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WAR RELOCATION AUTHORITY

MANUAL
OF
HEALTH SERVICE RECORDS
FOR
USE ON PROJECTS

INTRODUCTION

The records enclosed in this folder relate mostly to hospital and clinic operation. Primarily, they are concerned with recording care given to individuals. Some, however, are service forms to facilitate actual hospital and out-patient operation and maintenance. You will note that certain records are strictly for out-patient use; other records are strictly for in-patient use; and some may be used for both purposes. Additional records, obviously necessary in the operation of the health services, will be made available as soon as possible. The records enclosed were considered of major importance.

A brief description accompanies each record. While the purpose and method of use of many of the records is obvious it was recognized that in some instances additional description was necessary. It is hoped that with the information contained herein that the records will prove convenient to you in recording significant facts and in expediting necessary procedures in the operation of the health service.

Your comments after use of these records for several months will be greatly appreciated in order that improvements may be made before reprinting is ordered.

These records were finally adopted after much study. Forms used by the U. S. Army Medical Department, by the United States Public Health Service Marine Hospitals, by the United States Indian Service hospitals, and by the Wartime Civil Control Administration in the Assembly Centers were reviewed and followed to a considerable extent. Preliminary drafts were reviewed by and altered to incorporate suggestions of several project medical and nursing staffs. We also had the benefit of comment of both Assembly Center and Relocation Project staffs after their use of the WCCA forms.

Frequently it was necessary to combine several forms in the interest of printing economy.

All forms designed to become part of the patient's permanent record are on 8½" x 11" paper and were arranged for binding at the top margin with identification data at the bottom of the page. No hospital number, out-patient number, or serial number is used, the individual's identification number being used exclusively.

Perhaps a statement summarizing the thoughts of those who contributed to the development of these forms will be helpful to you.

In developing these forms it was the intention to have convenient working forms based on actual service rendered rather than on any theoretical plan. Also, it was the general plan that all patients' records would be filed in one place, the hospital's Central Chart Room. A few exceptions to this general rule were recognized as being desirable in certain projects, namely: Immunization Record, Dental Record, and the Minor Ailment Record. Whenever a patient's record leaves the Central Chart Room the person in charge should make a proper notation of its destination and who is responsible.

Medical service to individuals at the project, by necessity of living accommodations, varies considerably from that of the normal community. It includes two distinct types of service usually available in the normal American community. One is the type usually obtained through hospital In-Patient Service, through hospital Out-Patient Departments or clinics, or through private physicians' offices. The other is the home remedy type usually of minor nature which is obtained in the individual's own home often without the visit of a physician, and sometimes prescribed from the local drug store. On the project the following distinct types of services to individuals appeared clear:

1. In-Patient Service. This service includes hospitalization of patients on the usually accepted grounds, and also includes an infirmary type of service for minor illness.

2. Out-Patient Department Service. This service involves the operation of regularly scheduled diagnostic, treatment, and preventive clinics as often as the need requires and the staff can attend. These clinics should operate on an appointment basis, patients being referred from the In-Patient Service, the Sick Call Service, the Emergency Room Service, or the Home Service.

3. Sick Call Service. This service may be considered equivalent to the daily sick call of the Army and to a large extent should be able to adequately provide for the care of minor ailments. Sick Call Clinic should be scheduled regularly, and as often each day and at as many points of the project as necessary and feasible. To assist in this service each school building was designed with a health room. The school health room was conceived not only for school use but also for community use. It could be utilized very well in the Sick Call Service. At some projects a section of one of the regular barrack buildings is being utilized. In a few instances dispensary buildings have been erected. The record designed for use of this service is

short and simple. It is believed that full and proper use of this type of service will meet not only the health needs of the evacuees, but also prevent needless crowding of the regular type Out-Patient Clinics with patients whose diagnoses and therapy are obviously simple.

4. Emergency Room Service. This service is available on 24-hour basis as needed. It will provide service for accidents and for the more serious cases reported at times when the Out-Patient Department or Sick Call Service is closed.

5. Home Service. This service is available on 24-hour basis as needed. While it should be kept at a minimum, there will be homes requiring the call of a physician before proper disposal of a particular medical problem can be made.

In order that the medical service may operate with greatest efficiency all evacuees, so far as possible, should report the onset of their illness at the regular sick call period. In this way the Emergency Room Service and the Home Service will not be overburdened, reserving them for real need; and the regular Out-Patient Department Clinics will not be overburdened with minor illness, reserving them for patients requiring more extensive study and treatment. At the sick call the patient will receive immediate consideration which may take the form of (1) immediate simple advice, prescription, or treatment, (2) referral with an appointment to a regular Out-Patient Clinic, (3) request for hospitalization, or (4) any combination. Patients seen in the Emergency Room or on a Home Service call will receive the necessary immediate care and then disposed of by (1) referral to an Out-Patient or Sick Call clinic, (2) request for hospitalization, or (3) discharged.

It is desirable for efficient use of patients' records that a definite order of arrangement be followed both for use of the records on the wards, in the Out-Patient service and also for final filing in the Central Chart Room. The sequence of Out-Patient records is most convenient when the same order is followed for Out-Patient use anf for Chart Room filing. For In-Patient records the sequence will vary from the wards to the Chart Room files.

Because all WRA records of patients' care will be permanently filed and some uniformity will be desired for all projects the following sequence is requested to be followed for In-Patient and Out-Patient forms when the patient's record is made ready for the Central Chart Room.

In-Patient Records Sequence for Filing

1. In-Patient Admission & Discharge Record
2. Consent to Care at Hospital
3. (a) Clinical History Record, or
   (b) Ante Partum Record, if used, or
   (c) Newborn Record, if used
4. Physical Examination Record
5. Ward's Surgeons Progress & Treatment Record
6. Laboratory Record
7. X-ray Report
8. Report of Anesthesia
9. (a) Surgery Record
   (b) Labor and Postpartum Record
10. Unusual Occurrence Report
11. Permit for Postmortem Examination
12. Autopsy Record
13. Doctor's Order Sheet
14. Temperature Chart
15. Bedside Record

Out-Patient Records Sequence for Filing and For Use in Out-Patient Service

1. (a) Dispensary Minor Ailment Record, if used
   (b) Clinical History Record, if used, or
   (c) Ante Partum Record, if used
2. Physical Examination Record
3. Out-Patient Progress Record
4. Laboratory Record
5. X-ray Report
6. Report of Anesthesia
7. Surgery Record
8. Unusual Occurrence Report
9. Public Health Nursing Record

For service on the Wards the following sequence of In-Patient records is suggested. Obviously, a full set of these records will not be needed for patients such as well newborns.

1. Temperature Chart
2. Doctor's Order Sheet
3. Bedside Record
4. In-Patient Admission & Discharge Record
5. Consent to Care at Hospital
6. (a) Clinical History Record, or
   (b) Ante Partum Record, if used, or
   (c) Newborn Record, if used
7. Physical Examination Record
8. Ward's Surgeons Progress & Treatment Record
9. Laboratory Record
10. Report of Anesthesia
11. Surgery Record
12. Labor and Postpartum Record
13. Unusual Occurrence Report
14. Permit for Postmortem Examination

The following persons contributed in the preparation and review of preliminary forms and in the drafting of the final records:

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Lauren Neher, M.D. - Minidoka Relocation Project
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TABLE OF CONTENTS

RECORDS

CONSENT TO CARE AT HOSPITAL, WRA-39

This form must be completed on every admission and signed by the patient. If the patient is a minor or is physically or mentally unable to sign for himself the nearest of kin should sign the record. In these instances when the patient cannot sign for himself and delay in locating the immediate relatives would be detrimental to the patient's subsequent care such care may be rendered without signed consent. When this condition prevails the facts pertaining should be recorded on the consent slip and signed by the admitting officer. However, the consent slip should be signed in the regular manner as soon as possible thereafter.

It is the responsibility of the admitting officer to see that this form has been completed on each admission. It is the responsibility of the operating surgeon to see that this form has been signed and included in the history before any surgery is performed upon a patient.

This form becomes a part of the patient's permanent record.

WRA-39

CONSENT TO CARE AT HOSPITAL

Consent to Care by or in Hospital

The undersigned consents to any and all medical and surgical treatment prescribed by the physician or surgeon attending

.....;

and to the administration of and/or performance of all necessary examination, treatments, anaesthetics and operations which may be necessary or advisable during (his) (her) (my) care as a patient in the hospital.

Agree to Remain Until Discharged

It is agreed that the said patient is to remain in the hospital until the attending physician in charge of the case recommends discharge. Should the patient leave without discharge, the following signer assumes all responsibility for any and all untoward results that may follow and not hold any blame therefor against the physician or the hospital.

SIGNATURE.....
(Patient)

.....

.....
(Relationship to patient)

.....
(Physician)

.....
(Witness)

DATE.....TIME.....

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET, S. F. 8-42 25M

IN-PATIENT ADMISSION AND DISCHARGE RECORD, WRA-40

The purpose of this form is to summarize the patient's entire In-Patient hospital record. The first physician examining the patient after admission will complete the top third of the form and sign it at that time. The rest of the record is to be completed and signed by the discharging physician.

This form becomes part of the patient's permanent record.

WRA-40

IN-PATIENT ADMISSION AND DISCHARGE

Project address of patient ..... Sex ..... Race .....

Birthplace ..... Date of birth: Day ..... Mo. ..... Yr. ..... Age .....

S ..... W .....

Religion ..... Marital state: M ..... D ..... Occupation: .....

In case of emergency notify .....
(Name) (Project address) (Relationship)

Main admitting diagnosis .....

.....

Date admitted ..... Signature ..... M.D.

Final Diagnosis	Diagnosis No.	Date of Diag.	Treated	Un-treated	Oper-ated	Condition on Disposition
1.						
2.						
3.						
4.						
5.						
Sequelae to major condition 1a						
1b						

State chief diagnosis on Line 1; other diagnosis in order of importance; include dental diagnosis.

Operation (Name)	Oper. No.	Anesthetic	Date of Operation	Name of Surgeon
1.				
2.				
3.				

Other significant summary and data—Recommendations .....

.....

.....

.....

.....

Discharged to .....

..... | ..... | ..... M.D.
(Date of discharge) (Hospital days) (Signature of discharging physician)

..... | .....
(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET, S. F. 8-42 25M

WRA-41

ADMISSION REPORT

Date..... Hour.....

..... | .....

(Surname of patient) (Given name) (Identification No.)

has been admitted to Ward.....

Bed..... on..... service by Dr.....

Admitting diagnosis.....

This copy for (check)

Chief Medical Officer..... Ward.....

Chief Nurse..... Admitting office.....

RECORDER-SUNSET. S. F. 8-42 125M Other.....

ADMISSION REPORT, WRA-41

This record is a report of the actual admittance of a patient and is intended to provide daily information to certain hospital staff. It is to be made out in quadruplicate or with additional copies if desired at the time of the patient's admission; one copy being sent to each of the following:

Chief Medical Officer
Chief Nurse
Ward
Admitting Office

(Other copies may be required --- one to business office, etc.). On each copy it should be indicated by check mark for whom the copy is intended.

This form is not intended to become part of the patient's permanent record.

DOCTOR'S ORDER SHEET, WRA-42

The orders given by physicians in regard to their patients are to be entered on this form with ordering time indicated. All orders, whether written by the physician or nurse, must bear the physician's signature. The nurse checking the doctor's orders will insert her initials with the exact time the order is checked.

This form becomes part of the patient's permanent record.

WRA-42

DOCTORS' ORDER SHEET

Ward..... Bed..... Diagnosis.....

Time Ordered		DOCTOR'S ORDER	Physician's Signature	Nurse's Initials. Time and date order checked
Date	Hour			

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 25M

WRA-42

DOCTORS' ORDER SHEET

Ward..... Bed..... Diagnosis.....

Time Ordered		DOCTOR'S ORDER	Physician's Signature	Nurse's Initials. Time and date order checked
Date	Hour			

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET. S. F. 8-42 25M

TEMPERATURE CHART, WRA-43

This is a usual hospital temperature chart providing for certain additional patient data in summary form. The accompanying form has been made out as a sample.

Your attention has already been called to the error in printing with regards to ploting temperatures. A series of 4 dots should have been printed instead of 3 dots between each set of horizontal parallel black solid lines. The chart is usable if one extra dot is inserted. Forms correctly printed are being obtained. Temperatures will then be easily recorded in either the Centigrade or Fahrenheit scale, depending on which type of thermometer has been made available to you.

This record becomes part of the patient's permanent record.

WRA-43

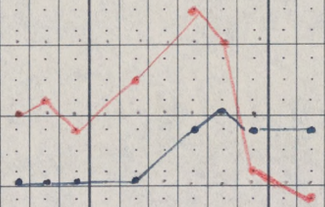
TEMPERATURE CHART

WARD Men's Surgical BED NO. 5

DATE	12-1-42	12-2-42	12-3-42	12-4-42	12-5-42	12-6-42	12-7-42
Day in Hospital	Admission	1	2	3	4	5	6
Day of Operation / Delivery		T & A	1	2	3	4	5
HOUR OF DAY	3 7 11 3 7 11	3 7 11 3 7 11	3 7 11 3 7 11	3 7 11 3 7 11	3 7 11 3 7 11	3 7 11 3 7 11	3 7 11 3 7 11 3

RESP. | PULSE | TEMP.

160 — 41 (105.8)
150
140 — 40 (104.0)
130
120 — 39 (102.2)
110
100 — 38 (100.4)
90
80 — 37 (98.6)
70
60 — 36 (96.8)
50
40 — 35



Respiration	18 16 18	18 20 18 18	16
Stools	1	1	
Fluid Intake	1500 cc	2000 cc	
Urine	800 cc	1000 cc	
Weight	120 lbs		
Blood Pressure	120/78	118/76	
Diet	Liquid	Liquid	Liquid

RED = Pulse BLACK = Temperature

Doe (SURNAME OF PATIENT) John (GIVEN NAME) A12360 IDENTIFICATION NUMBER

RECORDER-SUNSET, S. F. 6-42 50M

BEDSIDE RECORD, WRA-44

This record will be used by the nurse for all in-patients, except when the Newborn Record is used. It is not necessary that a new sheet be used at the beginning of each day, but each day's entries should be clearly separated from those of the previous day by two lines drawn across the page in red ink with the date written in red ink between these lines. All records for the day are closed at 12 midnight.

This record becomes part of the patient's permanent record.

WRA-44

BEDSIDE RECORD

Ward..... Bed.....

Hour	Temp.	Pulse	Resp.	Food - Medicine - Fluid Intake	Urine	Def'n.	Treatment and Remarks

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 250M

WRA-44

BEDSIDE RECORD

Ward..... Bed.....

Hour	Temp.	Pulse	Resp.	Food - Medicine - Fluid Intake	Urine	Def'n.	Treatment and Remarks

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET. S. F. 8-42 250M

CLINICAL HISTORY RECORD, WRA-45

The Clinical History Record will be completed by the attending doctor on every patient admitted to the hospital except obstetrical patients and newborns. This form will also be used in the Out-Patient Department clinics, except Sick Call.

This form becomes part of the patient's permanent record.

WRA - 45

CLINICAL HISTORY RECORD

Family History—Past History—Present Illness

(Examining physician)

(Use other side if necessary)

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET, S. F. 8-42 50M

PHYSICAL EXAMINATION, WRA-46

The Physical Examination record will be used by the attending physician for every patient admitted to the hospital except obstetric patients and newborns. This form will also be used in the Out-Patient clinics whenever Form WRA-45, Clinical History Record, is used.

This form becomes part of the patient's permanent record.

WRA-46

PHYSICAL EXAMINATION

Headings: General appearance, weight (normal and present), eyes, ears, nose, tongue, teeth, throat, lungs, heart, arteries, pulse, blood pressure, abdomen, intestines, liver, spleen, kidneys, skin, mucous membranes, bones, joints, muscles, glandular system, nervous system, genito-urinary system.

Date..... Hour.....

Diagnosis.....

.....

.....

(Examining Physician)

(Use other side if necessary)

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET, S. F. 8-42 50M

WARD SURGEON'S PROGRESS AND TREATMENT RECORD, WRA-47

This form will be used for the follow-up care and progress notes of all in-patients, except obstetric patients and newborns, by all the attending physicians and dentists, including individuals called in professional consultation.

This form becomes part of the patient's permanent record.

WRA-47

WARD SURGEON'S PROGRESS AND TREATMENT RECORD

Ward surgeons will record on this sheet the diet, treatment, complications, changes of diagnosis, intercurrent diseases, and daily progress of the case, and will initial each notation.

Date	

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET. S. F. 8-42 150M

WRA-47

WARD SURGEON'S PROGRESS AND TREATMENT RECORD

Ward surgeons will record on this sheet the diet, treatment, complications, changes of diagnosis, intercurrent diseases, and daily progress of the case, and will initial each notation.

Date	

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET. S. F. 8-42 150M

ANTE-PARTUM RECORD, WRA-48

This form is to be completed as fully as possible on the occasion of the patient's first registration in the pre-natal clinic. Space is provided for 18 ante partum visits. If more space is needed, the Out-Patient Progress Record Form WRA-62 should be used. When patients on whom this form has been prepared enter the hospital this record becomes part of the In-Patient record and should precede the Labor and Postpartum form in the patient's hospital record.

This form becomes part of the patient's permanent record.

WRA - 48

ANTE PARTUM RECORD

S..... W.....

At Term.....

Abnormalities:.....

Age..... Gravida..... Abortions..... M..... D.....

Relevant Family History.....

Medical History: (Particularly Cardiac, Renal, Pulmonary, Venereal Diseases).....

Menses: Began at..... Usual Duration..... Usual Interval.....

Remarks: (pain, etc.).....

OBSTETRICAL HISTORY

Date	Course of Pregnancy	Details of Labor	Puerperium	Child: sex, weight, health

Remarks:.....

Husband's History: (Note V.D. or Tbc.).....

PRESENT PREGNANCY

General Examination: Temp..... Pulse..... Resp..... B.P..... Ht..... Wt.....
(Note: heart, lungs, teeth, throat, thyroid, skin, extremities, etc.)

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET. S. F. 8-42 5M

L. M. P. date:..... Type..... P. M. P. date:.....

Date of Quickening..... Nausea..... Vomiting.....

Bleeding..... Constipation.....

Headache..... Edema.....

Other.....

Breasts.....

Abdomen: Ht. of fundus..... Striation..... Hernia.....

Pelvic.....

.....

Measurements: Sp..... Cr..... Tr..... Ext. Conj..... Bitub..... C. D.....

Pubic angle..... Spines..... Sacrum..... Prognosis.....

.....M.D.

(Signature)

Date	Alb.	Sugar	Wt.	B.P.	Edema	F.H.T.	Ps. and Pr.	Remarks and Treatment	M.D.'s Initials

LABOR AND POSTPARTUM RECORD, WRA-49

This record will be opened for every obstetrical patient at the start of labor. It provides for medical findings during the labor, during the puerperal period and also for the return postpartum check-up at the Out-Patient maternity clinic.

The regular out-patient ante partum record will serve as the in-patient history and physical examination record. When additional space is required for medical notes for unusually long periods of obstetrical hospitization, use the regular War Surgeon's Progress and Treatment Record Form WRA-47.

Abbreviations used on this record are as follows:

HR - Heart
BP - Blood Pressure
Resp - Respiratory
Ps-Pn - Position and Presentation
FHT - Foetal Heart Tones

This form becomes part of the patient's permanent record.

WRA-49

LABOR AND POSTPARTUM RECORD

FIRST STAGE:

Ward.....

Bed.....

GENERAL PHYSICAL EXAMINATION

Temp..... Pulse..... Resp..... B. P..... Heart..... Lungs..... Resp. Infection..... Other.....

Abdominal Examination: Ps. & Pr..... Engagement..... F.H.T.....

Rectal Examination: (initial) Station..... Effacement..... Dilatation.....

Pains began at..... Character..... Frequency..... Duration.....

Membranes ruptured: Yes..... No..... Spon..... Art..... Time.....

Medication.....

SUBSEQUENT EXAMINATIONS

Date	Hr.	B.P.	F.H.T.	Engagement Above at Below Spines	Cervix Dilatation Consistency	Ps. and Pr.	Rectal or Vaginal Exam.	Remarks

SECOND STAGE:

Began..... Delivery: Date..... Hr..... Type delivery.....

If abnormal describe.....

.....

Anesthesia..... Administered by.....

Baby: Stillborn..... Alive..... Sex..... Condition.....

Remarks.....

.....

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 5M

THIRD STAGE:

Total blood

Placenta delivered at: Hour..... Intact..... Lost .....

Medications:.....

.....

Episiotomy: Repair.....

Lacerations: 1st°..... 2nd°..... 3rd°..... Repair.....

Lacerations cervical..... Repair.....

Anesthesia..... Administered by.....

Remarks.....

.....

.....M.D.

(Signature)

DAILY SUMMARY DURING PUERPERIUM

Date	Fever	Ht. of Fundus	Lochia	Breasts	Perineum	General Condition—Remarks	M.D.'s Initials

CONDITION ON DISCHARGE .....

.....

Date discharge..... Return to Postpartum clinic..... .....M.D.

(Discharging physician)

POSTPARTUM EXAMINATION: Temp..... Pulse..... Resp..... B.P.....

General Examination.....

.....

Pelvic Examination.....

.....

Recommendations:.....

.....M.D.

(Signature)

NEWBORN RECORD, WRA-50

The Newborn Record will be used for all well babies during the newborn period. Newborns who become ill and are transferred out of the nursery will require the usual Bedside Record Form WRA-44 as well as the usual Clinical History and Physical Examination Records, Forms WRA-45 and 46. Each newborn should be thoroughly examined at birth and the findings recorded within 24 hours of the delivery. All abnormal findings upon physical examination should be fully described.

The abbreviations used on this sheet are as follows:

OM - occipitomental
OF - occipitofrontal
SOB - suboccipitobregmatic
BP - biparietal
BT - bitemporal

This form becomes part of the patient's permanent record.

WRA-50

NEWBORN RECORD

Mother's Name..... Iden. No.....

Date of birth..... Time..... Full Term..... Sex.....

Type of delivery.....

Medications given..... Eye Prophylaxis.....

Physical examination at birth (Note: Eyes, mouth, heart, lungs, cord, genitals, anus, spine, extremities)

Length..... Weight.....

.....

.....

.....

Diameters at birth: O.M..... O.F..... S.O.B..... B. P..... B.T.....
(In centimeters)

Circumferences at birth: O.M..... O.F..... S.O.B..... Shoulders.....
(In centimeters)

..... M.D.
(Signature)

NURSE'S NOTES

Days	Date	Temp.	Wt.	Eyes	Skin	Cord	Stools	Urine	Feeding: Type, Amount, Schedule—Remarks
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 5M

Physician's Progress Notes:

Date of Circumcision: Performed by: M.D.

EXAMINATION ON DISCHARGE

Skin Eyes Mouth

Heart Lungs

Umbilicus Genitals Buttocks

Injuries Anomalies

Condition on discharge:

MODE OF FEEDING:

Breast

Formula

Schedule

RETURN TO WELL BABY CLINIC

DATE OF DISCHARGE

M.D.
(Signature)

SURGERY RECORD, WRA-51

This record form must be completed on all cases receiving surgical treatment.

The primary pre-operative diagnosis will be entered on this form before surgery is started.

The postoperative diagnosis will be inserted on this record immediately following surgery. The surgeon will describe the surgical procedure and findings on the day of surgery.

The Pathologist Report will be completed as early as possible on every case on which specimens are submitted for examination.

WRA-51

SURGERY RECORD

Room or Ward No. ..... Bed ..... Date .....

Preoperative Diagnosis .....

.....

Postoperative Diagnosis .....

.....

Findings: (Including condition of all organs examined) .....

.....

.....

.....

.....

.....

Operation: (Including Incision, Ligatures, Sutures, Drainage, and Closure) .....

.....

.....

.....

.....

.....

..... M.D.

(Use other side if necessary) (Surgeon)

Pathologist's Report .....

.....

.....

.....

.....

.....

..... M.D.

(Pathologist)

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET. S. F. 8-42 10M

REPORT OF ANESTHESIA, WRA-52

It is the responsibility of the individual administering the anesthetic to see that this form is accurately completed and inserted into the patient's record the same day the operation is performed. No anesthetic is to begin until the portion above the graphic record is completed. Of particular importance is the check of the sponge count before and after each operation and the insertion of the name of the person making such check.

This form becomes part of the patient's permanent record.

WRA-52

REPORT OF ANESTHESIA

Ward..... Bed..... Date..... Age..... Wt..... Temp.....

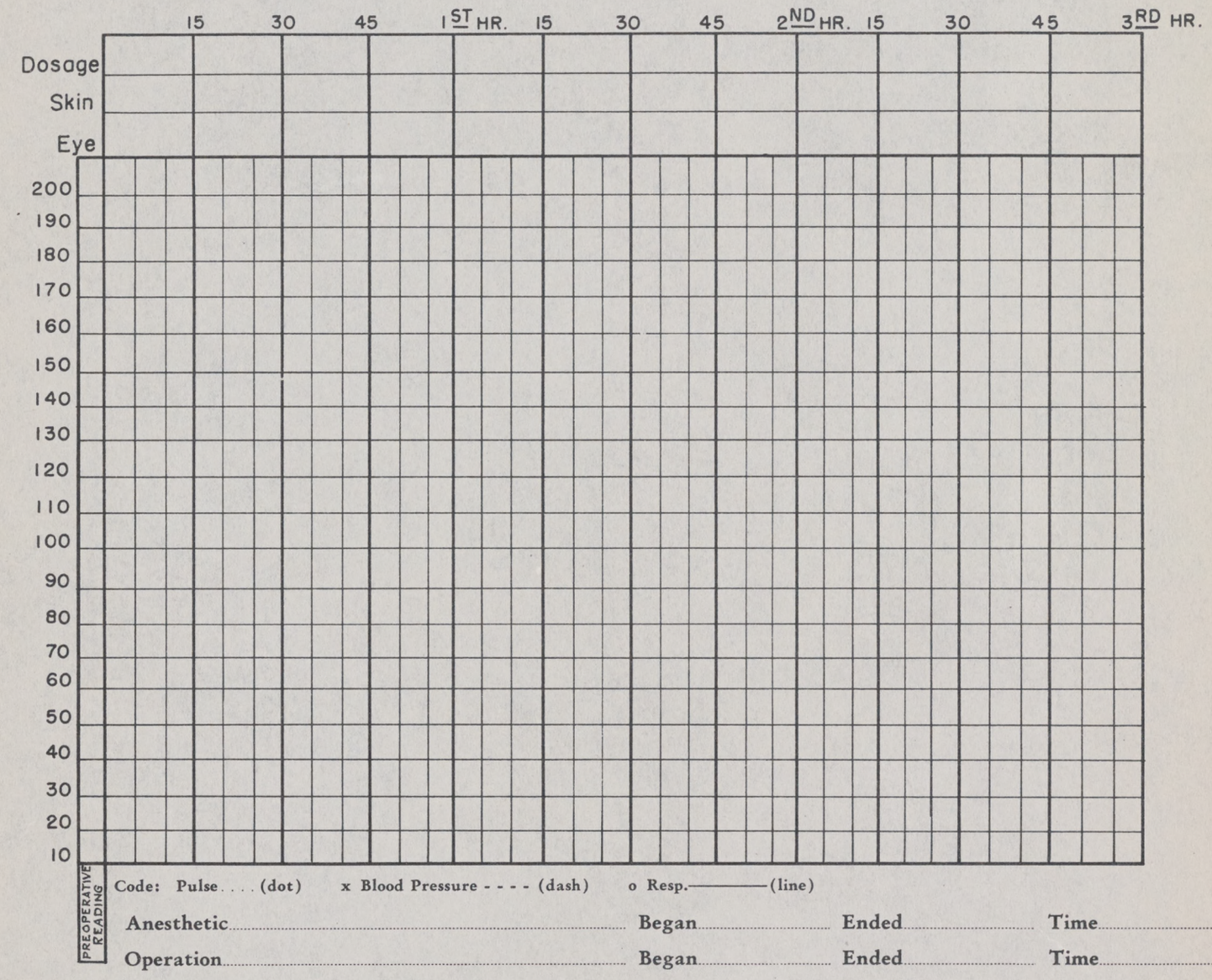
Surgeon..... Assistant.....

Preoperative diagnosis..... Habits: Tobacco.....

Preoperative examination: Heart..... Lungs.....

Preoperative Urine Examination.....

Preoperative medication.....



Code: Pulse . . . . (dot) x Blood Pressure - - - - (dash) o Resp.————(line)

Anesthetic..... Began..... Ended..... Time.....

Operation..... Began..... Ended..... Time.....

Medication in Surgery.....

Sponge Count: Before..... After..... Checked by.....

Condition at close.....

Remarks.....

.....

(Signature of anesthetist)

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET. S. F. 8-42 5M

WRA-53

REQUEST FOR LABORATORY EXAMINATION

Name..... Iden. No.....

Ward..... Bed..... Date.....

Probable diagnosis.....

Specimen to be examined.....

Examination desired.....

.....

Remarks.....

.....

.....

.....M.D.

per.....

RECORDER-SUNSET, S. F. 8-42 250M

REQUEST FOR LABORATORY EXAMINATION, WRA-53

This is not a portion of the patient's permanent record but is a request to technicians for examinations desired.

LABORATORY RECORD, WRA-54

This record is for use in both the In-Patient and Out-Patient services and becomes part of the patient's permanent record. Data will be recorded by laboratory staff or other individual performing tests.

Caution is particularly needed in the use of this record in order to avoid waste. Avoid using a separate sheet for recording each laboratory test. Generally, one sheet should serve for one hospital admission and related Out-Patient department visits.

WRA - 54

LABORATORY RECORD

Ward.....

URINALYSIS

Date:					
Quantity					
Specific Gravity					
Reaction					
Albumin					
Sugar					
Red blood cells					
White blood cells					
Casts					
Miscellaneous					
Examiner					

BLOOD EXAMINATION

Date:					
Hemoglobin					
Red blood cells					
White blood cells					
Polymorphonuclears					
Segmented					
Non-segmented					
Small mononuclears					
Large mononuclears					
Eosinophiles					
Abnormal					
Transitional					
Parasites					
Wasserman					
Kahn					
Miscellaneous					
Examiner					

SPINAL FLUID

Date:					
Cell count					
Polymorphonuclears					
Lymphocytes					
Red blood cells					
Wasserman					
Kahn					
Albumin					
Colloidal Gold					
Miscellaneous					
Examiner					

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 50M

OTHER EXAMINATIONS

Type: ..... Date:	Type: ..... Date:	Type: ..... Date:	Type: ..... Date: .....

Remarks:

X-RAY REPORT, WRA-55

This record is a combination request and report form. The upper half of the record will be completed by the attending physician and the sheet sent to the X-Ray department. The X-Ray department shall send for the patient at the most convenient time soon thereafter. The form should be completed by the roentgenologist or in his absence by the physician interpreting the film within 24 hours and inserted into the patient's record.

This form becomes part of the patient's permanent record.

WRA-55

X-RAY REPORT

Ward..... Bed No..... Date.....

X-Rays requested.....

.....

.....

.....

.....

Clinical Diagnosis and Data:.....

.....

.....

Dressings (may) (may not) be removed. Patient's age.....

Date..... .....

(Physician in charge)

Size of Film	Number of Films	Position

Roentgenologist Report.....

.....

.....

.....

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(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET. S. F. 8-42 25M

WRA-56

REQUEST FOR CONSULTATION

Date.....

Iden. No.....

Name.....

Ward No.....

To: Doctor.....

Working Diagnosis.....

Remarks.....

.....

.....

.....

Consulting doctor will please write report on patient's progress record.

.....M.D.

RECORDER-SUNSET. S. F. 8-42 5M

REQUEST FOR CONSULTATION, WRA-56

This record has been prepared for the convenience of the requesting and consulting physicians. The physician requesting consultation will complete this form.

It is not expected that this Request for Consultation shall become part of the patient's permanent record. The consultant's remarks should be recorded on the Patient's Progress Record in the proper chronological sequence, properly dated and signed.

PERMIT FOR POSTMORTEM EXAMINATION, WRA-57

No autopsy shall be performed until the Permit for Postmortem Examination has been completed in triplicate and the original copy with the rest of the patient's record given to the physician performing the autopsy. All copies must be duly signed, two copies remaining in the office of the Project Medical Officer.

The original copy becomes part of the patient's permanent record.

WRA - 57

PERMIT FOR POST-MORTEM EXAMINATION

This certifies to the authority given the staff surgeons of the ..... Project Hospital to conduct a post-mortem examination, and to remove specimens necessary for gross and microscopic examination, on the body of ....., who was related to me as my ..... .

SIGNED: .....

Address: .....

Identification No. .....

Witness:

..... Date .....

Permit obtained by ..... M.D.

Approved by .....

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET. S. F. 8-42 5M

AUTOPSY RECORD, WRA-58

This form will be completed by the autopsy physician.

This record becomes part of the patient's permanent record. It should be completed and filed with the rest of the patient's chart as soon as possible

WRA - 58

AUTOPSY RECORD

Date of Death ..... Hour .....

Date of Autopsy ..... Hour begun ..... Ended .....

Diagnosis: .....

Autopsy Limited? .....

Gross and Microscopic Findings: .....

..... M.D.
(Signature)

(Use reverse side if additional space required)

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET, S. F. 8-42 5M

UNUSUAL OCCURRENCE REPORT, WRA-59

This form, while it should be needed only infrequently, must be completed for the reporting of all unusual occurrences in the In-Patient or Out-Patient services. Examples of incidents which may occur and should be described on this form are as follows:

Fall of the patient from bed or other accident to patient.

Patient leaving hospital without permission, etc.

It is to be completed in duplicate, the original copy to become part of the patient's permanent record and the second copy to be forwarded directly to the office of the Project Medical Officer.

WRA - 59

UNUSUAL OCCURENCE REPORT

Ward..... Bed..... Date..... Time.....

NURSES' STATEMENT:

.....
(Nurse's signature)

DOCTOR'S STATEMENT:

.....
(Doctor's signature)

(Surname of patient) (Given name) (Identification number)

RECORDER-SUNSET, S. F. 8-42 2500

WRA-60

NURSERY SUMMARY SHEET

Date:

Name	Weight		Temperature		Stools	Remarks
	Yester-day	Today	Yester-day	Today		

RECORDER-SUNSET, S. F. 8-42 2500

NURSERY SUMMARY SHEET, WRA-60

This form is for the convenience of the nurse in attendance on the newborn and is to be kept in the Nursery. A separate sheet is to be used each day. The information on this form is to be transferred to the Newborn Record.

DEFECATION AND URINE LISTS, WRA-61

This form is for the convenience of the nurse or nurse aide and is to be kept in the Utility Room. The nurse or nurse aide when emptying bedpans or urinals chart the defecation and voiding, measuring urine in cc's. The information on this form is to be transferred to the individual patient's Bedside Record and Temperature Chart. A separate sheet is to be used each day.

WRA - 61

DEFECATION AND URINE LISTS

Urine measured in cc.
Defecation indicated by Ṫ

Ward... Date:...

Bed or Room	NAME		REMARKS	Specimen Sent to Laboratory	A.M.												P.M.											
					1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
		Def.																										
		Urine																										
		Def.																										
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RECORDER-SUNSET, S. F. 8-42 25M

DISPENSARY MINOR AILMENT

OR

OUT-PATIENT PROGRESS RECORD, WRA-62

This form has been prepared for use (1) in the sick call service, that is for cases with minor ailments or (2) in the Out-Patient clinics as a progress record. All cases seen in Out-Patient clinics will, of course, have completed history and physical examination forms either upon admission to the In-Patient or Out-Patient service.

As a dispensary minor ailment record it was designed to eliminate unnecessary detailed medical reporting and recording whenever possible. It was not intended to suggest or encourage inferior or short-cut medical procedure. Its use for selected patients, rather than the complete clinical history and physical examination forms, is based on the fact that the living facilities at the project necessarily eliminated in considerable degree commonly carried out home remedies and first aid. A large measure of such services can be performed at sick call. While the usual complete history and physical examination required for hospital admissions and for Out-Patient diagnostic services is not necessary for this minor ailment group, there is still an important need for an adequate record of such visits.

When used as a minor ailment record, it is most unlikely that more than one or two pages will ever be required for any individual. It may be kept in the patient's regular file or filed separately in the sick call file. The more complete patient's record is readily available, if needed, in the Central Chart Room.

When used on an Out-Patient Progress Record, it will accompany the regular clinical history and examination forms and thus be filed as part of the patient's complete health record and kept in the Central Chart Room.

The physician has a responsibility of major importance at sick call. He must render quick and accurate service to patients permitting not only reliable care of evacuees, but, also, proper screening and selection of cases who require the more thorough study and treatment of the Out-Patient Department clinics.

WRA-62

DISPENSARY MINOR AILMENT
or
OUT-PATIENT PROGRESS RECORD

Date first visit..... Age..... Sex..... Race.....

Referred by..... Occupation.....

Significant present and past history on initial visit.....

.....

.....

.....

RECORD OF VISITS

Date	Service	Diagnosis, Treatment, and Progress	Work Ability	Physician Signature

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET. S. F. 8-42 50M

RECORD OF VISITS

Date	Service	Diagnosis, Treatment, and Progress	Work Ability	Physician Signature

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 50M

IMMUNIZATION RECORD, WRA-63

This record will be used for every individual in the Center for whom any immunization procedure has been done.

It is intended to be filed in a special immunization file and not in each individual's permanent hospital record. When the patient is transferred to another Project or when the Project is closed, this record should be inserted in the patient's permanent record file.

WRA - 63

IMMUNIZATION RECORD

(Surname) (Given name) (Identification No.)

Block address..... Age.....

Dates of Previous Immunizations	Typhoid	Smallpox	Diphtheria	Other

Smallpox vaccination: Dates:..... Result.....

DIPHTHERIA

Date	Type	Amount

TYPHOID

Date	Type	Amount

RECORDER-SUNSET, S. F. 8-42 125M

OTHER IMMUNIZATIONS

Date	Specify: Disease - Type - Amount	Date	Specify: Disease - Type - Amount

Remarks:.....

WRA-64

HOUSE CALL REPORT

(Surname of patient) (Given name) (Identification No.)

Block Address Sex Age

Temp. Pulse Resp. B.P.

Present complaint

Positive findings

Rx.

Remarks:

(Use reverse if necessary)

RECORDER-SUNSET, S. F. 8-42 25M

HOUSE CALL REPORT, WRA-64

This record was prepared as a memo pad to be used by the physician on every home call. Significant information on it shall be transferred within 24 hours with the physician's name to the patient's regular record, either the Dispensary Minor Ailment record or the Out-Patient Progress Record, as seems appropriate.

While the data on the House Call Report is for the permanent record the form itself is not intended for the permanent file.

PUBLIC HEALTH NURSING RECORD, WRA-65

This form is to be used by individuals assigned to Public Health Nursing duties for home visits, office visits, and conference or clinic visits. A guide is under preparation outlining the information to be recorded under "Nurses Notes" for various types of cases.

In the column marked "Service" should be recorded the type of service i.e.; ante partum, post-partum, infant, morbidity, etc.

In the column marked "Type Visit" should be recorded H.V. (home visit), O.V. (office visit), C.V. (clinic or conference visit).

This form will be kept in the patient's permanent record in the Central Chart Room so that reference can be made to it when necessary. This form may be taken from the patient's permanent record by the Public Health nurse for use on home visits.

WRA - 65

PUBLIC HEALTH NURSING RECORD

DATE	SERVICE	NURSE'S NOTES	TYPE VISIT	NURSE'S SIGNATURE

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 5M

WRA - 65

PUBLIC HEALTH NURSING RECORD

DATE	SERVICE	NURSE'S NOTES	TYPE VISIT	NURSE'S SIGNATURE

(Surname of patient) (Given name) (Identification number)

(over)

RECORDER-SUNSET, S. F. 8-42 5M

WRA-66

SUPPLY ROOM LOAN RECORD

Date.....

Article

Taken by:.....

Taken to:.....

Remarks:

RECORDER-SUNSET, S. F. 8-42 35M

SUPPLY ROOM LOAN RECORD, WRA-66

This is not a permanent record but is to be used in every case of borrowing of permanent supplies. The slips are made out in duplicate when the article is borrowed, one is retained by the Supply Room or ward lending. When the article is returned to the Supply Room or ward from which it was borrowed the slip on file there is destroyed as is the one on the ward borrowing. The ward slip is used merely to keep the Head Nurse reminded of the borrowed articles that are on her floor.

WRA-67

REQUISITION FORM

Ordering From.....

Ward or Dept. ordering..... Date.....

Article	Amount Requisitioned	Amount Delivered

Original containers including ampules to be returned unless otherwise specified.

Filled by:..... Requested by:.....

Rec'd by:..... Approved by:.....

RECORDER-SUNSET, S. F. 8-42 10M

REQUISITION FORM, WRA-67

This form is to be used for all ward or departmental requisitions. It is to be made out in duplicate - both copies being sent to the warehouse - pharmacy - etc. When the order has been filled and checked, one copy is retained by the warehouse, pharmacy, etc. The other is returned with the supplies requested.

WRA - 68

REPAIRS FORM

Ward or Dept.:..... Date..... Type of repairs.....

Location	House Report	Workman's Report and Signature

RECORDER-SUNSET. S. F. 8-42 5M

Signature of person requesting repairs.

REPAIRS FORM, WRA-68

The repair form is to be used for any type of repair work necessary either on the wards or in any particular department. After "Type" should be listed whether repairs are to be electrical, plumbing, etc. The name or number of the ward or department should be listed and the date the repair is requested. Under "Location" should be specified where the article to be repaired is situated, that is, Utility Room, lavatory, etc. Under "House Report" should be listed the report of the person requesting the repair, that is, "electric light in linen closet will not work", "sink in Utility Room will not drain", etc. The "Workman's Report" is to be filled out by the person repairing the article, that is, "soap and sediment in trap or sink removed". Workman should also sign report, and give any instructions for the particular care of the article repaired. Repair slip should be signed at the bottom by the person requesting the repair.

LINEN REQUISITION SLIP, WRA-69

The linen requisition slip is used to request linen from the Central Linen Room. Slips are made out in duplicate, one being sent to the Linen Room, the other being retained in the ward. Requisitions should be made out and sent to the Linen Room the night before the linen is needed.

VRA - 69

LINEN REQUISITION

Ward..... Date.....

No. Beds.....
No. Patients.....

Articles	On Hand	Wanted	Listed
Blankets, Bath			
Blankets, Bed			
Blankets, Chair			
Bags, Bedside			
Bags, Clothes			
Bags, Rag			
Bathrobes			
Binders, Breast			
Binders, Scultetus			
Binders, T			
Caps, Ether			
Chest Jackets			
Cloths, Dust			
Cloths, Wash			
Compress Cloths, small			
Compress Cloths, med.			
Compress Cloths, large			
Covers, Hot Water Bag			
Covers, Linen Hamper			
Covers, Pitcher			
Gowns, Doctors			
Gowns, Patients			
Size			
Leggings, small			
Leggings, large			
Pajamas			
Size			
Pillow Cases, small			
Pillow Cases, large			
Sheets			
Sheets, Crib			
Sheets, Draw			
Sheets, Split			
Spreads			
Towels, Bath			
Towels, Hand			
Towels, Kitchen			
Towels, Surgical			

.....
(Signature)

RECORDER-SUNSET, S. F. 8-42 20M

WRA - 70

PRESCRIPTION BLANK

Hospital....., ..., 19.....

For.....

℞ Gms. or Mils.

.....

No..... Physician in Charge

RECORDER-SUNSET, S. F. 8-42 250M

PRESCRIPTION BLANK, WRA-70

To be used for dispensing all drugs or supplies to patients from the pharmacy.