NURSING PROGRESS NOTE

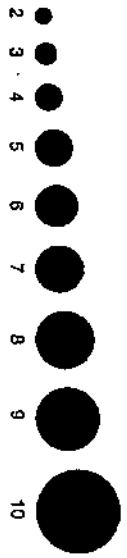
4 Aug 02 0930: Foley + IVF D/C'd as per MD order. Pt was assisted to BSC - ⊖ BM. A+Ox3. N/o c/o pain this time. Pt pleasant, cooperative. Chest + back dsgs C/D+I. LCTA. ⊕ BS x4. VSS. No AE. (b)(6)-2 AN
1100: Bilat shoulder dsgs c/d.

NURSING PROGRESS NOTE

*SEE PROGRESS NOTES:

PROCEDURES / TIME	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
NEUROLOGICAL	→ SEE CODE →		
Eyes Open (Closed by swelling = C)	4		
Verbal Response (ET Tube or Trach = T)	5		
Motor Response	6		
Pupils R - react NR - non SR - slow — Size R	5		
Reaction	+		
Size L	6		
Reaction	—		
Hand Grasp R / L	+ / +		
[redacted]ath Sounds	CTA bilat		
Sputum Character	—		
Nasal Endotracheal Suctioning Q ____	—		
Chest PT Q ____	—		
CDB/IS Q ____	—		
Vent. ✓'s	—		
E.T. Tube @ ____	—		
Cuff ✓/Pr/cc's	—		
C.T. Strip & Vent Q ____	—		
C.T. Fluctuates / — cm.	—		
[redacted]ripheral Pulses ** U	P		
L	LP — 2+		
Circ. Distal to A-Line	—		
Monitor Alarm On	Yes		
PA Line	—		
CVP/Other	—		
Art Line	—		
Peripheral	R arm		
Peripheral	—		
PT/Family Teaching/Support	—		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES / TIME	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
Bowel Sounds	+ x4		
ABD Size/Firmness	soft		
NG Secure/Proper Pos.	—		
✓ Patency Q4°	—		
Aspirate Contin. Feed Q4	—		
Aspirate Prior to Bolus Feed	—		
Stool Char./Guaiac	—		
Urine Color/Character	Clear Yellow		
Foley Secure/Patent	D/C'd 0930		
External Cath.	—		
Catheter Care	—		
Colostomy/Ileostomy Care	—		
Bath	✓		
Turn & Position Q ____	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	—		
ROM	—		
Dangle	✓		
Restraints Released Q2H	—		
OOB to Chair	✓		
Ambulation	—		
Side Rails ↑	—		
Drsng. Δ	✓		
Drsng. Δ	—		

ADDRESSOGRAPH

AMEPW [redacted]

(b)(6)-4

ICU 1

SPECIMEN/LAB RPT.

MISC

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

PATIENT STATUS: ☐ BED ☐ A OUTPATIENT ☐ ☐ NP ☐ C

SPECIMEN SOURCE (Specify)

0725

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2 | (b)(6)-2 | REPORTED BY | MD TECH | DATE 7-31-02 | LAB ID NO.

REMARKS

Lytes, BUN, Crea, Glu

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
	7/31	06		

Glucose - 96 Cl - 95
BUN - 10 tCO2 - 27
CRE - 0.7
CK - 1733
Na^+ - 119
K^+ - 3.7

PICCOLO
07/30/02 07:14 PM
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 2261BA4
OPER #: (b)(6)-2 DR #: 000
SERIAL #: (b)(6)-2

GLU	96	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	1733*	38-360	U/L
NA+	119*	128-145	MMOL
K+	3.7	3.3-4.7	MMOL
CL-	95*	98-108	MMOL
tCO2	27	18-33	MMOL

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

(b)(6)-4

ICU 1

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

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

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

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

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2 | (b)(6)-2 | REPORTED BY (b)(6)-2 | 0725 MD TECH | DATE 7-31-02 | LAB. ID. NO.

REMARKS

CBC

HEM0728

549-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	(X) REQUESTED	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	PTT CONTROL	PTT PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	7/31	06																													
RESULTS				3.49	9.9	29.6	84.8	28.4	33.5	6.3										19					13.9	0.9						

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FPMR (41-CFR) 201-45.505

MISCELLANEOUS

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.

REQUESTED

RESULTS

Gluc- 89
Bun- 12
na+- 143
K+- 3.5
Cl- 103
CO_2- 25
Creat- 0.8

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
557-107

REMARKS

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

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

REPORTED BY (b)(6)-2 | MD | DATE 7/30/02 | 9:10 TECH

Bun/Cr/Lytes

ICU #1 Bed #5

(b)(6)-4

MISC

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

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

SPECIMEN SOURCE (Specify) Vein

LAB ID NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.

RESULTS	REQUESTED	(X)
3.76	RBC COUNT	(L)
10.7	HEMOGLOBIN	(L)
31.5	HEMATOCRIT	(L)
85.7	MCV	
29.2	MCH	
34.1	MCHC	
8.1	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
156	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
7.8	PTT CONTROL	
0.7	PTT PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

REMARKS CBC

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

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

REPORTED BY (b)(6)-2 | MD | DATE 7/30/02 | 0745 TECH

H+H

ICU #1 Bed #5

(b)(6)-4

HEMATOLOGY

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MISC

SPECIMEN/LAB RPT. NO.

ICU#1

(b)(6)-4

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

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY (b)(6)-2 | 7-31-02 - 1235 TECH | MD | DATE | LAB ID NO.

REMARKS

557-107

STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
31 Jul 02	1210	

REQUESTED Electrolytes

RESULTS

Gluc ___ 90 mg/dL
BUN ___ 11 mg/dL
Na ___ 136 mmol/L
K ___ 3.3 mmol/L
Cl ___ 94 mmol/L
CO_2 ___ 29 mmol/L
Hct ___ 29 %PCV
tHb ___ 10 g/dL

Sample Type: 31JUL02 12:15

Oper: (b)(6)-2

Physician: (b)(6)-2

07

S043C
W A84

MEDCOM - 3100

- i-STAT G3+

Pt Name: [redacted]

TCO2_____30 mmol/

At 37C

PH_____7.192

PCO2_____72.6 mmHg

PO2_____291 mmHg

HCO3_____32 mmol/L

BEecf_____4 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

29JUL02 12:17

Oper: 1423

Physician:_____

Ser# 39665

Oper: JAMS043C
CLEW A84

i-STAT G3+

Pt Name:_____

TCO2_____24 mmol/

At 37C

PH_____7.379

PCO2_____38.9 mmHg

PO2_____*** mmHg

HCO3_____23 mmol/L

BEecf_____ mmol/L

sO2*_____** %

*calculated

Sample Type_:

29JUL02 13:17

Oper: 1423

ysician:_____

r# 39665

r: JAMS043C
CLEW A84

i-STAT G3+

: 106

Name:_____

O2_____35 mm

At 37C

PH_____7.445

PCO2_____34.8 mmHg

PO2_____150 mmHg

HCO3_____24 mmol/L

BEecf_____0 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

29JUL02 07:07

Oper: 1423

Physician:_____

Ser# 43004

Oper: JAMS043C
CLEW A84

i-STAT G3+

Pt: 106

Pt Name:_____

CO2_____32 mmol/L

At 37C

PH_____7.449

PCO2_____43.6 mmHg

PO2_____80 mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2*_____96 %

*calculated

Sample Type_:

29JUL02 09:55

Oper: 1423

Physician:_____

Ser# 40004

Oper: JAMS043C
CLEW A84

Pt #[redacted] ICU #1 BED #5

Chem 7 / BUN/CR
(Istat 6)
↳ Mag ?
Hct

MICRO-BIOLOGY 1

SPECIMEN LAB RPT NO

PATIENT STATUS
☒ BED
☐ AMB
☐ OUTPT
☐ DOM
☐ NP

INFECTION
☐ ADMITTED WITH HOSPITAL ACQUIRED
☐ PRE OPERATIVE
☐ POST OPERATIVE
☐ NON SURGICAL
☐ POSTPARTUM
☐ NEWBORN
☐ OTHER (Specify)

PATIENTS MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE
DR. [redacted]

REPORTED BY
[redacted] MD
TECH

DATE 7/29/02

LAB ID NO

CLINICAL INFORMATION (including specimen source)
[redacted]

ANTIBACTERIAL THERAPY

SPECIMEN TAKEN
DATE
TIME
A.M. P.M.

EXAMINATION REQUESTED
☐ SMEAR ☐ CULTURE ☐ COLONY COUNT
☐ SENSITIVITY

REPORT

Glu 113
Bun 15
Cr 1.1
Ca >5000
Na+ 124
K+ 3.4
Cl- 100
tCO2 22
Hgb - 10
Hct - 29

553-107

MICROBIOLOGY 1
STANDARD FORM 553 Rev. 3-77
Prescribed by GSA/ICMA
FPMR (41 CFR) 201-45.505

URINALYSIS (Standard Form 550)

RESULTS	TEST(S)	
	DATE / TIME (A.M./P.M.) — SPECIMEN TAKEN	
	REQUESTED	(X)
	ROUTINE	
Dk yellow	COLOR	
1.015	SPECIFIC GRAVITY	
0.2	UROBILINOGEN	
Lg	OCCULT BLOOD	
	BILE	
SM	KETONES	
Neg	GLUCOSE	
Trace	PROTEIN	
8.0	pH	
	MICROSCOPIC	
	WBC	
	RBC	
	EPITH CELLS	
	WBC (CASTS)	
	RBC (CASTS)	
	HYALINE (CASTS)	
	GRANULAR (CASTS)	
	BACTERIA	
	CRYSTALS	
	MUCUS	
	NITRITE	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

URINALYSIS 550-107
Standard Form 550 (Rev. 4-77)
General Serv. Committee on Med.

REMARKS: MAJ. (b)(6)-2
UA / ∅ Micro

REQUESTING PHYSICIAN'S SIGNATURE
Enter in above space: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY (b)(6)-2
TECH 9/EM4 DESTUD?
MD DATE

URINALYSIS — URGENCY: ROUTINE / TODAY / PRE-OP / STAT X
PATIENT STATUS: BED / AMB / OUTPATIENT / NP / DOM
SPECIMEN SOURCE: ROUTINE / OTHER (Specify)
LAB. ID NO.
SPECIMEN/LAB RPT N

(b)(6)-4

EMT

HEMATOLOGY (Standard Form 549)

RESULTS	TEST(S)	(X)
DATE 28 Jul 02	TIME 1826 — SPECIMEN TAKEN	
4.58	RBC COUNT	
14.2	HEMOGLOBIN	X
39.2	HEMATOCRIT	X
85.6	MCV	
31.1	MCH	
36.3	MCHC	
11.5	WBC COUNT	X
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	X
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
207	PLATELET COUNT	X
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
12.5	PT CONTROL	
13.2	PT PATIENT	
	PTT CONTROL	
	PTT PATIENT	
	% ACTIVITY	
1.0	RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR

CBC

REMARKS (b)(6)-2
REQUESTING PHYSICIAN'S SIGNATURE
Enter in above space: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY (b)(6)-2
TECH
MD DATE 7-28-02
LAB. ID. NO.

HEMATOLOGY — URGENCY: ROUTINE / TODAY / PRE-OP / STAT
PATIENT STATUS: BED / AMB / OUTPATIENT / NP / DOM
SPECIMEN SOURCE: VEIN / CAP / OTHER (Specify)
PATIENT'S MED. RECORD

(b)(6)-4

ICU#1

URINALYSIS (Standard Form 550)

Pt. # (b)(6)-4 ICU#1 BED#5

UA / Microscopic

URIN-ALYSIS — URGENCY: ROUTINE / TODAY / PRE-OP / STAT
PATIENT STATUS: BED / AMB. / OUTPATIENT / NP / DOM.
SPECIMEN SOURCE: ROUTINE / OTHER (Specify)
SPECIMEN/LAB

Enter in above space: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY (b)(6)-2
MD / TECH
DATE 7-29-02
LAB. ID. NO.

REMARKS: Brown yellow; ↑ nitrite + bili; micro; m RBCs; R Rec Blc cell cast

RESULTS	TEST(S)
	DATE / TIME (A.M./P.M.) — SPECIMEN TAKEN
	REQUESTED (X)
	ROUTINE
Cloudy	COLOR
1.030	SPECIFIC GRAVITY
5.0	pH
=	GLUCOSE
TR	PROTEIN
+++	OCCULT BLOOD
+	KETONES
	MICROSCOPIC
	WBC
	RBC
	EPI CELLS
	WBC (CASTS)
	RBC (CASTS)
	HYALINE (CASTS)
	GRANULAR (CASTS)
	BACTERIA
	CRYSTALS
	MUCUS
	BILE
NEG	URO-BILINOGEN
	BENCE-JONES PROTEIN
	HEMOSIDERIN
	PSP
	15 MIN.
	1 HR.
	HCG

URINALYSIS
Standard Form 550 (July 1971)—GSA FPMR 101–11.6

3+

Pt: (b)(6)- (b)(6)-4

Pt Name:___________

TCO2________26 mmol/L

At 37C

pH_______7.435

PCO2______37.5 mmHg

PO2__________59 mmHg

HCO3________25 mmol/L

BEecf________1 mmol/L

sO2*________91 %

*calculated

Sample Type_:

28JUL02 10:05

Oper: (b)(6)-2

Physician:___________

0007

AB6:S

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.

REQUESTED

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

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2 | REPORTED BY (b)(6)-2 | MD | DATE

REMARKS MAJ

91km4 TECH 28JUL02

EMT

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

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

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO.

MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) 557-107

(b)(6)-4

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.

REQUESTED

PT/PTT

RESULTS

PT - 19.7

INR - 1.56

PTT - 17.0

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

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2 | REPORTED BY (b)(6)-2 | MD | DATE

REMARKS MAJ.

91km4 TECH 28JUL02

Emt

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

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

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO.

MED. RECORD

MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) 557-107

(b)(6)-4

(b)(6)-4

EMT

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE (Specify)

PATIENTS MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2 | REPORTED BY (b)(6)-2 | MD | DATE | LAB ID NO.

REMARKS MAJ

91km4 TECH 28JUL02

TEST(S): Trauma Panel

SPECIMEN TAKEN: DATE | TIME | A.M. / P.M. | REQUESTED

RESULTS

ALB-*3.2-L

ALP-72

ALT-31

AST-*95 H

Amy-*104 H

T.Bili-1.2

Bun-12

Creat-1.1

Gluc-114

GGT-9

T.P.-*4.9 L

CA+-*7.5-L

Na+-140

K-4.2

Cl-105

CO_2-20

MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505 557-107

MEDCOM - 3103

HEMATOLOGY

TEST(S)		
SPECIMEN TAKEN		
DATE	TIME	A.M. P.M.
RESULTS	REQUESTED	(X)
3.95	RBC COUNT	X
11.7	HEMOGLOBIN	X
33.4	HEMATOCRIT	X
84.5	MCV	
29.5	MCH	
34.9	MCHC	
12.0	WBC COUNT	X
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
160	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTIME CONTROL	
	PROTIME PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

REMARKS: LY % 6.8 LY # 0.8

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

REQUESTING PHYSICIAN'S SIGNATURE: DR (b)(6)-2

REPORTED BY | MD | DATE | TECH

Am EPW

(b)(6)-4

ICU #1

HEMATOLOGY
URGENCY: ☐ ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)
LAB. ID. NO.
SPECIMEN

MISCELLANEOUS

TEST(S)
SPECIMEN TAKEN
DATE | TIME | A.M. P.M.
REQUESTED
RESULTS

Na	139
K	3.5
Cl	99
BUN	13
Glu	107
Hct	32

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
557-107

REMARKS: Electrolytes w/ Bun + creat.

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

REQUESTING PHYSICIAN'S SIGNATURE: DR (b)(6)-2

REPORTED BY | MD | DATE | TECH

AM EPW

(b)(6)-4

ICU #1

MISC
URGENCY: ☐ ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DC
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

(b)(6)-4

EMT

HEMATOLOGY

SPECIMEN/LAB RPT. NO.
URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)
PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: MAJ (b)(6)-2
REPORTED BY: (b)(6)-2 91KM4
MD | DATE: 28JUL02 | TECH
LAB. ID. NO.

REMARKS

TEST(S)	
SPECIMEN TAKEN — DATE / TIME	
RBC COUNT	4.63
HEMOGLOBIN	13.1
HEMATOCRIT	39.6
MCV	85.5
MCH	28.2
MCHC	33.0
WBC COUNT	10.2 H
IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	14.7 L
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED. RATE	
PLATELET COUNT	53 L
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PTT CONTROL	
PTT PATIENT	
PROTIME CONTROL	
PROTIME PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	
LE PREP	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

516-108

NSN 7540-00-634-4153

MEDICAL RECORD — **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

S/P GSW

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
(b)(6)-2	N/A	N/A	
ANESTHETIST	**ANESTHETIC**		**TIME BEGAN:** 1149
(b)(6)-2	General		**TIME ENDED:** 1250
CIRCULATING NURSE	**SCRUB NURSE**	**TIME OPERATION BEGAN**	**TIME OPERATION COMPLETED**
(b)(6)-2 SMD	(b)(6)-2 MSMD	1210	1248

OPERATIVE DIAGNOSES

Chest + back wounds - deep

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
Foley inserted prior to entering OR	+ Sharps / CORRECT

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

N/A

OPERATION PERFORMED

Irrigation & closure chest GSW

Irrigation Back GSW

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION
Mon EBC No Complications		

SIGNATURE (b)(6)-2 — DATE 3 Aug 06

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility) — REGISTER/I.D. NO. — WARD NO.

(b)(6)-4

AMEPW

FAKAD

OPERATION REPORT
Medical Record

516-108

NSN 7540-00-634-4154

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

S/P OSW bilateral legs, R shoulder

SURGEON (b)(6)-2	FIRST ASSISTANT	SECOND ASSISTANT	
ANESTHETIST (b)(6)-2	ANESTHETIC General		TIME BEGAN: 1050
CIRCULATING NURSE (b)(6)-2 M.D.	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN 1120	TIME ENDED: 1542 / TIME OPERATION COMPLETED 1525

OPERATIVE DIAGNOSES

Penetrating Ocular Injury c Retained Intraocular Foreign Bodies, OU and Hyphemia and Vitreous Hemorrhage

DRAINS (Kind and number)	SPONGE COUNT VERIFIED

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

① CSM Left Eye (Micro) Sent To

② CSM Right Eye (Micro) Sent To

OPERATION PERFORMED

Closure Sclera Wound Right Eye; Injection of Antibiotics and Steroids OD; Corneal Wound Repair Left Eye; Exploration of Globe; Sclera Wound Closure; Injection Antibiotics, Steroids

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION

SIGNATURE OF SURGEON (b)(6)-2 | DATE 2 Aug 02

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility) (b)(6)-4 | REGISTER/I.D. NO. | WARD NO.

OPERATION REPORT
Medical Record

516-105

NSN 7540-00-634-4156

MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS
S/P GSW ~ bilateral legs, (L) shoulder debrisment

SURGEON (b)(6)-2 | FIRST ASSISTANT (b)(6)-2 | SECOND ASSISTANT

ANESTHETIST (b)(6)-2 | ANESTHETIC general | TIME BEGAN: 1723 | TIME ENDED: 1948

(b)(6)-2 RN | (b)(6)-2 -91D | SCRUB NURSE (b)(6)-2 Z 91D | TIME OPERATION BEGAN 1752 | TIME OPERATION COMPLETED 1930

OPERATIVE DIAGNOSES
Gunshot wounds (L) shoulder, back and both legs
open fracture (R) foot

DRAINS (Kind and number)
Foley + Chest tube inserted prior to entering O.R.

SPONGE COUNT VERIFIED + Sharps correct

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
N/A

OPERATION PERFORMED
Bilateral debridement of legs, pectoralis Repair, partial closure of clavical, I+D of shoulder + back

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.)

DATE OF OPERATION

I+D (B) legs, (R) foot
2° closure (B) leg wounds
I+D chest, back wounds with packing of wounds
Ø cap
200 EBL

SIGNATURE (b)(6)-2

DATE 30 July 02

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

REGISTER/I.D. NO.

WARD NO.

(b)(6)-4

OPERATION REPORT
Medical Record

516-108

NSN 7540-00-634-4156

MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS

GSW | Shrapnel (R) shoulder / bi-lat legs

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT
(b)(6)-2	(b)(6)-2	(b)(6)-2

ANESTHETIST	ANESTHETIC	TIME BEGAN	TIME ENDED
(b)(6)-2 / (b)(6)-2	General	354	528

CIRCULATING NURSE	SCRUB NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
(b)(6)-2 RN / (b)(6)-2 910	(b)(6)-2 910 / (b)(6)-2 910	1455	1515

OPERATIVE DIAGNOSES

GSW (L) CWI shoulder

Shrapnel (L) Knee, (R) Foot open Metatarsal fractures, traumatic arthrotomy s.v.f.a

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
Foley + Chest tubes bilat inserted prior to entering O.R.	✓ sharps / correct

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

N/A

OPERATION PERFORMED

Debridement (R) shoulder
chestwall, (R) knee (R) Foot + (R) subtaylor arthrotomy
(R) hand

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION

IVD as above

ϕ EBL

ϕ Comp

Sling to (L) shoulder

Splint to (R) foot

(b)(6)-2

SIGNATURE (b)(6)-2

DATE 26 July 02

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

REGISTER/I.D. NO.	WARD NO.

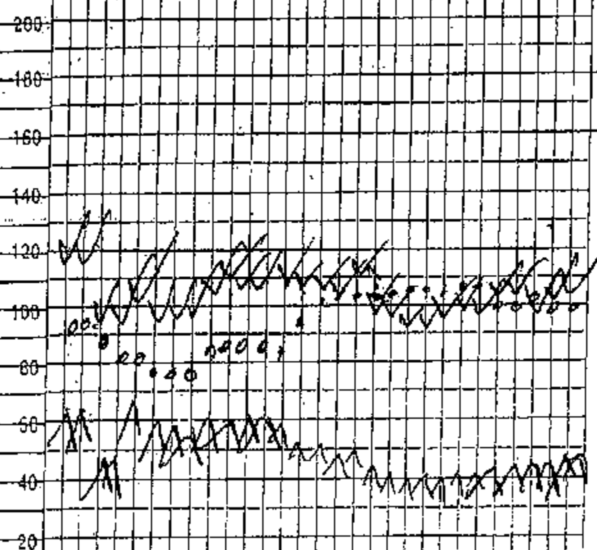
(b)(6)-4

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

ANESTHESIA RECORD

POSITION / EVENTS	1045 (TIME)	11	X	12	X	13	Totals
l/min O₂	3	2	2	2	2	2	
l/min N₂O / Air							
% Sevoflurane / Desflurane ISO	2	1.8 / 1.5		1.6	1.7	1.0	
mg PENT / (PROPOF) / (Lido)	160						
mg DTC / SUCC / MIVACR / ROC/RAP							
mg MSO₄ / mcg ml (FENT)	3 2						
mg MIDAZ							
vecuron	8		2				
Morphine			5		5		



TV/RIP 650/26 ... 650/26 / 650/19

ESL

Urine — 2

IV #1 LR1000

Incision 1120

☒ BP (R) L

EKG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
ETCO₂		2	31	38	39	39	37	34	35	
SpO₂	98	97	99	99	100	100	100	100	100	100
Temp		36	3	36	36	36.4	36.7	36.9	36	37.2
Resp										

☐ Tourniq

Procedure: Closure of Scleral Wound injection of antibiotics & steroids OD,

Premeds: None

Wt

Allergies: NKDA

(b)(6)-2

PT ID ☒ Verbal ☐ Armband Sign

ATBX: ______ TIME: ______

☒ GA. INHA ☐ GA. IV ☐ MAC ☐ Bier Block

☐ Spinal ☐ Epidural ☐ Nerve Block

Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask ☐ Nasal Cannula

Intubation ☒ Oral ☐ Nasal RAE ☐ ☐ LMA

☐ Stylette ☐ Cuff Tube Size: 8.0

Blade: Mil 3 ×1 ☐ Cricoid Pres (Easy)/Difficult

Atraumatic

Eyes ☐ Lube/Teardrops ☐ Taped ☐ Laser Protect

Arms Board L R Tucked (L) (R) Padded (L) (R)

1155 Bradycardia given Atropine .8

1225 Intra Ocular pressure [illegible]

1335 vecuron 2mg

1345 morphine 5mg

Crystalloids	Colloids	Total EBL
2200	Ø	
		Urine

Diagnosis: Multiple GSW c̄ projectile injury B/L eye

Anesthesiologist	Anesth. Start	Anesth. End	Date
(b)(6)-2	1050	1545	2AUG02

ASA 1 (2) 3

	BP	P	R	O₂Sat	Temp
Phase I	135/89	100	16	100	100.9
Phase II					

Surgeon

(b)(3)-1

(b)(3)-1

Patient Identification

(b)(6)-4

Afganistan

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION

PHYSICAL STATUS

1 2 3 4 5 E

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... WBC ..... HCT ..... OTHER	

Not known to us previous anesthetics Chart reviewed Pt examined

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(CHEST, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)

PREVIOUS ANESTHETICS AND COMPLICATIONS

PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS

PREOPERATIVE DIAGNOSIS

PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN

DATE 2 AUG 02

POSTANESTHETIC VISITS

(b)(6)-2

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1996 - 716-954/83312

Pre-op - Multiple GSW - chest, (R) leg, foot + hand

Postop - Bilat Hemo Thorax, GSW (R) leg, (R) foot, (R) hand

Procedure: Bilat Resuscitative Thoracotomy c̄ chest tubes
(R) fem/pop Exploration, debridement. Bilat chest +
back wounds, Debride (R) foot wound (GSW)

Team - (b)(6)-2 / (b)(6)-2

EBL 1l

Fluid 3 unit Whole blood + 7000 crystalloid

Drain - Bilat Tube Thoracostomy

Tol Well to ICU stable but critical

? U.O. ~~1300cc~~ 2700cc

(b)(6)-2

(b)(6)-4

27 July 02

II/II

POSITION / EVENTS

TIME 1315 X 14 X 15 X

O₂ l / min. 2 — 2 — 2 — 2 —

N₂O / Air l / min

% Sevoflurane / Desflurane Iso 1.0-1.5 — 1.1 — 1.3 —

mg PENT / PROPOF (Qtd)

mg DTC / SUCC / MIVACR / ROC/RAP

mg MSO₄ / mcg ml FENT 7 5 4 1 0.4

mg MIDAZ

Vecuron

Morphine

Robinul / Neostigmine

200 180 160 140 120 100 80 60 40 20

(b)(6)-2

EBL

Urine

IV #1 RLactate (2)

Incision

BP R L

Tourniq

EKG SR SR SR SR SR SR SR SR

ETCO₂ 32 32 32 37 37 37 37 35

SpO₂ 98 99 99 100 100 100 100 100

Temp 378 378 378 37 38 38

Resp

Totals

Premeds | Wt | Allergies

PT ID

☐ Verbal ☐ Armband Signature

ATBX: TIME:

☐ GA, INHA ☐ GA, IV ☐ MAC ☐ Bier Block

☐ Spinal ☐ Epidural ☐ Nerve Block

Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask ☐ Nasal Cut

Intubation ☐ Oral ☐ Nasal RAE R L ☐ LMA

☐ Stylette ☐ Cuff Tube Size.

Blade: ☐ Cricoid Pres. Easy/Difficult

Eyes ☐ Lube/Tearisol ☐ Taped ☐ Laser Protect

Arms Board L R Tucked L R Padded L R

Procedure

See page 1

Crystalloids | Colloids | Total EBL

Diagnosis

See Page 1

Anesthesiologist (b)(6)-2

Anesth. Start | Anesth. End | Date 24AUG02

ASA 1 2 3

Surgeon

Phase I BP P R SpSat Temp

Phase II

(b)(3)-1

(b)(3)-1

Afganistan

Patient Identification

(b)(6)-4

ANESTHESIA RECORD

POSITION / EVENTS		TIME 1715	x	18	x	19	x	Totals
l / min.	O_2	2	1			1	2	
l / min	N_2O / Air		1			1		
% Sevoflurane / Desflurane	ISO	2	1	1.5	1.0	1.5	X	
mg PENT / PROPOF (Um)		160						
mg DTC / SUCC / MIVACR / ROC/RAP		100						
mg MSO_4 / mcg ml FENT		2	3			3		
mg MIDAZ		1.5						

Premeds: ~~None~~ Fentanyl 100mcg

Wt

Allergies: NKDA

(b)(6)-2

PT ID

☒ Verbal ☐ Armband Signature

ATBX: Ancef 1gm 1720

☒ GA, INHA ☐ GA, IV ☐ MAC ☐ Bier Block

☐ Spinal ☐ Epidural ☐ Nerve Block

Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask ☐ Nasal Dentures

Intubation ☒ Oral ☐ Nasal RAE R L ☐ LMA ___

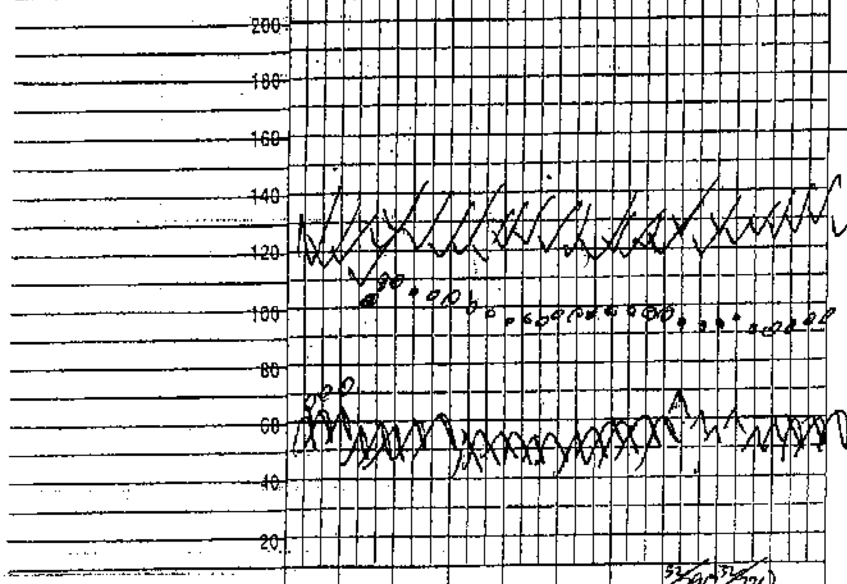
☐ Stylette ☐ Cuff Tube Size 8.0 M1/3x1

Blade: ______ ☐ Cricoid Pres Easy/Difficult

Smooth uneventful. N induction easy

Eyes ☐ Lube/Tearisol ☐ Taped ☐ Laser Protect

Arms Board L R Tucked L R Padded L R



1900 Break Ehlurdn chaw

EKG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
$ETCO_2$		53	42	36	30	29	25	29	29	
SpO_2	100	100	100	100	100	100	100	100	100	100
Temp		98	99	99	99	98	99	100	101	100
Resp	O	⊗	⊗	⊗	⊗	⊗	⊗	⊗	⊗	O

EBL

Urine

IV #1

Incision

BP R L

☐ Tourniq

Pt suctioned breathing well Extubated c awake good Air exchg to ICU II Tolerated well Demerol 12.5mg IV now

Procedure: Debridement partial pectoralis repair + closure. Debride wounds of Back Debridement of foot

Crystalloids	Colloids	Urine
1200	Ø	150

Diagnosis: Multiple GSW R chest

Anesthesiologist (b)(6)-2

Anesth. Start	Anesth. End	Date
1720	1948	30JUL02

ASA 1 (2) 3

Phase I BP 98/88 P 40 R 20 O_2Sat 94 Temp

Phase II

Surgeon (b)(6)-2

(b)(3)-1

(b)(3)-1

(b)(6)-4

(b)(6)-4

Patient Identification

(EPW)

Afganistan

ANESTHESIA RECORD

MEDCOM - 3113

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Debridement			Enemy POW

PHYSICAL STATUS: 1 (2) 3 4 5 E

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) B/L Chest tubes ~~CVA~~	BP ..... PULSE ..... EKG (IF PERTINENT) WNL	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) None	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS
No complications Operations x2	Ancef Tgn

PREOPERATIVE DIAGNOSIS	PREMEDICATION	
	Fentanyl 100 mcg	
	SIGNATURE OF EVALUATING (b)(6)-2	DATE 30JUL

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1998 - 716-994/80312

25 July 02
0545 neuro → paralyzed on board

C-V → LSCTB. (B)CT c̄ min. drg at this time. S1S2 ST c̄ ectopy.
ETT 9.0 27cm @ lip. RP 2+ x 2 LDP 2+ RDP 1+

G-I → (+)BS, abd soft, flat

G-U → 16 fr foley c̄ clear, yellow urine

M-S → Paralyzed on board

<u>Vent</u> 5 peep
Peak 60
Rate 20
TV 920

(b)(6)-2 SSG 91W30M6

28 July 02 0600 Dsg D/I to (L) foot by (b)(6)-2 (b)(6)-2 SGT 91W20M6

28 July 02 0685
DSG Δ

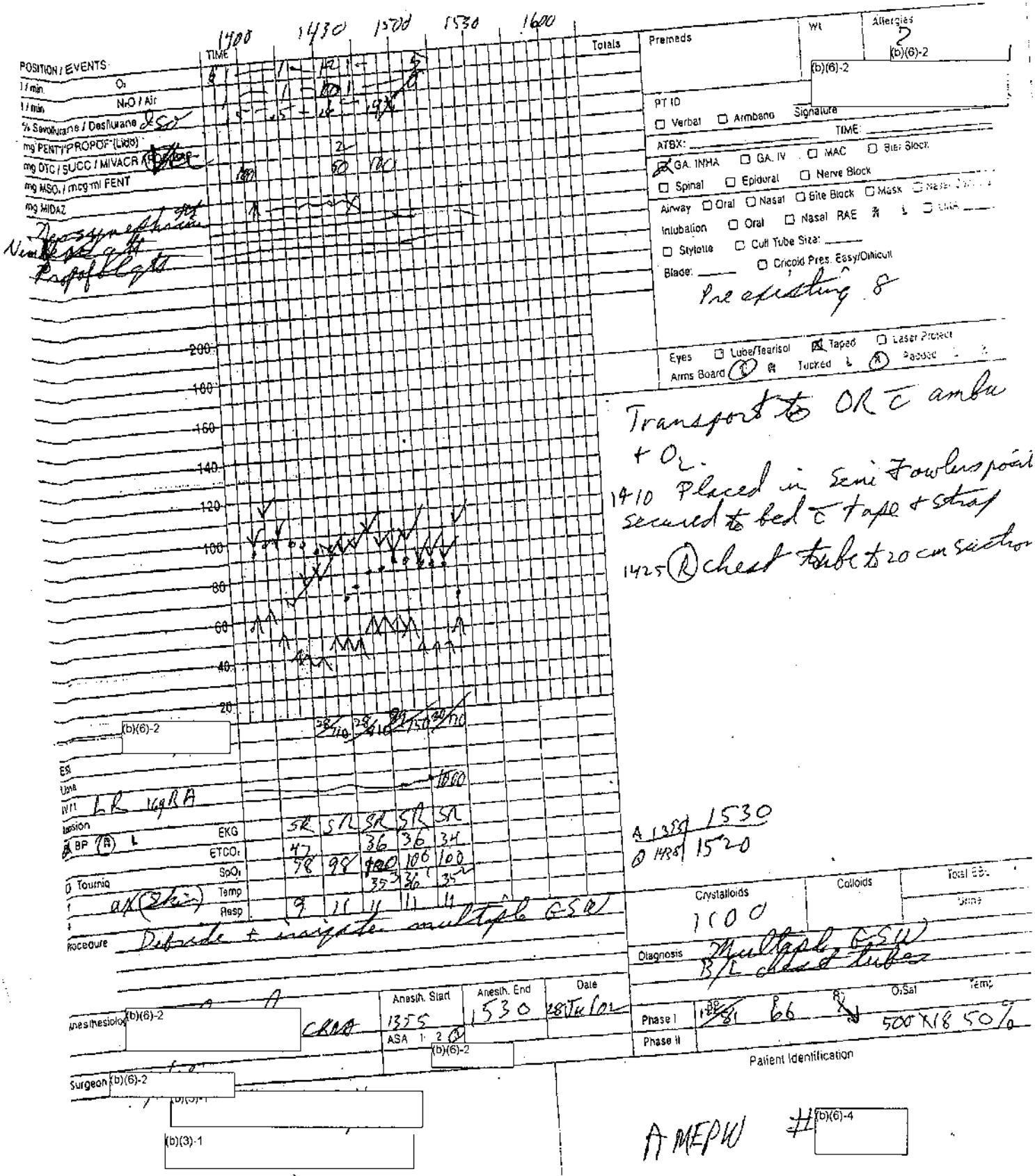
(L)CT → CT intact. Xeroform in place. s̄ drg noted. ABD in place c̄ occlusive drg

ant drg → min drg noted, saline packing removed. tissue pink. saline packing replaced. ABD replaced c̄ occlusive drg.

Post drg → serosanguinous drg. saline packing replaced. ABD occlusive drg

(R)CT → CT intact. Xeroform replaced. min drg for CT. ABD occlusive drg.

(b)(6)-2 SSG 91W30M6



ANESTHESIA RECORD

MEDCOM - 3116

Standard Form 517 1849

1830 **CLINICAL RECORD** ASA IE **ANESTHESIA**

ANESTHETIC(S)	HOUR 19 – 20 – 21 – 22
Forane	.3 .4 .5 .4 off
Neosynephrine	
Scopolamine	0.4
Versed mg	X 3 5
Fentanyl	X 1 1 2 5
Norcuron mg	10
SAT	93 99 100 100 99 99 99 98 98 97 96
ETCO2	33 34 33 33 33 34 34 34 34 34 34
OXYGEN	60 60 60 60 60 60 60 60 60 35 35
CO2 ABSORP.	
LEVEL OF ANAL-ANES.	O2 4/min ⟶ 2 ⟶

INDUCTION

SATIS ______

UNSATIS AND WHY ______

REMARKS

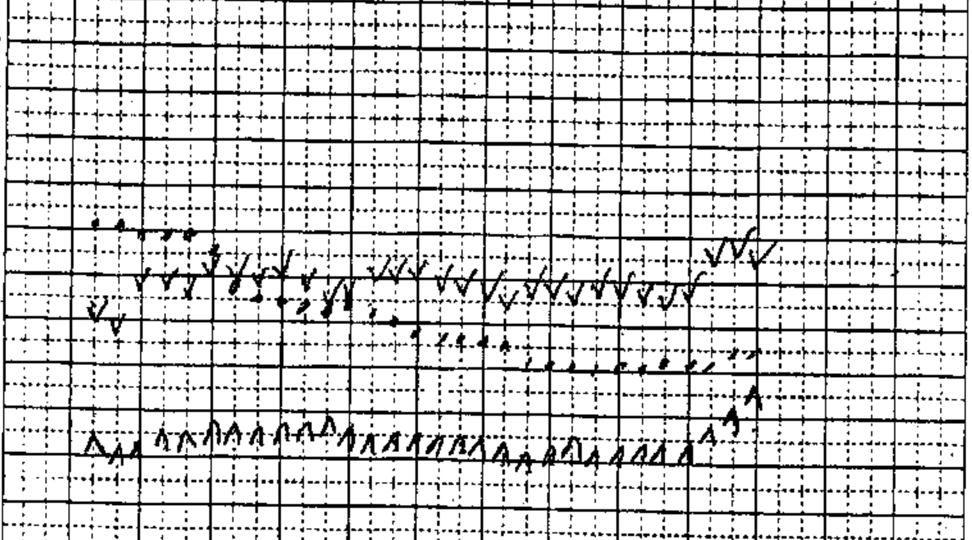
14 G ® A

18 G Ⓛ A

1935: Arterial line ® IUPB

CODE: ● PULSE, ○ RESP., V/Λ B.P., X ANES., ⓞ OPER., T TOURN.

FLUIDS: B BLOOD, N SALINE, G 5% G/W, DX EXPAND.



NUMBERS FOR REMARKS	Whole Blood ⟶ #1 #2 #3 ⟶
IV FLUIDS	Albumin X 50 ; X 1000/2000/5000 / ⟶ 2000
POSITION	Hespan ; Supine ⟶ X 500 /

AGENTS AND TECHNICS X ⓞ

Anesthesia 1849 / 2130 ; Surgery 1855 / 2110

1850: Induction Etomidate 20 ; Sux 160 ; Xylocaine 100

ENDOTRACHEAL: SIZE 8.0 BLADE 4 MAC ORO ______ NASO ______ CUFF ______ PACK ______

REMARKS: Direct Visualization Cords visible ⊕ ETT ⊕ Epigastric ETC 24 cm ET

OPERATION PERFORMED

Bilateral Resuscitative Thoracotomies, ® Popliteal Exploration, Debridement of Multiple GSWs.

TOTAL FLUIDS: Whole Blood #3 ; Crystalloid 5000 ml ; Albumin 50 ; Hespan 500 ml

(b)(6)-2

(b)(6)-2

(b)(6)-2

RECOVERY

REFLEX IN O.R. ______

EMESIS ______

ASPIR. ______

EXCITEMENT ______

HYPOTENSION ______

OTHERS ______

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

REGISTER NO. | WARD NO. | DATE 27 July 02

Trauma #1

(b)(6)-4

EBL: 1000 ml

U/O: 2700

ANESTHESIA

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS FPMR 101-11.806-8 OCTOBER 1975 517-109

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

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

- ☒ TYPE AND SCREEN
- ☐ CROSSMATCH

DATE REQUESTED: 7-28-02

DATE AND HOUR REQUIRED: 7-28-02 930AM

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: Maj. (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Mult wounds (chest)

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

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO. #(b)(6)-4

DONOR

RECIPIENT

ABO: ABO B

Rh: Rh POS.

TEST INTERPRETATION

ANTIBODY SCREEN: NEG

CROSSMATCH: ~~NEG~~

PREVIOUS RECORD CHECK: ☐ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2 911 SM4

☑ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 7-28-02

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

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

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN _____ ML

TIME DATE COMPLETED INTERRUPTED

REACTION ☐ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER _____

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

☐ NO ☐ YES *(Specify)* _____

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION – USE EMBOSSER *(If not typed or written entries give: NAME – Last, first, middle; rank; rate; hospital number and name of facility.)*

#(b)(6)-4 Afghani Male EMT

SEX: M

WARD: EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 6-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

NSN 7540-01-155-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED: Chest

AGE: [illegible] | SEX: M | SSN (Sponsor): | WARD/CLINIC: ICU I | REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☒ NO

(b)(6)-2 | Sgm. | TELEPHONE/PAGE NO.:

SIGNATURE OF REQUESTER: (b)(6)-2 SGM | DATE REQUESTED:

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*: Follows up. Post-op

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

RADIOLOGIC REPORT

No significant change

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle, Medical Facility)*

(b)(6)-4

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER 12 AUG 02 TIME OF ORDER 1000

LIST TIME ORDER NOTED AND SIGN

① discharge today (b)(6)-2

② ok Gent & Ancef (b)(6)-2

③ Eye drops as per optometry (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 12 AUG 02

TIME OF ORDER ______ HOURS

PT. TO RETURN TO OPTOMETRY ON 10 SEPT FOR REMOVAL OF SUTURES IN LEFT CORNEA. (b)(6)-2 CPT, OD, MSC

REMOVAL TO BE DONE AT DETAINEE LOCATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

FORM 4256, 1 APR 79 REPLACES EDITION OF 1 JUL 77 ...

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

AM EPW

11 AUG 07

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED SIGNATURE

1 Remove all Staples

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

ICU | | 9

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

IRSING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NG UNIT | ROOM NO. | BED NO.

FORM APR 79 **4256** REPLACES EDITION OF 1 JUL 72

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER 19:30 HOURS | LIST TIME ORDER NOTED AND SIGN

7 AUG | D/C ATROPINE

CONTINUE C PRED FORTE AND OCUFLOX QID OU

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 CAPT, OD, MS

(b)(6)-2 Rx

7 AUG 02 2000

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER 10:00 HOURS

10 AUG

ADD CILOXAN TO DRUGS GIVEN Q6H

(b)(6)-2

(b)(6)-2

(b)(6)-2 CAPT, OD, MS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

11 AUG 02 @ D/C AMICIN

1520 @ D/C 6 on taper (a)

(b)(6)-2

(b)(6)-2 RECEIVED

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

URSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

AM EAR

Bed 9

NURSING UNIT | ROOM NO. | BED NO.

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

4 Aug 02 — 1450 HOURS

① Transf To ICU

② DX: multi GSW

③ MEDS: Percocet 1-2 PO Q4-6° PRN

Tylenol 650mg Supp OR PO Q4-6° PRN

Ancef 1Gm IV Q8° (8A 4P 12M)

Gentamycin 400mg IV QD (11P)

Pred Forte 1 gtt OD QID (5A 11A 5P 11P)

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

IV Heplock — HOURS

Atropine 1% 1 gtt OU bid (9A 9P)

Occuflox 1 gtt OS Q2° (odd)

Occuflox 1 gtt OD QID (5A 11A 5P 11P)

④ Diet: As tolerated

⑤ Activity: NWB ® leg.

⑥ Wet to dry dsg BS to back wounds & Drains Solution BID. (Add 1000)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

ER | TIME OF ORDER

QT, AN — HOURS

NURSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER

PRED FORTE QID OU

SAME TIME AS OTHER EYE MEDS — HOURS

RSING UNIT | ROOM NO. | BED NO

(b)(6)-2

(b)(6)-2

(b)(6)-2

CPT, MD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

AM EPW

NURSING UNIT | ROOM NO. | BED NO.

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

3Aug02 Admit ICU
S/p I+D
Resume preop orders
except:
1) wet → dry dressing Δ's to back wounds c̄ Dacon's solution bid.
2) clears liquids, ADAT to Reg
(b)(6)-2
(b)(6)-2 ILT ANC

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

3Aug02 1510 V/o from Dr (b)(6)-2 : Start DSG Δ's to back wounds in AM 8/4/02.
(b)(6)-2 ILT ANC

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

3 Aug 02
1550 V/o from Dr (b)(6)-2
[illegible] Tylenol 650mg PO also
(b)(6)-2 ILT ANC

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

3 Aug 02 1650 HOURS
1. Patch + shield OS to be changed daily.
2. Shield OD may be removed (D/C'd) @ 72 hrs post op.
3. Atropine 1% gtt i OU bid!
Ocuflox, gtt i-ii OD qid
4. Keep eyelids clean, O.D. & (cont).
Continuing (b)(6)-2
Col

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 3124

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
2 Aug 02	1650 HOURS	

Ind. Sterile saline
packs x gentle irrigation -
NO PRESSURE ON EARDS.
5. Brek Tabs, gtt i BD q id.
6. Pt to be discharged by
Opt. [(b)(6)-2]
Thanks, HM

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

[(b)(6)-2]

CPT 69420-LT

NURSING UNIT | ROOM NO. | BED NO.

[(b)(3)-1]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
3 Aug 02	1750 HOURS

Ciprodex gtt i-ii OS q 2 hr.
Tx Pred Forte OS.
Thank you

[(b)(6)-2]

CPT 69420-LT

NURSING UNIT | ROOM NO. | BED NO.

[(b)(6)-2]

[(b)(3)-1]

PATIENT IDENTIFICATION

DATE O | TIME OF ORDER

ILT ANC 1837 3 Aug 02

HOURS

3 days on D/C Foley

D/C IV [(b)(6)-2] → Heplock

ILT ANC 0912 4 Aug 02

4 Aug 02

NURSING UNIT | ROOM NO. | BED NO.

1200 Percocet 5/325 Tab PO q 4-6 hr pain

[(b)(6)-2]

ILT ANC 4 Aug 02 1150

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

HOURS

31 July 2 ① Repeat exn 1 Aug 02 (b)(6)-2 B6-2

11:45

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

11:45 HOURS

31 JULY

1 gtt OCUFLOX OU Q2H B6-2

2 Aug 02 (b)(6)-2 CAT, OD, MS

1552L - VS q 2 hrs x 2 then 4 hrs

Advance diet as tolerated

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Gentamycin 400 mg IV q 8 HOURS

Ancef 1 g IV q 8 hr

Foley catheter to gravity

IVF: LR at 100 cc/hr

Tylenol 650 mg supp PR q 4-6° PRN

Percocet 5/325 q 4° PRN pain

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

ICT ANC 8/2/02 1730

2 Aug 02 2:16 HOURS

① Ice chips & sips of water - may advance if tolerated

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

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

30 July 02 1800

Δ IVF to LR @ 150cc/hr

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

30 July 02 Admit ICU

s/p I+D

LR IV @ 125cc/hr

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Ancef 1gm IV q8°

Gentamycin 440mg IV qD

Taquent 300mg IV Sid

MSO4 2-5mg IV q2°prn

NPO ✕ ice chips ± sips H2O

NURSING UNIT | ROOM NO. | BED NO.

Chest tubes to cwus

NG Tube to cwus

Foley to GD

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Sling to L shoulder

NWB RLE / LUE

CXR in AM 7/31

CBC, lytes / BUN, Cr / Glu in Am 7/31

VS q2° x 4, then q4°

NURSING UNIT | ROOM NO. | BED NO.

Wet → Dry Gauze dressing d's to Both back wounds

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Fentanyl 50mcg IV Q1° PRN

(b)(6)-2

31 July COB to chair

(b)(6)-2

D/C Taquent

Lasix 20mg IVP X1

Δ IVF to NS @ 100cc/hr

-current bag

NURSING UNIT | ROOM NO. | BED NO.

Fe Na+ @ noon

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	HOURS	
29 Jul 02		
	Morphine 7mg IV x1	
	Lytes/ H+H @ 1800	
	IV Zofran @ 1800	
29 Jul 02		
1340	① CXR By @ 800 30 Jul 02	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	
29 Jul 02	1330 HOURS	
	X-Ray ① ANKLE	
	V/O Dr (b)(6)-2	
	Taken by (b)(6)-2 ILT ANZ	
	29 Jul 02	

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
29 Jul 02		
1540	H+H, Bun, C, lyte 0700 30 Jul 02	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
29 Jul 02	HOURS	
1930		
	V/O Dr (b)(6)-2 ! my hand	
	small cut & ice chips prn	
	pleasure.	
	Taken by (b)(6)-2 ILT ANZ	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
29 Jul 02	(b)(6)-2	
1951		
29 Jul 02	2030 HOURS	
① Tylenol ~~325mg~~	(b)(6)-2	
	650mg Suppos. hs @ 4-6° prn	
② CXR	(b)(6)-2	
24		
(b)(6)-2	30 Jul 02	
	29 Jul 02 Valium 1mg IV x1 for Agitation	
	V/O Dr (b)(6)-2	

URSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER — HOURS	LIST TIME ORDER NOTED AND SIGN
27 Jun	Lantoryl 50 mcg/hr IV Rx	
1230h		
27 Jun	IV Tagamet 300 bd Rx	
1700h		
27 Jun	Resume the op orders	
1600h	ABG @ 1700 hrs Vent TV 600 RR 16 40%	
	Get CBC tm clear.	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER — HOURS	
28 Jun	ABG @ 0700 L on 27 Jun 87	
2130		
28 Jun 02	500cc Fluid bolus then T rate to	
0530	125 cc/hr.	
	BUN/CR/Chem 7 this AM Vo. Dr	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER — HOURS	
29 Jun 87	↑ IV to 150 ml/hr	
0700h	LASIX 40mg IV now	
	2 Amps Bicarb to 1L NS Done	
	Potas 500 cc IVF x1 now	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER — HOURS	

NURSING UNIT | ROOM NO. | BED NO.

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

HYSICIAN ORDER SHEET

DATE	ORDERS	TIME
28 Jul 02	Etomidate 20mg IV	
	Vecuronium 10mg IV	
	1G Ancef IV	
	Repeat Vecuronium 10mg IV	
	Propofol IV Drip	
	CBC, electrolyte, coags	
	U/A	
	CXR	
	ABG	
	CT head chest, ABD Pelvis (b)(6)-2	
	Xray (L) thigh (R) foot (L) knee (b)(6)-2	
	BL hands	
28 Jul 02	ADMIT ICU	
1107	NPO	
	IV LR - 100ml/hr	
	Vent TV 450 ml	
	Rate 10	
	A/C 12 BPM	
	FiO2 100%	
	ABG @ 1200 hrs	1200 [illegible]
	Meds Ancef 1g q 8 hrs	
	Next dose 1800L	
	Gentamycin 400mg IV q day	
	NIMBEX IV	
	titrate to effect	
	begin @ 5 ml/hr	
	Propofol IV	
	titrate to effect	
	max 25 mcg/min	
	Chest tube to suction	
	XR LAT C-spine / swimmers view	
	I + O	
	VS q 1hr x 12 hr then	
	q 2 hr	
	Consult Dr (b)(6)-2 (Done)	
	LAB ~~H+H~~ @ 1600 and	
	CBC	
28 Jul 02	MSO4 - 10mg IV now (Done)	
	Δ Vent to TV 500ml / A/C 18 / FiO2 60% ABG 1 hr	

WARD	ID NUMBER:	DIAGNOSIS
PATIENT DATA (b)(6)-4	VERIFICATION	

CLINICAL RECORD

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

Mo. ____ Yr. ____

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				1 Aug
1 Aug 02	(b)(6)-2	Wet to dry drsg 4's to pack wound [illegible] solution	10	(b)(6)-2
	-----	BID	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Multi - GSW

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

Am EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

CLINICAL RECORD

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

Mo 8 Yr. 02

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/4	8/5
3 Aug	(b)(6)-2	Δ Patch + shield OS QD	1700	DC	
3 Aug		D/C shield OD @ 72° Post op	1700	/	/
3 Aug		Keep eyelids c/lean QD on	1700	(b)(6)-2 DC'd	
/	/	bid & sterile saline soaks +			
/	/	gentle wiping. NO Pressure			
/	/	on eyelids			

ALLERGIES! ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P multi GS wounds

ADDITIONAL PAGES IN USE! ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

AM EPW (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

2 of 2

CLINICAL RECORD

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

Mo. 8 Yr. 02

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6 7 8 9 10 11 12 13 14 15
6Aug02	(b)(6)-2	Pred Forte 1% QID	05	(b)(6)-2
	-----	OU ([redacted])-Same	11	
	-----	time d'other eye	17	
	-----	mark BOTH EYES	23	

9Aug	-----	PRED FORTE, OCUFLOX OU	5 11 17	(b)(6)-2
9Aug	(b)(6)-2	PredForte QID ou right	5 11 17 23	(b)(6)-2 (b)(6)-2
9Aug	(b)(6)-2	Ocuflox QID ou	5 11 19 23	(b)(6)-2
	-----	11 gtts		
10Aug02	(b)(6)-2	CILOXAN OU Q10	05 11 17 23	(b)(6)-2
6Aug02	(b)(6)-2	Heplock flush		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Multi - GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

(b)(6)-4

AM EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
4/6/2012	(b)(6)-2	Percocet 5-325 1 PO q4-6° prn	3/12 0100
4/6/2012	(b)(6)-2	Tylenol 650 mg Suppos PO q4-6° prn	0900 12AM (b)(6)-2

*U.S. GPO: 1998-454-110/85216

~~[redacted]~~ MARS 8/4/02 1 of 2

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

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8/4	8/5	8/4	[redacted]	[redacted]	[redacted]
8/4/2	(b)(6)-2	ANCEF 1 Gm IV Q8°	05	(b)(6)-2					
			13						
			21						
8/4/2	(b)(6)-2	GENTAMYCIN 400mg IV QD	13						
8/4/2		PRED FORTE 1 GTT OD	05						
		QID (RIGHT EYE)	11						
			17						
			23						
8/4/2	(b)(6)-2	ATROPINE 1% 1 GTT	09						
		OU BID (BOTH EYES)	21						
8/4/2	(b)(6)-2	OCCUFLOX 1 GTT OS	07						
		Q2° (ODD HOURS)	09						
		(LEFT EYE)	11						
			13						
			15						
			17						
			19						
			21						
			23						
			01						
			03						
			05						
8/4/2	(b)(6)-2	OCCUFLOX 1 GTS OD	05						
		QID (RIGHT EYE)	11						
			17						
			23						
8/4/2	(b)(6)-2	HEPLOCK IV FLUSH		(b)(6)-2					(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: MULTI-GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION: (b)(6)-4

AM EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

WOUND CARE

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. ______ Yr. ______

Order Date	Clerk/ Nurse	~~SINGLE DOSE/~~ PREOPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8/4/2	(b)(6)-2	WET TO DRY DSG CHANGES TO BACK WOUNDS c̄ DAKINS SOLUTION BID.	8/5 (b)(6)-2	10	8AM 10AM	
		Transcribed to	(b)(6)-2			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
8/4/2 11 Aug	(b)(6)-2	Percocet ī-īī PO Q4-6° PRN	(b)(6)-2 [illegible] 8/7/2 1300; 2240; 8/12 1030; 8/14 2300
8/4/2 11 Aug	(b)(6)-2	TYLENOL 650mg Supps or PO Q4-6° PRN	(b)(6)-2 [illegible]
			Transcribed to sheet #2
8/7/02	(b)(6)-2 15:10	OCUFLOX, PRED FORTE ATROPINE OU 1gtt	9:00 15:00

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

MEDCOM - 3136

1 of 2 MARS

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE [illegible] (MEDICATIONS)

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8/1	8/2	8/3	8/4
		GENTAMYCIN 400mg IV QD	23	(b)(6)-2			
		ANCEF 1gm IV Q8°	09	IV	(b)(6)-2		
			17				
			01	(b)(6)-2			
		CIPROFLEX 400 IVPB Q12°	09		(b)(6)-2		
			11				
			13				
			15				
			17				
			19				
			21				
			23				
			01				
			03				
			05				
			07				
		NSS-IV @ 100 cc/Hr	08				
			20				
		DRESSING A TO BILAT BACK WOUNDS W/D GAUZE QD/PRN		IV 1ST 8/1 OR			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

#

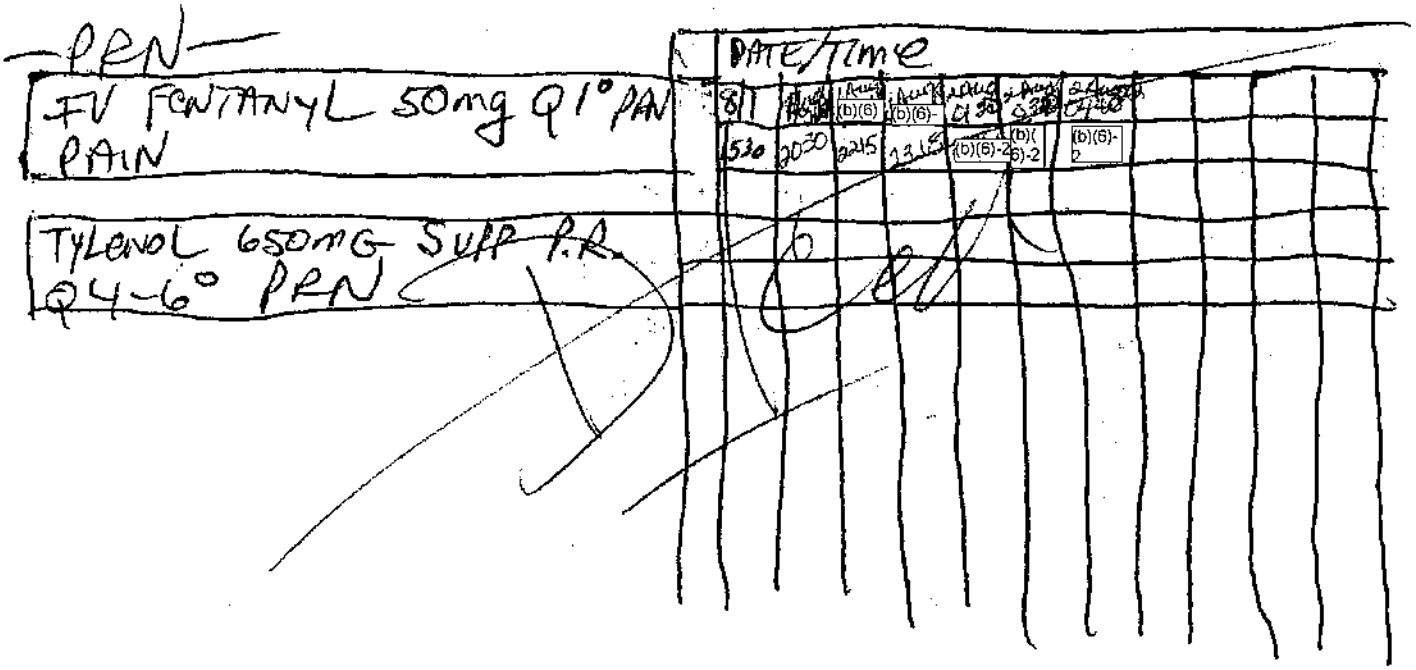
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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


PRN
IV FENTANYL 50mg Q1° PAN PAIN
TYLENOL 650mg SUP P.R. Q4-6° PRN
DATE/TIME
8/1
1530
2030
2215
(b)(6)-
(b)(6)-2
(b)(6)-2
(b)(6)-

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

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: Bilat Resect Thoracotomy, R POP Expl, Debr
PHYSICIAN: (b)(6)-2
ANESTHESIA BY: (b)(6)-2
Gen Spinal [illegible] Local Bier Epidural Other

ALLERGIES: NKA
AIRWAYS: Time DC'D
(ETT) Nasal Oral Trach
OXYGEN:
Mask Nasal Prongs Face Tent Blow-By
Liter/min. 5 %

ASA ___ History GSW Chest
Cardiac Rhythm ST
IV#1 LR (Patent) Infiltrated
Site LAC Rate 100 Gauge 18
IV#2 RL (Patent) Infiltrated
Site LR Rate 200 Gauge 18

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Loc L R Upper Lower; Pulse DP PT RAD
PRE-OP	130/95	155	•										
2200	170/78	120	20			Paralyzed							Blanche Pulse Warm Moves Y N
2215	171/98	81	12	81									Blanche Pulse Warm Moves Y N
2230	129/91	86	13	99								Vent	Blanche Pulse Warm Moves Y N
2245	130/86	77	15	99								Bag	Blanche Pulse Warm Moves Y N
2300	191/80	86	14	84								Bag	Blanche Pulse Warm Moves Y N
2315	145/86	83	20	91								Vent / paralyzed	Blanche Pulse Warm Moves Y N
2330	131/77	87	20	92								Vent / paralyzed	Blanche Pulse Warm Moves Y N
2400	138/87	83	20	97									Blanche Pulse Warm Moves Y N
0030	159/94	80	20	92								Vent / paralyzed	Blanche Pulse Warm Moves Y N
0100	164/90	125	20	94								Vent / paralyzed	Blanche Pulse Warm Moves Y N
0130	155/101	110	20	91									Blanche Pulse Warm Moves Y N
0200	142/95	92	20	91									Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

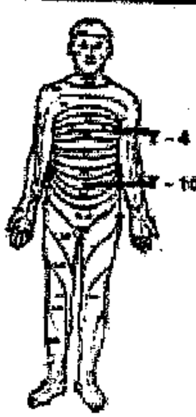
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 94°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze / 6x12 e. Kerlix	old Stain	R+L Chest
	old Stain	R Foot
Bandaid		
Steri-strips		
Collodion		
Telfa-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac, (Foley), NGT, (Chest) Bilat, Jackson-Pratt

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC
(b)(3)-1

DATE
27 July 02

PATIENT IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)
(b)(6)-4

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

DA FORM 1 MAY 78 4700

FE NDA OP 152-11a (Revised) 1 Oct 94

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AM
OR	Whole Blood	1500	OR	EBL	1000 2500
"	Crystaloid	700	OR	Urine	2700
"	Albumin	50	2330	2320 Urine	300
"	Heapa	500	2400	Urine	1700
0045	Whole Blood	700			
0249	NS	1000			
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FM MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

2200 Received fm OR. Intubated responding to painful stimuli - attempt fo spontaneous resp. Sats dropped into 70's - Ambu bag - Sats 98-100% - placed on Vent A/C TV 1000, Rate 12. SAO2 - 70-80's - Settings changed to TV 920 - Peak Flow 4.45 Rate of 19 SAO2 92-95% CO2 26-30 fo
2320 Paralyzed & Vecuronium to prevent fighting of vent —
0045 SAO2 dropped into 70's - Additional Vec & MS given
0115 Vent settings adjusted to TV 920 - Rate 20 - Peak Flow 60
SAO2 94-95% (b)(6)-2 , MD, AN
0345 Reacts to painful stimuli - fighting vent - Vecuronium & Versed given to good effect - SAO2 93-94% (b)(6)-2 MD RN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	EFFECTIVENESS
(b)(6)-2 MD;	Versed	1 mg	IV	2315	
(b)(6)-2 AN	MS	2 mg	IV	2315	
MD; AN	Narcan	1 mg	IV	2345	
MD; AN	Narcan	1 mg	IV	0015	
MD; AN	MS	1 mg	IV	0020	
MD; AN	Versed	1 mg	IV	0020	

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Ambulating status: _____ PAR Score _____ Safety Straps _____
Report given to _____ Patient released by Anesthesia _____
Time out _____ Nurses Signature: _____

OR
MS 2 mg @ 2200
Versed 2 mg @ 2315
Droperidol @ 2320
Lasix 10 mg @ 2330

MED. RECORD-SUPPLEMENTAL MEDICAL

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

OTSG APPROVED *(Date)*

REPORT TITLE
Clinical Record Doctors Orders

POST OP

(1) Diagnosis: Multiple GSW Bilat. Chest : Hemo-pneumo Thorax, GSW (2) foot & Knee

(2) Procedures: Bilat Emergency Thoracotomy, (R) Popliteal Exploration, Debridement GSW

(3) Allergies NKDA

(4) Condition: Good (Fair) Poor

(5) Vital Signs Q 5 to 10 minutes until stable then Q 30 minutes

(6) I & O Q-1 hour ~~X~~ 8 hrs

(7) Activity: Bedrest

(8) ~~IV Fluids: LR@ 50 cc/hr x 2 liters~~ NS@_____cc/hr x ___liters

9. Blood: Transfuse 1 Units PRBCs if Hct < 30.

(10) Oxygen: ~~2 to 5 liters/min via mask~~. Titrate to SAO2 >90%.

(11) Chest Tube: 20 cmH2O ~~Water seal~~ ~~N/A~~ Bilat

(12) Vent settings: SIMV: 12/min., TV: 12cc/kg. 02 Flow to maintain SAO2 >90% PEEP 5c
Peadk Flow 45 liters per minute and adjust as needed.

(13) Extubation criteria : ~ 6 hrs.
Pateints spontaneous respiration is 14 to 20 inhalations per minute
Patient is able to cough and breathe.
Pulse oximeter setting must be no less than 92%.
Patient arouses spontaneously and can lift head off bed.

~~14. NG Tube:~~ LIS Clamped N/A

(15) Medications:
Antibiotics (check one)
—Cefazolin Sodium, 1 Gm, IV, q8H due @ 0330
—Cefoxitin Sodium, 1 to 2 Gms, IV, q6 to 8H
— Gentamycin Sulfate, ___Mgs q___H

Analgesics:
Morphine Sulfate, 2 to 10 Mgs, IV, q2H prn. Dilute: Add 2.5 mg, Vol → 2 cc + 5 mg Vol in 10 cc = 200 cc Continuous

16. Patient Release:
A. Release form medical evacuation when patient arouses spontaneously, can lift head off bed, when BP is equal to or greater than 100 mm Hg (systloic) and stable, and when there is no evidence of rebleeding.
B. Discontinue chest suction and place Heimlich valve on all chest tubes.
C. Discontinue NG tube suction and ensure that tube is open to air or to straight drainage.

17. Hct 54

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)-2	(b)(3)-1	27 Jul 02

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*
(b)(6)-4

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

DA FORM 4700, MAY 78

TWENTY-FOUR HOUR PATIE[redacted]E AND OUTPUT WORKSHEET

FROM [redacted] HOURS TO [redacted] | TOTAL HOURS COVERED ~ | DATE 8-1-02

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1915	WATER/Juice	400	
2200	Juice		
2315	Juice		
	NPO p Midnight	0	

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1300	KVO	LR @ 150	700	1915	
1915	1000	NSS @ 100/hr			
2300	50	Gentamycin 50cc	50	2300	
0200	50	Ancef 1gm IVPB	50	0235	

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1915	1800	—			
2150	1200				

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1954 — 300-727/10425

TWENTY-FOUR HOUR PATIENT I[redacted]E AND OUTPUT WORKSHEET

FROM [redacted] HOURS TO [redacted] | TOTAL HOURS COVERED 0700Hr 24 | DATE 2 Aug 12

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		LR @ 150cc/°			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

(b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0700					

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3880(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

ADMISSION [illegible]ODING INFORMATION

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

1. REPORTING MTF: 1 A (b)(3)-1 [redacted]

2. [illegible]ATION (State or Country Code): 7 A, 8 F

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4 [redacted]

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

4. PAY GRADE: 16 17

5. SEX: 18 M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29 — 18 y

8. RACE: 30 X

9. ETHNIC BACKGROUND: 31 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE: 32 33 34

ETS:

11. FMP: 35 9, 36 9

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4 [redacted]

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: 46 M

HOUR OF ADMISSION: 0958

BRANCH / CORPS:

14. FLYING STATUS: 47 N, 48 /, 49 /

15. BENEFICIARY CATEGORY: 50 K, 51 7, 52 8

16. ZIP CODE OF RESIDENCE: 53 0, 54 9, 55 3, 56 5, 57 4, 58, 59, 60, 61

17. UNIT LOCATION (State or Country Code): 62 A, 63 F

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71 9

PREV. ADMISSION: YEAR — [X] NO

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

WARD: ICU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 [redacted] BAGRAM AF

21. TYPE OF DISPOSITION: 73 Ø, 74 5

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

23. DATE OF DISPOSITION (Y Y M M D D): 81 0, 82 2, 83 0, 84 8, 85 1, 86 2

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

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

26. DATE THIS ADMISSION (Y Y M M D D): 97 0, 98 2, 99 0, 100 7, 101 2, 102 8

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

28. MTF OF INITIAL ADMISSION: (b)(3)-1 [redacted]

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 0, 112 2, 113 0, 114 7, 115 2, 116 8

FOR LOCAL USE

MULTIPLE GSW
X2 CHEST T: 1
1 FEMUR Inj: 450

Dx: 8601, 2704, 8900, 8920, 8782, 8840, 7806
7950, 7912, 37933, E9915

PR: 1229, 1381

ADMITTING OFFICER (Signature, as required): (b)(6)-2 [redacted] (b)(6)-2 [redacted]

SIGNATURE OF ADMITTING CLERK: (b)(6)-2 [redacted]

DA FORM 2985, MAR 89 — EDITION OF MAY 7 (b)(6)-2 [redacted]

ADMISSION / DISPOSITION INFORMATION

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

1. REPORTING MTF	2.	3.	4. STATION (State or Country Code)	
(b)(3)-1	7	8		
A	A	F		

5. REGISTER NUMBER	NAME (Last, First, Middle Initial)	6. PAY GRADE	7. SEX
9 10 11 12 13 14 15	ARGHAN, Mike Detainee	16 17	18
(b)(6)-4	(b)(6)-4		M

8. DATE OF BIRTH (Y Y Y Y M M D D)	9. AGE AT ADMISSION	10. RACE	11. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 8 4 0 1 0 1	1 8 y	X	9	MUSLIM

12. LENGTH OF SERVICE	ETS	13. FMP	14. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 (b)(6)-4
2 2 2		20	(b)(6)-4

15. ORGANIZATION (Active Duty Only)	16. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	0958	
	M		

17. FLYING STATUS	18. BENEFICIARY CATEGORY	19. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
N	K 7 8 ✓	0 9 3 5 4

20. UNIT LOCATION (State or Country Code)	21. MOS	22. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR ☒ NO
[redacted]		9	

23. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU 1	ADDRESS OF EMERGENCY ADDRESSEE (Include Zip Code)
Ø		

(b)(3)-1 TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
BAGRAM AF	

24. TYPE OF DISPOSITION	25. MTF TRANSFERRED TO	26. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
Ø 5		0 2 0 8 1 2

27. CLINIC SVC - ADMITTING	28. MTF TRANSFERRED FROM	29. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102
A A A A		0 2 0 7 2 8

224
909

30. LOCATION OF OCCURRENCE (Battle Casualty Only)	31. MTF OF INITIAL ADMISSION	32. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
A F	(b)(3)-1	0 2 0 7 2 8

15

FOR LOCAL USE

MULTIPLE GSW BC Trauma 9 Inj 549
YR CHEST 04:8629
FEMUR 82110 PR: 3479
7935 Procedure I guessed at type of repair.

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING OFFICER (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79

INPATIENT TREATMENT RECORD COVER SHEET *(For Printing)*

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)*

Afghan Male Detainee

(b)(6)-4

Muslim

30Y

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

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: Home DS

26. DATE OF DISPOSITION: 20AUG07

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Mult. GSW (R) LE

Debridement Wound Dressing 8-12 8/13 8/14 8/15

1 Aug 07 ~ AKA

3 Aug. Debridement/Revision Stump

8 Aug 07 - Debridement stump Right Thigh

11 Aug 07 - Debridement R Thigh

S/P (R) AKA

☐ 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
				20	

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
				20	

(b)(6)-2

(b)(6)-2

DA FORM 3647-1, 1 MAY 1979 EDITION OF

MEDCOM - 3148

DATE	NOTES
19 Aug 02 0930	Gen Surg
	S – Less c/o Pain Does well c Haldol
	O – VSS afeb Wound clean No New pus Pockets
	A -> Wound Improved
	P – ↓ Pain MEDS Give Haldol Regularly For Transfer 20 Aug if Wound Looks good
	(b)(6)-2
19 AUG 02	Pt afebrile, some pain complaints But minimal, resting comfortably, wound [illegible] clean dressing changes made [illegible] to IDF tomorrow
	(b)(6)-2
20 Aug 02 0930	Gen Surg
	Wound Clean No Pus No Fever
	Transfer to Detainee Center today
	(b)(6)-2 LTC [illegible]

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7/91)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(?)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16Aug02	GenSurg
0940	Dressing changed under Ketamine Sedation
	& Complications No New Evidence of
	Infection Dressing Remain wet Discharge
	Ketamine 50mgm IV
	Versed 2.5mgm IV
	If enrolled to Control Urine Will Reinsert
	Foley
	(b)(6)-2 LTCol
16AUG02	1st dressing change well T 99.2
	AM BP Improved BP 132/84. Cont present Tx.
	(b)(6)-2 LTCol
17 Aug02	GenSurg
0925	Dressing CHANGED Wound Becoming
	more purulent & Packets of Pus
	Will start BID Dressing change Wet
	To Dry
	(b)(6)-2 LTCol
18 Aug 02	GenSurg
0935	Wound Looks much better 2 Areas
	Remain & ↑ Drainage. Will continue
	BID Dressing changes
	(b)(6)-2 LTCol

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 AUG 02	Pt with 3 u PRBC within 24°, [illegible] But [illegible] seizing [illegible] Abd [illegible] tach, lungs [illegible] clear, [illegible] revision ventricle [illegible] may need further surgery.
	(b)(6)-2
11 AUG 02	Pt for [illegible] revision & [illegible] [illegible] 108 cont [illegible] Bowels [illegible] [illegible] lungs clear
	(b)(6)-2
12 AUG 02	[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] WBC 11.0 Hct 36.1 4.3 < 134/101 [illegible] RSR lungs clear for further surgery — [illegible] revision
	(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

14 AUG 02 Pt. tol surgery well. Unit RSR drsgs clean
remains QS. No ↑ pain recently. Wound culture
enterobact cloacae & mixed skin flora; G-stain max
cont. present ↑.

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6AUG02	Pt became SOB dyspneic last PM - started on O2 febrile this AM 101.9 Tmax 101. CBC improved, 6,000 < 8.6 / 26.6 RBC 292 Chest x-ray this AM small (B) pleural fluid no active disease [illegible] Babesia [illegible]
	[illegible] CT abd this AM. Cont. to monitor CBC & O2
	(b)(6)-2 [redacted]
7AUG02	Pt ē sl. temp this AM - 99. Less pain. Bowels moving well. pulse ox 91% RA. [illegible] make [illegible] PRN, CT → no abscess but ↑ inflammation.
	(b)(6)-2 [redacted]
10Aug02	Gen Surg
1225	S - c/o pain stump - unchanged since Admission
	O - VSS afeb u/o stable Dressing STABLE
	A → B/P stabalized Hct Improved lytes Need Correct
	P → IV N/S Recheck LABS IN AM (b)(6)-2 [redacted] LT Ca[illegible]
	O2 IN AM

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] | 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. ICW

Pt # (b)(6)-4 [redacted] Bed # 8

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Aug 02 cont'd	Ext: (R) stump – Nsg. soaked.
	Plan:
	– OR today
4 Aug 02 8PM L	S/ Restless. Constantly requesting "injection". Trial of MSO4, Fentanyl, Valium and finally Haldol @ 07[15] – Successful
	O/ Tm 38[3] ~~HR~~ 102 BP 150/80 93% on 3L
	Gen: currently asleep in NAD
	No other Δ's
	Labs: Hct 6.7 prior to transfusion.
	Plan:
	– MV H/H
5 Aug 02	

(b)(6)-2

(b)(6)-2

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
	Trauma H/P
1 August	Young Afghan o/p s/p multiple GSW (R) LE Shot Running from site of bombing
	Pulses hypotensive unable to doppler (R) LE
	PMH: ϕ PSH: ϕ Meds: ϕ
	Allergies: NKDA
	PE WD Afghan o/p Lethargic
	BP 70/40 HR 130 RR20
	HEENT: NCAT, PERRL, EOMI
	Neck: supple, NT
	Lungs: CTA
	Cardiac: tachycardic
	Abdomen: soft, nontender, +BS
	Pelvis: stable
	Extremities: tense hematoma (R) inguinal
ϕ pulse RLE	ligament to (R) knee, multiple through and through wounds, (R) buttock entry wound. Large wound (R) medial foot c active bleeding
	Neuro: ϕ movement ϕ sensation (R) LE ϕ
	Impression: Vascular injury RLE / Open medial foot
	Plan: Urgent exploration

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

1 August 02

Op Note

Pre-Op Dx: GSW (R) LE (multiple)
Post-Op Dx: GSW (R) LE (multiple)
Transected (R) SFA
Transected (R) SFV
Open (R) midfoot

Procedure: Exp Celotomy (Vascular Control)
Exploration (R) LE vascular tree
Reversed SVC interposition (R) SFA
Ligate (R) SFV
Thromboembolectomy (R) SFA
~~I & D~~ (R) foot

Surgeons: [redacted] [redacted]
Anesthesia: [redacted]
EBL: 6 l
IVF: 8 whole RBC, 1 PRBC, 10 l IVF, 1 l hetastarch
OR → Bagram Critical

*** Important (R) thigh packed for hemostasis due to coagulopathic hemorrhage. Packs will need to be removed when Coagulopathy Corrected [redacted]

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
01 Aug 02 2220	ABG: pH 7.36 / PCO_2 33.5 / PO_2 208 / HCO_3 19 / Sat 100%. Will ↓ FIO_2 to 40% & ↑ rate to 12. (b)(6)-2 (b)(6)-2
2 Aug 02 0515	S/ PTR p Vent. failure. No other problems.
	O/ VSS Vent: SIMV 10 VT 800 FIO_2 40% Gen: sedated Cor: tachy Lg: O wheeze Abd: (+) BS Ext: S/P (+) AKA. Labs: IC 5-3 Hb A/P (1) S/P (+) AKA - monitor H/H (2) ↓ K^+, suppl. - resolved (6) Vent. support - wean (b)(6)-2
3 Aug 02 815 L	S/ Tol. extubation. Febrile O/ Tm 38.6 VSS 93% Gen: AA in NAD →

STANDARD FORM 600 (REV. 6-97) BACK
☆ U.S. GPO:1998-432-786/75236

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01 AUG 02	ADMIT NOTE
2114	Afganee male (appears to be in his 30's), brought to ICU from OR $\bar{p}$ (R) AKA. Pt is sedated, paralysed and on ventilator. Pt had uncontrolled bleeding of (R) lower ext, which required tourniquet application and amputation. Pt received PRBC while in OR.
	137/91 P78 O_2 Sat 100% Vent Rate 10
	Gen: Sedated, NG & Foley in place
	Heart: sinus s, d split s_2
	Lung: (R) rhonchi, $\downarrow$ wheezing, $\downarrow$ crackles
	Abd: laparotomy incision, non distended, $\downarrow$ BS
	Ext: mild clubbing, $\downarrow$ edema
	s/p (R) AKA
	A/P ① s/p (R) AKA
	- morphine for pain
	② On vent
	- sedated & paralysed
	- ✓ ABG
	③ Labs: ✓ CBC, Chem 7 (replace K^+)
	④ Small amt blood/fluid via NG - observe

ABG 7.39 / 372 / 360 / 60%

PT/PTT 14.9/34.7/1.32

145 / 98 / 7 / 182 / 2.7

13.1 / 8.8 / 40.2 / 252

Pr 5.0, Alb 3.2, Alk 43, TB:I 1.9, Amy 109, AST 81, ALT 20, GGT 35

HOSPITAL OR MEDICAL FACILITY	STATUS (b)(6)-2	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	R

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.

Pt # (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1 AUG 02	8.0 ET @ 24 cm to lip closed abd incis xyphoid to Umbilicus STAPLED AIRWAY PATENT. BREATHING VIA IMAR TV 600 BBS+=clr
138/85	
105	MULT GSW RLE. S/P OPERATIVE REPAIR
15 br Pm	↓ PULSE R FOOT. POST R THIGH wound. pbd applied
SO_2 29	1 U PRBC O- up (1425z) complete
100%	2 (R) thigh TOTAL GSW
	(R) SAPHENECTOMY Lower Leg
	(R) FOOT wound PACKED
	L. MEDIAL Thigh SMALL incision STAPLED
17/25	~~+1 PRBC up Pre~~ (b)(6)-2
	#2 U PRBC up w/o
	Central line (R) clear in to LR wide open
	CXR done
	10 mg (b)(6)-2 VEC (1426z)
	1905hr-14/77 · 115(R) · 15(R) · O_2 100% CO_2-34
	40 mEq/hr K-IV (pending) hanging (b)(6)-2

RELATIONSHIP TO SPONSOR	(b)(6)-4 LAST	SPONSOR'S NAME FIRST	MI	SPONSOR'S SSN OR ID NO.
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

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR 101-11.4)

01 AUG

(b)(6)-4

18 Prototype

EMERGENCY PHYSICIAN RECORD
Multiple Trauma (5)

TIME SEEN:_____ ROOM:_____ __ EMS arrival

HISTORIAN: __patient __spouse __paramedics

__HX / X EXAM LIMITED BY: Intubation

HPI chief complaint: Injury to: (R) LE

occurred:
__just PTA
X today
__yesterday
days PTA

where:
__home __school
__neighbor's __city park
__work __street

context: Afghan male S/P OXP. lap. S/P Grafting (R) femoral artery & Revere (L) SAPHENOUS vein. Pt required above procedure 2ry GSW/Shrapnel

location of pain/injuries:
head face mouth
neck chest abdomen
back upper mid lower
radiating to R / L thigh / leg

-right-		-left-	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
mild
moderate
severe

associated symptoms:
__lost consciousness / dazed
duration:
remembers:
impact coming to hospital
__seizure

ROS ☐ all systems neg except as marked
__loss feeling/power arms/legs
__headache
__double vision/hearing loss
__trouble breathing/ chest pain
__nausea/vomiting
__loss of bladder function
__skin laceration
__recent fever/illness

UNABLE TO OBTAIN

SOCIAL HISTORY __recent ETOH __smoker __drug abuse
UNK

PAST HISTORY __negative

UNK

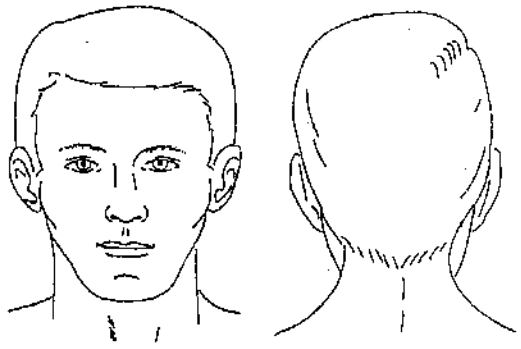
Meds- __none / __see nurses note UNK
Allergies- __NKDA / __see nurses note UNK

☐ Nurses note reviewed ☐ Tetanus immun. UTD ☐ Vital signs reviewed

PHYSICAL EXAM __Alert __Lethargic __Anxious Intubated
Distress- __NAD __mild __moderate __severe
Other- __c-collar (PTA / in ED) __back-board __IV __splint

HEAD
✓no evidence of trauma
__see diagram
__Battle's sign / Raccoon Eyes

NECK
__non-tender
__painless ROM
✓trachea midline
__see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck



EYES
__PERRL
__EOMI
__unequal pupils R-____mm L-____mm
__EOM entrapment / palsy
__subconjunctival hemorrhage
PINPOINT PUPILS

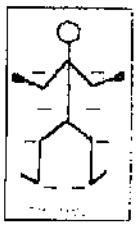
ENT
✓nml external inspection
✓no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

RESP & CVS
__chest non-tender
✓breath sounds nml
__heart sounds nml
__see diagram (on reverse)
__decreased breath sounds
__wheezing / rales
__splinting / paradoxical movements
Q HR

ABDOMEN
__non-tender
__no organomegaly
__see diagram (on reverse)
__tenderness / guarding / rebound
__mass / organomegaly
multiple scan S/P exp. lap.

GENITAL / RECTAL
__nml genital exam
__nml vaginal exam
__nml rectal exam
__heme negative stool
__perineal hematoma
__blood at urethral meatus
__decreased rectal tone
(R) groin hematoma

NEURO / PSYCH
__oriented x3
__mood & affect
__CN'S nml as tested
__sensation & motor nml
__confusion / disorientation
__EOM palsy / anisocoria
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit

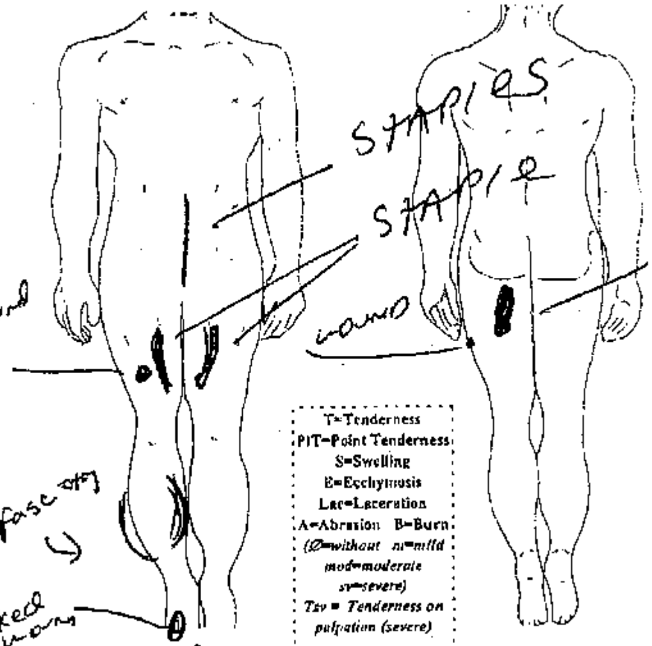


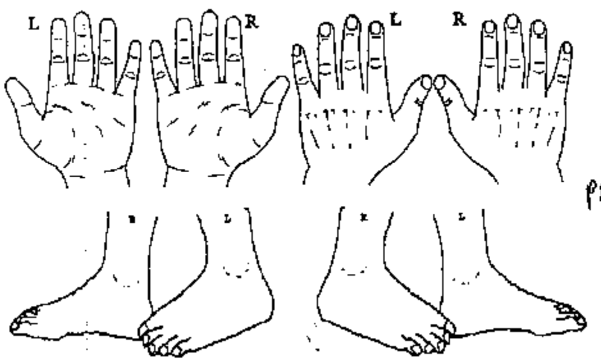
Intubated - moved UE SPONTANEOUSLY

SKIN
✓ see diagram
__intact
__crepitus / diaphoresis
__warm, dry

BACK
__see diagram
__no CVA tenderness
__vertebral point-tenderness
__CVA tenderness
__no vertebral tenderness
__muscle spasm / limited ROM
(−) wounds

EXTREMITIES
✓ see diagram
__atraumatic
__bony point-tenderness
__pelvis stable
__painful / unable to bear weight
__hips non-tender
__pulse deficit
__no pedal edema
__nml ROM
Joint Exam:
__limited ROM / ligaments laxity / joint effusion





PROGRESS:
NO PULSES OR (R) LEG
CHANGES (R) LEG
COLD LEG.

XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/radiologist	
C-Spine D-Spine LS-Spine	
__nml / NAD	__reversal / straightening of cerv. lordosis
__no fracture	__DJD / spondylosis / spurring
__nml alignment	
__soft tissues nml	
CXR	__rib fracture
__nml / NAD	__infiltrate / atelectasis
__no infiltrates	ET tube in good
__nml heart size	position (−) Ptx.
__nml mediastinum	
OTHER: ☐ See separate report	

Wound Description/Repair
length____cm location______
__superficial __SQ __muscle __linear __ˆstellate __ˆirregular
__clean __contaminated *moderately / *heavily*
distal NVT: __neuro & vascular status intact __no tendon injury
anesthesia: __local __digital block ______cc
__lidoc 1% 2% epi / bicarb __marcaine .25% .5% __LET
prep:
__Shur-Clens / Betadine / Hibiclens __ˆdebrided / undermined **extensively*
__irrigated /washed w/saline **extensively* __foreign material removed *minimal moderate ˆextensive*
__explored
repair: *Wound closed with: wound adhesive / steri-strips*
SKIN- #____ ____-0 nylon / prolene / staples
*SUBCU- #____ ____-0 vicryl / chromic
**may indicate intermediate repair ˆmay indicate intermediate or complex repair*

__Discussed with Dr. ______ *will see patient in: office / ED / hospital*
__Counseled patient / family regarding: *lab results diagnosis need for follow-up*
__Rx given __Admit orders written
__CRIT CARE- *30-74 min 75-104 min ____ min*
__Prior records ordered
__Additional history from: *family caretaker paramedics*

CLINICAL IMPRESSION:

contusion					sprain / strain
head		wrist	R / L		neck dorsal lumbar
face		hand	R / L		
chest		hip	R / L		
abdomen		thigh	R / L		concussion
back		knee	R / L		with LOC w/o LOC
shoulder	R / L	leg	R / L		
arm	R / L	ankle	R / L		
elbow	R / L	foot	R / L		laceration
forearm	R / L				

- Multiple GSW/Shrapnel wounds
- S/P exp laparotomy
- S/P Repair Femoral Artery lac via Graft
- Hypothermia
- Coagulopathy

DISPOSITION- ☐ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☐ stable
TO OR

PHYSICIAN SIGNATURE- (b)(6)-2

(b)(6)-2

Multiple Trauma - 18

27

510-112 NSN 7540-00-634-412

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Aug 02		1645	Pt transferred from ICU I via litter. USS- Pox 85% on RA - O2 on @ 2L Pox 93% - c/o pain "all over" & medicated as ordered - F/c patent & draing clear yellow urine - Vitals @ bedside - Pt attached to bed c (L) wrist + (L) ankle attached to bedframe — (b)(6)-2 — Sft
4 Aug 02		2030	Pt is A&O x3 speaks (native) English, understands commands. temp 102.4 Vitals encouraged, Tylenol 650mg administered. Foley draining clear yellow urine in quality. Pt complained of generalized body pain. "Very pain fine" will continue Fentanyl as prescribed — (b)(6)-2 — RN
4 Aug 02		2230 2300	(b)(6)-2 Pt asleep, no further S/Sx of discomfort Foley draining to gravity. IV infusing NS @ 125 c difficulty. Antibiotic IV to finish. Npo for OR Sx. Consent @ bedside. (R) arm + (L) ankle shackled-to-bed (b)(6)-2 RN
5 Aug 02		0240	Fentanyl given c/o "fine pain" will continue to monitor. (b)(6)-2 RN
5 Aug 02	0700		urine output 1900 for the Night evening shift (12 hrs) clear amber urine. IV site WNL Continue on reverse side (b)(6)-2 RN

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

Pt # (b)(6)-4

REGISTER NO.

WARD NO. ICU

Back #8

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/5/2	0800		A+Ox3; min english use; Foley intact and draining clear yellow urine; Entrapment of (R) clavicle D+I and infusing LR @ 200 @ KR; DSD on (R) AKA intact ⊼ S/S Re-Hemorrhage. [redacted] CPT, AN, USA
5 Aug 02			
5 Aug 02	2050		C/O "S.O.B."! Slight wheezing on Expiration. TEMP. 103.8 - 98-20. DR. NOTIFIED C/O INCISIONAL PAIN". UNABLE TO Determine Pain level. IV Site @ (L) FOREARM INFILTRATED & D/C'd. X-RAY (CS) done as ordered RESPIRATION 20 NON labored. Will Medicate As ordered. [redacted] Anc
8/6/02	0800		A+Ox3; retains sc; min. english use; DSD intact on (R) AKA; Foley intact draining clear yellow urine; (R) clavicle Central line intact ⊼ heparin; constant c/o pain; SPO2 95% on O2 via NP in attendance; PT shackled to bed ⊼ S/S trauma to shackled foot. [redacted] PT, An
8/6/02	1210		Pt medicated with 50mg Demerol for pain. [redacted] RN
6 Aug 02		2235	A+O. minimal English use. C/O pain T° 102 Tylenol given. SPO2 98/RA. Central line intact for IVPB. Remains shackled to bed (R) wrist + (L) ankle. Foley intact draining dk and yellow urine. Bath given [redacted] ST

*U.S. Government Printing Office: 1995 - 404-763/20085

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7Aug02	0830		Pt resting in bed. R-26 T99.6-82-136/80 c/o pain. Central line flushed & WNL. Demerol admin per physician order. Appetite poor. Fluids encouraged. Pt drank 1 cup apple juice. Foley draining clear amber urine. AM personal hygiene care given. Turned & Repositioned. (b)(6)-2
7Aug02	0940		Pt assisted to BR. No discomfort noted. (b)(6)-2 RN
7Aug02	1030		Pt interpreter unit assist from interpreter. Pt stated he is scared, refuses to eat. Requests IV medication. Communication placed to physician. Phenergan 12.5 administered (b)(6)-2 RN
7Aug02	1200		Pt ambulated to eat two appeal tolerated w/o N/V.
7Aug02	1430		Pt c/o pain. medicated with demerol 25mg (b)(6)-2 RN
7Aug02	1725		Resident paid pt stated "able to rest". will continue to monitor. (b)(6)-2 RN
8Aug02	0900		Pt AOx3 ambulating meals. Appetite fair. ate 4/4 of meal. Voiding adequate quantity clear amber urine. Bmx1 soft brown stool. AM care given. T↑101 (Continue on reverse side) 0825 admin. (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

Amputee

REGISTER NO.

WARD NO

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 Aug 02	1000		T 100.6 pt resting in bed. NPO for OR. (b)(6)-2
8 Aug 02	1300		Needed held NPO for OR (b)(6)-2 RN
8 Aug 02	1530		pt returned from OR via litter. 2L O2 via NC 96%. P130 BP 124/85-97-28. [illegible] continue to monitor. Demerol 25mg IV given for [illegible] pain. LR @ 200cc/° to central line infusing S difficulty. (b)(6)-2 RN
8 Aug 02	1545		118/86 - 136 - 94[7] - 24
8 Aug 02	1630		129/85 - 124 - 94[8] - 26. c/o [illegible] pain [illegible] PRN given. Pulse ox 99% 2L NC O2. will continue to monitor [illegible]
8 Aug 02	1700		urine output 100cc clear yellow urine. fluids encouraged PO (b)(6)-2 RN
8 Aug 02	1730		PT drinks water, refuses to eat dinner. C/o of "[illegible] pain" 125/81 - 121 - 26 - 98[6]. (b)(6)-2 RN
8 Aug 02	18[00]		VS 122/80 - 121 - 24 - 98[1] PT resting in bed C O2 applied via NC. Pulse ox 98%. Foley patent draining clear yellow urine 120cc this hour. (b)(6)-2 RN
8 Aug 02	1900		Pt c/o pain - demerol 25mg admin. [illegible] reinforced. (b)(6)-2 RN
8 Aug 02		2115	A&Ox3 [illegible] Urine Output maintained (foley) documented. IV Subclavian LR infusing @ 200cc/° [illegible] antibiotics given. C/o thirst. Sleeping for long intervals. T° 101.9° Tylenol [illegible] given. [illegible] [illegible] verbalized ↓ pain. (b)(6)-2 (b)(6)-2
9 Aug 02	0800		alert in bed; kept NPO for surgery [illegible] English use - interpreter brought for [illegible]. Cont (b)(6)-2

510–112 NSN 7540–00–634–412

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9Aug02	0800		(cont) Central line of (R) subclavian intact s̄
			s/s infection; resp unlabored on RA; foley
			intact and draining clear amber urine QS;
			constant c/o wanting something to sleep
			and wanting something to eat or drink
			despite I/S by interpreter; OSD intact
			on (R) AKA; IV LR @ 200cc/hr via
			central line. (b)(6)-2 CPT, AN NSAR
9Aug02		1730	Pt received from OR s̄ ANC on
			floor; Ø PRBC available on ward;
			report given to 91W s̄ full comprehension;
			staff nurse not notified; pt BP ↓ 80/4[illegible];
			ii units PRBC brought in and given
			by MAJOR (b)(6)-2; ICU nurse, Dr (b)(6)-2 [illegible]
			staff assessed/Tx pt; returned to VSS
			and s̄ s/s distress; LR @ 150cc/Hr
			infusing via flowmeter; Ø resp. distress.
			Foley intact and draining clear yellow
			urine; OSD intact on (R) AKA.
			(b)(6)-2 CPT, AN
9Aug02		22[10]	A&Ox3 VS remain [illegible]. Subclavian intact. IV infusing
			LR @ 150cc/hr. Antibiotic IVPB's given. Monitored VS. O2 @ 5L
			via NRB. Medicated for pain by [illegible] (b)(6)-2 continues
			to c/o pain. foley intact [illegible] (b)(6)-2 91W [illegible] (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.

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10Aug02	0800		Pt alert in bed; n/m in attendance; minimal English use; (R) SC central line intact and LR infusing @ 200cc/HR; H&H <28% @ 27 and 1 unit PRBC #462601 infused per protocol s̄ reaction starting @ 0815; foley draining clear yellow urine but appears to be leaking causing wetting; Pt c/o constant pain and requesting pain med every hour; BSD intact on (R) AKA; O2 rebreather @ 2L; ~~med~~ [redacted] CPT, AN, USAR
10Aug02	0945		Blood completely infused s̄ incident [redacted] CPT, AN
10 Aug 02	1500		Pt assessed c̄ ~ 99.7 (F) Temp; c/o Pain @ (R) stump: (10) rate 120; Diaphoretic; Pt given Tylenol & Demerol PRN; will monitor for effectiveness. [redacted] / [redacted] 1LT BSN/USA
10AUG02		2230	145/67-20-116-100. IV infusing to central line. Antibiotic therapy cont. urine output clear yellow 400cc draining to gravity via foley. Skin dry. (R) amputated stump resting on Chucks pads to catch drainage. Tylenol admin for ↑ temp. PO fluids encouraged. [redacted] RN
10AUG02		0040	Clear yellow urine 200cc draining to gravity via foley cath. Demerol given for pain. Turned & repositioned. IV NSS infusing ø difficulty noted. [redacted] RN

510-112

NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 Aug 02	0800		Pt resting in bed. NPO status OR this AM urine output per Night 1500 clear yellow urine. (R) Stump dressing. Placed on pads. Antibiotic therapy cont. NSS @ 200cc infusing to central line. VS. 124/91 - 124 - 24. — (b)(6)-2 RN
11 Aug 02		2030	Pt ambulated - Voids clear yellow urine. O2 2L via NC 98% - 101-126-24 146/86 Skin warm/dry. NSS infusing @ 200cc to central line. Foley draining clear yellow urine. Tylenol admin per Temp. (R) Stump dressing pads placed upon pt to absorb moisture. PO fluids encouraged. — (b)(6)-2 RN

(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

Bed #8

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2

510–112 NSN 7540–00–634–4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12 Aug 02		1700	RETURNED FROM O.R. DRSG DRY & INTACT. RESP. 22 Regular Pulsox 98% RA. Voiding via Foley CATH. 400ML. ProPag APPLIED. IVF INFUSING NSS @ 125cc/hr VIA INTERNAL Jugular. Will CONT. TO OBSERVE. (b)(6)-2 mg ANC
12 AUG 02		2000	Pt in bed resting. VSS 124/77-135-99-96% pulse ox RA. IJ site (R) side clean intact infusing NSS @ 125cc°. Foley cath draining clear yellow urine. Darvil 50mg given for rest. Evening Sitol provided. (b)(6)-2 RN
13 Aug 02		1450	118-124/71-98.7-97% pulse ox O2 mask 2L. Returned from OR. LR infusing (R) IJ. pt c/o pain demerol given as per physician order. Ø voiding. Will continue to monitor. (b)(6)-2 RN
13 AUG 02		1510	Morphine 5mg administered per physician order. Drsg dry & intact (b)(6)-2 RN
13 AUG 02			123-123/84-24-97 Pox 95% 2L mask. Dressing Drsg dry & intact. Foley draining to gravity c/o [illegible] pain Toradol administered (b)(6)-2 RN
13 Aug 02		2200	Pt voided <30 cc & Fo; SP [illegible] from & distension; will continue to monitor. (b)(6)-2 CPT/RN
13 Aug 02		2400	Str. cath for ~100cc clear yellow urine; Ø S/S distension; Ø c/o pain. (b)(6)-2 CPT/RN

Continue o

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) REGISTER NO. (b)(6)-2 WARD NO.

NURSING NOTES

Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Aug 02	0400		Voided 600 cc clear amber urine. (b)(6)-2
14 Aug 02	1130		A+O x3 Speaks very little English. VSS IV NS infusing @ 125ml/hr via IV. patent s/s of infiltration or infection @ site VSS. C/o (verbalized) pain (b)(6)-2 91W3M6 (b)(6)-2
			nausea Remains NPO for OR.
14 Aug 02		1425	Pt returned from OR VSS 99°-102-20
			Verbalized c/o pain while on litter. Transferred to bed. IV intact infusing 125cc/hr (b)(6)-2 91W3M6 (b)(6)-2
14 Aug		2110	Pt resting in bed c/o pain. ... admin. VS 117. 124/68 - 101.4 - 26 Pulse ox 97% on RA. Tylenol admin for temp. Po fluids encouraged. (R) stump draining. Reinforced dx applied moisture absorbing pad beneath stump. Amber colored urine 200cc voided into urinal.
15 AUG	0600		Toradol given for "fire pain" as described by pt. (b)(6)-2
15 AUG 02	0245		Pt stated "injection no good, another injection." IV Demerol 25mg given for pain of (R) stump. (b)(6)-2
15 Aug 02	1035		A+O x3 Speaking very little English Requesting H2O Remains NPO for OR. IV LR ... resume NS @ 125cc/hr via IV. T 100° VS remain. C/o pain. (R) stump continues to drain lg amt. of serous serosanguinous. Voids using urinal amber in color (b)(6)-2 91W3M6 (b)(6)-2
15 Aug 02		1530	Pt returned from OR. Alert IV infusing c/o extreme pain. 99.1-(110)-24 131/76 SpO2 100% (b)(6)-2 91W3M6 (b)(6)-2

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Aug 02	✓	1500	46 staples removed from abd-incision approximated. No S/S of infection to site. (b)(6)-2 (9103rd)
8/15/02		1930	Alert & oriented x minimal confusion; use of DSD contact on (R) AKA; voided 500 cc clear yellow urine; Temp 102.2 and Tx c Tylenol as per order; nPin attendance; Haldol given as per order 2° insomnia; takes analgesic IV prn - timely c % sleep/comfort. (b)(6)-2 CAT, AV, USAR
16 Aug 02		2130	Pt A+O c use of little English - Pt voiding clear yellow urine c difficulty - Dressing intact on (R) AKA - Moderate amount of serous drainage noted on dressing & Dressing reinforced - IV patent & infusing NS @ 125 cc/hr - Taking in po fluids - c/o (R) AKA pain & Medicated c Demerol also c/o nausea & medicated c Phenergan - Pt agitated & c effects of Demerol noted when medicated c Haldol as ordered - (b)(6)-2 SGT, USMC
17 Aug 02	0630		0 BM this shift - Medicated for pain throughout night - Eating breakfast c much staff encouragement (b)(6)-2 SGT, USMC
18 Aug 02	0800		Responds TO All Stimuli. DRSG. TO RLE Saturation c ODOR OF URINE. INCONTINENT of Lg Loose BM. VS: WNL. IVF INFusing Well into RIJ @ 125/hr NS.

*U.S. Government Printing Office: 1995 - 404-753/20085

(b)(6)-4

(b)(6)-2

0 (REV. 7-91) BACK

MEDCOM - 3171

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 Aug 02	/	1500	46 staples removed from abd. incision approximated
			No S/S of infection to site — (b)(6)-2 [redacted] 91W3M
8/15/02		1930	Alert in bed c̄ minimal english use; DSD
			intact on Ⓡ AKA; voided ā 500cc clear
			yellow urine; Temp 102.2 and Tx c̄ Tylenol
			as per order; no pain attendance; Haldol given as
			per order 2° insomnia; takes analgesic IV non-
			timely c̄ c/o sleeplessness. (b)(6)-2 [redacted] CPT, AN, USAR
16 Aug 02		2130	Pt A+O c̄ use of little English — Pt voiding
			clear yellow urine s̄ difficulty — Dressing
			intact on Ⓡ AKA — Moderate amount of
			serous drainage noted on dressing +
			Dressing reinforced — IV patent + infusing
			NS @ 125cc/hr — Taking in PO fluids —
			c/o Ⓡ AKA pain + Medicated c̄ Demerol
			also c/o nausea + medicated c̄ Phenergan —
			Pt agitated + effects of Demerol noted wear
			then medicated c̄ Haldol as ordered —
			(b)(6)-2 [redacted] Sgt 91WM
17 Aug 02	0630		Ø BM this shift — Medicated for pain
			throughout night — Eating breakfast c̄
			much staff encouragement
			(b)(6)-2 [redacted] Sgt, 91WMP
18 Aug 02	0800		Responds to All Stimuli. DRSG. TO RLE Saturation
			c̄ ODOR OF URINE. INCONTINENT of Lg Loose BM.
			VS: WNL. IVF INFUSING Well into RIJ @ 125/hr NS.
			(b)(6)-2 [redacted] MAJ ANC

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16 Aug 02	0730		Responds To All Stimuli. Follow Simple Commands. NPO MAINTAINED. Voiding Via Urinal QS. Pulses 99% RA. IVF INTOSing Well LR into RIJ @ 125cc/hr. NO Overt Complications @ This Time, (b)(6)-2 wife at.
16 Aug 02		1830	Pt Alert responsive. IV NSS 125cc infusing RIJ. Refused dinner. Drank. Repositioned voiding clear yellow urine in bottle. Turned, and repositioned (b)(6)-2 RN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19 Aug 02	0745		Alert while eating breakfast but hard to arose for VS. VSS. IV KVO infusing @ 125cc/hr via RD IV. Voids urinal. Verbalizes no pain — (b)(6)-2
8/19/02	2000		Pt resting on bed; gesture to keep control line to be removed; related site out of way and gestures to pt not to remove or dislodge line in any manner; shakes head to indicate agreement/understanding; (R) AKA Site moist c dressing and intact; Some english use as he desires; voiding QS clear yellow urine QS; VSS; NP in attendance. (b)(6)-2 CPT AN
8/20/02	0800		98 y/o - 74 - 118/82 - 18 Pt Alert Oriented, resting in bed. Does not speak english. Communicates through gestures & nods. Follows simple commands with guidance. PO intake 75% tolerated & N/V/D. Voided dark yellow urine in bottle. Assist of 1 with transposition (R) AKA - moist dressing applied. (b)(6)-2 KS

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

For use of this form, see AR 40-407; the proponent agency is OTSG

1. Date/Time: 20 Aug. 2002

2. Discharge to: ☐ Home Other (specify) DENTAL CENTER

3. Mode: ☐ Ambulatory Other (specify)

4. Accompanied by:

5. Activity: ☐ Limitations (specify) Bed Rest

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☑ No Dietary Restrictions If special, identify Regular

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
- Hal Dol	2mg,	PO	Daily
- MOTRIN	800mg,	PO	3x Daily
- DAKIN'S SOLUTION FOR DRSG			Change Daily.

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:	Patient/ S.O. observed Demonstrations (Date)	Patient/S.O. Returned Demonstration (Date)
NONE		

Equipment/Supplies (Specify)

9. Follow-up: You should be seen in _____ clinic in _____ (time period).

None

_____ Patient/S.O. communicates understanding of follow-up instructions.

10. Patient's Condition (Health Status relative to Nursing Care Plan):

Improved

11. Signature (Registered (b)(6)-2 (b)(6)-2 May RNC

12. Additional Information:

13. Patient Identification:

(b)(6)-4

COPY 1 - INPATIENT RECORD COPY

(b)(3)-1

BAGRAM AFGHANISTAN DISCHARGE SUMMARY

Date:
Name:
Grade:

Summary Of Injuries:

1
2
3
4
5

Operating Procedures:

Date:

1 AUG
3 AUG
5 "

Findings:
1 uncontrol Bldg (B) thigh GSW
2 dead muscle (B) femur
3
4 delayed - wound closure
5
6
7
8
9

Treatment (B) leg:
1 AKA (B) leg
2 debridement (B) - [illegible]
3
4
5
6
7
8
9

Discharge Meds:

Other Diagnosis & Condition(s):

Recommendations:

Signature/Title

MEDCOM - 3176

(b)(3)-1 BAGRAM AFGHANISTAN DISCHARGE SUMMARY

Date:20 August, 2002
Name: #(b)(6)-4
Grade:
Unit:

Summary Of Injuries:

1. MULTGIPLE GUNSHOT WOUND TO RLE
2. S/P RIGHT AKA
3.
4.
5.

Operating Procedures: WOUND DEBRIDEMENT (9 aug, 11 aug, 13 aug),
REVISION OF STUMP (1 aug 3 aug 5 aug , 8 aug) &
DRESSING CHANGES(14 aug, 15 aug, 16 aug)

Date:

	Findings:	Treatment
1	UNCONTROLLED BLEEDING	
2	RIGHT THIGH, SECONDARY TO GSW	1. AKA RLE
	NECROTIC MUSCLE RIGHT THIGH	2.
4		4
5		5
6		6
7		7

Discharge Meds:
HALDOL 2MG, PO, DAILY
DAKIN'S SOLUTION FOR DAILY DRSG CHANGE
COTRIM 800MG,PO 3 TIMES DAILY

Other diagnosis & Condition(s): *NONE*

RECOMMENDATIONS: DAILY DRSG CHANGES WSITH DAKIN'S SOLUTION

Signature/Name (b)(6)-2 LTC, MC
(b)(6)-2

MEDICAL RECORD — INTRAOPERAT. DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY litter

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 15 Aug 22 TIME PATIENT ARRIVED IN SUITE 1500

4. PATIENT IN ROOM TIME 1500 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D	RELIEF SCRUB	n/a
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: armboards

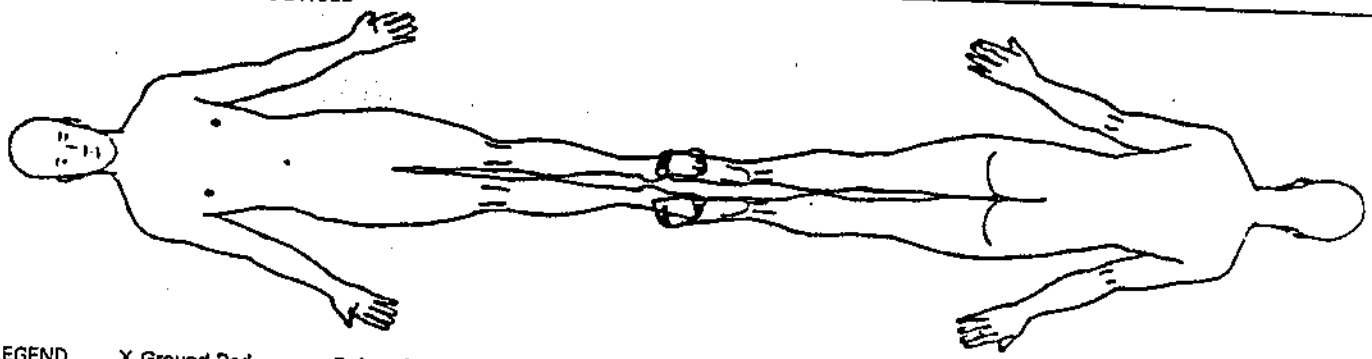
8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* n/a
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No		n/a			
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

(b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 3178

13. PROSTHESIS, IMPLANTS ☐ YE ☑ NO IF YES NAME: ID NUMBEI ANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☑ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2 LTC MC

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Gauze/Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED Debridement Wound

21. PATIENT TRANSFERRED TO ICU TIME 1525 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN/BSN LT

MEDICAL RECORD — INTRAOPERAT. DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2

3. DATE 14 Aug 02 TIME PATIENT ARRIVED IN SUITE 1525

4. PATIENT IN ROOM TIME 1525 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 RD	RELIEF SCRUB	U G
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: armboards

8. SKIN PREPARATION

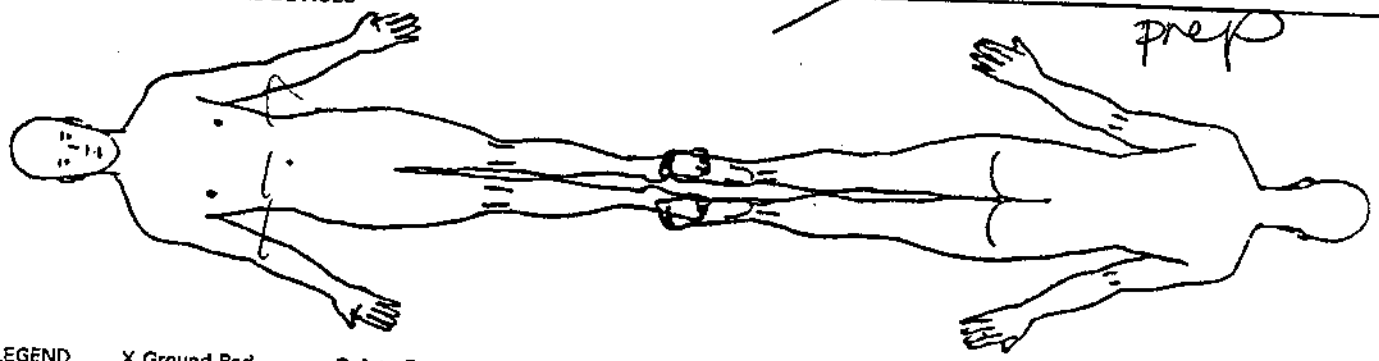
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine over Hump (b)(6)-2
SITE: R Hump BY WHOM: (b)(6)-2
SITE: BY WHOM:

COMMENTS: No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No			4		
Needle Sharp	☐ Yes ☐ No					
Instrument	☐ Yes ☐ No			4		
Other	☐ Yes ☐ No					

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

(b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIG (b)(6)-2

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* laps/Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

dsg

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU		litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RNBSN ICU

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2

3. DATE 13 Aug 02 TIME PATIENT ARRIVED IN SUITE 1335

4. PATIENT IN ROOM TIME 1335 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 RN	RELIEF SCRUB	RN
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 RN	RELIEF CIRCULATOR	RN

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

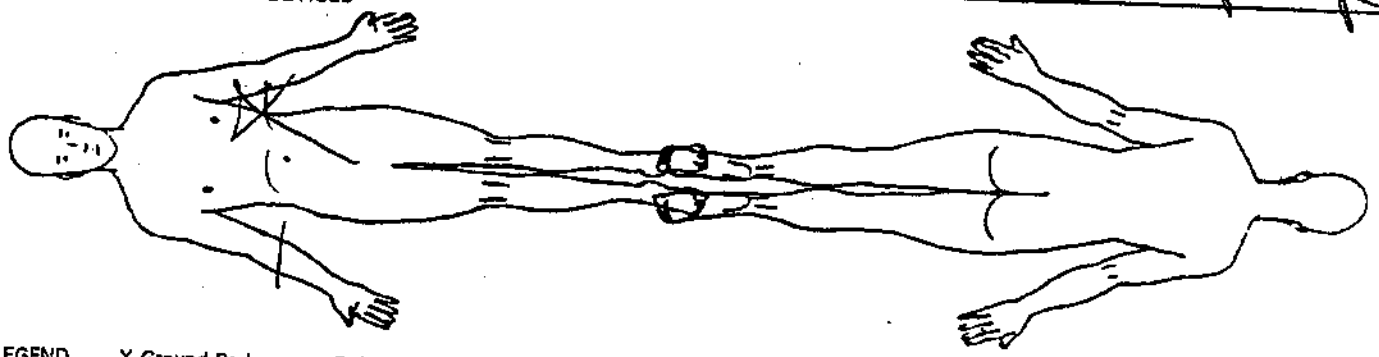
PREP SOLUTION (Specify) Betadine

SITE: R AKA BY WHOM (b)(6)-2

SITE: BY WHOM:

COMMENTS: No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ~ Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count
Sponge	☐ Yes	☐ No			
Needle Sharp	☐ Yes	☐ No			
Instrument	☐ Yes	☐ No			
Other	☐ Yes	☐ No			

SCRUB (b)(6)-2

CIRCULATOR (b)(6)-2 RN

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

(b)(6)-4

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

☒ ESU NO: 0101

GROUND PAD: BRAND ValleyLAB

LOT NO: 58804 / 2004 02

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN (b)(6)-2 LT C MC

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* gauze/Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
E+D of (R) AKA

21. PATIENT TRANSFERRED TO ECW TIME 1412 METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RNBSN LT

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2

3. DATE 12Aug02 TIME PATIENT ARRIVED IN SUITE 1620

4. PATIENT IN ROOM TIME 1630 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 (b)(6)-2 91D	RELIEF SCRUB	N
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 91D	RELIEF CIRCULATOR	A

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: armboards

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine

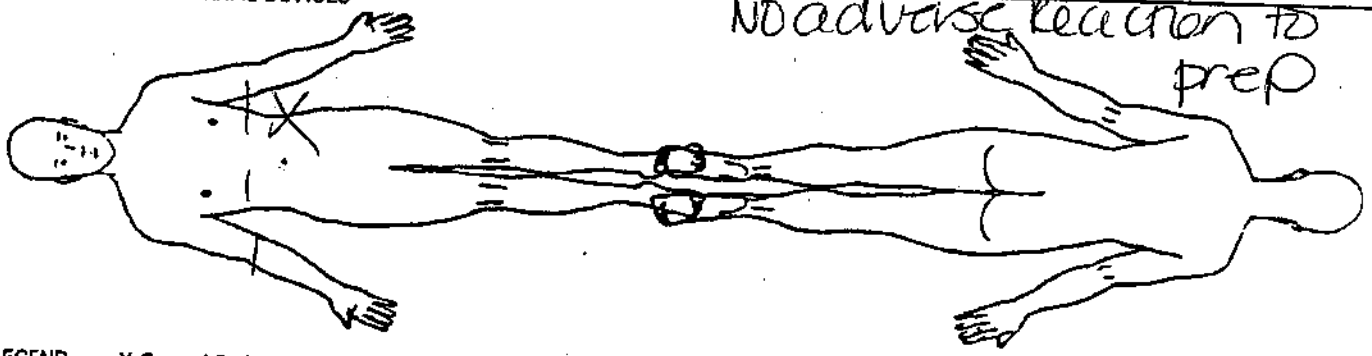
SITE: (R) AKA BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: NO loading of solution I

9. LOCATION OF EXTERNAL DEVICES

NO adverse reaction to prep



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No			N		
Other	☐ Yes	☒ No			A		

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

(b)(6)-4

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

☒ ESU NO: 01011

GROUND PAD: BRAND Valleylab

LOT NO: 58309 / 2004-02

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLA... DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE (b)(6)-2 LTCMC

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME N/A	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Gauze/Raps/Kerlix/ ~~peg~~ Stockinette

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. N/A	2.	3.
SITE	1. N/A	2.	3.

19. ADDITIONAL INFORMATION
Foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement/irrigation (R) AKA

21. PATIENT TRANSFERRED TO ICU TIME 1700 METHOD W/ TOR

(b)(6)-2 REGISTERED NURSE SIGNATURE RNBSN/LT

MEDICAL RECORD — INTRAOPER[illegible]OCUMENT

For use of this form, see AR 40-407, the pro[illegible]t agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM — VIA: LITTER — BY: (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: (b)(6)-2 (b)(6)-2

3. DATE: 11 Aug 02 — TIME PATIENT ARRIVED IN SUITE: 1107

4. PATIENT IN ROOM — TIME: 1107 — NUMBER: 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D	RELIEF SCRUB	9
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	
	(b)(6)-2 91D		

7. POSITION AND POSITIONAL AIDS (Specify)

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

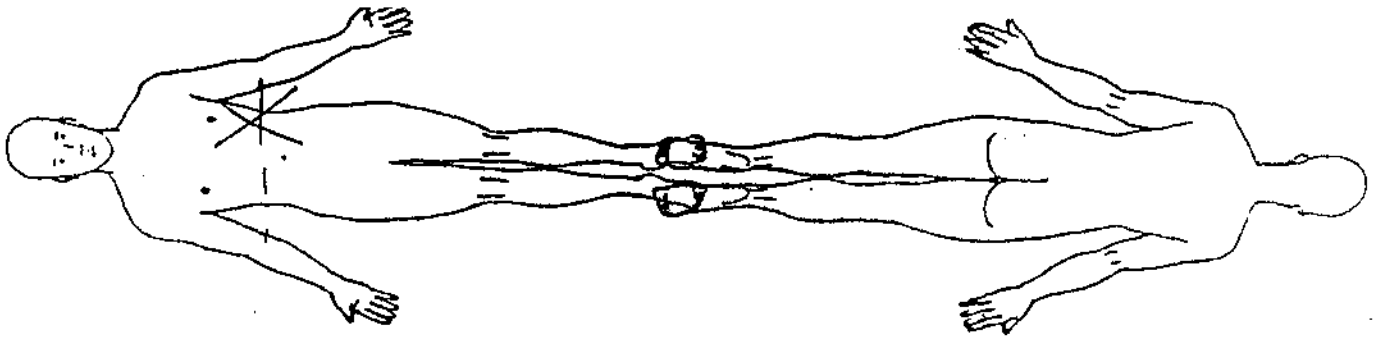
COMMENTS: armboards

8. SKIN PREPARATION

HAIR REMOVAL: ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION (Specify): Betadine
SITE: (R) AKA — BY WHOM: (b)(6)-2
SITE: — BY WHOM:
COMMENTS: No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ≈ = = Tourniquet

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No				(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☐ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: 01011
GROUND PAD: BRAND Valleylab
LOT NO: 563891 2004/02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUME M: CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNA (b)(6)-2 LTC MC

15. X-RAY IN OPERA IF YES, SITE
YES ☐ NO ☐

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* gauze/laps/Kerlix/Ace

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION
foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement/irrigation (R) AKA

21. PATIENT TRANSFERRED TO	TIME	METHOD
DAU	1130	litter

(b)(6)-2 RN BSN LT

MEDICAL RECORD — INTRAOPERA[illegible]OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM — VIA: litter — BY: (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: (b)(6)-2 / (b)(6)-2

3. DATE: 9aug02 — TIME PATIENT ARRIVED IN SUITE: 1615

4. PATIENT IN ROOM — TIME: 1615 — NUMBER: 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 QID	RELIEF SCRUB	N/a
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 QID	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

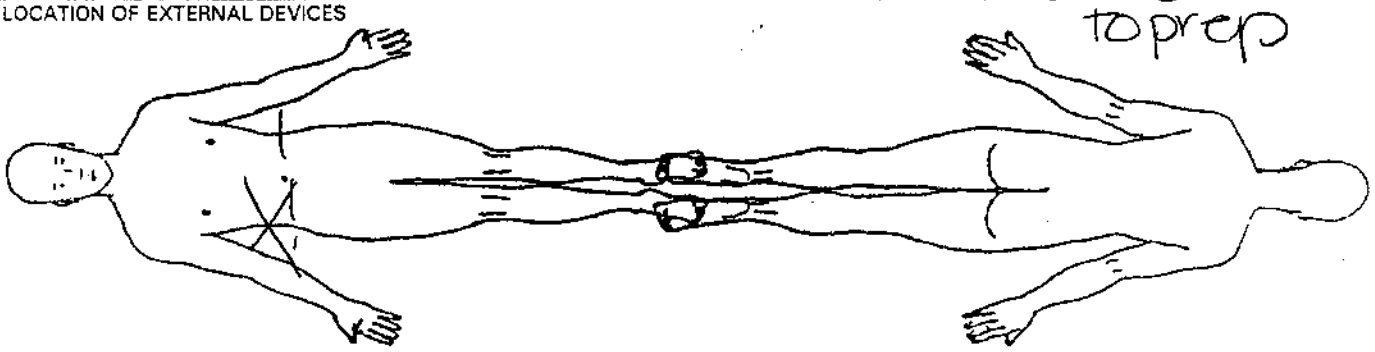
PREP SOLUTION *(Specify)*: Betadine

SITE: (R) AKA — BY WHOM: (b)(6)-2

SITE: — BY WHOM:

COMMENTS: No pooling of sol / No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2 QID	(b)(6)-2 RN
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

(b)(6)-4

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

☒ ESU NO: Valleylab / 01011

GROUND PAD: BRAND 58309/2004-2

LOT NO:

☐ ESU NO: N/a

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/a					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY
N/a		

PHYSICIAN'S SIGNAT (b)(6)-2 LTC mc

15. X-RAY IN OPERA IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

gauze/Kerlix/pres

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

debridement

21. PATIENT TRANSFERRED TO ICU TIME 1740 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN ILT

REVERSE OF DA FORM 3179-1, OCT 87

USAPA V1.00

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

For use of this form, see AR 40-407, the prop[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 / (b)(6)-2

3. DATE 8 August TIME PATIENT ARRIVED IN SUITE 1402

4. PATIENT IN ROOM TIME 1402 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: sedated / language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 RN	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: NA

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: NA

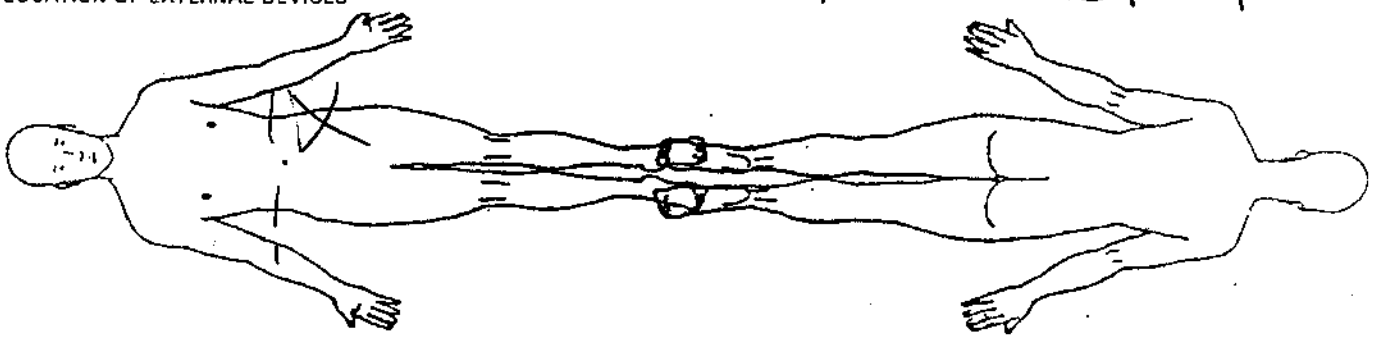
PREP SOLUTION *(Specify)* Betadine

SITE: R thigh BY WHOM:

SITE: BY WHOM:

COMMENTS: no pooling / no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS (C = Correct I = Incorrect)

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2 RN	(b)(6)-2 RN
Needle Sharp	☒ Yes ☐ No					
Instrument	☒ Yes ☐ No					
Other	☐ Yes ☒ No					

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

(b)(6)-4

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

☐ ESU NO: 01011

GROUND PAD: BRAND Valleylab

LOT NO: 58364 / 2004 / 2

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUM M CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2 TTCMC

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ (b)(6)-2 IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
I+D R ARM

21. PATIENT TRANSFERRED TO FC TIME 1530 METHOD litter

(b)(6)-2 RN BSN ILT

REVERSE OF DA FORM 3179-1, OCT 87

MEDICAL RECORD — INTRAOPERA[illegible]OCUMENT

For use of this form, see AR 40-407, the propo... ... agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2

3. DATE 8-5-02 TIME PATIENT ARRIVED IN SUITE 0935

4. PATIENT IN ROOM TIME 0935 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 SD	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

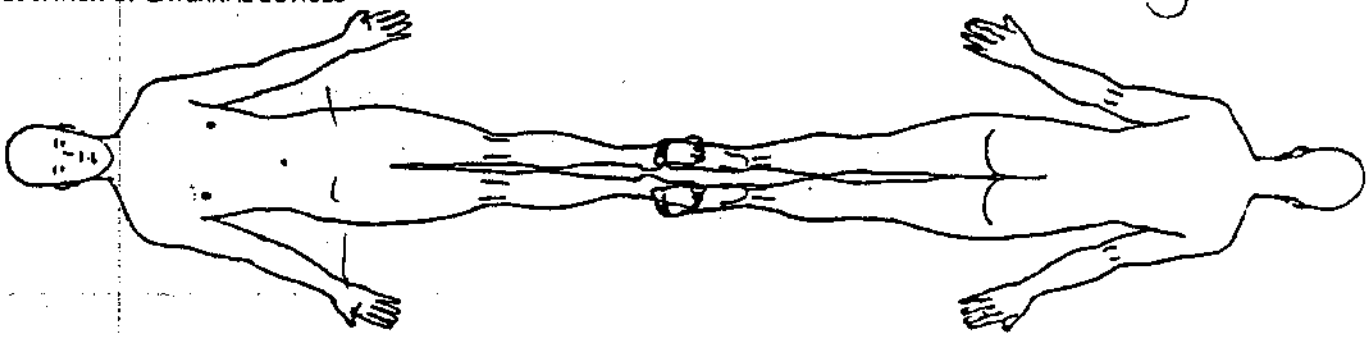
COMMENTS: arm boards

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* betadine
SITE: R leg BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: No adverse to prep/ No pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2 SD	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☐ ESU NO: N/A
GROUND PAD: BRAND N/A
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM FACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Ancef	1gm	Intraop	Irrigation	(b)(6)-2	Surgeon
N/a					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
Cefazolin 1gm/1L LR

OTHER ORDERS	TIME	CARRIED OUT BY
N/a		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME N/a	NAME N/a
FROZEN SECTION (FS) YES ☐ NO ☒	NAME N/a	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. N/a	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform/gauze/kerlix/tape

19. ADDITIONAL INFORMATION
foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement/wound closure @ leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
LRS	1116	Litter

(b)(6)-2 RN BSN ICU

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — **INTRAOPE[illegible]E DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM — VIA litter — BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2

3. DATE 30 Aug 02 — TIME PATIENT ARRIVED IN SUITE 1155

4. PATIENT IN ROOM TIME 1155 — NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D	RELIEF SCRUB	9
	(b)(6)-2 91D		
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	
	(b)(6)-2 91D		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

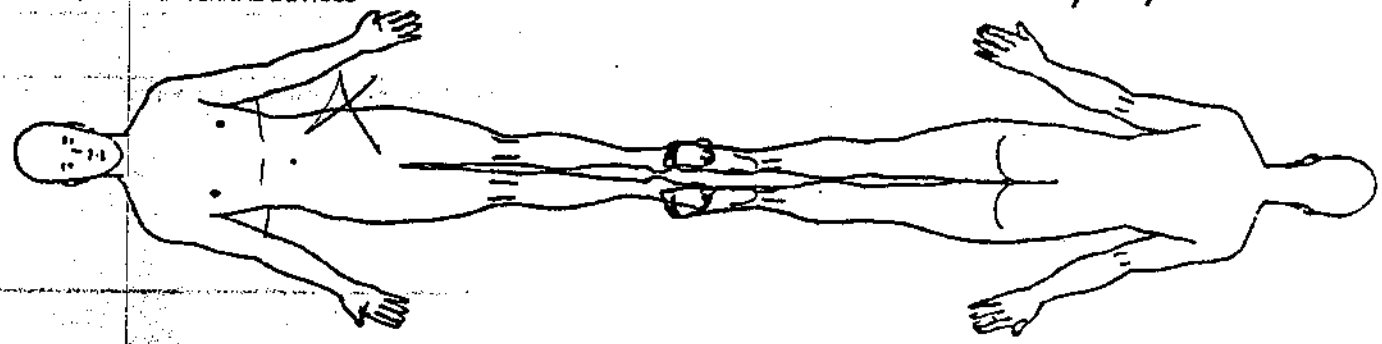
PREP SOLUTION *(Specify)* Betadine

SITE: L leg — BY WHOM: (b)(6)-2

SITE: — BY WHOM:

COMMENTS: No pooling / no adverse reactions to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ~ Safety Strap = = = Tourniquet

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: 000999

GROUND PAD: BRAND Valleylab

LOT NO: 58309 / 2004-02

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
ancef 1 g	1gm	intra-op	irrigation	(b)(6)-2	(b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
ancef / NSS

OTHER ORDERS	TIME	CARRIED OUT BY
NPO		

PHYSICIAN'S SIGNATURE (b)(6)-2 LTC MC

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

Xeroform / gauze / Kerlix / Coban / ABD's

19. ADDITIONAL INFORMATION
Foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
Modification of AKA

21. PATIENT TRANSFERRED TO PACU TIME 1235 METHOD Litter

(b)(6)-2 RN BSN CA

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDICAL RECORD — INTRAOPERA DOCUMENT

For use of this form, see AR 40-407, the prop... agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2 (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2

3. DATE 10 Aug 02 TIME PATIENT ARRIVED IN SUITE 1917

4. PATIENT IN ROOM TIME 1917 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D (b)(6)-2 91D	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify)

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

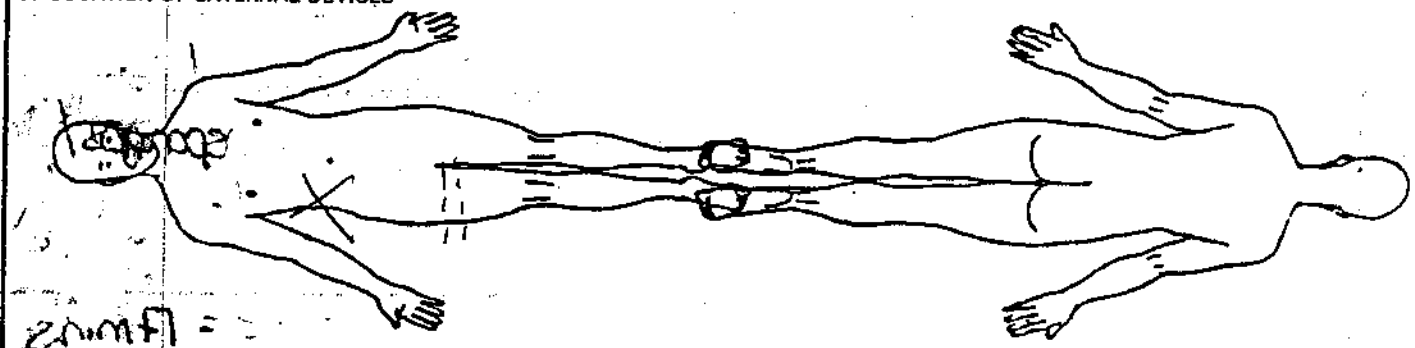
COMMENTS: N/A

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine BY WHOM: (b)(6)-2
SITE: (L) leg BY WHOM:
SITE:
COMMENTS: N/A

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2 RN
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

(b)(6)-4

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

☒ ESU NO: 000999
GROUND PAD: BRAND Valleylab
LOT NO: 54223

☐ ESU NO:
GROUND PAD: BRAND N/A
LOT NO: 2003/12

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS [ ] NO IF YES NAME: ID NU MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Cefazolin	1gm	1900	irrigation	(b)(6)-2	(b)(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN (b)(6)-2 LTC MC

15. X-RAY IN OPER YES [ ] NO [ ] IF YES, SITE N/A

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [X] NO [ ] NAME (R) leg		NAME
FROZEN SECTION (FS) YES [ ] NO [X] NAME		NAME
CULTURE (C) YES [ ] NO [X] NAME		NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION (Specify) (R)ankle = 2 lap sponges / Kerlix / PEB

17. TUBES, DRAINS/PACKING YES [X] NO [ ]

TYPE/SIZE	12 Lap sponges	2.	3.
SITE	(R)ankle	2.	3.

19. ADDITIONAL INFORMATION

(R)leg tourniquet ~ start 1916 down 1934 Total time = 17mins

foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED

A.K.A

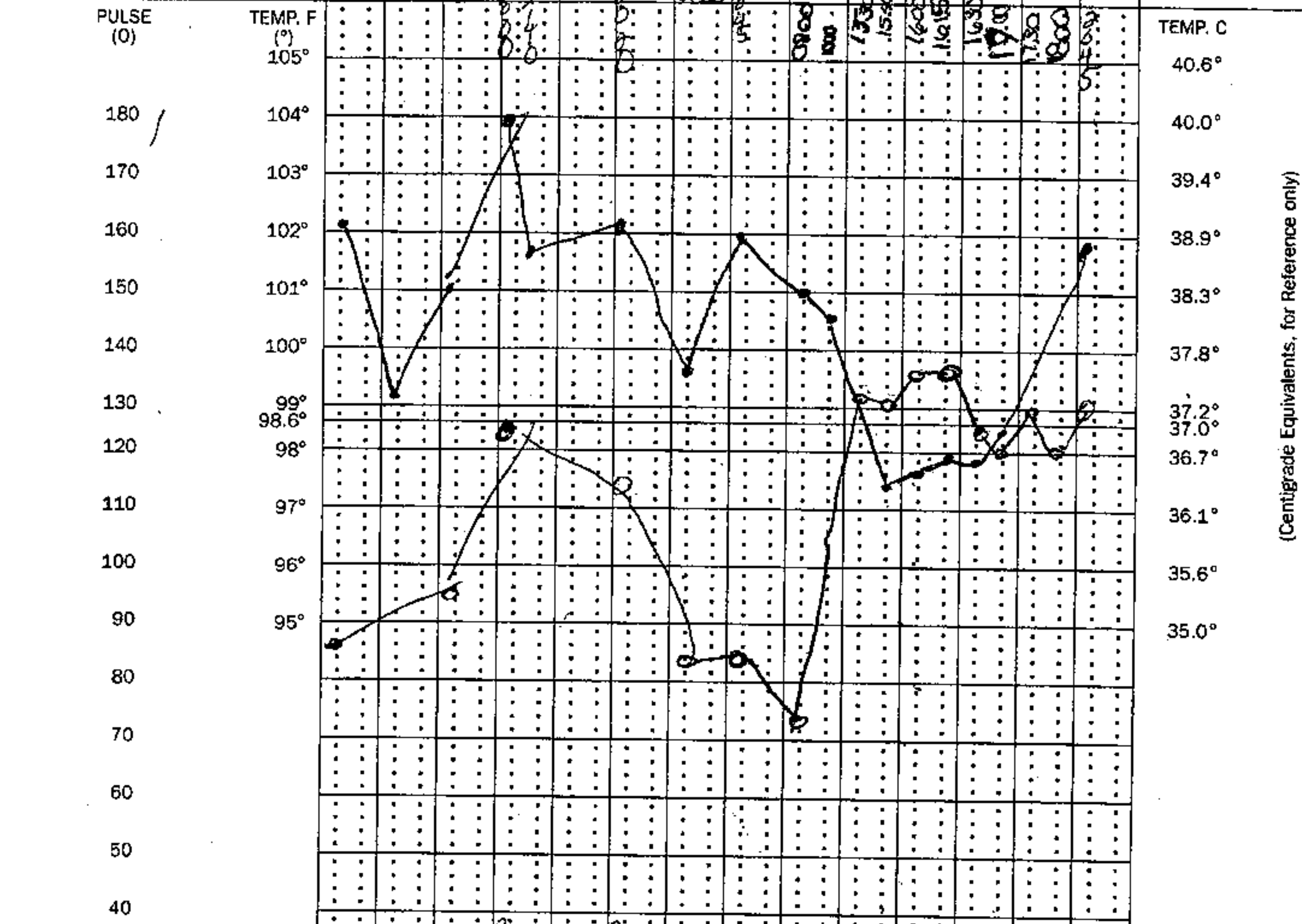
21. PATIENT TRANSFERRED TO ICU TIME 2040 METHOD litter

(b)(6)-2 RN, BSN, LT

REVERSE OF DA FORM 3173-1, OCT 87 USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	Aug 4	5 AUG 02	6 Aug 02	Aug 7	Aug 8	Aug 8	Aug 8 02
19 / HOUR	2000, 2130	0800	0800	0830	0800, 1000, 1330, 1545	1600, 1615, 1630	1730, 1800, 2045



RESPIRATION RECORD	24	20, 28	28	26, 22	26	28, 26, 26, 24	24, 24
BLOOD PRESSURE	150/80	136/74; 2000 130/78	2000 138/82	136/80; 2015 130/72	0800 134/86; 1530 124/85; 118/86; 1615 129/94; 1630 129/85	129/85; 1540; 1700 124/87	122/80; 2015 130/... (b)(6)-
HEIGHT: / WEIGHT →							
		SpO2 92; 2000 ... RA	SpO2 90; 2000 ... RA	SpO2 90; 2045 RA			SpO2 2045 99
					Pulse ox 94%; 2L; 1615 99% 2L		(b)(6)-2

Record special data only when so ordered

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

Pt # (b)(6)-4

Bed #8

REGISTER NO.

WARD NO. ICW

STANDARD FORM 511 (REV. 7–91) BACK

*U.S. Government Printing Office: 1992 — 312-071/50030

511-117

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS
Medical Record

STANDARD FORM 511 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

511-117

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 15 Aug | 16 Aug | 17 Aug | 18 Aug | 19 Aug

19 | HOUR

PULSE (O) | TEMP. F (°)

105° | 180 | 104° | 170 | 103° | 160 | 102° | 150 | 101° | 140 | 100° | 130 | 99° 98.6° | 120 | 98° | 110 | 97° | 100 | 96° | 90 | 95° | 80 | 70 | 60 | 50 | 40

TEMP. C

40.6° | 40.0° | 39.4° | 38.9° | 38.3° | 37.8° | 37.2° | 37.0° | 36.7° | 36.1° | 35.6° | 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS
Medical Record

STANDARD FORM 511 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-407; the proponent agency is the OTSG

WARD: ICU

This form may be used for more than one day be drawing a heavy line and adding date. Insert column headings as required.

DATE: 11 Aug 02

11 Aug 02 PATIENT'S NAME		START						
UNIT #1		0915	0930	1000	1030	1100	1130	
# (b)(6)-4	T	100.1	99.6	99.9	99.8			
	P	110	116	108	104			
	R	20	20	20	20			
	B/P	147/84	145/83	140/82	142/82			
UNIT #2					1035	1105	1135	
# (b)(6)-4	T				99.6	99.2		
	P				110	110	100	
	R				20	20	(b)(6)-2	
	B/P				140/72	129/78		

DA FORM 3950, JUN 91 — Previous editions are obsolete. — *U.S. GPO: 1995-386-733/03913

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 4 AUG 02

INTAKE

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR				125	125	125	125	125																
meds					50																			
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total		850																						
Cumulative Total		1700																						

OUTPUT CC/HR

OUTPUT

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly				550				600																
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

MEDCOM - 3202

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV	675			
NG				
Bld				
TOTAL				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN	1150			
NG				
TOTAL				

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 4 AUG 02

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.
0720	Haldol 2.5mg	IM	(b)(6)-2
0900	Acetaminophen 650mg	PO	
0930	Demerol 25mg	IV	
1030	Fentanyl 50mcg	IV	
1300	Fentanyl 50mcg	IV	
1500	Fentanyl 50mcg	IV	

DRUG/DOSE	Route	Init.

DRUG/DOSE	Route	Init.

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES
ADDRESSOGRAPH

Tylenol 325 mg ~~ii~~ 650 PO q 6° PRN Fever
Fentanyl 50 mcg IV q 2° PRN pain
Demerol 25 mg IV q 6° PRN Pain
11

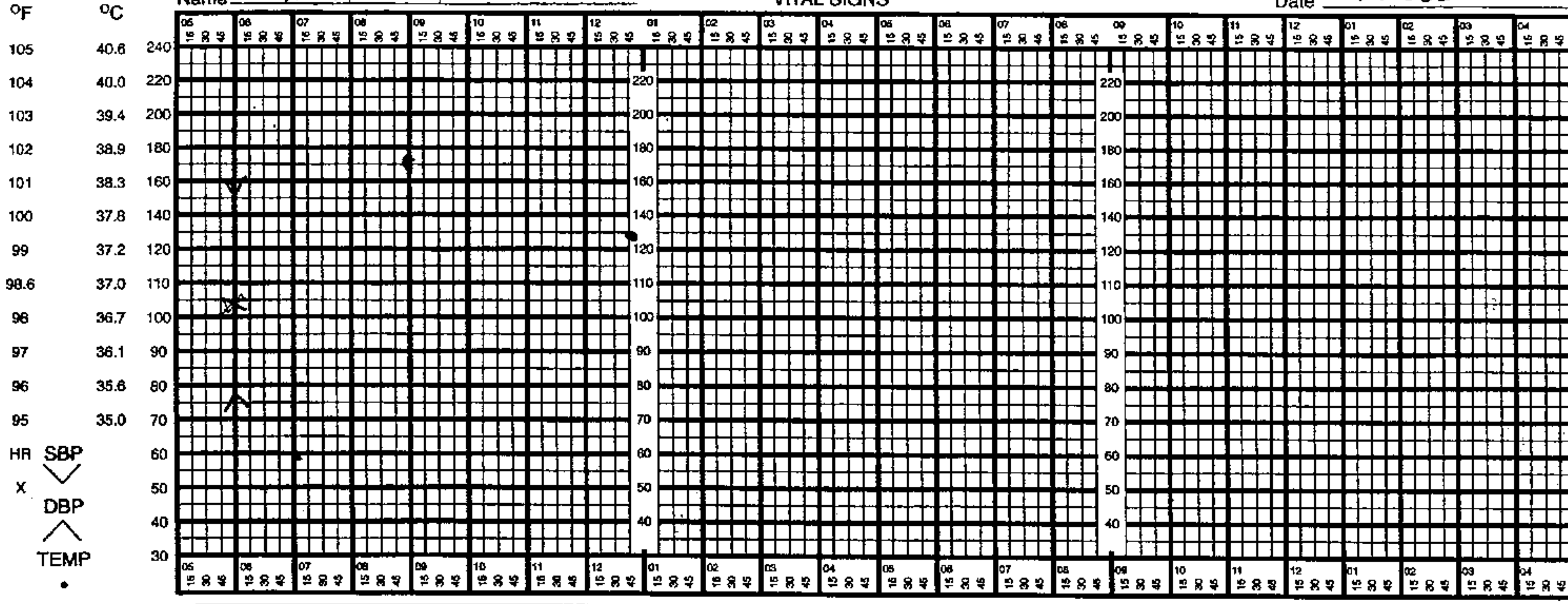
SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2 ILT ANC	(b)(6)-2
(b)(6)-2 JE	

PT # (b)(6)-4

*SEE PROGRESS NOTES:

Name ___ (b)(6)-4 ___ VITAL SIGNS ___ Date ___ 8 AUG 02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR		104	100	108				108																
Rhythm			ST	ST				ST																
RESP.			20	26				24																
CUFF BP		157/77	150/90	158/74				138/71																
MAP			87	98				90																
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SVRI		95	93	90				98																

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Ancef 1gm IV q 8							(b)(6)-2																		
Gentamycin 500mg IV q D																									

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

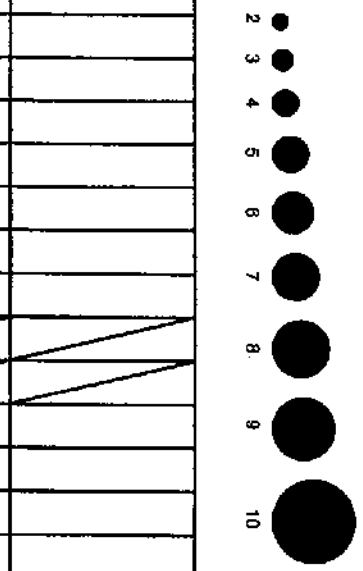
0800 Awake Alert Resp easy Skin warm [illegible] lungs clear ABD soft
Nontender ⊕BS (R) [illegible] dsg with ⊕ [illegible] dry [illegible] approximated
c̄ staples [illegible] incision approximated c̄ staples intact [illegible] 0900
(b)(6)-2 (b)(6) [illegible]

NURSING PROGRESS NOTE

*SEE PROGRESS NOTES:

PROCEDURES / TIME			OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
NEUROLOGICAL			→ SEE CODE →		
Eyes Open	Closed by swelling = C		4		
Verbal Response	ET Tube or Trach = T		5		
Motor Response			6		
Pupils R - react NR - non SR - slow		Size R	3		
		Reaction	R		
		Size L	3		
		Reaction	R		
		Hand Grasp R / L	5 / T		
Breath Sounds			clear		
Sputum Character			-		
Nasal Endotracheal Suctioning Q ____			-		
Chest PT Q ____			-		
CDB/IS Q 1-3			-		
Vent. ✓'s			-		
E.T. Tube @ ____					
Cuff ✓/Pr/cc's					
C.T. Strip & Vent Q ____			/	/	/
C.T. Fluctuates / ___ cm.			~	~	~
Peripheral Pulses **		U	1/5 A		
		L	1+ 1+		
Circ. Distal to A-Line			-		
Monitor Alarm On			-		
PA Line			-		
CVP/Other			-		
Art Line			-		
Peripheral			-		
Peripheral			-		
PT/Family Teaching/Support			-		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER. . . . . D

PALPABLE. . . . . P

STRONG. . . . . S

WEAK. . . . . W

ABSENT. . . . . A

PROCEDURES / TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+)x4		
ABD Size/Firmness	Flat/soft		
NG Secure/Proper Pos.	N/A 0900		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	✓		
Aspirate Prior to Bolus Feed	✓		
Stool Char./Guaiac	✓		
Urine Color/Character	clear		
Foley Secure/Patent	✓		
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	✓		
Bath	✓		
Turn & Position Q 3	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	✓		
ROM	✓		
Dangle	✓		
Restraints Released Q2H	Shackled		
OOB to Chair	✓		
Ambulation	✓		
Side Rails ↑	✓		
Drsng. Δ	N/A		
Drsng. Δ			

ADDRESSOGRAPH

PT # (b)(6)-4

MEDCOM - 3206

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 8/5/08

Time				1715																				
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC				[illegible]																				
Hb/Hct				[illegible] / 9.7																				
PLT				14[illegible]																				
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.
07:00	Tylenol 650mg	PO	(b)(6)-2	03³⁰	Fentanyl / 50mcg	IV	(b)(6)-2				
0900	Fentanyl 50mcg	IV		05³⁰	Fentanyl / 50mcg	IV					
1430	Fentanyl 50mcg	IV									
1515	Demerol / 25mg	IV									
1500	Tylenol 650mg	NG									
1630	Fentanyl 50mcg	IV									
1930	Fentanyl 50mcg	IV									
2120	Fentanyl 50mcg	IV									
22⁰⁰	Demerol 25mg	IV									
23³⁰	Fentanyl / 50mcg	IV									
23³⁰	Elavil 50 mg	IV									
01³⁰	Fentanyl 50 mcg	IV									
02⁰⁰	Demerol 25mg	IV									

~~MSO4 2.5mg Q1 PRN~~

Tylenol 325mg ... ii [illegible]

Fentanyl 50mcg IV Q3° PRN

Demerol 25mg ~~[illegible]~~ IV q 4° PRN pain

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.

WGT.

WGT.

YESTERDAY

PREVIOUS DAY

INTAKE

OUTPUT

BSA

ALLERGIES

ADDRESSOGRAPH

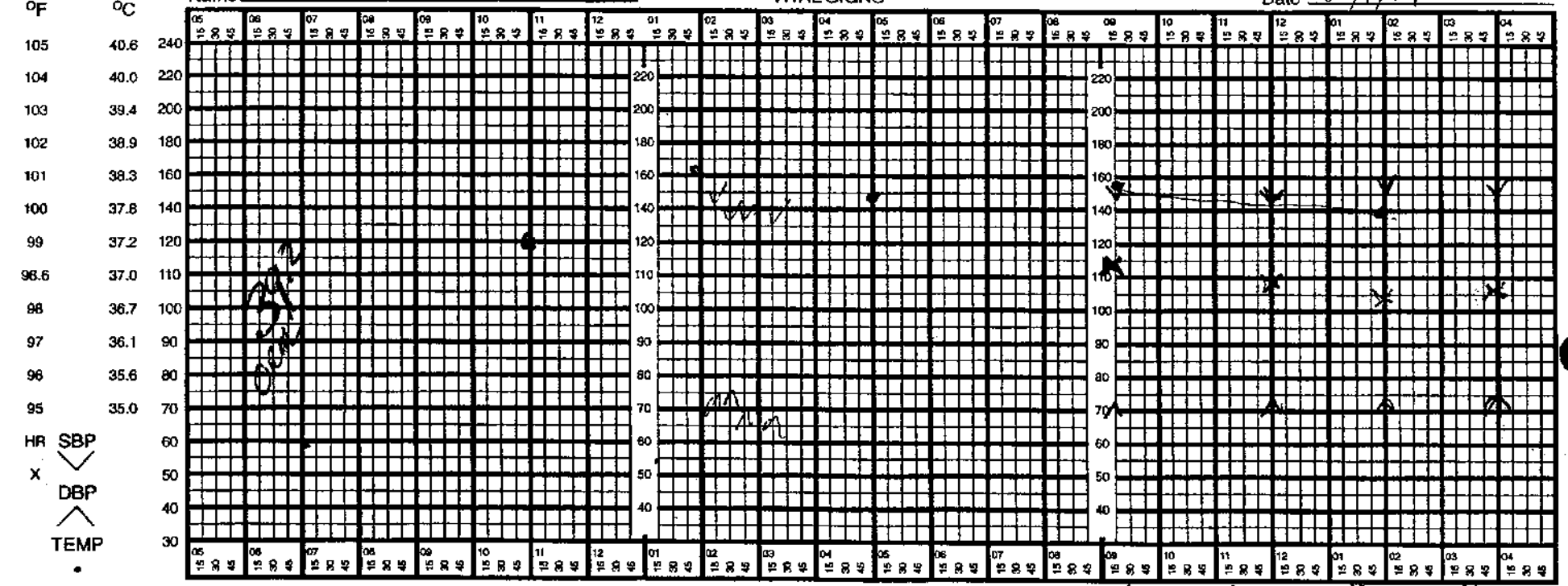
(b)(6)-4

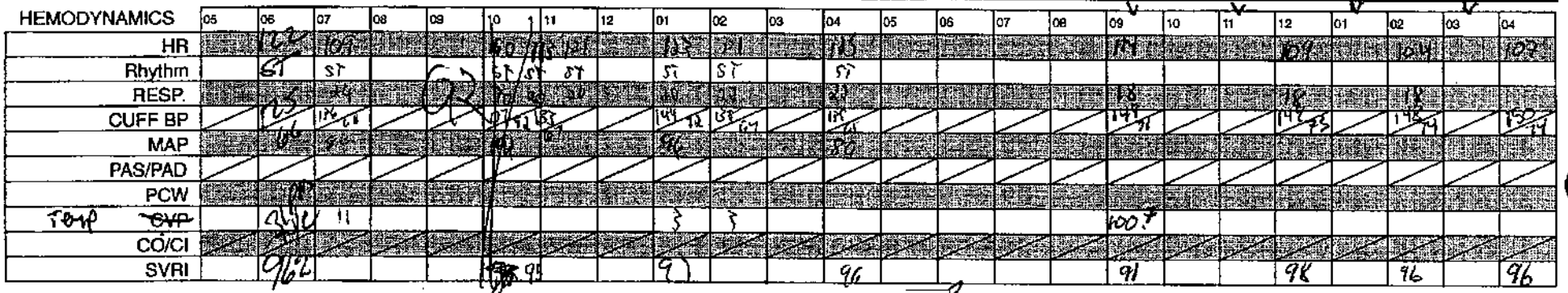
SIGNATURE AND INITIALS NURSE/RESP THERAPIST	Init.
(b)(6)-2 [illegible]	(b)(6)-2
(b)(6)-2 ILT ANC	

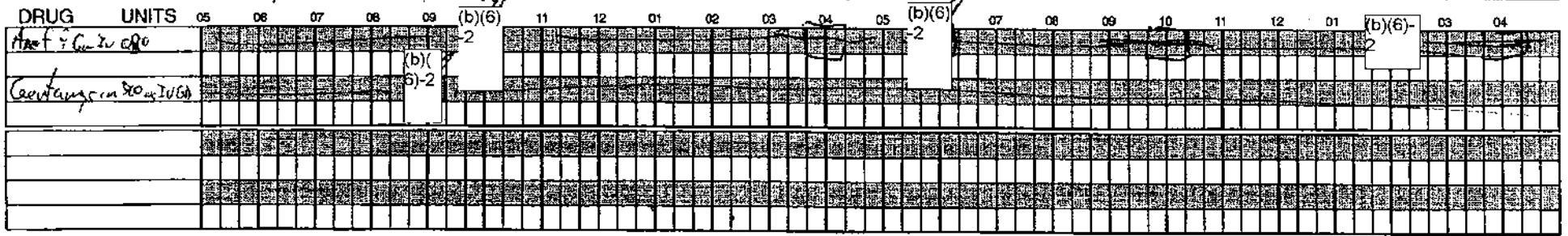
MEDCOM - 3207

*SEE PROGRESS NOTES: (b)(6)-4

Name _____ VITAL SIGNS Date 8/3/09







MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE	NURSING PROGRESS NOTE
Awake Alert oriented. Resp easy, lungs clear, HR 110s-130 sinus Tach [illegible].	
ABD [illegible] well approximated c staples intact (L) leg incision dry,	
well approximated c staples intact (R) stump dsg intact c large amt	
serosanguineous drainage. To OR for Revision [illegible] of (R) stump.	
Dr [illegible] advised of H/H @ 1930. 2 PRBCs transfusion initiated.	
(b)(6)-2	
2130 - VS 100⁷ F - 114 regular - 18 even and unlabored,	
lungs clear bilaterally - 149/71. Pulse oximetry 98%.	
Drsgs to (R) stump + abd clean and intact. TERL alert.	
IV site (L) arm + (R) shoulder patent. 1 unit blood running.	
NSS running 100 cc/hr. O_2 4 L via nasal cannula. NG	
Tube in place. Foley cath patent draining yellow urine.	
(b)(6)-2 1LT ANC	
0330 - II units O+ blood given, H+H @ 0400	
0600 - 3rd unit blood given - H+H 21/7 (b)(6)-2 1LT ANC	

FORM 0021

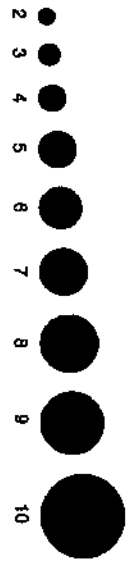
MEDCOM - 3209

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES / TIME	7 - 4	4 - 12	12 - 8
NEUROLOGICAL	→ SEE CODE →		
Eyes Open (Closed by swelling = C)	4		
Verbal Response (ET Tube or Trach = T)	5		
Motor Response	6		
Pupils R - react NR - non SR - slow — Size R	3		
Reaction	R		
Size L	3		
Reaction	R		
Hand Grasp R / L	5 / 5		
Breath Sounds	clear		
Sputum Character	/		
Nasal Endotracheal Suctioning Q ____	/		
Chest PT Q ____	/		
CDB/IS Q ____	/		
Vent. ✓'s	/		
E.T. Tube @ ____	/		
Cuff ✓/Pr/cc's	/		
C.T. Strip & Vent Q ____	/		
C.T. Fluctuates / — cm.	/		
Peripheral Pulses ** U	1+ NT		
L	1+ PS		
Circ. Distal to A-Line	✓		
Monitor Alarm On	✓		
PA Line	✓		
CVP/Other	✓		
Art Line	/		
Peripheral	✓		
Peripheral	✓		
PT/Family Teaching/Support	✓		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES / TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+) x 4		
ABD Size/Firmness	Flat soft		
NG Secure/Proper Pos.	✓		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	/		
Aspirate Prior to Bolus Feed	/		
Stool Char./Guaiac	/		
Urine Color/Character	clear Amber		
Foley Secure/Patent	✓		
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	/		
Bath	✓		
Turn & Position Q 2°	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	✓		
ROM	✓		
Dangle	/		
Restraints Released Q2H	shackles		
OOB to Chair	/		
Ambulation	/		
Side Rails ↑	✓		
Drsng. Δ	NSL		
Drsng. Δ			

ADDRESSOGRAPH

MEDCOM - 3210

*SEE PROGRESS NOTES: 127

INTAKE CC/HR

Date 8-3-02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
IRR/125		250	125	125	125	125	125	PICC		125	100	100	100	125										
IV MIDS				50	100								50											
Blood Products																								
PRBC														500										
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly		800			100		126					350	120											
Urine Cumulative																						350		
NG -	CLAMPED																							
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.
PRBC	(b)(6)-4				

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV	1025			
NG				
Bld				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN	1026			
NG				

Elvis 50.

NURSING PROGRESS NOTE	RESPIRATORY PROGRESS NOTE
07:00 - Pt Restless, c/o Pain all night medicated several times c MSO4 - @ thigh Continued to ooze Sero/sang thru. Dressing CDI Reinforced - Urine output BS clear Yellow-amber @ Start of tour 23:00	pt b 0830 pt BS clear/dim. SaO2 93 on 3L NC HR 123 RR 1706 pt stable on 3L NC humid. HR 136 RR 20 SAT 95 BS clear/dim — (b)(6)-2 /RT

ADDRESSOGRAPH

(b)(6)-4

*SEE PROGRESS NOTES: (b)(6)-4

STAT LABORATORY DATA

Date 24 Aug 06

Time																							
Glucose																							
BUN/CR.																							
Na+																							
K+																							
Cl-																							
HCO_3-																							
WBC																							
Hb/Hct																							
PLT																							
PT/ct																							
PTT/ct																							

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init. (b)(6)-2	TIME	DRUG/DOSE	Route	Init. (b)(6)-2	DRUG/DOSE	Route	Init.
05:00	MSO4 2mg	IV		03:45	MSO4 5mg	IV				
0930	MSO4 2mg	IV								
0945	MSO4 5mg	IV								
1130	MSO4 5mg	IV								
1330	MSO4 3mg	IV								
1500	Acetaminophen 650mg	PO								
1445	MSO4 5mg	IV								
1600	MSO4 9mg	IV								
1730	MSO4 5mg	IV								
2030	MSO4 5mg	IV								
2200	MSO4 5mg	IV								
0000	MSO4 5mg	IV								
0200	MSO4 5mg	IV								

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES
ADDRESSOGRAPH

Propofol 5-50 mcg/kg/min
Titrate
MSO4 2.5-5 mg Q1° PRN
LR @ 125 cc/Hour

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

(b)(6)-2	Init. (b)(6)-2

MEDCOM - 3213

NURSING PROGRESS NOTE

0800 Awake Alert. Extubated to Simple Facemask @ 5 LPM. Resp easy. Lungs clear bilaterally ō ↓ sounds (L) base. HR 140s ST's ectopy. ABD soft Flat. NGT draining dk green-brown bilious fluid. Midline incision ō Swelling approximated ō Staples intact. (R) leg incision dry & approximated ō staples intact. (R) Stump dsg intact ō large amt serosanguinous drainage. Receiving MSO4 2-5mg IV for pain. PRBCs transfused as per Dr [redacted] (b)(6)-2 [redacted] (b)(6)-2 advised of ↑ temp [redacted] (b)(6)-2 CPT AN

21:30 - Pt @ 20:30 c/o Throbbing Pain in (L) LE. Pt medicated ō 5mg MSO4 @ LE. Parts of Dressing Saturated ō Sang fluid. Does not appear to be actively Bleeding. BS Bilateral Diminished O2 Sat 97% on 3 LPM n/c. - Pt (L) UE (L) LE Cuffed to Bed. MP x II close By Bed. midline ABD Incision ō Staples CDI - no Drainage - (L) LE and thigh medial aspect Incision ō Staples CDI - 1LT [redacted] (b)(6)-2 RN

00100 - Pt (L) UE - Released from Cuff By MP - to Exercise Arm - No Problem Occured. VSS. Medicated for Pain. Pt tolerating PO intake. LT [redacted] (b)(6)-2

NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

0500 pt stable on vent/current settings per Dr. order: RR 10 VT 750 FIO_2 ↓ 40% weaning protocol started ETT 8.0 26 @ lip (approx.) ♡R 135 RR 12 SAT 100 BS clear/dim (b)(6)-2 RT

0530 due to weaning switched to SIMV per Dr. B (b)(6)-2 RT

0630 Rate ↓ 8, FIO_2 ↓ 35% → NEB

0735 weaning protocol MODE to CPAP ABG 30 min. (b)(6)-2 RT

0820 pt extubated, placed on cool mist @ 5L SaO_2 100. RR 28 ♡R 145 BS clear/dim (b)(6)-2 RT

1600 pt stable on supplemental O_2 humidified 3L NC ♡ 146 RR 30 SAT 97 BS clear/diminished (b)(6)-2 RT

1800 pt stable on 3L NC ♡R 136 RR 28 SAT 99 BS clear/dim (b)(6)-2 RT

2127 pt stable on 3L NC humidified ♡R 133 RR 23 SAT 98 clear/dim (b)(6)-2 RT

2310 pt stable/sleeping 2.5L NC humid ♡R 117 RR 25 SAT 94 BS clear/d (b)(6)-2 RT

ADDRESSOGRAPH

PT NUMBER (b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 2 Aug 02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2	40	40	31	30%	EXTUBATED																			
Ventilator Model	754	754																						
PEEP/CPAP, cmH_2O	0	0																						
Vent Mode	AC	SIMV		CPAP																				
Volume set, $ml \cdot breath^{-1}$	750	750																						
Rate $set \cdot min^{-1}$	10	10	8																					
Insp. Flow Rate, $l \cdot min^{-1}$	—	—																						
Pres. Support, $cm H_2O$	—	—																						
Spontaneous Rate	2	2																						
Spontaneous TV	—	—																						
Tot Min Vent, $l \cdot min^{-1}$	8.9	9.0																						
Pres. Control cmH_2O	—	—																						
Peak Airway Pressure	20	14																						
Therapist's Initials	(b)(6)-2											(b)(6)-	(b)(6)-2				(b)(6)-2		(b)(6)-2					

BLOOD GAS LABORATORY VALUES

Time Obtained																	2138		2309					
Source (A or V)																								
pH																								
PCO_2 mmHg																								
PO_2 mmHg																								
tO_{2c} Vol %																								
HCO_{3c} mmol/L																								
ABE_c mmol/L																								
tHb g/dL																								
O_2Hb %																								
SO_2 %																								
Ca ++ mmol/L																								
Na + mmol/L																								
K + mmol/L																								
Cl- mmol/L																								
Tonometer PCO_2																								
Ton-Art PCO_2																								

ON-LINE PARAMETERS

Pulse Oximeter SaO_2	100	100	100		100							97		99			98		96					
Oximeter SvO_2	—	—	—		—							—		—			—		—					

*SEE PROGRESS NOTES:

PROCEDURES / TIME	7 - 4	4 - 12	12 - 8
NEUROLOGICAL	→ SEE CODE →		
Eyes Open (Closed by swelling = C)	4		
Verbal Response (ET Tube or Trach = T)	5		
Motor Response	6		
Pupils R - react NR - non SR - slow — Size R	3		
Reaction	R		
Size L	3		
Reaction	R		
Hand Grasp R/L	S		
Breath Sounds	Clear		
Sputum Character	C		
Nasal Endotracheal Suctioning Q ____	✓		
Chest PT Q ____	✓		
CDB/IS Q ____	✓		
Vent. ✓'s	✓		
E.T. Tube @ ____	✓		
Cuff ✓/Proc's	✓		
C.T. Strip & Vent Q ____	✓		
C.T. Fluctuates ✓ ___ cm.			
Peripheral Pulses ** U	PC (b)(6)-2		
L	②		
Circ. Distal to A-Line	(b)(6)-2 ✓		
Monitor Alarm On			
PA Line			
CVP/Other R SC	✓		
Art Line			
Peripheral			
Peripheral			
PT/Family Teaching/Support			
	—		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
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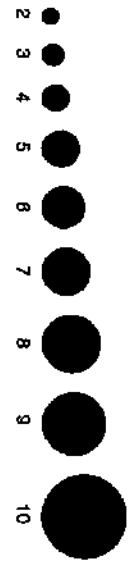

**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

PROCEDURES / TIME	(b)(6)-2 4	4 - 12	12 - 8
Bowel Sounds	(b)(6)-2		
ABD Size/Firmness	distended		
NG Secure/Proper Pos.	(b)(6)-2		
✓ Patency Q4D			
Aspirate Contin. Feed Q4			
Aspirate Prior to Bolus Feed			
Stool Char./Guaiac			
Urine Color/Character	Straw/clear		
Foley Secure/Patent	(b)(6)-2		
External Cath.			
Catheter Care			
Colostomy/Ileostomy Care			
Bath			
Turn & Position Q ____	(b)(6)-2		
Skin Care			
Mouth Care			
Trach / E.T. Care			
ROM			
Dangle			
Restraints Released Q2H	Shackles		
OOB to Chair			
Ambulation			
Side Rails ↑	(b)(6)-2		
Draing. △			
Draing. △			

ADDRESSOGRAPH