CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

DATE OF ORDER: 9 Jul 03 | TIME OF ORDER: 1745 | HOURS

1. Admit to ICU2 [redacted] b6-2
2. Dx: heat injury
3. Cond: VSI
4. VS: q1h SCP
5. Act: BR
6. NPO A
7. Mgt: IV x 2, ice to groin & axillae until core temp < 102°, fan also
8. IVF: NS @ 150 cc/hr
9. Vent SIMV 14 TV 700 PEEP 5 FIO2 100% x wean & keep sats > 92
10. Levo gtt @ 3 mg/hr + titrate
   Versed gtt @ 3 mg/hr + titrate
   Fentanyl 50 mcg/hr gtt
11. No tylenol for now

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

DATE OF ORDER | TIME OF ORDER | HOURS

12. Chem 8, LFT's q AM
13. NGT clamped. Notify MD if ABD becomes distended.

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

Verbal LT [redacted] 1835 9/7/03

b6-2

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

DATE OF ORDER: 10 Jul 03 | TIME OF ORDER: 0645 | HOURS

1. D/C versed, levo, fentanyl gtt's

noted @ 0655 hrs 10 JUL 03

b6-2 [redacted]

[redacted]

MEDCOM - 14041

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

PATIENT IDENTIFICATION | DATE OF ORDER: 11 July 03 | TIME OF ORDER: 0815 HOURS | LIST ORDERS NOTED / SIGN

1. Transfer to ICW#2 [redacted] b6-2
2. Dx: heat injury/goiter
3. Cond: good
4. Act: BRP per ward discretion
5. NKDA
6. Diet: regular
7. IVF: saline lock

DATE OF ORDER | TIME OF ORDER HOURS

8. Meds: tylenol 325 mg TT PO q4° prn
9. metlyte 8, CBC in (AM) - use central line

[redacted] b6-4

b6-2 [redacted]

noted [redacted] b6-2 91WM6 11 July 03 1750

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER: 12 JUL | TIME OF ORDER: 21:30 HOURS

VO
D/C (R) and (L) PIV sites now
Dr [redacted]
b6-2
24°/done [redacted] 2I/AA

noted 21:30 ~~D/C~~ 12 JUL [redacted] 2I/AA

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER: 12 JUL 03 | TIME OF ORDER: 0457 HOURS

VO/CBC and Metlyte 8 in AM/13 JUL 03
Dr [redacted] b6-2 2I/AA

noted 0457 12 Jul 03 [redacted] 2I/AA

NURSING UNIT | ROOM NO. | BED NO.

12 Jul 03 1600
CBC now - done [illegible] b6-2
[redacted]
noted [redacted] 91WM6 13 July 03 1605

24°V Q [illegible] [illegible] [redacted] 1250

MEDCOM - 14042

ACLU-RDI 1625 p.2

DOD-027594

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted] b6-4

DATE OF ORDER 12 July 03 TIME OF ORDER 2000 HOURS

LIST T ORDE NOTED SIGI

① CBC in AM
② NPO p MN

noted [redacted] b6-2 9/11/03 2053

NURSING UNIT 9 NW | ROOM NO. | BED NO. [redacted] b6-2

PATIENT IDENTIFICATION [redacted] b6-4

DATE OF ORDER 7-12-03 2350 13 July CTS HOURS

① Reg diet ✓
② D/C Foley ✓
③ NS @ 75 c/hr through central line

noted [redacted] b6-2 9/11/03 13 July 03 0745

NURSING UNIT ICW2 | ROOM NO. | BED NO. [redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER 13 July 03 TIME OF ORDER 0930 HOURS

V.O. from Dr. [redacted] to LT [redacted]:
① D/C Foley now please

noted [redacted] b6-2 OUT/AN b6-2 13 July 03 930

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 13 July 03 TIME OF ORDER 1615 HOURS

① NCE contrast CT of neck + chest to R/O mass

noted [redacted] b6-2 9/11/03 1620

NURSING UNIT | ROOM NO. | BED NO. 9 NW [redacted] b6-2 [redacted] b6-2 7-13-03 0515.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 Jan 03 TIME OF ORDER 1600 HOURS

LIST T ORDE NOTED SIGI

① CBC / Diff

② NPO @ MIDNITE

b6-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 Jan 03 TIME OF ORDER 1600 HOURS

① Cancel NPO / CBC

② Maybe DC to EPW Camp

When Ambulatory

b6-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted]

b6-2

[redacted] 7-15-03 0035 U

15 Jan 03 0815

① I/C Central Line

b6-2 [redacted]

24°V's

b6-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted]

b6-2 HOURS

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. July Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 9 10 11 12 13 14 15 16 17 18 19 20 21 22
9/7	[redacted]	COND: VSI	05	[redacted]
			17	[redacted]
9/7	[redacted]	VS: Per SOP	05	[redacted]
			17	[redacted]
9/7	[redacted]	ACT : BR	05	[redacted]
			17	[redacted]
9/7	[redacted]	NKDA	05	[redacted]
			17	[redacted]
9/7	[redacted]	NURSING: Ice to GROIN + AXILLARY until core temp <102 °F for also		D/C 10JUL03
9/7	[redacted]	VENT: SIMV, RR14, TV 700, PS, FIO2 100%. Wean to keep SATS >92%	05	[redacted] D/C 10JUL03
9/7	[redacted]	NGT CLAMPED. NOTIFY MD IF ABD BECOMES DISTENDED	05	[redacted] S/Cld 10 JUL03
9/7	[redacted]	Chem8, LFT'S QAM	05	[redacted] orders

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: DX: HEAT INJURY / GOITER

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: _____

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

4Hy/00 ♂

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

b6-2 b7C

b6-2 b7C

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 14045

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/7	[redacted]	ADMIT TO ICU 2	9/7	NOW	1800	[redacted]
10 Jul	[redacted]	√ K^+ ↓ K^+ Runs Finished	10 Jul	↓ K^+ Runs	1200	[redacted]
11 Jul	[redacted]	Markyte 8, CBC in (AM)	12 Jul	AM	SEE Flow Sheet	
	[redacted]	USE CENTRAL LINE				
	-----	DC				

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Jul Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12	13	14	15	16
10 JUL 03	[redacted]	CLEAR LIQUIDS IN 2° THEN ADVANCE	05	[redacted]						
		DIET AS TOLERATED	17	[redacted]						
11 Jul	[redacted]	DIET: REGULAR	07	[redacted]						
			11	[redacted]						
			17	[redacted]						
11 Jul	[redacted]	ALT: BRP PER	05	[redacted]						
		WARD DISCRETION	13	[redacted]						
			21	[redacted]						
11 Jul	[redacted]	IVF: Heplock	05	[redacted]						
			13	[redacted]						
			21	[redacted]						

See Below

Write Sheet

all 66-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	HEAT INJURY / GOITER	PAGE NO:

PATIENT IDENTIFICATION:

[redacted] 66-4

41y/o ♂

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, 1 OCT 78 | EDITION OF 1 DEC 77 MAY BE USED. | USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo July Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11Jul	[redacted]	TRANSFER TO ICW #2	11 Jul	—		[redacted]
11Jul	[redacted]	DX: HEAT INJURY / GOITER	11Jul	—		[redacted]
11Jul	[redacted]	COND: GOOD	11Jul	—		[redacted]
11Jul	[redacted]	METLYTE 8, CBC IN (AM)	12Jul	AM	done	[redacted]
	-----	USE CENTRAL LINE				
11Jul	[redacted]	D/C @ and @ PIV x 1 now	11Jul	2130	done	[redacted]
12Jul	[redacted]	Metlyte 8, CBC in AM	13Jul	0400	done	
12Jul	[redacted]	CBC in AM	13Jul	0400	done	
12Jul	[redacted]	NPO @ MN	13Jul	2400	done	[redacted]
12July	[redacted]	CBC NOW	12July	1600		DONE
13July	[redacted]	DC Foley now please	13July	0930	0930	[redacted]
13Jul	[redacted]	non-contrast CT of neck & chest to	13July			[redacted]
	-----	R/O mass				
14	[redacted]	May D/C when from event to ICW comp				

	-----					

all 66-2

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. JULY r. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13	14
9/7	[redacted]	Versed gtt @ 3mg/hr titrate	05	[redacted]					
			17	[redacted]					
9/7	[redacted]	Vecuronium gtt 3mg	05	[redacted]					
			17	[redacted]					
9/7	[redacted]	~~Versed~~ Fentanyl/gtt 50 ~~mg~~ mcg/hr	05	[redacted]					
			17	[redacted]					
9 Jul 03		IV: NS @ 150 cc/hr	05						
			17						
11 Jul 03	[redacted]	IVF: Heplock	05	[redacted]					
		Central Line q	13	[redacted]					
		Shift	21	[redacted]					
13 Jul 03	[redacted]	NS @ 75cc/hr through	05	[redacted]					
		central line	13	[redacted]					
			21	[redacted]					

D/C 11 Jul 03

D/C @ 0700hrs 10 Jul 03

See below

D/C

all b6-2

ALLERGIES: ☐ YES ☒ NO
KNDA

PRIMARY DIAGNOSIS:
DX: HEAT INJURY / GOITER

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO.

PATIENT IDENTIFICATION:
EPW # [redacted] b6-4
41y/o ♂

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	

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. July Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 JUL	[redacted]	KCL 40 mEq in 100cc NS over 2hrs x 2	10 JUL	NOW	① 0835 ② 0945	[redacted]
10 Jul	[redacted]	Ambien 10mg PO x1 for sleep	10 Jul	NOW	0050	[redacted]
		b6-2				b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
10 Jul	[redacted]	Tylenol 325mg	10 Jul 1000 [redacted]
	b6-2	2 tab PO q 4° PRN	[redacted] b6-2

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): A (1 D (
2. MTF LOCATION (7–8) *(State or Country Code.)*: I Z

3. REGISTER NUMBER (9–15): [redacted]

NAME *(Last, First, Middle Initial)*: EPW [redacted] b6-4

4. PAY GRADE (16–17):

5. SEX (18): M

6. DATE OF BIRTH *(YYYYMMDD)* (19–26):

7. AGE AT ADMISSION (27–29):

8. RACE (30): Z

9. ETHNIC BACKGROUND (31): 9

RELIGION: unk

10. LENGTH OF SERVICE (32–34):

ETS: N/A

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): Ø Ø Ø Ø Ø Ø [redacted]

ORGANIZATION *(Active Duty Only)*: N/A

13. MARITAL STATUS (46): u

HOUR OF ADMISSION: 9925

BRANCH / CORPS: N/A b6-4

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): K 7 9

16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION *(State or Country Code)* (62–63):

18. MOS (64–70):

19. TRAUMA (71):

PREV. ADMISSION YEAR: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): Ø

WARD: ICU2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*:

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73–74): 5 Ø

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION *(YYMMDD)* (81–86): 0 3 0 7 1 5

24. CLINIC SVC - ADMITTING (87–90): A A A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION *(YYMMDD)* (97–102): Ø 3 Ø 7 Ø 9

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103–104):

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION *(YYMMDD)* (111–116):

FOR LOCAL USE

Dx: Heat injury

Dx 9925 Proc 9671
2409
Trauma 9
Inj 809
[redacted]

ADM[redacted] b6-2 Dr [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] b6-2 SPC, 91G10

DA [redacted]

MEDCOM - 14051

ACLU-RDI 1625 p.11

DOD-027603

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) SPW# [redacted] b6-4				3. GRADE NO	ADMISSION REMARKS
4. SEX M	5. AGE 25y	6. RACE X	7. RELIGION Muslim	8. LENGTH OF SVC unk	9. ETS unk	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION SPW			14. WARD ICU1
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS NO	19. UIC/ZIP unk		20. TYPE CASE Surg/ int. med
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION A			22. HOURS OF ADMISSION 1745	23. CLINIC SERVICE AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION 21	26. DATE OF DISPOSITION 030722		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO. unk	28. DATE OF THIS ADMISSION 030709		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]				30. DATE OF INTIAL ADMISSION 030709		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Infected wound (A) chestwall

875.1
682.2
E986

34.4

35. Total Days This Facility					
a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS 14	f. TOTAL SICK DAYS 14
0	0	0	0		

36. Total Days All Facilites					
a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS 14	f. TOTAL SICK DAYS 14
0	0	0	0		

SIGNATURE OF [redacted] OFFICER b6-2 [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] b6-2

DA FORM 3647 [redacted] EDITION OF [redacted]

USAPPC V1.10

MEDCOM - 14052

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

EPW, prob [illegible] infield
Chest wall wound s/p self inflicted
stab wound.

PHYSICAL EXAMINATION

(L) perimammary erythema and pus
lung (B) clear
Heart regular
Abd benign

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

Dx Infected (L) chest wall
stab wound
Rx Debride
IV ABX
To OR [illegible] for I&D

SIGNAT[redacted]IAN	DATE	IDENTIFICATION NO.	ORGANIZATION

b6-2

[redacted] en entries give Name last, first, [redacted] e; hospital or medical facility)

REGISTER NO.	WARD NO.

[redacted]

b6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐	
	H/H			SUP 02	PH	PO2	RESULTS		
	PLT			PCO2	SAT	OTHER			
PT				U/A	DIP		EKG INTERPRETATION		
APTT		BHCG	ETOH	GLU	MICRO				

PROVIDER HISTORY/PHYSICAL

NKDA

Chest: ⊕ multiple See Surgery H&P
open wounds ⓒ chest wall (anterior)
c pus @ pectoralis level c surrounding erythema
Lungs: ⊖ rales ⓑ
⊖ retractions/accessory muscle

A/P stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE & STAMP

b6-2

PROVIDER SIGNATURE

DIAGNOSIS: Chest wall puncture wound
cellulitis

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

10 Jun 03 Brief OP Note
Surg Dx (L) Chest wall Abscess
Post op Dx SAME
Procedure Excision of Chest wall Abscess, debridement.
Surgeon Muller
Anes General
Findings large pus pocket with denuded fascia. Pectoral muscle fascia intact. No violation

TO ICU / Stable

Pt returned to OR in 72° at TID during ds.

[redacted] b6-2

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	1730 -10 JUL -03 VSS 96, 111/60, 16, 97 RA, 98 RA.
	[N] Follows commands, A+O
	[M] LLA; (-) C/S/S (gross)
	[CV] NSR; (-) edema; 3+ pulses x4 extrem, <3 sec cap refill
	[GI] Absorbed evening meal (+) BO; distends abdomen
	(+) BS x4
	[GU] Voids spont. clear
	[SKIN] Middle [redacted] midline thoracic dsg - bulky/c/d/I.
	[RESP] to OR in morning.
	[IV] HL x2 (L)(R) - b6-2 [redacted] LLA
115July03 0530	Pt rsd at lying in bed sleeping WNL, see flow sheet for assessment. Pt had wheezing in lungs. Elevate HOB & encouraged to cough & use incentive spirometer. Will auscultate breath sounds again after 2hrs. [redacted] b6-2
0730	Pt ate 70% of meal & went back to sleep @ %pain [redacted]
1300	Dsg. D to chest dried tissue noted, redness W-D W/ Montgomery strips in place. [redacted] b6-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4

REGISTER NO. | WARD NO.

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

MEDCOM - 14056

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10JUL03 0545	Assumed care of pt. Resting quietly. Assessment complete (see flow sheet) (L) FA heplock & (R) AC IV site intact Ø S/S redness or edema. Dsg Δ to (L) chest @ 0100. Ø S/S of distress noted. Will continue to monitor [redacted] b6-2
0900	Pt. sitting up in bed, eating & tolerating well. Pt. using sparameter & will continue q1h pt. is awake. Will continue to monitor. [redacted]
1130	Pt. c/o very little pn. Tolerating meals well. Continues to use the sparameter. Will continue to monitor [redacted] b6-2
1400	Dsg Δ to (L) chest. Pt. resting @ this time. Ø complaints [redacted] b6-2
1630	Dr. by bedside to check on pt. status. Will brief oncoming shift [redacted]
1730 12JUL03	USS - Alert x 3 DRSG to (L) chest is dry and intact. Saline lock to (R) AC and (L) FA are patent c Ø S/S infiltration. Afebrile Ø c/o pain or discomfort present. Resting quietly sitting up in bed present. — SGT [redacted] 9/C3
0200 13JUL03	USS - DRSG Δ to (L) upper chest mod. amt of blood & drainage noted on dsg. Repacked c moist 4x4 cover c Dry 4x4 and cover c Abds pads. Ø S/S infection. IV Ancef and clindamycin given 2200. Resting quietly in bed c restraints to UE in place and secure. — SGT [redacted] 9/C20 b6-2
0430 13JUL03	USS - IV Ancef Lan and clindamycin 900 g given. Resting quietly c Ø c/o pain or discomfort. Restraints to UE in place and secure-safe [redacted]

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

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

FPCO # [redacted] b6-4

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

MEDCOM - 14057

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0300	Assumed care of pt. VSS. A/O x 3. Pt. resting @ this time. @ tenderness to (L) chest wall, wound present. Remains NPO until I&D performed in O.R. today. Ø c/o pn @ this time. Will continue to monitor [redacted] 66-2
0600	Dsg Δ to (L) chest. Slight drainage present, green in color. Redness around wound. [redacted]
0730	Urinated via urinal, output was 1050cc, dark yellow in color. [redacted] 66-2
0920	Pt. to O.R. [redacted]
1030	Pt. returns to ICU 1 fr O.R. T&D of (L) chest, stab wound. VSS. SpO2 100% on RA. LA infusing into (L) FA. Will receive remainder of PRBC, 1000cc, TKO. Pt. resting @ this time. Possibly had brief period of hallucinating, interpreter not in place, assumptions based upon gestures of pt. Pt. did receive 2mg of Versed more in O.R. CRNA, maj [redacted] 66-2 additional 25mg of Demerol on the ward. Restraints in place, noncombative @ this time. Will continue to monitor [redacted]
1230	Pt. continues to rest. Ø distress noted [redacted]
1630	Pt. sitting up & eating, coherent/cooperative. Ø % pn. [redacted] 66-2 Will brief oncoming shift

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

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

EPW # [redacted] 66-4

REGISTER NO. | WARD NO.

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

MEDCOM - 14058

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 JUL 03 0800	Pt. A/O x3 VSS. Awake lying in bed. (L) FA Heplock & (R) AC IV site both intact Ø S/S of infiltration. +2 radial & pedal pulses palpable. Ø C/O pn on inspiration or exhalation to (L) chest wall. Dressing to (L) chest CDI. Ø S/S of distress. Will continue to monitor [redacted]
13 Jul 03 0830	Drsg A, minimum amt of blood. Currently using spirometer [redacted] Will continue to monitor
13 Jul 03 0830	Pt. ate & tolerated breakfast @ 0800. Conducted personal hygiene. Voided via urinal, output 900cc. Usually voids once per shift. Average output of 850 cc. Urine drk. yellow [redacted] sediment.
13 Jul 03 1130	Pt. urinating a bit more frequently. Output 700cc. Continues to use spirometer. Will continue to monitor [redacted]
13 Jul 03 1400	Dsg A of (L) chest complete, pt. resting quietly [redacted]
13 Jul 03 1600	Pt. resting quietly, Ø changes, Ø S/S distress. Will brief oncoming shift [redacted]
14 July	1700 - Received pt from Sgt [redacted]. No c/o pain. VSS. Assessment done. Dressings changed. Site has purulent drainage. Sgt [redacted] (EPW)
	2200 - RAC IV d/c'd. LFA IV d/c'd, new IV started in left hand [redacted]
	0200 - Pt sleeping. No c/o pain [redacted]
	0400 - Pt sleeping. VSS [redacted] EPW

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* EPW- [redacted] b6-4

REGISTER NO. | WARD NO.

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

MEDCOM - 14059

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 July 03	0630 Patient assessment performed. See ICU-1 flowsheet. DRSG A performed to (R) chest wound. Site looks good, minimal amount of greenish-yellowish discharge noted on old DRSG. Site is red, b6-2 beefy in appearance. Will continue to monitor [redacted]
14/1403 1515	pt. transferred to ICW 2 from ICU 1 on 1400 ambulatory in stable condition - VSS - SL in (L) hand patent IBg - dsg on (L) chest CDI, montgomery straps secure - hyperactive BS - lungs CTA x (L) upper lobe, inspiratory & expiratory rhales noted - pt. restrained on (R) wrist & (L) ankle per b6-2 protocol for EPWS - pt. A&Ox3 - [redacted]
14 July 03	2310 Assume pt care @ 2100. VSS. HL to (L) hand no s/s redness/infiltration & flush. Dsg to (L) chest wall CD+I montgomery straps intact. NPO p MN for on-call to OR in am. No c/o pain @ this time will continue to monitor — [redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD NO. ICW 2

EPW [redacted] ICU 1
b6-4

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

MEDCOM - 14060

DICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 July 0730	Pt care assumed @ 0500. VSS, pt awake and alert s̄ c/o pain. Lung sounds CTA, pulses palpable x4, bs⊕x4 quads. HL to (L) wrist flushes s̄ s/s infection. Dsg on chest c̄ montgomery straps CDI, s̄ s/s infection. Pt c̄ surgery today, NPO right now. Continue to monitor. b6-2 [redacted] 91W MC
15Jul03 1325	assumed care @1300 - VSS - no c/o pain @ this time - LR @ 100cc/hr started thru 18g (L) hand IV 2° to NPO status - pt. o/c to OR - chest dsg CDI - [redacted] b6-2
15 Jul 03	Brief OP note
	Preop Dx - Infected chest wall
	Postop SAA -
	Procedure - chest wall washout / closure
	[illegible]
	Surgeon [illegible]
	Anes GA
	Findings: wound looks good. Skin [illegible] and closed [illegible]
	Complic [illegible]
	[redacted] b6-2

ONSHIP TO SPONSOR | SPONS[redacted] | SPONSOR'S ID NUM (SSN or Other)
LAST | FI[redacted] | MI
T./SERVICE | HOSPITAL OR MEDICAL FACILIT[redacted] | [redacted]INTAINED AT
REGIS[redacted] | WARD NO. [illegible]

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

[redacted] b6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

MEDCOM - 14061

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Jul03 1630	pt. returned from recovery @ ~1530 - S/P chestwall wound washout & closure - JP to bulb suction - dsg on (L) chestwall drainage marked - no c/o pain @ this time - LR @ 125 cc/hr infusing into (R) hand 18 g a.c. - lungs CTA (B) - (+) BS - pt. DTV by 2200 tonight, bladder not distended - pt. awake VSS b6-2 [redacted] CRNA
15 Jul 03 23:00	Recd c/o pt. @ 21:00. Awake and alert in bed. VS WNL per flowsheet. RR 22 (L) WNL. Skin color WNL. LCA (B) ↓ diminished slightly (L) mid lobe. JP drain intact & scant amt. bloody drainage. DSG to (L) ↑ chest intact & sm. amt. bloody drainage c/o pain x1. IV Percocet given. will cont. to mon [redacted] b6-2
0900 16 Jun	Pt care assumed @ 0500. VSS, awake and alert & no c/o pain. Lung Sounds CTA, diminished @ bases, more so in left base. Pulses palpable x4, b:(+) x4 quads. HL @ IVA intact, IV ABV. Dsg on (L) chest CDI, drainage marked by previous shift, no c/o pain @ site. JP draining minimal amount of bloody fluid, will continue to monitor. b6-2 [redacted] MEMO
16 Jul 1325	- Received PT ~~CMC~~ @ 1300. PT is awake and alert. VSS PT has no c/o pain. Lungs sound CTA. Continue to be diminished @ base, b. lateral. Good PRE motor function on all extremity. Bowel sound, x4, Dsg on (L) chest CDI. PT has drained 10cc of bright red blood, from JP. PT is resting comfortably in bed & c no c/o pain. will continue to monitor. [redacted] b6-2

AUTHORIZED FOR LOCAL REPR

CAL RECORD | PROGRESS NOTES

NOTES

16/July 1830 — Performed Dressing change @ 1415. Moderate smart of drainage on the dressing. [redacted] Cpl

16July — PT had 10cc of Bright red blood from J-P. [redacted] b6 Cpl

16 July 2300 — New IV placed in LFA, flushes well c Scc NS. ~~c~~ S/s of infection or infiltration. HR Regular. Lung sands diminished Lower lobes bilat. Dsg to Lside of chest CDI, JP drain to suction draining bloody fluid. Pt. ~~c~~ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT HN

17 July 0645 — Pt care assumed @0500. VSS, pt sleeping awoken by verbal stimuli, no c/o pain. Lung sands CTA, Vat bases, pulses ⊕ x4, bowel sands ⊕x4. Dsg on chest CDI, JP intact. JP draining small amounts of bloody fluid. HL in LFA flushes well, IV Abx running. No new complaints, cont to monitor. [redacted] b6-2 SPC

17July03 1500 — assumed care @1300 - VSS - no c/o pain @ this time - SC patent in LFA - staples CDI on L chest wall, JP to bulb suction lungs CTA(B), slight expiratory wheeze heard in upper L lobe [redacted] b6-2 2LT HN

17July 2300 — Pt awake & alert in bed up eating MRE. HR Regular, Lung sands clear bilat, bowel sands (+) x 4 quads. HL in

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

IDENTIFICATION (Typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO | WARD NO 1CW2

EPN # [redacted] b6-4

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

TE	NOTES
17 July 2300	(L) FA flushes well c 3cc NS c s/s of infection. Incision on (L) upper chest 6inch horizontal below nipple is approximating well c s/s of infection. JP to bulb suction draining very small amt of red tinged fluid. Pt. c complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] JCTF/N b6-2
18 July 03 0830	Pt alert lying in bed. VSS, lungs CTA, HR reg, BS(+). Staples to (L) chest, intact ø s/s infx. DSG to JP. Small amount of drainage noted in bulb. HL to (L) arm. Voicing ø complaints at this time. Will cont to monitor [redacted] b6-2
18/7/03	Assumed PT care @ 1305. Pt is lying in bed c ↓% pain or discomfort. Staples to (L) chest, intact ø s/s of infection. ø drainage to JP. Lung sounds are clear Bilateral. Will continue to monitor PT. [redacted] b6-2 Cpl
19 July 03	2000 - PT had ø drainage from J.P. Will continue to Monitor. [redacted] b6-2 Cpl
19 July 03 0200	Pt. asleep in bed. HR Regular, Lung sands clear bilat, bowel sounds 4) X4 quads. HL in (L) FA fused well c 3cc NS c s/s of infection. Horizontal incision below (L) nipple approximating well c s/s of infection. DSG to (L) side of chest CDI, JP drain to bulb suction draining very small amt of red tinged fluid. Pt. c complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] JCTF/N b6-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 July 03	0830 - Pt alert laying bed. VSS, lungs CTA, BS@. Pulses @ & strong bilat to 4th d extrem. Staples intact to @ & chest. JP draining very small amount of red fluid. Site reinforced c 4x4s. HL to @ forearm. Voicing & complaints at this time. Will cont to monitor — [redacted] (b6-2) — YN
19 July 03 1300	- Recvd Pt Alert & oriented. VSS. Lungs CTA. BSx4. Staples WDL to @ chest. JP draining small amount of clear red blood. Pt has @ c/o pain or discomfort. Will continue to monitor. [redacted] (b6-2) YN
19 July 03 1620	JP was D/C by MD [redacted] (b6-2) YN
19 July 03 2250	Pt. awake & alert in bed. HL in @ FA infiltrated ? red, new IV will be placed. HR Regular, Lung sands clear bilat, bowel sands (+) x 4 quads. Horizontal incision beneath @ nipple approximating well c s/s of infection. Small wound to @ axillary c 2x2 CDI. Pt. c complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] (b6-2) SLY HN
2300	New IV placed in @ FA [redacted] (b6-2)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO. ICW 2	

PT [redacted] b6-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
0630	Pt. care assumed @ 0500. VSS Ø pain. HR Reg, lungs CTA Bilat. Staples to chest OTA S/S infection. ABD soft ± BS ⊕ X4. HL to R AC intact, flushed ± diff., Ø S/S infection will cont. to monitor. b6-2 [redacted] RN
20July03	- Record PT @ 1300 VSS. Ø Pain. Leg sand are clean & intact. STAPLES to chest are clean + Dry. Ø S/S of infection. BSx4. Good ROM on all extremity. HL to Ø AC WNL flushes well. will continue to monitor PT. [redacted] b6-2 CPT
21July03 0100	Pt. awake & alert in bed. HR Regular, Lung sands clear bilat, bowel sands (+) X4 quads. Horizontal incision below ⓛ nipple approximating well ± s/s of infection. Pt. ± complaints @ this time. VSS. All other assessment findings WNL. Will continue to monitor. b6-2 [redacted] RN/HS
21July03	0535 Assume pt care @ 0500. pt awake and alert. VSS. HR reg. Lungs CTA. Abd soft BSx4. Horizontal incision below ⓛ nipple staples intact. no S/S infection. No c/o pain @ this time. HL to Ⓡ FA no S/S redness/infiltration ± flush. Will continue to monitor b6-2 [redacted] RN/MS

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD | PROGRESS NOTES

ATE | NOTES

21 July 03 1300 - Assumed PT care. PT is resting in bed c ⊖% pain or discomfort. VSS. BS x 4. Lungs are clear Bilateral. Good ROM on All extremity. Skin is warm & Dry. HC to ® forearm pressure well c 3cc NSA staples to Left chest are clean & Dry c no S/S of infection. Will continue to monitor PT. [redacted] b6-2 LPN

⇒ 1 July 03 2130 Pt. awake & alert sitting up in bed c complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Horizontal incision below ® nipple approximated well c s/s of infection. HL in ® FA c s/s of infection. All other assessment findings WNL. Will continue to monitor. [redacted] b6-2 RN/BSN

22 Jul Assumed care of pt @ 0200. Pt asleep. VSS. Lungs CTA. BS x 4 quads. Abd. soft and tender. HL in ® arm patent. Pt has ⊘ c/o pain / discomfort. Will continue to monitor. [redacted] b6-2, LPN. SGT

22 July 2020 - Awaiting discharge to EPW camp. [redacted] b6-2 LPN

G SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
E	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
FICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	
[redacted] b6-4			TCW 2	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. [illegible])
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.10[illegible]

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD | PROGRESS NOTES

ATE | NOTES

2200 Pt care assumed @2100. VSS, no c/o pain. Lung
22JUL03 sounds CTA, pulses palpable x4, bs+x4quads.
Wound c staples OTA on chest CDI, no c/o pain @ site.
Pt taking PO meds, c d/c order and summary awaiting
transportation to epw camp. b6-2 [redacted] akumo
2:22/1403 - Assumed PT care. VSS 0 c/o pain. Lungs clear
1305 Bilateral, Good PMS to all extremity, OS x4.
SCD cont Dry. PT is Awaiting transportation to
epw camp. Will cont to monitor [redacted] ypr
b6-2

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

epw [redacted] b6-4

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted] b2-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 9 Jul 03 | TIME: 1745

TRANSPORTATION TO FACILITY: medevac

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE	HOME PHONE		FLYING STATUS			
28	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: None

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Stab wound

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 17:47

INITIALS: [redacted] b6-2

VITAL SIGNS

TIME	1745				
BP	106/52				
PULSE	99				
RESP	20				
TEMP	99.0				
WT	70kg				

LAB ORDERS

(CBC/DIFF)	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM: Lytes
BLOOD C&S X			BUN/CR

X-RAY ORDERS

☒ (CXR) PA & LAT/PORTABLE		C-SPINE
☐ ACUTE ABDOMEN		LS SPINE
☐ SINUS		HEAD CT
☐ ANKLE R/L		

ORDERS

☒ PULSE OX 99%
☐ MONITOR
☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1749	1gram Ancef IV	JP		1754	900mg Clindamycin IV [redacted] b6-2
1747	50mg Phen	JP			
1749	.5mg tetanus	JP			
1751	50mg Phen	JP			

DISPOSITION
☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY
☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE: ICU

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD | PROGRESS NOTES

ATE | NOTES

7/22/03 DC Summary

EPW with infected chest wall to clinic. Wound debrided and treated with wet to dry. Subsequently developed drain. Doing well. Would like to go

Final Dx- Infected Chest wall wound

Procedure - Chest wall debrided

Chest wall wound closed

Discharge DC to EPW Camp

Levofloxacin 500 QD for 7 days

Staples removed in 3 weeks

May shower

b6-2

[redacted]

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

E | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20

MEDCOM - 14070

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 25
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
?

4. PROPOSED SURGICAL PROCEDURE:
I&D Lt Chest Wall abscess

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco ✓ ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g., warm blanket, touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] b6-4

Ecu 1

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility 2) Positioning 3) Existing Disease 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. N/A Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. c Pt. will be transferred safely to OR table. c Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	c Introduce self. Keep pt. informed as to where he she is and what is happening. c Inform pt. in which direction to move and assist if necessary. c Speak clearly and slowly. c Address pt from _____ side. c Validate pt.'s understanding of verbal communication. c Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] 06-2 MAN AN 10 JUN 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☑ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities
☐ Transferred to litter ~~with roller due to spinal~~ by OR staff
SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 06-2 MAN AN
DATE: 10 JUN 03 TIME: 0910

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 06-2 MAN AN
DATE: 10 JUN 03 TIME: 1023

REVERSE OF FORM 5179, JUN 91 MEDCOM - 14072 USAPA V1.0

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM BY MAJ [redacted] / MAJ [redacted] TIME PATIENT ARRIVED IN SUITE 0720 b6-2
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted] b6-2
3. DATE 10 Jun 03
4. PATIENT IN ROOM TIME 0920 NUMBER 1-1
5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

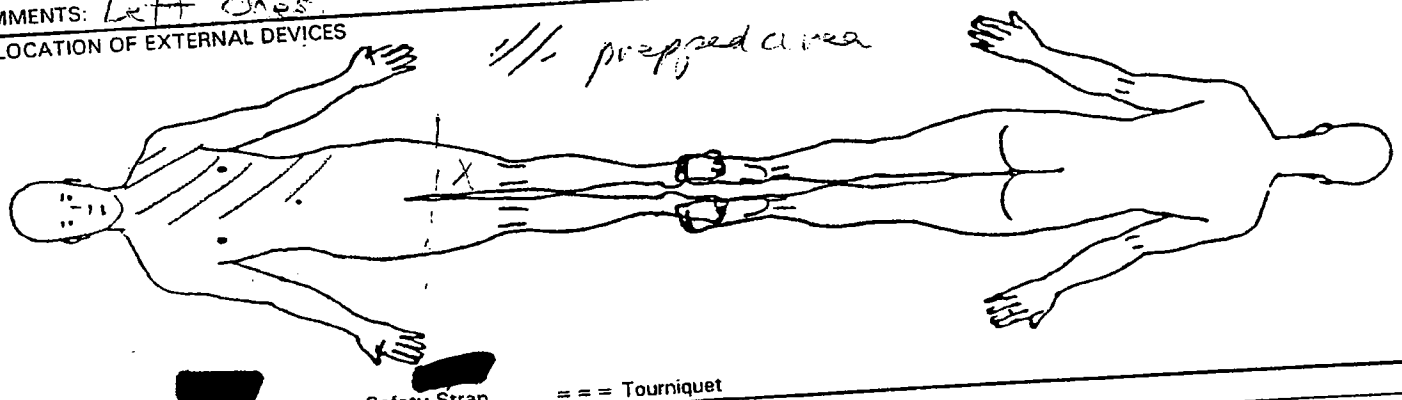
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Povidone Iodine Solution BY WHOM: MAJ [redacted] b6-2
SITE: Left chest BY WHOM:
SITE:
COMMENTS: No povidy at solution

9. LOCATION OF EXTERNAL DEVICES



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

SCRUB: SPC [redacted] b6-2; SPC [redacted]
CIRCULATOR: MAJ [redacted] b6-2; MAJ

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

[redacted] b6-4
ICU 1

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

[X] ESU NO: Valleylab - #1
GROUND PAD: BRAND Valleylab
LOT NO: 65766 Exp 2004-1

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

MEDCOM - 14073 USAPA V1.
REPLACES DA FORM 5179-1 [illegible] WHICH IS OBSOLETE.

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): N.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 c) Swabs x2 from Lt chest	NAME wall for gram stain
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☑ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Petrolene soaked kerlix
Fluffs
Montgomery straps

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted] b6-2
Anes MAJ [redacted]
Cult: 3d Gram's

20. OPERATION(S) PERFORMED
I&D left chest wall abscess

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU b6-2	1015	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN at 07

REVERSE OF DA FORM 5179-1, OCT 8[illegible] USAPA V1.01

MEDCOM - 14074

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Cart BY: Anes. Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: [redacted] CPT [redacted] AN

3. DATE: 15 Jul 03 TIME PATIENT ARRIVED IN SUITE: ICU2 → OR

4. PATIENT IN ROOM TIME: b6-2 NUMBER: 2-1 / 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO FMW.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

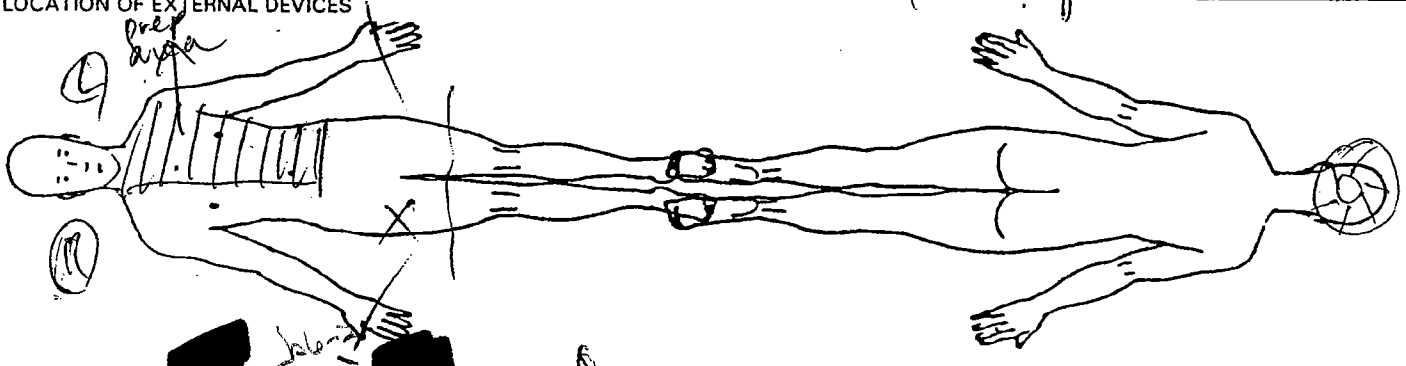
COMMENTS: (B) arm to padded armboard C90°

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine S/Sol
SITE: Chest
SITE: ~
BY WHOM: CPT. [redacted] b6-2
BY WHOM: ~
COMMENTS: & prodrapes

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Gr[redacted]ad -- Sa[redacted]p = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☑ Yes	☐ No		C	C	SPC [redacted]	CPT. [redacted]
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

EPW # [redacted] b6-4

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND: Polyhesive II
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:

☐ BIPOLAR NO:

Cut: 30

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; NUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin oint	QS	intra-op	topical use	[redacted]	Dr. [redacted] b6-2

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* 4x4 Tape

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	1. comm. J.P		
SITE	1. Chest		

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] b6-2
Anes: [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Chest wall wd clean & debridement. and closure

21. PATIENT TRANSFERRED TO	TIME	METHOD
b6-2 ICU	See Anes. Record	Litter

22. REGISTERED NURSE SIGNATURE [redacted] RDT (AW)

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 14076

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

105°
104°
103°
102°
101°
100°
99°
98.6°
98°
97°
96°
95°

180
170
160
150
140
130
120
110
100
90
80
70
60
50
40

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

[redacted] 66-4

REGISTER NO.

WARD NO.

1 CW 2

STANDARD FORM 511 (REV. 7–95) BACK

MEDCOM - 14077

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

POST- OR

MONTH-YEAR	DAY	HOUR
19	9 July 03	1400
	10 July	0800
		1200
		1600
		2000
		2400
		0400
	11	0800
		1200
		1600
		2000
		2400
		0400
	12	0800
		1200
		1600
		2000
		2400
		0400
	13	0800
		1200
		1600
		2000
		2400
		0400
	14	0800
		1200
		1600
		2000
		2400
		0400
	15	0800
		1200
		1600
		2000
		2400
		0400
	16	0800
		1200
		1600
		2000
		2400
		0400
	17	0800
		1200
		1600
		2000
		2400

PULSE (O) / TEMP. F (°) / TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE	1400	0800	1600
B/P	93/47	98/52	101/61
AR	16	16	14
HR	78	73	77
SAT	96%	95%	95%
Temp	97.1		98

HEIGHT: WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW 2

EPW [redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDCOM - 14078

1600-2400
15 Jul 03

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

[redacted] b6-2 ~~NASOGASTRIC~~ [illegible] output

	TIME	AMOUNT	TYPE	ACCUM TOTAL
	2000	10	bloody	10cc
July 17	1200	10	bloody	10cc
	2100	5	bloody	15cc
18 Jul	04	7cc	red tinged fluid	7cc
	12	2.5cc	red tinged	9.5cc
	20	Ø		9.5cc
19 July	04	3cc	red tinged fluid	3cc
	12	2cc	"	5cc
	20			
20 July	04			
	12			
	20			

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

EPW [redacted] b6-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

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

b6-4

ID: 000[redacted]
MB

12-07-03
03:52

			Patient Limits	
WBC	8.0	x10^3/uL	4.5	10.5
RBC	4.58	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	41.0	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	27.6	Pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	298.	x10^3/uL	150.	450.
Lym%	39.2	%	20.5	51.1
Lym#	3.2	x10^3/uL	1.2	3.4

b6-4

ID: 000[redacted]
MB

13-07-03
04:13

			Patient Limits	
WBC	9.5	x10^3/uL	4.5	10.5
RBC	4.66	x10^6/uL	4.00	6.00
Hgb	12.9	g/dL	11.0	18.0
Hct	42.0	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	27.7	Pg	27.0	31.0
MCHC	30.7 L	g/dL	33.0	37.0
Plt	308.	x10^3/uL	150.	450.
Lym%	28.9	%	20.5	51.1
Lym#	2.7	x10^3/uL	1.2	3.4

b6-4

ID: 000[redacted]
MB

11-07-03
03:47

			Patient Limits	
WBC	7.3	x10^3/uL	4.5	10.5
RBC	4.10	x10^6/uL	4.00	6.00
Hgb	11.6	g/dL	11.0	18.0
Hct	36.9	%	35.0	60.0
MCV	89.8	fL	80.0	99.9
MCH	28.2	Pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	256.	x10^3/uL	150.	450.
Lym%	37.2	%	20.5	51.1
Lym#	2.7	x10^3/uL	1.2	3.4

b6-4

ID: 000[redacted]
MB

10-07-03
03:59

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.04	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	34.3	%	35.0	60.0
MCV	85.7	fL	80.0	99.9
MCH	28.0	Pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	220.	x10^3/uL	150.	450.
Lym%	31.6	%	20.5	51.1
Lym#	2.8	x10^3/uL	1.2	3.4

ON: [illegible] | REQUEST | YSICIAN: [redacted] 66-2

ST, MI: [redacted] 66-4 | DATE 7-12-03 | TIME 0400 | SSN/PSEUDO SSN:

LABO[illegible]ORY RESULT FORM
(Subject to the Privacy Act of 1974)

(Hematology) CBC

RESULT	REF. RANGE
	4.8-10.8 x 10^3
	4.7-6.1 x 10^6
	14-18 g/dl (M) 12-16 g/dl (F)
	42-52% (M) 37-47% (F)
	80-94 fl (M) 81-99 fl (F)
	130-500 x 10^3 verified
	20.5-51.1%

[illegible]ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	
	42-52% (M) 37-47% (F)	

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

CS:

ED BY: [redacted] **DATE:** **LAB ID NO.:**

66-4

IV # 1

REQUES PHYSICIAN

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

NAME: [redacted] b6-4

DATE: 13 JUL 03 TIME: 0400 SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF RANGE
		4.8-10.8 x 10^3
		4.2-6.1 x 10^6
		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
		80-94 fl (M) 81-99 fl (F)
		150-500 x 10^3 /cmm
		verified
		26.5-51.5%

Urinalysis

TEST	RESULT	REF RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis

(Hematology) Manual Differential

Mono		
Eos		
Baso		
Imm		
	42-52% (M) 37-47% (F)	

CSF

Cell Count		
Direct gen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF RANGE
		9.8-13.0 secs
		21-34 secs
		< 20 ng/ml
		10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

CS:

ED BY: [redacted] DATE: TAR HEEL:

b6-4 13 July 03

ON: ICU #1 | REQUES. | YSICIAN: [redacted] 66-2

ST, MI. EDCU [redacted] 66-21 | DATE 7-11-03 | TIME 0330 | SSN/PSEUDO SSN:

LABO. ORY RESULT FORM
(Subject to the Privacy Act of 1974)

(Hematology) CBC

RESULT	REF. RANGE
	4.8-10.8 x 10^3
	4.7-6.1 x 10^6
	14-18 g/dl (M) 12-16 g/dl (F)
	42-52% (M) 37-47% (F)
	80-94 fl (M) 81-99 fl (F)
	130-500 x 10^3 verified
	20.5-51.1%

ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	

	42-52% (M) 37-47% (F)

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

KS:

ED BY: | DATE: | LAB ID NO.:

on: ICU #1 REQUES... YSICIAN:

LABO...ORY RESULT FORM
(Subject to the Privacy Act of 1974)

ST. MI... EPW #[redacted] b6-4 DATE 10 July TIME 0400 SSN/PSEUDO SSN:

(Hematology) CBC

	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph		20.5-51.1%

...ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	

	42-52% (M) 37-47% (F)

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

KS:

ED BY: [redacted] DATE: LAB ID NO.:

b6-4

EMT Dr. [redacted] b6-2

[redacted] b6-4 9 July 03 | 1819 | 0428

(i-STAT)		
TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry		
TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12		
TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l

======= PICCOLO =======
09/07/03 18:18
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100697

GLU	99	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	214	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus		
TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte		
TEST	*RESULT*	*REF. RANGE*
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 9JUL03

LAB ID NO.:

NKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)							TOTALS
Midazolam (mg)	1.5	0.5	0.5				2.5
Fentanyl (mcg)	50 – 25		50	25	25	25	200
Lidocaine (mg)	100						100
Propofol (mg)	180						180
Ketamine (mg)		10	10	5			25

TOTAL EBL: 30

TOTAL URINE: Ø

VOLAT AGENT: Iso — % del: 1.5 1.0 1.5 X — % e.t.

AIR L/Min

N2O L/Min

O2 L/Min — 10 2 2 10

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

LINE site: LR 18G @ A ☒ Warmed — #1

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS SUMMARY

CRYSTALLOID – 400

COLLOID –

BLOOD – Ø

LOSSES: EST BLOOD LOSS 25; URINE –

ASA STATUS: (2) 3 4 5 E

TIME: 0900 · 30 · 1000 · 30 · 1100

BODY WEIGHT: 75 (KG)

HEMATOCRIT:

INITIAL DATA: 101/61, P– 77

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK for PROCEDURE? — [redacted]

TIME – 0845

SYMBOLS: BP by cuff ∨ ∧; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T – X; ANES – X-X; PROC ⊙ – Ø

66-2

(Grid scale 220–20: BP approx. 110–100 / 45, HR approx. 80)

VT – ml	+	300	410	450
f – breaths/min	—	11	14	12
Peak inf pres / PEEP	—	—	—	—
MODE – S(pon), A(ssist), C(on)	S	S	S	S
✓ BP/Auto Cuff ✓ ET CO2 (torr)	40	42	37	42
BP / oth ✓ FIO2 (Frac or %)	0.89	0.89	0.88	0.88
ART line ✓ SpO2 (%)	100	100	100	100
Steth- PC/ES ✓ ECG	SR →	→		
Gas analyzer ✓ TEMP- site Ax	—			
N-M Block (T/4)				
BS	+ —			
✓ Warming blkt ✓	X 1 wool blanket → → →			
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS: (1)(2) (3)(4)

Position →

REMARKS – Code drugs with numbers, event with letters

(1) Pre-op assessment NPO, pt voided & pt understood To OR

(2) Glycopyrrolate 0.2 IV, monitors O2 Room, Induced eyelids taped See airway management Bite block to teeth

(3) SV >8 & <30 BPM ETCO2 <50, Respon LMA removed

(4) TO litter TO ICU & Report to nurse.

RECOVERY AT 1015 — PACU (ICU) (Specify) — OTHER: T–95.5

CONDITION: Stable

RESP – 10, SpO2 – 99

BP – 117/74, HR – 85

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0855	0900	1025

	Ready	Begin	End
PROC	0930	0947	1006

PROCEDURES and CPT Codes: I&D of Chest stab wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — LMA #4 seated + BBS Sust ETCO2

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

EPW # [redacted] 66-4

SURGEONS: [redacted]

AN[redacted]

MAJ/CRNA

MEDICAL RECORD – ANESTHESIA — [redacted]

PROCEDURE LOCATION: 1

DATE: 10 July 03

PAGE 1 OF 1

WAMC OP 376 REVISED Jan 99

66-2

PATIENT RECORD [redacted]

☆ U.S. GPO: 1999 – 528-336/10

MEDCOM - 14086

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 25 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D (L) Chest wall Infection
SURGICAL SERVICE: OT
NPO SINCE: pm

ASA Physical State 1 (2) 3 4 5 E
WT: ~ 85 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (N)
ETOH: (N)
DRUGS: (N)

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Clindamycin 900 mg 912.
( ) ____
( ) Ancef 1gm 98.
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
pending
HB/HCT: ____ / ____
U/A: ____
OTHER: ____

129	107	8	
3.8	23	0.5	99

CK 214

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	Exp. wheeze (R) L.
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	NA
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	Self-Inflicted Stab wounds X3 to Chest

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 101/61 HR 77 R 14 T 98
Pain Scale 0-10 ____
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck FB3
Oropharnyx grade II
Nares ____
CHEST: ~~Clear~~ scattered Rhonchi
CARDIAC: S1 S2 S (M)
EXTREMITIES: ____
IV Access: #20GAC (R) arm
Ulnar Filling: R6 (L) arm
BACK: ____
OTHER: ____

Sat 95

NPO Since pm

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (L) General: Mask Intubation

Via Interpreter [redacted] MD/CRNA

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: 10 July 03 Time: 0200 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] 66-4 (ICU)

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

)IVF

MEDICAL RECORD - ANESTHESI

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

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

DRUG	(Units)				
Fentanyl	(mcg)	100	50	50	50
Versed	(mg)	3			
	( )				
Propofol	(mg)	170			
Sux	(mg)	80			
	( )				
VOLAT AGENT Forane	% del	1.2-1.5			
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	4			

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

FLUIDS

LINE site (3) #20 L/R	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES	
EST BLOOD LOSS	
URINE -	

TOTALS

TOTAL EBL: 10

TOTAL URINE: NM

FLUIDS SUMMARY
- CRYSTALLOID- 500
- COLLOID-
- BLOOD-

REMARKS
Code drugs with numbers, events with letters
1. (1) [illegible]
2. (2) See below
3. (3) V6 / CQ7

PHYS STATUS: 1 (2) 3 4 5 E

TIME → 1330 14

BODY WEIGHT: 85 KG

HEMATOCRIT: 41

INITIAL DATA:
BP- 110 / 60
HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1300

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

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

VENTIL

VT - ml	600			
f - breaths/min	10			
Peak inf pres / PEEP	22	23	24	24
MODE - S(pon), A(ssist), C(on)	C	C	C	C

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	29	30	30	30
BP/oth	✓ FIO2 (Frac or %)	1.0	.8	.8	.8
ART line	✓ SpO2 (%)	100	100	100	100
✓ Steth- PC/ES	✓ ECG	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site	35	35	35	35
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS EVENTS Position → [illegible]

RECOVERY AT: PACU (ICU) 2 (Specify)
OTHER
CONDITION:
RESP- SpO2- 100
BP- 100/59 HR- 62

ANESTHESIA / PROCEDURE TIMES

ANES	Start 1300	Room 1315	End 14
PROC	Ready 1335	Begin 1345	End 14

PROCEDURES and CPT Codes: I & D (L) Chest Wall

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA / SCCA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #2 Intub WDVL BL=BS [illegible] Eyes taped

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted] b6-4

SURGEONS: [redacted] b6-2

AN[redacted] Cevans

PROCEDURE LOCATION:

DATE: 15 July 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 1408[redacted] COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ACLU-RDI 1625 p.48

DOD-027640

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ___ DAYS MOS YRS   Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: I + D (L) Chest Wall
SURGICAL SERVICE: GS
NPO SINCE: NA

ASA Physical State 1 (2) 3 4 5 E
WT: 85 KG/LB HT: ___ IN.
ALLERGIES: ___

HABITS:
TOBACCO: (+)
ETOH: (-)
DRUGS: (-)

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Clinda
( ) Cinof
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ___ Hrs) /CC
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 12 / 41
U/A: ___
OTHER:
K 3.8
Na 129

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension (N) Y
- Angina (N) Y
- MI (N) Y
- CVA (N) Y
- Other (N) Y

Pulmonary System:
- Asthma (N) Y
- Bronchitis/URI (N) Y
- COPD (N) Y
- Other (N) Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis (N) Y
- Hiatal Hernia (N) Y
- PUD/GERD (N) Y

Endocrine System:
- Diabetes (N) Y
- Steriods (N) Y
- Thyroid (N) Y

Neurological:
- Seizures (N) Y
- Neuropathy (N) Y
- Other (N) Y

Gynecological:
- Pregnancy N Y n/a

Other Significant Hx:
- (N) Y
- (N) Y

Familial HX N Y [illegible]

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth Good
Trachea midline
TMJ/Neck ___
Oropharynx soft
Nares ___
CHEST: ___
CARDIAC: S1 S2
EXTREMITIES: ___
IV Access: ___
Ulnar Filling: ___
BACK: ___
OTHER: ___

NPO Since ___

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ___ {✓} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient/legal guardi[redacted]rees. Questions answered. 66-2
Signed: [redacted] Date: 13 July 03 Time: 12^00 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

[redacted] 66-4

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

ICW2 / ICU2

PATIENT RECORD COPY

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

MEDCOM - 14089

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

O [redacted] b6-4

DATE OF ORDER 7/9/03

TIME OF ORDER ______ HOURS

LIST TI ORDE NOTED SIGN

1) Admit ICU
2) Dx Infected (L) Chest Wall wound
3) Vitals q 4°
4) Activity Bedrest
5) Diet regular NPO after MN
6) To OR in Am for I&D
7) MEDS
Clindamycin 200mg IV q12 1745
Ancef 1gm IV q8° 1730
Percocet i-ii po q 4° prn
Tylenol i-ii po q 4° prn
8) CBC in AM.
9) Call MD T>102.5, SBP >180 <90,
10) Dry/Dsg Dressing to (L) Chest TID

[redacted] b6-2

[redacted] b6-2

CPT ... 7/9/03

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

URSING UNIT | ROOM NO. | BED NO.

MEDCOM - 14090

ACLU-RDI 1625 p.50

DOD-027642

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Jul 03
TIME OF ORDER: ______ HOURS
LIST TIME ORDER NOTED AND SIGN

1) To ICW 1
2) Dx S/P Exam Chest Wall Abscess
3) Condition: Stable
4) Vitals Q1° x 2, then Q4°
5) Activity Bedrest
6) Diet as tolerated when

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER

alert and awake HOURS

7) IV LR at 125cc/L
8) Incentive Spirometry Q1° while Awake
9) TID wet to dry dressing
Dressing ...
10) MEDS
MSO4 i-ii mg Q1-2° prn

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER
25
______ HOURS

Percocet i-ii po Q4° prn

Clindamycin 900mg IV Q12°

11) Call MD T>101.5, SBP >180 <90
No wt bearing 80° post op.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER
12) CBC in [redacted] HOURS
b6-2

DA FORM 4256, 1 APR 79

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

MEDCOM - 14091

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

PATIENT IDENTIFICATION

EPW [redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

DATE OF ORDER: 7/14/03 | TIME OF ORDER: ____ HOURS | LIST ORD NOTED SIG

1) Transfer to ICW 2
2) Dx (L) [illegible]
3) [illegible] Status
4) Admit Adult
5) Diet [illegible] NPO after MN
6) IV heplock

PATIENT IDENTIFICATION

[redacted] b6-4 EPW

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

DATE OF ORDER | TIME OF ORDER: b6-2 [redacted] HOURS

7) MEDS
Ancef 1gm IV Q8
Clindamycin 900 IV Q12
Percocet i-ii PO Q4 prn
Tylenol i-ii PO Q4 prn

PATIENT IDENTIFICATION

EPW [redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

DATE OF ORDER | TIME OF ORDER: ____ HOURS

8) [illegible] [illegible] [illegible] wash out.
9) Call MD T>101.5, SBP >180 <[illegible]

b6-2 [redacted]

PATIENT IDENTIFICATION 24 JUL 07 [redacted]

EPW [redacted] b6-4

DATE OF ORDER: 7-15 | TIME OF ORDER: [redacted] 37 HOURS

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 19

MEDCOM - 14092

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION
EPW
[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 19

DATE OF ORDER: 15 July 03 | TIME OF ORDER: HOURS | LIST TIME ORDER NOTED AND SIGN

1) To ICW2 → ICW2
2) Dx S/P Chest wall wound and drain
3) Vitals per unit Q shift
4) Admit Adult
5) Diet reg when alert and awake
6) IV rate 125cc/h ... heplock when tolerating po well
7) JP to bulb suction / record output Q8°/QD
8) MEDS
Clindamycin 900 mg IV Q12
Ancef ... IV Q8°
MSO4 1-2 mg IV Q1-2° prn
or
Percocet 1-2 PO Q4° prn
Zofran 4mg IV Q6° prn
9) Call MD T ≥ 101.5, SBP > 180 < 90, no void 8° post op
... cath.

PATIENT IDENTIFICATION
EPW
[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 19

PATIENT IDENTIFICATION
EPW
[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 19

PATIENT IDENTIFICATION
EPW
[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 19

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

b6-2

24° [redacted] ... /AD

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

MEDCOM - 14093

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

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER 7/17/03 TIME OF ORDER ______ HOURS

1) Back to ward QD
2) Recent JP output / change JP as needed q80.

[redacted]

0830 17 Jul 03

NURSING UNIT ICW2 | ROOM NO | BED NO. 19

18 Jul 03 0900 24° chart ✓ [redacted] b6-2 2LT/AN

PATIENT IDENTIFICATION

EPW [redacted] b6-4

DATE OF ORDER 7/22/03 TIME OF ORDER ______ HOURS

1) DC to EPW Camp
2) Staples out in 3 weeks either camp or here.

[redacted] b6-2

0900 [redacted] b6-2 noted

NURSING UNIT ICW2 | ROOM NO. | BED NO. 19

2RVS 22 Jul 03 2200 [illegible] [redacted] b6-2

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

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

MEDCOM 14094

U.S. GOVERNMENT PRINTING OFFICE

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mos July Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12	13	14	15	16	17	18	19	20	21
9 July	[redacted]	Vitals Q4 hrs	06	[redacted]												
			18	[redacted]												
9 July	[redacted]	Activity Bedrest	06	[redacted]												
			18	[redacted]												
9 July	[redacted]	Regular diet	07	[redacted]												
			12	[redacted]												
			17	[redacted]												
9 July	[redacted]	CBC in Am	04	[redacted]												
		call MD for Temp >102.5	06	[redacted]												
9 July	[redacted]	Sys B/P >180	18	[redacted]												
		DSG A to (L) chest	06	[redacted]												
		TID	14	[redacted]												
			22	[redacted]												
11 July	[redacted]	Incentive Spirometer	08	/	/	[redacted]										
		Q 1° when awake	18	/	/	[redacted]										
14 July	[redacted]	~~condition stable~~	05													
			17													
14 July	[redacted]	~~Activity Ad lib~~	05													
			17									DC'd				
14 July	[redacted]	~~Regular Diet~~	07													
			12													
			17													
14 July	[redacted]	~~IV Heplock~~	05													
		flush q shift	17													
~~14 July~~	[redacted]															
14 July	[redacted]	~~call MD for T>101.5~~														
		SBP >180/90														

DC'd 14 July

Q11 b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (L) chest wall wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 MEDCOM - 14095 JSED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9July	[redacted]	Admit to ICU #1				[redacted]
9July	[redacted]	NPO p MN for D+D				[redacted]
14July	[redacted]	transfer to ICW 2				
14July	[redacted]	NPO after MN	14July			
14July	[redacted]	Plan- OR in AM 7/15/03 for washout				

911 b6-2

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 7 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22
14	[redacted]	Activity: ad lib	05	/	[redacted]							
15			13									
			21									
			/									
14	[redacted]	Regular diet	07	/	[redacted]							
15			12	/								
			17									
			/									
14	[redacted]	Vitals QS - call MD	05	/	[redacted]							
15		T >101.5 SBP >180 <90	13									
			21									
			/									
15	[redacted]	JP to bulb suction	05	/	/	[redacted]						
		record output q8°	13	/	[redacted]	D/C'd 19 July 05						
		and QD	21	/								

all b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ① infected chest wall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Ltpw [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 MEDCOM - 14097 SED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 7 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
14	[redacted]	transfer to ICWZ	14	now	1400	[redacted]	
14		condition stable		noted			
14		NPO p MN	15	0001	0001		
14		o/c to OR in AM for washout	15	o/c			
15		NO void 8° post-op may I/O cath	15	2200			
15		ICWZ → ICWZ	15		1530		
15		SIP chest wall washout and closure	15	noted			
22		DC to Camp	22 July				
22		Staples out in 3 weeks; either camp or here	3 wks				

all b6-2

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13
9July	[redacted]	Clyndomycin 900mg IV @ 12hrs	18	✓				
			22	[redacted]				
9July	[redacted]	Ancef 1gm IV Q8hrs	06	✓				
			14	✓				
			22	[redacted]				
~~14July~~	[redacted]	~~Percocet 1-2 pop q 4~~						

D/C 16-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (L) chest wall wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 MEDCOM - 14099 D UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. July Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	-----					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
9 July	[redacted]	Percocet T-II po	② 2220	# 1300	② 711											
-----	-----	Q4hrs PRN for Pain	7/10/03	7/11	[redacted]	66-2										
9 July	[redacted]	Tylenol T-II po PRN														
-----	-----	Q4hrs for Pain														
[illegible]	[redacted]	MSO4 T-II mg Q	D/C'd 14 July 2003													
-----	66-2	1-2° prn														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 14100

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 7 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14 15 16 17 18 19 20 21 22 23
14	[redacted]	SL-Flush QS	05	✓ [redacted] D/C See below
			13	[redacted]
			21	[redacted]
14	[redacted]	ancef 1gm IVPB	06	✓ [redacted]
15		q8°	14	[redacted]
			22	[redacted]
14	[redacted]	clindamycin 900mg	10	✓ [redacted]
15		IV q12°	22	[redacted]
15	[redacted]	LR@125cc/hr	05	✓ ✓ [redacted]
		(A2) whentol PO	13	✓ [redacted]
			21	✓ [redacted]
17	[redacted]	Bactracin to wound		✓
		QD	10	[redacted] ✓ [redacted]
				all b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P chest wall washout & closure (2) infected chest wall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 MEDCOM - 14101 UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 7 Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
14 17	[redacted]	Percocet 1-11 PO q4° prn-pain	2005 I [redacted] PB
14 17	[redacted]	Tylenol 1-11 PO q4° prn-pain/fever	
15 18	[redacted]	MSO4 1-2mg IV q1-2° prn-pain	all bb-2
15	[redacted]	Zofran 4mg IV q6° prn-nausea	

USAPA V1.00

For use of ...DICAL RECORD—SUPPLEMENTAL MEDICAL D...
see AR 40-66; the proponent agency is the Office of T...

REPORT TITLE

INTENSIVE CARE ...URSING FLOW SHEET

1 General

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	1900	INITIALS [redacted]		INITIALS	0530	INITIALS [redacted]
NEURO	PUPILS		2mm Reactive	b6-2			PERRLA, 2mm	b6-2
	SENSORIUM		A+O x3				A+Ox3	
			MAE x4					
RESPIRATORY	RESPIRATORY PATTERN		event unlabored				even, unlabored	
	BREATH SOUNDS		Clear bilat				CTA(B)	
	SECRETIONS		Ø secretions noted SATS 95-97 on RA				Ø	
SKIN	COLOR		Normal for Race				NFR	
	INTEGRITY		Race - Intact				warm & dry, intact	
IV SITE	LOCATION		(R) AC H/L				(L) FA	
	CONDITION		(L) FA IV				(R) AC H/L	
GASTRO	ABDOMEN		BS (+) x 4 quads				soft ND/NT x4	
	BOWEL SOUNDS							
GU	URINE:		voiding via urinal				via urinal	
	COLOR/CLARITY							
CARDIOVASCULAR	CARDIAC RHYTHM		SR 105 80's				S1S2, NSR	
			2+ pulses x4 Ext				+2 radial pulses	
			S1 S2 present				+2 pedal pulses	
			Ø edema					
			Afebrile					

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)
)

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE
10 Jul 03

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

EPW [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	101/				98/	109/					117/		107/				109/	
BP Cuff	61				50	81					74		64				39	
Temperature	98.1				98.8	96.2												
Pulse	77				71	81					88		64				67	
Respiratory Rate	14				16	20					15							
SAT	95	C			96	96					97		96				97	
						RT					RA		RA				RA	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVPB																		
TOTALS																		

OUTPUT

		HOUR / TOTAL																	
URINE																			
		Sp gr																	
		S/A																	
NG		OUTPUT																	
		pH																	
		GUIAC																	
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

EPW [redacted] b6-4

POST-OP DAY

PAGE 3 OF 4

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	
BP									
HR	96						94		
R	16						16		
Sats	97						97		
Temp									

VITAL SIGNS	16	17	18	19	20	21	22	23	8°T
I/O									

RESPIRATORY

	TIME												
	MODE												
	F_iO_2												
	TV												
	RATE												
	PEEP												
A	pH												
A	PCO_2												
A	pO_2												
B	HCO_3												
B	SAT												
G	BASE												

LABORATORY

	TIME												
	GLUCOSE												
	Na/K												
	Cl/CO_2												
	BUN/Cr												
	WBC/PLATELET												
	Hct/Hgb												

ACTIVITIES OF DAILY LIVING

	TIME												
	MOUTH CARE												
	BATH												
	SKIN CARE												
	FOLEY CARE												
	TRACH CARE												
	ROM EXERCISES												

TURN

TIME					

SUCTION

TIME					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

EPW [redacted] b6-4

For use of ... MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
... see AR 40-66; the proponent agency is the Office of The Sur...

REPORT TITLE
INTENSIVE CAI ...RSING FLOW SHEET b6-2

...TSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSE...MENT

		TIME	INITIALS	[redacted]	INITIALS		INITIALS
NEURO	PUPILS	0630		PERRL			
	SENSORIUM	AF		A+OX3			
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		even unlabored			
	BREATH SOUNDS	Wheezing (B)		Wheezing (B)			
	SECRETIONS	∅		∅			
SKIN	COLOR	WNL T Pal S		normal for race			
	INTEGRITY	Dry, intact		intact			
IV SITE	LOCATION	(L) FA 18 (R) AC 14		(L) FA 18 (R) AC 14-HL			
	CONDITION	HL					
GASTRO	ABDOMEN	Soft NT-D		soft non tend.			
	BOWEL SOUNDS	Hyper		present x4 quad			
GU	URINE	clr yellow		clear			
	COLOR/CLARITY			yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 Adec		NSR			
		PP x4		S1S2			
				2+ Pulses x4 Extr.			

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC: ICU 2 ... | DATE: 7-11-03

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

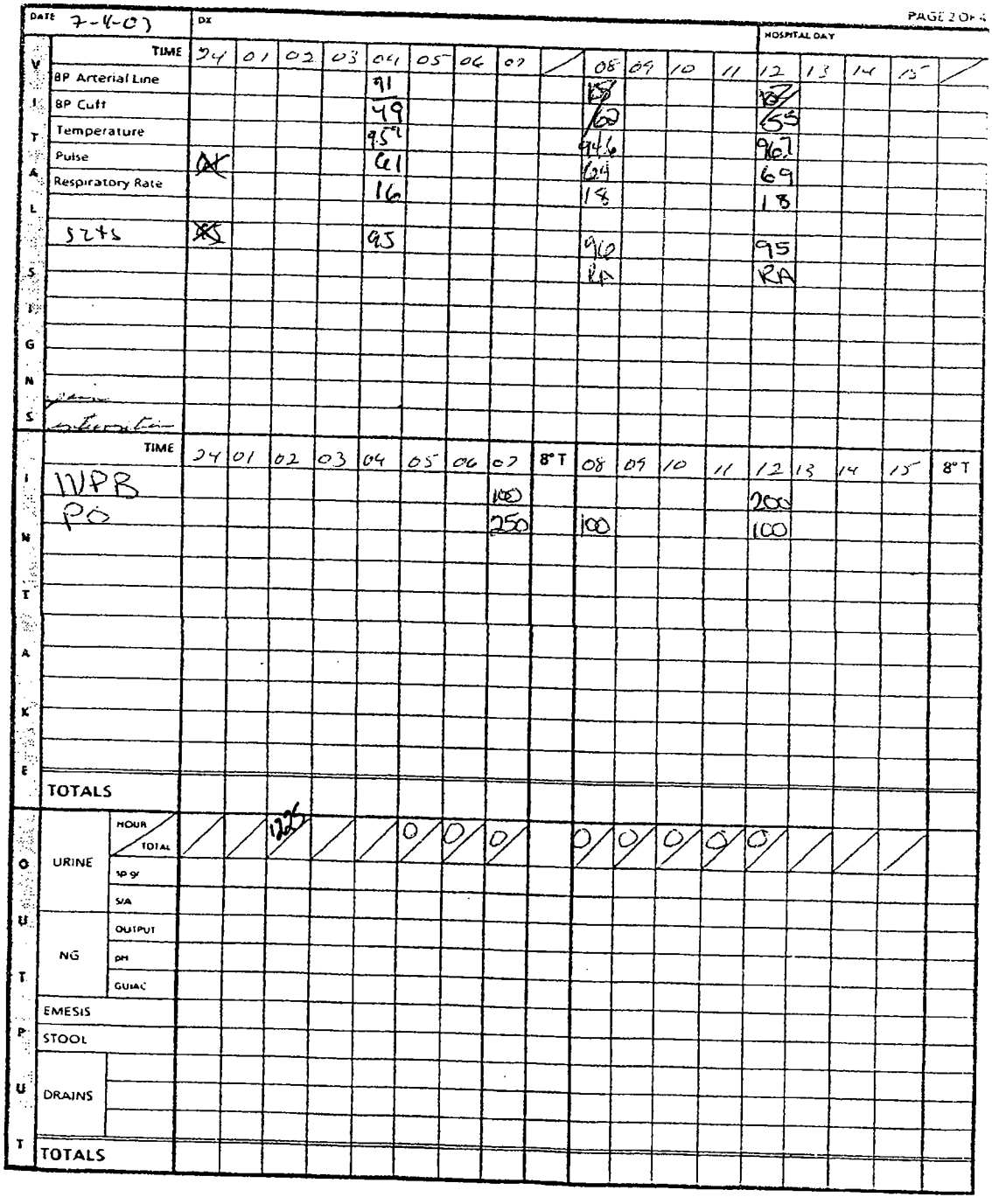
EPW [redacted] b6-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

[redacted] b6-4



DATE 7-4-03 DX PAGE 2 OF 3

HOSPITAL DAY

VITALS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff					91					89				82				
	Temperature					99					100				99				
	Pulse	~~24~~				95					94.6				96.7				
	Respiratory Rate					61					64				69				
						16					18				18				
	5248	~~RS~~				95					96				95				
											RA				RA				

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVPB								100						200				
	PO								250		100				100				
	TOTALS																		

OUTPUT		HOUR / TOTAL			120			0	0	0		0	0	0	0	0				
	URINE	sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

EDL [redacted] b6-4

POST-OP DAY

VITAL SIGNS

	16	17	18	19	20	21	22	23	
BP	118/		[illegible]				112		
	/50		[illegible]				65		
T	37		96.6						
P			86				83		
R	96		16				16		
SpO2	96		98				96		
-RA	97		RA				RA		

INTAKE / OUTPUT

	16	17	18	19	20	21	22	23	8°T
PO Fluid	100						200		
Urine	0								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME					TURN / SUCTION	TIME				
MOUTH CARE										
BATH										
SKIN CARE										
FOLEY CARE										
TRACH CARE										
ROM EXERCISES										

24° I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday ______ wt Today ______		
INTAKE: IV ______ po ______		
OUTPUT: Urine: ______		
TOTAL ______ TOTAL ______		
BALANCE ______		

[redacted] b6-4

MEDCOM - 14108

For use of ...ICAL RECORD--SUPPLEMENTAL MEDICAL DATA
...ee AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE
INTENSIVE CARE ...SING FLOW SHEET

APPROVED (Date)
GA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	0800	[redacted]	1800	[redacted]		
	SENSORIUM	PERRLA		PERRLA			
		A/Ox3	b6-2	Alert x3		b6-2	
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored		even, unlabored			
	BREATH SOUNDS	CTA(B)		CTA BIL			
	SECRETIONS	∅		∅			
SKIN	COLOR	NFR		NFR			
	INTEGRITY	warm & dry		warm & dry			
				DRSG to ⓓ chest bx, intact			
IV SITE	LOCATION	(L) FA H/L		(L) FA			
	CONDITION	(R) AC		RAC			
GASTRO	ABDOMEN	soft ND/NT ⓓ feed-		soft NT			
	BOWEL SOUNDS	ings around (L)		BS ⓓ x4 quads			
		chest wall wound, dress					
		ing intact BS x 4					
GU	URINE	via Urinal		via Urinal			
	COLOR/CLARITY	has not voided @					
		this time					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR		NSR			
		S1 S2		S1 S2			

LEGEND: Cr - Creatinine; FiO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

[redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE

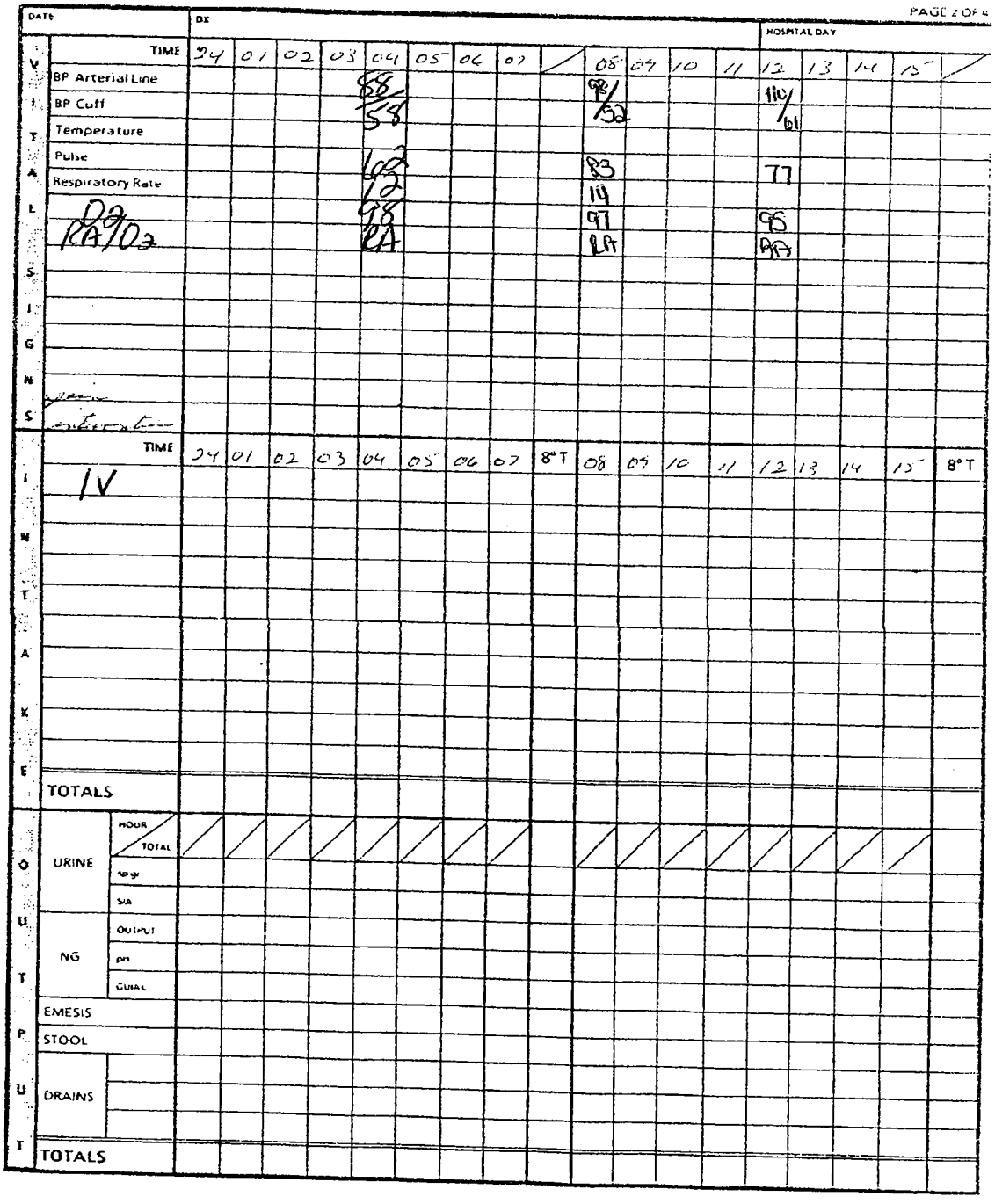
IDENTIFICATION (For typed or printed entries give: Name—last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

[redacted] b6-4



DATE

DX

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line					68/58					98/52				110/61				
BP Cuff																		
Temperature																		
Pulse					62					83				77				
Respiratory Rate					12					14								
RA/O2					98 RA					97 RA				95 RA				

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV																		
TOTALS																		

OUTPUT

	HOUR / TOTAL																	
URINE																		
NG																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

[redacted] b6-4

POST-OP DAY

VITAL SIGNS	16	17	15	19	20	21	52	23	
	113/65		135/68				100/57		
			992				95		
	78		93				65		
	15		16				18		
	95		96				97		
	RA		RA				RA		

	16	17	18	19	20	21	22	23	8° T
Ancalt..							50		
Clinomycin 900							100		
PO									
VRu			800						

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
	ABG	pH									
		PCO_2									
		pO_2									
		HCO_3									
		SAT									
		BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME					TIME				
	MOUTH CARE				TURN					
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	______	Urine:	______
po	______		______
TOTAL	______	TOTAL	______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

MEDCOM - 14111

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 17 Jul 03
Time In: 1440
Allergies: 0
Pre-op V/S: 110/60
Procedures: Debridement

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP 0 EBL
Meds/Times: 3 Versed 350 Fent last 1400

Drains	Airway
Hemovac	Nasal
NG	Oral
(JP)	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds

History

Time	1340	1400	1420	1435	1510		1530
SaO2	98	100	100	100	98	98	96
FiO2	60	40	40	60	40		28
Methods	RA	RA	RA	RA	RA		
240							
220							
200							
180							
160							
140							
120							
100	^		^	^		^	
		^					
80							
60							
			^	^		^	
40		^					
20							
RR	11						
T	96	96.8		97	98		

Time	1440	1445	1455	1500	1510		
Pain (0-10)							
~~100~~ 142	68	70	61	58	60	60	

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2	**AIRWAY** A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula **V/S** X = A-line BP ^ = Cuff BP = Pulse **TEMP** S = Skin O = Oral A = Axillary T = Tympanic R = Rectal **LOS** C = Cervical T = Thoracic L = Lumbar S = Sacral
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	9	12	12	

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | DATE

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

[redacted] 66-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1441	5					
1446	Small	Ø				

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

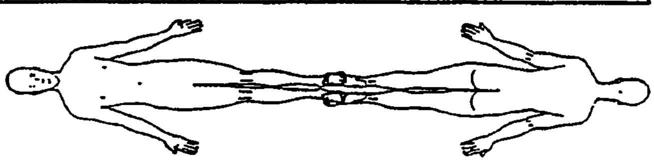
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) chest	Bulky	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1441 Pt arrived via litter accompanied by Anesthesia. Drsg (L) chest wall intact c̄ JP Drain pt arousable move one arm when asked to move extremities. Ø c/o pain lungs CTA ↓ (L) side Palpable b6-2 periferial pulse. [redacted] may
1514 Pt awake move all four extremities Periferal pulses present (B) placed on RA pulse ox remains @ 100 will cont to monitor — b6-2 [redacted] may/ran
1535. Pt cont VSS chest drsg c̄ mod amount serous sang drainage awake alert follows commands 5cc Bloody drainage from JP pt transfered via litter to ICW2 [redacted] may/ran b6-2

Discharge Criteria:
Date: 15 Jul 03 Time: ~~1501~~ PARS:
BP: 99/45 T: 98 HR: 66 RR: SaO2:
Pain Level at D/C (0-10):
Intake: TKO IV LR Output: Ø
Additional Data:
Transferred To: ICW 2
Report Given To: Staff ICW 2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] may/ran
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: b6-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

MG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	INITIALS	INITIALS	INITIALS
NEURO	PUPILS	PERRLA, 3mm	Perrla 3mm	
	SENSORIUM	A/Ox3	A&Ox3	
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored	even unlabored	
	BREATH SOUNDS	CTA(B)	CTA-B	
	SECRETIONS	∅	∅	
SKIN	COLOR	NFK	NFR	
	INTEGRITY	warm, dry, intact	dry, intact dressing on left chest	
I.V. SITE	LOCATION	(L) FA/L(R)AC site	LFA HL	
	CONDITION	NO S/S infiltration, patent	RAC -HL	
GASTRO	ABDOMEN	soft ND/NT	soft, nontender	
	BOWEL SOUNDS	X4	+BS x4qds	
GU	URINE:	via urinal, has yet to void	urinal	
	COLOR/CLARITY			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR S1S2	S1S2 NSR +2 pulses/pedal radial L3 sec cap refill	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SIA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

[redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 13 JUL 03

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

EPW [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

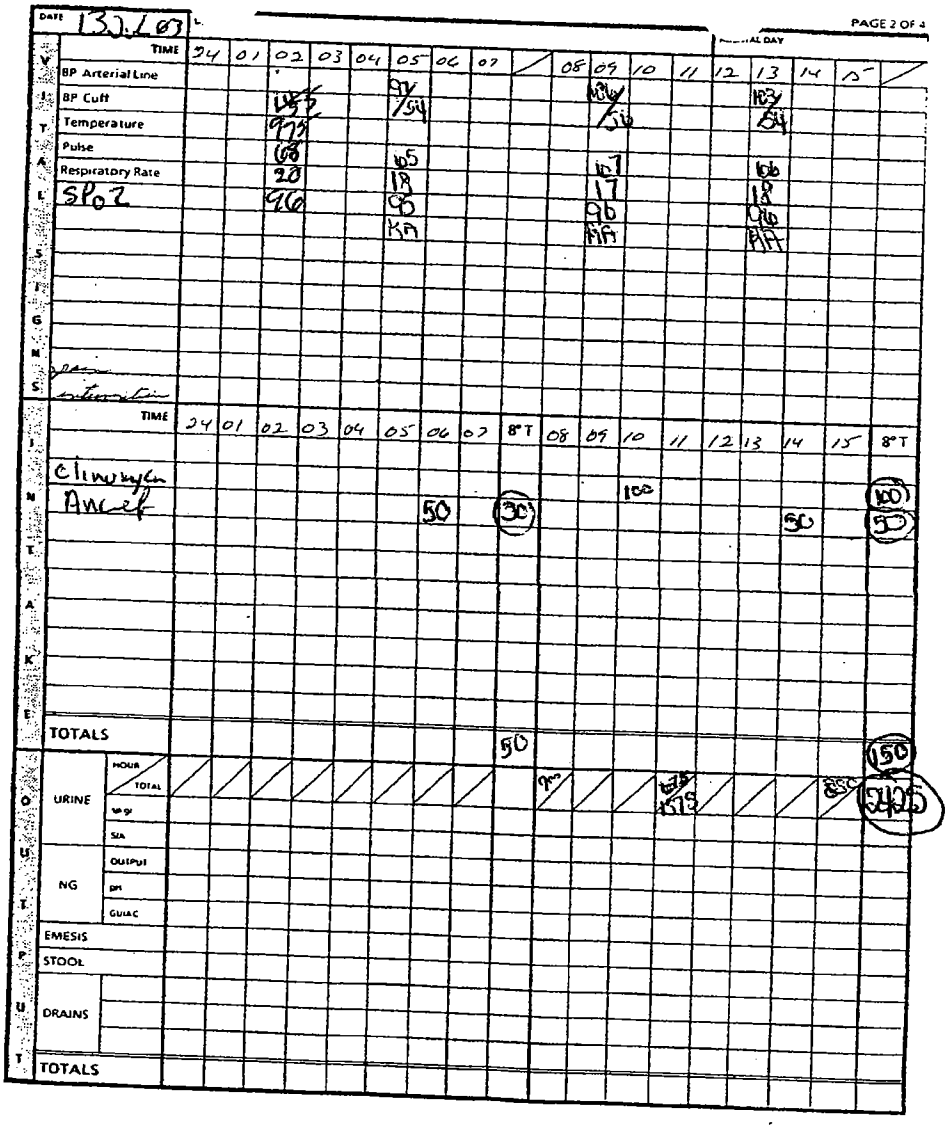
☐ DIAGNOSTIC STUDIES

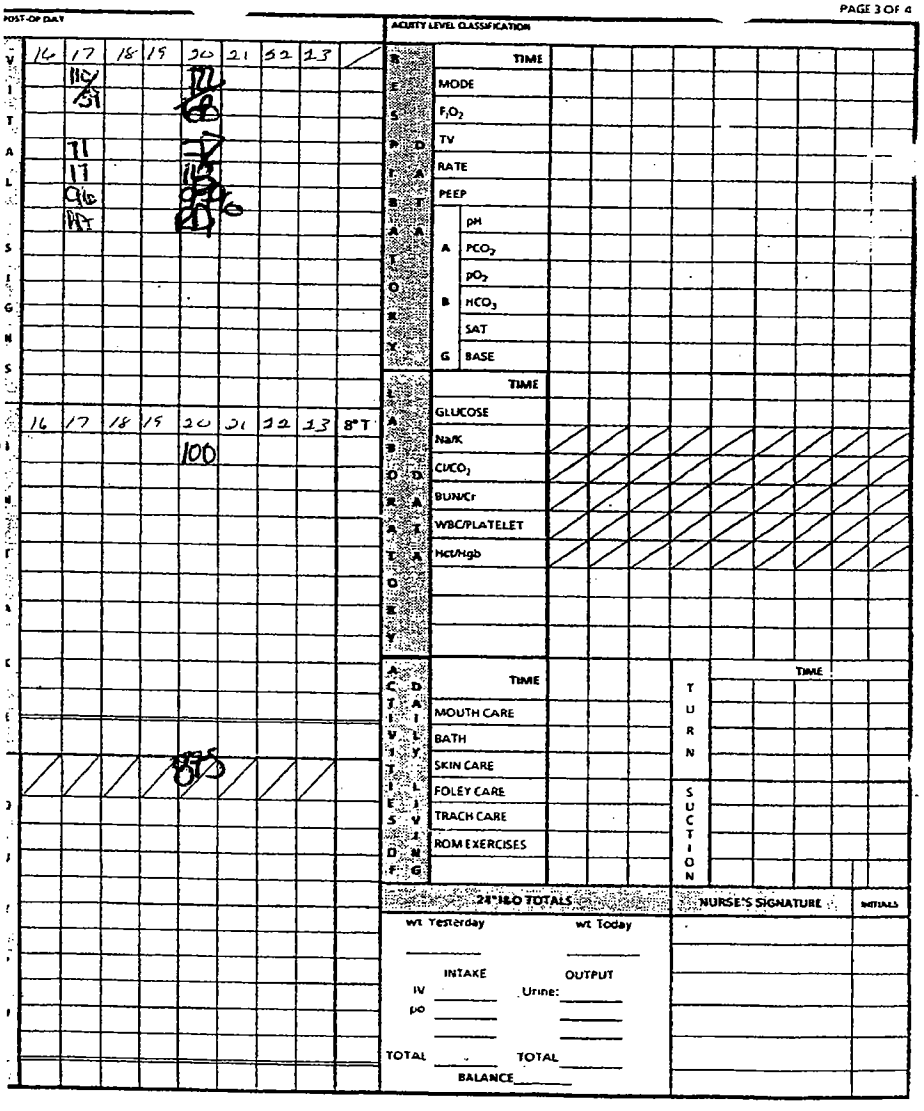
☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)




POST-OP DAY
ACUITY LEVEL CLASSIFICATION
16 17 18 19 20 21 22 23
VITAL SIGNS
RESPIRATORY
TIME
MODE
F_iO_2
TV
RATE
PEEP
A pH
PCO_2
pO_2
B HCO_3
SAT
G BASE
LABORATORY DATA
TIME
GLUCOSE
Na/K
Cl/CO_2
BUN/Cr
WBC/PLATELET
Hct/Hgb
IV Meds
100
ADDITIONAL DATA
TIME
MOUTH CARE
BATH
SKIN CARE
FOLEY CARE
TRACH CARE
ROM EXERCISES
TURN
SUCTION
24 HR I&O TOTALS
NURSE'S SIGNATURE
INITIALS
wt Yesterday
wt Today
INTAKE
IV
po
TOTAL
OUTPUT
Urine:
TOTAL
BALANCE

unc. op.

√a c √a PAGE 2 OF 4

DATE | DX | HOSPITAL DAY

		24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
VITALS	TIME																		
	BP Arterial Line		124/116					65/60					96/62						
	BP Cuff		65/60																
	Temperature																		
	Pulse		06 67					63					62						
	Respiratory Rate		16 16																
	Sp02		96 96 96					97					99						
			100																
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	TOTALS																		
OUTPUT	URINE HOUR																		
	URINE TOTAL																		
	URINE SpGr																		
	URINE SA																		
	NG OUTPUT																		
	NG pH																		
	NG GUAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. [illegible] LOCATION (State or Country Code.)	
1	2	3	4	5	6	7	8
A	L	L	D	L		I	Z

3. REGISTER NUMBER: 9 10 11 [redacted]

NAME (Last, First, Middle Initial): # [redacted] EPW b6-4

4. PAY GRADE: 16 17 — unk

5. SEX: 18 — M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 — unk

7. AGE AT ADMISSION: 27 28 29 — 25 4

8. RACE: 30 — X

9. ETHNIC BACK-GROUND: 31 — 9

RELIGION: muslim

10. LENGTH OF SERVICE: 32 33 34 — unk

ETS: unk

11. FMP: 35 36 — 9 9

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — 0 0 0 0 0 0 [redacted]

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46 — unk

HOUR OF ADMISSION: 1745

BRANCH / CORPS: NO b6-4

14. FLYING STATUS: 47 48 49 — NO

15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 — unk

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71 — 9

PREV. ADMISSION: YEAR — ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — D

WARD: ICU 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAM[redacted] b2-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — 2 1

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 7 2 2

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A A A A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 7 0 9

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116 — 0 3 0 7 0 9

FOR LOCAL USE

DX: infected chest wall (R) (Wound) DX 8751
E956
Proc 3401 x2
Trauma 9
Inj 649

ADMITTI[redacted] (Signature, as required) b6-2 jezik

SIGNATURE OF ADMITTING CLERK [redacted] b6-2

DA F[redacted]

MEDCOM - 14118

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted] b6-2		N/A	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	31 y	Z	unk	N/A	N/A	NO
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
99	[redacted]		N/A			ICU 2
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
N/A		K79	N/A			NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0130	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION	ADMITTING OFFICER
—	50	10 Jul 03	b6-2 Dr. [redacted]
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	**27b. TELEPHONE NO.**	**28. DATE OF THIS ADMISSION**	
—	—	10 Jul 03	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		**30. DATE OF INTIAL ADMISSION**	**32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED**
[redacted] b6-2			

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Scalp laceration

DX: 8730, 78009, E9174, [redacted] b6-2

PROC: 8659

Trauma IM: 9, 989

850.1
873.1
E968.2
86.59

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
[redacted] MD Dr. [redacted] b6-2	For [redacted] b6-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 14119

9 July 03 Abu Ghraib Prison
1003B Camp Vigilant
Fighting to breakup fight
S: hit in the head with a
tent pole in the yard.
LOC, not responsive to
pain, (LOC ~30min)
O: lac ~5cm scalp.
bleeding controlled
136/82 P79 RR20 O2 100% on 100% mask
CTA PERRL but
sluggish, RRR
ekg
Neuro unresponsive to
pain.
A: Closed Head Injury/
Laceration Scalp.
P: MEDEVAC - CT head
① TKO fluids ② pressure
③ 100% mask O2 to scalp
④ C-spine control, lab

[redacted] b6-2
MC BN Surgeon

TE	NOTES
10 July 0200	Pt admitted from emt @0130. VSS, alert and awake, c/o small amount of pain at laceration. Patent has insiratory wheezing noted bilaterally, pulses palpable x4, b&Ox4 quads. Pt c NS from emt, d/c IV after bag finishes. Laceration to scalp @ stapled, CTA. Wand is intact, small amount of blood noted. Pt c d/c orders, needs d/c meds. Will continue to monitor. [redacted] b6-2 91WM6
10 Jul 0500 96.1 66 16 104/60 99%	Assumed care of pt @ 0500. Pt asleep. VSS. Pt has small laceration on scalp. Lungs CTA. Abd. soft and tender. Pt c d/c orders. D/C meds in medical folder. IV NS d/c'd. 0 c/o pain/discomfort @ this time. Will continue to monitor. [redacted] b6-2 91WM6, SGT
10Jul03 1530	assumed care @1300 - VSS - pt. ready to return to EPW camp when transport available - pt. has meds and discharge Summary - [redacted] CRT, AW b6-2

EPW# [redacted] b6-4

b2-2 NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted] (EMT)

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 09 July 03 | TIME: 2345

TRANSPORTATION TO FACILITY: Med Evac

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE	HOME PHONE		FLYING STATUS			
31	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Z Antivert

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: laceration to head / loss of consciousness

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2358

INITIALS: C

VITAL SIGNS

TIME	2352					
BP	134/60					
PULSE	70					
RESP	19					
TEMP	97					
WT	65 kg					

LAB ORDERS

☒ CBC/DIFF	ABG ☒	PT/PTT	BHCG/URINE/BLOOD/QUANT		
URINE C&S	UA MSCC/CATH		CHEM: [redacted] Chem 7 w/ Lytes		
BLOOD C&S X					

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	☒ HEAD CT
ANKLE R/L	

ORDERS

☒ PULSE OX 100 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2358	d 70 .5 IVF	[redacted]	b6-2		
2358	1 gm Rocephin IV				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 14122

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC — WBC 7.7; H/H 12.9/41; PLT 176

SMAC — 142 | 106 | 10 / 4.4 | 32 | 127 / 1.1

PT 14.0

APTT 23.5

BHCG | ETOH | GLU

ABG/PULSE OX: SUP 02 | PH | PO2 | PCO2 | SAT | OTHER

U/A: DIP | MICRO

RADIOLOGY — Check if read by radiologist ☐

RESULTS: CT Head — WNL

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

31 ♂ EPW hit in head c̄ tent pole while trying to break up a fight. pt arrived via [illegible]

c̄ scalp laceration.

G: [illegible]

H: [illegible] 2 inch laceration on [illegible]

N: [illegible]

L: [illegible]

[illegible]

Ext: [illegible]

(A/P) Keflex / Tylenol / remove staples in 10 days. — return to EPW [illegible]

GERD / BA — [illegible] / [illegible]

Anesthesia scalp / close c̄ staples (5)

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] 2 May

b6-2

DIAGNOSIS Scalp laceration 1½ inches

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] b6-4

EMERGENCY CARE AND TREATMENT ***(Doctor)***
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 14123

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

JULY 19 2003 HOUR

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIG[redacted]

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW 2

EPW

[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 14124

Ward/Section:	REQU[redacted]NG PHYSICIAN:	[redacted]MISTRY RESULT FORM (Subject to the Privacy Act of 1974)
FMH	DR [redacted] b6-2	
LAST, FIRST, MI: [redacted] b6-4	DATE: 9 Jul	TIME: 2359
		SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.5	3.3-5.5 G/DL
ALP	64	26-84 U/L
ALT	37	10-47 U/L
AMY	99*	14-97 U/L
AST	36	11-38 U/L
TBIL	0.2	0.2-1.6 MG/DL
BUN	10	7-22 MG/DL
CA++	8.9	8.0-10.3 MG/DL
CHOL	133	100-200 MG/DL
CRE	1.1	0.6-1.2 MG/DL
GLU	127*	73-118 MG/DL
TP	6.8	6.4-8.1 G/DL

PICCOLO
10/07/03 00:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #: 678 DR #: 00
SERIAL #: 0000100684

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}	142	128-145 mmol/l
K^{+}	4.4	3.3-4.7 mmol/l
CL^{-}	106	98-108 mmol/l
tCO_2	32	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2 | **DATE:** 10 Jul 03 | **LAB ID NO.:**

b6-4

ID: 00[redacted]
WB

10-07-03
00:09

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	4.55	x10^6/uL	4.00	6.00
Hgb	12.9	g/dL	11.0	18.0
Hct	41.8	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	196.	x10^3/uL	150.	450.
LYX	30.8	%	20.5	51.1
LYH	2.4	x10^3/uL	1.2	3.4

[redacted]

MEDCOM - 14126

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 9 Jul 03	TIME: 2359
		SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.0	9.8-13.6 secs
APTT	23.9	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] DATE: 10 Jul 03 LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b6-4

[redacted]

b6-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TITLE AND/OR NOTED SIGN
10 Jul 03	0028 HOURS	
Admit to ICW 2		
Dx: SCMP (recently)		
Condition: stable		
V.S.: per Routine		
Allg: NKDA		
Meds: Keflex 250 mg p.o. Q.D.		
Tylenol #3 tablet p.o. Q 4 hrs p.r.n. pain		

Noted 7/10/03 0128

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
Diet: Regular		
Activity: AT standard		
Plan: ① return to EPW Camp in AM		
② Fill attached Keflex prescription		
③ Transfer summary & medical files to EPW Camp.		
Discharge patient at 0700 and Release to EPW Camp.		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

b6-2

[redacted]

2 Jul 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

Mo. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10 11 12
7/10	[redacted]	Vitals Per routine	5	[redacted]
			13	[redacted]
			21	
7/10	[redacted]	Reg Diet	7	[redacted]
			11	[redacted]
			17	
7/10	[redacted]	Act as tol	5	[redacted]
			13	[redacted]
			21	

all b6-3

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Scalp Lac

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 14129

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 07 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/10-	[redacted]	Admit IRW#2 Stable	7/10	0130	0130	[redacted]
7/10-	[redacted]	Return to Erw camp in am	7/10	AM		[redacted]
7/10-	[redacted]	Fill attached Keflex Prescription				[redacted]
7/10-	[redacted]	Transfer Summary attached				[redacted]
7/10	[redacted]	Discharge pt @ 0700 s return to Erw camp	7/10	0700		[redacted]

all b6-2

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

USAPA V1.00

[redacted] [redacted]

MEDCOM - 14130

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407: the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12
7/10	[redacted]	Keflex 250mg P.O.	06	[redacted]		
b6-2		QID	12		b6-2	
			18			
			24			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Scalp Lac

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: # [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14	
E	15	16	17	18	19	20	21	22	
N	23	24	01	02	03	04	05	06	

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 14131

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
7-10	[redacted]	Tylenol #1 tab. 00 q4h for HA or pain	

USAPA V1.00

[redacted] [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
[redacted]							EPW [redacted] b6-4			M

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC		RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	BACK-GROUND	
								3	1	y	Z	9		Unk

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER									
32	33	34		35	36	37	38	39	40	41	42	43	44	45	
			NA	9	9	0	0	0	0	0	0	[redacted]			

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	0130	N/A

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE									
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	
			K	7	9										

Returned EPW Camp ~~Custody~~

17. UNIT LOCATION (State or Country Code)		18. MOS				PREV. ADMISSION	
62	63	64	65	66	67	YEAR	X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WA	SHIP OF EMERGENCY ADDRESSEE
72: 0	1CW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b2-2	

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)						
73	74	75	76	77	78	79	80	81	82	83	84	85	86	
5	0							0	3	0	7	1	0	

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)						
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	
A	B	A	A							0	3	0	7	1	0	

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (Y Y M M D D)						
103	104	105	106	107	108	109	110	111	112	113	114	115	116	

FOR LOCAL USE

Dx: Scalp laceration

Patient Died not die

Dx: 8231 E9289

Trauma ICH Injury

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b6-2 Dr. [redacted]	[redacted] b6-2 PFC 9/6/10

DA FORM 1966, MAR 90

MEDCOM - 14133

INPATIENT TREATMENT RECORD COVER SHE

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

1. [redacted]	2. NAME (Last, First, MI) EPW [redacted] b6-4	3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 58y	6. RACE Z	7. RELIGION unk
8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION N/A	14. WARD ICW2
15. FLYING STATUS N/A	16. DSG	BEN K78	18. BRANCH/CORPS N/A
19. UIC/ZIP	20. TYPE CASE NBI		

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0140	AS FA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	50	14 Jul 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	13 Jul 03	b6-2 Dr [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] 628		

31. SELECTE[redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(L) auricular hematema

380.31
920
921.1
910.0
782.3
E968.8

38031 T I
920 9 929
7245-
E962?

[redacted] b6-2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIG[redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

Dr [redacted] For [redacted]

DA F[redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

b6-2

MEDCOM - 14134

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

58yoIm Brought there By task force 20. Pt states he was assaulted by US Soldiers. Pt presents c Left periorbital ecchymosis + edema. Left Cheek edema c pain on palpation. Pt also c left ear edema + ecchymosis. left forehead abrasion & Right Cheek abrasions

PHYSICAL EXAMINATION

PMH: Hepatitis B

PSH: denies

Meds: none

allergies: NKDA

VS 154/90 P 93 R18 T98.3

CT face/head:

Head - negative

CT Face - negative for facial fractures. Pt c (B) max sinus membrane thickening

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

Heent: PERRL / EOMI
(-) Battles sign.
ears patent.
TM clear (B)
mandmand stable
no palpable steps noted

A/P 58yoIm s/p alleged assault c no s/s of facial fx.
(1) observe left ear

[redacted] b6-2

SIGNATURE OF PHYSICIAN	DATE	[redacted] ANIZATION

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

= [redacted] b6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7-13-03	0200: Pt. transfered to DCW#2 via litter. VSS x O2 sat 95% RA. HR Reg, Lungs c insp. ronchi throughout. Pt. has non-productive cough, has cipro in pocket. BS @ X4. Large hematoma noted @ peri-auricular area, TTP. PERRLA. Pt given PO motrin for pain & Ambien for sleep/anxiety. Will cont. to monitor. b6-2 [redacted] CT/dv
13July03	0525 Assume pt care @ 0500. Pt awake and alert. C/o dizziness. VSS. PERRLA, @ auricular
0500 97.6 64 24 126/82 96%	hematoma, small scrape noted to @ ear. HR reg. Lungs CTA c non-productive cough. Abd. soft NO tenderness or distension noted. BS x 4. Pt has full ROM to extremities, pulses strong. Has belt around waste for back problems per pt. No c/o pain @ this time. Will continue to monitor. b6-2 [redacted] GWM
13July03 1330	Assumed pt care @ 1300. Pt Awake & alert. Dr. [redacted] @ bs new orders rec'd & noted. bruising noted to face. (L) eye swollen & bruised (L) ear bruised. Airway patent, lungs CTA, Abd soft, round nondistented nontender, BS(+)x4. pt has belt around waist states "its for back problems" ↓ & ↑ Ext c full ROM (+) pulses. (D) IV access noted. pt c/o back pain, given: 800mg motrin cont'd

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted] b6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont'd 13July03 1330	given per pen orders. [redacted] will cont to monitor. [redacted] b6-2 Qiwmle
2145.	Pt. care assumed @ 2100. Temp 100.0. Pt. given motrin for mild discomfort to (L) side of face. Pt. provided c warm compress. Pt. praying @ B.S., cooperative c care. PERRLA. HR Reg, Lungs CTA. ABD rotund, soft c BS @ X4. Pt. wearing gait belt for back problems. Purple hematoma noted to (L) peri auricular area c swelling & drainage noted. will cont. to moniter. [redacted] b6-2 /COLAM
14July03	Recieved Pt Alert to verbal stimuli. VSS. Pt c/o mild pain to (L) side of face. PERRLA. (L) Auricular hematoma noted. NO JVD noted. Lung sound clear Bilateral. Good Pulse motor function on All extremity. BSX4. Continue to monitor Pt. [redacted] b6-2 LPN
14July03	0615 - Gave Pt T Ibuprofen motrin for c/o pain and a warm compress. Will continue to monitor Pt. [redacted] LPN b6-2
14 Jul 03 @ 0719	OMFS Pt lying in bed c compress to face. ecchymosis edema still present. c edema to VSS AP (1) return to MP custody. [redacted] b6-2
14July03 @ 10:00am	- Pt is resting comfortably in bed c no c/o pain or discomfort. [redacted] LPN
1430	Pt D/C'd to EPW Camp c escort - [redacted] b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

OMFS

13Jul03
@1312 Pt S/P assault c no facial fxs.
Pt c c/o Back pain
VSS AF
facial edema + left ear ecchymosis still present.

A/P
(1) Motrin 800 mg
(2) warm moist compress to face.

[redacted] b6-2

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

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

REGISTER NO. | WARD NO.

[redacted] b6-4

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

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Discharge Summary
13 Jul 03	
@ 1843	Admit Dx: facial trauma
	D/C Dx: Same
	D/C Cond: Stable
	D/C meds: motrin 800 mg 1 tab po q8°
	Procedure: CT Head + Face Both
	negative for fractures and intracrania
	Pathology
	D/C diet: regular
	Plan:
	① warm moist compress to face
	+ left ear
	b6-2
	[redacted] MAJ
	Maxillofacial Sx

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

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

#[redacted] , b6-4

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

MEDCOM - 14139

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DAY	MONTH	YR.	TIME	PRIVATE VEHICLE / AMBULANCE / OTHER (Specify)		PATIENT / OTHER (Specify)
3	JUL	03	0100	OTHER: Ø	Ø	ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Facial Trauma

SEX: M AGE: 58

POSSIBLE THIRD PARTY PAYER? YES NO

VITAL SIGNS

TIME	0100
BP	154/90
PULSE	93
RESP.	18
TEMP.	98.3
SpO2	95 [redacted]

b6-2

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

b6-2

ORDERS	INITS	TIME
CT Head	[redacted]	0110
Waters view		

ASSESSMENT/DIAGNOSIS
① Auricular Hematoma ②
② Contusion to face

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 0102

~~Hep B~~

58 y/o ♂ sent here by TASK Force 20. for a Head CT. pt with pain only on face & EARS. pt c/o no other complaints.

G: WD, WN, NAD, A&O? Handcuffed & shackled into ED unassisted. c guard.
H: Ⓛ auricular hematoma, Ⓛ superficial laceration
Ⓡ Ear. o/p Ⓡ hematoma TM ⊘
⊘ Ecchymosis below Ⓛ Eye.
PERRL, EOMI ⊘ Diplopia c upward gaze
⊘ Entrapment.

N: ⊘ ...
L: CTA Ⓑ ⊘ ...
Ext: ⊘ C/C/E

PMH - Hep B
PSH - Ø
Tm - ?
SOC Ⓐ 0103

CT Head
WNL
waters view
WNL
? FX

A/P Admit to ICW #2. consult OMFS in A.M.

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic): EMERGENCY / TODAY / 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: ICW #2

CONDITION UPON RELEASE
- ✓ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0135

(CONTINUE ON SF 507, IF NEEDED)

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

[redacted]
EPW
660-00-[redacted]
b6-4

SIGNATURE OF PROVIDER AND ID STAMP
[redacted] ... 2 Jul 03

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

b6-2

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 14140 Copy

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

0442

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST T ORDE NOTED SIGN

13 July 03 0440

Admit ICW #2

Dx: ① Anxiety ② Heatstroke

②

Condition: Stable

Vitals: per routine

Allg: NKDA

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Meds: ② 800 mg motrin P.O.

5 mg Ambien tablet p.o.

Keflex 250 mg tablet P.O. q.i.d.

Diet: Regular

Activity: as tolerated

R/N consult MAJOR [redacted] of OMS surg in the A.M. after 0800.

b6-2

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

13 Jul 03 @ 1315

① Warm compress to ear

after TID

[redacted]

b6-2

noted [redacted] 91WM 1330

24 hr GRAM LITAN 7/13/03 2315

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

14 July 03 0720

① Okay to D/C tom P custody

[redacted]

b6-2

URSING UNIT | ROOM NO. | BED NO.

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. LOCATION		(State or Country Code.)
1	2	3	4	5	6	7	8	
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
[redacted]							EPW [redacted] b6-4			M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								5	8	Y	9	Z	unk

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER									
32	33	34		35	36	37	38	39	40	41	42	43	44	45	
			N/A	9	9	Ø	Ø	Ø	Ø	Ø	Ø	[redacted]			

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		b6-4
N/A	U	Ø148	unk

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
			K	7	9									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		
Ø	ICW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b2-2		

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
5	Ø							Ø	3	Ø	7	1	4

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	F	A							Ø	3	Ø	7	1	3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (YYMMDD)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

Dx: (L) auricular hematoma

ADM[redacted]nature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b6-4 b6-2 Dr [redacted]	[redacted] b6-2 PFC, 91G10

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 13 | 14 | 15 | 16 | 17 | 18

19 | HOUR

PULSE (O) | TEMP. F (°) | TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT: [redacted]

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

EPW # [redacted] 66-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 14143

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16
7-13	[redacted]	Vitals per routine.	5	[redacted]			
		b6-2	13	[redacted]			
			21	[redacted]			
7-13	[redacted]	Diet: Regular	7	[redacted]			
		b6-2	11	[redacted]			
			17	[redacted]			
7-13	[redacted]	Activity as tol	5	[redacted]			
		b6-2	13	[redacted]			
			21	[redacted]			
		b6-2					
13 Jul	[redacted]	warm compress to	6	[redacted]			
		ear at face tid	14	[redacted]			
			21	[redacted]			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (4) auricular hematoma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW # [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 14144

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-13	[redacted]	Admit ICW #2	7-13	0145	0145	[redacted]
	-----	b6-2 Stable			b6-2	
7-13	[redacted]	Consult Major [redacted] b6-2 of	7-13	0900	1300	[redacted]
	-----	Oral Surgery in A.M. 0800				

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

USAPA V1.00

CLINICAL RECORD	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* ____ *Yr.* ____

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15													
7-13	[redacted]	Keflex 250mg	06	[redacted]															
66-2		PO QID	12	[redacted]															
			18	[redacted]			D/C												
			24	[redacted]					all	66-2									

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (L) auricular hemotoma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

EPW# [redacted] 66-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 14146

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
7-13	[redacted]	800mg motrin PO	7-13 0200 I; 7-13 2145 I; 7/14 0615 I (2)
		Q8° PRN	
	bb-2		7-13 0200 bb-2
7-13	[redacted]	5mg Ambien PO	[redacted]
		PRN @ HS	

USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
[redacted]	UNK [redacted]	b6-4	NA	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	UNK	UNK	UNK	NA	NA	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	000-00-0[redacted]	NA	ICU1

15. FLYING STATUS	16. RATING/ OSG	17. DEPT / BEN	18. BRANCH/CORPS	19. . . . UIC/ZIP	20. TYPE CASE
NA		NA b6-4	NA		NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From Emt	1330	AAJA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	24	10/6/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	7/13/03	b6-2 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF BLOOD/ COMPONENT TRANSFUSED
[redacted] b2-2	7/13/03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (MULTIPLE) C PARAPLEGIA

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0 b6-2	0 b6-2	0	85 b6-2	85

SIGNATURE OF [redacted] Dr. [redacted] b6-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] b6-2

DA FORM 3647, MAY 79 MEDCOM - 14148 USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
[redacted]	UNK			NA	
4. SEX	5. AGE	6.	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	UNK	UNK	UNK	NA	NA	NO
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
99	000-00-0[redacted]		b6-4 NA			ICU1
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
NA		NA	NA			NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From Emt	1330	AAJA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	24	10/6/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	7/13/03	b6-2 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF COMPONENT TRANSFUSED
[redacted] b2-2	7/13/03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (MULTIPLE) E PARAPLEGIA

Dx 874.8, 880.00, 879.2, 326.0, 344.1, E991.2

Px 46.10, 45.79, 80.16, 84.15, 86.28, 34.04

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

SIGNATURE OF A[redacted] b6-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] b6-2

DA FORM 3647, MAY 79 [redacted]OM - 14149

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)				3. GRADE	ADMISSION REMARKS
[redacted]	UNK				NA	
4. SEX: M	5. AGE: UNK	6. RACE: UNK	7. RELIGION: UNK	8. LENGTH OF SVC: NA	9. ETS: NA	10. PREVIOUS ADMISSION: NO
11. FMP: 99	12. SSN: 000-00-0[redacted]		13. ORGANIZATION: b6-4 NA			14. WARD: ICU1
15. FLYING STATUS: NA	16. RATING/ DSG	17. DEPT./ BEN: NA	18. BRANCH/CORPS: NA	19. UIC/ZIP		20. TYPE CASE: NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from Emt	1330	AAJA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	24	10/6/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	7/13/03	b6-2 Or [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF COMPONENT TRANSFUSED
[redacted] b2-2	7/13/03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (MULTIPLE) c PARAPLEGIA

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0 b6-2	0	0	85	85

SIGNATURE OF [redacted] Or [redacted] -b6-2- SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647, MAY 79 MEDCOM - 14150 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

July 03

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

EPW # [redacted] 66-4 ē MGSW s/p ex lap ē Hartmans, Ⓛ knee washout and resuscitation, med-evac to [redacted] 622 hemodynamically stable, hypothermic (94° Re) intubated, minimally responsive ē Ⓡ CT / Abdo drsg / Ⓛ Chest Ø bleeding from Ⓡ neck base, Ⓛ knee (ē penrose), foley, Ⓛ fem V cordis, Ⓛ 14 arm.
OR @ [illegible] FST found,
① Ⓛ Ⓡ Ⓒ retroperitoneal hematoma - non expanding
② thru/thru Ⓛ colon ē min spillage, ? chylous leak, Ø free blood.
Pt arrived @ [illegible] in extremis; 5 l crystalloid, 2 u PRBC, 200 cc 25% albumin

PHYSICAL EXAMINATION

Min responsive, pupils 3-4mm responsive
lungs CTA Ⓑ / symm
RRR, ØJVD, Øm/r/g
neck ē s hematoma, small Ⓡ base entrance wound,
ABS, mid-line lap ē staples - oozing, pink Ⓛ colost
legs cool / dry, weak distal pulses
arms ē symm weak pulses

Ⓡ post. iliac crest ē SGSW
Ⓡ axilla ē large exit wound
Ⓡ 3-4th toes ē lacerations
back Ⓛ / hematoma ecchymosis
Ⓡ tibia thru/thru

neck CXR Ø fx
CXR - atelectasis, Ø htx, ptx
pelvis Ⓡ iliac frag
Ⓛ knee Ø fx or frag
Ⓡ tib/fib Ø fx or frag

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

Plan. ① Zone 2 neck injury ē bleeding
→ explore
② Washout @ axilla wound

SIGNATURE OF P[redacted] 66-2 LTC	DATE 15 July 03	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201 45 505
OCTOBER 1975
USAPPC V1 00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7aug 03	Pt stable at this time. AAOx3. PERRLA. Mucous
1330	membranes pink, moist & intact. Neck supple
	Rhom. Lungs CTA bilat, Ø resp distress. NSR.
	Abd soft, non-tender, bowel sounds active x 4
	quads. Colostomy to (L) Q&T soft brown stool.
	Dry to (L) under arm, (R) shoulder and midline
	abd CDI. (R) leg exercised, Rom to (R) knee.
	Suture line to (R) lower leg CDI, open to air.
	(L) TKA Suture line intact Ø drainage
	noted, open to air. Ø complaints at
	this time — 66-2 [redacted] LT/RN
1400	Foley draining clear yellow urine. 80cc in
	bag at this time. [redacted] 66
2030	Foley emptied to 700cc clear yellow
	urine. Colostomy emptied to leg. Amt
	soft brown stool. Abd dsg Δ wet
	to dry, wound healing well. Dsg to
	(L) axillary region Δ'd wet to dry. Dsg
	to (R) arm CDI. Pt repositioned. [redacted] RT/RN
2330	Pt care assumed @2100. VSS, alert and aware 5 % pain. 66-2
	Lung sounds CTA, RSTx4. Colostomy bag ☐ flatus, ☐ output.
	Foley site intact, draining C/U. Dsg to abd colostomy, L'd

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

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

REGISTER NO.

WARD NO. ICU 2

#[redacted] 66-4

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

MEDCOM - 14152

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	On previous shift. Dsg ↓ to ® shoulder and Ⓛ axillary CDI. LBKA ∓ sutures CTA, no c/o pain. Pt ∓ head @ 30°, currently on Ⓛ side and being log-rolled every 2°. Will continue to monitor. b6-2 [redacted] Glenn RN
8 August 03 0600	Pt. awake & alert ∓ HOB @ 20°. HR Regular, lung sands clear bilat, bowel sounds (+) x 4 quads. VSS, temp slightly ↑ @ 100.2, ↑ tylenol ↑ given, pt also complaints of pain. Ht in Ⓡ FA ∓ s/s of infection. PSG's to ABD & bilat axillary areas CDI. Sutures to Ⓛ BKA intact, site ∓ s/s of infection, incision approximating well, sm. amt. of ecchymosis on knee. Colostomy draining dark brown formed stools, stoma pink & moist ∓ s/s of infection. Foley draining clear, slightly dark colored urine. All other assessment findings WNL. Pt ∓ other complaints @ this time. Will continue to monitor. [redacted] RT/AN b6-2
8 Aug 03 1300	Pt stable. OOO x 3. PERRLA. Mucous membranes pink moist & intact. Neck supple, FROM. HOB ↑ 20°. Lungs CTA bilat, no resp distress. NSR. Card soft, non-tender, bowel sound active x 4 quads. Colostomy producing large amts of gas. Indwelling foley draining clear yellow urine. Dsg to Ⓛ axillary region, Ⓡ shoulder and midline abd CDI. Rom to Ⓡ leg & knee. Pt ∓ complaint of pain to Ⓡ knee, repositioned. Ⓛ TKA incision open to air, CDI. ∅ complaints b6-2 [redacted] LT/RN
2000	Foley emptied ∓ 720 cc clear yellow urine. Colostomy emptied & cleaned. Soft brown stool. Abd dsg Δ done W↑D, wound healing well [redacted] b6-2

NSN 7540-00-634-4176 600-108

HEALTH RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03 0030	Pt care assumed @ 2100. VSS, alert and awake, c/o slight pain to abdomen. Lung sounds clear bilaterally, pulses palpable in UE, rle, bs+x4. foley catheter intact, draining CYU = difficulty. Colostomy bag intact, solid feces in bag. LBKA c sutures CTA intact, some dried blood noted. Abd dsg CDI, @ s/s infection. Pt turned Q2°, IV c ABX intact. Will continue to monitor. — b6-2 [redacted] gallmo
12 Aug 03	0520: Assume pt. care @ 0500; pt. awake. A&Ox3. Lungs CTA. @ BSx4. Colostomy bag intact. @ BKA c sutures intact. Dsg to abd & axilla CDI. RLE @ FA intact = signs of infection. Foley to gravity c clear yellow urine. @ complaints @ this time. Will continue to monitor — b6-2 [redacted] gallmo
12 AUG 03 1305	- Assumed PT care: PT is asleep in bed c @ % pain or discomfort. VSS. Lung CTA. BSx4. colostomy bag intact colostomy is pink & moist. Dsg to abdomen is CDI. sutures to @ leg stump is dry & intact c staples. IVC to @ FA intact, foley draining clear clear urine. will cont to monitor Pt. [redacted] b6-2 IPN

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

[redacted] b6-4 ICW2

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 14154 ...TES

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.12.03 2217	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS @ X4. MC ABD dsng CDI. Foley → gravity draining cyo, @ leakage @ meatus. Ostomy pink draining soft formed stool. Colostomy bag intact. @ TKA sutures OTA ~ s/s infection @ R VE ~ palpable pulse, cap refill < 5 sec. HL to @ FA flushes ~ diff. @ s/s infection. Will cont. to monitor. — b6-2 [redacted]
2247	ROM performed to @ R VE. Pt. c/o some pain when doing ROM @ R VE. Pt. ~ some ROM @ R VE, unable to wiggle toes or bend knee > 5°. Pt. says he has full sensation of @ R VE. Pt. Leposid to @ side. — [redacted] b6-2 [redacted]
13 Aug 03 0030	Pt. colostomy bag Δ'd —
1030	Pt asleep in bed easily aroused by verbal stimuli. HR Reg, lungs sands clear bilat, bowel sands(+) x 2 quads. DSG Δ'd to ABD & @ axilla. Vertical ~~Horizontal~~ wound to mid abd. healing well, red, moist, ~ drainage or s/s of infection. Oval wound to @ axilla red, moist, ~ s/s of infection. Sutures on @ TKA intact, site ~ s/s of infection. Colostomy stoma pink & moist. Pt. is able to move both @ & @ leg slightly, & can also bend his @ knee slightly. HL in @ FA flushed well ~ 3cc NS ~ s/s of infection. Pt ~ 2 quarter size scabs on head. Pt. 3 complaints @ this time. VSS. Will continue to monitor. — b6-2 [redacted] Pt
13 AUG 03 1300	- PT Alert + oriented X 3. PT has low Grad temp 100.0. PT is also hypertensive (150/96 BP). Breath sands clear B. bilat. Dressing to Abdomen + Axx CDI & @ s/s of infection. Sutures on @ TKA CDI. Colostomy stoma is pink + moist. PT is able to move both @ Lg + @ stump. @ to @ ft flushed well ~ 3cc NS. Will monitor PT. [redacted] b6-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 14155

ACLU-RDI 1625 p.115

DOD-027707

AUTHORIZED FOR LOCAL RE

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
13Aug03	0600 (cont) HL to (R) FA patent ⊼ redness/infiltration. Dsg to sacrum CD+I. Tylenol given @ this time. Will cont. to monitor [redacted] b6-2 SWMs
	0830 Dsg Δ's done Abd ML W→D area pink no s/s infection. Dry sterile dsg to BUE area pink no s/s infection. Sacrum area wound Dry dsg applied area pink no drainage noted [redacted] b6-2 SWMs
	1126 Colostomy cleaned. Formed stool approx 1/4 cup. Stoma pink. [redacted] b6-2 SWMs
14Aug03	2000: Assumed care @ 1300: VSS. Lung sounds clear BS x 4. colostomy intact - no output @ this time. Abd. dressing ▷ done. W→D ⊂NS. Sm amt serosanguinous drainage noted. Decubitus ulcer 3/4 inches to sacral area covered ⊂ 2x2 dressing. Stitches to stump intact. Turned q 1°. ℅ pain. Medicated ⊂ Tylenol #3 ⊤ PO @ [redacted] b6-2 SWMs
18Aug03	2112: Late entry for 1900. Physician notified that urine is tea colored ⊂ sediment and diminishing output. Physician stated that he would tell Dr. [redacted] b6-2 SWMs

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F
Prescribed by GSA/ICMR FPMR (41CFR) 101-1

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0530 Aug 03	NURSING (continued): ~~c~~ BLE has some laxity per pt report but no instability. Staples to (L) AKA has sutures open to air c no drainage. Sutures are well approximated and c s/s of infection/inflammation. PROM to BLE only. Dsg to (L) thigh, abd are CDI. Stoma/colostomy site to (L) side of abd is pink and pouting out slightly. No blood noted at this time. Sacral b6-2 decubitus ulcer covered c 4x4 gauze. IV to (R) FA c s/s infiltration or infection [redacted]
1830 Aug 03	Assumed care @ 1300. A+Ox3, Lung sounds clear b/l ant. Abd. soft + nondistended. BS x4. Colostomy intact, draining large, brown, formed stool. Foley patent, draining tea colored urine c sediment noted. Sutures to (L) leg intact. 1 inch sacral decubitus ulcer dressed c 4x4 dressing, dressing Δ to abd done w/ D. Serosanguinous drainage noted. IV in (R) FA patent, will continue to monitor. [redacted] b6-2
2005 Aug 03	800cc blood tinged urine emptied from foley catheter. [redacted] b6-2
2126 Aug 03	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. ML ABD dsng CDI colostomy intact, ostomy passing soft formed stool. Foley to gravity draining amber urine c sediment. Pt. c/o pain (L) TKA. Tylenol given. (L) TKA c sutures OTA, ~~s~~ s/s infection. (R) LE c palpable pulse, (+) sensation, but ↓, (+) but ↓ ROM, cap refill < 5 sec. will cont. to monitor. [redacted] b6-2
0600 Aug 03	Assume pt care @ 0500. pt awake and alert c/o pain VSS x temp of 99.4. HR reg. Lungs CTA Abd ML dsg CD+I BS x4. Colostomy intact Foley to gravity draining tea colored urine. (L) TKA sutures intact. (R) LE c limited ROM, (+) pulse (+) sensation (cont)

MEDICAL RECORD	PROGRES

DATE	NOTES
continued 22Aug03 2100 :	(+) Sensation to top of (R) foot & bottom (R) foot, numbness in (R) toes. Turning frequently ~ Q1'-Q2' (log roll). Foley to gravity draining clear yellow urine. Continuing IV antibiotics around the clock. Will cont. to monitor. [redacted]
23Aug03 1000	VSS Pt A & Oriented. Tylenol # 3 given for pain. Dsg to (R) Axilla, Midline Abd, and [illegible] area changed as ordered. (R) foot elevated to keep (R) heel clear of bed to prevent pressure area. Restraints removed & reapplied. will check restr frequently to check circulation. (R) wrist saline lock patent & intact. Ø redness or swelling noted to IV site. Colostomy & foley done with AM care. Will continue to monitor [redacted]
23 Aug 03	2040= VSS, A+O X3, c/o pain, T3 ii tabs given PO as ordered, Dsg to Abdomen Δ'd W→D, Colostomy care as needed, stoma site beefy red & appears very healthy, pt. putting out solid dark brown stool chunks, (+)BS x4 quads, tolerates PO well, (L) LE amputation → end has sutures approximated, (L) LE elevated, log roll & Q2' turns. Foley to gravity

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

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

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

[redacted] b6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1!
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

MEDCOM - 14158

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	putting out clear yellow urine. No other remarkable assessment findings. Hl IV to ⓛFA flushed, continuing Rocephin around the clock. Will continue to monitor. b6-2 [redacted]
24 Aug 03 0735	Pt received lying in bed awake & alert, on ⓡ side & turned to ⓛ side, skin note c tachycardic rhythm & ⓞ pulses in bilat UE & ⓡ LE, lungs CTA bilat, ⓑ bowel sounds c colostomy ⓡ LQ, foley to gravity draining clear yellow urine. Drsg to ⓛ axillary Δ'd, drsg to abdomen Δ'd, sutures to ⓡ LE intact 3 s/s of infx, cont. to monitor. b6-2 [redacted]
24 Aug 03	1950 = VSS, c/o pain → ii T3 tabs PO given as ordered, A+Ox3, W → D Dsg Δ'd to midline incision to Abdomen, stoma site beefy red → cleaned out & Δ'd colostomy bag → had solid brown stool, turning pt. q2° log roll, ⓡ LE BKA c stump → sutures @ end → ⓛ LE elevated on pillow. ⓡ LE minimal movement, ⊕ sensation to top of foot & bottom of foot but ⓞ sensation in toes. IV Hl to ⓛ FA flushed & patent. ⓡ PS x 4 quads. ⓞ other remarkable assessment findings. Will continue to Monitor. Foley to draw drainy clear yellow urine. Tolerates PO well. b6-2 [redacted]
25 AUG 03	(1045) Assumed care of pt @ 0700 p report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated this am c ii T3 for pain c good relief. Pt cont to be turned q2° using log roll. Sutures to ⓡ LE stump CDI. Stump elevated on pillow. Wet → dry dsg to

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

PROGRESS NOTES

30 Aug 03 (2015) cont/ Q2 repositioning & log roll. Stoma beefy & moist. BM x1 (dark BM + soft). ⊕ BS x4 hyperactive. Foley drained 1800 clear amber urine. Abd Drsg d'd: CDI. Will cont to monitor. b6-2 [redacted] 9 NWM

31 Aug 0450 Pt had 1 semi-soft brown BM. Voiding adequately by foley. Will cont to mon b6-2 [redacted] atomb

31 AUG 03 0700 VSS alert & cooperative. Oriented Regular diet. HOB 120°. Logrolled x3 to change position for comfort. Foley to gravity drainage amber urine. Colostomy pouched and moist (stoma). ⊕ stool present @ this time. Drsg to (L) Axilla, abd midline and sacral area bed cx ordered. All cx healing well. ⊕ S/S of infection. IV Antibiotic D/C this AM. Restraints removed and reapplied. Skin intact. Will check restraints, skin integrity and circulation to extremities b6-2 [redacted] 2LT RN

31 Aug @ 1900 VSS, pt alo, resting in bed. HOB 1. Q2 repositioned. Foley to gravity draining amber urine. 2 pt restraints on, circulation assessed. ⊕ c/o pain @ this time. abd. incision healing & open to air. Drsg to axilla CDI. Lower extr. ROM done per pt comfort. Will cont to mon b6-2 [redacted] 9 NWM

01 SEP 03 (1255) Assumed care of pt @ 0000 per report from night shift. Pt alert, speaking freely. VSS. Pt cont. to be turned q2° using log roll. Foley to

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE	
continued	> out hard dark brown feces after
29 Aug 03 1940	> stoma care. Skin around stoma cleaned. Stoma appears beefy red & Vascular. Encouraged pt. to ↑ H_2O intake R/T possible constipation. IV HL to (R) FA patent when flushed. Continuing IV Rocephin BID. (+) BS x4, (+) appetite. Ø other remarkable assessment findings. Will continue to monitor. b6-2 [redacted]
30 Aug 0800	VSS. A&O (R) FA HL Patent & intact. Flushes without difficulty. Lungs clear bil. Resp even and unlabored. Abd soft non distended. BS (+) x4 quadrants. Colostomy stoma covered with closing bag with Ø stool present. Consumed regular diet for breakfast. Repositioned for comfort. will change position log rolling Q 2° and prn for comfort. Foley draining clear amber urine. Foley care done c AM care. Restraints removed. Skin intact. Reapplied restraints will check frequently along with circulation and skin integrity b6-2 [redacted]
30 Aug 2015	Pt alOx3, VSS, c/o pain to (L) leg at incision site. ii Perc. given. HRRR, lungs CTAB, (+) circulation assessed. 2 pt restraints in place.

(Continue on reverse side)

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

000-00-0[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE 3 Sep 03 @ 1930	Pt resting in bed. pulse: tachy: ϕ c/o pain, colostomy bag intact & formed brown stool. (R) stump ↑ on pillow. abd. incision open to air. drsg to axilla & sacrum CDI. cont Q2 turn & leg roll. 2 pt restraints on. circulation assessed. Encouraging H2O intake. H2O @ BS within reach. Deb breathing encouraged. Will cont. to monitor [redacted] b6-2 [redacted] 911 0m6 SPC
4 Sept 03 0745	Resting in bed. A&O appropriately. VSS. Colostomy care completed. Formed brown stool. Stoma beefy red appearance. Skin integrity intact. Pt assisted c stoma care. (L) Axilla wound & sacral wound drsg ∆ complete. ϕ drainage. (L) stump ↑ on pillow & looking well. Pt foley draining dark amber/brown urine. Encouraged pt to ↑ p.o. flds. Turned to (R) side. Aps care done. Heel support to (R) ft. 2 pt restraint. Circulation & skin integrity intact. Will continue monitor [redacted] b6-2 mod Bn
4 Sept 03 1640	Resting in bed. Washed face. Continues brown formed stool via colostomy. Urine remains dark amber/brown. Continue monitoring & turning [redacted] b6-2 mod Bn

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

[redacted] b6-4

PROGRESS NOTES

DATE	
4SEP03 1933	ISS. AO. Turned to (R) side c c/o pain to (R) AKA. Provided ∂ T#3. DSG to (L) axilla CDI. Abdominal wound CDI. Catheter bed brown formed stool x1 and cleaned. (R) AKA incision site CDI. Resting comfortably in bed. b6-2 [redacted]
5Sep03	1945=VSS, tachycardic but ∅ SIS of distress, encouraged pt. to drink ↑ H_2O (pt. usually runs ↑ HR), A+O X3, ∅ c/o pain, did PROM exercises to (R) LE. Pt. exercises (L) LE stump independently ∃ difficulty ∁ good ROM. (B) LE's elevated. Scar to (R) side of neck. Old incision wound scarring to midline abdomen — open to air. 2+ pulses to (B) LE's (L) LE has ⊕2 fem pulse). Colostomy to (L) abdominal region putting out semi ∂ solid brown stool, stoma site beefy red & appears very vascular. Encourage pt. to do own ostomy care. Q2 turns — log roll. Pt. has DSG to sacral area — some breakdown — CDI. (R) BSX4 tolerates PO well. ∅ other remarkable findings. Will monitor. b6-2 [redacted]
5Sep03	2000: Addendum Note: Foley to gravity draining clear, yellow urine. Restraints x1 in place. Skin integrity intact. b6-2 [redacted]
6Sep05	0530: colostomy bag Δ'd & stoma care done this AM — had pt. assist ∁ care. [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE

07SEP03 0546 (SB) Nurses asked me to look in on Spine Fracture and skin breakdown. He has ongoing left Phantom Limb pain after amputation. ↓ He wishes to try a trial of Foley D/C.
Exam Finds him looking well for the most part.
He has stage III breakdown ~2cm over Sacrum
He has a 1-cm eschar over lateral (R) ankle
Sensation intact to Foley tug.
Meds reviewed.

(A/P) (1.) Paraplegia with decubitus ulcers x2.
Will ↓ transfer to ICU for softer bed.
(2.) Wishing D/C Foley trial. Will pull and observe 6-12 hours.
(3.) Phantom Limb Pain. ↑ Neurontin to 600 TID

b6-2
4797

07SEP03 1243 Addendum:
Pt on hospital bed.
X-rays show no change in normal alignment when upright. Will allow care team to sit patient in chair.

b6-2
4797

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries ... ne - l... st, middle; grade; rank; rate; hospital o... acility)

REGISTER NO.

WARD NO.

#[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7
Prescribed by GSA/ICMR, FIRM
CFR) USAF

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
13Sep03	(cont) restraint in place & complications. Will continue to monitor. b6-2 [redacted]
13Sep03 1910	Pt sleeping on & off. VO: see SF 511. Ø c/o pain @ this time. Lungs CTA(B), HRRR, (+)BS x4. +2 pulses. colostomy care done by pt. Q2 turns & occasional assistance. 1 pt restraint on, circulation to area intact. Will monitor. [redacted] 91WM6
2000	Prsg to Wachim A'd. b6-2 [redacted] 91WM6
2130	Pt OOB to chair for 1 hour. Foot care (R) done. Neurontin & Elavil for pain control. Will monitor b6-2 [redacted] 91WM6
14Sep (0510)	Pt sleeping, Ø distress noted [redacted] 91WM6
1 Sep [illegible]	Received pt resting in bed, VSS, turned q2°. Alert and oriented x3, quiet nt. Pallative. Lungs CTAB, HRR & regular, BS(+), colostomy patent and putting out semiloose stool. SWP, pt had "accident" x1, thus shuff, c/o pain, medicated w/ 1/1 tab Tylenol. Relief noted. Sacral decub dsg's Ø other needs at this time. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO. (SSN or Other) [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT b6-2

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

REGISTER NO. | WARD NO. 1CCU1

#C[redacted] b6-2

PROGRESS NOTES
Medical Record

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

MEDCOM - 14165

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Sep 03 1945	Pt resting in bed, VS: see SF511, ∅ c/o pain @ this time. lungs CTAB, HRRR, +BS x4, +2 pulses: R stump ROM done by PT. R leg ROM done. colostomy bag intact, stoma: beefy red putting out semi-solid brn stool. Pt empties own colostomy bag/care. neurontin & klavik cont for pain control. Sacrum dsg Δ'd. OOB to chair for 30 min. 1 pt restraint on, circulation intact. Will monitor [redacted] b6-2
15 Sep 03	Received pt resting in bed. VSS and baseline, medicated w/ 1 tylenol this am for mild c/o pain. Turns self q2° w/ minimal assist. Sacral decub II & healing. ROM performed. Colostomy beefy red and output soft brown stool, pt performs self care. ∅ other remarkable assessments noted. Restraint per CDW protocol. ∅ S/S skin breakdown/circulation issues. Will cont to monitor. [redacted] b6-2
16 Sep 03 @ 0215	Assumed care @ 1800; VSS; pt A&O x3, ∅ c/o pain @ this time; RS, S2; LS CTA BL; +BS x4; pt voiding QS c/g urine; colostomy intact, stoma - beefy red, putting out semi-formed brown stool; pt empties own bag; sacral dsg Δ'd, DQ healing well; ∅ Δ's in assessment; 1 point restraint in place; + circulation, ∅ skin breakdown; cont to monitor. [redacted] b6-2
16 Sep 03 @ 0220	Pt OOB to chair x 45 min; ROM completed; [redacted] b6-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Sept 03 0800	VSS. A+O Lungs clear Bilat BS(+) x4 quad Colostomy stoma pink & moist. Colostomy drsg with serosang drng stool. Pt perform colostomy care and emptied ostomy bag. PROM performed. @ leg AKA stump, staples & incision well approximated. MD in to evaluate sacral decub. Dry Sterile dsg this time. Skin under restraint intact. Will continue plan of care. b6-2 CTA
16 Sept 03 1935	Rt a/o, ø c/o pain @ this time. Lungs CTAB (+) BS, HRRR, colostomy intact, stoma beefy & red. (doing own stoma care) c assistance if needed. Sacral decub drsg d.d. 1 pt restraint on, circulation intact. (L) AKA stump elevated + ROM done. neurontin & claritin cont for pain control. (2) turns will monitor [redacted] b6-2
17 Sept 03 0800	VSS Alert & oriented. Lungs clear Bilat/Trach BS (+) x4 quadrants Colostomy stoma pink And moist. Pt does colostomy care [illegible]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or DoD ID)
	LAST	FIRST	MI	[redacted]

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
		b6-2

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
H [redacted] b6-4		

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Continue)
17 Sept 03 0800	PROM done to (L) AKA stump. Drsg sel to sacral area superficial wound. Skin under restraint intact. Reposition q 2° for comfort. Will continue plan of care b6-2 [redacted]
17 Sep 1900	Pt A10, C10 pain often. colostomy bag intact, stoma beefy, red + vascular. Pt doing own stoma care c̄ min assistance (L) stump ROM done by pt, for comfort. (R) leg ROM done. 1 pt restraint on circulation intact WNL men b6-2 [redacted]
18 Sept 03 0800	VSS, alert & oriented. Lungs clear (B). BS (+) X4 quads. Colostomy stoma pink & moist. Colostomy draining bag c̄ air ∅ stool @ this time. Consume Regular diet for breakfast (L) stump incision healed. PROM done Reposition self with minimal assist. Pt uses side rails to assist c̄ repositioning. Pt emptied colostomy bag. Will continue plan of care b6-2 [redacted]
18 SEP 03 2017	VSS. AO. LS CLAB. S,S,. BS (+) X4. (R) AKA WNL and ∅ c/o pain @ this time. Placed comfeel/duoderm other to sacral, stage II 3cm ulcer. Scab to back of head CDI c̄ 5cm of hair loss as well as band of hair loss to back of head. Turned to (L) side s̄ complaints. Midline abdominal incision CDI and LUQ colostomy produced brown, soft stool. b6-2 [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20SEP03	(cont) and to shower this pm. Td. well. Will cont. to monitor. b6-2 [redacted] GWAV
(1920)	Rt alo, clo limb pain often. Colostomy drg int-act, pt doing self care. stoma beefy red & vascular; putting out semi-solid brn stool. Sacral drsg d/d. Lungs CTAB, OBS, HRRR, Q2 turns. voiding adeq. cyu. Neurontin + Klonid around the clock. Rt doing ROM to D stump for comfort. 1 pt restraint on. + circulation will monitor. b6-2 [redacted] GWMC
21Sep03	Assumed care of pt AAO x 3. VSS, & clo pain or discom
0730-	@ this time sitting up in bed eating breakfast. AM care stoma care self. Q2h position change prevent breakdown 10cm stage 2 breakdown to sacrum dressing d/d cdi & drainage noted healing. Lungs CTA HRRR. Encouraged to consume Ensure 3 meals will cont to monitor b6-2 [redacted] GWM.C.
1920	Rt alo, & clo pain @ this time. Self care done to stoma. Q2 turns. Sacral decub drsg d/d. & drainage noted. voiding adeq. cyu. OOB to chair @ this time. (R) foot ROM done, (L) stump ROM

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

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

#[redacted] b6-4

REGISTER NO.

WARD NO. ICW #1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21Sep03 1920 (cont)	done by PT. 1 pt restraint on c̄ circulation contact. Will monitor b6-2 [redacted] 91W MC
22SEP03	(1430) Assumed care of pt @ ΦΦΦΦ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol/ Neurontin. Pt OOB to chair independently. AM care done by pt along c̄ colostomy care. Dsg to sacral decub Δd. Pt turning self q2-3° and doing ROM c̄ BLE for comfort. Tol. reg diet well. Voiding s̄ difficulty. 1 point restraint in place s̄ s/sx complications. Will continue to monitor. b6-2 [redacted] LT AN
22Sep03	2000 = VSS, A+Ox3, Φ c/o pain @ this time, OOB to chair s̄ difficulty, x1 restraint - skin integrity intact, colostomy bag intact, putting out adequate brown stool, pt does own colostomy care, Dsg to sacral decub Δ'd CDI, turning Q2 log rolls, Φ other remarkable findings. Continue to monitor. b6-2 [redacted] LT AN
23SEP03	(1030) Assumed care of pt @ ΦΦΦΦ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Neurontin. Pt OOB to chair. Personal hygiene done by pt. Pt doing ROM c̄ BLE for comfort. Turning q2-3°. Colostomy bag Δd by pt this am. Dsg to sacral decub Δd - Φ s/sx infection. 1 point restraint in place s̄ s/sx complications. Will continue to monitor. [redacted] LT AN b6-2

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

MEDCOM - 14170

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23Sep03	1930=VSS, A+OX3, ø c/o pain @ present, pt. doing own colostomy care – pt. given supplies to do so, Dsg to sacral decub – Δ'd CDI, ROM exercises to BLE's assist, DOB to chair ≤ difficulty, Q2° turns log roll, & other remarkable findings. Continue to monitor — b6-2 [redacted] RN
24SEP03	(1405) Assumed care of pt @ bedside ≈ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ≈ Neurontin. Ambulated ≈ CGS ft COB to chair and back to bed ≤ assist. Personal hygiene done by pt. Dsg to sacral decub CDI. ø S/Sx infection. Pt turning self and doing ROM ≈ BLE. Colostomy care done by pt this am. Pt tol. reg diet well. Voiding ≤ difficulty. 1: point restraint in place ≤ Sfx complications. Will continue to monitor. b6-2 [redacted] RN
1940	Rt alo, speaking arabic, colostomy bag intact, care done by pt, Dsg to sacrum Δ'd. Rt turning Q2 ≈ reminder. ROM done. neurontin & elavil cont. COB to chair ≤ difficulty. Will monitor [redacted] b6-2 [redacted] RN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#Ø [redacted] b6-4

REGISTER NO.

WARD NO. KCWH1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25Sept03 0900	VSS, Alert & Oriented. OOB to chair with minimal assist pvn staff. Ate breakfast and completed AM care up in chair. Tolerated well. Pt completed colostomy care. Bed was soiled with urine. linen changed. No acute care needed. will continue plan of care. b6-2 [redacted]
25sept03 2015	Assumed care @1800 / All VSS, pt A+OX3 speaking arabic; pt OOBTC for 30 min X1; tol well; @ c/o pain or discomfort @ this time; pt completed own colostomy care ☐ assistance; sacral DSG Δd, @ S/SX infection; pt turning self & doing ROM @ LE; N/S Δ in assessment; restraint in place; @ circulation, @ skin break ↓; Cont to monitor b6-2 [redacted]
26sept03 1000	Assumed care of Pt @ 0000. VSS-A+O Pt speaking in arabic. Pt. completed colostomy care ☐ assistance, Sacral Dresng Δd. CDI. @ Pedal + Radial pulse ☐ restraints in place. @ skin breakdown. Pt. turning himself q 2° + doing self ROM exercises will cont. to mont. b6-2 [redacted]
26Sept03 1600	Pt. resting well @ this time @ c/o pain. b6-2 [redacted]
26Sept03 2000	VSS, @ c/o pain @ present. q2 turns log roll - pt. can help ☐ this very well, Dsg to Sacral decub Δd - CDI, pt. does ROM exercises to @ stump, assist ☐ ROM exercises to @ LE. Colostomy bag intact putting out formed stool.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	brown colored, pt. does own colostomy care when given supplies. Other remarkable findings. Continue to monitor for A's — b6-2 [redacted]
27SEP08	1200 - received pt. @ adeq. assessment completed. Pt. tolerated breakfast well. Ø c/o pain. Encouraging pt. to do rom exercises. Log Roll pt. QS. Pt. turns on his own. Colostomy bag intact putting out formed stool. Pt. OOB in chair @ this time. Will continue to monitor pt. — b6-2 [redacted]
27SEP08	1414 - Pt. had a spell of urinary incont. x2. changed pt. clothes + sheets. Changed dressing to sacral decub. dsg CDI ⊖ sign infection. Pt. OOB to chair @ this time. Will cont. to monitor. b6-2 [redacted]
28SEP08	1030 - Pt. OOB into chair. Pt. urinated onto chair. changed pt. clothes. Will cont. to monitor. — b6-2 [redacted]
	(1600) I concur ⊂ above assessment. — [redacted] LPN AW

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 SEP 03 2035	VSS. AO. Speaking small amount of arabic. BS(+)x4. Abdominal incision intact and clean. (+) pulses to all extremities. Voiding light amber urine quantity sufficient. Colostomy to LUQ producing light brown stool and intact. BS(+). Encouraged to use BS urinal as explained that falls would be placed. Pt understood and used urinal properly. b6-2 [redacted] RN
28 Sep 03 0700	- Assumed care of pt A+O x3. VSS. C/O pain to (L) AKA scheduled neurontin given c relief. Lungs clear HRRR Active BS x4 Tolerating PO well. Urinating s difficulty per urinal (+)BS OOB to chair Q2° rotate to prevent break down. Will cont to monitor b6-2 [redacted]
29 SEP 03 0505	VSS. Patient has no significant changes. [redacted]
29 Sept	pt. awake ~~alert~~ oriented x3. VSS colostomy bag intact, sacral drsg clean dry and intact, pt moved out of bed to chair, tol food well ∅ voiding per urinal sometimes in the bed, restraints x2 in place b6-2 ∅ s/s of skin breakdown, circulation intact [redacted]
29sep03@2110	Assumed care @1800; VSS, pt A&Ox3, pt OOBTC x1 for 30 min; dsg to sacral Δd, CDI; FT draining QS, clear, dark yellow urine; cont c Q 2° turns; pt does own colostomy care, - CDI; cont c Neurontin for pain; Restraints in place, (+) circulation, (-) skin breakdown; cont to monitor [redacted] b6-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 Sep03 0645	- Assumed care of pt. A+O X3 VSS Ø c/o pain or discomfort @ this time. sitting up in bed eating breakfast. Foley to gravity clear yellow urine QS. Ostomy care self c̄ assistance stoma beefy red vascular. Lungs clear HRRR Active BS. Will cont to monitor 66-2 [redacted]
30 Sep03 @ 2130	Assumed care @ 1800; All VSS, pt A+O, Ø c/o pain/discomfort @ this time; OOBTC X1; FTG draining QS, clear, yellow urine; performs own colostomy care-bag CDI; stoma beefy s̄ s/sx infections; Restraints in place; ⊕ circulation Ø skin break↓; cont to monitor 66-2 [redacted]
1 Oct 03 ~~30 Sep 03~~ 0700	- Assumed care A+O x 3. Ø c/o pain or discomfort @ this time. Foley to gravity draining light yellow urine QS Ⓛ LQ stoma vascular beefy red self care. Clear lungs throughout. HRRR Active BS Tolerates PO well. Will cont to monitor 66-2 [redacted]
	(1740) I concur c̄ above assessment. [redacted]
1 Oct 03	2000 = VSS, Ø c/o pain, A+O X3 new duoderm dsg placed on sacral decub - white appearance breakdown ↓ing site looks like it is healing well, pt. does ROM exercises c̄ stump on his own, assist c̄ ROM exercises to Ⓑ LE'S PRN, pt. ~~A's~~ cleans out own colostomy bag &

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] 66-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	does colostomy care when given supplies, Foley to gravity draining clear yellow urine, OOB to chair 5 difficulty. Other remarkable findings. POC: Pain mgt, palliative care, Q2 turns (pt. does himself) wound care/mgt. Crestraints ~~x2~~ x1 when in bed, ~~O~~ skin breakdown noted, will continue to monitor — b6-2 [redacted]
20Oct03	0500. USS Alert & Oriented. Colostomy stoma pink & moist. Foley to gravity draining clear yellow urine. Reposition in bed for Comfort. Using prominence pads to prevent pressure ulcer. Will continue plan of care — b6-2 [redacted]
20Oct03	2030= VSS, ~~O~~ c/o pain, A+Ox3, Q2 turns- pt. assists on this, Dsg Δ'd to sacral decub CDI, colostomy intact putting out brown semi-solid stool, pt. does own care when given supplies, foley to gravity draining clear yellow urine x1 restraint when in bed, skin integrity intact, OOB to chair 5 difficulty. Will continue to monitor for acute S- [redacted] b6-2

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

[redacted] b6-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Oct 03 0700	- Assumed care of pt. A+O x3. VSS. AM care self & assist. complete @ bedside. Ostomy care self: stoma beefy red vascular open to air for 30 mins (L)AKA & pain or discomfort to stump. Stage II decub to sacrum healing. ROM performed to (R) LE. Will cont to monitor b6-2 [redacted] 4 Evenings.
30Oct03	1930: VSS, 0/10 pain @ this time, A+OX3, Duoderm CDI to sacral wound, Q2 turns log roll, colostomy intact - pt does own colostomy care, OOB to chair S difficulty. 0 other remarkable findings. x1 restraint when in bed @ skin breakdown. Continue to monitor for acute Δ's. b6-2 [redacted] Addendum - foley to gravity draining clear yellow urine b6-2 [redacted]
4 Oct 03	- Assumed care pt. A+O x3. (L)AKA & c/o pain or discomfort @ this time - Self ostomy care performed stoma vascular. OOB to chair stage II breakdown to sacrum healing dressing intact will cont to monitor b6-2 [redacted] 4 Evenings

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted] b6-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b6-2
Ø4OCTØ3	(16Ø5) I concur c̄ above assessment —— [redacted] LPN
4OCT03 2109	VSS. AO. ⊕pulses to RLE and BUE. Emptied colostomy by self c̄ difficulty. Placed OOBTWC on ward for 30 min. c̄ tolerated well. ø c/o pain. Colostomy and FTG intact. Voiding light yellow urine, quantity sufficient. PSG to sacral ulcer CDI - trimmed to fit. b6-2
	—— [redacted]
5 OCT 03 0700	Assumed care of pt. A+O x3. VSS ø c/o pain or discomfort @ this time. Lungs CTA HRRR Active BS x4 stoma vascular self care c̄ assistance. Foley to gravity clear yellow urine QS. OOB to wheelchair self c̄ assistance transfer from bed to wheelchair. Stage II to sacrum healing dressing CDI Will cont to monitor —— b6-2 [redacted] 91 WMB.
5OCT03 2031	VSS. AO. OOBTWC c̄ difficulty. Colostomy and FTG intact and voiding light yellow urine quantity sufficient. provided Δ of clothes and bedding. BS ⊕x4. Colostomy ejecting light brown soft fecal stool. Δ'd sacral DSG. —— b6-2 [redacted]
Ø6OCTØ3 0815	Pt Awake in bed. A&O. c/o pain in lower back. Rotated to Ⓡ side. VSS. LS CTA Ⓑ, S1 S2 present ⊕ BS x 4 quads. FTG Draining CYU. Colostomy to LLQ. CDI. Will continue to monitor. —— [redacted] SC 91WMB
	b6-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11JUL03	Neurosurgery
0636	(S/O) Extubated, awake
	Moving uppers. Lowers paretic.
	Draining CSF from L-Spine.
	(A/P) Penetrating injury L-Spine with CSF leak.
	Lumbar drain today when in OR.
	Continue [redacted] Flat / Log roll.
	b6-2
	4797
11July03	Surgery.
	extubated, good cough - productive
	neck incision c/d/i 108 >20.1 144
	lungs clear c large airway sounds 734/32/91/19/7-6
	hypo BS, soft, NT, wound c/d/i SL FM
	stoma pink, min gas
	Lg warm, dry, trace edema, incision c/d/i.
	Imp. ① pen BKA / anemia / complete cord L4 / lumbar CSF leak / SIP & Lip fracture
	Plan. ① OR today to close stump, place lumbar drain
	② cont pulm toilet
	③ start nutrition later today - will need aspiration precautions

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Walter Reed	Complete K		
SPONSOR'S NAME	[redacted] b6-2	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank; Grade.)*		REGISTER NO.	WARD NO.

[redacted] b6-4

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

MEDCOM - 14179

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Jul 03	(1300) pt arrived from OR; VSS; ventilated; no s/s of respiratory distress; transferred to bed c monitor; Blood product hemorrhagic report taken
	(1600) pt stable; no change in assessment; MD called for transfusion of uncrossmatched O+ unit PRBC's; adverse effects. No new orders given by MD; lab supervisor informed; HN informed; incident report started by HN nursing; no adverse reactions noted.
14 July 03	Surgery-
	CTSP for ↓ pulses in Ⓛ leg c ↑ swelling of leg.
	On exam pt's leg tight, monophasic flow by doppler when knee flexed; min flow leg extended. Pt not consistent c neuro examination. Although cannot move legs well, min extension @ hips, min leg movement.
	Imp ① impending Ⓛ leg compartment syndrome
	② Question popliteal fossa injury
	③ LE weakness
	Plan Ⓛ LE fasciotomy / angiogram
	CT abdo to R/O spine injury today. [redacted] b6-2

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

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

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

[redacted] b6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	1700 13JUL03: Took care of patient. - Assumed care. CBC/MET & DRAW; currently propofol/LR hanging as ordered. Assessment as follows.
	[N] PERRL SLUG at 3mm; sedated at propofol 21.6cc/hr. Responds to painful stimuli; Silent; ∅ Foll. commands.
	[CV] Sinus Rhythm - currently @ 90; $S_1 S_2$; cool distal extremities ..., ↓ pulses to bilat LEs (+2 to (L) pedal; +1/dop to (R) pedal) (L) radial pulse +2; (R) rad (+?); <3/3 sec cap refill [illegible] to extremities. Temp: 34.7 ~~[R]~~
	[RESP] (R) side chest tube to 20 cm suction. SIMV of 12; FiO_2 40%, 7.5cm to lip. ETT; CTA, ↓ in bases; ⊖ rads. Breath sounds heard; Sats 100% on above vent settings.
	[GI] Colostomy to (L) side; NGT to LIWS
	[GU] Foley to gravity with ~100cc/hr, dark amber urine; bowel [illegible]
	[SKIN] Multiple [illegible] that are dry, small area of surgical [illegible]. [illegible] (R) side of neck dry.
	[LINES] (L) fem cath; (L) radial art line, [illegible] (L) side; foley,
	[redacted] b6-2 [redacted]
	[redacted] 1LT [illegible]

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

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

[redacted] b6-4

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

MEDCOM - 14181

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03	Brief Op Note
	Pre Op Dx GSW @ neck, Zone 2
	Post Op Dx Same
	Procedure R neck exploration, washout @ axilla
	Surgeon [redacted] b6-2 [redacted]
	Findings Jugular & subclavian V exposed, fist over subclavian artery exposed 5 hematoma or thrill.
	EBL 75cc
	IVF 3u FFP / 2u PRBC
	Pt remained intubated, to ICU stable.
	b6-2 [redacted] CTC MC

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW [redacted] b6-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 2005	Attending Surgeon
0540-0700	yo Iraqi National who sustained multiple GSW to torso, base-of-neck, both legs, + arrives hypotensive + obtunded. ATLS protocol followed, 8 Fr. Cordis (L) femoral vein, 16 ga. angiocath (L) hand.
	Responded quickly to volume resuscitation, 3-4 l crystalloid, maintained SBP in 100s - 110s, 1st Hct 20 → 2 units PRBCs. Foley → clear urine, no blood. (R) 36 Fr. tube thoracostomy → air, no blood.
	While being resuscitated, had improved ocs, + developed a tender/distended abdomen.
	CXR = well-positioned CT (R) side, No hemo- or pneumothorax. + shrapnel (R) axilla
	KUB/pelvis films = multiple shrapnel (R) pelvis
	HEENT - (R) lateral face puncture wnd.
	Neck - (R) base-of-neck, supraclavicular entry wnd → exit (R) axilla
	Chest - equal BS bilaterally; index finger enters (R) pleural space via ax. wnd.
	CV - RR + R
	⇒

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

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

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

MEDCOM - 14183

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Abdomen - flat + soft on arrival, then distended + markedly - tender ↑ 2 units PRBCs + 4 l crystalloid (+)(R) flank entry wnd, posterior axillary line, just above iliac crest. (+) venous bleeding ↓ resuscitation. Extr - thru + thru wnd. (L) tibial plateau (R) distal pretibial, superficial thru + thru wound. Perineum / anus OK. A/P: ↓ Δ in abd exam + ongoing blood requirements, to OR for laparotomy.
0900 ⇒	Op Note. DX: Penetrating Trauma flank Retroperitoneal hematoma distal descending colon laceration. ? chylous leak. Proc: Laparotomy, ~~Repair~~ Hartmann ↓ procedure. [redacted] / [redacted] GET EBL = 100 cc. Drains: ∅ Complications: ∅ Findings - retroperitoneal hematoma, RLQ, LLQ + central, none pulsatile / expanding; ↓ DJ both ureters → no laceration / contusion; thru + thru colon lac ↓ minimal spillage; chylous fluid; no ~~clot~~ free blood.

STANDARD FORM [redacted] CK

MEDCOM - 14184

[redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	2200 14JUL03 - Pt received from OR. Assessment is follows:
	[N] Unresponsive. Sedated from anesthesia; currently no sedation on; Ø FC; (+) eye open when painful stimuli to chest; PERRL 3mm
	[R] SIMV 10; PEEP 5; [illegible] FiO2 - 25 @ lip #8 ETT; Ø secret CTA ↓ in bases (R) side of chest suctured to (L) side; CT to LCWS suct to (R) side;
	[CV] ST at 111; Temp cool to touch; placed in warming blanket; S1S2; cool extremities. Ø pulses to doppler to (L) LE - MDs aware;
	[GI] NGT to LIWS; colostomy to (L) side
	[GU] Foley to gravity. Good u/o of 50cc/hr.
	[SKN] multiple GSWs; [illegible] to upper extrem/torso - C/D/I. Midline abdominal incision has small amount of serosang fluid. (R) knee - C/D/I; (L) LE has bulky dsg - serosang noted.
	[IV] (L) fem angiocath / (L) IJ A-line / (R) A/C PIV.
	[Plan] explore site; determine LLE pulses; CT in AM will monitor [redacted]
	[redacted] b6-2

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

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

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

REGISTER NO. | WARD NO.

[redacted]

b6-4

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

MEDCOM - 14185

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7.14.03/0700	Assumed pt care from LT [redacted] @ approx 0700, pt in no apparent distress @ change of shift, LR infusing @ 125cc/hr, fentanyl drip off, propofol @ 40mcg/kg/min NG @ CIS CT @ continuous suction, no air leaks detected (R) axilla wound dressing mod amounts dressing reinforced, (R) leg dressing C/D/I, (L) CE C/D/I, midline abdominal dressing C/D/I, neck incision staples intact approximated well, small amount of serosang drainage, (L) ? colostomy, stoma pink, (R) CT dressing C/D/I. [redacted] b6-2 1LT RN
7.14./0805	Propofol drip off since 0750, fentanyl @ 50mcg/hr in preparation for extubation, pt breathing @ 20-30/min b6-2 SpO2 100%, pt moving all extrem. Dr Sau notified [redacted] 1LT RN
7.14/0835	Pt extubated c Cpl Roberts (RT) & LTC Sau present during extubation. Pt placed on SM @ 6L pt SpO2 100%, 15 mins (approx) later pt placed on NC 2L SpO2 99-100%, RR @ 23-25. [redacted] HR 147 fentanyl ↑ 150mcg/hr. Breathing even unlabored BS CTA diminished @ bases, will draw ABG in 15 min. [redacted] b6-2 1LT RN
7.14/1500	Notified LTC [redacted] b6-2 of Ø pedal or posterior tibial pulse by palpation or doppler, Dr. [redacted] b6-2 @ bedside evaluating (L) extrem [redacted] 1LT RN b6-2

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

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

REGISTER NO.	WARD NO.

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

MEDCOM - 14186

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
14 July 03	Surgery-
	Quiet night, sedated, stable Afeb 134/89 120
	anicteric, edematous conjunctiva, PRRL
	lungs coarse (B) I/O 1.7 > 80cc/h
	ABS, firm, stoma pink CT 160 total
	legs w/o, ↓ pulse (L) ØAL
	CXR Ø ptx / ... , the good position
	10/800/.4/5 7.35/37/110/21/-5
	15.2 > 36 < 81 135 / 5 | 110 / 21 | 10 / .7 < 109
	Imp stable S/P MGSW c̄ lap/Hartmans, neck exploration.
	slightly underresuscitated still
	thrombocytopenic
	Plan IVF Bolus 500cc NS.
	wake/wean/extubate today.
	Δ fentanyl/ ~~MSO4~~ to MSO4, no gtt once extubated.
	routine drsg care
	con't NGT to LCWS
	chest/pulm toilet once extubated. [redacted] b6-2

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

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

#[redacted] b6-4

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

MEDCOM - 14187

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 July 03	Surgeon Brief Op Note Pre Op Dx ① ④ leg compartment syndrome ② occluded ④ popliteal artery Procedure ① ④ leg fasciotomy ② ④ popliteal artery interposition graft c ⓡ GSV ③ Pre-Op / Post-Op ankle brachial angiogram Surgeon fasciotomy – [redacted] b6-2 Pop bypass – [redacted] Anesthesia GETT Drain ∅ Complications ∅ Specimen ∅ Findings Pt's Soleus min-mod movement, gastroc moves well, anterior compartment ∅ movement. Dk muscle beefy red c frank necrosis. Post-op Angiogram shows spasm, pop open to trifurcation post tib open into foot, string-like vessels ant tibial / peroneal. Foot cool, good cap refill [redacted] b6-2 LTC

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

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

REGISTER NO.	WARD NO.

EPW [redacted] b6-4

BCD C

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

MEDCOM - 14188

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 July 03	Surgery-
	CT L-spine reviewed L4-L5 shattered, CT out
	Awake am AF VSS
	lungs coarse
	⊕BS, soft, stoma pink, min gas
	legs cool Ⓡ, cold Ⓛ
	800 / 5 / 5 / 10 7.33 / 43 / 101 / 23 / -3 / 97%
	10 28 70 139 109 11 / 4.1 25 <100 CXR [illegible]
	MGSW
	Imp L4-5 Spine injury anemic
	thrombosed Ⓛ lower leg
	s/p Ⓡ neck exploration
	s/p exp lap c Hartmans
	Plan To OR for eval, likely BKA poss AKA
	Ortho / neuro eval spine injury
	long term placement.
	[redacted] b6-2 CPT

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

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

REGISTER NO. | WARD NO.

EPW [redacted] b6-4

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

MEDCOM - 14189

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
15 July 03	0115 Surgery
	Pre-op Dx Clotted pop bypass graft
	Procedure (1) explore bypass (2) declot x many
	(3) Angiogram —— b6-2
	Surgeon [redacted] / [redacted]
	Anaesthesia GETA
	Findings: Graft clotted off; declotted c̄ #3 Fogarty
	x many c̄ good back bleeding & antegrade bleeding
	Vessels occluded both prox/distally within minutes!
	Intraop angio showed PT run-off to foot after
	much work, but quickly clotted. Will need BKA/AKA
	but wait until demarcates.
	[redacted] b6-2
7/15/03	0310: NSG: Pt returned from OR. USS; CTA (B) ↓ in
	lines #8 ETT 22cm + is set at SIMV 10, PEEP 5, FiO2
	40%; S1/S2 ⊖ ... ; ↓Temp - currently 36.0 - Goal ↑ to 37.0;
	(L) LE (foot) ∅ pulse; cold to touch; Urine output to be measured for
	first full hour 03-04; [LINES] Art to (L) radial, (L) fem vasc. access; PIV x2 to
	(R) UE; Foley; ETT; [GI] colostomy to (L) side, NGT clamped; [PLAN] CT/XR/Ammons
	to OR in AM —— [redacted] 1Lt / AN

[redacted] b6-2

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

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

REGISTER NO. | WARD NO.

GAW [redacted] b6-4

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

MEDCOM - 14190

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/15/0600	Assumed pt care from LT [illegible], pt in no apparent distress, VS [illegible] @ 150cc/hr. NG clamped, CT to [redacted] suction. All VSS CCE dressing reinforced [redacted] LT RN b6-2
7/15/0800	Pt returned from CT, VS remained stable throughout CT stay [illegible] to [illegible] from CT, CT removed nonocclusive dressing intact, [illegible] [illegible], physician evaluated no [illegible] [illegible], SpO2 100% on 40% fio2. [redacted] LT RN b6-2

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

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

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

REGISTER NO. | WARD NO.

[redacted] b6-4

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

MEDCOM - 14191

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15JUL03	Neurosurgery Consult
0931	HPI EPW admitted here 15JUL after multiple GSW in Fire Fight. Pt suffered injuries to chest, abdomen, L-Spine, and lower extremities. He will undergo (L) BKA for failed revascularization today.
	Exam Intubated, sedated, agitated.
	Back dressed (R) Flank, (-) CSF drainage.
	LE's dressed, no movement to noxious.
	Rest sensation T-12 to pinprick (R).
	(-) sensory response to Foley tug.
	CT L-Spine shows L1 intact, L2 Bilateral pedicle and lamina Fractures, L3 Comminuted Fractures of middle and posteric columns, L4 Lilateral pedicle Fractures and Comminuted lamina Fractures with Fragment in (R) L4-5 Foramen, L5 Right lamina Fracture nondisplaced.
	Impression: T12 Paraplegia with unstable Fractures L2-5.
	Recommendations: Foley, bowel program, bed rest Flat with log roll spine precautions. Will Follow. b6-2 [redacted] 4197

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; [redacted] Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

EPW #[redacted] b6-4

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

MEDCOM - 14192

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 July 03	Brief Op Note
	PreOp Dx thrombosed (L) lower leg
	Procedure (L) knee disarticulation
	Surgeon [redacted] / [redacted] / [redacted] b6-2
	Anesth GETA
	IVF 1u PRBC, 500 cc crystalloid
	EBL 150 cc.
	Findings Anterior compartment necrotic; soleus edematous
	and ischemic, gastrocnemius viable @ knee.
	Pt tol procedure well. To RR intubated.
16 July 03	Surgery. No problem (+) CSF leak [redacted]
	Tm 37.3 120/60 110 SaO2 100% b6-2
	omictoni Mo 70-95cc/°
	↓ ss (R) chest CXR clear
	RRR, ◎ SM BM/R 10/27 180 141/4.1 | 109/22 | 12/82
	hypo/-BS 7/700/40/5 → 7.31/43/95/21/-5
	warm, dry. (L) leg dsg dry / (R) leg SVG site clean
	Imp S/P MGSW of legs / (R) neck exp / (R) pop bypass / (L) BKA / CSF leak
	lumbar spine fxs c̄ paraplegia
	Plan (1) wean to extubate
	(2) to OR thurs for washout / closure / CSF drain

HOSPITAL OR MEDICAL FACILITY (3) CPT once extubated.	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME (4) Bx Δ's	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* (5) Supportive care.

REGISTER NO.	WARD NO.

[redacted] b6-2

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

MEDCOM - 14193

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	2250 15 JUL 2003 — NURSING —
	Attempted wean patient from vent throughout night. ↓RR rate to 7; ↓ F_iO_2 to 30%; Sedation turned off. Patient off sedation for 4 hours & ↑ in agitation. RR 12-15; SATs 95-99 on monitor. Called RT for potential extubation. ABG obtained. ABG results: 7.37, 36.2 = pCO_2; pO_2 = 53, HCO_3 21, sats 86, BE -4; Pt ↑ in agitation. ↑ in peak pressure from biting on ETT; Notified on call staff ([illegible]). Keeping patient intubated for night. Placed pt. back on propofol @ 20mcg/kg/min; #8 ETT with SIMV 10, PEEP 5, 40% F_iO_2, 800 TV, 25 cm to lip, in place. ~~[illegible]~~ Current VS: 128, 123/60, 10, 97 sats. Will monitor
	[redacted] b6-2 1LT AN
	[redacted]
16 July 03 0540	Assumed care of pt @ 0500. Neuro: PERRLA #3. Pt arouses to light stimulation. Moves head spontaneously. Pulm: LS coarse throughout. Diminished bases b/l. PCXR done this am. (L) lateral chest dressing c/DI. Dry previous C-tube. On SIMV 10. TV 800. FiO_2 .40 Peep 5. Sat'ing 98%. Possible extubation today. AM ABG unremarkable. CV: Pulses palpable x3 UTA (L) LE AK amputation / dressing. S_1S_2. ST HR 100-110's. BP stable. GI: NG to LIS draining greenish fluid. BS hypoactive vs absent.

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

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

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

REGISTER NO.	WARD NO.

[redacted] b6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
16 Jul 03	Assessment continued c [redacted] GI: Ostomy draining minimal amt
0852	serosanguinous fluid. GU: draining dark yellow urine via foley approx
	50-70cc/hr. NS @ 150 via PIV (L) fem. Heme: Hct 26 this am down
	from 28 yesterday (L) axillary dressing c small amt serosang drain. Bilat hip
	dressing C/D/I. (L) leg covered c ace wrap over gauze (L) BKA c
	serosang drainage. VS: T 37.7 Tylenol given per night shift for T>38.
	Psych: On fentanyl @ 30mcg/hr propofol @ 35mcg/kg/min for sedation. Will
	cont to monitor [redacted] b6-2
16JUL03	Neurosurgery
0625	(S/O) Stable overnight. Afebrile.
	Tolerated (L) BKA.
	Failed vent weaning trials
	Now sedated c propofol
	Labs this AM p.
	(A/P). Complex spinal Fx p GSW L-spine
	Will await more awake / medically stable
	Observe for CSF drainage
	Continue flat bed rest / log rolls
	[redacted] b6-2 4757

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

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

[redacted] b6-4

REGISTER NO. | WARD NO.

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

MEDCOM - 14195

ACLU-RDI 1625 p.155

DOD-027747

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 July 0845	Addendum: Deep suction c thick green secretions possible mucous plug (R) lung sounds improved post suctioning. Pt failed weaning HHT2 possibly due to mucous plug. will attempt to wean again later this am. b6-2 [redacted]
16 July 0930	Pt extubated per RT @ 0850. Sating 98% on 6L SM. LS Coarse c exp crackles thoughout. Will cont to monitor b6-2 [redacted]
16 July 1130	(L) axillary dressing (L) CT dressing changed. b6-2 [redacted]
16 July 1500	(L) axillary dressing, (L) CT dressing, (L) hip, (R) hip dressing changed. Brethaire applied (L) leg wound. (R) femoral catheter d/c'd. Chest PT done per RT. Pt sating 94% on 6L SM. b6-2 Coughing up thick yellow secretions spontaneously [redacted]
NS 16 July 1800	Assumed care @ 1700. VSS. pt lying flat in bed. c FM @ 8L. A'd pt to 6L NC pt continues to maintain SATS @ 90-97%. Assessment done. see ICU Assessment sheet for details. will continue to monitor b6-2 [redacted] CRT/AW
17 July 0100	pt dsg A's done. SATS ↓ to 88% FM Applied @ 10L. SATS ↑ to 96%. pt Received 1 unit of PRBC. this shift. Assessment unchanged from earlier. will continue to monitor. [redacted] CRT/AW

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE b6-2	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

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

MEDCOM - 14196

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry) [redacted]
17 Jul 03 @	1700 Pt Received, Physical assessment Completed [redacted]
17 Jul 03 @	1800 Orders Received From Dr. Chen & redrawn, 500 cc Bolus NS started [redacted] CPT/AW b6-2
17 Jul 03 @	2000 SpO_2 100% FiO_2 ↓ 80% [redacted] CPT/AW
17 Jul 03 @	2200 Pt Turned to (R) Side SBP ↓ From 110-90 to 70's, Pt placed Back on Back [redacted] CPT/AW b6-2
17 Jul 03 @	2330 24° I+O In IV 4044 Out Urine 5362 NG 535 Lumbar Drain 163 Out Total 6060 [-2012] Balance
	[redacted] b6-2 CPT/AW
18 Jul 03 @	0200 Pt's Dressing to (R) Upperchest Ded + (R) Lower back, Bedding changed + Patient turned to Right Side [redacted] CPT/AW b6-2
18 Jul 03 @	0350, AM Labs drawn, ABG Completed + Recorded on Flow sheet, PH 7.43 $PaCO_2$ 39.3 PO_2 161 HCO_3 26 BEect 2 SO_2 99% [redacted] b6-2 CPT/AW
18 Jul 03 0523	PERRLA. Agitated when sedation lightened. Sedated on Versed 5.5 and Fent 100. ST 120's V/E Pulses +2 radial bilat. (R) LE +1 DP. UTA (L) leg r/t amputation/drsg. Intubated. ETT 26 cm TOL. SIMV 12 TV 800 FiO_2 .50. Peep 8, sats 100%. AM ABG shows metabolic alkalosis. LS coarse ē exp crackles. GI: NG (R) nare draining green contents. BS absent. Ostomy LLQ. Abd staples intact midline. s/s infection. Foley draining dark yellow urine ē sediment. AM Chem shows K 2.8 will need replacement. Drsg's intact to (L) axillary. Bilat hip. (L) leg staples C/D/I. (R) BKA drsg s̄ drainage. LP drain →

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

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

REGISTER NO.	WARD NO.

[redacted] b6-4

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

MEDCOM - 14197

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
12 JUL 03 0530	FM e 10L O_2. LABS RETURNED – Results show K^{+} at 2.9 MMOL/L, HCT at 9.3 g/dL. Pt due for surgery & revisit of Hep this AM – able to cough – secretions yellow [redacted] 66-2 suction orally –
	Pt had chest x-ray done upon log rolling Dr. [redacted] observed leakage of spinal fluid at site on (R) lateral dressing mid spinal column. MD [redacted] recommend application of shunt to prevent infection. — [redacted] 66-2
12 JUL 03 0900	Pt receiving IVF and urine out adequate, as charted. Pt able to rest with FM e 8L O_2, SO_2 98%, on IV Fentanyl. Orders written for KCL, also consideration for TL in OR due to potential for SW sites related to illness [redacted] 66-2
12/JUL/03	1000, 1st U PRBC'S GIVEN OVER 2° PER ORDERS # 4824487 [redacted] 66-2
	4824487
	1005 K^{+} RUN STARTED @ 25CC/HR PB c NS @ 125CC/HR [redacted]
	1010 SEC. RBC SHEET FOR CONTINUOUS [illegible]
	1030 Pt TRANSPORT TO OR c PRBC'S INFUSING [illegible]

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

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

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

REGISTER NO. | WARD NO.

EPW [redacted] 66-4

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

MEDCOM - 14198

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

[redacted] b6-4

Pt Name:_____

TCO2_____20 mmol/L

At 37C

pH_____7.507

PCO2_____24.7 mmHg

PO2_____70 mmHg

HCO3_____20 mmol/L

BEecf_____-4 mmol/L

sO2*_____96 %

*calculated

At Patient Temp

pH_____7.461

PCO2_____28.2 mmHg

PO2_____86 mmHg

Patient Temp: 104.0F

FIO2_____: 10

Sample Type_: ART

17JUL03 16:09

Oper: [redacted]

Physic

911 b6-2

[redacted]

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4

REGISTER NO. | WARD NO.

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

MEDCOM - 14199

d 17 ^ / RU PREC'S
7740 KBLQ

I-STAT G3+

Pt: [redacted] 66-4

Pt Name: ___________

TCO2 ________ 28 mmol/L

At 37C

pH ________ 7.48

PCO2 ________ 29.0 mmHg

PO2 ________ 51 mmHg

HCO3 ________ 22 mmol/L

BEec ________ -2 mmol/L

sO2 ________ 99

Q1166-2

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

Received from OR on stretcher. [illegible] given, SpO2 @ 85-86% on [illegible] via FM. [illegible] [illegible] [illegible] [illegible] unlabored. [illegible] [illegible] [illegible] in bases. [redacted]

DR [redacted] @ bedside. orders [illegible]. pt more responsive [illegible] [illegible] [illegible]. Lasix [illegible] IVP given [illegible] [redacted]

DR [redacted] @ bedside. orders received [illegible] drain open [illegible] [illegible] bag. drain placed to lower level for drainage. [redacted]

300cc UOP noted in bag. DR [redacted] updated on pt's status. orders received to hold [illegible] for now. [redacted]

17 Jul 03 1500 [illegible] 1500 UOP noted in bag. [illegible] several times to stimulate pt to cough. [redacted]

1530 DR [redacted] notified of elevated temp. Tylenol [illegible] given, [illegible] given [illegible]. [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted] 66-4

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

MEDCOM - 14200

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 July 03	Surgery Brief Op Note
	Pre Op Dx ① Open ② TKA / CSF Leak
	Procedure ① Lumbar Drain
	② Wash out ② TKA
	③ Place ① SOV 3-lumen cath.
	Surgeon [redacted] / [redacted]
	Anesthesia GETA. b6-2
	Drain - Lumbar / ① 3-lumen SOV
	Complication ϕ
	findings: no prs, knee healthy, maladorous through
	[redacted] LTC
	b6-2

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

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

[redacted] b6-4

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

MEDCOM - 14201

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Jul 03	1630 Anesthesia - Called to ICU for intubation Preoxygenated → MAC #3, #8.5 ETT oral used, succ supplied 20mg + Sux 100mg IVP. Dl x 1 ↓ preoxygenation → grade 2 view; swelling in airway but cords visable → ETT easily passed. BBS+/typed. L3 ex. teeth. f/u VS - 120/55 - 140 - 100% - put on vent. [redacted] mg/kg)

b6-2

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

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

REGISTER NO.	WARD NO.

[redacted]

b6-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 July 03	Surgery Brief Op Note Pre Op Dx: ① Open ② TKA / CSF Leak Procedure: ① Lumbar drain ② Wash out ② TKA ③ Place ② SOV 3-lumen cath. Surgeon [redacted] / [redacted] b6-2 Anesthesia: GETA. Drain - Lumbar / ② 3-lumen SOV Complications: Ø Findings: no prs, knee healthy, malodorous thruout
	[redacted] UTC b6-2

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

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

H [redacted]

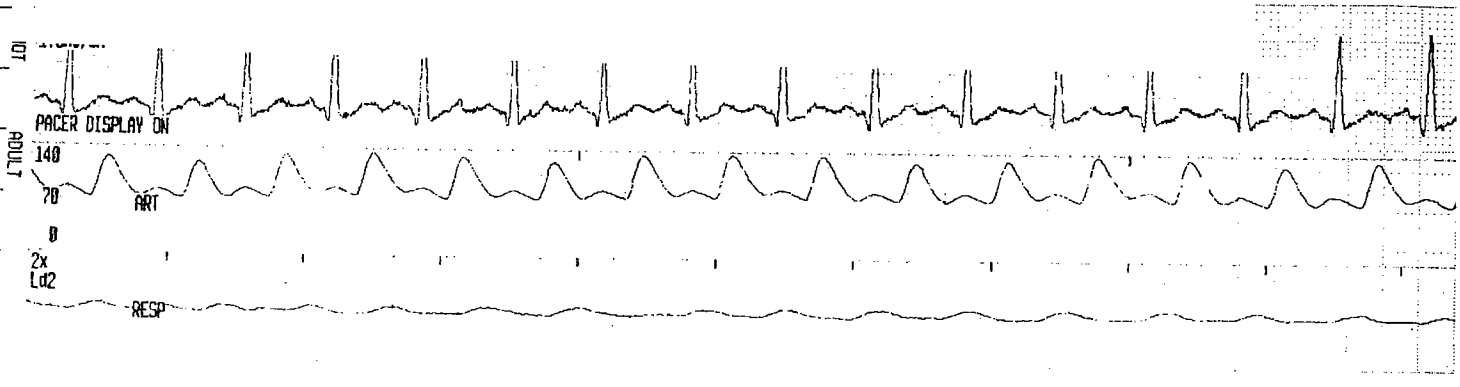
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 14203

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/17/03/0500	ASSUMED CARE. Report given see initial assessment for assessment on ICU-T Flowsheet. [redacted] 0515 labs drawn per A-line. Team to lab. [redacted] b6-4



17Jul03 0530	BT awoke during assessment, communicates in TRADI - gestures used to communicate injury & spine and reason for not wanting him to sit up. Dressings to sides and (R) LKA intact. Abdominal ~~dressing~~ staples intact x 30 staples. Edges approximated. No secretion at site. BT has pronounced upper lung sounds, lung sounds diminished in lower lobe S.O. 97% RA ⇒ POD

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

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

REGISTER NO.	WARD NO.

4/4/04

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

EPW [redacted] b6-4

MEDCOM - 14204

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 July 03 2245	Pt K 2.8 in am 40meq given IV via art line post chem K 3.1, currently receiving second 40meq in 100cc NS. ETT suction, thick white secretions moderate amt. currently satting 100% on .40 FiO2 T 37.7. will cont to monitor —— b6-2 [redacted]
18 Jul 03 @ 1200	Pt Received, physical assessment Completed + Recorded, (L) BKA Dressing CDI, (R) Underarm Upper Chest Wound Dressing Seeping Sero Sang Fluid, (R) Lower back Dressing CDI, Staples (R) Lower Leg Seeping Sero-Sang Fluid, Midline - Staples Sero-Sang Fluid, Dressing Lumbar Drain CDI [redacted]
18 July 03 @ 2100	Pt T 101.5 Tylenol 650 mg PR [redacted] b6-2 CPT/AN
18 July 03 @ 2400	24° I+O IV in 4927 U/O 2310 lumbar out 431 NG out 50 Total out 2791 — Balance [+2136] — Dressing (R) + (L) Lower back Change Saturated Sero-Sang Fluid, Dressings (R) Upper Chest + Arm pit Dcl Saturated Sero-Sang Fluid, Fluid Bloody Sero-Sang seeping From Lower 1/3 Midline Abd incision Sero-Sang Fluid seeping from incision (R) Leg [redacted] b6-2 CPT/AN
18 Jul 03 @ 0350	Pad under Patient Dcl ABG labs drawn ABG PH 7.585 Pco_2 32.5 PO_2 241 HCO_3 31 BEcef 9 SO 100% Vent Rate ↓ 10, FIO_2 ↓ 30% [redacted] CPT/AN b6-2

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

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

REGISTER NO.	WARD NO.

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

MEDCOM - 14205

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 JUL 03 0010	Pt intubated simv 12, 800, 60%, +8, PIP 27. Pre tx 133, RR 13, SPO2 1000%. UD Alb given. BBS CTA very diminished @ bas. Post tx HR 137, RR 12, SPO2 1000%. BBS no D's — Sg [redacted]
18 July 03 0409	UD Alb tx given BBS (-) coarse (-) Rhonci (-) wheezing Hr 129 SpO2 100 RR 12 Post tx HR 126 BS improved RR 12 SpO2 99% b6-2 SGT [redacted] T
18 July 03 0753	UD Alb tx given HR 120 RR 13 SpO2 100% BBS Coarse ↓ Bases Post tx BBS improved still ↓ Bases HR 123 RR 12 SpO2 100% — SGT [redacted] KJ
18 JUL 03 1957	Pt intubated simv 12, 800 35%, +8, PIP 29. Pre tx HR 114, RR 12, SPO2 100%. UD Alb given. BBS CTA ↓ @ bases. Post tx HR 122, RR 12, SPO2 100
27 July	UD Alb/Atro tx given to pt HR 104 RR 37 SpO2 99 BS (+) Coarse (-) wheezing CPT Done Pt able to cough some Secretions Post tx HR 112 RR 38 SPO2 97% BS improved b6-2 SGT [redacted] RT
27 July 0630hrs	U/D Alb tx given. BBS coarse but ↓'d at bases. Pre tx HR 117 B/P 132/82 RR 43 PO2: 97% CPT done during tx. Post tx HR: 116 B/P: 132/82 RR: 46 SPO2%: 98 BS are unchanged post CPT tx. Post neb tx HR: 123 B/P: 135/80 RR: 43 SPO2: 95% Post neb tx BS: unchanged Will continue to monitor pt's resp. status — CRT [redacted] b6-2 CRT
27 July 1616hrs	U/D Alb/atrovent tx given. BBS coarse but ↓'d at bases. Pre tx HR: 127 RR: 49 BP: 88/75 SPO2 93% CPT done during tx. Post CPT tx 130 RR 46 SPO2 95 BS: Breath sounds are unchanged post tx ABG drawn: PH 7.49 PCO2 31.7 PO2 66 HCO3 23 SPO2% 94. Placed nasal trumpet for deep suctioning.

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

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

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

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

[redacted] b6-4

will continue to monitor pt's resp. status ——— CRT [redacted] CRT

b6-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Jul03	Neurosurgery
0714	(S) Afebrile.
	Lumbar drain 20/hr/serosanguinous.
	Wounds draining xanthochromic fluid, less output
	from flanks.
	Opens eyes to noxious.
	Localizes noxious (B) UE.
	Remains plegic in lowers
	A/P GSW L-spine with CSF drainage.
	Continue bed rest/log roll.
	Continue CSF drainage 20/hr.
	[redacted] b6-2
	[redacted]
19 July 03	Surgery
Cont	T 101 127/65 117s [redacted] I/O 4927/2791
Cipro	slightly icteric, anasarcic, injected
Zosyn	lungs clear RRR (+)VD abdo firm, quiet, stoma p.
	min gas in bag, legs cool, edematous.
Reglan	wounds clean, weeping in axilla, leg, abdo.
MSO4/Versed	Na 4 33 187 121/3.3 97/27 201 133 tbili CXR (B) diffuse infiltrate
— b6-2	10/800/50/8 743/43/105/25/4
[redacted]	Imp CSF leak/pneumonia/complete low spine injury/ileus
	hyponatremia / hypokalemia

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

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

[redacted] ER NO. b6-2 | WARD NO.

#0[redacted] b6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7-19-03/ 0600	Assumed pt care from CPT [redacted]. Pt in no apparent distress @ change of shift. Verbal improving @ 45cc/hr, MSO4 4mg/hr, LR@125cc/h Lumbar drain off, NG to CTS draing small amt green emesis noted (L) LE stump elevated, pt HOB 20°. VSS [redacted] b6-2 LT RN
7-19-03/ 1100	Pt returned from OR hemodynamically stable & in no apparent distress. [redacted] b6-2 LT RN
7-19-03/ 1500	Dressing d/s done to (R) axilla region - cautery to bleeder, large clot serous fluid from axilla region. (R) hip d/s saturated c clear serous fluid, Bacitracin applied to (R) leg incision approximating well c staples OTA. Lumbar drain insertion site intact. (D) flank dressing d/s, dressing saturated c serous fluid, Pt SaO2 96-95% @ 3L, then rolled returned 99% @ 3L c in 30-35 min post d/s change. [redacted] b6-2 LT RN
19Jul03@1946	Rpt Received, Physical Assessment Complete, 3% NaCl started @ 40cc/hr for 1x Ltr, TT 102.4°, Tylenol 650 mg PR, Cool Compresses to Forehead or Neck [redacted] b6-2 CPT/HN
19Jul03@1950	Pt SBP 80's MAP <60 Dr Notified orders for Bolus of 250cc 5% [redacted] b6-2 CPT/HN
19Jul03@2200	Tube Feeding Ensure @ 10cc/hr [redacted] b6-2 CPT
19Jul03@2300	24° I+O IV in 4691 4/6 3105 Nb out 100 Lumbar drain out 330 Total out 3435 Balance +1256 [redacted] b6-2 CPT/HN

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

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

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

MEDCOM - 14209

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 July 03	Surgery (Con't) Wire Replete electrolytes Con't Vent Con't Abx CBT drain per necessary drsg D/C to stump another 48 hrs daily stump sup.
19 July 03	Brief Op Note Pre Op Dx ① TKA / pneumonia / dvt Procedure ① Bronchoscopy ② Washout ② knee ③ close axilla wounds Surgeon [redacted] b6-2 Anesthesia GETA Findings ① Tracheal tree clean. ② ① knee still slightly maladerous, ↓ drainage pt to ICU stable, intubated. b6-2 [redacted]

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4

REGISTER NO. | WARD NO.

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

MEDCOM - 14210

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20JUL03	Neurosurgery Drain #4
0627	(S/O) T$_m$ 35.3, VSS
	I/O 4691/3795, Drain 15-20/hr.
	Eyes open to noxious.
	Na-139 K-3.5 HCT 29 WBC 8.9
	Localizes noxious in uppers.
	Lowers remain plegic.
	Foley / Colostomy in place.
	(A/P) (1) CSW L-Spine - Static paraplegia c improved
	(R) Flank Wound. (L) continues to drain copious
	Xanthochromic Fluid. Continue lumbar drainage.
	(2) Lumbar Sp. Inj - remains unstable. Continue
	bed rest / log rolls.
	(3) Hyponatremia - responds to supplementation c
	3% NaCl. Continue BID Labs; ↑ G-Tube
	supplement. b6-2
	[redacted]

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

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

[redacted] b6-4

REGISTER NO.	WARD NO.

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

MEDCOM - 14211

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entr[redacted]*
20 Jul03 @ 0205	(✓) Residual TF 30cc, Tube Feed Continued [redacted]
20 Jul 03 @ 0400	AM Labs & ABG Completed [redacted]
20 Jul 03 @ 0440	NA 139, 3% NACL gtt Stoped [redacted] /AW
	b6-2
20 July 03	Surgery.
	BP dropped, responded to vol & ↓ Versed. Good UO, Tolerating TF.
	T 38.6 120/61 110 sinus I/O 4691/3435 UO > 100cc/°
	slightly icteric, ↓d facial edema CXR improved infilts
	lungs clear 13 > 30 < 190 139/3.5 | 104/27 | 12/.7 < 87
	abdo quiet, ND, wound sl full 10/35/800/5 7.42/43/109/28/4
	stoma pink, some gas in bag.
	stump clean, Ⓛ leg wound clean weeping
	Imp. Hyponatremia resolved? / ileus / anemia / hypokalemia
	C-spine complete / Open stump Ⓛ / pneumonia / CSF leak
	Plan. Replete K will d/c remove few abdo staples.
	Hold NaCl & NuT & 3% NaCl infusion
	wean sedation, hold Tube feeds. ↓
	may extubate fascial dehiscence
	CSF leak per Neurosurg. will go to OR today
	recheck Na+. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] ...TAINED AT b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.

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

MEDCOM - 14212

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 July 03	Surgery Brief Op Note Pre Op Dx fascial dehiscence Procedure exp lap / adhesiolysis / washout / retention sut Surgeon [redacted] b6-2 Anesth GETA Drain 0 Specimen 0 Findings decompressed small bowel, gas in T-colon. 1 l xanthochromic-clear abdo fluid. No abscesses. No additional injury. Large retroperitoneal hematoma - no bleeding. Pt to OR pre well, to ICU stable intubated. [redacted] b6-2

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

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

MEDCOM - 14213

800 NS Exp lap NKS 500 mcg Fentanyl F/O
R. gen 100 Albumin r BL 150

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Jul 03	1300 Received from OR. Report given 800 NS given, 100 Albumin, EBL 100, 500mcg Fentanyl, Foley output 150, S/P exp lap: BP 157/89, HR 140's, RR 20's, SPO2 99, Vent setting Rate 10, FIO2 30%, TV 800, peep 5cm c RR 12. b6-2 [redacted]
	1330 Lavage, ett c RT present. Sx'd thick copious amt of thick white secretion per ett. Oral care given as well. b6-2 [redacted]
	1340 Tylenol supp. PR given Temp 39.3
	1500 updated Dr [redacted] on pt status orders received to give Ducolax supp.
	1600 Ducolax supp per rectum. update given to DRS. ... orders received b6-2 [redacted]
	1710 Report given to oncoming shift

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

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

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

REGISTER NO. | WARD NO.

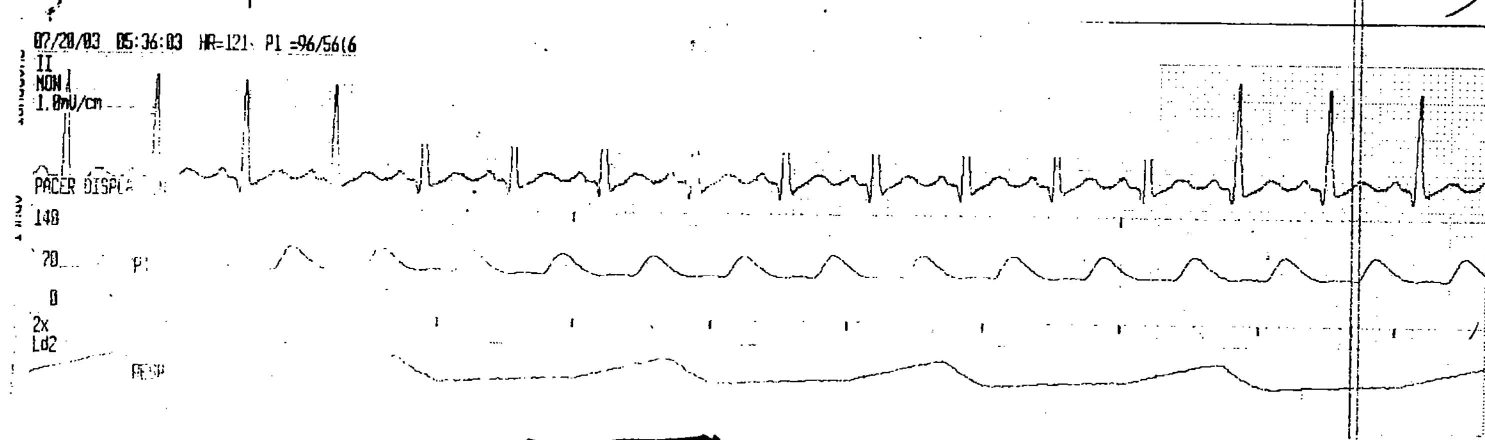
EPW # [redacted] b6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Jul03	0500 Report given. See ICU flow sheet for initial assessment



DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Jul03	0630 Dr [redacted] @ bedside. drsg D/C'd on (L) side & (R) lower back [redacted]
20Jul03	0635 Residuals check 30cc refeed back to pt. [redacted]
	0730 CXR taken [redacted]
	0900 Dr. [redacted] @ bedside. midline abd drsg D/C'd. (R) lower BKA drsg D/C'd by Dr. [redacted]
	0930 labs drawn per A-line. Sent
	1000 Na 140. update given to Dr [redacted] [redacted]
	1130 placed on stretcher for OR [redacted]

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

all b6-2

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

EPW [redacted] b6-4

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

MEDCOM - 14215

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	1700 20 JUL 03 – Received care of patient. Pt is comfortable in bed. Assessment as follows: [N] Sedated on MSO4 @ 4cc/hr and versed @ 3/hr; PERRL @ 4mm; lumbar drain intact draining CSF/serosang fluid; Retracted (B)E to painful stimuli [R] on Vent settings of SIMV of 10, PEEP of 5, 35% TV 800; Coarse Breath sounds (crack/rhonchi) in upper lobes, ↓ in bases; ⊕ exp. wheeze; Resp [illegible] as ordered; ⊖ s/s of cyanosis noted [CV] S1, S2; ⊕ ST on BOS; hypotensive 100/60s, febrile @ 39.0; Edema is +3 in (B)E; +2 in UEs; +2 pulses x3 [GI] ⊘ BS; colostomy intact to (L)UQ; NGT to (R) nare with LIS in place, Foley to gravity [Skin] (R)LQ inc. with ⊕ serosang drainage, reinforced dsg; midline abd inc. has retention sutures in place; [illegible] dsg has serosang fluid; (R)LE dsg c/d/i (L) [illegible] (L)IJC; (L) [illegible] foley, ETT. [Plan] is to [illegible] for [illegible] care —
	[redacted] 1LT, AN
	[redacted]
	b6-2

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

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

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

REGISTER NO.	WARD NO.

[redacted] b6-4

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

MEDCOM - 14216

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/21/03/0500	Assumed care. Report given
	see ICU-7 Flowsheet for initial
	assessment —— [redacted]
	0615 Dr. [redacted] b6-2 @ bedside, drsg
	d/cd. lower back (B). CSF fluid
	taken. send to lab —— [redacted]
	0630 oral care given. sxd. small
	amt of thick secretion. —— [redacted]
21 July 03	Surgery.
Gent	Tm 104 → 98.6 ecs ... 1200/1000 ... 50-100 b6-2
Cipro	sl ...
...	lungs clear 18 30 234
	RRR ... 135/37 104/28 16 ... 91 t.bili 13.8
Reglan	... wound c/d
Santac	stump c/d 10/35/800/5 74/44/107
...	(R) Axilla c/d
...	... Open (L) TKA - clean Plan OR tomorrow for stump closure
Tylenol	Open abdo incision - clean replete K / begin TF/MVI
...	open (R) Axilla erythromycin ...
	ileus / pneumonia / malnutrition / hyperbili (? ...) cont supportive care.
	hypokalemia / leukocytosis / anemia [redacted] b6-2

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

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

REGISTER NO.	WARD NO.

Ø [redacted] b6-4
EPW

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

MEDCOM - 14217

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
21 Jul 03	0915 All drsg ∆'ed. per Dr. [redacted] orders received [redacted]
	1000 Meds given down NGT. chang... ETT sx'd. pt opens eyes to verbal commands. ø tracking c̄ eyes [redacted]
	1140 Place back to sx ... reposition c̄ log roll [redacted]
	1300 TF ing started @ 10cc/hr of ensure. [redacted]
	1450 Linen ∆'ed. bath given. reposition c̄ assist log roll placed on (L) side. [redacted]
	1600 ø residuals noted. VSS. [redacted]
	1710 Reglan given. [redacted]

all b6-2

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

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

[redacted] b6-4

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

MEDCOM - 14218

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1720	TOOK OVER CARE of patient. Resting comfortably
22 JUL 03	in bed. ASSESSMENT AS FOLLOWS:
	[N] PERRL @ 3mm; reacts to painful stimuli; sedated on MSO4
	at 4mg/hr + versed @ 2mg/hr; lumbar drain inted - draining
	small amount of CSF - see I/O. [R] SIMV 14, PEEP 5, 35%, TV 800
	#8 ETT 23cm @ lip; ⊖ s/s of cyanosis noted; [illegible];
	CTA [redacted] improving in ant. registers ⊖ wheezing; CTA [redacted] minimal amount
	of adventitious sounds; ↓ breath sounds to (R) LL; [CV] febrile at 38.4
	S_1/S_2; multiple +2-3 edema throughout extremities; +1-+2 pulses x 3;
	sinus tach 110-130; BP stable 120s-130s systolic; [GI] NPO to
	(R) [illegible] + LLW; moderate amount of drainage noted; colostomy
	with minimal serous drainage from (L) side; TF @ 10cc/hr.
	(+) BS [GU] foley to gravity - dark amber colored urine; I&O
	maintained; [Skin] multiple tears + inc. sites. Most notable
	are midline epigastric with retention sutures - C/D/I; (R) axilla
	is to heal + C/D/I; (R) LE synth. dressing - C/D/I, [lines]
	(L) rad art; ETT; (L) SC; foley, NGT to (R) nar.
	[redacted] [illegible]
	b6-2

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

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

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

REGISTER NO.	WARD NO.

[redacted] b6-4

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

MEDCOM - 14219

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21JUL03	Neurosurgery
0624	(S/O) Tm 39.1, VSS
	I/O 1214/2078, Lumbar drain 10-20/hr.
	Paraplegia persistent.
	Drainage (R) Flank minimal, (L) Flank Xanthochromic.
	WBC 17.7 today.
(A/P)	(1) GSW L-spine - Continue Leg Roll.
	(2) CSF Leak - Day 5 drainage. Continue.
	(3) Fever - on Gent/Cipro/Zosyn. CSF sent.
	b6-2
	4757
22JUL03	Neurosurgery
0621	(S/O) Tm 38.7, VSS.
	Lumbar Drain ~ 10/hr/Xanthochromic.
	Paraplegia persists.
	Flank dressings: (R) Xanthochromic Fluid.
(A/P)	(1) GSW L-spine - Unstable. Leg Roll. Bed Rest.
	(2) CSF Leak - Day 6 Drainage. Continue until Friday.
	(3) Fever - CSF WBC 22/Gram Stain ⊖ Bacteria.
	Continue Gent/Cipro/Zosyn.
	b6-2
	4757

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 JUL	(0700) lumbar drainage ↑ to 30cc/hr; no other change
	in POC; assessment completed & charted; am care done;
	[redacted]
22 July 03	Surgery
	Tm 101.5 VSS I/O 6080cc/° CXR - no change, lower lobe
Cipro	fluffy infiltrates
Cont	lungs clear RRR, ⊖S1S2
Zosyn	Very hypo BS, ⊕gas in colostomy bag, min stool.
	legs cool/dry, edematous.
Reglan	abdo wound dry, ⊕granulation, no fluid, no dehiscence.
Zantac	
Erythromycin	stump - T. bili 11.8
Rilcolip OD	147/28 286 Na 128/3.9 K 99/28 Cl 7
	lung ileus 10/800/35/5 7.4/43/87/30
MSOy Versed	lumbar spine transection/instability/CSF leak
	pneumonia
Albut/Atrov	malnourished.
NF 125	anemia/hyponatremia/hypokalemia/hyperbilirubinemia
	Plan Con't Abx
	Con't PNGT erythromycin / Restart TF
	replete K (Mg)/Na
	Will wait till no fever 24° befor closing stump.
	Δ central line today.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] MAINTAINED AT b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.

EPW [redacted] b6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 Jul 03	Surgery CX today; Stump dsg Δ'd; area red; small oozing of serosang fluid; abdominal dsg Δ'd; area red; small S/S fluid; W→D dsg + cirrule; CL per MD; CXR ordered pt tolerated procedure well; [redacted]
22 July 03	Surgery. Central line changed to new site ® SCV. Sterile technique mod-seldinger tech used, threaded easily, withdrawn easily, flushes easily. Sewed c̄ 3-0 silk x 3, caps secured / locked. CXR shows good position. May use catheter now, will d/c previous line. Pt tolerated procedure well. 10 cc 1% xylocaine used for local. [redacted] b6-2
	(1100) CL RAD read by MD; ND to change over to site 2 use ® SL TLC; Ⓛ TLC blk-infant; [illegible] [illegible] 3-5 mm; Ⓑ BS; SAO2 > 96%; no Δ in RR; equal rise/fall of chest; TF started @ 10; goal of 2200-2500 Kcal / 24°
	(1300) no change in status; no new orders [redacted]
	(1500) no change in status; [redacted]

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

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

REGISTER NO. | WARD NO.

EPW [redacted] b6-4

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

MEDCOM - 14222

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	1100 22 JUL 03: Pt recieved from report. Resting
	comfortably in bed. Assessment as follows:
	[NS] sedated on MSO4 @ 4, versed @5; PERRL @3m; retracts
	to painful stimuli; [R] SIMV 10 Vt 800 PEEP 5 35%; #8 ETT
	25cm @ lip. ↓ in crackles/rhonchi, ↓ BS in bases. CXR in progress;
	rehab 04; ⊖ s/s of cyanosis; minimal amount of rad, thick, white
	secretions; [CV] +2 edema to UE/LE; +2 pulses x3; febrile currently
	at 38.8°, ST 126; 120s-130s sys; S1/S2 [GI] colostomy to Ⓛ side,
	hypoactive bowel sounds x4; NGT with feeds @10cc to Ⓡ nare
	[GU] foley to SD with moderate U/O - see I/O; [Skin] multiple
	dsgs most notably Ⓡ axilla; midline incision; Ⓡ LE - all to
	be d/c'd with dsg changes; [Lines] Ⓡ SC; Ⓛ radial, easy, ETT;
	will monitor [PLAN] strongly closer pending — [redacted] 1LT
	b6-2

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

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

REGISTER NO.	WARD NO.

[redacted] 22 JUL 03

b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Aug 0?	Surgery
	still no sleep last pm
	Afebrile VSS 1/0 M > 100 cc/o 14 < 27 1475
NS @ 125 u/o	icteric, responds to voice, touch 136 | 105 | 10 / 3.1 | 25 | .7 < 144
Albut neb q4	lungs coarse (B), large airway 14.6 ↓ 4.1
Reglan 10 q 8°	RRR, ..., ...
Lovenox w/ AM	(+)BS, stoma pink, edematous, wound granulating, (-)stool
TF	leg w/o, stumps c/d/i, (-)skin necrosis
	Imp lumbar spine transection c CSF leak.
	pneumonia resolved — now c secretions again
	ileus resolved. anemia
	mental status "resolving" retroperitoneal hematoma
	ORW ankle wound dehiscence
	Plan. D/c Reglan
	CPT c nebs q4°
	translator to speak c pt OD.
	↓IVF
	d/c Nall replacement
	replete KCl
	pt needs reclassified as civilian then to chronic care
	[redacted] b6-2

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

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

REGISTER NO. | WARD NO.

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

MEDCOM - 14224

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July 2003	Nutrition
@ 1130	Pt current TF Ensure @ 20 cc/hr. Goal per MD is
	2200-2500 Kcal/day.
	Recommend Jevity Plus (Ready to Hang) formula
	@ 85cc/hr to provide 2448 calories
	per 24 hr period (including 110g protein).
	[redacted] b6-2
23JUL03	Neurosurgery MAJ, SP, RD
0645	S/O Temp 38.7 this AM
	Lumbar drain 6-20/hr.
	Dressings: Mild serosanguinous fluid.
	Arousable. Localizes uppers. Lowers plegic.
	WBC 11.3
	A/P ① Lumbar GSW/FX - unstable. Log Roll.
	② CSF leak - CSF output decreasing. Continue
	drainage Day 7 today.
	③ Fevers - WBC trending down. Continue
	Gent/Cipro/Zosyn.
	[redacted] b6-2
	4T77

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV[redacted]	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP [redacted] SPONSOR	

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

EPW [redacted] b6-4

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

MEDCOM - 14225

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July 2003 @ 1130	Nutrition Pt current TF Ensure @ 20 cc/hr. Goal per MD is 2200-2500 Kcal/day. Recommend Jevity Plus (Ready to Hang) formula @ 85 cc/hr to provide 2448 calories per 24 hr period (including 110g protein). [redacted] b6-2 MAJ, SP, RD
23JUL03 0645	Neurosurgery S/O Temp 38.7 T 115 Am Lumbar drain 6-20/hr. Dressings: Mild sanguinous fluid. Ambulate. Localizes uppers. Lowers plegic. WBC 11.3 A/P 1. Lumbar CSW/FX - unstable. Log Roll. 2. CSF leak - CSF output decreasing. Continue drainage Day 7 today. 3. Fevers - WBC trending down. Continue Gent/Cipro/Zosyn. [redacted] b6-2 MD

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4

REGISTER NO. | WARD NO.

EPW

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

MEDCOM - 14226

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)
23 July 03	Surgery responsive
	[illegible] pm defervesced, VSS [illegible] 80-165cc/°
Gent/Cipro/Zosyn	112/64 113 sims 1/0 ?
Nystatin	slightly icteric CXR - improved
	lungs clear ; productive mucous [illegible] 6-26cc/°
MSO4 /Versed	RRR, Ø m/R 11 > 355 / 25
	Ø BS, soft, NT 123/96/8 / 3.9/22 < 123
Reglan / [illegible]	abdo wound s granulation or serous drainage [illegible] 104
Sarafem	Ⓡ axilla wound c clear drainage LFTs s/up
	legs warm, dry, [illegible] anasarca. 7.55/35/130/31/9
Albuterol / Atrovent	on 10/800/35/5
	Imp Pneumonia improved
NaCl 4g q6°	hyponatremia
	hyperbilirubinemia resolving
	Ileus / open Ⓡ TKA / open abdo wound
	hypoventilated / anemia
	Plan ↑ TF to 40 c Jevity Plus
	add 3% NaCl if Na really 123 (will repeat).
	↓ imv
	Possible chest [illegible] Am if 24° afebrile
	diurese . b6-2
	Cont Abx, [illegible]; supportive care . [redacted]

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

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

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

REGISTER NO.	WARD NO.

EPW # [redacted] b6-4

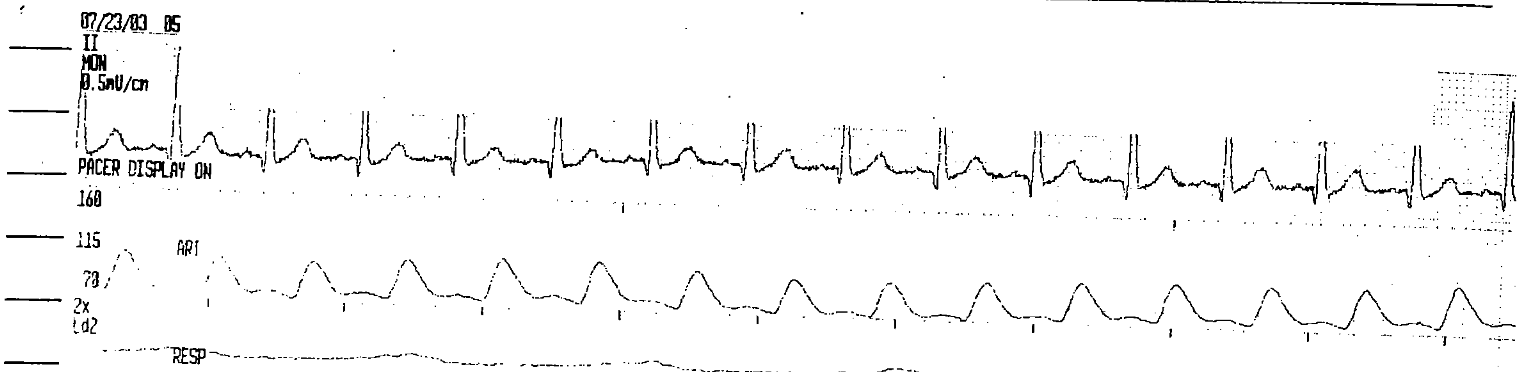
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
7/23/03	0500 Assumed care. Report given. See ICU-4 flowsheet for initial assessment



7/23/03	0630 [illegible] @ bedside. update given on pt's status [redacted]
	0730 all dsg d/c'ed. midline abd dsg c retension suture intact. weeping remains from sides (B) [redacted]
	0810 Dr [redacted] @ bedside. update given
	0945 [illegible] dsg d/c'ed per Dr [redacted] orders received [redacted]
	1050 lab drawn per A-line [redacted]
	1100 d/c rate 8. per orders
	1130 ABG drawn. reviewed by Dr [redacted]. orders received [redacted]

all 6/9?

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTA[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.

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

MEDCOM - 14228

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
7/23/03 1140	Na 126. 3% NaCl @ 20cc/hr per [illegible]
	1230 [illegible] release pt. secure by [redacted]
	even pt. unlabored. SpO2 @ 98%-99% [redacted]
	1340 [illegible] [illegible].
	1430 Oral care given. s/d [illegible] [redacted]
	white secretion per [illegible]
	1540 Repositioned c̄ support. Oral care given [redacted]
	1700 Report given to oncoming personnel [redacted]
24JUL03	Neurosurgery
0636	(S/O) Afebrile since [illegible] WBC 10.1 Na 123.
	CSF dark (maroon) drainage overnight - hematoma from initial injury probably breaking down.
	Dressings minimal drainage.
	Paraplegia static.
	(A/P) (1) Lumbar GSW - unstable - spine precautions.
	(2) CSF leak - continue drainage, today day 8
	(3) Fevers/WBC - improved on antibiotics. Complete course.
	[redacted] 4797

all b6-2

FPI. LEX. Printed on Recycled Paper

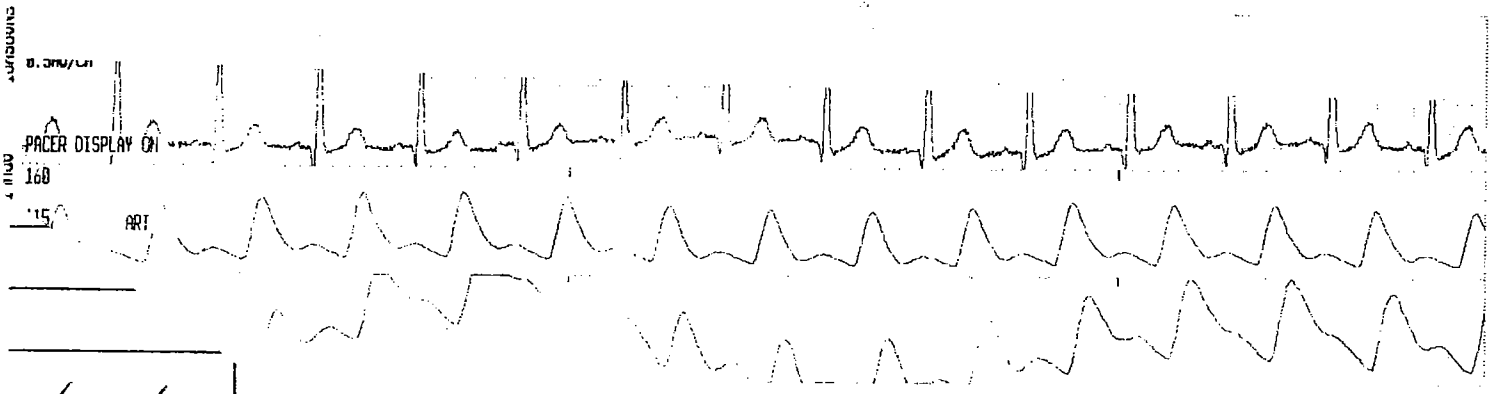
STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 14229

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/24/03/0500	Assumed care. Report given see TCU-2 Flowsheet for initial assessment. [redacted] b6-2



7/24/03 0650 Updated Dr [redacted] on patients status. O orders received
0730 Dr [redacted] @ bedside. Orders received
update given on current labs [redacted]
0750 IV Na @ 84 @ 3½ @ 30cc/hr.
Na 125.
0850 Rbum started @ 50cc/hr [redacted]
0950 Report given, assumed using [redacted]
1300 Sponge bath given. [redacted]
1510 Prepared on stretcher for OR [redacted]

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

all b6-2

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4

REGISTER NO.	WARD NO.

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

MEDCOM - 14230

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24 July 03	1730 Assumed care. pt post op for stump closure. Labs drawn CBC, Metlyte 8, ABG, VSS. will continue to monitor. CBK
	1905 – pt extubated. 5 difficulty. 45% via FM. C SATS @ 99–100% VSS. pt given MSO4 for pain. [redacted] CPT/AN
	2100 – pt placed on NL 5 L C SATS @ 99% [redacted] CPT/AN
	2200 pt O2 ↓ to 2L via NL C SATS @ 98–100% pt takes deep breaths and coughs. VSS. pt given MSO4 for pain. will continue to monitor. [redacted] CPT/AN
25 July 03	0048 pt given haldol for agitation and moving around in bed. pt pulling of dsg's, colostomy, & monitors. [redacted]
	0055 pt given 2mg Ativan for continued agitation will continue to monitor. VSS. [redacted] CPT/AN
	0130 pt given #2 dose of Haldol 5mg for continued agitation. VSS will continue to monitor [redacted] CPT/AN
	0300 Dsg A's done. will continue to monitor. VSS. CBK
	0400 Labs drawn. [redacted] CPT/AN
25 July 03	0500 Assumed care after report assessment done. Pt sleeps on & off talking air Quad when awoke dry dressing CDI VS stable. Will continue to monitor [redacted] RT AN
	0600 Residual checked 0cc. Increased TF @ 60cc/hr
	0800 Lasix given per Dr's Order 20mg IVP [redacted] RT AN

HOSPITAL OR MEDICAL F[redacted] | DEPART./SERVICE | [redacted] ASSIGNED AT

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

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

all 66-2

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

MEDCOM - 14231

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 Jul 03	1818 Rpt Recieved, physical assessment complete, Pt Alert but confused, Lungs CTA c̄ Diminished bases bilat, Abd Soft, Non-Tender, BS x4 hypo, +2 Pulses UE bilat, +1 Pulse RLE, (L) BKA, Dressing Midline Abd CDI, Dressing (R) Outer Chest CDI, Dressing (R) Flank CDI, (L) Flank CDI, (L) BKA CDI, IV (L) FA Patent, Ch (R) SC Patient, [redacted] b6-2
25 JUL 03	Neurosurgery b6-2
0652	(S/O) VSSA. WBC 15.
	Awake, paraplegic.
	(L) Flank sealed. (R) Flank minimal drainage.
	Lumbar Drain q-18/hr.
	(A/P) GSW L-spine. Log roll precautions.
	CSF leak. Continue drain until dry.
	b6-2
	[redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 14232

ACLU-RDI 1625 p.192

DOD-027784

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25JUL03	Neurosurgery
0638	(S/O) Temp 101.3 this AM. Stable overnight.
	Extubated yesterday...
	Na 129. Drain Output 10-44/hr.
	Awake, moving uppers normally. Lowers plegic.
	Flanks drying up.
	(A/P) Doing well from neuro standpoint
	Will watch for dry flank dressings x 24°
	before removing lumbar drain.
	Continue bed rest. [redacted] b6-2
	1797
25 July 03	Surgery
	Tm 101.3 0055r JP 50cc overnight
	afebrile lungs CTA/sym lumbar 261cc
	RRR ØM ⊕BS soft NT
	abdo wound dry, beginning granulation tissue.
	sking dsgs dry, ⓡ bd edematous. 15.3 > 27 < 871
	lungs stable 248/38/103/28 - 2 lnc
	Plan ① ID per neurosurg ④ Con't 3% NaCl 120 | 97 | 6 / 3.9 | 23 | .6 < 132
	② skin dsgs x 48° → Δ ⑤ diuresis
	③ ↑ TF to goal ~80cc/°

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

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

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

#0[redacted] b6-4

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

MEDCOM - 14233

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
26 July 03	Surgery. Agitated overnight
NS @ [illegible]	T 100.6 . 180/80 110-180 (c agitation)
Albut	icteric, confused, slow Lumbar drain 230/240
	lungs clear ant/post JP [illegible]/240
[illegible]	RRR Øm
Nystatin	hypo BS soft, Ø tenderness, abdo wound granulating, ⊕ stool in bag
	leg wd Ø edema, stump Ø active bleeding, Ø drainage
[illegible] 20 00	
3% NaCl	Imp: hyperbilirubinemia 15 > 25.4 < 272 138 / 3.6 | 105 / 22 | 8 / .7 < 162
Reglan	ileus resolving
	anemia / thrombocytosis
TF @ 60	Na normalizing / hypokalemia
	Plan d/c 3% NaCl – ~~use 4g NaCl per NG~~ hold b/c of CSF leak
	D/c oral haldol
	increase TF
	discuss c neurosurg getting move to take PO but will need
	to be able to protect own airway before taking po.
	has been on Abx 7-10 days, will d/c & follow wbc/fever
	disease
	supportive care
	[redacted] 6b-2
27 JUL 03	Neurosurgery
0647	(S/O) VSSA.
	Drain 20/hr.
	Flanks dry.
	(A/P) Stable p GSW L-Spine. 6b-2
	Will clamp Lumbar Drain. [redacted] 4797

FPI. LEX. Printed on Recycled Paper   STAN[redacted]RM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28JUL03	Neurosurgery
0649	(S/O) VSSA. WBC 25
	Awake, nonverbal, left head turn preference. ⊝ Meningitis
	Localizes noxious in uppers. Unable to ask questions.
	Flanks dry – lumbar drain discontinued.
	(A/P) (1) lumbar Fx 2° to GSW – spine precautions.
	(2) CSF leak – resolved.
	(3) Encephalopathy – unclear, presumed metabolic.
	Will stimulate to eat, interact, etc.
	[redacted] b6-2
	1797
28 July 03	Surgery. [illegible]
	Afebrile, nonfocal, [illegible] still [illegible] tracks
ASA 325	VSS, more tachycardic (to 150 sinus) [illegible] 2435
[illegible]	[illegible] 136/3.8 | 103/29 | 14/.6 <136 25>35 2008
[illegible] 10	lungs CTA/[illegible] [illegible] 46 (3% bands)
[illegible]	RRR/ØM CXR clean, tip 3[illegible]
[illegible]	[illegible], [illegible] AXR [illegible] ?duodenum or distal stomach
	leg w/o c̄ edema, [illegible] c/d/[illegible]
	[illegible] fever source? central? CSF?
	Plan translator to speak with [illegible] / [illegible] / [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted] b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO. | WARD NO.

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

MEDCOM - 14235

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Ophth Svc
29 July 1936	asked to do retina exam to investigate evidence of septic emboli or fungal retinitis
	O/M/V/p WNL ϕ hemorrhages/ retinitis
	[redacted] b6-2
	[redacted] MD
	607th, LTC
	Ophth SVC

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28/Jul/03/1600	[illegible] along c [illegible] lung [illegible] 2000 [illegible] colostomy. b6-2 [redacted]
28 Jul 03/1737	Rpt Received, Physical assessment, Pt lethargic, c distant stare, Purposeful in movement, Lungs CTA, Abd Soft, Non-Tender BSx4 Active, Colostomy LUQ Pink c Brown Liquid stool, Pulses +2 UE B.lat, +1 RLE, LLE BKA, Skin Jaundice, Diaphoretic, Warm, Dressing to Midline Abd incision, CDI, Dressing (R) Under Arm - CDI, TL RSC - Patent CDI, PIV (L) FA Patent CDI, Incision - (L) LE CDI [redacted] cpt/AN b6-2
28 Jul 03/2200	Suctioning pt throat. SPO2 ↓ 91% Pt placed on Vent Mask @ 30% [redacted] b6-2 cpt/AN
28 July 03/2400	Pt Bathed, T 103.6, Tylenol 650mg PR Given, Dressings Ied, Foley Ied [redacted] cpt/AN b6-2
28 Jul 03/0335	T 103.6 Tylenol 650mg PR given [redacted] cpt/AN
28 JUL 03 0638	Neurosurgery (S/O) Flanks dry. Febrile overnight. WBC ↑ ~~270~~ 27K. No meningismus. Now on antibiotics. (A/P) (1) FUO p GSW L-spine. Will LP today. (2) Unstable spine. Continue log roll precautions. [redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
		[redacted]	
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPO[redacted]**	4RT

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

MEDCOM - 14237

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 JUL 03.	pt continues c̄ HR 130-140; BP WNL; SaO2 97-99% on
	30% VM decreased to 26% 3L c̄ SaO2 98%; will CTM;
	lungs ↓ (R); RR 30's; TF residual <30cc; ↑ TF to
	60cc/hr; goal is 80cc/hr; Colostomy continues draining;
	distal pulses palpable; MD Sam has seen c̄ [redacted]
	b6-2
29 July 03	Surgery mental status still poor; large airway secretions
	Tm 103.6 130/80 120-150 reg. 40-85 cal°
Haldol	icteric
Mystatin	lungs coarse (B) - upper airway 273 / 30 — 1733
Vanco Ativan	RRR, [illegible] 137 | 104 | 22 / 3.9 | 22 | .6 < 141
ASA 325	(+)BS, stoma pink / functional
ceftriaxone	leg w/o incision healed. urine neuro ØBact
	on whl
Atrovent / CPT / [illegible]	Imp fever - source ? retroperitoneal hematoma / CSF
TF @ 60%	clouded mental status
	leukocytosis s̄ bandemia / thrombocytosis
	Intravascularly dry
	Plan d/c haldol
	d/c ativan
	d/c halcion
	cont Abx
	CSF tap & send for gm stain b6-2
	cont supportive care [redacted]
0830	PIV x 2 to LUE; CL d/c intact, pressure held x 5 min; Ø
	drainage ↓ SaO2; Lung sounds coarse (R) side (L); Nasal SX
	c̄ purpose (F) results; up @ bedside —

FPI. LEX. Printed on Recycled Paper STANDARD FORM 600 (REV. 6-97) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 July 03	Surgery
0510	Afebrile, VSS good UO, following CF/PO
	mental status improved but still not "normal"
	icteric
	lungs clear, upper airway moist 13.5 / 35 — 1581
	RRR, ⊘m
	⊘BS, Renal colostomy 132 / 4.4 | 100 / 22 | 12 / .8 < 135
	Wound/dry
	Mgt lumbar para / mental status improving
	Plan: d/c Vfeeds to q 4°
	begin reg diet
	d/c Vanco
	d/c ativan prn
	d/c IVF
	awaiting placement.
1 August 03	Surgery
1100	Afebrile, VSS following CO + cough
	icterus lungs CTA/sym rare ⊘m ⊘BS, Renal ostomy.
	wounds stable. 183 / 37.5 — 1682
	Mgt L-spine fx c paraplegia 125 / 7.3 | 98 / 31 | 14 / 1.1 < 146
	stable
	Plan: Placement / lab holiday / increase calories / [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] AINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	[redacted] b6-2

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4

REGISTER NO.	WARD NO.

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

MEDCOM - 14239

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03	Surgery
0950	Afebrile VSS, tolerating PO, Colostomy func.
	anicteric
	lungs clear & symm
	RRR ⊖m
	⊕BS
	abdo wound c good granulation base, retention sutures loose.
	stump clean, little bleeding from medial margin. No
	tissue loss or edema.
	(R) axilla clean/dry, good granulation base. 21.8/35 - 15?4
	Imp stable s/p GSW c lumbar spine transection → paraparesis
	[illegible]
	Plan. Placement, although pt [illegible]
	remove sutures from neck, (R) chest, (R) axilla &
	retention sutures
	encourage calories / physical therapy
	will keep in ICU another day due to 9CSC, no obvious
	sign of infection although diflucan stopped
	due to supply issues.
	cont supportive care. [redacted] b6-2

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

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

REGISTER NO.	WARD NO.

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

MEDCOM - 14240