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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19 Oct 03	1640 Surgery
	Pt c̄ Temp 101.2 Repeat WBC = 14.2 (↑)
	Exam: Abd: Tender, Guarding, ± Rebound
	Bowel Sounds Hypo-Active.
	Pt's clinical condition is worse c̄ Temp, ↑WBC,
	Abd Tenderness.
	Plan Exp Lap. (b)(6)-2 [redacted]
	Pt remains slightly somnolent and refuses to converse
	with us thru interpreter. I feel clinically the surgery
	is indicated as pt appears uncomfortable from abd pain,
	has ↑HR, ↑Temp, increasing WBC. (b)(6)-2 [redacted]
19 Oct 03	Surgery
1650	I agree with above assessment. I agree
	pt should undergo emergent laparotomy to
	R/O intraabdominal injury. Has ↑'d WBC,
	prolonged and Temp of 101.2, still
	altered mental status. (b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST, FIRST | [redacted] | R'S ID NUMBER (Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGIS[redacted] | [redacted]D NO.

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

Potus # (b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
19 Oct 03 2100	Op Note Pre-op Dx: Shrapnel Wounds to Abdomen Post-op Dx: Shrapnel Wounds to Abd c Sm Bowel + Colonic Injury Proc: Exp Lap, Repair of Sigmoid Colon Enterotomy, Repair of Small Bowel Enterotomy Resection of Small Bowel Injury with Stapled Anastamosis. Appendectomy Surgeon: (b)(6)-2 Anesth: GETA EBL = 200 Fluids: 5000 Findings: Small 3-4mm Sigmoid Colon Injury, Opened Slightly & Minimally Debrided. Closed in Two Layers c Interrupted 3-0 Silk 1cm Prox Sm Bowel Injury - Repaired in Two Layers with Interrupted 3-0 Silk 3cm Prox Sm Bowel Injury. Resected & Repaired c Stapled Side to Side (Functional End to End) Anastamosis. □ Incidental Appendectomy Performed (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	GYN Staff Note
20OCT03	S: pt seen problems discussed through [illegible] interpreter
0912	pt having pain in abdomen "can't talk" would like
	something for pain. long MS since surgery. S/P 1U
	PRBC transfusion. No other c/o's.
	O: VSS Tmax 99.6 since surgery
	lungs CTA b/c [illegible]
	heart RRR [illegible]
	abd soft NTND [illegible] ; Bandage dry ⊕ tender ⊖ BS all 4 quad
	ext [illegible] strong [illegible]
	LABS: [illegible] 10/.9 130 Bili 2.5 AST 81 ALT 74 12.2) 12.9/37.4 (234
	Imp: ① S/P Partial SBR, reanast; large + small bowel
	enterotomy repairs, appy POD # 1
	PLAN: ① consider tube feedings
	② continue abx, IV fluids
	③ [illegible]

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

POTUS #

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
20 Oct 03	Nutrition Consult
S	Consult for nutritn support recs
O	Iraqi ♂ s/p partial SBR, reanastomosis, large + small bowel enterotomy repairs. POD # 1
	Diet: NPO @ bowel sounds Meds: Unasyn, zantac
	Labs (10/20) gluc 130, Bun/Cr 10/.9, alb 2.5, chol < 20
	Height/weight: N/A Weight est @ 135# height ~ 65"
A	Nutr dx statement
	(1) Possible malnutrition based on lab/anthropometric data. ↓alb could be 2° hydration/fluid shifts + is not a reliable indicator of nutr status in critically ill.
	(2) ↑ needs to support healing
	Nutr needs est @ 1800-2100 Kcal/d (30-35 kcal/kg) + 75-90 gm pro/d (1.2-1.5 gm/kg.)
R/P	Enteral feeding @ return of bowel fxn to improve nutr stores + promote healing.
	Osmolite HN - initiate at 20 cc/hr & advance q 6-8 hr as tolerated to goal rate of 80 cc/hr to provide 85 gm pro and ~2000 Kcal, 1600 cc free water. Will need additional 400 ml H_2O to meet fluid needs. Monitor Mg, K, PO_4 for refeeding syndrome. Will follow.
	[b](6)-2 NLT, SP, MD, RD

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

POTUS [b](6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
POTUS # (b)(6)-2			

DATE	NOTES
	GYN/Surg Note
21OCT03	S Pt seen problems discussed through interpreter. Pt
1000	pain better and minimal pain med requested.
	Patient has some "dysuria, difficulty urinating" but
	has catheter in. Mobilizing more fluid c drainage
	NGT, ↓ in abd pain overall. ⊖ flatus ⊖ BM Ⓡ knee
	sore near kneecap
	O: VSS Tmax 100.9° I ≈ 0, ~100cc NG output
	lung CTABL s wh
	heart RRR s @ click mb
	abd soft NTND c mastlomy. ⊕ BS (mild) in 3 quad, min
	serous drainage on bandage, dressing Δ'd last pm
	ext ppp c 4 string s e/c/c; Ⓡ knee palpated s edema
	crepitence or swelling ⊖ Homans ⊖ Mose
	LAB: 120 | 99 | 10 / 4.0 | 27 | 1.8 (133 6.2) 9.1 / 26.6 (195
	A/P: ① S/P ex lap, small + large bowel enterotomy
	repairs, partial SB resection c 1° reanastamosis,
	appy POD #2
	PLAN: ① monitor I+O orally → consider pulling NG tube
	if output low
	② tube feed/oral intake when bowel fxn
	③ ice chips ambulation
	④ seen c Dr (b)(6)-2
	(b)(6)-2

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21 Oct 03 2100

Temp 101.8, Pt in now distress
- Wound Open & Clean
- Chest → ↓BS (R) Base

CXR → Atelectasis (R) Base
LG in Duodenum
Had Pt do Incentive Spirometry.
Also did N-T Stimulation c Moderate Effort Cough.
(A) Temp most likely do to atelectasis
(P) Continue I:S & Coughing.

(b)(6)-2

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

DEPART.. SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

Patus

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 REV 5-891
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	POD #3
22OCT03	S: pt seen problems discussed interpreter not
0950	available. "water hurts" and pt is ambulating,
	so Foley could be pulled. Not coughing/expectorating
	effectively due to pain. Abd pain better. No N/V,
	but sipping water causes his stomach to "hurt"
	O: VS Tmax 101.8 ax
	lungs ↓ BS in (R) lower field, otherwise CTA RRR s̄ m/r/g
	heart: MMS ↑CR x̄ tachy
	abd bandage dry, hih BS, NTND s̄ masses meg
	ext ↑↑↑ - 1 strong p̄ cl c/c
	A/P: (1) S/P appy, exlap, enterotomy repair (SB+LB), part
	SB resection s̄ 1° reanast - POD #3 (stable)
	(2) FUO - suspect atelectasis/bronch vs WI
	PLAN: (1) remove Foley today
	(2) await better BS before clamp NG tube + consider D/c
	or tube feeding. (b)(6)-2
	(3) replace Na^+

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

509-114

DATE	NOTES
	GYN note
22Oct03	S: pt seen problems discussed through interpreter.
2000	Called to eval pt re: 102° temp lasting. Rectal tylenol given. Pt reports 2 voids since Foley removed → no dysuria or difficulty. (+) better cough effort → still not forceful. Ambulating c̄ difficulty (+) Flatus (−) BM, (+) belching. Tolerating sips of H_2O c̄ N/V. Abdominal pain low baseline well controlled
	O: VSS Tmax 102.1° (on Primaxin)
	lungs CTAB/L c̄ mild (+) rhonchi (L) base clear c̄ cough
	heart RRR c̄ (m) click/rub
	abd: incision clean – no rubor/calor, ø ecchymosis or erythema, NTND c̄ masses neg (+) BS all 4 quad (−) rebound
	ext PP = + strong ø c/c/c
	LAB: u/A sm. bacteria (−) nit (−) LE sm blood
	I/AP: (1) S/P enterotomy repairs (SB + LB), partial SBR c̄ 1° reanastomosis, ex lap + appy POD#3
	(2) FUO suspect atelectasis vs bronchitis/pneumonia
	Plan: (1) Δ'd abx, encourage cough + expectoration + IS
	(2) Foley, NG out
	(3) clear liquids as tolerated
	(4) continue present management
	(b)(6)-2 [redacted]
20 Oct 03 2045	
	As Above.
	Lung Exam: Breathsounds Absent (R) Base.
	Pt N-T Suctioned, Good Cough + Sputum.
	Re-Exam: Much Better Breathsounds (R) Base
	(b)(6)-2 [redacted]

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

23 Oct 03 0936 Surgery POD #4

+ Pt ambulating
+ Tm 102.4 (Current 100.6)
Lungs: Decreased @ Base, But Improved.
Pt with improved Resp effort & cough.
Abd: Wound Open, Clean.

$\frac{23}{214}$ / 5.5 $\frac{136}{3.6}$ | $\frac{99}{24}$ | $\frac{12}{1.0}$ / 117

- Pt stable overall
Improved Resp Status but still c Atelectasis vs Pneumonia @ Base
- Cont pulm Rx - Nebs, N-T Suction
Primaxin

(b)(6)-2

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

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

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

Patus

(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)

509-114

NSN 7540-00-634-4178

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23Oct04	(2230) Nurse note: Pt sleeping supine position; easily arousable to gentle touch. Pleasant disposition; cooperative; Denies pain @ this time D5NS @ 20 KCL infusing to 18G PIV to (R) FA. S/S of complications. Midline incision dressing c/d/I. Active BS x 4 quadrants. Lung sounds diminished in middle & lower lobes. (+) Spontaneous productive cough. thick / yellow & bloody. Return demonstration given for I/S use. Will continue to monitor for Δ in status – [b)(6)-2] CRT
24Oct04	0130 - OOB to BSC unassisted; movements slow and steady. Ambulated from unit to DFAC. Staff and MP Escort present. Urine not as concentrated as before. (+) small amount mucous stool. Pt back to bed and sleeping @ present time. – [b)(6)-2] CRT
	0400 Vitals - Bp 123/57 – RR -14 – HR 99 – Temp 100.7 Pox -99%.
	0730 VS - BP 123/71, HR 102, RR 16, SpO_2 96% on RA T 101° pt had med BM; IS used + was able to achieve 3 balls x4; NAD; pt. now resting in bed; does not c/o any pain; has not required any pain med – [b)(6)-2]
	@0930 VSS BP 120/76, HR 101, RR 14 SpO_2 99% RA T 101° tylenol given 650 mg PO per doctors Orders –

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

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

Potus [b)(6)-4]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24oct03	Ø c/o pain at this time will continue to monitor
@ 1030	pt up to chair, walked 3 times to DEF AC and back. Tolerated well Ø c/o pain Dizziness or light headed. Will continue to monitor [b)(6)-2]
1230	VS BP 123/70, HR 101, RR 14, SpO2 98% on RA; T-99°; pt ate (drank) 50% of clear liquid diet; Ø c/o pain; tolerated well; IS used + achieved 3 balls x6; NAD. pt. now resting in bed; will cont. to monitor [b)(6)-2]
1500	Pt ambulated hall x3 ~ difficulties. Able to get self out of bed ~ assistance. Used IS when returned from ambulation. Able to maintain suspension on all 3 balls on IS. Dressings [b)(6)-2] to fingers on (R) hand bacitracin applied. IVF D5 1/2 NS ~ 20mEq/kcl/L infusing @ 50 cc/hr to 18g in (R) FA. Tolerating P.O. BS Active x4. Pt cooperates ~ commands. Lungs clear throughout but diminished in (R) base. Coughs ~ productive cough [b)(6)-2]
1600	T 99° @ BP 117/65 P 97 R 18 SaO2 100% pt back in bed. Voided clear yellow urine [b)(6)-2]
1705	c/o 2-3/10 abd pain, states pain ↑ to 6-7/10 ↓ drinking cold fluids. Percocet 1 po given for abd. pain. Had BM ~ hard stool, gets in/out of bed ~ assist. [b)(6)-2]
1900	T 100.7 @ BP 119/66 HR 97 SaO2 98% R 18 Pt c/o mild headache [b)(6)-2] Pt ambulated to radiology for PA/lat CXR. Pt c/o feeling dizzy from medication (Percocet). Used IS. Also explained thigh intimate need for pt to ↑ po fluid intake [b)(6)-2]
2030	
2130	IV in (R) forearm d/c'd because pt c/o pain. XCVP 206 ml started in (R) upper arm [b)(6)-2]

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION** *(Sign each entry)*
24 OCT 03	Surg Note POD #5
0900	Pt seen problems discussed thru interpreter. Pain
	continues to improve w/ new Op's. Pt walking,
	urinating w/ difficulty (+) Flatus (+) BM (x3) since
	yesterday. Pt doing IS + also breathing txs.
	Fever persists + resp. effort still ↓
	O: VS Tmax 101° @ 0130 today
	lungs CTA b/l w/ WR. ⊕ Ronchi / ? rales (R) side
	heart RRR ⊖ click/rub
	abd soft NTND w/ midline incision dry well approx,
	⊕ BS all 4 quad
	ext PPP = ⊕ strong ø edema
	LAB: 6.3) 9.3 / 26.9 (328 136 / 98 / 11 / 4.0 / 22 / 0.7 (112
	Imp: (1) S/P ex lap, partial SB resection c̄ reanast.,
	small + large bowel enterotomy repairs, appy POD #5
	PLAN: (1) ↑ diet to clears (2) F/U - doubt belly @ this time
	(2) continue breathing txs, IS
	(3) encourage ambulation
	(b)(6)-2

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

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

POTUS (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	24 Oct 03 @ 2215 Nurse note. Vitals Bp 125/68, HR 104, Temp 100.0, RR 20, POX 97%.
	Pt sitting up p̄ N-T suctioning ⊕ bloody secretions. min
	amount. 20 G PIV to Ⓡ arm. BS clear except to RLL
	(diminished) BS x4 quadrants. Dressing to midline incision
	intact c̄ 2 small areas of drainage. Encourage deep
	cough / breathing and use of I/S. Will continue to monitor
	for Δ in status —— (b)(6)-2 CPT
	(2345) Dressing Δ'ed to midline incision. Incision moist
	c̄ open areas ⊕ minimum drainage. Staples + sutures
	in place to keep incision approximated. Ø S/S of infection.
	Pt tolerated well. —— (b)(6)-2 CPT
25 Oct 03	(0200) – Vitals – Bp 118/55, Pulse 85, POX 98%, Temp 99, RR 20 – Easily
	arousable. Ø complaints @ this time. I/S used – (b)(6)-2 CPT
	0630 – VS HR 101, BP 129/67, SpO2 100%, RR 14, T 100.1; lung
	sounds clear Ⓑ in all lobes; BS active x4 quad.; pulses ⊕
	+ normal Ⓑ radial + Ⓑ pedal; NAD; VSS; pt denies having any
	pain; IS was used + pt able to maintain 3 balls for 2-3 sec.
	each time; pt is resting c̄ eyes closed; stated he would like
	to wait on breakfast; will cont. to monitor —— (b)(6)-2
	(1030) T 100.3, BP 128/69, HR 107, 98% SpO2 on RA; pt was up
	out of bed this AM, ambulated up + down corridor x 3; pt

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)

Potus # (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)

509-114

DATE	NOTES
25Oct03	1030 cont. then sat in chair for 1 hr. + did personal hygiene; dressings were Δ'd on Ⓛ hand; IS was used again + was able to maintain 3 balls; had med. BM (liquidy in consistence); now is resting in bed; MD is changing dressing to abdominal incision; NAD; VSS; will cont. to monitor ——— [b)(6)-2] [illegible] PC
25 Oct 03 1450	VS: BP 127/63, T- 101.2 oral, P- 108, RR- 40, SpO_2 96% on RA. Awake, alert, appears oriented, Ⓑ grips equal + strong, MAE, PERLA. Heart sounds normal, tachycardic. Lungs CTA in all lobes, ↓↓ diminished in RLL. Pt c/o Ⓡ upper chest pain c deep inspiration. Abd flat, soft, non-distended. Ⓑ radial + pedal pulses 2+; skin warm, dry, brisk cap. refill; + bowel sounds x 4 quadrants. Ⓡ bicep IV c NS NS + 20KCl @ 50 cc/hr, site c/d/i s/s/s infiltration or infection. Abd dsg d+i. Voiding dark yellow urine in urinal, qs. ——— [b)(6)-2] MAT AN
1500	RR remains 40, shallow, appears unlabored. Will cons. lt c physician ——— [b)(6)-2] MAT AN
1555	Dr. [b)(6)-2] in to assess pt @ ~ 1505. STAT CBC + UA ordered + sent. Pt appears in no acute distress. WBC- WNL [b)(6)-2] MAT AN
1600	Tylenol ii po given @ 1530 for T- 101.2 oral @ 1450. Current temp is 101.5 oral, Dr. [b)(6)-2] aware. [b)(6)-2] MAT AN
1900	VS @ 1855: BP- 124/70, T- 99.4 oral, P- 112, RR- 36, Sp_2- 98% on RA. Remains tachypneic, resp. are shallow and unlabored. Ate 10-20% of dinner. Ambulated to MWR → ER/Radiology → back x 2 c Ø assistance. Had one BM, minimal amt of lt brown flakes/specks. [b)(6)-2] MAT AN
1930	No changes in physical assessment noted since previous one (1450 today) [b)(6)-2] MAT AN

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Surg note
25OCT03	S: pt seen problems discussed (c interpreter): walking
0945	c difficulty, urinating c difficulty (+) Flatus (+) BM, switched
	to oral pain meds c good control
	O: OSS Tmax 100.1°
	lungs CTAB/LS [illegible]
	heart RRR s [illegible]
	abd soft NTND s masses neg Incision dry (+) BS
	ext PPP - 4 strong
	Imp: (1) POD#6 enterotomy repairs, SB anast, appy
	(2) FUO - responding
	PLAN: (1) 24° more afebrile, consider d/c planning
	(2) continue care (b)(6)-2 [redacted]
	(3) ↑ diet
25Oct03	1630 T = 101.5 Pt c
	No Complaints
	Lungs: ↓ BS (R) Base
	Abd: Soft. (+) Bowel Sounds. Wound Clean
	UA (−) WBC 7.9
	Reviewed CXR Again - Still Residual Atelectasis/Infiltrate (R) Base
	Will Cover c po Levaquin

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

REGISTER NO.	WARD NO.

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

POtus (b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Oct 03 2100	T- 100.4 oral. Cont. to use IS well, lifting all 3 balls, has poor cough, mainly clearing throat for mod-lg amt of white, frothy secretions. Denies further pain in RU chest c deep inspiration. Poor po intake, UOP ~ 200 dark yellow urine per hour. [b)(6)-2] MD RN
25 Oct 03 2245	T 101°, Bp 125/60, RR 32 (shallow), Hr 120, Sp 96%. - Small BM OOB to chair for deep breathing + cough. Pt does not understand concept. Interpreter present and assisting unsuccessfully. IS used c better results. Tylenol 650 mg po given. Dressing to midline incision intact c old drainage. IVF infusing c difficulty. Will continue to encourage deep breathing and monitor temperature. [b)(6)-2] CPT(A)
26 Oct 03 @ 0100	Lung clear in upper lobes, diminished in middle + bases. Pt's Temp 99° orally. - OOB to BSC used IS x 10. [b)(6)-2] CPT(A)
(0800)	- 130/65, HR 85, T 98.5, RR 28, Pox 100% - Pt c/o pain. Pt not sleeping @ this time. encourage Cough + deep breathing. - [b)(6)-2] (b)(6)-2 Medicated — [b)(6)-2]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

POTUS [b)(6)-4]

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
26 OCT 03 0700	Nursing Notes: VSS: T 97.8, Pulse ox 98%, BP 117/59, P [redacted], RR 16. Pt cooperative, A+O X3, pt ate 50% breakfast. Pt OOB in bedside chair, pt amb w difficulty. 22 g IV cath in upper (R) arm patent + infusing D5 NS c 20 mEq KCL @ 50 cc/hr w difficulty, site w redness, edema, or pain. Midline abdominal incision c dressing CDI. Pt performed IS and cough/deep breathe. Will continue to monitor. [redacted]
26 Oct 03 1100	Surgery – Pt w/ that complaints. Ate 40-50% Breakfast – NAD. Pleasant Abd: Soft. ⊕ Bowel Sounds. WBC = 9.4 No Pain w Palpation Hct = 27 Lungs: ↓BS @ Base – Stable. Temp down this a.m. Still concerned w Possible Pneumonitis Still Concerned w abd process/abscess, but abd exam at this time is Benign – Continue po Levaquin. Cont to follow closely [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		NUMBER
	LAST	FIRST	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

Potts [redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26OCT03	11:00 - T 98.6 /
26OCT03 1430	T 99.8 HR 98 BP 120/63 SaO_2 98% R 18 Pt assessment complete. Pulses 2+ in all extremities BS Active x4. Pt voids quant. aff clear yellow urine. Lungs clear in upper lobes (R) remains diminished in (R) L. Coughs, deep breather and uses IS. — (b)(6)-2 — LCTAN
1645	Pt ambulated halls and to outside at his request. Sitting in chair @ bedside. — (b)(6)-2 — LCTAN
1720	T 99.6 @ pt back in bed. Consumed 50% of dinner. (b)(6)-2 LCTAN
1900	T 100.4 @ IS complete 10x. Cough + deep breathe. (b)(6)-2 LCTAN
2100	T 99.9 @ BP 118/61 HR 92 SaO_2 98% R-18 (b)(6)-2 TAN
2300	T 100.6 BP 123/60 HR 114 SaO_2 99% RA RR 18. Pt ambulated w/ difficulty. Using incentive spirometer 3 balls ↑ x 10. (R) base cont ↓, BS x 4 midline abd dsg d+i Voiding qs — (b)(6)-2 LCTAN
27OCT03 0500	T 99.6 BP 117/66 HR 99 SaO_2 98 RR 16. Incentive spirometer done. (b)(6)-2 MAT/AN
27OCT03 0800	NAD. Negative Complaints. A&Ox3 Lungs CTA (B) ✓ BS (R) base ABD Soft & non tender @ BS X4 QUADS. 2+ peripheral pulses. (b)(6)-2 LCT, AN
27OCT03 0930	OOB to Chair. Ambulated in hospital Corridors & outside AM care done T 98.7 P 94 BP 119/65. NAD - (b)(6)-2 LCTAN.
27OCT03 1235	Released to NOK's. Discharge instructions given to NOK's/Medications & Dvsg D/S) HL dcid & Cath intact & no S/Sx of infection or infiltration. NAD. — (b)(6)-2 LCTAN.

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27OCT03	Surg Note POD # 8
0930	S: pt seen problems discussed thru interpreter.
	No pain. Ambulating, voiding, eating s̄ difficulty.
	(when I asked him why he eats so little - is it type of
	foods or pain - he indicated he only eats small meal
	he is hungry + eats until full) ⊕ Flatus ⊕ BM.
	O: VSS Tmax 106.6 present T 98.7°
	lungs CTABIL ↓ air
	heart RRR s̄ m/r/g
	abd soft NDNT s̄ masses. Incision dry, closing
	ext ___ s̄ swelling c/c/c
	LAB: 136 | 97 | 8 ⟨ 98 9.9 ⟩ 9.5 / 27.8 ⟨ 640
	4.1 | 25 | 1.0
	Imp: ① S/P ex lap, appy, partial SB resection, 1° re-
	anastamosis + small + large bowel enterotomy
	repairs POD # 8
	PLAN: ① ensure supplements
	② Ambien long qhs prn sleep
	(b)(6)-2

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

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

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

REGISTER NO.	WARD NO.

Potas # (b)(6)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DAU
558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 19 | MONTH OCT | YR. 03 — TIME: 0900

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

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

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: UNKNOWN

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

HOME TELE. NO. (Inc. area code)

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

SEX: M | AGE: UNK

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS

TIME	0910		
BP	124/73		
PULSE	91	96	
RESP.	29	20	
TEMP.	—	—	
WT. (Child)	91%		

CATEGORY (See reverse)

- [X] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

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)

Adult ♂ local national of unknown age transferred from FSB at TALIFAR P sustaining injuries in grenade attack. Subject is alleged perpetrator of attack, arrived in custody of US personnel, will not speak or answer questions, reeks of crystalloid

AMPLE history - unobtainable - prior to transfer

urine 950cc

A - patent and maintained Nasal trumpet in place

B - Breath sounds symmetric

C - Small amount of bleeding from fragmentation wounds BP normal, pulse ~ 100

D - GCS - 12 + (? sedation) PERL, MAE

E - Completely exposed, rolled

16.4 / 12.5 / 32.4 / 279

UA - SG: 1.022 large blood 20-30 RBC

GENERAL: Male ♂ adult ♂ sedated, arousable but noncommunicative

SKIN: Warm + dry

HEENT: NC ⊃ small penetrating wound (R) temporal area. PERRL/EOMI/Sclera clear (L) nostril ⊃ Nasal trumpet TM's unremarkable not well visualized ⊘ blood in EAC Small penetrating wound (R) anterior neck

LUNGS: CTAB ⊃ W/R/R

CV: NRR ⊃ (m) no S1/S2

CHEST: Numerous small penetrating wound fragments

ABDO: Scattered small fragments

BACK: Normal tone/NT - blood pleural area ⊃ fragments

(CONTINUE ON SF 507, IF NEEDED)

ORDERS

ORDERS	INITS.	TIME
MAINTAIN IV NS at KVO TKO		
2nd IV NS at KVO TKO		
FOLEY TO GRAVITY		
CBC, UA, T+S		
X-rays - CHEST, ABDO, PELVIS, SKULL		

ASSESSMENT/DIAGNOSIS: MULTIPLE FRAGMENTATION WOUNDS

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): GENERAL SURGERY
- EMERGENCY | TODAY
- 72 HOURS | ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED | UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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

POTUS [redacted] (detainee)

[redacted]

[redacted]

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

EXTREM - Fragmentation wound (L) shoulder (L) Thumb ⊃ open laceration at distal pad (L) 3rd digit laceration sutured closed prior to arrival

ON: Foley in place, gloves ⊃ cautery scrotum ⊃ two small areas of penetrating trauma ⊘ scrotal edema

CTR, MLC

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	
POD	

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

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

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

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAJ	ICU	19 OCT 03

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

POTUS (b)(6)-4

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

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R										2				2								2		
	L										2				2								2		
	DORSALIS PEDIS R										2				2								2		
	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											ϕ				ϕ								ϕ		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)											✓				S_1S_2								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)															NSR								SR		
SWAN GANZ CATHETER (Zeroed & calibrated)															ϕ										
ARTERIAL LINE (zeroed & calibrated)															ϕ										
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST														✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓								✓		
	HOB 30 DEGREES										✓				✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE														✳								✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended											2				2								2		
BOWEL SOUNDS (active all quads)											✓				x4								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT															✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
mult frag wounds	Surgical Wounds										✓				✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18 (b)(6)-2	(R) AC	18 OCT 03	CDI Heplocked
18 (b)(6)-	(L) AC	19 OCT 03	CDI

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

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

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

DATE: 19OCT03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open										3		4		4		4						3		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response										1*		5		5		5						5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response										5		5		5		5						5		
GLASCOW COMA SCALE (A+B+C)										9		14		14		14						13		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R										4+		3+		3+		3+						13		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L										4+		3+		3+		3+						13		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE										4				4		4						4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE										4				4		4						4		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE										4				4		4						4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE										4				4		4						4		
GRIP (S) Strong (W) Weak (-) absent — R										W				W		W						W		
GRIP (S) Strong (W) Weak (-) absent — L										W				W		W						W		
RESPIRATIONS — REGULAR										✓				✓										
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED										✓				✓										
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL										3				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL										3				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL										5				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL										5				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES										1				1								1		
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																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min) 2										✓				2L/M								2L/NC		
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____ 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		

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
	100.5 oral	101	14	129/71	100%		90										4LNC
1100																	
1200	99.6 Tymp	102	14	117/71	100%												2LNC
1300																	
1400	100.5 ax	114	26	123/75	100%		94										2LNC
1500																	
1600	101.1 ax 101.2 oral	109	23	127/77	100%		96										RA
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300	99.9	126	26 24	143/80	95		105										RA
2400	99.1	139	20	147/77 138/81	100		103										

Off & Recovery

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19 oct 03	1030		Pt received from EMT accompanied by MP personnel and hospital guard. See flowsheet for complete assessment. Pt opens eyes spontaneously and with vigorous tactile stimulation. Not responding verbally & following commands. Spontaneous movement of 4 extremities noted. HOB ↑ 30° [redacted] MAT RN
	1130 hrs		Dr [redacted] in to see pt, MP guard & bedside [redacted] MAT RN
	1420		Pt moaning in bed c/o pain to LLQ bandages in place at sight. @ middle finger c bandage covering sutches CDI. Multiple frag wounds on (R) LE and chest. Ecchymosis to penis but no hematuria visible. Opens eyes spontaneously and moves all extremities. Nasal cannula in place to (R) nare. IV in (R) ac flushes well & S/Sx infection/infiltration (R) AC infusing D5 1/2 NS @ 100cc/hr. Pt ignores interpreter when trying to talk to him. [redacted] PAN
	1630		Pt O2 ↓ to RA sats 100%, guarding abd. c/o pain when he opens eyes. [redacted] MAT RN
	1640		Dr [redacted] and [redacted] @ bedside - will take pt to OR for exploration
20 oct 03	2200 →		Assumed Care of pt. VSS. Recovery completed by previous shift. Attempted to open eyes on Verbal Command. Lungs clr. HR 120's NSR by monitor. Reacted on 3L 2° O2 Sat 89%. NC ad incision x (R) hand dressings CDI. Pulses palp. All extremities. Numerous superficial wounds from shrapnel noted. Cont to monitor. IV (R) infusion at 125cc/hr via pump S/Sx of infiltration or infection. Continue to monitor [redacted] CAT RN
	~~2330~~	2330	HR to 140's. Phys notified. New Orders noted. Cont. to monitor.
20 oct 03		0045	1st unit up. Cpe shows HOB of 31 cm H2O. HR remain 120's - 130's. Cont. to monitor. [redacted] CAT RN

	INTAKE									OUTPUT						
	D5½NS	IVPB	LR	Albu					Total	Urine	EBL	NGT			Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100	100 / 100	50 / 50														
1200	100 / 200									300 / 300						
1300	100 / 300	50								250 / 550						
1400	100 / 400	50														
1500	100 / 500															
1600	100 / 600									325 / 875						
8 HR	600	50							16 HR. 650	875					16 HR. 875	
1700	100 / 700									125 / 125						
1800	OK									OK						
1900																
2000																
2100	5000 / 5100									250 / 250	200 / 200					
2200			150							100 / 350						
2300		100	150 / 300	1000						100 / 450						
2400			150 / 450						6550	42 / 492					692	
8 HR									24 HR. 7200						24 HR 1567	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	19 Oct 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	7200
24 Hour Output	1567
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		(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A		N
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SPTAN	ICU	20 Oct 03

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

Potts (b)(6)-4

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

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2		2				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 (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			Ø						Ø		gen				✓				–				Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓		✓				✓				–				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NST						ST		ST				✓				–				NST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE		✓												✓				–				✓		
	ORAL CARE								✓						✓				–						
MOBILITY	BEDREST		✓						✓		✓												✓		
	BSC																								
	DANGLE																								
	CHAIR											✓													
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓						✓		✓														
	HOB 30 DEGREES		✓						✓		✓				✓				–				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓						✓						✓				–				✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2						2		2				2				–				2		
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		✓						✓		✓				✓				–				✓		
SCATTERED Puncture wounds	Rashes, Lac's, etc										✓				✓				–						
DRESSING (Dry & Intact: specify site below)																									
#1 mc Abd			✓						✓		✓				✓				–				✓		
#2 (R)-hand			✓						✓		✓				✓				–				✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) AC	18 ga	19 Oct	s̄ s/sx of infiltration LR@150cc/hr /1000
(R) FA/HL	18 ga	19 Oct	s̄ s/sx of infection /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 N
No Change from Previous Assessment "

DATE: 20OCT03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4						4		4				4				–				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5						5		5				5				–				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6						6		6				6				–				6		
GLASCOW COMA SCALE (A+B+C)		15						15		15				15				–				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		3+						2+		2+				12				–				2		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		3+						2+		2+				12				–				2		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4						4		4				4				–				4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		4						4		4				4				–				4		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		4						4		4				4				–				4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		4						4		4				4				–				4		
GRIP (5) Strong (W) Weak (-) absent — R		W						W		W				5				–				5		
GRIP (5) Strong (W) Weak (-) absent — L		W						W		W				5				–				5		
RESPIRATIONS — REGULAR		✓						✓		✓				✓				–				✓		
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		3				3				–				5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		5						5		3				3				–				5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES		1						1		1				1				–				✓		
COUGH — NONE		✓						✓		✓														
COUGH — SPONTANEOUS																						✓		
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																						2		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min) RA								✓		✓				✓				–						
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____ 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				(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	99.1	120	20	138/81	100		103										3L NC
0200		112	20	130/76	95		98										RA
0300		116	22	137/84	95		103										RA
0400		111	16	135/78	97		102										RA
0500	99.9	114	25	136/83	95		103										RA
0600		111	19	139/74	97%		98										RA
0700		112	24	142/79	98%		101										RA
0800	98.5	109	24 97	139/74	97%		95										RA
0900		111	22	142/71	100%		99										
1000		118	26	143/69	95%		98										
1100	100.4 (99.9)	123	34	127/66	95%		91										RA
1200																	
1300																	
1400		103	19	136-74	96		98										RA
1500																	
1600																	
1700																	
1800	97.6	104	20	131-76	100		97										
1900																	
2000																	
2100																	
2200	100.7	112	24	131/62	99%												
2300																	
2400																	

	INTAKE										OUTPUT									
	AR	IVPB	PRBC's							Total	Urine	NGT								Total
0100	150 / 150	50	1 @300								125 / 125									
0200	150 / 300										100 / 225									
0300	150 / 450										125 / 350									
0400	150 / 600										120 / 470									
0500	150 / 750	100 / 150									80 / 550									
0600	150 / 900																			
0700	150 / 1050																			
0800	150 / 1100	50 / 200									450 / 1000									
8 HR	1100	200								8 HR. 1300	1000									8 HR 1000
0900	100 / 100																			
1000	100 / 200										450 / 450									
1100	150 / 350	100 / 100									300 / 750									
1200	125 / 475										225 / 975									
1300	125 / 600										100 / 1075	200 / 200								
1400	125 / 725										200 / 1275									
1500	125 / 850										225 / 1500									
1600	125 / 975	100 / 200									300 / 1800									
8 HR	975	200								16 HR. 2475										16 HR. @3000
1700	125 / 125	100 / 100									500									
1800	125 / 250										275 / 775									
1900	125 / 375										125 / 900									
2000	125 / 500										200 / 1100									
2100	125 / @25										100 / 1200									
2200	125 / 750										135 / 1335									
2300	125 / 875	100 / 200									40 / 1375									
2400	125 / 1000	100 / 300									300 / 1715									
8 HR	1000	300								24 HR. 3775	1715									24 HR 4715

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20 Oct 03	0145		1st unit Blood finished. VSS. Will await to infuse 2nd unit ē AM CBC results. Continue to monitor. Currently on RA ē attempts by pt to take off NC. O2 Sat 94%. HR to 110's. Continue to monitor. [redacted]
20 Oct 03	0400		Eyes closed. Snoring softly. Ø pain noted ē MSO4 @ 2230. VSS ē blood. HR remains 110's. LR @ 150cc/hr. Remains on RA. Continue to monitor. [redacted]
20 OCT 03	0600		Report received, assumed care of patient. Appears asleep, no distress noted [redacted]
	0800hrs		AM care done, see flowsheet for assessment. Ⓛ hand soaked, dressing again cleaned, dsd applied. Dsg's Δ'd to fragwound sites i dry. [redacted]
10/20/03	1115		Temp 100°(A). Medicated c MSO4 6mg IVP. OOB to Chair c assistance of 2 staff members. Tolerated well. See flowsheet for assessment [redacted]
Oct 20, 03		1400	Sleeping well NAD noises and fall of chest noted. Awake to sound of voices. ML ABD dressing intact with some drainage. Dressing to B/L hands intact. NG to Ⓛ nare intact. Has some pain but refuse any med at this time. ID will be used w/A. Understand my instruction about pain. W/A translator has no question at this time. [redacted]
		1815	OOB to chair. Tolerated well need some assist. received 3mg MSO4 for abd pain [redacted]
		1850	↓ in pain will cont to monitor per orders [redacted]
		1945	Return to bed tolerated well. Stated comfortable at this time. Will cont to monitor [redacted]
20 Oct 03		2200	resting @ this time, assessment completed c Ø s/s of pain shown, Ø s/s of resp distress, All dressing CDI, Ø Bowel sounds heard @ this time [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	190ct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+425
24 Hour Intake	4900
24 Hour Output	4475
Weight on Admission	
Weight Yesterday	
Weight Today	

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

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

(b)(6)-2	Department/Service/Clinic	DATE
LPN	ICU	210ct03

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

Potus # (b)(6)-4

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

DA FORM 4700
1 MAY 78

		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			0				Gen				Gen				0				0						
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			WNL				✓				✓				✓				✓						
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)							✓				ST				ST				ST						
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH		✓								✓														
	FOLEY CARE										✓														
	ORAL CARE										✓														
MOBILITY	BEDREST		✓				✓																		
	BSC																								
	DANGLE																								
	CHAIR										✓														
POSITIONED	RIGHT																			✓	✓				
	LEFT																								
	SUPINE						✓								✓										
	HOB 30 DEGREES		✓				✓								✓	✓	✓	✓	✓			✓			
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓																						
	PAIN SCALE (1-10)										✓				min	+		+				÷			
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)			Ø ✓				Ø ✓				Ø ✓				+LLQ				X						
NG / DOBHOFF PLACEMENT VERIFIED															✓				✓						
RESIDUAL ASSESSED															N/A										
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 ABD - CDE			✓				✓				✓				✓				✓						
#2 (R) thorel CDE			✓				✓				✓				✓				✓						
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) AC	18G	19 OCT 03	CDE /0600 /1000 / 1400 mp
(R) FA	18G	19 OCT 03	CDE /0600 /1000 D/Cd

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes N
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from --
			DATE: 21 OCT 03	Previous Assessment

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

(3/6/12)

VITAL SIGNS

(3/6/12)

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
~~0100~~	~~100.3~~	113	~~26~~	130/66	98	[redacted]	90										~~BT, RA~~
~~0000~~ 0200	100.3	113	26	130/66	98		90										RA, NAD
0300																	
0400																	
0500																	
0600	99.9 (A)	106	20	130/58	95		85										
0700																	
0800																	
0900																	
1000	100.2 (A)	121	38	142/63	96		89										
1100																	
1200	100.0 (A)																
1300																	
1400	100.5 (A)	110	20	119/64	98		87										
1500																	
1600																	
1700																	
1800	101.6 (A)	104	28	127/67	98		89										
1900																	
2000	101.8 (A)																
2100																	
2130	101.0 (A)																
2200	100.4	105	20	131/61	99		88										
2300																	
2400																	

	INTAKE										OUTPUT									
	D5 NS 20 KCL	IVPB								Total	Urine	NG							Total	COMMENTS
0100	125 125										100 100									
0200	125 250										100 200									
0300	125 375																			
0400	125 500																			
0500	125 625										575 575									
0600	125 750										100 875									
0700	125 875										↓									
0800	125 1000										400 1275									
8 HR	1000									8 HR. 1000	1275								8 HR 1275	~~275~~
0900	125 125																			
1000	125 250	100 100									325 325									
1100	75 325										↓									
1200	75 400	100 200									225 550									
1300	75 475										↓	300 300								
1400	75 550										125 675									
1500	75 625																			
1600	75 700	100 300									250 925	300 600								
8 HR	700	300								16 HR. 2000	925	600							16 HR. 2800	~~800~~
1700	75 75	100 100									200 200									
1800	75 150										100 300	200 200								
1900	75 225										200 500									
2000	75 300										75 575									
2100	75 375										100 675	200 400								
2200	75 450										75 750	150 550								
2300	75 525	150 250									225 975	150 700								
2400	75 600	100 350									150 925	50 750							1675	
8 HR	600	350								24 HR. ~~2900~~ 4900	925	750							24 HR 1675	

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Oct 03 1400 mj		1400	Pt used IS c encouragement, able to lift ball #2 x 3. C+DB c IS c abd splinting → thick, dark brown sputum, looks like dried blood. States has only slight pain in abd per interpreter. NG → LIS c dark green drainage. (2) AC IV patent c S/Sx infiltration or infection. [b)(6)-2] MHS, RN
21 Oct		1900	0 abd pain x 2 this shift. 4mg MSO4 IVP given @ 1645 and 1845. Pt appears able to rest c doses. Hypoactive bowel sounds heard in LUQ and LLQ; 0 heard on (R) abd. Midline abd dsg c no new drainage this shift; dsg d'd per Dr. [b)(6)-2] Temp @ 1800 was 101.6 oral → Tylenol supp given. [b)(6)-2] MAJ, RN
		1930	Pt ambulated to EMT entrance and back with minimal assistance; sat in chair @ bedside. Cont to cough up mod-lg amt frothy, white secretions.
21 Oct		2040	Dr. [b)(6)-2] notified of pt temp (101.8 oral). Lung sounds bb diminished RLL → NI stimulation c 14 Fr catheter thru (R) nare → 2-3 deep coughs for small amt thick, yellow, blood-tinged secretions. Do IS q1° while awake and q2° when sleeping. Per X-ray, NG → in duodenum, pulled back x 6 in by Dr. [b)(6)-2] NG continues to drain lg amt dark green fluid. [b)(6)-2] flor, RN
		2215	0 c/o pain up to chair c difficulty, 0 S/S of resp distress will cont to monitor pt [b)(6)-2] c/c
		2300	c/o pain after return to bed, pain medication given (see MAR) will cont to monitor [b)(6)-2]
		2330	sleeping @ this time [b)(6)-2] cp

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19oct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+650
24 Hour Intake	3405
24 Hour Output	1755
Weight on Admission	
Weight Yesterday	
Weight Today	

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

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

(b)(6)-2

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	22oct03

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

Patus # (b)(6)-4

☐ HISTORY/PHYSICAL ☑ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2							2								2		
	RADIAL L		2					2							2								2		
	DORSALIS PEDIS R		2					2							2								2		
	DORSALIS PEDIS L		2					2							2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8							1 3 8								1 3 8		
EDEMA			Ø					Gen							Gen								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					ST							SR								NSR		
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		[illegible]												*										
	PAIN SCALE (1-10)							*							*										
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2							2								2		
BOWEL SOUNDS (active all quads)			Ø					Ø															low		
NG / DOBHOFF PLACEMENT VERIFIED								✓																	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓					✓																	
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓															✓		
SKIN INTEGRITY	No Breakdown							✓																	
	Surgical Wounds																								
BLE shrapnel	Rashes, Lac's, etc														✓										
DRESSING (Dry & Intact; specify site below)																									
#1 ABD - CDI			✓					✓							*								✓		
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) AC	19G	19Oct03	CDI / 0700
NGT (L)	(L) NARE	19 OCT 03	Patent, intact to LIWS / 1400 D/C'd 10/22

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		0 1	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	1 3	1 4	1 5	1 6	1 7	1 8	1 9	2 0	2 1	2 2	2 3	2 4
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4					4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5					5							5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6					6							6								6		
GLASGOW COMA SCALE (A+B+C)			15					15							15								15		
PUPIL RESPONSE Size - mm; React to Light (+); No Response (-)	R		2+																				2+		
	L		2+																				2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4					4							4								4		
	LUE		4					4							4								4		
	RLE		4					4							4								4		
	LLE		4					4							4								4		
GRIP (S) Strong (W) Weak (A) Absent	R		S					S							S								S		
	L		S					S							S								S		
RESPIRATIONS	REGULAR		✓					✓							✓								✓		
	IRREGULAR		/																				/		
	UNLABORED							✓							✓										
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5					5							5								5		
	LUL		5					5							5								5		
	RLL		5					5							1								1		
	LLL		5					5							5								1		
	BOTH BASES		5					5							✓								1		
COUGH	NONE		/																						
	SPONTANEOUS		/												✓								✓		
	PRODUCTIVE														✓								/		
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear			2					1,5							1,5								2		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin			3					3							3								3		
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE ETT = _____	NC (l/min)							4																	
	FM (l/min)							4																	
	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE			✓					✓																	
ETT / NT SUCTIONED			✓					✓							✓										
INCENTIVE SPIROMETRY DONE			✓					✓							✓								✓		
COUGH / DEEP BREATH			✓					✓							✓								✓		
INITIALS			(b)(6)-2					(b)(6)-2							(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	98.5	110	20	125/67	99%		89										
0300																	
0400																	
0500																	
0600																	
0700	101.8(o)	121	18	133/68	95		90										
0800																	
0900	101.8(o)	111	20	130/63			89										
1000																	
1100																	
1200	101(o)	111	20	130/63			89										
1300																	
1400	100.1(o)	99	17	130/60	97												
1500																	
1600																	
1700																	
1800	102.4(o)	118	24	134/70	98%												
1900																	
2000	101.2(o)																
2100																	
2200																	
2300																	
2400																	

	INTAKE				OUTPUT			
	NS 20KCL	IVPB	PO	Total	Urine	NG	Total	COMMENTS
0100	75 / 75				50 / 50	Ø / 0		
0200	75 / 150				100 / 150	250 / 250		
0300	75 / 225				200 / 350	0 / 250		
0400	75 / 300				30 / 380	0 / 250		
0500	75 / 375	100 / 100			20 / 400	0 / 250		
0600	75 / 450				↓			
0700	75 / 525				255 / 655			
0800	75 / 600	50 / 150			100 / 755			
8 HR	600	150		8 HR. 750	755	250	8 HR 1005	-255
0900	75 / 75				75 / 75			
1000	75 / 150				↓			
1100	75 / 225				125 / 200			
1200	100 / 325							
1300	100 / 425							
1400	100							
1500	100 / 625							
1600	100 / 725			725	225 / 425			post foley D/C voided
8 HR	725			16 HR. 1475	425		16 HR.	680
1700	100 / 100				175 / 275			
1800	100 / 200							
1900	100 / 300	100 / 100						
2000	100 / 400		30 / 30		425 / 700			
2100	100							
2200	100							
2300	100							
2400	100 / 800			430	300			1075
8 HR				24 HR. 3405			24 HR	1755

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22OCT03		0215	-C10 pain via interpreter, pain medication given (see MAR) will continue to monitor pt Temp 101.8°CA). IS used c consistant elevation of 2 balls Medicated c TYLenol 650mg + PR. c HOSM 4mg IVP. See flow SHEET FOR ASSESSMENT. [b)(6)-2] ICT, RN
22OCT03		1025	OOB to Chair over 1 hr. Ambulated to HWR & back. Tolerated well. Continue frequent IS Able to get third ball up c coaching. Ineffective Cough. RT-T Suction per Dr [b)(6)-2] RTD TO BED. NGT D/c'd. [b)(6)-2] ICT, RN
		1400	Assumed care. Pt resting comfortably in bed. Encouraged IS and deep cough. Pt c/o "clear" c cough. RT induced Cough c N-T Sxn. Abd dsg. c scant serous drainage on upper 2/3, sxn. all serosanguinous drained on lower 1/3. Will continue to monitor. [b)(6)-2] RN
		1430	RT Pt c/o Mild pain on lateral side of R foot. Encouraged pt. to move foot Thru entire ROM. [b)(6)-2] RN
		1580	lung sounds improved p RT deep sxn and deep Cough. Pt sitting @ 90° in bed. [b)(6)-2] RN
		2000	Pt ambulated to EMT doorway Thru down to DPAC and back s difficulty. Pt continues use c IS and pulls enough air to raise all 3 balls. Frequent coughing. Pt sat @ bedside for 1°. New IV started in R FA. IV in R AC d/c'd d/t leaking and signs of phlebitis. [b)(6)-2] RN
		2100	D [b)(6)-2] @ bedside, NT suction complete, light cough produced bloody sputum. IS complete [b)(6)-2] RN

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19Oct03
DOS	23OCT 03
POD	

24 HOUR DATA	
24 Hour Balance	+1100
24 Hour Intake	2000
24 Hour Output	-900
Weight on Admission	
Weight Yesterday	
Weight Today	

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

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

PREPARED BY (Signature and title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	230ct03

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

Potus # (b)(6)-4

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

DA FORM 4700
1 MAY 78

		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	2	
	RADIAL L		2				2				2				2								2	2	
	DORSALIS PEDIS R		2				2				2				2								2	2	
	DORSALIS PEDIS L		2				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			Ø				Ø				Ø													Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				✓		(5)(6)(7)		✓				✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR ST				ST				ST									SR	
SWAN GANZ CATHETER (Zeroed & calibrated)			N/A																						
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC		✓																						
	DANGLE																								
	CHAIR						✓				✓												✓		
POSITIONED	RIGHT																						S		
	LEFT																						C		
	SUPINE																						I		
	HOB 30 DEGREES		✓												✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE						D/O	D/O			✓				✓ D/O								PF		
	PAIN SCALE (1-10)						↓	↓							↓										
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2	2			1				2								2		
BOWEL SOUNDS (active all quads)			WNL				hyp				hyp				Hypo								WNL		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.							dark				dark												clear		
SKIN INTEGRITY	No Breakdown						✓				✓				✓								✓		
	Surgical Wounds		✓																						
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 INCISION ABD (midline			✓				✓				✓				✓								✓		
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
RIV 16G	(R) FA	220ct03	CDI

(b)(6)-2

PUPIL SIZE		PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal		0 = No Movement	Present ✓
2 mm	R	Reactive		1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive		2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
				3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger		4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes N
				5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		DATE: 28 OCT 03	No Change from Previous Assessment –

TIME		0102	0304	0506	0708	0910	1112	1314	1516	1718	1920	2122	2324
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4		4		4		4					4
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5		5		5		5					5
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6		6		6		6					6
GLASGOW COMA SCALE (A+B+C)		15		15		15		15					15
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+		2+		2+		+2					3+
	L	2+		2+		2+		+2					3+
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4		4		4		4					4
	LUE	4		4		5		4					4
	RLE	4		4		4		4					4
	LLE	4		4		5		4					4
GRIP (S) Strong (W) Weak (-) absent	R	S		S		S		S					N
	L	S		S		S		S					N
RESPIRATIONS	REGULAR	✓		✓		✓		✓					✓
	IRREGULAR												
	UNLABORED	✓		✓		✓		✓					✓
	LABORED												
	SHALLOW												
	RETRACTIONS												
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5		5		5		5					5
	LUL	5		5		5		5					5
	RLL	1		1		1		1					1
	LLL	1		1		1		1					1
	BOTH BASES			1		1		1					1
COUGH	NONE												
	SPONTANEOUS	✓		✓		✓		✓					✓
	PRODUCTIVE	✓		✓		✓		✓					✓
	NONPRODUCTIVE												
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2		5		5		5					5
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		3		3		3		3					3
VENTILATOR	Vt												
	FIO2												
	RATE (SIMV/CMV)												
	PEEP CPAP												
	PRESS. SUPPORT												
OXYGEN DELIVERY DEVICE	NC (l/min)												
	FM (l/min)												
ETT # _____	NRBM (l/min)												
	ETT _____ cm gums												
ETT CARE / POSITION CHANGE													
ETT / NT SUCTIONED													
INCENTIVE SPIROMETRY DONE				✓		✓		✓					✓
COUGH / DEEP BREATH		✓		✓		✓		✓					✓
INITIALS		(b)(6)-2		(b)(6)-2		(b)(6)-2		H					(b)(6)-2

VITAL SIGNS

TIME	T	P	R	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.9	110	16	116/58	99%												
0300																	
0400																	
0500																	
0600	100.6	109	16	125/68	97%												
0700																	
0800																	
0900																	
1000	100.6	109	18	114/59	96%												
1100																	
1200																	(5/6)(2)
1300	[redacted]																
1400	100.8	105	16	125/63	97%												
1500																	
1600																	
1700	101.3																
1800																	
1900	99.6	101	16	124-70	98%												
2000																	
2100																	
2200																	
2300	98.3	94	16	120/76	99%	—	93										
2400																	

	INTAKE				OUTPUT		
	NS+KCL	PO	IVPB	Total	Urine	Total	COMMENTS
0100	100						
0200	100						
0300	100						
0400	100				100		
0500	100						
0600	100 600	90 90	100 100				
0700	100 700				175 275		
0800	100 800		50 150				
8 HR	800	90	150	8 HR. 1040		8 HR 275	+
0900	100 100		(b)(6)				
1000	100 200		[redacted]				
1100	100 300				75 75		
1200	100 400		100 100				
1300	100 500				100 175		
1400	100 600				150 325		
1500	100 700						
1600	100 800		50 150				
8 HR	800		150	16 HR. 950	325	16 HR. 600+	
1700	100						
1800	100 200		100				
1900	100 300						
2000	100						
2100	100						
2200	100						
2300	100		50 150		300		
2400	100		100 250			900+	
8 HR	800		250	24 HR. 2000		24 HR. 900+	

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0200		resting @ this time will continue to monitor pt. [redacted]
23OCT03	0600		Pt cooperative & alert & oriented X3. VS: T max 100°F encourage d pt to cough, deep breath & ↑ fluid intake. Pt attempted to eat Jello, finished <20% & drank water ~ N or V; pt c/o abd pain from sitting up in chair during breakfast, pain scale 3/10. Pt making effort to cough up dark tan & brown sputum. Pt urinated 200 cc dark yellow urine, pt encouraged ↑ fluids, Pt cooperative and verbalized understanding. IBG IV in LFA patent & infusing maintainence IV fluids. Will continue to monitor. [redacted]
23OCT03	0700		Pt c/o pain 6/10 abdominal pain, medicated pt c MSO4 4mg IV per prn pain order. Pt received immediate relief & asked to stay in chair at bedside instead of bed. Will continue to monitor pt. [redacted]
		1445	M.D at the bedside doing NT suction tolerating well. NAD encourage coughing and Deep breathing. See DA Form 4700 for assessment. Will cont to monitor per MD orders. [redacted]
		1640	↑ OOB walking hall NAD. Doing well. Needed very little assist just getting out of bed. ↑ Setting in Chair and working on IS. Will cont to monitor per orders [redacted]
		1840	Back to bed NAD doing well. will cont to monitor per order. [redacted]
		2110	Sleeping eyes closed resp and heart sounds noted. [redacted]

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 19 Oct 03
2. ADMITTING/DIAGNOSIS: Abd Shrapnel Wounds
3. PERTINENT LAB, X-RAY, FINDINGS:
Small Bowel Injur
CXR Normal Except Elevated Right Diaphram
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
Exp Lap 19 Oct with Repair of Small Bowel Injury X2 and Sigmoid Colon Injury X 1
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
Shrapnel Wounds to Abdomen with Small & Large Bowel Injury
6. ACTIVITY: As Tolerated
7. DIET: Regular
8. MEDICATIONS:
☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
Levaquin 500mg twice a day until gone
Zantac 150mg twice a day until gone
Tylenol ~~650mg~~ 325mg One or Two every 4° As Needed for Pain
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:
Drink Fluids - Extra
10. DISCHARGING PROVIDER:
(b)(6)-2 (b)(6)-2 ed Name)
PATIENT IDENTIFICATION
POTUS (b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☒ OTHER MP's
☒ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☒ OTHER MP's
3. PATIENT EDUCATION:
Completed and patient prepared for home care. ☒ YES ☐ NO
If no, explain:
Patient ☒ states ☐ demonstrates understanding of home care needs.
Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
☒ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
Regular
7. MEDICATIONS: → TO MP's
Explained by: ☒ NURSE ☐ PHYSICIAN ☐ PHARMACIST
Printed medication literature provided. ☐ YES ☒ NO
MP's ~~Patient~~ states understanding of prescribed medications. ☒ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
4X4's & 2X2's TAPE
CHange DRESS EVERY 1-2 days.
IF increased redness & drainage Notify CSH
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
CSH or unit MEDIC
(b)(6)-2 BY:
ture and Title) 10/27/03 1230 (Date and Time)
A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.
(b)(6)-2
nature) 27 OCT 03 1230 (Date and Time)

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Army BY [signature]

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

3. DATE 6/12/03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: without response to interpreter any questions, or what is being us

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	SGT (b)(6)-2 1245-EOC
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	[illegible] (b)(6)-2 745-EOC

7. POSITION AND POSITIONAL AIDS (Specify)

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

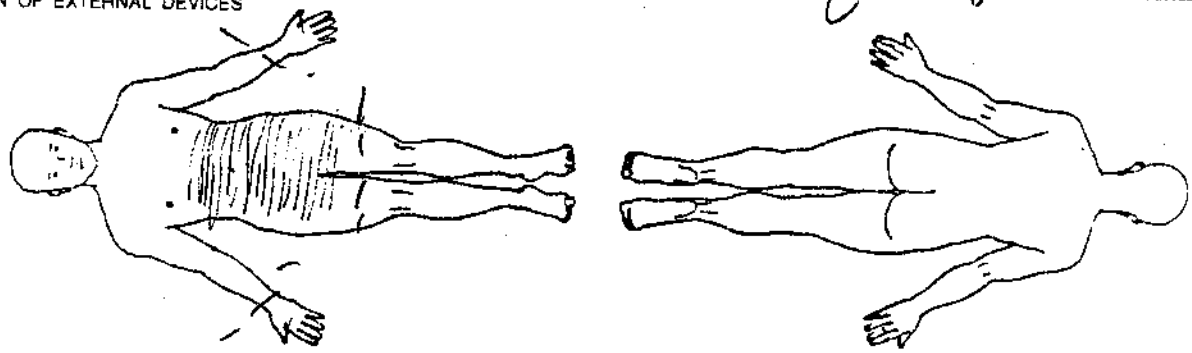
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Betadine
SITE: Abdomen BY WHOM: CPT [illegible]
SITE: BY WHOM:
COMMENTS: no pooling of sol.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No		0	0
Needle Sharp	☒ Yes ☐ No			
Instrument	☒ Yes ☐ No			
Other	☐ Yes ☐ No			

SCRUB (b)(6)-2 CIRCULATOR (b)(6)-2

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

Potts # (b)(6)-4

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

☒ ESU NO: 077934 52/10
GROUND PAD: BRAND Valleylab
LOT NO: 69621 05764

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* 2x2s 4x8s tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. #16 Fr foley	2.	3.
SITE	1. Bladder	2.	3.

19. ADDITIONAL INFORMATION

No

No

(b)(6)-2

20. OPERATION(S) PERFORMED

Ex lap, appy, part sm. bowel resection, anastamosis SM & Lg Bowel Enter. repairs —

21. PATIENT TRANSFERRED TO ICU TIME See D METHOD Stretcher + safety Strap

22. REG (b)(6)-2 Major

REVERS

*U.S. GPO: 1998-404-813/40449

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE: 24 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1130	clear liquids	500	500
1800	Jello	50	550
1800	Water	120	670
2030	Gatorade	200	870
2255	jello	50	920

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0200	1000	D5 NS ē 20 KCL	400	0600	400
0530	100	primaxin	100	0600	500
0730	50	Zantac	50	0815	550
1130	100	Primaxin	100	1230	1050
1400	800	D5 NS ē 20KCl	800	1400	1450
1600	50	Zantac	50	1630	1500
1800	100	Primaxin	100	1900	1600
2200	400	D5 ½ NS ē 20 kcl	400	2200	2000
2320	50	Zantac	50	2350	2050

IV Cont.

~~IRRIGATIONS~~ (N.G. Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE: +2970

USAPPC V1.00

Potus # (b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0145	200	200			
0330	400	600			
1400	700	1300			
1600	250	1550			
1800	250	1800			
2130	300	2100			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0120	light	mucousy	SM	
0900	light brown	soft stool	Med	
1345	"	"	"	
1800	light brown	hard formed	sm	

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

Potts # (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	150	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS
TOTAL HOURS COVERED
DATE 25 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	Gatorade	90	90
1800	Gatorade	60	150

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0020	100	PrimaxIN	100	0100	100
0545	100	Primaxin	100	0615	200
2200	400	D5NS E 20 KCl	400	0600	600

IRRIGATIONS (N G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE [redacted] 750

USAPPC V1.00

POTUS #[redacted]

(b)(6)-4

(b)(6)(2)

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0215	400	400			
0420	350	750			
1500	225	975			
1555	120	1095			
1650	200	1295			
1830	~200	1495			
2030	225	1720			
2300	300	2020			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1830	lt brown	flakes/specks	min	min
2245	green	smear	small	small

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS
TOTAL HOURS COVERED
DATE 20Oct03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0605	Water Po	100cc	100cc
0800	Water Po	120cc	220cc
1000	Water	90cc	310cc
1400	Water	240	550
1600	Water	240	790
1700	Soda	300	1090
2100	Water	240	1330

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000	1000	D5NS @ 2KCL	300		300

IRRIGATIONS (N.G. Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE 1630

USAPPC V1.00

Potus #1 [redacted]

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0230	200	200			
0930	375	~~575~~ 675			
1100	375	1050			
1530	350	1400			
1600	350	1750			
1700	325	2075			
1800	250	2275			
1900	300	2575			
2030	250	2825			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1330	Brown	Semi-solid	Sm	x1

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT 2825

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	150	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0300	1000	1000			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

POTUS (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST	UNIT	RANK	S
(b)(6)-4			(b)(6)-4

Physician:	Ward:			Date and Time:	Reported by:	Date and Time:
Dr. (b)(6)-2		X	STAT	19Oct03 1020	(b)(6)-2	19Oct03
			Routine			

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-85 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	12.5 *	4.8-10.8 x10(3)/uL
	RBC	3.63 *	4.2-6.1 x10(6)/uL
	Hgb	11.4 *	12.0-18.0 g/dL
	Hct	32.4 *	35.0-60.0%
	MCV	89.3	80.0-99.0 fl
	MCH	31.4 *	27.0-31.0 pg
	MCHC	35.1	33.0-37.0 g/dL
	Plt	279	130-400 x10(3)/uL
	LY%	4.7 *	15.0-55.0%
	LY#	0.6 *	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	s/tCldy	Clear
Glucose	250	Negative
Bilirubin	neg	Negative
Ketone	neg	Negative
SG	1.022	1.010-1.025
Blood	large	Negative
pH	6.0	5.0-8.0
Protein	neg	Negative-Trace
Urobili	Norm	Negative
Nitrite	neg	Negative
Leuko	neg	Negative

Urine Microscopic

WBC	0-3	Epi	rare
RBC	20-30	Mucus	Trace
Bacteria	light	Yeast	
Casts:			
Crystals:			
Other:			

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S	O	POS

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: CBC, Type screen, UA

[redacted] 2003

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
(b)(6)-4	NA ICU	NA	(b)(6)-4

Physician:	Ward:		STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU		X Routine	19 Oct 1530	(b)(6)-2	19 Oct 13 1535

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-16.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	14.2	4.8-10.8 x10(3)/uL
	RBC	4.08	4.2-6.1 x10(6)/uL
	Hgb	11.7	12.0-18.0 g/dL
	Hct	36.5	35.0-60.0%
	MCV	89.5	80.0-99.0 fl
	MCH	28.7	27.0-31.0 pg
	MCHC	32.1	33.0-37.0 g/dL
	Plt	270	130-400 x10(3)/uL
	LY%	5.8	15.0-55.0%
	LY#	0.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

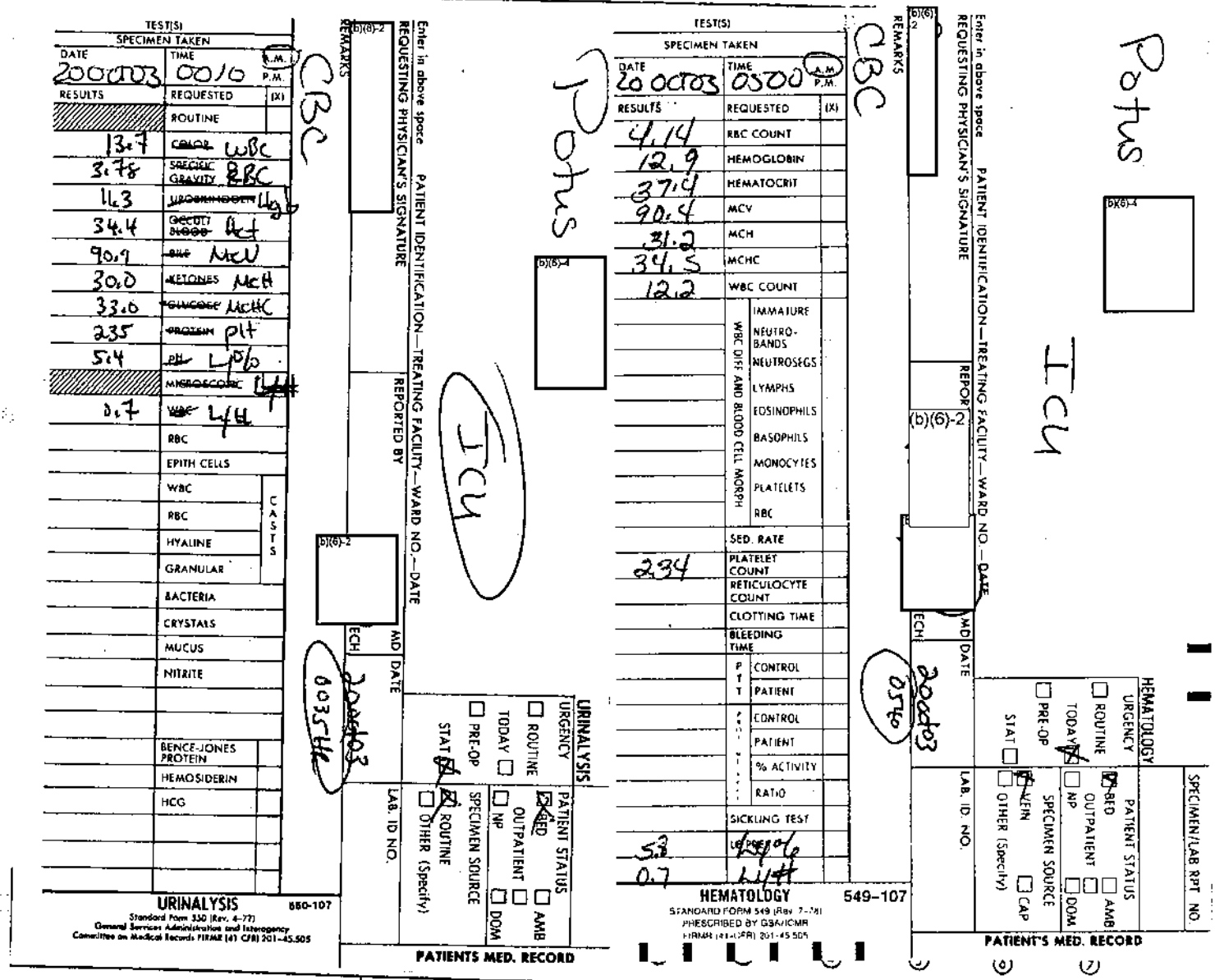
Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: CBC

STANDARD FORM 545 Rev.
10-75 545-100

LABORATORY REPORT DISPLAY



TEST(S) SPECIMEN TAKEN
DATE 20 OCT 03 TIME 0010 A.M. P.M.
RESULTS | REQUESTED (X)
ROUTINE
13.7 COLOR WBC
3.78 SPECIFIC GRAVITY RBC
Neg UROBILINOGEN Hgb
34.4 OCCULT BLOOD Hct
90.9 BILE MCV
30.0 KETONES MCH
33.0 GLUCOSE MCHC
235 PROTEIN plt
5.4 pH L/D
MICROSCOPIC L/H
0.7 SPEC GRAV L/H
RBC
EPITH CELLS
WBC
CASTS: RBC, HYALINE, GRANULAR
BACTERIA
CRYSTALS
MUCUS
NITRITE
BENCE-JONES PROTEIN
HEMOSIDERIN
HCG
REMARKS: CBC
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
ECH
MD DATE 20OCT03 0035Hr
LAB. ID NO.
URINALYSIS URGENCY: ROUTINE, PRE-OP, STAT
TODAY
SPECIMEN SOURCE: ROUTINE, OTHER (Specify)
PATIENT STATUS: INPT, OUTPATIENT, AMB, DOM
URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505
550-107
PATIENTS MED. RECORD

TEST(S) SPECIMEN TAKEN
DATE 20 OCT 03 TIME 0500 A.M. P.M.
RESULTS | REQUESTED (X)
4.14 RBC COUNT
12.9 HEMOGLOBIN
37.4 HEMATOCRIT
90.4 MCV
31.2 MCH
34.5 MCHC
12.2 WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
234 PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT CONTROL, PATIENT
PROTHROMBIN TIME CONTROL, PATIENT, % ACTIVITY, RATIO
SICKLING TEST
5.2 UREA NITROGEN
0.7 SPEC GRAV
REMARKS: CBC
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
ECH
MD DATE 20OCT03 0536
LAB. ID NO.
HEMATOLOGY URGENCY: ROUTINE, PRE-OP, STAT
TODAY
SPECIMEN SOURCE: BLD, NP, OUTPATIENT, AMB, DOM, LUMBAR PUNCTURE, CAP, OTHER (Specify)
PATIENT STATUS
SPECIMEN/LAB RPT. NO.
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-75)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
549-107
PATIENT'S MED. RECORD

Pathus
ICU
CBC
(b)(6)-2
(b)(6)-4

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

< SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

MOUNTED ON STRIPS 1 THROUGH 7
- ☐ CHEMISTRY I (SF 546)
- ☐ CHEMISTRY II (SF 547)
- ☐ CHEMISTRY III (SF 548)
- ☐ HEMATOLOGY (SF 549)
- ☐ URINALYSIS (SF 550)
- ☐ SEROLOGY (SF 551)
- ☐ SPINAL FLUID (SF 555)

MOUNTED ON STRIPS 1, 3, 5, AND 7
- ☐ PARASITOLOGY (SF 552)
- ☐ IMMUNOHEMATOLOGY (SF 556)
- ☐ ASSORTED FORMS
- ☐ OTHER (Specify)

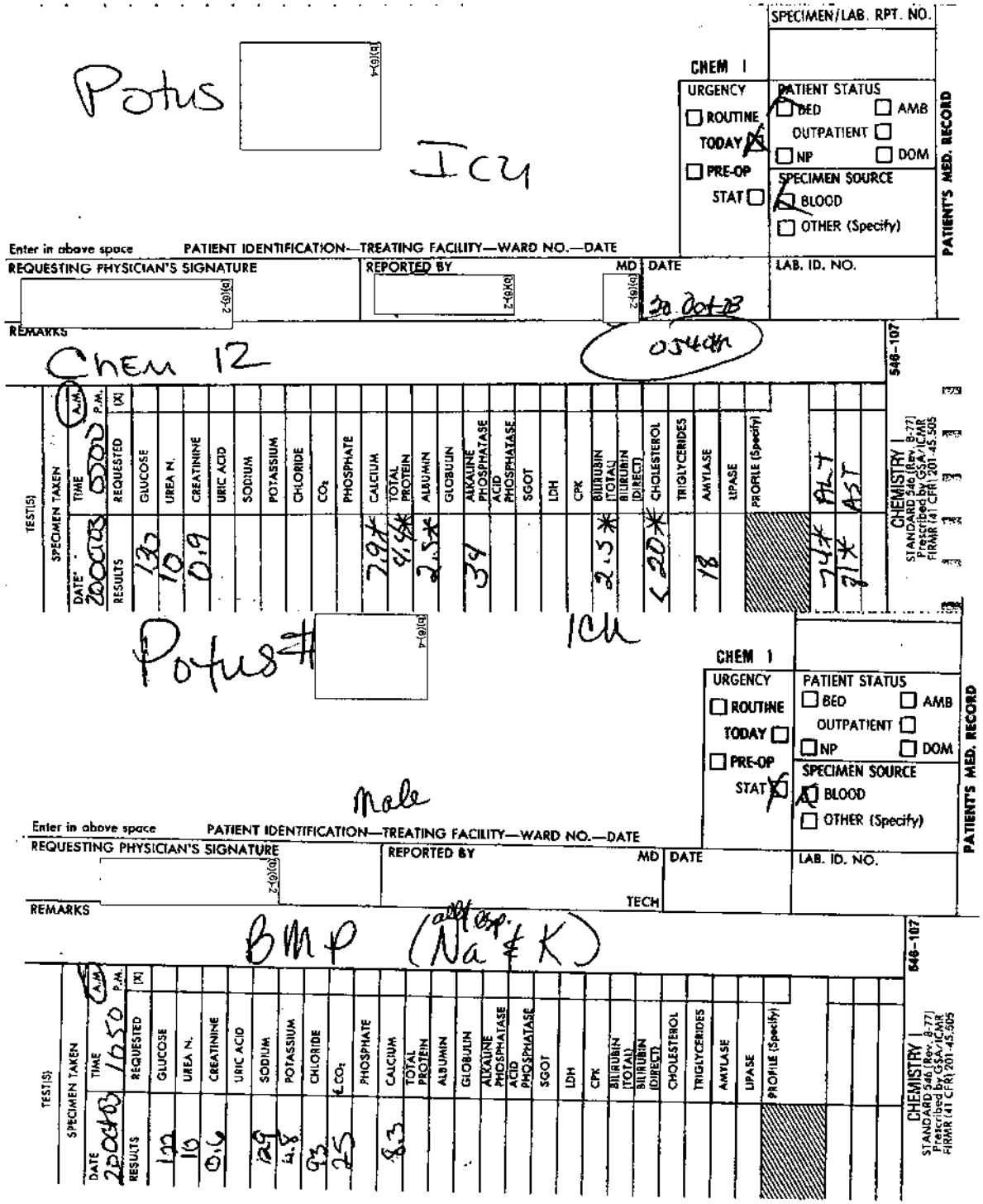
MOUNTED ON STRIPS 1, 4 AND 7
- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

General Services Administration and Interagency Committee on Medical Records ICMR 201-45.505

LABORATORY REPORT DISPLAY

MEDCOM - 2479

☆ GPO—1991—304—610


Potus
ICU
CHEM 1
SPECIMEN/LAB. RPT. NO.
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
PATIENT'S MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD
DATE
LAB. ID. NO.
REMARKS
Chem 12
0540h
546-107
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M.
P.M.
REQUESTED
RESULTS
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
CHEMISTRY I
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
Potus #
ICU
Male
BMP (all resp. Na & K)

CHEM 1

SPECIMEN/LAB. RPT. NO.

URGENCY: [X] ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: [X] BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: [X] BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

Potus [redacted] (b)(6)-4

ICU

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

REPORTED BY [redacted] (b)(6)-2

DATE 21oct03 0530hr

REMARKS: Met 8, BMP c Mg & PO4

TEST(S) — SPECIMEN TAKEN: DATE 21OCT03 TIME 0530 (A.M.)

TEST	RESULTS
REQUESTED (X)	
GLUCOSE	133
UREA N.	10
CREATININE	0.8
URIC ACID	
SODIUM	126
POTASSIUM	4.0
CHLORIDE	99
CO_2	27
PHOSPHATE	
CALCIUM	7.8
TOTAL PROTEIN	
ALBUMIN	
GLOBULIN	
ALKALINE PHOSPHATASE	
ACID PHOSPHATASE	
SGOT	
LDH	
CPK	1546
BILIRUBIN (TOTAL)	
BILIRUBIN (DIRECT)	
CHOLESTEROL	
TRIGLYCERIDES	
AMYLASE	
LIPASE	
PROFILE (Specify)	

CHEMISTRY I
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

546-107

PATIENT'S MED. RECORD

HEMATOLOGY

URGENCY: [X] ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: [X] BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: [X] VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

Potus [redacted] (b)(6)-4

ICU

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

REPORTED BY [redacted] (b)(6)-2

DATE 21oct03 0545hr

REMARKS: CBC

TEST(S) — SPECIMEN TAKEN: DATE 21OCT03 TIME 0530 (A.M.)

TEST	RESULTS
REQUESTED (X)	
RBC COUNT	2.94
HEMOGLOBIN	9.1
HEMATOCRIT	26.6
MCV	90.6
MCH	30.8
MCHC	34.0
WBC COUNT	6.2
WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	5.5%
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED. RATE	
PLATELET COUNT	195
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PTT CONTROL	
PTT PATIENT	
CONTROL	
PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	
LE PREP	
4E	0.5

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
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FIRMR (41 CFR) 201-45.505

549-107

PATIENT'S MED. RECORD

DATE 10/22/03 | TIME 1040

Physician (b)(6)-2

Clinic/Ward/UCA ICU

☐ Clean Catch ☒ Catheterized

☐ Routine ☐ Today ☒ STAT

Patient ID

POTUS

(b)(6)-4

Urine Chemistry — Complete

Glu Neg pH 8.5
Bil Neg Pro 30
Ket small Uro Neg
SG 1.010 Nit Neg
Bld mod Leu Neg

UA

Color Amber
Appearance Clear
Clinitest
Acetest
Ictotest
SSA

Microscopic

Casts /LPF
Type
WBC 0-1 /HPF
RBC 0-1 /HPF
Crystals
Epi Cells /HPF
Type
Yeast
Trichomonas
Bacteria light
Mucous
Other

Clinical Data:

Reported By: (b)(6)-2

Date: 22 Oct 03

Note: Micro exam only when abn. chem. found or upon special request.

Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

DARNALL ARMY COMMUN
DEPARTMENT OF PA
FH MDA FORM 8 1

CHART COP

TEST(S)
SPECIMEN TAKEN
DATE 22Oct03 TIME 0415 A.M. P.M.
REQUESTED
RESULTS

Glu-113
BUN-9
CRE-0.7
CK-1201
Na-121*
K-3.9
Cl-99
tco2-24
Ca-8.2

REMARKS met 6, met lyte 8, Hmg, PO4, (BMP) [redacted] (b)(6)(2)

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

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

Potus #

(b)(6)-4

ICU

REPORTED BY (b)(6)-2

MD TECH DATE 22Oct03

LAB ID NO.

MISC
URGENCY ☐ ROUTINE TODAY ☐ PRE-OP STAT ☒

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

SPECIMEN SOURCE (Specify) Blood

SPECIMEN/LAB RPT. NO

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

PATIENT'S MED. RECORD

SPECIMEN/LAB RPT. NO

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

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

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

PATIENT'S MED. RECORD

Potus # (b)(6)-4

ICU

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

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

REPORTED BY (b)(6)-2

MD TECH DATE 22Oct03 0440

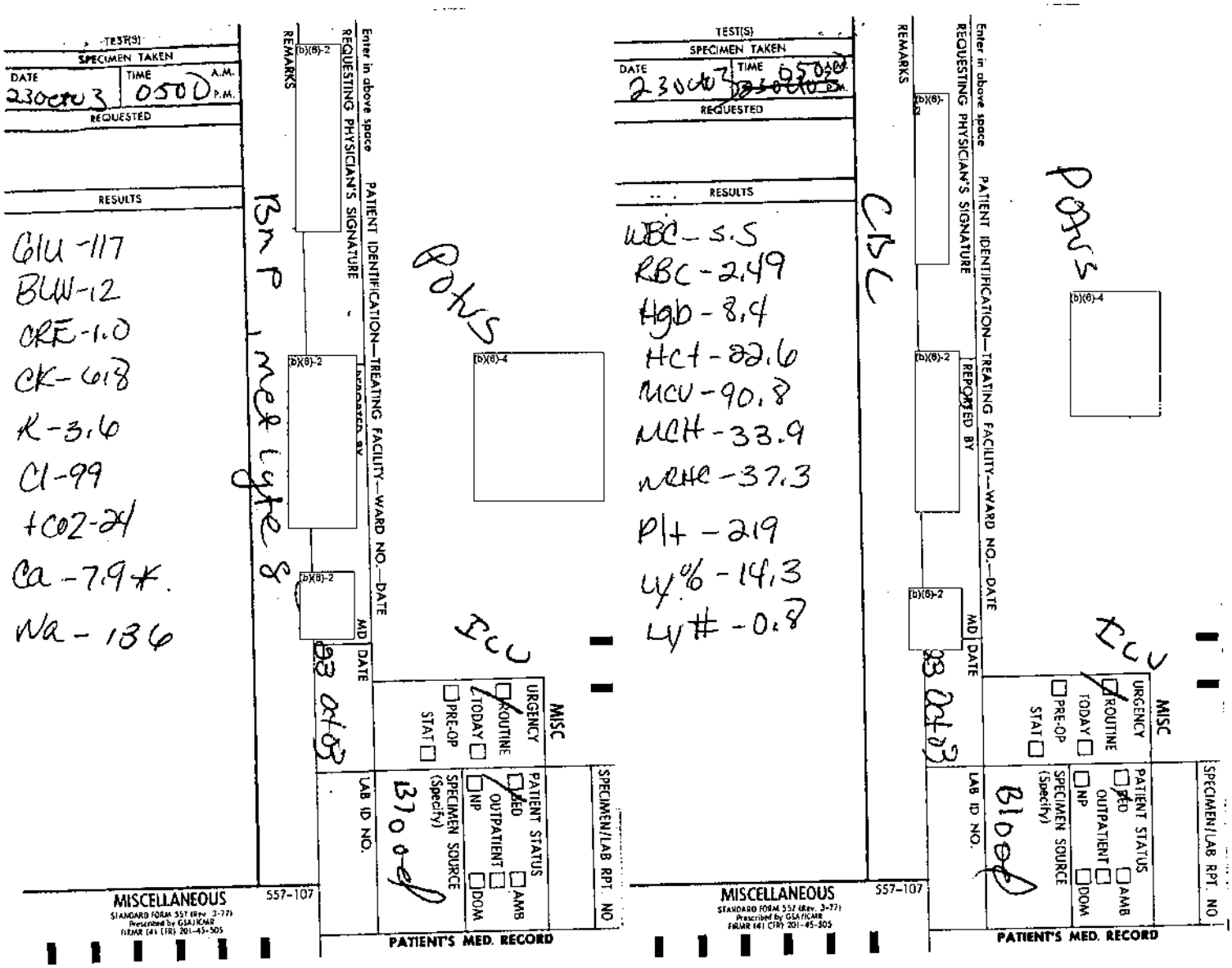
REMARKS CBC, BMP [redacted] (b)(6)(2)

TEST(S)
SPECIMEN TAKEN
DATE 22Oct03 TIME 0415 A.M. P.M.
REQUESTED
RESULTS

WBC 5.1
RBC 2.57
Hgb 9.1
Hct 25.9
MCV 102
MCH 35.5
MCHC 35.2
Plt 215
L% 14.3
L# 0.7

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

MEDCOM - 2482


TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M.
P.M.
REQUESTED
RESULTS
Glu -117
BUN-12
CRE-1.0
CK-618
K-3.6
Cl-99
tCO2-24
Ca-7.9*
Na-136
BMP
1 mek lyte &
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTED BY
MD
DATE
POWS
ICU
MISC
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
OUTPATIENT
AMB
NP
DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO
MISCELLANEOUS
S57-107
PATIENT'S MED. RECORD
TEST(S)
SPECIMEN TAKEN
DATE
TIME
REQUESTED
RESULTS
WBC-5.5
RBC-2.49
Hgb-8.4
Hct-22.6
MCV-90.8
MCH-33.9
MCHC-37.3
Plt-219
Ly%-14.3
Ly#-0.8
CBC
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
POWS
ICU
MISC
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
OUTPATIENT
AMB
NP
DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
Blood
SPECIMEN/LAB RPT. NO
MISCELLANEOUS
S57-107
PATIENT'S MED. RECORD

HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

DATE	TIME
24oct03	0444 A.M.

RESULTS	REQUESTED	(X)
2.FF[illegible]	RBC COUNT	
9.3	HEMOGLOBIN	
26.9	HEMATOCRIT	
90.0	MCV	
31.2	MCH	
34.6	MCHC	
6.3	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
22.7%	LYMPHS %	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
328	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
1.4	L[illegible]	

REMARKS: CBC

REQUESTING PHYSICIAN'S SIGNATURE (Enter in above space): Dr. (b)(6)-2

REPORTED BY (b)(6)-2

TECH | MD | DATE 24oct03

0516hr

Potus

(b)(6)-4

ICU

PATIENT IDENTIFICATION—TREATING FACILITY—WARD

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107
STANDARD FORM 545 (Rev. 7-?) PRESCRIBED BY GSA/ICMR FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

CHEMISTRY I

TEST(S)

SPECIMEN TAKEN

DATE	TIME
24oct03	0442 P.M.

RESULTS	REQUESTED	(X)
112	GLUCOSE	
11	UREA N.	
0.7	CREATININE	X
--	URIC ACID	
13[illegible]	SODIUM	
4.0	POTASSIUM	
98	CHLORIDE	
22	CO_2	
NA	PHOSPHATE	X
8.1	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
NA	Mg	X

REMARKS: MET 8 c̄ BMP

REQUESTING PHYSICIAN'S SIGNATURE (Enter in above space): Dr. (b)(6)-2

REPORTED BY (b)(6)-2

TECH | MD | DATE 24oct03

0516hr

000000[illegible]

POTUS # (b)(6)-4

ICU

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

CHEMISTRY I 546-107
STANDARD 546 (Rev. 8-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: Potus [b)(6)-4] | UNIT | DOB | RANK | SSN

Physician [b)(6)-2] | Ward: ICU | STAT / Routine | Specimen Date and Time: | Reported by: [b)(6)-2] 1745 | Date and Time: 25Oct03

Chemistry (i-STAT): 6+ 7+ 8+ Glu Crea

Chemistry (Piccolo Analyzer): Chem 12 MetLyte8 BMP Liver

Hematology: CBC Malaria H/H

X

TEST(S)
SPECIMEN TAKEN
DATE: 25 Oct 03 TIME: 1520 A.M. P.M.

RESULTS	REQUESTED	(X)
2.90	RBC COUNT	
8.8	HEMOGLOBIN	
26.0	HEMATOCRIT	
89.5	MCV	
30.5	MCH	
34.1	MCHC	
7.9	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
394	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT CONTROL	
	PT PATIENT	
	PTT CONTROL	
	PTT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
17.0	LE PREP	
1.3	4+	

REMARKS

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

TECH

MD

DATE

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

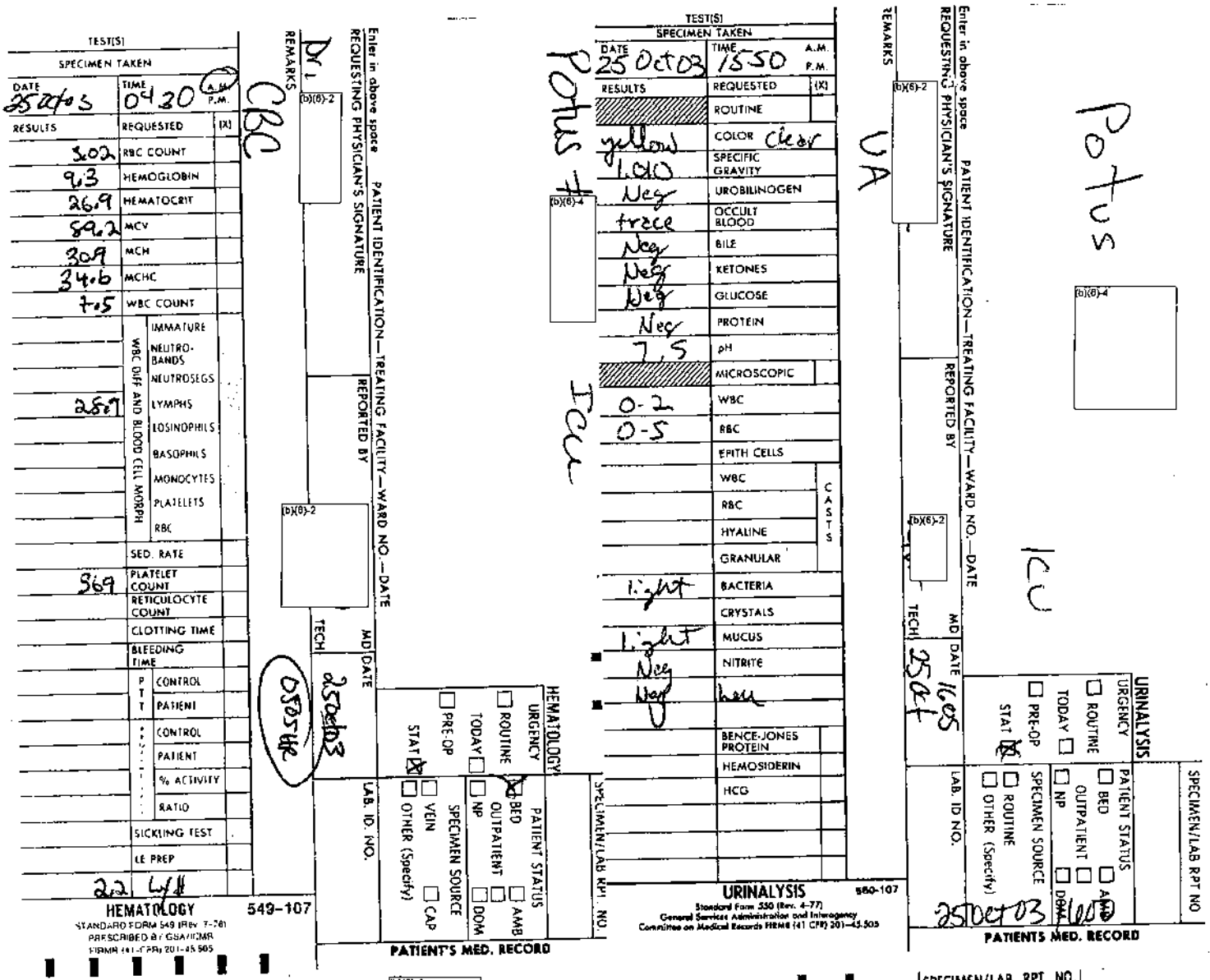
CBC 25Oct03 1545

PHYSICIAN COPY

REF. RANGE
3.3-5.5 g/dL
26-84 U/L
10-47 U/L
14-97 U/L
11-38 U/L
0.2-1.6 mg/dL
7-22 mg/dL
8.0-10.3 mg/dL
100-200 mg/dL
30-170 U/L
98-108 mmol/L
18-33 mmol/L
0.6-1.2 mg/dL
5-65 U/L
73-118 mg/dL
3.3-4.7 mmol/L
6.4-8.1 g/dL
128-145 mmol/L
emistry
Negative
Negative
Negative
Negative
Negative
< 4.3 ng/mL
< 0.19 ng/mL
< 107 ng/mL
iology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL
	Differential		
Segs	35		Mono 9
Bands	19		Eos 5
Lymph	29		Baso
Atyp Ly			Immature cells
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%
	Malaria Smear		
	Thin		No Plasmodium See
	Thick		No Plasmodium See
	Sed Rate		
	Sed Rate		1hr = 0-20 mm
	Coagulation		
	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL
	Blood Bank		
	ABO/Rh		
	T&C		
	T&S		

Nitrite		Negative	FecLeuk		Negative
Leuko		Negative	Gram Stain		
Urine Microscopic			WetPrep		Negative
WBC		Epi	KOH		No Fungal Elements
RBC		Mucus	OccBld		Negative
Bacteria		Yeast	O&P		No Ova/Parasite
Casts:		Spermatozoa	HCG		
Crystals:		Amorph Sed	Urine		Negative
Other:			Serum		Negative
Other:					



HEMATOLOGY
STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
549-107

TEST(S)
SPECIMEN TAKEN
DATE 25 Oct 03
TIME 0430 A.M. P.M.
RESULTS | REQUESTED | (X)

RESULTS	REQUESTED	(X)
3.02	RBC COUNT	
9.3	HEMOGLOBIN	
26.9	HEMATOCRIT	
89.2	MCV	
30.9	MCH	
34.6	MCHC	
7.5	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
2567	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
369	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
22	Lyt	

REMARKS: Dr [redacted] CBC
Enter in above space: REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
[redacted]-2
REPORTED BY
[redacted]-2
TECH
MD
DATE 25oct03
LAB. ID NO.
05870E
HEMATOLOGY
URGENCY: ROUTINE, TODAY, PRE-OP, STAT (X)
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
PATIENT STATUS: BED (X), AMB, OUTPATIENT, NP, DOM
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

Potus # [redacted]-4 ICU

TEST(S)
SPECIMEN TAKEN
DATE 25 Oct 03
TIME 1550 A.M. P.M.
RESULTS | REQUESTED | (X)

RESULTS	REQUESTED	(X)
	ROUTINE	
yellow	COLOR clear	
1.010	SPECIFIC GRAVITY	
Neg	UROBILINOGEN	
trace	OCCULT BLOOD	
Neg	BILE	
Neg	KETONES	
Neg	GLUCOSE	
Neg	PROTEIN	
7.5	pH	
	MICROSCOPIC	
0-2	WBC	
0-5	RBC	
	EPITH CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
light	BACTERIA	
	CRYSTALS	
light	MUCUS	
Neg	NITRITE	
Neg	[illegible]	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency
Committee on Medical Records FIRMR (41 CFR) 201-45.505
550-107

REMARKS: UA
Enter in above space: REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
[redacted]-2
REPORTED BY
[redacted]-2
TECH
MD
DATE 25oct
LAB. ID NO.
URINALYSIS
URGENCY: ROUTINE, TODAY, PRE-OP, STAT (X)
SPECIMEN SOURCE: BED, NP, OUTPATIENT, DOM, OTHER (Specify)
PATIENT STATUS: AMB (X)
SPECIMEN/LAB RPT NO
PATIENTS MED. RECORD

Potus
[redacted]-4
ICU

Potus # [redacted]-4 ICU

CHEM 1
URGENCY: ROUTINE, TODAY, PRE-OP, STAT (X)
PATIENT STATUS: BED (X), AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

Enter in above space: REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
Dr [redacted]-2
REPORTED BY
[redacted]-2
MD
TECH
DATE 25oct03
LAB. ID NO.
REMARKS: Met 8 ~~Mg~~ ~~PhOs~~ BMP
05870E

TEST(S)
SPECIMEN TAKEN
DATE 25Oct03
TIME 0430 A.M. P.M.
RESULTS | REQUESTED | (X)

RESULTS	REQUESTED	(X)
99	GLUCOSE	
9	UREA N.	
1.1	CREATININE	
	URIC ACID	
133	SODIUM	
3.7	POTASSIUM	
98	CHLORIDE	
23	CO_2	
	PHOSPHATE	
8.2	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
190	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

CHEMISTRY 1
549-106

HEMATOLOGY

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
20 Oct 03	0410	

RESULTS	REQUESTED	(X)
2.97	RBC COUNT	
9.0	HEMOGLOBIN	
26.9	HEMATOCRIT	
90.6	MCV	
30.2	MCH	
33.3	MCHC	
9.4	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
12.4%	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
465	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE-PREP	
1.2	4/4	

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

REMARKS: CBC

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE: Dr. [redacted]

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE: Potus [redacted] ICU

REPORTED BY [redacted]

TECH 20Oct03 MD DATE 0415hr

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

CHEMISTRY I

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
20Oct03	0410	

RESULTS	REQUESTED	(X)
116	GLUCOSE	
9	UREA N.	
0.7	CREATININE	
	URIC ACID	
131	SODIUM	
3.5	POTASSIUM	
97	CHLORIDE	
24	CO_2	
	PHOSPHATE	
8.2	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

CHEMISTRY I 546-107
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

REMARKS: Met 8, BMP [redacted]

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE: Potus [redacted] Pressors not taking [redacted] ICU

REPORTED BY [redacted]

TECH 20Oct03 MD DATE 0450hr

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

TEST(S)
SPECIMEN TAKEN
DATE 27oct TIME 0500 A.M. P.M.

RESULTS	REQUESTED	(X)
3.05	RBC COUNT	
9.5	HEMOGLOBIN	
27.5	HEMATOCRIT	
91.0	MCV	
31.0	MCH	
34.1	MCHC	
9.9	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
0020 20.2	LYMPHS 20.2%	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
642	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT CONTROL	
	PT PATIENT	
	PTT CONTROL	
	PTT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

20 Lft

REMARKS CBC

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE | PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE REPORTED BY

(b)(6)-2

TECH | MD | DATE

(b)(6)-2

27oct03 0500hr

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

LAB. ID. NO.

SPECIMEN SOURCE: VEIN ☐ CAP ☐ OTHER (Specify)

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

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

HEMATOLOGY

PATIENT'S MED. RECORD

Potus

(b)(6)-4

tcu

CHEM 1

URGENCY: ROUTINE ☐ TODAY ☐

PATIENT STATUS: BED ☐ OUTPATIENT ☐ AMB ☐

SPECIMEN/LAB. RPT. NO.

D. RECORD

TEST(S)
SPECIMEN TAKEN
DATE 27oct TIME 0500 A.M. 1600 P.M.

RESULTS	REQUESTED	(X)
98	GLUCOSE	
8	UREA N.	
1.0	CREATININE	
	URIC ACID	
136	SODIUM	
4.1	POTASSIUM	
97	CHLORIDE	
25	CO_2	
	PHOSPHATE	
8.5	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

BMP

REMARKS

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE | PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE REPORTED BY

(b)(6)-2

TECH | MD | DATE

(b)(6)-2

27oct03 0500hr

CHEMISTRY I
STANDARD FORM 548 (Rev. 8-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
548-107

LAB. ID. NO.

SPECIMEN SOURCE: BLOOD ☐ OTHER (Specify)

PRE-OP ☐ STAT ☐

Potus

(b)(6)-4

tcu

PATIENT'S ME

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

Potus (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)												
Versed (mg)	1											
Fentanyl (ug)	100		100/	100			100			100		
Propofol (mg)	100											
Sux/Vec (mg)	80/5	3		2		2	2			1		
VOLAT AGENT: Forane % del / % e.t.	2	1.5	2	2	1.5	1.5	1.5	1.5	1.5	1.5	1.5	
AIR L/Min									.5	.5	.5	
N2O L/Min												
O2 L/Min	6	2	1	1	1	1	1	1	.5	.5	.5	

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

TOTALS | TOTAL EBL | TOTAL URINE

FLUIDS

LINE site: 18g L AC; 18g R — ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LR#1 — LR#2 — LR#3 — LR#4 — LR#5

FLUIDS - SUMMARY: CRYSTALLOID- / COLLOID- / BLOOD-

LOSSES

EST BLOOD LOSS

URINE - foley — 50 — 75/125

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: ~135 (LB)

HEMATOCRIT: 32.4

INITIAL DATA: BP- 130/80; HR- 102

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1700

TIME: 1700 — 30 — 18 — 30 — 19 — 30

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

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

REMARKS

Code drugs with numbers, events with letters

1730 Unasyn 3Gm IVPB

VENTIL

VT - ml		650	640	700	660	690	690	720	700	740	760
f - breaths/min		10	10	10	8	8	8	8	8	8	8
Peak insp pres / PEEP		22	24	25	25	25	25	25	25	25	25
MODE - S(pon), A(ssist), C(on)	SV CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	(+)	33	33	31	33	33	32	33	34	37	35
BP/oth	✓ FIO2 (Frac or %)	1—	0.78	0.79	0.79	0.81	0.80	0.80	0.79	0.66	0.50	0.51
ART line	✓ SpO2 (%)	100	100	100	99	99	99	99	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR
✓ Gas analyzer	✓ TEMP-site Skin		37.5	37.5	38	37.5	38	38	37	37.5	37.5	37.5
	✓ N-M Block (T/4)	4/4	0/4	1/	0/		1/	2/	0/4			
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS. EVENTS Position → DS →

RECOVERY AT 2250; FAC: ICU ... (Specify); OTHER: SV FiO2 0.66; CONDITION: 99.6; RESP- SpO2- BP- 137/91 HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1650	1700	2250
	Ready	Begin	End
PROC	1708	1714	2249

PROCEDURES and CPT Codes: Ex Lap, Appy, Enterotomy Repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA ME OETT

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical Facility — Pulmo # (b)(6)-4 [redacted]

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL ... grade [illegible] Suctioning Laryngoscopy thick mucus and blood, grade views 7.5 ETT Stylet 23 [illegible] ETCO2

SURGEONS: Dr. (b)(6)-2 [redacted]

PROCEDURE LOCATION: OR #1

DATE: 10/19/03

MEDCOM - 2489

PREANESTHETIC SUMMARY

OPERATION PROPOSED
Exp lap-

AGE ~20

WEIGHT (LBS.) ~135

PHYSICAL STATUS 1 (2) 3 4 5 6 7 E

SPECIAL INFORMATION

URINALYSIS
NORMAL ....
ABNORMAL AND WHY?

HEMATOLOGY
HGB .... WBC .... HCT ....
OTHER
11.4 / 32.4

BLOOD CHEMISTRY

RESPIRATORY SYSTEM
(X-RAY, ASTHMA, OTHER PATHOLOGY)
Unknown

CIRCULATORY SYSTEM
BP 127/77 PULSE 109
ECG (IF PERTINENT)
101.3
Unknown

CENTRAL NERVOUS SYSTEM
(CEREBROVASCULAR, POLIO, NEUROLOGICAL)
Unknown

OTHER SYSTEMS
(ALLERGIES) Unknown
Unknown

PREVIOUS ANESTHETICS AND COMPLICATIONS
Unknown.

PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS Unknown.

PREOPERATIVE DIAGNOSIS

PREMEDICATION

(b)(6)-2 [redacted]

DATE 10/19/03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS
20 OCT 03 / 0745 Chart review completed. Transfused 2U PRBCs ≈ 0045 2° ↑ HR ~140's. H&H prior 11.3/32.2. No apparent anesthetic sequelae. VSS remain stable this AM. ———— (b)(6)-2 [redacted] CPT, CRNA ——

#(b)(6)-4 [redacted]

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDICAL RECORD - ANESTH[illegible]

[illegible]se of this form, see AR 40-66; the proponent a[illegible] the OTSG

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)						TOTALS
VCB (mg)	1					
( )						
Morphine (mg)				3		
( )						
( )						
( )						
VOLAT AGENT Iforane % del / % e.t.	1	1	.5X			
AIR L/Min	.5	.5	X			
N2O L/Min						
O2 L/Min	.5	.5	6 →			

TOTAL EBL: 200

TOTAL URINE: 250

FLUIDS - SUMMARY

CRYSTALLOID- 5000

COLLOID-

BLOOD-

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

FLUIDS

LINE site	
18g L AC ☐ Warmed	5000
16g R ☐ Warmed	
☐ Warmed	
☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE - 150/250

PHYS STATUS: 1 (2) 3 4 5 (E)

TIME → 1915, 20, 30, 21

BODY WEIGHT: ~135 KG (LB)

HEMATOCRIT: 32.4

INITIAL DATA:

BP- 130/80

HR- 102

EQUIP CHECK

OK?- Y N

PATIENT

OK for PROCEDURE?

TIME-

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-∅

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

VENTIL

VT - ml	770	720	830		
f - breaths/min	18	18	20		
Peak inf pres / PEEP	25	25	26		
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	SV →	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	34	35	29	40	45
BP/oth	FIO2 (Frac or %)	.51	.52	.77	.80 →	
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST		
Gas analyzer	TEMP-site Skin	36.5	37	37		
	N-M Block (T/4)				4/4	
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS Position → 05 →

REMARKS

Code drugs with numbers, events with letters

2025 Neostigmine 3mg Robinul 0.6mg

2240 SV/RR ⊕ Flex/Ext all extremities ⊕ Head lift x 5 sec Extubated ̄c suctioning oral pharynx. TOICU SV.

RECOVERY AT

PACU ICU ______(Specify)

OTHER ______

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Ex lap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

Pchrs (b)(6)-4 [redacted]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

PROCEDURE

DATE 5/19/03

PAGE 3 OF 3

DA FORM 7389, FEB 1998

MEDCOM - 2491

COPY 2 - ANESTHESIA PROVIDER

USAPA V1.00

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _______ units)
- [ ] CRYOPRECIPITATE (Pool of _______ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ___

VOLUME REQUESTED (If applicable) 1 unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 19 OCT 03

DATE AND HOUR REQUIRED 19 OCT 03 2350

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ___

HEMOLYTIC DISEASE OF NEWBORN? ___

REQUESTING PHYSICIAN (Print) [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE S/p Schrapnel wounds S/p Ex lap

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

SIGNATURE OF VERIFIER [redacted] Error [illegible] /SPC, [illegible]

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO O
Rh NEG	Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
not performed	comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

[redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 20 Oct 03

REMARKS: Due to the critical condition of the below named patient, the requesting physician named above is requesting immediate release of this blood product w/out complete testing, and is accepting full responsibility of the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

[redacted]

AT (Hour) 0030 ON (Date) 20 October 2003

IDENTIFICATION

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

[redacted] Cpt AN

[redacted] SPC, [illegible]

PRE-TRANSFUSION

TEMP. 98.8 PULSE 120 BP 147/72

DATE OF TRANSFUSION 20 OCT 03

TIME STARTED 0045

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 Unit ML

TIME/DATE (COMPLETED) INTERRUPTED 0145 20 Oct 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 99.1

PULSE 120

BLOOD PRESSURE 138/42

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [X] NO
- [ ] YES (Specify)

[redacted] Cpt AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, ... rate; hospital or medical facility)

Name/Rank: Potus [redacted]

SSN#:

DOD:

unit:

Male

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2492

Medical Record Copy

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

Potus # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

DATE OF ORDER 10/19/03 TIME OF ORDER 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU s/p Scrotal Wounds
   ? LOC (b)(6)-2
2. Condition stable
3. Vital q 2°
4. Neuro Dsq 1°
5. Activity Adl rest
6. IV D5 1/2 NS @ 100 cc/hr HOURS
7. Ancef 1 gram IVPB q 8°
8. HOB @ 30 degrees
9. Diet NPO
10. CBC, BMP in AM

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/19/03 TIME OF ORDER 1445 HOURS

1. CBC @ 1500

(b)(6)-2

1530 notified

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus [redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 Oct 03	2100 HOURS	
1	Admit to ICU		
2	Dx: s/p Repair of Small & Lg Bowel Injury		
3	Vitals: q 1°, I&O's		
5	Act: Up to Chair q Shift beginning 20 Oct		
6	Diet: NPO		
7	O2 - Wean to Maint O2 Sat > 93%		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
8	Foley to Gravity	HOURS	noted 1900 21 Oct [redacted]
9	NG to Low Int Suction		
10	IV: LR at 150cc/hr		
11	Unasyn 3.0gm IVPB q 6°		
12	Zantac 50mg IVPB q 8°		
13	Morphine 2-8mg IVP q 1-2° prn		
14	Phenergan 12.5mg IVP q 4° prn Nausea		
15	If Able - Incentive Spir q 10 WA		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
16	CBC, Chem-7 q am	HOURS [redacted]	

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	19 Oct 03	2300 HOURS	
1	Bolus 1 Liter LR, Done/Gr	[redacted]	noted 19 Oct 03 2305 [redacted]

DA FORM 1 APR 79 4256 REPLACE MEDCOM - 2494 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus [(b)(6)-4]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 19 Oct 03 TIME OF ORDER 2350 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) CBC NOW Done

(2) Transfuse 2 Units PRBC Noted

call am Hgm 20 Oct 03

0030

[(b)(6)-2]

[(b)(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 Oct 03 TIME OF ORDER 0920 HOURS

(1) Nutrition Consult

[(b)(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. [(b)(6)-2] | NO.

DATE OF ORDER 20 Oct 03 TIME OF ORDER 1045 HOURS

(1) Met Lytes / BUP

(2) Change IV to D5 1/2 NS ~~c~~ 20 meq KCl/l at 125 cc/hr

Noted ICTP 10/20/03 1137

[(b)(6)-2]

[(b)(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. [(b)(6)-2] | NO.

DATE OF ORDER 20 Oct 03 TIME OF ORDER 1241 HOURS

(1) Change A.M. Labs to CBC & BUP

(2) Change IV to D5 1/2 NS ~~c~~ X 20 meq KCl/l at 125cc/hr

(3) ↓ Vitals to q 4°

(4) Tylenol 650 mg PR q 6° prn Temp > 101°

Noted ICTP 10/20/03 1457

[(b)(6)-2]

[(b)(6)-2]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

POTUS # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20OCT03 TIME OF ORDER 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Tube feedings ē osmalite HN 20cc/h, advance by 10cc/h q 6h as tolerated until target rate of 80cc/h when bowel fx
2. daily Net-6 Panflex Mg+ # PO4 (qAM)

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER 20OCT03 1740 HOURS

1. Ensure can be substituted if osmalite HN not available

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 20 Oct 03 TIME OF ORDER 2103 HOURS

1. Hold Tube feeds for now
2. Cont NG to LIS

(b)(6)-2

(b)(6)-2

2103 20OCT03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 21OCT03 TIME OF ORDER 1000 HOURS

1. ice chips as tolerated (80 q shift)
2. ↓ IV rate to 75cc/h D5 NS ē 20mEq
3. encourage ambulation

(b)(6)-2

(b)(6)-2

(b)(6)-2

Noted 21 Oct 03 0940

(b)(6)-2

NURSING UNIT | RO | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

POTUS tt [b(6)-4]

NURSING UNIT | ROOM NO. | BED NO.

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

21 Oct 03 | 2017 HOURS

1. PCXR

[b(6)-2]

21 Oct 03 2018 [b(6)-2] done 2030

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO. [b(6)-2]

NOTED 21 OCT 03 1024

DATE OF ORDER | TIME OF ORDER

22 Oct 03 | 1024 HOURS

1. V-T Suction q 4°
2. ↑ Maint IV to 100cc/hr.
3. UA to Lab
4. d/c Unasyn
5. Primaxin 500mg IV q 6°

[b(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO. [b(6)-2]

DATE OF ORDER | TIME OF ORDER

22 Oct 03 | 1219 HOURS

1. d/c VG - done
2. d/c Foley done 1200hrs.
3. Due to Void by 2000

[b(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

2 Oct 03 | 2000 HOURS

1. clear liquids as tolerated

[b(6)-2]

noted 2 Oct 03 2005 [b(6)-2]

---

240 Chart ✓ [b(6)-2] 2 Oct 0001

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus # [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
22 Oct 03	2051 HOURS	

① Mucomyst / Albuterol Neb q 4°

[redacted]

noted 2300 hrs [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU		

24 Chart ✓ Amparo 22 Oct 03 @ 2355

PATIENT IDENTIFICATION

POTUS # [redacted]

DATE OF ORDER	TIME OF ORDER
23 Oct 03	0951 HOURS

① Dulcolax Supp PR Now and Repeat in 3°

② d/c Tylenol Suppository

③ Tylenol 650mg po q 4° prn Temp > 101°

④ NPO ✕ Meds.

noted 23 Oct [redacted]

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU		

PATIENT IDENTIFICATION

POTUS # [redacted]

DATE OF ORDER	TIME OF ORDER
24 Oct 03	0900 HOURS

① clear liquid diet as tolerated

② ambulate TID AT LEAST Q. 6D

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 2VO	Chart ✓	[redacted]

24 Oct 03 @ 2300

PATIENT IDENTIFICATION

POTUS # [redacted]

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT	ROOM NO.	BED NO.
ICU		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
24 Oct 03	1418 HOURS	
① Decrease Albuterol Nebs to q Shift		noted 24Oct03 1420
② ↓ Maint IV to 50cc/hr		

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

24 Oct 1749

DATE OF ORDER	TIME OF ORDER
24 Oct 03	1749 HOURS
① Percocet 1-2 po q 4-6 prn	

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER	TIME OF ORDER
24 Oct 03	2012 HOURS
① Change Percocet to T po q 4° prn	
② d/c Morphine	
(b)(6)-2	
③ CXR PA & Lat	
(b)(6)-2	

(b)(6)-2 noted 24Oct03 2015

NURSING UNIT | ROOM NO. | BED NO.

2ND Chart ✓ Ambulate ad lib 24 Oct 03 @ 2300

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
24 Oct 03	2330 HOURS
① d/c UT Suction	
(b)(6)-2	

Tube (b)(6)-2 24Oct03 @2330

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

Potus # [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 Oct 03 | TIME OF ORDER 0945 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ↑ diet to soft
2. ↑ diet as tolerated for dinner to regular
3. d/c Primaxin
4. Levaquin 500mg po bid

25 Oct 03 1410 MT

[redacted]

PATIENT IDENTIFICATION

Potus # [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

25 Oct 03 HOURS

26 Oct Oct 1516

1. CBC, UA Stat
2. d/c Zantac
3. d/c Levaquin

25 Oct 03

[redacted]

PATIENT IDENTIFICATION

Potus # [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

25 Oct 03 1634 HOURS

1. Levaquin 500mg po bid

25 Oct 03 1640 MT

[redacted]

24° chart ✓ completed [redacted] CPT on 25 Oct 03 2333

PATIENT IDENTIFICATION

Potus # [redacted]

NURSING UNIT | ROOM | NO.

DATE OF ORDER | TIME OF ORDER

26 Oct 03 1049 HOURS

1. Hep-Lock IV
2. Zantac 150 mg po bid
3. Dulcolax Supp PR ✓ X 1 this a.m.
4. PA + Lat CXR

10/26/03

[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Potus (b)(6)-4		26 Oct 03 — 1330 HOURS	
	①	Colace 100mg po bid	
		(b)(6)-2	
(b)(6)-2 noted 1330			
NURSING UNIT: clart ✓ ROOM NO.: 27oct02			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Potus (b)(6)-4		27 Oct 03 — 0930 HOURS	
	①	Ambien 10mg qhs prn insomnia	
	②	ensure, 1 container b/w meals at least 1X/day	
		(b)(6)-2	
(b)(6)-2 noted 10/27 0930			
NURSING UNIT: ROOM NO.:			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Potus (b)(6)-4		27 Oct 03 — 1030 HOURS	
	①	d/c Daily CBC, RUP	
	②	d/c Hep-Lock (b)(6)-2	
NURSING UNIT: ROOM NO.: BED NO.:			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Potus (b)(6)-4		27 Oct 03 — 1200 HOURS	
done 1230 (b)(6)-2	②	d/c to MP's Custody	
		(b)(6)-2	
NURSING UNIT: ROOM NO.: BED NO.:			

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

MEDCOM - 2501

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.

MAY Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22
19Oct	(b)(6)-2	VS: q 2°	D	(b)(6)-2			
			E				
			N				
19Oct		Neuro ✓ q 1°	D	(b)(6)-2			
			E				
			N				
19Oct		Activity: Bed Rest	D	(b)(6)-2			
			E				
			N				
19Oct		HOB @ 30 degrees	D	(b)(6)-2			
			E				
			N				
19Oct		Diet: NPO	D	(b)(6)-2			
			E				
			N				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p scrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS # (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
19Oct	(b)(6)-2	Admit to ICU; S/P scrapral wounds; Dr Eastman	19 Oct	now	1050	(b)(6)-2
19Oct		Condition: Stable	19 Oct	now	1650	
19Oct		CBC, BMP in AM	20 Oct	0500		
19Oct		CBC @1500	19Oct	1500	(b)(6)-2	

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

MAR

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

MoAUT Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION — DATE COMPLETED 19 20 21 20
19 Oct	(b)(6)-2	IV D5 ½ NS @ 100cc/hr	D	(b)(6)-2
			E	
			N	
19 Oct	(b)(6)-2	Ancef 1G IVPB 98	03	D/C to Surgery
			11	(b)(6)-2
			19	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P scrapnal wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS # (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 - 2504

MAR

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. Oct Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27
19Oct03	[redacted]	O_2 - wean to maintain	D	/ [redacted]
		Sats >93%	E	/
			N	[redacted]
19Oct03	[redacted]	IV - LR @ 150cc/hr	D	/ (b)(6)-2 Date 10/20/03
			E	/
			N	[redacted]
19Oct03	[redacted]	Unasyn 3.0gm IVPB	05	/ [redacted] Date 10/22/03
		q6°	11	/
			17	[redacted]
			23	/
19Oct03	[redacted]	Zantac 50mg IVPB	08	/ [redacted] Date 25 Oct 03
		q8°	16	/
			24	[redacted]
20Oct03	[redacted]	D5½NS ē 20meq Kcl	D	/ Date 10/20/03
		@125cc/h	E	/
			N	/
20Oct03	[redacted]	D5NSē 20meq/Kcl	D	/ [redacted] Date 10/22/03
		@ 125cc/h	E	/
21Oct	[redacted]	VD5NSē 20Kcl to Fish	N	/
20Oct03	[redacted]	Tube Feeding ē Osmolite HN	D	/
		20cc/h ↑ by 10cc/h q6° as	E	/
		tolerated until target rate	N	/ Date 10/20/03
		of 80cc/h When bowel		/
		Sound returns May sub		/ [redacted]
	[redacted]	ē Ensure if no Osmolite		/
20Oct03		Hold Tube Feeds for now		/ [redacted]
				/

ALLERGIES: ☐ YES ☒ NO — NKA

PRIMARY DIAGNOSIS: S/P Repair of Small + lg bowel injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO: 3

PATIENT IDENTIFICATION: Pohus [redacted]

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 - 2505

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
19oct	(b)(6)-2	Bolus 1L LR	19oct	NOW	2305	(b)(6)-2
20oct	(b)(6)-2	Give 2 unit PRBC's #1	20oct	ASAP	0045	
		#2	20oct	ASAP		
20oct	(b)(6)-2	Continue NG to LIS and hold tube feeds for now	20oct	Now		
23 oct	(b)(6)-2	Dulcolax supp PR now + repeat in 30	23oct	1000	done	
			23oct	1300	1320	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
19oct	(b)(6)-2	Morphine 2-8mg IVP q 1-2° prn	4mg 2215	4mg 2230	2mg IV 0900	10/20 1100	10/20 1300	10/20 1825	10/21 0410	10/21 0530	10/21 0620	10/21 1015	10/21 1140	10/21 1645	10/21 1845	10/21 2100
			19oct	19oct	20oct	4mg IV	4mg IV	3mg	3mg	4mg	2mg IV	2mg IV	4mg	4mg	4mg	4mg
			(b)(6)-2					(b)(6)-2								
19oct	(b)(6)-2	Phenergan 12.5mg IVP q 4° PRN nausea														
20oct 03	(b)(6)-2	TYLENOL 650mg PR	10/20 1255	10/21 1850	10/22 0700	10/22 2000	D/C 23oct03									
		Q6° prn Temp > 101°	T [illegible]	T [illegible]	T [illegible]	T [illegible]										
			(b)(6)-2													
19oct	(b)(6)-2	Morphine 2-8mg IVP	10/22 0615	10/22 0715	10/22 1825	10/23 0230	23oct 0700	23oct 3mg	23oct 2308	D/c'd 24oct03						
		Q 1-2° prn	4mg	4mg	3mg	2mg	[illegible]	[illegible]	[illegible]						(b)(6)-2	
			(b)(6)-2													
23 oct	(b)(6)-2	Tylenol 650mg po	10/23 1700	10/25 1530	10/25 2310											
		q4° prn T>101	(b)(6)-2													

★ U.S. GPO-1997-418-290/55267

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. OCT Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27
19OCT03	b(6)-2	Vitals q1°, I+Os	D	/ b(6)-2 D/C 25Oct03
			E	/ b(6)-2
			N	/ b(6)-2
19OCT03	b(6)-2	Activity - up to chair	D	/ b(6)-2
		q shift beginning 20 OCT	E	/
		Ambulate at least QID	N	/
19OCT03	b(6)-2	Diet: NPO ± sips	D	/ b(6)-2 D/C 22OCT03 b(6)-2
			E	/ b(6)-2
			N	/ b(6)-2
19OCT03	b(6)-2	Foley to gravity	D	/ D/C 22Oct03
			E	/
			N	/ b(6)-2
19OCT03	b(6)-2	NG to low int	D	/
		Suction	E	/ D/C 22Oct03
			N	/ b(6)-2
19OCT03	b(6)-2	If able - incentive	D	/ b(6)-2
		spir q1° WA	E	/
			N	/ b(6)-2
19OCT03	b(6)-2	CBC, chem7 qAM	05	/
20OCT03	b(6)-2	CBC & BMP QAM	05	/
19OCT03	b(6)-2	I&O Q1°	D	/ b(6)-2 D/Cd 10/22/03
			E	/
			N	/
20OCT03	b(6)-2	VITAL SIGNS Q4°	D	/
			E	/
			N	/

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: s/p Repair of small + lg bowel injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

Potus b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 4699

MEDCOM - 2507

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 0CT Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19OCT03	(b)(6)-2	Admit to ICU		Noted		
20 Oct 03		MET LYTES / BMP	10/20	asap	1050	(b)(6)-2
21 Oct	(b)(6)-2	Portable CXR	21 Oct	now	2030	
22 Oct		Due to void by 2000 hrs	22 Oct	2000		
23 OCT03	(b)(6)-2	CXR Pa/lat	23 OCT	NOW	2030	
25 Oct	(b)(6)-2	CBC, UA STAT	25 Oct	done	1545	
26 OCT		PA & LAT CXR	10/26	now	1105	

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

☆ U.S. GPO:1987-418-230/55267

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. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21 22 23 24 25 2401
20Oct03	[b)(6)-2]	Daily Met-6 panel	05	[b)(6)-2]
		Mg i PO4 q AM		
10/21/03	[b)(6)-2]	ICE CHIPS AS TOLERATED	D	[b)(6)-2]
		Q Shift	C	[b)(6)-2] - D/d 22Oct03
			N	
20/21/03	[b)(6)-2]	Encourage Ambulation	D	[b)(6)-2]
			E	D/C 22Oct03
			N	[b)(6)-2]
10/22/03	[b)(6)-2]	N-T Suction Q 4°	D	[b)(6)-2]
			C	D/C d 23Oct03 2400 2339
			N	
22Oct03	[b)(6)-2]	Clear Liquids as	B	[b)(6)-2]
		Hydrated	L	D/C 23Oct03
			D	[b)(6)-2]
23Oct	[b)(6)-2]	NPO x meds	D	[b)(6)-2]
			E	D/C 24Oct03 0673
			N	
24Oct03		clear liquid diet as	D	[b)(6)-2]
		tolerated	E	Ad 25Oct03
			N	[b)(6)-2]
24Oct03		Ambulate at least	D	[b)(6)-2]
		Q.I.D	E	
			N	
25Oct	[b)(6)-2]	↑ diet to soft advance	B	[b)(6)-2]
		to regular as tolerated	L	[b)(6)-2]
			D	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair of Small & LRG bowel rupture

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

POTUS [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 - 2509

CLINICAL RECORD

THERAPEUTIC SUPPLEMENTATION CARE FLOW SHEET-MEDICATION
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

10 Oct 03

PRINT BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22/23 24/25 26/27
10/22/03	[b](6)-2	DSNS @ 20 mcg	D	[b](6)-2
		KCl @ 100cc/hr	E	Did 24 Oct 03 (b)(6)-2
			N	
10/22/03	[b](6)-2	Penicillin 500mg	06	
		IV @ 6°	12	25 Oct 03
			18	@ 1400 (b)(6)-2
			24	
22 Oct 03	[b](6)-2	Mucomyst/Albuterol	D	
		Nebs q 4°	E	[b](6)-2 Did 24 Oct 03 (b)(6)-2
			N	
22 Oct 03	[b](6)-2	Mucomyst/Albuterol	02	
		Nebs q 4°	06	[b](6)-2
			10	Did 24 Oct 03
			14	[b](6)-2
			18	
			22	
24 Oct 03	[b](6)-2	Maint IV to 50cc/hr	D	(b)(6)-2 Did 10/26/03
		DSNS @ 20 mEq/kg/hr	E	[b](6)-2 [b](6)-2
			N	[b](6)-2 [b](6)-2
24 Oct 03	[b](6)-2	Albuterol neb q	06	
		shift	14	[b](6)-2
			22	
25 Oct 03	[b](6)-2	Levaquin 500mg	06	Did 25 Oct 03
		po BID	18	(b)(6)-2 MT
25 Oct 03	[b](6)-2	Levaquin 500mg	06	
		po BID	18	

ALLERGIES: [ ] YES [ ] NO

PRIMARY DIAGNOSIS: S/P Repair of Small & Colon Bowel Injury

ADDITIONAL PAGES IN USE: [X] YES [ ] NO

PAGE NO: 4

PATIENT IDENTIFICATION:

POTUS [b](6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 3 9 10 11 12 13 14 15

1 16 17 18 19 20 21 22 23

MEDCOM - 2510

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON-MEDICATION)

Mo Oct Yr 03

Order/ Start Date	Clerk/ Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 Oct	(b)(6)-2	Percocet 1 2 po q 4 6° prn mj				

Order/ Start Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
24 Oct	(b)(6)-2	Percocet 1-2 po q 4-6° prn pain	24 Oct 1805 tmj - D/C 24 Oct 03 (b)(6)-2
24 Oct	(b)(6)-2	Percocet 1 640 PRN	24 Oct 2000 (b)(6)-2

"M.A.R."

CLINICAL RECORD

THERAPEUTIC SUBSTITUTION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

16 Oct 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27
10/24/03	Recopied [b)(6)-2]	ALBUTEROL NEBS q.	06	/ [b)(6)-2]	
	[b)(6)-2]	Shift	14	[b)(6)-2]	
			22	[b)(6)]	
10/24/03	Recopied [b)(6)-2]	LEVIQUIN 500mg PO	06	/ [b)(6)-2]	
		BID	18	[b)(6)-2]	
10/26/03	[b)(6)-2]	ZANTAC 150mg PO	10	[b)(6)-2]	
		BID	22		
10/26/03	[b)(6)-2]	HEPLOCK IV	D		
		(FLUSH Q Shift & PRN)	6		
			N		
26 Oct		Colace 100mg po	06		
	[b)(6)-2]	BID	18		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Lapsin Sml & Lob bowel

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS [b)(6)-4]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 3 9 10 11 12 13 14 15

[illegible] 16 17 18 19 20 21 22 23

Verify by initialing

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON MEDICATION)

Mo OCT Yr 2005

Date Due	Clerk/ Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/26	[b)(6)-2]	DULCOLAX Supp. Pr X 1 ~~Month~~ this am	10/26	A.M.	1130	[b)(6)-2]

Order/ Entry Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
10/19	Recupiel [b)(6)-2]	PHENERGAN 125mg	
		IV Q 4° PRN NAUSEA	
10/23	Recupie [b)(6)-2]	TYLENOL 650 mg PO	
		Q 4° PRN T > 101	
10/24	[b)(6)-2]	Percocet 1 PO Q4°	
		PRN	
10/27	[b)(6)-2]	Ambien 10mg QHS	
		PRN INSOMNIA	

CLINICAL RECORD

THERAPEUTIC SUBSTITUTION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-400; 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 17 28 29
10/17	(b)(6)-2	ENSURE 1 CONTAINER	10	
		B/W MEALS AT LEAST	14	
		1X/day	18	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair SMI & CRC Bowel

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 3 9 10 11 12 13 14 15

8 16 17 18 19 20 21 22 23

4 [illegible]

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

Unsign 3gm 1730, NGT

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Exp lap, appy, ventral hernia repair

PHYSICIAN: [redacted]

ANESTHESIA BY: MAJ [redacted]

(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. ____ %

ASA II History ____

Cardiac Rhythm ____

IV#1 LRCTKO Patent Infiltrated
Site R FA Rate ____ Gauge 16

IV#2 LRC Patent Infiltrated
Site 16D Rate ____ Gauge 18

DAC

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	130/80	102											Extr: L R Upper Lower; Pulse: DP PT RAD
PRE-OP	/												Blanche Pulse; Warm Moves Y N
2100	137/81	117	18	100%	99.6	1	1	2	0	2	6		Blanche Pulse; Warm Moves Y N
2105	141/76	114	16	100%		1	1	2	0	2	6		Blanche Pulse; Warm Moves Y N
2110	149/78	113	16	100%		1	1	2	0	2	6		Blanche Pulse; Warm Moves Y N
2125	170/77	115	18	100%		1	2	2	0	2	7		Blanche Pulse; Warm Moves Y N
2140	147/77	119	19	100%		1	2	2	1	2	8		Blanche Pulse; Warm Moves Y N
2155	134/80	123	19	99%		1	2	2	1	2	8		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

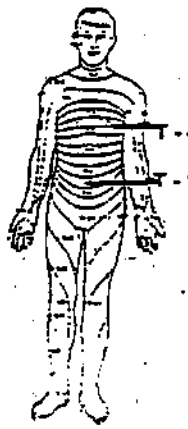
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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
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): [redacted] MAN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 19 OCT 03

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

Pohs [redacted]

☐ 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	UR	8000	OR	EBL	200
			OR	Urine	250
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

2115 - Midline weisen covered c fluffs and foam tape. Multiple areas c bandaids on chest. Hand (R) wrapped in kerlix all disp CDI. Lungs clear in upper lobes. Rhonchi to Bases (B). NGT placement verified now to LIS. Foley patent draining dark yellow urine. [b)(6)-2] KN

2130 - O_2 Mask removed Sats 100% on RA [b)(6)-2] KN

2205 - To Icu status. Remains unresponsive. Cont to follow [b)(6)-2] KN

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: CDI PAR Score 8 Safety Straps Y
Report given to N/A Remains in ICU. Patient released by Anesthesia
Time out 2205. Nurse Signature: [b)(6)-2] KN

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A (b)(3)-1
2. MTF LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): Potos (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D):
7. AGE AT ADMISSION:
8. RACE:
9. ETHNIC BACK-GROUND:
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 9 8
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS:
HOUR OF ADMISSION: 1020
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 6
16. ZIP CODE OF RESIDENCE: 0 9 3 3 4
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA:
PREV. ADMISSION YEAR: NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0
WARD: ICU
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 0 5
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 2 0 0 3 0 2 7
24. CLINIC SVC - ADMITTING: A B A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 2 0 0 3 1 0 1 8
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION: A 1 4 0 1
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 2 0 0 3 1 0 1 9
FOR LOCAL USE: A

TRAUMA 9

Dx: 86354 86331 86397 6831 8738 E8719 2768 490 9584 9110 5180 88000 7806

Px: 4562 4675 4671 8365 4719 6794 966 4502 4503 4607 8622 X3

INJURY 559

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

MEDCOM - 2517

(b)(3)-1

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

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

PATIENT DATA ITEMS 1 - 30 (...

(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

(b)(6)-4

(b)(6)-4

25. TYPE DISPOSITION

DC

...OSITION

3 Nov 03

(b)(6)-2

...TS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

33. CAUSE OF INJURY

Gunshot wound

☐ CHECK IF CONTINUED ON REVERSE

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

1) Grade III liver lac (R) lobe 998.2 ICD9, FX02
2) Total disruption (R) Kidney 760.55 ICD9. FX02
3) T12 Paraplegia 344.1 ICD9 FX02
4) (D) thigh GSW @ fx 890.0 ICD9, FX02
5) Ex lap ō (R) Nephrectomy / Repair 864.05, ICD9, FX02 Liver lac
6) Median sternotomy 75e.3 ICD9, FX02

...TAL DAYS THIS FACILITY

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

☐ CHECK IF CONTINUED ON REVERSE

(b)(6)-2

		c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL	...BED	

...CER

Patient (b)(6)-4 (Detainee)

(b)(6)-4

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

PATIENT'S 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 CL/An (EMT - KN)

Patient's 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: DATE	DEPOSITS: SIGNATURE (Custodian)	WITHDRAWALS: DATE	WITHDRAWALS: SIGNATURE (Patient or intermediate individual)
001	Watch-1 (Black)	23Oct03	SPC (b)(6)-2		
002	Jeans-1 (Black)	23Oct03	SPC		
003	Belt-1 (Black)	23Oct03	SPC		
004	Shoes-2 (Black)	23Oct03	SPC		
005	Socks-2 (Black)	23Oct03	SPC		

(b)(6)-2

DA FORM 1 DEC 77 3696 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED. ★U.S.GPO:1991-0-301-988

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See SF 558
for complete H&P available
@ this time.

PHYSICAL EXAMINATION

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

[b]

[b](6)-2

ATE 23OCT03	IDENTIFICATION NO.	ORGANIZATION
ve Name last, first, r medical facility)	REGISTER NO.	WARD NO.

Potus #[b](6)-4

[b](6)-4

MEDCOM - 2520

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/31/03	Surgery
1330	Pt c/o: ↓ bloating, diarh, ⊕ BS/flatus
	VSS Afeb
	L - CTA, CXR - no Δ
	CT-Ⓛ with 100cc
	CT Ⓡ with 250cc
	CV - RRR s̄ ⓜ
	Abd - mild distension, wound healing
	A/P s/p GSW to liver Ⓡ nephrectomy - stable
	D/c 2 CT continue Ⓡ post tube
	✓ CXR (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.0

)-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

ICAL RECORD | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

DATE	
)ct03	Surgery Note
)730	20's yo ♂ who attacked party and sustained GSW to (R) chest and abd, (L) thigh. Presently hypotensive c obvious paraplegia of low ext. CXR-WNL x bullet fragment, Abd film c fx transverse process (L). To OR for emergent Exploration. [redacted] (b)(6)2
	(b)(6)-2
23Oct03	Brief OP Note
1130	Pre-op, GSW to Abd/Chest
	Post op same + (1) Injury to (R) dome of liver (2) through and through injury to (R) kidney (3) large paraspinal dissection / bony disruption spinal cord c obvious transection
	Procedure: (1) Ex lap (2) Median Sternotomy (3) Removal (R) Kidney (4) Repair laceration dome (R) side liver c omental pack

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

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

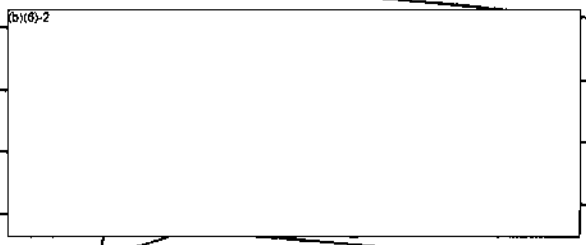
CHRONOLOGICAL RECORD OF MEDICAL CA
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

(b)(6)-2

(b)(6)-2



FPI, LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23Oct03	0730: Arrived via ground to (b)(3)-1 Mosul, Iraq. Placed on monitors, clothing cut away, 100% O_2 ⊕spontaneous respirations RT and full medical staff at bedside. ∅ IV access at this time (upon arrival)
0730	HR: 104 BP: Unable to obtain ox: Unable to obtain MD starting central line ⓇFem. Working on IV access
0735	HR: 94 BP: RR: ox: 99% IV 18G start ⓁAC 1000cc ↑
0740	HR: 87 BP: RR: ox: 95% 1000cc in, #2 2L IVF ↑
0743	Succinylcholine 100mg IVP/Ames; pt orally intubated, 22 cm@ teeth Blood ↑UPRBC↑ via Ⓡ Fem central line. Labs drawn & sent. Foley placed – U/A sent CXR
0750	HR: 94 BP: 96/43 RR: Bagging 100% ox: 100% Versed 2mg IV, Vec 10mg IVP #2 of 2 PRBC↑
0757	HR: 101 BP: 85/38 RR: Bagging 100% ox: 99% Dopamine started 5mg/kg/min
0800	HR: 95 BP: 94/59 RR: Bagging 100% ox: 100% ↑ Dopa 10mg/kg/min (26.3cc) Dr (b)(6)-2 placed CT to ⓁCW – Pt prepared for surgery

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

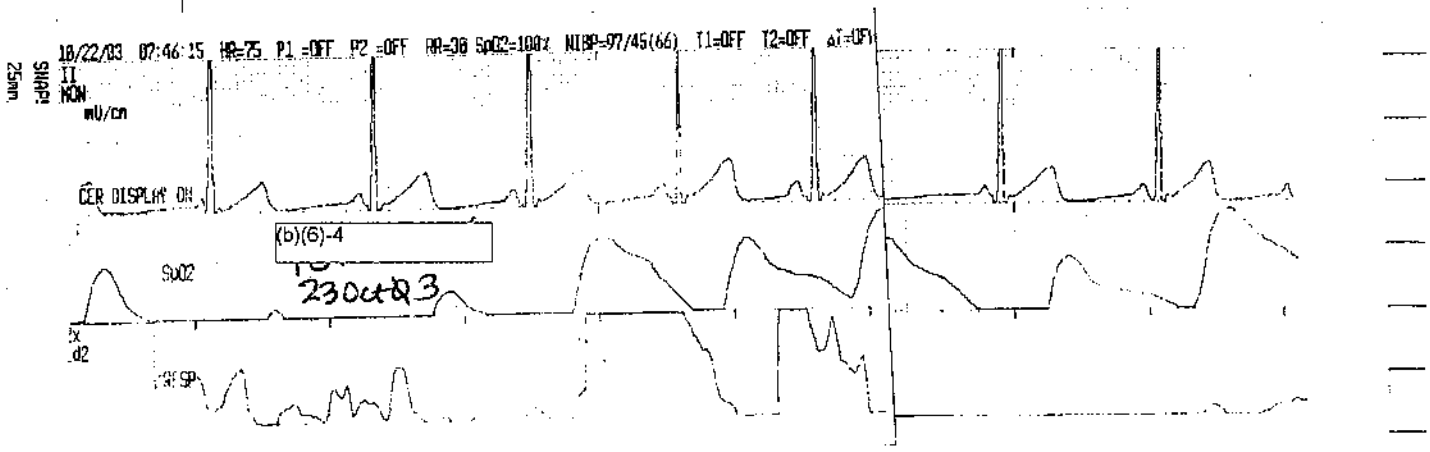
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

Iraqi EPW

REGISTER NO.	WARD NO.
(b)(6)-2	54/1

Potus # (b)(6)-4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont from front 23Oct03 0805	→ Pt transported to OR. Sent along with patient. Ancef 1 GM IVPB & Tetanus 0.5cc injection. (b)(6)-2 RA/1



3/327 HHC Scouts SPC Hopkins, Amarei
Enemy drove off Interstate. Occupants exited car and begin to fire at Sniper teams located in OP. Snipers returned fire killing 2, injuring 1, and 1 enemy escaped.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES		
DATE	23 Oct 03		NOTES
Unit #1	BP	T (AX)	P
Pre (1950)	104/65	96° (AX)	92
1955	127/81	96°	89
2000	135/44	96.1	92
2005	123/45	96.1	87
End #1 2015 ~~2020~~ My	134/73	96.3	91
Unit #2			
Pre 2025	142/58	96.3	91
2030	147/48	96.5	85
2035	150/82	96.8	90
2040	99/68	96.8	103
~~2700~~ 2053 My	109/77	96.8	98

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

Potus (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)

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
10/24/03 1900	Surgery ND#1 .. POD#1
	Pt sedated, on vent, follows commands, triggers extremities, No movement of lower ext
	Vss Apyrb
Resp	Good ABG → 40%, PEEP 5 TV 800 Sats 100% No acidosis
	CXR - clear
	CT - ϕ airleak serous output
CV	NSR/RRR
	Requiring Vasopressin / Dopamine
Abd	- ϕ BS, nondistended
	No minimal output
Renal	good UOP I/O = equal
	Hgb 13.3 WBC 16.9 PLT 102
	CR 1.3
	ALK ϕ 40 ALT 243 AST 242 Tbili 3.3
A/P	L2 Paraplegia / Incomplete / (R) Hydronephrosis
	(1) Continue supportive care Hemodyne (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

Pt's (b)(6)-4

DATE	NOTES
	(2) Maintain vent @ present setting (3) Catheter CT to suction @ 20 cm

(b)(6)-1

540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	Surgery ND#2 POD#2
25Oct03	Pt stable on Vent
1400	awake, alert
	Hemodynamics more stable
	VSS Afeb
	L-CTA [illegible] WOB on 40% FIO2
	CXR-clear CT ∅ airleak / ∅ [illegible]
	CV-RRR S(M)
	sternum-stable
	Abd-∅BS, soft nondistended
	Incision intact
	Renal-good UOP
	B/O (+) 1600
	WBC 12.3 PLT 96
	CR 1.3 Tbili 1.0 ALT 151 Alk Ø [illegible] AST 122
	K 3.6
	A/P S/P GSW (R) Nephrectomy / liver repair
	T paraplegia
	(1) Δ Vent to IMV Rate 8 - continue weaning
	(2) Δ IV to D5NS c 20 KCl @ 125cc/hr
	(3) Vasopressin weaned to off
	(4) Weaning [illegible]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE [redacted] | RECORDS MAINTAINED AT [redacted]

(b)(6)-4 [redacted]

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

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

[redacted]CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

Pohrs (b)(6)-4 [redacted]

MEDCOM - 2529

Q

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/27/03	Pt extubated last PM, breathing comfortably
0900	No real c/o's, + appetite
	VSS AF
	I-ETA [illegible] [illegible] 2L NC
	CT ~ 150 each 24hr
	CXR - mottled small (L) effusion
	CV - RRR, NSR
	Wound healing well
	Abd - + BS nontender
	K 3.1 WBC 6.7
	CR 1.2 Hgb 8.4
	S/0 [illegible] 800
	A/P S/P GSW to [illegible] (R) Nephrectomy
	(1) Clear liquid
	(2) D/c A line
	(3) [illegible]
	(4) K replacement [illegible]

(b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | SPONSOR'S ID NUMBER *(SSN or Other)*

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

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

Pohns (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11/3/03	Surgery
0850	24 y/o ♂ who presented in hypovolemic as well as spinal shock following 2 GSW to abdomen and (L) thigh. Upon arrival was fluid resuscitated and started on pressors. PE revealed L2 paraplegia, hypotension and an acute abdomen. He was taken to the OR for exploration. His injuries included a large stellate laceration to the (R) lobe of liver near the dome which required extensive mobilization of the liver → this was completed through a midline laparotomy / median sternotomy for adequate mobilization. Pt also had a devitalized lacerated (R) kidney requiring nephrectomy. No bowel injury. A large bony defect of the lumbar spine required removal of metallic fx and packing for control of hemorrhage along (R) psoas margin. Postoperatively, the patient stabilized in 72 hours and has done well since that time. Chest tubes were removed over last 2-3 days, CXR clear. Pt has had return of bowel function, tolerating regular diet and is ambulating

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

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

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

Potus (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
	Good training. Foley in place. No return of any neurologic function. By xray appears to be stable fx @ [illegible] c̄ intact and [illegible] columns. Pt should have CT [illegible] remain in place x48hr. All surgical sites healing well. To be Transferred to [illegible] for [illegible].
	(b)(6)-2 [redacted]

58-103 (See Instructions on Back of this Sheet) 09 #1062 NSN 7540-01-075-3786

EMERGENCY CARE AND TR...INT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DAY	MONTH	YR.	TIME
3	OCT	03	0730

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

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

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: unknown

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

HOME TELE. NO. (Inc. area code)

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

SEX: M AGE: unk

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS

TIME	0730		
BP	96/43		
PULSE	94	40 ml/min	
RESP.	30		
TEMP.	/		
WT.(Child)	100% BURN		

CATEGORY (See reverse)
- ☒ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INIT'S.	TIME
1 L 2 BOLUS	MAW	0735/0740
2L NS OR LR		
MONITORS	MAW	0730
BC, T+C, UA	MAW	0743
NR, AB AO	MAW	0743
FOLEY	MAW	0743

ASSESSMENT/DIAGNOSIS
CHW, Thorax, abdomen

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)

Iraqi ♂ of unknown age brought to CSH via FLA in custody of [b)(3)-1] (SPC [b)(6)-2]) ? sustaining GSW to chest, hemodynamic value over chest wound, no IV access on arrival

"AMPLE" History unobtainable

A - patent, grunting respirations
B - Breath sounds, chest rise symmetric, tachypnic
C - Intermittent thready peripheral pulses, active bleeding from ⓑ posterior thoracic chest wound
D - Moving upper extremities only; flaccid + unresponsive at lower extremities
E - Completely exposed, rolled and examined.

Succinocholine 100mg IV - 0743/MAW
Vecuronium 10mg IV 0754/MAW
Versed 2mg IV 0750/MAW
Dopamine gtt - 0757/MAW
Ancef 1 gm IV slow to 0757/MAW
Tetanus ORT/MAW

Ventilations assisted by BVM, 16 ga IV cath ⓛ FA, 8.5 F cordis placed Ⓡ femoral vein by Dr. [b)(6)-2]

RSI ☒ 100mg succinylcholine, intubated by MAT [b)(6)-2] 8.5 ET tube via OL

ⓛ chest tube Thoracostomy placed by Dr. [b)(6)-2]

2,500 cc crystalloid and 2 units Emergency release blood administered and transferred to OR

(CONTINUE ON SF 507, IF NEEDED)

DISPOSITION (Check all that apply)

- ☐ HOME
- ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

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

(1 of 2)

POTUS# [b)(6)-4]

[b)(6)-4]

[b)(6)-2] USN, MC

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

PIXR - ⓛ Subcardiac missile fragment

Abdo - ⓛ paraspinal missile fragment, loss of psoas shadow

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

58-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE (DAY, MONTH, YR.) / TIME

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Patients immunization and other data)

1 of 2

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

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

SEX

AGE

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME			
TP			
PULSE			
RESP.			
TEMP.			
WT.(Child)			

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

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS
- SW Thorax and Abdomen

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

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)

2° survey -
GENERAL: minimally responsive moving upper extremitys only, weakly
INTEG: Pale, cool, clammy
HEENT: No obvious injuries os enucleated (old injury) od pupil dilated, reactive
LUNGS: Tachypneic, grunting chest rise, breath sounds symmetric Penetrating wounds ① anterior paraxternal ② posterior-lateral thorax
CV: Heart sounds distant
BACK: Penetrating wound ② posterolateral only
ABDO: Rigid, tender
GU: nl ♂ EG ∅ trauma
RECTAL: ∅ blood; flaccid tone
EXTREM: ∅ obvious trauma, DP's apparently consusable
NEURO: moving upper extremities only initially; mildly purposful movmts

18.2 | 13.8 / 40.1 | 414
134 | 100 | 318
4.3 | 1.9 | 16

UA - SG = 1.030 ∅ glucose ∅ ketone
(large blood) 0-5 WBC/TNTC RBC

(CONTINUE (b)(6)-2)

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

(b)(6)-2

(2 of 2)

IRAQI DETAINEE

(b)(6)-4

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

TO OR

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMD

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 oct 03
DOS	23 oct 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		N/A	
Call Light Within Reach		↓	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAS (AN)	ICU	23 oct 03

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

POTUS (b)(6)-4

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

		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		1					1				1	
	RADIAL L												2		1					1				1	
	DORSALIS PEDIS R												2		1					1				1	
	DORSALIS PEDIS L												2		1					1				1	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale													1 3 8		1 4 8					1 4 8				1 3 8	
EDEMA													Ø		Ø					Ø				Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)													✓		✓					✓				✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)													SR/BB		SR					SR				SR	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)													✓		✓					✓				✓	
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST												✓		✓										
	~~BSC~~ LOGROLL												✓											✓	
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓					✓					
	HOB 30 DEGREES																							✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																	✓						✓	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended												✓		2					✓				2	
BOWEL SOUNDS (active all quads)													Ø		Ø					Ø				Ø	
NG / DOBHOFF PLACEMENT VERIFIED													✓		✓					✓				Ø	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT													✓		✓					✓				✓	
VOIDING CLEAR, YELLOW URINE q.s.													✓		✓					✓					
SKIN INTEGRITY	No Breakdown																								
Midline ABD	Surgical Wounds												✓		✓					✓				✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD													✓		✓					✓				✓	
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18ga	(R) hand	23Oct	CDI
TLC	(R) fem	23Oct	CDI - D/C'd 23 Oct 03 (b)(6)-2
A-Line	(L) radial	23Oct	CDI
Cordis	(L) groin	23 Oct 1800	CDI

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active; against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes N
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	DATE: 23OCT03	No Change from Previous Assessment –

	TIME	0 1	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	1 3	1 4	1 5	1 6	1 7	1 8	1 9	2 0	2 1	2 2	2 3	2 4
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open													1		1				4	4				4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response													T		T				T	T				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				6	6				6	
GLASGOW COMA SCALE (A+B+C)													2T		2T				10T	10T				10T	
PUPIL RESPONSE Size - mm; React to Light (+) No Response (-)	R												6+		7+				6+	6+				5T	
	L												N/A		N/A				N/A	N/A				N/A	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE												Ø		Ø	1	3		3	3				3	
	LUE												Ø		Ø	1	3		3	3				3	
	RLE												Ø		Ø	Ø	Ø		Ø	Ø				Ø	
	LLE												Ø		Ø	Ø	Ø		Ø	Ø				Ø	
GRIP (S) Strong (W) Weak (-) absent	R												–						V	V				V	
	L																								
RESPIRATIONS	REGULAR												V		V				E	E				E	
	IRREGULAR												E		E				N	N				N	
	UNLABORED												N		N				T	T				T	
	LABORED												T		T										
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL												5↓		5/1				5					5	
	LUL												5↓		5/1				5					5	
	RLL												5↓		5/1				5					5	
	LLL												5↓		5/1				5					5	
	BOTH BASES												1		1				1	1				1	
COUGH	NONE												✓		✓				✓	✓				✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt												700		700		800		800					800	
	FiO2												1.0		1.0		.6		.4					.4	
	RATE/SIMV ~~CMV~~												V		10		10		10					10	
	PEEP / CPAP												+5		5		5		5					5	
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT = 8.5	NRBM (l/min)																								
	ETT 22 cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																								RT	
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS													(b)(6)-2												

VITAL SIGNS

TIME	T	P	RR	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
1100																	
1200	35	81	10/10	~~136/59~~		130/59	78										
1300	35	81	10/10			136/59	78										
1400	90 (A)	77	12/10	95/52	100	100/50	63										
1500	91 A	81	10/10	106/64	98	100/53	66										
1600	92° A	93	10/10	123/67	100	120/70	88										
1700	93 (A)	100	16/10	118/64	100	126/66	84										
1800	94 (A)	99	15/10		100	69/44	58										
1900	95 (A)	99	10/10	113/65	100	120/65	79										
2000	96° (A)	89	16/10	127/81	100	128/70	86										
2100	96 (A)	81	10/10	123/86	100	114/75	89										
2200	97.8	97	12/10	114/75	100	136/76	89										
2300		90	10/10	93/-	100	93/53	64										
2400		76	10/10	132/77	100		100										

	INTAKE								OUTPUT							
	LR	D5W	V350	PRBC	IVPB			Total	Urine	CT #1/#2	CT #3/#4	NGT		Total		COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR								8 HR.							8 HR	
0900																
~~LGHT~~ OR	OR 8500	Alb 100		OR 600					OR 200			EBL/OR 1000				
1100																
1200	150 / 150	7 / 7	15 / 15						400 / 400	#1 0 / #2 20	#3 0 / #4 350					
1300	150 / 300	7 / 14	15 / 30	401 / 401					650 / 650	#1 0 = 0	340 = 340					
1400	150 / 450	7 / 21	15 / 45	472 / 873	50 / 50				150 / 800	#1 0 / 40	#3 40/90 / #4 125/345					
1500	150 / 600	7 / 28	15 / 60		100 / 150				225 / 1025	#1 0/0 / 15	#3 20/110 / #4 60/405					
1600	150 / 750	7 / 35	15 / 75		1000 / 1150				325 / 1350	#1 0/0 / 15/135	#3 115/125 / #4 20/625					
8 HR	750	35	75	873	1150			16 HR. 2883	1350	0 / 135	125 / 625	1000		16 HR. 3235		- 352
1700	150 / 150	7 / 7	20 / 20		1000 / 1000				350 / 350	#1 0/0 / 20/20	#3 20/20 / #4 80/80					
1800	150 / 300	9 / 16	30 / 50						200 / 550	See separate sheet attached						
1900	150 / 450	12 / 28	30 / 80						200 / 750							
2000	150 / 600	15 / 43	38 / 118	414 / 414					120 / 870							
2100	150 / 750	15 / 58	30 / 148	417 / 831	500 / 1500				200 / 1070			MIN.				
2200	150 / 900	15 / 73	30 / 178		50 / 1550				175 / 1245							
2300	150 / 1050	12 / 85	15 / 193						125 / 1370							
2400	150 / 1200	15 / 100	17.5 / 210.5						200 / 1570	0 / 120	105 / 585					
8 HR	1200	100	210.5	831	1550			24 HR. 3791.5	1570	0 / 305	130 / 880			24 HR 3985		

6220

NSN 7540-01-317-7367

MEDICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M. / P.M.	OBSERVATIONS Include medication and treatment when indicated
23OCT03 1300hrs		Pt discharged from recovery status see flowsheet for details. Dr [b)(6)-2] notified see pt. #1 of 2 w/ pressors. HR/BP continue labile, titration of IV gtts required. CT dry contents moderate, UOP adequate [b)(6)-2]
23 Oct 03	1730	Pt's BP ↓ to sys 70s → 80s ~1600. Vasopressin ↑ to .3u/min and 1 Liter RL given IVP. Received 4mg MSO4 and 2mg Versed @ 1515 and 1525. Pt's sys BP ↑ to >100 c bolus + ↑ vasopressin. Dr [b)(6)-2] in to see pt → ↑ vasopressin to .4u/min and ↑ dopamine to 9ml/hr (3 mcg/kg/min) using 80 Kg as estimated pt's weight. Sys BP 110-120 @ this time. [b)(6)-2] CTJ RN
23 Oct 03	1930	↓ BP 60's/40's by A-line + cuff. (R) femoral cordis found completely out, hand/wrist restraints intact c pt hands @ side. Minimal blood loss from cordis site, IV fluids running on to bed. Pressure held to (R) femoral site x 5 min, no hematoma noted. (L) femoral cordis inserted per Dr [b)(6)-2] c complications, good blood return. Vasopressin + dopamine titrated to ↑ sys BP >100. Pt was awake, responding and moving (B) arms while BP was in the 60's. Hands wrapped c Kerlix to protect pt & prevent him from pulling out invasive lines. [b)(6)-2] MJ RN
23 Oct 03	2200	Recvd supine. VSS. BP in 150's. Eyes closed. Resp. pervent. Chest rises & falls equally, bilat. Restraints intact. Assess completed. Vent settings TV 800, PEEP 5, F_iO_2 40%. Pulses barely palpable 2° Dopamine. Cont to monitor [b)(6)-2] RT/RN
23 Oct 03	2300	BP ↓. ↑ Dopamine + Vasopressin ↑ MSO4. Continue to monitor. Pt asymp. c ↓ in BP. [b)(6)-2] RT/RN

est tube Output - 23 ct 03

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

CONTINUED POST-ANESTHESIA CARE UNIT FLOW SHEET

OTSG APPROVED 17 Jan 80

Time	B/P	P CT1	R CT2	O_2Sat CT3	T CT4	Act	Resp	Circ	LOC	Skin	PARS	Other	Neuro-Vascular	COMMENTS
~~PRE-OP~~	/	/	/	/	/								Extr: L R Upper Lower Pulse: DP PT RAD	
1700	/	0/0	20/20	20/20	80/80								Blanche Pulse ___ Warm Moves Y N	
1800	/	0/0	20/40	15/35	50/130								Blanche Pulse ___ Warm Moves Y N	
1900	/	0/0	40/80	40/75	40/170								Blanche Pulse ___ Warm Moves Y N	
2000	/	0/0	50/130	10/85	30/200								Blanche Pulse ___ Warm Moves Y N	
2100	/	0/0	20/150	0/85	20/220								Blanche Pulse ___ Warm Moves Y N	
2200	/	/	/	/	/								Blanche Pulse ___ Warm Moves Y N	
2300	/	0/0	40/190	20/105	35/255								Blanche Pulse ___ Warm Moves Y N	
2400	/	/	/	/	/								Blanche Pulse ___ Warm Moves Y N	
24 oct 0100	/	/	/	/	75/								Blanche Pulse ___ Warm Moves Y N	
0200	/	0/0	30/30	30/30	75/75								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	
	/												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	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC

DATE

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

Potus # (b)(6)-4

☐ HISTORY/PHYSICAL

☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION

☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDCOM - 2541