* U.S.GPO:1991-0-298-652/40648

11-185-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

ATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR w Abn	41	M	#EPW [redacted]	ICU2	
	FILM NO. b(4)-4				PREGNANT ☐ YES ☐
	REQUESTED BY (Print)				TELEPHONE/PA
	SI[redacted] b(4)-2				DATE REQUEST 14/6/03

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

CT

F EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

OGIC REPORT

T'S IDENTIFICATION *(For typed or written entries give: last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS

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 13 Jun 03 TIME OF ORDER 1230 HOURS

LIST TIME ORDER NOTED AND SIGN

1- ↓ FIO_2 TO 40% + ✓ ABG in 30 min — 13Jun03 1300 [redacted] b(6)-2

2- ↓ KVL TO 8

3 - ANCEF 1gm q8°

4 - Tylenol elixir THROUGH NG FOR TEMP >/100° — done 1420

5. ABG ↑ OXYGENATION — done

PATIENT IDENTIFICATION

DATE OF ORDER 14/6/03 TIME OF ORDER 2000 HOURS

(1) V.O. 4mg MS04 IVP for pn with CPT & Activity.

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

NURSING UNIT	ROOM NO.	BED NO.

✓ Chart 14/6/03 [redacted] 0400

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER 15 Jun 03 TIME OF ORDER 1245 HOURS

(1) Fentanyl patch 50mcg change q 3 days 1250 b(6)-2

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

15 Jun 03 1600

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 15 Jun 03 TIME OF ORDER 1540 HOURS

✓ 1- Regular Diet b(6)-2

Dr [redacted] b(6)-2

038

NURSING UNIT	ROOM NO.	BED NO.

24° chart ✓ 17 June 03 @ 0855 MR

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	13 JUNE 03	1335 HOURS	
✓	1- CT TO 20cm H2O SUCTION		13JUN03
✓	2- DC PROPOFOL		
✓	3- PHENYLEPH 25 g IVPB q6° PRN HYPOTENSION		
	4- NC TITRATE TO O2 SAT 92%		b(6)-2 CRN 1500
	b(6)-2 [redacted]		

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

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	0030 ↔ 14/6/03	HOURS	
	Albuterol neb tx prn for wheezing +/- √SPO2.		noted
	√.O. Dr. b(6)-2 [redacted]		

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

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	14/6/03	0030 HOURS	
(1)	D/C albuterol q order		
(2)	Albuterol neb tx x1 now. 0.5/2.5 NS. √.O. Dr. [redacted] b(6)-2		

Noted 14Jun03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	14 JUN 03	HOURS	
√	1- CT TO WATER SEAL - CXR in 2		1000
√	2- ALBUTEROL TX NEBULIZED q4° .5/2.5 NS		1000 b(6)-2 [redacted] CRN
√	3- AMBULATE q4° C ASSISTANCE		
√	4- I&O min q°		14JUN03 1030
√	5- CXR in AM		
√	6- Clone LIQUID DIET		
√	7- IVF to 50 cc/hr	1030 [redacted]	
	8- NT suction q2° x1		b(6)-2

038

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

1235 extub
135
25
100%
11/56

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER: 13 JUN 03 — TIME OF ORDER: 0630 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ 1- Admit to ICU
✓ 2- NPO
✓ 3- VS per Routine
✓ 4- 500 @ 2351
✓ 5- NKDA
✓ 6- Heparin 5000 u SQ q12°
✓ 7- Zantac 50 mg IVPB q8°

Noted [redacted] b(6)-2 0800 13 June

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

✓ 8- MSO4 1-4 mg q° prn PAIN
✓ 9- Propofol 10 mg q° drip. Titrate to sedation
✓ 10- Vent TV 750 RR 14 PEEP 5 FIO2 60%
✓ 11- ABG, CBC, Chem 12 on Arrival
✓ 12- Foley to Gravity

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

✓ 13- CXR on Arrival and q A.M.
✓ 14- IVF LR @ 100cc/hr
✓ 15- Admit to ICU GSW Chest

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER: 13 June — TIME OF ORDER: 1200 HOURS

Albuterol .5/NS 2.5 inhalation now x 1

V/O R. [redacted] b(6)-2

b(6)-2 [redacted] 12 ... MAJ/mw

NURSING UNIT | ROOM NO. | BED NO.

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

EPW # [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 16 JUN 03 | TIME OF ORDER: ______ HOURS | LIST TIME ORDER NOTED AND SIGN

1- DC foley b(6)-2 [redacted]

2- [illegible] @ [illegible]

noted 16 Jun 03 [redacted] CPT [illegible]

24° chart ✓ 17 June 03 @ 0355 [illegible]

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Jun 03 | TIME OF ORDER: 1145 HOURS

✓ 1- TRANSFER TO ICW

✓ 2- REGULAR DIET

✓ 3- VS PER ROUTINE

✓ 4- UP AD-LIB BUT AMBULATE AT LEAST q4°

✓ 5- [illegible] q°

✓ 6- Hep-lock IV

17 Jun 03 1230 [redacted] 2Lt AN b(6)-2

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

DATE OF ORDER | TIME OF ORDER ______ HOURS

✓ 7- T3 1-2 po q4° prn pain

8- MSO4 1-2mg q° prn breakthrough pain

9- Ancef 1gm q8° x 3 more doses b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° /s 2300 17 Jun 03 [illegible] [redacted]

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

DATE OF ORDER | TIME OF ORDER ______ HOURS

Ø38

NURSING UNIT | ROOM NO. | BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] b(4)-4	19 Jun 03		b(6)-2
NURSING UNIT: TCW2 / ROOM NO.: / BED NO.: 4			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	6/20	b(6)-2 HOURS	
	2200 VS. [redacted] ct Standard		
	@0600 mg Tylenol 40X now		
20 V's	[redacted]		
NURSING UNIT / ROOM NO. / BED NO.			b(6)-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW# [redacted] b(4)-4	21 Jun 03	2250 HOURS	Noted 2250
	V.O. 650mg Tylenol PO x1 now for pain		21 Jun
	Dr [redacted]	b(6)-2	
	b(6)-2 [redacted]	b(6)-2	b(6)-2
NURSING UNIT: TCW2 / ROOM NO.: / BED NO.: 9	22 [redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	23 June 03	HOURS	
	1-DC		
	[redacted]	b(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			

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

b(4)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16	17	18
13June03	[redacted]	NPO Clear liquid diet	07	[redacted]					
			11	[redacted]					
			17	[redacted]					
13June	[redacted]	VS per routine	05	[redacted]					
			17	[redacted]					
13June	[redacted]	Bed Rest	05	[redacted]					
			17	[redacted]					
13June03	[redacted]	Vent TV 750 RR 14	05	[redacted]					
		Peep 5, FIO2 60%	17	[redacted]					
13June03	[redacted]	Foley to Gravity	05	[redacted]					
			17	[redacted]					
13June03	[redacted]	CXR Q AM	04	[redacted]					
13Jun	[redacted]	CT to 20cm H2O	15	[redacted]					
		Suction	17	[redacted]					
13Jun	[redacted]	Foley to gravity	05	[redacted]					
			17	[redacted]					
14Jun	[redacted]	CT to water seal	05	[redacted]					
			17	[redacted]					
14Jun	[redacted]	Ambulate q4° c	05	[redacted]					
		assistance	17	[redacted]					
14Jun	[redacted]	IS 10min q hour	05	[redacted]					
			17	[redacted]					
14Jun	[redacted]	NT suction q4°	05	[redacted]					
			17	[redacted]					
15Jun	[redacted]	Regular diet	07	[redacted]					
			11	[redacted]					
			17	[redacted]					

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(4)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(4) - 12 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 06 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
13 June	[redacted]	Admit to ICU GSW Chest	13 June 03	Admit	0655	[redacted]	
13 June	[redacted]	ABG, CBC, Chem 12 on arrival	13 June 03	Admit	0810	[redacted]	
13 June	[redacted]	CXR on arrival	13 June 03	Admit	0735	[redacted]	
13 Jun	[redacted]	ABG in 30 mins	13 Jun	NOW	1345	[redacted]	
13 Jun	[redacted]	ABG p extubation	13 Jun	NOW	1445	[redacted]	
14 Jun	[redacted]	CXR in 1°	14 Jun	1000	1000	[redacted]	
14 Jun	[redacted]	CXR in AM	15 Jun	0500	0535	[redacted]	
14 Jun	[redacted]	NT suction q 2° X2	14 Jun	1000	1000	[redacted]	
			14 Jun	1200	1200	[redacted]	
16 Jun	[redacted]	CXR @ 1000	16 Jun	1000	1100	[redacted]	

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

USAPA V1.00

b(6)-2
All

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. 6 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
17 Jun	[redacted]	Diet: Regular	07	/	[redacted]												
			12	/													
			17	[redacted]													
17 Jun	[redacted]	Vital Signs per routine	05	/													
			13	[redacted]													
			21														
17 Jun	[redacted]	Up ad Lib but Ambulate at least Q4	04	/													
			08	/													
			12	/													
			16	[redacted]													
			20														
			24														
17 Jun	[redacted]	IS 10min Q1°	05	/													
			13														
			21														
17 Jun	[redacted]	Heplock IV	05	/													
			13	/													
			21	/													

See White Sheet

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: GSW CHEST

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 6 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 Jun	b(6)	Transfer to ICU	17	done		[redacted]
19	[redacted]	CXR in AM	20	1815		[redacted]
23		DC TODAY	23	today		
	b(6)					

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. 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18
13 June 03	[redacted]	Heparin 5000 unit SQ	10	[redacted]					
b(6)-2		Q 12°	22						
13 June 03	[redacted]	Zantac 50mg IVPB	08	[redacted]					
b(6)-2		Q 8°	16						
			24						
13 June 03	[redacted]	Propofol 10mg Q° drip	05	[redacted]		D/C 13 June 03			
b(6)-2		titrate to sedation	17						
13 June 03	[redacted]	IVF LR @ 100 cc/hr	05	[redacted]		D/C			
b(6)-2			17						
13 Jun	[redacted]	Ancef 1gm IV q 8°	06	✓	[redacted]				
b(6)-2			14						
			22						
13 Jun	[redacted]	NC titrate to O2	05	✓					
b(6)-2		sat > 91%	17						
14 Jun	[redacted]	Albuterol Tx nebulized	04	✓	✓				
b(6)-2		q 4° (0.5/2.5 NS)	08	✓	[redacted]				
			12	✓					
			16	✓					
			20	✓					
			24	✓					
14 Jun	[redacted]	IVF LR @ 50cc/hr	05	✓					
b(6)-2			17	✓					
15 Jun 03	[redacted]	Fentanyl patch		✓					
b(6)-2		50mcg/hr Change	13	✓	✓	[redacted]	✓	✓	✓
		q 3 days		✓	✓	✓	✓	✓	✓

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW Chest

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

PATIENT IDENTIFICATION: [redacted]

b(a)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (*MEDICATIONS*)	Mo. 6 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
13 Jun	[redacted]	Albuterol 0.5/2.5NS x 1 now	13 Jun	now	done	[redacted]
13 Jun	[redacted]	↓FiO2 to 40%	13 Jun	/	1245	[redacted]
14/6	[redacted]	Albuterol 0.5/2.5NS x1 now	14 June	now	0100	[redacted]
14/6	[redacted]	MSO4 4mg IVP x1 for pn c̄ Activity	14/6	Now	2000	[redacted]

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
13 June 04	[redacted]	MSO4 1-4mg Q° prn pain	0820 [redacted] 4mg	13 Jun 2mg 1220	13 Jun 4mg 1900	13 Jun 4mg 1945	13 Jun 2mg 2000	13 Jun 4mg 2130	13 Jun 4mg 2300	13 Jun 4mg 0000	14/6 4mg 0115	14/6 4mg 0230	14/6 4mg 0410	14 Jun 2mg 0700	14 Jun 0840	14 Jun 1045
			[redacted]													
13 Jun	[redacted]	Tylenol 650mg NGT for temp >100.5	13 Jun 1420 [redacted]	13 Jun 0030 650	14 Jun 1200 [redacted] 650 po	14 Jun 1100 650	15/6 2000 650 [redacted]	15 Jun 1200	14 Jun 1300							
13 Jun	[redacted]	Phenergan 25mg IV q̄ 6° prn nausea														
Rewritten 14 Jun	[redacted]	MSO4 1-4mg IV q̄ ° prn pain	14 Jun 1230 2mg	14 Jun 1530 3mg	14/6 1800 4mg	14/6 1900 4mg	14/6 1940 2mg	14/6 2000 6mg	14/6 2100 4mg	14/6 2200 4mg	14/6 2300 4mg	15/6 0000 4mg	15/6 0100 4mg	15/6 0200 2mg	15/6 0300 4mg	17/6 0400 4mg
			[redacted]													
-----	-----	MSO4 1-4mg IV q° PRN for pn.	15 Jun 2mg 0550	15 [redacted] 0650	15 1000	15 Jun 2mg 1225	15 Jun 1700									
-----	-----															
-----	-----															
-----	-----															

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

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. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
17 Jun	[redacted]	Ancef 1gm Q8°	06	[redacted]		X	—	—	—	—	—	—	—	—	—	—	—
b(6)-2		x 3 more doses	14		X	X	—	—	—	—	—	—	—	—	—	—	—
			22		X	X	—	—	—	—	—	—	—	—	—	—	—
17 Jun	[redacted]	Heplock IV	5	[redacted]								D					
b(6)-2			13														
			21														
17 Jun	[redacted]	Heplock IV	5	/	/	/	/	/	/	[redacted]			DC	[redacted]			
b(6)-2			13	/	/	/	/	/	/								
			21	/	/	/	/	/	/								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW CHEST

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			*Mo.*_____ *Yr.*_____	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
6/20	[redacted]	650 mg Tylenol PO	6-20	2200	2200	[redacted]
6/20	[redacted]	650 mg tylenol PO	6/20	2230	0030	[redacted]

	-----					

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

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	***INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION*** **TIME/DATE DISPENSED**
Jun 17	[redacted]	T3 1-2 PO Q4 PRN Pain	6/18 2430 PO [redacted]; 6/19 1030 T PO [redacted]; 18 Jun 21:00 II PO [redacted]; 19 Jun 0805 PO [redacted]; 19 Jun 1235 PO [redacted]; 19 1830 BRS II; 19 Jun 0817 PO II [redacted]; 20 Jun 1230 II PO [redacted]; 22 June 0815 II PO [redacted]; 22 Jun 0000 II PO [redacted]; 23 June 0725 [redacted]
Jun 17	[redacted]	MSO4 1-2 mg Q° PRN breakthrough pain	
Jun 17	[redacted]	b(6)2	
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→ b(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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	INITIALS [redacted]	b(6)-2	INITIALS [redacted]	b(6)-2	INITIALS
NEURO	PUPILS	2mm Sluggish	3mm Brisk			
	SENSORIUM	Sedated Opriviam	PERRLA			
		infusing				
RESPIRATORY	RESPIRATORY PATTERN	Vent SIMV 14 TV 750 60% FS	RR 16-30			
	BREATH SOUNDS	Coarse @ wheezing chest	Shallow			
	SECRETIONS	Thick Tan secretions	Slight wheezing			
		Chest expansion	throughout RtL			
			Diminished @ bases L & R			
SKIN	COLOR	Normal	Normal for Race			
	INTEGRITY	incisions intact	Inc - median Sternum			
			warm - dry			
I.V. SITE	LOCATION	DEJ. (L) AC	(R) ES (L) AC 18g			
	CONDITION	CDI S/S infiltration	use of SL equipment			
GASTRO	ABDOMEN	Soft, ND, nofound	SNTND			
	BOWEL SOUNDS	Absent bowel	X2 BS hyperactive			
		Sounds	Sips of H2O QI-2°			
GU	URINE:	foley	foley - cyu ~70cc°			
	COLOR/CLARITY	clear yellow				
CARDIOVASCULAR	CARDIAC RHYTHM	ST & HR 109-113	ST & HR 120-130's			
			= pulses throughout			
			CR < 3sec			

LEGEND

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 13 Jun 03

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

EPW [redacted] b(6)-4

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

13 Jun 03

1235 ✓

DATE | DX | HOSPITAL DAY

	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
VITAL SIGNS	BP Arterial Line																		
	BP Cuff					130/86	112/66	113/72	129/65		128/70	129/65	121/64	119/60	113/55	135/71	119/65	127/72	
	Temperature					98.7		101.1			102.8		102.1					100.5	
	Pulse					114	115	113	121		137	136	131	126	135	125	120	135	
	Respiratory Rate					31	14	14	21		25	24	27	26		18	20	36	
	SpO2					98	100	100	100		100	100	98	98	94	99	99	96	86
	FIO2					60	60	60	60		15L	3L	3L	5L	5L	5L	5L	5L	
															[redacted]				
																	602		
	pain																		
	intervention																		

	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
INTAKE	LR				200	100	100	100	100	600	100	100	100	100	100	100	100	NPO	
	Diprivan				24	24	21	24	24	117	off	off	off	off	0	0		0	
	IVPB					50				50		50		50					
					-	154	129	124	124		100	150	100	150					
	TOTALS				224 200	328 350	250 150	348 250	767	767	100	250	350	500	100	100	100	900	900
OUTPUT	URINE HOUR / TOTAL																		
	URINE 10gm Urea			200	200	400	100	150	150		150	125	100	75	75	70	70	70	2025
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS JP				75	80		80			35	60		10				60	
	DRAINS CT						28	59						20				5	
					275	480	128	289	150		185	185	100	105					
	TOTALS			200	475	955	1108	1321	1522	1522	185	370	470	575				640	640

POST-OP DAY

VITAL SIGNS

	21 / 16	22 / 17	23 / 18	00 / 19	01 / 20	02 / 21	03 / 22	04 / 23	
BP	110/66	104/62	105/67	109/63	107/64	104/65	111/64	124/72	
T				101.1	100.5				
R	127	123	121	122	120	115	111	115	
RR	29	19	20	12	12	15	14	30	
O2	91	95	98	99	98	99	100	94	
	RA	6L	4L	4L	4L	4L	4L	4L	
		NC	NC	NC	NC	NC	NC	NC	
	VCS		VCS		NCR4 / c SCD		VCS	VCS	

INTAKE

	21 / 16	22 / 17	23 / 18	00 / 19	01 / 20	02 / 21	03 / 22	04 / 23	8° T
	100	100	100	100	100	100	100	100	2200
		~~50~~		50					117
		50		50					300
									(2017)
	1000	1150 ~~1145~~			1500			1800	[illegible]

OUTPUT

					400				
	80	80	80	90	70	70	70	70	2035
				40				30	470
				5				15	131

ACUITY LEVEL CLASSIFICATION

estimated

RESPIRATORY DATA

TIME	0700	0800	1235	1445
MODE	SIMV			
F_iO_2	60		40	10L
TV	750			
RATE	14		8	
PEEP	5			
ABG pH		7.34	7.36	7.44
PCO_2		42	45.5	39.8
pO_2		290	111	135
HCO_3		23	26	27
SAT		100	98	99
BASE		0	1	3

LABORATORY DATA

TIME	
GLUCOSE	150
Na/K	146 / 3.4
Cl/CO_2	109 / 24
BUN/Cr	12 / 1.3
WBC/PLATELET	5.2 / 336
Hct/Hgb	48 / 14.6
Alb / ALT	3.6 / 134
Amy / AST	557 / 124
Ca.	8.2

DAILY LIVING ACTIVITIES

TIME	1900 / 0446
MOUTH CARE	✓
BATH	✓
SKIN CARE	✓
FOLEY CARE	✓
TRACH CARE	/
ROM EXERCISES	/
I	

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE: IV 2017; po ______

OUTPUT: Urine: 2035; JP/CT ~~[illegible]~~ 470/131

TOTAL 2017 TOTAL 2636

BALANCE − 19cc

NURSE'S SIGNATURE | INITIALS

[redacted]

LT [redacted]

b(6)-2

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	INITIALS AW	1800	INITIALS DLP		INITIALS
NEURO	PUPILS	3mm Bush	3mm-4mm Brisk			
	SENSORIUM	Alert, talkative	AOX3 talkative			
		Appropriate in conversation	FC MAE + holds conversation appropriately			
RESPIRATORY	RESPIRATORY PATTERN	Reg, nonlabored, but	RR 14-20's, shallow			
	BREATH SOUNDS	shallow. Crackles	mildly labored c			
	SECRETIONS		Bronchi + wheezing			
		Diminished to bases (B)	throughout. Diminished			
			@ bases c LLL throughout			
			SpO2 ~98% 2L NC Pulm toilet			
SKIN	COLOR	Normal	Normal for Race c			
	INTEGRITY	Intact; incisions c	Purple undertones			
		dressing CDI. Breakdown	Sternum - coccyx/chest			
IV SITE	LOCATION	L PAC R EJ	@ AC 18g			
	CONDITION	Oss infiltration	Flushes well			
GASTRO	ABDOMEN	Round, ND, NT	Round, SND slightly			
	BOWEL SOUNDS		tender c BSx3			
			hyperactive.			
GU	URINE:	Yellow	Golden - golden yellow			
	COLOR/CLARITY	dark yellow concentrated	~70cc			
CARDIOVASCULAR	CARDIAC RHYTHM	ST c HR 117	ST-HR 117-120's.			
		Palpable pulses (B)	3+ pulses throughout			
		Cap refill ≤ 3secs	CRT 3secs			
		Pedema noted	+face edema, [redacted] +b(6)-2			

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

(Continue on reverse)

PA[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 14 Jun 03

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

[redacted] b(6)-4

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

14 Jun 03

DATE | DX | HOSPITAL DAY

VITAL SIGNS																			
TIME	~~05~~ 04	~~06~~ 07	~~07~~ 02	~~08~~ 03	~~09~~ 04	~~10~~ 05	~~11~~ 06	~~12~~ 07		13 ~~08~~ 08	14 ~~09~~ 09	15 10	16 ~~11~~ 11	~~17~~ 12	~~18~~ 13	~~19~~ 14	~~20~~ 15	
BP Arterial Line		114/63																
BP Cuff	121/68	~~104/63~~	123/70	109/62	117/66	119/73	115/63	108/61		112/61	149/61	131/73	111/60	~~111~~/60	117/65	125/72	139/74	
Temperature			99.6				101.4			102			98	101.8	101.3	/	/	
Pulse	114	119	116	117	118	126	130	128		135	138	135	141	137	123	121	130	
Respiratory Rate	18	14	14	15	16	32	20	16		21	21	29	24	28	23	22	24	
SpO2	97	99	100	98	96	95	98	98		96	96	96	97	98	97	99	98	
															2L	2L	2L	
															NC	NC	NC	
															ICS	ICS	IC	
																CDB	CDB	
open intermittent																		

INTAKE																			
TIME	~~05~~ 04	~~06~~ 07	~~07~~ 02	~~08~~ 03	~~09~~ 04	~~10~~ 05	~~11~~ 06	~~12~~ 07	8°T	~~13~~ 08	~~14~~ 09	15 10	16 ~~11~~ 11	~~17~~ 12	~~18~~ 13	~~19~~ 14	~~20~~ 15	8°T
LR	100	100	100	100	100	30	50	50		50	50	50	50	50	50	50	50	1030
	20	20	20	20	20	20												120
IVPB		50		50							50		LR Ondis 1000					1150
	120	170	120	170	120	50	50	50		50	100						2800	2800
TOTALS	120	290	410	580	700	750	800	850		50	150							

OUTPUT																			
URINE	HOUR	50	50	100	50	75	75	50	50		75	25	40	80	80	85	80	80	1050
	TOTAL		100	200	250	325	400	450	500		75	150							1040
	SpGr																		290
	S/A																		
NG	OUTPUT																		
	pH																		
	GUAC																		
EMESIS																			
STOOL																			
DRAINS	JP		20			5	Removed					OUT							25
	CT		10									7					10		27
			130	230	50	80	75												
TOTALS		50	~~80~~ 130	~~120~~ 230	280	360	435	485	535	~~535~~								702	

1 1 - 0

POST-OP DAY: 21 | 22 | 23 | 24 | 01 | 02 | 03 | 04

VITAL SIGNS

	21	22	23	24	01	02	03	04	
	16	17	18	19	20	21	22	23	
	✓	✓							
	149/60	117/62	111/61	119/67	110/61	119/61	119/68	109/62	
	✓	✓	✓	✓	✓	100.3	✓	✓	
	131	124	124	122	120	121	123	126	
	98	99	14	19	22	15	14	8	
	98	99	98	99	99	98	98	97	
	2L	2L	2L	2L	2L	2L	2L	2L	
	NC	NC	NC	NC	NC	NC	NC	NC	
	105	105	105	105	105	103	—	105	
	COPD	COPD	COPD	COPD	COPD	COPD	CPT	CPT	
				NPB				NEB	

INTAKE

	21 16	22 17	23 18	24 19	01 20	02 21	03 22	04 23	8° T
	50	50	50	50	50	50	50	50	410
		50		50					100
									2810

OUTPUT

	50	50	50	50	50	50	50	50	1390
				15				30	72
									1390

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME	1900	2300
MOUTH CARE	✓	✓
BATH	✓	
SKIN CARE	✓	
FOLEY CARE	✓	
TRACH CARE	✓	
ROM EXERCISES	✓	

TURN

TIME					

SUCTION

24°I&O TOTALS

wt Yesterday: ____ wt Today: ____

	INTAKE	OUTPUT
IV	2810	Urine: 1387
po		
TOTAL		TOTAL
BALANCE		+1423

NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	b(6)-2 INITIAL [redacted]	1730 INITIAL [redacted]	b(6)-2 INITIALS
NEURO	PUPILS	=Reactive 3mm	PERL @ 3mm Brisk.	
	SENSORIUM	Alert, oriented	Alert awake oriented	
		Talkative	MAE x 4. Responds	
			appropriately to	
			commands.	
RESPIRATORY	RESPIRATORY PATTERN	Reg, unlabored	Unlabored, Regular.	
	BREATH SOUNDS	upper clear, diminished bases	Ronchi throughout.	
	SECRETIONS	Ø	BS diminished @ bases	
		I/S in use & coughing	+ Coughing non pro-	
		nonproductively	ductive. (2) CT to	
			water seal. 2LNC. Osats 97%	
SKIN	COLOR	Normal. incisions	Normal for race.	
	INTEGRITY	intact Ø drainage	Intact.	
		noted		
I.V. SITE	LOCATION	L) hand 18G	(L) HAND 18G	
	CONDITION	COI Ø SS infiltration	Ø SS of infiltration	
GASTRO	ABDOMEN	Round NT, ND	Round, soft non	
	BOWEL SOUNDS	hypoactive	distended. Hyperactive	
			BS x 4 quadrants	
GU	URINE:	dark yellow	Dark yellow.	
	COLOR/CLARITY	foley	Foley to gravity	
CARDIOVASCULAR	CARDIAC RHYTHM	ST & HR 1105-120's	ST HR 110's-130's.	
		Palpable pulses	PPP x 4 extremities.	
		Ø edema		

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 15 Jun 03

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

EPW [redacted] b(6)-4

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

DATE 15 JUN	05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
BP Arterial Line																		
BP Cuff	123/65	129/71	131/73	130/68	125/73	117/66	116/66	123/73		138/64	127/70	127/71		120/68	127/71	136/46	102/76	
Temperature		99⁹				99⁸		101				99¹				98⁸		
Pulse	124	123	127	120	108	117	118	121		131	116	117	120	129	124	126	122	
Respiratory Rate	23	20	12	15	21	17	18	28		25	20	22	24	25	25	28	25	
O2 Sats	94	94	98	92	97	96	97	98		96	99	94	97	95	95	95	95	
FiO2														NC 2L	N.C. 2L	N.C. 2L	N.C. 2L	

gain
intervention

TIME	~~24~~ 05	~~01~~ 06	~~02~~ 07	~~03~~ 08	~~04~~ 09	~~05~~ 10	~~06~~ 11	~~07~~ 12	8° T	~~08~~ 13	~~09~~ 14	~~10~~ 15	~~11~~ 16	~~12~~ 17	~~13~~ 18	~~14~~ 19	~~15~~ 20	8° T
LR	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
IVPB		50		50							50		50					
PO					60		60	150					50					
		100	50	100	110	50	110	200		50	100	50	150	–	50	50	50	
TOTALS	50	150	200	300	350	400	510	710	(710)	50	150	200	350	400	450	500	550	(550)

OUTPUT																			
URINE	HOUR / TOTAL	40	45	50	50	100	150	200	100		125/125	150/275	200/475	60/535	60/595	50/645	100/745	150/895	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT hourly																		
	CT TOTAL	203																	
TOTALS																			

535
-203

POST-OP DAY 21 22 23 24 01 02 03 04

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	21	22	23	24	01	02	03	04	
	~~16~~	~~17~~	~~18~~	~~15~~	~~20~~	~~21~~	~~22~~	~~23~~	
	124/67	138/74	117/70	131/74	130/90	123/65	135/64	120/70	
		99				99		100.0	
	123	130	120	130	117	120	106	111	
	22	25	20	26	20	22	20	18	
	96	95	95	95	91	96	95	95	
	2L	2L	2L	2L	NC 2L	NC 2L	2L	2L	
	21	22	23	24	01	02	03	04	

INTAKE

	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	8° T
	50	50	50	50	50	50	50	50	
		~~150~~		50					
									1760
	50	150	50	50	50	50	50	50	
	~~50~~	200	250	300	350	400	450	500	(500)

OUTPUT

	50/945	50/995	100/1050	75/1170	75/1245	75/1320	100/1420	100/1520	(1520)
									1852
									332

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

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

TURN

TIME	
Amb	

SUCTION

24 HR I&O TOTALS

wt Yesterday _____ wt Today b(6)-2

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

INITIALS [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 8 Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

		0515 TIME / INITIALS [redacted]	1900 / INITIALS [redacted]	2200 / INITIALS [redacted]
NEURO	PUPILS	Pupils 2-3mm + brisk.	PERRL 3mm	
	SENSORIUM	Round + reactive to light. Alert + Oriented x3, very interactive	alert - communicates appropriately / & acute distress - smiles at times denies pain	
RESPIRATORY	RESPIRATORY PATTERN	Lungs diminished in bases bilaterally c crackles noted in (R) lower lobe. Chest tube to (L) lateral side to water seal	non-labored / shallow at times	Slight distant crackles insp. (B) VL; diminished (B) bases
	BREATH SOUNDS		clear c fine inspir crackles & diminished in bases.	
	SECRETIONS		& secretions	
SKIN	COLOR	Color normal for race	WNL for race, pink mucous membranes	midline chest incision c staples intact & SIS infection. (L) chest & dressing c/d/I.
	INTEGRITY	Drsg to chest clean, dry, + intact	Dsg (L) chest dry + intact. midline staples chest dry + intact	
IV SITE	LOCATION	IV in (L) hand c NS	IV (L) hand infusing well	IV (L) hand infusing c difficulty, positional at times
	CONDITION	infusing c 50cc/hr. No evidence of edema or erythema noted	& patent & swelling	
GASTRO	ABDOMEN	Abdomen round + taut c hyperactive bowel sounds noted	Abd Round, Firm BS hyperactive	abd. round, firm non-tender to palp hypoactive BS x 4 quadrants (+) flatus
	BOWEL SOUNDS			
GU	URINE:	foley to gravity		
	COLOR/CLARITY	draining amber colored urine		
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus tachycardia noted c HR in high one hundreds and low 120's. (+) palpable pulses noted	ST & ectopy all paced	Sinus tachy. (+) pulses x 4 extremities

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

b(6)-4

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 16 JAN 03

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

[redacted] b(6)-4

EPW

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

CSW TO CHEST

DATE 16 JUN 03 | DX S/P Pericardial Window/Sternotomy | HOSPITAL DAY

VITALS/SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff	137/74	131/80	127/76	133/81	125/66	129/74	135/75	141/79		137/83	114/67	119/70	123/64	122/71	117/80	145/88	147/6?	
	Temperature		100.3			100.2							100.7	99.7					
	Pulse	116	117	110	124	113	117	129	122		118	117	97	105	109	109	110	111	
	Respiratory Rate	14	21	20	24	25	23	21	33		17	19	23	22	23	20	24	22	
	O2SATS	98%	96	98	97	96	98	96	95		97	99	99	95	99	96	96	94	
	FiO2	4L	4L	4L	4L	4L	4L	4L	4L		4L	4L	4L	4L	4L	2L	2L	2L	
	open intubation	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
	IVPB		50		50							50		50					
	PO			100									100		250 →				
		50	100	150	100	50	50	50	50		50	100	150	100	50				
	TOTALS	50	150	300	400	450	500	550	600 + 200	600	50	150	300	400	450	500	550	850	

OUTPUT			TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE	HOUR		150	85	175	150	Foley d/c'd			900							500			
		TOTAL		150	235	410	560											1060			
		sp gr																			
		S/A																			
	NG	OUTPUT																			
		pH																			
		GUIAC																			
	EMESIS																				
	STOOL																				
	DRAINS	CT/hourly		0	15	0	0	CT pulled													
		CT TOTAL		535	550																
	TOTALS			150	250	325	505				1405	(1405)						1905			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	24	22	23	24	01	02	03	04
	116/66	121/68	109/61	121/64	129/77	139/80	131/64	139/71
				98.8				
	108	114	103	112	110	97	103	106
	16	20	19	18	24	18	20	18
	99	99	100	98	100	100	99	96
	4L	4L	4L	4L	4L	4L	4L	4L
	21	22	23	24	01	02	03	04

INTAKE

	16	17	18	18	20	21	22	23	8° T
IV	50	50	50	50	50	50	50	50	
PO		50		50					
	900	950	1000	1100	1150	1200	1250	1300	1300

OUTPUT

			100/180				500/1240		340

RESPIRATORY

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

LABORATORY

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

ACTIVITIES OF DAILY LIVING

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

TURN

TIME					

SUCTION

TIME					

24° I&O TOTALS

NURSE'S SIGNATURE | INITIALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

[redacted]

b(6)-2

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	18	22
EYES OPEN	SPONTANEOUSLY	4	4	4
	TO SPEECH	3		
	TO PAIN	2		
	NO EYE OPENING	1		
BEST VERBAL RESPONSE	ORIENTED	5	5	5
	CONFUSED	4		
	VERBALIZES	3		
	VOCALIZES	2		
	NO VOCALIZATION	1		
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	6	6
	LOCALIZES PAIN	5		
	FLEXION WITHDRAWAL	4		
	ABNORMAL FLEXION	3		
	EXTENSION TO PAIN	2		
	NO MOTOR RESPONSE	1		

LIMBS MOVEMENT		18	22
ARMS	NORMAL POWER	✓	✓
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LEGS	NORMAL POWER	✓	✓
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		

PUPILS			18	22
RIGHT	SIZE			3
	REACTION			++
LEFT	SIZE			3
	REACTION			++

PUPIL SCALE: ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

LEGEND
- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- ++ Brisk
- + Slow
- − No Response
- + Intact
- − Abnormal

VASCULAR ASSESSMENT

HOURS	
	R L
	R L
	R L
	R L
	R L

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	b(6)-4	INITIALS		INITIALS
NEURO	PUPILS		PERRL, 3mm					
	SENSORIUM		A&O×3, Moves all					
			extremities, talks abt					
RESPIRATORY	RESPIRATORY PATTERN		CTA diminished in					
	BREATH SOUNDS		the bases. ∅ cough					
	SECRETIONS		or congestion. ∅					
			secretions					
SKIN	COLOR		warm, pink, dry					
	INTEGRITY		midline incision @ chest					
			dressing CDI					
IV SITE	LOCATION		IV LR @ 50cc/hr @ hand					
	CONDITION		Patent ∅ S/S of infection					
GASTRO	ABDOMEN		round ∅ masses or wounds					
	BOWEL SOUNDS		Bowel sounds Hypoactive					
GU	URINE:		voids ∅ urinal					
	COLOR/CLARITY							
CARDIOVASCULAR	CARDIAC RHYTHM		RRR, tachy, S1 S2					
			∅ ectopy @ Pulses					
			in all extremities					

LEGEND

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE
17 June 03

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

EPN# [redacted] b(6)-4

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

DATE 17 June 03 | DX GSW to chest | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	BP Arterial Line																
	BP Cuff	130/78	134/80	129/80	130/88	134/78	120/66	130/70									
	Temperature	99.4						100									
	Pulse	102	100	106	106	104	104	106									
	Respiratory Rate	14	16	16	16	20	24	20									
	O2 Sat	97%	94%	95	96	92	99%	93%									
	FiO2	2LPM	2LPM	RA	RA	RA	2LPM	RA									

INTAKE	TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	LR	50	50	50	50	50	50	50									
	IVPB		50		50												
	PO																
	TOTALS																

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	URINE			100 cc			580 cc											
		sp gr																
		S/A																
	NG	OUTPUT																
		pH																
		GUIAC																
	EMESIS																	
	STOOL																	
	DRAINS																	
	TOTALS																	

POST-OP DAY

VITAL SIGNS	21	22	23	24	00	01	02	03	
INTAKE	21	22	23	24	00	01	02	03	8°T
OUTPUT									

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN	TIME					
SUCTION						

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

GSW chest intub EMT unconscious

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

OTSG APPROVED (Date)

Date: 13 Jun 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block 3L (EMT)

Time In: 0650

Allergies: OR Intake: Crystalloid Colloid 2500

Pre-op V/S: 5997, 105 OR Output: UOP 1500 EBL 1000

Procedures: Sternotomy, pericardial window Meds/Times:

fent 50mg
Versed 5mg
Zofran 4mg
Ø reversal

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | IO History

Time	0650	0700	0705	0710	0715	0720	0725	0730	0735
SaO2	100	100	100	100	100	99	99	100	
FiO2	100	100	100					100	
Methods	BVM								

166/91
103
21
100%

0750 dip

9 4 2

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0520					200

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S: X = A-line BP, * = Cuff BP, = Pulse

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

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

RR	30	13	12	20	14	32	40	31		
T		98			99					
Time										
Pain (0-10)										
LOS										

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 13 Jun 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

66-2 all

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0820		MSO4 4mg	IV			[redacted]

NEUROVASCULAR

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

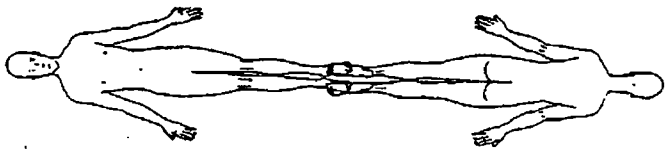
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Sternal	4x4	CDT
30'	"	"	"
60'	"	"	"
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0700	ST	Ø	

WAMC OP 173-E

NURSING NOTES

0655 - Arrived from OR. vent SIMV R14 PS TV 607. CT to 20cm suction to (L) CW. Hyperdrive 16/99 MD aware. Aline (R) Radial clotted. NGT + Foley drained clamped. T 93.4 [redacted]

0750 - Diprivan started 10mg 1kg/min BP 156/108 Pt c twitching movement of head and UE biting ETT. IVF LR infusing TKO. (R) EJ line ETT 27c bite block #8.5 [redacted]

0820 - Dr [redacted] informed of T 93.4 pt cool to touch, BP ↑ orders given to titrate diprivan and continue to apply blankets. Will cont. to monitor ST c HR 110. Transfer from PACU status to ICU [redacted]

Late entry: 0710 BP ↑ 190/112, pt moving head/UEs. Attempting to notify MD [redacted] date

0740 BP 214/115 HR 106 R40 MDC bedside beginning diprivan drip to sedation [redacted]

Late entry 0820: Continuing to reassure pt c blanket c slow progression. 160's/80's BP. Will cont. to monitor status [redacted]

Discharge Criteria:
Date: 13 Jun 03 **Time:** 0830 **PARS:** (see PARS
BP: 164/83 **T:** 94.2 **HR:** 101 **RR:** 31 **Sa02:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. ...r LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A								

3. REGISTER NUMBER						
9	10	11	12	13	14	15
0	0	1	3	4	6	3

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

4. PAY GRADE			5. SEX	
16.	17	EPW	18	
			M	

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

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
Z			—	9	9	[redacted]								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: 2		b(6)-4

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
N	O		K	7	9									

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	NO
I	Z								9		☐

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICU #1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
28TH CSH -	UNK	UNK

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
Ø	5							0	3	0	6	2	3

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	E	A	A							0	3	0	6	1	3

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

FOR LOCAL USE

DX: GSW to chest

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

ADMITTING DR [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2095 MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

1. NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
00135173	EPW # [redacted] b(6)-4	—	

4. AGE	5. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M 33Y	Iraqi	—	—	—	NO

12. SSN	13. ORGANIZATION	14. WARD
[redacted]	b(6)-4	ICW2

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

21. ADMISSION AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE	ADMISSION REMARKS
Direct from ER		Orthopedics	662

24. RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK		2003 June 19

27. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27a. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	2003 June 06	[redacted]

29. AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	31. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
28 CSH (CAMP Dogwood)		

32. ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. HISTORY

34. INVESTIGATIONS AND SPECIAL PROCEDURES

DX → GSW (L) abdomen

35. Days This Facility

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

36. All Facilities

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

37. ATTENDING MEDICAL OFFICER: b(6)-2 [redacted]

38. SIGNATURE OF RMO OR MEDICAL RECORDS OFFICER: [redacted] SPC b(6)-2

DA FORM 3647, MAY 79

MEDCOM - 10675

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

33 YO IRAQI POW SHOT IN LEFT FLANK/ABDOMEN
C/O ABDOMINAL PAIN.

FLUIDS: Ø PSH: Ø ALL: Ø MEDS Ø

PHYSICAL EXAMINATION

GEN: AOX3, MOD DISTRESS VS: 110/78 HR 109 RR 22 97% RA
HEENT: UNREMARKABLE CARDIAC: RRR S SUBDIAPHRAGMATIC FR
NECK: CTA B/L PELVIC: NL
CHEST: CTA B/L
CARD: RRR TACHYCARDIC
ABD: TTP SUPRAPUBIC & LLQ
RECTAL:
GU: TESTES WNL Ø MASS
NEURO: 5/5 MOC GROSSLY INTACT

LABS 15.6 12.0/209 89.5
139/107/12/119
4.3 26 .8

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

POD: GSW TO ABDOMEN
PLAN: TO OR FOR EX LAP

[redacted] b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

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

b(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 JUN 03	OP NOTE
	PRE-OP DX: GSW TO ABDOMEN
	POST-OP DX: PENETRATING SPLENIC LACERATION / SMALL COLONIC
	INJURY OF DESCENDING COLON
	PROCEDURE: SPLENECTOMY + CLOSURE OF COLONIC INJURY
	+ EX-LAP
	SURGEON: [redacted] b(6)-2
	EBL: 300
	FLUIDS 4500cc LR
	UO = 200cc
	COMPLICATIONS: Ø
	STABLE TO ICU
	ABX: CEFOTAN ENROUTE [redacted] b(6)-2
14 JUN 03	SURGERY PROGRESS NOTE
1230	33 YO MALE POST SHOT IN ABDOMEN DOING WELL
	Ø ABDOMINAL PAIN CONTROL - LOW CARB DIET NPO
	LUNGS: CTA ABD: SOFT, NTND BBS 14.5 11/37 03
	CVS: RRR
	IMP: POD #1 SPLENECTOMY / REPAIR OF COLONIC INJURY
	PLAN: DC NG - CLEAR LIQUID DIET - AMBULATE
	CONT IV FLUIDS ADDED OUT PROPHYLAXIS

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Jun 03	PROGRESS NOTES 33 YO [illegible] POD #2 SPLENECTOMY & REPAIR OF colonic injury DOING well, AMBULATING & TOLERATING LIQUIDS AFEBRILE TODAY VS: HR 90-120 116/67 94% RA T max 101 T 98.8 CVS: TACHYCARDIC LUNGS: CTA ABD: SOFT, minimal TTP/ ND BS Imp: POD #2 Plan: AMBULATE b.i.d DRESSING CHANGES ✓ LABS in AM b(6)-2 [redacted]
16 Jun 03	SURGERY 33 YO male POD #3 splenectomy, REPAIR of colonic injury NOW AMBULATING BETTER & BOWEL SOUNDS & IMPROVING pulmonary HYGIENE VS: HR 99 120/80 96% RA RR 23 CVS: INTERMITTENT TACHYCARDIA LUNGS: CTA ABD: SOFT, NTND BS WOUNDS looking well I/O /4629 Imp: DOING well Plan: DC foley TO WARD TODAY [redacted] b(6)-2
2124 7 Jun 03	P.T. recieved 650mg of tylenol for fever of 101.4. [redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRO

MEDICAL RECORD | **PROGRESS NOTES**

b(6)2 AM

DATE	NOTES
13-JUN-03 2030	PT admitted to ICU #2 from O.R. via Gurney. PT Dx'd S/P GSW & S/P Ex/LAP and Splenectomy. VS 132/73-96.5-117-20-100% SpO2 on 10 LPM NRB. PT is EPW and restraints are in place. Received report from O.R. PT is situated on ICU #2. See PA form 4700 dated 13-JUN-03 for assessment. [redacted] SSG
13-JUN-03 2130	PT washed, foley care done, mouth care done. PT's wx to (L) flank redressed. Wx is an entrance wx about 6 mm in diameter. Serosanguinous fluid noted. PT awakened during bed wash and attempted to pull NGT while he was being cleaned. Will monitor [redacted] SSG
13-JUN-03 2200	PT started Unasyn 3gm IV. Will monitor for reactions. [redacted] SSG
13-JUN-03 2230	PT's Unasyn complete, ø reactions noted, VSS. PT removed from NRB mask. Sats > 95% on RA. Wt Dressings ~~increase~~ Δ's in size of blood spots. PT arousable to speech. [redacted] SSG
14-JUN-03 0130	PT's HR stays in 120's. PT bolused c̄ 500cc LR IV. Will monitor for effects. [redacted] SSG [redacted]
14-JUN-03 0300	PT's VS 122-132/86-19-100.2-94% SpO2 on RA. PT's HR Remains in 120's p̄ fluid bolus. [redacted] SSG
14 JUN 03 0400	PT's T 100.6. MD notified per orders. Tylenol 650mg PR given will monitor for effectiveness. VS 128/71-120-21-96% on RA. PT responds to verbal stimuli. Alert. CBC sent to lab. [redacted] SSG

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.

EPW # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2
A11

LAST NAME	ST NAME	MID.	TIAL	ID NUMBER

DATE	NOTES
14 June 03 0515	Recvd. Eyes closed. Resp even & unlabored. NO apparent distress. VSS. Cont to monitor. —[redacted] CpT AN
14 June 03 0600	Assessment Completed. M504 given at 0540 for pain. Ø further c/o pain. NGT to (R) nare on LS. Has min drainage. Dressing to (L) flank is CDI, Abd dressing marked c↑ drainage. Drainage min. Ø reinforcement indicated. Pulses palp all extremeties. Foley patent to gravity c clr yellow urine @ 50 cc/hr. HL to DAC. 14 ga (R) FAC LR infusing at 125 c/hr. See DA 4700 for complete assessment. Cont to monitor —[redacted] CpT AN
14 June 03 0800	Resting quietly ⅀ c/o. VSS. Ø apparent distress. Min drainage from NGT. cont to monitor. —[redacted] CpT AN
14 June 03 0945	c/o abd pain. Translator at bedside. Pain at 10 of 10. 4 mg M504 given. Apparently effective. HR ↓ & Resp ↓ to low 100's & 20's respectively. Continue to monitor. —[redacted] CpT AN
14 June 03 1200	c/o pain. M504 given. Ø Δ to initial assessment. M504 effective. Attempted to show how to use IS. Ineffective breathing. Temp 99.2°F. Continues to monitor —[redacted] CpT AN
14 June 03 1230	Dr [redacted] at bedside. New Orders recvd & rec'ed. NGT D/C'd. VSS. Cont to monitor —[redacted] CpT AN
14 June 03 1300	M504 given prior to ambulation. —[redacted] CpT AN
14 June 03 1330	↑ amb on unit. Assist x 2 secondary to fears of falling. Gait unsteady at times. ~~Remains~~ inappropriate at times using IS but lungs remain clear. Does not breathe in even c prompting by interpreter. VSS. Continue to follow —[redacted] CpT AN
14 June 03 1700	M504 given p ambulation. Cont. to follow —[redacted] CpT AN
14 June 03 1900	Temp 100.5. Physician notified. Voices Ø c/o. Ø apparent distress. SS by monitor @ 125 cc/hr. Cont. to monitor —[redacted] CpT AN

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

AUTHORIZED FOR LOCAL REPRO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 June 03 1745	Received pt. @ 1700 from day shift. Pt. resting c eyes ~~closed~~ error from Closed, in ϕ apparant distress. Assessment completed. Neuro: A+O x 3, PERLA. Pt. responds appropriately to Commands. Resp: Breathes even, unlabored. CTA throughout, diminished @ bases. Encouraged use of IS Q1: Cardio: HR ranges 90s - 110s. ST c ectopy. GI: Abd. flat, soft to palp. BS absent @ UQ hyperactive @ LQ. Tolerating CL diet. GU: Foley catheter to gravity drainage c clear yellow urine. Skin: midline abd. incision c dressing cdi. Pt. has ϕ c/o @ this time. Will cont. to monitor. [redacted] LCF/Am b(6)-2
14 June 03 2230	Tmax 101.1 @ 2000. MD notified, prn tylenol ordered & administered. Encouraged pt. to use IS, pt. knows how to use IS but refuses to use it as frequently as needed. Pt. ambulated to both ends of the unit & back to bed c minimal assist. Administered 2mg MSO4 IVP for pain from amb. Pt. now sleeping ∫ complaint. [redacted] LCF/Am b(6)-2
15 June 03 0400	Pt. slept well through the night. Woke up periodically c c/o pain relieved by MSO4 2mg IVP. Tylenol 650mg PO given this Am for temp 101.1. Am care done. [redacted] LCF/Am b(6)-2

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.

LAST NAME	FIRST NAME	MID	TIAL	ID NUMBER

DATE	NOTES
15 June 03 1830	Received pt @ 1700, pt. sleeping in ϕ apparent distress. Nursing assessment done: Neuro: A+O x 3. Pupils equal in size @ 2mm, sluggish. Responds appropriately to commands. Cardio: Tachycardic in 90's - 110's. ④ pulses x 4. Resp: Lungs CTA throughout. Cont. to encourage use of IS, pt. is non-compliant. Pox ranging 94-98%. RA. GI: BS x 4 quadrants, hypoactive. Cl diet - takes sips of H2O. GU: Foley to gravity drainage c clear yellow urine. Skin: midline abd. incision c staples intact. ϕ S/S of infection. Entrance wound on ⓛ side c dressing CDI. b(6)-2 [redacted] ICT Ann
15 June 03 2045	Wet → dry dressing Δ done to entrance wound. Old dressing removed. Old blood + serosanguinous drainage saturated dressing. Pt. OOB → chair c minimal assist. Pre-medicated c MSO4 2mg IVP. Used IS - able to get to 900cc/sec. ϕ c/o @ this time. Will cont. to monitor. b(6)-2 [redacted] ICT Ann
16 June 03 0430	Pt. able to sleep through most of night c/o. Did wake up @ 0300 c/o abd. pain. Tylenol #3 given PO for pain control. Am labs drawn. Am care done. b(6)-2 [redacted] ICT Ann
16 June 03 0700	Up to chair x 1. Ambulated x 1. Alert cooperative. Respirations unlabored c BBS CTA. Incentive spirometer in use. Palpable pulses. Abd. tender to touch. Staples to midline abdominal incision. Foley cath to BSD. IVF LR @ 125/hr. IV Heplocked (L) AC. No distress noted. Ileostomy patent well [redacted] b(6)-2
1000	Report given to ICW2. No changes in status. VSS. Denies any pain. Will Cont. to monitor status. b(6)-2 [redacted]
1055	D3 given PO for c/o pain [redacted]
1100	Foley D/C'd [redacted] b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Jun 03 1240	Pt transferred to ICU II from ICU "I" @ 1230. Pt A x O. Pt has TKO LR in (R) arm. HL in (L) arm - patent. Pt has staples down mid-section of abdomen. Abd. tender. Lung CTA. Minimal bowel sounds x4 quads. Pt is able to grasp and wiggle fingers. Pt is now resting quietly. 0 % pain or discomfort @ this time. b(6)-2 [redacted] LPN, SGT
16 Jun 03 2035	assumed care @ 1300 - VSS - IV patent, saline locked - Staples intact - pt. used IS q1° and did C3DB exercises when instructed - tolerated clears for dinner b(6)-2 [redacted] CR, AA
2200	Pt. care assumed @ 2100. Temp 101.6. Pt. c/o pain. 2/11 T#3 given PO. HR Reg, lungs CTA, ABD soft & active BS (+) x4. Midline ABD incision & staples OTA. 0 S/S infection @ incision site. Will cont. to monitor. [redacted] CR, AA
2223	P.T. voided 380cc light yellow urine b(6)-2 [redacted] CR, AA
17 June 03 0520	Assume pt care @ 0500. pt awake, c/o pain to midline abd incision. Staples open to air, intact. 2/11 tylenol #3 given PO. temp 100.2°. VSS. HR regular. Lungs CTA. Abd. soft BSx4 active. Free ROM to U/L extremities (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. HCW 2

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(a)-2
All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17June03	0520. HL to (R) AC flushes & no S/S redness/ infiltration. HL DC'd from (L) AC due to infiltration. plan to ambulate today / encourage IS and I's + O's. Will continue to monitor. [redacted] Stump
	1050 pt ambulated this am. BM @ 0930. OOB to chair approx. 35 min. Encouraged IS. [redacted] Stump
	RW/1050 ~~Error~~ pt weaned from O2 SpO2 @ 95%. [redacted] Stump
17Jun03 1800	assumed care @ 1800 VSS, T 100.2° - PVF @ 100cc/hr due to b/o - pt ate only a small amount of chicken for dinner - Staples intact - pt. using IS q 1°, ambulated this shift - lungs CTA (B), (+) BS [redacted]
2030 18Jun03	Pt care assumed @ 2100. T @ 2120 was 101.4, pt uncovered, temp @ 2235 99.8. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. Pt has IV @ LFA running 50cc/hr (TKO) well @ dsg. No cap this shift. Staples to abd OTA, site CDI, no S/S infection. Pt 0 c/o complaints at this time, will continue to monitor. SPC [redacted] 9LWMC
0200 18 June03 0800	UOP 450cc (+). SPC [redacted] 9LWMC
	Pt. up out of bed ambulating. BM x1. VSS: BP 118/65, sats 95, P101, T100.4. PO Tylenol #3 given for pain & fever. Incision site is well approximated & signs of infection. LR TKO in (R) FA & S/S of infection or infiltration. Pt & other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] RT/FAO

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

MEDICAL RECORD	PROGRESS NOTES

b(6)-2

DATE

[redacted]

19 June 03 R vitals taken BP 100/62 P. 90, R. 16 TEMP. 99.2

2100

[redacted]

b(6)-2

20 June 03

RC No.

0600 T 98.8

P 78

R 14

BP 100/56

98%

20 JUN 03 PC NOTE

PT DOING WELL

VSS / AFEBRILE

BOWEL FUNCTION

PC TODAY ON T3 PT NEEDS STAPLES

REMOVED IN 3-5 DAYS

[redacted]

b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

APW

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
15 19 Jun	Surgery
	PT STABLE
	VSS Tmax 38[3]
	Lungs: CTA
	Cor: RRR
	ABD: soft NT ND BS ⊕BM
	Pain: PO #5
	Plan: cont current Tx [redacted]
	b(6)-2
19 Jun 0800	Assumed care of pt @ 0500. Pt VSS. Pt tolerated breakfast well. Lungs CTA. Staples down midsection of abd. - intact. Pt has c/o gas. Pt is now resting quietly. b(6)-2 [redacted] 91WM6, SGT
1100	Pt ambulated for 17 minutes. Pt has c/o pain. Pt was given T-3 ii. Pt is now resting quietly [redacted] 91WM6 SGT
1500	Assumed care of Pt @ 1300. VSS c̄ mild temp. A+Ox3. Ⓑ LS CTA. Ambulates s̄ assistance. Mid abd. incision c̄ staples CDI OTA. Ø c/o pain TKO LR via Ⓡ FA PIV patent. O/W assessment WNL. Will Monitor b(6)-2 [redacted]
2120	Pt care assumed @2100. VSS, no complaints at this time, pt alert and awake. Midline abd incision c̄ staples CDI ota, Ø s/s infection. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads, Pt resting, will continue to monitor. SPC [redacted] 91WM6
2125	Pt c/o pain in upper back, encouraged sitting up and stretching, pt refused. Will continue to monitor. SPC [redacted] 91WM6
	b(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
18JUN03 1500	Assumed care of PtC @ 1500. VSS. AOx3. CTA @ BS x 4. M-D ABD incision c staples OTA c D/C @ si/sx of infection. Pt ambulatory c assistance @ 1500. LR @ TKO via PFAP IV. o/w [redacted] b(6)-2
18JUN03	PROGRESS NOTE SINGLE TOUCHING DUST VSS / AFEBRILE LUNGS: CTA CVS: RRR ABD: SOFT, NT, ND @ BS EXT: STABLE FROM #4 PLAN: CONT CURRENT MANAGEMENT [redacted] b(6)-2
2145.	Pt. care assumed @ 2100. Pt. febrile @ 101.4. Pt. given IS, using @ 1° while awake. T3 ½ given for pain & temp. Pt. refusing to walk, but cooperative & using IS. HR Reg, Lungs CTA. BS @ x4, ABD soft, flat. Midline incision OTA, staples, S/S infection. LR infusing to @ VE @ TKO c diff. will continue to monitor. [redacted] b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. 2CW2

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(a)-2

558-103 Sp[redacted]

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGE[redacted]Y CARE AND TRE[redacted]MENT
(Medical Record)

TREATMENT FACILITY (Stamp) 28th CSH

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE: DAY 13	MONTH June	YR. 03	TIME 1720	☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Helo		☐ PATIENT ☐ OTHER (Specify)
						ALLERGIES (

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX M | AGE 33

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS		
TIME	1730	1750
BP	110/70	112/72
PULSE	109	104
RESP.	22	20
TEMP.		
WT. (Child)	97%	100%

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

ORDERS	INITS.	TIME
CBC Chem 20		
Type Screen UA		
1gram Ancef	[redacted]	[redacted]
Tetanus .5	1745	[redacted]
Morphine 3mg	1750	[redacted]
Foley	1750	[redacted]

ASSESSMENT/DIAGNOSIS

GSW to Abd

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Wound to left flank alert Responds approp Moving all ext approp. Heart RRR NSR on monitor Lungs CTA (B), BS (B)

Abd GSW (L) flank [illegible] bleed
[illegible] diffuse abd pain on palp
rectal:

- A/P GSW to Abd → [redacted]

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ✓ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF N[redacted]

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

[redacted]

b(a)-4

SIGNATURE OF PROVIDER AND ID STA[redacted] b(a)-2

INSTRUCTIONS TO PATIENT (Inclu[redacted]imitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

MEDCOM - 10688 Copy

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

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

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

4. PROPOSED SURGICAL PROCEDURE:
GSW Abd

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL _____Potential for anxiety related to: _____1) Surgical Procedure & Operating Room Environment _____2) Separation Anxiety (Child) _____3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g., warm blanket, touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION _____Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT _____Potential impairment of skin integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

EPW [redacted] b(6)

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION _____Potential for inadequate tissue perfusion due to: _____1) Intraoperative Mobility _____2) Positioning _____3) Existing Disease _____4) Safety Devices _____5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1._____Potential impairment of mobility due to: _____1) Pain _____2) Intraoperative Hazards _____3) Prosthesis _____4) Positioning _____5) Transfer pt. to/from OR table E.2._____Potential discomfort due to: _____1) Length of Surgery _____2) Positioning _____3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1._____Diminished visual perception due to being: _____1) Pre-Medicated _____2) W/O Glasses F.2._____Potential for decreased communication due to: _____1) Diminished Hearing _____2) Language Barrier F.3._____Potential injury due to dentures: _____1) Upper _____4) Caps _____2) Lower _____5) Crowns _____3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. c Pt. will be transferred safely to OR table. c Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	c Introduce self. Keep pt. informed as to where he/she is and what is happening. c Inform pt. in which direction to move and assist if necessary. c Speak clearly and slowly. c Address pt. from _____ side. c Validate pt.'s understanding of verbal communication. c Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b(6)2 [redacted] CRNA 13 Jun 02 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y)/N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☑ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y)/N)

LEVEL OF ACTIVITY: ☑ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liner with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and T[illegible] [redacted] CRT/ANT

DATE: 13 Jun 02 TIME: 1800

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Ti[tle]) [redacted] b(6)2

DATE: 13 Jun 02 TIME: 2030

MEDICAL RECORD — **INTRAOPERA[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM — VIA: Litter — BY: Anes. Staff
2. PATIENT I[illegible]FIED, RECOR[illegible]MED AND PROCEDURE — VERIFIED BY: [redacted] CPT/AA
3. DATE: 13 Jun 03 — TIME PATIENT ARRIVED IN SUITE: EMT → OR
4. PATIENT IN ROOM — TIME: 1800 — NUMBER: 12-1/3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. PT came directly to OR from EMT.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 71D) b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj [redacted] AA CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) b(6)-2

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

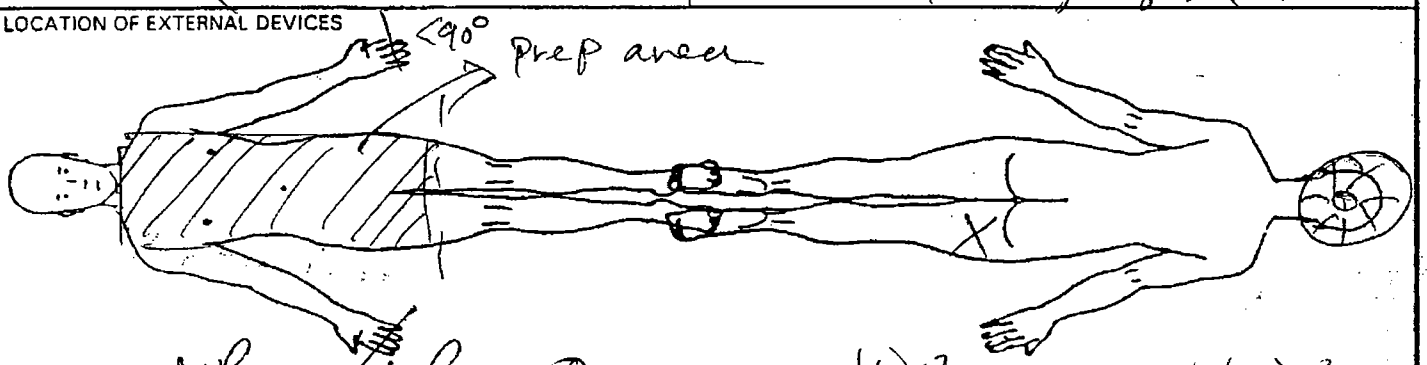
COMMENTS: Anatomical body alignment maintained during the procedure

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine 5/Sol
SITE: Abd Chest BY WHOM: CPT. [redacted]
SITE: Upper Bil Hands BY WHOM: b(6)-2
COMMENTS: 2 pourings of Sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = Tourniquet

C = Correct I = Incorrect

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

Factual: SCRUB [redacted] b(6)-2 CIRCULATOR [redacted] b(6)-2

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

Zpw # [redacted] b(6)-4

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND Polyhesive II
LOT NO: 68936/2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Coag: 30 Cut: 30

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

b(6)-2 ATT

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION (Specify) 4x8 dsg tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Foley		
SITE	Bladder (Foley)		

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] / Dr [redacted]
Anes: CRNA [redacted] (CRNA)
CPT [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Exp Lap, Splenectomy

21. PATIENT TRANSFERRED TO PACU TIME 2030 METHOD Litter Car

22. REG [redacted] PT. AN

REVERSE OF DA FORM 5179-1, [illegible] 87 USAPA V1.01

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 0000 HOURS | TOTAL HOURS COVERED 24 | DATE 17 Jun

INT

INPUT ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0830	Water	120	120
0830	Milk	240	360
"	Jello	120	480
1700	H2O	60	540

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0800	100cc	IV MED	100cc	0830	100cc
1800	500	LR@100cc/hr			

OUTPUT — IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	CYU	325	325
~~0800~~	CYU	450	450cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] EPW

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 — ITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) UL 7

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED 24 | DATE 6/18/03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0745	milk	30cc	30cc
0800	water	100cc	130cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	400cc	LR @ 50cc/hr			

Atpt urine IRRIGATIONS (N/G, ~~Bladder, etc.~~)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0200	clear yellow urine	450cc	450cc
1230	clear yellow urine	300cc	750cc
1730	clear yellow urine	300cc	1050cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

FPW [redacted] bilo-4

lcw2

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1 HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-19-93

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	OJ	120	120
0700	Milk	120	240cc
0700	(1) Waffle		
1200	OJ	120	360cc
1200	Peaches		
1200	Jello		
1200	H_2O	120	480cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN		LR	925	0400	925

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0900	Lt yellow urine	700cc	700cc
1534	Lt " "	300cc	1000cc
2024	Lt " "	400cc	1400cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOUR TO ____ HOURS | TOTAL HOURS COVERED | DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0900	500 cc	500	500

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 16 Jun | DAY: 17 | 18 | 19 | 20 | 21 | 22

HOUR: 19

PULSE (0)	TEMP. F (°)
	105°
180	104°
170	103°
160	102°
150	101°
140	100°
130	99° / 98.6°
120	98°
110	97°
100	96°
90	95°
80	
70	
60	
50	
40	

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

Sats 93% 96%

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

[redacted] b(4)-4

REGISTER NO.

WARD NO. ICU2

VITAL SIGNS RECORDS

Medical Record

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

d/Section: EMT | TING PHYSICIAN: Gonzo | [redacted]

ST, FIRST, MI: [redacted] b(6)-4 | DATE: 13 June | TIME: 1745 | SSN/PSEUDO SSN

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
L		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
opamin-I		
rug of buse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.2	3.5-5.5 g/dl
ALP	45	26-84 u/l
ALT	16	10-47 u/l
AMY	82	14-97 u/l
AST	21	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
BUN	11	7-22 mg/dl
CA++	8.6	8.0-10.3mg/dl
CHOL	102	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	128	73-118 mg/dl
TP	5.9	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	119	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	139	39-380 u/l (M) 30-190 u/l (F)
NA+	139	128-145 mmol/l
K+	4.3	3.3-4.7 mmol/l
CL-	107	98-108 mmol/l
tCO_2	26	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)-2 | **DATE:** | **LAB ID NO.:**

EMT 13 June (Gonzo)

[redacted] b(6)-4 Ok

Clotted ... [illegible]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	15.6	4.8-10.8 x 10^3
RBC	4.91	4.7-6.1 x 10^9
Hgb	12.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.5	42-52% (M) 37-47% (F)
MCV	80.4	80-94 fl (M) 81-99 fl (F)
Plt	209	130-500 x 10^3 verified
Lymph %	15.7	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	yell	N/A
App	Cldy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	13 Jun 03	

b(6)-2

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

LAST, FIRST, MI. #[redacted] b(6)-4 | DATE 14-JUN-03 | TIME 0100 | SSN/PSEUDO SSN: #[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	19.8	4.8-10.8 x 10^3
RBC	4.59	4.7-6.1 x 10^9
Hgb	19.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.1	42-52% (M) 37-47% (F)
MCV	80.9	80-94 fl (M) 81-99 fl (F)
Plt	113	130-500 x 10^3 verified
Lymph %	9.4	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			

oun ematocrit		42-52% (M) 37-47% (F)
ed Rate		
ther		

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. RANG
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
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: clots seen in tube. [redacted] b6-2

[redacted] 14 Jun 03

b(6)-2

/ard/Section: ICU 2 | STING PHYSICIAN: [redacted] b(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

AST, FIRST, MI. EPW # [redacted] b(6)-4 | DATE 14 June 03 | TIME 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
/BC	25,2	4.8-10.8 x 10^3
BC	3,82	4.7-6.1 x 10^9
gb	9,5	14-18 g/dl (M) 12-16 g/dl (F)
ct	31,0	42-52% (M) 37-47% (F)
ICV	81,3	80-94 fl (M) 81-99 fl (F)
lt	342	130-500 x 10^3 verified
ymph %	10,7	20.5-51.1%

(Hematology) Manual Differential

Segs	84	Mono	3
Bands		Eos	1
Lymph	12	Baso	
Atyp		Imm	
RBC Morph			

oun ematocrit		42-52% (M) 37-47% (F)
ed Rate		
Other	platelets adequate	

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. RANG
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
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

EMARKS:

b6-2 [redacted] 14 June 03

b(6)-2

rd/Section: ICU #2 | K[illegible]TING PHYSICIAN [redacted] | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

ST, FIRST, MI: EPW # [redacted] b(6)-4 | DATE: 16 June 03 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg-(art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
U		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
b		12-17 g/dl

Misc. Chemistry

EST	RESULT	REF. RANGE
ponin-I		Negative
ug of use		Negative
		Negative
		Negative
		Negative

(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	91	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	150	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	32	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

EMARKS:

EPORTED BY: b(6)-2 [redacted] | DATE: 16 Jun 03 | LAB ID NO.:

b(6) 2 M1

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

EPW

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	13 JUNE 03	2020 HOURS	
1	Admit to ICU #2		
2	Dx - SP SSW - STP Exlap		
3	Condition - Stable		
4	Vitals - per routine		
5	Allergies - unknown		
6	Activity - bedrest. EPW [redacted]		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
7	Nursing - notify MD for temp > 100.4, BP > 160/90 or < 90/60; HR > 130 or < 50 RR > 25 or < 10; UOP < 40 cc/hr		[redacted] 2030 13 JUNE 03
8	Diet - NPO		
9	IVF - 125 cc/hr LR		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
10	LABS - CBC in AM		
11	Meds: Unasyn - 3.0 grams IVPB q6° MSO4 - 1-4 mg IVP q 2° prn Phenergan - 12.5-25 mg IVPB q 4-6° prn		
12	NGT to low intermittent suction		
	foley to gravity		
	3 IVM/CRT [redacted]	13 JUN 03 @ 2331	[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	14 JUN 04	HOURS	
✓	1- AMBULATE ☐ ASSISTANCE		
✓	2- DC NG TUBE Done 1230		
✓	3- CLEAR LIQUID DIET		
✓	4- IS 10 min q°		
✓	5- Heparin SQ 5000 q 12°		[redacted]
	24 ✓ 15 June 03 @ 0055 MZ		[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
14 June 03	1950 HOURS	

① Tylenol 650mg PO prn temp. b(6)-2

V.O. Dr. [redacted] / [redacted] 15 June 03 1950 MZ

24° chart ✓ 15 June 03 @ 0400 MZ

PATIENT IDENTIFICATION

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED

DATE OF ORDER	TIME OF ORDER
15 JUN 03	HOURS

1- T3 1-2 PO q4°p.r.n pain [redacted]

PATIENT IDENTIFICATION

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	B

DATE OF ORDER	TIME OF ORDER
15 JUN 03	1525 HOURS

1- Entrance wound dressings dry wet to dry B.I.D

V2- CBC + CMOM 7 ∞ AM

24° ✓ chart 16 June 03 0430 MZ

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

b(6)-2

CL[illegible]ORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

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

16 JUN 03

1- TRANSFER TO ICU

2- TKO IV FLUIDS ✓

3- VS per ROUTINE ✓

4- I/O q SHIFT ✓

5- UNASYN 3gm q 8° IVPB ✓

6- HEPARIN 5000 u SQ q 12° ✓

7- CLEAR LIQUID DIET ✓

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

8- AMBULATE q SHIFT ✓

9- IS 10 min q° ✓

10- PT NEEDS PNEUMOCOCCUS, Hib & MENINGOCOCCUS VACCINATIONS

11- T3 1-2 PO q3-4° prn PAIN ✓

12- 1-2 mg q° MSO4 IVP for BREAKTHROUGH PAIN ✓

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

24°VS [redacted] LOTION 6.16.03 2330

1- Regular DIET ✓

2- OC UNASYN ✓

3- OC MSO4 [redacted]

noted

b(6)-2

24°VS 01 [redacted] LOTION 6.18.03 2325

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
	24VS	2130

DATE OF ORDER | TIME OF ORDER | HOURS

19 JUN 03 1630

D4L IV

[redacted]

b(6)-2

b(6)-2

19 Jun 03 [redacted]

DA FORM 1 APR 79 4256 REPLACES E

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
	20 JUNE 03	0820 HOURS	
1	IVC IV		
2	IVC TO PRN CAP		
3	TRANSFER #3 TO [redacted]		
	POST 6° PRN		
	b(6)-2 [redacted]		

b(6)-2

MED MC

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
20 JUN 03	HOURS
1- DC SAMPLES IN 5 DAYS	

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

b (6)-1 AR

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16	17	18	19	20	21	22	23	24	25	26
13JUN03	[redacted]	DX: S/P GSW - S/P EX/LAP	05	[redacted]													
			17	[redacted]													
13JUN03	[redacted]	Condition - Stable	05	[redacted]													
			17	[redacted]													
13JUN03	[redacted]	Vitals - Per Routine	05	[redacted]													
			17	[redacted]													
13JUN03	[redacted]	Allergies: Unknown	05	[redacted]													
			17	[redacted]													
13JUN03	[redacted]	Activity: Bed Rest - EPW	05	[redacted]													
		Protocol	17	[redacted]													
		Nursing - Notify MD for	05	[redacted]													
		temp > 100.4, B/P > 160/90 or	17	[redacted]													
		< 90/50, HR > 130 or < 50,															
		RR > 25 or < 10, UOP < 40cc/hr															
13JUN03	[redacted]	Diet: NPO	06	[redacted]													
			12	[redacted]													
			18	[redacted]													
13JUN03	[redacted]	to NGT to LIS	05	[redacted]													
			17	[redacted]													
13JUN03	[redacted]	Foley to gravity	05	[redacted]													
			17	[redacted]													
14June	[redacted]	Ambulate - assistance	05	[redacted]													
			17	[redacted]													
14June	[redacted]	Clear liquid diet	06	[redacted]													
			12	[redacted]													
			18	[redacted]													

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

Δ 14 June 03

Δ 14 June 04

D/C 14 June 03

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS:

S/P EXLAP DX: GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW

II [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 1 OCT 78 4677

MEDCOM - 10707

E USED.

b(6)-4 A.11

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION) — Mo JUNE Yr 2003: SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13JUN	[redacted]	ADMIT ICU2 x1	13JUN	NOW	[illegible]	[redacted]
13JUN	[redacted]	labs: CBC in AM	14JUN	0500	[illegible]	[redacted]

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

☆ U.S. GPO -290/55267

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. 06 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14 June	[redacted]	15 Q 10 Wheles x 10	05	[redacted]													
b(6)-2		min	17	[redacted]													
15 June	[redacted]	Enhance wound Dressing	08	/	/	[redacted]											
b(6)-2		WC → Dry BID (L Heel)	20	/	[redacted]												
15 June	[redacted]	CBC with Chem 7 imaan	09	/	/	[redacted]											
b(6)-2																	

b(6)-2 RN

ALLERGIES: ☐ YES ☑ NO — unknown

PRIMARY DIAGNOSIS: GSW / Ex lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

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

b(6)-2 All

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. 6 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16 17 18 19 20 21 22
16 Jun	[redacted]	VS q shift	05	/ [redacted]
		b(6)-2	13	[redacted]
			21	
		b(6)-2		
16 Jun	[redacted]	I+O's q shift	05	/ [redacted]
			13	
			21	
		b(6)-2		
16 Jun	[redacted]	Cl. Liq. Diet	07	/ [redacted] > DC 17 Jun 03 1130 KW
			EE	
			17	
		b(6)-2		
16 Jun	[redacted]	Ambulate q shift	05	/ [redacted]
			13	
			21	
		b(6)-2		
16 Jun	[redacted]	IS 10 min q°	05	/ [redacted]
			13	
			21	
		b(6)-2		
17 Jun	[redacted]	REG DIET	05	/ / [redacted]
			11	/ [redacted]
			17	/ [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Splenectomy S/P

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk [redacted]	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16Jun	[redacted]	Transfer to ICU II from ICU II	16 Jun		1220	[redacted]
16Jun		Pt needs pneumococcus, meningococcus, & Hib vaccinations	16Jun 03			

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

USAPA V1.00

b(6) - 2 All

CLINICAL RECORD

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

Mo. 06 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18	19	20	21	22	23	24	25	26
13JUN	[redacted]	IVF @ 125cc/hr LR	05	/	[redacted]												
			17	[redacted]													
13JUN	[redacted]	Urasyn 3.0gm IVPB q6°	04	/	[redacted]												
			10	/	[redacted]												
			16	/	[redacted]												
			22	[redacted]													
14June	[redacted]	Heparin SQ 5000u Q12°	10	/	[redacted]												
			22	/	[redacted]												

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS:

S/P BSW - S/P EX/Lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW

[redacted] b(6) - 4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. JUNE Yr. 2003

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													
13 JUN 03	[redacted]	MSO4 1-4mg IVP q2° prn	13 Jun 03 2130 4mg	13 Jun 03 2330 4mg	14 Jun 03 0100 2mg	14 Jun 0300 4mg	14 Jun 0540 4mg	14 Jun 0945 4mg	14 Jun 1200 2mg	14 Jun 1300 2mg	14 Jun 1400 2mg	14 Jun 1600 4mg	14 June 1715 2mg	14 June 1815 2mg	14 June 1900 2mg	14 June 1945 2mg
			[redacted]													
13 JUN 03	[redacted]	Phenergan 12.5-25mg IVP q4-6° prn														
14 June 03	[redacted]	Tylenol 650mg PO prn Temp	14 June 2000 650mg PO [redacted]	15 June 0400 650mg PO [redacted]												
14 June 03	[redacted]	MSO4 1-4mg IVP q2° prn (cont.)	15 June 03 0050 2mg [redacted]	15 June 03 0330 2mg [redacted]	15 June 03 0430 2mg [redacted]	15 June 0910 I (+)	15 June 2020 2mg [redacted]									
15 June 03	[redacted]	T3 1-2 PO q4° prn pain	T / M Z	0900 [redacted] ii (+)	1200 [redacted] ii (+)	1900 14 June ii [redacted]	14 June 0230 ii [redacted]	14 June 1055 AW ii								
13 June	[redacted]	MSO4 1-4mg IVP q2°	T / M Z	0900 JD 1mg (+)	1100 JD 1mg (+)	1515 JD 2mg (+)	15 June 2020 2mg [redacted]	16 June 0300 2mg [redacted]								

b(6)-2

USAPA V1.00

b(6)2 All

MEDCOM - 10713

b(4)-2A11

CLINICAL RECORD

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

Mo. 6 Y 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21
16 Jun	[redacted]	TKO IV Fluids	05	/	[redacted]				
	------	LR	13	[redacted]					
	------		21	[redacted]					
	------								
16 Jun	[redacted]	Unasyn 3gm q8°	08	/	[redacted]				
	------	IVPB	16	[redacted]					
	------		24	[redacted]					
	------								
16 Jun	[redacted]	Heparin 5000u SQ	06	/	[redacted]				
	------	q12°	18	[redacted]					

D/C IVFLUIDS 03 1130 MW

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Splenectomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 10714

b(6)-2 All

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. 6 Yr. 03	
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
16 [redacted]	needs pneumococcus	not available			
b(6)-2	influenza (H1D)	not available			
	meningococcus vaccinations	16		1900 [redacted]	b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
16 Jun	[redacted]	Tylenol #3 po q3-4° pm	16 Jun 2100 [redacted]
~~16 Jun~~	[redacted]	~~MSO4 IVP 1-2 mg q° for pain~~	[redacted]
16 June	[redacted]	MSO4 IVP 1-2 mg q° for pain	DC'D PATIENT 1130 RW

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

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	2400 INITIALS [redacted] b(6)-2	INITIALS	INITIALS
	PUPILS	2 mm Reactive		
	SENSORIUM	Pt aroused by touch still drowsy		
RESPIRATORY	RESPIRATORY PATTERN	Even, non-labored		
	BREATH SOUNDS	equal rise and fall of chest		
	SECRETIONS	ø secretions, NRB mask @ 10 lpm O2, sats @ 100%		
SKIN	COLOR	Normal for race		
	INTEGRITY	Warm, dry skin, mucous membranes moist		
IV SITE	LOCATION	14g in Ⓡ forearm c LR @		
	CONDITION	125cc/hr, heplock in Ⓛ AC		
GASTRO	ABDOMEN	ND, BS in LUQ & LLQ		
	BOWEL SOUNDS	ABD incision dressing C/D/I, Dressing to Ⓛ flank C/D/I, NGT to LIS		
GU	URINE:	Foley to gravity,		
	COLOR/CLARITY	clear yellow urine		
CARDIOVASCULAR	CARDIAC RHYTHM	ST, Rate 110-120		

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

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
b(6)-2 [redacted] 556 91WM6	ICU 2 east	13-JUN-03

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

EMW # [redacted] b(6)-4

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

DATE		DX													HOSPITAL DAY				
VITAL SIGNS	TIME	05	06	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
	BP Arterial Line																		
	BP Cuff																		
	Temperature																		
	Pulse																		
	Respiratory Rate																		
	PM																		
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	UL																		
	IVF M																		
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	21	22	23	24	01	02	03	04
	137/73	122/76	137/81	126/82	123/79	117/86	132/80	129/77
	96	100%	100%	100%	100%	100%	100%	100%
	117	117	121	119	121	122	123	120
	20	21	22	18	19	20	20	21
	100%	100%	100%	96	95	94	94	96
	10L	10L	6L	RA	RA	RA	RA	RA

RESPIRATORY THERAPY

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

LABORATORY DATA

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

INTAKE

	21	22	23	24	01	02	03	04	8° T
	125/45	125	125	125	125	125	125	125	
		100							
		1			500				
		250	375	500	625	1250	1875	1600	

OUTPUT

50/50	90/100	120/140	120/140	60/210	60/270	60/320	100/420	
							70	

ACTIVITIES OF DAILY LIVING

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

TURN / SUCTION

TIME						

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE +1350

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

DOB-2 DOB-2

NEUROLOGICAL ASSESSMENT

			HOURS	21	24
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4		
		TO SPEECH	3		3
		TO PAIN	2	2	
		NO EYE OPENING	1		
	BEST VERBAL RESPONSE	ORIENTED	5		
		CONFUSED	4	4	
		VERBALIZES	3	3	3
		VOCALIZES	2		
		NO VOCALIZATION	1		
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6		6
		LOCALIZES PAIN	5	5	
		FLEXION WITHDRAWAL	4		
		ABNORMAL FLEXION	3		
		EXTENSION TO PAIN	2		
		NO MOTOR RESPONSE	1		
LIMB MOVEMENT	ARMS	NORMAL POWER		✓	✓
		MILD WEAKNESS			
		SEVERE WEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE			
	LEGS	NORMAL POWER		✓	✓
		MILD WEAKNESS			
		SEVERE WEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE			
PUPILS	RIGHT	SIZE		2	3
		REACTION		T	+
	LEFT	SIZE		2	3
		REACTION		+	+
PUPIL SCALE				● 2	● 3 ● 4 ● 5 ● 6 ● 7 mm
ICP					
CEREBRAL PERFUSION PRESSURE					

LEGEND

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

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

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

VASCULAR ASSESSMENT

		HOURS	21	24
upper	R		+	+
	L		+	+
lower	R		+	+
	L		+	+
	R			
	L			
	R			
	L			
	R			
	L			

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS [redacted]
NEURO	PUPILS		equal reactive				b(6)-2	
	SENSORIUM		Awake, Alert, Oriented per interpreter					
RESPIRATORY	RESPIRATORY PATTERN		RRR unlabored					
	BREATH SOUNDS		CTA					
	SECRETIONS		Ø					
SKIN	COLOR		pale					
	INTEGRITY		Surg to abd					
I.V. SITE	LOCATION		(R) AC HL (R) FA					
	CONDITION		S Sx infection or infiltration					
GASTRO	ABDOMEN		covered by abd dressing					
	BOWEL SOUNDS		hyperactive bowel					
			gluconate					
			NGT to LIS					
GU	URINE:		Foley					
	COLOR/CLARITY		clr yellow					
CARDIOVASCULAR	CARDIAC RHYTHM		ST ± ectopy @ 112bpm					

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 14-JUN-07

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

Ft [redacted] b(6)-4

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

DATE 14 June 03 DX S/P GSW S/P Ex lap HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	123/78	124/80	133/72	129/79	119/73	118/73	118/67	120/64			120/72		127/74		122/70		124/79	
Temperature		99.9						99.2					100.5		100.8		101.1	
Pulse	112	114	110	107	109	110	111	120			118		120		92		96	
Respiratory Rate	20	18	18	20	24	21	19	20			24		28		18			
SaO2	95	96	96	95	95	96	96	95			93		93		94		93	
O2	RA	RA	RA	RA	RA	RA	RA	RA			RA		RA		RA		RA	
open intubation																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	
IVPB							100		100				100					
LR Bolus													1000					
	125																	
TOTALS	125																	

OUTPUT

	HOUR / TOTAL	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
URINE		50/40	50/100	50/150	45/195	40/235	50/285		150/435	435		125/560		150/710		200/910		45/1205	
	sp gr																		
	S/A																		
NG	OUTPUT								10cc	10cc	D/c'd -14 June								
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	20	22	23	24	00	02	03	04	
		124/61		110/71		122/71		114/67	
		101		99.9		100.3		101	
		89		98		114		94	
		20		18		20		18	
		93		94		94		94	
		RA		RA		RA		RA	

INTAKE

	20	22	23	24	00	02	03	04	8° T
IV	125	125	125	125	125	125	125	125	
PO		100						100	

OUTPUT

	100/1400		100/1500		200/1700		450/2230		

RESPIRATORY DATA

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

LABORATORY DATA

	TIME	0100								
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET	19.8/113								
	Hct/Hgb	32.1/13.3								

ACTIVITIES DAILY LIVING

	TIME		0330								
	MOUTH CARE		✓								
	BATH		✓								
	SKIN CARE										
	FOLEY CARE	✓									
	TRACH CARE										
	ROM EXERCISES										

TURN / SUCTION — TIME

24° I&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S SIGNATURE — INITIALS

[redacted] b(4)-2 b(4)-2

NEUROLOGICAL ASSESSMENT

COMA SCALE

HOURS

EYES OPEN
- SPONTANEOUSLY 4
- TO SPEECH 3
- TO PAIN 2
- NO EYE OPENING 1

BEST VERBAL RESPONSE
- ORIENTED 5
- CONFUSED 4
- VERBALIZES 3
- VOCALIZES 2
- NO VOCALIZATION 1

BEST MOTOR RESPONSE
- OBEYS COMMANDS 6
- LOCALIZES PAIN 5
- FLEXION WITHDRAWAL 4
- ABNORMAL FLEXION 3
- EXTENSION TO PAIN 2
- NO MOTOR RESPONSE 1

LIMB MOVEMENT

ARMS
- NORMAL POWER
- MILD WEAKNESS
- SEVERE WEAKNESS
- ABNORMAL FLEXION
- ABNORMAL EXTENSION
- NO RESPONSE

LEGS
- NORMAL POWER
- MILD WEAKNESS
- SEVERE WEAKNESS
- ABNORMAL FLEXION
- ABNORMAL EXTENSION
- NO RESPONSE

PUPILS

RIGHT	SIZE	
	REACTION	
LEFT	SIZE	
	REACTION	

PUPIL SCALE: ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

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

+ + Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS

	R L
	R L
	R L
	R L
	R L

LEGEND

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

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL [illegible] ASSESSMENT

	TIME		INITIALS [redacted] b(6)-2	INITIALS	INITIALS
NEURO	PUPILS	Reactive			
	SENSORIUM	Alert, oriented			
RESPIRATORY	RESPIRATORY PATTERN	Regular, unlabored			
	BREATH SOUNDS	BBS CTA			
	SECRETIONS	Ø secretions			
SKIN	COLOR	Normal			
	INTEGRITY	intact incisions well approximated			
IV SITE	LOCATION	RFA, LUAC			
	CONDITION	CDI, Ø SS infiltration			
GASTRO	ABDOMEN	Tender to touch			
	BOWEL SOUNDS	hypoactive to 4 quads			
GU	URINE: COLOR/CLARITY	yellow Ø sediments			
CARDIOVASCULAR	CARDIAC RHYTHM	SR - HR 90's palpable pulses			

LEGEND

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

(Continue on reverse)

[redacted] b(6)-2

[redacted] NCSTP

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 16 Jun 03

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

[redacted] b(6)-4

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

DATE 10 June 03 | DX S/P GSW s/p Ex lap | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	120/66	118/68		121/69	108/61	111/66												
Temperature				97.5														
Pulse	102	99	98	95	85	88												
Respiratory Rate	17	23	20	22	21	27												
O2 Sat	96	94	96	97	99	96												
FiO2	RA	RA	RA	RA	RA													
Walk (amb)				✓														
↑ in chair				✓														
Bed																		
[illegible]																		
[illegible]																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR @ 125cc/hr	125	125	125	125	125	125	125											
IVPB Unasyn																		
PO		30		30														
		155	125	155	125	125	125											
TOTALS	125	280	405	560	685	810	935	935										

OUTPUT

		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
URINE	HOUR / TOTAL	150/150	200/350	100/450	100/550	50/600	75/675											
	SP GR																	
	S/A																	
NG	OUTPUT						675											
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	21	22	23	24	00	01	02	03	/

INTAKE

	21	22	23	24	00	01	02	03	8°T

OUTPUT

	/	/	/	/	/	/	/	/	

RESPIRATORY

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

LABORATORY

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

ACTIVITIES OF DAILY LIVING

	TIME									
	MOUTH CARE	0600								
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN

TIME					

SUCTION

24°I&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
blg-2	

NEUROLOGICAL ASSESSMENT

COMA SCALE

EYES OPEN

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

BEST VERBAL RESPONSE

ORIENTED	5
CONFUSED	4
VERBALIZES	3
VOCALIZES	2
NO VOCALIZATION	1

BEST MOTOR RESPONSE

OBEYS COMMANDS	6
LOCALIZES PAIN	5
FLEXION WITHDRAWAL	4
ABNORMAL FLEXION	3
EXTENSION TO PAIN	2
NO MOTOR RESPONSE	1

LIMB MOVEMENT

ARMS

- NORMAL POWER
- MILD WEAKNESS
- SEVERE WEAKNESS
- ABNORMAL FLEXION
- ABNORMAL EXTENSION
- NO RESPONSE

LEGS

- NORMAL POWER
- MILD WEAKNESS
- SEVERE WEAKNESS
- ABNORMAL FLEXION
- ABNORMAL EXTENSION
- NO RESPONSE

PUPILS

RIGHT	SIZE	
	REACTION	
LEFT	SIZE	
	REACTION	

PUPIL SCALE: ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

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

◆ ◆ Brisk
◆ Slow
– No Response

◆ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	

LEGEND

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. MTF LOCATION		(State or Country Code.)
1	2	3	4	5	6	7	8	
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
0	0	1	3	4	7	3	EPW # [redacted] b(6) 4			M

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								3	3	Y	X	9	

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
				7	0									

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1720	
	U		

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		
0 Direct from ER	ICW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION			22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74		75	76	77	78	79	80	81	82	83	84	85	86
5	0	DISCHARGED TO CAMP							0	3	0	4	1	9

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	E	A	A							0	3	0	4	1	3
ORTHO															

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

FOR LOCAL USE

DX → GSW (R) abdomen

865.19
863.53
E-991.2
998.89

41.5
46.75

b(4) 2

Dx: 86513
86353
86359
E9912
Trauma - 1
Injury - 480

Px: 415
4673
4675
8622 X2

ADMITTING OFFICER (Signature, as require

SIGNATURE OF ADMITTING CLERK [redacted] SPC

b(4) - 2

DA FORM 2098E, MAR 90

MEDCOM - 10728

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
001474	EPW [redacted] b(6)4	N/A	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	44y	Z	unk	N/A	N/A	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	b(6)4 [redacted]	N/A	ICU2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K79	N/A		WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	2020	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	50	22 Jun 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		13 Jun 03	b(6)-2 [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b2-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P Ex-Lap GSW (R) flank

Dx: 86813
E9912

Proc: 541

T... Trauma ...
1

blood ... NO

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	10	10

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	10	20

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

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

DA FORM 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDCOM - 10729

b(6)-2

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL
DATE: DAY 13 | MONTH 6 | YR. 03 | TIME 1735

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

CURRENT MEDS. (tetanus immunization and other data)
Mylota

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
GSW R Flank

SEX: M | AGE

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

TIME SEEN BY PROVIDER
1735

VITAL SIGNS			
TIME			
BP	144/89	131/80	
PULSE	99		
RESP.	20		
TEMP.			
WT. (Child)			

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

ORDERS	INITS.	TIME
IV Bolus TL RS		
Morphine 75 mg		
Type Cross / CBC		
PT/PTT / UA/Tox		
Tet 5cc IM		

ASSESSMENT/DIAGNOSIS
GSW to abd.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

41 y/o ♂ s/p GSW SPTA, ϕ hx' adm.'l

RUA

ROT

PMH/SH: NKA

Abd: ⓐdist abd, ⓑdiff tnd
ⓒⓕ flank wound, ϕ active bleed
rectal: def + OR
Back: ϕ lesions

A/P ① GSW to Abd

b(6)2

[redacted]

(CONTINUE ON SF 507, IF NEEDED)

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY | MONTH | YEAR
REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

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

b(6)-4

[redacted]

SIGNATURE OF PROVIDER AND ID STAMP

[redacted]

INSTRUCTIONS TO PATIENT (Include medica... ...ions and follow-up plans)

b(6)-2

EMERGENCY CARE AND TREATMENT

MEDCOM - 10730 ...opy

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

MEDICAL RECORD	PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
13 JUNE 03	General Surgery H&P
2046	41 yo EPW [illegible] sustained a single GSW
	to right flank. c/o pain in abdomen, (-) LOC
	[illegible] to [illegible] to CSH
	PMH PSH MEDS ALL SH
	NEG [illegible] NKDA [illegible]
	Exam: BP 140/80 HR 100 RR 18 SaO2 98% RA
	Alert, conversant
	Chest CTA B/L
	Cor [illegible]
	ABD soft, TTP (R) flank, (+) [illegible]
	single GSW to (R) flank - [illegible]
	EXT (-) [illegible] femoral pulses 2+
	Rectal: NL tone guaiac (-)
	LABS CXR ABD Film
	UA - (+) blood (-) PTX/HTX (+) foreign body
	Hct 46 [illegible] [illegible]
	IMP/PLAN: 41 yo EPW sustained single GSW to abdomen
	To OR for exploration. [redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 10731

038

NAME | FI | MIDD |) NUMBER

DATE	NOTES
	Surgery
13 JAN 03	Brief Op Note
2051	pre-op dx: GSW to right flank
	post op dx: [illegible] duodenal ecchymosis, GSW
	procedure: exploratory laparotomy, appendectomy, lysis of adhesions
	Surgeon [illegible] Lacey
	Anesthesia GET
	EBL 200
	fluids 3000 LR UO 300
	findings: small ecchymotic area to duodenum, [illegible]
	complications: none to appendix - [illegible] to
	small bowel.
	b(6)-2 All
	[redacted]
13 JAN 03	Noted swelling of abdomen. Abdomen measured
2200	36.5 inches. Dr [redacted] notified. Evaluated pt and
	ordered HCT & CBC sent to lab. [redacted]
13 JAN 03	CBC results notified to Dr [redacted] Abdo-
2315	men measured unchanged. MD aware. [redacted]
14 JAN 03	Pt doing well. Abdominal dsg & (R) flank
0430	dressing D&I. c/o pain overnight medicated
	with a total of 8mg MSO4 & 15mg Toradol.
	Rested well thru night. RA O2 SATS 97% and
	above. NGT to LIS. Foley to gravity. Report
	given to incoming nurse. [redacted]

AUTHORIZED FOR LOCAL REPROD

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 JUNE 03	General Surgery
0805	POD #1, s/p ex-lap - GSW to (R) flank, → colon, [illegible]
	at [illegible] overnight. [illegible]
[illegible]	Afeb 99.4 HR 98-110 BP 103/74 RR 22 97% RA I/O 1090/775
	Chest CTA B/L uo 100cc/°
10.8 / 45 / 166	Cor RRR [illegible] JP - [illegible]
[illegible]	[illegible] dressing dry, [illegible]
[illegible]	Ext (-) edema,
[illegible]	[illegible]: POD #1 s/p ex-lap
[illegible]	[illegible] - stable
	[illegible] N/V - [illegible]
	ambulate
	cont IVF, NPO until return of bowel function 2°
	to [illegible] [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Jun 03 0900	Nursing Assessment: Assumed care of patient at 0500. Neuro: Opens eyes to voice, touch. Moves all extremities well. Pain controlled c MSO4 and toradol IVP, will try to reduce MSO4 and only give toradol. Resp: lungs clear, breath sounds equal, even and unlabored. Resp rate 16-20, sats 99% on RA. Ø cough, will ambutate and encourage IS today. CV: HR mild ST, 100 x 110, BP stable 90-110/50-60, pulses palpable, skin warm + dry, afebrile 98-99°. GI: BS hypoactive, NGT to SX, clamped @ 0730 will remove this pm if no N/V. Abd mildly distended, slightly firm, tender over incision only Ø Stool. GU: foley draining 50cc dark yellow urine Q 1°. Skin: midline incision covered CDI. Ø drains. Lines: bilateral 18g IV, LRC 100cc/°. Plan: Ambulate today, remove NGT, encourage IS. Will continue to monitor [redacted] CPT [redacted] b(a)-2
14 Jun 03 1645	Shift summary: Uneventful shift, up to chair x1, ambulated length of ward x1. NGT DC @ 1230, Ø N/V, abd appears slightly more distended. Bowel sounds summed but present. Report given to oncoming Shift [redacted] CPT [redacted] b(a)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 JUN 03 1730	Receive pt from offgoing nurse. (NEURO) Alert awake and oriented. Follows commands. PERL @ 3mm. c/o pain around gunshot area and abdomen. MAE x 4. (CV) Smis tach & ectopy. (+) S1, S2. Low grade temperature. Peripheral pulses palpable x 4 extremities. (RESP) (B) CTA. Room air OxSats 98-100%. Ø respiratory distress. Equal chest rise & symmetrical. (GI) Very hyperactive BS. Abd round tender to touch. Midline abdominal dsg with quarter size blood spot marked. (GU) Foley to gravity draining clear sm. amts of urine every hour. (SKIN) warm, dry. (N) Blank dsg intact. b(6)2 Will keep monitoring for any changes. [redacted] Up
14 JUN 03 1945	Report given to IT nicholson. Pt Alert awake. Cooperating with nursing staff. Transfer to 2CW2.
b(6)-2	[redacted] b(6)-2
15 JUNE 03 1300	Pt. [redacted] BP 100/72, P. 110, R. 16, TEMP 101.6 b(6)2 [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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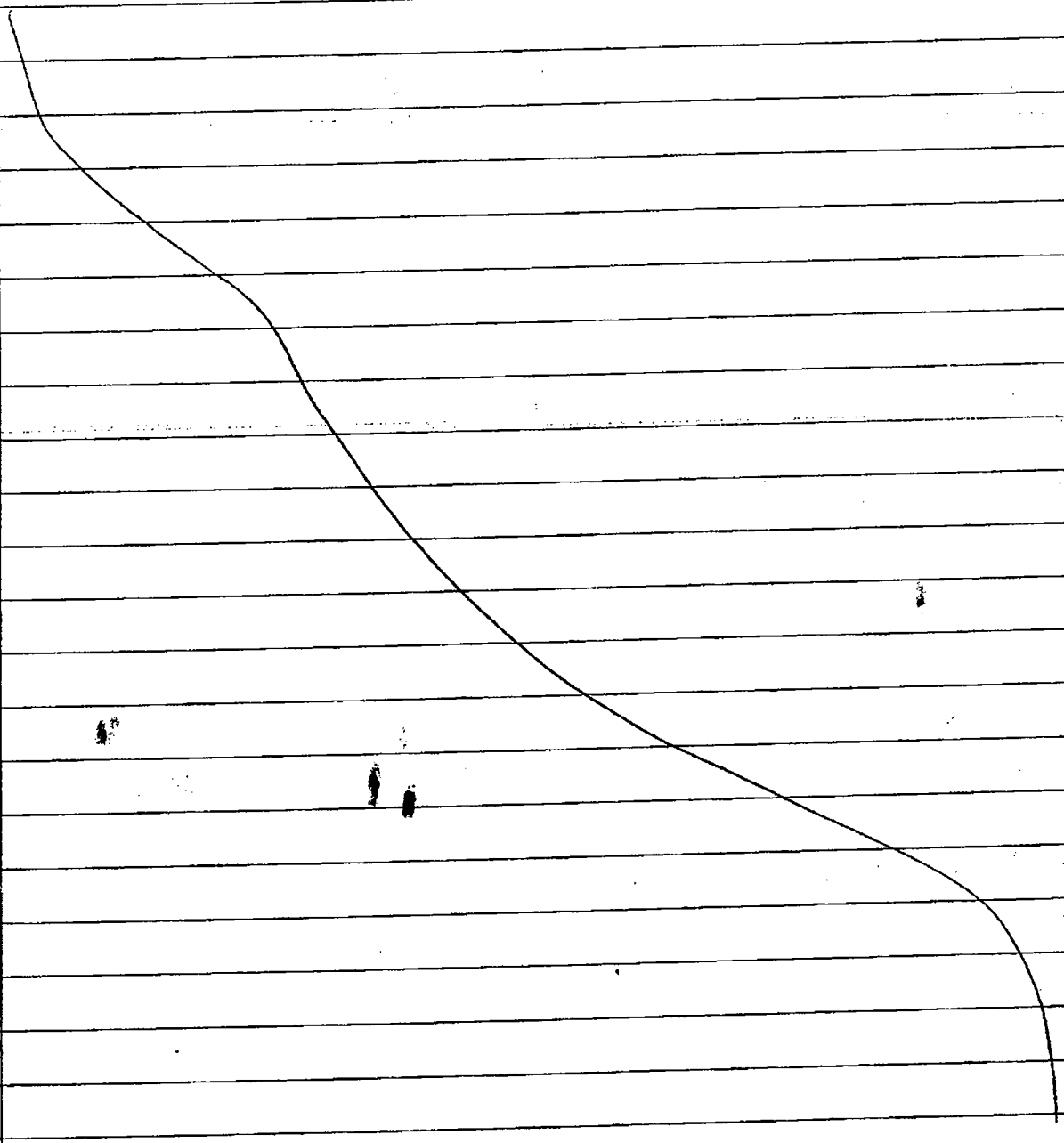
AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15JUN03 ~~2000~~	Assumed care of 14@ 1300. VSS. A10x3 @LS CTA.



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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Jun 03 2020	Pt transferred from ICU #2 @ 2000. Via stretcher. A+Ox3 b(6)-2 VSS. Will monitor [redacted]
14 Jun 03 2100	Pt. awake and alert. Pt. OOB to chair = difficulty C assistance c/o pain in ABD. Toradol given for pain control C relief. VSWNL RRRAWOL. LCAB. BSHypoactive x4. Midline ABD dsg Intact. Sm. amt drainage noted on last shift. Drainage exceeded drawn outline. R flank dsg C/D/I. PIV LAC LR @ 125cc/hr patent. Foley patent draining clr. Yellow urine. No further complaints @ this time b(6)-2 [redacted] DIT AW
0445	Pt. alerting staff for help. Pt. in apparent resp. distress episode. O2 sat 99%. RR 40 bpm. HR 125. Insp/Exp wheezing. Pt. per interpreter states he can't breathe Diaphoretic. HOB↑. O2 mask NRB @ 6L placed. F mask placement HR 100 O2 sat 100. IV fluid stopped. Pt encouraged to take long deep breaths. b(6)-2 Dr [redacted] aware. Stat CXR, EKG, LABS ordered will b(6)-2 monitor [redacted] DIT AW
15 Jun 03 0755	Assume pt care at 0500. Pt awake and alert. N. c/o pain at this time. VSS. HR regular. Lungs CTA. Abd. Dressing sm amt drainage marked. R flank dsg CDI. LR @ 125cc/hr to (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)*

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EPW

[redacted] b(2)4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont)	to (R) AC no s/s redness / infiltration. Foley to gravity draining clear amber urine. No s/s redness / irritation at insertion site. Full ROM to U/L extremities MD in to look at x-ray and labs and EKG - no new orders. Will continue to monitor [redacted]
15 June 0800	NC @ 2L O_2 [redacted]
	b(6)-2
15 June 03	General Surgery
0815	[illegible]
P) 40	[illegible]
	[illegible]
	[illegible] b(6)-2 [redacted]
	- ambulate - [illegible]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 JUN 03 2000	Assumed care of Pt @ 1200 VSS, A+Ox3. (B) x5 CTA (+) BS x4 Hypo. Abd dsg reinforced, oozing @ staples. (-) c/o pain. Palpable pulses x4. OOB to chair x5 assistance. Foley to gravity clear. I+O's. LR @ 75 via (R) AC PIV. (-) [redacted] b(6)-2 Assessment WNL. Will Monitor [redacted] 15 JUN 03
16 Jun 03 0252	2000 - Pt awake and alert in bed. PERRLA (+) VS WNL x Temp 101.4. 1 Tylenol given. Skin W+D. LCA (B). BS (+) x4. Dsg to ML ABD incision intact C sm. amt. drainage exceeding border of marking drawn @ this time. IV LR @ 75cc/hr patent. (+) PPP (B). Dsg. to (R) Flank C/DI. Will cont to mon. [redacted] b(6)-2
16 June 03	0045 Assume pt care @ 0500. Pt awake HOB elevated. [redacted] LR @ 75 cc/hr to (R) AC. C/o pain to (L) side of Chest Lungs CTA throughout HOB ↑, no complaints since. ↑ temp 101.2°, 1 tylenol adm PO. HR regular. Abd soft. midline incision staples intact dsg drainage marked and timed. (R) Flank dsg CDI. Foley to gravity draining Clear yellow UOP - 400cc out @ this time. Will continue to monitor. b(6)-2 [redacted]
16 June 03 1000	MD in to do dsg change. New orders written. MD note on back. b(6)-2 [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. TCW2

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16JUNE03	General Surgery
0830	POD#3 s/p Ex-lap 2° GSW to (R) flank.
	Female overweight 101.5 BP 115/65 HR 105 RR 24
	Looks well, c/o (R) chest pain c deep 98.2
	inspiration. 1100/1945 [illegible]
	~~[illegible]~~ Chest CTA B/L c decr [illegible]
	CV RRR → ST [illegible]
	ABD soft (+) BS [illegible]
	Wound - midline incision (+) serous drainage
	from mid aspect [illegible] continues.
	Ext [illegible]
	Imp/Plan: POD#3 s/p Ex-lap, LOA, [illegible] 2° GSW
	fever c drainage from incision site.
	- Wound opened c removal of a few staples
	@ site of drainage, debris - blood, fluid
	expressed - removed
	- ✓CXR - c/o [illegible] /14 [illegible]
	- HCT → clear diet → [redacted] b(6)-2
	[illegible]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16June03	1005 pt OOB to chair for approx 40 min. No c/o pains or discomfort. CKR done. Encourage use of IS. [redacted] b(6)-2
	1250. IV HL'd, Foley D/C'd, pt diet CL advance as tol. No c/o pain. CKR at FOB [redacted] SWM
16Jun03 1920	assumed care @1300 – tolerated clear diet – voided 300cc & Foley removed – pt. using IS 91°, encouraged to deep breath – Tmax 101.9, given T#3 for fever and pain in abdomen – pt. OOB to chair x 30 minutes – HL patent – VSS, sat 94% RA b(6)-2 [redacted] CRAV
2150	Pt. care assumed @ 2100. HL flushed to (R) FA. @ S/S infection. Pt. premed. for dsng Δ c 4mg MSO4. HK Keg. Lungs CTA. O2 sats 95% RA. Pt. placed on 2L O2 NC to keep sats 95%. Pt. using IS well. ABD distended. Upper quadrants soft. (L)LQ firm. Staples midline OTA. Dsng to lower half incision Δ'd W→D. Dsng CDI. Will cont. to monitor. b(6)-2 [redacted] CTAN
17June03 0605	Assumed pt care @ 0500. pt asleep easy to awake for assessment. HL to (R) AC flushes S S/S

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)*

[redacted]

REGISTER NO.

WARD NO. ICU 2

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 June 0005	Of redness / infiltration & flush. VSS. SpO_2 97% c 2L O_2 via N/C. HR regular. Lungs CTA - pt c/o chest pain on (L) side. Abd. soft, midline incision staples intact, dsg CD&I. no signs of drainage, (R) flank dsg CD&I. Full ROM U/L extremities. Plan to ambulate pt today, encourage IS and [redacted] dsg Δ. Will continue to monitor. —— [redacted] b(6)-2
1045	pt clear yellow UOP 450cc. pt ambulated this am, attempted BM & success. Abd. distended. Diet Δ'd to sips of clears. IS encouraged. Dsg Δ by MD note written. —— [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD	PROGRESS NOTES

DATE	
12 NOV 03	General Surgery
1025	POD #4 s/p ex lap / LOA / [illegible] 2° GSW (L) flank.
	Pt c/o abdominal fullness / distention
	(-) BM, (+) flatus, good [illegible]
	Febrile to 101 HR 105 BP 120/82 [illegible] 2L O2 [illegible]
	Looks relatively uncomfortable UO - 1400/24°
	Chest CTA - few respiratory wheezes
	[illegible]
	ABD (+) distention (+) BS. slightly tympanitic
	wound - serous drainage from [illegible]
	Ext [illegible]
	A/P: Post op ileus 2° to extensive [illegible] of [illegible]
	- [illegible] of [illegible]
	- ambulate
	- follow fluid status closely - UO currently [illegible]
	- cont. wound care
	[redacted] b(6) - 2
	[redacted]
	MO [illegible]

(Continue on reverse side)

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

EPW

[redacted]

b(6)-4

REGISTER NO.

WARD NO. 4CW2

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
17 Jun 03	assumed care @1300 - VSS, T 100.7° - pt's
1620	lungs c audible rhonchi in upper lobes &
	decreased BS in lower lobes (B) - IS q30 min,
	C&DB q30 min, chest PT done X15 minutes
	S Significant improvement, pt's has very poor
	coughing effort, O_2 sat on RA 94-95%, pt.
b(6)-2	requested O_2 NC, Dr. [redacted] approved as it
	seems to calm pt. - pt. has hypoactive B.S,
	no BM, abdomen distended and rigid to
	touch, medicated for pain @ 1430 c adequate
	results - will continue to monitor [redacted]
17 Jun 03	abdominal dsg Δ'd @ 1900 due to leakage - b(6)-2
1900	thick, light brown drainage noted on dsg &
	abdomen; no frank blood, wet → dry dsg.
	replaced in two open wounds and 4x4's
	placed on top - pt. continues to use IS q1° &
	attempts to cough & deep breathing - tolerated
	broth for dinner [redacted] SCR b(6)-2
2300	Pt care assumed @ 2100. VSS, alert and [redacted]
	c/o pain at this time. Pain @ 2200, 4mg MSO4 given.
	Lung sounds CTA, diminished in bases bilaterally. Pt ambulated
	x1, pulmonary toilet x2 when pt aware, IS encouraged, pt taught
	significance of IS and pulmonary toilet [redacted] via Babi (interpreter).
	Bowel sounds present but hypoactive. HL to CFA c/d, flushes well.
	Dressings on abd c/d, [redacted] abd is rigid and tender to touch.
	No complaints at this time, will continue to monitor.
	SPC [redacted] RN MC b(6)-2

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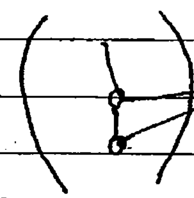
MEDICAL RECORD	PROGRESS NOTES

DATE	
18June03 0600	Pt. awake ē alert in bed. VS: BP 117/80, Sats 93% on RA, P111, T 99.8. Midsternal incision well approximated s̄ signs of infection. DSG's CDI. Pt. states that when he eats his stomach expands ē he has pain. He also complains that he's having a lot of gas. HL in (R) AC s̄ signs of infection. Pt. has no other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2Lt/AN
	b(6)-2
18JUNE03 1215	General Surgery
	POD#5 — Ex-lap, CDA, [illegible] 2° GSW (R) flank
	[illegible] return of bowel function
	(+) flatus (−) stool, tol clear diet?
	↓ distention today
	Tm 100.8 ↓99.5 122/82 HR 100 98% RA [illegible]
	[illegible]
	Chest CTA [illegible] ↓ [illegible] (R)
	[illegible]
	[illegible] distention (+) BS, [illegible]
	s̄ infection, (+) [illegible]
	CT (R) [illegible] — [illegible]
	[illegible] stop
	— cont clear diet
	— [illegible]
	— [illegible] 2° [illegible]



[illegible] 2° [illegible]

[redacted]

b(6)-2

(Continue on reverse side)

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

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WARD NO. ICW2

b(6)-4

EPW # [redacted]

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
1400	assumed care @ 1300. VSS, A+Ox3. OOB → chair x 1 hr. ⊕ IS, Deep Breath + cough, ⊕ BS x4, Ⓑ LS CTA ⊕ expiratory wheezing. ABD distended ⊕ flatus Ø BM tol CL DIST. UO @ 100cc/hr. Spontaneous void 150cc @ 1430. ABD staples OTA CDI. Dsg Δ Ø SI/SO o/w assessment WNL. Will monitor [redacted] b(6)-2
2130	Pt. care assumed @ 2100. VSS. HR 110, pain ambulating. Pt. OOB → chair x1°. Pt. ambulate to BR. Pt voided Ø BM. Pt. c/o gas. ABD firm, distended c̄ active BS x4. MD consulted, simethicone given PO. HR Reg. Lungs have insp. s̄ exp. wheezes to Ⓡ Lung, Ⓛ Lung CTA. Midline ABD c̄ staples OTA s̄ drsng CDI. IV infusing CR to Ⓡ UE s̄ difficulty. Will cont. to monitor. [redacted] b(6)-2

PROGRESS NOTES

DATE	
18 Jun 03 0905	Assumed care of pt @ 0500. Pt is up-finishing breakfast. Lungs CTA. Abd distended and tender to touch. Staples down mid-section of abdomen. Dsg-mid lower part of abd. A&D by MD. Pt has c/o gas pain. Pt was oob ambulating for 10 mins. b(6)-2 [redacted] 9 Jun 03 SGT
19 Jun 03 0600	Pt vitals taken BP 120/70, P 108, R 18 Temp 98.6 [redacted] SPC
19 Jun 03 2350	Assumed care of pt @ 21:00. VS WNL. PERRLA. Skin WD. LCAB. BS+x4. +PPP. 0 complaints @ this time. 00:37 Pt. given dose of one of IVPB. Pt states made him nauseous. Pt. Emesis x1 green in color. approx 500cc+ of emesis. Attempted to give phenergan. Precip. in line. IV tubing d/c'd new tubing hung. Pt 0 further complaints of N/V. will cont. to mon. [redacted] b(6)-2
20 Jun 03	Assumed pt care @ 0500. Pt. awake. A+ox3. Lungs CTA in all fields. +BSx4. +Pulses x4. Denies any complaints @ this time. IVF: LR @ 100cc/hr infusing in RAC 3 difficulty. will continue to monitor [redacted] 9 Jun 03 b(6)-2

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MEDICAL RECORD | PROGRESS NOTES

DATE

19 JUNE 03 — General Surgery
0825 — POD #6 s/p ex lap, LOA, ... GSW (R) flank.
... ⊕ flatus, ⊖ BM, ↓ ... distention, tol clears.
Tm 100.8 ↓ 98.6 118/78 - 105 - 97% RA
Looks better, ... well   I/O - NAR
Chest CTA B/L
Cor ...
ABD: ↓ distention, ⊕ BS ... TTP, ...
Wound: ... granulating ...
... drainage.
Ext ⊖ edema

A/P:
... better - slow return of bowel function after ... of ...
- ... am
- Cont ... wound care ...
- ...

[redacted] b(6)-2

...

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

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PROGRESS NOTES
Medical Record

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#[redacted] b(6)-4

MEDICAL RECORD	PROGRESS NOTES

DATE	
20 JUNE 03	General Surgery
0945	POD#7 - s/p ex lap, [illegible] of [illegible], [illegible]
	2o GSW (R) flank.
LABS	Pt c prolonged ileus post op - resumed [illegible] to
	[illegible]. Pt c NG [illegible]
98/35\287	for [illegible] - NG [illegible] [illegible] post-op. Continues to pass flatus (+) [illegible]
130/100/110 4.2/25/0.4 <111	last pm 1 800cc. Slightly ↓ distension today.
	[illegible] Tm 99.3 HR 90-110 BP 130/80 [illegible]
	Looks better, conversant [illegible] not accurately
	(+) [illegible] (+) flatus [illegible]. [illegible]
	Chest CTA B/L
	CV RRR S [illegible]
	ABD soft, (+) BS, distension [illegible]
	[illegible] of incision, wound (-) erythema
	[illegible] drainage from [illegible] of wound
	Ext [illegible]
A/P	- [illegible] [illegible] [illegible] - [illegible]
	slow improvement
	Cont. wound care [illegible]
	more accurate [illegible]
	[signature] [redacted] b(6)-2

(Continue on reverse side)

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

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PROGRESS NOTES
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PROGRESS NOTES

DATE	
20 June 03 1420	assumed pt care @ 1300. VSS. lungs CTA, abd c̄ incision & staples OTA, drsing CDI. ⊕ BS ↓ & ↑ ext c̄ full rom ⊕ pulses. IV Ⓡ AC infusing LR s̄ diff ∅ s/sx of infiltration, drsing Ⓡ hand by thumb CDI. pt sitting up in chair x 30 mins tol well. ∅ c/o pain voided @ this time. Will cont to monitor b(6)-2 [redacted] GIWML
20 June 03 2200	Pt vitals taken BP 102/64, P.90 R.16, temp. 100.2 b(6)-2 [redacted]
20 Jun 03 22:54	Assumed pt. care @ 21:00. Pt. awake and alert in bed. VS WNL x̄ temp ↑ 100.2. Pt c/o pain. ii Tylenol #3's given. PERRLA ⊕ Skin PWD. LCA Ⓑ. BS ⊕ x 4. ML ABD incision c̄ staples intact and well approximated. Dsg @ end of ML incision C/D/I. DSG to ↑ Ⓡ lateral chest wall C/D/I. ∅ c/o NVD. Pt voided 400cc @ this time. Amb well to commode s̄ difficulty. Will cont. to mon [redacted] /AN b(6)-2
0057	Pt c/o being hot. Temp ↓ 99.0°. Will cont. to [redacted] /AN
21 June 03	0645 Assume pt care @ 0500. Pt asleep, easy to awake for assessment. VSS. PERRLA. HR regular. Lungs CTA throughout. Abd soft. midline incision staples intact. Dsg CD+I. Dsg to Ⓡ flank CD+I. pt amb - well. c/o pain to ⓇUQ abd. Will continue to monitor b(6)-2 [redacted]
	0950 Dsg Δ. Bacitracin and 2x2 applied to Ⓛ hand and Ⓛ side. W→D dsg applied to abd. All sites free of s/s of infection. pt using IS @ this time [redacted] SCK b(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES

DATE	
	General Surgery
21 JUNE 03	POD#8 s/p ex-lap / LOA / ...
1045	Pt doing better. (+) BM x2 - diarrhea (3 episodes)
	Some c/o abdominal cramps - (R) flank today
	(-) N/V. Wants more to eat.
	Tm 100.2 Tc 98° - no fever > 101 since 16 JUNE
	BP 110/80 HR 70-90 RR ... U.O. adequate.
	b(6)-2 [redacted]
	Abdomen soft. TTP (?) incision, dressing
	post ...
	some serous fluid (-) erythema
	Imp/Plan: Improving
	- advancing diet - loose stools ...
	c return of bowel function.
	- ... per pt request
	- cont wound care.
	[redacted] b(6)-2
21 JUN 03	(L) AC PIV not flushing, leaking fluid D/C, cath intact
1330	but crimped off. New 22G PIV started (R) hand.
	Flushes well. ——— [redacted]
	b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW2

b(6)-4

EPW # [redacted]

PROGRESS NOTES
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USAPPC V1.00

PROGRESS NOTES

DATE	
22Jun03 2025	assumed care @ 1300 - VSS - IOs sufficient - IV patent - no c/o pain @ this time - abd. dsg Δ'd as ordered, granulation tissue noted in both T & + wound - pt. ambulated x 2 this shift, IS q1° and OOB → chair - ate cake and orange juice for dinner - lungs CTA (D) BS, (D) [redacted] loose stool b(6)02 [redacted] c/r
2355	Pt. care assumed @ 2100. VSS. Pt. pre-medicated c MSO4 for dsng Δ. W-TD done on ABD wound. (D) s/s infection noted upon dsng Δ. midline incision c staples OTA. HR Reg. lung bases c ronchi, upper lobes CTA. BS (D) x4. Pt ooes to ambulate and then b(6)-2 [redacted] to chair x 1 hour. Will cont. to monitor.
22June03 0600	Assume pt care @ 0500. Pt asleep easy to awake for assessment. VSS. [redacted] HR regular. c/o pain to (L) flank. Dsg CDI. Lungs CTA. Abd. soft, no c/o pain. midline incision intact, Dsg CDI. BS x4 active. pulses strong x4. Full ROM U/L extremities. Will encourage use of IS today and ambulation. LR @ 100cc/hr to (R) hand no s/s redness/ b(6)-2 [redacted] infiltration.
22June03 1415	assumed pt care @ 1300. pt resting quietly. VSS. Airway patent, lung sounds CTA. abd soft midline incision dsng CDI, BS (D) x4 quads. ↓ & ↑ ext c full ROM strong (D) pulses. IV (R) hand infusing LR @ 50cc/hr (D) S/Sx of infiltration. Wound to (R) hand OTA (D) signs of infection noted. pt ↑ walking c diff. Did well. (D) c/o pain voided. Will cont to monitor. [redacted] 911 time

b(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Jun 1200	Pt was given 4l O2. Pt was trying to cough and started to have difficulty breathing. Pt Sats are now 97% with the O2. Pt is also sitting up on side of bed. Pt oob in chair for 30 minutes @ 1030. b(6)-02 [redacted] 9Wm6, S6T
1220	Pt taken off O2 @ 1220 Sats 95%
23 Jun	b(6)-2 [redacted], 9WM8, S67
23 Jun 03 2000	assumed care @1300 - VSS - pt. using IS q1°, ambulated to OOB → chair this shift - abd dsg Δ'd, (R) & flank dsg Δ'd, no dsg on (R) hand - HL patent - tolerated regular diet - (+) BS - (B) T lung lobes (↓) breath sounds, pt's coughing effort very poor - medicated for Pain @ (2) side of abd wounds b(6)-2 [redacted]
2300	Pt care assumed @ 2100. Pt. OOB to BRC @ B/M. Pt. c/o gas. Mylanta 30cc given PO. Ff. using IS well & sitting in chair. AK Reg, Lungs CTA & Vinesses. ABD soft, rotund & active BSXP. Midline ABD incision c staples OTA. Dsng to ABD CPT. Will cont. to monitor. b(6)-2 [redacted]
24 Jun 03	0630 VSS. Ø%. NAD. Pt awake & alert. Ambulated to BR & difficulty, UOP 400cc clear yellow, small formed stool. IS x10 min. Dressing to abd. c small amt of dried drainage, secure. Saline lock patent, site & redness or edema. BBS CTA & =. Resting quietly @ present. b(6)-2 [redacted]
500 T98.6 BBS RLL BP 100/68 96%	

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:DICAL RECORD	PROGRESS NOTES

DATE	NOTES
22 June 03 2130	Pt vitals taken. BP 118/70, P 80, R 16, Temp 99.6 [redacted] b(6)-2
22 JUN 03 22:24	Rec'd pt @ 21:00 Awake + Alert in b[redacted]s WNL PERRLA LCA(B), BS(+)x4, (+)PPP(B), ML ABD inc. well approx. Dsg C/D/I. IV infiltrated (R) Hand. New 22G PIV initiated s̄ difficulty (L) FA patent c̄ LR @ 50cc/hr Will cont. to mon [redacted] b(6)-2
23 Jun	Assumed care of pt @ 0500. Pt alert and oriented. Lungs CTA. Bowel sounds x4 quads. VSS. Pt has two wounds on midsection of abd. Bandages dry and intact. Pt has LR running @ 125/hr. in (L) arm. Patent c̄ signs symptoms of infiltration. [redacted] 91WM6, SG b(6)-2
23 JUNE 03 0950	General Surgery
	POD 10. Pt continues to improve [illegible] [illegible] but not [illegible] much. Passing flatus.
	AFEB HR 90s BP 130/84 [illegible], chest CTA B/L [illegible]
	ABD soft, slightly distended @ [illegible]
	wound: dressing [illegible] serous fluid [illegible]
	Imp/Plan: Cont. wound care [redacted] b(6)-2
	Advance diet as tolerated
	[illegible] [illegible]

[RELATIO]NSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID N[O.] (SSN or Other)

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

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (R...
Prescribed by GSA/ICMR FPMR (41CFR) 101-1...

MEDICAL RECORD	PROGRESS NOTES

DATE	
24 JUNE 03	General Surgery
0840	POD#10. Pt continues to improve daily.
	(+) BM x [illegible] PO AM. [illegible]
	fevers change in status.
	tol use of a reg. diet
	Looks better - [illegible]
	AFEB HR 80-90s
	Chest CTA-B/L
	CV reg s M
	Abd soft (+) BS (-) TTP [illegible]
	wound - small drainage from superior
	[illegible], (+) granulation tissue
	[illegible]
	lower wound looks good.
[illegible]:	wound vac applied
	Δ dressing in 3 days.
	cont to advance diet.
	b(6)-2
	[redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO. ICW2

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
24 June 03 1900	Assumed pt care @ 1300. VSS. pt awake & alert. voices no c/o pain @ this time. lung sounds CTA w/ L side diminished. abd soft tender. drsng CDI c JP suction intact & drainage noted. BS+. +ve & +ext c full rom + pulses. HL to LFA flushes & dsg. no s/sx of infection noted. pt encouraged to use IS. Will cont to monitor — b(6)-2 [redacted] 9 Wmle
24 June 03 1800	pt c/o pain, IV Tylenol #3 given per orders. Will cont to monitor — b(6)-2 [redacted] 9 Wmle
24 Jun 03 22:00	Pt. rec'd @ 21:00. Sleeping in bed easily awakened. VS WNL. PERLA+ WNL. Lungs sound diminished @ bases. BS+ x4. Dsg to abd intact C/D. JP drain to suction & drainage in it. No c/o @ this time will cont to mon. [redacted] 2LT AN
25 June 03	0200 - Pt Alert OX3 x2, Tylenol #3 given for pain to abd. Lungs CTA, HL reg, BS+. Dsg intact to abd c JP to suction. HL to [redacted] Vein & cathlet. Will cont to monitor — [redacted] 2LT b(6)-2
25 June 03 1550	Assumed pt care @ 1300. VSS. pt awake & alert. lung sounds CTA, abd drsng CDI c JP tube intact, emptied 5 cc reddish brown drainage. BS+. +ve & +ext c full rom + pulses. HL to LFA + redness/swelling noted. + c/o pain voiced @ this time. Will cont to monitor — [redacted] 9 Wmle SGT b(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
25 Jun 03	General Surgery
	POD#11 Pt continues to improve. Tol the [illegible]
	[illegible] "gas" [illegible] B/C [illegible]
0500 T 98.8	of [illegible]. [illegible]
P 73	[illegible]
R16	(+) cough [illegible]
BP 108/60	[illegible] HR 70-80s [illegible] O2 [illegible]
94%	[illegible] CTA B/L [illegible]
	[illegible]
	ABD soft, ND, [illegible]
	(+) BS throughout
	[illegible]
	[illegible]
	[illegible]
	Imp/Plan:
	[illegible]
	- ↑ [illegible]
	- [illegible] #2
	- [illegible] progress. [redacted] b(6)-2
	[redacted]
25 Jun 03	Rec'd pt @ 21:00. Awake and alert in bed. VS [redacted] according to flow
22:29	sheet. PERRLA(+) WNL. Skin W/D. LS- Rub noted in (R) lower base.
	Dr Dixon aware and has seen pt. (L) lobe CTA throughout. (R) ↑
	lobe CTA throughout. BS hypoactive x4. DSG to ABD C/D/I. JP drain

(Continue on reverse side)

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EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
	cont'd - intact c̄ serosanguinous drainage noted. ⊕ PPP Ⓑ. Pt.
	amb to BR s̄ difficulty. Will cont. to mon [redacted] /AW
26 Jun 03	0600. Pt awake & alert. VSS. NAD. ∅ c/o. JP drain
	to abd. c̄ mod amt of serous drainage. BS CTA c̄ exception
	of Ⓡ ↓ base. S.L. intact, site s̄ redness or edema. —
0500 T. 98.6	——— b(6)-2 [redacted]
P 87	26 June 03 1530: assumed pt care @ 1300. VSS. pt awake et
R 16	alert. lung sounds CTA, abd c̄ drsng CDI c̄ JP tube to
100/71	suction intact. ↓ et ↑ ext c̄ full rom strong ⊕ pulses. HL to
97%	Ⓛ FA flushes s̄ diff. ∅ complaints voiced @ this time. Will cont
	to monitor ——— [redacted] 91wmle SGT —
	b(6)-2
26 JUNE 03	General Surgery
1955	POD # [illegible]
	Continues to improve slowly
	[illegible]
	⊕ BM
	AFVSS
	Abd soft [illegible]
	JP drain in place
	A/P [illegible]
	[illegible]
	[illegible]
	[redacted] b(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES
DATE	
27Jun03 00:08	Rec'd pt @ 01:00 26Jun03. Pt. resting in bed awake + alert. VS WNL per flowsheet. Skin W/D. PERLA ⊕ WNL. LCA ⊕ BS ⊕ x4. ⊕ PPP ⊕. ABD dsg C/D/I. JP drain intact c̄ serosang drainage. ∅ c/o pain @ this time. Will cont to [redacted] /AN
	b(6)-2
27 JUNE 03 0855	General Surgery
	POD #12. [illegible] [illegible] [illegible] [illegible]
	[illegible] c̄ R [illegible] [illegible] - [illegible]
	[illegible] [illegible] ⊕ flatus / BM
	AFEB HR 70s BP 100/62 RR 16
	CHEST CTA B/L
	COR RRR
	ABD soft. ND, R [illegible] [illegible] @ [illegible]
	WOUNDS: [illegible] removed - good granulation
	tissue @ base wounds, [illegible]
	[illegible] [illegible] [illegible] @ [illegible]
	Imp/Plan: [illegible] [illegible]
	- record [illegible] q [illegible]
	- wound care q 3days.
	[redacted] b(6)-2

(Continue on reverse side)

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

EAW b(6)-4 [redacted]

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
27 Dec 05 1030	Pt. asleep in bed easily aroused by verbal stimuli. MD in to perform dressing Δ. Pt. has an intermittent suction instead of bulb suction. Lung sands clear bilat. Pt. VSS. All other assessment findings WNL. Pt. is complaints @ this time. MD wants strict I&O's on pt. [redacted] b(6)-2 Will continue to monitor.

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

MEDICAL RECORD	PROGRESS NOTES

DATE

27 June 03 assumed pt care @ 1300. pt sleeping easily
1450 aroused to verbal stimuli. VSS. lung sounds CTA
c (R) lower lobe diminished. abd dressing CDI c intermittent
suction, (-) drainage noted to suction @ this time. BSO
Ext c full ROM @ pulses. ↑ ext c full ROM @ pulses.
New IV started RFA c 22g x 1 stick good blood
return flushed well. IV HL to CAC dc'd, pt denies
pain @ this time. Will cont to monitor [redacted] 9lwm6SGT
b(6)-2
28 Jun Pt care assumed @ 2100. VSS, pt sleeping aroused to
0300 verbal stimuli. lung sounds CTA, RL diminished. Abd dsg
CDI, JP draining to US. HL @ RFA flushes well. Pt
ambulated x 1 this shift, NO complaints of pain,
will continue to monitor b(6)-2 [redacted] 9lwmce
28 Jun 0800 - Pt alert. Ate only a small amount of
breakfast. C/O pain, gave MSO4 for breakthrough,
will cont c T3 as needed. VSS, lungs CTA,
HR reg, Abd dsg CDI c intermittent Suction.
Small amount of drainage noticed. HL to
(R) forearm. Will cont to monitor — [redacted] b(6)-2
1030 - Abd x-ray done. Ambulated to X-Ray c
X-rayed. Fleece put down on bed Pt lying
on side. Will cont. to monitor [redacted]
b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. 2CW2

EPW b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
23 Nov 03	General Surgery
0930	POD # 14 [illegible] Ex-lap, [illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	AFSA VSS
	[illegible]
	CHEST CAL 3 [illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	- [illegible]
	- [illegible] [redacted] b(6)-2

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

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:DICAL RECORD | PROGRESS NOTES

DATE	NOTES
28 June 03 1520	Assumed pt care @ 1300. pt resting quietly. VSS. @ 1520 c/o pain rated @ this time. lung sounds CTA, abd dsg CDI c suction intermittent @ drainage noted @ this time. ↓ et ↑ ext c full ROM @ pulses x4. back area c sm area of skin breakdown, pt placed on (L) side. HL to (R) FA @ S/Sx of infection noted. Will cont to monitor [redacted] b(4)-2 illumic SGT
29 June 03	Received pt @ 2330. Alert. Medicated w/ 4 mg for pain. LS CTA @, ADD soft, dsg intact, suction on intermittent. Pulses equal bilat. IV flushes + patent w/ @ fa. Will cont to monitor [redacted]
29 June 03 0730	Assume pt care @ 0500. Pt awake b(4)- and alert. VSS. HR regular. Lungs CTA. Abd. dsg CD&I c intermitten suction. Sm amt brown drainage noted. BS x4 active. pt c/o gas. Pt ambulates w difficulty. pt ate 50% of breakfast c 120cc H2O. Fleece pad to bed to prevent further skin breakdown on back. HL @ FA flushes well. Will Continue to monitor b(6)-2, [redacted]

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO (SSN or Other)
	LAST	FIRST	MI	
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EPW [redacted] b(4)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (F

29 JUNE 03 General Surgery

0755 POD #15. Doing well. (+) BM (+) flatus

tol [illegible] of a regular diet. [illegible]

[illegible] Rig - [illegible] improved. [illegible]

[illegible] (-) [illegible] (-) [illegible].

A/P - [illegible]

[illegible], wound [illegible] in place

[illegible] Rig

[illegible] for [illegible] I-III

[illegible] / [illegible] Doing well [illegible]

wound [illegible] x 3 days before dressing [illegible].

[redacted]

b(6)-2

NOTES

DATE

NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

EDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL R

DATE	NOTES
30JUN03	Rec'd pt @ 21:00. Pt. awake and alert in bed. Pt. up
0151	to amb. and sit in chair s̄ difficulty. PERRLA ⊕ WNL Skin
	W/D. LCA ⊕. BS ⊕ x4. ⊕PPP ⊕. Abd incision dsg C/D/I c̄
	drain to intermittent suction intact and draining bloody
	drainage. Above ~~d~~ (error) drsg small hole noted. 4x4 dsd
	applied. ø drainage noted. PIV patent. VS WNL x̄ temp ↑
	101.0. ii Tylenol #3 given. Will cont. to mon [redacted] b(6)-2
0319	C/o pain ii Tylenol #3 given Will mon [redacted] b(6)-2
30 Jun	Assumed care of pt @ 0500. Pt is awake. VSS.
	Pt is asking for Dr. [redacted] b(6)-2 in regards to his
	midline incision. Lungs CTA. Dsg dry and intact
	on abd. incision. Drain to intermittent suction on
	mid-abdomen. HL (L) hand - patent and flushed. ~~Pt~~
	~~given ii tabs T-3 for c/o pain~~. Will continue to
	monitor. b(6)-2 [redacted], LPN; SGT
30JUN03	General Surgery note. Wound has spontaneous opening of [illegible]
1840	[illegible] [illegible]. [illegible] [illegible] [illegible]. Feels well. [illegible] c̄
	[illegible]. Tol diet ? [illegible]. [illegible]. Wound granulating well. [illegible]
	[illegible] perfused to look for underlying fluid [illegible] = ø.
	[illegible] [illegible] [illegible] [illegible] - [illegible] [illegible] [illegible] [illegible]

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

b(6)-2

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EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

EPW 296 FIRST NAME | MIDDLE INITIAL | ID NUMBER

NOTES

30Jun03
1815 assumed care @ 1300 - MD in to see pt, removed abd. dsg & drain and replaced c wet → dry gauze & 4x4s, dsg to be Δ'd BID - IV SL patent in (R) FA - pt ate chicken breast, 1/2 C corn and 3/4 orange for dinner - ambulated this shift to relieve gas pains - (+) BS, lungs CTA, using IS q2° [redacted] CPT, AN
b(6)-2

1July03
0030 Pt care assumed @ 2100. VSS, A+Ox3, c/o slight pain @ dsg site. Lungsounds CTA, BS(+)X4 quads, pulses palpable X4. HL dated 27 Jun, restarted @ RAC. Dsg to abd CDI, dsg Δ done @ 2300. Wound is red and moist, Ø s/s infection. No complaints at this time, will continue to monitor [redacted] b(6)-2 91WM6

1July03 0745 - Pt alert ambulating X1 this AM. VSS, lungs CTA, HR reg, BS(+). Dsg intact to ABD. Will Δ later this
0500 98.2 shift. HL to (R) wrist patent. C/o pain to incision
78 site → gave ii T3. Will cont to monitor [redacted]
18
108/66 b(6)-2
98%

1Jul03 General Surgery
1355 POD#17. Pt [illegible] to [illegible] - [illegible]
Tm 101 [illegible]. [illegible] UES
ABD [illegible] - [illegible] | [illegible] [illegible] [illegible]
good [illegible] | [illegible]
[illegible] @ bedside | [illegible]
[illegible] - [illegible]

[redacted]

EPW [redacted] b(6)-4 b(6)-3 ICWZ

NSN 7540-00-634-4176

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MEDICAL RECORD | ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ Progress note

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Jul 03	Pt rec'd @ 21:00. Amb till 23:00 s̄ difficulty. Upon
23:00	return to bed BP ↓ 84/46 P-95 T-96.6°. Extremities
	cold to touch. poor cap refill. ML Abd incision c̄ Dsg intact
	drainage, bloody noted and drainage exceeded border of gauze
	drawn x2 Ø drainage noted in suction tubing or canister.
	Pt. placed c̄ feet elevated and Dr. [redacted] notified LR b(6)-2
	500cc bolus given. @ 23:23 c̄ new PIV initiated.
	BP ↑ 98/76 @ 23:37 BP 104/72 P-72. c/o LLQ Abd
	pain. Interpreter paged to help c̄ communication will
	cont to mon. [redacted] /AD b(6)-2
3 July 03	Assumed pt. care @ 0500. Pt. awake A+Ox3.
	lungs CTA, ⊕ pulses x4. Hypo active BS x 4. Dsg
	to mid abd intact. Wound vac s̄ any output.
0600 96.7	Hl Ⓛ AC patent. Ø c/o @ this time. Will
68	Continue to monitor. [redacted] 91WM6 —
18	General Surgery b(6)-2
100/64 96%	
	POD# 19. [illegible] care issues. Doing well. [illegible]
	[illegible]: [illegible] - [illegible] - [illegible]
	- [illegible]
	[illegible] x 3 days - remove [illegible] on 5 [illegible]
	[redacted] b(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. ICW2

EPW # [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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 JUL 03	Rec'd pt @ 2100. VS WNL according to flowsheet. Skin
23:33	W/D. Awake + Alert. Voiced concerns about abd wound.
	looks very worried. will mon. LCA(B). BS ⊕ x4 ⊕ PPP(B).
	PIV (R) FA patent. ABD dsg C/D/I ⊕ PPP(B). ⊖ c/o pain
	will cont to mon [redacted] 2T/AD
	b(6)-2
2 July 03	Assumed pt care @ 0500. pt awake. A+O x3.
	⊕ Pulses x4. lungs CTA. ⊕ BM x4. Drsng to abd CDI.
	HL (R) FA patent. Denies any c/o @ this time.
0800 97.5	Will continue to monitor. [redacted] 91W M6
100/74	b(6)-2
96%	
70	
14	
2 July 03	General Surgery
1015	POD 18. Cont. current care
	feels well, [illegible]
	Tol diet, [illegible] abdominal pain
	wound exam x3 - upper [illegible] - granulating [illegible]
	middle [illegible] - granulating
	lower - [illegible]
	- wound wave [illegible] applied b(6)-2
	change [illegible] 3 days. [redacted]
2 July 03	assumed pt care @ 1300. pt awake et alert, VSS. lungs CTA
1415	abd c̄ drsng CDI c̄ suction to intermittent. HL intact. BS ⊕ x4
	↓ ext ↑ ext c̄ full ROM ⊕ pulses. HL (R) wrist, flushes well ⊖
	s/sx of infection. ⊖ c/o pain, will cont to monitor [redacted] 91W M6
	b(6)-2

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DICAL RECORD | PROGRESS NOTES

DATE	NOTES
3 July 03 KJD	Assumed pt care @ 1300. pt sleeping easily aroused to verbal stimuli. VSS. Airway patent, lungs CTA, Abd soft BS present. draing to abd CDI suction intact, scant amount of drainage noted ↓ET ↑ ext ✓ full ROM ✓ pulses x 4. HL to ⓑAC ⓓ redness/edema noted. ⓓ complaints voiced @ this time. Will cont to monitor [redacted] Awake SGT b(6)-2
30 July 2259	Received pt resting in bed, alert. Sleeping intermittently, easily awakened. VSS, CSLTA ⓑ, HRR, abd SNT, BS ⊕. Dsg to abd intact & sit to intermittent suction. Full ROM pulses equal bilat. HL to ⓑ ac patent. Resting quietly. Will cont to monitor & medicate as appropriate [redacted] LTA b(6)-2
4 July 03	0900- Pt alert voicing no complaints. VSS, HR regular, BS ⊕. Dsg intact to abd connected to LIS. Some old drainage noted. HL to ⓑ AC → patent. Will cont to monitor b(6)-2 [redacted]
4 Jul 03 400	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg intact to abdomen & wound VAC to LIS, scant drainage [redacted]

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST b(6)-2 | MI | SPONSOR'S (SSN or Other)

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EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

:DICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOC/

DATE	NOTES
3 July 03 KJD	Assumed pt care @ 1300. Pt sleeping easily aroused to verbal stimuli. VSS. Airway patent, lungs CTA, Abd soft BS present. draing to abd CDI. Suction intact, Scant amount of drainage noted. ↓ ↑ ext @ full ROM @ pulses x 4. HL to @ AC ⊖ redness/edema noted. ⊖ complaints voiced @ this time. Will cont to monitor [redacted] q hr to SGT
3 July 2259	Received pt resting in bed, alert. Sleeping intermittantly, easily awakened. VSS, CSL TA @, HRR, abd SNT, BS ⊕. Dsg to abd intact & sut to intermittant suction. Full rom pulses equal bilat. HL to @ ac patent. Resting quietly. Will cont to monitor & Medicate as appropriate [redacted] (LTA) b(6)-2
4 July 03	0900 - Pt alert voicing no complaints. VSS, HR regular, BS ⊕. Dsg intact to abd connected to LIS. Some old drainage noted. HL to @ AC → patent. Will cont to monitor [redacted] b(6)-2
4JUL03 1400	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg intact to abdomen [redacted] VAC to LIS, scant drainage + [redacted]

NSHIP TO SPONSOR | SPONSOR'S NAME

LAST | FIRST b(6)-2 | MI | (SSN or Other

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EPW # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL RE

DATE	NOTES
4 Jul 03 1920	pt. ate 50% of dinner - SL patent in (R) FA - ambulated to BR had BM —— [redacted] CR, AN b(6)-2
4 Jul 03 21:15	Rec'd pt @ 21:00. Awake and alert in bed. Skin W/D PERRLA (+) LCA (B). BS (+) x4. (+) PPP (B). ABD dsg intact to suction. Amb s difficulty. PIV patent & c/o pain @ this time. Will cont. to mon [redacted] BAD/AN b(6)-2
5 July 03 0830	Pt. awake & alert in bed c HOB @ 30° IV in (R) AC HL, flushed well c 3cc/NS. VSS. ABD dressing to intermittent suction. Pt. ambulatin s difficulty. HR reg., lung sounds clear bilat. Pt. s complaints @ this time. All other assessment findings WNL. Dr. [redacted] b(6)-2 will be here this AM to Δ dressing & evaluate wound in ABD. Will continue to monitor. —— [redacted] CT AN b(6)-2
5 July 03 0948	General Surgery Team Note S: (no) new complaints. Tolerating regular diet. Has continued on wound vac x3 days. O: Afebrile normotensive wound vac d/c'd wound cleaned & dressed well healing - shallow + 3-4 cm long - 2 cm deep c yellow base - umbilicus - shallow wound A/P: POD #21 s wound complication (1) TID w/D wound dressing D/C (2) Cont'd care post op Care

[redacted]
Aded 5 July 03 1015

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REGISTER No. [redacted] WARD No. JCW

EPW [redacted] b(6)-4

[redacted] b(6)-2

PROGRESS NOTES
Medical Record
STANDARD FORM 509

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

5July03 1025 MD Δ'd dressing to ABD. Ordered Dsg. Δ's new TID w→D, pack middle wound w/gauze soaked in sterile water. Pt c/o pain, tylenol #3 ii given. Will [redacted] b(6)-2

5July03 1335 Assumed pt care @ 1300. Pt awake et alert. VSS. Lungs CTA bilat, abd soft nontender BS⊕x4 quads, dressing CDI. Wet ↑ ext ± full ROM ⊕ pulses x4. HL to RAC flushes 5 diff ⊖ redness/swelling noted. ⊖ complaints voiced @ this time. Will cont to monitor [redacted] b(6)-2 9 WMC SGT b(6)-2

5Jul 2348 Received pt resting in bed. Alert, VSS see SF511. LSCTAB, HRR, BS⊕x4, abd SNT. Dsg, tan midline abd Δ'd this shift, iodoform guaze to upper + lower openings, gauze to middle opening. IV to R AC patent. Will cont to monitor [redacted] b(6)-2

6July03 0815 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕, Dsg intact to incision on ABd. HL @ AC, b(6)-2 Voicing no complaints. Will cont to monitor [redacted] Kurt

6July03 1430 Assumed pt care @ 1300. pt sleeping. VSS. assessment findings WNL. dressing to abd CDI. ⊖ c/o pain voiced. Will cont to monitor [redacted] b(6)-2 9 WMC SGT

6Jul 2209 Received pt resting in bed, Alert, VSS see SF511. LSCTAB, BS⊕x4, ABD SNT, HRR. Dsg on abd, midline, intact with slight seropurulent drainage on bottom thirds edge noted. Δ'd. IV intact, patent. Will cont to monitor [redacted] b(6)-2

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)ICAL RECORD | PROGRESS NOTES

)ATE | NOTES

11-Jul 03 (0900) VSS. NAD. DSG to abd. D+I. S.L. leaking @ site, pcd & cath intact, site ~ redness or edema. M.D. to be notified. BBS CTA+=. Pulses strong @ =. BS(+)x4.

0500 97.3 ambulates well. Tolerating reg diet. 90% ealen. Voiding quietly & present. [redacted] b(6)-2

72
14
98/66
94%

7 Jul 03 1080 General Surgery Team Note

S: ① new complaints. Continues to c/o gas & pain well controlled & ↓ pain meds.

O: Afebrile & normotensive

Wound ① - shallow well healing
② - 2cm deep - yellow d/c - copiously irrigated
③ - unbiopsied
④ - scabbed over

Dressing ①'s & wound irrigated - packed w/ kerlix

A/P: POD #23 & wound complication

(1) Continue TID dressing ① & ② changes to follow healing progression

(2) Simethicone 80 mg PO TID PRN

(3) Get interpreter to discuss bowel movement hx

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PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

CPW [redacted] b(6)-4

DATE	NOTES
7 JUL Y03 1500	Assumed care of Pt @ 1300. BP ↓ 78/48 on (R) side. Woke pt up. denies N/V, pain, dizzyness. Pt diaphoretic, wound is hot. Retook BP 86/58 on (L) arm. Will monitor BP. (+)LS CTA, (+)BS x 4 abd firm, not distended, tender to touch. multimodal drsg CDI. Pt A+O x 3. Palapable pulses x 4. denies pain. Resting comfortable (-) IV access. N/V assessment WNL. Will monitor — b(6)-2 [redacted]
1900	Pt ate 100% of meal b(6)-2 [redacted]
7 JUL Y03 2200	Received pt resting in bed. VSS, BP noted @ 92/40, enc PO fluids, no complaints @ this time. Will cont to monitor. LSCTAB, HRR, BS(+)X4, ABD, firm, slightly tender to touch multimodal abd drsg c/d/i. Pt Alert, pulses equal + strong. (-) IV access. will cont to monitor. pt b(6)-2 [redacted]
8 JUL Y03 0530 98.0 75 18 96/68 100%	Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. Abdominal wound A'd and cleaned. Bowel sounds x 4 quads. Pt ate all of breakfast. Pt still passing gas. 0 % pain or discomfort @ this time. Will continue to monitor — b(6)-2 [redacted], CPN - SGT
8 JUL Y03 1400	Assumed pt care @ 1300. Pt resting quietly. VSS. Lungs CTA, abd drsg CDI. BS (+) x 4 quads. ↓ & ↑ ext c full ROM (+) pulses x 4. 0 % pain/discomfort noted Will cont to monitor — [redacted] Plumb SGT b(6)-2

DATE	NOTES
10 Jul 03 0600	pt's umbilicus. Pt. c/o pain ∑ palpation to that site. HR Reg, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt. ∅ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] N/A
10 Jul 03	General Surgery Team Visit b(6)-2
	S & Pt ∑ new compression, to bedside per nurse's request to evaluate wound.
	O: Afebrile & normotensive. Bedside wound debridement performed, fascia intact. Edges & wound granulating well. Wound extended superiorly to allow for more effective wound treatments. Pt tolerated procedure well.
	A/P: POD #2 ∑ wound complication.
	① Continue B:D w/D dressing Δ's.
	[redacted] b(6)-2

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ICAL RECORD | PROGRESS NOTES

DATE	NOTES
8 JUL 03	Rec'd c/o pt @ 21:00. Awake + alert in bed. Skin W/D.
22:02	VS WNL x BP↓ 90/66 per flowsheet. PERRLA ⊕. LOA ⓑ
	BS⊕ x4. ⊕PPP ⓑ. ML ABD dsg c̄ mod amt serous drainage.
	Bacitracin ointment applied to Ⓡ hand. c/o pain from gas.
	Will cont. to mon [redacted]
0043	Dsg Δ'd old dsg c̄ sm amt bloody yellow drainage b(6)-2
	s̄ odor. c/o pain. new dsg C/D/I [redacted]
9 July 03	0730 - Pt alert lying in bed. VSS, lungs CTA,
	HR regular, BS⊕, pulses ⊕. Dsg Δ'd to midline
	incision to abd. Ø S/S of infx. Minimal
0600 97.1	drainage on old dsg. Gave ii T3 for pain.
67 / 16	Will cont to monitor b(6)-2 [redacted]
100/60	1900 - Assumed care of Pt @ 1300. VSS. A+O x3
97%0	Ø c/o pain. Ⓑ LS CTA. ⊕ BS. ⊕ flatus. Drsg Δ W→D
	Ø S/S x infxn. TOL REG DIET. ATE 90% of dinner. b(6)-2
	O/W assessment WNL. Will monitor [redacted]
2130	Pt. care assumed @ 2100. VSS HR Reg, Lungs CTA,
	BS⊕ x4. ML ABD drsng CDI. Pt c/o gas, 8/10
	Simethicone given. will cont. to monitor [redacted] b(6)-2
10 July 03 0600	Pt. asleep in bed, easily arroused by verbal stimuli. Dressing
	to ABD CDI. 2 inch vertical strip of hardened area on the Ⓡ side of

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PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

CPW [redacted] b(6)-4

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CAL RECORD | PROGRESS NOTES

FE | NOTES

10 July 03 Assumed pt care @ 1300. pt resting quietly, arouses to verbal stimuli. Assessment findings WNL. Abd dsg, c mod amt of light red drainage noted, area marked & timed. ⊕ IV access noted. ⊖ c/o pain voiced @ this time. Will cont to monitor — [redacted] SGT b(6)-2

1335

10/10/03 2229 Recd c/o pt @ 21:00. Awake and alert in bed. Restraints x 2 ⊕ wrist and ankle. VS WNL per flowsheet. Skin W/D. PERLA⊕WNL LCA⊕. BS⊕x4. ABD dsg intact c mod amt. bloody drainage ⊖ exceeding border drawn by evening shift. ⊕ PPPB. HL initiated @ 2:30 ⊕ c/a by Anesthetist. ⊖ c/o pain @ this time will cont. to mon

b(6)-2 [redacted] SGT/MD

0000 @ 23:38 4mg MSO4 IVP given. Dsg ∆d @ 0000. old dsg c moderate amt. serosang. and bloody drainage noted. new dsg C/D/I will cont to mon. [redacted] SGT/MD b(6)-2

11 July 03 0950 - Pt alert AOB x1 this AM. Wet → dsg dsg ∆ done on middle abd. Tunneling cont to middle incision. Attempted to clean out ē swabs. 4mg MSO4 given for pain followed by two percocets. VSS, lungs CTA, HR reg, BS⊕, will cont to monitor [redacted] b(6)-2

0645 97.4 67 16 90/58 97%

SHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (SSN or Other)
	LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
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EPW b(6)-2 [redacted]

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

TE	NOTES
11 Jul 03 1330	assumed pt care @ 1300. pt resting, arouses to verbal stimuli. VSS. Assessment findings WNL. abd dressing CDI. HL to (R)FA ① redness/swelling noted. ① c/o pain voiced. Will cont to monitor — [redacted] q1wnl b(6)-2
11Jul03 2330	Rec'd c/o pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. Skin W/D. PERLA ⊕. LCA ⊕. BS ⊕ x4. HL (R) FA patent. ML ABD DSG CDI. ① c/o pain @ this time. ⊕ PPP ⊕. Will cont. to mon [redacted] ALT/AD b(6)-2
0000	W→D dsg D/C'd 5 difficulty. Premedicated c MSO4. Old dsg. c bloody drainage scant amt noted. Wound @ top of initial incision ~~[redacted]~~ c ⊕ granulation tissue. Wound above umbilicus approx 1 inch deep c granulation tissue around surface. 2 suture bands visible inside wound. debrided mod amt. White viscous tissue. ① c/o pain @ this time will cont to mon [redacted] ALT/AD
12 July 03	1020 - Pt lying in bed, alert & oriented b(6)-2. VSS, lungs CTA, BS ⊕. HL to (R) forearm, patent. DSG D/C'd to midline abd incision. Wet→dry dsg applied. Gave MSO4 4mg for pain. Voicing no complaints at this time. Will cont. to monitor — b(6)-2 [redacted] ALT
12 July 03 1335	Assumed pt care @ 1300. pt awake & alert. VSS. Assessment findings WNL. abd dressing CDI. HL (R) FA flushes 3 diff. ⊖S/Sx of infection noted. ① c/o pain voiced @ this time. Will cont to monitor — [redacted] q1wnl — b(6)-2

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CAL RECORD | PROGRESS NOTES

NOTES

14Jul03 0347 C/o gas pain. 80 mg Simethacone/Maalox given will cont. to mon. [redacted] PT/AN

b(6)-2

0615 96.4 16 90/60 95% Assumed care of pt @ 0600. VSS. Pt asleep. Lungs CTA. Pt has no c/o. pain / discomfort. Dsg A done at 1000 hrs. Dsg has small amount of bloody discharge. Will continue to monitor. [redacted] 9/40 M6, SGT

b(6)-2

1400 Assumed care of Pt @ 1300. VSS. A+Ox3 c/o pain. (B) LS CTA. (E) BSx4. (R) FA PIV HL patent c/s/s infection. ABD DRSG CDI. OOB S assistance. O/w assessment unc. will Monitor - [redacted] SGT

2150 Pt. care assumed @ 2100. VSS. HR Reg, Lungs CTA, BS (E) X4. ML ABD drsng CDI. Pt. assisted 1 to ambulate and to sit in chair. Pt. assisted c use of IS. HL to (R) FA flushed, c/s/s infection or infiltration. will cont to monitor. [redacted] b(6)-2 SGT/AN

15Jul03 1200 - Pt alert laying in bed. VSS, lungs CTA, BS (E). Dsg d/d to abd. Incision closing. HL to (R) forearm, patent. Gave T3 for pain. Will cont to monitor [redacted] SGT/AN

b(6)-2

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

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[redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

TE	NOTES
12JUL03 0000	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x 2 (R) wrist and ankle. VS WNL per flowsheet. PERRLA (R) LCA (R). BSO x 4. ML to (R) FA patent. MK ABD dsg (D) old dsg C scant amt. serosang. drainage noted. Scant amt. white substance debrided from wound. Skin @ wound surface pink and granulated. Dew W→D dsg. C/D/I (+) PPP (R). Premedicated c 4mg MSO4. (-) c/o pain during dsg (-). Will cont. to mon [redacted] b(6)-1
13JUL03 0605	0615 - Pt alert OOB x 1 this Am. VSS, lungs CTA, BSO. Dsg to abd CDI. ML to (R) forearm, patent. Pulses (2+) & strong bilat to U & L extremities. Voicing of complaints at this time. Will cont to monito- [redacted] b(6)-2 ZLT/AN
0605 98.1 77 16 100/68 95%	1130 - Dsg Δ done on incision to abd. Had MD look at it. Noted that wound was healing well. Gave MSO4 for pain. Followed by VT3 [redacted] b(6)-2 2LT AN
13JULY03 1430	Assumed pt care @ 1300. VSS. Assessment findings WNL Abd dressing CDI. ML (R) FA (+) redness/swelling. (-) c/o pain voiced @ this time. Will cont to monitor [redacted] b(6)-2 9/Wmle
13JUL03 0345	Assumed c/o pt @ 21:00. Awake and alert in bed. Restraints X 2 (R) wrist and ankle. PERRLA (R) WNL. Skin (W/D). LCA (R) BSO x 4. ML ABD W→D dsg C/D/I C some scant serous drainage PIV ML patent. Premedicated C MSO4 for dsg Δ. (-) c/o pain Will cont mon [redacted] b(6)-2 2LT/AN

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DICAL RECORD | PROGRESS NOTES

DATE	NOTES
15July03 1808	assumed pt care @ 1300. pt awake et alert. VSS lungs CTA, abd soft BS+. ↓ et ↑ ext c full ROM +pulses. dressing to abd CDI. HL to RFA intact -S/Sx of infection noted. Will cont to monitor — [redacted] b(6)-2 RN
15July03 2250	Assume pt care @ 2100. pt awake and Alert. C/o gas @ this time. W→D dsg Δ done area free of s/s infection. VSS HR reg. lungs CTA. Abd. soft BSx4. HL to RFA flushes well. Will cont. to mon— [redacted] b(6)-2 RN
16July03	1100- Pt Alert ORX2 this Am. C/o of gas. → given Maalox plus. VSS, HR reg, lungs CTA, HL to R arm. patent. Dsg d/t to abd. Gave T3 II for discomfort. Voiding & complete cath this Time. Will cont to cont.— [redacted] b(6)-2 RN
16July03 1330	assumed pt care @ 1300. pt awake et alert. VSS. lungs CTA, abd midline incision. dressing CDI. BSP BLE c full ROM + pulses. RFA c HL -S/Sx of infection BLE c full ROM + pulses. - C/o pain voiced. Will cont to monitor — [redacted] b(6)-2 RN

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[redacted] b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
	296		

DATE	NOTES
16July03	2405 Assume pt care @ 2100. pt awake and alert. VSS. HL to Ⓛ FA no s/s redness / infiltration c̄ flush. HR reg. Lungs CTA. Abd W→D Midline Dsg Δ done site free of infection. BSx4 pt c/o gas. Amb s̄ difficulty Will cont. to mon. [redacted] b(6)-2
17Jul03 1030	General Surgery Team Note
	Wound continues to heal well. Good granulation tissue - PDS sutures no longer visible. ∅ evidence of infection. Pt to this am c/o chronic Ⓡ knee pain and reports being previously treated c̄ indocin-like medicine. Will restart indocin. [redacted] b(6)-2
17 Jul	Assumed care of pt @ 0500. Pt asleep. VSS. Pt was given 3 mg MSO4 @ 1000 hrs before dsg Δ. Dsg Δ went well. MD looked at wounds. Healing very good. Pt has c/o Ⓡ leg pain. MD notified and ordered new med. Will continue to monitor. [redacted] LPN, SGT b(6)-2

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
17 July 03 1345	Assumed pt care @ 1300. Pt awake et alert. VSS. assessment findings WNL. Abd dsing CDI @ c/o pain voiced @ this time. HL to (R) FA @ s/sx of infection noted. Will cont to monitor b(6)-2 [redacted] IVWMP
18 July 03 0050	Assume pt care @ 2100. pt Awake and Alert. VSS. HL to (R) FA no s/s redness/ infiltration & flush. 3mg MSO4 IVP prior to dsg Δ. Abd wound red, sm amt of green pus cleaned from b(6)-2 middle. New dsg CD+I. Will cont. to monitor [redacted] S/M
18 Jul	Assumed care of pt @ 0500. Pt asleep. VSS. @ c/o pain / discomfort @ this time. Lungs CTA. Bowel Sounds x 4 quads. Bandage to mid-abdomen. b(6)-2 [redacted] PN, SGT
18 JUL 03 0900	Assumed care of pt. b(6)-2 [redacted]
18 JUL 03	Assumed c/o pt @ 21:00 Pt. sleeping in bed. Awakened 2145 easily. Alert. VS WDL per flowsheet. Restraints x 2 (D) wrist. Skin W/D. LCA (R). BS (+) x 4 ML ABD dsg CDI c/o little ass pain to (D) ABD. Received maalox dose @ 18:00. No further c/o pain. (R) FA HL patent. Will cont. to mon [redacted] SPO/AW

IP TO SPONSOR				
	LAST b(6)-2	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
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REGISTER NO. | WARD NO. LCW2

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Jul	Assumed care of pt @ 0500. Lungs CTA. Bowel sounds x4 quads. VSS. Dsg Δ done. Ø c/o pain/discomfort — b(6)-2 [redacted] SGT, 9/WM6
19Jul03 1500	Assumed care of pt. @ 1300 - VSS - given scheduled i-doc in RO - abd dsg CDI, (+)BS - lungs CTA(B) - pt. ambulated to BR, gas o-ly - SL patent in (R) FA - through translator purpose of colace explained b(6)-2 to pt. and he stated understanding [redacted]
19Jul03 23:57	Recd c/o pt. @ 21:00. VS WNL per flow sheet. Awake and alert in bed. LCA(B). BS(+)x4 (+)PPP(B). HL (R). FA patent ML ABD dsg C/D/I. ~~(+)PPP(B).~~ Ø c/o pain @ this time will cont. to mon [redacted] SGT/AN b(6)-2
0545	Pt c/o pain to ABD x 1 tt PRN given will mon — b(6)-2 [redacted] SGT/AN
Late Entry 20:30	W→D dsg Δ performed. Debrided c swab and fluff and NS. ~~Wet kerlix 4x4 app.~~ Old dsg c [redacted] scant amt yellow-whitish viscous drainage. NS soaked kerlix 4x4 applied packed c DSD. Pt tolerated procedure well. will cont. to mon.
b(6)-2 0349	[redacted] SGT/AN Pt c/o gas pain (+) flatus. 200c Mealox Plus given will cont. to mon. [redacted] SGT/AN b(6)-2
20Jul03	0550: Assumed pt. care @ 0500. Pt. A+Ox3. Lungs CTA (+) pulses x4. Hypo active bowel sounds. HL (R) FA 5 signs of infection. Prong to mid abd. c small blood tinge spot. c/o gas. will continue to monitor. [redacted] b(6)-2 glucose

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20JUL03 1900	assumed care @ 1300 - VSS - no c/o pain @ this time - SL patent - abd dsg. reinforced as tape was not holding. pt. ambulated to BR, no BM - ate 75% of dinner - (b)(6) BS (b)(6)-2 [redacted] RN
21JUL03 23:30	Recd c/o pt @ 21:00 VSWD restraints x2 @ wrist (b) ankle. PIV HL (b)(6) patent/intact. (b)(6) skin color WD. LCM (b)(6) BS (b)(6) x4. ML ABD dsg D'd
21 Jul	Assumed care of pt @ 0500. Pt asleep. Pt eats all of his breakfast and then asks for pain meds to sleep. VSS. Lungs CTA. Will continue to monitor. (b)(6)-2 [redacted] 91WM6, SGT
21JUL03 1430	assumed care @ 1300 - VSS - abd dsg CDI, pt. reinforced dsg c more tape - SL removed, site SS/S infection - meds, x-rays, transfer summary @ bedside - pt. awaiting ~~to~~ DC to EPW camp - [redacted] CPT AN (b)(6)-2

DISCH To EPW CAMP

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

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

b(6)-2 [redacted] CPT IAN 13 JUNE 03 DATE

11. POSTOPERATIVE EVALUATION:

Awake, able to follow commands. moving DRSGNG site clean & dry. Bowel Sits clean dry

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
b(6)-2 [redacted] CPT IAN	b(6)-2 [redacted] HOSP AN
DATE: 13 JUNE 03 TIME: 1800	DATE: 13 JUNE 03 TIME: 2040

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 13 June 13 TIME PATIENT ARRIVED IN SUITE 1805	4. PATIENT IN ROOM TIME 1805 NUMBER H 13

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: no pre-op interview conducted, pt came directly to OR from ED

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: correct body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted] b(6)-2 CPT [redacted] b(6)-2

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

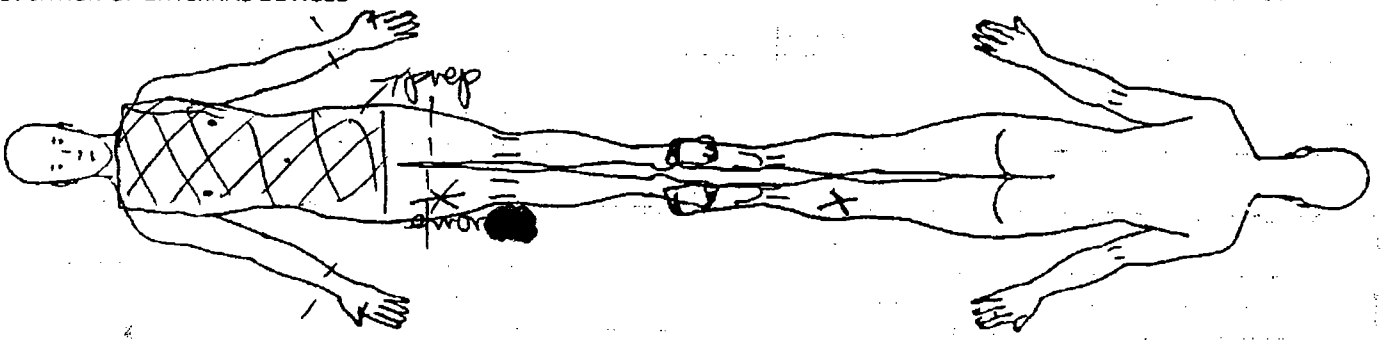
PREP SOLUTION (Specify) Beta (Beta [redacted] b(6)-2

SITE: Abdomen (see #9) BY WHOM [redacted]

SITE: BY WHOM:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial: [redacted] b(6)-2

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	5	5	5
Needle Sharp	☒ Yes ☐ No	1		
Instrument	☒ Yes ☐ No	3		
Other	☐ Yes ☒ No			

SCRUB [redacted] b(6)-2

CIRCULATOR [redacted] b(6)-2

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

EPW [redacted] b(6)-4

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

☒ ESU NO: Valleylab Force 2 #1

GROUND PAD: BRAND Valleylab REM Polyhesive II

LOT NO: 68936 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIA [redacted] b(6)-2

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 Fr FIC		
SITE	Bladder		

19. ADDITIONAL INFORMATION b(6)-2
Surgeon: Dr. [redacted], Dr. [redacted] b(6)-2
Anesthesia: Dr. [redacted] b(6)-2
FIC in place prior to arrival to OR
Brief Site clean before & after surgery.

20. OPERATION(S) PERFORMED
Exploratory Lap / appy.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2095	see DA 7389	Liberty safety strap

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/N

REVERSE OF DA FORM 3979-1, OCT b(6)-2

USAPA V1.01

PT'S NAME: # b(6)-2 [redacted] 41 y/o ERW ID#: b(6)-2 [redacted] DATE: 14 JUN 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP	103/69	104/73	100/69	96/67	100/66	97/65	105/67	99/64	95/64	96/65	89/57	94/59	101/65	99/62	102/63									
TEMP				99.2				100.1				100.1		100.3	100.1									
HR	109	111	104	104	101	104	114	119	116	107	108	113	117	112	106									
RR	22	18	16	20	18	20	20	18	18	20	16	20	16	25	22									
SP02	97	99	99	99	99	99	98	98	98	98	98	99	99	99	99									
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA									
INPUT																								
[redacted] LR)	130	130	130	130	130	130	130	130	130	130	130	130	130	130	110									
[redacted] GT																								
[redacted] plus					500																			
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE	50	50	50	50	50	50	50	50	50	50	50	50	60	50										
NGT																								
STOOL																								
[redacted]																								
SUB TOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 10789

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS
TO 0359 HOURS

TOTAL HOURS COVERED: 24

DATE: 14 JUN 08

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
14 Jun	1000cc	Hang in ICU	2400	0000	400

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	Ø		

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	Ø		

GRAND TOTAL INTAKE

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

SPW
[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 7

MEDCOM - 10790

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

URINE ~~ORAL~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
2344	Dk yellow	1000cc	1000cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 2359 HOURS | TOTAL HOURS COVERED 0890 | DATE 15 JUN

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0930	300cc	LR		1400	500
1400	500	LR	450	2205	950
2206	500	LR	150	0005	1100

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 2 TO 2351 HOURS | TOTAL HOURS COVERED 24 0 | DATE 15 JUN 08

INT

[redacted] URINE

TIME	TYPE	AMOUNT	ACCUM TOTAL
0330	CLEAR AMBER URINE	120	120
0830	Clear Amber Urine	475	595
1145	clear [redacted] urine	425	1020
1545	CLEAR YELLOW	425	1445
2000	CLM	400	~~2085~~ 1845
0000	dark urine	~~350~~ 100	1945

EMESIS [redacted]

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

STOOL [redacted]

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER [redacted] OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

OUTPUT

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0 HOURS TO 2400 HOURS | TOTAL HOURS COVERED 24 | DATE 16 Jun 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
07	Jello	120	120
19	H2O	60	180

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0030	350	LR@75cc	300	0444	300
0444	500	LR@75cc/hr	250	0900	550
1600	50	ancef	50		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

INTAKE

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

EPW# [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* .30
SMALL FRUIT CUP 120
COFFEE CUP..............160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS
TO ____ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

URINE

TIME	TYPE	AMOUNT	ACCUM TOTAL
0015	Dk yellow	350	350
0400	Dk yellow	120	470
0645	Clear yellow	400	870
1300	yellow	200	1070
	Foley d/c'd		
1200	Yellow	300	1100
2000	Yellow	300	1400

FEEDS

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

STOOL

NASOGASTRIC (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

OUTPUT

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

EPW# [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-17-05

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0830	Water	240	240
0930	Milk	240	480
1200	lunch	0	480
1605	H2O	60	540
1800	Soup	240	780

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	50	Ancef	50	0030	50
08	50	ancef	50		100
16	50	ancef	50		150

OUTPUT IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0900	CYU	450	450
1400	CYU	100	550
1850	CYU	50	600
2300	CYU	200	800

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

b(6)-4

EPW # [redacted]

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT IN[illegible] AND OUTPUT WORKSHEET	FROM ______ HOURS TO ______ HOURS	TOTAL HOURS COVERED	DATE

IN[illegible]

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

011

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

INTAKE EQUIVALENTS (*Serving levels cc*)

MEDICINE GLASS (*1 oz*) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP..............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ___ HOURS TO Mid HOURS | TOTAL HOURS COVERED 24 | DATE 6-18-05

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	broth	100cc	100cc
0830	water	200cc	300cc
1230	water	50cc	350cc
1700	Broth	100cc	450cc
2200	Hgl	100cc	550

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1230	1000cc	LR @ 100 cc/hr			
1600	100	Heparin			

output

~~IRRIGATIONS (NG, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0145	dark colored urine	150cc	
1430	dark urine amber	150cc	300cc
2200	unknown amt Pt voided when attempting BM.		

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL ;

MEDCOM - 10798

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE: 6-19-03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	OJ	120cc	120cc
0700	Strawberry Milk	120cc	240cc
0700	Waffles	½	

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0800	~~0830~~	Ancef	50cc	0830	50cc

Output

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	dk urine	500cc	500cc
1330	yellow urine	400cc	900cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW # [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JU

*U.S.GPO:1986-404-613/30345

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM MN HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-18-03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	50	Ancef	50	0030	50
		LR	975	0400	1025

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 2 HOURS TO 1 HOURS | TOTAL HOURS COVERED 24 | DATE 2 JUN 08

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0300	Water, Jello,	400	—
	juice	—	400cc
12	juice	240	640
17	juice	240	880

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0035	50cc	Ancef 1gm	50	0145	50
0200	100cc	LR	100	0300	150
0300	500cc	LR	500	0730	650
0735	500cc	LR	500	1230	1150
0745	50	Ancef	50	0800	1200
1230	500	LR			
16	50	ancef	50		

OUTPUT

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0730	urine	350cc	350 cc
1030	urine	200cc	550cc
1235	urine	325cc	875cc
1630	" "	500cc	1375 cc
1930	" "	300cc	1675 cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM (UNIT) HOURS TO 0800 HOURS | TOTAL HOURS COVERED | DATE 20 JUN 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1200	JUICE	100	
	JELLO	180	
	SOUP	240	520
1700	SOUP	240	
1700	JELLO	180	940

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0500	900	LR	900	1300	900

URINE / IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1100	X1 TOILET		
1400	250 cc C/U	250 cc	250 X 1

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

OUTPUT

TWENTY-FOUR HOUR PATIENT ...AKE AND OUTPUT WORKSHEET

FR... TO 2359 HOURS | TOTAL HOURS COVERED 24 | DATE 23 Jun

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
13	H2O	100	100
17	juice	120	320

INTRAVENOUS

TIME STARTED	AMOUNT ORDERED	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000	450	LR	425	0530	425
0830	500	LR	350	1000	775

URINE (Foley, IV/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0930	H yellow urine	300 cc	300 cc
1411	"	300	600
19	"	200	800
22	"	300	

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM MN HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-22-03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0900	Juice water	300cc	300
1200	Juice	240	540
1700	Juice	240	780

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	50	Ancef	50	0030	50
0600	500	LR @ 100cc/hr	425	2200	475
2000	500	LR @ 50cc/hr	500	0530	525

OUTPUT

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0730	CYU	500cc	500
0815	CYU	150cc	650
1080	CYU x1		x1
1415	CYU	400cc	1050cc x1
1700	CYU	300cc	1350cc
2050	" "	400cc	1750cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW # [redacted] b(a)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM MN HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-24-05

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
05:05	50cc	NS	50cc	05:05	50cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

UOP ~~TRANSACTIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	600 YELLOW	600	600
0800	300 (ø BM)	300	900
~~1130~~	XT		+ XT
1500	~~0000~~ YELLOW	300	1200
~~1700~~			

STOOL ~~OTHER INTAKE~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	XT SMALL, FORMED	XT	
0830	XT MED, FORMED	XT	XII
	GRAND TOTAL INTAKE		

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

EPW # [redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP.....120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND ~~OUTPUT~~ WORKSHEET

FROM _____ HRS TO _____ HOURS | TOTAL HOURS COVERED | DATE 24 JUN 93

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	JUICE	240	240
1130	JUICE	240	480
1700	Kool-aid	240	720

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT ... AKE AND OUTPUT WORKSHEET

FR[illegible] HOURS TO [illegible] HOURS | TOTAL HOURS COVERED 24 | DATE 26 Jun

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1730	Juice	~~240~~ 120	120
0730	H2O	120	240
1700	H2O	120	360

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OUTPUT

Urine — IRRIGATIONS (~~N/G, Bladder, etc.~~)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	UC	450	450
1030	UC	500	950
~~1030~~	~~BM~~ ?		
2200	commode	x1	

Drain JP — OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	Bloody	30	30
1800	Bloody	20	50
2050	Brownish	5	55
	GRAND TOTAL INTAKE		

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HRS TO 2359 HOURS | TOTAL HOURS COVERED 24 | DATE 25 Jun

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
07	Juice	150	
12	Juice	150	
1700	Juice	150	

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

Urine ~~IRRIGATIONS (NG, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
08	urine bucket	?	
12		200	200
21	urine bucket	x1	

Drai ~~BLOOD~~/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
13		30cc		
1930	blood tinged red	10cc		

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW# [redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL

MEDCOM - 10808

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT ... TAKE AND OUTPUT WORKSHEET

FR[illegible] HOURS
TO 2359 HOURS

TOTAL HOURS COVERED 24

DATE 02 Jun 08

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	Chocolate milk	200cc	200cc
1130	juice	100cc	300cc
1130	wheat bread	1 piece	"
1700	½ piece Chicken		
1700	½ bits of peas		
1700	H2O	50cc	350

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

JP drain ~~IRRIGATIONS (N/G, Bladder, etc.)~~ output

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0428	blood tinged	10cc	10cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

MEDCOM - 10809

*U.S.GPO:19.

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE 28 Jan

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
08	Applesauce		
	Ø fluid		
1000	H2O	100	
12	1/2 lasagna		
	Greenbeans		
	1/2 orange		
1700	Spaghetti		
1700	Corn		
1700	1/2 Water	50	

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

MEDICATIONS (IV/G, Enema, etc.)

Urine

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
08	Urine	475	

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

Drain

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2045	blood darkened	5cc	5cc
0430	—	0cc	5cc

GRAND TOTAL INTAKE

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

EPW 55 [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDI 1 JUL 72 WHICH MAY BE USED. MEDCOM - 10810 REPLACES DA FORM 3830(TEMP)

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 05 TO 05 HOURS | TOTAL HOURS COVERED 0500-0500 | DATE 29 June

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0720	H20	120	120cc
0900	H20	60cc	180cc
1200	H20	60cc	240
17	H20	100	340

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	~~TYPE~~ OUTPUT	AMOUNT	ACCUMULATIVE TOTAL
0730	X2 adequate amt		
1030			
13-21	X2		

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION 1 JUL 72 WHICH MAY BE USED. MEDCOM - 10811 REPLACES DA FORM 3630(TEMP)

*U.S.GPO:1996-404-613/30343

0

TWENTY-FOUR HOUR PATIENT IN[TAKE] AND OUTPUT WORKSHEET

FROM ______ HOURS TO ______ HOURS | TOTAL HOURS COVERED | DATE [illegible]

INT[AKE]

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	H_2O	120	120cc
0800	~~200~~ H_2O	120	220cc
1800	milk	240	460cc

~~INTRAVENOUS~~ Chocin

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

Output ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0730	lt yellow urine	300cc	300 cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30
SMALL FRUIT CUP 120
COFFEE CUP.............160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION 1 JUL 72 MEDCOM - 10812 PLACES DA FORM 3630(TEMP)

*U.S.GPO:1996-404-613/30343

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

		INITIAL ASSESSMENT		
	TIME	2100 INITIALS [redacted]	b(6)-2 INITIALS	INITIALS
NEURO	PUPILS	Pinpointed		
	SENSORIUM	Response to tactile stimulation		
RESPIRATORY	RESPIRATORY PATTERN	Equal Bilat.		
	BREATH SOUNDS	Clear bilat.		
	SECRETIONS	~~0~~		
SKIN	COLOR	Normal		
	INTEGRITY	Cut to (R) hand		
		Cast in		
I.V. SITE	LOCATION	(L) AC, (R) AC		
	CONDITION	(L) Signs of infection		
GASTRO	ABDOMEN	Exlap; Dsg is D&I		
	BOWEL SOUNDS	Hypoactive		
		Slight swelling/edema to incisional site area		
GU	URINE:	~~No~~ Foley		
	COLOR/CLARITY	Clear & yellow		
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Rhythm		

LEGEND

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

(Continue on reverse)

PREPARED [redacted] b(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU 2 east | DATE 13 JUN 05

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

[redacted] b(6)-4

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

NSN 7540-00-634-4124

511-119

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003

DAY: 14 15 16 17 18 19 20

HOUR

PULSE (O) | TEMP. F (•)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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. ICW2

EFW

[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-

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June DAY

19 2003 HOUR

	21	22	23	24	25	26	27
DAY							
HOUR							

PULSE (O) | TEMP. F (•)

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

STANDARD FORM 511 (REV. 7-95) BACK

EPW [redacted]

b(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 28 Jan | DAY 28 29 30 1 2 3 4 5

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)*

55

epw [redacted] b(6)-4

REGISTER NO.

WARD NO. 7CW2

STANDARD FORM 511 (REV. 7-95) BACI

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 6 7 8 9 10 11 12

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] 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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 | DAY 13 14 15 16 17 18 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

100/68 96/68 | 90/60 100/66 | 104/58 88/60 | 122/70 104/70 | 108/70 | 114/61 | 110/76 100/76 | 114/76 100/60 | 104/64

HEIGHT: | WEIGHT →

95% | 95% 96% | 96% | 97% | 98% | 98% | 98% 96%

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. ICU2

[redacted] b(a)-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 Jun 03 | DAY 20 - 21 | 21

19 | HOUR

PULSE (O)	TEMP. F (°)
	105°
180	104°
170	103°
160	102°
150	101°
140	100°
130	99° / 98.6°
120	98°
110	97°
100	96°
90	95°
80	
70	
60	
50	
40	

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 →

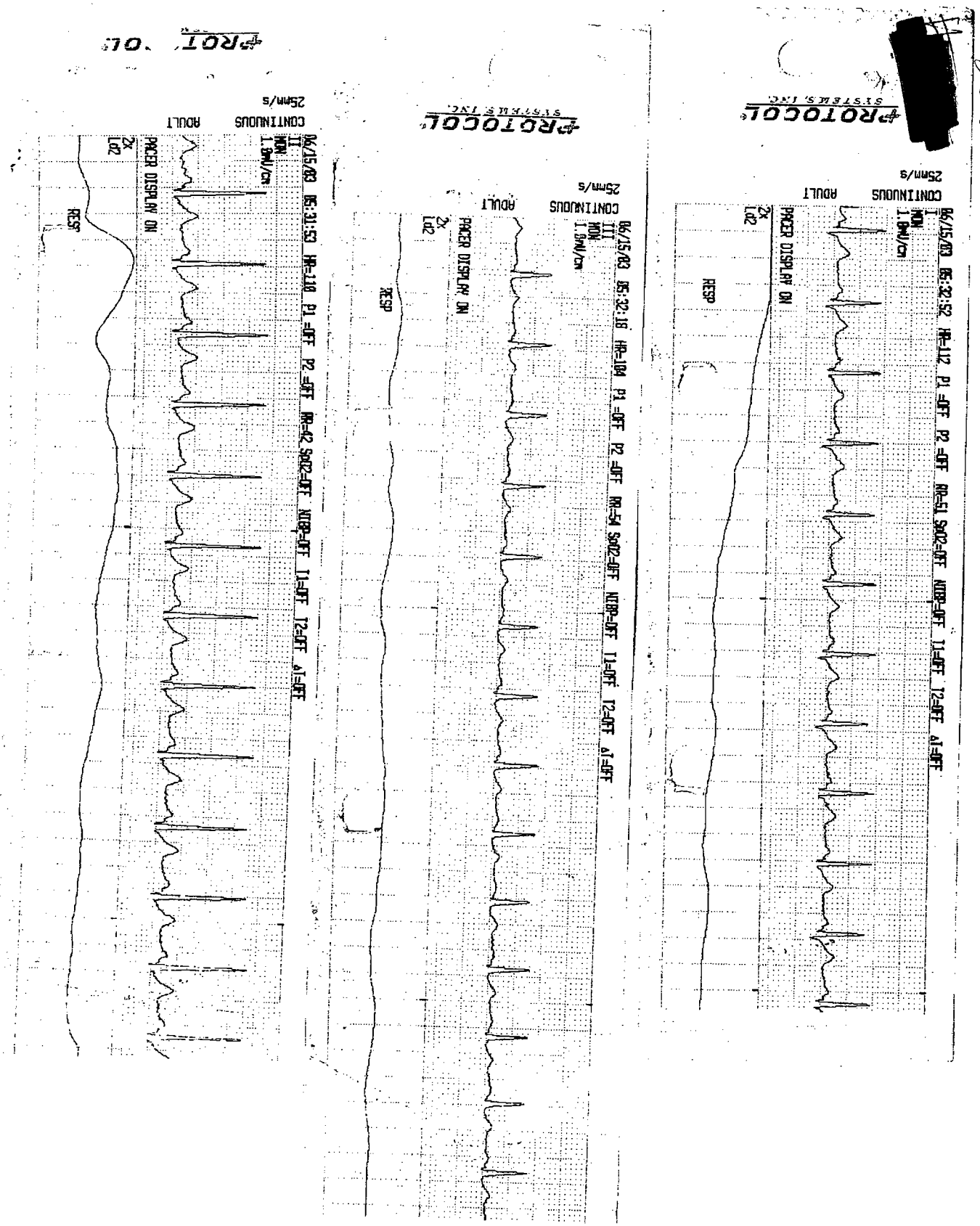
Record special data only when so ordered

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

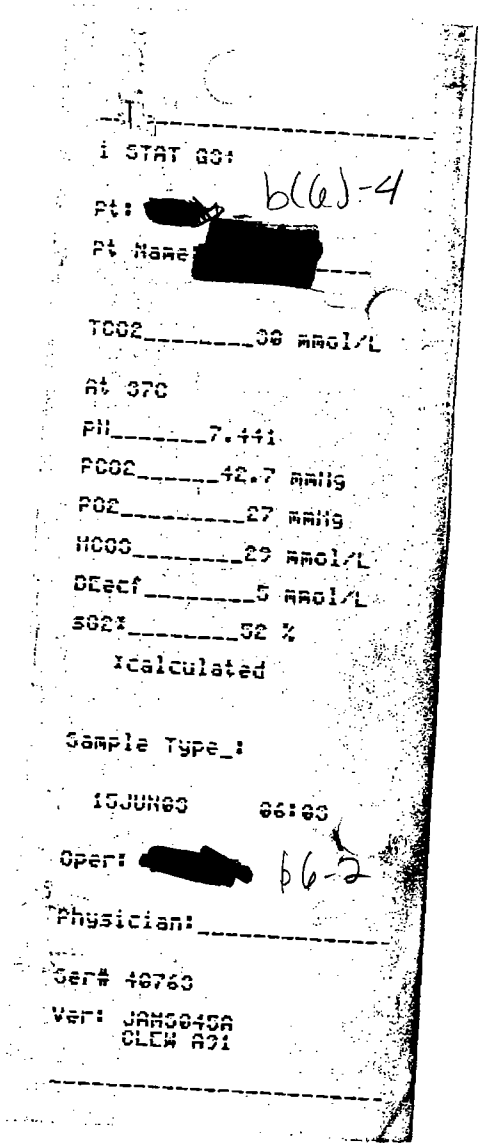
REGISTER NO.

WARD NO.

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


PROTOCOL
SYSTEMS, INC.
06/15/03 05:32:52 HR=112 P1=OFF P2=OFF RR=51 SpO2=OFF NIBP=OFF I1=OFF I2=OFF aI=OFF
I
MON
1.0mV/cm
CONTINUOUS
ROUL
25mm/s
2x
Lo2
PACER DISPLAY ON
RESP
PROTOCOL
SYSTEMS, INC.
06/15/03 05:32:18 HR=104 P1=OFF P2=OFF RR=54 SpO2=OFF NIBP=OFF I1=OFF I2=OFF aI=OFF
III
MON
1.0mV/cm
CONTINUOUS
ROUL
25mm/s
2x
Lo2
PACER DISPLAY ON
RESP
PROTOCOL
SYSTEMS, INC.
06/15/03 05:31:53 HR=110 P1=OFF P2=OFF RR=42 SpO2=OFF NIBP=OFF I1=OFF I2=OFF aI=OFF
II
MON
1.0mV/cm
CONTINUOUS
ROUL
25mm/s
2x
Lo2
PACER DISPLAY ON
REST

b(6)-4



i STAT 03:

Pt: [redacted] b(6)-4

Pt Name: [redacted]

TCO2_____30 mmol/L

At 37C

PH_____7.441

PCO2_____42.7 mmHg

PO2_____27 mmHg

HCO3_____29 mmol/L

BEecf_____5 mmol/L

sO2%_____52 %

Icalculated

Sample Type_:

15JUN03 06:03

Oper: [redacted] b6-2

Physician:_____

Ser# 40763

Ver: JAN3040A
CLEW A01

d/Section: ENT | ATTENDING PHYSICIAN: [redacted] | [redacted]

ST: [redacted] b(6)-2 | b(6)-2 | DATE: 13 June 08 | TIME: 1750 | SSN/PSEUDO SSN

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ect		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
L		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% RCV
b		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
uponin-I		
rug of buse		

(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	143	73-118 mg/dl
BUN	9	7-22 mg/dl
CA^{++}	9.8	8.0-10.3 mg/dl
CRE	1.0	0.6-1.2 mg/dl
NA^+	139	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB	3.8	3.3-5.5 g/dl
ALP	89	26-84 u/l
ALT	25	10-47 u/l
AMY	92	14-97 u/l
AST	34	11-38 u/l
TBIL	0.5	0.2-1.6 mg/dl
GGT	27	5-65 u/l
TP	7.8	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:

UA micro analysis: 30-40 RBCs/hpf many epics

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

b(6)-2

EMT

EPW [redacted] b(4)

b(2)

[redacted] 13June03 1740

OR

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	5.9	4.8-10.8 x 10^3
RBC	4.91	4.7-6.1 x 10^9
Hgb	14.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	46.2	42-52% (M) 37-47% (F)
MCV	94.3	80-94 fl (M) 81-99 fl (F)
Plt	204	130-500 x 10^3 verified
Lymph %	21.8	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	yellow	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	large	Negative
pH	6.0	N/A
Prot	2+	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

SSA = 3+

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	14.1	9.8-13.6 secs
APTT	22.0	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: 13Jun03	LAB ID NO.:

[redacted] b(2)

Ward/Section: 1042	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)-4	DATE: 13 June	TIME: 2200
SSN/PSEUDO SSN: # [redacted] b(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.5	4.8-10.8 x 10^3
RBC	4.58	4.7-6.1 x 10^9
Hgb	13.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	43.3	42-52% (M) 37-47% (F)
MCV	94.5	80-94 fl (M) 81-99 fl (F)
Plt	179	130-500 x 10^3 verified
Lymph %	10.8	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			
oun ematocrit		42-52% (M) 37-47% (F)	
ed Rate			
ther			

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<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. RANG
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:

[redacted] 13 Jan 03

b(6)-2

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

LAST, FIRST	DATE	TIME	SSN/PSEUDO SSN:
H[redacted] b(6)-4	14 JUN	0480	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.8	4.8-10.8 x 10^3
RBC	4.77	4.7-6.1 x 10^6
Hgb	14.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	45.0	42-52% (M) 37-47% (F)
MCV	94.3	80-94 fl (M) 81-99 fl (F)
Plt	166	130-500 x 10^3 verified
Lymph %	8.7	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			

oun ematocrit		42-52% (M) 37-47% (F)
ed Rate		
ther		

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. RANG
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
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

EMARKS:

[redacted] b(6)-2

1LT

Ward/Section: 1CW2 | REQUESTING PHYSICIAN: b(6)-4 CBC | DATE 15 Jun 03 | TIME 0615

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

LAST, FIRST, MI: [redacted] | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.5	4.8-10.8 x 10^3
RBC	4.19	4.7-6.1 x 10^9
Hgb	12.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.5	42-52% (M) 37-47% (F)
MCV	94.4	80-94 fl (M) 81-99 fl (F)
Plt	151	130-500 x 10^3 verified
Lymph %	9.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lyn ph		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: [redacted] b(6)-2 15 June 04

ICW2 b(6)- 19

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI: EPW # [redacted] - Chem 8 | STATUS | DATE: 15 June 03 | SSN

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	1.0	0.6-1.2 mg/dl
BUN	6	7-22 mg/dl
GLU	141	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	128	128-145 mmol/L
K^+	5.7	3.3-4.7 mmol/L
Cl	102	98-108 mmol/L
$^+CO_2$	27	18-33 mmol/L
CK	1327	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RAN
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^3
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%
Retic		0.5-1.5% (adu
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% 37-47%
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	Malaria
Other	

SP

b(6)-2

Ward/Section: ICW #2	REQUESTING PHYSICIAN: Dr. [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted]	DATE: 20 Jun 03 / TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.8	4.8-10.8 x 10^3
RBC	3.78	4.7-6.1 x 10^9
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.5	42-52% (M) 37-47% (F)
MCV	93.7	80-94 fl (M) 81-99 fl (F)
Plt	287	130-500 x 10^3 verified
Lymph %	35.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

b(6)-4 **Urinalysis**

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: b(6)-2 [redacted]	**DATE:** 20 JUN 03	**LAB ID NO.:**

ICW #2

PR [redacted] b(6)-2

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI: EPW # [redacted] b(6)-4 | STATUS | DATE: 20 Jan 03 | SSN

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	0.9	0.6-1.2 mg/dl
BUN	10	7-22 mg/dl
GLU	111	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	130	128-145 mmol/L
K^+	4.2	3.3-4.7 mmol/L
Cl^-	100	98-108 mmol/L
$^+CO_2$	25	18-33 mmol/L
CK	161	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RAN
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^3
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%
Retic		0.5-1.5% (adu
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (37-47% (
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source			
Gram Stain			
Culture			
KOH/WP			
O&P			
Occ Bld		Malaria	
Other			

E/H E

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Fentanyl	(mcg)	100 150	250
propofol	(mg)	140	140
sux/vec	(mg)	160/5 2 1/1 1 1 1	160/12
MSO4	(mg)	2 2 2 3	10
	( )		
	( )		
VOLAT AGENT: Iso	% del	0.4 1.5 1.5 1.5 1.5 1.5 1.0 1.0 0.6 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6 — 2 — 2 — 2 — 2 — 2 — 2 — 2 — 2 — 6	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1)(2) (3) (4)

TOTAL IN: 300

TOTAL URINE: 200

FLUIDS

LINE site		
18g LAC	☐ Warmed	RL — /#2 — 1700 — 2000 — #3
14g RFA	☐ Warmed	RL — /#2 — 1700 — 1900/#3
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	100 200
URINE –	100 200

FLUIDS – SUMMARY

CRYSTALLOID– 4500

COLLOID– Ø

BLOOD– Ø

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

Emergent case, direct from EMR

(1) To room, SOC mons, preO2.

(2) RSI & I ĉ CCP.

(3) Cefotetan 2gm IV PSR.

(4) Zofran 4mg IV

(5) Responsive, suctioned & extubated to ICU stable.

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

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 39.5

INITIAL DATA: BP – 112/73; HR – 103

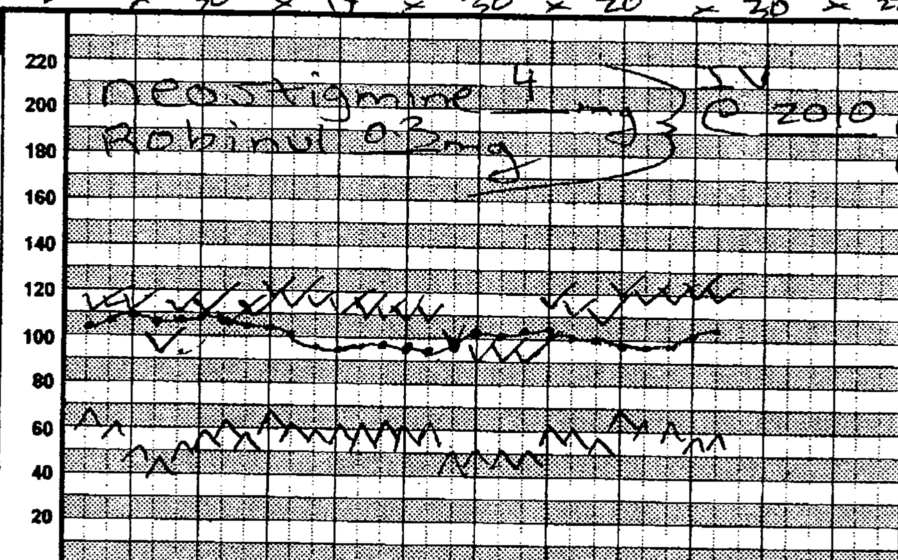
EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE: Y; TIME – 1755

33 y/o EPW

TIME → × 30 × 19 × 30 × 20 × 30 × 22

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



VENTILATION

VT – ml	730	780	750	740	710	650	350	
f – breaths/min	10	10	10	10	10	8	22	
Peak inf pres / PEEP	22	22	22	21	21	21	—	
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S

MONITORS & EQUIPMENT

✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	34	34	34	34	31	31	36	42
BP / oth	✓ FIO2 (Frac or %)	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth– PC/ES	✓ ECG	ST	ST	ST	SR	SR	SR	SR	SR	ST
Gas analyzer	TEMP- site skin		99	99	99	99	98	98	98	off
	N-M Block (T/4)		2/4	4/4	1/4	1/4 3/4	2/4	1/4	2/4	4/4 ĉ sust
Warming blkt										
Conv warmer										

b(6)-2 [redacted]

RECOVERY AT PACU (ICU) 2 (Specify)

OTHER 968

CONDITION:

RESP– 20 SpO2– 97

BP– 132/73 HR– 112

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1755	1755	2035

	Ready	Begin	End
PROC	1805	1817	2022

Mark with letters & symbols, explain under REMARKS **EVENTS** arms out

Position → O— → CPT [redacted] Break ✓ →

PROCEDURES and CPT Codes

(1) Ex lap, splenectomy, repair lt colon laceration

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* [redacted]

GETA

8.0 ETT

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

Eyes taped, DLx1 s̄ trauma, ⊕ ETCO2, BS=B. OGT ↓. Secured 23cm @ teeth.

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

b(6)-4

[redacted]

SURGEONS: b(6) [redacted]

ANESTHETISTS: [redacted] MAJ CRNA

2 [redacted] RECORD – ANESTHESIA

PROCEDURE LOCATION: 2-1

DATE: 6/13/03

PAGE 1 OF 1

WAMC OP 376 REVISED

MEDCOM - 10830 1 Jan 99

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS YRS Sex (/) MALE ( ) FEMALE

PROPOSED PROCEDURE: Ex lap
SURGICAL SERVICE: GS
NPO SINCE: unknown

ASA Physical State 1 2 3 4 5 E
WT: 60 KG/LB HT: ____ IN.
ALLERGIES: ? NKDA

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed in EMT
( ) Ancef 1gm
( ) MSO4 3mg
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 12 / 39.5
U/A: WNL
OTHER: Lyte 209

TBS done

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
?

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck MPS
Oropharnyx ____
Nares ____
CHEST: CLR
CARDIAC: RRR/CTAB
EXTREMITIES:
IV Access: x 2
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since ?

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discus[redacted]an.

b(6)-2

T[redacted]understand and agrees. Questions answered.
[redacted] MAS, CRNA Date: 6/13/03 Time: 1830 Hrs

POST-[redacted]ASU)
{ } [redacted] { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU2

[redacted] b(6)-4

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	13 JUNE 03	2040 HOURS	
1	MOVED TO ICU-2 FROM OR		
2	FOR GSW TO NECK - EX-LAP		
	CYST OF OMENTUM, APPENDECTOMY		
3	FOLEY		
4	NPO		
5	ACTIVITY OOB W/ RN		
6	DIET: NPO		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
7	IVF: LR @ 150 cc/h		
8	MEDS: MSO4 1-6 MG IVP Q 1H PRN pain		
	PHENERGAN 25 MG IVP Q 6H PRN NAUSEA		
	REGLAN 10MG IVP Q 6H PRN NAUSEA		
	TORADOL 15 MG IVP Q 8H PRN		
9	ABG, CBC IN AM		

noted [redacted] CPT 2130

PATIENT IDENTIFICATION

URSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
10	NURSING - TID q 1h		
	FOLEY to gravity		
	ESMOLOL		
	CBT to CVS		
	[redacted] b(6)-2		
	NS		
	MBO me		

ATIENT IDENTIFICATION

RSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	13 JUNE 03	2200 HOURS	
	HCT NOW — V/O Dr [redacted]		
	done 2215 13 JUN 03 Check 2400		
	[redacted] b(6)-2		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

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

DATE OF ORDER: 14 JUNE 03 | TIME OF ORDER: 0815 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) [illegible] - [illegible]
[illegible] this afternoon - D/C [illegible] — noted [redacted]

(2) Ambulate as [illegible] — 0900 6/14/03

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

DATE OF ORDER: 14 JUNE 03 | TIME OF ORDER: 1845 HOURS

(1) Transfer to ICU-2 [redacted]

(2) [illegible] to (R) [illegible]

(3) [illegible]

(4) NKDA

(5) Vitals per [illegible] protocol

(6) Activity [illegible] TID

(7) Diet NPO

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

DATE OF ORDER | TIME OF ORDER | HOURS

(8) IVF: [illegible] @ 125 cc/hr

(9) Meds: [illegible] 1-6 mg IV q 1° PRN
Toradol 15 mg IV q 6° PRN
Reglan 10 mg IV q 6° PRN
Phenergan 25 mg IV q 6° PRN

(10) [illegible] q 1° [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[illegible]

[redacted] b(6)-4

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

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

Noted [redacted]

[redacted] [illegible]

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

NURSING UNIT | **ROOM NO.** | **BED NO.**

[redacted]

DATE OF ORDER 15 JUN 03 **TIME OF ORDER** 0445 **HOURS**

LIST TIME ORDER NOTED AND SIGN: noted 15 Jun 0527 [redacted]

V.O.

STAT CXR x1 now

STAT EKG x1 now

O_2 NC for POx < 95%

CBC, Chem 8, ABG x1 now

Dr [redacted]

[redacted] 15 Jun 03 b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT ICW2 | **ROOM NO.** | **BED NO.**

DATE OF ORDER 15 Jun **TIME OF ORDER** 0606 **HOURS**

noted 15 Jun 0606 [redacted]

V.O b(6)-2

Wean pt. off of O_2 mask and use NC O_2 @ 2L to keep sat < 95%

[redacted] b(6)-2

15 Jun 03

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT ICW2 | **ROOM NO.** | **BED NO.**

DATE OF ORDER 15 Jun 03 **TIME OF ORDER** 0835 **HOURS**

1. ↓ IVF to 75 cc/hr
2. Please record I's & O's q 4°
3. Contact ... if UO < 120cc / 4°

noted 15 Jun [redacted] 0845

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT ICW2 | **ROOM NO.** | **BED NO.**

DATE OF ORDER 15 JUN 03 **TIME OF ORDER** 01:09 **HOURS**

noted 15 Ju... [redacted]

V.O.

ii Tylenol P.O. x1 now for fever

Dr [redacted]

[redacted] b(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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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: 1CW2 | ROOM NO. | BED NO.: 5

DATE OF ORDER: 16 JUNE 03 | TIME OF ORDER: 0800 HOURS | LIST TIME ORDER NOTED AND SIGN

1. HL IV ✓
2. CLEAR LIQ ADVANCE AS TOLERATED ✓
3. TYLENOL #3 I-II TABS PO q4° PRN ✓
4. CBC THIS AM ✓
5. [illegible] CARE - WET TO DRY [illegible] & [illegible] ✓ to [illegible]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: 1CW2 | ROOM NO. | BED NO.: 5

DATE OF ORDER / TIME OF ORDER HOURS

[illegible]

6. AGGRESSIVE PULMONARY TOILET c̄ AMBULATION, COUGH & INCENTIVE SPIROMETRY ✓
7. [illegible] 8° ✓
8. d/c foley [redacted] ✓

[redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: 24 VS | BED NO.: 5 2300

DATE OF ORDER / TIME OF ORDER: 24° VS [illegible] 6-16-03 2230 HOURS

17 JUNE 03 1020

1. DO NOT ADVANCE DIET - ONLY [illegible] OF CLEARS

17 June 1039

[redacted] b(6)-2

17 JUN 03

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] 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.

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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

EPW # [redacted] b(6)-4

noted 18 June 03 1230 ICW

	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	18 JUNE 03 1220 HOURS	
①	IVF ē LR @ 100 cc/°	
②	DRESSING D/S TO ABDOMINAL WOUND TID.	
③	BACITRACIN TO HAND WOUND & Ⓡ ankle wound BID.	
	THANKS [redacted] b(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER	
	HOURS	b(6)-2
6·18·03 2140	VO Dr [redacted] LT [redacted]	
	b(6)-2 [redacted] ① 30cc Mylanta ē Simethicon PO / now [redacted]	
2140	VO [redacted] LT/RN	6-19-03 0015 b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER	
	19 JUNE 03 0830 HOURS	
①	CBC, CHEM 7 in AM 20 JUNE	
	NOTED 20 JUN 03 / 0640 [redacted] b(6)-2	
	[redacted]	
	b(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER	
	20 JUNE 03 0950 HOURS	20 Jun 03 1037 [redacted]
①	ACCURATE I's & O's please.	
	[redacted]	
	b(6)-2 [redacted]	b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted] RN

FORM 4256 1 APR 79 REPLACES E[redacted] OF 1 JUL 77, WHICH MAY BE USED. b(6)-2

U.S. GC

MEDCOM - 10836

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

TIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted] EPW		21 JUNE 03 1045 HOURS	b(6)-2
	1	ADVANCE DIET - ANYTHING PT. WANTS TO EAT.	noted [redacted]
		b(6)-2	21 June 03 1150
		[redacted]	
RSING UNIT: ICW2 / ROOM NO.: / BED NO.: 5		24° ✓ [illegible] 6-22-03 MW	
TIENT IDENTIFICATION b(6)-4 EPW [redacted]		22 JUNE 03 1100 HOURS	b(6)-2
	1	↓ IVF to 50cc/° ✓	noted [redacted]
	2	Δ wound care to 2x2 gauze c̄ NSL ✓ to each open wound BID	9 June 22 June 03 1130
RSING UNIT: ICW2 / ROOM NO.: / BED NO.: 5		b(6)-2 24° ✓ [redacted] AA	
TIENT IDENTIFICATION b(6)-4 EPW [redacted]		23 JUNE 03 0850 HOURS	23 Jun 1030
	1	DC IV	
	2	DC ANCEF	
		b(6)-2 [redacted]	[redacted]
RSING UNIT: ICW2 / ROOM NO.: / BED NO.: 5			24 hrs b(6)-2
TIENT IDENTIFICATION b(6)-4 EPW [redacted]		DATE OF ORDER / TIME OF ORDER [illegible] V.O. Dr. [redacted] / LT [redacted]	
		[illegible] (1) 30cc Mylanta c̄ simethicone PO x1 now	
		b(6)-2 [redacted]	
RSING UNIT: ICW2 / ROOM NO.: / BED NO.: 5		24° ✓ [redacted]	

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b(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

EPW b(6)-4 #[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		5

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
24 June 03	0730 HOURS	
1 Wound vac supplies		Notified @ 1130 24 JUN 03
Bulb suction @ all times		
2 Do not D wound		
dressing		
Thumb [redacted]		
24 June [redacted]		

PATIENT IDENTIFICATION

EPW #[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		5

DATE OF ORDER	TIME OF ORDER	
27 June 03	0900 HOURS	
4 Coke 100 mg po Bid		
5 please record Is & Os		
meals eaten.		
3 Location to VP Unit		
MAX location, MAX time on		
min time off - [redacted]		
4 May clamp tube		
to [redacted]		

PATIENT IDENTIFICATION

EPW #[redacted] b(6)-4 24°/s 0300

NURSING UNIT	ROOM NO.	BED NO.
ICW2		5

DATE OF ORDER	TIME OF ORDER	
28 Jun 03 [redacted]		
28 June 03 0845	HOURS	
1 Fleece pad to bed pt 5		
Page I Shift Recvs.		
2 Upright [redacted]		

PATIENT IDENTIFICATION

[redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24°/s	6

EPW [redacted] b(6)-4

DATE OF ORDER	TIME OF ORDER	
30 Jun 03	1330 HOURS	
1 DC I/O's Pt's Dr. [redacted] Taken by		
2 Continue to record % of meals eaten		
3 Ardia RIN - wet→dry - no to do Am dsg Δ		

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

ePW b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
1 July 03	1355		noted 1July03 @2200 b(6)-2
(9) Please increase dressing as to the [redacted] b(6)-2			
2nd V done [redacted] DLT/AN			

PATIENT IDENTIFICATION

ePW b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS
2 July 03	1015	
(8) Wound VAC Applied & Dressing as needed		
NOTED 2 July 03 1030 [redacted] b(6)-2		
[redacted] b(6)-7		

PATIENT IDENTIFICATION

ePW b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
[redacted] b(6)-2		

DATE OF ORDER	TIME OF ORDER	HOURS
2JUL 03	2300	
VO. 500cc LR Bolus x1 now		
Dr. [redacted] b(6)-2		
2359 [redacted]		

noted 23:00 2JUL 03 b(6)-2

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
		[redacted] b(6)-2

DATE OF ORDER	TIME OF ORDER	HOURS
3 Jul 03	0700	
(1) TID Dressing Δ's		
done [redacted] b(6)-2		

4 FORM 1 APR 79 4256 RE[redacted]77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

IDENTIFICATION

[redacted] b(4)-4

; UNIT: ICW2 | ROOM NO. | BED NO.: 4

DATE OF ORDER: 4 Jul 03 | TIME OF ORDER: 1830 HOURS | LIST TIME ORDER NOTED AND SIGN

① Simethicone - 80mg po TID pm

② D/C IV

Noted [redacted] b(4)-2

IDENTIFICATION

[redacted] b(4)-4

; UNIT: [redacted] b(4)-2 | ROOM NO. | BED NO.: 204

DATE OF ORDER: 4 Jul 03 | TIME OF ORDER: 1630 HOURS

Q Ensure or Carnation supplement

Q Bid Dressing W/D b(4)-2

Noted [redacted]

DATE OF ORDER: 18 Jul 03

① 2-4mg MSO4 IVP pm Prior to dressing Δ's

noted 18JUL03 1230 dt

[redacted] b(4)-4

G UNIT: ICW2 | ROOM NO. | BED NO.: 4

[redacted] 0845 22° Vone [redacted] b(4)-2

T IDENTIFICATION

[redacted] b(4)-4

DATE OF ORDER: 17 Jul 03 | TIME OF ORDER | HOURS

① Indocin - 25 mg po TID

noted 1100

IG UNIT: ICW2 | ROOM NO. | BED NO.: 4

[redacted] b(4)-2

24°V [redacted] 18 Jul 03