M AL RECORD-SUPPLEMENTAL MEDI ATA

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

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

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0630 INITIALS: [redacted]	TIME: INITIALS:
NEURO	PUPILS	3mm PERRL Bilat	3mm PERRL
	SENSORIUM	Awake responds to commands	A+O x 3
	EXTREMITY MOVEMENT	appropriately. LUE unable to	able to follow simple
	SEDATION	move. All other extremities	commands External
	PAIN CONTROL		fixation to LUE. NROM
			to other 3 extremities
RESP	RESPIRATORY PATTERN	RRR symmetrical rise + fall	RRR
	BREATH SOUNDS	of chest CTA bilat	CTA Bilat
	SECRETIONS	Ø secretions	
	O2 SOURCE/FLOW/SAO2	RA 95-98% SaO2	
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	S_1S_2 Cap refill <3 sec	S_1S_2 (+) pulses to all
	CAPILLARY REFILL	+2 pulses x4 extremities	4 extremities. <3 sec
	PULSES		cap refill.
	EDEMA		
GI	ABDOMEN	+BS x 4 quads Soft non	(+) BS x 4 quads. ABD
	BOWEL SOUNDS	tender Ø distention	soft round nondistend
	BOWEL MOVEMENT		non tender.
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to gravity	pt voiding spontaneously
	COLOR/CLARITY	Clear yellow	clear yellow urine.
SKIN	COLOR	NFB Dsg's to Upper	NFR DSG to (L) UE
	INTEGRITY	legs bilat CDI	+ legs Bilat DSG is
			C/D/I
ACCESS	#1 TYPE/LOCATION/SIZE	20ga to (R) Forearm	HL to (R) FA (+)
	DRESSING CONDITION	Patent to flush	flush Ø S/S of
	IV FLUID/RATE	Ø Erythema	infection
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

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

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

DATE: 16 Sep 03

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

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

UNIT: GENDER: M

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

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

DA FORM 4700, MAY 78

MEDCOM - 17041

USAPPC V2.00

ICU1

Patients Name: # [redacted] (6)(6)-4　　Date: 16SEP03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			131/65				129/75				118/66															
TEMP			100.2				98.5				100.1					110/68				108/68				113/61		
HR			104				93				98				101.4		100.1									
RR			19				21				18					92				96				96		
SaO2			99%				99				100					20				21				[illegible]		
FiO2																100%				99%				100%		
Source			RA				RA				RA															
MAP																RA				RA				RA		

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

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

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	16
BP Arterial line																		
BP Cuff	110/60	115/60	106/60	112/58	111/59	124/65	111/59	116/63		120/63	107/62	110/56	120/72	122/61	159/75	115/61	118/63	108/64
Temperature	99.3	—	—	99.1	—	99.3	99.2	98.9		99.6								
Pulse	82	85	94	84	86	87	92	88		88	91	88	90	92	101	89	84	91
Respiratory Rate	24	12	22	20	23	25	28	25		(58)	21	23	26	23	21	20	20	12
SaO2	98%	97%	96%	95%	95%	97%	96%	93		95	96	94	97	97	99	95	97	96
O2 Method	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

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

OUTPUT

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

POST-OP DAY									
VITAL SIGNS	17	18	19	20	21	22	[illegible]	24	
	124/71		159/43	104/46	119/62	127/71	124/62	122/72	
			95	94	93	94	90	93	
			13	15	14	18	20	16	
			99	98	97	96	98	99	
			RA	RA	RA	RA	RA	RA	

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

OUTPUT								
	200	100	170	200	80	200	220	190

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN SUCTION	TIME					

24°180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	______	Urine:	______
Po	______		______
TOTAL	______	TOTAL	______

BALANCE ______

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

M .L RECORD-SUPPLEMENTAL MEDIC ATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

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

SHIFT ASSESSMENT

		TIME: 0600 INITIALS: [redacted]	TIME: 1925 INITIALS: [redacted]
NEURO	PUPILS	3mm PERRLA, able to follow	3mm Perrla
	SENSORIUM	commands + express needs	follows commands & expresses
	EXTREMITY MOVEMENT	SPEAKS SOME ENGLISH, LIMITED	needs. Speaks some english
	SEDATION	ROM Ⓛ ARM DUE TO EX-FIX, MSO4	↓ Rom to Ⓛ arm r/t
	PAIN CONTROL	+ percocet for pain control	Ex-fix, MSO4 + percocet
			for pain control
RESP	RESPIRATORY PATTERN	RRR, RR 16, equal chest rise	RRR
	BREATH SOUNDS	CTA throughout	Clear Bilat
	SECRETIONS		—
	O2 SOURCE/FLOW/SAO2		—
	VENTILATOR SETTINGS		—
CV	CARDIAC RHYTHM	SR c̄ Ø ectopy HR 88, Cap refill	SR Ø Ectopy HR 98
	CAPILLARY REFILL	< 3 sec, +2 pulses in all ext x̄ Ⓛ	Cap Refil < 3 sec.
	PULSES	radial +4 bounding. Ø edema	+ pulses in all ext x̄ Ⓛ radial
	EDEMA	noted	+3-+4 Ø edema
GI	ABDOMEN	soft, nontender	Soft, nontender
	BOWEL SOUNDS	(+) in all 4 quadrants	+ in all 4 quads
	BOWEL MOVEMENT	Ø noted	Ø noted
	NGT/OGT		
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	urinal	to urinal
	COLOR/CLARITY		
SKIN	COLOR	Ex-fix Ⓛ upper arm. Ⓛ arm in sling	Ex-fix Ⓛ upper arm.
	INTEGRITY	Drsg C,D,I. Ⓛ arm elevated	Sling in place Drsg CDI
ACCESS	#1 TYPE/LOCATION/SIZE	Ⓡ FA H.L. c̄ Ø s/s of infection.	Ⓡ FA HL
	DRESSING CONDITION	Flushes well.	Ø s/s of infection
	IV FLUID/RATE		Flushes well
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

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

DATE: 17 Sept 03

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

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

UNIT: GENDER:

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

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

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

TALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
ine																										
P	116/58				117/58				106/54					131/74				124/65				117/60				
MP	98.8				99.0	99.4	99.0	99.0	99.4					99.7				[illegible]				99.0				
	98				98				96					103				88				88				
	16				18				16					16				18				16				
O2	99%				99%				99%					100%				100				100				
2	—				—				—					—				—								
urce	RA				RA				RA					RA				RA				RA				
AP	—				—				—					—				—								

NTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
/F																				150						450
/PB	100		50				100				50		300	100												
IGT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE			x1					x1			x1		x III													
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700 INITIALS	INITIALS	1815 INITIALS
NEURO	PUPILS	PERRL Z+		
	SENSORIUM	A&O unable to evaluate. Movement to All Ext. Does not Follow Commands		PERRL. Pt is awake & tries to verbalize.
RESPIRATORY	RESPIRATORY PATTERN / BREATH SOUNDS / SECRETIONS	RR-25 SPO_2-96% on Humidified RA to trach collar. Trached blood tinged sputum c̄ productive cough. BS. CTA (B) ↑ lobes & wheeze (B)		[illegible]
SKIN	COLOR / INTEGRITY	Normal for Race. Open Wound to Abd, Burns. T- 99.1		NFR, wound on (B) legs, abdomen
IV SITE	LOCATION / CONDITION	(R) Forearm 20g infusing ½NS @ 50cc/hr & MS04 @ 8cc/hr		18, (L) wrist. ½NS @ 50cc/hr & MSO4 @ 8cc/hr.
GASTRO	ABDOMEN / BOWEL SOUNDS	Large open wounds JP drains dressing CDI. B.S. Normoactive		abdominal wound c̄ ABD dressing, ABS
GU	URINE: COLOR/CLARITY	clear yellow draining via Foley to gravity		to foley, QS, clear/yellow
CARDIOVASCULAR	CARDIAC RHYTHM	HR-106 BP-134/81. Pulses strong x4. Capillary Refill ≤3sec		S,S normal, no ectopy/murmur noted. Pulses palpable x 4 extremities.

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

(Continue on reverse)

PREPARED BY: (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 17 Sep 03

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

EPW (b)(6)-4

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

MEDCOM - 17047

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

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

INITIAL SHIFT ASSESSMENT

		TIME 0700 INITIALS	INITIALS	1815 INITIALS
NEURO	PUPILS	PERRL 2+		PERRL. Pt is awake
	SENSORIUM	A&O unable to		& tries to verbalize.
		evaluate.		
		Movement to All Ext.		
		Does Not Follow Commands		
RESPIRATORY	RESPIRATORY PATTERN	RR-25 SPO₂-96%		[illegible], non labored [illegible]
	BREATH SOUNDS	on Humidified RA to		[illegible] [illegible] [illegible]
	SECRETIONS	trach collar. Trached		lung sounds course bilat.
		blood tinged sputum		
		c̄ productive cough		
		BS. CTA (B) ↑ lobes & wheeze (B)		
SKIN	COLOR	Normal for Race		NFR, wound on (B)
	INTEGRITY	Open Wound to Abd, Burns		legs, abdomen
		T- 99.1		
IV SITE	LOCATION	(R) forearm 20g		18g (L) wrist. ½NS
	CONDITION	infusing ½NS @ 50cc/hr		@ 50cc/hr c̄ MSO4 @
		& MSO4 @ 8cc/hr		8cc/hr.
GASTRO	ABDOMEN	Large open wounds		abdominal wound c̄ ABD
	BOWEL SOUNDS	JP drains dressing		dressing (H)BS.
		CDI		
		B.S. - Normoactive		
GU	URINE:	clear yellow		to foley DS, clear/yellow
	COLOR/CLARITY	draining via Foley		
		to gravity		
CARDIOVASCULAR	CARDIAC RHYTHM	HR-106 BP-134/81		S,S normal, no
		Pulses strong x4		ectopy/murmurs noted.
		Capillary Refill ≤ 3sec		Pulses palpable x 4
				extremities.

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

(*Continue on reverse*)

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

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 17 Sep 03

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

EPW (b)(6)-4

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

DATE 17Sep03 | DX Multiple GSW | HOSPITAL DAY

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff	146/77	134/81	129/79	139/74	143/86	142/81	107/60	128/67		112/63	140/87	133/77	151/77	137/79	129/82	129/75	136/74
Temperature		99.1	—	99.8		98.4				98.9			98.4	98.7		98.3	98.1
Pulse	113	105	113	104	111	98	92	94		92	102	98	103	101	102	105	99
Respiratory Rate	18	25	26	27	24	25	27	27		30	24	26	18	28	14	19	21
SpO2	97%	96	97	96%	95%	97%	94%	93%		94%	94%	98%	99%	98	98	98	98
method	HRA	H-RA	H-RA	H-RA	HRA	HRA	HRA	HRA		HRA	HRA	HRA	HRA	HRA	HRA	HRA	HRA

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°
.45% NS	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
MSO4	8	8	8	8	8	8	8	8		8	8	8	8	8	8	8	8	
IVPB	100	/	50	/	100	0	100	/		/								
TF	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
J-Tube flush/Meds					20													
	258	158	208	158	278	158	258	158		158	158							
TOTALS	258	416	624	782	1060	1118	1376	1534		1692	1850							

OUTPUT		06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
URINE	HOUR / TOTAL	Ø/Ø	Ø/Ø	Ø/Ø	525/505	180/605	180/785	150/935	150/1085	1085	120/	170/290	170/460	120/580	120/700	100/800	150/900	120/1020
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL					275													
DRAINS	JP-1																	
	JP-2																	
	JP-3																	
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	22	23	00	01	02	03	04	05	
BP	143/83	154/8[illegible]	158/88	157/80		176/8[illegible]	162/80	152/80	
T		98.8	98.3	98.3		98.9	98.8	98.8	
P	107	103	115	116		113	120	112	
R	24	12	22	18		28	24	15	
O2	95	97	98	97		96	100	100	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	

INTAKE

	22	23	00	01	02	03	04	05	8° T
[illegible]	50	50	50	50	50	50	50	50	
[illegible]	8	8	8	8	8	8	8	8	
[illegible]		150	~~150~~						
TF	100	100	100	100	100	100	100	[illegible]	
[illegible]		10							

OUTPUT

100	100/200	100/300	120/420	80/500	100/600	150/750	100/850	850

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

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

TURN / SUCTION

TIME					
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	______	Urine:	______
po	______		______
	______		______
TOTAL	______	TOTAL	______

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME: 0638 INITIALS	INITIALS	INITIALS
NEURO	PUPILS	3mm PERRL		3mm PERLLA
	SENSORIUM	Awake Moves extremities x 4 c purposeful movement		Awake, able to follow some simple commands; moves all 4 extremities
RESPIRATORY	RESPIRATORY PATTERN	RRR symmetrical		RR pt trached
	BREATH SOUNDS	chest wall expansion		CTA Bilat equal
	SECRETIONS	thick white secretions clears c cough		rise & fall of chest Bilat. pt has thick white secretion c cough.
SKIN	COLOR	NFR		NFR, wound to
	INTEGRITY			midline abd. Dressing CDI.
IV SITE	LOCATION	18 ga IV to (L)		18G IV to (L)
	CONDITION	wrist site CDI ø erythema		wrist site is CDI ø s/s of infection. (+) flush NS @ 50cc/hr, MSO4 @ 3mg/hr
GASTRO	ABDOMEN	+BS x 4 quads		(+)BS x 4 quad
	BOWEL SOUNDS	Soft non tender		soft round nondistended pt on Sevity through Dreading @ 50cc/hr.
GU	URINE:	Foley to Gravity		Foley to gravity.
	COLOR/CLARITY	clear yellow		clear yellow urine
CARDIOVASCULAR	CARDIAC RHYTHM	$S_1 S_2$ +2 Pulses x 4 extremities, <3 sec cap refill		$S_1 S_2$ (+) pulses x 4 extremities, ≤3 sec cap refill.

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

(Continue on reverse)

PREPARED BY: (b)(6)-2
DEPARTMENT/SERVICE/CLINIC:
DATE: 14 SEP 03

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

(b)(6)-4

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	~~14~~	14	15	16	17	18	19	20	21	
BP Arterial Line																		
BP Cuff		139/81	121/70	119/73	132/72	113/62	146/80	108/65			143/84	148/86	154/89	159/88	147/91	168/92	154/79	
Temperature		100.1	99.2		99.9		99.8	99.7			99.1			99.2				
Pulse		110	102	101	103	92	102	92		103	104	103	108	107	110	108	108	
Respiratory Rate		41	21	45	27	37	35	33		25	38	41	20	28	29	26	32	
S_aO_2		99	97	97	97	97	99	97		99	98	99	97	99	99	99	99	
Method		RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IV	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
IVPB	50		50			100						50		100				
TF	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
MgSO4	8	8	5	5	5	5	5	3		3	3	3	3	3	3	3	3	
TOTALS																		

OUTPUT

		06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	
URINE	HOUR / TOTAL	150/150	150/300	160/460	140/620	150/750	120/870	120/990	100/1090	1090	100/100	110/210	60/270	60/330	80/410	88/	100/	75/	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

22	23	24	01	02	03	04	05	
118/69	168/93	111/62	125/71	138/93	152/90	134/92	159/90	
110	~~98~~	91	92	104	110	106	117	
36	28	26	30	22	26	33	21	
99	99	97	99	99	99	99	99	
RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

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

OUTPUT

66	150	88	75	200	180	163	180	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

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

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________
____
TOTAL ________

OUTPUT
Urine: ________
____
____
TOTAL ________

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.

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

OTSG APPROVED (Date)

Date: 9/18 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
Time In: 1705
Allergies: PCN OR Intake: Crystalloid 500 Colloid
Pre-op V/S: 149/69 85 OR Output: UOP ∅ EBL ∅
Procedures: I/D Left arm Meds/Times: —

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1705	1710	1715	1730	1745	1800
SaO2	96	96	97	97		
FiO2						
Methods	RA	RA	RA	RA		
RR	10	13	10	12		
T	96.9					

(Vital signs grid 240–20: systolic ✓ at approx. 120 for 1705, 1710, 1715 and approx. 150 for 1730; diastolic ^ at approx. 60 for 1705, 1710, 1715 and approx. 70 for 1730; pulse • at approx. 80–110.)

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

(Continue on reverse)

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

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

(b)(6)-4

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

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

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

NEUROVASCULAR

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

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

C-SECTIONS

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

DRESSINGS

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

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

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

NURSING NOTES

Pt arrived from OR. O2 sats 98%. A+O VSS No c/o pain. Report given to Sgt [redacted]. O2 sats 99% other VSS stable (b)(6)-2

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

WAMC OP 171-E

MEDCOM - 17055

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet** | OTSG APPROVED *(Date)*

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

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1055	1100	1105	1115	1120	1150
SaO2	100	100	100	100	100	100
FiO2	35	35	35	35	35	36
Methods						
RR	29	30	25	30	28	
T	96					

Time	1105	1120	1140
Pain (0-10)	UTA	UTA	UTA
LOS			

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, ˅ = Cuff BP, • = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

(Handwritten margin notes:) 1055 HR 102 BP 160/58 RR 29 SpO2 100 96; 1100 HR 110 BP 168/60 RR 30 SpO2 100; 1105 HR 97 129/67 RR 25 SpO2 100; 1115 HR 95 137/78 RR 30 SpO2 100; 1120 HR 93 136/77 RR 28 SpO2 100 Temp 98; 1150 HR 94 136/59 RR 26 SpO2 100 Temp 98.2

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC PACU | DATE 9-19

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

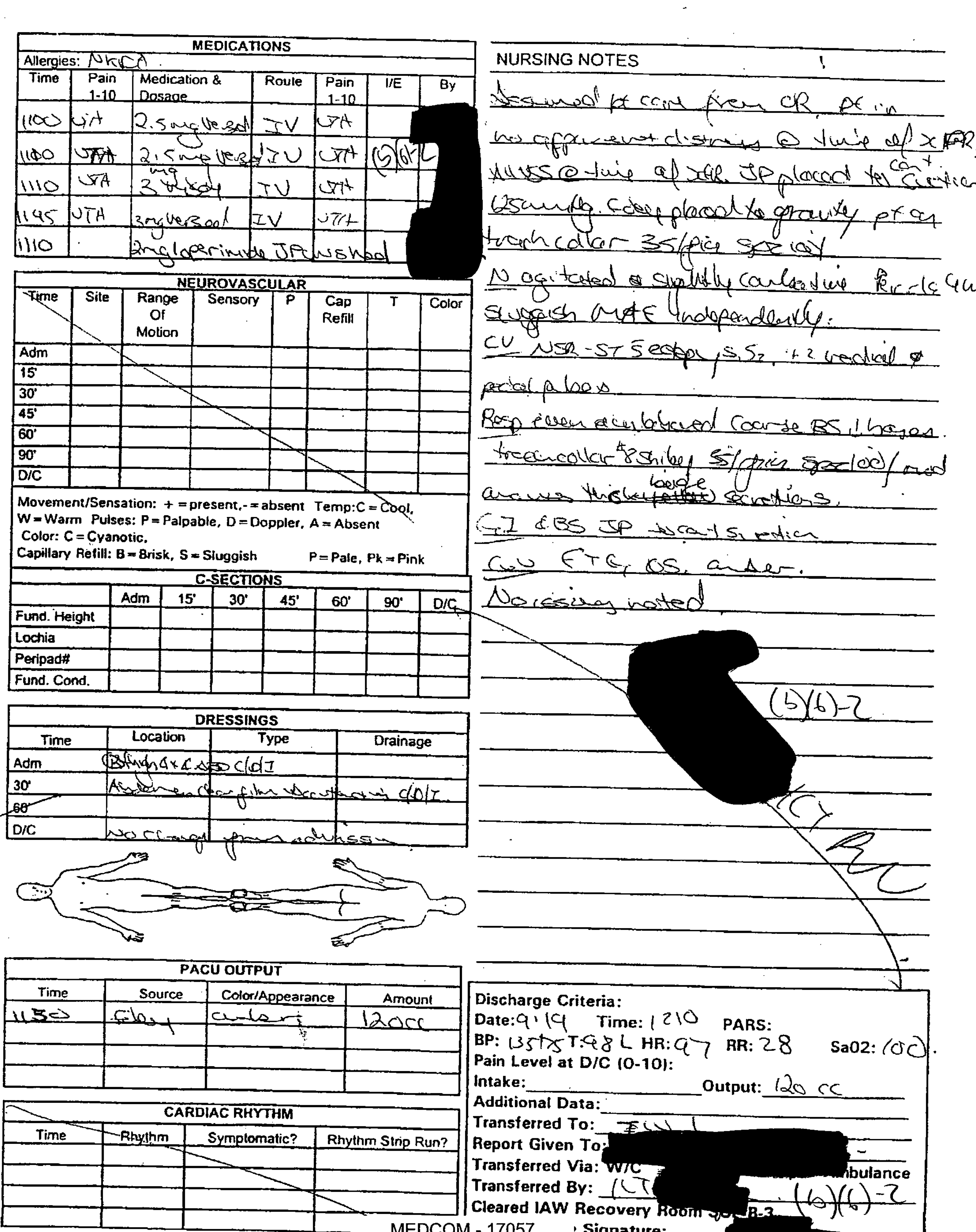
EPW [redacted] (b)(6)-4

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

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

USAPPC V2.00

MEDCOM - 17056



MEDICATIONS

Allergies: NKDA

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

NEUROVASCULAR

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

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	[illegible] 4x4 [illegible] c/d/I		
30'	[illegible] film [illegible] c/d/I.		
60'			
D/C	No change from admission		

PACU OUTPUT

Time	Source	Color/Appearance	Amount
1150	Foley	amber	120cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Assumed pt care from OR, pt in no apparent distress @ time of xfer. [illegible] @ time of xfer. JP placed to cont suction [illegible]. Foley placed to gravity pt on trach collar 35% [illegible] SpO2 100%
N agitated & slightly combative [illegible] sluggish MAE independently.
CV NSR-ST s ectopy, S1 S2, +2 radial & pedal pulses
Resp even and labored coarse BS, [illegible] trach collar #8 Shiley 35% [illegible] SpO2 100% / and [illegible] secretions.
GI & BS JP [illegible] suction
GU FTG, OS, amber.
No [illegible] noted

(b)(6)-2

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

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700 INITIALS	INITIALS	1830 INIT	
NEURO	PUPILS	PERRL		PERRLA 3mm (b)(6)-2	
	SENSORIUM	follows simple command		Follow simple commands	
		cooperative		moves all extremities	
				MSO4 5mg/h	
				ō Restraint x 2	
RESPIRATORY	RESPIRATORY PATTERN	RRR		RRR RA 97%	
	BREATH SOUNDS	mild crackles		crackles clear ē suction	
	SECRETIONS	throughout		thick white secretions	
		thick secretions placed		from Trach	
		on humidified air		#8 Shilley Trach ē	
				Trach collar	
SKIN	COLOR	normal for race		Normal for Race	
	INTEGRITY	abd wound packed ē		Suction Vac to abd wound	
		W-D BLE [illegible]		intact, to 125mmHg vaccum	
IV SITE	LOCATION	superficial [illegible] & back		Drsg BLE intact	
	CONDITION	of the head (W-D)		Drsg Posterior Head Intact	
				PIV 18G Ⓛ Wrist	
	IV	Ⓡ arm D5I ½NS		D5.45NS ē 20K @ 125cc/h	
		@ 50, MSO4 @ 3mg/hr			
GASTRO	ABDOMEN	soft non tender		Soft, Round, Nontender	
	BOWEL SOUNDS	active		⊕	
		ostomy draining loose		Ostomy to RUQ draining	
		stool		loose stool	
GU	URINE:	foley		foley to gravity	
	COLOR/CLARITY	clear yellow		light yellow ē small	
				amount of sediment	
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 NSR-ST		SR, S1/S2	
		↓100		Pulses +2 x4 extremities	
		no edema noted		Φ edema noted	
				Cap Refill < 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

(b)(6)-2

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC:

DATE: 19 SEP 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

NEUROLOGICAL ASSESSMENT

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

LEGEND

C Closed by swelling

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

R Right
L Left

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

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS		
	R / L	
	R / L	
	R / L	
	R / L	
	R / L	

LEGEND

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

M AL RECORD-SUPPLEMENTAL MEDI DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

(b)(6)-2

SHIFT ASSESSMENT

		TIME: 0700 INITIALS	TIME: 1930 INITIALS
NEURO	PUPILS	PERRLA	Perrla
	SENSORIUM	Alert, confused	Alert, Confused
	EXTREMITY MOVEMENT	Active in all extremeties	Full movement in all extremities
	SEDATION	Receiving Morphine + Ativan	MSO4, Ativan, Haldol
	PAIN CONTROL	Morphine drip	MSO4 gtt @ 4cc/hr
RESP	RESPIRATORY PATTERN	Regular, unlabored	Regular, unlabored
	BREATH SOUNDS	Coarse in all lobes	Coarse throughout
	SECRETIONS	Thick yellow	
	O2 SOURCE/FLOW/SAO2	Room Air Trach Collar	Humidified air via trach collar
	VENTILATOR SETTINGS	Humidified Air	
CV	CARDIAC RHYTHM	SR to ST	SR - ST
	CAPILLARY REFILL	< 3 secs	< 3sec
	PULSES	+3 in all extremeties	+3 all extremities
	EDEMA	None	
GI	ABDOMEN	Soft, Nondistended	Soft, nondistended
	BOWEL SOUNDS	Absent	⊖
	BOWEL MOVEMENT	Liquid brown BM in Colostomy	
	NGT/OGT	J-tube Clamped	J-Tube Clamped
	TUBE FEDDINGS		
	DRAINS	JP Drains x 4 to Gravity	JP Drains x 4 to bulb suction
		JP Drain from Wound Vac to Cont. Suction	Wound Vac to cont. suction
GU	VOIDING	Foley to Gravity	Foley cath to gravity
	COLOR/CLARITY	Clear, Golden	Clear yellow
SKIN	COLOR	Normal for Race	Normal for race
	INTEGRITY	Dressing to Back of Head, Ⓡ	Drsg to back of head, Ⓡ flank
	flank,	Ⓡ Shoulder, BLE C/D/I	Ⓡ shoulder, BLE
ACCESS	#1 TYPE/LOCATION/SIZE	PIV Ⓛ FA	PIV Ⓡ wrist
	DRESSING CONDITION	∅ S/S of infection	∅ S/S of infection
	IV FLUID/RATE	D5/2 NS c̄ 20meq KCl @ 120cc/hr	D5½ NS c̄ 20 meq kcl @ 120
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 1LT/AN

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

DATE: 20 SEP 03

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

NAME: EPW (b)(6)-4 RANK: AGE:

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17060

USAPPC V2.00

:U1 Patients Name: CIV [redacted] (b)(6)-4 Date: 20 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	150/88	134/60	135/74	107/75	162/71	153/79	112/82	135/89	172/87	108/89	117/81	132/67		114/64	121/72	111/67	136/73	132/73	153/83	136/77	147/83	150/82	146/96	167/87		
TEMP			97.8																							
HR	85	89	89	83	102	85	86	87	92	81	88	81		75	83	80	83	82	107	94	102	103	97	112		
RR	22	25	23	23	27	24	27	34	29	22	22	23		25	34	23	21	27	42	36	27	29	19	22		
SaO2	96	94	98	96	97	98	96	98	97	95	100	98		96	97%	99%	98%	98%	96%	99%	96%	96%	99%	96		
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		
Source																										
MAP	112	95	100	85	115	106	96	111			97	91		85	88	85	99	95	109	104	109	106	100	119		

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF D5½NS 20K	120	120	120	120	120	120	120	120	120	120	120	120		120	120	120	120	120	120	120	120	120	120	120	120	
IVPB			50								50															
NGT																										
Morphine	5	5	5	5	5	5	8	8	8	8	8	8		4	3	3	3	3	3	3	3	7	7	7	7	
J Tube					60	60																				
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100	100	250	300	125	140	185	210	110	170	120	180		200	180	170	240	200	200	170	170	150	125	125	170	
NGT																										
STOOL																										
DRAIN JP VAC																										
JP # 1																										
JP # 2																										
JP # 3																										
JP # 4																										
Total																										

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

REPORT TITLE

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

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800 INTIL [redacted]	1800 INTIL [redacted]	INTILAS
NEURO	PUPLIS	PERR	PERRL	
	SENSORIUM	awake easily aroused	awake + responsive to	
		c̄ mild sedation	commands. mild sedation	
		of MSO4.	c̄ MSO4	
		unable to follow commands		
RESPIRATORY	RESPIRATION PATTERN	RRR no SOB	= rise + fall of chest	
	BREATH SOUNDS	CTA c̄ scattered mild	bilaterally CTA b/l	
	SECRETIONS	rhonchi (L) LL,	trach open to air	
		O2 sat @ 95-96%	O2 sat 97-100% small	
		whitish secretions	amounts of tanish secretions	
		in moderate to scant		
SKIN	COLOR	WNL, wound (R) side	NFR burn (R) axillary	
	INTEGRITY	abd wound, LG +	abd surgical wound dry CDI	
		head pressure sore, dressing	dressing to open clean	
IV SITE	LOCATION	(R) arm	(R) arm	
	CONDITION	D + I s̄ redness c̄	CDI no erythema or	
		infection	swelling IV D5.45NS c̄ 20K	
		IVF D5-.5 c̄ 20k	@ 120 MSO4 @ 3mg/hr	
		@ 120, MSO4 titrated		
		for sedation		
GASTRO	ABDOMEN	soft nontender	soft flat. Ostomy c̄	
	BOWEL SOUNDS	BS. Ostomy not	brown loose stool RQ	
		draining 2° NPO	JP x4 (R) RQ LL + LQ	
		status	Ø BS	
GU	URINE	Foley draining qs	Foley to gravity	
	COLOR/CLARITY	clear yellow urine	clear yellow urine	
CARDIOVASCULAR	CARDIACRHYTHM	NSR - ST mid 80s -	S1S2 s̄ extra sounds	
		90s	pulses +2 U + L extremities	
		no edema noted	cap refill <3 secs	

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

(Continue on reverse)

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

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

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

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

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form see AR 40-66; the proponent agency is The Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		INTILAS		INTILAS		INTILAS
NEURO	TIME				1845	
	PUPLIS				PERRL	
	SENSORIUM				Pt lightly sedated c̄ MSO4 + Ativan. Responsive + arousable to voice + touch stimuli.	
RESPIRATORY	RESPIRATION PATTERN				Reg R+R	
	BREATH SOUNDS				CTA throughout	
	SECRETIONS				thick yellow from trach Shiley trach #8 O_2 sats @ 92-99% on RA	
SKIN	COLOR				NFR	
	INTEGRITY				Dressings C/D/I	
IV SITE	LOCATION				Ⓡ FA 20G, dressing	
	CONDITION				C/D/I, Ø Ntd erythema/edema Receiving D5½ NS c̄ 20Kcl @ 120 + MSO4 @ 2	
GASTRO	ABDOMEN					
	BOWEL SOUNDS					
GU	URINE				Voiding clr yellow urine	
	COLOR/CLARITY				via Foley to gravity in adequate Amounts	
CARDIOVASCULAR	CARDIACRHYTHM				NSR, HR-86 BP 183/53 +2 radial + pedal pulses c̄ brisk cap refill. Ø Ntd edema	

LEGEND

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

(b)(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 91WM6

DEPARTMENT/SERVICE/CINC: ICU 1

DATE: 21 Sep 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)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DATE 21 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	162/92						170/92		136/87	118/69	124/73	142/74	116/72	127/68	109/57	107/55	108/57	
Temperature	99.5						99.7					99.8				99.6		
Pulse	113						112		113	92	89	92	92	90	90	89	88	
Respiratory Rate	34						36		19	21	23	44	35	off		30	20	
SaO_2	98						95		98	92	92	92		(89)	(89)	93	94	
O_2 Meth	RA						RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE / OUTPUT

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½ 20kcl							120		130	120	120	120	120	120	120	120	120	
IVPB										50								
MSO4	—	—	—	—	—	—	7	7	1	7	7	7	7	7	7	7	7	
TOTALS																		
URINE HOUR/TOTAL							220				200						190	
URINE SP gr																		
URINE S/A																		
wound vac. (~~NG~~) OUTPUT										100								
PH																		
GUIAC																		
EMESIS																		
STOOL										⊗								
DRAINS 1	—	—	—	—	—	—	—	—	—	5								
DRAINS 2										5								
DRAINS 3										10								
TOTALS 4										⊗								

POST-OP DAY									
VITAL SIGNS	16	17	18	19	20	21	22	23	
	93/52	102/54	106/55	103/53	114/60	95/52	133/71	117/65	
	99.7		—	99.3	—	99.6	—	—	
	83	81	89	88	83	89	78	84	
	27	8	20	14	23	21	27	23	
	92	91	94%	94%	95%	96%	96%	96%	
	RA	RA	H-RA	RA	RA	RA	RA	RA	
INTAKE	14	17	18	19	20	21	22	23	8°T
			120	120	120	120	120	120	
			7	7	7	7	7	7	
OUTPUT					210	45		220	

ACUITY LEVEL CLASSIFICATION

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

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

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

24°180 TOTALS

WT Yesterday ________ wt Today ________

INTAKE

IV ________

Po ________

TOTAL ________

OUTPUT

Urine: ________

____

TOTAL ________

BALANCE ________

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

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0800 INTILAS	INTILAS	2000 INTILAS
NEURO	PUPILS	PERRL		Perrla
	SENSORIUM	Intermittent restlessness		Pt agitated when
		MSO4 4-7mg for pain		awake.
		sedation c̄ Ativan		
		1mg PRN		
RESPIRATORY	RESPIRATION PATTERN	RRR		RRR
	BREATH SOUNDS	CTA c̄ scattered rhonchi		Clear Bilat c̄
	SECRETIONS	cleared up c̄ coughing		coughing or suction
		+ suctioning		
		whitish mucous		
SKIN	COLOR	WNL, multiple wounds		Normal to Race
	INTEGRITY	abd. flank, hand +		Multiple wounds
		LE W-D dressing		
IV SITE	LOCATION	(R) arm		(R) wrist
	CONDITION	D+I		D+I
GASTRO	ABDOMEN	colostomy draining watery		Colostomy (R) side
	BOWEL SOUNDS	stools, normal BS		BS normoactive
		TF@100cc/hr		TF@ 100 cc/hr
GU	URINE	foley		foley
	COLOR/CLARITY	clear yellow urine		clear yellow urine
CARDIOVASCULAR	CARDIACRHYTHM	NSR ↑90s - ST ↓100's		SR 90's
		$S_1 S_2$ no noted ectopy		$S_1 S_2$ No ectopy

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_1O - Fraction of inspired O_2	PCO_2 - PRESSURE OF ARTRIAL CO_2	SAI - Saturation
F_1O_2 - Bicarbonate	PEEP - Positive end Expiratory Pressure	TRACH - Iracheostomy

(b)(6)-2

(Continue on reverse)

PRE[redacted] /AN

DEPARTMENT/SERVICE/CINC

DATE 23 Sep 03

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

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

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

DATE: DX ... HOSPITAL DAY

VITAL SIGNS

TIME	~~24~~	01	.	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	/	~~08~~	6.	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	/
BP Arterial line	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
BP Cuff	125/67	147/78	115/66	124/73	147/74	119/72		113/64	122/63	114/71	126/63	114/78	111/66	124/66		115/67	139/66	
Temperature	98.6				98.7					98.9								
Pulse	105	115	105	89	92	92		95	93	96	93	94	119	99		96	97	
Respiratory Rate	25	(43)	28	23	(44)	35		28	(40)	25	20	25	31	10		26	26	
FiO2/sat	92	98	97	92	92	98		95	100	96	97	96	98	99		96	96	
source	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA		RA	RA	

INTAKE

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
TIME	~~24~~	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5.5 c 20 kcl	600	120	120	120	120	120	120	120	120	120	120	75	75	75	75	75	75	
HSO4	31												5	5	5	5	5	
Zantac	—	—	50								50							
TF (Jevity)												[illegible]	100	100	100	100	100	
TOTALS																		

OUTPUT

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

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

14	17	18	19	20	21	22	23	
23	24	01	02	03	04	05		
134/84	164/88	155/95	97/53	107/50	113/54	122/57		
100	125	122	104	99	98	95		
24	35	36	28	28	27	28		
96	94	95	100	100	100	96		
RA	RA	RA	RA	RA	RA	RA		
23	24	01	02	03	04	05		

INTAKE

14	17	18	19	20	21	22	23	8°T
75	75	75	75	75	75	75		
5	5	5	5	5	5	5		
	50							
100	100	100	100	100	100	100		

OUTPUT

100	100	40	100	100	100	100		

RESPIRATORY DATA

TIME										
MODE										
F_IO_2										
TV										
RATE										
PEEP										
ABG pH										
PCO_2										
pO_2										
HCO_3										
SAT										
BASE										

LABORATORY DAILY DATA

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

ACTIVITIES DAILY LIVING

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

TURN SUCTION — TIME

24°180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE — IV ______ Po ______ TOTAL ______

OUTPUT — Urine: ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE — INITIALS

(b)(6)

DATE 23 Sep 03

DX

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	/	/	116/70	123/64	141/77	131/71												
Temperature	/	/						98.6										
Pulse	/	/	101	99	100	101												
Respiratory Rate	/	/	15	16	14	15												
SaO2			99	97	100	97												
			RA	RA	RA	RA												

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5 ½NS c 20 K	/	/	120	120	120	120												
MgSO4			4	4	4	4												
Feeding Jevity			70	70	70	70												
TOTALS																		

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	–	–	250	100	200	200												
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form see AR 40-66; the proponent agency is The Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

Section	Item	0700	INTILAS		INTILAS	2000	INTILAS (b)(6)-2
NEURO	TIME	0700				2000	
	PUPILS						
	SENSORIUM	pt A&O - unable to assess				Unable to assess	
		pt medicated c ativan/				mental status	
		Haldol as per Dr's orders					
		Purposefull movement x4					
RESPIRATORY	RESPIRATION PATTERN	RR- 20 SpO2- 98				RRR	
	BREATH SOUNDS	on Humidified RA via				Breath sounds	
	SECRETIONS	trach. (B) Expiratory				clear c coughing &	
		snoring thick				suction	
		mucousy secretion					
		from trach					
SKIN	COLOR	Normal For Race				NTR	
	INTEGRITY	Abd wound burns				ABD wound & Burns	
		(B) forearm (B) LE					
IV SITE	LOCATION	(B) Forearm infusing				(L) wrist	
	CONDITION	D5½ NS c 20K & MSO4				D5½NS c 20 kcl + MSO4	
		site CDI s S/S of					
		infection / infiltration					
GASTRO	ABDOMEN	midline Abd wound				Midline Abd wound	
	BOWEL SOUNDS	soft flat non-distended				active BS	
		Bowel Sound (+) x4					
GU	URINE	Clear yellow voiding				foley cath	
	COLOR/CLARITY	via foley to cath.				clear / yellow	
CARDIOVASCULAR	CARDIACRHYTHM	HR- 83 BP- 115/63				ST-100's	
		cap refill ≤ 3sec				cap refill ≤ 3sec	
		Peripheral pulses x 4					

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CINC ICU

DATE 25 Sep 03

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

EPW (b)(6)-4

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

DATE 25 Sep | DX | HOSPITAL DAY

VITAL SIGNS

TIME	~~24~~ 06	~~01~~ 07	08	~~03~~ 09	~~04~~ 10	~~05~~ 11	~~06~~ 12	~~07~~ 13	8T	~~08~~ 14	15	~~10~~ 16	~~11~~ 17	~~12~~ 18	~~13~~ 19	~~14~~ 20	~~15~~ 21	
BP Arterial line																		
BP Cuff	115/63	91/62	93/53	109/57	96/57	97/50	99/55	108/53		91/49	104/53	136/71	104/55	92/49	91/52	129/61	132/63	
Temperature	98.7			99.1							98.1							
Pulse	83	87	83	83	80	85	82	83		78	80	87	77	77	76	97	103	
Respiratory Rate	20	24	25	18	25	26	27	20		14	27	22	15	12	11	15	37	
SpO2	98	100	99	97	98	96	98%	98		98	98	96	97	95	100	98	100	

INTAKE

TIME	~~24~~ 06	~~01~~ 07	~~02~~ 08	~~03~~ 09	~~04~~ 10	~~05~~ 11	~~06~~ 12	~~07~~ 13	~~8T~~	~~08~~ 14	~~09~~ 15	~~10~~ 16	~~11~~ 17	~~12~~ 18	~~13~~ 19	~~14~~ 20	~~15~~ 21	8°T
IVF	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
TF																		
J-Tube			60											100	100	100	100	400
MSO4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	7	
IVPB			50									50						
TOTALS	80	160	300	380	460	540	620	780										

OUTPUT

URINE HOUR / TOTAL	80 / 80	80 / 160	80 / 240	80 / 320	80 / 400	80 / 480	80 / 560	80		80 /	80 /	50 /	40 /	80 /	70 /	70 /	70 /	
URINE SP gr																		
URINE S/A																		
NG OUTPUT																		
NG PH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

R 40

VITAL SIGNS									
	22	23	24	01	02	03	0[illegible]	05	
	113/59	134/71	142/78	142/75	131/82	135/76	172/85	165/79	
	93	97	98	101	105	105	121	114	
	20	21	19	22	26	17	10	26	
	100	97	94	100	98	100	98	98	

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

OUTPUT								
	80	80	80	200	200	200	100	100

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN / SUCTION — TIME

24°180 TOTALS

WT Yesterday ________ wt Today ________

INTAKE — IV ________ Po ________ TOTAL ________

OUTPUT — Urine: ________ ________ TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	

M AL RECORD-SUPPLEMENTAL MEDI ATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT		TIME: [illegible] INITIALS: (b)(6)-2	TIME: INITIALS:
NEURO	PUPILS	PERLA 3mm brisk	
	SENSORIUM	Alert	
	EXTREMITY MOVEMENT	Moves all ext.	
	SEDATION	[illegible]	
	PAIN CONTROL	[illegible]	
RESP	RESPIRATORY PATTERN	Trach Resp 20-30's	
	BREATH SOUNDS	B/L Breath sounds clear Equal exp.	
	SECRETIONS	Ø	
	O2 SOURCE/FLOW/SAO2	Room air	
	VENTILATOR SETTINGS	Ø	
CV	CARDIAC RHYTHM	ST HR 116. BP 167/84	
	CAPILLARY REFILL	Good < 3 sec	
	PULSES	all (+)	
	EDEMA	(−)	
GI	ABDOMEN	Nondistended Nontender	
	BOWEL SOUNDS	(+) x4	
	BOWEL MOVEMENT	Colostomy drainage [illegible]	
	NGT/OGT	Ø	
	TUBE FEDDINGS	J Tube [illegible] plus [illegible]	
	DRAINS	JP	
GU	VOIDING	Foley	
	COLOR/CLARITY	yellow clear	
SKIN	COLOR	Normal	
	INTEGRITY	Surgical wound [illegible] Mid abdomen.	
		Multiple open areas [illegible] hand	
		and lower ext [illegible] upper arm	
		(R) side of chest wall.	
ACCESS	#1 TYPE/LOCATION/SIZE	(L) hand.	
	DRESSING CONDITION		
	IV FLUID/RATE	[illegible] NSS [illegible]	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION	DRY	
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(6)-2: ICU #1,

DATE: 26 Sep 03

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

NAME: EPW RANK: AGE:

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

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

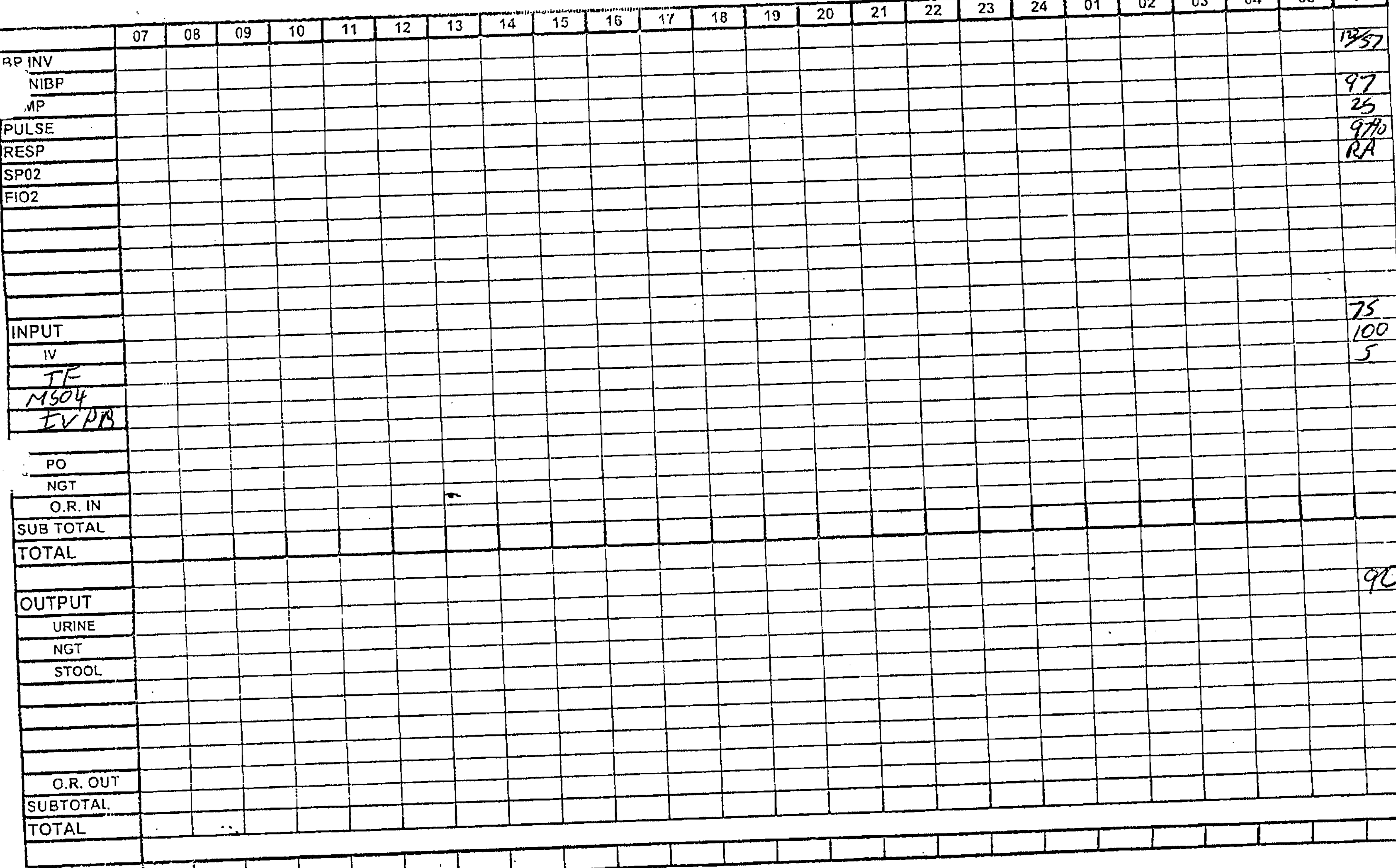
VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP	167/94	164/84	152/77	148/83	116/64	120/66	101/53	97/55	110/55	110/53	140/55	98/51		98/51				141/75			152/85				177/98
TEMP	98.0				98.3	.		0	98.5						98.1			98.0			99.9				98.2
HR	115	116	111	166	103	96	94	84	86	89	86	91		89				100			105				113
RR	23	23	28	23	27	22	20	24	24	23	24	22		27				20			27				24
SaO2	98																								
FiO2	–	97	98	97	97	97	98	99	99	99	97	97		97				96%			100%				100%
Source	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA				RA			RA				RA
MAP	–	117	105	105	84	88	75	78	75	73	75	69		67				105			110				129

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	25	75	75	75	75	75	75		75	75	25	25	75	25	75	75	75	25	25	25	
IVPB			500								50									150						
~~NGT~~ TF	100	ø	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
MFW	5	5	5	5	5	5	5	5	5	5	5	5		5	5	5	5	5	5	5	5	5	5	5	5	
PO																										
Total	180/180	80/260	[illegible]/[illegible]	180/670	180/850	180/1030	[illegible]/1110	130/1240	180/1410	180/1590	230/1880	180/2060	2060	180												

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100/100	120/220	60/280	[illegible]/[illegible]	180/601	180/750	100/840	70/950	60/1010	80/1080	100/1190	70/1260	1260	85/85	60/145	140/285	130/415	110/525	110/635	110/745	215/960	140/1100	270/1370	250/1620	160/1780	1780
NGT																										
STOOL (vol)			250																							
DRAIN																										
Total	100/[illegible]	[illegible]/220	410/630	[illegible]/[illegible]	[illegible]/920	[illegible]/1110	[illegible]/1210	[illegible]/1280	60/1340	80/1420	100/1520	70/1590	1540	85	60											

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

DATE 24 Sep 03



	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
																								132/57
BP INV																								
NIBP																								97
MP																								25
PULSE																								97%
RESP																								RA
SP02																								
FIO2																								
																								75
INPUT																								100
IV																								5
TF																								
MSO4																								
IVPB																								
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
																								90
OUTPUT																								
URINE																								
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								

MI[illegible]L RECORD-SUPPLEMENTAL MEDIC[illegible]ATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

(b)(6)-2

SHIFT ASSESSMENT

		TIME: 0800 INITIALS: [redacted]	TIME: 1930 INITIALS: [redacted]
NEURO	PUPILS	Perl 3mm Brisk	Perrla +3
	SENSORIUM	alert, follow commands	Alert
	EXTREMITY MOVEMENT	Moves all extremities	
	SEDATION	[illegible] Haldol	
	PAIN CONTROL	MSO4 5mg/h	MSO4 gtt 5cc/hr
RESP	RESPIRATORY PATTERN	Trach Resp 20-30's	Trached RRR
	BREATH SOUNDS	Breath sounds clear bil. Equal chest	Clear Bilat
	SECRETIONS	expansion. Ø	
	O2 SOURCE/FLOW/SAO2	Room air Sat 97-100% [illegible]	Room air
	VENTILATOR SETTINGS	pulse oximeter	—
CV	CARDIAC RHYTHM	ST	SR-ST
	CAPILLARY REFILL	<3 sec	≤ 3 sec
	PULSES	all ⊕	pulses +2 all ext.
	EDEMA	Ø	Ø
GI	ABDOMEN	Soft Non tender and Nondistended	Soft, non distended
	BOWEL SOUNDS	+ x4	+ all quads
	BOWEL MOVEMENT	colostomy draining to bag	colostomy to drain bag
	NGT/OGT	Ø / J-Tube c̄ Jevity 100cc/h	J-Tube c̄ Jevity @ 100 cc/hr
	TUBE FEDDINGS		
	DRAINS	JP x4	JPs x4
GU	VOIDING	foley	foley cath
	COLOR/CLARITY	yellow clear	clear/yellow
SKIN	COLOR	Normal	NTR
	INTEGRITY	Surgical wound to mid abdomen. Multiple open areas to [illegible] lower ext's, Right upper arm, Right side of chest wall	Surgical to ABD midline, open area below and to Ⓡ of wound. Burns to Ⓡ chest, shoulder, B/E. Breakdown to head
ACCESS	#1 TYPE/LOCATION/SIZE	Ⓛ hand (HL)	Ⓛ hand, Heplock
	DRESSING CONDITION	intact	Intact
	IV FLUID/RATE	Ø	—
	#2 TYPE/LOCATION/SIZE	Right forearm	Ⓡ Forearm
	DRESSING CONDITION	Intact Ø S/S infection/infiltration	Intact
	IV FLUIDS/RATE	D5½NS c̄ 20mEq [illegible] MSO4 at 5ch	D5½NS c̄ 20 meq [illegible] MSO4 gtt @ [illegible]

PREPARED BY (Signature & Title): (b)(6)-2 [redacted] 91WM6

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

DATE: 27 Sep

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

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

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 17076

USAPPC V2.00

ICU1

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

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	110/80				144/65				130/76					94/48				101/52				97/62				
TEMP	99				98.7				98.5																	
HR	112				113				99					84				95				92				
RR	29				23				25					26				19				28				
SaO2	80				97				98					99				97				98				
FiO2	100%				RA				RA					RA				RA				RA				
Source																										
MAP	112				103				100					[illegible]												

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	
IVPB			50								50									50						
~~NGT~~ TF	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
MSO4	5	5	5	5	5	5	5	5	5	5	5	5		5	5	5	5	5	5	5	5	5	5	5	5	
PO																										
Total	180/180	180/360	230/590	180/770	180/950	180/1130	180/1310	180/1490	180/1670	180/1850	230/2080	180/2260	2260	180	180	180	180	180	180	280						

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE					1000/1000							600/1600	1600	80	80/160	80/240	80/320	80/400	80/480	90	90	100	100	100	100	
NGT																										
STOOL																										
DRAIN													300													
58																										
Total					1000/1000							600/1600														

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

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals:	Time: 2000 Initals:
NEURO	Pupils		
	Sensorium LOC / GCS	A&O – unable to assess pt move all extremities doesn't Follow commands	A&O moves all extremities
CARDIAC	Cardiac Rhythm	HR 101 BP 119/65	SR-ST
	PRI / QRS:		
	Pulse Strength	Pulses	+3
	Cap Refil / JVD	Capillary Refill	cap refil ≤ 3sec ⊖ JVD
	Edema	No swelling noted	Ø
	Chest Pain	Ø chest pain	Ø
RESP	Respiratory Pattern	RR-10 SpO2 - 99%	RRR Trached
	Breath Sounds		Clear Bilat
	Secretions	thick yellow, green sputum	
	Cough	spiratic productive cough	spiratic productive cough
SKIN	Color	Normal for Race	NTR
	Integrity	break down healing burns &	intact x wounds
	Backside	Abd wound	
IV	Access Devices	Ⓡ wrist infusing 75 D5½NS	Ⓡ wrist PIV
	Location	c̄ 20K and 5cc/hr MSO4	D5½NS c̄ 20 meq kcl @ 75cc/hr
	Condition	No S/S infection, CDI	
GI	Abdomen		
	Bowel Sounds		normo active
	Stoma/Ostomy	J-tube dressing CDI Ostomy draining Runny Brown	Colostomy, J-Tube
GU	Device	Foley to gravity draining	Foley to gravity
	Color / Clarity	clear yellow urine	

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU #1

DATE 24 Sep 03

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

NAME: (b)(6)-4 RANK: AGE:

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

PT'S NAME:

DATE: 24 Sep 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV. / NIBP	119/65	125/63	128/62	130/72	110/70	119/66	98/53	149/89	136/60	116/63	116/53	122/74	124/66	146/81		126/70	144/84	112/65	140/74	141/79	132/70	128/66	125/65	
T	98.4		98.6			98.7			98.9															
PULSE	98	90	95	94	76	97	92	105	99	90	93	90	95	103	99	100	114	102	99	107	101	96	94	
RESP	~~99~~ 10	28	28	26	24	32	35	28	32	33	29	27	43	10		44	35	29	26	29	30	42	45	
SP02	99	98	98	96	98	97	96	99	96	97	97	97%	98%	94%	98	98	97	96	100	99	99	98	99	
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
INPUT																								
IV	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
TF	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
MSO4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	
IVPB																								
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE	80	80	80	80	130	100	80	80	120	80	80	110	180	140	140	110	110	280	210	130	130	130	160	
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

N AL RECORD-SUPPLEMENTAL MEDI ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0810 INITIALS: (b)(6)-2	TIME: INITIALS:
NEURO	PUPILS	Perl 3mm brisk	PERRL
	SENSORIUM	alert follow commands	Pt awake able to
	EXTREMITY MOVEMENT	Moves all extremities	follow simple commands
	SEDATION	Ativan 5mg/h	moves X4 extremities
	PAIN CONTROL	MSO4 5mg/h	MSO4
RESP	RESPIRATORY PATTERN	Reg.	RRR
	BREATH SOUNDS	wheeze to upper lobes. Equal ...	CTA B/that
	SECRETIONS	∅	white frothy secretions from
	O2 SOURCE/FLOW/SAO2	Room air	RA
	VENTILATOR SETTINGS	∅	∅
CV	CARDIAC RHYTHM	ST. HR 107-120	S1 S2
	CAPILLARY REFILL	≤3 sec	≤3 sec
	PULSES	all ⊕	NFR
	EDEMA	∅	⊕ X4 extremities
			∅
GI	ABDOMEN	Soft nontender	Soft round nontender
	BOWEL SOUNDS	⊕ ...	⊕ x 4 quad
	BOWEL MOVEMENT	colostomy	Colostomy draining
	NGT/OGT	∅	liquid stool
	TUBE FEDDINGS	... J-Tube	JP x 4
	DRAINS	JP x 4	
GU	VOIDING	Foley	Foley to gravity
	COLOR/CLARITY	yellow/clear	Clear yellow
SKIN	COLOR	intact except for Abdominal	Abd incision midline
	INTEGRITY	surgical wound Head wound ...	pressure sores to head ...
		Right upper arm burn Right chest ...	to Ⓡ arm/chest
		burn both lower legs burn	
ACCESS	#1 TYPE/LOCATION/SIZE	Right forehand. 20G	R FA 20g ⊕ flush
	DRESSING CONDITION	Dry/intact	D5 1/2 NS c̄ 20 KCL
	IV FLUID/RATE	D5 1/2 NS c̄ 20 kcl @ 75 cc/h MSO4 5mg/h	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 DATE
ICU #1

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

NAME: RANK: AGE:

UNIT: GENDER:

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

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

DA FORM 4700, MAY 78

MEDCOM - 17080

USAPPC V2.00

ICU1

Patients Name: EAw█████ (b)(6)-4 Date: 29 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	185/96				124/64				150/79					154/91				150/80				154/98				
TEMP	97.6				96.8									96.8				96.9				97.9				
HR	111				100	~~100~~			100					96				102				94				
RR	22				18				35					25				21				24				
SaO2	100				100				96					97				97				97				
FiO2	RA				RA				RA					RA				RA				RA				
Source																										
MAP	128																									

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

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100/100				700/800							1500/2300	2300		200		150		200		150	150				
NGT																										
STOOL																										
DRAIN																										
Total																										

M ... L RECORD-SUPPLEMENTAL MEDI... ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: INITIALS:	TIME: 1855 INITIALS:
NEURO	PUPILS	3mm PERRL	Perrla 3mm
	SENSORIUM	Awake Moves extremities	
	EXTREMITY MOVEMENT	x4 c̄ purposeful movement	
	SEDATION		
	PAIN CONTROL	MSO4 @ 10mg/hr	
RESP	RESPIRATORY PATTERN	RRR 8 Shiley Trach	RRR #8 shiley trach
	BREATH SOUNDS	RA CTA bilat.	Clear Bilat
	SECRETIONS		
	O2 SOURCE/FLOW/SAO2		RA sats 98-100
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	S1 S2 +2 pulses x4 extremities	S1 S2 no ectopy
	CAPILLARY REFILL	<3 sec cap refill	<3 sec
	PULSES		+2
	EDEMA		
GI	ABDOMEN	+BS x4 quads Abd soft	soft nondistended
	BOWEL SOUNDS	non-distended	+BS x 4 quads
	BOWEL MOVEMENT	TF Jevity @ 100cc/hr	
	NGT/OGT	Colostomy to R UQ	
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to gravity	Foley to gravity
	COLOR/CLARITY	Clear yellow urine	Clear yellow urine
SKIN	COLOR	NFR	NTR
	INTEGRITY		
ACCESS	#1 TYPE/LOCATION/SIZE	18 ga IV to (R) FA	18 guage IV to (R) FA
	DRESSING CONDITION	D5 1/2NS + 20KCL at 75cc/hr	D5 1/2 NS + 20 meq kcl @ 75cc/hr
	IV FLUID/RATE	Site CDI	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY: (b)(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU #1

DATE
30 Sept 01

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

NAME: RANK: AGE:

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

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

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

ICU1 Patients Name: [redacted] (b)(6)-4 Date: 30 Sept 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17
A-Line												
NBP			143/92				132/93				123/93	
TEMP			98.2				98.6					
HR			117				99				102	
RR			21				17				26	
SaO2			97				96				100	
FiO2												
Source			RA				RA				RA	
MAP												

VITALS	18	19	20	21	22	23	00	01	02	03	04	05
A-Line												
NBP												
TEMP												
HR												
RR												
SaO2												
FiO2												
Source												
MAP												

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total
	25	25	25	25	75	75	25	25	25	25	25	75	900
			50								50		100
F	100	100	100	100	100	100	100	100	100	100	100	100	1200
s04	10	10	10	10	10	10	10	10	10	10	10	10	120
PO													
Total													

INTAKE	18	19	20	21	22	23	00	01	02	03	04	05	Total
	25	75	75	75	75	75	75	75	75				
F	100	100	100	100	100	100	100	100	100				
s04	10	10	10	10	7	7	5	3	3				
PO													
Total													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total
URINE							825						
NGT													
STOOL													
DRAIN													
Total							825						825 556

OUTPUT	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	825	66	66	67 200	80	90	80	80	80	80	100	100	
NGT													
STOOL													
DRAIN													
Total													

MEDCOM - 17083

N AL RE :D-SUPPLEMENTAL MED: DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 1LT/AN

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

DATE 01 OCT

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

NAME: (b)(6)-4 RANK: AGE:

UNIT: GENDER:

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

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

ICU1

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

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	132/96				164/88				133/69			139/64					133/69				124/60				118/60	
TEMP	98.9								98.6			98.4					98.8				98.2				97.9	
HR	112				119				92			91					95				92				91	
RR	27				30				28			27					13				28				25	
SaO2	98				98				98			100					99				98				98	
FiO2	—				—				—			—														
Source	RA				RA				RA			RA					RA				RA				RA	
MAP	—				—				—			—					92				82				84	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	/	/	/	/	/	/	75	450	75	75	75	75	75	75	75	75	75	75	75	75	900
IVPB	100						100		100				300													
~~NGT~~ TF	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
M504														3	3	3	3	3	3	3	3	3	3	3	3	36
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE						200	65	140	55	55	100	110	725				600/600				400/1000				450/1450	1450
NGT																										
STOOL				100cc														150								
DRAIN																										
Total																										

MEDCOM - 17085

ICU Flowsheet Patient Name: Date: / / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	98.7	98.7		98.6	99.2	99.3																				
Pulse	118	120	119	116	114	115																				
B/P A-Line	111/67	112/64	110/64	107/60	98/58	97/57																				
MAP		80		75	71	67																				
~~B/P Cuff~~ CVP				17	15	13																				
Respirations	16	16	16	16	16	16																				
Sa02	100%	100%	100%	100%	100%	100%																				
Mode	vent	vent	vent	vent	vent	vent																				
FiO2	60%	60%	60%	60%	60%	55%																				

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF	200	200	200	200	200	200							1200													
IVPB		50											50													
Bolus	400 PRBC												400													
vec	12	12	12	[illegible]	[illegible]	6																				
versed	3	3	3	3	3	3							18													
~~PO intake~~ fent	12.5	12.5	12.5	12.5	12.5	10																				
O.R. IN																										
Totals													16992													

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	90/640	95/735	50/785	70/855	60/915	36/951							951													
NG Tube													75													
Drains #1																										
#2																										
EBL #3													1600													
Emesis/Stool																										
O.R. OUT													125													
Totals													2751													

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

MEDCOM - 17086

...CAL RE...RD-SUPPLEMENTAL ME... DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT		TIME: 0740 INITIALS: [redacted]	TIME: 1900 INITIALS: [redacted]
NEURO	PUPILS	PERL	Perrla
	SENSORIUM	alert + responsive	A + responsive
	EXTREMITY MOVEMENT	moves all extremities well	moves all extremities well
	SEDATION		
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	RR 23 nonlabored	RRR - unlabored (Trached)
	BREATH SOUNDS	wheezing	
	SECRETIONS	coughed up thick red-tinted sputum	
	O2 SOURCE/FLOW/SAO2	RA	RA
	VENTILATOR SETTINGS	Ø	Ø
CV	CARDIAC RHYTHM	HR 92	SR-ST
	CAPILLARY REFILL	good cap refill	≤ 3sec
	PULSES	+ pulses	+2 pulses
	EDEMA	Ø edema noted @ present time	Ø
GI	ABDOMEN	soft & nondistended	Soft, non distended
	BOWEL SOUNDS	colostomy - Q4 quads.	Colostomy - Q 4 quads
	BOWEL MOVEMENT		
	NGT/OGT		
	TUBE FEDDINGS	Jevity @ 100cc/hr	Jevity @ 100 cc/hr
	DRAINS	JP drains x 3 to abd.	JP drains x 3 abd
GU	VOIDING	F/C to BS	F/C to BS
	COLOR/CLARITY	dark yellow	dark yellow urine
SKIN	COLOR	Burn to (R) shoulder area, wounds	Burn to (R) shoulder +
	INTEGRITY	to B-legs.	BLE
ACCESS	#1 TYPE/LOCATION/SIZE	PIV to (R) FA	PIV to (R) FA
	DRESSING CONDITION		
	IV FLUID/RATE	IVF: D5½NS c̄ 20Kcl @ 75cc/hr	D5½NS c̄ 20kcl @ 75 cc/hr
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE: 02 Oct 03

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

NAME: EPW # [redacted] (b)(6)-4
RANK:
AGE:
UNIT:
GENDER:
STATUS: US: AD / CIV   IRAQI: CIV / EPW

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

ICU1

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

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP		159/83				139/74			136/69					163/77												
TEMP		97.7							97.3																	
HR		92				77			78					81												
RR		23				10			18					18												
SaO2		100				99			100					100												
FiO2																										
Source		RA				RA			RA					RA												
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75	900	75	75	75	75	75	75	75						
IVPB		100					100					100	300													
NGT																										
TF	100	108	100	100	100	100	100	100	100	100	100	110	1200	100	100	100	100	100	100	100						
MSO4	3	3	3	3	3	3	3	3	3	3	3	3	36	3												
P.O.		360			480			480			360		1680													
Total													4116													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		500/300				300/800					600/1400									380						
NG																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17088

CAL RECORD-SUPPLEMENTAL MEI DATA

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

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

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0900 INITIALS:	TIME: 1900 INITIALS:
NEURO	PUPILS	3mm PERL	PERRL
	SENSORIUM	WNL	A+O X3
	EXTREMITY MOVEMENT	MAEW x4	minimal
	SEDATION	minimal	Ø
	PAIN CONTROL	adequate	adequate
RESP	RESPIRATORY PATTERN	reg unlabored	RRR
	BREATH SOUNDS	CTA	CTA
	SECRETIONS	thick white	white phlegm (spit)
	O2 SOURCE/FLOW/SAO2	RA	RA
	VENTILATOR SETTINGS	Trach (Trach Dc'd 1500)	
CV	CARDIAC RHYTHM	NSR	NSR
	CAPILLARY REFILL	<3sec	<3 secs
	PULSES	palpable x 4 extremities	palpable X4 extremet
	EDEMA		Ø
GI	ABDOMEN	soft	Soft (incision wound)
	BOWEL SOUNDS	present	active
	BOWEL MOVEMENT	via colostomy	colostomy
	NGT/OGT	Ø	Ø
	TUBE FEDDINGS	J tube feeds @ 100cc/h	Jevity J tube 100cc/hr
	DRAINS	JP to bulb suction	JP Ⓛ to bulb suction
GU	VOIDING	foley to gravity drain (Dc'd @ 1700)	Spontaneous voiding
	COLOR/CLARITY		dark yellow
SKIN	COLOR	WNL	NFR
	INTEGRITY	abd wound c̄ dressing	abd wound dressing CDI
		L+R leg wounds c̄ dressing	Ⓛ Ⓡ legs neck
ACCESS	#1 TYPE/LOCATION/SIZE	20G peripheral IV R Arm @ 1700	Ⓛ wrist Ø erythema or swelling
	DRESSING CONDITION	20G peripheral IV L arm @ 1730	LR @ 75cc/hr
	IV FLUID/RATE	LR @ 75cc/h	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE
3 Oct 03

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

NAME: (b)(6)-4 RANK: AGE:

UNIT: GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

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

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	147/83						//	140/72						134/68						150/71						
TEMP																										
HR	91							79						83						85						
RR	21 -							18						17						17						
SaO2	97							98						97						98						
FiO2	/																									
Source	RA							RA						RA						RA						
MAP	/																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	28	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75		
IVPB	100						100																			
~~NGT~~ TF	100	100	100	100	100	100	100	100		100	100	100		100	100	100	100	100	100	100	100	100	100	100		
PO	0																									
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	100						250					300			2[illegible]			325				200				
NGT																										
STOOL												[illegible]														
DRAIN																										
Total																										

:AL RECORD-SUPPLEMENTAL MED DATA

For use of th... ..m, see AR 40-66; the proponent agency is the Offic... ...ne Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0730 INITIALS:	TIME: 2000 INITIALS:
NEURO	PUPILS	PERRLA	PERRLA 3mm brisk
	SENSORIUM	Alert, Does not follow commands	Alert, confused, Ø follow cmnd
	EXTREMITY MOVEMENT	Active	MAE x4
	SEDATION	None	
	PAIN CONTROL	Morphine	
RESP	RESPIRATORY PATTERN	Regular + Unlabored	even + unlabored
	BREATH SOUNDS	coarse	coarse crackles ē good strong cough
	SECRETIONS	Thick White	
	O2 SOURCE/FLOW/SAO2	Room Air	RA 96%
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	———	
	CAPILLARY REFILL	Cap Refill < 3 secs	cap refill < 3 sec
	PULSES	+3 in all extremeties	+2 x 4 ext
	EDEMA	(B) LE +2 edema	resolving edema
GI	ABDOMEN	soft, Nondistended	soft, round, ND
	BOWEL SOUNDS	Hypoactive	hypoactive
	BOWEL MOVEMENT	Colostomy	colostomy bag replaced
	NGT/OGT	J-Tube	J-tube (awaiting confirmation)
	TUBE FEDDINGS	Jevity @ 100 cc/hr	jevity on hold
	DRAINS	~~JP x 3~~ JP x 4 [redacted] 0800	JP x 4
GU	VOIDING	Voiding	urine urinal
	COLOR/CLARITY	Clear Yellow	
SKIN	COLOR	Normal for race	normal for race
	INTEGRITY	Midabdominal wound, (R) flank wound, Burns to (R) shoulder, BLE	mid-ab wound, (R) flank, (R) axilla/shoulder burns, (B) LE burns
ACCESS	#1 TYPE/LOCATION/SIZE	18 G PIV (R) AC	~~18g (L) AC~~ [redacted] AC PIV
	DRESSING CONDITION	C/D/I	
	IV FLUID/RATE	D5½ ē 20meq KCl @ 100cc/hr	D5/S4 infusing
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE	(b)(6)-2	

(Continue on reverse)

PREPARED BY [redacted] ...

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

DATE
4 Oct 03

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

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

UNIT: GENDER:

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

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

ICU1

Patients Name: (b)(6)-4 Date: 4Oct03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP		128/80 →					156/79				143/80					153				136/59				140/60		
TEMP		97.7 →					98.3				97.5				98	76				98.1				98		
HR		75 →					83				80					84				80				76		
RR																				18				19		
SaO2		98% →					98				96					96				96				95		
FiO2		RA →					RA				RA					RA				RA				RA		
Source																										
MAP							109				106					105				90						

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

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		200			250						260									300						
NGT																										
STOOL			300							250		50														
DRAIN																										
JP #1																										
#2																										
#3																										
Total																										

MEDCOM - 17092

...EDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FL(OW) (S)HEET

OTSG APPROVED (Date)
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals: (b)(6)-2	Time: Initals:
NEURO	Pupils		PERRL
	Sensorium	A&O unable to assess	Pt disoriented
	LOC / GCS	Purposefull movement x4	able to move all 4 extremities
		Does not follow commands	will not follow commands
CARDIAC	Cardiac Rhythm	HR- 80 BP- 151/82	HR 78
	PRI: / QRS:		
	Pulse Strength	Peripheal pulse ++ x4	+ Pulses to peripheral
	Cap Refil / JVD	Cap Refill ≤ 3 sec	pulses < 3 sec cap
	Edema	slight edema B ↓ Extremities	refill
	Chest Pain	Ø chest pain	
RESP	Respiratory Pattern	RR-28 SPO2 - 98 on RA	RR + R
	Breath Sounds	R clear L slightly wheezy	SPO2 @ 97%
	Secretions		CTA Bilat
	Cough	productive cough spontaneous	productive cough white
			frothy sputum.
SKIN	Color	Normal for Race	NFR
	Integrity	Burn near R shoulder open Abd	incision to midline abd.
	Backside	wound B lower extremity burns	healing, burn to R axillary
		Dressing CDI	area, Dressings C/D/I
IV	Access Devices	18g IV in R forearm infusing	20g to L FA c̄ 5% dextrose
	Location	D5 ½ NS c̄ 20K @ 75cc/hr	½ NS c̄ 20k @ 75cc/hr
	Condition	Flushes well.	
GI	Abdomen	J-tube infusing 100cc/hr	JP drain to R side abd x 3.
	Bowel Sounds	of Jevity.	J-tube infusing Jevity
	Stoma/Ostomy	ostomy draining brownish	@ 100cc/hr. Ostomy draining
		stool liquid	brownish liquidy stool.
GU	Device	normal	urinating via urinal
	Color / Clarity	clear yellow	clear yellow urine

(b)(6)-2

(Continue on reverse)

PREPARED BY [redacted] CJT / [illegible]

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

DATE 5 Oct 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU 3 Patients Name: [redacted] (5)(6-4 Date: 5 Oct 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP			151/82				145/77				158/80					144/72				186/69				192/87	
TEMP			98.3				97.6				98.2					98.5				97.9				98.9	
HR			80				71				78					75				82				78	
RR			28				24				28					26				24				28	
SaO2			98				98%				92					98%				97%				97%	
FiO2			RA				RA				RA					RA				RA				RA	
Source																									
MAP																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	Heplock	75	75	75	75	
IVPB	100	~~100~~																							
NGT																									
TF	100	100	100	100	100	100	100	100	100	100	100	100	1	100	100	100	100	100	100	Heplock	100	100	100	100	
PO																									
Total																									

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
URINE	(+)					225											325								
NGT																									
STOOL																									
DRAIN																									
JP #1	10cc																								
2	20cc																								
3	3cc																								
Total																									

*Pt walking with the use of walker.

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

SHIFT ASSESSMENT

	0630	TIME: 0630 INITIALS: [redacted]	TIME: 1930 INITIALS: [redacted]
NEURO	PUPILS	Perrla 3mm brisk	PERRLA 3mm Brisk
	SENSORIUM	alert	Alert, Follows simple commands
	EXTREMITY MOVEMENT	Moves all extremities	Moves independently
	SEDATION	Ø	Ø
	PAIN CONTROL	Ø	Ø
RESP	RESPIRATORY PATTERN	Reg. unlabored.	RRR
	BREATH SOUNDS	Clear Equal chest expansion	Rhonchi throughout, Clears c̄ cough
	SECRETIONS	Ø	None
	O2 SOURCE/FLOW/SAO2	Room Air	RA / >96%
	VENTILATOR SETTINGS	Ø	N/A
CV	CARDIAC RHYTHM	SR. HR 70-80"	SR, S1/S2
	CAPILLARY REFILL	≤ 3 sec	< 3 sec x 4
	PULSES	all ⊕	+2 x 4
	EDEMA	Ø	Ø
GI	ABDOMEN	Non distended Soft.	Flat, soft
	BOWEL SOUNDS	⊕	⊕
	BOWEL MOVEMENT	colostomy.	Colostomy RUQ
	NGT/OGT	Ø	Ø
	TUBE FEDDINGS	Jevity 100	J-tube, Jevity 100cc/°
	DRAINS	JP	JP
GU	VOIDING	USET URINAL	Voiding spontaneously
	COLOR/CLARITY	Yellow, clear.	
SKIN	COLOR	Normal	Normal for Race
	INTEGRITY	Surgical wound to mid abdomen	Mid Abd drsg CDI
		Burns to upper right arm and right	Burn drsg to RUE/Ⓡ Upper chest CDI
		Side of chest. Burns to left lower leg	
ACCESS	#1 TYPE/LOCATION/SIZE	IV left arm	PIV Ⓛ FA
	DRESSING CONDITION	LR TKO	CDI
	IV FLUID/RATE		LR 75cc/°
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE
6 OCT 03

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

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

UNIT: GENDER:

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

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

DA FORM 4700, MAY 78

MEDCOM - 17095

USAPPC V2.00

ICU1

Patients Name: [redacted] (5)(6)-9 Date: 6 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	151/73				132/85				141/79					136/81				134/86				119/71				
TEMP	97.6				98				98					97.5				97.6				98.6				
HR	77				70				72					70				76				69				
RR	30				27				30					24				26				22				
SaO2	97				96				[illegible]					96				97				97				
FiO2	RA				RA				RA					RA				RA				RA				
Source																										
MAP	106				109									107				~~105~~								

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	9[illegible]
IVPB							100							100				100								
NGT	100	100	100	100	100	100	100	100	100	100	100	100		200	100	100	100	100	100	100	100	100	100	100	100	120[illegible]
																	240							240		480
Total	175/175	175/350	175/525	175/700	175/875	175/1050	275/[illegible]	175/1400	175/1575	175/1750	175/1925	175/2100		275/275	175	175	415	275	175	175	175					2580

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		300/300	100/400		150/550		200/750	[illegible]/800			400/1200	100/1300					500/500				450/950			275/1225		1225
NGT																										
STOOL																										
DRAIN																										
Total													1300				500/500				450/950			275/1225		1225

2525

MI L RECORD-SUPPLEMENTAL MEDIC ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0610 Initals: (b)(6)-2	Time: Initals:
NEURO	Pupils	PERL 3mm Brisk	
	Sensorium	Alert follows commands	
	LOC / GCS	Moves all, got able to ambulate	
CARDIAC	Cardiac Rhythm	SR. HR 70-80's	
	PRI: / QRS:		
	Pulse Strength	All ⊕	
	Cap Refil / JVD	<3 sec	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	Reg 20's	
	Breath Sounds	Clear, Bilaterally Equal chest	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	Normal	
	Integrity	Surgical wound Mid Abdomen. Burns	
	Backside	(R)(L) upper arm and Rt side of chest	
IV	Access Devices	(L) hand. PIV	
	Location	(L) hand	
	Condition	Intact, Ø s/s of infect/infiltration. D5½NS + KCl 20 keel @ 75cc	
GI	Abdomen	Nondistended soft to touch.	
	Bowel Sounds	⊕ Colostomy. Bag J Tube c	
	Stoma/Ostomy	Jevity 100cc h JP x2	
GU	Device	USET 42NA1	
	Color / Clarity	Yellow clear.	

(b)(6)-2

PREPARED BY (Signature) [redacted] 1LT/AN

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

(Continue on reverse)

DATE 10 OCT 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

DA FORM 4700, MAY 78

USAPPC V2.00

ICUS Patients Name: EPW [redacted] (b)(6)-4 Date: 70903

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	136/76				142/67				132/81																	
TEMP	98.8				98.6				98.1																	
HR	76				72				76																	
RR	22				20				24																	
SaO2	96				97				96																	
FiO2	RA				RA				RA																	
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
F	75	75	75	75	75	75	75	75	75	75	75															
PB	100						100																			
IT	100	100	100	150	150	100	100	100	100	100	100															
PO		360																								
Total	225	535	175																							

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

MEDCOM - 17098

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 23 Oct 03
Time In: 1049
Allergies: NKDA
Pre-op V/S: 145/75 90
Procedures: Skin graft donor R thigh

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1300 LR Colloid
OR Output: UOP — EBL Min
Meds/Times: 5mg Versed Sufenta 40mcg

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds — History

Time	1049	1054	1059	[illegible]
SaO2	99	100	99	100
FiO2				
Methods	RA	NC	RA	RA
RR	23	17	19	16
T	98.4			

(Vital signs chart scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 23OCT03

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

(b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

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

C-SECTIONS

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

DRESSINGS

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

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

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

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p skin graft. Maj [redacted] gave 5mg MSO4 while here. Pt SpO2 100% RA. Pt c/o little pain. Pt transferring to ICW1. Report given to Spc. [redacted]
Pt has no c/o pain SpO2 @ 100%. [redacted] CPN
(b)(6)-2

Discharge Criteria:
Date: 23Oct03 Time: 1120 PARS: 10
BP: 137/64 T: 95.6 HR: 75 RR: 18 Sa02: 100%
Pain Level at D/C (0-10):
Intake: — Output: —
Additional Data: —
Transferred To: ICW1
Report Given To: Spc [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

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

OTSG APPROVED (Date)

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

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

Date: 11/17/03
Time In: 1010
Allergies:
Pre-op V/S: 150 80 - 76
Procedures: STSG RLE + debridement

OR Intake: Crystalloid 1600 cc Colloid
EBL min
OR Output: UOP
Meds/Times: 2mg morphine

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

History

Pre Op Meds

Time	1010	1015	1025	1035	1050	1105
SaO2	98	94	100	96	99	98
FIO2						
Methods	RA	RA	RA	RA	RA	RA
RR	21	21	15	11	11	10
T	96				98.3	
Time						
Pain (0-10)						
LOS						

(Vital signs graph, scale 20–240)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
10:10	RL	300	(L) Arm		150

Labs:

X-rays:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

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

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/17/03

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

[redacted] ...ed or written entries give: Name — last, first, middle; ... or medical facility)

(b)(6)-4

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

Previous edition is obs[olete]

WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)

DA FORM 4700, MAY 78

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1040	5	morphine 4mg	SQ/IV			
					(b)(6)-2	

NEUROVASCULAR

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

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, 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 1010	(R) LEG	ACE, Kerlix	⊘
30' 1040	(R) LEG	ACE + Kerlix	⊘
60' 1110	(R) LEG	ACE + Kerlix	⊘
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

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

WAMC OP 173-E

NURSING NOTES

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

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

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

1055: Pt remains calm. No bleeding from dressing noted.

1105: Pt discharged to [illegible], reporting pain & CT movement. Pt to stay in bed for three days.

Discharge Criteria:
Date: 11/17/03 Time: 1110 PARS: 10
BP: 133/71 T: 96.5 HR: 68 RR: 20 Sa02: 98
Pain Level at D/C (0-10):
Intake: 1100 cc Output: ⊘
Additional Data:
Transferred To: TCW 1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Rec
Charge Nurse Signat

(b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — A

2. MTF LOCATION (State or Country Code.)

3. REGISTER NUMBER: 9 10 11 12 13 14 15

NAME (Last, First, Middle Initial): EPW # unknown Iraqi civilian

4. PAY GRADE: 16 17 — EPW

5. SEX: 18 — M

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25

7. AGE AT ADMISSION: 27 28 29 — 5 6 Y

8. RACE: 30 — X

9. ETHNIC BACKGROUND: 31 — 9

RELIGION: (b)(6)-4

10. LENGTH OF SERVICE: 32 33 34 — —

ETS: —

11. FMP: 35 36 — 99 / 20

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

ORGANIZATION (Active Duty Only): —

13. MARITAL STATUS: 46 — Z

HOUR OF ADMISSION

BRANCH / CORPS: —

14. FLYING STATUS: 47 48 49 — —

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

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

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

18. MOS: 64 65 66 67 68 69 70 — —

19. TRAUMA: 71 — 0

PREV. ADMISSION: YEAR — NO ☑ — ازالة ورقي

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

WARD: ICU1 — Dr. order 4256 — عسكري / مدني

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

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

21. TYPE OF DISPOSITION: 73 74 — 0 5

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

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

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

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

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

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

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

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

FOR LOCAL USE

DX S/P STSG to abd.

Dx: 88102, 86813, 8750, 86131, 86354, E9912

Px: 4673, 8622, 5472, 8628, 311

(b)(6)-2

ADMITTING (Signature, as required): Dr.

SIGNATURE OF ADMITTING CLERK

DA FORM 3985 MAR

MEDCOM - 17103

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER:
2. NAME (Last, First, MI): EPW #
3. GRADE: EPW
4. SEX: M
5. AGE: 18
6. RACE:
7. RELIGION: —
8. LENGTH OF SVC: (b)(6)-4
9. ETS: —
10. PREVIOUS ADMISSION: NO
11. EMP: 20
12. SSN:
13. ORGANIZATION: —
14. WARD: ICW 2
15. FLYING STATUS: —
16. RATING/DSG: —
17. DEPT./BEN: K78
18. BRANCH/CORPS: —
19. UIC/ZIP: —
20. TYPE CASE: WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER
22. HOURS OF ADMISSION: 1140
23. CLINIC SERVICE: AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
25. TYPE DISPOSITION: 50
26. DATE OF DISPOSITION: 18 aug 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
27b. TELEPHONE NO.: UNK
28. DATE OF THIS ADMISSION: 16 aug 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: Baghdad
30. DATE OF INITIAL ADMISSION:
31. SELECTED ADMINISTRATIVE DATA: (b)(2)-2

☐ Check if Continued on Reverse

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:

ADMISSION REMARKS

ADMITTING OFFICER: DR.

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) foot

35. Total Days This Facility

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

36. Total Days All Facilites

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

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

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

PMH ⊖

PSH - ⊖

ALLERGIES [illegible]?

PHYSICAL EXAMINATION

WDWN

NECK - BITE MARK CONTUSION (R) SIDE OF NECK

CHEST - NT

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

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

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

(1) GSW (R) FOOT

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

(b)(6)-2

SIGNATURE OF [redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	16 AUG 03		

PATIENT [redacted] *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
# [redacted] (b)(6)-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

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

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

REGISTER NO. | WARD NO.

[redacted]

EPW

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

X-ray Foot

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Aug03 1720	B/P 125/70. HR 72 Resp 14 POX 99 VSS. Pt A10X3.
	follows commands. S1 S2 Auscultated. NSR. Lungs
	CTA Bilaterally equal. BS Present X4 quads.
	peripheral pulses +2 pedal +2. GSW (R) foot.
	Dressing CDI IV (L) FA CDI. NO C/O pain
	at this time [redacted] RN
1830	Pt A+O, follows commands + gestures. 2+ pulses all
	extremeties, S1 S2 Ø murmur, LSCTA, resp reg,
	unlabored, VSS. 18G (L) FA intact Ø S/Sx infection
	Bandage CDI to (R) foot. Voiding via urinal
	sufficient amts. Plan to monitor until
	ward bed available. [redacted] LTAN
17AUG03	Old IV site leaking 18G started (L) wrist
0030	Pt sleeping Ø C/O pain. will monitor. [redacted] LTAN
Ø83Ø	Pt awake A+OX3, VSS HR 67; RR 17; B/P 117/66; O2 100%;
	Temp 98.Ø, ⊕ Periphial Pulses + Pedal Pulses, Skin turgor
	brisk, Cap refill <3secs, DRSG C/D/I, free of s+s of
	infection, (R) [redacted] wrist restraint removed for breakfast
	than placed back on, Pt resting in bed. SPC [redacted] 91WM6
1145	Pt Voided 55Øcc clearyellow urine. 91WM6 [redacted]
1830	Assumed care @ 1815. VSS. pt sitting up in bed
	c̄ HOB ↑ to 45°. see Assessment on back [redacted]

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

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

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

EPW # [redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

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

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

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03	1000 Received report. See [illegible] worksheet for initial assessment. 0900 VSS. Afebrile. Dr [illegible] @ bedside, orders received. [illegible] 1530 Dr. [illegible] @ bedside, orders received. [illegible] cast placement [illegible]
18 Aug 03 1700	Transferred from ICU 2. VSS. Lung sounds clear. BS x4. GSW to lateral portion of Ⓡ foot. Dressed c̄ Band-aid. Will continue to monitor. [redacted]
8.19.03 0026	Pt. care assumed @ 2100. VSS. Pt. has ∅ complaints. Ⓡ LE cast intact. Pt. c̄ ⊕ sensation, ⊕ ROM, brisk cap refill toes Ⓡ LE. Will cont. to monitor. [redacted]
19 0530 Aug 03	Nursing Note: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA Ⓑ. Abd soft, nontender, s̄ distention. BS ⊕ x4. Voids spontaneously. [illegible] and neurovascular intact to all extremities. ROM limited to Ⓡ ankle 2° cast; however, neurovascularly intact. IV to Ⓛ hand/wrist, secured c̄ tape. IV flushes well s̄ s/s infection. [redacted]
19 Aug 03 1555	DC'd to EPW camp @ 1545. VSS. X-rays, meds and discharge summary c̄ pt. [redacted]

(b)(6)-2

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

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT
(Patient)

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED

(b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

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

TRANSPORTATION TO FACILITY

SEX: M

AGE: 18

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: NO

ALLERGIES: Benzolyn

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO
IS THIS AN INJURY?		X
INJURY/SAFETY FORMS		

WHEN *(Date)*

WHERE

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1030

INITIALS: SJ

VITAL SIGNS

TIME	1030				
BP	143/66				
PULSE	89				
RESP	18				
TEMP	98.6				
WT					

LAB ORDERS

✓	CBC/DIFF		ABG		PT/PTT	
	URINE C&S		UA MSCC/CATH			
	BLOOD C&S X					

	BHCG/URINE/BLOOD/QUANT
X	CHEM:

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1130	Perscrip lab		1130		
1130	Xray @ foot				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

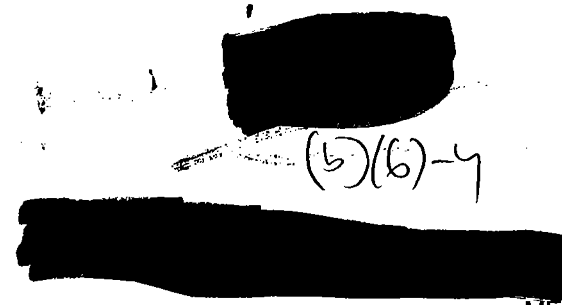
TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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



EMERGENCY CARE AND TREATMENT ***(Patient)***
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

18 y/o Iraqi male aerovac. Presents with GSW to Ⓡ foot 4 days ago EPW c/ HX ØM Lungs clear

PMH Ø
PSH Ø
FH Ø

O. Right foot edema tons DP 2+ able to flex & ext foot unable to move toes 2° pain

neck purple mark Ⓛ side Ⓛ thigh bite ecchymosis - renal [illegible]

A. GSW Ⓡ foot

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

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
8/15/03		2000	Pt was c/o pain in (R) foot prn
			Med was given
			(b)(6)-2

Continue on reverse side

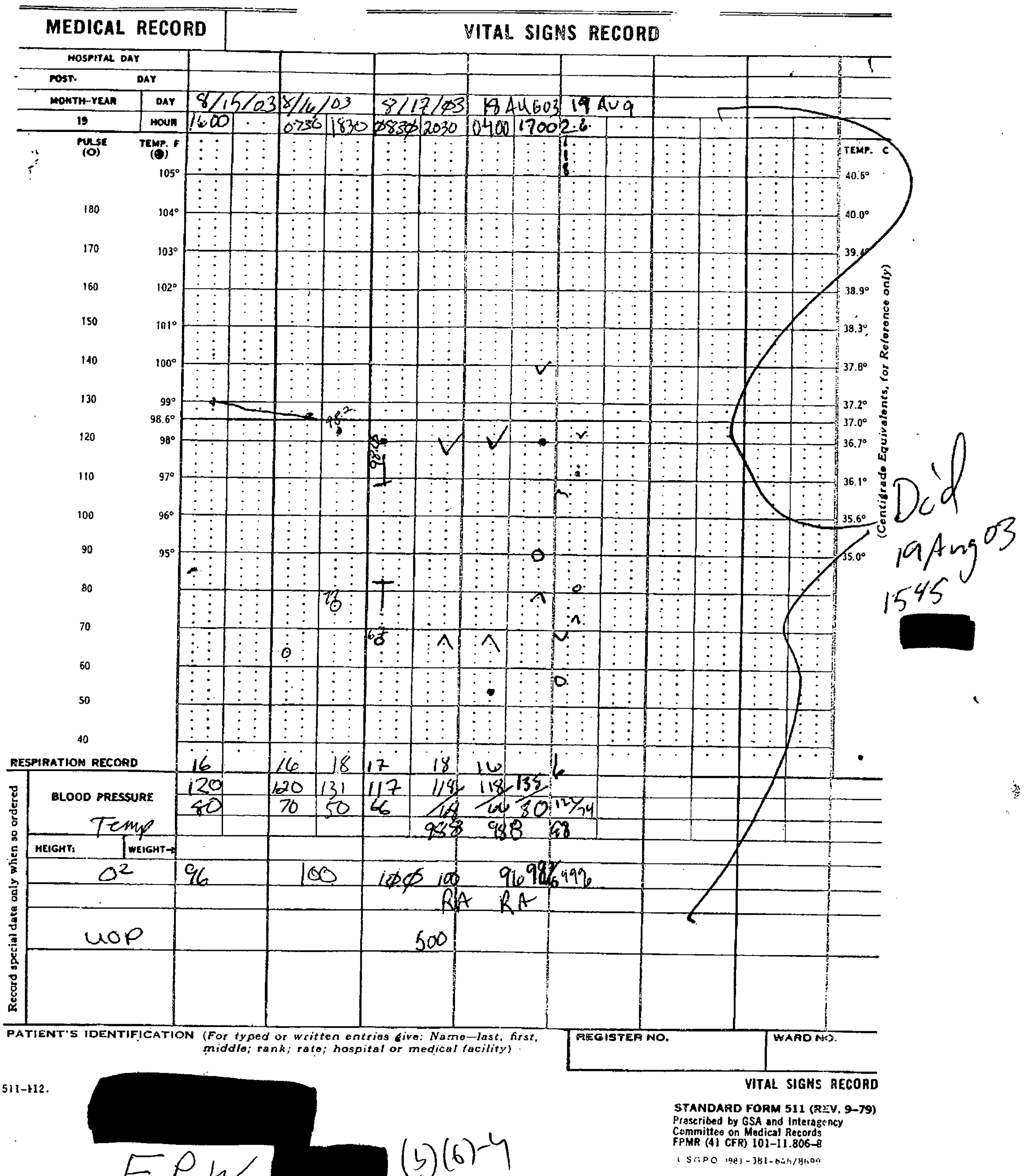
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO

WARD NO.

EPW

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



MEDICAL RECORD — **VITAL SIGNS RECORD**

HOSPITAL DAY									
POST- DAY									
MONTH-YEAR / DAY	8/15/03	8/16/03		8/17/03		18 Aug 03		19 Aug	
19 / HOUR	1600	0730	1830	0830	2030	0400	1700	2-6	
RESPIRATION RECORD	16	16	18	17	18	16		16	
BLOOD PRESSURE	120/80	120/70	131/50	117/66	114/14	118/66	135/80	124/74	
Temp					98.8	98.8	98		
O^2	96	100		100	100 RA	96 RA	98%	99%	
UOP					500				

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

TEMP. F (●) — 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

TEMP. C — 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0° (Centigrade Equivalents, for Reference only)

HEIGHT: WEIGHT→

Record special data only when so ordered

Dc'd 19 Aug 03 1545 [redacted]

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

REGISTER NO. WARD NO.

511-112.

[redacted]

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

VITAL SIGNS RECORD

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

U.S.G.P.O. 1981-381-646/8699

MEDCOM - 17113

ICU1 Patients Name: EPW [redacted] (b)(6)-4 Date: 18 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	114/68						113/72																			
NBP																										
TEMP	98.6																									
HR	75						80																			
RR	74						14																			
SaO2	98%						96%																			
FiO2	RA						RA																			
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF																										
IVPB					50																					
NGT																										
PO			240				300																			
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							800				600		1400													
NGT																										
STOOL																										
DRAIN																										
Total													1400													

(b)(6)

ID: [redacted]
WB

16-08-03
10:54

			Patient Limits	
WBC	7.6	x10^3/uL	4.5	10.5
RBC	5.19	x10^6/uL	4.00	6.00
Hgb	15.1	g/dL	11.0	18.0
Hct	46.8	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	277.	x10^3/uL	150.	450.
LY%	26.7	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4 16 Aug	TIME 1036	SSN/PSEUDO SSN:

(I-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST RESULT REF

```
======= PICCOLO =======
16/08/03              10:51
REFERENCE RANGE: (b)(6)-4 MALE
PATIENT #:
GENERAL CHEMISTRY 12
DISC LOT #:     (b)(6)-2 3142AA4
OPER #:         DR #: 000
SERIAL #:
..........................
ALB    3.8    3.3-5.5    G/DL
ALP    69     26-84      U/L
ALT    29     10-47      U/L
AMY    56     14-97      U/L
AST    39*    11-38      U/L
TBIL   1.0    0.2-1.6    MG/DL
BUN    12     7-22       MG/DL
CA++   9.8    8.0-10.3   MG/DL
CHOL   134    100-200    MG/DL
CRE    0.7    0.6-1.2    MG/DL
GLU    100    73-118     MG/DL
TP     8.4*   6.4-8.1    G/DL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE: 16 Aug 03	LAB ID NO.:

(b)(6)-2

MEDICAL RECORD | CONSULTATION SHE[illegible]

REQUEST

TO: Ortho

ity) Cd Me

DATE OF REQUEST: 16 Aug 03

REASON FOR REQUEST (Complaints and findings)

Gunshot wound to right foot

(b)(6)-2

PROVISIONAL DIAGNOSIS

Gunshot wound right foot

DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

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

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

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

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

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

CONSULTATION SHEET
Medical Record

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
15 Aug 03 1600		Keflex 500 mg po qid	
		Percocet 1 tab po q 4 to 6 H PRN for pain	
		Diet: Regular. As tolerated.	
		Dr [redacted]	
NURSING UNIT [redacted] / ROOM NO. (b)(2)-2 / BED NO.		(b)(6)-2	8/15/03 1600 [redacted]

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ___ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ___ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ___ HOURS	
(b)(6)-4 [redacted] EPW			
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 17118

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	18 AUG 03	1140	HOURS	
	TO ICU-2 [illegible]			
1	ADMIT ICW 2 [illegible]			
2	DX: GSW (R) FOOT			
3	CONDITION [illegible]			
4	VS Q SHIFT			
5	[illegible]			
6	ELEVATE (R) FOOT			
7	REGULAR DIET			
8	HEP LOCK			
9	TYLENOL 650 mg P.O. Q 4 hrs prn			
10	PERCOCET 1-2 P.O. Q 4-6 hrs prn			
11	ANCEF 1 gm [illegible] Q 8 hrs			
12	CIPROFLOXACIN 500 mg P.O. BID			
	Noted @ 1430			

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER	HOURS
	18 Aug 03	1015	HOURS
	[illegible] to ICW 2		
	[illegible] same orders		
	[illegible]		
	(b)(6)-2		

NURSING UNIT | ROOM NO. | BED NO.

249 V5 [illegible] AN 8 19 03 0032

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

* U.S. GOVERNMENT PRINTING OFFICE: 1986—409-924

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/15	8/16
	-----	Cephalexin 500mg po qid	07	X	0730 AS
	-----		12	X	
	-----		17	1620	
	-----		22	2200 CRN	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW

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.

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
8/15		Percocet 1 tab PO q 4-6 (Pain)	8/15/03 2000 [illegible]													
	(5)(6)-2															

☆ U.S.G.P.O.: 1985 - 491-003/43119

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19
16Aug03		Condition Stable	06				
			18				
16Aug03		VS Q Shift	06				
			18				
16Aug03		Elevate (R) Foot	06				
			18				
16Aug03		Regular Diet	06				
			18				
16Aug03		UP ADLIB per	06				
		EPW protocol	18				

DC'd 19Aug03 1545

(b)(6)-2

(b)(6)-2

ALLERGIES: [X] YES [ ] NO
Benzolyn

PRIMARY DIAGNOSIS: GSW (R) Foot

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO
PAGE NO: ______

PATIENT IDENTIFICATION:
EPW

(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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ______ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----	Admit to ICU	DC'd 19 Aug 03 1545			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
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USAPA V1.00

CLINICA[illegible] EUTIC DOCUMENTATION CARE PLAN (*MEDICATIONS*)

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

Mo. ____ *Yr.* ____

VERIFY BY INI[illegible] — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

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

(b)(6)-2

(b)(6)-2

ALLERGIES: [X] YES [ ] NO — Benzolyn

PRIMARY DIAGNOSIS: GSW (R) foot

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO

PAGE NO. ____

PATIENT IDENTIFICATION: EPW # [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* — TIME/DATE DISPENSED					
16Aug93	[redacted]	Tylenol 650mg	Date time					
(5)(6)-2		Q4° prn	Dose init					DC'd 19Aug93 1545
16Aug93	[redacted]	Percocet 1-2 Tab	Date time	16Aug 1945	17Aug 2110	[redacted]	18Aug 1730	
		PO Q4-6°	Dose	II	II	[redacted]	II PO	
				(5)(6)-2				[redacted]

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): A / / D / [shaded]

2. MTF LOCATION (7–8) (State or Country Code.): I Z

3. REGISTER NUMBER (9–15): [redacted]

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

4. PAY GRADE (16–17): EPW

5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD) (19–26):

7. AGE AT ADMISSION (27–29): 0 1 8

8. RACE (30): Z

9. ETHNIC BACKGROUND (31): Z

RELIGION: unk

10. LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 1140

BRANCH / CORPS: —

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): K 7 8

16. ZIP CODE OF RESIDENCE (53–61):

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

18. MOS (64–70):

19. TRAUMA (71): 9

PREV. ADMISSION — YEAR: — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0 (b)(2)-2

WARD: ICW#2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: unk

[redacted] MEDICAL TREATMENT FACILITY: Baghdad

21. TYPE OF DISPOSITION (73–74): 5 0

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (YYMMDD) (81–86): 0 3 0 8 1 8

24. CLINIC SVC - ADMITTING (87–90): A F A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (YYMMDD) (97–102): 0 3 0 8 1 6

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

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION (YYMMDD) (111–116):

FOR LOCAL USE:

DX: 8920
8760
E9712
E9065

Px. 8628 (X2)

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

SIGNATURE OF ADMITTING CLERK:

DA FO[redacted], MAR 89

USAPPCV1.0

MEDCOM - 17126

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER: [redacted]
2. NAME (Last, First, MI): EPW [redacted]
3. GRADE: N/A
4. M
5. unk
6. RACE: Z
7. RELIGION: unk
8. LENGTH OF SVC: N/A
9. N/A
10. PREVIOUS ADMISSION: No
11. FMP: 9920
12. SSN: [redacted]
13. ORGANIZATION: N/A
14. WARD
15. FLYING STATUS: N/A
16. DSG
17. BEN: K78
18. BRANCH/CORPS: N/A
19. UIC/ZIP: [redacted]
20. TYPE CASE: WIA

ADMISSION REMARKS

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER C
22. HOURS OF ADMISSION: 2315
23. CLINIC SERVICE: AAJA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk
25. TYPE DISPOSITION: ~~50~~ 41
26. DATE OF DISPOSITION: 16 Aug 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk
27b. TELEPHONE NO.: unk
28. DATE OF THIS ADMISSION: 16 Aug 03

ADMITTING OFFICER

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

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel to head

Dx 873.9
E991.9

Trauma 9 Inj 569

35. Total Days This Facility

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

36. Total Days All Facilites

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

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

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647 ... MEDCOM - 17127 ... IS OBSOLETE

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	

2. MTF LOCATION (State or Country Code.)

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15

NAME (Last, First, Middle Initial) (b)(6)-7
EPW

4. PAY GRADE

16	17

5. SEX

18
M

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29

8. RACE

30
Z X

9. ETHNIC BACKGROUND

31
9

RELIGION: Unk

10. LENGTH OF SERVICE

32	33	34

ETS: N/A

11. FMP

35	36
2	0

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS

46
u

Z

HOUR OF ADMISSION: 2315

BRANCH / CORPS: N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63
I	Z

18. MOS

64	65	66	67	68	69	70

19. TRAUMA: BC

71

PREV. ADMISSION
YEAR
[X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
Ø

C (b)(2)-7

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: Unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

21. TYPE OF DISPOSITION

73	74
~~5~~	~~Ø~~

4

22. MTF TRANSFERRED TO

75	76	77	78	79	80

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

81	82	83	84	85	86
Ø	3	Ø	8	1	6

24. CLINIC SVC - ADMITTING

87	88	89	90
A	A	J	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

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

97	98	99	100	101	102
Ø	3	Ø	8	1	6

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104
I	Z

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: Shrapnel to head

(b)(6)-2

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

SPC, 9/6/10

MEDCOM - 17128

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: [redacted]
2. NAME (Last, First, MI): EPW [redacted]
3. GRADE: NA
4. SEX: M
5. AGE: 55
6. RACE: UNK
7. RELIGION: UNK
8. LENGTH OF SVC: NA
9. ETS: NA
10. PREVIOUS ADMISSION: NO
11. FMP: 99
12. SSN: [redacted]
13. ORGANIZATION: NA
14. WARD: ICU
15. FLYING STATUS: NA
16. RATING/DSG:
17. BENEF: (b)(6)-4 NA
18. BRANCH/CORPS: NA
19. UIC/ZIP:
20. TYPE CASE: NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from Emt
22. HOURS OF ADMISSION: 0147
23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
25. TYPE DISPOSITION: 50
26. DATE OF DISPOSITION: 9/15/03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
27b. TELEPHONE NO.:
28. DATE OF THIS ADMISSION: 8/18/03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]
30. DATE OF INITIAL ADMISSION:
31. (b)(6)-2

ADMISSION REMARKS

ADMITTING OFFICER: (b)(6)-2 Dr. [redacted]

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

I & D (L) HIP WOUND

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF MEDICAL OFFICER: [redacted]

SIGNATURE OF R...: FOR [redacted]

(b)(6)-2

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

55 EPW sustained shrapnel to (L) flank
[illegible] (L) lung [illegible]
[illegible] wound [illegible]
[illegible]

PHYSICAL EXAMINATION

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

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

[illegible] shrapnel to (L) flank
[illegible] Admit/ Explore wound [illegible]

S[redacted]	DATE 18 MAY 03	IDENTIFICATION NO.	ORGANIZATION
P[redacted] typed or written entries give Name last, first, [redacted]le; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

(b)(6)-2

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Aug 03	Received report earlier from ongoing shift. Pt in bed resting.
0820	Afebrile VSS from the previous shift. IVF D5.5 20K @ 75cc/hr
	Pt was reported to have mild respiratory difficulty but in
	NAD. MD aware. Ordered CXR + (L) pelvic x-ray today.
	Continue c̄ current POC. H.L. IV ______ [redacted] Maj/AN
1000	Pt taken to X-ray for chest + pelvic via gurney. Tolerated
	procedure well. ______ [redacted] Maj/AN
1300	Pt c/o shortness of breath + c/o fatigue. Noted to
	have SOB on ↑ activity i.e. OOB. Hands + leg edema
	noted. MD made aware. Ordered Lasix 20mg IVP
	and started Digoxin 0.25 mg q day. First dose
	given @ this time. On examination noted (R) JVD.
	Continue on O2 3L NC, sat 91-93%. Continue
	to monitor status closely. ______ [redacted] Maj/AN
1430	Pts foley put out 725 cc clear yellow urine from
	1300-1430 and continue to drain. ______ [redacted]
1700	Continue to put out large amt of urine. Pt remain
	in bed resting for most of the day. States feeling
	better. O2 sat @ 96% c̄ 2L NC. Colace supp
	put on hold 2° patients SOB ō getting out of bed today.
	______ [redacted] Maj/AN
2350	RT note: Pt awake Pre tx HR 97, RR 22, SPO2 97 on 4L NC. UD
	Alb given via aerosol mask. Post tx HR 103, RR 24, SPO2 97-99%
	BBS CTA c̄ slight diminished at bases. ______ Sgt [redacted]
26 Aug 03 0540	RT note: Pt panting requests water. Breathing labored SPO2 96% on 4L
	RR 28, HR 100. Water given pt calming. UD Alb neb given. BBS coarse
	↓ @ bases. Post tx HR 109, RR 32, SPO2 98%. ______ Sgt [redacted]

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
24 Aug 03	Ø distress noted @ present time. Will cont.
2010 cont.	to monitor. [redacted]
2206	Pt. resting in bed c̄ eyes closed. Ø distress noted.
	SpO2 94%. RR 22. Easily aroused. Will con[redacted]
	monitor.
0002	Pt. resting c̄ eyes closed. Easily aroused. Sp[redacted]
	RR 27. Will continue to monitor.
0211	Pt. resting in bed s̄ discomfort voiced. Ø distress noted
	@ present time. SpO2 95%. Will continue to m[redacted]tor.
	[redacted]
0454	Pt. resting in bed s̄ distress. SpO2 94%. W[redacted]tinue
	to monitor. [redacted]
25 Aug 03	Progress Note
	Patient s̄ complaints
O2 sat on	afebrile
4L	[illegible] soft NTTP [illegible]
94%	(+) small [illegible]
	[illegible] soft
(Art [illegible] / VBT [illegible])	WBC ↑ 28 69% Segs c̄ 6 Bands 14% mono (+) target cells
	Hb ↓ 12 Ck 9201

(b)(6)-2

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

DEPART./SERVICE | MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/99)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

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

PROGRESS NOTES

DATE	
26 Aug 03	Pt started on Dobutamine Drip @ 5mcg/kg/min.
1603	ABG + VBG done 30 mins after. Results shown to
	Drs [redacted] and [redacted]. Dobutamine Drip DC'd @ 1550
	and pt placed back on 4L NC. Sats 96-98% RR 25-30s
	Breathing remains fast + labored. [redacted]
26 Aug 03	Nursing: Pt started on 1L NS bolus @ 1605. ABG + VBG
1809	results shown to Drs [redacted] [redacted]. Pt Typed + Crossed
	for 2u PRBC. Pt having occasional multifocal PVCs
	since Dobutamine drip started. Dr. [redacted] notified,
	no new orders written. Report given to night shift
	nurse. [redacted]
1830	Recieved report from off going nurse. Pt. resting in bed
	s̄ complaints @ present time. Two UPRBCs ordered. Noted
	labored breathing @ this time. Edema noted [redacted]
	extremities.
2018	Blood Transfusion started @ this time. B/P 100/64
	Pulse 83 Temp 97.5 Ø reaction noted. Will m[redacted]
2023	BP 103/63 Pulse 109 Temp 97. Ø Reaction noted @ present
	time. Will continue to monitor for S/Sx of adverse
	reaction. [redacted]
2028	BP 111/65 Pulse 117 Temp 97.4 SpO2 98%. 2LNC. Ø adver[redacted]
	reaction noted. [redacted]
2033	BP 96/57 Pulse 112 Temp 97.4 [redacted]
2038	BP 103/54 Pulse 110 Temp 97.3. Ø adverse reaction noted.
	Will continue to monitor for S/Sx of adverse reac[redacted]

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
26 Aug 03 0740	Nursing: BP 92/69, MAP-77, HR-119, R-37, T-97.2, sats 96% on RA. See ICU flowsheet for nursing assessment. Pt ~~assisted~~ assisted up to BSC. (+) flatus. Pt had ~~[illegible]~~ 0755 small smear of BM. Pt sat up on BSC x 30 mins. Sats 96-98%. Moderate amount of serosanguinous drainage noted from mid-abdominal incision. Pt assisted back to bed c̄ assistance from 0800 5 staff members. Pt unable to bear weight on legs and c/o feeling tired. Foley to gravity, voiding >100cc/hr. Dr. Jeyoir notified of pt's lab results and current condition. Ø new orders written @ this time. [redacted] RN
26 Aug 03 1240	Nursing: (R) subclavian cordis c̄ swan catheter inserted by Dr. [redacted] (b)(6)-2 PA 53/17, PCWP-27. Swan catheter 47cm @ hub. CXR done @ 1230. Swan catheter secured c̄ Op Site and tape. HOB ↑ 45°. Dr. [redacted] attempting A-line. [redacted] RN
26 Aug 03 1414	Nursing: (R) radial A-line secured c̄ tape. Swan + A-line ~~[illegible]~~ 1417 leveled + zeroed per protocol. ABG + Venous Gas drawn and shown to Dr [redacted] (b)(6)-2 C.O. calculated to be 3.4 based on Fick formula. [redacted] RN
26 Aug 03 1450	Nursing: Pt placed on 100% NRB, sats 100%, RR 26. ABG + VBG done. Results shown to Drs. [redacted] RN

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27Aug03 0510	Resting in bed. C/o Stomach pain. No complaints voiced Will monitor. (b)(6)-2
27 Aug 03 0830	Nursing: VSS, afebrile. See ICU flowsheet for VS and nursing assessment. Sats 95-97% on 4LNC. RR-28-33. Respirations less labored. Lungs CTA. A-line and PA line ~~levelled~~ (b)(6)-2 0842 levelled and zeroed. Waveform sharp. Aline and (R) IJ cordis c̄ Swan catheter patent + intact. ∅ S/S of infection noted. PIV Heplock in (R) AC. Patent to flush s̄ S/S of infection. Pt had large black tarry stool. Sent to lab for Guiac. Hemoccult Positive. Dr. (b)(6)-2 notified. Serial CBCs ordered. Bath and foley care completed. Moderate amount of serosanguinous drainage noted from mid-line abdominal 0855 ~~[illegible]~~ incision and incision in LLQ. Incision 0857 ~~[illegible]~~ sites cleaned c̄ NS and abdominal dressings applied. Pt refusing to eat. Pt highly encouraged to drink ensure for nutrition. Pt sleeping quietly @ this time s̄ complaints. /and
27 Aug03 1121	Nursing: Sats 98%, RR 20. Respirations regular and unlabored while pt sleeping. /an
27 Aug 03 1259	Nursing: Pt had large black tarry stool. Pt cleaned and repositioned in bed. Pt refusing lunch but drinking ensure + water. Hgb - 8.1 Hct - 26.7. 1300 Attempted to locate Dr (b)(6)-2 or (b)(6)-2 s̄ success. Message left to have either MD notify ICU

(1999) BACH

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
26 Aug 03	B/P 105/60 Pulse 111 RR Temp 97³. ∅ adverse
2049	reaction noted. Will monitor.
2114	2nd Unit of PRBCs started @ present time. BP 112/56 Temp 97²
	Pulse 108 ∅ adverse reaction noted. Will monitor.
2127	B/P 109/49 Pulse 109 Temp 97² ∅ adverse reaction
	noted @ present time. Will monitor.
2136	B/P 111/61 Pulse 107 Temp 98°. ∅ adverse reaction noted
	@ present time.
2200	2nd unit of PRBCs completed s̄ adverse reaction. Will
	continue to monitor.
27 Aug 0001	2nd Alb/Atr tx given HR 106 RR 28 SpO2 95% on 4L NC
	BBS Clear and ↓ Bases
0009	Alb. tx @ this time. Pt. resting s̄ complaint. 1BM this am;
	moderate amount of semi-solid brown stool noted. Will
	continue to monitor.
0120	Resting in bed s̄ complaint. ∅ distress noted. Will
	continue to monitor.
0347	BM x 1 moderate semi-formed stool. Resting in
	bed c̄ eyes opened @ present time. ∅ acute
	distress noted, will monitor.

(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 (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FFMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27AUG2003	Pulmonary / Critical Care
08^30	50 year old Iraqi male s/p ex-lap and pulmonary
	embolism. Improvement in dyspnea overnight. Had bowel
	movement → reported as melena with ⊕ guaiac
	106/65 98.3 90 28 4L NC PA - 48/17
	General: able to speak in full sentences
	LUNGS: CTA(B)
	CV: RV heave nl S1 S2
	Ext: 2+ edema
	(Labs) Albumin 2.6 ALT-164 53/1.3 149 7.54/26
	371) 8.6 ⟨ 109 / 28.4 AST-69
	T. Bili-1.7
	(28 bands)
A/P	① Neuro → awake, alert talks with interpreter. Less dyspnea
	② Pulmonary → lower PA pressures, still requiring 4L NC.
	Chronic pulm HTN with development of PE post op
	making pulm HTN difficult to manage. Needs
	Greenfield filter in the face of PE and GI bleed
	③ GI → melena with Hct unchanged after 2 units
	✓ serial CBCs. Will need to stop Lovenox of
	pressors. Will not use. Vasodilators in face of GI bleed at this time.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | SPONSOR'S ID NUMBER

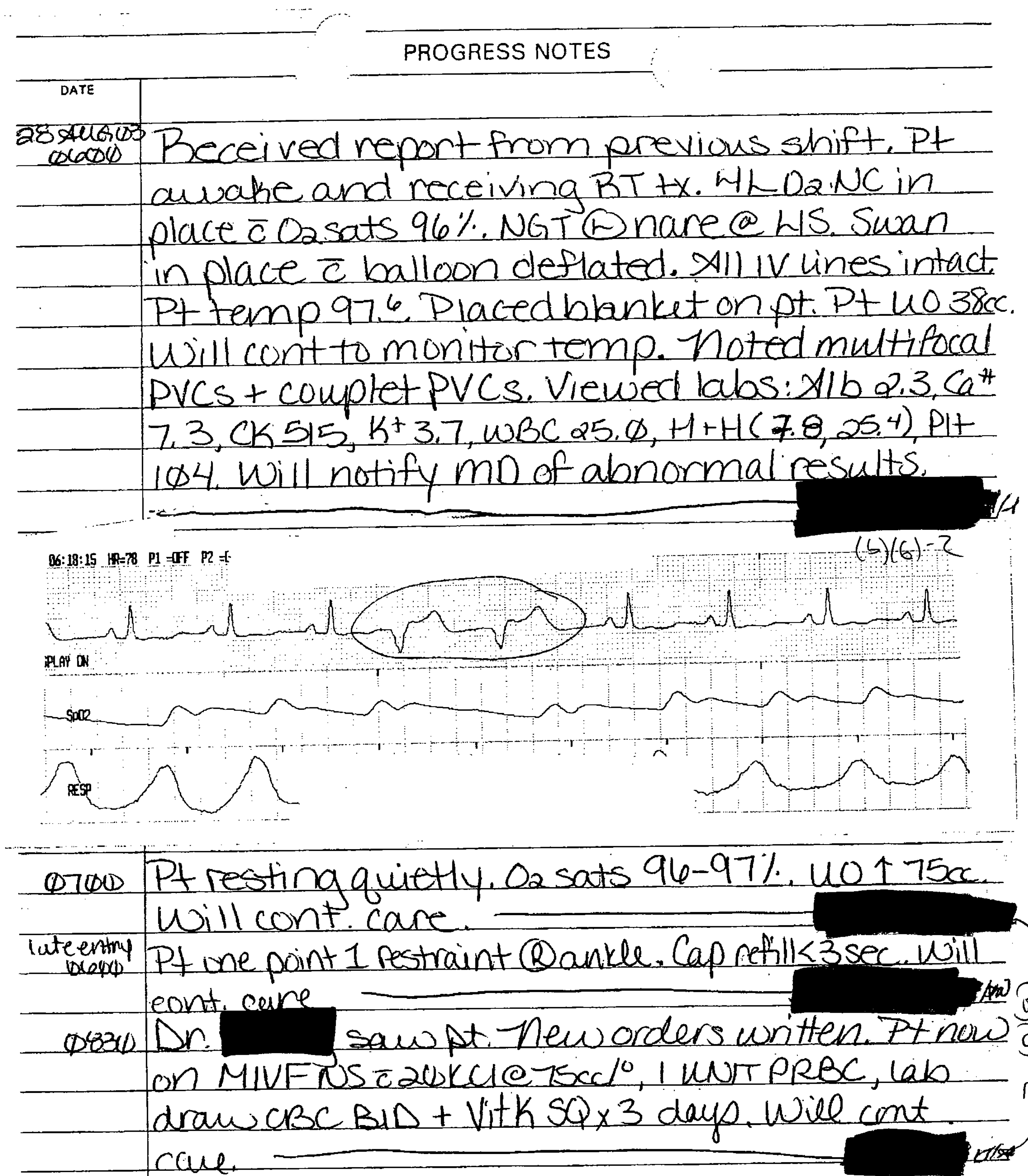
DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

(b)(6)-2

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

EPW-

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



PROGRESS NOTES

DATE	
28 AUG 03 0600	Received report from previous shift. Pt awake and receiving BT tx. 4L O_2 NC in place c̄ O_2 sats 96%. NGT (L) nare @ LIS. Swan in place c̄ balloon deflated. All IV lines intact. Pt temp 97.6. Placed blanket on pt. Pt UO 38cc. Will cont to monitor temp. Noted multifocal PVCs + couplet PVCs. Viewed labs: Alb 2.3, Ca# 7.3, CK 515, K^+ 3.7, WBC 25.0, H+H (7.8, 25.4), Plt 104. Will notify MD of abnormal results. [redacted]

0700	Pt resting quietly. O_2 sats 96-97%. UO ↑ 75cc. Will cont. care. [redacted]
late entry 0600	Pt one point 1 restraint (R) ankle. Cap refill<3sec. Will cont. care. [redacted]
0830	Dr. [redacted] saw pt. New orders written. Pt now on MIVF NS c̄ 20 KCl @ 75cc/°, 1 UNIT PRBC, lab draw CBC BID + Vit K SQ x 3 days. Will cont care. [redacted]

(b)(6)-2

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

MEDICAL RECORD	(b)(6)-2 PROGRESS NOTES
DATE	
27 Aug 03 1500	Nursing: Dr. [redacted] notified of ↓ H/H. Pt made NPO and started on PO ~~protonix~~ Prilosec. EKG done per MD orders. [redacted]
27 Aug 03 1626	Nursing: Pt had large black tarry stool. Stool shown to Dr. [redacted] (b)(6)-2 + [redacted]. Pt cleaned up + repositioned in bed. HOB ↑ 45°. Plan to do NG lavage. [redacted]
27 Aug 03 1706	Nursing: 16Fr NG inserted via (L) nare s̄ resistance. Lavaged c̄ 180cc of Sterile Water. Suctioned back 180cc of clear fluid c̄ small brow particles. ∅ blood noted. NG set to LIS per Dr (b)(6) [redacted]. ∅ further lavage required per Dr [redacted]. NG secured. Interpreter @ BSD to explain procedure to pt and provide ~~to~~ support during procedure. 1709 [redacted]
28 Aug 03 [illegible]	Pt asleep. Pre tx HR 76, RR 16, SPO₂ 98% on 4LNC, UD Alb neb given via face mask. Post tx HR 78, RR 20, SPO₂ 98-100%. BBS CTA but diminished @ base, Pt taking shallow breaths — Sgt [redacted]
28 Aug 03 [illegible]	Pt awake. Pre tx HR 78~87, RR 20, SPO₂ 98% on 4LNC. BBS diminish 2° shallow breathing. UD Alb neb given HR-76-86, RR 18-22, SPO₂ 98-100% on 4L NC. — Sgt [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.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
28 AUG 03 1800	Pt resting quietly. O2 sats 98% on 4L O2 via NC. Gave report to night shift. Will cont. care. [redacted]
28 Aug 03 1800	Received report from day shift. Pt appears to be sleeping comfortably in bed foley to gravity NG tube to Ⓛ Nare (clamped) Cordis to Ⓡ IJ, A line to Ⓡ radial ⊕ flush, zeroed. 4L NC sats @ 98% Will continue to monitor. [redacted] SPC, 91WM6
2110	Dr [redacted] (b)(6)-2 requested NG tube be removed. Pt tolerated removal of NG tube well, VSS will continue to monitor. [redacted] SPC, 91WM6
29 Aug 03 0100	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] SPC, 91WM6
29 Aug 03 0500	Pt resting comfortably in bed, VSS. Will continue to monitor. [redacted] SPC, 91WM6
29 Aug 03 0716	Nursing: VSS, afebrile. See ICU flow sheet for nursing assessment. ∅ respiratory distress noted. RR 20s, sats 98% on 4L NC. ∅ SOB. Skin warm + dry. Ⓡ IJ Swan intact. Proximal ports x 2 and cordis line all patent. Swan 47cm
(b)(6)-2	[redacted] 0724 @ hub. PA leveled and zeroed. Waveform slightly dampened. Ⓡ radial A line intact, leveled + zeroed. Waveform sharp. Mid-line abdominal + LLQ dressing c/d/I. Dressing to Ⓡ buttock intact. Receiving NS c̄ 20KCl @ 75 cc/hr infusing through cordis line. BLE elevated. Pt tolerating PO fluids and jello s̄ N/V. [redacted]
29 Aug 03 0950	Nursing: Swan DC'd by Dr. [redacted] Cordis remains in place. 40 meq KCl PO given. ∅ complaints voiced @ this time. [redacted]

(b)(6)-2

STAN[redacted] 1) BACK USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE									
28 AUG 03 0958	Started 1 unit PRBC. Unit # 1435937. [redacted]								
	1003	1008	1013	1018	1033	1048	1103	1118	1140
NIBP	102/71	118/69	116/67	105/69	115/61	122/67	112/63		
A-line	134/71	146/74	127/66	137/69	125/70	133/72			
temp	98.3	98.3	98.3	98.3	98.3	98.1	97.9		
pulse	75	74	74	76	76	85	76		

1115 - transfusion completed s any difficulties.

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

1300 Pt resting comfortably c̄ no complaints. Wet lips periodically due to dry mouth. Maintain NPO status. O_2 sat 97-98%. 4L O_2 NC. Will cont. care. —— [redacted]

1535 Completed bed bath. Noted dark tarry stool small amt. Pt able to move + hold up body to side c̄ little assistance. Pt O_2 sats remained in 96-98%. Completed foley care + D/C'd IV (R) AC due to infiltration. Δ'd drsg mid abd. Staples in place and wound proximal c̄ little S/S of infection. Wound (L) flank scant amt brownish fluid. Placed abd pad on wound. Will cont care. —— [redacted]

1555 Clamped NGT per Dr. [redacted]. D/C'd nebs. Plan to D/C swan + have pt OOB tomorrow. [redacted]

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | PROGRESS NOTES

DATE 28AUG03

0830

Internal medicine

No events overnight. Resting comfortably with ↓ PA pressures

Prilosec — 116/66 97.9 P-76 18 100%-4L NC UO ✓

Albuterol — General: Resting comfortably and alert

Atenolol — LUNGS: CTA ⊖

Zosyn — CV: ⊕ ventricular heave

Digoxin — EXT: 2+ edema

25 > 7.8 / 25.4 < 104   123 / 103 / 32 / 3.7 / 19 / .9 / 120

A/P ① GI bleed → Hct 28-25 past 24hrs + 2 dark stools. Will transfuse 1unit. Give Vit K x 3days for nutritionally deplete. Prevacid PO. If more aggressive bleeding consider endoscopy but high risk given cardio status Reverse clot

② CV → ↓ PA pressures, less dyspnea. Swan out tomorrow. Hopefully with ↓ PA pressures clot resolving. Hemodynamics improved despite GI bleed

(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.

(b)(6)-4

PROGRESS NOTES

Medical Record

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

LAST NAME	NAME	MI. INITIAL	ID NUMBER

DATE	NOTES
29 Aug 03 1858	Received report from off going nurse. HC exchanged via off going nursing. Pt. c/o pain to scrotum area. Will notify MD of complaint. ⊖ actual distress noted. Will continue to monitor for s/sx of distress. Sgt [redacted]
2020	c/o pain from urethra area. BM x 2 black tarry stool noted. Dr. [redacted] (b)(6)-2 notified. Tylenol ordered for pain. Will continue to monitor. S[redacted]
2048	Pt. resting c̄ eyes closed. RR 17 ⊖ distress not[ed]. Will continue to monitor. Sg[redacted]
2200	Pt. cont to rest c̄ eyes closed. ⊖ distress noted @ present time. VSS. Will continue to monito[r] Sgt [redacted]
0004	Pt. lying in bed c̄ eyes opened. c/o pain. Explained to pt that it was too early to get more pain medication. ⊖ distress noted. VSS. Will monitor. Sgt [redacted]
0200	VSS. Pt. resting in bed c̄ eyes closed. Easily aroused. RR 15 + even. ⊖ distress noted @ present time. Will continue to monitor. Sgt. [redacted]
0401	⊖ complaints voiced @ present time. Thick white secretion noted to penial. Dr [redacted] (b)(6)-2 inform earlier of discharge from penial area. ⊖ orders noted for problems. VSS. ⊖ distress noted. SpO2 100%. Will monitor. Sgt [redacted]
0501	Pt. alert & oriented. Resting in bed c̄ eyes open ⊖ complaints. Will monitor. Sgt [redacted]

(b)(6)-2

STANDARD FORM 509 (REV. [redacted])

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29 Aug 03 1330	Nursing: UOP 18-20 cc/hr. Attempted to locate Dr [redacted] ̄s success. Message given to Dr [redacted] 1337 about low ~~UOP~~ UOP, no new orders written @ this time. Bath completed, foley care done. Attempted to flush ~~UOP ̄s success~~ foley ̄s success. Will continue to monitor. [redacted] /RN
29 Aug 03 1511	Nursing: Dr [redacted] (b)(6)-2 notified of ↓UOP. Ø new orders written. Bath completed, foley care done. Pt had small smear of black tarry BM. Pt assisted up to chair. BLE elevated on stool. Dressings Δ'd at mid abdomen and LLQ. Small amount of serosanguinous drainage noted on midabdominal dressing. Moderate amount of serosanguinous drainage noted on LLQ dressing. Will continue to monitor. [redacted] /RN
29 Aug 03 1826	Nursing: Pt c/o pain and pointing to foley. UOP remains 5cc/hr. Foley DC'D. Catheter obstructed. Pt voided ≈500cc of amber urine prior to foley insertion. New ~~foley~~ 1828 16Fr Catheter inserted. Pt cleaned and repositioned in bed. Report given to oncoming nurse. [redacted] /RN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

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

(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 Aug 03	Internal medicine
0815	Pt resting comfortably OOB yesterday did well
Prilosec 20 QD	168/96 70 27 74 98% 4L NC
NS 75cc/hr	General: asleep, awake interactive yesterday
Vit K 10 QD	Lungs: CTA ⊕
Atenolol 50 QD	CV: RRR ⊗ ventricular lose
Zosyn 3.375g q6°	Ext: ⊕ edema
Digibind .25	Abdomen: ex lap healing
	(Labs:) albumin - 2.2 ALT - 53 135/4.5 | 105/24 | 25/.6 109
	AST - 69
	143 > 9 < 88 / 29
A/P	① Neurologically → awake/alert doing well
	② CV: → ↑ BP today. Add low dose ace inhibitor if BP > 150. Titrating Dig/Atenolol
	PA catheter pulled yesterday
	③ Pulm → ↓ PA. Doing much better. Will wean O2 as tolerated
	④ Ex lap no current issues
	(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EPW (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

PROGRESS NOTES

DATE	
31 Aug 03 0900	Pt up on the chair, tolerated transfer by pivoting. A-line and foley D/ced @ this time. Thru the interpreter explained POC to pt. to include increase activities and to void w/in 8 hours. ——— [redacted] Maj/AN
1115	Pt up to gradually ambulate per PT, unable to tolerate @ this time. Returned to bed to rest. Will try again today. ——— [redacted] Maj/AN
1500	Pt remain in bed, awaken from sleep. Cte reach VSS, voided 200 cc clear yellow urine post foley discontinuation. ——— [redacted] Maj/AN
31 Aug 03 1845	Pt sitting up in bed c̄ feet hanging off the side, SpO2 94-95% @ O2 1L via NC. Pt helped to lie down & one point restraint in place. Will cont. to monitor. ——— [redacted]

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

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
30 Aug 03	Nursing: A-line positional. Able to draw blood
1814	back by repositioning A-line. Aline remains intact.
	Report given to night shift. — [redacted]
1800	Received report from day shift. Pt resting
	comfortably in bed VSS afebrile Pt on 2L NC
	sat's @ 97%. Will [redacted] cordis to (R) IJ
	(+) flush. NS c̄ 20 KCL @ 75 cc/hr. Foley to gravity
	draining minimal amounts of clear yellow
	fluids. Will continue to monitor. —
(b)(6)-2	[redacted] SPC, 9/WM6 —
2200	Pt resting comfortable in bed. VSS. Will
	continue to monitor. [redacted] SPC, 7/WM6
31 Aug 03	(0100) Pt sleeping in bed, VSS, ∅ c/o [illegible] Will continue
	to monitor. — [redacted]
	(0300) [illegible] Tylenol given @ 0230 for pain c̄ good effect. Pt
	now sleeping again. VSS. — [redacted]
	(0500) Pt sleeping in bed VSS, ∅ Δ's from above [redacted]
0700	Received report from ongoing shift, pt asleep but
	in no apparent distress. VSS.
0745	Pt up on the side of the bed for breakfast. Able
	to tolerate getting up c̄ one assisting. Breathing
	better, remain on O2 2L NC, sat 97%. Afebrile VSS.
	Plan: Increase activities gradually — [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.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

PROGRESS NOTES

DATE	
01SEP03	(2300) Pt sitting in bed, VSS, Ø c/o pain. Zosyn given IVPB. will continue to monitor [redacted]
02SEP03	(0115) Pt uses QS to urinal, Ø c/o pain, resting in bed. VSS, will continue to monitor. [redacted]
	(0300) Pt's VSS, Ø c/o pain sleeping in bed [redacted]
	(0600) Gave report to day shift. [redacted]
2 Sep 02 0600	report received from night shift patient's condition stable resting c O2 per NC, peripheral IV in L hand patent + intact [illegible]
2 Sep 02 1100	pt stable, IV heplocked, BM x 1 small amount of black tarry stool voiding in adequate amount 300-400 cc. bearing weight c assistance ambulating c assistance + walker, strength improving everyday [illegible] ward [redacted] AN

(5)(6)-2

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

(5)(6)-4

MEDICAL RECORD	PROGRESS NOTES

DATE	
	(b)(6)-2
01Sept03	(0600) Pt care Report Received from SA [redacted] Pt ∅ ?noted Reported acute episodes. [redacted] ?ums
01Sept03	(0645) ↑ CHAIR for Breakfast. ?assist ↑ active ROM/transfer. Supports weight c̄ standing/pivoting. To commode for eating for ?q Block. Tray stool Dangling @ Bedside for care. [redacted] ?ums
(0830)	Back to Bed s̄ incident. [redacted] ?ums
(1130)	To chair for lunch. Remains active c̄ transport. [redacted] ?ums
(1300)	Back to Bed s̄ incident. [redacted] ?ums
(1700)	PIV 18g to (L) post Hand by Maj [redacted] Pt s̄ Adverse effects noted. [redacted] ?ums
(1715)	(R) Coding D/C per Maj [redacted] Pt c̄ ∅ noted/Reported adverse effects. NS c̄ 20K to (L) Hand PIV via pump s̄ incident. [redacted] ?ums
(1745)	To CHAIR for dinner s̄ incident. [redacted] ?ums
(1900)	Pt in bed for BSC eating. Pt consumed 95% of meal. VSS. will continue to monitor. [redacted] ?ums
(2100)	Pt resting in bed. Urine QS clear/yellow ∅ clots. will continue to monitor. [redacted] ?ums

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
23Aug03(0645) cont.—	tolerated 1L so went to RA. Pt would stay around 93%. Had occassional drops down to 88%. Around 0600 bumped pt up to 0.5L. Sats dropped down to 90-94%. Put pt on 1L ; sats up to 98%. Tolerates well. Pt getting very hungry. Wants food. Straightened sheets on pt. ØBM. Circulation & movement ✓ good beyond restraints. [redacted] TIAN (b)(6)-2
23 Aug 03	Progress Note Patient is hungry this AM — Abx # 2 Zosyn NO other complaints weaned to 4L NC — Lovenox → Therapeutic dose
Gr 11.8	afebrile overnight abd soft nontender CXR fluid (R) fissure ? vs pneumo ing. NO Δ in current course Repeat CBC [redacted] (b)(6)-2 ...en.
24 Aug Ø3 Ø630	RT note: BBS CTA but diminished @ bases pt breathing shallow. UD Alb neb given HR-72-79, RR 22-26, SpO_2 97-99, on 2 L NC + 6 L nebs. [redacted]

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

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

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

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Aug	(0800) Assessment complete-(noted); report received; pt Alert, responsive; MAO. 2LNC SAT 98% ———
	(1200) no change in assessment; no new POC ———
	(1400) no @ OS for assessment; new abs noted; no change in POC ———
	(1700) 500NS over 2° per MD 4mg dA & ordr
23Aug03 (2150)	Received report from offgoing shift and assumed care of pt @ 1915. Pt's NS bolus was just finishing. Pt c/o pain in lower abdomen. Very minimal drainage from foley. Abdomen hard and painful to press on. Tried to irrigate foley. Wouldn't irrigate. Took out foley. Tip clogged. Pt voided some before foley replaced. Another foley inserted sterile. Adequate drainage. Pt not c/o lower abd. pain. Washed pt's perineum and back. Δ'd sheets. Applied petroleum gauze c̄ tegaderm over top to skin breakdown of Ⓡ buttocks/hip. HOB elevated. See DA Form 4700 for assessment data. Pt resting. Had to Δ out pulse ox for better readings. Pt does have periods of sleep apnea. ——— AN
24Aug03 (0550)	Pt has done OK throughout the shift. Pt still having periods of apnea. Recovers quickly. Still on 2L oxygen NC. Pt states that he is dying. VSS. Abx infused. Blood drawn @ 0425 and walked to lab. Pt has had 2 point restraints Bilateral ankles. Circulation and movement intact. Pt has been restless throughout the night. Foley draining adequately. LT/AN

(b)(6)

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17AUG03 0130	554.0. IRAQI EPW ADMITTED from EMT for shrapnel wounds [redacted] to (L) hip-flank. [Neuro] AOx3, moves all extremities c̄ pn to LLE when moved. OU 4-5mm brisk. (+) sensation throughout. [RESP] RR 20-24, SPO2 ~99% RA, CTA throughout. Even bilat. ↑↓. [CV] S1S2 HR 50-100's, SB. to NSR 3+ pulses c̄ CR <3sec throughout. [GI/GU] Flat, soft, tender abd to LLQ, LUQ upon palpation. BSx4 - hypoactive. U/O via Foley c̄ 500cc upon admit - cyu. φ BM. [Lines] 18g (R) hand + (L) hand c̄ LR TKO @ this time. [INteg] (L) femur/thigh/flank - dark blood seeping from wounds. Drsngs covering - drainage ↓ since arrival [POC] Exlap + F/O wounds. —— CPT [redacted]
0240	TO OR. —— CPT [redacted]
0415	PT returned from OR - VSS - SPO2 95% RA - pt put on O2 6LPM for SPO2 ~90% when sleeping - CPT [redacted]
0500	PT sleeping in bed c̄ FM 6L to obtain SPO2 ≥95%. Drsngs to (L) iliac crest area, (L) flank, ABD midline. HR SB - Asymptomatic. Pt denies pn + Able to communicate needs via English + gestures. See PACU recovery sheet for VS. ♀ Cont to monitor. ADV to CLD for a.m. meal —— CPT [redacted]

(b)(6)-2

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

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

REGISTER NO.

WARD NO. ICW

[redacted] EPW

(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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03	Pt resting c eyes closed. A+O x 3. HR 58; O2 100%; B/P
0730	124/65; Temp 98.6; RR 16; Clear yellow urine draining to
	foley; LR @ 150ml/hr. DRSG to (L) Hip C/D/I free of
	s+s of infection. Cap Refill 0 x 4 extremities <3 secs.
	Skin turgor brisk. PERLA. SPC [redacted] 91WM6
0800	HR 69; BP 128/71; O2 100%, 15 RR SPC [redacted] 91WM6
0915	Emptied foley; foley @ 300ml. SPC [redacted] 91WM6
1055	Emptied foley; foley @ 300ml. SPC [redacted] 91WM6
1900	T: 99.4 B: 130/68 HR: 70 RR: 28
2000	T: 99.8 B: 132/70 HR: 74 RR: 28 urine: [redacted]
2000	Nursing Note: Pt. is A+O. (L) side of
	lung c Rhonchi, (R) lung is clear. Hypoactive
	BS x 4 quad. Dsg to ExLap is
	D+I. Dsg to (L) flank area c drainage
	noted. Ø complaints of pain.
	Palpable pulse x 4, cap refill <3 sec x 4,
	Foley to gravity c clear + yellow
	urine. IV to (R) hand patent. IV to (L)
	hand c LR @ 150cc/hr. will continue
	to monitor. CPT [redacted]
2100	T: 99 BP: 131/69 HR: 69 RR: 24
2200	T: 99.2 BP: 130/66 HR: 70 RR: 26 urine: 100cc
2300	T: 99 BP: 133/67 HR: 62 RR: 24
2400	T: 98.2 BP: 134/67 HR: 63 RR: 22 urine = 100
01	T: BP: 130/70 HR: 69 RR: 20
02	T: 98.4 BP: 129/68 HR: 64 RR: 20 Urine 100
(03):	T: 98.2 BP 136/70 HR 70 RR: 22 (04): T: 98.4 BP 137/72 HR: 74 RR: 20
	(05): T: BP: 134/72 HR: 64 RR: 20 (06): T: BP: 142/66 HR: 97 RR: 22 urine: 100

STANDARD FORM 600 (REV. 6-97) BACK

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/18/03	Progress note
2148	Called to see patient for ↓ O2 sat 78% on RA
	placed on 10L FM c̄ ↑ 92%
	RR - 18 shallow
	Tachycardia 110
	No complaints of pain
	Lungs poor inspiratory effort
	but (B) breath sounds upper 1/2 lung.
	ē wheezing
	UOP marginal
8/19/03	Pt resting breathing pattern slightly labored pre tx
0332	HR 93 SPO2 98% on 8L Non-rebreather Mask BBS Diminished Post tx
	HR 93 SPO2 98% on 6L Non rebreather BS No change — Sar[redacted] RT
0338	325cc orange color urine from Foley — [redacted]
190530 Aug 03	Nursing Assessment: Assumed pt care. AAOx3. Airway intact, breathing shallow and
	tachy. Sating 97% on 6L per nonrebreather mask. LS Clear to upper fields (B) but significantly
	diminished to bases during deep breathing. Abd soft, tender to palp near midline incision and drsg
	to (L)LQ. BS⊕x4 but hypoactive. Tolerating CL diet. Drsg to midline incision has serosang shadowing
	to superior most 1½ inches. Remainder of drsg is CDI. Drsg to (L)LQ is CDI. Foley to gravity
	draining clear amber urine at ≈30cc/hr. Pt is currently on cardiac monitor c̄ pulse 80-100 bpm

(b)(6)-2

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

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

REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
190530 Aug 03	Nursing (continued): HR is irregular, c̄ sporadic PVCs, and what appears to be excess p-waves. No widening of QRS interval or atrial flutter/fib noted. FROM and neurovascularly intact to all extremities. IV of NS c̄ 40K @ 125 to (R) hand. HL to (L) hand. Both run well and are s̄ s/s infiltration or phlebitis. ——— [redacted]
0807 19 Aug 03	Pt vitals pre tx HR 97 SpO2 94% on 5LNC BBS clear Diminished in Bases UD Alb tx given Post tx HR 100 RR 22 SpO2 96% on 5LNC ——— SG [redacted] 91V2X
190600 Aug 03	Nursing LATE ENTRY: Pt 98% per mask (non-rebreather) @ 6L O2, ↓ to 4L per NC ——— [redacted]
190730 Aug 03	Nursing LATE ENTRY! Pt 95% per NC c̄ O2 @ 4L. Pt [illegible] of this time. ——— [redacted]
19 Aug 03	1420: Assumed care @ 1300: VSS. Telemetry on SR @ 97 c̄ PVCs, O2 Sats: 93% on 4L/NC. NS @ 125cc/h infusing in (L) FA. Abd large, ~~nontender~~ nontender BS x4. Drsg to midline abd, CD&I. Drsg to (L) iliac crest CD+I. Trace edema noted in lower extremities. c/o pain in abd. 4mg MSO4 IV given. Will continue to monitor. ——— [redacted]
2208	Pt. care assumed @ 2100. VSS, patient sats 92%-95% on 6L O2 via NC. HR irregular, monitor shows occasional PVC's, Lungs CTA throughout, resp are unlabored. ABD rotund, soft c̄ hypoactive BS x2. ML ABD incision c̄ staples OTA s̄ s/s infection. (L) flank incision c̄ sutures OTA s̄ s/s infection. LR infusing s̄ diff to (L) hand. Will cont. to monitor. ——— [redacted]
[illegible]	[illegible]
[illegible]	[illegible]

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Aug 03	Pt resting c̄ eyes closed. Awakens upon
0730	stimuli. VSS. Mid ABD wound DRSG C/D/I.
	Pt ate 70% of Breakfast. Will continue to
	monitor throughout shift. SPC [redacted] 91WM6
0845	Pt complained of stomach pains. Pt was given
	3mg MSO4 for pain. SPC [redacted] 91WM6
0930	Urine output 75ml Amber urine. SPC [redacted] 91WM6
1215	Urine output 125ml Amber urine SPC [redacted] 91WM6
1510	Urine output 100ml Amber urine. SPC [redacted] 91WM6
1430	Pt complained of pain, was given 3mg MSO4.
	SPC [redacted] 91WM6
	Pt nauseated during shift was given 4mg Zofran
	by CPT [redacted] for Nausea: SPC [redacted] 91WM6
1800	Pt voided 75cc Amber Urine. NS @ 200cc/hr. SPC [redacted] 91WM6
18Aug03	Assumed care @1900, transfered from ICU 2. VSS. Stage
	2 decubitus ulcer noted on buttocks. Other breakdown
	beginning on back and buttocks. Dressing to Ⓛ Flank
	saturated c̄ serousanguinous drainage - reinforced c̄ additional
	gauze. SL in Ⓡ hand. LR @125cc/hr infusing in Ⓛ
	hand. Foley patent - draining tea-colored urine
	Will continue to monitor. [redacted]

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REGISTER NO.	WARD NO.

[redacted] EPW

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2134	Pt. sats 78% RA. Pt. placed on 10L face mask, sats ↑ 91% c̄ encouraged deep breathing. MD aware. ——— [redacted]
214ϕ	RT note: Pt breathing shallow but even ≈ 18-2ϕ BPM. HR 9ϕ-11ϕ. Pulse is irregular to palpation. BBS CTA. Pt now on 1ϕ LSM sat 91-93. UD Alb given. Post tx HR 93-118 RR 2ϕ. SpO_2 93 on 8L SM. Will IS c̄ good effort + able to follow simple commands. — Sgt [redacted]
2327	MD @ BS by 2145. CXR PA, lat obtained EKG obtained CBC, chem 8 drawn and sent. Neb tx done by RT. Pt placed on monitor. 5mg Lopressor given IVP, 20mg Lasix IVP. MD @ Bedside. ABG drawn and sent. Pt. O_2 ↓ 8L, O_2 sat 97%. Dr [redacted] into Δ dsng to Ⓛ flank. Pt. alert, slightly diaphoretic. Will cont to monitor. [redacted]
19 Aug ϕ3 ϕϕ1ϕ	RT note: Pt resting awakes to gentle stimuli breathing shallow RR 24, HR 1ϕϕ, SpO_2 97 on 7L SM. BBS CTA but ↓↓ 2° shallow breath. UD Alb neb via face mask given HR still irreg ≈ 9ϕ-1ϕϕ, RR 26, SpO_2 94% on 4ϕ% Venti Mask. IS c̄ great effort. ——— Sgt [redacted]
0039	Pt. c̄ HOB @ 45°. Pt sat @ 95% HR 89. Pt resting quietly. Foley → gravity c̄ dark yellow urine. HR cont to be irregular. [redacted]
0200	Pt having ↑ PVCs. BP 115/73, O_2 97% HR 88 MD aware. ——— [redacted]

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

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

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

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

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/19/04	Brief note
	Afebrile VSS [illegible]
	Advance Diet
	[illegible]
	(b)(6)-2
20Aug03	0722 Assume pt care @ 0500. VSS. LR @
	50 to (L) FA s̄ redness/infiltration. HL to (R)
FA (+) flush s̄ redness/infiltration. 2.5 L O2 via NC. [illegible]	
unreg. Lungs CTA. resp unlabored equal rise and fall	
of chest. [illegible] ML incision staples intact OTA. [illegible]	
@ (L) [illegible] OTA sutures intact. Tolerating clear liquids	
Foley to gravity c̄ CY UOP. No c/o pain or	
discomfort @ this time. Will cont to monitor	
20 Aug 03	Progress Note
	[illegible] flatus — Plan (1) Cont [illegible]
	afebrile [illegible] — x 7.20
	hypoactive but present BS — (2) Advance diet
	[illegible]
	(b)(6)-2
	[illegible]: s/p (-) [illegible] (+) [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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(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)
20 Aug 03	1505: Assumed care @ 1300. A+O. VSS, SpO_2 94-96% on 4 L O_2/NC, BS x4. No c/o pain or discomfort @ this time. Staples intact to midline abd. incision, no drainage @ this time. Incision to (L) flank intact c̄ no drainage. Trace edema to lower extremities. Will monitor for SOB and pain. ——— [redacted] LT, AN
2200	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ x4 but hypoactive (R) ↑ quad. No c/o pain or discomfort. Foley to gravity c̄ dark orange/tea colored urine. ML ABD incision c̄ staples OTA, ∅ s/s infection. Incision to (L) flank OTA, CDI. HL to (R) hand intact. Will cont. to monitor. ——— [redacted] LT, AN
2300	Pt. assist OOB → BSC x 2 person assist. Pt had scant amt. diarrhea. Pt. assisted back to bed x3 person assist p̄ becoming diaphoretic, asking for help and moaning. Pt. bleeding from wound to (L) flank. Pressure drsng applied to area where it appears pt. tore out 1 suture. Bleeding stopped c̄ dressing. Pt O_2 sats 89%, O_2 ↑ 6L to bring O_2 sats to 94-96%. VSS @ HR 98-108, BP 109/70, RR 22. Will cont to monitor. ——— [redacted]
21 Aug 03 0700	Pt awake and alert. Lungs CTA bilat, ∅ respirations. O_2 sat @ 94% c̄ 4L via NC. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Midline incision to abd CDI. Staples open to air. Drsg to (R) hip CDI. Foley draining clear yellow urine. Strong pulses and brisk cap refill x4 extremities ——— [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/21/03	Surgery (b)(2)-2
	Pt Tx'd today from [redacted] on
	Rounds to be hypoxic and Tachypnic
	VS HR ~100 SAT 86% RA
	Chest - CBTA (Ant exam only)
	ABG - 7.48 / 25.6 / 68 / 19 / -4 / 9?0 FiO2
	22 / 41.6
	CXR - No effusion poor effort
	(R) LL infiltrate
	A/P (1) Probable pneumonia
	Hypoxia, infiltrate, rule start Zosyn
	(2) Cannot R/O PE but low suspicion
	start Lovenox 80 BID
	(3) Dehydration from NPO
	[redacted]
	(b)(6)-2

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REGISTER NO. | WARD NO.

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

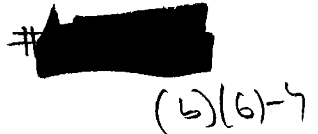
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02SEP03	(1345) Pt admitted to unit from ICU#1 via W/C in stable cond. Pt alert, speaking some English. VSS. Pt on 2L O2 per NC. ∅ C/O SOB. Pt using IS s̄ difficulty. Lungs CTA Ⓑ. ⊕ bs X4 quads. Staples to abd midline CDI - covered c̄ bandage. Pt voiding s̄ difficulty. SL in Ⓛ hand flushes well s̄ s/sx infiltration/infection. Pt tx to bed from W/C c̄ assist of walker. Tol reg lunch well. 2 point restraints in place - ∅ s/sx complications of circulation/skin break. Will cont. to monitor. (b)(6)-2 [redacted] RAW
2Sep03 @ 1920:	Pt sleeping, easily aroused. VSS O2 sat @ 97% c̄ O2 2L by NC. HOBT. resp. even & unlabored, lungs CTA Ⓑ, ⊕ bs x4 qd. +2 pulses, staples to mid-abdomen C.D.I. & covered c̄ bandage. brisk cap refill. 2pt restraints on, circulation assessed HL to Ⓛ hand flushing easily. will cont to monitor [redacted] 91WM6 [redacted]
2100	Pt c̄ some edema to extr. O2 sat 97% 2pt restraints on. circulation assessed. Will monitor [redacted] 91WM6 SPC (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
		(b)(6)-2	[redacted]

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR
		(b)(2)-2

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

REGISTER NO.	WARD NO.
	ICW 1



(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)*
03SEP03	(1225) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking sm. amount of english. VSS. Lungs CTA(B) ⊕BS x4 quads. O2 sat 96-97% on 2L O2 per NC. ∅ c/o SOB. Pt amb in room shortly c̄ assist. of walker. Pt ↑ in chair @ this time. Tol. reg diet well. Voiding s̄ difficulty. SL in (L) hand flushes well s̄ S/Sx infiltration/infection. Staples to midline abd CDI - covered c̄ 4x4 drsg. Small amount sero-sang drainage noted on old drsg. 2 point restraints in place while pt is in bed - ∅ S/Sx complications c̄ circulation/skin breakdown. Will continue to monitor. [redacted]
	(1420) Pt to BSC. Had mod amount dark brown BM - formed. Pt back to bed s̄ difficulty [redacted]
3 Sep 03 @ 1900	Pt lying in bed. HOB ↑30°. VSS, lungs CTAB, ⊕BS x4 qd. O2 sat 97%. 2L NC. resp. even & unlabored. HL (L) hand flushing easily. ∅ s/sx infection or infiltration. 2pt restraints on, circulation assessed. +2 pulses to extr. voiding adeq. c/o s̄ difficulty. Will cont. to monitor [redacted]
2100	amb. around room c̄ walker/assistance. Will monitor [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

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

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Sept 03 0830	A&O appropriately. Eating breakfast. VSS. Lungs CTA (B) Resp. even/unlabored. (+) BS x4 quads. Voiding dark amber urine per urinal. MAE. +2 pedal pulses. (B) feet c̄ nonpitting edema. Nailbeds pink c̄ ≤ 2 sec cap refill. Staples to mid abd C.D.I. c̄ packing to small opening near base of incision. ABD drsg applied. 2X2 to (L) lower quad (lateral) of abd wound. Small amount light yellow drainage. Various shrapnel wounds to back healing. Beginning redness & chafing of skin to abd skin folds & groin area. Sacral pressure point dark brown. Complete bed bath given. Will get OOB to walker for ambulation. O2 @ 2L. Sat 97% [redacted]
4 Sept 03 1600	OOB to chair. Ambulated in room then hallway using walker. Tolerated well. Will continue monitoring. O2 @ 2L NC Sat 97%-98% [redacted]
4SEP03 1947	VSS. AO. Voiding light amber urine, quantity sufficient. 2L NC @ 99%. Ambulated x1 on ward [illegible]. DSG [illegible] to abdomen. BS (+) x4. (+) pulses in all extremities. Noted redness and chaffing to [illegible] abdomen. Sacral ulcer @ stage I. [redacted]

(b)(6)

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REGISTER NO. | WARD NO.

#

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Sep 03 0700	- Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort at this time HOB elevated facilitate breathing O2 SAT 98% 2L NC. Good skin turgor. cap refill and skin color WNL Ø signs Ⓑ Edema to Bilat lower extremities. Lung CTA HRRR Active BS. Tolerating PO well. Urinating into urinal QS c̄ difficulty Will cont to monitor
	Cont. Wound to abd. c̄ dry dressing Ø drainage staple ODZ.
5 Sep 03 -	c̄ Ambulated pt. O2 SAT Prior to 98% RA. O2 NC wheeling off. walker assisted c̄ ambulation steady gait voiced being tired. instructed to deep breath. Upon completion of ambulation maintaining 94% on RA - Will cont to monitor
5 Sep Ø3	1845 = VSS O2 Sats @ 95% RA, Ø S/S of respiratory distress, LCTAB, ⊜ rise & fall of chest, Resps WNL, weaned off O2 via NC, continuing to monitor resp status closely, A+O X3 - Speaks good English to communicate needs/questions. Staples to midline Abdomen c̄ Dsg CDI over it. Dsg Δ's BID. Pt. sleeping @ present but will get pt. OOB to ambulate this evening. IV HL to Ⓛ brachial c̄ 3 way stopcock - flushed and patent c̄ good blood return. 2+ pitting edema to Ⓑ feet, 2+ pulses Ⓑ feet. Ø c/o pain. Will continue to monitor
5 Sep Ø3	1925 = feet Ⓑ elevated on rolled blanket to ↓ edema. Restraints X2 in place.
6 Sep Ø3	0530 = Dsg to abdomen wound Δ'd - CDI.

(5)(6)-2

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MEDICAL RECORD | **CHRONOLOGICAL RECORD O[...] 'CAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5Sept 03	Pulmonary / Critical Care
0845	EPW s/p ex-lap and pulmonary embolism. Walked to end
Prilosec	of hallway with walker. Resting well
Akrolol	134/72 98.6 59 [illegible]
Digoxin	General: pleasant good spirits
Colace	LUNGS: CTA(B)
Heparin 5000 SQ BID	CV: RRR
	Abdomen → small amount [illegible] incision drainage
	Ext: (-) edema
	Labs: 129 / 101 / 9 97 ; 3.8 / 21 / .9 ; 5.4 > 10/32 < 132
A/P	(1) Pulmonary → wean O2 to off. Clot resolved.
	Continue DVT prophylaxis. Long term a problem needs
	3-6 months of anticoagulation but GI bleed.
	(2) Physical therapy → continues to work well
	(3) Abdomen → small amount of drainage [illegible] following
	(b)(6)-2

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(b)(6)-4

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

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep 03	- Pt. resting in bed A+O x3 VSS Ø c/o pain or discomfort
0730	@ this time. Orders to wean off O2. SAT of 96% RA. Encouraged
	to deep breath IS @ bedside Lung CTA bilat. HRRR S1 S2 present
	Active BS tolerating PO well surgical incision to abdomen dressing
	Δ'd CDI stapled [redacted] (b)(6)-2 . Breakdown to groin area and GSW to
	(L) hip fold of abd. Will cont to monitor [redacted]
	(1045) I concur c̄ above assessment. [redacted]
6 Sep 03	Pt resting. VSS O2 Sat 94-96% RA. Lungs CTA (B),
@ 2055	resp. even & unlabored. HRRR, ⊕ BS x4 quads, +2
	pulses to all extr. 2+ pitting edema to (B) feet.
	Staples to midline c̄ 2x2 drsg covering open (b)(6)-2
	area. Ø c/o pain. voiding adequate qty. Will amb-
	ulate c̄ walker later tonight. Will cont to
	monitor [redacted]
6 Sep 03	Drsg (2x2) to abdomen Δ'd. [redacted]
7 Sep @ (0330)	temp. 102.2 ii Tylenol given. [redacted]
0550	temp ↓ to 98.3 [redacted] 6 Sep

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[redacted] (b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 Sep 03 0700	Assumed care pt A+O x3. State being tired spiked temp c sweating and chills last night temp ↓ 97.5 orally. Lungs CTA HRRR Active BS x4 quads. Tolerating PO well. Wound care dressing changed, surgical incision to abd. c staples CDI 2x2 dressing applied to site of drainage. Will cont to monitor — [redacted]
7 Sep 03 1600	- Upon accessing pt notice evidence of skin break down to his back. Redness and peeling of skin found. Dead skin removed by washing back further prevention measure taken. Resting on side @ this time. Will cont to monitor —— [redacted]
7Sep Ø3 1830	Pt sitting ↑ in bed. O2 sat 96%. VSS, lungs CTA (B) HRRR, ⊕BS x4 qds. abd incision c staples CDI. 2X2 applied to open area. Ø drainage noted. Resp. even + unlabored. Pt OOB to chair @ 1900, new linen + mattress put on bed to prevent further skin breakdown. 2 pt restraints put back on. circulation intact. Will monitor —— [redacted] 91WM6.
1900	Pt ambulated c walker s assistance. steady gait. Pt back in bed O2 sat @ 96% RA. Ø c/o SOB. Restraints on —— [redacted] 91WM6.
8 Sep Ø 0500	labs drawn —— [redacted] 91WM6
08SEP03	(1415) Assumed care of pt w/ ØØØØ p report from night shift. Pt alert, speaking some English. VSS. Ø C/O pain. Pt amb in hallway x2 this shift c min. assist of walker. Ø C/O SOB. Staples to midline abd CDI. Drsg to open area of staples Δd. Sm. amount sero-sang drainage noted on old drsg. Pt OOB to chair for 2°. Tol. well. AM care done by pt c some assist.

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
08SEP03	(cont) Pt tol reg diet well. Voiding s̄ difficulty. ⊕BM. 2 point restraints in place s̄ S/Sx complications from skin breakdown/circulation. Will cont to monitor. [redacted]
8 Sep 03 1955	Pt resting in bed, A+OX3, VSS, LS CTA (B), ⊕BS x4, T-101.4, adm 2 Tylenol tabs as per orders, dsg midline abd CDT, staples on incision ∅ s/sx of infex, ∅ c/o pain @ this time, voiding c/y urine, proper circulation & skin integrity on pts of restraint [redacted]
~~9 Sep 03~~	~~Assume care of Pt 1143 hrs, VSS, A+OX3.~~
09SEP03	(1200) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking some English. VSS. ∅ c/o pain. Pt OOB to amb in hallway, c̄ min. assist from walker. Gait steady. Dsg to staples ⊘d this am. Sm. amount serosang drainage noted on old dsg. Staples CDI. Pt tol. reg diet well. Voiding s̄ difficulty. Pt ↑ in chair @ this time. SL in (L) arc, flushes well s̄ s/sx infection/infiltration. 2 point restraints in place while in bed s̄ s/sx complications of circulation/skin breakdown. Will continue to monitor. [redacted]

(b)(6)-2

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

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

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

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

MEDCOM - 17170

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9Sep03 @ 2015	Assumed care @ 1800; All VSS, pt afebrile, A&Ox3 speaking both english & arabic; Ø c/o pain or discomfort @ this time; midline dsg to staples Δd; sm amt sero-sang. drainage on old dsg; staples intact & well approximated; pt voiding QS, clear, yellow urine s̄ difficulty; Tol diet; pt amb x1 in hallway c̄ minimal assistance from walker, pt has slow, steady gait, Ø c/o dizziness during amb; 2 point restraints in place; ⊖ skin breakdown; circ. intact. will cont to monitor
10Sep03 0630	Pt c/o being cold. Temp 103.7°F (O). Blankets removed. (b)(6)-2 x3 episodes of emesis. Pt BS x4 decreased. Dr. notified. Blood cx, urine cx, UA, cx ordered. NS 75cc/h via 20 G @ FA. — pc 91WM6
10Sep03 0600	Pt A&O c/o being tired. S_1 S_2 present RR, LS CTA (B). VSS Temp 99.1°F (O) Pt Ambul. Will continue to Monitor. — pc 91WM6
	(1530) I concur c̄ above assessment. — AD
10Sep03	1830: VSS, A+Ox3, Ø c/o pain, Sats @ FA, pt. does IS exercises well – encouraged to do every hour while awake. Ø S/S of resp. distress, LCTAB, ⊜ ↑ & ↓ movement of chest (B). Dsg to Abd wound CDI, Δ'ing BID. IV to (R) FA running NS @ 75cc/. Tolerates PO, ⊕ BS x4. Gets OOB & ambulates as tolerated. Ø other remarkable assessment findings. Will monitor — AN
10Sep03	2000 – pt. OOB & ambulated in hall x30 mins s̄ difficulty. Restraints x2 in place, extremities restrained – & skin integrity intact. — AT

(b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

MEDICAL RECORD | PROGRES[S N]OTES

DATE

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

11Sep03 0940 Pt Awake A&Ox3 LS CTA(B) S, S2 present (+) BS x4 quads. Ambulated c walker. Denies pain at this time. VSS. Will continue to monitor — [redacted] Spc 91WM6

11Sep03 1930: VSS, sats@98% RA ø s/s of respiratory distress, encouraging IS exercises Q1° while awake, Dsg Δ'ing to midline Abd BID, Dsg CDI. IV to (R) AC running NS@ 75cc/, Ambulating in hallway prn s difficulty. Verbalizes need [redacted] prn. Continue to monitor. — [redacted]

12Sep03 (1725) Assumed care of pt a) ø ø ø p report from night shift. Pt A/O, speaking some English. ø c/o pain. Pt OOB to shower this am and amb x2 in hallway this shift s walker. Pt OOB to chair for 2°. Steri strips to abd incision CDI. Dsg to (L) hip CDI - applied by MD. IVF infusing into IV in (R) ac s s/sx infection/infiltration. 2 point restraints in place s s/sx complications of circulation/skin breakdown. Will cont. to monitor. — [redacted]

(Continue on reverse side)

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

REGISTER NO.

[redacted]

(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	
12Sep03	1930 = VSS, A+OX3, Ø c/o pain, O2 sats @ 96% RA and ↑ to 98% RA after IS exercises. Encouraged IS exercises Q1° while awake. IV to (R) AC patent and running NS @ 75cc/°. Midline abdominal wound has steri-strips CDI. (L) hip Dsg CDI, being Δ'd QDay or PRN. Restraints x2. Skin integrity intact to extremities restrained. Ambulates in hall as needed. Ø other unremarkable findings. Continue to monitor. [redacted]
13SEP03	(1445) Assumed care of pt w/ Ø (illegible) p̄ report from night shift. Pt alert, speaking some English. VSS. Ø C/O pain. Pt amb in hallway X3 this shift and OOB to chair for 2°. Pt tol well. Drsg to (L) hip Δd this am. small amount yellow/green drainage noted on old drsg. Pt tol reg diet well. voiding s̄ difficulty. (+)BM. IVF infusing into IV in (R) AC. s̄ S/Sx infection/infiltration. 2 point restraints in place s̄ S/Sx complications. will continue to monitor [redacted] 2A
2000	Pt OOB to chair. VSS, Ø c/o pain. ambulated x1. IVF to (R) AC Ø S/Sx infection/infiltration. O2 sat @ 97% (RA). Ø SOB. (+)BSx4. HRRR. Will continue to monitor [redacted] 91WM6
2200	ambulated in hallway for 15 min. steady gait, Ø dizziness or SOB. OOB to chair for 1 hour. Will monitor [redacted] 91WM6

2-(9)(6)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

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

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H[redacted]

[redacted]9 (REV. 5/1999) BACK

USAPA V1.00

MA[redacted]

MEDCOM - 17174

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Sept03 [illegible]	Received pt resting in bed, VSS, OOBTC and amb x2. New IV 20g ① fa. LSCTA B, ø respiratory distress noted. Afebrile. VSS. Drsg intact. ø c/o pain. Tol po well. SVGS. ø other remarkable assessment.
14 Sep ø3 1935	Pt a/o, VSS, ø c/o pain. lungs: C[illegible] ⊕BSx4, O2 sat @ 96-97%. ø SOB ambulated in hallway for 30 min c̄ steady gait. IVF infusing into ⓛ arm ø s/s of infiltration/infection. ⓛ hip wound drsg Δ'd. ø drainage noted. 2 pt restraints on. circulation intact. Will monitor — [illegible]
15 Sept03 @ 1215	Received pt resting in bed, VSS, a+ox3, speak arabic. Amb x2, OOBTC. Steady gait and ø assist. ⊕ BM. SVGS. IVF infusing via access in ⓛ fa, 20g @ 75 cc/hr, NS. ⓛ hip wound drsg Δ'd, no s/s infection noted, serous drainage noted. Restraints per cpw protocol, ø skin breakdown or circulatory issues noted. ø other remarkable assessments or resp distress noted. Will cont to monitor.

(b)(6)-2

(b)(6)-2

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

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

REGISTER NO.

WARD NO. ICW 1

(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)*
16sep03 0245	Assumed care @ 1800; All VSS, pt SATS in constant 96-98%; pt A&O X3, Ø c/o pain or discomfort @ this time; pt ↑ OOB to chair for 2°, amb X1 in hall s̄ difficulty, slow steady gait; dsg to (L) hip CDI s̄ drainage; HL patent (+) BS x4; (+) BM x1 — Ø Δs in assessment; restraints in place; (+) circulation, Ø skin break; cont to monitor
16 Sept 03 0800	VSS alert & Oriented. OOB to BR c̄ shower tolerated well. Lungs clear BS (+) x4 quad. Abd large soft non-distended. Peripheral pulses +2. Assumed regular diet for breakfast HL P/C'd. Pt awaits d/c to EPW camp. Skin under restraint intact. (L) hip drsg changed. Will continue plan of care. LTA
16 Sept 03 1320	Escorted by MP's to transport to EPW camp. — LTA

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 17176

NSN 7540-01-075-3786

MEDICAL RECORD — EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER	TREATMENT FACILITY
RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

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

TRANSPORTATION TO FACILITY

SEX: M

AGE: 55

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			✓
FLYING STATUS			✓

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		✓
DD 2568 IN CHART		✓

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☒ NO

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

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2325

INITIALS: (b)(6)-7

VITAL SIGNS

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

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

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

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

55 yo male [illegible] c/o (L) hip pain. No c/o [illegible] [illegible] and pain.
[illegible]
[illegible]
[illegible] 112/60 [illegible]
NAD. A+O x3 [illegible] (L) [illegible] (L) [illegible] 3-4 [illegible]
[illegible]
[illegible]
[illegible]

5 mg morphine 2330 KG

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

EMERGENCY CARE AND TREATMENT ***(Doctor)***
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Aug 03		1820	EPW # [redacted] age unknown transferred for
			ICU monitoring for respiratory distress.
			according to nurse taking care of the
			patient, pt was experiencing acute
			respiratory distress. SaO2 ↓ to 90% in room
			air. Tachypneic, RR labored - rate @ 36-38
			per minute. placed on 100% NRB on ward.
			SaO2 ↑ to 99%. RR 35 breaths/min. portable
			CXR done. M.D.'s @ bedside. Lung - upper
			airway, CTA - ↓ breath sounds to
			base (R) & L. Ø coughing or wheezes
			noted. Pt received albuterol TX on
			ward. ABG obtained. ABG pH 7.485
			pCO2 25.6, PO2 68, HCO2 19, BE -4, SaO2 95%
			M.D. suspects pt may have a pneumonia
			CXR shows (R) lower lobe infiltrates.
			pt fully awake and cooperative despite
			language barrier. No signs of agitation
			or restlessness noted @ this time. placed
			pt on heart monitor. Monitor displays NSR
			rate @ 88, Ø ectopy. S1S2, Ø murmurs.
			Skin cool to touch, afebrile. Temp
			97.7°F. Ø peripheral edema noted; capillary
			refill <2 sec. Radial pulses strong and regular
			Dorsalis pedal pulses strong and equal @ 2+.
			pt able to move extremities but unable
			to raise up or turn side to side. - cont.

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

MEDCOM - 17179

(b)(6)-2

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 aug 03		1835	(R) antecubital PIV site intact. Site free of infiltration or signs of infection. Receiving 1L LR bolus for now. Foley intact - draining dark amber color urine. abd. large - non tender - c/o slight tenderness c palpation. Hypoactive bowel sounds x 4 quad. ↑ HOB to 45°. abd incision - staples intact. Incision 30 cm. Ø erythema or drainage noted on incision. Ø dressing on.
		1845	V/S HR 97, 100/68, RR 30, SaO2 99%. pt continues to be tachypneic. will need to monitor resp. status closely. pt breathing hard and warm skin dry. [redacted] 1647
		1800	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

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

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22 Aug (cont)		1400	no change in assessment status; no new orders written; CTM; SM O_2 ↓ 4L - SaO_2 97%; RR 20 — [illegible]
		1700	Pt assessed by MD; CXR in AM ordered + noted; no change in assessment — [redacted]
		1720	RT note: Pt resting awake to verbal commands, somewhat understanding. Pre tx HR 65, RR 23 SpO_2 97% on 6L SM. UD Alb tx given via aerosol mask. BBS CTA but diminished at bases. Post tx HR 70, RR 26, SpO_2 97% on 6L SM. Will continue to monitor — Sgt [redacted] 91V20
		1900	report given; pt unchanged; MAS — [redacted]
22Aug2003		2015	Pt resting in bed. Received report from CPT [redacted] and assumed care of pt @ 1915. Pt arouses easily. Even regular breathing on 4L NC. Continuous pulse ox. See OA form 4700 for assessment data. Pt asking for H_2O to drink. Swallows s̄ difficulty. NF bag s/d. Infusing s̄ problems. [redacted] 1AN
		2130	2 point leather restraints applied to (L) wrist and (R) ankle. [redacted] AN
		2400	No Δ in pt assessment. Wakes up occasionally asking for water. Good circulation beyond restraints. RT in working c̄ pt giving tx. [redacted]
		0330	Pt started dry heaving. Pt had questions. Interpreter brought in to answer questions. Pt stated not feeling nauseated just hungry. Pt stated having passed gas. Abdomen soft. [redacted] 1AN
		0645	Started weaning pts' oxygen around 0430. Pt

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

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22 Aug 03	0800		assessment complete/charted; pt alert, responsive, appropriate
			NAD; RR rate 20-25; SM placed @ 6L; SaO2
			97%; pt tolerating well; new orders noted;
			K+ run from Rx due; interpreter called to commun
			c pt; MD [redacted] (b)(6)-2 has assessed pt — [redacted]
		0900	SM @ 6L then 8L off ↓ SAT 94%; will CTM; PIV on (L)
			A/C Attempted x1; will attempt later; pt tol well — [redacted]
22 Aug	0940		Surgery
			Breathing easier still on 8L FM
			VS HR 83 Tm 95.6 106/74 98%
			UO: 100 cc/hr
			exam
			Chest Clear c sl ↓ BS @ (R) Base
			ALS 29
			LABS 13.2 / 37.7 < 107 ; 136 / 2.9 ; 103 / 24 ; 90 ; 186 ; 1.7 — ALT 626
			AP 76
			AST 1297
			A/P (1) Pneumonia improving, TB 1.2
			Clinically CXR then am
			(2) ↑ LFT prob low flow from
			yesterday will follow — [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) [redacted] (b)(6)-4

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23AUG03			[illegible]
22:20			Resting comfortably [illegible] 70
			[illegible]
			96 70 20 95/69
			General pleasant
			[illegible]
			LUNGS: CTA(B)
			CV: [illegible]
			Ext: Oedema
			Labs 136/[illegible] 25/[illegible] 7.52/29/[illegible]
		A/P	(1) Pulmonary - [illegible] dilated RV
			with ↑ pressures suggestive of [illegible] PE
			post-op day [illegible] [illegible] BID
			Slow clinical improvement. Will require 3-6
			months of anticoagulation. Difficult with
			[illegible] status
			(b)(6)-[illegible]
			[redacted]

STANDARD FORM 510 (REV. 7-91) BACK

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

MEDCOM - 17183

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			1900 21 AUG03: Assumed care for patient. PT resting in bed with HOB ↑ 30°. Assessment as follows: [N] PERRL @ 2mm; follows commands; purposeful movements; sight UE grip weak; [R] RR 30↑ (a 28-36); sats 99 on 4L facemask; auscultation reveals ↓ breath sounds in bases; ULL > URL; ⊕ Acc muscle use; ⊖ cyanosis [CV] NSR w/ occasional PVCs noted, HR 80-90, S1, S2; scant edema to Ⓑ LE; +2 pulses x4 (Ⓛ > Ⓡ; Ⓡ US Ⓛ U); ≈ 3 sec window on capfill; cool extremity [GI] distended abdomen ⊖ ~ ⊖ U; BS ⊖; [GU] moderate urine output of dark amber urine (... 75cc); [Skin] midline abd inc C/D/I with staples [Lines] PIV in Ⓛ AC running @ 125; foley; [Plan] monitor resp status; possible intubate if resp distress does not resolve; ... ; rather as ... will continue to monitor ———
			[redacted] 127,1 ———
			[redacted] (b)(6)-2
			0315 22 AUG03: Pt weaned to 6L NC; sats 97%; ↑ in activity sats ↓ to 88 w/ multiple, frequent PVCs; noticeable agitation / ↑ work of breathing with exertion (none in bed). Placed back on 10L NRB; sats 100%; PVCs continue although ↓ in frequency

(Continue on reverse side)

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

[redacted] (b)(6)-7

NURSING NOTES

Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Aug 03 0636			infusing @ 125 cc/hr. Assume care as planned. [redacted] /AN
1015			Pt drinking large amt of p.o. fluids. IVF ↓ to 75 cc/° Plan: [illegible], MD to change antibiotic to p.o. [redacted] /AN
1300			Pt wean off O_2, observe, give O_2 if Sat ↓ < 85%.
1600			OOB - BSC c̄ assistance, sat on the commode for an hour, unable to produce stools. Pt became diaphoretic. BP and SAO_2 unchanged from baseline. Pt requested to go back to bed. Returned to bed c̄ assistance, asked to rest @ this time.
1700			Pt refused to ambulate, states tired from getting out of bed & sitting on the chair, pt remained in bed, appeared to be sleeping all this time. Respiration even slightly labored but in no apparent distress [redacted] /AN
1730			pt has stage II bed sore Ⓡ buttocks approx 3 x 2 cm. Applied vaseline gauze c̄ tegaderm. Encourage turning pt occasionally or out of bed [redacted] /AN
24 Aug 03 1800		1800	Received report from Major [redacted]. Pt. alert and aware of place. 2L O_2 via NC. Staples noted to abd. Edema noted to extremities. ∅ complaints voiced. ∅ distress noted @ present time. Will cont [redacted] monitor.
2010		2010	C/o bed being uncomfortable for back. Explained that there isn't anymore beds like the ones out front. SpO_2 96% ∅ other complaints voiced.

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

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Aug 03			Progress Note
			Patient did well overnight
			ECHO completed yesterday c̄ dilated (R) A/RV
			c/w PE
			Respiratory status improved: weaned to 2L NC
			c̄ O2 Sats > 90 this am (97% @ Rest)
			Developed small decubitus ulcer
			VS HR 79 RR 21 124/76 T 98 afebrile
			abd soft + NTND
			Labs 138 / 98 / 25 ; 3.9 / 27 / 1.3 ; 138 ; 21.1 ; 11.5 / 32.3 ; 101 ; AST 243 ; ALT 367
			Imp: Stable after PE s/p stepped inj?
			& (L) thigh
			Cont anticoagulation
			Cont antibiotics @ this time, Δ to
			oral antibiotics to [redacted]
			[redacted]
			[redacted] (b)(6)-25
24 Aug 03			Received report from outgoing staff. Pt on O2 2L NC for
0630			occasional desaturation, SaO2 97-98%. Pt appears to be
			drowsy but awakens intermittently to request needs.
			Verbalizes being very thirsty, had water 100cc. Foley
			draining 750cc/hr clear yellow urine. D/F D5 .5 20K

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

NURSING NOTES

Medical Record

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

(b)(6)-2

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA wheeled litter BY CPT [redacted]

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

3. DATE 17 AUG 03 — TIME PATIENT ARRIVED IN SUITE 0300

4. PATIENT IN ROOM TIME 0300 — NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: NKA (Ancef 1gm given)

6. NURSING PERSONNEL

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

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

[ ] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

c̄ safety straps. Folded towels under heels.

COMMENTS: Correct Body Alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [X] RAZOR by CPT [redacted] [ ] CLIP

COMMENTS: No cuts or knicks noted

PREP SOLUTION *(Specify)* Beta/Beta

SITE: Abdomen-[redacted] BY WHOM: CPT [redacted]

SITE: (as below) BY WHOM:

COMMENTS: no pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES

LEGEND [redacted] X Ground Pad [redacted] Safety Strap === Tourniquet N/A [hatched] -prep

(b)(6)-2

10. COUNTS — C = Correct I = Incorrect

10. COUNTS		Initial	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No	C	C	C	SSG [redacted]	CPT [redacted]
Needle Sharp	[X] Yes [ ] No	C	C	C	"	"
Instrument	[X] Yes [ ] No	C		C	"	"
Other	[ ] Yes [X] No					

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

[redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: 4
GROUND PAD: BRAND REM Polyhesive II Valleylab
LOT NO: 68936/2005-03

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

MEDCOM - 17187

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

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

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

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

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

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

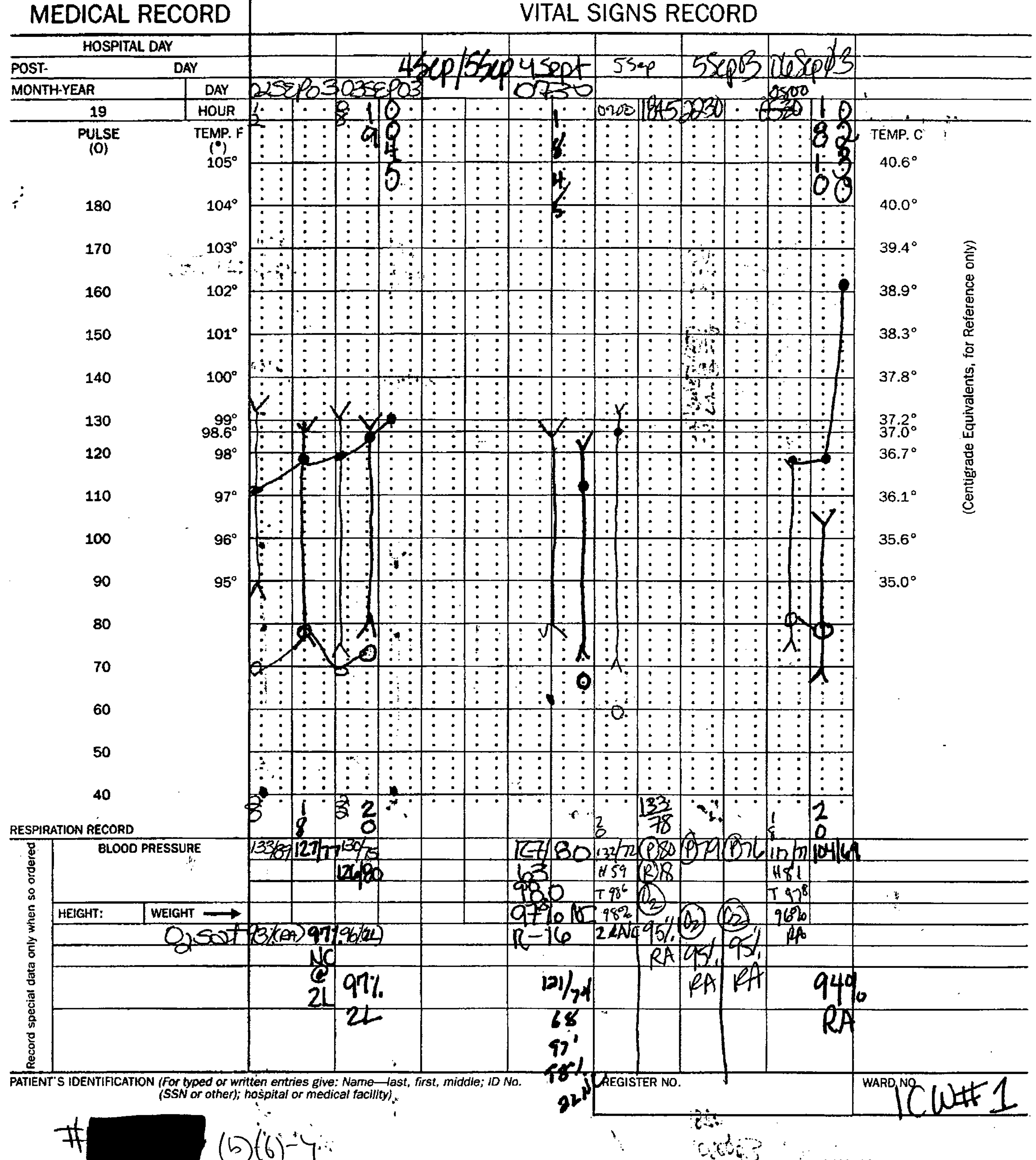
2[redacted] carlon

(b)(6)-2

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD



HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

105° 40.6°

(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.

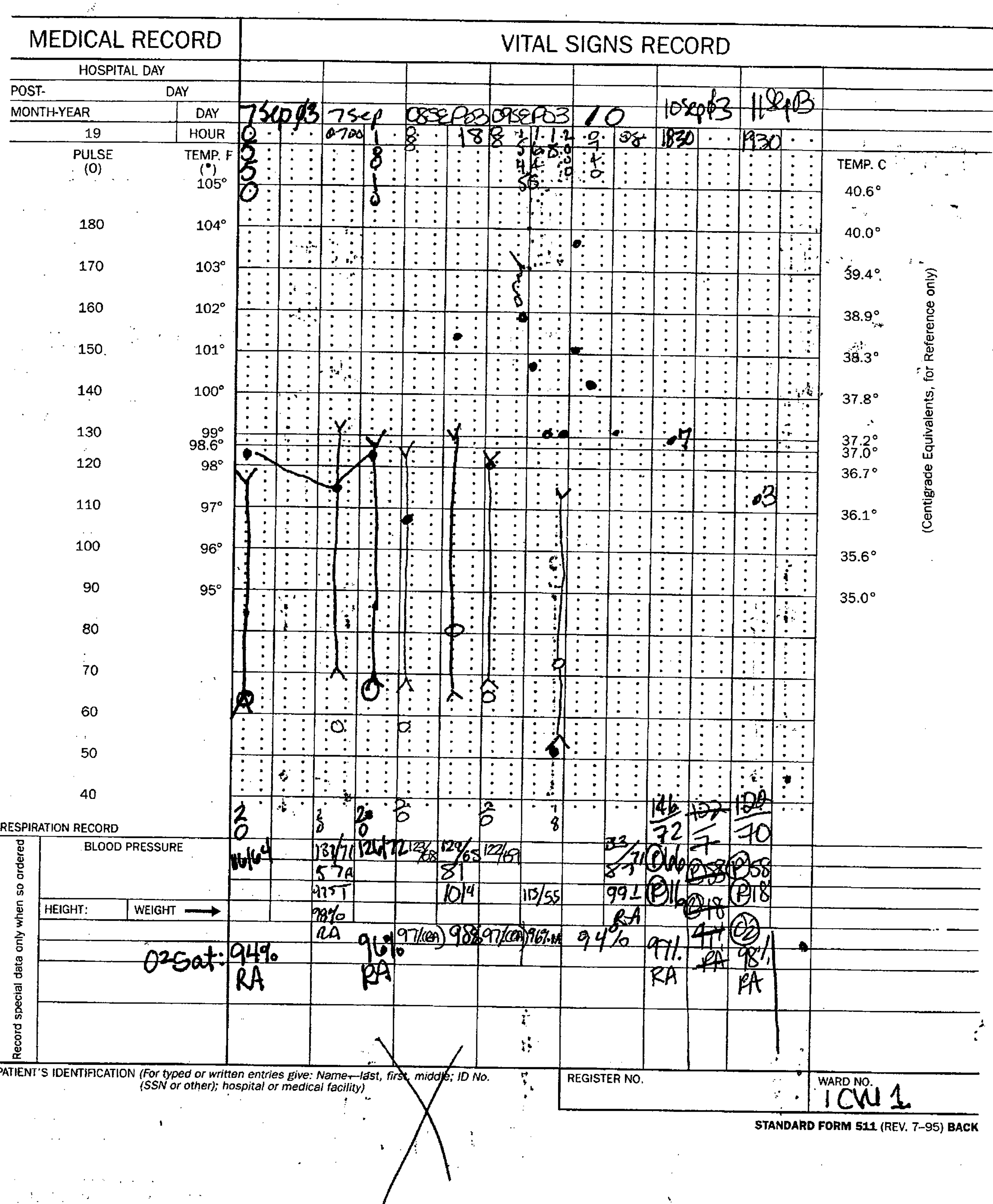
WARD NO. ICW#1

(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 DAY

19 HOUR

PULSE (O) TEMP. F (•) TEMP. C

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. ICW 1

STANDARD FORM 511 (REV. 7-95) BACK

MEDCOM - 17190

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY	23							
MONTH-YEAR Aug 2003 — DAY	8							
~~19~~ — HOUR	8							

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

(Centigrade Equivalents, for Reference only)

Charted (hour 8): temp 96.8; pulse 70

sats	98
RESPIRATION RECORD	20
BLOOD PRESSURE 0000 ~~0100~~	95/69
HEIGHT: / WEIGHT →	
UOP	100
Fluids	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

511-119 NSN 7540-00-634-41

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY					
POST- DAY					
MONTH-YEAR / DAY	12SEP03	13SEP03	14Sep	15Sep	16 Sep
19 / HOUR		1930	1800	03	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE: 116/73, 115/66, 113/66, 111/68, 111/69, 125/62, 114/63

HEIGHT: WEIGHT →

O2 sat: 96 (RA), 96%, 97 (RA), 97%, 97%, 98%, 97% RA, 98

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August 19 2003

DAY	18	19	20	21
HOUR	1800, 2000, 2100	6, 10, 14, 18	[illegible]	0600, 1600, 1300

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 22, 24 | 2, 2 | 18, 20, 23

Record special data only when so ordered

BLOOD PRESSURE: 124/66 | 97/64, 100/65, 116/41 | 105/68, 78/74 | 112/69, 105/63

95% 97% 93% 96% 98 | 94% 92%

HEIGHT: WEIGHT →

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. ICWR

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

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR AUG Ø3	DAY	18												
19	HOUR	Ø6ØØ	Ø7ØØ	Ø8ØØ	Ø9ØØ	1ØØØ	11ØØ	12ØØ	13ØØ	14ØØ	15ØØ	16ØØ	17ØØ	18ØØ
PULSE (O)	TEMP. F (•)	99.7	98.2	98.5	99.1	98.7	98.2	99.5	99.2	99.9	99.5	98.Ø	99.4	99.5
BLOOD PRESSURE	Systolic	125	123	139	143	144	13Ø	136	133	123	157	14Ø	13Ø	124
	Diastolic	68	67	67	72	76	72	78	75	8Ø	73	78	73	66
		97	97	97	96	97	95	95	94	95	95	95	96	95
HEIGHT:	WEIGHT →	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

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

TEMP. F (•): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

TEMP. C: 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

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**

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY -	Admit												
POST- DAY													
MONTH-YEAR / DAY	16 AUG						17 Aug						
AUG 2003 / HOUR	0130	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	
TEMP. F	98.0				98.9		98.6	98.8	98.5	98.9	99.1	98.6	99.?
BLOOD PRESSURE systolic	119	123			123	119	124	128	132	131	140	137	132
diastolic	68	107			71	107	65	71	92	72	79	77	71
	98%	99%			100	100	100	100	100	100	100	100	97
HEIGHT: / WEIGHT →	RA	RA			4LPM	4LPM	4LPM	4LPM	4LPM	4LPM	4LPM	4LPM	RA

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

TEMP. F (•): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

TEMP. C: 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

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

(b)(6)-4

[redacted] EPW

REGISTER NO.

WARD NO. ICU 2

VITAL SIGNS RECORDS

Medical Record

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

NRB

i-STAT G3+

Pt: (b)(6)-4

Pt Name:____________

TCO2________24 mmol/L

At 37C

PH_______7.614

PCO2______23.2 mmHg

PO2_________95 mmHg

HCO3________24 mmol/L

BEecf________2 mmol/L

sO2*________99 %

*calculated

At Patient Temp

PH_______7.619

PCO2______22.9 mmHg

PO2_________93 mmHg

Patient Temp: 98.0F

FIO2________: 100

Sample Type_:

26AUG03 14:42

Oper: (b)(6)-2

Physician:______________

Ser#

Ver:

NRB

i-STAT G3+

Pt: (b)(6)-4

Pt Name:____________

TCO2________25 mmol/L

At 37C

PH_______7.523

PCO2______29.7 mmHg

PO2_________22 mmHg

HCO3_______[illegible] mmol/L

BEecf_____2 mmol/L

[illegible]________46 %

*calculated

At Patient Temp

PH_______7.528

PCO2______29.2 mmHg

PO2_________22 mmHg

Patient Temp: 98.0F

FIO2________: 100

Sample Type_:

26AUG03 14:49

Oper: (b)(6)-2

Physician:______________

Ser#

Ver:

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

LABORATORY REPORT DISPLAY

BASELINE
~~Arterial~~

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________23 mmol/L

At 37C

pH_______7.612

PCO2______21.9 mmHg

PO2_________56 mmHg

HCO3________22 mmol/L

BEecf________1 mmol/L

sO2*________94 %

*calculated

At Patient Temp

pH_______7.617

PCO2______21.6 mmHg

PO2_________54 mmHg

Patient Temp: 98.1F

Sample Type_:

26AUG03 13:35

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

MV BASELINE

i-STAT G3+

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

Pt Name:____________

TCO2________22 mmol/L

At 37C

pH_______7.510

PCO2______27.2 mmHg

PO2_________18 mmHg

HCO3________22 mmol/L

BEecf_______-1 mmol/L

sO2*________34 %

*calculated

At Patient Temp

pH_______7.514

PCO2______26.8 mmHg

PO2_________18 mmHg

Patient Temp: 98.1F

FIO2________: 4

Sample Type_: [redacted]

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

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

Baseline

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________24 mmol/L

At 37C

pH_______7.539

PCO2______26.8 mmHg

PO2_________19 mmHg

HCO3________23 mmol/L

BEecf________0 mmol/L

sO2*________37 %

*calculated

At Patient Temp

pH_______7.543

PCO2______26.5 mmHg

PO2_________18 mmHg

Patient Temp: 98.1F

FIO2________: 4

Sample Type_: [redacted]

26AUG03 13:58

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

BASE LI... ED ON ... MISTRY ... MISTRY ... MISTRY ... ATOLO...

URINALYSIS
SEROLOGY
SPINAL FLUID
MISCELLANEOUS
ASSOCIATED FORMS

[redacted] (b)(6)-4

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

LABORATORY REPORT DISPLAY

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

** PR ED :

(5)(6)-7

Dobutamine 5mcg/kg/min

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________23 mmol/L

At 37C

PH_______7.621

PCO2______21.9 mmHg

PO2__________99 mmHg

HCO3_________23 mmol/L

BEecf_________1 mmol/L

sO2*_________99 %

*calculated

At Patient Temp

PH_______7.621

PCO2______21.8 mmHg

PO2__________99 mmHg

Patient Temp: 98.5F

FIO2________: 100

Sample Type_: [redacted]

26AUG03 15:44

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

Dobutamine 5mcg/kg/

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________24 mmol/L

At 37C

PH_______7.522

PCO2______28.5 mmHg

PO2__________20 mmHg

HCO3_________23 mmol/L

BEecf_________1 mmol/L

sO2*_________41 %

*calculated

At Patient Temp

PH_______7.523

PCO2______28.5 mmHg

PO2__________20 mmHg

Patient Temp: 98.5F

FIO2________: 100

Sample Type_: [redacted]

26AUG03 15:52

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

p̄ 1L NS Bolus

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________21 mmol/L

At 37C

PH_______7.606

PCO2______20.3 mmHg

PO2__________56 mmHg

HCO3_________20 mmol/L

BEecf________-1 mmol/L

sO2*_________94 %

*calculated

At Patient Temp

PH_______7.613

PCO2______19.9 mmHg

PO2__________54 mmHg

Patient Temp: 97.8F

FIO2________: 4

Sample Type_: [redacted]

26AUG03 16:44

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

p̄ 1L NS Bolus

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________24 mmol/L

At 37C

PH_______7.553

PCO2______25.9 mmHg

PO2__________17 mmHg

HCO3_________23 mmol/L

BEecf_________0 mmol/L

sO2*_________33 %

*calculated

At Patient Temp

PH_______7.560

PCO2______25.4 mmHg

PO2__________17 mmHg

Patient Temp: 97.8F

FIO2________: 4

Sample Type_: VEN

26AUG03 16:50

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

(5)(6)-2

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

TEST(S)

SPECIMEN TAKEN

DATE 21 AUG 03 TIME 1717 P.M.

RESULTS	REQUESTED	(X)
4.23	RBC COUNT	
13.2	HEMOGLOBIN	
41.6	HEMATOCRIT	
98.2	MCV	
31.2	MCH	
31.7	MCHC	
21.9	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	
	NEUTRO-BANDS	
pH	NEUTROSEGS	
	LYMPHS	
7.361	EOSINOPHILS	
	BASOPHILS	
PCO2 43.3	MONOCYTES	
PO2 30	PLATELETS	
	RBC	
	SED. RATE	
152	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
49.1	PTT CONTROL	
	PTT PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

CBC, Lytes, ABG

(b)(6)-2

EPW # (b)(6)-4

ICW 1 Bed 3

SIGNATURE — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY — MD DATE — TECH

HEMATOLOGY URGENCY: ROUTINE, TODAY, PRE-OP, STAT [X]

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

SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify) [X] Art

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

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

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE 26 Aug TIME 0400 A.M. P.M.

REQUESTED

CH 8

RESULTS

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

REQUESTING PHYSICIAN'S SIGNATURE Dr (b)(6)-2

REMARKS

REPORTED BY — MD DATE — TECH — LAB ID NO.

EPW (b)(6)-4

MISC URGENCY: ROUTINE, TODAY [X], PRE-OP, STAT

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

SPECIMEN SOURCE (Specify)

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD

EPW

SPECIMEN/LAB RPT. NO.

MISC

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE Dr

REPORTED BY — MD DATE — TECH — LAB ID NO.

REMARKS

TEST(S)

SPECIMEN TAKEN

DATE 26 Aug TIME 0400 A.M. P.M.

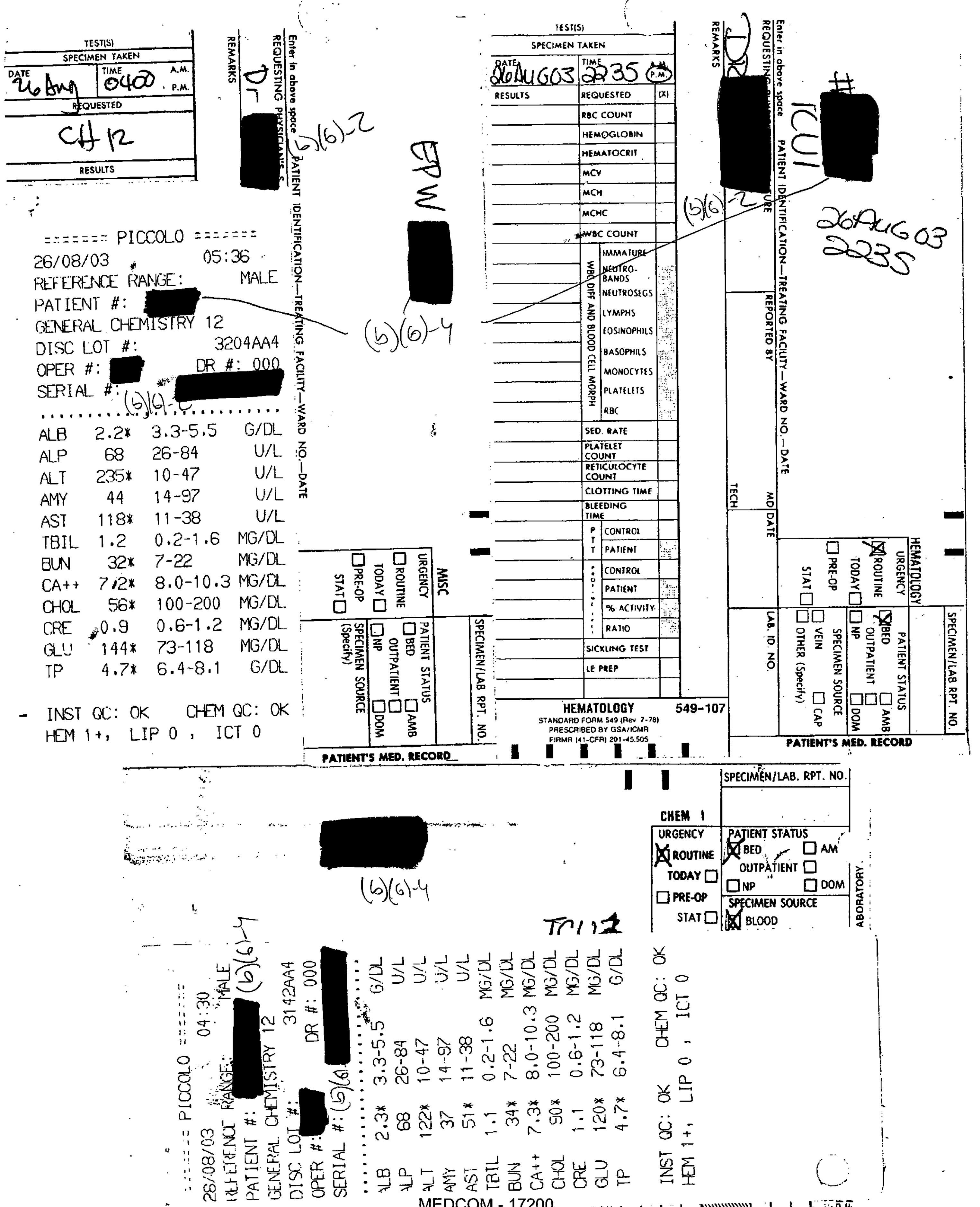
REQUESTED CBC

RESULTS

MISCELLANEOUS 557-107

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

MEDCOM - 17199



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

REMARKS

Dr

REQUESTING PHYSICIAN'S S

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

(b)(6)-2

EPW

(b)(6)-4

```
======= PICCOLO =======
26/08/03            05:36
REFERENCE RANGE:      MALE
PATIENT #:
GENERAL CHEMISTRY 12
DISC LOT #:        3204AA4
OPER #:          DR #: 000
SERIAL #: (b)(6)
..............................
ALB    2.2*   3.3-5.5    G/DL
ALP    68     26-84      U/L
ALT    235*   10-47      U/L
AMY    44     14-97      U/L
AST    118*   11-38      U/L
TBIL   1.2    0.2-1.6    MG/DL
BUN    32*    7-22       MG/DL
CA++   7.2*   8.0-10.3   MG/DL
CHOL   56*    100-200    MG/DL
CRE    0.9    0.6-1.2    MG/DL
GLU    144*   73-118     MG/DL
TP     4.7*   6.4-8.1    G/DL

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

MISC

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

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

TEST(S)		
SPECIMEN TAKEN		
DATE 26AUG03	TIME 2235 A.M. (P.M.)	
RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

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

REMARKS

REQUESTING PHYSICIAN'S SIGNATURE: Dr

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

ICU1 #

(b)(6)-2

26AUG03 2235

REPORTED BY

TECH

MD DATE

HEMATOLOGY

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

LAB. ID. NO.

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

SPECIMEN/LAB. RPT. NO.

CHEM 1

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

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

SPECIMEN SOURCE: ☒ BLOOD

ABORATORY

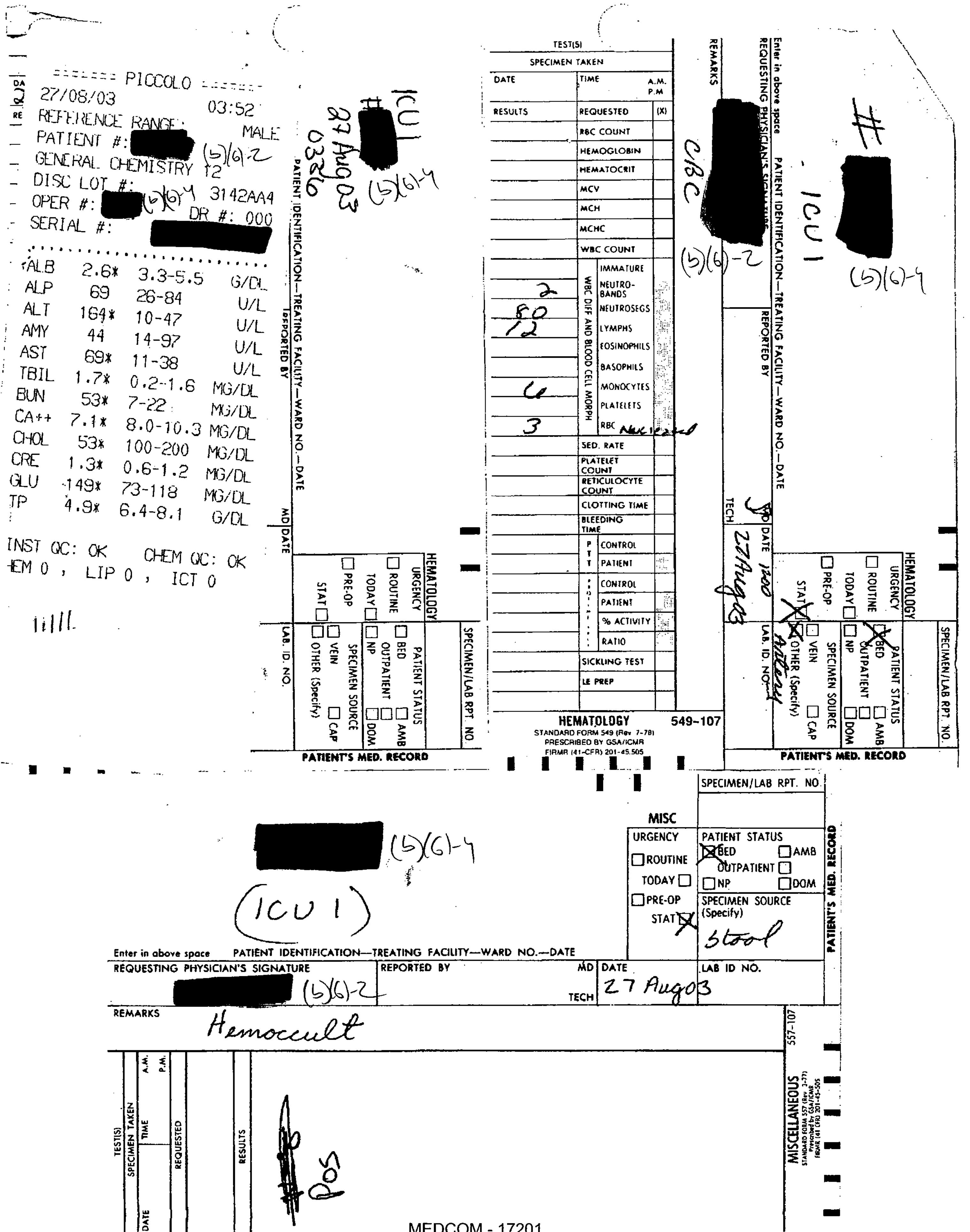
(b)(6)-4

TC112

```
======= PICCOLO =======
28/08/03            04:30
REFERENCE RANGE:      MALE
PATIENT #: (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #:        3142AA4
OPER #:          DR #: 000
SERIAL #: (b)(6)
..............................
ALB    2.3*   3.3-5.5    G/DL
ALP    68     26-84      U/L
ALT    122*   10-47      U/L
AMY    37     14-97      U/L
AST    51*    11-38      U/L
TBIL   1.1    0.2-1.6    MG/DL
BUN    34*    7-22       MG/DL
CA++   7.3*   8.0-10.3   MG/DL
CHOL   90*    100-200    MG/DL
CRE    1.1    0.6-1.2    MG/DL
GLU    120*   73-118     MG/DL
TP     4.7*   6.4-8.1    G/DL

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

MEDCOM - 17200



PICCOLO
27/08/03 03:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-2
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-4 3142AA4
OPER #: [redacted] (b)(6)-4 DR #: 000
SERIAL #: [redacted]

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

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

ICU 1
27 Aug 03
0326
(b)(6)-4

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

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

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

REMARKS: CBC
REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
[redacted] ICU 1 (b)(6)-4
REPORTED BY — TECH — DATE 1200 27 Aug 03
HEMATOLOGY URGENCY: ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒
PATIENT STATUS: BED ☒ AMB ☐ OUTPATIENT ☐ NP ☐ DOM ☐
SPECIMEN SOURCE: VEIN ☐ CAP ☐ OTHER (Specify) ☒ Artery
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

MISC

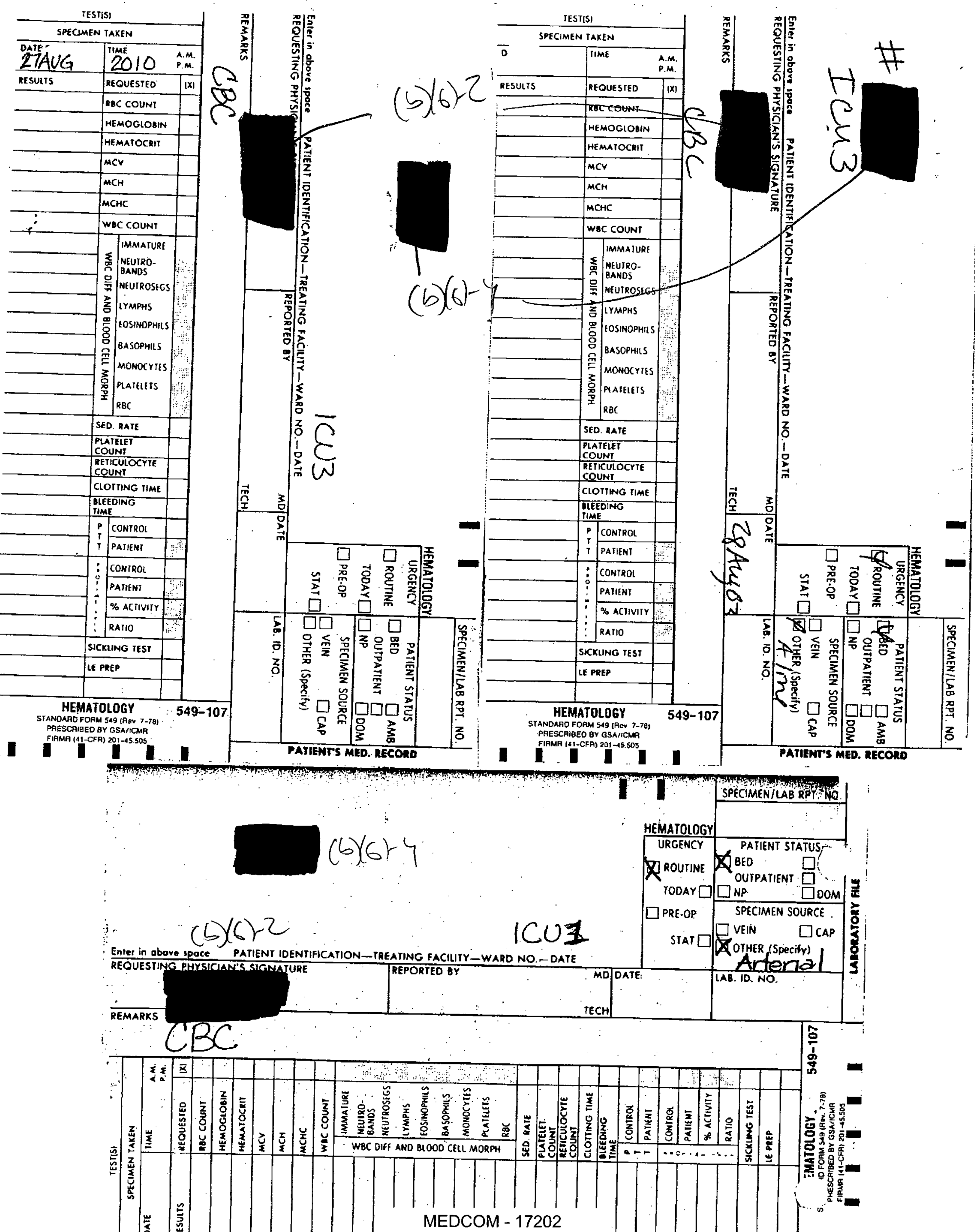
SPECIMEN/LAB RPT. NO.
URGENCY: ☐ ROUTINE TODAY ☐ ☐ PRE-OP STAT ☒
PATIENT STATUS: ☒ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify): Stool

[redacted] (b)(6)-4
(ICU 1)

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2
REPORTED BY — MD — TECH
DATE 27 Aug 03
LAB ID NO.
PATIENT'S MED. RECORD
REMARKS: Hemoccult

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

MISCELLANEOUS STANDARD FORM 557 (Rev 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505 557-107



HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

DATE 27AUG TIME 2010 A.M. P.M.

RESULTS | REQUESTED (X) CBC

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

REMARKS

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE (b)(6)-4 ICU3

REPORTED BY MD DATE TECH

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

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

PATIENT'S MED. RECORD

HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

DATE TIME A.M. P.M.

RESULTS | REQUESTED (X) CBC

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

REMARKS

REQUESTING PHYSICIAN'S SIGNATURE

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE # ICU3

REPORTED BY MD DATE 28Aug07 TECH

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☒ OTHER (Specify) A line

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

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

PATIENT'S MED. RECORD

SPECIMEN/LAB RPT. NO.

(b)(6)-4

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☒ OTHER (Specify) Arterial

(b)(6)-2 ICU3

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

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY | MD | DATE: | LAB. ID. NO.

TECH

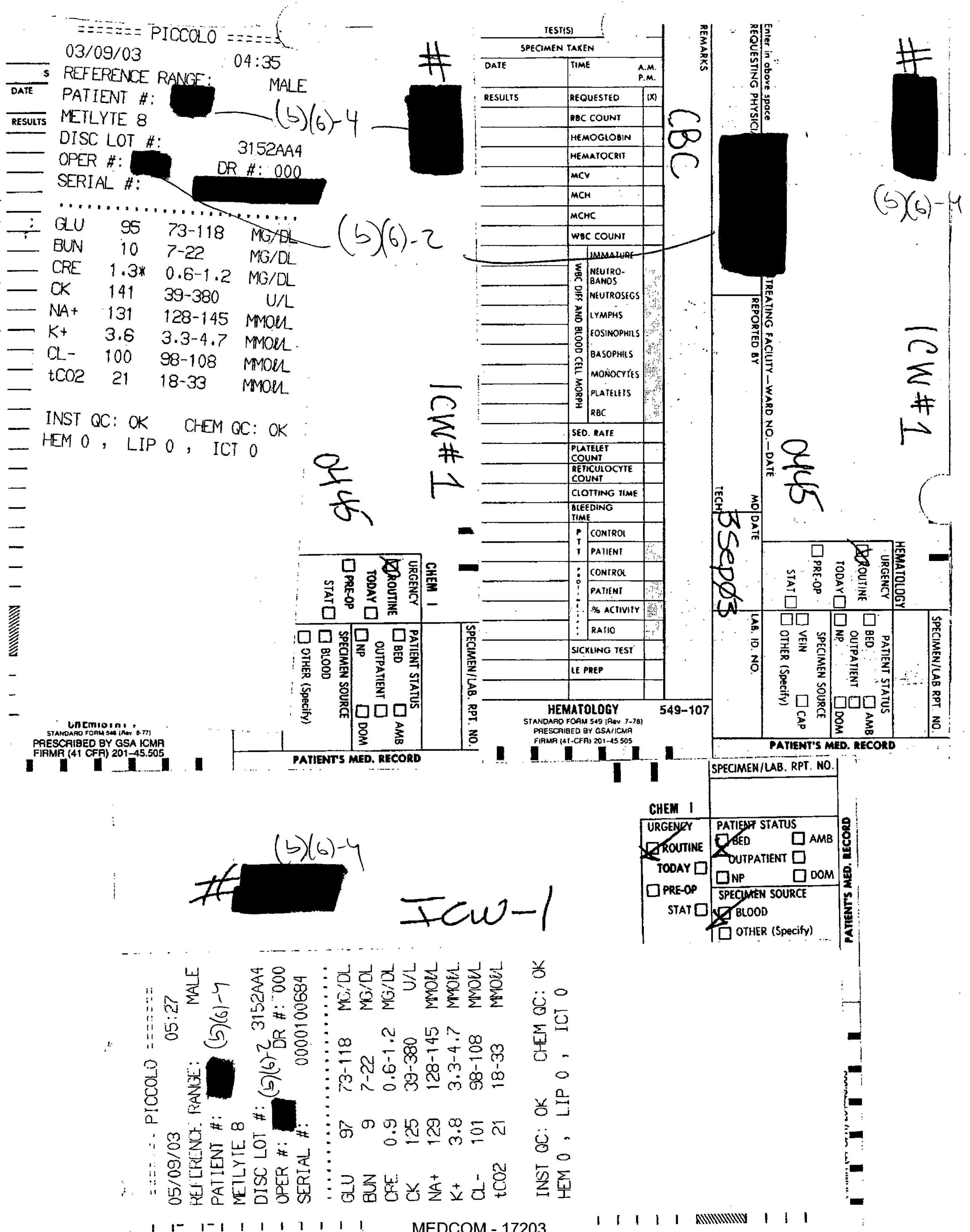
LABORATORY FILE

REMARKS CBC

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

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

MEDCOM - 17202



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

03/09/03 04:35

REFERENCE RANGE: MALE

PATIENT #: (b)(6)-4

METLYTE 8

DISC LOT #: 3152AA4

OPER #: (b)(6)-2 DR #: 000

SERIAL #:

Test	Result	Range	Units
GLU	95	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	141	39-380	U/L
NA+	131	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

#(b)(6)-4 ICW #1 0446

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

CHEMISTRY I STANDARD FORM 546 (Rev. 8-77) PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45.505

HEMATOLOGY — TEST(S): CBC — SPECIMEN TAKEN: DATE, TIME A.M./P.M.

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

REMARKS — REQUESTING PHYSICIAN — TREATING FACILITY—WARD NO.—DATE — REPORTED BY — LAB. ID. NO. — MD DATE — TECH 3Sep03 — 0445

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

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

#(b)(6)-4 ICW #1

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

#(b)(6)-4 ICW-1

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

05/09/03 05:27

REFERENCE RANGE: MALE

PATIENT #: (b)(6)-4

METLYTE 8

DISC LOT #: 3152AA4

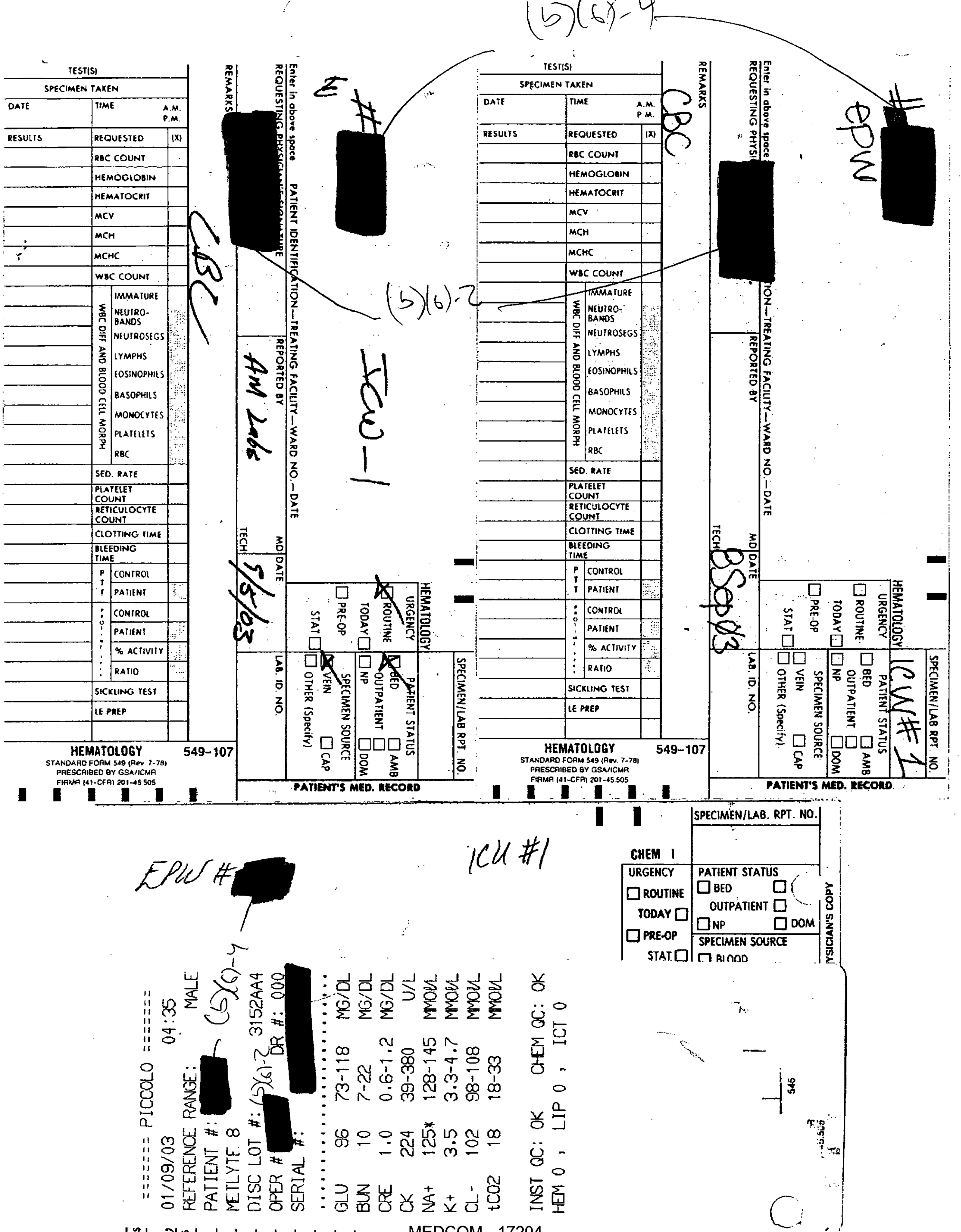
OPER #: (b)(6)-2 DR #: 000

SERIAL #: 0000100684

Test	Result	Range	Units
GLU	97	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	125	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0



(b)(6)-4

HEMATOLOGY (form 1)

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

REMARKS: CBC

REQUESTING PHYSICIAN'S SIGNATURE (Enter in above space)

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

E #[redacted] — (b)(6)-2

ICW-1

REPORTED BY: AM Labs

MD | DATE: 5/5/03

TECH

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

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

PATIENT'S MED. RECORD

HEMATOLOGY (form 2)

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

REMARKS: CBC

REQUESTING PHYSICIAN'S SIGNATURE (Enter in above space)

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

EPW #[redacted]

REPORTED BY

MD | DATE: 8 Sep 03

TECH

URGENCY: [ ] ROUTINE, [ ] TODAY, [ ] PRE-OP, [ ] STAT

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

SPECIMEN SOURCE: [ ] VEIN, [ ] CAP, [ ] OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.: ICW #1

HEMATOLOGY 549-107

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

PATIENT'S MED. RECORD

CHEM I

ICU #1

SPECIMEN/LAB. RPT. NO.

URGENCY: [ ] ROUTINE, TODAY [ ], [ ] PRE-OP, STAT [ ]

PATIENT STATUS: [ ] BED, [ ], OUTPATIENT [ ], [ ] NP, [ ] DOM

SPECIMEN SOURCE: [ ] BLOOD

PHYSICIAN'S COPY

EPW #[redacted] — (b)(6)-4

```
====== PICCOLO ======
01/09/03          04:35
REFERENCE RANGE: [redacted]  MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2  3152AA4
OPER #: [redacted]  DR #: 000[redacted]
SERIAL #:
..........................
GLU    96    73-118   MG/DL
BUN    10    7-22     MG/DL
CRE    1.0   0.6-1.2  MG/DL
CK     224   39-380   U/L
NA+    125*  128-145  MMOL/L
K+     3.5   3.3-4.7  MMOL/L
CL-    102   98-108   MMOL/L
tCO2   18    18-33    MMOL/L

INST QC: OK   CHEM QC: OK
HEM 0 , LIP 0 , ICT 0
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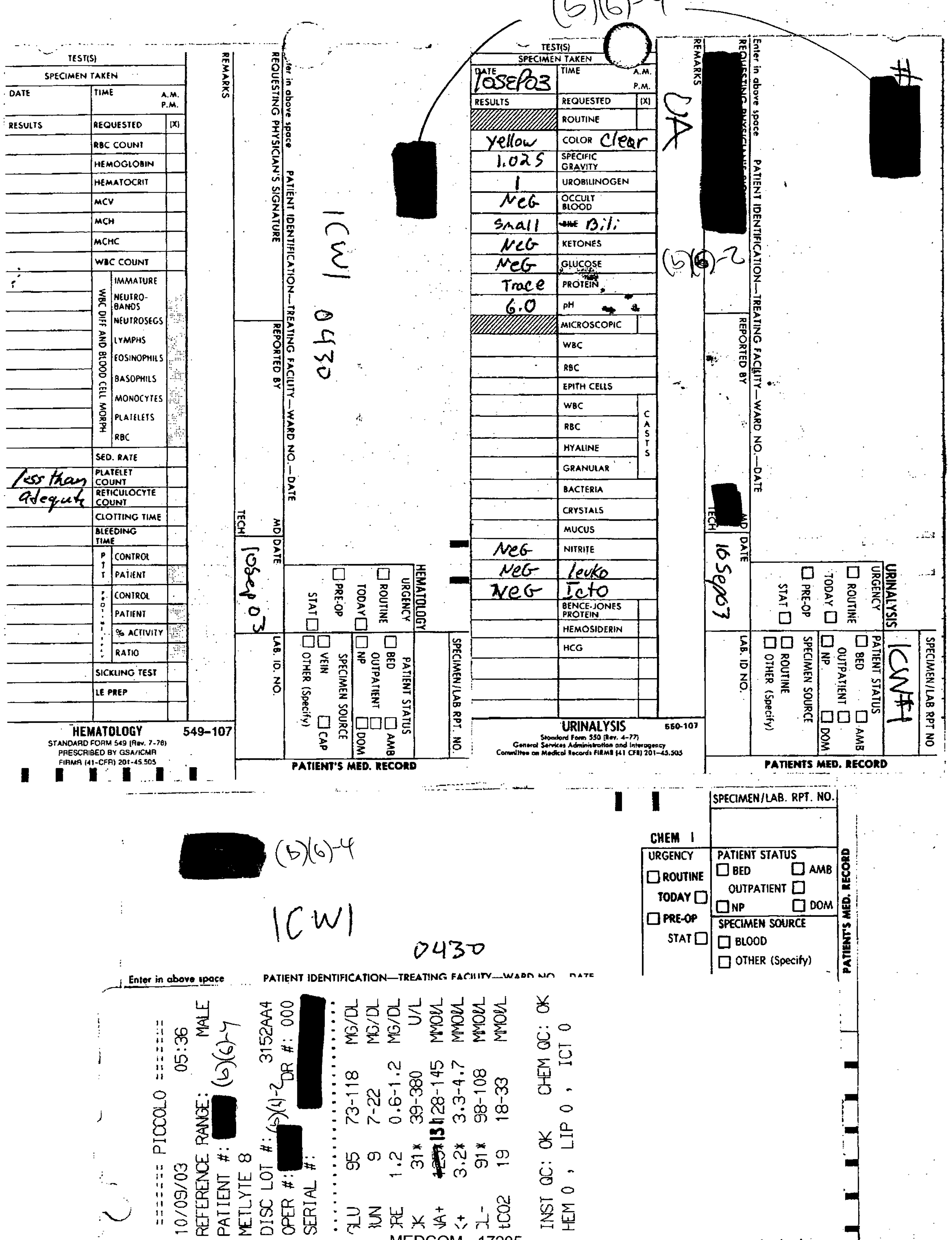
MEDCOM - 17204



(b)(6)-4

HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

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

REMARKS

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

REQUESTING PHYSICIAN'S SIGNATURE

ICW1

0430

REPORTED BY

TECH — MD — DATE: 10Sep03

LAB. ID. NO.

HEMATOLOGY — URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

PATIENT'S MED. RECORD

URINALYSIS

TEST(S)

SPECIMEN TAKEN

DATE 10SEP03	TIME A.M. P.M.	
RESULTS	REQUESTED	(X)
	ROUTINE	
yellow	COLOR Clear	
1.025	SPECIFIC GRAVITY	
1	UROBILINOGEN	
NeG	OCCULT BLOOD	
Small	Bili	
NeG	KETONES	
NeG	GLUCOSE	
Trace	PROTEIN	
6.0	pH	
	MICROSCOPIC	
	WBC	
	RBC	
	EPITH CELLS	
	CASTS — WBC	
	CASTS — RBC	
	CASTS — HYALINE	
	CASTS — GRANULAR	
	BACTERIA	
	CRYSTALS	
	MUCUS	
NeG	NITRITE	
NeG	leuko	
NeG	Icto	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

REMARKS

UA

(b)(6)-2

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

TECH — MD — DATE: 16Sep03

LAB. ID NO.

URINALYSIS — URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE: ☐ ROUTINE ☐ OTHER (Specify)

SPECIMEN/LAB RPT NO. ICW#1

URINALYSIS 550-107

Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency
Committee on Medical Records FIRMR (41 CFR) 201-45.505

PATIENTS MED. RECORD

#

CHEM I

(b)(6)-4

ICW1

0430

SPECIMEN/LAB. RPT. NO.

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

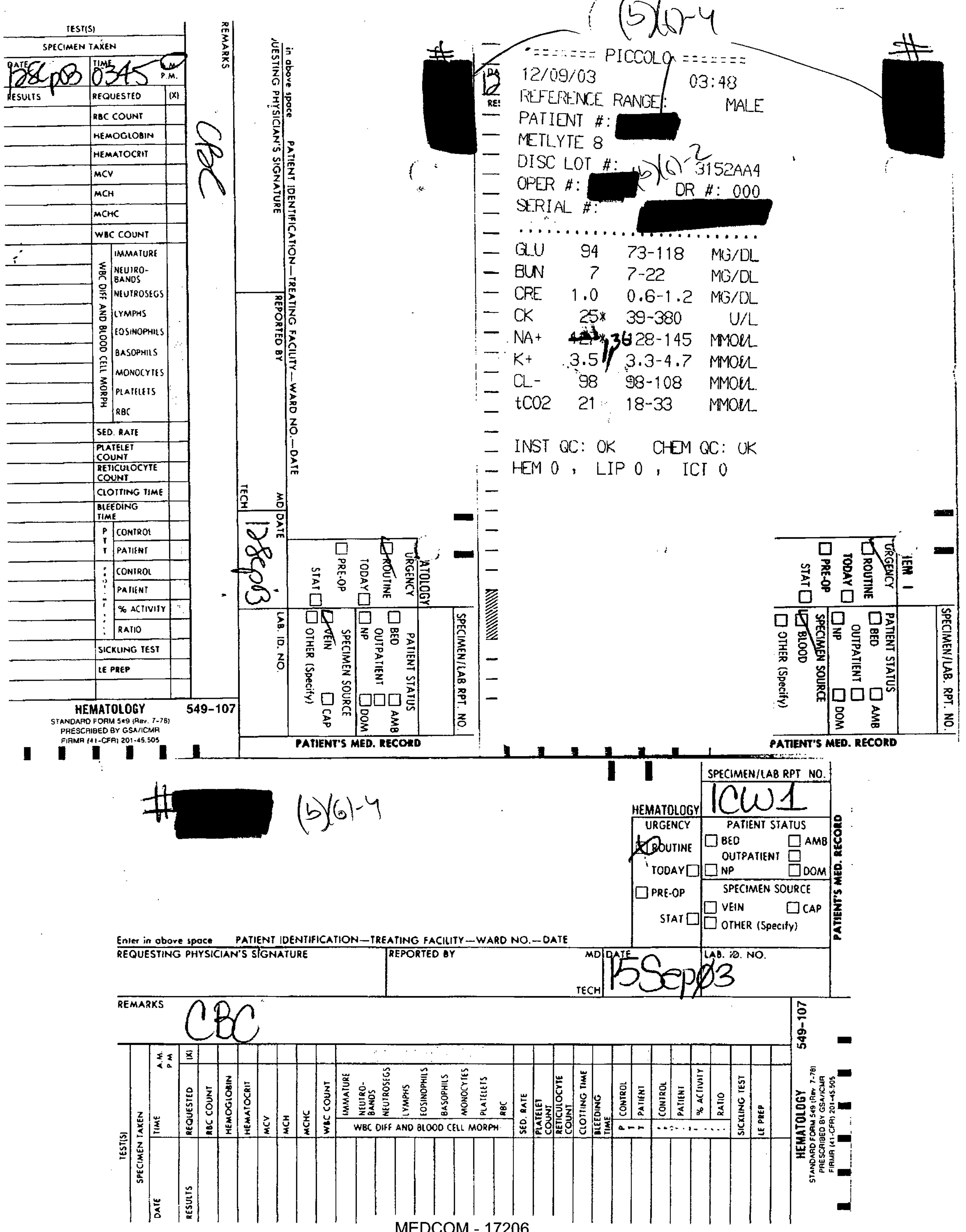
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO. DATE

```
====== PICCOLO ======
10/09/03           05:36
REFERENCE RANGE:   (b)(6)-4   MALE
PATIENT #:
METLYTE 8
DISC LOT #: (b)(6)-2   3152AA4
OPER #:           DR #: 000
SERIAL #:

GLU    95     73-118    MG/DL
BUN     9     7-22      MG/DL
CRE   1.2     0.6-1.2   MG/DL
CK    31*     39-380    U/L
NA+  131      128-145   MMOL/L
K+   3.2*     3.3-4.7   MMOL/L
CL-   91*     98-108    MMOL/L
tCO2  19      18-33     MMOL/L

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

MEDCOM - 17205



(b)(6)-4

PICCOLO
12/09/03 03:48
REFERENCE RANGE: MALE
PATIENT #:
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: DR #: 000
SERIAL #:

GLU	94	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	25*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

DATE 12Sep03 TIME 0345 A.M.
REMARKS CBC
MD DATE 12Sep03
URGENCY: ROUTINE (checked)
SPECIMEN SOURCE: VEIN (checked)
PATIENT'S MED. RECORD

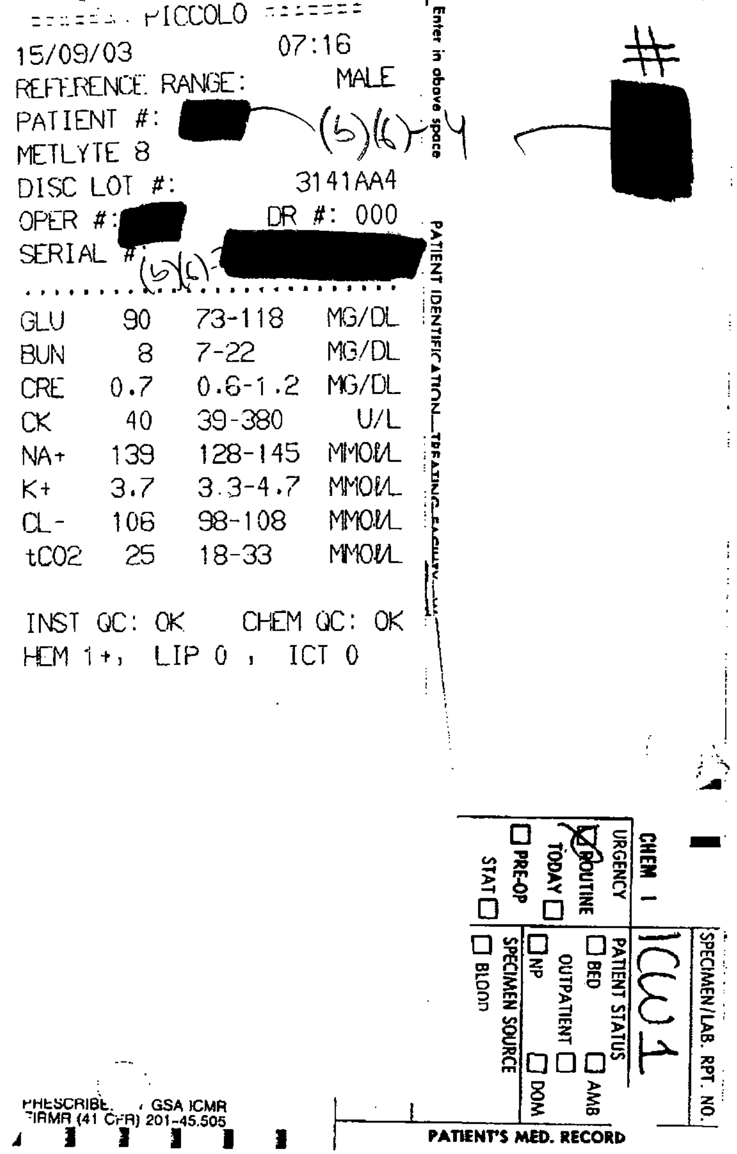
(b)(6)-4

HEMATOLOGY
SPECIMEN/LAB RPT NO. ICW1
URGENCY: ROUTINE (checked) TODAY PRE-OP STAT
PATIENT STATUS: BED AMB OUTPATIENT NP DOM
SPECIMEN SOURCE: VEIN CAP OTHER (Specify)
PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD DATE 15Sep03
TECH
LAB. ID. NO.
REMARKS CBC

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

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505



PICCOLO
15/09/03 07:16
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: DR #: 000
SERIAL #: (b)(6)

GLU	90	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	40	39-380	U/L
NA+	139	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

Enter in above space
PATIENT IDENTIFICATION TREATING FACILITY

#

CHEM 1
URGENCY
☒ ROUTINE
☐ TODAY
☐ PRE-OP
☐ STAT

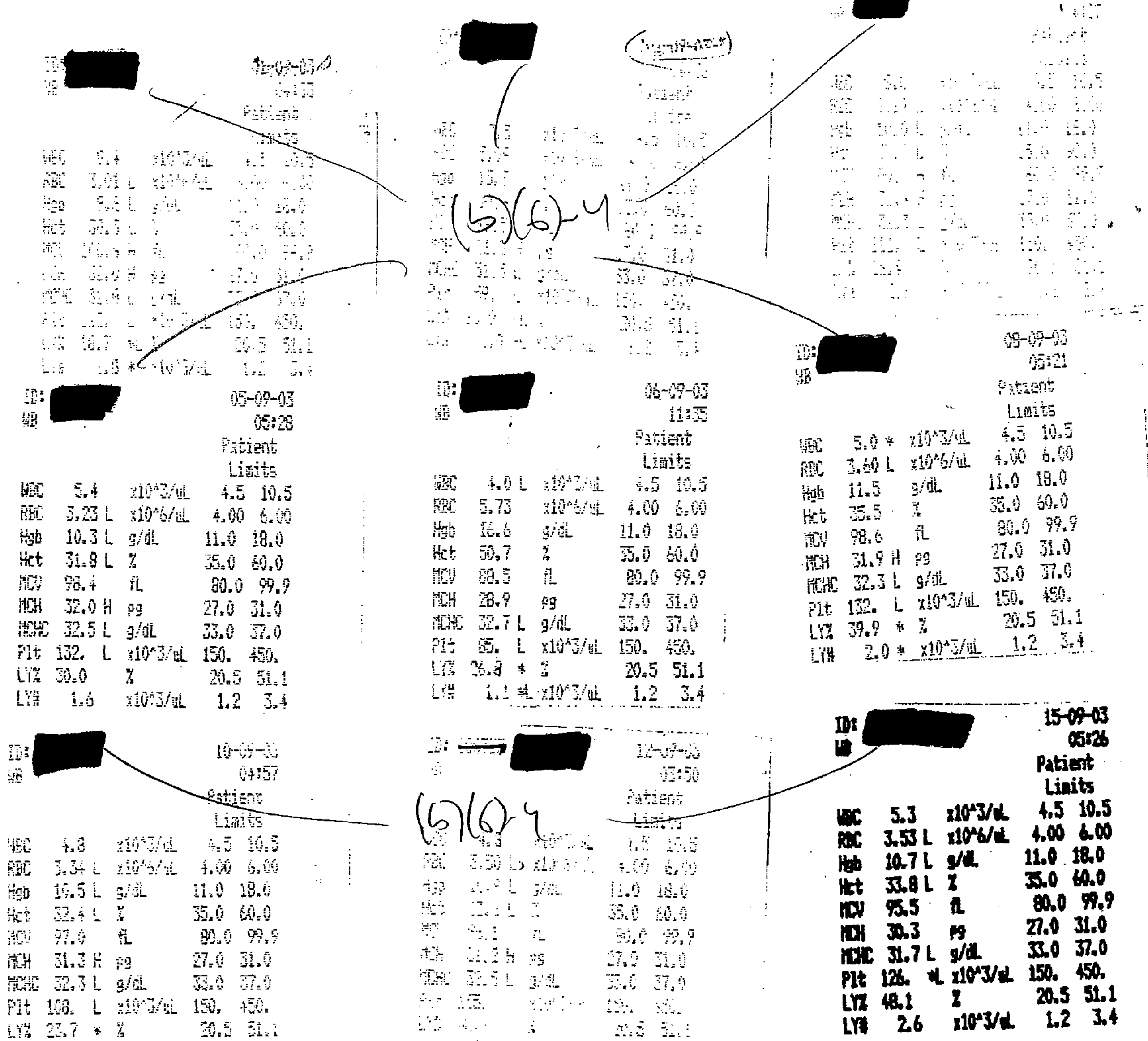
SPECIMEN/LAB. RPT. NO.
ICU 1

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

SPECIMEN SOURCE
☐ BLOOD

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

PATIENT'S MED. RECORD



(b)(6)-4

ID: [redacted]
WB

05-09-03 05:28

			Patient Limits	
WBC	5.4	x10^3/uL	4.5	10.5
RBC	3.23 L	x10^6/uL	4.00	6.00
Hgb	10.3 L	g/dL	11.0	18.0
Hct	31.8 L	%	35.0	60.0
MCV	98.4	fL	80.0	99.9
MCH	32.0 H	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	132. L	x10^3/uL	150.	450.
LY%	30.0	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

ID: [redacted]
WB

06-09-03 11:35

			Patient Limits	
WBC	4.0 L	x10^3/uL	4.5	10.5
RBC	5.73	x10^6/uL	4.00	6.00
Hgb	16.6	g/dL	11.0	18.0
Hct	50.7	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	32.7 L	g/dL	33.0	37.0
Plt	85. L	x10^3/uL	150.	450.
LY%	26.8 *	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

ID: [redacted]
WB

09-09-03 05:21

			Patient Limits	
WBC	5.0 *	x10^3/uL	4.5	10.5
RBC	3.60 L	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	35.5	%	35.0	60.0
MCV	98.6	fL	80.0	99.9
MCH	31.9 H	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	132. L	x10^3/uL	150.	450.
LY%	39.9 *	%	20.5	51.1
LY#	2.0 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

10-09-03 04:57

			Patient Limits	
WBC	4.8	x10^3/uL	4.5	10.5
RBC	3.34 L	x10^6/uL	4.00	6.00
Hgb	10.5 L	g/dL	11.0	18.0
Hct	32.4 L	%	35.0	60.0
MCV	97.0	fL	80.0	99.9
MCH	31.3 H	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	108. L	x10^3/uL	150.	450.
LY%	23.7 *	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

(b)(6)-4

ID: [redacted]
WB

12-09-03 03:50

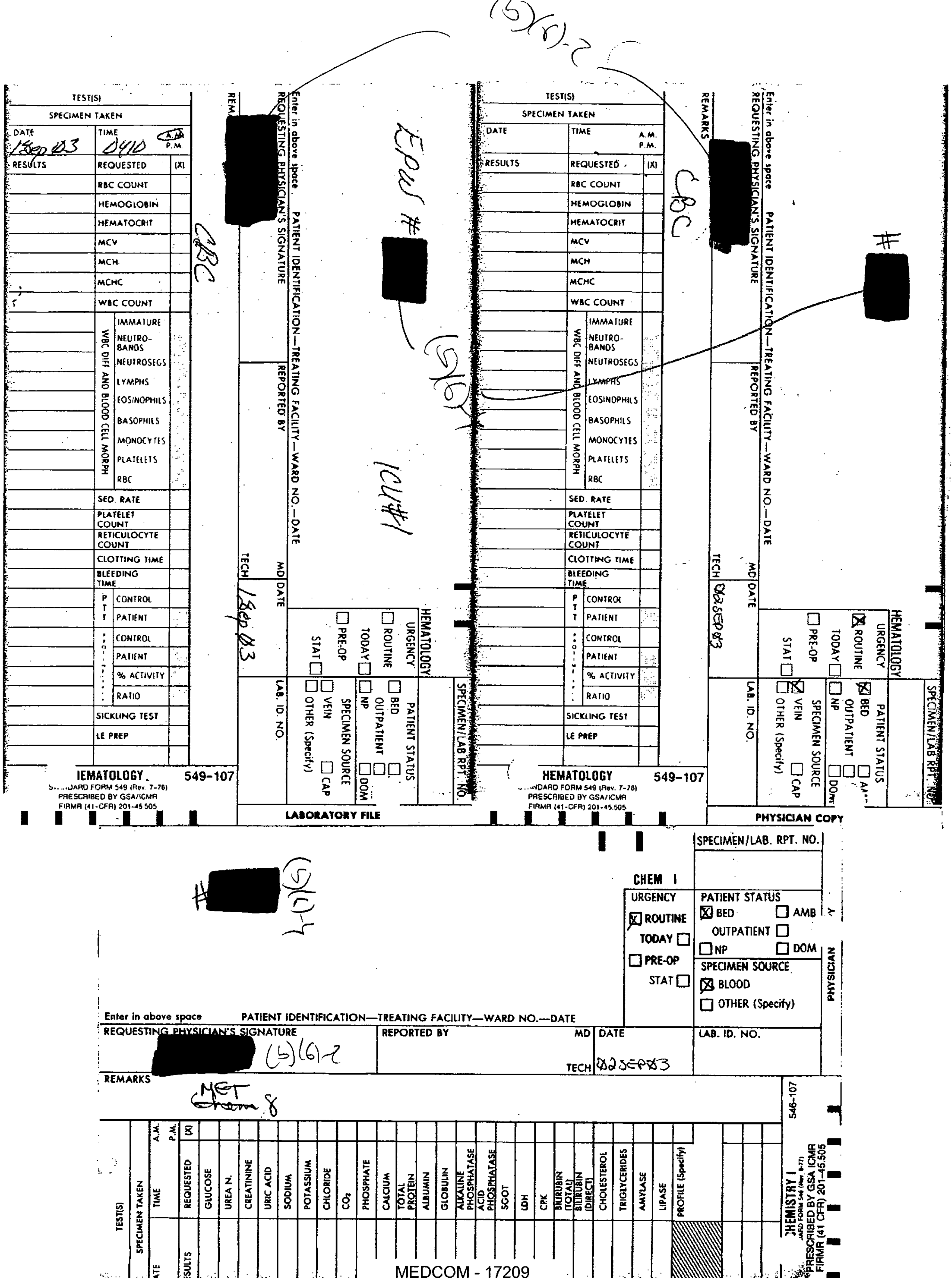
			Patient Limits	
WBC	4.3	x10^3/uL	4.5	10.5
RBC	3.50 L	x10^6/uL	4.00	6.00
Hgb	[illegible] L	g/dL	11.0	18.0
Hct	[illegible] L	%	35.0	60.0
MCV	[illegible]	fL	80.0	99.9
MCH	31.2 H	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	[illegible]	x10^3/uL	150.	450.
LY%	[illegible]	%	20.5	51.1
LY#	[illegible]	x10^3/uL	1.2	3.4

ID: [redacted]
WB

15-09-03 05:26

			Patient Limits	
WBC	5.3	x10^3/uL	4.5	10.5
RBC	3.53 L	x10^6/uL	4.00	6.00
Hgb	10.7 L	g/dL	11.0	18.0
Hct	33.8 L	%	35.0	60.0
MCV	95.5	fL	80.0	99.9
MCH	30.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	126. *L	x10^3/uL	150.	450.
LY%	48.1	%	20.5	51.1
LY#	2.6	x10^3/uL	1.2	3.4

MEDCOM - 17208



(b)(6)-2

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. P.M.
13Sep 03	0410	A.M.

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

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
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FIRMR (41-CFR) 201-45.505

REMARKS CBC

REQUESTING PHYSICIAN'S SIGNATURE

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

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

ICU#1

REPORTED BY

MD DATE

TECH 13Sep 03

LAB. ID. NO.

HEMATOLOGY

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

PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

LABORATORY FILE

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. P.M.

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

HEMATOLOGY 549-107

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

REMARKS CBC

REQUESTING PHYSICIAN'S SIGNATURE

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

[redacted]

REPORTED BY

MD DATE

TECH 02SEP03

LAB. ID. NO.

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PHYSICIAN COPY

SPECIMEN/LAB. RPT. NO.

[redacted] (b)(6)-4

CHEM I

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PHYSICIAN

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

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

REPORTED BY

MD DATE

TECH 02SEP03

LAB. ID. NO.

REMARKS MET ~~Chem~~ 8

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

GLUCOSE, UREA N., CREATININE, URIC ACID, SODIUM, POTASSIUM, CHLORIDE, CO_2, PHOSPHATE, CALCIUM, TOTAL PROTEIN, ALBUMIN, GLOBULIN, ALKALINE PHOSPHATASE, ACID PHOSPHATASE, SGOT, LDH, CPK, BILIRUBIN (TOTAL), BILIRUBIN (DIRECT), CHOLESTEROL, TRIGLYCERIDES, AMYLASE, LIPASE, PROFILE (Specify)

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 17209

ID: [illegible]
WB
23:22

			Patient Limits	
WBC	16.1	x10^3/uL	[illegible]	10.5
RBC	4.61	x10^6/uL	[illegible]	6.00
Hgb	14.3	g/dL	[illegible]	18.0
Hct	[illegible]		35.0	60.0
MCV	96.3	fL	80.0	99.9
MCH	31.0	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	179.	x10^3/uL	150.	450.
LY%	11.7 *	%	20.5	51.1
LY#	[illegible] *	x10^3/uL	1.2	3.4

(5)(6)-4

ID: [illegible]
21:52

			Patient Limits	
WBC	15.4 H	x10^3/uL	[illegible]	[illegible]
RBC	4.37	x10^6/uL	[illegible]	6.00
Hgb	[illegible]	g/dL	11.0	18.0
Hct	[illegible]	%	35.0	60.0
MCV	96.2	fL	80.0	99.9
MCH	[illegible]	pg	27.0	31.0
MCHC	[illegible] L	g/dL	33.0	37.0
Plt	[illegible] L	x10^3/uL	150.	450.
LY%	[illegible] *L	%	20.5	51.1
LY#	[illegible] *	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-22-03
20:35

			Patient Limits	
WBC	22.1 H	x10^3/uL	4.5	10.5
RBC	3.82 L	x10^6/uL	4.00	6.00
Hgb	11.8	g/dL	11.0	18.0
Hct	37.0	%	35.0	60.0
MCV	96.8	fL	80.0	99.9
MCH	30.9	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	107. L	x10^3/uL	150.	450.
LY%	17.0 *L	%	20.5	51.1
LY#	3.8 *H	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-23-03
20:38

			Patient Limits	
WBC	21.1 H	x10^3/uL	4.5	10.5
RBC	3.70 L	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	36.3	%	35.0	60.0
MCV	98.0	fL	80.0	99.9
MCH	31.1 H	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	101. L	x10^3/uL	150.	450.
LY%	18.0 *L	%	20.5	51.1
LY#	3.8 *H	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-23-03
06:56

			Patient Limits	
WBC	22.7 H	x10^3/uL	4.5	10.5
RBC	3.69 L	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	36.6	%	35.0	60.0
MCV	99.0	fL	80.0	99.9
MCH	30.9	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	112. L	x10^3/uL	150.	450.
LY%	18.8 *L	%	20.5	51.1
LY#	4.3 *H	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-24-03
20:52

			Patient Limits	
WBC	28.8 H	x10^3/uL	4.5	10.5
RBC	3.65 L	x10^6/uL	4.00	6.00
Hgb	11.2	g/dL	11.0	18.0
Hct	35.8	%	35.0	60.0
MCV	97.9	fL	80.0	99.9
MCH	30.6	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	138. L	x10^3/uL	150.	450.
LY%	11.1 *L	%	20.5	51.1
LY#	3.2 *	x10^3/uL	1.2	3.4

(5)(6)-4

Mono-6
lymph-4
Seg-63
band-38

5-NRBC

See back
more manual ct.

ID: [illegible]
WB
08-25-03
20:13

			Patient Limits	
WBC	31.2 H	x10^3/uL	4.5	10.5
RBC	2.73 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	27.5 L	%	35.0	60.0
MCV	100.6 H	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	30.5 L	g/dL	33.0	37.0
Plt	138. L	x10^3/uL	150.	450.
LY%	13.5 *L	%	20.5	51.1
LY#	4.2 *	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-26-03
19:54

			Patient Limits	
WBC	37.1 H	x10^3/uL	4.5	10.5
RBC	2.83 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	28.4 L	%	35.0	60.0
MCV	100.1 H	fL	80.0	99.9
MCH	30.3	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	109. L	x10^3/uL	150.	450.
LY%	10.9 *L	%	20.5	51.1
LY#	4.1 *	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-26-03
15:01

			Patient Limits	
WBC	47.9 H	x10^3/uL	4.5	10.5
RBC	3.43 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	34.4 L	%	35.0	60.0
MCV	100.3 H	fL	80.0	99.9
MCH	30.4	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	131. L	x10^3/uL	150.	450.
LY%	7.5 *L	%	20.5	51.1
LY#	3.6 *	x10^3/uL	1.2	3.4

manual
Diff

ID: 000596
WB
08-27-03
12:32

			Patient Limits	
WBC	31.0 H	x10^3/uL	4.5	10.5
RBC	2.55 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	25.9 L	%	35.0	60.0
MCV	101.6 H	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	99. L	x10^3/uL	150.	450.
LY%	11.2 *L	%	20.5	51.1
LY#	3.5 *H	x10^3/uL	1.2	3.4

(5)(6)-4

ID: [illegible]
WB
08-28-03
10:50

			Patient Limits	
WBC	27.0 H	x10^3/uL	4.5	10.5
RBC	2.93 L	x10^6/uL	4.00	6.00
Hgb	8.9 L	g/dL	11.0	18.0
Hct	30.0 L	%	35.0	60.0
MCV	102.3 H	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	29.8 L	g/dL	33.0	37.0
Plt	99. L	x10^3/uL	150.	450.
LY%	9.8 *L	%	20.5	51.1
LY#	2.6 *	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-27-03
20:30

			Patient Limits	
WBC	25.0 H	x10^3/uL	4.5	10.5
RBC	2.51 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	25.4 L	%	35.0	60.0
MCV	100.9 H	fL	80.0	99.9
MCH	31.1 H	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	104. L	x10^3/uL	150.	450.
LY%	13.0 *L	%	20.5	51.1
LY#	3.3 *	x10^3/uL	1.2	3.4

ID: [illegible]
WB
08-27-03
03:40

			Patient Limits	
WBC	33.7 H	x10^3/uL	4.5	10.5
RBC	2.62 L	x10^6/uL	4.00	6.00
Hgb	8.1 L	g/dL	11.0	18.0
Hct	26.7 L	%	35.0	60.0
MCV	101.6 H	fL	80.0	99.9
MCH	30.7	pg	27.0	31.0
MCHC	30.2 L	g/dL	33.0	37.0
Plt	108. L	x10^3/uL	150.	450.
LY%	9.5 *L	%	20.5	51.1
LY#	3.2 *	x10^3/uL	1.2	3.4

(b)(6)-4

======= PICCOLO =======
23/08/03 04:38
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	170*	73-118	MG/DL
BUN	52*	7-22	MG/DL
CRE	1.8*	0.6-1.2	MG/DL
CK	198	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

======= PICCOLO =======
23/08/03 04:35
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

(b)(6)-4

ALB	2.7*	3.3-5.5	G/DL
ALP	81	26-84	U/L
ALT	461*	10-47	U/L
AMY	26	14-97	U/L
AST	405*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
BUN	61*	7-22	MG/DL
CA++	7.5*	8.0-10.3	MG/DL
CHOL	81*	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	172*	73-118	MG/DL
TP	6.0*	6.4-8.1	G/DL

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

======= PICCOLO =======
24/08/03 04:43
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
BUN	25*	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	371	39-380	U/L
NA+	[illegible]	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

(b)(6)-4

======= PICCOLO =======
24/08/03 04:40
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	94*	26-84	U/L
ALT	367*	10-47	U/L
AMY	43	14-97	U/L
AST	243*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	29*	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	64*	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	139*	73-118	MG/DL
TP	5.8*	6.4-8.1	G/DL

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

======= PICCOLO =======
25/08/03 05:13
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

(b)(6)-4

ALB	2.5*	3.3-5.5	G/DL
ALP	98*	26-84	U/L
ALT	391*	10-47	U/L
AMY	43	14-97	U/L
AST	310*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
BUN	23*	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CHOL	76*	100-200	MG/DL
CRE	0.6	0.6-1.2	MG/DL
GLU	166*	73-118	MG/DL
TP	5.8*	6.4-8.1	G/DL

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

======= PICCOLO =======
25/08/03 05:03
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	164*	73-118	MG/DL
BUN	21	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	2101*	39-380	U/L
NA+	126*	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

126 | 100 | 21
4.6 | 19 | 1.1

28) 11 / 36 138 ALT-391 AST-310

23 / 6 ...

MEDCOM - 17211

(b)(6)-4

PICCOLO

28/08/03 04:37

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

(b)(6)-2

GLU	120*	73-118	MG/DL
BUN	32*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	515*	39-380	U/L
NA+	123*	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

PICCOLO

02/09/03 04:36

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	100	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	199	39-380	U/L
NA+	128	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

i-STAT EC8+

Pt: [redacted]

Pt Name:____________

Glu__________89 mg/dL

BUN__________14 mg/dL

Na__________145 mmol/L

K___________3.0 mmol/L

Cl__________108 mmol/L

TCO2_________43 mmol/L

AnGap________-1 mmol/L

Hct__________38 %PCV

Hb*__________13 g/dL

*via Hct

pH_______7.372

PCO2______70.0 mmHg

HCO3_________41 mmol/L

BEecf________15 mmol/L

Sample Type_:

06SEP03 06:25

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

i-STAT CREA

(b)(6)-4

Pt: [redacted]

Pt Name:____________

Crea_______1.8 mg/dL

Sample Type_:

16AUG03 23:26

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

i-STAT EC8+

Pt: [redacted]

Pt Name:____________

Glu_________165 mg/dL

BUN__________36 mg/dL

Na__________142 mmol/L

K___________2.9 mmol/L

Cl__________105 mmol/L

TCO2_________28 mmol/L

AnGap________14 mmol/L

Hct__________42 %PCV

Hb*__________14 g/dL

*via Hct

pH_______7.457

PCO2______37.4 mmHg

HCO3_________26 mmol/L

BEecf_________3 mmol/L

Sample Type_:

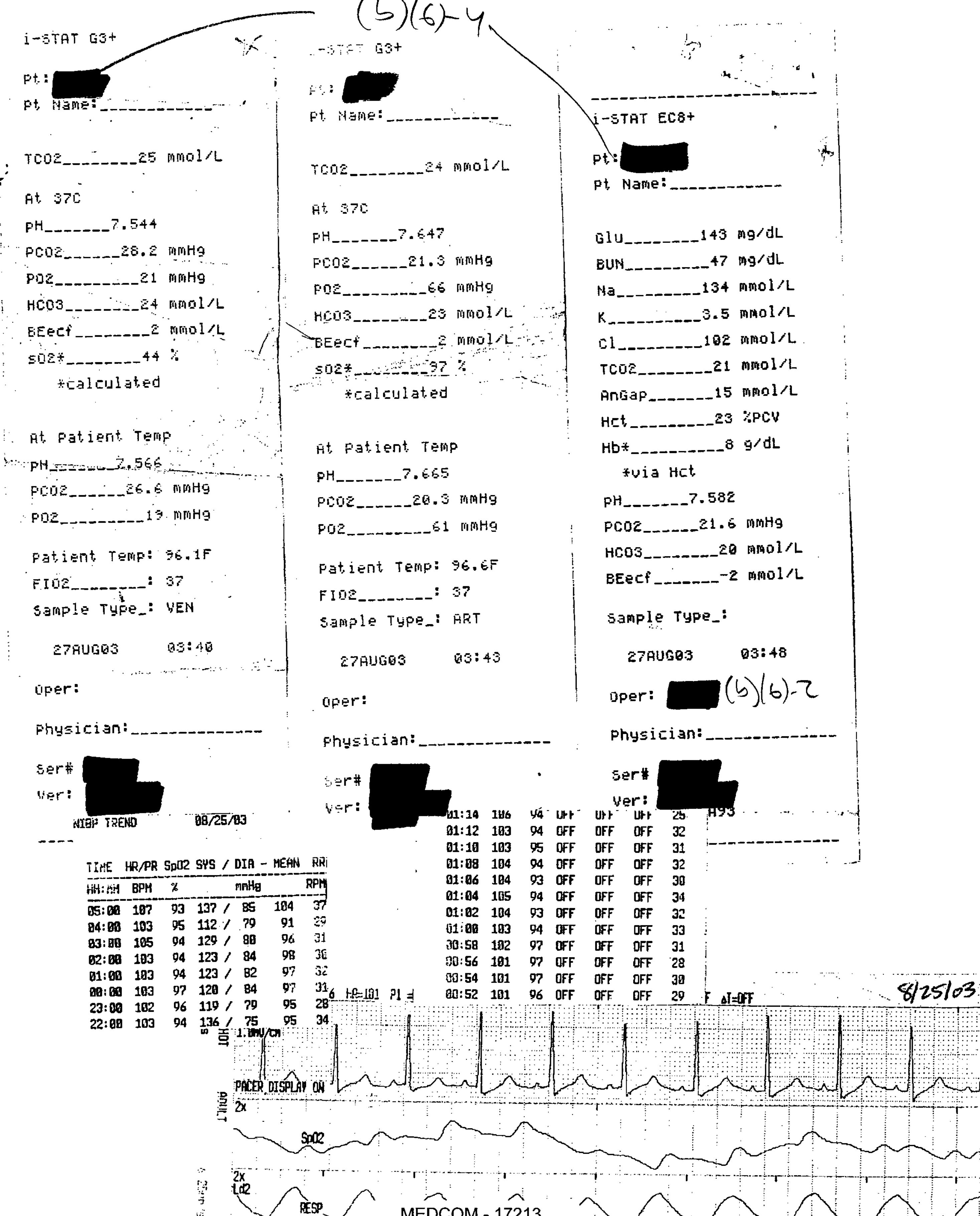
16AUG03 23:25

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]



(b)(6)-4

i-STAT G3+

Pt:

Pt Name:____________

TCO2_________25 mmol/L

At 37C

pH_______7.544

PCO2______28.2 mmHg

PO2_________21 mmHg

HCO3________24 mmol/L

BEecf________2 mmol/L

sO2*________44 %

*calculated

At Patient Temp

pH_______7.566

PCO2______26.6 mmHg

PO2_________19 mmHg

Patient Temp: 96.1F

FIO2________: 37

Sample Type_: VEN

27AUG03 03:40

Oper:

Physician:______________

Ser#

Ver:

i-STAT G3+

Pt:

Pt Name:____________

TCO2_________24 mmol/L

At 37C

pH_______7.647

PCO2______21.3 mmHg

PO2_________66 mmHg

HCO3________23 mmol/L

BEecf________2 mmol/L

sO2*________97 %

*calculated

At Patient Temp

pH_______7.665

PCO2______20.3 mmHg

PO2_________61 mmHg

Patient Temp: 96.6F

FIO2________: 37

Sample Type_: ART

27AUG03 03:43

Oper:

Physician:______________

Ser#

Ver:

i-STAT EC8+

Pt:

Pt Name:____________

Glu________143 mg/dL

BUN_________47 mg/dL

Na_________134 mmol/L

K__________3.5 mmol/L

Cl_________102 mmol/L

TCO2________21 mmol/L

AnGap_______15 mmol/L

Hct_________23 %PCV

Hb*__________8 g/dL

*via Hct

pH_______7.582

PCO2______21.6 mmHg

HCO3________20 mmol/L

BEecf_______-2 mmol/L

Sample Type_:

27AUG03 03:48

Oper: (b)(6)-2

Physician:______________

Ser#

Ver:

NIBP TREND 08/25/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN			RR
HH:MM	BPM	%	mmHg			RPM
05:00	107	93	137 /	85	104	37
04:00	103	95	112 /	79	91	29
03:00	105	94	129 /	80	96	31
02:00	103	94	123 /	84	98	30
01:00	103	94	123 /	82	97	32
00:00	103	97	120 /	84	97	31
23:00	102	96	119 /	79	95	28
22:00	103	94	136 /	75	95	34

01:14	106	94	OFF	OFF	OFF	25
01:12	103	94	OFF	OFF	OFF	32
01:10	103	95	OFF	OFF	OFF	31
01:08	104	94	OFF	OFF	OFF	32
01:06	104	93	OFF	OFF	OFF	30
01:04	105	94	OFF	OFF	OFF	34
01:02	104	93	OFF	OFF	OFF	32
01:00	103	94	OFF	OFF	OFF	33
00:58	102	97	OFF	OFF	OFF	31
00:56	101	97	OFF	OFF	OFF	28
00:54	101	97	OFF	OFF	OFF	30
00:52	101	96	OFF	OFF	OFF	29

MEDCOM - 17213

(b)(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________31 mmol/L

At 37C

pH_______7.532

PCO2______35.6 mmHg

PO2________117 mmHg

HCO3________30 mmol/L

BEecf________7 mmol/L

sO2*________99 %

*calculated

FIO2________: 60 10L

Sample Type_: BM

16AUG03 23:19

Oper: [redacted]

Physician:_____________

Ser# [redacted]

Ver: [redacted]

---

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________20 mmol/L

At 37C

pH_______7.485

PCO2______25.6 mmHg

PO2__________68 mmHg

HCO3________19 mmol/L

BEecf_______-4 mmol/L

sO2*________95 %

*calculated

At Patient Temp

pH_______7.483

PCO2______25.7 mmHg

PO2__________69 mmHg

Patient Temp: 98.8F

FIO2________: 40

Sample Type_:

21AUG03 17:22

Oper: [redacted]

Physician:_____________

Ser# [redacted]

Ver: [redacted]

---

i-STAT EC8+

Pt: [redacted]

Pt Name:____________

Glu________135 mg/dL

BUN_________35 mg/dL

Na_________135 mmol/L

K__________3.9 mmol/L

Cl_________102 mmol/L

TCO2________25 mmol/L

AnGap_______13 mmol/L

Hct_________24 %PCV

Hb*__________8 g/dL

*via Hct

pH_______7.481

PCO2______32.3 mmHg

HCO3________24 mmol/L

BEecf________1 mmol/L

Sample Type_:

26AUG03 05:38

Oper: [redacted]

Physician:_____________

Ser# [redacted]

Ver: [redacted]

(b)(6)-2

(b)(6)-2

Ward/Section: 1CAV	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 23 Apr	TIME 1915	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs	68	Mono	6
Bands	1	Eos	
Lymph	24	Baso	1
Atyp		Imm	
RBC Morph	6NRBC		
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE: 4-23-03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU 1

REQUESTING PHYSICIAN: (b)(6)-2

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

LAST, FIRST, MI. (b)(6)-4 EPW

DATE 9/23 | TIME 0425 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	22.1	4.8-10.8 x 10³
RBC	3.82	4.7-6.1 x 10⁶
Hgb	11.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.0	42-52% (M) 37-47% (F)
MCV	96.8	80-94 fl (M) 81-99 fl (F)
Plt	107	130-500 x 10³ verified
Lymph %	17.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Patients Name: EPW # [redacted] (b)(6)-4 Date: 24Aug2003

PM 24 Aug 03 | AM 24 Aug

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	06
A-Line																									98.0	
NBP																				116/70	114/78	114/73	109/74	108/66	124/76	108/70
TEMP																										
HR																				71	78	75	76	75	74	77
RR																				20	20	17	24	18	21	20
SaO2																				98%	96%	97%	96%	96%	97%	97
FIO2																				2L	2L	2L	2L	2L	4L	2L
Source																				NC	NC	NC	NC	NC	NC	NC
MAP																				93	92	91	88	85	95	88
~~FiO2~~																										
~~Source~~																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF	~~125~~																			125	125	125	125	125	125	125
IVPB																						50				
NGT																										
PO																				120			240			
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
URINE	~~105~~ 90																			105	56	100	134	175	70	
NGT																										
STOOL																										
DRAIN																										
Total																										

(b)(6)-2

Ward/Section: ICU I	REQUESTING PHYSICIAN: [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE [illegible] TIME 0945	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

Chem 8

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW # (b)(6)-4	DATE 18Aug	TIME 2240	SSN/PSEUDO SSN: (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4

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

Ward/Section: ICW2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	

LAST, FIRST, MI. [redacted] EPW	DATE 18 Aug	TIME 2245	SSN/PSEUDO SSN: EPW [redacted]

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8 (circled) Chem 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
18/08/03 22:56
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-2
METLYTE 8
DISC LOT #: (b)(6)-4 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	153*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	811*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	94*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 18 Aug 03	LAB ID NO.:

MEDCOM - 17220

(b)(6)-2

Ward/Section: ICW	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: (b)(6)-4	DATE 8/22	TIME 043–	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	2.9	3.5-4.9 mmol/L
Cl	103	98-109 mmol/L
pH	7.522	7.31-7.45
PCO2	29.1	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	122	80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	24	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99%	95-98%
BEecf	3	(-2) – (+3) mmol/L
AnGap	13	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	90	8-26 mg/dl
GLU	156	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	35	38-51% PCV
Hgb	12	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.9	3.5-5.5 g/dl
ALP	76	26-84 u/l
ALT	676	10-47 u/l
AMY	28	14-97 u/l
AST	1297	11-38 u/l
TBIL	1.2	0.2-1.6 mg/dl
BUN	78	7-22 mg/dl
CA^{++}	7.9	8.0-10.3mg/dl
CHOL	112	100-200 mg/dl
CRE	1.7	0.6-1.2 mg/dl
GLU	164	73-118 mg/dl
TP	6.6	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: ICU# 1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4	DATE 8/22	TIME 0450	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.2	4.8-10.8 x 10³
RBC	3.90	4.7-6.1 x 10⁶
Hgb	12.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.7	42-52% (M) 37-47% (F)
MCV	96.9	80-94 fl (M) 81-99 fl (F)
Plt	107	130-500 x 10³ verified
Lymph %	14.1	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: (b)(6)-7	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 16 Aug	TIME 2315	SSN/PSEUDO-SSN: (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Hazy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	trace	Negative
pH	5.0	N/A
Prot	Trace	Negative
Urob	Norm	0.2-1.0
Nit	neg	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

WBC = 5-8
RBC = 1-3
Hyaline Cast - 8-10 LPF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.9	9.8-13.6 secs
APTT	22.3	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: 16 Aug 03	LAB ID NO.:

(b)(6)-7

(b)(6)-4

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 05 Sept	TIME 1105	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

TEST	RESULT	REF. RANGE
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	Yel	N/A
App	Hzy	N/A
Glu	N	Negative
Bili	N	Negative
Ket	N	Negative
SG	1.025	N/A
Bld	Large	Negative
pH	6.0	N/A
Prot	30+	Negative
Urob	N	0.2-1.0
Nit	N	Negative
Leuk	Large	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA 2:34
WBC <50
RBC <50
Bact: [illegible]

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

(b)(6)-4

Ward/Section: EMT | REQUESTING PHYSICIAN:

LAST, FIRST, MI: (b)(6)-2 | DATE: 9 Sep | TIME: 1103 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST | RESULT | REF. RANGE

```
======= PICCOLO =======
06/09/03    (b)(6)-4 11:47
REFERENCE RANGE:        MALE
PATIENT #:
GENERAL CHEMISTRY 12
DISC LOT #:          3082AA4
OPER #:            DR #: 000
SERIAL #:
.........(b)(6)-2..........
ALB    3.4   3.3-5.5    G/DL
ALP    78    26-84      U/L
ALT    22    10-47      U/L
AMY    48    14-97      U/L
AST    21    11-38      U/L
TBIL   0.8   0.2-1.6    MG/DL
BUN    11    7-22       MG/DL
CA++   9.0   8.0-10.3   MG/DL
CHOL   211*  100-200    MG/DL
CRE    1.3*  0.6-1.2    MG/DL
GLU    95    73-118     MG/DL
TP     7.1   6.4-8.1    G/DL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: (b)(6)-2 | **DATE:** 6 Sep 03 | **LAB ID NO.:**

MEDCOM - 17225

3x4 Simultaneous Report

Name: (b)(6)-7
Number:
Sex: Male
Date of Birth: 8/18/1948 (55 years)
Height/Weight: 67in / 223lb

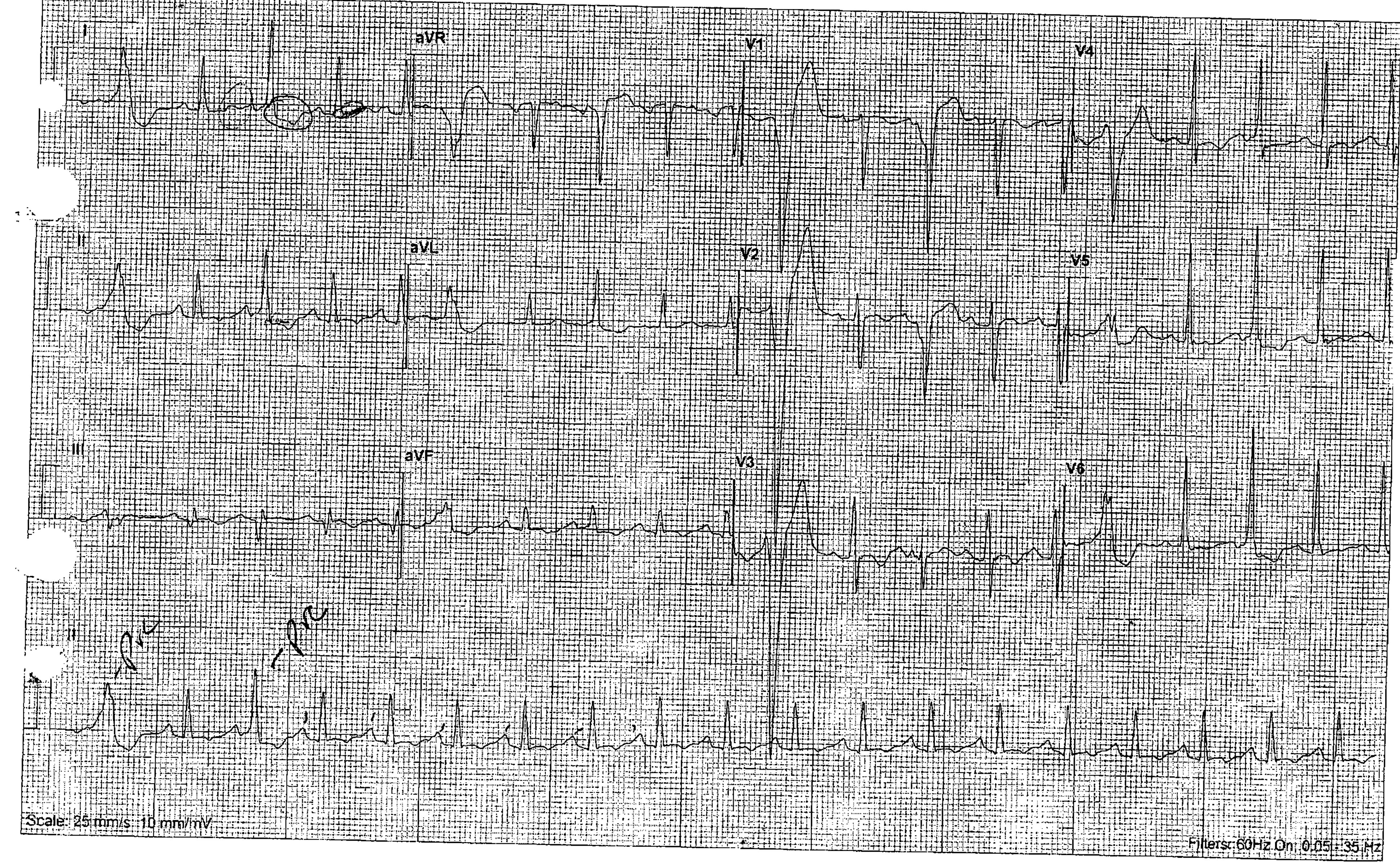
Recorded: 8/18/2003 10:23:21 PM
Device: CL 131132

Measurements

Heart Rate: 116 bpm
P Duration: 122 ms
PR Interval: 184 ms
QRS Duration: 78 ms
QT Interval: 314 ms
QTc Interval: 437 ms
P,QRS,T Axis: 52°, 17°, -45°

Interpretation (Unconfirmed)

Sinus tachycardia
Atrial flutter with a variable block cannot be ruled out
Abnormal repolarisation, possible coronary ischemia



MEDCOM - 17226

 File: viewECG.scp Printed: 8/18/2003

(Data must be reviewed by a qualified physician)

Confirmed by:

3x4 Simultaneous Report

(b)(6)-4

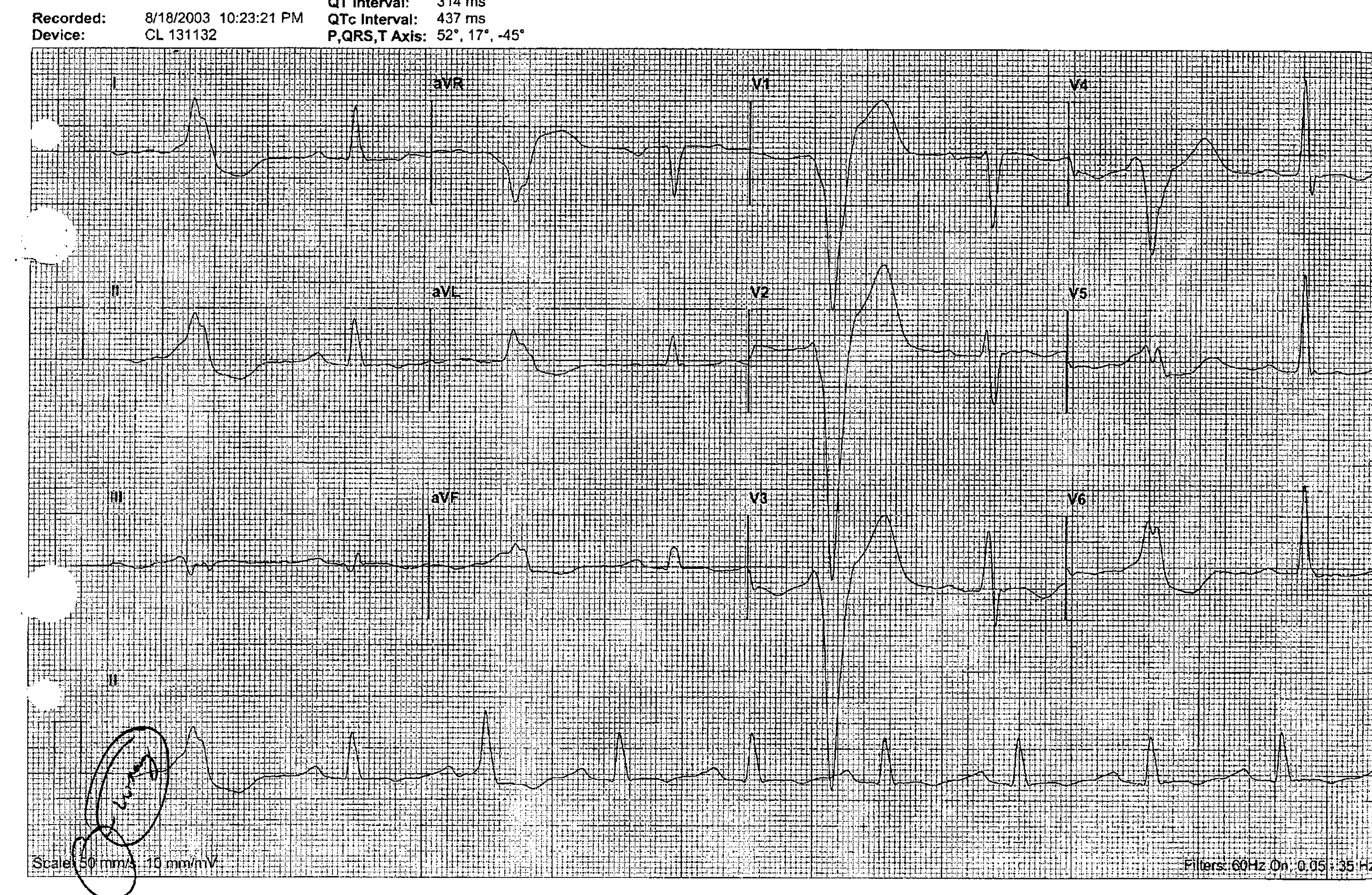
Name:	
Number:	
Sex:	Male
Date of Birth:	8/18/1948 (55 years)
Height/Weight:	67in / 223lb
Recorded:	8/18/2003 10:23:21 PM
Device:	CL 131132

Measurements

Heart Rate:	116 bpm
P Duration:	122 ms
PR Interval:	184 ms
QRS Duration:	78 ms
QT Interval:	314 ms
QTc Interval:	437 ms
P,QRS,T Axis:	52°, 17°, -45°

Interpretation (Unconfirmed)

Sinus tachycardia
Atrial flutter with a variable block cannot be ruled out
Abnormal repolarisation, possible coronary ischemia



MEDCOM - 17227

 File: viewECG.scp Printed: 8/18/2003

(Data must be reviewed by a qualified physician)

Confirmed by:

3x4 Simultaneous Report

(b)(6)-4

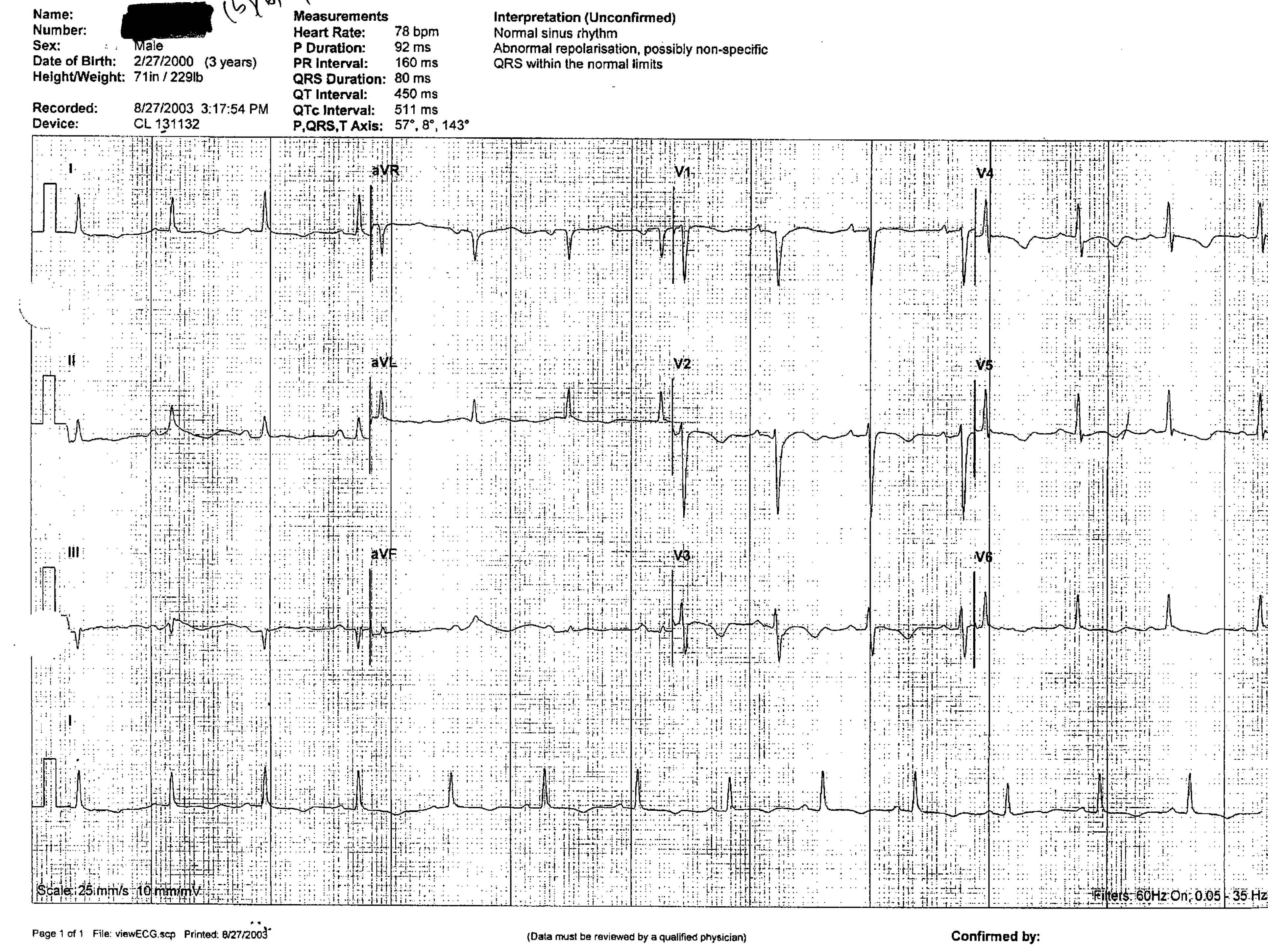
Name:	
Number:	
Sex:	Male
Date of Birth:	2/27/2000 (3 years)
Height/Weight:	71in / 229lb
Recorded:	8/27/2003 3:17:54 PM
Device:	CL 131132

Measurements

Heart Rate:	78 bpm
P Duration:	92 ms
PR Interval:	160 ms
QRS Duration:	80 ms
QT Interval:	450 ms
QTc Interval:	511 ms
P,QRS,T Axis:	57°, 8°, 143°

Interpretation (Unconfirmed)

Normal sinus rhythm
Abnormal repolarisation, possibly non-specific
QRS within the normal limits



MEDCOM - 17228

(Data must be reviewed by a qualified physician)

Confirmed by:

ICU 2

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	Doses	TOTALS
Versed (mg)	2	2
Fentanyl (mcg)	50 50/100 50	250
Propofol (mg)	100	100
SCH (mg)	120	120
Vecuronium (mg)	10	10
Labetalol (mg)	40	
VOLAT AGENT Iso % del	1.2-1.8 — 0.8 X	
% e.t.		
AIR L/Min		
N2O L/Min		
(O2) L/Min	10 — 2 — 2 — 2 — 10	

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

TOTAL EBL: 100
TOTAL URINE: 450

FLUIDS SUMMARY
CRYSTALLOID- 1600
COLLOID- 300
BLOOD- Ø

FLUIDS

LINE site	Warmed	
18g (L)	☐ Warmed	LR ——— X Hespan ——→
	☐ Warmed	→ 1600
18g (R)	☐ Warmed	LR ————————→

LOSSES
EST BLOOD LOSS
URINE - Foley 450

PHYS STATUS: 1 (2) 3 4 5 (E)
BODY WEIGHT: KG LB
HEMATOCRIT:
INITIAL DATA: BP- 112/57 HR- 57
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK: OK for PROCEDURE? Okay TIME- 0245

TIME → 0300 15 30 45 0400 15 30

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

	0300	15	30	45	0400
VT - ml	—	740	750	750	1.1
f - breaths/min	20	8	8	8	16
Peak inf pres / PEEP	—	18	20	20	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S
X BP/Auto Cuff / X ET CO2 (torr)	(+)	33	31	31	38
BP/oth / X FIO2 (Frac or %)	.70	.70	.70	.70	.70
ART line / X SpO2 (%)	100	100	100	100	100
Steth- PC/ES / X ECG	SR	SR	SR	SR	SR
Gas analyzer / X TEMP-site	36.5	36.4	36.4	36.4 X	
X N-M Block (T/4)		0/4	0/4		1/4 4/4 ST@50
Warming blkt					
Conv warmer					

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

REMARKS (Code drugs with numbers, events with letters)

0250 Pt. d/on ICU 2 chart reviewed, 0300 In room, monitors, O2, IV induction, Eyes taped. OG placed, stomach sxn. 0324 Procedure started 0350 Procedure complete 0400 Pt reversed c 5mg Neostigmine c 0.9 mg Robinul 0405 Pt. Po sxn x 2. Extubated s difficulty. To ICU 2 in stable condition. Report to [redacted]

RECOVERY AT 0410
PACU ICU 2 (Specify)
OTHER
CONDITION: Stable
RESP- 20 SpO2- 95% A
BP- 136/84 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0250	0300	0415
	Ready	**Begin**	**End**
PROC	0312	0324	0350

PROCEDURES and CPT Codes: Ex lap; I&D (L) Hip

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — RSI c Cricoid pressure, DL x 2 attempts, Grade I view c MAC 3, #8 ETT placed @ 22cm teeth, (+) BBS, (+) EtCO2 ...

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

SURGEONS: [redacted] [redacted]
ANESTHETISTS: (b)(6)-2
PROCEDURE LOCATION: OR 1
DATE: 17 Aug 03
PAGE 1 OF 1

PRE-ANESTHETIC ASSES[illegible] ND PLAN OF CARE

AGE: 55 Days Mos Yrs (circled: Yrs)

GENDER: (X) Male ( ) Female

ALLERGIES: ____

P S: 1 2 3 4 5 (E) (handwritten: 8?)

WT: 85 Kg/Lb HT: ____ In.

PROPOSED PROCEDURE: Ex Lap

SURGICAL SERVICE: Gen

NPO SINCE: ____

PREOP DX / MECHANISM OF INJURY: S/P Blast Injury – Shrapnel wounds (L) Hip Flank

HABITS:	PAST MEDICAL HISTORY / SYSTEMS REVIEW	SURGICAL HISTORY
Tobacco: Ø EtOH: Ø Drugs: Ø	*Cardiovascular:* Hypertension N Y Angina N Y ? MI N Y CVA N Y Other N Y	?
CURRENT MEDICATIONS: ( ) = ordered as premed ( ) Ancef } EMT ( ) Tetnus } ( ) ( ) ( ) ( )	*Pulmonary:* Asthma N Y ? URI N Y COPD N Y Other N Y	**PHYSICAL EXAMINATION** BP: 112/57 HR: 57 RR: ____ T: 99.?
PREMEDICATIONS: None / Yes @ ____ Hrs	*Renal System:* ARF/CRF N Y Foley Other N Y *Gastrointestinal:* Hepatitis N Y Hiatal Hernia N Y ? GERD/PUD N Y	Pain (0/10 Scale): ____ Airway Exam: Dentition ____ Trachea ____ TMJ/C-spine ____ Oropharynx ____
LABORATORY STUDIES: 10.1 / 14.3 / 44.4 / 178 Other: PT 14.9 PTT 22.3	*Endocrine:* Diabetes N Y Steroids N Y Thyroid N Y *Neurological:* Seizures N Y Neuropathy N Y *Gynecological:* Pregnancy N Y N/A Other N Y *Other Problems:* N Y *Familial Hx* N Y	Chest: Lungs CTA Heart ____ IV Access: 18g x 2 Ulnar Filling: ____ Back: ____ Other: ____

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

INFORME[redacted]NSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed w[redacted]l guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

(b)(6)-2

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

Signed: [redacted] CRNA CPT Date: 17 Aug 03 Time: 0235

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: ____

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

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

VOLUME REQUESTED (If applicable) ____ ML

REMARKS: 1 UNIT

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 28 AUG 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

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

REQUESTING PHYSICIAN (Print): Dr. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P EX LAP, (R) Iliac Fx

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct. (b)(6)-2

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 28 Aug 03

TIME VERIFIED: 0850

SECTION II – PRE-TRANSFUSION TESTING

UI [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O, Rh positive

RECIPIENT: ABO O, Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compatable

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DATE: 28 Aug 03

REMARKS: EXP 3, Sept 03 (b)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) [redacted]

AT (Hour) [redacted] ON (Date) 28 Aug 03

IDENTIFICATION

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

1st VERIFIER (Signature) [redacted] /SGT/AN

2nd VERIFIER (Signature) [redacted] SM/AN

(b)(6)-2

PRE-TRANSFUSION
TEMP. 97.8 PULSE 75 BP 136/68

DATE OF TRANSFUSION: 28 Aug 03

TIME STARTED: 0958

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME/DATE COMPLETED/INTERRUPTED: 1115 28 AUG 03

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE: 97.9

PULSE: 75

BLOOD PRESSURE: 107/74

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [x] NO
- [ ] YES (Specify)

SIGNATURE [redacted] /LT/AN

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

[redacted] (b)(6)-2

SEX: M

WARD: ICW1

[redacted]

(b)(6)-4

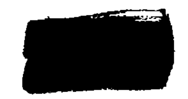
BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 17231

Medical Record Copy



518–124 NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

REQUESTING PHYSICIAN (Print)

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P EX LAP

DATE REQUESTED: 26 AUG 03

DATE AND HOUR REQUIRED: ASAP

(b)(6)-2

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

VOLUME REQUESTED (If applicable) ____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

DATE VERIFIED: 26 Aug 03

TIME VERIFIED: 1713

REMARKS: 1 unit

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

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compatible

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

SIGNATURE OF PERSON PERFORMING TEST: CS

	DONOR	RECIPIENT
ABO	O	O
Rh	POS	POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS: Expi ~~27 Aug 03~~ 02 Sep 03 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) ... AUG 03

IDENTIFICATION

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

1st VERIFIER (Signature)

(b)(6)-2

TEMP. 97.7 | PULSE 108 | BP 112/56

DATE OF TRANSFUSION: 26 Aug 03

TIME STARTED: 26 Aug 03 @ 2114

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 2200 @ 26 Aug 03

REACTION
- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE: 98.6 | PULSE: 107 | BLOOD PRESSURE: B/P 117/56

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

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

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

91WM6

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

(b)(6)-2

SEX: M | WARD: ICU 1

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 17232

Medical Record Copy

518–124 NSN 7540–00–634–4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P EX LAP

(b)(6)-2

DATE REQUESTED: 26 Aug 03

DATE AND HOUR REQUIRED: ASAP

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

VOLUME REQUESTED *(If applicable)* ______ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: [redacted]

REMARKS: 1unit

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED: 26 Aug 03

TIME VERIFIED: 1713

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compatible

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

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

	DONOR	RECIPIENT
ABO	O	O
Rh	POS	POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: EXP: 27Aug03 @2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSP[ECTED BY (Signature)]: [redacted]

AT [redacted] ON *(Date)* 26 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the pa[tient's identification band]

1st V[erifier]: [redacted]

2nd V[erifier]: [redacted] /AN

(b)(6)-2

PRE-TR[ANSFUSION]

TEMP. 97 | PULSE 83 | BP 100/64

DATE OF TRANSFUSION: 26 Aug 03

TIME STARTED: 2018

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 26Aug03 @ 2114

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE: 97 | PULSE: 108 | BLOOD PRESSURE: 112/56

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

[redacted] 9WMG

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

(b)(6)-2

SEX: M

WARD: ICU

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 17233

Medical Record Copy

NSN 7540-01-165-7294 591-301

RADIC IC CONSULTATION REQUEST/F RT

(Radiology/Nucl. .edicine/Ultrasound/Computed Tomography . .ations)

EXAMINATIONS (S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINC	REGISTER NO.
CXR		M		10W#4	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)*: Dr

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR (b)(6)-2

DATE REQUESTED: 10SEP03

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

↓ O2 sat
fever

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1—MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 591-301

RADI( )GIC CONSULTATION REQUEST/ ORT

(Radiology/N Medicine/Ultrasound/Computed Tomograph inations)

EXAMINATIONS (S) REQUESTED

p CXR

AGE	SEX	SSN *(Sponsor)*	WARD/CLINC	REGISTER NO.
			ICU	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)*

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR Dr [redacted] (b)(6)-7

DATE REQUESTED 26 Aug 200

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

swan ganz line placement

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1—MEDICAL RECORD

STANDARD FORM 519-B (6-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

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

Noted 19Aug03 1450

(b)(6)-2

DATE OF ORDER 19 Aug 03

TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1- [illegible] 1-2 [illegible] po q4° prn pain

2- Colace 100 PO bid

3- [illegible] q6 [illegible] prn

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

8/20 [illegible]

HOURS

[illegible]

1 30cc Mylanta [illegible]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2220 8/23/03

1 CBC [illegible] Q Day

Noted 08/23/03 2310

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

U.S. GOVERNMENT PRINTING OFFICE: 1986—493-924

"USE BALL POINT PEN. PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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

DATE OF ORDER: 8/18/03 TIME OF ORDER: 2145 HOURS

LIST TIME ORDER NOTED AND SIGN

- Albuterol treatment q4° ✓ overnight then prn
- CXR, PA/LAT tonight after treatment ✓
- wean O_2 to keep Sat >92% ✓
- Incentive Sp[...] q2hrs while awake ✓
- Please get [...] rhythm [...] ✓
- Send CBC, [...] ✓

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 8/18/03 TIME OF ORDER: 2240 HOURS

1. Lopressor 5mg IVP now ✓
2. Lopressor 25mg po BID ✓ unavailable
3. Lasix 20mg IVP now ✓
4. Lovenox 40mg SQ QD → 1st dose tonite ✓
5. ABG tonite ✓

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19 AUG 03 TIME OF ORDER: [...] HOURS

1. Atenolol 50mg po QD

(b)(6)-2

Noted 19 Aug 03 1445

NURSING UNIT | ROOM NO. | BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE: 1986—409-924

"USE BALL POINT PEN. PRESS FIRMLY. NO CARBON PAPER REQUIRED"

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8/19	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	(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.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER 18 AUG 03 | TIME OF ORDER ______ HOURS | LIST TIME ORDER NOTED AND SIGN

1) Admit [illegible]
2) Dx: [illegible] Ofer
3) [illegible]
4) [illegible] q10
5) [illegible]
6) NPO
7) [illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER ______ TIME OF ORDER ______ HOURS

8) [illegible] to [illegible]
9) MEDS
MSO4 2-6 mg [illegible]
[illegible] 4mg [illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER Ancet 1gm | TIME OF ORDER [illegible] 80 HOURS

10) [illegible] T>101.5 , SBP >180 [illegible]
UOP < 30cc/hr

✓chart 0147 CP[illegible] noted/done

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1990—403-524

"USE BALL POINT ... CARBON PAPER REQUIRED"

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)-7

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/18 TIME OF ORDER: 0300 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU postop
2. s/p exp lap [illegible]
3. Stable
4. VS routine
5. Foley
6. Morphine 2-6mg iv q1°
7. Ancef 1g ivp q8°

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

8. LR @ 150cc/hr
9. Clears
10. Zofran 4mg iv q6° prn nausea
11. Incentive Spirometer

NURSING UNIT | ROOM NO. | BED NO.

[illegible] 0800 [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 8/18/[illegible] TIME OF ORDER: 1613 HOURS (b)(6)-2

NMO

800[illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 18 Aug 07 TIME OF ORDER: 1779 HOURS

Transfer to ICW / Dx s/p Ex lap

VS q4° x 48° then q8°

IVF LR @ 125cc/h

NPO, clears in AM

Foley to gravity drainage

NURSING UNIT | ROOM NO. | BED NO.

MSO4 2-4mg q2° PRN, phergan 12.5mg IVP q6° PRN

Ancef 1gm q8°

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

Incentive Spirometer (b)(6)-7

OOB TID

[illegible]