NURSING PROGRESS NOTE

4/9/92 0930: Body temp 105.0 took cob pm order. Pt was
conscious at 0600. 0730m, Pt. 123:30 had 8pm last time. Pt
recoaster, no coughing. Chest x-ray done 05/08. 04/21. 02
(11:00) Pt. NS. 12/11. 12/11: Pt. NS.

1110: Right shoulder OSW 24-24.
**ICU**

**Glucose - 94**
**BUN - 10**
**CRE - 0.7**
**CK - 1733**
**Na+ - 119**
**K+ - 3.7**

**CBC**

**Hematology**

**IMMUNOLOGIC**

**WBC**

- **Neutrophils**
- **Lymphocytes**
- **Monocytes**
- **Eosinophils**
- **Basophils**

**DIFFERENTIAL**

- **Neutrophils**
- **Lymphocytes**
- **Monocytes**
- **Eosinophils**
- **Basophils**

**MEDCOM - 3099**
WBC: 5.4
RBC: 17,400,000
Hct: 53.7
Hgb: 17.4
Platelets: 102,000
**MEDICAL RECORD**

**OPERATION REPORT**

**PREOPERATIVE DIAGNOSIS**

S/P G510

<table>
<thead>
<tr>
<th>SURGEON</th>
<th>FIRST ASSISTANT</th>
<th>SECOND ASSISTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Blank]</td>
<td>[Blank]</td>
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<table>
<thead>
<tr>
<th>ANESTHETIST</th>
<th>ANESTHETIC</th>
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<tbody>
<tr>
<td>[Blank]</td>
<td>General</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CIRCULATING NURSE</th>
<th>SCRUB NURSE</th>
<th>TIME OPERATION BEGAN</th>
<th>TIME OPERATION COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Blank]</td>
<td>General</td>
<td>12/10</td>
<td>12/10</td>
</tr>
</tbody>
</table>

**OPERATIVE DIAGNOSES**

Chest + Back Woods - deep

**DRAINS (Kind and number)**

[Blank]

**MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION**

[Blank]

**SPOKE COUNT VERIFIED**

+ Sharps / Correct

**OPERATION PERFORMED**

- Irrigation & closure chest GSW
- Irrigation back GSW

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

Min EBC

- Complications

**PROSTHETIC DEVICES**

[Blank]

**DATE OF OPERATION**

[Blank]

**SIGNATURE**

[Blank]

**DATE**

3 Aug 06

**PATIENT'S IDENTIFICATION**

[Blank]

**OPERATION REPORT**

Medical Record

MEDCOM - 3105

STANDARD FORM 516 (REV. 3-00)

Prepared by GSA and JCMR, PWR 101-13-864-1
PREOPERATIVE DIAGNOSIS
S/P bil lacerated legs, O double

SURGEON

FIRST ASSISTANT

SECOND ASSISTANT

ANESTHETIST

ANESTHETIC

CIRCULATING NURSE

SCRUB NURSE

TIME OPERATED Began

TIME COMPLETED

OPERATIVE DIAGNOSIS
Repetitive Ocular Injury - Retained Intravitreal Foreign Bodies, Corneal, Conjunctival, and Vitreous Hemorrhage

DRAINS (kind and number)

SPONGE COUNT VERIFIED

MATERIAL forwarded TO LABORATORY FOR EXAMINATION

(0) CSM Eye (0165)

(0) CSM Eye (0125)

OPERATION PERFORMED
Classic Schlemm's Wound Right eye; Injection of Antibiotics and Steroids O.D.; Corneal Wound Repair Left eye; Exploration of Glaucoma Schlemm's Wound Closure; Injected Antibiotics, Steroids

DESCRIPTION OF operation (If any) of nature and gross findings, etc.

PROSTHETIC DEVICES

DATE OF OPERATION

SIGNATURE DESCRIPTION

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Home - last, first, middle; Armed Forces, date of hospital or medical facility)

OPERATION REPORT

Medical Record

MEDCOM - 3106

STANDARD FORM 818 (REV. 5-83)

Prescribed by GSA and ICMR, FMV 10-11-802-6
MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS
S/P GSW ~ bilateral legs, # shoulder debridment

SURGERY
(010-2) 08-06-22

ANESTHETIST
(010-2) 08-06-22

FIRST ASSISTANT
(010-2) 08-06-22

SECOND ASSISTANT
(010-2) 08-06-22

TIME OPERATION BEGAN
2910 1752

TIME OPERATION COMPLETED
1930

GENERAL

OPERATIVE DIAGNOSIS
Gunshot wounds # shoulder, back and both legs
Open fracture # foot

TRAITS (Kind and number)

POLICY: Chest tube inserted prior to entering OR

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

YAG

SPONGE COUNT VERIFIED: Sharps

PROSTHETIC DEVICES

DATE OF OPERATION

DESCRIPTION OF OPERATION (Type of cases, drugs, findings, etc.)

1Od. B legs, B foot
2d. closure B leg wounds
1Od. chest, back wounds with packing of 6s

6 Cep

200 EBL

DATE
30 July 02

PATIENT IDENTIFICATION (Not typed or written on this page. Name - last, first, middle, sex, date of birth, hospital or medical facility)

REGISTER/ID. NO.

WARD NO.

OPERATION REPORT
Medical Record

MEDCOM - 3107

STANDARD FORM 518 (REV. 5-83)
Precribed by USA and ICRA, P05A 101-11.626-6
PREOPERATIVE DIAGNOSIS:
EDN | Shrapnel @ Shoulder / bi-lat legs

ANESTHETIC:
General

OPERATIVE DIAGNOSIS:
6SW @ Cnt Shoulder
Shrapnel @ Knee, @ Foot, open metatarsal fractures, traumatic amputation stump

OPERATION PERFORMED:
Laceration @ Shoulder
Chestwall, @ Knee, @ Foot + @ subtrochanteric femur

DESCRIPTION OF OPERATION (Type(s) of future X-ray, gross findings, etc.)
ITD as above
+$ EBL
+$ Cop
Sling to @ Shoulder
Splint to @ Foot

DATE: 26 July 62
**ANESTHESIA RECORD**  
MEDCOM - 3109

---

**Position / Events**

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Event</th>
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<td>12</td>
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**Premeds**

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<tr>
<th>Premeds</th>
<th>Mt</th>
<th>Allergies</th>
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<tbody>
<tr>
<td>None</td>
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<td>NCDA</td>
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**Medications**

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<tr>
<th>Time (min)</th>
<th>Meds</th>
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<tbody>
<tr>
<td>3</td>
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</tbody>
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**Other Relevant Information**

- 11:55: Bradycardia: given Atropine 0.5
- 12:5: Intracocular pressure 24mm
- 13:35: Vecuronium 0.1
- 13:45: Morphone 5mg

---

**Signatures**

- US Army Forces: [Signature]

---

**Additional Notes**

- Closure of scleral wound by Dr. [Signature]
- Doctor: [Signature]

---

**Patient Identification**

- EID: [Signature]
- [Other Patient Information]
# Preanesthetic Summary

<table>
<thead>
<tr>
<th>Operation Proposed</th>
<th>Age</th>
<th>Weight (Lbs)</th>
<th>Special Information</th>
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<table>
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<th>Physical Status</th>
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<tbody>
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<td>1 2 3 4 5 6</td>
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<table>
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<tr>
<th>Urinalysis</th>
<th>Hematology</th>
<th>Blood Chemistry</th>
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<tbody>
<tr>
<td>Normal</td>
<td>WBC</td>
<td>Other</td>
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<tr>
<td>Fetal</td>
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<td>Hemoglobin</td>
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<table>
<thead>
<tr>
<th>Respiratory System</th>
<th>Circulatory System</th>
<th>Central Nervous System</th>
<th>Other Systems</th>
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<tr>
<th>Chief of Staff, etc.</th>
<th>Nurse</th>
<th>Blood Pressure, Pulse, etc.</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>(Circulatory, Pulmonary, Nervous, etc.)</td>
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</table>

<table>
<thead>
<tr>
<th>Anesthesiology and Complications</th>
<th>Pathology and Therapy, Allergy, etc.</th>
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<tbody>
<tr>
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<table>
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<th>Preoperative Diagnoses</th>
<th>Preoperative Treatment</th>
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<table>
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<tr>
<th>Signature of Examining Physician</th>
<th>Date</th>
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## Postanesthetic Visits

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<tr>
<th>(00:00)</th>
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<tr>
<td>00:00</td>
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</table>

Record all pertinent complications.
Car of - Military GSW 7.62 x 51mm (a) 15, foot - hand
Gunfire - 12 foot from target, GSW x 15, foot - hand
Procedure - Body Recumbent, Perforating Choke Area
(a) Jumper Exploration, Debridement, Flat Sheets
Debris, Debris (a) per wound GSW

Team -

Exp 1h

Fluid Burn - What? Blood = 7000 cc's

Dress - Field Trauma

Tol Well to U1 status but altitude 2,500 cc

27 Oct 02

MEDCOM 3111
<table>
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<th>18</th>
<th>19</th>
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<td>Multiple GSW @ chest</td>
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<td>Anesthesiologist</td>
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<tr>
<td>EPW</td>
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</tbody>
</table>

ANESTHESIA RECORD
# Preanesthetic Summary

**Operation Proposed:**

Debridement

**Physical Status:**

1 2 3 4 5

**Special Information:**

Enemy

**Unanalyzed Blood:**

Normal

Leukemia and White

**Hematology:**

Hgb 10.6

MCV 105

**Blood Chemistry:**

Not Available

**Respiratory System:**

A. (MRI, Asthma, Other Pathology)

B/L Chest Hug

C. (End of Interview)

**Circulatory System:**

WNL

**Central Nervous System:**

WNL

**Other Systems:**

NKDA

**Previous Anesthesia and Complications:**

No Complications

**Present Drug Therapy:**

Aneurin Tynex

**Preoperative Diagnosis:**

Fentanyl 100 mg

**Preoperative Education:**

Fentanyl 100 mg

**Signature of Evaluating MD:**

Date: 3/04

**Postanesthetic Visits:**

Record ALL pertinent complications
25 July 02

0545

News & packages on board

C-2: 1346. CDT @ 0600 by this time - 3.5, 81, ST 20 east

C-2 1346. CDT @ 0600 by this time - 3.5, 81, ST 20 east

6-1: 1346. CDT @ 0600 by this time - 3.5, 81, ST 20 east

6-1: 1346. CDT @ 0600 by this time - 3.5, 81, ST 20 east

6-1: 1346. CDT @ 0600 by this time - 3.5, 81, ST 20 east

Veins to feed

Rule 60

Rate 20

TV 920

28 July 02 0000

Dry & Dr @ foot by 36

536 5143016

28 July 02 0055

DS 6

1. CDT @ 0545. Patient improves, dry mouth, 3 kg muscle. Add infusion 5

2. CDT @ 0645. Patient improves, dry mouth, 3 kg muscle. Add infusion 5

3. CDT @ 0745. Patient improves, dry mouth, 3 kg muscle. Add infusion 5

4. CDT @ 0845. Patient improves, dry mouth, 3 kg muscle. Add infusion 5

5. CDT @ 0945. Patient improves, dry mouth, 3 kg muscle. Add infusion 5

MEDCOM - 3115
**CLINICAL RECORD**  
**ASA IE**  
**ANESTHESIA**

**ANESTHETICS**
- **Propofol**
- **Ketasizine**

**LEVEL OF CONSCIOUSNESS**
- Awake

**CODE**
- Pulse: 90
- Resp: 12
- B/P: 120/80
- Temp: 100.4
- HR: 110
- O2 Sat: 98%

**FLUIDS**
- NS 2000 ml
- LR 500 ml

**POSITION**
- Supine

**AGENTS AND TECHNIQUES**
- Anesthesia: 1849
- Steroid: 1855

**REMARKS**
- Induction:
- 14 G:
- 18:

**OPERATION PERFORMED**
- Bilateral Resection: 2500 ml
- Thoracentesis: 2000 ml
- Thrombectomy: 500 ml

**ANESTHESIA**
- Propofol: 1000 ml
- U/O: 2700 ml

**GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS**
- Form: 126-11-202
- Date: 10/15/75

**MEDCOM - 3117**
MEDICAL RECORD
BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT REQUESTED (CHECK ONE)
☐ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS (Pool of ____ units)
☐ CRYOPRECIPITATE (Pool of ____ units)
☐ Rh IMMUNE GLOBULIN
☐ OTHER (Specify)

TYPE OF REQUEST (check only if blood or blood component products are requested)
☐ TYPE AND SCREEN
☐ CROSSMATCH

REQUESTING PHYSICIAN (Prints)

DIAGNOSIS OR OPERATIVE PROCEDURE

DATE REQUESTED
7-28-02

DATE AND HOUR REQUIRED
7-28-02 9:00 AM

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

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO.

PATIENT NO.

TRANSFUSION SITE

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH

PREVIOUS RECORD CHECK

□ RECORD

□ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

DONOR

RECIPIENT

ABO

ABO

Rh

Rh

§

CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 7-28-02

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INJECTED AND ISSUED BY (Signature)

AT (Hour)

ON (Date)

IDENTIFICATION

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

1ST VERIFIER (Signature):

2ND VERIFIER (Signature):

REACTANTS (check only if reaction suspected)

□ URticaria

□ Chills

□ Fever

□ Pain

□ Other

OTHER DIFFICULTIES (check only if reaction suspected)

□ NO

□ YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE

POST-TRANSFUSION DATA

AMOUNT GIVEN

TIME DATE COMPLETED

INTERUPTED

ML

REACTION

□ NONE

□ SUSPECTED

DESCRIPTION

SEX

EMT

Ward

BLOOD OR BLOOD COMPONENT TRANSFUSION

STANDARD FORM 518 (REV. 6-96)

General Services Administration

Interagency Committee on Medical Records

FIRM 1 (41 CFR) 201-45.005

518-122

MEDCOM - 3118

MEDICAL RECORD COPY
RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
Chest

AGE/SEX SSN (Sponsor)
M

WARD/CLINIC REGISTER NO.
ICU I

FILM NO.

PREGNANT
☑️ NO

TELEPHONE/PAGE NO.

SIGNATURE DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST (Complaints and Indications)
Follow up Post-op

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

RADIOLOGIC REPORT
No significant change

PATIENT'S IDENTIFICATION (For imprint or written entries use:
Name = last, first, middle, Medical Facility)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 3118
REQUEST/REPORT

STANDARD FORM 518-B (8-93)
12 Aug 02

Discharge today

Block Cont'd.

Discharge due 12/15.

NURSING UNIT
ROOM NO.  
BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER     TIME OF ORDER

12 Aug 02

Pt. to return to optometry on 10 Sept for removal of sutures in left cornea.

CAPT. CO, MSC

Removal to be done at Detained Location.

NURSING UNIT
ROOM NO.  
BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER     TIME OF ORDER

HOURS

NURSING UNIT
ROOM NO.  
BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER     TIME OF ORDER

HOURS

NURSING UNIT
ROOM NO.  
BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER     TIME OF ORDER

HOURS

NURSING UNIT
ROOM NO.  
BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER     TIME OF ORDER

HOURS

FORM 4256
REPLACES EDITION OF 1 JUL 79
MEDCOM - 3120
<table>
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<th>Date of Order</th>
<th>Time of Order</th>
<th>Hours</th>
<th>Patient Identification</th>
</tr>
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<tbody>
<tr>
<td>10 Aug 2022</td>
<td>10:00</td>
<td></td>
<td>Add Ciloxan to Drops</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GI</td>
</tr>
</tbody>
</table>

**Nursing Unit**

**Room No.**

**Bed No.**

**Notes:**
- Add Ciloxan to Drops given.
- GI noted.
- Tube feed ordered.
- Captopril 25 mg PO BID.
<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
<th>HOURS</th>
<th>List Time Order Noted and Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Am Oz</td>
<td>7:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Transf. To ICU</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. O2: Multi ESW</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Meds: Periact 1/2 PO @ 4:00 AM</td>
<td>Townsend 650 mg Sup 12 @ PO 14:00</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Anser 16 mg IV @ 8:00 (8 AM-12 PM)</td>
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<tr>
<td></td>
<td>Gentamicin 400 mg IV QD (12)</td>
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<tr>
<td></td>
<td>Pred Forte 1/4 H on QID (5 AM &amp; 5 PM)</td>
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<tr>
<td></td>
<td>IV Heparin</td>
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<td></td>
<td>Actamin 1/2 IV qid on bid (9A 9P)</td>
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<tr>
<td></td>
<td>Occuflex II 1/2 H 03 Q2 (odd)</td>
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<tr>
<td></td>
<td>Occuflex II 1/2 H 00 Q1D (5A 11AM &amp; 5P)</td>
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<tr>
<td></td>
<td>Diet: As tolerated</td>
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<tr>
<td></td>
<td>Activity: NURS @ leg.</td>
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<tr>
<td></td>
<td>List to dry on &amp; to back wounds 2 Dakins solution 3% (at 1000)</td>
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<td>CGT AN</td>
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<td></td>
<td>Time of Order</td>
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<td>Pred Forte QID on</td>
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</tr>
<tr>
<td></td>
<td>Same time as other ES Meds</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time of Order</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HOURS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NURSING UNIT | ROOM NO. | BED NO. | PATIENT IDENTIFICATION | (868)4 |

NURSING UNIT | ROOM NO. | BED NO. | PATIENT IDENTIFICATION | (166)2 |

NURSING UNIT | ROOM NO. | BED NO. | PATIENT IDENTIFICATION | (558)4 |

NURSING UNIT | ROOM NO. | BED NO. | PATIENT IDENTIFICATION | (565)2 |

NURSING UNIT | ROOM NO. | BED NO. | PATIENT IDENTIFICATION | (565)2 |

For use of this form, see AR 40-400, the presenting agency is the Office of The Surgeon General.
<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Apr 02</td>
<td>1650</td>
<td>3</td>
</tr>
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<table>
<thead>
<tr>
<th>Nursing Unit</th>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
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<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Apr 02</td>
<td>1650</td>
<td>2</td>
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<table>
<thead>
<tr>
<th>Nursing Unit</th>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Apr 02</td>
<td>1650</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing Unit</th>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
</thead>
</table>

- **Admit ICU SPFED**: Resume preop orders except:
  - IV antibiotics
  - Oral fluids ad lib
  - Back pain 6 hourly

- **2 Apr 02 1510**: IV in the morning (IV site clear)
- **3 Apr 02 1550**: IV in the afternoon

- **3 Apr 02**: Start dexamethasone 4 mg IV
- **3 Apr 02**: Start ceftriaxone 2 g IV

- **3 Apr 02**: Neurological examination
- **3 Apr 02**: Pain management
- **3 Apr 02**: Keep the patient's head up at least 30 degrees
<table>
<thead>
<tr>
<th>Patient Identification</th>
<th>Date of Order</th>
<th>Time of Order</th>
<th>Noted and Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Aug 02</td>
<td>1650</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2nd Orthopedic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Orthopedic Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10 Pressure ORBts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>73 Gx 36 L, 47 DD Ap</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23 L 4, 9 16 Ap</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Aug 02</td>
<td>1050</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Orthopedic Unit</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
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<td></td>
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**Pharmacology**:

<table>
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<th>Time of Order</th>
<th>Noted and Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1837 3 My 02</td>
<td></td>
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**Radiology**

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<th>Time of Order</th>
<th>Noted and Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24 My 02</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medicine**

<table>
<thead>
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<th>Date of Order</th>
<th>Time of Order</th>
<th>Noted and Sign</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>24 My 02</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Surgery**

<table>
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<th>Date of Order</th>
<th>Time of Order</th>
<th>Noted and Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24 My 02</td>
<td></td>
<td></td>
</tr>
<tr>
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</tr>
</tbody>
</table>

**Urology**

<table>
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<th>Date of Order</th>
<th>Time of Order</th>
<th>Noted and Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24 My 02</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pathology**

<table>
<thead>
<tr>
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<th>Date of Order</th>
<th>Time of Order</th>
<th>Noted and Sign</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>24 My 02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Identification</td>
<td>Date of Order</td>
<td>Time of Order</td>
<td>List Time</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>-----------</td>
</tr>
<tr>
<td>10(06-4)</td>
<td>8/15/72</td>
<td>11:45</td>
<td>1 Aug 82</td>
</tr>
</tbody>
</table>

**Nursing Unit**

<table>
<thead>
<tr>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Identification**

<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 July</td>
<td>11:45</td>
</tr>
</tbody>
</table>

**1st Ocuflox On GZH**

<table>
<thead>
<tr>
<th>Nursing Unit</th>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1521 L 2</td>
<td>3 X 2</td>
</tr>
</tbody>
</table>

**Advance Fluids**

<table>
<thead>
<tr>
<th>Gentamycin 400 mg</th>
<th>IV PG 2A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cresol 1 g</td>
<td>8/hr</td>
</tr>
<tr>
<td>Foleys connected to gram</td>
<td></td>
</tr>
<tr>
<td>NE: 180 at 10 cc/hr</td>
<td></td>
</tr>
<tr>
<td>Trazodone 50 mg cap 2 X 10 mg (PN)</td>
<td></td>
</tr>
<tr>
<td>Emergen-C 3 grams, 2 cap 2 caps or 2 cap</td>
<td></td>
</tr>
</tbody>
</table>

**Nursing Unit**

<table>
<thead>
<tr>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Identification**

<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Aug 82</td>
<td>21:16</td>
</tr>
</tbody>
</table>

**LC4OE 8/12/72 12:30**

**Nursing Unit**

<table>
<thead>
<tr>
<th>Room No.</th>
<th>Bed No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Identification**

<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Time of Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Aug 82</td>
<td>21:16</td>
</tr>
</tbody>
</table>

**Ice chips 8 caps 8 oz water**

*May substitute if L/P needed*
**CLINICAL RECORD - DOCTOR'S ORDERS**

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

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

<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION</th>
<th>DATE OF ORDER</th>
<th>TIME OF ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>22JUL92 Admit ICU</td>
<td>30JUL92 1300</td>
<td>2(3):2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSING UNIT</th>
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<th>BED NO.</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION</th>
<th>DATE OF ORDER</th>
<th>TIME OF ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>LR IV @ 125 cc/hr</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSING UNIT</th>
<th>ROOM NO.</th>
<th>BED NO.</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION</th>
<th>DATE OF ORDER</th>
<th>TIME OF ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampef Teq IV q6h</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentamycin 400 IV q8h</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tegretol 300 oral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morph 2 mg IV 3 x q6h</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPO x ice chips 1/3p H2O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest tubes to lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No face to aus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foley to C/D</td>
<td></td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>NURSING UNIT</th>
<th>ROOM NO.</th>
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</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION</th>
<th>DATE OF ORDER</th>
<th>TIME OF ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shig to @shoulder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUR B Rel Q UE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CXR in Am 7/31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBC, Hct 18.6, 16/16 in Am 7/31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VS 20 x 4, 4.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wet Dry Gauze dressing 6 to 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both back wounds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSING UNIT</th>
<th>ROOM NO.</th>
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<tbody>
<tr>
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</tbody>
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<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION</th>
<th>DATE OF ORDER</th>
<th>TIME OF ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leuc 20 Jup x1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A FUS to VDS @ 10cc/hr</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSING UNIT</th>
<th>ROOM NO.</th>
<th>BED NO.</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Order</td>
<td>Time of Order</td>
<td>Hours</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
<td>-------</td>
</tr>
<tr>
<td>24 Jul 72</td>
<td>19:30</td>
<td></td>
</tr>
<tr>
<td>14 Sep 72</td>
<td>00:00</td>
<td></td>
</tr>
<tr>
<td>28 Jul 72</td>
<td>20:30</td>
<td></td>
</tr>
</tbody>
</table>

**Nursing Unit**

**Room No.**

**Bed No.**

**Patient Identification**

**Date of Order**

**Time of Order**

**Hours**

**List Time Order Noted and Sign**

**Nursing Unit**

**Room No.**

**Bed No.**

**Patient Identification**

**Date of Order**

**Time of Order**

**Hours**

**List Time Order Noted and Sign**

**Nursing Unit**

**Room No.**

**Bed No.**

**Patient Identification**

**Date of Order**

**Time of Order**

**Hours**

**List Time Order Noted and Sign**

**Nursing Unit**

**Room No.**

**Bed No.**

**Patient Identification**

**Date of Order**

**Time of Order**

**Hours**

**List Time Order Noted and Sign**

**Nursing Unit**

**Room No.**

**Bed No.**

**Patient Identification**

**Date of Order**

**Time of Order**

**Hours**

**List Time Order Noted and Sign**

**Nursing Unit**

**Room No.**

**Bed No.**

**Patient Identification**

**Date of Order**

**Time of Order**

**Hours**

**List Time Order Noted and Sign**
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Order</th>
<th>Nursing Unit</th>
<th>Room No</th>
<th>Bed No</th>
</tr>
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<tbody>
<tr>
<td>2/20/77</td>
<td>12:00</td>
<td>IV Trazodone 300mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/21/77</td>
<td>19:00</td>
<td>IV 50mg Isoniazid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/22/77</td>
<td>19:00</td>
<td>Discontinue IV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/23/77</td>
<td>23:00</td>
<td>ABG from 0700 L-0-7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/23/77</td>
<td>22:30</td>
<td>500 cc Fluids for T rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/24/77</td>
<td>08:00</td>
<td>BUN/Creatinine 7.3 cmol/L</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2/24/77</td>
<td>19:00</td>
<td>IV to 100 units</td>
<td></td>
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</tr>
<tr>
<td>2/25/77</td>
<td>13:00</td>
<td>Lasix 40 mg IV</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Poloc 500 cc IV</td>
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**DA FORM 4256**

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 3129
<table>
<thead>
<tr>
<th>DATE</th>
<th>ORDERS</th>
<th>TIME</th>
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</thead>
<tbody>
<tr>
<td>28/02/2022</td>
<td>Enedolaze 200 mg IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vecuronium 10 mg IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thymacin IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fentanyl IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emphal Vecuronium 2 mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBC, ESR, BMP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>U&amp;L</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CXR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CT Head, Chest &amp; Pelvis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IV 50% FS, NS 200 mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AL Hands</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>WARD</th>
<th>ID NUMBER</th>
<th>DIAGNOSIS</th>
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<tbody>
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</table>

MEDCOM - 3130
<table>
<thead>
<tr>
<th>ORDER DATE</th>
<th>CLERK/NURSE</th>
<th>RECURRENT ACTIONS, FREQUENCY, TIME</th>
<th>HR/DATE COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Aug</td>
<td></td>
<td>Δ Patch &amp; shield 05 QD</td>
<td>9/4 7/5</td>
</tr>
<tr>
<td>3 Aug</td>
<td></td>
<td>D/C shield 06 p 17° post 3 P</td>
<td></td>
</tr>
<tr>
<td>3 Aug</td>
<td></td>
<td>Keep eyelids clean QD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>grid &amp; sterile, saline soaks +</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sentinel, NO Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>on eyelids</td>
<td></td>
</tr>
</tbody>
</table>

**ALLERGIES**: YES NO  
**PRIMARY DIAGNOSIS**:  
S/P multi GS wounds

**PATIENT IDENTIFICATION**:  
Am Emy

**ACTION TIMES**

USE PENCIL, CIRCLE ACTION TIMES

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

---

**DA FORM 4677**  
**EDITION OF 1 DEC 77 MAY BE USED.**

MEDCOM - 3132
<table>
<thead>
<tr>
<th>Order Date</th>
<th>Clerk/Nurse</th>
<th>Recurring Medications, Dose, Frequency</th>
<th>HR</th>
<th>Date Dispensed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Aug</td>
<td></td>
<td>Pred Forte Q10 OU (Same)</td>
<td>10</td>
<td>11 12 13 14 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OU (Same) Other Eye</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BOTH EYES</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>1st Aug</td>
<td></td>
<td>Pred Forte Q10 OU</td>
<td>10</td>
<td>11 12 13 14 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pred Forte Q10 surgically</td>
<td>11</td>
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<td></td>
<td>23</td>
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<td>1st Aug</td>
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<td>Ciloxan OU Q10</td>
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<td>11 12 13 14 15</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>23</td>
<td></td>
</tr>
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</table>

**Allergies:**
- Yes
- No

**Primary Diagnosis:**
- Multi - GSW

**Dispensing Times**

**Use Pencil, Circle Med Times**

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
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<tbody>
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**Patient Identification:**

- AM EPW

**DA Form 4678 Edition of 1 Dec 77 Will Be Used Until Exhausted.**

**MEDCOM - 3133**
<table>
<thead>
<tr>
<th>ORDER DATE</th>
<th>CLERK/CLINICIAN</th>
<th>RECURRING MEDICATIONS, DOSE, FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/4/02</td>
<td></td>
<td>ANSEF T 10mm IV Q8h 05</td>
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<tr>
<td>8/4/02</td>
<td></td>
<td>GENTAMYCIN 100mg IV QD 13</td>
</tr>
<tr>
<td>8/4/02</td>
<td></td>
<td>PRED FOE 10gt OD 05</td>
</tr>
<tr>
<td>8/4/02</td>
<td></td>
<td>OCCUFLOC IF GTT OD 05 Good (Left Eye)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/4/02</td>
<td></td>
<td>OCCUFLOC IF GTT OD 05 Good (Right Eye)</td>
</tr>
<tr>
<td>8/4/02</td>
<td></td>
<td>HEPLOCK IV PUSH</td>
</tr>
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</table>

**ALLERGIES:** NO

**PRIMARY DIAGNOSIS:** MUlti-GSW

**DISPENDING TIMES**

**USE PENCIL, CIRCLE MED TIMES**

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
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<td>15</td>
<td>23</td>
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<tr>
<td>8</td>
<td>16</td>
<td>24</td>
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<tr>
<td>9</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>10</td>
<td>18</td>
<td>26</td>
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<tr>
<td>11</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>12</td>
<td>20</td>
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<td>22</td>
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</tr>
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**DA FORM 4678**

**MEDCOM - 3135**
## WOUND CARE

**THERAPEUTIC DOCUMENTATION CARE PLAN**

**MEDICATIONS**

<table>
<thead>
<tr>
<th>Order Date</th>
<th>Nurse/Clerk</th>
<th>Date to be Given</th>
<th>Time to be Given</th>
<th>Time Given</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/4/2022</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/5/2022</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **WET TO DRY DSG**
- **Change to back**
- **WOUNDS & BAKINGS SOLUTION AD**

---

**MEDICATION, DOSE, FREQUENCY**

<table>
<thead>
<tr>
<th>Order Date</th>
<th>Nurse/Clerk</th>
<th>PRN</th>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/4/2022</td>
<td></td>
<td></td>
<td>PEROCET</td>
<td>50</td>
<td>2X4-6G PEN</td>
</tr>
<tr>
<td>8/5/2022</td>
<td></td>
<td></td>
<td>I.V. DEXOM</td>
<td>50</td>
<td>2X4-6G PEN</td>
</tr>
</tbody>
</table>

**TIME/DATE DISPENSED**

- **8/4/2022 00:00**
- **8/5/2022 00:00**

---

**OCTOPHARM, PRED FORIG ATROPIE ON 2 G**

**TIME**

- **9:00 18:00**

---

**U.S. GPO: 985-454-110/95216**

**MEDCOM - 3138**
<table>
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<th>ORDER DATE</th>
<th>CLERK/NURSE</th>
<th>RECURRING MEDICATIONS, DOSE, FREQUENCY</th>
<th>HR</th>
<th>DATE DISPENSED</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>GENTAMYCIN 100mg IV Q8H</td>
<td>23</td>
<td>9/1/87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>O.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NS 100cc IV @ 100cc/15min</td>
<td>08</td>
<td>9/1/87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSING A TO BILAT BACK WOUNDS, W/D</td>
<td>15</td>
<td>9/1/87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GRUZE QD/PRN</td>
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<td></td>
</tr>
</tbody>
</table>

**ALLERGIES:** Yes    **PRIMARY DIAGNOSIS:**

**PATIENT IDENTIFICATION:**

**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  

**MEDCOM - 3137**
### POST ANESTHESIA CARE UNIT FLOW SHEET

**PROCEDURE:** General Anesthesia

**ANAESTHETIST:**
- **Airways:** Nasal
- **EtT:** Oral
- **G Portal:** Intubated
- **Site:** Nasal
- **Gauge:** 8

**THERMAL ENVIRONMENT**
- **Temperature:** °C
- **Humidity:** %

**VITAL SIGNS**

<table>
<thead>
<tr>
<th>Time</th>
<th>P/S</th>
<th>T</th>
<th>A</th>
<th>R</th>
<th>Temp</th>
<th>A</th>
<th>P</th>
<th>E</th>
<th>LOC</th>
<th>Sk</th>
<th>Obs</th>
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</thead>
<tbody>
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<td>00:00</td>
<td>181</td>
<td>80</td>
<td>12</td>
<td>7</td>
<td>95</td>
<td>1</td>
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<td></td>
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</tr>
<tr>
<td>00:05</td>
<td>180</td>
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<td>7</td>
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<td>00:10</td>
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</tr>
<tr>
<td>00:15</td>
<td>181</td>
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<td>7</td>
<td>100</td>
<td>1</td>
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<tr>
<td>00:20</td>
<td>181</td>
<td>78</td>
<td>12</td>
<td>7</td>
<td>100</td>
<td>1</td>
<td>20</td>
<td></td>
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<tr>
<td>00:25</td>
<td>181</td>
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<td>00:30</td>
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<td>00:35</td>
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</tbody>
</table>

**COMMENTS**
- Vital Signs:
- Stable
- ECG:
- No abnormalities

**NEUROLOGICAL**
- Glasgow Coma Score: 15
- Orientation:
- None
- Speech:
- None

**POST ANESTHESIA RECOVERY SCALE "PARS"**

- **GCS:** 15
- **E:** 6
- **V:** 6
- **M:** 3

**TREATMENTS**
- None

**CLOTHING**
- None

**DRESSINGS**
- None

**TUBES**
- None

**DIABETES**
- None

**HISTORY/PHYSICAL**
- None

**FOLLOW-UP**
- None

**OTHER EXAMINATION OR EVALUATION**
- None

**DIAGNOSTICS STUDIES**
- None

**TREATMENT**
- None
<table>
<thead>
<tr>
<th>TIME</th>
<th>TYPE</th>
<th>AMT</th>
<th>INTAKE</th>
<th>OUTPUT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**NURSING CARE PLAN**

1. **Nursing Care Problem No.**
   - Safety: Risk of falls
   - Bed rest
   - Pain control

2. **Nursing Care Plan No.**
   - Keep bed rails up
   - Check for pressure areas
   - Turn every 2 hours
   - Monitor vital signs
   - Administer medications as prescribed
   - Monitor intake and output

**Intake and Output**

<table>
<thead>
<tr>
<th>AMT</th>
<th>INTAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**Medication Administration**

<table>
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<tr>
<th>DRUG</th>
<th>MEDICATION</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>TIME</th>
<th>EFFECT</th>
<th>NURSE SIGNATURE</th>
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<tbody>
<tr>
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</tbody>
</table>

**Prescription Signatures**

- Patient Name: [Redacted]
- Prescriber: [Redacted]
- Pharmacist: [Redacted]

**Nurse Signatures**

- [Redacted]
- [Redacted]
- [Redacted]

**Patient Information**

- Allergies: [Redacted]
- Vital Signs: [Redacted]
- Diagnoses: [Redacted]
**Clinical Record**

**Doctors Orders**

**Post OP**

**Diagnosis:** Malignant G5W Chalky Nest (Entry: G5W 0) Poor

**Procedures:** B S/A Recontour Throat 0, Rectal Exploration 0, DC. Debride G5W

**Allergies:** N/A

**Condition:** Good

**Vital Signs:** Q 5 to 10 minutes until stable then Q 30 minutes

**I & O:** Q-1 hour or B hrs

**Activity:** Bedrest

**IV Fluids:** NS@ cc/hr x liters

**Blood:** Transfuse 1 Units PRBCs

**Oxygen:** 240 liters/min via mask. Titrato to SAO2 > 90%

**Chest Tube:** 20 cmH2O Water-seal

**Vent settings:** SIMV: 12/min., TV: 12cc/kg. 02 Flow to maintain SAO2 > 90% PEEP 5c PeakI Flow 45 liters per minute and adjust as needed.

**Extravasation criteria:**

Patients spontaneous respiration is 14 to 20 inhalations per minute

Patient is able to cough and breathe.

Pulse oximeter setting must be no less than 92%.

Patient awakes spontaneously and can lift head off bed.

**NG Tube:** LIS Clamped N/A

**Medications:**

- Antibiotics (check one)
  - Cefazolin Sodium, 1 Gm, IV, q8H
  - Cefotaxim Sodium, 1 to 2 Gms, IV, q6 to 8H
  - Gentamycin Sulfate, Mgs q...

**Analgesics:**

- Morphine Sulfate, 2 to 10 Mgs, IV, q2H pm.

**Patient Release:**

A. Release from medical evacuation when patient awakes spontaneously, can lift head off bed, when BP is equal to or greater than 100 mm Hg (systolic) and stable, and when there is no evidence of rebleeding.

B. Discontinue chest suction and place Heimlich valve on all chest tubes.

C. Discontinue NG tube suction and ensure that tube is open to air or to straight drainage.

**Prepared by (Signature & Title):**

**Department/Service/Clinic:**

**Date:** 27 Feb 01
### Twenty-Four Hour Intake and Output Worksheet

#### Oral Intake

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Amount</th>
<th>Accum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>19:15</td>
<td>Water/Juice</td>
<td>400</td>
<td></td>
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<tr>
<td>23:00</td>
<td>Juice</td>
<td></td>
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<tr>
<td>23:15</td>
<td>Juice</td>
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#### Intravenous Intake

<table>
<thead>
<tr>
<th>Time Started</th>
<th>Amount</th>
<th>Type (Include Medications)</th>
<th>Amount Rec'd</th>
<th>Time Compl</th>
<th>Accum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>13:00</td>
<td></td>
<td>LV @ 50</td>
<td>700</td>
<td>19:15</td>
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</tr>
<tr>
<td>14:15</td>
<td>1000</td>
<td>NS @ 100 (B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:00</td>
<td>50</td>
<td>(Nursing P.B. 5000 mg 15D)</td>
<td>23:00</td>
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</table>

**NPO Post Midnight**

#### Irrigators (i.e., Bladder, etc.)

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Amount</th>
<th>Accumulative Total</th>
</tr>
</thead>
</table>

#### Blood/Blood Derivatives

<table>
<thead>
<tr>
<th>Time Started</th>
<th>Product (i.e., B1, A/b, F, cells, etc.)</th>
<th>Time Compl</th>
<th>Amount</th>
<th>Accum Total</th>
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</thead>
</table>

#### Other Intake

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Amount</th>
<th>Accumulative Total</th>
</tr>
</thead>
</table>

#### Grand Total Intake

### Patient Identification
For typed or written entries give: Name - Last, first, middle, grade; date; hospital or medical facility.

### Intake Equivalents (Serving sizes cc)
- **Medicine Glass (1 oz):** 30
- **Half Pint Milk:** 240
- **Small Fruit Cup:** 120
- **Large Soup Bowl:** 240
- **Coffee Cup:** 160
- **Large Water Glass:** 240
- **Large Coffee Mug:** 160
- **Plastic or Paper Juice Container:** 100

**DD FORM 792**

**Edition of 1 Sep 64 is Obsolete. Replaces DA Form 5010 (Temp) 1 Jul 72 which may be used.**

**MEDCOM - 3142**
### Urine

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>G20</td>
<td>1200</td>
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### Nasogastric

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<tr>
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<th>Amount</th>
<th>Accum. Total</th>
<th>Type</th>
<th>Accum. Total</th>
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### Chest

<table>
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<th>Amount</th>
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### Emesis

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<th>Amount</th>
<th>Accum. Total</th>
<th>Type</th>
<th>Accum. Total</th>
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### Stools

<table>
<thead>
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<th>Time</th>
<th>Color</th>
<th>Character</th>
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<th>Accum. Total</th>
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### Other Output

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<tr>
<th>Time</th>
<th>Amount</th>
<th>Type</th>
<th>Accum. Total</th>
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</table>

### Remarks

**Patient's Identification:** (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

<table>
<thead>
<tr>
<th>No.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Intake Equivalents** (Serving levels cc)

- Medicine Glass (1 oz) .30
- Small Fruit Cup .......120
- Coffee Cup .............160
- Large Coffee Mug ....180
- Plastic or Paper Juice Container ...180

**Total Output:**
## Twenty-Four Hour Patient Intake and Output Worksheet

### Intake

<table>
<thead>
<tr>
<th>Time</th>
<th>Type (Include Medications)</th>
<th>Amount</th>
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</thead>
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<tr>
<td></td>
<td>LR (6 1500)</td>
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### Oral

<table>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

### Intravenous

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Amount</th>
<th>Accum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Irrigations (IV, Bladder, etc.)

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Amount</th>
<th>Accumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Blood/Blood Derivatives

<table>
<thead>
<tr>
<th>Time Started</th>
<th>Product (i.e. B1, RBC, etc.)</th>
<th>Time Compl</th>
<th>Amount</th>
<th>Accum Total</th>
</tr>
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<tbody>
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### Other Intake

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Amount</th>
<th>Accumulative Total</th>
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</thead>
<tbody>
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</table>

### Grand Total Intake

### Intake Equivalents (Serving levels cc)

- **Medicine Glass (3 oz)**: 30 cc
- **Half Pint Milk**: 240 cc
- **Small Fruit Cup**: 120 cc
- **Large Soup Bowl**: 240 cc
- **Coffee Cup**: 160 cc
- **Large Water Glass**: 240 cc
- **Large Coffee Mug**: 180 cc
- **Plastic or Paper Juice Container**: 160 cc
<table>
<thead>
<tr>
<th>TIME</th>
<th>AMOUNT</th>
<th>ACCUM TOTAL</th>
<th>TIME</th>
<th>AMOUNT</th>
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<th>CHEST</th>
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<th>EMESIS</th>
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<th>STOOLS</th>
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<td>TIME</td>
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<tr>
<th>OTHER OUTPUT</th>
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<tr>
<td>TIME</td>
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<th>GRAND TOTAL OUTPUT</th>
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<td>TIME</td>
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</table>

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

INTAKE EQUIVALENTS (Serving ales of)

- MEDICINE GLASS (2 oz) - 20
- SMALL FRUIT CUP - 100
- COFFEE CUP - 100
- LARGE COFFEE MUG - 180
- LARGE SOUP BOWL - 240
- LARGE WATER GLASS - 240
- PLASTIC OR PAPER JUICE CONTAINER - 240

DD FORM 792

MEDCOM - 3145
NAME (Last, First, Middle Initial): Archamhiel, Deaniee

DATE OF BIRTH (MM/DD/YYYY): 12/01/1984

AGE AT ADMISSION: M

RACE: M

ETHNIC BACKGROUND: Muslim

SOCIAL SECURITY NUMBER: 385-24-2982

MARITAL STATUS: M

BIRTHPLACE: M

SEX: M

LENGTH OF SERVICE: 22

ENLISTMENT SERVICE: 20

ORGANIZATION (Active Duty Only): M

UNIT LOCATION (State or City): K714

MOS: 015B

TRAUMA: ICUT

TRAVEL AGENT: BAGRAM AF

DISPOSITION: TRAUMA

DATE OF DISPOSITION (MM/DD/YYYY): 12/02/1984

CLINIC SVC - ADMITTING: 05

MTF TRANSFERRED TO: 05

MTF TRANSFERRED FROM: 05

LOCATION OF OCCURRENCE (Battle Casualty Only): 05

DATE THIS ADMISSION (MM/DD/YYYY): 12/02/1984

DATE INITIAL ADMISSION (MM/DD/YYYY): 12/02/1984

INJURY: 9

PROCEDURE: 3479

PROCEDURE AT TYPE OF REPAIR: 7935

ADMITTING OFFICER (Signature, if required):

DA FORM 2985, MAR 89

EDITION DATED 1989

MEDCOM - 3147
Afghan Male Detawee

Muslim

30 Y

Home 06

20 Aug 72

32. CAUSE OF INJURY

Multiple GSW Head

DIAGNOSES/OPERTIONS AND SPECIAL PROCEDURES

30. TOTAL DAYS THIS FACILITY

A. ABSENCE SICK DAYS
B. OTHER DAYS
C. CONV LV/COOP CARE DAYS
D. SUPPLEMENTAL CARE DAYS
E. BED DAYS

31. TOTAL DAYS ALL FACILITIES

A. ABSENCE SICK DAYS
B. OTHER DAYS
C. CONV LV/COOP CARE DAYS
D. SUPPLEMENTAL CARE DAYS
E. BED DAYS
11 Aug 02  
Gen Syg
S-Loss W/Pain Drw well - Hldr
W/ Aus & Wnd clean No New
B/P Pocket
A - Wnd Imp'd
P - P- Pain meds Gave Hldr
As Ordered Fr Thu Fr 20 Aug
If Wnd looks G o o

14 Aug 02
Got spare one pair clearly cut minimally.
Best comfortably, later getting clean dressing.
Changes until tomorrow.

20 Aug 02  
Gen Syg
Wound clean No Pus No Fever
Transfer to Detainee Center today

MEDCOM - 3149
16 Aug 02
0910
Dressing changed under Ketamine Solution
No complications. No New Evidence of Infection.
Dressing remains wet. Ketamine
sedation is no longer needed.

16 Aug 02
0925
Dressing changed. Wound becoming more evident. 2 pockets of pus are
present. Will start BID Dressing Change Today.

18 Aug 02
0925
Wound looks much better. 2 areas remain 1 drainage. Will continue
BID Dressing Changes.
10 AUG 82

Put with 3 w/BBE with 24" tags but dying quickly. Had 2 dye techs work on it. Dye was clean. Had dye removed. EKG needs further surgery.

11 AUG 82

Got for x-ray on EKG. Was about 120. Blood pressure was 180/90.

12 AUG 82

14 AUG 02 Pot. 11p. anergy well. Unt B + C S C d - clean
wound. Q & S: 90% P pain presently. Wound culture
sent. CCA choice & mixed skin JG-ster max.
Cent. present ty.
06/06/02  Pat Greger 803 discharged from unit – Diagnosed
06/06/02  Call Dr. Rm 10-04 Trend heart rate 66. CBC framed
06/06/02  Rec 9-32 QRS X thorax normal Dr fulled
06/06/02  Admit charge admit arm continued
06/06/02  9:30 AM卡通 to maintain 90% 02

7/06/02  Pat 9:30 AM runoff arm 99 drop pain
06/06/02  Blood moving well pulse of 91 RR 17 T Scherv
06/06/02  hasn't made much better feel CTS 1
06/06/02  10:00 AM
06/06/02  Sensory
06/06/02  1:25 PM
06/06/02  C/M Brain stump unchanged since
06/06/02  Admission
06/06/02  V/S after 101 stable dressing
06/06/02  Aspirin stablized Antifungal Ibad
06/06/02  NIV Nebulizers
06/06/02  WARD NUMBER
06/06/02  MEDCOM - 3153
Aug 02

R: Stump - NSG. Dranked

Plan: OR today

Aug 02


Trialt of MOA, Fentanyl, Valium, and finally Halodol @ 0.75 - Successful.

Tm 38.3, HR 102, BP 150/80, 93% on 3L O2. Currently asleep, no NIP.

No other A's

Labs: Hb 6.7 prior to transfusion.

Plan: M V H/H

Aug 08
August
Young Afghan, 24 yr, multiple ASW
Started bleeding from area of injury.
Patient's condition may be worse than

White: 0.9 KPH
Med: 0
Allergies: NEDA
PE: Undaunted, 2 llb
BP: 70/40; HE 130, R: 220

Head: NICE, PEARL GROVE
Night, apple, NT
Liver: OCA

Cardiac, breathing, circulatory
Alcohol: CoP, alcohol, QS5

Severe, tense immunity, B; surgured
Femur; agent to B knee, multiple thigh
Suprascapular, R buttock, entry wound.
Large wound R medial and active bleeding

Medicine: Vaginal, entry, 125 L per min.

Chair: Urgent Attention

RELATIONSHIP TO SPONSOR
SPONSOR'S NAME
SPONSOR'S ID NUMBER
ISSN or Other

MEDCOM - 3155
August 02
Op Note

Pre-Op Dr: C50e One (multiple)
Post-Op Dr: C50e One (multiple)

Operated @ SFA
Operated @ SV
Operated @ midfoot

Procedure: Exp Celeotomy (Vascular Control)
Exploratia @IE vascular tree
Ligated SVA Intersecio @ SFA
Ligated @ SV
Dorsal Vascularized @ SFA

W: 5'10" D: 140 lb

Surgeon: □
Anesthia: □

EBL: 620 mL

IVF: 8 whole RBC, 1 PRC, 10L IVF, 12 bottles

OR: 5:00 PM Critical

** Important O thigh pack due to Coagulopathy

**hemostasis due to Coagulopathy

**hemorrhage. Packs will need to be removed for Coagulopathy

**hemostasis

MEDCOM - 3156
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Apr 02</td>
<td>ALT: 12.7, 7.86    /     Hct: 33.5 /     Pd: 208 /     Hgb: 14 /     Sat: 90%</td>
</tr>
<tr>
<td>02 20</td>
<td>WNL x FEO 42%   /     AL rate 12</td>
</tr>
<tr>
<td>05 07</td>
<td>81 HR p VENT failure. No other problem</td>
</tr>
<tr>
<td>07</td>
<td>VSS</td>
</tr>
<tr>
<td></td>
<td>vent: senv 12      /     VR 860    /     FiO 40%</td>
</tr>
<tr>
<td></td>
<td>Ext: ARD PA</td>
</tr>
<tr>
<td></td>
<td>Lab: K 3.5   /     Hb</td>
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<td></td>
<td>AP</td>
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<td></td>
<td>3</td>
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<td>7</td>
</tr>
<tr>
<td>08 Apr 02</td>
<td>81 Tel. extubation. Fever</td>
</tr>
<tr>
<td>11</td>
<td>81 TM 38.6 VSS 93%</td>
</tr>
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<td>Ex: AKA ini NPO</td>
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</table>
2119

Adm note (appears to be in his 30's), brought to ICU from OR.
Paralyzed and on ventilator. Pt had uncontrolled bleeding of lower extremity, which required tourniquet application and amputation. Pt received PBB while in OR.

137/91 77.6 02 Sat 100% Vent Rate 10

SIP: 71 SIP

Abd: Abdominal incision, bandages, red mark

Ext: Milk cloting, edema

AKA

78/48 9/27 10/26

Pt 5'0, 115 lb, APG 45

7/1 17, Am 127

AST 31, ALT 29, GGT 18

HOSPITAL OR MEDICAL FACILITY:
STATUS: 01/01/202

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 9-97)
Prepared by: SSA/CMR
PRMR: 01572-01 251-3 2002-1

MEDCOM - 3158
1 Aug 62
8:50 Est 24 CWT LBP
Cleft and Incisions X/Phoid to Umbilicus Stopped
Airway Patent
Breathing via 14Fr TV CO2 88.8 60

138/85
105
m/L GSW R.L.E. S/L operative report
15:30 om PULSE R Fort Post R thigh wound gauze applied
CO2 29
1L HBC O- up (4/25 Complete)
16010
2 immature GSW

12/6

11070

2 immature Total GSW

L medial thigh small incision stopped

7/25

11070 8 Fr}

2 L/PBC up 1/0

Central line 75 chest to LF wideopen

CXR done

10:25 VEC (4/26) 2

1905Hr-14/77.1150 150 02 100% CO2 34

40mg K+ in the evening.

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME

DEPARTMENT

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

MEDCOM - 3159
**SKIN**
- intact
- warm, dry

**BACK**
- no CVA
- tenderness
- no vertebral tenderness

**EXTREMITIES**
- struma
- pelvic stable
- hip non-tender
- pedal edema
- joint Exam:
  - limited ROM / ligaments laxity / joint effusion

**X-RAYS**
- interpretable by me
- reviewed by me
- dictated by radiologist

- C-spine NAD
- reversal / straightening of cerv. kordosis
- no fracture
- DJD / spondylitis / spurring
- no alignment
- soft tissues noted

- CXR:
  - rib fracture
  - infiltrate / atelectasis
  - no infiltrates
  - ml heart size
  - ml mediastinum

**OTHER**
- see separate report

**WOUND DESCRIPTION/REPAIR**
- length cm
- location
- _superficial_ SQ muscle linear _stellate_ irregular
- clean _contaminated_ moderately _severely
- distal NVT: neuro & vascular status intact _no tendon injury
- anesthesia:
  - local _digital block_ cc
  - lidoc 1% 2% epi / bupivacaine _marcaine 25% 5% LET
- prep:
  - Betadine / Betadine / Hibiclens
  - debride / undermined
  - irrigate / wash with saline
  - foreign material removed
  - minimal _moderate_ extensive
- explored
- repair:
  - wound closed with wound adhesive / suture
  - SKIN:
  - #0 nylon / prolene / staples
  - SUBCUT:
  - #0 Vicryl / chromic

*may indicate intermediate repair *may indicate intermediate or complex repair

**DISPOSITION**
- home
- admitted
- transferred

**PHYSICIAN SIGNATURE**
- DMR-2

**MEDCOM - 3161**
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>OBSERVATIONS</th>
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<tbody>
<tr>
<td>4 Aug 02</td>
<td>14:45</td>
<td>Pt transferred from ICU I via litter</td>
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<tr>
<td></td>
<td></td>
<td>USF: FOK 85% on 8/14 - O2 once 2L FOK 93% - no pain &quot;all over&quot; in med. Graded as ordered - Fe patientを得ing clear. Yellow urine: Urine @ bedside. Pt. no longer attached to bed frame.</td>
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<tr>
<td>4 Aug 02</td>
<td>23:50</td>
<td>Pt in bed, meatting needs stepped need.</td>
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<td>Wound assessment. Commanded temp. 103.4. Transfer to inpatient floor.</td>
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<td>Ordered clorazapate dipotassium, 0.5 mg.</td>
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</tbody>
</table>
|          |        | Ordered clorazapate dipotassium, 0.5 mg.
| 5 Aug 02 | 02:40  | Treatment given for "pain, 유지 continue to monitor. |
| 5 Aug 02 | 07:00  | Urine output 1900 g for the night ending...
NURSING NOTES
(Sign all notes)
OBSERVATIONS
Include medication and treatment when indicated

DATE       A.M.       P.M.  
8/1/02  0800

8/2/02  0900

5/Aug/02  0900

5/Aug/02  2050  C/O "S.O.B." Slight wheezing on expectoration. Temp 103.8-98.20, DR. Notified C/O incisional pain, unable to determine level. IV site of forearm infected. X-Ray done as ordered. Respiration 20 MHR 100-120. IV (Medicate as ordered)

8/10/02  0800

8/16/02  0800

8/16/02  1210

8/16/02  0900

8/16/02  0900


MEDCOM - 3163
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>OBSERVATIONS</th>
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<tr>
<td></td>
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<td>Appetite poor. 2 mL of 10% dextrose encouraged. Pt. drank 1/2 cup apple juice. 1/2 cup orange juice. Abdominal pain. Pt. given a prescribed codeine.</td>
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<tr>
<td>7 Aug 2</td>
<td>0940</td>
<td>Pt. additional nausea no discontinuation noted.</td>
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<tr>
<td>7 Aug 2</td>
<td>1030</td>
<td>An interview with patient and interpreter. Pt. stated the interpreter's responses to not accept any medication or communication.</td>
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<td>Requested per physician. Phenergan 12.5 administered.</td>
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<tr>
<td>7 Aug 2</td>
<td>1300</td>
<td>Pt. as above (as per two previous iterations noted).</td>
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<tr>
<td>7 Aug 2</td>
<td>1330</td>
<td>Pt.冲突 medicated with demand 25mg</td>
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<tr>
<td>7 Aug 2</td>
<td>1725</td>
<td>Reassure patient per treat 08:00 to rest. (will continue to monitor.)</td>
</tr>
<tr>
<td>8 Aug 2</td>
<td>0900</td>
<td>Pt. 20x3 (as noted previously). Appetite given.</td>
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</table>

Pt. 4% of meal. Ordered today 100g of quietly clear, amlodipine, 4 mg PO TID. Am. Note given T 10% of water admin.
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<tr>
<th>DATE</th>
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</thead>
<tbody>
<tr>
<td>8/10/96</td>
<td>10:00</td>
<td>T 10:00 re: child in back NPO for OR.</td>
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<tr>
<td>8/10/96</td>
<td>13:00</td>
<td>NPO leg. NPO for OR.</td>
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<tr>
<td>8/10/96</td>
<td>15:30</td>
<td>Pt continued conv OR until 21:00. 96%. 2:00 86 24 36-94-28. 1:00.</td>
</tr>
<tr>
<td>8/10/96</td>
<td>15:45</td>
<td>Continue to monitor. Ordered 3% w/v irrigate for site prep. LR @ 200 cc/h to</td>
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<td>control line infusing S anesthetic.</td>
</tr>
<tr>
<td>8/10/96</td>
<td>16:30</td>
<td>15% 15-124 40% 26% CIV site prep blended p. ox 98% 21% 80 cc drip continue</td>
</tr>
<tr>
<td>8/10/96</td>
<td>17:00</td>
<td>Time out prep. 100% CAV access.</td>
</tr>
<tr>
<td>8/10/96</td>
<td>17:30</td>
<td>PT denied water, refused ice cream. 1/2 of site prep. 125/81-121-26-98%.</td>
</tr>
<tr>
<td>8/10/96</td>
<td>18:00</td>
<td>VS 1260-121-24 98% 37 noting infant CO2 ap-op.</td>
</tr>
<tr>
<td>8/10/96</td>
<td>19:00</td>
<td>PT c/o pain. CIV access 3% w/v adm in drip.</td>
</tr>
</tbody>
</table>

NURSING NOTES
(Sign all notes)

OBSERVATIONS
Include medication and treatment when indicated

DATE | HOUR | AM | PM
--- | --- | ---
9 Aug 07 | 0800 | (cont) Central line and subclavian intake 5 L 5% dextrose 500 mL solution on IV bag. Urine output 850 mL. Intake and drainage clear and yellow. O2 contact 0%. Patient wanting something to eat and drink. Despite this, they are still fed.

0 Aug 07 | 1300 | Received 3 ampules of RP on floor. RCBC available on ward..

Staff nurse notified, PT BP 180/4;
6 mL of RCBC brought in and given.

Leg mass 2; leg nurse, B1;

Staff assessed to O2; returned to 85;

0 Aug 07 | 1700 | 10 mL of 0.9% NaCl solution on IV bag. IV tubing connected to 950 mL of solution.

0 Aug 07 | 2200 | 20 mL of 0.9% NaCl solution on IV bag. IV tubing connected to 950 mL of solution.

NURSING NOTES
Medical Record

MEDCOM - 3166
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Aug 02</td>
<td>2:00</td>
<td>Alert in bed; M/F; in attendance; oral intake; SC 600 mcg intestinal fluid;</td>
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<tr>
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<td>SC 20 mg, LPR position; 30 cc of 5% D5NS was infused; 88°F, 87% O2, 27 RR;</td>
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<td>1 unit FBC was administered. (Prochlorperazine 5 mg was administered at 08:15.)</td>
</tr>
<tr>
<td>10 Aug 02</td>
<td>1:25</td>
<td>Foley drains clotted; urinary output appears to be leaking drainage tubing;</td>
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<tr>
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<td>90 consistent pain and requesting pain med every hour; 50% intact on O2;</td>
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<td>AKA O2, redimethazine 1 mg, PRN.</td>
</tr>
<tr>
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<td>Blood completely infused and in feet.</td>
</tr>
<tr>
<td>10 Aug 02</td>
<td>1:20</td>
<td>Phased.</td>
</tr>
<tr>
<td>10 Aug 02</td>
<td>07</td>
<td>Temp = 97.6°F; PRN O2.</td>
</tr>
<tr>
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<td></td>
<td>100 cc of respiratory 5% D5NS was given.</td>
</tr>
<tr>
<td>10 Aug 02</td>
<td>06</td>
<td>145/87 - 121/66 - 60. IV minocycline was started.</td>
</tr>
<tr>
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<td></td>
<td>Antibiotics were kept, urine output and clean yellow urine draining to gravity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tubing was started. Skin was dry.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory demand resting on chair bed; no oral drainage. Type I suction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>was used; drainage is type I suction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PRN sedative was administered.</td>
</tr>
<tr>
<td>10 Aug 02</td>
<td></td>
<td>PCA was discontinued.</td>
</tr>
</tbody>
</table>

**MEDICAL RECORD**

<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
</table>
| 11 Aug 02 | C800 | Deverseing in bed. NPO gastric OB: \( \text{\textit{de}} \) urine output for Night 1500 cc (dark yellow).  
\( \text{\textit{de}} \) Stump dressing changed and pads.  
Antiseptic therapy cont. NSS @ 20cc infusion to central line. \( V0.14/1 - 124 - 24 \). |
CA: 
\( \text{\textit{de}} \) na 96 - 101 - 24 146  
SkID: N14 infusion 2000 cc to central line. VD: Vomiting cleared, clear suction wash.  
Tidal airway for T-End.  
\( \text{\textit{de}} \) Stump dressing pads placed in urethra to absorb remaining  
\( \text{\textit{de}} \) fluids encouraged. |

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

<table>
<thead>
<tr>
<th>REGISTER NO.</th>
<th>WARD NO.</th>
</tr>
</thead>
</table>

**NURSING NOTES**  
Medical Record

Bed 48
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>MEDICAL RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-4-02</td>
<td>1700</td>
<td>Returned from OR. Dr's sign, O.K. TREM, I intact. RPR 2.8. Regular, 101.5&amp; 11%. Vomiting. Foley cath. 400 ml. PRO-DAG applied. IVF Infusing N 5% 125 ml NaVA Interal Jugular. Will cont. to observe.</td>
</tr>
<tr>
<td>13-5-02</td>
<td>1450</td>
<td>118-12:47-98.7-97% pressure. O2 mask.</td>
</tr>
<tr>
<td>13-5-02</td>
<td>1515</td>
<td>118-12:47-98.7-97% pressure. O2 mask.</td>
</tr>
<tr>
<td>13-5-02</td>
<td>1450</td>
<td>118-12:47-98.7-97% pressure. O2 mask.</td>
</tr>
<tr>
<td>13-5-02</td>
<td>2100</td>
<td>Blood cultures: S. aureus aerobic (3 positive). Deinfe. GCS intact.</td>
</tr>
<tr>
<td>13-5-02</td>
<td>2100</td>
<td>Blood cultures: S. aureus aerobic (3 positive). Deinfe. GCS intact.</td>
</tr>
<tr>
<td>13-5-02</td>
<td>0000</td>
<td>Pt. glucose ≤30°C 3%. SpO₂ from 5% decline. Monitor will continue to monitor.</td>
</tr>
<tr>
<td>17-5-02</td>
<td>2400</td>
<td>Sti. Cathy for 1100 cc clear yellow urine. 5% dextrose/bicarbonate.</td>
</tr>
</tbody>
</table>
NURSING NOTES
(Sign all notes)

DATE | A.M. | P.M. | OBSERVATIONS
--- | --- | --- | ---
11 Aug 07 | 0800 | | Voided 600 cc clear yellow urine.

11 Aug 07 | 1130 | | Allen's exam very belligerent.

11 Aug 07 | 1435 | | P/F returned from OR 99° 18% 20 P/0 3.2

14 Aug | 1200 | | Pressure ulcer will be treated with CHG 1X, not 5X.

14 Aug | 1505 | | Pressure ulcer will be treated with CHG 1X, not 5X.

15 Aug | 1145 | | Pressure ulcer will be treated with CHG 1X, not 5X.

15 Aug | 1530 | | Paresthesias, pain 9/10

 MEDCOM - 3170
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>A.M.</th>
<th>P.M.</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Aug</td>
<td>1500</td>
<td></td>
<td></td>
<td>Ht. staples removed from head. Inj. scopolamine.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No S/S expt. head.</td>
</tr>
<tr>
<td>8/15/02</td>
<td>1930</td>
<td></td>
<td></td>
<td>Alert in bed. Minimal activity. DSD yellow urine. Tend to 1/2-3 and T.V. cried as periods of inactivity. Held general poorly. Insomnia; told analgesics. P.T. never cyclic to sleepiness.</td>
</tr>
<tr>
<td>16 Aug</td>
<td>2130</td>
<td></td>
<td></td>
<td>Pt. AFO - use of little English. Pvt. down.</td>
</tr>
<tr>
<td>17 Aug</td>
<td>0630</td>
<td></td>
<td></td>
<td>OBM: This shift. Medication given throughout night. Eating well. Not much staff endorsement.</td>
</tr>
<tr>
<td>18 Aug</td>
<td>0800</td>
<td></td>
<td></td>
<td>Responds to all instructions. Dr. to relieve irritation. E odors of urine. Incontinent. 1/2 loose enem.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>V.S. 1/2. INF. INFUSING W.C. into R.T. @ 125 ml/hr.</td>
</tr>
</tbody>
</table>

MEDCOM - 3171
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/17/02</td>
<td>6:30</td>
<td>46 diapers removed from patient and更换 medication and dressing.</td>
</tr>
<tr>
<td>4/15/02</td>
<td>11:30</td>
<td>Patient had a minimal amount of use of DSD contam. Patient received 50cc of clorazon yellow urine. Tidal 102 cc and 7 cc Bladder. No suction, no incontinence. Hadol general. Pain orders, sleep order, analgesic. Non-English speaking patient.</td>
</tr>
<tr>
<td>4/17/02</td>
<td>0:00</td>
<td>OBN this shift. Medication given throughout night. Eating breakfast. No much staff encouragement.</td>
</tr>
<tr>
<td>4/18/02</td>
<td>0:30</td>
<td>Responds to all stimuli. Drug TO RE SATURATION. C. ODOR OF URINE. INCONTINENT of loo loose 15 min. V/S: WNL. IVF infused well into RIVA 125 ml NS.</td>
</tr>
<tr>
<td>DATE</td>
<td>A.M.</td>
<td>P.M.</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>16 Aug 02</td>
<td>0730</td>
<td></td>
</tr>
</tbody>
</table>

Responds to all stimuli. Follows simple command. No
 Maintained voiding via catheter Q 4h. P. S. Pulse 94/60
K.A. IVF infusing well LR into R. V. Q 125 mL/hr.
No other complications at this time.

K.A. 07
R.V. Pt. Alert, responsive, IV NSS 125 mL, infusing
P.T.P., P. S. Cerebral edema, Beck’s. myriad
Voiding came green urine into bottle - turbid
and reconstituted

(Continue on reverse side)
<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 Aug 92</td>
<td>045</td>
<td>Alert, brisk fisting, talked to nurse, noted VS. 15.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VS: 24, Ht: 140, Grav 12, Apgar 9/9/9, Wld wrst.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper abdominal pain (080-2).</td>
</tr>
<tr>
<td>8/19/92</td>
<td>0600</td>
<td>Pt resting on bed, gesturing toward center.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trying to turn, no rotation, sits up.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt in agitation, not to remove.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagreed with any changes, shake head to indicate agreement, understanding.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sgt. must do dressing and intub. Some English use as he desires, reading.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0600. Sgt. &amp; 2nd LT. in attendance.</td>
</tr>
<tr>
<td>8/20/92</td>
<td>0600</td>
<td>98° 1, 14. 106°-18. Pt. had one-sided vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oily hair. Oil smell. Cold feeling, continually through gestures &amp; speaking.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sgt. uses simple commands with guidance. Do (ca) left.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45° tilted to right. Vn: ( ) Various facial movements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urine in ( ) Pressure at ( ) infusion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( ) Posture dressing applied.</td>
</tr>
</tbody>
</table>
MEDICAL RECORD - NURSING DISCHARGE SUMMARY

1. Date/Time: 30 Aug, 2002

2. Discharge to: Other (specify) Center

3. Mode: Ambulatory

4. Accompanied by: 

5. Activity: 

Bed Rest

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

6. Diet: 

No Dietary Restrictions

Patient/S.O. communicated understanding of dietary restrictions. Regular

7. Medications: 

- HaI 0.1mg PO Daily
- Motrin 800mg PO 3x Daily
- Dakin's Solution for Dress Change Daily

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

8. Treatments/Care:

Instructions Given:

NONE

Equipment/Supplies (Specify)

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

NONE

Patient/S.O. communicated understanding of follow-up Instructions.

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

IMPROVED

11. Signature (Registered Nurse)

12. Additional Information:

13. Patient Identification:

DA FORM 3888-3, JUN 91
REPLACES DA FORM 2886-5 (MAY 95) WHICH IS OBSOLETE.
MEDCOM - 3175
Date:
Name:
Grade:

Summary Of Injuries:
1
2
3
4
5

Operating Procedures:

Date:

Findings:
1
2
3
4
5
6
7
8
9

Treatment:
1
2
3
4
5
6
7
8
9

Discharge Meds:

Other Diagnosis & Condition(s):

Recommendations:

Signature/Title
**BAGRAM AFGHANISTAN DISCHARGE SUMMARY**

Date: 20 August, 2002
Name: [Redacted]
Grade: [Redacted]
Unit: [Redacted]

**Summary of Injuries:**

1. MULTIPLE GUNSHOT WOUND TO RLE
2. S/P RIGHT AKA
3.
4.
5.

**Operating Procedures:**
- WOUND DEBRIDEMENT (9 aug, 11 aug, 13 aug),
- REVISION OF STUMP (1 aug 3 aug 5 aug, 8 aug) &
- DRESSING CHANGES (14 aug, 15 aug, 16 aug)

**Date:**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. UNCONTROLLED BLEEDING</td>
<td>1. AKA RLE</td>
</tr>
<tr>
<td>2. RIGHT THIGH, SECONDARY TO GSW</td>
<td>2.</td>
</tr>
<tr>
<td>NECROTIC MUSCLE RIGHT THIGH</td>
<td>4.</td>
</tr>
<tr>
<td>3.</td>
<td>5.</td>
</tr>
<tr>
<td>4.</td>
<td>6.</td>
</tr>
<tr>
<td>5.</td>
<td>7.</td>
</tr>
</tbody>
</table>

**Discharge Meds:**
- HALDIX 2MG, PO, DAILY
- DAKIN’S SOLUTION FOR DAILY DRSG CHANGE
- 10TRIP 300MG, PO 3 TIMES DAILY

**Other diagnosis & Condition(s):** **NONE**

**Recommendations:** DAILY DRSG CHANGES W/ DAKIN’S SOLUTION

**Signature:** [Redacted]

MEDCOM - 3177
1. PATIENT TRANSPORTED TO OPERATING ROOM VIA WINTER BY WINTER.

3. DATE: 5/28/03

5. PREOPERATIVE EMOTIONAL STATUS
   COMMENTS: LANGUAGE BARRIER

6. NURSING PERSONNEL
   ASSIGNED SCRUB
   ASSIGNED CIRCULATOR

7. POSITION AND POSITIONAL AIDS (Specify)
   REFERENCES
   LATERAL:  

8. SKIN PREPARATION
   HAIR REMOVAL
   DONE BY:  
   METHOD:  

9. LOCATION OF EXTERNAL DEVICES

10. COUNTS
    SPONGE:  
    NEEDLE (SHARP):  
    INSTRUMENT:  
    OTHER:  

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

12. ELECTROSURGERY DEVICE(S) (ESU) YES NO
    GROUND PAD:  
    BRAND:  
    LOT NO:  
    BIPOLAR NO:  

MEDCOM - 3178
13. Prosthesis, Implants: □ Yes □ No
   If Yes: Name, ID Number, Manufacturer

14. Irrigation/Medications Given in Operating Room (Not by Anesthesia)

   Medications/Solution:
   Dosage: 
   Time: 
   Method: 
   Prepared By: 
   Given By: 

   Wound Irrigation: □ Yes □ No, Type(s):

OTHER ORDERS

Physician's Signature: [Signature]

15. X-Ray in Operating:
   Yes □ No □
   If Yes, Site:

16. Laboratory Specimens

   Specimen(s): Name
   Frozen Section (FS): Name
   Culture (C): Name
   Name: Name

17. Tubes, Drains/Packing:
   Type/size: 1. 
   2. 
   3.
   Site: 1.
   2.
   3.

18. Dressing/Immobilization (Specify):

19. Additional Information

20. Operation(s) Performed:
   [Described: Wound]

21. Patient Transferred To: [Name]
   Time: [Time]
   Method: [Method]

22. Registered Nurse Signature: [Signature]

Reverse of DA Form 5179-T, Oct 8.
5. PREOPERATIVE EMOTIONAL STATUS

COMMENTS: Language Barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB [Barred]

RELIANCE SCRUB [Barred]

ASSIGNED CIRCULATORY

RELIANCE CIRCULATORY

7. POSITION AND POSITIONAL AIDS (Specify)

Supine

Lithotomy

Prone

Kraske

Lateral: No

Left Side Up

Right Side Up

COMMENTS: Ambuloids

8. SKIN PREPARATION

HAIR REMOVAL

DONE BY: [Barred]

METHOD: [Barred]

PREP SOLUTION (Specify): Tetradine

BY WHOM: [Barred]

COMMENTS: No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES

[Diagram of body with annotations]

LEGEND: X Ground Pad — Safety Strap — = = Tourniquet

10. COUNTS

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Other**</th>
<th>First Closing Count</th>
<th>Final Closing Count</th>
<th>SCRUB</th>
<th>CIRCULATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needle Sharp</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instrument</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

[Field left blank]

12. ELECTROSURGERY DEVICE(S) (ESU)

YES [Barred]

[Fields left blank]

DA FORM 5179-1, OCT 87

MEDCOM - 3180
13. PROSTHESIS, IMPLANTS ☐ YES □ NO
   IF YES NAME: ID NUMBER, MANUFACTURER

14. MEDICATIONS/ORDERS
   IRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA):
   YES ☐ NO □

<table>
<thead>
<tr>
<th>MEDICATION/SOLUTION</th>
<th>DOSAGE</th>
<th>TIME</th>
<th>METHOD</th>
<th>PREPARED BY</th>
<th>GIVEN BY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| WOUND IRRIGATION    ☐ YES □ NO, TYPE(S):
|                     |        |      |        |             |          |
| OTHER ORDERS        TIME | CARRIED OUT BY |
|                     |          |      |        |             |          |
| PHYSICIAN'S SIGNATURE |    |

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

16. LABORATORY SPECIMENS
   SPECIMEN(S) ☐ YES □ NO
   NAME
   NAME
   FROZEN SECTION (FS) ☐ YES □ NO
   NAME
   NAME
   CULTURE (C) ☐ YES □ NO
   NAME
   NAME
   NAME

17. TUBES, DRAINS/PACKING
   TYPE/SIZE
   SITE

18. DRESSING/IMMOBILIZATION (Specify)
   [signature]

19. ADDITIONAL INFORMATION
   [signature]

20. OPERATION(S) PERFORMED
   [signature]

21. PATIENT TRANSFERRED TO
   TIME METHOD

22. REGISTERED NURSE SIGNATURE
   RN/BSN

REVERSE OF DATA FORM STUDY OCT 8.
MEDCOM - 3181
## Medications/Orders

<table>
<thead>
<tr>
<th>Medications/Solution</th>
<th>Dosage</th>
<th>Time</th>
<th>Method</th>
<th>Prepared By</th>
<th>Given By</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Wound Irrigation**  
NSS

**Other Orders**

**Physician's Signature**  
LT C MC

**X-ray in Oper.**

**Laboratory Specimens**

<table>
<thead>
<tr>
<th>Specimen(s)</th>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tubes, Drains/Packing**

<table>
<thead>
<tr>
<th>Type/Size</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Fa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

Fa

**Operations Performed**

E+D or T Aka

**Patient Transferred to**

Time: 14/2  
Method: Litter

**Recipient Signature**

LRNB8N1LT
1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER BY [signature]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [signature] [date]

3. DATE [date]
TIME PATIENT ARRIVED IN SUITE [time]

4. PATIENT IN ROOM TIME [time]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: [language barrier]

6. NURSING PERSONNEL

<table>
<thead>
<tr>
<th>ASSIGNED SCRUB</th>
<th>RELIEF SCRUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>[signature]</td>
<td>[signature]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSIGNED CIRCULATOR</th>
<th>RELIEF CIRCULATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>[signature]</td>
<td>[signature]</td>
</tr>
</tbody>
</table>

7. POSITION AND POSTURAL AIDS (Specify)

- SUPINE
- LITHOTOMY
- PRONE
- KRAKSE

LATERAL: [LEFT SIDE UP]
[RIGHT SIDE UP]

COMMENTS: [board]

8. SKIN PREPARATION

<table>
<thead>
<tr>
<th>HAIR REMOVAL</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>DONE BY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>METHOD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEPILATORY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAZOR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLIP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PREP SOLUTION (Specify): Betadine

BY WHOM: [signature] [date]

COMMENTS: 

9. LOCATION OF EXTERNAL DEVICES

- No adverse reaction to prep

LEGEND

- X Ground Pad
- Safety Strap
- Tourniquet

10. COUNTS

<table>
<thead>
<tr>
<th>Sponge</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle Sharp</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Instrument</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Other</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

C = Correct
I = Incorrect

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

12. ELECTROSURGERY DEVICE(S) (ESU)

- YES
- NO

ESU NO: [number]
GROUND PAD: [brand]
LOT NO: [number]

ESU NO: [number]
GROUND PAD: [brand]
LOT NO: [number]

BIPOLAR NO: [number]
## Prosthesis, Implants

- **PROSTHESIS, IMPLANTS**
  - **Y.**
  - **NO**

### Medications/Orders

<table>
<thead>
<tr>
<th>MEDICATION/SOLUTION</th>
<th>DOSAGE</th>
<th>TIME</th>
<th>METHOD</th>
<th>PREPARED BY</th>
<th>GIVEN BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ma</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Wound Irrigation**
- **YES**
- **NO, TYPE(S):** NSS

### Other Orders
- **Ma**

### Physician's Signature
- **LTCMC**

### X-Ray in Op
- **YES**

### Laboratory Specimens

<table>
<thead>
<tr>
<th>SPECIMEN (S)</th>
<th>NAME</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frozen Section (FS)</td>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Culture (C)</td>
<td>Name</td>
<td>Name</td>
</tr>
</tbody>
</table>

### Tubes, Drains/Packing
- **YES**

<table>
<thead>
<tr>
<th>TYPE/SIZE</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITE</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
</tbody>
</table>

### Dressing/Immobilization (Specify)
- **Gauze Urapey Kelly / Peg Stackenett**

### Additional Information
- Foley indwelling Huno to entering OR

### Operation(s) Performed
- Debridement/Inspection @ AKA

### Patient Transferred To
- **1700**

### Signature
- **RNBWNLT**

**Operation Date:** 10-09-06
**Location:** MEDCOM - 3185
5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: languagebarcer

6. NURSING PERSONNEL

- ASSIGNED SCRUB
- RELIEF SCRUB

- ASSIGNED CIRCULATOR
- RELIEF CIRCULATOR

7. POSITION AND POSITIONAL AIDS (Specify)

- SUPINE
- LITHOTOMY
- PRONE
- KRASKE

COMMENTS: ambulcarts

8. SKIN PREPARATION

- HAIR REMOVAL
- YES
- NO

- DONE BY:
- METHOD:
- DEPILATORY
- RAZOR
- NURSING UNIT
- CLIP

- PREP SOLUTION (Specify)
- BEPANSHIP

- SITE: N/A
- SITE BY WHOM: N/A

COMMENTS: Reaction to Prep

9. LOCATION OF EXTERNAL DEVICES

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

10. COUNTS

<table>
<thead>
<tr>
<th></th>
<th>C</th>
<th>I</th>
</tr>
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<tbody>
<tr>
<td>Sponge</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Needle Sharp</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Instrument</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other</td>
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<td>No</td>
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</table>

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

12. ELECTROSURGERY DEVICE(S) (ESU)

- YES
- NO

- ESU NO:
- GROUND PAD:
- BRAND:
- LOT NO:

- ESU NO:
- GROUND PAD:
- BRAND:
- LOT NO:

- BIPOLAR NO:

DA FORM 5179-1, OCT 87
REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 3186
14. PROSTHESIS, IMPLANTS

15. X-RAY IN OPERATING ROOM

16. LABORATORY SPECIMENS

17. TUBES, DRAINS, PACKING

18. DRESSING/IMMOBILIZATION (Specify)

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO

MEDCOM - 3187
<table>
<thead>
<tr>
<th>MEDICATIONS/SOLUTION</th>
<th>DOSAGE</th>
<th>TIME</th>
<th>METHOD</th>
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<th>GIVEN BY</th>
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</tbody>
</table>

WOUND IRRIGATION

- **YES**
- **NO**: TYPE(S): NSS

OTHER ORDERS

- **YES**: TIME | CARRIED OUT BY

PHYSICIAN'S SIGNATURE: L.T. C.

X-RAY IN OPERATING ROOM

- **YES**: IF YES, SITE

LABORATORY SPECIMENS

- **YES**: NAME
- **NO**: NAME

FROZEN SECTION (FS)

- **YES**: NAME
- **NO**

CULTURE (C)

- **YES**: NAME
- **NO**: NAME

19. DRESSING/IMMOBILIZATION (Specify)

TUBES, DRAINS/PACKING

- **YES**: TYPE/SIZE 1. 2. 3.
- **NO**: 1. 2. 3.

ADDITIONAL INFORMATION

OPERATION(S) PERFORMED: Debridement

PATIENT TRANSFERRED TO: ICU

METHOD: W-10

REGISTERED NURSE SIGNATURE: RNBSNJIT

REVERSE OF DA FORM 519-1, OCT 87

MEDCOM - 3189
**MEDICAL RECORD**

1. **PATIENT TRANSPORTED TO OPERATING ROOM VIA litter**

2. **PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED**

3. **DATE**

4. **TIME PATIENT ARRIVED IN SUITE**

5. **TIME PATIENT IN ROOM**

6. **PREOPERATIVE EMOTIONAL STATUS**

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

   **COMMENTS:**

7. **NURSING PERSONNEL**

   **ASSIGNED SCRUB**

   **ASSIGNED CIRCULATOR**

   **RELIEF SCRUB**

   **RELIEF CIRCULATOR**

8. **POSITION AND POSITIONAL AIDS (Specify)**

   - [ ] SUPINE  [ ] LITHOTOMY  [ ] PRONE  [ ] KRAKSE  [ ] LATERAL:  [ ] LEFT SIDE UP  [ ] RIGHT SIDE UP

   **COMMENTS:**

9. **SKIN PREPARATION**

   **HAIR REMOVAL:**

   - [ ] YES  [ ] NO

   **DONE BY:**

   **METHOD:**

   **DEPILATORY**  **RAZOR**

   **NURSING UNIT**

   **PREP SOLUTION (Specify):**

   **SITE:**

   **BY WHOM:**

   **COMMENTS:**

10. **LOCATION OF EXTERNAL DEVICES**

11. **PATIENT IDENTIFICATION**

12. **ELECTROSURGERY DEVICE(S) (ESU)**

   - [ ] YES  [ ] NO

   **GROUND PAD:**

   **BRAND:**

   **LOT NO:**

   **ESU NO:**

   **GROUND PAD:**

   **BRAND:**

   **LOT NO:**

   **BIPOLAR NO:**

---

**DA FORM 5179-1, OCT 87**

REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

**MEDCOM - 3192**
14. MEDICATIONS/ORDERS

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<th>TIME</th>
<th>METHOD</th>
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<th>GIVEN BY</th>
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<tbody>
<tr>
<td>Dextrose</td>
<td>1 gm</td>
<td>Intreg</td>
<td>Intravenous</td>
<td>Nurse</td>
<td>Surgeon</td>
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WOUND IRRIGATION

- Yes  
- Type(s): Dextrose 1 gm LR

OTHER ORDERS

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PHYSICIAN'S SIGNATURE

16. X-RAY IN OPERATING ROOM

- Yes

16. LABORATORY SPECIMENS

<table>
<thead>
<tr>
<th>SPECIMEN(S)</th>
<th>NAME</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Frozen Section (FS)</td>
<td></td>
<td>NAME</td>
</tr>
<tr>
<td>Yes</td>
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<td>Culture (C)</td>
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<td>NAME</td>
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17. TUBES, DRAINS/PACKING

<table>
<thead>
<tr>
<th>TYPE/SIZE</th>
<th>SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Na</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
</tbody>
</table>

18. DRESSING/IMMOBILIZATION (Specify)

- Xeroferrin
- Sponge
- Tape

19. ADDITIONAL INFORMATION

Polyinserted prior to entering O.R.

20. OPERATION(S) PERFORMED

- Debridement/wound closure @ leg

21. PATIENT TRANSFERRED TO

- Teller

- Time: 11:40

- Method: bitten

- RN: BSN 1ST
### MEDICATIONS/ORDERS

<table>
<thead>
<tr>
<th>MEDICATION/SOLUTION</th>
<th>DOSAGE</th>
<th>TIME</th>
<th>METHOD</th>
<th>PREPARED BY</th>
<th>GIVEN BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anectra</td>
<td>1 gm</td>
<td>intraperitoneal</td>
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</tbody>
</table>

**WOUND IRRIGATION**

- Yes: Anecra/LNA

**OTHER ORDER**

- Neosporin

**PHYSICIAN'S SIGNATURE**

LTC M S

### LABORATORY SPECIMENS

- Specimen(s): Yes
- Frozen Section (FS): Yes
- Culture (C): Yes

**NAME**

- NAME

**DRESSING/IMMOBILIZATION (Specify)**

- Keratinize/Cover/Axis

### ADDITIONAL INFORMATION

- They inserted prior to entering O.R.

### OPERATION(S) PERFORMED

- Modifier and AKA

### PATIENT TRANSFERRED TO

- Time: 12:35
- Method: 

**RECOMMENDED SIGNATURE**

- RNBSND "C"

---

**MEDCOM - 3195**
1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER

2. PATIENT IDENTIFIED: RECORD REVIEWED AND CORRECTED BY

3. DATE: 10/02 1917

4. PATIENT IN ROOM TIME 1917

5. PREOPERATIVE EMOTIONAL STATUS
   - CALM
   - ANXIOUS
   - EXCITED
   - CRYING
   - ANGRY
   - WITHDRAWN
   - OTHER (Specify)
   COMMENTS: intubated

6. NURSING PERSONNEL
   - ASSIGNED SCRUB: O/D (2)
   - RELIEF SCRUB: W/P
   - ASSIGNED CIRCULATOR: RN (2)
   - RELIEF CIRCULATOR: O/D

7. POSITION AND POSITIONAL AIDS (Specify)
   - SUPINE
   - LITHOTOMY
   - PRONE
   - KIRK PERSK
   LATERAL: "I/G
   COMMENTS: "N/A

8. SKIN PREPARATION
   - HAIR REMOVAL: "YES"
   - DONE BY: "N/A"
   - METHOD: "CLIP"
   - PREP SOLUTION (Specify): "BETADINE"
   - SITE: "LEG"
   - BY WHOM: "N/A"
   COMMENTS: "N/A"

9. LOCATION OF EXTERNAL DEVICES

10. COUNTS
    - SPONGE: "YES"
    - NEEDLE SHARP: "YES"
    - INSTRUMENT: "YES"
    - OTHER: "YES"

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

12. ELECTROSURGERY DEVICE(S) (ESU)
    - YES
    - ESU NO: 000999
    - GROUND PAD: BRAND
    - LOT NO: 5866/37/12
    - BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.
USAPA V1.00
MEDCOM - 3196
### 14. IRRIGATION/MEDICATIONS/ORDERS

<table>
<thead>
<tr>
<th>MEDICATION/SOLUTION</th>
<th>DOSAGE</th>
<th>TIME</th>
<th>METHOD</th>
<th>PREPARED BY</th>
<th>GIVEN BY</th>
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</thead>
<tbody>
<tr>
<td>Antiseptic</td>
<td>1 gm</td>
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<tr>
<td>WOUND IRRIGATION</td>
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</table>

**OTHER ORDERS**

**PHYSICIAN'S SIGN**

**15. X-RAY IN OPERATING ROOM**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

**16. LABORATORY SPECIMENS**

<table>
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<tbody>
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<td>Leg</td>
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**17. TUBES, DRAINS/PACKING**

<table>
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<tr>
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<th>SITE</th>
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<tbody>
<tr>
<td>Sponge</td>
<td>Rough</td>
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</tbody>
</table>

**18. DRESSING/IMMOBILIZATION (Specify)**

*Rough = 2 lap sponges*  
*Kevin I PE*  
*Start 19:16 Total time = 71 mins*

**19. ADDITIONAL INFORMATION**

*Leg tourniquet On 19:16, down 19:34*  
*Two sponges inserted prior to entering O.R.*

**20. OPERATION(S) PERFORMED**

Hemorrhage

**21. PATIENT TRANSFERRED TO**

<table>
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<tr>
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<th>TIME</th>
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<tr>
<td>RN, BSN, LT</td>
<td>2040</td>
<td>Litter</td>
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<tr>
<td>DATE</td>
<td>PATIENT'S NAME</td>
<td>T</td>
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<tr>
<td>11 Aug 62</td>
<td>UNIT #1</td>
<td>100.1</td>
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<td>UNIT #2</td>
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<td>UNIT #3</td>
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**WARD**

**DATE**

**11 Aug 62**
### Neurological Observations

<table>
<thead>
<tr>
<th>Procedure</th>
<th>12-8</th>
<th>4-12</th>
<th>7-4</th>
<th>Spontaneous</th>
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<tbody>
<tr>
<td>Eyes Open</td>
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<tr>
<td>Oral Response</td>
<td>G</td>
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<tr>
<td>Motor Response</td>
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<tr>
<td>Pupils R (size)</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>None</td>
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<td>Pupils L (size)</td>
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<tr>
<td>N.R. - non reactive</td>
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<tr>
<td>SR - slow</td>
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<tr>
<td>Breath Sounds</td>
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<tr>
<td>Sputum Character</td>
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<td>Nasal Endotracheal Suction Q</td>
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<td>Vent. / e</td>
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<td>E.T. Tube Q</td>
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<td>Gulf / Intrac</td>
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<td>G.T. Strip &amp; Vent Q</td>
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<td>G.T. Fluoroscint / cm.</td>
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<td>Circ. Distal to A-Line</td>
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<tr>
<td>P/F/ Family Teaching/Support</td>
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### Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>12-8</th>
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<th>7-4</th>
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<tbody>
<tr>
<td>Bowel Sounds</td>
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<tr>
<td>ABD Size/Firmness</td>
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<td>H.G. Secure/Proper Pos.</td>
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<td>Patency Q4</td>
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<td>Aspirate Cortisone, Feed Q4</td>
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<td>Aspirate Prior to Bolus Feed</td>
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<td>Stool Chor/Gelatin</td>
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<td>Urine Color/Character</td>
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<tr>
<td>Bath</td>
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<tr>
<td>Turn &amp; Position Q</td>
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<tr>
<td>Skin Care</td>
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<td>Mouth Care</td>
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<tr>
<td>Trach / E.T. Care</td>
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<tr>
<td>H/O/M</td>
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<tr>
<td>Danglo</td>
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<td>Restraint Relesed Q2H</td>
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<tr>
<td>O2 to Chair</td>
<td></td>
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<tr>
<td>Ambulation</td>
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<tr>
<td>Side Hauls</td>
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</tr>
<tr>
<td>Drench, A</td>
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</tr>
<tr>
<td>Drench, A</td>
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### Relevant Notes

- **ADDRESSOGRAPH**
  - **PF**: (?) (?)(?) (?)
  - **MEDCOM**: 3206
### STAT LABORATORY DATA

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<tr>
<th>Time</th>
<th>Glucose</th>
<th>BUN/CREA</th>
<th>Na+</th>
<th>K+</th>
<th>Cl-</th>
<th>HCO3-</th>
<th>WBC</th>
<th>Hb/Hct</th>
<th>PLT</th>
<th>PT/PTT</th>
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<tbody>
<tr>
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</tbody>
</table>

**Time**
- 07:00: Tylenol 650mg PO
- 09:00: Tylenol 650mg PO
- 11:00: Tylenol 650mg PO
- 15:00: Tylenol 650mg PO
- 17:00: Tylenol 650mg PO
- 21:00: Tylenol 25mg IV
- 23:00: Zofran 50mg IV
- 01:00: Zofran 50mg IV
- 02:00: Zofran 25mg IV

**One-Time/PRN Medications**
- 03:00: Fentanyl 50mcg IV
- 05:00: Fentanyl 50mcg IV

### SIGNATURE AND INITIALS
- Physician: [Signature]
- Pharmacist: [Signature]

### Notes:
- Tylenol 325mg x 6 tablets
- Fentanyl 50mcg IV Q8HR
- Zofran 25mg PO x 3 tablets
250 - VS 100+F, HR 114, RR regular, 18 even and normal, lungs clear, bilateral, 1/4/21. Pulse oximetry 96%.

IV site (C) arm + (R) shoulder patent without blood running.

NS 100 cc/hr, O2 1 L via nasal cannula. No tube in face. Foley catheter draining yellow urine.

D350 - 17 units of blood given, H+H 2/4.

D500 - 3rd unit of blood given, H+H 2/4.
<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>OBSERVATIONS</th>
<th>TREATMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME</td>
<td>7 - 4</td>
<td>4 - 12</td>
</tr>
</tbody>
</table>

**NEUROLOGICAL**

- Eyes Open
  - Checked by something else
  - 4
- Verbal Response
  - Size M
  - 4
- Motor Response
  - Size L
  - 2

**Breath Sounds**

- Cough
  - No
- O2
  - 2

**Sputum Character**

- Nasal Endotracheal Suctioned O
  - Yes
- Chest PT O
  - No
- CDBAS O
  - No
- Vent. Y's
  - Yes
- E.T. Tube O
  - Yes
- Cuff IP/loc/e
  - Yes
- C.T. Strip & Vent O
  - Yes
- C.T. Fluids
  - U cm.
- Peripherical Supplies
  - U cm.
- Circ. Distal to A-Line
  - L
- Monitor Alarm Ca
  - PA Line
- CVP/Outer
  - Art. Line
  - Peripheral
  - Peripheral
- PT/Family Teaching/Support

**PULSE CODE**

- DOPPLER
  - D
- PALPABLY
  - P
- STRONG
  - S
- WEAK
  - W
- ABSENT
  - A
- FLEETING
  - F

**PROCEDURES**

- Bowel Sounds
  - 4
- ABG Sins/Firmness
  - 4
- NS Secure/Proper Pos.
  - 4
- Patent O
  - 4
- Aspirate Cont. Feed Q4
  - 4
- Aspirate Prior to Bolus Feed
  - 4
- Stool Char/Gluco
  - 4
- Urine Color/Character
  - 4
- Foley Secure/Patent
  - 4
- External Cath.
  - 4
- Catheter Care
  - 4
- Colostomy/Resection Care
  - 4
- Bath
  - 4
- Turn & Position O
  - 4
- Skin Care
  - 4
- Mouth Care
  - 4
- Trach/E.T. Care
  - 4
- ROM
  - 4
- Dangle
  - 4
- Restraints Released O2H
  - 4
- OOB to Chair
  - 4
- Ambulation
  - 4
- Side Rails
  - 4
- Drying
  - 4

**ADDRESS GRAPH**
07:20 - Pt. Rosen, C/M: 140/90, 13,800 15, 122 123 38
Pt. clear/Jan. 8:00 9:30, 2:40, 12:00, 3:00
Pt. stable on 3L, N/V. Exam: D. 1700 17 136 12 10 164
Pt. clear/Jan. 8:00 9:30, 12:00, 3:00
<table>
<thead>
<tr>
<th>Time</th>
<th>Drug/Dose</th>
<th>Route</th>
<th>Init.</th>
</tr>
</thead>
<tbody>
<tr>
<td>03:45</td>
<td>MSO4 3mg</td>
<td>IV</td>
<td>(b)(8)</td>
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<tr>
<td>09:30</td>
<td>MSO4 4mg</td>
<td>LV</td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td>MSO4 5mg</td>
<td>IV</td>
<td></td>
</tr>
<tr>
<td>14:45</td>
<td>MSO4 5mg</td>
<td>IV</td>
<td></td>
</tr>
<tr>
<td>16:00</td>
<td>MSO4 5mg</td>
<td>IV</td>
<td></td>
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<tr>
<td>17:00</td>
<td>MSO4 5mg</td>
<td>IV</td>
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</tr>
<tr>
<td>20:00</td>
<td>MSO4 5mg</td>
<td>IV</td>
<td></td>
</tr>
<tr>
<td>22:00</td>
<td>MSO4 5mg</td>
<td>IV</td>
<td></td>
</tr>
</tbody>
</table>

Proposed 5-50 mcg/kg/min

Time: 12:00
MSO4 5mg q4h PRN
LIT @ 125 cc/hr

Signature and Initials:
NURSE / THERAPY: (b)(6)-2

[Provided by: MEDCOM - 3213]
NURSING PROGRESS NOTE

2130 - Pt C 88.30 - O/T Threading P/20 220 220 220

Pt appears clear mentally. Lt. sounds clear HR 110
SpO2 92% ABG 94/62 Pt having to cutting clamps
Further questioning Pt appears to be in left COPD
Pt. Depressed Stupor Pk (R) 220 220 220
Left arm on transfusion arm, Pt. requested AB 10.00 am

27/04. Pt transferred to floor

advised of Tum

MEDCOM - 3214
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>05:00</td>
<td>Pt stable on vent/current settings per Dr order: RR 10</td>
</tr>
<tr>
<td></td>
<td>VT 75 D FI O₂ 40% wearing protocol started ETT 8.0</td>
</tr>
<tr>
<td>06:30</td>
<td>Due to weaning switched to SIMV per Dr. E</td>
</tr>
<tr>
<td>06:30</td>
<td>Room V, FIO₂ 135%</td>
</tr>
<tr>
<td>07:35</td>
<td>Weaning protocol made to CPAP. A/D 30 min</td>
</tr>
<tr>
<td>08:20</td>
<td>Pt extubated, placed on humidified 3L NC, O₂ 14%</td>
</tr>
<tr>
<td>08:28</td>
<td>Ob 14% BS clear/dim</td>
</tr>
<tr>
<td>16:00</td>
<td>Pt stable on supplemental O₂ humidified 3L NC, O₂ 14%</td>
</tr>
<tr>
<td>18:00</td>
<td>Pt stable on 3L NC + O₂ 22% RR 23, SAT 99 BS clear/dim</td>
</tr>
<tr>
<td>21:27</td>
<td>Pt stable on 3L NC + humidified O₂ 23% RR 23, SAT 98 BS clear/dim</td>
</tr>
<tr>
<td>23:10</td>
<td>Pt stable/sleeping 2.5L NC humid + O₂ 23% RR 25, SAT 94 BS clear/dim</td>
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</tbody>
</table>
**Respiratory Support System**

<table>
<thead>
<tr>
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<th>05</th>
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<th>07</th>
<th>08</th>
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<tr>
<td>Volume set, mln/ breath⁻¹</td>
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<td>Rate secon⁻¹</td>
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<td>P. Support, cmH₂O</td>
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<td>Peak Airway Pressure</td>
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**Blood Gas Laboratory Values**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Source (A or V)</td>
<td>(1.35)</td>
</tr>
<tr>
<td>pH</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{PaCO}_2), mmHg</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{PaO}_2), mmHg</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{HbA}1c), Vol %</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{HCO}_3), mmol/L</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{BE}), mmol/L</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{Hb}), g/dL</td>
<td>(\text{NOT TESTED})</td>
</tr>
<tr>
<td>(\text{WBC}), /μL</td>
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<tr>
<td>(\text{Ca}++), mmol/L</td>
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<tr>
<td>(\text{Na}+), mmol/L</td>
<td>(\text{NOT TESTED})</td>
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<tr>
<td>(\text{K}+), mmol/L</td>
<td>(\text{NOT TESTED})</td>
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<tr>
<td>(\text{Cl}⁻), mmol/L</td>
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<tr>
<td>Temperature (\text{PCO}_2)</td>
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<tr>
<td>Toh-Art (\text{PCO}_2)</td>
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**On-Line Parameters**

<table>
<thead>
<tr>
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<th>Value</th>
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<tbody>
<tr>
<td>Pulse Oximeter (\text{SaO}_2)</td>
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<tr>
<td>Oximeter (\text{SvO}_2)</td>
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**PT NUMBER**

MEDCOM - 3216
**NEUROLOGICAL**

<table>
<thead>
<tr>
<th></th>
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<th>4 - 12</th>
<th>12 - 8</th>
<th>SEE CODE</th>
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<tr>
<td>Eyes Open</td>
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<tr>
<td>Eye Motility</td>
<td>G</td>
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<tr>
<td>Motor Response</td>
<td>G</td>
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</tr>
<tr>
<td>Pupils</td>
<td>Size R</td>
<td>Reaction</td>
<td></td>
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<tr>
<td>R - react</td>
<td></td>
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<tr>
<td>N.R. - non</td>
<td></td>
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<tr>
<td>S.R. - slow</td>
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<tr>
<td>Grasp</td>
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<tr>
<td>Extremity</td>
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</tbody>
</table>

**Sputum Character**

- ______

**Nasal Endotracheal suctioning Q**

- ______

**Chest PT Q**

- ______

**CO2/S O**

- ______

**Vent. s/a**

- ______

**E.T. Tube @**

- ______

**Cuff #/Predc's**

- ______

**C.T. Strip & Vent Q**

- ______

**C.T. Fluoros**

- ______

**Peripheral Puls**

- ______

**Circ. Distal to A-Line**

- ______

**Monitor Alarm On**

- ______

**PA Line**

- ______

**CVP/Other**

- ______

**Art Line**

- ______

**Periphery**

- ______

**Peripherals**

- ______

**PT/Family Teaching/Support**

- ______

**PROCEDURES**

<table>
<thead>
<tr>
<th>TIME</th>
<th>PROCEDURES</th>
<th>OBSERVATIONS</th>
<th>TREATMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 - 4</td>
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<td>12 - 8</td>
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</table>

**PROCEDURES**

<table>
<thead>
<tr>
<th>TIME</th>
<th>PROCEDURES</th>
<th>OBSERVATIONS</th>
<th>TREATMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b)(6)</td>
<td></td>
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</tbody>
</table>

**OBSERVATIONS**

- To Speech: 3
- To Pain: 2
- None: 1
- Bowel Sounds: 2
- ABD Size/Firmness: 2
- NG Secure/Proper Pos: 2
- Patency Q4: 2
- Aspirate cont/o. Feed Q4: 2
- Aspirate prior to BoliFeed: 2
- Stool Chal/Guela: 2
- Urine Color/Character: 2
- Foley Secure/Patient: 2
- Extension to Pain: 2
- External Cath: 2
- Catheter Care: 2
- Colostomy/Ileostomy Care: 2
- Bath: 2
- Turn & Position Q: 2
- Skin Care: 2
- Mouth Care: 2
- Trach/E.T. Care: 2
- ROM: 2
- Dangle: 2
- Restraints Released Q2H: 2
- OOS to Chair: 2
- Ambulation: 2
- Side Rails: 2
- Draping: Δ
- Draping: Δ

**TREATMENTS**

- Spontaneous: 4

**PULSE CODE**

- DOPPLER: 2
- PALPABLE: 2
- STRONG: 2
- WEAK: 2
- ABSENT: 2

**ADDRESSOGRAPH**

MEDCOM - 3217