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 | ROOM NO. | BED NO.

DATE OF ORDER 18 Sep 03 TIME OF ORDER 0900 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D 5 to Ensure plus 1-2 Cans q 6°
2. NPO p 3:00 AM (c° Before Surgery
3. D_5NS Era 125 cc After 3:00 AM
4. Creat / K^+ in AM

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 Sep 03 TIME OF ORDER 1030 HOURS

1. Restoril 15mg P.O q HS x PRN.
   If in P.M. Not asleep or x Hrs
   may Repeat 15mg p.o. x 1

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 Sep 03 TIME OF ORDER 1400 HOURS

- Restoril to 30mg P.O. QHS
- U.O. QAM

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 Sep 03 TIME OF ORDER 1625 HOURS

- CBC & diff
- Portable CXR - AP & Lat

18 Sep 1625

(b)(6)-2

---

18 SEP 03 0920

(b)(6)-2

WHICH M

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

19Sept03 _____ HOURS

Admit to ICU-1

(b)(6)-2

OOB QID — 5 or 6 times (b)(6)-2

Turn on side q 2°.

NG for feeds like

Bolus IJ care

Advance - oral DIET As tolerated

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

(b)(6)-2 1250 19Sept

Ensure (+) T-II Com q 6°.

D5 NS ℰ 20 mEq KCl /L TPA 100 c/°

Heplock when po good.

~~Foley~~

Ranitidine 150 mg IV q 24°

MSO4 2-10 mg IV q 1-2° PRN Pain

Tylox T-II po q 6° PRN Pain

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

Zosyn 3.375 gm IVPB q 6°.

Ditropan 5 mg po q 6° PRN Bladder spasm

Levoquin 500 mg IV q 24°

ZANAC 150 mg po - TP

change Dressing BID.

K+ Check ON 21 Sep 03

may Restrain as needed.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(b)(6)-2

Reglan 30 mg PO q HS.

PRN Insomnia

19Sep03 1250 (b)(6)-2

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

DATE OF ORDER 19 Sep 03 TIME OF ORDER 2130 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)-2

(1) Bisacodyl 50 mg po qH (b)(6)-2 (b)(6)-2

9/19 2200

NURSING UNIT | ROOM NO. | BED NO.

19 Sep 03 2240 (b)(6)-2 LTAN

PATIENT IDENTIFICATION

DATE OF ORDER 20 Sep 03 TIME OF ORDER 1300 HOURS

(1) D/C foley.
(2) AK ✓ UA After foley removed
(3) START New IV site
(4) D/C IV.
(5) D/C Gentamicin.
(6) If Temp > 101°, obtain Blood cultures x 2 sites x 2.

Noted 9/20/03 1340 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER (b)(6)-2

(7) TRANSFER to ICU-2 @ 1800 hrs
(8) Resume previous ORDER'S (b)(6)-2

Noted

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 22 Sep 03 TIME OF ORDER 1054 HOURS

(1) Start glipizide 5 mg po 1st dose at lunch today & then 1 breakfast & supper tomorrow

noted (b)(6)-2 SPC

(2) FBS Q A.M.
(3) U/A Q A.M (b)(6)-2 MD

Lieutenant (b)(6)-2 Chief, Depart (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

23 Sept 03 2355 (b)(6)-2

DA FORM 4256

MEDCOM - 1919

04
12
20

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4		22 Sep 03	
	(1)	Post-void residual	
	(2)	Packing c̄ iodoform, damp to dry dressings.	
	~~(3)~~	~~K+ KCL 20 mEq KCL in 50 cc NS ... over~~	
NURSING UNIT / ROOM NO. / BED NO.	(3)	KCL 40 mEq KCL in 50cc NS to run in over 2°.	noted (b)(6)-2
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER HOURS	
	(4)	K+ in AM. (b)(6)-2	
	(5)	Ⓡ Arm restraint as needed PRN (b)(6)-2	
	(6)	↓ ... T ... (b)(6)-2	
	(7)	Portable Ⓛ hip XRAY.	
NURSING UNIT / ROOM NO. / BED NO.		DATE OF ORDER 22 Sep 03 TIME OF ORDER 1213 HOURS	
PATIENT IDENTIFICATION	(1)	Ativan 2 mg IV now & then ... 2 mg IV Q8°	noted (b)(6)-2
	(2)	Post void residual urine	
		(b)(6)-2 Lieutenant Colonel, Medical Corp Chief, Department of Medicine	
NURSING UNIT / ROOM NO. / BED NO. 23 Sep 03 2358 (b)(6)-2		given	
PATIENT IDENTIFICATION		DATE OF ORDER 23 Sep 03 TIME OF ORDER 1500 HOURS	noted (b)(6)-2
	(1)	KCl 16 meq P.O. TID (3 times a day), preferably c̄ food	
	~~(2)~~	D/C HS Benadryl (b)(6)-2 Chief, Department of Medicine	
NURSING UNIT / ROOM NO. / BED NO.			

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.

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 23 Sep 03 TIME OF ORDER 1623 HOURS

(1) Flush FC in & out cath & assess bladder volume

(2) ↑ KCl to 20 meq p.o. TID c̄ food or drink

(b)(6)-2

(b)(6)-2

(b)(6)-2

Lieutenant Colonel, Medical Corps
Chief, Department of Medicine

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 25 Sep 03 TIME OF ORDER 0500 HOURS

(1) ✓ Transfer to EPW camp

(2) ✓ DIC FC

(3) ✓ DIC NGT

(4) F/U Surgery 1300 Spec Clinic Dr. (b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER HOURS

PATIENT IDENTIFICATION

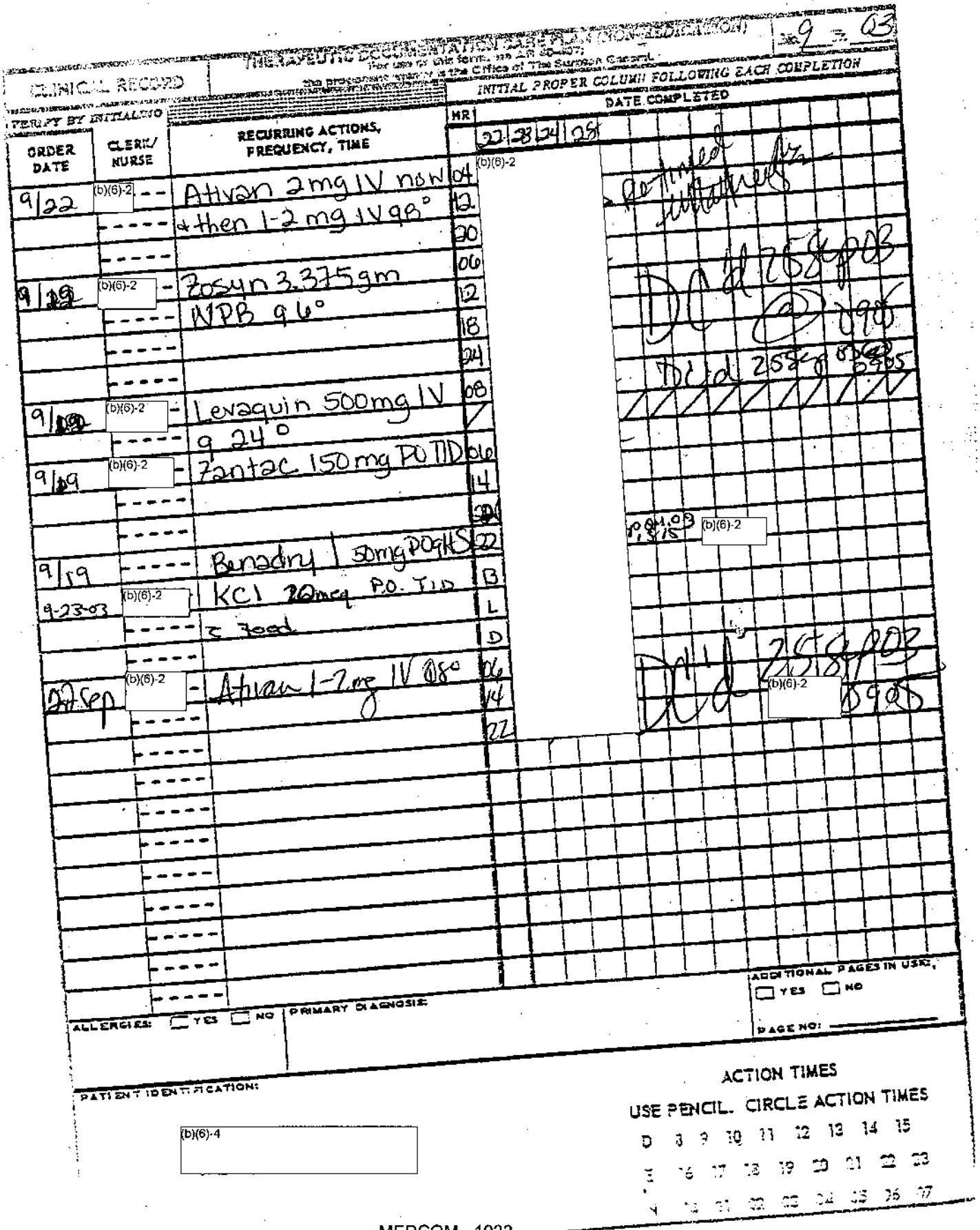
NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

MEDCOM - 1921



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION/CARE PLAN (CONTINUATION)

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
9/22	(b)(6)-2	Ativan 2mg IV now
		& then 1-2 mg IV q8°
9/22	(b)(6)-2	Zosyn 3.375gm
		NPB 9.6°
9/22	(b)(6)-2	Levaquin 500mg IV
		q 24°
9/22	(b)(6)-2	Zantac 150mg PO TID
9/22		Benadryl 50mg PO HS
9/22		KCl 20meq P.O. TID
9-23-03	(b)(6)-2	& Food
22 Sep	(b)(6)-2	Ativan 1-2mg IV q8°

DATE COMPLETED

HR: 22 | 23 | 24 | 25

(b)(6)-2

Refused Antibiotics

DC'd 25 Sep 03 0905

DC'd 25 Sep 03 0905

(b)(6)-2

ALLERGIES: YES NO

PRIMARY DIAGNOSIS:

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON MEDICATION)

Mo _____ Yr _____

Order Date	Clerk/Nurse	SIGNATURE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/22	(b)(6)-2	Glipizide 5mg PO c lunch today	9/22	1400	1350	(b)(6)-2
9/22		Glipizide 5mg po c breakfast	9/23	0730		
9/22		Glipizide 5mg PO c supper	9/23	1730	1830	(b)(6)-2
9/22		40mEq KCl in 50cc NS to run over 2°	9/22	ASAP	1345	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
19 Sept	(b)(6)-2	MSO4 2-10mg IV	
		q 1-2° PRN pain	
19 Sept		Tylox 1-2 po q 4°	22 Sep 1400
		prn pain	(b)(6)-2
19 Sept		Ditropan 5mg po	22 Sep 1400
		q8° prn bladderspasm	(b)(6)-2
19 Sep F		Restoril 30mg PO	
		qHS prn Insomnia	

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.

26 8 03

TEMPT BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27
26AUG	(b)(6)-2	Vitals - Q1° (routine	D	/	(b)(6)-2	
		for ICU)	E	/		DC'd 0900
			N	(b)(6)-2		
26AUG	(b)(6)-2	Activity - BR	D	/		
			E	/		
			N	(b)(6)-2		
26AUG	(b)(6)-2	Diet - clears → PEG	B	/		
		as tol	L	/		
			D	/		
26AUG	(b)(6)-2	CK Q8°, I strat-6,	06	/		
		Glucose, Cr, UA & MICRO	14	/		
			22	/		
26AUG	(b)(6)-2	Leave dispo for MD	D	/		
		to A	E	/		
			N	/		
26AUG	(b)(6)-2	Intake/Output -	D	/		
		If < 150cc/o for 4hrs	E	/		
		(give mannitol prn)	N	(b)(6)-2		
26AUG	(b)(6)-2	If pt needs foley cath	D	/		
		replaced or A'd Col	E	/		
		Borawski must do it	N	/		
26AUG02	(b)(6)-2	A VS to q2hrs	D	/		
			E	/		
			N	/		

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: poss. Rhabdo S/P I°D LUE/LLE, LUE BEA EX-FIX (L) Femur & limited internal fixation

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

PATIENT IDENTIFICATION: (b)(6)-4

(EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 8 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26 AUG	(b)(6)-2	Admit ICU-Z, Dr The — Dr Prevost	/	0700	/	/
		cond guarded				
26 AUG	(b)(6)-2	(b)(6)-2 ~~CBC~~, Chem 7 in AM	26 AUG	0600	0520	(b)(6)-2
26 AUG		CK Q8h	26 AUG	0600		
26 AUG		Please ask pharmacy to make up 2 bottles	/	(b)(6)-2 1400	/	/
		of Dextran Solution — have 1 @ BS	26 AUG	~~ASAP~~ 1600h		
26 aug	(b)(6)-2	NPO	26 aug	0800	done	(b)(6)-2

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

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.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22 23 24 25
9/22	(b)(6)-2	FBS QAM	05	(b)(6)-2
9/22		U/A QAM	05	
9/22		Change Dressings BID	10	
		Packing Chloroform Damp Dry	22	
9/22		BArm Restraint as	D	
		needed PRN	E	
9			N	
9/22	(b)(6)-2	Ensure plus 1 can	02	
		9 60°	08	
			14	
			20	
9/19	(b)(6)-2	OOB to chair 5 or	08	
		le times per day	11	
			14	
			18	
			21	
9/19		Benadryl 50mg PO q 6h PRN		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo _____ Yr ____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/22	(b)(6)-2	Post Void Residual	9/22	ASAP		(b)(6)-2
9/22		K+ in AM	9/23	0500	0500	
9/22		Portable (L) hip X-ray	9/22	ASAP	1400	
9/25		Transfer to EPW Camp	9/25	TODAY		
9/25		NC IV	9/25	Done	Done	
9/25		D/C NGT	9/25	ASAP	0930	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
9/30		If Temp >101°	
		Obtain Blood	
		Cultures x2 sites x2	

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.

26 8 TH 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28
26AUG	(b)(6)-2	IVF - NS@150cc/°	D	/	(b)(6)-2		
			E	/		D/C 26 aug 03	
			N	(b)(6)-2	/		
26AUG		Fancef 1gm IVPB TID	06	/	(b)(6)-2		
			14	/			
			22	/			
26AUG		Gentamicin 80mg IVPB	07	/			
		Q8°	15	/			
			23	/			
26aug03		Pen G IV 4million	03	/			
		units q 6°	09	/			
			15	/			
			21	/			
26aug		LR @ 200 cc/hr	D	/			
			E	/		D/C 27aug03 0800	
			N	/			
27aug		D5 1/2 NS @ 20KCL @	D	/			
	-----	110 cc/hr	E	/			
	-----		N	/			
27 Aug	-----	Albuterol Neb	06	/			
	-----	(std. adult dose) Q8°	14	/	/		
	-----		22	/	/		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P I&D LUE/LLE, LUE BEA
EX-FIX - LLE (femur) & internal fix

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

PATIENT IDENTIFICATION:
Poss Rhabdo

(b)(6)-4

(CEPW)

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 8 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26 aug	(b)(6)-2	dt 0.5 mg IM	26aug	0830	0832 ® delt	(b)(6)-2
26 aug		Tetanus IG 250 Units IM	26aug	0830	0830 ® quad	
26 aug		Bolus 1 L LR now	26aug	0930	0930	
		CBC ē afternoon labs	27aug	1400		
27 Aug		T&C x2units	27aug	0840	0840	

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED					
26 AUG	(b)(6)-2	Tylox I-II po Q4-6°	26Aug 1420	27Aug 0053				
		prn pain	2	2300 (b)(6)-2				
26 AUG		MSO4 2-4mg IVP Q1°	26Aug 0400	26Aug 0730	26Aug 1205	26Aug 1630	26Aug 2105	27Aug 1140
		prn pain	3mg (b)(6)-2	3mg	4mg	4mg	4mg	(b)(6)-
26 AUG		Mannitol 25g IVP	26Aug 25g	D/C 27aug03 0800				
		Q4° prn VOP < 100 cc/ 150cc/ 26aug	0500 (b)(6)-					

CLINICAL RECORD

Medication

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.

VERIFY BY INITIALING

28 Aug 05

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION — DATE COMPLETED: 27	28	29	30	31	1	2	3
27 Aug	(b)(6)-2	Ancef 1GM IV Q 6°	06	✓ (b)(6)-2							
			12	✓							
			18								
			24								
27 Aug	(b)(6)-2	Gentamycin 300mg IVQD	16						D/C 31 Aug 05 1030		
27 Aug	(b)(6)-2	Penicillin G IV 1 million units Q 4 D	03								
			09						D/C 31 Aug 05 1030		
			15								
			21								
27 Aug	(b)(6)-2	LR @ 80 cc/hr	D								
			E						D/C 31 Aug 05 1600		
			N								
27 Aug	(b)(6)-2	Albuterol neb Cstd adult dose Q 8°	03								
			16						D/C 31 Aug 05 1600		
			24						D/C (b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Revision Q LE Revision Q LE Amputation 5/P I+D (L) L.E. L (L) LE

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

16 17 18 19 20 21 22 23

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 08 Yr 03

Order Date	Verify by initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27Aug	(b)(6)-2	MSO4 1-5mg IV Q 5min max 15mg	27Aug			(b)(6)-2
30Aug		Dulcolax Supp ÷ PR NOW	30Aug	2130	2130	
31Aug		Transfuse ī unit prbcs ō 4 hrs	31AUG	ASAP	0045	
31Aug		Transfuse ī unit prbcs ō 4 hrs	31AUG	ASAP	0455	
31Aug		Lasix 20mg IV p̄ 1st unit prbc's	31AUG	1st unit	0420	
31Aug		Lasix 20mg IV p̄ 2nd unit prbc's	31aug		0830	
31aug		I stat 6, Creat CBC p̄ transfusion	31aug		0930	
31Aug		25mg Demerol / c̄ 12.5 Phenergan WP [illegible]	31Aug		2250	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
27Aug 30Aug	(b)(6)-2	MSO4 1-4mg IV Q 1° prn pain	27Aug 1735 4mg; 28aug 0820 2mg; 28Aug [illegible] 3mg; 29Aug 0530 3mg; 29Aug 4mg 2145; 29Aug 4mg 2240; 30Aug [illegible] 0700; 30Aug [illegible]; 31Aug 0422; 31aug 0900; (b)(6)-2
27Aug 30Aug		Tylox 1-2 tabs po Q6° prn pain	27Aug 2245; 27Aug 2245; 28Aug 1521; 28Aug 1830; 27Aug 0400; 29Aug 1350; 29Aug 2050; 30Aug [illegible]; 30Aug [illegible]; 30Aug [illegible]; 31aug 0800; 31Aug [illegible]; D/C'd 31AUG; (b)(6)-2
[illegible] Aug		MSO4 1-5mg IVP Q5min max 15mg	08Aug 5mg 1740; 28Aug 1945 2mg; (b)(6)-2 — Post operative single action
29 Aug		650mg Tylenol q 4-6° prn as needed	29Aug 1300; 29AUG 2215; 30Aug 1234; 31aug 1227; (b)(6)-2
30Aug		Dulcolax Supp ÷ PR QD prn	30Aug 2140; 31aug 1030; (b)(6)-2

MEDCOM - 1931

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.

26 DEC 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27 28 29 30 31 01 02 03 04 05 06
27 Aug	(b)(6)-2	Regular Diet	B	(b)(6)-2
			L	Δ 30 Aug 03
			D	
8/27		OOB to Chair TID	D	
			E	
			N	
8/27		Strict Nursing ⓁLE	D	
			E	
			N	
8/27		BD dressing changes to ⓁThigh, 25% Dakins Solution	10	
			2A	
27 Aug 03		~~Vitals q 2 hrs~~	D	
28 Aug 03		vital signs q 8°	E	
			N	
30 Aug		CBC qd	05	
30 Aug		NPO	B	
			L	
			D	
30 Aug		Loose ⓁLE below knee ⓇLE foot wounds open to air	D	
			E	
			N	
31 Aug		4 IVF @ ASNS @ 20 KE 100 cc/hr	D	
			E	
			N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Revision Ⓛ AE amputation
S/P I+D ⓁUE & ⓁLE, Revision ⓁAE & ⓁLE fx

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

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
16 17 18 19 20 21 22 23

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 08 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/27	(b)(6)-2	Transfer to ICU II Dr. (b)(6)-2	8/27	Routine OK	1345	(b)(6)-2
8/27		D/C Foley in AM 8/29/03	8/28	DO NOT D		
8/27		CBC Chem 7 in AM	8/28		0700	
8/28		NPO ∫ MN	8/29	DNI	∫MN	
30 Aug		KUB	8/30	ASAP	1900	
30 Aug		CBC, SMA-7, LFT's	8/30	ASAP	1900	
31 Aug		D/C Foley catheter	31 Aug			
31 AUG 03		KCl 40 meq IV over 2 hours x 2	31 AUG	#1 1600		
		∫	31 AUG	#2 1805		
31 AUG 03		Lat CXR	31 AUG	1610		
31 AUG 03		After - KCl complete - d/c central line	31 AUG 03	2100		
31 Aug		CXR KUB in AM	Sept 03	0600	0600	

I Telephoned (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
30 AUG 2560	(b)(6)-2	Demerol 25 mg IV	2100 2230 (b)(6)-2
		Phenergan 12.5mg	25mg/12.5 12Sep 13Sep
		IV q 4-6 hrs	(b)(6)-2

CLINICAL RECORD

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

Mo. ___ Yr. ___

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1 2 3 4 5
1Sept 03	(b)(6)-2	Zantac 50mg IVq 8°	02	
			10	(b)(6)-2
			18	
1Sept 03	(b)(6)-2	Erythromycin 250mg IV piggyback Q6°	05	
			11	(b)(6)-2
			17	
			23	
1Sept 03	(b)(6)-2	NGT to LIS	D	(b)(6)-2
			E	
			N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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	

MEDCOM - 1934

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

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

REWRITTEN

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. 9 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5
9 Sep	(b)(6)-2	OOB to Chair TID	10	(b)(6)-2				
			14					
			20					
1 Sep		STRICT NWB LLE	D					
			E					
			N					
1 Sep		D Thigh Dsg Δ BID	10					
1 Sep		@ 25% DAKINS Soln	22					
		VS q 8°	D					
			E					
1 Sep			N					
1 Sep		CBC q AM	05					
		Diet - NPO	B					
			L					
1 Sep			D					
		D BK & R Foot wounds	D					
		OPEN TO AIR	E					
1 Sep			N					
		IVF D5NSS 20 KCl	D					
		@ 100 cc/hr	E					
1 Sep			N					
		Ancef / Gm IVPB q	01					
		6°	13					
			18					
			24					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: REVISION LLE AMPUTATION
LLE EXT FIXATOR, S/P I&D
LLE & LUE

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

DA FORM 4677

MEDCOM - 1936

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ________ Yr ______

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Sept	(b)(6)-2	Place NGT	1 Sept	NOW	1030 ~~1100~~ (b)(6)	(b)(6)-2

Re-written 5 Sept 03 [initials] 5 Sept 03

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED		
1 Sep	(b)(6)-2	Demerol 25mg / Phenergan 12.5mg IVP q 4-6 hrs	0650 [illegible] 1 Sept 25/12.5		
1 Sep		Ducolax supp i PR QD PRN			
1 Sep		Tylenol 650 mg PO q 4-6° prn			
1 Sep		MSO4 1-4 mg IVP Q1° prn pain	0730 (b)(6)- 1 Sept 2mg 1100	9/1 0855 [illegible] (b)(6)-2	9/2 1030
1 Sept		Tylenol supp i PR q 6° PRN temp > 101° F	(b)(6) 1 Sept [illegible] TPR		[illegible] (b)(6)-2
1 Sept		O2 Per NC 3L PRN Status			

MEDCOM - 1937 USAPA V1.00

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 9 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1 2 3 4 5 6
Sep	(b)(6)-2	NPO	D	(b)(6)-2
			E	
			N	
Sep		Act: OOB to chair tid	10	
			14	
			20	
Sep		vitals - routine	06	
		for ICU	14	
		no. Q & if WNL	22	
Sep		IVF: D5 NS @	02	
		20 mEq KCl @ 100cc/hr	E	
			N	
Sep		ancef 1g IVPB	02	
		q 8°	10	
			18	
Sep		Erythromycin 250	06	
		mg IVPB q6°	12	
			18	
			24	
Sep		N/C O2 3 l prn	D	
		sats > 92%	E	
			N	
Sep		NGT to LIWS	D	
	------		E	
	------		N	
	------	See next page		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: ② LE amp; ① LE ex fix sp blast injury @ I/D

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

(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 ______ Yr ______

Order Date	Clerk Nurse (Verify by Initialing)	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 sep	(b)(6)-2	cond & fair	1 sep	Ø3	—	(b)(6)-2
1 sep		Radiology: ② shoulder series	1 sep	—	—	
1 sep		CBC, chem 7 in am	2 sep	0500	—	
2 sep		T̄C 2 units PRBCS Transfuse	9/2	Unit #1 ASAP	1230	
		over 4° each unit #2	9/2	4 hrs Post #1	1510	
2 Sep 03		Lasix 20mg IV p̄ each unit of PRBCs	9/2	P# 1	1500	
			9/2	P# 2	1830	
2 Sep 03		CBC c̄ Diff in AM	9/3	0500	0800	
2 Sep 03		KUB ABD in A.M.	9/3	0600	0615	
2 Sept 03		Repeat Dose of Demerol 25 mg c̄ Phenergan 12.5 mg IVP Now	9/2	2300	done	

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED													
1 Sep	(b)(6)-2	Demerol 25 mg	2 Sep 2100	3 Sep 0330												
		c̄ 12.5 mg phenergan	25/12.5	25/12.5												
		IV q 4-6° prn pain	(b)(6)-2													
1 Sep	(b)(6)-2	Tylenol 650-1000 mg	1400 1100	0145 2 Sep	9/2 1050	9/3 0530										
		PR (suppository)	650 / 1000 (b)((b)(6)-2	650 (b)(6)-2	(b)(6)-	(b)(6)-2										
		q 4-6° prn T > 101°F														

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. Sept Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6
1 Sep	(b)(6)-2	Wet to dry dressings	10	(b)(6)-2					
		(L) LE bid please	22						
		(no Pakins)							
1 Sep		Zantac 50 mg	08						
		IV q 8°	16						
			24						
2 Sep 03		GENTAMICIN 300mg	11			✓	✓	✓	✓
		IV Q DAY X 3 DAYS	✓	✓	✓	✓	✓	✓	✓
2 Sep 03		CREATINE Q DAY	05						

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: (L) UG amp, (L) LE Ex Fix Sip blast injury & I/D

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

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

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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3 4 5 6 7 8 9 10
	(b)(6)-2			(b)(6)-2
3Sept		Diet: NPO	B	
			L	
			D	
3Sept		OOB to chair BID	D	
		- tid	E	
			N	
3Sept		Vitals routine	D	
			E	
			N	
3Sept		D5 NS c 20meq KCl	D	
		100cc/°	E	
			N	
3Sept		Ancef 1gm IVPB	02	
		q8°	10	
			18	
3Sept		Erythromycin 250mg	06	
		IVPB q 6°	12	
			18	
			24	
3Sept		Gentamicin 300mg	11	
		q day x 2 days		
3Sept		NGT to LIS	D	
			E	
			N	
3Sept		Wet to dry dressing	10	
		(D) leg c packing of	22	
		wound BID please		

New orders 4 Sept 03

D/C'd 8 Sept 03 1200

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P Blast injury & I+D (D) Below Elbow Amp (D) LE Ex fix

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)

Verify by Initialing

Mo ________ Yr ________

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 Sept	(b)(6)-2	Admit to ICU #1				(b)(6)-2
3 Sept		Cond: fair				
3 Sept		X-Ray - (L) femur, Portable	3 Sept	post-op	1145	
3 Sept		CBC, Chem 7 in AM	4 Sept	AM	0520	
4 Sept		Demerol 25mg / Phenergan 12.5mg IV x 1 now	4 Sept	now	1215	
4 Sept		D/C NGT	4 Sept	NOW	12:00	

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED													
3 Sept	(b)(6)-2	Demerol 25mg c̄ 12.5mg phenergan IV q̄ 4-6 PRN Pain	9/3 1315 (b)(6)-2 E	3 Sep 0150 (b)(6)-2	0140 4 Sp (b)(6)	0910 4 Sep (b)(6)- E	See single action (b)(6)-	2000 2300 25mg (b)(6)	0045 5 Sep (b)(6)- E	5 Sep 1020 (b)(6)- E						
3 Sept		Tylenol 650-1000mg PR (Supp) q̄ 4-6 PRN T >101° F	9/3 1225 (b)(6)-2 E	3 Sep 1600 1gm (b)(6)-2	4 Sept 1345 (b)(6) 1gm	5 Sep 1350 (b)(6)										
3 Sept		D/C O2 3L PRN SAT < 92%														

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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7
3Sept	(b)(6)-2	Zantac 50mg IV q8°	08	(b)(6)-2				
			16					
			24					
3Sept	(b)(6)-2	Wet Washcloth if	D					
		patient wants fluid	E					
			N					
3Sept	(b)(6)-2	O2 to keep Sats ≥92	D					
		(3L/NC)	E					
			N					
3Sept	(b)(6)-2	Continue Gentamicin	11					
		300mg IV q day						
3Sept	(b)(6)-2	Daily Creatanin	08					

Med Stop 6 Sept 03

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P Blast injury & I&D ⓛ Below Elebow amp ⓡ LE Ex fix

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

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

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

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: I&D LUE
DSG D TO LLE
PHYSICIAN: DR. (b)(6)-2
ANESTHESIA BY:
(Gen) Spinal MAC Axiliary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: _____ Time DC'D ____
ETT Nasal Oral Trach
OXYGEN:
Mask Nasal Prongs Face Tent Blow-By
Liter/min. _____ %

ASA 2 History MULT TRAUMA INJURIES
Cardiac Rhythm ST & ECTOPY
IV#1 _____ (Patent) Infiltrated
Site RT I Rate 125 Gauge ____
IV#2 _____ Patent Infiltrated
Site _____ Rate ____ Gauge ____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper: Lower: Pulse DP PT RAD
PRE-OP	/												Blanche Pulse Warm Moves Y N
1205	126/80	110	23	95%	97.4	2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1210	126/80	110	19	98%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1215	135/87	110	21	96%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1220	136/84	108	14	96%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1245	129/84	111	22	95%		2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

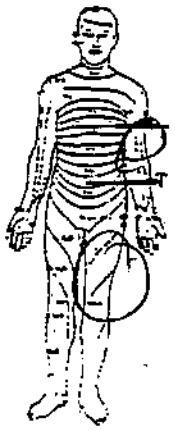
Activity - SAB or Subarachnoid Block
2–Moves all four extremities with control
1–Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
(Gauze)	CD&I	LUE AMPUTATION
Opsite	CD&I	(L) THIGH
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

PREPARED BY (Name & Title): (b)(6)-2 LPN I Am

DEPARTMENT/SERVICE/CLINIC: ICU # 1

DATE: 9/19/03

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)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	D5NS	800	OR	EBL	Min
		100	OR	Urine	100
TOTAL	D5NS T 20 KCl	900	TOTAL		100

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

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

1205 Transfer from OR via litter. Transfer to bed Connected Propaq. VSS
See flowsheet for Assessment. (b)(6)-2 10, RN

1245 Pt Alert. VSS. (b)(6)-2 (LT), RN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
Zofran OR LT (b)(6)-2	Zofran		IVP	1130		
	MSO4	2mg	IVP	1245		(+)

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____Resolved; No.'s_____Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse's Signature:_____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED *(Date)* 17 Jan 80

PROCEDURE: Washout (-)OE

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: DCA (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Prongs Face Tent Blow-By

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 Patent Infiltrated
Site Rate Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS
PRE-OP	/											
PRE-OP	/											
1515	134/84	125	18	96%	99	2	2	2	2	2	10	
1550	144/84	130	14	96%								
1555	130/92	131	18	92								
1600	~~134/84~~											
1600	137/81	129	18	98%								
1615	/	See		Trend		notes						
	/											
	/											
	/											
	/											
	/											
	/											

Neuro-Vascular

Extr: L R Upper Lower
Pulse DP PT RAC

Blanche Pulse
Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

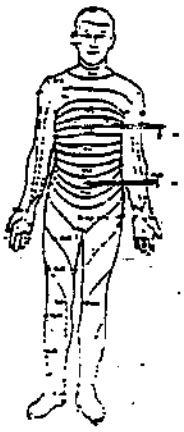
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH HDA OP 132-11a (Rev)
1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE		TIME	TYPE	AMT
OR	LR	200	OR	EBL	m.n 400
				Urine	400
TOTAL			TOTAL		

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

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

1545- PT to ICU from OR. NGT [redacted] placed + sutured to nares. PT attempting to pull NGT - tied (R) hand to bed. IV dc in OR. STILL has (R) IJ currently infusing LR. Ex fix (L) femur intact- dressing CDI. (R) UE Dressing CDI. Foley intact. Cardiac monitor ~ ST - / RR. Sats 96% on RA. [redacted] Morton

Refer to ICU flow sheet for further details.

[redacted] Morton

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved: No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse's Signature:_____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: I&D LUE/LLE
SPLINT PLACEMENT
PHYSICIAN: (b)(6)-2
ANESTHESIA BY: Dr (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: _____ Time DC'D ____
ETT Nasal Oral Trach
OXYGEN:
Mask Nasal Prongs Face Tent Blow-By
Liter/min. _____ %

ASA ___ History _____
Cardiac Rhythm _____
IV#1 _____ Patent Infiltrated
Site _____ Rate ____ Gauge ____
IV#2 _____ Patent Infiltrated
Site _____ Rate ____ Gauge ____

VITAL SIGNS / PAR SCORE

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS
PRE-OP	/										
PRE-OP	/										
1945	124/86	109	11	97	96.8						
1950	128/87	119	22	96							
1955	135/87	120	19	97							
2000	138/77	126	19	95		2	2	2	2	2	10
2015	135/66	133	20	98@1L							
2045	143/77	115	18	96							
	/										
	/										
	/										
	/										
	/										
	/										

OTHER

COMMENTS

Neuro-Vascular

	Extr: L R	Upper	Lower
	Pulse	DP	PT RAD
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		
Blanche / Warm	Pulse / Moves Y N		

POST ANESTHESIA RECOVERY SCORE "PARS"

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

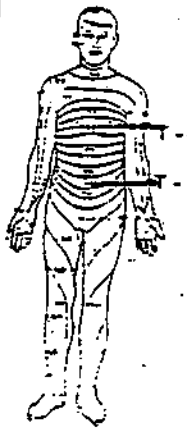
Activity - SAB or Subarachnoid Block
2–Moves all four extremities with control
1–Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze	CLEAN	RUE/LLE
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY: (b)(6)-2 CRT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 135EP03

muddle; grade; date; hospital or n (b)(6)-2 *or written entries give: Name–last, first, facility)*

(b)(6)-4

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

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	500 LR	500	OR	EBL 30	30
			OR	Urine 0	
TOTAL		500	TOTAL		30

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MOA OP 39

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

1915 - Pt arrived from OR via gurney. Pt has COT dsg on LUE/LLE IJ to place Infusing LR @ 100cc/hr. Pt Alert and disoriented at this time. Pt dislodged NG tube. HS - RRR, LS - CTA bilaterally, BS x4 quads. Moves all Extremeties & good neuro vs (b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved: No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: C/D/I PAR Score 10 Safety Straps _____
Report given to CPT (b)(6)-2 Patient released by Anesthesia Dr (b)(6)-2
Time out 1915 Nurse's Signature: (b)(6)-2

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: End of D Arm

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:
Mask (Nasal Prongs) Face Tent Blow-By
Liter/min. 3L %

ASA ___ History

Cardiac Rhythm

IV#1 Patent Infiltrated
Site (L Hand) Rate 100 cc/hr Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAC
PRE-OP	159	110	16	94%									Blanche Pulse Warm Moves Y N
1050	123/78	102	9	98%	98.8	1	2	2	1	2	8	Received from OR	Blanche Pulse Warm Moves Y N
1055	122/76	100	9	99%		1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
1100	123/78	99	9	97%	98 AX	2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1115	124/76	108	14	98%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1130	149/85	110	18	97%		2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
1145	145/90	116	19	99%	99 AX	2	2	2	2	2	10	Recovered	Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

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

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

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

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

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

DRESSING:	Status	Location
Gauze	C, D, I	LUE, LLE
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 11 SEP 03

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

(b)(6)-4

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

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

500 fentanyl Ancef 1 g

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	300 cc		OR	EBL Minimal	
			OR	Urine Spontaneous void	
TOTAL			TOTAL		

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

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

Received pt from OR via litter @1050. Pt put on 3 L O^2 NC w/ sat of 98%, LUE bandage is C,D, and I, LLE DRSG A is C,D+I, VSS, UR infusing to @ Hand @ 100cc/hr, IV line is patent and S sign of infiltration or infection. Pt recovered to SPC (b)(6)-2 RN #1.

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse's Signature:_____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: (C) BE AMP / (B) Open Femur Fx I&D E Shortening of Fem
PHYSICIAN: Dr (b)(6)-2
ANESTHESIA BY CRNA (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: Time DC'D
ETT (Nasal) Oral Trach
OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min: 4L/min %

ASA 1 History Multiple Orth Surgeries
Cardiac Rhythm NSR
IV#1 (Patent) Infiltrated
Site RFA Rate Gauge 18g
IV#2 (Patent) Infiltrated
Site RFA Rate Gauge 16g

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Ext: L R Upper Lower; Pulse DP PT RAC
PRE-OP	/												Blanche Pulse; Warm Moves Y N
1200	134/85	94	10	95%	94.5	2	2	2	2	1	9		Blanche Pulse; Warm Moves Y N
1205	133/89	97	12	95%		2	2	2	2	1	9		Blanche Pulse; Warm Moves Y N
1210	126/87	95	9	97%		2	2	2	2	1	9	VO2 2L/min	Blanche Pulse; Warm Moves Y N
1215	127/81	94	10	100%	94.8	2	2	2	2	1	9		Blanche Pulse; Warm Moves Y N
1230	141/93	94	19	100%	95.0 AX	2	2	2	2	1	9		Blanche Pulse; Warm Moves Y N
1245	130/85	99	12	98%	96	2	2	2	2	2	10		Blanche Pulse; Warm Moves Y N
1300	132/84	101	13	95%	95.5 AX	2	2	2	2	2	10		Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

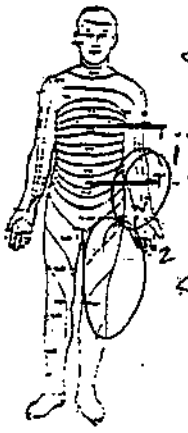
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

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

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

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

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



DRESSING:

	Status	Location
(Gauze)	CDI	LUE
Opsite	CDI	RUE
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

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

DEPARTMENT/SERVICE/CLINIC: ICU # 1

(Continue on reverse)

DATE: 9/8/03

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

(b)(6)-4

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

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1000	OR	EBL	Min
	D5NS + 20KCl	100	OR	Urine	50
TOTAL		1100	TOTAL		Min

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MOA OP 39

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

1200 TRANSfer from OR via Litter Connected to Propo & O2 4L/NC See Critical Care Flowsheet & PACU Flowsheet for assessment [redacted] 1Cfm

[redacted]

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
[redacted]	Demerol	25 mg	IV	1230	7	
[redacted]	Phenergan	12.5 mg	IV	1230	7	

DISPOSITION SUMMARY: Nursing Care Problems No.'s 6 Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CD&I PAR Score 10 Safety Straps N/A
Report given to N/A Patient released by Anesthesia CRNA [redacted]
Time out 1300 Nurse's Signature [redacted] [redacted]

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: Washout + CUE/ LLE

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. _____ %

ASA 2 History _____

Cardiac Rhythm ST

IV#1 _____ Patent Infiltrated

Site _____ Rate _____ Gauge _____

IV#2 _____ Patent Infiltrated

Site _____ Rate _____ Gauge _____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												Blanche Pulse Warm Moves Y N
1645	137/84	104	17	93	98.8								Blanche Pulse Warm Moves Y N
1650	136/78	99	18	92								2L O2	Blanche Pulse Warm Moves Y N
1655	143/86	94	17	93									Blanche Pulse Warm Moves Y N
1710	138/89	91	12	100									Blanche Pulse Warm Moves Y N
1725	137/91	93	19	94									Blanche Pulse Warm Moves Y N
1740	136/92	98	16	95									Blanche Pulse Warm Moves Y N
1810	125/84	92	20	97									Blanche Pulse Warm Moves Y N
1840	141/97	97	18	94	98.6								Blanche Pulse Warm Moves Y N
2000	143/84	92	24	100	99.6	2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

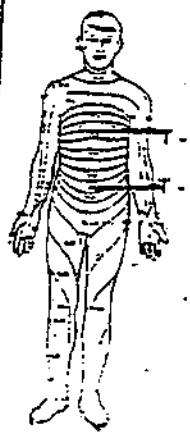
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	8mg Fentanyl		OR	EBL Minimal	
OR	300 LR		OR	Urine	
TOTAL			TOTAL		

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

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

1645 - Pt arrived from OR. New C/O/E dress on LUE/LLE. Pt dense's PASW. Lungs CTA bilaterally, HR cont & ST. Bowel Sounds hyperactive. Pt A/O @ this time (b)(6)-2 RN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
(b)(6)-2	Fentanyl	50mcg	IV	1655	9/10	
(b)(6)-2	Demerol	25mg	IV	1835	9/10	

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

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: L Stump Revision LVE washout LLE
PHYSICIAN: DM (b)(6)-2
ANESTHESIA BY: CRNA (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

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

ASA 1 History _____
Cardiac Rhythm ST & ectopy
IV#1 _____ Patent Infiltrated
Site LEJ Rate 100 Gauge 16 g
IV#2 _____ Patent Infiltrated
Site _____ Rate _____ Gauge _____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper: Lower: Pulse DP PT RAD; Blanche Warm Pulse Moves Y N
PRE-OP	/												Blanche Warm Pulse Moves Y N
1000	119/78	112	16	91%	100'(A)	2	2	2	1	2	9	Placed on O2 6L/M	Blanche Warm Pulse Moves Y N
1005	119/76	111	11	94%		2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
1010	122/77	109	11	95%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1015	118/77	111	12	94%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1030	122/74	111	15	91%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1045	120/72	109	11	93%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

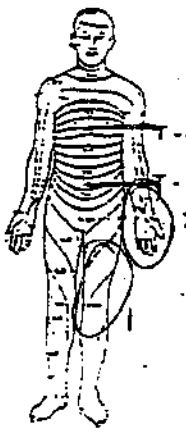
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze 1	SS	(R) THIGH
Opsite	CD&I	LVE
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap 2		

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

(b)(6)-2 (Name & Title) LCT, AN DEPARTMENT/SERVICE/CLINIC ICU#1 DATE 9/3/03

(b)(6)-2 STATIONARY IDENTIFICATION (For typed or written entries give: Name-last, first, grade; date; hospital or medical facility)

(b)(6)-4

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

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	800	OR	EBL	Min
1000	D5NS + 20 KCl	100	OR	Urine	0
TOTAL		900	TOTAL		0

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

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

1000 Transfer from OR. Moved to bed by 4 STAFF members. Connected to Pr/AO & O2 @ 6L/min See Clinical Care Flowsheet for Assessment (b)(6)-2 (b)(6)-2 (b)(6)-2 IVF in.

1100 Pt recovered & complications. VSS. —

MEDICATION GIVEN BY:

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.

Dressing status: LLE-SS LUE CDI PAR Score 10 Safety Straps N/A

Report given to N/A Patient released by Anesthesia (b)(6)-2

Time out 1100 Nurse Signature (b)(6)-2 (b)(6)-2

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: [illegible] (R)

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary

Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By

Prongs Tent

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 2R Patent Infiltrated

Site Rate Gauge

IV#2 Patent Infiltrated

Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAC; Blanche Pulse; Warm Moves Y N
PRE-OP	132/85	116											
[illegible]	141/86	124	20	94%	101 ax	[illegible]	2	2	0	2	7		
1410	143/94	124	18	98%	101 ax	1	2	2	0	2	7	02 4L	
1415	138/93	120	18	100%	101 ax	1	2	2	1	2	8		
1430	142/86	118	21	97%	100 ax	2	2	2	1	2	9		
1445	130/87	124	22	99%	100.7 ax	2	2	2	1	2	9	O2 3L	
1500	135/86	121	28	98%	101.3 ax	2	2	2	2	2	10	O2 3L	
	/											O2 3L	
	/												
	/												
	/												
	/												
	/												
	/												

Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

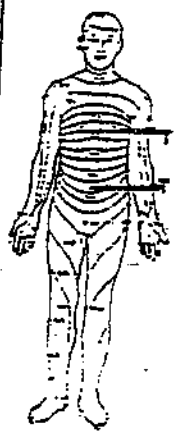
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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

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

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

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



DRESSING: Status Location

Gauze
Opsite
Bandaid
Steri-strips
Colledian
Peri-pad
Coban
Cotton Balls
Ace Wrap

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

PREPARED BY (Signature & Title)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 15 Sep 03

(Continue on reverse)

If other than patient, give: Name--last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

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

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	700	OR	EBL	Min
			OR	Urine	300
TOTAL			TOTAL		

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

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

1430 Pt back from OR 1405. Pt groggy but will open eyes + lift head on command. Dg - 3 l nc but + to 4 l 1407. Dg 4 to 3 l nc 1430 - sats 97%. IV D5 NS @ 20 KE @ 100 cc/hr (R) FA + s/s infection/infiltration. (L) Trans-amputated below the elbow dressing (Kuler) CDI. (L) ex fix in place (L) femur - dressing currently CDI - small area of open ~~area~~ wound upper thigh - covered + CVU due to oozing. (L) DP pulse palpable + pt able to move toes. no to LTS - minimal bile colored drainage. ABD distended - + BS. mult abrasions abd + lower extremities. (b)(6)-2

MD DON

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____.

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Washout @ LE + DVE

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKA

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN:

Mask (Nasal) Face Blow-By
Prongs Tent

Liter/min. 3L/min %

ASA ___ History _____

Cardiac Rhythm ST

IV#1 R IJ (Patent) Infiltrated

Site LR Rate 30 Gauge ___

IV#2 _____ Patent Infiltrated

Site _____ Rate ___ Gauge ___

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper: Lower: Pulse DP PT RAD Blanche Warm Pulse Moves Y N
PRE-OP	/												Blanche Warm Pulse Moves Y N
1025	138/52	146	34	96	99.3	1	2	2	1	2	8	RA;	Blanche Warm Pulse Moves Y N
1030	104/87	144	17	97%		1	2	2	1	2	8	6L O2 NC	Blanche Warm Pulse Moves Y N
1035	155/85	140	22	97%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1045	169/92	131	16	99%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1100	157/87	130	10	99%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1115	148/93	148	20	98%	102.7	2	2	2	2	2	10	5L O2 NC	Blanche Warm Pulse Moves Y N
1130	149/87	142	14	99%		2	2	2	2	2	10	O2 off, Incentive Spirometry	Blanche Warm Pulse Moves Y N
1200	137/76	137	8	99%		2	2	2	2	2	10	5L O2 NC	Blanche Warm Pulse Moves Y N
1230	138/78	134	18	98%	103.7	2	2	2	2	2	10	5L O2 NC	Blanche Warm Pulse Moves Y N
1300	135/67	132	20	96%		2	2	2	2	2	10	2L O2 NC	Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

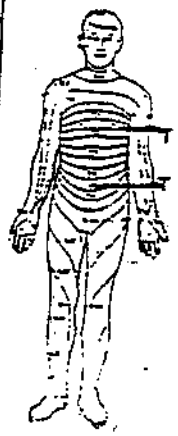
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze Kerlix	LLE CDI	LLE
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	CDI	LUE
ExFix		LLE

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

PREPARED BY (Name & Title): (b)(6)-2 SPC

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 29 Aug 03

(Continue on reverse)

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)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1L	OR	EBL	
			OR	Urine	150cc
TOTAL			TOTAL		

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

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

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
OR	MSO4	30mg	IV			
OR	Fentanyl	50 mcg	IV			
OR	Esmolol		IV			

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Washout

PHYSICIAN: (b)(6)-2

ANESTHESIA BY:

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: Unknown

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN:

Mask (Nasal Prongs) Face Tent Blow-By

Liter/min. 3L %

ASA ___ History Unknown

Cardiac Rhythm NSR

IV#1 LR (Patent) Infiltrated

Site RIJ Rate 80 Gauge ___

IV#2 ___ Patent Infiltrated

Site ___ Rate ___ Gauge ___

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper: DP PT Lower: RAD; Pulse; Blanche; Warm; Moves Y N
PRE-OP	/												Pulse; Blanche; Warm; Moves Y N
1345	144/80	140	20	97%	98.2	0	2	2	0	2	6	3L O2	Pulse; (Blanche); (Warm); Moves (Y) N
1350	133/86	140	15	98%	99.4	0	2	2	0	2	6	3L O2	Pulse; (Blanche); (Warm); Moves (Y) N
1355	130/83	139	20	99%	99.6	0	2	2	0	2	6	3L O2	Pulse; Blanche; Warm; Moves (Y) N
1400	132/88	141	22	99%	100.4	0	2	2	0	2	6	3L O2	Pulse; Blanche; Warm; Moves Y N
1405	139/85	140	19	99%	-	0	2	2	0	2	6	3L O2	Pulse; Blanche; Warm; Moves Y N
1410	138/84	139	19	99%	100.6	0	2	2	0	2	6	3L O2	Pulse; Blanche; Warm; Moves Y N
1425	147/88	141	17	98%	98.9	0	2	2	0	2	6	1L O2	Pulse; Blanche; Warm; Moves Y N
1440	138/87	145	16	97%	101.9	2	2	2	2	2	10	1L O2	Pulse; Blanche; Warm; Moves Y N
	/												Pulse; Blanche; Warm; Moves Y N
	/												Pulse; Blanche; Warm; Moves Y N
	/												Pulse; Blanche; Warm; Moves Y N
	/												Pulse; Blanche; Warm; Moves Y N

POST ANESTHESIA RECOVERY SCORE CARD

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

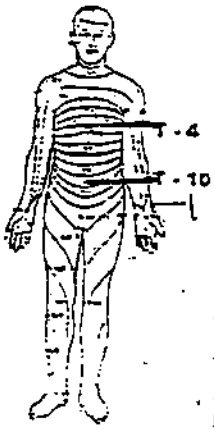
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze	Acewrap COI	(R) UE Amp
Opsite	COI	(B) LE pinsite
Bandaid	OTA	ABD
Steri-strips	OTA, Scabbed	(L) leg
Colloidian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 27 Aug 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)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	900 Error [b)(6)- Crystalloid	900	OR	EBL 100 [b)(6)-2	100
1445	LR	80	OR	Urine 850	850
TOTAL			TOTAL		

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

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

1345 - transferred from OR via litter, sleeping. O2 sat 99%, 0 S/S of SOB observed, O2 3L NC, Abrasions to RBD OTA White in color, Amputation site to R UE ACE wrapped/ CDI, Scabs to L leg OTA pink in color, Dressing to R LE CDI & pins in place, Foley draining clear yellow urine, Edema 1+ to R UE, lungs clear, bowel sounds slow x 4 quads will continue to monitor pt [b)(6)-2] (RN)

1445 Transferred from recovery to ICU, Alert & pain level 6 via interpreter, pain med given (see below) for pain & temp, will continue to montor O2 sat 97% on 1L of O2 NC [b)(6)-2]

MEDICATION GIVEN BY [b)(6)-2] (RN)

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
Tylox	1	PO	1445	6	

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

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **POST ANESTHESIA CARE UNIT FLOWSHEET**

OTSG APPROVED *(Date)* 17 Jan 80

PROCEDURE: I & D LUE/LLE LUE BEA, LLE-EX FX
PHYSICIAN: (b)(6)-2
ANESTHESIA BY:
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

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

ASA II History
Cardiac Rhythm NSR
IV#1 PIV Patent Infiltrated
Site (R) Hand Rate ___ Gauge 18
IV#2 CL Patent Infiltrated
Site JV Rate ___ Gauge ___

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	127/94	110	20	95	/								Extr (L) R Upper (Lower); Pulse (DP) PT RAD
PRE-OP	/												Blanche Warm Pulse Moves Y N
0045 ~~0050~~	141/96	119	21	97	92^{8}	1	2	2	1	Ø	6	RA	(Blanche) Warm Pulse Moves (Y) N
~~0050~~ 0050	158/96	116	19	95	/	2	2	1	1	Ø	6		(Blanche) Warm Pulse Moves (Y) N
0055	148/91	114	19	95	/	2	2	2	1	Ø	7		(Blanche) Warm Pulse Moves (Y) N
0100	155/98	118	25	95	/	2	2	1	1	Ø	6		(Blanche) Warm Pulse Moves (Y) N
0105	148/93	113	20	95	93^{4}	2	2	2	1	Ø	7		(Blanche) Warm Pulse Moves (Y) N
0110	136/94	116	23	96	/	2	2	2	1	Ø	7		(Blanche) Warm Pulse Moves (Y) N
0115	148/97	115	24	95	94^{1}	2	2	2	1	Ø	7		(Blanche) Warm Pulse Moves (Y) N
0130 ~~0145~~	131/83	112	18	91	945	2	2	2	1	Ø	7		(Blanche) Warm Pulse Moves (Y) N
0145	131/82	115	19	95	95^{4}	2	2	2	1	1	8		(Blanche) Warm Pulse Moves (Y) N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

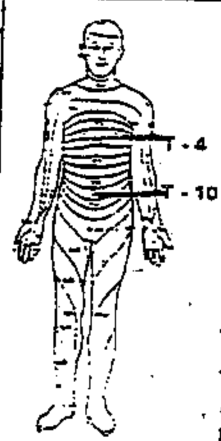
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

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

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

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

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



DRESSING: Status / Location
Gauze: CDI. / (R) Ankle
~~Opsite~~ Guaze / Bandaid: Intact, bloodied / (L) LE
Steri-strips
Collodian
Peri-pad
Coban
Cotton Balls
Ace Wrap: CDI / (L) UE

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU-2

DATE: 26 AUG 03

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

(b)(6)-4

(EPW)

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

DA FORM 4700, 1 MAY 78

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1966

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	PRBC	900	OR	EBL 500-1000 cc	
OR	LR 3000 ~~2335~~		OR	Urine	750 cc
TOTAL			TOTAL		

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

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

0045 Pt admitted to PACU-ICU-2 @ 0045 via litter semi-conscious responds to commands, RECEIVED fluids via Subclav central line (R) & (R) hand 18G PIV LR & NS @ 150cc hour RA; breaths regular unlabored. (L) LE gauze dressed c blood staining to thigh. (R) LE ACE bandage CDI. (R) ankle gauze dressing intact c staining. Extremities x3 cold Pulses x3 normal present WP CVBS — [(b)(6)-2] RN

0055 X-rays taken of pt's chest & (L) LE — [(b)(6)-2] RN

0110 Pain medication administered — [(b)(6)-2] RN

0200 Pt moved to ICU status — [(b)(6)-2] RN

0135 D/C (R) hand PIV d/t infiltration & per physician instruction — [(b)(6)-2] RN

MEDICATION GIVEN BY [(b)(6)-2]

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
Mannitol	50	IV	0110		

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: Intact blood soaked PAR Score 8 Safety Straps N/A
Report given to N/A Patient released by Anesthesia
Time out 0200 Nurse Signature: [(b)(6)-2]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A I 4 A 1	7 8: I 2	9 10 11 12 13 14 15: (b)(6)-4	(b)(6)-4	16 17	18: M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	

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
	46	1900	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: E 7 6	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: F 2	64 65 66 67 68 69 70	71	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: D	ICU2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: BAMC, 2100 COPP		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y Y Y M M D D)
73 74: 9 1 D/C to Cage	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 9 2 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y Y Y M M D D)
89 90 91 92: A E A A	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 8 2 5

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
107 108	109 110 111 112 113 114: A I 9 A 7	115 116 117 118 119 120 121 122: 2 0 0 3 0 8 2 5

FOR LOCAL USE

Dx: 8870
82032
8900
E9919

Procedure: 7713 843 8874
8605 8961 8962
7715 9904 (8)
7815 8744 8827
7855 8819 E7791
8628

Inj Trauma
549 9

ADMITTING (b)(6)-2

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

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

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

21(-)

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

(b)(6)-4

(b)(6)-4

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

ADMISSION REMARKS

DOB 19840101

ADMITTING OFFICER

(b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 17Sep03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P Re-exploration — 54.0 ICD9FY02

Abd abscess — V55.9 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

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

(b)(6)-2 MD

36. TOTAL DAYS ALL FACILI

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

(b)(6)-2

SIGNATURE OF ATTENDING MEDICAL OFFICER

FAMILY PRACTICE

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

DA FORM 1 MAY 79 3647-1

EDITION OF 1 AUG 76 IS OBSOLETE.

(b)(6)-2

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

PATIENT DEPOSIT RECORD

For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☒ *wish to make a deposit at this time.*

(b)(6)-2 1LT AV.

(b)(6)-2 *signature (or witness's, if patient is unable to sign)*

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

FUNDS

DATE	DEPOSITS		WITHDRAWALS		BALANCE		SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS		WITHDRAWALS	
		DATE	SIGNATURE *(Custodian)*	DATE	SIGNATURE *(Patient or intermediate individual)*
1	Silver Ring	12 Sep 03	(b)(6)-2		

DA FORM 1 DEC 77 3696 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED.

*U.S.GPO:1981-0-301-988

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Pt. 19 yo Iraqi. GSW (L) flank. Pt. complains of SA pain. Pt. also c side pain. Pt. brought to ER by medics.

Penicillin	PSHx	Allergies
ϕ	ϕ	NKDA

PHYSICAL EXAMINATION

BP 111/81 111 22

Sep SF 558

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

Arr: Pt. c GSW (L) flank.
(+) FAST exam. ϕ exit wound.
Shrapnel near spine on AXR X-ray
(1) Pt. to OR for exploration

(b)(6)-2	DATE 11 Sept 01	IDENTIFICATION NO.	ORGANIZATION
(Last name first, give Name last, first, middle initial or medical facility)		REGISTER NO.	WARD NO.

MAJ MC

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

NSH Note

NSN 7640-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
9/10/03	Prehospital - 20 y/o ♂ Iraqi c GSW to (L) Flank.
(2337)	Arrived Litter c Pressure dsg / NRB c IT Lps.
(2338)	Alaina - Monitors Placed. v.ss O_2 via NRB c IT Lps.
	# 16 ga PIV Placed x difficulty (L) AC. NS + c Bolus.
	Labs Sent. 18 fr Foley Inserted x difficulty c ~ 30 cc
	Dark Blood Return.
(2340)	Airway Patent. GCS - 15. Lngs CTAB. ABD diffuse Point
	Tenderness c guarding. FAST exam Reveals (+) Retroperitoneal
	Hematoma.
(2342)	(B) Lower Extremities Unremarkable. Pt unable to Move Legs.
	(-) Motor (+) Sensory.
(2343)	Pt Rolled c Log Roll for Posterior exam. Posterior Unremarkable.
	Rectal Normal ♂ Tone. (+) Prostate.
(2350)	XR c Bedside for Pelvis / Pelvis. v.ss. Surgery Consulted.
(2352)	Pt Placed on Backboard c Soft Restraints. Given Meds for
	Sedation. v.ss.
(0002)	Pt to X-ray c Monitors / Attendant x IT.
(0020)	Repeat CBC - X-match for IT Units.
(0025)	Pt Given IVP Dye for IVP Procedure. Remains on Monitors. v.ss.
	IV's x Bolus. O_2 via NRB c IT Lps.
(0055)	Anesthesia c Bedside. Report Given to CRNA (b)(6)-2 Pt Transported
	to OR x difficulty. v.ss.

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

OVER →

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

(b)(6)-4

Iraqi Civ ♂ Trauma

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

MEDCOM - 1972

Vitals

2335 $\frac{111}{81}$ - 111 - 24 - 98.9(o) - 100%

2340 $\frac{133}{92}$ - 93 - 20 - 99%

0005 $\frac{129}{67}$ - 92 - 20 - 99%

0020 $\frac{132}{72}$ - 89 - 20 100%

0040 $\frac{128}{78}$ - 96 - 22 - 100%

0056 $\frac{136}{76}$ - 92 - 20 - 100%

Meds

2345 MSO4 5 g IVP

2352 MSO4 5 g IVP

0002 MSO4 5 g IVP

0012 MSO4 5 g IVP

0025 Versed 2.5 g IVP

0040 Versed 2.5 g IVP

0055 Unasyn ~~III~~ 3gm IVPB

(b)(6)-2

I&O

IVF's 2400 cc

UA 450 cc

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Sept 03	Brief Op note
0415	1) Pre-op Dx - GSW (L) Flank
	2) Post-op Dx - GSW (L) Flank, Large Retroperitoneal Hematoma, Duodenal Injury X 2, Gallbladder Injury, ~~Liver Laceration~~, IVC injury at origin of (R) renal vein (L) renal location Through & Through liver injury
Lumbar Spine FX	3) Procedure - Ex Lap, Removal of Bullet Fragments from Liver & lumbar spine, Repair of Duodenal Injury X 2, Repair of IVC, Cholecystectomy, Post. Drg
	4) Surgeon - (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2
	5) Anesthesia - GETA
	6) Findings - Bullet Fragment on dome of liver, Bullet fragment in lumbar spine 2 duodenal injuries (distal 3rd portion of duodenum), Hole in GB, IVC tear, (L) renal laceration X 3 w/ ureters & aorta, Large retroperitoneal hematoma
	7) EBL - 850 cc
	(over) GV

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAIN

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

DATE	NOTES
	Brief note, Cont'd
	8) Fluids - 4000 cc c-ry, 1000 cc Lefatal, 4y PRBC
	9) UOP - 600 cc
	10) Complication - 0
	(b)(6)-2
	MJT mc

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

Problem List

DRAFT

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

11 Sep 93 – GSW to Abdomen → Ex Lap (L) flank/

– Gross Hematuria → Non-IVP ABD RUG

– (L) Kidney Laceration 2° Shock wave

– Spinal cord transection by bullet/GS @ ___ level ∴ resulting paraplegia

– Retroperitoneal Hematoma

– Duodenal injury x 2

– Gallbladder injury → cholecystectomy

– IVC GS injury ∴ origin (R) renal vein

– Lumbar Spine fracture Transverse process

– Liver Laceration – 7th T

– Blood transfusions x4 - 11 Sep 93

– A line

– ~~Paraplegia~~ Mechanical Ventilation

#003 11Sep

OMFS/

Pt noted to have lid lac on right eye by nursing staff. examined.

Dx: 1½cm superficial lac OD just inferior to brow

Op: Repair eyelid lac Phillips / asst Dunn Local anesthesia

(1.5cc) 2% lido c epi 1:100,000 (1.5cc) 0.5% bupi c epi 1:200,000 5.0 Fast for deep

5.0 prolene interrupted to close epithelium. Sx tracer.

To remove in 5-7 days

(Continue on reverse side)

(b)(6)-2 GC DRSma

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. (b)(6)-2

WARD NO.

PROGRESS NOTES

Medical Record

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

Respiratory

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
17Sep03	pt rcvd From OR @ 0455 c 8.0 ET Tube placed on vent c Settings VT 700ml RR 12 Fio2 80% peep 5 I:E 1:2 pt MD ABG DRawn Upon Arrival and vent Sent UP Ph 7.326 PCO2 57.0 PO 298 HCO3 29 SO2 160% B/E -7 ↓ FiO2 80%
0530	↓ 70% Result of ABG PO2 298 Sats 100% HR 74 BP 120/92 RR 12 BS — (b)(6)-2 SGT 9/1620
1100	Pt FiO2 Δ↓ to 60% — SGT (b)(6)-2 9/1620
1130	Pt FiO2 Δ↓ to 50% — SGT 9/1620
1600	Pt FiO2 Δ↓ to 40% — SGT 9/1620
2000	pt FiO2 Δ↓ to 35% — SGT 9/1620
0600	Order Written Keep sats ↑ 95 Fio2 40% FiO2 Δ From 35% - 40% — SGT (b)(6)-2 1620
1200	pt Resting c 8.0 24@lip on Vent — SGT (b)(6)-2 9/1620
1600	pt intubated c 8.0 24@lip BS CTA — SGT (b)(6)-2 9/1620
2200	pt intubated c 8.0 24@lip BS CTA, HME on Circuit pt's vent settings Verified — SGT (b)(6)-2 9/1620
2340	pt intubated c 8.0 24@24lip BS CTA — SGT (b)(6)- 9/1620
0400	pt intubated c 8.0 24@lip added Board inline
	Suctioned c minimum Secretions — SGT (b)(6)-2 9/1620
0800	Wean ↓ Rate Moved to 10 — SGT (b)(6)-2 9/1620

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

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

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

PROGRESS NOTES
Medical Record

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

DATE	NOTES
9/14 1603	Rate ↓ & pt stable 128/68 129 21 100% — (b)(6)-2
9/14 1652	@ Vent Failure pt hooked up to BVM and Ventilated pt hooked Back up — SG1 (b)(6)-2
1617	Pt MD ordered Suction Q2 c pulmtail — (b)(6)-2
1700	Suctioned inline c Ballard Used 2.0 cc NS pt HR 131 124/60 FiO2 100% pt Hyperoxygenated c 100% FiO2 3min prior to suction No adverse Rx — SG1 (b)(6)-2
1900	pt suctioned Trace Bloody Secretions Pt Moves a lot easily agitated — (b)(6)-2 no
2100	pt suctioned before Suction HR/RBP 122/60 Used 2.5 NS Thick Bloody Secretions No adverse Rx post tx HR/BP 122/60 — SG1 (b)(6)-2
1010	↓ RR to attempt to wean — SG1 (b)(6)-2
1515	Suctioned NO adverse Rx — SG1 (b)(6)-2 RT
1530	Small amount thick yellow Secretions no NS used — SG1 (b)(6)-2
1600	attempted to wean pt desat to 85% Pt BVM to 100 Sats ↑ 100% pt placed back on RR of 12 VT 700 FiO2 40% Suctioned Pt had Few thick secretions — SG1 (b)(6)-2 9 1020

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
12 Sept 09	Surg ICU note
0910	∅ sig Δ overnight
	Neuro - Sedated on versed, Paralyzed c̄
	Vecuronium
	CV - BP = 104-129/59-80 HR = 81-106
	RRR
	Pulm - Pale Ⓑ, equal breath sound
	Intubated - vent SIMV R=12 TV=700
	PEEP=5 FIO_2 = 40%
	ABG - 7.462/34.1/186/ BE=2
	Sats = 99-100%
	GI - OGT c̄ bogota bag, ∅ BS
	NGT in place - 75cc over past 8hr
	Abd - soft
	I/O = 4168/7595
	ID - On Unasyn WBC = 11.3
	H/H = 10.5/29.8 PLT = 126
	136/105/18/128 7.6
	4.1/23/0.9
	A/P: Pt. POD1 ex lap/duodenal repair/
	IVC repair [illegible] stable
	① Cont vent/sedation/paralytic
	② Plan to take pt. to OR for washout/
	abd closure tomorrow

(Continue on reverse side)

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

(b)(6)-2 [redacted]

Medical Record

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

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

13 Sept 03
1445 Brief Op Note

1) Pre-Op Dx - Gsw (R) Flank/ S/p Dvc & duodenal repair/ (L) renal Lac/ Open Abdomen
2) Post-Op Dx - SAA
3) Procedure - Re-exploration/ wash out/ G-tube/ J-tube/ Placement of drain RUQ/ Closure of abd/ Incidental Appendectomy
4) Surgeon - (b)(6)-2 / (b)(6)-2 / (b)(6)-2
5) Anesthesia - GETA
6) Findings - Dvc & duodenal repair intact
7) EBL - minimal
8) Fluids - 1200 cc cryst
9) UOP - 100 cc
10) Complications - 0
11) Condition - stable to SICU
12) See Urology note for cysto findings

(b)(6)-2

9/13/03 Urology
Cysto under anesthesia.
Nml Bladder + Urethra, cap. & drain 450 cc
Rose' effux left UO, clear Rt UO
17 fr. Siepe. Foley placed

(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) | WARD NO.

Cog MC PROGRESS NOTES
Medical Record

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

MEDCOM - 1980

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
14 Sept 03	Surg ICU note
0915	S: events - ∅ overnight
	Neuro - sedated on fentanyl + versed
	CV - BP = 112-122/61-71 HR = 115-132
	Tachy
	Pulm - vent SIMV R = 12 TV = 700 PEEP = 5
	FiO2 = 40%
	⊕ rales Ⓑ
	ABG = 7.37/45.2/120/100%
	GI - Abd - soft, dressings in place
	∅ BS
	G-tube - ∅ J-tube - ∅ JP = 350 cc serosang
	I/O = 1206/885 over past 8 hours
	H/H = 7.8/22.5 Plt = 164
	ID - Vanco day 4 WBC = 7.4 Tm = 100.6 Tc = 100
	F/E/R - 139/105/18 / 3.5/28/1.0 /124
	A/P: Pt. POD 3/1 Ex lap / Abd wash out /
	Repair of IVC + duodenum / J-tube / G-tube
	stable on vent
	① Wean off vent in attempt to extubate
	② Lasix
	③ Continue current management

(b)(6)-2

(Continue on reverse side)

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

Medical Record

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

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES

DATE	
15Sept03	Surg ICU note
0450	Sig Events - attempted to wean off vent
	yesterday - failed
	Neuro - sedated on versed & fentanyl
	CV - BP = 107-134/52-59 HR = 107-128
	tachy
	Pulm - Vent R = 12 TV = 700 PEEP = 5
	FiO_2 = 40%
	ABG last night - 7.407/49.9/222/100%
	This AM ABG = 7.327/60.7/97/96%
	Rales (B)
	GI - Soft, ND, ⊕ BS
	Incision C/D/I c̄ staples
	G-tube = 575cc J-tube = 345
	JP = 300 cc
	I/O - 4654/4590 Past 8hrs - 1132/2250
	~~135/98/... 4.1/24~~ 135/98/9 (112 Ca = 7.8
	4.1/24/1.0
	H/H = 7.6/22.2 plt = 207
	ID - Tm = 102.5 Tc = 101° WBC = 6.8
	A. on vanco
	A/P: Pt. POD 4/2 Ex lap/ Repair of IVC & duodenum/
	Abd washout/ G-tube/ J-tube Stable on vent.

(Continue on reverse side)

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

(b)(6)-4 [redacted]

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

...TES

Medical Record

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

MEDCOM - 1982

PROGRESS NOTES

DATE

15 Sep 03
1000

ICU Note Cont'd

(1) Attempt to open offset

(2) Plan to start small feed through J-tube

(3) Leave JP in place

(4) G-tube - continue to gravity drain

(b)(6)-2

MAJ MC

*U.S. Government Printing Office: 1998 - 404-763/20101

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
16 Sept 03	Surg ICU Note
0915	Sig events - failed wean off vent yest
	Neuro - Sedated on versed & fentanyl
	CV - BP = 102-120/49-58 HR = 117-144
	Tachy
	Pulm - vent SIMV R=12 TV=700 PEEP=5
	FiO_2 - 40%
	ABG - 7.42/53/141/99% BE=10
	CXR = ~~[illegible]~~ few atelectasis, o/w clear
	GI - soft, no, few BS
	Incision C/D/I c staples
	JP=40 G-tube=1575 J-tube - Vivonex at 20cc/hr
	I/O = 2764/2010 urine clear
	H/H = 7.8/22.4 Plt = 272
	ID - WBC = 8.8 Tm = 103.1 101.7
	Vanco day 6
	128/97/9 / 4.5/26/0.9 (125 Ca = 7.9
	A/P: Pt. POD 5 s/p Ex lap / duodenal & IVC repair
	Artery / J-tube / G-tube stable on vent
	1) Attempt to wean again today
	2) Cont Abx
	3) Cont Tube feeds
	4) ↓ IVF & switch to [illegible]

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

(b)(6)-4

PROGRESS NOTES

Medical Record

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

509-113

NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

Vent on Surgery Trauma note

0920 Pt. brought to ER after gunshot wound to the left flank. IVP negative. patient taken to OR for exploratory laparotomy on ventilator. Patient found to have through & through injury to the liver - bullet fragment removed from dome of (R) lobe of the liver. Pt. also found to have bullet fragment in lumbar spine between the IVC & aorta. IVC was located near junction of (R) renal vein - repaired with prolene suture. Pt. was found to have injury to the 2nd portion of the duodenum (distal) x 2. Small lacerations repaired in 2 layers. The right kidney was normal. The left kidney had 3 lacerations. Bilateral ureters were normal. A Foley 6.0 was placed due to edema of the bowel. Pt. will take for re-exploration 2 days later - ventilator on was not performed.

(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.

99

(b)(6)-2

(b)(6)-4

Medical Record

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

MEDCOM - 1985

PROGRESS NOTES

DATE

Sept 03

0925 Surg Note Cont'd

Repairs were intact. JP drain placed near the duodenum. G-tube & J-tube placed. ASA was cleared. Cystoscopy was done due to blood in the urine - no significant pathology found. Urine cleared during the hospitalization. Pt. has been intubated throughout. Vent settings SIMV R=12 TV=700 PEEP=5 FIO2=40% Pt. started on Vivonex tube feeds - 20 cc/hr through the J-tube. G-tube to gravity. Foley catheter in place. Pt. has been stable. [redacted] On arrival originally to ER, pt. had no sensation or movement of the lower extremities.

Injuries

Spinal fracture (lumbar) - L3 - all

Left Renal laceration

DVC laceration - repaired

Duodenal Injury x 2 - repaired

Thoracic & Thoracic liver injury

Incidental Appendectomy

[redacted]

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

STANDARD FORM 509 (REV. 7-91) BACK

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT

(Medical Record)

TREATMENT FACILITY (b)(3)-1 "N"

LOG NUMBER

ARRIVAL		TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE: DAY 10 MONTH Sep YR. 03	TIME 23:37	PRIVATE VEHICLE / AMBULANCE / OTHER (Specify)	Unk?	✓ PATIENT / OTHER (Specify)
				ALLERGIES: Unk?

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

HOME TELE. NO. (Inc. area code)

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

SEX: M — AGE: 20 ish

POSSIBLE THIRD PARTY PAYER? YES / NO

TIME SEEN BY PROVIDER: OA

VITAL SIGNS			
TIME	2337	0045	
BP	111/81	129/75	
PULSE	111	94	
RESP.	22	21	
TEMP.	98.9		
WT. (Child)	100% NRB		

CATEGORY (See reverse)
- EMERGENT
- ✓ URGENT
- NON-URGENT

ORDERS	INITS.	TIME
MSO4 - 2mg IV		
Versed 5mg IV		
Unasyn 3g IV		

ASSESSMENT/DIAGNOSIS
1. GSW (L) flank
2. spinal cord injury

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

REFERRED TO (Indicate clinic)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: OR

CONDITION UPON RELEASE
- IMPROVED / ✓ UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0010.

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

20ish y/o Iraqi or civilian s/p GSW (L) flank. Brought by medics 507nd. Stable en route. c/o back/abd pain

C - w/o acute distress.
A - intact, speaking
B - B=BS
C - CR<2S
D - GCS 15. Ø moving lower ext.

HEENT - small 2cm lac (R) supraorbital area c/w ND.
CV - reg & nl lungs - CTA (B)
abd - diffuse ttp c vol/invol guarding Ø mass
neuro - flaccid paralysis (B) LE
rectal - Ø gross blood - Ø tone
areflexic (+) priapism
Ø sensation
back - GSW (L) flank

EDC - Stable initial VS. Foley placed c gross hematuria. FAST c Retroperitoneal hematoma SOD (Eastman) notified. Ortho notified

P/Ø
S/Ø
LPC ~19

CXR Ø
pelvis Ø
FAST c (+) retroperi hemat

44
10
UA 32
gross hemat

(CONTINUE ON SF 507, IF NEEDED)

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

(b)(6)-4

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2 ...MC

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

Spinal prec. maintained throughout. No indication for roids since penetrating trauma.
To OR for ex lap c SOD
One shot IVP -

(b)(6)-2

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 1987

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep 03
POD	DOS

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

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

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

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	11 Sep 03

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

(b)(6)-4

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

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

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
16 G	L AC	11 Sep 03	OPSITE, Silk tape, patent
18 G	R AC Heplock	11 Sep 03	OPSITE, SILK TAPE, patent
A-line	R Radial	11 Sep 03	Sutured, OPSITE, SILK tape

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

MOTOR FUNCTION

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

CHART CODES

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

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					X			1				1			1							1X		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					X			1				1			1							1X		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					X			1				1			1							1X		
GLASCOW COMA SCALE (A+B+C)					X			3				3			3							3X		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R								2				2			2									
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L								2				2			2									
MOVEMENT (See Motor Function Scale at Top of Page) — RUE					X			0				0			0							X		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE					X			0				0			0							X		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE					X			0				0			0							X		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE					X			0				0			0							X		
GRIP (S) Strong (W) Weak (-) absent — R								–				–			–							–		
GRIP (S) Strong (W) Weak (-) absent — L								–				–			–							–		
RESPIRATIONS — REGULAR								✓				✓			✓							VENT		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED																								
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW								✓				✓			✓									
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES					5			5				5			5							5		
COUGH — NONE								X				X			✓									
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt					700			700				700			700							700		
VENTILATOR — FiO2					100%			100%				50%			40%							35		
VENTILATOR — RATE (SIMV/CMV)					12			12				12			12							12		
VENTILATOR — PEEP / CPAP					5			5				5			5							5		
VENTILATOR — PRESS. SUPPORT					–			–				–			–							–		
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT # _____ — ETT 23 cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS					(b)(6)-2			(b)(6)-2				(b)(6)-2			(b)(6)-2							(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	94°	76	13	130/80	100	131/90											
0600		77	13/12		100	127/81											
0700	93 oral	72	16/12		100	118/77											
0800	94 oral	80	22/12	124/70	100	116/67											
0900	94.6 oral	78	12/12		100	116/63											
1000	94.8 A	90	16/12		100	107/66											
1100	95.3 A	82	12/12		100	112/65											
1200	95.9 A	84	12/12	109/64	100	118/71											
1300	96.9 A	99	12/12		100%	115/68											
1400	96 A	110	12/12	[illegible]/62	100%	113/62											
1500	97 A	114	12/12		100%	111/60											
1530																	10mg Epi
1600	97 A	97	12/12	121/64	100%	108/61											
1700	98 A	106	12/12	[illegible]	100%	118/61											
1800	98 A	110	12/12		100%	116/59											
1900	97 A	108	12/12		100%	115/52											
2000	97 A	111	12/12		100%	124/68											
2100	97.5	120	12/12		100%	114/60											
2200	98.4	106	12/12	115/93	100%	118/66											
2300	98	104	12	117/67	100%	123/69											
2400	98.7	103	12		99	132/74											

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
11Sep03	0500		Pt to ICU 1 from OR. placed on cardiac
			ē pulse oximetry monitors. Vent set up
			and operational. settings and assessment
			per flowchart. Pt currently sedated
			on versed and Vecuronium gtts (see medsheet)
			Abd ē opsite over lap sponges. Open
			incision ē bogota bag in place per
			surgeon. ~~Currently~~ (b)(6)-2
	0530		Currently paralyzed ~~ē train of twitches~~ error
			train of four. Repositioned instrument and
			obtained train of 1 to Ⓛ temple. (b)(6)-2
11Sept03	0855		received pt from prev shift @0600. pt vented
			see flow sheet. (b)(6)-2 abd dsg ~~of~~ draining bloody
			discharge. reinforced ~~sx~~ 4-5x. Urine
			draining (b)(6)-2 dk pink. BS ~~hypo~~ (b)(6)-2 ~~Dsg~~ (b)(6)-2 very hypo
			will cont to monitor (b)(6)-2
11Sept03	1100		FiO_2 @ ~~10~~ 60%, RT brought it ↓ will cont to
			follow (b)(6)-2
11Sept03	1300		pt has 1/4 TDF. (b)(6)-2
	1340		@1322 adm 1mg vec for restlessness pt now calm
			TOF 1/4 ~~4mg~~ (b)(6)-2 no apparent distress. NG draining
			foley to gravity. draining med pk urine
			dsg to abd reinforced dsg to back reinforced
			@ 1230 will cont to monitor (b)(6)-2
11SEP03	1600		Pt BP ↓ to $\frac{60-70}{30-70}$ pt given LR bolus 400cc + 10mg
			ephedrine IVP BP up to 118/60 (b)(6)-2 [illegible]
	1630		Dr (b)(6)-2 to suture lac over Ⓛ eye (b)(6)-2 [illegible]
	1800		Dsg on back D/C'd due to saturated [illegible] (b)(6)-2 [illegible]
	2200		Assumed care of pt. Sedated. ~~Flagged~~ role
			for dsg reinforcement and change of
			disposables. (b)(6)-2
	2230		Assessment per flowsheet midline incision
			(cont)

	INTAKE									OUTPUT							
	LR	PB	Vec	Versed	Fentanyl				Total	Urine	NG				Total	COMMENTS
0100																
0200																
0300																
0400																
0500	150		1	4												
0600	150 300		1	4												
0700	150 450	50	2	4						475						
0800	150 600	[illegible]	4 8	4 8						150 625	50 50					
8 HR	600	50	8	16					8 HR. 674	625	50				8 HR. 675 (b)(6)-2	
0900	150 750	100 150	4 12	4 12						75						
1000	150 900		4 16	4 16						50 125						
1100	150 1050		4 20	4 20						100 225						
1200	150 1200	100 250	4 24	4 24						200 425						
1300	150 1350	[illegible]	4 28	4 28						50 475						
1400	150 1500	50 300	4 32	4 32						100 575	50 50					
1500	150 1650		6 36	4 36						100 675						
1600	150 1800		6 42	4 40						100 775						
8 HR	1650	250	36	32					16 HR. 2672	825	50				16 HR. 1550	
1700	150 1950	100 350	6 48	4 44	1 1					150 925						
1800	150 2100		6 54	4 48	1 2					150 1075	50 100					
1900	150 2250		6 60	4 52	1 3					150 1225						
2000	150 2400		6 66	4 56	1 4					100 1325						
2100	150 2550		6 72	4 60	1 5					150 1475						
2200	150 2700	50 400	6 78	4 64	1 6					75 1550						
2300	150 2850	150 550	6 84	4 68	1 7					100 1650						
2400	150 3000	150 700	6 90	4 72	1 8					70 1720						
8 HR									24 HR. 4168	1895					24 HR 2595	

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

11/8/03 (Cont) 2230 continues to drain mild amt serosanguinous fluid under right side of dsg. Cardiac monit and pulse oximetry on and working. (B) Ac IV site patent & S/S of infiltration. Foley patent draining amber urine. A-line & extremity edema. ABP corresponding to NBP. (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) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep 03
POD	1

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

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

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

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU 1	12 Sep 03

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

(b)(6)-4

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

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2			2				2			2								2		
	RADIAL L				2			2				2			2								2		
	DORSALIS PEDIS R				2			1				1			1								2		
	DORSALIS PEDIS L				2			1				1			1								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1 3 8			1 3 8				1 3 8			1 3 8								1 3 8		
EDEMA					1+			1+				1+			1+								1		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓			✓				✓			✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					✓			✓				✓			✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)					✓			✓			✓				✓								✓		
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE																								
MOBILITY	BEDREST				✓			✓				✓			✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓			✓				✓			✓								✓		
	HOB 30 DEGREES														✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)												SEP													
PAIN	PAIN FREE																						X		
	PAIN SCALE (1-10)							Scale not received																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended					X				*			NO D			BS								X		
BOWEL SOUNDS (active all quads)					X				*			NO A			ø								X		
NG / DOBHOFF PLACEMENT VERIFIED					✓																				
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT					✓				✓			--			✓								X		
VOIDING CLEAR, YELLOW URINE q.s.									Amber			--			DARK								X		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds				✓				✓			--			✓								✓		
	Rashes, Lac's, etc				✓				✓			--			✓								✓		
DRESSING (Dry & Intact: specify site below)												--													
#1 ANT Midline					✓				Staples Removed			--			✓								✓		
#2 GSW @ FLANK					✓							--			✓								✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	RAC	11 Sep	OPSITE, Silk tape 1000/1100
16g	L AC	11 Sep	OPSITE, Silk tape 1000/1110
A-line	R Radial	11 Sep	Sutures opsite silk tape 1000
18 ga	RAC	11 SEP	D s/s int / patent (b)(6)-2 1400
16 ga	LAC	11 SEP	D s/s int / patent 1400
A line	RRADIAL	11 SEP	D s/s int / patent 1400

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

MOTOR FUNCTION

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

CHART CODES

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

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open					1			1				1				1							X		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response					1			1/T				1/T				1							X		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response					1			1				1				1							X		
GLASCOW COMA SCALE (A+B+C)					3X			3T				3T				3							X		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R							2+				--				2+									
	L							2+				--				2+									
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				X			0				0				/							X		
	LUE				X			0				0				/							X		
	RLE				X			0				0				/							X		
	LLE				X			0				0				/							X		
GRIP (S) Strong (W) Weak (-) absent	R				X			0				0				/							X		
	L				X			0				0				/							X		
RESPIRATIONS	REGULAR				Vent			V				V				V							V		
	IRREGULAR							L				L				E							E		
	UNLABORED															D							D		
	LABORED							T				T				T							T		
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5			5				5				5							5		
	LUL				5			5				5				5							5		
	RLL				5			5				5				5							5		
	LLL				5			5				5				5							5		
	BOTH BASES				5			5				5				5							5		
COUGH	NONE				✓			✓				✓				✓							✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt				700			700				700				700							700		
	FIO2				35			35				40				40							40		
	RATE (SIMV/CMV)				12			12				12				12							12		
	PEEP / CPAP				5			5				5				5							5		
	PRESS. SUPPORT				–			/				0				0							–		
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8	NRBM (l/min)																								
	ETT 22 cm gums	Bite Block										–				✓							✓		
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS				(b)(6)-2				(b)(6)-2				(b)(6)-2				✓							(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	98	106	12	118/74	99	135/75											
0200		88	12	104/55	100	120/59											
0300	99	80	12	127/70	100	146/72											
0400		81	12	129/55	100	147/73											
0500	98	99	12	129/80	100	146/88											
0600	96.4 (A)	93	12	124/75	100	135/72											
0700	96 (A)	89	12	123/72	100	138/69	89										
0800	96.5 (A)	86	12	112/62	100	130/61	79										
0900	97 (A)	86 89	12	104/59	100	120/59	76										
1000	97.3 (A)	93	12	103/60	100	107/53	73										
1100	97 (A)	97	12	110/59	100	126/61	78										
1200	97.3 (A)	99	12	113/60	100%	135/84	83										
1300	97.3 (A)	99	12	114/62	100%	136/63 150/57	81										
1400	98 (A)	100	12	115/60	100%	138/61	81										
1500	98 (A)	101	12	115/62	100%	145/62	81										
1600	98.9 (A)	104	12	116/64	100%	141/58	79										
1700	99 (A)	101	12	119/61	100%	134/63	88										
1800	98 (A)	97	12	119/58 (b)(6)-2	100%	131/56	84										
1900	99 (A)	94	12	111/58	100%	135/56	79										
2000	99 (A)	101	12	128/70	100%	133/58	97 +12										
2100	99 (A)	94	12	113/64	100%	131/56	73										
		92	12 (b)(6)-2	115/59	100%	138/60	83										
2200	98.1 (A)	95	12	113/59	100%	138/60	83										
2300	98	90	12	110/57	100	125/61											
2400	98	86	12		100	130/60											

NSN 7540-00-634-4123

MEDICAL RECORD	NURSING ES (Sign all notes)	
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12Sep03	0130		Assessment ≡ change.
	0145		SBP ↓ to 80. 10mg Ephedrine, LR Bolus Started
			Discussed ≡ Dr. (b)(6)-2 (b)(6)-2
	0100		SBP to 102. will continue to monitor (b)(6)-2
	0200		SBP 116 - will continue to monitor (b)(6)-2
	0300		(R) Lateral drsg changed. urine output ↓ but still adq. (b)(6)-2
12Sep03		0400	Pt supine & flat. VSS. NAD noted. Versed gtt @ 4mg/hr Vecuronium @ 6mg/hr & Fentanyl @ 1cc/hr IV. See flowsheet for assessment. ~~Abdomen~~ Abdomen ≡ ⊖ B/S slightly tense. Midline drsg ≡ op site staturated. Will cont to monitor (b)(6)-2 LVT, RN
12Sep03	0800		FiO_2 ↓ to 40% per CVV order (b)(6)-2 LVT, RN
12Sep03	1100		No Δ's from previous assessment. VSS. Will Continue to monitor (b)(6)-2 LVT, RN
12Sep03		1430	Pt assessment complete. Pt cont on same IVF/meds as previous shift to apply Lacrilube to eye (b)(6)-2
		2100	Drsg on back D'd - 250cc SANGUINOUS fluid drained from front opsite. (b)(6)-2
		2700	Assumed care of pt. Remains sedated. Continues ≡ serosanguinous fluids from around midline incision & urine lines x 3 patent, sites ≡ S/S of infiltration. Assessment per flowsheet. Continues ≡ sedation and paralyzed, pt appears ≡ mild generalized edema since admission. NGT ≡ dark green aspirate. abd ≡ BS disp remain intact ≡ drainage as noted previous. Urine ≡ blood tinged, QS. (b)(6)-2

	INTAKE								OUTPUT					
	LR	Versed	Vecuronium	Fentanyl	IVPB	BOLUS	Total		URINE	STOOL	NG	BLOODY DRAINAGE	Total	COMMENTS
0100	150 / 150	4 / 4	6 / 6	1 / 1	100 / 100				70 / 70					
0200	50 / 200	4 / 8	6 / 12	1 / 2	100	400 / 400			50 / 120					
0300	150 / 350	4 / 12	6 / 18	1 / 3	100	400			40 / 160					
0400	150 / 500	4 / 16	6 / 24	1 / 4	100	400			50 / 210					
0500	150 / 650	4 / 20	6 / 30	1 / 5	100	400			80 / 290					
0600	150 / 800	4 / 24	6 / 36	1 / 6	50 / 150	400			80 / 370					
0700	150 / 950	4 / 28	6 / 42	1 / 7	0 / 150				45 / 415		25 / 25			
0800	150 / 1100	4 / 32	6 / 48	5 / 12	50 / 200				75 / 490					
8 HR	1100	32	48	12	200	400		8 HR 1792	490		25		8 HR 515	⊕1277
0900	150 / 150	4 / 4	6 / 6	5 / 5					55 / 545					
1000	150 / 300	4 / 8	6 / 12	5 / 10					50 / 105					
1100	150 / 450	4 / 12	6 / 18	5 / 15					60 / 165					
1200	150 / 600	4 / 16	6 / 24	5 / 20	100 / 100				60 / 225					
1300	150 / 750	4 / 20	6 / 30	5 / 25										
1400	150 / 900	4 / 24	6 / 36	5 / 30					75 / 300		25			
1500	150 / 1050	4 / 28	6 / 42	5 / 35	100 / 200				100 / 400					
1600	150 / 1200	4 / 32	6 / 48	5 / 40					50 / 450					
8 HR	1200	32	48	40	200			16 HR 3312	450		25		16 HR 990	⊕2327
1700	150 / 150	4 / 4	6 / 6	5 / 5					30 / 480					
1800	150 / 300	4 / 8	6 / 12	5 / 10	100 / 100				50 / 530					
1900	150 / 450	4 / 12	6 / 18	5 / 15					75 / 605			250 / 250		
2000	150 / 600	4 / 16	6 / 24	5 / 20					75 / 680					
2100	150 / 750	4 / 20	6 / 30	5 / 20					50 / 730					
2200	150 / 900	4 / 24	6 / 36	5 / 25	150 / 150							20		
2300	150 / 1050	4 / 28	6 / 42	5 / 30	150 / 150				75 / 805					
2400	150 / 1200	4 / 32	6 / 48	5 / 35	100 / 250			1585	50 / 855			270	1125	+440
8 HR								24 HR 4877					24 HR 2115	⊕2762

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep 03
POD	2

24 HOUR DATA	
24 Hour Balance	+ 2367
24 Hour Intake	5062
24 Hour Output	2695
Weight on Admission	
Weight Yesterday	
Weight Today	

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

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

PREPARED BY (Name and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU 1	13SEP03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) AC	11 Sep	Opsite silk tape /0600 x/1000
16g	(L) AC	11 Sep	Opsite silk tape /0600 x/1000
A-line	(R) RADIAL	11 Sep	Suture Opsite tape /0600 x/1000

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

MOTOR FUNCTION

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

CHART CODES

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

DATE: 13 Sept 03

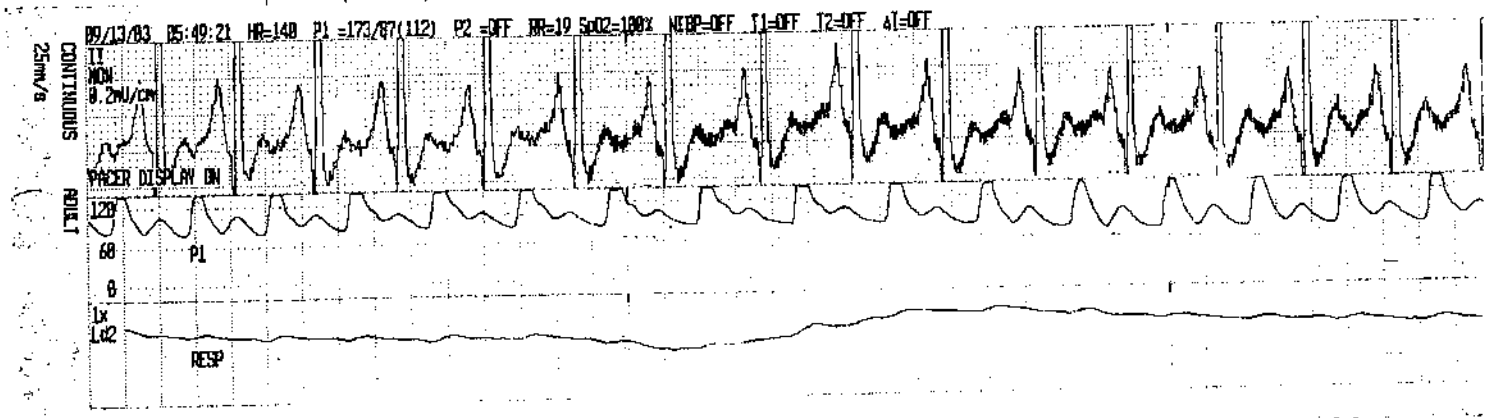
TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open						1				1						Sedated + Paralyzed						Sedated		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response						1 T				1 T														
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response						1				1														
GLASCOW COMA SCALE (A+B+C)						3T				3T														
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R						2+				2+						2+						2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L						2+				2+						2+						2+		
MOVEMENT (See Motor Function Scale at Top of Page) RUE						0				0						0 Paralyzed						0		
MOVEMENT (See Motor Function Scale at Top of Page) LUE						0				0						0						0		
MOVEMENT (See Motor Function Scale at Top of Page) RLE						0				0						0						0		
MOVEMENT (See Motor Function Scale at Top of Page) LLE						0				0						0						0		
GRIP (S) Strong (W) Weak (-) absent R						0				0						0						0		
GRIP (S) Strong (W) Weak (-) absent L						0				0						0						0		
RESPIRATIONS REGULAR																								
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED						Vent				Vent												Vent		
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL						5				5						5						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL						5				5						5						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL						1				1						1						1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL						1				1						1						1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES						✓				✓						✓						✓		
COUGH NONE																								
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt						700				700						700						700		
VENTILATOR FiO2						40%				40%						40%						40		
VENTILATOR RATE (SIMV/CMV)						12				12						12						12		
VENTILATOR PEEP / CPAP						5				5						5						5		
VENTILATOR PRESS. SUPPORT						0				0														
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT # 8 NRBM (l/min)																								
ETT # 8 ETT 23 cm gums										✓						✓						✓		
ETT CARE / POSITION CHANGE										✓												Oral		
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS						(b)(6)-2				(b)(6)-2						(b)(6)-2						(b)(6)-2		

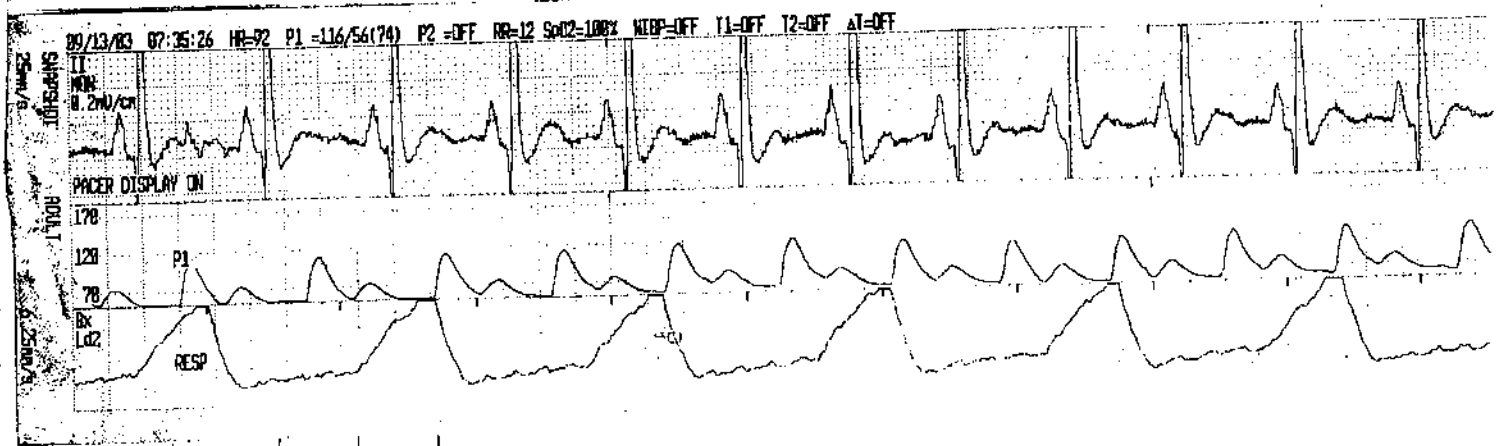
VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	98.3	91	12	113/53	100	131/59											
0200	98.4	82	12	118/50	100	127/57											
0300	98.5	86	12	123/57	100	135/61											
0400	98.3	95	12	~~130/63~~ 134/66	100	130/63											
0500	98.5	87	12	116/63	100	137/59											
0600	97.4(AX)	97	12	123/62	100%	144/64	84										
0700	97.4	94	12	110/53	100%	114/51	70										
0800	98.4	97	12	118/57	100%	120/59	78										
0900	98.8(CA)	98	12	126/64 (b)(6)-2	100%	139/63	83										
1000	99.4(CA)	104	12	126/66	100%	142/62	83										
1100	99.4(CA)	101	13	116/54	100	133/55	77										
1200	99.2(CA)	144 100%	12	140/80	~~100%~~ 103%	185/86	104										PT RECEIVING BED BATH
1300																	
1400	TO OR																
1500																	
1600		Recovery															
1700	96.6	86	12	130/73	100%	159/72	95										
1800	97.5	92	12	122/63	100%	142/67	85										
1900	97.8	94	12	121/66	100%	141/69	88										
2000	98.3	97	12	123/66	100%	143/69	90										
2100	98.6	107	15	123/64	100%	145/66	88										
2200		115	25/12	118/62	100%												
2230	99.3(AX)	112	24/12	121/61	100%	142/66	86										
2300	99.4(AX)	126	24/12	121/64	100%	143/65	91										
2400	99.5(AX)	109	12/12	110/62	100	145/56	85										

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
138/03	0105		Assessment & change. VSS. will monitor. (b)(6)-2
	0300		Pt dsg c continued leakage of serosanguinous fluid from midline wound. Padsclumped disposable clean change, skin care given. (b)(6)-2
	0530		Ø Δ in status. (b)(6)-2
9/13/03	0630		Pt c Transient Episodes of TACHY Cardia 130-140's & c Hypertension 160-170/90's. Pt given 100mcg boluses of Fentanyl which brought HR & BP back to 120's/50's HR 90's. Pt c Cardiac & generalized edema. Continues to have large amount of serous Sanguinous drainage from Bezata bag & GSW site Dr's reinforced. See flowsheet for further assessment. (b)(6)-2





	INTAKE									OUTPUT						
	LR	VERSED	VECURONIUM	FENTANYL	IVPB	BOLUS			Total	URINE	STOOL	NG	INCISIONAL DRAINAGE / EBL	JP	Total	COMMENTS
0100	150 / 150	4 / 4	6 / 6	5 / 5						75 / 75						
0200	150 / 300	4 / 8	6 / 12	5 / 10						50 / 125						
0300	150 / 450	4 / 12	6 / 18	5 / 15						50 / 175						
0400	150 / 600	4 / 16	6 / 24	1 / 16						100 / 275						
0500	150 / 750	4 / 20	6 / 30	1 / 17						50 / 325						
0600	150 / 900	4 / 24	6 / 36	1 / 17	100 / 100					75 / 400		300 / 300				
0700	150 / 1050	6 / 30	6 / 42	1 / 18	50 / 150					50 / 450						
0800	150 / 1200	6 / 36	6 / 48	1 / 19						50 / 500						
8 HR	1200	36	48	19	150				8 HR. 1453	500		300			8 HR 800	+ 653
0900	150 / 150	6 / 6	6 / 6	1 / 1						75 / 75						
1000	150 / 300	6 / 12	6 / 12	1 / 2						100 / 175						
1100	150 / 450	6 / 18	6 / 18	1 / 3						75 / 250						
1200	150 / 600	6 / 24	6 / 24	1 / 4						75 / 325						
1300	150 / 750	6 / 30	6 / 30	1 / 5	100 / 100					100 / 425		175 / 175				
1400																
1500 OR	1400 / 2150								OR	75 / 500			100	~~100~~	155	
1600	125 / 2275	6 / 36	6 / 6	1 / 1					2353	300 / 800				55	175	
8 HR	2275	36	36	6					16 HR. 3806	800		175	100	55	16 HR. ~~1130~~	1930
1700	125 / 125	6 / 6	OFF	1 / 1												
1800	~~150~~ 125 / 250	~~6~~ 6 / 12	OFF	1 / 2	100 / 100					125 / 125				40 / 40		
1900	125 / 375	6 / 18		1 / 3												
2000	125 / 500	6 / 24		1 / 4						150 / 275				40 / 80		
2100	125 / 625	6 / 30		1 / 5												
2200	125 / 750	6 / 36		1 / 6						150 / 425				30 / 110		
2300	125 / 875	6 / 42		1 / 7						100 / 525						
2400	125 / 1000	6 / 48		1 / 8	100 / 200					100 / 625				30 / 140		
8 HR							1256		24 HR 5062						24 HR 2695	+ 2367

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
9/13/13 1000	NO Δ's from previous assessment. (b)(6)-2 ICT,
9/13/13 1300	Picked up by OR staff & transported to OR via Gurney NAD noted. VSS (b)(6)-2 , ICT,
1700	Pt returned from OR, went to recovery. NGT taken out in OR. J tube & tube placed to gravity drain, JP to RUQ sanguinous drainage. Urine pink-tinged per foley cath. Vec turned off @ 1630, Versed infusing @ 6mg/hr, Fentanyl @ 50mcg/hr, D5 1/2 NS ⊼ 20kcl @ 125cc/hr @ all infusing to ⓛAC. ⓡAC HL. Dressing on ⓒ flank removed and d'd packed ⊼ wet saline 4x4 gauze. Covered ⊼ abd pad and tape (b)(6)-2 LTA
3200	Pt dressing on ⓒ flank changed @ 2100. Serosanguinous drng on drsg. G tube and J tube ⊼ drng. (b)(6)-2 LTAN
2300	Dr. (b)(6)-2 notified of ST. Will repeat ~~CBC~~ if HR stays 130's. MSO4 given ~~2230~~ 2300. Cuff BP reading SBP ~20 mm lower than Aline. Pt moving hands but not following commands or opening eyes. (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) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep / 13 Sep
POD	3/1

24 HOUR DATA	
24 Hour Balance	+64
24 Hour Intake	4654
24 Hour Output	4590
Weight on Admission	
Weight Yesterday	
Weight Today	

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

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

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAJ/DN	ICU	14 Sep 03

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

(b)(6)-4

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

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

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) AC	11 Sep 03	Ø s/s of infection or infiltration
Dc'd 16g	(L) AC	11 Sep 03	Ø s/s of infection or infiltration
A-line	(R) Radial	11 Sep 03	sutured/dsg site - Ø s/s infection/infiltrate
18g	(L) Bicep	14 Sep 03	patent. spike, silk tape

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

MOTOR FUNCTION

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

CHART CODES

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

DATE:

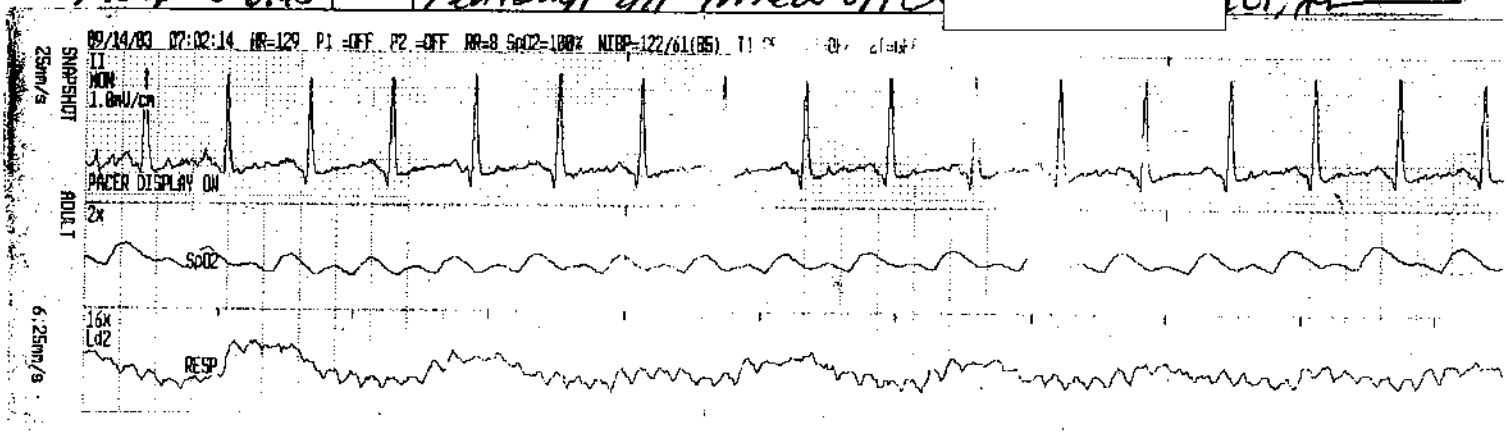
TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		2					1				1				1				2					
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		ET					1 T				1 T				ET				ET					
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response							4T				4				4				4					
GLASCOW COMA SCALE (A+B+C)							6T				6T				6T				6T					
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+					2+				2+													
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+					2+				2+													
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4					4				4				5				5					
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		4					4				4				5				5					
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		4					0				0				+				+					
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		0					0				0				–				–					
GRIP (S) Strong (W) Weak (-) absent — R		S					N/A				N/A				S				S					
GRIP (S) Strong (W) Weak (-) absent — L		S													S				S					
RESPIRATIONS — REGULAR		✓																						
RESPIRATIONS — IRREGULAR		Vent					Vent				X													
RESPIRATIONS — UNLABORED		✓									✓				VENT				Vent					
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		4					3				3				3				3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL		4					3				3				3				3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL		4					3				3				3				3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		4					3				3				3				3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES		1					3				3				3				3					
COUGH — NONE		✓					✓				✓				✓									
COUGH — SPONTANEOUS																			✓					
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		D													white/ clear				K					
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt		700					700				700				700				700					
VENTILATOR — FiO2		40					40				40				40				40					
VENTILATOR — RATE (SIMV/CMV)		12					12				12				12				12					
VENTILATOR — PEEP / CPAP		5					5				5				5				5					
VENTILATOR — PRESS. SUPPORT							0				0													
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
OXYGEN DELIVERY DEVICE — ETT 23 cm gums (ETT # 8)							✓				✓				✓				✓					
ETT CARE / POSITION CHANGE		✓				✓		✓			✓				✓		✓		✓					
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2						(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.4 ax	115	M/12	122/62	100%	M8/58	82										
0200	100.2 ax	119	12		100	142/63	87										
	100 ax																
0300		125	20/12	120/62	100%	126/87	100										
0400	100.6 ax	125	12	120/63	100%	128/77	94										
0500	102.3 ax	121	16/12	124/66	100%	138/68 124/92	90 88										
0600	100.3	132	12	127/71	100%												
0700	100.1 (A)	128	12	122/61	100												
0800	100.1 (A)	133	10	121/61	100												
0900	100.4 (A)	131	15	125/65	100												
1000	100.4 (A)	136	21	125/58	100												
1100	100.0 (A)	131	22	123/62	100												
1200	100.8 (A)	139	22	116/62	95												
1300	101.0 (A)	137	22	113/63	100												
1400		127	22	118/55	100												
1500	100.2	130	22	129/60	100												
1600	101.1	121	21	124/62	100												
1700		122	21	122/59	100												
	100.5																
1800		115	22	128/66	100												
	100.5																
1900		112	22	134/64	100												
2000		110	20	124/63	100												
	99.8																
2100		109	21	122/60	100												
	100.1																
2200																	
2300	100.1	103	20	117/52	100%												
2400																	

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
14Sep03	02		Dressing ↑ to ① flank. Mod. amt but not soaked to chux, HR ↑ 130's - CBC Sent. T = 100°ax - notified LTC (b)(6)-2 who will notify surgeon - in OR. Instructed to give Tylenol 650 mg PR now. Assessement done - Generalized edema. PT moving upper extremities c strong grip at times but not following commands. (b)(6)-2 NOTED
14Sep03	0530		Unable to flush or draw blood off A-line - cath D/C - ϕ s/s of infection @ site. Cath. intact. (b)(6)-2 NOTED
14Sep03	0700		See flowsheet for assessment. Pt c episodes of agitation Flexing Arms towards Chest c ↑ HR 130's-140's. Pt does not follow Commands. G & J Tubes to drainage bags c drainage. JP patent & intact c ~~Bl~~ Serous Sanguinous drainage. Generalized edema to include sclera. Will Continue to monitor. (b)(6)-2 LCT, RN
14Sep03	0919		↓ Vent rate to 10. NAD noted. VSS (b)(6)-2 (b)(6)-2 LCT, RN
14Sep03	0935		Lasix 20mg IV given (b)(6)-2 LCT, RN
14Sep03	0945		Fentanyl off turned off (b)(6)-2 LCT, RN



14Sep03	1003		↓ rate to 8 (b)(6)-2 LCT, RN
14Sep03	1102		↓ rate ~~off~~ to 6 (b)(6)-2 LCT, RN
14Sep03		1220	Pt ~~Sat~~ desaturated to 80's. placed Vent rate back to 12 BVM. Vcvsed ↑ 2 mg IV. SAT ↑ 100%. Will Cont. to monitor. (b)(6)-2 LCT, RN

	INTAKE										OUTPUT						
	PIV	Versed	Fentanyl	IVPB					Total		Urine	G tube	JP	T tube		Total	COMMENTS
0100	125 125	6	1								75 75						
0200	125 250	6 12	1 2								100 175		30 30				
0300	125 375	6 18	1 3								125 300		30 60				
0400	125 500	6 24	1 4								100 400		30 90				
0500	125 625	6 30	1 5								100 500						
0600	125 750	6 36	1 6	150							50 550		30 120				
0700	125 875	6 42	1 7								100 650						
0800	125 1000	6 48	1 8								75 725		40 160				
8 HR	1000	48	8	150					8 HR. 1206		725		160			8 HR. 885	@ 321
0900	125 125	6 6	1 1								100 100						
1000	125 250	3 9	.5 1.5								800 900		35 35				LASIX 20mg IV given @ 0955
1100	125 375	1 10	0 1.5								600 1500						
1200	125 500	1 11									175 1675						
1300	125 625	1 12		100 100							125 1800						
1400	125 750	2 14									100 1900		40 75				
1500	125 875	2 16									150 2100						
1600	125 1000	2 18		50 150					1169		150 2250					2325	
8 HR	1000	18	1.5	150					16 HR. 2375		2250		75			16 HR. 3210	
1700	125 125	2 2									125 125						
1800	125 250	2 4									75 200						
1900	125 375	2 6		100 100							100 300		25 25				
2000	125 500	2 8									100 400						
2100	125 625	2 10									75 520		+75	175			
2200	125 750	2 12									100 620		25 50	25 195			
2300	125 875	4 19	6 6	50 150							80 700						4654 4590 64
2400	125 1000	2 21	2 8	100 250					2279		150 1070		15 65	50 245		1380	
8 HR	1000	21	8	250					24 HR. 4654		1070		65	245		24 HR. 4590	+64

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE 1/4/03 (1400) Assumed care of pt. Assg. change and lines change pertaining to GSW & wet/dry dsgs, scant bleeding noted & removal of drsg ~~redressed~~ (b)(6)-2

(1500) Assessment per flowsheet. Lungs & mild rhonchi throughout, ~~Sputum reduced~~ ETT suctioned for scant white > clear secretions. Pt ~~agitated~~ will procedure restraints maintained to protect tubes and drains. Abd midline drsg dry & intact. remains & absent bowel sounds. Continues & blood tinged urine, QS.

(1530) Pt appears more agitated & increased contraction of upper extremities, MSO4 given per order (b)(6)-2

(1630) Pt & continued fussy, GS aware, orders carried out (b)(6)-2

(1730) Temp 100.5. will continue to assess (b)(6)-2

(1915) Pt & bloody secretions on suctioning ETT. noted bloody sputum coming up ETT. HO notified will monitor (b)(6)-2

(1930) Pt & ↑ agitation MSO4 2mg given, will monitor (b)(6)-2

2010 Pt fighting against restraints. MSO4 2mg given will monitor

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11 SEP 03
DOS	11 SEP / 13 SEP
POD	4/2

24 HOUR DATA	
24 Hour Balance	-4246
24 Hour Intake	2764
24 Hour Output	7010
Weight on Admission	
Weight Yesterday	
Weight Today	

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

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

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 USAN	ICU #1	15 SEP 03

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

(b)(6)-4

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

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding	RADIAL R	2						2								2									
(3) Full	L	2						2								2									
(2) Normal	DORSALIS R	2						2								2									
(1) Faint (0) Absent	PEDIS L	2						2								2									
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale		1 3 8						1 3 8								1 3 8									
EDEMA		✗														✗									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S1S2						✓								✓									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST						ST								ST									
SWAN GANZ CATHETER (Zeroed & calibrated)		Ø																							
ARTERIAL LINE (zeroed & calibrated)		Ø																							
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST	✓						✓								✓									
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓						✓								✓									
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	Sedated Intubated						Sedated								Sedated									
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended	✗														✗									
BOWEL SOUNDS (active all quads)		Ø						Ø Ø								✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓						✓								✓									
VOIDING CLEAR, YELLOW URINE q.s.								✓								✓									
SKIN INTEGRITY	No Breakdown							✓								✓									
	Surgical Wounds	✓						✓								✓									
	Rashes, Lac's, etc															~~✓~~									
DRESSING (Dry & Intact: specify site below)								✓																	
#1 Midline silk tape 4x4s		✓						✓								✓									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) AC	11SEP03	Ø S/S infection / infiltration
PIV 18G	(L) bicep	14SEP03	patent Ø S/SX infection / infiltration / 0800
PIV 18G	(R) wrist	15SEP03	Ø S/SX infection / infiltration / 0300