INPA... TREATMENT RECORD COVER SHEET *(I-c... ...ate Imprinting)*

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

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

(b)(6)-4

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

ADMISSION REMARKS

ADMITTING OFFICER

25. TYPE DISPOSITION: RTD

26. DATE OF DISPOSITION: 22JAN02

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY: GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Back.

22Jan02 CT Chest
CT ABPC

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	

SIGNATURE OF ATTENDING (b)(6)-2

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

DA FORM 3647-1, 1 MAY 1979 EDITION O... USAPA V1.00

MEDCOM - 2977

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Afghani male transfered to our facility from Kandahar. Pt c̄ GSW (R) back, chest tube placed prior to arrival at FOB and some sort of ABD surgery. Chest tube was D/C'd prior to transfer. At arrival to our facility c̄ ↑ RR and A+Ox3. Refer to FAST medical note for further info re. care provided prior to arrival to our facility

ALLERGIES:

MEDICATIONS: MS04

PAST ILLNESS/PREGNANCY: (R) thigh scar

LAST MEAL: > 48 hrs ago

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL
		Pulse ox 92% RA
HEENT	✓	
NECK	✓	
CHEST	(R) chest tenderness	
LUNGS	↓ BL fields	
HEART	RRR	
ABDOMEN	Supra umbilical incision c̄ 6 sutures	
RECTAL		
EXTREMETIES	✓	
NEURO	✓	

Back – Suprascapular 3 inches incision c̄ sutures ⊖ drainage
Infrascapular incision c̄ 4 sutures ⊖ drainage

PROGRESS *(Enter date of discharge and final diagnosis)* Post 12th R.B Fx

IMPRESSION: GSW (R) chest/back
S/P CT placed
S/P DPL vs exp lap?

Chest tube site sutured and intact. All areas are tender to P

TREATMENT:

(b)(6)-2

CXR   LABS (CBC, electrolytes, coags, U/A)
CT ABD   O2   PPD

Left margin notes: CT ABD ⊖ intraabd. pathology. CXR – type + screen. HB (+). CT chest – Post 12th (R) RB fx. ⊖ bullet in musculature of back or in the intrathorax region. ⊖ lung consolidation

SIGNATURE | DATE 2/11/1702 | IDENTIFICATION NO. | ORGANIZATION

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

(b)(6)-4

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

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | **PROGRESS NOTES**

DATE	(b)(3)-1 CSH (FWD) NOTES
22 July 02	Gen Surg Consult
1135	Patient Examined chart, Records CT & CXR
	Reviewed
	S - Patient Transferred For Eval & SW BACK
	Sustained 18 July 02 @ Approx 2100hrs Local.
	Treated By Afghan MD & Chest tube R
	Pleural Space & Midline Incision Abdomen
	Transferred to FST For Eval CT Drainage
	minimal & Kandahar x Chest Tube Removed
	Transferred to (b)(3)-1
	O - USS A for Wound medial & Inferior to
	R Scapula. Ecchymosis Around Area x Small
	Incision c/w/D 2° to Chest tube Lungs clear
	Heart - RRR Abdomen ≈ 6-8cm upper midline
	Incision c Sutures In Place Non tender BLS
	Normal Active
	CT -> No Evidence Intra Abdominal Injury. at
	Level of Incision Does Not Appear Incision was
	Carried into the Abdomen
	A -> No Evidence Intra Abdominal Injury
	P -> Pt as tolerated MAY Be Transferred when (Boon)

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
Prescribed by GSA/ICMR FPMR (41CFR) 101

medically cleared. ~~Chest minimal~~
chest minimal consolidation R-base by CT scan
clinically breathing well.
can follow wounds as an outpatient
(b)(6)-2
LTC MC

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Iar
28 Jun [illegible]	Prev. notes reviewed.
1130	Afghan male c̄ Hx GSW to torso - Placement chest tube
	Brought to (b)(3)-1 CSH for evaluation.
	Seen by [illegible] - see report
	Surgeon - " "
	CT ABD ⊖
	CT chest consolidation (R) base
	post op Δ
	[illegible] (L) rib # 12th
	metal FB posterior to (L) 12th rib
	(P) (1) At this time, surgeons feel no surgery needed. Also that pt is stable for t/f to detainee centre.
	Detainee Centre physical done by Dr (b)(6)-2
	@ 1130 HRS (Local) 22 Jun [illegible] -
	(2) ? consolidation D/W Dr [redacted] will give Z-pak.
	B6-2 (b)(6)-2 [signature]

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

28 yr old AFGHAN M.

LAST NAME (b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-22-02	electrolytes BPO
0653	CBC
	Coag studies
	vitals: 125/73
	P: 91
	R: 36
	SPO_2: 92
0700	Identifying marks:
	occlusive dressing under (R) arm pit
	vertical ~~scar~~ stitch line to mid abdomen
	vertical scar to lateral thigh and buttocks
	tattoo of webbing of (L) thumb and forefinger (green)
	tattoo on left wrist (5 dots)
	stitches to (R) scapula
	stitches to Lower (R) Scapula
	Scar to (L) scapula
	vertical scar @ (L) shin
	tatoo in Arabic on (R) forearm
0704	3 Lpm O2 via NC
0705	PPD test administered (R) forearm
0730	Labs drawn CBC, lytes T+C
0745	IV LR established (R) FA. KVO Rate
0810	Pt over for CT of abdomen. Rec IV contrast.
0840	Pt returned
0850	Pt over to ICU-1 Report given

(b)(6)-2 RN

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21July02 2150	(Si) Called to see detainee because he was acting violent. Pt. threw his chest tube bag against the wall + ruptured it. MP's requested assistance in evaluating chest tube and in sedating pt. for transport.
	(Oi) Obese male - restrained, fighting restraints.
Initial vitals R-38 P-100	Chest: Chest Tube in place. & Drainage bag ruptured. CTAB, & BSEB, & Wheeze/Crackles.
	(Ai) Agitation vs. ? Illicit drug withdrawl. Ruptured CT tube drainage bag.
	(Pi) Dr. (b)(6)-2 consulted for advice on sedation regimen. Diazepam - 5mg IM x 1 Haldol - 2mg IM x 1 Benadryl - 50mg IM x 1. After drugs administered pt's vitals rstd - R-34, P-94. Will continue to monitor until pt departs for Bagram. CT Tube removed + occlusive dressing placed at insertion wound. (b)(6)-2 M.D. CPT, MC Staff Pediatrician
21 July 02 2150	Consult Tech by Physician on Call. DR. (b)(6)-2 S/O: Concerns ∈ PT's ↑ bizarre behavior. "Allegedly pulled chest tube bag and drank blood-flecked" → (b)(6)-2 Quick

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV.	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.)

(b)(6)-4

REGISTER NO. | WARD NO.

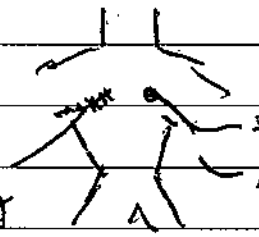
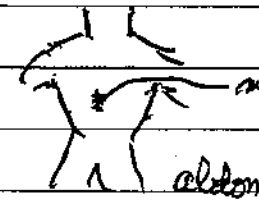
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FI" R (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 July 02 2150	- Caretaker reports "definite fluctuation on PT's behavior" Allegations by interpreter of PT's statements not matching story of events - "PT allegedly stated "He was shot by his brother".
	Record review shows "recent sedation ō morphine for pain management. Some suspiciousness of "Opium" use (tract on arms).
	(b)(6)-2
	Vital signs has been consistently stable. PT. was not been hypotensive.
	- PT. stated "mildly agitated despite 5mg valium inj. 15-25 mints prior to this writer first interaction.
	P.E. limited by PT's defense condition.
	MSE: Unable to assess.
	A/P: Suspect - Post-Surg - Post pain management sedation or withdrawal from Opium.
	(P) ① Haldol 5mg Im. given c̄ 50mg Benadryl inj. to right and left upper outer gluteal area respectively.
	② PT. sedated 15-20 post inj.
	③ Recommend repeat same dose above if need prior to am eval.
	④ Lab screening: i.e. glucose level LFT's ect. upon arrival to CASH. R/O other organic problems

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Pt is 724hr out from CP placement and abd. exploration — pt can be transferred to CSH. He will monitor respiratory status — repeat films, ~~I&O~~ Output from CT.
	Recommend: ~~transfer~~ to CSH - BAGRAM.
	(b)(6)-2 LTC AC (b)(3)-1
21 Jul 02	PT SEEN c̄ R. [illegible]
2146H	AGREE c̄ HIS ASSESSMENT: THIS
2010	PT IS STABLE, S/P GSW YESTERDAY
	TREATED c̄ LAPAROTOMY/ ~~[illegible]~~ CHEST TUBE
	REC. TRANSFER TO CSH
	(b)(6)-2
	COL. (b)(3)-1
20 Jul 02	Pt. c̄ SpO_2 86% lying flat on room air. ⊘ Resp distress.
2148	4L O_2 FM c̄ ↑SpO_2 to 95%. Pt. resting comfortably no complaints
	CXR: ⊕ scarring Ⓛ lower lobe poss 2° to prior surgery/injury c/w scar Ⓛ posterior chest.
	KUB: ⊕ Bullet seen in mid-left abdominal field. ⊘ free air, ⊘ signs of SBO, nl gas pattern
	Abd lateral: ⊘ signs of bullet in abd. compartment. Suspect retroperitoneal.
	A/P: Stable s/p GSW to Ⓡ back, c̄ pigsticker tube Ⓡ chest.
	① Vitals q4° (includes SpO_2), 2L NC O_2
	② Unasyn 3gm IV q6h (next dose @ 0300), IVF 80cc/hr LR
	③ Call MD for 55<P>110, 8<RR>22, SpO_2<92%, 60<DBP>90 90<SBP,
	④ Maintain HOB @ 45-60°
	⑤ f/u c̄ C/Med @ Compound in q (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/20/02	Surgical Consult
2235	Alleged male 24Hr S/P GSW entering below (R) scapula ~no exit.
0/S 2145	Cath displacement of chest tube ~ allegedly 2L of bloody fluid discharge over
-88↓	24hrs. He/she/they had no medical notes on procedures. Pt denies patient
24	had mini lap. He/she/they not been able to speak to the pt ~no interpreter.
BP - 122/68	
SpO^2 86	PE: BACK
	
O/S - 2130	
P - MID 94/67	
R - 32	
BP - 128/76	
SpO^2 - 94	FRONT
	
O/S - 2145	pt is obese -
P - 85	very comfortable -
R -	walking - speaking - we just
BP -	can't understand him.
SpO^2 96	Chest: clear Cor: RSR rate 70 - pulse ox > 95% on room air
	H/H 15/45%.
	CXR: underpenetrated - but no mediastinal shift - no pneumothorax/hemothorax
	Abd: appropriately tender.
	Imp: (R) chest & abd wound
	Plan: IV - RL @ 125ml/hr Hourly pulse ox M Sats as necessary
	Unasyn 3gm IV q 6° H&H q 4°

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE (Trauma)	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.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.202-1
USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Jul 02	Current meds
20 July 02	
1900 hrs [S]:	Afgan Taliban Commander shot while being captured on 19 July 02 @ approximately 2100 hours local time. Pnt reports through interpreter that he was shot from behind in the back. Pnt seen and treated by local Afgan physician c chest tube placed on (R) side of chest wall. Pnt reports that chest tube bag has been drained once (approximately 2 liters) Pnt states chest bag filled up in 18 hours. No food in last 18 hours. Pnt had antibiotic after surgery prior since!
VITALS [O]:	Afgan Male, INAD, A & Ox 3, well appearing
P- 72	HEENT: No blood in mouth
R- 30	CHEST: Faint lung sounds on (R) lower chest; chest
B/P 145/90	tube in place anterior axillary line at level of 4th and 5th rib c 100cc of blood in bag.
	ABDOMEN: no bowel sounds, abdomen obese/obtuted @ abdomen rigidity, c 3cm vertical midline wound repair c suture in place 2cm above ubilicus @ cellulitis/
	BACK: 6cm horizontal wound repair c sutures in place c good wound margins
	EXTREMITIES: Good tone, @ wounds (lacerations

(over)

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.)*

(b)(6)-4

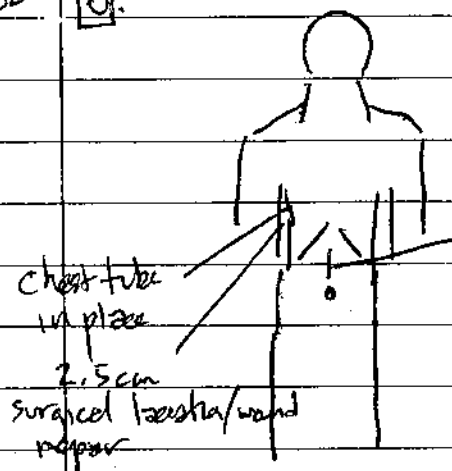
REGISTER NO. | WARD NO.

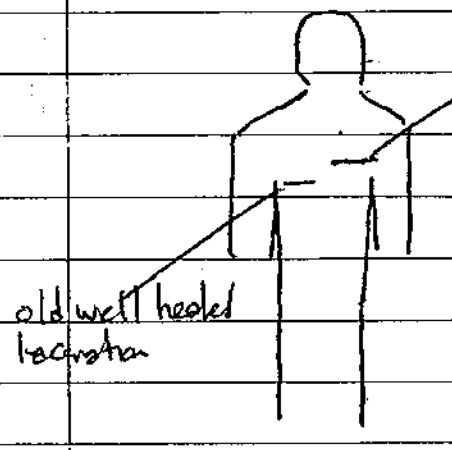
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

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

20 July 02

O:





A: GSW to ® posterior chest wall
GSW/Laceration to ® posterior thoracic
GSW/Laceration to abdomen (surgical?)

P: ① IV LR 125 cc/hour ② meds Unasyn 3 gm q 6 hour. Morphine 2 mg titrate to pain q 4-6° hours ③ LABS: H & H ④ CXR, FLAT PLATE ABDOMEN ⑤ Vitals q 2 hours ⑥ re-evaluate in 6 hours. ⑦ Notify Surgeon Dr. (b)(6)-2 if abdomen becomes rigid, ↑ pain, > 40 respirations < 12, ↓ BP < 90 systolic < 50 diastolic. ⑧ Dress wounds

per Dr. (b)(6)-2 FST surgeon

(b)(6)-2

(b)(6)-2

CPT, USPHS APA

STANDARD FORM 600 (Rev. 6-97) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*		
2145			
BP 124/72	Intake	output	.5 mL
P	2155: 250 cc	ø	morphine Inj
R 21	2230: 250 cc	ø	@ 0042
SPO2 (86%)	~~0030~~ 150 cc	ø	
~~0030~~	~~0045~~ 905 cc	650 cc	
BP 112/82	~~0125~~ 420 cc	ø	
P 72	~~0400~~ 870 cc	ø	
R 24	~~0530~~ 750 cc	100 cc	
SPO2 93%	1616 200 cc	ø cc	
on 2L By mask	~~1700~~ 450 cc	300 cc	
~~0725~~	1800 200 cc	150 cc	
BP 126/68	1845 250 cc	ø	
P 100	1927 200 cc	100 cc	
T (99.8)	~~2000~~ 200 cc	ø	
R 40	2030 Refused water		
SPO2 88%			
P 103			
BP 145/64			
R 40			
2326			
B/P 142/90	Pulse 103		

(OUCH)

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.

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)*
21 July 2002	Pt. seen 2 days s/p GSW (R) Back, s/p c modified
0325	(R) pleural drainage tube placed, Roughly 45cc output overnight
	SaO2 87% on RA & lying supine. ↑ to 95% c 4L FM O2
T: 98.4	Afeb, VSS, Ø distress. Receiving Unasyn 3gm IV q6h x 2
R: 14	doses, Morphine 10mg IV q6° prn pain.
P: 87	Exam: CT dressing clean, dry + intact, Ø purulent drainage
Ø540	Drainage tube patent c (+) flow to drainage bag ~ 45cc
BP 112/76	Pul: CTA (L), (R) base ↓ Breath sounds, Ø crackles
P 96	COR: RRR
R 28	Abd: midline xiphi-celiotomy incision c/d/I - Abd NT/ND (+)BS
Temp 99.2°	(+)BM (+) flatus
	A/P: s/p GSW (R) chest. Stable
	(1) Continue Unasyn 3gm IV q6hr.
	(2) MSO4 10mg IV q6h
	(3) Continue O2 4L FM in flight.
	(4) Stable no contraindications for flight/transport.
	(b)(6)-2 (b)(6)-2 (b)(6)-2
21 Jul 02	
0830	Pt resting well as per (b)(6)-2
	guards. Pertaining to airlift
	pt is stable for C130 flight
	to Bagram (b)(6)-2
	chest tube out in last
	8hrs = Ø Pulse Ox 91% RA [redacted] B6-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2000-461-707/20309

NURSING PROGRESS NOTE

0900 Admitted to ICU #1, 28 y/o Afghan detainee ♂ S/P GSW
(R) Posterior Chest Wall. Awake Alert Resp easy. Lungs clear bilaterally ē
decreased sounds in bases. HR 80s-90s NSR s̄ ectopy. 6cm incision on (R) posterior
chest wall & dry, approximated ē sutures intact. (R) posterolateral chest tube site dry & intact.
Old well healed incision line present (L) posterior chest wall. Raised nonmovable
nodule noted (L) lower posterior chest wall. (−) Subcutaneous emphysema. Vertical
8cm incision epigastric area dry & well approximated ē sutures intact. ABD
Round soft Nontender. ESOXA bilaterally secured to bed. Handcuff
Secured to siderails bilaterally. Medicated @ 0930 for relief of incisional
pain. (b)(6)-2 (b)(6)-2 AN
1130 D/C ē Guard to detention camp ... IV

NURSING PROGRESS NOTE

FORM 0021

MEDCOM - 2991

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	(b)(6)-2	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0930	MSO4 4mg	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST	Init.

MEDCOM - 2992

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
UR				(b)(6)-2	100																			
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total					100																			
Cumulative Total																								

OUTPUT CC/HR

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

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

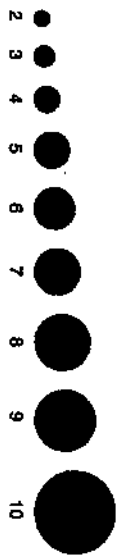
TOTAL OUTPUT

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

*SEE PROGRESS NOTES:

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

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



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

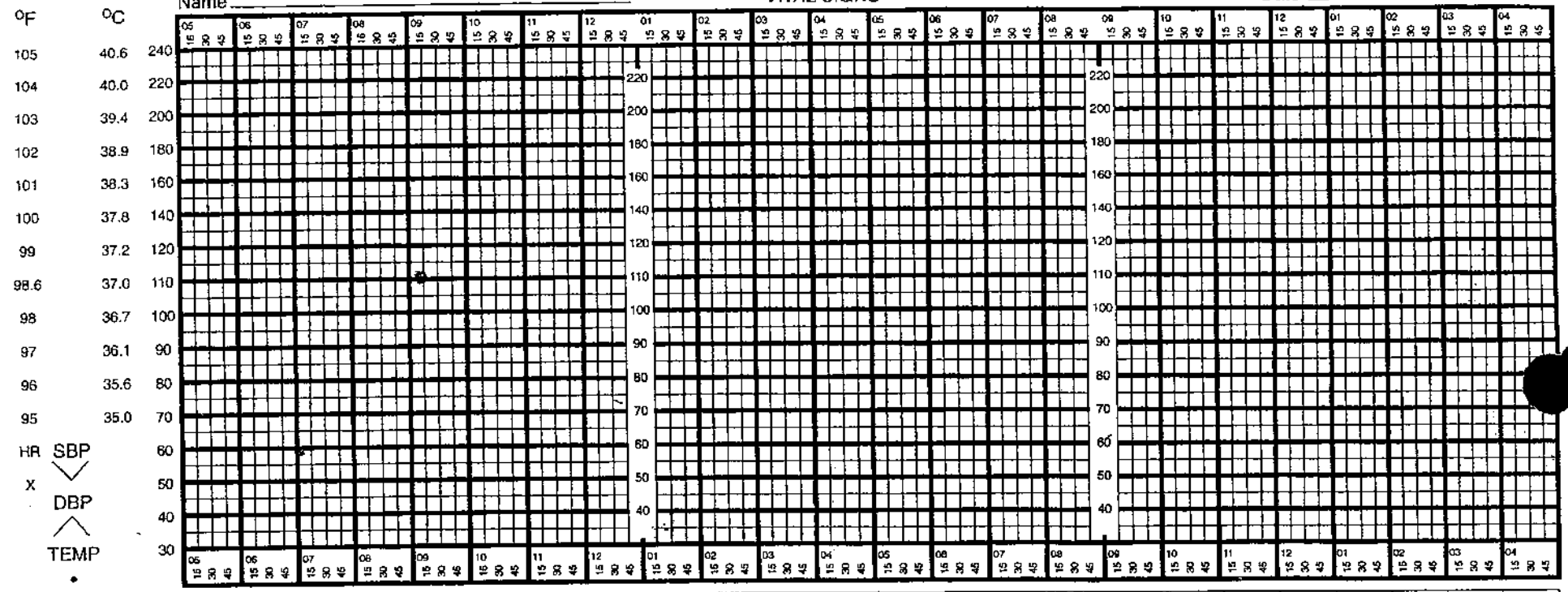
PROCEDURES	OBSERVATIONS		TREATMENTS
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	Gxx		
ABD Size/Firmness	Flt soft		
NG Secure/Proper Pos.	✓		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	✓		
Aspirate Prior to Bolus Feed	✓		
Stool Char./Guaiac	✓		
Urine Color/Character	✓		
Foley Secure/Patent			
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	✓		
Bath	✓		
Turn & Position Q _____			
Skin Care	✓		
Mouth Care			
Trach / E.T. Care	✓		
ROM	✓		
Dangle	✓		
Restraints Released Q2H	Slacked for Hand cuffs		
OOB to Chair			
Ambulation			
Side Rails ↑			
Drains. △			
Drains. △			

ADDRESSOGRAPH

MEDCOM - 2994

*SEE PROGRESS NOTES:

Name _____ VITAL SIGNS Date _____



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR				88		96																		
Rhythm				SR		SR																		
RESP.				20		24																		
CUFF BP				100/73		128/77																		
MAP				93		96																		
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SVRI																								

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Zantac 50mg IV Q8H																									

MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 2995

(b)(6)-4

28 yo
Afghan

SPECIMEN/LAB RPT. NO.

MISC

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

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE 7-22-02 0806

LAB ID NO.

REMARKS

COAGS

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
				PT – 13.3 Ratio 1.1
				aPTT – 25.0

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

557-107

(b)(6)-4

28 yo
Afghan

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

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

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

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

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE 7-22-02 0844

LAB. ID. NO.

REMARKS

CBC

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
			RBC COUNT	4.58
			HEMOGLOBIN	13.4
			HEMATOCRIT	38.0
			MCV	83.0
			MCH	27.1
			MCHC	32.7
			WBC COUNT	7.4
			WBC DIFF AND BLOOD CELL MORPH: IMMATURE / NEUTRO-BANDS / NEUTROSEGS / LYMPHS / EOSINOPHILS / BASOPHILS / MONOCYTES / PLATELETS / RBC	
			SED. RATE	
			PLATELET COUNT	325
			RETICULOCYTE COUNT	
			CLOTTING TIME	
			BLEEDING TIME	
			PROTIME: CONTROL / PATIENT	
			PTT: CONTROL / PATIENT	
			% ACTIVITY	
			RATIO	
			SICKLING TEST	
			LE PREP	

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

549-107

STANDARD FORM 545
545-106

LABORATORY REPORT DISPLAY

TRT System

TEST(S)		
SPECIMEN TAKEN		
DATE	TIME	A.M. P.M.
RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	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 546-107
STANDARD FORM 546 (Rev. 8-77)
General Services Administration and Interagency Committee on Medical Records, FPMR (41 CFR) 201-45.808

REMARKS (b)(6)-2

Lytes

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

(b)(3)-1

(b)(6)-4

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

Name: _____

REPORTED BY

TECH

MD

DATE 7-22-02 0844

Glu_____93 mg/dL
BUN_____21 mg/dL
Na_____144 mmol/L
K_____3.4 mmol/L
Cl_____109 mmol/L
TCO2_____24 mmol/L
AnGap_____15 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct
pH_____7.461
PCO2_____32.5 mmHg
HCO3_____23 mmol/L
BEecf_____-1 mmol/L

Sample Type_:

22JUL02 (b)(6)-2

Oper: (b)(6)-2

Physician: _____

Ser# (b)(6)-4

Ver: (b)(6)-2

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.

PATIENTS MED. RECORD

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

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.

ENTER IN 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
FPMR 101-11.806-3

LABORATORY REPORT DISPLAY

☆ GPO : 1989-0-233-621

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)*

____ ML

REMARKS:

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

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)*

MGT (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR	RECIPIENT
ABO	ABO AB
Rh	Rh POS.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NIP	

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

(b)(6)-2 DATE 9/1/04

- [X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

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

IDENTIFICATION:

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

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. ____ PULSE ____ BP ____

DATE OF TRANSFUSION ____ TIME STARTED ____

POST-TRANSFUSION DATA

AMOUNT GIVEN ____ ML

TIME DATE COMPLETED ____ INTERRUPTED ____

REACTION

- [ ] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

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

- [ ] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

28YR AFGHAN ♂

SEX ♂

WARD [illegible]

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

RETURN TO TRANSFUSION SERVICE

MEDCOM - 2998

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR R/o PTX

CT ABD

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
78	M		EMT	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print) (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE (b)(6)-2

DATE REQUESTED

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

GSW to (R) chest s/p Methose removal

s/p pneumothorax (R) side

s/p OPG vs ex lap

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
(b)(6)-2		

RADIOLOGIC REPORT

CXR

No PTX

Consolidation mid/or effusion (L) base

Metal FB LUQ

(b)(6)-2

CT chest - consolidation R base

post op changes (R) thorax with soft tissue emphysema

posterior (R) rib fx 12th

metal FB posterior to (L) 12th rib.

CT Abd - No evidence of pathology in peritoneal cavity.

(b)(6)-2

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

TP II (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION

MEDCOM - 2999

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

PHYSICIAN ORDER SHEET

DATE	ORDERS	TIME					
21 Jul 02	Admit - ICU 1 (b)(6)-2						
	Dx - GSW (R) Chest (b)(6)-2						
	S/P DPL vs Exp. lap						
	Cond'n - Good						
	Vitals - q shift						
	Allergies - ∅						
	Diet - NPO						
	IVF - LR at 100cc/hr						
	Meds - MSO4 - 4mg						
	q 6° PRN						
	Pain						
	- Zantac 50mg						
	IV q 8°						
	- O2 - 2L NC						
	Labs - H/H q						
	Shift						
	Read PPD at 2448 hr (b)(6)-2						
	Record urine output (b)(6)-2						
	q shift						
	TB Precautions						
	Surgeon [illegible]						
	(b)(6)-2 CPT AN						
22 Jul 1300 hr	Discharge to						
	Detention Camp						
	D/C IV						
	D/C O2 (b)(6)-2						

WARD | ID: NUMBER | DIAGNOSIS

PATIENT DATA (b)(6)-4 | VERIFICATION

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1 / A(b)(6)-4
2. LOCATION (State or Country Code.): A F
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): (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: 28
8. RACE: X
9. ETHNIC BACK-GROUND: 9
RELIGION: ISLAM
10. LENGTH OF SERVICE:
ETS:
11. FMP: 20
12. SOCIAL SECURITY NUMBER: 801-00-1000
ORGANIZATION (Active Duty Only): Afghan Militay Forces
13. MARITAL STATUS:
HOUR OF ADMISSION: 2150
BRANCH / CORPS:
14. FLYING STATUS: N
15. BENEFICIARY CATEGORY: X 9 9
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code): A F
18. MOS:
19. TRAUMA: Y
PREV. ADMISSION: YEAR: NO: X
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: T
WARD: ICU1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 BAGRAM, AFGHANISTAN
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: Ø /
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20020720
24. CLINIC SVC - ADMITTING: A E A A
25. MTF TRANSFERRED FROM: (b)(3)-1
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20020721
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION: (b)(3)-1 / (b)(6)-4
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 20020721

FOR LOCAL USE
HOW: Patient suffered a Gunshot wound to the Back
When: 21 July 02 Approximate time unknown
Where: Qandahar Afghanistan

T: 1 Dx: E760
E750
E922
Inj: 4150

ADMITTING OFFICER (Signature, as required):
SIGNATURE OF ADMITTING CLERK: (b)(6)-2

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

ADMISSION AND DISPOSITION INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code)
(b)(3)-1 6 A (b)(6)-4	7 8: A F

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34:		35 36: 2 0	37 38 39 (b)(6)-4: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
Afghan Military Forces	46: S	2150	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N 1 1	50 51 52: X 9 9 K78	53 54 55 56 57 58 59 60 61: 0 9 3 5 4

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: X 1	ICU1	N/A
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 BAGRAM, AFGHANISTAN		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74: ~~DT~~ 05	75 76 77 78 79 80:	81 82 83 84 85 86 87 88: 2 0 0 2 0 7 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A E A A	93 94 95 96 97 98: (b)(3)-1	99 100 101 102 103 104 105 106: 2 0 0 2 0 7 2 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: A F	109 110 111 112 113 114: (b)(6)-4 (b)(3)-1	115 116 117 118 119 120 121 122: 2 0 0 2 0 7 2 1

FOR LOCAL USE

HOW: Patient suffered a Gunshot wound to the Back
When: 21 July 02 Approximate time unknown
Where: Qandahar Afghanistan

DX 8761

BC
Trauma 9
Inj 559

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

MEDCOM - 3002

AEROMEDICAL EVACUATION PATIENT RECORD

(b)(6)-4

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U P R	5. GRADE
(b)(6)-4					

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A-5F)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
28	✓ Male / Female			AMBULATORY ☒ LITTER		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	16a. MEDICAL / 16b. NON MED

17. DIAGNOSIS
S/p GSW ® chest x4 days

18. ☐ BATTLE CASUALTY ☐ DISEASE ☐ NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.			HYPERTENSION	f.			MOTION SICKNESS	k.			AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			EARS/SINUS	j.			SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
21 JUL 02	0830	UNKNOWN

20d. DIET ☐ REG ☐ 3GM NA ☐ CARDIAC ☐ DIABETIC ___ CALS
☐ RENAL ___ Gm prot ___ Gm Na ___ Meq K ___ mg PO4
☐ TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
☐ PEDIATRIC: AGE ___ ☐ OTHER (Specify) ___
☐ TPN: Change to D10 at ___ cc/hr for max of ___ days
☐ TUBE FEEDING ___ at ___ strength at ___ cc/hr

20e. IV/BLOOD LR 125 cc/hr

20f. SPECIAL EQUIPMENT

☐	SUCTION	☐	IV PUMP	✓	CHEST TUBE/HEIMLICH
☐	NG TUBE	☐	TRACH	☐	RESTRAINTS
☐	STRYKER FRAME	☐	MONITOR	☐	OTHER (Explain in 23)
☐	INCUBATOR	☐	FOLEY		

	TRACTION	☐	ORTHOPEDIC BRACES

O2: ☐ LITERS: ☐ ROUTE:
☐ VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

☐	OUTPATIENT RECORDS	☐	X-RAYS	☐	FINANCIAL
☐	INPATIENT RECORDS	☐	OB RECORDS	☐	OTHER (Specify)
✓	NARRATIVE SUMMARY	☐	DENTAL RECORDS		

20i. MEDICATIONS/TREATMENTS
1. IV LR 125 cc/hr
2. Unasyn 3gm IV q 6hr
3. Morphine 2mg q4h PRN for PN
4. Vitals q 2h
5. I/O of chest tube
6. Monitor chest tube for potency

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. PULSE BP	21d. RESP	21e. BP Pulse
22 July 02		142/90		103

22. BRIEF NARRATIVE
At 36h s/p GSW ® chest Tx c Laparotomy & chest tube by local physicians. At now stable & complaining of pain at wound sites. Pt stable & clear for C130 flights for transfer.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES
22 July 02	Handoff ——→ beginning
0830Z	Pt was received under guard
0330L	distal pulse strong &
	movement of all extremities. Unable
	to view chest tube due to restraints
	Skin pink warm & dry. Respirations
	@ 35 & Regular. Pulse is Full & Regular
	——→ SSgt (b)(6)-2
0100Z	upon review of Pt chart CT
0400L	has been DC'd and site
	covered & occlusive dsg. SSgt (b)(6)-2
0130Z	No change in privials. No
0430L	signs of drug from wound
	sites. Resp normal @ 32. SSgt (b)(6)-2
0153Z	160z HO PO ——→
0463L	——→ SSgt (b)(6)-2
0215Z	PMS to extremities x4
0515L	P:90 Full & regular R:32 &
	Bilateral Rise and Fall of Chest (b)(6)-2
	CRFill within 7sec ——→ SSgt (b)(6)-2

(b)(6)-2 OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

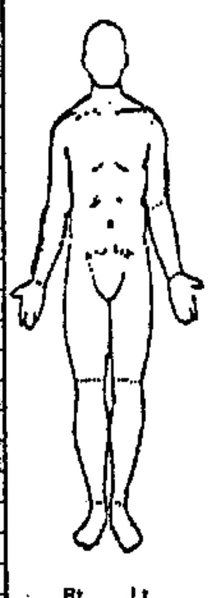
AF FORM 3899, MAR 95

23. **ASSESSMENT/PROGRESS** *(Continued)*

DATE/TIME	NOTES	DATE/TIME	NOTES
0900?	pt deplaned @ Bagram /		
0600 (	Sgt (b)(6)-2		

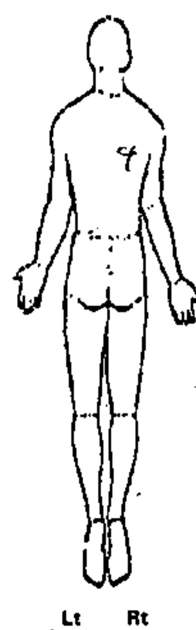
GLASCOW COMA SCALE		DATE/TIME PREFLIGHT	INFLIGHT 2 Jul 07 2045Z	INFLIGHT	INFLIGHT	INFLIGHT	INFLIGHT	POSTFLIGHT
1. EYE OPENING	SCORE							
SPONTANEOUS	4							
TO SOUND	3							
TO PAIN	2							
NO RESPONSE	1							
2. BEST VERBAL RESPONSE	SCORE							
ORIENTED	5	5	5					
DISORIENTED	4							
INAPPROPRIATE WORDS	3							
INCOMPREHENSIBLE SOUNDS	2							
NONE	1							
2. BEST VERBAL RESPONSE	SCORE							
OBEYS COMMANDS	6	6	6					
RESPONSE TO PAIN								
LOCALIZES	5	5	5					
WITHDRAWS	4							
DECORTICATE	3							
DECEREBRATE	2							
NO RESPONSE	1							
TOTAL = 1 + 2 + 3								

[X] IDENTIFY FINDING BY NUMBER



1 - BURN
2 - CAST/SPLINT
3 - DRESSING
4 - DRAINAGE
5 - ECCHYMOSIS
6 - HEMATOMA
7 - PAIN
8 - PRESSURE AREA
9 - RASH
10 - OTHER

WRITE # FOR FINDING ON DRAWING



AF FORM 3899, MAR 95 *(REVERSE)*

GPO: 1997 511-910

INPATIENT TREATMENT RECORD COVER SHEET *(For private imprinting)*

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

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

AFGHAN MALE
EPW

(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

ADMITTING OFFICER

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: 01 - RTD

26. DATE OF DISPOSITION: 20020812

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

multiple GSW
(L) chest
face / right
leg
arm

2 Aug BICAT REPAIR

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

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

36. TOTAL DAYS ALL FACILITIES

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

(b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

DA FORM 3647-1, 1 MAY 1979 EDITION OF 1

USAPA V1.00

MEDCOM - 3005

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

GSW x? MIW Afghan ♂ VS @ 1900L: P=155 B/P: 133/45
1910 L: P=111 B/P: 106/63
1000mL LR @ 1845L 1925 L: P=123 B/P = 147/65

Chest tube → drainage, F/C → drainage minimal output
1u PRBC O neg started @ 1855L

1935 - #2 Liter IV fluid - 1 GMS Kefzol given IV 119/-16 x51

PHYSICAL EXAMINATION

GSW Ⓡ ant chest, Ⓡ back, mid back over thoracic junction, GSW Ⓡ thigh, Ⓡ foot, scrotum.
Head intubated unresponsive
Chest CT Ⓛ, ØBS Ⓡ
Abd soft GSØ Ø ..., - foley in place ... Ø gross blood, ... scrotum.
Ext. GSW Ⓡ thigh, Ⓡ foot, Ⓡ MC-P joint #2
Neuro - sedated
To OR STAT for Resuscitative Thoracotomy

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

(b)(6)-2

		DATE	IDENTIFICATION NO.	ORGANIZATION
(b)(6)-2	UAT	27 Jul 02		(b)(3)-1

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

(b)(6)-4

REGISTER NO.	WARD NO.

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

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Afghan male who presents for further eval from the East. Pt c GSW (R) Chest; (R) Back; multiple back (R) Thigh (R) Foot (R) Scrotum (L) Knee (R) MCP Joint #2.

ALLERGIES: Unknown

MEDICATIONS: Unknown

PAST ILLNESS/PREGNANCY: Unknown

LAST MEAL: Unknown

Pt c Airway Resvc / Recv Tripple and BL Ct tube at the East

ALB 3.2 Alk Ph 72 Alt 31 AST 95 Amy 104 + Bili 1.3

PT 14.7 INR 1.56 PTT 17.0

U/A - Blood large

12 114 9.1 42 20 105 66 9 75 tP 49 13.1 39.6

HR 95 BP 2R 17 Pulse OX 00%

PHYSICAL EXAMINATION

NORMAL Intubated / sedated / Paralyzed ABNORMAL

HEENT (L) Periorbital ecchymosis c BL Scleral Injection
NECK Post neck c wound at midline (cervical region)
CHEST 2 (R) Chest wounds; BL Ct; RR; BL BS BL Chest c STAPLES.
LUNGS
HEART
ABDOMEN Soft ND
RECTAL no tone
EXTREMETIES (R) Thigh wound (L) Knee wound (R) Foot wound (R) Thigh STAPLES
NEURO Paralyzed
Genitalia (R) Scrotal wound laceration (R) Foley in Place
BACK - See Post next (L) Upper back wound

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

IMPRESSION: - Multiple GSW Chest, Back, Scrotum, Extremities
- S/P BL Chest tube Placement
- Laceration

TREATMENT: Ct Head; Chest; Abdomen + Pelvis

{b)(6)-2

PATIENT'S IDENTIFICATION	DATE	IDENTIFICATION NO.	ORGANIZATION
(For typed or written entries give Name Last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

{b)(6)-4

{b)(6)-4

Hx

c PW

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

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

INITIAL ASSESSMENT

AIRWAY / BREATHING

- ☐ Patent ☐ Obstructed ☐ Symmetrical
- ☐ Asymmetrical ☐ Unlabored ☐ Labored
- Trachea midline? ☐ Yes ☐ No
- Breath Sounds: Present ☐ Right ☐ Left
  - Clear ☐ Right ☐ Left
  - Decreased ☐ Right ☐ Left
  - Absent ☐ Right ☐ Left
  - Rales/rhonchi ☐ Right ☐ Left
- Crepitus? ☐ Yes ☐ No

CIRCULATION

- Skin/mucous: ☐ Pink ☐ Pale
- Membrane color: ☐ Flushed ☐ Jaundiced ☐ Ashen ☐ Cyanotic
- Pulses: ☐ Normal, Site ☐ Bounding, Site ☐ Weak, Site ☐ Absent, Site
- Rate _____ /minute Rhythm _____
- Skin temp: ☐ Warm ☐ Hot ☐ Cool/cold
- Skin moisture: ☐ WNL ☐ Dry ☐ Moist

DISABILITY

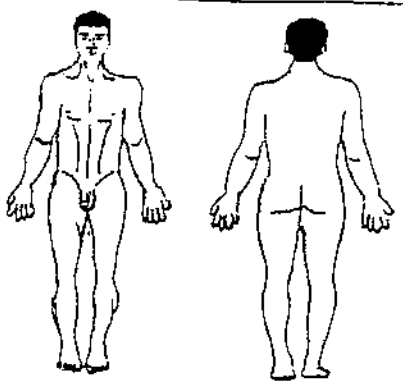
GLASGOW COMA SCALE

EYE OPENING	SPONTANEOUS	4
	TO VOICE	3
	TO PAIN	2
	NONE	1
VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	INAPPROPRIATE WORDS	3
	INCOMPREHENSIBLE WDS	2
	NONE	1
MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZED PAIN	5
	WITHDRAW TO PAIN	4
	FLEXION TO PAIN	3
	EXTENSION TO PAIN	2
	NONE	1

GCS TOTAL:

Pupil Reaction	OS Size	OD Size
☐ Brisk	____ mm	____ mm
☐ Constricted	____ mm	____ mm
☐ Sluggish	____ mm	____ mm
☐ Dilated	____ mm	____ mm
☐ Nonreactive	____ mm	____ mm

IDENTIFY INJURY SITE BY NUMBER



1. Laceration	6. Open fx	11. Edema
2. Abrasion	7. GSW	12. Amputation
3. Hematoma	8. Stab	13. Avulsion
4. Contusion	9. Burn	14. Pain
5. Deformity	10. Cold	

Head:

Nasal tube ET tube in place

Maxillofacial:

C-spine/neck:

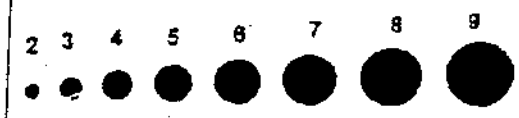
Chest:

Bilateral tubes GSW to chest

Abdomen

Perineum

Musculoskeletal



SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

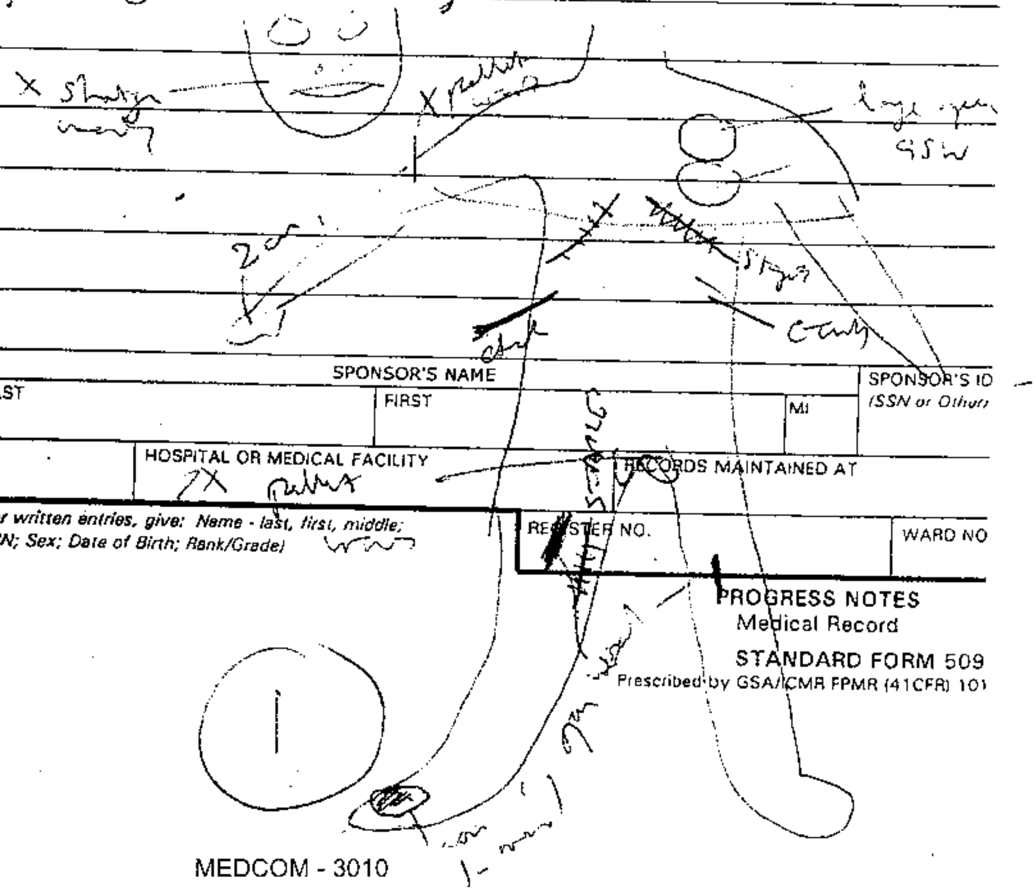
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
PT (b)(6)-4			

DATE	NOTES
28 July 02	Young Afghan male presented c multiple GSW to torso
0845	and extremities. PT arrived via medevac c bilateral chest
	tubes and ET tube in place. PT being bag ventilated. Initial
	vitals on arrival B/P 131/77 P105 R18.
	DR (b)(6)-2 evaluated PT. PT given 20mg Etomidate and 5mg
	Vec. IV for further sedation and paralyzation.
	- Trauma labs drawn. Confirm ET tube placement by
	auscultation and Chest x Ray. 8.0 Tube. 26mm at incisors.
	- Pleura Vac Systems added to each chest tube.
	- Foley Cath already in place. Note 300 cc blood tinged
	and gross blood in tubing. Portable x-rays series complete.
0937	5mg Vec given 2nd dose. PT on Vent Setting TV 800 R12 FiO2 100%
0930	PT surgically evaluated by DR (b)(6)-2 / DR (b)(6)-2
1000	PT placed on full board c C-collar and head immobilizers
1010	PT placed on Depravan Drip 25mcg/MIN. Give 1gram Ancef IV.
1025	PT over for complete CT: Head, Chest, Abdomen, Pelvis.
	While in CT. PT received 10mg Vec. IV for paralysis.
1050	PT report given to ICU by DR (b)(6)-2 PT then transferred
	to ICU. B/P 123/75 P114 R20 O2 SAT 97. (b)(6)-2 RN

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | ICU | **PROGRESS NOTES**

DATE	NOTES
	H + P
28 Jun 2	CC Multiple GSW
1110L	HPI Taken Afghan 07. Multiple GSW
	1° treatment at FST includes bilateral chest tubes
	for ? pneumothorax. Resus thoracotomy B/L, (R) peritoneal exam
	→ OR @ CSH ? CT head, neck, abdo, pelvis
	shows multiple shotgun pellets + 2 severe knife
	wounds on chest ? exit over neck + scapula.
	Bullet rides in globes
	All unknown MEDS unknown
	PMH " ROS unavailable
	O/E Lab 140/105, 4.2/20 < 12, 11, 1.1 INR 1.5 10.2 > 13.7 / 34.6 < 53
	PTT 17
	u/A ⊖
	VSS P 101 BP 163/82 PO2 98% R 12 (vent)
	Skin pale dry. Ears ⊖ eyes see below



RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID (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.

Pt (b)(6)-4

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

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	Eye exam for (b)(6)-2 on
	(L) Severe damage to ant. Segment. Severe edema + bleeding
	(R) Early Dilated vessel changes. Ant Segment free of blood. Trans intact.
	Dilate (L) eye not successful.
	PROBLEMS
	S/P BIL THORACOTOMY
	(L) Pneumo Rx Resolved
	BIL CHEST TUBES
	VENTILATION
	. Severe eye injury
	- X wounds — Chest - hemothorax > 2
	— Knee, feet.
	Platelets 50
	↑ LFT but GGT(N) ∴ c/w muscle damage.
(P)	Vanc Mx
	IV Abx
	IV fluids
	Surg w/u
	Follow H+H / platelets
	Pain Mx treated

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

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

2

DATE	NOTES
	ICU
28 Jun 02	Pt is condition d/w surgeons LTC (b)(6)-2, CPT (b)(6)-2. Labs
1420	ABG, CT + X-rays reviewed
	(P) (1) ortho - OR currently as [illegible]
	(2) Resp - stable on vent. if possible D/C A/Am.
	(3) GSW - on Abx
	(4) ophthalmic - D/W LTC (b)(6)-2 / OPHTH to follow.
	Surgical approaches not presently available. Opt. believes
	that pt not immediate danger to loss vision (R) eye.
	(L) eye no operative option possible at present
	(b)(6)-2
29 Jun 02	ICU
0948	S - stable on [illegible]. ↓ output [illegible]
	O - VSS T max 37.2 [illegible] I 1100 O 418
	Lab 124 / 3.6 | 22 < 18 / 113 / 1.1 H+H 10/29
	O/E pt sedated. (L) pupil unreactive, (R) [illegible]
	H) S1 S2. tachycardic 124 ↓ c MS04
	B) CTA
	Wounds - not [illegible]
	A/P (1) ortho - follow orders Dr (b)(6)-2. AMP + [illegible]
	(2) Resp - plan wean if [illegible] on.
	(3) GSW - on (1)
	(4) ophth - I.V. Abx. Teleconsult.
	(5) Hypernatremia - follow lytes. NS or [illegible]
29 July 02	Patient tolerated Vent. wean & CPAP x 45 min
11[10] L	ABG: 7.449/43.6/80/30 96%
	Extubated successfully @ 11[08] to 10L via VM

FPI LEX Printed on Recycled Paper

STANDARD FORM [illegible]

(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1350 pm 28 Jul 02	ORTHO Skeletally immature ♂ who sustained multiple shrapnel wounds to (B) hands, (L) knee, (R) foot as well as GSW to (L) chest wall + shoulder. Arrived in ER with intubated ad paralyzed ∴ no N/V exam possible. PE: pulses 2+ (B) UE/LE ē <3 sec cap refill 2° ortho survey reveals ϕ crepitus ē FROM all joints in (R) UE/LE ē exception of (L) shoulder. Pt is intubated + paralyzed. Xray: (L) Hand/(R) Hand: Shrapnel in SQ area, ϕ fx (L) Elbow: shrapnel superficial, ϕ fx (L) Shoulder: comminuted scapular neck fx ē AC disruption ad acromial fx (L) Knee: SQ shrapnel, ϕ FB in joint ϕ free air (R) Foot: Comminuted Metatarsal fx 3/4/5 ē good alignment. Shrapnel in sinus tarsi area A/P) Multiple wounds requiring I+D. NO possible ORIF ē these injuries. S/p to (L) arm ad splint to (R) LE.

(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.	

Pt # (b)(6)-4

3

PROGRESS NOTES
Medical Record

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

MEDCOM - 3013
509-114

29 Jul 02 2013 — ICU E NOTE (CONT)

Labs from earlier: U/A ⊖ nitrite

micro: many rbc, rare rbc cast

12 | 11.7 / 33.4 | 160 — 139 | 99 | 13 / 3.5 | 107

A/P ① Fever: UTI unlikely
Atelectasis possible
doubt wound infective
pt is on gentamycin & ancef

② Tachycardia: may be related to fever
doubt pt is volume down

③ ✓ CXR.

④ Start Tx of Tylenol

[redacted] (b)(6)-2

29 Jul 02 2106 — CXR: NO infiltrate. No atelectasis. B.I.V chest tubes

[redacted] (b)(6)-2

30 July 02 8^10 L — S/ Above noted. patient quite restless last night. Still tachy. Wants to eat.

O/ Tm HR 104 127/67 Sat 94% RA.

Gen: AA in NAD.
Cor: tachy
Lys:
Abd:
Ext: ① LE -
Neuro: ① eye - no reaction

[redacted] (b)(6)-2

Labs: Hb 10.7 WBC 8.6 plt 116

A/P ① Mult. injuries: ① eye - FB: needs Vitrectomy (for ophthy)
- Bi
re VCXR & consider removal. →

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
29 Jul 02 1310	CXR → No Evidence Pneumothorax
	CT Drainage Decreased. Will Get
	CXR in AM & if OK may Remove
	Chest Tubes Per Further Surg (b)(6)-2
29 Jul 02 1040	ICU
	c/o tenderness Ⓛ ankle - XR ⊖ soft tissue swelling
	early ↓ Na Rx ↑ fluids / lasix / lytes as ↓ uri + ↑ cr
	Now Na 139. BUN ↓ 17
	→ INC 125 ml. follow I + O
	H + H Hct 32.
	(b)(6)-2
29 Jul 02 2015	Since extubation, pt has been tachypneic with
	resp rate 28-32. O_2 Sat has been 92-94%. Also
	HR has been 121-141. Pt is running a fever at
	101.9. Pt is taking shallow breath, states it hurts
	to take deep breath (he has bilateral chest tubes in).
	BP has been stable at $\frac{113-153}{55-92}$. Pt has foley
	Gen: NAD
	Heart: Tachycardic
	Lung: shallow breath, no wheezing, no crackles
	Abd: ⊕ BS, soft (CONT) (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID (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

Pt (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

(4)

cont'd Gen: Cor / intable in NAD
Cor:
Chest: B/L CT
Abd: (R) BS
Ext: moves (L) LE

Labs: Lytes - WNL ~~K~~ (Na 119)
CK 1733 Hb 9.9 ~~Plt 195~~ WBC 6.8

A/P
(1) Mult. injuries
- eye: await ophthalmologist
- chest: consider D/C (R) CT. cont. abx.
- ext: cont. sling & splint.

(2) ↓ Na+ - suspect fluid retention. Will mon. thirst.

(b)(6)-2

31 Jul 02 1110 Both chest tubes removed S complications O2 Sat Remains @ 96% Clinically Good B/S Both Lung Fields will check CXR in AM

(b)(6)-2

1 Aug 02 1002 S/ Neg. report blue-green discharge from posterior wounds & (L) ant. chest wound.

O/ Tm 37.8 VSS 97% on 2L
Gen: resting comfortably in NAD
Cor: reg
Lys: S/P D/C B/L chest tubes c sig. not removed
Abd: (+) BS

(b)(6)-2

cont'd

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 July 02 contd	- Open (L) upper chest tube:
	- await further recs from surgery
	- (L) UE, s/p debridement, cont. sling.
	- Shrapnel (L) knee;
	- stable.
	- (R) foot & (R) subtalar arthrotomy:
	- cont. splint
	- Disp:
	- needs to be placed for long term medical care. ? where
	(b)(6)-2
31 July 02 8³⁰ L	S/ No new problems. Still stable p̄ extubation. Still restless. Currently, resting comfortably.
	O/ Afeb VSS 97% on 4 L →

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.

Pt (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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 Aug 02 cont'd	A/P ① Mult. injuries 2° GSW, s/p debridement now c discharge suggestive of pseudomonas: - D abx. - cont. dsg. A" per surgery - cont. sling & splint ② V Nat. - resolved, refd 135

(b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID (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

Pt. (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Pre-Op Note - Ophthalmology
Aug 1 02	Young Middle Eastern male (unknown age, (15 yrs) name & nationality) DOW c̄ multiple gunshot & grenade injuries presents c̄ ↓ V.A. OD & red, edematous OS. c/o no V.A. OS and trouble reading OD. Speaks fluent English. No c/o ocular pain. Incident occurred 5 d. ago.
[illegible]	Exam: VA OD reads medium sized letters on 4x4" sponge pkg
	VA s̄c OS L.P. but no projection
	Lids: Crusting & discharge OU, OS >> OD. OS 1-2+ edema. Appears mild, c̄ full ROM.
	Pupils OD ~3 mm, reactive.
	OS difficult to visualize, 2° large
	Conj: OD ~~small cornea wound~~ small subconj hem. nasal to limbus. OS 2-3+ subconj. hem. & 1+ edema -
	Cornea OD cl
	OS Irregular, large corneal wound (full-thickness).
	AC OD appears cl to hand lt.
	OS uncertain. Corneal wound plugged with entrapped iris.
	Indirect scope exam:

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

#(b)(6)-4

PROGRESS NOTES
Medical Record

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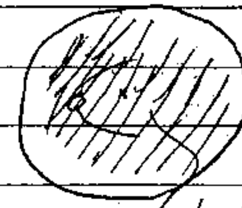
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Cont.

OD 

OS 

No fundus details seen. One white FB present in mid vit.

CAT scan shows FB's (1 ea) OU - roughly mid vit.

Imp - Penetrating ocular injury OU c̄ presumed metallic FB's (grenade fragments?)

- Surprisingly little inflammatory reaction OU (almost none OD) - doubt endophthalmitis
- Exposed uveal tissue OS x 5 d. makes sympathetic ophthalmia a concern.
- Assuming FB's are not copper, will plan to leave in place OU (no vitrectomy capabilities here).
- Pupils have not been dilated, ∴ →

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REGISTER NO.	WARD NO.

(b)(6)-4

pynechiae may have formed ☒.
- IOP unknown but will be determined in O.R. tomorrow
- No steroids have been used - may have major inflammatory reaction (OS > OD)

Plan: In a.m.: 1) explore OD globe ✓ repair wounds) in layers.
2) explore OS globe; repair corneal wounds. Enucleate pm.
Remove lens pm. ↑ ✓ any other wounds.
3) Intravitreal injection of antibiotics ✓ steroids bv.

Problems: 1) No enucleation set available.
2) No electrosurgery instruments available.
3) No scleral buckling instruments ✓ elements available.
4) No cryosurgery available (no liquid N_2 ✓ no dry ice)
5) No ophthalmic ultrasound available.

Plan discussed ☐ pt. He understands ✓ has had an opportunity to ask questions. Pt. is febrile (101°) ✓ is having pain/soreness from corneal wounds. Has been having trouble breathing ☐ RA O_2 sat 88% this p.m. More comfortable on O_2.

(b)(6)-2

Cpt. USA - MC
Ophthalmology

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Icm
2Aug02	S/P stuff both eyes. No enucleation done
1855 L	(P) receive pre op orders eg Ancef + Gent IV Forty
	will D/W Dr (b)(6)-2 (ophthalmology) further Rx (b)(6)-2

Op Note

2 Aug 02 Pre-op Dx - Penetrating ocular injuries c retained intra-ocular FB's OU; hyphema
1845 v vitreous hemorrhage OS.

Post-op Dx - same

Surgeon - (b)(6)-2

VSAV - MC Col. Ophthalmology -

Anesthesia - gen.

Assistant - 0.

Procedure - ~~OD~~ (NO OPERATING MICROSCOPE AVAILABLE)
OD: Exposure v exploration of 4 scleral quadrants;
no post. wounds found.
Closure of anterior scleral wound
(deep shell) w 2 mm post to
limbus, close to 3 o'c. c 7-0 Vicryl
Injection of intravitreal antibiotics IV

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.

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Eternal *
- Closure of conjunctiva c 5-0 (1) gut -
Ending pressure 4 mm Hg (Schiotz).
OS: Exploration of all scleral quadrants -
no ext. wounds found
Excision of entrapped uveal tissue (iris)
in corneal wounds.
Repair of 2 irregular, necrotic corneal
wounds c 10-0 nylon.
Closure of 1 small superotemporal scleral
wound c 7-0 Vicryl.
No attempt made to remove presumed
ruptured lens, since no phako, cryo-
unit or lens loop available.
No attempt made to remove vit. hem., since
no vitrectomy instrumentation
available.
Intravitreal injection of antibiotics* &
Ending Pressure** unrecordably low (Schiotz).
OU: No attempt made to remove intraocular
foreign body, since no ultrasound,
magnet, vitrectomy - equipment or
scleral suturing equipment available.
At end of procedure, Atropine 1% and
Pred Forte and Gentamycin gtts
instilled OU.

Pt. condition - good -
Blood loss - < 5 cc -

* ceftazidime 1 mg in 0.1 cc (0.1 mg)
Vancomycin 1 mg in 0.1 cc (0.1 mg)
** Dexamethasone 4 mg in 0.1 cc (0.4 mg)

(b)(6)-2

USA - MC Col.
Ophthalmology

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Jun 02	surprisingly, but hyphema mostly cleared.
P.O. Day #1	Pupil - 4 mm
Note cont.	Vit. & fundus not visualized - ? red reflex
	in just vit. lens.
	Imp: Excellent status OD.
	Expect recovery of some useful vision
	OD.
	Corneal wounds OS may be infected.
	(C&S pending).
	Retained intravitreal FB's OD.
	OS may develop R.D. & eventual phthisis
	unless repair of R.D. can be done +
	vitrectomy.
	Disp - Atropine 1% gtt i OD bid
	Pred Forte OD gtt i qid. (not OS)
	Ocuflox OD gtt i qid
	" OS q 2 hrs.
	To be followed by Cpt. [redacted] (b)(6)-2
	[redacted] (b)(6)-2 Col USA-MC
	Ophthalmology

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

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

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

[redacted] (b)(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Aug 02	Post Op Day #1 - Ophthalmology No ↓o pain or. OD: VSC can visualize objects on ceiling. lids - 0 edema conj - clear, small ant. subconj. hem. cornea - cl a.c. formed, deep + cl to trace light lens - apparently cl to trace light. ant. - cl. hazy but clearer than pre-op. fundus - retina flat, disc pink, macula clear g.t. 2 - white FB in mid-vitreous OS: VSC "light is brighter) than b4 pre surgery. lids - 2+ edema, small ant. discharge. conj - clear, 3+ subconj. hem., 4-5 mm port. to limbus - cornea - wound edematous, white-gray, sutures intact. a.c - formed, deep, small ant. hem. sup. ↓

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

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PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Aug 02 0725L	S/P Ophtho. procedures – see op. note. No new problems. Tol. PO. Back wound discharge – serosanguinous. O/ Afeb VSS. Gen: AA in NAD. Wounds – no Δ.
A/P	1) Mult. GSW c resultant mi/musc – cont. abx – cont. dsg. Δ's. – cont. phys & splint.

(b)(6)-2

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

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

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

(b)(6)-4

PROGRESS NOTES
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7 AUG 02 Pat resting with. Heart RSR [illegible] go clear
await eye eval [illegible] mission cont to wound
dressings to Back

(b)(6)-2

8 AUG 02 Pat cont to improve afebrile
wounds on Back clean; cont ō present
dressings. Transfer when dry dressings only needed.

(b)(6)-2

9 AUG 02 no complaints afebrile Heart RSR
lungs clear cont present dressing tx.

(b)(6)-2

10 AUG 02. wounds looking much improved c̄ evidence of
granulation present. Little - no change.
Cont present dressing lungs clear eyes cont to improve [illegible]

(b)(6)-2

11 AUG 02 wounds cont to clear. no complaints afebrile
staples removed this AM. Heart lungs stable.
probable detainee center tomorrow

(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 Aug 02 0932	S/ Quiet night. No new problems. O/ Afeb. VSS Grafts unchanged Plan: – cont. abx – cont. dsg. A+C (b)(6)-2
5 AUG, 02	OPTOMETRY: PT SEEN FOR F/U ON BILATERAL REPAIR OF PENETRATING INJURIES TO GLOBES. RIGHT EYE IS CLEAR AND QUIET WITH NO HYPEMA OR SYNECHIA. LEFT EYE HAS SMALL HYPHEMA WITH CENTRAL CORNEAL OPACITY FROM PENETRATING INJURY. MEDS: ATROPINE, OCUFLOX, BACITRACIN OINTMENT, LASH DEBRIS REMOVAL BID. (b)(6)-2 CAPT, OD, NSC

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.

Pt - (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12AUG05	discharge ~~[illegible]~~ summary
1000	Pt presented c̄ multiple GSW including pellet wounds, shrapnel & gunshot. Sustained penetrating wounds to both eyes no vital structures damaged. Initially presented c̄ Bilat chest tubes & intubated from chest wounds (R) & (L) shoulder, shrapnel (L) elbow communited fx (L) scapular, proximal fx, shrapnel in: (L) knee, (R) foot communited fx. multiple areas cleansed, debrided, surgical repair (R) foot, (L) chest wounds, ophth surgery for eye eval., pt extubated 24° after admission, drainage from wounds [illegible] [illegible] closed, ophth drops [illegible] [illegible] healed progressively. wounds responded to ~~debridement~~ & dressing changes well., vision increasing Back wounds debridement clean & granulating, cont. c̄ dressing changes, D/C antibiotics. F/U 1 month c̄ cont. eye tx, reg diet (b)(6)-2 dressings Δ BID, (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
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USAPA V1.00

510-112 NSN 7540-00-634-41…

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/1/02	1?	1345	Arrived as transfer from ICU via litter
			c 2 assist; may assist to transfer to bed.
			IV LR @ 125cc/hr infusing via flowmeter
			AUE; foley intact and draining clear yellow
			urine in bag; DSD intact on bilat shoul-
			ders and Lt ↑ chest; shackled c MP in
			attendance; excellent use of english;
			LUE in sling; no c/o pain at
			this time. (b)(6)-2 CPT, AN, USAR
1 Aug 02		2130	Lying in Bed, eye closed most of this shift
			IV NSS @ 100cc/hr. O2 titrated. Present @ 2L/min
			PulseOx = 99%. Cont. pro pag to monitor VS &
			3 Lead EKG. Foley Cath draining clear amber
			urine. MP @ bedside. C/O pain x2 level "8".
			Medicated as ordered. Sling in place. Drsg
			intact. Will cont. to observe. (b)(6)-2 MAJ. ANC
2 Aug 02		0800	Alert in bed; lethargic; O2 2LNC; pulse ox >90%
			c O2; sling on LUE; foley intact and draining
			clear yellow urine; RUE IV site intact and
			infusing NSS @ 100 ml/hr via flowmeter;
			DSD intact over back/Lt ↑ chest wounds/Rt
			↑ rib site; NPO 2° surgery; no c/o pain at
			this time. (b)(6)-2 CPT, AN, USAR

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, m… hospital or medical facility) (b)(6)-2 | REGISTER NO. | WARD NO.

(b)(6)-4

NURSING NOTES
Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Aug 02	0800		(cont) No c/o pain at this time; resp unlabored; minimal self movement. — (b)(6)-2 CPT AN, USN
5 Aug 02	1000		Wound care to Bilat T tracy wounds: packing removed, WD c Dakins solution repacked in sites; LT wound T amount green drainage c min fresh blood. Covered c abd pads, tape; tolerated poorly c T pain; self medicates c pain pills (b)(6)-2 Prior to wound care CPT, AN
5 Aug		1900	A&O x3. Pleasant & Compliant c back pain. T° 100.4 Tylenol given rest VSS Vags WNL intact (R) FSA. Unable to tolerate sitting. (b)(6)-2 9/1/03, MC (b)(6)-2
6 AUG 02			OPTOMETRY: LEFT EYE CONTINUES TO IMPROVE WITH REDUCED ANTERIOR CHAMBER REACTION AND REDUCED HYPOPION. RIGHT EYE IS CLEAR C SEALED PUNCTURE NASALLY. BOTH PUPILS ARE MAXIMALLY DILATED. WILL BEGIN STEROID (PRED FORTE) IN OS TODAY (b)(6)-2 CPT, OD
6 Aug 02		2230	Responds To All Stimuli. DRSG Δ as ordered. Medicated FOR PAIN. Will CONT. TO OBSERVE. (b)(6)-2 AMC

*U.S. GPO: 1989-242-450/02341

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD — **NURSING NOTES** (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
8/4/2		1500	Received at transfer from ICU ; max assist to transfer from litter to bed ; NWB RLE ; ⊕ IV heplock site of RUE D&I. Resting s̄ responses ; alert during transfer s̄ c/o. ACE wrapping of RLE D&I ; RLE WNL to touch. DSD intact on back and LT ↑ chest wounds. PT demonstrates good to excellent use of English ; staple site wounds of bilat [illegible] intact s̄ s/s drainage ; MP in attendance ; leg shackle on LLE s̄ s/s trauma to site. ∅ DSD on [illegible] ; (b)(6)-2 CPT, AN, 05AR
4 Aug 02		2035	A&Ox3. Pt c/o pain [illegible] - medicated c̄ ii percocet @ 20^00. Heplock intact [illegible]. VS WNL [illegible] 100 [illegible] medicated c̄ Tylenol 650 mg. [illegible] (b)(6)-2 91W3M6 (b)(6)-2
5 Aug 02	0800		alert in bed ; RLE drsng D&I ; multiple wound sites c̄ staples D&I ; IV site of LUE s̄ s/s infection ; DSD intact on ↑ LT & RT back & ↑ LT chest ; very good use of english ; voiding ∅ s̄ difficulty yellow urine ; eye care by CPT (b)(6)-2 Cont (b)(6)-2

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

REGISTER NO. — WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

BOD 9

510-112 NSN 7540-00-634-4124

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7Aug02	0830		Pt A&Ox3 - Denies c/o pain - Dressings remain intact - Verbalizing c̄ staff when spoken to but does not verbalize (I) for conversation - Only verbalizes to make needs known - VSS —— (b)(6)-2 [redacted] SGT, 91WY2 MC
7Aug02		2100	Pt A&Ox3 - HPB given (HL with Err adequate) VSS. Denies c/o pain. —— (b)(6)-2 [redacted] 91WBMC
8Aug02	1130		Pt A&Ox3 - VSS - Denies pain but was premedicated prior to dressing Δ's - Verbalized effectiveness of pain medication p̄ dressing Δ - Small amount of bleeding noted from bilateral back wounds - Moderate amount of serosanguinous drainage noted on removed dressings - Ø odor noted - Dakin's solution applied to W2D - Staples + sutures intact s̄ drainage - (L) arm remains immobilized - Splint intact on (R) lower extremity - Ø ↑ inflammation noted c (L) eye - IV site patent & flushable - (b)(6)-2 [redacted] SGT, 91WY2 MC
AUG 8 2002	1340		OPTOMETRY:
			PT HAS CLEAR ANTERIOR CHAMBER OD c̄ RING OPACITY ON ANTERIOR LENS CAPSULE. OS HAS SMALL HYPOPYON c̄ A RESOLVING CORNEAL WOUND (2 SUTURES PRESENT). OVER →

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW

(b)(6)-4 [redacted]

Bed #9

NURSING NOTES

Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			INTRAOCULAR PRESSURES WERE 10.2 OD AND 4.0 OS (BOTH WELL BELOW NORMAL) CONTINUE TO PRED FORTE AND OCUFLOX Q6H OU
			(b)(6)-2 CAPT OD, MSC.
			OPTOMETRY: ADDED CILUKAN TO MEDS GIVEN Q6H OU. LEFT EYE HAS RESOLVING CENTRAL PUNCTATE OD IS CLEAR, PUPILS REMAIN DILATED OD>OS
			(b)(6)-2 CAPT OD, MSC

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10Aug02	0800		(cont.) ∅ S/S dehiscence; voiding QS clear yellow
			urine; appetite fair at times; minimal
			move-ment in bed; sling on LUE. ∅
			c/o pain at this time. (b)(6)-2 AD, USAR
10Aug02	0830		Dressing Δ of ↑ back/daltoid Δ by M.D. —
			(b)(6)-2
10Aug02		2300	Pt A+O x3 — Tolerating IV meds — Dressing D/S
			done as ordered — (L) arm remains in sling. Pre-
			medicated c Percocet prior to dressing Δ —
			Drinking H_2O — Urine clear + yellow — USS —
			(b)(6)-2 SGT, 91WM6
11Aug02	0830		Pt A+Ox3 — H/L (R) F/A for IVPB patent ∅ S/S of infiltration.
			Flushes easily. Ate 90% breakfast. VDGS. VSS. (L) Arm
			remains in sling. Drsgs to back dry & intact. Pt requested
			to get OOB to chair to get washed. Verbalized c/o
			pain thus far. (b)(6)-2 91W3M6 (b)(6)-2
11Aug02		1440	(L) flank/chest 14 staples removed ∅ S/S of infection.
			incision site approximated. (R) flank/chest 13 staples
			removed site approximated ∅ S/S of infection. 13 staples
			+ 8 stitches removed from sternal site which edges
			are approximated ∅ S/S of infection. (L) LE 2 staples
			removed (R) LE 13 staples + 8 stitches removed edges
			approximated ∅ S/S of infection to incision site. Drsg
			Δ'd to back + shoulder. Dakins W→D dress applied
			Denies c/o pain — (b)(6)-2 91W3M6 (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 3035

510-112 NSN 7540-00-634-41

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 Aug 02		2130	A&O x3. Pleasant & Compliant. Hl. (R) hand patent for IVP antibiotics. VSS. Ø Verbalized c/o pain [illegible] (b)(6)-2 [redacted] 91WBM (b)(6)-2 [redacted]
9 AUG 02			OPTOMETRY:
			PT HAS CLEAR ANTERIOR CHAMBER OD WITH RING OPACITY (CATARACT) ON ANTERIOR LENS CAPSULE. LEFT HAS SMALL HYPOPION IN INF. ANGLE, CENTRAL CORNEAL OPACITY WITH 2 SUTURES, REDUCED HEME IN ANGLE. POST VITREOUS CLEAR OD, HAZY OS.
			(b)(6)-2 [redacted] CPT, OD MSC
9 Aug 02	0800		Alert in bed; voiding QS clear yellow urine; DSD intact on bilat ↑ back; IV site of [illegible] D&I; Suture sites over flank/chest intact c good adhesion; receives ophth gtts through day per order. Some c/o "Bitter" taste in throat – relayed to MD. (b)(6)-2 [redacted] PT, AN, USN
9 Aug 02		2?25	A&O x3 Pleasant + Compliant. VSS. Hl (R) F/A patent for IVP antibiotics DSD [illegible] Eye gtts given. No verbal c/o pain. [illegible] intervals. (b)(6)-2 [redacted] 91WBM (b)(6)-2 [redacted]
10 AUG 02	0800		A&O x3 in bed; very good english use; DSD intact on ↑ back/shoulder and LT deltoid; incisions over (R) flank/chest staples intact [illegible] (b)(6)-2 [redacted]

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

REGISTER NO. WARD NO. [redacted]

LPW

(b)(6)-4 [redacted]

NURSING NOTES
Medical Record

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

MEDCOM - 3036

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

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

1. Date/Time: 12 Aug 02

2. Discharge to: ☐ Home Other *(specify)*

3. Mode: ☐ Ambulatory Other *(specify)*

4. Accompanied by:

5. Activity: ☐ Limitations *(specify)*

OOB TO CHAIR With THe ASSIST OF ONE. AS TOLERATED.

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

6. Diet: ☐ No Dietary Restrictions If special, identify

Reg KOSHER

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

7. Medications: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
Eye Drops; SEE MEDICATION SHEET.			

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

8. Treatments/Care:

Instructions Given:	Patient/ S.O. observed Demonstrations (Date)	Patient/S.O. Returned Demonstration (Date)
Wound CARE @ (R) & (L) UPPER BACK: WET TO DRY With DAKIN'S SOLUTION. TWICE A day.		

Equipment/Supplies (Specify)

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

(b)(6)-2

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

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

Improved; PT is Partial Care Now.

(b)(6)-2

MAJ ANC

12. Additional Information:

PT is ABLE: (1) Partial Bath Self (2) Feed Self (3) Speak Clear Concise English

13. Patient Identification:

#

(b)(6)-4

COPY 1 - INPATIENT RECORD COPY

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY (b)(6)-2 / (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Anesthesia, Surgeon

3. DATE 28 JUL 02 TIME PATIENT ARRIVED IN SUITE 1354

4. PATIENT IN ROOM TIME 1354 NUMBER (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Intubated prior to entering O.R.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

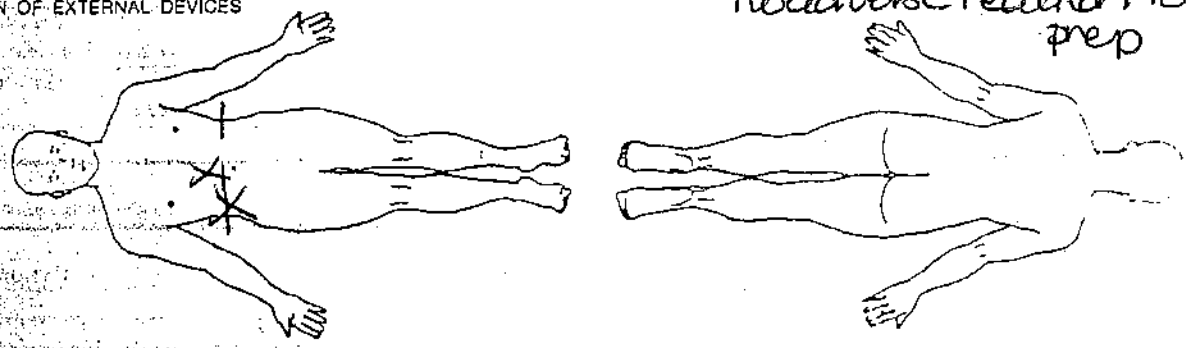
COMMENTS: modified beach chair tape strap across forehead + abdomen & towels

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: Shoulder / BY WHOM: (b)(6)-2 / (b)(6)-2
SITE: Chest bilat legs
COMMENTS: no pooling of solution / no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: 001011
GROUND PAD: BRAND Valleylab LOT NO: 567733 2003/12
☒ ESU NO: 000994
GROUND PAD: BRAND Valleylab LOT NO: 567733 2003/12
☐ BIPOLAR NO: N/A

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME, ID NO., SERIAL NO., MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Cancef	1gm	intra-op	IVPganen	(b)(6)-2	Surgeons

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
ancef 1gm / L NSS

OTHER ORDERS	TIME	CARRIED OUT BY
PHYSICIAN (b)(6)-2 (b)(6)-2		

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION (Specify)
shoulder - gauze/opsite
legs - gauze / opsite / foot - Kerlix - gauze / Kerlix
(R) hand - gauze / Kerlix

19. ADDITIONAL INFORMATION
bilateral chest tubes + foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement of (L) shoulder, chestwall (L) knee, (R) hand (R) foot (R) subtalar arthrostomy

21. PATIENT TRANSFERRED TO ICU TIME 1528 METHOD litter

(b)(6)-2 RN ICT

REVERSE OF DA FORM 5179-1, OCT 87

U.S. GPO: 1988-104-813/40449

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

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

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

3. DATE 30July02 — TIME PATIENT ARRIVED IN SUITE 1720

4. PATIENT IN ROOM TIME 1720 — NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 Z 91D N 91	RELIEF SCRUB	4
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 91D	RELIEF CIRCULATOR	9

7. POSITION AND POSITIONAL AIDS (Specify)

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [X] LEFT SIDE UP [ ] RIGHT SIDE UP

2nd

COMMENTS: Armboards Pillow between legs, arms tape strap across arms, thighs, knees

8. SKIN PREPARATION

HAIR REMOVAL DONE BY: METHOD: [ ] YES [X] NO [ ] OR [ ] NURSING UNIT [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N 9

PREP SOLUTION (Specify) Betadine

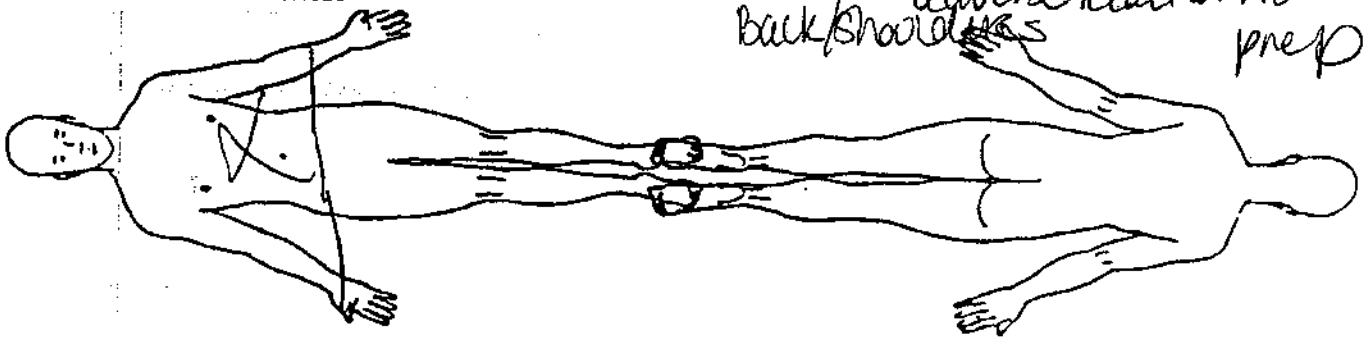
SITE: R lat leg — BY WHOM: (b)(6)-2

SITE: L shoulder — BY WHOM:

COMMENTS: no pooling of solution / no adverse reactions

9. LOCATION OF EXTERNAL DEVICES

Back/Shoulders prep



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	[X] Yes [ ] No		C	C
Needle Sharp	[X] Yes [ ] No			
Instrument	[ ] Yes [X] No			
Other	[ ] Yes [X] No			

SCRUB (b)(6)-2 91D — CIRCULATOR (b)(6)-2 RN

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

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: 001011

GROUND PAD: BRAND Valley Lab

LOT NO: 56773 / 2003 12

[ ] ESU NO:

GROUND PAD: BRAND N

LOT NO: 9

[ ] BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NU: F JFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Ancef	1gm	IV/A-op	IV/gravity	(b)(6)-2	(b)(6)-2 Surgeon

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
Ancef 1gm / NSS

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐ (b)(6)-2 7/26/02

TYPE/SIZE	1. ext 4	2. Kerlix	3.
SITE	1. RC 7-26-02 4	2. Back	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlaform / gauze / Kerlix
Multiple sites

19. ADDITIONAL INFORMATION
N/A

20. OPERATION(S) PERFORMED
debridement bilateral legs, Pectoralis repair, partial closure right shoulder, I+D of shoulder abscess

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1950	Litter

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

REVERSE OF DA FORM 3179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — INTRAOPE : DOCUMENT

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

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

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

3. DATE 2 Aug 02 TIME PATIENT ARRIVED IN SUITE 1050

4. PATIENT IN ROOM TIME 1050 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

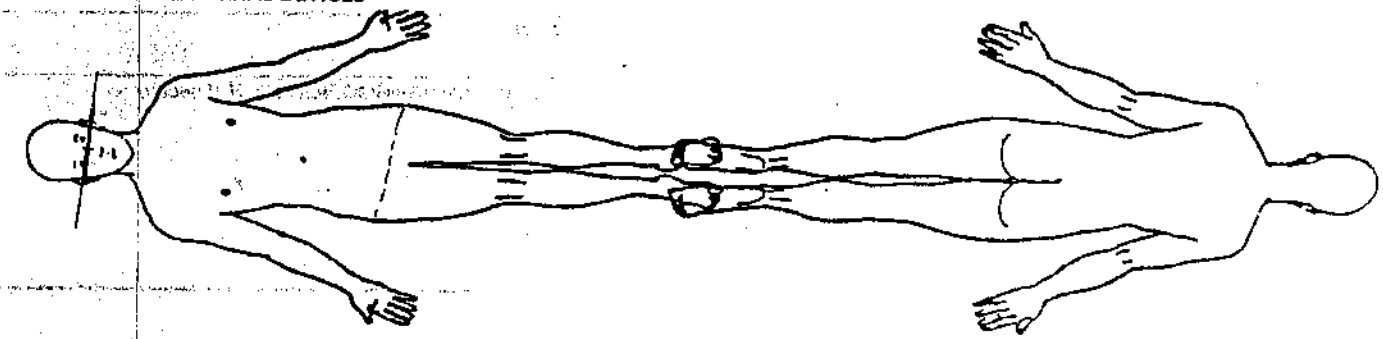
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: face BY WHOM: CRT (b)(6)-2
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

BSS 15ml

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 OCSM ~~Left~~ Right Eye	NAME OCSM ~~Left~~ Eye.
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Right Eye - 4x4's, 1" Tape over plastic contanier — Left Eye - 4x4's, 1" Tape over plastic Eye

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

Closure Sclera Wound ~~Left~~ Right Eye; Injection of Antibiotics and Steroids O.D.; Cornea Wound Repair Left Eye; Exploration of Globe; Closure Sclera Wound OS Eye; Injection of Steroids/Antibiotics

21. PATIENT TRANSFERRED TO	TIME	METHOD
TCU		Litter

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

REVE

USAPA V1.00

MEDICAL RECORD — INTRAOPER 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 Cotter BY NAS (b)(6)-2

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

3. DATE 03 AUG 2002 TIME PATIENT ARRIVED IN SUITE 1159

4. PATIENT IN ROOM TIME 1139 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Language Bar 03 AUG 2002

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Axillary Roll, Chest Rolls Front & Back, Pillow Between Legs, Safety Straps Armboard, Axilla, Left Arm

8. SKIN PREPARATION

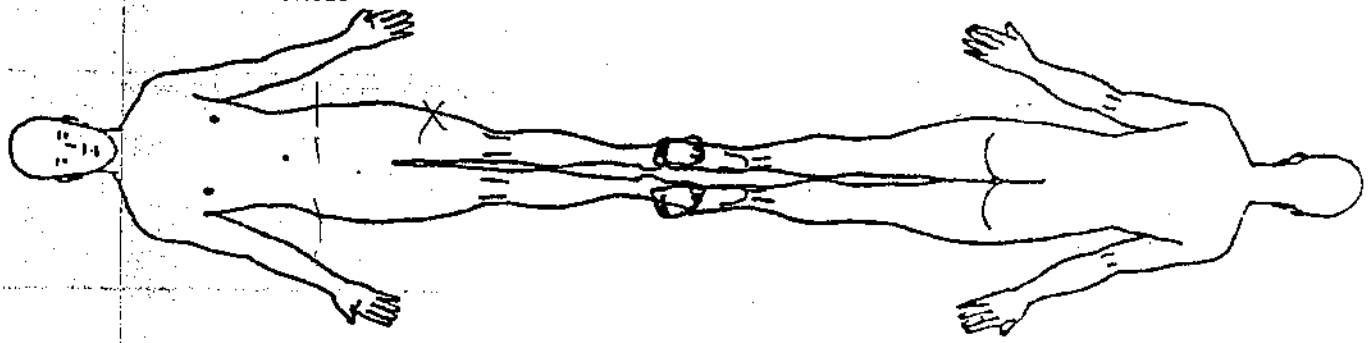
HAIR REMOVAL DONE BY: ☐ YES ☒ NO
METHOD: ☐ OR ☐ NURSING UNIT ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: N/A

PREP SOLUTION (Specify) Betadine Solution
SITE: Upper (2) Quadrant BY WHOM: NAS (b)(6)-2
SITE: Chest to Back BY WHOM:

COMMENTS: No PAD LINE, No ADVERSE RXN

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad — Safety Strap = = = Tourniquet

10. COUNTS (C = Correct I = Incorrect)

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

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

(b)(6)-4

AMEDD

(b)(6)-4

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

☒ ESU NO: 00/011
GROUND PAD: BRAND Valley Lab
LOT NO: 56773 / 2003-12

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

☐ BIPOLAR NO:

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

N/A

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
ANCEF	1gm/L		Irrigation	(b)(6)-2	Surgeon
	N/A				

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

Ancef 1gm/L

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSIC (b)(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

N/A

18. DRESSING/IMMOBILIZATION (*Specify*)

Xeroform/gauze/tape

~~Kerlix~~ (b)(6)-2 Surgeon

19. ADDITIONAL INFORMATION

Foley inserted prior to entering OR

GSW Back packed w/ 3" Kling w/ NSS

(b)(6)-2 RN, BSN 1LT

20. OPERATION(S) PERFORMED

Irrigation & closure chest gsw

Irrigation Back gsw

21. PATIENT TRANSFERRED TO ICU 1 TIME 1252 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 9rD / (b)(6)-2 RN BSN LT

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

MEDCOM - 3045

511-117

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	16 AUG 07	17 AUG	18 AUG
POST- DAY	1700 HRS		
MONTH-YEAR / DAY			
19 / HOUR			

PULSE (O) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

Bed 9

AM ER

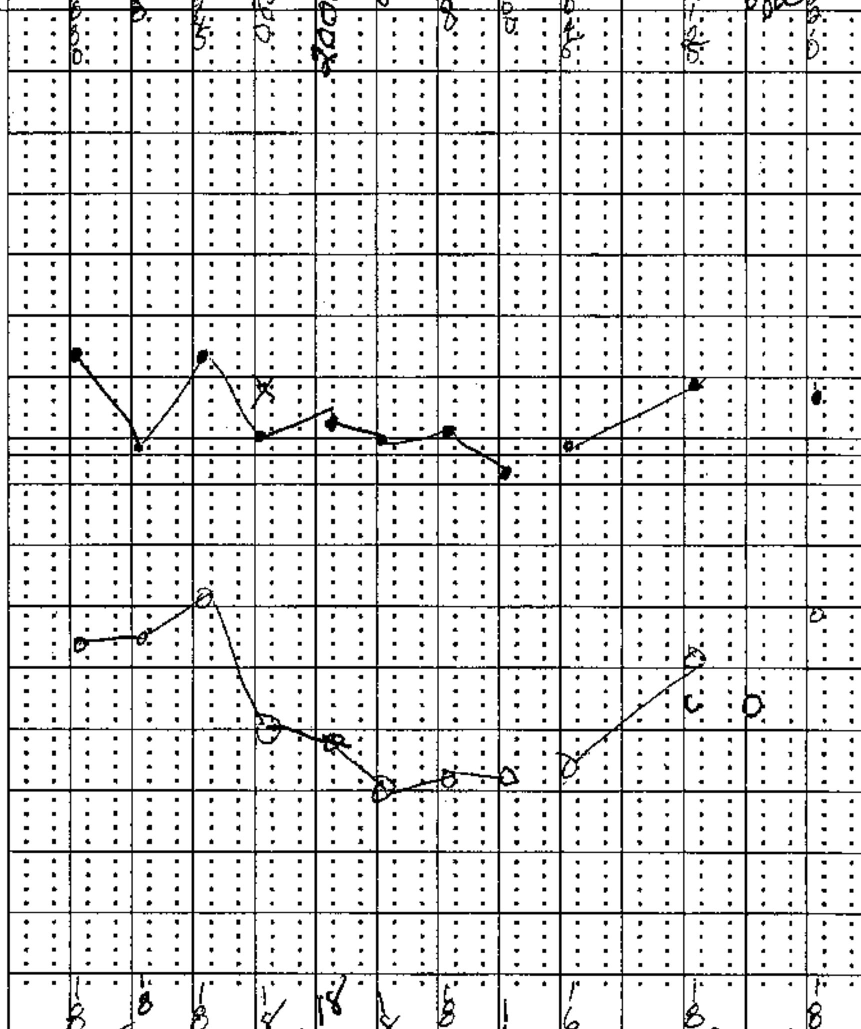
VITAL SIGNS RECORDS
Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	2002							
POST- DAY	8/4	8/5	8/6	8/7/02	8/7	8 Aug 02	09 AUG 02	
MONTH-YEAR / DAY								
19 / HOUR	2000	0800 / 1945	0800 / 2000	0800 / 2100	0800 / 2045	2125	0800 / 2210	

PULSE (O) · TEMP. F (°) · TEMP. C



RESPIRATION RECORD	18	18 / 18	18 / 18	18 / 18	16 / 16	18	18
BLOOD PRESSURE	2000 96/64	128/84; 1945 110/74	0800 122/86; 118/74	0800 116/82; 2100 120/76	0800 124/86; 2045 112/78	2125 128/68	104/68; 2210 124/70
HEIGHT: / WEIGHT →							
	SPO2 92 2000 RA	SPO2 92 1945 RA		SPO2 96 2100 RA		SPO2 95 2125 RA	SPO2 93 2210 RA

Record special data only when so ordered

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

STANDARD FORM 511 (REV. 7-91) BACK

*U.S. Government Printing Office: 1992 — 312-071/60030

(b)(6)-4

VS Q4°

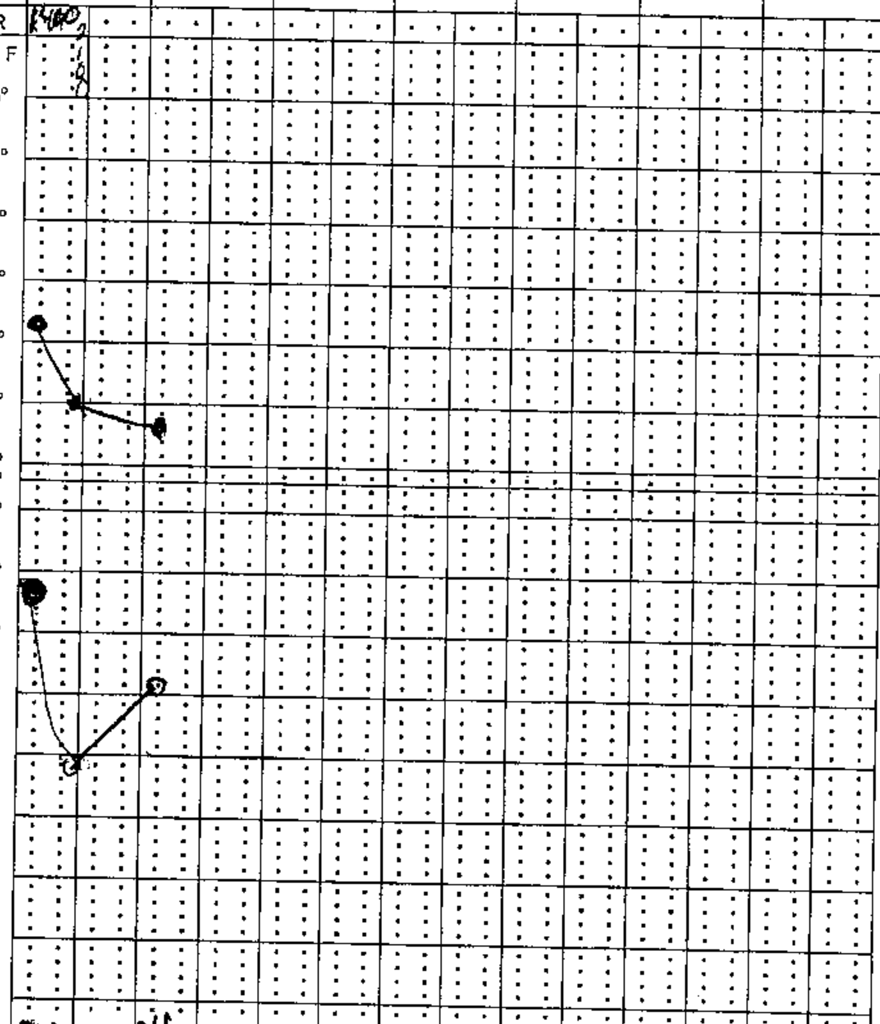
MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		
POST- DAY	8/1/07	8/2
MONTH-YEAR	DAY	
19	HOUR	1400

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

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD: 24 | 24

Record special data only when so ordered

BLOOD PRESSURE: 126/67 | 116/41
2100 119/65

HEIGHT: | WEIGHT →

2100 SPO2 99 | SPO2 99% 2100

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

(b)(6)-4

REGISTER NO. | WARD NO.

STANDARD FORM 511 (REV. 7-91) BACK

*U.S. Government Printing Office: 1992 — 312-071/60030

(b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 28 Jul 02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2							100	100	50		50	40			40		40	~~40~~		40				
Ventilator Model							AC	AC	AC		AC	AC			AC		AC			AC				
PEEP/CPAP, cmH_2O							10	10	10		10	10			10		10			10				
Vent Mode							AC	AC	AC		AC	AC			AC		AC			AC				
Volume set, ml•breath^{-1}							450	450	500		500	600			600		600			600				
Rate set•min^{-1}							12	12	14		18	16			16		16			16				
Insp. Flow Rate, l•min^{-1}							—	—	—		—	—			—		—			—				
Pres. Support, cm H_2O							—	—	—		—	—			—		—			—				
Spontaneous Rate							—	—	—		—	—			—		—			—				
Spontaneous TV							—	—	—		—	—			—		—			—				
Tot Min Vent, l•min^{-1}							5.4	5.4	9.0		9.0	9.5			9.5		9.5			9.4				
[redacted] Control cmH_2O							—	—	—		—	—			—		—			—				
Peak Airway Pressure							30	30	30		29	36			34		29			34				
Therapist's Initials																								

(b)(6)-2

BLOOD GAS LABORATORY VALUES

Time Obtained								1217	1317				1709											
Source (A or V)								A	A				A											
pH								7.192	7.379				7.483											
PCO_2 mmHg								77.0	45.1				32.3											
PO_2 mmHg								291	—				137											
tO_{2c} Vol %								20	24				25											
HCO_{3c} mmol/L								28	23				24											
ABE_c mmol/L								0	2															
tHb g/dL								—	—				—											
[redacted]%																								
SO_2 %								100	98				99											
Ca ++ mmol/L																								
Na + mmol/L								—	—				—											
K + mmol/L																								
Cl- mmol/L								—	—				—											
Tonometer PCO_2																								
Ton-Art PCO_2								—	—				—											

MEDCOM - 3049

ON-LINE PARAMETERS

Pulse Oximeter SaO_2												100	100	100			100			100				
Oximeter SvO_2																								

NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

1200 ABG results indicate excess CO_2 w/ ↓pH. ↑RR 18 ↑VT 500 ml FIO_2 5 (b)(6)-2
remains 10 PEEP A/C BS clear eq/bil. T
1317 ABG results improved - pt stable ALRT
1535 pt returned from OR intub. BS clear bil/eq. RT
1615 Dr. (b)(6)-2 order for vent: VT 600 RR 16 10 Peep FiO2 40% S/RT
ABG @ 1700 VR 65 RR 16 SAT 100 S/RT
1715 ABG drawn no changes per Dr. (b)(6)-2 S/RT
1900 pt stable, suctioned - no sputum. BS bil/eq. RT
2130 pt stable on vent VR 107 RR 16 SAT 100 BS clear/bil RT
2400 pt stable on vent RT

ADDRESSOGRAPH

EKG RHYTHM STRIPS

MEDCOM - 3051

*SEE PROGRESS NOTES:

(b)(6)-4

INTAKE CC/HR

Date 28 July 07

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR							100	100	100			100	100	100	100	100	100	100	100	100	100	100	100	100
Nimbex							5	5							5	5	7	7	7	7	7	7	7	OFF
Propofol							3	10							15	15	125	25	25	25	25	25	25	25
meds																								
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total															120	120	132	132	132	132	132	132	132	132
Cumulative Total															120	240								1300

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly								425				550					250	20	30	35	65	35	35	30
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																	250							600
Spec. Grav./U.R.																								
Gastric pH																								

MEDCOM - 3052

TRANSFUSION THERAPY

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

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV	223			
NG				
Bld				
TOTAL				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN	550			
NG				
TOTAL				

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

STAT LABORATORY DATA

Date 30 July 05

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.
1210	MSO4 5mg	IV	(b)(6)-2
1215	MSO4 5mg	IV	
1245	Fentanyl 50mcg	IV	
1300	Fentanyl 50 mcg	IV	
1730	Fentanyl 50 mcg	IV	
1950	Fentanyl 100 mcg	IV	
2100	Fentanyl 50 mcg	IV	
2200	Fentanyl 50 mcg	IV	
2300	Fentanyl 50mcg	IV	
0400	Fentanyl 50 mcg	IV	
[redacted]00	Fentanyl 50 mcg	IV	
0040	Tylenol 650 supp	PR	
0210	50mcg Fentanyl	IV	

TIME	DRUG/DOSE	Route	Init.
0430	Fentanyl 50 mcg	IV	(b)(6)-2

DRUG/DOSE	Route	Init.

Fentanyl 50-100 mcg Q1°PRN

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

(b)(6)-4

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

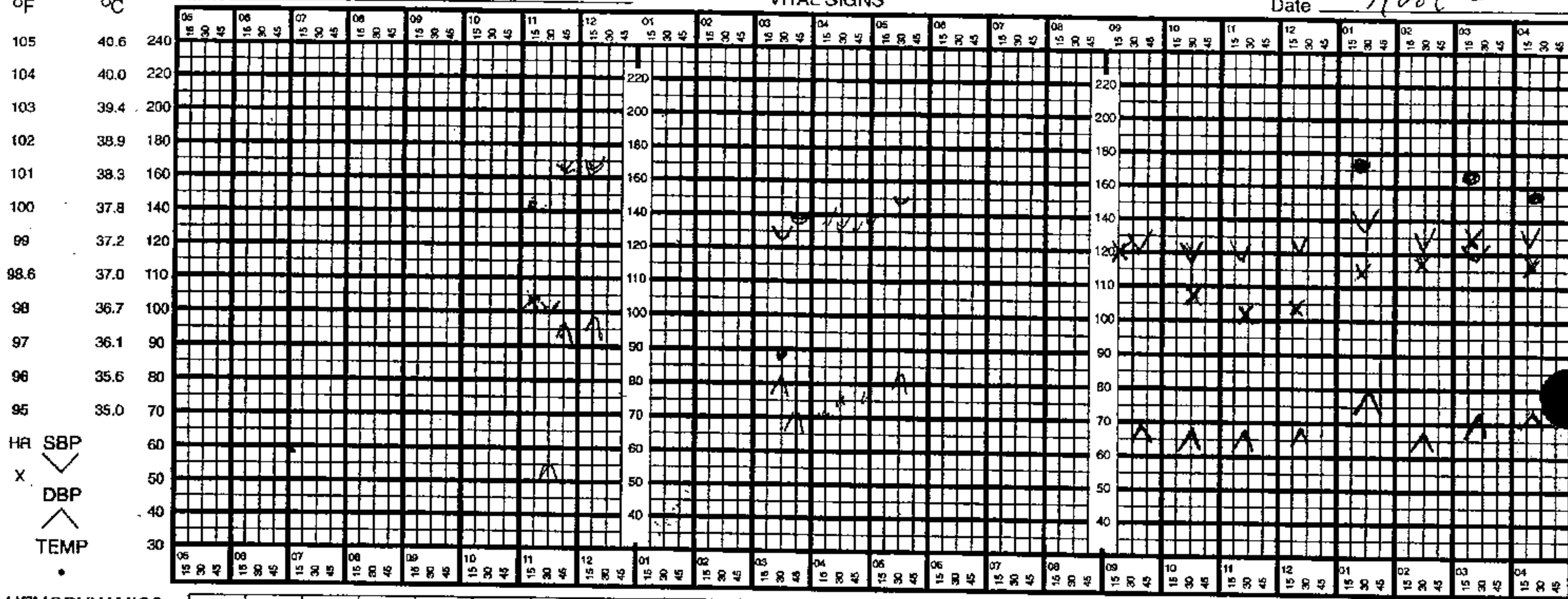
(b)(6)-2	QN	Init. (b)(6)-

*SEE PROGRESS NOTES:

Name (b)(6)-4

VITAL SIGNS

Date 7/28/02



HEMODYNAMICS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR						105	130	108	OR		68	64	90	[illegible]			120	107	101	104	114	119	121	117
Rhythm						ST	ST	ST			SR	SR	SR	SR			ST	ST	ST	ST	ST	ST	ST	ST
RESP.						12	12	12			18	18	18	16				12	18	18	18	16	16	16
CUFF BP						136/78	167/96	99/54			158/71	135/77	127/70	115/75			120/69	116/68	119/67	120/69	132/80	120/66	118/71	126/74
MAP							122	69			95						(86)	(84)	(85)	(84)	(98)	(86)	(88)	(93)
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SpO2 ~~SVRI~~						100	100	99			100	100	100	100			100	100	100	100	100	100	100	100

DRUG UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
ANCEF 1 GM																								
GENTAMYCIN 400MG IV Q D																								
NIMBEX IV TITRATE/EFFECT							5	8	5		5	5	[illegible]	5			7							
PROPOFOL IV TITRATE/EFFECT							3 3 3	10	10 10		10	10	10 15	15	15		25							
Tagamet 300mg IV BID																[illegible]								

(b)(6)-2

(b)(6)-2

MISCELLANEOUS HOURLY OBSERVATIONS

(b)(6)-2

MEDCOM - 3054

NURSING PROGRESS NOTE

1115 Admitted to ICU #1 Afghan ♂ S/P multiple GSW & misc wounds
Sedated, paralyzed intubated. (R) pupil reactive. (L) eye damaged & non reactive.
HR 80c Tas NSR s ectopy. Lungs clear. Bilateral thoracotomy incisions. ⌀
approximated c staples intact. Bilateral Chest tubes intact → Pleurevac
both draining small amt serosanguineous fluid. SubQ emphysema
present between (R) chest tube & axilla. [illegible] penetrating wound noted
posterior throat approx 6cm (L) [illegible] of Neck (L) Large open wound
present (L) anterior chest wall approx 4X8cm packed c guaze. (b)(6)-2
soft BS present x4. Multiple small misc wounds present (R) hand/face
2 wounds noted (R) Scrotum c swelling noted. Dsg & Bilateral knee
wounds dry & intact (R) foot dsg dry/intact. [illegible] given for tachycardia
@ 1210 & 1215 [illegible] c slight relief. Fentanyl given @ 1245 for more
complete relief of tachycardia & Propofol IV to 10 mcg/kg/min. To OR
for multiple wound debridements @ 1315 Returned 150[illegible]
(b)(6)-2 [illegible] ARC

(2030) Assessment complete + noted; monitor intact c alarms on;
pt. sedated c propofol + nimbex + receiving Fentanyl PRN for
pain control; NG to (R) nare + LIS c lt green/brown drainage
present; ETT secured to vent c settings of AC/16/600/40%/+10; C-
collar intact; (L) chest wound dressing intact c no active
drainage/bleeding; (R)+(L) Thoracotomy incisions c staples
intact; (R)+(L) Chest tubes secure to 20cm suction, sanguinous
drainage present in chamber; (R) lateral chest c small amount
of air noted + marked; Dressing to (R) hand c sanguinous drainage
present; scrotum c 2 small puncture wounds + no present
drainage; foley secure + patent c clear yellow urine; (R) Thigh,
calf + foot dressings dry/intact; (L) knee dressing dry/intact -CAT
(2100) Pt. awakens, tries to communicate + sit up; 50mcg Fentanyl
for pain; propofol ↑ 25mcg/kg/min; Nimbex ↑ 7mg/hour -CAT
(0100) Urine appears to have residue (cloudy) in it -CAT (0140)
Temp 101° axillary; Tylenol supp. PR x1 -CAT (0330) Nimbex
off -CAT

FORM 0021

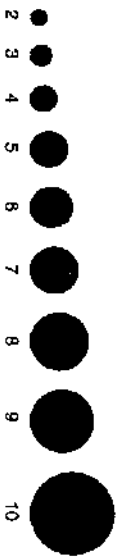
MEDCOM - 3055

☆U.S. GPO: 1997—608-276

*SEE PROGRESS NOTES:

PROCEDURES / TIME	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
NEUROLOGICAL	→ SEE CODE →		
Eyes Open (Closed by swelling = C)	4	2	
Verbal Response (ET Tube or Trach = T)	ET	ET	
Motor Response	1	5	
Pupils R - react NR - non SR - slow — Size R	2	2	
Reaction	R	R	
Size L	NR	NR	
Reaction		NR	
Hand Grasp R / L	R / L	Secured	
[illegible]ath Sounds	clear	CTA Bilat	
Sputum Character	?		
Nasal Endotracheal Suctioning Q ____			
Chest PT Q ____			
CDB/IS Q ____	(b)(6)-2		
Vent. ✓'s		CAT per RT	
E.T. Tube @ 24 cm		24	
Cuff ✓/Pr/cc's			
C.T. Strip & Vent Q ____			
C.T. Fluctuates ___/___ cm.			
[illegible]ipheral Pulses ** U		P	
L		P	
Circ. Distal to A-Line			
Monitor Alarm On		CAT	
PA Line			
CVP/Other			
Art Line			
Peripheral		CAT	
Peripheral		CAT	
PT/Family Teaching/Support			

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



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES / TIME	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
Bowel Sounds	(+)x	(+)x4	
ABD Size/Firmness	Soft/Firm	Firm Soft	
NG Secure/Proper Pos.	(b)(6)-2	CAT	
✓ Patency Q4°			
Aspirate Contin. Feed Q4			
Aspirate Prior to Bolus Feed			
Stool Char./Gualac			
Urine Color/Character	clear/yellow	clear yellow	
Foley Secure/Patent	(b)(6)-2	CAT	
External Cath.			
Catheter Care			
Colostomy/Ileostomy Care			
Bath			
Turn & Position Q ____			
Skin Care			
Mouth Care			
Trach / E.T. Care		CAT	
ROM			
Dangle			
Restraints Released Q2H			
OOB to Chair			
Ambulation			
Side Rails ↑			
Drains. Δ (A)foot		CAT	
Drains. Δ Cecilia	on	CAT	

ADDRESSOGRAPH

(b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 7/24/02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2	40		40		40	30																		
Ventilator Model	754		754		754	754																		
PEEP/CPAP, cmH_2O	10		10		5	5																		
Vent Mode	A/C		A/C		A/C	A/C																		
Volume set, ml•breath^{-1}	600		600		600	600																		
Rate set•min^{-1}	16		16		16	12																		
Insp. Flow Rate, l•min^{-1}	—		—			—																		
Pres. Support, cm H_2O	—		—																					
Spontaneous Rate	0		0		0	6																		
Spontaneous TV	—		—		—	—																		
Tot Min Vent, l•min^{-1}	9.6		9.5		9.5	9.6																		
[redacted]. Control cmH_2O	—				—	—																		
Peak Airway Pressure	35		34		29	29																		
Therapist's Initials	(b)(6)-2																							

BLOOD GAS LABORATORY VALUES

Time Obtained			0907																					
Source (A or V)			A																					
pH			7.445																					
PCO_2 mmHg			36.6																					
PO_2 mmHg			150																					
tO_{2c} Vol %			15																					
HCO_{3c} mmol/L			24																					
ABE_c mmol/L			0																					
tHb g/dL			—																					
[redacted]%			—																					
SO_2 %			99																					
Ca ++ mmol/L			—																					
Na + mmol/L			—																					
K + mmol/L			—																					
Cl- mmol/L			—																					
Tonometer PCO_2			—																					
Ton-Art PCO_2			—																					

ON-LINE PARAMETERS

Pulse Oximeter SaO_2	100		100		100									93				94						
Oximeter SvO_2																								

(b)(6)-4

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 7/29/02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR	125	500	125	125	150	150	500	185	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
Propofol	25.5	25.5	25.5	25.5	25	25	30	15	5	5	5	—								500				
MEDS				50															50					
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL								140																
Hourly Total	150	525	150	200	175	175	530	140 500	130	130	130	125	125	125	125	125	125	125	175	500	125	125	125	125
Cumulative Total	150	1675	825	1025	1100	1275	1805	1945	2075	2205	2335	2460	2585	2710	2835	2960	3085	3210	3385	3885	4010	4135	4260	4385

OUTPUT CC/HR

-15

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	30	30	45	60	50	90	200 400	1000	230	85	70	70	70	65	110	70	75	90	80	30	80		180	140
Urine Cumulative																								
(L) CT															80									10
NG Total	200															Call day	100		100					200
Emesis/Gastric																								
Stool																								
(R) CT															20									10
Output Hourly	30 230	45	60	50	90	400	1000	230	315	70	70	70	65	220	70	75	790	80	130	80		180	340	
Output Cumulative	260	305	365	415	505	905	1905	1135	1450	1520	1590	1660	1725	1945	2015	2090	2880	2960	3090	3170		3350	3740	
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

TOTAL OUTPUT

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

NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

0500 pt stable on vent, settings on reverse side of chart, ♡R 117 RR 16 SAT 100 BS clear, ET tube 8.0 2[illegible] @ lip — (b)(6)-2 /RT

0714 pt stable ABG results good, RT suggest ↓ RR & PEEP, will wait for Dr. order BS clear B/L equal tube placement 24cm @ lip cuff pressure 28 cm H2O — (b)(6)-2 /RT

0828 ↓ PEEP to 5 as per Dr. (b)(6)-2 suggestion he's recieving too much O2 — (b)(6)- /RT

1055 ABG 30 min CPAP suggests extubation @ 1115 — B6-2

RR 26 ♡R 134 SaO2 96% BS 10L 5M w/ humid. — [illegible] /RT

1430 ♡R 112 RR 28 SaO2 97 BS clear eq./bil. 5L 5M w/ humid. — B6-

1800 pt stable on 5L humidified O2 ♡R 119 RR 32 SAT 92 BS cle[illegible]

→ TMS/RT

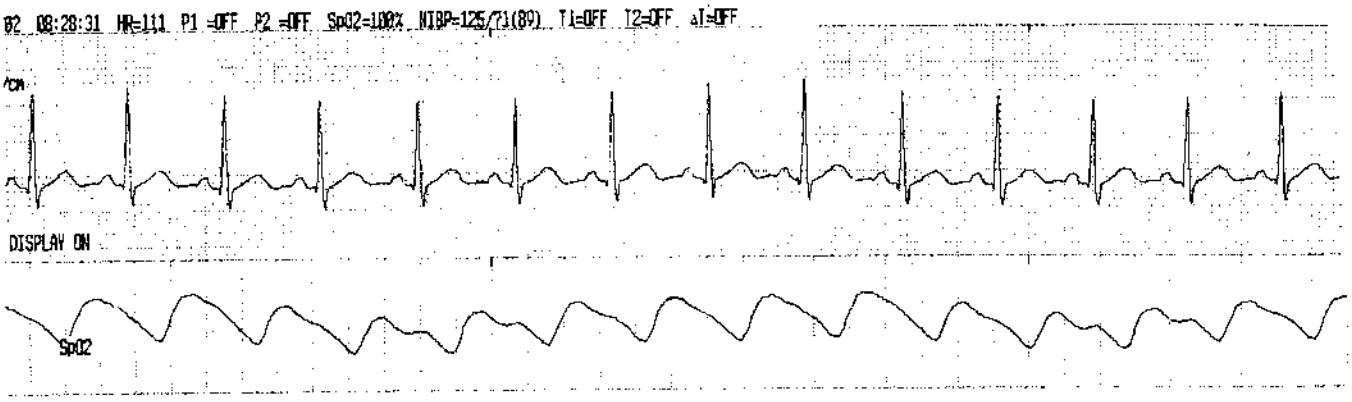
2200 pt stable on 5L humidified O2 ♡R 112 RR 30 SAT 94 BS clear — (b)(6)-2 /RT

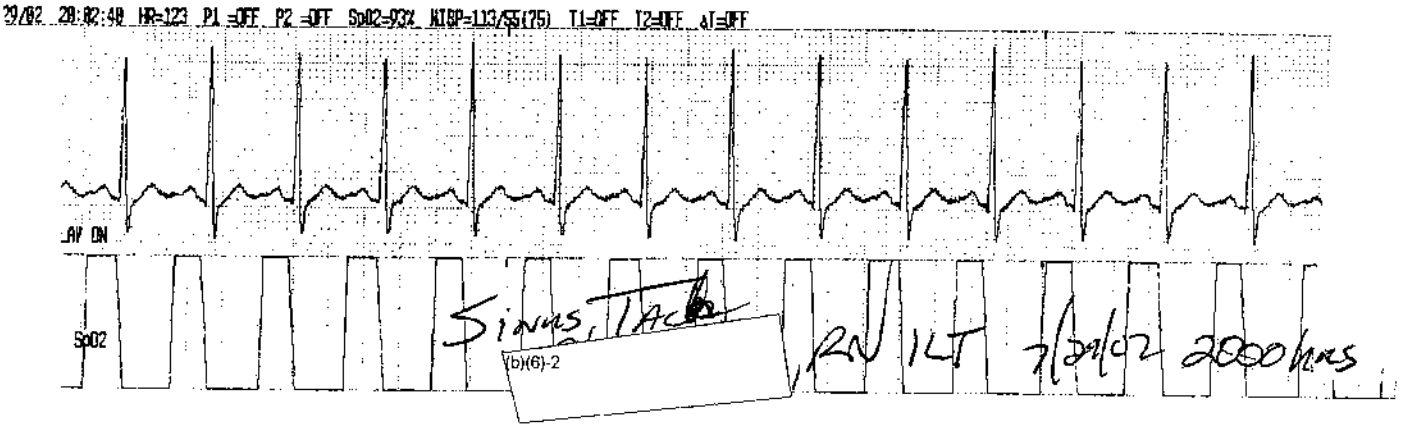
2330 pt stable on 5L humidified O2 ♡R 102 RR 27 SAT 93 (b)(6) /RT

ADDRESSOGRAPH

AM & PM (b)(6)-4

EKG RHYTHM STRIPS





ADDRESSOGRAPH

Amstrup #

(b)(6)-4

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

STAT LABORATORY DATA

Date 7/29/02

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init. (b)(6)-2
0600	50 mcg Fentanyl	IV	
0715	50 mcg Fentanyl	IV	
0815	50 mg Fentanyl	IV	
0915	50 mg Fentanyl	IV	
0920 1020	5 mg MSO4	IV	
1030	50 mg Fentanyl	IV	
1035	Lasix 40 mg	IV	
1130	50 mg Fentanyl	IV	
1230	50 mg Fentanyl	IV	
1330	50 mg Fentanyl	IV	
1515	50 mg Fentanyl	IV	
1720	50 mg Fentanyl	IV	
1830	50 mg Fentanyl	IV	

DRUG/DOSE	Route	Init. (b)(6)-2
2115 50 mcg Fentanyl	IV	
2215 50 mcg Fentanyl	IV	
2345 50 mcg Fentanyl	IV	
0140 50 mcg Fentanyl	IV	
0205 Valium 1mg IV	IV	

DRUG/DOSE	Route	Init.

Fentanyl 50-100 mcg Q1° PRN-PAIN

~~Nimbex 7mg IV Q1° D/C - 7/29/02~~

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

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

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

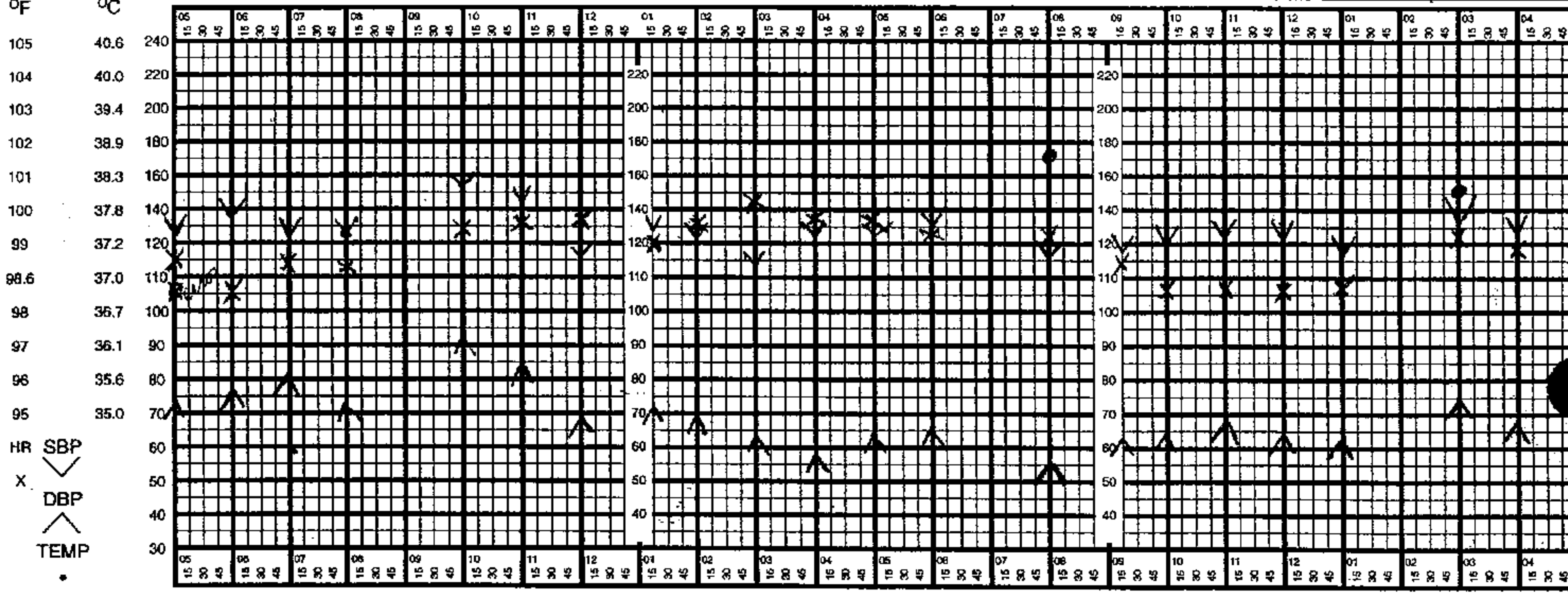
HT. _____
WGT. _____
WGT.
YESTERDAY _____
PREVIOUS DAY
INTAKE _____
OUTPUT _____
BSA _____
ALLERGIES _____
ADDRESSOGRAPH

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

Name

VITAL SIGNS

Date 7/29/02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	116	105	115	112		136	131	136	120	131	141	136	131	125		121	114	106	107	106	107		121	118
Rhythm	ST	ST	ST	ST		ST	ST	ST	ST	ST	ST	ST	ST	ST		ST	ST	ST	ST	ST	ST		ST	ST
RESP.	16	18	16	14		36	28	32	24	32	32	28	32	28			32	30	28	28	30		85	28
CUFF BP	124/73	136/76	124/81	123/71		153/92	141/83	116/67	121/71	128/69	114/63	124/58	129/63	130/65		113/55	118/62	120/69	123/67	129/63	119/62		130/75	127/67
MAP	(92)	(98)	(95)	89		111	102	92	91	90	80	86	85	84		(73)	(81)	(80)	(77)	(84)	(83)		(92)	(88)
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SpO2 ~~SVRI~~	100	100	100	100		100	93	94	94	96		94	92	92		93	94	94	93	95	97		93	92

DRUG UNITS	05	06	07	08	09	10	11 SFm	12 SFm	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gentamycin 400mg IV Q[illegible]														[illegible]		2320				[illegible]				
Propofol (Titrate)																								
Tagamet 300mg IV Q[illegible]				[illegible]												[illegible]								
Ancef 1Gm Q 8°													[illegible]								[illegible]			

MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 3062

NURSING PROGRESS NOTE

0720 - Cpt. (b)(6)-2 to see patient - at (0715) awake; reaching for ETT; 50mcg Fentanyl for pain control + sedation (b)(6)-2

0800: Pt intubated / sedated. (L) eye pupil (-) c̄ periorbital edema. # ET @ 26cm mid lip. VF ↑ to 150 cc/HR for ↓ u.o. NGT to LIS. Bilat CT to sx, (-) drainage. Foley to gravity c̄ orange juice type urine. Nimbex d/c'd on night shift. Propofol at 25 mcg/kg/hr (25 cc). Brisk capillary refill to bilat LE. Lungs c̄ few coarse rhonchi bilat. Lt chest dsg intact. See Resp notes for vent settings. (b)(6)-2 1LT ANC

0920: Pt for CXR. Awaking + reaching for ET tube. Bolused c̄ 3 cc Propofol for ↑ sedation for Xray. (b)(6)-2 1LT ANC

0925: Propofol bolus effective. 1LT ANC

0950: Nimbex 7mg IVP given as per order. 1LT ANC

1020: Started weaning ventilation. See Resp notes.

1030: Propofol ↑ to 30 mcg/kg/min. (b)(6)-2 1LT ANC

1115: Propofol weaned to 5 mg/kg/min. Pt extubated. Tolerating PM well. Pt alert enough for interpreter to explain surgeries. Pt acknowledged understanding. Requested food. Foley draining large amts of clear urine. Propofol to be d/c'd after this bottle completed. (b)(6)-2 1LT ANC

1300: Pt verbalizing pain in (R) hand / (L) ankle. Asked for the time in English. Explain to pt extent of surgeries + also explained that he will be medicated for pain frequently. Told pt to take deep breaths + cough. Pt complied c̄ deep breathing. Will continue to monitor frequently. (b)(6)-2 1LT ANC

1500: Propofol D/C'd at this time. (b)(6)-2 1LT ANC

(2015) Assessment complete + noted; NPO; pt. denies pain; monitor intact c̄ alarms on; C-collar intact; NG to (R) nare + LIS; (L) chest wound dressed c̄ tegaderm, dark brown drainage present; Bilateral CT's to 20cm suction + intact c̄ serosanguinous drainage present in chambers; bilateral thoracotomy incisions c̄ staples intact / no drainage; foley patent + draining; (L) knee dressing dry / intact; (R) leg dressings dry / intact; pt able to move (R) foot on command; scrotal wounds not draining (b)(6)-2

NURSING PROGRESS NOTE

(2045) PCXR for fever + Rhonchi - at (2045) Ice Chips c̄ difficulty - at (2220) C/O (L) elbow pain; 50mcg Fentanyl - at (0130) Pt. frequently awake, demanding H_2O; explained about NPO, constantly trying to remove (L) arm from sling (b)(6)-2

FORM 0021

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES / TIME	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
NEUROLOGICAL	→ SEE CODE →		
Eyes Open (Closed by swelling = C)	ET	3	
Verbal Response (ET Tube or Trach = T)	ET	5	
Motor Response	3	6	
Pupils R - react NR - non SR - slow — Size R	4	4	
Pupils — Reaction	NR	R	
Pupils — Size L	6	(b)(6)-2	
Pupils — Reaction	N		
Hand Grasp R / L	— / —	T / T	
[redacted]ath Sounds	Bilat Rhonchi	Right Rhonchi	
Sputum Character	—		
Nasal Endotracheal Suctioning Q PRN	PRN		
Chest PT Q ____	—		
CDB/IS Q ____	—		
Vent. ✓'s	PRN		
E.T. Tube @ 26 cm	✓		
Cuff ✓/Pr/cc's	✓		
C.T. Strip & Vent Q ____	—		
C.T. Fluctuates / —cm.	—		
[redacted]ripheral Pulses ** U	+ P	P	
[redacted]ripheral Pulses ** L	Brisk R	R=Weak L=P	
Circ. Distal to A-Line	—		
Monitor Alarm On	Yes	(b)(6)-2	
PA Line	—		
CVP/Other	—		
Art Line	—		
Peripheral	(R) arm	(b)(6)-2	
Peripheral	(L) arm		
PT/Family Teaching/Support	—		

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

**PULSE CODE

DOPPLER . . . . . D
PALPABLE . . . . . P
STRONG . . . . . S
WEAK . . . . . W
ABSENT . . . . . A
FLEETING . . . . . F

PROCEDURES / TIME	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
Bowel Sounds	Hypo x4	(+) x4	
ABD Size/Firmness	S/NT	Soft	
NG Secure/Proper Pos.	✓	(b)(6)-	
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	—		
Aspirate Prior to Bolus Feed	—		
Stool Char./Guaiac	—		
Urine Color/Character	Orange Juice	Clear Amber	
Foley Secure/Patent	✓	(b)(6)-2	
External Cath.	—		
Catheter Care	✓	(b)(6)-2	
Colostomy/Ileostomy Care	—		
Bath	—		
Turn & Position Q ____	—		
Skin Care	—		
Mouth Care	—		
Trach / E.T. Care	✓		
ROM	—		
Dangle	—		
Restraints Released Q2H	—		
OOB to Chair	—		
Ambulation	—		
Side Rails ↑	—		
Drsng. Δ	—	CAT	
Drsng. Δ	—	CAT	

ADDRESSOGRAPH

AMERN

#(b)(6)-4

(b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 7/30/02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2																								
Ventilator Model																								
PEEP/CPAP, cmH_2O																								
Vent Mode																								
Volume set, $ml \bullet breath^{-1}$																								
Rate $set \bullet min^{-1}$																								
Insp. Flow Rate, $l \bullet min^{-1}$																								
Pres. Support, cm H_2O																								
Spontaneous Rate																								
Spontaneous TV																								
Tot Min Vent, $l \bullet min^{-1}$																								
[redacted] Control cmH_2O																								
Peak Airway Pressure																								
Therapist's Initials																								

BLOOD GAS LABORATORY VALUES

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

ON-LINE PARAMETERS

Pulse Oximeter SaO_2																96								
Oximeter SvO_2																								

(b)(6)-2

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 7/30/02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR	150	150	150	150	150	150	50	50	300	150	150	150	OR			125								125
MEDS				50	50							50	OR			50			50		50			
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds			35		25	50				25														
ORAL																								
Hourly Total	150	150	150	200	200	200	50	50	300	175	150	200												
Cumulative Total	150	300	450	650	850	1050	1100	1150	1450	1625	1775	1975												

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	185	110	120		550	100	100	25	30	130	100	180							300					
Urine Cumulative		295	415		765	865	965	990	1020															
(L) CT								0																
(R) CT								0																
Emesis/Gastric (NG)								800																
Stool																								
Output Hourly																								
Output Cumulative	185	295	415																					
Spec. Grav/U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

TOTAL OUTPUT

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

NURSING PROGRESS NOTE

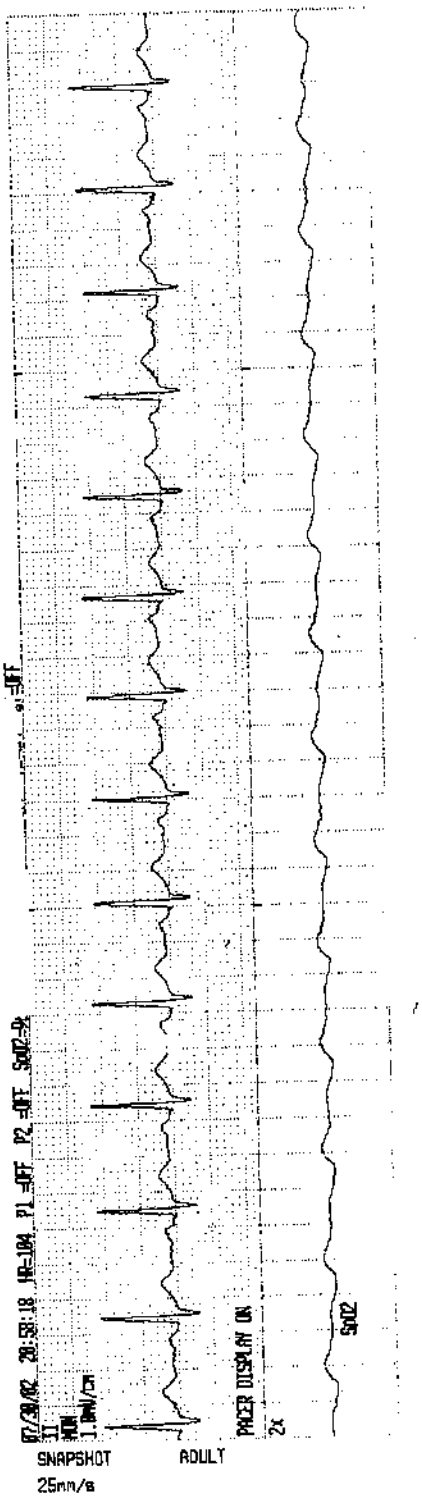
RESPIRATORY PROGRESS NOTE

1330 NC 2L no humid. SaO2 97 BS diminished — (b)(6)-2 RT

2030 NC 5L no humidity ♡R 100 RR 24 SAT 97 BS diminished (b)(6) /RT

ADDRESSOGRAPH

EKG RHYTHM STRIPS



PROTOCOL SYSTEMS, INC.

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

STAT LABORATORY DATA

Date 1/30/06

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0530	50mcg Fentanyl	IV	(b)(6)-2						
0740	50mcg Fentanyl	IV							
1000	Tylenol 650mg	PO							
1230	Fentanyl 50mcg	IV							
1500	Fentanyl 50mcg	IV							
1700	Fentanyl 50mcg	IV							
1900	Fentanyl 50mcg	IV							
2000	Demerol 12.5mg	IV							
22:00	MSO4 5mg	IV							
0:10	MSO4 5mg	IV							
0200	Fent 50mcg	IV							
0400	Fent 50mg	IV							

Fentanyl 50~~mg~~ mcg Q1° PRN PAIN
Tylenol 650mg Supp OR Q4-6° PRN

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

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

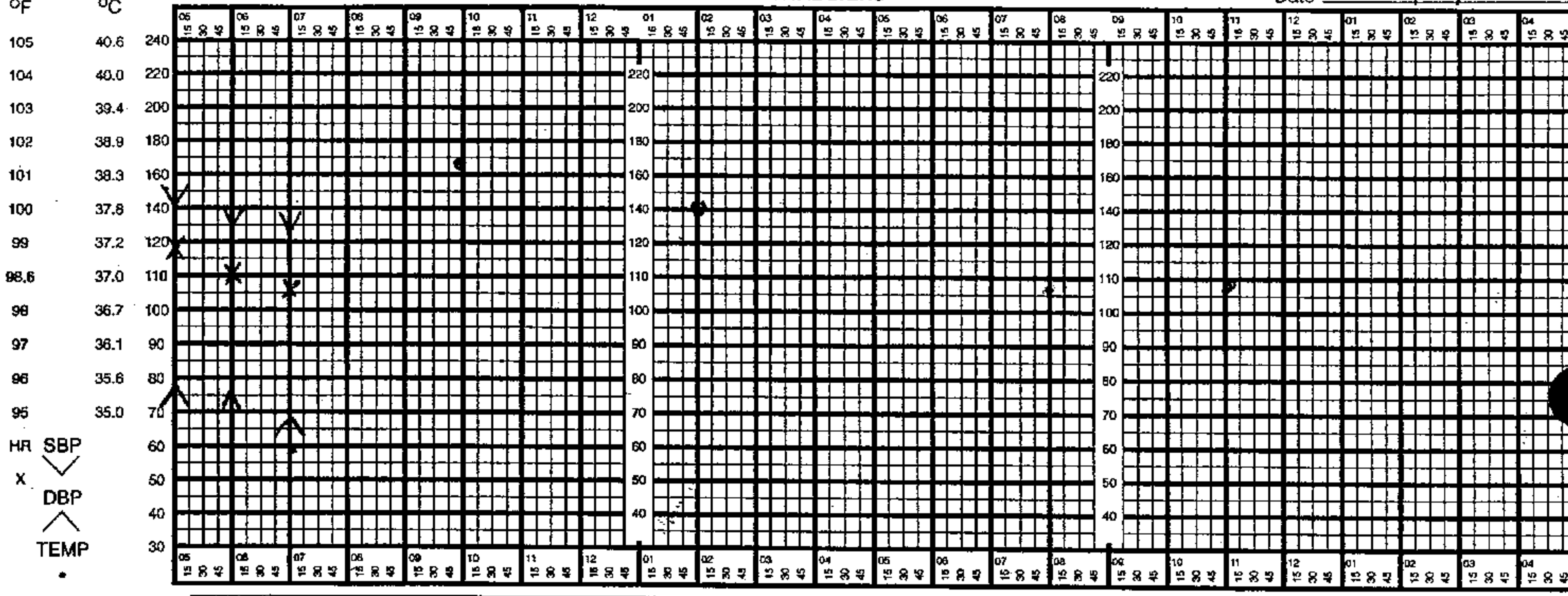
ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

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

Name ______ **VITAL SIGNS** Date 7/30/02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04
HR	119	110	105	103	103	96	[illegible]	[illegible]	97	94	98	101
Rhythm	ST	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR	ST
RESP.	35	32	26	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CUFF BP	140/78	135/75	129/67	127/60	104/48	131/72	116/60	85/[illegible]	118/65	130/64	133/66	134/67
MAP	(98)	(95)	(86)	84	82	91	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAS/PAD												
PCW												
CVP												
CO/CI												
SPO2 ~~SVRI~~	91	96	97	96	96	97	90	96	97%	95	95	95

HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04
HR				104	105	106	109		103		85	
Rhythm				SR	SR	SR	SR		SR		SR	
RESP.				22	[illegible]	16	14					
CUFF BP				152/92	143/[illegible]	131/64	135/67		131/61		130/63	
MAP				105	104	[illegible]	(93)		(84)			
PAS/PAD												
PCW												
CVP												
CO/CI												
SPO2 ~~SVRI~~				95%	98%	94%	94.		94%		95%	

DRUG	UNITS
Gent 400mg IV QD	
Ancef 1gm IV Q8H	
Tagamet 300mg IV BID	

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

MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 3070

NURSING PROGRESS NOTE

0500 Awake Alert Oriented. Lungs clear bilaterally. HR 90's (R) Tachycardia.
(L) eye damaged as previously noted ē change. Bilateral Thoracotomy incisions
well approximated ī staples intact. Bilateral chest tubes → Pleurevacs
draining scant serosanguineous fluid ē Air leaks. Cast Splint → (R) lower leg
dry intact. (R) Foot warm ī good capillary refill, motor. Foley draining clear
Amber urine.
Responsive, c/o back pain, repositioned PRN,

NURSING PROGRESS NOTE

MEDCOM - 3071

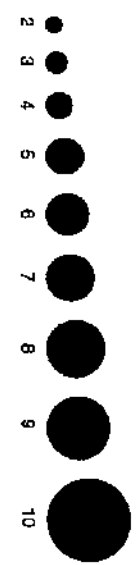
FORM 0021

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

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

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



**PULSE CODE

DOPPLER	D
PALPABLE	P
STRONG	S
WEAK	W
ABSENT	A
FLEETING	F

PROCEDURES / TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(b)(6) +4		
ABD Size/Firmness	Flat (b)(6) Ft		
NG Secure/Proper Pos.	(b)(6) -2		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	\		
Aspirate Prior to Bolus Feed	\		
Stool Char./Guaiac	\		
Urine Color/Character	Clear Amber		
Foley Secure/Patent	(b)(6)-2		
External Cath.	\		
Catheter Care	\		
Colostomy/Ileostomy Care	\		
Bath	\		
Turn & Position Q ____	(b)(6)-2		
Skin Care			
Mouth Care			
Trach / E.T. Care			
ROM			
Dangle	\		
Restraints Released Q2H	\		
OOB to Chair	\		
Ambulation	\		
Side Rails ↑	(b)(6)-2		
Drsing. △			
Drsing. △			

ADDRESSOGRAPH

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

STAT LABORATORY DATA

Date 11/21/06

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init. (b)(6)-2
0732	Fentanyl 50mcg	IV	
1000	Furosemide 20mg	IV	
1045	Fentanyl 50mcg	IV	
1130	Fentanyl 50mcg	IV	
1345	Fentanyl 50 mcg	IV	
1545	Fentanyl 50mcg	IV	
1700	Fentanyl 50mcg	IV	
1730	Fentanyl 50mcg	IV	
2100	Fentanyl 50 mcg	IV	
0200	" " "	IV	
0500	" " "	IV	
0030	Fentanyl 50 mcg	IV	
0200	Fentanyl 50 mcg	IV	

DRUG/DOSE	Route	Init. (b)(6)-2
0330 Fentanyl 50 mcg	IV	
0500 F		

DRUG/DOSE	Route	Init.

Fentanyl 50mg Q1° PRN Pain

Tylenol 650 mg Supp PR Q4-6° PRN

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

SIGNATURE AND INITIALS
NURSE/RESP. THERAPIST

(b)(6)-2	(b)(6)-
(b)(6)-2 RT ANC	

MEDCOM - 3073

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

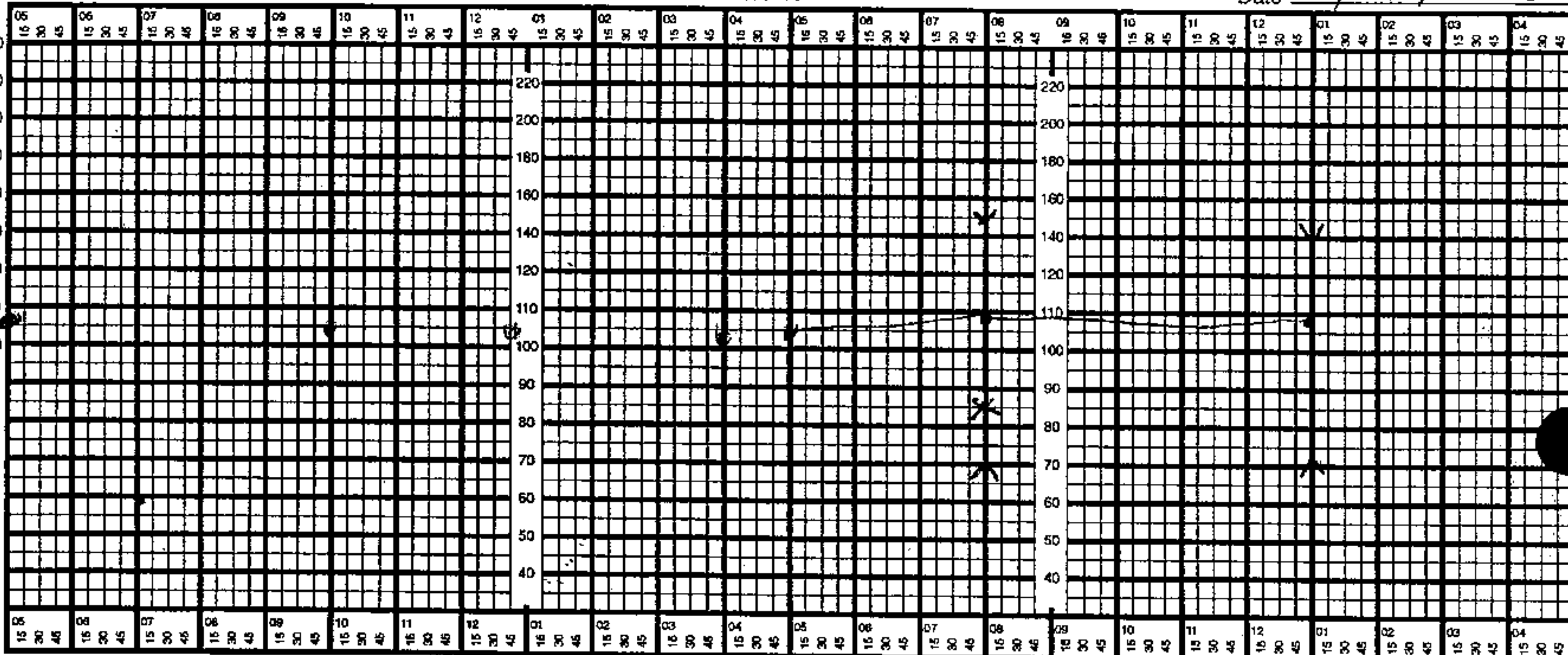
Name ______

VITAL SIGNS

Date 7/31/02

°F	°C	
105	40.6	240
104	40.0	220
103	39.4	200
102	38.9	180
101	38.3	160
100	37.8	140
99	37.2	120
98.6	37.0	110
98	36.7	100
97	36.1	90
96	35.6	80
95	35.0	70
		60
		50
		40
		30

HR x, SBP ∨, DBP ∧, TEMP •



HEMODYNAMICS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	85		70	76	75	83	87	80	77	78	96	100	72			85					81			98
Rhythm	SR		SR	SR	SR	SR	SR	SR					SR			SR					SR			
RESP.	[illegible]		18	26	23	20	20	18					22			20					18			
CUFF BP	137/71		144/64	139/80	140/71	135/69	135/74	138/74				135	136/75			144/70					140/72			
MAP			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					95			96					94			
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SpO2 ~~SVRI~~	97		99	97	94	96	97	96	76	95	76	100	96			96					97			

V 5 85 SR 20 144/75 100 100

DRUG UNITS

DRUG UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gent 400 mg IV QD					(b)(6)-2								(b)(6)-2						(b)(6)-2					
Ancef 1gm IV Q8H																					(b)(6)-2			
~~[illegible] 300 mg IV[illegible]~~																(b)(6)								
Oc[illegible] [illegible]									(b)(6)-2		(b)(6)-2		(b)(6)-2		(b)(6)-2		(b)(6)		(b)(6)-		(b)(6)		(b)(6)-	

MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 3074

NURSING PROGRESS NOTE

06:00 - Pt Slept Part of night - AT Parts During
night Pt Restless - Frequently Asks for H_2O.
USS - OO - QS Clear yellow via Foley cath.
Dressing OK. CDI. CT - Drainage minimal.
Sero/Sang Drainage. Medicated During night
for Pain. —— 1LT (b)(6)-2 RN

0830 Awake Alert oriented Restless. Lungs clear bilaterally. HR 80s-90s
NSR [illegible]. (L) shoulder [illegible] dry & intact. Bilateral thoracotomy
incisions well approximated c staples intact. Bilateral chest tubes →
Pleurevac draining scant serosanguineous fluid. [illegible]
[illegible]. (R) [illegible] dsg dry & intact. (R) [illegible] c [illegible]
Chest tubes Removed by LTC [illegible] 1100. [illegible] @ 1200.
[illegible] shoulder [illegible] CXR → Chair [illegible] assistance 1330-1730
Tolerated well. Tolerating liquids well PO. Drsg → Posterior chest wall
Δ for large amt musty smelling Blue Green drainage. (R) Posterior
shoulder wound 3x4cm x 2-3cm deep. (L) Posterior shoulder wound
3x3cm x 3cm deep. Packing Δ [illegible] covered c [illegible]
(b)(6)-2 [illegible] AN

2130 VS 98.4 F - 85 regular - 20 even and nonlabored,
lungs clear bilaterally - 144/70. Pulse oximetry 96%.
Drsgs to both sides of chest, (L) anterior chest and
(R) foot clean and intact. Pedal pulse ⊕ (R) foot.
Urine 800cc in Foley bag, dark yellow, Foley patent.
IV (R) arm running LR 100cc/hr. 2L nasal cannula
running. (L) leg cuff nonbinding. (L) foot warm,
strong pedal pulse. Given 50 mcg Fentanyl @ 2100 for
pain. Drank 1 cup cold water, 1 orange juice. (b)(6)-2 1LT AN

NURSING PROGRESS NOTE

FORM 0021

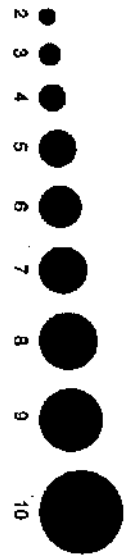
MEDCOM - 3075

☆U.S. GPO: 1997—508-276

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

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

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



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

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

ADDRESSOGRAPH

*SEE PROGRESS NOTES: (b)(6)-2

INTAKE CC/HR

Date 7/31/02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR@100	100	100	100	100	100	100	100	100	100	50	50	50	100											
													50											
Meds																								
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds					50			50			50													
ORAL					50			50			50													
Hourly Total																								
Cumulative Total																								

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	700				160		140	160				200										1600		
Urine Cumulative																600						2200		
(1) CT	60																							
(2) CT	20																							
Emesis/Gastric()																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav/U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

TOTAL OUTPUT

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

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 1 AUG 0C

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0500	Fentanyl 50 mcg	IV	(b)(6)-2						
0700	4 mg MSO4	IV							
0900	Fentanyl 50 mcs	IV							

IV Fentanyl 50mg q1° PRN pain

Tylenol 650 mg supp PR q 4-6° prn

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2 1LT ANC	(b)(6)-

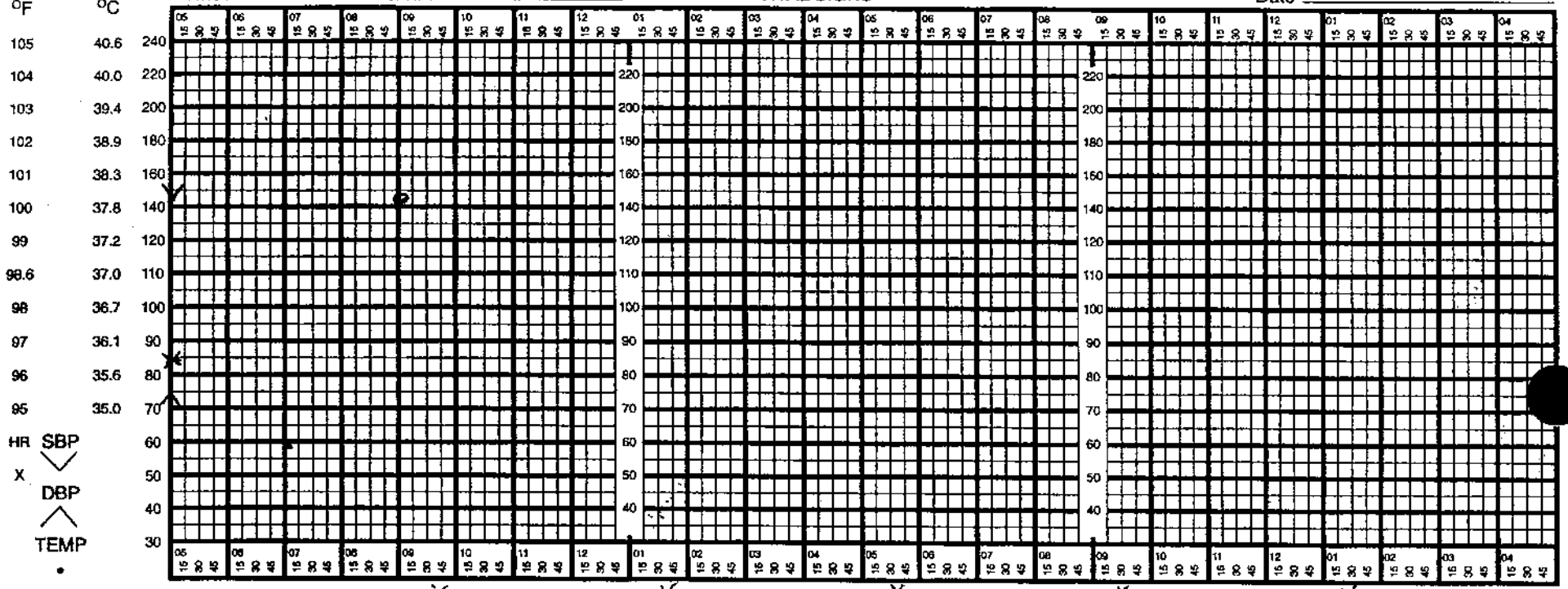
(b)(6)-4

*SEE PROGRESS NOTES:

Name (b)(6)-4

VITAL SIGNS

Date 1 AUG 02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	85					85																		
Rhythm	SR			SR		SR																		
RESP.	20					20																		
CUFF BP	144/76			128/76		128/76																		
MAP	100					93																		
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
pulse oximetry ~~SVRI~~	100			100		94																		

DRUG	UNITS	05	06	07	08	09	10	11	12	13	14	15	16	17	06	07	08	09	10	11	12	01	02	03	04
Gent. 400mg IV q8						(b)(6)-2																			
Ancef 1gm IV q8'																									
				(b)(6)-2		(b)(6)-2																			
OcoPlex 1 gtt OU q2																									

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

0800 Awake Alert Oriented Resp easy lungs clear bilaterally HR 90's 100% NSR → ST ē ectopy. Bilateral thoracotomy incisions approximated ē staples intact. (L) anterior shoulder dsg dry/intact. Bilateral posterior shoulder dsgs dry/intact. (R) leg dsg dry/intact. (R) foot warm ē good capillary refill. OOB → chair for BM. Transferred to ICW @ 1300.

(b)(6)-2

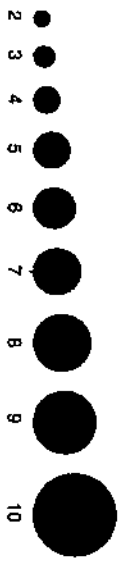
CPT AN

NURSING PROGRESS NOTE

*SEE PROGRESS NOTES:

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

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



**PULSE CODE

DOPPLER	D
PALPABLE	P
STRONG	S
WEAK	W
ABSENT	A
FLEETING	F

PROCEDURES	OBSERVATIONS		TREATMENTS
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+) (b)(6)-2		
ABD Size/Firmness	G/F Soft		
NG Secure/Proper Pos.	✓		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	✓		
Aspirate Prior to Bolus Feed	✓		
Stool Char./Guaiac	✓		
Urine Color/Character	Clear Amber		
Foley Secure/Patent	✓		
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	✓		
Bath	✓		
Turn & Position Q ____	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	(b)(6)-2		
ROM	✓		
Dangle	—		
Restraints Released Q2H	—		
OOB to Chair	—		
Ambulation	✓		
Side Rails ↑			
Drsng. △			
Drsng. △			

ADDRESSOGRAPH

(b)(6)-4

NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

07[15] - Disp D to back wounds - repacked + dressed
ī wet→dry NSS —— (b)(6)-2 ILT/MC

ADDRESSOGRAPH

(b)(6)-4

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 1 AUG 02

INTAKE

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR	100	100	100	100	100	100	100																	
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

MEDCOM - 3083

OUTPUT CC/HR

OUTPUT

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly		900				800																		
Urine Cumulative		900																						
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

TOTAL OUTPUT

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

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 4/11/09 U.A.

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
2240	Fentanyl 50mcg	IV	(b)(6)-2						
0100	Fentanyl 50mcg	IV							
0300	Fentanyl 50	IV							
0452	Fentanyl 50	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

ADDRESSOGRAPH

(b)(6)-4

Advana Dict as directed
Ancef 1 Gm IV Q8°
Gentamycin 400 mg IV QD
LR @ 100 cc/HR
Tylenol 650 mg supp PR Q 4-6° PRN
Fentanyl 50 mcg IV Q1° PRN pain

AM & PM

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

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

MEDCOM - 3084

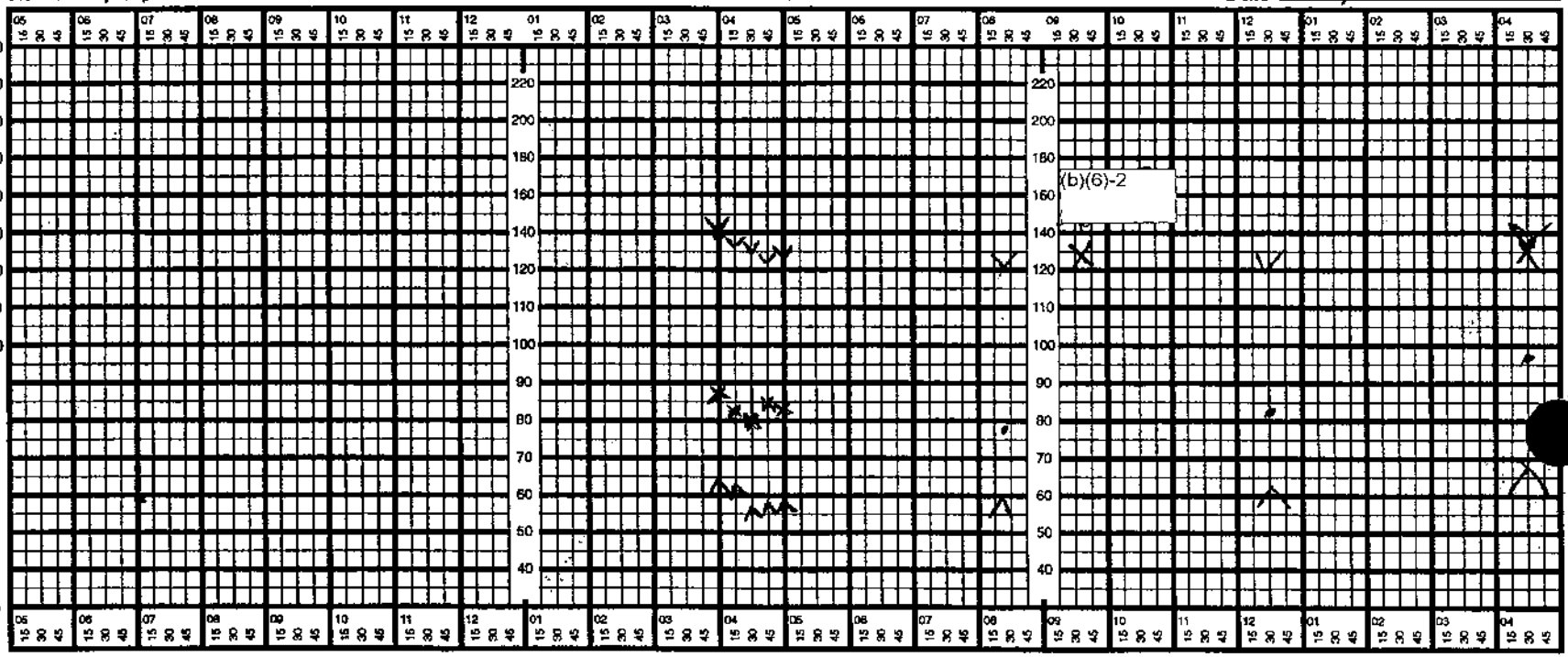
*SEE PROGRESS NOTES: (b)(6)-4

Name _____

VITAL SIGNS

Date 2 Aug 02

°F	°C	
105	40.6	240
104	40.0	220
103	39.4	200
102	38.9	180
101	38.3	160
100	37.8	140
99	37.2	120
98.6	37.0	110
98	36.7	100
97	36.1	90
96	35.6	80
95	35.0	70
HR	SBP	60
X	DBP	50
	TEMP	40
	•	30



HEMODYNAMICS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR												88	83		97	97				82				97
Rhythm												SR	SR		SR	SR				SR				SR
RESP.												24	20		20	20				20				20
CUFF BP												140/94	128/58		130/70	120/70				120/80				130/66
MAP															93					83				
PAS/PAD																								
PCW																								
temp CVP																	4/4							3
CO/CI																								
SaO2, ~~SVRI~~												100	100		100	100				96%				93%

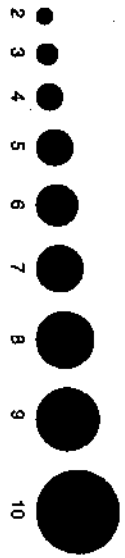
DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gentamycin 400mg IV														(b)(6)-2						(b)(6)-2					
QD																									
Ancef 1Gm IV @ 8°																									

MISCELLANEOUS HOURLY OBSERVATIONS

*SEE PROGRESS NOTES:

PROCEDURES / TIME	OBSERVATIONS 7 - 4	TREATMENTS 4 - 12	TREATMENTS 12 - 8
NEUROLOGICAL	→	SEE CODE	→
Eyes Open (Closed by swelling = C)		4	
Verbal Response (ET Tube or Trach = T)		5	
Motor Response		6	
Pupils R - react NR - non SR - slow: Size R		WNL	
Reaction		WNL	
Size L		WNL	
Reaction		WNL	
Hand Grasp R / L		weak R-splint	
[redacted]th Sounds		CTA	
Sputum Character		—	
Nasal Endotracheal Suctioning Q ____		—	
Chest PT Q ____		—	
CDB/IS Q ____		BNC	
Vent. ✓'s		—	
E.T. Tube @ ____		—	
Cuff ✓/Pr/cc's		—	
C.T. Strip & Vent Q ____		—	
C.T. Fluctuates ___/___ cm.		—	
[redacted]pheral Pulses ** U		RF) F	
L		LF) (+)	
Circ. Distal to A-Line		—	
Monitor Alarm On		—	
PA Line		—	
CVP/Other		—	
Art Line		—	
Peripheral		RH [redacted]	B6-2
Peripheral		—	
PT/Family Teaching/Support		—	

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



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES / TIME	OBSERVATIONS 7 - 4	TREATMENTS 4 - 12	TREATMENTS 12 - 8
Bowel Sounds		(+)4	
ABD Size/Firmness		SNT	
NG Secure/Proper Pos.		—	
✓ Patency Q4°		—	
Aspirate Contin. Feed Q4		—	
Aspirate Prior to Bolus Feed		—	
Stool Char./Guaiac		—	
Urine Color/Character		CL yellow	
Foley Secure/Patent		(b)(6)-2	
External Cath.		—	
Catheter Care		—	
Colostomy/Ileostomy Care		—	
Bath		—	
Turn & Position Q ____		SW	
Skin Care		—	
Mouth Care		(b)(6)-2	
Trach / E.T. Care		—	
ROM		SW	
Dangle		—	
Restraints Released Q2H		—	
OOB to Chair		—	
Ambulation		—	
Side Rails ↑		—	
Drsing. Δ		D&I	
Drsing. Δ		—	

ADDRESSOGRAPH

AMEPW (b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 2 Aug 02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2																								
Ventilator Model																								
PEEP/CPAP, cmH_2O																								
Vent Mode																								
Volume set, $ml \bullet breath^{-1}$																								
Rate set $\bullet min^{-1}$																								
Insp. Flow Rate, $l \bullet min^{-1}$																								
Pres. Support, cm H_2O																								
Spontaneous Rate																								
Spontaneous TV																								
Tot Min Vent, $l \bullet min^{-1}$																								
[redacted] Control cmH_2O																								
Peak Airway Pressure																								
Therapist's Initials												(b)(6)-2												

BLOOD GAS LABORATORY VALUES

Time Obtained																			2303					
Source (A or V)																								
pH																								
PCO_2 mmHg																								
PO_2 mmHg																								
tO_{2C} Vol %																								
HCO_{3C} mmol/L																								
ABE_C mmol/L																								
[redacted]Hb g/dL																								
[redacted]b %																								
$[redacted]O_2$ %																								
Ca ++ mmol/L																								
Na + mmol/L																								
K + mmol/L																								
Cl- mmol/L																								
Tonometer PCO_2																								
Ton-Art PCO_2																								

ON-LINE PARAMETERS

Pulse Oximeter SaO_2												100		100			99		95					
Oximeter SvO_2																								

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 2Aug02

INTAKE

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR @100															100	100	100	100	100	100	100	100	100	100
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

MEDCOM - 3088

OUTPUT CC/HR

OUTPUT

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly											200													
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

TOTAL OUTPUT

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

Pt 106

NURSING PROGRESS NOTE	RESPIRATORY PROGRESS NOTE
1600 Admitted to ICU #1 Bed #4 post operatively, On 10L SM, SaO2 100% [illegible]. VSS. T 100, Bilat eye [illegible] intact, (L) upper chest, (R) chest, (L) chest [illegible] intact. (L) [illegible] slightly [illegible] Poly drain clear yellow urine. IVF [illegible] @ 100cc/Hr, Abd soft, (+) BS. [illegible], Pt shackled to bed. MP [illegible] — (b)(6)-2 [illegible]	1600 pt brought out of OR on supplemental O2 10L SM ♡R 91 RR 21 SAT 100 BS clear — (b)(6)/RT
2000 assumed care — (b)(6)-2 [illegible]	1800 pt stable on 4L NC ♡R 81 RR 18 SAT 100 BS clear (b)(6)/RT
2200 - DSgs to bilat. eyes D&I, awake, alert. N. site RFA leaking, Δ'd to R hand - infusing LR @ 100° - site intact. VSS. Pulse ox 99% on 1L O2 NC. Staples intact [illegible] other incisions. SR on monitor. DSg D&I to bilat ribs (outer) and (L) collarbone area. (+) cap refill (brisk) to (R) foot, splint intact. sling intact to (L) arm. Foley patent & drng clear yellow urine. — (b)(6)-2 [illegible]	2124 pt stable on 4L NC ♡R 88 RR 16 SAT 99 BS clear (b)(6)/RT
addendum - Ice chips given - tolerated well — (b)(6)-2 [illegible]	2303 pt stable/sleeping 2L ~~humidified~~ unsat NC ♡R 93 RR 28 SAT 94 BS clear (b)(6)/RT
add 50mcg fentanyl given IV for c/o (L) shoulder pain - area clean dry - dsg intact — (b)(6)-2 [illegible]	

ADDRESSOGRAPH

AM EPW #(b)(6)-4

MEDCOM - 3089

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 2 NOV 05

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.
0800	Fentanyl 50mg	IV	(b)(6)-2
1000	Fentanyl 50mg	IV	
1430	Fentanyl 50mcg	IV	
1600	Tylenol 650mg	PO	
1700	Fentanyl 50mg	IV	
1845	Fentanyl 50mg	IV	
2037	Fentanyl 50mg	IV	
2327	Fentanyl 50mg	IV	
0125	Fentanyl 50mg	IV	
0230	Fentanyl 50mg	IV	
0330	Fentanyl 50mg	IV	

DRUG/DOSE	Route	Init.

DRUG/DOSE	Route	Init.

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

Advance diet as tol
Ancef 1 gm IV Q8°
Gent 400mg IV QD
LR@ 100°
tylenol 650mg supp PR Q4-6° prn
Fentanyl 50 mcg IV Q 1° prn pain
Tylenol 650mg PO Q4-6° PRN

SIGNATURE AND INITIALS

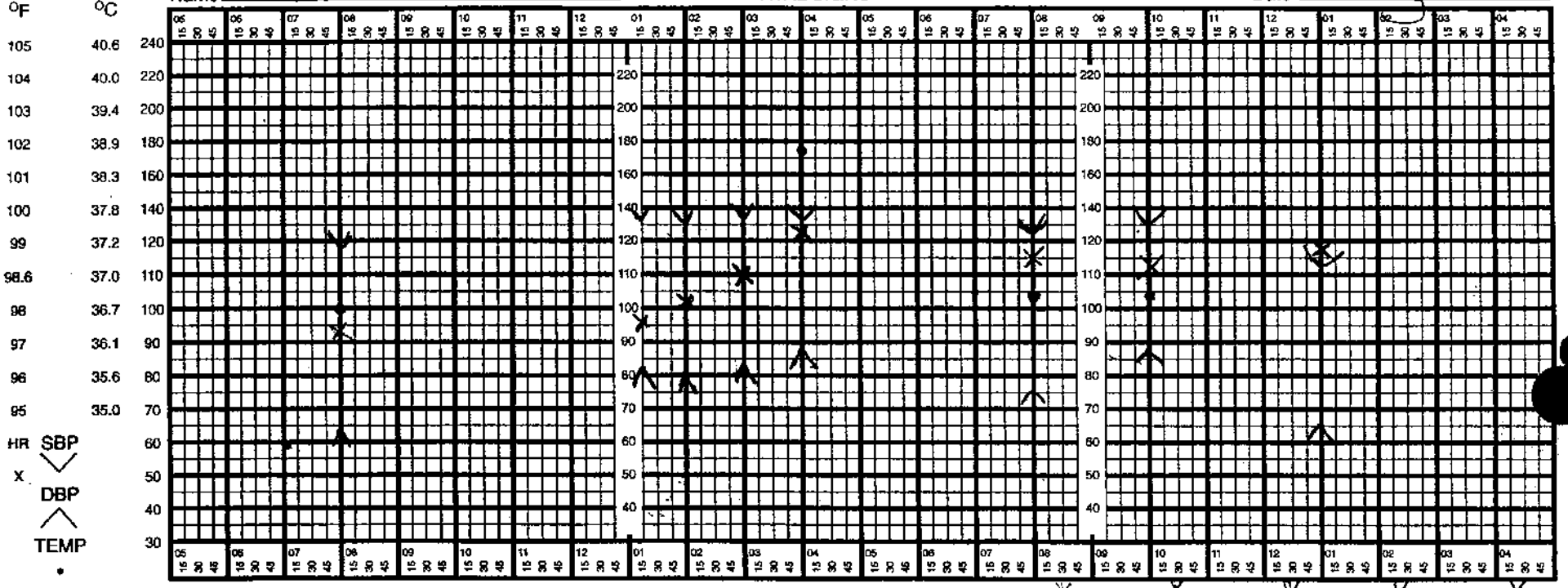
NURSE/MEDD THERAPIST	Init/
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	
(b)(6)-2	

AM & PM

(b)(6)-4

MEDCOM - 3090

*SEE PROGRESS NOTES: Name (b)(6)-4 VITAL SIGNS Date 3AUG02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR				94					97	102	110	186				115		111			119		103	
Rhythm				SR																				
RESP.				23					19	25	35	23				21		18			20		22	
CUFF BP				154/92					133/92	131/80	134/83	135/87				145/75		130/86			116/66		129/71	
MAP																								
PAS/PAD																								
PCW																								
Temp ~~CVP~~				36.7								101.8				101.1		101.5					98.7	
CO/CI																								
SaO2 ~~SVRI~~				98% 2LNC					95%	97%		100%				95%		88%			96		93	

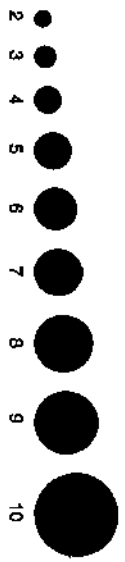
DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gent 40mg IV QD																				(b)(6)-2					
Ancef 1gm IVPB					(b)(6)-2							(b)(6)-2									(b)(6)-2				
Pred forte 1 gtt OD QID													(b)(6)-2							(b)(6)-2					
Atropine 1% 1 gtt OU BID																									
Oxuflox 1 gtt OS Q2°														(b)(6)-2											
Oxuflox 1 gtt OD QID																									

MISCELLANEOUS HOURLY OBSERVATIONS

*SEE PROGRESS NOTES:

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

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



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

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

ADDRESSOGRAPH

AMEPW # [redacted]

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 3 Aug 02

INTAKE

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR @ 100																								
LR @ 100	150	100	150																					
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

MEDCOM - 3093

OUTPUT CC/HR

OUTPUT

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	1325													525										
Urine Cumulative																						2000		
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative	1325																							
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

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

TOTAL INTAKE

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

TOTAL OUTPUT

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

NURSING PROGRESS NOTE

0300 dsgs Δ'd to bilat back c NS W→D. Irrigated c NS - & packed, covered c DSD. Large amt of green/bloody dsng - 2 exit wounds c red tissue - foul smelling. Premedicated c Fentanyl 50 mcg. —— (b)(6)-2

0820 Responds to verbal stimuli, Oriented (L)+(R) chest

0823 Dr. I (R)LE dsg c splint intact, (L) arm sling, IVF infusing

c difficulty. Foley draining clear yellow urine, shackled to bed.

MP present. medicated c 50mg fentanyl IVP for c/o pain (b)(6)-2

2044 - Stable dressings on eyes, chest and Foot clean and secure, HR is at 107, BP - 125/77 SpO2 - 92, R - 25, T - 100.7, IV line in (R) arm running good. GS wound on (L) shoulder Threw all both sides. GS w. Too (R) Foot, (L) knee wound Lung sound clear and equal, he has wounds too both eyes can't see out of OD and minimum out of OS

ADDRESSOGRAPH

AMEPW # (b)(6)-4

3 Aug 02

RESPIRATORY PROGRESS NOTE

MEDCOM - 3094

*SEE PROGRESS NOTES: (b)(6)-2

STAT LABORATORY DATA

Date 7/14/06

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

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0528	Fentanyl 50 mcg	IV	(b)(6)-2						
0630	Fentanyl 50 mcg	IV							
1015	Fentanyl 50 mcg	IV							
1345	Percocet ##	PO							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

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

ADDRESSOGRAPH

(b)(6)-4

Advance diet as tol
AQ cef 1gm IV Q8°
Gent 400 mg IV QD
LR @ 100°
Tylenol 650mg supp PR Q4-6° PRN
Fentanyl 50 mcg IV Q1° PRN Pain
Percocet ## PO Q4-6° PRN

AM EPW

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

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

MEDCOM - 3095

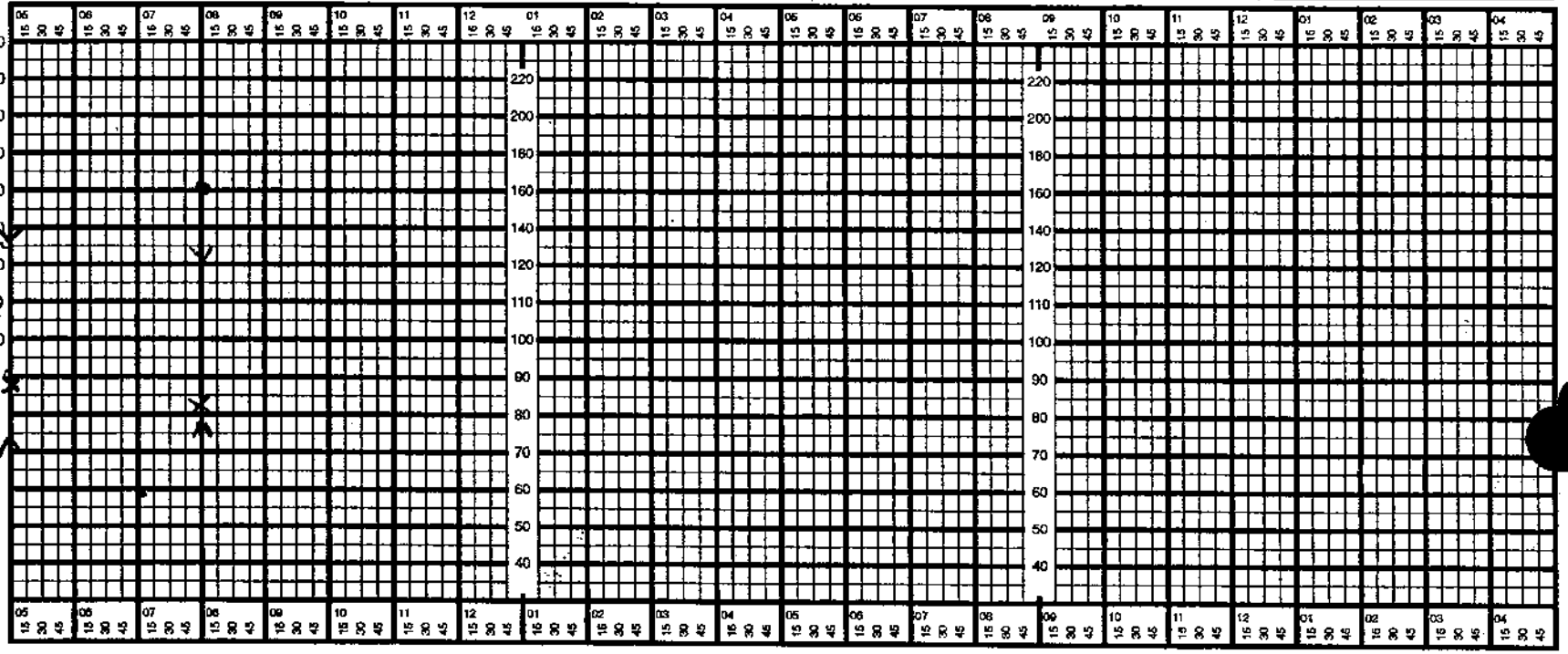
*SEE PROGRESS NOTES: Name (b)(6)-4

VITAL SIGNS

Date 4/Aug02

°F	°C	
105	40.6	240
104	40.0	220
103	39.4	200
102	38.9	180
101	38.3	160
100	37.8	140
99	37.2	120
98.6	37.0	110
98	36.7	100
97	36.1	90
96	35.6	80
95	35.0	70
		60
		50
		40
		30

HR SBP X DBP TEMP *



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	84			80																				
Rhythm																								
RESP.	19			28																				
CUFF BP	126/74																							
MAP				134/79																				
PAS/PAD																								
PCW																								
Temp ~~CVP~~				101.6																				
CO/CI																								
SpO2 ~~SVRI~~	94%																							

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gentamycin 400mg IV q D																									
Ancef 1gm IV q 8°																									
Pred Forte - gtt OD																									
Atropine 1% - gtt OU																									
Ocuflox - gtt OS Q2																									
Ocuflox - gtt OD Q4																									

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

MISCELLANEOUS HOURLY OBSERVATIONS