INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		Iraqi				

11. EMP	12.	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICW3

15. FLYING STATUS	16 RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	2100	ABFA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	Home	6 May 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		4 May 03	

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

31 SELECTED

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

E991 Grenade

Soft tissue inj to both thighs, r arm, penis, & left groin

916.9 959.1

Dressing 93.57

959.09
69610 CPT
911.0
890.0
884.0

35. **Total Days This Facility**

a. AESFNT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
					250.00

36. **Total Days All Facilites**

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

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

LTC, MC

GENERAL SURGEON

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 | OF 1 AUG 76 IS OBSOLETE | USAPPC V1.00

MEDCOM - 4687

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION

11. EMP CLASS	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		

15. PAYING STATUS	16. RATING DSG	17. DEPT / BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					Inj

21. SOURCE OF ADMISSION AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	2100	AEAA

24. NAME RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	Home	6 May 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		4 May 03	

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES OPERATIONS AND SPECIAL PROCEDURES

Soft tissue inj to both thighs, R arm, penis & Left groin

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER

=original signed=

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1

MEDCOM - 4688

PROGRESS NOTES

DATE	
4 May 03 2200	VS 110/60, 20, 96%, 87, 98.9°, Pt has wounds to (R) outer thigh, Stitches in Place, 4X4 to (L) Lower Thigh and Perineal area, & complaints @ this time. [redacted] granule/sgt
4 May 03 2330	PT received from Evening SGT. FS BG 267 - NPH [redacted] 30 sum SQ ABD. PT Ate eat Evening Meal. MM Soft tissue wounds S S/S of complication. PT C/O Pain Med
5 May 03 0030	& Tr T#3 PO. [redacted] MNT MN V.S. 118/72 68 16 98.7 Pain Med effective. [redacted] MNT MN
0600	Pt resting and slept throughout remainder of shift. [redacted] MNT MN
5MAY03	VSS- Glucose 109 30 NPH administered. BP 120/76 P-76. RR-19 SAO2 99% Pt resting in bed. At 0830. Orders given to take the Am before breakfast. 10U. Given 30 NPH after breakfast. Several wounds soft tissue wounds. WD Dsg to Upper (L) thigh dsg CDI. Upper (R) thigh dsg Dsg CDI also. No complaints of pain from Pt. Large amounts CA Bilat. BS active +4 Foley Cath patent C3 sacral on all activities. [redacted] granule
5 May 03 1500	VS 110/60, 72, 98, 20, T. 98.2°, Pt resting in Bed, & complaints, dsg to RLE CDI, Packing in Place & Stitches. Will continue to monitor. [redacted] granule/sgt

☆U.S. GPO: 1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4689

MEDICAL RECORD	PROGRESS NOTES
DATE	
5 May 03 2350	V.S. 118/72 68 16 98.4; PT's has incisional wounds post-op several weeks old. that are c/s/s of complications. PT resting c complaint. [redacted] MAT HM
6 May 03	VS - BP 120/80, HR-67, 99.0, SAO2 98%
0300	Chronic, Inc. 30 ml PH given [redacted] spt [redacted] given
6 May 03	Pt D'cd to home, ambulatory, Pt states
0300	Understanding of instructions, Drsg changed prior to D'C, Pt has meds for home use, instructions and follow-up procedures explained for drsg change. [redacted] 4 Kim 6/sgt

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. ____ Yr. ____

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6
4May03	(b)(6)-2	VS - PR	07			
			15			
			23			
4May03	(b)(6)-2	Activity as tolerated	07			
			15			
			23			
4May03	(b)(6)-2	Diet - Regular	07			
			12			
			17			

ALLERGIES. ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Set of tissue wounds, IDDM

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	1%	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA

MEDCOM - 4691

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo MAY Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4May03	(b)(6)-2	cond- Stable ADMT TO FCN-3	4 May	NOW	~2200	(b)(6)-2

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

USAPA V1

MEDCOM - 4692

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE (MEDICATIONS)

For use of this form, see AR 40-7; the proponent agency is the Office of The Surgeon General.

Mo.____ Yr.__

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6
4May03	[redacted]	Continue Current Insulin	07	/		
		dose A/C in Am	15	[redacted]		
			23	[redacted]		
4May03	[redacted]	NPH 34 U Before	07	[redacted]		
		1/2 evening meal	18	[redacted]		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Sec of DM Tissue wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted]

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 **9** 10 11 **12** 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 **02** **03** **04** 05 06

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

MEDCOM - 4693

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
4 May 03	(b)(6)-2	MSO4 2-5mg IV q 3-6° prn	
4 May 03	(b)(6)-2	Tylenol #3 1-11 po q 4-6° prn	0030 SMart (b)(6)-2

ADMISSION AND _ODING INFORMATION

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

1 REPORTING MTF (Code) — 2 LOCATION — 3 REGISTER NUMBER — NAME (Last, First, Middle Initial) — 4 PAY GRADE — 5 SEX

6 DATE OF BIRTH (Y Y Y Y M M D D): 19550101 — 7. AGE AT ADMISSION: 48 — 8. RACE: X — 9. ETHNIC BACK-GROUND: 9 — RELIGION

10 LENGTH OF SERVICE — ETS — 11. FMP: 99 — 12. SOCIAL SECURITY NUMBER

ORGANIZATION (Active Duty Only) — 13 MARITAL STATUS: 2 — HOUR OF ADMISSION — BRANCH / CORPS

14 FLYING STATUS — 15. BENEFICIARY CATEGORY: K91 — 16. ZIP CODE OF RESIDENCE: 093300000

17 UNIT LOCATION (State or Country Code) — 18 MOS — 19. TRAUMA: Inj — PREV. ADMISSION YEAR / NO

20 SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: E&I — WARD — NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE — ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) — NAME AND LOC — TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21 TYPE OF DISPOSITION: 05 Home — 22. MTF TRANSFERRED TO — 23 DATE OF DISPOSITION (Y Y M M D D): 20030401

24 CLINIC SVC. ADMITTING: AEAA — 25 MTF TRANSFERRED FROM — 26. DATE THIS ADMISSION (Y Y M M D D): 20030504

27 LOCATION OF OCCURRENCE (Battle Casualty Only): IZ — 28 MTF OF INITIAL ADMISSION — 29. DATE INITIAL ADMISSION (Y Y M M D D)

FOR LOCAL USE DX: 88111
99012
8905
8901
8781
87271
25000
E9919
soft tissue inj to both thighs, R arm, penis, & groin
Px: 8622 8674 8015.194
Trauma 1
Inj 445

ADMITTING OFFICER (Signature as required): EBHS
=original signed=

DA FORM 2985, MAR 89

MEDCOM - 4695

ADMISSION A CODING INFORMATION

For use of this form, see AR 40.400; proponent agency is OTSG

1. REPORTING MTF LOCATION (State or Country Code): (b)(3)-1

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:

8. RACE: Hisp

9. ETHNIC BACK-GROUND:

RELIGION:

10. LENGTH OF SERVICE:

ETS:

11. FMP: 9 9

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS:

HOUR OF ADMISSION:

BRANCH / CORPS:

14. FLYING STATUS:

15. BENEFICIARY CATEGORY:

16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or County Code):

18. MOS:

19. TRAUMA:

PREV. ADMISSION YEAR:

NO: X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: D

WARD: ICU2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: Home

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): 03 05 06

24. CLINIC SVC - ADMITTING: A B A A

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): 03 05 04

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

Soft tissue inj to both thighs R arm, penis, & L groin

ADMITTING OFFICER (Signature as required): (b)(6)-2, MC

FTC, MC

GENERAL SURGES

(b)(6)-2

(b)(6)-2

DA FORM 2985, MAR 89

MAY 79 IS OBSOLETE

MEDCOM - 4696

(b)(3)-1

Name: (b)(6)-4

CHCS Name: (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Good

Date of Admission: 4/10/2003

Date of **Transfer:**

History:

48 y/o Iraqi male, multiple soft tissue wouns from a hand genade, ***5*** days prior to admission. Wounds to rt elbow, left groin, bilateral thihgs, and penis.

Hospital Course:

Pt developed infected hematoma rt thigh. Cultures + for acinitobacter/enterobacter. Wounds healing by secondary intention with advancement every three days. Afebrile, nl wbc, DM well controlled. Needs assistance with ambulation. AD TM perf repaired,

Diagnoses:

Soft tissue injuries to both thighs, right arm, penis and left groin; Diabetes Mellitus type 2; AD TM perf

Surgeries/Treatmen

DPC wounds after I&D 15 Apr 03, I&D Rt thigh infected hematoma/abcsess 17 Apr 03; Extraction of schrapnel'fromleft hip joint 20 Apr 03; DPC wounds after extraction of schrapnel Rt thigh 23 Apr 03, SIP right tympanoplasty 25APR

Recommendations:

Soft tissue wound care, oral DM medication, NPH Insulin for tight control until wounds healed. FIU with Medicine, ENT, General Surgery or Ortho.

SpecialNeeds:

Completed Primaxin course. PT for gait and ROM . Wet to dry NS dressing changes. NS W to D changes BID. Change cotton ball in right ear daily and start cortisporin ear drops 3 drops BID for 10 davs in rioht ear. no water in the ear.

Physician:

(b)(6)-2 CDR Dept of General Surgery

5/3/2003

(b)(3)-1

(b)(6)-4

CHCS Name: (b)(6)-4

(b)(6)-4 EPW

Date of Admission: 411012003

Date of Transfer:

Age: Gender: M

History:
48 ylo Iraqi male, multiple soft tissue wouns from a hand genade, 5 days prior to admission.

Hospital Course:
Pt developed infected hematoma rt thigh. Cultures + for acinitobacter/enterobacter. Wounds healing by secondary intention
with advancement every three days. Afebrile, nl wbc, DM well controlled. Needs assistance with ambulation

Diagnoses:
Soft tissue injuries to both thighs, right arm, penis and left groin, Diabetes Mellitus type 2, AD TM perf

Surgeries/Treatment:
DPC wounds afler I&D 15 Apr 03, DPC wounds afler extraction of schrapnel Rt thigh 23 Apr 03, Extraction of schrapnel from
left hip joint 20 Apr 03

Recommendations:
Soft tissue wound care, oral DM medication, **NPH** and sliding scale insulin for tight control until wounds healed. Gait assistance with walker of crutches.

Special Needs:
Continue primaxin for 4 days. PT for gait assistance. ENT Tympanoplasty if perf doesn't heal. Wet to dry NS dressing changes. Small sites we use iodoform gauze.

Prognosis: Good

Physician: (b)(6)-2 CDR Dept of General Surgery 4/24/2003

MEDCOM - **4698**

CLINICAL RECORD

ABBREVIATED MEDICAL RECORD
(Sign all notes)

TRIAGE CATEGORY (Circle one)
Immediate
Delayed
Minimal
Expectant

ate: 10 Time: 1530 arrived on board USNS Comfort

ansported by: (Circle one) Helo Boat Pier Other

IA: (Circle one) LITTER AMBULATORY

GE: 47 HEIGHT (ft' in"): Weight (lbs):

ISTORY: Pt camp to (b)(3)-1 with X MGW X 5 days.

ALLERGIES: UKNA
CURRENT MEDS: Pills for Diabetics
PAST ILLNESSES: Diabetic
LAST MEAL: (Date) 09NOV03 (Time) Dinner
Events Preceding injury: Hand Grenade, Rebelled to Iraqi Soldiers.

VITAL SIGNS	TIME	TEMP	PULSE	B/P	RESP RATE	GCS	~~CAP REFILL (pressure)~~
ADMISSION	1530	101.9	94	106/66	24	15	sp02 95%
DISCHARGE							

Pupils: (Circle one) = OR ≠

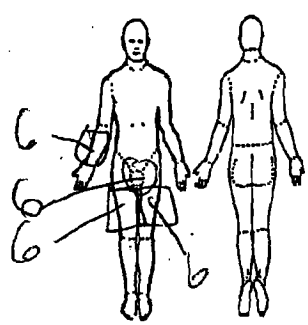
L reactive / sluggish / fixed (Circle one)
R reactive / sluggish / fixed (Circle one)

L ● ● ● ● ●
R ● ● ● ● ●

INJURIES

1. Airway Obstruction ☐ Yes ☐ No
2. Breath Sounds (+ / -)
3. Hemorrhage
4. Laceration
5. Puncture
6. Wound
7. Trauma, Amputation
8. Concussion
9. Fracture
10. Dislocation
11. Burn
12. _____
13. _____

BURN
1° ____ %
2° ____ %
3° ____ %



LAB
Hb/Hct
Lytes/BUN/Glue
ABG
UA
T&C 4 units
PT, CMP

XRAY
C-spine
CXR
Abdominal
IVP
Extremity

Glasgow Coma Score (GCS)

		Points
A. Eye Opening		
	Spontaneous	4
	To voice	3
	To pain	4
	None	1
		(Total "A")
B. Verbal Responses		
	Oriented	5
	Contused	4
	Inappropriate words	3
	Incomprehensible words	2
	None	1
		Total "B"
C. Motor Responses		
	Obeys command	6
	Localize pain	5
	Withdraw (pain)	4
	Flexion (pain)	3
	Extension (pain)	2
	None	1
		Total "C"

DIAGNOSIS:

~~Level of Consciousness~~ (LOC) (Circle one)
A - Alert
V - Responds to Vocal Stimuli
P - Responds to Painful Stimuli
U - Unresponsiveness

Continue on reverse side

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 F
STANDARD FORM 539
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
510-110

MEDCOM - 4699

b)(3)-1

CASUALTY RECEIVING

MEDICAL TREATMENT RECORD (*continued*)

AIRWAY nasal ▮ oral Incubate nasal ▮ oral _____ mm tube @ _____ cm teeth ▮ nares

OXYGEN Room Air Face Mask @ 12 L / min OTHER _____

TUBES CHEST TUBE: size ▮ site _____

N/G: guaiac neg/pos _____

FOLEY: dipstick blood neg ▮ pos _____

IV SITES	SIZE
L Forearm	18G

IV SOLUTION	AMT INFUSED
#1 NS	~~1000cc~~
#2	300cc
#3	
#4	

BLOOD PRODUCTS	AMT INFUSED

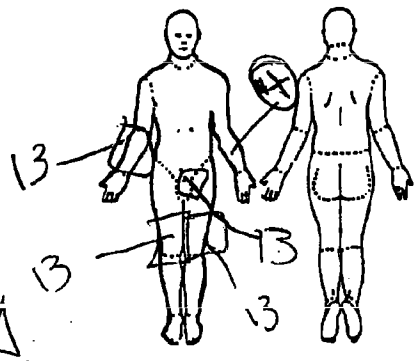
PERITONEAL LAVAGE

Comments _____

Results: (Circle one) **POSITIVE** **NEGATIVE**

TREATMENTS.

1. Oxygen
2. Cricothyrotomy
3. Tracheotomy
4. IV Sites
5. Pressure Dressings
6. MAST
7. Apply Hemostat
8. Sutures
9. Tourniquet
10. Bandage
11. Splint
12. Cast
13. Dressing
14. _____



OUTPUT

Chest Tube _____ cc

Gastric _____ cc

Foley _____ cc

TOTAL INTAKE _____ cc **TOTAL OUTPUT** _____ cc

MEDICATIONS	Dose	Route	Time	Initials
Morphine	5mg	IVP	1813	(b)(6)-2
Mefoxin				
Ancef	1gm	IVPB	1900	(b)(6)-2
Tet Tox				
Hypertet				

MEDICATIONS	Dose	Route	Time	Initials

DATE	HOUR AM.	HOUR P.M.	TRANSFERRED Time: _____ to OR ICU BURN ICU WARD: _____

☆ U. S. GPO: 1987-181-247/60056

MEDCOM - 4700

(Reverse)

MEDICAL RECORD | PROGRESS NOTES

TE

48 y/o Iraqi male, 5 days ago grenade ~~6 SWs~~ + Frag wounds to multiple sites, penis, (L) leg, Rt elbow. Underwent debridement + exploration of (L) femoral artery at the time. Also, sustained head ⊂ POSH 5 days ago, no LOC

Meds - Profetes pills NKDA Lost meal yesterday. PMH - OM II H2O on Lorazepam

P.E.

Head - small nodule, top of scalp. No other injuries. PERRL. Neck not tender.

Chest - clear

Heart - RR

Abd - benign. Superficial wound (L) groin.

Ext - (R) forearm, superficial wound. Both thighs with soft tissue wounds, clean

Back - no injury

Rectal - negative

Motor, sensory, + pulses intact.

EVEF

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4701

PROGRESS NOTES

DATE

A: 1) Multiple soft tissue injuries, including (R) forearm, (L) groin, both thighs.
2) Type II DM-

P: 1) Admit to ward
2) Wound care, daily wet to dry's
3) IV antibiotics
4) Monitor blood sugars.

(b)(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

DATE 12APR03 1120

Medical Nutrition Tx's

S: ~~Patient RD~~ S: Per translator ate breakfast.

O: Dx: Multiple GSW. Wt ≈ 85kg. Meds: MVI & PAM.

Labs 11APR03: Glucose 261↑

Labs 10APR03: Hgb/Hct 8.9↓/26.3↓ 133↓/96/12/166↑ 3.3↓/31/1.8

Diet Rx: TK+/ADA

A: Glucose ↑ - Hx of DM? Hgb/Hct ↓ - will monitor c MVI tx. Na^+/K^+ ↓ - will monitor.

Kcal needs: 30-35 kcal/kg/day = 2550-2975 kcal/day

Protein needs: 1.5-2.0 g/kg/day = 127-170 g/day

P: Pt would benefit from Regular diet & concentrated sweets & snacks of olives (AM) + nuts (PM & HS)

fsbg glucose - will f/u x 2-3 days.

(b)(6)-2 MPH, RD

(b)(6)-2 MPH, RD

LT, MSC, USNR (b)(6)-2

12Apr03 1620

S: Doing well. Vague pain in testicles today. Mild pain, controlled c meds

O: wounds dressed, drains.

A: 1) Soft tissue wounds - slow healing process starting

P: 1) Cont wound care. 2) f/u on pelvis to look for retained foreign bodies.

A: 2) DM II - on PO

P: 2) Follow glucose levels. CPT

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO. (b)(6)-2

(b)(6)-2

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4703

PROGRESS NOTES

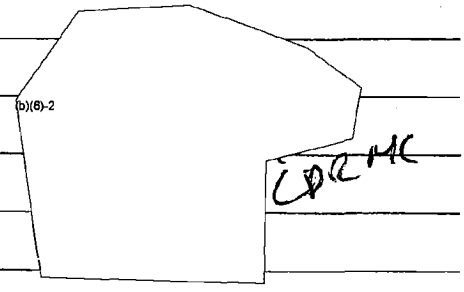
DATE

14 Apr 03

Surg

Asked to see pt with wound care issues. Multiple clean wounds. Rt thigh may require grafting + advancement. All others may benefit from debridment + delayed closure.

Will schedule for MAR.



CPT MC

(b)(6)-2

☆ U.S.G.P.O.:1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4704

ICAL RECORD | PROGRESS NOTES

OP Note:
Preop Dx: Multiple GSW Rt Elbow, Left groin x2
Rt Thigh x2 Left Thigh x3.
Post op Dx S AA.
Surgeon [redacted]
Procedure I+D Above wounds, Advancement flap
closure (L) + Rt thigh.
Findings NO pos or abscess. RT thigh hematoma
evacuated.
EBL minimal.
To RR Stable.

[redacted]

Doc POD 1 DPC.
5 new explants. Sl drainage around bi-positive
Wound RT Ear Dmin pus → seen by ENT.
Dressing during.
USS open.
No signs of infection
Ambulate

[redacted]

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

[redacted]

ER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4705

PROGRESS NOTES

DATE	
16 Apr -	CTSP for T102 [redacted]
	No pain, cough, or discharge.
	Chest bilaterally clear
Blo's 224	Wound Rt elbow 5 eschar
T 210.	Left brain 5 eschar.
	Left thigh drainage around gauze. Weschar.
	Rt thigh drainage around gauze Weschar.
	Bld cx x 2 Urine cx. Changed Dressing but left packing
	Dx: SIP I+D x DPE. No overt sign of infection
	all wounds draining 5 eschar
	Plan 1) Cx spikes. Cbld + urine.
	2) Cx R in AM.
	3) Continue current care [redacted]
	4) ICS & IO

DICAL RECORD | PROGRESS NOTES

Prep

3 (D) Thigh, Groin Dressing D. Rt Thigh
Reden Explanation/Debridement
Prep Dx Poss muscle necrosis ? organised hematoma
or infected Rt Thigh
Need for Dressing D's.

Post Dx SQA. RT Thigh poss hematoma infected

Surg (b)(6)-2

EBL Minimal.

Cx's RT Thigh taken.

To RR Stable.

(b)(6)-2

Apr 03 Surgn FIU.

PO had one long spike which was ex'd (blood culture) and ward md. All are adequately drained. Exploration of the Rt superior thigh demonstrated an undrained hematoma & necrotic muscle which could have been the source. All wounds were repacked. Cx's of wounds @ First operation were (+) for acinetobacter. Glucose control is good → We'll treat & Continue on reverse side

REGISTER NO. | WARD NO.

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

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4707

PROGRESS NOTES

DATE	
	Cruiexin, Contact Precautions, Aztreonam 3% draining D/s and, re-wrapped. Any temp spikes ✓ bld cx's x2. IDT wound staffs aware. (b)(6)-2 CORMC
17 Apr 03	Surgery Dressing D/s. BLE, RUE. Wounds are widely open. Trax 104. Bld cx's. Charged nurse this afternoon to Cruiexin from Bwcf. No fresh pos on culture. Wounds + Dressings draining. Ø erythema. Ø rash. Pt alert + conversing. D/C WTOD 3rd Rocephin acid D/C IV Sedation 20mg MSO4 / 3 Versed pulse ox 100% ra throughout. (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	

18 Apr 03 Pt alert + oriented. feels well.
Temp 104° ~ 4-6 hours p operative washout.
Ox (+) B.L.L.E Thigh fasc washout 15 Apr.
for Acinetobacter. Bld cx's pending.
Placed in contact precautions. started Pmyxin.
Dressing d's on ward going well.
Today Reg'd 35 mg MSO4 + 3 mg Versed.
He was still alert.
All wounds look clean appos + widely
draining. Acetic acid 3% to Dressing d's.
15.3 / 7.8 / 23.5 / 415 BG 207
for Acinetobacter Wound infection.
DM.
Plan) BID / TID Dressing Δ's.
2) Primaxin [redacted]
3) Bld cx's.
4) Tight control of DM + sliding scale
+ oral agent.
5 Continue surveillance for sources of
undrained pus

(Continue on reverse)

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

(b)(6)-4

(b)(6)-2

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4709

PROGRESS NOTES

DATE	
18APR03	Medical Nutrition Tx's F/U's
1325	O: Ate lunch per RN. FBS 17APR=87; 18APR 207 ss insulin. Diet Rx's Regular.
	A/P: Blood glucose elevated F/Bs AM - ~~will~~ [redacted] error Recommend offer HS snack c cheese/eggs + fruit to ↓ FBS in AM. RD to f/u q 2-3 days. MPH, RD
	[redacted] MPH, RD LT, MSC, USNR [redacted] MPH, RD
18Apr03	Surg A wound dressing c Kling spike of pus wound is beefy red c exudate. Bld x2. on Pmax [redacted]
	[redacted] CX am
19 Apr 03	Surg Staff Pt alert + cooperative VSS Tmax 102 CX's pending UOP qs AM fasting blues 97 Rec'd 24 a Twin Lab WBC ↓. Wounds look healthy, granulating + no eschar. Widely drained. Dx: GSW pelvis + lower extremity Plan CT Acetabulum + Rt elbow; Wound care - [redacted]

* U.S.G.P.O: 1988-491-248/20616

STA [redacted]

MEDCOM - 4710

DOD 11922

ACLU-RDI 1255 p.24

MEDICAL RECORD — PROGRESS NOTES

DATE

9 Apr 03 1930 Surg
C/O pain & Rt elbow.
(L) hip: ballet frag wound Traveling femoral head
(R) Elbow fragment wound Traveling radial head
Concern for intra articular fragment & poss
suppurative septic arthritis → Dr [redacted] (b)(6)-2
Debrided & looked Rt Elbow scope
+ Left hip explored. I&I done.
dressing & tray complete

[redacted] (b)(6)-2

EDCMC

19 Apr 03 2020 Δ Dressings
All appear healthy & healing.
To OR Tomorrow

[redacted] (b)(6)-2

EDCMC

19 Apr 03 Wound Care.
Wounds clean. Reduced
drainage. daily. S/P Exam of (L) Hip
intra articular ballet fragment. Continue
present care.

[redacted] (b)(6)-2

WARD NO.

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

[redacted] (b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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MEDCOM - 4711

DATE	PROGRESS NOTES
Apr 20 '03 2200	Internal Med Present regimen for DM - SS plus NPH 4 AM / 4 PM, plus glyburide 10 mg qAM. BG <200, no clear trend & frequent NPO periods etc. Will ↑ glyburide to 10 BID + monitor, goal is one +/- NPH for xfer to level 2 ((b)(6)-2
21APR03 1650	Medical Nutrition Dx's F/U's Ate 75% of dinner. Diet Rx's Regular; DENSE (Glucose) Labs 21APR03: FBS 144, 1100=156, 1600=98 Hgb/Hct & INI 23.9↓ mcv/mch 83.5/31.9 A/P: Hgb/Hct↓ - recommend FeSO4. PO intake good. Blood glucose levels normal since 18APR03 - will monitor & Regular diet, RD to f/u q 2-3 days. (b)(6)-2 MPH, RD LT, MSC, USN

* U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4712

PROGRESS NOTES

DATE

4/20/03

Brief Op Note

Pre Op Dx: Multiple GSW (B) Thigh, (R) elbow

Procedure ~~Post Op Dx~~: (L) hip arthrotomy c fragment removal

Dressing Δ's BLE, RUE

~~Procedure~~

(b)(6)-2

Surgeons:

(b)(6)-2

Compl: 0

EBL: min

Fluids: 1100 cc

Findings - fragment anterolat to femoral head, intracapsular

Disp: PACU, stable

(b)(6)-2

(b)(6)-2

(b)(6)-4

PROGRESS NOTES

DATE

1600 Surg
PE 5 complaints. tol po
[redacted] DM Glucose consistently <150.
Wounds clean + granulating (L) hip saying
site clean & signs & infection. (x) (R)
Rt elbow wound clean but not granulating
Bld ex. (R).
Pt: 1) DM controlled.
2) 2° Granulating Wounds
Mult GSW

[redacted]

0622 03 1652 Internal Med
Reid Glyburide 10 BID on 2/24 -
BG first day 144/158/98/110. Then following
Am (today) not recorded. Apparently did not
receive Am MRN or 5/26 today - + BG
-/147/162. I have requested proven &
staff hope to get better adherence and/or
records. No A ch again. Awaiting d/c or
SS soon though

[redacted]

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.G.P.O.: 1986-491-248/20616

MEDCOM - 4714

MEDICAL RECORD

DATE

PROGRESS NOTES

2(Apr)

Surg

Trauma Lo c. Dm controlled 10 mg Glyburide. BID
+ Humulin 2x/d - Glucose 154.
VSS. tol during Δ's will 10 mg MSO4/2 Vaso.
LE pelvic wounds granulating L elbow ODC
but with granulation.
Surgical wound: still dressed. → will staple tmrw
7.1 / 23.9 / 485 (8x) NO DIFF. 132/97/8 / 3.7/32/0.8 144.
Bld cx sets x 3 No Growth
Urine Cx >10⁵ E cloacae.
Wound Cx E cloacae + Acinetobacter
both orgs sens Imipenem only.
F: Doing Well.
DM controlled medically
Multiple GSW.
POD 1 (L) Hip dislocation - articular fracture s/p ORIF B/L
Plan) Continue Current Care.
& PT Gait

(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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MEDCOM - 4715

MEDICAL RECORD | **PROGRESS NOTES**

DATE

23 Apr 03 Surgery.
Prep: DM.
Scheduled Rt Thigh X 2.
DPC
Post op Dx SOA
Finding Schegnd. X2 Rt Thigh.
Clean Wounds
Surgeon [redacted] / Hm3 [redacted]
QBL minimal.
To PACU stable.

24 Apr 03 Surg Staff:
Feels good - 6 medication required for pain 0 - 10 eg IM Morphine.
Wound clean + dry. Erythema minimum Dexudate.
Hip incision clean. → staples should come out.
4 more days (Monday). Rt Thigh staples should come out next wed.
Dr: Schegnd Wards -
DM.
P(m) 100 2) DC

(Continue on reverse)

WARD NO.

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

[redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

MEDCOM - 4716

PROGRESS NOTES

DATE	
24Apr03	P.T. Note
1440	Pat seen this P.M., stood up at bedside and then ambulated 80ft ⊼ assistive device. Pat would occassionally utilize other Hospital Beds for support. Pat refused crutches. Nurse staff notified. D/C from P.T. @ this time. (b)(6)-2 Hmc(FmF) P.T. Tech
25APR03	Medical Nutrition Tx's F/U:
1800	O: Per Hall- PO intake good. Eating apple. ss insulin Glucose 155 T. Fe 44↓. Diet Rx's Regular; ENSURE A/P: Iron stores low - recommend FeSO4. Blood glucose level elevated - will monitor ⊼ ss insulin. PO intake good - will monitor. RD to f/u q 3-5 days. (b)(6)-2 MPH, RD (b)(6)-2 MPH, RD LT, MSC, USNR (b)(6)-2
26Apr03	P.T. Note
1445	Pat seen by P.T. this P.M., ambulated 160ft ⊼ assistive device, utilized other Beds for support occassionally. Will ambulate QD. (b)(6)-2 Hmc(FmF) P.T. Tech

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4717

PROGRESS NOTES

DATE	
	OTO HNS
25 APR 2003	Oral Consent Obtained
0800	Drugs made c AM perforation c/p Weck mjzg one week ago. no otorrhea, no vertigo. PE — 35% AT Pars Flaccida central perforation dry. Plan - medical graft tympanoplasty
25 APR 2003	Rmvd Op note
1130	Pre Op Dx: R/O AM. Perforation 35% clean Post Op Dx: SAME Procedure: medical Graft Tympanoplasty AD Surgeon: (b)(6)-2 Anes Mgmt: LMA GET Comp: Ø FB post Op Cx/fb to PACU 512 to operated ear Facial nerve Intact
26 Apr 03	Surg 5 complaints and relates c same w/ stairs USS offers. QSS Insdrd. (b)(6)-4 ear, intact + clean. Dx: Dx in Well. (b)(3)-1 (b)(6)-4 (b)(3)-1 (Continue current care.

(b)(6)-2

(b)(6)-2

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
27APR	P.T. Note, Pt sitting @ EOB just returning from head (ind) Pt ambulated appx 80 feet c occassional reaching for balance when asked if he needed to hold on for balance, Pt was able to amb ind. D/C P.T. @ this time. Reconsult if needed — HM3 (b)(6)-2
27APR03 1515	Medical Nutrition Tx: FLU: S: Per translator: 4/26 - Ate 3 meals + apple + orange + ENSURE 4/27 - ate 2 meals + 1/2 chocolate milk + 1 orange + ENSURE O: Diet Rx: Regular. + current labs. A/P: PO intake good - recommend continue to encourage PO intake. RD to f/u q 3-5 days. (b)(6)-2 MPH, RD LT, MSC, USNR (b)(6)-2 MPH, RD

(Continue on reverse side)

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

(b)(8)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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MEDCOM - 4719

MEDICAL RECORD	PROGRESS NOTES
DATE	

29 Apr 03 Surgery
Pt E Penicillin. + requests to leave.
USS - appt.
Rt thigh staples + Ⓓ hip staples ? infection
- Tourniquet ✓ wounds + advance closure

[redacted]

30 Apr 03 @ 0205 24° Chart [redacted] EWS [redacted]

29 Apr 03 On to HNS
Post op AI Tympanoplasty Doing well
Ear - clear + dry
Ⓛ Hear B/L. Discharged
Will start drops in 2 days.

[redacted]

30 Apr 03 Surgery
Doing well DC'd staples Advanced
wound closed Rt Thigh + Ⓓ Medial Thigh.
Continue present [illegible] 4579

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

[redacted]

[redacted]

Prescribed by GSA/[illegible]
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 4720

PROGRESS NOTES

DATE	
30APR03	Medical Nutrition Tx's F/U's
1435	S: Per translator: 4/29 – Ate 3 meals 4/30 Ate 2 meals.
	O: Diet Rx: Regular ... Labs 4/30: glucose = 77
	Labs 29APR: Glucose @ 0504 = 118, 1216 = 183 H, 1610 = 87.
	A/P: Blood glucose levels mostly WNL. PO intake good. Recommend continue encourage PO intake ≥ 3 meals q day. RD to f/u q 3-5 days.
	MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2

★U.S.GPO:1990-262-081/20173

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4721

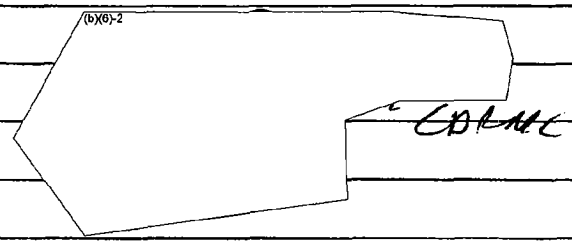
PROGRESS NOTES

DATE	
1 MAY 03	Surg Staff. (LT 5 new complaints Wounds healing 2° intention ± serial closure & 3 days. Most wounds closed. DM controlled ± NIDDM oral agents f/u: Scheduled wounds. (Lt.) Good to go. (b)(6)-2 CDR M<
2 MAY 03	Surg Staff: Wounds clean & healing. DM good control. Ready to go. (b)(6)-2

★U.S.GPO:1990-262-081/20173 STANDARDFORM 509 BACK (Rev. 11-77)

MEDCOM - 4722

MEDICAL RECORD	PROGRESS NOTES
DATE	
3 May 03	USS afeb. DM controlled. Wounds clean + healing 2°. Ambulating. tol ASA Diet Transport



(Continue on reverse side)

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

REGISTER NO.	WARD NO.

TES

STANDARD FORM 509 (Rev. 11-71)
Prescribed by GSA/ICMR,
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509-111

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/25/03		1650	assumed pt care V/S Stable Pt has dressing on (L) EAR CDI Pt has staples on (R) thigh NO signs of redness. ALL Dressings ON (R) thighs are CDI, groin area is also Dressed CDI Pt is resting comfortably in RACK NO C/O pain will continue to monitor (b)(6)-2 LPN
4/26/03		1450	Assumed care - @ a.m. bedside in place. Dr (b)(6)-2 completed dressing change. medicated. MSO4 10mg.
4/27/03		1430	Pt Ambulating on ward. Wound care team on ward to Δ dsg. No C/O pain. minimal drng on (L) ear dsg. (b)(6)-2 RCPE
4/27/03		2020	VSS. Pt. occasionally sitting up on edge of bed. Ate well at dinner. BG - 138 at 1630. Voiding - nl. (L) thigh dressing - serosanguinous scant amt. from sutured area. Reinforced dressing & reapplied ~~stockinette~~ steristrips. N/V checks LLE - normal. Will continue to monitor. (b)(6)-2 CDR, NC
4/28/03		1340	Pt Ambulating on ward. No C/O Pain this afternoon. dsg Δ by Wound care team, medicated ~~c~~ Hyd MSO4 ~~c~~ good results. Will continue to ambulate & monitor. (b)(6)-2 LPN

Continue on reverse side

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

REGISTER NO

WARD NO.

(b)(6)-4

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

MEDCOM - 4724

NURSING NOTES

(Sign *all notes*)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 April 03		1500	Assumed care 1500, pt sitting up in bed, no c/o pain, (R) ear dsg small amount serous drainage, Dsg (R) elbow CDI, (R) Thigh Dsg CDI, (L) Thigh Dsg CDI, (L) groin staples intact OTA no S/S infection, Dsg (L) lower abd CDI — (b)(6)-2 — BBS, wc
29 April 03	0600	Pt. slept well thru the night. BG - 118 @ 0430. VSS. Will continue to monitor — (b)(6)-2 — CCRN
29APR03	0715	lying in bed VSS no distress noted PERRLA AxO, S,S, RRR, lungs clear equal bilat BS (+)x4 fol reg diet. Wounds to (L) elbow (L) thigh and (R) thigh OTA gauze/spandage dressings c/d/i Staples to (L) groin OTA c/d/i edges well approximated will continue to monitor — (b)(6)-2 — (b)(6)-2 — rs/kw
			HL to (L) FA site WNL — rs/kw
30APR03	0345	Pt. had emotional evening - crying due to concern regarding his family per translator. Ate snack well, No c/o pain. Will continue to monitor — (b)(6)-2 — CCRN
30APR03	0736	VSS no distress noted AxO PERRLA S,S, RRR lungs clear BS(+)x4 Wounds to (L) elbow + (R) thighs gauze dsg c/d/i staples to (L) groin OTA c/d/i will cont to monitor — (b)(6)-2
30APR03	2100	Assumed care of pt. V.S.S @ this time. pt is in no apparent distress. pt is ~~also~~ asleep. Will continue to monitor VS and pain management — (b)(6)-2 — kw
01MAY03	0730	VSS c distress noted AxO PERRLA RRR S,S, lungs clear equal bilat BS(+)x4 steri strips to (R) upper thighs c/d/i incisions to RLE & sutures c/w I&D c/d/i. Hematoma gauze to (L) elbow c/d/i will cont to monitor — (b)(6)-2

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/4/03	0840		Assumed pt care this am. Pts VS are WNL and pt shows no signs of distress. Am care was completed and pt ate 100% of meal. Pt tub bathed well. Pts CE are dressed and dressing is CDI. wound care will be performed later by nurse will cont to monitor throughout shift and Cont with Motrin prn. (b)(6)-2
	0940		Concur with above RN, BSN, MC

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4726

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
01May03	2000		Assumed care of pt. VSS. @ this time pt is sleeping and in no apparent distress. Will continue to monitor v.s and pain management. (b)(6)-2
02MAY03	0800		VSS ø distress noted ambulating ẽ difficulty S1S2 CTA lung sounds clear equal bilat. BS@x4 incisions to ©elbow Ⓡ & © groin ẽ sutures & w3D dsg c/d/i incisions to Ⓑ over thighs ẽ steristrips c/d/i will cont to monitor (b)(6)-2
02May03	2000		Assumed care of pt. v.s.s. and pt is in no apparent distress @ this time. Will continue to monitor v.s. and pain management. (b)(6)-2
03MAY03	0730		VSS ø distress noted A+O PERRLA CTA S1S2 lung sounds clear equal bilat. BS@x4 sutures w/ incisions to Ⓑ upper thighs ẽ sutures & w3D dsg c/d/i wound to Ⓡ elbow OTA incisions to Ⓑ upper over thighs ẽ steristrips c/d/i; T#2 2 tabs given for lower back soreness Will cont to monitor (b)(6)-2
03 May 03	2100		Assumed care of pt. r.s.s. @ this time; pt is sleeping and in no apparent distress. Will Continue to monitor vital signs and pain management (b)(6)-2

Continue on reverse side

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

JD # (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

MEDCOM - 4727

CLINICAL RECORD — NURSING NOTES

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
4/10	2330		Pt. arrived via stretcher. NAD noted. Bsg. to (R) Arm, (L) groin and bilat. femurs CDI. voiding spontaneously. VSS. Will cont. to monitor. — (b)(6)-2
11APR03	0115		ASSUMED CARE. PT. HAD MULTIPLE GSW/SHRAPNEL TO BOTH UPPER THIGHS, (R) ELBOW, (L) PELVIS, AND PENIS. UPPER THIGH DRESSINGS TO BOTH THIGHS ~~WAS~~ PAM HAD SEROUS DRAINAGE. DRESSING CHANGE PERFORMED @ 0030. DRESSING ON (R) ELBOW C/D/I. NO DRAINAGE. DRESSING ON PELVIS C/D/I. NO DRAINAGE. PENIS DRESSING C/D/I. NO DRAINAGE. DRESSINGS ON UPPER THIGHS C/D/I. NO DRAINAGE @ THIS TIME. IV SITE ON (L) FOREARM C/D/I. NO S/SX OF INFECTION. PT. HAS NO C/O OF PAIN. PT. CURRENTLY SLEEPING. VSS. WILL CONTINUE TO MONITOR. — (b)(6)-2 HN/USN
11APR03		1410	AM Care done. LR infusing @ 175. Wet to dry done to (R) Forearm and (R) thigh. PT tolerated c lots of anxiety and pain after pre-medicated c 5 mg MSO4 and 5 mg during D. Ativan ordered obtained. (L) groin and (R) thigh dressing to be done Continued on reverse side — (b)(6)-2 ENS, NC

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

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

MEDCOM - 4728

CLINICAL RKORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 LVL APR 03	0200		ASSUMED PT CARE @ 2330 12 APR 03. MULTIPLE GSW/SHRAPNEL TO BOTH UPPER THIGHS, (R) ELBOW, (L) PELVIS, & PENIS; BOTH UPPER THIGH DRESSINGS C/D/I. (R) ELBOW DRESSING C/D/I. PELVIS DRESSING C/D/I. NO DRAINAGE @ THIS TIME. IV SITE (L) FA C/D/I S/SX INFECTION. PT C/O PAIN, NOTIFIED RN, PAIN MED GIVEN. WILL CONTINUE TO MONITOR. HN (b)(6)-2
16 APR 03	0215		ASSUMED CARE OF PT @ 2330. A/O x 3. CHANGED WRAP OF LRE, DUE TO MODERATE DRAINAGE OF OLD WRAP. N/V CHECKS WNL OF BOTH LE. PT HAD COMPLAINT OF MILD LE PX. PT WAS GIVEN PX MEDS WITH NO FURTHER COMPLAINT. WILL CONTINUE TO MONITOR. (b)(6)-2
			(b)(6)-2 HN
17 APR 03	2200		Assumed pt. care @ 1500. Dsg. Δ done by Dr. (b)(6)-2 in treatment room. O2 6L NC applied and NS @ KVO started. MSO4 20mg and Versed 3mg given during procedure. Pt. had pulse ox 98-100% during procedure and no complications noted during procedure. Pt. had 104.4 temp. Tylenol 650mg given, wet clothes applied, blood ex done ex Dent

Continue on reverse side

(b)(6)-2

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

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/18/03	0435		Assumed pt care @ 2330. Dressing ③ thigh c/d/i, ④ inguinal area c/d/i, ⑫ upper arm c/d/i. Pt c/o of throat pain. ~~Throat~~ Appears swollen. Encte drink fluid & cepacol was given. Pt seem to have some relief but still c/o of pain. Will notify MD in the morning. Pt temp 100.8° @ 2400 down from 103.5° from previous shift. Temp 100.7 @ 0400 Tylenol 650 mg given. Will continue to assess & monitor patient's status. (b)(6)-2 (b)(6)-2 Ens, NC

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders) — Nurse's notes

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
	0510		Received for MOR on stretcher.		
			Orders @ 9448 on RA. @ 13/hour drip		
			@ High BS reported by Shelly,		
			North Sand CTAO.	(b)(6)-2	
	0335		Nurse drip @ high mouth drip,		
			ok by TDN. Report called		
			to ALL 3	(b)(6)-2	CM
19APR2003 1635			Assumed pt care at 1530. Pt awake, alert, sitting up in bed. Lungs CTAB. Productive cough, thick yellow sputum. CV - RRR. (+)BS all four quadrants. Elbow drsg - CDI. RLE, LLE drsgs - CDI. (L) groin drsg - CDI. Drsgs to be Δd this PM by Dr. Jones. NPO p MN on call to OR in AM	(b)(6)-2	EWSRC
19APR2003 2040			Drsgs Δ'd by Dr (b)(6)-2. Pt received Morphine 30mg IVP, Versed 3mg - tolerated drsg Δs well. VSS remained stable throughout.		
				(b)(6)-2	EWSRC
			MSO4 2g IV		
4/20/03	1000	r	Assumed care to pt - NPO at midnight to have TEE, in OR today		
			Pt is aware.	(b)(6)-2	

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

1S6

(b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111

☆ U.S.G.P.O.: 1985 - 491-248/20237

MEDCOM - 4731

CLINICAL RKORD	NURSING NOTES (Stemall Army Hosp.)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
4/20/03	1000		Note cottoned - Rt. Extremity drsng intact - will have flex changed in AM. IV was not able to be started on NOC - contacted OR to see if central could be done. Will obtain BC in the morning. Held Am Glyburide & NPH insulin due to pt. on. Will continue to monitor. (b)(6)-2
4/20/03	1600		Pt returned from OR S/P shrapnel removal from (c) hip. (b) hip/inguinal incision dressed & drng noted. Bilat leg wounds dressed w/ minimal drng, noted to dressings. Pt A&Ox3. Some c/o pain. Will medicate and monitor as needed. (b)(6)-2
4/21/03	1054		Assumed care - VS stable. Drsng to (L) hip, bilat lower extremity - dry, intact. Have not done the shave - waiting to see if he is to have dressing change - Dr (b)(6)-2 IV - NS @ KVO. BG - @ 1100 156 - 2 units given. No complaints will continue to monitor. (b)(6)-2 Dr

Continue on reverse side

PATIENT'S IDENTIFICATION (b)(6)-4

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

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101–11.8064 — October 1975
510–109

MEDCOM - 4732

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21APR2003 1850			Assumed pt care at 1530. Pt awake, alert. (R)elbow dsg - CDI. BLE dsgs - CDI. Dsgs to be Δd this PM by Dr. [(b)(6)-2] 0% pain. [(b)(6)-2] ens/RC
21APR2003 2245			Dsgs Δ by Dr Jones. Morphine 10mg IVP Versed 2mg IVP [(b)(6)-2] ens/RC
4/22/03	0122		Assumed care - NPO for OR this AM will clarify to see if he will be going today. Dressing to be changed q [(b)(6)-2] unless he goes to OR. [(b)(6)-2] CDI m
4/22/03		1800	ASSUMED PT CARE @ 1530 PT AAOX3. ALL DSGS C/D/I TO BE CHANGED BY DR. [(b)(6)-2] PT NOT C/O PAIN @ THIS TIME [(b)(6)-2] EN
22APR2003 2230			Dsgs Δd this shift by Dr. [(b)(6)-2] sutures placed to (L)thigh + (R) thigh wounds. Morphine 20mg IVP Versed 2mg IVP given. Pt tolerated well [(b)(6)-2]
Addendum: on call to OR in AM. NPO p MN. [(b)(6)-2]			
4/23/03	0100		- Assumed care - NPO. Waiting f/ call to OR. B6 obtained - pending. Dressing intact [(b)(6)-2]

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M. / P.M.	OBSERVATIONS Include medication and treatment when indicated
4/23/03	1700	Assumed pt care pt returned from OR V/S Stable Dressings to (B) thighs are CDI Dressing to groin area is also CDI pt has NO C/O pain @ this time no other problems to report will continue to monitor (b)(6)-2
4/24/03	1300	Assumed care – VS stable. Pt (b)(6)-2 changed all dressing. MSOY 10mg IVP giving pain. Up ambulating w difficulty. Plan for LOO to level II Hospital @ some time. Pt voices complaints of discomfort. Is treating duty will continue to monitor. He is plan for antibiotic tx. (b)(6)-2
4/24/03	1800	assumed pt care pt + V/S Stable. NO C/O pain all dressings are CDI Pt IS resting comfortably IN BED AWAITING LOO NO other problems to NOTE (b)(6)-2
25Apr03	1244	Pt returned from OR. S/P (R) tympanoplasty. Pt has band aid on right ear. Ø drainage. 1" incision c sutures above R ear. Ointment on incision. Scant bloody drainage on R elbow W+D area c (b)(6)-2 distract

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

REGISTER NO. | WARD NO

JD # (b)(6)-4

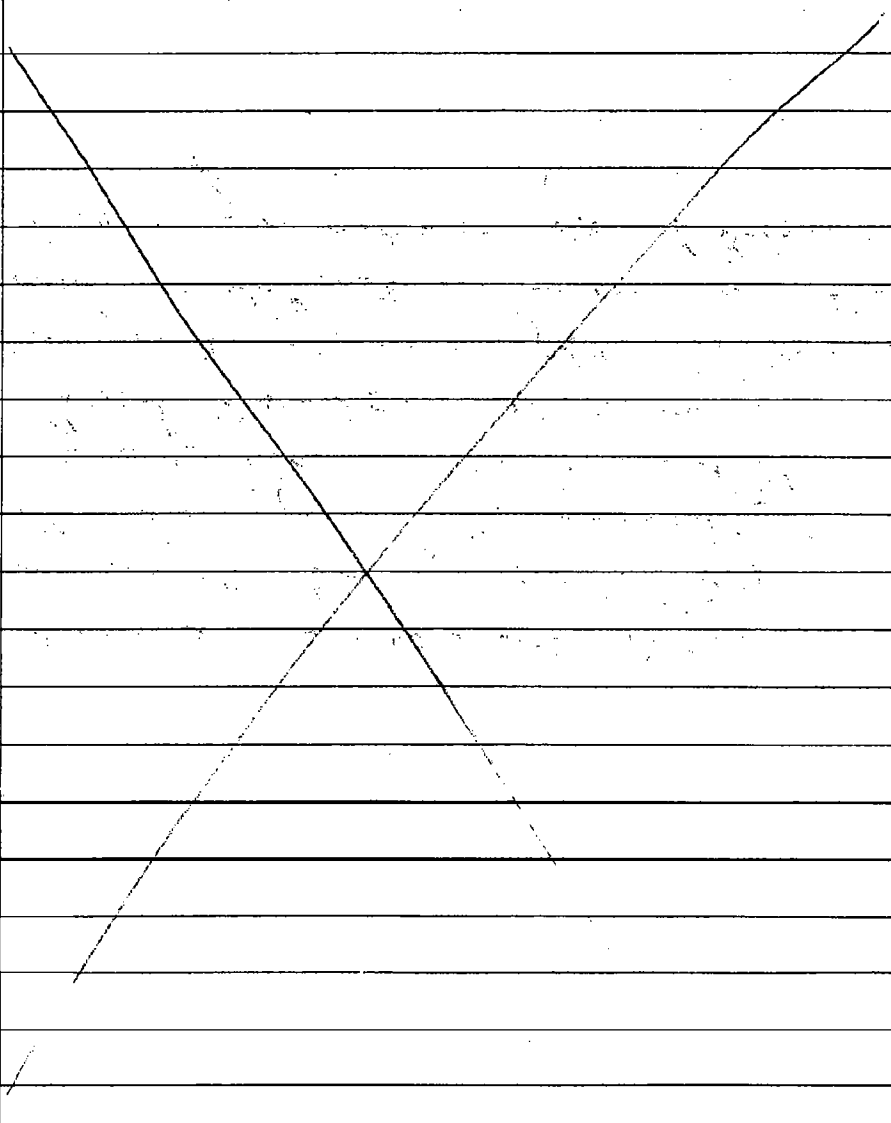
NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101–11.806–8—October 1975
510–109

MEDCOM - 4734

NURSING NOTES

(Sign all note~)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28Apr08		cont 1244	cover dsg (R)groin. staples intact. Ø drng noted. W+D dsg beside staples CDI. R thigh dsg minimal drng noted. Circ/neuro WNL. LLE dsgs intact c. dried drng noted. Circ/neuro intact. Pt medicated c T3 & MSO4 for pain. (b)(6)-2 NC



(b)(6)-4

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

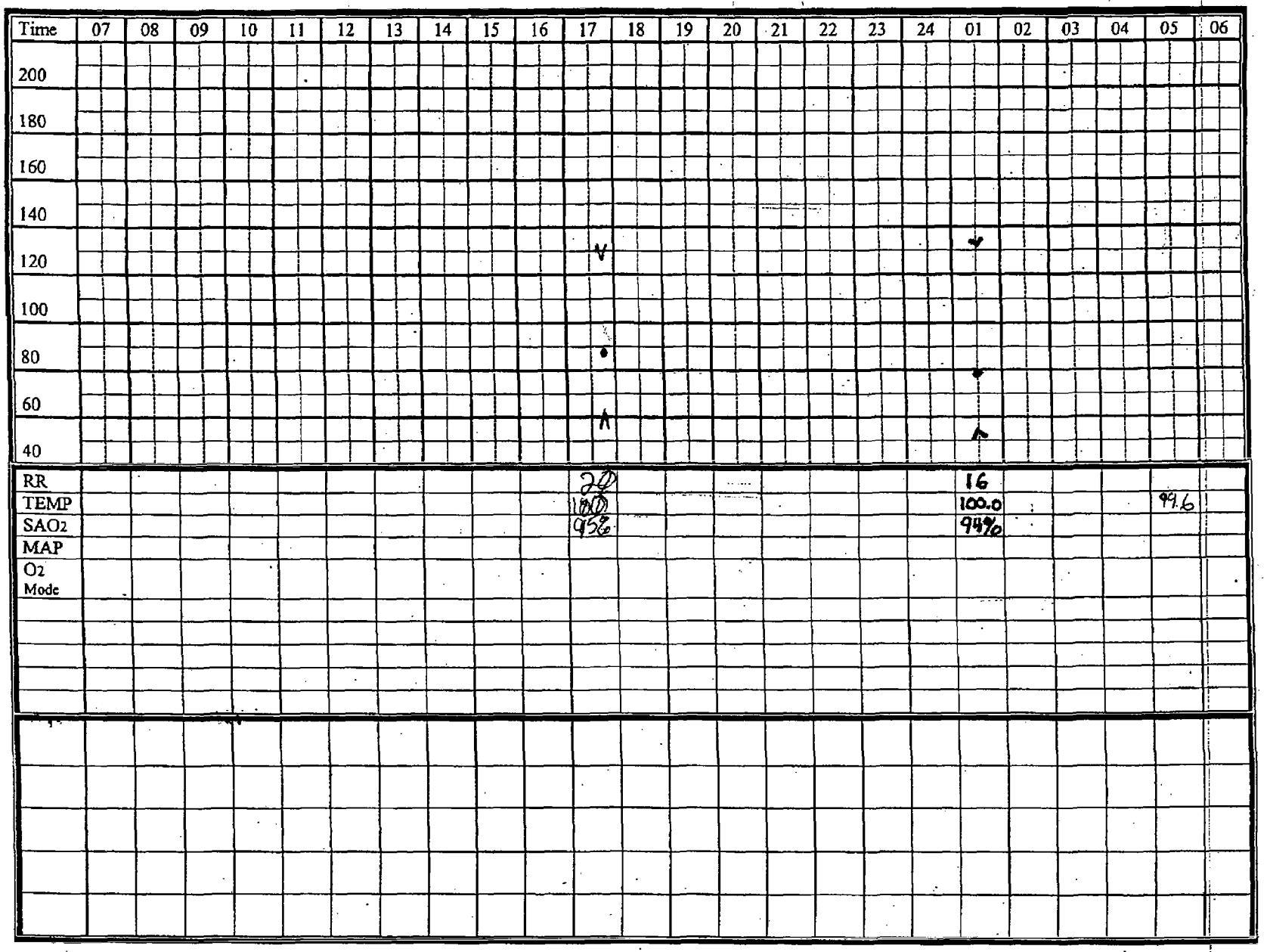
NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4735

Name: 21 (b)(6)-4

NURSING FLOW SHEET
MEDICAL/Temp Form

Date: 10 APR 05

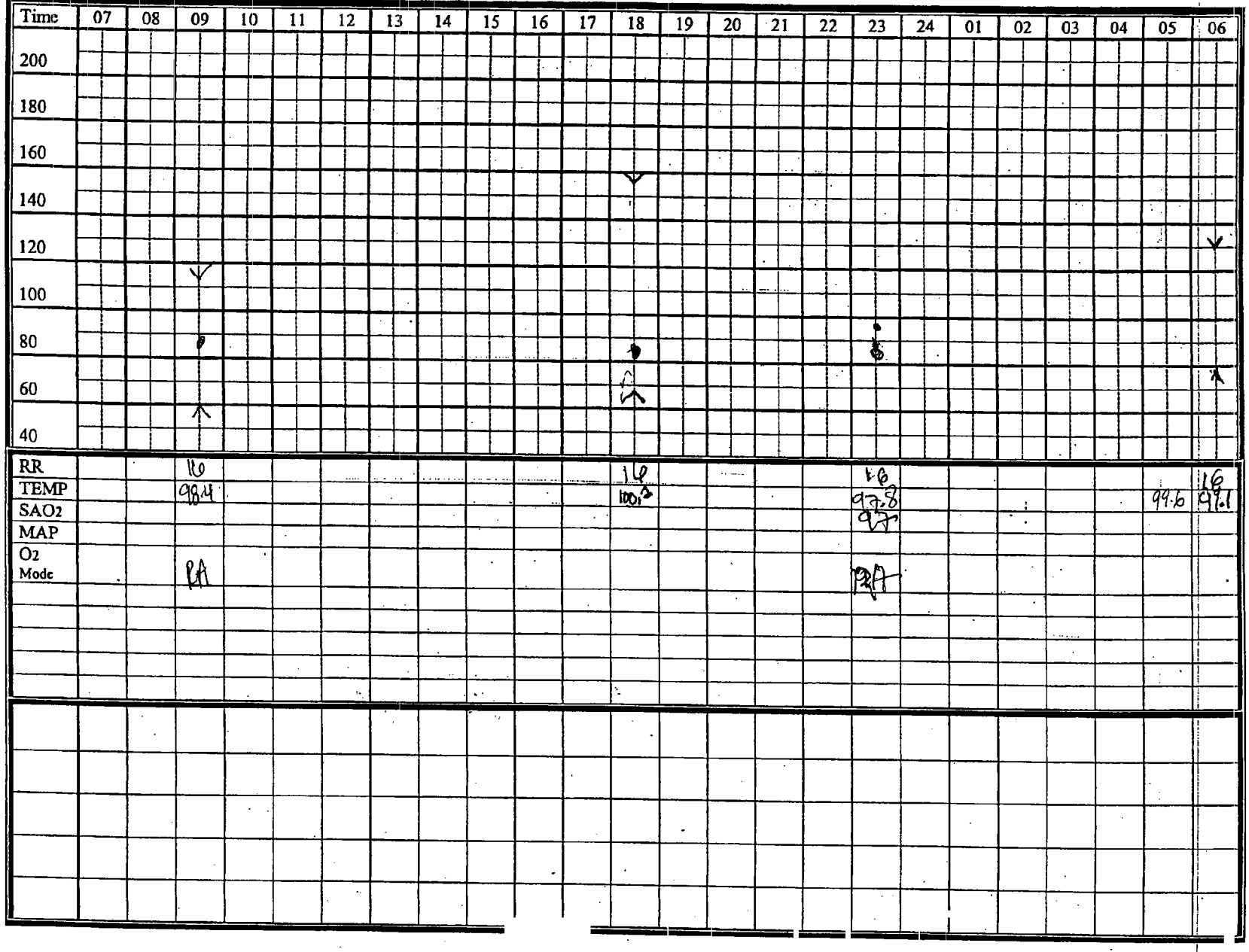


Name: [redacted]

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 11APR03



MEDCOM - 4737

DOD 11949

ACLU-RDI 1255 p.51

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																		240								
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	
FOLEY																										
UOP																		600	450	420				480		
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

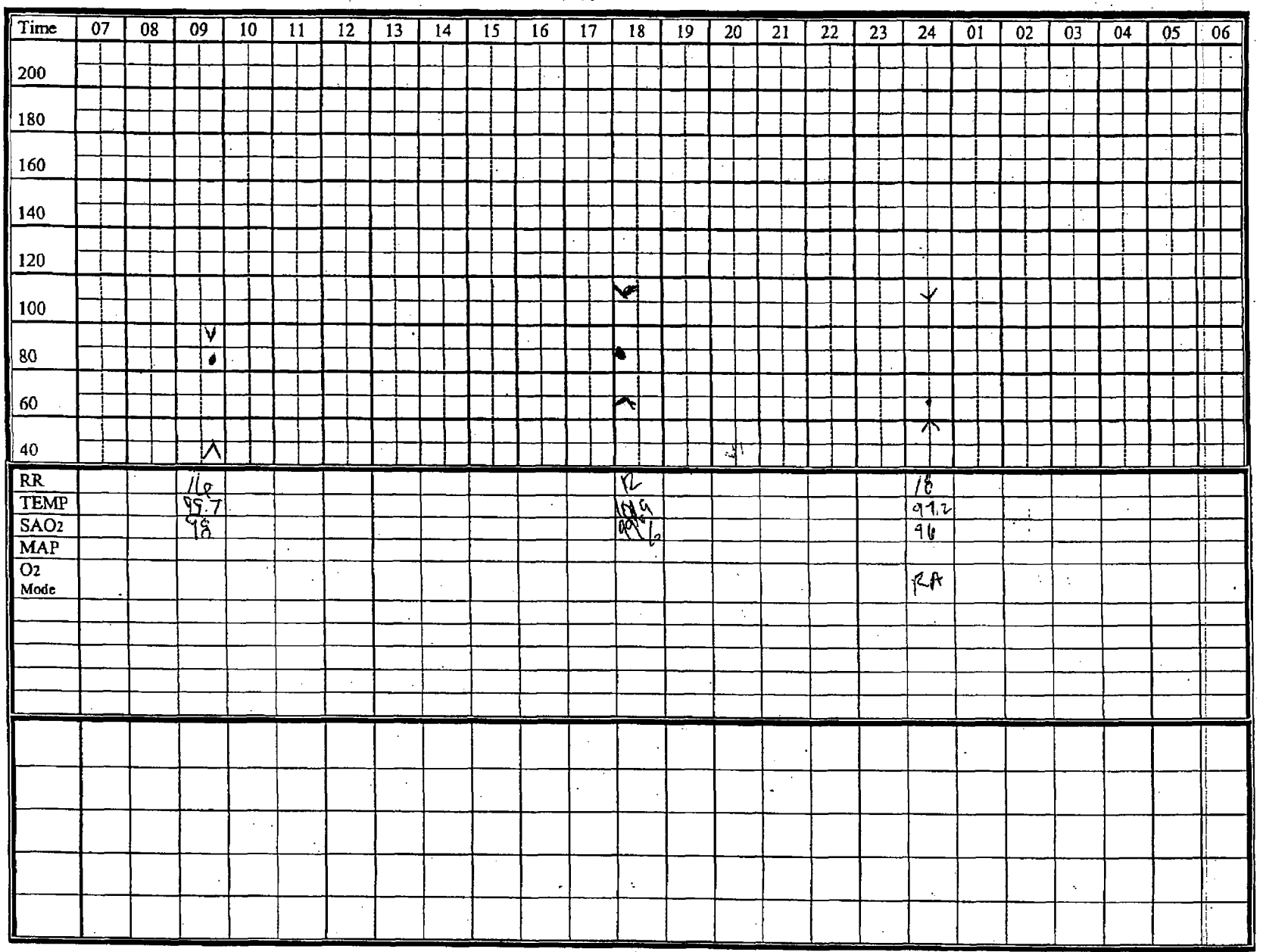
PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4738

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 12APR03



FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
FOLEY												475														
UOP		400	200					500						425	490		500							500		
																								550		
BM			XI																							

PREVIOUS **24 HOUR INPUT**_____ **PREVIOUS 24 HOUR OUTPUT**_____ **PREVIOUS WEIGHT**_____

PRESENT **24 HOUR** INPUT_____ **PRESENT 24 HOUR OUTPUT**_____ **PRESENT** WEIGHT_____

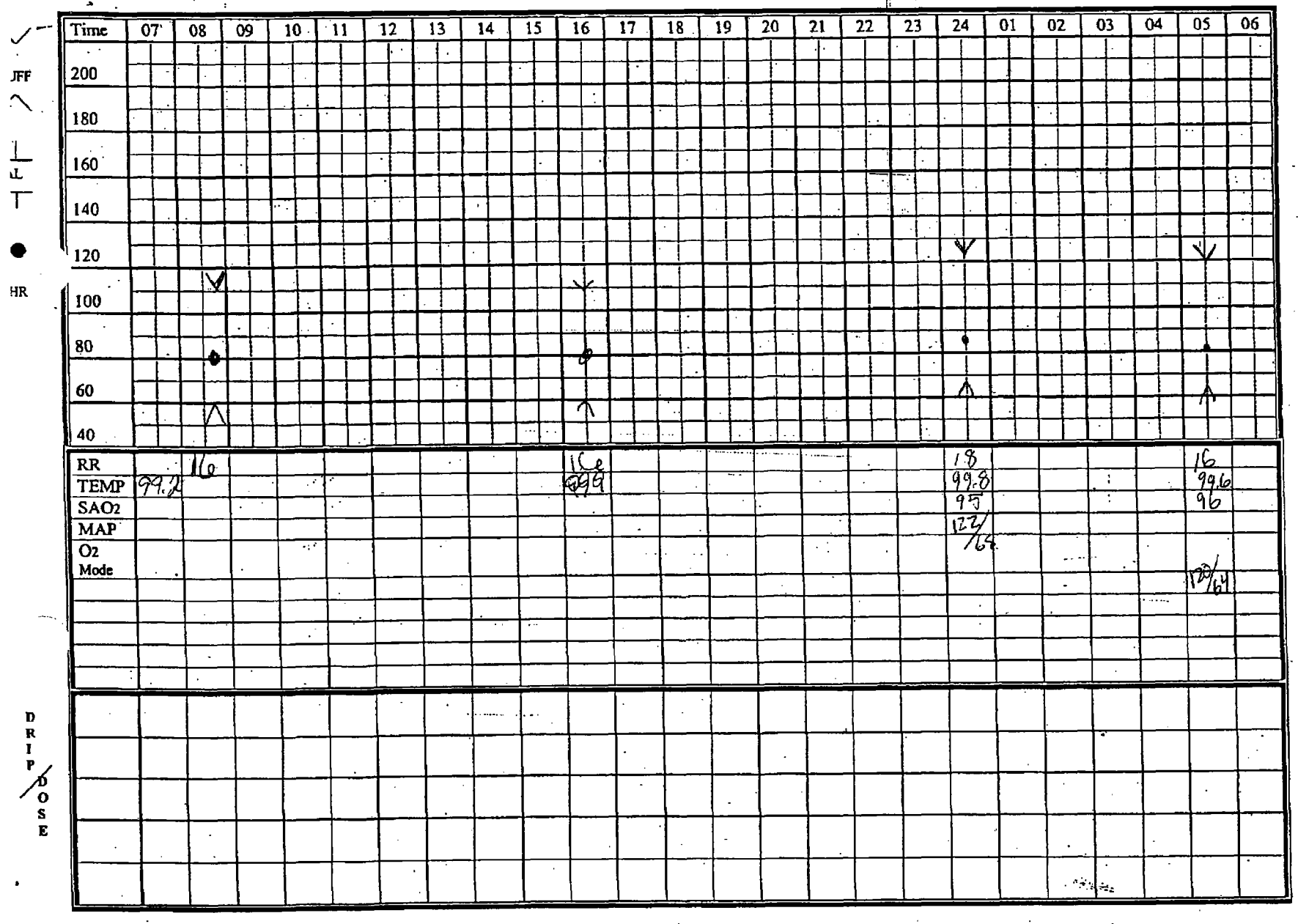
MEDCOM - 4740

DOD 11952

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREE AC 6550/12/Temp Form

Date: 13APR03



FREQ. VITAL SIGNS

TIME	2400															
BP	112/60															
HR	68															
RR	18															
TEMP	97.2															
SAO_2	96															

Notes: _____

INPUT/OUTPUT

Changed @ 1355

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB										16																

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT
FOLEY																										
UOP					450		800		450		425						450		475							
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4742

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC 6550/12/Temp Form

Date: 14 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		16					16			16									16					16
TEMP		99.1					99.1			100.8				100.4					98.1					98.8
SAO_2										96									96					96
MAP																								
O_2 Mode										DA														
																			110/70					120/72

DRIP / DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes: _____

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PB																										

MEDCOM - 4744

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
EY						400					500															
UOP															500		400		400			600				
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

NURSING FLOW SHEET
MEDTREPAC 6550/12/Temp Form

Date: 15 APR 03

CUFF

AL

DRIP / DOSE

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120	✓																		✓					
100								✓		✓														
80	•							∩		•														
60	↑							•		∩									∩					
40																								
RR	16							18		16									16					
TEMP	98.8							97.5		98.3									98.6					
SAO2	96							97		96									97					
MAP								Ø																
O2 Mode								Ø																
BP:	120/72							111/93																

START 5x1 5x2 5x3 1x5 15x2 5x3 30x1 3x2 1x1

FREQ. VITAL SIGNS

TIME	2200	2225	2250	2315	2330	2355	0300	0330	2420	0120					
BP	120/70	120/68	116/68	116/68	114/61	118/66	114/66	110/68	114/66	116/70					
HR	87	73	76	73	65	72	75	74	75	70					
RR	16	16	16	16	16	16	18	16	18	16					
TEMP	99.1	99.5	99.6	99.5	98.2	98.9	98	98.5	98.4	98.7					
SAO2	98	95	95	94	93	94	95	96	96	96					
	RA	RA	RA	RA	RA	RA									

Notes:_____

INPUT/OUTPUT

I.	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
/PB																										

MEDCOM - 4746

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY								340																		
UOP			320						300	500				400	300	400	300		500							
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 H O M OUTPUT_____ PRESENT WEIGHT_____

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC [redacted] F/Temp Form

Date: 16 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
JFF / TF T HR 200																								
180																								
160																								
140																								
120																		V						
100		V								V														V
80		•								•								•						•
60		^																A						^
40										^														
RR		16								16														16
TEMP		101.1°								97.8	102.1		101	101.1		100.4	99.7	99.2						99.8
SAO2		96%								95								97						95
MAP																								
O2 Mode										RA														
																		119/64						114/64
DRIP / DOSE																								

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
FOLEY										↑								900			1000				600
UOP	350	375								300															
BM																									

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4748

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC- 2/Temp Form

Date: 17APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
JFF / 200																								
180																								
160																								
140																								
120					↓																			
HR 100										↓						↓		↓					↓	
80										•						•		•					•	
60					↑					↑						↑		↑					↑	
40																								
RR					18											16		16					18	
TEMP					98.1					99.9			104.2			103.5		100.8				100.7	100.5	99.6
SAO2					100%					99						98		98					98	
MAP					D																			
O2 Mode					NC					RA						RA							RA	
					121/74																			
DRIP / DOSE																								

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

Notes: _____

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
VPB																										

MEDCOM - 4750

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT
FOLEY		300		700		350								1200			0			300		300				
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Name: [redacted] (b)(6)-4

NURSING [redacted] W SHEET
MEDTREFAC 2/Temp Form

Date: 14 APR 03 [redacted]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
JFF ✓ T ● HR 200																								
180																								
160																								
140																								
120																								
100		↓								↓														
80																								
60		↑								↑														
40																								
RR										16														
TEMP										102			1634											
SAO2										04														
MAP																								
O2 Mode																								
BP										110/58														
DRIP/DOSE																								

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

Notes: _____

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
VPB																										

MEDCOM - 4752

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP						400			120											400	400	400		350		
BM																										

PREVIOUS 24 HOUR INPUT _____ **PREVIOUS 24 HOUR OUTPUT** _____ **PREVIOUS WEIGHT** _____

PRESENT 24 HOUR INPUT _____ **PRESENT 24 HOUR OUTPUT** _____ **PRESENT WEIGHT** _____

Name: b)(6)-4

NURSING FLOW SHEET

MEF AC 6550/12/Temp Form

Date: 4/19/93

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF 200																								
180																								
160																								
AL 140																								
120		↓																						
R 100																			↓			↓		
80		•								•														
60																			↑			•		
40		↑																						
RR										20				20					19			18		
TEMP	98	99.7								100.4				102.0		101.0			99.4			98.7		
SAO2		95								95%				96%					95			95	96	
MAP																								
O2 Mode										RA				RA										
BP										118/58				130/68										
IVP																						500cc		
DRIP/DOSE																								

FREQ. VITAL SIGNS

TIME	2050	2103	2108	2113	2128	2133	2148	2248	2348	0010					
BP	96/52	98/50	98/50	98/50	98/50	98/54		102/52	104/52	120/60					
HR	94	89	88	84	85	86	85	82	77	70					
RR	20	16	16	16	16	16	18	16	18	18					
TEMP	102.0	101.3	101.2	101.5	101.1	100.8	101.0	101.1	102°	101°					
SAO_2	98%	98%	94%	93%	98%										

post transfusion

Notes: Pt. Sleeping from premedication for OR & TRANSFUSION (b)(6)-2 icon/pc

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT.
FOLEY																										
UOP	350				400							300										300				
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Name: (b)(6)

NUR MED G FLOW SHEET
AC 6550/12/Temp Form

Date: 20 APR 03

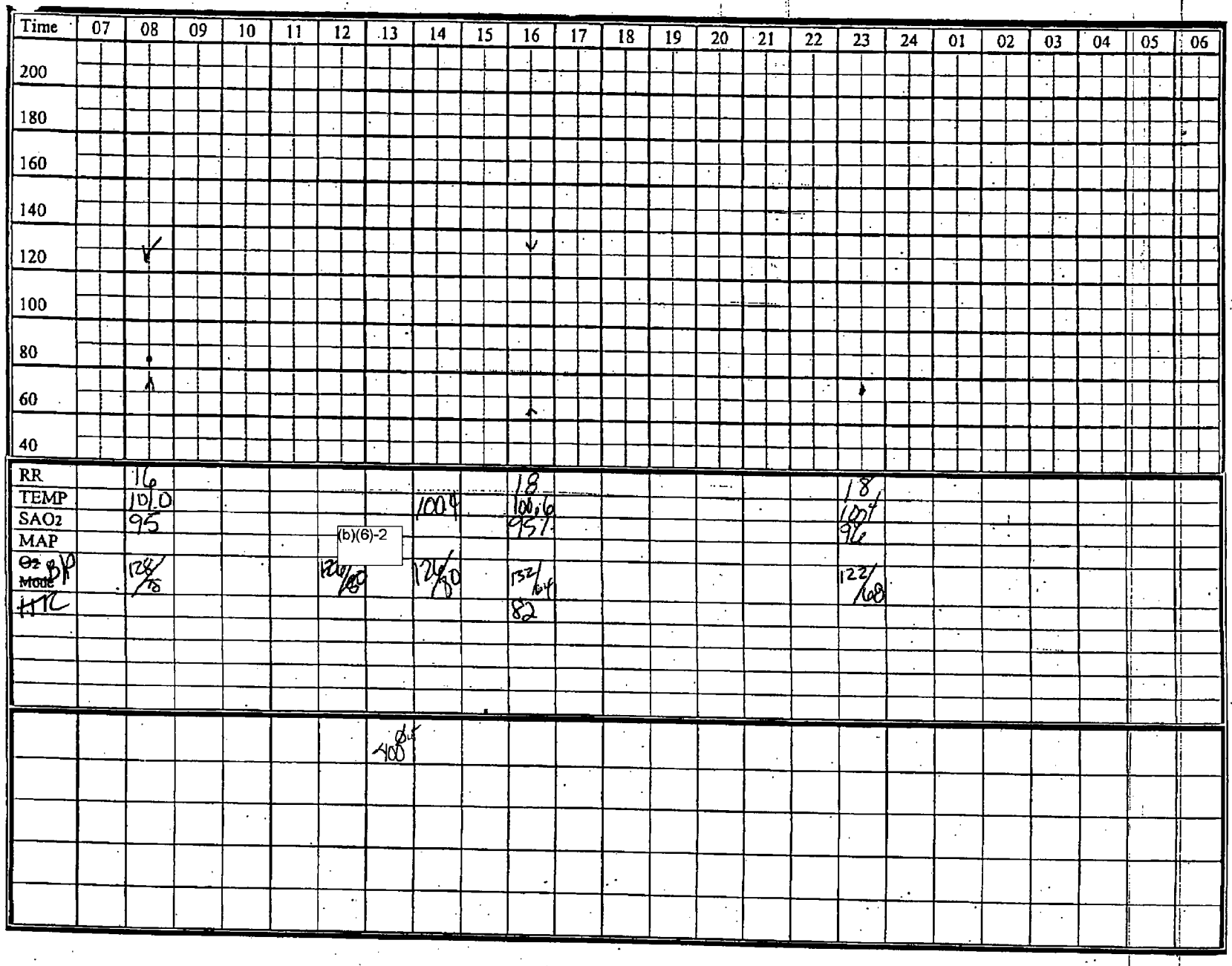
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF 200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		16														16	20							
TEMP		99.9								100.4						102	102	101.6					100.8	
SAO2		96															92							
MAP																								
O2 Mode		RA																						
		148/102								140/68 2nd														
									P	92														
DRIP/DOSE																								
UOP		200			400					450					200								300	300

(b)(6)-4

NURSING FLOW SHEET

MEDICAC 6550/12/Temp Form

Date: 21 MAR 03



Name: (b)(6)-4

NURSING [illegible]HEET
MEDTREFAC-655[illegible] Temp Form

Date: 22 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		16			16					14				16			14							
TEMP		99.1			99.2					99.5				99.0			98.6							
SAO2		96			95												97							
MAP																								
O2 Mode		110/60			114/68					110/70				124/66										
UOP					560			260	400													300		

DRIP / DOSE

Name:

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date:

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF 200																								
180																								
AL 160																								
140																								
120																								
R 100																								
80																								
60																								
40																								
RR																								
TEMP																								
SAO_2																								
MAP																								
O_2 Mode																								
400P									400															
DRIP/DOSE																								

MEDCOM - 4758

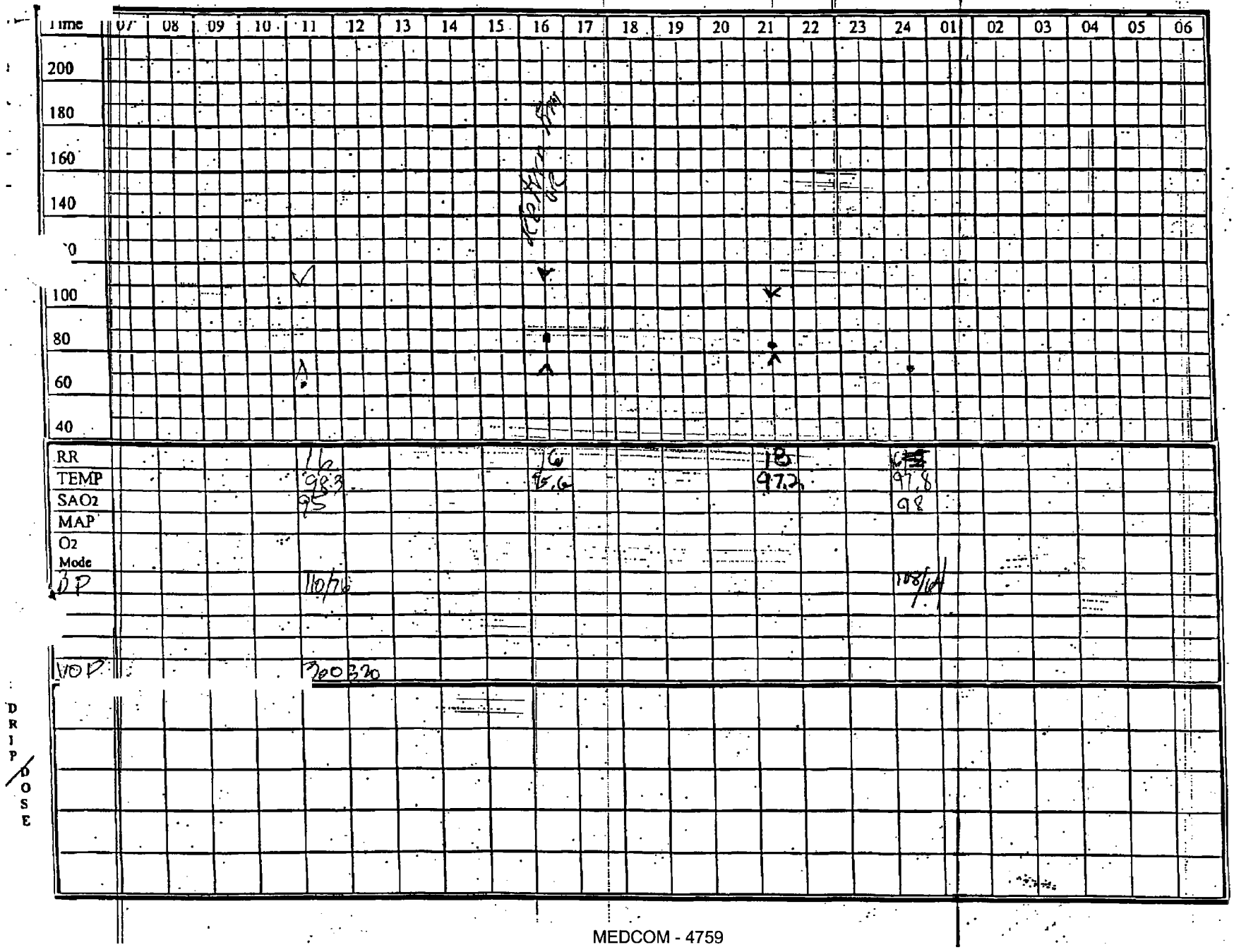
DOD 11970

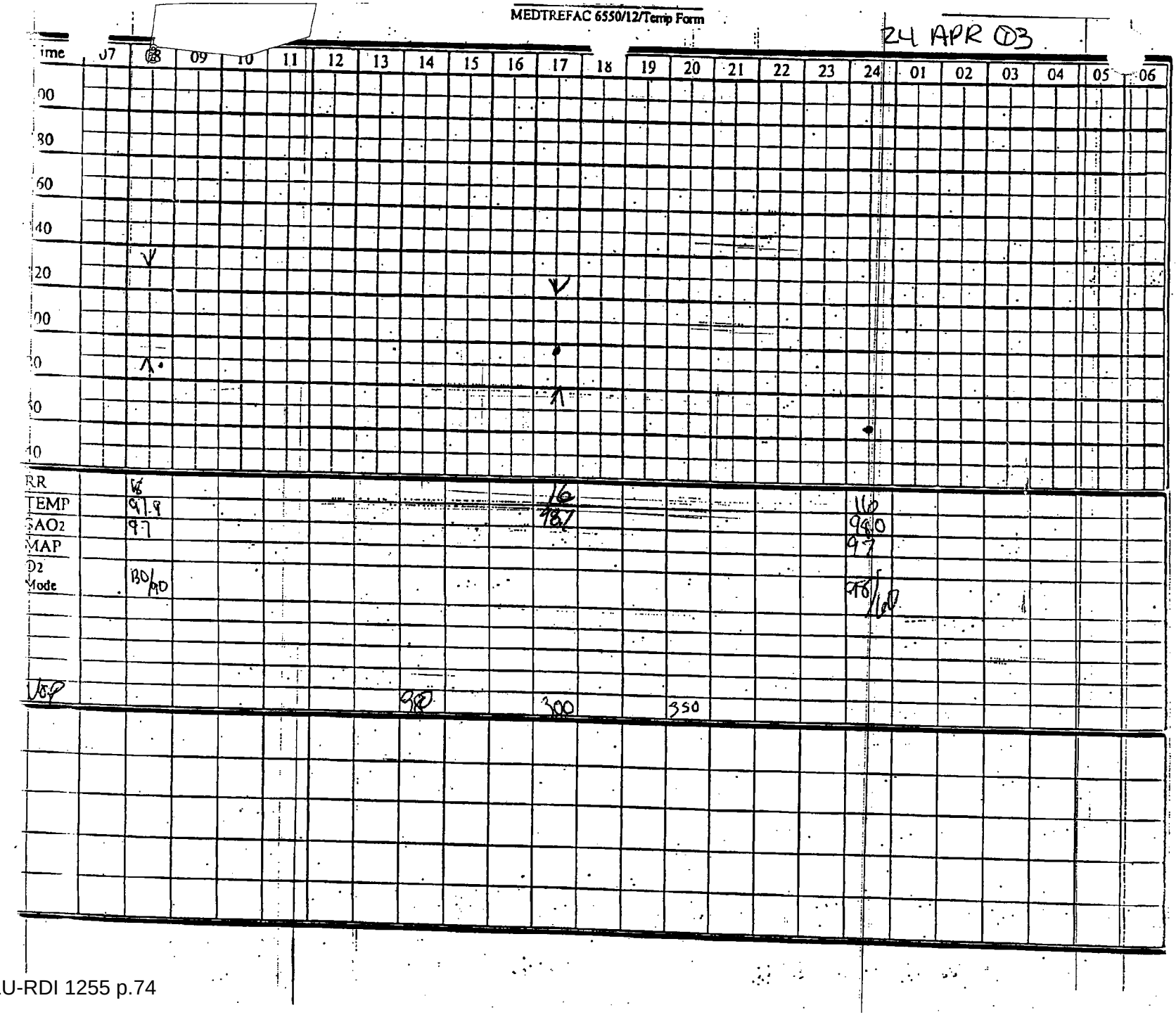
ACLU-RDI 1255 p.72

Name: (b)(6)-4

NU[illegible]G [illegible]SHEET
MED [illegible]EFAC-655[illegible] emp Form

Date: 23 APR 03





25 APR 03
MEDCOM - 4761
(b)(6)-4

MEDCOM - 4762

27 HPK 03
(b)(6)-4

(b)(6)-4

28 APR 03

07 08 09 10 11 12 13 14 15 16 17 18 19 21 22 23 24 01 02 03 04 05 06

18
98.2
97%

RA
100/68

116
98.0
95

112/68

116
99.1
97%

RA
104/64

FREQ. VITAL SIGNS

ME																		
K																		
R																		
EMP																		
AO2																		

otes

INPUT/OUTPUT

V	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
/PB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP								330																	
RM																									

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

FREQ. VITAL SIGNS

INPUT/OUTPUT

PREVIOUS WEIGHT

PRESENT WEIGHT

PREVIOUS 24 HOUR OUTPUT

PRESENT 24 HOUR OUTPUT

MEDCOM - 4766

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH–YEAR DAY
19 HOUR

PULSE (O) — TEMP. (●)

PULSE (O)	TEMP. (●)
	105°
180	104°
170	103°
160	102°
150	101°
140	100°
130	99°
	98.6°
120	98°
110	97°
100	96°
90	95°
80	
70	
60	
50	
40	

TEMP. C

TEMP. C	
40.6°	
40.0°	
39.4°	
38.9°	
38.3°	
37.8°	
37.2°	
37.0°	
36.7°	
36.1°	
35.6°	
35.0°	

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT:

Record special data only when so ordered

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

REGISTER NO.

WARD NO

511-113

(b)(6)-4

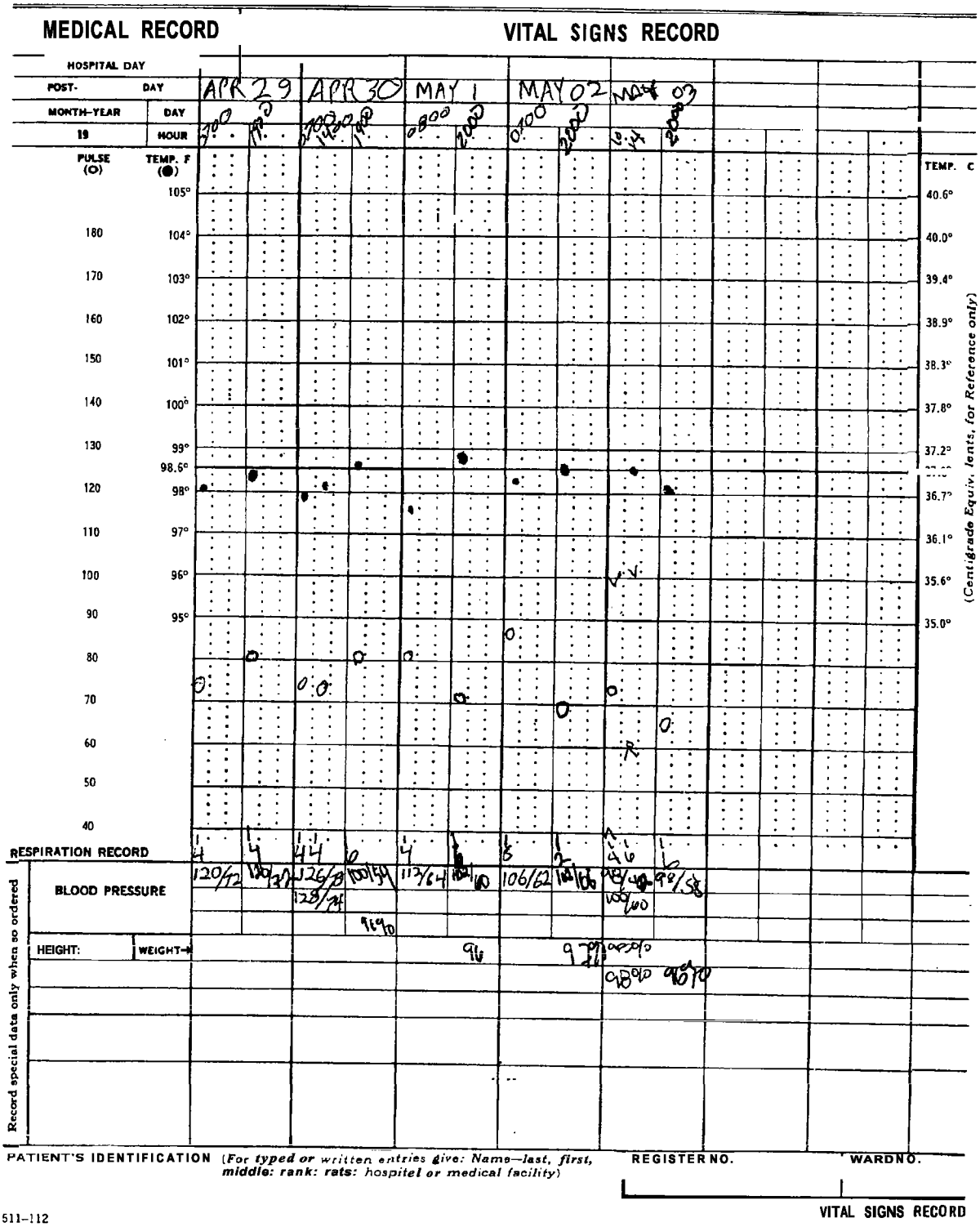
VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9–79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201–45.505

*U.S. Government Printing Office: 1989-241-175/80290

MEDCOM - 4767

MEDICAL RECORD — VITAL SIGNS RECORD



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

VITAL SIGNS RECORD

511-112

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

MEDCOM - **4768**

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Mar 03 - 11 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/1d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

11 Apr 03 @ 0555 (Coll) SERUM
Order comment: FASTING BLOO

GLUCOSE	261	H	(76-110)	mg/dL

10 Apr 03 @ 1636 (Coll) PLASMA

APTT	20.4	L	(23.8-35.5)	Seconds
PT	11.8		(11.6-14.4)	Seconds
INR	0.8			

Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

10 Apr 03 @ 1636 (Coll) BLOOD

STATWBC	9.6		(4.8-10.8)	K/UL
RBC	2.8	L	(4.7-6.1)	1X10 6/UL
HGB	8.9	L	(14.0-18.0)	g/dL
HCT	26.3	L	(42-52)	%
MCV	94.0		(80-94)	fL
MCH	31.9		(27-32)	pg
MCHC	34.0		(31-37)	g/dL
RDW	12.0		(12-14)	%
PLT CNT	292		(150-450)	1x10 3/UL
MPV	8.1		(7.4-10.4)	**FL**
NEUT/100 **WBC**	72.7			%
NEUT%	7			1x10 3/UL
LYMPHS/100 WBC	21.4			%
LY#	2.1			1x10 3/UL
MONO/100 WBC	5.9			%
MO#	0.6			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

10 Apr 03 @ 1636 (Coll) SERUM

STAT NA+	133	L	(137-145)	mmol/L
K	3.3	L	(3.6-5.0)	mmol/L
CL-	96	L	(97-107)	mmol/L
C02	31		(22-31)	mmol/L
BUN	12		(9-21)	mg/dL
GLUCOSE	166	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5).	mg/dL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod S I=Intermed

Personal Data - Privacy Act 1974 (PL 93-579)
Review Results

Report requested by: b)(6)-2

Patient: b)(6)-4
Date of Birth: 10 Apr 2003
Age: 0
Outpatient Record Loc.:
Duty Station/Unit:

FMP/SSN: b)(6)-4
Sex: MALE
Home Phone:
Work Phone:
Register Number: b)(6)-4

---

b)(3)-1

DIAGNOSTIC RADIOLOGY X7420
Procedure: PELVIS (AP ONLY)
Exam Date: 12 Apr 2003@1646
Requested by: b)(6)-2
Status: COMPLETE
Ward/Clinic: b)(3)-1 STBD 5-43-0 X7103
Exam #: b)(6)-4
Pregnant:

Reason for Order:
CONCERN FOR FOREIGN BODY. PLEASE EVALUATE. THANK YOU.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

An AP view of the pelvis demonstrates metallic fragments overlying the left hip and ischium as well as the soft tissues of the left proximal thigh. No fracture or dislocation. Bone island, right femoral head.

Transcription Date/Time: 12 Apr 2003@1731

Interpreted by: b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: b)(6)-2 CDR,MC,USN 12 Apr 2003@1849
Supervised by:

Personal Data - Privacy Act 1974 (PL 93-579)
Review Results

Report requested by: (b)(6)-2

Patient: (b)(3)-1
Date of Birth: 10 Apr 2003
Age: 0
Outpatient Record Loc.:
Duty Station/Unit:

FMP/SSN: (b)(3)-1
Sex: MALE
Home Phone:
Work Phone:
Register Number: (b)(6)-4

**********ATTENTION**********
* THIS REPORT IS PENDING APPROVAL BY RADIOLOGY AND *
* SHOULD NOT BE INTERPRETED AS THE FINAL REPORT. *
****

(b)(3)-1

Procedure: ELBOW, RT
Requested by: (b)(6)-2
Ward/Clinic: (b)(3)-1 5-43-0 X7103

DIAGNOSTIC RADIOLOGY X7420
Exam Date: 12 Apr 2003@1646
Status: TRANSCRIBED
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
CONCERN FOR FOREIGN BODY. PLEASE EVALUATE. THANK YOU.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Four views of the right elbow demonstrate a soft tissue defect involving the dorsal aspect of the proximal forearm. No joint effusion. No acute fracture or dislocation. Metallic fragments in the soft tissues dorsal and radial to the radial head. Enthesophyte at the olecranon.

Transcription Date/Time: 12 Apr 2003@1710

Interpreted by: (b)(6)-2, CDR,MC,USN
Supervised by:

Approved by:
Supervised by:

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 12 Apr 2003@1249
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: [redacted] FMP/SSN: [redacted]

[redacted]

DIAGNOSTIC RADIOLOGY X7420
Procedure: CHEST,PA/LAT
Exam Date: 11 Apr 2003@2204
Requested by: [redacted]
Status: COMPLETE
Ward/Clinic: WARD [redacted] 5-43-0 X7103
Exam #: [redacted]
Pregnant:

Reason for Order:
Repeat from portable. Please evaluate. Thank you.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Mild cardiomegaly. Mild, diffuse increased interstitial markings throughout the lungs. Question possible long smoking hx in this pt vs. occupational dust exposure.

Transcription Date/Time: 11 Apr 2003@2317

Interpreted by: [redacted] CAPT,MC,USN
Supervised by:

Approved by: [redacted] CAPT,MC,USN 11 Apr 200382320
Supervised by:

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2 √

(b)(3)-1

13 Apr 2003@0752 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 14 Mar 03 - 13 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/3d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

13 Apr 03 @ 0628 (Coll) SERUM

NA+	135	L	(137-145)	mmol/L
K	3.4	L	(3.6-5.0)	mmol/L
CL-	101		(97-107)	mmol/L
CO2	32	H	(22-31)	mmol/L
BUN	8	L	(9-21)	mg/dL
GLUCOSE	192	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

515 – 110

MEDICAL RECORD | TISSUE EXAMINATION

SPECIMEN SUBMITTED BY | DATE OBTAINED

SPECIMEN

BRIEF CLINICAL HISTORY *(Include duration of lesion and rapidity of growth, if a neoplasm)*

PREOPERATIVE DIAGNOSIS

OPERATIVE FINDINGS

POSTOPERATIVE DIAGNOSIS

NAME OF LABORATORY

(Gross description, histologic

PATIENT I.D. AND BLOOD ISSUE TAG

(record copy)

RECEIVED

APR 1 4 2003

* Check One

_✓_ Crossmatch

___ Fresh Frozen Plasma

Triage Number ___

(b)(6)-4

Name

SSN

Location __ (b)(3)-1 __

Automatic Release Time _____

(b)(3)-1

BLOOD BANK (2/91)

SIGNATURE OF PATHOLOGIST

TIFICATION NO.

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

(b)(6)-4

TISSUE EXAMINATION

STANDARD FORW [illegible] (REV. 9–77)

Prescribed by GSA [illegible]AR, FIRMR (41 CFRJ20145.505

MEDCOM - 4774

2 √

(b)(3)-1 (b)(3)-1

15 Apr 2003@0656 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 16 Mar 03 - 15 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/5d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

15 Apr 03 @ 0503 (Coll) BLOOD

WBC	8.6		(4.8-10.8)	K/UL
RBC	2.7	L	(4.7-6.1)	1X10 6/UL
H G B	8.9	L	(14.0-18.0)	g/dL
HCT	25.9	L	(42-52)	%
MCV	94.9	H	(80-94)	fL
MCH	32.5	H	(27-32)	pg
MCHC	34.2		(31-37)	g/dL
RDW	14.1	H	(12-14)	%
PLT CNT	419		(150-450)	1x10 3/UL
MPV	6.9	L	(7.4-10.4)	FL
NEUT/100 WBC	66.8			%
NEUT%	5.7			1x10 3/UL
LYMPHS/100 WBC	24.2			%
LY#	2.1			1x10 3/UL
MONO/100 WBC	9.0			%
MO#	0.8			1x10 3/UL
EO#	c0.7			1x10 3/UL
BAS#	c0.2			1x10 3/UL

15 Apr 03 @ 0503 (Coll) SERUI

Order comment: FASTING BLOOD GLUCOSE ALSO

NA+	134	L	(137-145)	mmol/L
K	3.6		(3.6-5.0)	mmol/L
CL-	102		(97-107)	mmol/L
C02	31		(22-31)	mmol/L
BUN	10		(9-21)	mg/dL
GLUCOSE	219	H	(76-110)	mg/dL
CREAT	0.7	L	(0.8-1.5)	mg/dL

L=Lo H=Hi *=Critic R=Resist S=Susc MS=Mod Susc I=Intermed

MEDCOM - 4775

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 15 Apr 03 - 16 Apr 03

Report requested by: b(6)-2

b(6)-4 b(6)-4 M/6d Reg #: b(6)-4
Ph: Military Unit: UNKNOWN

16 Apr 03 @ 0537 (Coll) SERUM
Order comment: ALSO DO FASTING BLOOD GLUCOSE

NA+	132	L	(137-145)	mmol/L
K	3.6		(3.6-5.0)	mmol/L
CL-	98		(97-107)	mmol/L
C02	29		(22-31)	mmol/L
BUN	9		(9-21)	mg/dL
GLUCOSE	198	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL
CA	7.4	L	(8.8-10.4)	mg/dL
PHOSPHORUS	3.4		(2.5-4.5)	mg/dL
URIC ACID	2.1	L	(3.3-8.4)	mg/dL
PROTEIN TOTAL	5.5	L	(6.3-8.3)	g/dL
ALBUMIN	2.4	L	(3.5-5 .0)	g/dL
AST	21		(15 -46)	U/L
ALT	33		(11-66)	U/L
LDH	497		(313-618)	U/L
ALK PHOS	71		(70-250)	U/L
TBILI	1.0		(1.0-10.5)	mg/dL
GCT	26		(8-78)	U/L
CK	94		(0-203)	U/L
MG	2.1		(1.7-2.2)	mg/dL

Interpretations:

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 22 Apr 03 - 23 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/13d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

---

23 Apr 03 @ 1116 (Coll) SERUM

ASAP GLUCOSE . . . . . 108 (76-110) mg/dL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

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Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LR

For: 22 Apr 03 - 23 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/13d Req #: (b)(6)-4

Ph: Military Unit: UNKNOWN

23 Apr 03 @ 1718 (Coll)				SERUM
GLUCOSE	180	H	(76-110)	mg/dL
23 Apr 03 @ 1116 (Coll)				SERUM
ASAP GLUCOSE	108		(76-110)	mg/dL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

516-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

GSW R. Lateral Thigh / Groin
(R) Elbow

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
D~ (b)(6)-2	—	—	
ANESTHETIST	**ANESTHETIC**		**TIME BEGAN:** 0836
LCDR (b)(6)-2	General ETT		**TIME ENDED:** 1133
CIRCULATING NURSE	**SCRUB NURSE**	**TIME OPERATION BEGAN**	**TIME OPERATION COMPLETED**
LCDR (b)(6)-2	ltw (b)(6)-2	0915	1128

OPERATIVE DIAGNOSES

SAME

DRAINS (Kind and number)	SPONGE (b)(6)-2
(R)	

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
1.) (L) Groin Aerobic + Anaerobic Cultures — To Lt Flank — 1000cc
2) (R) Thigh Aerobic + Anaerobic Cultures — EBL 2500cc
non-sig

OPERATION PERFORMED
I+D Rt elbow Rt thigh Left groin x2 + Left thigh x 3
Advancement flap RT Thigh + Left thigh.

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

Converted + debrided all wounds.
CX's taken of medial (L) Thigh + (R) ant thigh. Irrigated c Bacitracin + NS. Closed wounds loosely c Iodoform wicks between nylon vertical mattress sutures, 3-0
Dressed c gauze + Kerlex -
Hold down c spandage.
To RR Stable. No pus/abscesses found -
(Rt Rectus-portion debrided c supercan to unveil + heal from cavity debrided)

PROSTHETIC DEVICES (Lot no.)

DATE OF OPERATION
15 Apr 03

Iodoform Packing
(L) Anterior Thigh - 4 pieces
(L) Lateral Thigh - 1 piece
(L) Groin - 3 pieces
Superficial Area medial (L) Th - 1 piece
(R) Elbow - 5 pieces
(R) Thigh - 1 piece
(R) Thigh - 6 pieces

SIGNATURE OF SURGEON	(b)(6)-2	(b)(6)-2	DATE
			15 Apr 03
PATIENT'S IDENTIFICATION (For typed or written en grade; date; hospital or m		REGISTER/I.D. NO.	WARD NO.
(b)(6)-4			

OPERATION REPORT
Medical Record

U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

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

MEDCOM - 4779

518-103

NSN 7540-00-[illegible]-4156

MEDICAL RECORD — **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

"Multiple GSW Rt Elbow, Left groin x2, Rt thigh x2, + Left thigh x3."

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr (b)(6)-2	—	—	TIME BEGAN: 08:21
ANESTHETIST Dr (b)(6)-2	ANESTHETIC General,		TIME ENDED: 1950
CIRCULATING LT (b)(6)-2	SCRUB NURSE Hmz (b)(6)-2	TIME OPERATION BEGAN 08:57.	TIME OPERATION COMPLETED 09:40
OPERATIVE (b)(6)-2			

X Pos Muscle necrosis Rt Thigh (Requisite Debridement.

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
	N/A.

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

(1) Aerobic Cx Rt thigh wound (2) Anaerobic Cx Rt thigh wound / gram stain.

OPERATION PERFORMED

EBL: 200
Fluids: 1300
U/O: NM

X I+D 4/9 wounds Debridement of RT Rectus Femoris.

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION
Hm 3 (b)(6)-2 (b)(6)-2	—	17 APR 03

Removed wound packing. Irrigated Wounds
Replaced packing (L) Thigh + groin. RT Rect Femoris.
explored → Muscle necrosis + liquefaction hematoma
Evacuated + Debrided. (Cx taken) Packed.
Tol well → to RR stable.

SIGNATURE OF SURGEON

X (b)(6)-2

DATE 17 Apr 03

PATIENT'S IDENTIFICATION (For typed or hand-printed entries, this block should be completed.)

(b)(6)-4

M

(b)(6)-4

(b)(3)-1 10APR03

PERSONAL DATA PRIV ACT 1974

MEDCOM - 4780

516-108 NSN 7540 00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

GSW (L) Thigh / Hip
(R) Thigh, (R) Elbow

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
DC (b)(6)-2	DC (b)(6)-2		
ANESTHETIST	**ANESTHETIC**		TIME BEGAN: 1232
~~DC~~ (b)(6)-2 LT (b)(6)-2	General ETT		TIME ENDED: 134
CIRCULATING LCDR (b)(6)-2 LT (b)(6)-2	SCRUB NURSE HN (b)(6)-2	TIME OPERATION BEGAN 1302	TIME OPERATION COMPLETED 1340

OPERATIVE DIAGNOSES

SAH

DRAINS *(Kind and number)* d

SPONGE COUNT VERIFIED (b)(6)-2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
Aerobic & Anaerobic CX (L) Hip wound

OPERATION PERFORMED
Removal Fragment (L) Hip Joint
Debridg Wounds Bilateral Legs, (R) Elbow

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

PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION
	20 April 03

Anterior Approach to hip
Fragment visualized with
assistance of C-Arm. Capsulotomy
performed and Fragment removed
and passed off table. C-Arm
confirms of fragment. Joint irrigated
No endoscope of injects of implants.
Pt tolerated procedure well. Capsule
to closed using 2 Vicryl Skin closed w Staples

Total Fluid - 1100cc
EBL - minimal
UOP - NM

SIGNATURE OF SURGEON	DATE
(b)(6)-2	20 April 03

PATIENT'S IDENTIFICATION (b)(6)-4 *(Name - last, first, middle: ...ity)* | REGISTER/I.D. NO. | WARD NO.

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-401

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, **FPMR 101-11.006-8**

MEDCOM - 4781

HM4 Case #1

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS
Shrapnel / G.S.W BLE
HM3 (b)(6)-2 Surgical Resident

SURGEON (b)(6)-2	FIRST ASSISTANT	SECOND ASSISTANT	
DR.	Ø	Ø	
ANESTHETI (b)(6)-2	ANESTHETIC		TIME BEGAN: 1315
DR.	GEN ENT		TIME ENDED: 1429
CIRCULATING (b)(6)-2	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
LPN		1338	1425

OPERATIVE DIAGNOSES
SAM

(b)(6)-2

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
Ø	correct x 3

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
Ø

OPERATION PERFORMED
Bullet Extraction ® thigh X 2
Wound Closure ® thigh.

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION
HM3 (b)(6)-2 -Doctor 0.25% Marcaine Plain Ø cc	Ø	04/23/03

EBL Min
IVF 400

Prep + draped c betadine.
Rt thigh #15 blade → incised to subcut. → wound.
2 layer close c staples.
3. # 3-0 vyclm used to advance other wound on ® Thigh.
Dsgd c NS to pacu stable & alert.

(b)(6)-2

SIGNATURE OF SURGEON | DATE 04/23/03

PATIENT'S IDENTIFICATION (For typed or written entrie grade; date; hospital or med | WARD NO. Rm 9/case Ø1

(b)(6)-4

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-401

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

MEDCOM - 4782

516-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

AD Perforation
R + tympanoplasty

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT
(b)(6)-2 MS		
ANESTHETIST	**ANESTHETIC**	**TIME BEGAN:** 928
(b)(6)-2 md	Gen ET	**TIME ENDED** [redacted]
(b)(6)-2 Lt	**SCRUB NURSE** (b)(6)-2 Hn²	**TIME OPERATION BEGAN** 934 / **TIME OPERATION COMPLETED** [illegible]

OPERATIVE DIAGNOSES

AD Perforation

DRAINS *(Kind and number)* 0

SPONGE/SUR[illegible] (b)(6)-2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION 0

OPERATION PERFORMED

AD medial Graft Tympanoplasty

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)* (b)(6)-2 Hn

PROSTHETIC DEVICES *(Lot no.)*

DATE OF OPERATION 25 Apr 03

Findings - NL middle ear, NL round window niche EBL NIL
35% inferior posterior perforation, Chorda Tympani intact LR 500
Urine NR

Operation - General ETT anesthesia. Sterile prep right ear. Xylocaine 1% 8 cc epi
Harvest of post auricular temporalis fascia graft.
Tympanomeatal flap raised graft placed in medial fashion.
TM returned to normal anatomic position.
Perforation covered. Decadron/Cipro drops in OR
Gel foam in ear canal Bacitracin applied.
Pos? op 3/12 to operated ear. VII intact.
Tolerated procedure well.

SIGNATURE OF SURGEON (b)(6)-2

DATE 25 APR 2003

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

REGISTER/I.D. NO.

WARD NO.

10 APR 03

(b)(3)-1

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-[illegible]

PRIVACY ACT 1974 PERSONAL DATA PRINT

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

MEDCOM - 4783

COUNT SHEET

ITEMS		QUANTITY	ADDED	1ST	2ND	3RD
SUTURE NEEDLES		2				
KNIFE BLADES						
SCRATCH PAD		1				
HYPODERMICS		2				
CAUTERY TIPS						
RAYTEX		10				
LAP TAPES						
COTTONOIDS	1/4 x 1/4					
	½ x ½					
	½ x 1					
	½ x 3					
	1/8 x 1/8					
	1 x 1					
	3/4 x 3/4					
	1 x 3					
	1/4 x 6					
	½ x 6					
	3/4 x 6					
	1 x 6					
	2 x 6					
	3 x 6					
PEANUT/KITNERS						
BULL DOGS						
REELS						
HEMOCLIPS BOATS						
RUBBER SHODS						
DRAINS						
NOODLES						
UMBILICAL TAPES						
RUBBER BANDS						
SAFETY PINS						
NECK SPONGES						
TANN. FISIL TONSIL						
COTTON BALLS						
MISCELLANEOUS						

LOAD NO

(b)(6)-4

ADDRESSOGRAPH

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

INITIALS	OR NURSE SIGNATURE

MEDCOM - 4784

ANESTHESIA RECOR

ANHC 6279(12/00)

Wt (kg) - ~70 kg Ht (in) - ~5'10" gies - NKDA

Procedure	Anesthesiologist/CRNA & Clin.	Surgeon	OR # 1
(R) Tympanoplasty	(b)(6)-2 MD	(b)(6)-2	See Page One

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page 1 of 1
4.25.03	0820	0840	0934	1110	1125	—	

Time 0845 0900 X 30 X 1000 X 30 X 1100 X

O_2 L/M	8	1	1	1	1	1	1	1	2	2/8
N_2O / Air L/M		2	2	2	2	2	2	2 X		
Enflu. Halo / Iso / Sevo / Des		.4	.3	.3	.4	.4	.4	.4	.6	.6X
STP / Prop / Etomidate	200									
Sux / Cistracurium										
Ro / Rapa / Vec / curonium	8		2			4				
Lidocaine										
Neostigmine / Glyco										5/1
Ephedrine / Neo										
Midazolam										
MSO$_4$ / Remi / Su / Fentanyl	150									
Epid. Lido / Bupiv / Ropiv										
NS (LR)			200					400 - 500		
U/O	X									
EBL								min		

Checklist -
O$_2$ Suction Machine Consent NPO

Monitors -
SaO$_2$ ECG FiO$_2$ NIBP L / R arm
EtCO$_2$ PCS / ES PNS PIP Temp
Mass Spec Verbal TEE Fluid warmer
Air Warm Foley FHT Pulm Art cath
CVP IJ / SC / Fem L / R OG / NG L / R
A-Line Rad / Fem L / R

Position Pressure points padded Arms < 90°
Supine Prone Lithotomy Sitting Lateral L / R

Drawn ___ Used ___ Wasted ___ Witns ___
Drawn 250 Used 150 Wasted 100 Witns TL

IV - 20 Ga L / R Hand Wrist FA AC EJ
Tourniquet ___ mmHg Times I ___ I ___
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

		Antibiotics
	Total	Agent -
500	Total	mg
N/A	Total	over minutes
min	Total	@

● = Pulse
○ = Spont. Resp.
⊘ = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse - 74
BP - 122/79
Temp - 96.7
RR - 14
SaO$_2$ - 100%
Comps - + / -

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Np / Or / Sk / Ax Temp		36.1	36.1	36.0	35.9	35.9	35.9	35.9	35.9	35.9
% FiO$_2$	1.0	.3	.3	.3	.4	.4	.4	.4	1.0	1.0
% SaO$_2$	100	100	100	100	100	100	100	100	100	100
EtCO$_2$		33	34	34	35	35	34	34	34	34
TOF		4/4	4/4	0/4	3/4	4/4	0/4	0/4	0/4	4/4
TV	SV	785	CV	700	CV	710	CV	721	CV	720 SV
PIP (cmH$_2$O)		19		19		19		19		19
Resp. Rate		10		10		10		10		10 12

Induction Monitors On Preoxygenated Smooth Inhalation IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y N
Intubation Mac / Mil 4 Grade 1 view Tube Size 7.0 Attempts 1 Oral Nasal L / R w/o w/ Cuff Stylet Y N Bil BS / EtCO$_2$ / CXR
Tube taped @ 24 cm @ Lips / teeth / nares Trauma Y N FOB / LW / Blind LMA # ___ DLT ___ Fr L / R
Maintenance - Smooth Cuff checked Eyes taped / lubed
Extubation Smooth Reversed SV VSS Full TA / Head Lift / Sustained tetanus Suctioned Awake / Deep
Disposition PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Prep
☑ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ___ L / R
☐ Attempts ___

Blocks
☐ Nerve Stim ___ mA
☐ Transtracheal
☑ Dual cuff

Regional
☑ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ___
☐ Sitting
☐ Lateral R / L
☐ LOR to Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊖
☑ CSF ⊕ swirl

Regional
☐ Catheter out - tip intact
☐ Level ___

Lines
☑ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification (b)(6)-4

JD

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

MEDCOM - 4785

Pe[illegible]perative Plan Of Care & Nursing N[illegible]

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☑ Yes ☐ No

'rauma# or 'atient #

Diagnosis: GSW. Thigh Planned Procedure: (L) thigh Exploration

Side: ☐ N/A ☐ Right ☐ Left

Date: 4-20-03 Arrival Time: Interviewer: L C T (b)(6)-2 Age: HT: WT:

'rom:
- ☐ CASREC
- ☐ ICU
- ☐ Ward 5-F
- ☐ OTHER:

Transport Via:
- ☑ Gurney
- ☐ Litter
- ☐ Ambulated
- ☐ Wheelchair
- ☐ Other

Patient ID:
- ☐ Trauma card
- ☐ Verbal
- ☑ Chart
- ☐ Armband
- ☐ Other

Blood Ordered:
- ☑ N/A
- ☐ Yes ☐ Consent
- ☐ TIC #Units
- ☐ T/H #Units

Comments:

Surgical/Anesthesia Consent Verified:
- ☐ Procedure
- ☐ Consent complete, dated, signed
- ☑ Emergent case; no consent, MD note

'reop Labs (HCG, etc):
- ☑ None ☐ Yes

'est/Results:

Drug/Latex Allergies:
- ☑ NKDA

Allergy/Reaction:

Present On Admission:
- ☐ N/A
- ☐ Oxygen
- ☑ IV Site: #1 (L) arm
- #2
- ☐ Foley
- ☐ Endotrachial Tube
- ☐ Arterial Line Site:
- ☐ Drain(s)
- ☐ Chest Tube(s)
- ☐ See RN Note #

Past Medical History:
- ☑ None known
- ☐ Smoker ppdlyrs /
- ☐ ETOH ☐ Asthma
- ☐ HTN ☐ CAD
- ☐ GERD ☐ CBR exposure
- ☐ Other:

Past Surgical History:
- ☐ None known
- ☑ Yes

List:

Cultural Needs Addressed:
- ☐ Yes ☑ No

List:

're-Op Pain:
- ☐ No
- ☐ Yes Level (0-10)

ction Taken:

ocation/type:

Last PO Intake: (date/time)
Solid: 4-19-03 2400
Liquid: 4-19-03 2400

n Chart: ✓
- ☐ H&P Yes ☐ No
- ☐ EKG ☐ Yes ☐ No
- ☐ CXR ☐ Yes ☐ No
- ☐ Other:

Skin Condition:
- ☐ Intact
- ☐ Other: Dressing to (L) thigh area

Limitations:
- ☐ N/A
- ☑ Language
- mobility
- ☐ Other:
- ☐ Auditory
- ☐ Visual
- ☐ Prosthesis

Personal Items:

	Disposition:
☑ None	
☐ Military gear	
☐ Glasses	
☐ Dentures	
☐ Jewelry/wallet	
☐ Other	

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status:
- ☑ Alert/Oriented
- ☐ Disoriented
- ☐ Anxious
- ☐ Appropriate for age
- ☐ Other
- ☐ Calm
- ☐ Sedated
- ☐ Unresponsive

Comfort Measures Implemented:
- ☐ Clear, concise explanations
- ☐ Communicated patient concerns to other staff members
- ☐ Remain with patient during induction

Pre-op Teaching Included:
- ☑ N/A due to patient condition
- ☐ Physical layout of OR
- ☐ Personnel present during procedure
- ☐ Environment (noise, temperature, etc.)
- ☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☑ Yes ☐ No

Operative Position:
- ☑ Supine
- ☐ Prone
- ☐ Jackknife
- ☐ Lithotomy
- ☐ Other:
- ☐ Beach chair
- ☐ Sitting
- ☐ Lateral L / R

Positional Aids:
- ☐ Arms <90
- Armboard: ☑ L ☑ R
- Tucked: ☐ L ☐ R
- ☐ Airplane
- ☐ Fracture Table
- ☐ Hand Table
- ☐ Stirrups
- ☐ Other:
- ☐ Axillary roll
- ☐ Gel Pad
- ☐ Leg Holder
- ☐ Tape
- ☐ Bean Bag
- ☐ Gel donut
- ☐ Pillows
- ☐ Wilson Frame

Comments:

ESU #
Pad Site: (R) Flank
Pad Lot # 66916
Site Clear at end of case? ☐ No ☑ Yes
If No, see RN note #
Bipolar: Max Cut 40 Coag 40

DVT Prevention:
- SCD used ☐ No ☑ Yes
- Pressure: ☐ Left ☐ Right
- Teds: ☐ No ☐ Yes
- Bair Hugger used: ☐ No ☑ Yes
- Other warming techniques:

Tourniquet:
- ☐ Arm ☐ Leg
- ☐ Left ☐ Right
- ☐ webril applied
- # 2 1/2
- Applied by:
- ↑ ↓ ↑ ↓
- Total Min:

Comments:

(b)(6)-4

Comments:

(b)(3)-1

Potential For Infectio **Outcome**: Appropriate Actions Taken to Pre Infection ☑ Yes ☐ No

Wound Classification:
☐ I ☐ II ☐ III ☑ IV

Shave Prep:
☐ Shave ☐ Clipper
Area: _____ By: _____
N/A

Skin Prep:
☑ Betadine Scrub
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/M. ications:
☑ Normal saline ☐ Other: _____
☐ Sterile water
☐ Local _____
☐ Antibiotics _____

Drains/Packing: done
Foley FR: _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: S i z e . Location _____
Chest tube: Location _____
Size _____ H20 Pressure: _____
Packing: type/location: _____
See RN Note # ____ for comments

Dressing: Location: _____ L L) _____ R. le hm / _____

☑ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☐ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☑ Plains	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☑ Xeroform	
☐ Cast	☑ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

'ounts: (initials)
crub: RN: Correct?
Sharps ☑ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ ***NIA***
See RN note # ____ for additional comments

Xray:
☐ None ☐ Other:
☐ Portable
☑ C-Arm

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: multiple pencil dots on legs
☐ See RN note # ___ for additional comments.

nplants:
em / Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

omplications:
None Comments: _____
See RN note # ____ for additional comments

Transport From OR:
☑ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☑ PACU Report by:
☐ ICU ☐ Anesthesia provider ☐ RN
☐ Medivac
☐ Ward ____
☐ Other

ırgical Procedure Performed: (L) Hip Exploration / Draining D Both legs

N Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2
Primary OR RN Signature
Date 4-20-05
(b)(3)-1
Relief OR RN Signature
Date/Time

MEDCOM - 4787

PeriO··rative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☑ Yes ☐ No

Trauma# or Patient #	Diagnosis: R AD Perf [illegible] Planned Procedure: R Tympanoplasty Date: 25 Apr Arrival Time: Interviewer: (b)(6)-2		Side: ☐ N/A ☑ Right ☐ Left Age: HT: WT:

From:
☐ CASREC
☐ ICU
☑ Ward _____
☐ OTHER:

Transport Via:
☑ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☐ Chart
☑ Armband
☑ Other MD

Blood Ordered:
☑ N/A
☐ Yes ☐ Consent
☐ T/C #Units _____
☐ T/H #Units _____
Comments: _____

Surgical/Anesthesia Consent Verified:
☐ Procedure
☑ Consent complete, dated, signed
☐ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☐ Yes
Test/Results: _____

Drug/Latex Allergies:
☑ NKDA
Allergy/Reaction: _____

Present On Admission:
☐ N/A
☐ Oxygen
☑ IV Site: #1 L hand
#2 _____
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site: _____
☐ Drain(s) _____
☐ Chest Tube(s) _____
☐ See RN Note # _____

Past Medical History:
☐ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Past Surgical History:
☐ None known
☑ Yes
List: I & D

Cultural Needs Addressed:
☐ Yes ☐ No
List: _____

Pre-Op Pain:
☑ No
☐ Yes Level _____(0-10)
Action Taken: _____
Location/type: _____

Last PO Intake: (date/time)
Solid: _____
Liquid: 10 MAY

In Chart:
☑ H&P ☐ Yes ☐ No
☑ EKG ☐ Yes ☐ No
☑ CXR ☐ Yes ☐ No
☑ Other: _____

Skin Condition:
☑ Intact
☐ Other: _____

Limitations:
☑ N/A ☐ Auditory
☐ Language ☐ Visual
☐ Mobility ☐ Prosthesis
☐ Other: _____

Personal Items:
☐ None Disposition:
☐ Military gear _____
☐ Glasses _____
☐ Dentures _____
☐ Jewelry/wallet _____
☐ Other _____

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☑ Yes ☐ No

Mental/Emotional Status:
☑ Alert/Oriented ☐ Calm
☐ Disoriented ☐ Sedated
☐ Anxious ☐ Unresponsive
☐ Appropriate for age
☐ Other

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☐ Remain with patient during induction

Pre-op Teaching Included:
☐ N/A due to patient condition
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☑ Yes ☐ No

Operative Position:
☑ Supine ☐ Beach chair
☐ Prone ☐ Sitting
☐ Jackknife ☐ Lateral L / R
☐ Lithotomy
☐ Other:

Positional Aids:
☐ Arms <90
Armboard: ☐ L ☐ R
Tucked: ☐ L ☐ R
☐ Airplane ☐ Axillary roll ☐ Bean Bag
☐ Fracture Table ☐ Gel Pad ☐ Gel donut
☐ Hand Table ☐ Leg Holder ☐ Pillows
☐ Stirrups ☐ Tape ☐ Wilson Frame
☐ Other:

Comments: _____

ESU # _____
Pad Site: _____
Pad Lot # _____
Site Clear at end of case? ☐ No ☐ Yes
If No, see RN note # _____
Bipolar: ___ Max Cut___ Coag ____

DVT Prevention:
SCD used ☐ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☐ No ☐ Yes
Other warming techniques:

Tourniquet:
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
↑ ____ ↓ ____
↑ ↓
_____
Applied by: _____
Total Min: _____

Comments: _____

(b)(6)-4

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

Comments: _____

MEDCOM - 4788

Potential For Infec – Outcome: Appropriate Actions Taken to **[illegible]** Infection ☐Yes ☐No

Wound Classification: ☐I ☐II ☐III ☐IV

Shave Prep: ☐Shave ☐Clipper Area: ____ By: ____

Skin Prep: Betadine ☐Betadine Scrub ☐Hibiclens ☐Duraprep ☐Other:

Solutions/Medications: ☐Normal saline ☐Other: ____ ☐Sterile water ☐Local ☐Antibiotics

Drains/Packing: ☐None
Foley FR: ____
JP #1 Fr ___ Location: ____ #2 Fr ___ **Location:** ____
Hemovac: Size ___ Location ____
Chest tube: Location ____
Size ____ H2O Pressure: ____
Packing: type/location: ____
See RN Note # ___ for comments

Dressing: Location: ____

☐ABD	☐Cervical Collar	☐Kling	☐Steri-strips	☐Benzoin
☐Ace	☐Coban	☐Immobilizer	☐Tape	☐Mastisol
☐Bias	☐Drip Pad	☐Plains	☐Webril	☐Bacitracin
☐Band-Aid(s)	☐Fluffs	☐Sling	☐Xeroform	
☐Cast	☐Kerlix	☐Splint	☐Other:	

Miscellaneous

Counts: (initials)
Circulator: (b)(6)-2
Scrub: ____ RN: ____

Sharps	☐Yes	☐No	☐N/A
Sponges	☐Yes	☐No	☐N/A
Instruments	☐Yes	☐No	☐N/A

See RN note # ___ for additional comments

Xray: ☐None ☐Other: ☐Portable ☐C-Arm

Skin Integrity: ☐Clear & Intact (other than incision)
Comments: ____
☐See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date:
See RN note # ___ for additional comments.

Discharge from Operating Room

Complications: None Comments: ____
See RN note # ___ for additional comments

Transport From OR: ☐gurney w/ siderails up ☐Litter w/ safety strap in place ☐w/ Oxygen ☐w/ Monitor ☐Other:

Transferred To: ☐PACU ☐ICU ☐Medivac ☐Ward ____ ☐Other ____
Report by: ☐Anesthesia provider ☐RN

Surgical Procedure Performed: Tympanoplasty

PN Note: (number each note to corresponding area above)

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

Date Relief OR RN Signature Date/Time

(b)(3)-1

MEDCOM - 4789

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ANTIBIOTIC:
TIME GIVIEN:
OTHER:

ALLERGIES NKDA 500mg FLAGYL

OPERATION PERFORMED: I+D (2) Leg Bullet Removal Gen

AGENTS AND TECHNICS OF ANESTHESIA: Spinal

Level: N/A

EKG to monitor on [X]

Rhythm NSR

BP ± art

BP V cuff

Pulse = .

% Sat:

HOUR(S) 1300 15 30 45 1400 15 30 45 5 15 30 45

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

RESP. RATE

NUMBERS FOR REMARKS

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		AOW	1355
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	D/W	BLOOD	SALINE	OTHER
OPERATING ROOM	1000		200	
RECOVERY ROOM	400		0	
TOTAL	1400		200	

BLOOD LOSS IN OR: 20 cc

WARD PRE-OP BP 120 60 mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN L FA @ 1000 cc
OF NS AT KVO cc/hr AOW

IV IN L FA @ 600 cc
OF LR AT KVO cc/hr TOW

ART. LINE IN N/A

T-TUBES, HEMOVAC IN N/A

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5 F PORT
DATE 4/20/03 HRS 1350	DATE 4/20/03 HRS 1500
DRESSINGS: LOCATIONS (2) Leg	
STATUS: CD: I	STATUS: CD: I
ENDOTRACHEAL TUBE – ORAL OR NASAL	
☐ YES ☒ NO	☐ YES ☒ NO
AIRWAY / BREATH SOUNDS	
☒ CLEAR ☐ PLAST AIRWAY	STATUS: clear
☐ OBSTRUCTS EASILY	

	MOR	PACU
TIME		
cc	Ø	Ø
TOTAL		
SP. GR		
S/A		

URINARY OUTPUT

DRAINAGE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by (b)(6)-2

PMH: ASA Ø

Neuro: PT Awake and appropriate

Pain Yes/No Action: Will continue to monitor

CV: S1, S2 Ø murmurs IV: Patent

Other: Side Rails up x 2, Monitors on

Warm Blankets applied (CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES – 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT ____ HRS
SENSATION PRESENT AT ____ HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2			
Able to move 2 extremities voluntarily or on command	1	Activity	2	2
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2			
Dyspnea or limited breathing	1	Respiration	2	2
Apneic	0			
BP ± 20% of preanesthetic level	2			
BP ± 20-50% of preanesthetic level	1	Circulation	2	2
BP ± 50% of preanesthetic level	0			
Fully awake	2			
Arousable on calling	1	Consciousness	2	2
Not responding	0			
Pink	2			
Pale, dusky, blotchy, jaundiced, other	1	Color	2	2
Cyanotic	0			
		TOTALS	10	10

RECOVERY:
☐ COMPLICATED
☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AOW (b)(6)-2

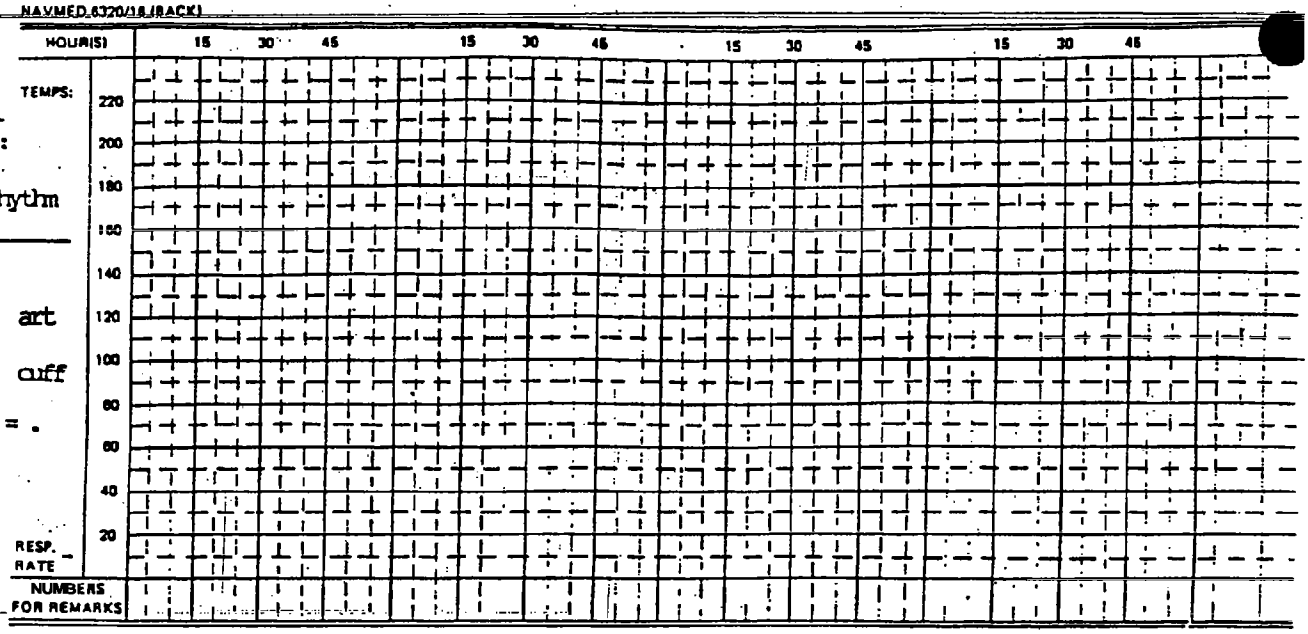
TOW (b)(6)-2

(b)(6)-2

MVS

MEDCOM - 4790

NAVMED 6720/18 (BACK)



Spinal Level:

EKG Rhythm

BP ┼ art

BP V ∧ cuff

Pulse = .

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1359	MSO4	2mg	IVP	
1402	MSO4	2mg	IVP	
1404	MSO4	2mg	IVP	
1406	MSO4	2mg	IVP	
1414	MSO4	2mg	IVP	
1420	MSO4	2mg	IVP	

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) PT Complaining of Pain Recieved 2mg MSO4. (3) BFS 168. ϕ insulin required per sliding scale (4) Cond stable Pt has met abd PACU d/c criter.. Report called to SFWD-P. (5) Transfered to SFWD-P via gurney. SR x 2. (b)(6)-2

TCW Note: Name: PT Awake & Alert

Pain: Yes (No) Action: Pain meds will be cont'd on ward

Pulmonary: CTA (B)

CV: S1,S2 (-) murmurs EKG Rhythm: NSR IV: Patent

Skin/Wound: Covered & Dressings Drainage Yes (No) Color: Edema Yes (No)

GI: Bowel Sounds Present. Tolerating CL ☺ N/V

GU: Foley Yes (No) Color of urine: ∅ Due to void: 1950

Instructions/Interventions in PACU: Unable to communicate c PT Due to language Barrier.

Report called to: SFWD Port By: (b)(6)-2

TCWed to: SFWD- Port By: HN (b)(6)-2 & HN (b)(6)-2

~30
~70 kg

ANTIBIOTIC: Ø
TIME GIVEN:
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

OPERATION PERFORMED: (R) TYMPANOPLASTY

AGENTS AND TECHNICS OF ANESTHESIA: GA Nit ISO Pro Fent 150

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		AOW	1130
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	500			
RECOVERY ROOM	50			
TOTAL	550			

HOUR(S) 15 30 45 40 45 50 55 1700 15 30 45 3 15 30 45

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

Spinal Level: N/A

EKG to monitor on ☑ Rhythm SR

BP ↓ ↑ art

BP V Λ cuff

Pulse = •

% Sat:

RESP. RATE 22 66 66

NUMBERS FOR REMARKS (1)

BLOOD LOSS IN OR: MIN cc

WARD PRE-OP BP 110 68 mmHg

~~TUBES: S-NG S-FOLEY~~ N/A

IV IN (R) hand ē ____ cc
OF ½ NS AT 110 cc/hr AOW

IV IN (R) LA ē 450 cc
OF ½ NS AT ~~160~~ cc/hr TOW

ART. LINE IN N/A

T-TUBES, HEMOVAC IN N/A

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5 FWD PORT
DATE 4/25/03 HRS 1116	DATE 4/25/03 HRS 1150

DRESSINGS: LOCATIONS (L) ear

STATUS: Bandaid cl/d/I

STATUS: Ø A

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☒ NO ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: Ø A

	MOR	PACU
TIME		
CC	X	Ø
TOTAL		Ø
SP. GR		
S/A		0

URINARY OUTPUT

DRAINAGE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by Anesthesia. (b)(6)-2

PMH: ASA II, Diabetes, GSW's

Neuro: Arousable c stimuli

Pain Yes (No) Action: Will continue to monit

CV: Cuff good S1S2 IV: PATENT, INTACT

Other: (R) AOW VIA GURNEY C SIDE RAILS ↑X2, HOB ↑ 30°, WARM BLANKETS (CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES → 1 2 3 4 5 6+ TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2			
Able to move 2 extremities voluntarily or on command	1	Activity	2	2
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2			
Dyspnea or limited breathing	1	Respiration	2	2
Apneic	0			
BP ±20% of preanesthetic level	2			
BP ±20-50% of preanesthetic level	1	Circulation	2	2
BP ±50% of preanesthetic level	0			
Fully awake	2			
Arousable on calling	1	Consciousness	1	2
Not responding	0			
Pink	2			
Pale, dusky, blotchy, jaundiced, other	1	Color	2	2
Cyanotic	0			
		TOTALS	9	10

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

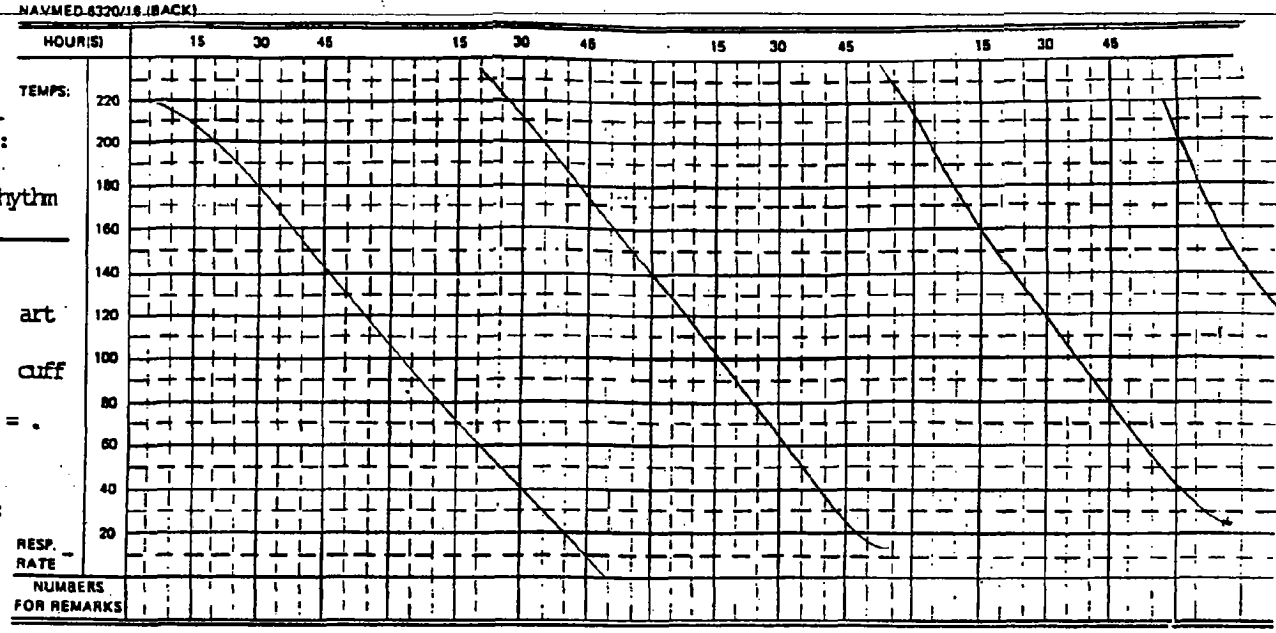
AOW (b)(6)-2

TOW (b)(6)-2

USN (b)(6)-2

MEDCOM - 4792

NAVMED 6320/18 (BACK)



MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Resting comfortably (3) Cond stable Pt has met all PACU D/C criteria. Report called to 5FWD-P to CDR Bales (4) Transferred to 5FWD-P via gurney SR + V2.

(b)(6)-2

TOW Note: Neuro: ALERT PT ABLE TO FOLLOW COMMANDS

Pain: (Yes) No Action: CONTINUE TO MONITOR.

Pulmonary: CTA (B) productive cough

CV: RRR EKG Rhythm: SR IV: (R) HAND PATENT

Skin/Wound: DRESSING CDI Drainage Yes (No) Color: Edema Yes (No)

GI: + B.S.

GU: Foley Yes (No) Attempted to void & succeeded Color of urine: Due to void: 1715

Instructions/Interventions in PACU: ASK FOR PAIN MEDS PRN.

Report called to: CDR (b)(6)-2 By: (b)(6)-2 LC

TOWed to: 5FWD P By: HM3 (b)(6)-2

MEDCOM - 4793

ANESTHESIA RECOR

JNMC (27FEB12000)

Wt (kg) - 76 Ht (in) - 170 cm . .gies - NKDA

Procedure: I+D Multiple GSWs Extremities

An (b)(6)-2 2 CDR/RRT CRNA Su (b)(6)-2 Resident/SRNA Ø

OR # 4 Page 1 of 2 See Page One

Date 4/15/03 Anes. Start 0815 In Room 0836 Surg. Start 0914 Surg. End 1128

Time	0830	X	0900	X	30	X	1000	X	30	X	1100
O_2 L/M	6-2	1	1	1	1	1	1	1	1-2	1	
N_2O Air L/M	3	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5-2	1.5	
Halo / Iso / Sevo / Des	0.8	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.6	
STP / Prop. / Etomidate	400										
Sux / Cisatracurium											
Ro / Rapa / Ve / Pancuronium	10										
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam	2										
MSO4 / Remi / Su / Fentanyl	100	50		50			50				
Eqid Lido / Bupiv / Ropiv											
Morphine (mg)						2			2	2	
NS / LR							1000				
U/O											
EBL											

● = Pulse ○ = Spont. Resp. ⊘ = Asst. Resp. Ⓥ = Ventilator X = MAP Λ/V = NIBP ⊥/T = A-Line

PACU / ICU 1137

Pulse - 73

BP - 146/90

Temp - 96

RR - 16

SaO_2 - 100

Comps - + (-)

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Es / Np / Or / Sk / Ax Temp	—	35.4	35.3	34.9	34.6	34.4	35.5	35.6	35.7	35.7
% FiO_2	100-50	40	37	37	37	36	36	36	50	50
% SaO_2	100	100	100	100	99	99	99	100	100	100
$EtCO_2$	↓ 34	31	31	30	30	31	32	32	48	50
	Ø Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ø Ø	Ø
TV		848	842	842	839	848	855	855	825	300
PIP (cmH_2O)		22	22	22	22	22	22	23	23	2
Resp. Rate		10	10	10	10	9	9	9	8	14

Checklist - O_2 Suction Machine Consent NPO

Monitors - SaO_2 ECG FiO_2 NIBP (L) R arm $EtCO_2$ PCS / ES PNS PIP Temp Mass Spec Verbal TEE Fluid warmer Air Warm Foley FHT Pulm Art cath CVP IJ / SC / Fem L / R OG / NG L / R A-Line Rad / Fem L / R

Position - Pressure points padded Arms < 90°

Supine Prone Lithotomy Sitting Lateral L / R Tested to ½

Drawn 2 Used 2 Wasted Ø Witns Ø

Drawn 250 Used 250 Wasted Ø Witns Ø

IV - 18 Ga (L) / R Hand Wrist FA AC EJ

Tourniquet mmHg Times I — I

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons Informed

Antibiotics

Total Agent - Ancef

1200 Total mg. - 1 gm

Total over 15 minutes

250 Total @ 0850

0930 - equs - Returned to [(b)(6)-2]

1050 Zofran 4mg IV

1100 Continued page 2

Induction - Monitors On Preoxygenated Smooth Inhalation (IV) Cricoid Pressure Rapid Sequence Mask ventilation easy (Y) / N

Intubation - Mac Mil 3 Grade I view Tube Size 8.0 Attempts 1 Oral / Nasal L / R w/o w/ Cuff Stylet (Y) N Bil BS, $EtCO_2$ x 3 CXR

Tube taped @ 22 cm @ lips / teeth / nares Trauma Y (N) FOB / LW / Burr LMA # Ø DLT Ø — Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation - Smooth Reversed SV VSS Full TOF Head lift Sustained tetanus Suctioned Awake / Deep

Disposition PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Prep: Sterile Technique; Disposable kit; Betadine prep x 3; Local infiltration; Site ____ L / R; Attempts ____

Blocks: Nerve Stim ____ mA; Trans-arterial; Dual cuff

Regional: Spinal / Epidural; Touhy / Whitacre / Quincke; Needle gauge ____; Sitting; Lateral R / L; LOR to Air / NS; Paresthesia + / -; Heme + / -; CSF + / -; Test dose Θ; CSF Θ swirl

Regional: Catheter out - tip intact; Level ____

Lines: Seldinger Technique; CVP manually transduced; Cordis 9.5 / 8.5 Fr; SLIC; 2 / 3 - lumen

Comments / Drugs:

Patient Identification

(b)(6)-4

ANESTHESIA RECOR

ANMC 4279(12/00)

Wt (kg) - 76 Ht (in) - 170 cm gies - NKDA

Procedure	Anesthesiologist	Surgeon	OR #
See Page I	(b)(6)-2 LCDR [illegible] CRNA	(b)(6)-2	4

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
4/15/03							2 of 2

See Page One

Time	1100	X	30	X	1200	X	30	X	1300	X	30
O_2 L/M	1	1									
N_2O / Air L/M	1.5	2									
Enflu / Halo / Iso / Sevo / Des	0.5	1.2									
STP / Prop. / Etomidate											
Sux / Cistracurium											
Ro / Rapa / Ve curonium											
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam											
MSO4 / Remi / Su / fentanyl											
Epid. Lido / Bupiv / Ropiv											
mg Morphine	2	2									
NS / LR			1200								
U/O											
EBL			~50								

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse -
BP -
Temp -
RR -
SaO2 -
Comps - + / -

ECG	SR	SR
Es / Np / Ax / Sk / Ax Temp	35.6	
% FiO_2	36	34
% SaO_2	100	100
$EtCO_2$	46	44
	0	0
TV	420	534
PIP (cmH_2O)	2	
Resp. Rate	16	13

Checklist -
☐ O_2 ☐ Suction ☐ Machine ☑ Consent ☐ NPO

Monitors -
☐ SaO_2 ☐ ECG ☐ FiO_2 ☐ NIBP L / R arm
☐ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp
☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer
☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath
☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R
☐ A-Line Rad / Fem L / R

Position - ☐ Pressure points padded ☐ Arms < 90°
Supine Prone Lithotomy Sitting Lateral L / R

Drawn ____ Used ____ Wasted ____ Witns ____
Drawn ____ Used ____ Wasted ____ Witns ____

IV - ____ Ga L / R Hand Wrist FA* AC EJ
☐ Tourniquet ____ mmHg Times I ____ I ____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

	Antibiotics
Total	Agent -
Total	mg -
Total	over minutes
Total	@

1114 LUNCH Relief RN CRNA CRT (b)(6)-2

1130 TOR 4/4, +SV. Good SV XT ON PRV, PD VERIFIED BY CRNA (b)(6)-2 (b)(6)-2

Induction - Monitors On Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y / N
Intubation - Mac / Mil ____ Grade ____ view Tube Size ____ Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN
Tube taped @ ____ cm @ lips / teeth / nares Trauma Y / N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R
Maintenance - Smooth Cuff checked Eyes taped / lubed
Extubation - Smooth Reversed SV VSS Full T4 / head lift / Sustained tetanus Suctioned Awake / Deep
Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR in Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose
☐ CSF @

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification
(b)(6)-4

ANESTHESIA RECOR

ANMC 4179 (12/00)

Wt (kg) - 75 Ht (in) - 170cm gies - Ø

Procedure	Anesthesiologist/CRNA Signature	Surgeon	OR #	See Page One
I+D (B) thigh wounds	(b)(6)-2 LCDR	(b)(6)-2 MD	5	

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page 1 of 1
4/17/03	0810	0821	0835	0940 / 0949	0958		

Time 0815 0830 0900 0930 1000

O_2 L/M	2	2	2	2	2	2	2.5
N_2O / Air L/M	4	4	X	2	2	2	X
Volatile Halo / Iso / Sevo / Des	4	4	4-2	2	1		X
STP / Prop. / Etomidate							
Sux / Cistracurium							
Ro / Rapa / Ve curonium							
Lidocaine							
Neostigmine / Glyco							
Ephedrine / Neo							
Midazolam	3 2						
MSO_4 / Reml / Sufent	50	50	50	50	50		
Epid. Lido / Bupiv / Ropiv							
MSO_4 (mg)				5	5	5	5
NS / LR		700		500		1000	1300
U/O							
EBL							

Checklist -
☒ O_2 ☒ Suction ☒ Machine ☐ Consent ☐ NPO

Monitors -
☒ SaO_2 ☒ ECG ☒ FiO_2 ☒ NIBP (L) R arm
☒ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☒ Temp
☒ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer
☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath
☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R
☐ A-Line Rad / Fem L / R

Position - ☒ Pressure points padded ☒ Arms < 90°
(Supine) Prone Lithotomy Sitting Lateral L / R

Drawn 5 Used 5 Wasted Ø Witns
Drawn 250 Used 250 Wasted Ø Witns
IV - 18 Ga (L) R Hand Wrist (FA) AC EJ
☐ Tourniquet ____ mmHg Times I____ I____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics
Total Agent -
Total mg
Total over minutes
Total @

Has 18G HL (L) hand. Poor flow.
18G IV started (R) FA ∓ induction.

(●) = Pulse
(○) = Spont. Resp.
(Ø) = Asst. Resp.
(V) = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse - 77
BP - 119/62
Temp - 96.8
RR - 16
SaO_2 - 100%
Comps - + / -

ECG	SR	SR	SR	SR	SR	SR
Is / Np / (On) / Sk / Ax Temp				36.0	36.2	36.3
% FiO_2	RA/30	50	50/100/50	50	50	50
% SaO_2	99	100	100	100	100	100
$EtCO_2$	40	45	52	49	49	47
TV		760	470	440	460	485
PIP (cmH_2O)	SV	SV	SV	SV	SV	SV
Resp. Rate	22	19	16	19	19	13

Induction - Monitors on Preoxygenated (Smooth) Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y (N) Full board
Intubation - Mac / Mil ____ Grade ____ view Tube Size ____ Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN
Tube taped @ ____ cm @ lips / teeth / gums Trauma Y / N FOB / LW / Blind LMA # 5 DLT ____ Fr L / R
Maintenance - (Smooth) Cuff checked Eyes taped / lubed
Extubation - Smooth Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep
Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Patient Identification
(b)(6)-4

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR to Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊖
☐ CSF ⊕ swirl

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

ANESTHESIA RECOR

ANMC (7/99(12/00)) | W) - | Ht (in) - | gies -

Procedure: [illegible] Hip Revision FB | Anes: (b)(6)-2 | Surgeon: (b)(6)-2 | OR # 9 | See Page One

Page 1 of 1

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA
01/20/03	1215	1230	1300	1340	1377	

Time: 1230 (1) + (3) + 30 + (4)

O_2 L/M	10	0.5	0.5	0.5	1.0
N_2O / Air L/M	↑	0.1	0.5	0.5	1.5
Vols. Halo / Iso / Sevo / Des		0.5	0.5	0.5	0.5
STP / Prop. / Etomidate	150				
Succ / Cisatracurium	100				
Ro / Rapa / Ve curonium					
Lidocaine					
Neostigmine / Glyco					
Ephedrine / Neo					
Midazolam					
MSO4 / Remi / Su / Fentanyl	250	50	50		
Epid. Lido / Bupiv / Rapiv					
Morphine			5/5		
NS / LR			1000		
U/O					
EBL					

Checklist - ☑ O_2 ☐ Suction ☑ Machine ☑ Consent ☐ NPO

Monitors - ☑ SaO_2 ☑ ECG ☑ FiO_2 ☑ NIBP L / R arm ☑ $EtCO_2$ ☐ PCS / ES ☐ PNS ☑ PIP ☐ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☑ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☑ Pressure points padded ☐ Arms < 90° Supine Prone Lithotomy Sitting Lateral L / R

Drawn 470 Used ____ Wasted ____ Witns ____

Rec'd Drawn 500 Used 500 Wasted 0 Witns

IV - ____ Ga L / R Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times I ____ I ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics

Ca	Total	Agent - Prim - X1
NS 1000	Total	mg 500 mg
Gentec	Total	over 45 minutes
EBL 20 cc	Total	@ 1215

● = Pulse
○ = Spont. Resp.
⊘ = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU

Pulse - 142
BP - 138/73
Temp - 98.1
RR - 16
SaO_2 - 99
Comps - + / (-)

ECG	SR	SR	SR	SR	SR
s / Np / Or / Sk / Ax Temp	37.0	37.9	37.9	37.5	37.6
% FiO_2	90	55	55	55	55
% SaO_2	100	100	100	100	100
$EtCO_2$	46	46	46	45	45
	60	60	60	50	50
TV	300	350	330		
PIP (cmH_2O)	20	29	29		
Resp. Rate	10	10	10		

Procedure #2
Dig. & BILE

1397 PT TO PACU, VSS
Report to RN

Induction - Monitors On / Preoxygenated / Smooth / Inhalation / IV / Cricoid Pressure / Rapid Sequence / Mask ventilation easy Y / N

Intubation - Mac / Mil 4 / Grade 1 / view / Tube Size 7.0 / Attempts 1 / Oral / Nasal L / R / w/o / w/ Cuff / Stylet Y / N / BILBS / $EtCO_2$ x 3 / CIN

Tube taped @ 22 cm @ lips / teeth / nares / Trauma Y / N / FOB / LW / Blind / LMA # ____ / DLT ____ Fr L / R

Maintenance - Smooth / Cuff checked / Eyes taped / lubed

Extubation - Smooth / Reversed / SV / VSS / Full T4 / Head lift / Sustained tetanus / Suctioned / Awake / Deep

Disposition - PACU / ICU / SV VSS / Awake / sleepy / Extubated / intubated

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR to Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊖
☐ CSF ⊖ s/w/r

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification

(b)(6)-4

ANESTHESIA RECOR

ANMC 4379(12/00) | Wt (kg) - 69 | Ht (in) - | gies - NKDA

Procedure	Anesthesiologist/CRNA/Student	Surgeon	OR #
Delay Closure	(b)(6)-2	(b)(6)-2	9

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
4/23/09	1300	1315	1318	1425	1435		1 of 1

See Page One

Time	1315	1330	1400		1500	
O_2 L/M	10	.7	.7	.7	.7	10
N_2O / Air L/M	2	2	2	2	X	
Inh. Halo / Iso / Sevo / Des	.8	.7	.6	.5	X	
KET	150					
STP / Prop. / Etomidate						
Sux / Cisracurium	100					
Ro / Rapa / Ve curonium						
Lidocaine						
Neostigmine / Glyco						
Ephedrine / Neo						
Midazolam						
MSO4 / Remi / Su / Fentanyl	10/150		(2)			
Epid. Lido / Bupiv / Ropiv						
NS / LR		200		300	350	
U/O						
EBL				10	12	

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

180 / 160 / 140 / 120 / 100 / 80 / 60 / 40

PACU / ICU
Pulse - 93
BP - 165/95
Temp -
RR -
SaO_2 - 99
Comps - + (-)

ECG	SR	SR	SR	SR	SR
Es / Nas / Or / Sk / Ax Temp		35.8	36	36	36
% FiO_2	100	28	28	28	100
% SaO_2	100	98	98	97	100
$EtCO_2$	+	36	35	34	35
TV		635	(CV)	635	S/V
PIP (cmH_2O)	S/4	18		18	
Resp. Rate		12		12	

Checklist -
☑ O_2 ☐ Suction ☑ Machine ☐ Consent ☐ NPO

Monitors -
☑ SaO_2 ☐ ECG ☑ FiO_2 ☑ NIBP L / R arm
☑ $EtCO_2$ ☐ PCS / ES ☐ PNS ☑ PIP ☑ Temp
☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer
☑ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath
☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R
☐ A-Line Rad / Fem L / R

Position - ☑ Pressure points padded ☐ Arms < 90°
Supine Prone Lithotomy Sitting Lateral L / R

Drawn 10 Used 2 Wasted 8 Witness
Drawn 250 Used 250 Wasted 0 Witness

IV - ____ Ga L / R Hand Wrist FA AC EJ
☐ Tourniquet ____ mmHg Times I ____ I ____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics
Total Agent - PRIMAXIN
Total mg - 500
Total over 30 minutes
Total @ 1315

Induction - Monitors On | Preoxygenated | Smooth | Inhalation / IV | Cricoid Pressure | Rapid Sequence | Mask ventilation easy Y / N
Intubation - Mac / Mil 4 | Grade 2 view | Tube Size 8 | Attempts 1 | Oral / Nasal L / R | w/o / w/ Cuff | Stylet Y / N | Bil BS / $EtCO_2$ x 3 | CIN
Tube taped @ 22 cm @ lips / teeth / nares | Trauma Y / N | FOB / LW / Blind | LMA # ____ | DLT ____ Fr L / R
Maintenance - Smooth | Cuff checked | Eyes taped / lubed
Extubation - Smooth | Reversed | SV VSS | Full T4 / Head lift / Sustained tetanus | Suctioned | Awake / Deep
Disposition - PACU / ICU | SV VSS | Awake / sleepy | Extubated / intubated

Patient Identification

(b)(6)-4

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR to Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊖
☐ CSF ⊕ swirl

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

NEUROLOGICAL CHECK

		1430	1445	1500	1515	1545
EXTREMITY	(R) LOWER EXTREMITY	(b)(6)-2				
PAIN	pain					
	/5					
	NUMBNESS					
	MODERATE					
	SEVERE					
SENSATION (sensation)	NORMAL					
	NUMBNESS					
	TINGLING	(b)(6)-2				
	ABSENT					
BLANCHING (Blanching) (B - Normal; S - Sluggish)		(b)(6)-2				
ACTIVE MOTOR FUNCTION	NORMAL	(b)(6)-2				
	LIMITED					
	ABSENT					
SIGNS OF COMPARTMENT SYNDROME	PAIN ON PASSIVE MOTION					
	PAIN UNRELIEVED BY ANALGESICS					

VASCULAR CHECK

		1430	1445	1500	1515	1545
COLOR (COLOR)	RED					
	PINK					
	PALE	(b)(6)-2				
	BLUE					
SKIN TEMPERATURE (SKIN TEMP)	HOT					
	WARM					
	COOL	(b)(6)-2				
	COLD					
PULSES (PULSE) SITE DORSALIS PEDIS	NORMAL	(b)(6)-2				
	WEAK					
	ABSENT					
EDEMA (EDEMA) SITE	NONE	(b)(6)-2				
	SMALL					
	MODERATE					
	LARGE					

COMMENTS

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2 HH					

23APR03

23 APR 03

		1430	1445	1500	1515	1545
NEUROLOGICAL CHECKS — EXTREMITY (L) LOWER EXTREMITY	PT	(b)(6)-2				
PAIN pain	ATLS-4					
	MODERATE					
	SEVERE					
SENSATION (sensation)	NORMAL					
	PURPOSES					
	TINGLING	(b)(6)-2				
	ABSENT					
BLANCHING (2 = Normal; 3 = Sluggish) Blanch 2		(b)(6)-2				
ACTIVE MOTOR FUNCTION	NORMAL	(b)(6)-2				
	LIMITED					
	ABSENT					
SIGNS OF DISCOMFORT TENDERNESS	PAIN ON PASSIVE MOTION					
	PAIN UNRELIEVED BY ANALGESICS					
VASCULAR CHECKS — COLOR COLOR	RED					
	PINK					
	PALE	(b)(6)-2				
	BLUE					
SKIN TEMPERATURE (SKIN TEMP)	HOT					
	WARM					
	COOL	(b)(6)-2				
	COLD					
PULSE (PULSE)	NORMAL	(b)(6)-2				
SITE DORSALIS PEDIS	WEAK					
	ABSENT					
EDEMA (EDEMA)	NONE	(b)(6)-2				
SITE	SMALL					
	MODERATE					
	LARGE					

COMMENTS

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2					

NNMC 6320/279 (Dec-10)

Pre / Post-anesthetic Summary

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I+D GSWs & closure wounds	47	69	170 cm	(b)(6)-2 1 (2) 3 4 5 E	NKDA

Chemistries 4/13/03: 135 | 101 | 8 ; 3.4 | 32 | 192 ; 0.8

Hematology 4/10/03: H/H - 8.9 / 26.3; Platelets - 292; WBCs - 9.6

Coags 4/10: PT - 11.8; INR - 0.8; PTT - 30.4↓

Urinalysis / HCG: Ø

NPO – p MN
Teeth – multiple missing + ↑ front loose
Airway – MP (1) II / III / IV
FROM, 3 FB O, 3 FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
→ Ø
Lung Exam: CTA (B)
CXR: mild cardiomegaly, mild diffuse interstitial markings throughout lungs. Possible low smoking RP

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
→ Ø
Exercise Tolerance: good
Cardiac Exam: RRR (N)
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:
→ Ø

Misc: Multiple GSWs – (soft tissue) → (L) leg (R) elbow

Other
Hepatic:
Renal:
→ Ø
GI:
Endo: Type I diabetes
Heme: Ø
EtOH: Ø
Tobacco: (b)(6)-2 Ø probably

Previous Anesthetics: no occup. dust exposure
I+D GSWs - GA → Ø comps

Family Hx: Ø

Current Medications:
Ancef
Keflex
Glibenide

Premedication:
Regular Insulin 5u sq @ 0700

Preoperative Diagnoses
(1) Multiple GSWs

Vitals	Pre-op	DOS
BP:	120/72	134/70
HR:	80	72
Resp:	16	18
Temp:	98.8	
FHR:		

Evaluator Signature / Date

Day of Surgery
☑ Chart Reviewed / patient examined
☐ Risks / benefits / options discussed with patient
☐ Patient questions answered
☐ Patient / parent / guardian understands and accepts risks
☐ NPO after ~~midnight~~ as above liq., ____ clears, ____ solids
Plan: GOTA

Staff MD / CRNA signature: (b)(6)-2
Date & Time: 15 APR 03 (0830)
CRNA / LCDR / NC

Patient identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature: (b)(6)-2
Date: 15 APR 03
CRNA / LCDR / NC

MEDCOM - 4801

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-80)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I+D (B) ant. thigh wounds	48	~95	170 cm	1 2 (3) 4 5 E	Ø

Chemistries
132 / 4.8 / 9 / 198
3.6 / 29 / 0.8 / Repeat 89
P 3.4
Alb 2.4 Ca 7.4 Mg 2.1

Hematology
H/H - 9/26
Platelets - 419
WBCs -

Coags
PT -
INR -
PIT -

Urinalysis / HCG

NPO – yes
Teeth – loose, protruding incisors
Airway – MP I / II / III / IV Poor
FROM, ___ FB O, ___ FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam: Ø
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias: Ø
Exercise Tolerance: good
Cardiac Exam:
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal: Ø

Misc
Frag. wounds (B) thighs (R) arm

Other
Hepatic: .
Renal: ↓Na, ↓K
GI: ↓ alb
Endo: DM ?Insulin
Heme: anemia
EtOH: denies
Tobacco: denies

Previous Anesthetics:
I+D (B) thigh frag wounds – GA

Family Hx: Ø

Current Medications:
Ancef
Glucotrol
LSS
Pain Meds PRN

Premedication:

Preoperative Diagnoses
Glucose intolerance ?
Anemia
Hyponatremia
Hypokalemia
Malnutrition
Mult. frag. wounds w/ infection

Vitals	Pre-op	DOS
BP:		
HR:		
Resp:		
Temp:		
FHR:		

Evaluator Signature Date

Day of Surgery
☑ Chart Reviewed / patient examined
☐ Risks / benefits / options discussed with patient
☐ Patient questions answered
☐ Patient / parent / guardian understands and accepts risks
☐ NPO after _____ liq., _____ clears, _____ solids
Plan: GA / LMA vs. mask

Staff MD / CRNA signature Date & Time
(b)(6)-2 MD (b)(6)-2 LCDR 4/17/03

Patient identification
(b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

MEDCOM - 4802

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I&D (L) H.P FB Removal / Drs a Bite	47	69	170cm	1 (2) 3 4 5 E	NKMA

Chemistries 04/1703
132 / 98 / 9 (98)
3.6 / 29 / 0.8
Alb 2.7 Ca 7.7

Hematology 04/2603
H/H - 9.2/26
Platelets - 419
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO – D mn
Teeth – mixed
Airway – MP I / II / III / IV
FROM, ~~FB O~~, ~~FB HM~~

Respiratory Hg 2.1
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam: mild crackings, poss Cong Smoke 1/2 ppd
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam:
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Misc

Other
Hepatic:
Renal:
GI:
Endo: type 2 DM
Heme:
EtOH:
Tobacco:

Previous Anesthetics:

Family Hx:

Current Medications:
Amox
Ibuprofen
Keflex
Glyburide

Premedication:

Preoperative Diagnoses
1) Multiple Stones

Vitals	Pre-op	DOS
BP:	126/60	
HR:	90	
Resp:		
Temp:		
PHR:		

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☐ Risks / benefits / options discussed with patient
- ☑ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☐ NPO after _____ liq., _____ clears, _____ solids

Plan:

Evaluator Signature (b)(6)-2 Date 04/26/03

Staff MD / CRNA signature (b)(6)-2 Date & Time 04/2600 1218

~~Hgt~~ Hg 9.2 Stewart
BSFS 203 1215

Patient identification (b)(6)-4

Post-operative note

No apparent anesthetic complications

Signature Date

MEDCOM - 4803

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-00)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Bullet Removal / Delay closure	~~XX~~ 26	69		1 2 (3) 4 5 E	NKDA

Chemistries: (108)

Hematology: H / H 7. (23) Platelets - WBCs -

Coags: PT - INR - PTT -

Urinalysis / HCG:

NPO – ~~6am~~ Very poor dentition Lose #6/#9
Teeth –
Airway – MP I / (II) / III / IV
(FROM) 4 FB O. 3 FB HM

Respiratory: Cough: Sputum: Asthma: COPD: Recent URI: Denied TB:
Lung Exam: CTA (B)
CXR:

CV: HTN: MI: Denied CHF: VHD: Arrythmias: Exercise Tolerance:
Cardiac Exam: RRR RRR
ECG:

CNS / Skeletal: Seizure: CVA: LOC: Neuro: Muscle: Skeletal: GSW BLE

Misc:

Other: Hepatic: ? Renal: GI: IRDM Endo: Heme: ?
EtOH: ?
Tobacco: denies

Previous Anesthetics: Mult GA ⊖ diff.
Family Hx:

Current Medications:
- 4 NPH
- Glyburide QAM
- Lovenox Q12

Premedication:

Preoperative Diagnoses:
1. S/P GSW
2. IRDM
3. Anemia.
4. Acinetobacter Colonized.

Resp:
Temp:
FHR:

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☐ NPO after _____ liq., _____ clears, _____ solids

Plan: GA / RSI

Staff MD / CRNA Signature: (b)(6)-2

Date & Time: 4/23/03

Patient identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

MEDCOM - 4804

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
(R) Tympanoplasty	~30	~70	~5'10"	1 (2) 3 4 5 E	NKDA

Chemistries: /

Hematology: H / H: — ; Platelets: — ; WBCs:

Coags: PT: ; INR: — ; PTT:

Urinalysis / HCG: —

NPO – p MN
Teeth – ø loose
Airway – MP (1) II / III / IV
FROM. 3 FB O. 3 FB HM

Respiratory: Cough: Sputum: Asthma: COPD: Recent URI: TB: } UNK
Lung Exam: CTA (A)
CXR: —

CV: HTN: CAD: MI; CHF: VHD: Arrythmias: Exercise Tolerance: } UNK
Cardiac Exam: RRR ø m/r/g's
ECG: —

CNS / Skeletal: Seizure: CVA: LOC: Neuro: Muscle: Skeletal: } UNK

Misc: —

Other: Hepatic: Renal: GI: Endo: - DM Heme: } UNK
EtOH:
Tobacco:

Previous Anesthetics: 3/03 - GETA - ø complic (GSW's)

Current Medications: —

Premedication: —

Pat ...: ?

Preoperative Diagnoses:
(1) Blast injury to
(R) tympanic membrane

Vitals	Pre-op	DOS
BP:	110/68	
HR:	68	
Resp:	16 →	
Temp:	—	
FHR:	—	

Day of Surgery
- ☐ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☑ NPO after MN liq., _____ clears, _____ solids

Plan: GETA

Finished Surgery: (b)(6)-2 Date: 4.25.03

Staff MD / CRNA signature: (b)(6)-2 Date & Time: 4-25-03 0810

Patient identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

10 APR 03

(b)(3)-1

PERSONAL DATA PR... ACT 1974

Signature Date

MEDCOM - 4805

b)(3)-1

Pe perative Plan Of Care & Nursing N

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

rauma# or atient #

Diagnosis: 65 M Mild Planned Procedure: D & D Right Mild / (R) Elbow

Date: 4/15/03 (R) Elbow Arrival Time: 0750 Interviewer: L C Da (b)(6)-2

Side: ☐ N/A ☒ Right ☐ Left Age: HT: WT:

rom:
CASREC
ICU
Ward 5-E
OTHER:

Transport Via:
☐ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☒ Chart
☐ Armband
O Other

Blood Ordered:
☒ N/A
☐ Yes ☐ Consent
☐ T/C #Units
☐ T/H #Units
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☒ Emergent case; no consent, MD note

eop Labs (HCG, etc):
None ☒ Yes
st/Results:

Drug/Latex Allergies:
☐ NKDA
Allergy/Reaction:

Present On Admission:
☐ N/A
☐ Oxygen
☐ IV Site: #1 (R) Hand
#2
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site:
☐ Drain(s)
☐ Chest Tube(s)
☐ See RN Note #

Past Medical History:
☐ None known
☐ Smoker ppd/yrs /
☐ ETOH ☐ Asthma
☐ HTN ☐ **CAD**
☐ GERD ☐ CBR exposure
☐ Other: DMII
Past Surgical History:
☐ None known
☒ Yes
List:

Cultural Needs Addressed:
☐ Yes ☐ No
List:

e-Op Pain:
No
Yes Level (0-10)
tion **Taken:**
cation/type:

Last PO Intake: (date/time)
Solid: 4/14/03 2400
Liquid: 4/14/03 2400

Chart:
H&P ☒ Yes ☐ No
EKG ☐ Yes ☐ No
CXR ☐ **Yes** ☐ No
Other:

Skin Condition:
☐ Intact
☐ Other: Dressing c Mild / (R) Elbow

Limitations:
☐ N/A
☐ Language ☐ Auditory
☐ Mobility ☐ Visual
☐ Other: ☐ Prosthesis

Personal Items:
☒ None Disposition:
☐ Military gear
☐ Glasses
☐ Dentures
O Jewelry/wallet
☐ Other

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

ental/Emotional Status:
Alert/Oriented ☐ Calm
Disoriented ☐ Sedated
Anxious ☐ Unresponsive
Appropriate for age
Other

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☐ Remain with patient during induction

Pre-op Teaching Included:
☒ N/A due to patient condition .
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☒ Yes ☐ No

erative Position:
Supine ☐ Beach chair
Prone ☐ Sitting
Jackknife ☐ Lateral L / R
Lithotomy
Other:

Positional Aids:
☒ Arms <90
Armboard: ☐ L ☒ R
Tucked: ☐ L ☐ R
☐ Airplane ☐ Axillary roll ☐ Bean **Bag**
☐ Fracture Table ☐ Gel Pad ☐ Gel donut
☐ Hand Table ☐ Leg Holder ☐ Pillows
☐ Stirrups ☐ Tape ☐ Wilson Frame
☐ Other:

Comments:

U # 4
Site: (R) Hand
Lot # 34010
Clear at end of case? ☐ No ☒ Yes
No, **see** RN note #
olar: Max Cut 30 Coag 30

D W Prevention:
SCD used ☐ No ☐ Yes
Pressure: ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair **Hugger** used: ☐ No
Other warming techniques:

Tourniquet:
Arm ☐ Leg # N/A comments:
☐ **Left** ☐ Right
☐ webril applied Applied
Total Min:

(b)(6)-4

Comments:

b)(3)-1 Peri e Plan Of Care & Nursing Note Page 1 of 2 (Rev 3/03)

MEDCOM - 4806

Potential For Infect **Outcome:** Appropriate Actions Taken to . Infection ☑Yes ☐No

Wound Classification: I ☐II ☐III ☐IV

Shave Prep: ☐Shave ☑Clipper Area: _____ By: ____ Both legs around wounds

Skin Prep: ☑Betadine Scrub ☐Hibiclens ☐Duraprep ☐Other:

Solutions/Medications: ☑Normal saline ☐Other: _____ ☐Sterile water ☐Local _____ ☐Antibiotics Bacitracin - Try Mycoguic

Drains/Packing: ☐None Foley FR: _____ JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____ Hemovac: Size ____ Location _____ Chest tube: Location _____ Size _____ H2O Pressure: _____ Packing: type/location: ½" Iodoform See RN Note # ____ for comments to wounds

Dressing: Location: Bilateral Thighs (R) Knee

☐ABD	☐Cervical Collar	☐Kling	☐Steri-strips	☐Benzoin
☐Ace	☐Coban	☐Immobilizer	☐Tape	☐Mastisol
☐Bias	☐Drip Pad	☐Plains	☐Webril	☐Bacitracin
☐Band-Aid(s)	☐Fluffs	☐Sling	☐Xeroform	
☐Cast	☐Kerlix	☐Splint	☐Other:	

Iodoform ½"

Miscellaneous

Gauntes: (initials) Scrub: [(b)(6)-2] RN: [(b)(6)-2] Correct? Sharps ☑Yes ☐No ☐N/A Sponges ☑Yes ☐No ☐N/A Instruments ☐Yes ☐No ☐N/A

See RN note # for additional comments

Xray: ☑None ☐Other: ☐Portable ☐**C-Arm**

Skin Integrity: ☑Clear & Intact (other than incision) Comments: _____

☐See RN note # ___for additional comments.

Implants: Item / Lot # I Exp Date:

See RN note # for additional comments.

Discharge from Operating Room

Complications: ☑None Comments: _____

See RN note # ____ for additional comments

Transport From OR: ☑~~Foley~~ w/ siderails up ☐Litter w/ safety strap in place ☐w/ **Oxygen** ☐w/ Monitor ☐Other:

Transferred To: ☐~~PACU~~ ☐**ICU** ☐Mcdivac ☐Ward ____ ☐Other

Report by: ☐Anesthesia provider ☐RN

Surgical Procedure Performed: I+D Bilateral Thighs (R) Knee

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

[(b)(6)-2] Primary OR RN Signature — Date: 4/6/05

Relief OR RN Signature — Date/Time

(b)(3)-1

Peri Operative Plan Of Care & Nursing N

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient #: 1

Diagnosis: Multi GSW (R) LE/groin Planned Procedure: I+D of groin / LE GSW.

Date: 17 APR 03 Arrival Time: 0 30 Interviewer: LT (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left Age: HT: WT:

From: ☐ CASREC ☐ ICU ☑ Ward ☐ OTHER:

Transport Via: ☑ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other

Patient ID: ☐ Trauma card ☐ Verbal ☑ Chart ☑ Armband ☐ Other

Blood Ordered: ☐ N/A ☑ Yes ☐ Consent ☑ T/C #Units 6 ☐ T/H #Units

Comments:

Surgical/Anesthesia Consent Verified: ☐ Procedure ☐ Consent complete, dated, signed ☑ Emergent case; no consent, MD note

Preop Labs (HCG, etc): ☐ None ☑ Yes Test/Results:

Drug/Latex Allergies: ☑ NKDA Allergy/Reaction:

Present On Admission: ☐ N/A ☐ Oxygen ☑ IV Site: #1 #18 LFA #2 ☐ Foley ☐ Endotrachial Tube ☐ Arterial Line Site: ☐ Drain(s) ☐ Chest Tube(s) ☐ See RN Note #

Past Medical History: ☐ None known ☐ Smoker ppd/yrs 1 ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ GERD ☐ CBR exposure ☑ Other: NIDDM

Past Surgical History: ☐ None known ☑ Yes List: Refer To Progress/OR note.

Cultural Needs Addressed: ☑ Yes ☐ No List:

Pre-Op Pain: ☐ No ☑ Yes Level 7 (0-10) Action Taken: Pain med by Anesthesia Location/type: groin/LE

Last PO Intake: (date/time) Solid: NPO since Liquid:

Chart: H&P ☑ Yes ☐ No EKG ☐ Yes ☑ No CXR ☐ Yes ☑ No Other.

Skin Condition: ☐ Intact ☑ Other: See progress notes

Limitations: ☐ N/A ☐ Auditory ☑ Language ☐ Visual ☑ Mobility ☐ Prosthesis ☐ Other:

Personal Items: ☑ None ☐ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other — Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status: ☑ Alert/Oriented ☐ Disoriented ☐ Anxious ☑ Appropriate for age ☐ Other ☑ Calm ☐ Sedated ☐ Unresponsive

Comfort Measures Implemented: ☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☑ Remain with patient during induction

Pre-op Teaching Included: ☑ N/A due to patient condition / Language ☐ Physical layout of OR ☐ Personnel present during procedure ☐ Environment (noise, temperature, etc.) ☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☑ Yes ☐ No

Operative Position: ☐ Supine ☐ Prone ☐ Jackknife ☐ Lithotomy ☐ Other: ☐ Beach chair ☐ Sitting ☐ Lateral L / R

Positional Aids: ☑ Arms <90 Armboard: ☑ L ☑ R Tucked: ☐ L OR ☐ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other: ☐ Axillary roll ☑ Gel Pad ☐ Leg Holder ☑ Tape ☐ Bean Bag ☑ Gel donut ☐ Pillows ☐ Wilson Frame

Comments:

SU #: 6 Pad Site: Rt Flank Pad Lot #: 61277 Site Clear at end of case? ☐ No ☑ Yes If No, see RN note #: 0 Bipolar: ☒ Max Cut 30 Coag 30

DVT Prevention: SCD used ☑ No ☐ Yes Pressure: ☐ Left ☐ Right Teds: ☑ No ☐ Yes Bair Hugger used: ☑ No ☐ Yes Other warming techniques:

Tourniquet: ☒ ☐ Arm ☐ Leg ☐ Left ☐ Right ☑ webril applied # Applied by: ↑ ↓ ↑ ↓ Total Min:

Comments:

(b)(6)-4

(b)(3)-1 10APR03

PERSONAL DATA PRIV ACT

(b)(3)-1 P

Potential For Infect — Outcome: Appropriate Actions Taken to Prevent Infection ☐ Yes ☐ No

Wound Classification: ☐ I ☒ II ☐ III ☐ IV

Shave Prep: ☒ ● Shave ☐ Clipper
Area: _____ By: ____

Skin Prep:
☒ Betadine Scrub / Paint
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/Medications:
☒ Normal saline ☐ Other: _____
☐ Sterile water
☐ Local _____
☐ Antibiotics _____

Drains/Packing: ☐ None
☐ Foley FR: _____
☐ JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
☐ Hemovac: Sue ____ Location _____
☐ Chest tube: Location _____
Size _____ H20 Pressure: _____
☒ Packing: type/location: W-D
☐ See RN Note # ____ for comments

Dressing: Location: _____

☒ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☐ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☒ Plains	☐ Webril	☒ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☒ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

Counts: (initials)
Scrub: RN:
(b)(6)-2 (b)(6)-2
Correct?
Sharps ☒ Yes ☐ No ☐ N/A
Sponges ☒ Yes ☐ No ☐ NIA
Instruments ☐ Yes ☐ No ☐ NIA
☐ See RN note # ____ for additional comments

Xray:
☐ None ☐ Other:
☐ Portable
☐ C-Arm

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: Multiple Staples / Gauze
☐ See RN note # 2 or additional comments.

Implants:
Item / Lot # / Exp Date: 0
☐ See RN note # ____ for additional comments.

Discharge from Operating Room

Complications:
☐ None Comments: _____
3 See RN note # ____ for additional comments

Transport From OR:
☒ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other.

Transferred To:
☒ PACU Report by:
☐ ICU ☐ Anesthesia provider ☐ RN
☐ Medivac
☐ Ward ____
☐ Other

Surgical Procedure Performed: I+D and Pack Staples / Gauze 18

RN Note: (number each note to corresponding area above) 2

(b)(6)-2
Name Box: (Please Print)
(b)(6)-2
(b)(6)-2
(b)(6)-2
17 Apr 03
Primary OR RN Signature Date
Relief OR RN Signature Date/Time

PeriO··rative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☑ Yes ☐ No

Trauma# or Patient #: (b)(6)-4
Diagnosis: Shrapnel BLE
Planned Procedure: Bullet Extraction / Wound Closure
Date: 04/23/23 Arrival Time: 1300 Interviewer: ITSG (b)(6)-2
Side: ☐ N/A ☐ Right ☐ Left
Age: 47 HT: WT:

From:
☐ CASREC
☐ ICU
☐ Ward _____
☐ OTHER:

Transport Via:
☐ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☐ Chart
☐ Armband
☐ Other

Blood Ordered:
☐ N/A
☐ Yes ☐ Consent
☐ T/C #Units _____
☐ T/H #Units _____
Comments: _____

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☐ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☐ Yes
Test/Results: _____

Drug/Latex Allergies:
☐ NKDA
Allergy/Reaction: _____

Present On Admission:
☐ N/A
☐ Oxygen
☐ IV Site: #1 _____
#2 _____
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site: _____
☐ Drain(s) _____
☐ Chest Tube(s) _____
☐ See RN Note # _____

Past Medical History:
☐ None known
☐ Smoker ppd/yrs ____/____
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other: diabetic

Past Surgical History:
☐ None known
☐ Yes
List: _____

Cultural Needs Addressed:
☐ Yes ☐ No
List: Eng; EPW

Pre-Op Pain:
☐ No Pain: unable to assess
☐ Yes Level _____(0-10)
Action Taken: _____
Location/type: _____

Last PO Intake: (date/time)
Solid: 7p MN
Liquid: 7p MN

In Chart:
☐ H&P ☐ Yes ☐ No
☐ EKG ☐ Yes ☐ No
☐ CXR ☐ Yes ☐ No
☐ Other: _____

Skin Condition:
☐ Intact
☐ Other: _____

Limitations:
☐ _____ ☐ Auditory
☐ La ☐ Visual
☐ viability ☐ Prosthesis
☐ Other: _____

Personal Items:
☐ None
Disposition:
☐ Military gear _____
☐ Glasses _____
☐ Dentures _____
☐ Jewelry/wallet _____
☐ Other

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status:
☐ Alert/Oriented ☐ Calm
☐ Disoriented ☐ Sedated
☐ Anxious ☐ Unresponsive
☐ Appropriate for age
☐ Other

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☐ Remain with patient during induction

Pre-op Teaching Included:
☐ N/A due to patient condition
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position:
☐ Supine ☐ Beach chair
☐ Prone ☐ Sitting
☐ Jackknife ☐ Lateral L I R
☐ Lithotomy
☐ Other:

Positional Aids:
☐ Arms <90
Armboard: ☐ L ☐ R
Tucked: ☐ L ☐ R
☐ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other:
☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape
☐ Bean Bag ☐ Gel donut ☐ Pillows ☐ Wilson Frame

Comments: _____

ESU #: 09
Pad Site: 06 07 08
Pad Lot #: 0X10M
Site Clear at end of case? ☐ No ☐ Yes
If No, see RN note # _____
Bipolar: ___ Max Cut 50 Coag 30

DVT Prevention:
SCD used ☐ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☐ No ☐ Yes UPP
Other warming techniques: Warm Sheet

Tourniquet: N/A
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
_____
Applied by: _____
↑ ____ ↓ ____
↑ ↓
Total Min: _____

Comments: _____

(b)(6)-4

Comments: _____

MEDCOM - 4810

Potential For Infec' – Outcome: Appropriate Actions Taken to ent Infection ☐ Yes ☐ No

Wound Classification: I ☐ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☐ Clipper
Area: _____ By: _____

Skin Prep:
☐ Betadine Scrub
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/Medications:
☐ Normal saline
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
☐ Other: _____

Drains/Packing: ☐ None
Foley FR: _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ____ Location _____
Chest tube: Location _____
Size _____ H2O Pressure: _____
Packing: type/location _____
See RN Note # ___ for comments

Dressing: Location: _____
☐ ABD ☐ Ace ☐ Bias ☐ Band-Aid(s) ☐ Cast
☐ Cervical Collar ☐ Coban ☐ Drip Pad ☐ Fluffs ☐ Kerlix
☐ Kling ☐ Immobilizer ☐ Plains ☐ Sling ☐ Splint
☐ Steri-strips ☐ Tape ☐ Webril ☐ Xeroform ☐ Other:
☐ Benzoin ☐ Mastisol ☐ Bacitracin

Miscellaneous

Counts: (initials)
Scrub [redacted] Circ [redacted]
Correct?
Sharps ☐ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A
See RN note # ___ for additional comments

Xray:
☐ None ☐ Other:
☐ Portable
☐ C-Arm

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: _____
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

Complications:
None Comments: _____
See RN note # ____ for additional comments

Transport From OR:
☐ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☐ PACU
☐ ICU
☐ Medivac
☐ Ward ____
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: Bullet Extraction

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)
[redacted]

[redacted]
Primary OR RN Signature

04/23/03
Date

Relief OR RN Signature

Date/Time

518-124 NSN 7540-00-634-4159

MEDICAL RECORD — BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable) _____ ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 4/14/03

DATE AND HOUR REQUIRED 4/15/03 O.R.

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING (b)(6)-2 DR

DIAGNOSIS OR OPERATIVE PROCEDURE: MULTIPLE GSW

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 (b)(6)-2

DATE VERIFIED 14APR03

TIME VERIFIED 1930

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

DONOR ABO A Rh POS

RECIPIENT ABO A Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMP

REMARKS: EXP 27APR03

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

(b)(6)-2

DATE 4/14/03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) (b)(6)-2

AT (Hour) 2205 ON (Date) 4/14/03

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) (b)(6)-2 2210 4/14/03

2nd VERIFIER (Signature) (b)(6)-2 2210 4/14/03 LTJG NC

PRE-TRANSFUSION TEMP. 99.0 PULSE 87 BP 120/70

DATE OF TRANSFUSION 14APR03 TIME STARTED 2220

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 0210 15 APR 03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.7	72	118/70

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, Filler Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 ne

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

(b)(6)-4

SEX M WARD 5 FWD STBL

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 4812

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
- [ ] CROSSMATCH

DATE REQUESTED
18APR03

DATE AND HOUR REQUIRED
18APR03 1030

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)*
DS (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
Shrapnel wounds

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
(b)(6)-2, EWS, NC

DATE VERIFIED
18APR03

TIME VERIFIED
1030

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
(b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	Comp

[ ] CROSSMATCH NOT REQUIRED FOR TH

REMARKS:
Exp 27 Apr 03

PREVIOUS RECORD CHECK:
[ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

(b)(6)-2

ED DATE 4-18-03

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*
(b)(6)-2

AT *(Hour)* 2040 ON *(Date)* 4-18-03

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.

(b)(6)-2 Doctor

(b)(6)-2 RN, NC

PRE-TRANSFUSION
TEMP. 102.0 PULSE 94 BP 96/52

DATE OF TRANSFUSION 4/18/03

TIME STARTED 2058

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE COMPLETED	INTERRUPTED
1 unit ML	0030	19Apr03	Yes NO

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.)*

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

SIGNATURE OF PERSON NOTING ABOVE
(b)(6)-2

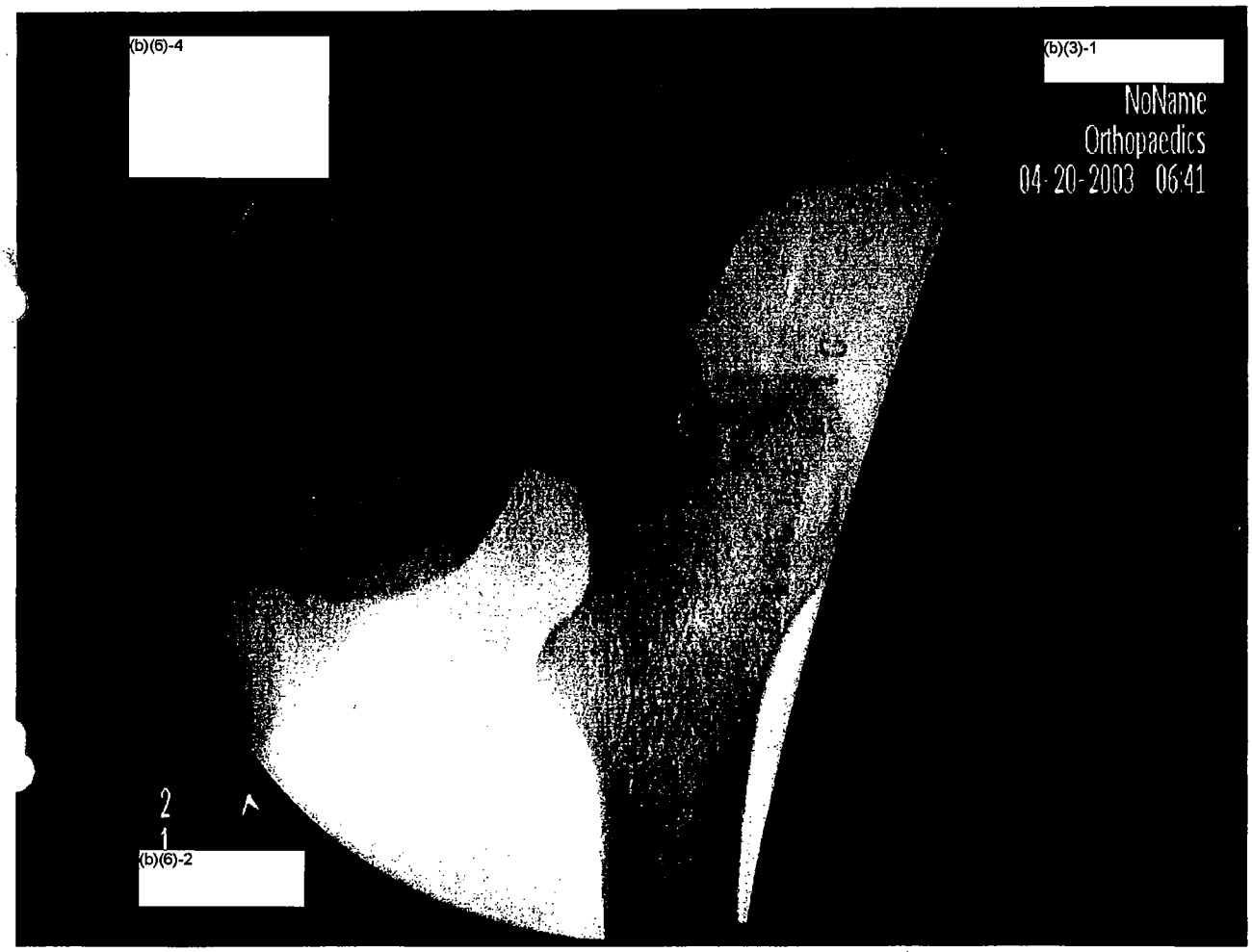
PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*
(b)(6)-4

SEX

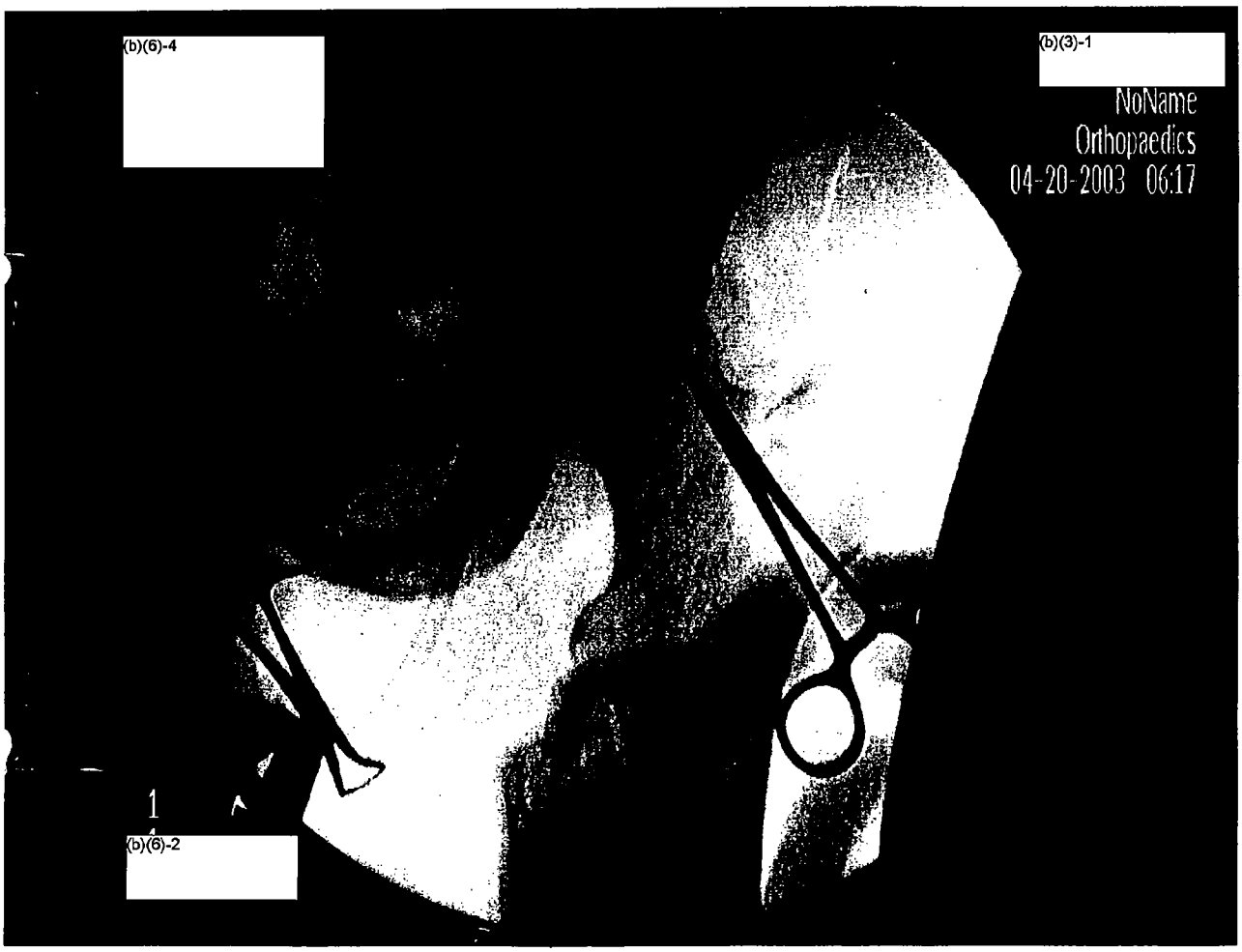
WARD
5 FWD

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-121

MEDCOM - 4813



MEDCOM - 4814



MEDCOM - 4815

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)
(b)(6)-4
Bed T

AGE | SEX: M | SSN (Sponsor) | WARD/CLINIC: CAS RR | REGISTER NO.

EXAMINATION REQUESTED (Use 519-B for multiple exams)
Abdomen, Right Femur, left Femur, left Knee, Right Elbow, Skull Series

REQUESTED BY
(b)(6)-2

TELEPHONE NO.

LOCATION OF MEDICAL RECORDS

FILM NO.

DATE REQUESTED: 06 AUG 03

PREGNANT ☐ YES ☐ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
(b)(6)-2
Ward III

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

RADIOLOGIC REPORT

KUB - air from stomach to rectum, LUQ 3 air in sm bowel. ? shrapnel frag in mid (R) abd. Shrapnel frags over (L) hip.
(R) elbow - single view lg shrapnel frag anterior to distal humerus, multiple sm frags over olecranon ? Fx fragment over inferior proximal ulna vs guaze.
(over)

SIGNATURE | LOCATION OF RADIOLOGIC FACILITY

1 — MEDI[illegible]

MEDCOM - 4816 REPORT STANDARD FORM 519-A (RN. 6-83) Prescribed by GSA/ICMR

Single (R) femur - shrapnel in lat STs. Ø dif Fx or cortical view interaction.

(R) knee - Ø Fx

(L) femur single view shrapnel in medial STs of prox thigh and 2 fragments over distal diaphysis Ø Fx but can't exclude cortical infraction.

(L) knee single view - 2 shrapnel frags over distal femur prox tib ~~fib~~ fib ~~s~~ Fx

Skull AP/lat - prominent dural vasc markings Ø depressed skull Fx can't exclude linear Fx

(b)(6)-2

NSN 7540-00-634-4162 519-218

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

(b)(6)-4

Bed T

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
	M		CAS RR	

EXAMINATION REQUESTED (DD 519-B for multiple exams)

AB Women, Right Femur, left Femur, left Knee, Right Elbow, Skull Series

REQUESTED BY	TELEPHONE NO.
(b)(6)-2	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
		06 AUG 03	☐ YES ☐ NO

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

(b)(6)-2

Ward III

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

RADIOLOGIC REPORT

KUB - air from stomach to rectum, LUQ air in sm bowel. ? shrapnel frag in mid (R) abd. Shrapnel frags over (L) hip.

(R) elbow - single view c/ shrapnel frag posterior to distal humerus, multiple sm frags over olecranon ? Fx fragment over inferior process ulna vs guaze.

(over)

SIGNATURE

LOCATION OF RADIOLOGIC FACILITY

1 — MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

☆ U.S GOVERNMENT PRINTING OFFICE : 1987-181-243/40522

STANDARD FORM 519-A (REV. 8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-45.505

MEDCOM - 4818

CLINICAL RECORD . DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

(b)(6)-4

ISING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
3/4/03	2300 HOURS	
Admit to ECW 3		
Dx - Set fx dist ulna,		
RDDM		
COND - ROUTINE		
VS PR		
Activity - As tolerated		

IENT IDENTIFICATION

ISING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
IVFOx 2-5 mg IV Q 3-4 PRN		
Tylenol #3 1-2 PO Q 2-4 PRN		
Diet - regular		
Continue current insulin reg		noted
A/C in AM		
[redacted] [b)(6)-2]		[b)(6)-2]

IENT IDENTIFICATION

ISING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	4 May 03 2030
NPH 30 u & Regular 5 u		
Q evening meal		
Chart Vel MAS [b)(6)-2]		
4 May 03 2357		
Chart Vel MAS [b)(6)-2]		
5 May 03 2358 [b)(6)-2]		

IENT IDENTIFICATION

SSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984—962 710

MEDCOM - 4819

508-111 NSN 7540-00-634-4121

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
10 Apr 03			1) Admit to Surgery.		(b)(6)-2
1840			2) Attending, CAPT [redacted]		(b)(6)-2
			3) Condition, Stable		(b)(6)-2
			4) NKDA		(b)(6)-2
			5) Meds -		(b)(6)-2
			a) Ancef 1gm IVPB, first dose in CASREC		(b)(6)-2
			6) IV - KL @ 75cc/hour		(b)(6)-2
			7) Foley to gravity		(b)(6)-2
			8) I+O Q8H		(b)(6)-2
			9) Vitals Q8H		(b)(6)-2
			10) Trauma Lab services, done in CASREC		(b)(6)-2
			11) Fasting Blood glucose in a.m., 11 Apr 1.		(b)(6)-2
			12) Daily wet to dry wound care to (L) groin, both thighs, penis		(b)(6)-2
			13) Call MD. if temp >101.5, BP >180, ≤ 100 Systolic		(b)(6)-2
			14) ~~Fentanyl~~ Morphine 2-4 mg IV Q 15 minutes, max Meds 10 mg, for severe pain.		(b)(6)-2
			b) Tylenol #3, 1 or ½ PO Q4H PRN moderate pain.		(b)(6)-2
			c) Tylenol 650 mg PO Q4H PRN temp >100.0		(b)(6)-2
			d) Maalox 30 cc PO Q4H PRN gastric, max		(b)(6)-2
			e) Milk of Magnesia 30cc PO Q4H PRN constipation		(b)(6)-2
			f) Ambien 5mg PO QHS PRN sleep.		(b)(6)-2

(Continue on reverse side)

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

4/10/03 2145

(b)(6)-4

REGISTER NO. Owens CAPT (b)(6)-2

(b)(6)-2

DOCTOR'S ORDERS

(b)(6)-2

STANDARD FORM 508 (Rev. 3-84)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4820

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
		15	Diet - regular	(b)(6)-2	(b)(6)-2
		16	X-rays - femur both / CAT legs, (R) forearm, C-spine - computer	(b)(6)-2	(b)(6)-2 (b)(6)-2 (b)(6)-2
4/10/03	2130			(b)(6)-2	
4/11/03	1400		Ativan 1mg - 1/2 tab tid prn anxiety. Glucotrol 5mg qam c breakfast.	(b)(6)-2	
11 APR 03	1615	①	Δ IV to .9% NSS.	(b)(6)-2	
		②	Multivit qAM.	CDR/NC/USN	
		③	High kcal diet. ADA diet.	(b)(6)-2	FNP
			Noted (b)(6)-2 LTJG, NC 4/11/03 1696		
11APR03	1655	④	Glucotrol Δ to Glyburide - pharmacy noted. Noted. (b)(6)-2 4/11/03 1800	(b)(6)-2	
12 Apr 03	0950		Valium 5mg IVP tid prn agitation q6° prn	(b)(6)-2 (b)(6)-2	(b)(6)-2 4-12-03 0950

(b)(6)-4

☆ U.S. GOVERNMENT PRINTING OFFICE: 1995-397-818

STANDARD FORM 508 (Rev. 3-94) BACK

MEDCOM - 4821

MEDICAL RECORD — DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
11 APR 03	1900	1	0.5 ml IM Td once	(b)(6)-2	(b)(6)-2
			0.5 mL Td given @ 1905	(b)(6)-2 CDR/NC/USN 2516	
4/12/03 @0245			Noted 24° chart verification	(b)(6)-2 /NC	
4/12/03	1415	1	BMP in AM - in chcs	(b)(6)-2	
			Noted (b)(6)-2 LT/MC 1600 4/12/03	CDR/NC/USN 2516	
4/13/03	0125		24° need verification	(b)(6)-2	Ens/N
4-13-03	1435		BMP in am.	(b)(6)-2	FNP
			(b)(6)-2 1600		
4-13-03	1622	1	CBC in AM	(b)(6)-2	
		2	D/C IV	CDR/NC/USN 2516	
		3	D/C Ancef		
		4	Keflex 250 mg PO q6° x 7 days.		
			Noted (b)(6)-2 LT/MC 4/13/03 1700	(b)(6)-2	FNP
Apr 14 @ 0045			24° chart verification		(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 608 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 4822

MEDICAL RECORD | **DOCTOR'S ORDERS** (*Sign all* orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
14 Apr 03		1	Void on call to OR.		(b)(6)-2
		2	NPO p MN		(b)(6)-2
		3	meds ē sip H2O		(b)(6)-2
		4	FBS in AM @ 0500		(b)(6)-2
			(b)(6)-2	(b)(6)-2	CDR MC
			(b)(6)-2 14 Apr 03 1335		
14 Apr 03		1	Repeat CBC.		(b)(6)-2
		2	T+C x 2 units pRBC.		(b)(6)-2
			Noted (b)(6)-2	(b)(6)-2	CDR MC
			1940 4/14/03 LTJ (b)(6)-2		
14 Apr 03 1950		1	Fasting glucose 0500 ~~on 4-16-03~~ 9 AM		(b)(6)-2
			Noted (b)(6)-2 LTJ CDR MC 4/14/03 2040		
4/14/03 2150			T.O. Dr. (b)(6)-2 LTJ/C (b)(6)-2		
			Transfuse 1u PRBC		
			Premedicate Tylenol 650mg + Benadryl 25mg PO X1		
			K Phos 20mEq PO X1 now		
			K Phos 20mEq PO X1 in 2 hrs		

(Continue on reverse side)

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

(b)(6)-4 Voided (b)(6)-2 LTJ/C MC REGISTER NO. 4/14/03 2205 Cont. (b)(6)-2

DOCTOR'S ORDERS

4/15/03 0045 24° Chart rev (b)(6)-2

STANDARD FORM 508 (Rev. 10-75) Prescribed by GSA and ICMR FPMR (41 CFR) 201-45-505 508-114

MEDCOM - 4823

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/14/03 2150			3u Humulin Insulin SQ X1 now CBC & Fasting Glucose in AM 4/15 Noted (b)(6)-2 LISW NC	(b)(6)-2	LISW NC
			4/14/03 2210		
4/14/03 2240			T.O. Dr (b)(6)-2 / LISW NC Δ K Phos to K Dur	(b)(6)-2	(b)(6)-2 LISW NC
			Noted (b)(6)-2 LISW NC	(b)(6)-2	
4/15/03 @ 0045			24° chart verification		(b)(6)-2
4/15/03 0830		(1) (2)	Humulin SQ 5u now Ancef 1gm IVPB now	none 4/15/03 0825 T. (b)(6)-2 CDR	

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

b)(6)-4

DOCTOR'S ORDERS

DD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR 141 CFR) 201-45-505
508-112

MEDCOM - 4824

506-111

NSN 7540-00-634-4121

MEDICAL RECORD — **,DOCTOR'S ORDERS**

*(Sign all **orders**)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUGORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS

4/15/03 (0930)

1. Admit to PACU.
2. Allergies: NKDA
3. Vital signs per PACU protocol.
4. O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM.
5. IVF: NS at KVO cc/hr
6. On ward: 02 @ 2-3 LPM via NC: YES (NO)
7. Pain medication:

   Ketorolac ____mg IV **x1** dose **(adults 30 mg max; peds consider 0.2-0.4 mg/kg)**

   15' MSO4 1-2 mg IV q **min** pm; max dose 20 mg

   2nd Fentanyl 25-50 **mcg** IV q 5 min prn; max dose 150 mcg

   Percocet _____ tab(s) p.o. with sip of water

   Other: Demerol 12.5-25 mg (max) IV prn shivering

   Morphine (b)(6)-2

8. Antiemetics:

   #1 Ondansetron _____ mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)

   #2 Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)

   Droperidol Ø mg IV x 1 dose ~~(0.01 mg/kg; max 0.625 mg)~~ ~~Must have baseline ECG~~ available before administration.

   Other Ø

   Clear liquids as tolerated: YES

10. Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.

(b)(6)-2

CRNA/Lcdr

(rev 3/2002)

(OVER)

(0930) 4/15/03

(Continue on **reverse** side)

PATIENT'S IDENTIFICATION *(For typed or written entries **give. Name–last, first.** **te:** hospital* or *medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by **GSA** ICMR FIRMR (41 CFR) 201-9.202-1

MEDCOM - **4825**

MEDICAL RECORD — DOCTOR'S ORDERS (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSES SIGNATURE
			ANESTHESIA ~~PACU~~ ORDERS == CONTINUED		
			11. Discharge patient from PACU per protocol: (YES) NO		
4/15/03 (0930)			12. When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
			13. Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
			14. Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
			15. TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			16. finger stick blood glucose now.		
			Signature (b)(6)-2 Beeper (b)(6)-2		
			LCDR/NC 4/15/03 (0930)		

STANDARD FORM 508 (Rev. 3-94) BACK

MEDCOM - **4826**

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
15 Apr 03		①	PACU then Tower 5 forward starboard.		(b)(6)-2
		②	Dx Sip Multiple I+D's GpS w		(b)(6)-2
		③	Stable -		(b)(6)-2
		④	VS q 6 hrs		(b)(6)-2
		⑤	NKDA.		(b)(6)-2
		⑥	Dressings: DO NOT Pull out Wicks placed in the wounds. IF Soaking through ⇒ CAREFully Remove Spandage, Remove Kerlex + all gauze. Replace with sterile gauze. prn. DO NOT pull out Wicks placed.		(b)(6)-2
		⑦	Resume medical regimen pt was on pre-op.		(b)(6)-2
		⑧	CBC + BMP in AM (fasting). 16, 17 Apr 03		(b)(6)-2
			FBS before meals. (mid day, evening + ghs)		
			If BG ≤ 200 ⇒ Humulin Taken 12 @ 1145 186.		
			> 201 ≤ 250 5u Humulin SQ		
			> 251 ≤ 300 8u " "		(b)(6)-2
			> 301 ≤ 350 12u " "		
			> 351 15u call MO		
1251			T.O. DR (b)(6)-2 / ENS (b)(6)-2	(b)(6)-2	ENS NC
			INDWELLING FOLEY —	(b)(6)-2	
				(b)(6)-2	USN

(Continue on re...)

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

(b)(6)-4

(b)(6)-2

5 Forward Starboard

15 Apr 1430

WARD NO.

16 Apr @ 0030 — 24° chart ver...

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

(b)(6)-2

MEDCOM - 4827

Voided + faxed 15 Apr 1222

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
16 Apr 03		1	DC Foley @ 2300 tonight		
		2	Due to void. 17 Apr 0900		
		3	If Dressings get soaked ⇒ Δ sterile technique.		
		4	ADA Diet.		
			(b)(6)-2 (b)(6)-2 CDR MC		
			noted (b)(6)-2 1215		
4/16	1600		V.O. from Dr. (b)(6)-2 to ENS (b)(6)-2		
			1) Blood Cultures x2		(b)(6)-2
			2) Urine C+S		(b)(6)-2
			3) Tylenol 650mg		(b)(6)-2
			(b)(6)-2 noted	(b)(6)-2	
4/16/03 1630		1.	Tylenol to 10 mg c breakfast/dr		(b)(6)-2 PAPC
			Noted (b)(6)-2 LTC/MC 4/16/03 1650		
16 Apr 03 1745		1	TLS q 8°		
		2	CXR PA + Lat	(b)(6)-2	
		3	Thank you		
			Noted (b)(6)-2		

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written ... middle; grade; rank; rate; hospital or medical facility) (b)(6)-2 ... last, first, 4/16/03 1945 REGISTER NO. WARD 110

(b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1983—201-760/66075

MEDCOM - 4828

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
16 Apr 03 1745		①	Δ Sliding Scale. Humulin ≤ 200 Ø U >201 ≤250 8 U >251 ≤300 12 U >301 ≤350 16 U >351 18 U call MO		(b)(6)-2
		②	Accu Tym IVPB @ 80	(b)(6)-2	
		③	DC Keflex.		
			Noted (b)(6)-2 LTJG (b)(6)-2 4/16/03 2000		
			T.O. DR. (b)(6)-2 /HN (b)(6)-2		(b)(6)-2
		①	PT TO OR 17APRØ3 @ Ø83Ø.		
		②	MUST HAVE INTERPRETER ON STAND BY BY Ø8ØØ.		
		③	PT NPO P MN.		
		④	IF PT SPIKES TEMP, SEND BLOOD CX X2 AND GIVE TYLENOL.		
		⑤	PT DTV BY Ø6ØØ 17APRØ3.		
			(b)(6)-2		
4/17/03 0030			Noted (b)(6)-2 24° chart verification		(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - **4829**

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
17 Apr 03		1	DC Avelox -		(b)(6)-2
		2	Primaxin 500 mg IV q 6°		
		3	Contact Precautions for acinetobacter		
		4	1 L acetic acid solution 3% for dressing D/C		
			(b)(6)-2	(b)(6)-2	
			Noted by (b)(6)-2	EN3/NC, RN (b)(6)-2	17 APR 03

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 4830

508-111

NSN 7540-00-634-4121

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/17/09 0958			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU.		
		2.	Allergies: Ø		
		3.	Vital signs per PACU protocol.		
		4.	O2: ~~RA~~ FM @ 5 LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		
		5.	IVF: NS at 100 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES (NO)		
		7.	Pain medication:		
			~~Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~		
			MSO_4 2.5 mg IV q 5 min prn; max dose 30 mg		
			~~Fentanyl _____ mcg IV q ___ min prn; max dose _____ mcg~~		
			~~Percocet _____ tab(s) p.o. with sip of water~~		
			Other: _____		
		8.	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide _____ mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol _____ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline EKG available before administration.~~		
			Other _____		
		9.	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)		

(OVER)

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD [illegible]

MEDCOM - **4831**

ACLU-RDI 1255 p.145

DOD 12043

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE / NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED	
		11.	**Discharge patient from PACU per protocol:** (YES) NO	
		12.	**When** epidural/spinal **patients meet discharge** criteria **per** protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.	
			FOR PACU KEEP PATIENTS ONLY	
		13.	Release **patient** from anesthesia care **to KEEP** status **when patient** meets **anesthesia discharge criteria: YES NO**	
		14.	Notify anesthesia (**1506**) **for airway** management and: (circle if applicable)	
			a. Pain management	
			b. Fluid management	
			c. Other _____	
		15.	**TOW patient** to ward in a.m. if patient **meets** discharge **criteria:** **YES** NO	
			Signature _____ Beeper (b)(6)-2	(b)(6)-2

STANDARD FORM 508 (Rev. 3-94) BACK

MEDCOM - **4832**

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			Post op.		
10Apr03		(1)	Resume Pre-op orders.		
		(2)	B i D Dressing Δ's ± MD only		
			encael 5-10 mg MSO4 IVP		
			1-2 mg Versed. IVP		
			Pulse ox. + Nasal O2. 6 L m. i.		
			Kerlex Bn hand 4 rolls.		
			2" tape, CTA's 10		
			4x4 guaze 3 tabs, Suture set.		
			ABD x 2		
		(3)	For Dressing Δ's → prefer gurney		
			at us exam Loop.		
		(4)	MD will call to premedicate.		
		(5)	CBC ± diff in AM of 19 Apr BMP in AM of 19 Apr		
		(6)	Advance Diet to AD As results.		
10Apr03		(1)	Cooling blanket, ice, Cool Pags prn T > 101		
		(2)	CBC, Bld cx's x2 UA, Urine Cx.		
		(3)	Tylenol 1 PO prn		

(Continue on reverse side)

PATIENT'S IDENTIFICATION (Last, first, middle; grade; rank; rate; hosp

give: Name - last, first,

4/17/03 2150

DOCTOR'S ORDERS

STANDARD FORM 509 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1983—201-750/80075

10APR03

PERSONAL DATA PRIV ACT 1974

MEDCOM - 4833

3+-4hr
3hr round

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/18/03	0110		24° chart verification done	(b)(6)-2	ENS, MC
4/18/03		(1)	Trasfusa 1 u [illegible]	(b)(6)-2	
		(2)	Tylnol ii po Benadryl, 25mg po		
		(3)	if temp > 101.5, vx bld x 2 give tylnol ii po + call MD page 140		
			(b)(6)-2		
			[illegible] Squall, NK 18APR03 @ 1000		
Apr 18 03		(4)	Heparin Lovenox ~~40 mg~~ 30mg 30mg	(b)(6)-2	
1730			Sub Q q D BID	(b)(6)-2	
			(b)(6)-2	(b)(6)-2	
Noted 4/18/03 @ 1900			(b)(6)-2 2 [illegible]		
			(b)(6)-2		

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 *(Rev.* 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - **4834**

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign *all orders*)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
APR 18 '03 2037		(1)	Tighten Sliding Scale as follows: (qAC/qHS)		(b)(6)-2
			Blood Sugar — units Reg. insulin		
			< 140 — 0		
			140 - 170 — 2		
			171 - 200 — 4		
			201 - 230 — 6		
			231 - 260 — 8		
			261 - 290 — 10		
			291 + — 12		
		(3)	In addition to sliding scale, give NPH insulin: 4 units pre-breakfast		(b)(6)-2
			4 units pre-dinner		
		(2)	CBC + BMP in AM (do CHCS/printed)		(b)(6)-2
			Thank you	(b)(6)-2	
4/18/03 2100			V.O. Dr (b)(6)-2 to 2CSR.	(b)(6)-2 (b)(6)-2	4/18/03
		(1)	Give tylenol 650mg PO q4 hrs for Temp >101.		
		(2)	Ice packs / cooling blanket to ↓ temps.	(b)(6)-2	2CSR
				(b)(6)-2	to Chart Verified 19 Apr 03 0500

PATIENT'S IDENTIFICATION (For typed or writ... middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

REGISTER NO (b)(6)-2 WARD NO

DOCTOR'S ORDERS

STANDARDFORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDCOM - 4835

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
19Apr03		(1)	✓ Glycharide 10mg q AM before breakfast		(b)(6)-2
		(2)	K-phos 20 meq po now + repeat q 1° x 2		
		(3)	Add table salt to diet		
		(4)	Encourage IS / TCDB		

Noted 1040 4/19/03 (b)(6)-2 (b)(6)-2

Apr 1903 1134		(1)	Vomited x1 this pm — distress with mobilization — in addition to pain med — ✓ (Bird)		(b)(6)-2

Noted 1220 4/19/03 (b)(6)-2 (b)(6)-2

4Apr03 1400		(1)	Pt not to mobilize — pending ortho eval — fragment in rectum (L) via foley		(b)(6)-2

Noted 1410 4/19/03 (b)(6)-2 (b)(6)-2

PATIENT'S IDENTIFICATION (For typed or writ... middle; grade; rank; rate; hospital or medical facility)
(b)(6)-4

...GISTER NO. | WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10–75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 20145–505
508–112

MEDCOM - 4836

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on firm surface; use pressure on ball point pen. **Sign** all orders.
Nurse: Remove one copy and send to Pharmacy after ***each*** order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/19/03			NPO p MN		(b)(6)-2
			On IV Amp (4/20/03)	(b)(6)-2	
	NOTED 4/19/03 1818		(b)(6)-2	(b)(6)-2	
			24° Change Ventilator 20 Mar 2008	(b)(6)-2	

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. **3–94**)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - **4837**

MEDICAL RECORD — DOCTOR'S ORDE (Sign all orders)

DATE AND TIME START	STOP	RX	DRUGORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS

1. Admit to PACU. (b)(6)-2
2. Allergies: NKA (b)(6)-2
3. Vital signs per PACU protocol. (b)(6)-2
4. O2: ___FM @ 10LPM, ___ ___% Blowby, 1 NP @ 2 LPM. (b)(6)-2
5. IVF: LR at KVO cc/hr (b)(6)-2
6. On ward: 02 @ 2-3 LPM via NC: YES NO (b)(6)-2
7. Pain medication:

~~Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~

MSO_4 1-2 mg IV q 2-3 min prn; max dose 20 mg (b)(6)-2

Fentanyl 25 mcg IV q5-7 min prn; max dose 75 mcg Hold RR 10 < BPM (b)(6)-2

Percocet 2 tab(s) p.o. with sip of water (b)(6)-2

~~O~~ (b)(6)-2 Demerol 12.5-25mg IV PRN Shivering MAX Dose 25mg. (b)(6)-2

8. Antiemetics:

Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg) (b)(6)-2

Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)

~~Droperidol ___ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~

Other BFS NOW Please (b)(6)-2 BFS 168 @ 1445

9. Clear liquids as tolerated: YES NO (b)(6)-2
10. Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2 (b)(6)-2 (b)(6)-2

Mod 4/20/03 1420 (b)(6)-2

(rev 3/2002) (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) (b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4838

MEDICAL RECORD — ,DOCTOR'S CRDERS
(S i p all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS -- CONTINUED

11. Discharge patient from PACU per protocol: YES NO (b)(6)-2

12. When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.

FOR PACU KEEP PATIENTS ONLY

13. Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO

14. Notify anesthesia (1506) for airway management and: (circle if applicable)

a. Pain management
b. Fluid management
c. Other _____

15. TOW patient to ward in a.m. if patient meets discharge criteria:

YES NO

(b)(6)-2

Signature (b)(6)-2 Beeper (b)(6)-2

CMO

MD 4/20/03 1425 (b)(6)-2

STANDARD FORM 508 (Rev. 3-94) BAC

MEDCOM - **4839**

MEDICAL RECORD — DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
20 Apr 03			Resume Pac-q Orders.	(b)(6)-2	
			(b)(6)-2		
			(b)(6)-2 4/20/03 1150		
20 Apr 03 2200			Increase Cybrid to 1.0g po BID		(b)(6)-2
			(b)(6)-2		
20 Apr 03		(1)	Hep lock IV.		(b)(6)-2
		(2)	US & Phens		(b)(6)-2
		(3)	CBC in AM & FBS		(b)(6)-2
		(4)	OOB to chair.	(b)(6)-2	(b)(6)-2
			PT w Assist & Ambul	(b)(6)-2	(b)(6)-2
			(b)(6)-2		
			COR, NC 4/20/03 2230		
21 Apr 03 2220		(1)	~~Sig~~ 1% Acetic Acid Soln 1 L. for Dressings.		(b)(6)-2
			Cepacol Lozenges. 1 po prn.		(b)(6)-2
			Add Table Salt to Diet.		(b)(6)-2
			K phosphate po 20 mEq now & in 1 hr.		(b)(6)-2
			PT Consult 6 Act Tmg Walker	(b)(6)-2	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO. (b)(6)-4

DOCTOR'S ORDERS (b)(6)-2

5 FWD – PORT

5-43-1

STANDARD FORM 508 (R
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-765/80076

MEDCOM - 4840

508–112 7540–01–044–5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	DATE AND TIME STOP	Rx	DRUGORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
22 Apr 03 0530			24° Chest Roentgenogram	(b)(6)-2	
22 Apr 03 0600			T.O. Dr (b)(6)-2 - may substitute Potassium Chloride 20 meq now and in 1 hr		
			(b)(6)-2	(b)(6)-2	
				Natalie 22 Apr 03 0600	
4/22/03	1040	D	FeSO4 325 mg PO QDAY V.O. Dr (b)(6)-2 MD	(b)(6)-2	CDR
4/22/03 1115		①	CBC, Iron, Retic Ct. ~ Orders in CHCS		(b)(6)-2
		②	PT Consult in CHCS		
		③	Pre-op Δ taught at minor surgery ~ Will need a sterile suture kit. ~ 2 packs of sterile hand towels ~ Betadine paint spray. ~ 1% Lidocaine, 20cc syringe, 26 gauge needle ~ I'll bring the sutures + scalpel.		(b)(6)-2
Noted 1315	4/22/03		(b)(6)-2	(b)(6)-2 CDR MC Chart verified.	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO. (b)(6)-4

WARD NO. 4/23/03 0100

DOCTOR'S ORDERS
Medical Record

FORM 508 (Re 4)
Prescribed by GSA/ICMR, FIRMR (4 CFR) 201–9.202–1

MEDCOM - 4841

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
22 Apr 03		1	NPO after MN		
		2	Hold NPH insulin in AM.		
		3	Give oral meds c sip H2O.		
		4	Void as call.		
			[redacted]		
			22/1700 2300 [redacted] MC		
4/23/03	0100		chart verified		
23 Apr 03		1	Resume all orders as written.	[redacted]	
		2	Post op Dressing D + Extraction Schrapnell Rt Thigh		
		3	Advance diet [redacted]		X2.
			[redacted]		
4/23/03	1615		[redacted]		CDMC.
4/24/03	0130		chart verified		

(Continue on reverse side)

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

[redacted]

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - **4842**

508-111 NSN 7540-00-634-4121

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/23/03 1430			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU.		
		2.	Allergies: NUBAIN	(b)(6)-2	
		3.	Vital signs per PACU protocol.		
		4.	O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ ___ LPM.		
		5.	IVF: LR at 75 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: (YES) NO		
		7.	Pain medication:	(b)(6)-2	
			Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO_4 1-2 mg IV q 6-8 min prn; max dose 20 mg		
			Fentanyl ___ mcg IV q ___ min prn; max dose ___ mcg		
			Percocet ___ tab(s) p.o. with sip of water		
			Other: ___	(b)(6)-2	
		8.	Antiemetics:		
		1	Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)	(b)(6)-2	
			Metoclopramide ___ mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol ___ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other ___		
		9	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.	(b)(6)-2	
			(rev 3/2002) Noted (b)(6)-2 LCDR /MC 1430 (OVER) 4/23/03		

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

(b)(6)-4

DOCTOR'S ORDERS
Medical Record

STANDARD ... DRM ...

MEDCOM - **4843**

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)			
DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.	(b)(6)-2	
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management	(b)(6)-2	
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature _____ Beeper	(b)(6)-2	
			(b)(6)-2	CCDR/RC 4/23/03	

STANDARD FORM 508 (Rev. 3-94) BACK

MEDCOM - 4844

508–112 7540–01–044–5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on firm surface; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	DATE AND TIME STOP	Rx	DRUGORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
Apr 24 '03 1650			Additional d/c meds for pt per Dr (b)(6)-2 — FeSO4 1 po TID #15 Vent 1 po qD #5		
			(b)(6)-2		
				24 Apr 03 1445	(b)(6)-2
25 Apr 03 0100			24° Chart review	(b)(6)-2	

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

DOCTOR'S **ORDERS**
Medical Record

STANDARD FORM 508 (Rev. 3–94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - **4845**

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME				
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE / NURSE'S SIGNATURE
24 Apr 03		(1)	LOD	
		(2)	Meds: Lovenox 30mg SQ BID. X 6 weeks	
			NPH Insolin 8u SQ ā breakfast.	
			4u SQ ā Dinner	
			Glyberide 10mg po BID. #60 days	
			Primaxin 500 mg IV q 6° X 4 days.	
			Percoset 1-2 po q 4° prn pain #30 tabs	
			NS for irrigate 2L.	
			20 rolls Kerlex	
			2 Bottles Iodoform 2" wide gauze.	
			4x4's 15 pks.	
			Wet to Dry NS or Iodoform gauze BID.	
			Staples Left Hip out Monday 28 Apr 03	
			Rt Thigh Wed 30 Apr 03	
		(3)	Dx Multiple Shrapnel Wounds Rt Elbow.	
			Left Groin, Penis, Bilateral Thighs.	
			DM type II requiring NPH through infection.	
			Perforated RD Ear Drum.	
			Left Hip with Fragment Excised.	

(b)(6)-2

(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

DOCTOR'S ORDERS 1/10 24 Apr 03

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-750/80075

MEDCOM - 4846

506-111

NSN 7540-00-634-4121

MEDICAL RECORD | **DOCTOR'S ORD'** *(Sign all orders)*

DATE AND TIME START	STOP	RX	DRUGORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS

4.25.03

1. Admit to PACU. (b)(6)-2
2. Allergies: NKDA (b)(6)-2
3. Vital signs per PACU protocol. (b)(6)-2
4. O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM. (b)(6)-2
5. IVF: LR at 110 cc/hr (b)(6)-2
6. On ward: 02 @ 2-3 LPM via **NC:** (YES) NO (b)(6)-2
7. Pain medication:

Ketorolac ___mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg) N/A

1-2 mg IV q 5 min prn; **max** dose 20 mg - 1 (b)(6)-2

Fentanyl _____mcg IV q____ min prn; max dose_____mcg

Percocet _____ tab(s) p.o. with sip of water

Other: _____

8. Antiemetics:

1 Ondansetron 10 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg) (b)(6)-2

2 Metoclopramide 4 mg IV x1 (0.15 mg/kg; max 10 mg) (b)(6)-2

Droperidol _____mg IV x 1 dose ~~(0.01 mg/kg; max 0.625 mg) Must have baseline ECG~~ available before administration.

Other _____

4/25/03 (b)(6)-2 1124

9. Clear liquids as tolerated: (YES) NO (b)(6)-2
10. Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting (b)(6)-2 not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2 MD (b)(6)-2

(rev 3/2002) (OVER)

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries gfve:Name–lasl, first. middle; grade: rank: rate; hospital or medical facility)*	REGISTER NO.	WARD NO.
b)(6)-4		

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - **4847**

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
(b)(6)-4		(b)(6)-4			

THESIA PACU ORDERS -- CONTINUED

4.25.03

11. Discharge patient from PACU per protocol: YES NO (b)(6)-2

12. When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.

FOR PACU KEEP PATIENTS ONLY

13. Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria. YES NO

14. Notify anesthesia (1506) for airway management and: (circle if applicable)
    a. Pain management
    b. Fluid management
    c. Other _____

15. TOW patient to ward in a.m. if patient meets discharge criteria:
    YES NO

(b)(6)-2

Signatur (b)(6)-2 MD

Beeper

STANDARD FORM 508 (Rev. 3-94) BACi

MEDCOM - **4848**

MEDICAL RECORD — DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
25 APR 2003		(1)	Regime pre op orders	(b)(6)-2	(b)(6)-2
		(2)	Advance diet from C Liquids to pre op		(b)(6)-2
			Liquids	(b)(6)-2	
					25 April 03 @ 1235
					P.R (b)(6)-2 NC
26 Apr 03 @ 0100			24° Chart Verified	(b)(6)-2	
28 APR 0830			Chart verified		(b)(6)-2

(Cont i non reverse side)

PATIENT (b)(6)-4 ...e: Name - last, first, middle; | REGISTER NO. | WARD NO.

10APR03

(b)(3)-1 PERSONAL DATA PRIV ACT 1974

(b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

MEDCOM - 4849

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
26 Apr 03	0		Ambulate 3 x a day minimum assistance if required.	(b)(6)-2	
			O Bake Urn ~ 4/26/03 Noted 450 ENS	(b)(6)-2 (b)(5)-2 (b)(6)-2 (b)(6)-2	
27 Apr 03	0004		Z40 Chat Check ENS	(b)(6)-2	
Apr 27 03 1018		(1)	D/c PCN NPH (make change on discharge med instructions too)	(b)(6)-2 (b)(6)-2 (b)(6)-2	
		(3)	Clarification on PCN NPH dose: it has been 4 units here on ward. Rx been written 8 units on discharge. Will continue on 4 units for now + Rx dose for D/C when D/C is imminent	(b)(6)-2	
4/20	4/27/03		(b)(6)-2	(b)(6)-2	

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDCOM - 4850

508-112

7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on firm surface; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	DATE AND TIME STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
30 Apr		(1)	QOD AM FBS DC all other sticks		
		(2)	NPH 3u a breakfast + 2 evening meal.		
		(3)	DC Primaxin	(b)(6)-2	
			noted 30 APR02 1235	CDR MC	
	Maybe		MD Chat Anne ENS	(b)(6)-2	

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

DOCTOR'S ORDERS
MEDICAL RECORD
STANDARD FORM 508 (Rev. 8-84)

MEDCOM - **4851**

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
5/1/03			permethrin cream apply to scalp for 8 hours - then rinse off.		
	FAXED		(b)(6)-2		
			noted 1MAY03 1100	(b)(6)-2	
2May03	0421		24° Chart Check EWS	(b)(6)-2	
3May03	0418		24° Chart Check EWS	(b)(6)-2	

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 4852

MEDICATION ADMINISTRATIO' :ORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN																	
4/10	MSO4 2-4mg	DATE	4/11	4/12	4/12	4/13														
	IV q 1° for	TIME	1330	0130	0930	1243														
	Severe pain	DOSE	4	4	4	5mg														
		INIT.	(b)(6)-2																	
4/10	Tylenol #3	DATE	4/11	4/12																
	1-11 po q 4°	TIME	0700	0715																
	prn moderate	DOSE	2 TAB	11																
	pain	INIT.	(b)(6)-2																	
4/10	Tylenol 650mg	DATE	4/11	4/12																
	po q 4° prn	TIME	1900	1900																
	Temp > 100.0	DOSE	1 1/2	1/2																
		INIT.	(b)(6)-2																	
4/10	Mylanta 30cc	DATE																		
	po q 4° prn	TIME																		
	gastric irritation	DOSE																		
		INIT.																		
4/10	MOM 30cc po	DATE																		
	q 4° prn	TIME																		
	constipation	DOSE																		
		INIT.																		
4/10	Ambien 5mg	DATE																		
	po q HS	TIME																		
	prn sleep	DOSE																		
		INIT.																		
4/12	~~Atiman~~ Valium	DATE																		
	5mg IV prn	TIME																		
	agitated	DOSE																		
	Q6° prn	INIT.																		

MEDCOM - 4853

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL
K Dur 20mEQ PO X1 Now	4/14	2300	(b)(6)-2				
K Dur 20mEQ PO in 2hrs	4/15	0100					
Tylenol 650mg PO X1	4/14	2145					
Benadryl 25mg PO X1	4/14	2145					
Humulin Insulin 3u SQ X1	4/14	2300					
Humulin Insulin Tuse	4/15	0125					
Tylenol 650mg PO X1	4/16	1650					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN																
4/10	MSCH 2-4MG	DATE	4/13																
	IV Q1° FOR	TIME	1243																
	SEVERE PAIN	DOSE	5MG																
		INIT.	(b)(6)-2																
4/10	TYLENOL #3	DATE	4/13	4/15	4/15	4/16													
	1-2 TABS PO	TIME	2335	1600	2350	0300													
	Q4° PRN MOD.	DOSE	2tabs	2	2	2													
	PAIN	INIT.	(b)(6)-2																
4/10	TYLENOL 650MG	DATE	4/16																
	PO Q4° PRN	TIME	1645																
	TEMP >100.6.0	DOSE	650mg																
		INIT.	(b)(6)-2																
4/10	MYLANTA 30CC	DATE																	
	PO Q4° PRN	TIME																	
	GASTRIC IRRITATION	DOSE																	
		INIT.																	
4/10	MOM 30CC PO	DATE																	
	Q4° PRN	TIME																	
	CONSTIPATION	DOSE																	
		INIT.																	
4/10	AMBIEN 5MG	DATE	4/14	4/14	4/16														
	PO QHS	TIME	0100	2034	0300														
	PRN SLEEP	DOSE	5mg	5mg	5mg														
		INIT.	(b)(6)-2																
4/12	VALIUM 5MG	DATE																	
	IV PRN	TIME																	
	AGITATION Q6°	DOSE																	
		INIT.																	

MEDICATION ADMINISTRATION **3RD (Back) SIN 0105-LF-216-5581**

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
(BID) on call for discharge Δ 5-10 mg Lwso4 IVP				K PHOSPHATE 20mEq PO	4/19	1200	
Ⓓ 1-2 mg Versed IVP				K PHOSPHATE 20mEq PO	4/19	1300	
MSO4 3cc mg IVP for DSZA 2-3 mg IVP	4/18/03	1630	(b)(6)-2	K PHOSPHATE 20mEq PO	4/19	1400	
Benadryl 25mg PO premed	4/18/03	2000					
Tylenol 650mg PO premed	4/18/03	2000					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																	
4/10	Morphine 2-4mg IV Q1° PRN Severe Pain	DATE	4/18																
		TIME	1630																
		DOSE	3																
		INIT.																	
4/10	Tylenol #3 1-2 Tabs PO Q4° PRN Mod. Pain	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
4/10	Tylenol 650mg PO Q4° PRN T >100.0	DATE	4/19	4/19															
		TIME	1930	2225															
		DOSE	2 Tabs PO	2 Tabs PO															
		INIT.	(b)(6)-2																
4/10	MOM 30cc PO Q4° PRN ~~Gastric Irritation~~ Constipation	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
4/10	Mylanta 30cc PO Q4° PRN Gastric Irritation	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
4/10	Ambien 5mg PO QHS PRN Sleep	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
4/12	Valium 5mg IV PRN Q6° Agitation	DATE																	
		TIME																	
		DOSE																	
		INIT.																	

MEDICATION ADMINISTRATION 3RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL
VERSED 1-2mg IVP c AMB	4/19		(b)(6)-2				
Versed 3mg IV	4/20	2130					
Dressing Δ — 35 mg MSO4 IVP 2.5 mg VERSED IVP	4/20	2145					
BENADRYL 50mg PO	4/23	2355					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN																		
4/10	MORPHINE	DATE	4/20	4/22	4/22	4/23	4/24	4/24													
	2-4 mg IV Q1°	TIME	1825		2130	1920	1830														
	PRN	DOSE	5mg		20mg	10mg	6mg														
	SEVERE PAIN	INIT.	(b)(6)-2																		
4/10	TYLENOL #3	DATE	4/23	4/24	4/24																
	1-2 TABS PO	TIME	1155	0946	1745																
	Q4° PRN	DOSE	1	1	2																
	MOD. PAIN	INIT.	(b)(6)-2																		
4/10	TYLENOL 650mg	DATE	4/19	4/19																	
	PO Q4° PRN	TIME	0300	2045																	
	T > 100.0	DOSE	650mg	650																	
		INIT.	(b)(6)-2																		
4/10	MOM 30cc	DATE																			
	PO Q4° PRN	TIME																			
	CONSTIPATION	DOSE																			
		INIT.																			
4/10	MYLANTA	DATE																			
	30cc PO	TIME																			
	Q4 PRN	DOSE																			
	GASTRIC IRRITATION	INIT.																			
4/10	AMBIEN 5mg	DATE	4/19	4/19	4/21	4/23															
	PO QHS PRN	TIME	0300	1830	2347	2355															
	SLEEP	DOSE	5mg	5mg	5mg	5															
		INIT.	(b)(6)-2																		
4/12	VALIUM 5mg	DATE																			
	IV PRN Q6	TIME																			
	AGITATION	DOSE																			
		INIT.																			

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

NKDA

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH April 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	10	11	12	13	14	15	16
4/10	Ancef 1gram IVPB q 8h	0200	X	(b)(6)-2					
		1000	X						
		1800	Cap rec	(b)(6)-2					
4/11	MVI 1 Tab PO QD	0900	X	X	(b)(6)-2				
4/11	Glipizide 5mg q AM=Breakfast	0700	X	X					
4/13	Keflex 250mg PO	0600	X	X	X	X			
	q 6° x 7 days	1200	X	X	X	X			
		1800	X	X	X				
		2400	X	X	X				

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE W S E ORDERS SEE REVERSE

MEDCOM - 4857

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE
	Bedrest	
	Bathroom Privileges	
	Up in chair	
	Ambulate	
	Commode	
	Needs assistance	
	Restricted to unit	
	Hospital Privileges	
	Other	

✓	BATH	DATE
	Bed bath	
	Shower	
	Tub	
	Needs assistance	

ORAL HYGIENE	DATE
Self	
Needs assistance	
Special	

DIET	DATE
NPO	
REG	4/17
ADA DIET ADD TABLE SALT	
NO ENSURE (4 BLD GIVEN)	

FEEDING	DATE
Self	
Needs assistance	
Gavage	4/16 (&O)

✓	VITAL SIGNS	FREQ
	Temp	
	Pulse	
	Resp	
	B/P	
	Other	

96°

FLUIDS
Farced to:
Restricted to:
95°

✓	SPECIAL NOTES
	Dentures
	Speech impediment
	Language barrier
	Prosthetic device
	Visual impairment
	Blind
	Contact lenses
	Glasses
	Hearing defect
	Other

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/16		Daily w-D wound care to (R) arm (L) groin, both thighs, penis	
4/16		Call MD if temp ≥ 102.5° BP ≥ 180 ≤ 100 systolic	
4/15		DO NOT REMOVE Wicks: reinforce dsg as needed (c Fresh dsg. don't remove wicks! use sterile technique	

Sol new profile

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/17		1L acetic acid solution 3% for irrigation q Δ's.	
4/16		IS x Q 1° - TCDB	
4/16		If spikes temp send blood cx x2 & give 2 tylenol	
4/17		BID dressing Δ's c MD only	
		on call 20-30 mg MSO4 IVP	
		2-3 mg titrated IVP	
		Keflex on hand 4 refills	
		2" tape, NIAS 10, 4x4 gauze	
		3 tubs, suture set, ABD x 2	
4/17		For dressing Δ's - perform in exam room	
		MD will call to prescribe ATT	
		Dr (b)(6)-2	

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

DIAGNOSIS DM
Multiple GSW
Shrapnel penis
Knee Elbow

OP/SPECIAL PROCEDURES
Multiple I+D's
4/15 Dr (b)(6)-2

FINDINGS:

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION
stable

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

1 of 2

(b)(6)-4

MEDCOM - 4858 A

ALLERGIES:

N cab

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)
4/10		Ancef 1 gram IVPB q 8°	02 10 18
4/11		MVI 1 Tab QD	09
4/11		Glyburide 5mg qAM c Breakfast	07
4/13		Keflex 250mg PO Q6° X 7 days	
4/5		FBS q AC + HS	07, 11, 16, 22
		See Sliding Scale	
4/16		Glyburide 10mg PO c Breakfast	0700
4/16		Ancef 1gm IVPB Q8° 4/17	
4/17		Primaxin 500mg IV q 6°	
4/18		Lovenox 30mg SQ BID	9/21
4/14		Tylenol 650mg / Benadryl 25mg PO X1 for Premedication	
4/14		Humulin Insulin 3u X1 now	
4/14		K Phos 20mEQ PO X1 now	
4/14		K Phos 20mEQ PO in 2 hrs X1	
4/16		Tylenol 650mg PO X1	
4/17		Tylenol 650mg PO X1	
4/17		Before dressing A's 5-10 mg MSO4 IVP 1-2 mg versed IVP	
4/18		VALIUM 5 mg IVP TID prn agitation	
4/10		Ambien 5mg po q hs prn	
4/18		MOM 30cc PO q 4° prn constipation	
4/10		Mylanta 30cc po q 4° prn gastric irritation	
4/10		Tylenol 650mg po q 4° prn Temp 7100.0	
4/10		Tylenol #3 T-II PO q 4° prn moderate pain	
4/10		MSO4 2-4mg IV q 1° for severe pain	

DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/10	Trauma Lab done	none	
4/10	Fasting Blood Sugar in Am	4/11	
4/10	x-ray femur, both Legs, R forearm, CXR		4/10
4/10	Repeat CXR	☑	
4/12	BMP in AM 4/13		☐
4/11	0.5ml Td given	☑	
4/13	BMP in AM 4/14		☑
4/13	CBC in AM 4/14		☑
4/14	Fasting Glucose in AM 4/15		☒
4/14	Repeat CBC ~~in AM~~		☒
4/14	Type + Cross 2u		☒
4/14	Fasting Glucose 9AM		
4/14	CBC + Fasting Glucose in AM 4/15		☒
4/15	CBC + BMP in Am 4/16 ☒ 4/17 ☒		
4/16	Blood Cultures		☒
4/16	Urine C+S		☒
4/16	CXR PA + LAT		☒
4/17	CBC, Blood Cx		☒
	UA, Urine Cx		☒
4/17	CBC diff 4/18 ☒ BMP		☒
	CBC & diff, BMP 4/19		
4/18	CT Scan (R) Elbow and Pelvis	~~none~~	4/19

ADDRESSOGRAPH

(b)(6)-4

MEDCOM - 4859

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APR 19 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	13	14	15	16	17	18	19
4/15 4/11	MVI 1 TAB PO QD	0900	HOLD	HOLD	(b)(6)-2				
4/15 4/11	GLIBERIDE 5MG GAM C	0900	(b)(6)-2						
	BREAKFAST								
4/15 4/13	KEFLEX 250 MG PO	0600	X	(b)(6)-2					
	Q6° x 7 DAYS	1200	X	(b)(6)-2					
		1800	held	(b)(6)-2					
		2400	(b)(6)-2						
4/14	Fingerstick BS AM 4/15	0500	X	X	(b)(6)-2	X	X	X	X
4/15	FBS before meals	0700			X	X			
	see sliding scale	1100	X	X					
	& give Regular Humulin	1600		(b)(6)-2					
	insulin if needed	2200	X	(b)(6)-2					
4/15	Sliding Scale BC < 200 = 0 units				(b)(6)-2				
	> 201 ≤ 250 = 5 units								
	> 251 ≤ 300 = 8 units								
	> 301 ≤ 350 = 12 units								
	> 351 15 units call MD								
4/16	Glyburide 10mg PO c Breakfast 0700		X	X	X	X			
	3								

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPHPLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN &VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4860

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH April 15 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	16	17	18	19	20	21	22
4/15	MVI 1 Tab PO QD	0900	X	IN OR	(b)(6)-2				
4/14	Fingerstick BS AM	0500	X	87	207				
4/16	Sliding Scale - Humulin	0700	X	8 units	8 units				
	≤ 200 0 units	1100	X	IN OR	160 0 units				
	> 201 ≤ 250 8 units	1600	X	(b)(6)-2	193 12 units				
	> 251 ≤ 300 12 units	2200	874 (b)(6)-2						
	> 301 ≤ 350 16 units	X	X	X					
	> 351 18 units Call MO	X	(b)(6)-2	374 (b)(6)-2	(b)(6)-2				
~~4/16~~	~~Ancef 1gm IVPB 08°~~			1430 Given					
4/16	Glyburide 10mg PO c Breakfast	0700	X	[illegible]	(b)(6)-2				
4/16	Ancef 1gm IVPB 08°	0800	X	IN OR					
		1600	X						
		2400	(b)(6)-2						
4/17	Primaxim 500 mg q6° IVPB	0600	X	X	(b)(6)-2				
		1200	X	X	(b)(6)-2				
		1800	X	(b)(6)-2					
		2400	X	(b)(6)-2					
4/16	Lovenox 30mg SQ BID	0900			X				
		2100			(b)(6)-2				

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPHPLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE-OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4861

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APRIL 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/18	4/19	4/20	4/21	4/22	4/23	4/24
4/18	SLIDING SCALE (qAC/qHS)		X	X	X	X	X	X	X
	Blood Sugar Units Regular Insulin								
	<140 0	0700	X	166/2U	38/0	149/2U	68/0 (OJ)	194/4U	184/
	140-170 2	1100	X		229/6	156/2U	147/2U	107/0	155/held
	171-200 4	1600	X	334/12U	219/6U	98/0U	162/2U	+orange 4U NOW	84/0U
	201-230 6	2200	204/6U	201/6U	163/2U	140/0U	163/2U		120/0U
	231-260 8		X	X	X	X	X	X	X
	261-290 10		X	X	X	X	X	X	X
	291+ 12		X	X	X	X	X	X	X
4/18	IN Addition to sliding scale		Pre-B	(b)(6)-2		(b)(6)-2		[redacted]	b-6-2
	give NPH insulin:		PRE-D		(b)(6)-2				
	4 units pre-breakfast								
	4 units predinner								
4/15	MVI HAB PO QD	0900	X	X		(b)(6)-2		(b)(6)-2	
4/14	FINGERSTICK BS AM	0500	X	166 (b)(6)	135 (b)(6)-2	144 (b)(6)-2	68 (b)(6)-	196 (b)(6)	
4/17	PRIMAXIM 500mg q6° IVPB	0600	X	(b)(6)-2					
		1200	X	X	(b)(6)-2				(b)(6)-2
		1900	(b)(6)-2						
4/16		2400	(b)(6)-2						
4/18	~~LOVENOX 30mg SQ BID~~	0900	X	(b)(6)-2					
		2100	(b)(6)-2					(b)(6)-2	
4/15	GLYBESIDE 10mg PO ~ BREAKFAST	0700	X	(b)(6)-2					
4/20	Glyburide 10mg BID								

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

1 of 2

MEDCOM - 4862

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APRIL 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/21	22	23	24	25	26	27
4/20	Glyberide 10 mg po BID	0900	(b)(6)-2				Hold (b)(6)-2	(b)(6)-2	(b)(6)-2
		2100							
4/22	FeSO4 + FAB (325mg) PO QD	0900			(b)(6)-2	(b)(6)-2			(b)(6)-2
4/12	Primixim 500mg IVPB QL6H	0600							
		1200			(b)(6)-2				
		1800							
		2400							
4/18	Lovenox 30mg SQ BID	0900							(b)(6)-2
	HVI + PO (28)	2100							
4/15	HVI + PO QDay	0900							
4/18	SLIDING SCALE (qAC/qHS)	0700					80/00 (b)(6)-2	60/00	40/60
	Blood sugar Units Reg insulin	1100					held	60/00	120/ (b)(6)-2
	< 140 0	1600					80/00	180/40	
	140 - 170 2	2200					80/00 (b)(6)-2	160/20	
	171 - 200 4								
	201 - 230 6								
	231 - 260 8								
	261 - 290 10								
	291 + 12								
4/18	IN Addition to sliding Scale	Pre-B					Hold	HOLD	
	give NPH insulin: 4 units pre-	Pre-D					(b)(6)-2		
	breakfast and 4 units pre-dinner								
4/14	Fingerstick BS AM	0500					80/ (b)(6)-2	40/	40/

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPHPLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
. = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4863

MEDICATION ADMINISTRATION ID (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	INITIAL
K phosphate 20 meq PO	4/22	0400	(b)(6)-2
K phosphate 20 meq PO	4/22	0500	
Potassium Cloride 20meq PO	4/22	0600	
Potassium Cloride 20meq PO	4/22	0700	
Morphine 10mg IVP	4/22	1322	
Versed 2 mg IVP	4/22	1322	
MSO4 10 mg IVP	4/23	1945	
Bendryl 50mg	4/27	0030	

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN																
4/21	Cipracil 150 mg po TID PRN	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	Valium 5mg IVP TID AGITATION	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	AMBIEN 5MG PO QHS	DATE	4/23	4/24															
		TIME	2350	2330															
		DOSE	5mg	5mg															
		INIT.	(b)(6)-2																
	MOM 30cc PO Q4° CONSTIPATION	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	MV/ANTA 30cc PO Q4° GASTRIC IRRITATION	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	TYLENOL 650 MG PO Q4° T>100°	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	TYLENOL #3 I-II PO Q4 PAIN	DATE	DAP	4/25	4/26	4/26													
		TIME	1205	1545	1938	2330													
		DOSE	II	2	2	2													
		INIT.	(b)(6)-2																

4/30 recopied

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APRIL 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/27	4/28	4/29	4/30	5/1	5/2	5/3
4/20	Glyburide 10 mg PO BID	0900	X	(b)(6)-2					
		2100		(b)(6)-2					
4/22	FeSO4 + Tab (325mg) PO QD	0900	X	(b)(6)-2					
			X	X	X	X	X	X	X
4/17	Premarin 500mg PO BID Q6hr	0600	X	(b)(6)-2					
		1200		(b)(6)-2					
		1800		(b)(6)-2					
		2400		(b)(6)-2					
4/18	Lovenox 30mg SQ BID	0900	X	(b)(6)-2					
		2100		(b)(6)-2					
4/15	MVI + PO QDAY	0900	X	(b)(6)-2					
			X	X	X	X	X	X	X
4/18	[illegible]	AM	X	(b)(6)-2					
	[illegible]	PM	X	X	X	X	X	X	X
4/18	[illegible] Insulin AC & HS		X	X	X	X	X	X	X
	[illegible]	0600		(b)(6)-2					
	[illegible]	1200		(b)(6)-2					
	[illegible]	1100		(b)(6)-2					(b)(6)-2
	[illegible]	1600		(b)(6)-2					
	[illegible]	2200		(b)(6)-2					

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPHPLATE

(b)(6)-4

Injection Site Code

① = Left Bunock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
= Abdomen

WARD NO. 5 FWD

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4865

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN						
	MSO4 2-4mg IV Q1° PRN Severe Pain	DATE	[illegible]	[illegible]	[illegible]	4/25	4/25	
		TIME	1015	1320	2000	1015	1405	
		DOSE	4mg	4mg	4mg	4mg	4mg	
		INIT.	(b)(6)-2					
	Tylenol #3 1-2 Q4hr pain	DATE						
		TIME						
		DOSE						
		INIT.						
	AMBIEN 5mg PO Qhs	DATE	4/25 MLR					
		TIME	2224					
		DOSE	25					
		INIT.	(b)(6)-2					
	MOM 30cc PO Q4° Constipation	DATE						
		TIME						
		DOSE						
		INIT.						
	Mylanta 30cc PO q4° Gastric Irritation	DATE						
		TIME						
		DOSE						
		INIT.						
	Tylenol 650mg PO Q4hr T>100°	DATE						
		TIME						
		DOSE						
		INIT.						
	VALIUM 5mg IVP TID AGITATION	DATE	4/25					
		TIME	2232					
		DOSE	5					
		INIT.	(b)(6)-2					

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/30	Meclizine 25mg	DATE																
	po QD PRN	TIME																
	motion sickness	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 4867

4/30
recopied

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APR/MAY 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/30	5/1	5/2	5/3	5/4	5/5	5/6
4/20	Glyburide 10mg PO BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						
4/22	Fe SO4 1 tab (325mg) PO QD	0900	X						
4/18	Lovenox 30mg SQ BID	0900	X						
		2100	(b)(6)-2						
4/15	MVI 1 tab po QD	0900	X						
4/30	FSBS QOD in AM	0600	done	X		X		X	
4/30	NPH 3units SQ ā breakfast	0600		(b)(6)-2					
	and ā evening meals	1600	(b)(6)-2						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	b)(6)-2	(b)(6)-2	(b)(6)-2		

ADDRESSOGRAPHPLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Lett Arm
④ = Right Deltoid ⑧ = Right Arm
= Abdomen

WARD NO.

SINGLE DOSE. PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 4868

MEDICATION ADMINISTRATION **D (Back)** S/N 0105-LF-216-55B1

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
permethrin cream 5% topical	5/1	1630	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																	
	MSO4 2-4mg IVP Q1° PRN severe pain (last dose 4/29)	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	Tylenol #3 1-2 tabs Q4h PRN for Pain	DATE	4/30	5/2	5/3	5/4	5/5												
		TIME	2008	1820	0850	1350	2000												
		DOSE	2	2	2	✗	✗												
		INIT.	(b)(6)-2																
	Ambien 5mg PO QHS (4/29 last dose)	DATE	4/30																
		TIME	2008																
		DOSE	5																
		INIT.	(b)(6)-2																
	MOM 30cc PO Q4° Constipation PRN	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	Mylanta 30cc PO Q4° PRN Gastric Irritation	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
	Tylenol 650mg PO Q4° T>100°	DATE	5/2																
		TIME	0850																
		DOSE	650																
		INIT.	(b)(6)-2																
	Valium 5mg IVP TID PRN for agitation (4/28 last dose)	DATE																	
		TIME																	
		DOSE																	
		INIT.																	

Addressograph:

(b)(6)-4

Date: 4/7/03

Allergies

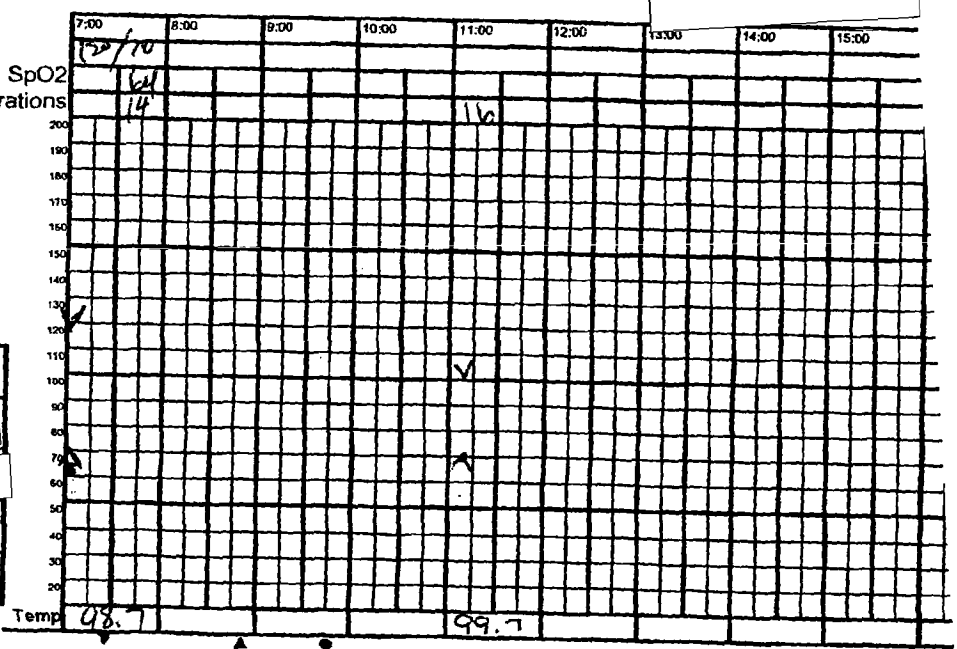
Diagnosis

Age:

DOB:

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

(b)(3)-1



IV'S	LR								1000		
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume	UOU									
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk respons

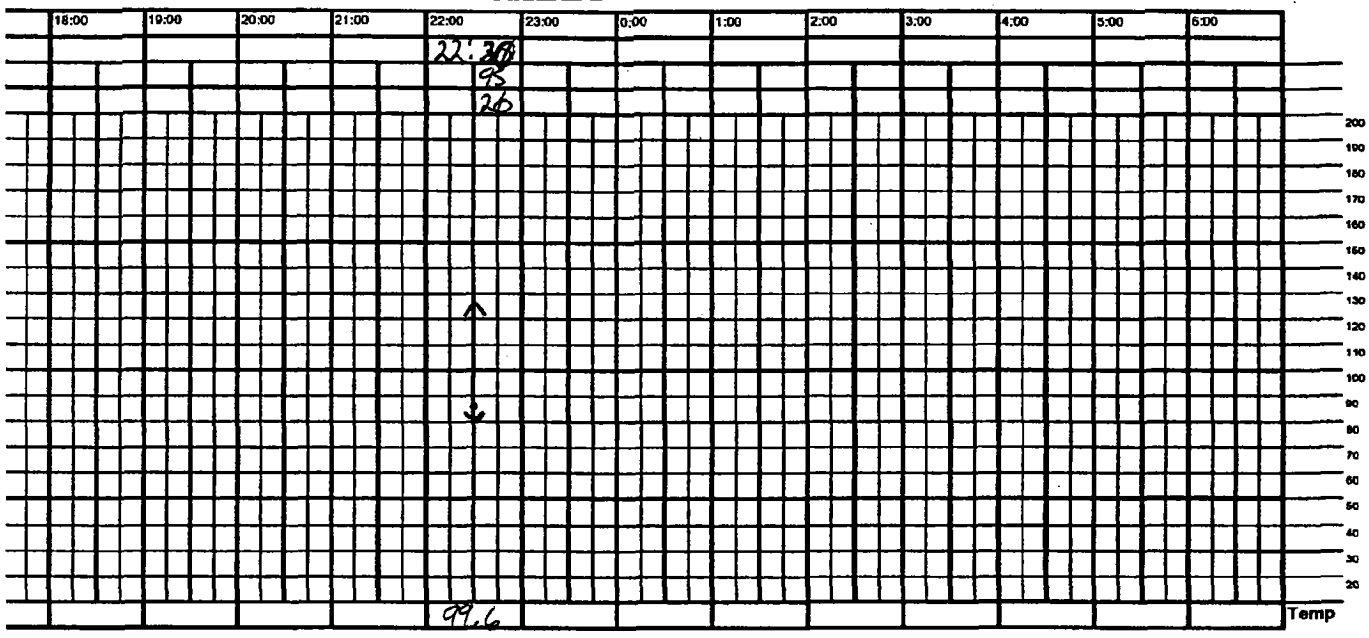
5 - Sluggish respon

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch. amb)		✓								
	IV Site CDI? Q2 hrs		✓								
	IV Site CDI? Q2 hrs										
	TCBD		✓								
	Wound care						/				
Miscellaneous											

MEDCOM - 4870

(b)(6)-4

TE WARD - 24 HOUR FLOW SHEET



glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

MEDCOM - 4871

FLTHOSPPNCLA 6320/1 (1/03)

2230

1900-0700 | Time: | Signatu (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Place X Time X
Responds to: Verbal X Pain ___ Unresponsive ___
Pupils R L
Size / 3 / B | 3 / B
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities: Upper L S R S; Lower L S R S
☐ See Narrative

CARDIOVASCULAR

Pulses R L
Radial + +
Femoral + +
Posterior Tibial + +
Dorsalis Pedis ? +
+ = Normal - = Weak 0 = Absent
Rhythm: RRR Ectopy: ___
Murmur: ___ Rub: ___ S1: V S2: V
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☐ Clear ☐ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive ▮ Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation:
Auscultation: BSx4Quad.
Palpation:
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
Laceration 1 inch at (L) side of shaft of Penus
Catheter:
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
Incisions / Dressings / Lesions / Dermal Ulcers
☐ See Narrative

Arrived via Convoy Security in CCE. MSO4 10mg IVP upon arrival. Wounds as follows (R) (L) inguinal Nickle Size (+) Femoral Pulse; Multiple lacerations to (L) medial thigh (3) from (L) mid thigh. 2 Nickle Size holes to (R) thigh superior to knee. 2 Penny Size whole to (R) elbow.

MEDCOM - 4872

FLEET HOSPITAL AC

Addressograph:

Date:
Allergies

Diagnosis
Age:
DOB:

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

SpO2
Respirations
Temp

7:00 8:00 9:00 10:00 11:00 12:00 13:00 14:00 15:00 16:00

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

IV'S												
INTAKE	PO											
	NG/TF											
	Other											
	Cummulative Intake											
OUTPUT	Urine Volume											
	Emesis											
	NG Residual/sump											
	Bowel Movement											
	OTHER											
	Cummulative Output											

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

PAIN	Medicated											
	Dose / Route											
	Intensity (1-10) Pre / Post Med											
	Sedation Scale											
Nursing care	BATH PARTIAL/COMPLETE											
	ACTIVITY(Turn L, R, B, ch, amb)											
	IV Site CDI? Q2 hrs											
	IV Site CDI? Q2 hrs											
	TCBD											
	Wound care											
Miscellaneous												

MEDCOM - **4873**

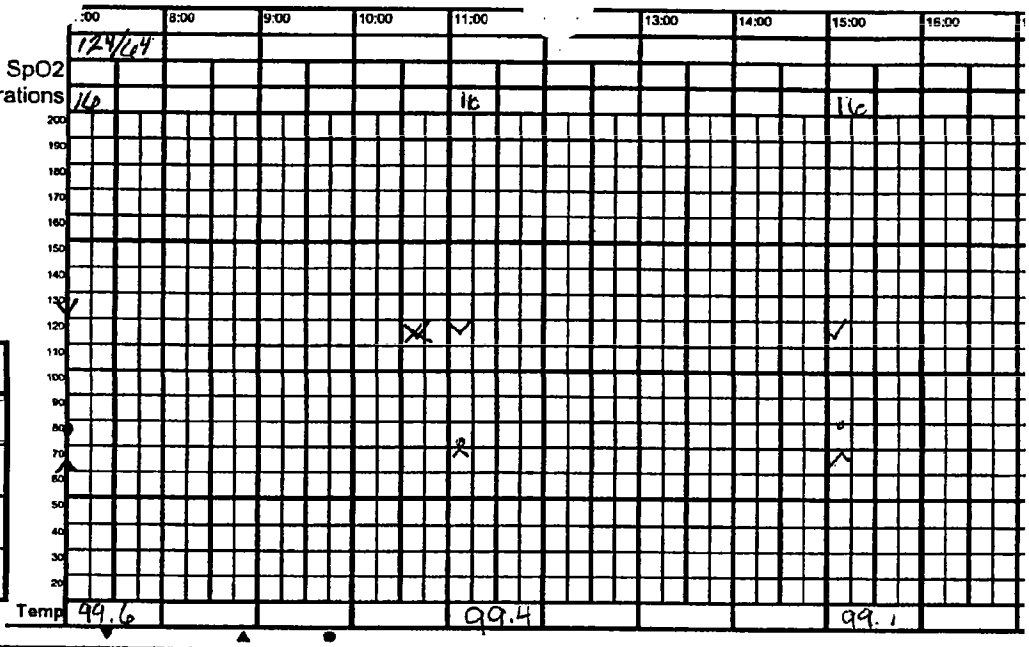
Addressograph:

(b)(6)-4

Date: 08 APR 03
Allergies NKDA

Diagnosis
Age:
DOB:

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

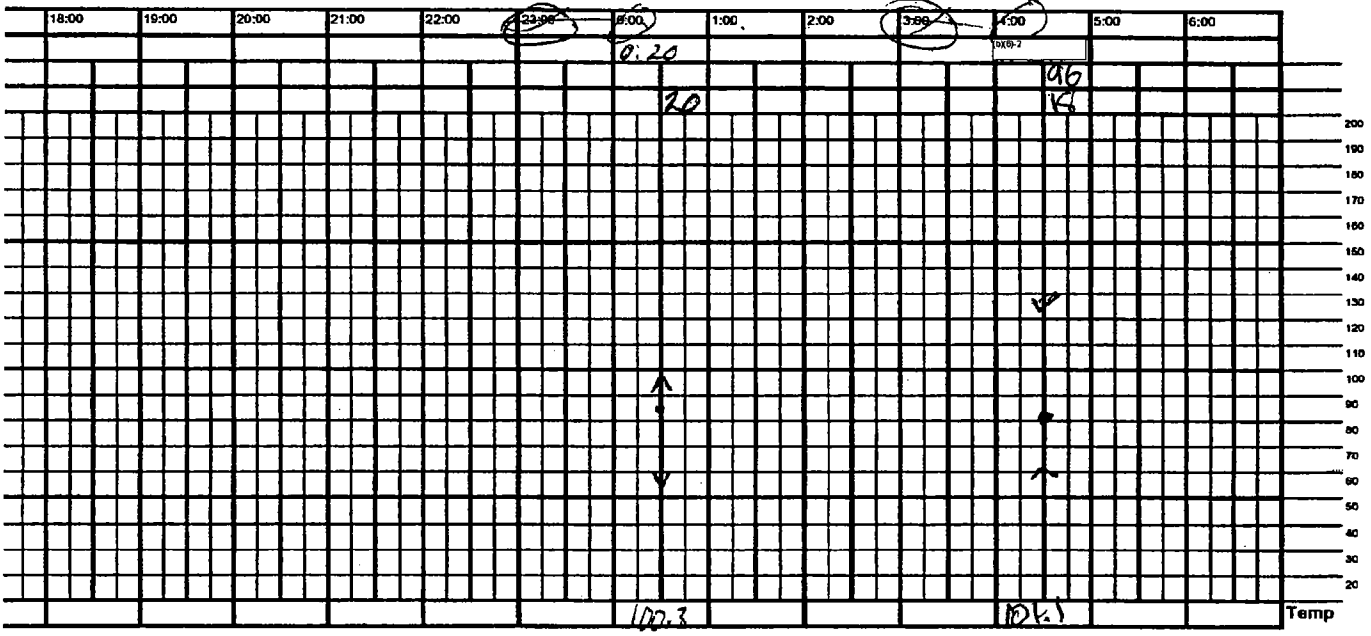


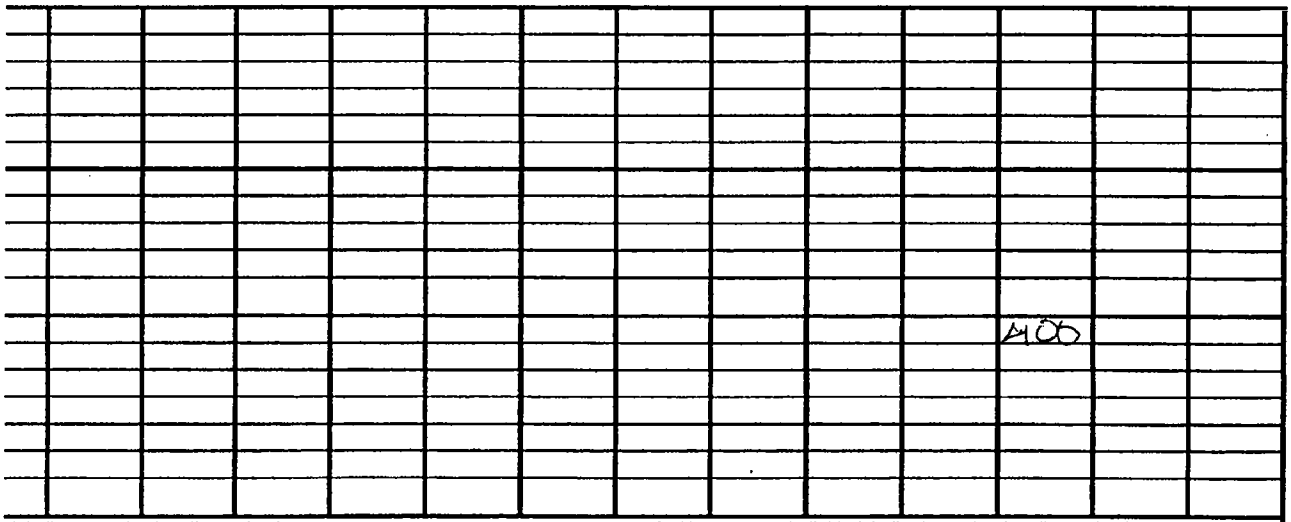
IV'S	LR											
INTAKE	PO											
	NG/TF											
	Other											
	Cummulative Intake											
OUTPUT	Urine Volume											
	Emesis											
	NG Residual/sump											
	Bowel Movement											
	OTHER											
	Cummulative Output											

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

PAIN	Medicated											
	Dose / Route											
	Intensity (1-10) Pre / Post Med											
	Sedation Scale											
Nursing care	BATH PARTIAL/COMPLETE											
	ACTIVITY(Turn L, R, B, ch, amb)											
	IV Site CDI? Q2 hrs											
	IV Site CDI? Q2 hrs											
	TCBD											
	Wound care											
Miscellaneous												

ΓE WARD - 24 HOUR FLOW SHEET





glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

ıt glabellar tap or loud auditory stimulus

MEDCOM - 4875

FLTHOSPPNCLA 6320/1 (1/03)

0700-1900 | Time: | Signature:

0900 Pt resting in Gurney - VSS, Pt Dressing to (R) Elbow c/D/I, Pressure Dressing to (L) UL, Mid thigh c/D/I, (R) thigh SA. Drainage - (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ✓ Unresponsive
Pupils R / L
Size / Reaction: / /
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities: Upper L W R S
Lower L W R W
☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	-	-
Femoral			Dorsalis Pedis	-	-

+ = Normal - = Weak 0 = Absent

Rhythm: Ectopy:
Murmur: S1: S2:
Neck Veins:
Edema:
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ☐ Bilat
Location:
Crackles /Rales: Dim:
Wheezes: Absent:
Rhonchi:
Cough: Productive / Unproductive:
Sputum: Color and Character:
Tubes: ☐ ET ☐ Trach
Size: Location:
O2: ☐ Canula ☐ Mask
Chest Tubes:
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: BSX4
Palpation: ☒ pain, ☒ Distention
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet:
Tubes | Bags | Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☑ Void Urine: Color | Character
DARK Amber
Catheter:
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
Warm / Bronze / Dry
Incisions | Dressings | Lesions / Dermal Ulcers

☑ See Narrative

MEDCOM - 4876

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/9/03

Allergies

Diagnosis

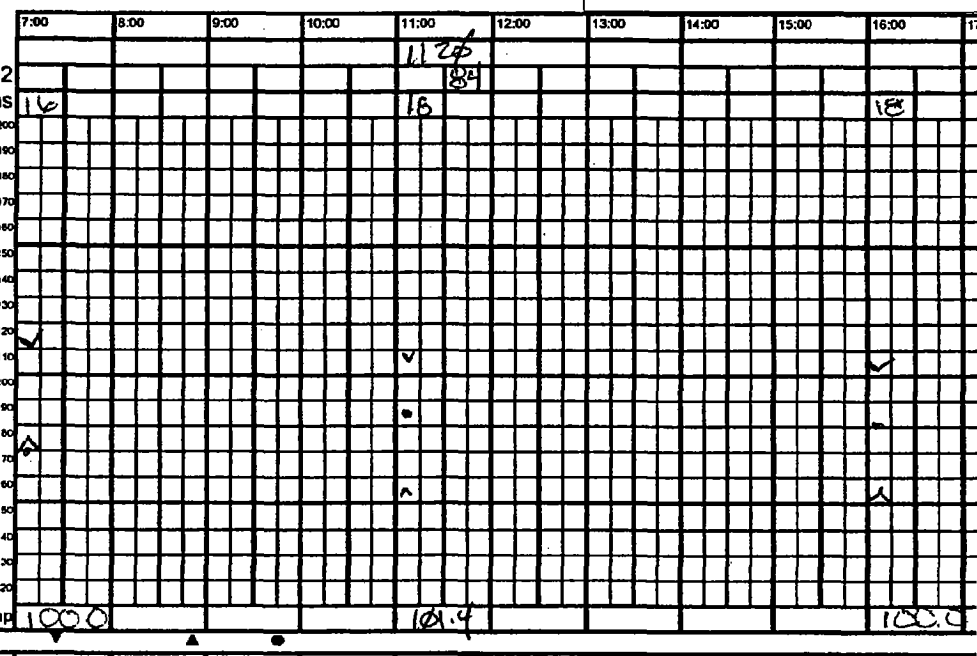
Age:

DOB:

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

SpO2

Respirations



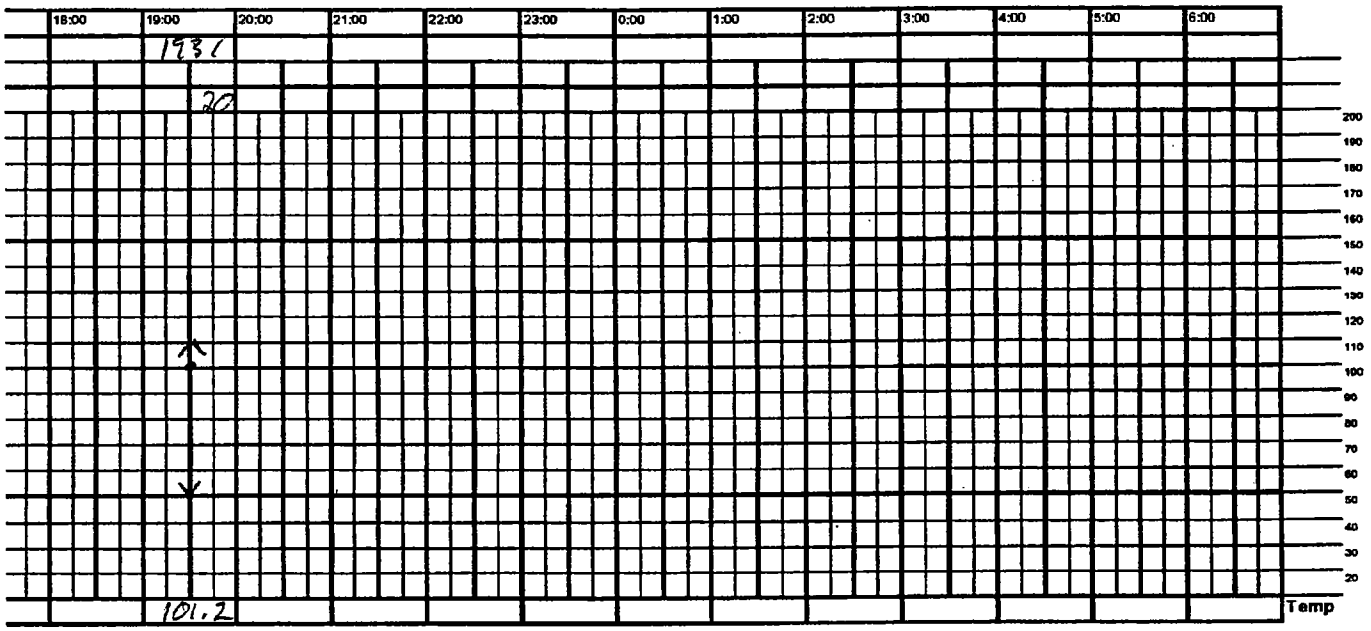
		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S											
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE: 1 - Pt. Anxious and irritated or restless; 2 - Cooperative, oriented and tranquil; 3 - Responds to commands only; 4 - Brisk response to; 5 - Sluggish response t

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated				1000						
	Dose / Route				1ul #3						
	Intensity (1-10) Pre / Post Med				O2						
	Sedation Scale				po						
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD				✓						
	Wound care										
Miscellaneous											

MEDCOM - 4877

TE WARD - 24 HOUR FLOW SHEET



glabellar tap or loud auditory stimulus

6 - No response lo light glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

MEDCOM - 4878

FLTHOSPPNCLA 6320/1 (1/03)

0700-1900 Time: 0600 Signature:

Med. Took Over

1200 IV d/c'ed (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ___ Pain ___ Unresponsive

Pupils R / + L / +
Size / Reaction:

Motor Strength S = Strong W = Weak TR = Trace A = Absent

	L	R
Upper		
Lower		

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	✓	✓	Posterior Tibial		
Femoral	✓	✓	Dorsalis Pedis	✓	✓

+ = Normal - =Weak 0 =Absent

Rhythm: ___ Ectopy: ___
Murmur: ∅ Rub: ___ S1: ∅ S2: ✓
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☑ Clear ☐ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ∅
Sputum: Color and Character: ∅
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: ___
Auscultation: BS+
Palpation: Soft
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:

☑ See Narrative ☐ NGT Placement

GU

☑ Void Urine: Color / Character
incontinent x2
Catheter: ___
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
WNL, good turgor
Incisions / Dressings / Lesions / Dermal Ulcers
Rash on thighs, Legs, penis, groin, knee

Surgeon in to change drsgs, Medicated c M804 10mg IV. (b)(6)-2

☐ See Narrative

MEDCOM - 4879

1900-0700 Time: Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Places Time X
Responds to: Verbal X Pain ___ Unresponsive ___

Pupils	R	L
Size /	3 / B	3 / B

Motor Strength Extremities:
S = Strong W = Weak TR = Trace A = Absent

	L	R
Upper	5	5
Lower	5	5

☐ See Narrative

CARDIOVASCULAR

Pulses	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: Flat
Auscultation: + BS
Palpation: Soft
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes | Bags | Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character

Catheter:
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

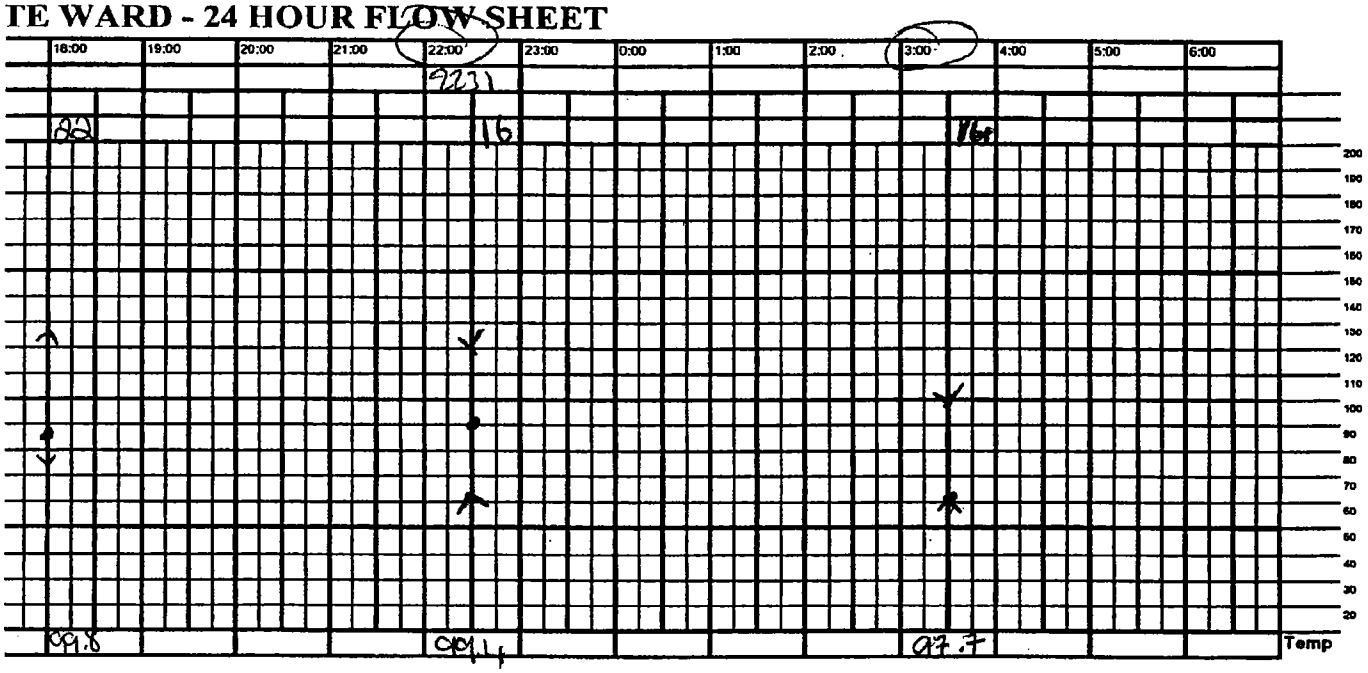
Incisions / Dressings / Leisions | Dermal Ulcers

☒ See Narrative

P31 Male Pt. has dsng on R Elbow, R thigh & L thumb & L lower abdomen. Pt also has dsng on penis — (b)(6)-2

MEDCOM - 4880

TE WARD - 24 HOUR FLOW SHEET



glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

MEDCOM - 4881 FLTHOSPPNCLA 6320/1 (1/03)

0700-1900 Time: Signature:

PT COMPLAINS OF PAIN IN BOTH THIGHS

NEUROLOGICAL

Level of Consciousness VERBAL CUES
Oriented to: Person ___ Place ___ Time ___
Responds to: Verbal ___ Pain ___ Unresponsive
Pupils R L
Size / Reaction: [ ] / [ ] [ ] / [ ]
Motor Strength Extremities: S = Strong W = Weak TR = Trace A = Absent

	L	R
Upper		
Lower		

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: FLAT
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive I Unproductive: ___
Sputum: Color and Character. ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: FLAT SOFT
Auscultation: +4Q
Palpation: NO DISCOMFORT
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
Catheter: ___
Other: ___
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
WARM DRY
Incisions / Dressings / Leisions / Dermal Ulcers
DRSG BOTH THIGHS; PENIS
☒ See Narrative

MEDCOM - 4882

1900-0700	Time	Signature	10 APR 03 0635 PTS VS BP 118/72 T 97.9 P 66 RESP 19. PT IS A+Ox3. & COMPLAINTS OF PAIN. WILL CONTINUE TO MONITOR. (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Place X Time X
Responds to: Verbal X Pain ___ Unresponsive ___

Pupils

	R	L
Size /	3 / 3	3 / 3

Motor Strength S = Strong W = Weak TR = Trace A = Absent

	L	R
Upper	5	5
Lower	5	5

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: Flat
Auscultation: +4Q
Palpation: No Discomfort
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void **Urine: Color / Character**

Catheter: None
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Lesions / Dermal Ulcers
DSG Both Thighs and Penis

☐ See Narrative

F/2DM

ANTIBIOTIC: Ancef
TIME GIVIEN: 0850
OTHER: 0

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV 11-77) S/N 0105-LF-206-3280

ALLERGIES: NKDA 10MG Morphine

OPERATION PERFORMED: I+D of Multiple GSW Abdomen, groin, legs, R arm

AGENTS AND TECHNICS OF ANESTHESIA: General 250mg Fentanyl IVP, 2 mg Versed, 4mg Zofran

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		ADM	1202
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	D5LR	BLOOD	SALINE	OTHER
OPERATING ROOM	300			
RECOVERY ROOM	450			
TOTAL	650			

BLOOD LOSS IN OR: 250 CC
WARD PRE-OP BP: 120/73 mmHg
TUBES: ☐ N/G ☐ FOLEY
IV IN: L hand @ 800 cc OF NS AT 125 cc/hr AOW
IV IN: R H @ 350 cc OF LR AT 125 cc/hr TOW
ART. LINE IN: 0
T-TUBES, HEMOVAC IN: 0

HOUR(S): 15 30 45 100 15 30 45 1300 15 30 45

TEMPS 220 200 180 160 140 120 100 80 60 40 20

RESP. RATE: 100 100 16 16 16 6 6 6 6 6 6 6

NUMBERS FOR REMARKS: 1 2 3 4 5 6

	ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY		
TO WARD		
DATE	15 APR	15 APR 03
HRS	1135	

DRESSINGS: LOCATIONS
1 D+I 2 forearm
3 D+I 4 D+I 5 R leg 6 thigh - sanguineous
STATUS: 1 D+I

ENDOTRACHEAL TUBE - ORAL OR NASAL
☐ YES ☒ NO ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS
☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY
STATUS: Clear bilat

	MOR	PACU	URINARY O...			DRAINAGE		
TIME	OR	1252						
CC	1135	1100						
TOTAL	2235	3335						
SP. GR	1.010							
S/A	3335							

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by CAPT (b)(6)-2
PMH: Multiple Surgeries ASA II
Neuro: A Ox3 eyes to verbal
Pain Yes/No Action: No requests for pain med
CV: NSR @ 60s IV: Patent
Other: Warm sheets applied, side rails up x2
(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES – 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT: N/A HRS
SENSATION PRESENT AT: HRS

CONDITION ON TOW: ☐ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY:
☐ COMPLICATED
☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2			
Able to move 2 extremities voluntarily or on command	1	Activity	2	2
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2			
Dyspnea or limited breathing	1	Respiration	2	2
Apneic	0			
BP ±20% of preanesthetic level	2			
BP ±20-50% of preanesthetic level	1	Circulation	2	2
BP ±50% of preanesthetic level	0			
Fully awake	2			
Arousable on calling	1	Consciousness	1	2
Not responding	0			
Pink	2			
Pale, dusky, blotchy, jaundiced, other	1	Color	2	2
Cyanotic	0			
		TOTALS	9	10

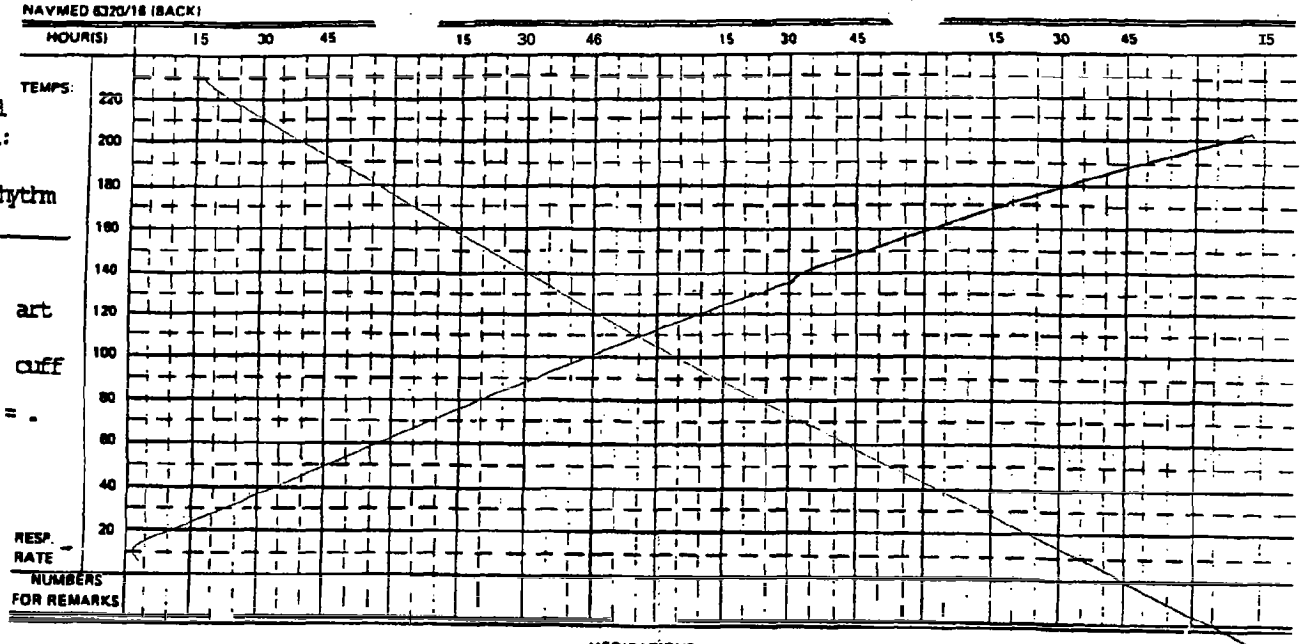
SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AOW (b)(6)-2 CDR/MC

TOW (b)(6)-2 ENS/NC

MEDCOM - 4884

NAVMED 6320/16 (BACK)



inal
evel:

G Rhythm

art

cuff

lse =

Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1150	MSO4	2MG	IVP	(b)(6)-2 ENS/NC
1200	MSO4	2MG	IVP	(b)(6)-2 ENS/NC
1205	Fentanyl	50mcg	IVP	(b)(6)-2 ENS/NC

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) BG = 188 (TOW) (3) Pt c/o pain med per MD's orders (TOW) (4) Pt c/o bladder spasm / straight cath ~~was pulled by~~ Verbal order given to CDR. (b)(6)-2 Dr. (b)(6)-2 (TOW) (3) 9/0 pain med effective (TOW) (5) Foley catheter placed / ordered by DR. (b)(6)-2 (TOW) (6) Pt meets PACU D/C Criteria per anesthesia. Report to 5FS (b)(6)-2 ENS/NC

TOW Note: Neuro: A9O x 3

Pain: Yes/No Action: Ø

Pulmonary: Clear Bilat

CV: S, S2

EKG Rhythm: SR IV: Patent

Skin/Wound: Warm + Dry Drainage Yes/No Color: ~~Bright red~~ Dark red Edema Yes/No

GI: Ø BS

GU: Foley Yes/No It was straight cath Color of urine: Clear Yellow Due to void: N/A

Instructions/Interventions in PACU: Ena to deep breathe / straight cath / Foley catheter placed Discharged to BS

Report called to: CDR (b)(6)-2 By: ENS (b)(6)-2

TOWed to: 5FS X7104 By: HM3 (b)(6)-2 / HM (b)(6)-2

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV 11-77) S/N 0105-LF-206-3281

ALLERGIES

ANTIBIOTIC: Ø
TIME GIVIEN:
OTHER: Nul 25g mca
5mg versed' 20mg MS04

OPERATION PERFORMED: 14 D of (B) Interior thighs

AGENTS AND TECHNICS OF ANESTHESIA: Gen

HOUR(S) 0900 15 30 45 1000 15 30 45 15 30 45

TEMPS / RESP RATE / NUMBERS FOR REMARKS

nal
al:
; to
itor
thm
NSR
art
cuff
se = •
at:

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		Ron 1000	
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	1300			
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: n.a. CC
WARD PRE-OP BP 125 60 mmHg
TUBES: ☐ N/G ☐ FOLEY
IV IN (L)arm @ 2032 cc
OF D5 AT 100 cc/hr AOW
IV IN _____ @ _____ cc
OF _____ AT _____ cc/hr TOW
ART. LINE IN
T-TUBES, HEMOVAC IN

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD SES
DATE _____ HRS 0950	DATE 17 MAR 02 HRS 1110
DRESSINGS, LOCATIONS (B) Interior thighs (L) groin	
STATUS: Clean, dry, intact (B) thigh & Groin CD: 1	STATUS:

ENDOTRACHEAL TUBE – ORAL OR NASAL
☐ YES ☑ NO ☐ YES ☐ NO

AIRWAY / BREATH SOUNDS
☑ CLEAR ☐ FLAST AIRWAY ☐ OBSTRUCTS EASILY
STATUS:

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2			
Able to move 2 extremities voluntarily or on command	1	Activity	2	
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2			
Dyspnea or limited breathing	1	Respiration	2	
Apneic	0			
BP ±20% of preanesthetic level	2			
BP ±20-50% of preanesthetic level	1	Circulation	2	
BP ±50% of preanesthetic level	0			
Fully awake	2			
Arousable on calling	1	Consciousness	1	
Not responding	0			
Pink	2			
Pale, dusky, blotchy, jaundiced, other	1	Color	2	
Cyanotic	0			
		TOTALS	(9)	

	MOR	PACU	URINARY OUTPUT	DRAINAGE
TIME				
CC	Ø			
TOTAL				
SP. GR				
S/A				

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by SR (b)(6)-2
PMH: ASA 3 Diabetes?
Neuro: PT Sleepy but Arousable
Pain Yes (No) Action:
CV: S1, S2 ⊖murmur IV: Patent
Other: Side Rails up x 2, Monitor on, Warm Blankets applied
(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☐ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT _____ HRS
SENSATION PRESENT AT _____ HRS

CONDITION ON TOW: ☐ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

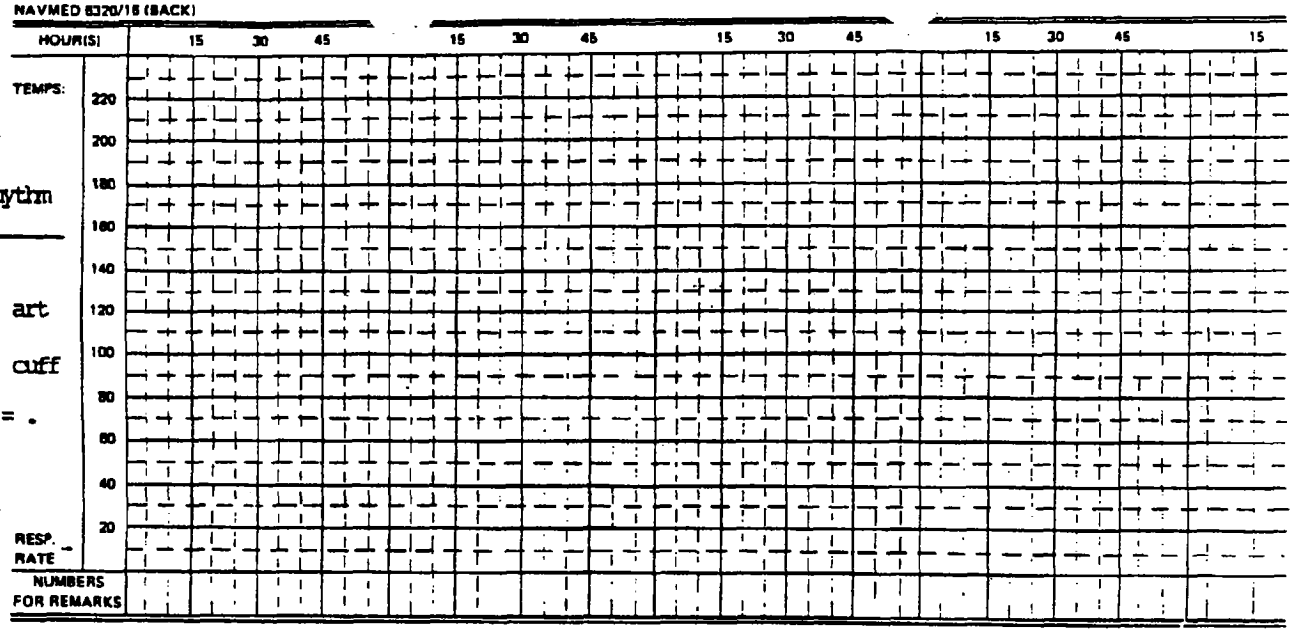
RECOVERY:
☐ COMPLICATED
☐ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2
TOW (b)(6)-2
(b)(6)-2

MEDCOM - 4886

NAVMED 6320/15 (BACK)



inal
evel:

KG Rhythm

P ↓ art
P ∧ cuff

ulse = .

Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1033	MSO4	3mg	IVP	

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

@ Interpreter in to see PT, PT crying and interrupted. Reassured PT and informed PT on Plan of Care. PT Recieved MSO4 for Small amt of Pain.

TOW Note: Neuro: Alert oriented X3

Pain: Yes (No) Action:

Pulmonary: CTA (B) PT ABle to maintain Sats on RA

CV: S1, S2 - murmurs NSR EKG Rhythm: NSR IV: Patent

Skin/Wound: Dressings over wounds Drainage Yes/No Color: ~~Red~~ Serosanguinous Edema Yes/(No)

GI: Bowel Sounds hyperactive Soft + Palpable

GU: Foley Yes/(No) Color of urine: Yellow Due to void: 1550

Instructions/Interventions in PACU:

Report called to: By: (b)(6)-2 CDR RN

TOWed to: By: (b)(6)-2 CDR

MEDCOM - 4887

ANTIBIOTIC: PROMAXIN 500
TIME GIVIEN: 1315
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES: ~~DIABETIC~~ NKA

OPERATION PERFORMED: DELAYED GSW CLOSURE

AGENTS AND TECHNICS OF ANESTHESIA: GENTA

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10	99	AOW	1448
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	ORAL	BLOOD	SALINE	OTHER
OPERATING ROOM	350			
RECOVERY ROOM	250			
TOTAL	600			

BLOOD LOSS IN OR: 12 cc
WARD PRE-OP BP 135 78 mmHg
TUBES: ☐ NG ☐ FOLEY N/A
IV IN LFA 20g OF LR AT 75 cc/hr 600 cc DC@1448 AOW
IV IN R HAND 20g OF LR AT 75 cc/hr 400 cc TOW
ART. LINE IN N/A
T-TUBES, HEMOVAC IN N/A

HOURS: 1400 15 30 45 1500 15 30 45 1600 15 30 45

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

Spinal Level:

EKG to monitor on ☑ Rhythm NSR

BP ↓ art / ↑ cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 3FP
DATE 23APR83 HRS 1429	DATE 23APR83 HRS 1540

DRESSINGS: LOCATIONS (R) HIP - ABD PADS & TAPE; (L) THIGH - GAUZE & CURLIX; (R) THIGH
STATUS: ALL → CDI
STATUS: GAUZE & CURLIX C,D & F

ENDOTRACHEAL TUBE - ORAL OR NASAL

☐ YES	☒ NO	☐ YES	☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: CLEAR

	MOR	PACU
TIME	AOW	TOW
cc	0	0
TOTAL	0	
SP. GR		
S/A		

URINARY OUTPUT

DRAINAGE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by CDR. (b)(6)-2
PMH: DIABETIC ASA 2
Neuro: PT SLEEPY BUT AROUSABLE
Pain Yes (No) Action: NONTAKEN
CV: S1S2
IV: NOT PATENT
Other: PT AOW VIA GURNEY WITH BEDRAILS ↑ x2 (CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2			
Able to move 2 extremities voluntarily or on command	1	Activity	2	2
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2			
Dyspnea or limited breathing	1	Respiration	2	2
Apneic	0			
BP ±20% of preanesthetic level	2			
BP ±20-50% of preanesthetic level	1	Circulation	2	2
BP ±50% of preanesthetic level	0			
Fully awake	2			
Arousable on calling	1	Consciousness	1	2
Not responding	0			
Pink	2			
Pale, dusky, blotchy, jaundiced, other	1	Color	2	2
Cyanotic	0			
		TOTALS	9	

NAUSEA AND VOMITING: ☐ NO ☒ YES (1) 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT N/A HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2 CDR
TOW (b)(6)-2 CDR

MEDCOM - 4888

NAVMED 6720/18 (BACK)

HOUR(S) 15 30 45 15 30 45 15 30 45 15 30 45

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

Spinal Level:

EKG Rhythm

BP ↓ art

BP ∨ cuff

Pulse = .

% Sat:

RESP. RATE

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1435	ZOFRAN	4ml	IVP	(b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONTD FROM FRONT)

(2) PT NAUSEATED. GIVEN MEDS AS NEEDED. (BLC) (3) IV SITE IN (L) FA. D/C'D 20g PUT IN (R) HAND. CONTINUE IV FLUIDS. (BLC) (4) WARM SHEETS PUT ON PT (b)(6)-2
(5) Temp ↑ 96.9 No further episodes of N+V. Denies any discomfort. PACU discharge criteria met. (b)(6)-2

TCW Note: Neuro: A+OX3

Pain: Yes/No Action: NON TAKEN

Pulmonary: Breath sounds equal & clear

CV: S1 S2 no M/G EKG/Rhythm: SR IV: PATENT

Skin/Wound: CLEAN & DRY Drainage Yes/No Color: N/A Edema Yes/No

GI: Abd soft ∅ BST

GU: Foley Yes/No Color of urine: N/A Due to void:

Instructions/Interventions in PACU: Encourage to deep breathe

Report called to: LCDR (b)(6)-2 By: LCDR (b)(6)-2

TCWed to: 5 Ward Nurse By: HN (b)(6)-2 /HN (b)(6)-2

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INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	5(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
		IRAQI	7			

11. EMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		FCU3

15. FLYING STATUS	16. RATING: DSG	17. DEPT.: BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO					Inj

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	2100	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		8MAY03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		4MAY03	

(b)(3)-1	30. DATE OF INTIAL ADMISSION	2. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

Check if Command-in Patient

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P Craniotomy ~~01.01~~

S/P Trach ~~31.1~~

S/P EX LAP ~~54.0~~

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BEDDLYS	f. TOTAL DAYS
4	4				4

36. Total Days All Facilites

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

(b)(6)-2

R MAJ MC USA

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1

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