(b)(3)-1

ATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4					N/A	
4. SEX / 5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
M	X	UNK		N/A			
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
99	(b)(6)-4		N/A			ICW	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
N/A		K78	N/A	N/A			

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0623	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		03 JUL 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		20 JUN 03	DR. (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO CHEST

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	13	13

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	13	13

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 LTC, MC

(b)(6)-2

(b)(6)-2 PAD OR MEDICAL RECORDS OFFI

NCOIC PAD

DA FORM 3647, MAY 79

MEDCOM - 6149

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

20yo Iraqi ♂ EP s/p GSW chest

Seen at Bn med → CT

Tx (b)(3)-1 [redacted] + 2 u PRBC, To OR

PHYSICAL EXAMINATION

VS 100/50 HR 90

Chest [illegible] bc (R). CT. [illegible] x2 [illegible]

CW [illegible]

Abd [illegible] ND

[illegible] (R) [illegible]

DIAGNOSIS (Enter date of discharge and final diagnosis)

A/ GSW chest, open lung c̄ CW defect

P/ To OR, explor [illegible]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-1..

MEDCOM - 6150

MEDICAL RECORD	PROGRESS NOTES
DATE	

6/20/03 Op Note

Procedure: Thoracotomy (R)
CT placement (R)

Surgeon: [redacted]

Anes GETA 2 volumes 4

Finding: (1) Large CDH defect
(2) Open pulmonary injury & leak
(3) Pulmonary contusion RML
(4) Hemothorax

Fluids EBL: 300 cc LR

TO ICU, intubated

[redacted]

[redacted] MD

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1030 20Jun03	Nursing Admit / Post op note: Patient returned from OR s/p ® chest exploration c 2 chest tubes, vented simv rate 18, TV 700, FIO2 100%, peep 5, sats 100%. Intubated c #8 ET, 23cm @ lip. CT put to 20 cm Suction, NGT to LIS. A line in place, zeroed + leveled. ABG, labs done. Drainage to CT dog marked, & xray done. Propofol, fentanyl gtt started, LR to 100cc/°. See post op VS below.

	HR	B/P	RR	Sats
1030	52	147/83	19	100%
1035	54	153/85	19	100%
1040	48	158/86	18	100%
1045	54	172/95	20	100%
1100	55	164/89	20	100%
1115	59	149/98	18	100%
1130	66	155/90	18	100%

Patient temp ↓ @ 93.5 initially, warm saline bag applied to armpits/groin. Temp now 95°. Will continue to monitor ——

(b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI)

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1130 20Jun03	Rate on vent ↓ to 14 bpm, FIO_2 to 50%. will repeat ABG in 30 mins. — [b)(6)-2]
1230 20Jun03	See ABG results, FIO_2 to 70%, rate to 16 bpm will repeat ABG in 30 mins. — [b)(6)-2]
1330 20Jun03	ABG; 7.39, 34, 160, 21 sats 99%. will leave vent setting as above, check ABG in AM & chest xray — [b)(6)-2] CPT/AN
1630 20Jun03	NN: Patient temp ↑ 100.6, UOP 50cc/hr x past 3hrs. MD team aware. Will continue to monitor trends — [b)(6)-2] CPT/AN
20 June 03 1800	Received report on pt, assumed care. Pt sedated, intubated, ventilated. IV: (+) Propofol → sedation, (+) Fentanyl → pain, (+) LR → maintenance fluids infusing through secured (L) ET, CT #2: (R) side, #2 radially secured w/ dressing, tape, drainage marked & unchanged from previous assessment. CT #1 to posterior (R) side in tact, secured c dsg & bandage - drainage marked, unchanged from previous assessment. CT #1 & #2 to 20 cm suction. NGT to (R) nare, secured, placed to LIS & minimal amt of yellow brown drainage out. 18g PIV to (L) AC intact, in place SL'd. CV: resp monitoring per A-L, secured, to (L) radial, in place & secured, (+) zero. (+) Coley to gravity, dark clear UOP, OP >180 cc/hr. VS stable. Full assessment c I/O's noted on DA Form 4700. Plan: Cont close monitoring resp, cardiac status. Maintain close vigil on neurologic status & maintaining sedative state via titration of propofol. Continue pain control via fentanyl cont infusion. Monitor fluid output/intake closely. — [b)(6)-2]
20/20	1730: pt spontaneously awakens, alert, oriented, requesting through hand gesturing pencil for writing. Pt scribbled note in arabic. Translation pending. Propofol bolus 3cc x administered c (+) reaction. VS remained stable.

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

[b)(6)-4]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 June 03	1725 (late note.) Lasix 20 mg IVSP administered through 18 g PIV UOP pending [b)(6)-2]
	1745: Propofol ↑ from 24.2 mcg/kg/min → 40 mcg/kg/min. = 13.3 cc/hr. VS stable
	99/62: HR 115 via A-Line RR 16 sats 100%. [b)(6)-2]
	1810: MAJ MORGAN places HOLE !
	2000: Pt remains sedated. VS stable [b)(6)-2]
	2100: KVO occluded, flushed, Propofol bolus 4 mg, BP ↓ 88/50 HR 100. Pt placed in reverse trendelenburg position, Propofol ↓ 7 cc/hr, HR 250 Bolus infused. [b)(6)-2]
	2120: BP 120/69 HR 104 pt awake alert, gesturing w/ hands. Propofol ↑ 13.3 cc/hr = 40 mcg/kg/min. Pt repositioned to HOB @ 15°. VS Remain stable [b)(6)-2]
	2130: Pt awake, gesturing + biting tube/ext. Propofol ↑ 60 mcg/kg/min = 19.8 cc/hr. Pt returns sedated state [b)(6)-2]
	2200: UOP hr 30 cc hr. LR ~~Bolus~~ (error [redacted](b)(6)-2) maintenance fluid ↑ to 200 cc/hr. UOP monitoring to cont [b)(6)-2]
	2230: FIO_2 ↓ to 60%, SaO_2 = 100% n = 16. [b)(6)-2]
	2300: ABG drawn: pH 7.551 PCO_2 46.3 PO_2 161; HCO3 23 SO_2 100%, TV: 700 RR: 16 PEEP 5: TV ↓ 650, FIO_2 ↓ 50% ABG draw in 30 min. CMC
	2310: Report given to incoming nurse, LT [b)(6)-2] Care of pt transferred @ this time

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

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

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Jun 03 2310	Report received from last shift, Client in bed connected to vent, monitor, chest tube x2, foley cath, NGT→LIS, and IVF and meds infusing. [redacted] LCT RN
2400	Complete assessment done, Pupils 2-3 mm, reactive to light, client sedated on propofol and fentanyl gtt drips. Heart in sinus rhythm c ectopy. Apical pulse strong and regular, pulses palpable. left radial art line intact, zeroed, good waveform on monitor, good blood flow, fingers to left hand warm c cap refill <2 secs. Abdomen flat soft c hypoactive BS. NGT placement checked c 30 cc air bolus, placement, connected to LIS, small amt brown drainage noted. foley patent c dark yellow urine draining to bag. Bath given. T+P for comfort. 8.0 mm ETT @ 23 cm @ lip line vent settings checked. breath sounds clear bilat c RLQ c diminished breath sounds. Chest tubes x2 to right chest, dressing intact over site c old drainage marked. no crepitus noted around site. Both chest tube to 20 cm H_2O suction, bubbling noted in both tubes. [redacted] LCT RN
21 Jun 03 0015	Abgs drawn from left radial art line [redacted] LCT RN
0030	Vent changes made, VT ↓ 600 ml / RR ↓ 14 / FiO_2 ↓ 45% due to Abg results of: PH 7.464, PCO_2 31.5, PO_2 100, HCO_3 23, BE -1, SO_2 98%. [redacted] LCT RN
0030	late entry @ 2400 client c fentanyl @ 100 mcg/hr, propofol @ 60 mcg/kg/min (19.8 ml/hr) and LR @ 200 cc/hr infusing via left neck PIV, flushes easily @ blood return. left forearm PIV clamped, flushed easily c 10 cc NS. [redacted] LCT RN
0240	NBP 87/42, ABP 80/41, Propofol titrated down to 40 mcg/kg/min, Fentanyl ↑ 150 mcg/hr. urine appears cloudy, 250 cc LR bolus given + UA sent to lab [redacted] LCT RN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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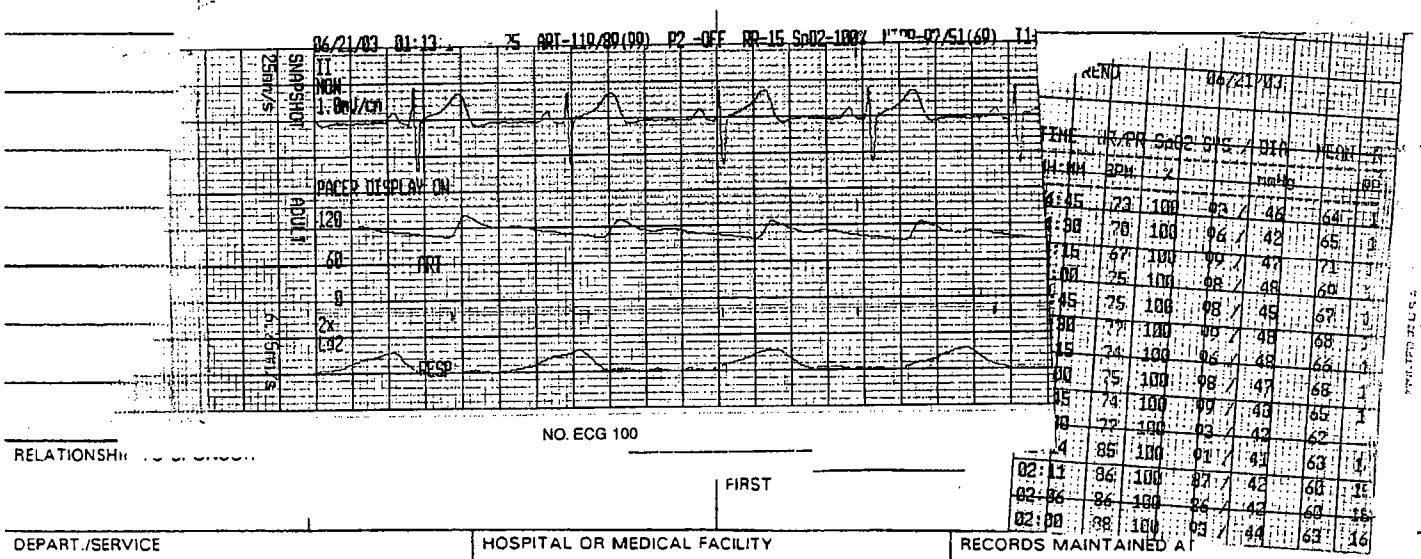
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun 03 0215	Art line waveform dampened, reading on monitor very positional NBP 91/41 will continue to monitor — (b)(6)-2 KT RN
0230	NBP 93/42, art line waveform continues to appear dampened (b)(6)-2 KT RN
0300	NBP 98/47, urine output 35cc this hour — (b)(6)-2 KT RN
0400	Assessment done, Propofol titrated down between 0200 and 0300 to 40mcg/kg/min (13² ml/hr) and between 0300 to 0400 to 30 mcg/kg/min (9.9 ml/hr) client tol well. Fentanyl titrated up to 150mcg/hr @ 0200, ~~Hbss~~ no change in assessment at this time — (b)(6)-2 KT RN
0500	Propofol titrated ↓ to 25mcg/kg/min @ 8.3 ml/hr, Hbgs done @ 0445 from right radial stick ~~5~~ difficulty — Report given to next shift — (b)(6)-2 KT RN



NO. ECG 100

RELATIONSHIP TO SERVICEMEMBER — FIRST

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1000 21Jun03	NN: Patient extubated @ 0930. NRB @ 12L placed, ABG obtained, neb given per RT. NGT d/c. Aline d/c. Will continue to monitor, repeat ABG this pm — [(b)(6)-2] CPT/ AN
21Jun03 1030	See Critical Care flowsheet for full Nursing assessment and VS — [(b)(6)-2] CPT/ AN
21 June 03 1300 Resp Therapy	Attempted to wean FIO2 on Pt. D/C O2 from NRB mask @ 10 L/min to a 50% Venturi. Pt desated to mid 80's quickly c c/o SOB & Difficulty breathing. Returned to NRB @ 10 L/min. Pt O2 SAT Returned to 98%. Pt resting Comfortably c no S/S of Resp difficulty. — [(b)(6)-2] CRT
21Jun03 1400	Patient c c/o pain ↑ temp to 102'. Medicated c tylenol and toradol per orders. Will Continue to monitor — [(b)(6)-2] CPT/ AN
21Jun03 1640	End of Shift note: no change in assessment from above. Will start on clears tonight given IS, will encourage use. — [(b)(6)-2] CPT/ AN

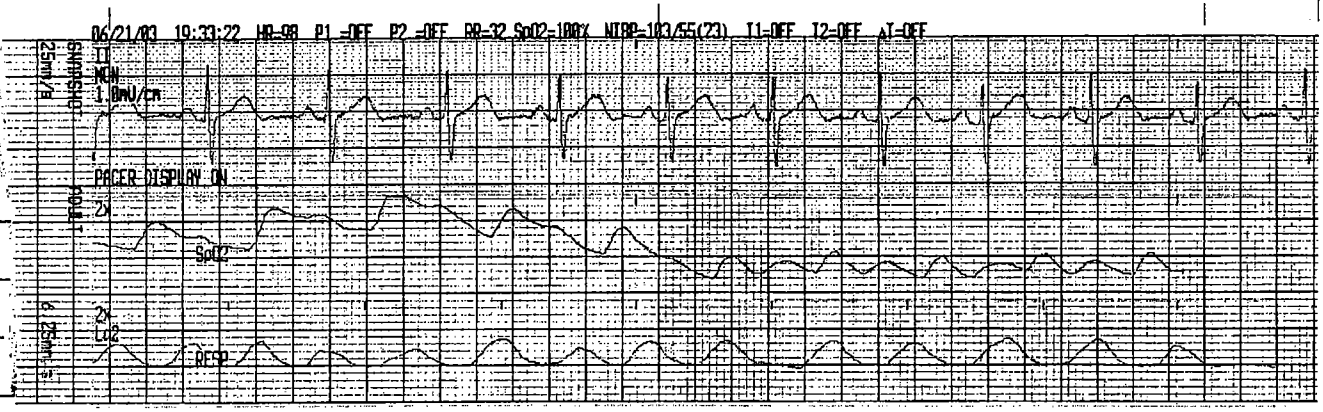
STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun 03 1700	Report from day shift, client in bed connected to monitor, on NRB mask, chest tube x2 to R/lt chest connected to suction @ 20cm H2O pressure. Foley patent and draining IVF infusing via Lt rock PIV. [redacted] LCTA
1800	Assessment done, see DA Form 4700. Good effort on incentive spirometer. [redacted] LCTA



NO. ECG 100

21 Jun 03 1945	Medicated c 4mg MSO4 for pain, sat client up in bed. TS x10, good effort. [redacted] LCTA
21 June 03 2100	pt requesting more blanket. Two blanket applied. SaO2 @ 89%. Encouraged to take deep breath. pt able to follow instructions. Lungs coarse rhonchi and crackles auscultated throughout

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

[redacted] [redacted] [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

REGISTER NO. | WARD NO.

[redacted]

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 June 03	Lung fields. ↑ work on pos breath sounds. HR IR BP 112/61 RR 36 shallow, pt on 100% NRB. Lasix 20mg IVP given. Evaluate Lung sounds for dyspnea. [redacted] MHA. CXR ordered. Dr. [redacted] called to bedside and here to evaluate pt @ bedside.
21 June 03 2120	pt unable to tolerate being flat. SaO2 ↓ 87% during portable CXR. ↑ HOB to 45°. SaO2 ↑ to 94% RR 40 to 45. labored. CXR shows ↑ infiltrants to (R) lower and middle lobe, continue to monitor RR closely. pt able to follow simple direction.
2125	pt requesting po H2O. Drank small amount H2O. SaO2 ↓ 87% i mask off for a minute. Skin warm, dry. [redacted] SMA Responding IVP lasix. Urine clear water color draining. Will check lyte, panel in A.M. pt calm and cooperative [redacted] RN
2200	Lung sounds improving scattered Rhonchi i crackles to bases O2 Sat ↑ 98%, RR 30, client calm, minimal accessory muscle use for respirations. [redacted] RN
2305	Medicated i 5mg Morphine for pain. [redacted] RN
2320	Medicated i 30mg Toradol for pain [redacted] RN
2325	Lungs i coarse Rhonchi and crackles bilat. Dr. [redacted] notified, order obtained 20mg Lasix given IVP, will monitor closely. [redacted] RN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 Jun03 2400	Assessment done, lungs c̄ wheezes bilat — (b)(6)-2 [redacted]
22 Jun03 0025	Albuterol treatment given by RT for wheezing — (b)(6)-2 [redacted]
0045	lungs c̄ rhonchi bilat, O_2 sat ↑ 100%, IS x10 c̄ good effort, — (b)(6)-2 [redacted]
0200	client asleep, lungs with scattered rhonchi, O_2 sat 99% on
	100% NRB, minimal use of accessory muscles for respirations — (b)(6)-2 [redacted]
0300	lungs c̄ scattered wheeze, O_2 sat 100% on NRB, changed to 50% venti-mask
	at this time, will monitor O_2 sat closely — (b)(6)-2 [redacted]
0310	O_2 sat 98% on 50% venti-mask — (b)(6)-2 [redacted]
0400	blood drawn and sent to lab, temp 101°, medicated c̄ tylenol
	for pain with 5mg MS, lungs clear to upper lobes, scattered
	rhonchi to bilat bases c̄ diminished sounds to RLL. — (b)(6)-2 [redacted]
0500	Report given to next shift — (b)(6)-2 [redacted]
23 Jun 03	Surgery POD 2
	Extubated yet currently febrile, poor inspiratory effort
	c̄ hypercapnia / hypoxia on 50% FM. Splinting, fluid [illegible]
	will d/c art line, check CXR, get pt out of bed, incentive spirometer
	Cont Abx
	(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

MEDCOM - 6160

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun03 2400	Assessment done, lungs c̄ wheezes bilat — [redacted]
22Jun03 0025	Albuterol treatment given by RT for wheezing — [redacted]
0045	lungs c̄ rhonchi bilat, O_2 sat ↑ 100%, IS x10 c̄ good effort — [redacted]
0200	client asleep, lungs with scattered rhonchi, O_2sat 99% on
	100% NRB, minimal use of accessory muscles for respirations — [redacted]
0300	lungs c̄ scattered wheeze, O_2 sat 100% on NRB, changed to 50% venti-mask
	at this time, will monitor O_2 sat closely — [redacted]
0310	O_2 sat 98% on 50% venti-mask — [redacted]
0400	blood drawn and sent to lab, temp 101, medicated c̄ tylenol
	for pain with 5mg MS, lungs clear to upper lobes, scattered
	rhonchi to bilat bases c̄ diminished sounds to RLL — [redacted]
0700	Report given to next shift — [redacted]
22Jun03	Surgery Pay 2
	Extubated yet currently febrile, poor inspiratory effort
	c̄ hypercapnia / hypoxia on 50% FM. Splinting, [illegible]
	will [illegible] and chest [illegible], get pt OOB [illegible], monitor [illegible]
	Cont [illegible]
	[redacted]

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

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

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

[redacted]

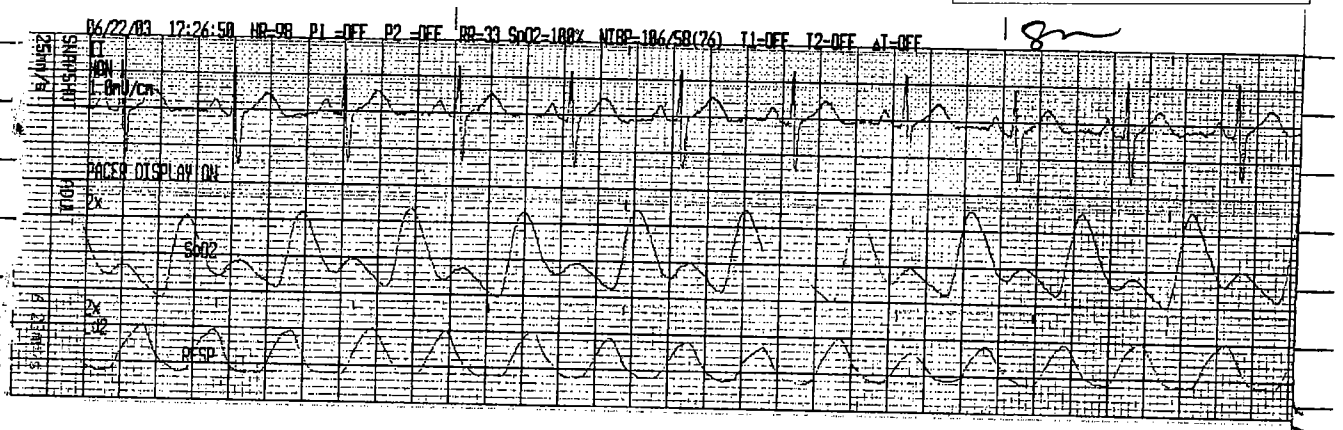
PROGRESS NOTES
Medical Record

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

MEDCOM - 6161

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 Jun 1600	Pt had a temp of 101.9 650mg Tylenol were administered, one hour later pt temp remains elevated @ 101.4. Pt c/o pain in middle of back. 3mg MSO4 administered. MD notified of temp. — [b)(6)-2] LPN
22 Jun 03 1700	Report received from day shift. Client in bed connected to monitor and oxygen. chest tube patent c 20cm H2O suction, foley → gravity IVF infusing via left neck PIV. — [b)(6)-2] AT
1720	Assessement done See DA Form 4700. — [b)(6)-2] LT



1900	Temp ↑ 101.9, medicated c tylenol PO, medicated with toradol 30mg + MS 5mg IVP for pain — [b)(6)-2] LT RN
2000	client OOB to chair with two assist, NRB mask @ 100%. D/C'd, placed on 50% venti-mask at this time — [b)(6)-2] LT RN
2100	Complete bath given in chair, foley care done / teeth brushed dressing change done to left neck PIV. — [b)(6)-2] LT RN
2200	back to bed, client temp ↓ 99.8, ↓ SiO_2 to 40% venti-mask — Sa
2215	Pulse ox 96% on 40% venti mask @ 84/m — [b)(6)-2] LT RN
2220	good effort c IS x10. lung clear RUL, RLL, LUL, diminished to right lower lobe. — [b)(6)-2] LT RN

STANDARD [illegible]

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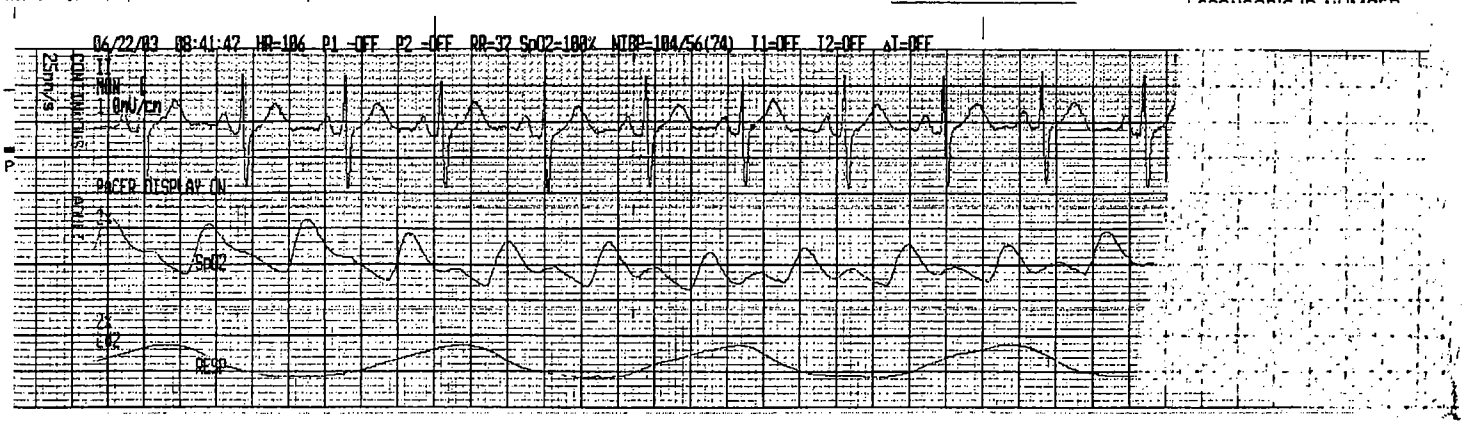
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22Jun03 0600	Pt awake - no % pain or discomfort however appears to be using accessory muscles to breathe @ a rate of 40-50. 4mg MSO_4 administered. Assessment performed - see DA 4700. VS otherwise stable, pleuravacs @ 20cm H_2O to suction putting out approx 5-10cc/° each. CXR repeated this AM. Will monitor — [redacted] LPN
0630	Pt attempted to eat breakfast however continued to de-sat to 85%. switched to non-rebreather @ 10lpm. ABG drawn - PO_2 @ 57 - MD notified — [redacted] SGT/LPN
0800	MD came to assess pt - pulled anterior chest tube. 3mg MSO_4 administered. — [redacted] LPN
1115	@ UO x 2° - MD notified. 30mg Toradol given in order to get pt OOB to chair — [redacted] LPN
1118	Patient c decreased breath sounds in all fields. Respirations labored w/ rate of 37-40. Pulse ox 100% on non rebreather. Equal rise and fall of chest noted without use of abdominal muscles. Dr [redacted] notified. Ordered to monitor after given Toradol 30mg IVPush and assist patient out of bed to chair. — [redacted] mgw
1300	Pt OOB in Chair - Spoke to interpreter, interpreter stated that his mental state was better today. Pt tolerated move OOB - voiced concern for his family. VSS — [redacted] SGT



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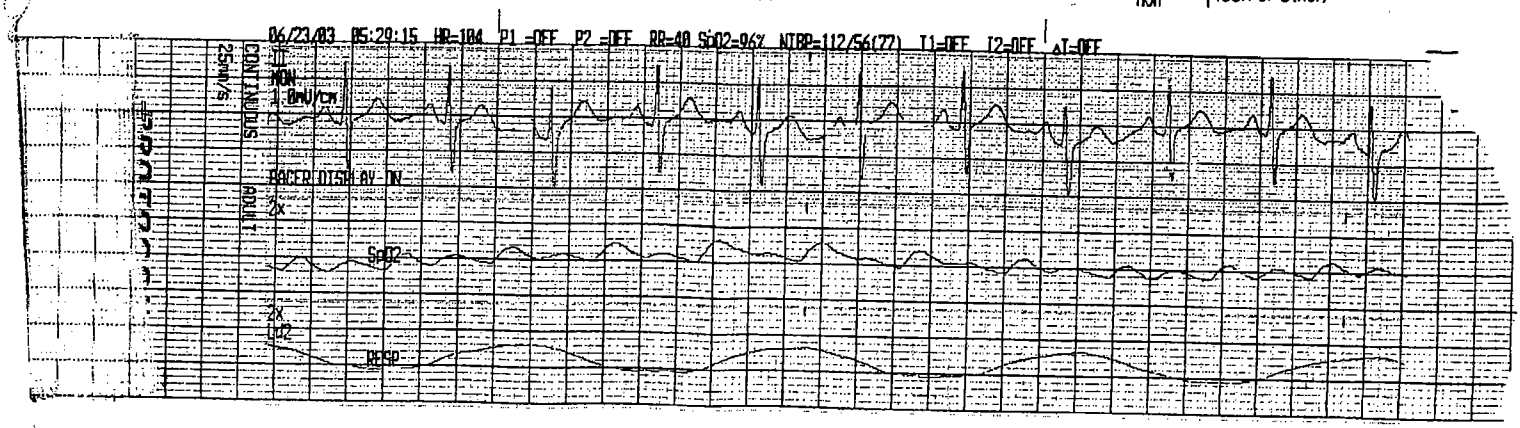
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22 Jun 03 2300	Report given to next shift, client in bed on 40% ventimask. LR @ 75 cc/hr via left neck PIV. right chest tube to suction/pressure, gently bubbling noted in chamber drsg D+I. HOB elevated. [redacted] (b)(6)-2 [redacted] LCTav.
23 June 03	2300: Received report, assumed care of pt. Pt sleeping supine, HOB @ 75°, (+) Vent mask in place @ 40% & 8L. RR = 23-25 BPM Sats 96-97% Ø evidence respiratory difficulties. Cardiac monitoring in place, cuff to (L) Brachial. VS stable. LR infusing @ 75 cc/hr (L) EJ Ø evidence of phlebitis or infection @ insertion site. (+) indwelling catheter, dark concentrated urine. UOP L 30 cc/hr. will continue to monitor. CT in place, to (R) thorax. dressing CDI, (+) Drainage @ 20 cm suction (+) Serous sanguinous drainage L 10 cc/hr. Plan: monitor resp status, attempt weaning, maintain HOB ↑. Encourage IS. Monitor UOP, consider Bolus & ↓ UOP, Maintain good pain control. Rested @ this time, asleep w/out evidence distress or discomfort. Complete assessment noted on DA Form 4900 [redacted] (b)(6)-2
	2330: VENTIMASK SETTING ↓ from 40% @ 8L to 35% @ 8L. Sats 97% RR 23-24, Ø evidence distress [redacted] (b)(6)-2
	2335: (+) IS - 10 Breaths @ app 200 cc/sec. [redacted]
	0115: UOP = 20 cc from 0000-0100, (+) ↑ crackles to (L) L base, inc 9%/RR Lasix 20 mg IVP administered. Eval pending [redacted] (b)(6)-2
	0135: Sats ↓ 89% HR 103 @ 75° RR 47. Repositioned on Ventimask

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



LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 June 03 0135 (Cont)	↑ from 35% to 40% @ 8L. Sat ↑ 94% - 95% RR ↓ 34 BPM
	VO? pending total since lasix administration. IS x 5 breaths between 600 - 650 cc/sec. Breathing remains tachypnic ; shallow.
	Pt encouraged slow, deep breaths. (b)(6)-2 [redacted]
	0315: Pt sleeping quietly VS stable sats 97% RR 34.
	Ø evidence respiratory difficulties. Will cont. to monitor
	0435: CBC, Chem 8 drawn from (L) AC. LR infusing (+) flush
	?, Ø evidence infiltration. Lab values pending. (+) IS
	x 10 c̄ 5 @ 700 cc/sec. 120cc PO H_2O. Pt returns to
	sleep VS. Stable (b)(6)-2 [redacted]
0530	Pt awake - assessment performed see DA4700 - VSS. Will
	monitor. (b)(6)-2 [redacted] LPN
0700	Still only 10cc urine out this shift - lungs still rhonchi
	on (R) side however breath sounds are diminishing - Pt ate
	Small amt breakfast - Ad to NC, tolerating well. Will
	monitor UO & resp status. (b)(6)-2 [redacted] LPN
1100	Pt was OOB to chair for one hour & 1/2. tolerated
	well. Repeat CXR done for CT waterseal. Awaiting orders
	from MD. (b)(6)-2 [redacted] LPN
1330	Still minimal urine output. Foley dc'd per Dr (b)(6)-2 [redacted]
	order. ii Percocet given for c/o pain in back. (b)(6)-2 [redacted] LPN
1430	Pt OOB to chair - incentive spirometer done. pt tolerated well.
	O_2 back ↓ to 4 lpm, sats 100%. (b)(6)-2 [redacted] LPN
1735	Received report, assumed care of pt. Pt supine in bed, awake, alert
	oriented. O_2 per NC @ 4L sats @ 99-100% RR 28-30 BPM, CT to water seal
	minimal op. Ø evidence resp. discomfort or distress. LR infusing
	to (L) E) w/o evidence infection or infiltration. infusion rate 75cc/h

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDCOM - 6165

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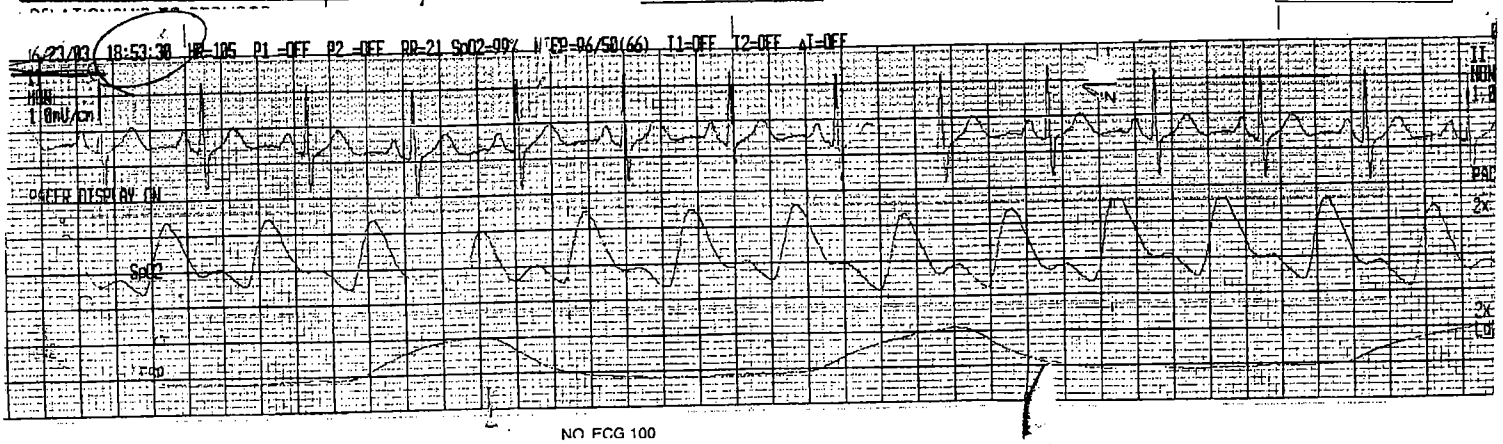
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 June 03	resting w/out resp. distress. @ diarrhea small, brown loose stool — [(b)(6)-2] 0415: Foley error. Pt c/o abd. pain. @ 5 5 x 4 g. @ tenderness on palpation, abdomen taut, @ distention. Foley placed > 400 cc dark concentrated urine out. Pt returned to sleep. NC placed @ 5L Humid. pt, sats @ 98-99% RR 22. Pt resting comfortably [(b)(6)-2] [(b)(6)-2] 0430: Labs drawn, CBC, chems — taken to lab values pending — 0445: Foley D/C'd 475 cc concentrated yellow urine output resting VS stable [(b)(6)-2]
24 Jun 03 0530	Assumed care of pt resting in bed. lungs ↓ course breath sounds noted bilaterally ↓ diminished breath sounds noted in @ lower lobe. @ lateral chest tube ↓ minimal amt of serous sanguinous drainage. Encourage use of incentive spirometer and coughing. O_2 @ 3L via NC ↓ sats 96-99%. Dr on PA 4700 for initial assessment. Pt still unable to void, will monitor urinary status. Will continue to monitor — [(b)(6)-2]
0700	Pt tolerated small amt of breakfast. Advised to eat more than a few bites. Currently denies discomfort, will continue to monitor — [(b)(6)-2] cpt/ts
0930	Pt ↓ diarrhea x1. Ambulated to chair and cleaned. c/o stomach cramps and was placed on bedside commode [(b)(6)-2] cpt/ts
1000	Pt ↓ another episode of diarrhea ↓ small amt of urine noted. HR increased to 110 ↓ resp rate. Encouraged cough + deep breathing. Will continue to monitor [(b)(6)-2] cpt/ts



LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 June 03 1735 (NSG cont.)	⊕ continuous cardiac monitoring. VS stable @ this time. UOP s/p D/C of foley pending. Plan: Cont. close resp monitoring. Encourage OOB, incentive spirometer c̄ goal of 10 consecutive breaths > 900 cc/sec. and participation in ADLs. Attempt wean from O_2 to ↓ from 4L - 2L NC. 2) Monitor UOP - I/O - carefully. In-out cath c̄ No or minimal output. 3) Maintain good pain control, RTC c̄ Percocet & Toradol. ~~Refill assessment per DA Form 4700~~ (b)(6)-2
1830:	Percocet ii Tab PO administered for pain control. —
1930:	Pt OOB to chair, ⊕ complete BATH, shampoo, ⊕ BM x1, small soft runny brown stool. UOP app. 15cc. Dr (b)(6)-2 notified. No action taken @ this time. PO fluid intake encouraged. Incentive spirometer x 20 c̄ pt successful c̄ 900 cc/sec x 10 breaths. Pt weak on feet, requires assistance OOB, to bed. Pt cooperative & calm @ this time. Sat @ 98-100% w/ O_2 @ 5L per NC. Deep breathing encouraged. Dressing to ET Δ'd R/T dampening from bath. —— (b)(6)-2
2130	Pt assisted back into bed. VS stable. O_2 ↓ 3L c̄ sats remaining @ 98%. RR 20-30's. No evidence of distress, pt calm & cooperative.
2135	LATE NOTE: 1830 Pt consumed 10-15% / evening meal c̄ ∅ N/V or abdominal discomfort. —— (b)(6)-2
2300:	Pt awake, ⊕ IS x 20 Breaths consistent at 900 cc/sec. Mouth care performed. Toradol 30mg slIVP administered for RTC pain management. BS: unchanged from previous assessment.
0100:	Pt sleeping quietly. VS stable. No evidence distress — (b)(6)-2
0315:	Pt to bedpan. ⊕ Desat to low 80's. RR 30's. BP WNL HR ~110. Ventimask placed @ 50% @ 10L, pt repositioned, HOB @ 90°, deep slow breathing encouraged. Sats stabilized @ 95% RR 20 HR 95. Pt

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(b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24Jun03 1200	Pt c another episode of diarrhea. Stool sample sent to lab for fecal WBC count. Pt c/o feeling dizzy, was cleaned and placed back into bed. VS stable, will continue to monitor — [redacted] (b)(6)-2 cpt/bm
1500	Pt c episode of incontinence/diarrhea. States he was asleep and noticed when he awoken that he had gone. Cleaned up and placed back in bed. Will continue to monitor — [redacted] (b)(6)-2 cpt/bm
1600	Pt c episode of diarrhea. Ambulated to bedside commode c difficulty. Doctors aware and Flagyl ordered. VS stable, will continue to monitor — [redacted] (b)(6)-2 cpt/bm
1700	Report given to oncoming shift — [redacted] (b)(6)-2 cpt/bm
1720	Pt sitting up in bed, answering questions from interrogator - Pt c NC @ 3L Pulse ox 97% VSS 105/72 P-100 R-16 ET 18G IV each infusing LR @ 75cc/hr (R) side labeled CT to 20cm suction Dsg CDI Sutures to (R) hand well approx & SI[redacted] — will continue to monitor & interrogation — [redacted] (b)(6)-2
1800	Pt. tolerating reg diet - Lungs (L) side upper lobe audible wheezes - Productive cough - weak effort (+) pain with cough guarding (R) side - Percocet for pain - Pt up to chair encouraged coughing and standing [redacted] arms - 200 cc PO H2O, apple, peanuts — [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Jun03	
2100	Pt - Pulse ox ↓ Pt lying in bed - sleeping - mouth breather ↑ O2 to 5L NC Pulse ox ↑ 98% EJ drsg Δ'd 200 cc UO - will continue to monitor — [b)(6)-2] [redacted] (b)(6)-2
2300	Pt up to chair x15 minutes IV ancef administered - CT draining sm amt of serosanguinous discharge — [b)(6)-2] [redacted] (b)(6)-2
0100	Pt sleeping, NAD, VSS 110/58 P-90 R-16 Pulse ox 92%-94% 3L NC — [b)(6)-2] [redacted] (b)(6)-2
0300	Pt c/o complaints — requested water 100cc CT output 50 cc serosanguinous 108/57 P-89 R-26 Pulse ox 100% 4L NC - Productive Cough enc. IS will continue to monitor — [b)(6)-2] [redacted] (b)(6)-2
0400	PCXR request sent in - Labs drawn Pt c/o complaints - awake 110/64 - P-93 Pulse ox 100% on 3L NC R-20 — [b)(6)-2] [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25Jun03	Pt OOB to BSC. Tolerated well. — [(b)(6)-2] LPN
0800	Pt had loose BM x 1 — [(b)(6)-2] LPN
1000	Pt OOB to BSC again. Pt had loose liquid BM x 1. [(b)(6)-2] LPN
1720	Received report from [redacted](b)(6)-2 on pt who is resting quietly c eyes closed. NC on @ 6 LPM humidified O_2. LR @ 75 cc/HR to (R) EJ. (-) SS of infiltration. HOB @ 30°, chest tube #1 to water seal on (R) chest, 20 cm H_2O. VSS — SPC [(b)(6)-2]
2130	PT → BTB Benadryl 50mg given as order for insomnia. Pt in bed c eyes closed. will monitor — [(b)(6)-2] SOT VSS given me
0100	Pt. set in portable toilet seat, after having had a BM in pants and defecated, stool was soft and runny, pt was able to dress self and be returned to bed. O_2 was turned down to 2 LPM via NC earlier, pt. has tolerated well, O_2 sat 98% will continue to monitor. — [(b)(6)-2]
0530	Report received. Pt awake & c/o pain in stomach. Benty/ given. Assessment performed - see DA4100. [(b)(6)-2] LPN

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

[(b)(6)-4]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
25Jun03	Pt OOB to BSC. Tolerated well. — (b)(6)-2 [redacted] LPN
0800	Pt had loose BM x i — (b)(6)-2 [redacted] LPN
1000	Pt OOB to BSC again. Pt had 50cc liquid BM x i. (b)(6)-2 [redacted] LPN
1720	Received report from [redacted] (b)(6)-2 on pt who is resting quietly c̄ eyes closed. NC on @ 6LPM humidified O_2. LR @ 75 cc/HR to (L) EJ. (-) s/s of infiltration. HOB @ 30°, chest tube x1 to water seal on (R) chest, 20 cm H_2O. VSS ~ SPC (b)(6)-2 [redacted]
2130	PT ↓BTB Benadryl 50mg given as order for insomnia. Pt in bed c̄ eyes closed will monitor — (b)(6)-2 [redacted] SGT US Army
0100	Pt. sat in portable toilet seat, after having had a BM in pants, and defecated, stools were soft and runny, pt was able to dress self and be returned to bed. O_2 was turned down to 2LPM via NC earlier, pt. has tolerated well, SpO_2 ≥ 98%. Will continue to monitor — (b)(6)-2 [redacted]
0530	Report received. Pt awake & c/o pain in stomach. Bentyl given. Assessment performed - see DA4100. (b)(6)-2 [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0700	Pt refused breakfast, drank apple juice. Refused Carnation shake. Still Ø BM this shift. Pt c/o mild nausea. Pt continues to sleep reguardless of nausea. Will monitor for discomfort. —— [(b)(6)-2] LPN
0830	Pt OOB to BSC. BMx 1, liquid 1 some semi formed stool, pt had Ø c/o nausea. Received 0800 dose of Phenergan. Returned to bed & is sleeping. Will monitor. —— [(b)(6)-2] SGT/LPN
1200	Pt attempted to eat lunch - had episode of nausea but no vomiting. 4mg Zofran given IV. —— [(b)(6)-2] LPN
1200	Chest tube turned on to suction per Dr. —— [(b)(6)-2] [(b)(6)-2] LPN
1400	Pt ō another episode of diarrhea, approx 500cc fluid, some semi formed stool. Dr. [(b)(6)-2] notified. [(b)(6)-2] LPN
1700	Report recieved from dayshift - Pt AAOx3 Vital
26 June 08	Signs Stable 112/60 P-92 R-26 Pulse ox 98% on 2LNC (L) EJ infusing LR @ 75cc/hr - patent, c/s/s of infx Lungs continue to sound junky - will enc. activity and incentive spirometry - productive rattling cough - Pt seems to have somewhat labored breathing Pt weak, not active ability CT x1 (R) lateral side dd by dayshift CDT 20 cm continuous suction to (L) CT average 10-20 cc output serous sanguinous - will continue to monitor —— [(b)(6)-2] SGT/LPN
1730	Pt tolerated diet 1 apple - 2 bites of bread 1 packet of jelly 50 cc H20 —— [(b)(6)-2] SGT/LPN
1800	Two Percocet for pain/prophylactic to enc coughing OOB activities ——

STANDARD FORM 509 (REV. 5/1999) BACK

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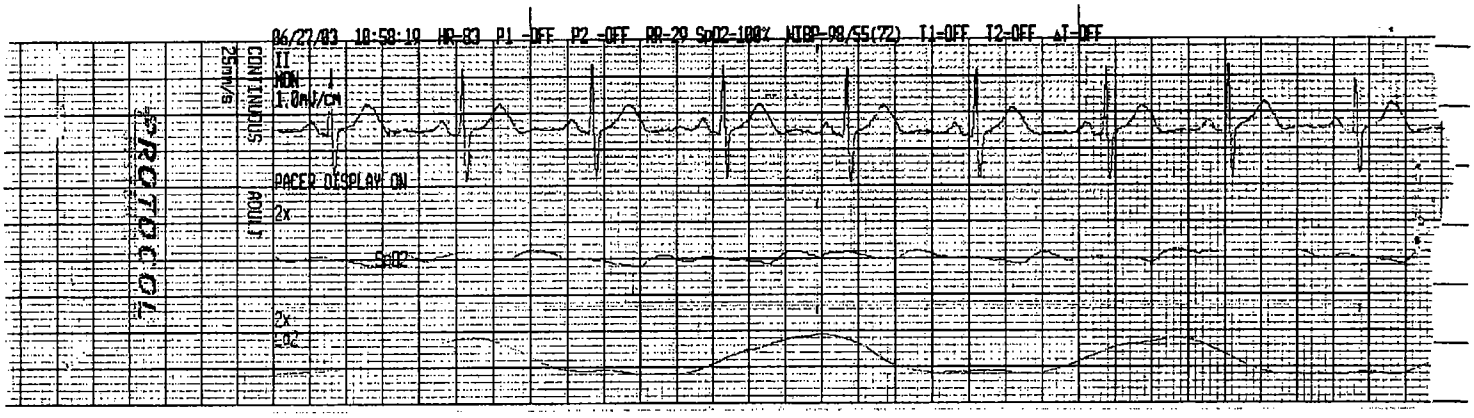
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

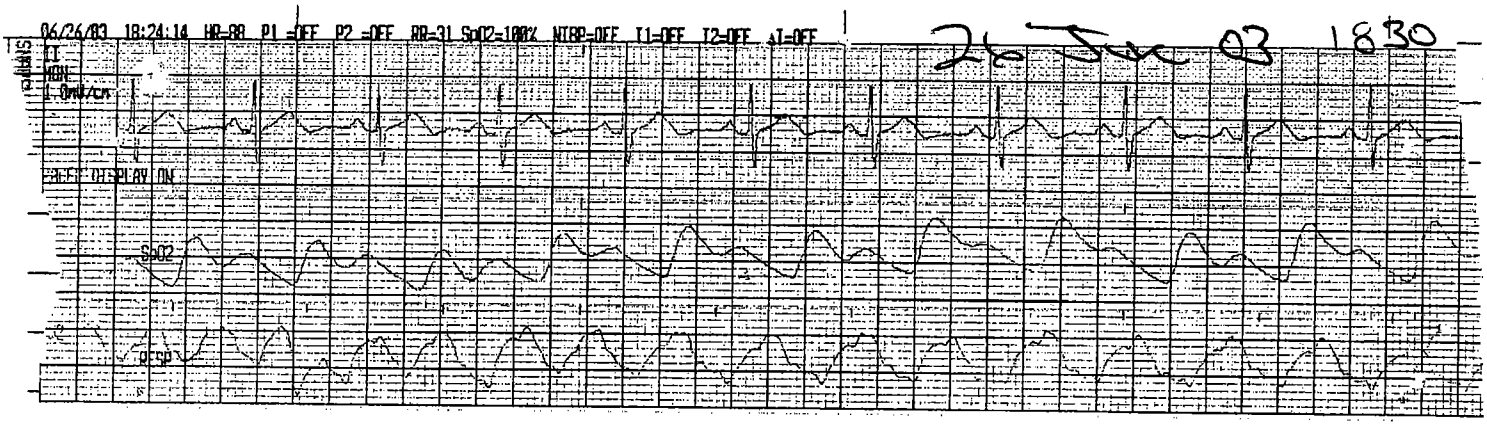
DATE	NOTES
27 June 1100	A back in bed c very little assist x1. (b)(6)-2



1230	Pt appetite fair for lunch, ate 75%. PO fluid intake good. Ø C/O nausea at this time. (b)(6)-2
1400	Temp starting to ↑ to 101. Will monitor. Skin warm to touch c Ø diaphoresis. (b)(6)-2
1600	Temp 99.7. Ø interventions given (b)(6)-2
1700	Report received from SPC (b)(6)-2, CT to (R) side, continuous suction, (R) IV c LR @ 75 cc/HR, (+) edema to (R) foot, (+) pedal pulses. SPC (b)(6)-2
1900	Pt. up to bedside chair c assistance x1 hour, walked up and down ward, USS SPC (b)(6)-2
28 2000	Pt. voided approximately 150 cc's. Zofran given to prevent further nausea. USS SPC (b)(6)-2
0200	Pt. resting quietly c eyes closed. USS — SPC (b)(6)-2
0400	Pt. resting quietly c eyes closed. USS - SPC (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



1830	Pt OOB to chair x20 minutes - tolerated well V.S. Sign Stable HR-93 Pulse ox 98% 2L NC Pt weak - productive cough c exertion no physical effort to move - Pt needs to be strongly enc to move —— [(b)(6)-2] SGT GRIM
2100	Stitches/Sutures x2 to (R) hand removed wound well approximated ~~0~~ SLSX of intact dry and scabbed over ~~0~~ pain, FROM (R) hand. [(b)(6)-2] SGT
2200	300 cc urine output yellow clear - (+) Flatus Pt OOB to commode x 20 minutes Temp 99° @ T-Tylenol 650mg PO administered IV 4mg MSO4 for comfort/sleep - Pt encouraged to Cough, Deep Breathe - will continue to monitor while asleep —— [(b)(6)-2] SGT GRIM
2300	Pt sleeping CT to section 200 on HS LR infusing @ 75 c/hr. Pulse ox 99% 2L
2200	Addendum to 2200 note MSO4 instead of percocet due to tylenol dosage

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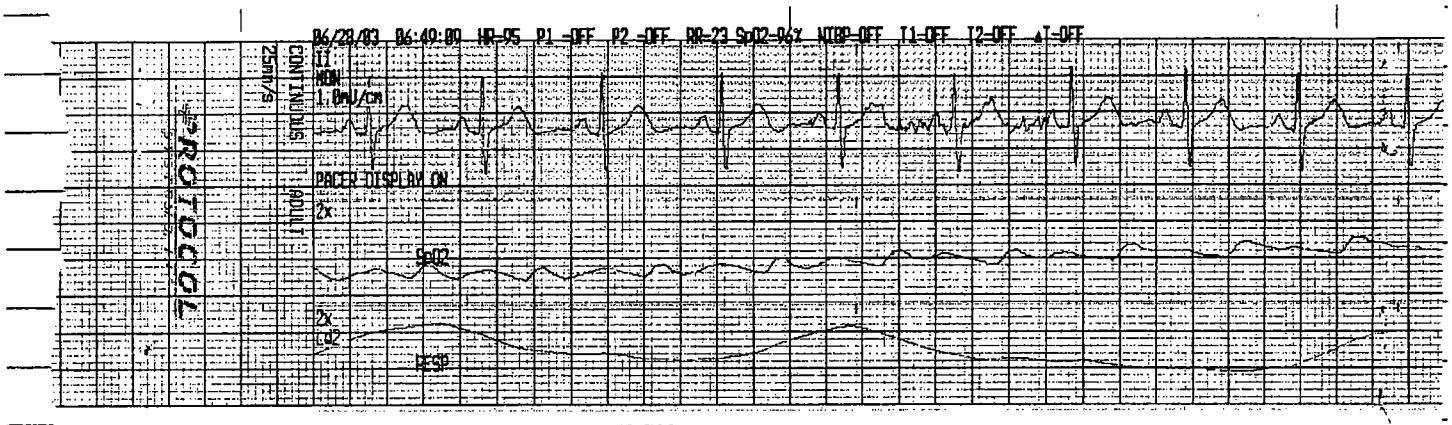
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 JUN 03 0515	Assumed care of pt @ 0500 report rec'd. Assessment complete see ICU Flow sheet. CXR obtained. (b)(6)-2



NO. ECG 100

0715	Pt ate 30% brkft. Encouraged to eat more but stated he was full. (b)(6)-2
0800	Am care done by pt. Assist only c washing c back. (b)(6)-2
0815	Pt assisted OOB to bedside chair c minimal assist x1 (b)(6)-2
0930	Pt ambulated ambulated approximately 300' c used assistance x1. Gait steady but took shuffled steps. Encouraged to take bigger steps but did not. SPO2 90-95% during ambulation. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Jun 1055	Order rec'd to transfer pt to ICW. —— [redacted] (b)(6)-2
1057	Report given to ICW nurse ——
1125	Transferred pt to ICW. Pt ambulated as he did earlier in AM,
	—— [redacted] (b)(6)-2
28 1200 Jun 03	NURSING ASSESSMENT: Pt ambulated to ICW c̄ staff. Pt is awake, alert, Ox3.
	Airway intact, breathing is even & unlabored. Lung sounds diminished to bases (B).
	CT to (R) flank. Drsg CDI. CT to low suction. Abd soft, nontender, s̄ distention.
	Pt c/o ↓ appetite. BS (+) x4 but hypoactive. Hasn't voided on ward but per
	report, pt voids spontaneously. FROM and neurovascularly intact to all extremities.
	IV to (L) FE?, flushes well c̄ no s/s of infiltration or infection. Restraints in
	place per EPW protocol. —— [redacted] (b)(6)-2
28 1800 Jun 03	UOP for shift = 675, dark, tea colored urine. CT output since arriving on ward = 5cc.
	—— [redacted] (b)(6)-2
28 JUN 03	RN Shift assessment: Chest tube
@ 1800	dressing is CDI. Resps are even
	and unlabored. Chest tube draining
	serosanguinous fluid. Appears very
	suspicious with regards to food.
	Encouraged pt by opening food
	packets in front of him. Will continue
	to monitor [redacted] (b)(6)-2
29 JUN 03	RN - Pt c/o pain at 2209 and
@ 0100	was given 10mg PRN MSO4. Pt was
	also repositioned and seemed to
	appear more comfortable - [redacted] (b)(6)-2

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
290700 JUN 03	NURSING ASSESSMENT: Pt is awake, alert, Ox3, airway intact, breathing is even and unlabored. Lung sounds diminished to bases (B). CT to (R) chest wall drsg CDI. Air leaks noted to tubing system, water seal = bubbles. CT is to continuous suction. Frothy tan mucoid serosanguinous fluid. Abd is soft, nontender, + distention. Pt voids spontaneously. PROM and neurovascularly intact to all extremities. IV to (L) ET, drsg loose. Re-dressed using sterile technique. Pt c/o pain to back side. Upon inspection, noted a ½ dollar sized 2° pressure sore to sacral area, at superior edge of anal cleft. Pt turned to (L) side and padded + blankets. Will continue to monitor. (b)(6)-2
290830 JUN 03	AMBULATION NOTE (NURSING): Pt ambulate approx 300 feet with standby assist. Also sat in chair for approx ½ hour. Appetite has been minimal. For breakfast, pt drank milk + Carnation Instant Breakfast. Able to finally talk pt into eating an apple. Drsg to (R) ET d/c using sterile technique. Site cleaned + probe + alcohol prior to replacing occlusive drsg. CT replaced to suction. (b)(6)-2
29 JUN 03 2040	RN shift assessment note: Pt appetite appears to be a bit heartier this shift, ate approx 40% of dinner (and verbalized a desire for nice fruit which he was given). Swelling to both feet/ankles still seen (non-pitting edema), so feet are raised on pillows. Denied any pain. Voiding + any difficulty. Breath sounds WNL for baseline. Will get

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

(b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	pt to get up to bedside chair. Will continue to monitor — [redacted] CRT
30 JUN 03 0200	RE + C/O pain to abd. Pointed to midline upabove umbilical area. MS04 for pain: [redacted]
30 JUN 03 2030	RN shift update: At approx 2200, [redacted] found pt's IJ IV to be non-patent and red. IJ removed, and new IV placed into left bicept area. Pt was also placed in a chair next to bed for approx ½ hr. C/O nausea upon getting back into bed and was given Zofran at 2300. No episodes of emesis. Will cont to monitor — [redacted] CRT
30 JUN 03 2045	RN: CXR done — [redacted] CRT
30 JUN 0620	Nursing Assessment: Pt awake, Ø C/O pain. Pt alert, attempts to respond using hand gestures. Lungs sound clr, difficult to get pt to take a deep breath, ↓ BS, Ø n/v @ present. Pt has mild edema BLE, feet are elevated. Chest tube to R flank to waterseal, intact; Ø drainage noted @ site. Dressing above chest tube CDI. Chest tube is draining sero-sang fluid — LT [redacted] RN
0620	Nursing Assessment: Pt has decub ulcer to sacral area, nickel size. Attempt to get pt off side & off ulcer, pt refusing. Repositioned blanket under pt to take pressure off area. Pt is voiding clr, tea colored urine — LT [redacted] RN
0715	Nursing - Pt ↑ OOB to chair, personal hygiene performed by Pt, Δ pt linen & pajamas — LT [redacted] RN
0920	Nursing: Pt back to bed & assist — LT [redacted] RN

PROGRESS NOTES

DATE	
30 Jun 03	Nursing: Nutrition: Pt refuse lunch brought by NCD.
1210	Ate rice from MRE meal, pt tolerated well ——— LT [redacted] AM
1840	Nursing: Chest Tube – Pt has 45 cc of sero-sang drainage from chest tube since 0500 ——— LT [redacted] AM
1800	Nursing assessment: Pt alert at this time. AAOx3. PERRLA. Mucous membranes pink, moist and intact. Neck supple, FROM. Lungs CTA bilat. Diminished breath sounds to (R) side. Chest tube drsg CDI, 00 new drainage noted. 30cc sero sanguinous drainage to water seal. NSR. Abd soft, non-tender, bowel sounds active x4 Quads. Ate good amt of dinner – rice, fruit and vegetables. Ø N/V. Strong pulses and brisk cap refill x4 extremities. Pt lying on (L) side to keep off of nickel sized decubitus ulcer on Sacrum. Ø drsg, open to air. [redacted] LT
01 July 03	Pt c/o "acidity" to abd. Given 20cc
0100	Maalox PO. Effective for pain. [redacted] LT/N
0300	Bs to bedpan x1. Dark, formed stool. 700 cc dark yellow urine to urinal [redacted] JT
0500	30cc sero-sanguinous drainage to chest tube since 1800 last night ——— [redacted] LT/N
0630	Nursing Note: Assist pt ↑ OOB to chair for breakfast ——— LT [redacted]
0820	Nursing Assessment: Pt ↑ in chair, requesting to get back in bed. Pt tachycardic, HR 110. Lungs CTA. BBS. c/o Drsg to (R) flank @ Chest tube c serous, dried drainage. Drsg

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	above chest tube site CDI. Pt ate approx 50% of Breakfast (fruit cocktail & WRS bread) — LCT [redacted] AN
0830	Nursing: Assist pt back to bed — LCT [redacted] AN
1205	Nursing: Pt ↑ OOB C assist. Ambulate the ward x 2. Pt tolerated well — LCT [redacted] AN
1450	Nursing: Vitals Pt temp ↑ 100.4, BP 88/52, R=28, Will recheck vitals — LCT [redacted] AN
1500.	Nursing: Vitals. Pt use IS x 10, ↑ OOB to chair. T=99.7, BP 98/58, R=30, P=109 palpated. Assist pt back to bed — LCT [redacted] AN
1520	Nursing: Vitals T 99.7 BP 88/33 R 30 P=111. Inform MD; MD wants pt ↑ OOB to amb — LCT [redacted] AN
1 July 13 @ 1750	Nursing note: Assumed care of Pt @ 0. Pt C/O of not wanting food Pt only ate Crackers and OJ. Pt non compliant when told he must turn to (R) Side Pt indicated C Signs that too much pain on (R) Side. Voided 450 cc dark urine in BS urinal will continue to monitor Status — [redacted] Comfort
2014	Assessment completed. Pt Ogoni noncompliant C getting out of Bed & turning on Right Side Dressing w/dry, Breathing Intact. Lungs CTA C V BS (R) Side. NO IV access Pt Voids Spontaneously will continue to monitor Status — [redacted] Comfort

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 Jul 03 0745	Nursing: Shift assessment Pt alert, ∅ resp. distress, ∅ SOB, lungs CTA, slight pain to (R) side, poor intake of V2C milk only, voiding >30cc/hr. BS (+) x4Quad, Pain meds given for discomfort. Continue to monitor [redacted] (b)(6)-2 CPT(BR)
2 Jul 03	NURSING ASSESSMENT- PT A+O x3, PERRLA, LUNGS CTA BICAT, S1-S2 STRONG AND REGULAR, CAP REFILL <3, RADIAL PALPABLE x 4 EXTREMITIES, HYPO ACTIVE BOWEL SOUNDS x4. DRSG TO (R) ANTERIOR CHEST C,D,I, INCISION SHOWS NO SIGNS OF INFECTION. PT IS RESTRAINED AND EXPECTED TO BE D/C SOON. COMPLAINS OF MINIMAL PAIN WILL CONTINUE TO MONITOR [redacted] (b)(6)-2 SGT, USN
3 Jul 03 0440	Nursing Note: Assessment: Pt awake, c/o acidity to stomach, a given Maalox. Pt ↑ OOB to chair for breakfast c minimal assist. Pt amb down ward x ↓ [redacted] (b)(6)-2 LCT, AF
0755	Nursing Assessment: VSS, lung CTA, BS x4, abd soft flat. Pt voiding tea color urine, 750cc. Drsg to (R) chest CDI, steri strips CDI c edges well approximated. Decub ulcer to sacrum open c ~~scale~~ white edges, ∅ drainage presently noted. Pt lying on side [redacted] (b)(6)-2 LCT, AF
3 July 03 ∅ A:	Nutrition Note Pt has been followed by NCD since admission. Pt has presented a challenge as he has been refusing most foods offered especially high protein foods. Intake of protein foods has been inadequate. Interpreter counseled pt to avoid

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/2/07	O/C Summary 15yo ♂ GSW chest 6/20 to OR for wound exploration, closure of chest, tube thoracotomy Post-op unremarkable. Pt D/C POD #12. Pt ↑ equal breath sounds, stable post-op D/C Diagnosis: GSW chest Procedure: thoracotomy 6/20 Med on D/C: Percocet prn pain

(b)(6)-2

MAC (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)*

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
3 July 03	Nutrition Note (cont)
A:	meat items from U.S. as they don't meet Islamic requirements. We attempted to work around this ~ peanut butter, milk and Hospitalian Rations with limited success. Pt has begun eating small amounts of meat. Pt's estimated needs: 2200-2300 kcal (45 kcal/kg) estimated 50 Kg 75-100 gms protein (1.5-2.0 gms/kg)
P:	Will monitor intake x 48° ~ kcal count to assess current intake. (b)(6)-2

MAJ, SP RD/LDN

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

(See Instructions on Back of this Sheet)

CASUALTY CARE AND TREATMENT (Medical Record) | TREATMENT FACILITY (Name) (b)(3)-1

20 JUN 03 0620 — X ... MP — u/k — u/k

GSW chest — EPW — m

POX	91	91	95
	0620	0630	0635
	105/?	105/51	105/50
	90	126	122
	44	44	44
	75	75	

PROCEDURE	INITS.	TIME
chest x-ray		0
chest tube		06
IV		0615
Ancef 1 gm IV		0621
.5 Tetnus		0621
Foley		0625

GSW (L) chest

Cut 3" - thumb (R) hand
chest tube in
PT arrived w/bandage over chest wound (R) upper chest - gunshot wound
IV in (L) arm - N/28 / 2nd IV in (R) arm - Ambu Bag /
0625 Blood drawn for testing
0625 Blood transfu — O Neg unit # 2453211 - 0653
O Neg unit # 1641861 - 0653 / 0710
IV out of (L) arm
suction/chest tube - switched out - 70cc blood — IV in jugular - 0640 - N
0647
Pox: 100 - Pulse: 93 BP: 111/46 Resp - 24 (w/amm)
-0645
100mg Fentanyl IV — 0645
5mg Versed IV — 0645
Ultrasound - FAST neg — 0646
0647 Ventilated by Ambu - resp stopped - chest tube in 649
100mg succinylcholine IV
ETT 8.0 at 24 — Placement Verified
NG Tube 0651 - gastric contents - placement verified
POx - 100 Resp: 20 Pulse 101 BP 101/48 Temp 98.7
On ventilator 0700 - 600TV speep 100% FiO2 Rate 14 — 0653
10mg Vecuronium / 600 tidal volume 100%
Ultrasound 0705 — FAST exam (-)
P-O2 100 Pulse 94 Resp: 20 BP 114/58 - 0710
0725 O2 Sat 91% 100% FiO2 Pulse 77 ST
123/75
ABG 7.2/47.5/179/19/-9 on 100% ↓
TO OR - 0754 - EBL (L) chest tube - 80cc ↑700TV ↑Rate 18
H+H 9.9/31.8 PT/PTT 13/28.1 UOP 10cc clear yellow
WBC 21.9 LR 1500cc PRBCs - II

DISPOSITION: OR - ICU
TIME: 0754

(b)(6)-4

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	TIME SEEN BY PROVIDER
		0620

TEST RESULTS

WBC	SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
21.9		SUP O2 100%	PH 7.246	PO2 420	RESULTS	
H/H 10/33		PCO2 HCO3 17	SAT	OTHER		
PLT 327	1.3 / 152	U/A DIP			EKG INTERPRETATION	
T	BHCG / ETOH / GLU	MICRO				

PROVIDER HISTORY/PHYSICAL

Pt is a ~20yo Iraqi EPW ♂ who had fired his AK47 vs a tank, then was shot x1 to Chest by M-4 @0330. Had CT placed @BAS in Samarra & sent here

PMH ?

O: WD Thin Iraqi ♂ in Mod Resp Ir dist Alert, moves spont Eyes spont, spont verbal.
HEENT: NC. Scant bld in A/W Trachea ML, ⊖JVD.
Lungs: ↓BS on (R) ↑ wet BS (B) Chest GSW x2: 1) (R) ant Chest wall 4th rib.
2) R ant ax line ~6th rib.
Cor RR ⊖.
Abd: ⊕BS. S. NT ND ⊖Rib. FAST ⊖.
GU NL.
Rectal: NL Pros. ⊖ Bld.
CT in (R) Chest + Helmich.

EPC: Hypotensive & Tension physiology → Tx'd for resuscitation & gave 2x O+ bld prbc c improved BP. Sats remained in low 90's even after CT put to suction. Pt then RSI'd c 8.0 ETT 20cm @ teeth

TOOR for wnd mgmt. 1) SIMV 14 600 5 100% 2) 600 5 100%

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2

DIAGNOSIS

GSW Chest

CODE

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

028

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
20 June 03	late	note	0817 See 558 for more info. 18-24 yo IRAQI EPW presented to ED p̄ being seen at TMC c̄ GSW entrance (Rt) ~~Lft~~ ant chest + exit (R) mid Axillary large blow-out. - chest tube already sutured in place c̄ Heimlich valve + switched to 20 cm H_2O seal suction pleurovac. Pt. obviously anxious, resp rate 40's, Breath sounds (B), slightly diminished (R) - f CXR showed collapsing chest wall (L) side + expanded p̄ wall suction, positive pressure ventilation (started c̄ 100% NRM) p̄ sedation, + intubation. RSI - see 558. Sat maintained > 90%, CXR confirmed placement ETT, CT, insert NGT, 82cc EBL chest tube, 1 Liter LR IV #18g (R) Ant. in. new (L) EJ inserted + II units PRBC given - Foley inserted maintained B/P > 90 sys, O2 sat > 95%, post CXR - (Rt) lung area re-expanded. Anesthesia + surgery at bedside - pt. stable - plan to take to OR for closure/explore GSW sites/chest. RT at bedside - see ABG's final setting SIMV rate 18, TV 700, FiO_2 100% + peep 5 - All tubes taped well - chest tube + external drainage sites dsg's reinforced c̄ tape - report given to OR/anesthesia - to OR 0754 via litter ——— (b)(6)-2 /MAJ/AN

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 6186

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 20 ish
HEIGHT:
WEIGHT: Unk

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

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

4. PROPOSED SURGICAL PROCEDURE: (R) Chest wound exploration

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition CWD to (R) Chest
Tobacco Unk ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL ASA/Motrin w/72 hrs (Y) (N)
ETOH Unk Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment NA 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids NA 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

(b)(6)-4

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOM.	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. N/A ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain 2) Intraoperative Hazards N/A 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning N/A 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated N/A 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: N/A 1) Diminished Hearing ✓ 2) Language Barrier F.3. N/A Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 ut/AN 20 Jun 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 ut/AN
DATE: 20 Jun 03 TIME: 0745

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 ut/AN
DATE: 20 Jun 03 TIME: 1010

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

2. PATIENT [illegible] AND PROCEDURE VERIFIED BY [redacted] (b)(6)-2 ct/RN

3. DATE 20 JUN 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0745 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt arrived from ER intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] (b)(6)-2, 91D	RELIEF SCRUB	
	Spc [redacted] (b)(6)-2, 91D		
ASSIGNED CIRCULATOR	RT [redacted] (b)(6)-2, 66E	RELIEF CIRCULATOR	
	RT [redacted] (b)(6)-2, 66E		

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Bean bag, pillow between legs; (L) axillary Roll; (R) arm & pillow on Mayo Stand

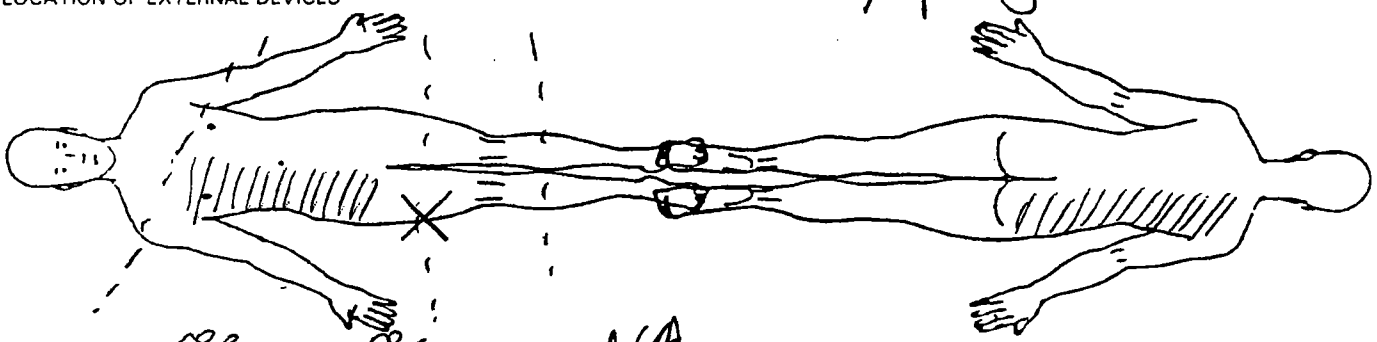
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Beta/Beta
SITE: (R) Thorax to post. + ant. midline. (R) arm to (R) hip BY WHOM: [redacted] (b)(6)-2
SITE: BY WHOM:
COMMENTS: ↓ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C	C	C
Needle Sharp	☒ Yes ☐ No	C	C	C
Instrument	☐ Yes ☒ No	/	/	/
Other	☐ Yes ☒ No	/	/	/

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

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

[redacted] (b)(6)-4

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

☐ ESU NO: #1 cut/coag = 50/50
GROUND PAD: BRAND Valley Lab
LOT NO: H9402 4

☐ 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

(b)(6)-2

PH

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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Foley	2. 36 fr x 2 Chest tubes	3.
SITE	1. Bladder -placed in ER-	2. ® Thorax	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
petroleum gauze 4x8s

19. ADDITIONAL INFORMATION
Dr (b)(6)-2
Dr (b)(6)-2

May (b)(6)-2 CRNA / CPT (b)(6)-2 CRNA / cpt (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
1) ® chest wound exploration
2) Chest tube placement x 2 ® Thorax
3) ® hand wound closure

21. PATIENT TRANSFERRED TO ICU TIME 10 10 METHOD litter

22. REGISTERED NURSE SIGNATUR (b)(6)-2 [redacted]

REVERSE OF DA FORM 5179-1, OCT

USAPA V1.01

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	9	10	11	12	13	14	15
POST- DAY	8	9	[illegible]	11	12	13	4
MONTH-YEAR Jun ~~19~~ 2003 — DAY	28	29	[illegible]	30	1 (b)(6)-2	[illegible]	(b)(6)-2
HOUR	[illegible] 1400 2200	0600 1400	[illegible]	0600 1400 2400	0600 1400 2200	0600 1400 [illegible]	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 20 | 18 | 18 | 18 | 19 | 22 | 22 | 18 | 20

Record special data only when so ordered

BLOOD PRESSURE	99/50 111/50 111/56	110/50 94/47	103/66	104/55 94/53 94/43	99/51 88/51 86/35	88/44 88/45 83/31	91/51
HEIGHT: WEIGHT →	99.9 99.4						
SPO2	95%RA 95%	97% 98	98%	95/95 96	95/95	99 98	100

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

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

PT# 0013
ETT 8.0
22cm @ lip

VENT FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
20 June	1030	SIMV	18	700	100%	+5	41	1:2.0	4	—	51	100%	169/91	8.0	MLT	[redacted]
ABG	1050	PH	7.430	PCO_2 30.0		PO_2 244		HCO_3 20		BE -4	SO_2	100%				
	1105	—	↓ 16	—	↓ 50%	—										
	1205	SIMV	14	700	50%	+5	37	1:2.0	2	—	86	98%	156/66	8.0	MLT	
ABG	1225	PH	7.253	PCO_2 45.3		PO_2 68		HCO_3 20			SO_2					
ABG	1230	PH	7.267	PCO_2 45		PO_2 69		HCO_3 21		BE -6	SO_2	90%				[redacted]
	1235	—	↑ 16	—	↑ 70%	—										
ABG	1330	PH 7.395	PCO_2 34.3			PO_2	160	HCO_3	21	BE -4	SO_2	99%				
	1400	SIMV	16	700	70%	+5	35	1:2.0	0	—	78	100%	140/72	8.0	MLT	
	1610	SIMV	16	700	70%	+5	34	1:2.0	0	—	96	100%	124/68	8.0	MLT	
	1810	SIMV	16	700	70%	5	33	1:2	0	—	106	100	101/63	8	MLT	
	2000	SIMV	16	700	70	5	31	1:2	0	—	110	100	97/57	8	MLT	
	2240	SIMV	16	700	60	5	33	1:2	0	—	85	100	104/60	8	MLT	
	2350	SIMV	16	650	50	5	34	1:2	0	—	89	100	96/63	8	MLT	
21 June	0200	SIMV	14	600	45	5	234	1:2	—	—	74	100	94/43	8	MLT	
	0430	SIMV	14	600	45	6	24	1:2	2	—	71	100	98/42	8	MLT	
	0500	S	7.38	38.6	80	23	2	96%								
	0600	SIMV	14	600	45%	+5	25	1:2.0	1	—	76	100%	85/53	8.0	MLT	
	0750	SIMV	14	600	45%	+5	29	1:2.0	3	—	90	100%	102/49	8.0	MLT	[redacted]
	0830	Pt Extubated and placed on NRB @ 12 L/min									108	98%	121/63	—		

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-4

i-STAT G3+

Pt: (b)(6)-4 NRB @ 12 L/min

Pt Name:_____

TCO2_____25 mmol/L

post extubation #1

At 37C

pH_____7.331

PCO2_____44.6 mmHg

PO2_____60 mmHg

HCO3_____24 mmol/L

BEecf_____-2 mmol/L

sO2*_____89 %

*calculated

At Patient Temp

pH_____7.336

PCO2_____44.0 mmHg

PO2_____58 mmHg

Patient Temp: 98.0F

FIO2_____: 70

Sample Type_: ART

21JUN03 10:01

Oper: 4132

Physician:_____

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

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

---

i-STAT G3+

Pt: (b)(6)-4 post extubation #2

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.336

PCO2_____44.3 mmHg

PO2_____67 mmHg

HCO3_____24 mmol/L

BEecf_____-2 mmol/L

sO2*_____92 %

*calculated

At Patient Temp

pH_____7.333

PCO2_____44.8 mmHg

PO2_____68 mmHg

Patient Temp: 99.0F

FIO2_____: 70

Sample Type_: ART

21JUN03 10:25

Oper: 8945

Physician:_____

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

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

---

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____29 mmol

At 37C

pH_____7.426

PCO2_____42.4 mmHg

PO2_____51 mmHg

HCO3_____28 mmol

BEecf_____4 mmol

*calculated

At Patient Temp

pH_____7.408

PCO2_____44.8 mmHg

PO2_____56 mmHg

Patient Temp: 100.8I

FIO2_____: 50

Sample Type_: ART

22JUN03 06:57

Oper: 1529

Physician:_____

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

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

_____31 mmol/L

At 37C

pH_____7.484

PCO2_____39.3 mmHg

PO2_____63 mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2*_____93 %

*calculated

At Patient Temp

pH_____7.471

PCO2_____40.8 mmHg

PO2_____67 mmHg

Patient Temp: 100.1F

FIO2_____: 70

Sample Type_: ART

22JUN03 08:24

Oper: 4132

Physician:_____

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

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

---

i-STAT G3+ VT 600
RR 14
FIO2 45
PEEP 5
Pt: (b)(6)-4
Pt Name:

TCO2 24 mmol/L

At 37C
PH 7.386
PCO2 38.6 mmHg
PO2 80 mmHg
HCO3 23 mmol/L
BEecf -2 mmol/L
sO2* 96 %
*calculated

At Patient Temp
PH 7.390
PCO2 38.1 mmHg
PO2 78 mmHg

Patient Temp: 98.1F
FIO2: 45
Sample Type: ART

21JUN03 04:46

Oper: 1383

Physician:

Ser# 42813
Ver: [redacted] (b)(6)-2

---

i-STAT G3+ 18,700
Pt: (b)(6)-4 ↑5 100%
Pt Name:

TCO2 22 mmol/L

At 37C
PH 7.389
PCO2 33.9 mmHg
PO2 244 mmHg
HCO3 20 mmol/L
BEecf -4 mmol/L
sO2* 100 %
*calculated

At Patient Temp
PH 7.430
PCO2 30.0 mmHg
PO2 231 mmHg

Patient Temp: 93.5F
FIO2: 100
Sample Type: ART

20JUN03 11:00

Oper: 4132

Physician:

Ser# 42813
Ver: [redacted] (b)(6)-2

↓ VT to 600 ml
↓ RR to 14
↓ SpO2 to 45%

i-STAT G3+
Pt: (b)(6)-4 TV 650
Pt Name: RR 16
FiO2 50%

TCO2 24 mmol/L

At 37C
PH 7.464
PCO2 31.5 mmHg
PO2 100 mmHg
HCO3 23 mmol/L
[illegible] mmol/L
[illegible]alculated

At Patient Temp
PH 7.466
PCO2 31.2 mmHg
PO2 99 mmHg

Patient Temp: 98.3F
FIO2: 50
Sample Type: ART

21JUN03 00:15

Oper: 4017

Physician:

Ser# 42813
Ver: [redacted]
(b)(6)-2

---

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____22 mmol/L

R 14
Tv 700
FIO2 50
P 5

At 37C

pH_____7.247

PCO2_____48.3 mmHg

PO2_____69 mmHg

HCO3_____21 mmol/L

BEecf_____-6 mmol/L

sO2*_____90 %

*calculated

At Patient Temp

pH_____7.267

PCO2_____45.3 mmHg

PO2_____62 mmHg

Patient Temp: 96.0F

FIO2_____: 50

Sample Type_: ART

20JUN03 12:30

Oper: 4132

Physician:_____

Ser# 42813

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

---

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____22 mmol/L

SIMV
FIO2 70
R 16
Tv 700
P 5

At 37C

pH_____7.395

PCO2_____34.3 mmHg

PO2_____160 mmHg

HCO3_____ mmol/L

BEecf_____ mol/L

sO2*_____

*calculated

At Patient Temp

pH_____7.397

PCO2_____34.0 mmHg

PO2_____159 mmHg

Patient Temp: 98.3F

FIO2_____: 70

Sample Type_: ART

20JUN03 13:32

Oper: 4132

Physician:__

Ser# 42813

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

---

20 JUN 03 1230
2 FIO2 = 60%
IV 700

---

i-STAT G3+ IMV 16
PEEP 5

: (b)(6)-4

Pt Name:_____

TCO2_____24 mmol/L

At 37C

pH_____7.551

PCO2_____26.3 mmHg

PO2_____161 mmHg

HCO3_____23 mmol/L

BEecf_____1 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

pH_____7.535

PCO2_____27.5 mmHg

PO2_____167 mmHg

Patient Temp: 100.4F

FIO2_____: 60

Sample Type_: ART

20JUN03 22:52

Oper: 98.3

Physician:_____

Ser# 42813

Ver: [redacted]

(b)(6)-2

ABG

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	4.2	3.5-4.9 mmol/L
Cl	99	98-109 mmol/L
pH	7.261	7.31-7.45
PCO2	43.0	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	195	80-105 mmHg (art) N/A (ven)
TCO2	21	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	100	95-98%
BEecf	-8	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	26	38-51% PCV
Hgb	9	12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 20 Jun 03

LAB ID NO.:

ABG

(b)(6)-4

i-STAT		
TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/L
K	4.3	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.282	7.31-7.45
PCO2	39.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	109	80-105 mmHg (art) N/A (ven)
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	98%	95-98%
BEecf	-8	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
iCa	1.23	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	28	38-51% PCV
Hgb	10	12-17 g/dl

[illegible] Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible] Chemistry		
TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[illegible] Chemistry		
TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

[illegible] Profile		
TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 20 Jan 03

LAB ID NO.:

Ward/Section: ICU 2 | REQUESTING PHYSICIAN: (b)(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | DATE: 20 Jun 03 | TIME: 1030 | SSN/PSEUDO SSN: (b)(6)-4

Hematology

TEST	RESULT	REF. RANGE
WBC	15.0	4.8-10.8 x 10^3
RBC	3.80	4.7-6.1 x 10^9
Hgb	10.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.9	42-52% (M) 37-47% (F)
MCV	89.2	80-94 fl (M) 81-99 fl (F)
Plt	168	130-500 x 10^3 verified
Lymph %	11.5	20.5-51.1%

Differential (Manual)

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Urine Cell Count

Cell Count			
Directigen		Negative	

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

UNIT	TYPE	CROSSMATCH

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

REMARKS:

REPORTED BY: (b)(6)-2 | DATE: 20 Jun 03 | LAB ID NO.:

(Chemistry Only)

Ward/Section: ICU 2

REQUESTING PHYSICIAN: (b)(6)-2

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

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

DATE 20 Jun 12

TIME 1030

SSN/PSEUDO SSN: (b)(6)-4

[redacted]

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
tCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
SO2		95-98%
Bfeed		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

[redacted]

TEST	RESULT	REF. RANGE
GLU	121 *	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	1356	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	5.0 *	3.3-4.7 mmol/l
CL^-	107	98-108 mmol/l
tCO_2	21	18-33 mmol/l

[redacted]

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

[redacted]

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

REMARKS: No Hemolysis noted!

Ward/Section: [illegible] | REQUESTING PHYSICIAN: (b)(6)-2 [redacted]

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

LAST, FIRST, MI: [redacted]

DATE: [illegible] | TIME: [illegible] | SSN/PSEUDO SSN: (b)(6)-4 [redacted]

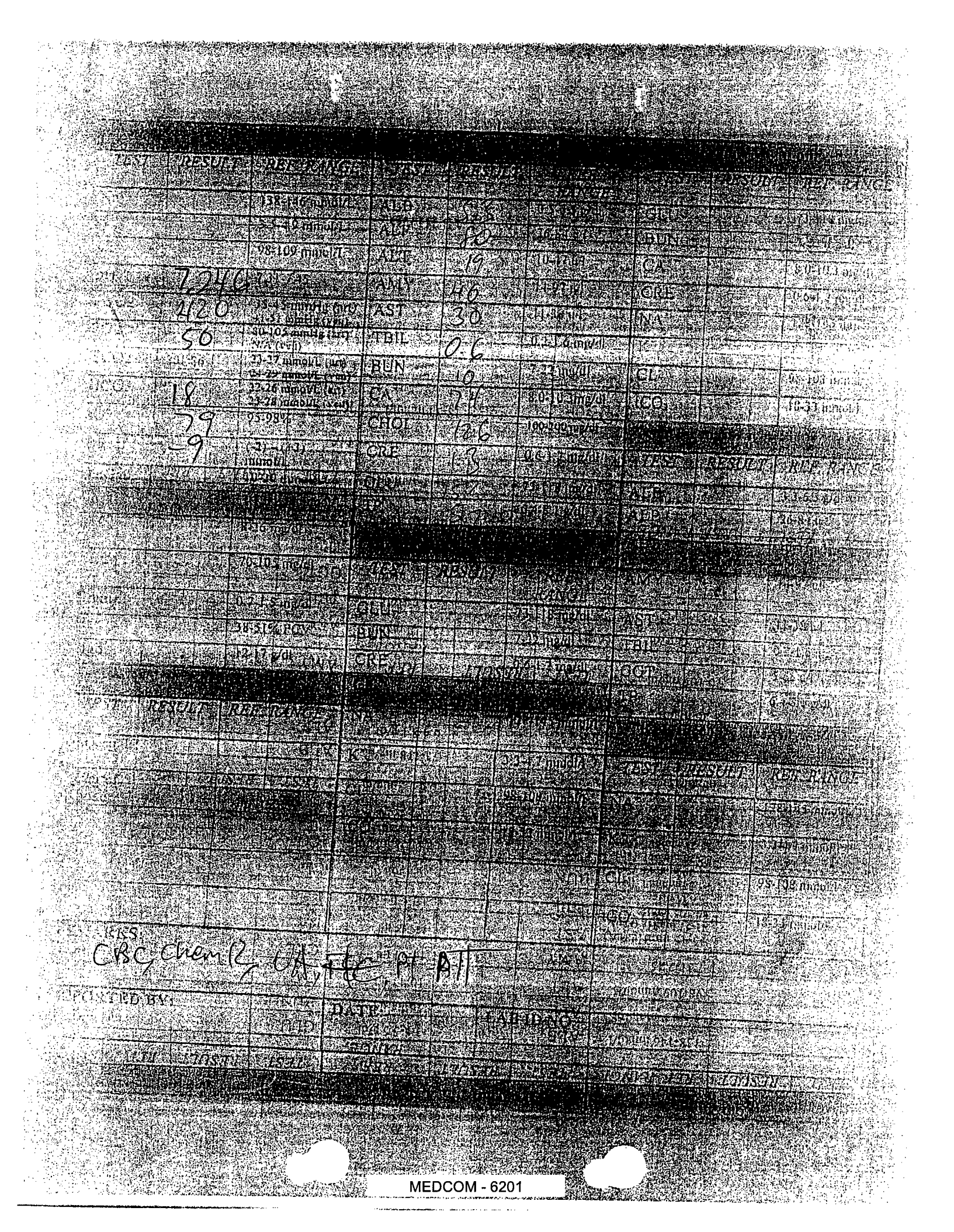
TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
WBC	2.9	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	3.5	4.2-6.1 x 10⁶	App		N/A	Mono		Negative
HGB	9.9	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative			
HCT	31.8	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	89.0	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
PLT	277	130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
		20.5-51.1%	Bld		Negative	H pylori		Negative
			pH		N/A	Micro Parasites		
		Mono	Prot		Negative	Malaria		
		Eos	Urob		0.2-1.0	O&P		
		Baso	Nitr		Negative	Other		
		Imm	Leuk		Negative			
			HCG		Negative			

TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
		42-52% (M) 37-47% (F)	CSF		
			Cell Count		MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
			Glucose		Negative
					ABO/Rh

TEST	RESULT	REF RANGE	UNIT	TYPE	CROSSMATCH
	13.0	9.6-13.6 secs			
	28.1	21-34 secs			
		<20 ug/ml			
		<10 ug/ml			

REMARKS:

VERIFIED BY: (b)(6)-2 [redacted] | DATE: | LAB ID NO.:



CBC, Chem12, UA, Tc PT AT

MEDCOM - 6201

Chemistry Only

Ward/Section: ICU

REQUESTING PHYSICIAN: Dr (b)(6)-2

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

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

DATE: 21 Jan

TIME: 0600

SSN/PSEUDO SSN: (b)(6)-4

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

MISCELLANEOUS

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

CHEM-7

TEST	RESULT	REF. RANGE
GLU	F7	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	148	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	2.0	3.3-4.7 mmol/l
CL^-	107	98-108 mmol/l
tCO_2	24	18-33 mmol/l

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

LIVER PROFILE

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

LYTES-4

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

REMARKS:

Ward/Section: ICU	REQUESTING PHYSICIAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 21 Jun	TIME 0400
		SSN/PSEUDO SSN:

Complete Blood Count (CBC)

TEST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10^3
RBC	3.02	4.7-6.1 x 10^9
Hgb	8.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.8	42-52% (M) 37-47% (F)
MCV	88.7	80-94 fl (M) 81-99 fl (F)
Plt	148	130-500 x 10^3 verified
Lymph %	22.9	20.5-51.1%

Differential (Automated)

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		

Other	

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App	--	N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

ESR

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	

Occ Bld		Negative
H. pylori		Negative

Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 21 Jun	LAB ID NO.: 07

Ward/Section: FCU

(b)(6)-2

PHYSICIAN:

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

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

DATE: 21 Jun 03

TIME: 0200

SSN/PSEUDO SSN: (b)(6)-4

Complete Blood Count

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

Differential/Manual Diff

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

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

Routine Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clrd	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	neg	Negative trace
pH	5.0 so sl	N/A
Prot	trace	Negative SSA=(2+)
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

ESR

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

0-5 RBC
much, much amorph sed

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Blood Bank Unit Crossmatch

SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

WARD SECTION: ICU | REQUESTING PHYSICIAN: DR (b)(6)-2 | LABS/KIT: ICU's form

LAST, FIRST, MI. (b)(6)-4 | DATE: 22Jun07 | TIME: | SSN / PSEUDO SSN (b)(6)-4

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of abuse		

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

TEST	RESULT	REF. RANGE
GLU	103	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	3152	39-380 u/l (M) 30-190 u/l (F)
NA+	139	128-145 mmol/l
K+	3.7	3.3-4.7 mmol/l
CL-	99	98-108 mmol/l
tCO_2	26	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

WARD/SECTION: ICU | REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2 | (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4 | DATE: 2 JUN 08 | TIME | SSN/PSEUDO SSN: [redacted] (b)(6)-4

TEST	RESULT	REF. RANGE
WBC	9.2	4.8-10.8 x 10^3
RBC	3.06	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.1	42-52% (M) 37-47% (F)
MCV	88.5	80-94 fl (M) 81-99 fl (F)
Plt	168	130-500 x 10^3 verified
Lymph%	23	20.5-51.1%

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

TEST	RESULT
Segs	
Bands	
Lymph	
Atyp	
Mono	
Eos	
Baso	
Imm	

TEST	RESULT
RBC Morph	

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

TEST	RESULT
Cell Count	
Directigen	Negative

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 | DATE: | LAB ID NO.:

FW

(b)(6)-2

LABORATE ... DS Form

(b)(6)-4

DATE 22Jun03 TIME 0020

SANTPSEUDO SSN

(b)(6)-4

[redacted]

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		86-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		23-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE

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

[redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

[redacted]

TEST	RESULT	REF. RANGE
NA+	134	128-145 mmol/l
K+	3.6	3.3-4.7 mmol/l
CL-	96	98-108 mmol/l
tCO_2	30	18-33 mmol/l

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

(Sub) ...o the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN:
	23 June	0400	1C (b)(6)-2

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.4	~~4.8-10.8 x 10³~~
RBC	2.80	4.7-6.1 x 10^9
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.0	42-52% (M) 37-47% (F)
MCV	89.8	80-94 fl (M) 81-99 fl (F)
Plt	154	130-500 x 10^3 verified
Lymph %	28	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Chem 8

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
GLU	104	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	2579	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	3.5	3.3-4.7 mmol/l
CL^-	97	98-108 mmol/l
tCO_2	27	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY:

DATE: 23 June 0400

LAB ID NO.:

ICU

LABORATORY

(b)(6)-4

DATE 25 Jan 03

TIME

SSN / PSEUDO SSN

CBC

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
Ecf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
LU		70-105 mg/dl
creat		0.7-1.5 mg/dl
ct		38-51% PCV
hgb		12-17 g/dl

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
GLU	89	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+	136	128-145 mmol/l
K+	3.7	3.3-4.7 mmol/l
CL-	97	98-108 mmol/l
tCO_2	30	18-33 mmol/l

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

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

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

RESULTED BY (b)(6)-2

DATE: 25 Jan 03

LAB ID NO.:

(b)(6)-4

Lab/Blood Section — Physician

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted]			

Hematology

TEST	RESULT	REF RANGE
WBC	10.0	4.8-10.8 x 10^3
RBC	3.26	4.7-6.1 x 10^6
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.6	42-52% (M) 37-47% (F)
MCV	90.6	80-94 fl (M) 81-99 fl (F)
Plt	365	130-500 x 10^3 verified
Lymph %	13.5	20.5-51.1%

Urinalysis

TEST	RESULT	REF RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Chemistry

Total Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation

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

Urine Pregnancy

TEST	RESULT
Call Count	
Directigen	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/RH	

BLOOD PRODUCTS

TEST	RESULT	REF RANGE	UNIT #	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

WARD SECTION: FCU | REQUESTING PH: (b)(6)-2 | LABORATORY: CHS Form

LAST, FIRST, MI: (b)(6)-4 | DATE: 26 Jun | TIME: 0500 | SSN / PSEUDO SSN: (b)(6)-4

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	96	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.3 *	0.6-1.2 mg/dl
CK	387 *	39-380 u/l (M) 30-190 u/l (F)
NA+	138	128-145 mmol/l
K+	3.6	3.3-4.7 mmol/l
Cl-	101	98-108 mmol/l
tCO_2	23	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2 | DATE: 26 JUN 03 | LAB ID NO.:

WARD/SECTION: ICU | REQUESTING PHYSICIAN: [b)(6)-2] | (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [b)(6)-4] | DATE: 26 Jun | TIME: 0500 | SSN/PSEUDO SSN: [b)(6)-4]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	12.1	4.8-10.8 x 10^3
RBC	3.11	4.7-6.1 x 10^9
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.4	42-52% (M) 37-47% (F)
MCV	91.1	80-94 fl (M) 81-99 fl (F)
Plt	384	130-500 x 10^3 verified
Lymph %	11.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

(Subject to the Priva

LAST, FIRST, MI (b)(6)-4	DATE 24 June	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.9	4.8-10.8 x 10^3
RBC	3.11	4.7-6.1 x 10^9
Hgb	9.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.0	42-52% (M) 37-47% (F)
MCV	89.8	80-94 fl (M) 81-99 fl (F)
Plt	269	130-500 x 10^3 verified
Lymph %	11.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 24 Jun 07	LAB ID NO.:

ICU (b)(6)-4 - ICU - 24 hr 03- 0400

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	1868	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l Z STAT
K^+	3.8	3.3-4.7 mmol/l
CL^-	98	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 24 Jan 03

LAB ID NO.:

Chem 8

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 18-23 HRS DAYS MOS (YRS) SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: ______ SURGICAL SERVICE: G.S.

ASA PHYSICAL STAUS 1 (2) 3 4 5 (E)
WEIGHT: 55 KG/LB HEIGHT: 69 IN.
ALLERGIES: ??

HABITS:

TOBACCO:
ETOH:
DRUGS:

CURRENT MEDICATIONS:

([ ] = ordered as premed)

[ ] UTA
[ ]
[ ]
[ ]
[ ]
[ ]

PREMEDICATION:

None Yes (@ ____ Hrs) /OC
____ , ____ mg IV IM PO
____ , ____ mg IV IM PO
____ , ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: 31.8 / ____
U/A:
OTHER:

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

System	Condition	N	Y	
Cardiovascular:	Hypertension	N	Y	
	Angina	N	Y	
	MI	N	Y	
	CVA	N	Y	
	Other	N	Y	
Pulmonary System:	Asthma	N	Y	GSW chest x2
	Bronchitis/URI	N	Y	by M-4
	COPD	N		(+)(R) C.T.
	Other	N	Y	
Renal System:	Acute/Chronic RF	N	Y	
Gastrointestinal:	Hepatitis	N	Y	
	Hiatal Hernia	N	Y	UTA
	PUD	N	Y	
Endocrine System:	Diabetes	N	Y	
	Steroids	N	Y	Pt.
	Thyroid	N	Y	intubated
Neurological:	Seizures	N	Y	
	Neuropathy	N	Y	Φ
	Other	N	Y	Plmths
Gynecological:	Pregnancy	N	Y	
Other Significant Hx:		N	Y	
		N	Y	
Familial HX				

PAST SURGICAL/ANESTHETIC HISTORY

UTA

PHYSICAL EXAMINATION

BP 90/40 HR ____ RESP ____
HEENT - Teeth
Trachea
TMJ/Neck intubated
Oropharynx in
Nares ER
CHEST:
CARDIAC: 8.0 ETT 20 cm
EXTREMITIES: - teeth
IV Access:
Ulnar Filling:
BACK:
OTHER:

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): ____ [X] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. T (b)(6)-2 [redacted] Questions answered.

S

DATE: 6/20/03 TIME: 0800 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ____

VITAL SIGNS: BP ____ HR ____ RESP ____ SuO_2 ____

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level ____

REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE

[X] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER

Pt. remains intubated
Φ apparent sx anesthesia comp.

(b)(6)-2 [redacted]

DATE: 6/20/03 TIME 2200 Hrs

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION: (Ward: ____)

(b)(6)-4 [redacted]

WAMC Form 2300
1 Aug 92 (HSXC-SU)

PREVIOUS EDITION IS OBSOLETE

MEDCOM - 6216

☆ U.S. GPO: 1994-628-533/00102

PATIENT RECORD COPY

F A-line / 1 attempt (L) radial #20G (L) US

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

DRUG	Units	Doses	TOTALS
Fentanyl	(mcg)	100 50 100 100 100 50	500
Vecuronium	(mg)	5 5 5 5 5	
	( )		
	( )		
	( )		
	( )		
VOLATILE AGENT: Forane	% del / % e.t.	1.0 1.3 1.2 1.2 1.5 1.4 1.0 X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8 1.5 — 1.5 — 1.5 — 1.5 — 8	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site		Warmed	
(R) IJ		Warmed	300
18 (L)		Warmed	(1000) 300

LOSSES
- EST BLOOD LOSS
- URINE – 550 150/700

TOTAL EBL: 250
TOTAL URINE: 700

FLUIDS – SUMMARY
- CRYSTALLOID – 1500
- COLLOID – Ø
- BLOOD – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: 28

INITIAL DATA: BP – 90/42; HR – 98

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? (✓) TIME – 0746

TIME: 0745 0800 · 30 · 0900 · 30 · 1000 · 30

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ↗; ANES– X-X; PROC–⊙–Ø

Grid scale: 220 200 180 160 140 120 100 80 60 40 20

Parameter	Values
VT – ml	740 730 740 760 780 810 640 700 700
f – breaths/min	9 8 8 8 7 7 8 8
Peak insf pres / PEEP	24 24 25/5 31/5 31/5 32/5 33 34 31
MODE– S(pon), A(ssist), C(on)	C C C C C C C C C
ET CO2 (torr)	31 31 34 32 30 33 33 33 31
FIO2 (Frac or %)	.8 .79 .79 .79 .79 .79 .79 .79 .79 .79
SpO2 (%)	99 96 98 97 98 100 100 100 100 100
ECG	ST SR SR SR SR SR SR SR SR SR
TEMP- site	98 — 97
N-M Block (T/4)	3/4 3/4 2/4 2/4 0/4

MONITORS: BP/Auto Cuff; BP / oth; ART line (L) X; Steth- PC/ES X; Gas analyzer X; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — **EVENTS** Position → pressure pts padded LLD BUE<90 ou taped

REMARKS– *Code drugs with numbers, events with letters*

1. → OR from EMT. ventilated c ambu bag.
2. → Standard O2/monitors. (L) DLT (37 FR) inserted (see below) Positioned 1/d c fiberoptic / ⊕BBS VV(R)
3. Positioned LLD c assist 5 personnel. ETT position verified c fiberoptic / BBS. Eyes/ears free of pressure. axillary roll / bean bag. (R) arm on pillow all pressure pts padded.

0915 (R) ↓ down (R) lung ↑.

0936 NaHCO3 50meq IV. DLT removed. #8.0 insert DLx1 MAC 3 22 cm (R) lip. → ICU via stretcher c ambu bag. Report

RECOVERY AT 1101
PACU (ICU) (Specify)
OTHER 93.7
CONDITION: intubated
RESP– 10; SpO2– 100; BP– 113/52; HR– 61

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0750	0745	1100
	Ready	Begin	End
PROC	0820	0849	1005

PROCEDURES and CPT Codes — CT placement x2 (R) (R) chest wound exploration

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — (L) NGT placed – Stomach ✓d. 3cc Bronchial 8cc Tracheal

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DV MAC 3 — pressure ETT removed under DL #37 (L) DLT inserted s difficulty 29 cm (R) lip ⊕ETCO2 BBS⊕ VV RLL. ⊕ placement verified c fiberoptic

SURGEONS (b)(6)-2

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

(b)(6)-2

(b)(6)-2 CPT cm

CPT, AN

PROCEDURE LOCATION OR 1-1

DATE 20 June 03

PAGE 1 **OF** 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan

PATIENT RECORD

MEDCOM - 6217

*U.S. GPO: 2002-729-180/40137

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Portable CXR		M	(b)(6)-4	ICW	
	FILM NO.			PREGNANT ☐ YES ☒ NO	
	REQUESTED BY (Print)			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR [redacted] (b)(6)-2			DATE REQUESTED 01Jul03	

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

S/P GSW Chest, S/P Thoracotomy
Chest tube (R) side

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

RADIOLOGIC REPORT

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

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	6/20/03	10A HOURS	
√ (1)	Admit ICU		
√ (2)	SIP GSW chest		
	√ SIA (E) Thoracotomy		
√ (3)	Chest tube x2 to -20 suction		
√ (4)	NG to LIS		
√ (5)	Foley to gravity		
√ (6)	Ancef 1g IVP q8°		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
√ (7)	Zantac 50 mg IVP bid		
(8)	Vent TV 700		
	PS		
	RR 10		
	FIO2 40%		
√ (9)	Wean PRN		
√ (10)	IVF 2 CRs @ 100 cc/hr		

noted & sent 20 Jun 03 @ 1135 (b)(6)-2 CRT/IOX

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
√ (11)	Labs now + q AM:		
	CBC, Chem 8		
√ (12)	CXR upon arrival to ICU		

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	6/20	1070A HOURS	
√ (1)	Fentanyl 1 titrate prn		
√ (2)	Propofol titrate prn		

noted & sent 20 Jun 03 1035 (b)(6)-2 CRT/IOX

(b)(6)-2

(b)(6)-4

(b)(6)-2

20° V 21 Jun 03 @ 0400 (b)(6)-2 ILTA

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		2200 HOURS	
①	↑ Maintenance IVF to 200 cc/hr. Keep UO > 50 cc/hr.		
②	↓ FiO2 to 60% - ABG in 30 min		
	VIO Dr. (b)(6)-2		
	(b)(6)-2		MHJ MC

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	20 June	2300 HOURS	
①	↓ TV 650, ↓ FiO2 50%		
②	ABG in 30 min		
	VIO Dr. (b)(6)-2		
	(b)(6)-2		MHJ AA

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	21 June	HOURS	
	↓ FiO2 to 45%		
	↓ TV 600		
	↓ IMV 14		
	~~ABG in 30 min~~		
	VO Dr. (b)(6)-2		
	(b)(6)-2		MHJ, MC

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	21 June 03	0200 HOURS	
	250 ml LR Bolus X1 now		
	VIO Dr. (b)(6)-2		
	(b)(6)-2		MHJ MC
	28V 21 Jun 03 @0400 (b)(6)-2		MHJ

20 Jun 03 @2300 MHJ

21 Jun 03 @ 0200 MHJ

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	20 JUN 03	1200 HOURS	
1	IV - ↑ Rate 175 cc/hr.		noted
	(b)(6)-2		(b)(6)-2 1230 6/20/03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	20 Jun 03	1615 HOURS	
1	Decrease IVF rate to LR @ 100cc/hr.		noted
	VO: Dr (b)(6)-2 (b)(6)-2		(b)(6)-2 1615 6/20/03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	20 Jun 03	1715 HOURS	
1	20 mg Lasix IVP now x1		
	VO: Dr (b)(6)-2		

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	20 June	2100 HOURS	
	250 ml		
	LR 500 ml Bolus X 1 now		
	VO Dr (b)(6)-2		
	(b)(6)-2		
	(b)(6)-2 21 Jun 03 @ 0400		LOA

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

get UA - done @ 0220 — 0500 HOURS

V/O Dr (b)(6)-2 — (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

21 Jun 03 — 1000 HOURS

↓ IVF to 100cc/° LR

DIC NGT, vent settings

DIC Fentanyl, propofol

noted (b)(6)-2 6/21/03

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

21 Jun 03 — 1200 HOURS

MSO4 4-6mg IVP Q 2° prn pain.

noted (b)(6)-2 6/21/03

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

Toradol 30mg IVP Q8° prn pain.

noted (b)(6)-2 6/21/03

Tylenol 650mg PO prn Q4° fever > 101.5.

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

(b)(6)-2

24°V 22 Jun 03 @ 0520

DA FORM 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USE

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994 - 363-710

MEDCOM - 6222

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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
				21 June 03	2100 HOURS	
				Lasix 20mg IVP X 1 now		noted (b)(6)-2
				portable CXR		
				(b)(6)-2	(b)(6)-2	
				VIO Dr. [redacted]		
				(b)(6)-2		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
				21 Jun 03	2325 HOURS	
				Lasix 20mg IVP X 1 now		
				VIO Dr (b)(6)-2	(b)(6)-2	
				(b)(6)-2		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
				21 Jun 03	2355 HOURS	
				Albuterol 0.5cc in 2.5 ml NS X 1 now		noted (b)(6)-2
				(b)(6)-2	(b)(6)-2	
				VIO Dr. [redacted]		
				(b)(6)-2		
				2 PV 22 Jun 03 0020	(b)(6)-2	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
				22 Jun 03	0215 HOURS	
				① Lasix 20 mg IVP X 1 now		noted
				(b)(6)-2	(b)(6)-2	
(b)(6)-4						

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 June 03 — TIME OF ORDER: 0700 HOURS — LIST TIME ORDER NOTED AND SIGN

Lasix 20mg IVP ← Duplicate order from 22 Jun 03 @ 0715

V.O. Dr. [redacted] [redacted] mg/kw

0730 [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6/22 — TIME OF ORDER: 8^00 HOURS

noted [redacted]

① OOB to chair b.i.d

② ↓ IVF to 75 cc/hr

22 Jun 03 1230

[redacted]

[redacted]

PATIENT IDENTIFICATION

[redacted]

23 June 03 0150

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ done [redacted]

DATE OF ORDER: 23 June — TIME OF ORDER: 0145 HOURS

✓ lasix 20mg IVP x1 now

V/O Dr. [redacted]

[redacted]

0200 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 23 June [redacted] — TIME OF ORDER: 0320 HOURS

Percocet I–II po Q4–6° prn

V.O. Dr [redacted] [redacted] mg/kw

0320 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 23 June 03 — TIME OF ORDER: 1630 HOURS — LIST TIME ORDER NOTED AND SIGN

Change Zantac 150 mg po BID

V.O. Dr. (b)(6)-2 (b)(6)-2 mvgw 1630

(b)(6)-2 (b)(6)-2 (b)(6)-2 U mvgw

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 23 June 03 — TIME OF ORDER: 1330 HOURS

D/C Foley

CT to H/O seal

Wean O2

(b)(6)-2

V/O Dr. (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-2 (redacted) 24 June 03 0430

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 June 03 — TIME OF ORDER: 0400 HOURS

I & O cath

Portable CXR q AM

V/O Dr. (b)(6)-2 (b)(6)-2

(b)(6)-2

MHJ. MC

PATIENT IDENTIFICATION: Chart Copy (b)(6)-2 0400 24

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6)-2 R — TIME OF ORDER: HOURS

24JUN 03 1600

① Flagyl 500mg po tid x 10d. 1st dose now

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

Added to chart @ 1615 (b)(6)-2 CMT

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4255 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
25 JUN 03	2030 HOURS	2100 25 JUN 03 (b)(6)-2

(1) Benty/ 20mg po qid - 1st dose now prn stomach cramps (only when needed)

(2) Benadryl 50mg po q 6 hrs prn insomnia.

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER	TIME OF ORDER
26	1100 HOURS

(1) CT to Surgery

(2) N/C Labs

(3) X-ray 627 Am (b)(6)-2 (b)(6)-2 (b)(6)-2

(4) Zofran 4mg IV (b)(6)-2

26 JUN 03 1200

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER
27 JUN	1615 HOURS

(1) Heplock IV

V O Dr (b)(6)-2

noted (b)(6)-2 1615 27 JUN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER
28 JUN	1055 HOURS

(1) Transfer to ICW c present orders

noted (b)(6)-2 1055 28 JUN

V.O. Dr (b)(6)-2

24° chart checked 29 JUN 03 (b)(6)-2

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-2

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

DATE OF ORDER: 6/29 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN: (b)(6)-2

1) CXR in AM 6/30

(b)(6)-2

2) q4° chest check (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

noted 1730 30 Jun 03 (b)(6)-2

DATE OF ORDER: 30 Jun 03 | TIME OF ORDER: 1730 HOURS

1) Mylox 20cc po now and q6° prn nausea

(b)(6)-2 MD

01 July 03 0500 (b)(6)-2 1LT/AN 24°✓

1 Jul 2003 1620

noted 1620

1) D/C Ancef

VO: Dr (b)(6)-2 / 1LT (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

24°✓ 02 July 03 @ 0230 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7/2 | TIME OF ORDER: 0930 HOURS

DC to EPW Cage with MPs

V.O. Dr (b)(6)-2 / (b)(6)-2 ..., AN

noted 3 July 03 (b)(6)-2

2) q4° chest check (b)(6)-2

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

C ...ICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
29 Jan 03	1430 HOURS	
Place CT to enter seal.		
V.O. Dr. (b)(6)-2 (b)(6)-2		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

DA FORM 1 APR 75 4256 REPLACES EDITION OF 1 JUL 77, WHICH 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/Jun Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	21	22	23	24	25	26	27	28	29	30	1	2
20Jun	(b)(6)-2	chest tube x2 to 20cm	05	(b)(6)-2						D/C d/t						
		suction	17	(b)(6)-2												
20Jun		NGT to LIS	05	(b)(6)-2						D/C 6/21/03						
			17	(b)(6)-2												
20Jun		Foley to gravity	05	(b)(6)-2						D/C d/t		23 June 03				
			17	(b)(6)-2												
20Jun		Vent settings: TV 700,	05	(b)(6)-2												
		Peep 5, Rate 18, FIO2 100%	17	(b)(6)-2						D/C 6/21/03						
		wean FIO2 as needed														
20Jun		CBC + chem 8 Qam	04	(b)(6)-2								D/C'd 26 Jun 03				
22Jun03		OOB → chair BID	05	(b)(6)-2												
			17	(b)(6)-2												
23 Jun		Chest tube to water seal	05													
			17													
23 June		Portable CXR q AM	04													DEMISE
24Jun03		CT to suction	05													D/C'd
			17													29 June 03
23Jun		Portable CXR q AM	04													
28Jun		NIO: ISO,	06													
			14													
			22													
29Jun		CT to interval	06													
	------		14													
	------		22													D/C

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS: S/P GSW / S/P ⓐ Thoracotomy

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

PATIENT IDENTIFICATION:

(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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 6 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20Jun	(b)(6)-2	Admit to ICU	20Jun	—	1015	(b)(6)-2
20Jun		Labs now + QAM: CBC, Chem 8	20Jun	—	1030	
20Jun		CXR upon arrival to ICU	20Jun	Now	done	
20Jun		Abgs in 30 min	20Jun	/	2300	
20Jun		↓ VT to 650, FiO_2 50%	20Jun	/	2300	
20Jun		Abg in 30 min	21Jun03 ~~20Jun~~	/	0015 ~~2300~~	
20Jun		↓ FiO_2 to 45%, ↓ TV 600, ↓ SIMV 14	21Jun03	/	0030	
21Jun03		Get UA	21Jun03	/	0200	
21Jun03		CXR portable	21Jun	/	2100	
23Jun		I&O catheter	23Jun	0600	0400	
26Jun		D/C labs	26Jun	AM	—	
26Jun		Xray 6/27 AM	27Jun	AM	Done	
27Jun		CXR in AM	30Jun	AM	Done	
7/2		DC to Camp c̄ MD	7/2	Today		

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

USAPA V1.00

MEDCOM - 6230

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 20 21 22 23 24 25 26 27 28 29 30 01 2 5
20Jun	(b)(6)-2	Ancef 1gram IVP Q6°	04	(b)(6)-2
			10	
			16	
			22	
20Jun	(b)(6)-2	Zantac 50mg IVP BID	10	Order DC 23Jun03
			22	
20Jun	(b)(6)-2	LR @ 100cc/hr	05	D/C 6/20 @ 1250
			17	
20Jun	(b)(6)-2	Fentanyl gtt, titrate to effect (1000mcg/100ml NS)	05	D/C 1000 6/21/03
			17	
			05	
			17	
20Jun	(b)(6)-2	Propofol gtt, titrate to effect	05	D/C 1000 6/21/03
			17	
20Jun	(b)(6)-2	LR @ 75cc/°	05	D/C 6/20 @ 1600
			17	
20Jun	(b)(6)-2	LR @ 100cc/°	05	date changed 20Jun 03.
			17	
20Jun 03	(b)(6)-2	↑ maintenance IVF to 200cc/hr	05	D/C 6/21 1100
		(LR)	17	
21Jun	(b)(6)-2	LR @ 100cc/°	05	
			17	
22Jun03	(b)(6)-2	LR @ 75cc/hr	05	
			17	
23Jun03	(b)(6)-2	Zantac 150mg po BID	10	
			22	
		~~Qz WEAN~~ enox	(b)(6)-2	

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
S/P GSW chest /STP @ Thoracotomy

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

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20Jun03	(b)(6)-2	↓ FiO_2 to 60%	20Jun	/	2300	done by [illegible] (b)(6)-2
20Jun		20mg Lasix IVP now X1	20Jun 03	/	1530	done by CPT (b)(6)-2
20Jun03		250ml LR bolus X1 now	20Jun03	/	2100	done by CPT (b)(6)-2
21Jun03		250 ml LR Bolus X1 now	21Jun03	/	0200	(b)(6)-2
21Jun03		Lasix 20mg IVP X1 now	21Jun	/	2100	
21Jun		Lasix 20mg IVP X1 now	21Jun	/	2325	
21Jun03		Albuterol 2.5mg in 3ml X1 now	22Jun03	now	0025	
22Jun 03		Lasix 20mg IVP x i now	22 Jun 03	0730	0730	(b)(6)-2
22Jun03		Lasix 20mg IVP x i now	22 Jun 03	0130	0130	
[illegible]		D/C Ancef			1620	
2 July		D/C to EPW Camp w/ MPS				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
21 Jun	(b)(6)-2	MSO4 4-6mg IVP Q 2° prn pain	21Jun 1200 5mg IVP; 21Jun 1400 5mg IVP; 21Jun03 1945 4mg IVP; 21Jun03 2330 5mg IVP; 22 Jun 0400 6mg IVP; 22 Jun 0600 4mg; 22 Jun 0800 3mg; 22 Jun 1600 3mg; 22 Jun03 1900 5mg IVP; [illegible] 2300 4mg; 28 JUN 2200 6mg; 29 JUN 2330 4mg; 30Jun 0200 1800 4mg (b)(6)-2
21 Jun	(b)(6)-2	Toradol 30mg IVP Q8° prn pain	21Jun 1400 30mg IVP; 21Jun 2320 30mg IVP; 22 Jun 1100 30mg IVP; 22Jun 03 1900 30mg IVP; 23 Jun 03 0400 30mg; 24Jun 1515 30mg IVP (b)(6)-2
21 Jun	(b)(6)-2	Tylenol 650mg PO Q4° prn fever >101.5	21Jun 1400 650mg PO; 22 Jun 03 0400; 22Jun 1500 650mg; 24Jun 03 1900 650mg PO; 25Jun 1200 650 (b)(6)-2
22 June	(b)(6)-2	Percocet i-ii po Q4-6° (b)(6)-2	22 June [illegible]; 23 Jun 0530 ii; 23 1830 ii; June ii; 24 Jun ii 0200; 24 Jun [illegible] 2100; 25 [illegible] 0510; 26 Jun 1800 ii; 27 Jun 2130 ii; 1 July 1830 (b)(6)-2

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MEDCOM - 6232

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.

Marine Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29	30	1	2	3
24 Jun	(b)(6)-2	O_2 - WEAN	05	/	(b)(6)-2							D/C'd		
			17	(b)(6)-2										
24 Jun	(b)(6)-2	Flagyl 500mg PO x 10 days,	08	/	/	(b)(6)-2								/
		1st dose now (PO)	16	(b)(6)-2		(b)(6)-2								/
			24	/	(b)(6)-2									/
25 June	(b)(6)-2	Bentyl 20mg p.o.	06	/	/	/	(b)(6)-2							
		Q12 - 1st dose now	12	/	/	/								
			18	/	/	/								
			24	/	/	(b)(6)-2	Held							

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
S/P GSW (R) chest S/P (R) thoracotomy

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	

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. Jun Yr. 2003

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
30Jun	(b)(6)-2	Maalox 20cc po now	(b)(6)-2 Now	now	1730	(b)(6)-2
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
25Jun03	(b)(6)-2	Benadryl 50mg p.o QHS prn insomnia	
~~26Jun03~~	(b)(6)-2		
26Jun	(b)(6)-2	Zofran 4mg IV q 4° prn nausea	26Jun 4mg 1200 (b)(6)-2; 27Jun 4mg 0030; 29Jun 4mg 2300; 30Jun 4mg IV (b)(6)-2
- - - - -	- - - - -		
27Jun	(b)(6)-2	Bentyl 20mg QID, prn stomach cramps	
- - - - -	- - - - -		
30Jun	(b)(6)-2	Maalox 20cc PO prn Q6° nausea	01Jul 0100 2006 (b)(6)-2; 03Jul 0016 2250 (b)(6)-2
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		

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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.

Medical Y rOB

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23 24 25 26 27 28 29 30 1 2 3
24 June	(b)(6)-2	O_2 - WEAN	05	(b)(6)-2 D/C'd
			17	(b)(6)-2
24 June	(b)(6)-2	Flagyl 500mg PM x 10 days, 1st dose now (PO)	18	(b)(6)-2
			16	(b)(6)-2 (b)(6)-2
			24	(b)(6)-2
25 June	(b)(6)-2	Bentyl 20mg p.o. QID 1st dose now	06	(b)(6)-2
			12	
			18	
			24	(b)(6)-2 Held

ALLERGIES: ☐ YES ☐ NO — unknown

PRIMARY DIAGNOSIS: S/P GSW (R) chest S/P (R) thoracotomy

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	

POST-OP DAY 23 24 01 02 03 04 05

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	23	24	01	02	03	04	05	
	100/72	94/66	114/85	85/76				
	99	87/48	97/57	93/44	98/47	98/48		
	994	98.3		98.6		98.1		
	80	95	86	85	74	75		
	16	16	14	14	14	15		
	100%	100%	100%	100%	100%	100%		
	50	50%	45%	45%	45%	45%		
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		

INTAKE

	23	24	01	02	03	04	05	
								287
	200	200	200	200	200	200		287
	0							200
	10	10	10	10	15	15		165
	19.8	19.8	19.8	19.8	13.2	9.9		222
	—							
	0			250				500
	—							6
								3968

OUTPUT

	23	24	01	02	03	04	05	
	30	30	30	25	35	40		1660
	1500	1530	1560	1585	1620	1660		
	25							
	0							
	0							
	4	10	15	5	0	5	0	219
	22	6	10	10	10	5	5	219
								2098

RESPIRATORY THERAPY

	TIME	1100	1230	1330	1800	2300	2305	2400	0030
	MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	F_iO_2	100	50	70	70	60	50	50	45
	TV	700	700	700	700	700	650	650	600
	RATE	18	14	16	16	16	16	16	14
	PEEP	5	5	5	5	5	5	5	5
A	pH	7.43	7.28	7.39		7.551		7.46	
A	PCO_2	30	45	34		26.3		31.5	
A	pO_2	231	69	160		161		100	
B	HCO_3	20	21	21		23		23	
B	SAT	100%	90%	99%	100%	100%		98%	
G	BASE	-4	-6	-4		1		-1	

LABS/DIAGNOSTIC DATA

	TIME	1030							
	GLUCOSE	121							
	Na/K	138/3.50							
	Cl/CO_2	107/21							
	BUN/Cr	9/.6							
	WBC/PLATELET	15/168							
	Hct/Hgb	10.8/33.9							

ACTIVITIES OF DAILY LIVING

	TIME					TIME							
	MOUTH CARE				TURN	q2h							
	BATH												
	SKIN CARE												
	FOLEY CARE				SUCTION								
	TRACH CARE												
	ROM EXERCISES												

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	_____	Urine: _____
po	_____	_____
	_____	_____
TOTAL	3968	TOTAL 2098

BALANCE +1870

NURSE'S SIGNATURE — INITIALS

(b)(6)-2 (b)(6)-2 (b)(6)-2 ILT AN

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME 1030 INITIALS [illegible]	TIME 1830 INITIALS [illegible]
NEURO	PUPILS	1mm, minimal reaction to light	Reaction slow-sluggish 2mm/2mm
	SENSORIUM	Sedated on 15mcg/kg/min propofol	SEDATED: Propofol 24 mcg/kg/min
		pain control ē 50mcg/1° fentanyl	Analgesia: fentanyl 100 mcg/hr
		Occasionally awakes spontaneously	⊕ intermittent spontaneous
		ē purposeful movements of Ⓡ UE	awakening ē Bilat upp. ext. movem[ent]
RESPIRATORY	RESPIRATORY PATTERN	Vent SIMV Rate 16, FIO2 70, TV 700	VENT SIMV R: 16 FIO2 70 TV 7[00]
	BREATH SOUNDS	Peep 5, sats 100%. #8 ET 23cm lip	peep 5, sats 100%. #8 ET @
	SECRETIONS	Small amount bloody secretions	23cm @ lip. ⊕ CT x 2, Ⓡ side
		suctioned initially upon return from	#1 posterior. Ø Δ in dressing drain
		OR. Ⓡ CT x2 (anterior, posterior)	#2 anterior - Ø Δ in dressing
		Ⓛ lung clear, Ⓡ lung ē pleural rub	drainage as marked on previous a[ssessment]
SKIN	COLOR	pale, warm, dry	BS: clear throughout, diminished
	INTEGRITY	Incision to Ⓡ chest wall ē dsg	in Ⓡ region of incult.
		drainage marked. Ø gross bleeding	
IV SITE	LOCATION	16g Ⓛ EJ - patent - LR @ 125cc/h	16 S EJ - opsite dsg CT - secured.
	CONDITION	18g Ⓛ FA - patent - HL	Ø evidence infect./infilt. ⊕ LR infusing
	IV meds -	Zantac 50mg IVPB BID	@ 100cc/hr. Fentanyl @ 10cc/hr / Propofol @
		Ancef 1gm Q 6°	mg/cc ⊕ 18 g Ⓛ AC opsite CT ~ [illegible]
	gtt -	fentanyl 10mcg/cc	Ø evidence infection ⊕ flush Ø Br[illegible]
		propofol 10 mg/cc	A-line Ⓡ Radial transduced: zeroed
GASTRO	ABDOMEN	Soft N/T, BS ⊕ Ø Stool	⊕ waveform, ⊕ secured.
	BOWEL SOUNDS	NGT in place to LIS, minimal	BS: ↓ BS x 4 q. abd soft, non
		output. Ø N/V/D, to cont.	distended, Ⓛ BM. NGT intact,
		remain NPO.	Ⓡ nare draining to LIS, minimal
GU	URINE:	Clear medium yellow, ↓ to	light brown OP.
	COLOR/CLARITY	1cc/kg/hr from 2-4cc/kg/hr	Indwelling foley to gravity, clear
		post op. Ø bladder distention	yellow urine UOP > 30cc.
CARDIOVASCULAR	CARDIAC RHYTHM	Initially bradycardic upon	NSR, tachy ~110's BP: 90's
		return from OR, now NSR	systolically, 50's diastolically
		rate 70-90, BP elevated (slightly)	- stable. T: 100.3
		but stable, Afebrile	Radial pulses Bilat +2. Pedal Bilat
			2+, cap refill ≤ 3sec. Ø swelling.

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 East

DATE: 20 Jun 03

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

(b)(6)-4 [redacted]

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

DATE		OR 05	06	07	08	09	10	11	12	13	14	15	16	17	HOSPITAL DAY 18	19	20	21	22
VITAL SIGNS	TIME																		
	BP Arterial Line						143/81	149/93	166/78	139/79	138/65	137/74	125/67	117/64	97/58	92/50	95/56	88/49	90/53
	BP Cuff						113/52	128/87	124/61	114/65	110/64	114/64	114/68	105/58	94/58	95/58	91/59	92/50	
	Temperature						93.5	95.1	96.0	98.3	98.5	99.2	100.6		100.3	100.1	100.9	100.5	99.9
	Pulse						61	59	78	81	77	91	92	109	112	111	112	100	100
	Respiratory Rate						25	14	14	18	16	16	16	16	16	16	16	16	16
	Sats						100	100	99	100	100	100	100	100	109	100%	100%	100%	100%
	FIO_2						100	100	50	40	70	70	70	70	70	70	70	70	60
	mode						SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	Simv	Simv	SIMV	SIMV	SIMV	Simv
	pain																		
	intervention																		
INTAKE	TIME																		
	time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
	LR						100	100	125	175	175	175	175	100	100	100	100	100	100
	IVPB							50					50	Ø	Ø	Ø	Ø	Ø	100
	Fentanyl							5	5	5	5	5	10	10	10	10	10	10	10
	~~Versed~~ Propofol							5	5	6	8	8	8	13.2	13.2	13.2	13.2	7	19.8
	Bolus/Blood																		
	Bolus LR																	250	
	Bolus Propofol															2cc		4cc	
	TOTALS						100	160	185	186	188	186	143	123.2	123.2	125.2	143.2	292	229.8
OUTPUT	URINE HOUR / TOTAL						0R	200 / 200	200 / 400	100 / 500	50 / 550	50 / 600	50 / 650	150 / 800	150 / 950	200 / 1150	150 / 1400	40 / 1440	30 / 1470
	sp gr																		
	S/A																		
	NG OUTPUT						Ø				25				75	Ø			
	NG pH																		
	NG GUIAC																		
	EMESIS														Ø	Ø	Ø	Ø	
	STOOL														Ø	Ø	Ø	Ø	
	DRAINS CT#1						52	38	34	4	7	2	4	2	3	6	10	12	6
	DRAINS CT#2						28	30	9	12	18	14	7	3	3	4	12	12	4
	TOTALS						80	68	43	16	25	16	11	5	6	10			

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS (b)(6)-2		INITIALS (b)(6)-2		INITIALS (b)(6)-2
NEURO	PUPILS	1-2mm minimally reactive		3mm Reactive			
	SENSORIUM	Propofol to 30mcg/°; fentanyl to 50mcg/° to extubate awake & Sport, moves all extremities		Alert and oriented moves all extremities.			
RESPIRATORY	RESPIRATORY PATTERN	Vent SIMV Rate 14, TV600		easy, nonlaboreal.			
	BREATH SOUNDS	FIO_2 45% Peep 5, breathing		diminished to RLL			
	SECRETIONS	over vent when awake		nonproductive cough.			
		Sats 100% Breath sounds		on 10L NRB mask; IS x 10			
		Clear, diminished @		↑ to 600 cc/sec. Right chest tube			
		pleural rub on (R) X-ray done		x2 patent, draining red drainage			
SKIN	COLOR	pale, warm + dry		WNL			
	INTEGRITY	Incision to (R) chest @		(R) chest drsg c drainage: unable			
		dsg @ new drainage noted		monitor, (+) crepitus in returns			
SITE	LOCATION	Hep to (A) ET @ 18 @ 20cc		(L) Hep lock, PIV @ LR @ 100 cc/hr			
	CONDITION	18G to (L) FA HL		Patent, (+) blood return			
	Aline	20G to (R) RAD @ poor wave form		dsg change done to site			
	CT #1	posterior chest 0-5cc/° bloody		PIV to heplock to left			
	CT #2	anterior chest 0-5cc/° bloody		AC, flushed, patent, (+)			
				blood return			
GASTRO	ABDOMEN	Soft, flat N/T BS(+)		soft, flat			
	BOWEL SOUNDS	NGT to LIS @ 25cc/40		(+) BS x 4 quads			
		brown drainage @ stool		adult jello (=) N/V.			
		@ N/V/D, remains NPO		(+) BM.			
GU	URINE:	medium yellow @		clear foley → grant to			
	COLOR/CLARITY	(hypoglobunemia) 1cc/kg/hr		clear yellow, patent			
		@ bladder distention					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR 70's, BP stable		sinus tach → sinus rhythm			
		afebrile H/H 26/8		VSS (+) pulses x4. Apical			
		pulses palpable x4 ext		pulse strong, regular, 5			
		leaks, ABG drawn		beats/min.			
	Plan:	Extubate this am					

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 21 Jan 03

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)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DATE 21-22 June 03 | DX S/P Gunshot Wound to chest s/p ex thoracotomy | HOSPITAL DAY

	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
VITAL SIGNS	BP Arterial Line	93/44	NA	NA	NA	NA	NA	N/A											
	BP Cuff	98/48	92/44	101/46	102/49	108/48	121/63	101/57	119/60		112/56	106/59	102/54	101/47	105/53	107/53	101/48	100/59	
	Temperature		98°				99°					102¹		100⁹		99⁶	99⁴		
	Pulse	75	73	72	89	96	105	92	105		115	111	102	88	90	101	88	90	
	Respiratory Rate	18	15	16	17	19	32	21	38		38	39	24	21	22	28	21	23	
	Sats	100%	100%	100%	99%	99%	97%	99%	100%		95%	98%	98%	100%	99%	99%	99%	99%	
	FiO_2	45	45	45	45	45	12L	12L	10L		10L	10L	10L	10L	10L	10L	10L	10L	
	Mode	SIMV	SIMV	SIMV	SIMV	SIMV	NRB	NRB	NRB		NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	
	pain																		
	intervention																		

	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
INTAKE	LR	200	200	200	200	200	200	100	100	1400	100	100	100	100	100	100	100	100	
	IVPB	50					100							50					
	Fentanyl	15	15	15	5	0	0	D/C		40									
	Propofol	8³	8³	7	3	0	0	D/C		26.6									
	PO															120			
	Subtotal										100	100	100	150					
	TOTALS	273	223	222	208	200	300	100	100		100	100	100	400					

		HOUR / TOTAL	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
OUTPUT	URINE		65/65	60/125	70/195	70/265	100/365	50/415	75/490	75/565	565	200/765	125/890	75/965	150/1115	65/1210	275/1485	150/1635	100/1735	1735
		10 gr																		
		S/A																		
	NG	OUTPUT		25°				D/C			25									
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	CT #1	0	10	5	5	10	25	5	5	5	15	0	0	5	20	5	10	15	
		CT #2	5	15	10	10	10	25	5	5	5	50	20	0	25	5	5	5	15	
	TOTALS		70												210					

110 BS RS 12

POST-OP DAY

VITAL SIGNS

21	22	23	24	01	02	03	04	
118/69	102/55	109/60	99/53	104/52	102/54	102/51	106/58	
	99⁸	99⁹			99⁶		101⁷	
89	105	104	91	102	99	100	116	
36	30	38	25	31	33	32	35	
84%	98⁶	94%	96%	99%	99%	100%	98%	
10L NRB	10L	10L	10L	10L	10L	10L	50%	
NRB	NRB	NRB	NRB	NRB	NRB	NRB	VM	

INTAKE

21	22	23	24	01	02	03	04	24⁰
100	100	100	100	100	100	100	100	3000
	100						50	350
								50
								26.6
							50	170
								3597

OUTPUT

								5185
500 / 500	960 / 1460	725 / 2185	575 / 2760	500 / 3260	100 / 3360	50 / 3410	40 / 3450	3450
↑		↑						
20mg IV Diuril		20mg lasix						
25	5	5	5	5	0	5	0	185
20	5	5	0	5	0	0	5	220
								5590

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0500
MODE	SIMV
F_iO_2	45%
TV	600
RATE	14
PEEP	5
ABG pH	7.39
PCO_2	38.1
pO_2	78
HCO_3	23
SAT	96%
BASE	-2

LABORATORY DATA

TIME	0400	22 0020
GLUCOSE	87	
Na/K	136 / 4.0	
Cl/CO_2	107 / 24	
BUN/Cr	12 / 0.9	
WBC/PLATELET	9.0 / 148	
Hct/Hgb	8.8 / 26.8	
CK / Lymph%	1848 / 22.9	
RBC / MCV	3.10 / 88.7	

ACTIVITIES OF DAILY LIVING

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

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE — IV ________ po ________

OUTPUT — Urine: ________

TOTAL 3597 TOTAL 5590

BALANCE ⊖ 1993

NURSE'S SIGNATURE | INITIALS

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

(b)(6)-2

DATE		DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS	TIME	~~[illegible]~~	~~[illegible]~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
	BP Arterial Line																		
	BP Cuff	109/58	100/50	102/67	109/61	111/55	104/51	109/56	109/52		81/54	103/57	106/54	102/52	104/53	103/51	110/63	102/46	
	Temperature	100.8		100.3	100.1	100.4			100.4				101.9		101		101.9	100.8	
	Pulse	112	103	97	104	108	101	109	117		117	109	117	109	101	104	119	113	
	Respiratory Rate	41	25	40	32	27	28	42	42		45	45	38	39	41	28	32	45	
	Ventimask 50%	10L	10L	NRB	Sim	11	Sim	12	12		12	12	12	12	NRB 12	NRB 12	NRB 12	Ventimask 50%	
	Sats	97%	95%	98%	100%	100%	100	100	99		100	99	100	100	100%	100%	99%	100%	
	Meds																		
	[illegible]																		
	intervention																		
INTAKE	TIME	~~05~~	~~06~~	~~07~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	8°T	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	8°T
	LR	100	100	100	100	75	75	75	75		75	75	75	75	75	75	75	75	
	PO				50				250										
	IV meds						100							50					
OUTPUT	TOTALS	100	100	100	150	75	175	75	325		75	75	75	125	75	75	75		
	URINE HOUR/TOTAL	70/70	0/	15/85	700/785	25/810	0/810	0/810	15/825		125/940	125/1065	0/1065	20/1085	30/1115	35/1150	25/1175	20/1195	
	URINE 10 SP																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT #1	10	0	5	0	0	0	5	10		15	25	0	0	0	0	10	10	
	DRAINS CT #2	10	0	5															
	TOTALS	90	0	90	750	810	810	810	825		965	2000	3057	4152	4227	4302	4402	4502	

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME 0530 INITIAL (b)(6)-2	1720 INITIALS (b)(6)-2	2320 INITIALS (b)(6)-2
NEURO — PUPILS	3mm, PERLA	PERRL	PERRL 3mm 3mm
SENSORIUM	Alert & oriented, awake, responds appropriately	Sleepy, but easily arousable to verbal stimulus	sleeping-awakens to external stimuli; alert oriented; moves all extremities; follows command[illegible]
RESPIRATORY — RESPIRATORY PATTERN	labored-rate 40-50	tachypneic 20-30s	Tachypneic - 24-27 BPM
BREATH SOUNDS	Rhonchi throughout, ↓ Ⓡ base	clear to upper lobes, scattered wheeze to LLL, diminished to RLL. Chest tube x1 to Rt chest, drsg intact. on 12L NRB mask	Chest movement symmetric[illegible] BS: crackles Ⓛ lower base Rhonchi Ⓡ UL; diminished Ⓡ m/L lobe.
SECRETIONS	Ø noted		Ø secretions orally. ⊕ CT Ⓡ anterior to [illegible] suction.
SKIN — COLOR	normal for race	WNL	skin: normal for race
INTEGRITY	intact - dressing to GSW entry/exit wounds in chest	small incisions ē stitches to [illegible] hand. Drsg DtI to Rt chest,	Dressing to Ⓡ mid clavicle[illegible]
IV SITE — LOCATION	Ⓛ IJ, Ⓡ FA	Rt neck PIV, flushes well	ē Ⓡ lateral thoracic re[illegible]
CONDITION	Ⓛ IJ patent ē LR @ 100cc/hr, Ⓛ FA patent, flushed, heplocked	⊕ blood return LR @ 75cc/hr infusing. left AC [illegible] heplock unable to flush, client pull back when attempted grimace, line d/c'd at this time	CDI, Ø drainage ⊕ Ⓛ EJ. LR infusing @ 75 cc/h. Ø site int[illegible] CDI, ⊕ BR, ⊕ positional.
GASTRO — ABDOMEN	soft, non-tender	soft nontender.	soft, nontender, non distended
BOWEL SOUNDS	⊕ x 4 quadrants	⊕ BS x 4 quads.	⊕ BS x 4 q.
GU — URINE:	Foley to gravity	foley → gravity	foley to gravity, UOP
COLOR/CLARITY	clear yellow	clear yellow Ø sediment.	dark yellow, concentrat[illegible] UOP ≥ 30 cc/h.
CARDIOVASCULAR — CARDIAC RHYTHM	NSR rate 100-105 see attached rhythm strip CT x 2 to 20 cm H₂O suction Output 5-10cc/° each	sinus tachycardia Ø ectopy pulses palpable x4 and strong. good cap refill.	NSR, S1 S2 present. HR 93-95 bpm. Ø peripheral edema cap refill <3 sec radial, pedal pulses x4 = +2

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

(Continue on reverse)

PREPARED BY (b)(6)-2 LPN/SGT | DEPARTMENT/SERVICE/CLINIC ICU 2 west | DATE 22 Jun 05

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

POST-OP DAY

VITAL SIGNS

21	22	23	24	01	02	03	04	
93/51	117/57	102/56	101/56	106/56	101/58	105/56	107/54	
	99.8	—	100.4			101.3		
99	112	93	94	96	109	101	114	
34	35	27	25	26	36	32	31	
vm 50%	vm 40	vm 40	vm 35%	vm 35%	vm 45%	vm 45%	vm 45%	
96%	94%	95%	96%	95%	96%	97%	96%	
				lasix				

INTAKE

21	22	23	24	01	02	03	04	24°
75	75	75	75	75	75	75	75	
		θ	θ	Ø	120	Ø	0	
	100	θ	θ	Ø	Ø	Ø	Ø	
75	175	75	75	75	195	75	75	2445

OUTPUT

25/1220	25/1245	19/1264	18/1282	20/1302	550/1852	175/2027	55/2082	2082
				Lasix 20 mg				
10	15	2	3	0	7	7	10	144
								10
35	40	21	21	20	557	182	65	2324

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0700	0830	2330	2330	0130				
MODE	Vent Mask	NRB	VM	vm	vm				
F_iO_2 (Vent mask)	50%	50%	40%	35%	40%				
TV									
RATE									
PEEP									
ABG pH	7.480	7.471							
PCO_2 44.9	42.4	40.8							
pO_2	56	67							
HCO_3	28	30							
SAT	87%	93%							
BASE	4	6							

LABORATORY DATA

TIME	0430							
GLUCOSE	103							
Na/K	139/3.7							
Cl/CO_2	99/26							
BUN/Cr	8/0.7							
WBC/PLATELET	9.2/168							
Hct/Hgb	27/8.9							

ACTIVITIES OF DAILY LIVING

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

24° I&O TOTALS

wt Yesterday ______ wt Today ______

	INTAKE		OUTPUT
IV		Urine:	2082
po			
TOTAL	2445	TOTAL	2321

BALANCE 119

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME 0530 — INITIALS (b)(6)-2	TIME 1830 — INITIALS (b)(6)-2	INITIALS
NEURO	PUPILS	3mm, PERLA	Perrl 3mm/3mm	
	SENSORIUM	alert & oriented, responds appropriately, follows commands	awake, alert, oriented, follows commands, moves all extremities vigorously.	
RESPIRATORY	RESPIRATORY PATTERN	rapid, unlabored	Tachypnic 20's-30's, non-labored	
	BREATH SOUNDS	Rhonchi Ⓡ side diminished base	" shallow, chest expansion equal, symmetrical	
	SECRETIONS	Ø noted	Ⓞ nasal flaring ⊝ retractions ⊝ accessory muscle use. BS - rhonchi bilat throughout. ⊕ CT to water seal	
SKIN	COLOR	normal for race	~~normal for race~~ ⊕ [illegible]	
	INTEGRITY	entry wound Ⓡ upper chest	serousanguinous drainage ⊕ dressing, dry intact, drainage yellowish noted to dressing [illegible]	
IV SITE	LOCATION	Ⓛ IJ, LR @ 75cc/hr	⊕ cough, [illegible] - non productive.	
	CONDITION	patent, Ø blood return but flushes	Dressing over CT insertion sites to Ⓡ lateral [illegible] midclavicular thoracic region. Patient [illegible] [illegible] to H_2O seal. ⊕ [illegible] infusing 75 cc/hr ⊝ evidence infection infiltration.	
GASTRO	ABDOMEN	soft, non-distended	soft, non tender	
	BOWEL SOUNDS	⊕ x 4 quads	non distended ⊕ BS x 4 q	
GU	URINE:	Foley to gravity	Ø foley - d/c'd early	
	COLOR/CLARITY	dark yellow, clear	pm UOP pending. No void @ this time	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR - sinus tach see rhythm strip	NSR - sinus tach. [illegible] ⊕ radial, pedal pulses 2+. ⊝ swelling peripherally. capillary refill ≤ 3 sec.	

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREP (b)(6)-2 SGT / LPN

DEPARTMENT/SERVICE/CLINIC: ICU 2nd west

DATE: 23Jun03

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

(b)(6)-4

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	—																	
BP Cuff	106/55	103/61	116/70	84/45	103/56	97/50	98/50	104/50	[illegible]/58	101/58	101/44	95/50	104/61	98/48	100/47	96/50	95/59	
Temperature	101.2				101													
Pulse	100	108	117	110	115	100	89	97	~~115~~	115	107	104	106	101	117	106	100	
Respiratory Rate	33	40	38	30	40	33	23	25	~~38~~	38	28	29	26	22	35	20	20	
Mode	VM	VM	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
FiO2	40%	40%																
SpO2	97%	95	98	99	99	99	100	100	96	96	98	99	100	100%	99%	99%	99%	
Liters O2	8L	8L	6L	6L	6L	6L	4L	4L	4L	4L	4L	5L	5L	4L	4L	3L	5L	
[illegible]																		

(b)(6)-2

(b)(6)-4

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8°
LR	75	75	75	75	75	75	75	75	~~75~~	75	75	75	75	75	75	75	75	
PO	120												0	Ø	240	Ø	Ø	
IV Meds	50							100					Ø	Ø	Ø	Ø	Ø	
TOTALS	245																	

OUTPUT

		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
URINE (Foley)	HOUR / TOTAL	0/0	Ø/Ø	10/10	20/30	20/50	100/150	75/225	10/285		Ø/285	Ø	Ø	Ø	Ø	0/Ø	Ø/Ø	15cc/300	
	sp gr										Foley D/c'd								
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS		0																	
STOOL		0																	
DRAINS	CT	5	5	5		Ø	10	10	Ø		Ø	Ø	Ø	15	5	18	10	5	
TOTALS																			

MEDCOM - 6246

POST-OP DAY 01 02 03 04

VITAL SIGNS	24	22	23	24	~~30~~	~~22~~	~~32~~	~~18~~	/
	95/59	105/51	[illegible]/5	107/61	99/48	98/55	128/68	98/54	
	100.1					98.7		100.0	
	100	98	100	104	91	89	103	98	
	20	22	20	29	18	19	34	21	
	NC	NC	NC	NC	NC	NC	[illegible] 30%	NC	
							NL		
	97%	100%	98%	95%	98%	97%	84%	99%	
	5L	.05L	3L	3L	3L	3L	5L	5L	
	Humidif						↓		
							VM		
							50%		
		Toradol				Percocet	↓ 95%		
							↓ NC		
INTAKE	21 26	17	18	19	20	21	22	23	8° T
	75	75	75	75	75	75	75	75	900
	120	Ø	Ø	240	Ø	Ø	0	240	960
	Ø	50	Ø	Ø	Ø	Ø	0	100	250
									2110
OUTPUT	Ø/290	Ø/290	Ø/290	0/290	0/290	0/290	0/290	450/740	740
							Foley Placed		
	X1					X1			
	5	Ø	Ø	5	Ø	10cc	10cc	~~450~~	~~740~~ (110)

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	0300	~~0300~~	0400					
	MODE	VM		NC					
	F_iO_2	50%		/					
	TV			✓					
	RATE			40					
	PEEP								
ABG	pH								
	PCO_2								
	pO_2								
	HCO_3								
	SAT								
	BASE								

LABORATORY DATA	TIME	0400							
	GLUCOSE	104							
	Na/K	128/3.5							
	Cl/CO_2	77/27							
	BUN/Cr	10/.05							
	WBC/PLATELET	9.4/194							
	Hct/Hgb	26/8.5							

ACTIVITIES OF DAILY LIVING	TIME	2300-0700		TURN / SUCTION	TIME
	MOUTH CARE	(b)(6)-2			
	BATH				
	SKIN CARE				
	FOLEY CARE				
	TRACH CARE				
	ROM EXERCISES				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	1150	Urine:	740
PO	960	Stool	X 2 app. 50cc
TOTAL	2110	TOTAL	790cc

BALANCE ______

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

- June 03

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		0530 TIME	INITIALS		INITIALS	2000	INITIALS
NEURO	PUPILS	Pupils 3mm+brisk.				Pupils 3mm Perrl	
	SENSORIUM	Round + reactive to light				9+0x3 @verbal	
		Alert and responds				to pain stimuli	
		appropriately to verbal					
		stimuli					
RESPIRATORY	RESPIRATORY PATTERN	lungs c course sounds				Diminished BS	
	BREATH SOUNDS	noted bilaterally, dim				bilat productive	
	SECRETIONS	breath sounds noted in				cough - weak effort	
		@ lower lobs. O2 sats 95-99%				NK 3L > sat 90%	
		on O2 @ 3-4L via nc. Resps				Desats at time of sleep	
		upon exertion. CT to chest				mouth breather	
SKIN	COLOR	Skin normal for race				normal for race	
	INTEGRITY	no evidence of skin					
		breakdown noted					
IV SITE	LOCATION	14 noted to @ ET patent				IV @ ES DSG	
	CONDITION	and c edema or				Dd & S/Sx of inf	
		erythema					
GASTRO	ABDOMEN	Abdomen round + soft				non-distended	
	BOWEL SOUNDS	c bowel sounds noted x				soft @ BM this	
		4 quads. Last BM last				shift	
		night					
GU	URINE:	Pt last voided c diuresis				+ void 200cc	
	COLOR/CLARITY	cath @ 0400. Will cont				dk yellow urine	
		to monitor bladder function					
CARDIOVASCULAR	CARDIAC RHYTHM	Normal sinus rhythm				normal Sinus	
		c rate in high 80's. @				Pulse rate 90-120s	
		palpable pulses in all				↑ upon exertion	
		extremities. No edema					
		noted.					

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU ~~Unit~~

DATE: 23 June 03

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

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

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

24 Jan 3

DATE 24 | DX CSW (R) chest | HOSPITAL DAY 5

	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
VITALS	BP Arterial Line																		
	BP Cuff	99/54	104/55	102/53	93/50	97/53	101/65	109/59	111/64		104/67	96/49	113/56	115/67	104/73	126/60	134/58	116/68	
	Temperature	100.0					97.5						99.6			98.8			
	Pulse	96	98	91	77	78	110	92	91		89	82	111	101	122	120	116	110	92
	Respiratory Rate	19	17	16	14	16	35	17	17		16	19	32	23	31	24	32	26	
	Sat%	99%	96	98%	100	98	95	98	98		100	100	93	96	97	96	93	91	
	Mode	NC	N/C	NC	N/C	N/C	N/C	N/C	N/C		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	NC
	flow rate	3L	3L	3L	3L	3L	3L	3L	3L		3L	3L	3L	3L	3L	3L	3L	3	3L
	humidified	Yes																	
	pain																		
	intervention																		

	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
INTAKE	LR	75	75	75	75	75	75	75	75	300	75	75	75	75	75	75	75	75	300
	PO	0	30				50								100			100	250
	IV meds	0					50						100						150
	Subtotal	75	105	75	75	75	145	75	75		75	75	175	75	75	75	75	175	150
	TOTALS	75	180	255	330	405	550	625	700	700	775	150	325	400	475				150

		HOUR / TOTAL	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
OUTPUT	URINE		0			—	x1										1900 200			
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUAIAC																		
	EMESIS		/																	
	STOOL		/				x1	x1		200				x1	x1					
	DRAINS	CT	0	0	0	5	0	50	0	0		0	0	0	0	0	0	0	0	
	TOTALS					5		55	255	255										200

24 June 03

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITALS / SIGNS

	24	22	23	24	01	02	03	04	
	101/55								
	92	96							
	16	22							
	91	92							
	NC	NC	NC	NC	NC	NC	NC	NC	
	3L	3L	3L	3L	3L	3L	3L	3L	

INTAKE

	24	22	23	24	01	02	03	04	8°T
	75	75	75	75	75	75	75	75	300
		50							50
									350
									1700

OUTPUT

			1200 2000						
	ϕ	ϕ							
									200
									650

RESPIRATORY

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

LABORATORY DATA

TIME	0400									
GLUCOSE	95									
Na/K	135 / 3.8									
Cl/CO_2	98 / 25									
BUN/Cr	14 / .7									
WBC/PLATELET	10.9 / 269									
Hct/Hgb	28.0 / 9.1									

ACTIVITIES OF DAILY LIVING

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

TURN

SUCTION

24 HR I&O TOTALS

NURSE'S SIGNATURE

INITIALS

(b)(6)-2

(b)(6)-2

(b)(6)-2

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1700	Urine:	650
po	X		
TOTAL		TOTAL	
		BALANCE	1050

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0530	INITIALS SS	1730	INITIALS		INITIALS
NEURO	PUPILS		2mm, PERLA		3— PERLA			
	SENSORIUM		Alert & oriented		A+O=3			
			responds					
			appropriately					
RESPIRATORY	RESPIRATORY PATTERN		unlabored, rate 20-35		RRR 30-35			
	BREATH SOUNDS		rhonchi @ side (R) diminished		rhonchi (R) side			
	SECRETIONS		Ø noted, pt is		diminished (R)			
			coughing productively		non-productive			
			but not spitting		cough & suction			
			sputum					
SKIN	COLOR		normal for race		normal for race			
	INTEGRITY		intact, GSW (R) upper		GSW to (R) chest			
			chest, chest tubes, te		CT to (R) side			
IV SITE	LOCATION		(R) IJ, LR @ 75cc/hr		(R) IJ LR @ 75			
	CONDITION		patent, infusing,		(R) IJ infusing			
			Ø s/s infiltration,					
			infection, dsg dd					
			last shift					
GASTRO	ABDOMEN		soft, non-distended		soft, non-distended			
	BOWEL SOUNDS		hyperactive x4 quads		hyperactive x4 @			
GU	URINE:		Ø urine out yet		dark yellow			
	COLOR/CLARITY		this shift					
CARDIOVASCULAR	CARDIAC RHYTHM		NSR		NSR			
			palpable pulses x4					
			HR 85-95					
			see rhythm strip					

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

(Continue on reverse)

PREPARED BY (b)(6)-2 LPN | DEPARTMENT/SERVICE/CLINIC ICU 2 east | DATE 23 Jun 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	05	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	13	~~14~~	~~15~~	
BP Arterial Line																		
BP Cuff	111/60	119/61	116/64	113/[illegible]	110/63	104/68	107/59	109/60		112/[illegible]	112/63	111/57	114/65	114/69	106/50	105/61		
Temperature	98																	
Pulse	89	91	94	86	88	93	81	95		88	95	94	117	106	108	87	87	
Respiratory Rate	26	30	34	23	13	32	27	27		31	39	31	42	34	34	30	32	
Sats	100	100	96	100	100	99	100	99		99	99	99	99	97	100%	100%	99	
O_2	6L	3L	3L	3L	3L	6L	6L	2L		2L	2L	2L	2L	6L	6L	6L	6L	
source			N/C	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
pain																		
intervention																		
INTAKE TIME	~~24~~	~~01~~	02	03	04	~~05~~	~~06~~	~~07~~	8° T	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	8° T
LR	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
PO					200		100	100										
IV meds						50												
Subtotal																		
TOTALS																		
OUTPUT URINE HOUR/TOTAL	Ø/Ø	Ø/Ø	Ø/Ø	Ø/Ø	Ø/Ø	Ø/Ø	Ø/Ø	Ø		Ø	Ø	Ø	Ø/Ø	Ø/Ø	0/0	0/0	0/0	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC			240cc	50cc		50cc												
EMESIS			X1	X1		X1							X1					
STOOL																Diarrhea x1		
DRAINS CT		10	15	10	Ø	10	Ø	Ø		5	Ø	5	15	Ø				
DRAINS																		
DRAINS																		
TOTALS																		

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

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	14	17	18	19	20	21	22	23
		140/61	137/63	101/57	106/61	103/59	113/67	118/61
		92	82	88	75	84	77	78
		27	32	34	31	32	34	32
		100	100	100	97	98	100	100
		2L	2L	2L	2L	2L	2L	2L
		NC	NC	NC	NC	NC	NC	NC

INTAKE

	16	17	18	19	20	21	22	23
	75	75	75	75	75	75	75	75
				50				50

8°T 1725 460 150

OUTPUT

	0/0	0/0	0/0	420/420	0/420	0/420	0/420	0/420
				Diarrhea x1				

420

RESPIRATORY

TIME										
MODE										
F_iO_2										
TV										
RATE										
PEEP										
ARTERIAL BLOOD GASES — pH										
ARTERIAL BLOOD GASES — PCO_2										
ARTERIAL BLOOD GASES — pO_2										
ARTERIAL BLOOD GASES — HCO_3										
ARTERIAL BLOOD GASES — SAT										
ARTERIAL BLOOD GASES — BASE										

LABORATORY

TIME	0400									
GLUCOSE	89									
Na/K	130/3.7									
Cl/CO_2	97/30									
BUN/Cr	15/0.7									
WBC/PLATELET	10/355									
Hct/Hgb	29.6/9.3									

ACTIVITIES DONE

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

TURN — TIME

SUCTION

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0530	INITIALS SS	1800	INITIALS SSL		INITIALS
NEURO	PUPILS		2mm, PERLA		Perrl 3mm			
	SENSORIUM		awake, alert, oriented, responds appropriately		awake dozy responds to verbal commands			
RESPIRATORY	RESPIRATORY PATTERN		unlabored, rate 20-30		somewhat labored			
	BREATH SOUNDS		rhonchi, diminished (R) side		breathing c exertion			
	SECRETIONS		productive cough, weak effort		rattly cough			
			IS q°					
SKIN	COLOR		normal for race		normal			
	INTEGRITY		CDI (R) upper chest - CT insertion site					
IV SITE	LOCATION		(R) IJ		(L) ES Dsg Δ'd			
	CONDITION		LR infusing @ 75cc/hr patent, Ø s/s infiltration		26 Jun @ 0530 site patent LR @ 75 cc/hr			
GASTRO	ABDOMEN		soft, non-tender		soft - non-tender			
	BOWEL SOUNDS		(+) x4 quads c/o pain & cramping episodes of diarrhea		normo active BS			
GU	URINE: COLOR/CLARITY		No urine yet this shift		will monitor.			
CARDIOVASCULAR	CARDIAC RHYTHM		NSR - see strip pulses palpable x4		normal sinus S1S2 cap refill brisk < 3 seconds			

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

(Continue on reverse)

PREPA (b)(6)-2 LPN | DEPARTMENT/SERVICE/CLINIC ICU 2 east | DATE 26 Jun 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE		DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITALSIGNS	TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
	BP Arterial Line																		
	BP Cuff	114/61	113/55	108/58	109/55	98/51	114/65	110/61	113/66		104/56	99/54	93/50	111/64	112/60	124/62	118/60	114/60	
	Temperature																		
	Pulse	78	80	75	83	68	88	79	92		95	89	85	85	92	90's	____	100's	
	Respiratory Rate	40	29	26	22	22	38	30	39		26	29	25	29	30	22	24	22	
	Sats	99	97	100	100	100	99	97	94		99	99	100	100	99	98	98	100	
	amt	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	
	method	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	pain																		
	intervention																		
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	75	75	75	75	75	75	75	75	300	95	75	75	75	75	75	75	75	300
	PO								200	200		-	200		50				250
	IV meds						50			50				50					50
	TOTALS									550									600
OUTPUT	URINE HOUR	0	0	0	0	100	0	350	0	450	0	400	0	0	0	0	0	0	750
	URINE TOTAL																		
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL					XT		XT				XT							
	DRAINS CT	~~0~~	~~0~~	20	20	10	0	15	25	120	25	10	10	0	0	5	5	0	55
	DRAINS	15	15																
	TOTALS																		

POST-OP DAY 2C | 2C 23 24 01 02 03 04

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23
	118/60	124/62	124/60	142/88	106/60	104/68	116/6-	102/5-
		99.6						
	96	98	98	106	108	92	90	88
	20	22	24	22	20	22	24	22
	99	99	99	100	100	98	99	99
	2L	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NC	NC	NC	NC	NC

RESPIRATORY

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

LABORATORY

	TIME	0500									
	GLUCOSE	96									
	Na/K	138/3.6									
	Cl/CO_2	101/33									
	BUN/Cr	11/0.3									
	WBC/PLATELET	12.1/484									
	Hct/Hgb	28.4/9									

ACTIVITIES OF DAILY LIVING

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

TURN

TIME						

SUCTION

TIME						

INTAKE

	16	17	18	19	20	21	22	23	8° T
	75	75	75	75	75	75	75	75	300
		100				100			200
				50				50	100
									600

TOTAL 1750

OUTPUT

	0	300	0	0	0				
	0	0	0	5	0	0	0	5	
									185

TOTAL 1435

24°H&O TOTALS

wt Yesterday	wt Today

INTAKE		OUTPUT	
IV	1100	Urine:	1250
po	650		
			185 drain
TOTAL	1750	TOTAL	1435

BALANCE +315

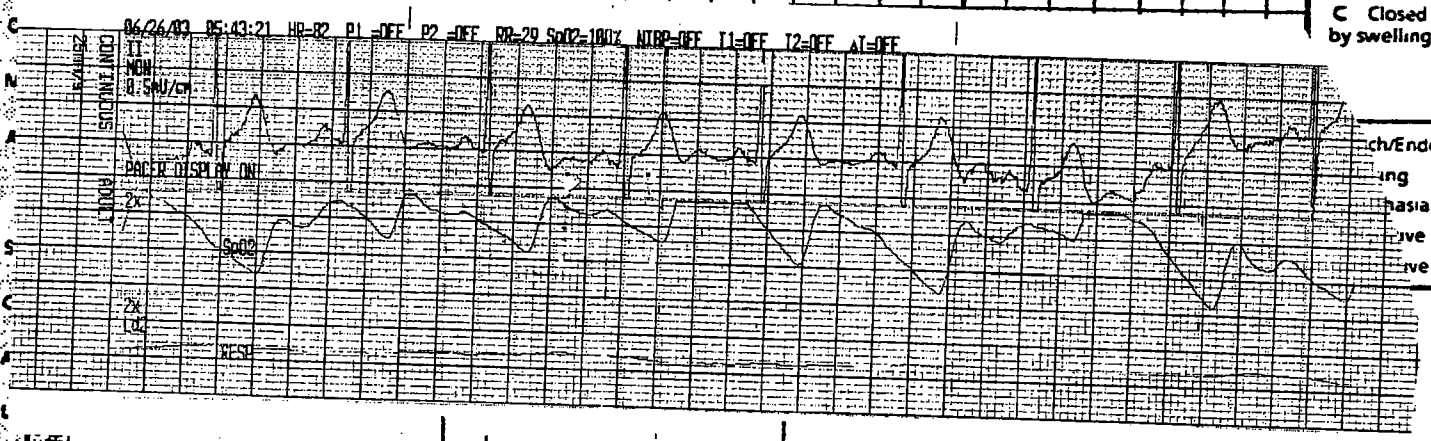
NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

NEUROLOGICAL ASSESSMENT

HOURS

LEGEND

C Closed by swelling



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ing
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LEVEL OF CONSCIOUSNESS

EXTENSION TO PAIN	2
NO MOTOR RESPONSE	1

LIMB MOVEMENT

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

R Right
L Left

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

PUPILS

RIGHT	SIZE	
	REACTION	
LEFT	SIZE	
	REACTION	

◆◆ Brisk
◆ Slow
- No Response

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

ICP

CEREBRAL PERFUSION PRESSURE

◆ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS

R	
L	
R	
L	
R	
L	
R	
L	
R	
L	

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME	0545	INITIALS (b)(6)-2	1730	INITIALS (b)(6)-2	INITIALS
NEURO	PUPILS	PEARL 4mm		ⓢ 3mm		
	SENSORIUM	Alert eyes open		A+O×3		
		on own ⊕ tactil				
		stimuli				
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		RRR		
	BREATH SOUNDS	↓diminished RML/RLL		diminished to Ⓡ side		
	SECRETIONS	clear RUL + L lung		Ⓛ side clear		
		Ø secretions		⊖ secretions		
		small nonproductive		non-productive cough		
		cough				
SKIN	COLOR	WNL		Normal for race		
	INTEGRITY	DSD over chest tube site		DRSG to Ⓡ chest over		
		DSD anterior CT site/DI		CT + Ⓡ posterior lung CDI		
IV SITE	LOCATION	Ø Ⓛ IJ		Ⓛ IJ		
	CONDITION	Ø infection Ø infiltration		⊖ ss of infiltration,		
		LR infusing @ 75cc/hr		⊖ infection		
				LR @ 75 cc/HR		
GASTRO	ABDOMEN	Soft non distended		soft - non-distended		
	BOWEL SOUNDS	⊕ 4 quads		⊕ ×4 hyperactive		
GU	URINE:	Ø at this time		none @ this time		
	COLOR/CLARITY					
CARDIOVASCULAR	CARDIAC RHYTHM	S_1 S_2 NSR		NSR		
		peripheral pulse +4		pulses ×4 to extremities		
		all extremities		cap refill < 3 sec.		
		1+ edema bilat Feet				

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 27 Jun 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ...)* (b)(6)-2 (b)(6)-4

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

28 Jun ← | 27 Jun →

DATE: DX | HOSPITAL DAY

	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
VITAL SIGNS	BP Arterial Line																		
	BP Cuff	104/53	101/52	104/56	99/53	111/65		107/58	115/76		104/57	104/60	92/46	98/55	101/55	103/56	91/45	109/53	
	Temperature	99.7		99.4				98.7			98.8	98.3	98.6	98.1	97.2	100.2	101.1	100.3	
	Pulse	83	74	70	84	111		89	98		83	114	106	100	78	103	105	100	
	Respiratory Rate	27	22	16	19	31		22	21		22	33	34	30	27	31	32	29	
	SpO_2	96	95	92	96	95		97%	98%		96%	94%	97%	98%	100	98	97	97	
	O2	2L	2L	2L	2L	2L		2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	
	pain intervention																		

	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
INTAKE	~~PO~~ IV	75	75	75	75	75	75	75	75/150		75/225	75/300	75/375	75/450	75/525	75/600	75/675	75/750	
	PO								320			180				480			
	IVPB												50						

	TOTALS																		
OUTPUT	URINE HOUR/TOTAL							700								1100/1100			
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT	20						35	30		5		25	15	0	0	50	20	
	DRAINS																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
	99/47	10/52	95/55	97/55	102/53	129/68	102/55	96/61	
	99	99				992			
	88	88	73	88	79	82	74	84	
	27	37	25	26	18	22	19	29	
	98	96	96	96	96	96	96	95	
	2L	2L	0	1L	0	1L	0L	0L	

INTAKE

	16	17	18	19	20	21	22	23	8° T
	75/825	0	75	75	75	75	75	75	
	50								
							50		

OUTPUT

					800				
	0	5	5	0	20	5	0	20	1480

RESPIRATORY

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

LABORATORY

	TIME	OKW								
	GLUCOSE	96								
	Na/K	138/5.6								
	Cl/CO_2	101/23								
	BUN/Cr	11/0.3								
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING

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

24° I&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S SIGNATURE	INITIALS

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME	0515	INITIALS [illegible]		INITIALS		INITIALS
NEURO	PUPILS	PEARL 2-3mm Brisk					
	SENSORIUM	reaction					
		Alert to tactil stimuli					
		Moves all extremeties					
RESPIRATORY	RESPIRATORY PATTERN	even unlabored					
	BREATH SOUNDS	diminished (L) lung, clear					
	SECRETIONS	(R) lung					
		Ø secretions Ø cough					
		at this time. Chest tube					
		to sx c̄ bloody drng					
SKIN	COLOR	WNL					
	INTEGRITY	DSD to Chest tube					
		insertion & infero-CT site					
IV SITE	LOCATION	(L) IJ					
	CONDITION	Ø infection Ø infiltration					
		heplock flushes s̄					
		difficulty					
GASTRO	ABDOMEN	soft nondistended					
	BOWEL SOUNDS	(+) 4 Quads					
GU	URINE:	Ø at this time					
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM	$S_1 S_2$ NSR					
		peripheral pulses (+)4					
		all extremeties					
		(+) edema bilat Feet					

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC
ICU 2 [illegible]

DATE
28 Jan 03

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

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

DATE		05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITALSIGNS	TIME	~~24~~	01	~~02~~	~~03~~	~~04~~	~~05~~	06	07		~~08~~	~~09~~	~~10~~	11	~~12~~	~~13~~	~~14~~	~~15~~	
	BP Arterial Line																		
	BP Cuff	106/58	~~108/54~~	~~104/60~~	~~102/64~~	~~92/54~~	~~99/62~~	~~99/66~~											
	Temperature		98.6	98.7	98.1	97.2	97.6	97.9											
	Pulse	76	82	99	124	115	104	92											
	Respiratory Rate	19	22	29	30	34	30	35											
	$S_c O_2$	95	96	94	92	96	96	97											
			(b)(6)-2																
	pain intensity	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
INTAKE	TIME	~~24~~	01	~~02~~	~~03~~	~~04~~	~~05~~	06	07	8°T	~~08~~	~~09~~	~~10~~	11	~~12~~	~~13~~	~~14~~	~~15~~	8°T
	LR	75	75																
	IVPB	50			450														
	PO				480	60													
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL																		
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT	15	20	15	20	14	Ø	5											
	DRAINS																		
	DRAINS																		
	TOTALS																		

POST-OP DAY								
	21	22	23	24	01	02	03	04
VITAL SIGNS	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~
	21	22	23	24	01	02	03	04
INTAKE	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	13
OUTPUT								

8°T

ACUITY LEVEL CLASSIFICATION

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

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

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

	TIME
TURN	
SUCTION	

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

____

TOTAL ________

OUTPUT

Urine: ________

____

____

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [illegible] LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	9 10 11: 0 0 0 (b)(6)-4	(b)(6)-4	16 17: —	18: M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 3 0 1 0 1	27 28 29: 2 0 4	30: X	31: 9	UNKOWN

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34: —	N/A	35 36: 9 9	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	0623	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N O	50 51 52: K 7 8	53 54 55 56 57 58 59 60 61: 0 9 3 2 3

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: 1 Z	64 65 66 67 68 69 70:	71: 9	YEAR: [ ] [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICW	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74: 0 5	75 76 77 78 79 80:	81 82 83 84 85 86 87 88: 2 0 0 3 0 7 0 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A B A A	93 94 95 96 97 98:	99 100 101 102 103 104 105 106: 2 0 0 3 0 6 2 0

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: 1 2	109 110 111 112 113 114:	115 116 117 118 119 120 121 122:

FOR LOCAL USE

DX: GSW TOCHEST

Dx: 8603
8820
E9912

Pr: 3402
3404

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)

(b)(6)-2 LTC, MC (b)(6)-2 (b)(6)-2 91G

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSC USAPA V1.00