[redacted] b(6)(4) Date: 11OCT

11OCT03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																							157/86	146/64	163/94	
IBP																										
TEMP																							97.1		97.8	
HR																							101	103	105	
RR																							21	22	21	
SaO2																							100	99	98	
FiO2																										
Source																							[redacted]			
MAP																							100			

b(6)(2)

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IF																							125	125	125	
O																										
Total																										

MEDCOM - 21241

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																							50	150	200	
EST																										
POOL																										
DRAIN																										
Total																										

RECORD-SUPPLEMENTAL MEL

For use of this fo... see AR 40-66; the proponent agency is the Office o... Surgeon General.

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

SHIFT ASSESSMENT

		TIME: 0700 INITIALS: [redacted]	TIME: 1900 INITIALS:
NEURO	PUPILS	+2 PERRLA b(2)-2	PERRLA 3mm brisk
	SENSORIUM	A&O x3	A:Ox3, moves independently
	EXTREMITY MOVEMENT	Purposeful movement x4	independent
	SEDATION	MSO4 2-8 IVP q2° prn Pain	
	PAIN CONTROL	Pain Controlled c MSO4	MSO4, Percocets
RESP	RESPIRATORY PATTERN	RR- 22 SPO2 - 96 on RA	RRR,
	BREATH SOUNDS	Lung Sounds - CTA B	CTA B
	SECRETIONS	Ø secretions	Ø
	O2 SOURCE/FLOW/SAO2	Ø O2 - RA	RA > 95%
	VENTILATOR SETTINGS	Ø Vent	NA b(2)-2
CV	CARDIAC RHYTHM	HR - 72 BP- 159/67	RRR [redacted] ST, S1S2
	CAPILLARY REFILL	Capillary Refill- ≤3sec	<3 sec x4
	PULSES	+4 Peripheal Pulses	+2 x4
	EDEMA	↓ Edema in Lower extremities	Ø
GI	ABDOMEN	Soft Flat Non tender Non distended	Sof, flat, nontender
	BOWEL SOUNDS	Bowel Sounds -> Hyperactive x4	(+)
	BOWEL MOVEMENT	Ø @ Present	(-)
	NGT/OGT	Ø NGT	NA
	TUBE FEDDINGS	Ø Tube feedings	NA b(2)-2
	DRAINS	Ø drains	NA [redacted] (L) Fem Hemovac
GU	VOIDING	Foley to gravity	Foley to gravity
	COLOR/CLARITY	Clear Yellow Urine Q.S.	Clear, Yellow
SKIN	COLOR	Normal For Race	Normal for Race
	INTEGRITY	No skin breakdown	Drsg to LLE CDI
		Pin for left knee Fx (open)	
ACCESS	#1 TYPE/LOCATION/SIZE	IV in Left Hand infusing NS. @	PIV (L) Wrist / (R) FA
	DRESSING CONDITION	125 cc/hr ~~Fluids~~ Flushes well no S/S	CDI / CDI
	IV FLUID/RATE	of infection, infiltration	NS @ 125cc/hr / HL
	#2 TYPE/LOCATION/SIZE	A-Line in (R) wrist to monitor	A-Line (R) Radial
	DRESSING CONDITION	Reading well	
	IV FLUIDS/RATE		NA

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU #1, [redacted] b(2)-2

DATE: 11 OCT 03

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

NAME: [redacted] b(6)-4 RANK: — AGE:

UNIT: [redacted] EPW GENDER:

STATUS: US: AD / CIV IRAQI: CIV / (EPW)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

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

Date: 11 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	↑	145/65		148/64		140/63		133/65		134/64		118/60		114/60	114/65	133/60	134/67	130/61	126/58	124/55	128/66	124/58	134/55	126/60	135/60	
NBP [redacted]	157/78																	118/68								
TEMP	100.3			102.9		102.0		101.0		101.5		99.6				100.3								98.2		
HR	126	134		136		141		136		137		135		131	133	131	126	123	130	126	126	140	122	126	120	
RR	37	17		21		28		31		21		19		22	13	26	20	21	24	16	32	12	18	16	18	
SaO2	98	96		97		95		94		97		94		98	95	94	95	97	98	97	97	95	97	96	95	
FiO2																										
Source	RA	RA		RA		RA		RA		RA		RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
[redacted]																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	125	125	125	125	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125	125	125	125	125	125	150
IVPB	50								50									50								5
NGT																										
		350	300	240	250	250	250	500	240	200	0	0		0		200			250			300		250		90
tal																										

TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
URINE	350	180	180	180	150	180	100	120	150	100	120	120		120 / 120	150 / 270	180 / 450	180 / 630	140 / 770	150 / 920	180 / 1100	200 / 1300	150 / 1450	150 / 1600	150 / 1750	150 / 1900	
NGT																										
STOOL																										
DRAIN																										
Leg →														300												
Total																										

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: **INTENSIVE CARE NURSING FLOW SHEET**

OTSG APPROVED (Date): **QA APPR 08MAR8**

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(6)-2	Time: 2100 Initals: [redacted] b(6)-2
NEURO	Pupils		
	Sensorium	A&O x3	A+O x3
	LOC / GCS	Purposeful movement, Follows Commands	Follows simple commands
	Meds →	MSO4 2-8 IVP q 1°	Percocet & MSO4
CARDIAC	Cardiac Rhythm	HR- 130 BP 121/72	RRR
	PRI: / QRS:		
	Pulse Strength	pedpheal pulse - Strong x4	+2 pulses
	Cap Refil / JVD	Cap Refill - ≤3sec Ø JVD	Cap refil ≤3 sec / Ø JVD
	Edema	Slight Edema	Slight edema
	Chest Pain	Ø chest pain	Ø chest pain
RESP	Respiratory Pattern	RR - 28 SPO2 - 95% on RA	RR 25-30 SPO2 97%
	Breath Sounds	Lung Sounds - CTA Ⓑ	Clear Bilat
	Secretions	Ø secretions Ø cough	Ø
	Cough	Incentive Spirometer 10x q 1°	
SKIN	Color	Normal for Race	NTR
	Integrity	Ⓛ Leg ORIF Dressing CDI	Ⓛ LE ORIF & hemovac
	Backside	Ø breakdown	Drsg CDI
IV	Access Devices	I.V. to Ⓡwrist infusing N.S. @	PIV Ⓡwrist - Heplock
	Location	125cc/hr Flushes well	
	Condition	No S/S of infection - infiltration	
GI	Abdomen	Soft Flat Non-tender Non-	Soft, Non distended
	Bowel Sounds	distendeed BS- Normoactive	normoactive
	Stoma/Ostomy	Ø ostomy Ø stoma	Ø
GU	Device	Foley to gravity	Foley to grav
	Color / Clarity	dark yellow urine Q.S.	dark yellow

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU3, [redacted] b(2)-2

DATE: 12 Oct 03

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

[redacted] EPW b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

Patients Name: EKW [redacted] b(6)-4 Date: 18 OCT 05

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	125/72			134/64			124/61			126/57				129/64				120/71								
TEMP	98.4			99.6			100.8			100.2				99.7				100°								
HR	130			129			134			121				122				121								
RR	28			19			29			19				26				18								
SaO2																										
FiO2	95			95			96			95				96				97%								
Source	RA			RA			RA			RA				RA				RA								
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	125	125	125	125	125	125	125	125	125	125	125	125		125						Heplock						
B	50																									
PO	250	250	250																							
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	125	120	200	200	200	200	200	300	300	400	360	150		150											2000	
NGT																										
STOOL																										
DRAIN	40																									
Total																										

RECORD-SUPPLEMENTAL ME… …TA

For use of this fo… …see AR 40-66; the proponent agency is the Office of… Surgeon General.

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

SHIFT ASSESSMENT

		TIME: 0700 INITIALS: [redacted] b(6)-2	TIME:	INITIALS:
NEURO	PUPILS	PERRL		
	SENSORIUM	A&O x 3		
	EXTREMITY MOVEMENT	Purposeful movement x 4 Follows		
	SEDATION	Commands Ø Sedation		
	PAIN CONTROL	MSO4 2-8mg IVP q1° prn pain		
RESP	RESPIRATORY PATTERN	RR- 28 SPO2- 97% on RA		
	BREATH SOUNDS	Lung Sounds CTA(B)		
	SECRETIONS	Ø secretions		
	O2 SOURCE/FLOW/SAO2	Ø O2		
	VENTILATOR SETTINGS			
CV	CARDIAC RHYTHM	HR- 121 BP- 129/57		
	CAPILLARY REFILL	Capillary Refill ≤ 3 sec		
	PULSES	peripheral pulse: strong x4		
	EDEMA	Swelling noted to Extremities		
GI	ABDOMEN	Soft Flat Non tender		
	BOWEL SOUNDS	BS- Normoactive x 4		
	BOWEL MOVEMENT	Ø B.M.		
	NGT/OGT	Ø NGT Ø OGT		
	TUBE FEDDINGS	Ø Tube Feedings		
	DRAINS	Ø Drains		
GU	VOIDING	Voiding per Foley to gravity		
	COLOR/CLARITY	clear yellow U.S.		
SKIN	COLOR	Normal for Race		
	INTEGRITY	S/P ORIF (L) Knee/Femur		
		No skin breakdown		
ACCESS	#1 TYPE/LOCATION/SIZE	IV in (L) wrist Hep locked		
	DRESSING CONDITION	No S/S of infection CDI		
	IV FLUID/RATE			
	#2 TYPE/LOCATION/SIZE			
	DRESSING CONDITION			
	IV FLUIDS/RATE			

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC ICU #1 [redacted] b(2)-2

DATE

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

NAME: [redacted] b(6)-4 RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 MEDCOM - 21246

ICU1

Patients Name: [redacted] b(6)-4 Date: 13 Oct

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	129/57			141/54			124/63																			
TEMP	98.7			99.9			100.1																			
HR	121			144			111																			
RR	28			18			21																			
SaO2	97%			100			99																			
FiO2	/			/			/																			
Source	RA			RA			RA																			
IV																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	Heplocked																									
IVPB	50																									
NGT																										
Total	/	/	/	/	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	/	/	/	/	

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
URINE	200	200	200	700/600	/	⊕/100	/	/	1600	/	/	600		/	/	/	/	/	/	/	/	/	/	/	/	
NGT																										
STOOL				⊕																						
DRAIN	10cc																									
Total	/	/	/	/	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	/	/	/	/	

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. Register Nbr	2. Name					3. Grade FGN	Admission Remarks
[redacted]	[redacted]						
4. Sex M	5. Age 23Y	6. Race X	7. Religion ISLAMIC	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 99	12. SSN [redacted]	13. Organization				14. Ward ICW1	
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER	18. BranchCorps	19. UIC / ZIP	20. Type Case BC			
21. Source of Admission Direct from ER		22. Hour Of Adm: 17:43	23. Clinic Service AEA - ORTHOPEDICS				
24. Name/Relation of Emergency Addressee		25. Type Disp TRF-C-ICU	26. Date of Disp 2003-10-15				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm: 2003-10-06	AdmittingOfficer: [redacted] b(6)-2			
29. ReportingMTF [redacted] b(2)-2			30. Date Init Adm 2003-10-06	32. Units Blood Components			

31. Selected Administrative Data

Marital Status:

In/Out Patient: Inpatient

DoB: [redacted] b(2)-4

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L FEMUR FX W/ EX FIX,

DX: 82111
E9912

Px: 7965
7815
7865
7935

Trauma
9
Beijing
569

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

Signature of Attending Medical Officer [redacted] b(2)-2 [redacted] rds Officer

MEDCOM - 21248

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23 y/o ♂ collecting scrap metal outside Fallujah, shot by American forces. Taken to FST today. Ex Fix

PMHx: ø
PSHx: ø
MEDS ø
Allergies NKDA
Soc Hx: ø TMV ø ETOH

PHYSICAL EXAMINATION

HEENT: WNL
Chest: CTA
COR: S1 S2
ABD: soft
Back: NT ø bruises
Ext: 5x5 cm anteromedial thigh wound, open, Ex fix in place
lateral wound closed, compartment soft, 2+DP/PT, 5/5 EHL/FHL

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

(A) open (L) femoral shaft Fx ø Ex Fix

(P) Admit.

b(2)-2 b(2)-4

SIGNA [redacted]	DATE 10-6-03	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.

[redacted]

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 - 21249

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

SEX: M AGE: 23 WGT: 68 Kg HGT: 5' 7"

ASA: 1 2 3 4 5 E

ALLERGIES: NKA

CURRENT MEDICATIONS: ϕ

PROPOSED SURGICAL PROCEDURE: Ex Fix ① Femur

PAST MEDICAL HISTORY: ϕ

AIRWAY: Intact Mallampati 1 2 3 4 Dentition Status: Intact

RESPIRATORY: BBSH

CARDIAC: S1 S2

RENAL: Intact

ENDOCRINE: Intact

PROPOSED ANESTHESIA TECHNIQUE: General

DISCUSSION OF RISKS AND BENEFITS:

ANESTHESIA PROVIDER: [redacted] b(6)-2

HOSP[redacted] b(2)-2 | STATUS | DEPART./SERVICE Anesthesia b(2)-2 | RECORDS MAINTAINED A

SPONSOR'S NAME [redacted] | SSN/ID NO. | RELATIONSHIP TO SPONSOR [redacted] | REGISTER NO. | WARD NO.

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(2)-4

MEDCOM - 21250

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Oct 03	Admit to ICU Diagnosis: L femur fx V. Stats: Per Routine Allergies: NKDA Nursing: Reinforce dressing prn Diet: NPO IVF: 0.9 NS at 200cc/hr Meds: Toradol 15mg IV Q8° prn pain MSO4 2-4 mg IVP Q2° prn pain Special: Evac Closed Pt needs armed guard Pt needs interpreter [redacted] MAJ, MC 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 ♂		

Iraqi Nat'l

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 - 21251

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | b(6)-2 **PROGRESS NOTES**

DATE	NOTES
6 OCT 03 2300	Pt admitted to ICW #1, VSS, BP-122/63 P-84, T-98.3 R-20 SPO2% 98%, IV (L) Hand intact infusing D5½ NS @ 125cc/hr, Ex Fix to (L) thigh in place, dsg on (L) thigh covered c̄ ACE wrap, blood tinged around bottom pins, JP drain to LLE draining blood [redacted], 90cc, foley to gravity draining c/y urine, Strict I's + O's, foley to be d/c in AM, pain controlled c̄ percs, LS CTA (B), ⊕ BS x4, S1 S2 present, able to move toes, cap ref <3 sec, pedal pulses equal (B). 2 pt restraint in place, ø s/sx of poor circulation or skin breakdown. b(6)-2 [redacted]
7 Oct 03 0800	VSS Alert & Oriented. (L) hand IV Saline locked p̄ [redacted] Pt consumed 85% of Breakfast. Lungs clear Bilateral. BS (+) x4 quadrants. Abd. soft non distended. JP to LLE draining serosanguinous fluids. Percocet given as schedule and effective for pain. Peripheral pulses +2. Capillary refill to (L) & (R) toes < 3 sec. Will continue care as planned.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | SPONSOR'S ID NUMBER (SSN) [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT b(6)-2

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

b(6)-4

[redacted]

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

MEDCOM - 21252

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2
7 Oct 03	Voided 400 cc of amber clear urine
1600	without difficulty [redacted]
7 Oct 03 - @2200	assumed care of pt @ 1800. VSS c/o pain to LLE, especially c movement. Alert, speaking Arabic, LSCTA, ⊕BS, voiding per urinal s difficulty, refusing OOB to AMB c crutches. LLE c femur ex-fix, Kerlix wrap dsg c sm amt of serosanguinous drainage around lower part of ex-fix. ⊕CMS to LLE, ⊕ DP & ⊕ popliteal pulses +2. JP c sanguinous drng, see I+O sheet for quantity for shift. Plan: monitor pain control c monitor NV status. NPO p MN for Sx tomorrow. 2pt restraint on c S/Sx of ~~infection/infiltration~~ skin or circulation compromise. [redacted]
8 Oct 03	Return from PACU via stretcher Alert oriented
0900	USS. Transferred from stretcher to bed with minimum assist. Lungs clear Bilateral, BS ⊕ x4 quadrants Peripheral pulses palpable +2. Ⓛ LE dsg dry & intact Ⓛ Exter fix in place. Pin sites without drainage or crustation Ⓛ FA Saline lock patent & intact. Ⓛ lower extremity ↑ on folded blanket. Pt resting c eyes closed. Will continue plan of care. b(6)-2 [redacted]
8 Oct 03 2100	assumed care of pt @ 1800. c/o pain to LLE, percocet given c good relief noted. ⊕CMS to LLE, ex-fix c dsg: c sm amt serosanguinous drnge noted. Tol reg diet, voiding s difficulty. Ⓛ FA SL flushes well. CONT'D

STANDARD FORM 509 [redacted]

b(6)-2

MEDCOM - 21253

ACLU-RDI 1661 p.13

DOD-034829

MEDICAL RECORD | **PROGRESS NOTES**

DATE

6 OCT 03
1210 PT Enters E.R. with gunshot wound to Left thigh PT Alert PT Arrived with Bandage and splint to (L) thigh PT had IV In (R) ARM N/S 1000 ml

12:15 B/P 125/65 P 104 R 18 T SPO2 100%

12:20 B/P 114/71 P 86 R 16 SPO2 100%

Allergies: Ø
Meds Ø
Hx Ø
FHP: Heart Dad Diabetes Mom
SUR: Ø
Smoke (+)

PT given IV 1000 mL to (L) Hand ~~Pt given morphine 5 mg~~
PT given 1g Ancef At 1235
PT given 5mg morphine at 1225
EXRAYS Taken At 1245 of (L) thigh
PT give Morphin 5mg At 1245

1250 BP 130/56 HR 77

(Continue on reverse side)

REGISTER NO. | WARD NO.

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

[redacted] b(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77) b(6)-2
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.806-[redacted]
509-110

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10-8-03	Op Note
	Preop Dx : Glaucoma
	Postop Dx : Same
	Procedure : IridectomY
	Surgeon : [redacted]
	Anesthesia : General mask
	EBL : Ø
	Fluids : 500cc
	Fully clear medications
	Cx : Ø

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.)* b(6)-4

[redacted]

REGISTER NO.	WARD NO.

MEDCOM - 21255

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
8OCT03 2100	(CONTD) S S/SX of infection or infiltration. Plan: monitor pain control, monitor NV status. 2pt restraint in S S/SX of skin/circulation compromise. b(6)-2 [redacted]
8OCT03 2245	new IV 18G started in (R) FA. 2° old IV pulled out @ am. Old IV D/C'd & catheter intact. Will monitor. b(6)-2 [redacted]
9OCT03 0944	Received pt resting in bed. VSS, lol PO amb w/ crutches and 2 Safetec to BK. BBM and am care provided. Ancef IVPBx cont. ++ percet for pain. (L) thigh ex fix intact w/ bulky dsg intact. small amt serosang drainage @ lateral pin site x2. IV to (R) hand patent, flushes easily, ø swelling or redness noted. Pt needs reinforcement w/ crutches, exc. Will cont to monitor pt.
b(6)-2 [redacted]	9OCT03 2130 - VSS, c/o pain, gave 2 percs for pain, Dsg to (L) LE d'd, pin care done (R) serosang drainage from old dsg's, dsg d'd over pin sites, (L) LE ↑, neurovascular

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 | REGISTER NO. | WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

MEDCOM - 21256

MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	intact, 2+ edema (L) LE, IV to (L) FA, continue Ancef IV. X2 restraints ⊖ skin breakdown. Ambulate c̄ crutches as needed. Contin to monitor for acute Δ's. [redacted]
10 oct 03 0200	- Assumed care of pt. A+O x3. VSS ø c/o pain or discomfort @ this time. (L) LE external fixator intact dsg wet → dry kerlix wrapped. Minimal drainage to dsg. Ambulates c̄ crutches s̄ difficulty. HL (L) FA patent IV ABX tx. Will cont to monitor. [redacted] b(6)-2
10OCT03 @2030	assumed care of pt @ 1800. VSS. c/o pain to (L) femur, percocet given c̄ good relief noted. Pin care completed, WTD dsg to (L) inner thigh completed, healthy granulating tissue noted. ⊕ CMS to LLE, +2 DP c̄ popliteal pulses. (L) FA HL flushes well, ⊖ S/Sx of infiltration/infection. Pt ↑ AMB in hallway c̄ crutches c̄ assist. c̄ interpreter reinforced NWB to LLE. Plan: IV ABX as ordered, pain control prn. D/C pt restraints on s̄ S/Sx of skin/circulation compromise. [redacted] b(6)-2
11 Oct '03	pt. VSS, pt ambulated to BR c̄ some difficulty, changed dsg around pin which had some sero-sang drainage, pin-care completed with ~~[illegible]~~ Cardi-Saline then betadine, wound dsg Δ'd c̄ serosang drainage, ⊕ circulation, skin intact, no signs of infection, restraints x2 in place.
	(1530) I concur c̄ above assessment. [redacted]

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

b(6)-2

MEDCOM - 21257

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
8 Oct 03	[redacted] b(6)-2 Pre-op Dx: (L) Femur Fx Post-op Dx: same Procedure: ORIF (L) Femur, Removal of Ex-fix Surgeon: [redacted] / Anesthesia: [redacted] GETA EBL - 250 cc Fluids: 1500 cc Urine: 150 cc Complications: None b(6)-2 [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) [redacted] b(6)-4 [redacted]		REGISTER NO.		WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

[redacted] ROOM - 21258

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
10 Oct 15 @ 2115	Assumed care of pt @ 1800. [redacted]. C/o pain to LE, but wants pain meds @ ns. Alert, speaking some English, LS CTA, + BS, voiding per urinal. LE femur ex-fix x2 sm areas (<0.5cm each) of brown s/w healthy granulation tissue noted. LE edematous in thigh area, +2 DP & popliteal pulses, + CMS. Pt ↑ amb on crutches c standby asst, reinforced NWB to LE (non-compliant). Plan: ↑ ambulation, pain control, NPO p MN for sx tomorrow. 2pt restraints in s/s of skin or circulation compromise. Will continue to monitor. [redacted]
12 Oct 15 1716	Assumed care of Pt @ 0600. VSS, A+Ox3. Ambulate c b(6)-2 crutches. Surgery was delayed till tommorrow, Pin care completed (L) Leg. Dsg Δ on (L) thigh. No sign of infection at ciket site. Skin intact @ 2x restraints. Circulation, distal pulse present. (L) leg needs to be elevated. c/o b(6)-2 no pain today. Will continue to monitor. ——— R/N [redacted]
12 Oct 15 2015	Assumed care @ 1800; A+Ox3, VSS, pt A&Ox3, + CMS, brisk cap Ref, + pulses, NV intact; pt c/o B to amb in hall c crutch assistance; Ex-fix to (L) LE in place, pin care complete c pt assistance; dsg [redacted] to (L) LE C, D, I; pt voiding c difficulty per urinal; Restraints in place, + circ, + skin warm & dry; cont to monitor [redacted]

SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other) b(6)-2
RELATIONSHIP TO SPONSOR	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) b(6)-4		REGISTER NO.	WARD NO.

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1

MEDCOM - 21259

FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES — ALL THIS PAGE - b(6)-2
13 Oct 03	Assume care of PT @ 0600. VSS, went to surgery this
1646	morning. Exfix was removed, replaced by ace bandage.
	PT hasn't been alert since arrival. Distal pulse present
	in Bx legs. (L) thigh wound also wrapped in ace bandage.
	Will continue to monitor. ——— RN [redacted]
13Oct03@2330	Assumed care @ 1800; All VSS, pt temp slightly ↑, cont to monitor; pt in
	apparent pain, ii percs given, c̄ 5mg MSO4 administered for BTP; dsg to
	(L) LE CDI s̄ drainage noted; (+) CMS, +2 PP, brisk cap Ref to affected leg; FTC
	patent draining QS, clear, dark yellow urine; OP recorded; Restraint
	in place; (+) circ (-) skin breakdown; cont c̄ pain control; cont
	to monitor ——— [redacted]
14Oct03	n/w staff
0823	Drsg clean + dry S/S - [illegible] 2+ DP/PT. [redacted]
	Well controlled.
	T: 99.6 105/78 P: 120 Sat 96% R.A.
	OOB to chair. [redacted]
14Oct03	Assume care of PT @ 0600. Seen by Dr, verbal order
	to remove foley. C/O pain given percocets every time
	Urine is dark yellow color. Restraints in place, no skin irritation
	present. Will continue to monitor. ——— RN [redacted]
14oct03@2045	Assumed care @ 1800; All VSS, pt A&O x3, pain controlled c̄ percs; dsg to (L)
	LE CDI s̄ drainage noted; (+) CMS, +2 PP, brisk cap Ref; pt voiding QS, dark
	Amber urine, OP recorded; Restraints in place, (+) circ (-) skin breakdown, cont
	to monitor ——— [redacted]

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

NOTES

DATE

10-15-03

Discharge Summary

This is a 23 y/o Iraqi male who sustained gunshot wound to left leg 10-6-03 Initially stabilized with external fixator which was replaced with internal fixation 10-13-03. A bridge plating technique was used and the reduction is not anatomic. He has a medial thigh wound that should continue to receive wet to dry dressing changes. As his swelling subsides, this wound can undergo delayed primary closure. He should remain non-weight on his left leg ~~and~~ for a period of six weeks. From week 6-12 recommend toe touch weight bearing with progression to full weight bearing after twelve weeks depending on radiographic findings. Continue antibiotics until wound is closed.

[redacted]

b(6)-2

b(6)-4

MEDCOM - 21261

STANDARD FORM 509 (REV. 5/1999) E

USAP/

[redacted]

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREA[redacted]

RECORDS MAINTAINED AT b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRE[redacted] b(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year) | TIME 1746

TRANSPORTATION TO FACILITY: AIR evac

THIRD PARTY INSURANCE

SEX: M

AGE: 23

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			

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

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: (L) leg pain.

VITAL SIGNS

TIME	1746					
BP	116/62					
PULSE	95					
RESP	22					
TEMP	97.1					
WT						

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1746

INITIALS: [redacted]

LAB ORDERS

☐ CBC/DIFF | ☐ ABG | ☐ PT/PTT | ☐ BHCG/URINE/BLOOD/QUANT
☐ URINE C&S | ☐ UA MSCC/CATH | ☐ CHEM:
☐ BLOOD C&S X

X-RAY ORDERS

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

ORDERS

☐ ECG
☐ MONITOR
☒ PULSE OX 99

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

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

PATIENT/DISCHARGE INSTRUCTIONS

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)

b(6)-4 [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 - 21262

NSN 7540-01-075-3786

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

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	H/H			SUP O2	PH	PO2	RESULTS	
	PLT			PCO2	SAT	OTHER		
PT				UA	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO	b(2)-2		

PROVIDER HISTORY/PHYSICAL

S) 23yo [redacted] transferred to the [redacted] S/P GSW to (L) femur. Pt was seen @ 3MCR @ 1215 today. Pt underwent I & D of (L) femur wound and external fixator placement on (L) femur fx. JP drain was also placed. Pt A&O x 3 upon arrival (slightly groggy from meds). (+) popliteal & pedal pulses to LLE. [redacted] b(6)-2

(+) TOB

PMHx

-0-

PSHx

-0-

See addt note

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted]

PR

DIAGNOSIS

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Oct 6		1523	VS T98' R 13 P 94 B/P 124/57 Sat 100% 4L O_2 Pt transferred to ICU from OR. Pt had ~~two~~ irrigation & Debridement (L) thigh, placement of Ext fixation to (L) femur. foley patent, IV. 0-9 [illegible] patent. lung sound Clear x 4 Sgt [redacted]
		1545	Pt had 12½ Demerol — Sgt [redacted]
		1635	400cc yellow urine output Sgt [redacted]
		1637	Pt awoke for awhile asking question then ... Sgt [redacted]

b(6)-2

MEDCOM - 21264 STANDARD FORM 510 (REV

MEDICAL RECORD — INTRAOPERA[illegible] OCUMENT

For use of this form, see AR 40-66, the propon[illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY FST EMT
TIME PATIENT ARRIVED IN SUITE 1250 hrs.

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 2LT [redacted] b(6)-4 NUMBER [redacted]

3. DATE 06 OCT 2003

4. PATIENT IN ROOM TIME 1330 hrs. b(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Arabic Interpretor Required

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
	PFC		
ASSIGNED CIRCULATOR	2LT	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

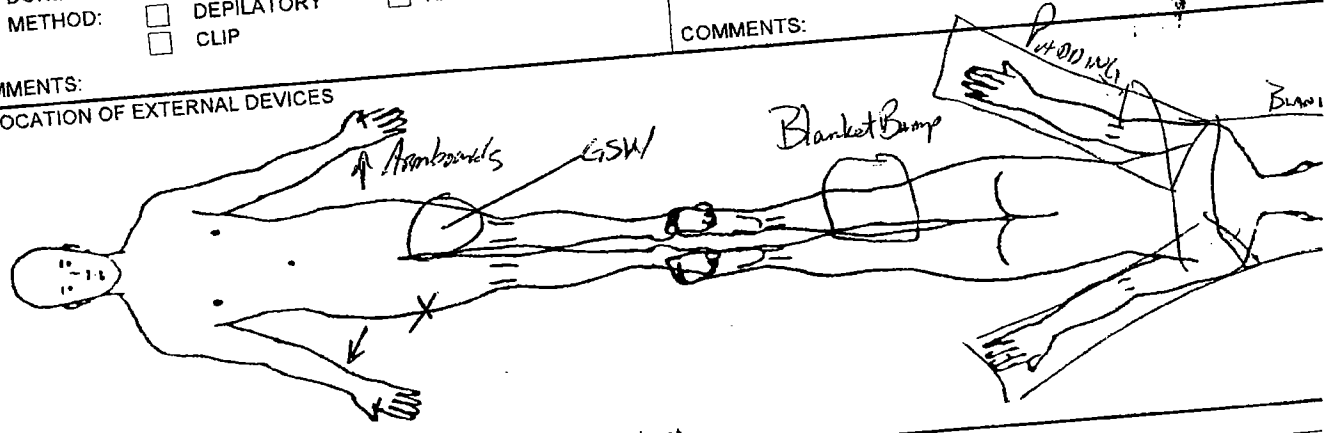
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) BETADINE SCRUB, DRAPER [redacted]
SITE: (L) LEG BY WHOM: 2LT [redacted]
SITE: BY WHOM: b(6)-2

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

10. COUNTS (C = Correct I = Incorrect)

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

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

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

[redacted] b(6)-4
IRAQI NAT'L
DOB [redacted] 23 y/o
[redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ N

☒ ESU NO: 500/3
GROUND PAD: BRAND 3M 1149
LOT NO: 2005-07

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 21265

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUME IUFACTURER

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): NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE (L) Femur

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)*

Xeroform Gauze
4x4 Dressings
Kerlix
ACE Wrap
External Fixator, (L) Femur

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm FLAT JP		
SITE	(L) Thigh		

19. ADDITIONAL INFORMATION

START TIME: 1335 hrs.
END TIME: 1501 hrs.

EBL 100mL

20. OPERATION(S) PERFORMED

Irrigation & Debridement (L) Thigh; Placement of External Fixator to (L) Femur

b(6)-2

21. PATIENT TRANSFERRED TO FST ICU TIME 1517 hrs METHOD LITTER

22. REGISTERED NURSE SIGNA [redacted]

MEDCOM - 21266

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 OPERATING ROOM VIA litter BY anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT / AN
3. DATE 80CT03 TIME PATIENT ARRIVED IN SUITE —
4. PATIENT I[redacted] TIME 0753 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt of english speaker. b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

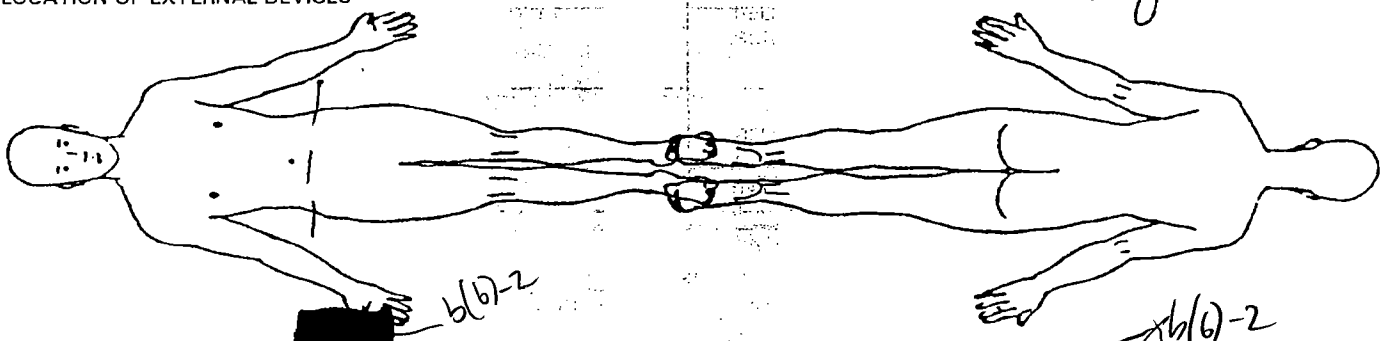
COMMENTS: b(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta/Beta
SITE: L leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad ~ Safety Strap = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No	C		C	SSG [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No	C		C		
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] 80CT03

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

☒ ESU NO: CUT [redacted] COAG
GROUND PAD: BRAND [redacted] E7507
LOT NO: 70011 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

MEDCOM - 21267

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; FACTURER

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

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

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

16. LABORATORY SPECIMENS

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

- fluffs
- Kerlix
- ace Wrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

anesthesia:
CPT [redacted] CRNA
b(6)-2
Surgeon:
Dr. [redacted]

20. OPERATION(S) PERFORMED

I&D (L) femur

21. PATIENT TRANSFERRED TO ICU3 TIME MEDCOM - 21268 METHOD Litter

22. REGISTERED NURSE SIGNATURE

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 OPERATING ROOM VIA litter BY anesthesia
2. PATIENT IDENTITY VERIFIED BY [redacted] CORD REVIEWED AND PROCEDURE CPT/HN
3. DATE 13 OCT 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 0935 b(6)-2 NUMBER 1-1 12)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D / b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	MAJ [redacted] 66E (Skin prep) CPT [redacted] (1215-1300)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: bump placed under Left hip.

8. SKIN PREPARATION

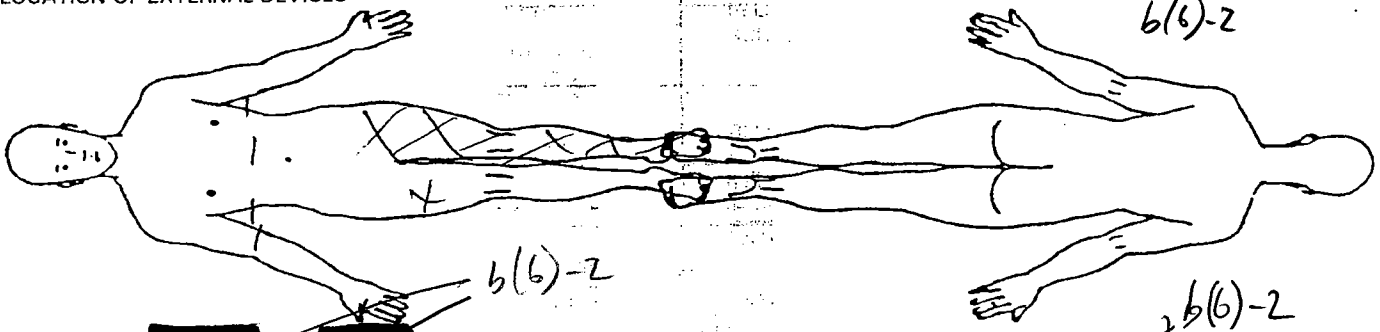
HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR b(6)-2 ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Beta/Beta
SITE: Left leg BY WHOM: CPT [redacted]
SITE: BY WHOM: MAJ [redacted] b(6)-2

COMMENTS: no nicks or cuts noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Safety Strap = = = Tourniquet XXX - prep.

10. COUNTS (initial)

C = Correct I = Incorrect

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

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

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

[redacted] b(6)-4 [redacted]
13 OCT 03

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

CUT 50 COAG 50

☒ ESU NO: Valleylab LO5305
GROUND PAD: BRAND Valleylab E7507
LOT NO: 70016 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

MEDCOM - 21269

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUMBER; FACTURER

Synthes DCP plates
Load# 0428502
14Hole plate

Synthes ASIF SCREWS
Load # 0428502
4.5mm cortical 36x4 34x1
38x2 44x1

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

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

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ CARM IF YES, SITE Left leg

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)*

- fluffs
- kerlix
-

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. 14 Fr. Foley to gravity	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

Surgeons:
DI [redacted] b(6)-2
DI

Anesthesia: b(6)-2
MAJ [redacted] CRNA

20. OPERATION(S) PERFORMED

ORIF Left Femur

21. PATIENT TRANSFERRED TO ICU 3 TIME METHOD Cotter

MEDCOM - 21270

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 13 OCT | 14 Oct 03

19 | HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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.

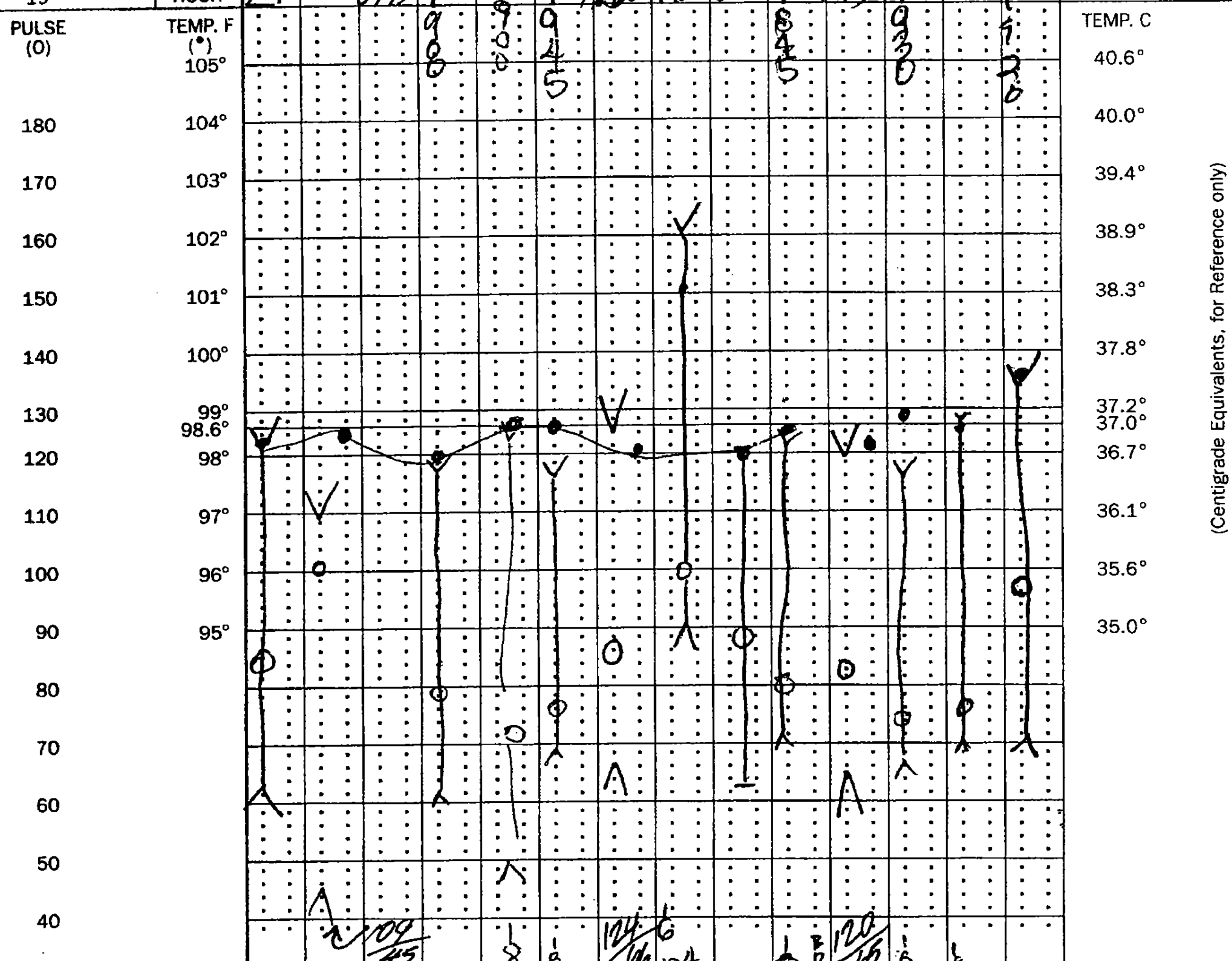
STANDARD FORM 511 (REV. 7–95) **BACK**

MEDCOM - 21271

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST-	DAY
MONTH-YEAR 10/03	DAY: 6, 7 Oct, 8 Oct, 9 Oct, 10 Oct, 11 Oct, 12 Oct 03
19	HOUR

PULSE (O) — TEMP. F (•) — TEMP. C



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] 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 - 21272

ACLU-RDI 1661 p.32

DOD-034848

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-407; the proponent agency is the OTSG

WARD: ICU

DATE: Oct 6, 03

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

PATIENT'S NAME [redacted]		T	P	R	B/P	SPO2		
1500	b(6)-4	98.1	94	19	124/57	100		
1520			81	18	129/59	100		
1533			72	23	121/66	100		
1543			78	16	134/55	100		
1600			83	18	136/60	100		
1615			88	14	134/61			

DA FORM 3950, JUN 91 Previous editions are obsolete. USAPPC V1.00

MEDCOM - 21273

TWENTY-FOUR HOUR PATI[illegible]E AND OUTPUT WORKSHEET

FRO[illegible] HOURS
TO [illegible] HOURS

TOTAL HOURS COVERED

DATE 24 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		NS OR	OL	1535	
1535	2	NS U-9			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

PATIENT'S IDENTIFICATION (Use typed or written stencil giving first, middle, grade, date, hospital or medical facility)

[redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP)
1 JU[illegible] MAY BE USED

MEDCOM - 21274

*U.S. Government Printing Office: 1994 — 300-727/10425

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2200	1600cc	1600cc			
0430	1000cc	2600cc			
1600	voided	400cc			
1800	300	700			
2215	600	1300			

~~NASOGASTRIC~~ JP

TIME	AMOUNT	TYPE	ACCUM TOTAL
0000	90cc	blood	90cc
0550	75cc	blood	70cc
1600			
1800	25	Blood	25
2215	10	sanguinous	35
0600	10	sanguinous	45

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		NS IV	1,000cc	0800	1,000cc
		Ancef	50cc	0330	1050cc

IRRIGATIONS *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. Bl, Alb, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

1 oct

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2200	420	420			
0555	425	~~425~~ 845			
0930	450				
1723	473	923			
2245	425	1348			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

b(6)-4 b(6)-2 b(6)-4

Ward/Section: EMT	REQUESTING PHYSICIAN: DOC [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 6 OCT 03 / TIME 1750	SSN/PSEUDO SSN [redacted]

(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	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.010	N/A
Bld	Trace	Negative
pH	7.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Rbc 1-5

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT b(6)-4 | REQUESTING PHYSICIAN: DOC [redacted] b(6)-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974) b(6)-4

LAST, FIRST, MI. [redacted] | DATE: 6 OCT 03 | TIME: 1750 | SSN/PSEUDO SSN: [redacted]

(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

======= PICCOLO =======
10/06/03 18:16
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	113	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	1384*	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	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
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
O2		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
MY		14-97 u/l
ST		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
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
O2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ID: [redacted] 06-10-03
WB 18:14

			Patient Limits	
WBC	11.5 H	x10^3/uL	4.5	10.5
RBC	4.91	x10^6/uL	4.00	6.00
Hgb	13.7	g/dL	11.0	18.0
Hct	43.6	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	27.8	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	234.	x10^3/uL	150.	450.
LY%	13.1 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

NT COAG A. ALYZER V4.54
... .005485 10/06/03 18:19

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.7 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.07
Sample Type:citrated wh. blood
Test Date :10/06/03
st Time :18:18
'd Lot [redacted]
erator : [redacted]

b(6)-4

DPOINT COAG ANALYZER V4.54
AL #005485 10/06/03 18:22

.atient ID [redacted]

b(6)-4

Test Name :APTT
Test Result:= 27.3 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/06/03
Test Time :18:19
Card Lot [redacted]
Operator : [redacted]

b(6)-4

MEDCOM - 21280

516-108 NSN 7540-00-634-4156

MEDICAL RECORD — **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS
GSW to (L) Thigh

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
MAJ [redacted]	MAJ [redacted]	PFC [redacted]	
ANESTHETIST	ANESTHETIST		TIME BEGAN: 1308 hrs
CPT [redacted]	General		TIME ENDED: 1524 hrs.
CIRCULATING NURSE	SCRUB NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
2LT [redacted]	SFC [redacted]	1338 hrs	1501 hrs.

OPERATIVE PROCEDURE
Open (L) femur fracture b(6)-2

DRAINS *(Kind and number)*	SPONGE COUNT VERIFIED
T 10 flat to Sabre	2LT [redacted]

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
NONE

OPERATION PERFORMED
Irrigation & Debridement (L) Thigh, Placemt of External Fixator to (L) Femur

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*	PROSTHETIC DEVICES *(Lot no.)*	DATE OF OPERATION
Pt given IVB and General anesthesia. Pt intubated and Tegram and ceftriaxone given IV. (L) leg prepped & draped. I & D wounds excised, DCD & necrotic tissue removed. Femur reamed inbord. External fixator applied. Wounds irrigated & drain placed. Dressings applied	NONE	06 OCT 2003

b(6)-2

SIGNATURE OF SURGEON [redacted], M.D. — DATE 6 Oct 03

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

[redacted]

IRAQI NAT'L
DOB – [redacted] 23 y/o
NKDA

b(6)-4

OPERATION REPORT
Medical Record

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

MEDCOM - 21281

MEDICAL RECORD - ANESTHESI[A] ... e OTSG

F... of this form, see AR 40-66; the proponent agen[cy is th]e OTSG

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

DRUG (Units)										TOTALS
Propofol (mg)	200/50		50							300
Sux (mg)	100									100
Morphine (mg)		3			2					5
Rocuronium (mg)				20						20
Neostigmine (mg)							2.5/2.5			5
Robinul (mg)							.5/.5			1
VOLAT AGENT ISO % del	3	1.2	1.2	2.0	2.0					
% e.t.										
AIR L/Min						2.5	2.5	1	.5	
N2O L/Min										
O2 L/Min	5	5	5	5	5					

TOTAL EBL: 100

TOTAL URINE: 500

FLUIDS SUMMARY
CRYSTALLOID- 2800
COLLOID-
BLOOD-

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

FLUIDS

LINE site										
(L) Hand ☐ Warmed — #18 LR	→	→	800	→	→	1000 NS	→	→	→	800
(R) Arm #18 NS ☐ Warmed	→	→	600	→	→	→	→	→	→	1000
☐ Warmed										
☐ Warmed										

LOSSES EST BLOOD LOSS / URINE -

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 68 KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 132/150 HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 1505

TIME → 1245, 1300, 15, 30, 45, 1400, 15, 30, 45, 1500, 15, 30

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

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

VENTIL

VT - ml						14	14	14	14	14
f - breaths/min	16	10	10	23	22					
Peak inf pres / PEEP						C	C	C	C	C/S
MODE - S(pon), A(ssist), C(on)	S	C	C	S	S					

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)						71	48	48	48	44
BP/oth	✓FIO2 (Frac or %)		72	72	80	80	100	100	100	100	100
ART line	✓SpO2 (%)	100	100	100	100	100					
Steth- PC/ES	✓ECG		97				97			97	
Gas analyzer	✓TEMP-site										
	N-M Block (T/4)										
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine c pressure points padded

REMARKS
Code drugs with numbers, events with letters

(1250) Pt. IDed. HX s Allergies reviewed. Anesthesia Instructions given. 50mg IV Zantac & 12.5 I[V] Phenergan given (1308) IV Induction. #8 ETT placed c #3 MAC s difficulty c Di[rect] view. BBS ... side. Teeth Int[act] (1355) Hct 34, Hgb ... K 3.9, Na 137, Glu ... BUN 9 b(6)-2 [redacted] (1500) Pt. breathing regular, Sa... 100%. b(6)-2 [redacted] (1518) Pt. breath[ing] regular s swallo[w] ETT pulled. Pt. [bre]athing s diffi[culty] (1524) Pt. to P[ACU] Report given.

RECOVERY AT: (PACU) ICU 1524 ...
OTHER
CONDITION: RESP- 19 SpO2- ... BP- 109/48 HR- 9...

ANESTHESIA / PROCEDURE TIMES

	Start	Room
ANES	1250	1300
	Ready	Begin
PROC	1315	1335

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — General

PROCEDURES and CPT Codes: External Fixation of (L) Femur

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — SEE Above Note

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(6)-4
M, 23 yr

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] AN CRNA b(6)-2

PROCEDURE LOCATION: (2)
DATE: 10-6-0...
PAGE 1 OF ...

MEDCOM - 21282 — PATIENT'S MEDICAL RECORD

23 y/o ♂ PMH ø PSH: L fem ex fix 10/6 GSW L thigh
NKA MPC I, F?? Gen Anes B3CTA, ? ??m 10/8/03
68kg 5'7" Ane?e 24 ... 98° - 80 - 120/70 ... 98% [redacted]

MEDICAL RECORD - ANESTHESIA

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

b(6)-2

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)			
Propofol ( )	100		
Fentanyl ( )	100/150		
( )			
( )			
( )			
( )			
VOLAT AGENT Forane % del	1.5	1.5	X
% e.t.			
AIR L/Min			
N2O L/Min			
O2 L/Min	8	4	8
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	①②		③

TOTALS	TOTAL EBL
	Min
	TOTAL URINE
	Ø

FLUIDS - SUMMARY
CRYSTALLOID- 300
COLLOID- Ø
BLOOD- Ø

FLUIDS

LINE site		
☐ Warmed		
18g (L) WRIST ☐ Warmed	LR	———
☐ Warmed		
☐ Warmed		

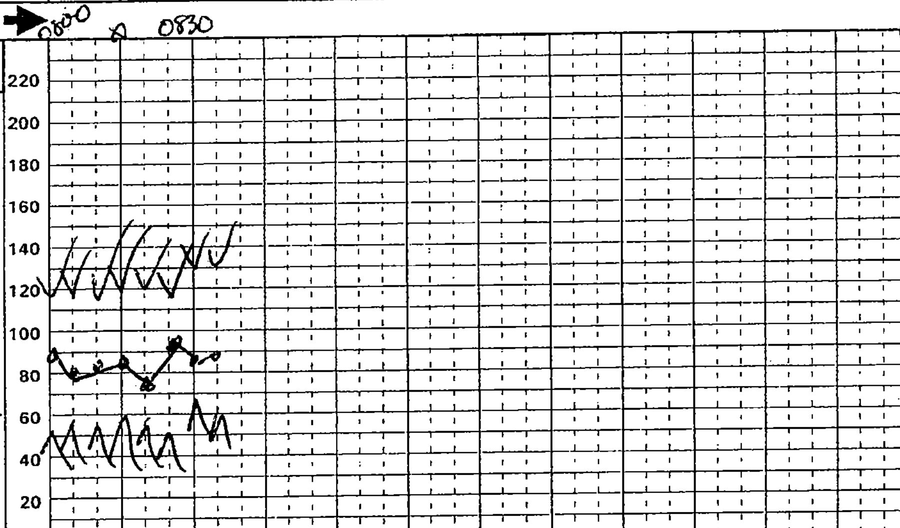
LOSSES: EST BLOOD LOSS / URINE -

REMARKS
Code drugs with numbers, events with lettters
① PT ID IN ICU2 Hx unchanged
② Km-O2-mon.
③ OCR TO PACU

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 68 (KG) LB
HEMATOCRIT: 43 6/10
INITIAL DATA: BP- 119/52 HR- 87
EQUIP CHECK OK?- Y N
PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 0800 0830

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



VENTIL

VT - ml	400	420	500
f - breaths/min	12	7	11
Peak inf pres / PEEP	/	/	/
MODE - S(pon), A(ssist), C(on)	SV	SV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	46	60	49
BP/oth	✓ FIO2 (Frac or %)	0.68	0.68	0.68
ART line	✓ SpO2 (%)	100	100	100
Steth- PC/ES	✓ ECG	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 → O—/

RECOVERY AT 0838 (PACU) ICU ____ (Specify)
OTHER
CONDITION: alert
RESP- 12 SpO2- 100
BP- HR- 90

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0738	0752	0840
	Ready	Begin	End
PROC	0753	0820	0834

PROCEDURES and CPT Codes: I&D (L) FEMUR

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA-MASK

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* MASK c̄ #90A

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] CPT CRNA

PROCEDURE LOCATION: 1-1
DATE: 8 OCT 03
PAGE 1 OF

DA FORM 7389, FEB 1998 MEDCOM - 21[redacted] COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

ACLU-RDI 1661 p.43

DOD-034859

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)														
MSO4	(mg)	2/2/4/2													
	( )														
	( )														
	( )														
	( )														
	( )														
VOLAT AGENT — ISO	% del / % e.t.	1.5	1.5	1.0 X											
AIR	L/Min														
N2O	L/Min														
O2	L/Min	1 — 2 — 2 — 6													
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →		(4)													

FLUIDS

LINE site 18g LFA ☐ Warmed	1000 — 1400														
☐ Warmed															
☐ Warmed															
☐ Warmed															

LOSSES

EST BLOOD LOSS	150 — 200														
URINE -	125 — 150														

TOTALS

TOTAL EBL	TOTAL URINE
10	

FLUIDS - SUMMARY

CRYSTALLOID:

COLLOID: See Pg

BLOOD: one

REMARKS

Code drugs with numbers, events with letters

(4) Suctioned Extubated, to PAW stable.

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 68 (KG) LB

HEMATOCRIT: 40

INITIAL DATA:

BP- 113/53

HR- 80

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

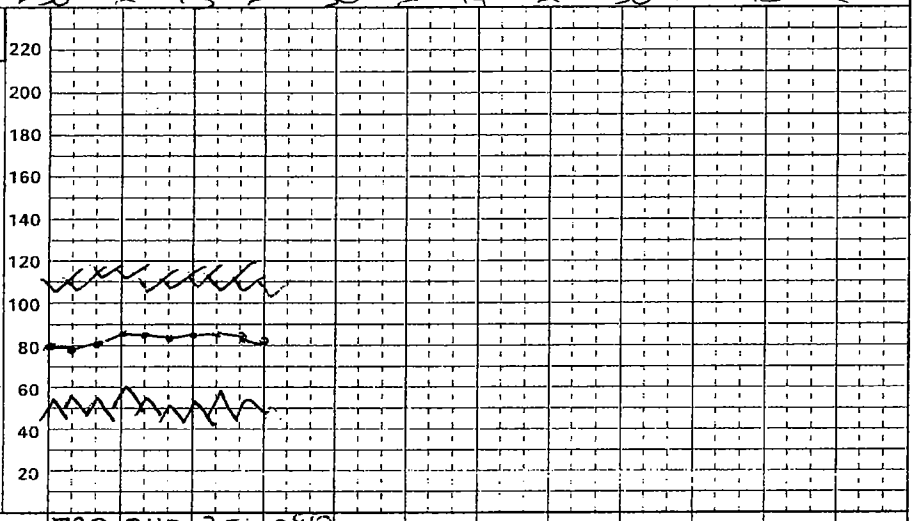
OK for PROCEDURE?

TIME-

TIME → 30 × 13 × 30 × 14 × 30 × 15 ×

SYMBOLS:

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



VENTIL

VT - ml	720	340	350	380	
f - breaths/min	8	16	12	18	
Peak inf pres / PEEP	25	—	—	—	
MODE - S(pon), A(ssist), C(on)	C	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36	44	48	46	
BP/oth	FIO2 (Frac or %)	0.8	0.8	0.8	0.8	
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP-site S	35	35	off		
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0 →

RECOVERY AT

PACU ICU (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

ORIF lt femur

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

CD [redacted] b(6)-4

23yo ♂ [redacted]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

See Page one

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

b(6)-2

SURGEONS: [redacted]

ANE [redacted] AAS CRNA

PROCEDURE LOCATION: 1

DATE: 10/13/03

PAGE II OF II

DA FORM 7389, FEB 1998 — MEDCOM - 21284 — THESIA PROVIDER — USAPA V1.00

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, "1" = CONSTANT INFUSION

DRUG (Units)													
Sufenta (Mcg)	5	15	15	5	10	5	[redacted] b(6)-2						
droperidol (mg)	1.25												
propofol (mg)	120					80							
Vec (mg)	10												
( )													
( )													
VOLAT AGENT Iso % del	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	6	1	1	1	1	1	1	1	1	1	1	1	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →	① ② ③												

FLUIDS

LINE site 18g LFA ☐ Warmed	LR ↑	500	600	700	800	#2							
20g LW ☐ Warmed	DC'd												
☐ Warmed													
☐ Warmed													

LOSSES

EST BLOOD LOSS													
URINE - Foley												150	125

TOTALS	TOTAL EBL
50	200
	TOTAL URINE
	150

FLUIDS - SUMMARY

CRYSTALLOID- 150 cc

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

Pt s chart. No Δ in status since prior anesth. Plan GETA.

① To room via litter, soc mons, preox

② I & I.

③ New IV placed.

④ [redacted] b(6)-2

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 68 KG LB

HEMATOCRIT: 40

INITIAL DATA:

BP- 113 / 53

HR- 80

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME- 0925

TIME → 30 | 10 | 30 | 11 | 30 | 12 | 30

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

Resp rate:

BR (transduced):

TOURNIQUET: T → ↑

ANES- X-X

PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL — HME

VT - ml	600	650	720	720	740	730	740	760	740	750	730	720	
f - breaths/min	10	10	10	10	10	10	10	10	8	8	8	8	
Peak inf pres / PEEP	21	22	22	23	23	23	24	24	24	25	24	23	
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36	36	34	31	35	35	33	31	33	34	37	36
BP/oth	FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8	.8	0.8	0.8	0.8	0.8	0.8	0.8
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 S		35	35	35	35	35	35	35	35	35	35	35
	N-M Block (T/4)								4/4 T				
										Sust tetany			
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ① → → → → → → → → → → → →

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 17 SpO2- 99%

BP- 109/62 HR- 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0925	0935	1325
	Ready	Begin	End
PROC	0940	1020	1315

PROCEDURES and CPT Codes:

ORIF ⓛ FEMUR

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

[redacted] b(6)-4 NKDA

ICW; 23 yo ♂ civ det

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, DL x 1, 3 trauma, ⊕ EtCO2, BBB. Secured c tape, soft bite block. 8.5 ETT, 3 mar, 23 cm. @ lip

SURGEONS: [redacted] b(6)-2

ANES [redacted] MAJ, CRNA

21285

PROCEDURE LOCATION: OR 1

DATE: 10/13/03

PAGE I OF II

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

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
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine // Meperidine 5 mg IV now and 5 mg q 3-5 min prn pain for a max dose of 10 mg.		
X	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
X	Metoclopramide____mg IV prn N/V x 1.		
X	Droperidol____mg IV prn N/V x 1.		
X	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ KVO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		

[redacted] CPT CRNA

8 OCT 03 0825

b(6)-2

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: _____

Nursing Unit	Room No.	Bed No.	Page No.
[redacted]			1 of 1

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

b(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

[redacted] b(6)-2

NURSING UNIT | BED NO.

PATIENT IDENTIFICATION 8/12/24

ICW#1

NURSING UNIT | ROOM NO. | BED NO.

24th / 2140 [redacted]

PATIENT IDENTIFICATION

960 [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

24th / 2100 [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10-6-03	HOURS	
Admit ICW-1 Dr. [redacted]		
(1) Femur Fx ϕ Ex fix		
Stable		
- Routine V. Tals		
- Ambulate c crutches on Adm, NWB @ LE		
- Record output of Drain q Shift		
- D/C Foley in Adm		
- Regular Diet		
- Ancef 1gm IVPB q8°		
- D5 ½ NS @ 125 c/hr, hep lock in Adm		
- Percocet 1 ϕ po q4°		
- Demerol 50-75 mg, 1 IV q4° PRN breakthrough		
- Phenergan 12.5-25 mg IV q6° PRN nausea		
- Ambien 5 mg po q HS PRN [redacted]		b(6)-2
10-7-03	1200 HOURS	
Clarification of order		
(1) Percocet 1 po Q4° PRN pain V.O Dr. [redacted]		b(6)-2
10-7-03	1800 HOURS	
- NPO ϕ MN [redacted]		b(6)-2
10-11-03	1730	
NPO PM		
[redacted]		b(6)-2

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

MEDCOM - 21287

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 | ROOM NO. | BED NO.

DATE OF ORDER 10-8-03 TIME OF ORDER 0830 HOURS

- ICW.
- Routine vitals
- Ambulate c crutches NWB RLE
- BID pin site care c 50/50 peroxide/saline
- QD wet to dry dressing to medial thigh
- Regular Diet
- Heplock IV

PATIENT IDENTIFICATION b(6)-2 noted [redacted] 08OCT03 0925

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Ancef 1gm IVPB q8°
- Percocet 1 tab po q 4°
- Phenergan 25 mg IVP q6° prn nausea
- Ambien 10mg po qHS.

[redacted] b(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10-12-03 TIME OF ORDER 1600 HOURS

Resume Regular Diet
NPO p MN

[redacted] b(6)-2

10/12/03 1600

PATIENT IDENTIFICATION b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13 OCT 03	1200 HOURS	
Admit ICU.		
Post OR IF (L) Femur		
- Bedrest today		
OOB to chair in AM		
- Incentive Spirometry		
- Routine Vitals		
- Resource Dressing PRN		

13 Oct 03 1445

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
- Foley to gravity. Record output q Shift		
- Regular Diet		
- IVF NS @ 125 c/hr, heplock IV on AM		
- Percocet 1 po q4h PRN		
- MSO4 2-8mg IVP q2h PRN breakthrough		
- Phenergan 25mg IVP q6h PRN nausea		

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICU 124 V	13 Oct 03 @ 1620	[redacted]

DATE OF ORDER	TIME OF ORDER	
	HOURS	
- Ambien 10mg po qHS		
- Ancef 1gm IVPB q8h		
- Levoquin 500mg IV qD		
- Lovenox 30mg QSQ BID		
- XR portable PA/LAT FEMUR (L) Femur		

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Noted

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
	15 Oct 03	0830

DATE OF ORDER	TIME OF ORDER	
10-15-03	0815 HOURS	
- Dressing change this AM		
- D/C to civilian hospital today		

b(6)-2

[redacted]

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

CLINICAL RECORD

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

Mo. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 6 7 8 9 10 11 12 13 14 15 16 17 18
10	[redacted]	Routine vitals	6	
			18	
10	[redacted]	AMB c crutches	6	
		NWB LLE	18	
10	[redacted]	Record output of drain QS	6	DE EP
			18	
10	[redacted]	Regular diet	6	
			18	
08 08 08	[redacted]	Routine vitals	06	
			18	
08	[redacted]	Ambulate c crutches	06	
		NWB LLE	18	
08	[redacted]	BID pin site care c	06	
		50/50 peroxide/saline	18	
08	[redacted]	QD wet to dry dressing	06	
		Δ to medial thigh	18	
08	[redacted]	Regular diet	06	
			18	

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) femur fx c EX-fix

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

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

Verity by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6	[redacted]	Admit ICW-1, Dr [redacted] stable				
6	[redacted]	D/C Foley in AM	7 OCT.		0540	[redacted]
6	[redacted]	NIO: DTV @ _____		[redacted]		
7	[redacted]	NPO p MN	7 OCT	2359		
08 OCT 03	[redacted]	ICW #1	08 OCT 03	———	———	[redacted]
11 OCT 03	[redacted]	NPO p MN	12 OCT 03	0001		
12 Oct	[redacted]	Resume Regular diet	10/12			
12 Oct	[redacted]	NPO p MN	10/12	2400		
		b(6)-2				

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

MEDCOM - 21291

POST-OP

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 ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15
10/13	[redacted]	Bedrest today. OOB	06	[redacted]		
		to chair in AM	18			
10/13	[redacted]	INCENTIVE SPIROMETRY	06			
			18			
			18			
			06			
10/13	[redacted]	ROUTINE VITALS	06			
			18			
			18			
			06			
10/13	[redacted]	F/Key to gravity.	06			
		Record OUTPUT q	18			
			18			
		SHIFT	06			
10/13	[redacted]	REGULAR DIET	06			
			18			
			18			
			06			
		b(6)-2				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: POST ORIF (L) Femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

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

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

MEDCOM - 21292

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo Oct Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/13	[redacted]	Admit ICW 1	10/13			
10/13		XR PORTABLE PA & LAT	10/13	[redacted]		
15 OCT 03		Dsg Δ this am		b(6)-2		
15		DC to civilian hospital today				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
10/13	[redacted]	Reinforce dsg prn b(6)-2	

USAPA V1.00

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY
6	[redacted]	Ancef + gm IVPB Q8°

6	[redacted]	D5½NS @125cc/hr HL in AM (TOCT)

6	[redacted]	Percocet 1 tab po Q4°

	-----	
8 10CT03	[redacted]	Heplock IV - flush q shift

8	[redacted]	Ancef gm IVPB q8°

8	[redacted]	Ambien 10mg po qHS

DATE DISPENSED

HR	6	7	8	9	10	11	12	13
8	\							
16	\							
24	[redacted]							
6	[redacted]							
10	[redacted]							
02	\							
06	\							
10	\							
14	\							
18	\							
22	[redacted]							
06	//							
18	//							
08	//							
16	//							
24	//							
22	//							

pre op

Ad 10CT03

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) femur fx c ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

PENCIL, CIRCLE MED TIMES

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 - 21294

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
		b(6)-2 (all)				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
6	[redacted]	Demerol 50-75mg IV Q4° PRN Breakthrough	D/T 1
6			
6	[redacted]	Phenergan 12.5mg-25mg IV Q6° PRN	D/T 1
6	[redacted]	Ambien 5mg po QHS PRN	D/T 1
[illegible]	[redacted]	Percocet 1-2 po Q4° PRN pain	D/T 1 [illegible] [illegible] 2130 0700
			D/I [redacted]
			I/E
[illegible]	[redacted]	Percocet 1-2 po Q4° PRN	D/T [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
			D/T [redacted]
[illegible]	[redacted]	Phenergan 25mg IVP Q6° PRN nausea	D/T
			D/I

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

POST-OP

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 13	14
10/13	[redacted]	IVF NS @ 125cc/hr	06		
		Hyplock IV in AM	18		
10/13	[redacted]	Ambien 10mg PO	22		
		q hs			
10/13	[redacted]	Ancef 1gm IVPB	08		
			16		
			24		
10/13	[redacted]	Levaquin 500mg IV	10		
		q D/			
10/13	[redacted]	Lovenox 30mg SQ	10		
		BID	22		
		b(6)-2			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: POST ORIF (L) Femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

EPW# [redacted] 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.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Oct Yr. 03			
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	b(6)-2 (all)				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
10/13	[redacted]	Percocet 1 1/2 po q 4° prn	Date	13 oct	Hoct	14 oct	14 oct	14 oct	15 oct								
			Time	1820	0020	0550	1240	1900	0950								
			Dose	1	1	1	1	1	1								
			Init	[redacted]													
10/13	[redacted]	MSO4 2-8mg IVP q 2° prn break-through pain	Date	13 oct	13 oct												
			Time	1845	2045												
			Dose	5mg	5mg												
			Init	[redacted]													
10/13	[redacted]	Phenergan 25mg IVPq 6° prn nausea															

*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: 8 OCT 03
Time In: 0838
Allergies: NKA
Pre-op V/S: 119/52 87
Procedures: I&D ⓒ Femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid 0
OR Output: UOP 0 EBL min
Meds/Times: 250 fent. / 100 propofol

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

Pre Op Meds

History

Time	0840	0845	0850	0900
SaO2	100	98	97	99
FiO2				
Methods	RA	RA	RA	RA

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

RR: 16 16 12 14

T: 97

Time
Pain (0-10)
LOS

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
0840	LR	600	L ARM		400
				b(6)-2	

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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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

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)

PREPAR[redacted] LPN b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 8 OCT 03

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

#[redacted]

☐ 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

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	LUE	LROM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

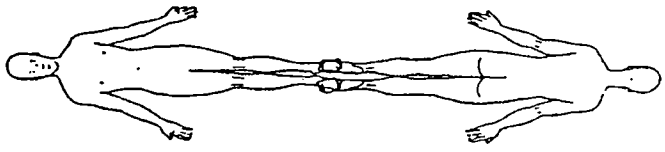
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LUE	ACE, Ltfix	min around pins
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0840	SR	○	○

NURSING NOTES

Pt to recovery room from OR via litter s/p I+D (L) leg. Ext fix & ace wrap in-tact. Min. drainage noted to pin sites. c/v initiated to (L) forearm LR infusing c s/s of hypoxia/OR swelling. VSS. NR/V/S in-tact. Will continue to monitor. [redacted] b(6)-2

NOTHING FOLLOWS

Discharge Criteria:
Date: 8/2/13 Time: 0910 PARS: 9
BP: 109/48 T: 97.6 HR: 81 RR: 16 Sa02: 98
Pain Level at D/C (0-10):
Intake: 200 Output: 0
Additional Data:
Transferred To: PCU b(6)-2
Report Given To:
Transferred Via: W[redacted]mbulance
Transferred By:
Cleared IAW Reco[redacted]
Charge Nurse Signature[redacted] ILT Av

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

DTSG APPROVED (Date)

Date: 13 OCT 03
Time In: 1320
Allergies: SULFA
Pre-op V/S: 115/53
Procedures: OPH Femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1500 Colloid 0
OR Output: UOP 150 EBL 200
Meds/Times: Sufenta, MSO4

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

Pre Op Meds: _____ History: _____

Time	1320	1325	1330	1345	1400	1410																		
SaO2	97	98	100	99	99	98																		
FiO2																								
Methods	RA	RA	RA	RA	RA	RA																		
240																								
220																								
200																								
180																								
160																								
140																								
120	V	V	V	V	V																			
100	•	•	•	•	•																			
80																								
60	^	^	^	^	^																			
40																								
20																								
RR	24	30	24	20																				
T	97.1	98.2		98.6																				
Time																								
Pain (0-10)																								
LOS																								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1320	LR	500	L ANK	[redacted]	500

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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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		10

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)

6(6)-2

PREPARED BY [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 13 OCT 03

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

[redacted] EPW

6(6)-4

- ☐ 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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1335		MSO4 2mg	IVP			RL

NEUROVASCULAR

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

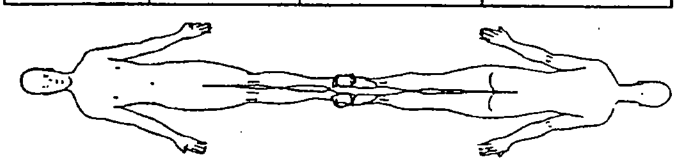
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	long leg ACE	∅
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1320	ST	∅	∅

NURSING NOTES

Pt to recovery room from OR via litter s/p ORIF (L) femur. Long leg ACE wrap to (L) leg intact. ∅ drainage noted. NVC's intact. IVF LR infusing into (L) arm. ∅ s/s of redness or swelling to site. VSS. ∅ c/o @ this time. [redacted]

1335 - c/o pain. Medicated c̄ 2mg MSO4 [redacted]

b(6)-2

Nothing Follows

Discharge Criteria:
Date: 13 Oct Time: 1450 PARS: 9
BP: 123/61 T: 97.3 HR: 92 RR: 26 Sa02: 99
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: ICW #1 b(6)-2
Report Given To:
Transferred Via: [redacted] Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Re[redacted]-3
Charge Nurse Signature:

AEROMEDICAL EVACUATION PATIENT RECORD

b(6)-4

NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
[redacted]	EPW	EPW	—	U (P) R	—

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION 91A-5F)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
M	Male / Female			AMBULATORY / LITTER X		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS	
	[redacted]	— b(2)-2	16a. MEDICAL	16b. NON MED
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	0	1
	[redacted] b(2)-2			

17. DIAGNOSIS

GSW (L) thigh
S/P ex fix

18.. X BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.			HYPERTENSION	f.			MOTION SICKNESS	k.			AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			EARS/SINUS	j.			SELF-CARE	o.			OTHERS

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES

20d. DIET: REG | 3GM NA | CARDIAC | DIABETIC ___CALS

RENAL ___Gm prot ___Gm Na ___Meq K ___mg PO4

TUBE ___TYPE ___cc/hr 1/2, 3/4, FULL STRENGHT

PEDIATRIC: AGE___ OTHER *(Specify)*___

TPN: Change to D10 at ___cc/hr for ax of ___days

TUBE FEEDING ___at ___strength at ___cc/hr

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT				
SUCTION		TRACTION		ORTHOPEDIC BRACES
NG TUBE		IV PUMP		CHEST TUBE/HEIMLICH
STRYKER FRAME		TRACH		RESTRAINTS
INCUBATOR		MONITOR	X	IV TYPE
		FOLEY		OTHER (Explain in 23)

O_2 | LITTERS | ROUTE:

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT REOCRDS	X	X-RAYS	FINANCIAL
X	INPATIENT RECORDS		OB-RECORDS	OTHER *(Specify)*
X	NARRATIVE SUMMARY		DENTAL RECORDS	

20i. MEDICATIONS/TREATMENTS

Ancef 1gm @ 1230

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. PULSE	21d. RESP	21e. BP

22. BRIEF NARRATIVE

See attached note [redacted] b(6)-2

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

MEDCOM - 21302

DOD-034878

ACLU-RDI 1661 p.62

3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	23Y	X	9	ISLAMIC
10. Length of Service	ETS b(6)-4	11. FMP	12. Social Security Number	
		99	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			17:43	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		BC	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-C-ICU		2003-10-15		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AEA - ORTHOPEDICS		2003-10-06		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
IZ		2003-10-06		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L FEMUR FX W/ EX FIX,

Procedure Narrative(s):

Cause of Injury Narrative:

b(2)-2

Admitting Officer (Signature, as required)	Signatur
[redacted]	[redacted]

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3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	23Y	X	9	ISLAMIC
10. Length of Service	ETS b(6)-4	11. FMP	12. Social Security Number	
		20	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			17:43	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		BC	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted]		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-C-ICU		2003-10-15		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AEA - ORTHOPEDICS		2003-10-06		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
IZ		2003-10-06		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW L FEMUR, EX FIX, L FEMUR

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Cl[redacted]
[redacted]	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

ADMISSION AND CODING INFORMATION

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

1	2	3	4	5	6	7	8
A							

(State or Country Code.)

3. REGISTER NUMBER [9 10 11 12 13 14 15] [redacted]

NAME (Last, First, Middle Initial)

4. PAY GRADE [16 17]

5. SEX [18]

6. DATE OF BIRTH (YYYYMMDD) [19 20 21 22 23 24 25 26]

7. AGE AT ADMISSION [27 28 29]

8. RACE [30]

9. ETHNIC BACKGROUND [31]

RELIGION

10. LENGTH OF SERVICE [32 33 34]

ETS

11. FMP [35 36]

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS [46]

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS [47 48 49]

15. BENEFICIARY CATEGORY [50 51 52]

16. ZIP CODE OF RESIDENCE [53 54 55 56 57 58 59 60 61]

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

18. MOS [64 65 66 67 68 69 70]

19. TRAUMA [71]

PREV. ADMISSION YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION [72]

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION [73 74]

22. MTF TRANSFERRED TO [75 76 77 78 79 80]

23. DATE OF DISPOSITION (YYYYMMDD) [81 82 83 84 85 86 87 88] 2 0 0 3 1 0 1 5

24. CLINIC SVC - ADMITTING [89 90 91 92]

25. MTF TRANSFERRED FROM [93 94 95 96 97 98]

26. DATE THIS ADMISSION (YYYYMMDD) [99 100 101 102 103 104 105 106] 2 0 0 3 1 0 0 6

27. LOCATION OF OCCURRENCE (Battle Casualty Only) [107 108]

28. MTF OF INITIAL ADMISSION [109 110 111 112 113 114]

29. DATE INITIAL ADMISSION (YYYYMMDD) [115 116 117 118 119 120 121 122]

FOR LOCAL USE

Dx 82111
E9412

Pr 7965
7815
7865
7935

Trauma
9

Injury
569

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	29Y	X	ISLAMIC			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICU2	
15. FlyStatus	17. Dept / Ben		18. BranchCorps	19. UIC / ZIP		20. Type Case	
	K78-PRISONER OF WAR/INTER					DIS	
21. Source of Admission			22. Hour Of Adm:	23. Clinic Service			
Direct from ER			20:05	ABA - GENERAL SURGERY			
24. Name/Relation of Emergency Addressee			25. Type Disp	26. Date of Disp			
			TRF-OTH	2003-10-19			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm:		AdmittingOfficer:	
				2003-10-07		[redacted] b(6)-2	
29. ReportingMTF				30. Date Init Adm		32. Units Blood Components	
[redacted] b(2)-2				2003-10-07			

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

PENETRATING WOUND R BACK LIVER LAC, HEMO/PNEUMO

860.5
867.1
893.1
891.1
879.7
E73.0
E998

b(6)-2

54.11
34.04

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	13	13

35. Total Days This Facility

Absent Sick Days	Other Days	Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
[redacted]	0	0	0	13	13

[redacted] Officer

DAVIS

Signature of PAD or Medical Records Officer

[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 21306

7 Oct - 2130

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

~30 y/o ♂ admitted c̄ fragment wounds of body
Meds ō Alls ō Sh? PMH?

PHYSICAL EXAMINATION 90/40 100 20

HEENT PERRL mouth OK answer ? appropriately GCS 15
small 2 cm lac occiput c̄ slight elevation of wound ~ 1 cm
neck - non tender
chest - ↓ BS Ⓡ chest c̄ bubbling from wound
CV - RRR 5 Ⓐ
abd - non tender FAST some blood Morison's pouch
pelvis - stable
rectal - good tone
ext - move all Ⓡ 2nd toe lac 1 cm
WBC 21.5 ; hct 44 ; plt 424 U/A 1030
CXR - CT tube in SQ
abd CT - frag thru Ⓡ iliac wing into bowel → lap

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

SIGNATURE [redacted]

IDENTIFICATION NO. | ORGANIZATION

PATIENT'S [redacted] *Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO. | WARD NO.

b(6)-2

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 - 21307

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE

NOTES 7 Oct - 19 Oct 2003

Transfer Summary

30 y/o admitted c frag wounds to back, arrived with (R) chest tube 350 cc plemovac, also 2 frag wounds of (R) hip; abdominal CT suggested penetration of (R) iliac wing with 1 fragment appearing to lay in bowel c Exploratory lap negative - no penetration c retro peritoneal hematoma

Pt recovered rapidly and uneventfully from laparotomy, but after placing on water seal after 2 days lung collapsed, replaced on suction x 2 days, + collapsed again on water seal. Placed on suction again x 48 hr and small 1 cm apical pneumo appeared but did not progress and CT reveal. Post removal XR still small apical pneumo. Has good breath sounds. Never had air leak, and drainage after initial 350 was less than 10 cc/day. No residual hemothorax, incision healed without infection.

Discharged with

frag wound R chest requiring chest tube for drainage of hemothorax

frag wound to (R) hip with negative laparotomy for suspected penetration

Will need suture removal from (R) chest in 5 days ~ 24 or 25 October

b(6)-2

b(2)-2

[redacted]

[redacted] b(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 21308

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCTION

DATE | NOTES

07Oct03 2130 - Transferred from ER to ICU 2 via litter. tolerated well. pt S/P grenade schrapnel wounds to (R) chest (R) thigh & (R) buttock. Pending cat scan results. Rests eyes closed easily roused A+Ox3 Pupils 2mm brisk. color good. noted lg amt blood on sheets & noted wound posterior (R) chest. Chest tube (R) lateral chest wall @ 350cc blood. To suction 20 sonometics Suction. IV 16G (L) AC, IV 18G (R) FA patent. VS 104/52 P 105 R 22 SaO2 100% 10L O2. color good LS - (+) diminished bases c wet LS (R) side. ABD soft (-) ON (-) BS (+) rigidity. capillfil brisk. will cont to monitor Foley to start dsg clear yellow urine SGT [redacted] 9mm

07Oct03 2145 — NG tubes placement (R) nare 16F by [redacted] tolerated well. LIS drain green bile c sm amt noted dark blood. Type + screen per MD request [redacted] pt denies surgery tonight. SGT [redacted] 9mm

RELATIONSHIP TO SPONSOR | LAST | SPONSOR'S NAME | 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 b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

b(6)-2 (all)

DATE	NOTES
07Oct03	- pt Transfered via litter to OR for
2200	Surgery SGT [redacted] 91WM6
08Oct03	Transfered via litter to bed. S/P ex lap
0040	new CT placement. See DA form 4700
	for recovery SGT [redacted] 91WM6
08Oct03	- VS 139/77 P70 R20 SaO_2 100% 10 L O_2 venturi
0200	T - 98.8 - to begin 1 unit PRBC per MO order
	lot 5306365 B pos exp 08Oct03. Confirmed
	lot by LT M. Zackowski RN. SGT [redacted] 91WM6 -
0205	134/74 P68 T98.6 Ø S+S of RX SGT [redacted] 91WM6
0210	137/81 P65 T98.3 Ø S+S of RX SGT [redacted] 91WM6
0215	139/78 P64 T98.4 Ø S+S of RX SGT [redacted] 91WM6 -
0220	140/78 P68 T98.1 Ø S+S of RX SGT [redacted] 91WM6 -
0225	140/79 P65 T98.1 Ø S+S of RX SGT [redacted] 91WM6
0230	138/80 P64 T97.9 Ø S+S of RX infusion
	Complete SGT [redacted] 91WM6
0245	138/78 P70 T97.8 Ø S+S of RX SGT [redacted]
0300	136/80 P65 T98 Ø S+S of RX f/u CBC
	drawn SGT [redacted] 91WM6
0600	Assumed care of pt ō night shift report given by SGT
8Oct03	[redacted] PA. Pt Alert. PERRL @ 2mm. (R) Subclavian area [redacted]
	CDI. Skin W+D to touch. (R) wrist A line intact. NSG (R)
	FA No S/S of infection noted ~~IV HL~~ error. (L) FA IV HL. No
	S/S of infection noted. (R) wrist A-line zeroed. LR @ 100
	cc/hr via (R) IVFA. DSG (R) lat. chest T+V CDI. DSG Midline
	ABD CDI. DSG (R) chest tube to 25cm suction. (R) lat
	DSG CDI. Foley to gravity c clear yellow urine. -

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 21310

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE | NOTES

8 Oct 0030

Op note

Expl lap for apparent bowel perforation + free intraperit air seen on CT

(−) lap ō retroperit hematoma SB, LB (cecum) nl

ō iliac vessel lig ō hematoma seen in pelvis

duo OK liver, diaphragm, spleen, stomach, panc OK

(−) lap

(R) CT replaced 350 out old pleurovac

fluid 3500 1 PRBC UO 700 [redacted] b(6)-2

8 Oct

S —

O — VSS Lat 37 p̄ ? 600 CT ō air leak

CXR UO XLNT

NG DC'd

P — ↑ act [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.

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 - 21311

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
08 Oct 03	Lung sounds course bil. ⊖ BS noted. ABD soft nondistended.
0630 (cont)	⊕ radial & pedal pulses bil. Cap refill < 3 sec @ finger nail & toenail beds bil. Will cont to monitor [redacted]
0700	IV Ⓛ & Ⓡ FA DC'd. Ⓡ AC 18G restarted. LR Δ'd to D5NS c 20K @ 100cc/hr. Will cont. to monitor [redacted]
0800	Alert. Ⓡ wrist A line intact. Lung sounds coarse Ⓡ & Ⓛ clear. ⊖ BS ABD soft nondistended. D5NS c 20K @ 100cc/hr via Ⓡ 18G AC. No s/s of infection noted. Will cont. to monitor [redacted] b(6)-2
1030	DSG Δ'd Midline ABD - small amt bloody drainage noted on old DSG. Incision c staples c/d/i. No active bleeding or drainage noted. Covered c ABD pad. Secured c tape. Ⓡ neck area DSG left open to air. Wound small @ ½cm x ½cm. No active bleeding or drainage noted. Ⓡ lat chest ↑ DSG Δ'd - Mod amt bloody drainage noted on old [redacted] b(6)-2
1400	Pt c/o Ⓡ chest pain. Pt taught that part of the pain was due to the CT. Pt was given [illegible] Percocet PO. Pt lungs coarse Ⓑ, more in Ⓡ. VS 110/69 - 93 - 30 100[illegible] - 98% SpO2 on RA. CT draining serous fluid, ø leaks, Dressing C/D/I to [illegible] Ⓡ flank. [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/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203
USAP

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08Oct03	1900 - Received report from oncoming shift. Pt awake alert Color good RRD VSS T-100.4 per la TOM. LS-diminished (R) side - CT - 25cm Suction drg - 10cc blood. for the hour SaO2 99% RA. ABD Soft Drs midline CDI, BS hyperactive x 4. (-) Rigidity. Drg around CT CDI. Drg (R) anterior thigh small and serous drg noted. (R) buttock dry small serous drainage noted. (R) radial line patent IV (R) AC, 1YG Patent run D5½NS @ 20K @ 100cc/hr. Foley to gravity drg light clear yellow urine. denies pain at this time. will cont to monitor SGT [redacted]
09Oct03 0100	Percocet 1 tab po for ABD pain VSS NAD drank 180cc H2O SGT [redacted]
090ct030230	- OOB to chair X 1 ½ hrs tolerated well VSS NAD Pt washed, linen Δ, pajama changed back in bed at this time. SGT [redacted] 9mm b(6)-2(all)
09Oct03 0400	- noted ON Pts tongue white irregular circular shapes (lesion) (R) (L) - Pt denies pain will report to dayshift to report to MD. SGT [redacted] 9mm

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
9Oct03 0600	Assumed care of pt @ Night shift report given by Sgt [redacted] PERRLA 3mm. PT Alert. Skin w&d to touch. (R) lat. chest DSG CDI. (R) lat (↓15th DSG) chest tube DSG CDI. Chest tube to suction (25cm). Foley to gravity c̄ clear yellow urine. (R) post. back DSG CDI. (R) Buttock DSG CDI. (R) ant. thigh DSG mod. amt bloody drainage noted. (R) AC 18G IV s̄ s/s of infection or infiltration noted. (R) AC toe c̄ sutures CDI. No active bleeding or drainage noted. D5NS @ 100cc/hr c̄ 20kcl @ 100cc/hr via (R) 18G IV patent. Will cont. to monitor. Lung sounds CTA, BS (+) in all 4 quads, ABD soft nondistended. Sgt [redacted]
9Oct	S- o c/o
	O- ↓ NTBS ō air
	abd- few BS
	b(6)-2
9Oct03 0630	DC'd 16F Foley 9cc removed from bulb. Bulb intact. 100cc clear yellow urine removed from foley bag. DC'd (R) radial A-line, applied pressure for 5 mins. Applied 2x2 & secured c̄ tape. IV fluids ↑ 200cc/hr. Chest tube to water seal. All per MD order. Will cont. to monitor. Sgt [redacted]
9Oct03 (late entry) 0600 (cont)	A-line secured. A-line (R) radial intact. [redacted] DSG CDI.
	Sgt [redacted] b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI | SSN or Other

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[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 21314

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0800	DSG's Δ'd: (R) lat. chest DSG Δ'd - scant amt brown drainage noted on old DSG. Applied 4x4's & secured c̄ tape. (R) lat. chest tube DSG Δ'd - Mod. amt bloody drainage noted on old DSG, chest tube intact. applied xeroform gauze & 4x4's. Secured c̄ tape. (R) buttock DSG Δ'd - Mod amt brown drainage noted on old DSG. Applied nonadhering DSG & secured c̄ tape. (R) post. back DSG Δ'd - large amt bloody drainage noted on old DSG. Applied 4x4's & secured c̄ tape. (R) ant. thigh DSG Δ'd - Mod amt bloody drainage noted on old DSG. ~~Incision~~ Wound c̄ 3 sutures intact. No active drainage or bleeding noted. Applied 4x4's & secured c̄ tape. Midline DSG Δ'd - ~~Pt~~ scant amt brown drainage noted on old DSG. Incision c̄ staples CDI. No active bleeding or drainage noted. Covered c̄ nonadhering DSG. Secured c̄ tape. Will cont. to monitor. ii Percocet po given @ 0755. ——— S[redacted]
1030	Lung sounds clear (L) (R) ↓ slight rhonchi noted [redacted] lobes clear (L) lobes. BS ⊕ in all 4 quads. No D/S in DSG. all CDI. SpO2 @ 97% R 23. IS used c̄ 1 c̄ 1st ball raised & 2nd raised @ x5. IV 18G (R) AC WNL. No S/S of infection/complication noted. Will cont. to monitor ——— S[redacted]
1100	Pt assisted up to chair. SpO2 @ 95% p̄ sitting in chair. Will cont to monitor R 27 p̄ sitting in chair [redacted]
~~1400~~ 1330	Pt assisted back to bed s̄ any problems noted. ——— S[redacted]
1400	Lung sounds clear bil. BS ⊕ in all 4 quads. 18G IV (R) AC WNL. No S/S of infection noted. Midline [redacted] DSG

STANDARD FORM [redacted] (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 21315

ACLU-RDI 1661 p.75

DOD-034891

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
	CDI. (R) Lat. Chest CDI. (R) chest tube site (lat. ↓ 1st DSG) CDI. Back DSG CDI. (R) thigh DSG CDI. (R) buttock DSG Δ'd. Mod amt bloody drainage noted on old DSG. Wound yellowish color approx @ 2cm x 2cm. Applied nonadhering DSG & secured to tape. (R) 3rd toe c̄ sutures CDI. No active bleeding or drainage noted. Will cont. to monitor [redacted]
09Oct03	-VSS NAD received report from outgoing shift b(6)-2
1830	PT A+OX3 PERRLA EOMI. color good. cap refil brisk NVI x 4. Drg ABD CDI, Drg (R) buttock CDI, Drg (R) thigh CDI back Drg CDI, CT to water seal ⊖ noted Drg ON Dressing. LS CTA diminished RLL. ABD soft ⊖ DTN hypoactive BS. Sutures (R) 2nd toe intact. minimal dried blood noted NVI. - able to move unable to check cap refil - toe warm to touch. IV 18G (R) FA intact/patent Rung D5NS c̄ 20K @ 200cc/hr. spontaneous void will cont to monitor SGT [redacted] 91WM6 b(6)-2
10 OCT 03	Pt care assumed at 0600 hours Pt A+O
1147	LS CTA (B) S₁S₂ present. (R) Buttocks Drsg CDI (R) thigh Drsg CDI. Back Drsg CDI. CT to

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

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[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 - 21316

ACLU-RDI 1661 p.76

DOD-034892

b(6)-2 (all)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Water seal. No Dranage on Dsg noted.
	Am care completed. IV 18G In Ⓡ FA.
	Infusing 125cc/h [redacted] Will continue to monitor
10oct03@2045	Assumed care @ 1800; All VSS, pt A&O, pain controlled c̄ percocet; pt void
	per urinal s̄ difficulty; SSz, LS CTA(B), equal & unlabored, IS enc. Q1° while awake;
	dsgs to Ⓡ thigh Ⓡ buttock & posterior CDI, ⊖ drainage; CT to H_2O
	seal intact, ⊖ output; PIV patent infusing D5 NS c̄ 20Meq KCL @ 200
	cc/hr s̄ s/sx infection/infiltration; cont to monitor —— [redacted]
11OCT 03	Assumed care of Pt @ 0600. VSS Pt A&O Pain
	controlled c̄ percocet LS CTA (B) IS 10x day,
	DS to Ⓡ thigh Ⓡ Buttocks, posterior CDI ⊖
	Drainage. CT to Ⓡ Flank CDI. CT to water
	Seal minimal Drainage. PIV Patent infusing D5
	NS c̄ 20meqKCL @ 200cc.h. [redacted]
	monitor —— [redacted]
	(1310) I concur c̄ above assessment. [redacted]
11 Oct	
	Good BS CT output 125, ō air leak will review CXR
	possibly pull tube adv to reg, DC IV + IVAB [redacted]
	middle urine clear dy
(2000)	Pt alert, temp 99, percocet given for pain.
	LCTAB ⊕ BS, HRRR, CT to Ⓡ flank (to water
	seal) Drsgs to Ⓡ thigh & buttock CDI. IV
	HLD. IS use encouraged. 2 pt restraint on
	s̄ compromise to skin/circulation. voiding
	clear mod. yellow urine via urinal. Will mon-
	itor —— [redacted] 91WM6

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

MEDCOM - 21317

ACLU-RDI 1661 p.77

DOD-034893

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
130CT03 0230	Pt had 2 episodes [redacted] diarrhea (watery [redacted] 9 WM6. b(6)-2
13 OCT SM	CXR [redacted]
13OCT03 1500	Pt Awake Stable. CT to suction then to Water seal at 0930. Pt to Radiology for CXR & Flat & upright Abd. IV started. LR @ 200 cc/h @ FA R & G. LS Diminished Lower lobes B. Lat. S1, S2 present Pt tachycardic. ~~Pt~~ 2 episodes of emesis. [redacted] b(6)-2 this sm will continue to monitor. [redacted]
13OCT03 2345	Assumed care of pt @ 1500. VSS slightly [redacted] @99.0. Cont IS and IVFs @200 cc/hr. MD Δ'd CT to SXN, Serosanguinous drainage noted. Sats 96% on RA no resp distress noted. LS CTA, but diminished @ u. Refused OOB to amb 2° pain, Percocet Given c good relief noted. Tol sm amt of reg diet for dinner. Plan: Monitor CT output, resp status, pain control, temperature. Pt restraints on 5 S/S of SXN/circulation compromise. [redacted]

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

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

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#[redacted] b(6)-4

REGISTER NO. | WARD NO. KWA4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

b(6)-2 (all)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Oct 03 1100	VSS Alert & Orient. OOB → BR and up in chair for PCXR with suction disconnected Dr [redacted] informed of 30 minutes without suction. Suction on @ this time. Dr [redacted] Sel. chest tube site drsg and removed Abd staples and replaced ē steri strips. Edges well approx to Midline abd incision. Lungs Clear Bilat ē diminished breath sounds to (R) LL. O2 SAT 97% RA Peripheral pulse +2. Tolerating Reg diet. (L) AC IV patent and intact infusing [redacted] 200cc/hr Will continue care as planned [redacted]
14 OCT 03 @2215	assumed care of pt @ 1800. VSS, 96% pulse ox on RA. alert, speaking arabic LS ē ↓ bases, IS encouraged. (R) chest CT intact, drsg CDI; CT draining sero-sanguinous drainage. CT system intact, to cont. wall suction. Ø resp distress noted. M abd drsg CDI, ⊕BS, ↑ AMB to BR, ⊕BM – loose but controlled. Tol sm amt of Regular diet, drinking H2O & juice. Voiding per urinal s̄ difficulty. LR @ 200 cc/° to (L) FA IV. Plan: monitor resp status, CT system, pain control. Will cont to monitor. ↓ pt restraints on s̄ S/Sx skin/circulation compromise. [redacted]
15 OCT 03 @ 0300	CT output approx 90cc of serosanguinous drainage noted in last 24°. will monitor. [redacted]

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

MEDCOM - 21319

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION
DATE	NOTES	

15Oct03 VSS Alert & Oriented. Lungs clear Bilaterally
1000 c ↓ (R) LL. CXR done & taken up stairs to OR
per request of Dr. [redacted]. Chest tube
to continuous portable suction. Dressing to
CT insertion site dry & intact. Voiding clear
yellow urine. OOB → BR for AM care
Consumed 40% of breakfast. Incentive Spiro-
used properly @ 900-1200 cc/sec. Will continue
to encourage use. Mid line Abd incision c
edges well approximated, with steri strips in place
& drainage noted from incision. Abd soft, non
distended. BS (+) x4 quadrant. Peripheral pulses +2
(L) AC IV patent infusing NS @ 200 cc/hr HOB ↑ 30. b(6)-2
will continue care as planned. [redacted]

15Oct03 Pt Has Verbal Notice via Intercom & Suprapubic
1700 cath clamped. Both episodes upon BR
unclamping suprapubic cath < 30 cc of
urine noted. Wrng pt [redacted] to OTA
b(6)-2

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

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[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

b(6)-2 (all)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15OCT03	@2045= VSS, ∅/10 pain @ present time, A+OX3, Chest tube intact → insertion site (R) lung ⊂ dsg over site CD1, ⊖ drainage on Dsg, drainage to H_2O seal, @ 1225cc upon start of shift, monitoring for further drainage, chest Xray done as ordered, lungs clear (B) but ↓ lung sounds to (R) lower lobe, O_2 sats @ 97% RA, ∅ SIS resp distress. IV peripheral to (L) FA running LR@200 cc/h ⊼ difficulty, Dsg to abdomen CD1, (A) BS X4 quads, X2 restraints ⊼ spin breakdown, Continue to monitor for acute Δ's, [redacted]
16OCT03	Assumed care of Pt @ 0600. Pt denies pain. Chest
1230	tube intact @ insertion site. Drsg CDI. CT → H_2O seal. ~~⊖ Drsg~~ Drainage. LS (R) LL Diminished. VSS LR @ 200 cc/h via 18g cath to (L) [redacted]. Will cont. To monitor. [redacted] 91WM6
16OCT03 @2030	Assumed care of pt @1800. VSS. No ∅ pain. alert, speaking Arabic. (R) CT to water seal, ∅ leaks noted dsg CDI. CT secured to pt's back & system secured to floor. LS CTA ⊃c ↓ bases. IS encouraged. Pt ↑ amb in hallway ⊼ assist. IVFs cont. Tol reg diet well. 2pt restraints on ⊼ SSX of skull or circulation compromise. Plan: monitor resp status, monitor CT & output, pain control [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 21321

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
17 Oct 03 0700	– Assumed care of pt. A+O x3 VSS Lungs clear slight wheezing to @UL. Water seal chest tube pulled per MD. Ø complications CXR ordered in 4°. PIV d/c'd. HRRR Active BS voiding per urinal ambulates w difficulty. Dressing to @chest wall vaseline gauze 4x4 sponge dsg intact Ø bleeding noted Will cont to monitor [redacted] Grn Me, b(6)-2
17 Oct 03 @2345	(1525) I concur c above assessment. [redacted] Assumed care of pt @1800. VSS, no c/o @this time. c/o @chest pain (mod old CT insertion site) taken this shift, Percocet given c good relief noted. @Chest dsg CDI. O2 sats remain in WNL 96-98% on RA. To rt/g diet well. Void per urinal qs quantity sufficient. Amb in hallway s assistance. Plan: CXR in AM, monitor pain control, monitor resp status, enc IS. 2pt restraint on s/s/x of skin/circulation compromise. [redacted] CP b(6)-2
18 Oct 03 0700	– Assumed care of pt. A+O x3. Ø c/o pain or discomfort @this time. Lungs clear. Dressing to @chest wall tube side CDI Ø active bleeding noted. CXR this am complete @bedside. HRRR – Active BS urinating per urinal QS. Ambulates ward s difficulty Will cont to monitor [redacted] Grn Me

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

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
	b(6)-2
18OCT03	(1500) I concur c above assessment. [redacted] AJ
18OCT03	assumed care of pt @ 1800. VSS. No C/O. LS CTA is encouraged,
@2245	sats 97-98% on RA. Pt DIP reg diet, ⊕BS, voided per
	urinal. Pt ↑ amb, took shower, adls difficulty. ®
	Hankdsg (D). Plan: enc amb, monitor resp.
	Status. Tpt restraints MS S/SX of skin/circulation
	compromise. Will monitor. [redacted]
	b(6)-2

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

USAPA V1.00

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

CITY | STATE | ZIP CODE

SEX: M

AGE: 30

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

ARRIVAL

DATE *(Day, Month, Year)*: 7 OCT | TIME: 2015

TRANSPORTATION TO FACILITY

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: SOB / BACK PAIN

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 2015

INITIALS

VITAL SIGNS

TIME	2105	2120	2145		
BP	93/65	118/58 (M)			
PULSE	107	109	101	123	
RESP	15	20	18	20	
TEMP				98.3 (R)	
WT					

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

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

☐ PULSE OX

ORDERS

☐ 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 ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] 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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC 9.1; H/H 14/44; PLT 424

SMAC: 127 | 100 | 14 / 3.8 | 24 | 170 / 1.4

PT

APTT | BHCG | ETOH | GLU

ABG/PULSE OX: SUP O2 | PH | PO2 | PCO2 | SAT | OTHER

U/A: DIP | MICRO

RADIOLOGY — Check if read by radiologist ☐

RESULTS

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

CT in @ 2045
Blood in chest
NG Tube c oral contrast 2110 c. good post tibial & Pulse 2050
O2 10L NON rebreather
Foley Catheter @ 2030
Bi lateral 18G (L) AC
18G (R) AC

45 mL ~~of~~ in chest 2055
200mL 2105

Head
(R) sup. supraorbital
(L) occipital
Legs: ↓ BS (R)
Post chest (R) - 2 shrapnel wounds c bubbling air
Abd - soft nondistended
FAST > fluid
(R) flank shrapnel injury.

2045 100 mcg phentanyl
2045 2.5 mg versed
2051 1gm Ancef @ TOB

PMHx
-0-
PSHx
-0-
Last meal
1400
~~Home Meds~~

A: (R) pneum/hemothorax
P: chest tube placed 38 Fr
50 cc blood out initially.

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted]

PROVIDER [redacted] MASPM

DIAGNOSIS

See above

CODES

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

[redacted] b(6)-4

EPW

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	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: 30 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): Ø NKDA
	3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ?

4. PROPOSED SURGICAL PROCEDURE:

pelvis? Exp Lap 300cc contrast CT via NG

5. ADDITIONAL INFORMATION: Last PO: NPO Medical Hx: ? Implants: ? Medications: ?
Jewelry removed: (yes)/no Family waiting: yes/no

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	Ø Pt. verbalizes any specific anxiety. Ø Pt. exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures, (e.g., warm blanket, touch) Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	Ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress Ø Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	Ø PT. will not exhibit signs of impair-ment of skin integrity (e.g., reddened areas.	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø 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

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

MEDCOM - 21326

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	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø 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	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. ø 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.	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø Validate pt.'s understanding of verbal communications. ø Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/N 7OCT03 DATE

11. POSTOPERATIVE EVALUATION:

Dressings DRI yes
Bowel sute CTI yes
Breathing easily
Move all extremities well

b(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Sign) [redacted] CPT/N

DATE: 7Oct03 TIME: 2235

13. PREOPERATIVE EVALUATION PREPARED BY ([redacted])

DATE: 7Oct03 TIME: 0033

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDCOM - 21327

VIA [redacted] TO OPERATING ROOM — BY [redacted] staff

3. DATE 20 Oct 03 — TIME PATIENT ARRIVED IN SUITE

2. PATIENT IDENTIFICATION VERIFIED BY [redacted] — RECORD REVIEWED AND PROCEDURE [redacted] CPM

4. PATIENT IN ROOM TIME 2305

5. PREOPERATIVE EMOTIONAL STATUS — NUMBER 2-1

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

COMMENTS: b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	[redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Pt placed on padded OR table [redacted] arms on armboards < 90°

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

COMMENTS: Nicks

8. SKIN PREPARATION

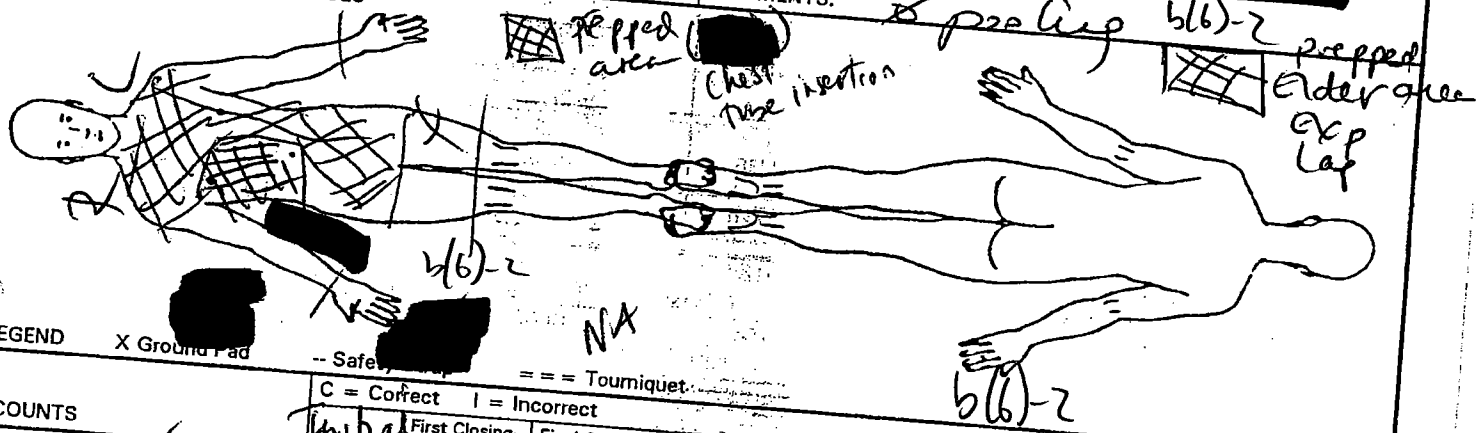
PREP SOLUTION (Specify) Beta / Beta

SITE: See #9 — BY WHOM: [redacted]

SITE: See #9 — BY WHOM: [redacted]

COMMENTS: x prepping b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

			Other	First Closing Count	Final Closing Count
Sponge	☑ Yes	☐ No	N/A	C	C
Needle Sharp	☑ Yes	☐ No	✓		
Instrument	☑ Yes	☐ No	✓		
Other	☐ Yes	☐ No			

SCRUB [redacted] CIRCULATOR [redacted]

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

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO 40/40

☑ ESU NO: VL Force R8B 10230/30 — GROUND PAD: BRAND VL Rem B1 V II — LOT NO: 70011

☐ ESU NO: — GROUND PAD: BRAND — LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ YE ☒ NO IF YES NAME: ID NUMBE[illegible] [illegible]FACTURER

b(6)-2 (all)

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

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 36FR Chest Tube	2.	3.
SITE	1. (R) Chest	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Staples - 4X8 Gauze Pad
tape 2"
Xeroform 2X2 Silk Tape

19. ADDITIONAL INFORMATION

[redacted]

[redacted]

b(6)-2 (all)

20. OPERATION(S) PERFORMED

Chest Tube Change OUT
Exp Lap

21. PATIENT TRANSFERRED TO ICU 2 TIME 0033 METHOD letter & O2 via face mask

22. REG[illegible]D NURSE SIGNATURE [redacted] CRNA

REVERSE

USAPA V1.00

MEDCOM - 21329

PT'S NAME: # [redacted] b(6)-4

DATE: 08 Oct 03

arrive 2000

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																		138/82	142/84	134/77	139/86	111/71	107/64	138/73
BP NIBP																0	0	96		98	98	99		99
TEMP																		168	164	170	165	168	172	171
PULSE																R	R	22	20	20	18	19	20	15
RESP																		100	100	100	100	100	96	100
SP02																		102	102	102	102	NA	NA	NA
FIO2																								
INPUT																								
IV																								
IVPB blood																	2500	[redacted]	100	100	100	100	100	100
																				450				
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
																	2500		2600	3150	3250	3350	3450	3550
OUTPUT																								
URINE																	700	[redacted]	250	130	200	150	250	300
NGT																		0	30	50	30	0	40	30
STOOL																								
CT																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
																		280	200	230	150	200	250	300
BALANCE																	700	-	780	1180	1410	1560	1850	2080

MEDCOM - 21330

ACLU-RDI 1661 p.90

DOD-034906

PT's NAME: # [redacted] b(6)-4

DATE: 08Oct03

b(6)-2

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	108/62	109/64	110/69	151/82	110/95	119/77	125/76	134/[illegible]	127/86	132/81	124/72	118/68	122/74	138/56	119/69	105/74	108/68	100/58	114/68
BP NIBP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	114/68	110/50	112/72	110/65				118/74	115/68			128/78		124/66					
TEMP	[illegible]	99.4	100.2	100.2	100.5	100.6	100.6	100.8	100.8	100.8	100.8	100.7	100.4	100.4		100.	99.8		99.6		100.2		98.0	
PULSE	69	74	75	92	79	83	83	89	93	94	81	88	77	68	72	84	74	68	79	88	76	75	68	85
RESP	19	25	25	26	27	24	26	26	30	30	20	34	19	24	26	18	20	22	18	19	22	14	16	18
SP02	97	97	95	95	97	95	95	98	98	99	99	100	100	100	100	100	100	100	100	100	100	100	100	98
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
IS			[redacted]																					
INPUT																								
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
IVPB	150							100	50			100						100						
	[redacted]																							
PO	440			60	30			60	60															
NGT																			180					
O.R. IN																								
SUB TOTAL																								
TOTAL	250	350	450	610	740	840	940	1200	1410	1510	1610	1810	1910	2010	2110	2210	2300	2500	2680	[illegible]	[illegible]	[illegible]	3180	3280
OUTPUT																								
URINE	400	90 [redacted]	100	50	60	100	100	100	100	400	200	200	150	200	200	175	200	250	200	175	200	200	150	150
NGT																								
STOOL																								
CT	25	25	5	Ø	Ø	25	25	50	5	20	20	20	[illegible]	[illegible]	15	20	[illegible]	20	[illegible]	[illegible]	15	10	10	5
O.R. OUT																								
SUBTOTAL																					215			135
TOTAL	425	540	605	655	715	840	965	1115	1220	1640	1860	2090	2090	2100	2115	2135	2145	2165	2175	2400	2615	2825	3055	3240
BALANCE																								

MEDCOM - 21331

#1

b(6)-4

09 Oct 03

MEDCOM - 21332

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

EPW

[redacted] b(6)-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 OCT 03 DAY

19 HOUR

5 OCT 03 | 10 | 11 OCT | 12 OCT | 13 OCT | 14 | 15 | 15

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)*

REGISTER NO.

WARD NO.

#[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

MEDCOM - 21334

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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	H2O	1000cc	1000cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	200cc	LR IVF	2400cc	0600	2400cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

MEDCOM - 21335

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
18-06 HOUR	1200	1200			
1800	800	800			
1500 03 2100	700cc	700cc			
2300	500cc	1200cc			
0045	500cc	1700cc			
0530	600cc	(2300cc)			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST TUBE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
14 0000	45cc				
15 (06-06) 0600	90cc	(90cc)			
1500 03 1800 Start of shift →		@ 1225cc			
1800 03 0600	0	(1225cc)			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
18-06	1200	1200			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600					
1800	100	100	1800		
18-06	60	160			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

REMARKS

GRAND TOTAL OUTPUT

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

[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 16 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	H20	500	500
1800	H20	500	1000
1800	JUICE	180	1180

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	200	LR		1800	2400
1800	200	LR	2400		4800

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

#[redacted] b(6)-4

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

b(6)-4

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		3.5-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/d
		7-22 mg/dl
		8.0-10.3 mg/
		100-200 mg/
		0.6-1.2 mg/d
		73-118 mg/dl
		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
		73-118 mg/d
		7-22 mg/dl
		0.6-1.2 mg/dl
		39-380 /l (M) 30-190 /l (F)
		128-145 mm
		3.3-4.7 mmol
		98-108 mmol
		18-33 mmol/

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/07/03 21:21

b(6)-4

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.2 sec.
Ratio = 1.2
Calculated INR = 1.28
Sample Type:citrated wh. blood
Test Date :10/07/03
Test Time :21:16
Card Lot [redacted]
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/07/03

b(6)-4

Patient ID: [redacted]
Test Name :APTT
Test Result:= 29.9 sec.
Sample Type:citrated wh. blood
Test Date :10/07/03
Test Time :21:17
Card Lot [redacted]
Operator [redacted]

b(6)-2

======= PICCOLO =======
07/10/03 21:04
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	170*	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	137	39-380	U/L
NA+	127*	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

b(6)-2

tCO2		18-33 mmol/l

RI

RE

:

Ward/Section: EMT	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted] b(6)-4	DATE	TIME	SSN/PEEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x10	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x10	App	clear	N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu	Neg	Negative	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili	Neg	Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x10³ verified	SG	1.030	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	~~Neg~~ Small	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	2+	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk	Neg	Negative	Macroscopic Urinalysis		
RBC Morph			HCG		Negative	SSA - Trace Epi-s-10 Heavy-MUCUS		

Spun Hematocrit		42-52%(M) 37-47%(F)	CSF		Blood Bank	
Set 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 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:

REPORTED BY: [redacted] b6-2	DATE:	LAB ID NO.:

Pats

b(6)-2

Ward/Section: IM2	REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] b(6)-4	DATE 10 OCT 03	TIME 2245
		SSN/PE[redacted]SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x1(verified
Lymph %		20.5-51.1%

(Hematology) Manual Different

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		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:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2 b(6)-4

Ward/Section: IW 2	REQUESTING PHYSICAN [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 10 OCT 03 TIME 2256	SSN/PEEUDO SSN: [redacted]

(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 =======
07/10/03 22:58
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	91	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	6.8*	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	133	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	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
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:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2 b(6)-4

Ward/Section: OR	REQUESTING PHYSIC [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE 7Oct03 TIME 2350	SSN/DE [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/dL
K	3.7	3.5-4.9 mmol/L
CI		98-109 mmol/L
pH	7.378	7.31-7.45
PCO2	37.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	454	80-105 mmHg (art) N/A (ven)
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-3	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.11	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	8	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
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^{++}		8.0-10.3 mg/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) Metlyte 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 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(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:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI. # [redacted] b(6)-4	DATE 08 Oct	TIME 0300	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M 37-47%(F
MCV		80-94 fi(M 81-99 fi(F)
Plt		130-500 x1 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differen

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		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: F/u after blood transfusion

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section: 1CU2 | REQU [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted] | DATE 0806 | TIME 0430 | SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)

PICCOLO
08/10/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
b(6)-2

GLU	146*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	905*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank (MUST SUBMIT SF 518 W REQ

UNIT		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro		

b(6)-2

REMARKS: [redacted] met 8

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. 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
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^{++}		8.0-10.3 mg/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) Metlyte 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 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(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:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 21346

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ~~ICU~~ ICU2 / b(6)-4 / b(6)-2

REQUESTING PHYSICIAN: [redacted]

LAST, FIRST,MI: # [redacted]

DATE: 09OCT TIME: 0400

SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (art)

(Piccolo) Chemistry 12

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

======= PICCOLO =======

09/10/03 04:47

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: [redacted]

OPER #: [redacted] DR #: /000

SERIAL #: b(6)-2 [redacted]

GLU	133*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	1955*	39-380	U/L
NA+	127*	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	23	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:

REPORTED BY:

)..:

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
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 x10³ 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)
Set Rate		
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: Met 8 CBC

REPORTED BY:	DATE:	LAB ID NO.:

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICW #1

REQUESTING PHYSICAN: [redacted] b(6)-2

DATE: 130ct

TIME: 1338

LAST, FIRST,MI. [redacted] b(6)-4

SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 mm 23-28 mm
SO2		95-98%
BEecf		(-2) - (+3 mmol/L
AnGap		10-20 mr
Ca		1.12-1.32
BUN		8-26 mg
GLU		70-105 r
Creat		0.7-1.5 r
Hct		38-51%
Hgb		12-17 g

Misc. Chemistry

TEST	RESULT	REF. R
Tropoin-1		
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
		8.0-10.3 mg/dl
		00 mg/dl
		.2 mg/dl
		8 mg/dl
		.1 g/dl
		REF. ANGE
		8 mg/dl
		mg/dl
		.2 mg/dl
		30 /l (M) 90 /l (F)
		145 mmol/l
		.7 mmol/l
		08 mmol/l
		3 mmol/l

(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^{+}	130	128-145 mmol/l
K^{+}	4.2	3.3-4.7 mmol/l
CL^{-}	94	98-108 mmol/l
tCO2	37	18-33 mmol/l

REMARKS: CBC + Lytes Please

REPORTED BY: [redacted]

DATE: 130ct13

LAB ID NO.:

b(6)-2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 24 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE:
SURGICAL SERVICE: I+D @ Arm + Leg
NPO SINCE: 1800

136/76 93

ASA Physical State 1 2 3 4 5 (E)
WT: 190 KG/LB HT: ____ IN.
ALLERGIES: NKA

HABITS:
TOBACCO: (X)
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( )
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

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

T&A
5 probs

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

T&A
(X) Probs

PHYSICAL EXAMINATION

BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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.

Signed: [redacted] b(6)-2 Date: 07 Oct 03 Time: 2020 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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.

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
Fentanyl (mcg)		150	100	250
Scopolamine (mg)	.4			
Vecuronium (mg)			5	5
Propofol ( )				
VOLAT AGENT Iso % del		1.3 - 1.0		
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min		3 - 3 - 10 - 10		

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

TOTAL EBL: mini - 350 c clot

TOTAL URINE: [redacted] 700cc b(6)-2

FLUIDS

LINE site
- 16g IV (L) forearm — Warmed
- R IJ 8.5 Fr Cordis — Warmed — 2100 crystalloid — 2500

FLUIDS - SUMMARY
- CRYSTALLOID- 2500cc
- COLLOID- Ø
- BLOOD- 1 unit

LOSSES EST BLOOD LOSS; URINE - Foley

PHYS STATUS (1) 2 3 4 5 (E)

BODY WEIGHT: 50 KG

HEMATOCRIT:

INITIAL DATA: BP- 82/42

HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE?

TIME-

TIME: 2300 15 30 45 0000 x 0030 x 0100 x 0130 x 0200

~ Walters in @ 2345

SYMBOLS: BP by cuff V ^; 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	730	750	700	800
f - breaths/min	8	8	8	10
Peak inf pres / PEEP	16	16	16	10
MODE - S(pon), A(ssist), C(on)	C	C	C	S

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

ET CO2 (torr)				37	35	36	35
FIO2 (Frac or %)	FM	.63	.63	.63	.73	.73	.73
SpO2 (%)		100	100	100	100	100	100
ECG	ST	ST	ST	ST	ST	ST	ST
TEMP-site							
N-M Block (T/4)					2/4		4/4 EST

Mark with letters & symbols, explain under REMARKS — EVENTS (1); Position

REMARKS

Code drugs with numbers, events with letters

(1) U/S Taken
(2) Inducted c̄ Norcuron 7mg, Diprivan 120mg, Anectine 120mg, O2 ; Intubated
(3) Procedure began
(4) 8.5 Fr cordis R IJ seldinger technique (sterile) ⊙ transduced / ⊙ comp.
(A) radial A-line
2335 ABG H2H 33/8 b(6)-2
0000 1 unit [redacted]

[redacted]

0015 Reversed c̄ Sm. Neostig 2.0mg, Robin 0.4mg
0030 Extubated c̄ positive, Awake to ICU c̄ Crash O2 - Report to RN

RECOVERY AT 0040

PACU (ICU) 2 (Specify)

OTHER

CONDITION: Stable mask O2

RESP- 28 SpO2- 100 c 10L

BP- 145/72 HR- 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2245	2305	0045

	Ready	Begin	End
PROC	2320	2340	0035

PROCEDURES and CPT Codes: Ex lap

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

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

[redacted] b(6)-4

SURGEONS [redacted]

ANESTHETI[redacted] CRNA [redacted] MDA

[redacted] Y 2 ANESTHESIA PROVIDER CRNA

b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 7 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 USAPA V1.00

MEDCOM - 21351

ACLU-RDI 1661 p.111

DOD-034927

518-123

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-4158

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable): 1 Unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 7 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print): [redacted] b(6)-2

DIAGNOSIS OR EXAMINATIVE PROCEDURE: Ex Lap

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 5 Oct 03

TIME VERIFIED: 1800

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: B
Rh: Pos

RECIPIENT
ABO: B
Rh: Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

DATE: 7 Oct 03

REMARKS: exp 14 Oct 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature): [redacted] b(6)-2

AT (Hour): 2300

ON (Date): 7 Oct 03

IDENTIFICATION

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

1st V[redacted] b(6)-2

nd VE[redacted]

RE-TRANSFUSIO

MP. 37

PULSE 96

BP 122/65

TE OF TRANSFUSION 7 Oct 03

TIME STARTED 2359

IENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, midd[redacted] rate; hospital or medical facility)

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: ALL ML

TIME/DATE COMPLETED/INTERRUPTED: 0010 8 Oct 03

REACTION
- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
37	95	125/65

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ]

SIGNATURE: [redacted] b(6)-2

CRWA

M

WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 21352

518-123

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-41

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable): 1 Unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 7 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print): [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Ex Lap

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 8 Oct 03

TIME VERIFIED: 0800

UNIT NO.: b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: B
Rh: Pos

RECIPIENT
ABO: B
Rh: Pos

SECTION II – PRE-TRANSFUSION TESTING

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DATE

REMARKS: Exp 8 Oct 03 b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature): [redacted] b(6)-2

AT (Hour): 0005

ON (Date): 8 Oct 03

IDENTIFICATION

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

1st VERIFIER (Signature): SGT [redacted] b(6)-2

2nd VERIFIER (Signature): [redacted] b(6)-2

PRE-TRANSFUSION
TEMP. 98
PULSE 70
BP 139/77

DATE OF TRANSFUSION: 08Oct03

TIME STARTED: 0200

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 (all) ML

TIME/DATE COMPLETED/INTERRUPTED: 0800ct03

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE: 97.4

PULSE: 64

BLOOD PRESSURE: 140/80 (arterial)

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: SGT [redacted] b(6)-2

SEX: M

WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 21353

ICW1 (1200) Thank you

NSN 7540-01-165-7254 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED
Portable
CXR
PA/LAT

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
			ICW1	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print) Dr [redacted]

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR [redacted] b(6)-2

DATE REQUESTED 12 Oct 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*
Chest tube removed
(R) side

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
17 Oct 03		

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
EPW##
[redacted] b(6)-4
Room 1
bed A

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 21354

NSN 7540-01-185-7294

Morning

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR - portable please		M	[redacted]	ICWF1	
	FILM NO.			PREGNANT ☐ YES ☒ NO	
	REQUESTED BY (Print) [redacted]			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR			DATE REQUESTED 20CT03 0400 please	

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

b(6)-2 b(6)-4

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
20/12/03		

RADIOLOGIC REPORT

Clin Note

1) RLL opacity
2) Small (R) Pneumothorax - (2cm - 3cm - (R) apex near.)
3) (R) CT
4) ghepard.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 21355

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 | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 Oct	0630 HOURS	[redacted] b(6)-2

1. A IV to D 1/2 NS1000 w/ 20 meq [redacted] at 100/h
2. DC NG
3. OOB chair PRN
4. sips of water
5. Percocet 1-2 po q4 prn pain DC MS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER

6. CXR AM 9 Oct also HC [redacted] b(6)-2
7. Incentive to 25 cm [redacted]
8. OOB chair
9. IS [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
9 Oct 03	0905 HOURS

△ IV to D5NS i 20 meq KCl @ 100 cc/hr

V/O Dr. [redacted] Noted Sgt [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM | BED NO.

DATE OF ORDER	TIME OF ORDER
11 Oct 1300	HOURS

1) Reg diet
2) DC IV + all IV meds
3) portable CXR now + 0400 12 Oct 03

[redacted] Noted [redacted] 11 Oct 03 [redacted] b(6)-2

DA FORM 4 APR 79 42 REPLACED ED CH MAY BE USED

11 OCT @ 2200 — 1

☆ U.S. G 1994-353-710

MEDCOM - 21356

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	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	9 Oct 03	0630 HOURS	
1	DC A line done		
2	DC Foley done		
3	full liq diet		
4	CXR portable 10 Oct am		
5	Nystatin DC nwirly + mouth		
6	↑ IVF to 200/hr		
7	1 lyte 10 Oct		

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICW	24	1

DATE OF ORDER	TIME OF ORDER
9 Oct 03	0630 HOURS
1 CT to water seal	
VO. Dr [redacted]	

b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW	1	

DATE OF ORDER	TIME OF ORDER
13 Oct 0930	HOURS
1 portable CXR 1600	
2 water seal	

[redacted] b(6)-2

noted [redacted] 13 Oct 03 1325

PATIENT IDENTIFICATION

[redacted] b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW	1	

DATE OF ORDER	TIME OF ORDER
13 Oct 1300	HOURS
1 Erect/upright CXR now eval for SBO and pneum	
2 IV LR at 200/hr	
3 CBC, 1 lyte	

[redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

MEDCOM - 21357

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	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10/13	2030 HOURS	

① CT to SKN

V.O. DR [redacted] CPT b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
[redacted]	24	14OCT03 @ 0200

PATIENT IDENTIFICATION

b(6)-4 [redacted]

14 Oct 03 1100 [redacted] b(6)-2

DATE OF ORDER	TIME OF ORDER
14 Oct 03	HOURS

b(6)-2

CXR now + am 15 Oct [redacted]

None

NURSING UNIT	ROOM NO.	BED NO.
24	14OCT03 @ 1945	

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER	TIME OF ORDER
16 Oct 0100	HOURS

CXR 0400

[redacted] b(6)-2

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24	17OCT03 0200	

PATIENT IDENTIFICATION

[redacted]

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.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-563-710

MEDCOM - 21358

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 / HOURS	LIST TIME ORDER NOTED AND SIGN
# [redacted] b(6)-4		13 Oct 0930	
	(1)	walk seal	
	(2)	CXR AT [redacted]	
		b(6)-2	
NURSING UNIT: [redacted] ROOM NO. [redacted] BED NO. [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 REPLACES EDITI MEDCOM - 21359 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 b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICWF1	[redacted]	A

DATE OF ORDER 19 OCT 0830 TIME OF ORDER _____ HOURS

discharge pt [redacted]

LIST TIME ORDER NOTED AND SIGN

19 Oct 03 1837

b(6)-2

PATIENT IDENTIFICATION b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

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 7 8 9 10 11 12
7OCT	[redacted]	DIET: NPO @ 18 NG TO LIS	06	/ / → D/cd 08Oct
			18	[redacted]
7OCT	[redacted]	ACTIVITY: BEDREST	06	/ → D/cd 08Oct
			18	[redacted]
7OCT	[redacted]	VS Q4°	06	/ [redacted]
			18	[redacted]
7OCT	[redacted]	(R) CT TO -20CM SUCTION	06	/ A/d.
			18	[redacted]
7OCT	[redacted]	FTG DRAIN - CALL MD	06	/
		IF UO < 60CC IN ANY	18	[redacted] F/o/g D/C'd
		2 CONSECUTIVE HOURS	/	[redacted]
7OCT	[redacted]	CT OUTPUT, IF >	06	[redacted]
		600 CALL M.D.	18	[redacted] CT to H2O Seal
8OCT	[redacted]	O2 SATS MONITOR	06	/ [redacted]
		≥ 90%	18	/ [redacted]
8Oct03	[redacted]	OOB Chair BID	06	/ [redacted]
			18	/ [redacted]
8Oct03	[redacted]	Sips of water	06	/ [redacted] D/C'd
			18	/ [redacted]
8Oct03	[redacted]	(R) CT to 25cm Suction	06	/ [redacted] CT to Water Seal
			18	/ [redacted]
8Oct03	[redacted]	IS	06	/ [redacted]
			18	/ [redacted]
9Oct03	[redacted]	Full liq diet	07	/ [redacted]
			12	/ / D/C'd IV/DB
			18	/ [redacted]
9Oct03	[redacted]	CT to H20 Seal	06	/ [redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: PENETRATING WOUND (R) BACK & PNEUMO/HEMO & LIVER PENETRATION (all) b(6)-2

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.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
07 Oct	[redacted]	admit to ICU 2 condition fair	~~07 Oct~~ ~~2130~~	2130	2130	[redacted]	
07 OCT		CONDITION: FAIR	7 OCT	—			
07 OCT		CBC, LYTES, PORTABLE CXR	8 OCT	0400	0400		
07 OCT		TYPE AND SCREEN	7 OCT	2145	2145		
08 OCT		PORTABLE CXR NOW					
8 Oct		CXR am 9 Oct also CBC	9 Oct	0400	0400		
9 Oct		CXR 10 Oct 03 AM & lytes	10 Oct	0400			
11 OCT 03		Portable CXR now	11 OCT 03				
12 OCT 03		Portable CXR @ 0400 12 OCT 03	12 OCT 03	0400			
		b(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED

MEDCOM - 21362

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

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 11	12	13	14	15	16	17	18	19
01 OCT 03	[redacted]	VS q4°	06	[redacted]								
			18									
08 OCT 03	[redacted]	OOB to chair BID	06									
			18									
08	[redacted]	IS	06									
			18									
09 OCT 03	[redacted]	CT to H2O seal & suction	06									
			18									
11 OCT 03	[redacted]	Reg diet	06									
			18									

DLCD

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Penetrating Wound (R) back Liver Lac Hemo/Pneumo

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

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

MEDCOM - 21363

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
11 OCT03	[redacted]	Portable CXR now	11 OCT03	—		
11	[redacted]	Portable CXR @ 0400 on 12OCT03	12 OCT03	0400	done	
13 Oct	[redacted]	Portable CXR @ 1600	10/13			
13 Oct	[redacted]	Flat & upright CXR now (Eval for SBO & pneumoperitoneum	10/13	1300		
	[redacted]		/			
10/13	[redacted]	CBC, lytes	10/13			
10/14	[redacted]	CXR in AM 15Oct	10/15	0400		
	[redacted]					
	[redacted]	b(6)-2				
	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					

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

MEDCOM - 21364

USAPA V1.00

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED
9/04/03	[redacted]	CT to H20 Seal	18	9 10 11 [redacted]
		b(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

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

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 7	8	9	10
7 OCT 03	[redacted]	IV LR @ 100cc/HR	06	✓		A	✓
			18	[redacted]			
7 OCT 03	[redacted]	ANCEF 1GM IVPB	06	✓	[redacted]		
		Q8°	14	✓			
	-----		22	✓			
8 OCT 03	[redacted]	CIMETIDINE 200MG	06	✓			DCd 11 OCT 03
		IV Q6°	12	✓			
	-----		18	✓			
	-----		24	[redacted]			
8 OCT 03	[redacted]	D5 ½ NS ⊂ 20 Meq KCL	06	✓		A	✓
	-----	@ 100cc/hr	12	✓			
8 Oct 03	[redacted]	D5 NS ⊂ 20 Meq KCL	06	✓	[redacted]		
	-----	@ 100cc/hr	18	✓		A	✓
9 OCT 03	[redacted]	D5 NS ⊂ 20 Meq KCL	06	✓	[redacted]		
	-----	@ 200cc/hr	18	✓			DCd 11 OCT 03
9 OCT 03	[redacted]	Nystatin Swish &	06	✓	[redacted]		
	-----	Swallow	18				

	-----	b(6)-2					

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: PENETRATING WOUND (R) BACK ⊂ PNEUMO/HEMO & LIVER PENETRATION

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.

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. OCT Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8 OCT 03	[redacted]	T UNIT PRBCs NOW				
11 OCT 03	[redacted]	D/C IV and all IV meds	11 OCT 03			[redacted]
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
		MSO4 2-6mg IV q 1-2 hrs prn PAIN	8 Oct 0835 4mg [redacted] RN
8 OCT 03	[redacted]	Percocet 1-2 po q 4° prn pain	1615 8 Oct 2030 8 Oct 0100 [redacted] 9 Oct 1855 9 Oct 1820 [redacted] 10 OCT 1500 10 OCT 1330 12 Oct 2225 11 Oct 0150 11 OCT 0817 [redacted]
		b(6)-2	

MEDCOM - 21367

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

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 11	12	13	14	15	16	17	18	19
10/03	[redacted]	ANTIBIOTIC	[redacted]	[redacted]								
		Bacitracin	18									
10/13	[redacted]	IV LR @ 200 cc	06 18 18 06	/ / / /								
		b(6)-2										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Penetrating Wound (R) back Liver Lac Hemo/Pneumo

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.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 10 Yr. 03

Verify by Initialing

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11 OCT 03	[redacted]	D/C IV and all IV meds	11 OCT 03			[redacted]
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — [redacted] SPENSED
08 OCT 03	[redacted]	Percocet 1-2 PO q4° prn pain	D/T 1630 2100 0730 1130 2200 0500 1700 2100 0415 0915 0900 1730
			D/I [redacted]
08 OCT 03	[redacted]	Percocet 1-2 PO q4° PRN pain	D/T 2215 1345 2015 1000 2015 1200 0100
			D/I [redacted]
		b(6)-2	

[redacted] b(6)-4

MEDCOM - 21369

*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: 08Oct03
Time In: 0040
Allergies: NKDA
Pre-op V/S: 82/42
Procedures: ex lap

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2500 Colloid
OR Output: UOP 700 EBL 350
Meds/Times: 2SD 1ent

Drains: Hemovac, (NG), JP, T-tube, (Foley), TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	0040	0055	0105	0120	0135	0150
SaO2						
FiO2						
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	16	18	18	20	18	
T	96.3	97.1	98	98.4		
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

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	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	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	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	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

PREPARED BY (Signature & Title)
SGT [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 2

DATE
08Oct03

(Continue on reverse)

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

[redacted] b(6)-2

[redacted] b(6)-4

- ☐ 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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0235	-	MSO4	IVP	4mg	E	MZ

NEUROVASCULAR

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

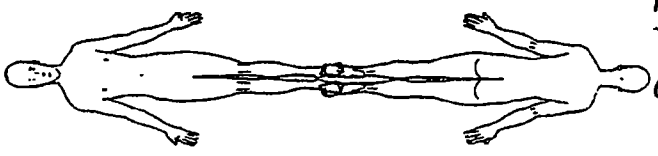
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	abd/R chest	bulky	0
30'	"	"	0
60'	"	"	0
D/C	"	"	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	SEE I+O		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		N/A	

WAMC OP 173-E

NURSING NOTES

b(6)-2

0040 - Transferred via litter to ICU2 S/p ex lap & chest tube replacement. Pt responsive to verbal (loud) pain 2mm sluggish VS 138/82 p68 R22 SaO2 100% 10L venturi. report received from Dr. [redacted] anesthesia present. Color good pacu score 7. able to move all extremities. Cordis @ jugular. blood tube c blood completed from OR still attached. site noted blood under op site. 16G @ AC patent flush LR @ 110 18G @ PA heplock c 3 way stopcock @ radial a-line zeroed, functions dyn midline abd bulky CDI, DRG @ lat chest wall c CT @ 20SM Sucha) 1600cc blood in pleural noted on arrival. Foley d/c'd at 0115 light yellow clear urine. will cont to monitor SBT [redacted]

0115 - unable to flush cordis Dr. [redacted] notified. cordis b(6)-2 (a)(1) removed & pressure held well. - cont SF 600 SBT [redacted]

911 WMC

Discharge Criteria: ADMIT
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: **Output:**
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

Admission [illegible]oding Information

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

1. Reporting MTF	2. MTF Lo	
0580 [redacted]	IZ	b(2)-2

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted] b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	29Y	X	9	ISLAMIC

10. Length of Service		11. FMP	12. Social Security Number	
	ETS	99	[redacted] b(6)-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	20:05	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU2	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
0580 - 28th CSH - Iraq; No Install Provided	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-10-19

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-07

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-07

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: PENETRATING WOUND R BACK LIVER LAC, HEMO/PNEUMO

Procedure Narrative(s): T: 1 Inj: 448 Dx: 86239 86410 8605 8901 8771 S731 E999.9 PR: 54 [illegible] 2

Cause of Injury Narrative: [redacted] b(6)-2

Admitting Officer (Signature, as req[illegible]: [redacted]

Signature of Admitting Clerk: [redacted] SPC, 9/6/12

MEDCOM - 21372

Automated Facsimile

IN. ATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name		3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4		FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	21Y	X	UNKNOWN			NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]	b(6)-4	ICW1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER	ARMY		BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	09:30	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-12

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-09	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-10-09	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L LEG INJURY

Open (E) TIB FRX

DX: 11042 20302 73020

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

[redacted] ding Medical Officer [redacted]

Signature of PAD or Medical Records Officer [redacted]

Automated Facsimile - DA FORM 3647, May 79

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

MEDCOM - 21373

(b)(2)-2

[redacted] MEDICAL TRANSFER REQUEST FORM

b(6)-2

DATE OF REQUEST: 07 OCT 03 b(2)-2

REQUESTOR: LTC [redacted] BN Surgeon

[redacted]

b(6)-4

ISN #: 18811

~~COMPOUND~~: Correction Hospital

PRIORITY: ASAP

LITTER/(AMBULATORY) (CIRCLE) with crutches

DESCRIPITION OF INJURIES:

Left tibia fracture 2° to GSW

Wears long-leg cast

* Requesting x-ray of LLE to asses healing status

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: Ø

DATE OF TRANSFER: 08 OCT 03

TIME OF TRANSFER: N/A

DESTINATION: [redacted] b(2)-2

POC AT DESTINATION: PAD

ANTICIPATED LENGTH OF TRANSFER: N/A

EQUIPMENT REQUESTS:

NOTE: COORIDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

Followed by Iraqi surgeon

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24 y/o Iraqi ♂ GSW (L) leg 2½ months ago - Treated & cast as OPT in Iraq hosp. x 2 months. EPW x 1 week

PMHx: x

PSHx: 0

Meds: pcn

Allergy NKDA

PHYSICAL EXAMINATION

Head: WNL

Chest: CTA

Abd: soft

Ext: Mid shaft soft tissue bx: exposed bone, chronic, 2+DP/PT

XR: Mid shaft fibula bone bx

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

(A) Chronic Open (L) TIB/FIB Fx

(P) Admit

b(6)-2

SIGN [redacted]	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.

b(6)-4

[redacted]

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07OCT03	S- Has a tibia fracture 2° to gun shot Has worn a long-leg cast for appx two months O Long leg cast on LLE c wound window just below calf Good pedal pulses [Wound care administered by an Iraqi surgeon] A Tibia fracture Long leg cast > LLE P- X-rays LLE to assess status of healing [redacted] LTC MC 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 [redacted] b(6)-2		

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

MEDCOM - 21376

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

Discharge Summary

10-12-03 This patient has a chronic left tibia fracture with osteomyelitis and segmental bone loss. This injury and chronic condition is not reconstructable at any U.S. facility in country. The only reasonable option for this patient is below knee amputation. This patient has ~~repeatedly~~ steadfastly refused below knee amputation on numerous occasions. Therefore he can be treated as an outpatient with chronic suppressive antibiotics and long leg cast for several months. His fracture will not heal and he will have chronic osteomyelitis and ~~minimally~~ functional extremity. Unless he requests below knee amputation, he does not require further inpatient orthopaedic care and outpatient follow up with Iraqi physicians at EPW hospital can be made in 2 months.

[redacted] USD)

b(6)-2

b(6)-4

[redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDCOM - 21377

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 OCT 03 0135	VSS. AO. 25 C2AB. HRR. ⊕ pulses to include Ⓛ foot. c/o 7/10 pain to Ⓛ leg and provided 4 mg MSO4. NPO for Sx on 10/11/03 by Dr. Olivaio. All other systems WNL. Voids light yellow urine sufficient. b(6)-2 [redacted]
11OCT03	(1620) Assumed care of pt w ... p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4. Dsg to LLE CDI. Pt's surgery rescheduled for 12OCT03. Pt aware. Pt amb c̄ crutches s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. SL in Ⓡ forearm flushes well s̄ s/sx infection/infiltration. Will cont. to monitor. [redacted]
11Oct03	@2000: VSS, ∅ c/o pain @ this time, A+Ox3, gets OOB & crutch walks s̄ difficulty, Dsg to Ⓛ LE CDI - reinforcing / Δ'ing PRN. NPO p̄ MN for OR tomorrow, initiating IVF's @ MN, HL to Ⓡ FA patent, x2 restraints when in bed s̄ s/s skin breakdown. Continue to monitor. b(6)-2 [redacted]
12OCT03	0910 Pt Transported to OR indicated he did not want BKA. Dr stated he would give him a cast & discharge when pt A&O VSS — [redacted] b(6)-2
12OCT03 @1131	VSS, 98% O2 Sat RA; HR 77; T-98.3; BP 112/57. NPO prior to OR and R after. LLE cast in b(6)-2 place c/d/i, amb indep on crutches. HL to Ⓡ arm patent. Restraints per ... [redacted]

STANDARD FORM [redacted] ACK
USAPA V1.00

MEDCOM - 21378

ACLU-RDI 1661 p.138

DOD-034954

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9OCT03	1720: Pt admitted to ICWI from ER via wheel chair. VSS. Pt. A+Ox3. Lung CTA. (+) BS x4 (+) pulses. +IL in (R) upper arm patent to flush. Pt. NPO pending OR. [redacted] on (R) lower leg c/o. Edema to (R) foot. (+) Complaints @ this time [redacted]
b(6)-2 (cont)	
5 OCT 03 1927	VSS. AO. (R) foot OTA = dry, crusted skin = edematous. (+) pulses to RLE and CMS intact. LSCTAB, HRR. NPO until 5x this PM. Provided blanket @ this time. [redacted]
10OCT03	(1055) Assumed care of pt @ 0600 per report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c MSOq. Drsg to LE d/d this am. Three wounds on LE draining small amount of sero-sang drainage. (+) pedal pulse equal bilat. Skin warm/dry to touch. Pt able to move toes. Pt OOB to BR c crutches, for personal hygiene. Amb well c crutches. Feet elevated in bed. SL in @ ac flushes well s S/Sx infection/infiltration. Tol. reg. diet well. Voiding s difficulty. 2 point restraint in place s S/Sx complications. Will continue to monitor. [redacted] MD, AD

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

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° | 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 enter: 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 - 21380

24yo Iraqi

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)
	( )
	( )
	( )
	( )
	( )
VOLAT AGENT	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

FLUIDS

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES

EST BLOOD LOSS	
URINE -	

TOTALS | **TOTAL EBL** | **TOTAL URINE**

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Versed 2mg IV
Fentanyl 50mcg IV
Rocuronium 80mg IV
Versed 2mg IV
Fentanyl 50mcg IV
Rocuronium 80mg IV
Versed 2mg IV
Fentanyl 50mcg IV
Rocuronium 80mg IV
end

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- ____/____

HR-

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME →

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	
f - breaths/min	
Peak inf pres / PEEP	
MODE - S(pon), A(ssist), C(on)	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)
BP/oth	FIO2 (Frac or %)
ART line	SpO2 (%)
Steth- PC/ES	ECG
Gas analyzer	TEMP-site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* →

RECOVERY AT

PACU ICU _____(Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

I&D

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

[redacted]

ICW, b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEON: [redacted] b(6)-2

ANESTHESIOLOGIST: [redacted]

PROCEDURE LOCATION:

DATE: 12 OCT 03

PAGE OF

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

MEDCOM - 21381

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 ____ HOURS	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] b(6)-4		10-9-03 [redacted] - Admit ICW - [illegible] 1 - Dr - Open tibia fx (L) leg - osteo - Stable - Routine Vitals - Reinforce Dressing (L) leg PRN - Ambulate c̄ crutches - ~~Regular Diet~~	NOTED 9 OCT 03 1700 [redacted] b(6)-2
NURSING UNIT / ROOM NO. / BED NO.			
EPW [redacted] b(6)-4		DATE OF ORDER / TIME OF ORDER ____ HOURS - NPO now - Heplock IV - Demerol 50mg IV q4° PRN pain - Phenergan 25mg IV q6° nausea - [redacted]	
NURSING UNIT / ROOM NO. / BED NO.			
b(6)-2 (all)		DATE OF ORDER 10/9/03 / TIME OF ORDER 1940 HOURS [redacted] V.O. ① Regular diet ② MSO4 [redacted] q4-6° [redacted] prn [redacted]	[redacted] 10/9
NURSING UNIT / ROOM NO. / BED NO.			
		DATE OF ORDER 10/10/03 / TIME OF ORDER 1930 HOURS ① Percocet tabs i-ii q4° PRN PO for pain ② NPO p̄ MN V.O. Dr. [redacted]	[redacted]
NURSING UNIT / ROOM NO. 22 [redacted]		0340	

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

DA FORM 4256

MEDCOM - 21382

ACLU-RDI 1661 p.142

DOD-034958

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	10-12-03	0900 HOURS	
	① D/C to EPW Hospital @ CAMP ASAP		
	b(6)-2	b(6)-2	
NURSING UNIT: ICW#1 / ROOM NO. / BED NO.			

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

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

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

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

MEDCOM - 21383

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo OCT Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9 OCT	[redacted]	Admit- ICW 1	9 OCT	DNR E		[redacted]
9 OCT		DX: OPEN TIB FX (L) leg c OSTEomyelitis	9 OCT	DNR E		
9 OCT		STABLE	9 OCT	—	—	
10 OCT		NPO pMN	11 OCT	0000	—	
12 OCT		D/C to EPW Hospital or camp				
		ASAP				
		b(6)-2			b(6)-2	

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

USAPA V1.00

MEDCOM - 21384

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. 05

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12
9 OCT	[redacted]	HEPLOCK IV	06	[redacted]			
	-----		18	[redacted]			

	-----	b(6)-2					

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Open fib 7x @ leg - Osteomyelitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [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 MEDCOM - 21385 ITIL EXHAUSTED.

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

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

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED			
9 OCT	[redacted]	Demerol 50mg IV	9 OCT 2030	10 OCT 1115	10 OCT 1815	
		q 4° PRN pain	50 [redacted]	50mg	50mg	
9 OCT		Phenergan 25 mg				
		IV q 6° prn nausea				
10 OCT		MSO_4 q 2-6° 2-8mg	D/T	10 OCT 0900	10 OCT 2030	10 OCT 0840
		prn	D/I	5mg [redacted]	3	5mg
10 OCT		Percocet i-ii PO	D/T	10/10 1930	11 OCT 1700	11 OCT 03 2115
		q 4° prn pain	D/I	2 [redacted]	II	ii

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

MEDCOM - 21386

Admission and Coding Information

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

1. Reporting MTF	2. MTF Loc.
0580 [redacted] b(2)-2	IZ

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] b(6)-4	[redacted] b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	21Y	X	9	UNKNOWN

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] b(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	09:30	ARMY

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:
0580 [redacted] Iraq; No Install Provided

Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH b(2)-2		2003-10-12

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-10-09

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-09

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L LEG INJURY

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 21387

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	20Y	X	ISLAMIC			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted] b(6)-4					ICU3	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
NO	K78-PRISONER OF WAR/INTER	ARMY		DIS			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		05:30	ABA - GENERAL SURGERY				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-11-03				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-10-10	[redacted] b(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] Iraq b(2)-2			2003-10-10				

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P EX LAP WOUND DEBRIDEMENT

Dx 998.32
868.14
877.1
04.13
04.16 V44.3
00.83 E991.2
890.0
876.0

Proc 83.02
86.59
86.04
46.10
88.40
87.44
99.04 (4)

b(6)-2

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	[redacted]	0	25	25

Signature of Attending Medical Officer [redacted]

Automated Facsimile - DA FORM 3647, May 79 MEDCOM - 21388

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
10 OCT 03	TRANSFER NOTE (CONT) AFTER INITIAL FLUID RESUSCITATION (R) WAS TAKEN TO THE O.R. AT LAPAROTOMY THERE WAS NO INTESTINAL INJURY OR FECAL SPILLAGE, BUT (R) HAS AN EXTENSIVE RETROPERITONEAL HEMATOMA. A DIVERTING SIGMOID END COLOSTOMY WAS DONE & THE (L) BUTTOCK WOUND WASHED OUT (NOTE - THERE IS STILL MILD/MOD OOZING FROM THIS WOUND). THE (R) KNEE WOUND HAS NOT BEEN ADDRESSED YET.
	IN SUMMARY, HE HAS AN EXTRAPERITONEAL RECTAL INJURY WHICH HAS BEEN DIVERTED, BUT HE WILL LIKELY NEED HIS RECTAL STUMP IRRIGATED & PRE-SACRAL DRAINS PLACED. HE HAS HAD 4 IV PRBC TRANSFUSED POST-OP.
	[redacted] MD, MC
	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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 OCT 03 (0330)	BRIEF OP NOTE PRE-OP DX: TRANSPELVIC GSW POST-OP DX: SAME, + EXTRAPERITONEAL RECTAL INJURY PROC: EX LAP, DIVERTING COLOSTOMY, (L) BUTTOCK WOUND IRRIGATION SURG: [redacted] b(6)-2 ANESTH: [redacted] FLUIDS: EBL: < 100mL UOP: FINDINGS: EXTENSIVE RETROPERITONEAL HEMATOMA W/ NO INTRAABDOMINAL FECAL SOILAGE, BUT (+) FECAL SPILLAGE FROM (L) BUTTOCK (EXIT) WOUND COMPLICATIONS: Ø CONDITION: GUARDED, TO PACU [redacted] MAJ, MC b(6)-2
10 OCT 03 (0400)	GENERAL SURGERY TRANSFER NOTE ~20 y/o IRAQI EPW SUFFERED GSW x 2 - ↓ THROUGH PELVIS + ↑ INTO (R) THIGH/KNEE. ON ARRIVAL PT WAS AWAKE + ALERT + HEMODYNAMICALLY STABLE. ON EXAM PT HAS AN ENTRANCE WOUND ON THE LATERAL (R) BUTTOCK + EXIT WOUND FROM LATERAL (L) BUTTOCK. FROM THE EXIT WOUND TRACT IS GROSS FECAL SPILLAGE C/W RECTAL INJURY, + IRR WAND (+) GROSS BLOOD ON RECTAL EXAM. INITIAL HCT = 39. ON THE (R) THIGH TRACT IS A MID-LATERAL ENTRANCE WOUND + NO EXIT. THERE IS NO FEMUR FX, A RETAINED FRAGMENT BEHIND THE (R) KNEE, + INTACT PULSES DISTALLY. →

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*U.S. GPO: 2000-461-707/20307

[redacted] b(6)-4 b(6)-2 (all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
	[redacted]		

DATE	NOTES
11Oct03	1440 labs drawn per A-line sent [redacted]
	1520 labs reviewed by Dr [redacted]
	orders received [redacted]
	1540 1st bag of KCl ē 15meq @ 150cc/hr hung [redacted]
	1710 DR [redacted] @ bedside. update given on ā WOE MTUF PES. orders received to extubate. pt paced.
	1720 DR [redacted] translator @ bedside update given to pt. pt nods ē respond to explanation. ↓ fentanyl gtt 50mcg/hr.
	1740 pt extubated. DR [redacted] @ bedside along ē RT. placed on 40% ō humidified SpO2 99%. RR 30s. NSB ES CTA [redacted]
	1750 ↓ fentanyl 25mcg/hr. ∅ distress noted @ this time [redacted]
	1810 report given along ē new orders
	1900 Report received; pt recently extubated. RR > 30, SaO2 98% on SM 40%; CTM; assessment complete & charted; HOB↑30° [redacted]
	interpreter called to have pt understand post extub instructions and general medical condition; questions answered by interpreter [redacted]
2000	DHT NC due to gagging of pt; pt repositioned for comfort [redacted]
2100	drsg W→D done to buttocks/ deep wound packed ē Kerlix; covered ē ABD; ∅ hemorrhage; minimal drainage; ⊕ foul odor; ∅ purulent d/c; abdomen drsg done; covered ē Kerlix – no d/c ē small x1 staple open to lower wound; MD in to see pt; V.O. for tylenol 650mg PR for temp > 101.5; Fentanyl 50mcg bolus given for drsg [redacted]

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b(6)-2 (all)

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11Oct03/0600	Report given. Dr [redacted] @ bedside, update given to Dr by Lt Ayer [redacted]
	0600 pt remains on Dopamine @ 3mcg/kg. tapered off. Labs sent placed on chart. [redacted]
	0720 sx'd scant amt of thin white secretion per ett/oral [redacted]
	0840 pt opens eyes to verbal stimulation, follows commands does not breath over vent setting Ø pain noted [redacted]
	1025 left for surgery
	1150 return back from surgery [redacted]
	1155 hung 2u PRBCs. [redacted] verified by 2RN, see DA Form 4700 for continuous VS. [redacted]
	1300 sx'd thick orange color secretion [illegible] NGT/WS c green to [illegible] drained noted. Flush c 30cc NS [redacted]
	1320 2nd u PRBC's completed [redacted]

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

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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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[redacted] b(6)-4

EPW

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Continual (24hr): nocturnal stirs; constantly reminded to keep O2 mask on [redacted]

face; VSS WNL no new issues

b(6)-2

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

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
12 OCT 03	BRIEF OP NOTE
	PRE-OP DX: 1.) R/O ABD WOUND DEHISCENCE
	2.) PELVIC GSW SIP COLOSTOMY
	POST-OP DX: 1.) ABD WOUND DEHISCENCE
	2.) PELVIC GSW
	PROCEDURES 1.) ABD WOUND EXPLORATION
	2.) LAPAROTOMY
	3.) RETENTION SUTURE PLACEMENT
	4.) (L) PELVIC WOUND I/D
	SURGEONS: [redacted] b(6)-2
	ANESTH: [redacted]
	FINDINGS: 1.) SMALL MIDLINE FASCIAL DEHISCENCE
	2.) CLOSURE W/ RETENTION SUTURES; SKIN/SQ LEFT OPEN/PACKED
	3.) PURULENT (L) BUTTOCK/PELVIC COLLECTIONS DRAINED & CX'ED
	SPEC: BUTTOCK WOUND CX
	COMP: Ø
	DISP: TO ICU #3 b(6)-2
	IVF: 800cc UOP: 100 [redacted] MAJ, MC

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)

[redacted] b(6)-4

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b(6)-2(c11)

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12Oct03	0600 Assumed care. Report given. See ICU-3 flowsheet for initial assessment. [redacted]
	0620 reinforced drsg on abd area wound oozing sm red blood.
	0730 Translator @ bedside. Pt date given to pt about NPO status ē surgery [redacted]
	0800 IS given. Dlaugi instructions pt able to completely blow IS [redacted]
	1030 VSS. oozing from mid line abd incision. Apply more drsg [redacted]
	1230 Temp 102. pt Tylenol given c sips of H_2O. [redacted]
	1440 Dr Davis @ bedside. update given about midline abd site. Orders received to watch site for continuous oozing [redacted]
	1500 abd drsg Δ'ed. [illegible] will continue to monitor for additional drainage @ site [illegible] [redacted]

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

E [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2, (c11)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12OCT03	1555 Taken to surgery and Tell Dept 1810 Report given. Pat remains in surgery [redacted]
20CT03@(2100)	Pt returned from OR @1915. Placed on 3L NC. Lines flushed and hooked up to fluids. NGT hooked up to LWS. Δ'd some sheets and placed bunn pads underneath Patient stable. Dr [redacted] stopped by to see pt. Put in Dobhoff through @ nares. Upper abdominal x-ray done. Dobhoff to Ⓓ of stomach. Dr [redacted] also checked in on pts Continuing to monitor. [redacted]
(2100)	See DA form 4700 OP 378 for assessment data. [redacted]
(0330)	Pts sats went down to 88-89% on 1L O2. Bumped back up to 3L Sats up to 91-92%. Worked with Incentive Spirometer and cough deep breath. Assistance & interpreter. Sats now up to 97-98%. Sleeping well. [redacted]
(0600)	Did dressing Δ to Ⓟ thigh c 4x4's Abd over top. Tissue beefy red healthy. Dressing Δ to Ⓞ buttocks cheek. W-D c 4x4's & 2x2 c ABD over top. Fentanyl 7 to 100 mg/hr for Dressing Δ. Pt worked on I.S. again. Not wanting to cough. Slightly uncooperative. [redacted]

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b(6)-2 (all

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13Oct03	/0000 Assumed care. Report given
	SEE ICU-3 flowsheet [redacted] RN
	0630 DR [redacted] @ bedside, dsg
	d/c'ed. orders received [redacted]
	0700 Tylenol given per NGT [redacted]
	1030 pt left for surgery.
	1310 Received from OR.
	1310 Buttock dsg d/c'ed. oozing noted
	from wounds. pt refused to use
	IS. CPT given to force coughing to
	clear secretions [redacted]
	1430 pt weaned to FIO2 2L/min, sats
	@ 98% - 99% [redacted]
	1650 new cannister placed for
	NGT, dk green drainage [illegible]
	1800 Report given [redacted]
13Oct03	Alert X3 - USS - O2 @ 2L via NC O2 @ 100%. IV @ LR c 15 meq
1900	q K+ infusing @ 100 ml/hr. to (L) cordis, Fentyl infusing to
	(R) subclavian c 60 mcg is patent A-line pressure 109/63 - MAP 84.
	DSGs to midline Abd, (R) hip, (L) buttock are intact, (L) buttock has (con

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

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[redacted] b(6)-4

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b(6)-2 (oll)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13oct03	lg Amts of drainage D/C @ 8° and Repacked c soaked w 25 in NS Placed
(Cont)	to gravity drainage clear yellow urine. T-101° Tylenol 650mg given
1800	per NG. ——— Sgt [redacted] 91C20
13oct03	NG and feeding Tube DC'd per VO from MD DR Davis.
2000	Artline accidently dislodged, pressure applied dressed c 4x4's.
	subclavian line drsgs Δ'd both Ⓡ and Ⓛ. Sgt [redacted] 91C20
13oct03	T-100° - VSS - Resting quietly. O2 on @ 2L SATs 94-96% via NC.
2100	Drsg Δ to Abd incision due scant amt of bloody drainage, Ⓛ buttock
	large Amt of light red drainage, Ⓡ thigh mod amt of
	bloody drainage noted. ——— Sgt [redacted] 91C20
14oct03	T-99° VSS - Ø c/o pain or discomfort. Sgt [redacted] 91C20
2400	
14oct03	T-99.5 VSS - Resting quietly. ——— Sgt [redacted] 91C20
0300	
14oct03	T-101.5 - Tylenol elix 6.5ml given PO. CBC lytes drawn.
0400	Tolerating small amts of H2O. ——— Sgt [redacted] 91C20

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15 Oct 1630	
	Op note
	Pulse lavage, debridement, vac drain application
	Fluid 800 EBL 50 Duration 1h b(6)-2
	Reapplication ostomy [redacted]
Post	PACU; Tylenol 650mg po; premed V.O. for MS [redacted]
	for temp > 101.5; will have Day shift report ab [redacted]
16 Oct	S - pain b(6)-2
	O - febrile 101.5 P 100
	might leave wound a little 'soupy' near ostomy wafer
	which tends to get loose there Δ'd again now
	vac drain fct'g
	WBC 14 (↑ from 8.0)
	A - stable
	P - cont vac drain re temp WBC + cleanliness [redacted] wound on
	next change in 1-3 days in OR [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

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b(6)-2 (all)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Oct 03	Assumed pt care @ 0600. Pt sleeping comfortable in bed c complains of pain. Given 5mg [redacted] Changed Abd dressing + colostomy bag. Started T[redacted] using 20cc/hr. Will continue to monitor [redacted] LT/AN
16 Oct 03 (2025)	Received report from [redacted] and assumed care of pt @ 1930. Pt resting in bed. See DA Form 4700 OP3[redacted] for assessment data. Pt c/o pain in abdomen and legs. MSO4 given as ordered. Relieved pain [redacted] No needs @ this time. AN
(2115)	Pre-medicated pt c 5mg MSO4. Δ dressing to ML abdomen w/ NS (2) 4x4's c Abd over top. Δ'd (R) lateral thigh c NS w→D (2) 4x4 c (4) 4x4 over top. Pt tolerated ok. Moved pt up in bed. Gave sip of H2O. Checked backside. Vacuum on [redacted] to vacuum. Dressing intact [redacted] AN
17 Oct 03 (0645)	Pt stable throughout night. Tmax 101.7. Tylenol given down to 101.°. Abdominal dressing Δ to done around 0400. Tolerated ok. Bed bath and foley care done @ 0430. Linen Δ'd. Pt stable @ this time. Report given to [redacted] AN
17 Oct 03	Assumed pt's care @ 0600. No [redacted] complaints @ this time. Pt is resting comfortable in bed [redacted] 755 NPO to go to OR. Δ'd Abd dressing [redacted]
1605	Pt went to OR VSS temp [redacted] LT/AN
1710	Came back from OR via Stretcher [redacted] pt 250mcg Fentanyl, 300cc Crystaloid, 98 urine output EBL 40cc.
1715	VS HR 80 BP 110/44 RR 18 O2 sat 97%
1730	HR 89 BP 111/52 RR 20 O2 sat 99%

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b(6)-2 (911)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2000 15Oct03	assumed PT care @ 1800. shift assessment on flow sheet. changed Thigh dressing and abdominal dressing. Small amounts of blood from Thigh dressing noted. Old dressing had new amounts of brownish yellow exudate soaking thru. abdominal dressing changed w/o lifting colostomy NS SOAKED w/ 4X4's then TAPE. wound appeared free from S/S of infection. SKIN on PT's back appeared Red w/ ~~this~~ SR Groove from sheet in it. PT LIPS have multiple pustules on them. With [redacted] given PT now resting comfortably ——— SPC [redacted]
15Oct03 2100	PT resting comfortably VSS will continue to monitor ——— SPC [redacted]
16Oct03 0200	PT resting pain controlled w/ M.O.Y. PT in NAD. SPC [redacted]
15Oct03 2245	Heparin shot given in (R) upper arm beneath deltoid Toward front of arm. Blue port on TRIPLE Lumen is NOT PATENT. ——— SPC [redacted]
15Oct03 2400	PT Legs Repos. Due to PAIN PT sleeping ——— SPC [redacted]
16Oct03 0015	VSS temp up to 100° still in PT's Parameters. PT has edema in hands and feet. Raised legs & had PT cross arms [redacted] while sleeping. ——— SPC [redacted]
16Oct03 0130	PT's KUB for Tube placement done. X-RAY @ bedside. PTs Legs repositioned again for pain. PT sleeping in NAD. — SPC [redacted]
16Oct03 0400	LABS Drawn for 1 time order CBC & LYTES PT sleeping comfortably dressings CDI in NAD ——— SPC [redacted]
16Oct03 0430	PT's condition of LIPS, pustules, dry, Passed on to DR who responded he will look at it in the am ——— SPC [redacted]
16Oct03 0500	PT temp spiked to 101.8 Tylenol given will cont to monitor [redacted]
16Oct03 0550	PT temp down to 101.4. PT sleeping comfortably. Legs repositioned, 0600 MARS run. ——— SPC [redacted]

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b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Oct03	1745 US HR 87 BP 111/52 RR 14 [redacted] % RA stable pain relieved ☺ 5mg MSO4. [redacted] LT/AW
17oct03 1830	Alert-X3 USS - T 100°. MSO4 5[redacted] c/o wound pain. IV of D5½NS ☐ 40 KCL @ 40 ml/hr to ① subclav line is patent all ports flush easily. Dressings to Abd midline, ® thigh, ① buttock CDI & drainage noted. b(6)-2 Sat [redacted]
18oct03 2400	USS - MSO4 5mg IVP given @ 2230 hr c/o ® thigh and ① buttock pain. Dressings to ® thigh, ~~① but~~ midline Abd. SD - Abd dsg had small amt of ~~bright red~~ bloody drainage - ® thigh moderate ~~amt~~ qty & Reel drainage both repacked moist 4x4's soaked NS covered ☐ Abd pad. Tolerating TF well is @ 80 ml/hr per NAT. - Sat [redacted]
22Oct [redacted]	b(6)-2 b(6)-2

O - afeb 110/50 100 Lot 23 WBC/P 130
Pre drsg 1100 100 24 / 20
wound clean 1.3 160 / 212
A - stable b(6)-2 300
P - wean off 24 Oct 100 / 1300
↑ TF to 100/hr [redacted]

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

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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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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10OCT03(2200)	Had one unit for pt to start. Unable to identify pt. Did another crossmatch & starting blood. No reaction at this time. [redacted] (2030)

Unit #1	Temp	HR	BP		
started 2135	100.9	127	109/56	(agitated)	b(6)-2
2140	100.3	121	91/45	(calm)	
2145	100.°	120	89/43		
2150	99.6	117	94/44		
2205	100.4	111	90/41		
2210	99.9	121	90/43		
2235		122	73/35		
2250	99.8	131	86/44		

(2250) Pt's BP started to go down to SBP 70's & MAP 50. Stopped blood occassionally. Called Dr [redacted] instructed to finish the blood and decrease Dopamine to 3mcg/kg/min. LR bolus approx 750cc given to pt as ordered earlier. CVP's from 11→18 ~ blood & LR. Pt received 250cc NS ~ blood. [redacted] 77n

Unit #2	Temp	HR	BP	11OCT03	Temp	HR	BP
(2300)	99.8	125	75/42	(0035)	99.°	118	92/53
2315	98.6	122	73/40				
2400	99.0	118	79/46				

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

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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		

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b(6)-2 (o11)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19Oct03	0800 4mg MSO4 IVP, c/o pain drsg Δ'ed completed on [redacted] Apap
19 Oct	SURG
	T 102 x1 yesterday
	O - looks better
	odor to wound
	cult c̄ coli sen to cefepitin
	tol TF at 80/h
	A - stable
	P - wash out [redacted]
19Oct03	1010 ABX drsg Δ'ed, viewed by DR [redacted], along c̄ bed wound. Orders received - [redacted]
	1020 Blood panel drawn p/k CVL, sent to lab. [redacted]
	1150 pick-up labs.
	1330 rotate to relieve pressure and buttocks
	1530 labs reviewed by DR [redacted]
	1610 update given to ~~DR~~ pt about surgery tomorrow per translator. [redacted]
	1810 report given.

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b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18Oct03/0000	Report given. Temp 102.[illegible] Tylenol given. Tolerated swallowing c difficulty [redacted]
	0730 pt assist c AM care. [redacted]
	0840 Dr [redacted] @ bedside. Update given. ∅ new orders received [redacted]
	0955 OOB to chair c assistance 4mg MSO4 IVP given for pain control. [redacted]
	1005 [illegible] [illegible]. reconnected to [illegible] @ 80cc/hr [redacted]
	1125 pt tolerate sitting up well. [redacted]
	1355 [illegible] back to bed. pt did most of work. [illegible] dsg [illegible] orders received from Dr [redacted]
	1350 MSO4 4mg IVP given c/o [redacted]
	1620 Dsg [illegible] on [illegible] [redacted]
	1810 Report given.
19Oct03/0600	Assumed care. Report given [redacted]
	0730 AM care given [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	[redacted] (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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[redacted] EPW

b(6)-4

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b(6)-2 (c4)

470mg Fan
2500 fluid

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20Oct03	0600 Assumed care, report given to 0830 [redacted] @ bedside. Update given: new orders received. Trans. [illegible] @ bedside. pt informed @ about surgery today [redacted]
	1100 c/o pain. MSO4 5mg IV given [redacted]
	1220 Taken to surgery
	1347 Return from surgery
20 Oct 03	Nutrition Note
1430	Pt c̄ GSW in rectal area. Currently on Perative TF @ 80cc/hr providing 2496 kcal/day + 128g Pro/day. Wt: 70 kg
	ENN: 2100-2450 kcal/day (30-35 kcal/kg) + 91-105g Pro/day (1.3-1.5g/kg). Recommend TF formula Δ when Perative runs out. Recommend Osmolite HN @100cc/hr to provide 2400 kcal/day + 106g Pro/day. [redacted] RD/LD
20Oct03	1420 Labs drawn [illegible] per [illegible] sent to lab. [redacted]
	1500 Rotate c̄ assistance. MSO4 given 5mg IVP [redacted]
	1600 Results given to Dr. [redacted] [illegible]

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.

EPW [redacted] b(6)-4

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b(6)-2 (cont)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Oct03	1720 [illegible] @ bedside. Instruction given to pt for rotation q 2 to prevent bed sores [redacted]
	1810 [illegible] given
21 Oct	0645
	S- pain
	O- afeb
	[illegible] TF at 80/h UOX [illegible] [illegible] 25 WBC 8
	wound clean lytes OK
	A- [illegible]
	P- q 2-3 d washout + vac dsg [redacted]
21Oct03 0658	Received pt resting in bed. VSS, A&Ox3.
	Perrla, dobhoff intact & infusing peratives
	@ 80cc/hr w/o apparent complication, RR, HBR,
	see flow sheet for vitals, triple lumen to (L) subclav
	patent & intact, ∅ redness or swelling noted
	@ insertion site. Mid line abd incision w/ dsg
	c/d/i, q4° Δ; LUQ colostomy, stoma pink, ∅ stool @
	this time. BS⊕x3. (L) hip wound intact to cont
	suction. Pulses palpable in (B) UE + (B) LE, pt has positive
	toe wiggle + push/pull strength w/ (B) LE. Dsg to (L)
	thigh c/d/i, foley + wound vac tubes secured. [redacted]
	LSCTA @ and equal rise/fall [redacted]
0830	Abd midline wound w/ retention sutures. Dsg
	Δ W->D, ∅ foul odor or foul drainage noted small

cont.

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b(6)-2 (all)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21OCT03 0830	cont serosang. drainage noted on old dsg. @ thigh Δ w/
	small amt serous drainage noted, Ø foul odor.
	Foley cat to drain clr, yellow urine, colostomy w/
	scant amt soft, formed stool. [redacted]
21Oct03	Pt sitting in chair, resting. [redacted] complaints
	verbalized @ this time. See flowsheet for [redacted]
	assessment [redacted] PT/AV
	1830: assessment complete; pt returned to bed; [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.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2300703	(1255) Pt admitted to ward via gurney from ICU3 in stable cond. Pt alert, speaking Arabic. VSS. Φ c/o pain. Vac. device to buttock drsg intact c high cont. suction draining sm. amount of sero-sang. drainage. Drsg to midline abd incision Δd, wet→dry. Site ∃ S/Sx infection. Binding straps intact. Osmolite tube feeding infusing into Dobhoff @ 100cc/hr ∃ difficulty. IVFs infusing into triple lumen in @ SC ∃ S/Sx infection/infiltration. Drsg to RLE CDI - changed in ICU this am. Tol reg diet. Foley draining quantity sufficient clear yellow urine. Foley Δd in ICU this am. 2-point restraints in place ∃ S/Sx complications. Colostomy bag intact c sm. amount loose brown stool. Bag emptied c min. assist from pt. Will continue to monitor. b(6)-2 [redacted] RN
	(1720) Pt OOB to chair independently. Tol. well. Personal hygiene done by pt. Dobhoff cleaned in @ nare - tape reapplied. Monitoring. b(6)-2 [redacted] RN
(1955)	Pt OOB to chair, VSS, c/o pain, medicated c 1 Perc-ocet. vac device intact to buttock drsg c high cont suction. midline abd drsg Δ'd (WTD). binding bande

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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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#1

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2 (all)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	intact. dophoff retaped to Ⓡnare. osmolite @100cc/hr unfuzing Ⓓsc triple lumen unf- uzing D5½NS ĉ 20meq KCl @40cc/hr. Θ edema or redness @ site. Drsg to Ⓡle CDI. Foley drain- ing QS cyu. Rt NPO p 0600 for OR. 2 pt restraints on 5 compromise to skin or circulation.
24OCT03 0400	Will monitor [redacted] 91 WMC. Tube feeding turned off, IVF ↑ to 100cc/hr. dophoff flushed & capped ots. Monitoring [redacted] 91 WMC.
24OCT03E 1300	Pt. received from PACU, S/P posterior to buttocks. Midline DRSNG to abdomen Δ'd moderate amount of yellow-red drainage, W→D DRESSING Δ'd Q4°. Colostomy bag Δ'd in OR, MD D/C'd NG tube. Pt. encouraged to eat full meal & drink Ensure ĉ every meal. Pt. ate 90% of meal & drank 1 can of Ensure. DRSNG to buttocks has high continuous suction, moderate amount of serosanguinous fluid. All other assessments WNL. [redacted]
24OCT03E 1700	Pt. OOB to chair. W→D DRSNG to midline abdomen Δ'd. Pt. offered Percocet for pain, Pt. refused. IV fluids D5½NS ĉ 20KCl @ 40cc/°. [redacted]
(2010)	Rt alo, VSS, clo pain, premedicated ĉ 5mg MSO4 for drsg Δ (Q4°). colostomy bag intact. Ø leakage noted. high cont suction to buttocks ĉ bloody drainage. D5½NS ĉ 20meq KCl @40cc/hr CL drsg CDI, Θ edema or redness @ site. Rt consumed 25% dinner. Will monitor [redacted]

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b(6)-2

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
23 Oct 03	Received pt from Cpt [redacted] Pt sleeping in bed, easily arousable. Pt has perative @ 100cc/hr running through dobbhoff tube, and D5NS ē 20k running through LSC Triple lumen @ 40cc/hr. pt has no c/o pain at this time. — Sgt [redacted] LAW 0715 - Dr [redacted] at bedside. Pt dressings changed. Abd wound very purulent. Thigh (R) wound beefy red. Colostomy emptied. — Sgt [redacted] LPK
23 Oct	S- O- afeb VSS wound - rough, slight necrotic central mid line crising otherwise granulating, good vac on dressing A - stable P - OR 24 Oct, ↑ act [redacted] ← b(6)-2 →
	0850 - CBC drawn, Foley changed. Pt being transferred to ICU. Pt VSS. Pt colostomy bag emptied for 2nd time today. No c/o pain Sgt [redacted] CPL
25 Oct 03	Changed out vac drain, wound (2) by mouth, + ant portion closed c 3 2-0 nylon. JP regulated in deep tract going laterally to pt's (R) & curled in rectal wound area →

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

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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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[redacted] b(6)-4

MEDCOM - 21411

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	+ packed c NS soaked gauze + betadine ointment applied
	Fluids 600 LRC min [redacted] b(6)-2
	note 1st 30 min spent d'ng colostomy bag, (R) thigh dressing + old wound dressing. Bag leaking all over pt's flank + into wound, + midline dressing soaked in green. Ostomy d'ng [redacted] is separated from skin @ 270°, otherwise OK. Wolff replaced, only 6" was in pt [redacted] b(6)-2

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b(6)-2 (c11)

LAST NAME | NAME | INITIAL AND NUMBER

DATE	NOTES
26OCT03	(cont) dd bag. Drsg to RLE cd wtd. Pt OOB to chair independently. Amb in room - c/o dizziness - returned to bed. Drsg to buttock wound c vac device to high cont. suction, leaking sm amount serosang drainage. MD aware. @ SC triple lumen infusing IVFs c S/Sx infection/infiltration. @ point restraints in place c S&Sx complications. Td. SOL reg diet well. Foley draining quantity sufficient clear yellow urine, will continue to monitor. [redacted] MW
27OCT03 0200	Assumed care of Pt @ 1800 hrs. Pt A&O Speaking Arabic. Pain controlled c percocet ~~MS~~ M504. Pt completed self colostomy care. NPO @ this time. cont Antibiotics Midline Abd Drsg Δ q 4°. LR infusing @ ~~150~~ 150 cc/h via L SC Triple lumen. 2 point restraint [redacted] Spc 91WM inplace. Will continue to Monitor.
27Oct03 1443	Assume care of Pt @ 0600. LSJ, A+OX3 2x restraints present without any signs of skin irritation. Colostomy bag intact. Hasn't eaten awaiting for surgery, c/o being hungry. Abd dsg to midline and (R) leg @ bleeding or infection. Will continue to monitor. [redacted] 9/W SPC

2NOV @ R

Wound washout - irrig clean - fully Δ'd

retention removed

[redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2
25OCT (0530)	UOP this shift 1100cc mod. yellow urines, input this shift 700cc. [redacted] 91WMla
25OCT03	(1710) Assumed care of pt @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Vac device to buttock wound intact to high cont. suction. Drsg to open midline incision dd q4°. Colostomy bag intact c sm. amount dark brown stool. Pt doing own colostomy care. IVFs infusing into triple lumen in OSC s S/Sx infiltration. OOB to chair independently. Tol well. 2 point restraints in place s S/Sx complications. Tol reg diet well. Foley to gravity draining quantity sufficient clear yellow urine will monitor. b(6)-2 [redacted] 91WMb
25 OCT 03 0145	Assumed care of Pt @ 1800. A&O VSS. Pain controlled c percocet and MSO4. Vac Device to Buttocks wound. Drsg to Open midline incision d. 94°. Colostomy Bag CDI. Foley To Gravity Draining CYU. Will continue to monitor. b(6)-2 [redacted] Spc 91WMb
26OCT03	(1610) Assumed care of pt @ 0600 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Abd drsg dd q4° WD. Colostomy bag dd d/t leakage from

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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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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
27 Oct 2000	
	Op note
	Pulse lavage wound good granulation; exposed bone is
	being covered; packed c̄ NS soaked Kerlix + will do
	at bedside for few days + ↑ act of pt → ambulate
	[redacted]
	b(6)-2

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

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PROGRESS NOTES
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MEDICAL RECORD — **PROGRESS**

DATE	NOTES
27OCT03	b(6)-2 Pt returned from ICU 3 via litter. Pt able to self from litter to bed. [redacted] Rectal wound draining Yellow/Green Fluid. Wound [redacted] is malodorous. NS ~ 20meq KCL running @ 40 cc/h. colostomy bag has thick Black Stool. FDG Draining CVL. Pain controlled ~ Ibuprofin. Will continue to Monitor. — [redacted] Spc 91W/M6
28OCT03 1135	VSS. AO. Sit'd OOB to abdomen and (R) inner outer thigh. Seen by MD this AM and instructed to sit on hip OOB in afternoon. Provided rag tube to patient while seated in chair. Ambulated ~ walker for 35 min ~ assistance. Minimal c/o dizziness @ first trial of ambulation and stated 0 c/o dizziness after resting. Noted stage II decubitis sacral ulcer 1.5 cm in diameter ~ eschar to 70% of surface and open stage II-III ulcer @ base of sacral region, on (R) inner buttock. Unable to interpret to explain status of wounds and need for ambulation, OOBTC and turning for relief of ulcers. Pt. unimproved understanding.
29oct03@0300	Assumed care @1800; All VSS, pt A&O speaking arabic; MD gave 1 time order For 10mg Ambien ~ pt stated he hadn't slept in 4 days; MC dsg

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

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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 | …ME | MI | … | …BER b(6)-2

DATE	NOTES
	(cont) dsg Δ'd, ⊖ s/sx infection, ⊖ drainage (R) hip dsg Δd ⊖ s/sx
	infection, ⊖ drainage; FT [illegible] draining QS, c/d/i colostomy intact
	pt performed own colostomy care; Restraints in place, ⊕ circ, ⊖
	skin breakdown, cont to monitor [redacted]
29 OCT 03	VSS. AO. DSG Δ'd to (R) Hip & buttock. ⊕ odor and bloody/purulent
1150	drainage. Restarted on IV ABx this AM. Colostomy intact
	and draining, soft formed, dark brown stool. ⊕ pulses.
	Abdominal wound c ⊖ s/s infection and perfused VSS Δ.
	Voiding light yellow urine, quantity sufficient to FTS.
	Stage II and stage III ulcer to sacral and perianal region
	remain and MD aware. Cont to monitor. [redacted]
29 OCT 03	Assumed Pt care @ 1800. Pt c/o pain. Maalox
2300	for epigastric pain. Pt refuses percocet. Motrin 400 mg
	~~[illegible]~~ is not effective. Abd. Drsg [redacted] WTD. Pt
	completed colostomy care. Will co[redacted]inue to Monitor.
	[redacted] 91WMb
30 OCT 03	(1440) Assumed care @ 0700. Pt alert, speaking Arabic VSS.
	Pain controlled c Percs. Drsg to midline abd incision,
	(R) thigh, and (L) buttock Δd WTD. MD @ bedside
	during drsg Δs. Pt medicated c 10mg MSO4 prior
	to drsg Δ and 5mg p Δ. Pt tol. well. φ s/sx
	infection @ wound sites. Colostomy bag Δd d/t
	leakage from old bag. Pt OOB to chair, amb in
	hallway holding onto IV pole. Gait steady. Pt
	tol. well. Foley d/cd this am. Pt DTV by 1530.
	Tol 50% lunch. IVFs infusing into (L) SC CL s s/sx
	infiltration/infection. 2 point restraints in place s

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30OCT03 (1440)	(cont) SISX complications. Will cont. to monitor. [redacted]
30OCT03 2200	Assumed care of Pt @ 1800hrs. A&O. Pt had Foley removed earlier shift. @ 1900hrs pt c/o Abd pain. Palpated abd and found Bladder distended. Inserted Foley catheter and Drained 975 cc of c/s urine. Midline Dressing Intact. Pt c/o epigastric pain. Maalox Administered [redacted] will cont to monitor. [redacted] 91WM6
31 Oct S	O- afeb wound clean, dry ambulating fully reinserted A- stable P- cont [redacted]

b(6)-2 (a)

[redacted] b(6)-4

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b(6)-2 (all)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 OCT Ø3 (113Ø)	Rt a10, VSS, C10 pain often. Premedicated c 10mg MSO4 IV for ® hip dsg change. packed loosely c NS soaked Kerlix. dsg to mid-abd incision Δ'd. colostomy bag c Ø leakage. emptied by pt x 2. Rt ambulated in hallway x 15 minutes using walker. foley to gravity draining qvu Q5. DSC CL S/SX infection/infiltration. Edem [redacted] Rt tolerated 50% of lunch, encouraging ↑ PO fluids. Turning often encouraged to prevent any further skin breakdown. 2 pt restraints on S compromise to skin or circulation. Will monitor [redacted] 9IWM6.
31 OCT Ø3 2Ø3Ø	Pt A+OX3, VSS, pain controlled c percs, adm 30cc Maalox, Δ'd midline abd incision dsg, skin granulated beefy red, Ø S/SX of infex, dsg on ® hip Δ'd, wound healing well, W⇒D dsg applied, IVF patent D5½ NS 20 KCL, Ø S/SX of infex or infiltration, NPO p MN, foley ⇒ gravity draining qvu, self care of colostomy bag, 2 point restraint S S/SX of complications, LS CTA ®, ØBS x4 [redacted] 9IWM

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
	LAST	FIRST	[redacted]

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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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b(6)-2 (all)

LAST NAME	1E	MI	ID; BER

DATE	NOTES
NOV 03 1900	Assumed care @ 0600; All VSS, pt A&O speaking arabic; pt refused percocet for pain; pt premedicated c 10mg m.s.04 prior to (L) hip dsg Δ W→D; skin beefy red, Ø s/sx infection; dsg to ML Δd W→D; Colostomy bag Δd, d/t pt pulling it off; pt OOB to amb in hall c walker assistance; FTG patent draining Q s, clear, yellow urine; pt TO! Rigolet, NPO for MN for OR tomorrow; Restraints in place, Ø circ, Ø skin break ↓, cont to monitor [redacted]
1 NOV. 03 1915	Pt A+Ox3, VSS, OOB → chair, tol well, medicated c 11 perces for pain, pt requested Maalox to prevent an upset stomach, foley draining blood tinged urine, dsg to ML abd Δ'd c W→D dsg, dsg on hip Δ'd, skin appears beefy s s/sx of infx, colostomy bag intact, peripheral pulses equal (B), 2 point restraint s s/sx of complications, LS CTA (B), (+)BS x4 [redacted] 9mm
2 nov. (1215)	Pt back from OR, received via gurney from PACU. Pt A&O, VSS, c/o mild pain. LR @ 125cc/hr to (D) SC, CL. Dsg intact to buttock c minimal drainage noted. midline abd dsg Δ'd, Ø leakage from colostomy noted. bag emptied by pct. (+) peripheral pulses equal bil. Pt medicated c 1 tt Percocet for pain & given Maalox. for gastric pain. 2 pt restraints on s compromise to skin or circulation. Will monitor; [redacted] 9mm

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2 NOV. 03 1900	Pt resting in bed, A+Ox3, VSS, midline abd dsg Δ'd, wound beefy red, Ø s/sx of infection, w→D dsg, dsg Ⓡ hip Δ'd, wound beefy red, sero sang drainage on old dsg, dsg to buttock Δ'd, moderate amount of drainage on old dsg, Foley to gravity draining cyu, medicated for pain ē 11 percs, followed by 30cc of Maalox, colostomy bag intact, loose brown stool, 2 point restraint in place, Ø s/sx of complications. b(6)-2 [redacted] QN I concur with above assessment
3 Nov 03 @	Assumed care @ 0600; A:I VSS, pt A+O x 3 speaking arabic; dsg to Ⓡ upper thigh Δ'd, Ø drainage; ML dsg Δ'd, Ø drainage; dsg to Ⓛ buttock Δ'd ē NS soaked Kerlix roll, lightly packed; moderate amt of drng to bld dsg; all dsgs CDI Ø s/sx infections; Colostomy bag intact, pt performs own Colostomy care FTG patent, draining QS, clear, yellow urine; pt premedicated ō 10m MS04 prior to dsg Δ for pain; Restraints in place, Ⓟ circ, Ⓟ skin breaks, Ⓟ [redacted] b(6)-2 count to monitor
3 Nov 03 1052	Transferred to [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.	

b(2)-2

PROGRESS NOTES
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VRAQ1

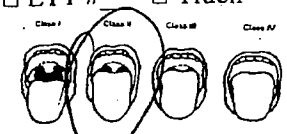
b(2)-2 [redacted]

Name_____ SSN _____ Unit_____ Location_____

INITIAL ASSESSMENT

Airway

☒ Patent ☐ Nasal ☐ Oral
☐ Intubated ☐ Crich
☐ ETT #__ ☐ Trach



C-Spine

☐ CC ☐ BB ☐ Secured ☐ Clear

NORM MS, COMPETENT, Ø MS Δ's, GCS 15, Ø ML TENDER, Ø DISTRACTING. INJ's.

Breathing

☒ Spont Rate Nl
Rhythm
☒ Reg ☐ Tachy ☐ Brady
☐ Sporad ☐ Even ☐ Abnl ___
Quality
☒ Reg ☐ Deep ☐ Labored
☐ Shall ☐ Sonorous ☐ Weak
☐ Assisted ☐ O_2 __L/min
☐ Ambu ☐ Vent
BBS R ☒ CLR ☐ RLS ☐ WHZ ☐ ABS
L ☒ CLR ☐ RLS ☐ WHZ ☐ ABS

Circulation

☒ Spont ☐ CPR
Rhythm ☐ REG ☐ TACH ☐ BRDY
Pulse _____ ☐ Strong ☒ Weak ☐ Thread
B/P ☐ RAD >80 ☐ FEM >70 ☐ CTD >60
PASG ☐ Legs ☐ ABD ☐ Both
IV's #1 18 ga RAC
#2 18 ga LAC
#3__ ga_____
☐ Tourniquet Where When What Why
☐ Other _____

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL_____
☐ DIA ☐ PIN ☐ UNI ☐ FIX ☐ SLOW

MOI/DESCRIPTION

☐ Blunt ☒ Penetrating ☐ Burn
☐ Blast ☒ GSW ☐ Heat
☐ MVC ☒ Shrapnel ☐ Chem
☐ Fall ☐ Stabbed ☐ Elect
☐ Assault WITH _____ SEE 9's ↓
☐ Other _____ EST %_____

EQUIPMENT

☐ Weapon _____
☐ Sens Items _____
☐ Other _____

Vitals: HR 60 B/P 116/51 RR 16 POX 97 RA % TEMP 96.6 °F °C

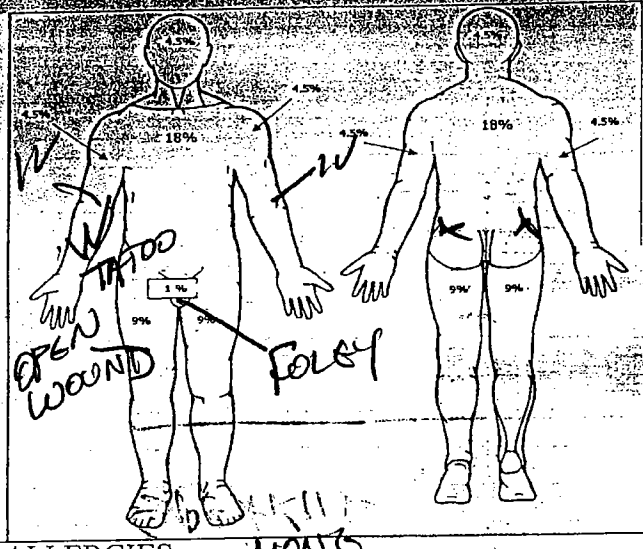
DATE/TIME	NOTES
10/10/09 0200	27 yM s GSW TO BUTTOCKS, GROSS BLOOD IN RECTUM. PT AGITATED & STABLE VS PLAN XLAP IN OR. PT A+O x3 NON ENGLISH SPEAKING. FOLLOWS SIMPLE COMMANDS.
	[redacted]
	b(6)-2

MEDCOM - 21422

b(2)-2

Name [redacted] SSN Unit Location

Head-2-Toe/Burn Chart



ALLERGIES NONE
MEDICATIONS NONE
PREVIOUS HX UNK
LAST MEAL UNK
EVENTS (see MOI)

Description of Illness

INTERVENTIONS

Airway
☒ Suction ☐ Position ☐ Oral ☐ Nasal
☐ Intubated/Trach ☐ Crich By Whom

Breathing
☐ Assisted ☐ O_2 L/min ☐ Ambu ☐ Vent
☐ Chest tube R #1 #2
L #1 #2
Time By Whom
☐ Needle decomp R Time L Time

Circulation Bag # and time
Fluid ☐ NS ☐ 1L bags ☐1 ☐2 ☐3
Blood ☐ PRBC ☐ Whole ☐1 ☐2 ☐3
PASG ☐ Legs ☐ ABD ☐ Both
☒ Foley 0148 ☐ NGT
Other

MEDICATIONS

TIME	MEDICATION	DOSE	RTE	BY

[redacted]

Name_____ SSN _____ Unit_____ Location_____

b(2)-2

PRE-OP/POST-OP

INTAKE

Time	Solution	Amount
FIG 40	START 1L NS	

OUTPUT

Time	Source	Amount

VITALS

Time	HR	B/P	RR	SaO_2	Temp	Notes
0155	89	96/43	23	100%		AWAIT OR
0200	84	118/42	20	100		
0210	100	93/50	30	93		TO OR

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL_____

☐DIA ☐PIN ☐UNI ☐FIX ☐SLOW

Time	Site	ROM	P	Cap Refill	T	Color

ROM
+ or -
Temp
C=cool
W=warm
Pulse
+ or –
Color
C = cyan
P = pale
Pk= pink

b(6)-4 [redacted] b(2)-2 Trauma Fl[illegible]et

Name (2) [redacted] SSN _____ Unit _____ | Blood Type

Date and time of injury: 11 Oct 03 Time of Arrival _____

MOI:

HPI:

PMHX:
PSHX:
Meds:
Allergies:

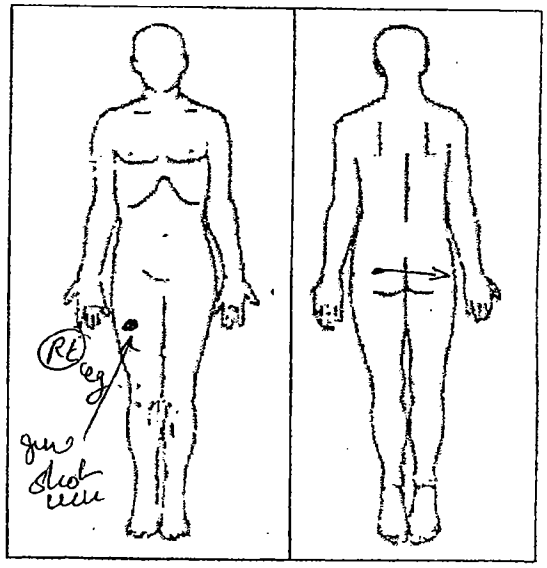
Primary Survey

Airway: (Patent) Mechanically maintained by _____
Breathing: Spontaneous Assisted by _____
Circulation:
Pulse: (Present) Absent CPR
Color: (Normal) Abnormal
Cap refill: (Normal) Delayed

Secondary Survey

Intial Vital Signs: b/p 110 64 pulse 88 Resp ____ Pulse Ox 95 Temp 98.8

GEN: in pain
HEAD: normocephalic
NECK: supple
HEART: RRR no (m)
LUNGS: CTA
CHEST: NC
ABD: tender all over (-) masses
PELVIS: NC
EXT: Quart shaped wound Mid Rt upper thigh
RECTAL: (+) Blood
~~NEURO~~: ~~oriented time place person~~.
Buttocks - Rt → Left entrance & exit of flee bullet.



Neuro
CN II - XII grossly intact
moves extremities
Spontaneously

GLASCOW COMA		
EYES OPEN	Spontaneously	(4)
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	(5)
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	(6)
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1

MEDCOM - 21425

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	(4)
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	(4)
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	(4)
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

Interventions

Airway: FACE mask NON RE BREATH

Breathing:

Circulation: IV NS (R) Brach
(L) AC

Other: Foley 200ml in/out @ Bld

MEDICATIONS

Time	Drug	Dose	Route	Initials
1:30	10mg morphine		IV	[redacted]
1:30	Penicillin	3g	IV	

b(6)-2

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
1045	116/51	91				
0150	96/43	91	17	98%		
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES:

(A) @ Mauersing GSW (R) to (L) Buttock
Suspect pelvic injury

(2) GSW (R) ~~Femur~~ Thigh.

(P) TO SURG FOR Surgical Exploration
Ag O/P Return

Prepared By: [redacted]
1LT PA-C

LABS
0200 13/39

b(6)-2

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 10 Oct 03 **Diagnosis:** [illegible] **HD:** [illegible] **POD:** 003

Date: 10 Oct 03 Time: 1500 RN Signature: [redacted]

Skin breakdown as evidenced by immobility, friction, shear, m[redacted]rasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location: [illegible] Size: [illegible] Drainage: [illegible]

Diabetic ulcer Tubes: none Pins: Ø Appearance:

Venous stasis ulcer Dressing change: TID

Other_____ Describe

Burn wound (s): % BSA__________ Partial__________ Full__________

Location:__________ Size__________

Appearance:__________

Dressing change:__________

Pressure Ulcer (s):

Stage I, II, III, IV (Circle the one that applies and describe below)

Location:__________ Size:__________

Wound character: Pink____ Moist____ Dry____ Granulation tissue____ Yellow slough____

Tunneling____ Undermining____ Odor____ Purulent discharge____ Eschar____ Exudates____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☒ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☒ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☒ Kerlix (super sponge)
- ☒ Gauze bandage
- ☒ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream

- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☒ t.i.d

b(6)-2

MD Signature and Date:

[redacted] [illegible]

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility) Medical Record, SF 509

EPW # [redacted] b(6)-4

[redacted]DCOM - 21427

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 10 OCT 03 **Diagnosis:** GSW Leg **HD:** AUA **POD:** DOS

Skin assessment must be done initially and every 7 days.

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

Add the total score ***Total Score:*** 10

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 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: RLeg Size:_____ Drainage: _____
Tubes: none Pins:_____ Appearance:_____
Dressing change: TID

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
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: Pink____Moist____Dry____ Granulation tissue_____ Yellow slough _____ Tunneling_____
Undermining_____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____ Date/time MD notified _____
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.

b(6)-2 (all)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Oct 03	0815		HR 126, 75/35 Given 100 fent / 2.5mg vers
			@ 730; [illegible] BP [illegible] T 97.4; Given 30 cc/l
			Solus. Will [illegible] Dr [redacted]
			[redacted]
			[redacted]
10 Oct 03	0830		At tower [redacted]
	1030		Returned for OR VS: 119, 93/52, 14, 100, T 98.0
			[illegible]
			[redacted]
			[redacted]
	1100		Assessment [illegible]
			[illegible]
			[illegible]
			BP 90-100/50s [illegible]
			[illegible]
			[illegible]
			[illegible] buttocks [illegible]
			[illegible]
			[illegible] [redacted]
			[redacted]
	1230		Boluses x2, going to keep patient intubated; [illegible]
			still in 70s/80s; will get CBC;
			[redacted] [illegible]
	1235		sent for CBC / ABG, Syst 70s / 40s
			[illegible]
			[illegible] 10mg / hr [illegible]
			[illegible] [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

MEDICAL RECORD

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 21429

ACLU-RDI 1661 p.189

DOD-035005

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
	0040		Initial VS: 96.3, 103, 107/67, 14, 100%
			Assessment [illegible] (0040) [illegible] paralyzed
			and remainder of sedation from surgery
			is still on board. [illegible]
			[illegible]
		—	[illegible] 25 cm @ teeth, [illegible] SIMV [illegible]
			PEEP 5; [illegible] (R > L); [illegible] 100% on
			[illegible] setting [illegible] 20; [illegible] S, S
			[illegible] ST, [illegible] cold [illegible]
			[illegible] pulse [illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible] drainage.
			[illegible]
			[illegible] placement); [illegible]
			[illegible] further [illegible]
			[illegible] [redacted] 127/[illegible]
			[redacted]
	0700		Last VS: 103, 123/77, 26, 100%; [illegible] 0560
			[illegible]

(Continue on reverse side)

b(6)-2

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

DATE [redacted] b(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 21430

b(6)-2

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10OCT03	1330		Last 30 min report: Pt ↓ BP in the SBP 70s-80s;
			⊖ verbal response. ⊕ move UE; ∅ sedation; Notified
			Dr. [redacted] of ↓'n BP (NIDDM ...); Started NS 1000cc
			bolus x2; Dr [redacted] arrived; Received order to
			start DOPamine @ 5ug/kg/min; Anesthesia service
			stat 1000mg of Neosynephrine; Started Heparin
			500cc/hr; Dr [redacted] started Ⓡ SC cordis;
			Currently CVP 5-7, SBP 100s/60s, RR 16;
			Vent settings 16, 650, 40%, 5; CBC drawn
			@1230 9.3/30.3 WBC is 1.3 (Plan) 9
			SBP, Started ... @ 50mg/hr; HR in 120s
			[redacted]
	1500		↑ DOPamine to 7ug/kg/min for ↓'n SBP, ...
			... [redacted] ...
	1550		SBP remain (art) 75-85; (cuff) 85-95; MAP
			for both are 60+; CVP is 5; Peak insp
			pressure remain in low 20s (20-23) [redacted]
10OCT03(1950)			Received report from LT [redacted] and assumed care
			of pt @1815. See DA Form 4700 OP 375 for assessment
			parameters. Dopamine ↑ to 8 mcg/kg/min d/t MAPS < 60s, Pt given
			1L NS bolus d/t ↓ BP's. Pt more stable. [redacted] RN

(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.

DATE [redacted] b(6)-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDCOM - 21431

b(6)-2 (all)

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
100CT03 (2200)			Dr [redacted] came into see pt. Talked to Dr about parameters. Talked to Dr about Temperatures [redacted] tried to put Dobhoff in pts (R) nares. Met resistance. Pt got bloody nose, stopped p minute. Put dobhoff down mouth. Got Abd. X-ray awaiting results. [redacted] Refer to other SF 509 for blood [redacted]
100CT03 (0400)			Dr [redacted] came in to see pt around 2300 d/t low BP's. Rewrote orders. Pt started #2 unit of PRBC. Also started levophed around 2400. got ABG and labs. Dr [redacted] comfortable c ABG. Redraw CBC p blood done. Pt more stable p levophed started. Continue to monitor [redacted]
(0520)			Pt's Fentanyl turned up to 100 mcg prior to dressing c. Redressed (R) lateral thigh wound. Packed c wet (NS) Kerlex 4"x4" over top DK red blood. Deep wound. Turned pt and packed (R) pullocks c (NS) wet Kerlex 4"x4"s over top. Linen c'd. Pt tolerate it OK. BP stable, HR stable 130's back down to NSR Levophed turned off @ 0515 to see how pt's BP's tolerate it. BP now 93/47 MAP 67. [redacted]

DATE | HOUR A.M. | HOUR P.M. | OBSERVATIONS

MEDICAL RECORD

STANDARD FORM 510 (REV. 7-91) BACK

U.S. Government Printing Office: 1995 - 404-763/20065

b(6)-2 (all)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15OCT03	0800		T-102.5 Tylenol 650mg Po given. O2 sat 96. O2 @ 2 4 via NC. MSO4 4mg IVP given for c/o pain. Resty quietly @ present. — SGT [redacted]
15 OCT 03	0740		Received report from previous shift. Pt lying in bed c ↑ temp. Dressing to Abd intact. Dressing to buttocks intact. Triple lumen cath to (L) subclavian intact c/o & s/s of infx. VSS. c/o @ 4 to 10. Pt remains NPO for surgery today. — [redacted]
15 OCT 03	0930		Pt continues to have ↑ temp. Medicated c 650mg Tylenol. — [redacted]
15 OCT 03	1130		Pt c/o pain. Medicated c 4mg MSO4. Will continue to assess. — [redacted]
15 OCT 03		1455	Pt to OR — [redacted]
15 OCT 03		1625	Pt from OR s/p washout rectal wound. Abd dressing to abd intact. Dressing to (L) thigh intact, minimal drainage noted. Rectal dressing to contain suction, intact to rectal area intact. Colostomy bag intact stoma pink & moist. Triple lumen cath intact. All ports flushed. Foley to start to drain concentrated yellow urine. [redacted] Pt 101-063 SpO2 96%. Will continue to monitor & assess. — [redacted]
15 OCT 03	0800	1615	Pt c/o pain. Medicated c 4mg MSO4 — [redacted]
DATE	TIME		
MEDICAL RECORD			

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STANDARD FORM 510 (REV. 7-91) BA

MEDCOM - 21433

b(6)-2
(611)

510-112 NSN 7540-00-634

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14Oct03	0600		Pt received from Sgt [redacted] VSS. Pt getting 150cc D5 ½ c 25K, lemcy Fentanyl. Pt assessment done. Dressings changed. R leg wound and abd wound beefy red. Left flank wound purulent. — Sgt [redacted] LPN
	0830		Dr [redacted] at bedside. DC'd Fent, Δ'd maintenance to D5½ NS c 40 KCl 100cc/hr. Removed R central line. Pulled out middle retention suture. — Sgt [redacted]
	1300		Pt temp 102.0. Gave 2 Tylenol. Will continue to monitor — Sgt [redacted]
14OCT03		1800	VSS - Alert X3, O_2 @ 2L via NC SATS 100%. 10 cc/hr D5 ½ NS c 40 mEq of KCl into (L) subclavian line all ports patent flush easily. Foley to gravity drain clear yellow urine 100-120 ml/hr. T-101.5 Tylenol 650 mg given PO. ∅ c/o @ present time. — Sgt [redacted]
14 OCT03		1900	T-101.5 Tylenol 650 mg PO given MSO4 6 mg given for c/o pain IVP. O_2 @ 2-4L via NC 100%. — Sgt [redacted]
14OCT03		2200	Drsgs to mid-line Abd incision, (R) thigh and (L) buttocks Δ'd: (L) buttock wound had lg amts of light red serous drainage foul smelly - wound to (R) thigh mod amts of serous drainage ∅ foul smell noted, midline incision small amt of bloody light red drainage. All wounds repacked c NS soaked gauze and covered c Abd pad. — Sgt [redacted]

(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

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 21434

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0650		: Received patient from off going shift.
			Assessment is following; [N] follows commands,
			moves all 4 extremities, appropriate interaction;
			Pain relieved with [illegible] IVP c Percocet;
			[R] Sat 96% on NC cannula ②, ⊖ cough; ⊖ sob
			cyanosis [CV] NSR-ST; BPs 100-110/50-60; S_1, S_2 ⊖ JVD
			<3 cap refill + pulses (3+) x4; [GI] midline and
			dsg c/d/i; colostomy to ⓛ side ~~ⓛ [illegible]~~ [redacted] yellow
			area immediately around colostomy side - [illegible]
			[illegible] or [illegible] ⊖ stool from colostomy
			[illegible] ~~[illegible]~~
			ⓛ [illegible], [illegible] ~~to midline scar~~
			[Lines] L SC [illegible] [redacted]
			Continue c assessment [illegible] [illegible]
			[illegible] [redacted]

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. ICU 3

[redacted] b(6)-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 21435

b(6)-2 (all)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 Oct?	1200		VSS; Placid patient. OOB + chair, Osls seen; Pt able to walk to chair or own. Muller Abd Clsg D'a [redacted] 1200
		2000	assessment completed; new orders per [illegible] surgeons; pt reports improved pain sensation c Maalox po; (via interpreter); pt to transfer to ward in AM; reposted for transport [redacted]
		2100	stoma bag Δ'd; area pink, stool formed, posterior; φ areas of breakdown noted. [redacted]
		2400	dsg Δ to abdomen / RLE drsg; green tinged drainage removed; W→d drsg; area pink/red, φ foul odor noted; minimal drainage [redacted]
	0400		no change in status; resting, [redacted]

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: 30 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): see chart @ PST team

4. PROPOSED SURGICAL PROCEDURE:
presacral drainage, rectal washout, arteriogram

5. ADDITIONAL INFORMATION: Last PO: ~~before midnight~~ Medical Hx: see SF513 Implants: Ø Medications: see chart
Jewelry removed: yes no Family waiting: yes no
ring removed and taped to chart PACU aware

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	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture. pt intubated	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ 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)

H [redacted] b(6)-4

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. o ✓ Check that safety straps are correctly applied. o ✓ Offer pillow for under knees. o ✓ Place and take down legs from stirrups with slow bilateral motion. o ✓ Check that rings 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 _____ 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. [redacted] MPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.
[redacted] CPT/AN 10OCT03 DATE

[redacted] TIVE EVALUATION:
Dressings CDI
Bowe pad site CDI
pt remains intubated, b(6)-2

12. [redacted] PREOPERATIVE EVALUATION PREPARED BY
[redacted] CPT/AN
10OCT03 0800

13. POSTOPERATIVE EVALUATION PREPARED BY
[redacted] CPT/AN
DATE: 10OCT03 TIME: 1035

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MEDCOM - 21438

MEDICAL RECORD — INTRAOPERATIVE RECORD

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 _____ BY _____

2. PATIENT IDENTIFIED, R[redacted] PROCEDURE
VERIFIED BY [redacted] b(6)-2

3. DATE _____ TIME PATIENT ARRIVED IN SUITE _____

4. PATIENT IN ROOM
TIME _____ NUMBER _____

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Head to foot, arms sbd C900 to padded

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

COMMENTS: armboards legs straight, bed padded.

8. SKIN PREPARATION

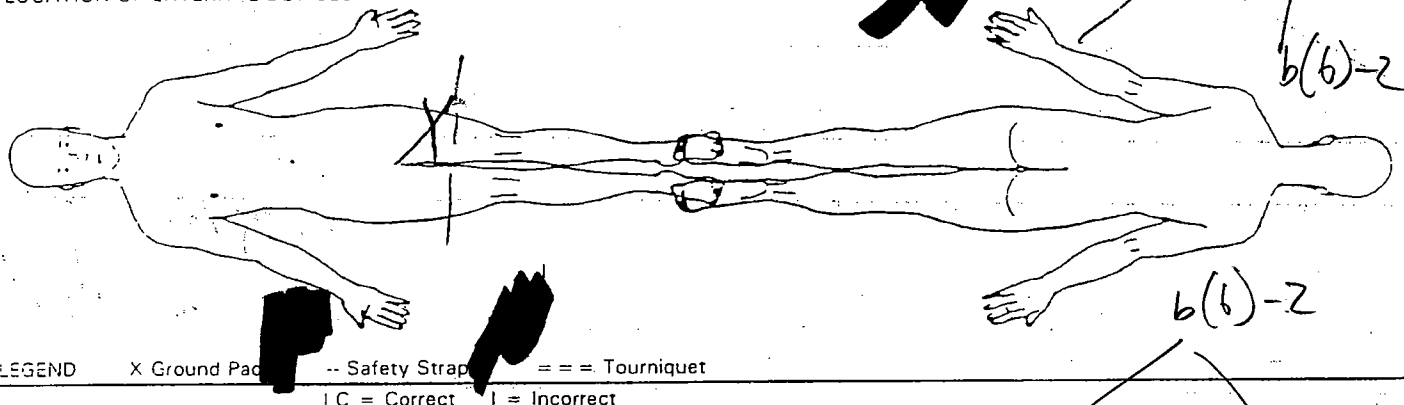
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify)
SITE: Abd BY WHOM: Beth [redacted]
SITE: [redacted] BY WHOM:

COMMENTS: [redacted] Ø Rad

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			
Needle Sharp	☐ Yes ☐ No			
Instrument	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

SCRUB: SPC [redacted] CIRCULATOR: CPT [redacted]

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

IRAQ NATIONAL

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

☐ ESU NO: A
GROUND PAD: BRAND 3M
LOT NO: 1999-11 Cu

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

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

X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN S YES ☐ NO ☐	NAME	NAME
FROZEN SECTION(S) YES ☒ NO ☐	NAME	NAME
CULTURE (S) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION (Specify) 4X8

17. TUBES DRAINS PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE SIZE	16 FR. foley		
SITE	Bladder		

19. ADDITIONAL INFORMATION

WC #11

Surgeon: [redacted] b(6)-2

Asst

20. OPERATION(S) PERFORMED

Ex lap b(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU		Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT 2d

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