Fentanyl, NSol

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1155	1200	1205	1220	1235	1250
SaO2	95	96	94	97	94	95
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140	V	V	V	V	V	V
120	•	•	•	•	•	•
100			V			
80	^	^		^	^	^
60			^	^		
40						
20						
RR	19	23	20	20	20	22
T	97.2					
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1155	LR	200	IVAC	[redacted]	800

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
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.	9	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)

PREPARED BY: [redacted] LPN 6(a)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 12 SEPT 03

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

[redacted]

EPW 7 ICW #1

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

DA FORM 4700, MAY 78 WAMC OP MEDCOM - 18769 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	(L) leg	WNL	+	P	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C	(L) leg	WNL	+	P	B	W	PK

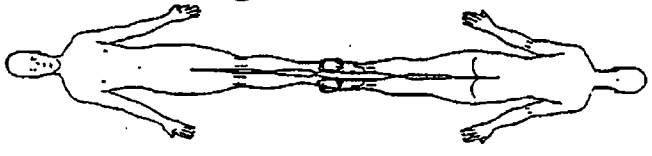
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	ACE c ext fix	mln
30'			
60'			
D/C	(L) leg	ACE c ext fix	mln



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1215	urine	clr yellow	500

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1155	ST	no	no

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p I+D washout (L) leg. Pt asleep, easily arousable. IV of LR infusing via (L) AC. S. 3/s of Honey Dressing (L) leg, long leg ACE c ext fix. Minimal drainage noted. (R) leg knee c ACE wrap. NV intact. VSS. @ cfs @ this time. Will continue to monitor & assess. [redacted] (R)LR
- Pt to ICW #1, report given to [redacted] (R)LR

b(6)-2

b(6)-2

Discharge Criteria:
Date: **Time:** **PARS:** 9
BP: 103/65 **T:** 97.9 **HR:** 121 **RR:** 26 **SaO2:** 95%
Pain Level at D/C (0-10):
Intake: 50 **Output:** 500
Additional Data:
Transferred To: ICW # [redacted]
Report Given To: SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: ST [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

10Sep03 PAGE 1 OF 4

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		INTILAS		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)

PREPARED [redacted] b(6)-2 | DEPARTMENT/SERVICE/CINC | DATE 10Sep03

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

[redacted]

b(6)-1

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

DA FORM [illegible] MEDCOM - 18771 WAMC OR 375 (Redesignated)

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	138/66							156/98				147/89		149/62		150/94		
BP Cuff	129/69	117/69	129/66	130/70	134/68	122/68	131/71	121/70		121/46	124/68	135/73	124/74	134/71	146/87	125/61		
Temperature	99.9		99.7		99.8			102.4										
Pulse	121	125	123	119	115	116	120	121		114	116	115	119	115	115	117		
Respiratory Rate	20	24	20	22	24	24	24	24		30	27	28	28	24	28	24		
SpO2	98	97	96	97	100	99	99	96		100	100	100	99	100	100	100		
	4 L/m	4 L/m	4 L/m	4 L/m	4 L/m	4 L/m	4 L/m	4 L/m		1L	1L	1L	1L	1L	1L	1L		
	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC		
~~IV Ancef~~	50																	
~~2 Antac~~	50																	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR 125	125	125/850	125/375	125/500	125/625	125/750	125/875	125/1000		125	125	125	125	125	125	125		
Ancef	50							50	100									
Zantac	50							50	100									
TOTALS									1250									

OUTPUT

		HOUR / TOTAL	170	130/300	100/810	100/490	100/590	115/705	150/855	152/1010		170	160/330	150/480	240/720	174/894	150/1044	230/1274		
URINE		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1530		Demerol 25m	IV			[redacted]
1530		IGM Anef	IV			[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) LG	+	+	DOP	<3	cool	PINK
15'	BLE	+	+	DP	<3	Warm	PK
30'	BLE	+	+	DP	<3	W	PK
45'							
60'							
90'							
D/C	BLE	+	+	DP	<3	W	PK

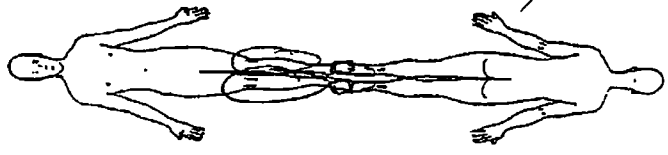
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) LC	Gauze	Ø
30'	BLE	Gauze	Ø
60'			
D/C	BLE	Gauze	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1530	F/C	yellow/clear	50

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1530	SINUS TACH	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt received from OR. VSS; Given 2 Tbsp dermal for sliming. C/A (R) UE biopsy sites; 3/9 sutures intact; ↓ pulse to (R) LE; dopplerable pulses; +3 edema thruout UE/LE; ØBS; ØROM; D/C @ tenant; (R) IJ; (Lines) NS to KVO (L) UE — [redacted] 17/k to (L) LE-2

Report given to [redacted] RN PT transported c O2 NC 2L. Orders for O2 given to report [redacted] (blue)-2

Discharge Criteria:
Date: 10Sep **Time:** 1609 **PARS:** 10
BP: 139/77 **T:** 97.4 **HR:** 116 **RR:** 20 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICU 2
Report Given To: Lt [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted]
**Cleared IAW Recovery Re[redacted] OP Bed [redacted]
Charge Nurse Signature [redacted]

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: 10 Sep 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1520
Allergies: NKDA OR Intake: Crystalloid LR 700 ml Colloid
Pre-op V/S: 112/60 110 OR Output: UOP 150 EBL
Procedures: (R) [illegible] Meds/Times:
[illegible]

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley (circled)	Other
TLS	(circled) [illegible]

Pre Op Meds History

Time	1530	1545	1552	1559	[illegible]
SaO2	96	95	95	96	94
FIO2	1L	1L	1L	1L	1L
Methods	NC	NC	NC	NC	NC

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

RR	24	24	24	24	24
T	97.4				97.4
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
~~1500~~ 1530	Ancef	50	1v	[illegible]	
1530	[illegible]	50	1v	[illegible]	

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	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	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.	7	10	10

Codes

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

V/S
X = A-line BP
= Cuff BP (circled)
= Pulse

TEMP
S = Skin (circled)
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) circled, Incentive Spirometer, Comfort Measures
Safety: SR up X 2, (Falls Precautions) circled, Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & T*[redacted] [illegible] | DEPARTMENT/SERVICE/CLINIC PACU/ICU | DATE 10 Sep 03

PATIENT'S IDENTIFICATIO[redacted] *first, middle; grade; date; hospital or medical facility)* *Name — last,*

b(6)-2

[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

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	2000	INTILAS [redacted]	1800	INTILA [redacted]		INTILAS
NEURO	PUPLIS	4mm Perrla		Pearl 3 m			
	SENSORIUM	A+Ox3 move all ext.		A&O x 3 - can move			
		left leg has ex fix brace		all extrem. x 4			
		can wiggle toes					
RESPIRATORY	RESPIRATION PATTERN	even, unlabored		even reg			
	BREATH SOUNDS	CTA-B		CTA-BIL			
	SECRETIONS	Sats 98% on 1LNC		SAT 96-97% 4m via NC			
SKIN	COLOR	NFR		NFR			
	INTEGRITY	dressing to R UE, ex fix on LL, [redacted]		pressure to VL Thigh cont @ leg dry intact - pins in place			
IV SITE	LOCATION	RW condis		(R) wrist covered			
	CONDITION	R fem A Line		R fem A-line			
		L hand infusing LR		(L) Peripheral line LR			
		@125cc/hr		@125cc/hr.			
GASTRO	ABDOMEN	soft nontender		Soft Round NT			
	BOWEL SOUNDS	hyperactive BS x 4 qds		BS (+) 4 quads			
GU	URINE	Foley, to gravity		foley to gravity			
	COLOR/CLARITY	clear yellow		clear yellow			
CARDIOVASCULAR	CARDIACRHYTHM	SR TSR		Pedal pulses +2 BIL			
		+2 pulses radial, doppler		& dopplers			
		for pedal, L3sec cap refill		Rad pul +3 cap refill			
		hands + groin +2 edema		L3 sec - +2 edema to feet B,L			

LEGEND

C_r - 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)

PREP[redacted]

DEPARTMENT/SERVICE/CINC: PACU

DATE: 08 Sep 03

PATIENT'S IND[redacted] written 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

MEDCOM - 18775

DATE 09Sept03 | DX GSW to bilateral legs, S/P I&D of wounds | HOSPITAL DAY 2

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	145/70	140/77	137/76	146/71	139/77	138/77	138/70	139/74	130/80	130/90	130/82	140/75	133/73	154/73	154/65	144/80	117/62	
Temperature	99.6 (A)		99.2 (A)		99.4 (A)		99.1 (A)	98.8									99.7	
Pulse	117	111	102	107	106	117	115	115	114	114	115	117	119	131	128	128	133	
Respiratory Rate	24	20	24	22	24	24	22	20	24	22	22	22	22	24	24	24	25	
FiO2	2L	2L	2L	2L	2L	1L	1L	1L	1L	1L	1L	1L	1L	2L	2L	1L	1L	
Mode	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
Sats	100%	100%	100%	100%	100%	99%	97%	98%	98%	98	97%	95%	98%	95%	99%	96%	99%	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	125	125	125	125	125	125	125	125		123	125	125	125	125	125	125	125	
IVPB	100									100								
P.O.					30			25						240				
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		175/175	200/375	250/625	250/875	250/1125	225/1350	200/1550	225		180/1730	190/1920	220/2140	240/2380	230/2610	230/2840	110/2950	110/3060	
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY 1

ACUITY LEVEL CLASSIFICATION IV

VITAL SIGNS

	16	17	18	19	20	21	22	23	
BP	110/69	139/71	114/74	115/70	127/62	115/60	122/63	116/63	
T			99.8						
HR	131	136	131	129/129	133	109	126	127	
RR	26	24	24	20	24	24	20	23	
O2:	1L	1L	1L	1L	1L	1L	1L	1L	
Nasal	NC	NC	NC	NC	NC	NC	NC	NC	
Sat	96%	97%	95%	95	99	98	97	97	

INTAKE

	16	17	18	19	20	21	22	23	8°T
LR	125	125	125	125/60	125/52	125/50	125/98	125/1100	111
IVPB	100						100	100	200
PO	50	300				60			910

OUTPUT

	16	17	18	19	20	21	22	23	
1635	100/100	115/1915	100/1975	100/2075	100/2175	100/2275	100/2375	1300/3675	2500

RESPIRATORY THERAPY

		TIME	0400								
		MODE									
		F_iO_2	3LNC 27%								
		TV									
		RATE									
		PEEP									
	A	pH	7.51								
	A	PCO_2	37								
	B	pO_2	93								
	B	HCO_3	30								
	G	SAT	98								
	G	BASE	7								

LABORATORY

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

ACTIVITIES

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

TURN / SUCTION

TIME					

24 HR TOTALS

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

INITIALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
Po			
TOTAL		TOTAL	

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 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS	1830	INITIALS [redacted]	b(6)-2	INITIALS
NEURO	PUPLIS			Perrl 4mm, brisk, Alert			
	SENSORIUM			Doesn't speak English.			
				Moves all extremities.			
				Limited BLE. @thigh Ex-fix.			
				See note on cms.			
RESPIRATORY	RESPIRATION PATTERN			Regular, unlab. CTA all			
	BREATH SOUNDS			lung fields. Weaned from			
	SECRETIONS			NRB 15L to RA. Sats >95%.			
SKIN	COLOR			WNL, Warm, Dry. Bandage			
	INTEGRITY			to @leg & @thigh. Drainage			
				from @thigh & @thigh.			
IV SITE	LOCATION			Cordis to @IJ. Flushes			
	CONDITION			well, CDT. @groin A-line			
				Old drainage Dressing/tube.			
				A-line zeroed. @hand			
				IV infusing LR @125cc/hr			
GASTRO	ABDOMEN			ABSx4. Soft. @BM			
	BOWEL SOUNDS			Nonterdus.			
GU	URINE			Foley to DD. Clear-			
	COLOR/CLARITY			light yellow urine.			
CARDIOVASCULAR	CARDIACRHYTHM			ST 120's-140's. S1, S2. Sec ppy			
				IBP & NIBP not correlating. Thighs			
				Edema. See note on circulation			
				Radial pulse 2+.			

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)

PREPARED BY [redacted] b(6)-2

DEPARTMENT/SERVICE/CINC: ICU 3

DATE: 09Sep03

PATIENT'S INDICATIONS *(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

DATE | DX | HOSPITAL DAY

	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
VITALSIGNS	BP Arterial line																		
	BP Cuff												128/60	124/67	120/60				
	Temperature												96.0	97.0				92.2	
	Pulse												131	138	138			92	
	Respiratory Rate												24	22	20			16	
	O_2 sat												100%	100%	100%			100%	
	Source												RA	RA	RA			SIMV	
																		50%	

	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
INTAKE	LR												125	125	125			125	500
	PRBC's															140	140	140	
	P.O.																		
	IVPB																		
	TOTALS																		

OUTPUT	URINE	HOUR / TOTAL												500	50/50	30/580			200/480	780
		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	
	168/92	170/45	136/78	155/77	136/67	143/68	136/76	141/69	
	93.0	96.3	99.7	100.8 @	100.5 @	101.0 @	100.2 @	99.9 @	
	89	135	114	132	133	136	123	122	
	16	24	23	24	28	30	26	22	
	100%	100%	100%	97%	98%	96%	100%	100%	
	SIMV	NR	NR	RA	RA	RA	NC	NC	
	50%	15L	15L	/	/	/	2L	1L	

INTAKE

	16	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
	LR 1000				KH 100				1600
						120			120
					100				100
									1820

OUTPUT

	600 /	425 T025	200 T225	275 T500	250 T750	250 2000	175 2175	150 2325	2325

RESPIRATORY

		TIME	2100	2130	2230						
		MODE									
		F_iO_2	21 RA	4L	1L						
		TV									
		RATE									
		PEEP									
	A	pH.	7.50	7.46	7.418						
	A	PCO_2	35.1	39.0	39.4						
	B	pO_2	56	140	68						
	B	HCO_3	28	27	25						
	G	SAT	91%	99%	94%						
	G	BASE	5	4	1						

LAB/DATA

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

ACTIVITIES/DAILY/LIVING

	TIME									
	MOUTH CARE									
	BATH	KH 2200								
	SKIN CARE	KH 2200								
	FOLEY CARE	KH 2200								
	TRACH CARE									
	ROM EXERCISES									
	Liren Δ	KH 2200								

TURN / SUCTION

	TIME									

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2700	Urine:	2325
Po	120		
TOTAL	2820	TOTAL	2325
BALANCE	+495		

MD/PA SIGNATURE [redacted] INITIALS

W(6)-2

MEDCOM - 18780

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: 17 Sep 03
Time In: 1635
Allergies: PCN
Pre-op V/S: 129/53-10V
Procedures: D&D-DPC of left wound

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid LR-1000 Colloid
OR Output: UOP 600 EBL: Min
Meds/Times: Fentanyl 50 mcg IV @ 1600

Drains: Hemovac, NG, JP, T-tube, (Foley), TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1635	1640	1655	1700
SaO2	96	98	97	98
FIO2	RA	RA	RA	RA
Methods				
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80				
60	^	^	^	^
40				
20				
RR	18	16	12	12
T				
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1635	LR	200	[redacted]	RL	800

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] RN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 17 SEP 03

(Typed or written entries give: first, middle; grade; date; hospital or medical facility)

Name – last,

[redacted]

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	LROM	+	+	B	W	Pk
15'	(L) leg	LROM	+	+	B	W	Pk
~~30'~~							
~~45'~~							
~~60'~~							
~~90'~~							
~~D/C~~							

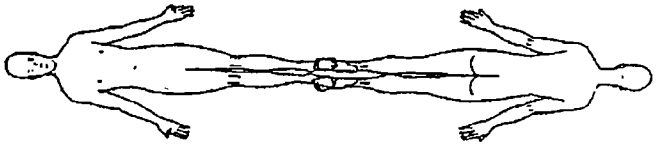
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	ACE	~~0~~
30'	(L) leg	ACE & Dxt Fix	~~0~~
~~60'~~			
~~D/C~~			



PACU OUTPUT

Time	Source	Color/Appearance	~~Amount~~

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1635	ST	~~0~~	~~0~~

NURSING NOTES

Pt to recovery room from OR via litter s/p I&D [illegible] wound & Ace wrap to (R) leg CSM. Long leg ACE wrap ext fix to (L) leg intact. IV of LR infusing into (L) arm 5 s/s of [illegible] edema. VSO c/o @ this time. Will continue to monitor. [redacted] LR

b(6)-2

Discharge Criteria:

Date: Time: PARS:
BP: 124/64 T: 96 HR: 110 RR: 22 Sa02: 95
Pain Level at D/C (0-10):
Intake: 50 Output: ~~0~~
Additional Data:
Transferred To: PACU #1
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: ST [redacted] b(6)-2
Cleared IAW Recovery Roo[redacted]
[illegible] se Signature: [redacted]

WAMC OP 173-E

MEDCOM - 18782

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: 30 Sep 03
Time In: 1615
Allergies: NKDA
Pre-op V/S: 135/66 110
Procedures: I&D (2) Legs

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

OR Intake: Crystalloid 400 LR Colloid ____
OR Output: UOP ∅ EBL <50
Meds/Times: 150mg Rent 70 273 HCT

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

Pre Op Meds

History

Time	1615	1630	1645	1700	1715
SaO2	99	99	100	99	98
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
	^	^	^	^	^
120	•				
100		•	•	•	•
80					V
60	V	V	V	V	
40					
20					
RR	21	12	19	14	19
T	98.3				

Time																	
Pain (0-10)																	
LOS																	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1615	600	LR	(R) Hand	MS	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2	V/S X = A-line BP ^ = Cuff BP • = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
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,	6	10	10	

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] SSG/CMA/Lic-1

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 30Sep03

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

[redacted] blw3-4

- ☐ 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

MEDCOM - 18783

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							

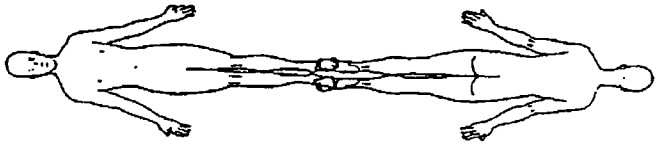
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1615 male EPW adm'd Hedd to PACU SP IVD @ Log. Pt responsive to physical stimuli. DSD 99% RA. No S/S respiratory distress. IV @ Hand LA @ TKO Patent. DSG to @ Log. COI. —
[redacted] SSG/LPN

b(4)-2 APD

Discharge Criteria:
Date: 30 Sep 03 Time: 1647 PARS: 10
BP: 139/72 T: 98.2 HR: 101 RR: 12 Sa02: 98%
Pain Level at D/C (0-10):
Intake: 2100 Output: 0
Additional Data:
Transferred To: ICU 1
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Room SOP
Nurse Signature:

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A L L D i	I Z	[redacted]	UNK - NAME	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	25 Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		~~9 9~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	7	1430	b(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
		1		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
0 5		0 3 1 0 1 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A F A A		0 3 0 9 0 8

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

FOR LOCAL USE

DX: ① GSW
② S/P I+D of leg wounds
Trauma Injury
9 569
[redacted] b(6)-2

Dx	Px
821.10	78.15
959.7	89.62
958.8	38.80 (x4)
959.6	83.09
959.5	99.04
E991.2	

ADMITTING OFFICER (Signature, as required)

SIGNAT[redacted]

DR. [redacted]

DA FORM 3985 MAR 89 MEDCOM - 18785

DETAILS OF CRIME (82 ABD) [redacted]

○ COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM ○ b(4)-4

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☒ Offense against Coalition Forces [check one] If "Other" then describe: INVOLVED IN A DRIVE BY SHOOTING AGAINST 82 ABD SOLDIERS

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☒ Assault/Attack on Coalition Forces b(2)-2
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

8 CHECK PT

Apprehending Unit: 3/325		Location Grid: [redacted]	
Date of Incident (D/M/Y): 08/07/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee # [redacted] b(4)-4				Key Connected Person: ☐ Victim ☐ Witness			
Last Name:				Last Name:			
First Name:	Given Name:			First Name:	Given Name:		
Hair Color: BLK	Scars/Tattoos/Deformities:			Hair Color:	Scars/Tattoos/Deformities:		
Eye-Color: BRN	Weight: 160 lb	Height: in		Eye-Color	Weight: lb	Height: in	
Address:				Address:			
Place of Birth: IRAQ				Place of Birth:			
Ethn/Tribe/ Sect:	Sex: ☒ M ☐ F	Phone#: DOB D/M/Y:	☐ Mobile ☐ Regular	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F	Phone#: DOB D/M/Y:	☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:				☐ Passport ☐ Dr. license ☐ Other (specify) Document #:			

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband	☐ Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:	Model:		Color/Caliber:
Serial No:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:	Where Found:		Owner:

Name of Assisting Interpreter: b(4)-4 Email, Phone, or Contact Info:

Detaining Soldier's Name: (Print): CPT [redacted] Last, First, MI		Supervising Officer's Name (Print): Last, First, MI	
Signature:		Signature:	
Email: [redacted] b(4)-2		Email:	
Unit Phone:	Date: / /	Unit Phone:	Date: / /

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
[redacted]	EPW UNK NAME			EPW	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	UNK	X	MUSLIM	—	—	NO
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
99	[redacted] b(6)-2		—			ICW1
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
—	—	K78	—	—		WIA ~~ICW1~~

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0945	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	D/C TO CAMP	22 Sep 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	29. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	12 Sep 2003	

28. 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

DX(1) S/P EX-LAP/GSW TO CX.

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	10	10

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

SIGNATURE OF ATTENDING MEDICAL OFFICER

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

DA FORM 3647, MAY 75 MEDCOM - 18787

EDITION OF 1 AUG 78 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NUMBER	2 NAME (Last, First, MI)	3 GRADE	ADMISSION REMARKS
[redacted]	EPW #[redacted] b(6)-4	NA	

4 SEX	5 AGE	6 RACE	7 RELIGION	8 LENGTH	9 EYES	10 PREVIOUS ADMISSION
M	27	Unk	Unk	NA	NA	NO

11 PMP	12 SSN	13 ORGANIZATION	14 WARD
99	[redacted]	NA	Iraq 1

15 FLY NO STATUS	16	17 DEPENDENT	18 BRANCH/CORPS	19 UIC/ZIP	20 TYPE CASE
NA	b(6)-4	NA	NA		NBI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22 HOURS OF ADMISSION	23 CLINIC SERVICE
Direct from Emt	0410	AEAA

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25 TYPE DISPOSITION	26 DATE OF DISPOSITION
Unk	50	12 SEPT03

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b TELEPHONE NO.	28 DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	Unk	12 SEPT03	DR [redacted]

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

MULTIPLE GSW TO CHEST/ABD/(2) LOWER EXTREMITY.

879.3
875.1
E991.1
V92.1
V25.43
423.90
E991.2

96.55
96.6
99.04
99.07
99.29
90.37

35 Total Days This Facility

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

36 Total Days All Facilities

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

SIGNATURE OF ATTENDING PHYSICIAN	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
[redacted] b(6)-2 PSSN	[redacted] b(2)-2

DA FORM 3647, [redacted] EDITION OF 1 AUG 75 IS OBSOLETE 1CIAPPC V1

MEDCOM - 18788

[redacted] [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

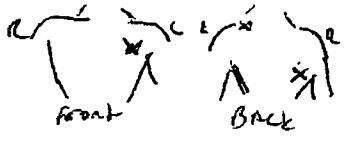
PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

27 40 irrgl male s/p multiple GSW
to FST where ① CT placed → [redacted] (b)(2)-2
Ankle moving c pain

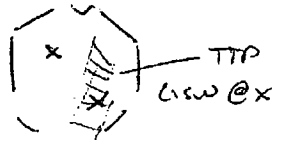
All ∅ PMH ∅ PSH ∅ Meds ∅

PHYSICAL EXAMINATION

98 123/63 100% SAT

NCAT
neck ⊖ inj
Chest


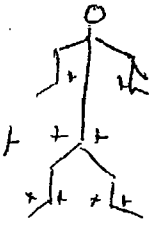
CBTA equal

Abd


rectal No tone Heme ⊖

ext. w/Hp GSW to @ Low leg / foot
GSW wrist

Neuro - moves legs

VASC


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

A/P GSW multiple to Chest / Abd / ⓛ Low ext

① CXR, KUB, ⓛ Low (x ray)
② IV Access
③ to OR for ex lap ? Pot washout.

b(6) - 2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	10sept03		

PATIENT (*When filled in, written entries give Name last, first, middle; grade; date; hospital or medical facility*) [redacted]

REGISTER NO.	WARD NO.

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
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

1 OSep 03
0410

OP Note

Exploratory Laparotomy
Repair Serosal tear of colon
(transverse) from shrapnel.
Surgeons: [redacted] / [redacted] b(6)-2
GETA
EBL: minimal
Specimens: ∅
Findings - Only 1 tiny serosal
Tear with shrapnel
sitting in it.
(R) Leg Washout and I+D
(R) cuboid Fx (open)
Repair Tib. Ant Tendon
Washout + Debridement of
shrapnel wounds (R) leg. b(6)-2
- Divers. concurrent c above lap
EBL: minimal.

[redacted]

[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

#[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
11Sep03	Surgery
Cipro	No complaint but sleepy and sedate
LR	99² 109 RR 97% 135/97
Albuterol	Chest CBOA but shallow wounds C/D
Toradol	CXR - ⊖ PTX ⊖ infiltrate
	Abd ND Quiet appropriate tenderness,
	ext - ⊖ by splinted to L/L ext
	wounds in AM
	A/P Very apathetic Needs Aggressive pulm toilet
	with get to chair BID
	incentive spirometry QI
	Albuterol neb
	NC O₂
	Toradol x 3 days

b(6)-2

[redacted]

11 Sep 03 1345	Toradol 30mg IVP to assist c pain control. Deep breathing exercises done. Pt very drowsy. Pt Sat 91-92%. On 2L NC placed. On Sat 95-98%. Interpreter explained to pt. plan for ↑ to chair & deep breathing exercises. Pt nodded understanding. [redacted] Page nos.

(continue on reverse side)

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

REGISTER NO. b(6)-2

WARD NO.

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 - 18791

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sep0300245	Assumed care @ 1800; VSS, pt A&O speaking arabic, ⊖ c/o pain @ this time; ⊕ CMS x4, NV intact throughout; cast intact; ⊕ BS x4, BM x1 this shift; pt amb to BR ⊼ assistance, ⊼ difficulty NAD, ⊖ c/o dizziness or SOB; LS CTA (B) ⊖ crepitus; dsgs Δ'd; W→D applied to (L) chest wall; petroleum gauze applied to old chest tube site; ⊖ S/Sx infection in either site; cast to (R) LE intact; PIV patent; infusing LR @ 150 cc/hr ⊼ S/Sx infection/infiltration; [redacted] pt in no apparent respiratory distress; 2 point restraints in place; ⊕ circulation, ⊖ skin breakdown; cont to monitor — b(6)-2 [redacted]
15Sep0600	Received pt resting in bed. VSS, A+Ox3, speaks Arabic. Medicated x1 tabs tylenol for c/o pain. Amb x1, gets up independently. W to D dsg to gunshot wound Δ, c/d/i @ this time. old clog noted to have serosang. drainage. Vaseline gauze dsg to old chest tube site c/d/i. No resp. distress noted this shift. LS CTAB, ⊖ crepitus noted to old chest tube site. cast to ~~RLE~~ RLE c/d/i w/ old marked drainage noted. Restraints in place per CPW protocol w/ S/S of skin breakdown or circulation issues. Toes to (R) LE warm w/ good cap refill noted. Will cont to monitor. [redacted] VLZAN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2
All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Sep 03 1930	Pt resting in bed, VSS, A+Ox3, LS CTA (B), (+) BS x4, dsg's on old chest tube site + upper chest CDI, steristrips to abd incision CDI in place, SPO2 - 99%, cast to R LE has old drainage mark, CDI, IV (R) FA intact infusing LR @ 150 cc/hr, c/o pain on (R) LE, proper circulation + skin integrity on pts of restraint. [redacted] 9/WM
16 Sep 03 0800	VSS. Alert & Oriented. [redacted] clean Bilaterally BS (+) x4 guad. Abd soft non-distended. Consumed Regular diet. OOB to BR for shower this AM Tolerated Well. On [redacted] dressing dsg to (R) foot. GSW dsg'd as ordered. Chest tube site without redness, swelling or drainage. (R) FA IV c/o pain, & redness or swelling IV D/Ced. Restarted IV to (L) FA X 1 attempt 18g 1 1/4 in cath. Tolerated well. Steri strips intact to abd midline incision with edges well approximated. Restraints supplied clean intact under wraps. Peripheral pulses +2. Will continue care as planned. [redacted] 2CDT
16 Sep 03 1915	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, Ø c/o pain @ this time, IV (L) FA patent infusing LR @ 150cc/hr, stitches on old chest tube site intact, Ø redness or swelling, abd soft flat nontender, steristrips intact, pt ambulates W assistance, OOB to BR, proper circulation + skin integrity on pts of restraint. [redacted] 9/W

STAND[redacted] BACK
USAPA V1.00

MEDCOM - 18793

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Sept 03 0900	VSS, Alert & oriented, Ambulating independently to BR and down hallway of ward. Ortho Pedic dsg in place on (R) foot. Splint to (R) lower leg removed & dsg change to (R) Leg wounds. Sutures intact & edges to (R) calf wound not well approximated. (L) chest gunshot wound dsg changed. old packing with serosanguinous drainage. Lungs clear Anterolaterally BS (+) x4 quad. Abd. soft non distended. Midline abd incision edges well approximated. steri strips in place. Skin intact under restraints will continue plan of care. [redacted] blue-2 ROR
17 Sep. 03 1845	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, Ø c/o pain @ this time, dsg on (R) leg CDI, pt ambulates ∑ difficulty, dsg (L) side of chest CDI, abd soft flat nontender, voiding ∑ difficulty, IV (L) FA intact infusing LR @ 150cc/hr, proper circulation + skin integrity on pts of restraint. — [redacted] 9IW blue-2

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

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

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

(6) [redacted] blue-4

PROGRESS NOTES
Medical Record

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

HCS-2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Sept 03 0800	VSS Alert & oriented @ FA IV patent rate infusing. CR @ 150cc/hr. OOB to Bathroom for BM & AM care. Tolerated well. Irrig clear Brittrol. BS(A) x4 quadrants. Abd soft, nondistended & nontender. Abd dsg dry & intact & incision = staples intact. (R) leg = Splint & dry intact. (L) chest GSW old packing removed with CNA & remaining drainage cleaned around & redressed as ordered. Weights pulses to L & R extremities. Plans of Care. [redacted] 24 hr
18 Sep 03 1950	Pt resting in bed, A&Ox3, VSS, LS CTA(B), (F) BS x4, IV (L) FA patent, voiding well, ambulates 5 complications, old chest tube site ø s/sx of infex, dsg (L) upper chest CDI denies pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] 9w
19 Sep 03 0730	Assumed care A to x3 VSS ø c/o [redacted] or discomfort @ this time lung clear HRRR Active BS x4 quads Tolerating PO well. Dressing A to (L) upper chest wall sutures to (L) flank prior chest. ø s/s of infection remain afebrile. Cast to (R) LE ortho shoe & ambulation. Will cont to monitor [redacted] 9w
20 Sep 03 0230	Assumed care @ 1800; All WSS; pt A&Ox3, ø c/o pain, pt amb x1 to BR (A) BM, dsg A to upper chest wall - CDI; sutures CDI, well approximated; Cast ~~intact~~ to (R) LE intact; ø A's from above assessments; restraints in place (B) circulation, (F) skin breakt; Cont to monitor [redacted]

STANDARD FORM [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20Sep03	PIV infiltrated; New one started in (R) FA; patent & intact infusing LR @150 cc/hr; cont to monitor [redacted] b(6)-2
20Sep03 0730	- Assumed care of pt. A+O x3 VSS & c/o pain or discomfort @ this time Dressing D+I to (L) upper chest wall complete. All care done. Cast to (R) LE intact ambulates 3 crutches. orthro shoe & ambulation. Lungs clear HRRR Active BS tolerating PO well Will cont to monitor [redacted] b(6)-2 (1550) I concur c above assessment. [redacted] b(6)-2
20Sep03 2015	ASS care @1500; VSS; A&Ox3, denies pain or discomfort @ this time; pt amb in hall x10 min c ortho shoe on, c difficulty; cast (R) LE intact; dsg to upper chest wall D+I - CDI; sutures to (L) mid-axillary CDI, well approximated, & S/S infection; PIV in (R) wrist patent & infusing LR @ 150 cc/hr; [redacted] restraints in place; (R) Skin break d; (R) circulation, cont to monitor [redacted] b(6)-2
21Sep03 0700	-Assumed care A+O x3 VSS. Denies having pain or discomfort @ this time. (R) foot dressing Ace wrapped clean dry and intact & bleeding noted ambulates c Orthopedic shoe c difficulty. Dressing to chest wall assessed & drainage noted Lungs CTA HRRR Active BS. Voiding per urinal QS Will cont to monitor [redacted] b(6)-2

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

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(3)
USAPA V1.00

[redacted] b(6)-2 A11 [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 Sep 03 (1905)	Rt alo, VSS, ϕ clo pain. ambulated x 1 c steady gait. lungs CTAB, HRRR, @BS x4 ads. +2 peripheral pulses @ CT sutures OTA ϕ drainage noted. Dsg to chest wall CDI. @ foot dsg c ace bandage CDI. W-D dsg d/s done. IS @ BS, being used every hr while awake c reminder. 2 pt restraints on, circulation intact. Will monitor. [redacted] MEMC
0400 I/O	Rt voided 1800cc this shift (cyu). Input 1 liter LR & bottled H2O. [redacted]
	Dc Summary
9/22/03	Dx Frag i noted in OSW. had exploratory laparotomy + chest tube insertion. No subsequent surgery. dsgs over fracture of @ foot. Wounds well healed. Continue oral antibiotics. Weight bearing as tolerated [redacted]
22 Sep 03 (1905)	Assumed care of pt @ 0000 & report from night shift. Pt alert, speaking Arabic. VSS. ϕ clo pain @ this time. Wet → dry dsg to OSW to chest d/d - ϕ s/sx infection. Dsg to @ foot d/cd by MD. Sutures intact. Pt OOB to shower this am. Amb S difficulty. Awaiting trans. to EPW camp. Will cont to monitor. [redacted] WDAW 0600 Sutures removed from RLE. Pt tol. well. Will monitor. [redacted] WDAW

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

[redacted] [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22SEP03@2045	Assumed care @ 1900; All VSS, pt A&Ox3 speaking arabic, Ø c/o pain or discomfort @ this time; ~~1st~~ pt ↑ OOB to amb in hall (X) for 15 min ∑ difficulty; W→D dsg to upper chest wall A², Ø s/s infection; ~~Sentences incoherent, Ø drainage, wound approximated~~ No Δ in assessment; restraints in place, ⊕ circulation ⊇ skin breaks; will cont to monitor. b(6)-2 [redacted] (LD)
23SEP03	(1340) Assumed care of pt @ change of report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain @ this time. Amb in hallway ∑ difficulty. incisions on RUE CDI-open to air. Wet→dry dsg to LSW to chest Δd - Ø s/sx infection. Tol. reg. diet well. Voiding ∑ difficulty. 2x point restraints in place ∑ s/sx complications. Will cont. to monitor. [redacted] (1400) Pt stable for d/c to camp-amb-escorted by mps. Prescriptions given. b(6)-2 [redacted] (LD)

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

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

[redacted]

b(6)-4

REGISTER NO.

WARD NO. ICW#1

PROGRESS NOTES
Medical Record

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

7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

6SEP03 (1210) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. VSS. Pt weaned off O_2 this am. O_2 sat 97-98% on RA @ this time. Chest tube pulled this am. Dsg applied by MD to site CDI. CXR done p tube pulled. Pt tol. procedure well. Pt OOB in chair @ this time. Foley d/cd this am. Pt DTV. Pain controlled c QID Toradol. Wet → dry dsg dd to GSW. ϕ s/sx infection. Pt OOB to chair for 3° - tol. well. Pt amb to BR c crutches s difficulty. IV and SL in ⓛ ac. d/cd d/t infiltration 18g IV started in ⓛ forearm. IVF infusing s s/sx infiltration. Steri-strips to end incision CDI. (1630) Pt voided s difficulty, quantity sufficient clear yellow urine. Cont. Albuterol tx q6° - pt tol. O_2 sat 96-98% on RA. ϕ resp. distress noted. Pt tol reg diet (= 50%) well. 2-point restraints in place s s/sx complications of skin breakd/circulation. Will cont. to monitor.

b(6)-2 [redacted] USAF

12Sep03 2000 Pt resting in bed, AtOx3, VSS, LS CTA Ⓑ, ⊕BSx4, S1 S2 present, dsg Ⓛ mid axillary CDI, dsg Ⓛ side of chest CDI, steri strips mid line c/d CDI, dsg Ⓡ LE CDI, ϕ c/o

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

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

b(6)-4

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

MEDCOM - 18799

ACLU-RDI 1648 p.159

DOD-032373

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Cont.	pain @ this time. IV (L) AC patent infusing LR @ 150 cc/hr, proper circulation + skin integrity on pts of restraint. [redacted] 91WM6 b(6)-2
13SEP03	(1435) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain @ this time. Pt amb to BR and to x-ray ≅ difficulty this shift. Pt OOB to chair for a°. Td. well. Ø s/sx resp. distress. Drsg to old chest tube site CDI. Wet → dry drsg to chest tube - Ø s/sx infection. Splint/drsg to (R) LE CDI - elevated on blanket. Pt able to move toes cap refill ≤3secs. 2-point restraints in place ≅ s/sx complications. Pt tol reg diet well. b(6)-2 Voiding ≅ difficulty. (+)BM. will cont. to monitor [redacted] 91WM6
13 Sep. 03 2045	Pt resting in bed, A+Ox3, VSS, SPO2 - 98%, Dsg on chest CDI, Ø c/o pain @ this time, LS CTA (B), (+)BS x4, splint dsg to (R) LE CDI, elevated ≅ blanket moves toes, IV (L) FA patent infusing LR @ 150 cc/hr, proper circulation + skin integrity on pts of restraint. [redacted] 91WM6 b(6)-2
14 Sept 03 0600	Received pt resting in bed, VSS, A+Ox3, speaks Arabic. Ø c/o pain @ this time. Amb x1, OOBTC. Ø resp. distress noted. Dsg D'd CDI. Vaseline gauze and dsg to old chest tube site CDI, Ø crepitus noted. Cast to (R) LE CDI. Toes warm to touch, brisk cap refill. Restraints per SOP protocol Ø skin integrity or circulation issues [redacted] b(6)-2

NSN 7540-00-634-4176 [redacted] [redacted] AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10SEP03	(1505) Pt admitted to unit via gurney in stable cond. from ICU#3. VSS. Pt responds to verbal stimulus. Pain controlled c IV MSOG. IVF infusing into LAC in ⓒ or c S/Sx infiltration. Pt weened off O2. O2 sat 94-95% on RA. ⊘ resp. distress noted. Chest tube ckd from cont. suction to H2O seal. CXR done 4° p put to H2O seal. Foley draining quantity sufficient clear yellow urine. Wet-dry dsg ckd on pts ⓒ upper chest. Dsg to midline abd intact c mod amount sero-sang drainage noted. Chest tube to ⓒ side of chest intact - dsg ckd - put out sm. amount drainage. Splint to ⓡLE CDI. Cap refill <3secs. Skin warm to touch. 2 point restraints in place + ⊘ S/Sx complication c circulation/skin breakd. Pt resting quietly @ this time. Will continue to monitor blood [redacted] IVDAU
10 Sep03	K130: VSS, A+Ox3, O2 SATS@95% RA, HOB ↑30, Chest tube c pleuravac drainage system draining to H2O seal. Output being marked to monitor any further drainage. ⊘ S/S resp distress. Encouraged IS exercises and remaining OOB. Dsg around Chest →

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]

blood-4

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

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	tube insertion site CDI. Lung (R) side CTA on ↑&↓ fields, lung (L) side clear in ↑ field but cloudy in ↓ field (chest tube). W→D Dsg Δ to (L) upper chest wall wound. Midline abdomen Dsg w/ slight shadowing & intact. (R) LE has cast, elevated on wound blanket to ↓ edema, neurovase ✓ assessed → (+) sensation, (+) wiggling of toes & dorsiflexion. CRT <3secs. Encouraging clear liquids, (+) BSX4. ¢ N/V @ this time. IV to (L) AC (18G) running LR @ 150cc/h. ¢ other remarkable assessment findings. Will continue to monitor. [redacted]
10Sep03	PAS= restraints in place, intervention continued. Skin integrity intact. [redacted]
11Sep03 0600	Pt Awake. [redacted] Denies pain at this time. Pt does not attempt to communicate. KS. Dsg To midline incision CDI c shadowing. Dsg → (L) upper chest CDI Dsg → (L) Axial chest Tube insertion [redacted] site CDI Dsg → (R) Lower extremity Bullet wound CDI. W chest Tube c water seal. (+) sensation [redacted] in all extremities R L E Pt wiggle toes, <3 sec cap refill. (+) BS x4 quads. 2 point restraint in place. [redacted]
11 Sep 03 1830	To Radiology via gurney for CXR PA/LAT [redacted]
11 Sep 03	Medicated c MSO4 2mg IVP for c/o pain during radiology procedure. Sat 93 94% [redacted]

FPI, LE... Printed on Recycled Paper STANDARD FO... BACK

MEDCOM - 18802

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY: Iraq | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 10 Sep | TIME: 0200

TRANSPORTATION TO FACILITY: A/E

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

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: mid GSW

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 0203

INITIALS:

VITAL SIGNS

TIME	0203				
BP	123/63				
PULSE	99				
RESP	20				
TEMP					
WT					

LAB ORDERS

☐ CBC/DIFF	☐ ABG	☐ PT/PTT	☐ BHCG/URINE/BLOOD/QUANT
☐ URINE C&S	☐ UA MSCC/CATH		☐ CHEM: Renal Lytes
☐ BLOOD C&S X			
☐ T+C x4			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX 100% | b(6)-2 | ☐ MONITOR | ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0200	Td .5cc IM	[redacted]	DCWG 4m/u	0200 IV	0220 - 1mg MSO4 - [redacted]
0210	MSO4 4mg IV			0210	0220 - 4million Units Pen G
0215	Ancef 2gm IV			0215	b(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

[redacted]/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(6)-2

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

27 y/o s/p GSW a 1° PTA. Pt c/o CP/SOB/pain/ext pain.
Seen by PST reported stable costmal: >12°
pain/SOB: ng

O: Awox4/— mod distress. VS.
Heart: RR/NR clear/nl noise, supple, NT Breath sounds equal, bilat BS
Chest: ⓟ GSW ⓛ apex/tangent. CT in place ⓛ side
abd: nm ↓BM/↑ft ⓡ ⓟ patchy ecchymosis and LUQ TTP ⓡ mild rectal hemorrhoids
mult shrapnel wounds ⓑ Lower ext
ⓟ ↓ dors pedis pulses ⓑ→ ⓟ to ⓟ calf
GU: ↓ cuff of genitalia
TTP ⓡ testicle
→ bag

R/P penetrating chest/Abd wound → [redacted] b(6)-2
Stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNA [redacted] b(6)-2

DIAGNOSIS (D)

CODES

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

[redacted]
b(6) -4

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

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 27

HEIGHT:

WEIGHT: 74kg

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

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

4. PROPOSED SURGICAL PROCEDURE:
Exploratory lap/(R) leg I&D

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

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

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

[redacted]

blue)-4

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

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

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

[redacted] MAJ AN 10 Sept 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 10 Sept 03 TIME: 0245

13. POSTOPERATIVE EVALUATION PREPARED (Signature and Title) [redacted] MAJ AN
DATE: 10 Sept 03 TIME: 0433

MEDICAL RECORD — **INTRAOPERA[redacted]OCUMENT**

For use of this form, see AR 40-407, the propo[redacted]gency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Cuffer BY Anesthesia

2. PATIENT I[redacted]EWED AND PROCEDURE VERIFIED BY [redacted] b(6)-2

3. DATE 10 Sept 03 TIME PATIENT ARRIVED IN SUITE 0255

4. PATIENT IN ROOM TIME 0255 NUMBER 24

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt able to move NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2 SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	DELA HOZ MAJ [redacted] CPT ELDER [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed in OR bed. arms on arm boards <90° stepped All PPs

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO

DONE BY: ☑ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: ϕ cuts or nicks noted

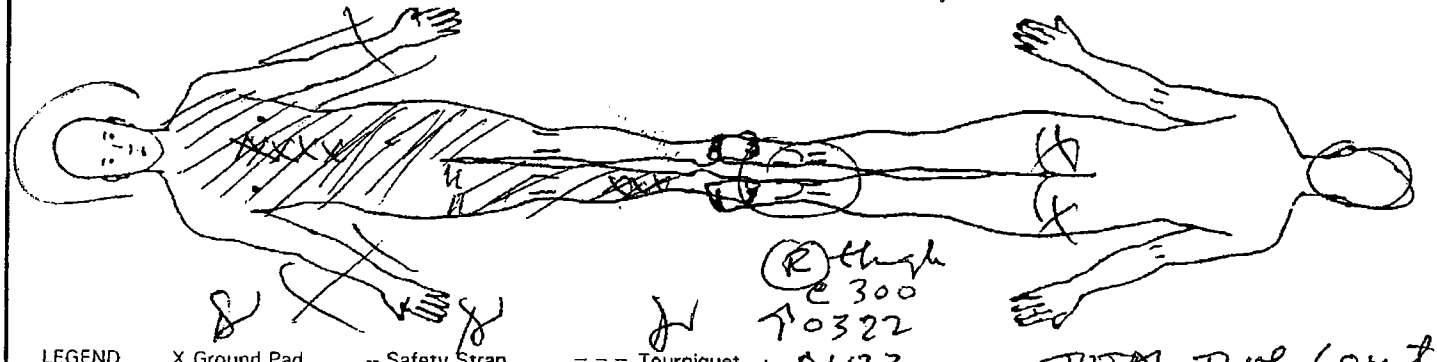
PREP SOLUTION (Specify) BETA / BETA

SITE: R leg BY WHOM: [redacted] b(6)-2

SITE: neck to groin BY WHOM:

COMMENTS: ϕ pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet TOTAL TIME 60 mins

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	INITIAL	C	C
Needle Sharp	☒ Yes ☐ No	u	C	C
Instrument	☒ Yes ☐ No	u	C	C
Other	☐ Yes ☒ No			

SCRUB [redacted] b(6)-2 SRL

CIRCULATOR [redacted]

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

[redacted] b(6)-2

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

☑ ESU NO: Valley Lab 40 102395 RBB Cut 30 Coag 20

GROUND PAD: BRAND Valley Pem

LOT NO: 69671 2005/04

☑ ESU NO: Valley Lab 40 RBB 10235

GROUND PAD: BRAND Valley Pem

LOT NO: 69671 2005/04

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 [redacted] LACES DA [redacted] I IS OBSOLETE MEDCOM - 18807 USAPA V1.00

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%

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Foley 16 Fr	2. 3/8" Penrose	3. 3/8 Penrose
SITE	1. Bladder EXIT	2. (R) FOOT	3. (R) LE

18. DRESSING/IMMOBILIZATION (Specify)
Leg: ABDOMEN
Fluff STEM - STRIPS
Kerlix Benzoin
ACE ABD. 4x8
TAPE

19. ADDITIONAL INFORMATION
S: [redacted]
A: [redacted]

b(6)-2 All

Bovie site clean, dry intact pre-post op
Tourniquet site clean, dry intact.

20. OPERATION(S) PERFORMED
Exploration Lap I&D (R) FOOT/LEG open fracture Repair of Tibialis anterior (quadricep)

21. PATIENT TRANSFERRED TO PACU TIME 0433 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 18808

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1

POST- DAY:

MONTH-YEAR: 10SEP03 | 11Sep03 | 12SEP03 | 12Sep | 13SEP03 | 14 Sept

DAY / HOUR: 19 | 9 2 6 2 10 6 | 18 | 8 | 18 | 0730

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

#[redacted]

b(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18809

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: Sept 15 | Sept 16 | 17 Sept | 17 Sep. | 18 Sep | 18 | 19 Sep

19 | HOUR: 08 18 | 0 18 | 0 1 1.5 | 18 | 0 | 18 | 0700

PULSE (O) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 113/72 120/80 89 112/65 90 96 110/62 89 99 2 109/62 82 99% 117/64 112/60 H 81 T 97.3 98% RA 97% RA

HEIGHT: | WEIGHT →

O2 SAT: 98% 99% 98 98% 97% 98 98% 99% 97% 98% 98% 97%

Record special data only when so ordered

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

[redacted] blood-C

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

MEDCOM - 18810

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST- DAY																			
MONTH-YEAR	DAY	20 Sep		21 SEP		22 SEP		23 Sep											
19	HOUR	0730	1 8	0730	1 8		1 8		1 8										
PULSE (O)	TEMP. F (°)																		TEMP. C
	105°																		40.6°
180	104°																		40.0°
170	103°																		39.4°
160	102°																		38.9°
150	101°																		38.3°
140	100°																		37.8°
130	99°																		37.2°
	98.6°																		37.0°
120	98°																		36.7°
110	97°																		36.1°
100	96°																		35.6°
90	95°																		35.0°
80																			
70																			
60																			
50																			
40																			
RESPIRATION RECORD		1 8		1 8			1 8		1 8										
Record special data only when so ordered	BLOOD PRESSURE	137/59		115/62	126/72	127/69		105/57	96%										
		77	125/81	H82				83	T96.8										
		97.8		T 97.7				98.7	H95										
	HEIGHT: WEIGHT →	96%		98%															
		QSAT	RA 99% HA	RA		99% (RA)		98%											
				99% (RA)			99.1°												

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(Centigrade Equivalents, for Reference only)

MEDCOM - 18811

[redacted]

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0200 HOURS TO 0200 HOURS | TOTAL HOURS COVERED 24 | DATE 10SEP03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H2O	120	120cc
11Sep03			
0500	H2O	60cc	60cc
0515	jello	120	180
0515	tea	30	210

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0700	1000	LR	1000	1630	1000cc
1010	250	Cipro	250		1250cc
1630	1000	LR			
1800	LR	150cc/ ⇒	1800cc		1800cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted]

b(6)-4

MEDCOM - 18812

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1130	1000	1000cc			
1730	875	1875cc			
1800 1530	1900cc	1900cc			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0700 0830	9cc 13cc	22cc			
1230	5	27cc			
1500	0	27cc			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted]

blus-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	1200	1200cc			
1700	1625	2825cc			
0230	1700	4525cc			
0550	1300	5825			
14 Stools					
0800	800	800			
1400	900	1700			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	50cc	77cc			
1700	46	96cc			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
1700	200cc	Sputum	200

GRAND TOTAL OUTPUT

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2400	H_2O	240	240

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	1000cc	LR ~~1000 cc~~	900 ~~1000cc~~	2200	900 ~~1000~~
		~~200~~cc D5W c̄ 400mg Cipro	200cc	2300	1100
2200	1000cc	LR	850cc	0530	1950
	3cc	Toradol c̄ NS flush	3		1953
	3cc	Toradol c̄ NS flush	3		1956
	1000cc	LR	1000		2956
	200cc	Cipro	200		3156

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

MEDCOM - 18815

[redacted] [redacted]

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE
			19 Sep 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600-1030	Bottle water	0.5L	500cc
2000 ~~1300~~	H_2O	250	750
0300		500	1250

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0700	1000	LR			
1100	1000	LR			2000
2200 ~~1900~~	1000	LR	950	0445	2950
0500	1000	LR			

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] b(6) - 4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0500	950	958			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
~~0700~~ ERROR	~~1~~		

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

ONGOING ASSESSMENT/INTERVENTIONS

TRAUMA FLOWSHEET

IV SOLTIONS/SITES

TIME	SITE/SIZE	IV FLUIDS/BLOOD	AMOUNT INFUSED		OUTPUT
	18G LAC	LR	2000 cc		CHEST TUBE:
Evac 1700	16G LAC	NS	500 cc		EMESIS:
F. Walk 1807	/	NS	1000 cc		NG TUBE:
2123		NS	1000 cc		URINE:
up cap 2135		NS	1000 cc		EBL:
					OTHER:

TOTAL IN:_____ OUTPUT: _____

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT
2105	143/81	99	24	100%	
2110	134/72	83	20	100%	

Additional Interventions/Assessments _____

TIME	MEDICATION	GIVEN BY:
1214	10 mg MSO4 5/5 1225	[redacted]
1218	1 gm MnBG	
0215	Tetanus Lyo Baxter	
0216	2 mg MSO4	
1255	1 gm Ancef	
0220	3 mg MSO4 + 4 mg MSO4 + 1 mg (Tentotal)	

PLAN: ☐ **To OR at** _____ ☐ **To ICU/Post-op at** _____ ☐

Belongings with Patient TO include: blood 2 All

PRIMARY NURSE: [redacted] **PRIMARY MEDIC:** [redacted]

ANESTHESIA: [redacted] **MD/SURGEON** [redacted]

OTHER: _____

b(6)-2

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 05Sep03	TIME 0200	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color	V	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	clr	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.020	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.5	N/A	Micro Parasites		
Segs		Mono	Prot	n	Negative	Malaria		
Bands		Eos	Urob	n	0.2-1.0	O & P		
Lymph		Baso	Nit	n	Negative	Other		
Atyp		Imm	Leuk	n	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS: b(6)-2

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

b(6)-2

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	TIME 10 Sep 03 0200	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		
T+S		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] RAPIDPOINT COAG ANALYZER V4.54
[redacted] 09/10/03 03:00 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.0 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.40
Sample Type:citrated wh. blood
Test Date :09/10/03
Test Time :02:54 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/10/03 03:00 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 40.5 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/10/03
Test Time :02:57 AM
Card Lot :[illegible]
Operator : [redacted]

ID: [redacted] 11-09-03
12:07
Patient Limits

WBC	10.1	K x10^3/uL	4.5	10.5
RBC	4.30	M x10^6/uL	4.00	6.00
Hgb	12.6	g/dL	11.0	18.0
Hct	37.6	%	35.0	65.0
MCV	87.5	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	33.4	g/dL	31.0	37.0
Plt	326.	x10^3/uL	150.	450.
Lym%	10.1	%	30.5	51.1
Lym#	1.3	x10^3/uL	1.1	3.1

======= PICCOLO =======
11/09/03 12:05
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6)-23141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	131*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	1416*	39-380	U/L
NA+	125*	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	104	88-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM (MEDCOM - 18821

======= PICCOLO =======
10/09/03 02:21
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(4) [redacted]

ALB	3.5	3.3-5.5	G/DL
ALP	42	26-84	U/L
ALT	26	10-47	U/L
AMY	29	14-97	U/L
AST	31	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
BUN	6*	7-22	MG/DL
CA++	7.5*	8.0-10.3	MG/DL
CHOL	73*	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	153*	73-118	MG/DL
TP	6.1*	6.4-8.1	G/DL

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

======= PICCOLO =======
10/09/03 02:21
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(4) [redacted]

GLU	148*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	770*	39-380	U/L
NA+	135	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	108	98-108	MMOL
tCO2	20	18-33	MMOL

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

Pt: [redacted] b(4)-4
Pt Name:_____

Glu_____149 mg/dL
BUN_____7 mg/dL
Na_____140 mmol/L
K_____3.7 mmol/L
Cl_____108 mmol/L
TCO2_____23 mmol/L
AnGap_____14 mmol/L
Hct_____35 %PCV
Hb*_____12 g/dL
*via Hct
pH_____7.341
PCO2_____40.4 mmHg
HCO3_____22 mmol/L
BEecf_____-4 mmol/L

Sample Type_:

10SEP03 02:29

Oper: [redacted] b(4)-2

Physician:_____

Ser# [redacted]
Ver: [redacted]

[redacted]

				Patient Limits	
WBC	16.9 H	x10^3/uL		4.5	10.5
RBC	4.41	x10^6/uL		4.00	6.00
HGB	12.9	g/dL		11.0	18.0
HCT	38.7	%		35.0	60.0
MCV	87.7	fL		80.0	95.9
MCH	29.3	pg		27.0	31.0
MCHC	33.4	g/dL		33.0	37.0
PLT	ZCA.	x10^3/uL		150.	450.
LYM	9.1	#L	%	30.5	51.1
LYM	1.5	x10^3/uL		1.0	3.+

EPW #732
000-00-0732

======= PICCOLO =======
12/09/03 05:28
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(4)-2 [redacted]

GLU	97	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	1035*	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

[redacted] b(4)-4 ICW1 0500

TEST(S) | SPECIMEN TAKEN DATE 9/11/03 TIME 1145 A.M. P.M. | REQUESTED | RESULTS

REMARKS [redacted] b(4)-2

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] Lyons

REPORTED BY MD TECH DATE

LAB ID NO.

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

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

SPECIMEN SOURCE (Specify): Blood

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

[redacted] b(4)-4 ICW1

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(4)-2

REPORTED BY [redacted] MD TECH DATE 11 Sep 03

REMARKS CBC

TEST(S) | SPECIMEN TAKEN DATE 9/11/03 TIME 1145 A.M. P.M. | REQUESTED | RESULTS

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

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

SPECIMEN SOURCE (Specify): Blood

LAB ID NO.

SPECIMEN/LAB RPT. NO.

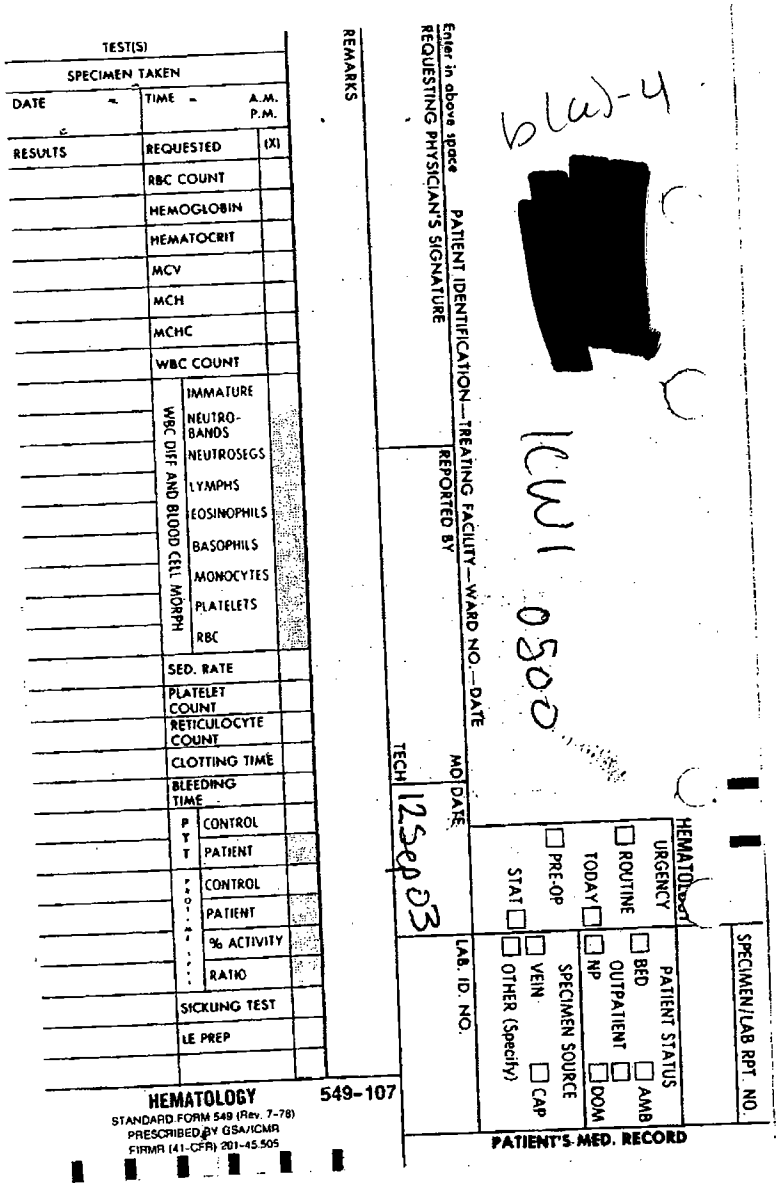
PATIENT'S MED. RECORD

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

MEDCOM - 18823

ACLU-RDI 1648 p.183

DOD-032397



TEST(S)
SPECIMEN TAKEN
DATE
TIME — A.M. P.M.
RESULTS
REQUESTED (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE; NEUTRO-BANDS; NEUTROSEGS; LYMPHS; EOSINOPHILS; BASOPHILS; MONOCYTES; PLATELETS; RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT: CONTROL; PATIENT
PROTIME: CONTROL; PATIENT; % ACTIVITY; RATIO
SICKLING TEST
LE PREP
REMARKS
Enter in above space REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MD
DATE
12 Sep 03
LAB. ID. NO.
HEMATOLOGY URGENCY: ROUTINE; TODAY; PRE-OP; STAT
PATIENT STATUS: BED; OUTPATIENT; NP; AMB; DOM
SPECIMEN SOURCE: VEIN; CAP; OTHER (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

b(6)-4
(CW1 0502)

PICCOLO

14/09/03 05:52

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-2 [redacted]

GLU	100	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	392*	39-380	U/L
NA+	132	128-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	22	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

[redacted] b(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE PATIENT IDENTIFICATION—TREATING FACILITY

[redacted] b(6)-4

PIC [redacted] IV-CIV

URGENCY ROUTINE TODAY PRE-OP STAT

PATIENT STATUS BED NP OUTPATIENT AMB DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

TEST(S) SPECIMEN TAKEN

DATE 14 Sep TIME 0530 A.M. P.M.

REQUESTED

CBC

RESULTS

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-45-505

557-107

[redacted]

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE PATIENT IDENTIFICATION—TREATING FACILITY

REPORTED BY

MD DATE

TECH 14 Sep

URGENCY ROUTINE TODAY PRE-OP STAT

PATIENT STATUS BED NP OUTPATIENT AMB DOM

SPECIMEN SOURCE (Specify)

LAB ID NO.

LABORATORY FILE

ID: [redacted] 14-09-03

WB 05:54

			Patient Limits	
WBC	8.1	x10^3/uL	4.5	10.5
RBC	3.45 L	x10^6/uL	4.00	6.00
Hgb	9.8 L	g/dL	11.0	18.0
Hct	29.8 L	%	35.0	60.0
MCV	86.5	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	33.0	g/dL	33.0	37.0
Plt	347.	x10^3/uL	150.	450.
LY%	27.6	%	20.5	51.1
LY#	2.2	x10^3/uL	1.2	3.4

EPW # [redacted] b(6)-4

[redacted]

PICCOLO

15/09/03 08:05

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(6) [redacted]

GLU	89	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	279	39-380	U/L
NA+	149*	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	111*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

b(6)-4

[redacted]

ICU1

0435

URGENCY: ROUTINE / TODAY / PRE-OP / STAT

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

SPECIMEN SOURCE: BLOOD / OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE / TIME A.M. P.M.

RESULTS / REQUESTED / (X)

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

REMARKS: CBC

HEMATOLOGY

STANDARD FORM 549 (Rev 7-78)

PRESCRIBED BY GSA/ICMR

FIRMR (41-CFR) 201-45.505

549-107

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

REQUESTING PHYSICIAN'S SIGNATURE / REPORTED BY / MD / DATE / TECH

15sep03

[redacted] b(6)-4

ICU1

0435

HEMATOLOGY

URGENCY: ROUTINE / TODAY / PRE-OP / STAT

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

SPECIMEN SOURCE: VEIN / CAP / OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO

PATIENT'S MED. RECORD

ID: [redacted]

WB

15-09-03

04:50

				Patient Limits	
WBC	8.8		x10^3/uL	4.5	10.5
RBC	3.48	L	x10^6/uL	4.00	6.00
Hgb	10.3	L	g/dL	11.0	18.0
Hct	30.4	L	%	35.0	60.0
MCV	87.5		fL	80.0	99.9
MCH	29.6		pg	27.0	31.0
MCHC	33.9		g/dL	33.0	37.0
Plt	45.	*L	x10^3/uL	150.	450.
LYM	39.3	*	%	20.5	51.1
LYM	3.4	*H	x10^3/uL	1.2	3.4

000-050-0732

TEST(S)
SPECIMEN TAKEN
DATE 16 Sep 03 TIME 0430 A.M. P.M.
REQUESTED
RESULTS
REMARKS [redacted] CBC
b(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY ICU #1 TECH MD
DATE 16 Sep 03
URGENCY ROUTINE TODAY PRE-OP STAT
LAB ID NO.
SPECIMEN SOURCE (Specify)
PATIENT STATUS BED AMB OUTPATIENT NP DOM
SPECIMEN/LAB RPT. NO.

[redacted] b(6)-4

PICCOLO
16/09/03 04:38
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #b(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	96	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	144	39-380	U/L
NA+	~~127~~ 151	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

[redacted] b(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
MD DATE
URGENCY ROUTINE TODAY PRE-OP STAT
LAB ID NO.
SPECIMEN SOURCE (Specify)
PATIENT STATUS BED AMB OUTPATIENT NP DOM
SPECIMEN/LAB RPT. NO.

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

LABORATORY FILE

PATIENT'S MED. RECORD

ID: [redacted]
WB
16-09-03
04:40

			Patient Limits	
WBC	9.8	x10^3/uL	4.5	10.5
RBC	3.50 L	x10^6/uL	4.00	6.00
Hgb	10.2 L	g/dL	11.0	18.0
Hct	30.6 L	%	35.0	60.0
MCV	87.4	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	33.3	g/dL	33.0	37.0
Plt	409.	x10^3/uL	150.	450.
LYZ	24.0 *	%	20.5	51.1
LY#	2.3 *	x10^3/uL	1.2	3.4

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)														
Fentanyl	(ucg)	50		50	50		100							
Propofol	(mg)	200				10	20	40	40					
Lidocaine	(mg)	120			40	100								
sux	(mg)	100												
Nimbex	(mg)		10											
Neost./RCB.	(mg)				<5/3>									
VOLAT AGENT 150	% del	x	2.0	2.0	2.0	1.0	1.5	0.4	4					
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	3	3	3	1	3	4	4					

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (4)

FLUIDS

LINE site														
18g (1) UE	☐ Warmed	#8LR (100 LR)												
18g (2) UE	☐ Warmed	#9LR (900 LR)												
	☐ Warmed				<800>									

LOSSES														
EST BLOOD LOSS						100								
URINE -						1000								

TOTALS	TOTAL EBL
250	MIN
	TOTAL URINE
	1000

FLUIDS - SUMMARY

CRYSTALLOID- 1800

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) PT ID IN ENT TO COME TO OR

(3) RM, O_2, monitors

(3) Ind/intubation

(4) PT c VT >4ml/k & ST → SKM-ext-SX

(5) RAT TO CPT [redacted] RN

PHYS STATUS 1 (2) 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 38.7

INITIAL DATA:

BP- 132, 77

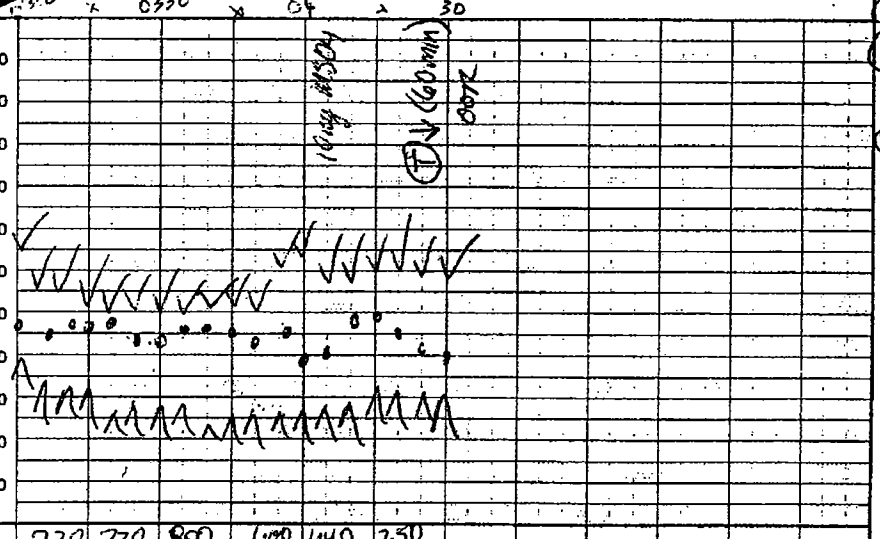
HR- 92

EQUIP CHECK OK? Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 0300 0330 04 30

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) ╪ | TOURNIQUET T—T | ANES- X-X | PROC- ⊙-⊙



VENTIL

VT - ml	720	720	800	600	640	250	
f - breaths/min	10	10	10	4	4	12	
Peak Inf pres / PEEP	22	22	23	20	19	/	
MODE - S(pon), A(ssist), C(on)	S-C	C	C	C	C	SV	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	51	42	33	47	47	50	
BP/oth	FIO2 (Frac or %)	.70	.69	.68	.68	.68	.68	
ART line	SpO2 (%)	100	99	99	99	99	99	
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site	X	36.0	36.2	X			
	N-M Block (T/4)	4/4	0/4	4/4		2/4		
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0

RECOVERY AT 0745

PACU ICU _____ (Specify)

OTHER _____

CONDITION: stable 945

RESP- 12 SpO2- 100

BP- 140/72 HR- 67

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0230	C255	
PROC	Ready	Begin	End
	0303	0324	0430

PROCEDURES and CPT Codes:

EX LAP / I & D (R) LEG

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x 3, grade III view, # 7.5 OETT TO 24cm @ L.P. (+) BBS (+) $ETCO_2$. Tape @ 00 secure - OA in as BB - TOTS

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: Z-1

DATE: 9/10/03

PAGE 1 OF

MEDCOM - 18828

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 10 Sept 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

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

DATE VERIFIED: 10 Sept 03

TIME VERIFIED: 0245

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.
DONOR	RECIPIENT
ABO	ABO
Rh	Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML | TIME/DATE COMPLETED/INTERRUPTED

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[ ] NONE [ ] SUSPECTED			

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)*.

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] b(6)-4

SEX: M

WARD: GMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 18829

Medical Record Copy

ACLU-RDI 1648 p.189

DOD-032403

518–124 NSN 7540–00–634–4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 10 Sep 03

DATE AND HOUR REQUIRED: 03 NOV

REQUESTING PHYSICIAN *(Print)*: [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

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

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 10 Sep 03

TIME VERIFIED: 0249

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH	PREVIOUS RECORD CHECK / SIGNATURE OF PERSON PERFORMING TEST
				☐ RECORD ☐ NO RECORD

DONOR	RECIPIENT
ABO	ABO
Rh	Rh

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION
TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML | TIME/DATE COMPLETED/INTERRUPTED

REACTION ☐ NONE ☐ SUSPECTED	TEMPERATURE	PULSE	BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☐ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] b(6)-4

SEX: M | WARD: EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 18830

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 10 Sep 03

DATE AND HOUR REQUIRED: As Rqd

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: C-Sec

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

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

DATE VERIFIED: 10 Sep 03

TIME VERIFIED: 0745

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.
DONOR	RECIPIENT
ABO	ABO
Rh	Rh

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN: ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] b(6)-4

SEX: M

WARD: EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 18831

Medical Record Copy

NSN 7540-01-165-7294 591-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATIONS (S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINC	REGISTER NO.
CXR - portable please @ 1230	M	ICU #1	
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) [redacted] b(6)-2		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR		DATE REQUESTED 10SEP03

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

Chest tube to H2O seal

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
#[redacted] b(6)-4	LOCATION OF RADIOLOGIC FACILITY

MEDCOM - 18832

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 [redacted] 10 Sep 03 0830

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

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	10 Sep 03	0830 HOURS	
1	CT to Head scan		
2	CXR @ 1230		
3	W-D dressing to Bullet wounds BID		
	Incentive Spirometry Q1° while awake		
	b(6)-2 [redacted]		

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	9-10-03	2130 HOURS	10 Sep 03 2130 RD
	Phenergan 25 mg IVPB q6° PRN nausea		
	[redacted] b(6)-2		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER	
	11 Sep 03	0200 HOURS	11 Sep 03 2750
1	Pharm sed for procedure R/O pneumothorax		
	b(6)-2		
	[redacted]		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

	DATE OF ORDER	TIME OF ORDER	
	11 Sep 03	1040 HOURS	
1	OOB to chair At least BID		
2	O_2 2-4 L NC to keep Sat > 98%		
3	Albuterol Nebulizer 0.5 ml 2.5 cc NS Q6° x 3 days		
4	Toradol 30 mg IV x 1 Now then 15 mg IV Q6° x 3 days		
5	C&C, Chem 3, QAM and Sept 13		
	[redacted] b(6)-2		

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

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED

MEDCOM - 18833

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

10 Sep 03 0410 HOURS

Postop ⇒ [redacted]

VS q4h

Strict I+O

NPO

~~Ancef 2g IV q 8h~~

b(6)-2

Cipro Flagyl 400mg IV q 12

Dressing changes by ortho

but reinforce dressing PRN

LRC 150 cc/hr

If doing well start on clear liquids after no

Incentive Spirometer

Foley to BSD.

D/c Foley at midnite 10 Sep

Morphine 4-6mg [redacted] PRN

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Tylenol 650mg [redacted] b(6)-2

PR/PO q4h PRN

Chest Tube to -20cm H2O suction

CXR in AM 10 Sep.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

10 Sep 03 0600 HOURS

① Versed 1-2mg q 5 min for total of 5mg PRN sedation [redacted] b(6)-2

[redacted]

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

MEDCOM - 18834 1-478-200

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 Noted [redacted]

NURSING UNIT | BED NO.

12 Sep 03 0950

	DATE OF ORDER	TIME OF ORDER		LIST TIME ORDER NOTED AND SIGN
	12 Sep 03	0947	HOURS	
1	CXR PA + LAT Now R/O PTX			
	S/P Chest tube Pull			
2	D/C Foley Due to Void w/in 8hrs			
3	Ambulate & Assist on crutches.			

[redacted]

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted]

NURSING UNIT | BED NO.

13 Sep 03 0840

	DATE OF ORDER	TIME OF ORDER		
	13 Sep 03	0745	HOURS	
1	~~Repeat~~ PA + LAT CXR Now R/O PTX Radiology to Read			b(6)-2

[redacted]

2P / 2045 13 Sep 03

PATIENT IDENTIFICATION

14 Sept 03 1250 [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2P / 2025 [redacted]

	DATE OF ORDER	TIME OF ORDER		
	16 Sep 03	1145	HOURS	
1	D/C LABS			
2	No dressing required at CT site.			

[redacted]

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted] 16 Sep 03

038

NURSING UNIT | ROOM | BED NO.

2P / 3 Sep 2000 [redacted]

	DATE OF ORDER	TIME OF ORDER		
	9/22/03	0900	HOURS	b(6)-2
	D/C Heparin Cap			

[redacted]

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

☆ U.S. ... MEDCOM - 18835 3-710

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

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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10 11 12 13 14 15 16 17 18 19 20 21 22 23
18SEP03	[redacted]	VS q4°	06	[redacted]
			18	
10	[redacted]	Strict I/O	06	[redacted]
			18	
10	[redacted]	NPO (if doing well start	06	[redacted]
		on clear liquids p noon)	18	
10	[redacted]	Incentive spirometer	06	[redacted]
		q 1° while awake	18	
10	[redacted]	Foley to BSD	06	[redacted]
			18	
10	[redacted]	chest tube to ~~suction~~ seal	06	[redacted]
		H2O ~~section~~ seal	18	
10	[redacted]	W→D drsg Δ to bullet	10	[redacted]
		wounds BID	22	
		~~TS~~		
11	[redacted]	OOB to chair @ least	06	[redacted]
		BID	06	
9/11	[redacted]	CBC, Chem 8 QAM	04	[redacted]
12SEP03	[redacted]	Amb c assist on	06	[redacted]
		crutches	18	
12	[redacted]	Reg diet	06	[redacted]
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX LAP/ GSW TO CX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18836

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 SEP03	[redacted]	Post-op → ICW	10 SEP03	—	—	[redacted]
10	[redacted]	D/C foley @ midnite (10SEP03)	10 SEP03	2400		
10	[redacted]	CXR in am today	10 SEP03	—	—	[redacted]
10	[redacted]	CXR @ 1230	10 SEP03	1230	—	[redacted]
11	[redacted]	Please send for PA & LAT	11 Sep 03	—	—	[redacted]
	-----	CXR R/O pneumothorax				
9/11	[redacted]	CBC, Chem 8 now	9/11	—		[redacted]
12 SEP03	[redacted]	D/C Foley - DTV in 8°	12 SEP03	—	0950	[redacted]
12	[redacted]	CXR - PA/LAT NOW R/O PTX S/P chest tube pull	12 SEP03	—	—	[redacted]
13 SEP03	[redacted]	PA/LAT NOW R/O PTX - RADIOLOGY TO READ	13 SEP03	—	—	[redacted]
20 SEP03	[redacted]	D/C to EPW camp				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
10SEP03 -----	[redacted]	Dressings as by ortho but reinforce drsg prn	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

[redacted] [redacted]

[redacted] blw-2 AM [redacted]

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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10 11 12 13 14 15 16 17 18 19 20 21 22 23
10 Sep 03	[redacted]	Ciprofloxacin 400mg	10	[redacted]
		IV q 12°	22	
10	[redacted]	UR @ 150cc/hr	06	
			18	
9/11	[redacted]	O2 2-4L NC to	06	[redacted] DC 10 Sep 03
		Keep Sats > 93%	18	
9/11	[redacted]	Albuterol Neb	06	X
		2.5 in 2.5cc NS	12	X
		q 6° x 3 days	18	X
			24	X
9/11	[redacted]	Toradol 15mg IV	06	
		q 6° x 3 days	12	1045 OP
			18	
			24	
12 Sep 03	[redacted]	Cipro 500mg PO BID	10	
			22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ex Lap / GSW to CX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:
[redacted]
DOB -9

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 - 18838

b(6)-2A11

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9/11	[redacted]	30mg Toradol IV x1 now	9/11		1045	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10SEP03	[redacted]	morphine 4-6mg IV q4° prn	D/T	10SEP 1400 6mg	10SEP 2130 6mg	11SEP 0330 6mg	11SEP 0930 2mg	12SEP 1045 4mg										
			D/I	[redacted]														
10SEP03	[redacted]	Tylenol 650mg PR/PO q4° prn	D/T	11SEP 2345	12SEP 1640	13SEP 1735	13SEP 1940	14SEP 0230	14SEP 2215									
			D/I	[redacted]														
10 SEP 03	[redacted]	Phenergan 25mg IVPB Q6° prn nausea	D/T/I	10SEP03 25mg 2130	[redacted]	11SEP03 0300 25mg	[redacted]											

USAPA V1.00

NCI 38

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE	OTSG APPROVED *(Date)*
Post-Anesthesia Care Unit (PACU) Flow Sheet	

Date: 10 SEPT 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
Time In: 0430
Allergies: NKDA OR Intake: Crystalloid 1000 Colloid
Pre-op V/S: OR Output: UOP 1000 EBL min
Procedures: Ex lap [illegible] Meds/Times: Ancef PCN [illegible]

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

Pre Op Meds [illegible] History

Time	[illegible]
SaO2	[illegible]
FiO2	[illegible]
Methods	[illegible]
240	
220	
200	
180	
160	
140	
120	[illegible]
100	[illegible]
80	[illegible]
60	[illegible]
40	[illegible]
20	
RR	[illegible]
T	97.5 [illegible]

94.5

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0600	LR	1L	(L) arm	[redacted]	b(6)-2

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2	**AIRWAY** A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2	**V/S** X = A-line BP ˄ = Cuff BP = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	**TEMP** S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	\	\	\	**LOS** C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9	

Time						
Pain (0-10)						
LOS						

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

(Continue on reverse)

PREPARED BY	DEPARTMENT/SERVICE/CLINIC	DATE
b(6)-2 [redacted] CPT HAN	ICU #3	10 SEP 03

PATIE[redacted] ... *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4

EPW

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