CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

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

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On		(b)(6)-2	
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 [illegible]	ICU-2	27 Aug 03

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

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

☐ HISTORY/PHYSICAL ☒ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding	RADIAL R			2			2									2							2		
(3) Full	L			UTA			UTA									☆							UTA		
(2) Normal	DORSALIS PEDIS R			UTA			UTA									2							2		
(1) Faint (0) Absent	L			UTA			UTA									2							2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale				1 3 7			1 3 7									1 3 7							1 3 7		
EDEMA																☆									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓									R									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				NST												NST									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE															✓									
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓									✓									
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE			✓			✓									✓									
	HOB 30 DEGREES			✓			✓									✓									
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				☆			☆																		
PAIN	PAIN FREE															☆									
	PAIN SCALE (1-10)			✓			✓																		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2			2									2									
BOWEL SOUNDS (active all quads)				✓			✓									✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓			—									—									
VOIDING CLEAR, YELLOW URINE q.s.				✓			—									—									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds						—									☆									
(R) label toe	Rashes, Lac's, etc			✓			✓																		
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE fixator				✓			✓									☆									
#2 (L) LE amp				✓			✓									☆									
#3 (R) ankle				✓			✓									☆									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	25 Aug 03	CDI patent
foley	groin	25 Aug 03	patent

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES	
Present	✓
Not Applicable / Absent	(blank)
Refer to Nsg. Notes	N
No Change from Previous Assessment	--

DATE: 27 Aug 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				3			3									4			4						
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				4			4									5			5						
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				5			5									6			6						
GLASCOW COMA SCALE (A+B+C)				12			12									15			15						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R															2+			2+						
	L															2+			2+						
MOVEMENT (See Motor Function Scale at Top of Page)	RUE			2			2									4			4						
	LUE			AMP			AMP									[illegible]			[illegible]						
	RLE			2			2									2			2						
	LLE			1			1									2			2						
GRIP (S) Strong (W) Weak (-) absent	R			W			W									S			W						
	L			AMP			AMP									[illegible]			[illegible]						
RESPIRATIONS	REGULAR			✓			✓									✓			✓						
	IRREGULAR																								
	UNLABORED			✓			✓									✓			✓						
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL			5			5									5			-						
	LUL			5			5									5									
	RLL			5			5									5									
	LLL			5			5									5									
	BOTH BASES			✓			✓									✓									
COUGH	NONE			✓			✓									✓									
	SPONTANEOUS																		✓						
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																		R						
	RATE (SIMV/CMV)																		O						
	PEEP / CPAP																								
	PRESS. SUPPORT																		O						
OXYGEN DELIVERY DEVICE	NC (l/min)			2			2									Ø			M						
	FM (l/min)																								
ETT #______	NRBM (l/min)																		A						
	ETT ______ cm gums																								
ETT CARE / POSITION CHANGE																			I						
ETT / NT SUCTIONED																			R						
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH							✓																		
INITIALS				(b)(6)-2																					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.9	123	21	133/68	98		91										2LNC
0300	/	122	12	142/76	97		100										2LNC
0400	99.8	118	14	134/78	98		102										2LNC
0500																	
0600	98.4	112	14	142/85	98%		106										2LNC
0700		109	16	145/86	95%		107										2LNC
0800																	
0900	98.6	105	14	160/97	97%		122										2LNC
1000																	
1100																	
1200																	
1300																	
1400																	
1500	100.8	142	15	139/78	97%		97										1L N/C
1600																	
1700	100.9	136	10	122/70	93%		89										RA
1800																	
1900	99.9	132	11	115/7	92%												RA
2000																	
2100	100.5	123	18	128/78	97%												
2200																	
2300	101.5	129	16	122/68	95%												RA
2400																	
[illegible]																	

	INTAKE									OUTPUT						
	LR	NS	Ancef	Gent	Pen G	D½NS 20mEq KCl	OR		Total	Urine	BM	OR			Total	COMMENTS
0100	200 / 200									115 / 115						
0200	200 / 400															
0300	200 / 600				50 / 50											
0400	200 / 800															
0500	200 / 1000									230 / 280						
0600	200 / 1200									50 / 300						
0700	200 / 1400			10 / 50						60 / 360						
0800	200 / 1600									60 / 420						
8 HR									8 HR 1200 ~~1650~~						8 HR 420	
0900					50 / 50	110 / 110				120 / 120						
1000																
1100																
1200																
1300																
1400	80 / 80						900 / 900					950 / 950				
1500	80 / 160				100 / 150					150 / 270						
1600	80 / 240			100 / 100						100 / 370						
8 HR	240			100	150	110	900		16 HR.	370		950			16 HR.	
1700	80 / 80									50 / 50						
1800	80 / 160	50 / 50								75 / 125						
1900	80 / 240									100 / 225						
2000	80 / 320									125 / 350						
2100	80 / 400	100 / 150								100 / 450						
2200	80 / 480									50 / 500						
2300	80 / 560									75 / 575						
2400	80 / 640	50 / 200								50 / 625						
8 HR									24 HR.						24 HR	

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26Aug03		2200	received report from previous shift 2220 drew labs from pt central line 2230 provided IVPB Antibiotic 2300 collected UA —— (b)(6)-2 91WM6
26Aug03		2345	Assessment complete LR@200cc/hr to ® IJ, Monitor c̄ alarms on B/P cuff to Ⓛ arm Blood probes on chest PSO2 probe on ® toe Ⓛ ankle guage wrapping CDI, UTA pulse, cap refill <3sec, ® thigh OTA abrasions, foley to gravity attached to ® thigh patent c̄ yellow urine NAD Ⓛ LE guaze c̄ tape over pins Ⓛ thigh bloody saturation to thigh no Δ per physicians instruction UTA Ⓛ pedial pulse d/t dressing to toes Ⓛ LE Amp c̄ ace wrapping CDI, IO Ancolette attached to Ⓛ shoulder LS CTA abd flat abrasions along waist pt not alert ® IJ patent, bandaging blood tinged MPCBS, UTA pain level interpreter CB3 —— (b)(6)-2 91WM6
27Aug03	0015		Hep flushed ® IJ by RN on duty 0115 pt put on 2L O2 via NC PSO2 89% by RT —— (b)(6)-2 91WM
27Aug03	0020		pt informed of NPO status —— (b)(6)-2 91WM
27Aug03	0235		pt c/o discomfort to ® LE, RN on duty administered MSO4 —— (b)(6)-2 91WM2
27Aug03	0300		Assessment complete PSO2 probe Ⓛ ear, pt on O2 via 20s NCC 2L 97% no other changes from previous assessment. —— (b)(6)-2 91WMC
	0600		AM Assistant completed VS P112 B/P 142/85 R 14 T98.4 IVF LR 200cc/hr Ⓛ Lung CTA, Congested Ⓑ Lung. all Lobes SSG (b)(6)-2 91WM ——
	0900		Dcd LR IVF Δ for D5½ 20Kcl as per Dr. for OR Lay SSG (b)(6)-2 91WM6 ——
	1100		Pt in route to OR SSG (b)(6)-2 91WM6 ——

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	Aug 25 03
DOS	25 Aug
POD	~~25 Aug 03 (DOS)~~ 1

24 HOUR DATA	
24 Hour Balance	(+1565)
24 Hour Intake	3890
24 Hour Output	-2325
Weight on Admission	unknown
Weight Yesterday	unknown
Weight Today	unknown
hospital balance	

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

Safety Checks	D	E	N
BVM at bedside			✓
Monitor Alarms On			✓
ID Bracelet On		17	✓
Allergy Bracelet On			
Call Light Within Reach			N/A
Side Rails Up			N/A
Bed in Low Position			N/A

(b)(6)-2	Title)	Department/Service/Clinic	DATE
	1/	ICU-2	Aug 28, 03

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

POTUS (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(Specify) Nursing notes
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2		2				2						2								2		
	RADIAL L		UTA		UTA				UTA						UTA								UTA		
	DORSALIS PEDIS R		UTA		1				1						1								UTA		
	DORSALIS PEDIS L		UTA		1				1						1								UTA		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 7		1 3 7				1 3 7						1 3 7								1 3 8		
EDEMA Ⓡ Ⓛ AM					✓				✓														★		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓		✓				✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓		✓				✓						★								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓						✓										
	FOLEY CARE								✓						✓										
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR										✓														
POSITIONED	RIGHT																						A		
	LEFT																						3		
	SUPINE																						:		
	HOB 30 DEGREES		✓		✓				✓						✓								S		
FALLS PROTOCOL INITIATED																							✓		
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓		✓																				
	PAIN SCALE (1-10)								5/10																
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2		2				2						1								1		
BOWEL SOUNDS (active all quads)			✓		✓				✓						✓								✓x4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓		✓				✓						✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓		✓				✓						✓								✓		
SCARS	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)																									
#1 Ⓛ LE Fixator			✓		✓				✓						✓								✓		
#2 Ⓛ UE Amp			✓		✓				✓						✓								✓		
#3 Ⓡ Ankle			✓		✓				✓						✓								✓		
									✓																

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	Ⓡ IJ	25 Aug 03	Intact
Foley	Groins	Aug 25,03	Patent

PUPIL SIZE
- 1 mm
- 2 mm
- 3 mm
- 4 mm
- 5 mm

PUPILS
- = Equal
- R Reactive
- NR NonReactive
- L > R Left Larger
- R > L Right Larger

MOTOR FUNCTION
- 0 = No Movement
- 1 = Slight Flicker/ Trace of Contraction
- 2 = Active (Gravity Eliminated)
- 3 = Active: against gravity, but not against resistance
- 4 = Active: Against Gravity and Resistance, not full strength
- 5 = Full Strength against Examiners Resistance

CHART CODES
- Present ✓
- Not Applicable /Absent (blank)
- Refer to Nsg. Notes X
- No Change from Previous Assessment --

DATE: 28 August 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			4		4								4		4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			5		5								5		5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			6		6								6		6								6		
GLASCOW COMA SCALE (A+B+C)			15		15								15		15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		+2		+2								+2		+2								+3		
	L		+2		+2								+2		+2								+3		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4		4								4		4								4		
	LUE		*		*								*		*								4A		
	RLE		2		2								2		2								2		
	LLE		2		2								2		2								2		
GRIP (S) Strong (W) Weak (-) absent	R		W		W								W		W								W		
	L		*		*								*		*								*		
RESPIRATIONS	REGULAR		✓		✓										✓								✓		
	IRREGULAR																								
	UNLABORED		✓		✓								✓		✓								✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5		5								5		5								5		
	LUL		5		5								5		5								5		
	RLL		1		1								1		1								1		
	LLL		1		1								1		1								1		
	BOTH BASES		1/1		1/1								1/1		1/1								✓		
COUGH	NONE		✓		✓								✓		✓										
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓								✓		
COUGH / DEEP BREATH			✓		✓								✓		✓								✓		
INITIALS		(b)(6)-2																							

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	101^{7}	115	16	120/73	95%												RA
0300																	
0400	99^{3}	116	18	118/70	96%												RA
0500																	
0600																	
	100^{2}	118	20	129/77	95%												RA
0700																	
0800																	
0900																	
1000																	
	987																
1100																	
1200																	
1300																	
1400	101.9	130	22	119/59	95%												RA
1500																	
1600																	
1700																	
1800																	
1900	99.9																
2000																	
2100																	
2200	100^{9}	130	20	137/73	93%	—	93										
2300																	
2400																	

	INTAKE									OUTPUT						
	LR	IVPB Ancef	~~[illegible]~~	~~[illegible]~~		~~OR~~ PO			Total	Urine					Total	COMMENTS
0100	80/80									75						
0200	80/160									50/125						
0300	80/240	50/50		~~50~~						100/225						
0400	80/320									75/300						
0500	80/400									75/375						
0600	80/480	50/100								50/425						
0700	80/560									50/475						
0800	80/640	50/150				240/240				50/525						
8 HR	640	150				240			8 HR. 1030	525					8 HR 525	
0900	80/80									100/100						
1000	80/160					120/120				100/200						
1100	80/240									100/300						
1200	80/320	50/50				60/180				50/350						
1300	80/400					100/280				50/400						
1400	80/480					150/430				100/500						
1500	80/560	100/150				100/530				100/600						
1600	80/640	100/250				100/630				100/700						
8 HR	640	250				630			16 HR. ~~1520~~ 2550	700					16 HR. ~~700~~ 1225	
1700	80/80					250/350				100/100						
1800	80/160	50/50				150/400				100/200						
1900	80/240									100/300						
2000	80/320									100/400						625
2100	80/400	100/150								~~[illegible]~~						
2200	80/480									100 ~~[illegible]~~						
2300	80					100				300						
2400	80	50								75						
8 HR	640	200				500			24 HR. 3890	1100					24 HR 2325	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
Aug 28, 03	0130		Resting well eyes closed. rises and fall of chest noted. Ø % discomfort at this time. Will con't to monitor per the order. (b)(6)-2
	0400		Sleeping NAD doing well. Ø Δ's from prior assessment. (b)(6)-2
	0600		received pt. NAD; resting c eyes closed (b)(6)-2
	0830		pt. received 2 mg MSO4 prior to sitting in chair; pt. had difficulty c transfer to chair c 75% assist; bath was given, will cont. to monitor (b)(6)-2
	1230		wound care on LLE done; pt. premedicated before dg Δ; will cont. to monitor (b)(6)-2
		1445	Assessment completed. (R) IV infusing LR @ 80cc/hr. Ø S/S of infection. (L) upper extremity amputation, dressing CDI. Clear serosanguineous fluid noted on (R) leg at operative sites. Foley draining clear dark yellow urine, Abdomen distended, but normal active bowel sounds x4. Abrasions on abdomen C+D, Breath sounds CTA, c diminished bases bilaterally. (b)(6)-2
		1600	Medicated c MSO4 per orders for transfer to chair. (b)(6)-2
		1745	Pt medicated c MSO4 per orders for pain Pt sitting up in chair. Pt ate 30% of meal. [illegible] Good PO fluid intake (b)(6)-2
		1830	Pt medicated c ii Tylox per physician's order. Pt transferred Back to bed. moderate amount of drainage still noted from operative site on (L) lower extremity. will cont. [illegible] Good IS use. (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	
Hospital Balance	

NURSE'S SIGNATURE	Initials
(b)(6)-2 CPT	(b)(6)-2
(b)(6)-2 BPC 91WMCU	
(b)(6)-2 CRN	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CPT	ICU-2	29 Aug 03

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

POTUS (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER (Specify) Nursing Note
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2														2		
	RADIAL L		UTA						UTA						Amp								UTA		
	DORSALIS PEDIS R		UTA						UTA														UTA		
	DORSALIS PEDIS L		UTA						UTA														UTA		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8						1 3 8														1 3 8		
EDEMA Ⓡ arm			*						*						*								—		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST						✓						ST								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																						✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																						✓		
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES								✓					✓											
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			PF					✓														*		
	PAIN SCALE (1-10)													9/10									✓		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended													1									1		
BOWEL SOUNDS (active all quads)				x4				✓						x4									x4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓					✓					✓											
VOIDING CLEAR, YELLOW URINE q.s.																							✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds			✓					✓					✓									✓		
	Rashes, Lac's, etc			✓					✓					✓									✓		
DRESSING (Dry & Intact: specify site below)																							✓		
#1 Ⓛ LE ex fix				✓					✓					✓									✓		
#2 Ⓛ UE				✓					✓					✓									✓		
#3 Ⓡ ankle				✓					✓					✓									✓		

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Central line	Ⓡ IJ	27 Aug 03	Opsite.

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present	✓
Not Applicable / Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	--

DATE: 29 August 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open					4				4						4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response					5				5						5								5*		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response					6				6						6								6		
GLASCOW COMA SCALE (A+B+C)					15				15						15								15*		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R				3+				3+																
	L				3+				3+																
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				4				4						4								4		
	LUE BEA				*				*						*								—		
	RLE				4				4						4								4		
	LLE				3				3						3								3		
GRIP (S) Strong (W) Weak (-) absent	R				W				W						W								W		
	L				—				—						—								AMP		
RESPIRATIONS	REGULAR				✓				✓						✓								✓		
	IRREGULAR																								
	UNLABORED				✓				✓						✓								✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5				5						5								5		
	LUL				5				5						5								5		
	RLL				1				1						1								1		
	LLL				1				1						1								1		
	BOTH BASES				1				1						1								1		
COUGH	NONE				✓				✓						✓								✓		
	SPONTANEOUS																						✓		
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																						RA		
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)														2L										
	FM (l/min)																								
ETT #______	NRBM (l/min)																								
	ETT ______ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓										
COUGH / DEEP BREATH					✓				✓						✓										
INITIALS				(b)(6)-2																					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	100.5	116	14	140/80	95%											—	RA
0900																	
1000																	
1100																	
1200																	
1300																	
1400	102.1	130	21	103/58	94%												2L O_2 NC
1500																	
1600																	
1700	99.7																
1800																	
1900																	
2000	99.4																
2100																	
2200																	
2220	99.6	107	19	127/75	93%		94										RA, NAD
2300																	
2400																	

	INTAKE									OUTPUT						
	LR	IVPD	OR	RR	PO				Total	Urine					Total	COMMENTS
0100	80 / 80									50						
0200	80 / 160															
0300	80 / 240	50 / 50														
0400	80 / 360									400 / 450						
0500	80 / 400															
0600	80 / 480	50 / 100														
0700	80 / 560															
0800	80 / 640									500 / 950						
8 HR	640	100							8 HR. 740	950					8 HR 950	
0900	80 / 80 ~~720~~															
1000	o															
1100	80 / 160 ~~800~~															
1200	80 / 240 ~~880~~															
1300	80 / 320 ~~960~~															
1400	80 / 400				100 / 100					500 / 500						
1500	80 / 480	100 / 100			100 / 200											
1600					100 / 300											
8 HR	480	100			200				16 HR.	500					16 HR.	
1700	80 / 560	100 / 100			240 / 240											
1800	80 / 640									500 / 500						
1900	80 / 720	100 / 200			100 / 340											
2000	80 / 800									125 / 625						
2100	80 / 880	100 / 300			~~100~~ / 440					150 / 775						
2200	80 / 960									150 / 925						
2300	80 / 1040															
2400	80 / 1120															
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
29Aug03	04		Pt sleeping, easily arousable. Ø complaints @
			this time. Encouraged a position change. done
			ō assist. Assessment complete pt Back to sleep (b)(6)-2
	0530		Pt request med for Ⓛ arm pain. MSO4 IV
			given. Reminded of NPO status. Given H_2O to
			rinse mouth and spit. Complete cooperation.
			Assistance given to move up in bed. (b)(6)-2
	0800		recieved pt this AM; NAD; VSS; pt. NPO for
			surgery; will cont. to monitor (b)(6)-2
	1025		pt. returned from surgery; NAD; VSS; will cont
			to monitor (b)(6)-2
	1230		Tmax 103.7; (b)(6)-2 informed; 650mg Tylenol
			given; will cont. to monitor (b)(6)-2
		1410	Pt T - 102.1. IS and CDB done. Pt
			uncovered, and cooling measures initiated.
			Assessment completed. Ō A+O x 3. Breath sounds
			CTA ē diminished bases bilaterally. ~~Moderate~~
			Minimal drainage from operative site
			noted at this time. ↓ Bowel sounds x 4
			Good po fluid intake. Non tender to
			palpation. Will continue to monitor - J Flem[illegible]
		1650	Occulsion noted from IJ. Attempts to
			flush unsuccessful. (b)(6)-2 notified
			O_2 Sat 95% on RA. (b)(6)-2 RN
29Aug03		2210	pt received 650 mg Tylenol prn pain (b)(6)-2
		2220	Assessment complete LR @ 80cc/hr to Ⓡ IJ, patent
			& intact, b/p cuff to Ⓡ arm, PSO2 monitor to
			Ⓛ earlobe, Ⓛ Amp LE Elevated pt responds to
			commands, opens eyes spontaneously, interpreter
			@ BS, no @ BS TD [illegible] to Ⓡ wrist Ⓡ
			ankle guaze wrap ē small amount of yellow
			fluid drainage to toes, Ⓛ LE elevated, calf

(b)(3)-1

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	4

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 91WM6	(b)(6)-2
(b)(6)-2 SPC 91WM6	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On		(b)(6)-	
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title): (b)(6)-2 91WM6

Department/Service/Clinic: ICU-2

DATE: 30 Aug 03

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

Potus (b)(6)-4 (EPW)

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2															2	
	L				UTA				UTA															UTA	
	DORSALIS PEDIS R				UTA				UTA															UTA	
	L				UTA				UTA															UTA	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1 3 8				1 3 8															1 3 8	
EDEMA					—				✓															X	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				✓															✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					NST				✓															NST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST				✓				✓															✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓																			✓	
	HOB 30 DEGREES								✓															✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)					—																			X	
PAIN	PAIN FREE				✓				✓															✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				1				1															1	
BOWEL SOUNDS (active all quads)					x4				X4															x4	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT					✓				✓															✓	
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown				✓																			✓	
	Surgical Wounds								✓															✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE Ex fix					✓				✓															✓	
#2 (R) LE					✓				✓															✓	
#3 (R) ankle					✓				✓															✓	

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	27Aug03	Intact
foley	GROIN	25Aug03	patent

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present	✓
Not Applicable /Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	--

DATE: 30 Aug 03

	TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4				4						4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5				5						5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6				6						6									6	
GLASCOW COMA SCALE (A+B+C)					15				15						15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				4				4						4									4	
	LUE				AMP				AMP						Amp									AMP	
	RLE				3				3						3									3	
	LLE				2				2						2									2	
GRIP (S) Strong (W) Weak (-) absent	R				W				W						W									W	
	L				✓				AMP						Amp									AMP	
RESPIRATIONS	REGULAR				✓				✓						✓										
	IRREGULAR																								
	UNLABORED				✓				✓						✓									✓	
	LABORED																								
	SHALLOW																							✓	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				—				5						5									3	
	LUL				—				5						5									3	
	RLL				—				1						1									1	
	LLL				—				1						1									1	
	BOTH BASES				✓				✓						1/1									✓	
COUGH	NONE				✓				✓															✓	
	SPONTANEOUS														✓										
	PRODUCTIVE																								
	NONPRODUCTIVE														✓										
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt				RA				RA						RA									RA	
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								[illegible]
	FM (l/min)																								
ETT #______	NRBM (l/min)																								
	ETT ______ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓										
COUGH / DEEP BREATH					✓				✓						✓										
INITIALS					(b)(6)-2																				

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	100^{4}	70	20	121/74	91%												
0700																	
0800																	
0900																	
1000	102^{5} (A)	161	18	126/78	91%												
1100																	
1200																	
1300																	
1400	101.9	118	24	116/56	93%												RA
1500																	
1600	100.9																
1700	100.4																
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2320	100^{9}	117	20	128/72	90%		91										RA/NAO
2400																	

	INTAKE									OUTPUT						
	LR	PO	IVPB						Total	Urine	BM				Total	COMMENTS
0100	80 / 80															
0200	80 / 160															
0300	80 / 240															
0400	80 / 320	100 / 100														
0500	80 / 400		50 / 50							975 / 975						
0600	80 / 480		100 / 150													
0700	80 / 560															
0800	80 / 640									400 / 1375						
8 HR	640		150						8 HR. 790	1375					8 HR 1375	
0900	80 / 80															
1000	80 / 160	120 / 120														
1100	80 / 240															
1200	80 / 320	120 / 240														
1300	80 / 400	240 / 480														
1400	80 / 480	100 / 580	100 / 100							650 / 650						
1500	80 / 560	100 / 680	100 / 200							100 / 750						
1600	80 / 640	100 / 780	100 / 300							125 / 875						
8 HR	640	780	300						16 HR.	875					16 HR.	
1700	80 / 80	240 / 240								100 / 100						
1800	80 / 160		100 / 100							125 / 225						
1900	80 / 240		100 / 200													
2000	80 / 320															
2100	80 / 400															
2200	80 / 480									700 / 925						
2300	80 / 560															
2400	80 / 640		50 / 250													
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
8/30/03	A.M.	P.M.	
0600			received pt this AM; NAD; VSS; will cont to monitor (b)(6)-2
		1400	Pt received in bed. Moderate drainage
			noted from (L) leg. (L) Amputation of R
			extremities CDI. Lung sounds CTA c̄ diminished
			bases. Abdomen grossly distended, minimal
			bowel sounds. IS q 1°. IS TLC CDI
			∅ S/S of infection noted. NST. Will
			continue monitor. (b)(6)-2
		1645	Pt remedicated c̄ 4mg MSO4 to get OOB
			Drainage from operative site, still moderate
			Will continue to monitor (b)(6)-2
		1730	Pt medicated c̄ ii Tylox for pain.
			Dr (b)(6)-2 notified of Abdominal distention
			Pt Per Dr (b)(6)-2 ∅ Solid foods. Will
			continue to monitor (b)(6)-2
Aug 30 03		2330	pt put on supplemental O2 via NC @ 4L d/t
			PSO2 @ 90% current PSO2 93% (b)(6)-2
		2335	assessment complete (L) LE ace wrapped c/p
			CDI, (R) IJ CL CDI, patent (R) LE non-pitting
			edema ∅ c/o numbness cap refill <3sec MPC
			BS (L) LE stitches OTA CDI, lacerations from
			thigh to ankle (R) foot edematous, cap refill <3sec
			sluggish. lacerations to (R) LE, pt moves
			extremities x4, abd rounded, distended, LS
			Rhonchi upper lobes, diminished lower lobes
			pt resting supine c̄ HOB elevated 30 degrees
			PSO2 probe on ~~R&~~ Error (R) hand c̄ constant supervision, 80cc/hr LR infusing into CL (R) IJ (b)(6)-2
		2345	administered Tylenol for elevated temp 100.9
			will reassess temperature (b)(6)-2
		0025	Began blood administration (b)(6)-2
Aug 31, 03	0310		Assessment complete B/p cuff on (R) Arm

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	31 Aug 03.
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

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

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN.	ICU #1	31 Aug 03

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

Tofus # (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

Assessment		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R																2						2		
	RADIAL L																2						2		
	DORSALIS PEDIS R																1						1		
	DORSALIS PEDIS L																1						1		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale																	1/3/8						1 3 8		
EDEMA																	+1						1		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)																									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																p								
	ORAL CARE																e r								
MOBILITY	BEDREST																								
	BSC																A M								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																✓								
FALLS PROTOCOL INITIATED																							✓		
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																0/10						[illegible]/10		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended																1						1		
BOWEL SOUNDS (active all quads)																									
NG / DOBHOFF PLACEMENT VERIFIED																	*						*		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																	✓								
VOIDING CLEAR, YELLOW URINE q.s.																	✓								
SKIN INTEGRITY	No Breakdown																								
	~~Surgical Wounds~~																*						*		
	Rashes, Lac's, etc																*								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									
																	(b)(6)						(b)(6)-2		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(R) IJ	(R) IJ	27 Aug 03	c/d/i -

PUPIL SIZE	PUPILS		MOTOR FUNCTION
1 mm	=	Equal	0 = No Movement
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)
			3 = Active: against gravity, but not against resistance
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength
			5 = Full Strength against Examiners Resistance
5 mm	R > L	Right Larger	

CHART CODES	
Present	✓
Not Applicable /Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	--

DATE: 27 Aug 03

	TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				4			4																		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				5			5																		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				6			6																		
GLASCOW COMA SCALE (A+B+C)				15			15																		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R						—																		
	L						—																		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE			3			4																		
	LUE			UTA			—																		
	RLE			3			3																		
	LLE			3			3																		
GRIP (S) Strong (W) Weak (-) absent	R			3			5																		
	L			UTA			—																		
RESPIRATIONS	REGULAR						✓																		
	IRREGULAR																								
	UNLABORED			✓			✓																		
	LABORED																								
	SHALLOW			✓																					
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL			3			5																		
	LUL			3			5																		
	RLL			1			1																		
	LLL			1			1																		
	BOTH BASES			✓			1																		
COUGH	NONE			✓			✓																		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)			4L			1																		
	FM (l/min)																								
ETT #______	NRBM (l/min)						--																		
	ETT ______ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2																						

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0110	100^{2}	~~80~~ 114	20	129/66	94%		90										4LNC/NAD
0200																	
0240	99^{2}	111	20	124/71	94%		92										4LNC
0300																	
0340	99^{2}	109	20	129/78	95%		92										RA
0400																	
0440	99^{6}	107	18	126/75	97%		91										RA/MSO4
0500																	
0505	98^{5}	109	18	129/82	97%		100										
0600		109	20	132/81													RA/NAD
0700	100	105	18	121/78			97%	RA									
0800	99^{5}	105	18	129/78													2nd U PRBC complete
0900																	
1000																	
1100																	
1200	101^{9}																Tylenol
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	RBC	LR	PO	IVPB					Total	URINE	BM				Total	COMMENTS
0100										325 / 325						
0200																
0300										200 / 525						
0400	400 / 400		100 / 100							150 / 675						
0500		80 / 80								1100 / 1775						
0600		80 / 160	50 / 150							550 / 2325						
0700		80 / 240								200 / 2525						
0800	400 / 800	80 / 320								50 / 2575						
8 HR	800	320	150						8 HR. 1270	2575					8 HR 2575	
0900	80		50													
1000	80 / 160															
1100	80 / 240															
1200	80 / 320															
1300	80 / 400									950 / 950						
1400	80 / 480															
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
31Aug03	0310		(continued) PSO_2 monitor on (R) hand PRBC transfusion continuing into (R) IJ CL, pt continues to place pressure on line, MCC BS abd causing pt discomfort but pt denies pain to that area, UO remains adequate —— (b)(6)-2
	0330		pt's efforts to stop flow of blood has dislodged IV. IV was removed, client currently sats c 97% CRA will continue to monitor —— (b)(6)-2
31Aug03	0425		First unit of RBCs administered —— (b)(6)-2
	0455		Initiated 2nd Unit PRBC Unit # 55 T20133. See separate progress note for vitals. Pt remains alert and request H_2O. H_2O given to rinse and spit. NPO status effective. Blood infusing s̄ difficulty. Ø reaction observed in 1st 15 minutes. Will continue to monitor c̄ LOS care. —— (b)(6)-2
31aug03	0600hrs		Report received, assumed care of pt. #2 u PRBC's infusing into (R) IJ TLC. See flowsheet for details of assessment. Pt using incentive spirometer. Abd cont distended, mildly firm + tympanic to palpation. BS x4, tinkling and high pitched in all 4 quads. (L) LE incision open to air, sutures intact ø drainage noted. —— (b)(6)-2
		0800hrs	2nd u PRBCs completed. Pt medicated c̄ Tylox Ti po for to get OOB. —— (b)(6)-2
		1000hrs	Pt back to bed, up in chair x1 hr. Dulcolax suppository given per Dr (b)(6)-2 Pt placed on bedpan. Repeat labs done. —— (b)(6)-2
		1245hrs	Pt requested bedpan. Sm amt smearing of stool ø BM. (R) IJ TLC continues very positional, o/w infusing/media/fast (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 91W M2	(b)(6)-2
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 91W M2

Department/Service/Clinic ICU-2

DATE 31 Aug 03

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

Potus (b)(6)-4 EPW

☐ HISTORY PHYSICAL
☐ FLOWCHART
☐ OTHER EXAMINATION Or EVALUATION
☒ OTHER (*Specify*) PROGRESS NOTES
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700
1 MAY 78

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 91WM2	(b)(6)-2
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 91WM2

Department/Service/Clinic ICU-2

DATE 31 Aug 03

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

POTUS (b)(6)-4 EPW

☐ HISTORY PHYSICAL
☐ FLOWCHART
☐ OTHER EXAMINATION Or EVALUATION
☒ OTHER (Specify) PROGRESS NOTES
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700
1 MAY 78

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600	101.5	90	18	125/74													
1700																	
1800	100.8																
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present	✓
Not Applicable /Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	--

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open																	4						4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response																	5						5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response																	6						6		
GLASCOW COMA SCALE (A+B+C)																	15						15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																4								
	L																+								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE																5						5		
	LUE																0						2		
	RLE																3						3		
	LLE																3						3		
GRIP (S) Strong (W) Weak (-) absent	R																S-						S		
	L																-								
RESPIRATIONS	REGULAR																						S		
	IRREGULAR																S								
	UNLABORED																						S		
	LABORED																S								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL																						5		
	LUL																5						5		
	RLL																5						4		
	LLL																4						4		
	BOTH BASES																5						7		
COUGH	NONE																						✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #______	NRBM (l/min)																								
	ETT ______cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																	(b)(6)-2								

	INTAKE									OUTPUT						
	iV	ivPB							Total						Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700		260 / 250														
1800		725 / 500								350					Foley o/c'd	
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

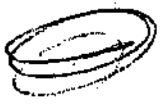
MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
31 Aug 03		1530	Pt arrived/assisted transport from icu #2. [illegible] febrile @ 101.5 - previously given tylenol. Will re-assess later, promote IS use. Dressing intact - c̄ (R) weeping (R) thigh. (b)(6)-2 [illegible]
		1730	Pt [illegible] - used BSC - (R) [illegible] stool - approx 100cc. Ast CXR per order - temp re-check @ 100.8. Interpreter called several times to explain NPO status. Pain med - Ty/oc x2 for c/o leg pain (L) LE. Positioned for comfort. Cont monitor. (b)(6)-2 [illegible]
31AUG03		2100	IJ d/c'd following KCL INFUSION. Stitches removed / pressure applied for 5 min. OPSITE IN PLACE OVER 2x2 - ⊖ drng noted @ this time (b)(6)-2
		2150	Assumed care of pt, Dsg Δ performed pt tolerated well. Redressed per order.
		2230	Pt c̄ c/o pain to LLE. Δ Clin [illegible] orders given, pt medicated per orders will monitor for effect. (b)(6)-2
		2300	Assessment per flow sheet. (R) [illegible] c̄ [illegible] and 2x2 dsg D&I, abd distended hypoactive bowel sounds x4 quads absent LUQ, most active RLQ. [illegible] to perineum LLE ace wrap D&I ⊘ drainage noted LLE Dsg D&I small amt of drainage noted posterior lateral portion. (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	~~1 Sep~~ 25Aug03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	



NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 CPT/AN	
(b)(6)-2 LPN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		
Call Light Within Reach	NA	(b)(6)-2	
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED (b)(6)-2 and Title) RN

Department/Service/Clinic Ker 1

DATE 1 Sep 03

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

Potus (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

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

☐ DIAGNOSTIC STUDIES 9VI

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full	RADIAL R							2							[illegible]										
(2) Normal	RADIAL L							[illegible]							NA										
(1) Faint	DORSALIS PEDIS R							2							2										
(0) Absent	DORSALIS PEDIS L							2							2										
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale								1 3 8							1 3 8										
EDEMA								+1							+1										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								✓							✓										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE							✓																	
MOBILITY	BEDREST							✓							✓										
	BSC																								
	DANGLE																								
	CHAIR							✓																	
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓							✓										
	HOB 30 DEGREES							✓							✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE														✓										
	PAIN SCALE (1-10)							Y/[illegible]																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							2							1										
BOWEL SOUNDS (active all quads)								+[illegible]							ND										
NG / DOBHOFF PLACEMENT VERIFIED															✓										
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds							✓							✓										
	Rashes, Lac's, etc														✓										
DRESSING (Dry & Intact; specify site below)																									
#1 Ⓛ thigh								Δ[illegible]							[illegible]										
#2 Ⓛ UE																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
IVP	Ⓡ Arm	~~1Sep03~~ 31Aug03	ØSS inf, CDI, patent
PIV	Ⓡ arm	31 Aug	Ø S/S of infection / infilt / trauma

MEDCOM - 1354

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES	
Present	✓
Not Applicable /Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	--

DATE:

	TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4							4										
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5							5 now										
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6							6										
GLASCOW COMA SCALE (A+B+C)								15							15										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							5							5										
	LUE							NA							NA										
	RLE							5							5										
	LLE							2							2										
GRIP (S) Strong (W) Weak (-) absent	R							S							S										
	L							NA							NA										
RESPIRATIONS	REGULAR							✓							✓										
	IRREGULAR																								
	UNLABORED							✓							✓										
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5							5										
	LUL							5							5										
	RLL							5							5										
	LLL							5							5										
	BOTH BASES							5							5										
COUGH	NONE							✓							✓										
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)														3										
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
	INITIALS							(b)(6)-2																	

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	102.8	129	21	113/64	93%												
0300																	
0330	101.1																
0400																	
0500																	
0600																	
0700																	
0800																	
0900	98.7° (O)																
0930		116	30	132/83	93%												
1000	101.6° (A)	~~108~~															
1100																	
1200																	
1300																	
1400																	
1500																	
1600	100.6 ax	130	32	123/74	94%	-on 1 l nC											Tylenol given
1700																	
1800	101.6 ax																
1900																	
	101.2																
2000	100.0	124	20	112/75	95%	2 L NC											
2100																	
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	IV (D5NS c 20K)	IV [crossed out]	LR						Total	Urine	NG				Total	COMMENTS
0100	100															
0200	100 / 200															
0300	100 / 300															
0400	100 / 400															
0500	100 / 500									360						
0600	100 / 600	50 / 50														
0700	100 / 700															
0800	100 / 800															
8 HR	800	50							8 HR IV ~~800~~ 0850						8 HR	
0900	100															
1000	100 / 200	50 / 50														
1100	100 / 300	100 / 150														
1200	100 / 400	50 / 200														
1300	to OR															
1400		~~200~~	~~200~~							300						
1500	100 / 500															
1600	100 / 600									375 / 675						
8 HR	600		700						16 HR. 1300	675					16 HR. ~~675~~ → 1035	
1700	100															
1800	100 / 100 / 200	50 / 50														
1900		100 / 150														
2000	100 / 300															
2100	100 / 400															
2200	100 / 500															
2300		150 / 300														
2400	100 / 600									350 / 250	250					
8 HR	600	300	~~700~~						24 HR 2100	350	250				24 HR 1635	

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
1 Sep 03	0100		Pt sleeping soundly. Resp even and unlabored, will continue to monitor (b)(6)-2
	0215		VSS as charted. Tylenol 650 given per order pt s distress. Ø change in assessment
	0400		Pt sleeping well, s complaint, RR-20 will continue to monitor (b)(6)-2
	0530		Pt voided QS, dark clear amber urine. Ø complaints or difficulty. (b)(6)-2
	0745		Dsg Ded to Ⓛ thigh pain meds adm., pt has BEA Ⓛ ace wrap to it. Exfix Ⓛ thigh will cont to monitor (b)(6)-2
	1100		@ 1030 NGT placed: Placement good, to LIS. pt O2 sat @ 88% order obtained for prn O2 3L NC. temp @ 101.6 °F. tylenol PR adm. will cont to monitor. (b)(6)-2
	1315		@ 1305 pt to OR (b)(6)-2
1 Sep 03	1400		Pt back from OR - Refer to PACU Sheets for details. (b)(6)-2
1 Sep 03		1830	Rec'd report and assumed care of Pt. VSS - Febrile @ 101⁶. Pt. rec'd anti-emetic @ 1640 - Monitor Temp. No c/o pain. NGT - LIS - Approx 600cc greenish drainage. PIV infusing s s/s complication. Dressings intact - Pt. resting s s/s of acute distress. Cont. monitor. (b)(6)-2
"		1940	T @ 101². Antiemetic due 2010 - Will recheck temp and administer (b)(6)-2
1 Sep 03			Pt Temp ↓ - 100° - interpreter on hand - no c/o pain - initially c/o hunger / thirst; however, declined swish + spit water due to NPO status. Will cont monitor. (b)(6)-2 encourage to use.
		2115	Physician in to Δ dressings. [illegible] - IV - Dry [illegible] shows Δ Pt tolerated well. Ⓛ thigh c [illegible] tissue - Ⓛ [illegible] edges. Will cont monitor. (b)(6)-2
		2200	Assumed care of pt. Ø distress noted SGT (b)(6)-2 will continue primary care. (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	1 Sep 03
POD	1

24 HOUR DATA	
24 Hour Balance	+ 465
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN.	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up	A	A	
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN.	ICU #1	2 Sep 03

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

Lotus # (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER (*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1359

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2				2		2									2	
	Brachial L				2				2				2		2									2	
	DORSALIS PEDIS R				1				2				2		2									2	
	L				1				2				2		2									2	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale					1/3/8				1 3 8				1 3 8		1 3 8									1 3 8	
EDEMA									LES 1+				LES 1+		1+									1+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				✓				✓		✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					ST				ST				ST		ST									ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE										✓														
	ORAL CARE				✓										✓										
MOBILITY	BEDREST								✓				✓		✓									✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓				✓				✓		✓									✓	
	HOB 30 DEGREES				✓				✓				✓		✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE				✓				✓				✓		✓										
	PAIN SCALE (1-10)																							✓	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				1				1				1		1									1	
BOWEL SOUNDS (active all quads)					*				Hypo x4				Hypo x4		LES									✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.					*																				
SKIN INTEGRITY	No Breakdown								✓				✓		✓									✓	
	Surgical Wounds				✓				✓				✓		✓									✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)									✓				✓												
#1 (L) Thigh									✓				✓		✓									✓	
#2 (L) Akm Amputation									✓				✓		✓									✓	
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(R) 4 ARM.	(R) 4 ARM.	31 Aug 03	S/D/I - Patent. 0700 [illegible] 1100
(L) arm 18 gA	"	31 AUG 03	D S/D of inf/infiltrate [illegible] 1107

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES	
1 mm	=	Equal	0 = No Movement	Present	✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	Not Applicable /Absent	(blank)
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)		
			3 = Active: against gravity, but not against resistance		
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes	X
			5 = Full Strength against Examiners Resistance		
5 mm	R > L	Right Larger		No Change from Previous Assessment	--

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4			4					4		4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5			5					5		5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6			6					6		6									6	
GLASCOW COMA SCALE (A+B+C)					15			15					15		15									5	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R				+										+										
	L				+										+										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				5			4					4		4									4	
	LUE				/			3					3		3									3	
	RLE				2			4					4		4									4	
	LLE				3			2					2		2									2	
GRIP (S) Strong (W) Weak (-) absent	R				S			S					S		S									S	
	L				/										—									—	
RESPIRATIONS	REGULAR				✓			✓					✓		✓									✓	
	IRREGULAR																								
	UNLABORED				✓			✓					✓		✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5			5					5		5									5	
	LUL				5			5					5		5									5	
	RLL				5			5/1					5/1		5									5	
	LLL				5			5/1					5/1		5									5	
	BOTH BASES							5/1 ✓					5/1		5									5	
COUGH	NONE				✓			✓					✓		✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							2L					2L		2L									ø	
	FM (l/min)																								
ETT #______	NRBM (l/min)																								
	ETT ______cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE								(b)(6)-2																	
COUGH / DEEP BREATH																									
INITIALS					(b)(6)-2																				

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	101^{4}																
0200																	
0300																	
0400	100^{5}	110	18	117/71	98% 3L												
0500																	
0600																	
0700	99^{7} (A)	107	26	109/67	95%												
0800																	
0900																	
1000																	
1100	102^{2} (A)	116	36	95/68	90%												
1105		114	28	114/69	95%												
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1830	100^{4}	102	26	123/72	95%												
1900																	
2000																	
2100																	
2140	100^{4}	109	30	114/6[illegible]	96%												
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	P.IV	IVPB	PO	PRBCs					Total	URINE	NGT				Total	COMMENTS
0100	100 / 100									550 / 550						
0200	100 / 200															
0300	100 / 300															
0400	100 / 400									400 / 950	100 / 100					
0500	100 / 500															
0600	100 / 600	50 / 50								300 / 1250	~~100~~ / ~~40~~					
0700	100 / 700															
0800	100 / 800	50 / 100														
8 HR	800	100							8 HR. 900	1250	100				8 HR 1350	75-450
0900	100 / 100															
1000	100 / 200	50 / 50								450 / 450						
1100	100 / 300															
1200	100 / 400	100 / 150														
1300	50 / 450			50 / 50						125 / 575						
1400	0 / 450			100 / 150							200 / 200					
1500	~~100~~ / 450			100 / 250						600 / 1175						
1600	~~100~~ / 650			50 / 300						500 / 1675						
8 HR	450	150		300					16 HR. 800	1675	200				16 HR. 1875	
1700	50 / 50									550 / 550						
1800	100 / 150									400 / 950						
1900	50 / 200	50 / 50														
2000	50 / 250	50 / 100								400 / 1350						
2100	100 / 350															
2200	100 / 450															
2300	100 / 550									250 / 1600						
2400	100 / 650	50 / 150														
8 HR	650	150							24 HR. 3600	1600					24 HR. 3475	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
2 Sep 03	0100		Pt sleeping s̄ s/s of acute distress. Has voided 550cc c/y urine. No c/o pain. No Δ in assessment. Dressing - w/o - (+) breakthrough drainage. Reinforced - Cont. Monitor. (b)(6)-2 LPN
	0140		TC 101.4 ∴ 650mg Tylenol PR per order. Monitor effect. (b)(6)-2 LPN
			Addition: Pt. turned toward (R) side to relieve pressure from backside - will attempt to reposition frequently. (b)(6)-2 LPN
	0400		Pt awake for void via urinal. No c/o pain - Temp ↓ to 100.3 - placed supine. NG - 100 mL drainage 04-04. Cont. monitor. Dressing reinforced c̄ combine. (b)(6)-2 LPN
9/2/03	0700		Linen Δ'd c̄ bed bath given. NAD noted. Continues to have clear to serous drainage from LLE. ⊖ c/o discomfort. Ex-Fix to LLE intact. ACE DRSG to LUE CD&I. VSS will continue to monitor. (b)(6)-2 1LT, AN
9/2/03	1100		DRSG Δ to LUE. Small amt of Sanguineous drainage. ⊖ odor(foul). Tissue dull pink color. ⊖ purulent discharge. NS Wet to dry DRSG reapplied. Pt tolerated procedure well (b)(6)-2 1LT, AN
9/2/03		1230	Began 1st unit of PRBC's. See SF 509 for IV Maintenance
2SEP03			IV stopped by Dr (b)(6)-2 until p̄ blood (b)(6)-2 1LT, AN
2SEP03		1830	2d unit of PRBC complete. IV site changed to (R) hand 18GA due to pt c/o pain @ prior site. Pt resting comfortably @ this time. (b)(6)-2 [illegible]
		2200	Assumed care of pt, assessment per flowsheet
		2230	pt c̄ c/o continued pain. Medicated ⊖ relief for c/o pain, Discussed c̄ Dr (b)(6)-2 1x order given. (b)(6)-2
		2300	Pt medicated, repositioned, will monitor for effect (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	1 SEP 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

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

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature & Title)	Department/Service/Clinic	DATE
(b)(6)-2 RN	ICU 1	3 Sep 03

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

Potus (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1365

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2			2				2									2	
	BRACHIAL L							2			2				2									2	
	DORSALIS PEDIS R							2			2				2									2	
	L							2			2				2									2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale (10) HOT								1 8 10			1 8 10				1 8 10									1 3 8	
EDEMA							LE's	1+			1+				+1									+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓			✓				✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST			ST				ST									ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)										✓															
HYGIENE	BED BATH	✓																							
	FOLEY CARE																								
	ORAL CARE	✓																							
MOBILITY	BEDREST							✓			✓														
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE										✓				✓										
	HOB 30 DEGREES			✓				✓			✓				✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE							✓			✓				✓										
	PAIN SCALE (1-10)			✓																					
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							1 soft			1 soft				1 soft									1	
BOWEL SOUNDS (active all quads)								HYPO			Hypo				HYPO									X	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								✓			✓				✓									✓	
SKIN INTEGRITY	No Breakdown							✓			✓				✓									✓	
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)								✓			SS ✓				✓									✓	
#1 LUE								SS																✓	
#2 LLE											SS				SS										
#3															(b)(6)-2										

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) Hand	2Sep03 0700/03g	patent, ø erythema, edema, phlebitis
16g	LEJ	2Sep03 1430 2SEP03 (b)(6)-2	Patent ō s/sx of infection or infiltration " " "

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Code	Mark
Present	✓
Not Applicable /Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	–

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4			4				4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5			5				5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6			6				6									6	
GLASCOW COMA SCALE (A+B+C)								15			15				15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R														+2										
	L														+2										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							4			4				4									4	
	LUE							3			3				3									3	
	RLE							4			4				4									4	
	LLE							2			2				2									2	
GRIP (S) Strong (W) Weak (-) absent	R							S			S				S									S	
	L							N/A			N/A				N/A									–	
RESPIRATIONS	REGULAR							✓			✓				✓									✓	
	IRREGULAR																								
	UNLABORED							✓			✓				✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5			5				5									5	
	LUL							5			5				5									5	
	RLL							5/1			5/1				5/1									5	
	LLL							5/1			5/1				5/1									5	
	BOTH BASES							5/1			5/1				5/1									5	
COUGH	NONE							✓			✓				✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							3L			5L				5L									2L	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																									

(b)(6)-2

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	102.6	117	22	117/70	94												
0600																	
0700	102.7 (A)	114	32	117/70	95												
0800	102.4 (A)																
0900	OR →																
1000	100.1 (A)	112	16	119/78	91%												
1100																	
1200	101.5 (A)	114	16	117/71	92%												
1300		111	15	117/72	93%												
1400	101.9 (A)	109	18	121/88	100%												
1500																	
1600	101.9 (A)	111	18	116/71	97%												
1700	101.5 (A)																
1800	100.6	107	18	120/72	97%												
1900																	
2000	99.5	101	15	111/70	94%												
2100																	
2200																	
2300	100.7	101	18		97												
2400																	

	INTAKE									OUTPUT						
	D5NS c KCl	IVPB	LR						Total	Urine	Stool	NG			Total	COMMENTS
0100	100/100															
0200	100/100	50/50								200/200						
0300	50/250															
0400	100/350									250/450						
0500	100/450									220/690						
0600	100/550											100/100				
0700	100/650	50/100								200/~~200~~ 890						
0800	100/750															
8 HR	750	100							8 HR. 850	890		100			8 HR 990	−140
0900	100/100	50/50														
1000	OR —		800/800													
1100	100/200	50/100														
1200	100/300	250/350														
1300	100/400	50/400														
1400	100/500											50/50				
1500	100/600															
1600	50/650	50/400								500/500						
8 HR	650	400	800						16 HR. ~~1900~~ 2750	1390		50			16 HR. 2430	
1700	100/100															
1800	[illegible]/100	100/100								500						
1900	100/200															
2000	100/300															
2100	100/400															
2200	100/500															
2300	100/600															
2400	50/650	50/150														
8 HR									24 HR.						24 HR	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
3 Sep 03 ~~0045~~	0045		Pt linen changed, washed pt after scant liquid stool, no substance in stool
			allowed pt to swish & spit. Tolerated
			entirety of procedure well. (b)(6)-2
	0310		Pt c/o pain, unable to get clear numeric
			rating ~~through~~ through interpreter. Repositioned
			for comfort at present. (b)(6)-2
	0500		Pt sitting in high fowlers. Reg repositioned. Labs
			drawn. will monitor. (b)(6)-2
	0530		Medicated for T (O) & A. Linen changed
			tolerated well. (b)(6)-2
3 Sep 03	0700		Portable KUB done. NAD ⊝ c/o discomfort. VSS
			Tem 102.7 Will Continue to monitor (b)(6)-2
3 Sep 03	0850		TO OR VIA Litter. NAD noted. (b)(6)-2
3 Sep 03	1000		RTD from or see CC flowsheets PACU flowsheet (b)(6)-2
3 Sep 03		1225	Medicated c Tylenol 650 mg PR for temp (b)(6)-2
3 SEP 03		1500	Pt moved back to bed tolerated transfer well
			Resting quietly @ this time (b)(6)-2
"		1600	Pt medicated c 1gm Tylenol as per MD. Temp (b)(6)-
"		2130	MD to D drsg. V→D drsg c wound packing replaced.
			Pt tolerated procedure well (b)(6)-2
		2200	Assumed care of pt, ⊝ distress, repositioned
			for comfort. (b)(6)-2
		2300	Assessment per flowsheet, Ⓛ EJ site s̄ s/s
			of infiltration, Replaced to Ⓡ hand patent
			also s̄ s/s of infiltration. abd remains
			distended c hypoactive bowel sounds. NGT
			retaped. Placement verified via aspiration
			and auscultation. (b)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

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

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

(detainee)

(b)(3)-1

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER (b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 29 Aug 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

war wounds

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

1) open (R) Thumb P1 fx & mc fx 817.1 ICD9.02
2) open (R) Tibia fx 823.90 ICD9.02
3) multiple (L) & (R) LE open wounds c̄ retained Shrapnel E991.9 ICD9.02
4) open (L) knee 891.0 ICD9.02
5) (R) Thumb ECL/ac (R) foot EHL/ac
6) I&D wounds / openarthrotomy (L) knee
7) Pinning (R) Thumb / (L) 2nd mc
8) Ex Fix (R) Tibia

☐ CHECK IF CONTINUED ON REVERSE

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

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2

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

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Iraqi male now 48 hours out from fight c̄ apache Helicopter Txled @ Iraqi hospital. Referred c̄ multiple wounds Ⓛ&Ⓡ LE ⓇUE. Radiographs reveal open Ⓡ Tibia fx, open Ⓡ Thumb MCPJ c̄ fx's P1/MC, and soft tissue defect Ⓡ calf c̄ ? fx Ⓛ Tibial ~~[illegible]~~ plateau

PMH — PSH — meds

PHYSICAL EXAMINATION

(PE) open Ⓡ Thumb @ MCPJ
open Ⓡ Tibia fx
open wounds Ⓛ&Ⓡ LE's

Ⓐ:

PROGRESS (Enter date of discharge and final diagnosis)

Ⓟ ① I&D extremity wounds
② Pinning Ⓡ Thumb MCP P1/MC fx
③ Ex-Fix Ⓡ Tibia
④ Remove Shrapnel

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
(b)(6)-2 MD	7/20/03		

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

Iraqi (b)(6)-4

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8
OCTOBER 1975 539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	op-note
	Pre-op Dx: (1) open (R) Tibia fx
	(2) open (L) knee
	(3) open (L) foot and MT fx
	(4) open (R) Thumb proximal phalanx
	(b)(6)-2
	(5) (R) foot EHL lac
	(6) (R) Thumb EPL lac
	(7) multiple (L)+(R) LE & (R) UE wounds
	Procedure: (1) I&D all wounds
	(2) open arthrotomy (L) knee
	(3) Ex-Fix (R) Tibia
	(4) Pinning (L) foot and MT fx
	(5) Pinning (R) Thumb MC / proximal phalanx
	(b)(6)-2
	GEA
	EBL low Ø comp
	(b)(6)-2
	To RR in stable cond
	(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.

Iraqi (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

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
	Op-note
7/28/03	
	Pre-op Dx: / open (R) Tibia fx c̄ EHL lac
	Post-op Dx / open (R) Thumb fx c̄ EPL lac
	open (L) Knee
	Procedure: I&D (L) + (R) LE + (R) UE
	Repair EPL,
	wound closures / Adjust Ex
	[illegible]
	EBL min
	TT 0
	to PACU [illegible]
	(b)(6)-2
	MD
30 July 03	Preop/Postop Dx: open (R) thumb fx c̄ EPL lac
	open (L) foot 2nd MT fx
	Procedure: (R) AICBG to (R) thumb and (L) foot
	I&D (B) LE; skin flap (R) hand
	wound closure,
	(b)(6)-2, (b)(6)-2, (b)(6)-2 anesthesia (b)(6)-2 (b)(6)-2
	EBL 100cc Fluids 800cc UOP NM ⊘ foley (b)(6)-2
	⊘ complications to PACU c̄ SV, VS WNL

(Continue on reverse side)

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

Iraqi # (b)(6)-4

REGISTER NO. (b)(6)-2 WARD NO. (b)(6)-2

PROGRESS NOTES

Medical Record

MEDCOM - 1374

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
2003	ortho note
31 Jul	POD #1 s/p Ⓡ A/CBG to R/ hand, L/ ft.. Adx: Ancef.
2030 S)	pt seems to be doing better c̄ less narcotic requirement IV. motrin and tylox -
	rects well. PO intake OK but not full meals. c/o pain Ⓛ leg
O)	Tm 100.2 at 1400 ↓d to 99.5 c̄ IS. P= 80's - 105 BP WNL
	Resting quietly.
	Earlier in day, Ⓡ hand dressing removed - viable skin flap, no necrotic or dusky
	edges. Good position of digits ∅ s/sx infex. Ⓛ Foot good alignment and
	all incisions/lacs c/d/i s̄ s/sx infex. splint placed on foot/leg.
	Ⓡ tib ex fix in good alignment s̄ s/sx infex at pin sites - tissue
	healthy. Hip dressing intact/dry CV RRR lungs CTAB Abd soft NTND
	plain films reveal good alignment of bone grafts to Ⓡ thumb; Ⓛ 2nd MT
	good position of ex fix.
A)	s/p Ⓡ A/CBG to Ⓡ thumb and Ⓛ Foot in addition to ex fix -
	multiple lacs, tendon repair since 26 July. Doing well s̄ s/sx of
	infection and continued viability of hand skin flap.
P)	continue present mgt c̄ newly placed splint Ⓛ LE, dressing
	changes, wound care. will encourage IS, po intake
	↑ OOB.
	(b)(6)-2
	(b)(6)-2 LTZ DDS w/

(Continue on reverse side)

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

Iraqi (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
2003	
3 aug	Ortho note
	POD #4 s/p (R) ATCA to (R) hand / (L) foot c̄ skin flaps
	no major complaints x̄ some paresthesia of (L) toes (2nd, great) x 2 days
	Family food brought in and using incentive spirometry and
	supplementary diet c̄ Ensure. Has been OOB more the last
	few days. wounds cleaned / dressed bid
	AF VS WNL
	A/O bright, enthusiastic moving well.
	all abrasions / lacs are healing well c̄ clean margins, good
	granulation, gd suture approximation. Skin flap viable
	on (R) hand (R) hip harvest site c̄ intact sterostrips
	ø hematoma, seroma
	(L) great toe can feel pressure, pinching, moderate touch
	(L) 2nd toe not feeling pinch / light touch
	(L) LE in cast
	Assessment / Healing well p̄ major trauma to (R) UE (hand), (R) LE c̄
	(R) LE exfix, (R) hand skin flap, bone graft to thumb, (L) foot
	bone graft, tendon repairs - No s/sx infex small area
	of (L) toe paresthesias. granulating skin flap donor site -
	tendon areas s̄ epithelial covering
	Plan cpm, cont. to dress wounds
	Plan suture removal and anticipate skin grafts
	(b)(6)-2
	(b)(6)-2 [signature]

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

x Aug 03 Nurses report one watery - loose BM yesterday
1100 x another this a.m. (b)(6)-2

Lieutenant (b)(6)-2 Corps
Chief, Department of Medicine

2003 ortho op Note
5aug preop/postop Dx: (R) LE ex fix, tendon repair
(R) hand bonegraft, skin flap potential infection / wound edge dehiscence; macerated tissue

Operation: (R) hand skin flap modification, debridement, repair
(R) LE debride / irrigate

(b)(6)-2 / (b)(6)-2 / (b)(6)-2 EBL min Fluids: see anesthes

Findings: good granulation (c) (R) hand donor site. No purulence around bonegraft / cortical + cancellous grafts intact. Debrided wound edges. 3.0 nylon to reapproximate - good reapproximation

Dressed c xeroforms, fluffs, Kerlix
Tolerated well. Extubated c difficulty TO PACU / ICU c SV usual
1g IVPB Ancef

(b)(6)-2

(b)(6)-2

6Aug03 0800: T=98', P=76 R=16, BP=115/50, sat=98. PT refuses breakfast - will offer Ensure in 1-2 hrs. Denies pain - c/o ace wrap (R) LE tight - re-wrapped &

(Continue on reverse side) (b)(6)-2

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

Iraqi (b)(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 1377

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
6 AUG 03 0800	cont informed dressing Δ. PT states ℓ leg feels better now. Pulses good (DP) b/l. VSS. Will defer Ⓡ hand dressing Δ to physicians since this is the first dressing Δ since surg yest. (b)(6)-2
6 AUG 03	1000 - (b)(6)-2 did Ⓡ hand dressing Δ — will use Xeroform dressing to graft site, dry gauze between thumb + 1st finger - then Kerlix wrap.
(b)(6)-2	Pt drank 1 can Ensure + ate 2 cookies. (b)(6)-2
06 Aug 03	Assumed care of dressing. VSS - afebrile No % pain. Cont monitor. — (b)(6)-2 LPN —
2003	surgery note
6 Aug 03	s/p multiple ortho procedures, exfix, modify skin flap.
	Pt still picky ē eating - will do Ensure and family bringing food.
	VS WNL AF
	Removed Ⓡ hand dressing - macerated web space, ∅ necrosis or dehiscence - bone graft covered. (+) sensation to digits (IF slightly less light touch)
	Dressing Δ ē xeroform, dry gauze, kerlix b/d (done ē Lt Chevron)
	Ⓡ LE ex fix intact, pins ŝ s/sx infex. Ⓛ LE 2nd digit ↓'d sensation c/w initial injury (also where bone graft placed b/o injury) Cast OK fit, NV intact. ∅ s/sx infex. Hip Axle intact. Sensation intact.
	A) Pt doing well - Ⓡ hand flap revision vital. web space macerated pending skin grafts for tendon covering
	P) Continue wound care. wed d/c w→d to avoid maceration will continue to observe for dehiscence/wound breakdown anticipate skin graft before d/c (b)(6)-2 (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

509–113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
6 Aug 03 @ 1200	Pt refused lunch initially, however, requested food ̄p thrown away. Provided soup + MRE - refused. ½ can ensure consumed - interpreter and physician discussed nutrition. Mon for effect of teaching (b)(6)-2
6 Aug 03 1715	Pt consumed approx 95% of evening meal without incident or difficulty. Vg. Dyo 400 cc clear yellow urine. Resting comfortably @ this time. SSG (b)(6)-2
6 Aug 03 1800	PT c/o pain to (L) LE. Administered #T Tylox. Will [illegible] effectiveness. SSG (b)(6)-2 LPN.
6 Aug 03 2000	Assessment completed VSS. 113/54 T. 99' R16 P87 Pox 96% RA. Zantac given. Dressing changes to (R) LE & (R) Hand completed. Tolerated well. Resting @ this time. Will continue to monitor. SSG (b)(6)-2 LPN
6 Aug 03 @ 2200.	Rcd report and assumed care of Pt. VSS - afebrile. No c/o pain @ this time. Dressings c/d/i; SL - (L) forearm flushed ̄c NS - patent: s/c c/d/i. ~ PV d/c'd 2° 3d placement. 20ga SL initiated (L) forearm - patent - c/d/i. Interpreter called - Pt. c/o slight numbness (L) LE. Physicians aware - cont. mon. for. Currently eating food brought in by interpreter. Cont mon. (b)(6)-2
6 Aug 03 2300 121/56 - 85 99' - 16	Pt. ̄c Abx therapy infusing ̄s s/s of complication. Consumed a "meals worth" of food provided by interpreter ~ vegetables/breads. (b)(6)-2
@ 0025	Pt c/o pain @ achilles area - (R) LE. Dressing removed, wet/dry A'd and gauze and kerlix wrap reduced in order to prevent pressure. Interpreter assisted ̄c communication. Cont. month (b)(6)-2
@ 0400	No d's - Pt has been sleeping ̄s s/s of acute distress. (b)(6)-2
7 Aug 03 0700	Assumed care of pt. Vital signs: BP 113/62 HR 89 Temp 98.7 Pulse ox 94% Resp 14. Assessment complete, brisk cap refill on upper extremities, popliteal pulses normal, cap

(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.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

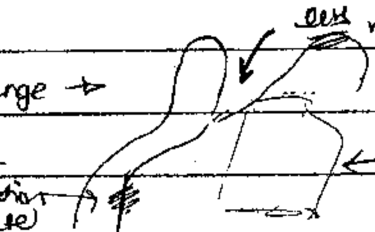
PROGRESS NOTES

DATE	
	refill on lower extremities brisk. Pt complaining of pain
cont.	under cast on LLE. Motrin 800mg PO given AS ordered.
7 AUG 03	Dressings on extremities C,D & I. Pt complaining on
	pressure/throbbing in (L) FA IV site. Site WAS
	patent and without sign of infiltration. Heploc WAS
	flushed. Lung sounds clear, S1 and S2, bowel sounds
	active. Asked doctor if Heploc can be DC'd and pt
	put on PO Antibiotics - denied. Will place a new
	Heploc site on (L) FA, due to pt discomfort and ancef
	running very slowly in current heploc. SPC (b)(6)-2
7 AUG 03 1251	Assisted Dr. (b)(6)-2 in removing LLE cast and
	some of the patient's stitches from wounds on LLE and
	(R) shoulder. Dr. will remove remaining stitches at a
	later date. ——— SPC (b)(6)-2
7AUG03 1430	Pt assessed @ this time. Wounds on upper body healing well.
	Lungs CTA bilaterally, BS x 4, HS - S1/S2, Pt drsgs on RUE, LLE,
	RLE C/D/I. RLE Drsg to be Δ'd by nursing staff. (b)(6)-2
	VSS - BP 107/69, HR 99, T-99.4, R-16, O_2 sat - 95%
7AUG03 2030	Drsg Δ to RLE completed. Wound looks red and beefy c̄
	minimal exudate present. Pt tolerated W→D Δ well.
	However, had 2 tylox prior for complaints of pain in
	LLE. MD aware ——— (b)(6)-2
7Aug03	VS are as follows: HR: 99 RR: 16 B/P: 103/52 Temp: 98.7 O_2 Sat: 95%
	Pt assessment as follows. Pt is A+Ox3 PERRLA (L) hand grip strength
	is strong. Pt is able to wiggle all fingers and toes. Pt's has RRR s̄ [illegible]
	pulses are strong in (R) UE, cap refill <2 sec x 4 extremities. Pt is s̄ pain @
	this time. Will continue to monitor. ——— SPC (b)(6)-2

509-113

NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
2003 2aug	attending note (R) hand dressing change →
	
	wee d/c IV antibiotics and change to po clindamycin for time being. (b)(6)-2
1430 8AUG03	Pt VSS: BP 86/45, HR 92, T-99.3, O_2 sats 96%, R-12. Pt took 1 can of e-juice. Had loose stool approx 300cc. Pt drsg on RUE, RLE, LLE are CDI @ this time. Physical exam other than lacerations/drsg unremarkable. (b)(6)-2
2030 8AUG03	W→D drsg Δ to RLE. Pt tol. well and assisted c̄ pin care. Wound appears beefy, red c̄ minimal exudate. W→D drsg reapplied; c̄ splint (b)(6)-2
8/9/03	op note Pre/postop Dx: Infected (R) Thumb flap Infected (L) foot graft Procedure: Remove grafts I+D Antibiotic cement spacer (R) thumb wound closure (b)(6)-2 EBL ... to ICU in stable cond

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; hospital or medical facility) (b)(6)-2

Iraqi # (b)(6)-4

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
8 AUG 03	
0700	Vital signs: HR-106 BP-115/59 Temp-99.0 Pulse ox-95% Resp-14
	Assumed care of pt. ——— SPC (b)(6)-2
8 AUG 11:35	Pt has had diarrhea x2 this morning. He requested
	meds, however Dr (b)(6)-2 says if diarrhea continues
	he will prescribe meds. Dressing on (R) leg changed as
	ordered. Small amount of bloody drainage and
	tissue by achiles tendon looks white today. Dr. changed
	(R) Hand dressing and will change (L) leg dressing tomorrow.
	Assessment complete, vital signs normal, brisk cap
	refill, pt experiencing numbness in (L) leg. Doctor states
	is normal for injury. Abrasions and lacerations appear
	to be healing well. Bowel sounds active x4, clear
	lung sounds, S1 and S2 heart sounds, Ø pain. SPC (b)(6)-2
8 Aug 03	Vital signs are as follows: HR-100 RR-12 BP-101/49 Temp-99.3 O2 Sat-%
2245	Pt report received. Pt is A+Ox3, PERRLA and pt is able to move all
	extremities. Pt c/o no pain, but does c/o numbness to the toe next
	to the great toe on (L) foot and pt has very little strength to that toe
	Pt has also c/o slight numbness to (R) index finger, strength is appropria[te]
	(R) hand grip strength strong and cap refill <2sec ē 2+ radial pulse.
	Cap refill for all extremities <2sec. Will continue to monitor. ———
	——— SPC (b)(6)-2 91C LVN
8 Aug 03	(Late note) Dressing Δ done per Dr (b)(6)-2 instructions. Wound is dark
2340	pink and meaty. 6 inches of Kerlex moistened then squeezed damp (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.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
8 Aug 03 2348	(cont.) placed over wound and Dry Kerlex was wrapped around pt's hand. Dressing secured c 2" silk tape. Will continue to monitor. — SPC (b)(6)-2
9 AUG 03 0700	Assumed care of pt. Vitals: BP-109/68 HR-101 Temp-97.7 Pulse ox-96%. Resp-14. Assessment complete, lung sounds clear, S1+S2 heart sounds, bowel sounds active x4, pt had diarrhea x1 today, Dr. (b)(6)-2 changed (L) foot and (R) hand bandages, nursing staff changed (R) leg dressing. Wound looks red and meaty. Pt to surgery @1500 for (R) Hand washout, NPO after 0800 breakfast. IV started in (L) FA, 18g, patent and ø sign of infiltration. IV Ancef prescribed and given as ordered. Pt reports ø pain. SPC (b)(6)-2
1400	assumed care of pt. sitting up in bed, ø distress VS: 106/60, P 96, R-16, T-99.2 SaO2-95. Pt NAD, ~~Alert~~ Alert & cooperative. lungs CTA (B), ø w rr heart RRR, S1 S2 ø murmurs or rubs abd soft & flat, (+) BS x 4 q. ø masses, tenderness or organomegaly. error OBS. peripheral pulses 2+ (B) UE & LE. ø strength & ROM all extremities. ø drainage to dsgs on wounds (b)(6)-2
1450	Pt to OR. Pt with Lorne stool x 1. ø distress noted. linens changed on bed. (b)(6)-2
1620	Pt to bed. see Postop note. (b)(6)-2
1735	Pt awake, offered food. pt refused. (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/20101 STANDARD FORM 509 (REV. 7-91) BACK

PROGRESS NOTES

DATE	
9Aug03 2220	Pt report received. Pt is A+O x3 PERRLA Ⓛ hand grip strong. Pt is able to move all (b)(6)-2 fingers and toes. Cap refill on all fingers and toes is <2sec. Pt c/o pain to Ⓛ Lower Leg and Ⓡ hand. Pt medicated c̄ ii tylox. Will continue to monitor. SPC (b)(6)-2
10Aug03 0315	VS are as follows: HR-82, RR-16, BP-113/59, Temp-99.2°O, Sat-94% on RA. Will continue to monitor. SPC (b)(6)-2
10AUG03 0800	Assumed care of pt. Vital Signs: Temp-97.3° Resp-14 HR-95 BP-115/62 Pulse OX-94%. SPC (b)(6)-2 WMC
10AUG03 0900	Assessment complete. Ⓡ LE needed one more Steri Strip applied by doctor due to separation of remaining stitches on top surface of foot. Ⓡ heel wound looks red and meaty. Overall appearance of skin was dry and scaling so lotion was applied after bed bath. @ 0830 output of 825cc urine, light yellow via bedside urinal. Cap refill <2 seconds in all extremities, pulses normal, lung sounds clear, S1+S2 heart sounds, pt complaining of itching on LLE, no complaints after lotion applied. Pt reports Ø pain. Bowel sounds present x4. SPC (b)(6)-2 91WMC
10Aug03 1100	I concur c̄ above assessment (b)(6)-2
10AUG03 1300	Dr. (b)(6)-2 to change dressing tonight only - due to surgery yesterday - no morning dressing change. Pt had output of 450cc urine, clear and light yellow. Pt complaining of Ⓛ leg + Ⓡ hand pain. 2 Tylox given as ordered. IV running LR @ 60cc/hr to Ⓛ FA, patent and Ø sign of infection. Pt drinking plenty of PO fluids. SPC (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/20101 STANDARD FORM 509 (REV. 7-91) BACK

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
1430 10AUG03	Pt assessment complete. VS 109/54, HR - 89, Pulse Ox - 95%,
	Temp 99.6 (o), Lungs CTA Bilaterally, HS - S_1/S_2, BS x 4 quads,
	IVF @ 60cc/hr (L) FA. Pt consumed 90% of evening meal.
	Drsg on (L) hand and both lower extremities C/D/I. Drsg Δ
	to be completed this evening to RLE — (b)(6)-2
2030 10AUG03	Pt drsg's changed on URE/[illegible]. Both wounds appear
	red and beefy c̄ minimal exudate on (b)(6)-2 (L)LE also c̄ sanguinous
	drainage. Both drsgs replaced as per MD instruction (b)(6)-2
2230 10AUG03	VS: 98/37 T 99.5 P95 96% RA R 15 LR infusing @ 60cc/hr
	into (L)FA, site patent ø s/sx infection/infiltration lungs CTA (B)
	Cardiac S_1S_2 s̄ murmur BS Active x4 peripheral pulses
	+2 in all extremities. (LLE, RUE, LUE) Pt c/o itching to lower
	extremities Dressings CDI. (b)(6)-2
11 AUG 03 0700	Assumed care of pt. Doc ordered NPO, possible skin
	grafting today. Output of 500cc medium yellow urine.
	Vital signs - BP 109/55 HR 97 Temp 98.8 Pulse OX 96 Resp 12
	(R) leg wound looking white near stitches on Achiles tendon,
	other areas more red with bloody drainage during
	dressing change. Pedal pulses normal, LUE normal radial pulse, RUE bandage is C,D,+I. Cap refill brisk in all
	extremities, lung sounds clear, S^1+S^2, bowel sounds
	active x4. LR infusing @ 60cc/hr to (L)FA, patent and ø
	sign of infiltration (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.

Iraqi (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
Continued	
11 AUG 03 0820	Pt told several times not to pick at scabs. Pt reports ø pain, however complaining of abdominal discomfort & diarrhea. ——— SPC (b)(6)-2 WMLe
11 AUG 03 0900	Dr. (b)(6)-2 said pt will not be getting skin graft today, pt no longer NPO ——— SPC (b)(6)-2
11 AUG 03 1320	Assisted Dr. (b)(6)-2 with (R) Hand + (L) Foot Drsg Δ's. Skin grafting may take place on Wednesday. No complaints and ø pain, pt had diarrhea x1 @ 1100 hrs. SPC (b)(6)-2
11 Aug 03 @ 1430 99⁴-80-110/56 18	Rec'd report and assumed care of Pt. VSS-afebrile. Dressings c/d/i. No c/o pain @ this time. IV ē LR @ 60/hr - ⓡ LE - s̄ s/s of complication. Cont. mon. Pt. (b)(6)-2
@ 1830	Pt consumed an approx. 40% of evening meal, and drank .5L bottle of gatorade. Has remained s̄ complaint. IV Bag currently infusing. (b)(6)-2 LPN
Addition:	Void via urinal: 500cc c/y urine. (b)(6)-2 LPN
@ 2150	Dressing Δ to ⓡ LE - Wet-to-Dry per order. Red/Healing looking tissue ē two areas approx 5mm-6mm ē slight purulence. Voided 350 cc c/y urine. Medicated for c/o pain (verified by interpreter) ē Tylox × II. Report status to on-coming shift. (b)(6)-2 LPN
12 AUG 03 0800 97², 80, 113/58 14	Assumed care of pt. VSS and afebrile. (R) Hand dressing has serous drainage on bandage, to be changed this am by Dr. (b)(6)-2 (R) LE Drsg changed, site looks very good, the wound is approximating and color is good. AM care complete w/assistance, bedding changed today. Pt used bedside commode, loose stool with 500cc light yellow urine. Lung sounds clear, S¹ and S², normal radial and pedal pulses and cap refill is brisk. ø complaints, ø pain, pt eating a good breakfast of fruit and MRE. SPC (b)(6)-2

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509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
12AUG03 0900	Drsg △ by Dr (b)(6)-2 Ⓡ thumb needs washout. NPO until surgery later this afternoon (1500hrs). —— SPC (b)(6)-2
12 AUG-03 0915	Interpreter explained to pt that Ⓡ thumb will be worked on in surgery, NPO until after surgery. Interpreter gave pt 2 bags of food, soda, and cookies from pt's family (b)(6)-2
12 Aug 03 @ 1430 99.4-16 117/38-56	VSS-afebrile. Assessment completed. Dressings C/D/I. Pt remains NPO 2° scheduled surgery. No complaints @ this time. Cont. monitor. (b)(6)-2
12 Aug 03 1630	Pt recovered from procedure. S/P Washout Ⓡ Hand. Pain controlled c̄ MSO4 during recovery (See PACU Flowsheet). Administered Tylox ii PO for further c/o pain upon completion of recovery. Dressings remain C/D/I. Post op Cont. monitor —— (b)(6)-2
@ 1800	Pt tolerated food brought by interpreter. Currently resting s̄ s/s of acute distress. (b)(6)-2
2020	I concur c̄ above assessment —— (b)(6)-2
12Aug03 2220	VS are as follows: HR-85 RR-16 BP-116/57 Temp-98.3 O2 Sat-97% Pt is A+O x3 PERRLA, pt is able to move all fingers and toes. Pt has RRR pulse is 2+ in Ⓛ UE cap refill is <2 sec. Pt is c/o pain to Ⓡ hand. Pt medicated c̄ ii tylox. Will continue to monitor. — SPC (b)(6)-2
13Aug03 0825	pt resting will cont to monitor —— (b)(6)-2
0830	P.T. consulted Sgt (b)(6)-2 stated she will be in this afternoon for stretching and getting him to chair will cont to monitor (b)(6)-2

(Continue on reverse side)

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1387

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
13 Aug 03 0920	1020 ~ @0930 Dr (b)(6)-2 in QBS to Δ dsg to (R) hand
BP-116/57	dsg to (L) LE Δed (b)(6)-2 wet > Dry, pin care
P-85	completed. lung assessment CTA. pulses
R-12	+2 ped + rad. pt had BM c urine this AM. Stool
T-99.3	was soft & non formed. cap refil brisk. pt
	refused Breakfast. Interpeter brought in food.
	IV Δed in (L) FA. patient + 4 O1 Dsg Δed to (L) foot
	sm amt of drainage to slotter. Non adhesive
	dsg placed, DSD, will cont to monitor (b)(6)-2
13 Aug 03 1300	PT note: pnt. is Iraqi male c multiple wounds - Ex. Fix (R)
	LE Tib/Fib/ankle & wounds to (L) ankle. c/o N/T
	in (L) LE down to toes. pnt has wound to (R)
	hand - skin flap - unable to use thumb.
	pnt. instructed (thru interpreter) in ex. program for bed activity
	: Quad sets x 10 reps c 3 sec. hold (B) LE q 3°,
	SLR's 10 reps c 3 sec hold (B) LE q 3°, ankle pumps
	and ankle circles (L) ankle x 10 each q 3° - wiggle
	toes (B) and II - V digits (R) hand throughout the
	day. pnt. ambulation status in question -
	WB status for (R) LE ex. fix ? & (R) hand expressly
	(R) thumb. status for WB through it for use of
	crutches? therapist will consult Dr. (b)(6)-2 &
	return for further ambulation coaching. will
	progress pnt. c exercises & WB/ambulation as
	tolerated.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-2 | REGISTER NO. (b)(6)-2 | WARD NO. MFT/Sgt/91WM9

Iraq (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
13 AUG 03 1430	Recieved Pt VSS = Oral temp 99.4, RR 16, HR 99, BP 102/55 O2 sat 99% RA, CTA X5, BSA X4 Quads, peripheral pulses strong equal Ø Complaints at this time Will continue to monitor (b)(6)-2 sgt 91WM6
13Aug03 2225	Received pt. VS are as follows: HR-84 RR-16 BP-109/56 Temp-99.2 O2 Sat-96%, Pt is A+O PERRLA grip strength strong on (L) UE, pt can move all fingers and toes. Cap refill <2 sec x4 extremities Pulses 2+ x (B) UE. Pt is s̄ c/o pain. Will continue to monitor. — SPC (b)(6)-2 91C LVN
14 AUG 03 0800	T=98.6, P=89, R=12, BP=98/52, sat=99 on RA. PT awoken for VS + assessment. PT refuses breakfast + am care. Cardiac - RRR s̄ MRG, lungs - CTA, BS active x4, pulses 2+ Bil - DP + radial. (L) (R) DP can't be assessed due to dressing. Good cap refill. Skin warm + dry. IV LR @ 60 cc/hr in (L) FA s̄ s/s of infection or infiltration. Dressing (R) hand - small area of serous drainage. (R) LE ex. fix. remains in place as well as splint c̄ wrap. — (b)(6)-2 MAJ/AN
0945	- PT OOB to chair - transferred himself s̄ diff. — (b)(6)-2 MAJ/AN
1500	Recieved Pt VSS = 99.1° HR85, BP 100/58 RR16 SAO2 98% RA, CTA X5, BSA X4 Quads peripheral pulses +2 Equal strong Ø complaints at this time will continue to monitor (b)(6)-2 SGT 91WM6 LVN
2200	Pt UOP = 1200 cc This shift (b)(6)-2 SGT 91WM6 LVN
14Aug03 2235	Pt voided 425cc of clear yellow urine. Pt is A+O x3 PERRLA (B) UE grip strength strong. Pt can move all fingers and toes. Cap refill is <2 sec x 4 extremities. VS are as follows: HR-94 RR-16 BP-105/48 Temp-99.0 SaO2 98%. Will continue to monitor. — SP (b)(6)-2

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
15 AUG 03 0720	Assumed care of pt. VSS, afebrile, Lung sounds clear, S1 and S2, bowel sounds active x4, pt
98.4, 98% 85 HR, 107/59 14 Resp	refused breakfast. Bandages C, D, + I, brisk cap refill, LR @ 60 cc/hr to (L) FA, patent and Ø sign of infection. SPC (b)(6)-2
15 AUG 03 0750	Pt had loose stool x1 and 575 cc Medium yellow urine. SPC (b)(6)-2
15 AUG 03 1005	Pt complaining of dry, flaking skin on scalp. Morning care complete, Drsg Δ's as ordered. No drainage on dressings, wounds looking good SPC (b)(6)-2 91WMK
15AUG03 1430	Pt assessment complete. VS - BP 107/61, HR - 89, T - 98.6, O2 - 98%, R - 16. LS - CTA Bilat., HS - S1/S2, BS x4 quads. NEURO VS WNL. IVF titled as per MD order (b)(6)-2
2110	Pt VOP - 700cc for shift. Drsg Δ's on RUE, RLE, LLE complete. wounds c̄ mod. exudate / appear red and beefy (b)(6)-2
15AUG03 2330	VS: 98.5, 102/55, 81, 98% RA R 18. Pt AOx3 Lungs CTA (B), heart RRR s̄ murmur, BS Active x4 IV in (L) FA flushes well Ø s/sx infection/infiltration. Pt neuro vasc. ✓ WNL on RUE, and (B)LE. Pt resting in bed (b)(6)-2
16 Aug 03 0730 BP 107/62 P 78 R 18 T 98.8 O2 99%	lung assessment CTA, A+Ox3 BS⊕ 4q flex + Extension (B)LE not full strength pulses +2 (B)LE + (B)UE, drg Δ'ed W→D on (R)LE. (L) foot drg Δ'ed. Bacraciatea & non adhesive drg applied. Bath complete will cont to monitor (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.

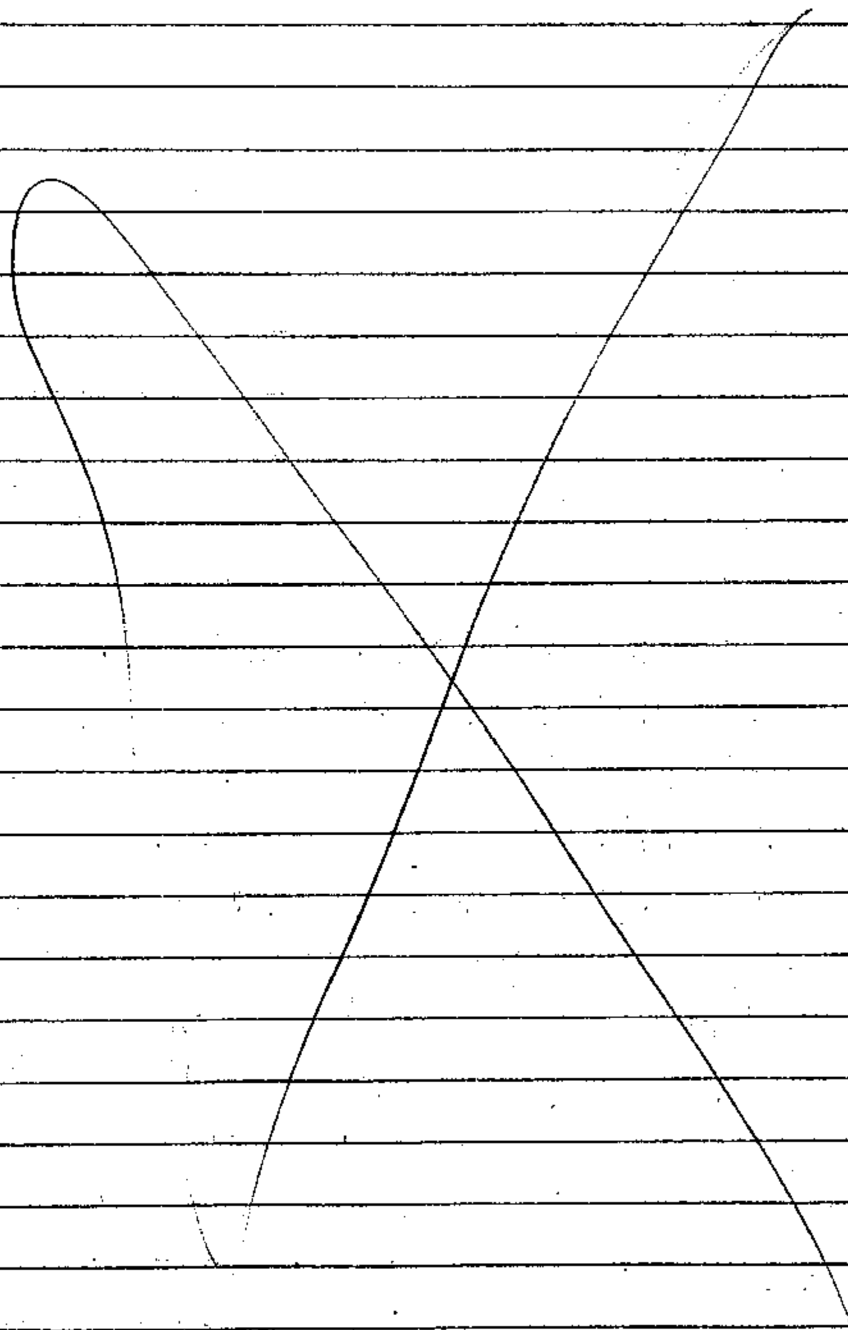
Fragi (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
1040 16Aug03	@ 0900 pt has sm watery BM c̄ urine ↑ to BSC. pt ate late breakfast Early lunch (interpeter brought in meal. will cont to monitor (b)(6)-2



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STANDARD FORM 509 (REV. 7-91) BACK

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
2003	ortho progress note
16 Aug	HD # 22 (24 Jul 03) s/p multiple ortho injuries / operations
	issues: skin graft (R) hand, (R) LE (cover tendon)
	strengthening exercises quads
	nutrition
	ex fix (R) LE
	multiple healing wounds - sutures, scar tissue (also s/p bone graft removal (R) hand, (L) foot 2° infection)
	? (R) thumb retention vs. amputation
	afebrile AF, VS WNL
	PT has consulted c̄ pt and pt has/is doing exercises per her recommendation
	interpreter brings pt meals; apparently throws some food away - but is eating better through day - will recommend supplement c̄ Ensure
	wounds daily dressed - ø s/s infection currently since PMMA/vanc (cement) placed 12 Aug 03 - no fluctuance, no purulence/exudate expressed
	doing well currently c̄ (R) LE ex fix, bone graft removal from infected (R) hand, (L) foot c̄ placement of 2nd vanc bone cement (PMMA) to (R) thumb. Sites beefy red and healthy for skin graft. (R) thumb/hand currently s̄ infex
	will continue to follow, monitor dressing Δ's / inspect wounds / push nutrition + exercise
	pending skin graft
	(b)(6)-2
	(b)(6)-2 [signature]

(Continue on reverse side)

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

IRAQI (b)(6)-4

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PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509–113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
16AUG03	Assumed care of pt. NAD, awake watching
1400	TV. VS – T 98⁶ P 89 BP 109/58 R-20 Lungs CTA, 2wR
	heart RRR, abd soft flat ⊕BS x4 quads
	skin warm dry intact. Moves ext. x4 ē =
	5/5 strength Ⓑ, neurovascular check intact.
	drsgs dry s̄ drainage. IV Ⓛ FA patent, s̄ erythema
	or edema (b)(6)-2
1700	Pt eating dinner, ∅ distress noted (b)(6)-2
1910	Pt c̄ % pain to Ⓡ LE. Medicated per order. (b)(6)-2
2120	Drsg Δ performed, pt tolerated well. good granulation
	tissue noted (b)(6)-2
16AUG03	VS- T=97⁸, P=80, R=16, BP=110/60 Sat=98% PT denies
2215 NAW	pain. Assessment complete- VSS, cardiac-RRR s̄ MRS,
	Lungs CTA, ABD- BSx4 - ∅TTP - Dressings Ⓡ hand,
	Ⓛ foot, Ⓡ LE CDI. Ex fix remains in place Ⓡ LE
	-Able to all extremities- good strength, good cap refill.
	HL Ⓛ FA s̄ S/S of infection. (b)(6)-2
17 AUG 03 0800	VSS, 750cc medium yellow urine, lung sounds clear,
98.10-99% 78-14-111/63	Bowel sounds Active x4, HepLoc in Ⓛ FA patent And
	without sign of infiltration. Brisk cap refill, good
	strength and movement. Pt denies pain. SPC (b)(6)-2
17 AUG 03 1155	Pt IV infiltrated. New Heploc placed in Ⓛ Hand.
	SPC (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.

IRAQI (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
17 AUG 1335	Pt refused Ensure @ 1000 hrs. [signature] (b)(6)-2
17Aug03 1335	I concur c above assessment (b)(6)-2
17AUG03 1530	Pt assessment complete. VS - BP 100/60, HR-97, O_2 SATS - 99%, T- 99
	Lungs CTA bilaterally, HR - RRR, BS x 4 quads, Good neuro V's
	+ cap refill, Drsgs on RUE, RLE, LLE - CDI (b)(6)-2
17Aug03 2230	T 98.3 @ BP 111/64 P 88 R16 SaO_2 99% Pt AOx3, Informed about
	NPO status p MN pt ate chips and drank water. HRRR murmur S_1S_2
	Lungs CTA (B) Pt has ∅ complaints on assessment BS Active x4
	Neuro Vasc ✓ WNL on all extremities (b)(6)-2
18AUG03 0900	Pt to go to surgery this A.M., NPO, VSS, AM care
100% - 87HR	complete, assessment done, lung sounds clear, S_1S_2,
98.2 oral 14	Bowel sounds x 4, brisk cap refill, DRSG Δ's AS
112/55	ordered - wounds are approximating. SPC (b)(6)-2
18AUG03	
1300	Pt recovered from surgery. DRSG Δ's to LLE and (R) Foot
	only. Dr (b)(6)-2 to change skin graft site and donor site
	in 3 days. Pt given MSO4 for pain as ordered,
	developed raised, irregular mounds on (L) FA, No SOB.
	Pt given Benadryl as ordered, raised patches dissolved.
18 AUG	SPC (b)(6)-2
1525	Pt complaining of pain At IV site when flushed.
	New Heploc placed in (L) FA per SG Carbee. No
98.8 oral	evidence of infiltration at site, however new line
105/58 97HR	was put in. SPC (b)(6)-2
14 Resp.	
98% RA	

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
	Ortho Op Note
2003	Pre/postop Dx: (R) hand (dorsum) and (R) Achilles tendon open wound
18 Aug	(skin avulsion)
	Op: skin graft (R) hand (dorsum) and (R) achilles tendon c̄
	(R) ant. thigh donor site
	Surg (b)(6)-2 / (b)(6)-2 / (b)(6)-2 / (b)(6)-2 CRNA (b)(6)-2
	EBL min fluids 700cc UOP Φ min 19 Ancef IVPB
	Findings: good grafts obtained, pie crusted, stapled, vaseline gauze/wrap
	bolster sutured, kerlix wrap. Good results. (photos x 12)
	Extubated s̄ difficulty → PACU (ICU) c̄ SV, VSWNL
	(b)(6)-2
	(b)(6)-2 [illegible]
18 AUG 03	VS: T 97.9 BP 103/32 R16 P80 SaO_2 98% RA Pt AOX3
2240	Lungs CTA (B) Cardiac RRR s̄ murmur S_1S_2 pt has ⊕ c/o
	pain @ graft site on hand & at graft donor site on
	thigh. BS Active X4 Neurovasc ✓ WNL on all
	extremities pt resting comfortably in bed — (b)(6)-2
19 AUG 03 0830	T=98.7, P=85, R=16, BP=112/57, Sat=99% on RA - pt awoken
	for VS & assessment. pt A&OX3. cardiac-RRR s̄ MRG
	lungs-CTA, abd-BS active X4, skin warm &
"	dry - extremities c̄ good cap refill + pulses B/L.
	Dressings! - (R) hand, CDI, (R) thigh - moderate
	serous drainage, (R) ankle - CDI. EX FIX
	remains in place (R) LE, pt denies pain.

(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. [illegible]

IRAQI (b)(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 1395

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE

19 AUG 0830 cont - HL (L) antecub - Ø S+S of infection or infiltration. ——— (b)(6)-2

19 AUG 1430 Temp-99.2 o, Resp-12, HR 94, BP 112/59, 97% RA. (L) Foot had very dry skin, lotion applied in order to discourage pt from picking. Assessment complete. Moderate amount of serous drainage on (R) thigh DRSG, (R) Hand (R) leg LS and (L) LS DRSG's all clean, dry, and intact. All pulses normal, brisk cap refill, lung sounds clear, S1 + S2 heart sounds, bowel sounds active x4. (R) leg external fixator in place. Ø pain, Ø complaints, pt OOB to chair. Stool x1 and 500cc medium yellow urine. (b)(6)-2

19 AUG 03 1900 Recieved pt Ø Complaints VSS = HR 70 BP 114/64 ORAl temp 97.5° RR 16 CTAX5, BSAX4 Quads, Voiding yellow urine, Ø pain, Nausea Will continue to monitor (b)(6)-2

20 AUG 0820 T=98.3, P=83, R=16, BP=119/67, Sat=98%. PT A+OX3 HL (L) antecub area Ø S/S of infection. Dressing (R) hand = CDI, (R) thigh - mod serous drainage - reinforced c̄ Kerlex, (R) ankle - CDI, Exfix still intact RLE. Cardiac - RRR S/MRG, lungs CTA, ABD - BS x4. PT denies pain, went for breakfast on desire for am care at this time. ——— (b)(6)-2

20 Aug 03 1530 T 99.2 P 89 R-20 B/p 119/68 SPO2 99%. Pt admitted from ICU. Assessment completed. PERRLA A+Ox3, Breath sounds CTA (B) Apex to base Edema noted on (L) foot, ~~[illegible]~~ Peripheral pulses present x4, Bowel sounds normal active x4. Dressing to (R) hand, thigh, and ankle CDI. Pt up to chair. Ø c/o pain discomfort, [illegible] (b)(6)-2

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509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
2230 Aug 20 03	A/O X3 - PERRL - LS CTA BS⊕4Q MAE Ⓡ Hand dressing C-D-I Ⓛ FA IV Hiplock ORIF Ⓡ LE SR ≥80's T 98.3 P80 R16 B/P 115-63. PT Has MP at the bedside. Has ∅ c/o discomfort at this time per translator will con't to monitor per orders (b)(6)-2
0200 Aug 21, 03	Doing well has No c/o at this time. say's doing ok per the translator. Will con't to monitor. (b)(6)-2
0430 Aug 21, 03	Resting well NAD will con't to monitor — (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)

1RAQ1 (b)(6)-4

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
22 Aug 2003	0605: (Nursing Notes Continued from reverse): (R) pedal pulse strong. (L) anterior foot suture line s̄ redness, edema, or pain. Pt makes ∅ c/o pain or discomfort. Will continue to monitor. (b)(6)-2 LPN
22 Aug 2003	0130: Pt output per urinal 400cc s̄ difficulty. Will continue to monitor. (b)(6)-2 LPN
22 Aug 2003	0950: Nursing Notes: Pt defecated in BSC, had large amt of liquid stool, denies abd pain. Will continue to monitor. (b)(6)-2
22 Aug 03	(1400) - denies c/o pain, ∅ SOB, dressing to (L) lower ext. CDI to pin site c̄ thigh; dressing to (R) hand CDI, IV to (R) AC CDI s̄ redness, pain, or swelling, will cont to monitor pt (b)(6)-2
2230 22 Aug 03	Took over care. VSS T 98.3 P 77 R 18 BP 113/59 sat's 94% RA A/O x 3 PERRL Chest CTA Heart RRR Abd (+) BS x4 non-distended non-tenderness MAE (R) Hand S/Graft C-D-I (L) LE ORIF + S/Graft CD-I. Will cont to monitor per orders. Has ∅ % discomfort at this time. (b)(6)-2
Aug 23, 03 0120	Sleeping eyes closed rise and fall of chest noted will cont to monitor per order. (b)(6)-2
0900	T 98.2F, BP 117/64, HR 80, RR 14, SpO2 100% on RA, NAD VSS, Dx to LE CDI, lung sounds clear, bowel sounds active x4 quad., pt sitting up in bed (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
21 Aug 03 1015	Pt assessment complete. Pt VS - 116/63, 80 Bpm, 100% SpO2, 97.9, RR 15. Lung fields CTA. Ø cough. + Pulses x4, good cap. refill. Pt able to move all extremities. Dressings changed by Dr's. Ø signs of infection. Dressings CDI. Bowel Sounds + x4. Pt up to chair. Pt states thru interpreter "I feel fine." Will continue to monitor. (b)(6)-2
21 Aug 03 1400	pt resting ē guard @ bedside, shows no S/S of difficulty breathing, denies c/o pain through hand motions, dressing to Ⓡ leg (pin site, thigh) CDI, dressing to Ⓡ hand CDI, IV site shows no S/S of redness, swelling or pain (b)(6)-2
2200 Aug 21, 03	Resting well NAD VSS T 99² P 94 R 18 B/P 112/63 A/Ox3 PERRL SR BS CTA MAE will con't to monitor per the orders (b)(6)-2
22 Aug 03	0605: ~~Assumed~~ ERROR (b)(6) Nursing Note: Assumed pt care. VSS: BP 116/70, P 83, T 98.5, RR 16, Pulse Ox 99% on Room Air. IV HL in Ⓡ FA patent & flushes easily, site s̄ redness, edema, or pain. Ⓡ hand dressing CDI. NSR, Ø ectopy, Ø murmurs, PPP. Ⓑ lungs CTA, cap refill Ⓑ 1 sec. BS ⊕ hyperactive X4 quads. Ⓡ upper leg drsg. CDI. Ⓡ Ext Fix to Ⓡ lower leg c̄ drsg @ pin site proximal ankle. (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)

Iraqi (b)(6)-4

REGISTER

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDICAL RECORD	PROGRESS NOTES

DATE	
23 Aug 03 1430	V/S: T-99.1 P-91 R-20 B/P 111/59 SPO2-100% RA Assessment completed. Lungs CTA A/B (B). Bowel sounds active x4 Peripheral pulses strong x4. A+O x3. PERRLA. Dressings CDI, ⊘ S/S of infection
23/8/03	Ortho
	Strangraft (R) calf (R) dorsum of hand c̄ 95% + take
	⊘ Drainage from (R) thumb
	(P) (1) IF wounds healing well, Transfer to EPW camp 8/29/03 (Friday)
	(2) WBAT (L) LE
	(3) pt instructed c̄ SGT Haise for ambulation c̄ crutches
	(4) Daily Dressing changes until wounds c/d
	(5) WND (R) LEx 2 weeks
	(b)(6)-2

(Continue on revers(b)(6)-2

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

(b)(6)-4

Iraqi (b)(6)-4

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45.505
509-111

PROGRESS NOTES

DATE	
23AUG03 2200	VS - T - 98.5 HR 91 Sat 99% BP 118/64 RR 12
	Pt appears to be sleeping in bed, NAD. Drsg to (R) UE + RLE
	CDI. NO c/o pain. Will continue to monitor — (b)(6)-2
24Aug03 1040	VS - BP 112/62, HR 81, RR 12, SpO2 100% on RA, T 98.4
	IV in (R) fa was DC'd; lungs sounds clear, BS active
	x4 quad.; Dr (b)(6)-2 did dressing Δ's to (L) hand
	+ RLE; CDI; pt. given Levaquin PO; NAD, VSS
	pt. sitting up eating will cont to monitor — (b)(6)-2
25AUG03 0530	Pt slept well through night. Voiced no c/o pain/discomfort.
	Voided QS clear yellow urine/urinal. — (b)(6)-2
25Aug03	1000 - Pt resting quietly in bed; ∅ c/o pain or dis-
	comfort. VSS T 98.2, P 83, RR 16, pulse ox 100%,
	BP 118/69. Pt breathing even and unlabored. Will
	continue to monitor. — (b)(6)-2
25Aug03	1200 - Pt has 350 cc output of dark, yellow
	urine per urinal. Pt refused breakfast
	& lunch. Will continue to monitor. (b)(6)-2
25Aug03	1330 - Pt requested equipment in order
	to bed bathe self. Gave pt the equip-
	ment & pt executed a self bed bath
	s̄ difficulty or assistance. (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

AL RECORD | PROGRESS NOTES

DATE	NOTES
03	(1400) pt resting comfortably, Ø c/o pain Ø s/s of SOB will continue to monitor pt (b)(6)-2
25 Aug 03 2145.	Ø c/o pain, discomfort. Ø S/S of distress. BM x1, urinating ō difficulty OOB for 1°. Ate own food. Stood on crutches x 10 minutes. Personal hygiene completed. Resting comfortably. (b)(6)-2
Aug 25, 03 2200	Have care in bed resting looking at a book. VSS T 98³ P 78 R 12 BP 115/64 SaO₂ 99% RA. PERRL A/O x3 Chest CTA Heart RRR Abd soft-Non tender MAE Has dressing to (R) Hand. Intact c̄ good sensation. OLSF to (R) LE. Dressing to upper (R) leg intact. Has Ø % discomfort at this time. Will cont to monitor per the orders (b)(6)-2 (b)(6)-2
Aug 26, 03 0200	Resting well eyes closed. NAD will cont to monitor per orders. (b)(6)-2 (b)(6)-2
Aug 26, 03 0530	NO Δ's in status (b)(6)-2 (b)(6)-2
26 Aug 03 0800	Pt appears to be resting comfortably. No distress noted (b)(6)-2
26 Aug 03 0900	Drs (b)(6)-2 in, Dsgs Δ'd to (L) achilles graft site + (L) thigh graft site. All remaining staples removed. DSD reapplied by Dr (b)(6)-2 sites clean, s̄ purulent drainage. (b)(6)-2
26 Aug 03 1400	Sitting ↑ in bed. Voices Ø %. Ø apparent distress. Continue to monitor (b)(6)-2 Cpt AN

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

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)-2

Iraqi (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
Aug 26, 03 2215	Sleeping eyes closed. NAD guard at the bedside. Rises and fall of chest noted. Will con't to monitor over the orders. (b)(6)-2
Aug 27, 03 0110	Resting in bed NAD (b)(6)-2
Aug 27, 03 0530	Resting well sitting up in bed. NAD Ø c/o ... at this time. (b)(6)-2
27 aug 1000	BP 117/62 HR 89 RR 18 SpO2 100% RA T 96.9. Pt drank c can ... Resting quietly in bed. (b)(6)-2
27 Aug 1810	↑ to amb + use BSC x3. Some loose stools. Walking on crutches s diff. Voices Ø c/o. Ø apparent distress (b)(6)-2
28 Aug 03 2205	Pt up ambulated c crutches ⊕ BM - loose stool. Ø difficulties c urination awake talking c me. Will continue to monitor for Δ. (b)(6)-2
	0035 C/o pain in leg p ambulation. Medicated c tylox. (b)(6)-2
28 aug 1050	BP 119/65 HR 89 SaO2 100% T 96.5 Pt resting ... ... complaints. (b)(6)-2
8/28/03	Ortho (b)(6)-2
	wounds C/D/I
	Skin grafts c 98% take
	Ø Drainage
	walking c crutches, bearing weight
	on Ⓛ LE + PWB Ⓡ LE
	ambulates short distances
	(Plan) Ⓡ Thumb MCPJ fusion
	c ICBG in 2-3 months p wounds
	healed / Ⓡ LE fx healed / Ø
	evidence infection

LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

(b)(6)-2

MEDCOM - 1403

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3 August 03	@ 2330. Pt sitting up in bed picking scars. AFO. Pleasant disposition. Ambulate on crutches c̄ SGT (b)(6)-2 Ø complaints @ this time. Will continue to monitor and prepare for d/c. (b)(6)-2
29 August 03 06:15	Nursing Notes: Assumed pt care. VSS: T 97-, BP 118/64, P 78, Pulse ox 99% on room air, RR 17. Pt resting quietly in bed c̄ eyes opened, Lung CTA, Ø resp distress noted. NSR, Ø ectopy, Ø murmurs. Ø IV access, ppp, MAE. Pt refused breakfast tray. Ø% pain. Will continue to monitor pt. (b)(6)-2 RN
29 August 05 10:21	Nursing Notes - Pt DC'd to EPW Camp via HMMV accompanied by 3 MP's c̄ his personal belongings, medicine and crutches. Pt ambulated c̄ crutches s̄ difficulty & slow, steady gait. (b)(6)-2 LPN

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)

Iraq (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

558-103 (See Instructions on Back of this ...) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 26 MONTH Jul YR. 03 — TIME 1800

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): PRIVATE VEHICLE / AMBULANCE / ☑ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): unknown

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

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

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? YES / NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS			
TIME	1800		
BP	104/50		
PULSE	110		
RESP.	24		
TEMP.	99.6		
WT. (Child)	99%		

CATEGORY (See reverse): EMERGENT / URGENT / NON-URGENT

ORDERS	INITS.	TIME
L+ R Femur PA+LAT		
L+ (R) Tib/Fib		
B6-2 Istat 6 cr CBC		1800
Bolus 1 liter N/S		1800
(R) hand Xray		
2mg MSO4		1802

ASSESSMENT/DIAGNOSIS: MULTIPLE PENETRATING WOUNDS, EXTREMITIES

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

22y Iraqi ♂ brought to CSH in custody of military police from local hospital. Individual sustained GSW and fragmentation wounds to (R) and (L) shoulders, (R) hand and B/L lower extremities and feet. Operated (?) debrided at local facility, details of care not available.

PMHx: Ø   Meds: unknown   PSHx: Ø   Allergies: NKDA   Hosp/SocHx: unknown

GENERAL: Thin Iraqi ♂ alert/answers questions through interpreter

6.9 \ 8.7 / 152 ; 26.7

INTEG: Warm + dry Ø rashes - wounds as noted

137 | 106 | 1.0 ; 3.0 | 91 | 10

HEENT: Frag wounds + abrasions (L) chin. Sutured scalp laceration (R) parietal area

LUNGS: CTAB Ø W/R/R - chest rise symmetric

CV: RRR, tachycardic, HR 54/52

ABDO: Soft/NT/ND/Ø mass abrasions (R) LQ

~~[crossed out]~~

CHEST: Healing penetrating wounds (L) and (R) shoulders

BACK: Healing grazing wounds upper back no penetrating trauma

GU: Ø penetrating trauma

BUTTOCKS: Ø trauma

EXTREM: Penetrating wounds LE's feet B/L (R) hand + partial amputation (R) thumb

(CONTINUE ON SF 507, IF NEEDED)

DISPOSITION (Check all that apply): HOME / FULL DUTY / QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs. / MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): ORTHOPEDICS — EMERGENCY / TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE:

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

(b)(6)-4

SIGNATURE OF PROVIDER: (b)(6)-2 (b)(6)-2 LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Trauma x-rays show (L) Tib-Fib fracture

Care transitioned to orthopedic surgery at 1830

EMERGENCY CARE AND TREATMENT   STANDARD FORM 558 (Rev. 6-82)

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jul 03
DOS	24 JUl 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

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

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			(b)(6)-2
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MDA	ICU I	26 JUl 03

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

I raq (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1406

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	**RADIAL** R																			brachial				2	
	L																							3	
	DORSALIS PEDIS R																		unable to assess					X	
	L																							4	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale																								4 1 8	
EDEMA																								Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)																								✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																								ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	**BED BATH**																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	**BEDREST**																							✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	**RIGHT**																								
	LEFT																								
	SUPINE																							✓	
	HOB 30 DEGREES																							✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	**PAIN FREE**																								
	PAIN SCALE (1-10)																							8	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended																							2	
BOWEL SOUNDS (active all quads)																								✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	**No Breakdown**																								
	Surgical Wounds																						(b)(6)-2		ple
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																							refer to [illegible] sheet		
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV	(L) FA 18g	26 JUL	Ø S/S of infection in [illegible]

PUPIL SIZE / **PUPILS**

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present	✓
Not Applicable / Absent	(blank)
Refer to Nsg. Notes	X
No Change from Previous Assessment	–

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open																								4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response																								5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response																								6	
GLASCOW COMA SCALE (A+B+C)																								15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																							2	
	L																							2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE																							4	
	LUE																							4	
	RLE																							4	
	LLE																							4	
GRIP (S) Strong (W) Weak (-) absent	R																							3	
	L																							4	
RESPIRATIONS	REGULAR																							✓	
	IRREGULAR																								
	UNLABORED																							✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL																							5	
	LUL																							5	
	RLL																							5	
	LLL																							5	
	BOTH BASES																							5	
COUGH	NONE																							✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																							2	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																								(b)(6)-2	

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
26 JUL		2325	From Recovery - Refer to PACU Flowsheet
			nursing care problems section for multiple
			lacerations, surgical wounds, dressings.
			PT received a total of 20 mg MSO4 in
			recovery as well as Tylox ii PO @
			2315. PT now resting quietly, cont. on
			2 l NC - will cont to wean O2 off
			as pt tolerates. (b)(6)-2 [illegible]

	INTAKE									OUTPUT						
									Total						Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300	1300 R									(b)(6)-2 100						
2400																
8 HR									24 HR.						24 HR	

MEDCOM - 1410

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	26Jul03
DOS	26Jul03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 (b)(6)-2	(b)(6)-2
ICT, An	
IG/M	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 S/C LVN	ICW#1	26Jul03

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

Iraqi (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☑ FLOWCHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER(Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700

MEDCOM - 1411

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		*					UTA							UTA								UTA		
	L		2					2							2								2		
	DORSALIS PEDIS R		*					UTA							UTA								UTA		
	L		*					UTA							UTA								UTA		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8					1 3 8							1 3 8								1 3 8		
EDEMA			*												[illegible]										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓							✓								S1S2 >	(b)(6)-2	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓					✓							SR								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST														✓										
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT		S2					S2															S2		
	SUPINE		L2					[illegible]							✓								[illegible]		
	HOB 30 DEGREES														✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓					✓							✓										
	PAIN SCALE (1-10)																					*			
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2							2								2		
BOWEL SOUNDS (active all quads)			+					✓						(b)(6)-2									✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown		✓					✓							✓								✓		
	Surgical Wounds														✓								✓		
	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)															✓										
#1 (R) shoulder			✓					✓							✓								✓		
#2 (R) Forearm/Hand			✓					✓							✓								✓		
#3 (L) Calf/Foot			✓					✓							✓								✓		
#4 (R) Calf/Foot			*					✓							✓							*			

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(L) Forearm	??? (26 Jul 03)	s s/sx infx or infiltration
PIV 18g	LFA	? 26 July 03	PATENT s s/sx of infection or infiltration
PIV 18g	(L) FA	26 Jul 03	patent; Ø s/sx of infection or infiltration
PIV 18g	(L) Forearm	?26 Jul 03?	patent s s/sx of infec or infiltration

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES	
1 mm	=	Equal	0 = No Movement	Present	✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction		
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent	(blank)
			3 = Active: against gravity, but not against resistance		
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes	X
			5 = Full Strength against Examiners Resistance		
5 mm	R > L	Right Larger		No Change from Previous Assessment	--

DATE: 27 Jul 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		through interp 5					5							UTA								N/A		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6							6								6		
GLASCOW COMA SCALE (A+B+C)		15					15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+																				2+		
PUPIL RESPONSE — L		2+																				2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4					4							4								4		
LUE		5					5							5								5		
RLE		3					3							4								4		
LLE		4					4							4								4		
GRIP (S) Strong (W) Weak (-) absent — R		*					UTA							UTA								UTA		
L		S					S							S								S		
RESPIRATIONS — REGULAR		✓					✓							✓								✓		
IRREGULAR																								
UNLABORED		✓					✓							✓								✓		
LABORED																								
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		5					5							5								5		
LUL		5					5							5								5		
RLL		5					5							5								5		
LLL		5					5							5								5		
BOTH BASES																								
COUGH — NONE		✓					✓							✓								✓		
SPONTANEOUS																								
PRODUCTIVE																								
NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
FIO2																								
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)		1L					1L							1L								1L		
FM (l/min)																								
ETT # ______ — NRBM (l/min)																								
ETT ______ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2																							

(b)(6)-2

1

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		95	13	119/61	97%												
0200		~~95~~	~~13~~	~~119/61~~	~~96%~~	(b)(6)-2											
		85	12	108/47	96%												
0300		92	10	113/57	96%												
0400		86	8	99/49	96%												
		~~81~~	~~9~~	~~103/46~~	~~96%~~	(b)(6)-2											
0500		81	9	103/46	96%												
0600		89	9	104/45	98%												
0700	97^{4}	89	11	102/48	98%	1L/NC											
0800		68	12	105/43	96%	1L/NC											
0900		99	17	96/49	91%	1L/NC											
1000		77	12	115/53	98%	1L/NC											
1100		82	12	111/52	98	1L/NC											
1200		83	15	108/50	97%	1L/NC											
1300		87	16	111/54	100%	"											
1400	99^{2}	93	19	113/54	98%	"											
1500		87	13	107/49	96%	1L/NC											
1600		89	12	104/46	97%	1L/NC											
1700		106	13	115/57	97%	on 1L/NC											
1800		92	15	118/48	96%	on 1L/NC											
1900		86	18	118/53	98%	on 1L/NC											
2000	99.6	89	19	118/56	100%	on 1L/NC											
2100		89	22	109/49	96%	on 1L/NC											
2200		82	13	104/59	100%	on 1L/NC.											
2300	99.7	94	10	124/62	96%	on 1L/NC											
2400																	

	INTAKE									OUTPUT						
	IV	IVPB	PO						Total	Urine	Stool				Total	COMMENTS
0100	100 / 100															
0200	100 / 200															
0300	100 / 300															
0400	100 / 400															
0500	100 / 500															
0600	100 / 600															
0700	100 / 700															
0800	— / 700	150 / 150														
8 HR	700	150							8 HR. 850						8 HR 0	
0900	100 / 100															
1000	100 / 200															
1100	100 / 300									300 / 300						
1200	100 / 400															
1300	100 / 500		200 / 200													
1400	100 / 600															
1500	100 / 700	150 / 150														
1600	100 / 800															
8 HR	800	150	200						16 HR 1150						16 HR 300	
1700	100 / 100									900 / 900						
1800	100 / 200															
1900	100 / 300															
2000	100 / 400															
2100	100 / 500															
2200	100 / 600									625 / 1525						
2300	100 / 700															
2400																
8 HR									24 HR.						24 HR	

MEDCOM - 1415

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
27Jul03	0230		Pt assessment complete. Pt is A+O x3 (assessed through interpreter) PERRLA (L) grip is strong (R) grip unable to assess due to fx and bandag. pt is able to move all fingers on (R) hand. Cap refill on (R) hand and (R) feet <2sec. 2+ pulse on (L) radial artery. Pt is able to wiggle all toes (R) and all fingers on (R) hand. Fingers on (R) hand is slightly edematous and toes are also slightly edematous. All dressing except (R) calf/foot are CDI. (R) calf/foot dressing has small amount (inch diameter) of serosanguenous drainage. Drainage has been circled on dressing c̄ date and time. Pt has yet to urinate this shift. Will continue to monitor. ———— SPC (b)(6)-2
27 JUL	0335		Auscultation done - cardiac - RRR s̄ MRG (b)(6)-2 Lungs CTA, abd - (+) BS all quads.
27Jul	0700		A+O X3. VSS. (-) Pain. Refused breakfast. No Δ from previous assessment. —— (b)(6)-2 1LT,
27JUL03	0945		Pt has not voided. TRANSLATOR STATES Pt said he does not have to urinate and he is not having pain. Pt states he would let us know if he does (b)(6)-2 1LT,
27Jul03		1030	Voided DARK amber urine 300cc (b)(6)-2 1LT,
27JUL03		1330	ATE CAKE c̄ drink, one juice. Refused the rest of lunch meal. Medicated c̄ Tylox II (b)(6)-2 1LT
27 Jul 03		1445	Pt. resting in bed; HOB ↑ @ 30°; able to communicate through sign language; answers yes/no; responds appropriately. Ancef given as ordered. No other concerns @ this time. Ext. fixator in place in RLE; LLE covered c̄ ace bandage. (+) CMS; toes sl. edematous @ +1; (R) shoulder c̄ bulky dsg. open wound to (R) lat. shoulder; CDI; (R) hand also covered c̄ bandage; (+) CMS. Will continue to assess and monitor. — (b)(6)-2 1LT/AN
		2007	Pt c/o "ouchy", pointing to (L) knee; given 2mg of MSO4 IVP as ordered. Will continue to reassess and monitor. ——— (b)(6)-2 1LT/AN

MEDCOM - 1416