MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0500	agitated	Versed 2mg	IVP			CRNA

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	WNL	WNL	WNL	<2	W	P
15'							
30'							
45'							
60'							
90'							
D/C							

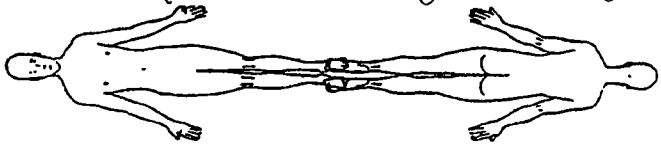
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ABD/(R) leg	Gauze/soft cast	none
30'			
60'	(R) leg	short leg splint	none
D/C	ABD	ABD pad + gauze	blood tinged



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0600	urine	clear yellow	800

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0443	NSR	no	no

WAMC OP 173-E

NURSING NOTES

0440 - Pt received from OR via gurney; accompanied by OR staff. Pt combative. Oral airway in place. O2 via NC @ 10L provided. VSS. Dressings C, D, I. Soft restraints placed x4. Will continue to monitor — [redacted] CPT

0600 - Pt sleeping. Oral airway d/c'd. O2 sats 98% on 4L N/C. VSS. Report given to SGT Harris — [redacted]

0615 - Report given to ICW #1 [redacted] LPN. Pt placed off O2. SpO2 94-98% - RA. Will continue to monitor. — [redacted] LPN

0630 Pt to ICW #1 [redacted] LPN

b(6)-2

Discharge Criteria:
Date: 10 SEP 07 Time: PARS:
BP: 136/74 T: HR: 77 RR: 16 Sa02: 95% RA
Pain Level at D/C (0-10):
Intake: 400 Output: 800
Additional Data: -0-
Transferred To: ICW 2
Report Given To: LPN [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: CPT [redacted]

b(6)-2

(b)(2)-2

MEDICAL RECORD –SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

[redacted]

TRAUMA FLOWSHEET

OTSG APPROVED *(Date)*

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 9/10/03 Arrival Time: 0050 Sex: (M) F Age: 22 Wt: 74kg

Allergies: KNDA Tetanus Status: UTD☑ Unknown

LMP: Last Meal: 1200 [redacted]

Chief Complaint:

PMH: Medications: Ø

Treatments PTA:

VITAL SIGNS: 0055 BP: 135/93 P: 92 RR: 13 TEMP: SAO2: 98

CHEST		*SKIN*	*ABDOMEN*	*NEURO*
TRAUMA YES ☐ NO ☐		☐ WARM	☐ SOFT	☐ PERRL ☐ YES ☐ NO R____mm L____mm
PAIN YES ☐ NO ☐		☐ DRY	☐ DISTENDED	GLASGOW SCORE 15
SOB YES ☐ NO ☐		☐ PALE	☐ TENDER	
LUNG SOUNDS	☐ DUSKY	☐ BOWEL SOUNDS		
R L	☐ MOIST	☐ YES ☐ NO		PUPIL SIZES 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9
☑ ☑ CLEAR		GULATEST		
☐ ☐ WHEEZES		☐ POS ☐ NEG		
☐ ☐ DECRESED				
☐ ☐ ABSENT				

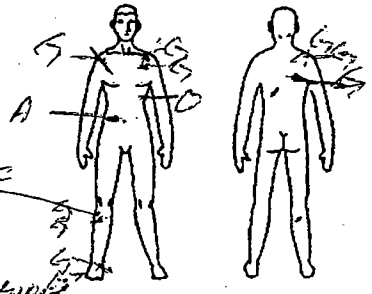
1. EYE OPENING	2. VERBAL REPONSE	3. MOTOR REPONSE
Spontaneous 4	Oriented 5	Obedient 6
To Voices 3	Confused 4	Prostrated 5
To Pain 2	Inappropriate 3	Withdrawal 4
None 1	Incomprehensible 2	Flextion 3
None 1		Extension 2
		None 1

EXTREMITIES
- ☐ DISTAL PULSES X3
- ☐ RT X2 LTX2
- ☐ MOVES EXTREMITIES X4
- ☐ NO EDEMA
- ☐ NO DEFORMITIES

EXCEPTIONS TO ABOVE PARAMETERS:

SPLINTS

TREATMENTS:
02: LPM NC MASK ORAL AIRWAY
ETT # MM ☐ ☐ NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: # DPL ☐ POS ☐ NEG
CHEST TUBE ☐ R ☐ L CM H2O



A= Abrasion
AP=Amputation
AV=Aversion
B=Burn
C=Contusion
D=Deformity
E=Extension
OF=Open Fracture
CF=Closed Fracture
G=GSW
L=Laceration
PW=Puncture Wound
S=Stab Wound
O=Other
O = Chest tube

Additional Interventions/Assessments Head from trauma
Chest tube

PATIENT'S IDENTIFICATION *For typed or written entries give: Name-last; first; middle; ...date; hospital or medical facility)*
Patient/Soldier's Name: [redacted] b(6)-4
Rank:
SSN: ___/__/____ DOB: 12/2/1976

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

DA FORM 4700

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A I I D I	I Z	[redacted]	EPW # [redacted] b(4)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	2 7 y	Z	9	Unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NA	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	0410	NA b(4)-4 1

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO
I Z			✓ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D b(2)-2	ICU 1	Unk
NA [redacted] b(2)-2		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: Unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
5 0		2 6 0 3 0 9 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A E A A		2 0 0 3 0 9 1 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)

FOR LOCAL USE

MULTIPLE GSW TO CHEST / ABD / (R) LOWER EXTREMITY

T: 9
Inj: 569

Dx: 8750
86352
8910
82533
E9912

PR: 4675
9659
8604

b(4)-2

ADMITTI[redacted] DRI

SIGNATURE OF ADMITTING CLERK [redacted] b(4)-2

DA FORM [illegible] MAR 2000 MEDCOM - 18843 EDITION OF MAR 88 IS OBSOLETE USAPA V1.00

ACLU-RDI 1649 p.3

DOD-032417

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	FZ	[redacted] UNK EPW	EPW	M

3. REGISTER NUMBER	6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	—	UNK	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	0945	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K78	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW1	—

NAME AND LOCATION [redacted] b(2)-2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	—	—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
05		030922

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030912

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

DX: S/P EX-LAP/GSW TO CX

T: 9 Dx: 8750 PR: 4675
86352 4659
8910 3604
82532
E9119
Inj: 869

b(6)-2

ADMITTING OFFICER [redacted] b(6)-2

DR.

SIGNATURE OF [redacted]

DA FOR[redacted]85, MAR 89 MEDCOM - 18844 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]					3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE W	—	—	b(6)-4	10. PREVIOUS ADMISSION NO
11. FMP 99	12. [redacted]		13. ORGANIZATION N/A			14. WARD ICU
15. FLYING STATUS —	16. RATING/ DSG b(6)-4	17. DEPT./ BEN TT78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1904	23. CLINIC SERVICE DENA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION SO		26. DATE OF DISPOSITION 030918	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 030910	ADMITTING OFFICER
29. [redacted] TION OF MEDICAL TREATMENT FACILITY [redacted]					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted] b(6)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW ® foot 892.1

E991.2

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
0	0	0	0	5	5

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] b(6)-2 [redacted] ICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 18845

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ	[redacted]	b(6)-4 [redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		Z	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	Z	1904	N/A b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	R 78	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
		9		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O b(2)-2 [redacted]	[redacted]	

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
SO		20030915

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
NENA		20030910

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)

FOR LOCAL USE

DX: [redacted]

8920 II T
E9229 1 450

DX

ADMITTING OFFICER (Si[redacted]s required) b(6)-4 [redacted]

MEDCOM - 18846

INPATIENT TREATMENT RECORD COVER SHEET

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

1.	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
[redacted]	UNK	b(6)-4	NA	

4. SEX	5. AGE	6. RACE	7. RELIGION	8.	9. ETS	10. PREVIOUS ADMISSION
M	29	UNK	UNK	NA	NA	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	b(6)-4 [redacted]	NA	ICU

15. FLYING STATUS	18. DSG	BEN	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	1300	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	21	11/1/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	9/11/03	b(6)-2 Or [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2	9/11/03	

31. SELECTED [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW (L) LEG TIB FIB

Dx: 891.0, 041.11, V09.0, 905.4, 733.81, 730.26, E991.2

Px: 79.36, 77.17 (x3), 83.98, 78.07, 77.79, 88.27

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	58	58

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
[redacted]	b 0	0	0	58	52

SIGNATURE [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

MEDCOM - 18847

DA FORM 3647-R-MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1 1.00

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Pt readmitted from EPW hospital
2° known MRSA.
No new c/o.

See

PHYSICAL EXAMINATION

No interim Δ
See prior H&P

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

Ⓧ Ⓛ tibia Fx ̄c MRSA osteomyelitis
① Readmit - delayed ORIF + grafting

b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	10-3-03		

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 18848

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

29 yoa abd Iraqi EPW - shot (L) Leg one month ago. Was in Iraqi hospital & prison & then moved to EPW camp 2 days ago. Lost about 15 days abd

Allergies: 0
MED: 0
PMH: 0

T-98.4 P 71 B.P. 107/64 RR-18
abd, awake in NAD
HEENT - WNL
Lungs - clear AP Heart - RR no M
Abd - soft; B.S. - Nml
Rt leg - Nml
Lt leg - 2" open wound ½ 4" distal (L) Knee
½ cm wound lateral aspect (L) proximal thigh
Lt foot - sensory - nml
Pulses - 2+ D.P. - unable to Dorsiflex - (L) ankle
comminuted
X-ray - Tib/Fib - Fx - with angulation - ½ 3" below Knee
CBC - Hgb 14.2 WBC 5.6cc

PROGRESS (Enter date of discharge and final diagnosis)

A) Abd GSW - (L) Lower leg
abd Tibula/Fibula Fx ½ 3" below (L) Knee
Fx - comminuted

b(6)-2

[redacted]

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0945 SEP 1 1 2003	1) GSW to (L) Leg, just below knee
	Left ~~Medial~~ Medial lateral side ~~side~~ of Leg, happened one month ago
29 yo old	2) patient complains of bloody stool
	for 1 month, when stomach hurts he
BP 98/68	can't pass his urine
SPO2 - 96	
P - 80	~~Hx~~ - Occurred 1 month ago - Cast
R - 20	about 15 days -
Temp - 98	Now pt complains severe
pain level - 10	increasing pain of wound site
	[illegible] Alert + coop -
	[illegible]
	[illegible]
	[illegible] - [illegible] good [illegible]
	B.S. norml - [illegible]
	(L) Leg - Long Cast
	[illegible] c/o [illegible] soft
	points over below knee of
	[illegible]
	A - [illegible] C [illegible]. (1) remove Cast b(6) - 2
	(2) X-ray - [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAIN[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.

b(6)-4 [redacted]

EPW [redacted] b(6)-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

EPW [redacted] b(2)-2 [redacted] (b)(2)-2

MEDCOM - 18850

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(2) replace cast -
	We will handle the bloody drainage + urinary symptoms b(6)-2 [redacted] for her

STANDARD FORM 600 (REV. 6-97) **BACK**
USAPA V2.00

MEDCOM - 18851

b(6)-2 AM1

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)*
9/11/03	Pt admitted to ICW #1 from EMT via litter. VS B/P 112/67, P 65, R 12 T 96.5 RA Sat 98%. PERRL. Lungs CTAB. Resp even/unlabored, HRR. Abd. soft, nontender c ⊕ BSX4 quads. Has not voided on this unit @ this time. LLE c splint c ace wrap. Moves toes. Gestures in discomfort when palpating toes which are dark ashy gray in color. Nailbeds dark also. (L) ft cool to touch. ⊖ pedal pulse upon palpation. Skin dry & flaking. Minimal to no blanching noted. Dr. [redacted] informed & assessed c concurrance. Att (L) femoral pulse +2. (R) pedal pulse +2. LLE ↑. NS@ TKO via 18G to (R) FA. ⊖ infiltration ⊖ infection. Will continue monitoring status. NPO p MN tonight for the OR tomorrow. [redacted] mbb RN
11 Sep 03	1845= VSS, ⊖10 pain, A+O x3, on Bedrest, IV (18G) to (R) FA running NS@ TKO. (L) LE has splint c ace wrap CDI. (L) foot cold to touch, but ⊕ sensation, ⊕ movement of toes, ~~⊖ pulse (pedal)~~ (L) foot elevated, difficult to detect pedal pulse to (L) foot on palpation → detected pulse to (L) foot (pedal) c doppler stethoscope. NPO p

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.

SPW # b(6)-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 - 18852

MEDICAL RECORD	PROGRESS NOTES
DATE	

12 Sept 03 ORTHO

Prep DX: (L) prox tib GSW (Grade II open) c osteo

Postop DX: Same

I/D

Open reduction

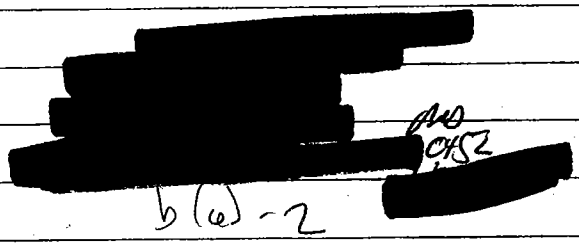
application ex fix.

HUGATE

QCOMP

to RR Stable

TT ~ 94 min.



AP LAT

b(6) -2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
13Sept03	ORTHO POD#1 @Sig events AFVSS + toe ext/flex slight ↓ sensation dorsum of foot Dressing c/d Stable PT for ROM ankle/knee repeat I/O in 2-3days. possible TCBG if clean. may need pne TAL to achieve plantigrade foot @ this point
	[redacted] MD HUGATE b(6)-2
14Sept03 0700	ORTHO POD#2 @newevents Tm 99.2 VSS
Lavicon Kepral	Dist NVI ankle stiff wound ✓ drain D/C'd. Stable WBAT. Start pin care to OR tuesday, Repeat xodiant +/- TCBG.
	[redacted] b(6)-2

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[redacted] b(6)-4

MEDCOM - 18854

MEDICAL RECORD	PROGRESS NOTES
DATE	

b(6)-2

MN, will continue to monitor. [redacted] MN

2Sep@0810 Received pt resting in bed. VSS, LS CTA B, pulses equal x bilat. ⊕ DP pulse dopplerable and marked for placement, foot [redacted] to touch and cap refill slow. IV @ fa patent x infusing NS TKO. Pt NPO and on call for OR. SVQ5 of red yellow/orange urine, clr. Will cont to monitor [redacted] b(6)-2

1733 Received pt from pacu in stable condition. Ex-fix intact, small amt serosang drainage noted. wrapped in ace wrap & splint. DP, [redacted] infusing, pulse intact. Will cont to monitor [redacted]

12Sep@1830 Assumed care @ 1800; VSS; A&O, speaking only arabic; c/o pain in [redacted] ces given; NV intact ⊕ CMS, ⊕ pedal pulse via doppler; affected foot cool to palpation & delayed cap ref; S1, S2, LS CTA B; ⊕ BSx4, pt voiding QS clear, dark yellow urine; ⊕ BM ~~x1 this shift~~; @ this time; Ex-fix intact wrapped & ace bandage, scant amt of serosanguinous drainage noted; pt to/fr CL dict; PIV in RFA patent & infusing NS TKO; 2 point restraints in place; ⊕ circulation & skin integrity; cont to monitor [redacted] b(6)

(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.
[redacted] b(6)-4		

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13Sep03 0920	Pt Awake and Alert. S_1 S_2 present, HRRR LS CTA (B). +BS x4 quads. External Fixator on (L) LE. Gauze & Ace wrap Dsg. Gauze shows Dried Blood. Pt exhibits slight movement of Toes. Foot warm to touch. unable to obtain pulse. Cap refil ≤3 sec. Pt c/o Tingling and slight ↓ of sensation in Dorsal of Foot. Will continue to monitor. —— b(6)-2 [redacted] Spc 9/WM6 (1030) Pedal pulse in (L) foot 10[redacted] c doplar. I concur c above assessment. —— [redacted]
13Sep03 1515	NV-I (L) Foot Warm and Dry to t[redacted] pulse c doppler c 100bpm. —— b(6)-2 [redacted] c 9/WM
13Sep03 2010	VSS. AO. +1 pulse to LE and palpable. Seen by PT and (L) leg stabilized to limits. Pt assessed accordingly c PT involvement. Provided pain meds. pain to ROM of LE. Tolerated dinner well. NS @ TKO. —— [redacted] RN
14Sep03 0900	Pt Awake A&O LS CTA (B), S_1 S_2 present, HRRR, +BS x4 quads. (L) LE External fixator pins CDI. Dsg on (L) Knee CDI. (L) Foot and ankle edema +2 Non pitting edema. Pt moves toes and 3sec cap refil. [redacted] pain at this time. Will continue to monitor. —— [redacted] 9/WM6

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER
	LAST	FIRST	MI	(SSN or Other)
		b(6)-2 [redacted]		

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

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I# [redacted] b(6)-4

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NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Sep03	1940: VSS, A+O X3, c/o pain to (L) LE, gave ÷ Percocet tabs PO for pain as ordered, could not palpate (L) pedal pulse → used doppler and heard (+) S_1S_2. (L) LE has external fixator in place, pin care done c ½ strength hydrogen peroxide & wrapped pins c W → D Dsg's. Dsg around external fixator CDI. (+) sensation, (+) movement to (L) LE & (L) toes but very minimal ROM to (L) foot (pain). Edema to (L) LE, elevating. HL IV to (R) FA flushed & patent. Continuing Ancef IV. Tolerates PO. Will continue to monitor for any acute Δ's. b(6)-2 [redacted] USN
15Sep03 1000 b(6)-2	Pt Awake A&O Denies pain. LS CTA (B). S_1S_2 present, HRRR. (+) BS x 4 quad. ~~EIG Draining clear yellow~~ [redacted] Voids without difficulty clear yellow urine. LLE warm to palpation. Unable to palpate pedal pulse. Heard (+) pulse c doppler. (L) LE external Fixator CDI. Dsg CDI on LLE. (+) sensation (+) movement. Non pitting edema to left foot & ankle. Will continue to monitor. b(6)-2 [redacted] 91WM6

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV [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.

[redacted]

b(6)-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 - 18857

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15Sep03	1930: VSS, A+OX3, premedicated pt. c 4mg MSO4 IV as ordered prior to pin care & Dsg Δ to (L) LE external fixator and incision wound c sutures. Pin care done c 1/2 strength hydrogen peroxide & W→D Dsg Δ's on pins & incision wound (some bleeding from site → minimal). Pedal pulse to (L) foot not palpable, but heard $S_1 S_2$ c Doppler. ⊕ sensation, minimal movement to (L) LE. IV HL to (R) FA flushed & patent, Will start IVF's p MN when pt. is NPO for surgery. (L) foot elevated to ↓ 2+ edema to (L) LE. ∅ other remarkable findings. Continuing IV antibiotics. Will continue to monitor. ——— [redacted] W/SN
15Sep03	2200: IV to (R) FA flushes but pt. c/o pain now to IV site, ∅ blood return c syringe, a little puffiness to site → D/C'd intact and restarted new 18G IV to to (R) FA medial aspect. HL'd & getting antibiotics via IV. ——— [redacted] W/SN
16 Sep 03 1100	Returned from PACU via litter. VS B/P 133/82 P 88 R 18 T 97.1, RA Sat 98%. NAD. LLE c short leg splent & external fixator intact. Skin warm & brisk capillary refil to nailbeds. LLE T on pillow. Medicated c 4mg MSO4 IVP for post-op pain. Will continue to monitor. 2 pt restraints on. [redacted] compromise. ——— [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

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b(4) - 2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sept03	ORTHO POD#3 I/D (c) tibia + ex fix
kyz-f	∅ new events
	AF VSS
	Dist N exam unch'd.
	pin sites ✓
	CX (P). XRAYS ✓
	— ✓ CX
	— NPO ∅ MN / hold lovenox for OR tomorrow. repeat I/D + new [redacted] b(6)-2
	heads.
16Sept03	ORTHO
1000	pmp / postop Dx: open (L) tibial Fx (30+ days out)
	Repeat I/D + ABX bead placement
	GETA
	EBL - 100 cc
	∅ comp
	to RR stable b(6)-2
	Tissue CX sent [redacted] pm

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

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

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

b(6)-4

EPW # [redacted]

PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	25 Aug 1500
	① Op note
	② subcl Hickman placed under fluoro - single lumen cath
	c̄ Dacron cuff; fluoro → correct position, CXR result:
	[redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
16 Sep 03 1210	Pt sleeping. NAD. [redacted] b(6)-2 MAG/so
16 Sep 03 1620	Medicated c percocet, 2(ii) tabs for c/o LLE [redacted] pain. Will assess for effect.
16 SEP 03 1921	VSS. AO. ⊕ CMS to LLE and post-op DSG CDI. Pain care performed per order. Able to move toes and DF ±2 seconds. No c/o pain @ this time. LLE elevated. [redacted] b(6)-2
September 1000	Received pt resting in bed, VSS, A+Ox3, ⊖ acute distress noted. ⊕ CMS to DLE: Toes warm, cap refill ⊕, able to wiggle toes. SVQ3, med yellow urine, amb w/ crutches and assist x1 to BR, ⊕ BM. PT to see pt to fit crutches. ROM LLE deny by PT. IV patent + intact ⊖ fa. Medicated w/ percocet per MAR. ⊖ other remarkable assessment noted, WNL. Will cont to monitor. [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
4Sep03 1920	ORTHO POD #1 q C/O's. ex fix intact. Dist NVI AFVSS - Stable. - Refer to OR 2wks for ICR6 - continue gel. - Δ Dressing tomorrow
17Sep03 2014	VSS. AO. Mild c/o 5/10 pain and provided Tylenol. Ambulated c crutches and assistance to BR and voided c difficulty. Ambulated on ward x1 for 5 min as tolerated. Became tired and experienced some pain. Performed pin care as ordered. DSG and pins to (+)LE CDI and (+)CMS, (+) pedal pulse and OR c/o records. b(6)-2
18Sep03	0853-VSS-A+O-Assessment completed. ambulated c crutches to BR. Pt had BM + conducted personal hygiene. Pt. ambulated up + down hallway. Tolerated well. Performed pin care. Hoplock (+) FA. CDI. (+) Pedal pulses. Skin integrity intact. Pt. voiding via BR. will cont. to mont. Pt. b(6)-2
18Sep03 1010	I concur c above. Medicated with Percocet two tabs p.o. prior to physical therapy for ROM exercises. mob

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

b(6)-2

b(6)-2 ARL

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19Sept03	1430 – performed aggresive pin care as ordered @ 1314. Pt. resting well @ this time [redacted]
19Sep03	1945: VSS, ⊖ temp, A+Ox3, Ø c/o pain until started pin care – pt c/o severe pain when cleaning pin insertion sites – premedicated c̄ 4mg MSO_4 IV & 12.5mg Phenergan IV prior to pin care again. Completed aggressive pin care c̄ ½ strength H_2O_2 solution. Cleaned out "gunky" appearing substances from insertion sites (yellow-green colored). Pt.'s (L) LE c̄ external fixator elevated to ↓ swelling, 1+ palpable pedal pulse to (L) foot – confirmed c̄ Doppler & heard S_1S_2. HL IV to (L) AC flushed + patent. Continuing Vancomycin Q12° IV. Ø other remarkable assessment findings. Will continue to monitor for acute Δ's [redacted]
20 Sept	VSS pt awake and alert x3 Ø c/o pain pt tolerated pin-care with pre/post medication, range of motion as tolerated during pin-care produced palpable pedal pulse to (L) foot, restraints in place x2 no Ø remarkable findings. [redacted]
	(1650) I concur c̄ above assessment. SL in (L) AC flushes well s̄ s/sx infiltration/infection. Cont. MRSA precautions. Monitoring. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(4)-2 A1
19sep03@0200	Assumed care@1800; VSS; A&Ox3 speaking arabic, ⊕CMS, NV intact; cap Ref in ⊕LE delayed; ⊕pedal pulse via doppler; dsg cDI, pin care performed, pt ↑ to BR; amb in hallway c crutch assistance; tol. okay; c/o pain post amb; medicated c ↑ percs; HL in ⊕FA patent-freely flushes; ⊕BM this shift; restraints in place; ⊕air ⊕skin breaks; cont to monitor [redacted]
19Sept03	0921 - VSS A+O speaking arabic. Pt. OOB ambulating to another room c crutches. Tolerated well. Performed AM care. Pt. had BM this AM. Tolerated breakfast well. Lungs CTA ⓑ Resp even, unlabored size, Abd. soft nontender. BSx4. Pin care conducted as ordered. ⊕cap Refill in ⓛLE + ⊕pedal pulses. HL ⓡFA. flush well. cDI. Will cont to monitor [redacted]
19Sept03	1133 - moved pt. to private room c infection control. DC'd IV to ⓡFA. New IV c heplock started in ⓛFA 18G cDI. Will cont. to monitor pt. [redacted]
19Sept03 1145	I concur c shift assessment above. MRSA precautions taken. 2pt restraint on. Skin intact. Circulation intact. Will continue monitoring [redacted]

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

E [redacted] b(4)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Sept 03	ORTHO
0715	∅ new c/o's.
	AFVSS Labs - WBC 8.6
	exam HCT - 32
	lat/prox pin site still a little Alb - 3.1
	sore.
	small amt draining mid nail.
	- Stable. b(6)-2 All
	- vanco.
	- will need picc or Hickman
	✓ creatinine as baseline, ESR as baseline [redacted]
	b(6)-2
20 SEP 03	VSS. AO. PERRLA. HRR, LSC 2AB. ⊕ pulses to BLE, ⊕1
2113	pulse to LLE. Performed pin care out toward well.
	Ambulated to BR c̄ minimal assistance & use of crutches.
	Scrubbed/washed Ⓛ foot and debrided dry skin.
	Cont to monitor. b(6)-2 [redacted]
21 Sep 03	Pt A&O LSCTA Ⓑ, S_1 S_2 Present HRRR. ⊕ BSx
	4 quads. Ⓛ LE Ex Fix c̄ 2̄ Drsg c[redacted] Denies
	pain will continue to monit[redacted] E ⊕ Pulse,
	⊕ Sensation ⊕ movement [redacted] [illegible]
21 SEP 03	VSS. AO. ⊕1 pulse to LLE. CMS intact [redacted] CDI to pins
	out LLE. Ambulated x1 for 15 min c̄ crutches on ward
	and to BR. [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18Sept03	ORTHO POD#2
0930	Q clo's
Keyzal	AFUSS
	pin sites OK
	Wound w/ Drsg Δ'd.
	DIST NVI
	Stable
	cont Abx
	[redacted] b(6)-2
19Sept03	ORTHO POD#3
0930	Q new c/o's
	AFUSS
	Cx - (+) MRSA
	Cut/prox pin c drainage
	Others pin sites ok.
	DIST NVI
	Stable
	will need PICC or Hickman for [redacted] b(6)-2
	Δ to Abx.
	pt in private Room
	aggressive pin care

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] EPW

b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21Sept03 0832	ortho POD#5 @ C/O's AFUSS pin sites ltrpain.
	Stable, cont cont Rx [redacted] b(6)-2 Stod Sogtn
22Sept03	Assume duty of Pt. VSS, A+Ox3. Ambulate with help of crutches C/O no pain. Maintains Reg diet. Changed dsg and provided pin care. Will continue to monitor [redacted]
22Sept03 0830 Vano Overnight	ortho POD#6 @ C/O's AFUSS PICC line for long term VANCO pin care ESR-97) 20 Sept03 Cr. 0.7) b(6)-2 [redacted]

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Sep03	2115= VSS, ✓10 pain@this time, pin care done to ex-fix to (L) LE, ~~2+pe~~ 1+ pedal pulse palpable (L) foot, edema 2+ to (L) LE/foot. IV to (L) AC infiltrated, D/C'd intact, restarted IV Hr to (R) AC 20G flushed & patent, continuing IV Vancomycin. Pain management & palliative care. (L) LE elevated to ↓ edema. ✓ other remarkable assessment findings. Continue to monitor. [redacted]
Addendum	= Restraints x2, skin integrity intact assist to use BR (FFNWB(L)E) prn. [redacted]
23Sept03	ortho POD#7
	✓new clo's
Vanco	AFUSS
Levaq	Distally NVI
	(+)TA, heals EHL/EDC
	pin sites ✓
	b(4)-2
	[redacted]
	cont Abx
	picc placed y-sterday.

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b(6)-2
A71

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
23Sept03 1245	Was informed by Radiologist of ~~Abbottp~~ attempt to insert PICC line yesterday and was unsuccessful. Equipment needed not complete. Will inform Dr [redacted] 2LT A
24 SEP 03 0135	VSS. AO. Completed pin care to R LE. OTA. ⊕1 pedal pulse remains palpable. Ambulated x1 COB to BR ≈ 5 difficulty or complaints. HRR, BS⊕x4. ≠SCL AB. PERRLA. Voids light yellow urine QS. [redacted]
24 Sept 0900	VSS AO COB to BR ≈ crutches. Pin care completed to ⊕LE external fix. ⊕ pedal pulse +1 Voiding clear yellow urine quantity sufficient ⊕ FA Saline lock patent & intact flushes without difficulty. Will continue care as planned. [redacted] 2LT A
24 SEP 03 0241	VSS. AO. Pin care performed and returned demonstration. ⊕1 pulse to LLE. Ambulated x1 to BR ≈ difficulty. Cont to monitor. [redacted]
25 Sep 03 0905	AEO. Ambulated to BR for Am care. Using crutches well. NAD. Aggressive pin care done to RLE. Stitches intact. Middle 2 lengths wound c small amount bloody drainage. Good pedal pulses. Brisk capillary

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]

b(6)-1

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 - 18869

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
	(cont.) refil. @ AC HL patent c Vancomycin 1 gram infusing. 2 pt restraint c compromise to skin & circulation. Checked throughout shift. Well continue to monitor. Denies pain at the time. [redacted] MA
25 Sept 03 0930	ORTHO POD # 9 ϕ new events AFVSS pin sites look good. b(6)-2 A11 Sutures out in 2-3 days Cont Alx / pin care. Hickman today c Dr. DAVIS D/C Lovenox. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/25/03 1420	To ICU from Recovery in OR. Hickman Catheter c dsg CDI to (L) Subclavian. Pt A&O. Eating lunch. Denies pain @ this time. Will continue to monitor. b(6)-2
2558/03	1930= VSS @ temp @ this [redacted], A+O x3, P c/o pain, b(6)-2 [redacted] catheter intact c dsg over insertion site CDI - flushed c NSS difficulty & good blood return. Pin care done (aggressively) to external fixator of (L) LE. Sutures (L) LE approximated CDI. (L) LE elevated to V edema, pedal pulse palpable 1+ (weak). Restraints x 2 when in bed - skin integrity intact FFNWB (L) LE as tolerated. 20 G IV to (R) AC hep d & patent. Will continue to monitor for acute s/s. b(6)-2 [redacted]
2558/03	0000= CL dsg bloody, Δ'd CL Dsg using sterile technique c 2x2 & opsite over CDI. Continue to monitor. [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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PROGRESS NOTES
Medical Record

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[redacted]
b(6)-4

b(6)-2
A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26Sept03	Assume care of PT. VSS, A+OX3 Ambulate with help. Distal pulse present. Meds administered. Diet is maintained. Pin care administered 50/50. No skin irritation R2. Will continue to monitor. SPC [redacted] 9/W
2030	Pt alo, VSS, ∅ c/o pain @ this time. LCTAB, HRRR, +BSx4 ad. (L) subclavian hickman catheter intact c drsg over site CDI, ∅ edema or redness noted. +blood return, Pin care done to DLE ex-fix, pedal pulses palpable. 20 ga IV to (R) AC HLd - flushing easily. vancomycin cont. 2pt restraints on. +circulation. Will monitor [redacted] 9/W
(2300)	Vancomycin administered; flushed c 2cc heparin in saline as ordered. ∅ complaints of pain or discomfort expressed. Will monitor [redacted] 9/W/M6-SPC

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27Sept03	ORTHO Pod#1
0514 -	Ø new evils. Hirlan in place
	AP VSS
	Dist NVE
	pin sites ✓
	Stable
	Cont current Rx
	✓ Creatinine Monday.
	[redacted] b(6)-2
27Sept03	(1315) Assumed care of pt ✓ chart & report from night shift. Pt alert, speaking arabic. VSS. Ø c/o pain. Amb well ✓ crutches. Ex fix in place on LE. NV VS WNL. Pin care done this am. Sutures to incision on LE d/cd by MD. Incision CDI. thickman flushes well ✓ S/Sx infection/ infiltration. LE elevated on blankets. Cont. MRSA precautions. ✓ point restraints in place ✓ S/Sx complicati Will continue to monitor. [redacted] MAW b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO. ICW #4	

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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b(6)-2 AR

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sep 03 2100	Rt c/o, VSS: afebrile, ϕ c/o pain, ambulated x2. had BM x1, formed brn stools, Pen care done. (D) SC CL dsg CDI, ϕ edema or redness noted. ex-fix intact to (D) LE. (D) pedal pulses palpable (weak). (D) foot care done. (+) brisk cap refill. (D) LE elevated. Hickman cath c good blood return, flushing easily. prev. inclusion site to (D) LE ~~LE ϕ drsg c ϕ edema CDI~~. Restraints on, circulation intact NV VS WNL. will monitor [redacted] given [redacted]
2000	received pt resting in bed, VSS, A+OX3. Amb w crutches indep. to BRM, SVQS. (D) LE ex-fix intact, pin care done, pins clean & dry, ϕ drainage noted. (D) SC CL dsg c/d/i, ϕ redness or swelling noted, flushes easily and line heparinized per MAR after vancomycin done this am. (+) pedal pulse noted. Restraints on per CPW protocol, ϕ skin breakdown noted on acute issues noted. ϕ other remarkable events this time. Will cont to monitor pt [redacted]
2000	[redacted] VSS, afebrile, percocet 1 given for pain. (D) leg ex-fix intact, pin care done, ϕ drainage noted (D) SC CL dsg CDI, good blood return, ϕ redness or edema noted. pedal pulse (D) leg weak but palp-

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
29Sept03	Discharge Summary.
9AM	29yo iraqi EPW 30 d s/p GSW to left prox tibia initially treated @ iraqi civilian hosp with attempt at closed reduction + casting. presented here 30 days p injury with draining sinus anterior leg and mal-reduction. taken to OR on 9/12/03 and 9/16/03 for I/D + ex fix + Antibiotic beads. CX grew Methicillin Resistant Staph (MRSA) placed on Vancomycin 1g IV q12°. PT for ROM knee, ankle. baseline creatinine 1.3 baseline ESR - 97. Hickman placed for IV antibiotics x6wks
	* D/C Medication: Vancomycin 1 gram IV q12° (please f/ weekly creatinine.) Percocet prn pain. Stool softener of choice
	* D/C instructions:
	(1) non weight bearing to left leg with crutches
	(2) pin care with 1/2 strength hydrogen peroxide 2x/day.
	(3) Physical therapy for Range of motion knee, ankle.
	(4) Return to Ibn Sina 10/14/03 to see Dr. [redacted] for wound check and possible OR for iliac crest bone grafting. b(6)-2
	(5) Isolate patient if possible (MRSA +) [redacted] LPT
	(6) Hickman care: Flush with 2cc hep saline

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
(con't) →	able. Restraints on ⊕ circulation. Will monitor
2100-28Sep	b(6)-2 [redacted] 91WM6-SC-
28Sep03 1200	Received pt resting in bed, see SF 511 for VS, A+Ox3
	speaks arabic. Tol po, sugs, amb to BR w/
	crutches, ⊕ CM. Pin care done, left open to
	air. medicated per MAR. MRSA precautions
	taken. CL flushed easily. Restraints per EPW
	protocol, ø breakdown noted. Will cont to monitor
	pt [redacted] b(6)-2
29Sep@ 2045	Assumed care of pt @1800. VSS. No c/o @ this time.
	LLE ⊕ CMS, +2 pulse DP. EX-FIX in place, pin care
	completed as ordered. Hickman cath drsg Δ'd
	ē sterile technique, no S/Sx of infection noted.
	MRSA contact precautions in place. 2pt restraint
	on s̄ S/Sx of skin or circulation compromise
	[redacted]
30Sept03 0900	VSS. OOB to BR for AM Care. Peripheral
	pulses palpable. Pin care done to ⓛ LE ex-fix.
	Hickman cath patent and intact. Received
	orders to D/C pt to EPW Hospital. D/C Rx
	sent to Pharmacy. Will continue plan of care.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID (SSN or Other)
				[redacted] b(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Sep 03 @2230	assumed care of pt @1800. VSS, c/o pain to LLE. medicated c percocet c good relief noted. LLE c ex fix, pin care completed. Healing incision line noted. ⊕ CMS to LLE. Hickman Cath to ⊕ chest drsg CDI, flushes well. IV Vanc given as ordered. 2pt restraint on S S/Sx of skin/circulatum compromise) Plan: monitor NV Vs, pain control. b(6)-2 [redacted]
1 Oct 03 0800	VSS Alert & oriented OOB x BR [redacted] Pre. Censused regular diet. ⊕ dorsal Hickman cath. patent & intact. Rad pulses palpable. ⊕ LE NV ✓ WNL Pt awaits Transport to EPW [redacted] b(6)-2

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

21 OCT 03

b(2)-2 [redacted] Record reviewed and note made of diagnoses (including MRSA being treated with Vancomycin).

b(2)-2 Discussed c [redacted] @ 1945. Not prepared to manage such patient here at [redacted] Will return patient to [redacted] in exchange for another, while we make preparations to receive such patients in the near future.

[redacted] LTC MD

b(6)-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]		

b(6)-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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03OCT03	Pt arrived via civ ambulance from EPW
1003	Camp. Ø C/O pn. cap refill <2 secs, Moist mucous membranes. Pt hx of MRSA (wound). Pt receiving vancomycin BID via hickman port to (L) chest wall [redacted] ICU RN
1049	labs sent earlier. Will send results to ICU. Pt admitted to ICU, [redacted] RN
	b(6)-2
	AM

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30CT03 1600	Pt A&O LS CTA (B), S, S2. Present (+) BS x [redacted] wds, KSS Ex fix on LLE Dsg CDI. Denies Pain at this time. will continue to monitor. [redacted] Sx 91WM6 b(6)-2
(2010)	Pt alo, VSS, complaint of pain to RLE. IV Percocet given. pin care done. prev. unciation site OTA. LCTAB, HRRR, (+) BS x4, (+) pedal pulses. MRSA precautions. CL drsg CDI, good blood return, flushes easily. (-) edema or redness @ site. 2 restraints on. (+) circulation. will monitor [redacted] b(6)-2 91WM6.
40CT03	0003 - VSS - Ao assumed care of pt @ 0000 assessment completed. Perrla, LS CTA (B), RESP. even, unlabored, and soft - non-tender BS x4. Voiding per urinal. BM this AM. Pin care completed to (2) LE. Ext. fix. (+) pedal + radial pulses. (L) SC central line clean, dry, intact (-) S/Sx infection. ROM exercise performed. TOL. well. MRSA precautions. Pt. resting well @ this time. will cont. to monitor. [redacted]
(1900)	I concur c above assessment. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other) b(6)-2

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04OCT03	Ortho
1000	Ø new c/o's. back here b/c of MRSA status.
	H&P md'd.
	AF VSS
	pin sites ✓
	mid wound c̄ some granulation. no sign infect
	~1x1cm granulated.
	- WTD to wound BID c̄ NS
	- cont pin care
	- ✓ XRAYS in ~10d. for ICBG + ORIF fem.
	b(6)-2 All [redacted]
Ø4OCTØ3	(153Ø) I concur c̄ assessment by SPC [redacted] this shift.
	wet → dry drsg on Ⓛ leg Δd per MD this am.
	Hickman flushes well s̄ s/sx infection/infiltration.
	Anbx infusing s̄ difficulty. monitoring. [redacted] UPAD
4 OCT. Ø3	Pt A+O x3, VSS, LS CTA Ⓑ, ⊕ BS x4, abd soft
	flat nontender, pain controlled c̄ percs, Ex
	Fix on Ⓛ leg in place, dsg on LLE CDI,
	dsg Ⓛ side upper chest CDI, Hickman intact
	Ø s/sx of poor circulation or skin break ↓
	on pts of restraint. [redacted] , 9W

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5oct03	0901- assumed care of pt. @ bedside. Assessment completed. Ex Fix (L) Leg in place. Pin care performed wet → dry dr sg on (L) leg Δ. (-) s/sx inf. min. drainage. Hickmans cdI. Two restraints in place (-) skin breakdown (+) circulation. LSCTH(B) Resp even, unlabored, NSR, S1S2 present, abd. soft non tender. Po tolerating po well. Voiding per urinal. [redacted] to monitor pt [redacted] blue-2
(1935)	Pt alo, VSS, NCTAB, HRRR, ex-fix intact to (R) leg, pin care done, w-d drsg Δ (2x2) to open area + wrapped c Kerlix. (+) pedal pulses. Huckman cath (LSC) cdI, -Q3day drsg Δ's. (+) blood return, flushing easily, (-) edema or redness @ site. voiding cyl via urinal. 2 pt restraints on c compromise to circulation/skin. will monitor c [redacted] blue-2 q1 hr's

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.

[redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6Oct03	RLS - assumed care of pt @ 0000. VSS-AO - LSCTA (B) RESP even unlabored. HR NSR, abd soft, non-tender. BM this am voiding clyu per urinal. EXT fix in place (1) LE. Pin care performed. W→D dsng Δ completed. Site (-) S/Sx inf. pt. resting well @ this time - Hickmans (L) SC CDI (-) redness (-) edema. Will cont to monitor [redacted]
6Oct03 1755	I concur c the above [redacted] note/ son
(1940)	VSS, a&o, ø complaints @ this time. pin care done, dsng Δ'd. LCTAB, ⊕BS, HRRR, amb x 1, had BM. Hickman cath (L) SC flushing easily, ⊕ blood return, ⊖ edema or redness @ site. 2 pt restraints on, ⊖ compromise to skin or circulation. Will monitor [redacted] 9lumo.
2010	C/o pain to fx-fix site, ii Percocet given. [redacted]
(7OCT) 0520	Ch dsng Δ'd using sterile technique, ø edema or redness @ site [redacted] 9lumb

b(4)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10Oct03 0830	Recd report and assumed care of pt. (-) S/S of resp distress, pain or discomfort @ present time. Hickman cath in place (-) edema or swelling @ insertion site. Steri strip on (R) shoulder. Ext fix to (L) leg. Pedal pulses heard CTA, BS (+). Tolerated reg diet well. Will continue to monitor [redacted] q1hr.
(1940)	Pt alo, VSS, NCTAB, HRRR, (+)BS, ext fix to (L) leg. Pin care done / dsg Δ d.t wrapped c kerlix. 1T Percocet given for pain. Hickman cath to (R) SC c ø edema or redness @ site, flushing easily, (+) blood return. (+) pulses to extr. ø pt restraints on c compromise to skin or circulation. Will monitor [redacted] q1hr.
80CT03 0029	0029 - VSS-AO c CTA (B), Resp ø distress even unlabored, abd soft nontender, BSx4, ext fix in place to (L) LE. Pin care completed. w→ D dsng Δ. CDI (-) SISSxInf. Hickman cath to (R) SC CDI c ø edema or redness. (+) pedal and radial

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)*

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PROGRESS NOTES
Medical Record

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E [redacted] b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont'd	pulses. tolerates PO well. ? restraint in place. will cont. to monitor pt [redacted]
080CT03 1240	ORTHO Q c/o's AP VSS DISTMS pin sites ✓ b(4) - 2 All MRAYS OR next week ICBG [redacted]
090CT03	Pt care assumed ~~by~~ at 1800 hrs. LS CTA(R) S, S_2 Present @ BS x4 quads. Foley Draining to gravity. CYU. Pt pain controlled c percocet. Drsg [redacted] will continue to monitor.
090CT0322	Received pt resting in bed, VSS, c/o PO, amb to BR w/ crutches. X-ray in hope, and ESR drawn + sent to lab. MSA precautions taken. IV flushes easily, ∅ resistance @ blood drawback. WABx cert. Pin care to (L) LE ex fix done by self. Restraints in place per epw protocol. Will cont to monitor pt + LOC thru breakdown. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 Oct 03 2030	VSS, ¢ c/o pain @ present time, A+Ox3, DOB & cutch walks to BR ⊖ difficulty. CL to ⊕ SC patent when flushed, ⊕ blood return. ⊕ LE c ef fix in place, pin care done - pt. assisted c this, Dsg Δ to wound on ⊕ shin region, CDi. Neurovascularly intact. Continuing IV antibx, ⊕ MRSA precautions noted X2 restraints when in bed, skin integrity intact, continue to monitor for any acute Δ's tonight. [redacted] b(6)-2
10 Oct 03 0842	ORTHO AFLSS Procedure ESR 25 (down from 97) XRays - good alignment. Will ICBG + ORIF when ort skin looks good. about 1 week. Cont IV ABX. b(6)-2

[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09OCT03 1457	Received pt resting in bed, VSS, lab pd, amb w/crutches indep. Pin care done by pt, Left OTA. MRSA precautions taken, smaller ~~2x2 placed on~~ wound noted on @ shin, 2x2 applied. IVABX cont. Restraints per cpw protocol, ø breakdown noted. Pt instructed to let nurse disconnect meds. Central line intact w/ dsg c/d/i. ø other remarkable assessments @ this time. Will cont to monitor. [redacted]
10OCT03 0100	Assumed care of pt @ 1800. VSS. @ CMS to bil, +2 DP & popliteal pulses. Pt did own pin-care, demonstated good technique. @ chest thickman catheter in place, flushes well, dsg CDI. Plan: b(6)-2 monitor pain control prn. Cpt restraints on S/Sx of skin/circulation preakdown. [redacted]
2300	Hickman catheter flushed ₣ vancomycin dose, heparin-locked @ 2cc 10,000:1ml heparin using sterile technique. b(6)-2 [redacted]
11OCT03	(1100) Assumed care of pt @ 0700 ₣ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled @ Percs. Ex fix in place on UE. Pt able to move toes

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.

C- [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11OCT03 (1100)	(cont) Skin warm/dry to touch. ⊕pedal pulse equal bilat. Pt amb c crutches s difficulty. Pin care done. Drsg to ⓒ shin cd. ϕ s/sx infection ↓ incision site. Pt tol. reg diet well. Voiding s difficulty. Hickman to ⓒ side of chest flushes well s s/sx infection/ infiltration. 2 pair restraints in place s s/sx complications. Will cont. to monitor. [redacted] WRAO
11OCT03 @2130	assumed care of pt @1800. VSS. No c/o. Alert, speaking arabic. LLE c Ex-fix in place, pin care completed. ⊕cms to LLE, +2DP & popliteal pulses. ↑ amb c crutches s difficulty. Hickman catheter to ⓛ chest flushes well, good blood return noted, ϕ s/sx of infection noted. 2pt restraints in s s/sx of skin or circulation compromise. Plan: monitor NV status, pain control, IV abx as ordered. Will monitor. [redacted]
11OCT03 2330	Hickman catheter line flushed ↓ vancomycin dose, then heparin-locked c 10cc of 10,000u/1ML Heparin deleted in lieu of NS. Will continue to monitor [redacted]

b(6)-2 AR

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 Oct 03 @ 1132	Received pt resting in bed, VSS, for PO, A+Ox3, amb indep on crutches. Hickman to (L) chest patent, flushes easily. PT in to see pt for ROM exercises this am. Pt performed own pin care and small 2x2 clean Δ on (L) extremity, (+)BM, and cane provided. MRSA precautions taken. Restraints per CAU protocol. Will cont to monitor pt. [redacted] b(6)-2
12 Oct 03 @ 2115	Assumed care @ 1800; A+O VSS, pt A+Ox3, (+) CMS throughout, +2 PP, brisk cap Ref, NV intact, pt amb c crutch assistance 3 difficulty; pt performs own pin care & dsg Δ to (L) LE, Ex-fix in place; Hickman to (L) chest patent; easily Flushes; MRSA precautions taken; Restraints in place, (+) circulation, (-) skin breakdown; will continue to monitor [redacted] b(6)-2
13 OCT 03	Pt Awake. VSS 5152 psent (+) BS x4quads. LS CTA (R), Dsg Δ c Pin care to (L) LE completed. Hickmann to (L) chest inplace Flushed & Patent. Denies pain. Will continue to monitor. [redacted] b(6)-2 9/W/MB
13 Oct 03 @ 2045	Assumed care @ 1800; A+O VSS, pt A+Ox3, (+) CMS to (L) LE, +2 PP, brisk cap Ref; pt amb c crutch assistance; pt performed own pin care; Ex-fix in place; Hickman to (L) chest patent patent & easily Flushes; cont c IV abx; MRSA precautions taken; Restraints in place, (+) circ, (-) skin breakdown, cont. monitor [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14Oct03 0900	VSS Alert & Oriented. OOB → BR ⊂ crutches for shower. Consumed Reg Diet for Breakfast. Pin sites cleaned Ø crusting or drainage noted. Hickman cath intact & patent. Resps clear. Peripheral pulses +2. Denies pain or discomfort @ this time. MRSA precautions continued. Will continue care as plan — b(6)-2 [redacted]
14Oct03@1920	Assumed care @ 1900; All VSS; pt A+Ox3, ⊕CMS, +2 PP, brisk cap Ref, NV intact throughout; OOB to amb ⊂ crutch assistance; pt performs own pin care, Ø S/Sx infection; Hickman cath patent, easily Flushes; Ø c/o pain or discomfort @ this time; Restraints in place, ⊕ circ, Ø skin breakdown, cont to monitor — b(6)-2 [redacted]
15OCT03@1200	Assessment done. V.S.S. Pt. A+Ox3. AM care done. Pin care done by pt. Hickman catheter DSNG d'd, Sterile technique used. Vancomycin IVPB complete; Central Line flushed & heparinized. [redacted] 2CT, AM
15OCT03@1630	Pt. OOB to BR, ambulates well ⊂ crutches. EPW restraint protocol, no skin breakdown noted. All other assessments WNL. [redacted] b(6)-2 2CT, AM
15OCT.03 2000	Pt A+Ox3, VSS, LS CTA Ⓑ, ⊕BS x4, Ⓓ subclavian cath intact, dsg CDI, Ø S/Sx of infex, flushes well, Ex Fix LLE in place open to air, OOB → BR ⊂ crutches, medicated for pain ⊂ 11/11 percs, 2 pt restraint in place ⊆ S/Sx of poor circulation or skin breakdown. — [redacted] b(6) 2 9W

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted] b(6)-4			

DATE	NOTES
16OCT03	ORTHO
0830	now ~ 5 wks S/p open reduction / ex fix c tibx bead placed
	been on IV Vanco for MRSA @ CX.
	AFebrile
	ESR 99 → 25
	wound looks good
	XRAYS show maintained good alignment
	OR tomorrow
	ORIF + ICBG
	CX
	probable remove Fixator @ that time.
	[redacted] b(6)-2 CPT [redacted]
17OCT03	ORTHO
1041	NO Δ
	AFVSS
	many thanks this AM in the OR.
	will put him on for tomorrow.
	[redacted] b(6)-2

EPW [redacted] b(6)-4

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b(6)-2
A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Continued)
17Oct03 0900	~~bone exposed~~ error ~~[redacted] drsg removed soaked c sanguinous~~ error ~~drainage~~. Will continue care as planned. [redacted] 2LT AN
17Oct03 1130	NPO status D/C. Canceled for OR Today. IVF d/c ~~until~~ until p MN Today. D/C for OR Tomorrow. Will inform next shift. [redacted] 2LT AN
17OCT03 2000	Pt A+Ox3, VSS, OOB → BR c crutches, voiding well, Ex Fix LLE pin sites CDI, NPO p MN to OR in AM, pt ate dinner, CL (L) SC intact, flushes well, peripheral pulses +2, cap ref. < 3sec, 2pt restraint s s/sx of complications. [redacted] 9W
18Oct03 1430	Received pt this am, VSS, NPO for surgery, exfix in place A&Ox3. Returned from surgery @ 1140. pt had bulky drsg w/ shadowed drainage to LLE. LLE ↑, medicated w/ percocet per MAR. Central line drsg Δ'd, LR @ 100 cc/hr infusing w/o apparent complication. Will cont to monitor pt. Vancomycin blood draw @ 1200 done ... redrawn per APW protocol, ∅ breakdown noted. [redacted]
18 OCT 03 2201	VSS. AO. (+) pulse to LLE (+)1. CR ≤ 2 [redacted] secs. Foot is warm to touch. LLE elevated and border marked of shadow. Continued c/o pain to (L) hip and LLE all provided 8mg MSO_4 and obtained relief. Voiding light amber urine quantity sufficient s difficulty. c/o ~~not~~ scratchy throat, but tolerable. [redacted]

[redacted]ANDARD FORM 509 (REV. 6/1999) BACK
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
16Oct03 1000	VSS Alert & Oriented, OOB c crutches to BR. Hickman cath patent / intact. Pin sites to (L) LE ext. fix without drainage or crustation. Incision healed to LLE c small scabbing to center of incision. (L) LE incision left OTA. Pedal pulses +2. Toes capillary refill <3 sec. Will continue care as planned. b(6)-2 [redacted] 2LT AN
16OCT.03 1830	Pt A+Ox3, VSS, denies pain @ this time, Ex Fix on (L) LE, area around pins healed, Hickman cath (L) sc intact, flushes well, NPO p MN, Start LR @ 100cc/hr, ~~to AM tom~~ ~~OR~~ to OR in AM, 2 pt restraint in place s s/sx of complications. [redacted] RN b(6)-2
17Oct03 0900	VSS Alert & Oriented OOB c crutches to BR. NPO and awaiting o/c for OR. (L) SC hickman cath patent & intact infusing LR @ 100cc/hr (L) LE ext fix pin sites without crustation / drainage. Pedal pulses +2. Toes capillary refill < 3 sec. ~~(L) LE wound with deep beefy red tissue and small amt of bone exposed~~ Error / wrong [illegible]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID
		b(6)-2		[redacted] 2LT AN

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 OCT 2003	POD#1
	↓ new c/o's. ↓ numb/ting
Vanco	AF ↓↓↓
	wiggles toes. NVI distally. Dressing stained/intact.
	- Cont IV Vanco for few more days. Plan D to Cipro po
	- Mon D/C to camp when wounds allow.
	- Cipro for another 2wks.
	- D/C Hickam catheter prior to Discharge.
	- return 2wks for clips out/sutures/wound ck/XRAYS.

[redacted]

b(6)-2

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

PROGRESS NOTES
Medical Record

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ID#[redacted]

b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/19/03	ONTTO
1/12	prop DX: (L) tibia Fx
: —	postop DX: same
	ORIF + ICBG + remove ex fix + I/D
	Hugate, Olivio
	GETA
	EBL 500 cc
	to RR stable
	w/o - 2
	& complication.

[redacted]

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19OCT03	1000- assumed care of pt. @ 0600
	Pt resting well at this time. VSS-
	A+O. Drsng to (L) LE intact c̄ drainag
	(+) pulsed to LLE (+) 1. cap refill <2.
	Elevated LLE c̄ pillow. Hickmans b(6)-2
	CDI. Will cont. to monitor pt. [redacted]
	(1740) I concur c̄ above assessment. [illegible]
19OCT03	Pt resting in bed, A+Ox3, VSS, LS CTA
2000	(B), (+) BSx4, Ex Fix LLE cover c̄ dsg + ACE
	wraps CDI, c/o pain, medicated c̄ [illegible] perc
	as per orders, Tol PO well, CL → (L) SC
	intact, Ø s/sx of infex, pedal pulses
	equal-(B), cap refill <3 sec, LLE elevated
	c̄ blanket, 2 pt restrain s̄ s/sx of compl-
	ications, dsg on (L) upper thigh CDI.
	b(6)-2 [redacted]
	I concur with above assessment [redacted]
20OCT03	VSS. AO. [illegible] c/o pain to LLE and provided 5mg MSO4
0725	and 2 percocet for pain. Tolerated well. DSG intact to
	LLE. (+) 2 [illegible] tibial pulse. CMS intact. Tolerating
	PO well. [illegible] [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | b(6)-2 | M | (SSN or Other)

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

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

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 OCT 03 2000	Pt A+OX3, VSS, LS CTA (B), (T) BSx4, medicated for pain = 2 percs, dsg LLE D'd, staples + sutures intact, dsg had ø drainage, dsg on (L) hip CDI, ate well, CL => (L) SC patent, flushes well, ø s/sx of infex, LLE elevated = pillow, 2 pt restraint in place = s/sx of complications. PA Pierrelli [redacted]
21 OCT 03 0905	VSS. AO. ø c/o pain this AM. Ability ambulate. Tolerated PO this AM well. Small, nonvoluminous urine, but enough to keep bladder and continue empty. Use of BR. Voids light yellow, quantity sufficient. (R) pulse & CMS intact to LLE. CR [redacted] DSG CDI to LLE.
1545	Seen by Asst (T) on ward. [redacted]
21 OCT 03 1930	Pt A+OX3, VSS, OOB to BR, LLE dsg D'd, small amount of drainage from incision, staples + sutures CDI, medicated for pain = perc abd soft flat nontender, incision on (L) hip open to air, sutures CDI, ø s/sx of infex, tol PO well, CL (L) SC intact, ø s/sx of infex, 2 point restraint = s/sx of complications. LS CTA (B), active BS. [redacted]
22 OCT 03 0850	VSS. AO. PERRLA. LSCTAB. OOB to BR = difficulty. Tolerated PO well this AM. Skin integrity intact = complications. Sutures to (L) OTA and CDI. (R) pulse to LLE and DSG CDI

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 A11
27Oct03 1741	Assume care of Pt @ 0600. A+Ox3, VSS c/o ~~0~~ pain. Removed sutures and staples, minimal bleeding. Ambulatory in 2pt restraints without difficulty while in bed. Will continue to monitor. [redacted]
27OCT03 2015	Pt A+Ox3, VSS, COB → BR c crutches, incision on LLE healed open to air, steri strips CDI, ~~0~~ drainage noted, medicated for pain c 2 percs as per orders, ~~during day shift while d/c CL~~ a piece of the CL cath remains on dd CL site, dsg over site saturated c blood, d'd CDI, possible d/c tomorrow, IV started @ FA, IV meds given, voiding w/o diff. ~~0~~ s/sx of complications on points of restraint. [redacted] aw
28oct03 0638	Late entry from 27 oct03, 0600 shift. Dr. [redacted] informed that a piece of CL cath remained in Pt while DC ing dc cath. Informed to place op site over cath and check for bleeding and Dr. [redacted] will remove rest of cath. At change of shift site CDI, no bloody drainage. No acute distress. Will cont. to monitor. [redacted] aws
28 Oct03 1600	Assume care of Pt @ 0600. A+Ox3, VSS Ambulate c crutches Dr. Davis removed rest of CL cath that remained from yesterday. Placed two stitches in Pt chest. Area is produces little to no bleeding. IV still intact. Went to OR this afternoon coming on return. Will cont. to monitor. [redacted]
28 Oct 03 1634	Pt concur c above assessment [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25Oct03	VSS Alert & Oriented OOB c Crutches to BR.
1930	(L) LE incision with staples intact. Incision edges well approximated. Incision without drainage or crustation @ this time. Pedal pulses +2. Capillary refill to toes <3sec. (L) LE T on pedal blankets. Will continue care as planned. [redacted]
	(L) Subclavian central line patent & intact. [redacted]
(1200)	Rt a10, VSS, medicated c Percocet II for c/o pain to (L) leg. (L) LE c staples intact, area cleaned & drainage noted @ this time. (+) + equal pedal pulses, brisk cap refill. (L) LE elevated. ROM encouraged. amb c crutches NWB LE x 1. H20 @ BS. 2 pt restraints on while in bed s compromise to skin or circulation. Will monitor [redacted]
26Oct03	VSS Alert & Oriented OOB c crutches to BR
1900	(L) chest Incision with patent & intact. (L) LE c staples intact and edges of incision well approximated. Pedal pulses palpable +2. Capillary refill brisk to toes LE T on pedal blanket

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SSN [redacted]

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/27/03	Dic Note 29 y/o ♂ = infected non union of Left tibia. After 6 weeks IV antibiotics patient had open reduction internal fixation with bone grafting. He is to remain non weight bearing for six weeks. Follow up in 6 weeks for repeat X-rays. Continue oral antibiotics x 2 weeks. [redacted] b(6)-2

#[redacted]

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

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MEDICAL RECORD | **PROGRES** 1.

DATE	NOTES
22Oct03	b(6)-2 All ↓
0880	BSFOx4. Smiling, light yellow urine, QS. [redacted] LLE elevated while in bed.
22OCT03	Pt A&O LS CTA (B). S1,S2 Present VSS.
0740	+BS x 4 quads; Pt voiding qs c/u 5 difficulty. (L)LE Dsg CDI. Pt Ambulates well c crutches. complains of Pain controlled c [redacted] SpC9 LW
23Oct03	Assume care of Pt @ 0500. VSS, A+Ox3 Ambulatory,
1509	C/o pain given two percocets. Elevated LLE while in bed. Skin intact @ restraint site x2. Will continue to monitor. 9 LW SPC Nash
23OCT03	Assumed care of Patient @ 1800 hr. Pt S1,S2
2300	present LS CTA (B). (+) BS x4 quads. Pt voiding c/s 5 difficulty. Tol PO well D/C hr (L)LE Dsg CDI. NO Dsg [redacted] Percocet [redacted] controlled, pain [redacted] SpC9 LW
24Oct03	Assumed care of Pt @ 0600. VSS, A+Ox3 C/O pain given
1542	two percocets. Dsg d/d to (R) leg. Pin care done as well. @ signs of infection, Stitches intact. In apt restraints, no signs of irritation. Ambulatory to bathroom

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME | ST | MI | ID NUMBER

DATE	b(6)-2 ALL NOTES
(cont.)	Will cont. to monitor. [redacted]
~~24Oct03 2100~~	[redacted]
24Oct03 2100	- Assumed care of pt. @ 1800. Assessment completed. PERRLA. LS CTA(B) Resp even un-labored, Abd soft non-tender, voiding per urinal. Pt. ambulated to latrine x two. Tolerates PO + Reg diet well. Pt. conduct self ROM exercises. Hickmas catheter dsg. C/D/I S/Sx infection. (L) LE wound cleaned c 1/2 Peroxide + NS staples intact C/D/I S/Sx of infection. Incision to (L) hip intact also cleaned c 1/2 peroxide + 1/2 NS. Pt resting well @ this time. Two pt. restraints in place. (-) skin breakdown (+) circ. Will cont. to monitor pt [redacted]
	ONCOMING STAFF
25Oct03	Wounds clean dry. Afeb VSS. Suture/Staple removal 3 days. Then D/C to CAMP. [redacted]
25Oct03 1550	Assume care of PT @ 0600. C/O pain given percocets VSS. A+O x3 c signs of skin irritation at 2x restraint sites. (L) leg is open to air, staples intact. Dist. pulse present in 2x legs. Will cont. to monitor. [redacted]
	(1735) I concur c above assessment. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/28/03	OpNote PreOpDx: Wound haematoma (L)leg PostOpDx: Same Procedure: Evacuation of haematoma Surgeon: [redacted] EBL: 50cc. Fluids: 1000cc Specimen: cultures obtained Cx: ✓

b(6)-2 A11

[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28OCT.03 2000	Pt A+O×3, LS CTA (B) (+) BS×4, VSS, dsg on old CL site CDI, dsg + ace wraps to LLE CDI, JP drain in place, draining blood, emptied 12cc of blood, pain controlled ē $\frac{11}{11}$ percs, pt tol PO well, HL (D) FA intact, flushes well, ø s/sx of infex, voiding ŝ diff, 2 point restraint ŝ complications. b(6)-2 [redacted] 91W
29 Oct 03 1427	Assume care of Pt @ 0600. A+O×3, VSS c/o pain given two percocets. Drainage from (R) leg, 20cc of blood @ 1200a. In 2pt restraints without skin irritation. Hep Lock to (R) arm. Will cont. to monitor. b(6)-2 [redacted]
29OCT@ @2300	Pt amb ē crutches. ŝ (L) Ft. elevated + wrapped in ace bandage. Pt c/o pain. medicated ē 2 percocets. JP drain in place. Draining blood. Will Record output at end of shift. ø S/Sx infection. [redacted] RN/AN
30Oct@0545	JP drain ex 10cc b(6)-2
30 Oct 03 0630	pt asleep at this time. (R) leg wrapped in ace bandage post-op JP drain in place draining blood. will monitor
0940	Dr [redacted] came down to do dsg Δ, wound intact ŝ

RELATIONSHIP TO SPONSOR b(6)-2 | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

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

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2 AU

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Oct 03	sutures intact, with no drainage skin ⊝ circulation - s/s of infection, povidine-iodine applied, then extremity covered with 4x4 curlex and ace bandage, drsg on Ⓛ pectoral changed sutures drsg CDI replaced with 2x2 and tape. Pt has ϕ c/o pain at this time. Restraints in place x2. Circulation intact. Meds given as scheduled. JP drainage recorded end of shift on vitals sheet. [redacted]
	(1725) I concur c̄ above assessment. [redacted]
30 Oct 03 1900	VSS Alert & oriented. Ⓡ FA Saline lock patent & intact. Peripheral pulses palpable x2. Drsg to Ⓛ LE dry & intact with ACE wrapping. Capillary refill brisk to Ⓛ toes. JP to Ⓛ LE draining small amt of serosanguinous fluid. Ⓛ LE ↑ on folded blankets. Will continue plan of care. [redacted]
31 Oct	Pt awake and oriented x3, pt had c/o of pain from Ⓛ extremity, pt given 2 percs, drsg to Ⓛ extremity JP drained 10cc, drsg appears CDI, pt given meds as ordered. No other remarkable findings.
1 Nov 03 @ 0315	assumed care of pt @ 1800. VSS. 90 h/a s̄ leg pain, percocet given c̄ good relief noted. alert, speaking arabic. LLE wrapped in drsg c̄ kerlix & ace wrap. ⊕ CMS to LLE, +2 DP pulse, equal B/L. Ⓡ AC flushes easily. 2pt restraint on s̄ s/sx of skin / circulation compromise. Plan: cont MRSA precautions, IV Abx; monitor I/O output, monitor CMS. [redacted]

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

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ACLU-RDI 1649 p.65

DOD-032479

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1/7/03	Discharge Summary This is an Iraqi EPW treated for his infected tibial non union & IV antibiotics and open reduction internal fixation & tibial crest bone grafting. His wounds are closed and they should continue to be dressed and kept clean & dry. Continue daily levoquin 500mg QD. Non weight bearing left lower extremity for 6 weeks. F/u here for suture removal in one week. [redacted] b(6)-2

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04NOV03	(1500) Pt stable for d/c to EPW camp. Escorted - ambulatory c crutches by MPs. [redacted] USA Voided-2

#07746

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

NSN 7540-01-075-3786

MEDICAL RECORD | **EMERGENCY CARE AND TREATMENT (Patient)** | LOG NUMBER | TREATMENT FACILITY | RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW camp
CITY | STATE | ZIP CODE

ARRIVAL
DATE (Day, Month, Year): 03 Oct 03 | TIME: 1010
TRANSPORTATION TO FACILITY: wheel vehicle

SEX: M
AGE
DUTY/LOCAL PHONE: AREA CODE | NUMBER
HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Vancomycin

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: 29 Sep | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS
DATE LAST SHOT | COMPLETED INTITIAL SERIES ☒ YES ☐ NO

CHIEF COMPLAINT: (2) Leg pain 2° injury

CATEGORY OF TREATMENT
☐ EMERGENT
☐ URGENT
☒ NON-URGENT
TIME: 1032
INITIALS: b(6)-2 [redacted]

VITAL SIGNS

TIME	1003				
BP	110/71				
PULSE	84				
RESP	16				
TEMP	97.7(1)				
WT					

LAB ORDERS
☒ CBC/DIFF | ABG | PT/PTT | ☒ BHCG/URINE/BLOOD/QUANT
URINE C&S | ☒ UA MSCC/CATH | ☒ CHEM: Lytes, LFTs
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 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY
MODIFIED DUTY UNTIL
DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.
RETURN TO DUTY
PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE
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)*

EPW [redacted] b(6)-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 - 18908

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	TIME SEEN BY PROVIDER 1015

TEST RESULTS

CBC: WBC	SMAC	ABG/PULSE OX: SUP 02	PH	PO2
H/H		PCO2	SAT	OTHER
PLT		U/A: DIP		
PT		MICRO		
APTT	BHCG	ETOH	GLU	

RADIOLOGY — Check if read by radiologist ☐

RESULTS

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

Pt is a 29 yo Iraqi ♂ EPW s/p GSW to (L) Tibia o/a 12 Aug & Br in) [illegible] ē Casting. Extfx'd 12 Sep due to draining Sinus tract. [illegible] ō Abx beads & I/D. Pt Later grew out MRSA & was Started on VAnc ~29 Sep. Pt was sent to Iraqi hosp but they were unable to care for him & sent him back to us.

O: WDWN NAD A+O x3 [illegible]
HEENT: WNL
Lungs (B) CTA
Cvm Dmm. Chest: (R) Hickman Catheter
Abd: (B) BS, [illegible]
Ext: (L) Tibia ex fix Wound [illegible].

P: Admit to Orthopedics.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

b(6)-2

CODES

DIAGNOSIS
MRSA (L) Tibia Osteomyelitis

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

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 - 18909

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW [redacted] b(2)-2

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 11 Sept 03 | TIME: 1106

TRANSPORTATION TO FACILITY: Ar Evac

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
29	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM: Interpreter				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Flagyl

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: GSW (C) leg 30 day ago

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1106

INITIALS: JLC

VITAL SIGNS

TIME	1106					
BP	107/65					
PULSE	71					
RESP	18					
TEMP	98.4					
WT						

LAB ORDERS					X-RAY ORDERS		
X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S	UA MSCC/CATH		X CHEM: Met Panel		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X					SINUS	HEAD CT
						ANKLE R/L	X T,L Fib

ORDERS

☒ PULSE OX 99% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1200	Toradol 30mg IV	[redacted]	b(6)-2	1203	pain better

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)*

EPW [redacted] b(6)-1

[redacted]

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 - 18910

NSN 7540-01-075-3786

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

BUN - 7 Creat 1.3

TEST RESULTS

CBC: WBC 5,600; H/H 14.2; PLT
SMAC: 138 | 4.1 | 101 | 24
PT
APTT
BHCG
ETOH
GLU 90

ABG/PULSE OX: SUP 02 | PH | PO2 | PCO2 | SAT | OTHER
U/A: DIP; MICRO

RADIOLOGY — Check if read by radiologist ☐
RESULTS
EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

5/29 Dragi GPW. with G.S.W (L) Leg - one month ago
Has had cast for 2 weeks. c/o pain from wound site.
0.) T-98.4 P-71 B.P. 107/65
alert
Lungs - clear
Heart - RR - no
Abd - soft
(L) leg - cast removed -
Approximately 4" below
(L) Knee - 1" wound
Back side - no exit
Lateral aspect (L) thigh
1cm - newly healed wound
Pulse ± 2+
Neuro =

CONSULT WITH	TIME	ACTION
Cell		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
[redacted] MD
b(6)-2

DIAGNOSIS
1.) G.S.W (L) Leg with Fx
Tib / Fib

CODES

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

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

MEDICAL RECORD — CONSULTATION SHEET

b(2)-2

REQUEST

TO: ORTHO - [redacted]

FROM: (Requesting activity) Dr. [redacted] (b)(6)-2 (b)(2)-2

DATE OF REQUEST: 11 SEPT 03

REASON FOR REQUEST (Complaints and findings)

GSW 30 days ago to Lt Leg - was in Iraqi hospital. Taken in to custody few days ago - Cast was applied (15 days after GSW) and sent to prison.

PROVISIONAL DIAGNOSIS: Please recondition & REPLACE CAST, after X Ray

CAST appears soft ~~and~~ provisionally

DOCTOR'S SIGNATURE: [redacted] b(6)-4

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

ATTEMPTED TO CALL [redacted] - Unable to establish contact due to technical issues. b(2)-2

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

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

[redacted] b(6)-4

SPN [redacted] b(2)-2

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD (Wounds ~ 30 days old) **PROGRESS NOTES**

Admission Date: 9-11-03 Diagnosis: GSW (L) leg Fx Tib-Fib (L) leg HD: 1 POD: 30 OR tomorrow 9-12-03

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)		**Mobility**	No limitations	4
	Slightly limited	3			Slightly limited	3
	Very limited	2			Very limited	(2)
	Completed	1			Completely immobile	1
Moisture	Rarely moist	(4)		**Nutrition**	Excellent	4
	Occasionally moist	3			Adequate (Eats >50%)	(3)
	Moist	2			Adequate (Rarely eats)	2
	Constantly moist	1			Very poor	1
Activity	Walks frequently	4		**Friction and Shear**	No apparent problem	3
	Walks occasionally	3			Potential problems	(2)
	Chairfast	2			Problems	1
	Bedfast	(1)				

Add the total score **Total Score**_____

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates **HIGH RISK** –Requires immediate Ulcer prevention program.

Surgical wound (s): Yes No Location: ~~Lt Le~~ Size: _____ Drainage: _____
Tubes: _____ Appearance: _____
Dressing change: _____

Pressure Ulcer (s): Yes (No)
Stage I, II, III, IV (Circle the one that applies and describe below)

Location: _____ Size: _____
Wound character: Pint_____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough_____
Odor _____ Purulent discharge _____ Eschar _____ Exudates _____

Type of dressing change: Wet-to-dry_____ Comfeel dressing _____ Carrasyn V-Gel_____ Alginate _____

Physician notified/consulted for wound debridement: Yes_____ No_____
CNS notified/consulted for Stage II and greater: Yes_____ No_____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes_____ No _____
Action Taken: _____ Date & Time: _____

REGISTER NO.	WARD NO.

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

PROGRESS NOTES

b(le)-4

EPW #[redacted]

Medical Record
STANDARD FORM 509

MEDCOM - 18913

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 29
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda

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

4. PROPOSED SURGICAL PROCEDURE: I+D ©Tibia, + Cast vs Ex Fix

5. ADDITIONAL INFORMATION: Last PO: NN Medical Hx: see H+P Implants: ø Medications: Flagyl
Jewelry removed: yes/(no) Family waiting: yes/(no) gsw © Tibia 30 days ago

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~, surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. N/A
B. AERATION ___ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o 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] b(6)-4
ICW-1

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; ~~shock; previous surgery~~	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. N/A o Check that safety straps are correctly applied. o Offer pillow for under knees. N/A o Place and take down legs from stirrups with slow bilateral motion. N/A o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. Potential impairment of mobility due to sedation; pain; injury E.2. Potential discomfort due to injury; pain	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, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. Disminished visual perception due to being injury; sedation; F.2. Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o 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 INTERVEN[redacted]ETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] 12 Sept 03 DATE

11. POS[redacted]ATIVE EVALUATIO[redacted]

Bowel Site: CDI

Drsg: CDI

Breathing: 5 problem

b(6) - 2 AM

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CRNA

DATE: 12 Sep 03 TIME: 2045

13. PREOPERTIVE EVALUATION PREPARED BY [redacted] LT/AN

DATE: 12 Sept 03 TIME: 1635

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

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 Litter BY Anesthesia

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

3. DATE 12 Sept 03 TIME PATIENT ARRIVED IN SUITE 1320

4. PATIENT IN ROOM TIME 1320 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted]	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	1LT [redacted] (1504)

7. POSITION AND POSITIONAL AIDS (Specify)

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

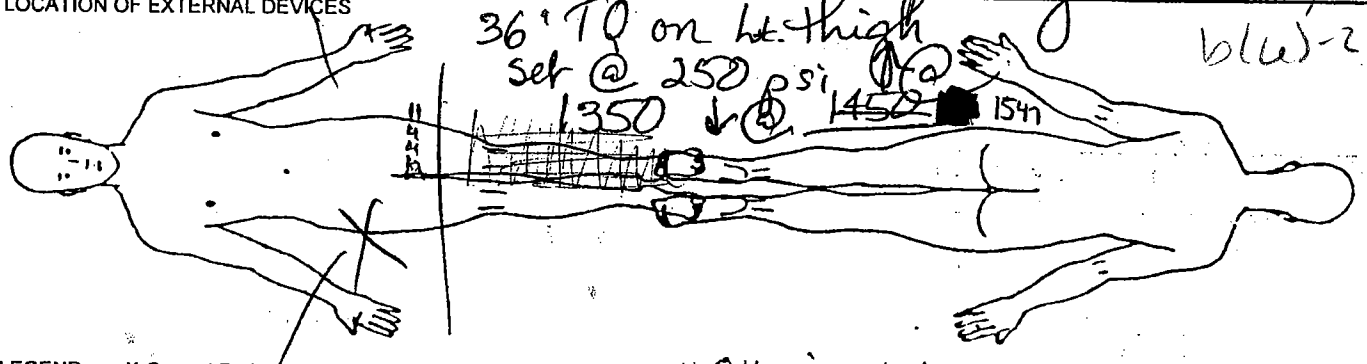
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine scrub/sol.
SITE: Lt. leg BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet X 94 min total @ 250mmHg

10. COUNTS

C = Correct I = Incorrect

		Initial Count	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	✓	C	C
Needle Sharp	☒ Yes ☐ No	✓		
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB Spc. [redacted] b(6)-2 CIRCULATOR LTC [redacted]

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

[redacted] b(6)-4

ICW-1

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

☒ ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM Polyhesive II
LOT NO: 69671

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 45 coag: 30 45

MEDCOM - 18916

13. PROSTHESIS, IMPLANTS ☒ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER Hoffman II

4920-2-020 x2
5018-5-150 x4
5023-6-150 x7

5029-8-830 x2

Tobramycin beads

load # 012530

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): 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] b(6)-2		

PHYSICIAN'S SIGN [redacted]

15. X-RAY IN OPER YES ☒ NO ☐ IF YES, SITE C-Arm. (Lt) leg

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☒	NAME Lt [redacted] tibia Aerobic & Gm. Stain	NAME
NAME ns	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION (Specify)

Fluffs
Kerlix
ACE

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1 (L) leg wound	2.	3.

19. ADDITIONAL INFORMATION b(6)-2

WC

Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: GETA

Bovie Pad site intact pre-op Clear; post-op ✓ Bovie Settings: Coag/Cut 30/30, 45/45

Tourniquet Site intact pre-op ✓: post-op ✓

Tourniquet Time: Up 1300 Down ~~1550~~ cm 1547 Total: 94 min

20. OPERATION(S) PERFORMED

I+D Lt tibia
Placement Ex Fix (L) tibia

b(6)-2

21. PATIENT TRANSFERRED TO b(6)-2 [redacted] PACU TIME See DA 7359 METHOD via Gurney

22. REGISTE [redacted] LTC AN [redacted] AN

REVE DRM 5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD — **INTRAOP[illegible]DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Wheeled litter BY Anesthesia
2. PATIENT IDENTIFIE[illegible]D AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 15SEP03 TIME PATIENT ARRIVED IN SUITE 0755
4. PATIENT IN ROOM TIME 0807 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA yelling once in room

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed, head on foam doughnut, Bilateral Arms extended out to sides < 90° in CAP. Secured to padded armboard & safety straps. LLE prepped into sterile field, folded towel under R heel

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

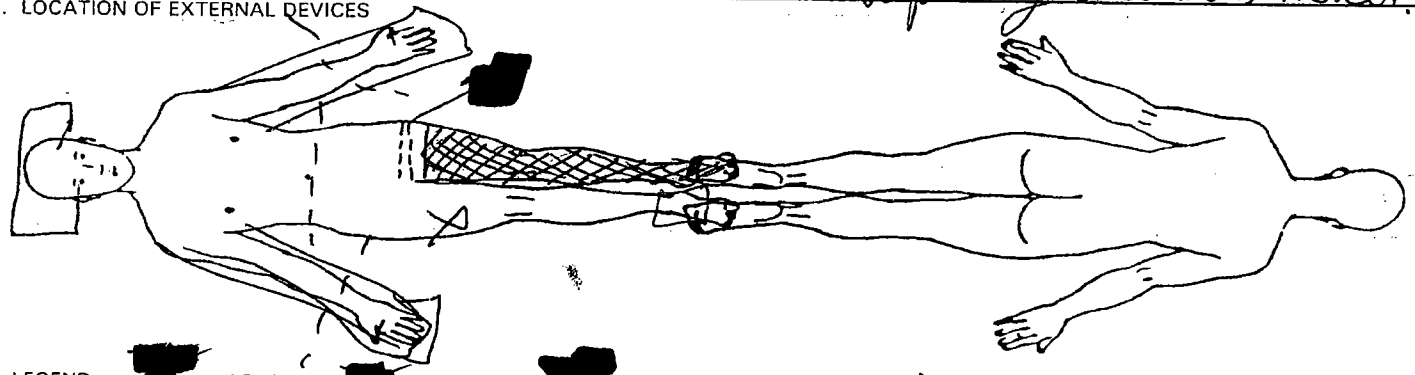
COMMENTS: Correct Body Alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: LLE BY WHOM: CPT [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS: No pooling of solutions noted.

9. LOCATION OF EXTERNAL DEVICES



10. COUNTS — C = Correct I = Incorrect

		Initial Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C		C
Needle Sharp	☒ Yes ☐ No	C		C
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB	CIRCULATOR
SPC [redacted] b(6)-2	CPT [redacted]

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

b(6)-4
[redacted]

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

☒ ESU NO: R8B 10239S
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 68245 / 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ NO:

MEDCOM - 18918

Limerick, Ireland.

Full Dose

REF 6191 0 001

LOT CLJ157 Exp 10-2007

c̄ 7 & surgical steel lot BA1056 + tobramycin 2.4gm

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Tobramycin 1.2gm	2.4gm	intra-op	implant via beads	Dr [redacted]	b(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):

QS, 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

	NAME	NAME
SPECIMEN (S) YES [ ] NO [X]		
FROZEN SECTION (FS) YES [ ] NO [X]		
CULTURE (C) YES [X] NO [ ]	Ⓛ proximal tibial tissue	
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES [X] NO [ ]

TYPE/SIZE	1. antibiotic bead packing	2.	3.
SITE	1. Ⓛ tibial wound	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlex Fluff, Kerlex Roll,

19. ADDITIONAL INFORMATION

WC-IV

Bovie pad site pre-op CDI post-op CDI Bovie 30/30 Blend 1

tourniquet site pre-op CDI post-op CDI

Dr [redacted] Anesthesia - CPT Serafin CRNA GEN/Endo

DA Form 5179-1 previously initiated no Δ's noted.

20. OPERATION(S) PERFORMED

I+D Ⓛ tibia c̄ antibiotic bead placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3/PACU	1015	wheeled litter

22. [redacted] CPT/AN

RE[redacted], OCT

USAPA V1.00

b(6)-2 5x30 15x5

MEDCOM - 18919

ACLU-RDI 1649 p.79

DOD-032493

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, th[redacted]y is th[redacted] of The Surgeon General.

1. PATIENT TRANSPORTED TO OPER. ROOM VIA litter BY Anesthesia

2. PATIENT [redacted] AND PROCEDURE VERIFIED B[redacted] CPT/Ar

3. DATE 25 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME blw-2 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SP[redacted] CPT blw-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure & padding under head (R) arms tucked @ side & fingers

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

COMMENTS: Skin checked by NSG staff & MD. Dr. [redacted] (CRNA [redacted])

8. SKIN PREPARATION blw-2

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR CPT Jones ☐ CLIP

COMMENTS: ☒ nicks or cuts noted

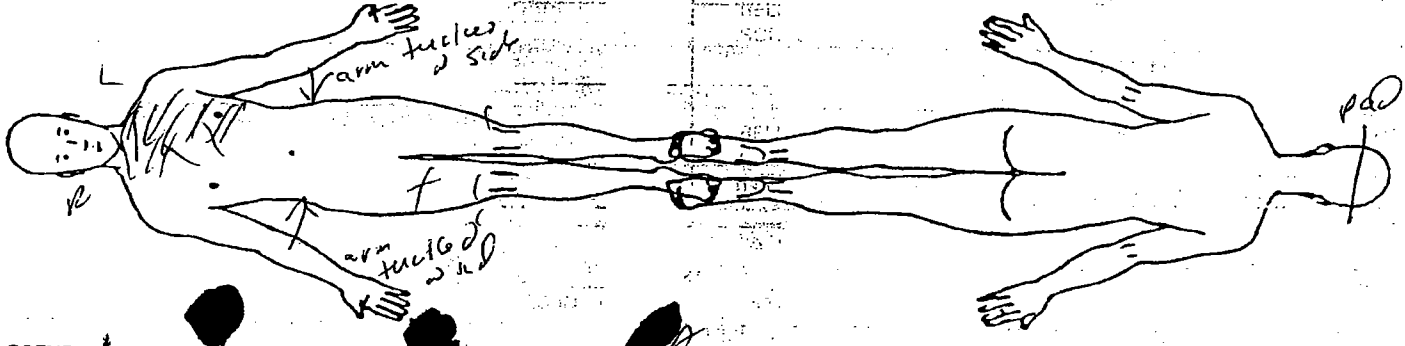
PREP SOLUTION *(Specify)* Betadine / Betadine

SITE: Chest BY WHOM: CPT [redacted] AR

SITE: ### Sec # 9 BY WHOM:

COMMENTS: ☒ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	C	C	C
Needle Sharp	☒ Yes	☐ No	C	C	C
Instrument	☐ Yes	☐ No			
Other	☐ Yes	☐ No			

SCRUB [redacted] CIRCULATOR [redacted] blw-7

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

[redacted] (EPW) ICW-1 blw-4

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

☒ ESU NO: ROE 105-305 30/30

GROUND PAD: BRAND Valley Lab

LOT NO: 70011 Exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 18920

25 Sept

13. PROSTHESIS, IMPLANTS ☑ | IF YES NAME: ID NUMBER | TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Heparin Sodium 1:1000 ☆ 1 L NS	1cc	Intra op	Flush	MTG	Dr. [redacted]

WOUND IRRIGATION ☑ YES ☐ NO; TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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

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)* 4x8 Tape Opsite Tape

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

19. ADDITIONAL INFORMATION

Surgeon [redacted] Anesthesia [redacted]

b(4)-2 All

20. OPERATION(S) PERFORMED

Hickman Catheter Placement

21. PATIENT TRANSFERRED TO PACU | TIME 1337 | METHOD Litter ☆ 2

22. REGISTERED NURSE SIGN [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 18921 USAPA V1.00

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPER... ROOM
VIA Litter BY Anesthesia

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

3. DATE 28Oct03 TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 1415 NUMBER 6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ø concerns voiced

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained

8. SKIN PREPARATION

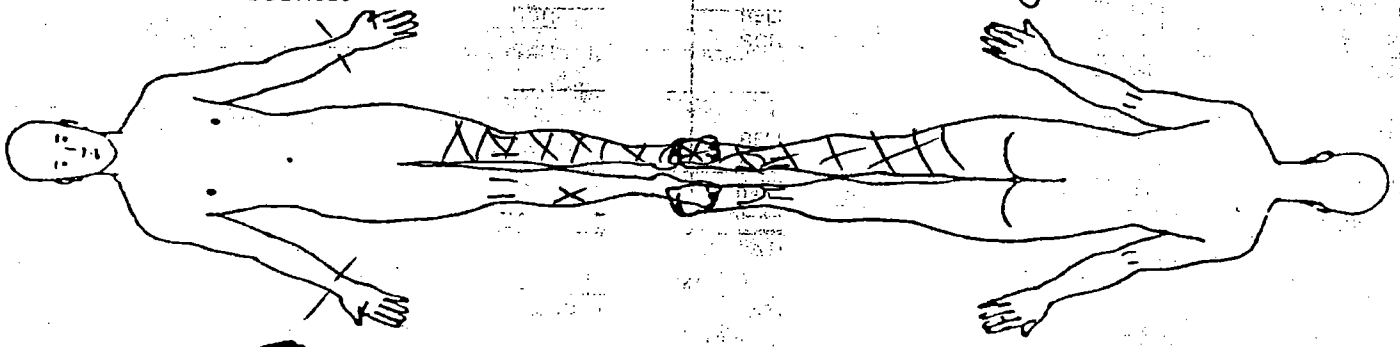
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Surgical Betadine Paint
SITE: (L) leg (2 in above knee to toes) BY WHOM: [redacted] b(6)-2
SITE: BY WHOM:

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet prepared

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	/	/	C	[redacted] b(6)-2	[redacted]
Needle Sharp	☒ Yes	☐ No	/	/	C	[redacted]	
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;)*

[redacted] b(6)-4
[redacted] b(2)-2
28Oct03

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
50150

☒ ESU NO: Valleylab Force 40
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 69671 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 18922

28 Oct

13. PROSTHESIS, IMPLANTS ☐ YES IF YES NAME: ID NUMBER; MA[illegible] URER

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): 0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIG[redacted] b(6)-2

15. X-RAY IN OPE[illegible]M IF YES, SITE
YES ☐ ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME ① Aerobic Cx ② Leg Wound	NAME ② Gram Stain ② Leg Wound
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*
Telfa
Kerlix
Ace wrap

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10 mm JP		
SITE	② Leg		

19. ADDITIONAL INFORMATION
Surgeon: [redacted] b(6)-2
Anesthesia: [redacted]
*MRSA pt.
-D4579 on chart, ø A's noted

20. OPERATION(S) PERFORMED
I+D ② knee wound, evacuation hematoma

21. PATIENT TRANSFERRED TO	TIME See D4389	METHOD
PACU (ICU3)		Litter

22. REGISTERED NURSE SIGNATURE
[redacted] CRNA b(6)-2

REVERSE OF DA FORM [illegible]-1, OCT 87 MEDCOM - 18923 USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

105° | 180 | 104° | 170 | 103° | 160 | 102° | 150 | 101° | 140 | 100° | 130 | 99° | 98.6° | 120 | 98° | 110 | 97° | 100 | 96° | 90 | 95° | 80 | 70 | 60 | 50 | 40

TEMP. C

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)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) **BACK**

511–119 NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY 1

POST- DAY

MONTH-YEAR Sept 2003 | DAY 11 12 13 14 SEP 03 15 16 9/16 17 Sept | HOUR 0815 0800 1900 1900 0800

PULSE (O) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW-[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18925

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

180 | 104°
170 | 103°
160 | 102°
150 | 101°
140 | 100°
130 | 99°
98.6°
120 | 98°
110 | 97°
100 | 96°
90 | 95°
80
70
60
50
40

TEMP. C

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)*

REGISTER NO.

WARD NO.

EPW # [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (0) | 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] blu-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) **BACK**

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) | TEMP. F (°)

105° | 40.6°

180 | 104° | 40.0°

170 | 103° | 39.4°

160 | 102° | 38.9°

150 | 101° | 38.3°

140 | 100° | 37.8°

130 | 99° 98.6° | 37.2° 37.0°

120 | 98° | 36.7°

110 | 97° | 36.1°

100 | 96° | 35.6°

90 | 95° | 35.0°

80

70

60

50

40

TEMP. C

(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)*

REGISTER NO.

WARD NO.

[redacted] p(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18928

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 19 OCT | 20 OCT | 21 OCT | 22 OCT | 24 OCT | 03 25 Oct | 26 OCT

DAY / HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

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: 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.

[redacted] b1(c)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18929

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

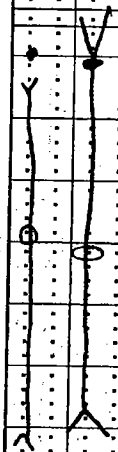
POST- DAY

MONTH-YEAR | DAY: 28

19 | HOUR: 20

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: 16

BLOOD PRESSURE: 113/58 124/93

98 99

92 87

HEIGHT: WEIGHT → 98.6 98.8

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.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Oct 03 | DAY: 29 | 30 | 30 | 31

HOUR: 19

PULSE (0) | 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

104/75	119/61	102/61	105/51
T98.1	92	92	
478	975	972	
	96%	100	
97%		98% RA	

HEIGHT: | WEIGHT →

Ht

[redacted]

10cc 10cc 10cc

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.

STANDARD FORM 511 (REV. 7–95) **BACK**

[redacted] b(6)-4

MEDCOM - 18931

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted]	TE 11 Sept	TIME 1135

SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
			Color		N/A	RPR		Negative
			App		N/A	Mono		Negative
			Glu		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
Segs			Prot		Negative	Malaria		
Band			Urob		0.2-1.0	O & P		
Lymp			it		Negative	Other		
Atyp			uk		Negative	**Microscopic Urinalysis**		
RBC Morph			G		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**	
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 18932

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	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		3.5-5.5 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
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Methyte 8

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

======= PICCOLO =======
11/09/03 11:46
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(a) [redacted]

GLU	90	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	9.3	8.0-10.3	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
NA+	138	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

Hugate

b(6)-2

Ward/Section: OR	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 12 Sep 03	TIME:	SSN/PSEUDO-SSN: [redacted]

b(6)-4 b(6)-4

(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		9.8-13.6 secs
APTT		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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain	Rt- tibia X 1400 = Neg	
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

REMARKS: NO Bacteria Seen

REPORTED BY: [redacted] DATE: 12 Sep 03 LAB ID NO.:

b(6)-2

[redacted] b(6)-4

OR

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

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

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] Grout b(6)-2

REPORTED BY MD TECH DATE

LAB. ID. NO.

REMARKS

549-107

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

TEST(S)	REQUESTED	RESULTS
SPECIMEN TAKEN DATE	9/12/03	
TIME A.M. P.M.	1600	
[X]		
RBC COUNT	XX	
HEMOGLOBIN		
HEMATOCRIT		
MCV		
MCH		
MCHC		
WBC COUNT		
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC		
SED. RATE		
PLATELET COUNT	X	
RETICULOCYTE COUNT		
CLOTTING TIME		
BLEEDING TIME		
PTT: CONTROL, PATIENT		
PROTIME: CONTROL, PATIENT, % ACTIVITY, RATIO		
SICKLING TEST		
LE PREP		

======= PICCOLO =======
19/09/03 11:03
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	3.1*	3.3-5.5	G/DL
ALP	77	26-84	U/L
ALT	71*	10-47	U/L
AMY	47	14-97	U/L
AST	96*	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
GGT	45	5-65	U/L
TP	7.2	6.4-8.1	G/DL

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

i-STAT EC8-

Pt: [redacted]

Pt Name:_____

Glu_____99 mg/dL
BUN_____9 mg/dL
Na_____136 mmol/L
K_____3.9 mmol/L
Cl_____98 mmol/L
TCO2_____34 mmol/L
AnGap_____10 mmol/L
Hct_____34 %PCV
Hb*_____12 g/dL
*via Hct

PH_____7.364
PCO2_____57.0 mmHg
HCO3_____33 mmol/L
BEecf_____7 mmol/L

Sample Type_:

195EP03 11:02

Oper: [redacted]

** PRINT CANCELLED **

EPW # [redacted] b(6)-4
ICW # 1
19 Sep 03

SPECIMEN/LAB RPT. NO

MISC

URGENCY
☐ ROUTINE

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ DOM

RCE

ID: [redacted] 19-09-03
WB 11:11

				Patient Limits	
WBC	8.6	x10^3/uL		4.5	10.5
RBC	3.60	L	x10^6/uL	4.00	6.00
Hgb	10.3	L	g/dL	11.0	18.0
Hct	32.1	L	%	35.0	60.0
MCV	89.0		fL	80.0	99.9
MCH	28.6		pg	27.0	31.0
MCHC	32.1	L	g/dL	33.0	37.0
Plt	288.		x10^3/uL	150.	450.
LY%	20.8		%	20.5	51.1
LY#	1.8		x10^3/uL	1.2	3.4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

REPORTED BY

[redacted]

LFT's / ESR

TEST(S) | SPECIMEN TAKEN | TIME 1049 | A.M. (circled) P.M. | DATE | REQUESTED | RESULTS

PATIENT'S MED. RECORD

557-107

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

MEDCOM - 18936

Ward/Section: ICU #1	REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI. EPW #[redacted] b(6)-4	DATE 20Sept	TIME 0740	SSN/BEEUDO SSN: #[redacted] b(6)-2

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	Macroscopic Urinalysis		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52%(M) 37-47%(F)	CSF			Blood Bank		
Set Rate	97		Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

REMARKS: ~~Serum Creatinin~~ ICT Sed rate (ESR)

REPORTED BY: DATE: LAB ID NO.:

Ward/Section: ICU1	REQUESTING PHYSICAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI: [redacted] b(6)-4	DATE: 20 Sep 03 TIME: 0740	SSN/PEEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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 (art)
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
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
20/09/03 08:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: [redacted]
.....b(6).....

GLU	109	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	28*	39-380	U/L
NA+	130	128-145	MMOL
K+	4.7	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	22	18-33	MMOL

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/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		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
AST		14-97 u/l
AMY		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
tCO2		18-33 mmol/l

REMARKS: Serum Creatinin

REPORTED BY: b(6)-2 [redacted]

DATE: 9-20-03

LAB ID NO.:

Serum lytes, Renal Panel (include creatinine)

Ward/Section: ICW1	REQUESTING PHYSICIAN: b(6)-4	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 9/29/03 TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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 (art)
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
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

PICCOLO
09/29/03 11:07 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	99	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	28*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	21	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/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
ST		14-97 u/l
MY		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
+		128-145 mmol/l
+		3.3-4.7 mmol/l
-		98-108 mmol/l
O2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

blu3-2

Ward/Section: EM	REQUESTING PHYSIC [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. blu3-4 [redacted]	DATE 3 Oct 03	TIME	SSN/PEEUDO SSN:

(Hematology) CBC

ID: [redacted]
WB

03-10-03
11:36

			Patient Limits	
WBC	4.4 L	x10^3/uL	4.5	10.5
RBC	4.29	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	37.0	%	35.0	60.0
MCV	86.1	fL	80.0	99.9
MCH	26.7 L	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	406.	x10^3/uL	150.	450.
LY%	36.6	%	20.5	51.1
LY#	1.6	x10^3/uL	1.2	3.4

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		

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

Set Rate			
Other		ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI.	DATE / TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANG
Na		138-146 mmol/(
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (a
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/
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
Tropoin-1		
Drug of Abuse		

tCO2		18-33 mmol/l

======= PICCOLO =======
10/03/03 12:07 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] 2116-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.8	3.3-5.5	G/DL
ALP	84	26-84	U/L
ALT	27	10-47	U/L
AMY	57	14-97	U/L
AST	25	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
GGT	22	5-65	U/L
TP	8.3*	6.4-8.1	G/DL

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/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		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
AST		14-97 u/l
AMY		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^{+}	138	128-145 mmol/l
K^{+}	4.3	3.3-4.7 mmol/l
CL^{-}	103	98-108 mmol/l
tCO2	29	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
S	10-03-03	

b(6)-2

Ward/Section: ICU#1	REQUESTING PHYSICAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,ML [redacted] b(6)-4	DATE 9007	TIME 1220	SSN/PEEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

[redacted]

WBC	4.2 L	x10^3/uL	4.5	10.5
RBC	4.31	x10^6/uL	4.20	6.00
Hgb	11.3	g/dL	11.0	15.0
Hct	36.6	%	35.0	60.0
MCV	84.7	fL	80.0	99.9
MCH	26.3 L	pg	27.0	31.0
MCHC	31.0 L	g/dL	32.0	37.0
Plt	318.	x10^3/uL	150.	450.
LY%	36.2	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

Hematocrit		42-52%(M) 37-47%(F)
Set Rate	25	
Other		

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	

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

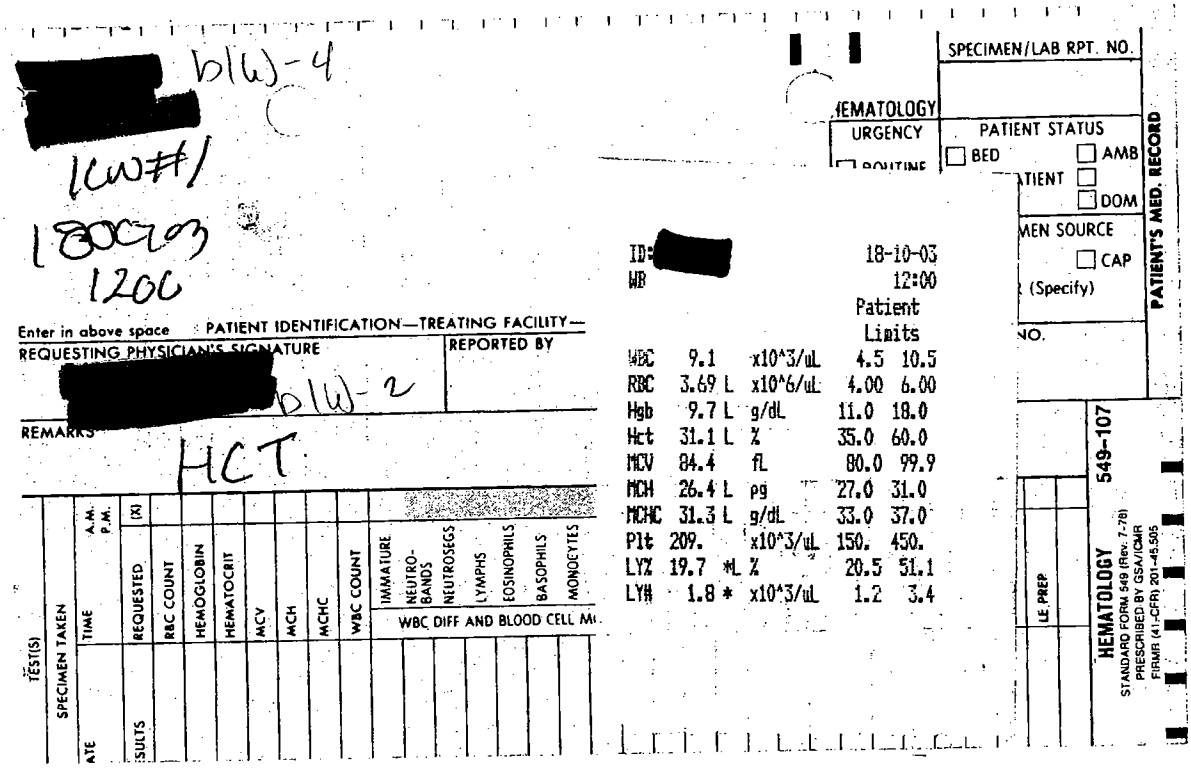
REMARKS: CSF Please

REPORTED BY: [redacted] b(6)

DATE: 9 OCT 03

LAB ID NO.:

MEDCOM - 18942



[redacted] b(6)-4

ICW#1

180CT03

1200

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

REPORTED BY

REMARKS HCT

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

URGENCY ☐ ROUTINE

PATIENT STATUS ☐ BED ☐ AMB ☐ DOM

PATIENT'S MED. RECORD

SPECIMEN SOURCE ☐ CAP (Specify)

ID: [redacted] 18-10-03 12:00

WB

				Patient Limits	
WBC	9.1		x10^3/uL	4.5	10.5
RBC	3.69	L	x10^6/uL	4.00	6.00
Hgb	9.7	L	g/dL	11.0	18.0
Hct	31.1	L	%	35.0	60.0
MCV	84.4		fL	80.0	99.9
MCH	26.4	L	pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	209.		x10^3/uL	150.	450.
LY%	19.7		%	20.5	51.1
LY#	1.8	*	x10^3/uL	1.2	3.4

TEST(S) | SPECIMEN TAKEN: DATE, TIME, A.M. P.M. | REQUESTED (X) | RESULTS | RBC COUNT | HEMOGLOBIN | HEMATOCRIT | MCV | MCH | MCHC | WBC COUNT | WBC DIFF AND BLOOD CELL M: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES | LE PREP

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

[redacted] b(2)-2

Microbiology Request Form

Last Name: # [redacted] b(6)-4
First Name:
Patient # or SSN:

Collected by: DR [redacted] b(6)-2
Date: 18 OCT 03
Time: 1000

Ward: OR
Room: 1
Bed:
Physician: [redacted] b(6)-2

Source: (L) leg
Site:

[redacted]

Received by:
Date:
Time:

Specimen #: W075

Laboratory Results

Staphylococcus hominis

Reported
Date:
Time:
Tech:
Reviewer: [redacted] b(6)-2

Number of attached sheets:

Microbiology Report

[redacted] (b)(2)-2

Name: [redacted] b(6)-4
Patient ID: [redacted]
Ward/Rm: /

Specimen: [redacted] (b)(6)-4
Source: Wound/Sterile site
Ward of Iso:

Status: Preliminary
Collected:
Attd. Phys:

1 Staphylococcus hominis subsp. hominis Status: Preliminary

1 **S. hominis-homin**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2				
Amp/Sulbactam (c)	<=8/4				
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	<=8				
Cefepime	<=8				
Cefotaxime (c)	<=8				
Ceftriaxone (c)	<=8				
Cephalothin	<=8				
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
Clindamycin	2	I			
Erythromycin	<=0.5	S			
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	<=4				
Levofloxacin	<=2	S			
Linezolid	<=2	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	<=2	S			
Oxacillin	N/R				
Penicillin	>8	BLAC			
Pip/Tazo (d)	<=4				
Rifampin	<=1	S			
Synercid	<=1	S			
Tetracycline	<=4	S			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name: [redacted] b(6)-4
Patient ID: [redacted]
Ward/Rm: /

Specimen: [redacted] (b)(6)-4
Source: Wound/Sterile site
Ward of Iso:

Status: Preliminary
Collected: b(6)-2
Req. Phys: [redacted]

Printed 10/22/2003 5:44:42 PM MEDCOM - 18945 Tech: _____

[redacted] b(2)-2

Microbiology Request Form

Last Name # [redacted] b(6)-4 Ward: ICU1

First Name: Room:

Patient # or SSN: Bed:

Physician: DR [redacted] b(4)-2

Collected by: DS [redacted]

Date: 28 Oct 03 Source: Wound

Time: 1445 Site: (L) Leg (Knee

[redacted]

Received by: SPC [redacted] b(4)-2 Specimen #: W096

Date: 28 Oct 03

Time: 1600

Laboratory Results

Gram Stain: NO Bacteria Seen

Micrococcus sp.

Reported

Date: 31 OCT 03

Time: 1000

Tech: IO

Reviewer: [redacted] b(4)-2 Number of attached sheets:

Micro... Report [redacted] (b)(2)-2

Name: [redacted] (b)(6)-4 Specimen: Status: Final
Patient ID: Source: site Collected:
Ward/Rm: W1/ W... of Is... Attd. Phys:

1 Micrococcus and Relate... enera Sta... s: Final

1 Micrococcus sp.

Drug	MIC	ter...	MIC	Interps
Amox/K Clav (c)	<=4/2			
Amp/Sulbactam (c)	<=8/4			
Ampicillin	<=0.25			
Azithromycin	>4			
Cefazolin	<=8			
Cefepime	<=8			
Cefotaxime (c)	<=8			
Ceftriaxone (c)	<=8			
Cephalothin	<=8			
Chloramphenicol	<=8			
Ciprofloxacin	<=1			
Clindamycin	<=0.5			
Erythromycin	>4			
Gatifloxacin	<=2			
Gentamicin	<=4			
Imipenem (c)	<=4			
Levofloxacin	<=2			
Linezolid	<=2			
Moxifloxacin	<=2			
Nitrofurantoin	<=32			
Norflo.acin	<=4			
Ofloxacin	<=2			
Oxacillin	N/R			
Penicillin	<=0.03			
Pip/Tazo (d)	<=4			
Rifampin	>2			
Synercid	<=1			
Tetracycline	<=4			
Trimeth/Sulfa	<=2/38			
Vancomycin	<=2			

S = Susceptible ...R = ... Reported Blank = Data not available, or drug not advisable or tested
I = Intermediate ... = ... Tested ESBL = Extended spectrum beta-lactamase
R = Resistance ...G = ... cine-de... Blac = Beta-lactamase positive
MIC = mcg/ml (mg/L)

R* = Resistant due to extended spectrum beta-lactamases (E...)
EBL? = Suspected ESBL. Confirmatory tests needed to differe... e ESBL ... other be...
IB = Inducible Beta-lactamase. Appears in place of Sensitiv... th speci... own to p... ...mases; potentially they may become resistant to all beta-lactam drugs.
Monitoring of patients during/after therapy is recomme... : Avoid c... /combine...

For blood and CSF Isolates, a beta-lactamase test is recommend... or Ente... cus specie...

(a) Use maximum doses of drug with an aminoglycoside for P. a... ...nosa i... ...ents with ... ...us infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axet... ...) use ... ...S=I, >... ...s to this drug.
(c) For streptococci refer to penicillin interpretations. For amox... ...K cla... ...cr a... ...ococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the ... ...illin int... ...ation. ... ...his drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 200... ...arfloxa... ...or Gram ... ...ofloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints a... ...for ... ...om p... ...s ...non-meningitis infections, use <2=S, 2=I, >2=R.

Name: [redacted] (b)(6)-4 Specimen: Status: Final
Patient ID: ...site Collected: (b)(6)-2
Ward/Rm: W1/ ... Of Is... Req. Phys: [redacted]

[redacted] b(2)-2

① Aerobic Cx
② Gram stain

Microbiology Request Form

Last Name: # [redacted] b(6)-4
First Name:
Patient # or SSN: # [redacted]

Collected by: DR. [redacted]
Date: 28 OCT 03 b(6)-2
Time: 1445

Ward: ICU 1
Room:
Bed:
Physician: Dr. [redacted] b(6)-2

Source: wound
Site: ① Leg (knee)

[redacted]

Received by: SPC [redacted]
Date: 28 OCT 03
Time: 1600

Specimen #:

Laboratory Results

Gram stain: No bacteria seen

Reported
Date: OCT 28 03
Time: 1900
Tech: SP
Reviewer:

Number of attached sheets:

Microbiology Report

[redacted] (b)(2)-2

Name: [redacted] (b)(4)-4
Patient ID:
Ward/Rm: /

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Preliminary
Collected:
Attd. Phys:

1 Staphylococcus hominis subsp. hominis Status: Preliminary

1 S. hominis-homin

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2				
Amp/Sulbactam (c)	<=8/4				
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	<=8				
Cefepime	<=8				
Cefotaxime (c)	<=8				
Ceftriaxone (c)	<=8				
Cephalothin	<=8				
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
Clindamycin	2	I			
Erythromycin	<=0.5	S			
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	<=4				
Levofloxacin	<=2	S			
Linezolid	<=2	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	<=2	S			
Oxacillin	N/R				
Penicillin	>8	BLAC			
Pip/Tazo (d)	<=4				
Rifampin	<=1	S			
Synercid	<=1	S			
Tetracycline	<=4	S			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. (b)(4)-2
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name: [redacted] (b)(4)-4
Patient ID:
Ward/Rm: /

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Preliminary
Collected:
Req. Phys: [redacted]

MEDCOM - 18949

Printed 10/22/2003 5:44:42 PM

Page 1 of 1

Tech: _____

ANESTHESIA PLAN OF CARE / PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

ASA Physical State (1 2 3 4 5 E

WT: ~70 KG/LB HT: ____ IN.

ALLERGIES: NKA

PROPOSED PROCEDURE: I & D L Tib poss bone graft 6 wks over 1 month ago

SURGICAL SERVICE: ortho

NPO SINCE: MN

HABITS:
TOBACCO: +
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Lovenox 1000
( ) Keflox 06
( ) ____
( ) LR IV
( ) MSO4 1900

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

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: ____

9.12 11.9 / 36.7 (292 X

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
Other Significant Hx:		
	N	Y
	N	Y
Familial HX	N	Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC

s/p I & D (L) leg Rx FIX

PHYSICAL EXAMINATION

BP 111/61 HR 85 R ↓ T 98.6
Pain Scale 0-10 ____ Sp 98%
HEENT - Teeth ____
Trachea ____
TMJ/Neck MPOI
Oropharynx ~~3+~~ 4
Nares ____
CHEST: BS ⊂ SA
CARDIAC: RRR ⊂ m
EXTREMITIES:
IV Access: (L) A 18g
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {X} 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 guardian seems to understand and agrees. Questions answered LTC

Signed: 9.16.03 Date: [redacted] Time: 0730 Hrs

blw-2

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICW 1 6A

[redacted]

blw-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.

S/P GSW to L thigh/tib

ANESTHESIA PLAN OF CARE- PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia) Smoker

Age 29 **DAYS MOS (YRS)** **Sex ( ) MALE ( ) FEMALE**

PROPOSED PROCEDURE: Washout D&D
SURGICAL SERVICE: Ortho
NPO SINCE: 1130 03

ASA Physical State 1 (2) 3 4 5 E
WT: 70 (KG/LB) HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) N/A
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

HB/HCT: ____ / ____
U/A: ____
OTHER: ____

N/A

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	____
Other Significant Hx:			
	N	Y	____
	N	Y	____
Familial HX	N	Y	____

ASSESSMENT
PAST SURGICAL/ANESTHETIC

N/A

PHYSICAL EXAMINATION
BP 161 HR 83 R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck FROM
Oropharynx Cl 3, 3/5 Th 1
Nares patent
CHEST: CTA/BS
CARDIAC: S1S2 RR
EXTREMITIES:
IV Access: RH (D) FA
Ulnar Filling: 2+
BACK: OK
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. via translator

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] b(6)-2 Date: 05 Jan 03 Time: 1320 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] b(6)-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.

MEDCOM - 18951

ACLU-RDI 1649 p.111

DOD-032525

MEDICAL RECORD - ANESTHESIA

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)	1330		1400		1430		1500	1530		1600	TOTALS	TOTAL EBL
Propofol (mg)	150							50			200	< 500cc
Fentanyl (cc)	2 3										5cc	
Succ (mg)	50										50	TOTAL URINE
Morphine (mg)						5		5			10mg	
( )												
Ancef (gm)			——— 1									
VOLAT AGENT Isoflurane % del	1.5 — 1.5 — 2 — 1.5 — 1.5 ——— 1.5 — 1.5 — off											
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	8 — 2 — 2 — 2 — 2 — 2 — 2 — 2 — 4 — 8											

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

FLUIDS

LINE site		
18g RFA	☐ Warmed	(400) (1004) LR #1 ~~~ #2 LR ~~~
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	500
URINE -	

FLUIDS - SUMMARY
CRYSTALLOID- 1900
COLLOID-
BLOOD- EBL - 500

REMARKS
Code drugs with numbers, events with letters

Anesthesia Break
Smooth induction
Eyes taped shut
1453 Tourniquet up for 60 min
1545 T down Total Time 92 min
@250 mmHg

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: ~ 70 (KG) LB

HEMATOCRIT:

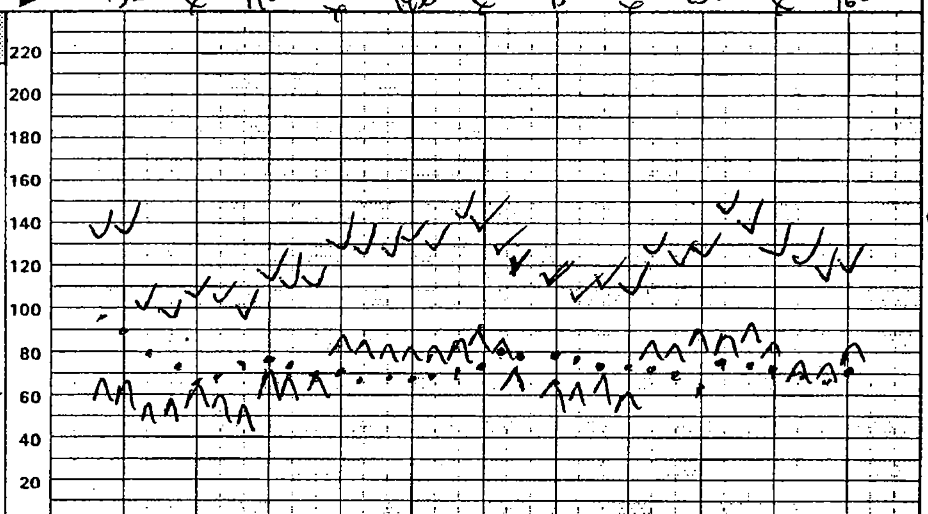
INITIAL DATA:
BP- 133/62
____/____
HR- 94

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE? ✓
TIME- 1315

TIME → 1330, 1400, 1430, 1500, 1530, 1600

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



VENTIL

VT - ml	750	780	810	810	820	810	820	820	800			
f - breaths/min	8	8	8	6	6	6	6	6	6			
Peak inf pres / PEEP	18	18	18	18	18	17	18	19	20			
MODE - S(pon), A(ssist), C(on)	S/A/C	C	C	C	C	C	C	C	C	A/S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)	38	33	31	29	32	33	37	35	33	47	47	51
BP/oth	✓ FiO2 (Frac or %)	1.0	1.0	.76	.76	.76	.76	76	76	76	76	76	76
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site skin			95	95	95	95	95	95	95	95	95	95
	N-M Block (T/4)												
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS EVENTS → Position: Supine

RECOVERY AT
(PACU) ICU ______ (Specify)
OTHER
CONDITION: Awake
RESP- 21 RR SpO2- 97%
BP- 142/87 HR- 123

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1325	1328	1619
	Ready	Begin	End
PROC	1335	1349	1607

PROCEDURES and Codes: I+D (L) OPEN TIBIA Fx w/external fixation

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* MAC 3 blade
OLX1 c #8.0 ETT. Secured @22cm lip (+) BBS (+) ETCO2

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: fw CRNA

PROCEDURE LOCATION: OR #2
DATE: 9/12/03
PAGE 1 OF 1

MEDCOM - 18952

DA FORM 7389, FEB 1998

ACLU-RDI 1649 p.112

DOD-032526

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
Propofol (mg)	150	150
Fentanyl (cc)	2 3	5cc
Vecuronium (mg)	6	6
Ketamine (mg)	20/20/10	50
Neostigmine/Robinul (mg)	3.0/0.4	3.0/0.4
( )		
VOLAT AGENT Forane % del	3—3—2.5—2—1.5—1.5—1	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	8-2—2—2—2—3—3—3—8	

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

TOTAL EBL 450

TOTAL URINE Ø

FLUIDS – SUMMARY
CRYSTALLOID– 1600
COLLOID– Ø
BLOOD– Ø

FLUIDS
LINE site 18g RAC ☐ Warmed (300) #1 (1000) #2
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS / URINE –

REMARKS– *Code drugs with numbers, events with letters*
Id'd / chart reviewed. To OR #2. Monitors, O2. Smooth IV induction, ETT taped. Start.
1005 Sx. Extubated c¯ (?) pressure N 100%.
To PACU.

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 70 KG

HEMATOCRIT 11.9/36.7

INITIAL DATA: BP – ___/___ HR–

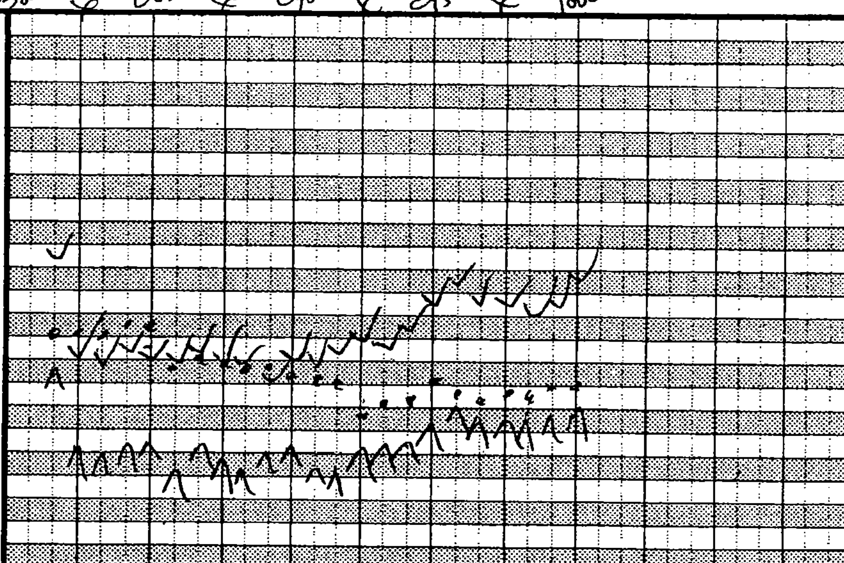
EQUIP CHECK OK?– (Y) N

PATIENT RECHECK OK for PROCEDURE? ✓ TIME–

TIME → 0800 x 0830 x 0900 x 0930 x 1000

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

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



VENTILATION

VT – ml / Mode	S/A/C – C – C	C	C	C'	A/S	S	S	S
f – breaths/min	8	7	7	7	7			
Peak insf pres / PEEP		20	20	20	19			
MODE– S(pon), A(ssist), C(on) TV		830	820	850	800			

MONITORS / ACCESSORIES
BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

ET CO2 (torr)		30	32	25	36	34	56	45
FIO2 (Frac or %)	.62	.64	.85	.84	.86	.86	.85	.91
SpO2 (%)	100	100	100	100	100	100	100	100
ECG	SR/ST	ST	ST	SR	SR	SR	SR	SR
TEMP- site skin		97	95	95	95	95	95	95
N-M Block (T/4)								

RECOVERY AT (PACU) ICU ______ (Specify) OTHER ______
CONDITION: Awake T-96.1
RESP– 20 SpO2– 98%
BP– 131/85 HR– 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0807	1015

	Ready	Begin	End
PROC	0815	0840	1000

Mark with letters & symbols, explain under REMARKS EVENTS Position → Supine arms on armboards < 90° @ shoulder

PROCEDURES and CPT Codes
I+D (L) tibia w/ antibiotic bead placement

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DL x1 (+)VC (+)ETCO2 (+)B=BS @ 22 cm lip MAC 3

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: NO afw

PROCEDURE LOCATION OR #2

DATE 5 wk 16 Sep 03

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(6)-4

MEDCOM - 18953 MEDICAL RECORD – ANESTHESIA

ACLU-RDI 1649 p.113

DOD-032527

GSW to leg 30 days AT0 → osteomyelitis
29 yo
MRSA
NKDA

MEDICAL RECORD — ANESTHESIA

DRUG (Units)	
MSO4 (mg)	10 / 4 / 4 / 2
lidocaine ( )	20
propofol ( )	200
VOLAT AGENT % del / % e.t.	Iso 1.5 1.5 1.5 X
AIR L/Min	
N2O L/Min	
O2 L/Min	8 - 2 - 3 - 2 - 6
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	induction

FLUIDS — LINE site: #20 (R) A/C — Warmed / Warmed / Warmed / Warmed — LR →

LOSSES — EST BLOOD LOSS / URINE –

TOTALS: 200 ml
TOTAL URINE —

FLUIDS - SUMMARY
CRYSTALLOID– LR - 1000
COLLOID–
BLOOD–

REMARKS-
Code drugs with numbers, events with letters
0730 - Met c 1° Pt Vol → Chart
1220 - On room. monitors on induction
1225 - Spont resp Opened eyes LMA ok
Recovered OK

PHYS STATUS 1 (2) 3 4 5 E
BODY WEIGHT 70 KG
HEMATOCRIT: 32.1 (19 Sept)
INITIAL DATA: BP – 111/61, HR– 85
EQUIP CHECK OK?– (Y) N
PATIENT RECHECK OK for PROCEDURE? (+)
TIME– 0730

TIME → 1215 x x (1230) x 30 x (1245)

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

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

VT – ml	160	430	310	230	
f – breaths/min	19	17	15	12	
Peak inf pres / PEEP	S/	S/	S/	S/	S/
MODE– S(pon), A(ssist), C(on)					
ET CO2 (torr)	48	41	51	41	40
FIO2 (Frac or %)	.64	.64	.64	.57	.98
SpO2 (%)	98	97	97	96	98
ECG	105	103	100	115	105
TEMP- site	axillary				
N-M Block (T/4)					

MONITORS / ACCESSORIES: BP/Auto Cuff, BP / oth, ART line, Steth- PC/ES, Gas analyzer, Warming blkt, Conv warmer — sheets/drapes

Mark with letters & symbols, explain under REMARKS — EVENTS Position → S armstucked c padded

smoker

RECOVERY AT PACU (circled) ICU (Spec) OTHER 35 Ske...
CONDITION: RESP– 15, SpO2– 10..., BP– 120/82, HR– 75

ANESTHESIA / PROCEDURE: ANES Start 1220 (0730 struck), Room 1220; PROC Ready 1230, Begin 123...

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
general LMA / 20 cuff - Eyes taped, soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Ready - LMA inserted x 1 attempt ETCO2 + ...

PROCEDURES and CPT Codes
Hickman Placement

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
4 [redacted] b(6)-4
TB

SURGEONS: [redacted] b(6)-2
ANESTHETISTS: [redacted]

PROCEDURE LOCATION #2
DATE 25 Sep
PAGE 1 OF

MEDCOM - 18954
WAMC OP 376 REVISED
1 Jan 99
PATIENT RECORD

ACLU-RDI 1649 p.114

DOD-032528

x1/63, 80, 18, T97.0
UKDA
vanco - colace

10/9/03
4.2 / 31 / 34.3
7

MEDICAL RECORD - ANESTHESIA

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)												
Versed (mg)	2/3				1.0						5	
Sufenta (mcg)	20	10										
Lido/propofol (mg)	30/110											
Vec	6	6								6	4	
MS04												
VOLAT AGENT: Forane % del												
% e.t.												
AIR L/Min		1	1	1	1.5	1.0	1.0	1.0	1.0	1.0	1.8	
N2O L/Min												
O2 L/Min	8	1	1	1	1	1	1	1	1	1	2	

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

FLUIDS

LINE site												
LR (500 ☐ Warmed		500					900	1000	1500	1700		
☐ Warmed												
☐ Warmed												
☐ Warmed					50	100	200	300	400	500		

LOSSES: EST BLOOD LOSS; URINE

TOTALS	TOTAL EBL
5 mg 45 mg	500
10 mg	TOTAL URINE: ∅

FLUIDS - SUMMARY

CRYSTALLOID- LR 1700
COLLOID- ∅
BLOOD- ∅

REMARKS

Code drugs with numbers, events with letters

0807 - Inv monitors applied,
0812 I & I ⊕ ETCO2 ⊕ B/L ab BS.
1625 Reversal 3mg Neostigmine 4mg Robinol
1045 Marcaine 5% by surgeon Dec loss Oral suction
1055 Spont resp purposeful movement extubated
1100 Transfered to Bed @ PACU spont Resp. Report given

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 70 (KG) LB
HEMATOCRIT: 36.6 (9 Oct)
INITIAL DATA:
BP- 137/75
HR- 77
EQUIP CHECK
OK? (Y) N
PATIENT RECHECK
OK for PROCEDURE?
TIME- 0740

TIME → X 30 X 09 X 30 X 10 X 30 X

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	5	800	760	600	640	620	690	740	700	450	SR	SR	
f - breaths/min	12	10	8	8	8	8	7	7	6	5	15		
Peak inf pres / PEEP		19	19	19	19	19	15	15	15	13		30	
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	50	48	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	32	31	30	31	32	32	32	32	40	50	167
BP/oth	FIO2 (Frac or %)	.67	.66	.67	.67	.67	.67	.67	.67	.67	.67	167	167
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Naso	SKIN			350			35	35		35		
	N-M Block (T/4)		0/4	0/4	0/4	0/4	0/4	0/4	1/4	3/4	4/4	5 Sec Rating	
Warming blkt													
Conv warmer													

RECOVERY AT 1105
PACU ICU ____ (Specify)
OTHER ____
CONDITION: awake cooperative
RESP- 20 SpO2- 100
BP- 135/75 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0700	0807	1105
PROC	Ready	Begin	End
	0815	OR 55	1052

Mark with letters & symbols, explain under REMARKS — EVENTS Position → o—/ T Ⓑ hip roll N

PROCEDURES and CPT Codes:
(L) Tibia

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
SFT placed one attempt grade 1 view - 3 mac blade secured 23cm teeth secured tape eyes taped

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2
ANESTHESIA: [redacted] CRNA b(6)-4

PROCEDURE LOCATION: OR 1
DATE: 10/18/03
PAGE 1 OF 1

MEDCOM - 18955 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

meds: V~~c Percocett Chart not ... BSCTA
Hx GSW ... 114/58 98-92-16 ... 98% ARRAY/om

MEDICAL RECORD - ANESTHESIA

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)				TOTALS
Fent	(cc)	3	2		5
...	( )	20/150			
VOLAT AGENT Iso	% del	1.5 — 1 — 1 — 1.6			
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	6 - 2 - 2 - 2			

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

TOTAL EBL: min
TOTAL URINE: ∅

FLUIDS

LINE site L PIV ☐ Warmed — 200 - 300 — 600
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS — 100
URINE -

FLUIDS - SUMMARY
CRYSTALLOID- LR 1000
COLLOID- ∅
BLOOD- ∅

REMARKS
Code drugs with numbers, events with letters
pt to stairs ... assist to OR. ... ... O2 ... ... induction
procedure done

PHYS STATUS 1 (2) 3 4 5 E
BODY WEIGHT: 70 (KG) LB
HEMATOCRIT:
INITIAL DATA:
BP- 112/60
HR- 92
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK
OK for PROCEDURE yes
TIME- 1400

TIME → 1430 x 1500 x 30

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

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

VENTIL

VT - ml	830	840	810	410	330
f - breaths/min	8	8	7	13	20
Peak inf pres / PEEP	14	14	15		
MODE - S(pon), A(ssist), C(on)	C	C	C	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	40	35	54	30
BP/oth	✓ FIO2 (Frac or %)	.7	.7	.7	.7	.7
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	Axill				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS → Position — OR Arms <90°

RECOVERY AT 1536
(PACU) ICU ____ (Specify)
OTHER
CONDITION:
RESP- 16 SpO2- 100%
BP- HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1400	1415	1540
	Ready	**Begin**	**End**
PROC	1420	1435	1530

PROCEDURES and CPT Codes:
I&D ; Washout (L) Tib

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
LMA #3 BS=B G.B.B. eyes taped
AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] Wd 1 Bed 7A
b(6)-4 ☆ MRSA ☆

SURGEONS: [redacted] b(6)-2
ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: OR 1
DATE: 28 Oct 03
PAGE 1 OF

DA FORM 7389, FEB 1998 MEDCOM - 18956 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

ACLU-RDI 1649 p.116

DOD-032530

NSN 7540-01-165-7294 591-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATIONS (S) REQUESTED	AGE / SEX	SSN *(Sponsor)*	WARD/CLINC	REGISTER NO.
(L) Knee (L) tibia AP/LAT	M		ICU	
	FILM NO.			PREGNANT ☐ YES ☐ NO
	REQUESTED BY [redacted] b(6)-2			TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR			DATE REQUESTED 13 SEP 03 in AM

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

1-day post op HD (L) tibfx

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
# [redacted] b(6)-4 EPW	LOCATION OF RADIOLOGIC FACILITY

MEDCOM - 18957

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

E PW [redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11 Sept	1300 HOURS	
1 Admit to ICU.		
2 Dx: GSW L leg (old)		
Fx Tib-Fib L leg (old)		
Condition stable		
2 V.S. per routine		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
3 I.V. Normal Saline at HOURS	TKO rate	
4 Activity: Bedrest		
5 CBC	already done in ER	
5 Vigot		
5 X-rays L leg		
6 Diet: Cereal diet		
7 NPO: after midnight		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
8 Notify Dr Hagate (ortho) of room # HOURS		
b(6)-2		
24 Chart [redacted] W/AN 12 Sept 0800		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
9/12/03	1615 HOURS	
MSO4 2mg IV q [redacted] MAX 20mg		
Phenergan 25mg IV PRN Nausea		
Demerol 12.5mg IV per shaver, MAX [redacted]		
[redacted] CRNA, CRT		
b(6)-2		

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

MEDCOM - 18958

☆ U.S. GOVERNMENT PRINTING OFFICE: 2001—478-200

b(6)-2 All

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] b(6)-4

DATE OF ORDER: 9/13/03 TIME OF ORDER: HOURS

LIST TIME ORDER NOTED AND SIGN: [redacted] 13 Sep

- Readmit to Floor
- S/p I/D / exfix / (L) tib fx
- Stable
- vitals / I&O's Routine
- NKDA
- FFNWB LLE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER: HOURS

- PT consult
- ROM (L) ankle, (L) knee
- ADAT to Reg
- LR @ 100cc/hr until tol po
- MSO4 1-4 mg IV q 20 min prn
- percocet 1-2 po q4 prn
- Tylenol 650 mg po/PR q6 prn

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER: HOURS

- phenergan 12.5 mg IV q6 prn
- AP/LAT (L) knee, (L) tibia in AM
- Lovenox 30mg SQ bid start AM of 9/13
- Routine call orders
- Distal NV ✓ q1° x4, then q4

NURSING UNIT: 24° 13 Sep 0005 [redacted]

PATIENT IDENTIFICATION: b(6)-4 # [redacted] Ø38

DATE OF ORDER: 14 Sep 03 0700 TIME OF ORDER: [redacted] HOURS

- Kefzol 1g IV q8° ✓
- Start pin care c 1/2 strength H_2O_2 BID.

[redacted] 9/14/03

NURSING UNIT: 1CW1 | ROOM NO. | BED NO.

[redacted] 14 Sep 03 0100 [redacted]

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

b(6)-2

MEDCOM - 18959

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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
b(6)-4
EPW # [redacted]

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

- NPO p̄ MN for OR tomorrow
- LR @ 100cc/° p̄ MN
- hold lovenox after PM dose
- D/C Bedrest. may ambulate FFWB LLE c̄ crutches

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted] [illegible] 24° Chart✓ 15Sep03 1930 [redacted]

PATIENT IDENTIFICATION
b(6)-4
EPW # [redacted]

DATE OF ORDER | TIME OF ORDER | HOURS
b(6)-2

16Sept03 1000
Readmit to Floor
Resume prev orders
ADAT to Regular.
LR @ 100cc/° until tol po - then hepwell
then continue Kefzol 1g IV q8°
resume Lovenox 30mg SC [redacted]

NURSING UNIT | ROOM NO. | BED NO.
ICU | | J24°

[redacted] 9/17/03 0430

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS
17Sept03 1921 b(6)-2 b(6)-2

May remove splint for PT
PT for ambulation, ROM (L) knee, ankle
FFWB LLE

b(6)-2
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted] [illegible] 24° Chart✓ 18Sep03 1930

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

18Sept03 0941
~~Pin care BID c̄ 1/2 str H2O2 please~~

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLA MEDCOM - 18960 ICH MAY BE USED.

b(6)-2 AR)

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

CPW b(6)-4 [redacted]

DATE OF ORDER | TIME OF ORDER (HOURS) | LIST TIME ORDER NOTED AND SIGN

19Sep03 0930 — D/c levofl
— Vancomycin 1g IV q12h
— Lytes, renal, ~~today~~ ESR today
— Aggressive pin care please to prevent infection.

NURSING UNIT: ICU | ROOM NO.: 24 Chart | BED NO.:

19Sep03 1945 [redacted] MD

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (HOURS)

UPDATE

Noted [redacted]

20Sep03 0717
Ensure c meals tid
Serum creatinine please.
ESR (sed Rate) today please.

NURSING UNIT: ICU | ROOM NO.: 2730 | BED NO.: 24 [redacted]

9/20/03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (HOURS)

21Sept03 0832 Colace T po bid [redacted]

NURSING UNIT | ROOM NO. | BED NO.: 24 [redacted]

0011 9/22/03

21 Sep 0830

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (HOURS)

22Sept03 0830
PICC Line - consult Dr. [redacted] of Radiology to PICC for long-term Abx.
Leave all wounds open to air please
no pin dressing please [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 18961 WHICH MAY BE USED.

b(6)-2

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 [redacted] COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

noted 25 Sep 03 2000

b(6)-4

25 Sep 1939 ____ HOURS

Flush Hickman each c 2 cc heparinized saline p wave administration (1st flush c NS) then 2 cc 1:10000 heparin in saline)

NURSING UNIT | ROOM NO. | BED NO.

24W RM [redacted]

PATIENT IDENTIFICATION [redacted]

25 Sep 03 2002

DATE OF ORDER | TIME OF ORDER

27 Sep 03 0913 ____ HOURS

b(6)-2

b(6)-4

MEDICAL ORDERS

29 Sep 03 0900

√ Serum lytes, renal today (incl glucose creatinine).

plan probable D/C to EPW on POD

NURSING UNIT | ROOM NO. | BED NO.

ICW [redacted]

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER | TIME OF ORDER

____ HOURS

noted 30 Sep 03 1000

30 Sep 03 9 AM

May D/C to EPW hospital when bed available

D/C sermons and sutures on chest.

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

noted [redacted] 30 Sep 03

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER | TIME OF ORDER

____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 18962 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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4	25 Sep 03	0932 HOURS	D/C lovenox
			b(6)-2 [redacted]
NURSING UNIT: ICU1 / ROOM NO.: 24V / BED NO.: 25803			1930 b(6)-2 [redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLA MEDCOM - 18963 ICH 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] b(6)-4

DATE OF ORDER 10-3-03 TIME OF ORDER ____ HOURS

LIST TIME ORDER NOTED AND SIGN

Re-Admit ICW-1 Dx [redacted] b(6)-2

✓ Routine Vitals

✓ Stable

✓ OOB & ambulate c̄ crutches

NWB (L) LE

✓ BID pin site care, ½ H2O2

✓ Regular Diet

noted 3 Oct @ 1930

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION [redacted] b(6)-4

DATE OF ORDER TIME OF ORDER ____ HOURS

✓ Percocet ii po q4° prn pain

✓ Vancomycin 1gm IVPB q12°

✓ PT for ROM exercises ankle & knee

✓ MRSA contact precautions

– ~~Sterile dressing DS q3 days at Hickman catheter site~~

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION 2340/2330 3 OCT 03 [redacted]

DATE OF ORDER TIME OF ORDER ____ HOURS b(6)-2

[redacted]

04 OCT 03 0955 – BID WTD NS Dressing DS to (L) leg

– Colace T po bid.

– pin care c̄ ½ Str. H2O2 [redacted] b(6)-2

Noted [redacted] 04 OCT 03 1045

NURSING UNIT ROOM NO. BED NO.

2340/ 05 OCT 03 ~~0550~~ [redacted]

PATIENT IDENTIFICATION b(6)-4 [redacted]

DATE OF ORDER 08 OCT 03 TIME OF ORDER 1200 HOURS

– AP/LAT (R) tib-fib today.

b(6)-2 [redacted]

Noted [redacted] 8 OCT 03 2245

NURSING UNIT b(6)-2 ROOM NO. BED NO.

2340/ 8 OCT 03 0030 [redacted]

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

MEDCOM - 18964

ACLU-RDI 1649 p.124

DOD-032538

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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
2A [redacted] b(6)-4	9 OCT 03	HOURS	
	AP/LAT (L) tib/fib today		
	ESR today please		
			9 OCT
NURSING UNIT / ROOM NO. / BED NO.			
2A Chart	9 OCT 03 1930		[redacted] b(6)-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
	16 OCT 03 0830	HOURS
	- NPO p MN	
	- LR @ 100 cc/ p MN	
	- plan OR tomorrow.	
		[redacted] b(6)-2
NURSING UNIT / ROOM NO. / BED NO.		
2A 0100 17 OCT 03		

PATIENT IDENTIFICATION	DATE OF ORDER
[redacted] b(6)-4	HOURS
17 OCT 03 0830A	Regular diet
	NPO - MN for OR tomorrow
	no OR today
	plan OR tomorrow
	LR @ 100 cc p MN
	keep vein open
NURSING UNIT / ROOM NO. / BED NO.	
2A 0100 18 OCT 03	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
[redacted] b(6)-2	18 OCT	1600 HOURS
	(1) MSO4 2-8 mg q 1-2 hr PRN pain	
		[redacted] b(6)-2
NURSING UNIT / ROOM NO. / BED		
2A [redacted]	18 OCT 03 2230	

DA FORM 1 APR 79 4256 [redacted] WHICH MAY BE USED.

MEDCOM - 18965

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] b(6)-4

NURSING UNIT [redacted] BED NO. [redacted]

DATE OF ORDER 10/19/07 TIME OF ORDER 1112 HOURS

LIST TIME ORDER NOTED AND SIGN

- Return to ICW 1 / [redacted]
- Resume preop orders / meds
- Fragmin ~~at~~ 5000u SQ BID start AM 10/19 b(6)-7 AM
- elevate LLE
- PT for ROM knee start [redacted] 10/21
- Regular diet

PATIENT IDENTIFICATION [redacted] b(6)-2

NURSING UNIT [redacted] ROOM NO. [redacted] BED NO. [redacted]

DATE OF ORDER [redacted] TIME OF ORDER [redacted] HOURS

- LR @ 100cc/° until tolpo
- HCT @ NOON please [redacted]
- 1 Xray, PA/LAT (L) knee portable VO Dr [redacted]

PATIENT IDENTIFICATION

NURSING UNIT [redacted] ROOM NO. [redacted] BED NO. [redacted]

DATE OF ORDER 19OCT07 TIME OF ORDER 1110 HOURS

- Dc Fragmin
- heparin 5000u SQ BID
- V.O. Dr. [redacted]

PATIENT IDENTIFICATION

NURSING UNIT 24 ROOM NO. [redacted] BED NO. 20 OCT @ 0230 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT [redacted] ROOM NO. [redacted] BED NO. [redacted]

DATE OF ORDER TIME OF ORDER HOURS

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

MEDCOM - 18966

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]

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

19 Oct 1003 D/C previous Morphine order. MSO4 1-5mg IV q 30 min pr encourage po.

blw-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER | TIME OF ORDER ____ HOURS

24°V 20 Oct @ 0230

24°V 24 Oct @ 0520

24°V 25 Oct @ 0005

[redacted]

blw-3

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 18967

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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				10-27-03	0530 HOURS	
				- Remove Staple (D) leg		
				Sutures (E) I+P		
				Apply benzoin steri strips		
				- D/C to AMP & crutches		
				- D/C central line		
NURSING U		BED NO.				
					b(6)-2 [redacted]	
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF O	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

MEDCOM - 18968

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	10/23/03 1520		
	POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. prn SaO_2 ↓ 93%		
(3)	Morphine / ~~Meperidine~~ ____ ~~mg IV~~ now and 2-4 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: LR @ 100 cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] b(6)		

PATIENT IDENTIFICATION

#[redacted] b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: Ø

Nursing Unit	Room No.	Bed No.	Page No.
PACU, [redacted]	b(2)-2		1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

b(6)-2 A11

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: b(6)-4 [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10-28-03	1000 HOURS	

NPO now

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU		

[redacted] 10/28/03 1030

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
10-24-03	1930 HOURS

- Resume pre-op orders, meds, activities.
- Regular Diet
- Record output of Drains & Foley.

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
24W	0400	2

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
10-25-03	1620 HOURS

Dc SQ heparin

[redacted]

[redacted] 0948

NURSING UNIT	ROOM NO.	BED NO.
24W	0330	1

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

MEDCOM - 18970

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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
blue-4 [redacted]	11-1-03	_____ HOURS	
	- D/C to EPW CAMP		
	- Include meds for D/C		
	- Give patient dressing supplies		
	4x4's, Kerlix roll and 4" ace wrap.		
blue-2 Voided [redacted]	- F/u 1 week.		
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		
		blue-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.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		_____ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLACE MEDCOM - 18971 WHICH MAY BE USED.

blue-2

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. 9 Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11 12 13 14 15 16 17 18 19 20 21 22 23
9/11	[redacted]	VS per Routine	06 18 18 06	[redacted]
9/11	[redacted]	Activity - bRest	06 18 18 06	[redacted] D/C 9/15/03 1110
9/11	[redacted]	General	06 18 [illegible]	[redacted] D/C 1
~~9/12~~	[redacted]	~~Finger Stick q 4p~~	~~[illegible]~~	[redacted]
			08 18 24	
12	[redacted]	I+Os Routine	06 18	[redacted]
12	[redacted]	FF NWB LLE (Flat foot)	06 18	[redacted]
12	[redacted]	Adv AT to Reg (ensure meals TID)	06 18	[redacted]
9/13	[redacted]	Restraint check q shift	6 18	[redacted]
9/14	[redacted]	Start pin care c ½ strength H2O2 pin care BID	08 20	[redacted]
9/15	[redacted]	May Ambulate FF NWB LLE c Crutches	06 18 18 22	X X X X X X X X [redacted]
9/19	[redacted]	Aggressive pin care please to prevent infection	06 18 18 06	[redacted]

ALLERGIES: ☐ YES ☐ NO NKDA

PRIMARY DIAGNOSIS: GSW (L) leg (old) S/P HD ex fix (R) tib fx Fx T12-Fx6 (L) leg (old)

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO: 1

PATIENT IDENTIFICATION: blue-4 [redacted]

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

MEDCOM - 18972

blue-2 A11

BLW-2 AVI

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sept Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/11	[redacted]	Admit to ICW, Stable	9/11			[redacted]
9/11	[redacted]	CBC, MET, X-rays leg	9/11	done in ER		[redacted]
9/11	[redacted]	NPO p MN	9/11	2400		[redacted]
9/11	[redacted]	Notify Dr [redacted] (ortho) of Admit	9/11			[redacted]
12	[redacted]	Readmit to Floor; Stable	9/12	—		[redacted]
12	[redacted]	PT consult; ROM (L) ankle (L) knee				[redacted]
12	[redacted]	AP/LAT (L) knee, (L) tibia in AM	9/13	—		[redacted]
9/16	[redacted]	NPO p MN. For OR tomorrow	9/15			[redacted]
9/16	[redacted]	Readmit to floor	9/16			[redacted]
9/17	[redacted]	May remove splint for PT	9/17	noted		[redacted]
9/17	[redacted]	PT for ambulation, ROM (L) knee, ankle & FTWB LLE	9/17	noted		[redacted]
9/19	[redacted]	Lytes, renal, ESR today	9/19		1040	[redacted]
20 Sept	[redacted]	serum creatinine please	20 Sept			[redacted]
20	[redacted]	ESR (sedrate) today please	20			[redacted]

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

USAPA V1.00

b(6)-2 Anl

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. SEP *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (24 25 26 27 28 29 30 1 2 3 4 5 6)
12SEP	[redacted]	Distal N/V Checks q4°	6 / 10 / 14 / 18 / 22 / 02	/ [redacted]
11SEP	[redacted]	Vital Signs Routine	6 / 18	[redacted]
12 SEP	[redacted]	FFNWB LLE (Flat foot)	6 / 18	[redacted]
12 SEP	[redacted] 9/28	Reg Diet	6 / 12 / 18	[redacted]
14 SEP	[redacted]	Pin Care c 50/50 H_2O_2 & H_2O BID "AGGRESSIVE"	10 / 22	[redacted]
15 SEP	[redacted]	Ambulate FFNWB c crutches LLE	06 18 / 18 30	[redacted]
29Sep	[redacted]	HICKMAN CATH DRSG Δ q3days c sterile technique	10	/ / [redacted] / / [redacted] / / ☐ / / ☐

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: SPI&D ex fix, tib fx — 68W @ leg old Tib fib @ leg old

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO PAGE NO: 3

PATIENT IDENTIFICATION: EPW # [redacted] b(6)-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

MEDCOM - 18974

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

b(6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 09 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/28	[redacted]	NPO p MN	9/28	2400	noted	[redacted]
9/28		To OR tomorrow	9/29			
9/29		V Serum lytes, renal today (include creatinine)	9/29	done		
9/29	[redacted]	Plan: Probably D/C to EPW Hosp on 10/1	10/1	1		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

b(6)-2 A11

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. 9 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 22 23 24 25 26 27 28 29 30
9/22	[redacted]	Leave all wounds open to air please. No pin dressing please	06 18 [redacted]	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

PATIENT IDENTIFICATION:

[redacted]

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

b(6)-2A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/22	[redacted]	PICC Line - Consult Dr	9/22	Sent 0855		[redacted]
	----	[redacted] of Radiology				
	----	for PICC for long term Abx				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED														
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----	----																
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USAPA V1.00

b(6)-2A11

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 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 29 30 31
0300	[redacted]	Routine Vitals	6	[redacted]
			18	
29	[redacted]	OOB & AMB c entries	6	
		NWB LLE	18	
	[redacted]	Regular diet	6	
		Encourage po	18	
	[redacted]	MRSA precautions	6	
			18	
	[redacted]	P.T. for ROM exercises	6	
		while here / knee ROM	18	
↓	[redacted]	Elevate LLE	6	
			18	
29 Oct	[redacted]	Record I/O output	8	
		8 shift	16	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (L) Leg TIB/FIB

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-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

D(4)-2 A 11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 10 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
01 NOV	[redacted]	DC to EAN camp - Include meds	01 Nov 03			[redacted]
↓	[redacted]	Give pt dsg supplies (4x4s, Kerlex, Ace wrap)	01			[redacted]
↓	[redacted]	F/U 1 week	01			[redacted]

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

USAPA V1.00

blw-2 ATL

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24	25	26	27	28
03 OCT 03	[redacted]	Routine vitals	06 18	[redacted]												
			18 06													
03	[redacted]	OOB & amb C crutches	06 18													
		NWB LLE	18 06													
03	[redacted]	BID pin site care 1/2	06 18													
		H2O2	18 06													
03	[redacted]	Regular diet	06 18													
			18 06													
03	[redacted]	MRSA precautions	06 18													
			18 06													
03	[redacted]	PT for ROM exercises	06 18													
		while here	18 06													
03	[redacted]	Sterile drsg Δ q 3 days	10	/	/	/	/	/	/	/	/	/	/	/	/	/
		Hickman Cath. site														
04 OCT 03	[redacted]	BID WD NS dressing	10	→												
		Δs to @ leg	22													
18	[redacted]	Elevate LLE	06	/	/	[redacted]										
			18	/	/											
18	[redacted]	PT to have ROM knee	06	/	/											
		Δ as tolerated Δ'd 10/21	18	/	/											
19 OCT 03	[redacted]	Encourage po	06 18	/	/											
			18 06	/	/											

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW @ LEG TIB FIB

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

blw-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

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 10	Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/16	[redacted]	NPO p MN	10/16	2400	2400	[redacted]
10/16	[redacted]	Plan OR tomorrow	10/17	O/C	Dec	
10/17	[redacted]	NPO p MN for OR Tomorrow	10/18	0001	0001	[redacted]
18	[redacted]	Return to ICW1 / Muscato				
18	[redacted]	Resume preop orders/meds				
18	[redacted]	HCT @ ~~1200~~ Noon, please	18 Oct	1200	1200	[redacted]
18	[redacted]	x-ray pa ap + lat @ knee;	18 Oct	—	—	[redacted]
27 Oct 03	[redacted]	Remove staples (R) leg/sutures (R) hip	27			
27	[redacted]	Apply benzoin & steri strips	27			
27	[redacted]	D/C to camp c̄ crutches	27			
27	[redacted]	D/C central line	27			
10/28	[redacted]	NPO	10/28	1000		

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

USAPA V1.00

MEDCOM - 18981

(DCW)-2 A11 (

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3 4 5 6 7 8 9 10 11 12 13 14 15
10/3/03	[redacted]	Routine vitals	06	[redacted]
10/3/03	[redacted]	Condition: stable	06	
10/3/03	[redacted]	OOB + ambulate c crutches NWB @ LE	06	
10/3/03	[redacted]	BID pin site care 1/2 H2O2	06	
10/3/03	[redacted]	Regular diet	06	
10/3/03	[redacted]	MRSA precautions	06	
10/3/03	[redacted]	PT for ROM exercises while here	06	
10/3/03	[redacted]	Sterile dsg Δ q 3 days @ Hickman catheter site	06 10 X	[redacted]
10/4/03	[redacted]	BID WTD NS Dressing Δs to @ leg	10 22	[redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (L) leg tib/fib

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

DLW-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

Rules - 2 All

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 10 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
08 OCT 03	[redacted]	AP/LAT R TIB/FIB TODAY	08 OCT 03			[redacted]
9oct	[redacted]	AP/LAT (L) tib fib today	9oct			
9oct	[redacted]	ESL today please	9oct			
03 OCT 03	[redacted]	condition-stable	03 OCT 03			

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

USAPA V1.00

b(6)-2A 11

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. SEP Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21 22 23 24 25 26 27 28 29 30 1 2 3 4 5 6 7
17 SEP	[redacted]	Lovenox 30mg SQ BID	10	[redacted] D/C 9/25/03
			22	
16 SEP	[redacted]	HL IV when Tolerating PO	6	[redacted]
			18	
19 SEP	[redacted]	Vancomycin 1gm IV q 12°	10	[redacted]
			22	
21 SEP	[redacted]	Celace PO BID	10	[redacted]
			22	
		PRN MEDS		
17 SEP	[redacted]	Ms Sulf 1-4mg IV q 20min PRN		
17 SEP	[redacted]	Percocet 1-2 po q 4° prn		28 Sep 2110 2 / 29 Sep 2000 11 / 30 Sep 2030 4 [redacted]
17 SEP	[redacted]	Tylenol 650mg po q 6° prn		
17 SEP	[redacted]	Phenergan 12.5mg IV q 6° prn		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW ② Leg (c/d)
s/p I&D
ext fix, tib fib Fx Tib Fib ② Leg (c/d)

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO. 2

PATIENT IDENTIFICATION:

E # [redacted] b(6)-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 - 18984

b(4)-2 A11

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. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9 20 21 22
				11 12 13 14 15 16 17 18 20 21 22 23
9/11	[redacted]	NS @ TKO rate	06 18 18 06	[redacted] D/C
12	[redacted]	LR @ 100cc/hr until tol PO	06 18	[redacted] D/C
12	[redacted]	Lovenox 30mg SQ BID; start 8PM of 9/13	16 22	[redacted]
12	[redacted]	Distal NVV q1° x4 then q4°	06 18	[redacted]
9/14	[redacted]	Kefzol 1g IVq 8°	06 14 22	[redacted] 9/14/03 D/C
9/15	[redacted]	LR @ 100cc° IV mw	06 18 18 06	XXXX [redacted] D/C'd 9/16/03
9/16	[redacted]	HL when tolerating PO	06 18 18 06	[redacted]
9/19	[redacted]	Vancomycin 1gm IVq12°	10 22	[redacted]
9/21	[redacted]	Colace 1 po bid	10 22	[redacted]

ALLERGIES: ☐ YES ☐ NO NKDA

PRIMARY DIAGNOSIS: GSW (L) leg (old) S/P I+D ORIF tx, HL & Fx TIB-Fib (L) leg (old)

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO. 1

PATIENT IDENTIFICATION:

EPW # [redacted]

b(4)-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 - 18985

b(6)-2 All

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Sept Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given** / **Initials**
9/15	[redacted]	Hold Lovenox p̄ pm dose	9/15		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
12	[redacted]	MS04 1-4mg IV	D/T	12Sep 1733	13Sep 0700	13Sep 1900	14Sep 0925	14Sep03 2145	15Sep03 1900	9/16	19Sep03 4mg					
		q20min PRN	D/I	4mg	4mg	4mg	4mg	4mg	4mg	2115	1920					
				[redacted]												
12	[redacted]	Percocet i – ii	D/T	11Sep 2050	13Sep 1345	13Sep 1900	13Sep 0800	14Sep 0930	14Sep03 1930	9/16 1620	9/16 2200	9/17 1900	~~9/18 2300~~	9/18 1010	18Sep 2030	20Sep 2100
		PO q 4° PRN	D/I	[redacted]							2	2	~~2~~	ii	ii	i
12	[redacted]	Tylenol 650mg	D/T	13Sep 1000	17Sep 2230											
		PO/PR q6° PRN	D/I	650	2											
				[redacted]												
12	[redacted]	phenergan 12.5mg	D/T	14Sep03 2145		19Sep03 1920										
		IV q6° PRN	D/I	12.5mg		12.5mg										
				[redacted]		[redacted]										
9/12	[redacted]	Percocet i – ii PO Q4 PRN	D/A/I			23Sep03 0330 ii										
						[redacted]										

USAPA V1.00

MEDCOM - 18986

b(4)-2 All

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 25 26 27 28 29 30
25Sep93	[redacted]	Flush Hickman Catheter c 2cc Heparinized Saline p Vancomycin administration (1st flush c NS, then 2cc 1:10,000 heparin. Saline)	0400 1800	X [redacted]

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: S/P I&D ex fix (L) tib fx GSW (L) leg (old) fx tib-fib (L) leg (old)

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

PATIENT IDENTIFICATION:
SPW
#[redacted]
b(4)-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 - 18987

b(6)-2 A11

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. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
30 OCT	[redacted]	Vancomycin 1gm	10	[redacted]
		IVPB q12°	22	
4 OCT	[redacted]	Colace + po BID	10	
			22	
~~4 OCT~~	[redacted]	LR @ 100cc/hr	06	D/C 17 OCT 03
			18	
17 OCT	[redacted]	LR @ 100cc/hr	06	D/C
		IV MN	18	
18	[redacted]	Fragmin 5000 u SQ	10	D/C 19 OCT 03
		BID, start AM of	22	
		10/19		
18	[redacted]	LR @ 100cc/hr until	06	[redacted]
		to PO	18	
19 OCT 03	[redacted]	Heparin 5000U SQ	10	
		BID	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 18988

DIED - 2 AM

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing — Mo. 10 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
17 oct	[redacted]	Heplock IV NOW	17 Oct	NOW	1100	[redacted]
18 OCT 03	[redacted]	D/C previous MSO4 order	18 OCT 03	—		[redacted]
19	[redacted]	D/C Fragmin	19	—		[redacted]

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY														
30 OCT	[redacted]	Percocet ii po Q4°	D/T	16 OCT 2215	17 OCT 2240	18 OCT 2002	18 OCT 2200	19 OCT 1100 ii	19 OCT 2215	20 OCT 0217	20 OCT 1915	21 OCT 0515	21 OCT 2000	22 OCT 1120	23 OCT 1105	23 OCT 2000
		PRN pain	D/	ii	ii		2	ii	ii	2	ii	ii	ii	2	ii	ii
				[redacted]												
18 OCT	[redacted]	MSO4 2-8mg q 1-2°	D/T	18 OCT 1611	18 OCT 2002	18 OCT 2310	18 OCT 1037	}								
		PRN	D/T	8mg 9M	8 TA	8 TA	8 TA	{ D/C 19 OCT 03								
					E	E	E	}								
19 OCT 03	[redacted]	MSO4 1-5mg IV q 30 min prn	D/T	19 OCT 1830	20 OCT 0617	20 OCT 2230	21 OCT 0515									
			D/T	3mg	5	5mg	4									
				[redacted]												
Rewrite	[redacted]	Percocet ii po Q4° Prn pain	DT		24 OCT 1245	24 OCT 2045	25 OCT 1330	25 OCT 2030	26 OCT 1100	26 OCT 2330	27 OCT 2220	28 OCT 1640	28 OCT 2015	29 OCT 0205	29 OCT 1025	30 OCT 0530
			D/T		ii	1 po	ii	[illegible]	2	[illegible]	ii	ii	ii	ii	ii	2
					[redacted]											
			D/T	30 OCT 1740												
			D/T	ii [redacted]												

*U.S. GPO: 1996-454-110/95216

MEDCOM - 18989

b(6)-2 All

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 Oct Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				3 4 5 6 7 8 9 10 11 12 13 14 15 16
3Oct03	[redacted]	Vancomycin 1gm IVPB q 12°	10 / 22	[redacted]
04 Oct03	[redacted]	Colace I po bid	10 / 20	[redacted]
16 Oct	[redacted]	LR @ 100cc ° p MN	06 / 18 / 18 / 06	[redacted]
3Oct03	[redacted]	PRN Medication		3Oct 2010, 4Oct 2020, 5Oct 2030, 10/6, 6Oct 2130, 7Oct 2000, 8Oct 2230, 9Oct 2215, 10Oct 1930, 11Oct 1655
		Percocet II PO q 4° PRN pain		[redacted]
		Percocet II po Q4° prn pain		11Oct 1915, 12Oct 2015, 13Oct 1930, 15Oct03 1840 / II II II II [redacted]
16 Oct	[redacted]			

ALLERGIES: ☐ YES ☒ NO | PRIMARY DIAGNOSIS: GSW ② leg tib fib

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. 1

PATIENT IDENTIFICATION:
[redacted] b(6)-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 - 18990

b(6)-2 All

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. 10 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1												
30 OCT	[redacted]	Vancomycin 1gm	10	.													
	-----	IVPB Q12°	22	[redacted]													
20 OCT	[redacted]	Colace 100 BID	10														
	-----		22	[redacted]													
18 OCT	[redacted]	HLIV	06	[redacted]													
	-----		18	[redacted]													
18 OCT	[redacted]	Heparin 5000 units	10	[redacted]													
	-----	SQ BID	22	[redacted]													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (L) Lg TIB/FIB

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 18991

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/ Explr Date / Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
31 Oct [redacted]	Percocet 1+po Q4P PRN	D/T	31 Oct	31 Oct 1900	31 Oct 2045											
	b(6)-2 All	D/T	1184	1+po	1+po											
1900 [redacted]	MSO4 1-5mg IV Q30 min PRN	D/T	[redacted]													
		D/T														

*U.S. GPO: 1998-454-110/95216

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: 12 SEPT 03 Anesthesia Type (Circle)): General Spinal Epidural
Time In: 1610 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 1900 Colloid
Pre-op V/S: 1610 OR Output: UOP EBL 500
Procedures: I+D (L) thigh Meds/Times: ANCEF, MSO4, fentanyl
left fix place.

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

Pre Op Meds History

Time	1610	1643	1720	1750	1755
SaO2	97	99	99	99	
FiO2					
Methods	RA	RA	RA	RA	

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

RR	20	18	20	20	
T	98.6				
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1610	LR	1000	(L) hand	DC	HOD

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
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	2	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			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	9	9	9

Codes

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

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)

PREPARING [redacted] LPN (blue)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 12 SEPT 03

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

[redacted] T-PA

[redacted] blue-2

ICW #1

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

blwd - 2 A11

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1615		MSO4 2mg	IV		I	[redacted]
1625		MSO4 2mg	IV		I	
1635		MSO4 2mg	IV		I	
1640		MSO4 2mg	IV		I	
1645		MSO4 2mg	IV		I	
1700		MSO4 2mg	IV			
1715		MSO4 2mg	IV			

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P.	Cap Refill	T	
Adm	(L) leg	LROM	+	P	B	C	PK
15'	(L) leg	LROM	+	P	B	C	PK
30'							
45'							
60'							
90'							
D/C	(L) leg	LROM	+	P	B	C	PK

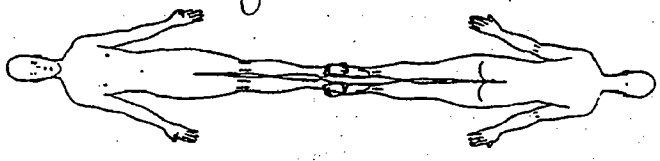
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	AE C dr-fix.	C
30'			
60'			
D/C	(L) leg	AE C dr-fix	C



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1610	ST	D	D

NURSING NOTES

Pt to recovery room from OR s/p I+D (L) tibia, ext fix. Placement of IV of LR infusing into (R) AC. c/s/s of redness or swelling to site. (L) leg AE C ext fix. NV intact. VSS. Will continue to monitor & assess. [redacted] QHR

1615 - Pt c/o pain. Medicated C 2mg MSO4 [redacted] HR

1625 - Pt continues to c/o pain. Medicated C 2mg MSO4 [redacted] HR

1635 - Pt continues to c/o pain. Medicated C MSO4 2mg; leg elevated. Will continue to assess [redacted] HR

1640 - Pt continues to cry C c/o pain. Medicated C 2mg MSO4 [redacted] HR

1645 - Pt continues to c/o pain. MSO4 2mg given. [redacted] HR

1700 - Medicated C 2mg MSO4 [redacted] HR

1715 - 2mg MSO4 [redacted] HR

Report given to RN. Pt to [redacted] #1 [redacted]

Discharge Criteria:
Date: 12 Sept **Time:** **PARS:** 9
BP: 136/89 **T:** 96.3 **HR:** 88 **RR:** 16 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 700 **Output:** 0
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: W/C Gurney Ambulance
Transferred By: ST
Cleared IAW Recovery Ro[redacted]
rse Signature: [redacted]

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: 16 Sept 03
Time In: 1010
Allergies: NKDA
Pre-op V/S:
Procedures: I+D (L) Thigh c Antibiotic Beads Placement

Anesthesia Type (Circle): ~~General~~ Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1600 Colloid
OR Output: UOP EBL
Meds/Times: Fentanyl Ketamine

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1010	1045	1055	1107	1120
SaO2	98	97	99	100	100
FiO2	RA	RA	RA	RA	RA
Methods	RA	RA	RA	RA	RA
RR	22	19	24	19	
T	96				

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1010	LR	800	R ANK	TC	200

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
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	2	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			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes

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

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)

b(6)-2

PREPARED BY [redacted] LRL

DEPARTMENT/SERVICE/CLINIC PACU

DATE 16 SEPT 03

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

EPW # [redacted] b(6)-4

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

bed - 2 All

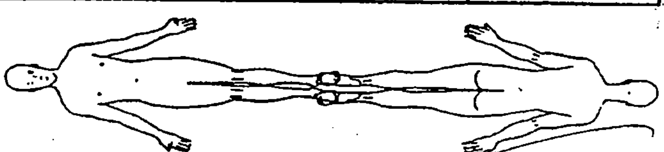
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg	(-) ROM	+		B	W	PK
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, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) leg	splint c ext fix	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1010	ST	Ø	Ø

NURSING NOTES

Pt to recovery room from OR s/p I&D (L) tibia c antibiotic bead placement. (L) leg has post leg splint c ext fix. IV of LR infusing into (R) arm. Ø s/s of redness or swelling to (L) ... VSS. NAD @ this time. Will continue to monitor & assess. [redacted]

Discharge Criteria:
Date: 16SEPT Time: 1040 PARS: 10
BP: 132/77 T: 96 HR: 91 RR: 16 Sa02: 98
Pain Level at D/C (0-10):
Intake: 100 Output: Ø
Additional Data:
Transferred To: ICW#1 [redacted]
Report Given To: SPC [redacted]
Transferred Via: W/C Litter Gurney Am[redacted]
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SO[redacted]
[redacted]e Signature: [redacted]

WAMC OP 173-E

MEDCOM - 18996

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: 18Sep03
Time In: 1107
Allergies: _____
Pre-op V/S: 137/75 HR 77
Procedures: ex fix removal, internal fix done left lower leg
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1700 Colloid _____
OR Output: UOP 0 EBL 500cc
Meds/Times: 5mg Versed 45mcg Sufenta 40mg MSO4

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

Pre Op Meds — History

Time	1107	1117	1117	1132
SaO2	RA	100	100	RA
FiO2				
Methods	RA	NC	NC	RA

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

RR	30	18	18	12
T	96			

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1130	LR	100	IV		100cc

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
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	2	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	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	10	10	10

Codes

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

Time										
Pain (0-10)										
LOS										

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) [redacted] b(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 18Sep03

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

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

b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1118		Demerol 25mg	IV			[redacted]
1135		" 20mg	IV			[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L leg	limited	+	P	B	C	PK
15'	L leg	limited	+	P	B	C	PK
30'	L leg	limited	+	P	B	C	PK
45'							
60'							
90'							
D/C	L leg	limited	+	P	B	C	PK

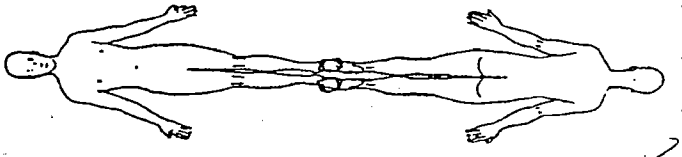
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L leg	ace wrap	Ø
30'	L leg	ace wrap	Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1107	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p ex fix removal, internal fix SpO2 100% RA. Pt c/o pain 25mg Demerol given for pain. 15mg Demerol given for shivering. 20 more mg Demerol given Report given to Lt [redacted] [redacted]

b(6)-2

Discharge Criteria:

Date: 18Sep03 Time: 11 PARS:
BP: 119/64 T: 98.2 HR: 112 RR: 16 Sa02: 100
Pain Level at D/C (0-10):
Intake: 0 Output: 0
Additional Data: none
Transferred To: ICW
Report Given To: Lt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery
Charge Nurse Signature [redacted]

b(6)-2

18Sept

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: 25 SEP 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1338
Allergies: NKDA OR Intake: Crystalloid 1000 LR Colloid Ø
Pre-op V/S: 111/61 / 85 OR Output: UOP Ø EBL Ø
Procedures: [illegible] Meds/Times: 20 morphine

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

Pre Op Meds History

Time	1338	13[illegible]	13[illegible]	1[illegible]	14[illegible]
SaO2	100	100	100	100	100
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140			V		
120	V	V		V	V
100					
80	Λ	Λ	Λ		
60				Λ	Λ
40					
20					
RR	15	16	15	15	15
T	96.[illegible]				97.[illegible]

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
1410	LR	1000	(R)AC	IV	50cc

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	Ø	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	Ø	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	Ø	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	Ø	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	Ø	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	Ø	Ø	Ø
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	9	10

Codes

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

Time						Patient teaching done; Wound Care, Pain Management,
Pain (0-10)						T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS						Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

b(6)-2

PREPARED BY [redacted] 91WM6 DEPARTMENT/SERVICE/CLINIC PACU DATE 25 SEP 03

[redacted] *(For typed or written entries give: Name — last, ... hospital or medical facility)*

[redacted]

b(6)-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

NEUROVASCULAR

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

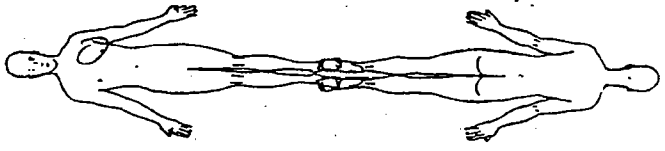
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Upper Chest	4x4	Ø
30'			
60'			
D/C	Upper Chest	4x4	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1410	NSR	Ø	Ø

NURSING NOTES

Pt recovered in PACU due to MRSA. PARS 10 @ Blood loss. S/P Hickman Placement — pfc [redacted]
PT discharged to ICU 6y pfc [redacted] & SGT [redacted]

DLW-2 All

Discharge Criteria:
Date: 8 Sep 03 Time: 1410 PARS: 10
BP: 126/67 T: 97 HR: 65 RR: 10 Sa02: 100
Pain Level at D/C (0-10):
Intake: 50cc LR Output: 0
Additional Data: Ø
Transferred To: ICU 1
Report Given To: MAJOR [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: pfc [redacted]
Cleared IAW Recovery Room [illegible]
[illegible] Signature: [redacted]

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: 28 Oct 03 — Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block — LMA

Time In: 1345

Allergies: NKDA — OR Intake: Crystalloid 1000 Colloid ____ — Scrient

Pre-op V/S: 110/60 SR — OR Output: UOP 0 EBL 50

Procedures: FAD Wester @ 7:10 — Meds/Times: ____

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds ____ History ____

Time	1515	1530	1545	1600	
SaO2	100	100	100	100	
FiO2	RA	RA	RA	RA	
Methods					
240					
220					
200					
180					
160					
140					
120	^	^		^	
100	^		°	^	
80	•	•	•	•	•
60	V	V	V	V	V
40			172		
20					
RR	15	20	22	20	14
T					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1540	LR	1000	LAtm	NS	1000

X-rays: ____ Labs: ____

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10		

Codes

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

Time	Patient teaching done: Wound Care, Pain Management,
Pain (0-10)	T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

b(6)-2 [redacted] SSG/CHN — DEPARTMENT/SERVICE/CLINIC: PACU — DATE: 28 Oct 03

PATIENT'S IDENTIFICATION (For ... entries give: first, middle; grade; date; hospi... Name – last,

[redacted] b(6)-4

MRSA +

Vanc

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 — WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) — Previous edition is obsolete USAPPC V2.00

MEDCOM - 19001

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1540	Alen	4mg MSO4	IVP			Ng
1600	Alen	2mg MSO4	IVP			Ng

NEUROVASCULAR

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

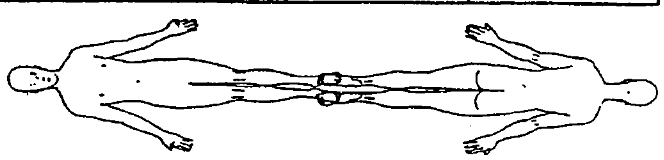
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

male Iraqi admitted to PACU s/p I&D washout (L) tib. PSO2 100% VSS
no s/s resp distress. JP drain
to (L) leg c small amount sanguinous
drainage. All dsgs CDI. Pt
A&O and c/o pain 4mg MSO4 given
[redacted] SSG/CR

D(L)-2 All

Discharge Criteria:
Date: 28Oct03 Time: 1610 PARS: 10
BP: 113/73 T: HR: 53 RR: 21 SaO2 100%
Pain Level at D/C (0-10):
Intake: 1 Lvo Output:
Additional Data:
Transferred To: ICW 1
Report Given To: SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Room [redacted]
...e Signature [redacted]

WAMC OP 173-F MEDCOM - 19002

ABU GHARAIB MEDICAL TRANSFER REQUEST FORM

DATE OF REQUEST: 02 OCT 03

REQUESTOR: LTC [redacted] MP BN Surgeon b(6)-2

(b)(6)-4 ISN #: [redacted] (b)(2)-2

COMPOUND [redacted] b(2)-2

PRIORITY: ASAP - Today, if possible

LITTER (AMBULATORY) (CIRCLE) With crutches

DESCRIPTION OF INJURIES: Fractures, LLE MRSA

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: 2

DATE OF TRANSFER: _____

TIME OF TRANSFER: _____

DESTINATION: _____

POC AT DESTINATION: _____

ANTICIPATED LENGTH OF TRANSFER: _____

EQUIPMENT REQUESTS: _____

NOTE: COORIDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A110 1	I2	[redacted]	UNK		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	29 y	2	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NA	~~09~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	2	1300	NA b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N	K78	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I2			YEAR ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D b(2)-2	ICW1	UNK

NAME AND [redacted] TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
21		031101

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AEAA		030911

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		030911

FOR LOCAL USE

Dx: GSW (L) LEG TIB FIB

Trauma Reg 9 569

Dx: 891.0, 041.11, V09.0, 905.4, 733.81, 730.26, E991.2

Proc: 79.36, 77.17 (x3), 88.27, 83.98, 78.07, 77.79

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b(6)-2 Or [redacted]	

DA FORM [redacted] MAR 89

MEDCOM - 19004

INPATIENT TREATMENT RECORD COVER S...

b(6)-4

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

1. REGIST...	2. NAME [redacted]	3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE Z	7. — SVC	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION N/A	14. WARD WW1
15. FLYING STATUS —	16. RATING/ DSG —	17. SEPT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1220	ER/TA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	SO	030915

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	030911	

29. NAME/...N OF MEDICAL TREAT... [redacted]	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE ... [redacted]

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW @ foot & @ thigh

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	4	4

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
		b(6)-2	[redacted]		

SIGNATURE OF AT... [redacted] ...OFFICER

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

MEDCOM - 19005

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A11D1	IZ

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	[redacted] b(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		Z	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A		1220	N/A b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
		9		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O b(2)-2	ICU1	

NAME OF MEDICAL [redacted]	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	ERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
SO		20030915

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
NEAN		20030911

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)

FOR LOCAL USE

DX: GSW @ foot & @ thigh

T: 1
Inj: 450

Dx: 8920
8900
E9912

ADMITTING OFFICER (Sign[redacted] b(6)-2 [redacted] G CLERK

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

MEDCOM - 19006

INPATIENT TREATMENT RECORD COVER SHEET

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

1	2 NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	b(6)-4 (EPW)	EPW	

4 SEX	5 AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	35y	X	MUSLIM			NO

11 FMP	12 SSN	13. ORGANIZATION	14 WARD
99	[redacted]	b(6)-4	ICU1

15. FLYING STATUS	16 PAYING DSG	17 DEPT. BEN	18. BRANCH/CORPS	19 UIC/ZIP	20. TYPE CASE
		K78			WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From ER		Orthopedics

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26 DATE OF DISPOSITION
	D/C TO CAMP	8 OCT 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b TELEPHONE NO.	29 DATE OF THIS ADMISSION	ADMITTING OFFICER
		11 Sep 2003	

29 NAME AND LOCATION OF MEDICAL [redacted] FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (1) GSW (B) LE

(2) S/P I+D (L) THIGH ex-fix (Open Femur fx (L))

Dx:
- 894.0
- 821.10
- 780.6
- E991.2

Px
- 88.27
- 77.17
- 78.15
- 77.15

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	27	27

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	[redacted]	0 b(6)-4	0	[redacted]	27

SIGNATURE OF ATTENDING MEDICAL [redacted]

DR. [redacted]

DA FORM [redacted] MEDCOM - 19007 USAPPC V1.10

12. Lemieux gun shot wound

E1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 Sep	BRIEF OP NOTE:
1940	PROCEDURE: ① I&D Ⓡ tibia
	② [illegible]
	PRE-OP DIAGNOSIS: Ⓡ femur fx, Ⓡ tibia [illegible]
	POST-OP DIAGNOSIS:
	b(6)-2
	SURGEON [redacted] ASSISTANT:
	EBL: [redacted]cc
	FLUIDS: 1800 crystalloid [illegible]
	UOP: Ø [illegible]
	TT: Ø
	POST-OP PLAN: To [illegible]
	Wash out 2-4 [illegible]
	? IM rod - locked
	[redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

LOG#: [redacted] b(6)-4
SSAN#: [redacted] & EPW
NAME:

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 - 19009

PREVIOUS EDITION IS USABLE

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Sep 03 1941	Recieved pt from OR. Pt sleeping with no signs of discomfort Pt responds to verbal stimuli & is able to follow simple commands Pt is being monitored via tele B/p 122/69 T-98 via skin probe R-14 P-75 SpO_2 96% RA IV (R) FA. LR's 120 cc/hr Lungs- Clear Resp- even & unlabored Bowels- hypoactive x 4 quad External Fixator (L) femur c clamp taped to Rod slight seepage on lateral aspect of (L) leg around distal pin. (R) tibia has bulky dressing, Kerlix c circumvential ~~slight seepage~~ Small amt bloody drainage on upper portion of dressing. dorsalis pedis & AT pulses present both feet. Will continue to monitor pt. Spc [redacted] b(6)-2
2000	Pt still resting quietly c no signs of discomfort B/p 121/64 P-74 R-13 Pt responds to verbal stimuli SpO_2 96% will continue to monitor pt - Spc [redacted]
2015	Pt still resting slowly starting to shiver administered IV Demerol 12.5mg hung new LR's 120 cc/hr B/p 106/70 R 33 P-72 SpO_2 97%. Pt denies any pain will continue to monitor pt - Spc [redacted] b(6)-2
2030	Pt resting no sign of discomfort B/p 128/69 R-14 P-78 BpO_2 96%. pt is ready for transport in 15 min- Will continue to monitor Spc [redacted] b(6)-2
2040	Pt is ready for transport B/p 128/ P80 R 14 SpO_2 97%
note cont	Gave report to Spt [redacted] IV LFA 1000cc recieved LR's 120 cc/hr

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	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] b(6)-4

REGISTER NO. | WARD NO.

Iraqui ♂ EPW

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

MEDCOM - 19010

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10Sep03	35 y/o Iraqi ♂ c GSW to (C) femur & (R) leg. Pt downed in Traction splint (2) thigh
	O: WDWN NAD VS noted AxOx3
1025	(2) lat leg - GSW - mild capillar hemorrhage
95	DP 2+.
99%	(L) ant thigh 1cm x 1cm exit wound
	DP 2+
	HEENT - WNL lungs CTA (B) CV: RRR s (-)
	ABD - soft
	neck - FROM & TTP
	A: GSW (L) thigh
	GSW (R) leg
	P: 1) to FST
	2) 1gm Ancef IV
	3) Morphine 5mg IVP
	b(6)-2 [redacted] USA PA-C

STANDARD FORM 600 (REV. 6-97) BACK

[redacted] b(6)-4

Iraqi ♂

MEDCOM - 19011

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10SEP03	SURGERY
1800	35 y/o ♂ c̄ GSW x2, 1st to (L) femur c̄ associated
	fx, 2nd to (R) low leg s̄ evidence fx.
	BP 102/59 HR 95
	Stable. Neurovascular exam stable to (B) LE
	No other obvious injuries to 2° survey.
A:	35 ♂ c̄ GSW x2 (R) low leg, (L) femur c̄ (L) femur fx.
P:	to OR for exfix vs pinning (L) femur and
	washout (R) tibial/low leg wound.
	b(6)-2
	[redacted]
	Ortho N/N 12/[illegible] CPT, MC.
	as above
	PE (L) distal thigh [illegible] c̄ [illegible] swelling
	NV intact
	knee moderately swollen
	(R) leg 1x5cm wound lat leg, 2° GSW
	NV intact
	XR- (L) distal femur metaphyseal fx
	min comminution
	(R) no tibia fx
	b(6)-4

[redacted]

Iraqi CPW

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 19012

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)*
11 Sep 03 2015	Pt sitting ↑ in bed. Recieved from ICU 3 via letter. S/p I+D (R) femur (ex fix) + I+D (R) ankle. VS: 127/64 R: 18 P: 89 O2 sat 98% Temp: 100.3. (R) femur ex fix intact c Kerlix. Pin site c some bloody drainage. → reinforced (R) ankle c drsg + ace bandage intact. c/o pain 2 mg MSO4 given IVP. NS @ 100cc/hr infusing into (R) FA. ø S/Sx infiltration or infection. +2 pulses palpable in (R) extr. 2 pt restraints on, circulation intact. Will monitor [redacted], 91WM6
	b(6)-2
12 Sep 03 0630	ORTHO POST I ex fix intact, Dist NI Dressings c/d T-100.5 VSS WBAT R NWB L plan no further OR @ this point will c/ wounds tomorrow and remove [redacted]
	b(6)-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]

b(6)-4

REGISTER NO.

WARD NO. ICW 1

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
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MEDCOM - 19013

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)*
11 Sep 2003 1500	Received Pt from EMT via litter. Pt Awake Alert & Oriented x3. Pt s/p GSW To Left Thigh and (R) Ankle. External Fixator To Left thigh. Dsg Blood soaked. Dsg [redacted] (R) Ankle CDI. Pt NPO c/c To OR for I&D. [redacted] (R) S/S Present HRRR. (R) BS x4 quads. (R) Pulses ✱ All [redacted] will continue to Monitor. [redacted] b(6)-2
11 Sept 2003	ORTHO pupOX: (1) Grade II open (L) dist Fem fx (GSW) (2) (R) leg soft tissue wound (GSW) postyOR: same - modify ex fix + I/D (L) Fem fx - I/D (R) leg wound. Hygate, Albutron GETA QCcomp to RR Stable b(6)-2 [redacted] CAT

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] b(6)-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 - 19014

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Lungs clear Resp even unlabored Bowels hyperactive x4 quad External Fixator (L) Femur c: ~~slight~~ Small Amt bloody drainage ~~seepage~~ on lateral aspect of (L) leg around distal pin. (R) tibia has bulky dressing c circumferential ~~slippage slight~~ Small Amt bloody drainage upper portion of dressing. Dorsalis pedis pulses present on both feet ~~upper portion~~ NOW transporting pt to pt hold via litter c 2 straps — 2045 — SIPC [redacted]
11 Sep 03 1245	ORNAO 35 male Iraqi GSW (R) post leg (tangential) and (L) Fem s/p I/D (R) leg + I/D ex fix (L) Fem @ FST. T-101.6 VSS AAOX3 NAD (R) LE tangential post/LAT GSW - penrose drain (L) thigh compartments soft ex fix intact XRAYS: (R) Leg - ~~4~~ Fx (L) Fem. distal 1/3 Fx appears extra-articular ~~AP~~ (R) LE soft tissue injury (GSW) leg (L) ~~tibia~~ Fem Fx GSW s/p ex fix. OR today I/D + reamers reduction. appears distal NVI (B) LEs palp pulses (B) blue [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS
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]

REGISTER NO.	WARD NO.

IRAQI Q EPW blue-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
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MEDCOM - 19015

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12SEP03	(1730) Assumed care of pt @ bedside w report from night shift. Pt alert, speaking Arabic. Pain controlled c MSO4 IV. Pin care done this am. Dsg to ex fix on (R) thigh Δd. Reinforced this pm d/t sero-sang drainage. Pt able to move toes on (R) foot. Cap refill <3 secs. (+) pedal pulse equal bilat. Drains on (R) thigh and (R) [redacted] covered c abd dsg - CDI @ this time. Dsg to sutures on (R) calf Δd this am. Sutures intact s sisx infection. Pt temp - 101.3 this am relieved c 650mg Tylenol. Temp @ 1700 - 101.8 medicated c Tylenol - will recheck temp in 1°. Pt amb c assist of crutches and PT in room. Tol. well. 2 point restraints in place s sisx complication of skin breakdown/circulation. Will cont. to monitor. [redacted] b(6)-2
12Sep03	1945 - VSS, 0/10 pain, A+O x3, IVK @ 100 cc running via IV to (L) Arm. (L) Lg has external fixator in place c Dsg's - reinforcing / s'ing as needed. (L) Lg elevated. 2+ popliteal & 2+ pedal pulse to (L) Lg. 2+ edema. Dsg to (R) LE CDI. Will continue to monitor for acute Δ's. Assisting OOB prn. [redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Sept 03	Ortho POD #1
	uneventful night.
	Tm 101.3 VSS
	Dressing c/d/i
	ex fix intact.
	Dist ant.
	Stable. Wounds / pill drain to remove [redacted]
18 Sept 03	POD #2
0700	Q new events
	Tm 102° VSS
	Dist ant.
	Wounds ✓ [redacted] blw-2
	Penrose D/C ✓ x2
	Stable
	Follow wounds.
	Mobilize [redacted] mm

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] blw-4

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

MEDCOM - 19017

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13SEP03	(1500) Assumed care of pt @ 0600 c report from night shift. Pt alert, speaking Arabic. VSS. Pt afebrile. Ex. fix in place on (L) thigh. Pt able to move toes. Cap refill <3secs. Pin care done. Drsgs to penrose drain sites CD&I - sutures intact c small amount sero-sang drainage noted. IVF infusing into IV in (L) arm s S/Sx infiltration/infection. Pt Tol reg diet well. Voiding s difficulty. 2 point restraints in place s S/Sx complications. Will continue to monitor. [redacted]
13 Sep03 1930	Pt sleeping, easily aroused. VSS, ex-fix intact to (L) thigh. Cap refill < 3 sec., pt can move toes. (R) ankle bandaged c ace wrap. IVF infusing into (L) arm, ø S/Sx infection/infiltration. Voiding adequate amt. yellow urine. 2 pt restraints on, circulation intact. Will monitor [redacted]
2200	c/o pain to (B) leg. tld given. used 10X. IS@ 85. Pt does not want to get OOB. Translator explained importance of getting OOB. Pt still hesitant. c/o extreme pain. 3mg MSO4 given for pain c relief. Will monitor [redacted]
2300	voiding adequate mod. yellow urine [redacted]
0430	voided about 1600cc clyw this shift [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 19018

RECORD OF ACUTE MEDICAL CARE

(Entries on this record should be restricted to further evaluation and treatment of complaint(s) screened)

END CARE LOCATION	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES

-14 S) 35yo host nation ♂ ☐ GSW (L) thigh & broken femur.

P-112/80

90

02 98 O) (+) puncture lateral side, exit medial thigh, (+) crepitus femur, (+) deformity

A) GSW (L) thigh/ Broken femur (L)/ GSW (R) distal

P) - 10mg Nubain IV 1522

102 96 - Dressed wounds

P 78 - traction splint

R 20

P

O 104/64

> 95

92 99

ref 16 1708

SIGNATURE OF HEATH CARE PROVIDER	SIGNATURE OF MEDICAL SUPERVISOR	AUDITOR'S INITIALS AND DATE

SPECIAL INSTRUCTIONS

orm will be utilized in lieu of SF 600 (Health Record-Chronological Record of Medical Care) at the BAS level and above care is initiated by an ADTMC screener. The record of acute, medical care will accompany the patient to the next level of remain in the BAS depending on disposition reached. This form will be filed in the HREC when evaluation and audit are eted.

E OF DA FORM 5181-R [redacted]

MEDCOM - 19019

USAPPC V1.00

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Sept03	ORTHO POD#3
0700	dc/o's
	TMAX 102 VSS
	ekfix intact.
	wounds ✓
	Dist NVI
	Stable. Still febrile.
	✓ UA. repeat I/o today
	b(6)-2
	[redacted]
	M.D.
18Sept03	ORTHO
	prop Dx/postopDx: open (L) Fem fx 2° GSW.
	(R) calf GSW
	Hygate Repeat I/D above wounds.
	GETA
	@Carp
	to AR [redacted]
	b(6)-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.)*

REGISTER NO.	WARD NO.

[redacted] b(6)-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 - 19020

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Sept03 1500	Received pt resting in bed. VSS, A+Ox3, LSCTAB HRR, BSO, Ex-fix to (L) thigh intact, drsg Δ, pin care done, serosang. drainage noted. Pt OOB to chair, amb to chair x2 safety/assists. To OR this shift for I&D. Returned to floor in stable condition. VSS w/ T of 100.9 # tylenol given w/ dinner. Will cont to monitor [redacted]
14 Sep Ø3 2000	Pt resting in bed. VSS, Ø c/o pain expressed. lungs CTAB, HRRR, ⊕BSx4, ex-fix (L) thigh intact pt able to move toes, cap refill ≤3 sec. (R) leg: ankle drsg CDI. Drsg to (L) knee CDI. 1 pt restraint on due to elevation of (L) leg + (R) ankle drsg., circulation intact. Will monitor — [redacted]
2340	Drsg to (R) ankle Δ'd. Sutures intact, scant amt drainage (serosang). Pin care done to (L) ex-fix. Knee drsg Δ'd. sero-sang drainage noted (scant amt). Pt c/o pain MSO4 given. Will monitor [redacted]
I+O) 0540	total output 1600cc (dyo) input approx: 1350 ØBM this shift. [redacted]

b(6)-2 All

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ACLU-RDI 1649 p.181

DOD-032595

①

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15Sept03	ORTHO POD#1
0830	∅C/o's
	AF VSS
	Dist NVI
	PT
	cont Abx
	b(6)-2 [redacted]
	[redacted] MD.
15Sept03 C/P	Received pt resting in bed, VSS, A+Ox3, speaking Arabic. Ex fix to Ⓛ femur intact, pin care done. Serous drainage noted on old dsg. Dsg changed to suture line above Ⓛ knee and to Ⓡ shin, c/d/i. X-rays of femur done this morning. OOB amb to BSC and to chair this shift. SVGS, BMⓅ. IV patent and intact Ⓛ fa, HL. Tol PO. enc H₂O intake. Amb short distances with crutches and assist. ↑ leg but pt is non compliant and kicks blankets out. ∅ other remarkable assessment [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	[redacted] b(6)-2

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.

E# [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16sep030230	Assumed care @ 1800; All WSS; pt A&O x3, speaking arabic; @ CMS x4, NV intact throughout; brisk cap Ref; Ex-fix intact; small amt of serous drainage noted on dsgs; dsgs to (R) shin & Above (L) Knee. CDI, sutures intact (-) S/Sx infection, well approximated; pt ↑ COB to chair x20 min; HL intact & patent @ LE ↑ while lying in bed; pt refused to walk, c/o dizziness & excessive pain pt placed in chair & then to bed; 2 point restraints in place; (+) circulation (-) skin breakdown; cont to monitor [redacted]
16 Sept 03 0816.	ORTHO POP #2 @ c/o's AF WSS
Lovenox	wound ✓ b(6)-2 AVL ex fix intact. knee 0-45° Actin. Cont current Rx. Rev XRAY in few weeks Mob, WB D/C Lovenox when more mobile [redacted] ORL
16 Sept 03 0800	VSS. Alert & Oriented. Lungs clear Bilaterally RS (+) x4 quad. Abd soft non distend. Consume Regular diet for Breakfast. Periphal pulses +2. Drsg Bed to (R) shin. Pin care done to (L) leg Ex-fix Left. (L) above knee sutures intact. Will continue care as planned. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16Sep03 1925	Pt a/o, VSS, lungs CTA B, HRRR, (+)BSx4, ∅ c/o pain @ this time. ex fix intact to (L) thigh, drsg to (R) ankle CDI, pin care done, drsg to knee (L) c̄ ∅ drainage. pt able to move toes, cap refill brisk, peripheral pulses palpable. voiding adequate mod. yellow urine. 2 pt restraints on. circulation intact. will monitor — [redacted] 91WM6 CPT b(6)-2
17Sept03 0810	V.S.S. alert & oriented. lungs clear, ~~[illegible]~~ bilaterally. BS(+) x4 quadrants. OOB to chair. Ambulated c̄ crutches with minimal assist x1 person. Peripheral pulses palpable to (L) thigh ext. fix in place with noted oozing of blood from pin sites p̄ ambulating. Dr [redacted] informed. ∅ new orders given. (L) thigh above knee incision with sutures intact. (R) ~~calf~~ calf incision with sutures intact. 2 pt limb restraints intact. Will continue plan of care — [redacted] b(6)-2

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

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 19024

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Sep03 1900	Rt a/o, vss, ø c/o pain @ this time. ambulated to bathroom. Bm x1, ex fix intact, pin care done. drsg to Ⓛ knee s̄ d, Ⓡ ankle drsg s̄ d. pedal pulses palpable brisk cap refill. 2 pt restraints on, circulation intact. Will monitor [redacted] 91Wm6 [redacted]
17 Sept03 [illegible] [illegible] 1918	ortho POD#3 ø C/O's. has ambulating some [illegible] AF VSS Dist NVI pins ✓ Stable Cont curr Rx. [redacted]
	b(6)-2 All
17 Sep (2000)	Dr [redacted] came by & looked @ pin sites. may leave OTA. also stated that Ⓡ ankle sutures may be left OTA. Ⓛ knee drsg CDI. minimal sero sang drainage. Will monitor [redacted] 91Wm6 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDCOM - 19025

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Sept 03	ORTHO POD #4.
0920	Ø new c/o's
—	AF VSS Ø new Labs
Lovenox	(R) leg wound dry. Ø sign infection. Ø new XRAYS.
	(L) thigh/knee - small serous drainage @ incision.
	pin sites OK. Ø pain c terminal ROM knee.
	DIST NVI. moderate effusion knee.
	cont PT for ROM knee
	cont current Rx. b(6)-2
	[redacted]
	HOGATE
18 Sept 03	VSS Alert & Oriented OOB ambulate c crutches
0930	to BR Tolerated well. AM care done
	in BR Lamp clean. BS (+) X4 quad. Abd soft
	non distended. Continued regular diet for breakfast
	Pin care to (L) ext fix done. [illegible] changed @ Alcohol
	Knee dry. sutures intact c small amt
	sero drainage noted. Will continue plan of care -

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST b(6)-2 | MI | SPONSOR'S ID NO. (SSN) [redacted]

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]

b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDCOM - 19026

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18SEP03 2025	VSS. AO. ⊕ pulses to BLE. Pin care performed as ordered. Tolerated well. Provided 2 percocet for pain @ 6/10. LSCTAB. BS⊕x4. S_1, S_2. Speaking minute English @ times. Sutures to upper thigh CDI s̄ evidence of bleeding or D/C. [redacted] b(6)-2
19Sept03	ortho POD#4 ∅new c/o's Tm - 103 yesterday → 100 VSS Ⓛ knee pain. minimal pain c̄ Roll. small s/s drain @ incision. pin sites ok - Stable - possible OR tomorrow. Will follow clinically. If ↑ pain, drainage, or cont Febrile, will repeat I/D tomorrow. b(6)-2 [redacted]
19SEP03	(1145) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pin care done to ex. fix. on Ⓛ thigh this am. Drsgs applied to pin sites d/t sero-sang drainage. ∅ s/sx infection. Pt OOB to chair and amb in hallway c̄ crutches s̄ difficulty. Sutures to Ⓛ thigh and Ⓡ calf CDI s̄ s/sx infection. ⊕ pedal pulses equal bilat. cap refill in feet <3 secs. Pt able to move toes. Pt tol.

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[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Sep 03	Assumed care of pt. A+O x3 VSS C/O pain upon ambulation c crutches to BR. Minimal bleeding to pin ~~site~~ site. Kerlix dressing applied pin care complete (R) ankle open to air sutures. Lungs CTA HRRR Active BS Urine per urinal QS. Will cont to monitor - [redacted] (1615) I concur c above assessment. [redacted] MD
(1900)	Rt A+O, VSS, ϕ c/o pain, ex fix intact (L) thigh. pin care done. mod. amt drainage (bloody) noted. (R) ankle sutures OTA. (L) knee sutures. OTA, ϕ drainag noted, ϕ ex. of infection. HL (R) AC flushing easily. HRR lungs CTAB. voiding mod. yellow urine via urinal. 2 pt restraints on (+) circulation - will monitor [redacted] alwmb.
21 Sep 03 0730	- Assumed care A+O x3 VSS sitting up in bed. External fix. to (R) LE pin care complete. Kerlix around pins minimal bleed from site. Lungs clear HRRR Active BS. Tolerating PO Urinating QS Encouraged to ambulate c crutches ϕ complaints at this time. Will cont to monitor [redacted] alwmb.
21 Sep 2000	Rt A+O, VSS, ϕ c/o pain, ex-fix intact (L) thigh-pin care done. mod. pero-sang drng noted. Sutures to (L) Knee + (R) leg OTA. ϕ drainage noted. Pt ambulated c crutches x1. voiding adeq. mod. yellow urine. Restraints on, (+) circulation. will mon [redacted] alwmb
22 Sep 03 0840	A+O. VSS. ϕ Complaints. NAD. Ex-fix to (L) LE intact. Sutures to (L) Knee area CDI. Pin Care done Will ambulate c crutches. Circulation & Skin integrity to restraint ext. [redacted] MEDCOM - 19028 L. Will continue to monitor

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19SEP03 (1145)	(cont) reg. diet well. BBM. voiding s difficulty. 3 point restraints in place s sfx complications. Will continue to monitor. b(6)-2 [redacted] WAW
1930	Pt sitting ↑ in bed, alo, VSS, ϕ c/o pain @ this time. ex fix intact (R) thigh. pin care done, scant sero-sang drainage noted. (R) ankle + (R) knee sutures OTA. ϕ drainage, ϕ s/sx infection noted. Lovenox cont as ordered. 1 pt restraint on @ this time, ⊕ circulation. Will monitor b(6)-2 [redacted] qHOUR
20 Sept 03	0100 – I concur c above assessment. [redacted]
20 Sept 03	ORTHO PODHS Pt c/o pain Tm 100 VSS Knee still warm, but ↓. pin sites OK. DIST NVI no drainage antecubital infection. I did pin care this AM cont to rotate clinically. if worsens (spikes, drainage) repeat I/O b(6)-2 [redacted] up.

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#[redacted]

b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21sept03	ORTHO POD#6
	↓ new c/o's
	AF VSS
	pin sites improving
	cont current Rx.
	[redacted] b(6)-2
22 Sept 03 0850	ORTHO POD# 7
	↓ new c/o's.
	AF VSS
	pin sites ✓
	cont Rx
	b(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22Sep03 0940	Sutures to (R) Ankle & calf region C.D.I. Pt T/C crutches to BR for A.M. care. C/O Complain of pain offered. [redacted]
22Sep03 1040	Medicated c Percocet 1/1 tabs p.o. for C/O pain. [redacted]
22Sep03 1250	Sleeping, WNL. [redacted]
22Sep03 1615	Medicated c Percocet two tabs po for C/O LE pain. Ace wrap intact. Ø drainage. (+) Pedal pulses. Brisk capillary refill to nailbeds. Will monitor for med effect [redacted]
22Sep03 2030	VSS, A+OX3, Medicated for pain c T/T percocet tabs as ordered, pin care done to (L) leg fix, (L) LE elevated, 2+ pedal pulse, 2+ edema, IV Hl to (L) FA flushed & patent restraints x2 in bed, Skin integrity intact assisting c ADLS PRN, Continue to monitor [redacted]
23Sep03 (1040)	Assumed care of pt @ 0800 c report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt amb in hallway c crutches c difficulty. OOB to chair tol. well. Personal hygiene done by pt. Ex. fix in place on

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DATE	NOTES
23SEP03	(cont) (L) thigh. (+) pedal pulses equal bilat. cap refill <3secs. Pin care done this am - (-) S/Sx infection @ pin sites. Sutures to RLE CDI - open to air. Tol. reg diet well. Voiding s̄ difficulty. 1 point restraint in place s̄ S/Sx complications. Will continue to monitor. [redacted]
23Sept03 1217	ORTHO [illegible] AF VSS plus - ant/lat pin still soupy. O/w nos. cont current Rx. b(6)-2 [redacted]
23Sep03	1930 = VSS, A+Ox3, ii percocet tabs given for pain as ordered, pin care done to ex-fix c̄ 1/2 strength H_2O_2 & sterile H_2O, (L) LE elevated, 2+ (L) pedal pulse, 2+ edema, (+) sensation, good CRT, sutures (L) thigh, (R) LE - approximated. Crutch walks PRN to BR s̄ difficulty. IV HL to (L) FA flushed + patent. Continue to monitor for acute Δ's. [redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24SEP03	(1525) Assumed care of pt @ bedside & report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt OOB to chair this am. Amb in hallway s difficulty c crutches. Personal hygiene done by pt. Pin care done. - ϕ S/Sx infection. Sutures to (B) LE c DI - open to air. Pt tol. reg diet well. Voiding s difficulty. 1 point restraint in place s S/Sx complications. Will continue to monitor. [redacted] RN
1920	Pt A&O, VSS, amb. in hallway x2 s difficulty (crutches) Pin care done. (sutures to (B) ankle & (D) knee OTA. ϕ S/Sx infection noted. ϕ c/o pain @ this time. 1 pt restraint on: (D) leg c ex-fix, (B) leg c ankle sutures). Will monitor - Richardson, B [redacted] RN
25Sept03	[redacted] b(6)-2

over

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sept 03 0928.	ORTHO POD # 10 c/NEW c/o's. AF VSS pin sites ✓ ✓ XRAYs in a few days D/C Lovenox Sutures out (L) thigh, (R) leg in 2-3 days. b(6)-2 [redacted] MD
25 Sep 03 @ 2030	Assumed care @ 1800; AA VSS, pt A&Ox3, pin cntrolled c pcrs; pin care completed c ~~stff~~ ½ sterile H2O, ½ peroxide; sutures to (R) ankle OTA, ⊖ S/Sx infection, well approximated; pt OOB to BR & in hall X/ for 10min c crutch assistance restraints in place, ⊕ circulation, ⊖ skin break ↓; ~~OTA~~ in assessment cont to monitor b(6)-2 [redacted]
26 Sept 03 1031	Assumed care of pt @ 0600. Assessment completed. LS CTA (B) RESP - even, unlabored, Abd - incision CDI, BS x4 voiding per urinal. OOB x 30 mins. Pin care completed. Sutures to (R) ankle + (L) thigh intact. IV HL dcld (L) FA. new IV c HL started in (R) FA CDI, PG (-) S/S inf. well cont to monitor pt. [redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03	RIS: VSS, C/O pain to ⊕LE, medicated c ÎÎ percocet tabs PO as ordered, pin care done to external fixator, ⊕LE elevated IV Hx to ℗ arm flushed & patent. When doing pin care, cleaned out pussy yellow substance from insertion sites, also cleaned off crusted skin. ⊕ bleeding from insertion sites during cleaning. POC: Pain Management, Infection Control, palliative care. Will continue to monito for acute Δ's. [redacted] b(6)-2
27Sept03	ORTHO Post #12
0925	Q new c/o's AF VSS Pin sites Soapy. Small drainage mid-thigh pin Knee ROM only 0-30° Repeat xray in couple days Start keflex for pin sites. pin care.

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[redacted] b(6)-2

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27SEP03 1727	VSS-A+O. assessment completed assumed care of Pt. @ 0600. TOL. Breakfast well. OOB to BR. ambulated x 10mins in hallway. Pin care performed pins cleaned. (+) drainage (+) Bleeding from pins. Dr. also performed pin care c (+) drainage (+) bleeding from pins. 0-30° ROM exercises performed. IV (R) FA CDI. flushes well. Pt. voiding per urinal dark yellow. 2 Restraints in place (+) circulation (-) skin breakdown. will cont. to monitor pt. [redacted]
(1615)	I concur c above assessment. [redacted] DAW
27 SEP 03 2039	VSS. AO. BS (+) x4 and voiding light amber urine, quantity sufficient. Pins intact to LLE c some purulent drainage to superior set and minimal to most inferior set. Provided 2 pennsets for with c/o pain. (+) pulse to LLE. [redacted]
28sep03 0700	-Assumed care A+Ox3 VSS @ c/o pain 8 of 10. Sconfort this time. Lungs CTA HRRR Active BS x 4 quads. Voids QS per urinal @ BS. Encouraged to ambulate c crutches. External exfixator to (L) LE intact Pin care complete ROM exercises will cont to monitor [redacted]
29SEP03 0505	VSS. Patient has no significant changes. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sept03 0923	POD# 14 @clo's. AFVSS pin sites improved perf. pin care today Sutures out b(6)-2 √ XRAYS Femur today. XRAYS- RO Δ in position. [redacted] MD.
Sept 29 1427	Assume care of PT @ 0600. VSS, A+Ox3 Ambulate enough to go to bathroom with aid of crutches. Exercised in hallway. Pin care on ex-fixator done on L Leg. Placed Kerlix on L leg due to skin irration from restraint. C/O ø pain. Will Continue to monitor. [redacted] RN
29Sept03 2137	Assumed care @1900; VSS, patho, ⊕CMS, NV intact throughout; PT ambs to BR X1 ⊕BM; Ex-Fix in place, pin care completed; contact IV abx; SL patent; Reservoir in place, ⊕ circulation, ⊖ skin breakdown continue to monitor [redacted]

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30Sept03	Assume care of PT @0600. VSS, A+Ox3 Ambulatory with aid of crutches. Did pin care and wrapped tightly in kerlix due to restraint rubbing against the wound. C/O no pain. Will continue to monitor. — SPC [redacted]
30Sep03@2030	Assumed care @ 1800; All VSS, pt A+O, ⊕CMS, NV intact throughout; pt ↑ amb to BR c/ in hall x1 for 10min. pin care complete ⊖drainage; ⊖C/O pain @ this time; SL patent, cont c IV abx; restraints in place, ⊕ circ. ⊖ skin brea ↓; cont to monitor — [redacted]
1OCT 03 0705	- Assumed care A+Ox3. VSS ⊘c/o pain or discomfort @ this time. External fixator to (L) LE pin care complete. Minimal drainage from insertion site. Cont IV ant. biotic tx. Ambulate c crutches c/ entry per ward and to BR. Will cont to monitor
	(1740) I concur c above assessment. [redacted]
1OCT03	2015: VSS, ⊘c/o pain @ present time, A+Ox3, pin care done to ex fix, some crusty liquidate cleaned, ⊕ foaming during cleaning, open to air, told pt. Not to cover ex fix c blanket R/T infection control. IV Hx to (R) FA, continuing IV Ancef around the clock, pain control ↓PRN, (L) LE elevated, OOB to go to BR (c crutches) c difficulty. ⊘ other remarkable assessment findings. Continue to monitor. x2 restraints when in bed, ⊖ skin breakdown. — [redacted]
1OCT03 2015	Addendum: Sutures to (R) ankle & (L) LE open to air CDI. — [redacted]

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DATE	NOTES
1 Oct 03	@2145: IV to (R) arm leaking, not flushable, D/C'd intact, restarted 18G to back of (R) FA, infusing Ancef 1gm IV S difficulty. [redacted]
2 Oct 03	VSS A&O x 4 Ambulates OOB ambulated c crutches to BR. Pedal pulses +2. Ecchymosis to (L) LE pin sites cleaned of crusting (R) FA saline lock patent & intact. Continues regular diet & voiding well. Continues plan of care. [redacted] 2127 hr
2 Oct 03	2030: VSS, A+O x 3, @ 0 pain, Hx IV (R) arm flushed & patent, pin care done to effix, @ foaming @ insertion sites during cleaning, @ crusty material & exudate (yellowish colored), (L) LE elevated, sutures to (L) LE CDI approximated, sutures to (R) ankle CDI & open to air, POC: Pain Mgt, infection control, x2 restraints when in bed, @ skin breakdown. OOB to BR PRN S difficulty. continues IV antibx. Continue to Monitor. [redacted]

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 Oct 03 0200	- Assumed care of pt. A+O x3. VSS. Encouraged to ambulate c̄ crutches to BR s̄ difficulty. Ex fix to (L) LE pin care given hard exudate removed minimal bleeding to insertion sites. Kerlix applied to absorb drainage. Will cont to monitor [redacted]
3 Oct 03	1915 = VSS, A+O x3, Ø c/o pain @ this time, pt. did pin care on his own when given supplies, (L) LE elevated, IV HL to (R) FA, getting IV Ancef around the clock. Ø other unremarkable findings @ this time. x2 restraints when in bed (-) skin breakdown. Continue to monitor. [redacted]
4 Oct '03	0615 VSS A+O x3, Ø c/o pain, pin care completed (-) drainage from pins, wounds healing well (-) edema Ø unremarkable findings, restraints x2 in place, (+) circulation [redacted]
	(1700) I concur c̄ above assessment. [redacted]
4 Oct 03 2127	VSS A.O. Performed pin care by self s̄ c/o pain or difficulty. (+) pulses to RLE & CR ≤ 2 sec. Up ad lib c̄ crutches on ward for 15 min s̄ c/o pain or difficulty. Voiding light amber urine, quantity sufficient. [redacted]
5 Oct 03 0709	ORTHO Ø change - less pain AF VSS DIST NVI Knee - 0-30° ROM only. Consider manipulation?

[redacted]

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