MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

26 YOM SHOT IN (R) FOOT / LEG IN (L) [illegible] 22 [illegible] AGO. ADMITTED FOR IT&T

PMH - Ø

PSH - ?

WKDAY 2 PACKS/DAY

PHYSICAL EXAMINATION

HT/WT

GOT - SMALL PUNCTURE WOUND (L) SCROTUM
LIV INTACT CROSSED

(L) FOOT - MODERATE WOUND WITH [illegible] OVER
TALUS. MOVES TOES WELL

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

(2) GSW

(L) ITD Wound 3

[redacted] b(6)-2

SIGNATURE OF P[redacted]	DATE 7 JUL 83	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] b(6)-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7AUG03	1430. Assumed care @ 1415. VSS. LR infusing @ 125cc/hr GSW to (L) elbow & (L) ankle. 1 inch open wound to (L) ankle. No drainage noted. Dressing in place, dry & intact. On call to OR. [redacted]
	1600: To x-ray via crutches. [redacted]
	1620: Returned from x-ray via crutches. [redacted]
	b(6)-2
7 AUG 03	On the Op Note.
1935	Pre-Op Dx: GSW (L) ankle with open talus fracture
	Post-Op Dx: Same
	Procedure: I+D (L) ankle, application of splint
	Surgeon: [redacted] Anesthesia: Plexus
	Est. EBL: 66.2 Blood: 2000 LR
	Findings: Open fx, 12 days old, some granulation material from talus neck fracture
	Plan: Avoid ↑ chem NPB @ 8 pm
	Weight: I+D 9 days
	[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)

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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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0045 8Aug03	Pt care assumed @ 2100. VSS, alert and awake ∃ c/o pain. Lung sounds CTA, pulses + (unable to assess lle), b=⊕x4. IV in lue running @ 125cc, IV ABX. Pt returned from OR today S/P I+D, scheduled for another I+D on 9Aug. LLE Dsg CDI, elevated. pt able to wiggle toes and ⊕ capillary refill. UOPCYC, no complaints. Will continue to monitor. [redacted] b(6)-2
0100	As per CRUA pt with penrose drain, under dsg. [redacted] b(6)-2
8Aug03 0700	Pt. awake & alert c/o ⓛLE pain, Tylenol given. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. HL in ⓛ unit ∃ s/s of infection. VSS. Ace wrap to ⓛLE CDI. Dime size wound on back upper ⓡ side open, 2x2 applied. All other assessment findings WNL. Pt. ∃ other complaints @ this time. Will continue to monitor. [redacted] b(6)-2
8AUG03 1330	Assumed care @ 1300. Alert & oriented. VSS. c/o mild pain in ⓛ foot. Tylenol 650mg PO given. Lung sounds clear. Ace wrap to ⓛLE. 1cm wound to inner ⓡ elbow. 1½cm wound to ⓡ upper back. 2x2 dressing applied. Sm amount purulent drainage noted. SL patent. Will continue to monitor. [redacted] b(6)-2

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

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

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WARD NO. CW2

EPW b(6)-4

#[redacted]

PROGRESS NOTES
Medical Record

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USAPA V1.00

NSN 7540-00-634-4176

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MEDICAL RECORD PROGRESS notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0350 10Aug03	SV infiltrated. Restarted Rt hand 20 Gauge, one stick
	Pt assisted to stretcher for OR case. [redacted] b6-2
10Aug03 0445	Ortho Op Note
	Pre Op Dx - Open (L) tibia fracture
	Post Op Dx - Same
	Procedure: I&D, (L) tibia fracture
	Surgeon: [redacted] b6-2
	Gas min
	Tourniquet - 300 Lbs
	Findings - Wound clean
	PLAN: 2D wound changes
	b(4)-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. ICW2

#1 [redacted] b(4)-4

PROGRESS notes
~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~
Medical Record

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

b(4)-2
A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/8/05 2105	Pt. care assumed @ 2100. HR Reg, lungs CTA, ABD soft c̄ BS ⊕ X4. ⓛ LE c̄ cast intact. ⓡ UE toes warm c̄ brisk cap refill, ⊕ sensation, ⊕ ROM. UTA pulse 2° obese. Will cont. to monitor. [redacted] TJAN
~~9Aug03~~	~~0540 Assume pt care @ 0500. Pt awake and alert. No c/o pain. NPO for on call to OR. HL to ⓛ wrist ⊕ flush c̄ redness/infiltration. VSS. HR reg. lungs CTA. Abd soft BSx4. erw~~ [redacted]
	~~VSS. HR reg. Lungs CTA. Abd tender to palpate to BLQ BSx4. No BM x 10 days. Foley to gravity. Clear yellow UOP c̄ sediment noted. erw~~ [redacted]
9Aug03	0540 Assume pt care @ 0500. pt awake and alert. No c/o pain. NPO (for OR today. HL to ⓛ wrist ⊕ flush c̄ redness/infiltration. VSS. HR reg. Lungs CTA. Abd soft BSx4. ⓛ LE ace wrap CDI. ⊕ movement ⊕ sensation to toes. ⓡ upper back sm dime sized wound covered c̄ 2x2. Will continue to monitor [redacted] WMP
9AUG03 1445	Assumed care @ 1300. VSS. Lung sounds clear. BS x4. SL in ⓛ wrist patent. Dressing to ⓛ LE. Good capillary refill. c/o tingling in ⓛ toes, sensation present, able to move. Δ'd dressing on ⓡ upper back c̄ 2x2 dressing. On call to OR, NPO. [redacted]
2155	Pt. care assumed @ 2100 VSS. Pt. NPO for surgery tonight. Pt caught eating < ½ bag trix. Pt. reinforced on NPO status. Pt. given food by neighboring pt. IVF infusing @ D5 to ⓡ A. HR Reg, lungs CTA, BS ⊕ X4. ⓛ UE c̄ splint CDI. Brisk cap refill, ⊕ sensation, ⊕ ROM toes. MD informed of pt. po intake. Pt. to remain NPO for surgery in AM. [redacted] TJAN

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug03	11 day GUNshot wounds - pierced (R) arm (R) posterior chest (L) ankle small puncture (L) side chest
temp 100.1	(R) chest x-ray (L) elbow (L) ~~ankle~~ ankle)
B/P 120/80	5 gunshot wounds
P 110	10 mg morphine IM 2/15
SpO2 98	
Do redo	11 day old injury
	Head - graze head wound
	Rt Axilla-to chest
	(L) leg
	(L) Ankle - fracture
	Lungs - clear CXR - [redacted]
	bilat - [redacted]
	Axilla - [redacted] b(6)-2
	~~Foot~~ - [redacted]
	~~Ank~~ - [redacted]
	(L) elbow - wound xray - [redacted]
	(L) ankle - entry wound -
	(L) leg - wound - [redacted]
A -	multiple gunshot
	(R) fracture (L) foot/ankle wounds
P -	[redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] MAINTAINED AT b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2335	Adjusted bandage (L) foot x tight f R & L CMS (+)
7 Aug 03 0420	Orders noted. Pt awake + conversing. To be transferred to CSH in am [redacted] SPC
0500	Pt c/o ankle wrap being too tight. Pedal pulse and capillary refill fine. Readjusted top of bandage slight [redacted] SPC
1039	OK for Cat [redacted]
	b(6)-2 All

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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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.)* [redacted]

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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b(6)-2 A11

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03	0610 ~~Assum~~ Received pt from ICU2 S/p I+D of LLE. Condition stable. Resume previous orders c̄ daily dsg Δ's beginning 11Aug. C/O pain to LLE, percocet given. VSS. LR @ 125cc/hr to (R) FA c̄ redness/infiltration. HR reg. Lungs CTA. Abd soft BS×4 no c/o pain or tenderness c̄ palpation. Ace wrap and dsg to LLE CDI. (+) movement (+) sensation to toes. Will continue to monitor — [redacted] SI/WMP
1400	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. (L) LE wrapped c̄ bandages and ace wrap, Ø new drainage noted to dsg. Strong pulse and brisk capillary to (L) foot. Ø complaints — [redacted]
10 Aug 03 21:23	Rec'd c/o pt @ 21:00. Restraints x 2 (R) wrist/Ankle. VS WNL per FS. Pt. sleeping in bed. awakens easily to verbal stimuli. Skin W/D. PERRLA (+) WNL. LCA (B) HRRS, S2. BS (+) x4. (+) PP (B) (L) LE c̄ ACE wrap dsg scant amt drainage noted mid-calf. wound to (R) upper aspect of back approximately 1½cm × 1cm. well approx. healing tissue noted. ∞ c/o pain @ this time. HL (B) hand patent. will cont. to mon [redacted]

HOSPITAL OR MEDICAL FACILITY		DEPART./SERVICE	RECORDS MAINTAINED AT
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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

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

b(6)-2
A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Addendum	⊕ROM ⊕ sensation ⊕ <3sec cap refill ⊕ warmth to ⊕ foot digits — [redacted] /AD
cont	c/o pain ⊕ LE "II Tylenol given. will cont. to mon [redacted]
11 Aug 03 05-0900	Pt resting in bed. ⊕ leg in soft dressing. Pt gets breakfast, medicated PO for pain. Dressing changed done to ⊕ leg. Lower foot wound has sutures, site clean - upper leg has small entry wound, area also clean. Both sites cleaned and new dressing applied. Pt tolerated procedure well. Effect and reactions — [redacted]
11AUG03	1450: Assumed Care @ 1300. VSS. Lung sounds [redacted] clear bilat, BS x 4. Dime-size wound to ⊕ upper back sm amt purulent drainage. Dressing to ⊕ lower extremity dry & intact. Hep-lock to ⊕ FA patent. Denies pain or discomfort @ this time. Will continue to monitor [redacted]
2234	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ XY. Drsngs to ⊕ LE CDI. NV checks ⊕ LE WNL. Pt. c/o pain, to ⊕ LE, given "II percocet po. Will cont. to monitor. — [redacted] CTAN
12 Aug 03 5-12p.	Pt VS stable, medicated PO for pain discomfort. Pt dressing ⊕ leg. glove. Wds clean and no drainage nor odor present. Pt ate breakfast and resting comfortably in bed [redacted]
12AUG03	1410: Assumed pt care @ 1300. VSS. HR - regular [redacted] lung sounds clear bilat. BS x 4. SL ⊕ FA patent. [redacted] dressing to ⊕ LE dry & intact. No c/o pain or discomfort @ this time. Will continue to monitor. — [redacted]

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b(4)-2) A11

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12 Aug 03 2308	Pt care assumed @ 2100. VSS, alert and awake [redacted] c slight c/o pain in lle. Lungs CTA, pulses (+)x4, bs(+). Dsg on lle CDI, patient can wiggle toes and has positive pulse. IV on (R) FA patent, IVAB x 1 will continue to monitor. [redacted]
13 Aug 03	0540 Assume pt care @ 0500. pt awake and alert. c/o pain @ HL site, HL dcid. c/o pain to (L) ankle, tylenol given. VSS. HR reg. Lungs CTA. Abd soft non tender non distended BSx4. Dsg to (L) LE CD&I. (+) ROM (+) sensation of toes, sm amt swelling noted. Will place new HL and cont to monitor. [redacted]
	0655 HL placed in (R) FA + flush [redacted] redness infiltration. [redacted]
13 Aug 03 2019	Assumed care @ 1300. Alert + oriented X3. VSS. c/o pain in (L) LE. Tylenol 650mg PO given @ 1820. Dressing Δ done c̄ Betadine solution. Sm amt drainage noted. c/o some tingling in (L) toes. Will continue to monitor. [redacted]

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

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

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8-13-03 2248	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, ABD soft c̄ BS (+) XY. (L) LE dsng CDI Toes (L) ft c̄ brisk cap refill, (+) sensation, (+) ROM. Will cont. to monitor. [redacted] CTAN
14 Aug 03 0615	Pt. awake & alert in bed. ∅ complaints @ this time. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. VSS. HL in (L) FA ∅ s/s of infection. Ace wrap to (L) LE CDI, limited ROM in digits, pt. unable to rotate ankle, (+) sensation in digits, ≤3 sec cap refill, pt. states that ROM in digits is painful. All other assessment findings WNL. Will continue to monitor. [redacted] AN
0900	DSG Δ'd to (L) inner aspect of ankle c̄ Dakins solution W→D. Sutures to wound intact, dime size open wound ∅ s/s of infection, pink & moist. [redacted]
1330	alert and oriented. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dsg to (L) ankle and foot CDI. Pt ambulating c̄ crutches. To have dsg c̄ Dakins this evening [redacted]
1830	Dsg to (L) ankle changed. Wound open, serosanguinous noted to dsg. W→D c̄ 1/4 Dakins soln then wrapped c̄ Kerlix and ace wrap. ∅ complaints [redacted]
2345	Pt care assumed @ 2100. VSS, a+o x3, c̄ 650mg Tylenol given for pain in (L) ankle. Lung sounds CTA, pulses + x4, BS (+). Pt ambulated c̄ crutches x1 to BSC, had BM. Dsg to (L) LE CDI (+) pulse and sensation. HL in RFA intact. Will continue to monitor. [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Aug 03 0550	Pt. awake & alert in bed c̄ pain in (L) foot, ~~tt~~ tylenol given. HR Reg, lung sounds clear bilat, bowel sounds (+) x 4 quads. DSG to (L) LE CDI, cap refill < 3 sec, (+) sensation, mild swelling noted in digits. HL in (R) FA ~~S~~ S/s of infection. Pt. ~~S~~ other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] RN/A
1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Dsg to (L) ankle CDI. Pt c̄ (L) foot elevated. Ambulating well with crutches. Ø complaints [redacted]
1630	Dsg Δ done to (L) ankle. Suture line CDI. Wound c̄ serosanguinous drainage. Ø purulent drainage noted. Dr. [redacted] to remove sutures tomorrow and cast (L) leg. Ø complaints. 1/4% Donkins soln used c̄ W→D dsg. [redacted] CE/RN
2000	Care assumed @ 2100. VSS, AOX3 c̄ c/o slight pain in (L) ankle. Lungs CTA bilaterally, pulses (+) x4, BS(+). HL in rfa intact, Ø s/s infection, IV ~~e~~ BX. Dsg on (L) ankle intact. Patient O/C to OR in am to remove sutures and cast leg. No complaints at this time, continue to monitor. [redacted] RN

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

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b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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FIRMR (41 CFR) 201-9.202-1

b(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
160520 Aug 03	NURSING NOTE: Assumed pt care, A&Ox3. Airway intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender, ↓ distention, NPO for OR today. BS(+)x4. Voids spontaneously. PROM and neurovascularity intact to BUE and RLE. LLE has Ace wrap to ankle (ACE wrap) that is CDI. ROM and neurovascularity intact to LLE ↓ pain limited by pain. HL to RFA ↓ s/s infection or infiltration [redacted]
16Aug03 1330	Alert and oriented PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dsg to (L) ankle CDI. Strong pedal pulses and brisk cap refill to bilat LE. Ø complaints — [redacted]
2211	Care assumed @2100. VSS, A&Ox3, 650 tylenol given for pain @2100. Lung sounds CTA, pulses (+)x4, bowel. Pt scheduled to have cast put on in 72° on llc. Pt ambulated x5 minutes ↓ pain. Dsg on llc CDI, pt able to wiggle toes and has rom in llc. HL patent, Ø s/s infection. Will continue to monitor. [redacted] gilmco
17Aug03 0200	Pt awake & alert in bed ↓ c/o pain in (L) foot, ii tylenol given. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. HL in (R) FA ↓ s/s of infection. VSS. Pt. removed Ace wrap & DSG to (L) LE. DSG wet ↓ Dakins soln applied covered ↓ 4x4. (L) LE pedal pulse palpable, (+) sensation, <3 sec cap refill, limited ROM in digits, Ø ROM in ankle. All other assessment findings WNL. (L) LE wound dime size ↓ s/s of infection. Will continue to monitor [redacted]
17Aug03 1500	Awake and alert in bed. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dsg to (L) ankle. CDI Ø c/o pain. (L) foot swollen. Strong pedal pulse and brisk cap refill to (L) LE [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03 1900	Dsg Δ done to (L) ankle. Small amt purulent drainage noted when old dsg removed. W7 Dsg done T 1/4% Dankins soln, then wrapped T gauze. Ø complaints — b(4)-2 [redacted]
2100	PA. care assumed @ 2100. HR reg, lungs CTA, BS(+)x4. (L) LE dsng CDI. (L) ft. T (+) sensation, (+) ROM, brisk cap refill, pulse 2+. will cont. to monitor — [redacted]
0520 18AUG03	PT. CARE assumed @ 0545. VSS. Lungs CTA, HRR, BS(+)x4 Dressing on LLE CDI. + pulses Quick cap Refill in left foot + sensation. PT complained of pain, will give meds c̄ breakfast — b(4)-2 [redacted]
18Aug03 1830	Assumed care @ 1300. Lungs clear. Abd soft nondistended, BSx4. Cast to (R) foot. Good capillary refill. % some tingling to (R) toes. Will continue to monitor [redacted]
18Aug03 2337	Care assumed @ 2100. VSS, no complaints, Lungs CTA, b(4)-2 bs(+). Cast on lle intact, (+) sensation and cap refill. PA c̄ d/c summary and orders, continue to monitor. b(4)-2 [redacted]
19 0730 Aug 03	NURSING NOTE: Assumed pt care. Alert, intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender, ē distention. BS(+)x4. Voids spontaneously. ROM and neurovascularly intact to (B) UE and (R) LE. Cast to (L) LE (just below knee to toes). Neurovascularly intact & otherwise ROM to LLE. IV to (R) FA ē s/s infiltration. b(4)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b(4)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. 1CW2

EPW # [redacted]

b(4)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Aug03	1545: D'c'd to EPW comp. VSS. X-rays and Discharge [redacted] Cpt.
	b(6)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03 1415	Ortho Discharge Note - 28th CSH
	26 YO with GSW to (L) foot 10 days prior to admission. Admitted 7 AUG 03 with draining wound leading to open talus fracture. Wounds I+D'd on 7 and 9 AUG. Wound closed except central 1 cm. Wet to dry dressing changes done. Now placed in short leg cast.
	PLAN: Ciprofloxacin 500mg P.O. BID x 30 days #60 Percocet 1-2 P.O. Q4-6hrs PRN #30. P/U at IBN SIHO hospital with 28th CSH in 3 weeks for cast removal, wound check, radiographs
	b(4)-2 [redacted]
	BVBWRZ CDR MC

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(4)-4

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

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

ARRIVAL

DATE *(Day, Month, Year)*: 7 AUG 03 | TIME: 1240

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 26

MILITARY STATUS			
ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: 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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW LEG (L) ELBOW (R) POSTERIOR CHEST

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 1240

INITIALS: b(6)-2 [redacted]

VITAL SIGNS

TIME	1240					
BP	140/80					
PULSE	125					
RESP	18					
TEMP	98.7					
WT						

LAB ORDERS

X	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

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1300	Tetanus shot	Davis	[redacted]		
1300	IVS 5mg IVP	Davis	b(6)-2		
1300	Ancef 1gm IVPB	Davis			

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS: to ICW2 prior to SY

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)*

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

NSN 7540-01-075-3788

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 11.4			134		12 / 129	SUP O2	PH	PO2	RESULTS CXR Chest - bullet fragments SQ to SKK (L) ankle shattered	
H/H 16.7 / 53.9			3.4	97	1.1	PCO2	SAT	OTHER		
PLT 761										
PT						U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU			MICRO			

PROVIDER HISTORY/PHYSICAL

S) Hx shot twice in LLE 12 days ago. Pt also shot in (R) posterior chest and (L) elbow. Pt had a grazing shot to the (R) side of his head. Denies SOB. (+) pedal pulses. (+) pulses distal to (L) elbow wound. [redacted]

26 yo

b(6)-2

O: VS noted Tachycardic Afebrile Responds appro to interpreter.
(1) Open wound to (L) elbow ⊖ erythema ⊖ drainage
(3) Small open wound to posterior chest ⊖ erythema ⊖ drainage scapula
Lung fields CTA bilateral lung fields. no use of accessory muscle. No crepitus over scapula
(3) (L) ankle, ~~large~~ erythematous painful to touch medial exit wound above (L) medial ankle ↑ DP pulse ⊖ movement toes pink Heart RRR Pulses ↑2 Radial, DP, Brisk capillary.
A: GSW to chest, elbow, ankle
P: to ICW 2 for hold until 7 Jun 54

CONSULTED	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
[redacted] (ortho)	1250	Admit	
b6-2			
			PROVIDER SIGNATURE AND STAMP [redacted] Capt FNP-C
			b(6)-2

DIAGNOSIS
S GSW to back, (L) elbow, (L) foot

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: 3 ortho -

[redacted] b6-2

DATE OF REQUEST: 7 Aug 03

REASON FOR REQUEST *(Complaints and findings)*

Gunshot wound - fracture ⑤ foot

PROVISIONAL DIAGNOSIS

b(6)-2 fracture ⑤ foot - 2° gunshot wound

[redacted] | APPROVED | PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ 72 HOURS | ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

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

SIGNATURE AND TITLE *(Continue on reverse side)* | DATE

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

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

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

[redacted]

EPW b(6)-4

CONSULTATION SHEET
Medical Record

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

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY 1

POST- DAY OP Day

MONTH-YEAR Aug DAY 7 8 9 10 11 12 13

19 2003 HOUR 1500 1345

PULSE (O) — TEMP. F (°) — TEMP. C

TEMP. F (°)	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] b(6)-4

REGISTER NO.

WARD NO. ICW 2

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 03 2003

DAY: 14 | 15 | 16 | 17 | 18 | 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° — 98.6° — 37.2°
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 →

O2 Sats →

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. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

EPW # [redacted]

b(6)-4

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 26

HEIGHT:

WEIGHT: 80 kg

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

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

4. PROPOSED SURGICAL PROCEDURE: I&D (L) foot & (L) elbow

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ____
Tobacco 2 ppd X 12 yrs. Body Piercing Ø Diabetes (Y) (N) ROM ____ ASA/Motrin w/72 hrs (Y) (N)
ETOH (+) GD Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	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. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Ø Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Ø Pt. will not exhibit signs of impairment 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

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0800 ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	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. ø Offer pillow for under knees. ø Place and take down legs from stirrups with slow bilateral motion. ø Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	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. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier - Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	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 communication. ø Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. b(w)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted] LTC, AN 7 Aug 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Ti[redacted] RN

DATE: 7AUG03 TIME: 1355

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 07Aug03 TIME: 1956

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPER[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY OR/Aneoth. personnel

2. PATIENT IDENTIFIED, REC[illegible]EVIEWED AND PROCEDURE VERIFIED BY LTC [redacted] b(6)-2

3. DATE 7 Aug. 03 TIME PATIENT ARRIVED IN SUITE 1845

4. PATIENT IN ROOM TIME 1845 NUM[illegible]R 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted] CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1905 - Eoc)

7. POSITION AND POSITIONING AIDS (Specify)

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

COMMENTS: Body maintained in proper alignment

8. SKIN PREPARATION b(4) - 2

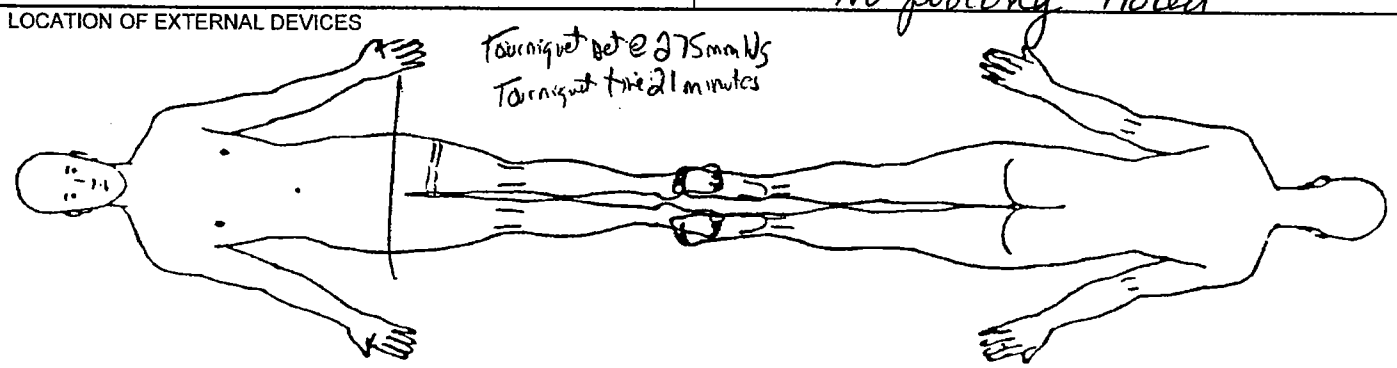
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)*
SITE: Lt. [redacted] arm BY WHOM: LTC [redacted] CPT [redacted]
SITE: Lt. [redacted] leg BY WHOM:

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Initial Other	First Closing Count	Final Closing Count	SCRUB b(4)-2	CIRCULATOR b(4) 2
Sponge	☒ Yes ☐ No	✓				
Needle Sharp	☒ Yes ☐ No	✓	C	C	SGT [redacted]	CPT [redacted]
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

b(6)-4
[redacted]

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

☐ ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM polyhesive II
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

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):
0.9% Na Cl -

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluff, Kelly, webril, splint, webril, Ace

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] b(6)-2 Anesthesia: (PT [redacted] (RNO Anesthesia Type: GETA

Bovie Pad site intact pre-op clear, post-op clear Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op clear : post-op clear
Tourniquet Time: Up___ Down___ See Block #9

20. OPERATION(S) PERFORMED
I&D (L) Foot
b(6)-2

21. PATIENT TRANSFERRED TO ICU 2 TIME 1955 METHOD Via Gurney

[redacted] LTA and Hydrom

MEDICAL RECORD — **INTRAOPERA[illegible]E DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anes

2. PATIENT IDENT[illegible]EWED AND PROCEDURE VERIFIED BY [redacted] b(6)-2

3. DATE 10 aug 03 TIME PATIENT ARRIVED IN SUITE 0410

4. PATIENT IN ROOM TIME 0400 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* A in proper body alignment. Arms on arm boards @ <90°

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

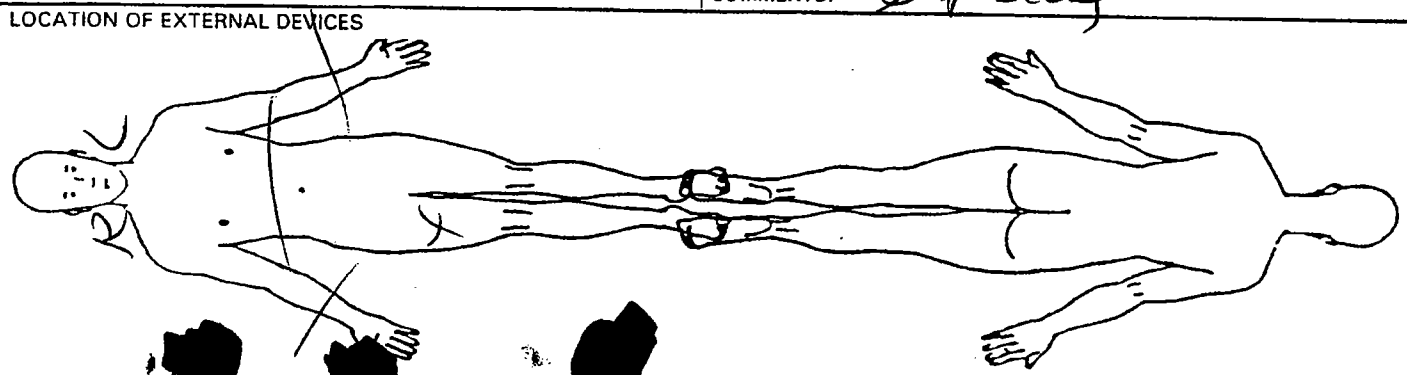
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: (L) CE BY WHOM: [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: Ø prolep

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

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

☒ ESU NO: VL #4

GROUND PAD: BRAND VL Pem Pad II

LOT NO: 608936

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace

19. ADDITIONAL INFORMATION

[redacted] surgeon
[redacted] CRNA
[redacted]
b6-2

Post-op-pt drowsy. Capillary refill < 3 secs in (L) foot. Dressing dry & intact. Drain site clear.

Masked gets

Penrose removed @ surgery during prep

20. OPERATION(S) PERFORMED

I+D (L) LE

21. PATIENT TRANSFERRED TO ICU 2 b(6)-2 TIME 0454 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted]

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

MEDCOM - 16067

i-STAT 6+

Pt: [redacted] b(a)-4

Pt Name:_____

Glu_____129 mg/dL

BUN_____14 mg/dL

Na_____134 mmol/L

K_____3.4 mmol/L

Cl_____97 mmol/L

Hct_____57 %PCV

Hb*_____19 g/dL

*via Hct

Sample Type_:

07AUG03 13:04

Oper: [redacted] b6-2

Physician:_____

Ser# 40763

Ver: JAM5046A
CLEW A93

ID: [redacted] 07-08-03
WB 13:05

				Patient Limits	
WBC	11.4	*H	x10^3/uL	4.5	10.5
RBC	5.88		x10^6/uL	4.00	6.00
Hgb	16.7		g/dL	11.0	18.0
Hct	53.9		%	35.0	60.0
MCV	91.7		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	31.0	L	g/dL	33.0	37.0
Plt	761.	H	x10^3/uL	150.	450.
LY%	22.0	*	%	20.5	51.1
LY#	2.5	*	x10^3/uL	1.2	3.4

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. H[redacted] b(6)-4	DATE 7 Aug	TIME 1245	SSN/PSEUDO SSN:	

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

[redacted]

======= PICCOLO =======
07/08/03 12:59
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100684

ALB	4.5	3.3-5.5	G/DL
ALP	128*	26-84	U/L
ALT	41	10-47	U/L
AMY	43	14-97	U/L
AST	29	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	10.6*	8.0-10.3	MG/DL
CHOL	243*	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	133*	73-118	MG/DL
TP	9.8*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	7 Aug 03	

Ward/Section:	REQUESTING PHYSICIAN: b(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	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		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE: 7Aug03	LAB ID NO.:
[redacted]		

b(6)-2

Tobacco

MEDICAL RECORD - ANESTHES

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

NKDA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION																		
DRUG	(Units)																	
Versed	(mg)	2																
Fentanyl	(mcg)	50-50-100-50																
MSO4	(mg)	2-2-2-2-2																
Propofol	(mg)	<100>	50	50														
	( )																	
	( )																	
VOLAT AGENT	50 % del	2.0	2.0	X														
	% e.t.																	
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	2	2	2	10													
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS																		
FLUIDS — LINE site 20G (R) 10	Warmed	4R-200																
	Warmed																	
	Warmed																	
	Warmed																	
LOSSES	EST BLOOD LOSS																	
	URINE -																	

TOTALS	TOTAL EBL
2	<50
250	
10	TOTAL URINE
	Ø

FLUIDS - SUMMARY
CRYSTALLOID- 300
COLLOID- 0
BLOOD- 0

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP- 133/60 HR- 90

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? JSV TIME- 0345

TIME → 0400 · 30 · 0500 · 30 · 0600

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

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

VENTIL					
VT - ml	—	300	300	260	
f - breaths/min	—	20	14	20	
Peak inf pres / PEEP	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	

MONITORS/ACCESSORIES					
BP/Auto Cuff	ET CO2 (torr)	—	45	45	45
BP/oth	FIO2 (Frac or %)	0.60	0.60	0.60	0.60
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site available →				
	N-M Block (T/4)				
Warming blkt	x1 Blanket →				
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 1 2 3 4

REMARKS
Code drugs with numbers, events with letters
1) Induce CTA (B) HR RRR (-) NPO status verified.
2) Room, mask O2
3) awake, pt removed oral airway + nasal probe himself
4) No complications to ICU O2 Report to RN.

RECOVERY AT 0455
PACU ICU (2) (Specify)
OTHER T 97.3
CONDITION: Stable, alert, comment extubated
RESP- 18 SpO2- 96
BP- 138/70 HR- 82

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0350	0400	0500
	Ready	Begin	End
PROC	0415	0425	0445

PROCEDURES and CPT Codes: I+D (2) foot

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GMA

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

#[redacted] b(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: OA-9mm / 34FR Nasal trumpet

SUR[redacted] b(6)-2

[redacted] CRNA/MA

PROCEDURE LOCATION: 7

DATE: 10 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 16071 [redacted]'S MEDICAL RECORD — USAPA V1.00

26 ♂ NKDA

MEDICAL RECORD - ANESTHE[SIA]

[For use of thi]s 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
Versed (mg)	3		3
Fentanyl (mcg)	50 50, 150		250
Propofol (mg)	150	50	200
SUX (mg)	120		
( )			
( )			

VOLAT AGENT Iso	
% del	1.9 - 1.9 - 1.X
% e.t.	
AIR L/Min	
N2O L/Min	
O2 L/Min	10 - 2 - 2 - 2 10

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

TOTAL EBL: min

TOTAL URINE: Ø

FLUIDS

LINE site: LR 18G (L) HA. ☐ Warmed — LR 300 + — x LR ———
☐ Warmed
☐ Warmed
☐ Warmed

FLUIDS - SUMMARY
CRYSTALLOID- 400 cc
COLLOID- Ø
BLOOD- Ø

LOSSES

EST BLOOD LOSS
URINE - Not measured

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

BODY WEIGHT: 76 (KG) LB

HEMATOCRIT: 16/39

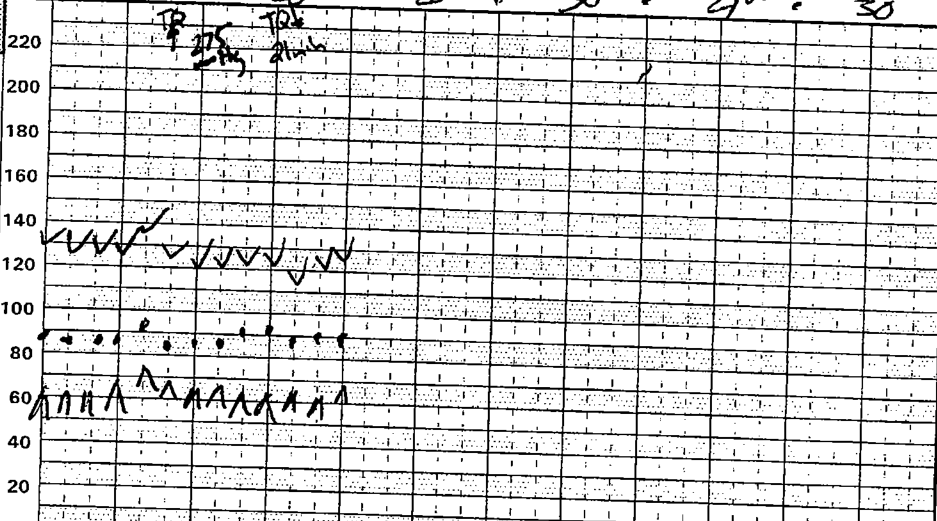
INITIAL DATA:
BP- 129/67
HR- 96

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? yes
TIME- 1850

TIME → 18[45] 19^00 · 30 · 20^00 · 30 · 21^00 · 30

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



VENTIL

VT - ml	630	600	760	500
f - breaths/min	10	10	8	12
Peak inf pres / PEEP	20	26	27	
MODE - S(pon), A(ssist), C(on)	S/A/C	C/A	C	A S

MONITORS/ACCESSORIES

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

ET CO2 (torr)	38	42	32	43
FIO2 (Frac or %)	86	87	.88	.88
SpO2 (%)	100	100	100	100
ECG	SR	SR	SR	SR
TEMP-site Skin	HYAL	98	97	97
N-M Block (T/4)	4/4	4/4	4/4	4/4

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

REMARKS

Code drugs with numbers, events with letters

(1830) IP PT stent removal Analgesia Plan discussed c PT. (1845) to room, standard monitors. 1905 Report Received CRT to relieve. 1945 PO sxn x 2. Pt extubated p awake c (+)HL, To ICU z in stable condition, Report to RW

RECOVERY AT 1900
PACU ICU Z (Specify)
OTHER
CONDITION: Stable 96.5
RESP- 16 SpO2- 100
BP- 123/68 HR- 95

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1830	1845	1955
	Ready	Begin	End
PROC	1855	1906	1948

PROCEDURES and CPT Codes: I+D (L) Axilla

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

#[redacted] b(6)-2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Pre-ox Sxn 88% FiO2. IV induction, easy mask ventilation DL c T miller 2 c cricoid pressure, Grade I view, 8.0 ETT placed 24cm @ lip (+)BBS (+)ETCO2 (+) Cuff @ SM

SURGEONS: ALBRIGHT [redacted]

ANESTHETI[ST] [redacted] b(6)-2 [redacted]

PROCEDURE LOCATION: Bastion

DATE: 7 Aug 08

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 16072 — COPY 1 - PATIE[NT] [redacted] MEDICAL RECORD — USAPA V1.00

ANESTHESIA PLAN OF CARE PRE PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D (L) foot + (L) elbow
SURGICAL SERVICE: Ortho
NPO SINCE: 0800 - food

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB) HT: 5'6" IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 2pks/day
ETOH: 0
DRUGS:

CURRENT MEDICATIONS: Ø
( ) = ordered as premed
INFER
(✓) Ancef 1gm IVPB @
(✓) MSO4 1 5mg IVP @ 1300
( ) 1300
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ____/____
U/A:
OTHER: CXR - lungs clear

11.4 / 16.7 / 53.9 / 761
134 / 10.6 / 18 / 3.4 / 97 / 1.1 / 129

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A x2
Other Significant Hx:	N	Y	GSW (L) foot + (L) elbow, (R) posterior chest
	N	Y	
Familial HX	(N)	Y	

Grazed wound (R) side of head (5 yrs ago)

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 108/60 HR 88 R 18 T 97.6 98% RA
Pain Scale 0-10
HEENT - Teeth chipped (R) front tooth
Trachea Midline x2 (Good)
TMJ/Neck FROM; TMD 3
Oropharnyx MP2
Nares patent
CHEST: CTA(B) ✓ breaths
CPT Dargis EMT - CXR lungs clear
CARDIAC: RRR - GSW - superficial
EXTREMITIES:
IV Access: 18Gr (L) arm
Ulnar Filling:
BACK:
OTHER:

NPO Since 0800

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

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

The [redacted] b(6)-2 [redacted] and agrees. Questions answered.
Signed: [redacted] CRNA/MAA Date: Aug 7, 2003 Time: 1450 Hrs

POST [redacted] THESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted]
b(6)-4

SEDATION KEY:

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

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

MEDCOM - 16073
PATIENT RECORD COPY

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

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]

EPW

NURSING UNIT	ROOM NO.	BED NO.
ICW2	b(6)-4	15

DATE OF ORDER 7 AUG 03 TIME OF ORDER 1345 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW-2
2. DX - GSW (L) LEG + GRAZE
3. CLOTHING - PRN
4. VS - ROUTINE
5. BRB ADT
6. NPO

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		15

DATE OF ORDER TIME OF ORDER

7. N - LR at 125 cc/hr HOURS
8. ANCEF 1 Gm IVPB Q 8 hrs - 16-24
9. MSO4 2-6 mg IVP Q 2 hrs
10. TO OR TODAY

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 7 AUG 03 TIME OF ORDER 1945 HOURS

S/P EXP (R) LEG

1. TO ICW-2
2. CARDIAC - STABLE
3. VS - ROUTINE
4. UP AD LIB PER EPW PROTOCOL, NWB RLE (R).
5. NURSING ADMIT

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

6. N - LR at 125 cc/hr, WOP LDL WSD, FOLEY P.O. WSD
7. ANCEF 1 Gm NPB Q 8 hrs
8. TYLENOL 650 mg P.O. Q 4 hrs PRN
9. PERCOCET, 1-2 P.O. Q 4-6 hrs PRN
10. PHENERGAN 25 mg N OR IM Q 6 hrs PRN
11. MSO4 2-6 mg N Q 2 hrs PRN
12. NPO after MIDNIGHT 8 AUG, PER OR 9 AUG

noted 0630 8 Aug 03

[redacted] b(6)-2

Ø38

NURSING UNIT	ROOM NO.	BED NO.
24 VS [redacted]	2330 0045 8 Aug 03	

DA FORM 1 APR 79 4256 [redacted] TION OF 1 JUL 77, WHICH MAY BE USED.

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

MEDCOM - 16074

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8 AUG 03 TIME OF ORDER: 2120 HOURS

LIST TIME ORDER NOTED AND SIGN

1. NPO after midnight
   Bathroom privs.

noted [redacted] 0540 9 Aug 03

[redacted]

PATIENT IDENTIFICATION 8/9/03 2200 24 US [redacted] HOSPITAN

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

DATE OF ORDER: 10 AUG 03 TIME OF ORDER: 0450 HOURS

Noted [redacted] 0540 10 Aug 03

1. Resume pre-op orders ✓
2. Resume diet ✓
3. IV - D5W @ 125cc/hr. [illegible]
   Lock with heparin PRN [illegible]
4. Daily dressing changes [redacted]
   Begin 11 Aug 03 [redacted]

PATIENT IDENTIFICATION 24 US 15 [redacted]

EPW [redacted]

b(6)-4

DATE OF ORDER: 8 Aug 03 TIME OF ORDER: 2250 HOURS

12 AUG 03 1610

Dakin's solution dressing changes to (L) foot wound BID.

Noted 12 Aug 03 1620 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		13

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

noted ¼ strength Dakins solution dressing changes to (L) foot wound BID
V.O. for Dr [redacted]

038

NURSING UNIT	ROOM NO.	BED NO.
	24 US	2300

8 Aug 03 [redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE

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] b(6)-2 [redacted]

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
1CW2		24 V5

DATE OF ORDER: 17 AUG 03 TIME OF ORDER: 1100 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) METHIS 800 mg P.O TID
@ 8 HRS.
b(6)-2 [redacted]

[redacted] 2107

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
	24 V5	2B30

DATE OF ORDER: 18 AUG 03 TIME OF ORDER: 1415 HOURS

(1) DISCHARGES TO EPW LOUNGE IN A.M.
(2) CAST TO (2) LEG, WBBT.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF [redacted] TIME OF [redacted] HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Ø38

DA FORM 1 APR 79 4256 [redacted] OF 1 JUL 77, WHICH MAY BE USED.

[redacted]

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12	13	14	15	16	17	18	19
7AUG03	[redacted]	V.S. Routine	05	/	[redacted]											
			13	[redacted]												
			21	[redacted]												
7AUG03	[redacted]	Bed Rest [redacted] Up Ad lib per epw protocol non weight bearing on RLE	05	/	[redacted]											
			13	[redacted]												
			21	[redacted]												
7AUG03 10Aug03	[redacted]	N/A [redacted] Regular Diet	05	/	[redacted]											
			13	[redacted]												
			21	[redacted]												
10Aug	[redacted]	Daily Dsg Δ's (beginning 11Aug03) c̄ Dakin's solution to ⓛ foot wound BID	10	/ / / / [redacted]												
			20	/ / / / / [redacted]												

Dc'd 19Au 1545 [redacted]

Cast to ⓛ foot 18 Aug03 [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ⓛ Leg & elbow S/P I+D ⓛ leg

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

b(6)-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7AUG0[redacted]	[redacted]	To ICW-2	7AUG03		1415	[redacted]
	.....	Condition: ~~Fair~~ [redacted] Stable				
7AUG0[redacted]		To OR today				[redacted]
7Aug	[redacted]	NPO ~~P~~ ~~MN~~ breakfast 8Aug, to OR 9Aug	8Aug	2400		
10		Resume previous orders	10Aug	0450	0535	

Dcd 19Aug 1545 AVA

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

USAPA V1.00

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12	13	14	15	16	17	18	19	20
7AUG03	[redacted]	IV- LR @ 125 cc/hr	05	/	[redacted]												
10Aug	------	(HL) when tolerating	13	[redacted]													
	------	Po well	21	[redacted]													

7AUG03	[redacted]	Ancef 1 GM IVPB Q8hrs	08	/	[redacted]												
	------		16	[redacted]													
	------		24	[redacted]													

7Aug03	[redacted]	IVL	05	—	[redacted]												
	------		13	—	[redacted]												
	------		21	—	[redacted]												

DC'd 19 Aug 1545 AVL

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW @ Leg + Elbow S/P I+D @ leg

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

b(6)-2 PRN

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	PRN ~~RECURRING~~ MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
7Aug03	[redacted]	MSO4 2-6mg IV/IM Q 2 hrs		
7Aug03	[redacted]	Tylenol 650mg PO Q4° prn		8Aug 0010 PO; 8Aug 1310; 10Aug 0001; 12Aug 1800 PO; 13Aug 0310; 13Aug 1820; 14Aug 0335; 14Aug 0800 PO; 14Aug 1600; 15Aug 0525 PO
7Aug03	[redacted]	Percocet 1-2 tabs PO Q4-6hrs prn		8/9 0113 4hrs; 10Aug 0540; 10Aug 1900; 11Aug 1615 PO; 11Aug 2031; 8/14 7 3 2; 12Aug 2015 PO; 8/17 0339 PO
7Aug03	[redacted]	Phenergan 25mg IV or IM Q6° prn		
copied	[redacted]	Tylenol 650mg PO q4° prn		16Aug 0525 650mg; 16Aug 1510 650; 17Aug 0308 650; 17Aug 0836 PO; 19Aug 1050 650
7Aug03	[redacted]	Motrin 800mg po TID & 8° PRN		17Aug 1050 PO; 17Aug 1538; 18Aug 0815; 18Aug 1552 PO; 18Aug 2338 PO; 19Aug 0700 PO

Dc'd 19Aug03 1545 Aug

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ____

PATIENT IDENTIFICATION: #[redacted]

b(6)-4 PRN

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

ASA 2
Tobacco
75 kg

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

OTSG APPROVED (Date)

Date: 10 Aug
Time In: <0000
Allergies: NKDA
Pre-op V/S: 133/100 90
Procedures: 1/D LLE

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3000 cc Colloid —
OR Output: UOP Ø EBL 250
Meds/Times: 2mg versed 250 fent 10 MS04

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

Pre Op Meds History

Time																		
SaO2	96	96	96	95	96	96												
FiO2	RA	RA	RA	RA	RA	RA												
Methods																		
240																		
220	138/70	140/72																
200																		
180																		
160																		
140																		
120																		
100																		
80																		
60																		
40																		
20																		
RR	16	24	14	14	14	20												
T	97																	
Time																		
Pain (0-10)	0																	
LOS	11																	

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	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	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	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature & Title): CPT [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 10 Aug 03

PATIENT'S IDENTIFICATION (Print or type or affix label here. Name — last, first, middle; grade; date; hospital or medical facility)

b(6)-2

EPW [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

NEUROVASCULAR

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

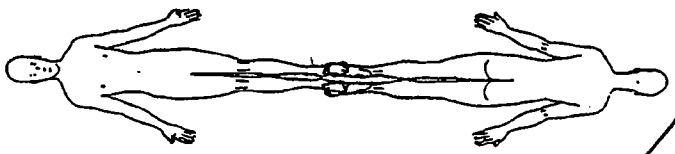
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

[illegible] received [illegible] from recovery room at [illegible] [redacted] [illegible] given to [illegible] [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 10 Aug **Time:** 0540 **PARS:** 10
BP: 126/61 **T:** 97.3 **HR:** 60 **RR:** 18 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: 0 **Output:** 0
Additional Data: None
Transferred To: [illegible]
Report Given To: [illegible]
Transferred Via: W/C [illegible] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room S.O.P. By: [redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 7 Aug 05
Time In: 2000
Allergies: NKDA
Pre-op V/S: 129/67 HR=96
Procedures: I&D (b) axilla
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 4 cc Colloid
OR Output: UOP 0 EBL min
Meds/Times: 25 Cy 06 Fent
open one drain

ASA II
Smoky
Wergin

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	20	20	20	20	20										
	00	05	10	15	20										
SaO2															
FiO2															
Methods															
240															
220															
200															
180															
160															
140		✓	✓	✓											
120	✓														
100															
80															
60															
40															
20															
RR	24	24	20	20	17										
T															
Time	2015														
Pain (0-10)	5														
LOS															

b(6)-2

[redacted]

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
2000	LR	1 L IV	(L) Arm		1 L IV

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˚ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

PREPARED BY (Signature [redacted]
b(6)-2

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 7 Aug 05

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

[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
2015	5	MS04/5mg	IV	3	E	[redacted]

NEUROVASCULAR

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

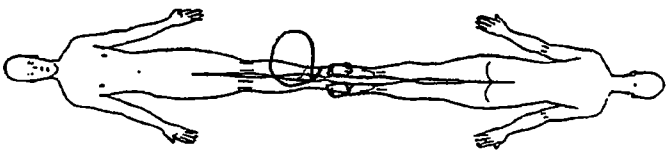
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) ankle	Bulk	Ø
30'	"	"	"
60'	"	"	"
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2000	SR	NO	NO

WAMC OP 173-E

NURSING NOTES

Nursing Notes: Pt. admitted to ICU #2 for recovery. Lungs clear, BS hyperactive, pulses palpable x 3 extremities, good cap refill x 4 extremities. IV to (L) hand patent. LR @ TKO. Will continue to monitor. [redacted]

b(6)-2

Discharge Criteria:
Date: 7 Aug **Time:** 2045 **PARS:** 9
BP: 144/80 **T:** 97.6 **HR:** 86 **RR:** 24 **Sa02:** 96
Pain Level at D/C (0-10): 3
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICU #2
Report Given To: [redacted]
Transferred Via: W/C [redacted] ney **Ambulance**
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

b(6) - 2

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.
27 July 03 1530	0073210 A

3. NAME	4. DATE OF BIRTH
[redacted]	21-7-75

[redacted]	6. SERVICE NO.
Iolus - 21	

7. UNIT OF EPW	8. CAPTURING UNIT
	Alpha Co IP

9. LOCATION OF CAPTURE (*Grid coordinates*)
MB 398 803

10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS
CAR Theft & Assault with	Gun shot wound	

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	Ø 2 6	Z	Z	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1240	— b(a)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø b(2)-2	ICW#2	UNK
[redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UN

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
30		0 3 0 8 1 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		0 3 Ø 8 Ø 7

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

FOR LOCAL USE

DX: Gsw to (L) leg & Elbow s/p IED (L) Leg.

Dx: 82531 8750 8911 8738 88101 E9912 E9919

Pro: 7967 8628

b(a)-2

ADMITTING OFFICER (Signature, as req[redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

Inj Trauma 450 1

Dr. [redacted]

DA F[redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 00 14206	2. NAME (Last, First, MI): UNK IRAQI EPW				3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: 34y	6. RACE: X	7. RELIGION: MUSLIM	8. LENGTH OF SVC: —	9. ETS: —	10. PREVIOUS ADMISSION: no
11. FMP: 99	12. SSN: [redacted]		13. ORGANIZATION: —			14. WARD: ICW2
15. FLYING STATUS: NO	16. RATING/OSG: b(4)-4	17. DEPT/BEN: K78	18. BRANCH/CORPS: —	19. UIC/ZIP		20. TYPE CASE: WIA.
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER				22. HOURS OF ADMISSION: 1515	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —			25. TYPE DISPOSITION: D/C TO CAMP		26. DATE OF DISPOSITION: 14 Sep 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —			27b. TELEPHONE NO.: —		28. DATE OF THIS ADMISSION: 16 AUG 2003	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P ex fix (L) femur.

821.30 78.15
736.89
E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	~~44~~ 37	~~44~~ 37

36. Total Days All Facilites b(4)-2

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	[redacted] 0	[redacted] 0	37	37

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible]

PHYSICAL EXAMINATION

[illegible]

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

[illegible]

b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	[illegible]		

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

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	S) Pt shot in (L) knee entrance + exit wound,
BP 110/80	Pt has broken femur. Traction splint. Pt
P 128	c/o dizziness. Pt shot 22-25 days ago.
R 16	O) morphine 5mg IM 2033 hrs
T	2050 - 5mg MS given IM in (R) Deltoid. B/P
	110/palp ā MS.
	Xrs displaced fracture
	(L) distal femur
	Leg:
	Legal
	Head
	NAD
	(L) thigh swollen shortened but with
	leg spasms
	distal limb intact
	only thigh → exit hole
	A - Gunshot wound - 20 days (L)
	fracture (L) femur
	P - G CSW. splint
	Ambulism - [redacted] 4/12

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

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

REGISTER NO. | WARD NO.

b(6)-2 EPW

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

deformed femur
AMB gunshot
to L. ankle

[redacted] b(6)-2

2230— 1L LR TKO ——————————— SGT [redacted] 91W

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07Aug03 1900	Pt received from ICU2 @ 1840. Pt stable at time of transfer. AAOx3. PERRLA. Mucous membranes pink, moist & intact. Neck supple FROM. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. W to (R) AC T LR @125 cc/hr. Pt drinking small amts clear flds. Refused dinner. Ex fix to (L) femur. Dsg to lower pin T minimal drainage. Ø complaints — b(6)-2 [redacted]
2030	Temp to 100.5F. Tylenol given — [redacted]
2035	Foley from ICU2 "fell out" @ 1945 due to balloon not being inflated. Replaced T 16Fr indwelling foley. Draining clear yellow urine in sufficient amounts Ø complaints — b(6)-2 [redacted]
2130	Pt care assumed @2100. T @ 100.9, 650 mg Tylenol @2040, will take again @2200. Lung sounds CTA, pulses + x4, bs + x4 quads. Ex fix with dsg on lle draining small amount of blood at lower pins site. lle T (+) pulse and sensation. Patent IV @ RFA infusing @125cc/hr. Foley catheter intact, draining C/U. Will continue to monitor. — [redacted]

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

EPW [redacted] b(6)-4

RECORDS MAINTAINED AT: b(6)-2 [redacted]

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

b(6) - 2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Aug 03	Pt temp taken 100.5 — [redacted]
7 Aug 03 2230	Temp ↓ to 99.5. — [redacted] allume [redacted]
080530 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ± distention. BS(+)4. Voiding per foley, clear, yellow urine. ROM and neurovascularly intact to (B) UE and (R) LE. (L) LE has ex-fix to lateral thigh, 4 pins, and ACE wrap to length of leg. Sensory deficit to distal two pinsites. Neurovascularly intact below pins but ROM limited by pain. IV to (R) AC ± s/s infection or infiltration. — [redacted]
080820 Aug 03	NURSING NOTE: T↑ to 102°F. Tylenol 650mg PO given for temp. Dr. [redacted] notified PE: absence of antibiotics and temp. Anct ordered and given. — [redacted]
081000 Aug 03	NURSING NOTE: Pin care withheld today per Dr. [redacted] instruction. Will start pincare tomorrow. — [redacted]
8 AUG 03 1300	- Received PT in bed. PT Temp 102 F. Tylenol 650mg PO Given in previous shift. Will encourage use of incentive spirometer. Lung sounds are clear Bilateral. BS x4. Abdomen soft + NON tender. PT has foley c̄ clear color urine noted. ex-fix to (L) leg is intact c̄ small amount of drainage noted from (1) pin. PT has (+) sensation to (L) foot. Will cont to monitor Temp. IV (L) to (R) AC flushes well c̄ 3cc/hr. Will cont to monitor. [redacted]
9 Aug 03 0100	Pt care assumed @ 0100. VSS, alert and awake ± c/o pain. Lung sounds CTA, pulses (+) x4 BS x4. IV restarted in LFA, IV ABX. foley site intact, voiding Clear yellow urine. LLE c̄ Ace wrap ~~SBL~~ c̄ small amount of bloody drainage @ pins. + Sensation and capfill in lle, no new complaints, cont to monitor. [redacted] allume

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 03		0420	Pt awake and conversing. Orders noted.
			Pt w/b transferred [redacted] CSH in am [redacted] SPC
		1039	Ok to [redacted] LCTSP b(6)-4

Continue on reverse side

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

[redacted]

EPW b(6)-2

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
		2126 X	1 Calexin (1g 6hrs)
		2126 X	1g Amsef IV
		1220 X	CMS ⊕ Distal pulse, Good motor skills babinski reflex ⊕, [redacted]
		2240	10 mg Valium given IM per V.O [redacted] PP: [redacted] 91W
2340			[redacted] ⊕ [redacted] b(6)-2 b(6)-2

U.S. GOVERNMENT PRINTING OFFICE : 1986 O - 154-830

NURSING NOTES
Standard Form 510
(Reverse)

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 August 03 0900	Pt. c/o upset stomach TT Maalox tabs given. VSS. HR Reg., lung sounds clear bilat, bowel sounds (+) x 4 quads. HL in (L) AC flushed well c̄ 3cc NS s̄ s/s of infection. Ex fix to (L) femur intact, distal pin c̄ scant amt of brown dried blood to DSG. Pt. c̄ (+) sensation to (L) foot, cap refill <3 sec, full ROM in ankle & digits. Foley draining clear yellow urine. All other assessments WNL. Pt. s̄ other complaints @ this time. Will continue to monitor. [redacted] PU/AN
9 Aug 03 1700	assumed care @ 1300 - VSS - SL patent - (L) femur ex-fix in place, pin sites dressed, no drainage noted, neurov's WNL in (L) foot - no c/o pain @ this time - foley draining QS dark yellow urine - [redacted] CR/AN
9 Aug 03 Cont	pt. has temp of 101.9, 1g tylenol given PO, will recheck temp for results - [redacted] CR/A
9 Aug 03 1815	pt. temp of this time is 100.6°F, will continue to MONITOR - [redacted]
10 Aug 03 0800	Pt care assumed @ 2100. VSS, A&Ox3, no c/o pain. ex fix on lle intact, dressed around pins, no drainage noted. (+) rom and sensation of lle, no c/o pain. Lung sounds CTA, pulses + x4, bs + x4. Foley intact draining c/c. Will continue to monitor. [redacted] Alum 6
10 Aug 03 0900	Pt. asleep in bed easily aroused by verbal stimuli. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. HL in (L) FA flushes

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

EPW

[redacted]

b(4)-4

ICW

RECORDS MAINTAINED AT:

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

b(a)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	well c̄ 3cc NS s̄ s/s of infection or infiltration. (L)LE ↑ on folded blanket, ext. fix intact, insertion sites s̄ s/s of infection, small amt. of drainage noted on most distal pin, yellowish in color, (+) sensation, full ROM in ankle & digits, cap refill <3sec. Pt. c/o (L) ear ache, MD notified & plans to remove small amt of ear wax lodged in ear canal. Pt. s̄ other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted]
10Aug03 1710	assumed care @1300 - VSS - debrox 5 gtts placed in (L) ear as ordered - dsg on pin sites, neuro V's WNL in (L) foot, motor (+) in (L) foot - SL patent - no c/o pain in (L) leg or (L) ear - Foley draining lt yellow urine, BS [redacted]
2322	Pt. care assumed @ 2100. VSS. HR reg, lungs CTA, BS (+) x4. (L) LE ex-fix intact. Pins to pin sites CDI. NV checks (L) LE WNL. HL (L) EA intact, flushes s̄ diff. ∅ s/s infection. Will cont. to monitor. [redacted]
11Aug03	0611 Assume pt care @ 0500. Awake and Alert c/o pain to BLQ of Abd. due to foley. Will talk to MD about Discontinuing foley. VSS. HL to (L) FA (+) flush s̄ redness/infiltration. HR reg lungs CTA BSx4. (L) thigh ex-fix intact. Dsg to pin CD+I. (+) ROM (+) pulse (+) sensation below pin sites. Foley to Gravity c̄ CYMOP. Will continue to monitor. No c/o pain to (L) ear @ this time. [redacted]

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Aug03	1027 Foley discontinued @ 0835 pt encouraged to drink water and void by 1230. Pin care done, percocet for pain — [redacted] SMMC
11Aug03 1400	assumed care @ 1300 - VSS - pt. voided b(6)-2 300cc dark amber urine @ 1350 - SL patient - abx completed - ex-fix remains on (L) thigh, no drainage noted on dressing. neuro V's WNL [redacted] in (L) foot — b(6)-2 [redacted] cm
2202	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. Pt. denies pain to (L) ear, but c/o pain to (L) LE. (L) LE ex-fix intact. Drsngs to pin sites CDI. (L) knee bent to 30° w/ blanket. NV checks (L) LE WNL. will cont. to monitor. — b(6)-2 [redacted] /LTJAN
12Aug03	0526 Assume pt care @ 0500. Pt awake and alert. VSS. C/O sm amt of pain to (L) femur, had percocet @ 0200. HL to (L) FA (+) flush ~~5~~ redness/infiltration. HR reg, lungs CTA Abd soft no c/o tenderness on palpation BS x4. Ex-fix to (L) LE intact. dsg's to pins ~~c~~ sm amt pink drainage. NV checks WNL (L) LE. No c/o pain to (L) ear @ this time. Will cont. to monitor — [redacted] SLWMC b(6)-2

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

EDW

[redacted] b(6)-4

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

b(6) - 2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03 1410	assumed care @ 1300 - VSS - S2 patent, due to be Δ'd 13Aug03 - no drainage noted from pin sites, knee & thigh remained edematous, neuro V's WNL in (L) foot - no c/o pain @ this time — [redacted]
12Aug03 2230	VSS - Alert x3 - lungs CTABIL even unlabored. HR-NSR - BS(+) x4 quads. Pulses to upper (L) leg intact. Percocet ii PO given for pain. (L) leg edematous. Restraints to upper and lower extremities in place and secure. — [redacted]
13Aug03 05-12 3/2	Pt complained of constipation in bed, also to get Pt out of bed to use urinal — to toilet. Pt provided ad deficiency. Pt had dressing down to (L) pins through femur. Pt fibrotic procedure cont. Pulse — dry, no exudate. area still tender to touch. VSS stable [redacted]
13Aug03 1300	Pt stable. AAOx3. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non tender, bowel sounds active x4 quads. (L) leg elevated, pins sites S S/S infection, dsg Ø CDI. Strong pulses and brisk cap refill to bilat LE. Ø complaints — [redacted]
2300	Pt care assumed @ 2300. VSS, a-ox3, percocet given prior to ROM. Lung sounds CTA, pulses + x4, BS + x4 quads. Ex fix to lle CDI, pt c (+) sensation and cap refill. Edema noted in lle. Pt c/o pain @ HL, HL dc'd. Will continue to monitor. — [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
14Aug03	0654 Assume pt care @ 0500. Pt awake and alert. C/o pain to LLE, percocet given as ordered. VSS. HR reg. Lungs CTA. Abd soft BS x4. Ex-fix to (L) thigh intact. Drgs CDI. ⊕ROM ⊕pulse b(6)-2 ⊕sensation below site. Will cont. to monitor [redacted]
14Aug03 1530	assumed care @ 1300 - VSS - no c/o pain @ this time - pt. ambulated c crutches assisted by PT - Small amount of drainage noted on top pin site dressing - neuro v's WNL in (L) foot [redacted]
14Aug03	VSS - Alert X3 - Peaulin 3mm - Lungs CTA B/L - HR - NSR. BS⊕ x 4 quads Pedal pulses ⊕3 Radial ⊕3 Pins to (L) leg intact clean ⊕drainage. Percocet II Po given for c/o pain. b(6)-2 Restraints in place and secure. — Sgt [redacted] /CCO
15 0530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAO x 3. Airway intact, breath, even and unlabored LS CTA ⊕. Abd soft, nontender, ↓ distention. BS⊕x4. Voids spontaneously. Normal neurovascularly intact to ⊕UE and RLE. LLE has Ex Fix to lateral thigh x 4 pins. Drsg to pin sites are CDI. Pt has limited ROM to LLE, neurovascularly intact to LLE. Sensitivity generalized to entire leg, however, — [redacted]
15 0700 Aug 03	NURSING NOTE: Pt awakened c/o increased pain to the most proximal pin. Percocet II tabs given PO. Will assess site c pin care this AM. — [redacted] b(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO. ICW2

EPW [redacted] b(6)-4

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
15 Aug 03	NURSING NOTE: Two most proximal pins are somewhat reddened and have some small amounts of purulent drainage to both. Two distal pins are ∅ drainage at this time. MD notified, suggested PO antibiotics or dakin's solution. Awaiting new orders. [redacted]
15Aug03 1820	assumed care @1300 - VSS, T100.2 - given 650mg tylenol @1445 for (D) leg pain c̄ good pain relief - dsg on pin sites CDI - ∅ SL - neurov's WNL in (D) foot - pt. ambulated c̄ PT using crutches - PO abx continue - [redacted]
15 Aug 03	VSS - Alert X3 - Pins clean and intact ⊖ s/s of infection. Pearl Rhythm HR-NSR - Lungs CTA BIL Resp Reg even. BS ⊕ x4 quads. Pedal and Radial Pulses +3. Percocet given for c/o (D) leg pain. Restraints to UE and LE in place and secure. - SGT [redacted]
16 Aug 03 0320	Resting quietly epresent. Percocet ii PO given for c/o (D) leg pain, has had ∅ further c/o pain. Restraints to UE and LE in place and secure. - SGT [redacted]
16 August 03 0620	Pt. awake & alert sitting up in bed eating breakfast. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. VSS. Pt. ∅ IV access. Ext. fix to (D) femur intact, distal pin draining yellowish fluid, pedal pulse (+), (+) sensation, cap refill <3sec, full ROM of digits & ankle, ∅ ROM in knee. Pt. c/o pain in (D) leg, ii tylenol given. Pt. ∅ other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted]
16Aug03 1440	assumed care @1300 - VSS - medicated c̄ 650mg tylenol PO prior to ambulation - scant drainage on pin site dsg close to ankle, neurov's WNL in (D) foot, (+) movement, (+) sensation - no c/o pain @ this time [redacted]

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MEDICAL RECORD Progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Aug03 2145	VSS Alert x3 Pearl 4mm - Lungs CTA B/L Resp even Reg HR-NSR BS(+) x4q cards Pedal and Radial pulses +4. Pins to (D) upper leg in place & drainage or S/S of infection. Restraints in place and secure. b(6)-2 [redacted]
17Aug03	0728 Assume pt care @ 0700. pt asleep easy to awake. VSS. C/o pain to (D) thigh ex fix @ first pin. Swelling noted to 1st pin. Dsgs CD+I @ pin sites. Limited ROM below ex-fix. (+) pulse (+) sensation. HR reg. Lungs CTA. Abd soft BS x4. Will cont. to monitor b(6)-2 [redacted]
1300	pin care done. discussed swelling @ 1st pin c̄ MD. Thigh elevated. b(6)-2 [redacted]
17Aug03 1530	assumed care @1300-VSS-sleeping until VS taken and no c/o pain-resp VS WNL (+) (2) foot, no drainage noted on dsg @ pinsites, leg elevated on blanket-PT has not been in to do crutch walking c̄ pt. today [redacted]
17Aug03	VSS-Alert x3 Pins to (D) leg clean and in place. swelling around pin sites noted. dsgs to pins dry and intact. Pearl 3mm Lungs CTA Resp even Reg. HR-NSR BS(+) x4 pulses. Abd soft NT. Percocet ii PO given for c/o pain. Restraints. +ve and LE in place and secure. — SGT [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.

WARD NO. ICW2

EPW # [redacted] b(6)-4

Progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 Aug03 0430	Percocet ii po given for c/o ⓛ leg pain @ 2330. ∅ further c/o pain or discomfort. Resting quietly @ present. Restraints to UE and LE in place and secure. — [redacted]
18 Aug03 0630	Pt. asleep in bed ⊼ c/o pain in ⓛ femur, ii percocet given. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Ext fix to ⓛ femur intact, pin site dsgs CDI, (+) sensation, pedal pulse palpable, ROM limited in digits, ankle & knee. Pt. ⊼ IV access. VSS. Pt ⊼ other complaints @ this time. Will continue to monitor. — [redacted]
18Aug03 1330	assumed care @ 1300 - VSS - Small amount of drainage from pin sites, neuro V's WNL in ⓛ foot - PT has not been in today to do crutch walking - no c/o pain at this time — [redacted]
19 Aug 0130	Care assumed @ 2100. VSS, afebrile, ii percocet given for pain @ 2200. Lungs CTA, pulses x4, bsx. Pins on lle intact, ∅ drainage. Pt ambulated to br x1, taking PO ABX. Will continue to monitor. — [redacted]
19Aug03	0632 Assume pt care @ 0500. Awake and Alert. c/o pain @ 1st pin site to ⓛLE ex-fix. percocet given VSS. HR reg. Lungs CTA. Abd soft BSx4. Amb ⊼ crutches and assistance. ⓛLE ex-fix intact. dsgs to pins CDI. Swelling noted @ 1st pin - elevated leg so pin would not dig into bed. Will cont to monitor — [redacted]
1330	Pt awake and alert. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, nontender, bowel sounds active x4 quads. Ex fix to ⓛ femur intact, dsgs CDI. Strong pulses and brisk

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03 (Cont)	Capsrefill to bilat lower extremities. Ø complaints to [redacted]
19Aug03 2300	Care assumed @2100. VSS, AOX3, 650 mg Tylenol given for pain. Lungs CTA, pulses palpable x4, bs(+). LLE c̄ ex-fix, ex-fix insertion sites intact. Pt able to ambulate c̄ crutches, needs assistance getting in and / out of bed. Will continue to monitor. [redacted] b(6)-2
20August03 0730	pt. asleep in bed easily aroused by verbal stimuli. HR Regular, lungs sounds clear bilat, bowel sounds (+) x4 quads. Pt ī IV access. VSS. Ext fix to (R) femur intact, DSG's to pin insertion sites CDI, pedal pulse palpable, (+) sensation, full ROM of digits & ankle, limited ROM of knee, cap refill <3sec. Pt. ī complaints @ this time. Will continue to monitor. [redacted]
20AUG03	Ortho Staff. Pan sites (R) femoral ex fix clean/dry. X-Ray 18AUG03 c̄ acceptable alignment. Needs ROM exercise of knee & crutch training. 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. CW2

CPW [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

b(6)-2911

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20Aug03 1330	Pt awake and alert. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex-fix to (L) femur intact pin sites ⅀ S/S infections. Dsgs CDI. Strong pulses and brisk cap refill to bilat lower extremities. Ø complaints [redacted] C/N
20Aug 2230	Care assumed @ 2100. VSS, a+ox3, no c/o pain. Lungs CTA, pulses ⊕x4, bs active x4 quads. Ex fix on lle intact, Ø S/S infection. Patient on PO ABX, will continue to monitor [redacted] 91WM6
21Aug03 0800	assumed care @ 0500 - VSS - no c/o pain @ this time - neurovs WNL in (R) foot, Dir site dsgs C/S cant drainage [redacted]
21AUG03	(1625) Pt admitted to unit via litter in stable condition. Pt A/O x3, speaking Arabic. Ex fix in place on (L) thigh. Pin care done this am. Pt moves (L) leg ⅀ difficulty. ⊕ pedal pulse. Cap refill <2secs. Pt medicated c̄ 11 perc for pain in (L) leg [redacted] c̄ good relief. ⊕ bm. Voiding ⅀ difficulty. Lungs CTA ⊕. ⊕ bs x4 quads. VSS. Will continue to monitor. ([redacted] 4A)
21AUG03 2240	VSS. Alert. LSCHAB. (L) leg elevated. DSG's CDI intact ⊂ ⊕ pulses. BS ⊕x4. ⊖ c/o pain @ this time. Able to move LLL on own. ⊕ swelling to (L) thigh. No c/o pain. [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

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
22AUG03	1010		Assumed care of pt @ 0700 ̄p report from night shift. Pt alert, speaking Arabic ∅ c/o pain. Ex fix in place on (R) thigh. Pin care done. ∅ S/Sx infection @ pin sites. Am care done by pt. Pt moving UE ̄s difficulty. ⊕ pedal pulses - equal bilat. Cap refill <2secs. Voiding ̄s difficulty. 2 point restraints in place. Pt resting quietly @ this time. Will continue to monitor.
			b(6)-2 [redacted] (WAJ)
22AUG03 2000			VSS. AO. PERRLA. LSCLAB. ̄s, ̄s. ⊕ Ex Fix pins CDI ̄s c/o pain or S/S of infection. UE Elevated per routine. BS ⊕x4 and voiding ̄ difficulty ̄s tolerating PO well. ⊕ pulses in all extremities.
			b(6)-2 [redacted]
22AUG03	0915		Assumed care of pt @ 0700 ̄p report from night shift. Pt alert, speaking Arabic. Pt medicated ̄c ̄ Percocet this am for pain in (R) leg ̄c good relief. Ex fix in place. Pin care done this am. ∅ S/Sx infection at pin sites. VSS. Pt voiding ̄s difficulty. Am care done by pt. 2 point restraints in place. UE elevated on blankets. Monitoring [redacted] (WAJ)
			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.

EPW # [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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 AUG 03 2100			VSS. Denies pain @ this time. PSG's to pain CPT. @ pulse @ LUE. Performed ROM and crutch walking. Resting comfortably in bed. b(6)-2 [redacted]
24 AUG 03 —	1115		Received pt after report in stable condition. VSS, alert, speaking very small amt of English. Medicated w/ ½ percocet for pain, relief noted. PT in to see pt for ROM. Pin care done, small amt of pus noted @ upper pin sites. Pt communicated that he feels leg is getting bigger and pain is increased @ upper pin site. Will notify MD. Will cont to monitor [redacted]
24 AUG 03 2000			VSS. NO. Denies pain @ this time. Ambulated x1 to bathroom BSO3 difficulty. Tolerated PO well and played cards to self. Utilized the process of unveiling to patient and pt understood via interpreter. Ate other options well. b(6)-2 [redacted]
Bauges	1100		Received pt resting in bed. Ambulated VSS, c/o pain medicated x1 ½ percocet. Medicated w/ MSO4 IM during PT session and pt and this shift. No remarkable assessment findings. Pin care done. Site looks improved since [redacted] cont to monitor [redacted] b(6)-2

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STANDARD FORM 510 (REV. 7-91) BACK

MEDICAL RECORD	PROGRESS NOTES
DATE	
27 AUG 0800	VSS Alert & oriented c/o pain @ 0700 rated 3/10 Tylenol given and effective Per Care done ∅ drainage noted around pin sites. OOB ambulate c crutches to BR with supervision. Tolerated Reg diet. Restraints removed & reapplied. Will check restraints & crutches / neuro vascu to extremities frequently [redacted]
27 Aug @2115	Pt a/o x3, VSS, lungs CTA (B), (+) BS x4 HRRR, [redacted] b(6)-2 ex-fix intact. c/o pain ⅡⅠ Percocet given c relief noted. Skin warm & slightly tender to touch. ∅ drainage noted @ pin sites. brisk cap refill & good pulses. circulation assessed. 2 pt restraints on. Will cont to monitor [redacted] B.
@2300	I concur above assessment. [redacted]
28 Aug @0100	Pt c/o pain. ⅡⅠ Per given c noted [redacted] b(6)-2 Will cont to monitor — [redacted] B [illegible]
28 Aug 1003	VSS. Alert & oriented. Percocet given for pain. Lungs clear. Abd soft [redacted] non distended BS (+) x4 quadrants. OOB ambulate c crutches to BR. Pin care done to (R) lower extremity ex. fixator. Rise paraplegic to (L) lower extremity [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. b(6)-2

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

PROGRESS NOTES

DATE	
	b(6)-2 AH
25 Aug 03 @ 2000	Pt a/o x3, VSS, medicated for pain c percocet II. ex fix intact. (L) LE elevated. (+) pulses & cap refill to extr. voiding ≡ difficulty. Reflex given. Will cont to mon — Richardson B 9WM6
26 Aug	Pt sleeping c ∅ distress noted [redacted] B
26 Aug 1000	VSS A&O. Ambulated c crutches to BR with supervision. Pin care done. ∅ drainage noted around pins. (L) LE c ex fix intact. (L) LE pulses palpable. (L) toes c capillary refill ≤ 3 sec. Tolerating Regular diet. No pain or distress voiced or noted [redacted] 2LT B
26 Aug 03 @ 1830	Pt a/o x3, VSS, c/o pain to (L) LE, area tender to touch & warm, pin sites c ∅ drainage. II Percocet given for pain. (L) LE elevated. pulses palpable & equal, brisk cap refill. 2 point restraints on. circulation assessed at all extr. ∅ IV access. H2O @ BS within reach. Will cont to mon — [redacted] B 9WM6
26 Aug @ 2300	Pt c/o pain at ex fix site II Percocet given Reflex PO given. ~~Will~~ X-ray consult ordered an for AM. Will cont to monitor — [redacted] B 9C6
@ 0115 —	I concur c above assessment. [redacted]
	b(6)-2

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

[redacted] b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
28Aug @1930	Rt A&O x3, VSS, HRRR, lungs CTA (B), (+) BS x4 qds, + 2 pulses, circulation assessed good pedal pulses, brisk cap refill. ex-fix intact. Ø c/o pain @ this time. Abx given. 2 point restraints on. encouraging H2O intake. H2O @ BS within reach. Will cont. to monitor. b(6)-2 [redacted], B 91WM6
28Aug03 28Aug03 @2100	2000: I concur c̄ above assessment [redacted] 29/AN Rt c/o pain to (D) thigh. ☞ Percocet given. c/o b/v relief. Will cont to monitor. b(6)-2 b(6)-2 [redacted] B 91WM6
29AUG03	(0915) Assumed care of pt @ 0000 p̄ report from night shift. Pt dent speaking Arabic. VSS. Pain controlled c̄ Percs. Ex fix in place on LE. Pt able to move LE. (+) pedal pulses equal bilat. Cap refill <3 secs. Skin warm to touch. Pin care done this am. Voiding s̄ difficulty. Tol reg diet well. AM care done this am by pt. 2 point restraints in place. - Ø s/sx complication c̄ circulation/skin breakdown. Will cont. to monitor. b(6)-2 [redacted] AD
29AUG03 1945	Pt asleep, ~~VSS~~ easily aroused, VSS, c/o mild pain on (D) thigh, LS CTA (B), (+) BS x4, Ex fix in place, LLE elevated c̄ blanket, (+) pedal pulses equal (B),

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

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

b(6) - 2
All

PROGRESS NOTES

DATE	
Cont.	Dsg (L) thigh CDI, (L) thigh swollen compared to (R), proper circulation + skin integrity on pts. of restraint. [redacted]
2130	Pt had a BM soft and form[redacted]
30AUG03	(0950) Assumed care of pt w/ ccco p̄ report from night shift. Pt dert, speaking Arabic. Pain controlled c̄ Percs. VSS. Ex fix in place on (L) thigh. Pin care done this am. (L) thigh swollen compared to (R). Blanket roll under knee. (+) pedal pulses equal bilat. Cap refill <3 secs. ~~wet → dry dsgs Δd on (L) thigh and~~ [redacted] ~~calf. ϕ sisx infection~~ ERROR ERROR. Voiding s̄ difficulty. AM care done this am by pt. Tol. reg diet well. 2 point restraints in place. - ϕ sisx complications c̄ circulation/skin breakdn. Will cont. to monitor. [redacted]
30AUG03 2000	Pt resting in bed, AtOx3, VSS, LS CTA (B), (+) BS x4, c/o some discomfort but refuses medication @ this time, Ex Fix in place on (L) thigh, (L) thigh elevated c̄ blanket, swollen compared to (R) thigh, peripheral pulses palpable equal (B), proper circulation + skin integrity on pts of restraint. [redacted]
0445	Dsg Δ, pin care given. [redacted]

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

b(6)-2 A11

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 Aug 03 @ 1800	Received pt resting in bed, VSS, a&ox3. Amb care provided. ⓛ thigh w/ ex fix in place dsgs intact, thigh swollen, ~~but consistent~~ w/ previous assessments. Amb w/ crutches & pt info see pt. medicated x1 w/ ii percocet. Sgns. & other remarkable assessments noted. Will cont to monitor [redacted]
31 Aug 03 @ 2320	Assumed care @ 1800; VSS, pt A&Ox3, NV intact, ⊕ movement & sensation, Ex-fix in place dsgs CDI, thigh maintains edematous; up amb c̄ crutches; medicated x1 c̄ ii perc; cont to monitor [redacted]
01 Sept 03 @ 1130	Received pt resting in bed, VSS. A+Ox3, ⓛ thigh ex fix in place, cap refill good, ⊕ pedal pulse. Dsgs Δ'd, ddfi. Lower pin site looks better than upper pin site. Thigh cont to be swollen, amb x1 w/ crutches. Medicated per MAR for pain. Will cont to monitor. [redacted]
1 Sep. 03 1900	Pt resting in bed, A+Ox3, LS CTAB, ⊕ BS x4, Dsg's Ex fix CDI, LLE elevated c̄ blanket, c/o pain, medicated c̄ ii percs, proper circulation + skin integrity on pts of restraint [redacted]

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

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

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 Sept 03 0500	VSS Alert & oriented. AM Care done (2) Ambulate c crutches c Physical therapist. Medicated c Percocets pain therapy. Regular diet consumed for breakfast. Pin care done. Voiding clear yellow urine. Restraints removed and reapplied. Skin under restraints intact. Will check restraints, skin integrity and extremities circulation frequently. [redacted]
2 Sep. 03 1830	Pt AOX3, VSS, LS CTA (B), (+) BS x4, c/o pain, medicated c 2 percocets, voiding c/y urine, Ex fix on LLE, dsg CDI LLE elevated c blanket, 2 pt. restraint, proper circulation + skin integrity. [redacted] 9IWT CPT
3 Sept 03 0800	VSS AOO. Lemp Clear (B) BS (+) x4. Ped PBM upon ambulating to BR c crutches. Medicated with Percocet for pain. Voiding clear yellow urine. (L) leg extension pin sites without drainage. Pin care done. Peripheral pulses palpable +2. Restraints removed and ~~reap~~ replaced. Skin under restraint intact. Will check restraints, skin integrity and circulation to extremities frequently. [redacted]

b(6)-2 A11

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STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Sep 03 1915	Pt AxOx3, VSS, LS CTA (B), (+) BS x4, S1 S2 present, peripheral pulses +2, abd soft flat non tender, Ex fix LLE, (O) thigh elevated c̄ blanket, pt ambulates c̄ crutches, dsg CDI, Ø c/o pain @ this time, assessed for proper circulation + skin integrity on pts of restraint [redacted]
1920	Pt had a BM this PM b(6)-2 [redacted]
4 Sept 03 0500	VSS Alert + Oriented Medicated c̄ Percocet for pain @ 0630. Medication was effective. Lungs clear Bilateral, BS(+) x Quadrant. Consumed regular diet. Peripheral pulses +2. Ass Care completed. Ex fix to (L) leg pin sites without drainage or redness. Pin care done. Restraint removed and repositioned. Slept intact under restraints. Will check restraints, skin integrity b(6)-2 and extremities circulation frequently [redacted]
4 Sep 03 @ 2000	Assumed care @ 1800; VSS, pt A&OX3 speaking only arabic; Ø c/o pain @ this time; S1 S2, (+) pulses x4, LS CTA (B), (+) BS x4, ß+ voiding QS, clear, yellow urine; BM x1 this shift; Ex. Fix. to (L) leg in place (O) drng noted; pt amb to BR; restraints in place, circulation & skin integrity intact; will continue to monitor [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted]

b(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05SEP03	(1305) Assumed care of pt w/ 0000 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb to BR c̄ crutches s̄ difficulty this am. ⊕BM. Voiding s̄ difficulty. Tol reg diet well. Ex fix in place on ⊖ thigh. Pin care done this am. ⊘ S/Sx infection w/ pin sites. ⊕ pedal pulse equal bilat. Cap refill <3 secs. ~~warm~~ [redacted] Skin warm to touch. Am care done by pt. 2-point restraints in place s̄ S/Sx complications c̄ circulation/skin break w/. Will cont. to monitor. b(6)-2 [redacted] (WDA)
5Sep.03 1845	Pt sitting in bed, A+Ox3, VSS, LS CTA(B), (A)BSx4 peripheral pulses palpable, ⊘ c/o pain @ this time, Ex Fix LLE, dsgs CDI, voiding c/y urine, proper circulation + skin integrity on pts of restraint. [redacted] GRW16 b(6)-2 [redacted]
06SEP03	(0830) Assumed care of pt w/ 0000 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Ex fix in place on ⊖ thigh. Pin care done this am. ⊘ S/Sx infection. ⊖ thigh swollen compared to ⊕. ⊕ pedal pulse equal bilat. Skin warm to touch. Tol reg diet well. Voiding s̄ difficulty. Am care done by pt. 2-point restraints in place s̄ S/Sx complications of skin break w/ circulation. Will cont. to monitor [redacted] (WDA) b(6)-2

b(6)-2 All

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep 03 1900	Pt resting in bed, AtO x3, LS CtA (B), (+) BS x4, S1 S2 present, VSS, pain controlled c̄ peres, (R) LE swollen compared to (L), Ex Fix in place, thigh elevated, dsg's CDI, peripheral pulses +2, voiding c/y urine, assessed for proper circulation + skin integrity on pts of restraint. [redacted]
2000	Pt had a BM this PM [redacted]
7 Sep 03 0000	Received pt in stable condition. VSS, AtO x3, LS CTAB, HRR, ABD SNT, NS(+), pulses equal + strong. (L) thigh ex fix in place, pin care done LLE w/ pulse intact + good sensation. Amb x2 w/ crutches and safety present. Vgs, medication per mar. Will cont to monitor [redacted]
7 Sep 03 @ 1900	Assumed care @ 1800; pt AtO x3 speaking only [redacted]; (+) movement & sensation NV intact; Ex-fix in place, (-) drainage noted; S1 S2 (+) pulses, LS CTA (B); BS x4; pt voiding QS, clear, yellow urine; BM x2 this shift; pt up amb c̄ difficulty; 2 point restraints in place, circulation & skin integrity intact; cont to monitor [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.

b(6)-4 [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
08Sept03 1555	Received pt resting in bed, VSS, A+OX3. (L) thigh remains swollen, ex fix intact. Pin care done w/ betadine solution for infection prevention per suggestion of fundoc nurse, MAS Melton. Amb x2, BM x2. Sugs, ∅ c/o burning on urinations. No other remarkable assessments. [redacted]
8sep03@1845	Assumed care @1800; VSS, pt A+OX3; Ex-fix in place; (L) Leg remains edematous dsg CDI; ↑ amb c crutch assistance x 2; BM; pt voiding QS; ∅ c/o pain @ this time; 2- point restraints in place; circ. & skin integrity intact; cont to monitor [redacted]
9 Sept 1200h	VSS. Alert & Oriented. Lungs clear. BS(+) x4 quadr. abdomen soft non distended. Peripheral pulses palpable. Voiding clear yellow urine. c/o pain during pin care. Percocet given and effective. Ambulated c crutches to BR. Restraints removed and replaced. Skin intact under restraints. Will continue to monitor [redacted] 27R
9 Sep 03 1855	Pt sitting in bed, A+OX3, VSS, LS CTA (B), (+) BS x4, S1 S2 present, abd soft flat non-tender, Ex Fix LLE, ext. elevated dsgs CDI, voiding c/y urine, ∅ c/o pain @ this time, ∅ skin breakdown + proper circulation on pts of restraint. [redacted] 9Sep03

b(4)-2 All

b(6)-2 A11

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Sept 03 0800	VSS A&O Lungs clear. BS (+) x4 quad. Peripheral pulses palpable +2. Pin care done. OOB c crutches ambulatory to BR. Restraints removed & reapplied after under restraints intact. Percocet given for pain [redacted]
10 Sep. 03 1900	Pt sitting in bed, A&Ox3, VSS, OOB to ambulate LS CTA (B), (+) BS x4, Ex Fix LLE, dsgs CDI, (-) c/o pain @ this time, voiding c/o urine, circulation + skin integrity assessed on pts of restraint. [redacted]
11 Sept 03 0800	VSS A&O x3. Lungs clear (B) Abd soft nondistended BM x1 this Am. Tolerating Regular diet. Peripheral pulses palpable +2. Pin care completed. Ambulatory to BR c crutches. Voiding clear yellow urine. Restraints removed & ~~reapp~~ reapplied after intact under restraint [redacted]
11 Sep 03	1200 Physical Therapy done. Pt c/o pain 10/10 post therapy. Percocet ~~1~~ 1 po given [redacted]
11 Sep 03	1700 Repeat (a) Femur series done [redacted]
11 Sep 03 @ 2000	Assumed care @ 1800; VSS; pt A&Ox3, (+) movement & sensation x4, strong pulses x4; NV intact; Ex-fix in place, leg remains edematous; (-) drainage @ pin site; dsgs CDI

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

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

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Ø c/o pain or discomfort @ this time; pt voiding BS, c/y urine; restraints in place; skin integrity & circ. intact; cont to monitor — [redacted]
12 Sep 03 0700 –	Assumed care of pt. A+O x3, VSS External fixator to (L) extremity. xrays @ BS. c/o pain schedule motrin administered. Lungs CTA HRRR swelling to (L) extremity. Active BS Tolerating PO well. Pin care this AM – Will cont to monitor — [redacted]
12 Sep 03 1915	Pt sitting in bed, A+OX3, VSS, LS CTA (B), (+) BS X4, Ø c/o pain, Ex Fix on LLE, dsg's CDI, (L) ~~leg~~ thigh swollen compared to (R), elevated, pt ambulates ē crutches, voiding c/y urine, proper circulation + skin integrity on pts of restraint. — [redacted] 91WM6
13 Sep 03 0700	– Assumed care of pt. awake A+O x3 VSS. Lungs CTA HRRR S1 S2 present. c/o pain to (L) LE medicated ē scheduled motrin for relief. Active BS x4 Encourage to ambulate urinal from BS. External ficator to LLE pin care this AM minimal bleeding to sites of pins, Will cont to monitor — [redacted] wma. (1600) I concur ē above assessment. — [redacted]
13 Sep. 03 2000	Pt recieved from OR, VSS, BP-114/54, T-98°, P-91, O2-98%, R-20, cast to LLE CDI, medicated for pain ē 11 percocet as per orders, LS CTA (B), (+) BS x4 pt tol PO well, IV (L) FA HL, flushes well Ø s/sx of infex, proper circulation + skin integrity on pts of restraint. — [redacted] 91WM

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STANDARD FORM 600 (REV. 6-97) BACK

(b)(6)-2 A1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Sep '03 0700	- Assumed care of pt. A+O x3. VSS s/p cast placement to LLE from hip to toes. good circulation AEB toes being warm to touch brisk capillary refill and able to wiggle toes. C/o pain scheduled motrin 800mg administer for relief WILL cont to monitor — [redacted]
15 Sep 03 @ 0015	Assumed care @ 1800; All VSS; pt A+O x3, c/o pain, medicated c̄ percs x1 c̄ good relief; ⊕ CMS, ~~All intact~~ x4; NV intact throughout; brisk cap Refill; cast intact; 2 point restraints in place; ⊕ circulation, ⊖ skin breakdown; cont to monitor — [redacted] pt amb x1 to BR, BM x1 this shift — [redacted] 9 MMb
15 SEP 03 (0900)	Assumed care of pt @ 0900 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. LLE in cast. Pt able to move toes. Cap Refill <3 secs. Pt amb c̄ crutches s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. ⊕BM. SL in ⊕ arm flushes well s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. — [redacted] WAW
15 Sep. 03 1900	Pt sitting in bed, VSS, A+O x3, cast to LLE intact, pain controlled c̄ percs, LS CTA (B), ⊕ BS x4, pt ambulates c̄ crutches, voiding s̄ difficulty, proper circulation + skin integrity on pts of restraint. — [redacted] 9MMb

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
	LAST	FIRST
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16SEP03	(1215) Assumed care of pt @ 0800 w̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled w̄ Percs/ND motrin. LLE in cast - CDI. Pt amb. w̄ crutches w̄ difficulty. Pt able to move toes on LLE. Cap refill <3secs. Pt tol. reg diet well. Voiding w̄ difficulty. Ø BM. 2-point restraints in place w̄ Sx complications. Will cont. to monitor. Awaiting trans. to EPW camp. b(6)-2 [redacted] WAO
16 Sep. 03	Pt sitting in bed, A+O x3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, cast on LLE, ambulates w̄ crutches, Ø c/o pain of pain @ this time, pt moves toes on LLE, cap ref <3sec, proper circulation + skin integrity on pts of restraint. [redacted] AWM [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

558-104 b(2)-2 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER [redacted] RECORDS MAINT [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: GPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 6 Aug 03 | TIME: 1241

TRANSPORTATION TO FACILITY

SEX: M

AGE: 34

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

CURRENT MEDICATIONS: Cephalexin, 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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1240

INITIALS: [redacted] b(6)-2

VITAL SIGNS

TIME	1240	1314				
BP	147/77	124/75				
PULSE	128	118				
RESP	18	18				
TEMP	99.9	98.6				
WT						

LAB ORDERS

☒	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT			
	URINE C&S	UA MSCC/CATH		CHEM: Met 8			
	BLOOD C&S X			Tox screen			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
BP	q 5 Tetanus Dx	[redacted]			
	And Tox N	[redacted]	b(6)-2		
MSO	Factual Admit N	[redacted]	1310		

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] 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)

b(6)-2

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

34 yo ♂ states he was shot in his knee x 2 days ago. PP +1. good sensation. VSS.

Pulse 64x NC

⊕ to 66

NKDA

See ortho note/HP

Chest CTAB

warm & left

Abd ⊖BS soft NT

Stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNA[redacted]

b(6)-2

PROVIDER SIGNATURE AND S[redacted]

DIAGNOSIS

(L) femur fx

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)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO: Ortho b(6)-2 [redacted] DATE OF REQUEST 7 May 03

REASON FOR REQUEST *(Complaints and findings)*

6 inch wound fracture ⊙ ~~[illegible]~~ femur

PROVISIONAL DIAGNOSIS

fracture ⊙ ~~[illegible]~~ Femur

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted]		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO b(6)-2 PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE			DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT	
RELATION TO SPONSOR	SPONSOR'S NAME *(Last, first, middle)*	SPONSOR'S ID NUMBER *(SSN or Other)*	
PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.

[redacted] b(6)-4

EPW

CONSULTATION SHEET
Medical Record

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

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 34

HEIGHT:

WEIGHT: unknown

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

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

4. PROPOSED SURGICAL PROCEDURE:
(L) femur Ex Fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco 2 ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH (+) 1 bottle Q.D. Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	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. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Ø Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Ø Pt. will not exhibit signs of impairment 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

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

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	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. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	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. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier - Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	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 communication. 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 COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPTION b/w-2 7 Aug 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] RN b/w-2
DATE: 7 Aug 03 TIME: 1330

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] PTION
DATE: 7 Aug 03 TIME: 1515 b/w-2

REVERSE OF FORM 3179, JUN 91

USAPA V1.0

MEDICAL RECORD | INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY Anesthesia

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

3. DATE 7 Aug 03 TIME PATIENT ARRIVED IN SUITE 1405

4. PATIENT IN ROOM TIME 1405 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(4)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] LT [redacted] (out @ 1440)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: proper body alignment maintained, arms at less than 90° on padded armboards, all pressure areas padded, position approved by surgeon + anesthe

b(4)-2 8. SKIN PREPARATION b(4)-2

HAIR REMOVAL [X] YES [ ] NO Dr. [redacted]

DONE BY: [X] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP Left thigh

COMMENTS: No nicks or cuts noted

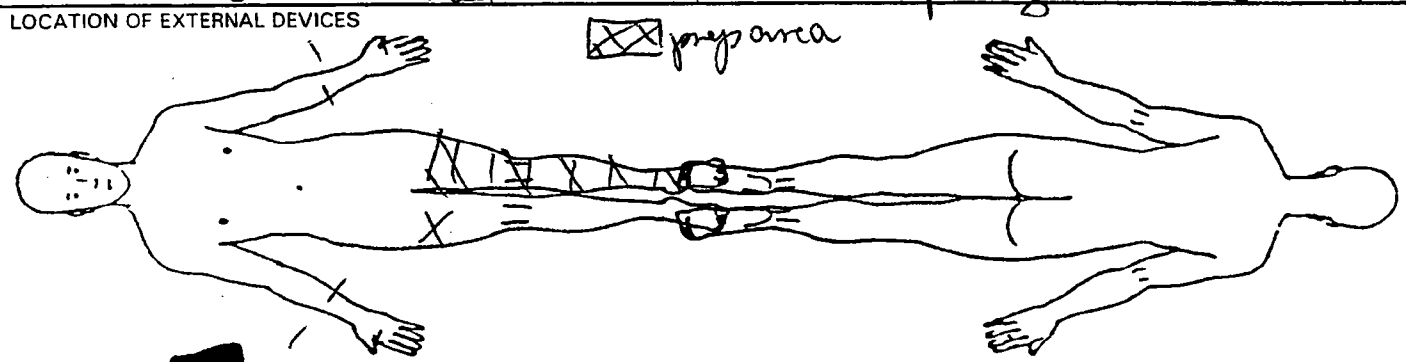
PREP SOLUTION (Specify) Betadine / Betadine

SITE: Left Leg BY WHOM [redacted]

SITE: BY WHOM:

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet (N/A)

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB b(4)-2	CIRCULATOR b(4)-2
Sponge	[X] Yes [ ] No	NA	C	C	[redacted]	[redacted]
Needle Sharp	[X] Yes [ ] No					
Instrument	[ ] Yes [X] No	NA	NA	NA	NA	NA
Other	[ ] Yes [X] No					

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

[redacted]

b(4)-4

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

[X] ESU NO: #3

GROUND PAD: BRAND VL REM Polyhesive II

LOT NO: 65706 EXP 2004-11

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

5018-6-180 x 4
4920-2-140 x 4
4920-2-020 x 2

4920-1-010 x 4
Carbon Rods x 2

Hoffman II
Lot # 0621303

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 - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-Arm 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	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Acewrap

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted]

b(4)-2
KIL

- DA 5179 Initiated

20. OPERATION(S) PERFORMED
Ex fix (L) femur

21. PATIENT TRANSFERRED TO ICU 2 TIME See DA7389 METHOD Litter

22. REGISTERED NURSE SIGNA[redacted]

MEDCOM - 16127

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 13 Sept 03 TIME PATIENT ARRIVED IN SUITE 1710
4. PATIENT IN ROOM TIME 1710 NUMBER 6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1700-1720)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

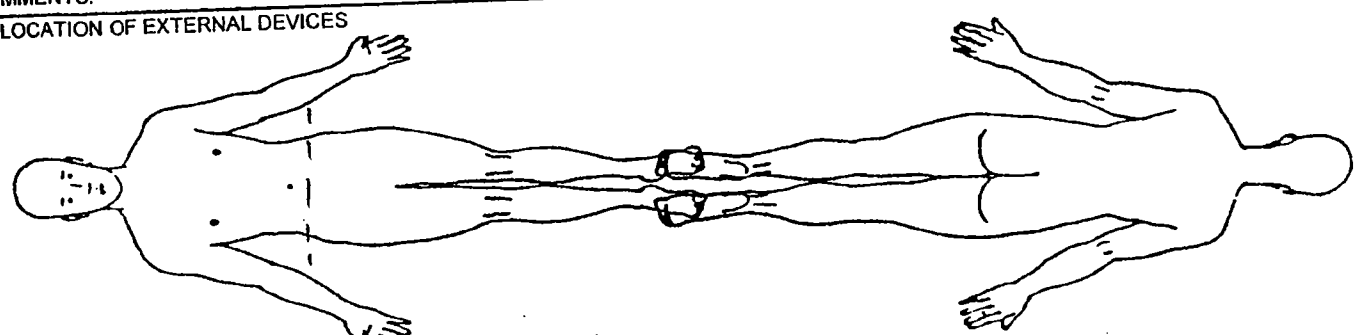
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* N/A BY WHOM:
SITE: BY WHOM:
SITE:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A -- Safety Strap [redacted] === Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

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

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

#[redacted]
ICW-1 b(6)-4

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

☐ ESU NO: N/A
GROUND PAD: BRAND
LOT NO:

☐ 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
N/A					

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Stockinette
Webril
[redacted] Sp Cast

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: GETA

Bovie Pad site intact pre-op N/A; post-op_____ Bovie Settings: Coag/Cut N/A
Tourniquet Site intact pre-op _____; post-op_____
Tourniquet Time: Up____ Down____

-5179 on chart, Ø Δ's noted

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU b(a)-2	1139	Litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPTRN [redacted] RN

MEDCOM - 16129

511–119 NSN 7540–

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 2003 DAY

19 HOUR

PULSE (O) — TEMP. F (•) — TEMP. C (Centigrade Equivalents, for Reference only)

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		

RESPIRATION RECORD

BLOOD PRESSURE

Pox

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. FCW 2

EPW b(6)-7

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95) Prescribed by DD 201-9.202-1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 8 | 9

POST- DAY

MONTH-YEAR: April 2003 | DAY: 14, 15, 16, 17, 18, 19, 20

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 →

O2 Sats →

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.

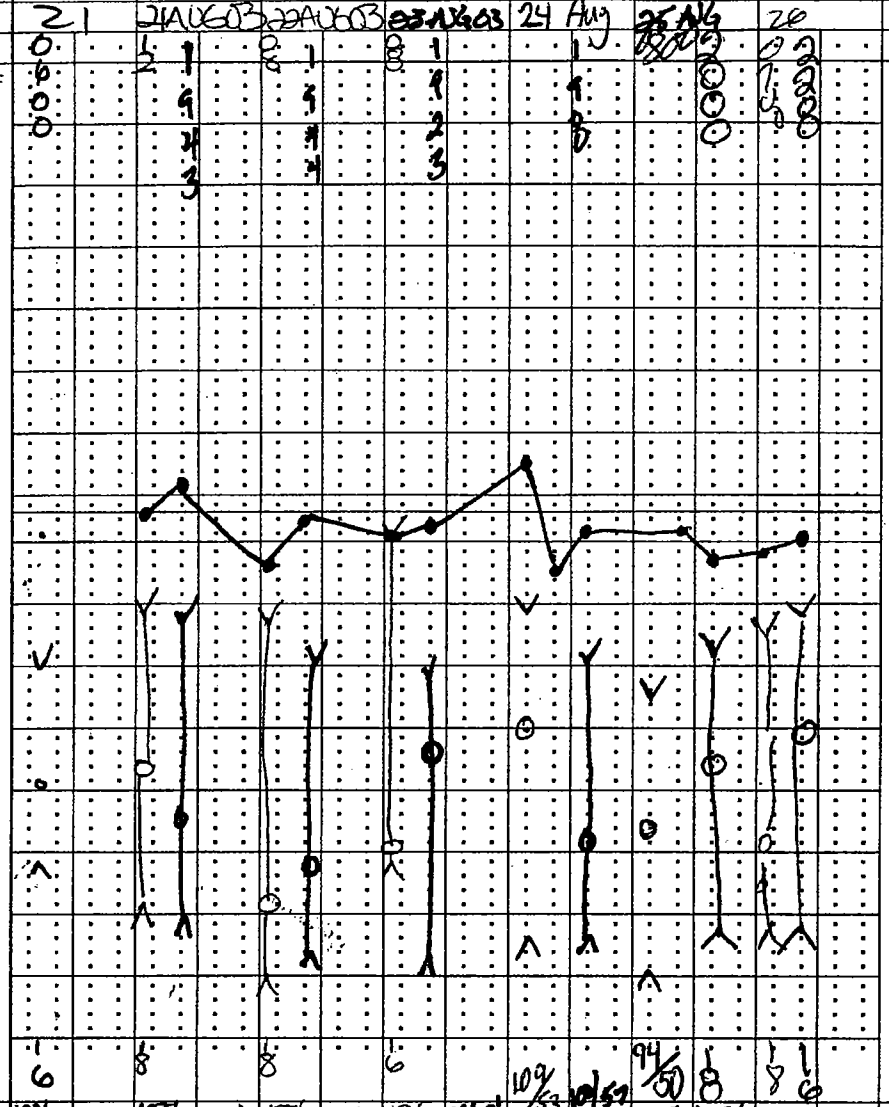
WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	B	1	2	3	4	5	6
POST-OPERATIVE DAY							
MONTH Aug / DAY	21	21 Aug 03	22 Aug 03	23 Aug 03	24 Aug	25 Aug	26
HOUR	0 6 0 0	12 4 8 12	4 8 12 4	8 12 4 8	12 4 8 12	4 8 12 4	8 12 4 8



RESPIRATION RECORD

	B	1	2	3	4	5	6
BLOOD PRESSURE	100/72	108/61	108/60	101/53	109/53	94/50	102/58
		74	88	88	88	P75	106/59
		97	97	98.6	97.5	98.2	98
HEIGHT: WEIGHT →		97.1(Ra)	97.1	97.1(Ra)	97.1	97.4	98.2
			98.6(Ra)	98.1	97.7	97.4	98/0
				97.1(Ra)	98.4	98.2	97%

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. ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 27 Aug

19 | HOUR: 1030

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: 99

BLOOD PRESSURE: 76/53

T: 98.4

Sp: 98

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY	2 Sept		2 Sep.		3 Sept										
19	HOUR	0700	19			18										

PULSE (0)	TEMP. F (•)	TEMP. C (Centigrade Equivalents, for Reference only)
	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		

RESPIRATION RECORD

Record special data only when so ordered	BLOOD PRESSURE	107/100	99/55	107/58	107/58	97/57										
		79	88			80										
		97.3	99			97.9										
	HEIGHT: WEIGHT →															
		R-16	97%		97%											
		98%														

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.

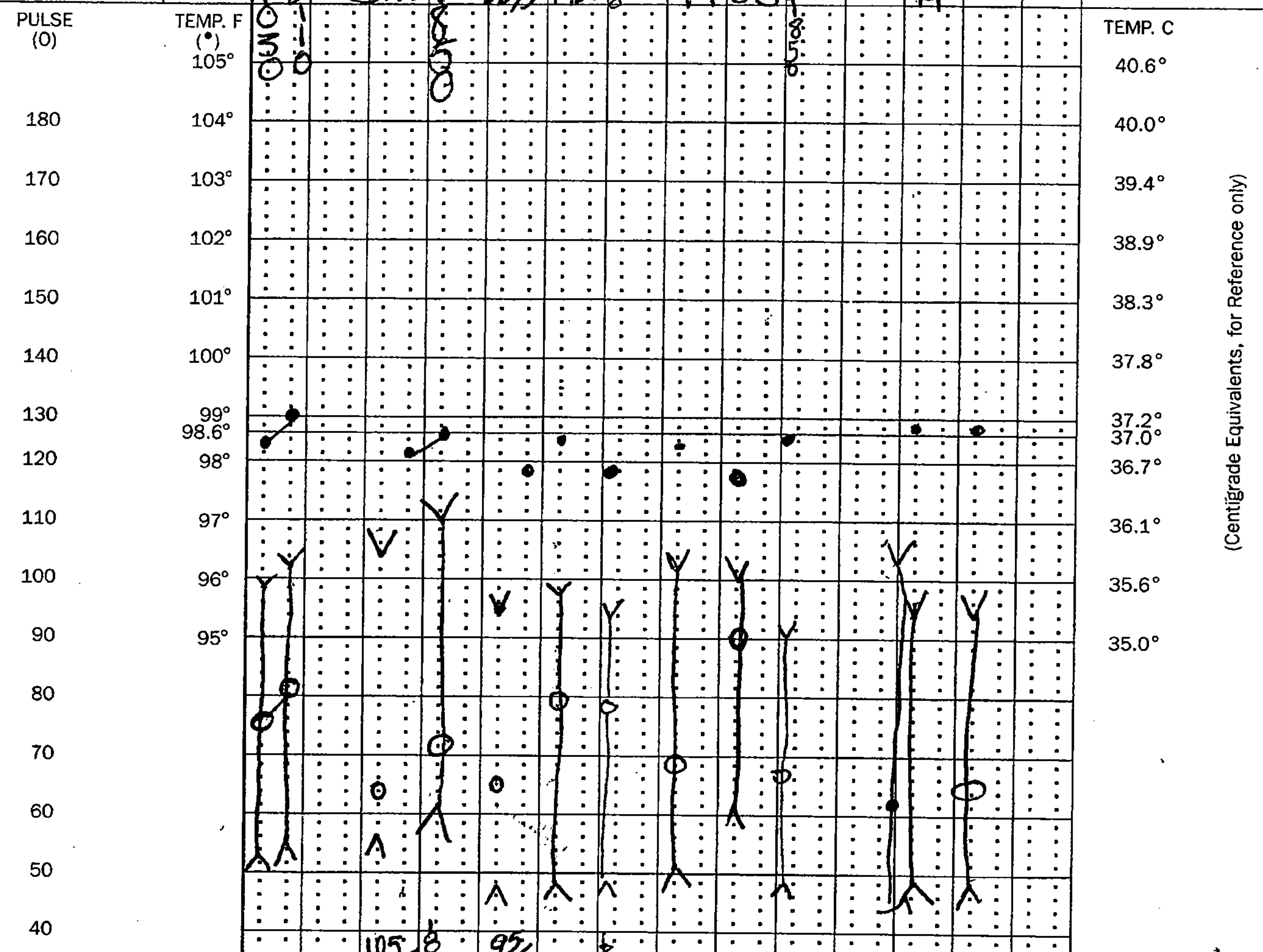
VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	27 Aug	28 Aug	29 Aug	30 Aug 08	31 Aug	1 Sept	
19 / HOUR	1 2	0900	0845 1900	8 19	0800	19	



RESPIRATION RECORD 105/56 8 110/62 95/47 8 24

Record special data only when so ordered

BLOCK PRESSURE: 99/53 103/56 P64 T98.2 P65 T97.9 97/47 79 98.4 94/48 102/51 69 98.3 101/60 90 97.8 91/48 116/48 62 97.5 94/48 63 98.8

HEIGHT: WEIGHT →

98/(RA) 98% 98% 98%

(O2 sat) 98% 98%

98% 98% 98% 98% 99%

98%

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**

epvt [redacted] b(6)-4

MEDCOM - 16135

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY												
POST- DAY												
MONTH-YEAR	DAY	12 Sep	13 Sep03	14 Sept		15 Sep03	16 Sep03		17 Sep			
19	HOUR	0700	18 0700	1715	1935	8 8	8 8	18				

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 | 20 | 107/56 | 20 | 18 | 18 | 19

Record special data only when so ordered

BLOOD PRESSURE	111/60	94/58	106/50	080	107/59	109/60	108/58	124/62	101/49
	66	82	67					100	88
	T 98	98.6	T 97	T 97.6				98.4	97.9
HEIGHT: WEIGHT →	98%								98
	RA	97%		98%	97% RA	98% (RA)	98% (RA)	99%	

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY		45pt												
MONTH-YEAR	DAY	0720	05SEP03	06SEP03	85pt			9 Sept03		10 Sept		11 Sep		
19	HOUR	8	18	8	18	8	18	8	18	8	18	8	18	
PULSE (O)	TEMP. F (•)	9				8				8		9		TEMP. C
	105°	3				3						7		40.6°
180	104°	0				0						0		40.0°
170	103°											6		39.4°
160	102°											0		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

		8	6	8		18	16	16				6		
BLOOD PRESSURE		102/59	124/63	103/60	109/57	112/61	104/51	100/63	100/63		114/62	118/56	119/65	114/54
		99	101/58	86		102	101/55	T97.7	T97.7			86	102/56	91
		97.8		98.6		98		H78	H78			97.9		98.1
HEIGHT:	WEIGHT →	97% RA												
		2-16	98% RA	96%	96% RA	97%	98% RA		98%		99%	99%	98%	98%
		96% RA					96% RA						98% RA	

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

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

ID: [redacted] 66-4

WB 07-08-03
13:02

			Patient Limits	
WBC	9.6	x10^3/uL	4.5	10.5
RBC	4.64	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	44.6	%	35.0	60.0
MCV	96.0	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	432.	x10^3/uL	150.	450.
LY%	20.2 *L	%	20.5	51.1
LY#	1.9 *	x10^3/uL	1.2	3.4

b(6)-2

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

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted]

DATE: 7 August | TIME: 1252

SSN/PSEUDO SSN: [redacted] b(6)-2

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

(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 =======
07/08/03 13:06
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100494

GLU	105	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	206	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

(Piccolo) [illegible] 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
CO2		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
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 7Aug03

LAB ID NO.:

MEDICAL RECORD - ANESTHE[illegible]

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

Robinul mg 1.2

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

DRUG	(Units)		
Propofol	(mg)	150	100 (MB)
Fentanyl	(ucg)	150	100
Versed	(mg)	2/2/1	
Lidocaine	(mg)	100	
Succinylcholine	(mg)	100	
MSO4	(mg)		10/10
VOLAT AGENT 1.50	% del / % e.t.	1.5/1.0/1.0/1.5/1.25/X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	5/3/3/3/3/3/8	

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

FLUIDS

LINE site		
18g (R) AC	☐ Warmed	(2) LR — 1000
	☐ Warmed	(1) LR — 300 (Fluids) (3) LR — 200
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
250	MIN
5	TOTAL URINE
20	Ø

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- /

BLOOD- /

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 44.6

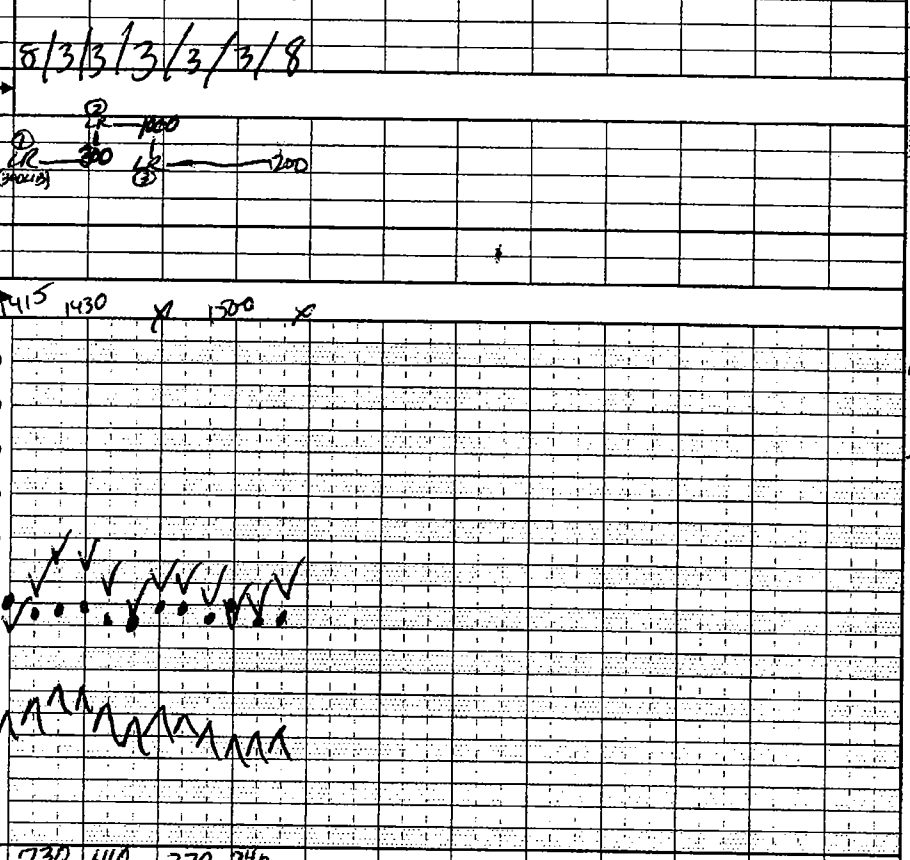
INITIAL DATA: BP- 121/67 HR- 113

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1407

TIME 1415 1430 X 1500 X

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



VENTIL

	1	2	3	4
VT - ml	730	410	270	340
f - breaths/min	10	6	7	4
Peak inf pres / PEEP	16	20	/	/
MODE - S(pon), A(ssist), C(on)	S-C	A	S	S

MONITORS/ACCESSORIES

		1	2	3	4
✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	49	56	59
BP/oth	✓ FIO2 (Frac or %)	.80	.90	.90	.90
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST
Gas analyzer	✓ TEMP-site SKIN	34.5	34.5	34.5	34.5
	✓ N-M Block (T/4)	4/4	4/4	4/4	
Warming blkt					
Conv warmer					

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

REMARKS — Code drugs with numbers, events with letters

1348 PT ID, FORM 2400 COMPLETE

1405 Rm. O2, MOA. ON

1408 RSI/C

1510 PT RTC-1 EET.

1516 RPT TO SGT GROVES (CHZ.

RECOVERY AT 1516

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP- 8 SpO2- 98

BP- 97/44 HR- 114

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1348	1405	1523
	Ready	Begin	End
PROC	1413	1440	1510

PROCEDURES and CPT Codes: EX FIX (L) FEMUR

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

#[redacted]

b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* RSI/C, BLOI, E3MIL, grade I view, #8.0 ETT TO 22cm @ LIP. @ ETCO2, @ BBS Tube SECURED TAPE, #9.0A in, eyes taped - TOPS

SURGEONS: [redacted] b(6)-2

[redacted] PT CNA

PROCEDURE LOCATION: 2

DATE: 7 AUG 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDCOM - 16140

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 34 **DAYS MOS YRS** **Sex** (X) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: EK FIX (L) FEMUR
SURGICAL SERVICE: ORTHO
NPO SINCE:

ASA Physical State 1 (2) 3 4 5 (E)
WT: 70 **KG/LB** **HT:** 69 **IN.**
ALLERGIES: NKDA

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

CURRENT MEDICATIONS:
( ) = ordered as premed
() Ancef (1300)
() Gentamicin (1300)
() Cephalexin
()
()
()

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

LABORATORY STUDIES:

HB/HCT: _____ / _____
U/A:
OTHER:

9.6 / 44.6 — 13.5 / 432

122	101	6	105
4.3	21	.6	

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

(Ø)

PHYSICAL EXAMINATION
BP 124/72 **HR** 118 **R** 18 **T** 98.6
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck 2.5 FB/FROM
Oropharnyx MPI
Nares patent
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: 18g (R) AC
Ulnar Filling:
BACK:
OTHER:

NPO Since midnight

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/[redacted] understand and agrees. Questions answered.
Signed: [redacted] PT CNA **Date:** 7 AUG 03 **Time:** 1350 **Hrs**

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } **NO APPARENT ANESTHETIC COMPLICATIONS** { } **OTHER**
b(6)-2

Signed: _____ **Date:** _____ **Time:** _____ **Hrs**

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.

Patient Identification: (Ward)

#[redacted]
b(6)-4

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
FENTANYL	(mcg)	100, 50 (50)
PROPOFOL	(mg)	150
GLY	(mg)	100
Nitroglycerine	(mcg)	< 300 >
	( )	
	( )	
VOLAT AGENT 1.5	% del	2.0 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 1

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

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

TOTALS	
200	

TOTAL BIL: Ø

TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID – 800

COLLOID – Ø

BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

FLUIDS

LINE site		
LR 18g (L) AC	☐ Warmed	500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 114/60; HR – 99

COMP CHECK: OK? – (Y) N

PATIENT ID CHECK: OK for PROCEDURE? yes; TIME – 1720

SYMBOLS: BP by cuff (V ^); Heart rate (●); Resp rate; BP (transduced) (⊥ T); TOURNIQUET (T – ✗); ANES – X-X; PROC (●) – Ø

TIME → 1705 30 · 18⁰⁰ · 30 · 19⁰⁰ · 30 · 20⁰⁰

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

VT – ml	900	1170	22
f – breaths/min	11	6	16
Peak inf pres / PEEP	18	12	
MODE – S(pon), A(ssist), C(on)	S/C	C	S
ET CO2 (torr)	31	42	56
FIO2 (Frac or %)	.85	.83	.77
SpO2 (%)	100	100	100
ECG	SR	SR	SR
TEMP- site	AVAC, BLR		
N-M Block (T/4)			

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

Mark with letters & symbols, explain under REMARKS. EVENTS Position → O

RECOVERY AT 1605; PACU ICU ____ (Specify); OTHER ____

CONDITION: RESP – 16; SpO2 – 99; BP – 125/63; HR – 128

	Start	Room	End
ANES	1700	1715	1600
PROC	Ready 1725	Begin 1727	End 1600

PROCEDURES and CPT Codes: Rx-Fix Removal / Casting of (L) leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: PRE-OP 5min 100% O2, induction, IV, MIDZ, Lorad, Tnew, 8.0 ETT Placed 22cm @ lips (+) BBS (+) ETCO2

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

#[redacted] b(4)-4

SURGEONS: [redacted] b(4)-2

ANESTHETIST: STA[redacted]PT, AM, CRNA

PROCEDURE LOCATION

DATE 13 SEP 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 16142

*U.S. GPO: 2002-729-180/40137

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Repeat ⓪ femur series (not mobile)				JCW 1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) Dr [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE [redacted] b(6)-2				DATE REQUESTED 11 Sept 03

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

Ones 9 Sept was too dark

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

RADIOLOGIC REPORT

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

RADIOLOGIC CONSULTATION REPORT MEDICAL RECORD

MEDCOM - 16143

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

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: TLW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 7 AUG 03 TIME OF ORDER: 1515 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW #2.
2. S/P EXT FIX (L) FEMUR
3. CONTINUE FLUIDS
4. VS - ROUTINE
5. UP AD LIB WITH CRUTCHES PRN EPW ROUTINE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

6. CRUTCH WEIGHT BEARING WITH PT WHEN
7. REGULAR DIET
8. N-LR AT 125 CC/HR, HOLD LOCK WHEN TAKING PO WELL
9. ATIVAN 1 MG P.O. Q 6 HRS X 48 HRS, THEN 1 MG P.O. Q 12 HRS X 24 HRS, THEN 1 MG P.O. Q DAY X 2 DAYS
10. TYLENOL 650 MG P.O. Q 4 HRS PRN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

11. PERCOCET, 1-2 P.O. Q 4-6 HRS PRN
12. MSO4, 2-6 MG ~~P.O.~~ Q 2 HRS PRN
13. PIN CARE DAILY.

[redacted]

b(6).2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Aug 03 TIME OF ORDER: 1640 HOURS

1. Place foley cath now
V.O. Dr [redacted]

Ø38

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

2 NOV 03
1520

Outpatient Op Note

Pre-Op Dx - (L) femur fracture
Post-Op Dx - Same
Procedure: Closed tx of x-fx (L) femur
Surgeon: [redacted] b6-2
CRNA: N/A
Anesthesia
Findings: Early callus on C-arm, ends moving together, minimal fracture motion.
PLAN: Ext fix x 3-4 weeks.
P.T., WBAT, crutches

b(6)-2 [redacted] esr m

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

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

b(6)-4

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW #2	24 V's	0120

DATE OF ORDER: 8/9 — TIME OF ORDER: 0820 HOURS — LIST TIME ORDER NOTED AND SIGN

Amoxil 1 gm IV q 8 hrs x 3 days

V.O. Dr [redacted] / [redacted]

b(6)-2 A11

Noted Sent

9 Aug 03 [illegible]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		9

DATE OF ORDER: 10 Aug 03 — TIME OF ORDER: _____ HOURS

1. Debrox 5 drops (L) ear BID x 2 days
2. Amalgan II QID PRN ear pain

[redacted] 1630

[redacted] major

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		9

DATE OF ORDER: 11 Aug 03 — TIME OF ORDER: 0226 HOURS

V.O.

Maalox 2-4 tablets PO x 1 now

[redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
038		

DATE OF ORDER: 11 Aug 03 — TIME OF ORDER: 0830 HOURS

V.O.

D/C Foley now from Dr. [redacted]

Noted [redacted] 11 Aug 0835

[redacted]

24 V's [redacted] ICW/AN 8-11-03 2200

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: EPW [redacted] b(6)-4

NURSING UNIT: 24 VS | ROOM NO.: 2200 | BED NO.: Ø 13 Aug 03

DATE OF ORDER: 13 Aug | TIME OF ORDER: 2200 HOURS | LIST TIME ORDER NOTED AND SIGN

VO from Dr. [redacted] to SPC [redacted]

D/C heplock

b(6)-2 [redacted]

2200 13 Aug 03

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

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 8/15/03 | TIME OF ORDER: 1200 HOURS

Keflex 500mg po QID

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

NOTED 15 Aug 03 1140

PATIENT IDENTIFICATION

NURSING UNIT: 24 VS | ROOM NO.: [redacted] | BED NO.: CUTAN 8/15/03 2327

8/25/01

x 12 days [redacted] plasma, dry & [redacted] IN AIR

noted 26 Aug 1830

NURSING UNIT: 24 VS | ROOM NO.: 0115 21 Aug 03 | BED NO.: [redacted] b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 29 Aug 03 | TIME OF ORDER: 2030 HOURS

V.O. Dr. [redacted] 24 [redacted]

Dulcolax supp ÷ x 1 OR fleets enema for constipation - [redacted] AN

RN 29 Aug 03 [redacted] b(6)-2

Ø38

NURSING UNIT: 24 VS | ROOM NO.: 0345 | BED NO.: 29 Aug 03 [redacted]

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]

NURSING UNIT: 240 | ROOM NO. | BED NO.

DATE OF ORDER: 3 SEP 03 | TIME OF ORDER: 1945 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) DIC KEFLEX
VO DR [redacted]
[redacted] b(6)-2

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

Noted 4 Sep 03

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 SEP 03 | TIME OF ORDER: 1625 HOURS

(1) AP + LAT (2) Blood
X 1 hrs
[redacted]

240 CHART 4 SEP 03 1915 RD LT/AN

PATIENT IDENTIFICATION: [redacted]

Noted 4 Sep 03

NURSING UNIT: 240/230 ASSIGNED | ROOM NO. | BED NO.

DATE OF ORDER: 4 SEP 03 | TIME OF ORDER: 1615 HOURS

(1) AP + LAT (2) Blood
IN 2 hrs
(2) NEPHROGRAM SOD WO PIDI BID
[redacted]

b(6)-2

PATIENT IDENTIFICATION: [redacted]

Noted 10 Sep 03 1730

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Sep 03 | TIME OF ORDER: 1730 HOURS

D Naprosyn VO Motrin
800 mg PO TID
VO Dr Oliverio / [illegible]
[redacted] b(6)-2

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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]				10 SEP 03	1630 HOURS	
			1	REPORT @ BEGIN SEIZURES. ONE YESTERDAY WAS TOO LONG.		
NURSING UNIT		BED NO.		[redacted]		
PATIENT IDENTIFICATION [redacted]				DATE OF ORDER	TIME OF ORDER	
				15 SEP 03	1645 HOURS	
			1	DISCHARGED TO PRISON CAMP TOMORROW		
			2	RETURN 500mg TID #40.		
			3	SHOWERS		
NURSING UNIT	ROOM NO.	BED NO.	4	RETURN IN 6 WEEKS [redacted] LEFT, X-RAYS [redacted]		
ICW						
PATIENT IDENTIFICATION [redacted]				DATE OF ORDER	TIME OF ORDER [redacted] 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.

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: 13 SEP 03 TIME OF ORDER: 1758 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PRIOR ORDERS
2. IV LR KT 125 cc/hr, HEP LOCK WHEN TOLD TO PO WITH
3. REGULAR DIET
4. DC CBC, + Gram IV PB Q 8 hrs x 3 doses THEN D/C IV

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

5. RESUME PRIOR ORDERS

[redacted]

b(6)-2

Noted 1700

PATIENT IDENTIFICATION

NURSING UNIT: 24 | ROOM NO.: 16 SEP 03 | BED NO.: 0200

DATE OF ORDER: 13Sep03 @ TIME OF ORDER: 1645 HOURS

1) MSO4 2mg IV Q3-5min max dose of 10mg.

V.O. CP[redacted]/CRNA [redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13 SEP 03
1800

Post Op Note

Pre Op Dx: (1) (L) femur fracture with x-fix
Post Op Dx: same
Procedure: (1) removal of x-fix (2) femur
(2) Application of long leg cast
Surgeon: [redacted] b6-2
Anes: -0
Findings: fracture site stable; No
evidence infection at pin sites
Wounds irrigated.
Plan: To GPW comp Nursing Keep

[redacted]

b(6)-2

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

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 SEP 03	Ortho Discharge - 28th CSH
KSD	Patient brought to [redacted] 62-2 on 7 AUG 03, after GSW to (L) femur 26 days previously. External fixator applied 7 AUG 03. Food quality gather at the time, alignment unable to be improved. Since then has shown slowly progressive healing by radiographs.
	On 13 Sept 03 the femoral x-fix was removed. No gross motion at fracture site. Pin sites clean. Long leg cast applied PLBU!
	Discharge to GPW Comp. Crutches, Cast Weight bear as tolerated. Motrin 800 mg TID pm #40. Follow up at 28th CSH in 6 weeks for cast removal and radiographs if still a prisoner.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted] SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST b(6)-2 [redacted]	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	[redacted]	

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. COL, [redacted]

WARD NO. ICW#1

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 08 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
28Aug	[redacted]	Percocet 1-2 tabs PO Q4-6hr PRN	D/T	4Sep 0630	4Sep 1347	4Sep 1710	4Sep 2226	05Sep 1025	05Sep 1445	5Sep 2245	6Sep 0330	06Sep 0755	06Sep 1350	6Sep 1830	10Sep 2245	7Sep 0621
			D/I	[redacted]												
7Aug	[redacted]	~~Tylenol~~ Tylenol 650mg PO Q4-6 PRN	D/T	8Sep 0420	08Sep 1805											
			D/I	[redacted]												
[illegible]	[redacted]	Amalgen ii QID														
		PRN for pruri														
7Sep	[redacted]	Percocet 1-2 tabs	D/T	7Sep 2240	8Sep 0600	08Sep 1643	8Sep 2215	9Sep 0445	9Sep 1030	10Sep 0705	10Sep 0416	10Sep 1100	10Sep 1635	10Sep 2035	11Sep 0055	11Sep 0200
		PO Q4-6hrs PRN	D/I	[redacted]												
		b(6)-2 A11	D/T	11Sep 7[illegible]	11Sep 1600	11Sep 2230	12Sep 1000	12Sep 1700	12Sep 2100	13Sep 0035	13Sep 1245	13Sep 2[illegible]	14Sep 0426	14Sep 2020	15Sep 0424
			D/I	[redacted]												
28Aug	[redacted]	~~Percocet~~ MSO4 2-6mg IVP Q2°PRN	D/T	12Sep 2330												
			D/I	5mg [redacted]												

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	4	5	6	07	08	09	10	11	12	13	14	15	16	17
15Aug	[redacted]	Keflex 500mg po QID	6														
			12														
			18														
			24														
09 Sep 03	[redacted]	Naprosyn 500mg po BID	10														
			22														
10 Sep	[redacted]	motrin 800 mg po TID	08														
			16														
			24														
13Sep	[redacted]	LR @ 125cc/hr.	00														
		HL when TOL P.O.	18														
		(NO FLUSH QSHIFT)	X														
13Sep	[redacted]	Ancef + gm IVPB	6														
		q8hrs x3doses	14														
		then DIC IV	22														

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX-FIX to (L) femur

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

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. 08 Yr. 03

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

ORDER DATE	CLERK/ [redacted]	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	31	01	2	3
15	[redacted]	Keflex 500mg	6	[redacted]													
b(4)		PO Q10	12														
			18														
			24														

Dbd b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to L femur

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

29 Aug 03 RD	SINGLE ORDER: Dulcolax Supp ÷ 1 x1 OR fleets enema for constipation.	D/T/I 29AUG 2050 1/JVR

b(6)-2

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 08 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
7Aug	[redacted]	Tylenol 650 mg PO q4 PRN		[redacted]
7Aug	[redacted]	Percocet 1-2 tabs PO Q4-6 PRN	D/T D/I E/I	[redacted] see below
10Aug	[redacted]	MSO4 2-6mg IVP q2° PRN		[redacted]
10Aug	[redacted]	Amalgan ii QID pm ear pain	D/T D/I C/I	
25Aug	[redacted]	Percocet 1-2 tabs PO q4-6 PRN		[redacted] see below
28Aug	[redacted]	Percocet 1-2 tabs PO q4-6 PRN	D/T D/I	[redacted]
		Percocet 1-2 tabs PO q4-6 PRN	D/T D/I	[redacted]

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S/P ex fix (L) femur

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

PATIENT IDENTIFICATION: ePW [redacted]

b(6)-2

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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. 8 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	13	14	15				20
7 Aug	[redacted]	Ativan 1mg PO	6	[redacted]												
		q 6° x 48 hrs, 1mg	12	[redacted]												
		PO q 12 hr x 24 hrs,	18	[redacted]												
		1mg PO qd x 28 days	24	[redacted]												
7 Aug	[redacted]	LR @ 125 cc/hr,	05	[redacted]												
		(H1) when taking	13	[redacted]												
		PO well	21	[redacted]												
8 Aug	[redacted]	Ancef 1gm IV q 8° x	08	[redacted]												
		3 days	16	[redacted]												
			24	[redacted]												
10	[redacted]	Debrox 5 gtts	10	[redacted]												
		(2) ear BID x 2 days	22	[redacted]												
15	[redacted]	Keflex 500mg PO q 8°	06	[redacted]												
			12	[redacted]												
			18	[redacted]												
		b(6)-2	24	[redacted]												

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to (L) femur

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

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	~~RECURRING MEDICATIONS, DOSE, FREQUENCY~~ PRN	HR	DATE DISPENSED
7Aug	[redacted]	Tylenol 650mg PO q4° PRN		7Aug 2040 650mg [redacted]; 8/8 0810 [redacted]; 8/8 1245 [redacted]; 9Aug 1900 [redacted]; [redacted]; 15Aug 1445 BRS [redacted]; 15Aug 2330 [redacted]; 16Aug 0630 [redacted]; 16Aug 7110 [redacted]
7Aug	[redacted]	Percocet 1-2 tabs PO q4-6° PRN		8/10 2336 [redacted]; 11Aug 1600 [redacted]; 11Aug 1745 [redacted]; 11Aug 2200 [redacted]; 12Aug 0200 [redacted]; 12Aug 0800 [redacted]; 12Aug 1330 [redacted]; 13Aug 2100 [redacted]; 14Aug 0600 [redacted]; 14Aug 1100 [redacted]; 14Aug 1445 [redacted]; 14Aug 2130 [redacted]; See below
7Aug	[redacted]	MSO4 2-6mg IV q2° PRN		8/17 0100 [redacted]
10	[redacted]	Amalgam ~~IV~~ QID PRN-ear pain		8/10 2245 [redacted]; 8/15 0830 [redacted]
7Aug	[redacted]	Percocet 1-2 tabs PO q4-6hrs prn		15Aug [redacted]; 0710 [redacted]; 15Aug 2330 [redacted]; 16Aug 0500 [redacted]; 16Aug 0800 [redacted]
7	[redacted]	Tylenol 650mg PO q4° prn-pain		16Aug 1330 650mg BRS [redacted]; 17Aug 650mg [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: b(6)-2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7Aug	[redacted]	Admit to ICW2 condition fair	7Aug		1730	[redacted]
11Aug	[redacted]	DC Foley Now	11Aug	0830	0835	[redacted]
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

b(4)-2

AL 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. 8 Yr 03

INITIALING				INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION																
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED																
				7	8	9	10	11	12	13	14	15	16	17	18	19	20			
7 Aug	[redacted]	VS routine	05	/ [redacted]																
			13	400 AM																
			21																	
7 Aug	[redacted]	UPad libt	05	/ [redacted]																
		crutches per EPW	13	/																
		routine	21																	
7 Aug	[redacted]	Crutching walking	05	/ [redacted]																
		TPT	13	/																
			21																	
7 Aug	[redacted]	Reg diet	06	/ [redacted]																
			12	/																
			17	AM																
7 Aug	[redacted]	Pin care daily	08	/ [redacted]																
7 Aug	[redacted]	Foley to gravity	05	/ [redacted]																
			13	400 PM																
			21																	

DC'd 11 Aug 03 0830

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to (L) femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW

[redacted]

b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26th	[redacted]	X-ray (R) femur, AP & LAT in AM	27th	0600	1015	[redacted]

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

USAPA V1.00

b(6)-2 b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	31	1	2	3
7Aug	[redacted]	Routine vitals	0	[redacted]													
			19														
7Aug	[redacted]	Up Ad lib c̄ Crutches per epw routine	5														
			19														
7Aug	[redacted]	Crutch walking c̄ PT	5														
			19														
7Aug	[redacted]	Regular Diet	5														
			1														
			17														
7Aug	[redacted]	Pin Care Daily	8														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex fix to ⓓ femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4Sep	[redacted]	XRAY APICAL (L) Femur	4Sep	Today	—	[redacted]
09 SEP03	[redacted]	AP/LAT (L) FEMUR IN AM	10 SEP03	"	0700	[redacted]
10 SEP03	[redacted]	Repeat (L) FEMUR SERIES (TOODAY)	10 SEP03	11 Sept 1640		[redacted]
13	[redacted]	Resume previous orders	13 Sep	—	—	[redacted]
9/15	[redacted]	D/C to Prison Camp tomorrow	16 Sept			[redacted]
9/15	[redacted]	Crutches	9/15	—	—	[redacted]
9/15	[redacted]	Return in 6 wks, remove cast,	In 6 wks	noted		[redacted]
	[redacted]	X-rays				

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

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
7	[redacted]	Routine vitals	6	[redacted]													
			18														
7	[redacted]	up ad lib c crutches	6														
		per SOW Routine	18														
7	[redacted]	Crutch walking c PT	6														
			18														
7	[redacted]	Reg diet	6														
reordered	3 SEP		18														
7	[redacted]	Pin Care Daily	08														
		With Betadine	18														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex-fix (R) femur

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

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6-Aug-03		10mg Diazepam IM in (R) Quad.	6-Aug	22:40	22:40	[redacted]
6-Aug		Ancef 1gm IV	6-Aug	21:26	21:26	[redacted]

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

☆ U.S.G.P.O.: 1985 - 491-003/43119

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.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				6-Aug	7-Aug												
6-Aug-05		Cephalexin 500mg PO QID	21	JRS 2120													
			03	X	JS 03												
			09	X													
			15	X													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 16167

70kg

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

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: 7 Aug 03
Time In: 1515
Allergies: NKDA
Pre-op V/S: 122/67 113
Procedures: ex (F) (L) femal

Anesthesia Type (Circle)): General Spinal Epidural ASA II
IV Sedation Nerve Block
OR Intake: Crystalloid 150 Colloid _____ Ancef 1gm
OR Output: UOP 0 EBL min
Meds/Times: 20M 20

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds _____ History _____

Time	1515	1520	1530	1540	1550	1600	1630	1645	1730
SaO2	99%	100							
FiO2									
Methods									
240									
220									
200									
180									
160									
140									
120									
100									
80									
60									
40									
20									
RR	11	14	16	22	18	14	14	18	20
T	98.7				99.4				
Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1730	NACL	KO	LRA	[redacted]	—

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	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature & Title): SGT [redacted] b(6)-2 RN/WMC
DEPARTMENT/SERVICE/CLINIC: ICU #2
DATE: 07 Aug 03

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

[redacted]

b(6)-4

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

b(u)- 2
A11

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		None				

NEUROVASCULAR

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

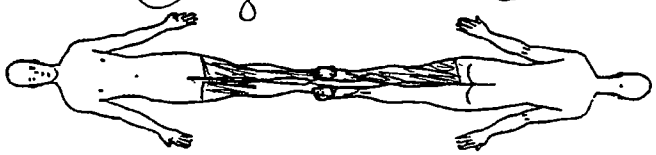
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	bulky ace ext fix	Ø
30'	(L) leg	" "	Ø
60'	(L) leg	" "	Ø
D/C	(L) leg	" "	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1730	Foley	Amber clear	975

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

34y o EPW ♂ transferred via litter to ICU 2 from OR for recovery. S/P ext fix (L) femur Fx repair. PT resting c̄ eyes closed. color good. Aroused c̄ verbal VSS IV RAC patent TKO. (L) leg ext fix skin warm cap refill brisk. pulses present LS CTA SGT [redacted] 91 hrs
1730 VSS sinus Tachy LS CTA A&OX3 pupils EOMI c̄ unable to rotate (+) rigidity over symphysis pubis, (+) tender - Foley 16 Fr c̄ bag. - 975 cc amber c̄ sediment (L) leg dry CDI pedal pulses present. NVI. IV 18G (R) AC patent flush TKO. denies pain. SGT [redacted] 91 hrs

Discharge Criteria:
Date: 07 Aug **Time:** 1730 **PARS:** 10
BP: 122/68 **T:** 99.2 **HR:** 125 **RR:** 20 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: 150 **Output:** 975
Additional Data: None
Transferred To: ICU 2
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP: [redacted]
Charge Nurse Signature [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 13Sep03
Time In: 1805
Allergies:
Pre-op V/S: 114/60 99
Procedures: Lydix removal

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP Ø EBL Ø
Meds/Times: 250mcg/Fentanyl

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1805	1810	1815	1820	1825	1845	1905	1920
SaO2	100	100	99	98	96	96	98	
FiO2	/	/	/	/	/	/		
Methods	RA	RA	RA	RA	RA	RA	RA	
240								
220								
200								
180								
160								
140								
120								
100								
80								
60								
40								
20								
RR	21	20	22	26	13	14	13	
T	97.1			98.0			98.0	
Time	1840	1850						
Pain (0-10)	5/10	5/10						
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1805	LR	200	UPA	[redacted]	

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	2	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.	10	10	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
• = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREP[redacted] & Title) [redacted] TPN b(4)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 13Sep03

PATIENT [redacted] typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

EPW #[redacted] b(4)-4

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

b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1850	5/10	2mg MSO4	IVP	7/10	I	[redacted]
1900	5/10	2mg MSO4	IVP	3/10	E	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Oleg	Moving toes limited	+	UTA	B	C	pK
15'	Oleg	cast limited	+	UTA	B	C	pK
30'	Oleg	limited	+	UTA	B	W	pK
45'	Oleg	limited	+	UTA	B	W	pK
60'	Oleg	limited	+	UTA	B	W	PK
90'							
D/C	Oleg	limited	+	UTA	B	W	PK

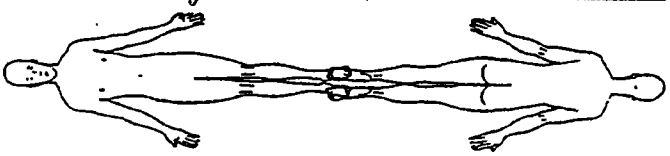
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Oleg	cast/hard	Ø
30'	Oleg	cast/hard	Ø
60'	Oleg	cast/hard	Ø
D/C	Oleg	cast/hard	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1920	—	—	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1850	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

(1855) Pt. arrived to PACU @ 1805 via litter accompanied by CRNA & nurse. Pt hooked up to monitor. HR tachy but down to 80's p a while. Pt has sensation in toes, can move toes and brisk cap refill. C/O some pain to Ⓓ thigh. MSO4 2mg given. Will evaluate. [redacted] TAM

(1910) Pt given a 2nd dose of MSO4. Pain better. No c/o in Ⓓ leg @ this time. Just hungry. VSS [redacted] TAM

(1920) Report given to Spc [redacted] Pt ready for transfer. [redacted]

b(6)-2

PACU OUTPUT

Time	Source	Color/Appearance	Amount
1920	—	—	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1850	SR	Ø	Ø

Discharge Criteria:
Date: 13 Sep 03 **Time:** 1920 **PARS:** 10
BP: 113/63 **T:** 98.6 **HR:** 85 **RR:** 18 **SaO2:** 98
Pain Level at D/C (0-10):
Intake: 150 **Output:** Ø
Additional Data: —
Transferred To: ICW 1
Report Given To: Spc [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] TAM
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] TAM

b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	[redacted]	b6-4 UNK IRAQI EPW	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	34Y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1515	— b(4)-2

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K78	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	—

NAME AND [redacted] TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	—

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø5		030914

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030807

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

FOR LOCAL USE

DX ① GSW TO (L) Femur
② S/P ex fix (L) Femur

DX-82110
T-1 E9912
I-450 PR-9359

b(4)-4 [redacted]

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
DR. [redacted]	[redacted] b(4)-2

DA FORM 3985 MAR 89

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
210	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
265	266	267	268	269	270	271	272
0	0	0	0				

MEDCOM - 16173

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW # [redacted] b(u)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 29	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICW2	
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN K78		18. BRANCH/CORPS b(6)-4	19. UIC/ZIP —	20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER					22. HOURS OF ADMISSION 1320	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION d/c to camp		26. DATE OF DISPOSITION 19 Aug 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 01 Aug 03	ADMITTING OFFICER
29. NAME AND LO[redacted]						30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) tib/fib > (L) AKA

897.2
V58.3
E991.2

84.17
86.28
86.59
93.53

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	12	12

36. Total Days All Facilites

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

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

29 Y.O., DRIVING TRUCK TO STELL CARG 1/2 DOC BEED
IN ON OLD INFECTED GSW TO PATELLA
TIB FIB, PUS IN WOUND, LARGE MOST DEBRIDED,
PLAN: ABOVE KNEE AMPUTATION.

ROS - NEGATIVE EXCEPT

ALLERGIES - NKDA

PHYSICAL EXAMINATION

AT/NL
CHEST - ATHEROMATIC
ABD - SOFT
EXT - LARGE SYS CH SOFT TISSUE DEFECT,
PUS POURING FROM WOUND, LARGE QUANTITY
OF NECROTIC TISSUE

PROGRESS (Enter date of discharge and final diagnosis)

X-RAYS - LARGE BONE DEFECT WITH GROSS OSTEOMYELITIS

b(6)-2

SIGNATURE OF [redacted]	DATE 7 DEC 04	IDENTIFICATION NO.	ORGANIZATION
PATIENT [redacted] (Typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

MEDICAL RECORD	PROGRESS NOTES
DATE 18Aug03 1320	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg intact on (L) AKA, Staples to be removed when order written → [redacted]
19 Aug 0130	Care assumed @ 2100. VSS, alert awake c̄ c/o back pain from staying in an Iraqi prison. Lungs CTA, bs(+)x4. Dsg intact on (L) AKA, pt's dsg q2° b(4)-2 ā difficulty. Taking PO ABX, c̄ d/c order and summary for 19 Aug. Will continue to monitor. [redacted] All 9Lumo
19Aug03	0615 Assume pt care @ 0500, pt awake and alert c/o pain to (L) AKA. percocet given @ this time. VSS. HR reg. Lungs CTA Abd soft BS×4 (L) AKA dsg CDI. pt's dsg q2°. ā difficulty. Amb c̄ crutches ā difficulty. Has discharge orders/summary meds @ pharmacy. Will cont. to monitor [redacted] 9Lum
	1500 Pt stable. (L) AKA wrapped. Ø Complaints, To be discharged to EPW camp today. Meds and xrays at bedside. [redacted]
	1545 Discharged to EPW camp in stable condition. [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)

EPW [redacted] b(4)-4

REGISTER NO. WARD NO. EPW 2

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45.505
509-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 Aug 03 1430	Admitted from EMT @ 1415. Pt stable. AAOX3. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Pt c̄ (L) tib-fib fx. Wound wrapped c̄ Kerlix. (L) leg elevated. Strong pulses and brisk cap refill x 4 extremities. (L) leg contorted, but most comfortable for pt. To go to OR for (L) AKA. — [redacted] w/ [redacted] b(4)-2
7 Aug 03 2210	Anth Op Note: Pre-Op Dx - Septic Gsle III B (L) tib-fib fx. Post-Op Dx - same. Procedure: (L) above knee amputation. Surgeon: [redacted] [redacted] b6-2 GBL - 3 U. TQ time - 42 mins. Blood: 1 U NS. Findings: Large loss of soft tissue distal (L) femur & tibia, sharing open pub. Large amount of necrotic bone in pus. No stability. Devascular

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	line extending posteriorly above popliteal fossa. AKA slowly no evidence of infection at site. Tibial fracture site shaped off with stockinette is bound.
	Plan: Consult closure of stump in 48 hrs. Today moderate clear skin closed loosely with sutures over pressure
	b(6)-2 [redacted]
8 Aug 08 0258	Rec'd C/O pt @ 22:30. Pt returned to ICW 2 via stretcher from ICW 2 recovery. VS WNL per flow sheet. Pt drowsy mildly difficult to awaken. Pupils fixed & light response d/t Anesthesia. see intraop sheet. Lungs ⊕ Rhonchi ⊗ ↑ lobes. Diminished @ bases. HRRS, S2. BS ⊕ x 4 ⊕ PP ⊗. ① AKA C̄ ace wrap dsg intact. HL ⊗ AC patent. Pt tolerating P.O. H2O. Voiding ⊖. c/o pain x1 ⅔ Percocet given. 50 mg Fentanyl Patch placed to ↑ ⊗ shoulder. ⊗ further c/os with man [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	b(2)-2
18 AUG 03	Outpatient Discharge Summary, [redacted]
	29 yo male shot in (L) leg 12 days prior to admission, placed in Iraqi jail. Brought to [redacted] 7 AUG 03 with septic, Grade III open (L) tibia and fibula fracture, with green pseudomonas type pus. Had open above knee amputation performed 7 AUG 03 with wound VAC, stump closed 11 AUG 03. Wounds have healed. Patient has been taught stump wrapping
	b2-2
	PLAN: Crutches. Stump wrapping by patient.
	Cipro 500 mg P.O. BID #20
	~~Phenergan~~ PERCOCET, 1-2 every 4-6 HRS PRN #30
	FLAVIL 75 mg P.O. Q DAY #20
	P/V PRN [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted]	TAINED 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. ECW2

GPW [redacted] b(6)-4

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15Aug03 2015	assumed care @1300-VSS-no c/o pain throughout shift-pt. alternating position from stomach to back q1-2° as ordered-c/o diarrhea x1 this shift-stump wrapped by pt. 3x this shift. dsg intact at this time b(6)-2 [redacted]
15Aug03 2200	VSS-Alert X3-Kerlix to stump c̄ ACE wrap is dry and clean @ S/S of infection. Pearl 3mm Lungs CTA B/L resp even Reg. HR-NSR-BS⊕ X4 quads. ∅ c/o diarrhea @ present. Restraint to UE in place and secure. offers ∅ c/o pain or discomfort @ present. b(6)-2 Sgt [redacted]
16Aug03 0330	Resting quietly @ present. Percocet #1 Po given for pain. has had ∅ further c/o pain or discomfort from (D) leg amputation site. Restraints in place and secure. b(6)-2 [redacted]
16 August 03 0600	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular, lungs sounds clear bilat, bowel sounds(+) x4 quads. Pt. ō IV access. Ace wrap to (D) AKA CDI. Pt. ō complaints @ this time. All other assessment findings WNL. Will continue to monitor. b(6)-2 [redacted]
16Aug03 1430	assumed care @1300-VSS-dsg in place on (D) AKA-no c/o pain @ this time-ambulated c̄ crutches for 10 minutes 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. ICW2

EPW [redacted]
b(6)-4

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

b(6) - 2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 2130	VSS - Alert x3 - Pearl 3mm - Lungs CTA B/L Resp even Reg BS ⊕ x4 quads - HR - NSR Radial and Pedal pulses +4. Stump clean Kerlix & Ace wrap dry and intact. Ø c/o e present. Restraints in place and secure. — Sat [redacted]
17 Aug 03	0713 Assume pt care @ 0500. Pt asleep, easy to awake. No c/o pain. VSS. HR reg. Lungs CTA. Abd soft BS x4. (L) AKA dsg CD+I. Will cont. to mon. — [redacted]
17 Aug 03 1525	assumed care @ 1300 - VSS - no c/o pain @ this time - Staples intact, no S/S infection @ suture line, dsg CDI on Stump - pt. ambulating c Crutches - pt. will not lie prone c/s much discussion and convincing [redacted]
17 Aug 03	VSS Alert x3 Pearl 3mm - Lungs CTA Resp Reg even HR - NSR BS ⊕ x4 quads Pedal pulse to ⊕ Dopp +3 Radial pulses +3. Stump dress dry and intact. Percocet II Po q4hr f/ c/o pain. Restraints to UE and LE in place and secure. — Sat [redacted]
18 Aug 03	Percocet II Po q4hr 0330 for c/o Stump pain. c/o RLS ⊕ further c/o pain @ present. Resting quietly. Restraints to UE and LE in place and secure. — Sat [redacted]
180800 Aug 03	Nursing Note: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA ⊕. Abd soft, nontender, ± distention, BS ⊕ x4. Moves spontaneously. ROM and neurovascularly intact to all extremities. Stump to L LE is ± dry, well approximated. Expect to remove staples today. Pt does c/o some phantom pain. Current Po meds seem to take care of that. — Ø IV access. — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03 1945	cast came off of (L) AKA stump, staples intact on stump - Dr [redacted] aware - Kerlix and ace wrap placed on stump and pt. placed prone - 650mg tylenol PO given for pain - b(6)-2 [redacted] ChAN
12Aug03	VSS - Alert x3 salulock in place flushes 5 diff. lungs CTAB resp regim. HR NSR - BS(+) x4 equals. Radial & (R) pedal pulses x3. dress to (L) stump dry and intact. Pearls restraints to upper and lower extremities in place and secure. uses bedside urinal & bedside urinal [redacted] sufficient amts urine light yellow. — [redacted] RN
13Aug03. 0500 12 30 PM	Pt slept well x3. Pt had DVC done & (L) stump AKA. Staples intact. No exudate. Pt healing well. Pt able to use crutches & ambulate. Pt Hgb, Chem-Metabolites 8, CBC. done awaiting results from lab — [redacted] b(6)-2
13Aug03 1300	Pt stable [redacted] this time. AAOx3. PERRLA. Lungs CTA bilat [redacted] resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Drsg to (L) AKA (D). (-) complaints — [redacted] RN

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

b(6)-4

EPW [redacted]

RECORDS MAINTAINED AT: ICW2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Aug 0800	Care assumed @ 2100. VSS, A+OX3, no c/o pain. Lungs CTA, BS⊕ X4. LBKA dsg reinforced 3x. Dsg CDI, no c/o pain, ⊕ sensation @ site. HL @ LFA infiltrated, restarted in RFA. No S/S, continue to b(6)-2 monitor. [redacted]
14Aug03 0730	Care assumed at 0500. VSS, A+OX3 BSX4 Lungs CTA, heart rate reg. LBKA dressing changed @ 0700 CDI. +cap refill in all extremities. Ambulate c̄ crutches w/o difficulty. Reposition R forearm will continue to monitor [redacted]
1250	New HL started in (L) FA ⊕ flush ⊖ redness/infiltration. [redacted]
14Aug03 1525	Assumed care @ 1300 - VSS - SL patent - ace wrap CDI on (L) AKA - pt. prone x 2° - no c/o pain @ this time - ambulated c̄ crutches during shift [redacted]
14Aug03	VSS - Alert x3. saline lock to (R) FA is patent o/s of infiltration. Pearia 3mm - Lungs: CTA B/L even rhythm - BR - NSR - BS⊕ x4 quads. Radial pulses +3 Pedal (R) +3 - Ace wrap to stump dry and intact. Percocet ii Po given for c/o pain. Restraints to UE & LE in place and secure. [redacted]
15Aug03 0800	Assumed pt care this AM. VSS. SL flushed c̄ no S/S infection, dressing CDI no pain noted. PT rested & ambulated. PC [redacted]
15Aug03 1030	PT complained of ~~diarrhea~~ constipation was given MOM. Later the Translator explained was diarrhea. Advice hold will inform shift change. Pt also very concerned about staples when they will be removed. TOLD 7-10 days was an estimate [redacted]
15Aug03 1120	Cipro held, waiting on Dr to see if can be given po. [redacted]

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03	On the Op Note
8 9/8	Pre-op Dx
	(D) (L) Above Knee Amputation
	Post-op Dx
	Same
	Procedure: Dressing change, skin removed, application of stump cast (D) BKA
	Surgeon [redacted] b6-2
	Assist ∅
	Findings: Wound clean, sutures stable, not yet healed, stump cast applied
	Plan: To OR in 1 week remove stapler.
	b(4)-2 [redacted]
12 Aug 03 1400	assumed care @ 1300 - VSS - SL patent - [redacted] cast intact on (D) AKA, bed flat c heavy blanket on stump to stretch hip flexor - pt. sleeping @ present - no c/o pain - this shift. [redacted] CHAN

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

EPW [redacted]

b(4)-2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

b(6)- 2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug. 2200	Pt. care assumed @ 2100. VSS. HR Reg. Lungs CTA, BS⊕ x4. (L) AKA dsng CDI. JP bulb intact, draining bright red bloody drainage. IV to (L) FA [redacted] flushes ∑ diff. will cont. to monitor. [redacted]
0315	10 cc out per JP serosanguinous drainage. [redacted]
110530 Aug 03	Nursing Assessment: Assumed care of pt, AAOx3. Airway intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender, ∑ distention. BS⊕x4. Voids spontaneously. Motor and neurovascular intact to (B) UE and (B) LE. LLE stump dsg is ACE & gauze, CDI. [redacted] twice folded towel for comfort. IV to (L) FA ∑ s/s infection or infiltration. [redacted]
111230 Aug 03	Nursing Note: 20cc serosang drng from JP drainage. [redacted]
2200	Pt. care assumed @ 2100. VSS. Pt. c/o pain. ii percocet given PO. HR Reg, lungs CTA. BS⊕ x4. (L) AKA dsng CDI, JP drain patent draining scant amt, bright red bloody drainage. IV HL to (L) FA intact, flushes ∑ difficulty. ∅ s/s infection or infiltration. will cont. to monitor. [redacted]
0500	25 cc bloody → serosanguinous drainage per JP. [redacted]
120530 Aug 03	Nursing Assessment: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, BS LS CTA(B). Abd soft, nontender, ∑ distention. BS⊕x4. Voiding spontaneously. Motor and neurovascularly intact to (B) UE and (B) LE. (L) LE has stump ∑ Kerlix/Gauze dsg that is CDI. JP to wound pulls serosang/sanguinous drng. IV to (L) FA flushes well, ∑ s/s infection or infiltration. [redacted]

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Aug03 0945	Orthro Op Note Pre Op Dx - (L) AKA, OPW Post Op Dx - same Procedure - I+D (L) AKA stump Surgeon - [redacted] Findings - some serous drainage. No necrotic tissue. Well clear open. Plan repeat I+D, DPC tomorrow. b(4)-2 All [redacted]
9Aug03 1645	assumed care @ 1300. VSS, T 100.3°F - SL patient dsg intact on (L) AKA, no drainage noted on ace wrap - no c/o pain @ this time - pt. to be NPO p MN tonight for OR in AM [redacted]
10Aug03 0145	Pt care assumed @ 2100. VSS, A+O x3, ∞ percocet given for pain. Lung sounds CTA, bs(+) x4. Dsg on LAKA ✓o1, good ROM. Pt seen by Dr. [redacted], NPO p MN tonight in AM for I+D, and closure of wound. — [redacted] gumco

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

ePW

[redacted]

b(4)-4

RECORDS MAINTAINED AT: ICW2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03 0800	Orthe Op Note Pre Op Dx - (L) AKA Post Op Dx - (L) AKA Procedure I+D (L) AKA DPC of stump Surgeon: [redacted] EBL 50 cc Findings - Clean wound. Closed in layers over drain. b(6)-2 All [redacted]
10 August 03 1000	Pt. back from OR via litter. Dsg ⊥ acc wrap to (L) AKA CDI. HR Regular, Lung sounds clear bilat, bowel sounds (+) x4 quads. Pt. c̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] JT/AN
10Aug03 1900	assumed care @ 1300 - VSS - medicated c̄ tylenol 650mg PO @ 1830, pt. sleeping at present - 75mcg Fentanyl in place on pt's (R) upper back - SL patent - dsg CDI on (L) AKA, JPC 35 cc output, Serosang drainage - xray done of (L) hand as ordered [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	S) AK47 - 11 days ago enter back of upper calf, exit distal to knee Ø PMH
BP 132/64	
P 118	O) 1cm puncture posterior upper calf lg cavitating exit wound prox
R 16	tibia just distal to knee on (L) leg. (R) leg normal. Edema
T 101.7	present (L) foot. Dorsalis Pedis + posterior tibial pulses present &
SPO2 95	strong.
	X Ray (L) leg, tibia just distal to tibial plateau is shattered. (L) arm
Meds	A) GSW (L) upper leg. shown scattered shrapnel from elbow to
1 shot 3 days ago	hand. Ø Fx.
Bacillus 1/2 muscle	P) Pt to holding in waiting for transfer to CSH
Keflex approved	Continue IV fluids
NKA	Ancef 1gm IV q8°. give 2g now
2100	MS 10mg IM place
	Clean & dress wound, place splint
	Notify [redacted] [redacted] 2LT, SP
2107	morphine Inj. 10mg IM B. O'neill 91W
2114	Ancef 2g IV Bag b(6)-2 B. O'neill
	Betadine Scrub brush to (L) leg, clean area. Rotated
	leg applied SAM Splint with Ace bandages to (L) leg,
	Betadine Scrub brush to (L) arm affected areas.

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

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

REGISTER NO. | WARD NO.

EPW

#[redacted]

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

Stitches still app t in wounds. Dressings applied to (L) leg prior to Splinting. Pulses apparent prior to and after splinting Leg.

Spc [redacted] 91 W

2200 IL NS spiked TKO

b(6)-2 Spc [redacted] 91W

[redacted] b(2)-2

NSN 7540-01-075-3788

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY [redacted]
		RECORDS MAINTAINED AT	b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: Dragi

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 7 Aug | TIME: 1250

TRANSPORTATION TO FACILITY

SEX: M

AGE: 29

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

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
IS THIS AN INJURY?			WHERE	TETANUS	
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1250

INITIALS: b(2)-2 [redacted]

VITAL SIGNS

TIME	1250				
BP	129/74				
PULSE	114				
RESP	14				
TEMP	100°				
WT 56 K	99%				

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		
URINE C&S	UA MSCC/CATH		☒ CHEM: MET 8		
☒ BLOOD C&S X					

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	50 Fentanyl [redacted] b(2)-2	1255			
	50mc Antibiotic [redacted]	1300			
	Advice Dr	1300			
	Anuf Tgm [redacted]	1300			

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] EPW

b(2)-2

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

[redacted] b(2)-2

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

29 y/o ♂ sent for unknown PST term. Pt 5/y GSW to (L) prox tib/fib 1 d ago
Unclear hx. Pt c/o L foot/leg
Gun shot last night

Pulse ++ NC
Ø NEURO

O: Alert & oriented in mod distress. VSC
Chest ot/no clear/mt unremarkable
Pelvis stable Abd Soft Chest CTAB Warm T/D sens Ø GT
Ext (L) lower ext: (+) lg open wound prox tib c extensively prox/open fx
↓ sensation to touch/hot/cold/pin ↓ movement (+) edema to thigh

A/P Open fx/GSW prox (L) → Admit b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE [redacted]

PROVIDER SIGNATURE AND STAMP [redacted]

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] EPW
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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO: Ortho

[redacted] Col MC

DATE OF REQUEST 9 Dec 83

REASON FOR REQUEST *(Complaints and findings)*

Gunshot wound Orbital - fracture

b(4)-2

PROVISIONAL DIAGNOSIS

fracture Orbital

DOCTOR'S SIGNATURE [redacted] M

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

b(4)-2

(Continue on reverse side)

SIGNATURE AND TITLE			DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT	
RELATION TO SPONSOR	SPONSOR'S NAME *(Last, first, middle)*	SPONSOR'S ID NUMBER *(SSN or Other)*	
PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.

[redacted]

b(4)-4

CONSULTATION SHEET
Medical Record

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

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
08 Aug 03	1030		Pt alert & oriented lying in bed. HL to (R) AC → patent. AKA covered c Ace wrap, Ø drainage noted. Small, round wound to (R) inner ankle. Some mucoid drainage on old dsg. New dsg applied. VSS, temp 100°, lungs CTA, HRR reg, BS (+), pulses (+) x3. IS given. Given Percocet II for pain. Will call out to [redacted]
8 Aug 03		1300	- Received PT Alert in bed. PT has Temp 101.2. PT has been encouraged to cough + deep breath. also c̄ incentive spirometer use. Gave PT Tylenol 650mg PO. b(6)-2 HRR. BS x4. Lung sounds clear bilateral. (L) leg stump noted drainage. Will notify MD. [redacted]
8 Aug		1730	- MD notified about stump drainage. MD stated to reinforce if drainage per ortho the sheets. Otherwise he will be up after breakfast. [redacted]
9 Aug		0130	Pt care assumed @ 2100. T @ 103.2 at 2130, 650mg Tylenol, blankets taken off. At 2200 T @ 101.2, Ice pack applied, H_2O encouraged. At 2300 T @ 100.1. Other VSS, patient awake and alert 3 c/o pain. Lung sounds CTA, BS+x4. Dsg on LBKA intact, drainage noted to posterior distal portion. IV @ RAC not patent,

(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. ICW

b(6)-4

EPW [redacted]

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

b(4)-2 A11

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9Aug	0130		Restarted in LFA. IV ABX. Pt npo, O/C to OR in AM, will continue to monitor. [redacted] Gillmore
9August03	0830		Pt. awake & alert ∅ complaints. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. VSS, slight temp of 99.9°. HL in (L) FA ∅ s/s of infection, flushed well. Ace wrap ∅ small amt of bright red blood on (L) AKA, site marked ∅ date & time. Pt. ∅ ↑ suture to (L) base of pinky finger. All other assessment findings WNL. Will continue to monitor. [redacted]
	0900		Pt. to OR via litter [redacted]
	1100		Pt. back from OR, PSG to (L) AKA CDL, pt stable [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 03		0430	Pt resting quietly. Orders noted. Transfer to CSH in am [redacted] SPC
7 Aug 03		0645	#18 IV to (R) AC. 1L NS c̄ 1gm Ancef running @ ≈ 200 [redacted] DJG
		1040	Ok to leave [redacted] b(4)-2 A11
		1100	Pt ate part of noon meal [redacted] SPC
		1151	Cont 1000 cc NaCl IV [redacted] SPC

Continue on reverse side

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

[redacted]

EPW

b(4)-4

REGISTER NO.	WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 29

HEIGHT:

WEIGHT: unknown

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

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

4. PROPOSED SURGICAL PROCEDURE: (L) AKA

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ____
Tobacco 3 ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ____ ASA/Motrin w/72 hrs (Y) (N)
ETOH (+) ½ QD Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	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. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	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)

#[redacted]

b(6)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0900 ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

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

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

[redacted]

07AUG03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT (Y)(N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☑ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☑ Moves All Extremities ☑ Moves Upper Extremities BREATHING EASY: (Y)(N)

☐ Transferred to litter with ~~pillow~~ sheet due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Ti[redacted] RN

DATE: 7Aug03 TIME: 1350

13. POSTOPERATIVE EVALUATION PREP[redacted] BY (Signature and Ti[redacted] CRNA

DATE: 07AUG03 TIME: 2212

b(6)-2 A11

MEDICAL RECORD — INTRAOPER DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROO[illegible] VIA Wheeled litter BY MAJ [redacted] MAJ [redacted]

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

3. DATE 07 AUG 03 TIME PATIENT ARRIVED IN ROOM 2020

4. PATIENT IN ROOM TIME 2020 NUMBER 2-6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	CPT [redacted] RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR Bed Head on foam doughnut. Arms ext. out to sides <90° in CAP, secured to padded armboards c safety straps.

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

Soaked towel under (R) heel - LLE prepped into sterile field.

COMMENTS: proper body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☒ NURSING UNIT CPT Holchek

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

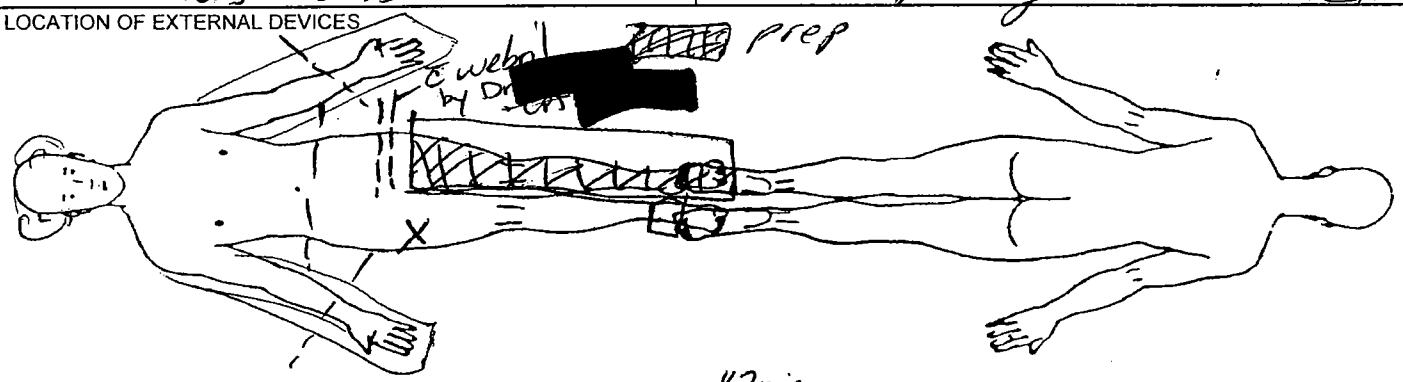
PREP SOLUTION (Specify) Beta/Beta

SITE: LLE (as below) BY WHOM: CPT [redacted]

SITE: BY WHOM:

COMMENTS: no pooling of solution noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet - 42min

b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C		C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C		C	" [redacted]	"
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

[redacted]

b(6)-4

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

☒ ESU NO: 3 SN# [redacted] b6-4

GROUND PAD: BRAND Valleylab REM Polyhesive II

LOT NO: 65706/2004-11

☐ 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): 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. 1 inch penrose	2. N/A	3. N/A
SITE	1. surgical site (L) AKA	2. "	3. "

19. ADDITIONAL INFORMATION

WC IV

Surgeons: [redacted] Anesthesia: MAJ [redacted] Anesthesia Type: Gen/Endotracheal

Dr [redacted] Assist

Bovie Pad site intact pre-op YES ; post-op YES Bovie Settings: Coag/Cut 40/40 Blend-1

Tourniquet site OK post-op

20. OPERATION(S) PERFORMED

(L) AKA, b/w-2 A11

21. PATIENT TRANSFERRED TO ICU 2 TIME 2212 METHOD wheeled litter

22. REGISTERED NURSE SIGNATURE [redacted] /MN

MEDICAL RECORD | **INTRAOPERA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesth.

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted]

3. DATE 9 Aug 03 TIME PATIENT ARRIVED IN SUITE 0900

4. PATIENT IN ROOM TIME 0900 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2 A11

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

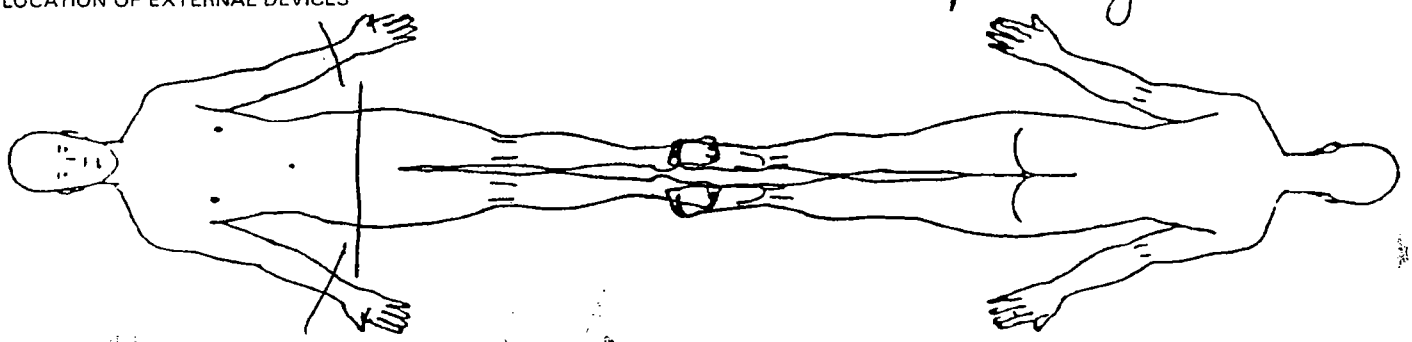
COMMENTS: Body in correct anatomical alignment

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine soap/sol.
SITE: Lt. BY WHOM:
SITE: BY WHOM: LTC [redacted]
COMMENTS: No pooling

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	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No	✓	C	C	Spc [redacted]	LTC [redacted]
Needle Sharp	[X] Yes [ ] No	✓				
Instrument	[ ] Yes [X] No					
Other	[ ] Yes [X] No					

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) [X] YES [ ] NO

[X] ESU NO: Valleylab Force 2 #4
GROUND PAD: BRAND REM polyhesive
LOT NO: 68936

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

[ ] BIPOLAR NO:

cut: 30 coag: 30

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):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

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. moist kerlix x2	2.	3.
SITE	1. Lt. AKA stump wound	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
kerlix roll
ACE

19. ADDITIONAL INFORMATION

DA 5179 In Chart

20. OPERATION(S) PERFORMED

I+D Lt. AKA stump

21. PATIENT TRANSFERRED TO b/w-2 ICU 2 TIME 0945 METHOD Litter

22. [redacted] LTC, AN

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-66, [redacted] Agency [redacted] Office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia (MAJ [redacted])

2. PATIENT [redacted] VIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 10-Aug 03 TIME PATIENT ARRIVED IN SUITE 0715

4. PATIENT IN ROOM [redacted] TIME 0715 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

b(6)-2 A11

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] CRT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure & pad under head. (3) arms on padded arm boards less 90°

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

COMMENTS:

8. SKIN PREPARATION

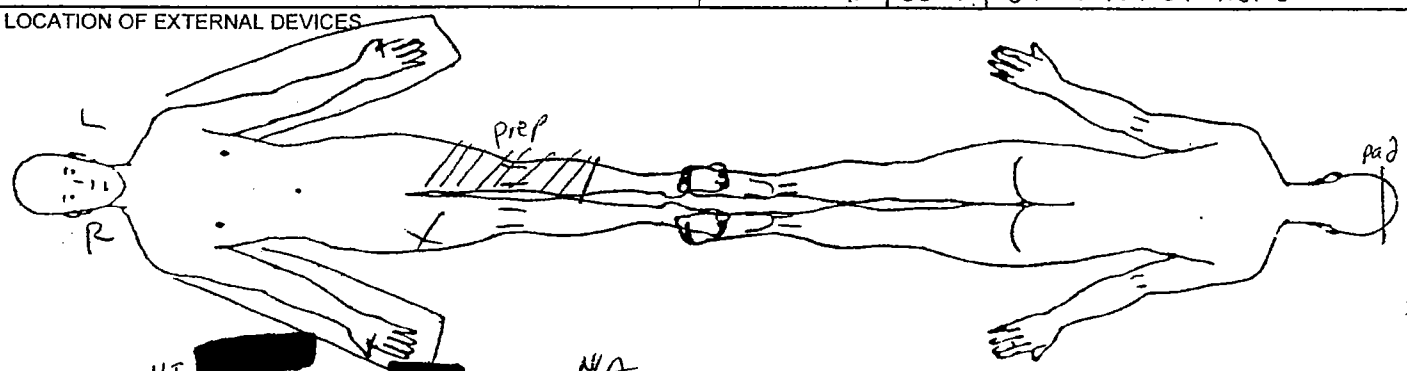
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betn / Betn
SITE: (L) stump BY WHOM: CPT [redacted] AN
SITE: XX see #5 BY WHOM:

COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (1LT [redacted]) -- Safety Strap ([redacted]) N/A === Tourniquet

10. COUNTS — C = Correct I = Incorrect

			initial	First Closing Count	Final Closing Count	SCRUB (1LT [redacted])	CIRCULATOR (PFC [redacted])
Sponge	☒ Yes	☐ No	/	/		PFC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

#[redacted]
ICU-2
b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO NOT USED

☒ ESU NO: #4
GROUND PAD: BRAND Valleylab
LOT NO: 68936/2005-03

☐ 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): 0.9% NACl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

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. Jp 10mm	2.	3.
SITE	1. (L) stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ABD
ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General (EMA)

Bovie Pad site intact pre-op YES; post-op YES Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A: post-op NA
Tourniquet Time: Up N/A Down N/A

b(4)-2 A11

20. OPERATION(S) PERFORMED
I+D (L) AKA c̄ Delayed Primary closure

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2 [redacted]	0830	Litter c̄ O2

22. REC[redacted]D NURSE S[redacted] CPT/An

REVERSE OF DA FORM 5179-1, O[redacted]

USAPA V1.01

b(6)-2 All

MEDICAL RECORD — **INTRAOPERA[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia [redacted]

2. PATIENT IDENTIFIED [redacted]WED AND PROCEDURE VERIFIED BY Sta[redacted] CPT [redacted]

3. DATE 12 Aug 03 TIME PATIENT ARRIVED I[redacted] 0845

4. PATIENT IN ROOM TIME 0845 NUMBER 1-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

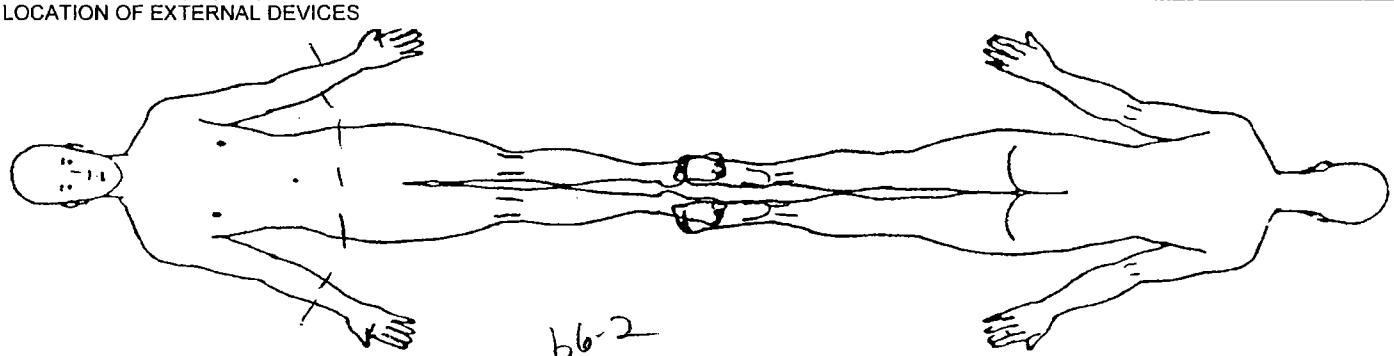
COMMENTS: proper body alignment maintained, arms at less than 90° on padded armboards, position approved by surgeon + anesthesia

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* N/A
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



b6-2

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

C = Correct I = Incorrect

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

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

#[redacted] b(6)-4

ICW2

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

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

☐ 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):

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Webril
Cast
Accuwrap

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: general / mask
b(6)-2

Bovie Pad site intact pre-op_____; post-op_____; Bovie Settings: Coag/Cut N/A
Tourniquet Site intact pre-op _____: post-op_____
Tourniquet Time: Up____ Down_____ N/A

- DA 5179 on chart

20. OPERATION(S) PERFORMED
Drsg. Δ and Stump cast

21. PATIENT TRANSFERRED TO Recovery b(6)-2 | TIME DA7389 | METHOD litter c safety strap in place

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN

REVERSE OF DA FORM [redacted] OCT 87 USAPA V1.01

MEDCOM - 16205

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY																	
MONTH-YEAR	DAY	8-6-03															
19	HOUR	2200															
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°	O															35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD		18															
BLOOD PRESSURE		128															
		78															
HEIGHT:	WEIGHT→																

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

511-112

[redacted] b(6)-4

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

USGPO 1983-381-646/8699

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4				
POST-OP DAY	DOS	1	2	3				
MONTH-YEAR / DAY	7 8	8	9	10	11	12-13	13	14
August 2003 / HOUR								

PULSE (O) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

PULSE (O): 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(a)-4

REGISTER NO.

WARD NO. JCWZ

VITAL SIGNS RECORDS

Medical Record

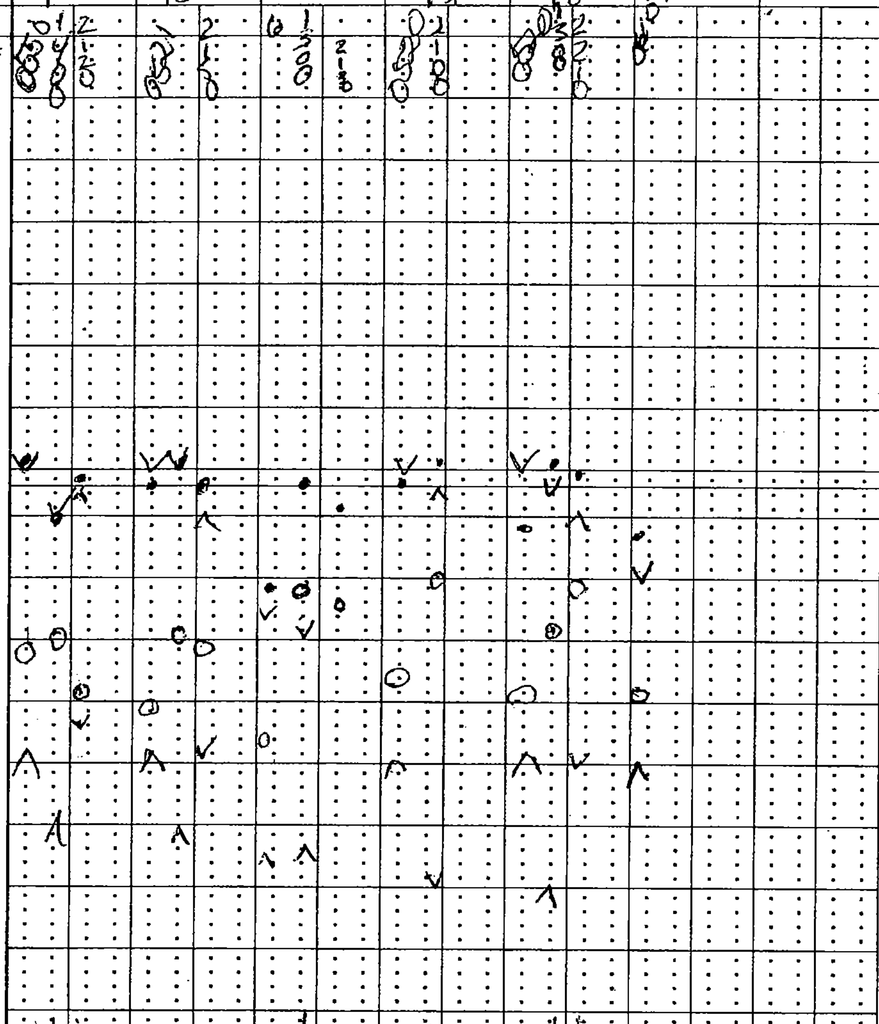
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	8							
POST- DAY								
MONTH-YEAR Aug 2000 — DAY	14	15	16	17	18	19		
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° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 14 16 | 16 | 16 | 18 16 | 14 16 16 | 18

Record special data only when so ordered

	14	15	16	17	18	19
BLOOD PRESSURE	135/80; 128/70	130/82; 120/70	105/65; 100/66; 120/80	130/90	130/82; 126/60	110/80
	98, 100	98, 99	98.6, 100	98, 99	99, 98	97.7
HEIGHT:	WEIGHT →					

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. ICWZ

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

-STAT 6+

Pt: [redacted] b(a)-4

Pt Name:_____

Glu_____94 mg/dL

BUN_____<3 mg/dL

Na_____133 mmol/L

K_____3.3 mmol/L

Cl_____110 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

Sample Type_:

07AUG03 13:15

Oper: [redacted] b6-2

Physician:_____

Ser# 40763

Ver: JAMS046A
CLEW A93

---

b6-4

ID [redacted] 07-08-03
WB 13:07

				Patient Limits	
WBC	13.7	*H	x10^3/uL	4.5	10.5
RBC	3.69	L	x10^6/uL	4.00	6.00
Hgb	10.4	L	g/dL	11.0	18.0
Hct	34.4	L	%	35.0	60.0
MCV	93.1		fL	80.0	99.9
MCH	28.0		pg	27.0	31.0
MCHC	30.1	L	g/dL	33.0	37.0
Plt	635.	H	x10^3/uL	150.	450.
LY%	16.0	*L	%	20.5	51.1
LY#	2.2	*	x10^3/uL	1.2	3.4

Ward/Section: Emf	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4	DATE: 2Aug	TIME: 1255	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: ~~B~~ ANEG

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 27Aug03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
07/08/03 13:03
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100676

GLU	100	73-118	MG/DL
BUN	3*	7-22	MG/DL
CRE	0.4*	0.6-1.2	MG/DL
CK	161	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	105	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/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

b(a)-2

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	7 Aug 03	

b(6)-4

Ward/Section	REQUESTI[redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 8 AUG	TIME: 0400	SSN/F[redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	20.0	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.50	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	35.6	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	93.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	688	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	6.7	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 8 Aug 03	LAB ID NO.:

b(4)-4

Ward/Section: TCW 2	REQUESTING PHYSICIAN: Dr. [redacted] b(4)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 8/13/03 TIME: 11 [illegible]	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

======= PICCOLO =======
13/08/03 11:06
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100676

GLU	93	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	143	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS: b(4)-2

REPORTED BY: [redacted]	DATE: 13Aug03	LAB ID NO.:

b(4)-4

Ward/Section: LC 2	REQUESTING PHYSICIAN: [redacted] b(4)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 8/13/03 TIME: 1100	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted]	**DATE:** 13 Aug 03	**LAB ID NO.:**

b(4)-2

66-4

ID: [redacted] 13-08-03
WB 11:06

				Patient Limits	
WBC	11.7	H	x10^3/uL	4.5	10.5
RBC	4.01		x10^6/uL	4.00	6.00
Hgb	11.6		g/dL	11.0	16.0
Hct	36.9		%	35.0	60.0
MCV	92.1		fL	80.0	99.9
MCH	29.0		pg	27.0	31.0
MCHC	31.5	L	g/dL	33.0	37.0
Plt	828.	H	x10^3/uL	150.	450.
LY%	12.5	*L	%	20.5	51.1
LY#	1.5	*	x10^3/uL	1.2	3.4

MKDA

MEDICAL RECORD - ANESTHES

Fo of this form, see AR 40-66; the proponent agen ne OTSG

procedure verified

DRUG (Units)														
Midazolam (MG)	40													
Fentanyl (UG)	250													
Propofol (MG)	150													
Sux (MG)	100													
MSO4 (MG)			10		2	5	3							
( )														
VOLAT AGENT 150 % del		2.0	2.0	2.0	2.0	2.0	2.0	X						
% e.t.														
AIR L/Min														
N2O L/Min														
O2 L/Min	8	2	2	2	2	2	2	2	8					

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

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

FLUIDS — LINE site L IJ ☑ Warmed; A/C ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

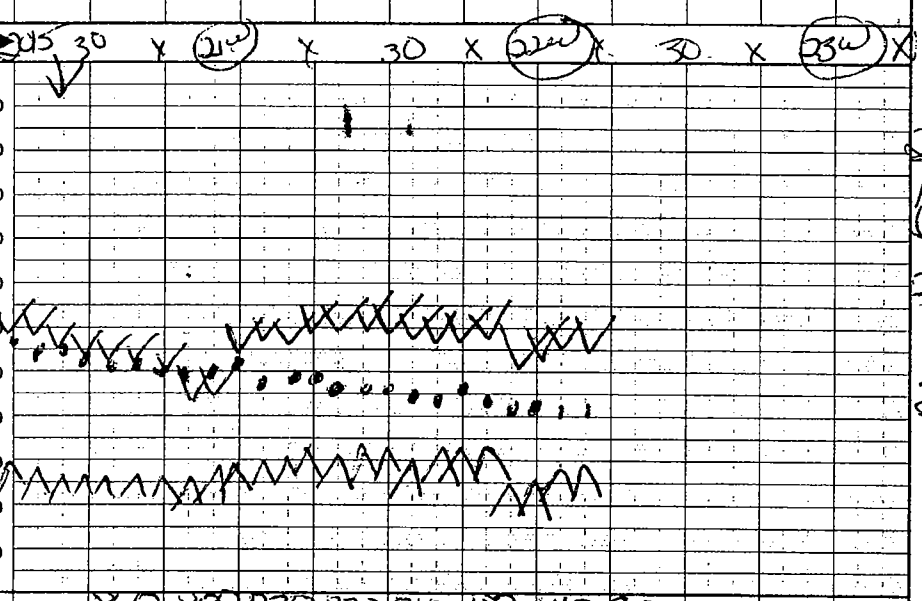
INITIAL DATA: BP- 120/60; HR- 110

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? +; TIME- 2200

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

TIME → 2205 30 X 2210 X 30 X 2220 X 30 X 2230 X



VENTIL									
VT - ml		860	800	730	720	710	180	410	310
f - breaths/min		7	7	6	6	6	13	8	15
Peak inf pres / PEEP		22	22	21	21	21			
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	CV	SV	SV	SV
MONITORS/ACCESSORIES: BP/Auto Cuff — ET CO2 (torr)		32	30	31	30	30	40	42	42
BP/oth — FIO2 (Frac or %)	.87	.87	.87	.87	.87	.87	.85	.85	.85
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	NS	NS	NS	NS	NS	NS	NS	NS	NS
Gas analyzer — TEMP-site	Skin	35	35	35	35	35	35	35	35
N-M Block (T/4)		4/4 ST							
Warming blkt	head wrap / warm blanket								
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → W arms 90 abducted/padded

TOTALS: 2500 MGS; TOTAL EBL: —; TOTAL URINE: 1200 ml

FLUIDS SUMMARY: CRYSTALLOID- UR - 500; COLLOID- —; BLOOD- —

REMARKS (Code drugs with numbers, events with letters): 2000 Pat + ID on ward - MGS place - Chart review Resp dose 2205 - On room monitors on induction/intubation 2203 TRANSFER - 2215 42 11 2212 - Spont resp opened eyes extubated extubated TO ICU

RECOVERY AT: PACU ICU (Specify); OTHER Stable

CONDITION: RESP- 19; SpO2- 93%; BP- 142/78; HR- 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2200	2205	2230
PROC	Ready 2225	Begin 2100	End 2210

PROCEDURES and CPT Codes: (L) AKA

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks (ETA - #8 ad ETT: taped 22 cm teeth #4 NAC. OOT to the tube ETS taped - soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Dx + T Difficult intubation - RST - GL view. ETT easily passed. BBS(+)/CTA. Atraumatic CO (A)B3

SURGEON [redacted] b(6)-2

ANES [redacted]

PROCEDURE LOCATION: #2

DATE: 17 AUG 05

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG	(Units)																		
phenergan	(mg)	25																	
MSO4	(mg)	5/1	4																
propofol	(mg)		150																
SUX	(mg)		100																
	( )																		
	( )																		
VOLAT AGENT: Iso	% del		1.5	2.0	1.0														
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	6	2	2	2	6													

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (1)(2) (3)

FLUIDS

LINE site			
20g LFA	☐ Warmed	LR	300
	☐ Warmed		
	☐ Warmed		
	☐ Warmed		

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

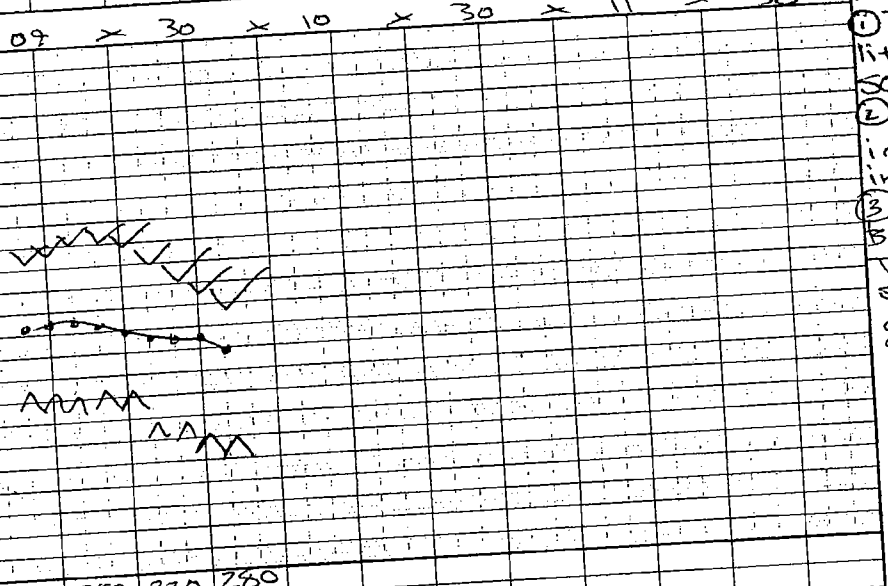
HEMATOCRIT: 35.6

INITIAL DATA: BP- 146/88; HR- 112

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE (Y); TIME- 0845

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



VENTIL

	0930	1030	1130
VT - ml	600	250	320	280
f - breaths/min	16	17	17	20
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

		0930	1030	1130	
BP/Auto Cuff	ET CO2 (torr)	44	38	37	48
BP/oth	FIO2 (Frac or %)	0.8	0.8	0.8	0.8
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST
Gas analyzer	TEMP-site skin	96	96	96	96
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

TOTALS	TOTAL EBL
10	min
	TOTAL URINE
	Ø

FLUIDS SUMMARY: CRYSTALLOID- 500; COLLOID- Ø; BLOOD- Ø

REMARKS

Code drugs with numbers, events with lettters

No Δ in pt status since prior anesthetic. char ✓. OK to proceed c̄ GETA.
(1) To room via litter, preO2, SOC monitors
(2) Smooth IV induction & intubation.
(3) Suctioned & extubated. To recovery stable, report given.

RECOVERY AT: PACU (ICU) (Specify); OTHER

CONDITION: RESP- 10 SpO2- 95; BP- 120/67 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0845	0855	0935
	Ready	Begin	End
PROC	0905	0917	0930

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

PROCEDURES and CPT Codes: I&D L AKA Stump

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

EPW #[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

Eyes taped. 2 miller DL x1 trauma, ⊕ ETCO2 BSEB. Secured 22cm @ teeth.

SURGEONS: [redacted] b(6)-2

AN[redacted]MAT CRNA

[redacted]ATIENT'S MEDICAL RECORD

PROCEDURE LOCATION: 1-1

DATE: 8/9/03

PAGE 1 OF 1

USAPA V1

DA FORM 7389, FEB 1998 MEDCOM - 16217

removed

29 Jul 04

NKDA

29yo - ⊖ 1- since 7 AUG 03

NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
MSO4	(mo)	<6> 2 2
propofol	(mo)	<200>
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT	150 % del	2 - 2 - 2 - 2 - 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 2 - 2 - 2 - 2 - 2 - 8

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

FLUIDS

LINE site		
#1 (D)	☐ Warmed	UR
PIC	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE -

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 70 (KG) LB

HEMATOCRIT

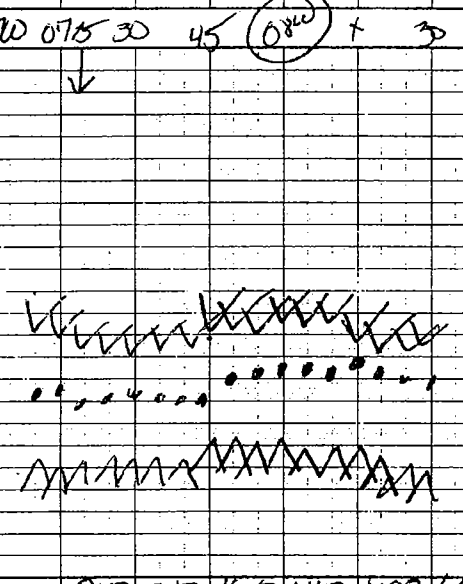
INITIAL DATA BP- 120/60 HR- 102

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? (+) TIME- 0700

TIME 0700 0715 30 45 (0800) + 30 +

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



VENTIL

VT - ml		210	210	160	410	490	460
f - breaths/min		10	6	6	9	6	8
Peak inf pres / PEEP		—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	SV	SV	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		41	50	50	55	53	48
BP/oth	FIO2 (Frac or %)	.64	.64	.64	.64	.63	.64	.64
ART line	SpO2 (%)	99	99	99	99	99	99	99
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS
Gas analyzer	TEMP-site	Skin		35	35	35	35	X
	N-M Block (T/4)							
Warming blkt	wool blanket/head wrap							
Conv warmer								

97

Mark with letters & symbols, explain under REMARKS — EVENTS Position → cl — arms ≤ 90 abducted / padded.

TOTALS 1000 — **TOTAL EBL** min — **TOTAL URINE**

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

REMARKS — Code drugs with numbers, events with letters

0700 Mot/10d
Procedure verified
Prep done
Chart reviewed
0710 - Dr Nam → monitors on
0730 spontaneous opened eyes
LMA D/C
To ICU for recovery

RECOVERY AT PACU (ICU) ____ (Specify) OTHER stable

CONDITION: RESP- 10 SpO2- 99% BP- 149/8 HR- 96

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0700	0710	0845
PROC	Ready	Begin	End
	0700	0740	0825

PROCEDURES and CPT Codes: D-D (LAKA / DPC

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

#[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks General/LMA

20" in cuff → Eyes taped. Soft tube block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Preox → LMA #4 inserted x1 attempt → atraumatic.

SURGEONS: [redacted] b(6)-2

ANES: [redacted] b(6)-2

PROCEDURE# / LOCATION: / DATE: 10 AUG 03 PAGE 1 OF 1

Versed 2mg
fentanyl 100mcg > pre-op

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Versed	(mg)	1
fentanyl	(mcg)	50
propofol	(mg)	150
	( )	
	( )	
	( )	
VOLAT AGENT ISO	% del	2 off
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6-3-3 off

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

FLUIDS

LINE site		
LR	☐ Warmed	300
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE -

PHYS STATUS 1/2/3 4 5 E

BODY WEIGHT 70 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP- 109/55 HR- 93

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0843

TIME → 0845 0900X

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

VENTIL

VT - ml	SV	680
f - breaths/min	TO	10
Peak inf pres / PEEP		
MODE - S(pon), A(ssist), C(on)	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	45
BP/oth	FIO2 (Frac or %)	.89	.8
ART line	SpO2 (%)	100	100
Steth- PC/ES	ECG	SR	SR
Gas analyzer	TEMP-site	Available	
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

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

TOTALS Versed 3mg, fentanyl 150mcg

TOTAL EBL ∅

TOTAL URINE ∅

FLUIDS - SUMMARY
CRYSTALLOID- 300ml
COLLOID- ∅
BLOOD- ∅

REMARKS
Code drugs with numbers, events with letters.
Pt ID'd - to OR. Monitoring.

Pt taken to PACU in stable condition. Report given

RECOVERY AT PACU ICU ____ (Specify) OTHER ____
CONDITION: Stable, Ala
RESP- 18 SpO2- 100
BP- 117/70 HR- 117

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0843	0910
	Ready	Begin	End
PROC	0847	0853	0908

PROCEDURES and CPT Codes: Dressing Δ / Stump Cast to (L)

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Mask GA

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

SURGEO[redacted] b(6)-2

ANESTH[redacted] MD

PROCEDURE LOCATION: 1

DATE: 12 AUG 03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

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

PROPOSED PROCEDURE: GSW (L) LEG
SURGICAL SERVICE: ORTHO
NPO SINCE: 10 Am

HABITS:
TOBACCO: Smoker
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: ____

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

(+)

PHYSICAL EXAMINATION
BP ____ HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth Poor Dentition
Trachea Mid Line
TMJ/Neck 3(+)
Oropharnyx MP 2
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 10 Am Nov 14/35

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {1} 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. b(4)-2

The patient/[redacted] stand and agrees. Questions answered.
Signed: [redacted] Date: 07 Aug 03 Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICW2 / ICU2

#[redacted] b(4)-4

SEDATION KEY:

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

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: 7 Jul 04 TIME OF ORDER: 1320 HOURS

LIST TIME ORDER NOTED AND SIGN

1. admit to ICW-2
2. Dx: OPLL, [illegible] (L) [illegible] following
3. Condition: stable
4. VS: routine
5. NPO

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER:

6. Bed rest _____ HOURS
7. IV: LR at 125 cc/hr
8. Ancef 1 Gram IVPB q 8 hrs
9. MSO4 2-6 mg IVPB q 2 hrs
10. To OR today

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 7 Jul 04 TI[redacted] 2210 HOURS

b(6)-2

1. To ICW-2 ✓
2. S/P (L) above knee amputation ✓
3. Condition: stable ✓
4. VS: routine ✓
5. Bed rest, role phone q 2 hrs ✓
6. Regular diet ✓
7. IV: LR at 125 cc/hr, heparin lock [illegible] ✓

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

Take PO when ✓ HOURS

8. CBC in AM ✓
9. Ancef 1 Gram IVPB q 8 hrs ✓ (8,16,24)
10. Ciprofloxacin 400 mg IVPB q 12 hrs ✓ (10,22)
11. Percocet 1-2 tabs PO q 4-6 hrs prn ✓
12. MSO4 - 4-8 mg IVP q 2 hrs prn ✓
13. Tylenol 650 mg PO q 4 hrs prn ✓
14. Fentanyl patch 75 mg now ✓ [redacted]

038

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 [illegible] [redacted]

[redacted]

b(6)-2

☆ U.S. G[illegible] MEDCOM - 16221 3-710

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(4)-4

NURSING UNIT: 1 CWD | ROOM NO.: | BED NO.: 24 V/S

DATE OF ORDER: 8 AUG 03 | TIME OF ORDER: 2120 HOURS

(1) NPO AFTER MIDNIGHT
(2) TO OR IN AM

b(4)-2 [redacted]

0130 9 Aug [redacted]

LIST TIME ORDER NOTED AND SIGNED: [redacted] noted 9 Aug 03 0130

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: 1 CWD | ROOM NO.: | BED NO.: 24 V/S

DATE OF ORDER: 9 AUG 03 | TIME OF ORDER: 0940 HOURS

(1) RESUME PRENATAL ORDERS
(2) RESUME DIET, NPO AFTER MIDNIGHT
(3) IV - LR AT 125 cc/hr, HEP LOCK WHEN TOLERATING P.O. WELL
(4) TO OR IN A.M. 10 AUG 03
(5) REINFORCE DRESSING [redacted]

b(4)-2 noted 9 Aug 1100

0145 10 August 03 [redacted] TIME OF ORDER [redacted] b(4)-2

PATIENT IDENTIFICATION

EPW

[redacted]

b(4)-4

NURSING UNIT: | ROOM NO.: | BED NO.: [redacted] 10 Aug 1230

10 AUG 03 0823

(1) RESUME PRENATAL ORDERS
(2) RESUME DIET
(3) N LR AT 125 cc/hr, HEP LOCK WHEN TOLERATING P.O. WELL
(4) EMPTY GO RECTUM DRAIN Q SHIFT
(5) (L) HAND AP, LAT, OBLIQUE [redacted] X-RAY, TODAY

b(4)-2

b(4)-2 noted

PATIENT IDENTIFICATION

[redacted]

[redacted]

0038

NURSING UNIT: | ROOM NO.: | BED NO.: 24 V/S [redacted] 8/10/03 2200

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: EPW [redacted]

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 8/12 | TIME OF ORDER: 0630 HOURS | LIST TIME ORDER NOTED AND SIGN

NPO for OR today.

V. on Dr. Albert [redacted] LGAW

[redacted] b(4)-2

PATIENT IDENTIFICATION: EPW [redacted] b(4)-4

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 8/12/03 | TIME OF ORDER: 0908 HOURS

1. [illegible] [redacted]
2. [illegible]
3. N-2h st [illegible] [illegible] LGAW
   [illegible] 121030
4. Drain D/C'd [redacted]

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 8

DATE OF ORDER: 8/13/03 | TIME [redacted] HOURS | b(4)-2 [redacted]

1. CBC, & [illegible] 8 [illegible]

[redacted]

2 [illegible] [redacted] [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 8/15/03 | TIME OF ORDER: 0830 HOURS | b(4)-2

1. Mom 30cc PO x 1 Now
   Again in 2hrs and then
   PRN constipation
2. Colace 1 PO BID

[redacted]

038

NURSING UNIT | ROOM NO. | BED NO.

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

b(6)-2 A11

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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	CLINICAL RECORD NOTED AND SIGNATURE
EPW [redacted]	ICW#2		8	8/5/03	HOURS	Noted [redacted]
				- D/L IV Ars λ ✓		
				- Start Cipro 500 mg po BID		
				- Ambien 5 mg po q HS		
				[redacted]		15/145
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
EPW [redacted]	ICW2		8	8/15/03	1613 HOURS	noted [redacted]
				repeat order		
				(1) AMBIEN 10 mg PO Q 4 S PRN INSOMNIA		1650
				(2) KADIAN 60 PO - PRN		
				[redacted]		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
EPW [redacted]	ICW2		8	24 VS [redacted]	ADE 174 N HOURS	2331 8/15/03
				8/18/03	1400	noted
				(1) STUMP WRAPPING BY [redacted] PATIENT Q 2 HOURS		1440
				(2) INSTRUCT TO CPW CARE INSTRUCTIONS		
				(3) CLAVIL 75 mg P.O. Q [redacted]		
				24 VS 0130	19 Aug [redacted]	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF [redacted] HOURS	

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

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12	13	14	15	16	17	18	19	20
7Aug	[redacted]	VS routine	05	[redacted]													
			13														
			21														
7Aug	[redacted]	NPO	06	D/C													
			12														
			17	AW													
7Aug	[redacted]	Activity: bedrest Roll Prone Q 2 hr	05	[redacted]													
			13	AW													
			21	CM													
7Aug	[redacted]	Regular Diet	07	[redacted]													
			12														
			17														
9Aug	[redacted]	Reinforce DSG PRN	06	[redacted]													
			14														
			22														
10Aug	[redacted]	Empty JP drain Q Shift	06	[redacted]													
			14														
			22														
18 RSAUG	[redacted]	Stump wrapping 92° by pt.	05	[redacted]													
			13														
			21														

D/C [redacted] 19Aug5

D/C 12Aug03

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) post tib/fib/S/P (2) AKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW# [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

DCW-2 - A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7Aug	[redacted]	Admit to ICW2	7Aug		1430	[redacted]
7Aug	[redacted]	To OR today	7Aug		Done	[redacted]
7Aug	[redacted]	Admit to ICW2 Condition stable	7Aug		Done	[redacted]
7Aug	[redacted]	CBC in AM	8Aug	0400	Done	[redacted]
8Aug	[redacted]	NPO p̄ midnight, OR in AM	9Aug	0001	Done	[redacted]
9Aug	[redacted]	NPO p̄ MN, to OR in AM 10Aug03	10Aug	0000	0700	[redacted]
10Aug	[redacted]	Hand AP, LAT, oblique xray today	10Aug	today		[redacted]
12	[redacted]	NPO for OR today	12	Now	0230	[redacted]
12	[redacted]	Resume Previous orders	12	Now		[redacted]
13	[redacted]	CBC & MET 8	13/P	1100	1100	[redacted]
15 Aug	[redacted]	MOM 30mL PO now and again in 2hrs	15 Aug	0830	0830	[redacted]
18	[redacted]	discharge to EPW camp 19Aug	19Aug			[redacted]
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/6	8/7												
8-6-03	[redacted]	Ancef 1Gm IV Q8h	[redacted]		[redacted]												
[redacted]			14														
		b(a)-2	20		[redacted]												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(a)-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 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6-Aug		Morphine Sulfate 10mg IM	6-Aug	2107	2107	[redacted] b(6)-7

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

☆ U.S.G.P.O.: 1985 - 491-003/43119

b(4)-2 All

CLINICAL RECORD

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

Mo. 8 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	13	14	15	16	17	18	19	20
7 Aug	[redacted]	LR @ 125 cc/hr	00	/	[redacted]												
12 Aug	[redacted]	(HL) when taking PO	13														
			21														
7 Aug	[redacted]	Ancef 1 gm IVPB q8°	08														
			14														
			22														
8 Aug	[redacted]	Ancef 1 gm IVPB q8°	08														
			16														
			22														
7 Aug	[redacted]	Ciprofloxacin 400mg IVPB Q12°	10														
			22														
15 AUG	[redacted]	COLACE PO bid	10														
			22														
15 Aug	[redacted]	Cipro 500 mg PO BID	10														
			22														
15	[redacted]	Ambien 5 mg PO qHS	22														
18	[redacted]	elavil 75 mg PO qhs	22														

DC'd 15 Aug 03 [redacted]

DC'd 15 Aug 03 [redacted]

DC [redacted] 19 Aug

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Grow Posterior (L) tibofib/ S/P (L) AKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW [redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	PRN ~~RECURRING MEDICATIONS, DOSE, FREQUENCY~~	HR	DATE DISPENSED
7Aug	[redacted]	MSO4 2-6mg IVPB q20° prn		
7Aug	[redacted]	Percocet 1-2 tabs PO q4-6° PRN		10 Aug 0800 [redacted]
7Aug	[redacted]	Tylenol 650mg PO q4° PRN		10Aug 1830 12Aug 1745 [redacted]
15	[redacted]	MOM 30cc prn constipation		
15	[redacted]	Kaopectate PO PRN-diarrhea		
7Aug	[redacted]	Percocet 1-2 tabs PO, 4-6° prn		[redacted]
		one Time Orders Medications		
7Aug	[redacted]	75ug/h Fentanyl Patch x1 now		Time Done 0240 8Aug05

DIC [redacted] 19Aug8

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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: 07 Aug 03
Time In: 2215
Allergies: NKDA
Pre-op V/S: 20/60
Procedures: (R) AKA

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

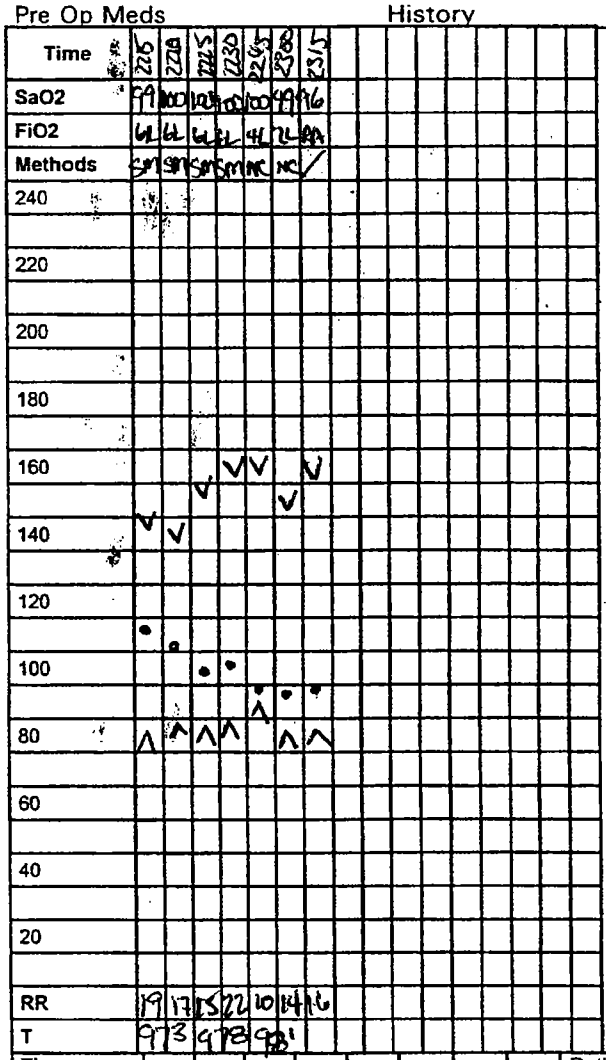
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 0 EBL minimal
Meds/Times: 20mg MSO4, 250mg fentanyl

Drains		Airway
Hemovac	1	Nasal
NG		Oral
JP		ETT
T-tube		Trach
Foley		Other
TLS		
penrose		

Pre Op Meds

History

Time	2215	2220	2225	2230	2245	2300	2315
SaO2	99	100	100	100	100	99	96
FiO2	4L	4L	4L	4L	4L	4L	RA
Methods	SM	SM	SM	SM	MK	NC	✓



RR	19	17	15	22	10	14	16
T	97.3	97.8	98				

Time								
Pain (0-10)								
LOS								

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
2215	LR	200 g	(L) AC	[redacted]	100cc
				b6-2	

X-rays: [redacted] 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	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	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

PREPARED BY (Signature & Title): [redacted] CRT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 07 Aug 03

PATIENT'S IDENTIFICATION [redacted] give: Name – last, first, middle; grade; date; hospital or medical facility) b(6)-2

EPW

[redacted] b(6)-4

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

b(4)-2 All

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		[redacted]				

None

NEUROVASCULAR

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

[redacted]

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

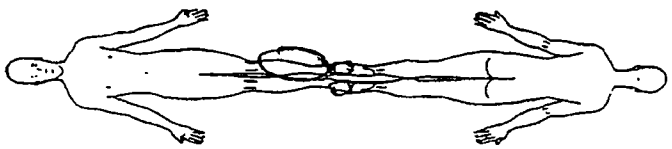
C-SECTIONS

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

[redacted]

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) LE	CDI	Ø
30'	(R) LE	Ace	CDI
60'	(R) LE	ACE	CDI
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2315	Ø	—	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

[redacted]

WAMC OP 173-E

NURSING NOTES

Admitted to ICU2 - PACU @ 2315, recovered on letter. O2 weaned off, sats > 95% RA, resp even unlabored. Awakens to voice touch. Follows commands. HR/BP stable, pulses palpable, DSG CDI. Ø c/o pain @ this time. 18g IV in (R) AC c LR @ 100 cc/o. new bag @ 2300. Report given to ICU2. [redacted]

* CIPRO 400mg IV given @ 0315

Discharge Criteria:
Date: 7 AUG **Time:** 2315 **PARS:** 9
BP: 1:98' **HR:** 94 **RR:** 15 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 100 cryst **Output:** Ø
Additional Data: DSG CDI
Transferred To: ICU2
Report Given To: [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted] CP7 (RN)

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: 9 Aug 03
Time In: 0945
Allergies: NKDA
Pre-op V/S:
Procedures: Stump wash out

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 LR Colloid
OR Output: UOP Ø EBL Minimal
Meds/Times:

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

Pre Op Meds History

Time	0945	0950	0955	1000	1015	1030
SaO2	95	95	94	95	97	97
FiO2						
Methods	NA	NA	NA	NA	NA	NA
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	23	19	15	13	13	11
T	98				100	

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

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	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	12	12

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

PREPARED BY (Signature & Title) b(6)-2 [redacted] 9 Aug 03

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 9 Aug 03

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

EPW [redacted] b(6)-4
29 4/0

☐ 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

b(w)-2A11

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		N/A				

NEUROVASCULAR

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

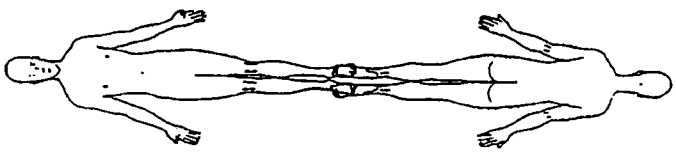
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(2) stump	Ace wrap	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

(0945) pt to ICU 3 for recovery from surgery VSS SpO2 95% on Room Air [redacted]
(0955) pt drowsy due to Phenergan given prior to xfer to ICU 3. VSS [redacted]
(1015) pt awake and audible VSS [redacted] Gurney
(1030) pt VSS, SpO2 97 on room air will be transfered to ICU 2 [redacted] Gurney

Discharge Criteria:
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:_____

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: 10 AUG 03
Time In: 0930
Allergies: NKDA
Pre-op V/S: 120/60
Procedures: Dx DCLOAKA DPC

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block LMA
OR Intake: Crystalloid LR-500 Colloid —
OR Output: UOP — EBL pmi
Meds/Times:

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

Pre Op Meds History

Time															
SaO2															
FiO2															
Methods															
240															
220															
200															
180															
160															
140	✓		✓	✓	✓	✓	✓	✓							
120		✓													
	•	•	•			•	•	•							
100				•	•										
80	^			^		^	^	^							
		^	^		^										
60															
40															
20															
RR															
T	97					97									
Time	1034														
Pain (0-10)	0		0												
LOS															

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

Pacu Intake b(4)-2

Time	Solution	Amount	Site	[redacted]	Infused
0844	LR	700	RFA	[redacted]	300

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes
AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
" = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU-2

DATE: 10 Aug 03

PA[redacted] (first [redacted] grade; date; hospital or medical facility) Name — last, b(4)-2

[redacted] b(4)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

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

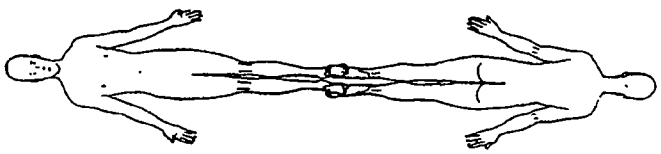
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	[illegible]	[illegible]	0
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0847	HAV		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0	Tachy	no	0

WAMC OP 173-E

NURSING NOTES

0840. Received from OR on stretcher. Report given [redacted] 0855 VSS. 0 distress. Assisted to bedside. Pt states he wants to smoke. [redacted] 0940 pt transferred to 1102. Report given [redacted] 0945 VSS. 0 distress. Moved [redacted]

b(6)-2
A11

Discharge Criteria:
Date: [illegible] Time: 0940 PARS: 10
BP: [illegible] HR: 60 RR: 18 Sa02: 99
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data:
Transferred To: 1102
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Rec[redacted]
Charge Nurse Signat[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 12 Aug 03
Time In: 0915
Allergies: NKA
Pre-op V/S:
Procedures: Arg A. + Stump

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

OR Intake: Crystalloid 300 cc Colloid
OR Output: UOP Ø EBL minimal
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds / History

Time															
SaO2															
FiO2															
Methods															
240															
220															
200															
180															
160															
140															
120															
100															
80															
60															
40															
20															
RR	15	14	11	15											
T															
Time															
Pain (0-10)															
LOS															

17/80
114
99
15

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	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	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)

PREPARED BY (Signature & Title) [redacted] CPT/Dr

b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 12 Aug 03

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

b(6)-2

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

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

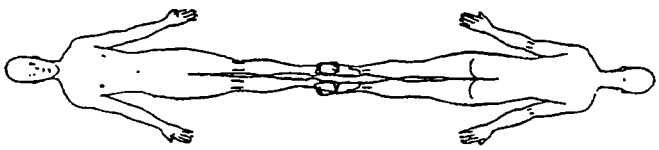
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Ostomy	gauze	none
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt arrived from OR via gurney drowsy but arousable. ; VS stable T sats 100% on RA. Dsg [redacted] BKA C/D, + Intact. Pt stable. Alert. TX to [redacted] ambulatory

b(6)-2
A 11

Discharge Criteria:
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 AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	29 Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1320	—

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 8 1 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 8 Ø 7

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

FOR LOCAL USE

GSW (L) rib/fib → (L) AKA

DX-8972
E9912
T-1
I-450
PR-8417
8622

b(u)-2

ADMITTING OFFICE [redacted]

[redacted] ERK

DA FORM 3985 MAR 89

MEDCOM - 16239

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted]			3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE 46	6. RACE UNK	7. RELIG UNK	NA / NA	10. PREVIOUS ADMISSION NO
11. FOR 99	12. SSN [redacted]	13. ORGANIZATION NA			14. WARD IQ2
15. SERVICE STATUS NA	16. CSG	17. USA/FMF EEN NA	18. BRANCH/CORPS NA	19. UIC/ZIP b(6)-4	20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM EMT			22. HOURS OF ADMISSION 2010	23. CLINIC SERVICE AEAA	25 [redacted]
24. NAME RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 25 AUG 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 07 AUG 03	ADMITTING OFFICER b(6)-2 OR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INITIAL ADMISSION	32. COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW TO (L) LOWER FEMUR

(L) FEMUR FX

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LW/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	18	18

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LW/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0 b(6)-2	0	18	18

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] Dr [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] Capt [redacted]

DA FORM 3647, MAY 75 EDITION OF 1 AUG 75 IS OBSOLETE USAPPC V