ICU3

Patients Name: Epc[redacted] b(6)-4 Date: 8·15·03

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		119/67																								
TEMP		97.3														97.6										
HR		67														53										
RR		18														18										
SaO2		99														98%										
FiO2																										
Source		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	Tota
IVF																										
IVPB																										
NGT																										
PO		350						600			300															
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			55				600				400							850							650	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 16441

MEDICAL RECORD-SUPPLEMENTAL MEDI[illegible]

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

REPORT TITLE	OTSG APPROVED (Date)
INTENSIVE CARE NURSING FLOW SHEET b(6)-2	QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initals: [redacted]	Time: 1900 Initals: [redacted]
NEURO	Pupils	3mm PERRL	Perrla
	Sensorium	Alert, able to follow	Alert & Oriented x 3
	LOC / GCS	simple commands and	follows commands
		express needs	
CARDIAC	Cardiac Rhythm	SR c Ø CP	NSR
	PRI: / QRS:	———	
	Pulse Strength	+2 pulses in all 4 ext.	+2 pulses all extremities
	Cap Refil / JVD	Cap refill < 3 sec	cap refill < 3 sec
	Edema	Ø noted	
	Chest Pain		
RESP	Respiratory Pattern	RRR, equal chest rise	RRR
	Breath Sounds	CTA throughout	Clear Bilat
	Secretions	Ø noted @ this time	Ø
	Cough	Ø noted	Ø
SKIN	Color	WNL for race	Normal to race
	Integrity	2 BLE wound c drsg	
	Backside	DH	
IV	Access Devices	(L) FA c NS @ 30cc/°	(L) FA IV
	Location	Ø s/s of infection	Ø s/s of infection
	Condition		
GI	Abdomen	Soft, nontender	Soft, non tender
	Bowel Sounds	(+) in all 4 quadrants	normoactive all 4 quads
	Stoma/Ostomy	Ø noted	
GU	Device	Urinal	pt voids to urinal
	Color / Clarity	Ø void @ this time	Clear yellow urine

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE 16 AUG 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

ICU3 Patients Name: 2PW [redacted] (b)(6)-4 Date: 16 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																										
NBP	120/68				128/61				143/69					135/70												
TEMP	96.5				97.3				97.[illegible]																	
HR	63				62				61					65												
RR	16				16				18					18												
SaO2	99				98				96					99												
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	30	30	30	30	30	30	30	30	30																	
IVPB																										
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	575		575											500				400					600			
NGT																										
STOOL																										
DRAIN																										
Total	575		575																							

. CAL RECORD-SUPPLEMENTAL MED 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 08MAR8

		INITIAL SHIFT ASSESSMENT	
N		Time: 1200 Initals: [redacted] b(u)-2	Time: 2400 Initals: [redacted] b(u)-2
E	Pupils	PERRLA	Perrla
U	Sensorium	A+O x 3	A+O X3
R	LOC / GCS	Follows Commands, Responsive	
O			
C	Cardiac Rhythm	——	——
A	PRI: / QRS:	——	——
R	Pulse Strength	+3 pulses in all extremities	+3 pulses x 4 extremities
D	Cap Refil / JVD	<3 secs / Ø JVD	Cap refil <3 sec
I	Edema	None	Ø
A	Chest Pain	None	Ø
C			
R	Respiratory Pattern	Regular + unlabored	RRR Ø SOB
E	Breath Sounds	Diminished but CTA	CTA
S	Secretions	None	Ø
P	Cough	None	Ø
S	Color	Normal for race	Normal for Race
K	Integrity	Wound to B/E	intact x wounds to B/E
I	Backside	None	Ø
N			
	Access Devices	18G IV in Ⓛ AC	18g PIV Ⓛ ac
I	Location		
V	Condition	Ø S/S of infection @ IV site	Ø S/S of infection or infiltration
	Abdomen	Soft, Tender to Palpation	soft, nondistended
G	Bowel Sounds	Hypoactive	
I	Stoma/Ostomy	Ø N/V	Ø
G	Device	Voiding ̄s difficulty	Voids to urinal
U	Color / Clarity	Golden yellow	

(Continue on reverse)

PREPARED BY: b(u)-2 [redacted] ... /AN

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

DATE: 18 Aug 03

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

[redacted] b(u)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: ________ b(3)-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																										
NBP							132/64																			
TEMP							97.8																			
HR							86																			
RR																										
SaO2							98																			
FiO2							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 LR	30	30	30	30	30	30	30	30	30	30	30	30	360													
IVPB																										
NGT																										
PO					240		260			240		240	980													
Total													1340													
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							900		500		475		1875					300					400			
NGT																										
STOOL																										
DRAIN																										
Total																										

~~MEDI~~CAL RECORD-SUPPLEMENTAL ME~~DICAL D~~ATA

For use of th~~is f~~orm, see AR 40-66; the proponent agency is the Office ~~of~~ The Surgeon General.

REPORT TITLE: INTENSIVE CARE NURSING F~~LO~~W SHEET

OTSG APPROVED (Date): QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	PERRL	
	Sensorium	Pt alert + responsive to	
	LOC / GCS	touch + voice stimuli	
CARDIAC	Cardiac Rhythm	Not on Monitor	
	PRI: / QRS:		
	Pulse Strength	Radial @ +3, Pedal @ +1	
	Cap Refil / JVD	brisk cap refill	
	Edema	Ø Ntd	
	Chest Pain	Ø	
RESP	Respiratory Pattern	Reg R+R, equal rise + fall	
	Breath Sounds	CTA bilat	
	Secretions	Ø Ntd	
	Cough	Ø Ntd	
SKIN	Color	NFR	
	Integrity	dressings intact	
	Backside	Ø Ntd problems	
IV	Access Devices	LFA PIV c̄ LR @ KVO	
	Location	Slight tenderness @ site c̄	
	Condition	Ø Ntd erythema/edema	
GI	Abdomen	Lower quads firm + tender to	
	Bowel Sounds	palpation, upper quads soft +	
	Stoma/Ostomy	non tender. BS + x 4 quads.	
		Ø Ntd N/V	
GU	Device	Pt voiding clr yellow urine to	
	Color / Clarity	urinal @ bedside in adequate	
		ammounts.	

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

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

(Continue on reverse)

DATE: 19 Aug 03

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

b(6)-2

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

DA FORM 4700, MAY 78

MEDCOM - 16446

USAPPC V2.00

ICU3 Patients Name: [redacted] Date: 19Aug03

b(a)-4

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	125/70		120/50																							
TEMP			97.6																							
HR	58		61																							
RR	18		16																							
SaO2	98%		98%																							
FiO2																										
Source	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																										
IVPB																										
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**	[illegible]
URINE			525																							
NGT																										
STOOL																										
DRAIN																										
Total																										

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

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 (9–15): [redacted]

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

4. PAY GRADE (16, 17): EPW

5. SEX (18): M

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

19	20	21	22	23	24	25	26
Z	Z	Z	Z	Z	Z	Z	Z

7. AGE AT ADMISSION

27	28	29
2	4	Y

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

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: 1430

BRANCH / CORPS: — b(6)-4

14. FLYING STATUS (47–49): —

15. BENEFICIARY CATEGORY

50	51	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: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): Ø

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION b(2)-2

73	74
5	0

22. MTF TRANSFERRED TO (75–80):

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

81	82	83	84	85	86
Ø	3	Ø	8	1	9

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM (91–96):

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

97	98	99	100	101	102
Ø	3	Ø	8	1	1

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

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

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

Cellulitis

b(6)-2

ADMITTING OFFICER (Signature, as required) [redacted]

INPATIENT TRATMENT RECORD COVER SHEET

b(6)-4 For use of this form, see AR 40-400; the proponent agency is OTSG

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	[redacted] EPW	[redacted]	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	22	—	—	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99 20	[redacted]	—	ICW#2

15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO	—	K-78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1843	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
unk	50	17 Aug 03

b(6)-2

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
unk	unk	14 Aug 03	DR. [redacted]

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to Ⓛ Calf / thigh

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	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	b(6)-2		b(6)-2		

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF MEDICAL RECORDS OFFICER
DR [redacted]	[redacted]

MEDCOM - 16449

DA FORM 3647, MAY [redacted]

EDITION OF 1 AUG 76 IS OBSOLETE

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

PHYSICAL EXAMINATION

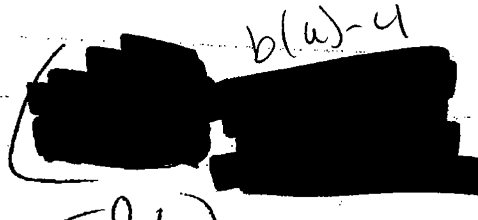
See

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.



b(6)-4

E&W

ABBREVIATED MEDICAL RECORD
Standard Form 509
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
509-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Aug03 2030	pt. admitted to ICW2 @1800 from EMT, S/P GSW (L) calf & (L) thigh, debridement done @ 624th FST today - Kerlix dsg on calf & thigh, small amount of blood on calf dsg. on admission - VSS, T 101.8, 650mg PO tylenol given, temp @ present 98.2 - lungs c slight exp. wheezes, pt. reports he smokes 1 PPD - BS ⊕ x4 quads - pt. oriented, understands small commands in english - pt. denies ~~illicit~~ illegal drug use - SL patent in (R) FA - thigh dsg CDI on admission, neurovit'S WNL in (L) foot - [redacted]
14AUG03 2130	VSS - Alert x3 PEARLA s̄ m - salinelock to (R) FA patent s̄ s/s infiltration. Lungs ~~CTA B/L~~ Rhanci B/L even Reg - HR - NSR - BS ⊕ x4 quads. Pedal pulses +3 Radial +3. Dsgs to (L) leg small amt of blood/drainage noted and intact. T-97°Ax. Amb x1 c̄ crutches to BR on ward. of this ø c/o @ present. Restraints to UE and LE in place and secure. [redacted]
15Aug03 0815	Pt. awake & alert sitting up in bed. HR Regular, bowel sounds (+) x4 quad. Lung sounds c̄ (R) sided inspiratory wheezes, (L) side c̄ inspiratory ronchi in upper lobe & inspiratory wheezes throughout. HL in (L) wrist flushed well c̄ 3cc NS. DSG's to (L) LE saturated c̄ bright red bld. DSG's Δ'd, to upper thigh c̄

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. ICW2

[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
USAPA V2.00

b(a)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	lower calf, 2 wounds to upper thigh & 2 wounds to lower calf all approx. dimensized packed c sterile iodiform, wounds s s/s of infection. (L) pedal pulse (+), (+) sensation, <3 sec cap refill, limited ROM in ankle, knee, & toes. Pt. s complaints @ this time. VSS. Will continue to monitor [redacted]
15Aug03 1700	assumed care @ 1300 - VSS, T 100.8 - no c/o pain @ this time - SL patent - dsg on (L) calf & thigh CDI, neurov's WNL in (L) foot - T @ present 100.4°F, given 650mg tylenol PO ——— [redacted] CR, AN ——
15Aug03 2130	VSS - Alert x3 - DRSG to (L) leg dry and intact. Pearl a gm HR - NSR - Lungs CTA BIL - Resp even reg BS ⊕ x4 quads. Pedal and Radial pulses +4, CMS >3 sec, heplock patent ⊖ S/S infiltration. Restraints to UE and LE in place and secure. ∅ c/o (L) leg pain @ present. up to ward BR c crutches per self M. ——— S [redacted]
16Aug03 0330	Resting quietly @ present. ∅ c/o (L) leg pain drsg dry and intact. Restraints to UE and LE in place and secure. IV Ancef given via peripheral saline lock is patent ⊖ s/s of infiltration. ——— [redacted]
16Aug03 0630	Assumed PT care at 0545. PT A&O x3. VSS. Laying in bed. No c/o pain or discomfort heplock flushed pulses + x4 Lungs CTA, BS +. Will continue to monitor ——— [redacted]
0845	Dsg Δ done. MD in to see wounds. 2 wounds to upper thigh and two wounds to lower calf of (L) LE. packed loosely c iodiform gauze. All sites free of infection. Limited ROM to (L) LE. NV checks WNL. Amb c crutches [redacted]

STANDARD FORM 600 (REV. 6-97) BACK USAPPC V1.10 USAPA V2.00

MEDCOM - 16452

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16Aug03 1450	assumed care @1300 - VSS - no c/o pain @ this time - small amount of serosang. drainage on underside of calf & thigh dsg - SL patent - pt. using crutches to ambulate - [redacted]
16Aug03 1620	neurov'S WNL in (L) foot, (+) movement, (+) sensation - had BM [redacted] CRNA
16Aug03 2145	VSS - Alert x3 dsgs to (L) leg dry and intact. Ø c/o pain or discomfort @ present. Pearla 4mm - Lungs - slight Rhonci and wheezes to upper lobes b/L. HR - NSR - BS (+) x4 quads Pedal and Radial pulses +4. Amb to BR via crutches c min Assist from staff. Restraints in place and secure. [redacted]
17Aug03	0718 Assume pt care @ 0500. Pt awake and alert. VSS. HR reg. Lungs CTA. Abd soft BS x 4. Amb c crutches to BR. Dsg to (L) thigh and (L) calf CD+I. (+) ROM (+) pulse (+) sensation to (L) LE. Tylenol 650mg given for pain. SL patent. Will cont. to monitor. [redacted]
1300	Dsg Δ done. wounds packed c iodaform. sites free of infection, possibly discharged in 2 days [redacted]

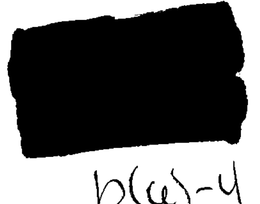
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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. ICW 2



EPW

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Aug 03	D/c Summary
	- s/p soft tissue GSW (L) calf & thigh
	- treated c Ancef / Keflex &
	dressing Δ,
	- Plan cont dsg Δs BID until
	wounds granulate
	b(6)-2
	All
17Aug03 1600	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg on (L) thigh & calf CDI, neurovascular WNL in (L) foot, no edema - SL patent - pt. has meds & DC Summary & awaits discharge to EPW camp or front gate -
17Aug03 1930	calf & thigh dsgs on (L) leg Δ, all 4 wounds tunnel slightly, no bleeding noted, serosang drg on old dsgs, wounds loosely packed c ½" iodoform, soaked in NaCl, pt. given ii Percocet for pain

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)*

(EPW)

REGISTER NO. | WARD NO. ICW2

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16454

b(6)-2

MEDICAL RECORD | PROGRESS NOTES

DATE	
17Aug03 2300	VSS - Alert x3 - dsg to (L) leg dry and intact. [illegible] Lungs CTA Resp even reg. HR - NSR BS (+) x4 quads. Pedal and Radial pulses +3. Restraints to UE and LE in place and secure. Saline lock to (L) wrist is patent (-) s/s of infiltration. Will keep safe [illegible] ——— SGT [redacted] /1100
18Aug03 0430	Percocet 5mg ĭĭ PO for c/o (L) leg pain. Resting quietly e present of further c/o pain or discomfort. Restraint to UE in place and secure ——— SGT [redacted] /1100
18Aug03 0700	Pt. asleep in bed s̄ complaints @ this time. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. VSS. HL in (R) wrist s̄ s/s of infection. DSG's to (L) thigh & calf C/D/I, pedal pulse palpable (+) sensation, cap refill <3sec. All other assessment findings WNL - Will continue to monitor ——— [redacted] /AN

(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.

PROGRESS NOTES
Medical Record

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

AUTH... ED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/14/63	
1445	22 y/o EPW s/p GSW x2 to (L) LE
	#1 - ant mid thigh, exit at post mid thigh
	#2 ant mid calf to post mid calf
	(+) PT/DP pulses strong
	no obvious hematoma, minimal destruction at exit site
	Xray of femur + tib/fib (-)
	A/P clean wound + debride devitalized tissue, pack c Iodoform
	- Ancef 1gm IV
	- tetanus if available
	- observe for 24 hours
	- frequent vascular ✓ - q1 x8 then q4 x8
	CPT USA
8/14/63	all 4 wound debrided
1500	c sterile cleansing
	packed c 1/4" Iodoform gauze

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.

b(6)-4

12 - 6 - 82

b(2)-2

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 - 16456

NSN 7540-00-634-4176

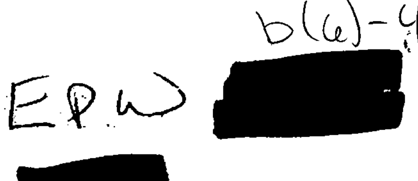
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03	D/C Summary
	-S/P soft tissue GSW (L) calf & thigh
	-treated c̄ ancef/Keflex and dressing Δ'S
	Plan-continue dressing Δ'S BID until
	wounds granulate

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.

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 [redacted]
		RECORDS MAINTAINED AT b(2)-2	

PATIENT'S HOME ADDRESS OR DUTY STATION — STREET ADDRESS; CITY; STATE; ZIP CODE

ARRIVAL — DATE (Day, Month, Year): 14AUG03 — TIME: 1630 — TRANSPORTATION TO FACILITY: MEDEVAC

SEX: 22 — AGE: M

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

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS ITEM	YES	NO
IS THIS AN INJURY?		
INJURY/SAFETY FORMS		

WHEN (Date) — WHERE — HOW

EMERGENCY ROOM VISIT — DATE LAST VISIT — 24 HOUR RETURN ☐ YES ☐ NO

TETANUS — DATE LAST SHOT — COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to (L) leg + thigh

CATEGORY OF TREATMENT

☐ EMERGENT — TIME
☐ URGENT — INITIALS
☑ NON-URGENT

VITAL SIGNS

TIME					
BP	142/80				
PULSE	99				
RESP	18				
TEMP					
WT					

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

X-RAY ORDERS: CXR PA & LAT/PORTABLE; C-SPINE; ACUTE ABDOMEN; LS SPINE; SINUS; HEAD CT; ANKLE R/L

ORDERS

☑ PULSE OX 97% — ☐ MONITOR — ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY — MODIFIED DUTY UNTIL

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

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ 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)*

[redacted]
b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC 17.8; H/H 13.6; PLT; PT; APTT

SMAC: 133 | 4.7 / 99 | 19; BHCG; ETOH; GLU 94

ABG/PULSE OX: SUP 02; PH; PO2; PCO2; SAT; OTHER

U/A: DIP; MICRO

RADIOLOGY — Check if read by radiologist ☐

RESULTS: X-ray (L) tib-fib-nml (L) thigh

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

22 yr old Iraqi male (EPW) shot by M.P. for reportedly selling illegal drugs. Has GSW (L) thigh & (L) tibia/fibula. (Seen by [redacted] b-2-2 Already had debridement

T P-99 BP 142/80

Allergies: 0
MEDS: 0
PMH: 0

Alert, oriented in NO severe distress
HEAD - normocephalic
EENT -
Lungs - clear A&P - scar on chest wall
Heart - S1S2 - nml wo S3 or S4 or M
Abd soft BS
Legs - Pedal pulses - nml Bilateral GSW - (L) thigh & (L) calve

Tatoo - rt arm

b(6)-2

Ortho cs [illegible]
soft - tissue GSW
plan admit for observation

[redacted] MAJ

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PR[redacted]

DIAGNOSIS
1) GSW (L) thigh (L) calve

CODES

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

#[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT (Doctor)
Medical Record

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

12-6-82 b(w)-4

4TH FORWARD SURGICAL TEAM PATIENT RECORD

1410

DTG IN: 8/14/03 1345

TO OR:

NAME: Iraqi EPW

SSN: N/A UNIT:

WT LBS: WT KG:

ALLERGIES: NKDA

TIME OF INJURY: ?

DETAILS OF INJURY EVENT: None available

GCS PRIOR TO ARRIVAL=

AIRWAY: (PATENT) ETT ORAL NASAL
Patent

CHEST: numerous scars on chest, tatoo (L) shoulder
Clear
RIGHT BS= LEFT BS=

NEURO: GCS= 15
A+O

HEAD, FACE, & NECK:
Clear

ABDOMEN:
(+) BS x 4 Quads

PELVIS:
clear

UPPER LEGS:
GSW (L) ↑ leg
~~GSW (L) ↓ leg~~

LOWER LEGS:
(+) pedal pulses / Abrasion to (R) inner ankle / tat (L) lateral aspect of foot
GSW (L) ↓ leg

ARMS:
~~Clear~~ tatoo (R) arm

POSTERIOR:
~~Clear~~ exit wounds (L) thigh ↑ (L) leg

TIME	IV	SZ	SITE
1415	1	18	(R) forearm
1420	2	18	(L) wrist
	3		
	4		

LITERS OF FLUID IN: 2 LR 1000 cc each b(w)-2

UNITS OF BLOOD IN:

TIME	MED & DOSE	
1425	Ancef 1gm	

TIME	INTERVENTION
Ø	OXYGEN ON & RATE:
	ETT SIZE:
	SURG. AIRWAY
	CT #1 & SITE:
	CT #2 & SITE:
	FOLEY
	GASTRIC

Front Back

ANESTHESIA / OR

TIMES	
IN:	
INCISION:	
PROC. END:	
TO ACW:	
ANESTESIA TECH.	
MAC:	
REGIONAL:	
GENERAL:	

MEDICATIONS: MIDAZOAM, PENTOTHAL, ETOMIDATE, FENTANYL, MSO4, SUCCINYL., ROCURONIUM, VECURONIUM, AGENTS:
ANTIBIOTIC:
REVERSAL:
OTHER:
Lidocaine 1% - Local

FLUID TOTALS	
CRYSTAL:	
COLLOID:	
EBV:	
EBL:	
U.O.:	
DRAINS:	

VITAL SIGNS			
TIME:	1415	1420	1425
BP:	129/83	138/78	148/72
HR:	98	99	84
RR:	16	16	16
SpO2:	98	98	100 RA
TEMP:			

RECOVERY

TIME IN: O2 VIA & RATE:

SURGEON(S): CPT [redacted] b(w)-2

PROCEURE:
Debridement of GSW's
↓ leg 1/4" entry, 1/4" exit
↑ leg dime size entry, 2cm exit wound

DRESSINGS:
(L) ↓ leg, idoform 1/2", 4x4, Kerlex
(L) ↑ leg idoform 4x4, Kerlex

IV	SZ	SITE	RATE	AMT IN BAG
18		(R) forearm		
18		(L) wrist		

POST-OP MEDICATIONS

TIME	MED & DOSE	ROUTE
1505	MSO4 4mg	IV

POST-ANESTHESIA RECOVERY SCORE

ADMIT=
30 MIN=
D/C=

VITAL SIGNS	ADMIT	D/C
BP:	148/86	124/70
HR:	82	82
RR:	16	20
TEMP:	97.8	99

SpO2 98 / 97

TUBES: Ø

DRAINS: Ø

CUMULATIVE I & O

INTAKE SOURCE	INTAKE AMT	OUTPUT SOURCE	OUTPUT AMT
LR	300 (ACW)	urine	
TOTAL=		TOTAL=	

i-STAT EG7+

Pt: 000000000000

Pt Name ___________

b(6) - 4

Na__________140 mmol/L
K___________4.0 mmol/L
TCO2_________27 mmol/L
iCa_______1.21 mmol/L
Hct__________45 %PCV
Hb*__________15 g/dL
*via Hct

At 37C
PH_______7.424
PCO2______38.8 mmHg
PO2__________62 mmHg
HCO3_________25 mmol/L
BEecf________1 mmol/L
sO2*________9[illegible]
*calculated

Sample Type_:

14FEB03 14:22

Oper 0000000

Physician:______________

Ser#

Ver: JAMS044C
CLEW A89

NIBP TREND 08/14/03

TIME	HR/PR	SpO2	SYS / DIA	MEAN	RR
HH:MM	BPM	%	mmHg		RPM
15:45	85	97	138 / 76	96	OFF
15:31	82	97	134 / 77	97	OFF
15:30	89	99	SEARCH		OFF
15:15	93	96	SEARCH		OFF
15:10	88	STBY	145 / 81	106	OFF
15:06	87	98	143 / 80	101	OFF
15:00	99	95	153 / 80	106	OFF
14:55	95	96	159 / 93	114	OFF
14:50	83	99	163 / 88	113	OFF
14:48	82	98	148 / 86	107	OFF

ADULT

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1								
POST- DAY									
MONTH-YEAR / DAY	14	15	16	17	18				
19 / HOUR									

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: 18, 16, 20, 16, 20, 16, 16, 16, 16

BLOOD PRESSURE: 138/98, 130/70, 134/70, 120/70, 104/70, 114/80, 120/76, 112/90

97, 95, 96, 95, 99%, 95, 97, 97, 97

Record special data only when so ordered

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. ICW2

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

Ward/Section: EMT

REQUESTING PHYSICIAN: b(6)-2

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

LAST, FIRST, MI: b(6)-4

DATE: 14-08-03

TIME:

SSN/PSEUDO SSN:

(I-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/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		
typ & hold		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
14/08/03              17:26
REFERENCE RANGE:       MALE
PATIENT #: b(6) 4
METLYTE 8
DISC LOT #:         3152AA4
OPER #:          DR #: 000
SERIAL #:
.........................
GLU    94    73-118    MG/DL
BUN    11    7-22      MG/DL
CRE    1.1   0.6-1.2   MG/DL
CK     824*  39-380    U/L
NA+    133   128-145   MMOL/L
K+     4.7   3.3-4.7   MMOL/L
CL-    99    98-108    MMOL/L
tCO2   19    18-33     MMOL/L

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

(Piccolo) Metabolic Panel

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

b(6)-2

REPORTED BY:

DATE: 8-14-03

LAB ID NO.:

Ward/Section: EMT

REQUESTING PHYSICIAN: b(6)-2

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

LAST, FIRST, MI. b(6)-4

DATE 14-08-03

TIME

SSN/PSEUDO SSN:

(Hematology) CBC

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

14-08-03
17:24

			Partial Limits	
WBC	17.7 H	x10^3/uL	4.5	10.5
RBC	4.73	x10^6/uL	4.00	6.00
Hgb	13.6	g/dL	11.0	18.0
Hct	[illegible]	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
PLT	362.	x10^3/uL	150.	450.
LY%	14.8	*L %	20.5	51.1
LY#	2.6	* x10^3/uL	1.2	3.4

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		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: 8-14-03

LAB ID NO.:

b(6)-2

b(6)-4 All b(6)-2 All

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] (EPW)

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 14 Aug 03 | TIME OF ORDER: HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ortho
s/p GSW (L) calf, (L) thigh
vitals routine
activity as tol.
diet reg
IV KVO
Meds Tylenol 650 mg po q 6 h
Ancef 1 gm IV q 8°

PATIENT IDENTIFICATION: [redacted] (EPW)

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER | TIME OF ORDER HOURS

[redacted] noted 1845

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

28° VS

DATE OF ORDER: 8/16/03 | TIME OF ORDER: 2328 HOURS

- Daily Dressing D's ✓
- Heplock IV ✓
- Percocet ii po q4° prn pain

noted 0817 16Aug03

PATIENT IDENTIFICATION: [redacted]

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

DATE OF ORDER: 17 Aug 03 | TIME OF ORDER: 1500 HOURS

- D/C to EPW Camp
- Keflex 500 mg po QID
- BID W to D D's

1505

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

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	14	15	16	17	18
14		vitals: routine	05	/				
			13					
			21					
			/					
14		as tol. activity	05	/				
			13					
			21					
			/					
14		regular diet	07	/				
			11	/				
			17	/				
16		~~Daily Dsg Δ's~~ Δ see below	08	/	/			
17		BID w/ Dsg Δ's	20	/	/	/		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) calf/thigh

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted]	admit-ortho	14	/	1800	[redacted]
17	[redacted]	DC to EPW camp	now	now		

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

USAPA V1.00

b(6)-2 All

CLINICAL RECORD

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

Mo. 8 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	14	15	16	17	18
14	[redacted]	~~IV: KVO~~	05	/	[redacted]			
16		HL ct tolerating po	13	[redacted]				
			21	[redacted]				
			/					
14	[redacted]	Ancef 1gm IV q8°	08	/	[redacted]		DC'd 17 Aug 03	
			16	[redacted]				
			24	[redacted]				
			/					
17	[redacted]	Keflex 500mg PO QID	06				/	[redacted]
			12				/	
			18				/	[redacted]
			24			/	[redacted]	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) calf/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

	-----	b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
-14-		Tylenol 650mg	14Aug 1830	650 mg	15Aug 0815 ii po	15Aug 1710 ii PO	16Aug 0615 ii po	16Aug 1205 ii po	17Aug 0717 ii po							
-----	-----	PO q6° pc – pain	(+)													
-----	-----															
-16-		Percocet ii PO q4° PRN	17Aug 1930	03 ii	17Aug 240											
-----	-----	for pain	(+)													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M — NATIONALITY / NATIONALITÉ

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE

- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE | 6. TOURNIQUET / GARROT: NO / NON, YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON, YES / OUI | DOSE / DOSE | TIME / HEURE | 8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

GSW to (L) thigh & leg.

18G IV Cath - 500cc NS
#1 Bag.

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- X EVACUATED / EVACUÉ [redacted]
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ | DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 — *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

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	/	/	D	/	

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)-4

4. PAY GRADE

16	17

CI

5. SEX

18
M

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
Ø	2	2

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
Z

RELIGION unk

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION ICW#2

BRANCH / CORPS

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

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
Ø

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

b-2-2

21.

73	74
5	Ø

22. ... TRANSFERRED TO

75	76	77	78	79	80

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

81	82	83	84	85	86
0	3	0	8	1	7

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	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
0	3	0	8	1	4

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

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: GSW to (L) Calf/thigh

Inj Trauma
450 1

Dx 890.0
891.0
E991.2

Proc 83.45
88.29

890.0
891.0
E991.2

b(6)-2

ADMITTING OFFICER (Signature, as required) DR

SIGNATURE OF ADMITTING CLERK

INPATIENT TREATMENT RECORD COVER SHEET داكي اولجاية

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	Unknow Iraqi name	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	56	X	Z	—	—	

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

15. FLYING STATUS	16. RATING CDS	17. DEPT / EEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
Z		K78			WIA

wounded in action

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
O. Direct from ER.	Dr. orders 08:46	[redacted]

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	05	03,11,30

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		03,11,16	

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

31. SELECTED [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX. S/P STS E [illegible]

Dr. O

GSW to Abdm
S/P Xlap
[illegible] Cardiojejunal
Tracheostomy.
STSG

879.3
E991.2
707.0

43.6
45.61
45.74
45.76
43.7
46.20
[illegible].14
45.79
46.99
43.3[illegible]

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	14	14

b(6)-2

36. Total Days All Facilities

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]	[redacted]	0	[redacted]	14	14

SIGNATURE OF [redacted] Dr. [redacted] | SIGNATURE [redacted]

DA FORM 3647, MAY 73 | EDITION [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

86y Iraqi EPW presented with GSW abd. [illegible] [illegible] [illegible] [illegible] on Bed.

[illegible] Ø

[illegible] Ø

[illegible]

PHYSICAL EXAMINATION

[illegible]

[illegible]

[illegible]

[illegible]

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

[illegible] GSW to Abd

[illegible]

b(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION

...l or written entries give Name last, first, ...ate; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

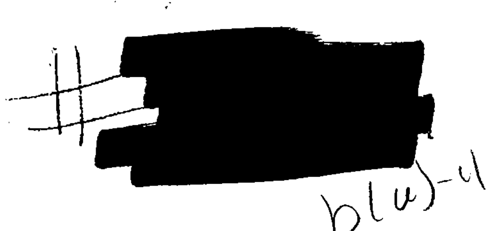
CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREAT[...]ANIZATION *(Sign each entry)*
16Aug03.	b(6)-2 A11
1845. ~~1800~~	500cc hespan started for ⊘ UOP and CVP @ ~10mmHg.
1900.	⊘ UOP recorded. MD aware. BP ↑ to 110's-120's, HR ↓ to
	120's. Will cont to monitor ———
1930.	CVP transduced @ ~ 11-12mmHg. 500cc ~~50~~5% albumin
	started. BP remains @ 110's-120's HR 120's. ~22cc urine
	noted @ this time ———
2000.	CVP transduced @ 14-15mmHg. 60cc UOP noted ~~W~~
	ABG obtained 7.288/44/371/21/-5/100%. RT @ BS.
	FiO2 ↓ to 60%. SpO2 holding @ 100%. Will monitor
2030.	Updated MD on pts. cond. CBC drawn and sent to
	lab.
2100.	Dr [redacted] updated on pt. condition. H/H 9/28.
	CVP 11mmHg. UO 90cc. Orders rec'd. ———
2130	500cc 5% Albumin started. Awaiting T+C to be
	completed for pending transfusion ———
2145	Returned phone call to Pt [redacted]
	explaining Pt had surgery & will go back in 24-48° for
	further surg, on vent cond guarded. She explained Pt is
	[redacted] (b)(6)-4 [redacted] LTC, a—
2200.	Albumin bolus complete. HR ↓ to 110's-120's, BP 110's/60's. Transfusion
	of PRBCs pending ———

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

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

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



b(6)-4

b(6) 2 All

16 Aug 03.	
2225.	Blood transfusion started using 16G IV to (L) AC. 98^{3}/122/ 118/69/100%/16. Will monitor
2230.	Pt suctioned x 2. Moderate amount tan secretions obtained. 128/114/62/16/100%/98.
2235	HR-125, BP 115/63, 16, SpO2 100% 98^{2}
2250.	HR 122, BP 117/66, RR 16, SpO2 ~~Hr~~ 100%. T 98^{5}
2320.	HR 120, BP 113/66, RR 16, SpO2 100%
2350.	HR 117, BP 111/63, RR 16, SpO2 100%
17 Aug 03.	
0030.	~~Dr~~ MD @ BS. Updated on pts condition. 1st Blood transfusion complete. Vitals stable. 98^{8}, 119, 114/68. Will start 2nd unit
0055	2nd transfusion started. 98^{8}, 119, 114/68.
0100.	HR 119, BP 110/68, RR 16, SpO2 100, 98^{6}
0105	HR 118, 110/66, 98^{6}
0115.	HR 119, BP 109/65, T
0140.	HR 117, BP 107/64 T $98^{?}$
0250.	HR 115, BP 109/62, 98^{6}. No S/S of transfusion reaction
0315.	Pt suctioned X3. Moderate amount tan colored secretions noted. SpO2 remains 100%. Updated MD on pts condition
0430.	ABG, CBC, Chem drawn via A-line and sent to lab. 7.33/36/13/19/-6/99%
17 Aug 03 0610	Received report from previous shift. Pt sedated + appears comfortable. HR 110, RR 10-16. BP Low (90s/50s). Will notify Dr. [redacted] UO > 30cc/°. All PIV intact $\bar{c}$ Ø S/S of infection Vent in place SIMV 16, 800, 5, 50%. peak 37. Drsgs D+I.

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Aug 03 1000	Received pt from OR via stretcher. Pt vented: SH A/C, TV 750, RR 12, FiO2 50%, peep 5. ETT #8.0 24 @ Lip secure. All PIV and A-line secure. Drsg midabd, (R)+(L) flank secure. foley draining Ø urine. Pt body temp cold. Unable to get temperature. O2 sats 100%. Placed extra blankets and heating lamp on pt. Will cont. care. ——— [redacted]
1035	Drew labs per order. Will report results to Dr. [redacted] ——— [redacted]
1104	Pt BP ↓ (80s/50s). Notified Dr [redacted] & [redacted] Gave 1L bolus LR @ 1125. Drew ABG @ 1137. Vent Δs made per Dr. [redacted] V.O. Will redraw ABG. ——— [redacted]
Late entry 1035	Started transfusion FFP. Pt temp still low. Applied MRE heaters and warm NS bottles per Dr [redacted] Will cont. care. [redacted]
1225	Gave 1 unit PRBC per order. Pt BP ↑ 120s/100s. Dr. [redacted] notified. ↑ MSO4 gtt to 5mg/°. Pt temp 91.6. Got heat blanket from EMT. (R) flank drsg saturated. Reinforced c̄ abd pads.
Late entry 1216	Drew ABG. Notified Dr. [redacted] of results. Will redraw ≈ 30 min. [redacted]

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

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

REGISTER NO. | WARD NO.

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

USAPA V2.00

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 1300	Started 2nd unit PRBC. Pt BP 100s/100s. Notified Dr. [redacted] Gave 4mg IVP. Will recheck BP ≈ 15min. Rechecked BP. No Δ in BP. Pushed 4 mg MSO4 @ 1320. Drew ABG @ 1313. Dr. [redacted] viewed ABG, Ø vent Δs made. Will cont to monitor pt condition. [redacted]
1350	↑ MSO4 to 7mg/°. BP 160s/100s. Notified Dr. [redacted] Fentanyl 100mcg IVP x 1 now. Ordered. Gave fentanyl @ 1405. Will cont to monitor. [redacted]
1425	BP remains 160s/100s. Will cont to monitor. [redacted]
1430	Pt moving head around. ↑ versed to 5mg/°. Will cont. care. [redacted]
1504	Pt BP 180s/100. Gave versed 3mg IVP. Will cont to monitor BP. [redacted]
1520	Pt temp ↑ 94°. Pt BP ↓ 120s/80s. ↑ versed 7mg/° due to pt moving head. [redacted]
1800.	Report received from LT [redacted]. Pt in process of receiving 1L LR bolus. BP ↓ to 100's/50's, HR ↑ 130's. UOP decreased. ABG obtained 7.25/42/52/19/-8/81%. Pt manually ventilated c̄ 100% O2. SpO2 ↑ to 100%. Vent changes TV ↑ to 800 and FiO2 ↑ to 100%. SpO2 maintaining @ 100%. ETT pulled 2cm back.
Late entry 1700	Drew ABG and labs per order. Will show results to Dr. [redacted] Pt BP ↓ 100s/80s and HR ↑ 120s-130s. Gave albumin 500cc bolus, fentanyl 100mcg IVP and vecuronium 10mg IVP per order. At 1745 Ⓛ SC cortis was placed. CXR completed to show proper placement. Pt started on fentanyl and vecuronium gtt. At 1705 Dr. [redacted]
~~1705~~	started 1000cc LR bolus. Will cont care. Gave report to next shift. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2

MEDCOM - 16477

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
	OP Note
8/16/03	indication GSW to Abdomen
	Procedure - see diagram
	① Distal Gastrectomy
	② SB Resection x 2
	③ Transverse colectomy
	④ sigmoid colectomy.
	Anesth - GETA
	Surgeons - [redacted] / [redacted]
	Findings: obliterated distal
	stomach, transection @ lig
	of treitz multiple enterotomies
	at mid small bowel
	Transverse colon transection
	and colotomy in sigmoid colon.
	hemostasis obtained and contamination
	controlled operation ended due
	↑ PT, PTT, Temp ~ 31°c, and Acidemia
	Plan reexploration .. 24-48hrs

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03	Brief Op Note
	(1) "Roux en Y" gastrojejunostomy with duodenojejunostomy
	(2) ileostomy
	(3) Right colon colostomy
	(4) Hartman's pouch
	(5) placement of duodenal drainage tube
	(6) Placement of feeding jejunostomy
	D. [redacted] / D [redacted]
	Fluid b(6)-2
	EBL 200 cc
	GETA
	Drains JP x2 / duodenal drainage tube / foley / colostomy, central line, A line, peripheral line, NG tube, intubated b(6)-2
	Complications Ø
	[redacted] MD

Diagram labels: stomach, drain, Duodenal tube, Duodenum, feeding tube, drain

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | b(6)-2 All | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 ф7фф	Dr. [redacted] viewed labs + ABG. ∅ vent Δ's made. CaCl ī amp & 5% Albumin ordered for low BP. Will cont. to monitor BP. H+H (11, 33). Ca⁺⁺ 6.5. ABG 7.338, 36.2, 135, 19, -6, 99%. Will cont. care. [redacted]
ф8фф	Pt BP ↑ 110s/60s. UO ↑ ≈ 2фcc. CVP ↑ from 1ф to 13. Will cont to monitor. [redacted]
ф9фф	Shaved pt. Cleaned pt face + body. Δ'd NGT and ETT tie. ETT remains 20cm @ lip. Completed foley care and did passive ROM. Δ'd drsg on (R) shoulder. Applied sulfamylon cream to burn p̄ washing wound c̄ NS. Pt temp remained in 99°. Temp ↓ 97.7 p̄ bed bath completed. Suctioned pt x ii. Thick white secretions noted. Peak remains 35. Will cont. care. [redacted]
11фф	Pt BP ↑ 120-130s/60s. ↑ed fentanyl to 90mcg/°. Will cont to monitor pain level and BP. Pt O2 sats remain 99-100% throughout morning part of shift. [redacted]
13фф b(6)-2	Drew CBC per order. Plt 64. Showed Dr. [redacted] Prep pt for OR. Sent 2 SF518's to lab. Will cont. care. [redacted]

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

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

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

b(6)-4

[redacted]

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

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Aug 03 1346	Drew ABG per Dr. [redacted] ABG 7.339, 40.5, 94, 22, -4, 97%. Drew Coag. per Dr. [redacted] Will report results — [redacted]
1424	Coag. results given to Dr. [redacted] Ordered 2 units FFP. Pt VSS for pt. HR low 100s, BP 120s/60s, RR16, O2 sats 99-100%. Will cont care. — [redacted]
1600	FFP not ready according to lab. Attempted to notify Dr. [redacted] Unsuccessful. Will try again. [redacted]
1650	Able to infuse 1 unit FFP. Pt BP ↑ 130s/70s. ↑ fentanyl to 100mcg/°. Pt have PVCs. Will cont to monitor. [redacted]
17 Aug 03	
2230	Pt returned from OR via litter, intubated. VSS. Pt stable. Wounds dry to abd. Pt connected to vent. SIMV16, 800, 50%, 5, SpO2 100%. Pt placed on versed @ 3mg/hr and fentanyl @ 100mcg/hr. HOB flat. Will cont to monitor — [redacted]
2240	ABG via A line - 7.34/38.7/89/21/-5/96% No changes at this time — [redacted]
0115	Pt resting quietly. No mvmts noted @ this time. Fentanyl ↓ to 80mcg/hr. Will monitor — [signature]
0600	Report given to LT [redacted] — [redacted]
18 Aug 03 0600	Received report from previous shift. Pt moving (L) arm and head slightly in bed. HR low 100s and BP 100s/40s. All PIV lines intact. Pt vented SIMV16, 800, 5, 55%, peak 37. Suctioned pt x ii. Thick white secretions noted in scant amts. O2 sats remained 98-99%. (R) duodenal drain to gravity. 2 abd JP drains in place and J-tube clamped. NGT @ LIS. Will cont. care. — [redacted]

STANDARD FORM 600 (REV 6-97) BACK

USAPA V2

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 0640	Dr. [redacted] viewed labs. Ø new orders given. Flushed duodenal tube. 155cc of brown drainage noted. Pt BP ↑ 130s/60s. ↑ed fentanyl to 80mcg/°. Pt resting comfortably @ this time. BP Low 100s/60s. Will cont. care. [redacted]
0800	Pt resting. O2 sats 97%. UO 36cc. Will cont to monitor UO. [redacted]
1000	Pt UO 26 @ 0900. Informed Dr. [redacted]. 5% Albumin in 500cc ordered. Transduced CVP 10. Will recheck p̄ albumin infusion. UO ↑ 60cc during half of infusion. Will cont. care. [redacted]
1040	Noted sputum in ETT. Deep suctioned pt x ii. Thin white secretions noted. Upon 2nd deep suction, pt spewed bloody sputum from mouth. Suctioned mouth x iii. Pt became more awake (moving BLE + BUE). Gave 4mg versed bolus. BP ↑ 190s/60s. ↑ fentanyl to 90mcg/°. @ 1100 pt appears calm. BP ↓ 120s/60s. HR ↓ 113. O2 sats 97-99%. Will cont. care. [redacted]
1200	Completed bed bath + foley care. Pt restless. Gave 2mg IVP versed. Pt appears calm. O2 sats 93% p̄ turning pt. Suctioned pt x iii. Thin white secretions noted. O2 sats remained 100% while ambu. Currently 97%. [redacted]

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

REGISTER NO. | WARD NO.

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03	Surgery POD 1/2
IVF	Very stable overnight
Versed	HR 100-110 Afeb BP 110-140/60's
Fentanyl	SAT 97% 58%
Unasyn	UO 26-120 cc/hr JP1 ~20cc/h
ZANTAC	JP2 ~20cc/h
	Duodenal Tube - ~100/Q2°
	Chest CATA
	COR RRR Z+P?
	Abd ND soft ⊝BS
	Wounds C/D
	LABS 6.0 > 33 < 62 ; 141 / 4.0 , 107 / 24 , 26 / 80 , 1.3 ; Alb 2.2
	Aϕ 27
	ALT 62
	ABG 7.37/40/89/-2 ; TB 2.8
	Amy 176
	A/P Doing well [illegible] fluid requirement,
	resolving tachycardia, [illegible] BS prior
	to TF. b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2

b(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03 1300	Wet to dry drsg midline abd incision: Scant amt sanguinous fluid. Replaced drsg around JP tubes, duodenal tube + J-tube due to saturation c̄ 4x4s. Pt moving BUE. Restrained pt BUE c̄ Kerlex. Gave pt 3mg versed IVP. ↑ fentanyl to 100mcg/° due to ↑ BP 140s/60s. Will cont. care. ——— [redacted] /CTA
1500	Pt BP 130-140s/60s. + Pt moving BUE. ↑ed versed to 7mg/° and gave 3mg IVP bolus. ~~Pt~~ Gave 30mcg fentanyl. Will cont. to monitor. ——— [redacted] /CTA
1600	Flushed J-tube c̄ 10cc NS. Flushed duodenal tube c̄ 10cc NS. Will cont. care. ——— [redacted] /CTA
1720	Ø Δ's made c̄ pt. HR ↓ 90s. BP 140s/60s. Pt appears comfortable. Will cont. care. ——— [redacted] /CTA
1840	Gave report to night shift. ——— [redacted] /CTA
1830	Recieved report from LT [redacted] ——— 9IWMG
2000	pt VSS. FiO_2 ↓ to 50%. Will do ABG in 30 mins [redacted]
2045	Results of ABG recieved. PO2 63 mmhg. RT suggests repeat ABG in 1 hour. Will repeat in 1hr ——— [redacted] 9IWMG
2145	Repeat ABG PO2 64. FiO_2 ↑ to 55% [redacted]
2340	FiO_2 ↓ to 50% ——— [redacted] 9IWMG
19Aug03 0030	ABG 7.43, 35, 85, 24, Ø, 97%. ↓ RR from 20 → 18 Sgt [redacted]

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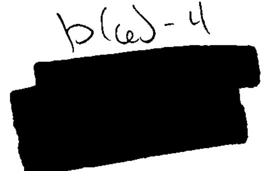
b(6)-4



CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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USAPA V2.00

b(6)-2
All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03 0130	PT BP 165/74, Fentanyl gtt ↑ to 150 mcg/hr, Versed gtt
	↑ to 8 mg/hr ———— [redacted]
0320	pt VSS, afebrile. Deep suction done [redacted]
0620	Report given to 1LT [redacted] ———— [redacted]
19 Aug 03 0600	Received report from previous shift. PT vented
	SIMV 18, 790, 5, 50%, peak 39. All PIVs, JP tubes, J-tube
	colostomy, duodenal tube intact. HR 90's. BP 140s/60s.
	Viewed labs, will report abnormal results to Dr. [redacted]
	All drsgs D+I x̄ a little drainage from duodenal tube.
	Will cont. care. ———— [redacted]
0650	Dr. [redacted] viewed labs. KCl run ordered + MIVF
	↓ed 75cc/° due to large hourly UO. Will cont care. [redacted]
0800	UO > 300cc/°. O2 sats 99%. Will cont. care. [redacted]
1000	Noted white secretions in pt ETT and in mouth. Suctd
	pt x iii. Large amt thin white secretions noted. O2 sats ↑
	from 96% to 98%. Drained JP tubes. JP1 + JP2 both have
	serous fluid. Temp 99.9. Will cont to monitor temp.
	Pt BP 190s/80s. ↑ Fentanyl to 175mcg/°. Will cont to
	assess pain level. ———— [redacted]
1100	Completed drsg Δ. Midabd incision noted greenish
	sanguineous drainage. Wet to dry drsg midabd
	incision + (R) abcess under colostomy. Applied
	silvadene to (R) shoulder/chest burn p̄ rinsing c̄
	NS. Completed bed bath + foley care. Flushed
	duodenal tube + J-tube c̄ 10cc NS. Covered (L)
	puncture wound c̄ 4x4. Noted sanguinous drainage.
	Pt O2 sats 99% throughout drsg Δ. BP 180s/60s. BP
	↓ 160s/60s. Gave 30 mcg fentanyl bolus. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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b(6)-2 All

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 AUG 03 1300	Pt stable @ this time. Temp 100.4 BP ↑ 160/80 but has ↓ 140s/70s in last half hour Duodenal drain flowing continuously. O2 sats 100%. Will cont. care
1500	Pt resting c̄ Ø problems/difficulty. O2 sats 100%. BP 140s/70s, RR 18. Will cont. care
1700	Pt resting s̄ any difficulty. Sating 100% vented. Temp 100.4. Will cont. care
1900	Received report from off going shift. Pt. condition remain stable. Temp 100.6. All lines intact Ø reddness/swelling noted to areas. JP drain to BS. F/C to BS. Will continue to monitor
2000	Pt. resting in bed s̄ discomfort noted. SpO2 98% Temp 100.8. Deep suctioning performed; got back moderate amount thick white secretions. Will continue to monitor
2032	Pressure 96/54 Versed ↓ 4mg and Fent ↓ 10mg. Will notify MD.
2315	Resting in bed s̄ discomfort noted. Versed ↑ 8 ... Fent ↑ ... Will continue to monitor.
2355	Filter exchanged via RT.
20 AUG 03 0053	Ø distress noted. Temp 100.1. Will continue to monitor.

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REGISTER NO. | WARD NO.

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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Prescribed by GSA/ICMR
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b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 AUG 03 Ø845	Pt restless and waking up. Gave versed 3mg IVP. Will cont. care. [redacted] 1LT/ANC
1Ø1Ø-121Ø	Completed bed bath, passive ROM and foley care. Completed drsg Δ wet to dry midline abd and Ⓡ flank wound. Noted green drainage from both wounds. Will notify MD. Δ'd burn drsg Ⓡ shoulder/chest. Used silvadene. Pt tol. drsg Δ well. Pt woke and moved around. Gave 4mg versed total throughout. Shaved pt face and Δ'd ETT tie. Applied bacitracin. Will cont care. [redacted] 1LT
112Ø	Started 2nd unit PRBC Unit # 2772416.

	1125	1130	1135	1140	1155	1210	1225	1240	1310	134Ø	144Ø	1535
Temp	100.4	100.4	100.6	100.6	100.7	100.7	100.7	100.6	100.5	100.6	100.5	100.3
HR	88	87	89	12Ø	91	85	86	8Ø	85	84	85	81
BP	170/70	175/73	170/74	153/82	190/76	173/71	149/66	147/65	168/72	172/68	171/73	139/68

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Infusion complete c̄ Ø transfusion rxn [redacted]
1255	Pt becoming agitated. Gave 2mg versed. Suctioned pt x II. Thin white secretions noted. [redacted] 1LT/ANC
15ØØ	Pt resting comfortably. Ø agitation noted. Blood infusing. Will cont care. [redacted] 1LT ANC
1545	Drew post K + CBC lab. Results H+H (10.2, 33.2), K+ 3.7. Will report results to MD. [redacted] 1LT/AN
1815	Received Report. [redacted] 1LT/AN
0600	Patient sedated. SIMV 18 TV 800 FiO2 50 Peep 5. Drains in place. PIVs flushed. Drsg mid abd CDI. Monitor resp, UOP, drains, sedation, ABP/NIBP. [redacted] 1LT

b(6)-2 All

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2Ø AUG Ø3 ØØØ	Received report from previous shift. Sputum noted in ETT. Deep suctioned pt x iii. Noted yellow tinged sputum. While suctioning, noticed pink frothy sputum from mouth. Notified Dr. [redacted]. Obtained CXR. (L) lung pneumonia and (R) upper lobe aspirate noted. New orders written. Will cont. care. — [redacted]
Ø65Ø	Dr. [redacted] viewed CXR. ETT advanced 2.Ø cm. Now 22 cm @ teeth. Started KCl 4Ø mEq run due to K^{+} 2.5. Started new abx Zosyn. Will start cipro. Will get repeat CXR for ETT advancement. Will cont. care. [redacted]
Ø8Ø5	Started 1st unit PRBC due to H+H (8.1, 25.5). Dr. [redacted] viewed CXR. Advanced ETT 1.Ø cm. Now 24 cm @ lip. Pt also had bowel movement into (R) colostomy. Brown liquid stool noted. Also green bile drainage noted around duodenal tube. Will complete drsg Δ. — [redacted]
Ø8ØØ	Unit WØØ13Ø3 Ø11Ø67.

	Ø8Ø5	Ø81Ø	Ø815	Ø82Ø	Ø835	Ø85Ø	Ø9Ø5	Ø92Ø	Ø95Ø?	1Ø2Ø	11[illegible]	1 HR
Temp	101^{5}	101^{5}	101^{5}	101^{5}	101^{4}	101^{4}	101^{3}	101^{2}	$101.^{1}$	$100.^{8}$	100.6	
HR	101	104	101	104	93	92	92	91	97	86	83	
BP	151/64	149/70	155/64	137/62	136/59	139/60	142/59	147/61	170/68	155/64	157/6[illegible]	

Infusion completed c̄ Ø difficulty. — [redacted]

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b(6)-4

[redacted]

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

USAPA V2.00

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Aug 20, 2003	Dr [redacted] notified of Pt. temp. 101.4 [redacted]
0206	Tylenol 650mg thru Dobhoff tube. [redacted]
0222	Tylenol 650mg given for ↑ temp of 101.4 [redacted]
	monitor. [redacted]
0326	Temp 101.8. Will continue to monitor. [redacted]
0513	Pt. resting in bed ō discomfort noted. Temp ↑ 101.7.
	SpO2 97%. Ø distress noted. Will continue to
	monitor. [redacted]
	Surgery Progress Note
meds	POD # 3 s/p Reconstruct[illegible]
Zosyn #1	[illegible] following GSW vent SIMV 18 / TV 810
Cipro #1	[illegible] abdomen. 50% PEEP 5
Versed	CV: HR 104 143/63 NSR [illegible] 5.4 81/28 (80)
Fentanyl	Pul (+) (L) pneumonia [illegible] aspirate on CXR RR 18
Zantac	vent as listed SaO2 98%
LR @ 75cc/h	ABG 7.502 / 32.4 / 72 / 25 / 2 / 96%
	Renal UOP x 24° 2127 cc / now ~ 50-60 cc/h.
Foley	Creat 1.2 143 / 109 / 20 < 83; 2.5 / 8 / 1.2
duodenal JP x 2	
~~J tube~~	NUT: Ø Alb 1.7
A line	
	ID: (+) pneumonia T max 101.7
	wound: green discharge f (R) GSW wound — Fluids: 85 OP1, 110 OP2, Bili drain 600
	Imp: ① ↓ Hct 25 — Plan: Transfer 2u PRBC
	② (L) pneumonia — KCl replacement
	③ K+ ↓ 2.5 — Δ to Zosyn / Cipro
	④ ↓ Alb — Extubate per [illegible] [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	23 AUG 03 ICU #1 DIET ROSTER
BED 1	588 - TUBE FEEDING JEVITY
BED 2	421 - REGULAR
BED 3	624 ✓ - REGULAR
BED 4	626 ✓ - REGULAR
BED 5	596 ✓ - REGULAR

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03 1150	Δ'd drsg (L) SC cordis using aseptic technique. Ø s/s of infection noted. Noted red fluid through NGT. Serous fluids in both JP tubes. Flushed duodenal tube + J-tube c̄ 10cc NS each. Irrigated (R) colostomy bag c̄ NS. Brown liquid stool noted. Will cont. care. ——— [redacted]
1330	Vent alarming high pressure. White colored sputum noted in ETT. Suctioned pt x ii. Pt also biting ETT and attempting to open eyes. Gave 3mg versed IVP. Also ↑ed rate versed to 11mg/°. Will cont care [redacted]
1445	Pt breathing over the vent + moving eyelids. Gave 3mg versed IVP. Will cont. care. ——— [redacted]
1600	Pt resting c̄ Ø s/s of wakefulness, ↑ BP, ↓ O_2 sats. O_2 sats 100%. Will cont. care. ——— [redacted]
1800	Drew K^+ lab. Gave report to night shift. [redacted]
1800.	Received report from LT [redacted]. Pt in bed. [redacted] ——— [redacted]
1945.	Lab results back. K+ 2.5. Notified Dr [redacted]. Order received. Pt given 40meq KCl IVP over 2 hrs. ——— [redacted]
2000	Pt suctioned x3. Copious amounts thin white secretions obtained. SpO_2 remains 100%. Will cont. to monitor ——— [redacted]
2115.	Dr [redacted] @ BS. Updated on pt condition and KCl results. Orders received. ——— [redacted]
2250	Drsg Δ'd to midline abd incision, R flank wound, (L) flank wound, tube sites and (R) chest burn area. Silvadene applied to burn. (R) flank and midline incision c̄ green/yellow drng noted, wounds pink in appearance. Wounds packed c̄ ¼ Dakins soaked gauze. Bacitracin applied around tube sites and covered c̄ gauze. No drng noted, but some redness noted. ——— [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03 0600	Received report from previous shift. Pt resting comfortably. NGT to LIS. Zosyn piggyback infusing. All IV lines intact. ETT #8.0 24cm @ lip. Vent: SIMV 18, 790, 5, 50%, peak 32, O2 sats 100%. Will cont. care. [redacted]
0630	D/C'd PIV (L) Hand due to infiltration. Δ'd IV tubing H.L and drsg Δ c̄ opsite to (R)+(L) FA PIVs. Pt UO > 30cc/°. Viewed labs: K+ 2.5, H+H (10.8, 34), ABG 7.488, 34.3, 99, 26, 3, 98%. Will report results to Dr. [redacted]
0800	KCl run 40 mEq started. Pt O2 sats 100%. Will cont. care ——— [redacted]
0930	Pt overbreathing vent. Gave 3mg versed IVP. Lovenox prophylaxis ordered. Informed Dr. [redacted] of green fluid in incisions. Dakin's solution ¼ strength ordered. Will cont. care ——— [redacted]
1050	Began drsg Δ Pt resp & BP ↑. Gave 3mg versed and 30 mcg Fentanyl. Pt well rested throughout drsg Δ. Noted greenish spots in both midline abd + (R) flank wound. Wet to dry using dakin's soln ¼ strength. Δ burn drsg (R) shoulder/chest. Applied silvadene p̄ washing c̄ NS. Applied emycin ointment to bilat. eyes. Completed bed bath + foley care. KCl run still infusing. Will cont care. ——— [redacted]

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21AUG2003	Internal medicine
0620	50 y WM POD #5 from GSW to Abdomen → colostomy, [illegible]
L Rat 150cc/hr	and burn to (R) chest. Stable overnight
Versed	127/62 temp - 101.6 (ccc) [illegible] 73 100% RR - 18
Fentanyl	General: asleep, sedated
Unasyn	LUNGS: scattered rhonchi
Zosyn	CV: RRR
Zosyn	Abdomen: ⊕BS incisions clean today
Cipro	Ext: ⊖edema
	(Labs) 144/110/18 94, 25; Alb - 1.7; 7.48/34/98; 12.3 > 11/34 < 144
	(CXR) progressive consolidation LUL → alveolar infiltrates diffuse (L) side; (R) upper lobe → chronic changes
A/P	(1) Neuro → sedated breathing with ventilation. Comfortable but arousable. ↑ activity with ↓ versed
	(2) Pulm → aspiration pneumonia versus early ARDS. NO ↑ O_2 requirements or high peak airway pressures. No Δ vent. Continue Zosyn / Cipro. Afebrile past 24 WBC - 12K
	(3) CVS → hemodynamically stable with good urine output
	(4) Renal → potassium replacement this am
	(5) Heme → H/H stable

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[redacted] b(6)-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(6) GI → remains NPO, several more days until
	bowel function returns
	(7) GI → prophylaxis
	(8) Needs DVT prophylaxis until plts over 144
	b(6)-2

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)*
21Aug03	
2250	Pt suctioned x3 by RT. SpO2 remains 100%. large amount thin White secretions obtained —— [redacted] b(6)-2

32 ART=104/85(94) CVP=17/7(11) RR=18 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION
22Aug03	
0400.	Labs + ABG drawn via A-line and sent to lab 7.48/32.9/118/26/25/99%. RT notified of ABG results. Rate ↓ to 16 BPM. K+ ↑ 3.3. KCl IVPB continues to infuse as ordered —— [redacted]
0515.	J-tube and duodenal tube flushed c̄ 10cc H_2O as ordered [redacted]
0600.	Report given to Lt [redacted] —— b(6)-2 [redacted]
22Aug03 0600	Received report from Lt [redacted] Pt vented SIMV16, 790, 5, 50%, peak 30. All IV lines + drsgs intact. Versed + fentanyl, + KCl 80mEq run infusing. Will cont care. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted]TAINED AT
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b(6)-4

[redacted]

REGISTER NO.	WARD NO.
	ICU3

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.23/0800 cont	draining scant serous drainage.
	GU foley to gravity amber as
	lines (L) SC cardis -> patent [redacted] / KT RN
8.23/1600	(L) SC cardis pulled, (R) SC cardis started by Dr. [redacted]
	pt tolerated procedure well, XRAY confirmed placement
	per Dr. [redacted] [redacted] KT RN
	b(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22Aug 03 2230.	Rt note: Pt arrived to unit one hour ago via litter + heli. Vent settings SIMV 16, 800, +5, 50% c̄ PIP @ 45. Sx pt out c̄ think yellow secretions PIP @ 32. ABG done @ 1009 7.46/35/131/25/1/99%. ↓ FiO2 40%. Vent setting at this time 1033 is SIMV 16 800 +5 40%, PIP 31, ETT 8.0 22 @ teeth. Will continue to monitor —— b(6)-? [redacted] 91U20
8-22/0930	Pt arrived via litter @ approx 0930. Pt in no apparent distress @ time of admission. Pt on 1mg/hr [illegible], 200mg/hr [illegible] @ 75cc D5½NS 20 KCl. Pt on vent SIMV 50%, 16, 5, 800, SpO2 100%. Pt's NG placed to LCS per [redacted] b(6)-2 @ bedside & changed colostomy bags & midline abdominal incision. Abdominal incision c̄ small purulent areas, area cleansed c̄ dakins 1/2 strength, incision packed c̄ 4x4s & covered c̄ 2 ABDs. Jejunostomy & duodenum site, [illegible] insertion sites c/d/i, no signs of infxn & redness, swelling or drainage. Pt tolerated dressing changes well, VS remained stable throughout. ABG sent per Dr. [redacted] b(6)-2. No other actions req'd @ this time [redacted] b(6)-2

EA# [redacted] b(6)-4

08/22/03 10:50:5 HR=88 P1 =88/81(84) P2 =OFF RR=16 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF 08/22
III
MON
0.5mV/cm
PACER DISPLAY ON
140
70 P1
0
2x
Ld2

III
MON
0.5mV/cm
PACER DIS
140
70
0
2x
Ld2

i-STAT EG7+
Pt: [redacted]
Pt Name: b(6)-4

Na	147 mmol/L
K	3.4 mmol/L
TCO2	26 mmol/L
iCa	1.13 mmol/L
Hct	28 %PCV
Hb*	10 g/dL

*via Hct

37C	
pH	7.463
PCO2	35.1 mmHg
PO2	131 mmHg
HCO3	25 mmol/L
BEecf	1 mmol/L
sO2*	99 %

*calculated

Sample Type:
22AUG03 10:0?
Oper: [redacted]
Physician:
Ser# [redacted]
Ver: JAM5046A CLEW A93

STANDARD FORM 600 (REV. 6-97) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	22 AUG 03 1920: Assumed care for patient resting comfortably in bed: Assessment as follows: (N) sedated on versed @ 7/hr + fentanyl 150/hr; Pupils @ 2mm sluggish; Responds to painful stimuli: (R) (b) coarse breath sounds; (L) > (R) upper < lower lobe; (-) s/s dyspnea; sats 99% on #8 ETT 22 @ lip w/ vent setting of SIMV 16, 35%; TV 800; PEEP 5. (CV) NSR (currently 81); S1, S2; pulses +3/4 to UE; +1/4; +2-3 edema to UE/LE; 99.6 (GI) NGT to (R) nare (LIWS) draining clear scant amount of drainage; JP x 2 to abd; jejunostomy tube running jevity @ 20; dressing d/i to (R) [illegible] small amount of clear drainage; midline abd inc C/D/I; colostomy to (R) side abdomen (GU) moderate clear urine from foley; (+) scrotal edema; (Lines) (L) SC cath; (L) radial art line; PIV x 2; foley, ETT; (Skin) (R) UE dsg is clean/D/I; (L) UE dsg C/D/I; (Psych) [illegible] in [illegible], [illegible]
	, 4, n
	b(u)-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(u)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8-23/0800	Assumed pt care at approx 0730 from LT [redacted]. Pt in no apparent distress @ change of shift, although slight ↑ WOB noted. Dr Yang aware of ↑ WOB no action rqd. Per Dr [redacted] b(6)-2 maintain versed off & titrate fentanyl V. Pt currently @ 20mcg/hr fentanyl. [illegible] D5 1/2 NS c 20 kcl @ 75cc/hr, jevity @ 20cc/hr. NG to LIS, FTG, jejunum drain infusing jevity, duodenum drain to gravity, colostomy draining semi solid waste. JP x2 intact @ ⊘ vacuum. No other issues noted. [redacted] b(6)-2
8-23/0810	N Perrl 3mm sluggish on 20mcg fentanyl, responsive to painful stimuli, + gag reflex.
	CV ST S1S2 ↑ ectopy, ↑BP 200/60s (Dr. Yang aware), +2 radial & pedal pulses bilat. +2 pitting edema bilat UEs & LEs, ⊘ JVD. Periorbital & scleral edema noted.
	Resp even & slightly labored vent SIMV 16 VT 800 PEEP 5 FiO2 35%, SpO2 97-99%. Coarse BS bilat upper lobes diminished lower lobes bilat. mod-lg thick white [illegible] suctioning. Per Dr. [redacted] no action rqd @ this time ETT #8 22cm @ lip
	GI Soft slightly distended, ⊕BS, NG (R) nare to LIS, jejunum drain infused c jevity 20cc/hr, colostomy (R) quad, stoma beefy red putting out mostly liquid stool but becoming increasingly more solid. Duodenum drain remains intact draining yellow fluid, JPs x2 intact

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

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

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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-4 8.23

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE					NOTES					
	06	07	08	09	10	11	12	13	14	15	16
HR	102*	106	103	101	111	109	103	104	101	114	111
BP: ALINE											
BP CUFF	201/112*	216/87	192/85	179/81	147/90	134/73	134/68	121/76	129/68	142/75	139/68
RR	28	34	24	26	16	16	24	26	26	16	16
SATS	100	100	95	98	98	98	99	98	98	99	99
MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
FiO2	35	35	35	35	50%	50	50	50%	50%	50%	
TEMP	98.7		100.4				99.4				
IVF	75	75	75	75	75	75	75	75	75	30	30
PRB IVF	50										
Fent	14	14	7	7	14	14	14	14	14	14	14
versed	6.5	off	off	off	2	2	2	2	2	2	2
Jevity	20	20	20	30	40	50	125	175	140	140	140.
Foley	100	110	95	110	85	70	55	60	40	140	60
duodenal	600		120				130				
NGT	100					50					
	[illegible]										
JP #1	5										
JP #2	25										

* sepsis minimal

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

DATE	NOTES
23AUG03	Surgery
1130	No events overnight (+) stool in bag with Abx
Versed	VS - Tm 99.3 HR 90's-100
20s? 400 syn	SAT 97% 40%
ZANTAC	UO 80 cc/hr Stool 500 Duodenal Tube - 180/shift
?	JP1 10 cc/shift JP2 15 ?shift
Vecuronium	Abd - ND soft wounds ? with some
Fentanyl	Necrotic tissue no ? . middle wound ok.
Cipro	chest ?
	CXR - (L) lung fluffy infiltrate
	24.6 / 32.2 < 335 ; 128 | 108 | 11 / 4.2 | 21 | 123 / 1.1 ; Alb 1.4 ; Ad 46 AST 30 ; Alt 25 TB 6.0 ; Amy 39
	A/P Overall doing well. ↑ WBC concerning
	? clear localization. would CT if Available.
	P- cont sed ween as available
	Resp - cont Abx for pneumon. No wean yet.
	CV no ?
	Renal - ok
	Heme - ok
	ID - WBC ? etiology ? when avail. ? today.
	GI - ? Duodenal content with feeds.

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FI[illegible] [illegible]E	MIDDL[illegible] [illegible]AL	ID NUMBER

DATE	NOTES
23AUG03	Procedure Note
	Central line
	PL ē 7 day old Ⓛ SC line
	Ⓡ SC cordis placed on 3rd stick
	using Modified sterile seldinger technique
	Placement confirmed using modified CVP.
	comp. Arterial stick but no [illegible]
	x2.
	CXR.

b(6)-2

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b(6)-2 All

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
25 AUG 03 1105	Pt resting comfortably. O2 sats 98%. RR 16. BP 110s/60s. Peak pressure 26. Will cont care. [redacted] LT/AN
1130	Pt BP ↑ 130s/60s. Eyes moving in eyelids. Gave 10mg propofol IVP. Will cont to monitor. [redacted] AN
1255	Pt overbreathing vent. Noted very little sputum in ETT. Peak 41. Suctioned pt x II. Large amt thin white sputum noted. Gave pt 30mg propofol IVP. Peak ↓ 30. Will cont to monitor. [redacted] LT/AN
1312	Pt BP 130s/60s. Attempted to Δ pt position. BP remain same. Gave pt 30mg propofol IVP. Will cont to monitor. [redacted] LT/AN
1415	Pt BP ↑ 150s/60s. Overbreathing vent RR 19-26. Gave 30mg propofol IVP & ↑ rate to 90mcg/k/min. Will cont care. [redacted] LT/AN
1420	Pt BP ↑ 140s/60s. Peak 31. Suctioned pt x II. Deep suctioned thin white secretions noted. O2 sats 98%. BP ↓ 130s/60s. Will cont care. [redacted] LT/AN
1514	Noticed feces near midabd incision. Δ'd drsg. Noted drainage around Ⓡ duodenal drain, JP1 + JP2, + J-tube yellowish fluid. Δ'd drsgs. Will cont care. [redacted] LT/AN
1700	Pt BP 140s/60s. Peak 28. O2 sats 99%. Will cont. care. [redacted] LT/AN
1755	Gave tylenol for temp 101.5 via NGT. Gave report to night shift. [redacted] LT/AN

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)
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USAPA V1.00

D(6)-2 All

LAST NAME	FIRST NAME	MIDDLE	ID NUMBER

DATE	NOTES
25 Aug 03 1800	Received report from 1LT [redacted] Pt on bed rest, Sedated. Pt on a vented. Cordis to (R) SC c̄ 3L. Foley draining to gravity. JP 1+2 to bulb drain. Will continue to monitor. [redacted] SPC, 91WM6
1900	Changed ostomy bag. Stoma look pink and beefy. Drained 200cc of liquidy stool. Will continue to monitor [redacted] SPC, 91WM6
2200	Drsg Δ complete. Areas look red and beefy. Will continue to monitor. [redacted] SPC 91WM6
26 Aug 03 0200	Pt resting in bed. VSS. Changed ostomy bag. drained 200cc of liquid stool. Will continue to monitor. [redacted] SPC 91WM6
26AUG03 0100	Received report from previous shift. Vented SIMV16, 800, 16, 5peep, 40% FiO2, peak 21. All IV lines intact. Temp 100.7, ST 100s, Sats 99-100%. NGT (R) nare to LIS. Propofol @ 100mcg/kg/min, fentanyl @ 125mcg/°, D5½NS c̄ 20KCl @ 36cc/° infusing in triple lumen, NS @ 30cc/° infusing into cordis (R) SC. All drains intact. Will cont. care. [redacted]
0630	Dr. [redacted] viewed labs & ABG. No new orders written. Viewed wounds. Completed drsg Δ. Midabd wound had yellowish substance. Yellow mucous from (R) JP tube and duodenal tube. Dr. [redacted] aware. Pt RR ↑ 40s. Gave 50mg propofal IVP. Also gave 30mg fentanyl @ 0710 due to ↑ BP 140s/50s. Wet to dry drsg to midabd incision + (R) flank wound using dakin's soln. cont [redacted]

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

b(6)-2 A11

LAST NAME	NAME	M	INITIAL	ID NUMBER

DATE	NOTES
26 Aug 03 1215	pressure ↓ 28. RR ↓ 22 BP still elevated & pt moving eyes + eyebrows. Gave 50mg propofol IVP. will cont [redacted]
1250	Stopped TF per Dr [redacted] Pt prep. for OR. [redacted]
1430	Pt to OR via stretcher c̄ O2. [redacted]
1640-1800	Pt return from OR. New order to hold TF. Noted 2 (R) JP drains + 1 (L) JP drain c̄ sanguinous drainage to bulb suction, duodenal drain in place, midline abd incision suture together c̄ penrose drain. (R) flank wound c̄ sanguinous drainage noted. Δ'd (R) colostomy bag. Δ'd (R) shoulder burn drsg. Applied silvadene. 2x2 gauze + penrose drain around 3 JP drains, J-tube, + duodenal drain. Pt O2 sats 90-94% upon arrival. Temp 97.7. Δ'd drsg (R) flank wound (applied 4x4). ETT remains 26cm @ lip. O2 sats ↑ 99% by 1800. RR 16, HR 80s-90s. Placed rolls under (B) feet. Gave report to Lt. [redacted]
26 Aug 03 1800	Report rec'd from LT [redacted]. Pt remains intubated. Will monitor [redacted]
	1 =OFF P2 =OFF RR=16 SpO2=100% NIBP=104/47(66) T1=OFF T2=OFF ΔT=OFF
2015.	Pt suctioned x4. Copious amounts thin white secretions. SpO2 ↑ to 99-100% following suctioning. SpO2 97% prior to suction. cont

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 All

DATE	NOTES
26 Aug 03 0630	cont'd... Ⓡ flank wound has yellowish substance.
	Dr [redacted] aware. Colostomy bag coming
	apart near wound. Used tincture benzoin to seal.
	Unsuccessful. Will attempt to Δ bag if possible. Pt
	temp ↓ 100.s. Will cont. care. [redacted]
0730	Pt RR 40s-50s. Gave 30mg propofol IVP. Will cont
	to monitor RR. [redacted]
0820	Completed bed bath + linen Δ. Completed foley
	care. Placed pt on Ⓡ side. Pt RR ↑ 40s. BP ↑ 140s/60's. Gave
	20mg propofol IVP. Δ'd drsg on Ⓛ radial A-line. A-line
	not correlating c̄ NIBP. Will cont. care. [redacted]
1000	Pt peak pressure 50. BP ↑ 150s/60s. RR ↑ 40s-50s. Deep
	suctioned pt x III. Noted large amt thin white
	secretions. O2 sats ↑ 96% - 98-99%. peak pressures ↓ 30
	BP ↓ 120-130s/50s. RR ↓ low 20s. Δ'd NGT tape. Applied
	emycin to Ⓑ eyes. Applied bacitracin to all drains.
	Will cont. care. [redacted]
1045	Pt RR ↑ 26. Gave 30mg propofol IVP. Will cont care.
	[redacted]
1215	Noticed RR ↑ high 20s. Peak pressure 40s. Deep suctioned pt x III. Noted
	large amt thin white secretions. BS rhonchi Ⓑ UL. Suctioned mouth. Peak cont'd

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

REGISTER NO.	WARD NO.

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | PROGRESS NOTES

b(6)-2 All

DATE	
26 Augus 2015 cont.	Peak pressure ↓ to mid to upper 30's ~~from~~ following suction from lower 40's prior to suctioning. Will cont. to monitor. Pt turned to (L) side and 30mg Propofol and 30 mcg fentanyl IVP given [redacted] ↑ work of breathing
2030	Pt appears more comfortable. SpO2 100%, RR 16 down [redacted] from 20's.
2300	Pt turned to (R) side. Pt suctioned. Copious amounts thin white secretions. SpO2 98%, Peak pressures upper 20's. Temp ↑ to 101.5 Tylenol 650mg [redacted] per NGT given. Will monitor
0200	Pt turned to (L) side. Pt suctioned x 3. Burn wound redressed per protocol. Drsg Δ'd to midline abd incision. Drsg saturated c sero- [redacted] sanguinous drng. Will monitor
0600	Report given to day shift
0615	Care of patient + report received from previous shift. VSS. Ø s/s of pain or discomfort. Will [redacted] LPN cont. to monitor
0800	Tube feeds started @ 60cc/hr Jevity c duodenal juice. Temp to 101.4 Pt given Tylenol 650mg AAC [redacted] other VSS. will cont to monitor

(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 [redacted]		

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

b(6)-2

DATE	NOTES
27 Aug 03 1000	Pt VSS T↓ 100.8. Ø s/s of pain or distress [redacted] will cont to monitor
1200	Pt VSS T - 100.7 Pt sedated. will cont to [redacted] monitor
1400	Tube feeds to goal rate of 125 cc/hr. VSS T - 100.8 pt shows Ø s/s of pain or discomfort [redacted] will cont to monitor
1700	Pt suctioned c̄ minimal secretions. T - 100.3 [redacted] VSS will cont to monitor
1800	T - 100.3 VSS Ø s/s of pain or discomfort. Report [redacted] + care of pt. given to oncoming shift
1800	Received report from Spc. [redacted] Pt. remain on vent. SIMV 16, 800, 16.5 peep, 40% FiO2 peak 34. Drsg D/C'ed as ordered. Duodenal & J-tube flushed. Temp 100.5. Tylenol given for ↑ temp. Edema noted to ↑ & ↑ Extremities. Ø distress noted @ present time. Will continue to monitor for s/sx of distress. [redacted]
2017	Bolus of propofol given via IV. Deep suction done; scant amount of secretion noted. SpO2 96%. Temp 101.3 will monitor temp. [redacted]
2207	SpO2 98%. Temp 100.8 Resting s̄ discomfort.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S SSN

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

REGISTER NO.	WARD NO.

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

b(6)-4

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

DATE	NOTES
28Aug03 2330	Temp 100.9 SpO2 98%. ∅ distress noted @ [redacted] time. Will continue to monitor. [redacted]
0215	Resting in bed s̄ discomfort noted. Will continue to monitor. [redacted]
0445	Resting in bed s̄ discomfort noted. Pt. NPO p̄ mn. To OR this am, possible trach. Will cont. to monitor [redacted]
	08/28/03 05:18:24 HR=91 P1 =OFF P2 =OFF RR=16 SpO2=100% NIBP=118/46(69) T1=OFF II MON 1.0mV/cm CONTINUOUS 25mm/s PACER DISPLAY ON ADJ. 2x SpO2 LO1 RESP
	b(6)-2 All
0615	Received report & care of pt from previous shift pt sedated in bed c̄ propofol + Fentanyl VSS. T-101.4 will cont to monitor [redacted]
0800	Pt VSS T-101.1 ∅ s/s of pain or discomfort will cont to monitor [redacted]
1015	Pt currently receiving first of two units PRBC. Transfusion started at 0955 Pt shows ∅ s/s of negative reaction. VSS will cont to monitor [redacted]
1215	Pt to OR 2nd of 2 units PRBC started at 1120 28Aug03 pt shows ∅ s/s of negative reaction. Transfusion to be completed in OR. VSS [redacted]

b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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[redacted]

b(6)-4

100

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
8/28	Op Note
	Procedures ① Tracheostomy
	② Abd Lavage
	Surgeon [redacted] b(6)-2
	Anes GOTA
	Fluids 1L
	EBL min
	Findings ① purulent trachea o/c
	② lesser sac abscess
	③ [illegible] 6L [illegible] x2 placed
	[redacted] b(6)-2

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/99)
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[redacted] b(6)-4

MEDCOM - 16510

MEDICAL RECORD	PROGRESS NOTES

DATE	
1Sept03	Surgery
	POD #1 from most recent washout of upper
	abdomen stable overnight
	Neuro - sedated, disoriented,
	resp - 7.39/36/93/22/-3/97%
	pneumonia cleared trached at [illegible]
	cont to wean vent
	cor - Tachy and hypertensive when sedation
	lifted
	Renal - 148 / 118 / 14 < 163; 3.0 / 23 / 1.4 Good UO.
	Heme - 15 / 29 < 1015 ↑ pt concerning for ongoing infx
	ID - No cx. to date will cx c̄ spike
	still concern for infx
	GI - TO Full TF.
	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

MEDCOM - 16511

MEDICAL RECORD	PROGRESS NOTES
DATE	
1 September 10:15 pm	Procedure Note (L) subclavian Pt unable to give consent (R) subclavian introducer and TLC >7 days old with fever last nite (L) subclavian TLC passed over wire without difficulty. Tolerated procedure well. (R) radial art line passed over wire. CXR confirmed placement of TLC (-) PTX. (R) subclavian pulled. Cath tips sent for culture. b(6)-2 [redacted] MD Pulm/Crit Care
2 Sep 03 1500	Nursing Cont'd: well. Pt opened eyes spontaneously but does not follow commands. Burn care done on (R) shoulder, BLE, and back of head. Stage III decub noted on back of head. 3° burns noted on (R) shoulder and BLE. Silvadene cream applied. Small amount of serosanguinous drainage noted on distal portion of mid-line abdominal incision. Incision cleansed c̄ soap + water. Dry dressing applied. (R) flank wound healing well. Ø drainage noted. Wound irrigated c̄ NS and packed c̄ gauze moistened c̄ Dakin's solution. Erythema noted around JP tubes ×5 and J Tube. Bacitracin applied around sites and covered c̄ 2×2 dressing. New colostomy wafer applied. Stoma red and healthy. Old wafer not sticking to skin well. Cont'd

(Continue on reverse side)

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

REGISTER NO. b(6)-2 [redacted]

[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	
2 Sep 03 1500	Nursing Cont'd: BUE and BLE elevated on blankets. Fentanyl concentration changed to 1000mcg/100ml. Continues to receive Fentanyl @ 100mcg/hr for rate of 10cc/hr. Pt resting quietly @ this s̄ distress.
2 Sep 03 1711	Nursing: T-101.2, Pt given 650mg Tylenol via J tube.
02 Sep 03 1900	Report rec'd from day shift. See DA 4700 for assessment
1930	SBP noted to be decreased to low 100's, 90's. Propofol ↓ to 60mcg/kg/min HR ↓ to low 100's-110. SpO2 remains 98%. RR 18-21/min Will cont to monitor
2000	Peak pressures ↑ to 30. RT @ BS. Suctioned pt x3. Thick yellow sputum obtained SpO2 remains 98%. Peak pressures ↓ to 26-27 p̄ suctioning.
2015	Map ↓ to 65-67 mmHg. SBP remains in low to mid 90's. UOP holding. Propofol ↓ to 50mcg/kg/min
2315	Drsg Δ's complete to wounds. Drsg's Δ'd to A-line and central line. No redness or drng noted from both sites. Drsg Δ'd to Ⓡ chest burn area per burn protocol. Ⓡ flank wound irrigated c̄ NS and repacked c̄ Dakins soaked gauze. Wound appears pink c̄ some active bleeding and areas of white exudate. Midline abd. drsg Δ'd. Sutures intact, wound approximated. Redness noted, but no drng. Tube insertion sites cleansed c̄ NS & betadine and redressed. Some redness noted around sites. Drsgs Δd to Ⓑ LE wounds using burn protocol. Bleeding noted around edges. Wafer Δ'd to Ⓡ colostomy. Stoma cont

b(6)-2 All

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

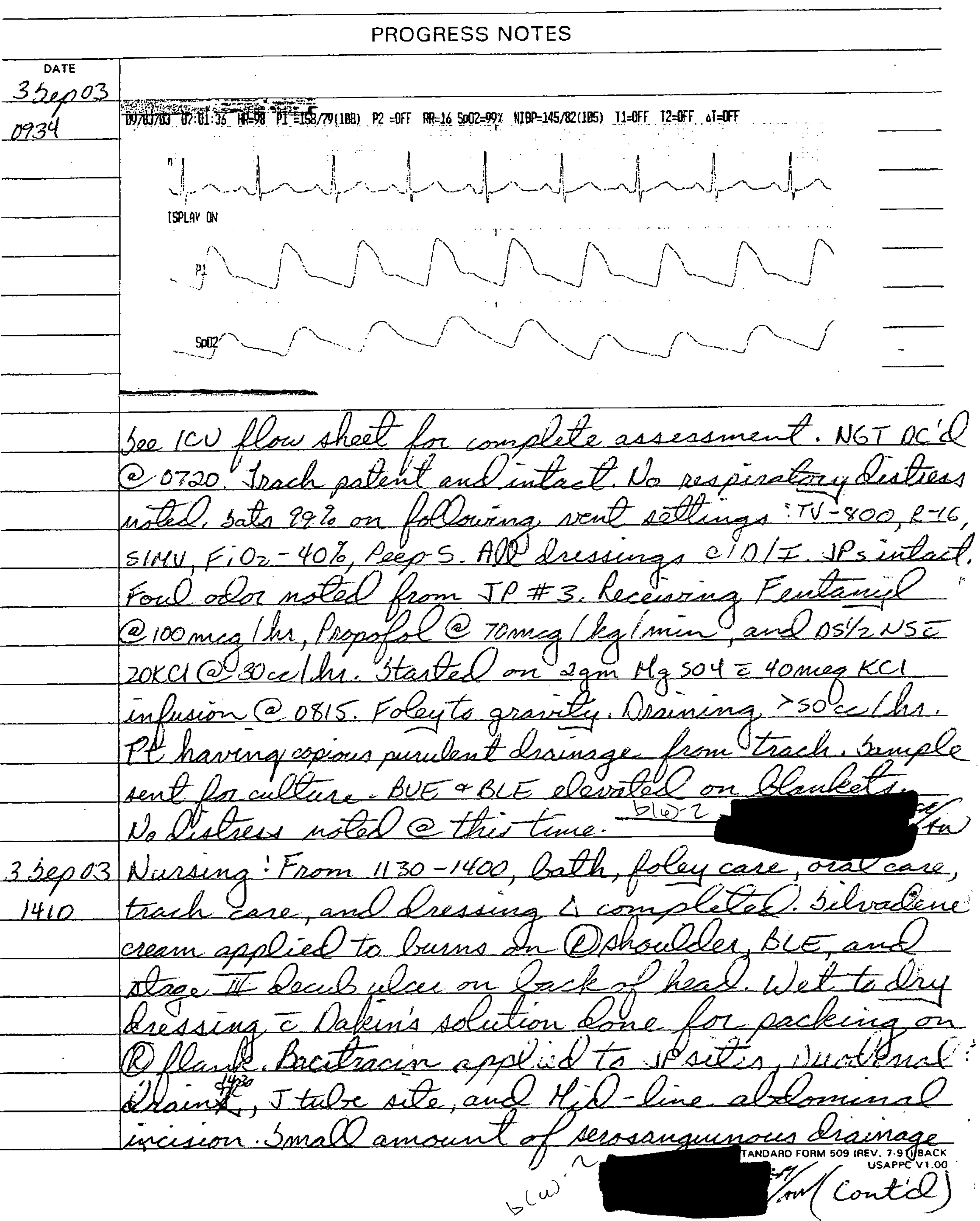
DATE	
02Sep03.	
2315 cont	Pt. appears pink and moist. Trach care complete.
	Pt suctioned X3. Obtained thick yellow sputum.
	Oral care complete. Linens Δ'd. Pt turned to
	Ⓛ side. VSS throughout. SBP ↑ to 150's, RR ↑
	to 30's. Propofol 80mg IVP given and gtt rate b(6)-2
	↑ to 60mcg/kg/min. Will cont. to monitor —
2330	+ RR ↓ to ~~16~~ 16-18/min. SBP ↓ to 120's.
03Sep03.	Will cont. care.
0100	Pt turned to Ⓡ side. Suctioned x2. Small amount
	thick yellow drng obtained. Distal & medial port
	flushed on CVC. Both ports flush easily and
	have + positive blood return.
0300	Pt turned to Ⓛ side. 600cc duodenal drng. 300cc
	added back to TF.
0350	CBC, Chem, ABG drawn and via A-line and
	sent to lab. ABG. 7.43/33.5/133/22/-2/99%
0500	Pt turned to Ⓡ side. SBP ↑ to 140's-150's. Propofol
	gtt ↑ to 70mcg/kg/min. Will monitor —

(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

DATE

3 Sep 03
0934

09/03/03 07:01:36 HR=98 P1 =158/79(108) P2 =OFF RR=16 SpO2=99% NIBP=145/82(105) T1=OFF T2=OFF ΔT=OFF

See ICU flow sheet for complete assessment. NGT DC'd @ 0720. Trach patent and intact. No respiratory distress noted, sats 99% on following vent settings: TV-800, R-16, SIMV, FiO2-40%, Peep-5. All dressings C/D/I. JPs intact. Foul odor noted from JP #3. Receiving Fentanyl @ 100mcg/hr, Propofol @ 70mcg/kg/min, and D5½NS c̄ 20KCl @ 30cc/hr. Started on 2gm MgSO4 c̄ 40meq KCl infusion @ 0815. Foley to gravity. Draining >50cc/hr. Pt having copious purulent drainage from trach. Sample sent for culture. BUE & BLE elevated on blankets. No distress noted @ this time. b(6)-2 [redacted]

3 Sep 03
1410

Nursing: From 1130-1400, bath, foley care, oral care, trach care, and dressing Δ completed. Silvadene cream applied to burns on Ⓡ shoulder, BLE, and stage II decub ulcer on back of head. Wet to dry dressing c̄ Dakin's solution done for packing on Ⓡ flank. Bacitracin applied to JP sites, duodenal drain, J tube site, and mid-line abdominal incision. Small amount of serosanguinous drainage

b(6)-2 [redacted] (Cont'd)

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

MEDICAL RECORD	PROGRESS NOTES

DATE	
3 Sept 03	Pulmonary / Critical Care
08[00]	EPW s/p ex lap, multiple washouts, trach. No
meds	events overnite
	154/78 98.8 100 16
Fentanyl	
Zantac	General: asleep arouses to stimuli. Does not follow commands
Lovenox	HEENT: trach
D5 1/2 NS + 20 KCl + 3 bicarb	LUNGS: scattered rhonchi
Jevity at 80cc/hr	CV: Regular ... (L) subclavian
Reglan	Abdomen: midline incision JP x5
Unasyn	Ext: (-) edema
	(Labs): 7.43/34/133 -2 18.1 > 9/28 < 941 I/O - 4564/4480
	151/123/20 131 AST-49 alk ϕ - 148
	3.4/23/1.0 ALT-35 T.Bili - 1.8
A/P	(1) Neuro → opens eyes intermittently. Does not follow commands
	Would decrease propofol daily to assess status.
	(2) Pulm → low O_2 requirements. Secretions around trach
	but no clinical pneumonia
	(3) CV → hemodynamically stable. Labetalol prn for elevated BP
	Needs standing dose of medication. Place on Atenolol 25 QD
	(4) Renal → needs free water or more 1/2 NS. Will ↑ fluids
	with more KCl given borderline K+
	(5) Heme → 9/28 no current issues
	(6) ID → changed Abx yesterday. WBC ↓ with plts. No fevers

(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

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b(6)-2

PROGRESS NOTES

DATE

source of infection. Do not have IV fluconazole. PO fluconazole for now but limited effectiveness for fungemia or systemic infection. If further fevers would Δ to [illegible]. Lines changed

(7) GI → planting tube feeds
24/80 Jevity + 24/30 720 propofol = (2640 kcal/day)
1920

Meeting Caloric requirements. Bile added to Jevity

(8) Abdomen followed by GEN SURG

(9) Disposition → expect prolonged ICU course. Biggest risk factor infection + MSOF

b(6)-2

LAST NAME	NAME	M. INITIAL	ID NUMBER

DATE	NOTES
4 sep 03	Surgery
	Neuro sedated, trached
	resp imv 16/800/5/40% 7.37/40/90/24/-2
	Doing well resolved/resolving pneumonia
	wean from Mech vent.
	cv - stable
	renal 148/121/22 143, 4.1/24/0.8 Doing well i.e. still 7ns
	well 7 Fw.
	Heme 20 / 289 / 908
	ID - ↑Temp 99-100.5 wbc 20
	midline wound opened Drains working
	Abx expanded to Fluc/Rocephin/unasyn. D#3
	Appears Defervescing today, will WATCH plan
	CT for persistent ↑WBC.
	GI Tol FS TF well.
	Lines: ® SC 3-lumen 2 days.
	b(a)-2
4 Sep 03 1933	Nursing: From 1130-1500 bath completed; foley care and trach care done. Dressings changed. Silvadene cream applied to burns on ® shoulder, BLE, and back of head. Wet to dry dressing using Dakins solution used on ® flank wound. Wound beefy red, ø purulent drainage noted. Opening in wound noted in mid-line abdominal incision. Dr. [redacted] notified (cont)

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b(a)-4

MEDCOM - 16518

b(a)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
04 Sep03	
0330.	Labs drawn via A-line and sent to lab. ABG 7.37/40.5/
	90/24/-2/97%. BP ↑ to 140's, HR ↑ 110, Peak pressure
	↑ to 40's. Propofol 80mg IVP given & rate ↑ to
	70mcg/kg/min. SBP ↓ to 110's, HR ↓ to low 100's, peak
	pressures ↓ to upper 20's, spO2 ↑ 98% —
0415	Pt turned to (R) side — b(6)-2
0600	Report given to day shift —
4 Sep 03	Nursing: HR-105, BP-143/64, R-20, Sats 98% on vent:
0746	TV-800, SIMV, R-16, FiO2-40%, Peep 5. Trach intact.
	Suctioning thick yellow blood tinged secretions
	from trach. Suctioning moderate amount of thin
	white oral secretions. No respiratory distress noted.
	See ICU flow sheet for complete nursing assessment.
	Receiving D5½NS c̄ 40meq KCl @ 100cc/hr, Fentanyl
	@ 100mcg/hr, and Propofol @ 70mcg/kg/min
	via proximal port. Medial and distal ports patent
	to NS flush. Foley to gravity. Voiding >150cc/hr
	BUE + BLE elevated on ~~pillows~~ 0800 blankets.
4 Sep03	Nursing: Pt sleeping quietly s̄ distress. Propofol
0831	0832 ~~↓60 mcg/hr~~ ↓ 60 mcg/kg/min. Labs shown to
	Dr. [redacted] No new orders written. —

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

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

b(6)-2 *11

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 Sep 03 1533	Nursing Cont'd: Sutures removed on 3/4 of wound. ~~Bowels loose~~ Intestines loosely packed c̄ Kerlix sponges moistened c̄ NS. Distal portion of incision continues to have small amount of serosanguinous drainage. 4x4 dressing applied, sutures intact. #5 JP drain DC'd by Dr. [redacted] 2x2 dressing applied. Erythema noted on JP drains, J Tube, and duodenal drain. Bacitracin applied and covered c̄ 2x2 dressings. Propofol held to determine pt's functional status. Pt opens eyes spontaneously and moves hands slightly but no purposeful movement noted. Propofol restarted @ 60mcg/kg/hr when pt's breathing becoming more labored, RR ↑40s, pt restless. RR ↓20s, pt sleeping more easily p̄ propofol restarted. D5½ NS c̄ 40KCl DC'd @ 1300. BUE, BLE, and scrotum elevated. [redacted]
4 Sep 03 1710	Nursing: BP ↓ 102/51, MAP 68. Propofol ↓ 50mcg/kg/min and Fentanyl ↓ 80mcg/hr.
5 Sep 03 0010	Pt BP ↓ 104/53, MAP 68, Propofol ↓ to 30mcg/kg/min to raise BP. Will cont. to monitor. [redacted]
5 Sep 03 @ 0120	Pt BP between 150s-140s, Propofol ↑ to 50 mcg/kg/min. Will cont. to monitor. [redacted]

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

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

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

REGISTER NO.	WARD NO.

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
USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Ø5Sept Ø3 ØØØØ	Received report from night shift. Pt sedated c̄ propofol @ 5Ø mcg/kg/min + fentanyl @ 8Ø mcg/°. (L) SC 3-lumen + (R) radial A-line intact. Flushed 3-lumen c̄ 5cc heparin. Flushes well. Pt vented SIMV 16, 8ØØ, 5, 4Ø%, peak pressure 29. TF running @ 12Øcc/°. Pt HOB ↑ 3Ø°. Noted pussy drainage in 4 JP tubes. Wet drsg in midabd incision. Will cont. care. b(6)-2
Ø65Ø	Pt BP 14Øs/6Øs-7Øs. ↑ fentanyl to 9Ø mcg/°. Will cont to monitor BP. b(6)-2
Ø745	Pt peak pressure 32-34. BP ↑ 14Øs-15Øs/6Øs-7Øs. BS rhonchi throughout. Deep suctioned pt x V. Thick white secretions noted. O2 sats 94-96%. p̄ suction O2 sats ↑ 98%. Peak pressure 31. BP ↓ 12Øs/6Øs. Rhonchi still heard ...

9/5/03 06:38:19 HR=112 ART=130/78(94) P2=OFF RR=33 SpO2=97% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/CM
PACER DISPLAY ON
160
110 ART
60
2x SpO2

Ø83Ø-1Ø3Ø	Completed drsg Δ to midline abd incision, (R) flank, (R) shoulder + (B) LE. Wet kerlex roll to open midline abd incision. Bacitracin to lower midline abd incision that is sutured. Noted serous colored drainage from lower abd incision. 1/4th strength dakin's soln for (R) flank wound wet to dry drsg. Wound looks clean. cont'd...

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b(6)-2 A11
05Sept03 0830-1030	cont'd... Cleaned (R) shoulder burn + (B)LE blisters c̄ hibiclens + rinsed c̄ NS. Applied silvadene + covered drsgs c̄ 4x4s. Completed bed bath + foley care. Used cloth tape to secure all drsgs. Elevated (B)UE + (B)LE due to edema. Will cont care. —— [redacted]
1000	Stopped propofol per V.O. Dr. [redacted] to wake pt. Pt temp @ 1000 98.8, O2 sats 94%, BP 109/66. BP ↑ 170s-190s/80s, RR ↑ 40s; O2 sats ↑ 98% p̄ suctioning x ii. Thin white secretions noted c̄ some thick mucous plugs. Suctioned pt mouth also. Pt eyes open + moving hands + head. Got interpreter x ii. Pt not responsive to any questions by interpretor. Gave 25mg atenolol @ 1100. Will cont to monitor [redacted]
1100-1230	Restrained pt due to almost pulled out A-line. Δ'd A-line drsg + (L) SC 3-lumen drsg using sterile technique. A-line positional. Suctioned pt x ii. Thin/Thick white secretions noted. Pt BP ↑ 160s-200s/80. Pt O2 sats 96-98%. Peak pressure mid 20s to low 50s during c̄ suctioning. RR 20s-low 30s. HR 100s-120s. Will notify Dr. [redacted] of these events. Will cont to monitor pt. Δ'd midline abd drsg due to saturation. Emptied JP drains. Noted pussy yellow drainage in JP #1, 2 + 4 + duodenal like drainage in JP 3. Semi formed pasty stool noted. Will cont. care. [redacted]

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

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 A[illegible]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05 Sept 03 1400	Pt temp ↑ 100.8, BP 163/76 via A-line but not correlating c̄ NIBP 156/94. O2 sats 98%. Suctioned pt x iii. Thick thin sputum noted. Will cont. care. ——
1530	Completed trach care. Pt sats 95-96% on RA. RR ↑ 34. Will cont. care. ——
1600	Dr. [redacted] V.O to turn propofol to 25mcg/kg/min. Raised pt HOB. O2 sats 98%. BP 140s/60s. Will cont. care.
1700	Pt resting c̄ eyes closed. BP 130s/70s. O2 sats 99%. HR low 100s. ——
1800	Gave report to night shift. ——
5 Sep 03 @ 2015	Pt suctioned by RT x iii for small thick white secretions.
5 Sep 03 2315	Dsg Δ's completed, trach care completed c̄ SpO2 98% on RA & RR ↑ 32. Will cont. to monitor.
6 Sep 03 0750	Nursing: T-101.5, BP 120/60, HR 109, R 16, sats 97% on following vent settings: TV-800, SIMV, R-16, FiO2-40%, Peep 5. Trach intact, ∅ respiratory distress noted. Receiving Fentanyl @ 90mcg/hr and Propofol @ 25 mcg/kg/min infusing through proximal port. Medial and distal ports flush easily s̄ resistance. Foley to gravity, voiding ≈ 100cc/hr. BUE + BLE elevated on blankets. Scrotum elevated c̄ towel. Pt resting quietly @ this time.
6 Sep 03 0825	Nursing: T-101.9, pt given 650mg Tylenol via J-Tube. Skin diaphoretic. Will continue to monitor.
6 Sep 03 1041	Nursing: T-101.7. Bath completed. Foley and oral care done. ~~Pt tra~~ (1042) Face shaved. Notified by Dr. [redacted] that pt is on call (1043) to O.R. Tube feeding stopped.

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
5 Sept 03	Pulmonary/Critical Care
08:30	Pt asleep with eyes closed but tachypneic. Labile
Meds	blood pressure overnight
Propofol	117/60 101' 16 97% Tmax 101'
Fentanyl	Gen'l: asleep but arousable, does not follow commands
Tube feeds	LUNGS: scattered rhonchi
Zantac	CV: RRR
Morphine	EXT: 2+ edema
Unasyn	Abdom: granulation tissue JPs draining
Fluconazole	(Labs): 23.2 10/31 839 ↑ 35/38/55 133/116/18 144 / 3.6/18/1.1
	Albumin - 1.5
A/P	(1) Neuro → wean propofol today. Need to assess
	mental status.
	(2) Pulm → Need to begin weaning process. When sedation
	is tolerated. Tachypnea + agitation with open abdomen
	limit progress
	(3) CV → will ↑ Atenolol and continue prn Lopressor
	BP a function of sedation
	(4) Renal → good urine output with nl BUN/Cr DC IV fluids Na-137
	(5) Heme → H/H stable
	(6) I.D. → fluconazole/unasyn/primary febrile today

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.

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PROGRESS NOTES
Medical Record

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LAST NAME	FI[illegible] ME	MIDD.[illegible]AL	ID NUMBER

DATE	NOTES
	New lines / cultures out
	(7) Continue to follow
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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b(6)-2 All

PROGRESS NOTES

DATE	
6 Sep 03 1817	Nursing: TF c̄ Jevity restarted @ 20 cc/hr. Dr. [redacted] notified of ABG and CXR results. Dr. [redacted] assessing pt. Dressing Δs for burns to (R) shoulder, BLE, and stage III decub to back of head completed. Silvadene cream applied. Pt tolerated procedure well. Report given to LT [redacted] [redacted]
1820	Dr [redacted] @ BS. Updated on pts. condition. Viewed CXR. Possible bronch to be done. Order for repeat ~~CXR~~ ABG.
1825	SpO2 ↑ to 100%, peak pressures ~ 24-25 cmH2O. 7.41/46.9/281/8/30/5/100%. Will monitor. [redacted]
1845	Dr [redacted] @ BS for bronch. Pt remained on vent during tx. SpO2 remained 91-93% during procedure. Peep ↑ to 10 following procedure, pt remains on 100% FiO2. Will wean FiO2 to keep SpO2 >93%. Will monitor [redacted]
1945	SpO2 remains 100% on 100% FiO2 and Peep 10. FiO2 ↓ to 50% while peep remains @ 10. Will cont. to monitor
2000	CXR obtained. Dr [redacted] shown results. New order for albuterol Nebs q 4°. Will notify RT.
2020	Dr [redacted] updated on pt condition. SpO2 holding @ 93-94% on 50% FiO2. No new orders rec'd. Will monitor [redacted]
2200	Drsg Δ's complete to (R) chest burn area. Wound appears white c̄ some pink areas noted. Redressed utilizing burn dsg protocol. Midline abd drsg Δ'd. Vaseline gauze placed over ~~bowel~~ exposed bowel. Normal saline gauze lightly packed into wound. Bowel appears pink and moist. (R) flank wound drsg appears pink and moist c̄ (cont)

MEDICAL RECORD | PROGRESS NOTES

DATE	
6 Sep 03 1305	Nursing: ABP 88/43, MAP 57. Propofol and Fentanyl drips held. BP ↑ 141/99. Fentanyl restarted @ 90mcg/hr and Propofol @ 25mcg/kg/min. Pt continues to move c̄ nonpurposeful movements. [redacted]
6 Sep 03 1320	Nursing: T-102.1 @ 1300. Unable to give Tylenol via J tube due to NPO status in preparation for OR. Ø Tylenol suppository in Pharmacy. Will continue to monitor. [redacted]
6 Sep 03 1400	Nursing: T-101.8, BP 138/80, MAP 100. Sats 97% on Vent support. [redacted]
6 Sep 03 1722	Nursing: Pt arrived back from OR @ 1640. See PACU flowsheet for frequent VS. Sats 88-90% on 40% FiO2 via Vent. Pt ventilated c̄ BVM. Sats ↑ 95% then went back down to 88% p̄ placed back on vent. ~~Pt suction~~ Trach suctioned, scant secretions removed. HOB ↑ 45° s̄ effect. Dr. [redacted] and Dr. [redacted] notified. FiO2 ↑ 100%. Sats ↑ 99%. ABG done and PCXR done per Dr. [redacted] request. Trach care completed. Trach patent. JP drains # 3 and #4 placed on LIS per Dr. [redacted]. SBP 100-110s, MAP ≈ 75. Fentanyl restarted @ 90mcg/hr and Propofol @ 10mcg/kg/min. Will continue to monitor. [redacted]

b(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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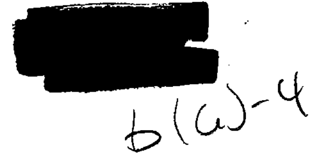


b(6)-4

PROGRESS NOTES

DATE	
07Sept 0600	cont'd... Jevity infusing @20cc/°. JP # 3+4 to LIS. JP #1+2 bulb suction. UO>30cc/°. All drsgs C,D,I. Will cont. care. ——— [redacted]
0700	Dr. [redacted] viewed labs. New orders given. ↓ed RR 12. Will get ABG in 1°. Portable CXR done. Will notify RT of vent Δ's. ——— [redacted]
0745	Repeat CXR. Drew ABG. Results: 7.434, 42.9, 119, 29, 5, O2 Sats 99%. Suctioned pt. thin white secretions noted. O2 sats 98-99%. Will cont care.
0800	Notified RT of vent Δ. Will notify Dr. [redacted] of ABG results. ——— [redacted]
0930-1100	Completed bed bath, passive ROM, + foley care. Δ'd burn drsg on (R) shoulder, blister drsgs (B)LE + decub drsg on head. Cleaned c̄ hibiclens + rinsed c̄ NS. Applied silvadene + covered c̄ 4x4s. Noticed decub on back of head near nap of neck. Made towel ring to keep head off bed. Elevated (B)LE + (B)UE. Δ'd (R) flank wound drsg c̄ 1/4 strength dakin's soln. Wound is pink. Δ'd midline abd incision. Placed petroleum gauze on intestines. Have placed NS soaked Kerlex into wound + covered c̄ abd pads. Applied bacitracin around JP drains + J-tube. Completed trach care. Noted copious white/yellow sputum when suctioning. Pt O2 sats ↑ 100% + peak pressure ↓ from 30s to 20s. Covered pt c̄ extra sheet due to temp 95-96°. Pt appears ~~to~~ less agitated. Will cont. care. ——— [redacted]

b(6) - 2
All

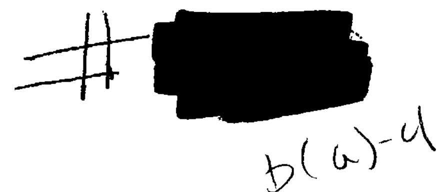
MEDICAL RECORD	PROGRESS NOTES
DATE	
06Sep03.	some white exudate noted. Wound repacked c̄ ¼ Dakins
2200 cont	soln gauze. Tube care completed. Trach care and
	oral care complete. Pt turned to (L) side following
	procedures. [redacted]
2230	~~SpO2 ↓ to 40%~~ FiO2 ↓ to 40%. SpO2 99-100%
	on 50%. Pt suctioned x 4. Copious amounts
	yellow secretions obtained. ~~SpO2~~ Pt manually
	Ventilated during procedure. SpO2 98-99% following
	procedure.
07Sep03.	/ ——— ——— ——— ——— ———
0005.	Pt turned to (R) side. Pt c̄ nonpurposeful
	mvmts. Propofol ↑ to 12.5mcg/kg/min and b(6)-2
	fentanyl ↑ to 100mcg/hr. Will monitor [redacted]
0200.	Pt placed on back. Pt continues c̄ non-
	purposeful mvmt. RR 17-22BPM, SBP 120's/130's. Will
	cont. gtts @ current rate. ——— [redacted]
0400.	CBC, Chem, ABG drawn and sent to lab. 7.52/33.8/
	84/28/5/97% ——— [redacted]
0430.	Abd wound drsg Δ'd for dampness. Gauze packing
	remains moist. ——— [redacted]
07Sept03 0700	Received report from previous shift. Pt moving BUE
	+ eyes open. Fentanyl @ 100mcg/° + propofol @ 20mcg/° infusing.
	BP 130s/70s. RR teens. O2 sat 90s. SIMV 16, 800, 10, 40% FiO2, peak 34 cont'd

(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

b(6)-2

PROGRESS NOTES

DATE	
07 Sep03 1800 cont	Pt unsuccessful. <2 sec cap refill noted to (B) hands, (+)2 (B) radial pulses, hands warm and dry. Will cont. to monitor
1900	Pt appears agitated, moving extremities, grimacing, lifting head. HR 90's, SBP 150's. Gave fentanyl 50mcg and 20mg propofol IVP. HR ↓ to 80's, SBP ↓ to 110's-120's. Pt ~~are~~ not grimacing moving extremities as much. Fentanyl gtt rate ↑ to 100mcg/hr. Will monitor
2130	Trach care complete. Pt suctioned x4. Copious amounts thick yellow secretions obtained. SpO2 100%. Drsgs Δ'd to (B) LE using burn protocol. Wounds appear white with bleeding noted at edges. Drsg Δ'd to (L) chest burn area using burn drsg protocol. Burn areas appear white c̄ ~~some~~ ~~w/~~ white areas noted. Some pink edges noted. Wounds cleansed to back of head. ~~He~~ Shaved ~~air~~ hair around wounds. Silvadene applied. Head wrapped c̄ gauze to keep drsgs intact. Head placed on foam doughnut. Pt tolerated procedures well. VSS throughout.
2330	Drsg Δ'd to midline abd incision. Xeroform gauze sticking to intestine. Irrigated c̄ NS to enhance removal of dressing. Intestine appear pink and moist. Vaseline gauze reapplied - packed lightly soaked in NS. Green liquid drng
08Sep03	noted from site.
0200	Pt suctioned x4 Manually ventilated during procedure. Copious amounts thin yellow secretions obtained. SpO2 100% during procedure. Placed back on vent p̄ procedure.

STANDARD FORM 509 (REV. 7-91) BACK

MEDICAL RECORD | PROGRESS NOTES b(6)-2 All

DATE	
07Sept03	Pt BP ↓ from 130s-150s/70s to 100s/60s. ↓ propofol gtt to 10mcg/kg/min
1340	Will cont to monitor. [redacted]
1445	Suctioned pt x III. Copious white/yellow sputum noted.
	Pt O2 sats 97%. RR12. Will cont. care. [redacted]
1455	Restrained pt Ⓡ arm due to pulling onto JP drain. Will cont.
	to monitor soft restraint. [redacted]
1600	Pt A-line about to be pulled out by pt. Redressed A-line.
	Good square wave form. Placed Ⓡ arm is sam splint to
	protect a line + restrained pts Ⓡ arm. Δ'ostomy bag
	due to leakage into midabd wound. Cleaned midabd
	wound c̄ NS. Δ'd drsg. NS soaked kerlex. Pt had BM
	brown liquidy. ↓ peep to 5 per V.O. Dr. [redacted]
	↑ed TF to 40cc/° due to V.O. Dr. [redacted] Disconnected
	JP# 3+4 from LIS. Now on bulb suction. Will cont.
	care. [redacted]
1700	↓ed pt Fentanyl to 70 mcg/° + ↑ed propofol to 20mcg/kg/min
	in attempt to slightly sedate pt while not ↓ing pt
	BP < 100 systolically. Will monitor BP. Pt O2 sats 98%.
	Pt temp ↑ 98³. Will cont. care. [redacted]
1800	Gave report to night shift. [redacted]
07Sep03 1800.	Report received. Pt currently in soft wrist restraints. Pt has
	numerous drains in abd and monitoring lines. Pt continues
	to move Ⓑ UE, pulling @ medical equipment. Pt does not appear
	oriented and makes non purposeful movements. Attempts to reposition (cont)

(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. ICU

EPW [redacted]

b(6)-2

PROGRESS NOTES
Medical Record

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b(6)-2
All

PROGRESS NOTES

08Sept 03 0700	cont'd... Notified RT. Will cont. care [redacted] LT/AN
0735	RT ↓ed RR to 8. Pt O2 sats remained >98%. Suctioned pt x iii. Copious yellow tinged sputum noted. Will cont. care. [redacted] LT/AN
0755	Got interpretor. Pt able to follow some simple commands. Pt closed eyes. Pt unable to squeeze hand. Interpretor believes pt still a little confused. Interpretor explained vent + tubes. Will recheck mental status in a couple of hours. [redacted] LT/A
0915	Placed pt on TC 50% FiO2 by RT. Interpretor @ bedside to explain events. Pt O2 sats 98-99%. RR 20s to 30s. Emptied JP drains. JP#1 sanguinous drainage. JP#2 pussy drainage. JP#3 duodenal juice. JP #4 pussy drainage. Dr. [redacted] aware. Suctioned pt x ii. Pt able to cough some sputum. Copious yellow tinged sputum noted. Will cont to monitor. [redacted]
1024	Midline abd drsg Δ'd by Dr [redacted] Used fluffs soaked in NS. Placed petroleum gauze on intestines + placed fluffs in areas of skin separation. Loosely packed. Noted some pussy drainage. Dr. [redacted] viewed ABG 7.56, 40.3, 87, 31, 8, 97%. O2 sats 98-100%. Suctioned pt numerous times. Copious yellow-tinged sputum noted. Will cont. care [redacted] LT/AN
1135	Started fentanyl gtt @ 10 mcg/°. Will cont to assess pain level. Completed bed bath, burn drsgs Δs + foley care. Δ'd linens. Will cont. care. [redacted] LT/AN

FORM 509 (REV. 7-91) BACK

MEDCOM - 16532

MEDICAL RECORD | PROGRESS NOTES b(6)-2 A11

DATE

08Sep03.

0400. CBC, Chem, ABG drawn ø via A-line and sent to lab. Results pending. Medial and distal port of CVC flushed c̄ blood return present. —

0530 J-tube flushed c̄ 35cc H_2O. Flushing sluggish. TF @ 50cc/hr p̄ pt had BM via colostomy. Pt suctioned x 3. SpO2 99-100% during procedure. Moderate amount - thin yellow secretions

0600. Report given to day shift. —

08 Sept 03 0600 Received report from previous shift. Pt awake + moving (B) UE + (R) ↓ ext unpurposefully. Propofol + fentanyl infusing. All IV lines are intact. (B) LE elevated. Jevity infusing @ 50cc/° from (L) J-tube. Two arm soft restraints in place. Cap refill <3 sec. Will cont. care. —

0700 Viewed lab results. ABG 7.496, 40.5, 112, 31.8, 99% @ vent settings SIMV 12, 800, 5, 40% peak 23. H+H 8.2, 25.7 Plt 662, WBC 17.6. Dr. [redacted] viewed labs & CXR. New orders to try pt on trach collar for 1° + ↑ TF to 80cc/°. Notified Dr. [redacted] that petroleum gauze sticking to intestine. Will do drsg Δ c̄ Dr. [redacted] Stopped propofol + fentanyl @ 0710 in preparation for trach collar trials. cont'd.

(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)
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USAPPC V1.00

b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
08 Sept 03	↑ed fentanyl to 15mcg/°. Completed mouth
1300	care + trachcare. Pt seems to tolerate fentany
	rate of 15mcg/°. ↑ed rate to 30mcg/°. Suctioned
	pt numerous times. Copious thick yellow-tinge
	sputum noted. Pt tol. trachcare well. Pt moving
	Ⓑ UE s̄ any difficulty. Moves Ⓑ LE occasionally.
	Ⓑ LE elevated. O_2 sats 100% on humidified
	trach collar. RR low 30s. Will cont. care. [redacted]
1500	Pt resting comfortably. O_2 sats 100% on 50% FiO_2 humidifie
	trachcollar. Suctioned pt x ii. Copious sputum noted.
	Restraint on Ⓛ wrist in place. cap refill < 3 sec. Will cont.
	care. [redacted]
1700	Pt resting. Ⓞ Δs. Will cont. care. [redacted]
1800	Gave report to night shift. [redacted]
1800	Received Report [redacted]
2300	Changed mid abd and Ⓡ flank and Ⓡ lat upper chest
	RUE burn drsg. Patient tolerated well. [redacted]
2330	Trach care done. Foley care done. [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)
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USAPPC V1.00

PROGRESS NOTES

DATE	
9Sept 07	Surgery
Atenolol	No events over night
Albuterol	Neuro Spont EO, lacky purposeful movement
AVCon [illegible]	Resp - Trach Good CXR with T infiltrate of
Rocephin	(R) Lung.
Unasyn	Cor HR 80-100 BP 140-180/70
Zantac	Renal - UO 110-150cc/hr ⊕ N1000cc for the day
Fentanyl	marked [illegible] peripheral Edema
	Heme - HCT 26 Plt 662
	ID Afeb WBC ↓ to 17.6
	GI tol TF @ Goal of 80cc/hr
	overall Doing well with wound c̄
	exposed bowel is [illegible] currently c̄ WTD
	Dressings. will eventually Require STSG when
	clean and Granulated.
	b(6)-2
9 Sep 03 0700	Received report from ongoing shift. Lines, drains, TC c̄ 35% intact. Pt on mild sedation of Fentanyl @ 60mcg/hr, pt wide awake c̄ appear to be unpurposeful movement. Donot follow command. Respond better to the interpreter but no consistency c̄ following command. VSS. Afebrile [illegible] Mcg/hr
1120	AM bed bath completed. Wound care done c̄ physician earlier. See above note. Pt received KCl 40meq drip for K+ 2-8. Thru TLC. Antibiotic therapy (Unasyn + Rocephin) in progress for WBC 17.6. General edema resolving + UO per foley >50cc/hr. Dressing changed as per ordered. Abd wound c̄ trace of infected exudate

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

b(6)-2-A11

PROGRESS NOTES

DATE	
10Sep03 0853	Nursing Cont'd: dressing changed by Dr [redacted] Stool leaking from colostomy site to wound. Wound irrigated c̄ sterile water. Vaseline gauze and Kerlex moistened c̄ NS applied to mid abdominal wound. New wafer and bag applied to colostomy site. Tincture of ~~bez~~ 0900 benzoin applied to skin to help c̄ adhesion of wafer. Stoma pink and healthy. Ø leaking noted from colostomy site. Wet to dry dressing change done on Ⓡ flank wound. Site packed c̄ Kerlex moistened c̄ Dakin's solution. Wound granulating, Ø drainage or foul odor noted. JP sites + J tube cleaned, Bacitracin applied and covered c̄ 2×2 dressings. Pt tolerated procedure. Pt restless, moving all over bed. BLE elevated. Will continue to monitor. [redacted]
10Sep03 1056	Nursing: Bath, ~~and~~ 1056 foley care, and oral care completed. Pt's face shaved. ROM exercises done on BLE. Pt moving BUE more frequently. Colostomy intact, wafer adhering to skin. JPs drained. Pt having ~~serous~~ bloody drainage from JP #1. Foul odor noted from JP #3. Serous drainage noted from JP #2-4. Pt repositioned in bed. Pt has strong cough and able to cough up thick secretions from the 1104 trach. [redacted]
10Sep03 1352	Nursing: Trach care completed. Pt continues to have productive cough. TLC Dressing Δ'd using sterile technique. Site cleaned c̄ Betadine. Tincture of ~~Benzoin~~ 1358 Benzoin applied for adhesion. Ø S/S of infection. [redacted]

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

MEDCOM - 16536

MEDICAL RECORD	PROGRESS NOTES

DATE	
	Confirmation b(6)-2
9 Sep 03	"appearing". MD made aware. Drains exit sites intact free from
1120	infection S+S. Colostomy wafer + bag changed, colostomy site (stoma)
	c̄ excellent vascularization s̄ drainage or irritation. VSS. [redacted]
1330	Pt turned q2° to relieve pressure off sacrum, no skin breakdown
	noted. Bed sore noted back of the head from prolonged bedbound
	applied dressing. Relieve pressure off affected area q2°.
1700	Pt turned q2° dressing changed to calf c̄ W-D dressing covered
	c̄ Tegaderm + Kerlix, dressing to the bed sore on the back of the
	head changed as well c̄ W-D dressing + tegaderm. Continue to
	reposition pt to take pressure off problem areas. Afebrile
	all shift. Remained on mild ~~sedation~~ extra sedation of Fentanyl
	60 mcg/hr. Remained awake most shift but continue to
	unable to obey commands. ——— [redacted]
1800	Received report. ——— b(6)-2 [redacted]
10 SEP 03 0300	Assessment completed @ 1830. VSS. A-Line BP does
	not correlate c̄ NBP, will continue to draw blood
	from A-Line PRN. Patient agitated most of night.
10 Sep 03	Nursing: See ICU flowsheet for assessment. VS: T-98.8,
0853	BP-152/82, HR-98, R-33, Sats 99% on 35% humidified
	trach collar. Trach patent. Suctioning moderate amount
	of thick yellow secretions from trach ~~x3~~ 0855 x6. Dr [redacted]
	notified of low Hct and K. Pt started on 20 meq KCl
	infusion @ 0850. Mid-line abdominal incision (Cont'd)

(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)-2

PROGRESS NOTES
Medical Record

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

EPW [redacted] b(6)-4

b(6)-2A1)

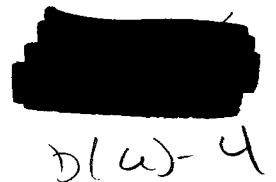
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Sep 03 1750	Nursing: A line DC'd. Direct pressure applied for 6 mins. Ø bleeding noted. 4x4 dressing placed on site. Mid-Abdominal dressing Δ'd by Dr [redacted] Vaseline gauze ē Kerlex moistened ē NS applied to wound. Ⓡ flank dressing Δ'd. Wet to dry dressing done. Report given to Cpt [redacted] [redacted]
10 Sep 03 1800	Received report from CPT [redacted], Pt resting in bed, HOB [illegible] TF @ 80 cc/hr, Fent @ 50 mcg/hr, JP drains to bulb suction, Pt wiggling in bed, VSS, will continue to monitor [redacted]
2200	Abdominal dressing changed. Vaseline gauze applied to exposed organs, Aseptic Technique. Fluff gauze moistened ē NS applied on top. Covered ē ABD dressing afterwards, Abdominal puncture wound dressing changed ē Dakins W-D dressing, JP drain insertion sites cleaned, no oozing noted, minimal redness & swelling around sites, lines stripped, 2x2 applied over site, Ⓡ chest dressing changed ō sulfamylon W-D dressing, Ⓑ LE dressing changed ō sulfamylon W-D dressing. Back of head dressing changed ē sulfamylon W-D dressing & covered ō opsite, [redacted] positioned pt for comfort. Placed pt on ~~RA ē humidified~~ humidified RA Sats remained in the mid-90's, RR-hi-20's, unlabored, Pt required frequent suctioning, thin, white

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.



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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0800 (11 Sep 03)	secretions, Pt c good strong cough. Will continue to monitor and leave in humidified RA for now [redacted] cpt/pd
11 Sep 03 0831	Nursing: See ICU flowsheet for nursing assessment. Sats 93% on RA, RR 30-40s. Pt placed back on O2 @ 28% FiO2 via ~~trach~~ humidified trach collar. Pt coughing up thick yellow secretions. Trach patent. ~~Respiratory~~ Pt restless, moving all over bed. Pt attempting to look over side rails and laying head on top of side rails. Pt not following commands. Two point soft restraints applied on BUE to keep pt in bed. Pulses strong and easily palpable. Ø skin breakdown noted @ restraint sites. Dr. [redacted] notified of lab results. Order written for KCl replacement. Will continue to monitor. [redacted]
11 Sep 03 1000	Surgery b(6)-2 A11
	No Acute events overnight. TO full TF
	Neuro - Awake, indicates No c Tongue click
	Resp - ↓ SAT to 93-94 today but was on RA increased to 24% Now 97% CXR post LLL infiltrate. → send Aspirate for cx
	CV - 90-100 - 150/96
	No issues
	Renal 154 / 113 / 13.7 ; 3.1 / 27 / 1.0 — Alb 2.1 AP 98 ALT 22 Amy 102 AST 31 TBI 1.2
	FEN Prob FWD 2° to TF and Diuresis. will Add FW c K Replacement and c TF tonite.
	[redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

MEDCOM - 16539

b(6)-2 All

PROGRESS NOTES

DATE	
11Sep03	Nursing Cont'd: applied for adhesion. ~~Pt remains~~ [redacted] 1057
1047	40meq KCl in 500cc D5W [redacted] ~~started~~ infusion started @ 1048. Pt remains restless, scooting down in bed, flailing arms and legs. Interpreter asked to speak to pt but pt not following commands. Restraints removed during bath and reapplied afterwards. Pulses remain strong, Ø skin breakdown noted. Pt repositioned in bed, placed on (L) side. [redacted]
1110	Wound care: pressure sore nursing note:
	LE: Change dressing to pressure sore to bilateral LE, yellowish scabs noted on the wound, measuring 2x3 cm and approximately 1x2 cm in same area (R) LE has 3 small wounds (L) LE has two. Applied sulfamylon solution ~~[illegible]~~ [illegible] W-D dressing, covered c tegaderm dressing to preserve moisture, per wound care nurse specialist recommendation.
	Scalp: Pt has 4 multiple sizes pressure sores (superficial) yellowish scabs noted. Applied ~~[illegible]~~ Sulfamylon solution W-D dressing covered c Tegaderm Transparent dressing. Staining of yellowish exudate noted on the old dressing, very minimal. Dressing has been changed c above procedure X 3 days. Plan: Observe wound appearance each day + document progress. [redacted] Maj / AN
11Sep03	Nursing: PIV started in (R) wrist c 18G IV. Patent to
1307	flush. Ø edema, Ø erythema. (L) Subclavian TLC DC'd. Pressure applied for 5mins. 4x4 dressing applied over site. Ø bleeding noted. Restraints on, Ø skin breakdown noted. Pulses easily palpable.

STANDARD FORM 509 (REV. 7-91) BACK
[redacted] APPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE	
11 Sep 03	Surgery (cont)
ZANTAC	Heme ⟩—⟨ 675 / 27
Lovenox	
Rocephin D9	FD WBC 16.4 AFeS wound looks good
Unasyn D9	① will D/C central line.
	② cont Abx for now.
	GI Tol TF well Alb >2.0. b(6)-2
11 Sep 03 1047	Nursing: Bath, foley care, and oral care completed. Stool leaking on abdominal dressing. Ø stool noted in wounds. Mid-abdominal wounds irrigated c̄ NS. Vaseline gauze, 1049 applied and Kerlex moistened c̄ NS applied. Wet to dry dressing change done on Ⓡ flank wound using Dakins solution. JP + J tube sites cleaned, Bacitracin applied and covered c̄ 2×2 dressing. Stoma cleaned, looks pink and healthy. New wafer applied, Tincture of Benzoin (Cont'd)
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. CH/Am

b(6)-4

b(6)-2

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Sep 07	Surgery
	No events over night
	VSS Afeb. 24% Trach collar c 94-98% SAT
	UO 60-200 cc/hr
	Chest CBTA
	Abd good stoma function Dressing clean
	Drains JP3 (Duod - 90cc/day.)
	A/P Doing well continued hypernatremia
	will add 50 cc/hr free water and
	Δ all infusions to D5W.
	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. ICU3

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

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MEDICAL RECORD | **PROGRESS NOTES** b(6)-2 A11

DATE	NOTES
12 Sep 03 0615	Received report + care of pt from previous shift
0830	Pt sleeping in bed. VSS Ø s/s of pain or discomfort will cont to monitor
1030	Dsg Δ's to Abd, (R) flank + bilat lower legs completed. Abdominal (R) flank wet to dry dressing c̄ Dakins solution. Wound appear pink to beefy red. Drsg's to bilat lower legs + (R) chest wet to dry dressing c̄ 5% Sulfa Mylon solution. No Eschar remains on wounds. VSS Ø s/s of pain or discomfort will cont to monitor
1245	Pt awake in bed. VSS T-99.6. Pt to start on D5W @ 50cc/hr and all infusions made with D5W per MD. will cont to monitor
1530	Pt remains on TC @ 24% O2 SaO2 94%-98%. Trach care performed. VSS will cont to monitor
1730	Ostomy bag changed + ostomy cleaned. VSS Ø s/s of pain or discomfort
1800	Report + care of patient given to oncoming shift
1800	Received report

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

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

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

REGISTER NO. | WARD NO.

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
588			

DATE	NOTES
~~12SEP~~ 2200	Drsg Δ to mid abd. Vasdline guaze to small area on (R) side of wound, wet→dry drsg applied. 2x2's cut and placed around drains. (L) medial wound dressed c̄ dressing soaked in ¼ strength Dakins soln. (R) lateral wound ~~dressed~~ c̄ dressing soaked in ¼ strength Dakins. Posterior calfs dressed with Sulfamylon-soaked dressings. Posterior cranium dressed c̄ sulfamylon dressings. Patient tolerated well. VSS remain stable. #8 Shiley ~~to~~ TC @ 24% O2, SaO2 > 95%. Foley to gravity. Drsg CDI to abdomen, BLE, posterior skull. ——— [redacted] 1Lt/AN
13Sep03 0600	Report recieved from 1LT [redacted]. pt VSS, afebrile. ——— [redacted] 91WM6
0800	pt bath done at this time ——— [redacted] 91WM6
	b(6)-2 A11
	Surgery
	No events over night
	VSS Afeb.
	Abd wound - cleaning up with evolving Granulation tissue.
	17 | 29 (671 139 | 103 | 20 / 3.9 | 25 | 0.9 < 180 Alb 1.9 AΦ 93 ALT 14 AST 27 Amy 41 TB 1.1
	A/P No Appreciable Δ's hyper Natremia resolved. ↑ TF to 100 D/C D5W in NS
	[redacted]

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

MEDCOM - 16544

b(6)-2
All

PROGRESS NOTES

DATE	
2200 11 Sep	0S continuation Abdominal wound dressing changed, petrolatum dressing applied on exposed organs. NS soaked fluff applied over it, Wound edges dark red c̄ minimal swelling, Ø discharge, Ø odor, Ø contamination from previous leak of ostomy, Ostomy wafer replaced, bag replaced. Tincture of ~~iodine~~ benzoin used for max adhesion, ~~Wound~~ for puncture wound below abdominal ~~adhesions~~ incision dressing changed c̄ NS W-D dressing, granulating well. wound edges look healthy c̄ min redness & swelling, Ø odor, Ø discharge: Addendum to stoma note: Stoma pinkish/red Ø signs of necrosis, (L) LE dressing changed c̄ sulfamylon W-D and covered c̄ Tegaderm. 2 wounds both covered c̄ yellowish layer, bleeding noted upon cleaning; minimal exudate on old dressing, (R) LE dressing changed c̄ sulfamylon W-D & covered c̄ Tegaderm, Wound c̄ yellowish layer, bleeding noted upon cleaning. Restraints released. ROM (B) UE done. good pulses, pt not fighting restraints, foley care done, Ø discharge noted, Trach care done. Pt requiring less suctioning, Pt placed on RA x 2 hrs, Sats ↓ 92%, placed back on 24% TC humidified @ 2100, will keep on 24% TC [redacted] CPT/pn
2400	Laid pt flat in bed, Ø leakage noted on ostom[redacted] wafer, [illegible]
0200 12 Sep	Restraints released. Ø skin breakdown noted, addendu[redacted] on 2200 stoma note. Skin breakdown noted on skin below stoma: possible skin tear from stoma wafer 2° to frequent wafer replacement because of leakage. Recommend placement of 4x4 on leakage site to prevent contamination vs replacement of ostomy wafer, leakage maybe unavoidable because of deepening contour of belly on leakage site & stiff construction of ostomy ring. Ø leakage noted @ this time, 4x4 in place and clean, pasty stool in ostomy bag. Pt. on (L) side. [redacted] CPT/pn
0400 12 Sep	Restraints released, Ø skin breakdown noted, labs drawn. Pt flat on back, 4x4 between stoma & wound clean [redacted] CPT/pn

(Sketch: stoma diagram — "skin breakdown")

[redacted] 509 (REV. 7-91) BACK
USAPPC V1.00

b(6)-2 All

MEDICAL RECORD | PROGRESS NOTES

DATE	
11 Sep 03 1750	Nursing: Stool leaking from colostomy wafer to mid-abdominal wound. Ø stool noted @ abdominal wound. Wounds irrigated c̄ NS. Vaseline gauze applied along c̄ Kerlex moistened c̄ NS. Pt sleeping quietly, report given to Cpt [redacted] ———— [redacted] 1LT/AN
11 Sep 03 1800	Report received from CPT [redacted]. Pt resting quietly & comfortably in bed, awakens easily, TF @ 80 cc/hr, MSO4 @ 7mg/hr RR - 20's even unlabored, 97% c̄ 24% TC. Will leave on 7mg/hr MSO4 for now & titrate down as necessary. JP's to bulb suction. Wafer around stoma leaking on abd incision site, Ø contamination noted on wound, Ø active oozing of stool noted on leak, MK Ø 4x4 gauze placed between ~~back~~ leakage site & wound to prevent contamination, will replace hourly, pt positioned on (R) side. Soft restraints x2 on (B) LE, good pulses, ~~restraints~~ released, Ø skin breakdown noted. will continue to monitor hourly
2000	Pt somnolent, ~~but~~ awakens easily, MSO4 ↓ 4mg/hr. RR - 20, even unlabored, will monitor & titrate MSO4 as necessary. Pt on (R) side [redacted] 1LT/AN ~~~~
2200	Pt on (L) side, Head dressing changed c̄ sulfamylon W-D & Tegaderm, 4 pressure sores, 3 c̄ yellowish skin layer, 1 c̄ red/black scab. ~~dou~~ head resting on donut, Ø discharge, Ø odor, (R) chest/shoulder dressing changed c̄ sulfamylon W-D. bleeding noted p̄ cleaning wound, yellowish skin layer slowly debriding. 2 wounds: one on (R) chest, one on armpit,

(Continue on reverse side)

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

continued next page

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
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b(6)-4

b(6)-2
All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Sept 03 1005	cont'd... aspect liver. Lower abd incision pink c̄ some yellowish plaque-like exudate. Wet to dry dsg c̄ NS. Will cont. care. [redacted] LTA
1100	Turned pt to (L) side. O2 sats 94%. Pt may go to OR later today. Drew chem 8. Results Na+ 146. Will cont. care [redacted] LTA
1245	Deep suctioned pt x iii. Copious white/yellow tinged sputum noted. O2 sats ↑ 96%. Will cont care. [redacted]
1400	Pt resting quietly. Pt on back. O2 sats 95%. Easily awaken. Will cont. care. [redacted]
1600	Ø Δ's in status. Receiving neb tx. O2 sats 95-98%. Will cont. care. [redacted]
1800	PT VSS c̄ Ø significant Δ's. Gave report to night shift. [redacted]
1820 15Sep	Received report from previous shift. Pt resting quietly in bed. D5W @ 50cc/hr, MSO4 @ 5mg/hr, Ø leak noted on colostomy wafer, will continue to monitor [redacted] CPT/[illegible]
2100	Pt c̄ vigorous cough, thick yellow sputum, [illegible] lavaged c̄ 3cc NS, bagged & suctioned. Copious thick yellow sputum upon suctioning. Pt on (L) side. [redacted]
2400 16Sep	Pt's facial hair & head shaved, Trach c[redacted] done, mouth care done, foley care done, Head dressing changed c̄ sulfamylon soaked W-D [illegible], (R) chest, shoulder dressing changed c̄ sulfamylon soaked W-D dressing. Abdominal incision dressing changed, petroleum dressing applied to protruding part of bowel, W-D dressing applied over Ø contamination noted from colostomy, continued

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sept03 0720-0910	cont'd... sulfamylon soln + tegaderm to (B)LE + head decub. Little drainage noted from (R) shoulder + scant amt bleeding. Used cloth tape to secure (R) shoulder burn. Completed foley care + turned pt onto (R) side. Completed passive ROM. Interpretor explained why do passive ROM. Ø % pain from pt. PT unable to move limbs + does not feel sharp pain (B)UE or (B)LE. Pt able to do shoulder shrug + follow some commands. Pt RR ↓ 25. O2 sats 93-96%. Received neb tx. Noted yellowish drainage from (L) J-tube. Applied bacitracin to all 4 JP tubes + J-tube. Δ'd (R) flank wound c̄ 1/4 strength dakin's soln. Wound pinkish/red c̄ small amt yellow exudate. Pt had copious amt sputum upon turning pt. Will cont. care. b(6)-2 [redacted]
0950	Completed trach care. Thick yellowish sputum noted in cannula. Pt O2 sats remain 93-94%. RR ↓ low-mid teens. Will cont. care. Emptied colostomy. Brown pasty-like feces noted. Stoma pink + moist. [redacted]
1045	Δ'd midline abd incision. Fistula scant amt blood. Placed vasaline gauze on fistula. Wound pink x̄ lower cont'd...

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

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

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Sep 2400	Continuation: W-D dakins solution to [illegible] wounds, WD [illegible] applied to bilateral VF wound & covered c̄ Tegaderm. VSS, will continue to monitor. b(6)-2
16 Sep 0300	Pt c̄ good strong cough. thick yellow sputum suctioned x3 humidified 24% TC, 97%, able to move all 4 ext, will continue to monitor VSS b(6)-2
16 Sept 03 0600	Received report from previous shift. Pt awake in bed. TC humidified air @ 24% FiO2. Copious white sputum noted. Pt appears more awake than yesterday. Moving all 4 extremities + able to turn self onto side. Gave pt H2O. Pt appears to tolerate well. Elevated HOB to 30°. All drsgs C,D,I. Ⓑ LE elevated. IV line intact.
0700-0830	Completed bed bath + foley care. Δ'd Ⓡ shoulder burn drsg, Ⓑ LE blister drsgs + decub head drsg. Washed all areas c̄ hibiclens + rinsed c̄ NS. Applied sulfamylon soln + covered c̄ tegaderm x Ⓡ shoulder burn drsg (covered c̄ cloth tape). ∅ S/S of infection noted. Δ'd Ⓡ flank wound + midline abd incision wound. Ⓡ flank wound pink c̄ minimal amt of yellow plaque substance. Wet to dry ¼ strength dakins b(6)-2

cont'd.

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)*

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

D(6)-2
All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Sept 03 0700-0830	cont'd... used. Midline abd incision moist c̄ Ø s/s of infection. Notified Dr. [redacted] of my concern about fistula of intestine. Dr. [redacted] said it was fine. Ø new orders written. Covered fistula c̄ vascaline gauze + wet to dry c̄ NS. Noted bloody mucus around J-tube. Applied bacitracin to all 4 JP tubes and J-tube. All 4 JP tubes to bulb suction. Emptied Ⓡ colostomy. Stoma pink + moist. Pasty-like stool noted. Δ'd linens. Elevated BLE + HOB. ↑ed MSO4 gtt rate to 7cc/° due to ↑ed HR 120s + ↑BP 140s/80s. Will cont care. [redacted] /CT LAN
0900	BP ↓ 130s/80s, temp 98.9, HR 107. Pt appears comfortable. Pt able to express needs through interpretor. Pt nods yes that he's comfortable, not in pain + it's hard to breath c̄ trach. Completed trach care. Pt 98% on RA. Copious white/blood tinged sputum noted. Pt has strong cough. Able to cough some sputum out. Will cont care. [redacted]
16 Sept 03	Surgery No events overnight VSS Afeb Tm 100.5 Chest CBTA Abd NABS wound good granulation Stoma viable ext wounds Granulating. 141 / 29 / 554 129 / 108 / 23 4.3 / 24 / 1.1 A/P stable cont fuel Dressing Δ's. OOB to chair today. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Sept 03 1104	Pt resting c̄ eyes closed. O2 sats 98+99% on 24% FiO2 humidified trach collar. Deep suction pt x iii. Copious amt ~~[illegible]~~ sputum noted. Will cont care. b(6)-2
1200	Dr. [redacted] viewed labs. Δ MIVF to ½ NS @ 50cc + activity up to chair. Will cont care. b(6)-2
1240	Δ'd colostomy bag + wafer due to leakage. Δ'd midline abd incision drsg due to soilage. Will cont. care. b(6)-2
1500-1620	Pt OOB to chair. Pt unable to sustain own body weight or stand erect. Pt on RA c̄ sats 98-99%. Interpretor present to explain procedure. Pt tol well. O2 sats 98-99% throughout. Pt able to communicate c̄ interpretor to express needs. Placed TF on hold. Pt c/o pain. ↑ed MSO4 gtt from 5mg to 7mg/°. Pt sat in chair ≈ 1°. Placed pt back in bed. Pt on RA c̄ O2 sats 98%, coughed copious white sputum. Deep suctioned x iii. Will cont. care. b(6)-2
1800	Gave report to next shift.

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

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

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

EPW [redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
#588			

DATE	NOTES
16 Sep 03	Report recieved from 1LT [redacted]. pt VSS
1805	SaO_2 98% on RA. [redacted]
1810	pt's colostomy leaked into abdominal wound. Colostomy
	waffer and bag were changed. Abdominal wounds were
	irrigated c̄ saline and dakins solution. Once Abd
	wounds were cleaned they were redressed. J. Morrison
2000	Dressings to burns on Ⓡ arm & Ⓡ chest Δ'd @ this
	time. Wounds appear to be healing well [redacted]
2045	Dressings to burns on BLE Δ'd @ this time.
	Wounds appear to be healing well [redacted]
2100	Dressings to back of head Δ'd. Healing well [redacted]
2130	Trach cleaned [redacted]
2200	Foley cath Δ'd. Ø s/s of infection when
	old catheter removed [redacted]
2400	pt becoming increasingly agitated MSO4 gtt
17 Sept 03	↑ to 8 mg/hr [redacted] 9WMG
0200	pt VSS, afebrile [redacted]
0400	AM labs drawn, CXR done [redacted]
17 Sept 03	pt report received @ 0600 from SPC [redacted] pt VSS pt assessment
@ 0710	complete see pt flowsheet for details pt dressing CDI @ this time
	will change per schedule pt resting in bed c̄ eyes closed no
	signs of acute distress noted @ present will continue to monitor
	throughout day [redacted] AC9 Kun
0815	Pt deep suctioned @ this time. 2 cc NS put down trach + pt
	suctioned. Able to cough well on his own. O_2 sat's @ 96% upon
	completion. [redacted] 9WMG

STANDARD FORM 509 (REV. 5/1999) BACK

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep 03 0200	Pt resting comfortably in bed, VSS Will continue to monitor [redacted] SPC, 91WM6
17 Sept 03 0600	Received report from night shift. Pt resting c̄ eyes closed. (L) arm elevated. Drsg (L) arm C,D,I. Ø c/o pain @ this time. PIV line intact. VSS. Will cont. care. [redacted]
0615	NV ✓ completed. +3 bounding (L) radial pulse. Pt able to feel sensation in thumb + pointer finger. No feeling in other three fingers. Will cont. care. [redacted]
0710	Pt c/o pain (L) arm pain. Motioning tightness. Gave MSO4 V mg IVP. Will cont. to assess pain level. [redacted]
0800-0930	Pt ambulate to bathroom s̄ assistance. (L) arm in sling. Δ'd linen. Completed bedbath c̄ some assistance. Elevated (L) arm. NV ✓ Δ's: pt able to Feel some dulled pressure on middle finger. Will cont care. [redacted]
1000	Pt c/o pain (L) arm. Gave MSO4 V mg IVP. Ø Δ's in NV ✓. Will cont to monitor pain control. [redacted]
1200	Pt resting c̄ eyes closed. Ø Δ's in NV ✓. Will cont. care. [redacted]
1330	Pt ambulate to bathroom c̄ little assistance. Medicated c̄ versed 4mg IVP + MSO4 5mg IVP for drsg Δ @ 1350. [redacted]
1400	Ø Δ's in NV ✓ of (L) arm. +2 pulse c̄ feelings (sensation to touch) on thumb, pointer finger + dulled sensation middle finger. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 A1

DATE	NOTES
0930	Pt OOBTC. Minimal C/O pain to LUE. Will cont to monitor
1030	Pt received 3mg MSO4 for C/O pain to LUE. VSS T-100.2. Will cont to monitor
1230	Pt back into bed from chair after ambulating on ward. Minimal C/O pain in LUE while ambulating. VSS T-98.5 will cont to monitor
1430	Pt sleeping in bed ⊗ s/s of pain or discomfort. will cont to monitor
1545	Dsg Δ to LUE completed. Pt received 7mg MSO4 + 2mg Versed for pain during dsg. Δ. [illegible] well VSS T-100.1 will cont to monitor
1630	Foley DC'd per Dr.'s orders
1800	Report + care of pt. given to oncoming [illegible]
1800	Received Report from SPC Palmer Pt resting comfortably in bed. VSS. External fixator to (L) arm. Dressing CDI. HL to (R) FA (+) flush ⌀ s/s of infection. Will continue to monitor SPC [illegible]
2200	Pt resting comfortably in bed. VSS. Will continue to monitor SPC 91WM6

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

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RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICU 1

b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Sep 03 1440	Completed drsg Δ. Pt tol well. Pt assisted as much as capable. Open incisions upper arm red, moist c̄ ∅ s/s of infections. Small amt bleeding when removed drsg. Sutures on forearm intact. Elevated Ⓛ arm when completed Δ. Washed wounds c̄ NS + applied fluffs. Replaced splint. Wrapped Ⓛ arm c̄ kerlex roll + ace bandage. Incision on Ⓛ upper thigh: staples intact, wound well approximated, ∅ drainage noted. Incision on Ⓡ upper thigh: sutures intact c̄ ∅ drainage noted. Covered incisions c̄ bacitracin 4x4 gauze + cloth tape. Will cont. care [redacted]
1600	∅ Δ's in NV v. +2 palpable pulse. ∅ c/o pain discomfort. Pt NPO p̄ MN to OR [redacted] Pt understands. Will cont. care. [redacted]
1620	Pt ambulate to bathroom. Pt grimacing in pain. Gave MSO4 5mg IVP. Will cont to monitor pain level. [redacted]
1730	Pt resting quietly c̄ eyes closed. Will cont. care [redacted]
1800	Gave report to next shift. [redacted]

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RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
				b(6)-2 All

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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b(6)-2 All

LAST NAME 723	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep03 1820	Report recieved from previous shift. Pt vss, afebrile. Ex fix to (L) arm, Drsg CDI. pulse in (L) arm +4. Full sensation to thumb & index finger, decreased sensation to middle finger, Ø sensation to remaining 2 digits —— [redacted] 91WM6
2000	Neuro ✓ (L) Hand: Full sensation to thumb & index finger, decreased sensation to middle finger, Ø sensation to remaining 2 digits. Pulse +4 —— [redacted]
2200	Patient lying in bed. ambulated to bathroom, percocet given for c/o pain to (L) arm. Neuro checks same as previous check. —— [redacted] 91WM6
2400	Neuro ✓ same as previous check [redacted]
0115	MSO4 5mg given for c/o pain in (L) arm —— [redacted]
0200	Neuro ✓ same as previous ✓ —— [redacted]
0400	Neuro ✓ same as previous ✓ —— [redacted]
0600	Neuro ✓ same as previous ✓. pt vss. Report given to dayshift —— [redacted] 91WM6
18Sept03 0630	Recieved report from Spc. [redacted] Pt. resting in bed s̄ complaints. (L) arm ↑ as ordered. Neuro ✓ to (L) hand: full sensation to thumb and index finger and decreased sensation to middle finger. No sensation to remaining two fingers. +4 pulse to extremities. Temp 98.7. Resp even & non labored: breath sounds clear @ present time. Will continue to monitor. —— [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES** b(6)-2 A-11

DATE	NOTES
17 Sept 03 @ 0910	pt VSS pt deep suction due to Sat ↓ 94% Sat ↑ 98 after suctioning pt laying in bed c̄ eyes open no signs of acute distress noted ——— [redacted] PFC 91W
17 Sept 03 @ 1115	pt VSS pt dressing Δ's complete all dressings CDI ostomy bag reinforced c̄ op site pt resting calmly @ present ROM complete no acute signs of distress noted @ present will continue to monitor ——— [redacted] PFC 91W
17 Sept 03 @ 1500	pt VSS pt deep suctioned for low O2 sat 93-94% pt sats @ 96-97% now pt became slightly agitated interpreter call to translate pt wanted "a knife to cut cords" pt calm now laying in bed with eyes open no other problems @ presents will continue to monitor throughout day ——— [redacted] PFC 91W
17 Sept 03 @ 1530	ostomy bag redone & changed by Maj. [redacted] pt doing well @ this time will continue to monitor [redacted] PFC 91W
1800	Took report from PFC Bentley. VSS. Pt in bed no distress noted. Pt's abdominal dressing Δ'd by MD on day shift. Will continue to monitor. ——— [redacted] 91W10M6
2000	Pt's VSS, abdominal dressing Δ'd due to colostomy bag leak. All other dressings Δ'd. Pt in bed awake. ——— [redacted] 91W10M6
2200	Pt's colostomy bag Δ'd along c̄ abdominal dressing. VSS. Will continue to monitor. ——— [redacted] 91W10M6 (over)

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)

EPW [redacted]

b(6)-4

REGISTER NO. | WARD NO. ICU 1

PROGRESS NOTES
Medical Record

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

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18SEP03	(0100) Pt's BP↑, resting in bed. all means SOT. will continue to monitor BP. [redacted]
	(0300) Pt pulled IV out. IV d/c'd to (L) wrist 18g. Pt's BP still elevated. Other VSS. afebrile. will continue to monitor [redacted]
	(0500) Pt's VSS, resting in bed. @14 @ 176. will continue to monitor. [redacted]
18 Sep 0814	RT note: Pt on ↓ collar - Pt removed. 97 SpO2 on RA HR 114, RR 18. UD Alb given + pt refused. to d/c [redacted]
0615	Received report + care of pt from previous shift. Pt awake in bed and appears to be agitated and is moving in bed attempts to pull trach out and pull IV out will cont to monitor [redacted]
0740	Pt received 2mg Ativan IV for agitation per MD orders VSS T 100.1 will cont to monitor [redacted]
0815	Fentanyl Patched, 50 mcg/hr, placed @ 0800 to backside of upper left shoulder VSS T. 99.2 Pt sleeping in bed Ø s/s of pain, distress or agitation will cont to monitor [redacted]
1100	Pt sleeping in bed. Ø s/s of pain or distress or agitation. VSS. will cont to monitor [redacted]
1330	Pt sleeping. VSS Ø s/s of pain or distress. Will cont to monitor [redacted]
1540	Dsg Δ's to Abdomen, (R) flank, back of head, bilat. lower legs completed. Trach care performed. Pt awake. VSS will cont to monitor [redacted]
1800	Report + care of pt given to oncoming shift [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

b(a)-2

DATE	NOTES
18Sep03 0745	MSO4 5mg given IV for pain.
0811	No Δ in neuro ✓ @ present time. Will cont to monitor.
0905	Ø further c/o pain @ present time. Pt remains NPO for surg. AM care completed @ 0830. Will continue to monitor.
0926	c/o (L) arm pain. MSO4 5mg IV given as pt for complaint. Will continue to monitor for s/sx of distress.
1032	MSO4 5mg IV given for c/o arm pain.
1032	No Δ in neuro ✓. +3 pulse to (L) ~~arm~~ Radial pulse.
1104	Pt resting in bed s̄ distress @ present time. No complaints voiced @ time. Will continue to monitor.
1202	+3 pulse to (L) radial. Ø complaints @ present time. Full sensation remain in thumb & index finger. ↓ sensation to middle finger. No sensation to last two fingers. Will continue monitoring pt as pt. [illegible] MD.

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

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Sept. 1215	Pt. to go to OR this pm. Dressing not done.
1230	Pt. c/o (L) arm pain. MSO4 5mg IV given for complaint.
1349	⊖ further complaints voiced @ present time
1404	Percocet Tab II p.o. given for c/o (L) arm pain. Will continue to monitor.
1405	Radial pulse to (L) extremity +3. Sensation to thumb & index finger. ↓ Sensation to middle finger & ⊖ sensation voiced of last two finger. Will continue to monitor
1441	No further complaints voiced @ present time. Will continue to monitor.
	Brief Op Note
	Pre Op Dx : open wound (L) Arm
	Post Op Dx : same
	Procedure : I&D DPC of (L) Arm — b(6)-2A1
	Surgeon : MATSUMOTO / OLIVORIO
	Anesthesia : GETA
	EBL : min
	Fluids : 600cc LR
	Findings : Clean wounds
	Cx : ⊖
18 Sept 03 1758	Return from OR. Ambulated per self c difficulty.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 All

DATE	NOTES
18 Aug 03 1800	Received report from SPC [redacted] Pt resting in Bed. Pt trached. IV to (L) wrist. Foley to gravity. Pt On restraints. VSS. Will continue to monitor [redacted] SPC, 91WM6
2000	Pt resting comfortably in bed VSS. Will continue to monitor. [redacted] SPC, 91WM6
2200	Dsg Δ complete. Trach care complete. VSS Will continue to monitor. [redacted] SPC, 91WM6
19 Sep 03 2400	Pt resting comfortably in bed VSS will continue to monitor [redacted] SPC, 91WM6
0200	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] SPC 91WM6
0800	Received report from ongoing shift. Pt in bed awake, seems oriented to simple command today. Calm & cooperative. Ostomy bag leaked to the dressing. Changed ostomy bag c̄ the dressing. Wound appear clean no infection noted in the edges, no odor. Pt NPO, stopped tube feeding for OR today to close the wound. VSS. Labs 12.9 8.7 / 27.3 ⟨ 504. Continue c̄ POC. [redacted] Maj / AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19SEP03	OP Note
1100	Indication open Abd
	Procedure STSG from (R) Ant Thigh
	to Abdomen
	Surgeons - [redacted] / [redacted] b(6)-2 All
	Anest GETA [redacted]
	Findings 2x8 - STSG @ 0.14 - taken
	from (R) Ant Thigh meshed 3:1
	Applied to Ant Abd wound with
	Modified VAC dressing.
	NO comps
	TO PACU in good cond.
	[redacted]
19 Sep 03	Graft to the abdomen from the (R) thigh
1250	JP drains. VSS 160-170 130/50 - 20 - 100% sat med awt
T98.2	Trach strong productive cough NSR 90's, [illegible] 2 mg J-tube hypoactive BS, 120cc foley. Versed 8 mg c̄ MSO4 3 mg @ 1145. Pt in bed awake + slightly disoriented. Gave Ativan 2 mg c̄ MSO4 2 mg IVP, ↑ MSO4 drip to 10 mg x 1 hour until sedation is reached then titrate down to effect. Wound dressing attached to suction. Continue c̄ post op + wound care.
	[redacted] [illegible]
1600	Pt calm, wound vac suction intact @ 125 mm Hg. Pt stable afebrile [redacted] [illegible]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2 All ↓
19 SEP 03 1800	Received Report. Abd vac to suction, Foley to Gravity, TC to Room air, $SaO_2 > 95\%$. 18G PIV Ⓛ Wrist, Resting quietly in bed c̄ HOB ↑ 30°. Drsgs to wounds intact. [redacted] 1LT AN
20 SEP 0100	Drsg Δ to Ⓡ abd, BLE. Trach Care. Change colostomy bag. Mouth Care. [redacted] 1LT/AN
0445	Report given. Patient resting comfortable. Restraints currently off. [redacted] 1LT AN
20 Sep 03 0944	Nursing: VSS, afebrile. See ICU flowsheet for nursing assessment. Pt receiving scheduled dose of Ativan plus PRN ativan as needed. Pt has episodes of restlessness but otherwise sleeping for most of shift. Receiving D5 ½ NS c̄ 20 meq KCl @ 120cc/° and Morphine @ 5mg/hr. Pt turned to Ⓡ side to facilitate drainage of colostomy bag. Ø leaks noted from colostomy bag. Wound vac to mid-abdominal wound intact. Will continue to monitor. [redacted] CPT/AN
1200	Pt sleeping in bed sedated c̄ MSO_4 + Ativan VSS. Afebrile Dsg Δ's complete. Ø s/s of pain distress. Will cont to monitor [redacted]
1530	Pt easily awaken by touch pt received 1mg Ativan

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[redacted]

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sept03	at 1400. VSS will cont to monitor — [redacted]
20Sept03	2350 : RT note : Pt awake pre tx HR 91, RR 23, SpO2 96 on RA
	BBS CTA, UD A/b given. Post tx HR , RR , SPO2 97%.
	∅ cough. Nurse states ~~just sx prior to~~ has sx a lot
	out of pt. Will continue to monitor — [redacted]
2200	Pt lying in bed. VSS. Increasing agitated. Ativan + Haldol
	being used for sedation. — [redacted] 91WM6
21Sep 0615	Received Report From Nightshift + assumed care of Pt. VSS, Pt
	Lying in bed sleeping + appears to be resting comfortably @ this
	time. — [redacted] 91WM6
1200	Pt mildly sedated c̄ MSO4 @ 7 mg/hr c̄ PRN Ativan. Received
	total of 2 mg @ 0900 – 1100. Wound vac intact to suction
	put out blood tinged secretions @ 100 cc @ 0600. JP X4 drained
	5-10 cc of yellowish cloudy secretions. Dressing changed W-D to
	LE, head, R side flank + axillary area. Wound appear clean.
	IV intact, D5W c̄ 20 kcl @ 120 cc/hr. Foley draining clear yellow
	urine q.s. Turned c̄ assistance, no skin breakdown in the
	sacral area. Afebrile VSS — [redacted] Maj /AN
1600	Pt c̄ intermittent agitation, well managed c̄ Ativan 1 mg - 2 mg IVP,
	c̄ MSO4 @ 7 mg/hr. Scant amt of dry secretions. RT came
	to administer nebs treatment and reinstall NS air humidification
	Afebrile, VSS — [redacted] Maj /AN
21Sep 1810	Received report from dayshift. VSS, Pt appears to be stable. ∅
	Concerns or Problems Ntd in Report. Pt Lightly sedated c̄ MSO4
	@ 7 mg/° + Scheduled + PRN Ativan. Will monitor. — [redacted] 91WM6
1845	Assessment complete, see DA 4700 — [redacted] 91WM6

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Surgery	Progress Note
20Sep03	Events - TO OR for STSG to Ant abd wall
	VS- stable AFeb UO 100-120cc/hr
	Chest CTA
	Abd - Vac Dressing in place s̄ contamination
	Stoma c̄ minimal output
	JPS 1 3
	2 4
	ext - Graft Donor site ok.
	LABS - 12.0 / 28.8 / 578 ; 140 / 103 / 15 ; 4.1 / 24 / 1.3
	A/P Doing well POD#1 STSG plan to take Dressing
	Down Mon ~ Noon as long as it is not
	Contaminated off Abx 24 hrs s̄ Fever.
	Continue Current care.
	b(6)-2 [redacted]

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

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

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

b(6)-4 [redacted]

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(a)-2 All ↓
11Sep 2005	Pt becoming very aggitated + restless, Medicated c̄ 1mg Ativan IVP per PRN orders. VSS, Will continue to monitor. ——— [redacted] 91WM6
2015	Pt Lying in bed sleeping + appears to be resting comfortable @ this time. Will continue current plan of care. —— [redacted] 91WM6
2230	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. VSS, sedated c̄ MSO4, Ativan, + haldol. Will continue to monitor. ——— [redacted] 91WM6
2330-2345	Dressing changes performed, Pt tolerated well. VSS, Will continue to monitor. ——— [redacted] 91WM6
12Sep 0200	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. Lightly sedated c̄ MSO4 + Ativan currently. VSS, Pt appears to be stable @ this time. Will continue to monitor. ——— [redacted] 91WM6
0345	Pt becoming aggitated, medicated c̄ 2 mg Ativan. Will monitor for effectiveness. ——— [redacted] 91WM6
0405	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. VSS, will continue c̄ current plan of care. ——— [redacted] 91WM6
0600	Report given to Nightshift. ——— [redacted] 91WM6

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.
	ICU-1

EPW # [redacted]

b(a)-4

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/22/03	Surgery
	No events
	VSS Afeb.
	Wound Abd Take of About 50% of STSG
	to Buttocks did not take on Wu.
	WBC ↓ 16/10 today off Abx.
	A/P Advance diet
	b(6)-2
23 Sep 03	Received report from ongoing shift. Pt VSS, intermittent
0800	agitation reported. Plan: Wound care to the abd + sphragnal
	wounds ~~pt~~ as ordered. ——— Maj/AN
0900	Pt extremely agitated. Thru the interpreter "he thought someone
	was chasing to kill him". Gave Ativan 1mg ē 4mg MSO4, ē
	excellent result. VSS ——— Maj/AN
1430	Dressing to the wounds changed. Abdominal wounds
	packed ē Vaseline gauze + W-D NS dressing. Site intact on
	the graft site. Pressure sore dressings changed wounds appear
	clean, debridement ē sulfamylon W-D effective. (R) aracpit
	dressing change ē sulfamylon, site with adequate vascularization

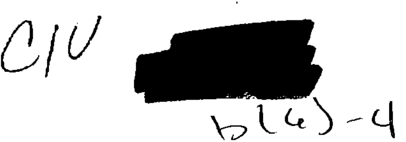
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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.

C/U



b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Sep 03 1430	b(6)-2 All
23 Sep 03 1545	Nutrition Note: 56yo M wt: 68kg, ht: 64" Current diet order regular. Per nursing, pt refuses food, drinks juice + water. Pt receiving Jevity Plus TF @ 100 cc/hr, providing 2880 kcals/day exceeding his ENN of 1700-2040 kcals/day (25-30 kcals/kg) + 82-102 g Pro/day (1.2-1.5 g/kg). Recommending a decrease in TF rate to 70cc/hr to provide 2016 kcals/day, [illegible] Decreasing TF may stimulate pt's appetite. Continue to encourage po intake. [redacted] RD/LD CPT, SP
1600	Pt remained manageable ̄s applying restraints all day X for one episode of restlessness early morning. VSS remained stable. Nutritionist came to evaluate nutritional status made recommendation on ↓ TF rate to 70cc/hr. MD made aware. Continues to have watery stools. Will recommend antidiarrhial medication to MD —— [redacted] [illegible]
1700	MD ordered Flagyl 500mg po/GT for "watery stool". Started first dose @ this time.
1820	Report recieved from Maj [redacted] Pt VSS, afebrile. Foley cath in place, PIV Ⓡ wrist, #8 trach, 4 JP drains to ABD, G tube - Jevity infusing @ 100 cc/hr —— [redacted]
23 Sep 03 2300	RT note: T collar off pt. Pre tx HR 99, RR 28, SPO2 98%. UD: Alb neb given. BBS coarse. Post tx HR 97, RR-36, SPO2 98%. Coughing up easily. Will continue & monitor— [redacted] [illegible]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 Sep 03	Change of shift. b(6)-2 All
0800	Received report from ongoing shift. Pt resting, calm and
:	appear to be asleep. Easily arousable to verbal stimuli.
	VSS, no significant change from previous day. Plan:
	Continue c wound care. Day 3 of wound vacuum. SP
	c minimal drainage c wound vac suction. MD made
	aware. Heat lamp placed on graft site @ this time.
	——— Maj / AN
1200	Dressing changed to the LE + head. Changed ostomy bag,
	drained small amount of stools (watery). Ostomy site c adequate
	vascularization. Afebrile, VSS. Mildly sedated — Maj / AN
1500	Wound vacuum to suctioned discontinued @ 1230. Graft site
	semi-grafted per MD. Changed packing to W-D dressing, wound
	appear clean. Other wounds packed c Dakin solution W-D.
	No other new issues @ this time. Started TF @ 30 cc/hr
	@ 1400, ~~[illegible]~~ increase by 10 cc q 2° until target rate
	of 100 cc is reached. ——— Maj / AN
23 Sep 03 0050	RT note: Pt resting. BBS CTA. Pre tx HR 95, RR 20, SPO2 97
	on RA. UD Alb given. Post tx HR 93, RR 23, SPO2 98-100%
	on RA. Will continue to monitor ——— 91W?
23 Sep 03 0458	RT note: Pt awake. BBS coarse c clears to cough. Pt coughed
	up ~ 5cc yellow thick sputum. Pre tx HR 98, RR 23, SPO2
	on RA 97%. UD Alb given via t-collar neb. Post tx
	HR 98, RR 24, SPO2 98%. Pt tol well — Sgt 91W?
23 Sep 03 0330	Emptied colostomy bag and changed sheets. pt is resting in
	bed s̄ any complaints will continue to monitor —

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24 sep (0100)	pt asleep @ this time. Ativan & Haldol used for agitation VSS —— [redacted] 91WM6
24 sep 03 @ 1010	pt report recieved From Spc [redacted] VSS Assessment WNL see flow sheet for details pt trach care complete pt restraint to wrist as per EPW protocol J-tube flushed pt laying in bed c̄ eyes closed @ this time no acute signs of distress noted will continue to monitor —— [redacted] PFC 91Wm
@ 1520	pt dressing Δ's completed tolerated well
@ 1920	Report recieved from PFC [redacted]. pt VSS [redacted]
24 Sept 03 2345	Rt note: Pt agitated + moving about. T collar off. BBS coarse ⊖ wheezes. UD Alb neb given. Pre tx 112, RR 28 SPO2 98% on RA. Post tx 114, RR 36, SPO2 99% on RA. Will continue to monitor —— (Sg [redacted] 91Wxx
2400	pt VSS, afebrile —— [redacted]
0600	Report given to dayshift ——
25 sep 03 @ 0730	pt report recieved from spc [redacted] VSS assessment complete pt resting quietly at this time no signs of acute distress noted @ this time will continue to monitor —— [redacted] PFC 91Wm
@ 1105	pt VSS no problems @ present will continue to monitor —— [redacted] PFC 91Wm

b(6)-2

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

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

REGISTER NO.	WARD NO.

EPW [redacted] b(6)-4
ICU 1

PROGRESS NOTES
Medical Record

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted]			

b(6)-2

DATE	NOTES
25sep03 @ 1800	Report recieved from PFC [redacted] pt vss [redacted]
@ 2200	pt vss, dressings to Abd & (R) shoulder, head and
	B/c done. [redacted]
@ 0200	PT vss, afebrile [redacted]
@ 0600	report given to dayshift [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Nursing Notes
26SEP03	Received Pt # 588 in ICU I Bed #2. Pt Alert. Moves all extremities. Pt is
0600	able to follow single commands in english. Cardiac Monitor shows
	ST. ⊖ JVD ⊘ edema. all peripheral pulses. VSS See intensive care flow
	sheet for more information. IV D5% NS ĉ 20 meq KCl at 75 cc/h infusing to left hand access
	site intact ⊘ s/s of infection or infiltration. MSO4 drip at 1mg/h infusing to left
	hand IV access. Pt breathing on room air. Breath sounds clear bilaterally. Equal
	chest expansion noted. No signs of distress noted. Abdomen nondistended, soft to
	touch. Nontender. Bowel sounds [illegible]. Mid abdominal surgical wound covered with
	dry dressing. JP tube to left abdominal quadrant with [illegible] infusing
	[illegible] colostomy to right abdominal quadrant. JP bulb suction x2 in use to abdomen.
	Foley cath in place draining yellow urine to bag. Skin warm to touch. See intensive care
0900	flow sheet for VS and more information. Pt agitated ativan 1mg IV given
1000	VSS ativan effective. AM care done. all dressings changed. Trach care done.
1100	Pt agitated Haldol 5mg IV given. Haldol effective [redacted]
1500	VSS No distress noted. Pt resting in bed [redacted]
1630	Dr [redacted] ordered VS Q4h. Pt agitated. Ativan 1mg IV given
1715	effective. Pt resting. No distress noted. MSO4 drip continues at 5mg
1800	IV D5% NS ĉ liter with 20 meq KCl at 75 cc/h continues. VSS No distress noted
	Report given to relief nurse [redacted]
26Sep 1800	Received report from Night shift + assumed care of Pt.
	VSS, will monitor. [redacted]

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

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EPW # [redacted]

b(6)-4

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Sep 1900	Pt medicated c 5mg haldol due to aggitation per PRN order.
	VSS, will continue to monitor. —— [redacted] 9/WMG
2145	New IV started. 20G to (R) FA. —— [redacted] 9/WMG
2355	Pt medicated c 1mg ativan d/t aggitation per PRN order. Will
	continue to monitor. [redacted] 9/WMG
17 Sep 0130	Pt medicated c 5mg haldol d/t aggitation per PRN order. VSS,
	Will continue to monitor. —— [redacted] 9/WMG
0250	Pt medicated c 1mg ativan d/t aggitation. VSS. Will
	continue to monitor. —— [redacted] 9/WMG
07 Sep 03	Nursing Notes
0600	Pt Alert follow commands No distress noted IV D5½NS IL c 20 kcl at 75 c/h and
	MSO4 5mg/h in progress. Trinity Plus at bed in progress. See care [redacted]
0700	flow sheet for more information. DR [redacted] visited Pt. [redacted]
10:00	VPI. All care done. Pt's Dressings changed. Pt received ativan 2mg at 0830
14:00	VS No distress noted. MSO4 drip continue at 5mg/h IV D5½NS IL c 20 kcl
15:00	continues at 75 c/h. Pt agitated ativan 1mg IV given effe[redacted]
18:00	Pt's condition unchanged MSO4 4mg/h continues IV D5½NS IL c 20 kcl at 75 c/h
	Continues. Report given to relief nurse. [redacted]
1820	Report recieved from dayshift. pt VSS —— [redacted] 9/WMG
2200	pt VSS, pt asleep @ this time. —— [redacted] 9/WMG
2400	pt Dressing Δs done —— [redacted]
0200	pt asleep VSS, afebrile —— [redacted]
0600	Report given to dayshift —— [redacted] 9/WMG
0605	Received Report from Spc [redacted] Pt. resting
	in bed c eyes opened. Ø distress noted. Drsg Δ
	completed @ present time. AM given also.
	Pt lying on back c eyes closed. Ø distress noted. —

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 All

DATE	NOTES
0900 28 Sept03	Pt. restless. Ativan 1mg given IV for agitation. Will monitor.
0950	Pt. resting s distress SpO2 100 RR 23. Will cont. to monitor.
1114	Pt. cont. to rest s distress. Will continue to monitor.
1200	Agitated: Ativan 2mg given for agitati[on]. Will monitor.
1335	Pt. lying in bed c eyes closed RR 20 SpO2 96%. Will monitor.
1631	Pt. resting in bed s distress @ present. Will monitor.
1731	Lying in bed c eyes closed. Ø RR distress noted @ present time. SpO2 100% RR 21. Will continue to monitor.
1820	Report recieved from SGT pt VSS. No significant Δ in condition over last 12 hours.
2230	pt dressing Δs done. Wounds healing well
2400	pt lying in bed, restraints to BUE. Continues to be uncooperative. VSS

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PROGRESS NOTES
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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sept 13 0810	Haldol 5mg IV given via LT.
1000	Pt. continue to remain restless. Ativan 2mg given IV for agitation. Will monit
1044	Resting in bed c eyes closed. Ø resp. distress @ present time. Will continue to monitor.
1221	Continue to rest quietly in bed c eyes closed. [illegible] labored. Ø distress noted @ present time. Will continue to monitor.
1325	Pt. very agitated. Broke J-tube tubing. Haldol 5mg IV given for agitation. Will continue to monitor.
1408	Pt. remain restless ativan 1mg given per for agitation. Will continue to mo
1409	Deep suction performed on pt. Thick white secretion noted. Will continue to monitor.
1556	Pulled J-tube out. Will notify MD
1628	J-tube replaced via Dr [redacted] x-ray of abd ordered c contrast. Will mo
1800	Received report from SGT Pt resting comfortably in bed. Will continue to monitor. SPC, [illegible]

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b(6)-2 A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sep03	Dressing Δ complete. VSS, Pt resting
2100	comfortably in bed. Will continue
	to monitor. [redacted] SPC, 91WM6
30Sep03	Pt pulled out JP tube to (L) side abd.
0030	Informed MOD; Will continue to monitor,
	MOD will re-evaluate site in the AM.
	[redacted] SPC, 91WM6
0100	Changed pt ostomy bag. Area looks
	pink and beefy. Will continue to
	monitor VSS. [redacted] SPC 91WM6
0300	Pt removed foley. Placed new foley
	@ 0310. Pt tolerated procedure well
	Will continue to monitor. [redacted]
0700	Received report from ongoing shift. VSS. No significant
	change from 24° shift. Foley replaced + in place
	draining clear yellow urine. See flow sheets for other
	pertinent information. Plan: Continue c̄ wound care &
	assist ADL & nutrition care [redacted]
1200	Wound care done. Dressing to the abdominal wound
	change W-D c̄ NS + zeroform applied. Wound clean
	c̄ adequate vascularization in the edges. No slough or

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.

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PROGRESS NOTES
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b(6)-2 (All)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Sep 03	Odor noted, shrapnel wounds packed c̄ W-D (NS)
1200	appear clean s̄ exudate. Ostomy in place, emptied
	watery stool, yellowish brown. Pressure sore to the
	head & LE evidence of healing & debridement in progress.
	(R) axillary burn change c̄ W-D (sulfamylon) dressing,
	healing noted on the edges. Continue c̄ W-D dressing
	change, document progress ——— [redacted] Maj, AN
1400	~~Pt received 15cc~~ Trach care performed. Pt
	awake c̄ Ø s/s of pain or distress will cont to
	monitor. [redacted]
1800	Report & care of pt given to oncoming shift [redacted]
	——— [redacted]
1810	Report recieved from SPC [redacted] pt VSS [redacted]
2200	pt VSS, continues to be uncooperative, does
	not follow directions given thru translator.
	Restraints applied to BLE. [redacted]
0200	pt VSS drsg Δ's done [redacted]
0600	Report given to day shift [redacted]
0800	Recieved PT from CPT [redacted] PT VSS, Trach in
	place & c̄ foley draining amber urine. Quanity sufficient.
1000	PT ↑ to Chair x2 hrs. PT displays slight weakness to
	↓ Ext x2.
1130	PT put back in bed ostomy bag Δ'ed and Abd Dressing Δ'ed
1430	Trach Care Completed, VSS, sat 98% RA.
1730	PT Drinked one cup of Dinner, Noticed Maintance fluids
	were not running Restarted fluids D5 ½ [redacted] @ 75 cc/h
	[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b(6)-2
01 OCT 1800	Received report. [redacted] 1LT/AN
1930	Assessment completed. [redacted] 1LT/AN
2200	Changed ostomy bag. Drsg Δ to abd, head, BLE. Retaped J-
	tube in place. [redacted] 1LT/AN
0600 02 OCT	Report given. Patient slept off and on throughout night.
	VSS remained stable. b(6)-2 [redacted] 1LT/AN
0615	Recieved report from Lt. [redacted]. Pt. resting in
02Oct03	bed. ∅ discomfort noted @ present time. Note colostomy
	bag half off. Drg Δ and new drg(s) ē colostomy bag
	done. 0800 Pt. up to chair s̄ discomfort. AM
	care done @ that time. 1035 Pt. back to
	bed s̄ discomfort. Will continue to monitor for
	any distress. [redacted]
1212	Pt. resting in bed ē eyes closed. ∅ resp. [redacted]
	noted. Will continue to monitor. [redacted]
1512	Trach care completed @ present time. Sitting up
	in bed attempting to make conversation ē b(6)-2
	staff members. ∅ Resp. distress noted. SpO2 100%
	Will continue to monitor. b(6)-2 [redacted]
1636	PT consult for pt. given to Spc [redacted] PT tech.
	Will continue to monitor. [redacted]

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

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

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EPW [redacted]

b(6)-4

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02Oct03 1741	Pt sitting up in bed s̄ distress. Consumed 30% of regular diet s̄ difficult. Will continue to [redacted] for any S/S of resp. distress.
1830	Report recieved from SGT [redacted]
2200	pt VSS, trach care done [redacted]
3Oct 0200	pt VSS, awake in bed [redacted]
3Oct03 0700	pt stable, tube feedg & IV fluids infusg [redacted]
1000	dressg done wounds healg well abd & legs [redacted]
1500	trach D/C'd s̄ difficult occlusive dsg to neck [redacted]
1600	pt ambulate x20 mints c̄ walker & assistance [redacted]
1700	pt ambulated x 30 minutes c̄ walker & assistance [redacted]
1730	IV restarted 20 gauge in L arm LR infusg @ 75cc/h [redacted]
3Oct03 1900	recieved report from day shift. Put patient OOBTC. tolerated sitting in chair. will cont to monitor. [redacted]
3Oct03 2100	Walked pt c̄ little assistance c̄ walker. no signs of distress. Tolerated dressing changes to abdomen, legs and neck. changed the colostomy bag. Semi solid substance in colostomy bag. Colostomy pink and moist. pt back in bed and resting. will cont to monitor. [redacted]
4Oct03 0100	Pt ambulated c̄ walker and minimal assistance. No signs of distress. will cont to monitor [redacted]
4Oct03 1130	Nursing: Pt sitting up in chair c̄ 2 point leather ~~resto~~ restraints on (B) wrists. Pt voided on floor without askin for urinal. Pt also spitting on floor. Pt attempting to get out of chair. Bedsheet tied around pt's waist to keep pt in ~~bed~~ chair. Pt able to pull (Cont'd)

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2400 3Oct	Atenolol given @ 2350, ambulated pt in unit, dressings changed. VSS [redacted]
0100	Pt ambulated in unit, positioned pt in bed for comfort afterwards. 10 mg Ambien given via J-tube
0500	Pt intermittently asleep. Awakens easily and attempts to get out of bed throughout the night. soft restraints on mitten gloves on. chest restraints on. VSS will cont to monitor [redacted] CPT/pd
05 Oct 03 @0640	pt report recieved From Cpt [redacted] p[redacted]sting quietly in bed @ this time no problems @ present will continue to monitor [redacted] PFC 91WM6
@ 1400	pt dressing Δ complete tolerated well pt walked to ICW 1 c̄ no problems pt cooperative no problems @ present Assessment WNL see ~~AA~~ Flowsheet VSS will continue to monitor [redacted] PFC 91WM6
@1655	pt doing well lay in bed with eyes open VSS will continue to monitor throughout day [redacted] PFC 91WM6
18ØØ	Received report from day shift. Pt resting comfortably in bed IV to (L) AC c̄ 5% dextrose in ½ NS c̄ 20 KCl going @75cc/hr. will continue to monitor [redacted] SPC, 91WM6
21ØØ	Dressing Δ complete. Pt tolerated procedure well. VSS will continue to monitor. [redacted] SPC, 91WM6
6Oct Ø3 24ØØ	Pt ↑ out of bed. Walked up and down hallway to main hallway x2. Sat ↑ in chair for ½ hr Pt tolerated well, VSS will continue to monitor [redacted] SPC, 91WM6

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b(6)-2A11

DATE	NOTES
4Oct03	Nursing Cont'd: out J-tube. Dr. [redacted] notified
1130	J tube reinserted by Dr. [redacted] - Dr. [redacted]
	20cc Gastrograffin given via J tube, ~~and~~ abdominal
	X-ray taken. Dressing change completed, pt
	tolerated procedure well. Wet to dry dressing
	done on mid-abdominal wound. Site healing
	well. Wet to dry dressing c̄ Dakins solution
	done for Ⓡ flank wound, and silvadene cream
	applied to burn sites. Rash noted ~~on bu~~ [redacted] 1049
	on skin surrounding ~~bur to~~ [redacted] 1158 burns. Possible
	allergic reaction from tape. Paper tape on order.
	Cloth tape used. Pt sleeping quietly. Will
	continue to ~~mon~~ [redacted] 1158 monitor. [redacted]
4Oct03	Nursing: Pt ambulated to ICW 2 using walker c̄
1725	minimal assistance.
4Oct03	Received report from previous nurse, pt sitting up in chair,
1800	will cont. to monitor. [redacted]
2000	Colostomy bag replaced, stoma beefy red, Ø skin breakdown
	noted around stoma, Dressing changed on mid
2400	Pt removed colostomy bag, bag replaced, J tube placement
	Confirmed by X-ray by Dr [redacted] TF started @ 2300

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[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 All
6 oct 03	Pt placed back in bed. VSS. Will continue
0100	to monitor. [redacted] SPC, 91WM6
0130	Pt placed on restraints. Continuously ~~[illegible]~~
	attempting to get out of bed. Will continue to
	monitor. [redacted] SPC [redacted] 91WM6
0400	Pt resting in bed. VSS. Restraints to (R) hand
	(L) leg. Will continue to monitor [redacted] SPC, 91WM6
0600	Reported off to day shift. R. [redacted] SPC 91WM6
	Nursing Notes
6 Oct 03	Received Pt in ICW 1 Bed #4. Pt alert follow commands. See Intensive
0630	care flow sheet for more information. Pt in bed No distress noted [redacted]
1000	VSS [illegible] dressings changed. Pt placed OOB to chair. [redacted]
1200	VSS Pt returned to bed. No distress noted [redacted]
1800	Pt's condition unchanged. IV D5½NS [illegible] continues [illegible]
	continues. Pt ate 20% of dinner. Report given to incoming nurse [redacted]
7 Oct 03	Received Pt in ICW 1 Bed #4. Pt alert follows commands. See Intensive care flow
0630	sheet for more information. No distress noted [redacted]
0800	Dr [redacted] [illegible] examined pt. He ordered Pt to be transferred to
	ward. Clinic contacted for bed awaiting Bed assignment. [redacted]
1000	VSS. Dressings changed done to all sites. Pt placed OOB to chair [redacted]
1200	VSS [redacted] noted. Pt to be transferred to ICW 2 Bed #1 [redacted]

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[redacted]

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Nursing Notes Con't.
1600	Pt's condition unchanged IV D5½NS c̄ KCl 20 at 75cc/h. [illegible]
1618	Report given to nurse on ICW 2. Pt transferred to Fcn 2. [redacted]
	b(6)-?

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3 Oct	Pt Awake + Alert oriented x3. VSS, pt has ∅ c/o of pain at this time. drsg to abd, right upper torso, and shoulder CDI ⓟPERRLA, Lungs CTA ∅ resp distress, colostomy intact with liquidy brown stool, 2 JP drains also in place + intact ∅ s/s infection. trach dressing CDI, pt ambulated to wheelchair, pt voiding via urinal clear yellow urine, restraints x2 in place ⊕ circulation
	b(6)-2 [redacted]
	(1800) I concur c̄ above assessment [redacted]
8 Oct 03 2005	VSS. AO. BS Cl in apices & diminished in bases. BS ⊕ x4 c̄ colostomy draining light brown stool, quantity sufficient. ⊕ pulses to all extremities & CR ≤ 2 seconds. JP #1 & #2 draining light green fluid JP #1 > JP #2. J-tube infusing Jevity @ 100 cc/hr. Voided x5 on own accord c̄ difficulty. Pt'd upper body DSG's Δ c̄ c/o pain @ this time. DSG to lower E's CDI. Abd wound beefy pink c̄ ↑ granulation. WTD applied. Silvadene applied to ⓡ upper torso & arm. Trach DSG Δ'd & packed c̄ iodoform gauze. Cont to monitor. b(6)-2 [redacted]

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[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 Oct 03 1600	Assumed care @ 1600. Pt A&O able to make needs known. Cardiovascular & Pulmonary system intact. GI - Colostomy c large amount of unformed light brown stool. Ostomy care done & bag changed. Stoma small & pink. Voiding clear yellow urine quantity sufficient via urinal. MAE. Skin warm & dry. R upper arm wound & chest wound healing. Drsg Δ done. Abd drsg Δ by MD. JP x2 c minimal light brownish green drainage. J tube flushes well. Jevity @ 100cc°. Drsg over old Trach site intact. New fentanyl patch placed today. Am care done. Ambulating c asst. Will continue to monitor. Pt teaching on pt not touching wound sites during drsg Δ c. [redacted] b(6)-2
(2030)	Pt alert, speaking in arabic, VSS, ∅ complaints of pain or discomfort. LCTAB, HRRR, colostomy draining loose light brn stool. Abd drsg Δ'd, R arm drsg Δ'd. Silvadene applied. JP x2 c minimal brownish green drainage. J-tube flushed. Jevity infusing at 100cc/hr. Drsg over trach site intact. ⊕ pulses to extr, voiding adeq. amt via urinal. 2 pt restraints on s compromise to skin or circulation. Will monitor. [redacted] 91WM6 b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 Oct 03 1300	Received pt resting in bed, VSS, tol po, Jevity via g-tube @ 100 cc/hr via alaris pump. S/S, JP x 2 w/ gray colored drainage, colostomy to RLQ putting out liquid, non formed stool. trach dsg to ant neck c/d/i, dsg to abd c/d/i, Δ'd. Pt cont to request to staff to have colostomy bag Δ'd, repeated attempts to pt to explain that Δing bag in not everyday. Assist pt in colostomy care, pt cont to need reinforcement for self care of colostomy. Pt able to amb w/assist. ø other remarkable assessments @ this time. will cont to monitor pt. ø breakdown noted @ this time [redacted] b(6)-2
10 Oct. 03 2030	Pt awake, [redacted] aking arabic, VSS, LS CTA (B), ⊕ BS x4, S1 S2 present, denies pain @ this time, colostomy bag on (R) UQ intact, liquid brown stool, dsg on (R) arm Δ'd, silvadene cream applied, dsg's on abd Δ'd, w→D, JP on RLQ draining minimal amount of gray drainage, Jevity tube feed @ 100 cc/hr, IS @ BS, voiding well, 2 pt restraint in place s̄ s/sx of poor

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REGISTER NO.	WARD NO.

E# [redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	circulation or skin breakdown [redacted]
11Oct03 0900	VSS Alert & O [illegible]. OOB to chair for breakfast. Tolerated well. Lungs clear. BS (+) x4 quad. Peripheral pulses +2. Dsg to Bil LE dry & intact. G tube flushed without difficulty. Voiding clear yellow urine. JP x1 with scant amt of serosanguinous drainage. Abd dsg dry & intact. Will change dsg later this shift. ~~Will~~ Colostomy stoma pink & moist. Will continue care as planned. [redacted]
11OCT03 2015	Pt A+O x3, VSS, dsg's on abd Δ'd, W->D dsg applied to granulated tissue, JP drainage to (R) flank draining small amount of sero-sang drainage, pt spilled colostomy bag on bed, cleaned pt and Δ'd bed, colostomy bag intact, loose brown stool, dsg's on (R) arm area Δ'd, applied silvadene cream to burn sites, dsg's on LE x2 Δ'd, J tube intact, Jevity feed @ 100cc/hr, IS @ bedside, voiding well c/y urine, 2 pt restraint in place s̄ s/sx of complications. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 Oct 03 Ø904	VSS Alert & Oriented, OOB c walker to BR for shower, dsg [illegible] & colostomy care. Tolerating well ~~JP~~ JP x 1 to bulb suction c [illegible] amt of drainage [illegible] greenish color. Abd soft [illegible] distended. Voiding clear yellow urine. G-T patent and infusing Jevity @ 100 cc/hr. Brown liquid stool noted for colostomy. Colostomy stoma pink & moist. Denies pain or discomfort @ this time. Will continue care as planned.
	b(6)-2
12 OCT. 03 1900	Pt A+Ox3, VSS, J-tube to LUQ intact, Jevity @ 100cc/hr, JP (R) flank draining small amount of blood, dsg on old trach site CDI, dsg on (R) arm and upper chest Δ'd, applied silvadene cream to burned area, dsg's on abd Δ'd, W→D dsg's applied, dsg on LE x2 Δ'd, voiding c/y urine s diff, 2 pt restrain s complications.
	b(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13OCT03	(1625) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway x2 this shift. Personal hygiene done in BR. Jevity @ 100cc/hr into feeding tube in (L) side of abd. Flushed s difficulty. JP to abd c scant amount serosang drainage. Wet → dry drsgs on abd Δd. Drsgs to BLE Δd. Silvadene applied to RLE and RUE/(R) shoulder burn wound. All wounds s s/sx infection. Colostomy bag intact. Pt doing own colostomy care. Drsg to old trach site Δd. Sutures intact. Pt tol. reg diet well. Voiding s difficulty. 2 point restraints in place s s/sx ~~infection~~ complication. Will cont. to monitor. b(6)-2
13OCT03 2015	Pt A+O x3, VSS, LS CTA (B), (+)BSx4, colostomy care done, dsg's on (R) upper arm area Δ'd, applied silvadene cream to burn area, dsg's on abd Δ'd, W → D to granulated tissue, JP in place (R) UQ draining minimal amount of blood, JP tube on (L) flank infusing Jevity @ 100cc/hr, Ø s/sx of infex, dsg's on LE x2 Δ'd, applied silvadene cream on burn sites on (R) LE. 2 pt restraint in place s complications. b(6)-2
14OCT03	(1355) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway x2 this shift s assist

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DATE	NOTES
14OCT03	(1405) (cont.) Drsgs to abd Δd wet → dry - Ø s/sx of infection @ wound sites. Drsgs to BLE Δd. Silvadene applied to wound on RLE. Drsgs to ® shoulder/arm Δd. Silvadene applied to burn sites. Colostomy bag Δd x2 this shift d/t leakage from bags. Sm. amount of soft brown stool in bag @ this time. Drsg to trach site Δd - sutures intact. Personal hygiene done by pt in BR this am. Tol. reg diet well. Tube feeding of Jevity infusing into tube on © side of abd. JP on RUQ draining scant amount of sero sang drainage. Voiding s̄ difficulty will continue to monitor. b(6)-2 [redacted]
(1905)	Pt alert, VSS, speaking arabic, Ø complaints of pain @ this time. abd drsg Δ'd (WTD) Drsgs to Ⓑ LE Δ'd. ® arm drsg Δ'd silvadene applied. colostomy bag draining unformed yellowish-brown stools. Jevity infusing s̄ complication. JP draining scant sero-sang drainage. Restraints on while in bed. s̄ compromise to skin / circulation will monitor. b(6)-2 [redacted]

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REGISTER NO. | WARD NO. CW#1

\# [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15OCT03 @ 0200.	J-tube flushed c̄ 10cc NS colostomy bag emptied. Will monitor — [redacted] RN
15OCT03	(0940) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. 0/10 pain. Pt amb well s̄ assist. Personal hygiene done in BR. Colostomy bag Δd d/t leakage from old bag. Abd drsgs Δd this am wet→dry. Drsg to arm/shoulder burns Δd - silvadene applied. Drsgs to BLE Δd. Silvadene applied to RLE wound. New Fentanyl patch applied to Ⓡ side of CW. [redacted] JP to RUQ c̄ scant amount sero-sang drainage. Feeding tube intact c̄ Jevity infusing @ 100cc/hr. Flushed c̄ NS s̄ difficulty. SL in Ⓛ forearm dcd d/t infiltration. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
(1900)	Pt alert, sitting ↑ in bed. VSS, Ø complaint of pain or discomfort. abd drsgs Δ'd (WTD) drsg to arms Ⓡ Δ'd, silvadene applied. Jevity @ 100cc/hr into Ⓛ side of abd. flushed c̄ 10cc NS, (3cc residual). trach drsg intact. JP drain to Ⓡ abd. c̄ scant sero-sang drainage noted. colostomy bag emptied by pt. loose brown stool noted, stoma moist & pink. Restraints on while in bed s̄ compromise to skin or circulation. Will monitor [redacted] RN

b(6)-2

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16OCT03@1000	Assessment done. Pt. sitting up in bed, A&O. Colostomy care done. ~~Minimal~~ (M.D.) Scant amount of serosanguinous fluid in JP drain at (R)LQ of abdomen. J-tube CDI. IVSC to (L)FA. DSNG to (R)LE Δ'd, CDI. Trach tube DSNG intact, Δ'd 15OCT. No other significant findings. EPW restraint protocol used. Ø signs of skin breakdown. b(6)-2 [redacted] ZLT, ANC
16Oct03@2000	Assumed care @1800; All VSS, pt A&O; Ø c/o pain/discomfort @ this time; colostomy bag Δ'd d/t pt pulling old one off; abd dsgs Δ'd w→D; dsgs to arms Δ'd, ~~...~~ silvadene D/C'd; JP draining scant amt sero-sanguinous fluid; J tube intact infusing Jevity @ 100cc/hr; J-tube flushed c̄ 30cc ~~...~~ NS s̄ difficulty; pt voiding s̄ difficulty; Restraints in place, (+) c/c. Ø skin breakdown, cont to monitor b(6)-2 [redacted]
17OCT03	(1310) Assumed care of pt @ ~~...~~ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to BR for personal hygiene this am. Amb well. Drsgs to abd, RLE, and (R) arm/shoulder Δd - wet→dry. Colostomy bag intact c̄ sm. amount loose brown stool. JP to RUQ c̄ scant amount sero-sang drainage. G-tube clogged - unable to flush. Will notify MD. Insertion sites of JP and GT cleaned c̄ 1/2 H_2O_2. Drsg to old trach site Δd. Tol reg diet well. Voiding s̄

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 * 11
17OCT03 (1325)	(cont) difficulty. 2 point restraints in place s̄ S/SX complications. Will cont. to monitor. [redacted]
17oct03@2000	Assumed care @ 1800; All VSS, pt A+Ox3 speaking arabic; denies pain, OOB to amb to BR s̄ difficulty; dsg to (R) arm/shoulder Δd, Moist → dry; dsgs to abd Δd W→D; very very minimal drainage noted, ⊘ s/sx infection; dry 4x4 bandaged wrapped c̄ Kerlix placed to (R) LE; New colostomy bag placed d/t pt D/C, intact, sm amt, loose brown stool; G-tube patent running Jevity @ 100 cc/hr; G-tube Flushed c̄ 30 cc NS; pt TOL Reg diet; Restraints in place, ⊕ circ, ⊖ skin break +, Cont to monitor [redacted]
18oct03@0545	pt Alaris pump alarm continues to go off stating "pt side occluded." Alaris pump was turned off; Jevity stopped; 6 attempts to contact SOD via radio were made s̄ success; SOD was in neither the SOD on call room, nor his personal living quarters, Plan: ~~[struck through]~~ ERROR Alert oncoming shift of problem; see if they can notify his personal MO; cont to monitor [redacted]
18OCT03	(1335) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ⊘ c/o pain. Pt amb to X-ray this am for contrast study to verify placement of J-tube. Correct placement verified by radiologist. CT done to R/O free air in abdomen. ⊘ free air viewed per radiologist. Pt amb from CT room to ward s̄ difficulty. DSGs to abd, RLE, shoulder and (R) arm Δd moist → dry. Colostomy bag Δd this am. Bag intact c̄ small amount loose brown stool. Jevity infusing into J-tube @ 100cc/hr. Tol. reg diet well. Voiding s̄ difficulty. Dsgs to old trach site and old JP site Δd. 2 point restraints in place s̄ S/SX complications. Will continue

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DATE	NOTES
18OCT03 (1335)	(cont) to monitor. —— [redacted] b(6)-2
18OCT03@ 1842	Pt AAO×3. Denies any pain. Jevity infusing at 100cc/hr s̄ difficulty. Lung sounds clear through all lobes. Abdomen soft + nontender. ⊕ Bowel sounds. Colostomy bag draining 100cc brown stool. ⊕ pedal pulses. 2 pt restraints c̄ ⊖ s/sx of skin breakdown. DSG to trach Ⓡ Arm+chest, + Abdomen CDI. —— b(6)-2 [redacted]
2000	DSG Δ's completed. Abdominal wound ⊖ s/sx of infection. Pink tissue c̄ granulation. Ⓡ Arm + Ⓡ chest ⊖ s/sx of infection. Ⓡ Pt ⊖ s/sx of infection. MD looked at wounds. Continue W-D D. —— [redacted]
19OCT@ 0600	Total 18-19Oct03 I: 2780, O: 1600 —— [redacted] b(6)-2
19OCT03	(1700) Assumed care of pt @ [illegible] p̄ report from night shift. Pt alert, speaking Arabic. VSS. Φ c/o pain. Pt amb in hallway x2 this shift s̄ difficulty. Abd drsgs Δd wet → dry, drsgs to Ⓡ shoulder/arm Δd moist → dry, wound on Ⓡ leg dressed c̄ moist → dry drsg. All sites s̄ s/sx infection. Jevity @ 100cc/hr infusing s̄ difficulty into J-tube. Tol reg

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b(6)-4

[redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19OCT03 (1700)	(cont) diet well. Voiding s̄ difficulty. Colostomy bag intact c̄ sm. amount loose brown stool. Pt doing own colostomy care well. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted]
19OCT03 2045	Pt awake and lying in bed. Colostomy care completed. Drsg Δs completed. VSS Ø c/o pain. Drsg to (R) LE CDI. Drsg to Abd. CDI. Drsg to (R) pectoral CDI. Drsg to (R) Bicept CDI. Will continue to monitor. [redacted] 91WM6
20 OCT 03	Surgery No complaints — b/(w) - 2 All VSS AFeb wounds All closing May need STSG to Ant Abd. A/P Doing well cont convalescing. [redacted]
20OCT03 (0800)	Pt awake, speaking arabic, VSS, MD @ BS. colostomy care done, bag Δ'd. drsgs to abd, (R) arms, trach site Δ'd. Jevity 100cc/hr infusing into (L) J-tube. J-tube flushed c̄ 20cc NS, LCTAB, productive cough. IS use encouraged. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor [redacted] 91WM6
(1000)	Pt ambulated in hallway s̄ difficulty [redacted]

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DATE	NOTES
20 Oct 03 1215	Nutrition Note: Pt c̄ GSW to ABD. Est wt: 80 kg (per nsg.) Currently on Jevity plus TF @ 100cc/hr providing 2880 kcals + 133g Pro/day. ENN: 2000-2400 kcals/day (25-30 kcals/kg) + 104-120g Pro/day (1.3-1.5 g/kg). Recommend ↓ TF rate to 83cc/hr, providing 2390 kcals + 110g Pro/day. [redacted] RD/LD b(6)-2 CPT, SP
20 OCT 03 2230	Assumed care of pt @ 1800 hrs. Pt has J Tube s̄ S&Sx of infection. Jevity @ 100cc/h. Voiding cyu spontaneously s̄ difficulty. Pt Denies pain Abdominal & (L) LE Drsg Δ'd. All Drsg CDI. Colostomy (R)LQ CDI c̄ Brown loose stool. Will continue to Monitor. b(6)-2 [redacted] SPC 91WM
(0900)	Pt A/O x3, VSS, ø c/o pain, colostomy bag Δ'd, stoma care done. drsgs abd & (R) arm Δ'd. Jevity @ 100cc/hr infusing. IS use encouraged. Q2° turning encouraged to prevent future skin breakdown. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor [redacted] 91WM6 b(6)-2

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DATE	NOTES
21Oct03 @ 2041	Pt laying in bed. Denies any pain. Lung sounds clear through all lobes (+) bowel sounds. (+) colostomy bag draining loose brown stool. D'ed bag 2° leak. Urinating in urinal clear, yellow. Drsg D'ed completed. Abdominal wound (-) S/Sx infection. Has pink + white granulocyte. (R) chest Drsg has green + yellow drainage c̄ slight odor (R) leg drsg has small amount of green drainage from site. b(6)-2
22 OCT 03 0200	Assumed care of pt A+O x3. VSS Ø c/o pain or discomfort @ this time. Lung clear HRRR Active BS Colostomy (R) UQ abdomen in light brown liquid stool. perform self care stoma beefy red vascular Urinates per urinal QS. Feeding Tube (L)Q Abdomen [illegible] 100cc/hr. Wound assessment: GSW to (R) [illegible]. [illegible] EX Lap wound open to air healing. (R) axillary superficial wound open to air Ø active bleeding. Escar small amts. Fentanyl patch in place (L) shoulder wall - Will cont to monitor b(6)-2
23Oct03	1145 - Returned from OR via litter. Pt A0-VSS LS CTA (B), resp. even unlabored, BSX4. Drsng to abd/chest/arm CDI (R) thigh drsng CDI. drsng to (L) LE CDI. IV (L) FA CDI. cholostomy bag intact c̄ light brown liquid stool stoma beefy red. voiding per urinal. Feeding tube intact (L) Q. Tube feeding flushed c̄ 10CC NS. Pt. has ф complaints @ this

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23OCT03	Surgery Op Note
	Procedure STSG from (R) thigh to Abd/chest/Arm
	Surgeon [redacted] b(6)-2
	Anesth GETA Banks
	IVF
	Findings .18 cm STSG taken from R thigh
	Applied to open wounds
	(R) low leg wound Debrided
	to PACU in good cond. b(6)-2
	[redacted]

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[redacted] b(6)-4

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DATE	NOTES
(cont'd)	time. Will cont. to monitor Pt. b(6)-2
23 Oct 03	Pt resting in bed. NAD. I concur c above
1300	assessment. 2 pt restraint. Ø skin or wound
	circulation problems. Will continue monitoring
	throughout shift. b(6)-2
23 OCT 03	Pt resting in bed, A+O x3, VSS, LS CTA (B), ⊕
1930	BS x4, colostomy bag intact, stoma appears
	beefy red, brown loose stool, J tube (L) side
	of abd intact + clamped, dsg on abd secured
	c staples CDI, dsg to (R) leg CDI, Ø c/o
	pain or discomfort, tol PO well, IV (L) FA
	H/L'd, Ø s/sx of infex or infiltration, voiding
	s diff, 2 point restraint in place s s/sx of
	complications. b(6)-2
	I concur c above assessment
24 OCT 03	- Assumed care of pt. A+O x3. VSS Ø c/o pain or
0200	discomfort @ this time. Fentanyl patch 50mcg placed
	(R) chest wall. Lungs clear non productive cough. HRRR Active
	BS poor appetite. Feeding tube clamped (L) abdomen (R) colosto.
	self care. Ambulates to BR urinates s difficulty. Skin graft
	to burns and abdominal wound CDI. Afebrile. Will monitor

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(2100)	Rt a&ox3, VSS, ø c/o pain. LCTAB, HRRR, ⊕BS x4qd. J-tube to Ⓛ abd: tube care done, Jevity restarted @ 75cc/hr. flushed c̄ 10cc NS s̄ difficulty. MD to change STSG site in 3-5 days. Ⓡ ankle WTD drsg Δ'd - sero-sang drainage noted. Ⓡ thigh graft site drsg dry & intact - retaped. colostomy bag intact - pt does own colostomy care. Encouraging Q2° turns to prevent any skin breakdown. 2 pt restraints on s̄ compromise to skin or circulation. will monitor ——— b(6)-2 [redacted] 91WM6
25 oct 03 0100	-Assumed care of pt. A+O x3. VSS ø c/o pain or discomfort Lungs clear HRRR Active BS colostomy Ⓡ UQ self care. feeding tube to Ⓛ abdominal wall Jevity @ 75 cc/hr. Wound assessment - Multiple skin graft to abdomin Ⓛ upper arm and chest Ⓛ LE moist dsg Q6° wet to dry Ⓡ LE ø s/s of infection Encourag position change ø evidence of skin breakdown noted Will cont to monitor ——— b(6)-2 [redacted]
26 OCT 03 0230	Assumed care of Pt @ 1800 hr. VSS denies c/o Pain at this time. Tube Feed of Jevity @ 75 cc/h via J tube. J tube flushed + Patent. Colostomy Self care completed. RLE Drsg wet. Drsg [redacted] d. Skin Graft Sites to Abd and RUE moistened [redacted] ... Will cont. to monitor ——— [redacted] 91WM6 b(6)-2

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b(a)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 OCT 03	- Assumed care of pt. A&O x3. VSS c/o pain to Ⓡ LE
0200	burn wound. Medicated c̄ relief. Lungs clear HRRR Active
	BS colostomy to Ⓡ UQ abdomin self care per pt. Wound accessment
	multiple skin graft sites. Ⓡ upper chest wall and arm and abdomin
	dsg Q6° NS wet to dsg. keep dressing moist. Ⓡ thigh donor site
	4x4 dsg intact. Ⓡ LE ankle burn kerlix wrapped Ø s/s of
	infection Will cont to monitor ——— [redacted]
27 OCT 03	Assumed care of Pt @ 1800 hrs. Pt A&O Speaks limited amount of
0200	English. Pt Denies pain. Pt completes colostomy care. J Tube in LLQ
	Jevity Feed @ 75cc/h. Graft site on Abd Drsg CDI [redacted] dsg on
	chest and RUE CDI. Soaked c̄ NS q 6°. Am[redacted] c̄ unsteady
	gait. Will continue to monitor. ——— [redacted] 91WM6
27 Oct 03	Assume care of PT @ 0600. C/O Ø pain, A&Ox3, VSS Drsg
	Δ to abd graphsite, wtd Drsg to Ⓡ Leg. Ambulatory to bathroom,
	Exercise in hall. Colostomy bag intact. No signs of infection
	at Drsg Δ sites. Will cont. to monitor. ——— 91W SPC[illegible]
27 OCT 03	Assumed care of Pt @ 1800. Denies pain @ this
2200	time. Drsg to Abd Δ'd silvadene cream applied. Chest
	and RUE Drsg moistened c̄ NS. Colostomy has
	minimal stool output. J tube flushed c̄ [redacted]nt. Jevity
	Infusing @ 75cc/h via J tube. RLE [redacted] Δ. Will
	continue to be monitored. ——— [redacted] 91WM6
	Assumed care @ 1800; AW VSS, pt A&O speaking arabic; Ø c/o pain; dsg to Ⓡ
	LE Δ'd W→D; Ⓡ thigh donor site Δ'd; abd skin graft site Δ'd c̄ silvadene cream
	Ø s/sx infection; dsgs to Ⓡ UE c̄ Ⓡ chest CDI, Ø drainage; colostomy intact,
	pt performs own colostomy care; J-tube patent, Jevity running @ 75cc/hr;
	Restraints in place, ⊕ circ Ø skin break & Cont to monitor [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28OCT03	Surgery
	No complaints
	VSS AFeb
	Skin graft sites with Good take
	Donor covered.
	A/P Doing well
	BID silvadene to STSG sites until
	interstices closed. b(6)-2

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DATE	NOTES
29 OCT 03 1205	VSS. AO. Tolerating PO well. Seen by MD this AM for DSG change to RLE. ⊕ pulses to all extremities. BS ⊕ x4. Up ad lib to ambulate for 30 min and tolerated well. DSG's to arm (R) and abdomen C/D/I. ⊖ s/s skin breakdown. b(6)-2 [redacted]
29 OCT 03 2300	Assumed Pt care @ 1800. Pt Denies pain. Drsg to (L) LE Δ'd. Wound has yellow coloring to area. Appear as individual pockets. Drsg to Abd Δ'd. [illegible] wound rinsed c̄ NS & Silvadene applied. IV [redacted] b(6)-2 J Tube Flushed c̄ Patent. Will cont to Monitor [redacted] [illegible]
30 OCT 03	(1910) Assumed care of pt @ 0600. Pt alert, speaking Arabic. VSS. Φ c/o pain. Drsgs to graft sites Δd. Silvadene cream applied to sites. Φ s/sx infection. Colostomy bag Δd d/t leakage from old bag. Pt OOB to amb in hallway - tol. well. Drsg to RLE Δd WTD. Φ s/sx infection. J-tube to LUQ flushes s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. b(6)-2 [redacted]
30 OCT 03 2200	Assumed care of pt @ 1800. A&O, Drsg to LLE Δ'd Wound is red granulated c̄ small area of yellow. Drsg to

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DATE	NOTES b(6)-2
30 OCT 03	~~Abd~~ Abd Δ'd cleaned wound c̄ NS and applied Silvadene.
Continued	Drsg to RUE Δ'd, Cleaned wound c̄ [redacted] and applied
	Silvadene. Pt completed colostomy care. [redacted] will continue
	to monitor. [redacted] 91WM6
31 Oct 03	Assumed care @ 0600; All VSS, pt A&O speaking arabic; ⊘ c/o pain or discomfort;
	abd dsg Δ^d, wound cleansed c̄ NS & Silvadene was applied, staples to skin graft
	~~site~~ AH D/Cd per MD; dsgs to Ⓡ UE & Ⓡ chest wall Δ^d c̄ Silvadene applied; dsg to Ⓡ LE
	Δ^d w→D; All dsgs ⊘ s/sx infection; pt performed own colostomy care; J-tube
	~~patent~~ patent, flushing s̄ difficulty; OOB to amb in hall s̄ difficulty; pt voiding
	QS, clear, yellow urine s̄ difficulty; TO1 Powell; Restraints in place, ⊕ circ, ⊘
	skin breakdown, cont to monitor [redacted] b(6)-2
31 OCT 03	Gen Surgery
	Pt. doing well
	No issues
	All staples removed from grafts
	RLE wound healing well
	Dougr c̄ gauze still intact
	Continue current care [redacted]
1 NOV 03	Surgery b(6)-2
	No new issues
	No Δ's
	Continue local wound Care to RLE [redacted]

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[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
ØINOVØ3	(152Ø) Assumed care of pt @ ØØØØ. Pt alert, speaking Arabic. VSS. Ø C/o pain. Pt amb well in hallway. Colostomy bag Δd d/t leakage from old bag. Drsgs to skin graft sites Δd. Silvadene applied to wounds. WTD drsg on RLE Δd. Ø S/Sx infection @ wound sites. Tol. reg diet well. J-tube flushes well. Voiding s̄ difficulty. 2 point restraints intact s̄ S/Sx complications. Will continue to monitor. b(6)-7 [redacted]
01NOV03 1900	VSS OOB → AMB to BR. Voiding clear yellow urine. Consume 80% of Regular diet for dinner. Colostomy ~~draining~~ draining soft brown stool. Drsg Δ'ed as ordered. Will Continue plan of care b(6)-7 [redacted]
Ø2NOVØ3	(1315) Assumed care @ Ø6ØØ. Pt alert, speaking Arabic. VSS. Ø C/o pain. Drsgs to skin graft sites Δd. Silvadene applied. Pt doing own colostomy care. Amb well. WTD drsg to RLE Δd. Ø S/Sx infection. Tol. reg. diet well. Voiding s̄ difficulty. J-tube flushes well. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. b(6)-7 [redacted]
2NOV03 2000	VSS alert & oriented. Consumed 70% of dinner. (B) Upper arm & (R) chest burns c̄ pink moist tissue noted. ABD wound c̄ grayish color. Colostomy stoma pink & moist. (R) LE wound c̄ pink tissue noted & small amt yellowish exudate noted. Will continue care as directed [illegible]

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DATE	NOTES
3 NOV 03 @ 1400	V.S.S., A&O×3. Pt. resting quietly in bed, All DRSNG's Δ'd, Silvadine applied to graft sites. W→D DRSNG Δ to ® LE, Colostomy care done by pt. Pt. ambulates s̄ difficulty to BR and in hallway. J-tube removed this AM by MD, covered c̄ dry gauze. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. b(6)-2 [redacted] 2LT, AN
3 NOV 03 @ 2330	assumed care of pt @ 1800. VSS, c/o some pain around the abd incision, but tol s̄ meds. LS CTA, ⊕ BS, ⊕ stool in colostomy. Void per urinal s̄ difficulty. Tol reg diet well. up Amb s̄ difficulty. RLE WTD dsg Δ'd, heal granulating tissue noted. ® arm, chest & abd wounds cleansed c̄ saline, silvadene applied. Pt ↑ amb s̄ assistance. Plan: monitor dsgs, enc po intake. 2pt restraints on s̄ S/Sx skin circulation compromise. Will cont. to monitor. b(6)-2 [redacted]
Ø4 NOV Ø3 (1Ø25)	Assumed care @ Ø6ØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb well. Drsgs to skin graft sites Δd. Silvadene applied to wounds. WTD drsg to RLE Δd. Ø S/Sx infection @ wound sites. Colostomy bag intact c̄ sm.

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DATE	NOTES
	b(6)-2
Ø4NOVØ3 (1Ø25)	(cont) amount soft brown stool. Pt cont. to do own colostomy care. Tol. reg. diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
4NOV03 @ 2300	assumed care of pt @1800. VSS. c/o pain to RLE. LS CTA, ⊕BS, ⊕ stool to colostomy RLQ, Tol. reg diet well; void per urinal lt amber urine s̄ difficulty. ML abd wound & Ⓡ chest & Ⓛ arm wound cleaned c̄ NS & silvadene applied. RLE wound healing, granulating tissue noted, ø drainage, WTD drsg Δ'd. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: enc po intake, enc AMB, enc independence. Will cont. to monitor. [redacted]
5NOVØ3	No New Issues All wounds healing well If a better granulation bed develops on the RLE, may be able to graft it in a week b(6)-2 [redacted]

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DATE	NOTES
Ø5NOVØ3	(1045) Assumed care @ 0800. Pt alert, speaking arabic. VSS. Ø c/o pain. OOB to amb in hallway s̄ difficulty. Drsgs to graft sites and RLE Δd c̄ MD present. WTD drsg applied to RLE. moisturin cream unavailable in hospital. vaseline gauze applied to graft sites. will notify MD. Colostomy bag intact c̄ sm. amount soft brown stool. Pt cont. to do own care. Pt voiding s̄ difficulty. Tol. reg diet well. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. — [redacted] WAU
5NOV03 @2300	assumed care of pt @ 1800. VSS. no c/o. alert, speaking little english, is OTA; ⊕BS, tol reg diet, ⊕ BM soft & brown per colostomy; void per urinal QS. Pt ↑ AMB s̄ assistance. NLard & Ⓡ chest/arm drsgs Δd, Silvadene applied to wounds. RLE calf drsg Δ WTD, ⊖ drainage noted. 2pt restraint on s̄ S/sx skin/circulation breakdown. Plan: enc AMB, enc independence, monitor drsgs. [redacted]
6 NOV03 0700	— Assumed care of pt. Ax0 x3. VSS Denies pain or discomfort @ this time. Lungs clear HRRR Active BS. colostomy Ⓡ UQ self care stoma vascular. Multiple skin grafts to chest and axillary region. Burn to ⓇLE dry dsg kerlix wrapped Sylvadene applied to wounds. Afebrile ⊘ S/S of infection. Will cont to monitor — [redacted]

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LAST NAME	'ST NAME	E INITIAL	ID NUMBER

DATE	NOTES
8 NOV 03 0200	- Assumed care of pt. A+O x3. Sleep yet easily arousable. VSS Denies pain or discomfort. Multiple skin graft sites dsg CDI sylvadene creme applied. Donor site healing well. Ⓡ LE wound sm amt of active bleeding. Wet to dry dsg kerlix wrapped CDI, Lungs clear HRRR Active BS colostomy self care ambulates ā difficulty urinating spontaneously Will cont to monitor b(6)-2
8 NOV. 03 1930	Pt A+O x3, VSS, LS CTA Ⓑ, ⊕ BS x4, ∅ c/o pain or discomfort, dsg's on abd + Ⓡ arm + chest Δ'd, applied silvadene to wounds, W→D dsg Δ'd on Ⓡ lower leg, colostomy bag intact + empty, voiding c̄ yu to urinal w/o diff, 2 point restraint ∅ complications. b(6)-2
9 NOV 03 0700	- Assumed care of pt. A+O x3. VSS ∅ c/o pain or discomfort voiced having not slept well last night. Lungs clear HRRR BP WNL Atenolol 50mg QD cont. Active BS colostomy self care tolerating PO well. Voids QS spontaneously per urinal. Wound accessment: Multiple skin grafts to upper chest wall and axillary region healing well. Skin graft also to abd. Sylvadene creme applied, dry dsg CDI. Wound to Ⓡ LE ankle wet to dry small amt of bleeding kerlix wrapped. ∅ evidence of skin breakdown noted Will cont to monitor b(6)-2

b(6)-4

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DATE	NOTES
7NOV 0005	Pt ⊖ C/O pain. ⊕ colostomy bag ~~draining~~ intact + draining loose brown stool. Pt empties own bag. DSG to abd, chest, + arm completed. Silvadene to wounds as per order. Ⓡ ankle WTD DSG completed. Pt amb to BR c̄ steady gait. VSS. Pt asleep + resting comfortably [redacted]
7 Nov '03	pt AOx3, VSS ∅ c/o pain ~~at~~ this time. dsg to Ⓡ upper flank, Ⓡ bicep, sternal and abd regions, covered with silvadene cream then 4x4s, wounds healing well, restraints x2 in place ⊕ circulation intact. [redacted] b(6)-2
8NOV⊘0010	VSS ⊖ C/O pain. Completed DSG to Ⓡ ankle. WTD. Silvadene cream placed on Abd, chest, + Ⓡ arm. Covered areas c̄ gauze. ⊕ Colostomy bag draining loose, brown stool. Pt asleep at this time. [redacted] T/DN b(6)-2
8NOV⊘3	Surgery No New issues May try to place STSG to RLE in 1-2 wks [redacted] b(6)-2

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

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

b(6)-4 [redacted]

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DATE	NOTES
9 NOV 2000	VSS Alert & Oriented. ® L Leg wound tissue pink & moist, evident drainage noted. ® chest and ® upper arm ~~2°~~ second degree burns c pink moist tissue noted. ABD wound with waxy looking ~~ele~~ tissue present ~~grayish~~ grayish in color. Colostomy stoma pink & moist. Voiding clear yellow urine. Denies pain or discomfort. Will continue care as planned [redacted] b(6)-2
9 NOV 03	Surgery Doing Well RLE wound healing Plan to place STSG next week [redacted] b(6)-2
10 Nov 03 1420	Assume care of PT @ 0600. VSS, A+O x3 In 2pt restraints without any skin irritation. WTD drsg Δ to ® lower leg, CDI. Abd, chest, arm silvadene was applied c 4x4's area healing nicely. Acd colostomy c assistance. Will cont to monitor. [redacted] b(6)-2

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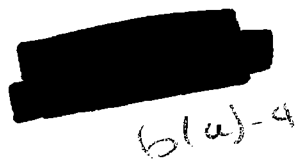

b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 NOV 03 2000	Pt A+Ox3, VSS, dsg's to abd, (R) arm, chest Δd, Ø s/sx of infex, silvadene cream to graft sites, WTD to (R) leg, Ø c/o pain or discomfort, colostomy bag intact, 2 point restraint, Ø complications, LS CTA(B), (+)BSx4, [redacted] mw
11 NOV 03	Assume care of PT A+O x3, VSS. Ø c/o pain. Ambulate without assistance. Δed colostomy bag. WTD to (R) leg. Δed Abd and (R) arm drsg c̄ silvadene cream. Ø signs of skin irritation at 2pt restraint sights. ~ 91WSK [redacted]
11 Nov 03	Assumed care of Pt. A&O VSS Ø c/o pain. Drsg to abd and (R) upper torso and RUE Δd. silvadene cream applied. Skin appears red around wounds where tape is ~~apt~~ touching skin. Will continue to monitor. [redacted] SPC 91WML
12 NOV 03	Surgery No issues Will plan to debride wound + place STSG Monday [redacted]
12 NOV 03	(1155) Assumed care ⓘ [illegible]. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway. Pt did own colostomy care in BR. Drsgs to skin graft sites Δd - silvadene applied to sites. WTD drsg on RLE Δd. Ø s/sx infection ⓘ wound sites. MD present ⓘ drsg Δs. Tol. reg diet well. Voiding

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12NOV03 (1150)	(cont) s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. b(6)-2 [redacted]
12 Nov 03	Assumed care of Pt @ 1800 hrs. Pt Denies Pain. VSS A&O. Drsg to RLE Δ'd. Wound is Pink & Smooth in appearance. Wound also appears to be smaller in size. ~~AAA~~ compare to several Days ago. Drsg to Abdomen, torso & RUE Δ'd. Silvadene applied. Pt scheduled for STSG next week. Will continue to monitor. b(6)-2 [redacted] 9WMB
13NOV03@1300	Assumed care of pt. @ 0600. V.S.S., A&O, Ø c/o pain. Pt OOB to BR this AM, ambulates well in hallway, steady gait. Colostomy care done & bag Δ'd. Silvadine applied to graft sites, dry gauze covering. W→D dressing Δ to Ⓡ LE, minimal sero-sang. drainage to old dressing. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] b(6)-2
13 NOV. 03 2015	Pt A+Ox3, VSS, LS CTA Ⓑ, ⊕BS x4, colostomy bag intact, abd dsg Δ'd, silvaden applied to all graft sites, Ⓡ arm + chest dsg's Δ'd, Ø s/sx of infex, WTD to RLE covered c̄ Kerlix, 2 point restraint s̄ s/sx of complications. b(6)-2 [redacted] 9IW
	I concur c̄ above assessment [redacted] 2W

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

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

#[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14NOV03	Plan for surgery for STSG Monday [redacted] b(6)-2
14 NOV03@1600	Pt. resting quietly in bed, V.S.S., Ø C/O pain. Pt. OOB to BR this AM, performed own colostomy care, ambulates well in hallway, steady gait. All dressings Δ'd as per MD orders, Ø signs of infection. Minimal sero-sang drainage to Ⓡ LE wound. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. —— b(6)-2 [redacted] 2LT, AN
14 Nov03	Assumed care @1800 Pt A&O. Ø c/o pain Drsg to RLE Δ. Wound is pink + moist Healthy in appearance Healing well. All drsg to torso Δ'd Silvadene applied. 2 point restraint Will cont. to monitor. —— [redacted] SPC 91WM6
15NOV03	Surgery Monday. No new issues [redacted] b(6)-2
15 NOV03 @ 1600	Assumed care of pt. @ 0600, V.S.S., A&O, Ø C/O pain. Fentanyl patches intact. All dressings Δ'd, Ø signs/symptoms of infection. Pt. OOB to BR, ambulates well. New colostomy bag, old bag was leaking. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. —— [redacted] 2LT, AN b(6)-2

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS N**

DATE	NOTES
15 Nov 03 2300	Assumed care @ 1800. VSS. LS CTA (B) $S_1 S_2$ Present (+)BS x4 quads Void spontaneously s̄ difficulty. Wound to (R)LE pink healthy and Healing Well. W→D dressing Δ completed. Skin graft wound [redacted] Abdomen Torso e RUE Cleaned and Silvadene applie[redacted] Will cont to monitor ——— b(6)-2 [redacted] Spc 91WM6
16NOV03	(0900) VSS. ⊖c/o pain. Pt ambō steady gait to BR. Pt empties own colostomy. Colostomy draining light brown, soft stool. ΔDSG Δ's completed. WTD to (R) ankle. Area pink c̄ ⊖s/sx of infection. Silvadene cream placed to mid Abdomen, (R) pectoral area, (R) bicep, + covered c̄ gauze. Tol DSG Δ well. Pt tol po diet well. ——— b(6)-2 [redacted] 2LT/AN
16Nov03 2000	VSS ⊖ c/o pain, LS CTA (B) HRRR, (+)BS x 4 quads. Colostomy Intact. Drsg to (R) Ankle Δ'd Wound is pink & Moist. Drsg to Abd, chest e RUArm Δ'd Silvadene applied. Will cont to monitor ——— [redacted] Spc 91WM6 b(6)-2

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

[redacted] b(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17NOV03	(1040) NSG - Pt amb to BR c̄ steady gait. VSS. (+) colostomy intact + draining brown, loose stool. Pt NPO since midnight. Pt in O.R. at this time for skin graft. b(6)-2 [redacted]
17NOV03	(1145) Pt back from O.R. (R) leg elevated c̄ blankets behind (R) thigh + (R) ankle. Dr. [redacted] b(6)-2 emphasized no pressure to (R) calf, keep (R) leg elevated, + strict ~~BR~~ bed rest x 3days. Pt aware of MD's instructions. DIC'ed IV in (L) wrist 2° IV infiltrated. Will continue to monitor ~~IV~~ site. (-) c/o pain. b(6)-2 [redacted]
17Nov03 2000	Pt VSS. R leg elevated c̄ No pressure to (R) calf. Drsg CDI Lotion applied to graft site [redacted] Abd, chest and RUE. OTA. Pt Denies pain [redacted] as well. Will cont. to monitor. b(6)-2 [redacted] 91WM6
18NOV03	(0900) NSG - VSS. Pt c/o pain. medicated [redacted] ii perc tabs. Will continue to monitor. (R) leg elevated c̄ blankets behind (R) ankle + (R) thigh. No pressure under (R) calf. (R) upper thigh soaked c̄ blood. Removed ~~ban~~ kerlex + put new gauze + kerlex. Will continue to monitor bleeding. Pt did own AM care in Bed. b(6)-2 [redacted]

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

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[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19NOV03 @0330	assumed care of pt @1800. VSS, no c/o. LSCTA, (+)BS, colostomy intact c̄ brown formed stool. void per urinal QS. RLE elevated s̄ pressure to (R) calf wound. (R) thigh donor site drsg-CDI. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: monitor drsgs, strict BR, pain control [redacted]
19NOV03	General Surgery POD#2 s/p STSG to RLE b(6)-2 Doing well no issues. Dressing Δ in 1-3 days Will allow to get OOB to bathroom. No standing or walking. No dangling his leg. [redacted] b(6)-2
19NOV03@1345	Assumed care of pt. @0600. VSS. A+O. Pt. resting quietly in bed. (R)LE elevated on blankets. Pt. on strict bedrest. Colostomy bag intact, formed brown stool. Moisturizing lotion applied to graft sites on chest & right upper arm. STSG to (R)LE, dressing intact, mod. brown drainage to dressing. MD to Δ dressing in 1-3 days. Pt. requests to have dressing Δ'd frequently. Will have interpreter explain that the MD does not want to Δ DRSNG at this time. Urinal @ bedside, clear yellow urine. Pt. given ii Percocet for pain this AM. Will cont. to monitor. Pt. in 2-point restraints Ø b(6)-2 signs of skin breakdown. All other assessments WNL. [redacted] 2LT, AN
19NOV03@1500	Dressing to (R) thigh skin graft donor site Δ'd, staples intact, mod. sero-sang drainage, vaseline gauze wrapped c̄ Kerlex. ii Percocet for pain. b(6)-2 [redacted] 2LT, AN

[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
19 NOV 1900	VSS. Ⓡ Leg ↑ on ~~pillow~~ folded blankets. Pedal pulses +2. Capillary refill brisk. Dry to RLE dry + intact. Colostomy bag intact. ~~colos~~ Colostomy stoma pink & moist. Re-enforce pt of strict bed rest. Pt consumed 75% of Regular diet for breakfast. Denies pain or discomfort @ this time. Will continue plan of care — [redacted]
20NOV03	Surgery POD#35 STSG Doing very well Dressing Δ tomorrow or saturday [redacted] b(6)-2
20NOV @ 1500	Assumed care of pt. @ 0600, VSS, A&O, C/O mild pain to Ⓡ LE, refused pain meds. Ⓡ LE elevated, pt on strict bed rest. DRSNG to Ⓡ thigh donor site CDI. Lotion applied to old SGST sites, ✓ Vent. patch Δ'd, applied to chest wall. Colostomy bag intact, brown watery stool. Pt. in 2-point restraints, Ø S/SX of skin breakdown. All other assessments WNL. Will cont to monitor. — b(6)-2 [redacted]

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

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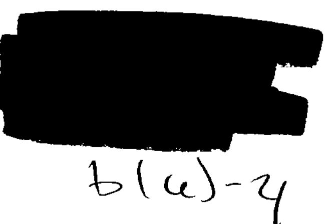

b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Nov03 2115	Assumed care of pt. @1800. VSS - A+O speaking in arabic + some english. pt. has no complaints of pain @ this time. LS CTA (B), Resp. even unlabored, BS x4. Pt. applied cream to chest + abd. to skingraph sites. (R) LE drsg CDI. Leg elevated c̄, no pressure applied to positive portion of his drsng. cholostomy bag intact. Two pt. restraints in place s̄ compromise to skin / circulation. Will cont. to monitor pt.
	I concur with above assessment
21 Nov '03	Assumed care 0600 pt awake + oriented x3 VSS b(6)-2 pt had ∅ c/o pain at the time. Pt did c/o of leak from colostomy bag. ^colostomy Bag replaced, pt self applies cream to chest. Drsg around graft site Δ'd except for the 2 4x4 stapled on those were reinforced w/o D with conlex wrap. (R) lower leg wrap in place and leg elevated as per orders. Restraints x2 in place c̄ circulation skin b(6)-2 intact. Will monitor.
21 Nov 03 1700	I concur c̄ above assessment.
21Nov03 @ 2050	Assumed care @ 1800; VSS, pt A&O speaking arabic; ∅ c/o pain, pt performed own colostomy care; dsg to (R) leg graft CDI, ∅ drainage, (R) Leg ↑ ∅ pressure applied; pt applies moisture cream to chest & abd; Restraints in place, ⊕ circulation, ∅ skin break↓, will cont to monitor b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22NOV03	Surgery POD#5 s/p STSG
	Dressing taken down c 100% take. Will
	likely be ready for the EPW camp in 1 week
	b(6)-2
22Nov'03	Pt. A+Ox3, VSS, pt has ∅ c/o pain at this time,
	dsg to lower (R) extremity Δ'd by Dr [redacted] healing well,
	staples from upper right thigh graft-site removed,
	pt maybe ready for EPW camp in a week. (Dr [redacted] predicts)
	(R) extremity wrapped with curlex and ace wrap, thigh
	injury wrapped with 4x4 curlex. Pt self applies moisturizer
	and empties colostomy bag. Will monitor Dressing to lower
	extremity changed with petroleum gauze + fluffs. Restraints x2 in place
	(+) circulation, ∅ new breakdown. SPC [redacted]
	(1630) I concur c above assessment. [redacted]
23Nov03 0410	Assumed care @ 1800; VSS, pt A+O speaking arabic; ∅ c/o pain or discomfort @
	this time; dsgs to (R) LE CDI, ⊖ drainage wrapped in kerlix + Ace bandage; b(6)-2
	pt performed colostomy care; applied moisturizing cream to chest c aid; Restraints
	in place, ⊕ circ, ⊖ skin break↓, cont to monitor. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 All
23 NOV 03 @ 1105	Pt a/o, VSS, Ø c/o pain, new fentanyl patch applied to (R) chest wall today per orders. Xeroform c̄ Kerlix to (R) thigh, (R) lower leg c̄ xeroform & dry drsg. Pt applies moisturizer cream to chest & abd, colostomy care done by pt. Restraints on s̄ compromise to skin/circulation. Will monitor [redacted] LPN
23 NOV. 03 2015	Pt A&Ox3, VSS, Ø c/o pain, colostomy bag intact, ace wrap RLE CDI, applying moisturizing cream on his own xeroform to (R) thigh + leg CDI [redacted] I concur c̄ above assessment [redacted]
24 NOV 03 1400	Pt a/o, VSS, Ø complaints, colostomy intact, emptied by pt., ace CDI to (R) LE, xeroform to (R) thigh. Cream moisturizer put on by pt. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor [redacted] 91WM6.
25 NOV 03 @ 0245	Assumed care of pt @ 1800. VSS, no c/o pain. LSCTA using IS, ⊕ BS, ⊕ stool per colostomy; voids per urinal QS. RLE drsg CDI, ⊕ CMS. (R) thigh donor site c̄ dry loose drsg. Pt ↑ AMB to BR s̄ assistance. 2pt restraints in s̄ s/sx of skin/circulation compromise. Plan: monitor drsg, enc AMB, enc po. [redacted]
25 NOV 03	Surgery POD#8 s/p STSG. No issues. Wounds almost healed. To prison camp in 4-5 days. [redacted]

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DATE	NOTES
25NOVØ3 @1130	Pt A10, VSS, Ø complaints, skin graft donor site to (R) thigh OTA. moisture cream applied. (R) lower leg c̄ cream applied, then xeroform & dry protective drsg. Colostomy & AM care done by PT. Pt ambulated in hallway for 15 min. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor [redacted] LPN–
1640	Pt amb. in hall x 30 min, & emptied colostomy bag. Cont mon [redacted]
26NOV03 @0200	assumed care of pt @1800. VSS, no % pain. LS CTA, ⊕ BS, tol reg diet well ⊕ stool to colostomy, stoma healthy & red; void per urinal / toilet qs. Pt ↑ AMB s̄ assistance. RLE drsg CDI (R) thigh graft site c̄ cream applied by pt. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: enc po, enc OOB, monitor drsgs. [redacted]
26 Nov '03	Assumed care of pt @ 0600, pt awake + oriented x3, VSS, pt changed leaking colostomy bag and self applies moisturizing cream, drsg to graft site changed with shape fitted xeroform + curlex, pt ambulates without difficulty, Restraints x2 in place ⊕ circulation Ø skin breakdown. Will monitor. [redacted]
	(1620) I concur c̄ above assessment [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Narrative Summary *(D/C summary
27NOV03	Date of Admission: 16AUG03
	Date of Discharge: 29NOV03
	Diagnosis: GSW to Abdomen with multiple
	injuries 1) Gastric Injury
	2) Small bowel injury x 2
	3) Colon injury
	Procedures / Dates:
	1) 16AUG03 = Ex lap, distal gastrectomy, small bowel
	segmental resection x 2; sigmoid colectomy
	2) 17AUG03 = Roux en Y gastrojejunostomy; ileoileostomy;
	Right sided colostomy; Hartmann's pouch;
	placement of duodenal drainage tube;
	Feeding jejunostomy
	3) 28AUG03 = Tracheostomy, Abdominal Lavage
	4) 19Sep03 = STSG to open Abdomen
	5) 28Oct03 = STSG to Right arm + chest
	6) 17NOV03 = STSG to Right Lower Leg
	Course In the Hospital: This patient had several
	different surgeons during his time @ this
	Facility. He was admitted c̄ a GSW to the
	Abd on 16AUG03 @ which time he underwent

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

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

[redacted]

b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27NOV03	Course in the Hospital: (cont)
	damage control surgery. He returned to the OR on 17AUG03 for definitive repair but they were unable to close his abdomen. He had one documented Abdominal Lavage on 28AUG03 when he had a tracheostomy placed. His abdomen was not able to be closed & a STSG was placed directly on his bowel 19Sep03. He had some burns to his RUE and his chest which were grafted as well as one the his RLE. He is now completely healed with no open wounds or drains.
	Medications: Percocet one or two every 4-6 hours as needed for pain
	Atenolol 50mg p.o. q day
	Moisturine cream to skin graft sites and donor sites twice a day
	Follow-up: This patient will require no surgical followup for 6-months to a year @ which point if the skin graft is loose over his bowel he could be evaluated for colostomy take down realizing he has significant alterations of his normal anatomy. It will be up to the surgeons who are available @ the time to decide.
	b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 All
27NOV03 @0300	Assumed care of pt @1800. VSS, no c/o pain. (R) LE drsg CDI, (R) thigh donor site healing well. Pt applied lotion to burn sites / donor site. Pt ↑ amb in halls, tol reg diet c̄ good appetite, Voids QS to urinal / toilet. 2pt restraints on s̄ S/Sx of skin / circulation compromise. Plan - enc independence, enc OOB, monitor drsg. [redacted]
27 NOV @ 1140	Pt A/O, VSS, ∅ complaints, (R) LE drsg Δ'd then removed by MD. (R) thigh site OTA. (B) sites healing well. Pt applies lotion to burn sites & donor sites himself. Colostomy bag Δ'd, pt does own colostomy care. Pt AM care complete, amb. in hallway for 10 minutes s̄ difficulty. Voiding qs via urinal. Awaiting next camp run. Discharge meds taken to Pharmacy. Will cont. to monitor — [redacted] LPN-
28Nov03 @0455	Assumed care @1800; VSS, ∅ c/o pain; pt A&O speaking both english & arabic; pt applied moisture cream to [redacted] all donor [redacted] & graft site; colostomy care provided per pt; pt amb in hall x1; ∅ [redacted] pertinent Δs in assessment; Restraints in place, ⊕ circ, ⊖ skin breakdown, wil[l] cont to monitor [redacted]
28NOV03	(1005) Assumed care @ 0700. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Amb in hallway s̄ diff. Colostomy bag changed x2 this shift d/t leakage. Pt applying moisturin cream to skin graft sites. ∅ S/Sx infection. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted]

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DATE	NOTES
28NOV03	No new issues. [redacted] b(6)-7
29Nov03 @0445	Assumed care @1800: VSS, pt alert speaking arabic; Ø c/o pain; pt OOB to BR, amb c̄ difficulty, colostomy care provided per pt; self-application moisture cream to all graft sites, Ø s/sx infection; pt awaiting D/C to camp; Restraints in place, ⊕ circ, Ø skin break. Cont to monitor [redacted] b(6)-2
29NOV03	(1355) Assumed care @ 0900. Pt alert, speaking Arabic VSS. Ø c/o pain. Amb well. Skin graft sites well healed - pt applying moisture cream. Awaiting trans to EPW camp. Monitoring. [redacted] b(6)-2
	(1340) Pt d/c to camp c̄ meds/colostomy supply. amb. escorted by MPs. [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Patient)*	LOG NUMBER [redacted]
		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: 0846

TRANSPORTATION TO FACILITY

SEX: M

AGE

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: 10 morphine; 1G Ancef

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW   Pox: 95

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NONURGENT

TIME: 1856 b(6)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	0846				
BP	114				
PULSE					
RESP	50				
TEMP					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0657	Foley	SS			
~~0719~~	~~10 morphine~~				
~~0717~~	~~Ancef~~				

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)*

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		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

56 y.o. EPW GSW to Abd. Transported to EMT

[illegible]

NKDA

PMH Ø

PSH Ø

PE. Lungs (B) breath sounds, mild Rhonchi

Heart regular

Abd wound Ant Axillary line

LUQ exit RUQ

Back s wounds.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER [redacted] E AND ST[redacted]

b(6)-2

COD[redacted]

DIAGNOSIS

GSW to Abd.

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

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 b(6)-2
24 AUG 03	1640		Pt restless. Gave 10mg propofol IVP. [redacted]
	1715		Pt over breathing vent RR 25. Gave 30mg
			propofol IVP. Will cont care. BP 190s/80s [redacted]
	1844		Gave report to next shift. [redacted]
	1800		Report received from LT [redacted] [redacted]
	2030		Wafer & colostomy bag Δ'd. Pt having yellow/green
			liquid stool. Stoma appears edematous and pink [redacted]
	2200		Drsg Δ complete to midline abd incision & Ⓡ flank
			wound. Both wounds appear pink c̄ greyish/green exudate
			noted. Wounds repacked c̄ 1/4 strength Dakins soln.
			Ⓡ chest burn area cleansed and silvadene applied.
			Bacitracin applied to tube insertion sites. Yellow drng
			noted duodenal tube & JP #1 ~~[illegible]~~ sites. Will notify
24 Aug 03			MD in AM. b(6)-2 [redacted]
	2245		Pt coughing. Attempted to suction pt. Unable to
			pass suction cath. SpO2 99%, peak pressures ↑ to
			50's. RT notified. RT @ BS. Manually ventilated
			pt. ETT kinked in back of mouth. Unkinked
			tube and suctioned. Small amount thin secretions
			obtained. Vocal sounds heard. Attempted to reinflate
			cuff per RT. ETT remains @ 24cm @ lip. SpO2
			↓ to 94-95%. Notified MD. Dr [redacted] b(6)-2 @ BS.
			Cuff leak present. Anesthesia notified for ETT
			replacement. Pt manually ventilated @ (cont.)

(Continue on reverse side)

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

b(6)-4 [redacted]

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

b(6)-2
All

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 AUG 05 cont'd	0900		50 mcg/° due to ↓ BP 150s/70s. [redacted]
	0924		↑ propofol to 60 mcg/K/min due to ↑ BP 126s/80s.
			Will cont to monitor & titrate as needed. [redacted]
	1000 - 1400		Completed bed bath & foley care. Δ'd drsg
			Cleaned burn drsg c̄ hibiclens & rinsed c̄ NS.
			Applied silvadene cream. Cleaned midline
			abd & (R) wound c̄ NS. Wet to dry drsg c̄ ¼ strength
			dakins soln used. Noted yellow fatty tissue.
			Cleaned JP tubes and duodenal tube insertion
			points c̄ NS. Will cont. care. [redacted]
	1130		Dr. [redacted] placed triple lumen in
			cordis. Confirmed placement through XR.
			[redacted]
	1300 - 1500 ~~1445~~		Turned off propofol per Dr [redacted] in prep
			for extubation. Pt has little movement.
			BP ↑ 200s/100s. Dr. [redacted] aware. labetalol
			20 mg IVP prn ordered. Will cont. [redacted]
	1545		Pt appears to be more awake. Moving head
			and (L) arm. suctioned pt × ii. Pt BP continue
			to be 170s/100s. Resp rate range 20-31, O2 sats 98-99%.
			Got interpreter but pt not responsive will
			cont care [redacted]
	1600		Started propofol to 60 mcg/kg/min per Dr [redacted]
			No extubation today due to labored breathing.
			+ BP 200/80s. Gave 20 mg propofol bolus. Suctioned
			pt × ii. Small amt thin white secretions noted.
			Will replace filter per R.T. [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065 STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 16630

b(6)-2 All

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			this time. ETT moved to 26cm @ lip, sitting @ vocal cords per anesthesia. Pt suctioned
			Copious amounts thin yellow secretions obtained.
			Pt placed back on vent c̄ 40% FiO2. SpO2 95%
25Aug03			Will monitor. Procedure complete @ appx 0020.
		0030	Pt turned to (L) side. Pt suctioned x3 c̄ copious
			amounts thin white/yellow secretions.
		0300	Pt turned on (R) side. Pt suctioned x5.
			large amount thin white secretions obtained. SpO2
			98-99% on 40% FiO2. Will monitor - [redacted]
		0400	Labs drawn from ~~CBC, Chem~~ A-line and
			sent to lab. 7.45/35.7/127/25/2/99% [redacted]
		0600	Report given to LT [redacted]
25AUG03		0600	Received report from night shift. Pt vented SIMV 16,
			800, 5, 40%, peaks 26. All IV lines intact. Emptied
			colostomy. Brownish yellow liquid noted. NGT (R)
			nare LIS. TF @ 125cc/° infusing. Will cont. care.
		0640	Dr. [redacted] viewed labs (H+H 33', 9.9), ABG,
			x-ray + midline abd + (R) flank wound. Ø new
			orders given. Completed drsg Δ. Wet-to-dry
			dakin's soln used for midline abd + (R) flank
			wound. Bacitracin placed around JP1, JP2,
			duodenal drain + J-tube. Washed (R) shoulder
			wound c̄ hibiclens + rinsed c̄ NS using aseptic
			technique. Flushed 3-lumen. Flushes well.
			Pt has low grade temp 101. Will cont to monitor.
			Give 20 mcg fentanyl for drsg Δ. [redacted]

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
			23Jun 1930: NSG Assessment as follows: (N) sedated on [illegible]/kg/h fent @ 3mg/kg/h versed; [illegible] with [illegible]/[illegible] stimuli: PERRL 2mm (CV) ST w/ Ø CC [illegible] noticed (a [illegible] (+) hx), S1, S2, +3 pulse x4 ext; +3 edema x4 ext (place UE in elevated position (UE > LE)); febrile @ 100.3, cap refill @ 3sec. (R) (Resp) bilat breath sounds; HOB up to 30°; [illegible] secretions; #8 ETT, 22cm at lip with setting at SIMV 16, PEEP 5; 800 TV and FiO2 @ 50%; (GI) NGT to LIWS in (R) nare; JP x2 to midline sec.; duodenal drain from (R) abdominal site, midline abd incision; C/D/I; ~~[illegible]~~, colostomy intact; Replace duodenal outputs with [illegible] @ 800/3hrs. (+)BS; (GU) foley to gravity; (+) [illegible] colored [illegible]; (Skin) [illegible] with [illegible] dressing; [illegible] (R) arm is C/D/I; (CNS) [illegible]; (R) SC [illegible] w/ D5½ 20[illegible] @ 20cc/h ———— [illegible] in AM ———— [illegible], LTC
			[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

MEDCOM - 16632

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)

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							
28 Aug 03	0955		0955	1000	1005	1020	1035	1050	1110	1st Unit PRBC Transfusion started at 0955 28 Aug 03 completed 1145 28 Aug 03 Pt. had Ø s/s of a negative reaction. — b(6)-2
NIBP			102/45	103/42	105/43	102/42	106/45	110/54	110/49	
HR			85	85	85	86	85	84	83	
TEMP			101.2	100.9	100.9	100.9	100.6	100.8	100.7	

DATE	HOUR A.M.	HOUR P.M.					
	1120		1120	1135	1150	1220	2nd Unit PRBC Transfusion started at 1120 28 Aug 03 completed in OR at 1245 28 Aug 03. Pt had Ø s/s of negative reaction. — b(6)-2
NIBP			114/49	118/53	120/53		
HR			83	81	82		
TEMP			100.5	100.1	100.3		

(Continue on reverse side)

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

b(6)-4

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

MEDCOM - 16633

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
28 Aug 03		1400	Pt returned from OR. 2nd unit of PRBC completed at 1245 28 Aug 03. Pt Ø negative reaction. Pt received Tracheostomy, 8 shiley, Ex lab + Washout of abdominal wound.
		1200	TF started at 60cc/hr advance to 125cc/hr within 6hrs. VSS pt shows Ø s/s of pain or discomfort.
		1800	Report + care of pt. given to oncoming shift
1800 28Aug 03	Received report.		T/AN
1830	Assessment completed.		T/AN

08/28/03 19:46:07 HR=96 P1 =OFF P2 =OFF RR=13 SpO2=98% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
25mm CONT II MON 1.0mV/cm
PACER DISPLAY ON
1x SpO2
4x Ld1 RESP

BLW-2

DATE	HOUR	OBSERVATIONS
2300		Drsg Δ to mid abd c̄ Ⓡ LQ. staples to mid abd intact s̄ s/s of drainage. RLQ wound drsg c̄ s/s fluid. LT/AN
0200 29Aug03		Foley care done. LT/AN
0600		Report given. LT/AN

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

STANDARD FORM 510 (REV. 7-91) BACK

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29Aug03	0800	-1030	cont'd... to (R) shoulder/chest region. Washed c̄ hibiclens + rinsed c̄ NS. Applied silvadene + covered c̄ 4x4 drsgs. Completed bedbath. Noted blister fluid-filled on (R) LE + Stage I decubitus on back of head. Placed silvadene + 4x4 gauze on head + donut to elevate head off of bed. Elevated (B) UE + (B) LE due to edema. Δ'd sheets. Will cont. care
	0820		Pt awake. Moving eyes. Gave 50mg propofol IVP. Will cont to monitor. b(6)-2
	1100		Completed oral care. Cleaned mouth c̄ scope. Completed trach care using clean technique. Pt off vent on RA for ≈5min. O_2 sats remained >90%, RR 45. Placed pt back on vent. O_2 sats presently 99% @ 1205. Noted occasional PVCs while pt slightly awake. Will notify Dr.

b(6)-2

2:12 HR=87 P1 =OFF P2 =OFF RR=16 SpO2=99% NIBP=122/59(81) T1=OFF T2=OFF ΔT=OFF

ON

RESP

b(6)-2

	1300		Pt resting comfortably. O_2 sats 99%. Will cont. care.

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 16635

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
29 AUG 03	0700		Received report from Lt [redacted] Pt vented #8 Shilley trach SIMV 16, 800, 5, 40%, peak 28. (B) UE + (B) LE elevated due to pitting edema. All 5 JP drains to bulb suction. (R) colostomy c̄ semiformed brown stool. NGT to LIS c̄ scant amt dark brown substance. Midline abd + (R) flank wound drsg C,D,I. Duodenal drain draining to gravity. TF @ 125cc/°. Viewed labs. ABG 7.381, 33.0, 108, 20, -6, 98%. H+H 29.7, 9.6, WBC 15.6, Plt 1000, K+ 3.8 will notify MD of abnormal results. Temp currently 99.4. Will cont. to monitor. [redacted]

07:15:16 HR=87 P1 =OFF P2 =OFF RR=16 SpO2=100% NIBP=109/55(76) T1=OFF T2=OFF ΔT=OFF

LAY ON

SpO2

RESP

	0800		Completed drsg Δ. Midline abd incision held by staples, well approximated. Packed (R) flank wound c̄ 1/4 strength dakin's soln wet to dry. Dr. [redacted] viewed wounds + JP drains. Ø new orders given. Put bacitracin around all 5 JP tubes + duodenal tube Δ'd burn drsg cont'd

(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.

NURSING NOTES
Medical Record

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

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
29 AUG 03	0400		Received report from Lt [redacted] Pt vented #8
			Shilley trach SIMV 16, 800, 5, 40%, peak 28. (B) UE
			+ (B) LE elevated due to pitting edema. All 5 JP
			drains to bulb suction. (R) colostomy c̄ semiformed
			brown stool. NGT to LIS c̄ scant amt dark brown
			substance. Midline abd + (R) flank wound drsg C, D, I.
			Duodenal drain draining to gravity. TF @ 125cc/°.
			Viewed labs. ABG 7.381, 33.0, 108, 20, -6, 98%.
			H+H 29.7, 9.6, WBC 15.6, Plt 1040, K+ 3.8 will notify
			MD of abnormal results. Temp currently 99.4
			Will cont. to monitor. ——— [redacted]

17:15:16 HR=87 P1 =OFF P2 =OFF RR=16 SpO2=100% NIBP=109/55(76) T1=OFF T2=OFF ΔT=OFF

LAY DN

SpO2

RESP

	0800		Completed drsg Δ. Midline abd incision held
			by staples, well approximated. Packed (R) flank
			wound c̄ 1/4 strength dakin's soln wet to dry.
			Dr. [redacted] viewed wounds + JP drains. Ø
			new orders given. Put bacitracin around all
			5 JP tubes + duodenal tube. Δ'd burn drsg cont'd

(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.

NURSING NOTES

Medical Record

MEDCOM - 16637

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

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 b(6)-2
29 Aug 03		1420	Δ'd Ⓡ SC cordis drsg using betadine + covered c̄ opsite ——— [redacted]
		1600	Notified Dr [redacted] of decub on back of head + blister Ⓡ LE. No new orders given. [redacted]
		1800	Temp ↑ 99.4. Will notify next shift. Pt resting c̄ Ø difficulty. O2 sats 99% @ rate 16 bpm. Gave report to night shift [redacted]
29 Aug 03		1800	Report received from LT [redacted] ——— [redacted]
29 Aug 03		2315	Drsgs changed to incisions. Tube sites cleansed and Bacitracin applied around sites. Wounds are red in appearance, 4x4s placed over midline abd incision. Sutures intact, no redness or drng noted. Ⓡ flank wound packed c̄ gauze soaked in Dakins soln. Wound appears beefy red c̄ small amount whitish exudate. Burn area to Ⓡ chest and arm Δ'd per burn protocol. Wound is white in appearance. Large blister areas noted to Ⓑ lower extremities. Wound debrided and cleansed using burn drsg protocol. Mouth care complete. Thick yellow film noted on tongue. Will notify MD in AM. Trach care complete. SpO2 > 92% during procedure c̄ RR ↑ to 50's. Pt suctioned. Copious amounts of yellow/white thin secretions (cont)

(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.

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
29Aug03	cont		obtained SBP @ 130's, put RR 30's on vent
2345 cont			following procedures. Propofol 9mg and
			fentanyl 50mcg IVP given. HR ↓ to 102,
			RR ↓ to 20's, SBP ↓ to 120's. Will continue
			to monitor ———
30Aug03	0215		Pt turned to Ⓛ side ———
	0330		labs drawn via A-line and sent to lab
	0445		Wafer and bag Δ'd to colostomy. Stoma is
			edematous, but pink. Pt turned to Ⓡ
			side. SpO2 ↓ to 96%, peak pressures ↑
			40's. Pt suctioned x4. Copious amounts b(6)-2
			thin yellow secretions obtained. Peak
			pressures ↓ to upper 20's and SpO2
			remains 96-97%. Will monitor —
30AUG03	0700		Received report from night shift. Pt vented
			#8 Shilley trach SIMV 16, 800, 5, 40% peak 36. O2
			sats 96-97%. Pt turned on Ⓡ side. All IV lines
			in place. Ⓛ radial A-line reddened around insertion
			site. Will notify MD. Duodenal drain to gravity.
			NGT Ⓡ nare to LIS c̄ brown colored fluid. Propofol
			fentanyl, D5½ c̄ 20KCL, NS infusing. Propofol
			rate ↓ed 90 mcg/kg/min. RR high 20s. Will
			cont to monitor. Ⓑ UE + Ⓑ LE elevated. HOB
			↑ 30°. Drsg Ⓑ LE C,D,I. Pt temp 100.5. Will
			cont to monitor. — b(6)-2
	0700		Dr. [redacted] viewed labs: WBC 14.5, H+H (9.0, 27.7),
			Plt 1026, K+ 3.4, ABG 7.438, 37.3, 121, 18, 99%. cont'd...

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
30AUG03	0700		cont'd... Ø vent Δ's made. Temp ↓ 100.0°. Notified Dr [redacted] of A-line in >15 days. Order to hold TF for surgery. (R) colostomy in place. Will cont. care ——— b(6)-2 [redacted]
	0800		Suctioned pt x iii. Thin blood-tinged secretions noted. Pt O2 sats ↑ed 99%. Peak 31. Will cont. care ——— b(6)-2 [redacted]
	1020		Completed trach care. Pt tol well. O2 sats 100%. Will cont. care. ——— [redacted]
5/30/03			Surgery
			[illegible]
			[illegible]
			[illegible]
			Trach clean
			[illegible]
			[illegible]
			[illegible]
			[illegible] [redacted] b(6)-4

(Continue on reverse side)

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

[redacted]

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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