LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	0300	0400	NOTES	0500	0600
pH	7.418	7.423 ✓		7.397	7.395
P_{CO_2}	38.2	39.3 ✓		36.2	37.5
P_{O_2}	59	61 ?		72	65
BE	0	1		-3	-2
HCO_3	25	26		22	23
SO_2	91	92 ?		94	92
Na+	153	153 ?		152	
K+	4.5	4.2 ✓		4.1	
HCT	43	43 ✓		40	
Hb	10	15 ✓		14	

* FiO_2 ↑ = 50%

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

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

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

LAST, FIRST, MI: [redacted] | DATE: 31OCT03 | TIME: 1826 | SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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
Appr		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] | DATE: 31OCT03 | LAB ID NO.:

(b)(6)-2

(b)(6)-7

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

LAST, FIRST, MI: [redacted] | DATE: 31 Oct 03 | TIME: 1808 | SSN/PSEUDO SSN: [redacted]

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

(b)(6)-4

======= PICCOLO =======
31/10/03 18:31
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: 678 DR #: 000
SERIAL #: 0000100684

ALB	3.8	3.3-5.5	G/DL
ALP	93*	26-84	U/L
ALT	37	10-47	U/L
AMY	39	14-97	U/L
AST	61*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	14	5-65	U/L
TP	7.0	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
31/10/03 18:28
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100494

GLU	96	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	9.2	8.0-10.3	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
NA+	136	128-145	MMOL
K+	4.5	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	21	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 1+, ICT 0

						tCO_2	18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-7 [redacted] | DATE: 31 Oct 03 | LAB ID NO.:

(5)(6)-2 CBC

Ward/Section: (5)(6)-4	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 31Oct03 TIME 2000	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

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: [redacted]	DATE: 31Oct03	LAB ID NO.:

(5)(6)-4

(5)(6)-4 (5)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 31Oct03	TIME:	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 1	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] (5)(6)-4	DATE	TIME	SSN/PSEUDO SSN:	

i-STAT

TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	4.4	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.170	7.31-7.45
PCO2	50.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	45	80-105 mmHg (art) N/A (ven)
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	~~20~~74	95-98%
BEecf	-10	(-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	34	38-51% PCV
Hgb	12	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/
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 m
BUN		7-22 mg/d
CA^{++}		8.0-10.3m
CHOL		100-200 m
CRE		0.6-1.2 m
GLU		73-118 mg
TP		6.4-8.1 g/d

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
31/10/03 22:02
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100494

GLU	119*	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	6.7*	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	137	128-145	MMOL
K+	4.9*	3.3-4.7	MMOL
CL-	112*	98-108	MMOL
tCO2	18	18-33	MMOL

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

REMARKS:
SMA-10 [redacted] T-95.1 , 1000

REPORTED BY:	DATE: (5)(6)-2	LAB ID NO.:

ID: [redacted]
WB

31-10-03
22:06

			Patient Limits	
WBC	4.3 L	x10^3/uL	4.5	10.5
RBC	3.93 L	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	36.3	%	35.0	60.0
MCV	92.2	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	256.	x10^3/uL	150.	450.
LY%	38.9	%	20.5	51.1
LY#	1.7	x10^3/uL	1.2	3.4

ID: [redacted]
WB

31-10-03
18:24

				Patient Limits	
WBC	14.5 H	x10^3/uL		4.5	10.5
RBC	4.96	x10^6/uL		4.00	6.00
Hgb	14.8	g/dL		11.0	18.0
Hct	46.5	%		35.0	60.0
MCV	93.6	fL		80.0	99.9
MCH	29.8	pg		27.0	31.0
MCHC	31.8 L	g/dL		33.0	37.0
Plt	416.	x10^3/uL		150.	450.
LY%	13.5 *L	%		20.5	51.1
LY#	2.0 *	x10^3/uL		1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:07

Patient ID: [redacted]
Test Name :PT
Test Result:= 17.3 sec.
Ratio = 1.4
Calculated INR = 1.76
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:05
Card Lot :080201
Operator : JACKSON

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:09

Patient ID: [redacted]
Test Name :APTT
Test Result:= 34.3 sec.
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:07
Card Lot :030201
Operator : JACKSON

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 18:30

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.5 sec.
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :18:28
Card Lot :080201
Operator : STILLWELL

ID: [redacted]
WB

31-10-03
20:09

			Patient Limits	
WBC	3.5 L	x10^3/uL	4.5	10.5
RBC	2.68 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	25.3 L	%	35.0	60.0
MCV	94.3	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	176.	* x10^3/uL	150.	450.
LY%	29.3 *	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 18:38

Patient ID: [redacted]
Test Name :APTT
Test Result:= 27.1 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :18:35
Card Lot :030201
Operator : STEWART

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (6)(6)-7	DATE 10/31 TIME 2356	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		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted]

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

LAST, FIRST, MI. [redacted] (b)(6)-4 | DATE 1 Nov | TIME 0027 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	4.6	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.197	7.31-7.45
PCO2	45.8	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	70	80-105 mmHg (art) N/A (ven)
TCO2	19	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	90	95-98%
BEecf	-10	(-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	40	38-51% PCV
Hgb	14	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		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.:**

(5)(6)-2

Ward/Section: CU 1	REQUES[redacted]	L[illegible]ORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M[redacted] (5)(6)-4	DATE 1 Nov	TIME 0026	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		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 Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU	REQUE[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-7	DATE 1 NOV	TIME 0050 SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		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.:

(6)(6)-7

Ward/Section: ICU | REQUEST: [redacted]

LAST, FIRST, MI.: [redacted] | DATE | TIME: 1504 | SSN/PSEUDO SSN:

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

i-STAT

TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	4.2	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.260	7.31-7.45
PCO2	46.0	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	108	80-105 mmHg (art) N/A (ven)
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	97	95-98%
BEecf	-10	(-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	37	38-51% PCV
Hgb	13	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(6)(6)-7

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

01/11/03 01:08

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3151AA4

OPER #: 678 DR #: 000

SERIAL #: 0000100494

GLU	122*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	2647*	39-380	U/L
NA+	125*	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	15*	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: [redacted] Temp: 97.2 FiO2: 100%

REPORTED BY: (6)(6)-2 | DATE: | LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4
SERIAL #005485 11/01/03 18:

Patient ID:
Test Name :PT
Test Result:= 18.9 sec.
Ratio = 1.5
Calculated INR = 2.08
Sample Type:citrated wh blood
Test Date :11/01/03
Test Time :18:41
Card Lot :080201
Operator : DAVIS

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 18:5

Patient ID
Test Name :APTT
Test Result:= 56.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :11/01/03
Test Time :18:52
Card Lot :030201
Operator : DAVIS

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 04:46

Patient ID:
Test Name :PT
Test Result:= 16.3 sec.
Ratio = 1.3
Calculated INR = 1.60
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :04:45
Card Lot :080201
Operator : JACKSON

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 04:50

Patient ID:
Test Name :APTT
Test Result:= 49.4 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :04:48
Card Lot :030201
Operator : JACKSON

(b)(6)-4

ID
WB 01-11-03
19:31

				Patient Limits
WBC	4.1 L	x10^3/uL	4.5	10.5
RBC	1.95 *L	x10^6/uL	4.00	6.00
Hgb	10.2 *L	g/dL	11.0	18.0
Hct	17.9 *L	%	35.0	60.0
MCV	91.7 *	fL	80.0	99.9
MCH	52.1 *H	pg	27.0	31.0
MCHC	56.8 *H	g/dL	33.0	37.0
Plt	122. *L	x10^3/uL	150.	450.
LY%	16.4 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

ID
WB 01-11-03
18:37

				Patient Limits
WBC	4.2 L	x10^3/uL	4.5	10.5
RBC	2.07 *L	x10^6/uL	4.00	6.00
Hgb	10.2 *L	g/dL	11.0	18.0
Hct	19.5 *L	%	35.0	60.0
MCV	94.0 *	fL	80.0	99.9
MCH	49.3 *H	pg	27.0	31.0
MCHC	52.4 *H	g/dL	33.0	37.0
Plt	125. *L	x10^3/uL	150.	450.
LY%	10.7 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

ID
WB 01-11-03
12:51

				Patient Limits
WBC	7.5 *	x10^3/uL	4.5	10.5
RBC	3.36 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	31.0 L	%	35.0	60.0
MCV	92.3	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	197.	x10^3/uL	150.	450.
LY%	21.5 *	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

ID
WB 01-11-03
04:43

				Patient Limits
WBC	4.7	x10^3/uL	4.5	10.5
RBC	4.87	x10^6/uL	4.00	6.00
Hgb	14.3	g/dL	11.0	18.0
Hct	44.6	%	35.0	60.0
MCV	91.5	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	259.	x10^3/uL	150.	450.
LY%	18.2 *L	%	20.5	51.1
LY#	0.9 *L	x10^3/uL	1.2	3.4

ID
WB 01-11-03
01:10

				Patient Limits
WBC	2.9 L	x10^3/uL	4.5	10.5
RBC	4.72	x10^6/uL	4.00	6.00
Hgb	13.9	g/dL	11.0	18.0
Hct	43.3	%	35.0	60.0
MCV	91.9	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	231.	x10^3/uL	150.	450.
LY%	37.3 *	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

MEDCOM - 22653

Ward/Section: ICU1	ING PHYSICIAN: [redacted] 9162	3ORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted]	DATE 01NOV	TIME 1930	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU-1	F	NG PHYSICIAN: [redacted] (6)(6-2	ORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (6)(6-4		DATE	TIME 1830	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: CBC & PT/PTT & Coags

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

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

LAST, FIRST, MI. [redacted] 15/61-4	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		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 Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE NOV 1	TIME 12:50	SSN/PSEUDO SSN:

i-STAT

TEST	RESULT	REF. RANGE
Na	148	138-146 mmol/L
K	2.8	3.5-4.9 mmol/L
Cl	112	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	21	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l

======= PICCOLO =======
01/11/03 13:00
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 (b)(6)-4
DISC LOT #: 3151AA4
OPER #: 777 DR #: 000
SERIAL #: 0000100494

GLU	130*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	3159*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	3.3	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	17*	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/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]	DATE: 11/1/03	LAB ID NO.:

(b)(6)-2

(5)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (5)(6)-7	DATE 01NOV	TIME 0450 SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

(Piccolo) M

TEST	RESULT
GLU	
BUN	
CRE	
CK	
NA^+	
K^+	
CL^-	
tCO_2	

(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
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

======= PICCOLO =======
01/11/03 04:20
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)-7
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100684

GLU	124*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	3517*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	110*	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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

r Panel Plus

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

ectrolyte

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

REMARKS:
SMA 10

REPORTED BY:	DATE:	LAB ID NO.:

T 96.7 50% O2

Ward/Section: ICU REQUESTING PHYSICIAN:

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

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: NOV 1 | TIME: 12:35 | SSN/PSEUDO SSN:

ABG

(i-STAT)

TEST	RESULT	REF. RANGE
Na	150	138-146 mmol/L
K	3.1	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.359	7.31-7.45
PCO2	38.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	65	80-105 mmHg (art) N/A (ven)
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	93	95-98%
BEecf	-4	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	26	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-4 | DATE: NOV 1 | LAB ID NO.:

** PRINT CANCELLED **

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i-STAT EG6+

Pt: [redacted]

Pt Name: _____

Na_____151 mmol/L
K_____4.4 mmol/L
TCO2_____26 mmol/L
Hct_____48 %PCV
Hb*_____16 g/dL
*via Hct

At 37C
pH_____7.410
PCO2_____39.0 mmHg
PO2_____68 mmHg
HCO3_____25 mmol/L
BEecf_____0 mmol/L
sO2*_____94 %
*calculated

At Patient Temp
pH_____7.410
PCO2_____39.0 mmHg
PO2_____68 mmHg

Patient Temp: 98.6F
FIO2_____: 55
Sample Type_: ART

02NOV03 11:31

Oper: [redacted]

Physician: _____

Ser# 42015
Ver: JAMS046A
CLEW A93

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 04:24

Patient ID: [redacted]
Test Name :PT
Test Result:= 19.4 sec.
RESULT OUT OF RANGE
Ratio = 1.6
Calculated INR = 2.12
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :04:23
Card Lot :080201
Operator : [redacted]

(5)(6)-4

66-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 04:29

Patient ID [redacted]
Test Name :APTT
Test Result:= 55.1 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :04:25
Card Lot :030201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 01:28

Patient ID [redacted]
Test Name :PT
Test Result:= 20.4 sec.
RESULT OUT OF RANGE
Ratio = 1.7
Calculated INR = 2.30
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :01:25
Card Lot :080201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 01:53

Patient ID: [redacted]
Test Name :APTT
Test Result:= 56.7 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :11/02/03
Test Time :01:49
Card Lot :030201
Operator : [redacted]

Ward/Section: ICU-1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-2	DATE: 11/02 TIME: 0054	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		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies

TEST	*RESULT*	*REF. RANGE*
PT		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: CBC · Coags.

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

Ward/Section: ICU-1	REQUESTING PHYSICIAN: [redacted] (6)(6)-7	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (6)(6)-7	DATE: 11/2	TIME: 0854
		SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	151	138-146 mmol/L
K	3.8	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.433	7.31-7.45
PCO2	34.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	131	80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	23	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99	95-98%
BEecf	-1	(-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~~		38-51% PCV
Hgb ~~13~~		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		

======= PICCOLO =======
02/11/03 01:25
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100684

GLU	91	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	138	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	114*	98-108	MMOL/L
tCO2	18	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

REMARKS: ① ABG · Chem 8
② 98.9 For 55 Sa_{O_2} 100%

REPORTED BY: [redacted] (6)(6)-7	DATE: 2 Nov 03	LAB ID NO.:

(6)16-2

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

LAST, FIRST, M: [redacted] | TIME: 64 | SSN/DOD ID NO. SSN: [redacted]

i-STAT

TEST	RESULT	REF. RANGE
Na	152	138-146 mmol/L
K	4.0	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.395	7.31-7.45
PCO2	38.7	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	76	80-105 mmHg (art) N/A (ven)
TCO2	25	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	24	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	95	95-98%
BEecf	-1	(-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	42	38-51% PCV
Hgb	14	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
BIL		0.2-1.6 mg/dl
CGT		5-65 u/l
TP		6.4-8.1 g/dl

(6)16-4

======= PICCOLO =======
02/11/03 04:17
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100684

GLU	92	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	140	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	114*	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: ABG T: 99 FIO2 50%

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

Ward/Section: ICU I	REQUESTING PHYSICIAN: (6)(6)-4	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] EPW	DATE 11/0.2 / TIME 1100	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		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: T 98.6 Veat +102 55%

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

(b)(6)-2

Ward/Section: ICU I	REQUESTING PHYSICIAN: Dr [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-7	DATE 11/02 / TIME 1645	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

ABG FIO2 53% T 96.6 Vented SIMV 16

REPORTED BY:	DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/03/03 00:01

Patient ID: [redacted]
Test Name :PT
Test Result:= 22.7 sec.
RESULT OUT OF RANGE
Ratio = 1.8
Calculated INR = 2.73
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :23:58
Card Lot :080201
Operator : [redacted]

66-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/03/03 00:06

Patient ID: [redacted]
Test Name :APTT
Test Result:= 96.9 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :00:02
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 19:57

Patient ID [redacted]
Test Name :PT
Test Result:= 21.6 sec.
RESULT OUT OF RANGE
Ratio = 1.8
Calculated INR = 2.52
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :19:55
Card Lot :080201
Operator : [redacted]

66-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/02/03 20:02

Patient ID: [redacted]
Test Name :APTT
Test Result:=102.6 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :19:57
Card Lot :100208
Operator : [redacted]

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i-STAT EG6+

Pt: [redacted]
Pt Name:_____

Na_____150 mmol/L
K_____3.7 mmol/L
TCO2_____23 mmol/L
Hct_____36 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.293
PCO2_____45.1 mmHg
PO2_____55 mmHg
HCO3_____22 mmol/L
BEecf_____-5 mmol/L
sO2*_____84 %
*Calculated

(6)(6)-4

At Patient Temp
pH_____7.308
PCO2_____43.0 mmHg
PO2_____51 mmHg

Patient Temp: 96.6F
FIO2_____: 55
Sample Type_:

02NOV03 16:58

Oper: [redacted]

Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

[redacted] 03-11-02 23:52

				Patient Limits
WBC	1.8	L	x10^3/uL	4.5 10.5
RBC	1.67	L	x10^6/uL	4.00 6.00
Hgb	11.4		g/dL	11.0 18.0
Hct	35.8		%	35.0 60.0
MCV	92.5		fL	80.0 99.9
MCH	29.4		pg	27.0 31.0
MCHC	31.8	L	g/dL	33.0 37.0
Plt	41.	L	x10^3/uL	150. 450.
LY%	25.9	*	%	20.5 51.1
LY#	0.4	*L	x10^3/uL	1.2 3.4

[redacted] 02-11-03 19:39

				Patient Limits
WBC	1.0	L	x10^3/uL	4.5 10.5
RBC	4.45		x10^6/uL	4.00 6.00
Hgb	13.0		g/dL	11.0 18.0
Hct	41.2		%	35.0 60.0
MCV	92.5		fL	80.0 99.9
MCH	29.2		pg	27.0 31.0
MCHC	31.6	L	g/dL	33.0 37.0
Plt	51.	*L	x10^3/uL	150. 450.
LY%	22.4	*	%	20.5 51.1
LY#	0.2	*L	x10^3/uL	1.2 3.4

[redacted] 02-11-03 04:18

				Patient Limits
WBC	5.1		x10^3/uL	4.5 10.5
RBC	4.86		x10^6/uL	4.00 6.00
✓ Hgb	14.5		g/dL	11.0 18.0
✓ Hct	44.8		%	35.0 60.0
MCV	92.1		fL	80.0 99.9
MCH	29.8		pg	27.0 31.0
MCHC	32.4	L	g/dL	33.0 37.0
Plt	115.	L	x10^3/uL	150. 450.
LY%	8.6	*L	%	20.5 51.1
LY#	0.4	*L	x10^3/uL	1.2 3.4

[redacted] 02-11-03 01:24

				Patient Limits
WBC	5.1		x10^3/uL	4.5 10.5
RBC	4.68		x10^6/uL	4.00 6.00
Hgb	13.7		g/dL	11.0 18.0
Hct	42.9		%	35.0 60.0
MCV	91.6		fL	80.0 99.9
MCH	29.2		pg	27.0 31.0
MCHC	31.9	L	g/dL	33.0 37.0
Plt	115.	L	x10^3/uL	150. 450.
LY%	8.4	*L	%	20.5 51.1
LY#	0.4	*L	x10^3/uL	1.2 3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 01:12

Patient ID [redacted]
Test Name :PT
Test Result:= 16.9 sec.
Ratio = 1.4
Calculated INR = 1.70
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :01:10
Card Lot :080201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 01:15

Patient ID [redacted]
Test Name :APTT
Test Result:= 37.6 sec.
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :01:12
Card Lot :030201
Operator : [redacted]

66-2

ID: [redacted] 03-11-01
MR 23:50

				Patient Limits	
WBC	1.1	L	x10^3/uL	4.5	10.5
RBC	4.27	*	x10^6/uL	4.00	6.00
Hgb	12.8		g/dL	11.0	18.0
Hct	39.1		%	35.0	60.0
MCV	91.6		fL	80.0	99.9
MCH	29.9		pg	27.0	31.0
MCHC	32.7	L	g/dL	33.0	37.0
Plt	46.	L	x10^3/uL	150.	450.
LY%	27.3	*	%	29.5	51.1
LY#	0.3	*L	x10^3/uL	1.2	3.4

i-STAT EG6+

Pt [redacted]
Pt Name:_____

Na_____150 mmol/L
K_____4.1 mmol/L
TCO2_____17 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct

37C

(5)(6)4

____23.9 mmHg
O2_____36 mmHg
HCO3_____17 mmol/L
BEecf_____-7 mmol/L
sO2*_____74 %
*calculated

At Patient Temp
pH_____7.476
PCO2_____22.1 mmHg
PO2_____32 mmHg

Patient Temp: 95.-
FIO2_____: 100
Sample Type_: ART

03NOV03 00:49

Oper: [redacted] 66-2
Physician:_____

Ser# 40746
Ver: JAMS046A
CLEW A93

i-STAT EG6+

Pt [redacted]
Pt Name:_____

Na_____148 mmol/L
K_____3.7 mmol/L
TCO2_____20 mmol/L
Hct_____36 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.285
PCO2_____40.2 mmHg
PO2_____*** mmHg
HCO3_____19 mmol/L
BEecf_____-8 mmol/L
sO2*_____*** %
*calculated

At Patient Temp
pH_____7.318
PCO2_____36.3 mmHg
PO2_____*** mmHg

Patient Temp: 94.4F
FIO2_____: 100
Sample Type_:

02NOV03 23:55

Oper: [redacted] 66-2
Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

Ward/Section: TCU-1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
EAST, FIRST, MI. [redacted]	DATE 5/6/14	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		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: CBC. PT/PTT

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: TCU-1 | REQUESTING PHYSICIAN: [redacted] (b)(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 11/2 | TIME: 2335 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-34 u/l
ALT		10-47 u/l
AMY	(b)(6)-7	
AST		1
TBIL		0.
BUN		7-
CA^{++}		8.
CHOL		1
CRE		0
GLU		7
TP		6

(Piccolo) Metly

TEST	RESULT
GLU	
BUN	
CRE	
CK	
NA^+	
K^+	
CL^-	
tCO_2	

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl

PICCOLO
23:58
02/11/03
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100684

GLU	28*	73-118	MG/DL
BUN	14	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
NA+	144	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	114*	98-108	MMOL/L
tCO2	18	18-33	MMOL/L

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

REMARKS: ABC - (T) 9414 Fro2 1W 18

REPORTED BY: | DATE: [redacted] | LAB ID NO.: 3 MW3

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-7	DATE 14 03	TIME 1930
		SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies.

TEST	RESULT	REF. RANGE
PT		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 Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: CBC, PT/PTT

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU	REQU[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 30 OCT 03	TIME 0425	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

(i-STAT)

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
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		3.5-5.5 g/dl

======= PICCOLO =======
03/11/03 00:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)-7
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100494

GLU	21*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	16*	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
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]	3/Nov03	

(5)(6)-7

NS 14.. / 46.5 \ 416 INR 1.18 PTT 27.1 4.5 | 100 | 1.3 S/P GSW (L) + R Buttocks → rectum

FMH#0 – Cotton BS # 2

* Unknown medical Hx

Flagyl 500mg IV
Gentamicin 80mg IV } EMT

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)										TOTALS
Fentanyl (mcg)	<250>		<250>		<250>					750
MSO4 (mg)	10	5	5							20
VCB (mg)	10		10							20
Versed (mg)			<2.5>	<2.5>						5
( )										
VOLAT AGENT Iso % del	1.0 ~ 1.0	1.5	1.5	1.5	1.5	0.8	1.0 ~ 1.0	1.0	X	
% e.t.										
AIR L/Min										
N2O L/Min										
O2 L/Min	2	2	2	2	2	2	2	2	2	2

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

TOTAL EBL: 500

TOTAL URINE: 700

FLUIDS

LINE site	Warmed					
18G (R) A	☐ Warmed	(500)	500 #5	#7	6L	8L	9.5
18G (L) A	☐ Warmed	(500)	500 #6			
(R) SC Cordis	☒ Warmed	LR #1	#2	#3	#4	#8
	☐ Warmed			PRBC	PRBC #2	

P

FLUIDS SUMMARY

CRYSTALLOID- LR / NS 10L

COLLOID- Ø

BLOOD- 2 ii

LOSSES

EST BLOOD LOSS: 100 — 200 — 400-500

URINE - foley out / surgeon 500 — 100 — 100

PHYS STATUS: 1 (2) 3 4 5 (E)

TIME → 1900 · 30 · 2000 · 30 · 2100 · 30

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 46.5

INITIAL DATA: BP- 176/103 HR- 131

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 1830

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

To ICU-1 SaO2 @ 98% ... Report to [redacted] (5)(6)-2

REMARKS

Code drugs with numbers, events with letters

(1) Received pt - GSW to rectum from EMT intubated; BP + monitors Room monitors O2 Vent

(2) Urine drained suprapubic tube

(3) 3.5 > 7.8 / 253 < 176 via SC cordis

(4) [redacted] 1645512 #1 PRBC per surgeon request

(5) Rectum oozing blood HR ↑ to 130's. #2 PRBC

4743806

(6) Vented · Wheezing SaO2 ↓ 77-80% Atracurium · 90% Bronchospasm. Suctioned ETT, Epi IV 30 mcg SaO2 @ 95% Phenylephrine 100mg IV

VENTIL

VT - ml	500	800	780	810	840	760	790	780	800
f - breaths/min	10	14	14	12	11	11	11	11	11
Peak inf pres / PEEP	28	26	27	30	31	30	30	31	30
MODE - S(pon), A(ssist), C(on)	C —	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	32	31	33	32	31	32	33	32
BP/oth	FIO2 (Frac or %)	0.78	0.78	0.77	0.77	0.77	0.77	0.77	0.78	0.78
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site Nasal	34.6 ~		35.2	35	35.2	35.0	36	36	35.9
	N-M Block (T/4)	4/4	0/4	0/4	1/4	0/4	0/4	0/4		0/4
	BS ↑									
Warming blkt	Room warmed									
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (5) (6); Position: low lith

RECOVERY AT 2130

PACU (ICU) 1 (Specify)

OTHER I-9...

CONDITION: Stable

RESP- 14 SpO2- 98-100% BP- 107/54 HR- 136

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1845	1900	2210
	Ready	Begin	End
PROC	1905	1920	2120

PROCEDURES and CPT Codes: - Colostomy
Ex lap: Suprapubic tube placement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
#[redacted] EPW
(5)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Intubated in EMT / 8.0 ETT 21cm @ teeth +BBS, + ETCO2

SURGEONS: [redacted]

CRNA/MAJ

PROCEDURE LOCATION: 2(2)

DATE: 31 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 [redacted] PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 22673

(5)(6)-2

OSW → Ring emergency Ex Lap

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)					TOTALS
Epinephrine (mcg)	<200>				
( )					
VOLAT AGENT % del					
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	2	2	2	2	

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

TOTAL EBL: 100

TOTAL URINE: 250

FLUIDS - SUMMARY

CRYSTALLOID- 1500

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site					
[illegible] mcg/kg/min ☐ Warmed	4	4	4	4	
LR ☐ Warmed					1500
☐ Warmed					
☐ Warmed					

LOSSES

EST BLOOD LOSS: 100

URINE - 250

REMARKS

Code drugs with numbers, events with letters

① Pre-op - Coded ICU-4 already opened to DR c BP + SaO2 + ABP monitor

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- ___ / ___ HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? [initials] TIME- 2030

TIME → 2045 21:00 • 30 • 22:00

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		660	590	540
f - breaths/min	16	18	20	22
Peak inf pres / PEEP	38/5	36/6	36/10	36/8
MODE - S(pon), A(ssist), C(on)	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	63	51	45	42
BP/oth	FIO2 (Frac or %)	.82	.82	.86	1.0
ART line	SpO2 (%)	94	94	90	96
Steth- PC/ES	ECG	ST	ST	ST	ST
Gas analyzer	TEMP-site				
	N-M Block (T/4)				
			OETT suctioned		
Warming blkt	Room warmed				
Conv warmer					

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

RECOVERY AT 2210

PACU ICU ____ (Specify)

OTHER ____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2000	2045	2220

	Ready	Begin	End
PROC	2055	2100	2200

PROCEDURES and CPT Codes: Ex - Lap

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

[redacted] (b)(6)-2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Intubated in ICU ⊕BBS ⊕ETCO2

SURGEONS: (b)(6)-4

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR 1

DATE: 2 NOV 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

[redacted]DCOM - 22674

ACLU-RDI 1673 p.34

DOD-036250

NIBP TREND 11/03/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
00:46	62	[illegible]	ERR# 15	11
00:41	100	[illegible]	[illegible] / 39 [illegible]	OFF
00:36	86	[illegible]	ERR# 15	22
[illegible]	[illegible]	98	[illegible] / [illegible]	18
[illegible]	[illegible]	93	[illegible] / [illegible]	18
[illegible]	[illegible]	[illegible]	[illegible] / [illegible]	18
00:15	[illegible]	93	[illegible] / [illegible]	18
00:10	[illegible]	94	[illegible] / [illegible]	18
00:05	[illegible]	94	[illegible] / [illegible]	18
00:02	[illegible]	95	[illegible] / 35 [illegible]	18
00:00	[illegible]	95	ERR# 11	18
23:55	[illegible]	96	76 / 36 [illegible]	18
23:50	[illegible]	96	76 / 37 [illegible]	18
23:46	[illegible]	96	77 / 36 [illegible]	18
23:40	[illegible]	96	81 / 39 [illegible]	18
23:35	[illegible]	95	79 / 40 [illegible]	18
23:30	119	95	75 / [illegible] [illegible]	18
23:25	120	95	77 / 35 [illegible]	OFF
23:21	120	96	[illegible] / 35 [illegible]	OFF
23:15	106	96	[illegible] / 38 [illegible]	OFF
23:10	120	96	79 / 40 [illegible]	OFF
23:05	[illegible]	[illegible]	82 / 38 [illegible]	20
23:00	121	[illegible]	83 / 40 [illegible]	17
22:57	[illegible]	[illegible]	[illegible] / [illegible]	
22:56	[illegible]	[illegible]	[illegible] / [illegible]	
22:50	120	93	[illegible] / [illegible] [illegible]	
22:45	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:40	[illegible]	93	[illegible] / [illegible] [illegible]	OFF
22:35	120	92	[illegible] / [illegible] [illegible]	OFF
22:30	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:25	119	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:20	[illegible]	84	[illegible] / [illegible] [illegible]	18
22:15	[illegible]	[illegible]	84 / [illegible] [illegible]	9
22:14	[illegible]	[illegible]	ERR# 2	[illegible]

ADULT

TREND 11/03/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
00:46	63	[illegible]	[illegible] / [illegible] [illegible]	14
00:44	63	[illegible]	[illegible] / [illegible] [illegible]	25
00:42	58	[illegible]	[illegible] / [illegible] [illegible]	10
00:40	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	16
00:38	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	26
00:36	89	[illegible]	[illegible] / [illegible] [illegible]	18
00:34	117	86	[illegible] / [illegible] [illegible]	18
00:32	119	89	[illegible] / [illegible] [illegible]	18
00:30	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:28	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:26	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:24	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:22	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:20	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	21
00:18	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:16	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
00:14	[illegible]	94	[illegible] / [illegible] [illegible]	21
00:12	[illegible]	93	[illegible] / [illegible] [illegible]	18
00:10	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:08	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:06	[illegible]	94	[illegible] / [illegible] [illegible]	18
00:04	[illegible]	95	[illegible] / [illegible] [illegible]	18
00:02	[illegible]	95	[illegible] / [illegible] [illegible]	18
00:00	[illegible]	95	[illegible] / [illegible] [illegible]	18
23:58	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:56	[illegible]	95	[illegible] / [illegible] [illegible]	18
23:54	[illegible]	96	[illegible] / 35 [illegible]	18
23:52	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:50	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:48	119	96	76 / 41 53	18
23:46	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:44	[illegible]	96	[illegible] / [illegible] [illegible]	18
23:42	[illegible]	96	[illegible] / 35 [illegible]	18
23:40	[illegible]	96	[illegible] / 35 [illegible]	18
23:38	[illegible]	96	[illegible] / 36 [illegible]	18
23:36	[illegible]	95	[illegible] / 36 [illegible]	18

:34	119	95	[illegible] / [illegible] [illegible]	18
:32	119	95	[illegible] / [illegible] [illegible]	18
:30	119	95	[illegible] / [illegible] [illegible]	18
:28	157	95	[illegible] / [illegible] [illegible]	OFF
23:26	120	96	[illegible] / [illegible] [illegible]	OFF
23:24	120	95	[illegible] / 36 [illegible]	OFF
23:22	120	95	[illegible] / [illegible] [illegible]	OFF
23:20	144	95	[illegible] / [illegible] [illegible]	OFF
23:18	128	95	77 / [illegible] 67	OFF
23:16	125	96	[illegible] / [illegible] [illegible]	OFF
23:14	[illegible]	95	[illegible] / [illegible] [illegible]	OFF
23:12	121	95	[illegible] / 36 [illegible]	OFF
23:10	120	96	[illegible] / 35 [illegible]	23
23:08	120	96	[illegible] / 35 [illegible]	18
23:06	[illegible]	96	[illegible] / 35 [illegible]	19
23:04	[illegible]	96	76 / 35 [illegible]	30
23:02	[illegible]	96	80 / 36 [illegible]	18
23:00	[illegible]	97	86 / 38 52	10
22:58	86	97	96 / [illegible] 59	OFF
22:56	[illegible]	98	107 / 45 62	OFF
22:54	[illegible]	96	143 / 64 87	OFF
22:52	120	94	[illegible] / [illegible] [illegible]	OFF
22:50	121	94	[illegible] / [illegible] [illegible]	OFF
22:48	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:46	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:44	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:42	[illegible]	93	[illegible] / [illegible] [illegible]	OFF
22:40	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:38	[illegible]	93	[illegible] / [illegible] [illegible]	OFF
22:36	[illegible]	93	[illegible] / [illegible] [illegible]	OFF
22:34	120	91	[illegible] / [illegible] [illegible]	OFF
22:32	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:30	[illegible]	82	[illegible] / [illegible] [illegible]	OFF
22:28	120	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:26	119	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:24	119	[illegible]	[illegible] / [illegible] [illegible]	24
22:22	120	84	[illegible] / [illegible] [illegible]	12
22:20	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	18
22:18	[illegible]	93	[illegible] / [illegible] [illegible]	18
22:16	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	8
22:14	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	17
22:12	[illegible]	[illegible]	OFF OFF OFF	OFF
22:10	121	[illegible]	OFF OFF OFF	OFF
22:08	[illegible]	OFF	NOT ZEROED	OFF
22:06	[illegible]	OFF	126 / 56 75	OFF
22:04	[illegible]	OFF	84 / 39 53	OFF
22:02	[illegible]	OFF	87 / 39 52	OFF
22:00	25	OFF	NOT ZEROED	OFF
21:58	[illegible]	OFF	95 / 40 55	OFF

ADULT

PROTOCOL SYSTEMS, INC.

22:50	120	93	[illegible] / [illegible] [illegible]	OFF
22:45	[illegible]	94	[illegible] / [illegible] [illegible]	OFF
22:40	[illegible]	93	[illegible] / [illegible] [illegible]	OFF
22:35	120	92	[illegible] / [illegible] [illegible]	OFF
22:30	[illegible]	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:25	119	[illegible]	[illegible] / [illegible] [illegible]	OFF
22:20	[illegible]	84	[illegible] / [illegible] [illegible]	18
22:15	[illegible]	[illegible]	64 / [illegible] [illegible]	9
22:14	[illegible]	[illegible]	ERR# 2	[illegible]

ADULT

IBP TREND 11/01/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
01:25	142	SRCH	103 / 52 70	14
01:21	140	SRCH	96 / 48 67	18
01:15	141	SRCH	95 / 48 66	16
01:10	143	SRCH	95 / 54 69	14
01:05	141	SRCH	100 / 52 73	17
01:00	141	SRCH	95 / 52 67	16
00:55	141	SRCH	92 / 48 66	14
00:50	141	SRCH	92 / 48 66	15
00:45	141	99	88 / 47 64	14
00:40	144	SRCH	86 / 46 63	15
00:35	145	SRCH	92 / 50 66	16
00:31	144	SRCH	94 / 44 65	15
00:26	144	99	92 / 46 65	15
00:20	144	94	89 / 47 64	15
00:15	[illegible]	SRCH	90 / 49 65	25
00:10	[illegible]	91	92 / 51 69	27
00:05	[illegible]	92	99 / 63 79	[illegible]
00:01	[illegible]	89	110 / 59 79	[illegible]
23:56	[illegible]	89	105 / 60 78	20
23:51	[illegible]	91	113 / 71 - 83	21
23:45	[illegible]	SRCH	135 / 100 - 110	18
23:40	[illegible]	95	ERR# 15	19
23:35	[illegible]	90	117 / 59 83	13
23:30	[illegible]	SRCH	109 / 64 82	20
23:25	[illegible]	90	99 / 66 - 76	21
23:20	[illegible]	91	102 / 58 74	27
23:15	[illegible]	SRCH	95 / 55 70	28
23:10	[illegible]	96	103 / 56 76	[illegible]
23:05	144	97	105 / 63 - 79	32
23:01	145	97	103 / 56 82	27
22:55	143	98	114 / 69 87	31
22:50	144	98	112 / 63 - 81	28
22:45	141	99	130 / 71 95	36
22:40	[illegible]	97	132 / 68 95	18
22:35	141	100	130 / 81 99	14
22:30	143	99	134 / 70 97	15
22:25	136	99	130 / 77 97	14
22:20	136	99	140 / 79 101	14
22:15	137	100	137 / 74 99	28
22:10	131	100	126 / 77 97	22
22:05	[illegible]	99	137 / 73 100	14
22:00	[illegible]	98	138 / 69 97	14
21:56	[illegible]	97	120 / 62 86	14
21:50	[illegible]	94	108 / 56 76	18
21:46	[illegible]	88	128 / 56 85	14
21:40	[illegible]	[illegible]	108 / 58 77	26
21:35	[illegible]	[illegible]	114 / 58 81	14
21:30	[illegible]	OFF	107 / 59 79	OFF

ADULT

PROTOCOL SYSTEMS, INC.

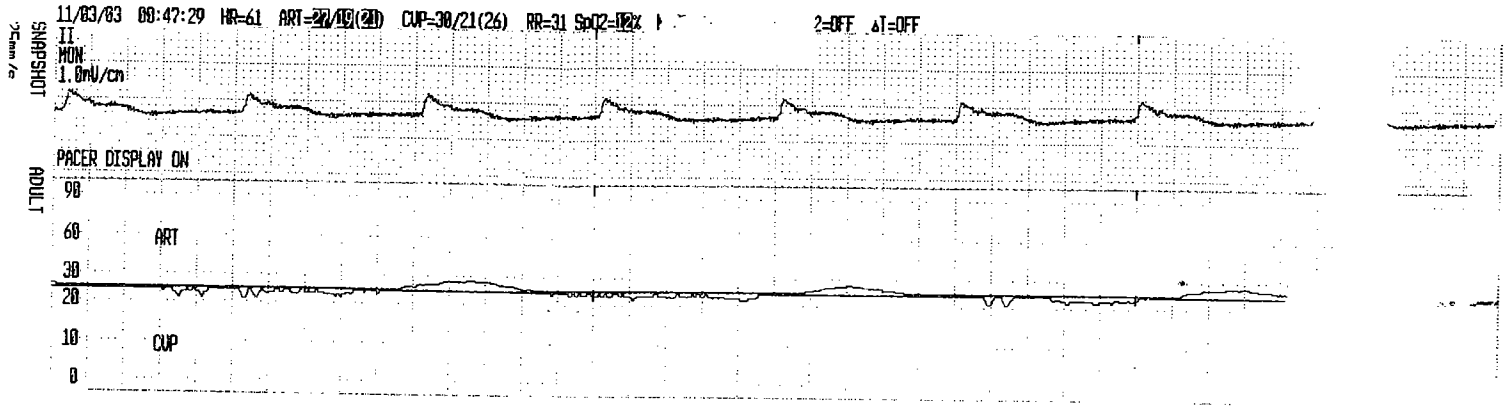
NIBP TREND 11/01/03

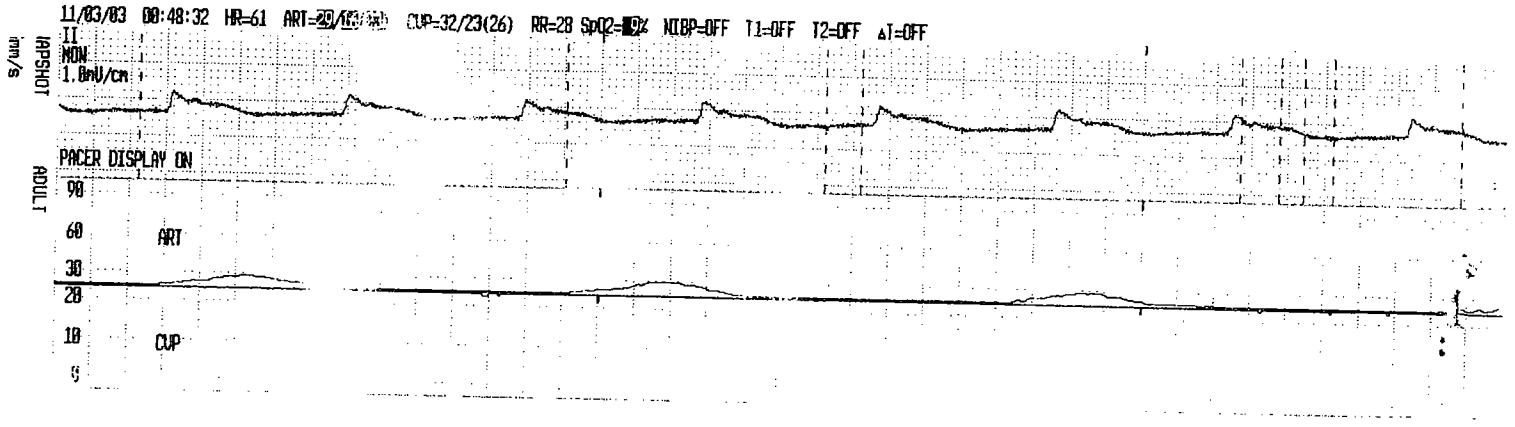
TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
06:03	[illegible]	89	87 / 49 66	26
06:00	[illegible]	91	89 / 42 - 62	20
05:56	[illegible]	98	ERR# 15	17
05:48	[illegible]	98	96 / 52 - 70	19
05:46	[illegible]	98	84 / 49 - 63	24
05:40	[illegible]	100	87 / 48 - 65	21
05:35	[illegible]	98	110 / 48 75	14
05:34	143	96	107 / 53 76	15
05:31	144	98	99 / 51 70	16
05:26	[illegible]	97	ERR# 15	15
05:20	141	93	107 / 61 79	26
05:15	154	95	105 / 62 80	20
05:10	144	98	109 / 62 88	22
05:07	[illegible]	86	ERR# 15	24
05:00	139	98	106 / 59 77	16
04:55	139	97	116 / 52 - 79	19
04:50	138	98	109 / 55 79	14
04:45	138	95	110 / 55 77	17
04:41	138	94	105 / 51 72	15
04:38	138	SRCH	103 / 51 73	14
04:35	141	SRCH	101 / 49 71	15
04:30	140	SRCH	102 / 51 72	16
04:25	139	SRCH	101 / 49 69	15
04:21	139	SRCH	92 / 46 65	14
04:15	138	SRCH	89 / 46 63	14
04:10	139	SRCH	90 / 47 64	14
04:06	139	SRCH	86 / 47 63	14
04:03	139	SRCH	86 / 47 62	14
04:00	140	SRCH	89 / 53 65	17
03:57	139	SRCH	84 / 46 61	14
03:50	140	SRCH	88 / 49 65	17
03:45	141	SRCH	87 / 52 67	15
03:40	142	SRCH	95 / 54 71	16
03:35	144	SRCH	93 / 55 77	26
03:30	144	SRCH	103 / 60 74	14
03:25	142	SRCH	92 / 53 69	15
03:20	144	SRCH	100 / 55 74	17
03:15	142	SRCH	95 / 56 72	16
03:10	142	SRCH	96 / 56 72	16
03:05	143	SRCH	95 / 56 69	14
03:04	144	SRCH	92 / 61 71	14
03:00	144	SRCH	95 / 53 70	14
02:56	144	SRCH	ERR# 15	19
02:50	146	SRCH	98 / 60 76	18
02:45	144	SRCH	97 / 55 73	17
02:40	143	SRCH	95 / 57 73	15
02:35	144	SRCH	96 / 55 72	16
02:30	144	SRCH	95 / 53 71	17
02:25	144	SRCH	96 / 56 72	16
02:20	146	SRCH	99 / 53 70	17
02:15	144	SRCH	94 / 54 70	18
02:10	144	SRCH	96 / 56 74	19
02:05	144	SRCH	94 / 56 72	16
02:00	142	SRCH	99 / 56 72	17
01:56	143	SRCH	90 / 52 66	15
01:50	143	SRCH	99 / 53 72	17

5	140	SRCH	102 / 52 73	15
40	139	92	101 / 52 71	14
36	140	SRCH	98 / 51 70	18
01:30	141	99	102 / 53 71	16
01:25	142	SRCH	103 / 52 70	14
01:21	140	SRCH	96 / 48 67	18
01:15	141	SRCH	95 / 48 66	16
01:10	143	SRCH	95 / 54 69	14
01:05	141	SRCH	100 / 52 73	17
01:00	141	SRCH	95 / 52 67	16
00:55	141	SRCH	92 / 48 66	14
00:50	141	SRCH	92 / 48 66	15
00:45	141	99	88 / 47 64	14
00:40	144	SRCH	86 / 46 63	15
00:35	145	SRCH	92 / 50 66	16
00:31	144	SRCH	94 / 44 65	15
00:26	144	99	92 / 46 65	15
00:20	144	94	89 / 47 64	15
00:15	[illegible]	SRCH	90 / 49 65	25
00:10	[illegible]	91	92 / 51 69	27
00:05	[illegible]	92	99 / 63 79	[illegible]
00:01	[illegible]	89	110 / 59 79	[illegible]
23:56	[illegible]	89	105 / 60 78	20
23:51	[illegible]	91	113 / 71 - 83	21
23:45	[illegible]	SRCH	135 / 100 - 110	18
23:40	[illegible]	95	ERR# 15	19
23:35	[illegible]	90	117 / 59 83	13
23:30	[illegible]	SRCH	109 / 64 82	20
23:25	[illegible]	90	99 / 66 - 76	21
23:20	[illegible]	91	102 / 58 74	27
23:15	[illegible]	SRCH	95 / 55 70	28
23:10	[illegible]	96	103 / 56 76	[illegible]
23:05	144	97	105 / 63 - 79	32
23:01	145	97	103 / 56 82	27
22:55	143	98	114 / 69 87	31
22:50	144	98	112 / 63 - 81	28
22:45	141	99	130 / 71 95	36
22:40	[illegible]	97	132 / 68 95	18
22:35	141	100	130 / 81 99	14
22:30	143	99	134 / 70 97	15
22:25	136	99	130 / 77 97	14
22:20	136	99	140 / 79 101	14
22:15	137	100	137 / 74 99	28
22:10	131	100	126 / 77 97	22

ADULT

PROTOCOL SYSTEMS, INC.


11/03/03 09:47:29 HR=61 ART=
CVP=30/21(26) RR=31 SpO2=
2=OFF ΔT=OFF
SNAPSHOT
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
90
60
ART
30
20
10
CVP
0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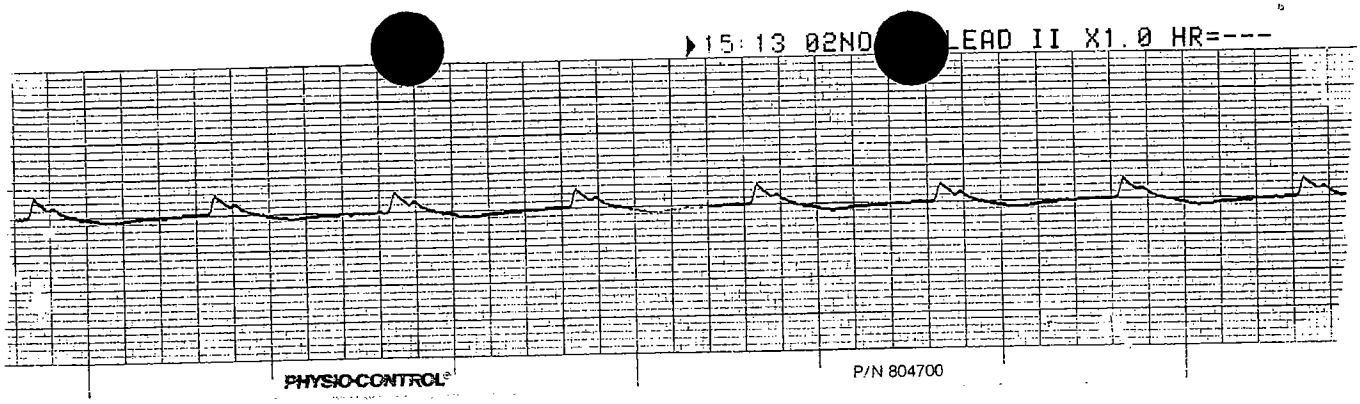
CVP=32/23(26) RR=28 SpO2=
NIBP=OFF T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm
PACER DISPLAY ON
ADULT
90
60
ART
30
20
10
CVP
5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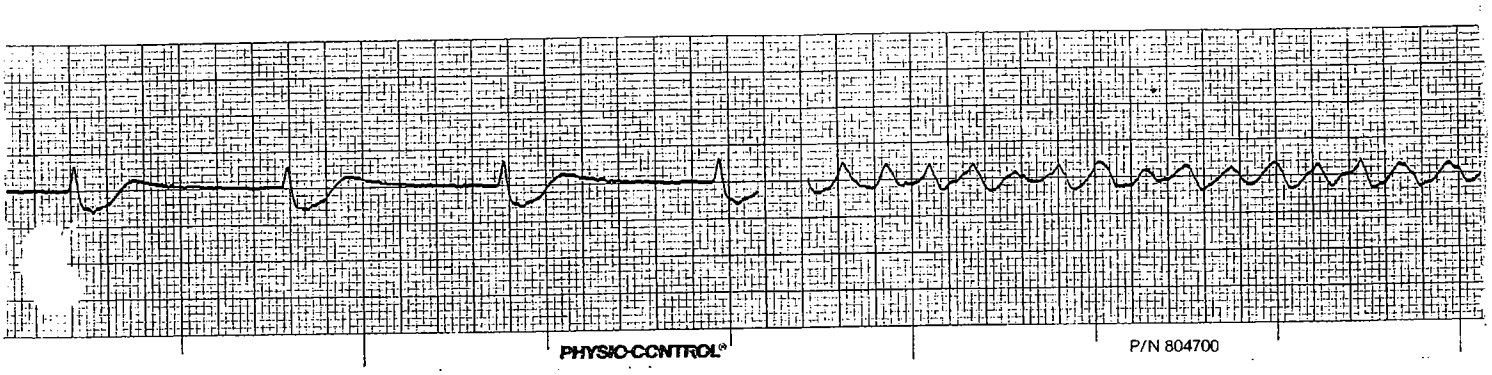
EAD II X1.0 HR=---
PHYSIO-CONTROL®
P/N 804700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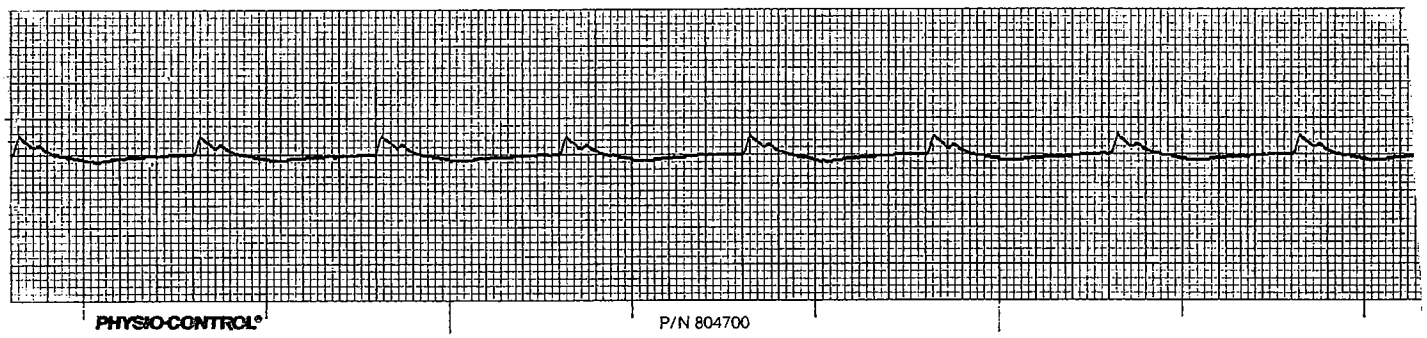
P/N 804700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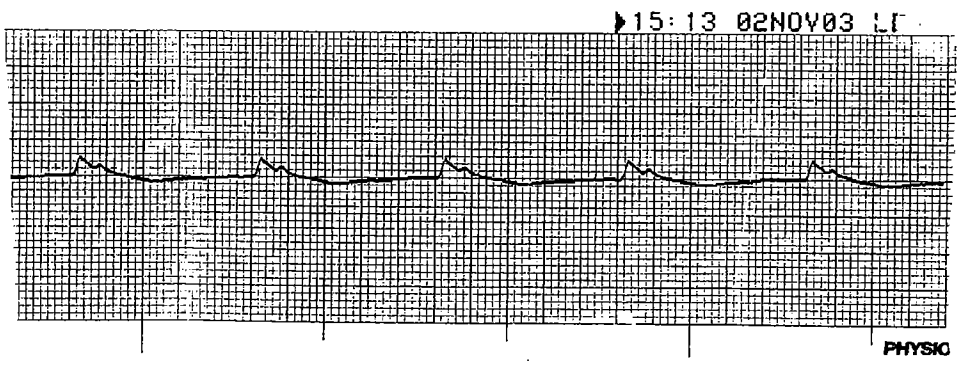
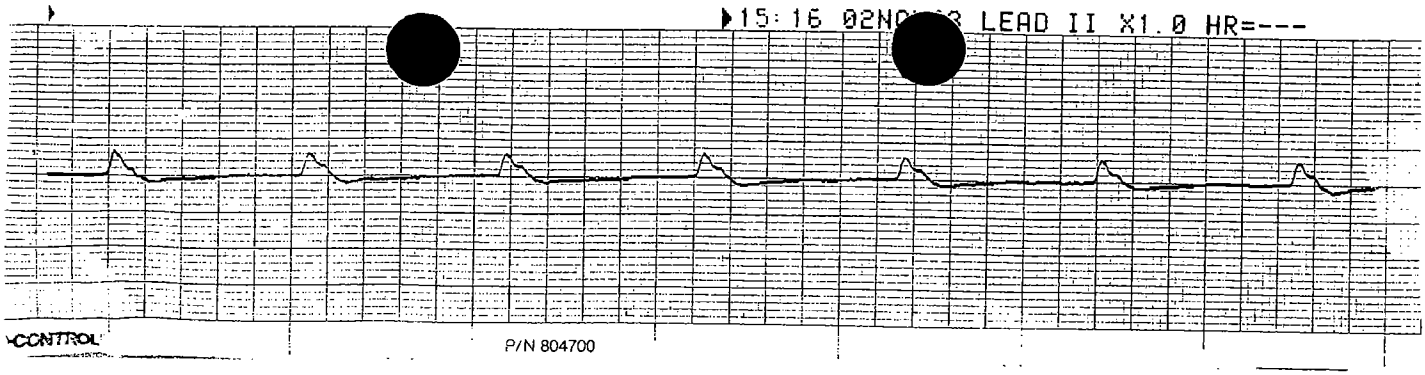
P/N 804700


15:13 02NOV03 LI
PHYSIC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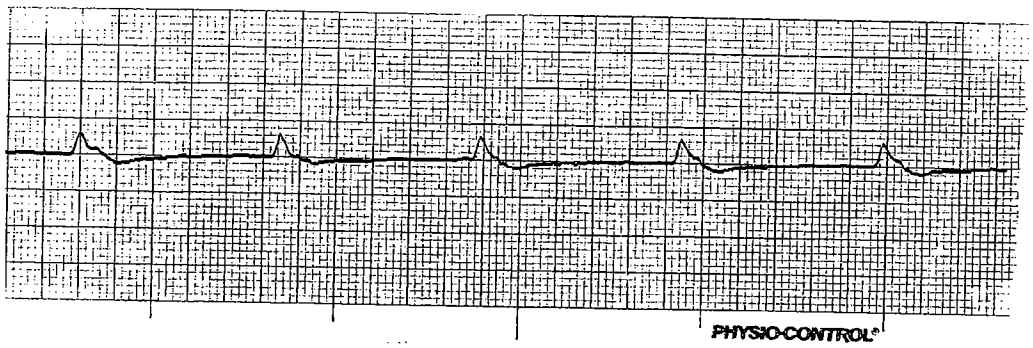
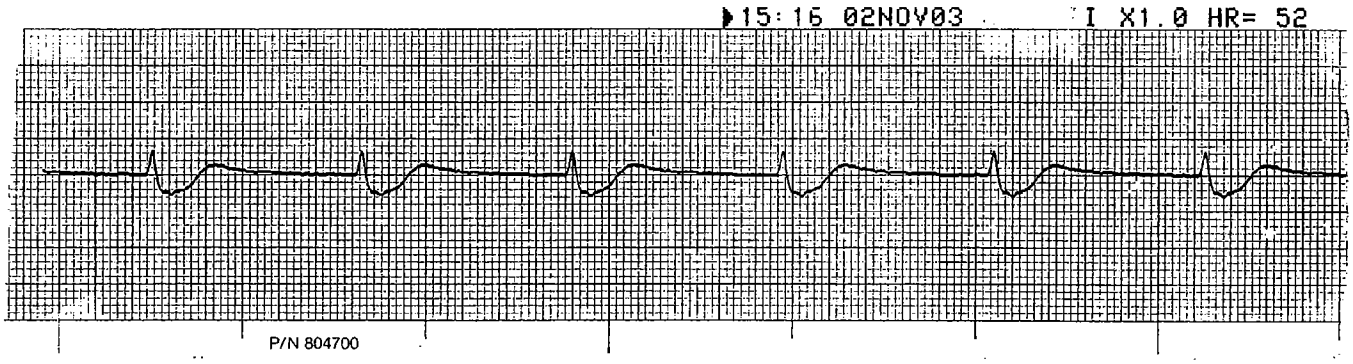
CONTROL
P/N 804700


PHYSIO-CONTROL®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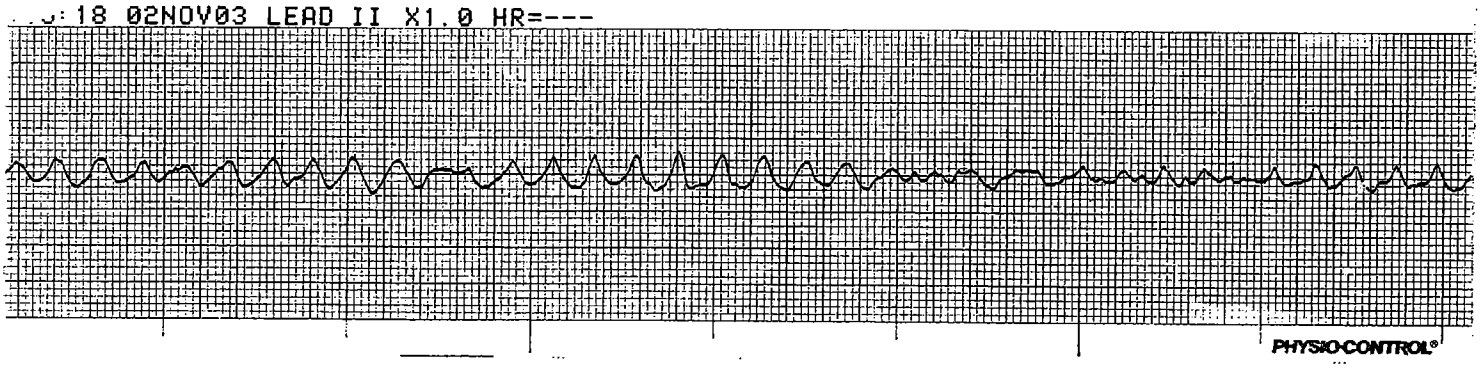

18 02NOV03 LEAD II X1.0 HR=---
PHYSIO-CONTROL®

518–123

NSN 7540–00–634–4158

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: 31Oct03 Returned @ 1900 [redacted] 5/16/2

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 31 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: 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 [redacted]

DATE VERIFIED: 31 Oct 03

TIME VERIFIED: 1826

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A Rh Pos

RECIPIENT: ABO A Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] 5/16/2

DATE: 31 Oct 03

REMARKS: EXP 03, Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED [redacted]

AT *(Hour)* 1646 2040 ON *(Date)* 31,Oct03

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 [redacted] (5)16/2

2nd VERIFIER

PRE-TRANSFUSION

TEMP.	PULSE	BP
36.2	123	101/41

DATE OF TRANSFUSION: 31Oct03

TIME STARTED: 2030

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

[redacted] (5)16/2

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME/DATE COMPLETED/INTERRUPTED: 31Oct03 2050

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
36.0	125	102/40

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE [redacted] RVM

SEX: M

WARD: EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.201–1

MEDCOM - 22680

518-123

NSN 7540-00-634-4158

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 U ML

REMARKS: Ptorned @ 1910 31Oct03 G

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 31OCT03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GS W

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 VERIFI[redacted]

DATE VERIFIED: 31 OCT 03

TIME VERIFIED: 1826

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONEN[redacted]

DATE 31,Oct03

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

REMARKS: EXP 03,NOV03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)* [redacted] ON *(Date)* 31,Oct03

IDENTIFICATION 2105 GS

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 the Component Transfusion Form and on the patient identification.

1st VERIFIER [redacted]

2nd [redacted]

PRE-TR[redacted]

TEMP. 35.9 PULSE 120 BP 88/44

DATE OF TRANSFUSION 31Oct03

TIME STARTED 2100

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

#[redacted]

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME/DATE COMPLETED/INTERRUPTED: 31Oct03 2115

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
35.9	116	92/50

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATU[redacted] CCNA/MAP

(b)(6)-2

(b)(6)-2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 22681

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
- [ ] CROSSMATCH

DATE REQUESTED: 10/31/03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: 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]

DATE VERIFIED: 10/31/03

TIME VERIFIED: 2259

(5)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A, Rh pos

RECIPIENT: ABO A, Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUE[redacted]

DATE 31 OCT 03

REMARKS: ex 3 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECT[redacted] (Signature)

AT *(Hour)* 233 ON *(Date)* 31 OCT 03

IDENTIFICATION

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

[redacted] CPT /[redacted]

[redacted] 94/59

TEMP. 96.7 PULSE 150 BP

DATE OF TRANSFUSION 31 Oct 03 TIME STARTED 2340

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, fi[redacted] rate; hospital or medical facility)

(5)(6)-2

[redacted]

(5)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1U ML

TIME/DATE COMPLETED/INTERRUPTED: 310e-2350

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
96.7	147	107/64

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: [redacted] CPT /[redacted]

SEX M WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 22682

Medical Record Copy

518–124

NSN 7540–00–634–4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:
1

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

DATE REQUESTED
NOW 10/31/03

DATE AND HOUR REQUIRED
NOW

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]
DIA[redacted]PROCEDURE
GSK

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
10/31/03

TIME VERIFIED
2259

SECTION II – PRE-TRANSFUSION TESTING

[redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO A
Rh pos

RECIPIENT
ABO A
Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	comp

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

SIGNATURE OF PERSON PERFORMING TEST
[redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 31 OCT 03

REMARKS:
ex 3 Nov 03

(5)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND IDENTIFIED BY *(Signature)*
[redacted]

AT *(Hour)* 2334 ON *(Date)* 31 OCT 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*
[redacted] CTT/AN

2nd VERIFIER *(Signature)*
[redacted] LT/AN

(5)(6)-2

PRE-TRANSFUSION
TEMP. 96.7 PULSE 148 BP 101/58

DATE OF TRANSFUSION 31 OCT 03 TIME STARTED 2353

POST-TRANSFUSION DATA

AMOUNT GIVEN 450 ML

TIME/DATE COMPLETED/INTERRUPTED 1 NOV 0030

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
97.2	146	98/62

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

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

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

SIGNATURE OF PERSON NOTING ABOVE
[redacted] LT/AN

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

[redacted]

(5)(6)-7

SEX M WARD 7CM

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 - 22683

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 1 NOV 03

DATE AND HOUR REQUIRED STAT

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]

DIAG[redacted] OR OPERATIVE PROCEDURE [redacted]

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

SIGNATURE OF VERIFIER SEE previous S18

DATE VERIFIED

TIME VERIFIED

2-25

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. 1188

DONOR

ABO A

Rh pos

RECIPIENT

ABO A

Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compat

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONEN

REMARKS: exp 3 NOV 03

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 1 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1[redacted] ON *(Date)* 1 NOV 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2[redacted]

PR[redacted]

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]

SEX M

WARD ICU

(6)(6)-2

(5)(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 - 22684

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 U _____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE

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]

DATE VERIFIED

TIME VERIFIED

(5)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO A Rh pos

RECIPIENT ABO A Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUEST

REMARKS: ex 3 Nov 03

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 1 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED BY [redacted]

AT (Hour) 1 1 5

ON (Date) 1 NOV 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER (Signature) [redacted]

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

(5)(6)-2

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

SEX M

WARD ICU 1

[redacted] (5)(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 - 22685

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

DATE REQUESTED 1 Nov 03

DATE AND HOUR REQUIRED STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE [redacted]

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 5 11

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO A Rh pos

RECIPIENT ABO A Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

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

SIGNATURE OF PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQ[redacted]

DATE 1 Nov 03

REMARKS: et 3 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1926 ON *(Date)* 1 Nov 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd V[redacted]

TEM[redacted] 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]

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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

MEDCOM - 22686

Medical Record Copy

NSN 7540-00-634-4159

518-124

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) 1u ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 1 Nov 03

DATE AND HOUR REQUIRED STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print) [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to Rectum [redacted]

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

SIGNATURE OF VERIFIER see previous

DATE VERIFIED 1 Nov 03

TIME VERIFIED 1813

(5)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO A Rh pos

RECIPIENT ABO A Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: or 3 Nov 03

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 1 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED BY (Signature) [redacted]

AT (Hour) 1930 ON (Date) 1 Nov 03

IDENTIFICATION

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

1st VERIFIER [redacted]

2nd VERIFIER [redacted] T/TW

PRE-TRANS BP

TEMP. PULSE

DATE OF TRANSFUSION TIME STARTED

(5)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE PULSE BLOOD PRESSUR

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 Ba

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)

SEX M WARD ICU 1

[redacted] (5)(6)-7

BLOOD OR BLOOD COMPONENT TRANSF

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 2(

Medical Record Copy

MEDCOM - 22687

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.
TCU I		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
31 OCT	2150 HOURS	

Admit to ICU

S/P direct trauma colostomy / suprapubic tube

Pressure dressings

Critical

VS - Q2°

Act - bedrest

Diet - NPO

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

HOURS

Nursing - I&O + Out / Central line per routine / Suprapubic tube to SSO / JP to bulb / penrose to gravity / NGT to LCWS

IVF - D5 1/2 NS 120 KCL @ 125 cc/hr

Meds - Ancef 1 gm IV Q8 x 48 hrs

Gentamycin 360 mg IV QD x 48 hrs

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

HOURS

Flagyl 500 mg IV Q6 x 48 hrs

MSO4 100 mg in 100 cc @ 10 cc/hr

Versed drip 1-5 mg/hr titrated to sedation

Atrovent neb .5 cc in 3 cc NS Q4°

NS @ 40 cc/hr via Dobhoff to suction to other end

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

HOURS

Labs -

CBC, SMA-10, PT/PTT

ABG in ICU now + 6AM

Vent TV - 800 R - 14 FiO2 - 100%

Peep 5 -

Wean FiO2 to keep sats 90%

[redacted]

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 [illegible]

MEDCOM - 22688

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 31 OCT 03 TIME OF ORDER 2245 HOURS

LIST TIME ORDER NOTED AND SIGN

Transfuse 2 units PRBC ... 1° each

[redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE [redacted] TIME OF ORDER 0100 HOURS

1 NOV

✓ Hydrocortisone 50 mg IV x 1

↑ PEEP 8 ✓

✓ CXR - done

Bolus 500cc x 1

CVP now

[redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE [redacted] TIME OF ORDER 0130 HOURS

1 Nov 03

album 500cc bolus

~~Albuterol nebs .5cc~~

[redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

D[redacted] TIME OF ORDER 0230 HOURS

Albuterol nebs .5cc ... 3cc NS ...

[redacted]

... [redacted] ... 2 L NS bolus

[redacted]

2nd done ... [redacted]

(b)(6)-4

(b)(6)-2

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

MEDCOM - 22689

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-7

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 NOV 03 TIME OF ORDER: 0423 HOURS

LIST TIME ORDER NOTED AND SIGN: [redacted]

V.O. [redacted] 1LT. [illegible]

[redacted]

(1) Neosynephrine drip 10 mcg/min titrate to effect.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 NOV 03 TIME OF ORDER: 0615 HOURS

5% Albumin 500 cc IV x1 over [illegible]. Transcribed from chart.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Nov 03 TIME OF ORDER: 0900 HOURS

1) ✓ ABG q 1°
2) 2 Amps Sodium Bicarb [illegible] done
3) [illegible] long IVP [illegible] [illegible] Warm [illegible] [illegible]
4) [illegible] done
5) CBC, ABG [illegible] done
6) 1 Amp [illegible] [redacted] done

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS

Add 2 Amps Sod Bi[illegible]

Noted 01NOV03 0900 [redacted]

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

MEDCOM - 22690

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 7 Nov TIME OF ORDER 1053 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) 2 Amps Na HCO3 [redacted]

VO Dr [redacted] CPT [redacted]

(2) 1L 5% Albumin @ 125 cc/hr

VO Dr [redacted] / CPT [redacted]

Noted @1054 [redacted]

(5)(6)-2

PATIENT IDENTIFICATION

(5)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

2 Amps Bicarb [redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 1 Nov 03 TIME OF ORDER 1235 HOURS

V.O. Dr [redacted]

Epinephrine drip titrate to MAP 765 [redacted] May/Nov

VOID

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7 Nov 03 TIME OF ORDER 1200 HOURS

(1) Wean epi to .15 mcg/kg/min if SBP 790 wean Neo to off

(2) 1 amp CaCl (3) 1 amp epi } IO x 1

(4) bolus 1L NS

[redacted]

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

MEDCOM - 22691

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	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	1 Nov	1530 HOURS	
P	Amp Na [redacted]		
	VO Dr [redacted] CT		
(2)	40 mEq KCl in 500cc NS VO Dr [redacted]		
	1 Nov 1700 noted [redacted]		

PATIENT IDENTIFICATION

(6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	1 Nov	1730 HOURS	
(1)	IL 5% Alb over 1°		
	VO Dr [redacted] /CPT		
	[redacted]	1800	

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	11/1/03	HOURS	
	Neo Epi @ 0.5cc q 1h MAP > 65		
	[redacted]		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	11/1/03	1930 HOURS	
	40 meq/KCl in 100 cc NS over 1° VO Dr. [redacted]		
	LTC [redacted]		
	[redacted]		

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

MEDCOM - 22692

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]

(5)(6)-4

DATE OF ORDER: 01 NOV 03 | TIME OF ORDER: 23 13 HOURS | LIST TIME ORDER NOTED AND SIGN

V O Dr [redacted] LT [redacted]

① ~~20 Kcl in 500cc NS in 1~~

② 1gm magnesium sulfate

[redacted]

Noted 02 Nov 0160 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

2 [illegible] [illegible]
[illegible] ABG [illegible]
If K < 3.5 [illegible]
2 [illegible] KCl [illegible]
ABG

NURSING UNIT | ROOM NO. | BED NO.

ZIV 11/2/03 e 0149 [redacted] ICT/RN [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

V.O. Dr. [redacted] / LT [redacted]
Δ IVF to LR @ 125 cc/hr.
1L LR Bolus ō keep CVP
>12. If no result 500cc LR
then ↑ epi to keep MAP >65.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

V.O. Dr. [redacted] / LT
[redacted] Dobutamine
Drip.

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

MEDCOM - 22693

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
	Surgery
1 Nov 03	Patient post-op day 1 s/p diverting colostomy, perineal drainage
1300	Afebrile Ar 140 150 BP 60-90 SBP on NEO SATS - 98%
	Vented SIMV 30% 800 14 PEEP 10
	Pulmonary - Vented ↓ A-a gradient
	ABG 7.36/38.2/71/22/95% BE -4
	Lungs few wheezes RRL
	Cardiac - Tachycardic despite good CVP (13-14)
	Poor peripheral perfusion but good UO
	Started on Epi drip + weaned off NEO.
	GI Ostomy ducky but viable, no air in bag
	NGT in place ; NPO
	Renal - Good UO ~200 cc/hr BUN - 10 Cr 1.1
	ID - No fevers WBC 2.9 on Unasyn/Levaq/Flagyl day 2/3
	Heme - Hct stable, no evidence of active bleeding
	13.9/45.3 231 Stable platelets
	Nutrition - NPO - will start TF when air in ostomy
	- Plan OR for washout tomorrow - may hold off
	til Monday if clinically does not improve

[redacted] (b)(6)-7

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

7 Nov 03 — 2210 HOURS

ADMIT TO ACU

S/P Debridement Perineum / open abd

CRITICAL

VS - Q1°

ACT - Bed REST

DIET - NPO

D5 1/2 NS + 20 KCL @ 125 cc/hr

MEDS: Ancef 1 gm IV q8

Gentamycin 360 mg IV QD

Flagyl 500 mg IV q8

Epinephrine drip } titrate to

Neosynephrine drip } SBP 90

~~Also~~ Versed drip titrate to sedation

. albuterol / Atrovent nebs Q4°

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

CBC, Chem 7, ABG in ICU @ noon

JP to bulb suction, JP in open abd to cont. wall suction,

Wet to dry to perineum BID

Dwell drain - Resume prior orders

Vent - SIMV 14 .75% PEEP-8 800

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

A-line / Central line per routine HOURS

Suprapubic drain to SBD

[redacted] (b)(6)-2

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2
31 Oct	[redacted]	VS q 2°	06	✓		
			18	[redacted]		
31 Oct	[redacted]	Diet BR	06	✓		
			18	[redacted]		
31 Oct	[redacted]	Diet - NPO	06	✓		
			18	[redacted]		
31 Oct	[redacted]	Nursing I&O's / Central line per routine / Suprapubic tube to straight bag drainage / JP to bulb / penrose to gravity NGT to LWS	06	✓		
			18	[redacted]		
31 Oct	[redacted]	CBC, SMA-10, PT/PTT	04	[redacted]		
31 Oct	[redacted]	Vent = TV-800, R-14, 100%, FiO2, Resp 5-8 wean FiO2 + Keep Sats >95% ↑ R-18	06	[redacted]		
			18	[redacted]		
01 Nov	[redacted]	CVP monitoring	06	[redacted]		
			18	[redacted]		
01 Nov	[redacted]	ABG q 1°	06	[redacted]		
			18	[redacted]		

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: diverting colostomy / suprapubic tube perineal drainage

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo ____ Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Admit to ICU / critical				
	----	ABG in ICU now				
	----	ABG in AM @ 06	NOW	06		(b)(6)-2
	----	CXR X1	NOW	NOW	0400	[redacted]
01NOV	[redacted]	CBC, ABG NOW	01NOV	01NOV	0900	done
	--(b)(6)-2					

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

CLINICAL RECORD

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

Mo.____ Yr. ____

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 31	1	2	3
3/10	[redacted]	IVF: D5½NS ē 20K @ 125 cc/hr	06, 18	[redacted]			
3/10	[redacted]	Ancef 1gm IV q8° x 48h	06, 14, 22	[redacted]			
3/10	[redacted]	Gentamycin 360 mg IV QD x 48°	10	[redacted]			
3/10	[redacted]	Flagyl 500 mg IV q6°	06, 12, 18, 24	[redacted]			
3/10	[redacted]	MSO4 100mg/100cc @ 10 cc/hr	06, 18	[redacted]			
3/10	[redacted]	Versed gtt 1-5 mg/hr titrate to sedation	06	[redacted]			
3/10	[redacted]	Atrovent nebs 1.5 cc/3cc NS q 4°	4, 8, 12, 16, 20, 24			[redacted]	
~~3/10~~		~~Alb. nebs .5cc ē 3cc~~ ~~NS~~					

(b)(6)-2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: diverting colostomy / suprapubic tube perineal drainage

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

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

DA FORM 4678, FEB 79

MEDCOM - 22698

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31 Oct	[redacted]	Trimethaphan 2U PRBC over 1° each ①	31 Oct	2300	2315	[redacted]
31 Oct	[redacted]	~~Hydrocortisone~~ ②	↓	2300	2345	[redacted]
31 Oct	[redacted]	Hydrocortisone 50mg IVP XI	31 Oct	0100	0115	[redacted]
01 Nov	[redacted]	Bolus 500 cc NS	31 Oct	2300	2300	[redacted]
01 Nov	[redacted]	Bolus 1000 cc NS	1 Nov	2330	2330	[redacted]
01 Nov	[redacted]	Bolus 1000 cc NS	1 Nov	0030	0030	[redacted]
01 Nov	[redacted]	Bolus 500 cc NS	1 Nov	0100	0100	[redacted]
01 Nov	[redacted]	Albumin 5% 500 cc bolus XI	01 Nov	0130	0300	[redacted]
01 Nov	[redacted]	Albumin 5% in 500 cc NS XI	01 Nov	0615	0700	[redacted]
01 Nov	[redacted]	2 Amps Sodium Bicarb.	01 Nov	0900	done	[redacted]
01 Nov	[redacted]	Vecuronium 10mg IVP now	01 Nov	0900	done	[redacted]
01 Nov	[redacted]	1 Amp Cal. Chloride	01 Nov	0900	done	[redacted]
01 Nov	[redacted]	2 Amp Sodium Bicarb	01 Nov	0900	done	[redacted]

(5/61-2)

(5/61-2)

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

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4
1 Nov	[redacted]	NS @ 40 cc/hr via	06	[redacted]				
	[redacted]	darvon c suction to	18	[redacted]				
		other end						
01 Nov	[redacted]	Atb. Needs .5–3cc NS	4	[redacted]				
		q4	8	[redacted]				
			12	[redacted]				
			16	[redacted]				
			20	[redacted]				
			24	[redacted]				
01 Nov	[redacted]	Neo drip 100mg/	06	[redacted]				
		min titrate to	18	[redacted]				
		effect.						
01 Nov	[redacted]	Vecuronium drip	06	[redacted]				
		7mg/L	18	[redacted]				
1 Nov	[redacted]	Epi drip wean epi to	06					
		.15 mcg/kg/min if SBP > 90	18			DICd		
		wean neo to off						
1 Nov	[redacted]	Epi drip wean 0.5cc	06	[redacted]				
		q1h to keep MAP	18	[redacted]				
		765						

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ___

PATIENT IDENTIFICATION:

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 - 22700

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	Initial
01 NOV [redacted]	2 Amps. Na. HCO3	01 NOV 03	NOW	1054	
1 Nov	1L 5% Albumin @ 125 cc/hr	1 Nov	now	0900	
1 Nov	2 Amps Na HCO3			done	
1 Nov	1 amp Ca Cl	1 Nov	done		
1 Nov	2 amp epi	1 Nov	done		
1 Nov	1L NS Bolus	1 Nov	done		
1 Nov	1 amp Na HCO3	1 Nov	done		
1 Nov	40 meq KCl in 250 cc NS	1 Nov	1500		
1 Nov	1L 5% Alb over 1°	1 Nov	1800		
1 NOV	40 meq KCl in 100 cc NS over 1°	1 NOV	2200	2200	
2 Nov	~~20~~ 40 meq KCl in 150 cc NS	Nov 2	done	done	
2 Nov	40 meq KCl in 100 cc NS (Not given)	Nov 2	~~done~~		
2 Nov	1 gm Mg+	Nov 2	done		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
		(5)(6)-2	

USAPA V1.00

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: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME:_____ ETA:_____ UNIT:_____

MED COM: [Y] [N] _____

ARRIVAL STATUS

TIME_____ ☐ IV x _____ ☐ O_2_____ 1/min ☐ C-Spine Immob

Meds: ☒ UKN ☐ None ☐ Yes:_____

Allergies: ☒ UKN ☐ None ☐ Yes:_____

Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake _____hrs

LMP:_____ ☐ _____

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☐ ETT____ ☐ _____

☐ Secretions_____

BRETHING

☐ Labored ☒ Unlabored ☐ Absent

TRACHEA: ☒ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] >=< [R]

CIRCULATION

PULSE: ☒ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warn ☐ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐_____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E_____

V_____

M_____

SPHINCTER TONE:
☐ WNL
☐ None

HEAD

PUPILS: ☐ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @_____

JVD: [Y] [N]

HEART

RHYTHM: ☐ Regular ☐_____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☐ Soft ☒ Rigid ☐ Non-Tender

☐ Tender:

PELVIS

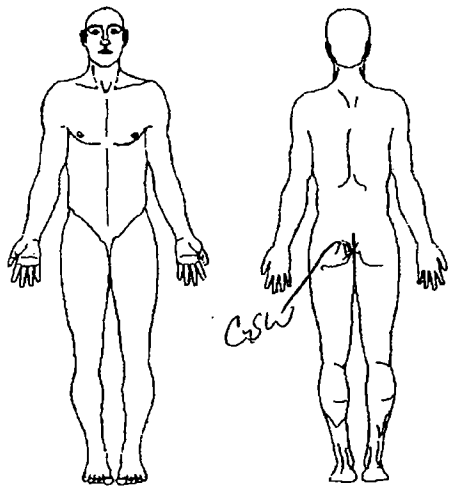
☐ Stable ☐ Unstable ☐_____

Blood at meatus/vagina: [Y] [N]

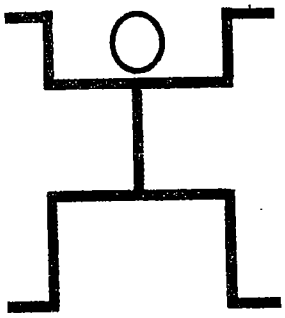
Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong | + Palpable | D Dopler

RN [redacted] (5)(6)-7

PHYSICIAN [redacted]

(Continue on reverse)

PREPARED BY *(Signatur* [redacted]

DEPARTMENT/SERVIC [redacted]

DATE 31 Oct 05

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

[redacted]

(5)(6)-7

☐ HISTORY/PHYSICAL (5)(6)-7 ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
1822	ET Intubation	8.0	☒ Oral ☐ Nasal Teeth	[redacted]	☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
1828	Gastric Tube	18 Fr.	☐ Oral ☒ Nasal	[redacted]	☐ Air ☐ Contents Verified_____ Suction: Y N
1845	Urinary	16 Fr	☐ Meatus ☐ Supra-Public	PR. [redacted]	☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed	(5)(6)-2	☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	%O_2	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☒ Chem ☒ PT/PTT
	☐ ETOH ☒ T&S ☒ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☒ Pelvis
	☐
	☐
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
1810	1	18	Y	N	ⓡ AC			
1814	2	18	Y	N	ⓡ AC			
1825			Y	N	Saline Lock ⓡ shoulder			
			Y	N				

MEDICATIONS

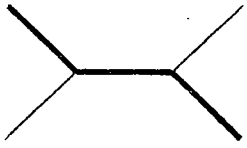
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Hrcd	1815	1g	IVP						
Tet.	1815	.5	IM						
Fentnl	1815	100	IVP						
Succs	1815	100	IVP						
Lidocaine	1815	100	IVP						
Etomidate	1815	20	IVP						
Vec	1825	10	IVP						
Cent	1826	80	IVP						
Fol gal	1826	500	IVP						

BLOOD PRODUCTS

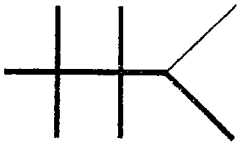
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

Accompanied By _____

MEDCOM - 22703 ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp: GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
1810	149/118	135									
1818	129/56	125									
1826	170/69	136									
1834	144/54	134									
1842	145/52	141									
	/										
	/										
	/										
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

IRAQI Male s/p GSW to [illegible] c̄ ⊕ exit @ [illegible] [illegible] [illegible]
wound. ⊕ [illegible] [illegible] [illegible] [illegible] Abd
VS initially tachy to 130's, BP [illegible] 140's/50's
CW: [illegible] [illegible]
Lungs: ⊕ wheezing Ⓡ [illegible], Ⓛ clear.
Ext: Pulses x4.

Meds / chart Reviewed

[redacted]

(b)(6)-2

MEDCOM - 22704

☆U.S. GOVERNMENT PRINT...

ACLU-RDI 1673 p.64

DOD-036280

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

(5)(6)-7

		TIME	INTILAS	2330	INTILA[redacted]	INTILAS
NEURO	PUPLIS			2mm Sluggish		
	SENSORIUM			awakable but		
				mildly sedated		
				from OR. Follows		
				simple commands		
RESPIRATORY	RESPIRATION PATTERN			Vent: RR 16 Fio2 100		
	BREATH SOUNDS			PIP 41 TV 800 PEEP		
	SECRETIONS			8. Sao2 92-98%.		
				Exp. wheezes R.		
				~~Expansion~~ Equal		
				BE. moderate secretion		
SKIN	COLOR			NFR.		
	INTEGRITY			Abd. incision		
IV SITE	LOCATION			1. Cordis (R) subclav c TLC ⇒ CVP		
	CONDITION			2. 18g (R) AC		
				3. 18g (L) AC	31 OCT	
				(L) A-line (R) rad		
				All site c/d/I c NO S/S of infection.		
GASTRO	ABDOMEN			soft. Incision mid abdomen.		
	BOWEL SOUNDS			Colostomy site dressed		
				BS hyperactive. Jarvid drain PR.		
GU	URINE			suprapubic catheter 70cc/hr		
	COLOR/CLARITY			yellow		
CARDIOVASCULAR	CARDIACRHYTHM			ST 130-150 / BP 70-90 / 50-60		
				ectopy.		

LEGEND

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

PREPARED BY *(Signature & Title)* *(Continue on reverse)*

DEPARTMENT/SERVICE/CINC ICU1 DATE 31 OCT 03

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

[redacted] (5)(6)-4

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

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 22705

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

DATE | DX | HOSPITAL DAY

		21	22	23	24	01	02	03	04	0	05	06	09	10	11	12	13	14	15
VITAL SIGNS	TIME	~~21~~	~~22~~	02	03	04	05	06	07			~~06~~	09	10	11	12	13	14	15
	BP Arterial line				110/59	74/54	82/54	95/53	89/58										
	BP Cuff	107/59	138/69	103/56															
	Temperature	92.3	95.4	96.9	97.1	97.2	96.4	97.2	98.1										
	Pulse	133	131	145	152	153	143	144	140										
	Respiratory Rate	14	27	36	16	14	18	14	14										
	SaO2	95	98	89	89	93	93	90	93										
	Source	vent	vent	vent	vent	vent	vent	vent	vent										
	FiO2	100	100	100	100	100	100	100	100										
	MAP	79	82	79	67	60	65	70	65										
	PEEP	5	5	5	8	8	8	8	8										
	PIP	34	37	39	36	38	41	38	39										
	CVP																		
		21	22	23	24	01	02	03	04										

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
INTAKE	TIME																		
	MIVF	125	125	125	125	125	125	125	125										
	IVPB					50	—												
	Bolus		1000	1000	—	1000	—	—	—										
	Msoy	5	5	5	5	5	5	5	2										
	Versed	5	5	5	5	5	5	5	2										
	CVP					11	14	10	10										
	Albumin							250											
	TOTALS																		

OUTPUT	Supra-pubic Cath URINE	HOUR			700	90	90	70	90	80	200	200							
		TOTAL			700	790	880	950	1040	1120	1320	1520							
		SP gr																	
		S/A																	
	NG	OUTPUT																	
		PH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS	JP			200	—	—	—	60										
		Jaund									300								
		Nasal suct									200								
	TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

16 17 18 19 20 21 22 23

INTAKE

16 17 18 19 20 21 22 23 8°T

OUTPUT

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

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

TURN SUCTION

TIME

24°180 TOTALS

NURSE'S SIGNATURE INITIALS

[redacted]

(6)(6)-2

WT Yesterday

wt Today

INTAKE

IV

Po

TOTAL

OUTPUT

Urine:

TOTAL

BALANCE

MEDCOM - 22707

[redacted] MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA [redacted]

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

REPORT TITLE

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

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL S[redacted]ESSMENT

		TIME 1000	INTILAS [redacted]		INTILAS	1800	INTILAS [redacted]
NEURO	PUPLIS	PERRLA 3mm sluggish				PERRL c 2mm sluggish	
	SENSORIUM	Ø spont movement				medically paralyzed	
		Vec - 7mg/hr, MSO4 - 2,				c vec. 7mg/hr, MSO4 - 2	
		Versed - 2,				Versed - 2.	
RESPIRATORY	RESPIRATION PATTERN	ETT# 8.5, 26.5 @ lip				ETT# 8.5, 26.5 @ lip	
	BREATH SOUNDS	SIMV-14, P-10, 50% FiO2				SIMV - 14 P - 7 - FiO2 - 50	
	SECRETIONS	TV-800, PIP-30,				TV - 800, PIP - 30	
		Ø secretions, 95%				~~[illegible]~~ Bloody nostrils	
		currently managing vent				97% sao2	
		status					
SKIN	COLOR	normal for race					
	INTEGRITY	Perineal penrose to gravity				NFB. ~~[illegible]~~ cool to	
		[illegible] c 40cc NS to suction				touch. (T) 95°F.	
IV SITE	LOCATION	(R) SC 3cc c cordis					
	CONDITION	(R) rad Aline				(R) ~~[illegible]~~ c cordis	
		(R) PIV				(L) AC 18g	
		Ø S/S of infxn				(L) Rad A-line	
						(L) cordis. subcla.	
						Ø S/S infection	
GASTRO	ABDOMEN	midline ab incision C/D/I					
	BOWEL SOUNDS	Colostomy stoma beefy				midline incision C/D/I	
		red. bloody drainage				colostomy stoma - red	
		small amt. hypo BS x 4 quad				BS hypo - active x 4	
GU	URINE	suprapubic cath					
	COLOR/CLARITY	clear light yellow adequate				Suprapubic catheter	
		amt				c clear yellow urine	
						>200cc/hr	
CARDIOVASCULAR	CARDIACRHYTHM	ST 150s, Neo titrate to					
		MAP ≥ 65, CVP - 10s,				ST 140s - 150s. Neo	
	5%	albumin @ 125 ml/hr				to keep MAP>65, Epi	
		D5½NS @ 125 ml/hr				to keep MAP>65	
						D5½NS @ [illegible]cc/hr.	

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CINC ICU

DATE 1 NOV 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, 1 MAY78

Proponent Dept of Nurs

MEDCOM - 22708

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

[redacted]

		DX	06	07	08	09	10	11	12	13		14	15	16	17	HOSPITAL DAY 18	19	20	21	
	DATE																			
VITAL SIGNS	TIME		24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line		104/45	86/64	82/57	101/59	87/50	91/42	83/44	101/63		90/59	90/48	99/50	93/44	101/46	50/27	95/57	93/63	
	BP Cuff			112/67																
	Temperature			98.4			96.7	96.7		96.5		95.8	95.9	96	95.8	95.8	95.6	95		
	Pulse		140	148	153	147	152	155	148	138		145	143	139	140	136	127	119	131	
	Respiratory Rate		14	14	14	18	18	14	14	14		14	14	14	14	14	14	18	18	
	SaO2		98	100	100	100	97	99	100	99		100	100	100	100	100	95	98	99	
	Source		V	V	V	V	V	V	V	V		V	V	V	V	V	V	V	V	
	FiO2		85	85	85	50	50	50	50	50		50	50	50	50	50	50	100	100	
	MAP		52	75	68	74	69	63	67	79		72	62	65	62	69	35	72	71	
	CVP		11	15	10	15	10	11	16	16		13	11	10	9	13	12	13	24	
			06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
INTAKE	TIME		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	MIVF		125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	D5	25	1000
	IVPB		1500				100				250	150		250						
	Versed		2	2	2	2	2	2	2	2	16	2	2	2	2	2	2	off	off	12
	MSO4		2	2	2	2	2	2	2	2	16	2	2	2	2	2	2	off	off	12
	Bolus					1000						1500					1000	1000	—	3000
	Blood																			
	Dextran		40	40	40	40	40	40	40	40	—	40	40	40	40	40	40	40	40	320
	Albumin 5%				50	125	125	125	500	125	1500					500				1000
	NeO		12.5	12.5	12.5	12.5	25	25	25	25	150	25	5	5	5	5	7.5	off	off	30
	Epi									13	13	1	1	1	1	1	1	2.5	2.5	11
	VEC																	7	7	14
	TOTALS										2945									
OUTPUT	URINE HOUR / TOTAL		200	70	200	250	200	200	230	170	1629	450	200	450	560	160	250	220	200	2700
	URINE SP gr																			
	URINE S/A																			
	NG OUTPUT																			
	NG PH																			
	NG GUIAC																			
	EMESIS																			
	STOOL																			
	DRAINS JP				30						30				30					30
	DRAINS Dextran						200				—				200					250
											1650									
	TOTALS									(T	1295)									

MEDCOM - 22709

[redacted]

POST-OP DAY 22 23 24 01 02 03 04 05

ACUITY LEVEL CLASSIFICATION 610

VITAL SIGNS		18	17	18	19	20	21	22	23				
		137/54	85/47	115/51	79/40	116/58	110/63	100/60	72/57				
		99/80	88/52	80/49	/	/	/	/	/				
		98.8	99.3	99.7	100.1	100.4	100.2	99	99.2				
		144	146	143	149	157	160	159	157				
		18	18	18	18	18	16	16	16				
		100	100	100	100	96	94	96	98				
		V	V	V	V	V	V	V	V				
		100	60	55	50	50	45	50	55				
		72	61	59	57	79	81	81	67				
		17	15	14	14	82	11	11	12				
		22	23	24	01	02	03	04	05				
INTAKE		18	17	18	19	20	21	22	23	8°T			
		125	125	125	125	D5	125	125	135				
		50	50	50	—	—	—	—	—				
		off	off	off	off	off	off	off	off				
		off	off	off	off	off	off	off	off				
		—	—	—	—	—	—	1000	—				
		1800	—	—	—	—	—	—	—				
		40	40	40	40	40	40	40	40				
		—	—										
		off	off	off	off	off	off	off	off				
		2	1.5	1	1	1	.5	.5	.5				
		7	7	7	7	7	7	7	7				
OUTPUT		300/300	300/600	350/950	300/1250	300/1550	360/1910	330/2240	260/2500				

RESPIRATORY DATA		TIME	09	10	11	12:30	15	16		18:42	1935	
		MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
		F_iO_2	80	50	50	50	50	50	50	50	50	40
		TV	800	800	800	800	800	800	800	800	800	
		RATE	14	18	14	14	14	14	14	14		
		PEEP	8	8	10	10	10	10	7	7		
	A	pH	7.19	7.39	7.36	7.36	7.30	7.33		7.30	7.165	7.2
	A	PCO_2	42	28.4	37.8	38.2	36	57.4		41.5	48.7	4
	B	pO_2	240	59	74	71	129	181		84	60	21
	B	HCO_3	16	18	21	22	18	20		21	18	2
	G	SAT	100	92	95	93	99	100		95	86	10
	G	BASE	-12	-7	-4	-4	-9	-6		-6	-11	-5

LABORATORY DATA	TIME	09									
	CLUCOSE										
	Na/K										
	Cl/CO_2										
	BUN/Cr										
	WBC/PLATELET	5.6/231									
	Hct/Hgb	11/35			26/9						

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

TURN / SUCTION — TIME

24°180 TOTALS

[redacted] TURE | INITIALS

WT Yesterday ____ wt Today ____

INTAKE OUTPUT

IV ____ Urine: ____

Po ____ ____

TOTAL ____ TOTAL ____

BALANCE ____

[redacted]

(5)(6)1-2

MEDCOM - 22710

[redacted] [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

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1000	INTILAS [redacted]		INTILAS	1800	INTILAS [redacted]
NEURO	PUPLIS	3+ sluggish				2+ sluggish	
	SENSORIUM	fully sedated				Paralyzed c vecur-	
						7mg/hr.	
RESPIRATORY	RESPIRATION PATTERN	BBS on the vent				Vent: RR 18 FiO2 65	
	BREATH SOUNDS	CTA c scattered				PEEP 8 TV 800 PIP 3[illegible]	
	SECRETIONS	crackles on the				↓ bases. movement	
		base.				Equal. dim. bases	
		Bloody secretions				bloody secretion	
		from the nare				from nares.	
SKIN	COLOR	ecchymosis noted				Incision to abd.	
	INTEGRITY	LE (feet) multiple				buttocks. Vasoconstric	
		wounds buttocks				tion to feet.	
IV SITE	LOCATION	(R) + (L) cardio				R ac. (R) subc. (L) 8[illegible]	
	CONDITION	(L) LR open (bolus)				(L) rad.	
		(R) epinephrine drip				All sites CDI	
		LR c 125				no S/S of infection	
GASTRO	ABDOMEN						
	BOWEL SOUNDS					Soft. BS hypoactive	
						JP drain. suprapubic	
						catheter.	
GU	URINE	IV NS flush SP tube				IV NS flush. Damn	
	COLOR/CLARITY	c 40cc/hr. Foley				Suprapubic cath. yellow	
		clear yellow/orange urine				urine.	
CARDIOVASCULAR	CARDIACRHYTHM	ST 147 >				ST 130'S. BP 96/48	
		↓ BP ~~to maintain~~				3+ Edema. Epi &	
		on epi drip to				neo drip to keep	
		maintain MAP > 65				MAP > 50.	

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CINC: ICU

DATE: 2 NOV 03

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

[redacted] (b)(6)-4

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

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 22711

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

DATE | DX [redacted] | HOSPITAL DAY

VITAL SIGNS	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial line	84/64	62/56	86/43	84/49	94/47			87/83		103/56	94/51	91/44	85/45	76/47	81/44			
BP Cuff	/	92/37	94/46	87/45	94/47	97/51	78/39	71/36										
Temperature	99	98.5	98	98.3		98.0		96.6		·	97.0				98.3			
Pulse	154	149	147	147	144	144	141	132		134	136	133	129	129	128	128		
Respiratory Rate	16	16	16	16	16	16	16	16		16	16	16	16	18	18			
SaO2	98	97	97	94	95	95	95	92		96	93	94	91	91	93			
Source	V	V	V	V	V	V	V	V		V	V	V	V	V	V			
FiO2	55	55	55	55	55	55	55			55	55	55	55	65	75			
MAP	61	60	63	65	57	70	55	58		73	66	58	58	55	56			
CVP	11	15	13	16	15	13	20	15		15	16	15	15	12	10			
PEEP															10			

INTAKE TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
MIVF	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125		
IVPB	50					50							50					
Versed	off	—				—												
MSO4	off	—				—												
Neo	off	—				10	10	10	10				:	10	10			
Epi	.5	.8	.8	.9	1.0	1	1	1	1					1	1			
Vec	7	7	7	7	7	7	7	7	7					7	7			
Nsgrin	40	40	40	40	40	40	40	40	40	40				40	40			
[illegible]	—	—	—	—	—	—	started	10.5	M					—	—			
LR			1000				1000							—	—			
albumin							~~125~~	~~125~~	125	125	125	125	—	—	—			
TOTALS																		

OUTPUT	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	
URINE HOUR/TOTAL	150/150	160/310	200/510	180/690	130/820	120/940	70/1010	70/1080	100/1180	100/1280	200/1480	100/1580	100/1680	138/1718	50/[illegible]	/	/	
URINE SP gr																		
URINE S/A																		
OGT ~~NG~~ OUTPUT													400					
OGT PH																		
OGT GUIAC																		
EMESIS																		
STOOL																		
DRAINS JP	40				60								30					
DRAINS [illegible]	200																	
TOTALS																		

OR 2nd code

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

	22	23	24	01	02	03	04	05	
VITAL SIGNS									
INTAKE	22	23	24	01	02	03	04	05	8°T
OUTPUT									

RESPIRATORY DATA

TIME		0C	1843
MODE		SIM	SIMV
F_1O_2		SS	65
TV		800	800
RATE		16	18
PEEP		7	8
ABG	pH	7.355	7.356
	PCO_2	37.5	41.2
	pO_2	65	52
	HCO_3	23	23
	SAT	92	85
	BASE	-2	-2

LABORATORY DATA

TIME		04	
CLUCOSE			
Na/K		140 / 3.9	
Cl/CO_2		114	
BUN/Cr			
WBC/PLATELET		5.1 / 45	
Hct/Hgb		30.8 / 11.2	
PT/PTT		14.4 / 35	

ACTIVITIES OF DAILY LIVING

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

TURN — TIME

SUCTION

24°180 TOTALS

NURSE'S SIGNATURE — INITIALS

[redacted] (b)(6)-2

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

MEDCOM - 22713

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE:

3. WITNESSED ARREST?
☒ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?
☒ YES ☐ NO

2. LOCATION OF RESUSCITATION EVENT
☒ MICU ☐ SICU ☐ CCU ☐ NICU ☐ ED ☐ PACU ☐ OR ☐ WARD: _____
☐ DIAGNOSTIC / PROCEDURE AREA: _____
☐ OUTPATIENT CLINIC: _____
☐ OTHER *(Specify)*: _____

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) **COMMENTS**

☒ IV Access	☐ Time: ____ : ____	
☒ Endotrachael Tube	☐ Time: ____ : ____	
☒ Mechanical Ventilation	☐ Time: ____ : ____	N/A
☒ Arterial Line	☐ Time: ____ : ____	
☒ Central Venous Line	☐ Time: ____ : ____	
☐ Pulmonary Artery Catheter	☐ Time: ____ : ____	
☒ Nasogastric Tube	☐ Time: ____ : ____	
☐ Pacing Device *(Specify type)*: _____	☐ Time: ____ : ____	
☐ Implantable Defibrillator / Cardioverter	☐ Time: ____ : ____	
☐ Other *(Specify)*: _____	☐ Time: ____ : ____	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*
☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☐ Other: PSVT

6. RESUSCITATION ATTEMPTED
☐ YES *(Check all that were used)*
☐ Chest Compressions
☐ Defibrillation
☐ Airway Management
☐ NO *(Check one)*
☐ False alarm/arrest (BLS / ALS not needed)
☐ Do not attempt resuscitation (DNAR)
☐ Considered futile ☐ Found dead

7. INITIAL CONDITION
CONSCIOUS
☐ Yes ☒ No
BREATHING
☒ Yes ☐ No Vent
PULSE
☒ Yes ☐ No
Site: _____

8. INITIAL RHYTHM PSVT
☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)
☐ Returned at: ____ : ____ ☐ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: ____ : ____

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☐ Death

PATIENT DISPOSITION:

9. EVENT TIMES
(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	____	____
CPR Started:	____	____
1st Defibrillation:	____	____
Airway Achieved:	____	____
1st Dose Epinephrine:	____	____

Code Team Called:
☐ Yes ☒ No Time: 1900 : ____

Code Team Arrived:
☐ Yes ☐ No Time: 1900 : ____

10. GLASGOW COMA SCALE
(Post-resuscitation)
Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
1 - No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
1 - No response

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
1 - No movement

SCORE: _____

PATIENT IDENTIFICATION

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

AGE: _____
GENDER: _____
HEIGHT (in): _____
WEIGHT (lbs): _____

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

1 NOV

(5)(6)-4

EMERGENCY RESUSCITATION RECORD - PART 2

EPW [redacted]

	TIME (Hr/Min):	1920	1925	1935	2000	2010							
VITALS	BLOOD PRESSURE	64/33	67/23	103/52	95/58	100/57							
	HEART RATE (* = CPR)	160	154	128	119	126							
	RHYTHM	PSVT	PSVT	ST	ST	ST							
	PULSE PALPABLE (Y/N)	Y	Y	Y	Y	Y							
	DEFIBRILLATION (Joules: 200, 300, 360)	—	—	→	—	—							
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—	✓	✓	✓	—							
	PACING PERFORMED (✓)	—	200	300	360	—							
	RESPIRATIONS	16	18		14	14							
AIRWAY	BAGGED w / 100% O2 (✓)	—	—										
	INTUBATED (✓)	✓	✓										
	MASK (Specify type)	—	—										
	% OXYGEN	100	100	100	100	100							
	O2 SATS	97	95	92	98	100							
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	drip 5 mcg	~~11~~										
	ATROPINE (0.5 -1 mg - IV / ET tube)												
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)			~~11~~									
	HCO3	~~1111~~											
	Blood					~~1111~~							
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
LABS	POTASSIUM (K) 40 meq					drip							
	GLUCOSE												
	CALCIUM (Ca)			T	1955								
	MAGNESIUM (Mg)				T								
ABGs	PH												
	pCO2												
	pO2												
	HCO3												

PHYSICIAN *(Signature & Title)*

Dr [redacted] / Dr [redacted]

NURSE *(Signature & Title)*

[redacted]

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(5)(6)-2

MEDCOM - 22715

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: NOV 2

2. LOCATION OF RESUSCITATION EVENT

☒ MICU ☒ SICU ☐ CCU ☐ NICU ☐ ED ☐ PACU ☐ OR ☐ WARD: ICU#1

☐ DIAGNOSTIC / PROCEDURE AREA: _____

☐ OUTPATIENT CLINIC: _____

☒ OTHER *(Specify)*: ICU#1

3. WITNESSED ARREST?

☒ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?

☒ YES ☐ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) **COMMENTS**

☑ IV Access	☐ Time: ___ : ___	
☑ Endotrachael Tube	☐ Time: ___ : ___	
☑ Mechanical Ventilation	☐ Time: ___ : ___	
☑ Arterial Line	☐ Time: ___ : ___	
☑ Central Venous Line x 2	☐ Time: ___ : ___	
☐ Pulmonary Artery Catheter	☐ Time: ___ : ___	
☑ Nasogastric Tube	☐ Time: ___ : ___	
☐ Pacing Device *(Specify type)*: _____	☐ Time: ___ : ___	
☐ Implantable Defibrillator / Cardioverter	☐ Time: ___ : ___	
☐ Other *(Specify)*: _____	☐ Time: ___ : ___	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☑ Hypotension
☑ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☐ Other: _____

6. RESUSCITATION ATTEMPTED

☑ YES *(Check all that were used)*
- ☑ Chest Compressions
- ☐ Defibrillation
- ☑ Airway Management

☐ NO *(Check one)*
- ☐ False alarm/arrest (BLS / ALS not needed)
- ☐ Do not attempt resuscitation (DNAR)
- ☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS
☐ Yes ☑ No

BREATHING
☐ Yes ☐ No > MVent

PULSE
☐ Yes ☑ No

Site: _____

8. INITIAL RHYTHM ☒ Agonal Rhythm

☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☑ Returned at: 20 : 15 ☐ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 20 : 15

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☐ Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	19	54
CPR Started:	19	55
1st Defibrillation:	N/A	N/A
Airway Achieved:	in	place
1st Dose Epinephrine:	running drip in place	
Code Team Called: ☑ Yes ☐ No Time:	19	54
Code Team Arrived: ☑ Yes ☐ No Time:	19	54

10. GLASGOW COMA SCALE

(Post-resuscitation)
Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
(1) No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
1 - No response (ETT)

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
(1) - No movement

SCORE: 2 ETT

PATIENT IDENTIFICATION

EPW [redacted]

(5)(6)(-4

AGE: _____
GENDER: M
HEIGHT (in): _____
WEIGHT (lbs): _____

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Hr/Min):	1955	2000	2010	2014	2015	2016	2020					
VITALS	BLOOD PRESSURE	MAP 40				178/65		149/51					
	HEART RATE (* = CPR)	60	CPR			146		136					
	RHYTHM	agonal	Asyncl	Asyncl	vfib	ST		ST					
	PULSE PALPABLE (Y/N)	N	N	N	N	Y	Y	Y					
	DEFIBRILLATION (Joules: 200, 300, 360)	—	—	—	—	—	—	—					
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—	—	—	—	—	—	—					
	PACING PERFORMED (✓)	—	—	—	—	—	—	— MV					
	RESPIRATIONS	MV	—	—	—			18					
AIRWAY	BAGGED w / 100% O2 (✓)	✓	✓	✓	✓	MV	—	MV					
	INTUBATED (✓)	in place	in place	in place	in place	in place	in place	in place					
	MASK (Specify type)	—	—	—	—	—	—	—					
	% OXYGEN	80	100	100	100	100	100	100					
	O2 SATS	40				96%	96%	96%					
								MV setting SIMV RR 18 TV 800 PEEP 10 FiO2 60					
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)												
	ATROPINE (0.5 -1 mg - IV / ET tube)		1mg										
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
	D50			1 Amp									
	CaCl				1 Amp								
	BiCarb					1 Amp							
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
	Neo	20 mcg / min infusing prior											
	Dobutamine	N/A											
	Epinephrine	1 mcg / m infusing prior											
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
							iStat						
ABGs	PH						7.35						
	pCO2						27						
	pO2						N/A						
	HCO3						15						
	BE						-10						

PHYSICIAN (Signature & Title) DR [redacted]

NURSE (Signature & Title) [redacted] COT/AN

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(5)(9)-2

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: 3 NOV 03

2. LOCATION OF RESUSCITATION EVENT

☐ MICU ☑ SICU ☐ CCU ☐ NICU ☐ ED ☐ PACU ☐ OR ☐ WARD: _____

☐ DIAGNOSTIC / PROCEDURE AREA: _____

☐ OUTPATIENT CLINIC: _____

☐ OTHER *(Specify)*: _____

3. WITNESSED ARREST?

☑ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?

☑ YES ☐ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) **COMMENTS**

☐ IV Access	☐ Time: ___ : ___	
☐ Endotrachael Tube	☐ Time: ___ : ___	
☐ Mechanical Ventilation	☐ Time: ___ : ___	
☐ Arterial Line	☐ Time: ___ : ___	
☐ Central Venous Line	☐ Time: ___ : ___	
☐ Pulmonary Artery Catheter	☐ Time: ___ : ___	
☐ Nasogastric Tube	☐ Time: ___ : ___	
☐ Pacing Device *(Specify type)*: _____	☐ Time: ___ : ___	
☐ Implantable Defibrillator / Cardioverter	☐ Time: ___ : ___	
☐ Other *(Specify)*: _____	☐ Time: ___ : ___	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☑ Myocardial Infarction or Ischemia
☐ Unknown
☐ Other: _____

6. RESUSCITATION ATTEMPTED

☑ YES *(Check all that were used)*
- ☑ Chest Compressions
- ☐ Defibrillation
- ☑ Airway Management

☐ NO *(Check one)*
- ☐ False alarm/arrest (BLS / ALS not needed)
- ☐ Do not attempt resuscitation (DNAR)
- ☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS ☐ Yes ☑ No

BREATHING ☐ Yes ☑ No

PULSE ☐ Yes ☑ No

Site: _____

8. INITIAL RHYTHM

☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☑ Bradycardia
☐ Pulseless Electrical Activity ☐ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☐ Returned at: ___ : ___ ☑ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 00 : 54

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☑ Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:	00	40
CPR Started:	00	40
1st Defibrillation:	N/A	
Airway Achieved:	00	40
1st Dose Epinephrine:	00	41

Code Team Called: ☑ Yes ☐ No Time: 00 : 40

Code Team Arrived: ☑ Yes ☐ No Time: 00 : 40

10. GLASGOW COMA SCALE

(Post-resuscitation)

Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
(1) - No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
(1) No response

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
(1) No movement

SCORE: 3

PATIENT IDENTIFICATION

EPW [redacted]

(5)(6)-4

0044 DX
0040 14

[redacted]

(5)(6)-2

AGE: [redacted]

GENDER: Male

HEIGHT (in): _____

WEIGHT (lbs): _____

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Hr/Min):	0040	0044	0046	0048	0050	0052	0054
VITALS	BLOOD PRESSURE	30/10	[illegible]	27/14	28/19	[illegible]/17	85/17	[illegible]
	HEART RATE (* = CPR)	44	63	63	69	54	56	Ø
	RHYTHM							
	PULSE PALPABLE (Y/N)	NO	N	Yes	Yes	yes	NO	NO
	DEFIBRILLATION (Joules: 200, 300, 360)	—						
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—						
	PACING PERFORMED (✓)	—						
	RESPIRATIONS	Bagging						
AIRWAY	BAGGED w / 100% O2 (✓)	✓						
	INTUBATED (✓)	✓						
	MASK (Specify type)							
	% OXYGEN							
	O2 SATS	100%						
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	IV 1mg 0041	1mg IV 0044	IV 0047	IV 0047	IV 0048	IV 0048	IV 0048
	ATROPINE (0.5 - 1 mg - IV / ET tube)	1mg IV 0041	1mg IV 0044	1mg IV 0047	IV 0049	IV 0050		
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)							
	D50	IV bolus 0042						
	Sodium Bicarb	0047	0048	0049				
	Calcium	0050						
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)							
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)							
LABS	POTASSIUM (K)							
	GLUCOSE							
	CALCIUM (Ca)							
	MAGNESIUM (Mg)							
	Chem 7	0042						
	ABG	0042						
ABGs	PH	2.449						
	pCO2	23.9						
	pO2	36						
	HCO3	17						

PHYSICIAN *(Signature & Title)*

NURSE *(Signature & Title)*

[redacted] RT/RN Night Neg Supp

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(5)(c1-2

Admission and Coding Information

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

1. Reporting MTF (b)(2)	2. M ...ion IZ			
3. Register Number (b)(6)-4 [redacted]	Name (Last, First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1978-07-01	7. Age at Admission 25Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 18:10	Branch / Corps:
14. Flying Status NO	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location IZ	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission 62-2 Direct from ER	Ward: ICU1	Name / Relationship of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 [redacted]q; No Install Provided		Address of Emergency Addressee		
		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-02		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-31		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-31		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: DIVERTING COLOSTOMY/ SUPRAPUBIC TUBE PERINEAL DRAINAGE

Procedure Narrative(s):

90387
Dx: 86819
86355
8671
E9912

Rx: 8628
5841
485

Cause of Injury Narrative: GSW BUTTOCKS

Admitting Officer (Signature, ... [redacted] (b)(6)-2

Signature of Admitting Clerk [redacted] SPC, 9/6/10

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 22720

Admission and Coding Information

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

1. Reporting MTF	2. MTF Lo			
[redacted]	IZ			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1984-01-01	19Y	X	9	
10. Length of Service	ETS (b)(6)-7	11. FMP	12. Social Security Number	
		20	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			21:51	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
N/A	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		BC	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - [redacted]aq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-11-09		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AAA - INTERNAL MEDICINE		2003-10-31		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-10-31		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: FRAGMENT WNDS L THIGH

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	

Automated Facsimile - DA FORM 2985, MAR[redacted] MEDCOM - 22721

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

20yo Iraq ♂ s/p multiple fragments wounds to (R) thigh. (Rolling stones).

Purple
Ø
PCMφ
Ø
NKDA
AX
Ø

PHYSICAL EXAMINATION

Pelvis Ø Fx
Femur XRAY = Ø Fx

~~bleeding controlled~~ (R)

(R) thigh
1" x 1" tissue defect

(H) 8
30. 261
29

1.3 INR

127 | 109 | 12
4.2 | 19 | 1.0 (160

LFTwl CK=229

PROGRESS (Enter date of discharge and final diagnosis)

Admit · Abx Amef.
· ~~return to Corp~~

SIGNATURE OF PHYSICIAN [redacted] (b)(6)-2 | DATE 31Oct03 | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S IDENTIFICATION (Typed or written entries give Name: last, first, middle; grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

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

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5NOV03 2000	VSS Alert & Oriented. C/O pain to (L) FA IV site upon flushing saline lock. No redness or swelling noted. (L) FA IV D/C'd. Restarted 18g 1¼ in IV to (L) FA X 1 attempt. (R) Thigh dry dry & intact. (R) Pedal pulses palpable +2. OOB → BR (I) Consumed 75% of regular diet for dinner. Voiding clear amber urine. Will continue care as planned. [redacted] CJ Ar
6NOV03	(1005) Assumed care of pt. Pt alert, speaking Arabic. VSS. ↓ C/O pain. Amb to BR for personal hygiene c difficulty. Drsg to (R) thigh d/d WTD. ↓ S/Sx infection. Pt OOB in chair at this time. SL in (R) forearm flushes well c S/Sx infiltration. Tol. reg diet well. voiding c difficulty. 2 point restraints in place while in bed c S/Sx complications. Will continue to monitor. [redacted] MA
06NOV03 2000	VSS alert & oriented. (R) FA Saline lock patent & intact. (R) thigh dry dry & intact. Consumed 80% of regular diet for dinner. Denies pain or discomfort. (B) Pedal pulses +2 Will continue care as planned [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)(C)		

PROGRESS NOTES
Medical Record

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

MEDCOM - 22723

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7NOV03 1124	VSS. AO. Up ad lib. s̄ difficulty to BR and to ambulate on ward. Did DSG to Ⓡ inner thigh. Wound sight appeared pink & healing well. ∅ s/s infection @ this time. LSCTAB. BS ⊕x4. CR ≤2 sec and ⊕ pulses in all extremities. Voiding light yellow urine, BS s̄ difficulty. Will cont to monitor. [redacted]
7NOV03 2300	Pt A&O Denies pain @ this time. OOB To BR. Ambulates well s̄ assistance. Drsg to Ⓡ thigh CDI Pt in 2 point restraint. Will continue to monitor. [redacted] 91WM6
8NOV03	DSG Δ. Wound pink s̄ D/c; still needs DSG Δ qd. [redacted] awaiting Img Map.
8NOV03 1012	VSS, AO. Performed self care & oral care this AM s̄ difficulty. ⊕ pulse to RLE. DSG to wound Δ'd by MD (see above). Ambulated well to BR this AM s̄ difficulty. [redacted] [signature]
8NOV03 1800	VSS A&O Pt OOBT BR. Ambulates well s̄ assistance. ~~##~~ ⓇLE Drsg c̄ Ace Wrap CDI. ⓇLE Warm & Dry to palpation. cap refil ≤3sec, ⊕ Pulse. ~~##~~ Denies pain @ this time Will cont to monitor. [redacted] 91WM

(b)(6)-2

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

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

MEDCOM - 22724

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 NOV 03 1900-1945	Pt A+OX3, VSS, LS CTA (B), OBS x4, OOB to BR + ambulated in the hall, Ø c/o pain, ace wrap on (R) thigh CDI, pedal pulses +2 equal (B), cap refill <3 sec, ambulates independently ± steady gait, voiding ± difficulties, SL IV (R) ±c intact, Ø s/sx of infex, 2 point restraint ± any complications. [redacted] GW
4 NOV 03 1108	VSS. AM. Ambulated this AM x1 to BR to perform oral care and bathe self. Ø c/o pain @ this time. DSG ± to (R) inner thigh perineal ± diffinitly. Wound remains healing well ± s/s infection @ this time. Ø pulse ± RLE. BS Ø x4. Tolerated PO well this AM. Skin integrity intact ± [redacted] AM
4 NOV 03 2000	VSS Alert & Oriented. (R) Thigh dsg dry & Intact Pedal pulses palpable +2. Toes with brisk capillary refill. OOB → BR independently. (L) FA Saline lock Patent & intact. Consume 50% of Regular diet for dinner. Voids clear yellow urine. No c/o pain nodal noted

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR [redacted]
	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] (5)(6)-4		

PROGRESS NOTES
Medical Record

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

MEDCOM - 22725

5 OCT 03 VSS. A0. Ambulated x 2 to BR and to house for personal use.
1140 ⊕ pulse & CNS to RLE. ⊖ c/o pain @ this time. Jointly light gelo
urine QTY sufficient 5 diffuses. Tolerating PO well. Left to RLE
CDT.

[redacted]

(5)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS N**

DATE	NOTES
31 OCT 03	Pt recieved from EMT via litter, shrapnel
2130	wound to (R) thigh, wound covered c̄ dsg +
	ace wrap CDI, LS CTA (B), (+)BS x4, A+Ox3,
	VSS, ∅ c/o pain or discomfort, IV SL (R) AC
	intact, ∅ s/sx of infex, peripheral pulses +2
	equal (B), pt able to move exts s̄ complica-
	tions, abd soft flat nontender, cap ref
	< 3 sec, S1 S2 present, 2 point restraint
	s̄ s/sx of complications. [redacted]
1 NOV 03	Assumed care of pt. A+Ox3. VSS ∅ c/o pain
0700	or discomfort @ this time. All care given. Lungs
	clear HLRR active BS Tolerating PO. HL (R) AC
	patent flushes well. Remains Afebrile ∅ s/s of infection
	Will cont to monitor. [redacted]
2 NOV 03	assumed care of pt @1800. VSS, no c/o pain. alert, speaking arabic.
@0100	LS CTA, (+)BS, voids difficulty to urinal. (R) thigh dsg CDI, (+)CMS to
	RLE, +2 DP pulses, equal (b/L). (R) AC HL flushes well. IV abx cont.
	2pt restraint on s̄ s/sx of skin/circulation compromise. Plan:
	cont IV Abx, monitor pain & dsg. [redacted]

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

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

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

[redacted] (b)(6)-7

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

MEDCOM - 22727

LAST NAME	NAME	MI	AL	ID NUMBER

DATE	NOTES
11/2/03 0915	Assumed care @ 0600. A & O able to make needs known. VSS. (R) thigh wound drsg Δ by Dr [redacted]. (+) pedal pulse. Nailbeds pink c̄ brisk capillary refill. Moves extremity purposefully. HL flushed ̄ patent to (R) AC. AM care done. Medicated c̄ T#3 two tabs p.o. for pain control R/T drsg Δ. Will continue Abx therapy & pain control as ordered. 2 pt restraint s̄ compromise to skin integrity/circulation. Provide emotional support. [redacted]
11/2/03 1630	Pt ambulating in room c̄ asst for exercise. Denies pain @ this time. Will continue to monitor. [redacted]
2NOV03 2000	VSS Alert & Oriented. (R) AC saline lock patent and intact. (R) Thigh drsg dry & intact. Pedal pulses +2. Toes c̄ capillary brisk. OOB → BR. Consumed 60% of Regular diet for dinner. No c/o pain or discomfort voiced or noted. Will continue care as planned. [redacted]
3 NOV 03 1003	VSS, AO. (R) AC SL. DSG c/d to (R) inner thigh c̄ WTD. ⊖ c/o pain. Ambulated x1 on ward this AM for 15 min. Seen by MD this AM. Tolerated PO well this AM. Wound is healthy pink s̄ s/s infection. [redacted] integrity intact. [redacted]

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Nov 03	#3 (R) thigh GSW
	Dsg Δ today; dried Seras Sangros dressing.
	o/w doing well. Healing [redacted]
6 Nov 03	#7 (R) thigh GSW (b)(6)-2
	Dsg Δ by RN's = ⊗D/C ; Ambulating; ⊗Fevers.
	Pain ↓↓. Healing [redacted]

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

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

REGISTER NO. | WARD NO.

[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

558-104

7540-01-075-378

MEDICAL RECORD — EMERGENCY AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY: DEPMC

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

AGE: 20

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

ARRIVAL

DATE (Day, Month, Year): 31 Oct 03 | TIME: 2200

TRANSPORTATION TO FACILITY: MEDIVAC

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: ϕ

ALLERGIES: ϕ

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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (R) Thigh

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: RAB

INITIALS: 2200

VITAL SIGNS

TIME	2200				
BP	112/66				
PULSE	112				
RESP	20				
TEMP	98.1				
WT					

LAB ORDERS

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

X-RAY ORDERS

CXR PA & LAT/PORTABLE		C-SPINE
ACUTE ABDOMEN		LS SPINE
SINUS		HEAD CT
ANKLE R/L		
✓ FEMUR AP + LAT		

☐ PULSE OX ☐ ECG

ORDERS

TIME	ORDERS	BY	TIME	PATIENT'S RESPONSE
2005	1 gm Ancef	[redacted]		

(b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 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)

MEDCOM - 22730

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP 02	PH	PO2	RESULTS	Femur AP/LAT – ØFB ØFx; pelvis – ØFB ØFx
H/H			PCO2	SAT	OTHER	EKG INTERPRETATION	
PLT			U/A DIP				
PT			MICRO				
PTT	BHCG	ETOH	GLU				

PROVIDER HISTORY/PHYSICAL

20 y/o ♂ c̄ Fragmentation injury to Ⓡ thigh while Rolling Robbing store..

PMH – Ø
PSH – Ø
meds – Ø
NKDA.

B: VS, ... , ...
...

Ⓡ thigh 1" x 1" soft tissue def

Ⓑ PT
Ⓡ DP > Dopplers confirmed

By myself
Dr [redacted] Surgery
(b)(6)-2

A/P Reflex/Pain meds/ Ready 2° status. Return to Clinic. Admit as needed.

b6-2

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
Dr [redacted]			

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

Ⓡ thigh fragmentation injury.

CODES

(b)(6)-2

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

[redacted]

[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)

038

MEDCOM - 22731

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

2 NOV 03 3 NOV 03 4 NOV 03

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

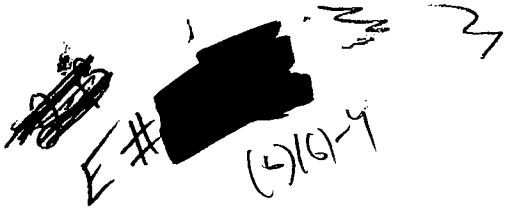
Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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



MEDCOM - 22732

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY 31 1 NOV 2 NOV 3 NOV 03 4 NOV 5 NOV 03 6

HOUR 24 0700 1 1 2 6 7 0 1 4 5 7 8 9

PULSE (0) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

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.

2-L [redacted]

(b)(6)-7

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 22733

(b)(6)-4

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

LAST, FIRST, MI: [redacted] # [redacted] (b)(6)-2 | DATE: 31 Oct 03 | TIME: 2241 | SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Other:

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
Appr		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

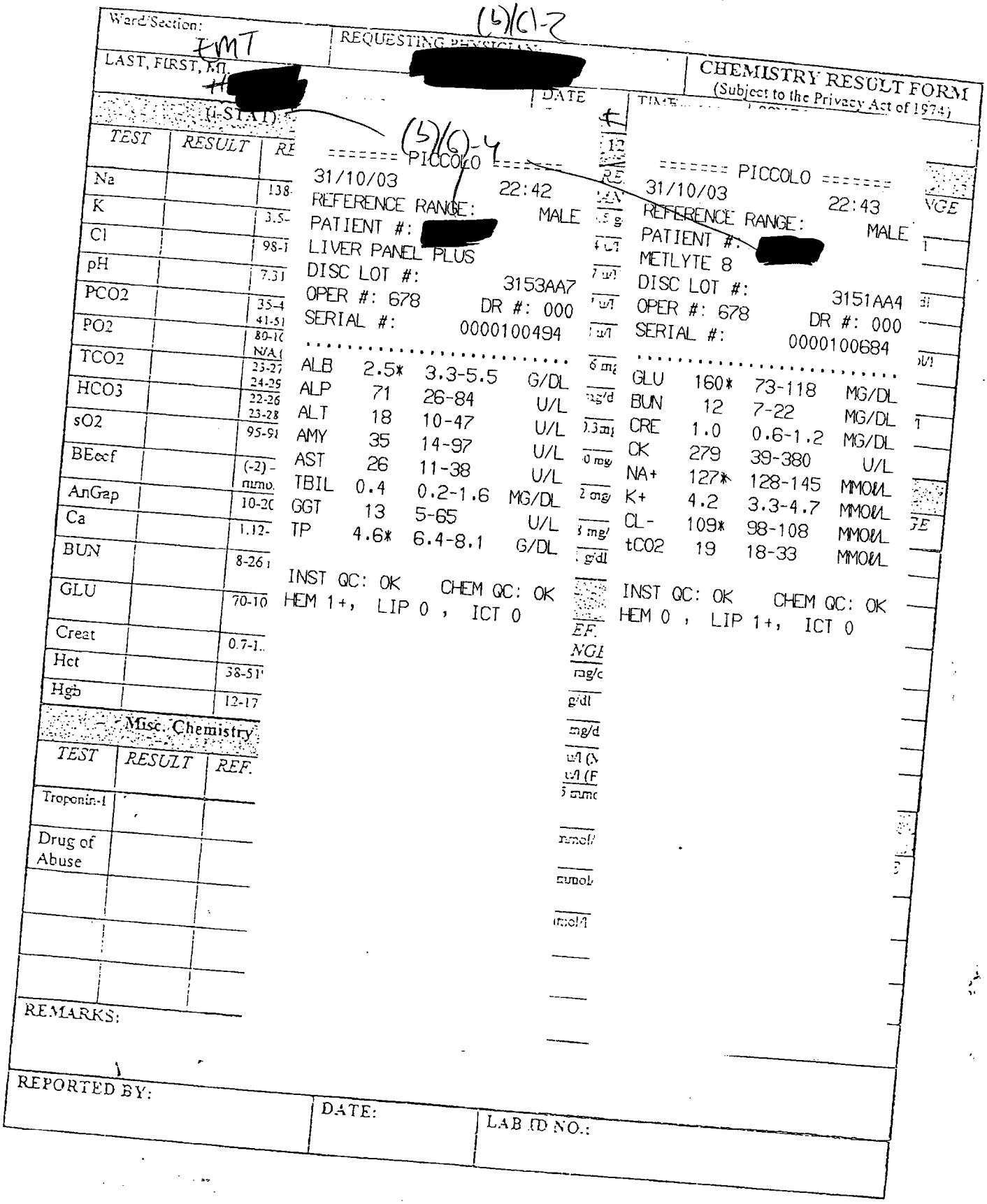
ABO/Rh:

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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



Ward/Section: KMT

REQUESTING PHYSICIAN: [redacted]

LAST, FIRST, MI: [redacted]

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

DATE

TIME

(b)(6)-2

(b)(6)-4

i-STAT

TEST	RESULT	RE
Na		138-
K		3.5-
Cl		98-1
pH		7.31
PCO2		35-4 / 41-51
PO2		80-1(/ N/A
TCO2		23-27 / 24-29
HCO3		22-26 / 23-28
sO2		95-9
BEecf		(-2)-
AnGap		10-2(
Ca		1.12-
BUN		8-26
GLU		70-10
Creat		0.7-1.
Hct		38-51
Hgb		12-17

Misc. Chemistry

TEST	RESULT	REF.
Troponin-I		
Drug of Abuse		

REMARKS:

======= PICCOLO =======
31/10/03 22:42
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: 678 DR #: 000
SERIAL #: 0000100494

ALB	2.5*	3.3-5.5	G/DL
ALP	71	26-84	U/L
ALT	18	10-47	U/L
AMY	35	14-97	U/L
AST	26	11-38	U/L
TBIL	0.4	0.2-1.6	MG/DL
GGT	13	5-65	U/L
TP	4.6*	6.4-8.1	G/DL

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

======= PICCOLO =======
31/10/03 22:43
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100684

GLU	160*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	279	39-380	U/L
NA+	127*	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	109*	98-108	MMOL
tCO2	19	18-33	MMOL

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

REPORTED BY:

DATE:

LAB ID NO.:

MEDCOM - 22735

ID: [redacted] 31-10-03
WB 22:40

			Patient Limits	
WBC	30.1 H	x10^3/uL	4.5	10.5
RBC	3.11 L	x10^6/uL	4.00	6.00
Hgb	8.9 L	g/dL	11.0	18.0
Hct	29.1 L	%	35.0	60.0
MCV	93.5	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	261.	x10^3/uL	150.	450.
LY%	8.9 *L	%	20.5	51.1
LY#	2.7 *	x10^3/uL	1.2	3.4

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:49

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.5 sec.
Ratio = 1.3
Calculated INR = 1.47
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:48
Card Lot :080201
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/31/03 22:52

Patient ID: [redacted]
Test Name :APTT
Test Result:= 18.0 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/31/03
Test Time :22:50
Card Lot :030201
Operator [redacted]

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

1A → [redacted]

NURSING UNIT | ROOM NO. 1040 | BED NO. [redacted]

DATE OF ORDER 31 Oct 03 | TIME OF ORDER ______ HOURS | LIST TIME ORDER NOTED AND SIGN

Adm't = ICW 2
Dx = Frag wounds.
Cond = stable
VS = q shift.
Act = EPW protocol.
All = NKDA
Nursing = DSg. Δ qd

PATIENT IDENTIFICATION

1516-4

[redacted]

DATE OF ORDER | TIME OF ORDER ______ HOURS

Diet = MRE
IV = S.L.
Special = ~~to EPW camp~~
Meds ~~Keflex 500mg QID~~
T#3 ii q 4-6° PRN pain
Ancef 1 gm q 6°

1516-2

NURSING UNIT | ROOM NO. | BED NO.

240/0145 1NOV03

[redacted] MAJ MC

PATIENT IDENTIFICATION

1152

[redacted]

06NOV03

DATE OF ORDER 6 Nov 03 | TIME OF ORDER 1000 HOURS

May d/c to civilian Hosp.

[redacted]

NURSING UNIT | ROOM NO. 1000 | BED NO.

2W8N [redacted]

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 - 22737

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.	MAY Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3	4	5	6	7	8	9	10
31	[redacted]	VS QS	6	[redacted]										
			18											
31	[redacted]	ACT: EPW protocol	6											
			18											
31	[redacted]	Drsg Δ QD	6											
			18											
31	[redacted]	DIET: MRE	6											
			18											
31 Oct	[redacted]	Drsg Δ QD (R) Thigh	D	/	/	/								

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Frag wounds (R) Thigh

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31	[redacted]	admit ICU, stable				[redacted]
06 Nov	[redacted]	May dlc to civ. hospital				
		(b)(6)-2				

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

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. 12/11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31 1 2 3 4 5 6 D7 8 9 10
31	[redacted]	IV: SL	6	[redacted]
	-----		12	
31	[redacted]	Ancef 1gm Q8°	6	
	-----		14	
	-----		20	
	-----	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Fragwounds (R) Thigh

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 **4678**

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 22740

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
31	[redacted]	T#3 #Q4-6° prn pain	D/T 1000 1200 2100 0600 0800
			D/T [redacted]
		(b)(6)-2	

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

#1192

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe: _____

- ☐ Arson (I.P.C. 3-2)
- ☐ 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: _____

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☐ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit:		Location Grid:	
Date of Incident: (D/M/Y) 31/10/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: 2151 hrs

Detainee # [redacted]	Key Connected Person: ☐ Victim ☐ Witness
Last Name: [redacted]	Last Name:
First Name: [redacted]	First Name: Given Name:
Hair Color: Scars/Tattoos/Deformities:	Hair Color: Scars/Tattoos/Deformities:
Eye-Color: Weight: lb Height: in (5)(6)4	Eye-Color: Weight: lb Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/ Sect: Sex: ☒ M ☐ F Phone#: DOB D/M/Y: 20yrs ☐ 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:	Number of People in Vehicle:
Model:	Type:	Plate No.:	
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: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email: Unit Phone: Date: / /	Email: Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? PT claims was looting in abandoned warehouse and was shot by US

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person? AL TAJI Iraq

Additional Helpful Information:

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade FGN	Admission Remarks
4. Sex M	5. Age 19Y (b)(6)-X4	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 20	12. SSN	13. Organization				14. Ward ICW1	
15. FlyStatus N/A	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case BC	
21. Source of Admission Direct from ER			22. Hour Of Adm: 21:51	23. Clinic Service AAA - INTERNAL MEDICINE			
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-OTH	26. Date of Disp 2003-11-09			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-10-31		AdmittingOfficer: (b)(6)-2	
29. ReportingMTF 0580 (b)(2)-2				30. Date Init Adm 2003-10-31		32. Units Blood Components	

31. Selected Administrative Data

Marital Status:

DoB: 1984-01-01

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

FRAGMENT WNDS L THIGH

Dx 890.1 E991.9

Px 99.29 88.29

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending Medical Officer

Signature of PAD or Medical Records Officer E-4

Automated Facsimile - DA FORM 3647, M

MEDCOM - 22744

(b)(6)-2

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] NoFirstNameGiven					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	(b)(6)-4	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICU2	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			DIS			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	07:30	AAJ - NEUROLOGY					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF C-ACF	2003-12-09					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-11-01	[redacted] (b)(6)-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
0580 [redacted] (b)(2)-2		2003-11-01					

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

HEAD TRAMA

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	40	40

35. Total Days This Facility

Absent Sick Days	Other Days	Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	40	40

Signature of Attending Me[redacted]	Signature of PAD or Medical Records Officer
[redacted] (b)(6)-2	[redacted]

Automated Facsimile - DA FOR [redacted] y 79 MEDCOM - 22745

Automated Facsimile

INPATIENT TREATMENT RECORD CO[illegible] SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] NoFirstNameGiven					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	(b)(6)-4	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICU2	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
N/A	K78-PRISONER OF WAR/INTER			DIS			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		07:30	AAJ - NEUROLOGY				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF C-ACF	2003-12-09				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-11-01	[redacted] (b)(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] (b)(2)-2			2003-11-01				

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

HEAD TRAMA

Dx

852.30
876.0
880.01
879.4
728.87
331.3
482.0
482.1
E991.9

Px

99.29
87.44
93.94
87.03

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Da[illegible]	Lv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending [redacted] (b)(6)-2 Signature [redacted] Officer

MEDCOM - 22746

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	PROGRESS NOTES
DATE 2 Dec 03	Nutrition Note: Pt continues poor po intake, unable to meet his EAN on regular diet. Calorie count reveals pt consumed approx 735 kcals one day, 1250 kcals next day, with >50% of kcal intake coming from Ensure Plus. Pt eats min food but will consume Ensure Plus + other fluids if given + if intake is monitored. Pts EAN: 2400-2800 kcals/day (30-35 kcal/kg) + 104-120 g Pro/day (1.3-1.5g/kg). Recommend continuing regular diet + 2 Ensure Plus per meal. 6 Ensure Plus/day will provide 2100 kcals (78g Pro). Remainder of pt's needs can be met through other fluids (milk, juice) + food. Will continue to monitor intake + follow [redacted] (b)(6)-7

wt 80 kg

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11Dec03	~~0700~~ (0330) VSS. ϕ c/o pain. Pt turns on own. Ⓛ sided weakness noted. Δ'ed DSG to upper back. ~~DS~~ Wound on Ⓡ side of back is pink ō yellow layer of tissue. Ⓛ side of back pink. Neither ϕ signs of infection. Voids clear, yellow into urinal ō difficulty. LS CTA. Ⓐ Bowel sounds. 2 pt restraints. ϕ signs/symptoms of skin compromise. [redacted] LT/MAN
11Dec.03 0700	Assumed care of pt, Alert, VSS, OOB → BR x2, BM x2, ambulates = assistance, weakness to Ⓛ side of body, dsg's to upper back i'd, wound Ⓡ upper back appears = s/sx of infex, minimal drainage WTD = Dakins solution, c/o pain + head ache, adm #11 T#3 for pain relief. LSCTA Ⓑ, Ⓐ BS x4. [redacted] 9IX
0925	Pt given #11 Tylenol #3 [redacted] Order continue to monitor [redacted] 11WLC
11Dec03	(2100) VSS. C/O HA. Pt asleep at time. Will continue to monitor pain. Δ'ed DSG to upper back ō Dakin's solution. Wounds ϕ signs of infection. Wounds pink ō minimal drainage. Wound on Ⓡ upper back has yellow drainage. Will monitor. Pt has Ⓛ sided weaknesses. Pt turns on own. 2pt restraints in

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV
Prescribed by GSA/ICMP FPMR (41CFR) 101-11.3
USA

(b)(6)-4 [redacted]

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9Dec03	-Assumed care of pt. A#003. VSS & c/o pain or dis-
1040	comfort @ this time. Lungs clear HRRR Active BS x4 quad's.
	Urinating spontaneously into urinal Tolerates p.o. well
	Wound to (R) shoulder dsg CDI wet & dry c 1/4 dakin solution
	Transfer from ICW #2 per wheelchair dx s/p craniotomy
	has (L) side weakness Fall precautions in place Unsteady
	gait. 2 point restraint EPW protocol & s/s of breakdown
	Will cont to monitor [redacted] 9LWM6
9Dec03	Assumed care of Pt @ 1800. VSS A&O c/o pain controlled
	c T#3. LS CTA (B), HRRR. (+) pulses in all extremities Skin Warm
	+ Dry to Palpation. (+) BS x 4 quads. Pt consumed 100% of
	meal. Void spontaneously c/w c difficulty qs. Dsg Δ to (R)
	shoulder c Dakins solution. Wound on (R) shoulder is
	3" x 5" down to muscle tissue has yellow Brown Fatty
	globbular appearance. [redacted] Fall precautions in effect. Pt in
	2 point [redacted] restraints. Will cont to monitor.
	[redacted] 9LWM6
10Dec03	VSS. A&O Consumed 30% of breakfast. Wounds
	to upper back shoulder area. (R) side pink pale
	moist tissue. (R) side edges wound tissue dusky
	pink color but moist. Voids clear yellow urine
	(L) Sided Weakness noted. Repositions c assist for
	staff Q2 hr Comfort. Fall precautions in progress
	Will transfer c +2 assist. 2 point restraints
	in place without compromising circulation
	or skin integrity. Will continue plan of care.
	[redacted] 7PA

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(cont) place c ϕ signs of skin compromise. [redacted]
Dec 12,03 0900	Medicated c / #3 two tabs for c/o head pain. A&O able to make needs known. Will continue to monitor. Falls [redacted]
Dec 12,03 1100	Pt Alert, speaking [redacted] arabic, c/o moderate pain to upper back, dsg upper back s/d, wounds appear pink ϕ s/sx of infex, small amount of drainage WTD dsg c Dakins solution, weakness of (L) side due to head injury on (R) side of head, ϕ complications voiding. [redacted]
1415	Pt given 1 tylenol #3 for pain. [redacted]
12DEC03 2100	assumed care of pt @ 1800. VSS. c/o pain to (R) occipital/temporal lobe near incision site. T#3 tabs given c good relief noted. LSCTA, @BS, tol reg diet well, void c difficulty. AtoX3, PERRLA, ϕ difficulty speaking. (+)CMS to all extremities c exception c movement to LLE/foot. Strength equal BUE, RLE strength 7 LLE. LLE drags during ambulation. (R) shoulder & back wounds healing well, WTD completed c Dakins Soln, wound bed c red granulation (CONT)

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20
USAPA

[redacted] (5)(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12DEC 2100	(CONT) tissue noted. Dry dressing applied to RLE calf wound, ⊖ drainage noted. 2pt restraints on s̄ S/Sx of skin/circulation compromise. Plan: monitor neuros, enc po, enc OOB, enc independence. Will monitor. [redacted]
12/13/03 1400	VSS. AO. PERRLA. OOB to BR and showered c̄ minimal assistance. DSG Δ's performed to Ⓡ shoulder Ⓛ shoulder and Ⓛ calf. Ambulated to BR c̄ minimal assistance Δ'd linens. Voiding spontaneously. [redacted] ø S/S skin breakdown. [redacted]
14DEC03 2100	assumed care of pt @1800. VSS, no c/o. alert, speaks clearly in arabic, PERRLA, BIL UE equal in strength, LLE < RLE in strength. amb while dragging LLE. Ⓡ shoulder & back wounds healing all 3 wound beds c̄ pink, granulating tissue noted. Drsgs Δd as ordered. LS CTA, ⊕BS, tolerating reg diet well, voiding QS s̄ difficulty. T#3 tabs given for pain c̄ good relief noted. 2pt restraints on s̄ S/Sx of skin or circulation compromise. Plan: enc OOB, enc po, monitor neuros. [redacted]
2100 -	assumed care of pt. @1800. VSS - AO ø c/o pain or discomfort @ this time. T1 tylenol #3 given @2000 for pain. ⊕ relief. Pt. OOB → chair x20 mins. Pt. stated he wanted to get back in bed. Ⓡ shoulder + back wounds healing well. ø s/sx infection. WTD c̄ .025 dakins solution. Dry dsg to Ⓡ calf. ø s/sx infection. Tol. dsg Δ well. voiding q yr ulaurinal s̄ difficulty. ^CP^ TT Two point restraints in place per ... protocol. Will cont to monitor pt. [redacted]

BACK

MEDCOM - 22751

ACLU-RDI 1673 p.111

DOD-036327

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
15 DEC 03 0600 entry from 17/14/03 @ 0900	VSS. AO. LSCTAB. HRR. Ⓓ pulses to all extremities. PERRLA. BS Ⓓ x4. SORT ambulate to BR = moderate assistance. Placed in chair for 25°. PROs d's performed to Ⓡ shoulder, Ⓛ shoulder and Ⓡ calf = stiffness. Ø s/s infection. Ø s/s of skin breakdown [redacted] Unit to monitor as pt. wish. —
12/15/03 0200	VSS. AO. Wound to Ⓡ shoulder leaky pink = s/s infection. W70 to Pt's shoulder and covered VSS's to Ⓛ shoulder and Ⓡ calf. CMS intact. OOB to ambulate = walker for 20 min = PT. Wounds healing well. Ø s/s skin breakdown to patient. [redacted] (5)(6)-1
0245	assumed care of pt. @ 0200. VSS-WNL. Ø c/o pain or discomfort @ this time. compl deg Δ to Ⓛ + Ⓡ shoulders + Ⓡ calf. Pt. tolerat well. wounds leaky pink = s/s inf. Pt. voiding cyu w/ urinals difficulty. Pt. constantly standing up beside bed trying to walk. Placed pt in 4pt. restraints for safety. Ø skin breakdown Ⓓ circulatio will cont. to monitor pt [redacted]

RELATIONSHIP TO SPONSOR 16 DEC 03 0200 | I concur c above | SPONSOR'S NAME (LAST, FIRST) assessm

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 56
Prescribed by BUMED/MARINE CORPS

[redacted] (5)(6)-4

MEDCOM - 22752

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16DEC03 1100	VSS AFO OOB → BR to shower prior to dsg changes to upper back area. Tissue to wound grafts pink + moist to (R) upper back. Consumed 20% of Breakfast Ambulated to BR c walker (I) with NP supervision. C/O pain HA Tylenol #3 given and effective. 2 pt restraints replace without compromising circulation or skin integrity. Will continue planned care. [redacted]
17DEC03 0340	-assumed care of pt @ 1800. VSS- AFO. Pt. has Ø c/o pain or discomfort @ this time. completed dsg Δs to upper back c .025 dakins solution. Ø S/Sx inf. healing well. pt consumed 50% dinner. Encouraging PO. voiding Dark yellow urine via urinal. c/o pain @ 2300. IT Tylenol #3 given. (+) relief. Pt asleep in bed @ this time in two point restraints per epic protocol. (-) Skin breakdown (+) Circulation. Will cont [redacted] to monitor pt
17DEC03 0500	VSS AFO OOB c walker to [redacted] assist x staff. Tylenol #3 2 tabs PO given for c/o pain HA. Consumed 30% of Breakfast. Dsg Δ to wound to (R) upper back. 2 pt restraints replaced without compromising circulation or skin integrity. Will continue plan of care. [redacted]
	Assumed care @ 1800; VSS, pain controlled c T3's, pt alert speaking arabic; dsg to (R) shoulder Δ'd w → D c Dakin's sol. Ø drainage, Ø S/Sx

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
	(Cont) infection; pt TOI Reg diet, voiding ~~S difficulty~~; Pt OOB to amb c walker assistance ~~S difficulty~~; Restraints in place ~~S~~ compromise to skin/circ; will cont to monitor [redacted]
18 Dec 03 0800	VSS A&O. Tylenol #3 given for C/O HA. OOB c walker & BR for AM care. OOB to chair To Breakfast. Consumed 10% of Breakfast & pert restraints in place while seated up in chair. Restraints applied without compromising circulation or skin integrity. Will continue plan of care. [redacted] USN
19 Dec 03 0525	Assumed care @ 1800; VSS, pt alert speaking arabic; C/O pain; pt dsg to back Ad. WSD c Dakins, site pink, beefy, healing well; ⊖ drainage ⊖ s/sx infection; pt OOB to amb c walker assistance; pt TOI Reg diet, voiding S difficulty; Restraints in place ~~S~~ compromise to skin/circ, cont to monitor [redacted]
19 DEC 03 @ 1430	Assumed care of pt. @ 0600. VSS, A&O. Pt. C/O pain to head, ~~PRN~~ T3's given PO. WTD DSG Δ to ⊙ upper back, wound pink & moist, mod. serous drainage to old dsg. Pt. OOB → BR, ⊕ BM, voids C&U S difficulty. Pt. given shave & haircut. Pt. ambulates S walks well, ⊙ sided weakness. Pt. in 2-point restraints, ⊖ S/Sx of skin breakdown. [redacted]

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

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

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

PROGRESS NOTES
Medical Record
STANDARD FORM 3[illegible]
Prescribed by SECNAVINST [illegible]

[redacted] (5)(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Dec03 0230	Assumed care @ 1800; VSS, pt alert speaking arabic; pain controlled ± Tylenol; dsg to (R) shoulder Δd w→D ± Dakins sol. ⊖drainage, ⊖S/Sx infection; Pt OOB to amb in hall ± use of walker, tol well; voiding ± difficulty; Tol Reg diet; Restraints in place ± compromise to skin/circ; cont to monitor [redacted]
20 Dec 03 @ 1600	Assumed care of pt. @ 0600. VSS, RAO, Tylenol 650mg x 1 this shift for C/O HA. Pt.'s abd. hard, slightly distended, BS hyperactive. MD informed, pt. given 30cc M.O.M. @ 1100. ⊕BM @ 1400, abd. non-distended & soft. Pt. OOB to BR ± assist, Ø walker. Voids C+U ± difficulty. WTD DSG Δ ± DAKINS sol. this AM, pink & moist, mod. yellow drainage, Ø S/Sx of infection. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL. [redacted]
21Dec03 0530	Assumed care @ 1800; VSS, [redacted] pain controlled ± Tylenol; pt OOB → BR X S, ⊕ loose stool D/T M.O.M. on previous shift; W→D dsg Δd to (R) shoulder ± Dakins; ⊖S/Sx infection; pt Tol Reg diet, voiding ± difficulty; Restraints in place ± compromise to skin/circ; Cont to monitor [redacted]
21Dec03 1030	Pt A+Ox3, VSS, LS CTA (B), ⊕BSx4, OOB → ambulate, weakness of (L) side, tol well, D'd dsg on (R) upper back, scant amount of drainage, wound appears pink, Ø S/Sx of infex, Dakins solution applied to dsg, voiding C+U ± difficulties. [redacted]
1100	Pt d/c to HA [redacted] will reassess [redacted]

STANDARD FORM 509 (REV. 5/1999) E.
USAPA

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2 DEC @ 0030	Assumed care of pt @ 1800. VSS, pt. asleep, ↑ T 3's for C/O pain to back & HA, WTD DSG Δ to (L) upper back ± Dakins sol., min. serous drainage, wound pink & moist, Ø S/Sx of infx. Pt. OOB to BR & ambulated in hallway ± assist. Pt. has mild (R) sided weakness. Pt. tol. regular diet well. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL, Will cont. to monitor. [redacted] CT AM
22 Dec 03 0945	Pt A+Ox3, VSS, LS CTA (B), +BSx4, OOB → BR ± minimal assistance, dsg (R) upper back d'd, wound healing well, scant amount drainage, Ø S/Sx of infx, pink appearance, voiding ↓ difficulties, weakness to (L) side of body, pt [redacted] (b)(6)-2 expressed he feels more strength to (L) side of the body than before, good appetite, Ø S/Sx of skin breakdown [redacted] (b)(6)-2 AM
3 DEC 03 @ 0050	Assumed care of pt. @ 1800. VSS. A&O during assessment. ↑ T 3x's this shift for C/O pain to upper back wound. Pt. asleep @ this time. Pt. reports limited vision to (L) eye. DSG Δ to (R) upper back, WTD ± DAKINS, pink & moist, yellow exudate to old dsg. Ø S/Sx of infx. Pt. ambulates ± min. assist. to BR. Pt. voids C ↓ U ↓ difficulty. (cont.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)(i)
USAPA V1.00

NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE | NOTES

23DEC03 (cont.) Pt. tol. reg. diet well. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. [redacted] 2LT, AOC

23Dec03 1100 Pt AtOx3, VSS, LS CTA(B), DBSx4, c/o pain to upper (R) back, T#3 adm for pain relief, wound on (R) upper back pink + moist, healing well, Ø s/sx of infex, weakness to (L) side, strength improving, c/o vision impairment decreasing on (L) eye, unable to identify far objects, able to see from close, consumed 80% of breakfast, Ø s/sx of skin breakdown, OOB → BR by self. [redacted] RN (5)(6)-2

1540 Pt had episode of (R) side chest pain, expressed that pain began on (R) upper back on wound area and radiated to the front, VSS, ↑ BP + P, SPO2-100%, BP- 131/70, P-102, cool to touch, Breath Sounds CTA (B), S,Sx present, portal CXR ordered, MD notified. [redacted] RN

STANDARD FORM 509 (REV. [illegible])

[redacted] (5)(6)-4

MEDCOM - 22757

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
23DEC03 1634	Neurosurgery (S) VSSA. Sats > 98% on RA. (O) Chest discomfort in pectoral region. (E) Scapular area granulating well. Lungs clear. C&R clear. Abd benign. (A/P) Stable - pt PRN. Chest clear - pt reassured no underlying pathology. Continue NH care / dressings for wound.
24DEC03 (0145)	Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c T3s. Dsg to @ shoulder c/d WTD c Dakin's soln soaked 2x2 and covered c 4x4. Pt amb in hallway: gait becoming more steady. TD. reg. diet well. voiding s difficulty. 2 point restraints in place s S/Sx complications. Will continue to monitor.

[redacted] (b)(6)-2

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

MEDCOM - 22758

24DEC03 assumed care of pt @0800. VSS. c/o pain to (R) back wound,
@1040 controlled c T#3 tabs. neuros unchanged alert, follows
commands well, MAE c slight (L) leg drag. LSCTA, (+)BS,
tol reg diet well, void s difficulty. (R) shoulder/
back wound c WTD dsg, wound s drainage, red &
beefy. (R) head incision healed. 2pt restraints
on while in bed, ø s/sx of skin/circulation compromise.
Plan: enc po, enc OOB, monitor neuros. [redacted] RN

25 Dec 03 @0415 Assumed care @1800; VSS, pain controlled c tylenol II tabs; pt A&O speaking
arabic; pt OOB to amb in hall, amb c slow, steady, slightly shuffling
gait; pt transferred to Rm 7; dsg to (R) shoulder Δd w→D c Dakins
ø drainage, ø s/sx infection; ø Δ NV; Restraints in place s
compromise to skin/circulation, cont to monitor [redacted]

25Dec03 Assume care of PT @0600. VSS, A+O ø c/o pain today.
1512 Ambulate to bathroom s difficulty. Δ'ed dsg to (R) side
upper back c dakins sol w→D. Had nose bleed earlier in the
day, was maintained. In 2pt restraint s skin breakdown.
Will cont. to monitor. [redacted]
I concur c above assessment [redacted]

25Dec03 (2340) VSS. c/o pain to head. Med c 2tab Tylenol #3.
3 hrs p pt cont to c/o of Headache. V.O. from
Dr. [redacted] for T#3. Med given. Will continue to
monitor. PERRLA. Neuros intact. Pt amb to BR c
steady gait. OOBTC ~2 hrs. Tol Well. Δ'ed DSG
to Back c Dakins solution. Wound appears pink c
ø signs of infection Will continue to monitor.
[redacted] RN/PN

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
26DEC03 @0915	Pt c/o ↑ loss of vision to (D) eye. also c/o pain moving from "back of head to front of head." & the pain "not improving." Pt states he thinks his (L) leg is weaker & "getting worse." Will notify MD. VSS. Will monitor. [redacted] (b)(6)-2 SM2
26DEC03 0945	MD@BS. CT ordered for today.
26DEC03 1134	Neurosurgery (S) c/o gradually ↑ HA over past several days/weeks. Subjectively, (L) VF watering / c/o ↑ more clumsy. CT head performed today. Ventricles mildly enlarged. LP performed. OP 18 cm H_2O, 50 cc clear, colorless CSF drained, CP 8 cm H_2O. Pt reports improved headache. Will send CSF & leave in bed x 6 hrs. (A/P) Post-traumatic hydrocephalus Inc/s of CSF tap. Cx to be evaluated. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (Last, First) | SPONSOR'S SOCIAL SECURITY NO. (SSN or Other)

DEPART. SERV. ID | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 REV. 8/85

[redacted] (b)(6)-4

26DEC03 1200 VSS. MD @ BS, performed LP. (See note.) Pt tol procedure well. Percocet given for back pain (near LP site). Pt states he does ∅ have h/a. BR for 6°, until 1730. LSCTA, ⊕BS, tol reg diet well, void QS ̅s difficulty. 2pt restraints on while in bed. Ⓡ back/shoulder wound healing, beefy red ̅c ∅ drainage. WTD dsg completed. Plan: BR. Pain control prn, monitor h/a. Will monitor. [redacted]

26DEC03 - 1507. Neurosurgery.

CSF Came back GPC on Gram Stain. I think this is a contaminant. Will observe. [redacted]

26DEC03 - 2240 - VSS. c/o HA. Med ̅c 2 perc. Will monitor. PERRLA. Follows directions appropriately. Amb to BR ̅c cane. ↑ weakness to Ⓛ foot noted. Pt drags Ⓛ foot. Dr. [redacted] notified & aware. Pt had large BM. Δ'ed DSG to upper back ̅c Dakin's solution. Wound appears pink. LP site covered ̅c bandaid. CDT Will continue to monitor. [redacted]

27DEC03 1200 VSS. AO. DSG Δ'd to Ⓡ shoulder. Beefy pink and pink margins. ∅ s/s infection. Other wounds OTA. Wound size: 12 cm x 4.5 cm approximately. Medicated c/o HA. Will monitor and provided relief. OOB to BR @ times for voiding spontaneously and oral care. but ̅c Ⓛ sided weakness upper & lower extremity. CNS intact. [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
28 DEC 03 @0130	Assumed care of pt. @ 1800. VSS, A&O. ÷ii Percocet for C/O pain to back & HA. Pt. reports Ø vision to Ⓛ eye & Ⓛ sided weakness, WTD DSG Δ to Ⓡ upper back c̄ Dakins sol., thick yellow exudate to old dsg, wound pink & moist. Pt. C/O itching to back, pt.: back scratched & lotion applied. Pt. tol. reg. diet well, ⊕ BS all 4 quads. Void CYU s̄ difficulty. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] LT AN
28 DEC 03 0800	VSS, AO. OOB ther Ast and ambulated to BR to perform oral care, wash and to toilet. c/o HA and provided 2 percocets for relief. Still stated not having vision to Ⓛ eye. Continued weakness to Ⓛ side - arm & leg. Gait remains unsteady c̄ use of cane. Voiding spontaneously CYU s̄ difficulty. [redacted]
0900	c/o constipation and provided ① Bisacodyl suppository and encouraged to drink water more often. Pt understood through use of interpreter. [redacted] (b)(6)-2
28DEC03@2310	Assumed care of pt. @ 1800. VSS, A&O. ÷ii Percocet [redacted] pain to back and head. ÷ Ambien given for sleep. Pt. C/O constipation early in shift. ⊕ BS all 4 quads, abd. firm. Pt. given DULCOLAX suppos.

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

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

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 11-77)
Prescribed by GSA/ICMR FPMR 101-11.806-8

[redacted] (b)(6)-4

28 DEC (CONT.) PR. ⊕ BM x 2, Pt. reports relief of constipation, Pt. tol. reg. diet well, Voids C4U ̄s difficulty. WTD DSG Δ ̄c Dakins sol. to Ⓡ upper back wound, yellow exudate to old DSG, wound pink & moist, Ø S/Sx of infection, Pt. ambulates ̄s assistance, Ⓛ sided weakness noted, ~~fingers~~ (ERROR) m.r., drags toes to Ⓛ LE, Small blister noted to Ⓛ temporal scalp, 2x2 applied, scant sang. drainage, Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. —— [redacted] 1LT, AN

12/29/03 1450 VS: AO. DSG Δ'd to Ⓡ shoulder. Beefy, pink — Ø s/s infection. Slight bleeding to scalp @ Ⓛ occipital and placed 2x2 ̄c [illegible]. Ambulated x2 on ward. BR x1 for BM. Med for constipation. Cont to have trouble seeing objects distinctly ̄c Ⓛ eye. Cont Ⓛ sided weakness. —— [redacted]

~~229~~ Assumed care of pt @ 1800 VSS A&O LSCTA

29Dec03 ⒮ ⊕ BS x4 quads. Voids qs <x2 ̄s difficulty c/o pain to head. Incision to scalp healed will cont to monitor. Dsg to Back Δ'd. Wound is healing well. —— [redacted] SWMC

30DEC03 1100 assumed care of pt @0600. VSS. [illegible] earlier this AM, controlled ̄c percocet tabs. LS CTA ⊕ BS, tol reg diet well void ̄s difficulty, maintains Ⓛ LE weakness noted when ambulating → pt drags foot slightly. Conts to have some vision problems to Ⓛ eye, states vision is blurry. Ⓡ back wound drsg Δd, wound bed pink c fibrous tissue/drainage. 2pt restraints on while in bed. Plan: enc po, enc OOB, monitor [illegible] —— [redacted]

MEDCOM - 22763

ACLU-RDI 1673 p.123

DOD-036339

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30Dec03	(2345) Assumed care @ 1900 Pt alert, speaking Arabic. VSS Pain controlled c Percs. Pt OOB to amb in hallway. Gait slightly unsteady. Used care to amb while in room. Dsg to (R) shoulder CDI WTD c Dakin's soln. Wound pink and moist c yellow exudate. Tol. reg. diet well. Voiding s difficulty. 2-point restraints in place s S/Sx complications. Will cont. to monitor. [redacted]
31Dec03 @1430	assumed care of pt @ 0600. VSS, ~~140~~ 96 n/a, medicated with Percocets c good relief noted. Alert, oriented, speaks arabic, PERRLA, (BIL) UE equal in strength, (L) LE < (R) LE in strength, UE shows difficulty c plantar flexion, evident in gait, pt drags toes. Pt stated through interpreter he feels worse since LP, LE strength is less s n/a continues. Wished to speak to MD. LS CTA, +BS, tol reg diet, void s difficulty. 2pt restraints on s S/Sx of skin/circulation compromise. Plan: enc OOB, enc PO, monitor neuros. [redacted] Addendum: Pt ↑ amb in hallway, pushing roommate in W/C, tol well. [redacted] Tan

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. ICU

[redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 22764

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31DEC03 1630	MD to BS, pt stated he had 0 issues @ this time contradictory to what pt told nursing staff. MD started pt on requestin for HA pain. [redacted] CRR
31DEC03	(2330) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. H/A pain controlled c Percs. Pt amb to amb in hallway c care - tol. well. Given Bisacodyl suppository for c/o constipation. 0 BM this shift. Pt sleeping @ this time. Dsg to R shoulder CDI - wound pink/moist c scant yellow exudate. Tol reg diet well. Voiding c difficulty. 2-point restraints in place c s/sx complications. Will cont. to monitor. [redacted]
1JAN04	1410 - Assumed care of pt @ 0800. VSS - A+O x4 watching arabic playing cards c roommate. amb to ambulate in hallway x30 minutes. (+) BM this am. Pt. tolerated breakfast well but refuses lunch. voiding clear yellow urine c difficulty spontaneously. Completed dsg change to (R) side of upper back. Wound pink and moist c s/sx infection. Pt has no complaints at this time. - In bed resting c two point restraints @ this time (+). Circulation (+) skin breakdown. Will continue to monitor pt. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDCOM - 22765

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2Jan04	(0240). VSS. ∅ c/o pain. Amb c steady gait. (L) ft drags slightly. PERRLA. A'ed DSG to upper back c Dakin's. ∅ signs of infection. Tol PO well. Voids CYU. Pt c/o ∅ BM. Administered Dulcolax pr. ∅ BM at this time. Will continue to monitor. [redacted] PT/AW
2Jan04	1800- assumed care of pt. @ 0000 VSS-A+O ∅ c/o pain or discomfort. Pt. c/o constipation. 30cc mom given as ordered. Will monitor Pt. Pt. ambulated in hallway x1 hr. Tol well. slightly drags (L) foot. completed dsg Δ. 1000 wound moist/pink healing well ∅ s/s/s infection. Voids CYU via urinal. Resting in bed c two point restraint (+) circulation (-) skin breakdown. Will continue to monitor plc [redacted]
2Jan04	1900- ∅ (-) BM. Gave pt. One bottle [redacted] c trace @ 0000. Pt. had (+) BM x3. [redacted]
1800	Pt c/o severe abd. pain [redacted]
03Jan04	(0245) VSS. c/o pain x2. Both times med c 2 perc. Pt amb on ward. (L) ft drags slightly. Maintains steady gait. Voids CYU. Pt had sm. BM. Tol PO well. A'ed DSG to upper back c Dakin's ∅ signs of infection. Will continue to monitor. [redacted] PT/AW
03Jan04	1500- assumed care of pt. @ 0000. VSS-A+O. c/o headache. IV tylenol given. Pt. refused meds. Pt. still in bed c/o pain @ this time. ambulated in hallway this am x1 hr. drags (L) ft. slightly. completed dsg Δ to upper (R) back.

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1102

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(cont'd)	pink + moist c̄ ø s/sx inf. Voiding cyu via urinal ⊕ BM today. Tolerates PO well. Pt, in bed @ this time c̄ two point restraints in place. Will continue to monitor pt [redacted]
04JAN04	(0930) VSS. C/o pain. Med c̄ 2 percocets. Amb on ward. St ↓ mobility to Ⓛ Ft. Tol PO well. ⊕ BM in PM. PERRLA. Moves extremities appropriately. Follows command. Voids clear yellow urine s̄ difficulty. Will continue to monitor. [redacted]
4JAN04 @0900	Falls risk assessment: Due to pt's diagnosis s̄ residual effects from surgery pt needs stand by assist when first getting in/OOB. Pt amb well c̄ cane. Will cont. to assess [redacted]
4Jan04	1400 assumed care of pt. @ 0800 VSS - Afeb ø c/o pain or discomfort @ this time. Found 0800 med oxycontin 30mg in/underneath pt. mattress. Refused medication. Ambulated x 30mins. Still slightly drags foot. Tolerates Reg diet voids cyu. Will cont to monitor pt [redacted]

(b)(6)-2

RELATIONSHIP TO SPONSOR [redacted] SPONSOR [redacted]

FIRST | MI

(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.

PROGRESS NOTES
Medical Record

[redacted] (b)(6)-4

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MEDCOM - 22767

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6 Jan 04 1730	Rec'd report on pt and assumed care. Dsg Δ to (R) ↑ back c̄ dakins solution. Area pink (−) packing needed. Lungs CTA (B) BS. Pt rec'd pain med @ 1645. Ambulated in hallway c̄ pt # 1128. (−) skin breakdown under 2-point restraints. Continue to monitor [redacted] 91W M6
Jan 04 @ 0100	Assumed care @ 2200; VSS, ∅ c/o pain, pt A&O, pt OOB to amb in hallway, tol well; Dsg to upper back Δ'd W-D c̄ Dakin's Soln, ∅ drainage, ∅ s/sx infection; pt voiding s̄ difficulty, tol Reg diet; Restraints in place s̄ compromise to skin/circ; cont to monitor [redacted]
1/7/04 0520	VSS. WNL. AO. Mild c/o HA. Provided 2 percocet for pain. Up ad lib this AM. All other systems WNL. ∅ change in CNS status. DSG Δ'd to wound to (R) shoulder. Wound is beefy pink and healing well. ∅ s/s infection. ∅ s/s skin breakdown. [redacted]
07 JAN 04 1953	Neurosurgery Pt suffered a seizure this evening with Todd's (L) paresis/confusion after. Will load with Dilantin. [redacted]
7 Jan 04 2012	Rec'd report and assumed care @ 1400. Pt ambulated in hallway. C/O constipation given MOM per MD order. Pt had BM. Upon returning to bed Pt had seizure which lasted @ 90 sec. Dr [redacted] called. Suction @ bedside VS 146/82 P130 - POx 98%. Pt given Dilantin per MD order. Confused but follows instruction. Will monitor - [redacted] 91W M6

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4Jan03 2200	Pt sitting up in bed. C/O mild pain. Pt given 1 percocet @2115 per MD order. Pt ambulated to BR [redacted] assistant. Will continue to monitor [redacted]
5Jan04@0430	Assumed care @2200; VSS, Ø C/O pain, 10mg Ambien for sleep; pt OOB to amb in hallway; dsg to back Δd w→D [redacted] Dakin's 3D Restraints in place [redacted] compromise to skin/circ; will cont to monitor [redacted]
1/5/04 1430	VSS, AO. Mild c/o pain this AM. Provided relief. All other systems WNL. Encouraged PO intake. Ate <40% of AM meal. 50% of lunch. Ø s/s skin breakdown. [redacted]
5Jan04@2400	Assumed care @1800; VSS, pt AEO; pain controlled [redacted] PCCS; pt OOB amb in hallway, tol well; dsg to back Δd w→D [redacted] Dakin's Soln; Ø Δ in assessments Restraints in place [redacted] compromise to skin/circ, cont to monitor [redacted]
1/6/04 1053	VSS, AO. Mild c/o HA this AM and provided 2 percocet. OOB to ambulate [redacted] wheelchair. [redacted] difficulty. Tolerating PO this AM <50%. Voids, spontaneously [redacted] difficulty. Ø s/s skin breakdown (D) stump dressing Δd [redacted] c/o pain. Wound is pink, moist [redacted] exudate. [redacted]

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

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

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PROGRESS NOTES
Medical Record

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AST NAME	FIRST NAME	MIDDLE IN.	ID NUMBER

DATE	NOTES
3Jan 1645	compromise. Cont to monitor - [redacted] PN
JAN04@0330	Assumed care of pt. @ 2200. VSS. A&O at time of assessment. Pt. given ✝✝ Percocet for c/o pain to head. WTD 036 Δ c Dakins sol. to ® upper back wound, pink & moist, mod, serous drainage, Ø S/Sx of infx. Pt. sleeping @ this time. Pt. in 2-point restraints Ø signs of skin breakdown. WNL other assessments WNL. Will cont. to monitor. [redacted] LT, AN
09Jan04 0930	VSS. A&Ox4. Pt adl c cane & ambile to BR for AM care. ® upper back wnd pink & moist. Old dsg saturated with serosanguinous drainage. Consumed 100% of Breakfast. Consume 100% of Ensure. Skin intact except for wound. 2 point restraints in place without compromising skin integrity or circulation. Will continue plan of care [redacted] RT
9Jan04 1645	Pt A&O, VSS, ® upper back dsg dcl, wound pink & moist c serous drainage. amb. c cane x 2 in hallway. Ø sided weakness cont. Øc/o pain. Ø seizure activity noted. 2 pt. restraints on 3 compromise. Cont to monitor [redacted] PN
10JAN04	(0001) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. HA pain controlled c Percs. Dsg to shoulder dcl clt pt d/c old dsg. wound pink, moist. Pt amb to amb in hallway while pushing roommates WC. Drags @ foot slightly. 2 point restraints in place 3 SSx complications. will cont.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 JAN04 @ 0415.	Assumed care of pt. @ 2200. VSS. Ø C/O pain. Pt. C/O constipation, ↑ Bisocodyl supp. PR. ⊕ BM. Pt. expressed relief of constipation. LS CTA bilat. HRR. ⊕ BS all 4 quads. Voids C7U ̄s difficulty. Pt. ambulated in hallway, slight limp, mild Ⓛ sided weakness. WTD dsg Δ ̄c Dakins sol. to Ⓡ upper back wound., mod. serous drainage, wound pink & moist, Ø S/Sx of infx. Pt. in 2-point restraints in bed, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. —— [redacted] LT, AN
8 Jan 04 0700	VSS A&O. Ø c/o pain and discomfort. (.) Acc in noted. Ø seizure activity noted @ this time. Lungs clear. Abd soft non-distended. voids clear yellow urine. Ⓡ upper shoulder area ̄c dsg / I dsg. OOB → BR. ̄c 2pt restraints in place without compromising circulation or skin integrity. Will continue plan of care. [redacted]
(1640)	Pt a/o, VSS, Ø complaints, LCTAB, ⊕ BS x4, drsg to Ⓡ upper back Δ'd WTD ̄c dakins solution. Sero-drainage noted. mild Ⓛ sided weakness, Ø seizures, ↑ to ambulate x1. 2pt restraints on. ̄s

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

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

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10JAN04 0010	(cont) to monitor. [redacted]
10 Jan 04 0730	VSS A&O Denies c/o pain / discomfort @ this time. Lungs clear, Abd soft - non-distended, BS(+) x 4 Quad. Peripheral pulses palpable +2. Continues with (L) side weakness noted c [redacted] hand grip & walks c limp. Ambulates c cane with slow steady gait. Consumed 40% of Breakfast c 100% of Ensure. 2 point restraints in place without compromising circ/skin integrity. Will continue care as planned — [redacted]
10JAN04 1800	Pt A/O, VSS, med. c percocet for c/o headache (L) sided weakness cont, OOB x 1 to BR. CTAB, (+) BS, voiding cyu. (+) appetite, ø seizure activity noted. dsg to (R) upper back & d, area pink + moist c serous drainage. 2 pt restraints on 3 compromise. Cont to monitor — [redacted] PN-
11JAN04 @ 0440	Assumed care of pt. @ 2200. VSS. ii Percocet for c/o pain to shoulder wound. WTD dsg Δ to shoulder wound, ø s/sx of infx, mod. serous drainage. Pt. ambulated in hall 30 min. Pt. sleeping at this time, 2-point restraints, ø signs of skin breakdown. [redacted] T, AM

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

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PROGRESS NOTES
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4/11/04 1300 VSS WNL. ∅ c/o pain this afternoon. OOB Ad Lib $\bar{c}$ difficulty. Voiding spontaneously. DSG Δ'd to (R) shoulder. Wound beefy pink & moist. ∅ s/s infection or skin breakdown. [redacted]

(b)(6)-2

#1198

MEDCOM - 22773

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12JAN04 @2115	assumed care @ 1400. VSS. Percocets given x1 for headache in (R) side of head, good relief noted. LSCTA, @BS, tol reg diet, voids difficulty; cont'd (L) LE weakness c plantar flexion, Pt ambs c slight drag in (L) foot. 2pt restraints on c skin/circulation compromise. Plan: enc ODB, encpo, monitor pain & neuro checks. Will monitor. [redacted]
13JAN04 0030	Assumed care of pt. @ 2200. VSS, A&O. [redacted] for C/O severe pain to head. Mild (L) sided weakness. WTD dsg Δ to (R) upper back, mod. serous drainage, pink & moist, Ø S/Sx of infx. Pt. resting quietly in bed @ this time, 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted]
13JAN04 1100	VSS WNL. Ø c/o HA this AM. Belly completed in bed c w/v/p. Tolerated PO well this AM. DSG Δ'd to (R) shoulder this AM. Wound bed is pink, moist c minimal serosanguinous drainage. Ø S/S of infxn or skin breakdown. Adl cares upon req. [redacted]
13JAN04 @1705	assumed care @ 1400. VSS. No C/O N/A @ this time. Neuro's unchanged, cont'd (L) foot plantar flexion deficit, noted when amb c dragging of (L) foot. Pt states vision to (L) eye cont's to Ø improve, requests to see MD. MD notified Dr Teff. 2pt restraint on [redacted] in bed, Ø S/Sx skin/circulation compromise. Plan: enc ODB, encpo, monitor neuros. [redacted]
14JAN04 (0200)	Assumed care @ 2200. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. OOB to amb in hallway cont. to drag (L) foot slightly - aided c cane. DSG to (R) shoulder Δ'd WTD. Wound red/moist c S/Sx infection.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Jan 04 (1610)	Rt a&o, VSS, ϕ c/o pain @ this time, ↑ to WC 2° amb pushing WC. (L) sided weakness cont, walks c slight limp. (R) upper back drsg Δd, pink + moist c serous drainage. ϕ seizure activity noted, good appetite, voiding cyu. 2 pt restraints on ∃ compromise. Will monitor [redacted] PN
(2030)	↑ pushing roommate around in WC. med c percocet for headache. ϕ new issues— [redacted] SN
12 JAN 04 0230	Assumed care of pt. @ 2350. VSS, ii Percocet for c/o pain. Pt. sleeping @ this time. WTD dsg Δ c Dakin sol. to (R) shoulder wound to back, pink & moist, mod. serous drainage, ⊘ S/Sx of infx. Pt. in 2-point restraints, ⊘ signs of skin breakdown. All other assessments WNL. Will cont. to monitor [redacted] AW
12 JAN 04 1245	VSS WNL. ϕ c/o HA this AM. COB Ad Lib to perform self care. Steady gait c use of cane. Voiding spontaneously ∃ difficulty. Dsg to (R) shoulder- pink and moist ∃ S/S infxtn. ⊘ S/S of skin breakdown to patient. [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)*

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[redacted] (5)(6)-7

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14JAN04 Ø200	(cont) voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted]
1/14/04 1205	VSS WNL. ø c/o pain @ this time. Tolerated PO well after Ad. DSG did to (R) shoulder s̄ difficulty. Wound pink, [illegible] s̄ s/s of infection. Up ad lib to BR s̄ difficulty & ambulated well. Voiding light amber urine, QS. Patient [illegible] left side weakness. ø s/s of infection to wound ø s/s skin breakdown [redacted]
14JAN04 @1715	Assumed care @ 1400. VSS. Percocet given for (R) sided h/a, good relief noted. ⊖ Δ in neuro exam, cont'd vision Δ in (L) eye, noted in depth perception tasks (reaching for objects). Cont'd (L) foot plantar flexion deficit. LSCTA, ⊕ BS, tol reg diet c̄ good appetite, void s̄ difficulty. Pt AMB frequently, enjoys interacting c̄ roommate. Plan: enc AMB, enc independence, monitor neuros, enc PO. [redacted]
15Jan04 @ 0200	Assumed care @ 2200; VSS, pt A&O, pain controlled c̄ percocet; dsg to back Δ'd w/ D c̄ Dakin's soln, site healing well + in size; ⊘ NVA ⊘ visual Δ; pt tol Reg diet; voiding s̄ difficulty; Restraints in place s̄ compromise to skin/circ; cont to monitor [redacted]

(b)(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

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

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(b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 JAN 04 @ 0630	Assumed care of pt sleep easily arousable A+Ox3 VSS Denies pain or discomfort. Ambulates c cane to BR for am care and shower. Lungs CTA HRRR Active BS x 4 quads. Voids spontaneously & diff. Wound to (R) upper back shows wet & dry 4x4 dsg Δ'd after shower vascular healing well & s/s of infection will cont to monitor [redacted]
15 JAN 04 @ 715	Assumed care of pt @ 1400. VSS; Percocet given for N/a, good relief noted. (R) shoulder wound almost healed, fibrous tissue noted, small amount of drainage. Neuro exam unchanged, cont'd (L) leg plantarflexion deficit. No other issues, all other exams WNL. 2pt restraints on & signs skin/circulation compromise. Plan: enc OOB & AMB, monitor neuro exam & N/a. [redacted]
16 JAN 04 @ 0105	Assumed care @ 2200; VSS; pt A&O, PWV, visual Δs; pt OOB to ambulate hall c use of cane; dsg to (R) upper back Δ'd, wound healing well, Ø s/sx infection; pt to BR well, voiding c difficulty; Restraints in place c compromised skin/circ; cont to monitor [redacted]
16 JAN 04 @	Assumed care of pt sleep easily aroused A+Ox3. VSS Lungs CTA HRRR Active BS x 4 quads Tolerating PO well Voids c diff. Ambulates in hallway c/c assistance. Wound to (R) Upper Back 4x4 2ny dsg healing Ø s/sx of infection Ø drainage or active bleeding Will cont to monitor [redacted]
16 JAN 04 1800	assumed care @ 1400. VSS. Pain N/a, percocet given c good relief noted. Ø drainage from shoulder wound. Neuro exam Ø Δs. AMB well c cane. Enjoys interaction c roommate. 2pt restraints on & skin/circulation compromise. Plan: enc po, ene AMB, plan for D/C, pain control, monitor neuros. [redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
17jan04@0340	Assumed care@2200; VSS, pt A&O, ø c/o pain, ø NV As; pt OOB to amb in hall c minimal assistance from cane; dsg to ® upper back Δd WNL ø drainage, ø s/sx infection; pt to PO well, voiding ō difficulty; Rest raints in place ō compromise to skin/circ will cont to monitor [redacted]
17 JAN 04 @ 0640	0640- Assumed care of pt. A TO x3. USS Denies pain or discomfort. @ this time lungs CTA bilat. Active BS x4 quads. Voids spontaneously ō [redacted] Ambulates ward c cane assistance. DSG dry & intact to shoulder CDI ø drainage bleeding noted ø s/sx of infection pt. afebrile. All other assessment findings WNL. OK for discharge to camp next transport day. Will cont to monitor [redacted]
17JAN04@ 1700	assumed care@1400. VSS. Pt c/o n/a, Percocet given c good relief noted. neuro exam unchanged. all other systems WNL. Pt ↑ amb ō cane. ® shoulder wound small, ø drainage, healing well. Dpt restraints on ō skin/circulation compromise. Plan: monitor neuros, pain control, enc OOB. [redacted]
17 JAN 04	Assumed care @ 2200 pt sleeping, pt easily roused from sleep. VSS A+Ox3, pt c/o head pain 2230 given tylenol, dsg to upper posterior back Δd with dakins solution cont=

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 JAN '04	wound is pink s̄ signs of infection, pt c/o of head pain, given 2 percs @ 2340 by RN Lt. [redacted] Restraints x2 in place will monitor [redacted]
18	(0240) I concur c̄ above assessment. [redacted]
18 JAN 04	@ 0700 - Assumed care of pt. A+O x3. VSS Denies pain or discomfort @ this time. Wound care given. (R) shoulder open wound wet to dry 2x2 dsg covered c̄ 4x4 dsg CDI ∅ bleeding or drainage. healing well. Other assessment finding WNL will cont to monitor [redacted]
18 Jan 04 @ 1745	assumed care @ 1400. VSS. c/o h/a, percocet given c̄ good relief noted. neuro exam: ∅ Δs. all other systems WNL. Cont to AMB s̄ cane, tol well. (R) shoulder wound healing well, ∅ drainage. 2pt restraints on s̄ skin/circulation compromise. Plan: enc OOB, enc po, monitor neuros, pain control [redacted]
18 Jan 04	@ 2355 - Assumed care of pt. @ 2100. ∅ c/o pain or discomfort @ this time. sleeping in bed. Neuro intact ∅ Δs. (+) circulation (-) skin breakdown. two pt. restraints in place per epw protocol. (R) shoulder dsg CDI. ∅ drainage noted. Will cont. to monitor pt [redacted]
19 JAN 04	@ 0615 - Assumed care of pt. A+O x3. VSS c/o pain medicated c̄ tylenol 650 for HA. Wound to (R) shoulder wet to dry 2x2 dsg small wound healing well ∅ s/sx of infection Lungs CTA HRRR Active BS x 4 quads Voids spontaneously per urinal ambulates c̄ cane Other assessment finding WNL ok for discharge 20 JAN Will monitor [redacted]

(5) 2-16-06

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES: Neurosurgery Narrative Summary / Discharge Note
7/19/04 18:22	20 y/o Iraqi ♂ with penetrating injuries to back, scapula, brain and flank from IED (noted to be placing EELs during the explosion) on 11/1/03. Taken to 28th CSH with GCS 6; E1 V1 M4 (localizing). CT
MEDS:	demonstrated Lg (R) hemisphere acute subdural hematoma, midline shift
Neurontin 300mg po TID	1.5 cm, penetrating fragments into the (R) parietal lobe & hemorrhage
Dilantin 100mg po TID	into the Sylvian fissure. He underwent an emergent (R) Fronto
Zantac 50mg po BID	temporal craniotomy with evacuation of penetrating bone, metal
Colace 100mg po BID	fragments, evacuation of a acute SDH & clipping of a distal
	ruptured traumatic MCA aneurysm.
	His pmhx significant for smoking & asthma which contributed to
	a post-operative course complicated by pseudomonas, klebsiella pneumonia.
	He underwent a tracheostomy, PEG, antibiotics and delayed removal
	of his ICP monitor w controlled ICP. He remained in the ICU for
	4.5 wks until his pulmonary state improved allowing transfer. During
	this time he had a progressive improvement in his neurologic
	status. He went from a dense (L) UE monoplegia, (L) LE paresis &
	(L) hemineglect to currently ambulating w only slight weakness of (L)
	foot dorsiflexors. Due to a breakthrough seizure 1/8/04 he remains on Dilantin 100 TID
	(additionally underwent a recent CT 2wks ago w/ communicating hydrocephalus which
	his headaches improved with an LP.

(b)(6)-2

[redacted]

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RELATIONSHIP TO SPONSOR	SPONSOR'S NAME (LAST / FIRST)	SPONSOR'S ID NUMBER (SSN or Other)
	LTC, MC, USA [redacted]	Commander

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY
	Baghdad

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	anesthesia

Diagnosis: (1). Penetrating Brain Injury

(2). Traumatic Brain Injury 2nd #1 with Residual (L) dors. flexion weakness of (L) foot (uses a cane to ambulate).

(3). Healing (R) Scapular wounds (dry dressing currently)

(4). Pneumonia Resolved.

(5). Seizures 2nd #1 Tx w/ Dilantin 100mg TID

(6). Communicating Hydrocephalus tx w/ Lumbar Puncture (May require subsequent CT Head in 2-3wks with repeat LP).

(b)(6)-2

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(b)(6)-2 – Hospital

Hospital

Baghdad, Iraq

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19Jan04	(1830) VSS. C/O pain to head at start of shift. Med c̄ 2 prc. Pt amb c̄ steady gait. Tol PO well. Voids cyll. Δ DSG to back c̄ Dakin's WTD. D/C orders written + summary written. [redacted]
20 Jan 04	0030 - assumed care of pt. @ 2200. A+O Ø c/o pain or discomfort @ this time. Pt. in bed speaking in Arabic c̄ Roommate. dsg D&I to upper back. Ø s/sx infection. Voids qs via urinal. Two point restraints in place. ④ circulation Ⓢ skin breakdown. D/C orders written + D/C summary. Awaiting D/C to camp 20 Jan. Will cont. to monitor pt. [redacted]
20	(0140) I concur c̄ above assessment. [redacted]
20 Jan 04	@0630 - Assumed care of pt. A+O x3. VSS Denies pain or discomfort. Lungs CTA. HRRR Active BS x4 quads. Voids s̄ difficulty. Wound to ® shoulder healing well Ø s/sx of infect. All other assessments WNL. OK for discharge to camp today. Will cont to monitor [redacted]

(b)(6)-2

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

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 NOV B	0800 Pt ate 10% of breakfast. [redacted] RT/AN 0930 Pt stable at this time. Alert and oriented to person, place. PERRLA. Ø C/O headache at this time. Weakness noted to (L) LE. Pt OOB to BSC. Large BM today. Dsg to back x 3. CDI. Trach dsg intact & petroleum gauze. Ø C/O pain, Ø weakness noted to (L) UE. [redacted] RT/AN 1200 BP 116/74 P92 R16 T98.8 O2 98% RA [redacted] 1835 Dsg Δ done. Dsg to (R) shoulder & purulent drainage. W>D dsg Δ done to 3 wounds on back. Ø C/O pain. [redacted] LT/AN
6 NOV B 2130	Pt awake & responds appropriately intermittently. HR Regular, lungs sands clear bilat, bowel sounds (+) x 4 quads. Wand to neck 2° to old trach site, slight whistling sound when pt speaks. DSG to (R) shoulder Δd w>D ENS, small amt of pseudomonas drainage noted on old dsg, wound pink & moist. Pt ⊃ IV access. Pt voiding via urinal ⊃ difficulty. Ø complaints @ this time. [redacted] CT/AN

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. ICU2

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

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

S/P Craniotomy

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 30 Oct 03 Diagnosis: GSW Head, S/P Trach HD: 29 POD: 27 / 14
Craniotomy, Multiple Shrapnel Injuries

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4		Mobility	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	(2)	2		Very limited	2	
	Completed	1			Completely immobile	(1)	
Moisture	Rarely moist	4		Nutrition	Excellent	4	
	Occasionally moist	(3)	3		Adequate (Eats >50%)	3	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	(1)	
Activity	Walks frequently	4		Friction and Shear	No apparent problem	3	
	Walks occasionally	3	1		Potential problems	(2)	
	Chairfast	2			Problems	1	
	Bedfast	(1)					

Add the total score 6 **Total Score** 10 8

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates **HIGH RISK** –Requires immediate Ulcer prevention program.

Surgical wound (s): Yes No Location:_____ Size: _____ Drainage: _____
Tubes: _____ Appearance: _____
Dressing change: _____

Pressure Ulcer (s): Yes No
Stage I, II, III, IV-(Circle the one that applies and describe below)

Location: _____ Size: _____
Wound character: Pint_____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough_____
Odor _____ Purulent discharge _____ Eschar _____ Exudates _____

Type of dressing change: Wet-to-dry_____ Comfeel dressing _____ Carrasyn V-Gel_____ Alginate _____

Physician notified/consulted for wound debridement: Yes_____ No_____
CNS notified/consulted for Stage II and greater: Yes_____ No_____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes_____ No _____
Action Taken: _____ Date & Time: _____

[redacted] (b)(6)-2

Wound and skin assessment started 28 NOV

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

[redacted] (b)(6)-4

PROGRESS NOTES

Medical Record
STANDARD FORM 509

MEDCOM - 22784

Medical Record — Progress Notes

Wound and Skin Assessment

Date and Time 28 NOV 03, 1430 Wound number ## 1
Stage I-IV N/A Surgical or Non-Surgical Shrapnel
Location (R) Shoulder
Shape oblong Measurements 12cm l x 6cm w x 2cm d
Tissue Color pink, moist, ø necrotic tissue, granulating
Drains and Type ø, ø odor
Drainage (amt and color) ø
Dressing Type Wet to dry
Dressing Change Frequency T.I.D Wound Cleansing NS
Additional Info (turning, elevation of extremeties, etc.)
Be sure to irrigate wound thoroughly c NS, pat dry c sterile gauze, pack loosely all tunneling & undermining apply dry gauze over drsg. & secure c tape.

Date and Time 28 NOV, 1430 Wound number ## 2
Stage I-IV N/A Surgical or Non-Surgical Shrapnel
Location (R) shoulder
Shape oblong Measurements 6cm l x 3cm w x 1cm d
Tissue Color pink & moist
Drains and Type ø
Drainage (amt and color) ø, no odor or necrotic tissue
Dressing Type wet-to-dry
Dressing Change Frequency T.I.D Wound Cleansing Same as above
Additional Info (turning, elevation of extremeties, etc.)
Healing

Date and Time 28 NOV 03, 1430 Wound number ## 3
Stage I-IV N/A Surgical or Non-Surgical
Location (L) Shoulder
Shape oblong Measurements 3cm l x 1.5cm w x superficial
Tissue Color pink & moist
Drains and Type none
Drainage (amt and color) ø, ø odor
Dressing Type Comfeel
Dressing Change Frequency Q 5-7 days Wound Cleansing Clean c NS, pat dry, apply Comfeel / Duoderm
Additional Info (turning, elevation of extremeties, etc.)
wound Healing well

Patient ID: Unit No.
→ Cont. on back
Standard Form 509

Medical Record — Progress Notes

Wound and Skin Assessment

Date and Time 28 NOV 03. 1530 Wound number # 4
Stage I-IV N/A Surgical or Non-Surgical
Location mid back
Shape oblong Measurements 2cm L x 1cm W, superficial
Tissue Color pink, epithealization process evident
Drains and Type Ø
Drainage (amt and color) Ø
Dressing Type Clear-Opsite
Dressing Change Frequency q 5-7 days Wound Cleansing same as previous
Additional Info (turning, elevation of extremeties, etc.)
Wound ~~bed~~ healed - site protected from friction injury.

Date and Time Wound number
Stage I-IV Surgical or Non-Surgical
Location
Shape Measurements
Tissue Color
Drains and Type
Drainage (amt and color)
Dressing Type
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Date and Time Wound number
Stage I-IV Surgical or Non-Surgical
Location
Shape Measurements
Tissue Color
Drains and Type
Drainage (amt and color)
Dressing Type
Dressing Change Frequency Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 30 Oct Diagnosis: (GSW to head) Craniotomy Trach HD: 29 POD: 27/14

Date: 28 NOV 03 Time: 1430 RN Signature: [redacted] 14J 4th

Skin breakdown as evidenced by immobility, friction, [redacted] wound, skin tear.

Wound type: Surgical wound (s) Location: (L) Shoulder (5)(6)-2 Size: (1) 2cm x 6x2 (2) 6cm x 3 x 1 (3) 2cm x 1.5 (4) 2cm x 1cm Drainage: Ø

Diabetic ulcer Tubes: Ø Pins: Ø Appearance: pink & moist Ø exudate or odor

Venous stasis ulcer Dressing change: TID

Other ✓ Describe Shrapnel wound

Burn wound (s): % BSA _____ Partial _____ Full _____

Location: _____ Size _____

Appearance: _____

Dressing change: _____

Pressure Ulcer (s):

Stage I, II, III, IV (Circle the one that applies and describe below)

Location: (L) Shoulder Size: #3

Wound character: Pink ✓ Moist ✓ Dry ___ Granulation tissue ✓ Yellow slough Ø

Tunneling Ø Undermining Ø Odor Ø Purulent discharge Ø Eschar Ø Exudates Ø

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☒ Wet to Dry Dressing (wound #1, #2)
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☒ Comfeel Dressing #3
- ☒ Op-site #4
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☑ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☑ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☑ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☑ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☑ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☒ t.i.d

MD Signature and Date:

CNS [redacted] 14J 4th

(5)(6)-2

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

[redacted] (5)(6)-4

MEDCOM - 22787

Medical Record — Progress Notes

Braden Scale Evaluation

Date: 12.503

Sensory Perception	No Impairment	(4)	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	(2)
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	(4)	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	(3)
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	(3)
	Walks Occasionally	3		Potential Problem	2
	Chairfast	(2)		Problems	1
	Bedfast	(1)			

Total Score: 18

Score <15 requires Immediate Ulcer Prevention Program

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Date: _____

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: _____

Score <15 requires Immediate Ulcer Prevention Program

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Patient ID:

Unit No. _____

Standard Form 509

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 11.28.93 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 27/14 | HOSPITAL DAY: 29

TRANSFER

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

Time 0954 To ICU#2 From ICU#2 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

Procedure/Diagnosis S/P craniotomy c depressed

B/P 110/61 P 110-120 R 33. T 98.8

LOC S/P trach, S/, skull fx, fx shoulder Neurovascular checks _____

Dressing/cast Sutures to head. Tubes Foley catheter.

Intake (IV, po) 20 g @hand Output (EBL, other) (5)(6)-2 Voided ☐ No ☐ Yes Amount: 200 - 300cc/h

Medication D5NS c 20 kcl @125. , soft mechanical diet. * calorie count

Other GSW to head. , motor paralysis @ L side

Report From CPT [redacted] Received By LT [redacted]

VITAL SIGNS

TIME:	1028	2028	0555													
BP ARTERIAL LINE	/	—	—													
BP CUFF	101/68	103/64	95/63													
TEMPERATURE	97.7	97.6	98.8													
PULSE	114	113	95													
RESPIRATORY RATE	30	26	16													
OXYGEN (L/%)	/	—	—													
PULSE OXIMETER	RA- 99%	99%	99													
O2 METHOD	99%	RA	99% Trach													

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

PAIN

TIME:	1028	2028	0130
PAIN INTENSITY (10 / 5 / 0)	0	4	4
MED ADMINISTERED (Y/N)	N	~	D
RELIEF ACCEPTABLE (Y/N)	N/A		N/A

SPECIAL NEEDS

TIME:	1028	0130
*Skin breakdown prevention	CB	[redacted] (5)(6)-2
*Falls prevention protocol		
*Restraint protocol	CB	
*Seizure precautions		N/A
*Isolation precautions		N/A

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine 2400		Stool			TOTAL OUT

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/P craniotomy

DRG: _____ ADMISSION DATE: 10/31/93

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: (5)(6)-2

PRIMARY CARE MANAGER: [redacted]

MEDCOM - 22789 EQUIRED (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 n... brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2130 [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.	☐ ALERT	☐	☐ Alert
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)*	☐ TACHYCARDIC @ 120	☐	☐ Tachy
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ TACHYPNIC @ 35 TRACH & HUMIDIFIED RA	☐	☐ Tachypnic Tracheostomy & nonidified O_2
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 to gravity draining clear, 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.	☐ ↓ ROM TO (L) SIDE	☐	☐ (L) sided paralysis
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SCALP LACTO (R) SIDE DSG TO (R) SHOULDER/UE LAC TO POST (R) LE OTA	☐	☐ scalp lac, Dressing to (R) scapula
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ PT DENIES	☐	☑ Scale 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ PT TRACHED UNABLE TO SPEAK	☐	☐

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

TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2130 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr: PRN
IV site care provided: ASSESS	IV site care provided:	IV site care provided: Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) RADIAL / OK	IV Site #1:	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: DSG'S + 20K @ 125	Comments:	Comments: Flushed + NS @ 125cc/hr (R) FA

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1100				
COLOR	P				
CAPILLARY REFILL	1				
TEMPERATURE	W				
EDEMA	0				
SENSATION	S				
MOTION R-©	[redacted]				
PASSIVE FLEXION	0				
PERIPHERAL PULSE	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 / OTHER

TIME:	1100		2130
ID band visible/legible	.		[redacted]
Orient to environment prn	U3		
Side rails (2/4) up	/		
Bed position low			
Call light within reach	/		
Review & post lab results	/		[redacted]
Notify MD abnormal labs	/		
			N/A
Incontinent urine/stool	/		[redacted]
Linen change prn	/		
Turn/reposition q2h	U3		
ROM q2h if immobile	/		N/A
Antiembolic hose	/		
	.		
	.		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: MECH SOFT	TYPE: MECH SOFT
PERCENT CONSUMED:	PERCENT CONSUMED: 40%	PERCENT CONSUMED: 60%
HOW TOLERATED:	HOW TOLERATED: WELL	HOW TOLERATED: WELL
☐ 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: 1100 INITIALS: U3	TIME: INITIALS:	TIME: INITIALS:
CONTENT: FEDB PRN HUMIDIFIED RESTRAINTS RESTRAINT PROTOCOL	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW [redacted] (b)(6)-4	[redacted]	[redacted] T 91WM6	09-21
		[redacted] D/AN	9P/9A
		(b)(6)-2	

(b)(6)-2

MEDCOM - 22791

ACLU-RDI 1673 p.151

DOD-036367

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2400	ⓡ shoulder ⓛ shoulder		

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 29 NOV 05 | PATIENT ACUITY LEVEL: IV | POST-OP DAY: 08/15 | HOSPITAL DAY: 50

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:	1200	2000	0400														
BP ARTERIAL LINE	105																
BP CUFF	71	104/69	105/58														
TEMPERATURE	99°	99.4	98.4														
PULSE	105	114	87														
RESPIRATORY RATE	20	20	18														
OXYGEN (L/%)																	
PULSE OXIMETER	98	97	98%														
O2 METHOD	humidified RA	RA	RA														

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

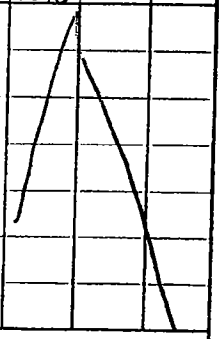
TIME:	1010	0800															
PAIN INTENSITY (10 / 5 / 0)	X																
MED ADMINISTERED (Y/N)	N	N															
RELIEF ACCEPTABLE (Y/N)	Y	N															

OTHER

TIME:																	
FINGER STICK GLUCOSE																	
INSULIN (Y/N)																	

SPECIAL NEEDS

TIME:	1010
*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

EPW

[redacted] (b)(6)-4

DIAGNOSIS: S/P Craniotomy

DRG: _____ ADMISSION DATE: 31 OCT 05

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: (b)(6)-2

PRIMARY CARE MANAGER: [redacted]

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: 1010 INITIALS: [redacted]	TIME: INITIALS:	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.	☒ Alert, -not oriented asking about needing to go to the hospital wondering why has weakness	☐	☐ Alert & oriented
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.	☒ trachyostomy c humidified O_2	☐	☐ Tracheostomy c humidified O_2 productive cough
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 to gravity clear yellow urine	☐	☐ foley to grav clear 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.	☒ (L) LE paralysis (L) UE able move but weak	☐	☐ Able to move all extremities weakness to (L) LE
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☒ abrasion to (L) scapula scalp lac	☐	☐ (B) scapula scalp lac
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ pt able to write in arabic and understand arabic - not english	☐	☐ combative; trying to make fist and hit staff

(b)(6)-2

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

	TIME: 1010 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr:			q 8 hr: PRN
IV site care provided:			Assessed
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(L) FA / OK		(R) FA / OK
IV Site #2:			
Comments:	NS @125		IV ABX

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: ULE	TIME:	1010	2300				
COLOR		P	P				
CAPILLARY REFILL		1	1				
TEMPERATURE		W	W				
EDEMA		0	0				
SENSATION		S	S				
MOTION		U	U				
PASSIVE FLEXION		0	0				
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 / OTHER

	TIME:	1010		2300
ID band visible/legible		[redacted]		[redacted]
Orient to environment prn		[redacted]		
Side rails (2/4) up		/		UTA
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: Mech Soft	TYPE: Mech Soft	TYPE: Mech Soft
PERCENT CONSUMED: 10%	PERCENT CONSUMED: 10%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	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: 1010 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: explained - pain management - call for assist - that he's in the hospital - by interpreter	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW [redacted] (6)(6)-4	[redacted]	[redacted] (6)(6)-2	1 99/0 1/9A

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1100 - Pt up to chair, shaved self, washed up, [redacted] 2LT/HN

1230 - Pt offered water and food for lunch [redacted] used to eat anything except bread [redacted] HN

1500 - Pt found standing on (R) leg in room when asked what he was doing stated he needed to go to an Iraqi hospital [redacted] 2LT/HN

1520 late entry for 1130 - Sutures removed from [redacted] per MD instructions [redacted] HN

2-5-6

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 30 NOV 03 | PATIENT ACUITY LEVEL: IV | POST-OP DAY: 09/16 | HOSPITAL DAY: 31

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:	2000	2130	0460	12													
BP ARTERIAL LINE	/																
BP CUFF	114/62		106/48														
TEMPERATURE	99.4		98.3														
PULSE	71		105														
RESPIRATORY RATE	16		16														
OXYGEN (L/%)	/																
PULSE OXIMETER	1100		100														
O_2 METHOD	RA																

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

PAIN

TIME:	1045	2130							
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)	N	N							
RELIEF ACCEPTABLE (Y/N)	N/A	N/A							

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	1045	2130
*Skin breakdown prevention	[redacted]	
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions	N/A	N/A
*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
									800					800

2-19(5)

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/P craniotomy, GSW (Shoulder)

DRG: _____ ADMISSION DATE: 31 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

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: 1045 INITIALS: [redacted]	TIME: 2130 INITIALS: [redacted] (b)(6)-2	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.	☐ follows simple commands. Communicates through writing.	☐ follows commands	☐
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.	☐ tracheostomy. Pt. C productive cough whitish sputum.	☐ tracheostomy DCd today. DSG C/D+I	☐
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 to gravity c clear yellow urine.	☐ Foley to gravity	☐
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.	☐ Partial motor paralysis @ UE, (L) side of body. OOB c assist x2	☐ ↓ Motor function (L) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Shrapnel wound to Both post. Shoulders.	☐ Shrapnel wounds Both Shoulders	☐
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: 1045 INITIALS: [redacted]	TIME: 2130 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided: assessed	IV site care provided: assess	IV site care provided:
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:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: IVF @ TKO	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: LUE, LLE TIME:	1045	2130					
COLOR	P	P	P	P			
CAPILLARY REFILL	1	1	1	1			
TEMPERATURE	W	W	W	W			
EDEMA	0	0	0	0			
SENSATION	S	S	S	S			
MOTION	M	M	M	M			
PASSIVE FLEXION	/	/	/	/			
PERIPHERAL PULSE	2+	2+	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:	1045	2130		
ID band visible/legible	[redacted]			
Orient to environment prn	[redacted]			
Side rails (2/4) up	[redacted]			
Bed position low				
Call light within reach				

(b)(6)-2

OTHER

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: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: See calculation sheet	PERCENT CONSUMED: Count sheet	PERCENT CONSUMED: Count sheet
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; 3 # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1045 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2130 INITIALS: [redacted]
CONTENT: 1.) Personal hygiene 2.) Ø visitors allowed	CONTENT:	CONTENT: . Call for assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] ICTAN SPC Gillma	D
		N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2130	(R) Shoulder	dsg falling off. areas pink no s/s infection	W→D DSG Δ

SECTION IV - NOTES

1015: Pt. OOB to chair and BSC x1 hr. — [redacted] (STAN)

1240: Pt. c/o severe pain to Rt. side neck radiating down to Rt. hip. MD called for pain medication order. — [redacted] (STAN)

(b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 1DEC03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 30/17 | HOSPITAL DAY: 32

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:	1200	2200	0400													
BP ARTERIAL LINE																
BP CUFF	105/66	119/71	127/66													
TEMPERATURE	98.2	97.5	98.4													
PULSE	97	78	109													
RESPIRATORY RATE	16	16	20													
OXYGEN (L/%)																
PULSE OXIMETER	100	99%	99													
O2 METHOD	RA	RA	RA													

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

PAIN

TIME:	0930	2240								
PAIN INTENSITY (10 / 5 / 0)	X	V								
MED ADMINISTERED (Y/N)	N	N								
RELIEF ACCEPTABLE (Y/N)	NA	N/A								

SPECIAL NEEDS

TIME:	0930	2246
*Skin breakdown prevention	NA	N/A
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

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

PATIENT IDENTIFICATION

EPW # [redacted]

DIAGNOSIS: S/P Craniotomy, GSW (R) shoulder

DRG: _____ ADMISSION DATE: 31OCT03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

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: 0930 INITIALS: [redacted]	TIME: 2240 INITIALS: [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.	☐ Pt has times where he acts confused even using a translator 2° to head injury	☐ At times pt will speak in complete sentences and at times he will act confused per translator.	☐
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.	☑	☑ Old Trach site c DSG	☐
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 to gravity - clear yellow urine	☐ Foley to gravity	☐
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.	☐ Pt unable to move (R) leg; limited ROM to (L) arm	☐ Limited ROM (R) UE and (R) LE. Unequal hand strips	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Scar to (R) temporal area, DSGs x3 to back	☐ DSGS to BACK CDI scar to (R) temporal area	☐
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.	☐ behavior can be confused (5)(6)1-2	☐	☐

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

TIME: 0930 INITIALS: [redacted]	TIME: 2240 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) AC / I	IV Site #1: (L) wrist / OK	IV Site #1:
IV Site #2: (L) wrist / OK	IV Site #2:	IV Site #2:
Comments:	Comments: HL	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:	0930	2240	
ID band visible/legible	[redacted]		(b)(6)-2
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

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:	Reg - 100% ensure	Reg	Reg
PERCENT CONSUMED:	15%	50% ensure 70% meal	75% Ensure 2240
HOW TOLERATED:	50-50	well	well
	☐ 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: 0930 INITIALS: [redacted]	TIME: 2240 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: OOB to Chair New IV Pt to drink water between meals	CONTENT: Encourage fluids (b)(6)-2	CONTENT:
☒ (Patient)/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	[redacted] II/MN SPC/91WMG	D N

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 2Dec03 | PATIENT ACUITY LEVEL: ~~I~~ II | POST-OP DAY: 31/18 | HOSPITAL DAY: 33

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:	1500	2000	2400													
BP ARTERIAL LINE																
BP CUFF	127/52	106/64														
TEMPERATURE	98.2	98.2	97.9													
PULSE	136	100	89													
RESPIRATORY RATE	16	16	16													
OXYGEN (L/%)																
PULSE OXIMETER	99%	99%	97%													
O_2 METHOD	RA	RA	RA													

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:	2000	2200							
PAIN INTENSITY (10 / 5 / 0)	0	0							
MED ADMINISTERED (Y/N)		N							
RELIEF ACCEPTABLE (Y/N)		NA							

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	1200	2200
*Skin breakdown prevention	[redacted]	NA
*Falls prevention protocol		
*Restraint protocol (b)(6)-2		
*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
	NA													

PATIENT IDENTIFICATION

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

DIAGNOSIS: S/p Craniotomy, GSW (R) Shoulder

DRG: _____ ADMISSION DATE: 31OCT03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: (b)(6)-2

PRIMARY CARE MANAGER: [redacted]

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: 1200 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted] (6)(6)-2	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.	☑	☐ -pt c brain injury, intermittent appropriate communication -(L) sided weakness	☐
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 D/ cd. Voiding 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.	☐ pt unable to move (L) leg.	☐ -pt c (L) sided weakness -unable to move (L) LE -2 point restraints	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ old trach site, wounds to (R) shoulder x2, (L) shoulder x1	☐ -post trach site -wounds to (L) & (R) shoulder	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑ Ø c/o pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ (6)(6)-2	☐ -neurological injury	☐

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

TIME: 1200 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr: PLO	IV patency ✓ q E hr:	IV patency ✓ q ___ hr:
IV site care provided: New IV.	IV site care provided: timed & dated	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) FA / OK	IV Site #1: (L) FA / ok	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HC'd.	Comments: HL.	Comments:

NEUROVASCULAR

SITE: ELE	TIME:	1200	2200				
COLOR		P	P				
CAPILLARY REFILL		1	1				
TEMPERATURE		W	W				
EDEMA		0	0				
SENSATION		S					
MOTION		Unable	U				
PASSIVE FLEXION		0	0				
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:	1200	2200	
ID band visible/legible	[redacted]	[redacted]	
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool		NA	
Linen change prn		[redacted]	
Turn/reposition q2h		MD	
ROM q2h if immobile			
Antiembolic hose			

2 (b)(6)

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: Reg	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 100%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED: well	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 2 point restraints

TEACHING

TIME: 1200 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2200 INITIALS: [redacted]
CONTENT: 1) Must eat or will have to get tube feeds.	CONTENT: (b)(6)-2	CONTENT: - DSG Δ's - nutrition
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW# [redacted] (b)(6)-1	[redacted]	[redacted] LVT/AN	D 1200
		LVT/AN	2100

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1800	(R) shoulder/scapula	erythem Beefy	wet ⇒ dry Δ
		(L) shoulder	erythem Beefy	wet ⇒ dry Δ

SECTION IV - NOTES

Pt (R) VPD. 0 c/o PN. (L) shoulder right (-) S/S of infection Right erythem, Beefy looking. Wet to dry ~ sodium chloride. (R) shoulder/scapular Right erythem wet to dry dress Δ ~ sodium chloride (-) S/S of infection (-) odor. Pt tolerated well [redacted] SPC (5/6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 3 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 32/19 | HOSPITAL DAY: 34

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

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 (ESL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	24HRS
BP ARTERIAL LINE				119
BP CUFF	100/60	114/70	116/88	128
TEMPERATURE	98.4	99.8	98.1	97.8
PULSE	93	88	74	84
RESPIRATORY RATE	14	14	14	16
OXYGEN (L/%)				
PULSE OXIMETER	98%	99%	99%	98%
O_2 METHOD	RA	RA	RA	RA

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

PAIN

TIME:	1200	2000	0059
PAIN INTENSITY (10 / 5 / 0)	X	X	X
MED ADMINISTERED (Y/N)			N
RELIEF ACCEPTABLE (Y/N)			N/A

SPECIAL NEEDS

TIME:	1100
*Skin breakdown prevention	NA
*Falls prevention protocol	↓
*Restraint protocol	[redacted]
*Seizure precautions	
*Isolation precautions	(b)(6)-2

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

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

PATIENT IDENTIFICATION

Civ [redacted] (b)(6)-1

DIAGNOSIS: S/P craniotomy, GSW (R) shoulder

ORG: _____ ADMISSION DATE: 31 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): (b)(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages*

MEDCOM - 22808

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: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2259 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.	☑	☐ (b)(6)-2	☑
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.	☐ Trach site covered.	☐	☐ Trach site dressing & sutures intact
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.	☑	☐	☐ incontinent urine x1
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.	☐ increased ability to weight bear LLE, but still marked ↓ in mobility LLE.	☐	☐ weakness (L) side ↓ mobility
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Shrapnel wounds x2 Rt. Shoulder x1 Lt. Shoulder.	☐	☐ GSW (R) shoulder shrapnel wound (L) shoulder
8. PAIN: No complaints of pain/ discomfort. (See page 1 for documenting pain intensity.)	☑	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐ (b)(6)-2	☑ language barrier

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

	TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2259 INITIALS: [redacted]
IV patency ✓ q 8 hr:	PRN		PRN
IV site care provided:	assessed.		Assessed
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(L) AC / OK.		(L) AC / OK
IV Site #2:			
Comments:	AC'd.		AL

NEUROVASCULAR

SITE: LIF TIME:	1100	1104 2259			
COLOR	P	/	P		
CAPILLARY REFILL	J	/	J		
TEMPERATURE	W	/	W		
EDEMA	0	/	0		
SENSATION	S	/	S		
MOTION	MS	U	MU		
PASSIVE FLEXION	0	/	0		
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:	1	2059
ID band visible/legible	[redacted]	
Orient to environment prn		
Side rails (2/4) up	N/A	N/A
Bed position low		
Call light within reach		

OTHER

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:	Reg	Reg	Reg
PERCENT CONSUMED:	30%	60%	70%
HOW TOLERATED:	well	well	well
	☑ 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:	INITIALS:	TIME: 2259	INITIALS: [redacted]
CONTENT:		CONTENT:		CONTENT: Call for assist	
☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	[redacted]	1

2-06

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		a ① ② Shoulder	① healthy pink tissue s/s infection	} W→D D
		② ④ Shoulder	② healthy pink tissue s/s infection	
		③ Tracheostomy	③ dry sterile dressing	N'd

SECTION IV - NOTES

MEDCOM FORM 659-R (TEST) (MCHO) MAR 99

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 4 DEC 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 5 | HOSPITAL DAY: 6

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 (ESL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE		/	/													
BP CUFF	116/60	106/66	106/62													
TEMPERATURE	97.5	96.9	97.2													
PULSE	71	83	82													
RESPIRATORY RATE	16	16	16													
OXYGEN (L/%)		/	/													
PULSE OXIMETER		96	97													
O2 METHOD		RA	RA													

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

PAIN

TIME:	1200	2230	0400													
PAIN INTENSITY (10 / 5 / 0)		0														
	X		X													
MED ADMINISTERED (Y/N)	N	Y														
RELIEF ACCEPTABLE (Y/N)	Y	Y														
Percocet		II														

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME: 2230

*Skin breakdown prevention	NA
*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

(b)(6)-2

[redacted]

DIAGNOSIS: Abd wound washout

DRG: _____ ADMISSION DATE: 29NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: [redacted] (b)(6)-2

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: 1510 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted] (b)(6)-2	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; shallow 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.	☐ ϕ 4QHNMD hyperactive BS CT scan @ 1500	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
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.	☑ up ad lib	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ dsg covering incision site CDI	☐ ML abd incision Dsg CDI.	☐
8. PAIN: No complaints of pain/ discomfort. *See page 1 for documenting pain intensity.)*	☐ percocet providing (+) pos effect.	☐ c/o pain to abd. incision. Percocet 1 PO given	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ family obs (b)(6)-2	☑	☐

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

TIME: 1510 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q ___ 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: RFA / ok	IV Site #1: RAC / ok	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: DL	Comments:	Comments:

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 / OTHER

	TIME:	1510	2230	
ID band visible/legible		[redacted]		
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		[redacted]		
Linen change prn				
Turn/reposition q2h			N/A	
ROM q2h if immobile				
Antiembolic hose			✓	

(b)(6)-2

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg	NPO	Reg
PERCENT CONSUMED:	10%		cup
HOW TOLERATED:	well		
	☒ 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: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
CONTENT:	-OOB c Asst. & shoes for safety. -pain control	-Plan of care	
	☒ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

(b)(6)-2

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

INITIALS	SHIFT
[redacted]	1
	5

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1510	Midline abd.	CDI	

SECTION IV - NOTES

2230: A+Ox3. 9/10 pain 5/10 to ML abd. incision [redacted] PT, Ate
PO given. Will continue to monitor.

(b)(6)-2

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 4 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 33/00 | HOSPITAL DAY: 35

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 (ESL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0800	0800	0400													
BP ARTERIAL LINE	/	/	/													
BP CUFF	150/64	150/52	120/56													
TEMPERATURE	97.6	97.2	98.6													
PULSE	97	80	82													
RESPIRATORY RATE	16	16	16													
OXYGEN (L/%)	/	/	/													
PULSE OXIMETER	99	99	99													
O2 METHOD	RA	RA	RA													

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

PAIN

TIME:	1100	0400							
PAIN INTENSITY (10 / 5 / 0)		X							
MED ADMINISTERED (Y/N)	Y								
RELIEF ACCEPTABLE (Y/N)									

OTHER

TIME:	1700								
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	1000	0200
*Skin breakdown prevention	[redacted]	
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions	N/A	
*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] (b)(6)-4

DIAGNOSIS: S/P craniotomy, GSW @ basilar

DRG: _____ ADMISSION DATE: 31 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

(b)(6)-2

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: 1100 INITIALS: [redacted]	TIME: INITIALS:	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.	☑ X pt. complains roomates complain he's senral.	☐	☐ Alert, occasionally oriented
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)*	☑	☐ (b)(6)-2	☑
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.	☐ Pt. ABD soft, flat C/O constipation. Ø results from Dulcolax Supp.	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑ using urinal needs prompting
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.	☐ ↑ mobility LLE, still ↓ strength, needs assistance for transfers.	☐	☐ weakness Rside
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.)*	☑	☐	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ (b)(6)-2	☐	☑

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

TIME: 1100 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2300 INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided: assed	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: RFA / OK	IV Site #1:	IV Site #1: X
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HC'd	Comments:	Comments:

(b)(6)-2

NEUROVASCULAR

SITE: LLE	TIME: 1100	2300				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	C				
EDEMA	0	0				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	0	0				
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: [redacted]	[redacted]
ID band visible/legible		
Orient to environment prn		
Side rails (2/4) up		
Bed position low		
Call light within reach		

OTHER

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: Reg + ensure	TYPE: Reg + Ensure	TYPE: Reg
PERCENT CONSUMED: 100% ensure	PERCENT CONSUMED: 100% + ensure	PERCENT CONSUMED: 50%
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 (circled) AMBULATE BSC BRP CHAIR (circled) ☐ 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:	INITIALS:	TIME: 2300	INITIALS: [redacted]
CONTENT:		CONTENT:		CONTENT: call for assist (b)(6)-2	
☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Civ (b)(6)-4 [redacted]	[redacted]	[redacted] JAN 01-09	1

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1000: Pt. assisted c oral hygiene, hair wash, facial shave. Pt. OOB x 2hours. Will cont to monitor. [redacted] RN (b)(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 5 Dec 05 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 34/21 | HOSPITAL DAY: 36

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:	1200	2000	0400															
BP ARTERIAL LINE																		
BP CUFF	110/78	110/80	115/61															
TEMPERATURE	98.6	97.0	98.4															
PULSE	78	95	75															
RESPIRATORY RATE	14	16	20															
OXYGEN (L/%)																		
PULSE OXIMETER	96%	99%	99%															
O_2 METHOD	RA	RA																

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:	1200	2000	2230	2430				
PAIN INTENSITY (10 / 5 / 0)	1	1	X	X				
MED ADMINISTERED (Y/N)			Y	N				
RELIEF ACCEPTABLE (Y/N)			Y	N/A				

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME: 2000 2430

- *Skin breakdown prevention: [redacted] MA
- *Falls prevention protocol
- *Restraint protocol (5)(6)-2
- *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
		N/A											

PATIENT IDENTIFICATION

EPW

[redacted] (5)(6)-4

DIAGNOSIS: S/P Craniotomy/GSW @ shoulder

DRG: _____ ADMISSION DATE: 31 Oct 05

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAG[redacted] _____

ISOLATION REQUIRED (Specify): (5)(6)-2

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: 1230 INITIALS: [redacted]	TIME: 0430 INITIALS: [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.	☑	☐ intermittently oriented (b)(6)-2	☐
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.	☑ old trach site covered c 4x4.	☑	☐
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.	☑ encourage PO intake.	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
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.	☐ ↓ROM, ↓ mobility LLE amb. c assist today	☐ - ↓Rom to LLE - L sided weakness	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ - wound to R shoulder - old trach site	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ - 5/10 pain HA	☐
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: INITIALS:	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: NO ✓ needed	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

[redacted] (b)(6)-2

NEUROVASCULAR

SITE: LLE TIME: 1200	2430					
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	N				
MOTION	P	U				
PASSIVE FLEXION	/	Ø				
PERIPHERAL PULSE	2+	DP				

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: [redacted]					
ID band visible/legible	[redacted]					
Orient to environment prn						
Side rails (2/4)-up	NA	NA				
Bed position low		[redacted]				
Call light within reach		NA				

OTHER

Review & post lab results		[redacted]				
Notify MD abnormal labs		[redacted]				
Incontinent urine/stool		NA				
Linen change prn		[redacted]				
Turn/reposition q2h		NA				
ROM q2h if immobile						
Antiembolic hose						

(b)(6)-2

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 75%	PERCENT CONSUMED: 75%	PERCENT CONSUMED: -
HOW TOLERATED:	HOW TOLERATED: Well	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	BEDREST, AMBULATE, BSC, SRP, CHAIR	BEDREST, AMBULATE, BSC, BRP, CHAIR
	☐ SELF ☒ ASSIST # TIMES/SHIFT	☐ SELF ☐ ASSIST # TIMES/SHIFT	☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: 2430 INITIALS: [redacted]
CONTENT:	CONTENT:	CONTENT: - pain management - DSG Δ's - call for assistance
☐ Patient/Family Verbalizes Understanding	☐ Patient Family Verbalizes Understanding	☒ Patient Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	1
	[redacted]	2-09

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2130	(R) shoulder	-wands pink moist	WTD DSG'S NS
	2200	(L) shoulder	-S/S of infection -Ø drainage noted	

SECTION IV - NOTES

5DEC03
1340 PT FOUND ON FLOOR E (L) ARM RESTRAINT OFF BUT INTACT ET LLE RESTRAINT ON ET INTACT; DR [redacted] NOTIFIED ET NEURO CHECKS DONE [redacted] INTACT E Ø Δ FROM PDE FALL CHECKS. [redacted] ET PIWNG

(5)(6)-7

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

Page 4 of 4 pages

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: Dec 08 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 26 | HOSPITAL DAY: 38

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:	1200	2000	0400														
BP ARTERIAL LINE		100	99														
BP CUFF	89/52	47	49														
TEMPERATURE	98.1	97.7	97.7														
PULSE	52	78	76														
RESPIRATORY RATE	16	16	16														
OXYGEN (L/%)																	
PULSE OXIMETER		100%	100%														
O_2 METHOD		RA	RA														

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

PAIN

TIME:	1830								
PAIN INTENSITY (10 / 5 / 0)	X								
MED ADMINISTERED (Y/N)	N								
RELIEF ACCEPTABLE (Y/N)	NA								

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	1830		
*Skin breakdown prevention	NA		
*Falls prevention protocol	[redacted]		
*Restraint protocol	(b)(6)-2		
*Seizure precautions	NA		
*Isolation precautions	NA		

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

EPW

[redacted] (b)(6)-4

DIAGNOSIS: S/p craniotomy

DRG: _____ ADMISSION DATE: 1 NOV 08

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: 1830 INITIALS: [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.	☐ Pt intermittently confused - per translator	☐	☐
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.	☐ Pt voiding to urinal	☐	☐
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.	☐ Pt c ↓ ROM to LLE - unable to amb 5 extensive assist	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Scar to side of head DSG to back ✓CS	☐	☐
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: ____ INITIALS: ____	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:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) LE	TIME: 1830						
COLOR	P						
CAPILLARY REFILL	1						
TEMPERATURE	W						
EDEMA	0						
SENSATION	A						
MOTION	U						
PASSIVE FLEXION	0						
PERIPHERAL PULSE	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 / OTHER

	TIME: 1830				
ID band visible/legible	[redacted]				
Orient to environment prn					
Side rails (2/4) up	NA				
Bed position low					
Call light within reach					
Review & post lab results					
Notify MD abnormal labs					
Incontinent urine/stool	I				
Linen change prn	[redacted]				
Turn/reposition q2h	NA				
ROM q2h if immobile					
Antiembolic hose					

(b)(6)-2

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: Well
☐ 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); ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: Call for assist - Pain Managment - Dsg Δ	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

(b)(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW	[redacted]	[redacted] IT/AN	N
[redacted] (b)(6)-4			

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2400	(R) shoulder	-Moderate amt purulent drainage	W→D dsg Δ
	2400	(L) shoulder	-Wound red-Ø drainage-tod sg	W→D dsg Δ

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 8 Dec | 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:	1200	2000	0400	0745												
BP ARTERIAL LINE			140	144/68												
BP CUFF	114/64	120/68	84	111/68												
TEMPERATURE		97°	97.6	98.4												
PULSE	81	82	72	66												
RESPIRATORY RATE	16	20	16	16												
OXYGEN (L/%)																
PULSE OXIMETER	96%	97%	96%	97%												
O2 METHOD	RA		RA	RA												

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

PAIN

TIME:	0900	1200	1830	09												
PAIN INTENSITY (10 / 5 / 0)	0		X													
MED ADMINISTERED (Y/N)	N		N													
RELIEF ACCEPTABLE (Y/N)	N		NA													

SPECIAL NEEDS

TIME:	0900	1800
*Skin breakdown prevention	N/A	N/A
*Falls prevention protocol	[redacted]	
*Restraint protocol		N/A
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

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

PATIENT IDENTIFICATION

EPW # [redacted]

(5)(6)4

DIAGNOSIS: S/P Craniotomy

DRG: _____ ADMISSION DATE: 0

LOS: _____ EXPECTED RELEASE: NOV

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

2-0(6)

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: 0900 INITIALS: [redacted]	TIME: 1830 (5/6/-2) INITIALS: [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.	☐ A+O improving PERRLA w/ glasses	☐ Intermittently confused PERRLA	☐
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.	☑	☑	☐
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.	☐ (L) sided weakness ↑strength c arm ↓	☐ (L) sided weakness ↓ ROM to (L) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ ~~Dry~~ WNL	☐ healing wound to (R) side of head	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☐ see pg 1	☐
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: _____ INITIALS: _____	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:	IV Site #1: Ø access	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE	TIME: 0900	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	C	W				
EDEMA	1	1				
SENSATION	N	A				
MOTION	U	U				
PASSIVE FLEXION	D	D				
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:	0900	1830				
ID band visible/legible						
Orient to environment prn						
Side rails (2/4) up	D/A					
Bed position low						
Call light within reach						

OTHER

Review & post lab results						
Notify MD abnormal labs						
Incontinent urine/stool						
Linen change prn						
Turn/reposition q2h	D/A					
ROM q2h if immobile						
Antiembolic hose						

(5)(6)-1

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 25 %	PERCENT CONSUMED: 60-70	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☒ 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: 1830	INITIALS:	TIME:	INITIALS:
CONTENT: call for assist		CONTENT: - Call for assist - restraints		CONTENT:	
☒ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

(5)(6)-2

PATIENT IDENTIFICATION

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	06/18 N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1700	(R) shoulder	clr, thoroughly	Dressing Δ to Dakins
	1700	(R) Scapula	clr, thoroughly	Dressing Δ to Dakins

SECTION IV - NOTES

@ 1700 did dressing Δ to (R) Shoulder/Scapular pt taught S/S of infection. Slight erythema Boggy looking c Slight drainage Lateral Scapula wound. Shoulder small wound erythema & Boggy @ S/C of infection, Pressed c Dakins & Combine dressings [redacted] SPC(R) 9/W (5)(6)-7

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 9 Dec | PATIENT ACUITY LEVEL: III | POST-OP DAY: 28 | HOSPITAL DAY: 40

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:	0945														
BP ARTERIAL LINE															
BP CUFF	111/68														
TEMPERATURE	98														
PULSE	66														
RESPIRATORY RATE	16														
OXYGEN (L/%)															
PULSE OXIMETER	97%														
O_2 METHOD	RA														

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:	0945								
PAIN INTENSITY (10 / 5 / 0)	X								
MED ADMINISTERED (Y/N)	N								
RELIEF ACCEPTABLE (Y/N)	Y								

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:			
*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

EPW #[redacted]

(5)(6)-4

DIAGNOSIS: S/P craniotomy

DRG: _____ ADMISSION DATE: 1 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ (5)(6)-2

PRIMARY CARE MANAGER: [redacted]

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: 0945 INITIALS: [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.	☐ A/OX2 ↓ ↓ dizziness ↓ ↓ HA PE-212x/Com1 (R) side weakness (5/16)-2	☐	☐
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.	☐ ✓	☐	☐
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.	☐ (R) side weakness UPE ext.	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ drsg to (R) clavicle wound site S/S/Sx of infx W/D drsg IAW C Pakins	☐	☐
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.	☐ ✓ (5/16)-2	☐	☐

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

TIME: 0945 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:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	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 / OTHER

	TIME: 0945			
SAFETY	ID band visible/legible	[redacted]		
	Orient to environment prn			
	Side rails (2/4) up	/		
	Bed position low	/		
	Call light within reach	/		
OTHER	Review & post lab results	/		
	Notify MD abnormal labs	/		
	Incontinent urine/stool	[redacted]		
	Linen change prn	/		
	Turn/reposition q2h	/		
	ROM q2h if immobile	/		
	Antiembolic hose	/		

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	RRG		
PERCENT CONSUMED:	70%		
HOW TOLERATED:	well		
	☑ 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: / INITIALS:	TIME: / INITIALS:
CONTENT: - OOB to chair ĉ restraints - OOB ĉ asst. - interpreter - pain control - keep A/ox	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ [redacted]/Family Verbalizes Understanding

PATIENT IDENTIFICATION

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

INITIALS	[redacted]URE	SHIFT
[redacted]	[redacted] 59 Eqh 30	1
	(5)(6)-7	

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 13 DEC | 14 DEC | 15 DEC | 16 | 17 | 18 | 19

19 | HOUR

PULSE (0) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 22835

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY 20 21 22 23 24 25 26

HOUR 0 2 0 2 0 2 0 2 0 2 0 2 0 2

PULSE (0) | TEMP. F (°)

105° | 104° | 103° | 102° | 101° | 100° | 99° | 98.6° | 98° | 97° | 96° | 95°

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

107/71 | 109/66 | 109/66 | 109/66 | 105/72 | 110/68 | 108/64 | 114/66 | 116/70 | 117/67 | 117/59

HEIGHT: | WEIGHT →

90 | 111 | 74

98 | 983 | 98°

100% | 98%

98% RA | 99% RA | 99% 99% RA | 100% | 98% | 100% | 99% RA | 99% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (5)(6)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR | DAY: 27 Dec | 28 | 29 | 30 Nov | 31 | 01 02 | 02
19 | HOUR

PULSE (0) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

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]
(5)(6)-4

VITAL SIGNS RECORDS
Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 03 04 5 6 7 8 9

19 | HOUR

PULSE (0) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

[redacted] (b)(6)-4

MEDCOM - 22838

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY 16 JAN 17 JAN 18 19 19 | HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)

511-119 NSN 7540-00-634-412

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR JAN DAY 9 | 10 | 11 | 12 | 13 | 14/15 | 15

19 2004 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

105° 40.6°
104° 40.0°
103° 39.4°
102° 38.9°
101° 38.3°
100° 37.8°
99° 37.2°
98.6° 37.0°
98° 36.7°
97° 36.1°
96° 35.6°
95° 35.0°

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

02 5M7

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. ICN1

[redacted] (6)(6)-4

VITAL SIGNS RECORDS
Medical Record

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

MEDCOM - 22840